‘Getting to 10’:
Successfully Transitioning to ICD-10

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About the Speaker

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As National Director of Government Affairs, Adele Allison monitors healthcare reform for Greenway, a leading provider of interoperability solutions that improve the delivery of healthcare and clinical, financial and patient health outcomes.

Currently the co-chair of the ONC Beacon-EHR Vendor Affinity Group, Allison has more than 25 years of healthcare experience and has been the guest speaker at dozens of national events, sharing her expertise on population management, big data analytics, PCMH, Meaningful Use, ACOs, ICD-10 and other topics.

A published author, Allison is a member of the University of Alabama at Birmingham (UAB) advisory board on curriculum development and previously served on UAB's HITECH Committee for HIT curriculum development.

The ICD-10 Changeover

- **Regulatory Foundation and Governance**
- Overview of ICD-10
- Understanding the Challenges
- Action Items and Planning
- Greenway and ICD-10
- Questions

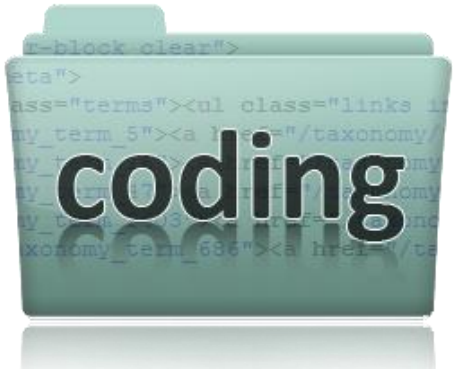
Poll: Let's Get Started…

My Provider has/is (select all that apply):

- Planning to purchase new CEHRT in the next 12 months
- Actively implementing CEHRT for MU
- Performed Stage 1 MU
- Part of an Accountable Care Organization
- Uses CEHRT provided by a Hospital or Health System

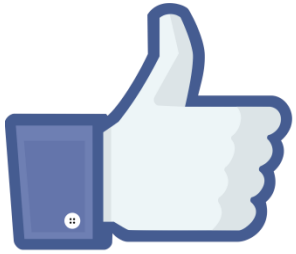
The Quest for Data – *How'd we get here?*

- **1890s –** French Statistician Jacque Bertillon
- **1990 –** WHO endorses ICD-10
- **2002 –** ICD-10 published in **42** languages
- **2009 –** 2 HHS final rules → **"5010 Rules"**
- **2012 –** Policy shift – Oct. 1, 2014 Compliance
- **2013 –** Healthcare data in the U.S. today
  - U.S. only industrialized nation not using ICD-10
  - Standardized answers to **2** questions:
    - **What did you do?** → Procedure Code
    - **Why did you do it?** → Diagnosis Code → ICD-9
- More than **14,000** ICD-9 codes vs. more than **69,000** ICD-10



To Change or Not to Change

- **"Pro-Changeover" → AHIMA** and **HIMSS**
  - Greater coding accuracy and specificity
  - More data to measure quality, safety and security
  - Improved efficiencies, lower costs and reduced coding errors
  - Alignment with worldwide coding systems
  - Improved patient experience and elimination of waste
  - Compliments goals of Meaningful Use
- **"Anti-Changeover" → AMA, MGMA** and **82 Provider Organizations**
  - Too burdensome, especially on small practices
  - Too costly for physicians
    - Estimates implementation costs from $83,290 (solo) to $250,000 (5-10 MDs) to $2.7 million
    - High risk of payment delay
  - Disruptive to physician health IT adoption efforts



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Poll: Are You Ready?

Which best describes your practice's state of readiness for ICD-10?

- We've done very little to prepare
- Behind, but beginning to focus
- On track for a smooth transition
- Ahead of the recommended timeline

ICD-10 Changeover Basics

- Effective Date ⟶ **October 1, 2014**
- Transition requires both ICD-9 and ICD-10
  - DOS < October 1, 2014 ⟶ **ICD-9**
  - DOS = October 1, 2014 or > ⟶ **ICD-10**
- CMS **CANNOT** process ICD-10 claims pre-changeover
- Does **NOT** affect CPT coding
- Applies to **ALL** HIPAA-covered entities
- **Medicare** is on track – Internal testing
- **Medicaid** – CMS monitoring

Significant Changes with ICD-10

- **Expanded** codes
- Added **code extensions** for injuries and external causes of injuries
- Added **Trimester** to OB codes
- **Significant revisions** to DM codes
- **Laterality** creates unique codes
- **Structural** differences in codes

ICD-10 Changeover Basics

- **ICD-10-CM** *(Clinical Modification)*
  - Morbidity classification and diagnostics specificity
  - **69,000+** codes that align with practice in the U.S.
  - Developed by CDC and NCHS for **outpatient** coding/reporting
- **ICD-10-PCS** *(Procedural Classification System)*
  - Completely separate from ICD-10-CM
  - **82,000** codes for use only in U.S. **inpatient**/hospital settings
  - Developed by CMS and 3M Health Information Mgmt.

The Side-by-Side

ICD-9-CM

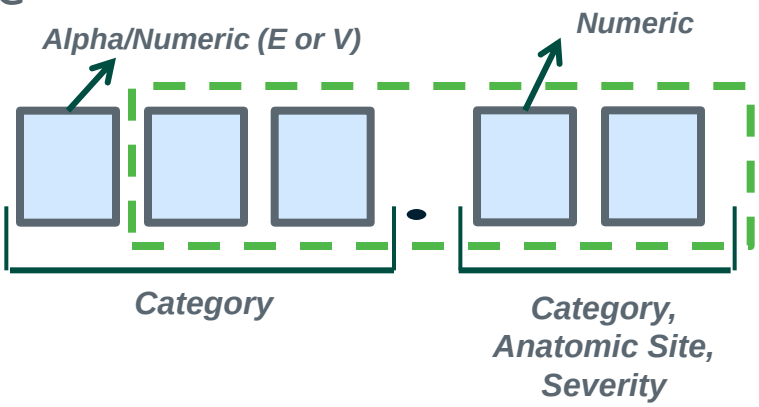
- Maintained by the National Center for Health Statistics (NCHS)
- **14,315** Codes
- **3-5** Characters
- First Character = **#, E, V**

ICD-10-CM

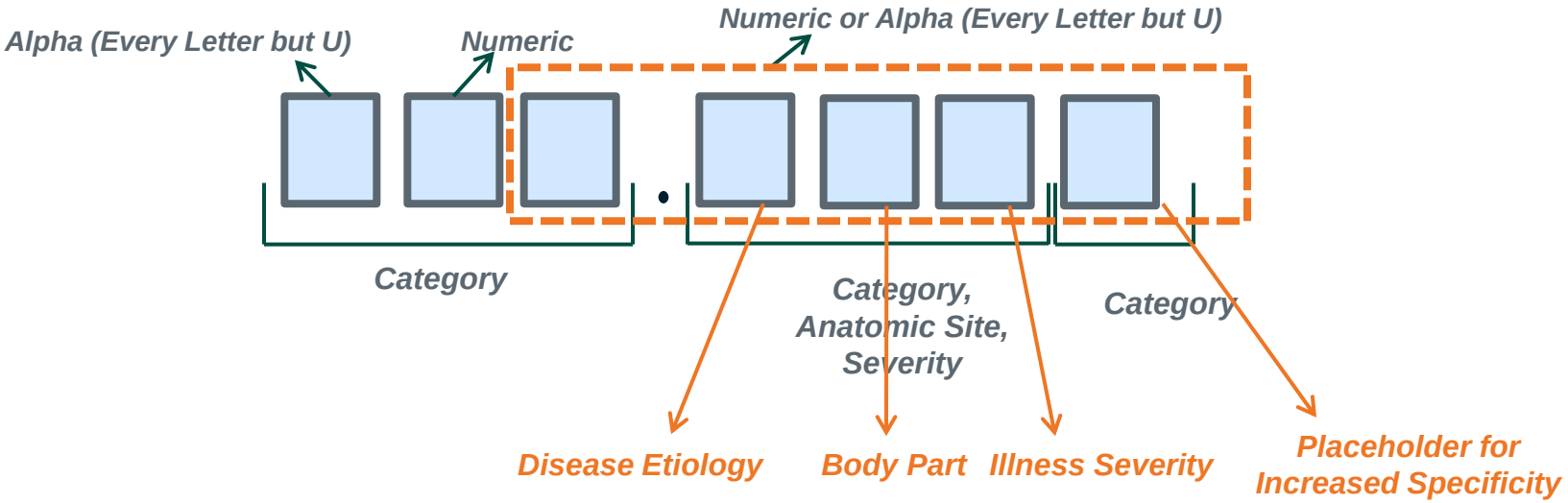
- Maintained by NCHS
- **69,835** Codes
- **3-7** Characters
- First Character = **Alpha – all letters except U**
- 7th Character for injury/external causes by **initial, subsequent** or **sequela**
- **50%** - Musculoskeletal
- **25%** - Fracture-related
- **36%** - Distinguish right/left

Overview of ICD-10

- **ICD-9** Structure



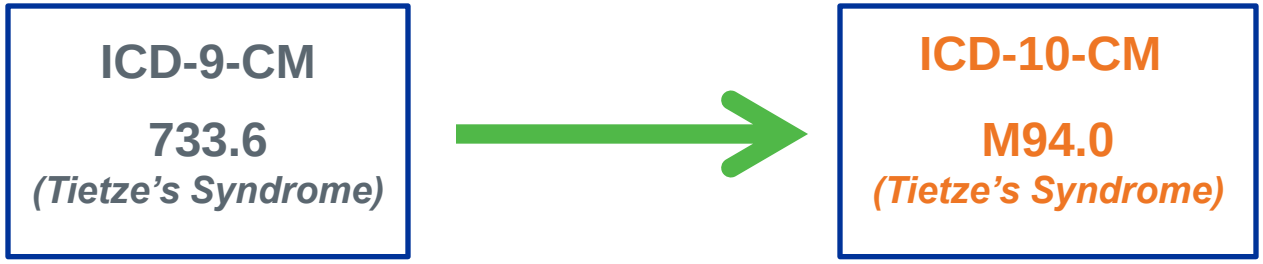
- **ICD-10** Structure



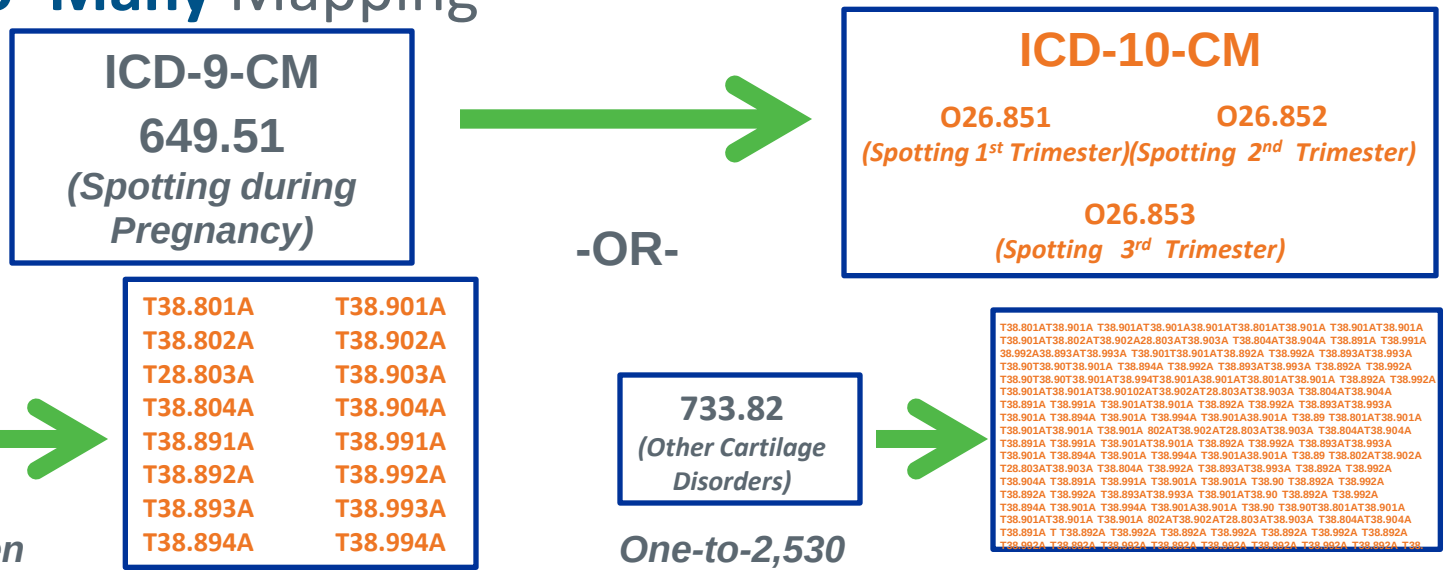
Why No "U?"

Mapping ICD-9 to ICD-10

- **One–to–One** Mapping



- **One–to–Many** Mapping



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Poll: Using the Code

When it comes to using the ICD-10 codes, what are your greatest fears?

- Practice productivity will suffer
- Cost of doing business will rise
- Ability to train my staff properly
- Lack of measurable effect on quality of care

Challenges

- **Pervasiveness** of ICD-9
- **Coordination** between providers, vendors, clearinghouses and payers → ***Will all players be ready?***
- **Shortage** of well-equipped professional coders
- **Learning curve for providers**
- **Systems** must support both **ICD-9** and **ICD-10**

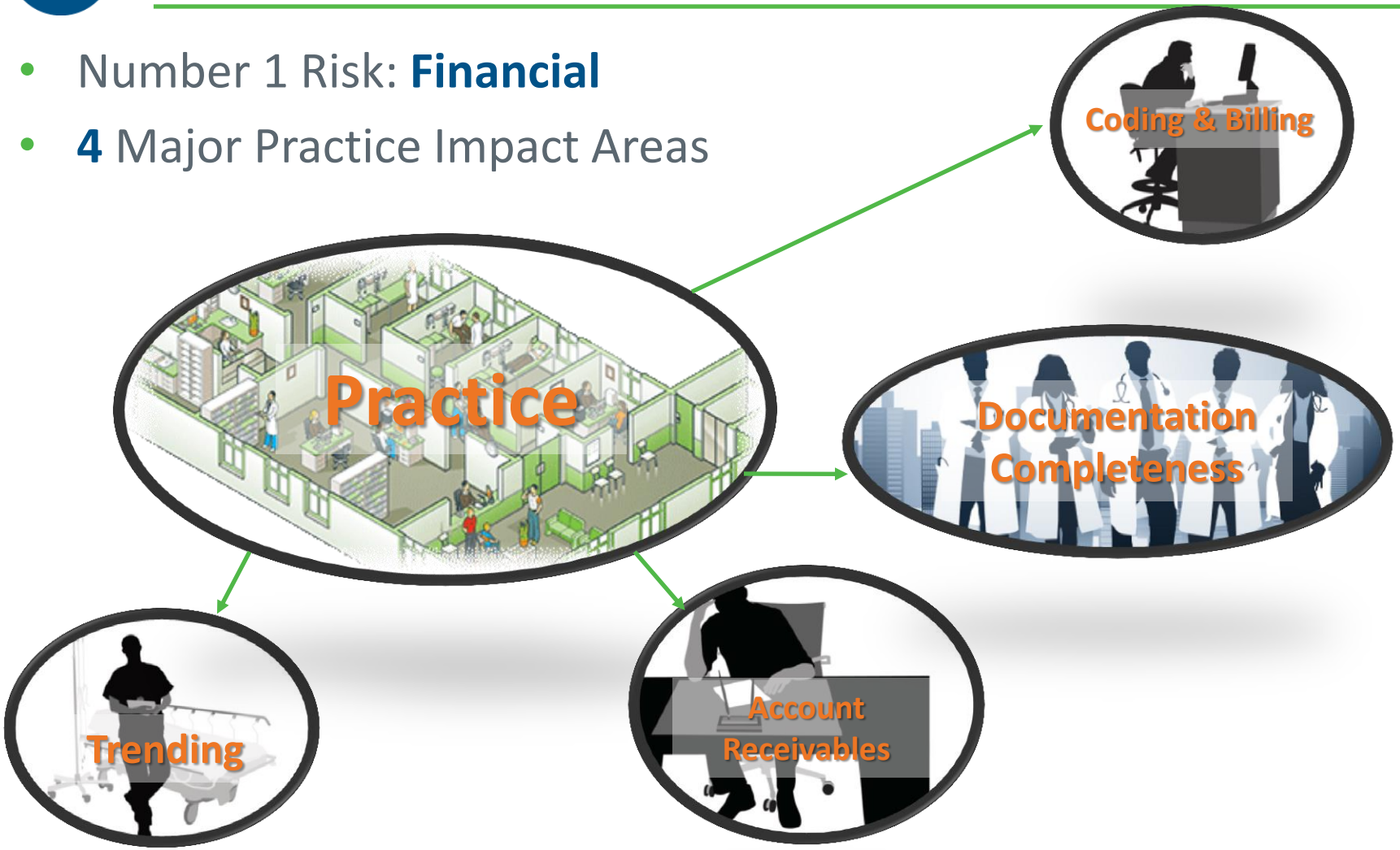
Mitigating Risk

- Must review **known risks** → Direct/avoidable
- Understand **hidden risks** → Indirect and complex
  - Payer **readiness variability**
  - Payer **conservatism**
    - Miscoding = increased denials
    - ↑ Appeals validation = cash flow issues
    - Use assumptive data trend to evaluate contracts
  - **Cash** "dry spell"
    - Evaluate margin
    - Get lines of credit in place now
  - **Payer rules** will adjust with experience
  - System **configuration mistakes** = need to re-bill

Source: HIMSS, ICD-10 Playbook, www.himss.org

Mitigating Risk

- Number 1 Risk: **Financial**
- **4** Major Practice Impact Areas



Mitigating Risk

- By Payer
  - **AR Days**
  - **Aging** of open AR *(days and dollars)*
  - **First pass payment** rate
- **Rejections** by payer *(number and type)*
- Number of **"pending" claims** for additional information

Mitigating Risk

- Coder **Productivity**
  - Experts say to expect up to **40%** decrease
  - Should be re-evaluated after some experience
- Coding **Accuracy**
  - Should include identifying root causes
  - Use strengths/weaknesses to target training

Mitigating Risk

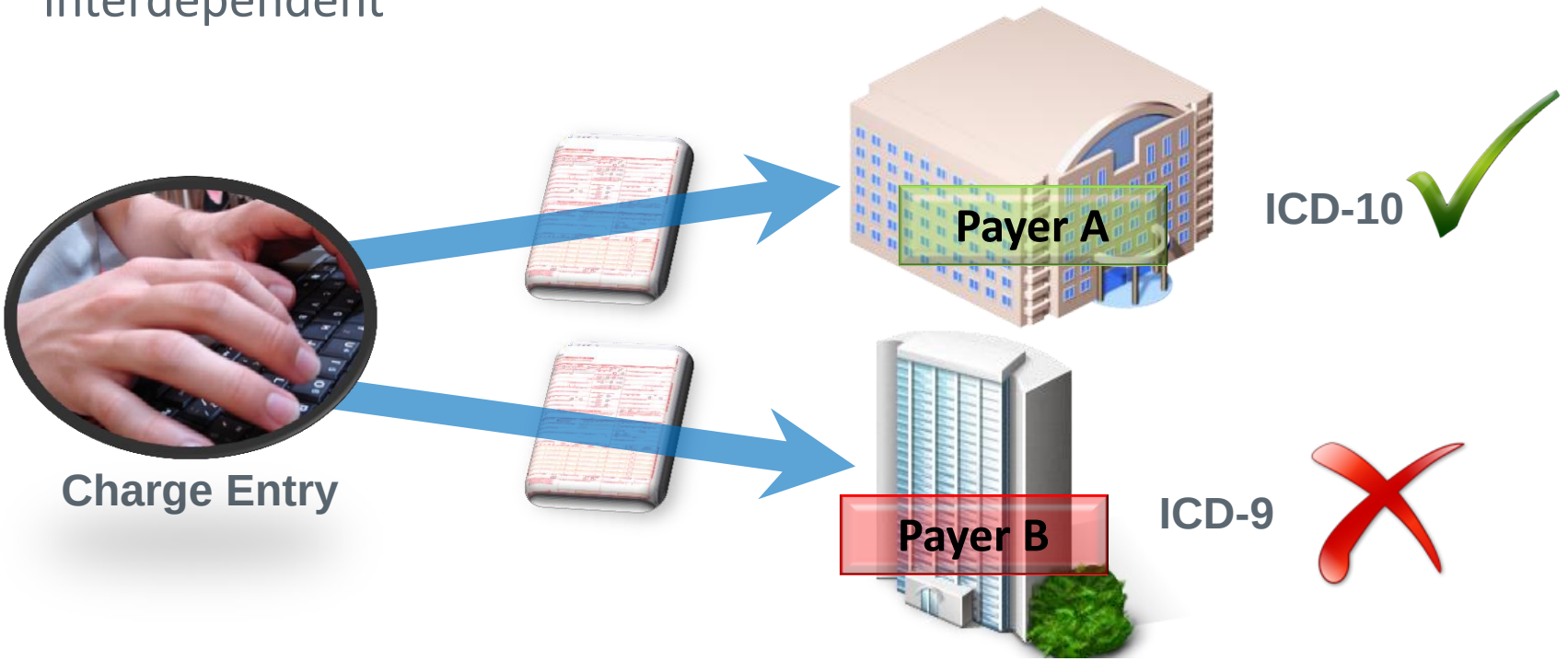
- **Metric Trending**
  - Critical to keeping a pulse on operations
  - **Trend** on critical metrics *(e.g., clean claim ratios)*
  - Will help **identify cash-flow "snags"** for remediation
  - Trend **key analytics** to payer interdependencies
  - Problem ⟶ Drill into underlying details quickly/benchmark *(e.g., reimbursement comparison reports)*

Mitigating Risk

- Billing **queries to providers**
- Provider **response time** to queries
- Percent of **queries** vs. **chart reviews**

Regulations vs. Reality

- **Regulations** require **EVERY covered entity** be **compliant** by Oct. 1, 2014
- **Reality** is **not everyone** will be *(e.g., Workers' Comp)* → Clients are interdependent



Documentation Capture

- **Non-Structured Information**
  - **Example:** Narrative typing or speech-to-text
  - **Pros:** Personalized note, ultimate flexibility, "the patient is still a human"
  - **Cons:** Not reportable, not researchable, not machine process-able, non-standard, ↑ risk
- **Structured Data**
  - **Example:** Combo or drop-down boxes; user-defined fields
  - **Pros:** Typically customizable, information uniformity, supports reporting
  - **Cons:** Not conducive to interoperability and industrywide standards

Documentation Capture

- **Codified/Object-Oriented Data**
  - **Example:** Vocabularies such as ICD-9, Snomed, LOINC
  - **Pros:** Very reportable, researchable, machine process-able, standardized, interoperable
  - **Cons:** Limits flexibility in documentation, "cookie-cutter" notes
- **Natural Language Processing**
  - **Example:** SIRI, Watson
  - **Pros:** Extracting data from information typed or dictated
  - **Cons:** Natural language "understanding" not currently practical, not available yet

Clinical Documentation Improvement

- **Review** current documentation for the most common codes
- **Work with staff** ⟶ Documentation specificity enough for best ICD-10 codes?
- Details can be added to **EHR templates**:
  - Laterality
  - Encounter type (Initial, subsequent, sequela, routine healing, delayed healing)
  - Anatomic details
  - Severity
  - Disease relationships

Injured because your water skis were on fire?

Technology

*"That it will ever come into **general use**, notwithstanding its value, is **extremely doubtful**; because its beneficial application **requires much time and gives a good bit of trouble** both to the patient and the practitioner; because its hue and character are foreign and **opposed to all our habits** and associations."*

What *London Times* said about the stethoscope — 1834

What technology? EHR? ICD-10?

Health Care and Change

Pragmatist

- 60% aim for minimum
- Only core processes for admin/compliance
- Last-minute adoption
- Penalties required
- Aiming for average = High potential risk

Collaborator

- 20-25% aim for opportunity
- Improve processes
- Advanced analytics, process improvement
- Rewards attained
- Aiming for improvement = Potential value for costs

Innovator

- 15-20% aim for transformation
- Complete change agent
- Training, outcomes mgmt.
- Rewards attained
- Aiming for excellence = Competitive advantage & strategic positioning

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Poll: Who's Leading the Charge

Do you have someone in your office leading the charge on ICD-10?

- Yes, the physician(s) mostly
- Yes, our practice administrator/manager
- No one in particular — it's a collaboration among all staff
- Not yet

ICD-10 Planning

- BCBS Association → **Coding errors** to increase **10-25%** in first year
- CMS estimates for trained coder needs: **179,267** PT/**50,000** FT
- ICD-10 goes well **beyond payer-provider** transactions
- ICD-10 affects all components of the practice
- **Impact Analysis**
  - What systems/workflows does ICD-9 touch today?
  - Who needs training? Coders, billers, physicians
  - EHR adoption and MU have tentacles into ICD-10 changeover
  - How will EHR adoption impact practice management, billing, coding, reporting, etc.?
  - **Greenway will support and continue to educate**

ICD-10 Training

- Training will need to be **widespread**
  - **All stakeholders** re: structure, benefits and changes
  - More intense coding for billing/coding staff
  - **Documentation** for providers

Financial Office Staff	Data Management	Data Security Staff	Auditors / Consultants	Clinicians
Clinic Dept. Managers	Quality Mgmt. Staff	Patient Access / Registration	Nursing Home Staff	Ancillary Staff (PT, OT, RT)
Visiting Nurses	Hospice Staff	Researchers	Billing Personnel	Accounting Staff
Compliance Staff	Data Analysts	Other Data Users	IT Personnel	

- Majority of participants should train **3-6 months** prior to implementation
- ICD-10-CM ⟶ **16 hours** for coding professionals; less if limited codes

ICD-10 Training

- Curriculum Considerations
  - **Basic** understanding of ICD-10 code set
  - **Coding** diagnoses
    - Providers don't have to be certified coders
    - Coders do not have to know all there is about medicine
    - BUT the two are interdependent for optimal accuracy
    - If no coders, provider responsibility?
    - Foster this relationship!
  - Clinical **definitions** and **terms**
  - Using **system updates**
  - Relevant **workflow changes**

Provider Documentation Training

- "If it's not documented, it didn't happen." = **Cannot bill**
- **More codes** = **more documentation**
- Documentation considerations
  - Linking relevant conditions
  - 7th character extension
  - Trimesters
- Conduct **Impact Analysis**
  - Clinical documentation assessments → Do random samples support ICD-10 coding?
  - Implement documentation improvement strategies → e.g., train, reassess, train again
  - ICD-10 implementation/documentation Champion
- **Let's look at a few examples!**

Provider Documentation Training

Area	ICD-9	ICD-10	Comments / Examples
Diabetes Mellitus	59 Codes	>200 Codes	• Adds "poorly controlled" in addition to "controlled" and "not controlled" • Adds multiple combination codes • Example: E09.11 → Type 1 Diabetes Mellitus with Ketoacidosis with Coma
Injuries	No expanded categories for injury	Adds 7th Character Extension to Identify the Encounter Type	• A = Initial Encounter • D = Subsequent Encounter for Fracture with Routine Healing • G = Subsequent Encounter for Fracture with Delayed Healing • S = Sequela • Other: Must code the type, cause, size and depth of injury
Drug Under-Dosing	Absent	Codes for when the patient takes less Rx than prescribed	• First code the medical condition • Secondary code of under-dosing • Tertiary Code of Reason • Example: Documentation must include "Patient could not afford their medication."
Cerebral Infarctions	No differentiation between type and late effects of stroke	Differentiation is made for late effects of stroke by type	• Combination codes exist for common etiologies or manifestations • Example: I63.012 → Cerebral Infarction due to Thrombosis of Left Vertebral Artery

Provider Documentation Training

Area	ICD-9	ICD-10	Comments / Examples
Acute Myocardial Infarction	Age definition is 8 weeks	Age definition is 4 weeks	• New categories for subsequent AMI and for complications within 4 weeks (28 days) of event • Difference in terminology • Laterality is included • Example: I21.02 → ST Segment Elevation Myocardial Infarction involving the Left Anterior Descending Coronary Artery
Musculoskeletal	Limited Diagnosis Codes	Expanded Diagnosis Codes	• Example: There are 8 codes for pathologic fracture in ICD-9; 150 codes in ICD-10
Pregnancy	Trimester not required, uses episodes of care	Documentation of trimester required	• Counted from 1st day of last period • Must document number of weeks • Episodes of care deleted • Obstructed Labor incorporates reason • Code extensions used to ID baby (1-5) affected by OB condition • Example: (Trimester) O15.03 → Eclampsia in Pregnancy in the 3rd Trimester • Example: (Obstruction/Baby ID) O64.1xx2 → Obstructed Labor due to Breech Presentation, Fetus 2

External Causes Codes

- **No** national requirement for **mandatory** ICD-10-CM **external cause code reporting**
- **Only required** for providers if:
  - State-based reporting mandate
  - Payer requirement
- In the absence of a mandate → Providers **encouraged** to voluntarily report on claims

Helpful Links

- **Code Set** and **Guidelines** → www.cdc.gov/nchs/icd10cm
- **Timeline** and **Cost Calculator** → www.aafp.org/icd10
- HIMSS — ICD-10 **Cost Predictive Modeling** Tool → http://bit.ly/181azGS
- CMS ICD-10 **Basics** → http://go.cms.gov/16pxHBI
- ICD-10 Changeover **Planning** – Getting Ready → http://slideshare/18ofvGq

Practice Action Items Summary

- **Impact Analysis** → What systems/workflows touch ICD-9 today?
- Identify potential **changes to workflows** and **business processes**
- Develop ICD-10 **Transition Plan**
  - Organizational-specific needs, vendor readiness, staff knowledge
  - Inventory systems, forms, manuals, policies & procedures, business assoc.
  - Identify needs, resources and associated costs for budgeting and timeline planning
  - Participate in available testing opportunities
- **Clinical Documentation Improvement (CDI)** program
- Communicate, communicate, communicate!
  - Pay attention to client announcements
  - **Are your key points of contact for domain areas current with your IT Partners?**

Cost Considerations

- It will cost in **resources** and **money**
- Coder compensation increases **20%** due to ICD-10 coder shortage
- **29%** decrease in coder productivity during training period
- **15%** decrease in coder productivity long-term due to slower process *(Includes increase of coding errors)*
- Many are looking to **outsourced coders** to compensate for coder productivity shortfalls
- Clinical **documentation** training critical
  - Rigorous documentation needed to code
  - Some ICD-10 will not allow code submission without specific documentation = lower payments or payment withheld
- Anticipate **slower collection** rates, including ↑ denials

Additional Considerations

Plan For...

- Hiccups in **cash flow**
- **Coding errors**
- **Productivity decrease**
- **Increase** in clinic **stress**

Consider...

- Financial **line of credit**
- **Train** and **educate**
- **Benchmark** and **measure** for purposeful improvements
- **Normalcy** should return in **4-6 months**
- **Celebrate your success!**

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Poll: Your Software & System

Have you upgraded your software or replaced your system to prepare for ICD-10?

- Not yet
- We've upgraded our software to the most current versions available
- We've replaced our practice management/EHR system
- We're considering replacing our system

Greenway's Course of Action

We are committed to being an industry leader in regulatory readiness

- **Product Readiness**
  - All PM & EHRs are ICD-10 ready
- **Testing**
  - Testing through Vitera Transactions Services (VTS)
  - Testing with trading partners and payers
- **ICD-10 Readiness Center** on Support Center
  - Collateral, toolkits and FAQs
  - Resources

Greenway's Course of Action

- **ICD-10 Taskforce**
  - Cross-functional team
  - Goals and objectives
    - Implementation **preparedness**
    - **Assist** customers during transition and post-implementation
    - Develop ICD-10 **workflow** documents and **computer-based training**
    - ICD-10 **webinars**
    - **Staff** education and training underway
    - Assess **alignment** with other initiatives such as MU and PQRS

Questions?