INGENIX | CONSULTING

WHITE PAPER

Preparing for ICD-10: Evaluating Approaches and Potential Pitfalls

Executive Summary

The health care industry breathed a figurative sigh of relief when the Department of Health and Human Services (HHS) extended its ICD-10 implementation deadline by two years, from October 1, 2011 to October 1, 2013. The extension provides organizations with additional time to prepare for the transition and to assess how the use of the new code set will affect them.

Currently, most organizations are in the discovery phase of their ICD-10 planning, focusing on identifying how ICD-10 will affect their information systems and internal processes. Payers and providers are determining their organization's training needs as well. Ingenix has prepared the following information to highlight issues that health care organizations—payers, hospitals, and physician practices— should consider as they assess their ICD-10 preparedness and develop their implementation plans.

Background

On January 15, 2009, the Department of Health and Human Services (HHS) released the final rule for the implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedural Classification System (ICD-10-PCS). The final rule pushed back the ICD-10 implementation date to October 1, 2013, instead of the October 1, 2011 date that was originally proposed.

In a related announcement on the same day, HHS released the final rule on implementation of the 5010 transaction standard. Similar to the ICD-10 implementation date, the 5010 implementation deadline was pushed back two years to January 1, 2012.

Biggest impact: The structure of ICD-10

While payers, hospitals, and physician practices will experience ICD-10 in different ways, all organizations will need to accommodate the revised structure of the new code set. The most obvious difference between ICD-9 and ICD-10 is the dramatic increase in the number of available diagnosis and procedure codes. Quite simply, many of the diagnosis and procedure categories in ICD-9 are full and cannot be expanded to incorporate emerging diagnoses and procedures. By contrast, ICD-10-CM and ICD-10-PCS have ample room to incorporate the expanding new technology and emerging diagnoses. Plus, ICD-10 is enhanced to capture greater detail including laterality—the ability to document if the condition or procedure is located on the right or left side of the patient.

There are also a number of structural changes within the ICD-10 code sets that will influence the many information systems that have traditionally used ICD-9 data. These structural changes include:

- Field length—Systems, interfaces, and databases will need to accommodate the larger seven-digit fields used in ICD-10.
- Alphanumeric characters—Systems, interfaces, and databases will need to accommodate the alphanumeric characters used in ICD-10-PCS codes.
- Database size—The ICD-10 code set is much larger than ICD-9, so it will require more storage space.
- Dual code sets—During the transition to the new code sets, most systems will need to simultaneously run ICD-9 and ICD-10, as well as the 4010 and 5010 transaction standards.

In addition, systems will need to accommodate multiple companion guides for 4010 and 5010 transactions.

Payers

The greater level of specificity within ICD-10 provides payers with additional data that can be leveraged in multiple ways, including:

- Value-based purchasing—The higher level of detail available in ICD-10 allows payers to drill down into claims data for use in care quality measurements, consumer-directed health care (CDHC), and pay-for-performance (P4P) initiatives.

- Fraud detection—ICD-10 reduces ambiguity and misinterpretation by providing more specific codes for many conditions. This benefit is likely to improve coding accuracy. The logic of ICD-10 facilitates the creation of tools that can be used in the detection of questionable patterns and suspected fraud. In contrast, the ambiguity of ICD-9 codes allow for greater interpretation of codes, making it more difficult to detect fraud.

- Historical claims analysis—The greater detail contained within ICD-10 claims will allow payers to gain a better understanding of the prevalence of chronic conditions among its membership, as well as the practice patterns of the providers within its network.

- Medical management—The increased detail can greatly assist efforts focused on disease, utilization and case management as well as medical policy.

To gain the benefit of these capabilities, payers will need to address some challenges during the transition to ICD-10. Payers, like providers, will need to modify or upgrade all systems that currently use the ICD-9 code set, and provide training in how to use the new ICD-10 classifications. In addition, payers will need to offer general ICD-10 training for staff members who work with the code set to develop business rules used in claims adjudication, fraud detection, medical management, medical policy, and any claims auditing efforts.

Despite the capability of ICD-10 claims to contain a higher level of specificity, hospital coders rarely take advantage of all the specificity available in ICD-9. While hospitals have been bolstering their clinical documentation programs to improve the quality and accuracy of documentation, parallel efforts on the physician side are lacking. Therefore, it's unlikely that physicians will take advantage of ICD-10's higher level of specificity—unless they are motivated. Payers can provide the proper incentives through value-based purchasing initiatives, such as Medicare's current P4P efforts that hold back a percentage of reimbursement unless providers submit their quality performance measurements.

During the transition to ICD-10, payers are likely to experience much higher call volumes to provider help lines. They can also expect to see lower first-pass rates for claims until providers get accustomed to using ICD-10. Also, there is the potential that some payers might get double billed by providers running dual billing systems that may send out claims in both ICD-9 and ICD-10 formats.

Following ICD-10 implementation, payers will need to develop strategies to compare historical ICD-9 data to new ICD-10 data. These comparisons are important for use in provider contracting and rate setting. General equivalency mappers (GEMs) are available in the public domain and provide equivalent code options to translate between ICD-9 and ICD-10. However, the mappings are not always a one-to-one correlation, and ICD-9 codes can map to multiple ICD-10 codes and vice versa.

Payers must utilize the reimbursement mapper for all payment methodologies that currently use ICD-9-CM codes. CMS has announced that the initial DRG assignments will be based on ICD-10 codes mapped to ICD-9.

ICD-10 CHALLENGES FOR PAYERS

- Older systems may not be able to handle the expanded character sets used in ICD-10
- Staff members will need ICD-10 training in order to develop business rules used in claims adjudication, fraud detection, medical management, medical policy, and any claims auditing efforts
- To improve clinical documentation, payers may need to provide the proper physician incentives
- Provider help lines will need additional staff to accommodate higher call volumes
- Payers may see a drop in reimbursement and lower first-pass rates for claims
- Providers running dual billing systems will likely submit claims in both ICD-9 and ICD-10 formats
- Systems may not be able to compare historical ICD-9 data to new ICD-10 data for use in provider contracting and rate setting
- Systems will need to utilize the reimbursement mapper for all payment methodologies that currently use ICD-9-CM codes

Hospitals and physician practices

With few exceptions, both hospitals and physician practices are likely to experience similar benefits and trials during and after the implementation of ICD-10. While ICD-10-CM will affect both hospitals and physician practices, ICD-10-PCS will only affect hospitals' reporting of inpatient services; the physician practitioners will only be required to utilize ICD-10-CM for diagnoses since physician procedure billing utilizes CPT®/HCPCS (according to HIPAA). Similar to payers, providers will need to modify or upgrade all systems that utilize ICD-9 data, and provide the necessary training for their staffs. Once implemented, the greater level of detail within the ICD-10 code set will provide hospitals and physician practices with valuable data that can be analyzed to monitor and measure care quality by provider or facility. The data can be used by organizations to focus on quality improvement efforts and to measure quality against peers. Although organizations can perform these analyses with ICD-9 data, the higher level of detail with the ICD-10 code set provides for more granular analysis.

The implementation of ICD-10 is likely to expand the value-based purchasing initiatives promoted by Medicare, state agencies, and commercial payers. For providers to collect full reimbursement, they will need to code encounters to the level of specificity demanded by payers in their provider contracts.

The structure of ICD-10 creates new opportunities for providers to introduce computer-assisted coding into the documentation processes. The consistent logic and terminology within the ICD-10 code set lends itself to hierarchical decisions in code selection, which can be utilized in computer-assisted coding.
Additionally, the ICD-10 structure may allow providers to maximize their investments in electronic health records (EHRs) by streamlining the process of converting clinical documentation into codes for billing.

For providers to benefit from the implementation of ICD-10, they will need to overcome challenges including:

- Clinical documentation—Provider organizations will need to train clinicians to improve their documentation practices so medical documentation will contain the details needed to support the higher level of specificity in ICD-10 codes.
- Retaining coding professionals—Organizations have faced a nationwide shortage of experienced coders for years, as many of the most experienced coders are nearing retirement age. Some organizations fear that some of their most experienced coders will retire, rather than learn a new coding system.
- Productivity decreases—Coding backlogs may develop as coders attend ICD-10 training sessions, and while coding throughput decreases during the initial learning curve.
- Training expenses—HHS estimates total training costs for full-time hospital coders at $2,750 per coder ($2,200 for lost work time, plus $550 for

training expenses), and $550 for part-time coders ($440 for lost work time, plus $110 for training expenses[1]) . Because many departments already invest in coder education, some organizations question if credit should be given in the amount of coding training already in annual budgets.
- Increased reporting requirements—The increased specificity provided by the new code sets may herald improved or expanded quality reporting because more information will be gathered through coded data.
- Increased claim denials—During the transition to ICD-10, it is anticipated that there will be an increase in claim denials due to provider errors and payer processing errors. These denials have the potential to slow cash flow as a result of the increased time that it takes to rework and resubmit claims.

Of specific concern to physician practices is the impact that ICD-10 will have on the superbills that providers fill out following patient encounters to document charges. With ICD-9, most practices use a superbill that contains a list of the most frequently used codes and their descriptions. Since the translation from the more general ICD-9 codes to greater specificity in ICD-10 means increased code options, these must be displayed on the superbill. Mapping strategies will need to be developed to make decisions about appropriate ICD-10 code selections for the superbills.

ICD-10 CHALLENGES FOR HOSPITALS

- Reporting requirements for inpatient services may increase
- Older technology systems need to accommodate code detail for increased number of available diagnosis and procedure codes
- New value-based purchasing initiatives may be introduced
- Budgets for investment in electronic health record (EHR) applications may need to be increased
- Computer-assisted coding may be introduced into the documentation processes
- Clinical documentation must be improved to support higher level of specificity within ICD-1
- Many coders may opt for retirement rather than learn a new coding system; hospitals may provide incentives to retain experienced coders
- Productivity may decrease due to coding backlogs
- Clinical and non-clinical staff will need training on the new technology and code set
- Provider and payer processing errors may cause claim denials and reduced cash flow

Do it yourself or outsource?

Most organizations in the early planning stages of their ICD-10 implementation are answering a difficult decision: How much of the process can they handle themselves versus how much (if any) should they outsource? As with most implementations, the decision depends on if the organization has the:
- Staffing resources to dedicate to ICD-10 planning and implementation while maintaining productivity standards for current operations.
- Expertise to conduct needs and gap analyses (processes and systems), plus implementation and training.
- Budget to cover one-time costs (training, system modifications/upgrades, outsourced implementation) versus recurring costs (employee salaries, etc.).

Fortunately, the decision to do it yourself or outsource is not an all-or-nothing proposition. Organizations can use the resources that they do possess and selectively outsource the components of the planning and implementation as needed. Outsourcing options can range from initial assessment and planning, to traditional process and system redesign and implementation. In addition, numerous training

resources are available, including onsite and classroom training, as well as Web-based training.

Evaluating vendors

Following an assessment of their systems impacted by the ICD-10 transition, organizations need to work with their vendors to determine if system modifications or upgrades are available. In some cases, older systems may be sunsetted by vendors. In any event, organizations need to ask their vendors the following questions:

- What is the status of their solutions becoming ICD-10 or 5010 compliant?
- Have their systems been tested and will they accept the ICD-10 code set once the final version becomes available in October 2013?
- Have their system's 5010 transmissions been tested for compliance?
- What is the availability schedule for solutions that will be ICD-10 compliant?
- What is the upgrade schedule for solutions that will not be ICD-10 ready by the implementation date?

Also, organizations need to evaluate the contracts for their existing systems. Many contracts do not specifically address how ICD-10 systems modifications or upgrades will be handled. Are the upgrades included in the maintenance agreements or will they incur additional fees? Some long-term contracts may need to be reworked to clear up any ambiguities regarding ICD-10 system compliance.

Budgeting

In its proposed rule for ICD-10 implementation, HHS referenced studies conducted by RAND Corporation[2] and Robert E. Nolan Company[3] that attempted to quantify industry costs resulting from the adoption of ICD-10.

The figures varied widely, ranging from $6 billion to $14 billion (Robert E. Nolan Company), to $1.15 billion (RAND Corp.). In another estimate, the Medical Group Management Association (MGMA) estimated that the average 10-physician practice will spend $285,000 to transition to ICD-10.

These figures are valuable to quantify the scale of the ICD-10 changeover, yet they are less helpful for organizations that are planning their ICD-10 budgets. However, within the pages of the proposed rule where HHS analyzes the results of these studies, the agency provides a framework that organizations can use to estimate their one-time and ongoing costs[4,5].

ICD-10 CHALLENGES FOR PHYSICIANS

- Existing practice management billing system software may need to be replaced or updated to accommodate 5010 electronic transactions standards
- Clinical and administrative staff will need training on new code sets and changes to technology
- Current practice work flow will need to be modified to accommodate new information technology
- Vendor, clearinghouse, and health plan contracts and data requirements will need to be reviewed and amended, or replaced
- Superbills and corresponding mapping strategies will need to be updated
- The quality and accuracy of clinical documentation practices must be improved to maintain compliant claims
- Billing forms must be revised or replaced

Adapting this approach, organizations could estimate their costs as follows:

- One-Time Costs
  - ICD-10 training
    - Inpatient coders
    - Outpatient coders
    - Physician office coders
    - Clinical documentation training for clinicians
    - Other users of ICD-10
  - Consulting
    - Assessment or planning
    - System selection
    - System configuration or modification
    - System implementation
    - Other users of ICD-10
  - Productivity losses resulting from
    - Coder training
    - Coder productivity decreases while first using ICD-10
  - Information Systems
    - Modifications
    - Upgrades
    - Testing
    - New purchases
- Recurring Costs
  - Salaries for those devoted to ICD-10 implementation and/or ongoing compliance
  - System (existing or new) maintenance agreements
  - Consulting and contract coders
  - Annual or monthly subscriptions to hosted systems that replace software-based systems

Unique ICD-10 timeline considerations

Nearly all organizations have implemented information systems and large-scale projects, and therefore understand how to develop a timeline to meet business and other objectives. The implementation of ICD-10, however, has some unique components that are worth considering in an effort to avoid potential problems.

The ambiguity of how organizations will address the ICD-10 implementation deadline of October 1, 2013 raises some interesting questions. In order to have a smooth transition, coordination and communication is necessary between Medicare, Medicare contractors, commercial payers, and providers. Most importantly, the appropriate variables must be accounted for in the implementation timeline, including the question of whether Medicare and other payers will offer transaction testing services for providers to submit "practice" claims to determine if their systems can format claims properly. Also, it's vital for organizations to coordinate their 5010 transaction standard implementation efforts with their ICD-10 initiatives.

Start ICD-10 preparations now

The ICD-10 implementation will be the most far-reaching change in U.S. health care to date. In an environment where data impacts the entire health care continuum, the coding system conversion will affect reimbursement, marketing, and research. Indeed, the October 1, 2013 deadline is fast approaching and all organizations need to start their plans immediately, if they are not already in progress. The sooner organizations can assess their strengths and limitations regarding ICD-10 implementation, the sooner that they can allocate the resources to streamline the transition to this long-awaited new code set.

For Information: 800.765.6034 | ingenuity@ingenix.com

Ingenix, Inc. | 12125 Technology Dr. | Eden Prairie, MN 55344

www.icd10prepared.com

About Us

Ingenix Consulting is a premier, data-driven health and human services consulting organization. We have over 1,000 consultants with experience working with hospitals, physician practices, health plans, employers, government agencies, and pharmaceutical companies. This scale and exclusive health and human services focus set us apart.

---

[1] Federal Register. "45 CFR Parts 160 and 162 HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule." Department of Health and Human Services, Office of the Secretary. August 22, 2008.

[2] Libicki, Martin C. and Brahmakulam, Irene T. *The Costs and Benefits of Moving of Moving to the ICD-10 Code Sets*. Rand. 2004.

[3] Robert E. Nolan Co. *Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS, Challenges, Estimated Costs and Potential Benefits*. October 2003.

[4] Ortolon, Ken. "Code Blues: Physicians Oppose Rushed ICD-10 Adoption." *TexasMedicine*. January 2009.

[5] Nachimson Advisors, LLC. *The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories*. October 8, 2008.