On October 1, 2015, the new code set for the International Classification of Diseases - the ICD-10-clinical modification/procedural classification system (CM/PCS) - will be required on all claims. That means all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must be able to conduct electronic healthcare transactions using ICD-10 diagnosis and procedure codes. Any claims that do not contain ICD-10 codes will not be processed or even more important, reimbursed.

Compared to ICD-9-CM/PCS, there is an eightfold increase in the number of codes in ICD-10, from 18,000 to 142,000. Diagnosis codes are increasing to approximately 70,000 from 14,000 codes and procedure codes to approximately 72,000 from 3,800 codes. The sharp increase in the total number of codes means a significantly greater level of specificity and detail is available for documentation in patients’ medical records. That means providers are responsible for understanding, knowing and being able to accurately assign all of the new codes for proper billing.

A successful transition to the new code set will require focused training and preparation, which many organizations have initiated. Major tasks that should be underway include:

- Coders and Clinical Documentation Improvement (CDI) Specialists reinforcing their training by practicing code assignment in a dual coding program and/or querying physicians for increased documentation
- Full integration testing through all hospital based systems that are involved in generating and/or retaining ICD-9 codes
- End-to-end testing with payors to validate claims can be processed with ICD-10 codes and reimbursement meets expectations

As your organization makes these final preparations, it is important to anticipate potential risks and have mitigation plans in place before October 1 to achieve stabilization in an effective and efficient manner. Here are five key areas to include in go-live preparation and post go-live mitigation plans to ensure a stable future and create bandwidth for optimization in early 2016.
1. Create a monitoring dashboard.

Use leading key performance indicators (KPIs) to build a monitoring dashboard to compare performance before and after the migration to ICD-10. Measure performance frequently – on a weekly basis if possible – to determine where to focus resources as soon as target range is exceeded.

**Recommendations:**
- Average time to code a chart (e.g., inpatient, outpatient day surgery/observation and outpatient diagnostic/clinic)
- Case mix index (CMI)
- Gross accounts receivable (AR) days in discharged not final coded (DNFC)
- Gross AR days in discharged not final billed (DNFB)
- Net AR days
- Cash collections as a percentage of net patient services revenue (NPSR)
- Initial denials as a percentage of NPSR
- Initial denials by reason code (focusing on those potentially impacted by ICD-10)
- Gross revenue per adjusted discharge
- Clean claim ratio
- Claims pending national coverage determination/local coverage determination (NCD/LCD) edits (dollar amount and total number)
- Claims held by clearing house (dollar amount and total number)
- Percentage of accounts reviewed by Clinical documentation improvement (CDI) (by payor for diagnosis-related group (DRG) reimbursed payors)
- CDI query rate
- Physician query rate response
- Physician agreement rate to queries

2. Ensure sufficient coder resource levels.

There will likely be a decrease in coding productivity as coders wait for final code assignments and become proficient in ICD-10-CM/PCS. If proper resources are not allocated, a backlog of accounts could develop. Productivity impact can be as high as 50 percent at go-live for inpatient coders, 35 percent for outpatient day surgery or observation coders, and 25 percent for outpatient diagnostic/hospital clinical coders. While productivity will increase as coders climb the learning curve, it is expected to remain below baseline by 15-20 percent.
Recommendations:

- Halt use of the ICD-10-CM/PCS code assignment for procedures performed on outpatient accounts. Only CPT codes are required on outpatient bills for procedures. Making this change will require support from key stakeholders first, to determine the impact on reporting and trending of data.
- Increase coding resources to allow coders more time to dual code before go-live and support code assignment after go live.
- Perform evaluation and return on investment (ROI) calculations for Computer Assisted Coding (CAC) technology to determine benefits for implementation.

3. Evaluate and enhance Clinical Documentation Improvement (CDI) programs.

Medical providers often document in clinical terminology which do not support accurate code assignments. Real-time verbal queries will teach medical providers which words to use for documentation specificity in patients’ medical records. This will support accurate and efficient finalization of code assignments. Analysis and review of documentation opportunities by medical specialty will provide information needed to build tools for focused medical provider education and new query templates.

Recommendations:

- Analyze accounts by Medicare Severity (MS) DRG frequency to determine where specificity is needed to continue to drive the accurate code assignment.
- Form a work team made up of CDI and coding team members to develop standard query templates to address known ICD-10 documentation requirements for complete and accurate coding.
- Build a process to share documentation gaps identified by coders with the CDI team to enhance efforts for medical provider education and concurrent query generation.
- Implement a CDI program in hospital outpatient treatment areas to round with physicians on cases and perform verbal queries to ensure specificity in the documentation.
- Develop specialty-specific training modules for physicians for the most frequent documentation gaps (i.e., one-on-one, existing physician meetings, rounding with medical providers).
- Create a focused plan for physician professional fee billing:
  ⇨ Consider analyzing the frequency of the most commonly selected diagnoses/codes - with a focus on unspecified codes - selected by medical providers in ICD-9. Identify the correct code and/or range of codes in ICD-10 and train on the documentation required to support code selection.
  ⇨ Review denials for medical necessity and identify areas of focused documentation review and educational opportunities.
  ⇨ Implement a concurrent CDI program where Clinical Documentation Specialists round with physicians during patient encounters for real-time queries to increase documentation specificity.
− Align tools used by physicians for ease of use when selecting diagnoses/codes so those used most often are sequenced first for selection.
− Complete medical provider education on documentation specificity supporting the most accurate code selection.

4. Build early warning triggers and response teams for increased edits, denials or pended clearinghouse claims.

The number of claims pending for final bill processing is very likely to increase as the number of NCD/LCD edits rises with the migration to ICD-10. Denials from payors will increase due to lack of medical specificity if unspecified codes are selected and/or if there are coding errors. Pended clearinghouse claims may increase as payors determine how to apply revised rules to make decisions about how to pay the claims.

**Recommendations:**
− Conduct analysis by reason code for edits, denials and pended clearinghouse claims, monitoring by total gross dollars and number.
− Add resources to review and resolve edits, denials and pended claims.
− Review update schedules for billing and encoder systems to ensure synchronization with NCD/LCDs updates.
− Perform root cause analysis to collect information and develop an action plan for long-term resolution.
− Provide focused documentation education and leverage the analysis performed to select unspecified codes/diagnosis by frequency and medical provider.

5. Evaluate and improve the quality of code assignment.

Code accuracy in ICD-10 is essential to ensure reimbursement, severity of illness and risk of mortality for patients are accurate. Quality indicators and abstraction of core measures by payors and various organizations are also impacted by accurate code assignment. As coders continue to improve their skill set with ICD-10, it is important to foster an ongoing, safe environment for them to learn and thrive. Validating code accuracy and sharing the information with the coders should continue after go-live. This will help coders continue to improve their accuracy as they transition to coding all encounters in ICD-10.

**Recommendations:**
− Create a communication plan for coders that outlines the process for reviewing accuracy and sharing results.
− Identify resources that can review a sample of encounters to validate accuracy in ICD-10 code assignment.
− Build feedback reports to track accuracy and provide summary information about erroneous codes and DRGs to share with coders on reviewed encounters.
− Set up small team conference calls for weekly study sessions with coders to review common errors and/or difficult cases for shared education with meaningful discussion and input.
− Recognize coders who accurately code difficult cases and give them the opportunity to share the case during the weekly study session.
About the Author

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Teresa is an experienced revenue cycle leader with more than 30 years of Health Information Management (HIM) experience within a large integrated healthcare system. Teresa has held multiple progressive HIM leadership roles, most recently as the system HIM director of an 11-hospital system. She excels at leading complex system related process improvement initiatives, working collaboratively with others to establish and achieve goals.

While the level of risk with the impending go-live of ICD-10 will vary by organization, it is essential to create and follow a plan that will proactively mitigate those threats. Incorporating these five areas into pre- and post-launch planning will help organizations successfully make the transition with minimal short-term impacts to productivity and accuracy and long-term efficiencies.

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