ICD-10’s Impact on Revenue Cycle A North Carolina Perspective

NCHIMA Triangle Region Meeting
November 1, 2013
Christian Omba, MA
Agenda

- ICD-10 Review
- ICD-10 Impact to Hospitals
- HIM/Coding
- Finance and Revenue Cycle
  - Sample Risks
- NC Specific Activities
  - NCHICA
  - WEDI-HIMSS
- Challenges and Opportunities
- Appendix
CHALLENGES & OPPORTUNITIES
Challenges

• Competing priorities?
• Resources
• Huge IT investments?
• Financial Neutrality?
• What level of compliance?
  – Minimal
  – Successful
  – Innovators
Opportunities

• Streamline & Innovate
• Positive impact on the quality of care
• Improve your organization’s operating and financial performance over the long term
ICD-10 Acknowledgement

- ICD-10 implementation is a complex, far reaching, and disruptive regulation to implement
- Providers and Payers cannot predict the coding patterns or reimbursement values
- It introduces significant Operational, Financial, and Technical risk to the entire supply chain
- It requires collaboration, mutual trust, and transparency at all levels amongst trading partners
ICD-10 Paradigm Shift

Objective
To determine the operational, technology, process, resource and revenue risks of ICD-10 compliance

Desired Outcomes
- Identify gaps in documentation and coding standards
- Understand Finance and Revenue Cycle impacts and determine appropriate mitigation
- Use real Clinical events/data to validate Payer Mapping processes and Impacts
- Fully engage trading partners and gain visibility into their readiness challenges
- Create a test data repository to be leveraged during System, Integration, and Operational Readiness testing
NASA lost a $125 million Mars orbiter because one engineering team used metric units while another used English units for a key spacecraft operation. "Our inability to recognize and correct this simple error has had major implications," said JPL Director Edward Stone.
ICD-10 General Impacts

Legend ICD-10 Impact

- 🗼 Medium Impact to Processes
- 🗼 High Impact to Processes
- 🌟 Medium Impact to Testing
- 🌟🌟 High Impact to Testing
ICD-10 General Impacts

• Average cost of implementing ICD-10 at a 200 bed facility is $750K

• Additional Cost considerations
  – Lost productivity
  – Processing errors
  – Increased denials
  – Reimbursement delays
# ICD-10 Areas of Commonality

<table>
<thead>
<tr>
<th>Provider</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Clinical Documentation</td>
<td>Medical Policy Update</td>
</tr>
<tr>
<td>Coding and Training</td>
<td>Claims Processing and Mapping Evaluation</td>
</tr>
<tr>
<td>Productivity</td>
<td>Utilization Management/ Auto Adjudication Rates</td>
</tr>
<tr>
<td>Revenue Cycle</td>
<td>Provider Relations, Member Services</td>
</tr>
<tr>
<td>IT Systems and Vendors</td>
<td>Products, and IT Systems and Vendors</td>
</tr>
<tr>
<td>• Patient Care</td>
<td>• Member Satisfaction</td>
</tr>
<tr>
<td>• Cash Flow/Reimbursement</td>
<td>• Provider Satisfaction</td>
</tr>
</tbody>
</table>
ICD-10 What Do We Know

• Operational Assessment/Workflow Review
• Coding Analysis
• Physician Documentation/Query Reviews
• Reimbursement History and Trending Analysis
• Information Technology System Compliance
333 Days & Counting

OCTOBER 1, 2014
CMS: No further delays in ICD-10-CM/PCS implementation

The Centers for Medicare and Medicaid Services (CMS) will maintain their commitment to the current ICD-10-CM/PCS compliance date of October 1, 2014, according to a letter sent to AHIMA President Kathleen A. Frawley, JD, MS, RHIA, FAHIMA. The letter was sent in response to AHIMA’s call for CMS to stand firm on its ICD-10 implementation date after more than 80 physician groups represented by the American Medical Association called on CMS in January to delay or abandon the ICD-10 conversion. CMS’ Acting Administrator Marilyn Tavenner formally declined the request in a letter sent February 6, stating a halt of implementation “would be costly, burdensome, and would eliminate the impending benefits” of ICD-10, according to an American Academy of Family Physicians blog post. Read more at the Journal of AHIMA website.
ICD-10 Overview

- Increased specificity — new technology, initial or subsequent encounter, etc
- Dummy placeholders — 5th or 6th character for future expansion
- Laterality — bilateral v. unilateral, left v. right, upper quadrant v. lower quadrant, etc.

<table>
<thead>
<tr>
<th>ICD-9-CM &amp; PCS</th>
<th>ICD-10-CM &amp; PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSIS</strong></td>
<td><strong>DIAGNOSIS</strong></td>
</tr>
<tr>
<td>13,000</td>
<td>68,000</td>
</tr>
<tr>
<td>3-5-CHARACTER ALPHANUMERIC</td>
<td>3-7-CHARACTER ALPHANUMERIC</td>
</tr>
<tr>
<td>855</td>
<td>2,033</td>
</tr>
<tr>
<td>CODE CATEGORIES</td>
<td>CODE CATEGORIES</td>
</tr>
<tr>
<td>PROCEDURES</td>
<td>PROCEDURES</td>
</tr>
<tr>
<td>3,000</td>
<td>87,000</td>
</tr>
<tr>
<td>3-4-CHARACTER NUMERIC</td>
<td>7-CHARACTER ALPHANUMERIC</td>
</tr>
</tbody>
</table>
ICD-10 IMPACT TO HOSPITALS
ICD-10 General Impacts

ICD Code Touch Points

- Scheduling/insurance verification
- Pre-Authorization
- Registration
- Financial counseling
- Care
- Discharge

- Chart analysis
- Coding Documentation
- Clinical Documentation Assessment

Patient Access

Patient care

Technology

Finance and Revenue Cycle

- IT Software Inventory
- IT Interfaces Inventory
- IT Infrastructure Analysis-Test Environments
- IT Vendor Readiness Analysis
- IT System compliance Validation

- Contract Terms of Agreement Review
- Billing/Collection Analysis
- Denial Tracking
- 3rd Party Payment
- Managed Care Contracting/Renegotiation

Validate policy and process decisions related to current processing and ICD-9 to ICD-10 compliance Regulations
ICD-10 Training Considerations

• Create organization-wide training plan
• Communicate and get buy-in from leadership
• Assess competence and tailor training to the individual- A&P etc.
• Create customized role based training
• Leverage multiple training methodologies
  – In-house, web based, group learning etc.
• Expand your training plan to encompass the full implementation time span and more
HIM Staffing Considerations

- Identify anchor resources- what is the impact of their departure
- Create retention plan
  - Factor in the retention cost in your budget
- Create dual coding plan, and plan for backfilling staff in training
- Perform post-training Coding and Documentation Audit to Identify additional training needs
- Constantly monitor industry trends
- Consider additional technology like a Computer Assisted Coding product
Patient Flow & Revenue Cycle

- ICD-10 will affect a number of processes associated with patient flow through the hospital as well as the revenue cycle.

- Provider core operations will be dramatically impacted by ICD-10, especially the revenue cycle.

Patient Access Services → Charge/Coding Integrity → Patient Financial Services
### Patient Access Impact

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>SUB-PROCESS</th>
<th>DEFINITION</th>
<th>ICD-10 IMPACT</th>
</tr>
</thead>
</table>
| PATIENT INTAKE | • Scheduling  
• Referral  
• New/Est Patient  
• Eligibility  
• Scheduling Requests  
• Encounter Definition  
• Registration  
• Contract Information | Process of registering new or existing patient with the hospital, including scheduling, registration, and initial health history. | • Update patient registration process to accommodate ICD-10 codes  
• Update decision support system business rules to capture ICD-10 codes  
• Capture clinical documentation requirements to support ICD-10  
• Update existing business policies to determine coverage (deductibles, copays)  
• Update business policies to determine patient eligibility for dual eligibility/SSI/COB for special clinical programs |
| REFERRAL | N/A | Recommendations from a primary care or other physician to see any practitioner or specialist | • Update referral process to accommodate ICD-10 codes where appropriate  
• Capture clinical documentation requirements to support ICD-10 |
## Patient Access Impact, cont.

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>SUB-PROCESS</th>
<th>DEFINITION</th>
<th>ICD-10 IMPACT</th>
</tr>
</thead>
</table>
| AUTHORIZATION  | N/A                     | The process of obtaining permission from a managed health plan for routine inpatient hospital admissions or outpatient therapy | • Update authorization process to accommodate ICD-10 codes  
• Capture clinical documentation requirements per ICD-10  
• Test with payers wherever possible to avoid experiencing problems processing authorization under ICD-10 |
<p>| PRE-ADMISSION  | Insurance &amp; eligibility updates | The process of gathering as much information as possible to streamline both administration and patient care upon admission | • Update pre-admission process to accommodate ICD-10 codes for such things as admission encounter interface transactions |</p>
<table>
<thead>
<tr>
<th>PROCESS</th>
<th>SUB-PROCESS</th>
<th>DEFINITION</th>
<th>ICD-10 IMPACT</th>
</tr>
</thead>
</table>
| ADMISSIONS | • Patient intake & registration systems  
• Insurance and eligibility updates  
• Determine power of attorney (POA) | Process of patient intake to the hospital care system | • Identify patient’s health state upon admission (including admitting diagnosis)  
• Identify pre-existing conditions upon admission  
• Identify reasons for admission using ICD-10 codes  
• Encounter transactions  
• Identify planned inpatient procedures |
NC SPECIFIC ACTIVITIES
Quick Checkpoint

How many of you have heard of NCHICA?

What does NCHICA stand for?

A. North Carolina Healthcare Information & Communications Alliance, Inc.
B. North Carolina Hospital Information & Communications Alliance, Inc.
C. North Carolina Health Information & Communications Alliance, Inc.

So what?
ICD-10 Task Force Activities

ICD-10 Web Site:  
www.nchica.org/HIPAAResources/icd10.htm
NCHICA ICD-10 Task Force

Established by NCHICA Transactions, Code Sets, and Identifiers Workgroup in February 2010

• Monthly Meetings since Feb. 2010

• 75+ Organizations
  – Including Providers, Payers, Clearing Houses, Professional Associations, Government Agencies (NC DHHS and CMS), Labs, Law Firms, Vendors, etc.

• 128+ Individuals

• Periodic Bulletins for Distribution to NCHICA Members and Members of Professionals Associations

• Collaboration on Educational Events
## ICD-10 Pilot Testing Participants

<table>
<thead>
<tr>
<th>UNC Healthcare System</th>
<th>Allscripts</th>
<th>American Coders</th>
<th>Axial Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamance Regional Medical Center</td>
<td>Allscripts</td>
<td>American Coders</td>
<td>Axial Exchange</td>
</tr>
<tr>
<td>BCBSNC</td>
<td>Cape Fear Valley Health System</td>
<td>Carolinas HealthCare System</td>
<td>CaroMont Health System</td>
</tr>
<tr>
<td>CCA Medical</td>
<td>CIBER</td>
<td>Clinical-Insights</td>
<td>CMS</td>
</tr>
<tr>
<td>Coastal Alliance</td>
<td>CSC</td>
<td>Cone Health</td>
<td>Crescent Health Solutions</td>
</tr>
<tr>
<td>Duke University Health System</td>
<td>echoBase</td>
<td>FirstHealth of the Carolinas</td>
<td>High Point Regional Health System</td>
</tr>
<tr>
<td>HIMformatics</td>
<td>HP Enterprise Services</td>
<td>IBM</td>
<td>Iredell Memorial Hospital</td>
</tr>
<tr>
<td>LabCorp</td>
<td>Mayo Clinic</td>
<td>MedCost</td>
<td>Nachimson Advisors</td>
</tr>
<tr>
<td>NC Community Health Center Association</td>
<td>NC DHHS</td>
<td>NCHIMA</td>
<td>NC Medical Group Managers</td>
</tr>
<tr>
<td>NC Medical Society</td>
<td>NC Nurses Assn.</td>
<td>NC Psychiatric Assn.</td>
<td>NC Psychological Assn.</td>
</tr>
<tr>
<td>New Hanover Regional Medical Center</td>
<td>Novant Health System</td>
<td>Oak Grove Technologies</td>
<td>Pitt Community College</td>
</tr>
<tr>
<td>Rex Healthcare (UNC Health Care)</td>
<td>Rural Health Group</td>
<td>Siemens</td>
<td>Southeastern Regional Health System</td>
</tr>
<tr>
<td>The SSI Group</td>
<td>TM Floyd &amp; Company</td>
<td>UNC Health Care System</td>
<td>Wake Forest Baptist Health</td>
</tr>
<tr>
<td>WakeMed</td>
<td>Lott QA Group</td>
<td>New Hanover Regional</td>
<td>Vidant Health</td>
</tr>
</tbody>
</table>
ICD-10- Medical Records

The human condition defined medically is common across all providers and payers
Medical Records - The Foundation

- An encounter is the initiation of the claims cycle
- Medical records - the foundation of testing process
- Establishes independent “source of truth”
- Transparent data subject to constant peer review
- Usable for current and future testing requirements
- Provides complete traceability of the test case from inception through payment remittance
- Allows trading partners to test the same transactions in their end-to-end testing lifecycle
Testing Problem

Many to Many Relationships - Multiple Test Sets

- PMS/HIS Vendor
- Provider
- Clearinghouse
- Payer

- Vendor
- Provider
- Clearinghouse
- Payer

- Vendor
- Provider
- Clearinghouse
- Payer

- Vendor
- Provider
- Clearinghouse
- Payer

- Vendor
- Provider
- Clearinghouse
- Payer
Testing Solution Standard

Needs to be circular relationship and include Medicare

Vendor- A/P provider

Vendor

Vendor

Vendor

Standard Test Scenarios

Provider/Practices/Physicians

Provider

Provider

Provider

Provider

Standard Test Scenarios-Vendor/Clearinghouse

Payer-Medicare

Payer

Payer

Payer

Payer

Payer

Payer
NCHICA Pilot Approach

- Business Driven Approach to Testing
- Coding Analytics for Providers and Payers
- Shared Delivery Model vs. Silo Delivery Model
- Gives Health Plans More Clinical Data not Mapped Data
  - Gives Health Plans Greater Provider Testing Involvement
  - Visibility into Provider Contracts and Revenue Cycle
- Verifiable Results to Assess Trading Partner Readiness
NCHICA Pilot Scope

Top 3 DRGs Per Specialty/Clinical Data

- Known Payment Changes
- Positive, Negative & Neutral
- A “Source-of-Truth” for Claim Scenarios
- Dual Coded ICD-9 and ICD-10 Transactions
- Experienced ICD-10 Coders and Clinician Peer Review
- Test Data Reusable Across All Trading Partners
- Agile Testing – Know the Answer Prior to Start
Stages of Testing

**STAGE 1**
- INTERNAL UNIT/INTEGRATION
  - MEDICAL RECORD SELECTION
  - DUAL-CODING EXERCISE
  - DUAL-CODED CLINICAL RECORDS
  - ICD-10 CODING ACCURACY
  - WORKFLOW PROCESS IMPROVEMENT
  - ICD-10 TRAINING
  - COMPUTER ASSISTED CODING
  - COMPLIANCE TESTING

**STAGE 2**
- SHARED CODING RESULTS
  - DUAL-CODED TRANSACTIONS
  - CODING CONSENSUS
  - ICD-10 CODING ACCURACY
  - SHARED WITH ALL TRADING PARTNERS (E.G. CLEARINGHOUSES, HEALTH PLANS AND VENDORS)
  - ADDITIONAL CODING REVIEW BY TRADING PARTNERS (IF REQUIRED)
  - BILLING TESTING
  - DEFECT RESOLUTION

**STAGE 3**
- TRADING PARTNER TESTING
  - BUNDLED MEDICAL RECORDS
  - DUAL CODING WORKSHEETS
  - DRG ASSIGNMENTS
  - 5010 TRANSACTIONS
  - SHARED WITH ALL TRADING PARTNERS (E.G. CLEARINGHOUSES, HEALTH PLANS AND VENDORS)
  - ADDITIONAL CODING REVIEW BY TRADING PARTNERS (IF NECESSARY)

**STAGE 4**
- END-TO-END TESTING
  - DUAL-CODED TXN’S
  - END-TO-END TESTS
  - COMPLIANCE TESTING
  - DEFECT RESOLUTION
  - HELP DESK
NCHICA Pilot Status

- The participating pilot hospitals have provided to date, more than 200 highly relevant clinical dual coded and peer reviewed scenarios

- Sharing of dual coded clinical scenarios with the participating health plans is underway

- Determining future state of the Pilot
ICD-10 Pilot Collaboration
Payer Impacts

Dual-Coded Medical Records
- 5010 ICD-9 Claims
  - Adjudication System 1
  - Adjudication System 2
  - Adjudication System 3
  - Adjudication System 4
  - Adjudication System 5
- 5010 ICD-10 Claims
  - Medicare Jurisdiction 1-n
  - Medicaid Jurisdiction 1-n

ICD-10 Map Testing
Contract Testing
Benefit Testing
Policy Testing
HiMSS-WEDI National Pilot

- Over 6 months of information sessions (with over 600 participants)—part of onboarding process
- More than 250-275 orgs joined the pilot and work groups
- 57 “early mover/early adopters” participated in the testing—not counting all subsidiaries
- 2 organizations dropped out due to staffing issues—illness or not ready to participate in pilot
- 5 organizations wish to remain anonymous—not included in the ICD-10 PlayBook listing or list reports
- CMS & National Government Services part of the work groups
Pilot lessons learned

• Averaging 2 medical records per hour (was 4+ per hour under 1-9)—productivity reduced by 50%
• Most advanced healthcare systems have a pro-active ICD-10 team supported by executive sponsors
• Early movers/early adopters always willing to learn— not afraid of transparency or being the first to try
• Organizations advanced in ICD-10 prep have a concrete budget and managing partners well; keeping relationships & communications with vendors top priority
Thank You!

Christian.omba@unch.unc.edu
SUPPLEMENTAL INFORMATION
ICD-10-CM Facts

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td><strong>Approximately 13,000 codes</strong></td>
<td><strong>Approximately 68,000 available codes</strong></td>
</tr>
<tr>
<td>First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric</td>
<td>Digit 1 is alpha; Digits 2 and 3 are numeric; Digits 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for adding new code</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy and richness of data for analysis</td>
</tr>
<tr>
<td>Codes are non-specific and do not adequately define diagnoses needed for medical research</td>
<td>Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>Does not support interoperability because it is not used by other countries</td>
<td>Supports interoperability and the exchange of health data between other countries and the U.S.</td>
</tr>
</tbody>
</table>
### ICD-10-PCS Facts

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>ICD-10-PCS Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 numbers in length</td>
<td>7 alpha-numeric characters in length</td>
</tr>
<tr>
<td><strong>Approximately 3,000 codes</strong></td>
<td><strong>Approximately 87,000 available codes</strong></td>
</tr>
<tr>
<td>Based upon outdated technology</td>
<td>Reflects current usage of medical terminology and devices</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Generic terms for body parts</td>
<td>Detailed descriptions for body parts</td>
</tr>
<tr>
<td>Limits DRG assignment</td>
<td>Allows DRG definitions to better recognize new technologies and device</td>
</tr>
<tr>
<td>Lacks precision to adequately define procedures</td>
<td>Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information</td>
</tr>
</tbody>
</table>

This will NOT replace CPT unless HIPAA is revised/changes
ICD-10 & Medicare

• How basic reimbursement works:
  – Hospital Inpatient Prospective Payment System
    • ICD-9/10-CM diagnosis and procedure codes group to form a DRG (Diagnosis Related Group)
      – The DRGs classify all human diseases according to the affected organ system, surgical procedures performed on patients, morbidity, and sex of the patient.
    • In 1982, Congress mandated the creation of a prospective payment system (PPS) to control costs
ICD-10 & Medicare, cont.

• How basic reimbursement works:
  - Hospital Outpatient Prospective Payment System (OPPS)
    • Unit of payment under the OPPS is the APC (Ambulatory Payment Classification)
      - CMS assigns individual services (Healthcare Common Procedure Coding System [HCPCS] codes) to APCs based on similar clinical characteristics and similar costs.
      - ICD9/10-CM diagnosis codes
      - October 1, 2000
ICD-10 & Mapping

The ideal unit of analysis is the patient’s medical record. Any ICD coded record is a partial description of the medical record behind it. ICD-9 and ICD-10 sometimes give different pictures. The GEMs are an attempt to reconcile those different views, and can never replace going back to the original medical record and coding it.

The Reimbursement Mapping was developed by 3M under contract to CMS, in response to industry requests for a 10-to-9 crosswalk that could be used for payment. CMS did not create it for itself and has announced at every opportunity that CMS will not be using the mapping for any purpose whatsoever.
ICD-10 & Mapping

By far the biggest misuse of the Reimbursement Map is when people try to flip it around to make an ICD-9–to–ICD-10 map. The GEMs are not mirror images of each other. Mapping from ICD-9 to ICD-10 is, in our opinion, not possible—certainly not advisable. Yes, we take ICD-9 coded records and create ICD-10 coded records from them to test our software, but we never claim that the ICD-10 records created are equivalent in any way to their ICD-9 predecessors - only that the ICD-10 record is a plausible example of how the chart that gave us the ICD-9 codes might be coded in ICD-10. For that exercise, we wouldn’t touch the Reimbursement Map with a ten-foot pole.

*Ron Mills is a Software Architect for the Clinical & Economic Research department of 3M Health Information Systems.*