WEDI ICD-10 Emergency Summit Summary

This document summarizes key discussion areas from the WEDI Emergency ICD-10 Summit held April 30, 2014 in response to the ICD-10 compliance date change necessitated by the Protecting Access to Medicare Act of 2014, signed into law on April 1, 2014.

In the January 16, 2009, Federal Register (74 FR 3328), HHS published a final rule adopting ICD-10-CM and ICD-10-PCS medical code sets as the HIPAA standards to replace the previously adopted ICD-9-CM medical code set for diagnosis and inpatient procedure coding. The compliance date established by the final rule was October 1, 2013. In the September 5, 2012 Federal Register the compliance date for this requirement was extended to October 1, 2014. With the recent passage of Protecting Access to Medicare Act of 2014, the compliance deadline for ICD-10 has now been extended at least one additional year.

In order to help develop a common industry roadmap for ICD-10 compliance, WEDI convened an ICD-10 Emergency Summit. At this Summit, WEDI engaged payers, providers, vendors and government agencies in a dialogue focused on both the key concerns by various stakeholders with the compliance date change and the development of strategies to mitigate those concerns, creating a roadmap toward compliance. The Summit drew approximately two hundred attendees with roughly half attending in person and half virtually.

The Summit focused on four key areas:

- Root causes of organizations not preparing for ICD-10
- Impacts of the delay and unintended consequences of the delay
- Suggested high level roadmap for dealing with the fallout and moving toward compliance
- Specific next steps the industry should consider

Each of these areas is discussed in greater detail below.

Root causes of organizations not preparing for ICD-10

The Summit examined underlying causes of the delay. The fact that some organizations were not ready is a symptom of another factor that caused them to not be ready. Without addressing the root cause(s) the industry could likely be faced with a similar lack of readiness next year.

Too many mandates: The entire healthcare industry is besieged by a multitude of mandates. Providers must comply with Meaningful Use requirements and PQRS reporting. Health plans must meet Affordable Care Act requirements while preparing for health plan ID and operating rules requirements. Additionally new payment models are being implemented. These activities place stress on limited resources, particularly in smaller organizations.
**Value proposition to physicians:** Physicians have not seen a convincing value proposition for ICD-10. Additional documentation requirements are perceived as taking time away from patient care.

**Negative messaging:** A significant amount of messaging and published articles uses cause of injury codes as examples of why ICD-10 is not needed. Often there is very limited focus on the clinical codes such as those related to diabetes or coronary disease. Some messaging related to contingency planning urges providers to take out lines of credit and establish cash reserves in case they don’t get paid during the ICD-10 conversion or if payments are reduced. The fact that physicians are paid primarily using CPT codes, not ICD codes is rarely mentioned.

**Political pressures:** There are also political pressures by organizations that favor never adopting ICD-10. Since WEDI does not engage in lobbying, this factor was not pursued at great length, but was recognized as being very significant.

**Historical actions:** The ICD-10 compliance date has changed several times from the proposed rule to the final rule to the last extension that established the October 1, 2014 date. Credibility that the date would be absolute was further eroded by the fact that other HIPAA implementations have had extensions and grace periods.

**Impacts of the delay and unintended consequences of the delay**

*Organizations not only need to prepare for a new compliance date, but also may need to take additional actions to continue using ICD-9 codes and to extend compliance efforts for at least another year.*

**Credibility:** As stated above, the compliance date for ICD-10 and other HIPAA mandates have often been extended. After repeated affirmation by CMS officials that this time the compliance date was final, the date was changed by Congressional action. Since the sustainable growth rate (SGR) will be reviewed again next year, there is no guarantee that the date would not be extended yet again. All this has eroded confidence that any new date would be adhered to.

**Slowdown or stoppage:** Some covered entities have decided to either slow down their compliance efforts or place a temporary halt on ICD-10 activity. This can lead to a self-fulfilling outcome where by delaying, they will not make sufficient progress to meet a new compliance date, leading to requests for further delay.

**Frustration:** Many organizations have spent large sums of money preparing for ICD-10. The change in compliance dates will necessitate modifications to project schedules and budgets. Some smaller providers were ready for the transition and do not have the resources to accommodate repeated compliance date changes. The change in dates seems to punish those that prepared for ICD-10 compliance while rewarding those who did not prepare.

**Budgets:** Most organizations did not budget for additional ICD-10 funding and resources beyond 2014. Some estimated that a one year delay will cost an additional five to ten million dollars which had not been budgeted. The delay also places stress on staffing, as personnel may be diverted to other efforts. It may be difficult to reacquire knowledgeable staff at a later time. Another side effect is the impact to
contracts with consulting or staffing firms. In some cases these contracts might be terminated or slowed down, but in others there may be guarantees involved.

State level / workers’ compensation: Property and casualty insurance is not subject to HIPAA regulations. However, the providers that treat patients covered via these benefits are subject to HIPAA. Since states control requirements for workers’ compensation, many states had decided to adopt ICD-10 in order to align with federal requirements and it seems that at least one state was already using these codes. This adoption was done via state regulation or legislation. With the change in compliance dates, states may need to amend and reissue requirements or subject providers to using two medical code sets concurrently. In some cases the state legislature would need to be reconvened to amend relative statutes. Additionally, Section 111 reporting to CMS required use of ICD-10 codes beginning in April 2015. This requirement will need to be revisited.

Incremental cost: Organizations that were planning to be ready for October 2014, will need to decide whether to implement ICD-10 changes and leave them inactive, or place a hold on implementation. In some cases some changes might need to be backed out, such as date edits that trigger which code set to use. The extension of project timelines and potential maintenance of inactive application code increases compliance costs. Organizations that had begun testing will need to retest in 2015, further increasing costs. In some cases retraining may be required as well.

Payment considerations: The delay may have impacts to payment related items such as provider contracts, MS-DRG’s, and national and local coverage determinations used in Medicare.

Suggested high-level roadmap

Due to the limited time available at the one-day Summit, it was not feasible to create a detailed industry plan of action. Instead a set of high level actions was identified that will need to be fleshed out over the coming weeks. It was noted that the roadmap might differ for those that were ready versus those that did not plan to be ready for the October 2014 date.

The vast majority of attendees favored keeping a single cutover date and supported October 1, 2015 as the date, and some expressed significant disappointment over any delay. Many expressed strong concern over suggestion of a phased implementation approach and raised issues over the impact to integrated delivery systems with a common billing office and to coordination of benefits as well as data correlation and other issues. If any change in implementation strategy was to be considered, it would require new impact assessments and increased costs to rework applications and processes as well as other potential unintended consequences.

Establish credibility: In order to gain industry support for a new date, the government must find a way to assure the industry that the date will not be changed again. Given the recent congressional override of the regulatory compliance date, this will be difficult to do, especially considering that another SGR bill is due to be voted on next year.
Convey a more positive message: The message to providers should avoid ‘doom and gloom’ terminology implying that their payments could be severely impacted and that cash reserves must be established to deal with payment disruption. If the fear can be mitigated it would lower resistance to the change. Use of success stories that illustrate the compliance effort is not as difficult as anticipated and that payments remain similar would go a long way toward gaining buy-in from physicians. Since most physicians are paid based on CPT codes, the ICD change should have minimal impact on their payment amounts. Also, since most providers use only a subset of codes, not the entire code set, the fear of needing to learn thousands of new codes could be dispelled via enhanced education. It would also be beneficial to note that many tools are available to assist with using the new codes.

Clarify terminology: There seems to be some lack of understanding of what is meant by dual coding versus dual processing versus runoff claims and single date cutover. Clarifying the distinction among these terms would enhance messaging efforts.

Build an effective testing process: It is not feasible for every provider and payer to test with each other. Rather than trying to conduct a massive end to end industry testing process it would be more beneficial to establish selective testing processes that illustrate that each key function is working correctly. For example, testing a key subset of claims for provider specialties could illustrate to each specialty that those claims are being processed correctly. Results of this testing could be shared so that it would not be necessary to test with every provider of that type. For physicians, it may prove more useful to test eligibility and prior authorization functions than to test the CPT payment process that has been in place for many years. Clearinghouses might be leveraged in testing, as they have direct connections to most large payers and many provide reports on key performance indicators that can be used to identify aberrations under ICD-10. Use of voluntary pilot operations might be of value, although there are numerous obstacles, such as aligning membership and benefit data, assuring vendor products are in place and utilizing the appropriate grouper.

Establish milestones and metrics: Without milestones it will be difficult to measure progress. The milestones must be clearly defined regarding what constitutes meeting each milestone. Use of checklists or bullet points may be useful in this regard. Metrics must also be established in order to track readiness. Clinical documentation improvement was suggested as an item to include in the milestones. Vendor readiness should also be tracked, recognizing that this might include features other than just ICD-10, such as support for meaningful use. Market pressure should be considered as a means to compel vendors to deliver needed updates.

Assess financial impacts of recurring delays: Much emphasis has been placed on the cost of compliance, with little or no discussion of the cost of changing the compliance date. Much of the compliance cost has already been expended by the industry and each delay adds to the cost as described above due to extending projects, retesting, retraining and other items. This impacts budgets and places stress on already limited resources.
**Assistance and education:** Many organizations, especially smaller ones, could use additional education or other assistance in their compliance efforts. It was suggested that perhaps the regional extension centers (REC’s) could be used in this regard. There is also a large volume of industry materials available that could be useful, but organizations may not be aware it exists. An outreach and awareness campaign could prove useful. It was suggested that use of incentives of some type might encourage organizations to move forward with their compliance efforts.

**Communication:** Some concerns may be attributed to the need for better communication and collaboration across the industry. Sharing of new edits or revised medical policies due to ICD-10 would help trading partners understand what may or may not be changing and will assist them in determining where to place emphasis during testing. Communicating readiness status will also help in planning for testing.

**Contingency measures:** The roadmap must recognize that with any large implementation, something is likely to go wrong and it would be wise to anticipate types of issues that could arise and prepare mitigation strategies.

**Suggested next Steps**

The roadmap identified high-level areas to address, but did not identify specific action items. Attendees discussed a few industry actions that could be taken in the shorter term.

**Communication and messaging:** Publicize where educational resources or other tools are available. Review industry literature and terminology to assure consistent messaging exists to the extent possible. Show success stories to illustrate that ICD-10 compliance can be done and that perhaps the effort is not as difficult as anticipated for smaller organizations. Utilize local or regional resources to reach a broader audience. Also, show the positive aspects of ICD-10 instead of focusing on cause of injury codes. Illustrate that most providers will only use a subset of codes.

**Illustrate financial impact of delays:** Compile information on what has been spent to date and how much additional cost is associated with each delay. This could show that delays are proving to be more costly to the industry than moving forward to completion of compliance efforts.

**Testing process:** Develop a strategic testing methodology that reduces the testing effort while increasing evidence that processes are functioning correctly.

**Track readiness:** Develop a means to track industry readiness, including readiness for testing and readiness of vendor products.

**Congressional outreach:** Determine if there is a way to educate Congress on the positive aspects of ICD-10 and the work (and associated cost) that has been done thus far in the industry. Although WEDI does not engage in lobbying, information of this nature might be useful to organizations that do.
Conclusion

The industry is still searching for the most effective methods to complete ICD-10 testing and implementation. Much work remains to gain support from all stakeholders and to convince the industry that there will be a definite compliance deadline.

WEDI is adjusting workgroup activities to accommodate suggestions from the Summit and will be conducting periodic readiness surveys to gauge industry progress toward compliance.