Faculty

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  American Academy of Professional Coders
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  American Medical Association
- **Robert Tennant**, Senior Policy Advisor
  Medical Group Management Association
Today’s Session

• Introduction: a look at ICD-10 from the physicians perspective

• Key Implementation steps:
  – Internal awareness/assessment
  – Working with your vendors
  – Developing a budget
  – Documentation and code assignment
  – Staff training
  – Testing
  – Reimbursement issues / contingency planning
The ICD-10 Challenge

• ICD-10 is one of the biggest changes in healthcare in over 20 years
• The most significant overhaul ever of the medical coding system
• For physicians, implementing ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code
ICD-10 in Context

• Not the only government regulation you have to contend with...
  – Jan. 1, 2013: Operating Rules (eligibility, claim status)
  – Oct. 1, 2013: Insurance Exchanges
  – Ongoing: eRx and PQRS reporting (penalties)
  – Ongoing: HIPAA Privacy/Security (enforcement)

• All impact technology, workflow, revenue!
Physician Misconceptions About ICD-10 Implementation

• Only a “back office,” coder, and IT issue
• My vendors will take care of this for me
• The compliance date now Oct 2014 – there is no rush
• ICD-10 will have little impact on my business processes
• There won’t be any impact on productivity or revenue
• If I ignore it...it might just go away
Implementation Steps
Building Internal Awareness

- Expect staff push back
- Explain new timing from CMS
  - Originally Oct. 1, 2013, now compliance will be Oct. 1, 2014
- Explain consequences in inaction
  - Potential of higher cost and/or disruption of claims revenue cycle
  - Potential of not identifying adequate coding support
Gaining Internal Buy-In

- Secure ownership/management support
- Create internal ICD-10 Team (senior management, medical staff, billing/coding, IT systems)
- Create a reasonable timeline, include action steps and assign staff
- Consider peer to peer awareness campaign
Internal Steps

- Include regular updates at staff meetings, internal communications
- Collect tools and resources
- Look at this also as an opportunity to review entire claims revenue cycle
- Take advantage of new admin simp standards and operating rules.
Conducting an Impact Assessment

• Internal analysis should review:
  – Practice infrastructure
  – Computer systems (core systems and key business area applications)
  – Processes that utilize codes (workflow)
  – Information management (data, extracts, reports, etc)
  – Linkages to other internal/external business areas
Critical Vendor Questions

– Upgrade or replacement?
– Timeline for installation / testing
– Which version(s) of the software will be upgraded?
– Hardware upgrades required?
– Utilize 4010 or 5010?
– Will software permit ICD-9/10 codes?
– Are they offering any training?
– Costs covered under maintenance agreement?
Clearinghouse Questions

– What ICD-10 services will you provide?
  • What if on 4010?
– What will be the cost of the service?
– When can you accept test claims?
– Can you run a report of my top paid/denied/pended claims?
– Can you run a report identifying top “unspecified” ICD-19-CM codes?
– Are you offering any training opportunities?
Primary expenses to budget for:

- Impact assessment
- Software/hardware
- Workflow redesign
- Staff training
- Superbill redesign
- Reduced clinician productivity
Additional Areas of Potential Cost

• Project cost (staff time NOT spent doing other activities)
• Documentation review (additional review?)
• Mapping cost (consultant needed?)
• Additional staff (temp/contract) / overtime costs
• Loss of RCM productivity – rebills, rejections, EOB work, medical necessity rejections/follow up, coder slow down
ICD-10 Documentation and Training
ICD-10’s Greatest Challenge

- Documentation sufficient to support:
  - Specificity
  - Granularity
  - Support medical necessity of the code descriptor
Supporting Medical Necessity

• Justification of care depends on information found in the medical record
  – Diagnosis codes identify circumstances of patient encounter
  – Medical record documentation must be supportive
<table>
<thead>
<tr>
<th>Clinical Concepts</th>
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<tbody>
<tr>
<td>• Type</td>
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<tr>
<td>• Temporal factors</td>
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<tr>
<td>• Caused by/Contributing factors</td>
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<tr>
<td>• Symptoms/Findings/Manifestations</td>
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<td>• Localization/Laterality</td>
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<td>• Anatomy</td>
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<td>• Associated with</td>
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<td>• Episode</td>
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<td>• Remission status</td>
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<tr>
<td>• History of</td>
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<td>• Morphology</td>
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<tr>
<td>• Complicated by</td>
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<tr>
<td>• External Cause</td>
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<td>• Activity</td>
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<tr>
<td>• Place of Occurrence</td>
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<tr>
<td>• Loss of Consciousness</td>
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<tr>
<td>• Substance</td>
</tr>
<tr>
<td>• Number of Gestations</td>
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<tr>
<td>• Outcome of Delivery</td>
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<tr>
<td>• BMI</td>
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ICD-10 Documentation Assessments

- Best way to begin to prepare clinicians
- Utilize your most frequently billed codes
- Evaluate
- Can we make the transition??
Use of unspecified codes

- Will NEVER be covered?
- Does not guarantee payment?
- We will pay you less for continued use?

How do I prepare and protect my practice for this?
Education and Training

• Physicians
  • Clinical concepts- don’t overwhelm with the listing of codes....

• Coders
  – What is their job?
    • Coders/billers
    • Inpatient/outpatient

• Ancillary and other staff
  – What effects them?
ICD-10 Testing and Reimbursement
Internal Testing

- Complete internal testing to ensure all systems and work processes can function properly with ICD-10 codes
  - Can you create administrative transactions, claim, eligibility request, prior authorization, etc.?
  - Can you generate other reports – quality, public health, etc.?
  - Is your PMS – EHR interface working?

- Include testing manual processes to see how they will flow with system changes
Internal Testing (cont.)

- Software vendor may do internal testing as part of their upgrade
  - Do your own testing in addition to vendor testing to understand how changes impact work flows
- Allow time to fix any issues identified during testing
Testing should involve all of the steps a claim goes through for processing

- Identify who to test with and when they will test

- If end-to-end testing is done, review the 835 closely to see how the claim processed
  - Did the claim reject or pend?
  - Is the reimbursement what you would have received under ICD-9?
  - Were there any adjustments in the payment?

- Allow time to fix any issues identified during testing
Testing with Payers

- **Medicare**
  - Holding a testing week March 3 – 7, 2014
    - “Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.”
    - Registration information will be made available by the MACs
    - LCDs targeted to be available April 2014

- **Contact your MAC, Medicaid, and commercial plans about release of their edits and testing logistics**
Testing with Other Trading Partners

- **Clearinghouses**
  - Confirm that clearinghouse receives transactions and creates HIPAA compliant transactions
  - If you do not have Version 5010 in place, work with your clearinghouse on how they will obtain the ICD-10 codes

- **Billing vendor**
  - Confirm that billing vendor can receive necessary data and create HIPAA compliant transactions

- Confirm that the clearinghouse and billing vendor are testing with your payers
Testing plan should include:

- What transactions can be tested?
- What data will be needed to complete testing?
- Which high priority clinical scenarios should be tested?
- How will issues identified be resolved?
- What resources are available to support testing?
Key Take-aways

- Focus on payers and trading partners that make up high volume/high dollar reimbursement
- Ideal testing will test the entire flow of a claim to the payer and back with a remittance advice
- Any testing is better than no testing
- Avoid testing “in production” after Oct. 1
Preparing for Reimbursement Under ICD-10
## CMS Impact Assessment of ICD-10

Report by Noblis dated July 22, 2009

<table>
<thead>
<tr>
<th>Business Areas</th>
<th>Associated Functional Areas</th>
<th>Major Risk if the Business Areas is Not Prepared for ICD-10</th>
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<tbody>
<tr>
<td><strong>Medicare FFS Claims</strong></td>
<td>• Payment Policy</td>
<td>• Payments to FFS providers could be incorrect.</td>
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<tr>
<td><strong>Very High Impact</strong></td>
<td>• NCD/LCD</td>
<td></td>
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<td></td>
<td>• FFS Claims Processing</td>
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<td>• MSP and COB</td>
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<td>• Manage Claim Repositories</td>
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<td>• Provider Cost Reporting</td>
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<td>• Appeals</td>
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### Impact Level

<table>
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<th>Impact Level</th>
<th>Definition</th>
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<td>Very High</td>
<td>If the risks associated with this business area are not addressed, CMS will not be able to achieve its fundamental functions, such as claims payment, or plan payment. Failure in these areas would also critically affect external stakeholders. Short-term workarounds are not available to mitigate any risks that will occur.</td>
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Reimbursement Concerns

- Handling of “unspecified” diagnosis codes
  - Will payers reject “unspecified” codes?

- Installation of payer edits
  - Will they be done in time to test?

- Changes to payers policies
  - Will payers restructure fee schedules based on diagnoses?
  - Will payers change any requirements for reimbursement?
  - Will payers require more attachments/documentation reviews?
Recommendations to Limit Cash Flow Interruptions

- Have ICD-10 changes in place, staff trained, and testing completed
- Limit spending leading up to compliance date
- Set aside cash reserves
- Establish a line of credit with financial institution
- File (ICD-9) claims on time/follow up on pended/rejected claims prior to Oct. 1
- Talk to your MAC about advanced payments
- Talk to your payers about any “safety net” actions they will take to keep claims processing
Other Recommendations

● Track metrics for reimbursement before and after the transition to ICD-10
  — # of pended claims for additional information
  — # of denied claims related to diagnosis code
  — Average reimbursement for priority services
  — Overall accounts receivable

● Billing staffing needs
  — Limit vacations during transition
  — Assess need for temporary staff
  — Assess coder readiness
Key Take-Aways

- Be as prepared as possible for ICD-10
- Expect some cash flow interruptions and be prepared for how to manage through it
- Monitor your claims processing and reimbursement closely to identify any problems or unexpected changes
Questions/Answers

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