

**ICD-10 is coming:
*What does this mean for you ?***

Advisor Live
March 31
2:00 to 3:00 EST

Agenda and Meeting Objectives

Introductions

The Perfect Storm

Overview of ICD-10 Mandate

- **Timelines**
- **Benefits**

Lessons Learned from Canada

Some Common Myths and Facts

Implementation Strategies

Implementation Planning

Introductions

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The healthcare information technology sector is experiencing *The Perfect Storm*

HIPAA 5010
Timeline

ICD-10 Timeline

ARRA Privacy and Security
Timeline

ARRA Meaningful Use
Timeline

Jan 2009
Government
published final
rule

Dec. 2009
Government
publishes
interim rule

Jan 2010
Begin
education
& planning

2010
Educate, strategize
and plan for meeting
Meaningful Use

Oct. 2010
Eligible hospitals and
providers can begin to
submit for incentives to be
paid starting Jan 2011

Jan 2010-2012
Implementation

Oct 2013
Compliance
for all entities

Jan 2009
Government
published final
rule

Aug 2009
Government
published final
rule

Jan 2010
Begin
planning

Feb 2010
Compliance for
all entities

Jan 2011
Implementation

Jan 2012
Compliance for
all entities

2015
Penalties begin if providers
cannot demonstrate
Meaningful Use

Overview of ICD-10

Background of ICD-10

- On March 17, 2009 the Federal Registry set the mandate for the US to implement ICD-10
- Specific dates of compliance are:
 - **January 1, 2012**; HIPAA Version 5010
 - **October 1, 2013**: ICD-10 code sets for all **covered entities**
 - Covered entities include health plans, clearinghouses, health care providers that transmit electronic health information
 - Diagnosis coding (ICD-10-CM (Clinical Modifications)) in **all** healthcare settings and providers
 - Procedure coding (ICD-10-PCS (Procedure Coding System)) for hospital inpatient procedures only
 - CPT and HCPCS will continue to be used in physician offices and ambulatory settings

Background of ICD-10

- The US has been using ICD-9 since 1979
 - Current system is outdated and antiquated
 - Not able to effectively assign new codes describing rapidly changing medical treatments and technological growth
- Clinical codes must be capable of accurately describing diagnoses, illnesses and medical procedures
 - Critical to improve the quality of healthcare
 - Critical to the design of a more equitable reimbursement model
- While the US is just beginning the planning from ICD-9 to ICD-10, many other countries have implemented ICD-10 (United Kingdom 1995, Canada 2001) and are already looking to move to ICD-11
- Magnitude of this change will bring significant risk and opportunities

Background Continued...

- Move from ICD-8 to ICD-9 was an update
 - **The move from ICD-9 to ICD-10 will be an overhaul !!**
- Technology and business costs of remediation will be enormous
- Virtually all technologies and processes will be affected
 - Transactional systems
 - Clinical systems
 - Back office systems (including storage capabilities)
 - Staff transition
 - Staff education (coders, physicians and other clinicians)
- Providers and payers will have similar challenges
 - Costs
 - Complexities
 - Change Management
 - Managing priorities

Comparison of ICD-9 to ICD-10

ICD-9-CM Volume 1 & 2	ICD-10-CM
13,677 diagnosis codes	68,065 diagnosis codes
3-5 characters in length	3-7 characters in length
First digit may be alpha (E or V) or numeric; digits 2-5 are numeric	First digit is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric
Limited capacity to add new codes	Flexible for adding new codes
Difficult to analyze data due to non-specific codes	Specificity improves coding accuracy and richness of data for analysis
Does not support interoperability	Supports interoperability and the exchange of health data within the US and other countries

Comparison of ICD-9 to ICD-10

ICD-9-CM Volume 3	ICD-10-PCS
3,768 procedure codes	72,600 procedure codes
Numeric code structure (up to 4 digits) – no embedded meaning in characters or digits	Alpha-numeric code structure (up to 7 characters) – semantic meaning within characters
Procedure codes based upon name of procedure	Intervention codes based upon intent of procedure
Use of generic terms for body parts with little detail for procedure types & approaches	Provides detailed descriptions on procedural methods, approaches, body parts, devices
Limited capacity to add new codes	Flexible for adding new codes
Reflects outdated technology and medical / surgical techniques	Reflects current usage of medical terminology and devices

Partial List of Impacted Areas in Healthcare Continuum

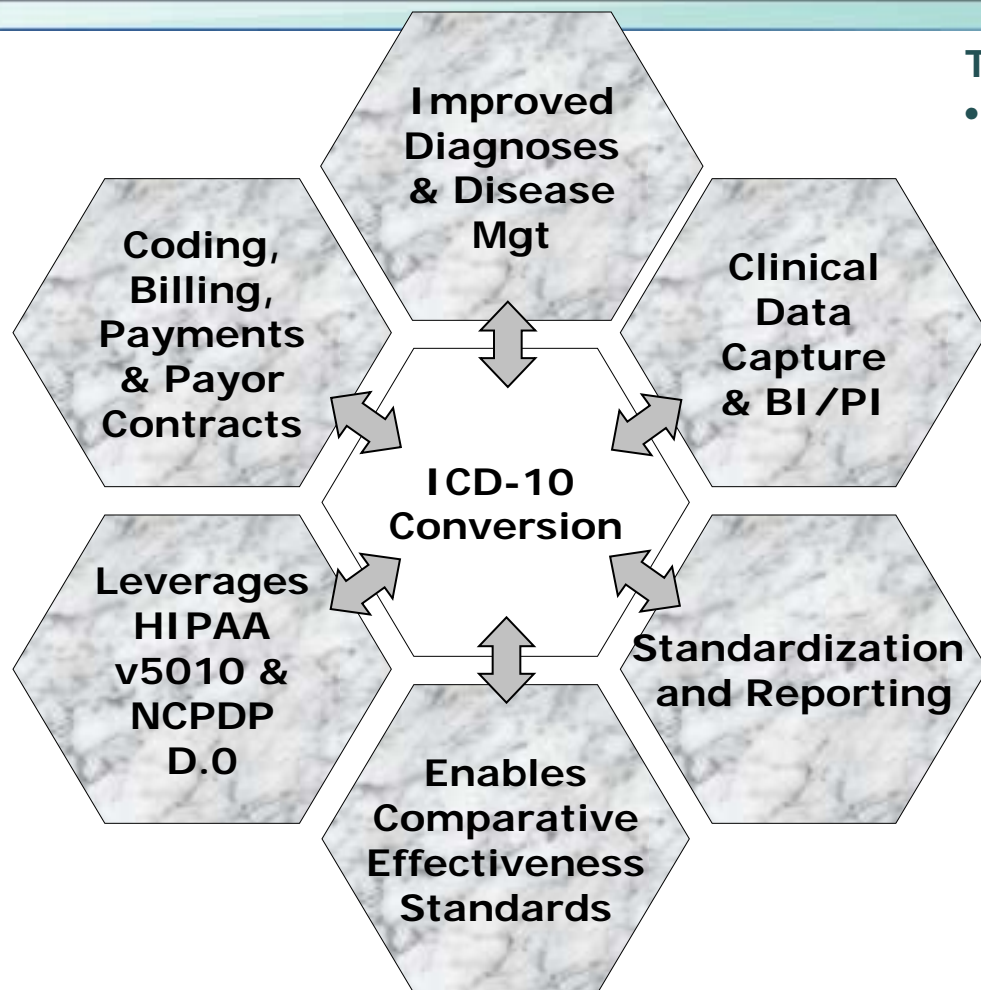
Key Constituents and Major Functions Impacted

Physicians	Hospitals	Health Plans and HMOs		Vendor
<ul style="list-style-type: none"> • Electronic Health Records • Practice Management Systems • Billing • Accounts Receivables • Net Productivity Loss 	<ul style="list-style-type: none"> • LAB • ADT • Radiology • Pharmacology • Physician Order Entry • Image Management • Supplies and Inventory Management • Bar Coding • Billing 	<ul style="list-style-type: none"> • Claims • Fraud and Abuse • Customer Service • Reimbursement • EOBs/EOPs • Network Contract • Actuarial • Underwriting • Rating 	<ul style="list-style-type: none"> • Enrollment • Utilization Review • Benefits • Contracts • EDI/Editing • OCR/Imaging • ERA/EFT • Reporting • Data Warehousing 	<ul style="list-style-type: none"> • Revenue cycle applications • Clinical documentation applications • Encoders/HIM applications • Decision support content providers • Specialty ancillary applications
Specialty Providers	Supplemental Health Industry Organizations	Health Care Tools /Decision Support	Government Programs	Major State Government Programs
<ul style="list-style-type: none"> • Veterans Hospitals • Federal Hospitals • Nursing Home • HHAs 	<ul style="list-style-type: none"> • TPAs • Workers Comp • Auto Liability • Self Admin. Employees 	<ul style="list-style-type: none"> • Predictive Modeling • Health Coaching • Personal Financial Tools (e.g. MSA, FSA, HRA, etc) 	<ul style="list-style-type: none"> • Medicare (Same as Health Plan – Less Network/Rating) • Medicaid (Same as Health Plan – Less Network/Rating) 	<ul style="list-style-type: none"> • University Medical Centers • Children’s Health Insurance Plans • Student Health Programs • Department of Corrections • Minority and Rural Health Programs • State Health Information Databases • State Public Health Programs

HIPAA 5010 is a Prerequisite

- Before the transition to ICD-10 can begin, organizations must move to the next generation of HIPAA transaction standard - Version 5010
 - This communication standard is necessary to utilize the new and improved ICD-10 codes
 - Current version 4010 will not work with ICD-10
 - Version 5010 is a major re-write of the HIPAA transaction standards
 - Proposed implementation date for Version 5010 is:
 - ***January 1, 2012***
 - 22 months before actual ICD-10 implementation
- Many of the same strategic and tactical planning activities for ICD-10 should be applied to the 5010 implementation
 - The need to begin these activities is ***now***
 - Testing activities for vendor, payer and clearinghouse systems must occur in 2011 in order to meet 2012 deadline

Transformational Value to Providers



Transformational Value to Providers

- ICD-10 conversion is transformational to all aspects of provider business
 - **Patient Care** – better diagnosis, diagnosis-based decision support, and support of federal clinical “Comparative Effectiveness” standards goals
 - **Financial** – improved billings and collections from Medicare; decreased diagnosis related denials; improved accuracy and margins in payor contracts
 - **Operations** – ICD-10 specificity creates huge advantages in Business Intelligence/Performance Improvement data sets
 - **IM/IT** - ICD-10 granularity allows for greater standardization between clinical and administrative applications and reporting capabilities
 - **Patient Security/Interoperability** - HIPAA v5010 and NCPDP (National Council for Prescription Drug Programs) D.0 implementation is fully leveraged to accommodate ICD-10

Lessons Learned from.....



Background of ICD-10 from Canada

- 1995 – Agreement reached between World Health Organization (WHO) and Canada to adopt ICD-10
 - Work began in 1999 to develop a Canadian version of ICD-10 and the Canadian Classification of Health Interventions
 - Resulted in ICD-10-CA/CCI (Canadian Classification of Interventions)
- ICD-10-CA/CCI was implemented in Canada on 01 April 2001
 - Supported by Federal Government
 - Developed and implemented by the Canadian Institute for Health Information (CIHI)
 - Provincial approach to staged implementation
 - Challenges were experienced
 - Many lessons were learned that can be applied to the US implementation experience

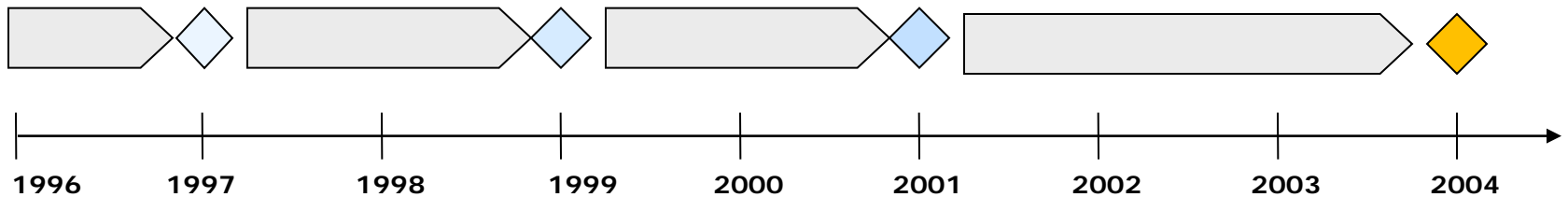
Canadian Implementation Effort

1997
National
Integrated Plan
approved

1999
ICD-10-CA
development

April 2001 mandated
implementation in 10
provinces to occur w/in
2 year timeframe

2004
Implementation
completed in 8/10
provinces



Expect Staff Productivity Losses

Across all types of care types

- From a workload perspective, this makes sense since coders are now looking for more information in patient record
 - Productivity never rebounded to pre-ICD-10 levels!!
- Use of pre-defined coding lists within ambulatory care settings mitigated loss of productivity

**Sample Canadian Coding Productivity (Charts Completed per Hour)
Pre- and Post-ICD-10 Implementation**

	ICD-9-CM (April 2002)	Start ICD-10-CA/CCI (July 2002)	ICD-10-CA/CCI (April 2003)
Inpatient	4.62	2.15	3.75
Day Surgery	10.68	3.82	8.53
Emergency	10.37	6.49	8.83

Note: Data taken from Humber River Regional Hospital, Toronto, Ontario

Expect Informational Issues

- Significant ICD-9 to ICD-10 code comparability concerns and differences in logic and hierarchical structure of the code sets
- Change in coding classifications required that all reports needed to be analyzed, validated and re-written
 - Field size changes
 - Numeric vs. alphabetic characters
 - Logic changes due to the revised structure of the codes
 - Data collection standards/rules and underlying principles
 - Challenges to trend historically
 - Crosswalks were not possible or were unreliable
- Requirement to retain historical data, and the applicable systems, for historical comparable data reporting
- This is an opportunity to review the quality and usability of your reports and other outputs

Expect Large Investment In Education

- Both for basic staff training and ongoing assessment of coding education and skills
- Start training early for key individual(s) who will be most closely involved with the implementation and conversions
- A wide variety of stakeholders, including physicians and other clinicians, will require training
 - In order to understand the new requirements for more detailed documentation
- The experience in Canada
 - 5 day self-learning package and 2 day in-person training was found to be insufficient for the acute care coders
- The amount of training allocated to staff also affected long term recovery of lost productivity

Expect Operational Issues

- As in any major system or process change implementation, unforeseen obstacles arose
- For example:
 - The flow of data elements and software functionality changed
 - Software enhancements were required for data quality edits
 - Mapping and reconciliation of the data from/to the various interfaced systems was required
- The vendor **must** be able to meet all stated facility requirements
 - These can be data, workflow or software functionality requirements

How did ICD-10 help Canada?

- The richness of the data provided value added benefits
 - Increased level of specificity for clinical, case costing, and decision support reporting.
 - Provided more relevant data for epidemiological, research and other secondary uses of data for population health management.
 - This mitigated the necessary costs, system and process changes and change management practices
- ICD-10 allowed for opportunities for clinical data comparisons (diagnoses, outcomes) to advance service delivery and system efficiencies and effectiveness
- CIHI (Canadian Institute for Health Information) now has a wealth of information which allows them to report on population health and wellness
 - Research
 - Resource allocation
 - Healthcare planning and decision making

Some Myths and Facts

ICD-10 Myth and Fact # 1

MYTH

- The October 1 2013 compliance date for implementation of ICD-10-CM/PCS should be considered a flexible date.

FACT

- All covered entities under the Health Insurance Portability and Accountability Act (HIPAA), 1996 MUST implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after 01 October 2013.
- HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required in order to implement ICD-10-CM/PCS by 01 October 2013.

Note: Department of Health & Human Services USA, ICD-10-CM/PCS Myths & Facts, June 2009, Medicare Learning Network, <http://www.cms.hhs.gov/MLNGenInfo>, ICN 902143.

ICD-10 Myth and Fact # 2

MYTH

- The increased number of codes in ICD-10-CM/PCS (> 140,000) will make the new coding system impossible to use.

FACT

- Just as an increase in the number of words in a dictionary doesn't make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn't necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS make it easier to find the right code.

ICD-10 Myth and Fact # 3

MYTH

- ICD-10-CM/PCS was developed without clinical input.

FACT

- The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

ICD-10 Myth and Fact # 4

MYTH

- Current Procedural Terminology (CPT) will be replaced by ICD-10-PCS.

FACT

- ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will NOT affect the use of CPT.

ICD-10 Myth and Fact # 5

MYTH

- There will be no hard copy ICD-10-CM and ICD-10-PCS code books. When ICD-10-CM/PCS is implemented, all coding will need to be performed electronically.

FACT

- ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher's book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

ICD-10 Myth and Fact # 6

MYTH

- ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

FACT

- ICD-10-CM/PCS codes have been updated annually since their original development in order to keep pace with advances in medicine and technology and changes in the health care environment. The coding systems will continue to be updated until such time that a decision is made to “freeze” the code sets prior to implementation.

ICD-10 Myth and Fact # 7

MYTH

- Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

FACT

- As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity.

ICD-10 Myth and Fact # 8

MYTH

- Implementation of ICD-10-CM/PCS can wait until after electronic health records and other health care initiatives have been established.

FACT

- Implementation of ICD-10-CM/PCS cannot wait for the implementation of other health care initiatives. As management of health information becomes increasingly electronic, the cost of implementing a new coding system will increase due to required systems and applications upgrades.

Implementation Strategies

ICD-10 implementation will present an opportunity to US organizations

- Re-evaluation of organizations strategic goals related to how it collects, maintains and uses its clinical information
- Impact of changes will be significant and widespread
 - Therefore, the opportunity for *advancing* key strategic initiatives is also widespread
- Organizations need to balance the level of change with its tolerance for risk, level of workload required in the context of other initiatives and economic/cost factors

Various implementation strategies can be used

Transformational

- *Leverage as a means to drive organizational change*

Tactical

- *Operational approach - “keeping the lights on”*

Blended

- *Pragmatic approach using strategic tools to manage change on a selective basis*

Transformational Strategy

- Implement ICD-10 as a means to
 - Introduce new clinical documentation improvement strategies
 - Change / redesign other processes, systems and technologies
 - Improve clinical data and information within your EHR / EMR
- Opportunity to design implementation to take advantage of and maximize ARRA changes
- Look for opportunities for future investments that are truly strategic and differentiating

Tactical Strategy

- “Keeping the lights on” - More of the same, i.e. business as usual with new coding methods
- Maintain existing business processes
- Limited system modifications to accommodate necessary changes
 - “Patch in” approach
- However, organizations will need to:
 - Ensure documentation practices can support new ICD-10 requirements
 - Educate physicians, other clinicians, HIM staff in new/improved documentation practices and policies
 - Make (potentially) significant changes to systems, including interfaces to downstream (internal and external) systems
 - Convert historical data and maintain concurrent coding practices for a period of time (for ambulatory procedural coding, permanently)
 - Ensure revenue cycle processes remain robust

Blended Strategy

- Use ICD-10 as a strategic tool to trigger more effective investments in new processes, systems and technologies on a selective basis, i.e. manage the change
- Enhance core systems for direct collection and processing of ICD-10 data
 - Upgrade/replace systems to retain core rules and functions as currently implemented
 - Review workflow processes in key areas such as HIM, Revenue Cycle, contract compliance, utilization and quality management

Implementation Planning

High Level Project Plan

Task	Date
Develop preliminary Impact Assessment	
Meet with Executive Leaders to obtain support and funding for implementation	
Develop ICD-10 Strategy and Tactical Plan	
Identify Key Stakeholders & Interdisciplinary Project Leadership and Staff to manage transition	
Develop Detailed Project Plan, timelines & Budget	
Develop Education and Training strategy and plan	
Confirm detailed Readiness Assessment , including scope of clinical documentation requirements	
Identify integration/interface requirements between systems	
Develop and Implement Change Management and Communication Plan	
Implement new / revised systems and processes; Manage Change	
Evaluate implementation and address remaining gaps; perform audit	

Readiness / Impact Assessment

- Creation of Implementation Project Team
- Creation of awareness throughout organization
 - Senior Management
 - Clinical Department managers and staff
 - Physicians and other clinicians
- Identify multi-year budget estimates for required:
 - System Changes
 - Education and Training – Physician, other clinician and HIM staff
- Develop/Refine Communication, Change Management and Data Quality Plans
- Define alignment and “fit” with overall EHR plan for organization and regional networks

Readiness / Impact Assessment

- Conduct detailed assessment of staff education and training requirements
 - This will extend beyond HIM and IS departments to accounting, auditors, quality management, utilization management, data analysts, researchers, data quality and security, and others
- Analyze current data and workflow processes to understand impact and level of change
- Assess potential reimbursement impact (changes in case mix index and reimbursement group (DRG) assignment, reimbursement/payment schedules, claims denials/rejections)

Education

- Investigate education for key individuals (trainers, SMEs) to act as lead resources for remainder of staff
- In-depth education is required; it may take a variety of forms:
 - On-site
 - Distance
 - Self-study
 - Proven self-directed learning specific to ICD-10 is available
- AHIMA / AHA estimates of education requirements
 - 16 hours for ICD-10-CM
 - 24 hours for ICD-10-PCS
 - 10 additional hours of practice applying both systems
 - Six month learning curve
- Coding evaluation at pre (baseline) and post-implementation timeframes will be required (automated tools are available)

Improvements to Clinical Documentation

- Conduct assessment of current clinical documentation processes and practices
- Identify deficiencies in documentation practices necessary to support more detailed coding requirements
- Identify target areas for improvement
 - Segments of physician staff
 - Types of care / service provision
- Emphasize value of more concise/detailed documentation by providing examples of
 - Enhancements to reimbursement
 - Better evidence of quality outcomes
- Develop plan for on-going monitoring of documentation practices post-implementation

Information Systems

- Understand vendor approach to software upgrade / new system implementation
- Conduct preliminary “readiness assessment” testing of abstracting software
 - Involve HIM and other key stakeholder staff
 - Include integration (ADT interface) data quality checks
 - Test enhanced reporting capabilities
 - Payer Claims transactions (at least six months prior)
- Key evaluation factor: the ability for the software vendor to be ready for on-going ICD-10-CM/PCS support and upgrade to new/revised codes and logic over time
- Expect major decisions
 - For example: Will historical coded data be converted into the new system? Can the system handle concurrent ICD-9 & -10 coding? If not, how will processes be managed to accommodate both systems?

Information Systems

- Conduct systems inventory and audit (all databases and applications utilizing ICD-9-CM codes)
- Assess changes to **all** systems and applications that send/receive coded data (EHR, decision support, order entry/results reporting, billing/accounting, etc)
- Determine length of time for dual system operation for operational reasons (coding backlogs) and historical data conversions
- Ensure that:
 - Servers and end-user workstations can adequately handle new software
 - Adequate number of PCs with new software test environment are available for initial and future testing
 - New and ongoing installation of new software and upgrades
 - Vendors have remote access to hospital servers

Concluding Remarks

- October 2013 is coming faster than you may realize
 - CMS has clearly stated that this timeframe will not change
 - Experience from other countries has shown that a minimum of three years will be required
- The conversion and transition to ICD-10 has the potential to be a major impact on an organization which can also present strategic opportunities
 - There is a strong interdependency with other mandated and organizational initiatives and projects

Concluding Remarks

- Areas of Largest Potential Impact (based on previous experiences and lessons learned)
 - Staff Productivity
 - Information Analysis and Reporting
 - Investment in Education
 - Operational and workflow issues
- Readiness / Impact Assessment and Planning should be occurring now, in the areas of:
 - Systems & Applications
 - Technology (integration, underlying infrastructure)
 - Education
 - Workflow and Organizational processes

For More Information

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