Answering the Tough ICD-10 Questions: Coding Experts Offer Tips on How to Make it to October 1, 2015 and Beyond

By Barbara Hinkle-Azzara, RHIA, and Kim Carr, RHIT, CCS, CDIP, CCDS

At a US House of Representatives subcommittee hearing on February 11, lawmakers and stakeholders agreed that the implementation of the ICD-10-CM/PCS code sets should not be further delayed. Moreover, in March the House passed legislation that provides a permanent replacement to the Sustainable Growth Rate (SGR) with no delay of ICD-10 added to the bill. The Senate confirmed its passage on April 14, 2015, further clearing the way for ICD-10 to become the US code set on October 1, 2015.

Now with only four months to go, it is imperative that providers prepare. This is the optimal time for health information management (HIM) directors to make their final push to secure resources and funds necessary to ensure a successful conversion to ICD-10. The healthcare industry must now move full speed toward October 1, 2015. This includes balancing the ICD-10 practice needs of tomorrow with the ICD-9 discharged not final billed (DNFB) demands of today.

It is now time to answer the tough ICD-10 questions lingering on the doorstep of the new code set's implementation. Below, HIM experts answer these questions and offer advice on how best to hit the implementation deadline running.

How to Overcome Organizational Skepticism After Years of Crying Wolf

After all the setbacks and delays, many hospital executives remain reluctant to dedicate additional resources toward the ICD-10 conversion. Few providers have sufficient resources to keep preparing year after year without benefit of progress or return on investment. But while caution is understandable, time has run out.

When the 2014 delay was announced, some organizations dropped their ICD-10 readiness programs altogether. Others maintained their progress, but at diminished rates. For example, hospitals on the progressive end of ICD-10 readiness continued to dual code, but decreased their volume. Hospitals on the conservative end stopped dual coding altogether and are just now reinstating their programs. And the perspective from IT departments is that some health information technology (HIT) software vendors also postponed ICD-10 software updates and transition testing.

Size makes a difference when it comes to ICD-10 preparation. Larger organizations are more likely than their smaller counterparts to have funding for multiple projects. Therefore, they've had more resources available to continue preparing for ICD-10.

Smaller facilities typically lack funding for more than one project at a time, and thus focused on immediate concerns during the past year. Resources went first to electronic health record (EHR) systems, and then to ICD-10. Each ICD-10 delay made it harder for HIM directors to convince team members that ICD-10 remained a priority.

But some remained vigilant in their ICD-10 preparations. Rochester Regional Health System, based in Rochester, NY, demonstrates how strong HIM leadership helps to sustain ICD-10 momentum. By maintaining their dual coding program and tightening collaboration with their ICD-10 planning team, the HIM team at Rochester Regional has successfully progressed toward ICD-10 despite the delay. For this organization, HIM is the epicenter of the ICD-10 change.

Regaining Lost ICD-10 Momentum Hard, But Possible

Serving New York's greater Rochester and Finger Lakes regions, Rochester Regional Health System combines the resources of legacy Rochester General Health System and legacy Unity Health System with a team of 14,000 caregivers providing services for more than 150 locations across four counties. The organization's HIM leadership team for ICD-10 includes: Karen M. Linder, BS, RHIT, CCS, CCS-P, AHIMA-approved ICD-10-CM/PCS trainer, coding manager; Julieanne Arcuri, MS, RHIT, CCS, AHIMA-approved ICD-10-CM/PCS trainer, coding manager; Kimberly Miller, RHIT, CCDS, AHIMA-approved ICD-10-CM/PCS trainer, manager of clinical documentation improvement; and Judy Kelly, MS, RHIA, CCS, CCS-P, AHIMA-approved ICD-10-CM/PCS trainer and senior director of HIM.

Linder, Arcuri, Miller, and Kelly kept implementation efforts steady during the delays, especially in the areas of dual coding and clinical documentation improvement (CDI). Also, the organization's ICD-10 project team remained intact and active, meeting every two weeks with representation from HIM, CDI, denial coordination, and information technology (IT) departments. Other attendees to the committee included the coding integrity coordinator and a physician advisor. The organization's testing and IT systems took a break from ICD-10 during the delay to address stage 2 of the "meaningful use" EHR Incentive Program, but as of January 2015 their focus was back on ICD-10 and system readiness.

"We maintained and kept our dual coding program going during the delays, while continuing to audit our dual coded cases," Arcuri says. "It took a lot of hard work and planning to get the program up and running initially, including contracting with an outside coding company for back-up inpatient (IP) coding support." The organization didn't want to waste the progress they had made. Furthermore, the ICD-10 executive sponsor remained supportive of funding the dual coding investment.

"To help subsidize our dual coding program, we split the costs between operations and the ICD-10 budget," Kelly says. Data gathered through dual coding now helps steer final preparedness efforts and support continued executive investments in the program.

However, continuing funding for the CDI program was difficult. "CDI team attrition occurred during the delay, which required additional funding for training. We're now rejuvenating the CDI team with new staff, but recruiting and training CDI specialists is challenging," Kelly says.

Top Obstacle to ICD-10 Implementation: Compliance Date Uncertainty

Since 2009, WEDI has conducted surveys to assess readiness for ICD-10 implementation. Findings from the latest WEDI survey, conducted in February 2015 and released April 3, show some progress since the 2014 survey.[1]

However, compliance date uncertainty has led to new readiness concerns, with more than 50 percent of all respondents—providers, vendors, health plans—citing "uncertainty over future delays" as the primary obstacle to implementation progress. About two-thirds of the 1,174 survey participants had slowed or entirely stopped preparation as a result of the delay. The 2015 survey included 796 providers, 205 health plans, and 173 vendors.

Four key areas were impacted by the 2014 delay, according to the WEDI survey:

1. Provider Impact Assessments

About 33 percent of providers had completed impact assessments, down from more than 50 percent in August 2014. Further analysis revealed:

- More than 60 percent of hospitals/health systems had completed assessments.
- Fewer than 20 percent of physician practices had completed assessments.

2. Provider Testing

Only 25 percent of respondents had begun external testing and only a few others had completed this step, down from about 35 percent in August 2014. Further analysis showed:

- More than 50 percent of hospitals/health systems had begun external testing.

- Approximately 10 percent of physician practices had begun external testing.

3. Health Plan Testing

More than 50 percent of health plans had begun external testing, and few had completed testing.

4. Vendor Product Availability

About 60 percent said their vendor products were available or they had started customer testing, a slight decrease from about two-thirds in August 2014.

Read the results of the full survey at www.wedi.org/docs/resources/full-comment-letter-and-survey-results.pdf?sfvrsn=0.

How to Find Coding Gaps, Analyze for Efficiency

During the delay, Rochester Regional used claims analysis software to review all dual coded claims and identify shifts in diagnosis-related groups (DRGs). The results of this analysis have helped the coding team understand ICD-9 versus ICD-10 coding as well as claims and reimbursement differences. The inpatient coding integrity coordinator/educator (CIC/E) continues to analyze the root causes of these differences and reports back to the ICD-10 team.

The DRG differences between ICD-9 and ICD-10 as identified through dual coded claims analysis fall into three categories:

1. Coder knowledge/learning/dealing with the new complexities of ICD-10
2. Documentation gaps/CDI opportunities
3. Changes to severity of illness classification—complication/comorbidity (CC) or major complication/comorbidity (MCC) cases

A pyramid of the coding team, CIC/Es, and CDI specialists focus on high-impact cases and areas to address the three reasons for DRG shift. By far, the most common reason for DRG shift is coding knowledge, particularly in the procedure coding system (PCS). Root operations, additional knowledge of anatomy and physiology, and device detail are key concepts for coders. The common themes found through auditing are shared with coders as broader educational efforts, including team huddles.

ICD-10 Has a Huge Learning Curve—Use Backups if Necessary

There is a huge learning curve for ICD-10. The goal at Rochester Regional is to make sure everyone responsible for any type of code assignment completes the curve prior to the October 1, 2015 deadline. Meeting this goal will help minimize the impact to accounts receivable (AR). However, it will always be a fine balance between ensuring thorough preparation for ICD-10 and maintaining a healthy AR.

To gain ICD-10 knowledge while simultaneously meeting ICD-9 deadlines, the organization partnered with an outside coding company early in the process and has continued to use their support. “Our back-up contract coders from HRS manage the day-to-day inpatient coding workload so that our internal coding team can dual code cases, keep practicing, and maintain their knowledge,” Arcuri says.

HRS also worked with Rochester Regional’s HIM team to create a set of practice cases for dual coding. These dual coded cases give the contract coding service provider an opportunity to establish Rochester Regional-specific coding guidelines for ICD-10 ahead of the curve. HRS will also support Kelly’s team during implementation to help cover expected productivity drops.

Organizations with minimal ICD-10 funding can take advantage of free coding seminars. Vendors, the Centers for Medicare and Medicaid Services (CMS), and the American Hospital Association (AHA) offer ICD-10 outreach and training webinars for all stakeholders. While many of these resources don’t provide complete coder training, they are a step in the right direction—offering comprehensive overviews of ICD-10 for general users and administrative audiences.

Most Physicians Don't Like ICD-10—Convince Them

When you're in the coding trenches, you understand the need for ICD-10. But beyond HIM, it is difficult for stakeholders—especially physicians—to swallow the short-term cash outlay to realize a long-term, global benefit. Likewise, it's hard to convince those not in the coding trenches that ICD-10 has long-term value. In fact, some physicians refer to ICD-10 as "the unpopular mandate." In terms of dollars, making the case for a huge short-term hit to achieve a long-term gain is not easy.

According to an article in AHIMA's *Perspectives in Health Information Management*, it will take inpatient coders 69 percent longer to code in ICD-10.[2] That is because the codes are much more specific, requiring additional documentation from providers. Education for physicians, mid-level providers, and other clinicians is critical for ICD-10's success.

In a recent study by Nachimson Advisors, it is estimated that the move to ICD-10 will increase documentation activities about 15 to 20 percent.[3] This translates into a permanent increase of three to four percent of a physician's time spent on documentation for ICD-10-CM. Nachimson suggests that this will be a permanent increase, not just an implementation or learning curve during the initial phase of ICD-10. It is a physician workload increase with no expected boost in payment, due to the increased requirements for providing specific information for coding.

Physicians must be educated on documentation requirements to allow assignment of the most specific and accurate codes when they are charting encounters. Even if they begin with a limited volume of cases, physician practices should ensure registration, coding, and billing staff are practicing with ICD-10. If they don't start soon, getting up to speed after the October 1, 2015 deadline will be difficult. "Our physician educational efforts were significantly impacted by the delay," Kelly says. The organization re-evaluated its timeline and is now restarting physician training for ICD-10.

For physician offices, Linder's focus is to "audit and educate" directly with clinicians. Her goal is to raise the urgency and focus on learning ICD-10 as it relates to their specific cases and patients. "There is a great need for outpatient (OP) CDI," Linder adds. "This need is not greater than inpatient, but it's just as important. The clinics have been very receptive to our reviews and help."

"Physician offices are generally places where people are coding, but they aren't necessarily trained coders. It's just a part of the job, not their designated role," Kelly says. Examples include front desk staff, nurse assistants, and physicians handling coding assignments themselves. Because these are non-traditional HIM areas, there is a strong possibility for pushback on more education. "We just want them to learn the basics at this point and by doing so begin looking ahead to how much more ICD-10 information they'll need in the year ahead," Linder says.

Best practice is to begin with the top 10 DRGs for each specialty. HIM teams should conduct documentation reviews for their affiliated practices and staff. Starting with notes for the physician visits, Rochester Regional has two resources dedicated to conducting office documentation reviews.

"Some doctors are going to hit a wall," Linder suggests. "Searching for ICD-10 narratives will take longer, and physicians may also experience a productivity setback on the number of relative value units they generate." Linder expects that HIM will be asked to do a lot more remedial work, education, and support for medical practices once ICD-10 is implemented.

Kelly and her team suggested other HIM departments work with their physicians to identify keywords that they can use within EHR systems to limit searches and find ICD-10 codes quickly. Physician practices are also advised to allow extra time for patient visits during the upcoming conversion.

At an executive level, Kelly and her team communicated the risk of poor physician practice readiness for ICD-10. There's still a significant amount of risk to hospital organizations with regard to physician practices and ICD-10, including:

- Physician practices don't have extra staff to allow for dual coding.
- Codes in everyone's "head" will change—you can no longer rely on memory.
- ICD-9 cheat sheets are no longer valid, and ICD-10 cheat sheets may be too onerous.
- Staff in offices may need to clarify more codes with the provider.
- Doctors are familiar with frequently-used ICD-9 codes; this will not be the case in ICD-10.

No One is Likely Responsible, So Take Responsibility for Updating the EHR

Finally, using tools already available is another good way to reignite ICD-10 education with physicians and begin improving clinical documentation for ICD-10. Building prompts into EHR documentation templates is one simple, yet effective, way to make physicians aware of additional documentation requirements for ICD-10.

While HIM is not directly responsible for building ICD-10 prompts into the EHR, they should work closely with CDI and IT teams to get the job done. Many organizations struggle to identify an official "owner" for this task, creating gaps in ICD-10 preparation.

At Rochester Regional, the CDI team prompts physicians for more specific documentation for ICD-10, especially around laterality. Some prompts have been implemented with the organization's order entry and problem list modules.

Stop Stalling and Get on Board the ICD-10 Wagon

At this point, the industry can't afford to postpone preparations any further. Though healthcare leaders are dealing with many priorities right now, they must get on board with ICD-10. The short-term costs will be forgotten once the long-term benefits are achieved.

In a letter to Department of Health and Human Services Secretary Sylvia Mathews Burwell, former Workgroup for Electronic Data Interchange (WEDI) Chair Jim Daley expressed concern about industry preparedness, stating that many organizations failed to take full advantage of the additional time afforded by the most recent one-year delay.[4] "Unless all industry segments take the initiative to make a dedicated effort and move forward with their implementation work, there will be significant disruption on Oct. 1, 2015," Daley says.

HIM professionals must lead the charge to regain ICD-10 momentum and keep that momentum going during the next few months and beyond. This includes reaching out to affiliated physician practices to provide support. Collaboration is the key to success. The sooner organizations realize this, the better off they'll be in this new world of ICD-10.

Notes

[1] WEDI. "WEDI Survey Suggests Mixed Industry ICD-10 Readiness." WEDI press release. April 6, 2015. www.wedi.org/news/press-releases/2015/04/06/wedi-survey-suggests-mixed-industry-icd-10-readiness.

[2] Stanfill, Mary et al. "Preparing for ICD-10-CM/PCS Implementation: Impact on Productivity and Quality." *Perspectives in Health Information Management*. June 2014. http://perspectives.ahima.org/wp-content/uploads/2014/06/PreparingforICD10.pdf.

[3] Nachimson Advisors. "The Cost of Implementing ICD-10 for Physician Practices – Updating the 2008 Nachimson Advisors Study." February 12, 2014.

[4] WEDI. "Letter to HHS Secretary Burwell on Workgroup for Electronic Data Interchange ICD-10 Survey Results." March 31, 2015. www.wedi.org/docs/resources/full-comment-letter-and-survey-results.pdf?sfvrsn=0.

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