Gauging Stakeholder Response to ICD-10

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Starting with services provided on or after October 1, 2015, health systems across the country transitioned to coding with the International Classification of Diseases, 10th Revision (ICD-10). Implementation of ICD-10 is intended to deliver both immediate and long-term benefits including greater specificity and data reporting, which can lead to more accurate reimbursement, increased coding accuracy, easier reporting across international lines, and improved patient care and public health surveillance.

By the end of October, the Centers for Medicare and Medicaid Services (CMS) reported that fewer than one in 1,000 Medicare claims filed in the first four weeks of ICD-10 submissions were rejected due to invalid ICD-10 codes. About two percent of the 4.6 million claims filed daily from October 1 to October 27 were rejected due to incomplete or invalid information, but that includes a variety of problems, CMS says. The rate of total claim denial, about 10 percent, was on par with the historical baseline rate when using ICD-9, according to CMS data.[1]

ICD-10 and EHRs

As the ICD-10 "go-live" deadline has officially passed, AHIMA has collected responses from different sources to begin to examine how facilities, payers, providers, and vendors have fared with meeting the compliance deadline. Additionally, AHIMA sought to examine the impact ICD-10 has had on an organization's electronic health record (EHR) through an informal survey conducted via the AHIMA Engage online community and e-mails with AHIMA Practice Council members.

When providers and facilities were asked if their vendors were ready for ICD-10, responses included "yes," "not until the very end," and "no." Those who did experience issues with vendors stated that most were resolved within 24 hours to a week. Payers appeared to be ready to receive facility/provider claims, according to respondents. At the time they were surveyed, some respondents indicated that it was still too early to tell if their claims were going to be paid correctly.

ICD-10 is integrated into other e-health initiatives such as the "meaningful use" EHR Incentive Program, and its granularity must be supported in EHR documentation. This granularity will contribute to improved quality and outcomes data, provide cost effective approaches to delivering healthcare, and supply information for better research. Meaningful use without ICD-10 could result in vague information exchange data; patient confusion with portal-based personal health data that is incomplete and even inaccurate; and quality measures that would remain tethered to obsolete documentation from ICD-9-CM.

Provider Reaction to ICD-10

All facilities and providers who responded to AHIMA's inquiry indicated that they dedicated the needed time and energy to ICD-10 preparation to ensure the implementation went well. Some of these responses are included below, with respondents remaining anonymous at their request to ensure frank details were included in their remarks.

"We put a lot of time and thought into testing systems and workflows. We also focused heavily on the transition period that began mid-summer to identify solutions and temporary configurations to aid in the receipt of future-dated orders for services and tests, medical necessity checking, and things of that nature," says one provider.

Coder productivity, a major concern for facilities and providers, was also investigated.

"Productivity has decreased on the inpatient side by approximately 30 percent. On the outpatient side however, since our organization made the decision to not require PCS codes on outpatient claims, outpatient productivity has actually increased.

Quality reviews have indicated that PCS is going to be the biggest risk for incorrect DRG assignment, and finding additional educational opportunities in that realm," one hospital states.

Other facilities where productivity had gone down indicated that this was an expected outcome of the ICD-10 implementation. Implementation issues from any vendor product or EHR would only further impede a coder's performance and production at a time when reduced productivity had already been predicted and experienced, survey results show.

Physician participation with documentation improvement was discussed by many physician/provider respondents. While there was some "grumbling," the overall effort on behalf of physicians has been positive, according to one respondent.

"We have been impressed on a daily basis with physicians who are suddenly cooperative and even seeking out documentation nurses to get help in proper documentation. Physicians who never signed queries before are taking the time to write out detailed answers and thanking us for helping them with the transition," one provider says.

The Vendor and Payer Perspective

Vendors should be up-to-date with all transition factors as additional ICD-10-CM/PCS updates will not be far behind. Timely ICD-10 updates are imperative, as the goal of an effective EHR is to make data easier to enter and retrieve. ICD-10 code selection requires a much higher level of acute granularity than ICD-9-CM, and if the technology is not in place for detailed, specific documentation within the EHR it can result in wasted time for both the physician and coding staff.

Facilities have invested a great deal of time and money in clinical documentation improvement (CDI) training and preparation. The EHR must be ready and capable to process the greater documentation detail that is being demanded from providers.

AHIMA asked vendors if their clients were ready for ICD-10 and most of them answered positively. "Most HIM and coding department staff were 'ahead of the curve' and did a spectacular job educating and coaching staff," one vendor says.

Some HIM departments started their ICD-10 project over two years ago—something they said has really paid off. For one respondent, their project plan included the following:

- A strong communication and education plan
- Working closely with physician education and nursing informatics groups on documentation changes
- Ensuring electronic documentation tools in the EHR were clearly explained
- Revising CDI queries to be in alignment with ICD-10 verbiage and documentation needs

Early preparation in these areas contributed to a much smoother implementation than some had anticipated. The billing processes at facilities, provider groups, and payers have been proceeding smoothly, according to various news reports and the respondents. Any glitches that have been experienced are related to software and systems but they have been easily corrected, one respondent says. Prior to October 1, 2015, some organizations were concerned there would be increased call volumes related to billing at both the facility/provider and payer ends, but the reality was little or no increase and volumes have continued to decline. Calls have also received quick resolution, respondents added.

Payers also reported to AHIMA positive input on the ICD-10 implementation. Claims are being submitted and no major issues or delays in claims payment have been identified, the vendors reported. As the vendors also reported, the call volume has been much lower than originally anticipated and staff that was shifted has been put back on their normal phone queues.

A subject matter expert working with a state Medicaid agency reported that the state had adjudicated two full claims runs and had not identified any major issues or delays in claims payment. A few providers have called requesting code translation and some even who claim they had no knowledge of the transition to ICD-10, but these calls have been minimal. The payer respondent attributes the smooth transition in this state to the extensive education and outreach done earlier this year that included 16 educational sessions offered in both rural and urban areas involving over 650 participants.

So Far So Good

Overall, it has been a smooth and fairly seamless ICD-10 implementation. It appears from AHIMA's analysis that the majority of providers, facilities, vendors, and payers were proactive and prepared for the ICD-10 implementation. Facilities provided the necessary education and training to coders and providers in the use of ICD-10-CM and ICD-10-PCS and made changes in clinical documentation to support the ICD-10 codes assigned. Providers and clinicians were educated in the increased specificity and guideline changes of ICD-10. Vendors helped facilities and providers to achieve successful implementation and update their software systems to accommodate the new code changes. Payers had time to update their software to accept and process ICD-10 codes as well as edit claims appropriately.

A new system always has bumps but from the input AHIMA has received, it appears that the ICD-10 implementation across the country went very smoothly. The implementation is complete but there are next steps. Coders need to ensure the ICD-10-CM and ICD-10-PCS codes assigned are accurate, complete, and fully supported by the clinical documentation in the EHR. The coding needs to clearly "paint the picture" of the patient encounter that will assist in providing improved patient care and public health surveillance in the future.

Note

1. Centers for Medicare and Medicaid Services. "ICD-10 Transition Moves Forward." October 29, 2015. www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-29.html.

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