Synergizing ICD-10: Integrating an ICD-10 implementation into other compliance programs will reduce costs, maximize investments

By Glenn Mitchell, MD, MPH

With ICD-10-CM/PCS, there is good news and there is bad news. First, the bad news-the implementation of ICD-10 in any healthcare facility will take ample staff time, financial resources, and strategic planning. But the good news-whether you are a C-suite leader, clinician, or worker bee, there is great potential for savings in time, money, and aggravation available within the ICD-10 conversion if it is synergized with other initiatives.

The first in a two-part series, this article looks at the potentially beneficial overlap of ICD-10 with other priority healthcare projects, which leads to the aforementioned savings. When ICD-10 implementation efforts overlap with other initiatives, the result is fewer committees and meetings, better coordinated communication to all levels of the organization, and fewer conflicting resource requirements. The experience gained from using this strategy can serve as the basis for other coming healthcare system changes such as bundled payments and reporting public data for comparative outcomes.

The various healthcare projects available for synergizing involve current, representative, health IT-related healthcare programs that interact with ICD-10 and with each other. Examples of these programs include the "meaningful use" EHR Incentive Program, the move to value-based purchasing, accountable care organization development, and the expansion by the federal government of tying reimbursement to quality measures. Exploiting ICD-10 overlaps can be beneficial in achieving the goals for each program and for reaching those goals faster, more efficiently, and with far less physician and employee dissatisfaction.

Several Healthcare Programs Overlap with ICD-10

Many providers are aware of the technical details and clinical and scientific implications of the change to ICD-10-which include improved stratification of clinical quality and comparative outcomes research data; improved characterization of individual provider and group practices in terms of patient complexity and therapeutic results; and improved incidence, prevalence, and outcomes comparisons worldwide (assuming the rest of the world doesn't move too rapidly to ICD-11). But what many have not embraced is how the ICD-10 conversion can sync with other healthcare initiatives. The ICD-10 upgrade should be seen by healthcare professionals as the hub of significant health IT changes (see Figure 1 on page 36).

As diagnostic related groups (DRGs) evolve and improve in specificity with ICD-10 detail, payers will be able to better analyze the performance of individual provider practices and niche hospitals. This will result in radically different negotiations for future contracts incentives and risk sharing arrangements with payers. Hospitals need to look carefully at their patient spectrum to plan for revenue stream adjustments or service line changes. Some organizations may find their patients identified as lower in severity and complexity than those patients with the same high-level diagnosis under ICD-9 treated at other institutions. This can have dramatic effects on revenue. Of course, institutions that care for the most complex, seriously ill, and injured patients could find their reimbursement increased under ICD-10.

The spread of ICD-10 coding to outpatient billing practices will occur nearly simultaneously with the inpatient space, although the persistence of outpatient CPT coding will buffer immediate process and reimbursement changes. This buffer will not last long in an environment of healthcare cost cutting. Over time, experience with the expanding data set will allow payers, organizations, and providers to fine tune contracts and focus on outcomes and quality much more than today. For the next decade, improved specificity of diagnoses and procedures will be a lucrative target for bringing down overall healthcare costs.

The timing and resource dedication required for ICD-10 conversion has less flexibility than one might think. The opportunity to analyze current coding results and clinical data and then forecast future coding impacts-both for individual providers and service lines as well as overall-will give a better picture of strengths and weaknesses before entering into negotiations with payers and providers. Information is power, and this early step in the ICD-10 process can be a powerful tool to facilitate the success of several vital programs.

Meaningful Use

The meaningful use incentive program being implemented under the federal American Recovery and Reinvestment Act of 2009 (ARRA) has an implied goal of installing an electronic health record (EHR) in virtually every healthcare provider office and facility in the United States by mid-decade. With nearly $19 billion set aside for health IT out of ARRA's $749 billion economic stimulus plan, the program affecting eligible Medicare and Medicaid providers has received a lot of attention. The Centers for Medicare and Medicaid Services and other healthcare industry stakeholders hope the implementation of health IT will save costs and improve the care provided. The program aims to create an IT backbone for a national approach to healthcare delivery and measurement of quality. The government hopes that eventually meaningful use will create a more uniform, interactive, and accessible health record system for US citizens. The capability to share patient data will be critical to acute healthcare outcomes, and population health will perhaps finally come into its own as a direct contributor to overall health.

Qualifying use of IT systems on a continuing basis-which is necessary to continue to receive annual installments of the incentive payments-will overlap with the ICD-10 conversion timeline and will use its coding for verification of compliance. Thus meaningful use will depend on the timely adoption of ICD-10 for success.

The stated goal of this multiyear program is to improve patient outcomes by offsetting the costs of the installation of computers and approved software in eligible hospitals and doctor's offices. Included is a requirement to have the capability to transmit and receive patient information so that a nationwide data-sharing network can be established. The creation of national-level data sets will not only allow instantaneous access to individual health records by practitioners, but it will also allow outcomes research that healthcare experts simply cannot perform today. This research could drive general improvements in patient outcomes as well as reductions in regional and local practice variances well documented by the Dartmouth Atlas project.

Meaningful use will give out enough money to those who meet its modest but increasingly steep goals over a five- to six-year period under the Medicare and Medicaid programs to offset a portion-but not all-of the cost of buying and installing a certified EHR. An exception is made for critical access hospitals so they obtain more complete support for IT implementation.

Time stamps and records of who entered what data elements in an EHR have revolutionized feedback to physicians about their current practices. It has been a challenge to get clinicians and their staff to consistently and appropriately record accurate data into the record. Meaningful use shines a very bright light onto how the industry actually does business in both individual practices and in hospitals. The need for producing auditable data for a variety of process metrics has caused providers to look hard at who is doing what tasks and when. ICD-10, with its increased specificity in coded information, can help with these metrics.

Accountable Care Organizations

Accountable care organizations (ACOs) are a model of healthcare structure and administration coming out of the Patient Protection and Affordable Care Act legislation that aims to improve quality care. ACOs will facilitate the introduction of revolutionary mechanisms such as bundled payments for episodes of care, and use novel mechanisms such as pay for outcomes and risk sharing for total costs of care. Patient-centered medical homes associated with the ACO approach have the potential to provide integrated and efficient mechanisms for managing patients, especially those with complicated conditions at high risk for frequent episodes of care. Medical organizations are currently trying to understand exactly what both these entities are going to look like, but it is already clear that accurate, detailed diagnostic and procedural data will be needed to construct risk analyses and predictive models that allow rational risk sharing. Today, payers know more about specific patient panels than their healthcare organizations, and that fact influences contract negotiations. Patient populations need to be defined, care paths assessed, and care outcomes understood much more clearly and deeply than they are today if payers, employers, and providers are to negotiate as equals. ICD-10 data will help organizations frame realistic agreements.

Integral to the development of ACOs is the certification of office practices as patient-centered medical homes by the National Committee for Quality Assurance (NCQA) using criteria that demand extensive data collection, analysis, and display capabilities. To be successful, the IT backbone of the practice must offer manipulable data elements covering nearly every quality measure so that things like real-time reports on patients who are lacking critical tests, procedures, or data elements can be generated on-demand.

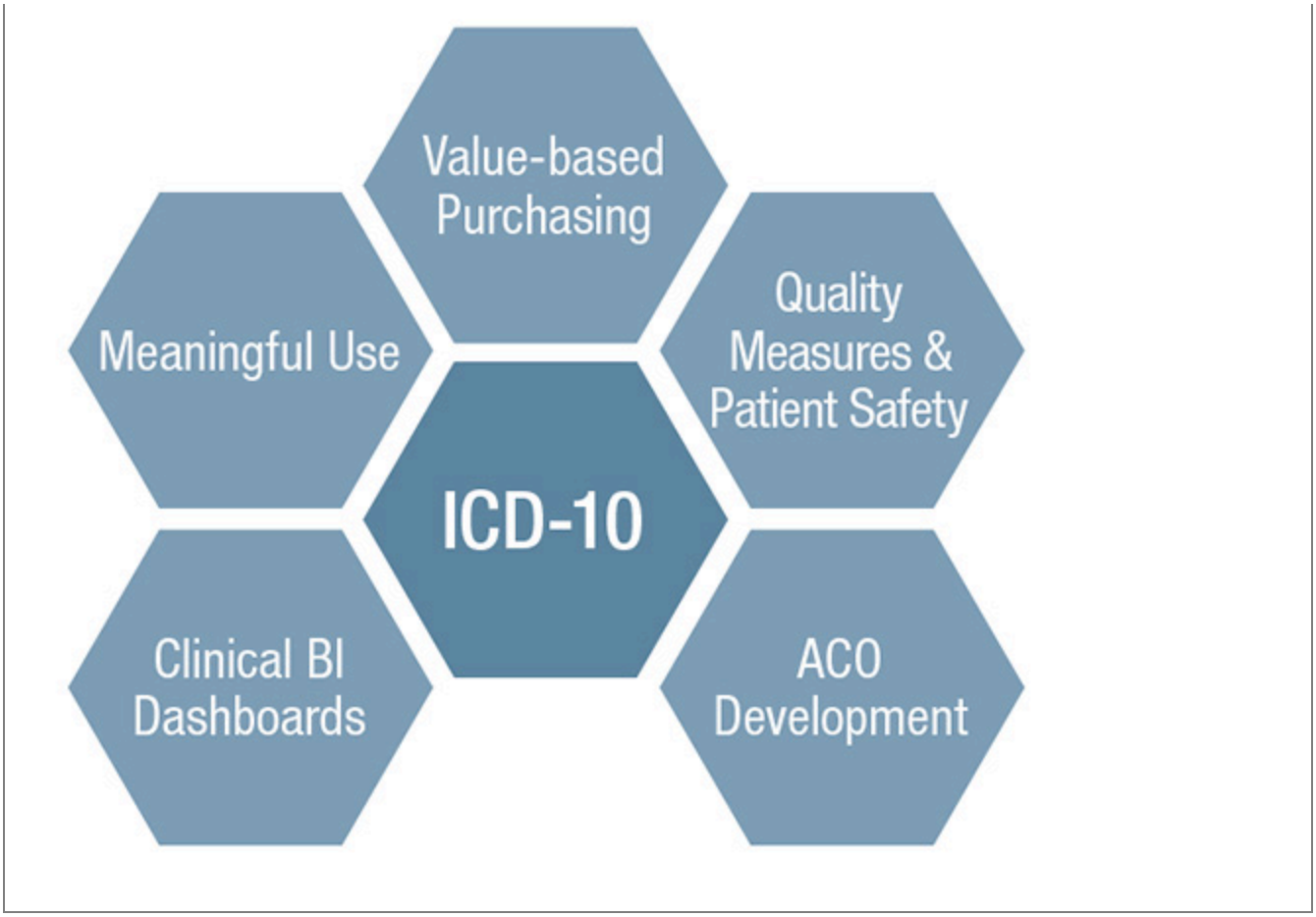
The requirement for ongoing, near real-time monitoring of outcomes in all venues of care is coming soon. ICD-10 can help with that. ICD-10 will allow the individual provider to see more clearly his or her own patients stacked against national benchmarks and against comparable local cohorts. In addition, ICD-10 codes allow better characterization of an individual physician's practice. This data will feed more relevant data to the Ongoing Provider Practice Evaluation (OPPE) which is required for performance evaluation reprivileging of all hospital-based licensed providers by the Joint Commission. The long-standing objection to peer comparisons because of differences in patient complexity will finally be addressed since data will be available from ICD-10 to perform valid risk adjustments.

Detailed data offered by the new ICD-10 codes are expected to finally put to rest provider cries of "my patients are sicker" that have been used for years by some to avoid admitting that their outcomes could be better. Arguments about sicker patients may shift to "they didn't access all my documentation" in a few years-but change will be difficult for many clinicians.

A near-term effort to define, improve, and exploit current ICD-9 coding performance can be helpful here too if it includes provider level analysis. There are several potential benefits. Individual providers with poor documentation practices can be mentored and shaped now to comply with the ICD-10 requirements. Also, the patient panels of individual providers in a group practice can be reasonably compared if severity adjustment is based on efforts to enter and analyze more complete diagnosis and treatment data. Anecdotal results suggest that reimbursement could be improved even today, prior to ICD-10's implementation. Finally, practices seeking NCQA certification can be much better prepared with improved documentation practices-which will also be necessary to capture the more specific ICD-10 codes.

Figure 1

This figure demonstrates the interrelationship of several current health IT programs.



Value-based Purchasing

CMS issued final rules for the first phase of its value-based purchasing (VBP) initiative in May 2011. VBP financially incentivizes improvements in quality of care and patient satisfaction in the inpatient environment by tying quality improvement measures to reimbursement. VBP pays for incentives awarded to the highest performers by using a 1 percent holdback in normal Medicare reimbursements. It is a system that financially penalizes poorer performers. The formulas used to calculate the final payouts are complex and cannot be accurately calculated before the end of a performance period-making interim monitoring difficult. The criteria used and the money withheld will be ramped up each year, and the program is expected to extend into the ambulatory space in the near future.

VBP is only a first step in ramping back reimbursements for inpatient healthcare services. Providers are well aware of the rising curve of healthcare costs in the US and the need to "bend the curve" back down. Mechanisms for doing so will likely appear in the future, and VBP-like schemes are expected to expand rapidly to virtually all payers.

Some providers are expected to lose money due to VBP. Like a casino, it is very hard to get into the highest winner's circle. Only half of hospitals at best will get at least their normal reimbursement for their standard set of Medicare DRGs-the remainder will lose ground compared to the previous year. This program is set to be budget neutral, so every winner facility has losers to fund their extra payment. The specificity and detail offered by ICD-10 codes will allow this process to be fine tuned and hopefully increase the fairness of comparisons. But the basic math will remain the same: more than half of US hospitals will likely see a reduction in CMS reimbursements over the next few years.

VBP started its first performance period on July 1, 2011-meaning providers should already be preparing for its soon-to-expand impact. The implementation of ICD-10 will cause VBP processes to change as the coding of severity and complexity improves. Experts say there is value in using current ICD-10 coding analysis to forecast the case mix profile changes anticipated from better documentation. The immediate effort to improve provider documentation in support of upcoming ICD-10 coding will likely also be helpful to today's bottom line.

Clinical Quality and Patient Safety

Clinical quality and patient safety metrics are already available to the public on the Internet, and sites advertising comparative outcome data for organizations and individual providers will increase in the near future. Today, websites such as HospitalCompare.com or WhyNotTheBest.com allow consumers to compare local hospitals and providers head-to-head or against national benchmarks. While many providers were used to patients viewing hospital-based metrics, they recently experienced the new trend of sites publishing individual provider metrics and outpatient care metrics. These efforts at transparency will increase over the next several years to include snapshots of organizational and individual performance across the entire spectrum of care.

There are many criticisms of publicly presented data, but these haven't shut down any sites yet. The data are "Web-true" to many patients (i.e., if it is on the Internet, it must be true). The relatively small percentage of patients who actually use these data today to make healthcare choices is only the beginning. Therefore, the data and its currency must be improved if patients are to make effective choices. Entities such as the Leapfrog Group and *Consumer Reports* are making diligent efforts to use the available data to assist consumers in comparing healthcare venues. The lack of specificity of ICD-9 codes smears clinical outcome variance across cases of different complexity. ICD-10 codes will allow much better stratification of data analyses and better assessment of complexities of cases included in these sets. If the burgeoning EHRs allow near real-time data collection, web-based comparisons will be able to inform consumer choices in more meaningful ways. ICD-10 and related efforts like meaningful use and NCQA that improve data completeness and accuracy will further improve these efforts.

While providers should not allow current ICD-10 conversion requirements to divert attention from core measures performance and other publicly reported metrics, providers can use early ICD-10 coding impact analysis to look at individual and group performance by stratification on mortality, infection rates, and other factors. When ICD-10 is fully implemented, the resulting quality and safety metrics based on the new coded information could become a potential marketing advantage that is exploited more effectively than today's poorly supported claims of superiority. Countless hospitals claim in highway billboards to be in the Top 100, usually based on wobbly metrics. With ICD-10's improved patient severity data, and the related advanced quality measures, it will soon be more difficult for providers to easily convince consumers of their value.

Clinical Business Intelligence Dashboards

Lastly, ICD-10 implementation efforts should be leveraged by clinical business intelligence dashboards. These provider-facing electronic dashboards display individual and group performance-along with appropriate benchmarks-on a near real-time basis. Most dashboards integrate data from health IT systems and can help drive performance for those providers who want to maximize the quality of their clinical outcomes and reimbursement. This area is where the discontinuity of an ICD-10 conversion can cause significant heartburn. The historical diagnostic and inpatient procedural data trends that are displayed on today's dashboards will not cross the magical ICD-10 conversion boundary intact. Translation functions can estimate what the old ICD-9 codes would have been if using ICD-10-or vice versa-but for the most part the graphs and bar charts will simply contain unhelpful discontinuities.

Being able to put real-time, accurate performance data-both process and outcome-in front of providers and managers has been proven to effectively motivate quality and quantitative improvements. There are few providers who are happy to see their own performance benchmarked against their peers when it demonstrates they are near the bottom of the pack. Of course, the leaders also want to stay the best, so they improve as well. This drives performance upward, a direction supported by all healthcare professionals.

ICD-10 codes will allow stratified and risk-adjusted results that are cleaner and more valid than providers can get today. These data and subsequent analyses will be more effective since they likely won't come with the usual arguments about whether or not they are accurate. But these benefits can be realized sooner if the ICD-10 coding analysis is used. Key performance indicators can be modified to include stratification before the shift to formal ICD-10 coding. This means that length of stay, mortality, and other tracking measures can be better defined and compared. Best practices may be able to be discerned sooner. And these stratified data dramatically improve the relevance and potential uses of materials in the individual provider's OPPE file.

The next installment in this two-part series will discuss how to leverage the overlaps of these programs to simultaneously reduce the pain of ICD-10 conversion and achieve efficiencies in carrying out the other health IT projects.

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