# The Final Countdown: Industry Moves Closer to ICD-10-CM/PCS Implementation Deadline



By Lisa A. Eramo

The clock is ticking, and in only 16 months the healthcare industry will begin to use, process, and exchange ICD-10-CM/PCS (ICD-10) codes. Readiness varies throughout the industry, with some stuttering after the Centers for Medicare and Medicaid Services delayed the ICD-10 implementation deadline in 2012. But CMS has publically stated that the implementation date of October 1, 2014 will not change-ready or not, ICD-10 is coming.

## Some Ready, Some Not

Industry data seems to suggest an overall push toward ICD-10 implementation in the healthcare industry, but not necessarily a sense of urgency. Some payers are making more strides than others. Approximately 50 percent of health plans had completed their ICD-10 assessment in early 2013, and another 25 percent were nearly done (i.e., providers that are more than 75 percent ready for ICD-10), according to a survey published by the Workgroup for Electronic Data Interchange (WEDI) in April. The survey polled 87 vendors, 109 health plans, and 778 providers, including both physician practices and hospitals. Of the surveyed providers, one-fifth were hospitals and half were physician practices. Vendors are progressing at a slower rate. Approximately 50 percent of vendors are less than halfway complete with their product development, according to WEDI.

Industry data suggests that many providers still have a long road ahead of them. Provider readiness seems to vary depending on the size of the organization. Larger hospitals and physician practices are mostly faring well, but smaller ones may be struggling to stay on track, says Sue Bowman, MJ, RHIA, CCS, FAHIMA, AHIMA's senior director of coding policy and compliance.

Three out of four providers are 25 percent or less completed with their ICD-10 implementation process, according to a survey conducted in February by the Aloft Group. The survey polled more than 260 providers, including community hospitals, healthcare systems, academic medical centers, critical access hospitals, acute care hospitals, and physician groups. Still, 55 percent of respondents said they were confident they will meet the October 1, 2014 compliance deadline.

WEDI found somewhat similar results. Approximately 40 percent of providers still don't know when they will finish their impact assessment and business process changes, according to its survey. Survey data is helpful, but only when provided in context, says Bowman. For example, both the Aloft Group and WEDI surveys could have been geared more toward smaller community hospitals or providers.

Results could also be skewed depending on who completes the survey, she adds. However, anecdotal data confirms a slow provider progression.

Lisa Woodward, MBA, health information services director of administrative and revenue cycle systems at the University of Wisconsin Hospital and Clinics (UW Health), a 566-bed facility in Madison, WI, says she has attended conference calls during which other health information management (HIM) professionals have lamented that they've only just begun to assess training needs and initiate other preparations. UW Health kicked off its enterprise-wide ICD-10 transition in 2010. Implementation of a clinical documentation improvement program was its first major milestone. Woodward says the hospital is already diving into DRG analyses, coder training, and more with regard to ICD-10.

Competing regulations that demand attention and resources is one of the biggest challenges that providers are facing in finalizing ICD-10 efforts, says Melissa Williams, MBA, RHIA, the COO and vice president of HIM at Grady Memorial Hospital, a 99-bed acute care hospital in Chickasha, OK.

"The [Recovery Audit Contactor program] burden has had an enormous impact on us," Williams says. "Now with the HIPAA mega rule coming out and with healthcare reform… we're trying to figure out how we're going to comply with all of these federal mandates. It's difficult and has been a struggle for us."

## Procrastinators Running Out of Time

Facilities, providers, payers, and vendors should ideally be moving into phases two and three of AHIMA's ICD-10-CM/PCS Planning and Preparation Checklist, [...]. The checklist, which divides ICD-10 implementation into four phases, places an emphasis over the next year on performing longitudinal data analysis, communicating with business associates, analyzing DRG shifts, and developing contingency plans. External testing and intense coder training should also emerge as priorities between now and the third quarter 2013.

In phase four (post-implementation), providers should shift their focus to monitoring coding accuracy and productivity as well as ICD-10's impact on reimbursement and denials/rejections.

Physicians and hospitals that are currently stuck in phase one-implementation plan development and impact assessment-will certainly face some challenges, Bowman says. "There's still time, but you're going to have to compress doing an impact assessment and then perform all of your systems changes all in a shorter period of time than what's outlined in the [AHIMA] timeline," she says.

## Start Analyzing the Financial Impact

The financial impact of ICD-10 is something every provider should be interested in, Bowman says. Evaluating potential DRG shifts and changes in case mix index should be top priorities at this point in implementation efforts. "If a particular hospital has a higher percentage of cases with DRGs that have a stronger potential for decreased reimbursement under ICD-10, then they could take a bigger financial hit," she says.

As part of a financial risk assessment, coders at UW Health completed dual coding on approximately 2,200 inpatient claims from July 2011. Coders are repeating the exercise using claims from July 2012 to determine whether DRG shifts are similar. "We picked the month of July because it was representative of our typical payer mix across a year," says Woodward, adding that preliminary analyses seem to suggest that many DRGs are not shifting significantly.

Payers are trying to understand potential DRG shifts as well. "WellPoint's affiliated health plans have processed at least 4,000 claims through a collaborative effort with a variety of providers," says Carol Spencer, RHIA, CHDA, CCS, program director of the ICD-10 Code Set Competency Center at WellPoint, based in Indianapolis, IN. "We try to differentiate between true shifts versus shifts due to incorrect coding." Spencer says that WellPoint's analysis has revealed multiple true DRG shifts thus far. Subsequently, WellPoint has built financial models to understand the impact of the DRG shifts on reimbursement and to validate these outcomes.

## Don't Forget the Physicians

Ensuring that physician practices are up to speed is a challenging yet necessary part of ICD-10 implementation. Grady Memorial Hospital, which includes a hospital-owned multi-specialty clinic, is in the process of training existing business office staff members to take over the coding function from physicians who currently assign their own codes.

"We needed to evolve in our clinic setting to mimic what we're doing on the hospital side," Williams says. "It's such a different mindset having trained coding professionals in the [practice setting]. It's a culture change for physicians."

Clinical documentation improvement has been, and will continue to be, a central part of ICD-10 preparations. However, the EHR has added a layer of complexity to these efforts, Williams says. "We're trying to work closely with our information services department to make sure that they're not just considering the end user but that they're also considering the quality of the documentation [for ICD-10]," she adds.

Physician education is another challenge. “We’re trying to tailor it to each specific provider,” Williams says. “We felt like we’d have more of an impact and it would be a better use of our time if we dealt with each provider as an individual using his or her own documentation.” This one-on-one education will be provided to each of the hospital’s 21 physicians and full-time hospitalist.

## Tackling Training Challenges

AHIMA estimates that inpatient coding staff will require appr

oximately 50 hours of training on ICD-10. Coding staff working in other settings will require approximately 16 hours of training on ICD-10-CM only. The exact timing of training will vary depending on a hospital’s unique needs. However, the association advocates for coders to undergo in-depth training no more than six to nine months prior to implementation.

Many organizations haven’t yet established the scope of training, nor have they given any thought to the logistics of that training, says Scot Nemchik, CCS, vice president of coding compliance and education at IOD Incorporated, an HIM outsource company based in Green Bay, WI that provides ICD-10 training. “The delay gave people time to get their act in gear, but there are still many hospitals… that don’t quite know what they want,” he says.

Clients that have established a scope of training are starting to request customization, Nemchik says. “Hospitals are becoming more specialized. They need to make sure that the training they’re getting is appropriate for the services they’re delivering,” he adds.

This customization has been difficult for vendors because it essentially requires them to perform claims analyses prior to training. “Clients want us to partner with them and have us look at the types of codes they code, the procedures they perform, and then develop a program around that,” he says. “When you’re a single vendor trying to meet the needs of many distinct clients, that can be a challenge.”

Some facilities are choosing to perform training using internal resources only. At UW Health, two full-time trainers were hired to perform enterprise-wide ICD-10 education starting in April 2013. Once coders are fully trained, they’ll spend one day per week coding in ICD-10 to keep their skills sharp, says Jody McClain, CPC, UW Health’s director of coding and charge capture.

Grady Memorial Hospital has also shifted its focus to coder training. In 2011, all coders underwent anatomy and physiology (A&P) training. The nine month training was divided into hour-long weekly sessions so that coders didn’t experience a disruption in productivity. After completion of the A&P training, coders underwent in-depth ICD-10 training.

Like UW Health, Grady Memorial Hospital decided to provide training internally. “When you’re relying on external sources, you’re somewhat at their mercy,” Williams says. “When you do it internally, you can set your own pace and tweak it for your own staff.”

An internal coding coordinator at Grady Memorial Hospital provided both the A&P as well as the in-depth ICD-10 training. The hospital and local vocational school where the coordinator teaches coding courses both funded the coordinator’s initial ICD-10 training through AHIMA.

“[The coordinator] then basically used our facility and our staff as guinea pigs to develop the school’s coding ICD-10 training program,” Williams says. “It accomplished what we needed in order to have our staff ready.” Coders will begin refresher courses in the next three to six months and will dual code for approximately six months prior to implementation. “We want to keep them in a state of continual readiness,” she adds.

## Putting ICD-10 to the Test

The sooner internal and external testing can begin, the better, Bowman says. “If [business associates] say they’re not going to be ready for testing until the middle of next year, that’s a concern,” she says. When testing with vendors, one shouldn’t limit their list to encoders or DRG groupers. Vendors include any companies that supply systems or applications that use ICD

codes, such as registration systems, lab systems, abstracting systems, medical necessity software, and compliance software, to name just a few, Bowman says.

Testing with payers is also crucial. Woodward says UW Health has successfully tested facility and physician practice ICD-10 claims with its own payers. However, some other payers aren't ready. "We feel this will be very similar to 5010. It's going to be on a payer by payer basis and will be right up until the transition date," she says.

WellPoint is in a test planning phase during which it is selecting claims from its affiliate plans. These claims are based on high volume, high dollar, and high risk ICD-9-CM diagnosis and procedure codes as well as DRGs and other criteria. Internal testing will begin in October 2013 followed by external testing with selected providers and vendors in early 2014.

"Testing is when you find out what's really working," Spencer says. "During testing, all defects need to be fixed prior to go-live on October 1, 2014."

### Develop a Contingency Plan

A contingency plan is essential should critical systems issues or other problems occur when ICD-10 implementation goes live. AHIMA says providers should closely monitor coding accuracy and productivity as well as denials/rejections through the fourth quarter of 2015.

UW Health has budgeted for overtime as well as additional staff for the period directly after the ICD-10 transition to manage any increase in denials or other unexpected problems that could occur. Providers may also want to ensure that a contingency fund is available. "The provider could be submitting a totally valid and compliant claim, but the payer may have a problem processing ICD-10 claims, or it could have a huge backlog in getting them paid," Bowman says.

WellPoint plans to monitor its maps closely during the year after implementation and focus on root-cause analysis to determine whether defects (i.e., increased suspended claims, denials, shifts in reimbursement) may be due to its mapping.

## Payers Begin ICD-10 Mapping

ICD-10 mapping is perhaps the most challenging aspect of ICD-10 implementation for payers, Spencer says. However, payers should already have started this task to ensure they're prepared for implementation. "We want to be as neutral as possible through accurate and appropriate translations for our business rules," Spencer says.

Like many payers and health benefit companies, WellPoint uses the General Equivalence Mappings (GEMs) as its baseline mapping system but may disable or add maps to a small percentage of codes to fit its rules. For example, the payer currently suspends claims coded with 413.9 (unspecified angina). "The goal is for us to suspend the unspecified angina code in ICD-10," Spencer says. However, code 413.9 also maps to approximately 24 variations of combination codes for atherosclerotic heart disease with angina.

"By allowing all the combination maps for this rule, we could be pending 45,000 claims if we didn't disable the map for those combination codes and specific business rule," Spencer says. "We retain the map for the other and unspecified angina-I20.8 and I20.9. We make these decisions rule by rule. There are hundreds of thousands of rules. Hundreds of thousands of codes are in those rules."

Payers should also be looking for code variances that could cause discrepancies in benefits or pricing. For example, GEMs for nicotine withdrawal didn't suit WellPoint's affiliate plans' drug benefits, Spencer says. "These codes ended up mapping with opiate withdrawals," she says. "The drug benefits are really designed for people with addictions to hard drugs. We had to disable the map and put these codes with the nicotine benefits."

The Code Set Competency Center at WellPoint maintains a list of all codes that require the payer to disable the GEM. The center also ensures consistency across the enterprise for all affiliate plans and throughout each claims platform. "I think

providers should take an inventory by payer to understand what the payer is doing [in terms of mapping]," Spencer says. Ask payers to identify their source for mapping as well as how they may be tailoring that map to fit their business rules, she says.

Woodward has heard that some payers plan to convert ICD-10 claims back to ICD-9 for payment rather than process ICD-10 claims natively. "This could result in under- or over-payments as well as denials," she says.

## Mitigating Coder Productivity Losses

Physician practices and hospitals should certainly be devising strategies to offset any anticipated decreases in productivity, including providing adequate training, considering outsourced personnel, and eliminating coding backlogs, Bowman says.

Consider hiring additional coders or at least developing a strategy to prevent a decrease in full-time employees as the hospital implements its EHR, Williams says. Many hospitals are forced to downsize their HIM department as the EHR is implemented and more processes become electronic. The EHR implementation is often occurring simultaneously with the ICD-10 implementation. Therefore, it's easy to experience a decrease in staff because of the EHR, which could pose a problem for ICD-10 since productivity decreases are expected.

"We have ample coding staff, and we have remained overstaffed because of ICD-10. We knew that with ICD-10 ahead of us that we would rather have those individuals on staff than run the risk of being shorthanded," she adds.

UW Health is adding additional coding full-time employees into the budget for both the facility and physician practices over the next two years to mitigate productivity losses. "However, like the rest of the country, we've realized that qualified coders are hard to come by. They're going to be harder to come by when we get to ICD-10," McClain says. To mitigate this, UW Health is working with its local technical college to create a six-month, part-time paid apprenticeship program in which students get hands-on inpatient and outpatient coding experience as well as experience working with an EHR. "At the end of the six months, we feel we'll be able to pick from the cream of the crop," she says.

UW Health is completing an initial implementation of a computer-assisted coding (CAC) solution in April that it hopes will increase coder productivity. "We don't expect CAC to eliminate the need for any additional FTEs," Woodward says. "However, we're hoping that it will indeed mitigate the total number of FTEs that need to be added on and allow us to have professional coders review all documentation instead of only selected areas."

Vendors are also gearing up to ensure that they can meet clients' productivity demands, Nemchik says. "We're starting to see an uptick in requested hours already. Time spent training is time lost coding," he says. And time lost from coding can quickly manifest itself in increased days-to-billing if not monitored.

Coding vendor IOD collaborated with Temple University's HIM department faculty to create a coder development program it feels will ensure it can meet these coding demands, which will only increase over time. In particular, the company is providing formal inpatient coding training, using real records, to recent program graduates and outpatient coders as well as those who previously worked in abstracting-a function that Nemchik says is increasingly diminishing due to the EHR.

In addition, IOD is building as much coder practice time as possible into its implementation strategy. The company uses proprietary software that provides immediate and automatic feedback to coders regarding their accuracy and productivity in a simulated ICD-10-based environment. Coders will use the software, which is also available to clients, throughout 2013 and 2014, Nemchik says. "We're beyond the planning phase," he says. "We're really in the phase where you need experiential learning. The software needs to be out there to support that. If that's not available, it's a handicap for the client."

## Concerns Loom Over Healthcare Industry

Despite the most diligent preparations, concerns about ICD-10 will likely continue to persist even after October 1, 2014 for many affected parties.

"There are things that you can't ever plan for," Williams says. "Staffing would be the one concern that I have, especially with our clinics. If we find that the workload is more than they can handle, will there be staff out there who can step in? Will we need to train these individuals?"

Not getting paid is perhaps everyone's biggest fear at this point, Bowman says. "That's why testing-and testing the whole process end to end-is really critical. CMS advocates for a full year of testing, which makes sense to me," she says.

Turnover is another concern. The average age of the inpatient coders at UW Health is 54 years old. "Inpatient coders are the most difficult to replace. None of them have said they're going to retire because of ICD-10, but they're all in that age range where retirement isn't too far from their future," Woodward says.

Woodward says she has spoken with the hospital's human resources department regarding her concerns about staffing. "The department is prepared, and they continue to do market analyses so that they can react at the point where the competition within the marketplace starts to increase," she says.

Questions about ICD-10 continue to persist as well. For example, payers have yet to clarify how they will handle authorizations that occur before October 1, 2014 and that include ICD-9-CM codes. Woodward wonders whether these authorizations will be valid for services that occur after the transition date and that are coded using ICD-10 codes. Longitudinal data presents another challenge. Providers should determine the impact of the ICD-10 transition on data analysis in the coming years.

Reports that rely on ICD-9-CM must be cross-walked and mapped to ICD-10, Williams says. The effort, which could involve hundreds of such reports, requires input from information services, coders, HIM, the revenue cycle team, and the business office.

"Our finance department relies on a lot of reports. Our monthly statistics, like occupied beds and case mix index-some are code related and some are not, but we'd have to go through each one to see if they are built and structured on ICD-9-CM," she says.

Providers must determine what legacy data they will convert and what data they will maintain separately, Bowman says. Researchers and others must also understand the effects of ICD-10 on that data.

"With longitudinal data, people are worried that it will look like trends in medical conditions or treatments have changed when really it's just a factor of the coding system having changed," she says. HIM professionals should be prepared to explain whether variances in the data are due to changes in the code set or actual changes in clinical care.

## Seeing the Bright Side

Experts are hoping that the light at the end of the tunnel beginning to appear will propel the industry forward through this last phase of implementation. With the deadline looming and the stress of implementation high, it can be easy to lose track of the benefits of the ICD-10 conversion. For example, ICD-10's richer reporting capabilities are something that everyone is looking forward to, McClain says.

"ICD-10 will eliminate so much of the gray that's been out there in the coding world," Williams says. "It's going to give us the level of detail that we need for accurate data. I can see it flowing over into our outcomes world, our quality arena, and our research.

"It's going to improve the data so dramatically."

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