YOU ARE HERE—ICD-10-CM/PCS Status Check: Three Hundred HIM Professionals Report

By Torrey Barnhouse and William Rudman, PhD, RHIA

Those who think their hospital is way behind in preparing for ICD-10-CM/PCS (ICD-10) should take note of the following. Several industry surveys reveal the same thing: most of the nation's 4,000-plus hospitals have only just begun implementation efforts.

That concerning conclusion was also reached this past fall, when vendor TrustHCS and AHIMA conducted a comprehensive survey of ICD-10 readiness through a professional survey firm, who interviewed more than 300 HIM professionals representing 293 healthcare facilities that included academic medical centers, teaching and non-teaching community hospitals, and critical access hospitals (CAHs). Eighty-four percent of the survey participants were HIM directors.

The goal of the survey was to identify the HIM themes and best practices that are emerging as the healthcare industry moves closer to ICD-10's October 1, 2014 deadline. This research revealed four preparedness patterns most important to AHIMA members-education, staffing, computer-assisted coding (CAC), and clinical documentation improvement (CDI).

Providers Behind on ICD-10 Readiness

According to the survey, over 50 percent were still in the beginning phases of ICD-10 migration in fall of 2012. A total of 25 percent had not even formed an ICD-10 steering committee, one of the first steps of implementation. Project plans were underway for only 17 percent of facilities, leaving the vast majority of providers with no plans, no budgets, and very little progress to report.

The exception to this procrastination was teaching community hospitals and academic medical centers, where 30 percent of HIM respondents in those types of facilities said they regularly meet with steering committees and have their ICD-10 transition projects underway. Critical access hospitals (CAHs) were identified as the slowest participants in the ICD-10 race, likely due to their exemption from DRG-based reimbursement. CAH facilities are not as likely to be affected by ICD-10 due to their capitated payment system, which is different than the rest of the industry. Finally, organization plans for education, staffing, and implementing computer-assisted coding and clinical documentation improvement programs were also uncovered as part of the interview process.

More ICD-10 Education Needed

Seventy-two percent of hospitals surveyed have already begun ICD-10 education. This bodes well for HIM's leadership role in the ICD-10 transition. However, much work remains. Of the hospitals without an ICD-10 steering committee, nearly half have not started education initiatives.

One third of the participants will exclusively use web-based coder education. Academic medical centers will also rely on in-house certified instructors and outside educators. Fifty-three percent of respondents would like an education firm to provide other ICD-10 services, which is a signal to vendors to also deliver coding compliance audits and outsourced coding services.

Budgets for ICD-10 training are higher within groups who have already established committees and have transition projects underway. The researchers behind the study believe this finding indicates that deeper and more extensive ICD-10 education is certainly required by many providers. AHIMA and the federal government predicted 50 hours of ICD-10 training would be needed for each full time coder to successfully transition to ICD-10.

The average overall education budget was $323,256 with coder training representing 43 percent of the organizations' overall ICD-10 budgets. Average cost per coder across all facility types was $12,200. The exception was in academic medical centers, where the cost per coder for ICD-10 education is $26,560.

According to Premier Healthcare Alliance's Spring 2012 Economic Outlook, 65 percent of hospitals indicated that capital budget expenditures for 2012 remained flat or increased only slightly over 2011. Therefore, the request for an additional $13,260–$26,560 per health record coder will not be welcome news for finance executives. However, the costs of undertraining are much higher. Denied claims, revenue take-backs, and lower quality scores all result from under-trained or poorly-trained coders. The bottom line is that actual training cost per coder must be identified and ICD-10 training is not a place to shave costs.

Staff Up or Pack Up

Study respondents said they are expecting to increase their coding labor needs by 23 percent over the next two years. This finding is consistent with other industry studies and HIM expectations. In fact, the US Department of Labor states there will be a 21 percent increase in health record coding jobs between 2010 and 2020.[1] Specifically, HIM professionals surveyed expect a spike in coding needs from the second quarter of 2013 through the first quarter of 2014.

Since a 30 percent coder shortage already exists, addressing additional coder staffing requirements is essential.[2] Among facilities expecting to expand coding labor for ICD-10, 63 percent of respondents said they will directly hire additional coders. Fifty-two percent of survey respondents said they will hire more inpatient coders, and 59 percent will bring additional outpatient coders on board. A quarter of respondents will outsource with over 50 percent preferring a per-hour rate.

A smaller percentage of hospitals plan to use a combination of hiring and outsourcing for inpatient and outpatient coding: 15 percent and 11 percent respectively. Respondents also believe that increased productivity gains through CAC technology will also help relieve spikes in coding demand.

Survey: CAC, CDI will Help ICD-10 Implementation

While CAC and CDI are additional projects that will compete for resources in the majority of organizations, they are key components for ICD-10. Eleven percent of the hospitals surveyed already have implemented a CAC system and 75 percent plan to have CAC in place by 2015. Of these, community teaching hospitals with more than 350 beds express the greatest hunger for CAC, with 83 percent planning to implement the technology. The majority of "other" medical facility types and CAHs not already using a CAC are not planning to implement the technology.

The adoption of CDI programs is more widespread, with two-thirds of hospitals already supporting an in-house CDI initiative. Furthermore, 41 percent of those without a program expect to start one in 2013. However, only one-fourth of existing CDI programs conduct audits of their programs.

Auditing of existing CDI programs involves reviewing the documentation being provided to coders for applying ICD-10 codes. If the documentation is not sufficient for ICD-10, queries can be made far in advance of the October 1, 2014 deadline in order to improve physician documentation behavior.

2013 Action Items for HIM

Based on the survey's results, four key action items stood out as imperative steps for HIM to take in 2013 to keep their organizations on track to ICD-10 implementation.

Get the Mix Right

Time, money, and human resources investments in CAC, CDI, education, and audits must be balanced, and all four efforts must be integrated. There is no silver bullet for ICD-10 transition success. Instead, HIM professionals should ensure a mixture of these four ingredients with steering committee oversight and governance.

Trust but Verify

Auditing of ICD-10 progress should be part of the entire transition project plan. Quarterly auditing will be particularly important later in 2013 as organizations move closer to the October 1, 2014 deadline.

Plan to Hire

Coder shortages will worsen and backlogs will occur due to ICD-10. This is the year to plan for hiring spikes, so budget accordingly. With many providers expected to begin dual coding in 2013, additional coders will be particularly needed. A hybrid combination of internal hiring and outsourced services will become best practice across most hospital organizations.

Fine-Tune Budgets

Finally, 2013 is the year to review existing ICD-10 budgets and to fine-tune them for more extensive coder education requirements and refined industry benchmarks. Based on survey results, revised coder education budgets should be established as follows:

- Number of coders x $12,200 = Coding education budget
- Divided by 43 percent = Total ICD-10 budget

No Time Like the Present to Get Started

This year is a crucial time for organizations to make progress on ICD-10. With half of the nation's hospitals still in the beginning stages, according to the 2012 survey, HIM professionals must dig deeper and push harder to entrench themselves in the implementation process. More than ever, communication and planning are the key factors to a successful transition. And once organizational buy-in is achieved, rapid action with quarterly auditing of progress is a must.

The move to ICD-10 is a long assembly line requiring a monumental amount of teamwork and coordination. HIM professionals should meet regularly with regional peers and trading partners and leverage all available industry resources in order to work together collaboratively with, at the very least, CDI, medical staff, finance, IT, and revenue cycle departments. Everyone has a role in making ICD-10 a success-especially HIM.

Notes

1. US Department of Labor, Bureau of Labor Statistics. "Occupational Outlook Handbook: Medical Record and Health Information Technicians." 2010. http://www.bls.gov/ooh/Healthcare/Medical-records-and-health-information-technicians.htm.
2. Meyers, Susan. "Coder Shortage Goes Straight to the Bottom Line." *Hospitals and Health Networks*, January 2004.

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