'Don't Slow Down': An ICD-10 Summit Wrap-Up

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By Chris Dimick

In an industry facing several distractions from various government initiatives and regulation changes, ICD-10-CM/PCS became the center of attention from April 16-17 as top experts and interested parties gathered in Baltimore, MD to discuss the ongoing transition to the new code set at the 2012 ICD-10 Summit.

As expected, the recently announced ICD-10 compliance delay was a main talking point at the ICD-10 Summit. Speakers addressed everything from what the delay means to the industry and why it was implemented to how industry professionals should modify ICD-10 plans in its wake.

The annual AHIMA meeting is dedicated to exploring the challenges and opportunities involved in the United States' transition to the ICD-10 coding systems. This year brought together over 550 HIM professionals, payers, vendors, consultants, and secondary data users looking to learn best practices and strategies for ICD-10 transition planning and preparation.

The following is a summary of the *Journal of AHIMA's* special coverage of the summit, featuring the hottest ICD-10 news to come out of the event.

Read a selection of quotes from the summit in this issue on page 108. For complete coverage of the ICD-10 Summit, including uncut articles, quotes, and poll questions, visit the *Journal of AHIMA* special Web site at http://journal.ahima.org/icdsummit.

Coding documentation gaps are discussed in this ICD-10 Summit wrap-up video. To view, visit http://journal.ahima.org.

CMS: Delay Necessary, But ICD-10 Will Happen

On the same day that a proposed delay for ICD-10 compliance officially hit the books, the Centers for Medicare and Medicaid Services (CMS) reiterated April 17 that they are committed to eventually implementing ICD-10.

Giving a "State of the Union" on ICD-10 during the second day of the ICD-10 Summit, Denise Buenning, MsM, acting deputy director of the Office of E-Health Standards and Services at CMS, explained why both a delay and the official implementation of the code set is essential for the healthcare industry.

"To borrow a line from our president, the state of ICD-10 at CMS is strong and our commitment to its implementation is strong and focused," Buenning said.

Buenning helped author the original final rule requiring ICD-10 on October 1, 2013, as well as the proposed rule published April 17 in the Federal Register that would delay implementation until October 1, 2014.

"AHIMA has been a staunch proponent of the 2013 deadline," she noted, before describing CMS' reasoning for the delay announced February 15. "The industry has expressed shock, surprise, and wonder as to why the decision was made."

"It is now so important that we raise the dialogue on ICD-10. We have been spending so much time on planning, and now the time has come to talk about implementation."

Patty Thierry Sheridan
MBA, RHIA, FAHIMA, AHIMA President, opening remarks

Reasons for the Delay

It was no one group that spurred CMS to propose the delay, but a series of events that made a delay inevitable, Buenning said. The primary reason was the industry's ongoing struggle to implement HIPAA Version 5010, a precursor to ICD-10 that was effective January 2012 but has seen enforcement delayed twice because many physicians have had technical trouble implementing the version update. CMS saw the Version 5010 issues, which some providers said prevented them from getting paid, as a signal that ICD-10 efforts would face a similar fate unless a delay was enacted.

AHIMA has officially recommended that the 2013 implementation deadline remain, saying a majority of the healthcare industry is on track to meet the deadline and that those who worked hard to meet the original deadline shouldn't be punished with the additional costs that will come with a delay.

While proposed rules typically receive a 60-day comment period, the ICD-10 delay rule was given a 30-day period in order to speed the delivery of a final rule. The healthcare industry is waiting for a solid deadline before it can redesign implementation plans accordingly.

Buenning encouraged everyone to submit comments and provide their feedback on the proposed rule. A one-year delay is "not a slam dunk," and CMS said it would be listening to industry feedback.

Stay the Course

Despite the delay, ICD-10 will be implemented, Buenning assured the audience.

"Regardless of the delay time, the worst thing you can do is to stop ICD-10 implementation," she said. "Follow our lead and stay the course."

HIM professionals are the "front lines" of outreach and education for providers, and Buenning encouraged the crowd to take a leadership role in ICD-10.

"Don't lose momentum; use the extra time, it is a gift to get this right," she said. "ICD-10 is going to happen."

> *"We need project managers to raise their hands, ask tough questions, and step in front of the train in order to keep an organization on the right path (toward ICD-10 implementation)."*
>
> Daniel Fagin
> MBA, PMP, CISA, managing director, with risk and business consulting firm Protiviti

Documentation, Delay Impacts, Stubborn Physicians Top Summit Topics

The proposed ICD-10 delay and how it impacts industry preparation plans was one of several hot topics permeating two days of sessions at the summit. This concern was reiterated during the final session of the summit, "Reflections of the 2012 ICD-10 Summit Reactor Panel," where presenters and subject matter expert attendees recapped their main takeaways from the event.

One main point: many attendees were on track to meet the October 1, 2013 deadline and are against any delay of ICD-10. The audience cheered when panel member Dr. Jeff Linzer, with the American Academy of Pediatrics, frankly stated that a delay is not necessary and the industry needs to stand behind the original deadline.

"We have known about this since 2009, with the proposed rule in 2008. The industry has put a lot of money into the 2013 deadline. If you are not ready, then shame on you," Linzer said.

Panelist Melody Mulaik, MSHS, CPC, RCC, with the Healthcare Billing and Management Association, said during the session that regardless of the final delay timeline, CMS needs to conduct some damage control and reiterate that it means business on ICD-10.

"I want to get them to promise that this is it, and we will see a hard and fast date," Mulaik said.

If ICD-10 is delayed, the industry should make the most of it and further their testing of the system-another hot topic of discussion. Whether they believed a delay was necessary or not, all presenters agreed that organizations should treat it as an opportunity for ICD-10 improvement.

"Don't slow down, and if you haven't started, start now" was a rallying cry heard throughout the summit, according to Faith C.M. McNicholas, CPC, CPCD, PCS, CDC, manager, coding and reimbursement/government affairs, at the American Academy of Dermatology, who moderated the panel.

Partial Code Freeze Will Remain Through ICD-10 Delay

A one-year delay of ICD-10 compliance will push back scheduled ICD-10 coding updates while maintaining the partial ICD-9 coding freeze currently in place, according to a presentation given by Pat Brooks, RHIA, senior technical advisor at the Centers for Medicare and Medicaid Services (CMS).

After the last regular coding update in October 2011, CMS instituted a partial code freeze that only allows code updates for new technology or diseases. That freeze was to be lifted on October 1, 2014-one year after the original ICD-10 implementation deadline. Once the delay was announced in February, many industry representatives asked CMS what would happen to the code freeze, Brooks said during her presentation.

"We will extend the partial freeze through the delay of ICD-10," Brooks said.

The first regular update to ICD-10 would be one year after the implementation deadline-October 1, 2015, if the HHS-proposed implementation date of October 1, 2014 is instituted after a rulemaking process.

The plethora of CMS resources that can be used to aid the ICD-10 implementation was also discussed at the session. ICD-10-CM/PCS teleconferences, training aids, and General Equivalence Mappings (GEMs) are just a few of the resources that healthcare stakeholders were encouraged to use in their transitions.

While the GEMs do enable the conversion of data from ICD-9 to ICD-10, Brooks reminded the audience they should only be used temporarily. "GEMs are not a substitute for learning how to code," she said.

Another frequently asked question addressed was the number of duplicate codes that appear in both ICD-9 and ICD-10. Out of the thousands of ICD-9 and ICD-10 codes, only 39 codes are duplicates, Brooks said, with all the duplicates starting with the letter "E."

> *"The delay gives us the opportunity to test, test, and test. We have a lot of opportunity around CDI, electronic physician documentation, and a delay allows us to put in strong prerequisites for ICD-10 success."*
>
> Tressa Springmann
> vice president and CIO of Greater Baltimore Medical Center

Provider, Payer, Vendor Share ICD-10 Concerns

During the first day of the summit, "Three Roads, One Destination: Providers, Payers and Vendors Speak Out" session gave representatives from each respective industry sector the chance to lay out chief specific concerns when it comes to ICD-10.

Also discussed were ways the three groups could work better together toward the common end goal of ICD-10 implementation.

Joanne Romasko, RHIA, CPC, CHDA, director of medical economics at Blue Cross Blue Shield of Montana, represented the payer on the panel and said that ensuring "neutrality" in various forms is a payer's primary ICD-10 concern. If neutrality is not

achieved in the transition, contracts and relationships would need to be redone, Romasko said.

The provider angle was represented by Keith Olenik, MA, RHIA, CHP, ICD-10 project manager at Cook County Health and Hospitals System based in Illinois. Many providers have decided to merely slow their ICD-10 conversion in light of the proposed one-year compliance delay, versus stopping altogether only to start again later-which would waste both time and money.

However, providers need to pick up their pace of implementation, as payers and vendors appear to be ahead.

"I know we are not supposed to be excited about this delay; some did give a small sigh of relief that there is more time to get ready," Olenik said. "That said, you have to continue to move forward."

Vendors were represented by Roy Foster, the director of regulatory compliance practice for Cerner. Most vendors have made the transition to ICD-10 their top priority, in part because providers and payers can't fully move forward with their implementation plans until their vendors are ready.

"We want all of our clients to survive ICD-10 so we can get back to business," Foster said.

Improved communication between all three sectors was cited as a way to help everyone reach implementation.

> *"Soon primary care physicians will see the EHR as essential as the stethoscope."*
>
> Doug Fridsma
> MD, PhD, director of the office of standards and interoperability at the Office of the National Coordinator for Health IT

ONC: Federal EHR Adoption Efforts on Track

Several federal programs that promote the use of health IT to improve healthcare outcomes are successfully on track, including the meaningful use EHR incentive program, according to Doug Fridsma, MD, PhD, director of the office of standards and interoperability at the Office of the National Coordinator for Health IT (ONC).

During his keynote address that kicked off the ICD-10 Summit, Fridsma gave an update on the progress ONC and the healthcare industry have made in adopting electronic health record systems and using them to exchange data for the improvement of care.

The number of primary care physicians who have adopted EHRs has doubled from 2009 to 2011, according to a recent ONC survey. This increase corresponds with the launch of ONC's various EHR incentive initiatives authorized by ARRA and the HITECH Act, including direct efforts to get more physicians and hospitals to use health IT through incentives and workforce training.

"The HITECH Act was revolutionary in that it said we don't want to pay doctors to adopt technology, we want to pay them for improved care through technology," Fridsma said.

Both rural and urban physicians increased their EHR usage since 2009, according to Fridsma, with 52 percent of the country's eligible office-based physicians signing up for ONC's meaningful use program.

Hospital adoption of EHRs has also doubled since 2009, increasing from 16 percent to 35 percent. A total of 85 percent of hospitals told ONC they intend to attest to the meaningful use program by 2015.

"We have made progress in the last few years and will continue to move forward," Fridsma said. "Interoperability is a journey, not a destination."

> *"It is almost intrinsic that there will be a payment impact to your bottom line."*

Maria Bounos
RN, MPM, CPC-H, business development manager at Wolters Kluwer Law & Business

Predictive Payment Modeling Foresees ICD-10 Impact

Crystal balls and tea leaf readings are not the only ways to foresee the impact ICD-10 will have on a hospital's bottom line. Advanced analytics can be used to understand how payments will change when using ICD-10 codes.

At an ICD-10 Summit session, Louis Rossiter, PhD, leader of scientific methods at New Health Analytics, and Maria Bounos, RN, MPM, CPC-H, business development manager with consulting firm Wolters Kluwer, showed how to leverage ICD-10 data within an organization in order to reduce uncertainty in how ICD-10 changes reimbursement.

While CMS has said their own predictive modeling of ICD-10 shows a neutral financial impact on providers, Rossiter and Bounos said that is not entirely true. Even as the overall impact on all providers nationwide is neutral, the specific impact will vary between facilities.

Conducting a detailed risk assessment is the first step to determining the financial impact.

"If you can convert your issues into dollar signs, you will get a hospital administration's attention," Rossiter said.

A payment impact analysis can be done by translating two or more years of ICD-9 hospital claims into ICD-10, then using the expected Medicare MS-DRG ICD-10 payment rates to compare reimbursement between ICD-9 and ICD-10. While translated historical data is not the same as live coded ICD-10 data, the comparison can enable a close look at reimbursement rates.

The impact can be broken down by facility, DRG, service line, and other line items.

In an example model, Rossiter showed how some DRGs can lose more than others. The DRG for "cardiac defibrillator implant w/o cardiac cath w/o MCC" showed a loss in reimbursement of $663,821 between ICD-9 and ICD-10 over the entire span of reviewed records. However, a look at all Medicare fee-for-service payments showed a 2.7 percent increase in reimbursement under ICD-10.

The model not only attaches a dollar amount to the impact of ICD-10, but informs strategic planning by service line.

Chris Dimick (chris.dimick@ahima.org) is staff writer at the *Journal of AHIMA*.

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