

INSIDE EDGE

ICD-10: Bring lawyers, guns and money

EXECUTIVE SUMMARY

When the deadline for healthcare organizations to comply with the International Classification of Diseases version 10, aka ICD-10, arrives on Oct. 1, 2013, there will be wailing and gnashing of teeth—unless you're doing that already. In that case, you should be fine.

Kidding aside, the conversion to ICD-10 code from ICD-9 code, mandated by the Department of Health and Human Services (HHS) in a final rule promulgated exactly two years ago, involves a change of seismic proportions: The number of diagnostic codes under ICD-10 will jump to 68,000 from 14,000 under ICD-9; Procedural codes will jump to 72,000 from a relatively meager 4,000. Consider Y2K a warm-up in comparison. This one will hurt if you do not comply because these codes are the key to reimbursement. Failure, as NASA says, is not an option.

Adding to the complexity is the necessarily pervasive aspect of the conversion, which involves the entire organization—personnel, processes and IT systems that must all be aligned under organizational strategy. It doesn't stop there. Not only are provider organizations such as hospitals and physician

practices obligated to adopt ICD-10 but so are payers. HIT vendors must also become key collaborators in their customers' ICD-10 initiatives.

To find out where health systems are and where they ought to be on the ICD-10 journey we called on experts from Scottsdale Institute members and sponsors: Ingenix, Deloitte, Trinity Health and Intermountain Healthcare. They gave us a great snapshot—one that thankfully was not in code. [Members can access teleconference presentations on ICD-10 on the SI website.]

We are the world

"The US is the last industrialized country to move to ICD-10," says Emily Rafferty, national 5010/ICD-10 program manager for Ingenix, as the simplest explanation for why the U.S healthcare industry must move to ICD-10 from ICD-9 coding. The standard will allow us to align with other countries for biosurveillance and research. "ICD-9 is extremely outdated. It's run out of room for new disease categories and treatments. ICD-10 allows the capture of new breadth and depth in the evolution of clinical information," she says.

For example, ICD-10 allows the capture of new specificity such as left arm, side

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- David W. Bates, MD, M.Sc., chief, Division of General Medicine, Brigham and Women's Hospital and medical director, Clinical and Quality Analysis, Partners Healthcare System
- Shobha Phansalkar, Partners Healthcare System
- David C. Classen, MD, MS, VP, CSC, and associate professor, Medicine and consultant, Infectious Diseases, School of Medicine, University of Utah

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Quality Measures for Stage 1 of Meaningful Use: The Data Capture Challenge

- Erica Drazen, managing director, Emerging Practices, CSC
- Jane Metzger, principal researcher, Emerging Practices, CSC

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SI-Cerner Users Collaborative No. 31: Care Collaborative Results

- Jeffrey Rose, MD, VP, Clinical Excellence, Informatics, Ascension Health
- Philip A. Smith, MD, VP, Chief Medical Information Officer, Adventist Health System
- Loran D. Hauck, MD, senior VP, Chief Medical Officer, Adventist Health System

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ICD-10: What is Hiding in Your Application Portfolio?

- Chris Davis, director, Healthcare Technology Practice, Deloitte Consulting LLP
- Christine Armstrong, principal, Deloitte Consulting LLP

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of the heart, sequence or stages of disease, cause of injury and methodology to treat it. By having that coding ability, healthcare delivery organizations will be positioned to create and manage the new level of data required for the move to performance-based payments from fee for service.

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Emily Rafferty, ICD-10 program manager, Ingenix

Pressured by the World Health Organization (WHO), HHS set October 1, 2013 as the deadline for payers and providers to comply with the ICD-10 format.

“The United States

is the last industrialized country to adopt ICD-10,” notes Rafferty. “But it’s not as simple as flipping a switch. It’s not just an IT issue” because of the complexities involved in such factors as provider/payer contracting, she says.

Inappropriate use of the General Equivalency Mappings (GEMs) in the conversion of ICD-9-CM MS-DRG to ICD-10 MS-DRG may result in unintended consequences. Accurate coding based upon medical record documentation is required to attain the best possible MS-DRG assignment. Since the code descriptions in ICD-10-PCS are designed to be more specific than ICD-9-CM by applying a standardized vocabulary of surgical concepts, body part terms, operative approaches and

other key factors of an operative procedure, frequently the GEMs will offer multiple alternative ICD-10-PCS codes that map to a single ICD-9-CM code.

For example there are eight ICD-10-PCS codes that in the current version of the GEM results for code 37.34, Excision or destruction of other lesion or tissue of heart, endovascular approach. One of the possible alternatives in ICD-10-PCS is code 02BL3ZZ, Excision of left ventricle, percutaneous approach, which according to the GEMs also maps to code 37.35, Partial ventriculectomy. However, codes 37.34 and 37.35 do not group to the same ICD-9-CM MS-DRG. Failing to select the most appropriate code from all possible alternatives can result in assignment to the wrong MS-DRG. Incorrect MS-DRG assignment can lead to significant over or under payment.

While GEMs may help in offering a set of all possible alternatives in ICD-10-CM or PCS from which to select, examination of the medical-record documentation with verification using the most current versions of ICD-10-CM/PCS reference (code book, encoding product) is important to assure coding accuracy and proper MS-DRG conversion.

Thousands of examples

“That’s a dramatic difference,” says Rafferty. “It demonstrates how critical it is for doctors and coders to accurately document care. That’s just one example but there are thousands.” It also means that hospitals and health systems will have to provide extensive education

programs for physicians and coders. Physician champions will have to convey to the other physicians what the significance of the new codes means to them. Education programs must be tailored according to clinical category because cardiologists and neurologists will have their own new codes.

Education and training programs will highlight the biggest risk areas in which, like the example above shows, even a tiny discrepancy can result in a loss of more than \$13,000 in reimbursement. Rafferty says provider organizations can begin educating physicians under the many documentation-improvement programs that already exist. Coders also have access to a variety of formal ICD-10 certification programs. “We’re expecting a six-month learning curve for coders. Everyone is in the phase of assessing where they are from a clinical perspective,” she says.

From an IT perspective, all of a hospital system’s applications that either produce or store ICD-9 code must be remediated by the Oct. 1, 2013 deadline based on discharge data to support both ICD-9 and ICD-10. Organizations should assign an executive sponsor such as a CIO, CFO or even CMO to head a steering committee that should also include a senior-level revenue-cycle administrator as well as IT and clinical leaders. Other key stakeholders should represent operational, reimbursement and clinical sides. “It’s really collaboratively driven. Typically, we’re seeing the CIO become the executive sponsor,

but the revenue-cycle administrator is another possibility because most of the weight is on their shoulders,” says Rafferty.

A task huge in significance is testing the new coding, which will require communication between providers and IT vendors and between providers and payers. Providers need to know, for example, what kind of mapping techniques may be used to link an ICD-10 code back to ICD-9.

Globalization of data

Chris Davis, a technology leader at Deloitte, notes that ICD-10 is part of the globalization of disease management. “The WHO provides the standard today for classifying diseases and procedures with ICD. ICD-10 gets us up to speed to do disease management and efficiency studies.” A second underlying reason is for organizations to understand what’s occurring internally in terms of quality. “The science of medicine has outstripped our coding ability to target protocols. We need to get better data,” he says.

Deloitte.

“There are lots of ramifications for those codes,” says Davis, which provide diagnosis and procedure codes that flow through mission-critical operational systems and analytical tools. Downstream the new codes will have a significant impact on databases and data warehouses and will require reengineering of workflows. “The process impact is tremendous. You need your

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Healthcare Supply Chain: Incentive and Value-Based Purchasing

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- Carolyn Howard, specialist leader, Deloitte Consulting LLP

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- Rick Turner, MD, MBA, CMIO, Saint Alphonsus Regional Medical Center, Trinity Health

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- Jeffrey Firlik, BS Pharm, MSA, RPh, pharmacist, principal, CSC, and Vice-Chair, Vermont Board of Pharmacy

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PHI: Mitigating Risks and Affects of Security/Privacy Breaches

- Ray R. Bonnabeau, Attorney at Law, Hellmuth & Johnson, PLLC

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SI-Cerner Users Collaborative No. 32: HIE Case Studies

- Bob Robke, Sr. VP, Cerner, moderator

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eyes wide open—operational changes are required,” he says.

Lessons learned from healthcare organizations in the field suggest that the challenge can be broken down into six basic tasks:

1. Conduct an operational impact assessment—what are your risk areas?
2. Perform an IT system inventory—most organizations do not have a handle on what software applications require remediation; reinvent the application inventory process you undertook for Y2K;
3. Develop an implementation plan—keep all things in a central plan;
4. Collect payer and vendor readiness data—how prepared are they for the conversion to ICD-10?
5. Create a budget—for the next three years;
6. Determine the crosswalk—using CMS’ published mappings between the old and new codes.

According to research by Deloitte, healthcare organizations generally take one of three stances regarding ICD-10. The majority—60 percent—are “pragmatists” who aim at basic compliance and view it as one among many mandates they face today, and one for which they expect a negative ROI. Another set—about one in four organizations—are more proactive “collaborators” who see the potential of at least breaking even as a result of their investment in ICD-10 compliance. Roughly one in five

organizations comprise a third group of “innovators” who see ICD-10 as an opportunity to differentiate themselves strategically.

Trinity Health

With 46 hospitals in nine states, 8,000 doctors on staff and a reputation for standardized and efficient IT implementations, Novi, Mich.-based Trinity Health offers a potential instructive example of how a large health system might approach conversion to ICD-10.



Kyle Johnson, VP,
Trinity Health

“We’re quite a ways down the path with Meaningful Use preparedness, but still in the early stages of ICD-10,” says Kyle Johnson, Trinity’s VP of application

services. “ICD-10 plugs in well to our existing Meaningful Use planning and governance structures, which gives us a quick jumpstart.”

Trinity uses a program-management methodology that tasks executive leads for process, technology, and adoption components and assigns them to a planning team that oversees the initiative. Leaders manage the program using QuickBase, an easy-to-use Quicken database tool that tracks high-level milestones and tasks associated with the component triad.

“ICD-10 plugs in well to our existing Meaningful Use planning and governance structures, which gives us a quick jumpstart.”

Trinity has just formed an executive steering committee, which includes senior level executives that oversee an ICD-10 steering committee responsible for setting direction and making 90 percent of the initiative's decisions. The steering committees consist of directors and senior executives, including Trinity's CFO, CMO, and CNO.

Last to touch a bill

Next steps include building tasks into the database and helping coders develop an understanding of how the new code maps to the old code. "We'll be performing parallel coding between January 2012 through the October 2013 deadline so the organization can understand the new reimbursement expectations with ICD-10," says Johnson. Parallel coding refers to providing the code in both ICD-9 and ICD-10.

Practicing the art of the possible is necessary for a health system whose diverse markets span nine states. For example, Trinity Health will work with its payers to determine if they can accommodate receipt of parallel coding during the year leading to ICD-10 launch. The health system also needs to identify what's required in terms of vendor upgrades and staffing needs, primarily for coders. Especially for inpatient accounts, coders, located in each hospital, are the last hands to touch a billing document.

Increasing the challenge is the fact that much of the coding will occur in the physician office setting. "How do we

help the physicians at the office level? It's very complex," says Johnson, adding that being part of a large health system is a real advantage because it provides access to the significant resources required to tackle such a complex project.

While Trinity will focus its physician program primarily on its 2,000 employed doctors, it will also reach out to many of its 6,000 independent doctors. "We're going to be asked to help them complete software upgrades, work with their vendors and do training," she says, acknowledging that conversion to ICD-10 constitutes yet another major driver in hospital/physician consolidation. "There is no question that conversion to ICD-10 will be a challenge for small physician practices," says Johnson. "A partnership with a larger organization will very likely help smooth some of the inevitable bumps in the road. As it relates to quality and patient care, both parties are interested in assuring this goes very well."

Intermountain

Despite several false starts with ICD-10 during the past five years, Salt Lake City-based Intermountain Healthcare is now moving steadily ahead on its ICD-10 initiative, says Craig Jacobsen, associate VP for IS finance administration. "We feel we're really mobilized," he says, having formed a steering committee and an operational group that oversees multiple work teams.

"There is no question that conversion to ICD-10 will be a challenge for small physician practices."



Craig Jacobsen,
associate VP,
Intermountain
Healthcare

“It’s a huge cash-flow issue for us.”

Last summer Intermountain hired a consultancy to perform a three-month readiness assessment that helped the organization formulate a comprehensive strategy and budget, including recommendations for communication, education and training. Reflecting how important the ICD-10 issue is for Intermountain, the organization has tapped its senior VP of finance and CFO as the ICD-10 steering committee’s executive sponsor. Meeting regularly since the end of last year, the steering committee includes other VPs for finance, revenue cycle and communications, as well as CIO Marc Probst, a regional VP for hospital operations, an executive for SelectHealth, Intermountain’s health plan, and COO of its employed-physician medical group.

“It’s a huge cash-flow issue for us,” says Jacobsen. “We’re concerned about getting our bills out and the productivity of coders, which we expect will drop 50 percent in the first year,” he says. That’s why Intermountain is focusing on recruiting, training and retaining coders. The organization is also concerned about the ability of payers to comply with the new code “if we do as well as we plan to in converting to ICD-

10. We’re actually working on contracts that would hold them accountable for ICD-10 compliance.”

There’s been a general industry perception, at least to date, that payers, anxious to gain any reimbursement edge, have forged ahead of provider organizations in addressing ICD-10. In that vein, SelectHealth, which represents 30 percent of Intermountain’s hospital payer mix and 40 percent for its medical group, initially wanted to undertake its code-conversion initiative independent of Intermountain’s provider organization. However, the two organizations are now aligned in their ICD-10 effort, and Intermountain is in discussions with other payers and with IT vendors.

“It’s a huge effort to upgrade these systems. You have to have the capability to do dual processing for some payers. Other payers like Worker’s Comp and auto liability are not required to comply with ICD-10. Our biggest issue is trying to handle both ICD-10 and ICD-9 codes in such a way that we can capture them and report on them. In many cases there’s a one-to-many relationship in terms of an ICD-9 code mapping to ICD-10,” says Jacobsen.

Conclusion

ICD-10 is just one piece of the ongoing transformation of healthcare that includes the emergence of bundled payments, accountable care organizations (ACOs), pay for performance (P4P), Meaningful Use and health informa-

tion exchanges (HIEs), notes Ingenix's Rafferty. "ICD-10 is not going to thwart those changes in any way but supports them and moves us toward better reporting and analytics."

She recalls how one healthcare executive characterized ICD-10 as "the Y2K of healthcare," in other words, a lot of fuss

about something that would ultimately prove to be inconsequential. "Nothing could be further from the truth," she says. "It's happening and you will be impacted. A better comparison would be if the United States America converted to the metric system. It's a completely new nomenclature."



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