



Leveraging ICD-10 for Strategic Advantage

Introduction

According to the ICD-10 Final Rule (CMS-0013-F), all covered U.S. health entities must use ICD-10 codes to submit claims for health services that are delivered on or after October 1, 2013.

ICD-10 will continue to be updated each year, along with the General Equivalence Mappings (GEMs) for ICD-9. However, the GEMs are not likely to be updated after 2016, and ICD-10 will need to be fully in place by that time. While these dates may seem aggressive, they're actually later than originally proposed. The input of industry specialists led the U.S. Department of Health & Human Services to give health care organizations more time to get ready.

Even so, health care organizations are already contending with a difficult economy and uncertainties surrounding the Health Care Reform and Modernization Act, so the prospect of undergoing a transition as significant as ICD-10 may be overwhelming.

BIG CHANGE, BIG IMPACT

The ICD-10 implementation will be the most significant change in U.S. health care IT to date. Given its scope and complexity, it's clear that U.S. adoption of the more granular ICD-10 code set requires a massive overhaul of the nation's medical coding system because the current ICD-9 codes are deeply embedded as part of the coding, reporting, and reimbursement analysis performed today. In fact, ICD-10 implementation has the potential to overtake Y2K in terms of impact and cost, according to many industry analysts.

Remediation efforts will require significant changes to system reviews, new medical coding, updates to existing software, and modifications to many system interfaces. Because of the complex structure of ICD-10 codes, implementing and testing the changes in the various health plan and physician systems—EMRs, billing systems, reporting packages, decision and analytical systems—will require more effort than simply testing data fields. It will involve installing new code sets, training coders, re-mapping interfaces, and recreating reports/extracts used by all constituents who access diagnoses codes. In short, ICD-10 implementation has the potential to touch nearly all operational systems and procedures of the core payer administration process and the physician revenue cycle.

STRATEGIC OPPORTUNITIES

Health plans and physicians who embrace the technology change—along with redesigned business processes that facilitate cost savings and new capabilities—will be best positioned to integrate their remediation efforts with other corporate initiatives, identify potential IT issues and options early on, and determine opportunities to optimize the overall business.

Organizations can achieve this strategic alignment by thoroughly assessing the people, processes, and technologies that could be affected by the changes. Only by evaluating the broader business impact can organizations adequately plan for the education and training, internal and external integration testing, and implementation of the new business process changes that both meet ICD-10 requirements and advance larger business goals.

Despite the potential strategic advantage, some industry estimates predict that almost 60 percent of all health care entities will achieve just “basic” ICD-10 compliance—the minimum required by law. This means they will be investing only in infrastructure to fulfill core CMS mandates. Ultimately, for many organizations, this could mean large costs that yield very little strategic value and negative ROI. For others, a thorough analysis of the business and its objectives—and a clear strategic roadmap—will enable them to fully leverage ICD-10 compliance as a way to further their market agendas, business models, and clinical capabilities.

Background

Almost 120 years ago, the International Statistical Institute in Chicago adopted the earliest “International List of Causes of Death” as a means of tracking global mortality statistics. Today, the World Health Organization uses an 11th-generation version of that code set, the International Statistical Classification of Diseases and Related Health Problems, or ICD, as it is known today, to track mortality and morbidity statistics.

In the United States, the health care system of physicians and health plans (both government and commercial) also use the codes in reimbursement systems and in their clinical decision support systems. However, the United States lags behind

most other industrial countries in its adoption of the latest code set, ICD-10. There are several compelling reasons to make the switch:

ICD-9-CM HAS RUN OUT OF SPACE

Perhaps the most practical reason for conversion to ICD-10 codes is the simple fact that ICD-9-CM has run out of space. The world of medicine has matured to the extent that ICD-9-CM simply cannot handle the magnitude of diagnosis, procedure, and device codes that now exist internationally.

ICD-9-CM IS OUTDATED

The medical world was a much different place when the CDC and CMS published the ICD-9-CM code set in 1979. Then, the concept of surgery was limited to the use of a scalpel. Now we see surgery performed with the use of endoscopy or laparoscopy or with the assistance of computers, gamma-knife, and lasers. ICD-9-CM is not very adaptive to new technologies like these, while ICD-10 can be updated with one character change or addition.

Another example of ICD-9-CM's outdated nature involves mitral valve insufficiency. If a patient has mitral valve insufficiency and aortic valve stenosis, ICD-9-CM assumes that the person had a history of rheumatic fever and classifies the condition a rheumatic heart valve disorder. Medical science now knows that this assumption is no longer accurate.

THE ICD-9-CM CONCEPTUAL FRAMEWORK DOES NOT MAKE LOGICAL SENSE

Because ICD-9-CM has run out of space, the inherent hierarchy has been breached, making it hard for novice (and sometimes expert) coders and researchers to easily find the appropriate codes. For example, codes for a combination defibrillator pacemaker are not in the cardiovascular chapter of ICD-9-CM with other defibrillator and pacemaker devices. Coders and researchers have trouble finding these codes with this type of erratic code assignment.

In addition, all the procedures in the 00 category in ICD-9-CM are procedures that would not fit in their appropriate anatomic areas. The American Health Information Management Association (AHIMA) has predicted that the ICD-9-CM procedure coding system will be out of codes in 2012 if every available space has been filled.

The goal of a classification system is to be able to put data into "buckets." When CMS had to begin assigning codes to

wherever they would fit, we began to lose the power of a classification system.

ICD-10 provides a more logical organizational structure that not only helps professional medical coders do their jobs, but also allows for greater use of computer-assisted coding. With an historic shortage of coders, this is an important benefit.

ICD-9-CM IS NOT GRANULAR ENOUGH TO MEET THE NEEDS OF QUALITY AND COST REPORTING

The major benefit that ICD-10 offers is added level of granularity, which can be broken down into three components: precision, accuracy, and laterality. However, this added level of granularity does not only impact coders—clinical documentation must now support it, too.

ICD-10 codes will allow for better identification of candidates for disease management programs. In ICD-9-CM, there are eight codes for coronary artery disease. In ICD-10-CM, there are 37. ICD-10-CM provides detail around associated types of angina and coronary spasm. Codes for patellar fracture increase from two in ICD-9-CM to 480, adding specificity in type of fracture, laterality, displacement and type of encounter (initial or subsequent). These details make it easier to identify the most appropriate patients for intensive intervention. For physicians, better documented and more precise identification of diagnosis and procedures should ultimately lead to better care for the patient.

Greater specificity also enables health plans to accompany any ICD-10 conversion initiative with subsequent work around pay-for-performance programs that take advantage of the more logical and descriptive codes.

THE REST OF THE DEVELOPED WORLD HAS CONVERTED <i>At publishing date, the following countries have converted to their own version of ICD-10:</i>	
United Kingdom (1995)	Russia (1999)
South Africa (1996)	Germany (2000)
Nordic countries (Denmark, Finland, Iceland, Norway, Sweden) (1994 –1997)	Canada (2001)
France (1997)	China (2002)
Australia (1998)	Thailand (2007)
Brazil (1998)	Korea (2008)
Belgium (1999)	

These countries have modified and manage ICD-10 in their own unique ways—though their data may not be directly comparable without some massaging. Nevertheless, the World Health Organization needs to be able to compare apples to apples when gathering and reporting international mortality and morbidity statistics.

To encourage international comparability in the collection, processing, classification, and presentation of these statistics, the U.S. needs to get on board.

Make a smooth transition

The case for ICD-10 seems pretty clear cut: More space, codes that more accurately reflect modern medicine, a conceptual framework that makes more logical sense, and a level of granularity that enables better quality reporting, more accurate claims payment, and improved international mortality and morbidity reporting.

In consideration of the conversion of our current coding system to ICD-10, we also need to look at it critically. We need to get an understanding of the value ICD-10 adds—as well as the limitations of the value-add—and fill the gaps those limitations imply. Health plans, physicians, and vendors need to focus on the portion of conversion work that will truly add value.

ASSESS IMPACT, CHART A ROADMAP

No health plan or physician has the luxury of time. Organizations must evaluate their approach and methodology to drive operational, technological, and educational prioritization by utilizing proven risk assessment methodologies. This is more than a mere organizational readiness exercise—it begins with the end in mind. An impact assessment moves the organization to set priorities in alignment with ICD-10 remediation phases.

With the requirements of ICD-10, organizations will find themselves in one of two scenarios. Either the organization is in its pre-planning and discovery stages, or it has jumped headlong into remediation. The sense of urgency is driven by compliance. Regardless of starting point, however, organizations should explore opportunities to drive business innovation and optimization—and ultimately, market advantage. As this is not purely an IT change, organizations should take a general systems/multi-disciplinary approach to solutions, recognizing the interdependencies of an organization's people, process, and technology and the significant capital and resources needed from most—if not all—business functions.

From the health plan's perspective, a cross-functional team needs to first assess all its core claims and billing operations (and ancillary systems) to determine the effect of the changing diagnoses codes and their derivatives on those systems. From a physician's perspective, all core business areas need to be assessed, including patient access, clinical and ancillary, health information management, claims, patient billing, receivables, and reporting/analytics. For all organizations, the foundation of this transition will come through four key organization support areas: project governance, education and training, compliance, and IT.

A business readiness assessment includes a comprehensive people, process, and technology impact assessment, organizational risk assessment, identification of education/training needs, clinical data quality assessment (physicians), and lastly, development of a roadmap to readiness to identify all key milestones and tasks, estimated work effort, and associated timeline. The objectives of the assessment are to determine all the systems that will need to be upgraded, replaced, or outsourced to meet the 2013 deadline, prioritize systems and processes to remediate, and prepare a summary of effort by hours and cost. In addition, through this exercise, organizations should explore every opportunity to answer the following questions:

- How much of an impact could ICD-10 have on our revenue?
- What conditions or services have the highest risk?
- What opportunities for additional revenue exist with ICD-10 implementation?
- Where should we focus our efforts to train coders and educate clinicians about the documentation requirements of ICD-10?

For example, realizing that system configuration is driven by items such as policy and contractual language enables health plans to benefit from a full impact assessment and effectively prepare for remediation.

Once the assessment is completed, the organization should develop a detailed two- to three-year strategy and plan for achieving timely compliance. Depending on the size of the health care organization, this phase can take several months.

GETTING THE VALUE ADD FROM ICD-10

One additional benefit of conducting a formal assessment and roadmap is the opportunity to identify innovative strategies that organizations can deploy to differentiate themselves from competitors that may assume a more straight-forward, compliance position.

Business intelligence

By leveraging business intelligence technologies and strategies, organizations can take the raw transactional ICD-10 data, and through a prescriptive modeling exercise, refine their risk position. As an outcome, an organization may re-calibrate its plan pricing structure based upon finer trend analysis. The organization might even discover latent risk populations as ICD-10 makes risk pools more transparent.

Product innovation

Because ICD-10 is more granular, consider the implications in product innovation. Health plans have an opportunity to craft plan-specific offerings. In the day of consumer-driven health plans, we've witnessed the emergence of diabetes health plans and wellness plans that promote and reward positive behavioral changes. ICD-10 is the new language that will articulate health and wellness behavior.

Physician/health plan synergies

While physicians and health plans enjoy a certain amount of operational autonomy, the clear view of the emerging landscape is tighter vertical integration. State health care exchanges are becoming the fertile ground that will advance electronic records. For a health plan that is ICD-10 ready, consider that physician networks—out of necessity—will align with organizations that will short-cycle adjudication and payment processing.

Protecting investments

The turn of the century witnessed an investment in billions of dollars to deploy ERP systems in every industry imaginable. It continues today. A significant portion of that investment was in educating and retaining people who possessed a high-demand competency. This will be true for those people who not only understand, operate, and thrive in an ICD-10 environment, but for those who drive organizational transformation.

Implementing systems and processes that are ICD-10 compliant is the minimum entry for all organizations. Consider that 40 percent of the ICD-10 code needs interpretation. If the organizational coders leave for a better opportunity, churn in an organization is depletion of resources and tribal knowledge. ICD-10 at the core is a strategic imperative. Organizations need to work to retain the most valued asset: knowledge.

Conversion strategies

TRANSLATION TOOLS

CMS has provided health care organizations with three sets of General Equivalency Mappers (GEMs) to assist with the conversion of ICD-9-CM codes to ICD-10. There are three categories of GEM mappers or crosswalks:

- ICD-9-CM to ICD-10
- ICD-10 to ICD-9-CM
- Reimbursement

Currently the GEMs are able to translate approximately 60 percent of the codes directly between the two systems. However, within this 60 percent are multiple instances where one ICD-9 code maps to many ICD-10 codes and vice versa. These codes will require an additional layer of analysis.

Additionally, the remaining 40 percent of the codes do not map at all. In other words, there is not a 1:1 correlation between the source and target in many instances. There is no simple crosswalk between the two code sets, as they are fundamentally different in design and concept. There are tens of thousands of codes that we will need to interpret manually. For example, myocardial infarction is construed differently in each code set. ICD-9-CM does not distinguish between the left and right coronary system. ICD-10 does. As most clinicians will tell you, because the right coronary system is a low pressure one that sends blood to the lungs, it is not as critical as the high pressure, left coronary system that sends blood to the heart. From a clinical standpoint, this is a highly important distinction that ICD-10 allows us to make.

Companies should explore automated mapping and translation tools to accommodate for the gaps and serve a broader set of requirements, including effectively and concurrently processing ICD-9 and ICD-10 transactions, enabling medical code translation between international markets, and streamlining adoption of SMOMED CT for electronic exchange of clinical health information.

ADDITIONAL RESOURCES

In addition, health care organizations should consider the additional coding staff needs required with this initiative, especially in the areas of IT, project management, education and training, and most importantly, coding and documentation specialists.

They must also ensure they have the right staffing levels to backfill coders taken away from their current work for training and a dual coding system operating environment during the initial years of the transition.

Waiting until the last minute to plan for the all-encompassing changes associated with the transition to ICD-10 could negatively impact health plan and physician revenue streams, national and international data sharing efforts, and most importantly, the safety of patients.

Other issues to consider

In addition to the GEM mappers not being sufficient to meet ICD translation needs, CMS still has not finished updating either the mappers or the American version of the ICD-10 code system itself. These are all still in a state of flux.

In addition, CMS will require health care organizations use both ICD-9-CM and ICD-10 systems simultaneously for two years so they can gather comparative data to rebuild a new set of payment systems.

Health care entities will also face challenges to get to the point of testing with trading partners at the same time. In other words, all health care organizations need to work with their trading partners to plan and design an integration test strategy to overcome this challenge.

Finally, the last issue to consider is the impact of the transition to ICD-10 on an organization's staffing levels. Several factors will impact coding staff:

- ICD-10 training and certification requirement
- Anticipated learning curve of at least six months for coding using ICD-10
- Need to operate in a dual-processing environment for at least two years post-compliance date
- A current shortage of industry coders, exacerbated by the fact that many seasoned coders are nearing retirement age

Organizations will inevitably face a loss in production and will need to develop a plan to mitigate any anticipated losses in production. Project management, IT, and education and training areas will also require an extensive number of resources to support this transition. As part of the readiness assessment process, organizations need to address the staffing plans in each of these areas to identify where additional resources may be required.

Conclusion

HIPAA and Y2K proved that health care regulatory remediation programs can take years of planning to achieve successful implementation. The window of opportunity for ICD-10 is closing very quickly on a number of fronts. All health care organizations should now be at the planning stage for their conversion to the ICD-10 coding system.

With only a few years remaining before all systems, processes, and personnel need to be ready to operate in an ICD-10 based industry, there is no time left in assessing the impact of one of the most significant overhauls in health care IT.

Industry action items:

- Complete a comprehensive readiness assessment
 - Identify impacted people, processes, and technology
 - Decide which systems need to be remediated or replaced
 - Address staffing needs
 - Identify revenue impacts and risk mitigation plan
 - Develop a roadmap to readiness
- Identify mapping and translation needs and select a tool to assist in the process
- Budget for remediation and implementation phases, taking into consideration systems remediation/replacement needs, education/training and resource requirements.

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