ICD-10 Operational Impacts

Is your team ready to master the maze of ICD-10?

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AMA Author

Impact Assessment
Risk
CDI
Post Implementation Challenges
Support
Education
Action Plan
Documentation Readiness

What is ICD-10?

• ICD-10 is the most current active version of the classification system from WHO
• ICD-10 has been in use since 1994 and currently employed by more than 153 countries
• ICD-10 system currently contains over 68,000 diagnoses codes, whereas ICD-9 has 14,000
• ICD-10 currently has approximately 87,000 procedure codes compared to 4,000 codes in ICD-9
  ▪ The additional number of codes, fields and characters used by ICD-10 coding schemes allow for significantly more detail and specificity
  ▪ This is very important as ICD-9 is running out of numbers for emerging procedures and diagnoses

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What is ICD-10?

When a physician evaluates a patient, the physician collects subjective and objective data (the “history and physical”) to diagnose the patient’s condition and develop a plan for treatment. The most widely used diagnostic taxonomy in health care is the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems (ICD). ICD is a coding system of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases that is used internationally to classify morbidity and mortality data for vital health statistics tracking and in the U.S. for health insurance claim reimbursement.

Source: http://www.who.int/classifications/icd/en/

Why So Important?

- Largest change to ever happen to healthcare
- All HIPAA covered Entities must transition to ICD-10
- Will take many hospitals and other healthcare organizations extensive resources to accomplish full implementation
- May require significant funding
- May take years to Recover
ICD-10 Sits Among the Top Issues the Industry Has to Weigh

There will be challenges, but we believe the transition will be able to be achieved by the organization because of the commitment and dedication of the entire organization. We will be ready October 1, 2015.

ICD-10—The Current State

- April 9, 2012 - HHS published the proposed rule extending the deadline for ICD-10 compliance to 10/1/2014
- March 27 2014-Congress extended deadline to 10-1-2015
- March 31, 2014-Senate passed the bill to delay ICD-10 until 10-1-2015
- We now have more time to get ready so get moving. There are much work to be done to complete the implementation tasks to get ready to “Go-Live” with ICD-10
- All HIPAA Covered Entities must transition to ICD-10 on October 1, 2015
WHY THE CHANGE

• ICD-9-CM Codes are based on the state of medical knowledge of the late 1970s* with periodic updates applied.

• As medical advances continue by leaps and bounds ICD-9-CM will continue to inadequately address the present state of medical knowledge - regardless of annual updates. The uses of coded data has expanded beyond the intended purposes of more than 30 years ago. The current ICD-9-CM system:
  – Lacks sufficient specificity and detail,
  – Is running out of space, and the limited structural design cannot accommodate advances in medicine and medical technology and the growing need for quality data,
  – Is obsolete and no longer reflects current knowledge of disease processes, contemporary medical terminology, or the modern practice of medicine,
  – Hampers the ability to compare costs and outcomes of different medical technologies, and
  – Cannot support the US transition to an interoperable health data exchange in the US

MAGNITUDE AND COST

• Migration from ICD-9-CM to ICD-10-CM/PCS represents one of the greatest changes in healthcare information management
  • ICD-10 will be used for analytic and reporting purposes
  • Estimates of the system implementation cost:
    • 400+ bed hospital range between $500,000 and $2,000,000 per entity
    • Physician practices are estimated from $5,000 to over $100,000
Physician Practice

Revenue cycle impact – erroneous coding; lack of sophistication with Payor systems; need to renegotiate contracts.

Training impact is significant – new and extensive coding scheme.

Impact on Quality of Care due to new more detailed coding schema.

Potential for serious financial consequences.

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The transition will significantly impact business operations and require changes to existing software and other technologies, and extensive training for physicians, clinicians, coders, and general staff. The migration to ICD-10 impacts many areas across the health system.

What Are The Impacts and Who Is Impacted?

Stakeholders throughout the healthcare industry will be impacted.

- Business Operations
  - Procedures
  - Policies
- Care Management
  - Medical & Treatment Policy
  - Medical Management
  - Reimbursements
- Technical
  - Software Upgrades
  - Databases & reports
  - Electronic Transactions
- Transition
  - Change Management
  - Training

Significant technology and process changes in addition to industry adoption will be required to achieve the intended benefits of ICD-10.

ICD-10-CM

- CPT and HCPCS will be the standard for reporting procedures and services
- ICD-10-CM will be the standard for reporting diagnosis codes
- ICD-10-PCS will be the standard for reporting Inpatient Hospital Procedures

Keep in mind Medical Necessity drives the payment!
ICD-10 Code Set Reporting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Date of Service</th>
<th>Code Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters</td>
<td>09/30/2015</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td></td>
<td>10/01/2015</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>Date of Discharge</td>
<td>Code Set</td>
</tr>
<tr>
<td></td>
<td>09/30/2015</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td></td>
<td>10/01/2015</td>
<td>ICD-10-CM &amp; ICD-10-PCS</td>
</tr>
</tbody>
</table>

ICD-10 Implementation

<table>
<thead>
<tr>
<th>Setting</th>
<th>Diagnosis Code Set</th>
<th>Procedure Code Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>ICD-10-CM</td>
<td>ICD-10-PCS</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>ICD-10-CM</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>Physician Facility</td>
<td>ICD-10-CM</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>Physician Office</td>
<td>ICD-10-CM</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>ICD-10-CM</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>Home Health</td>
<td>ICD-10-CM</td>
<td>CPT/HCPCS</td>
</tr>
</tbody>
</table>

Note: Only inpatient hospital setting is impacted by change in procedural coding system.
HOW ARE DIAGNOSIS AND PROCEDURE CODES CHANGING?

<table>
<thead>
<tr>
<th>ICD-9-CM Volume 1 and 2</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,077 diagnosis codes</td>
<td>69,847</td>
</tr>
<tr>
<td>3–5 characters in length</td>
<td>3–7 characters in length</td>
</tr>
<tr>
<td>First digit may be alpha (E or V) or numeric; digits 2–5 are numeric</td>
<td>First digit is alpha; digits 2 and 3 are numeric; digits 4–7 are alpha or numeric</td>
</tr>
<tr>
<td>Difficult to analyze data due to non specific codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Does not support interoperability</td>
<td>Supports interoperability and exchange of health data within the United States and other countries</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9-CM Volume 3</th>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,768 procedure codes</td>
<td>72,600 procedures</td>
</tr>
<tr>
<td>Numeric code structure (up to 4 digits) — no embedded meaning in characters or digits</td>
<td>Alphanumeric code structure (up to 7 characters) — semantic meaning within characters</td>
</tr>
<tr>
<td>Procedure codes based upon name of procedure</td>
<td>Intervention codes based upon intent of procedure</td>
</tr>
<tr>
<td>Use of generic terms for body parts with little detail for procedure types and approaches</td>
<td>Provides detailed descriptions on procedural methods, approaches, body parts, devices</td>
</tr>
<tr>
<td>Limited capacity to add new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Reflects outdated technology and medical/surgical techniques</td>
<td>Reflects current usage of medical terminology and devices</td>
</tr>
</tbody>
</table>

The benefits are significant, but it will require investment in changes to processes and technology across operations.

THE EXPECTED BENEFITS OF ICD-10 ARE SIGNIFICANT

Today’s data needs are dramatically different than they were 30 years ago when ICD-9 was introduced. ICD-10 will advance healthcare in many ways, with benefits accruing across five major categories.

- **Quality Measurement**
  - Data availability to assess quality standards, patient safety goals, mandates and compliance
  - Higher quality information for measuring healthcare service quality, safety, and efficiency

- **Public Health**
  - Improved disease and outbreak information
  - Improved ability to track and respond to international public health threats

- **Research**
  - Better data mining for increased analysis of diagnosis, treatment efficacy, prevention, etc.
  - Recognition of advances in medicine and technology

- **Organizational Monitoring and Performance**
  - Enhanced ability to identify and resolve problems and ability to differentiate payment based on performance

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Clinical Staff

• What’s changing in the codes:
  • Code Volume – 17,000 to 140,000
  • Code descriptions completely different
  • ICD-9 - Congenital bowleg deformity
  • ICD-10 – Congenital bowing of long bones of leg
  • Description length increases from an average of 25 to 45 characters
  • Groupings of codes (system vs. location)
• Impact: longer searches, more choices to mull through, system user interface inefficiencies – ultimately... a slow down

Clinical Staff—Changes in Workflow, Policies and Procedures

• Documentation habits
  • Problem lists – existing + newly defined
  • Paper inadequacies that must be replaced with electronic solutions
  • Decision support
  • Quality measures
  • Diagnostic testing orders, medical necessity
  • DME orders
  • Referrals and pre-authorizations
  • Population health procedures
  • Medical home policy/procedures
• Impact: productivity, administrative workload with medical oversight
Payor Readiness

% of Payors Surveyed
- Will meet deadline
- "Likely" to meet deadline
- Not sure or will NOT meet deadline

Total Number of Edit Claims by Type and Payor

<table>
<thead>
<tr>
<th>Type</th>
<th>Aetna</th>
<th>Anthem</th>
<th>Cigna</th>
<th>Humana</th>
<th>UHC</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>36,266</td>
<td>36,796</td>
<td>36,509</td>
<td>36,796</td>
<td>31,135</td>
<td>36,568</td>
</tr>
<tr>
<td>ASA</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
</tr>
<tr>
<td>NCCI</td>
<td>860,694</td>
<td>860,765</td>
<td>860,765</td>
<td>860,765</td>
<td>860,765</td>
<td>860,765</td>
</tr>
<tr>
<td>CMS</td>
<td>184,220</td>
<td>185,371</td>
<td>185,365</td>
<td>185,371</td>
<td>185,178</td>
<td>185,371</td>
</tr>
<tr>
<td>Payor Specific</td>
<td>62,335</td>
<td>76,726</td>
<td>1,190</td>
<td>5,033</td>
<td>82,868</td>
<td>19,683,450</td>
</tr>
</tbody>
</table>
WHY SO MANY DIAGNOSIS CODES?

- 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
- 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
- ~25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% Change in Code Volume from ICD-9 to ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious disease</td>
<td>2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>50%</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>71%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87%</td>
</tr>
<tr>
<td>Psychiatric/Mental Health</td>
<td>92%</td>
</tr>
<tr>
<td>Oncology</td>
<td>94%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>105%</td>
</tr>
<tr>
<td>Hematology</td>
<td>130%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>142%</td>
</tr>
<tr>
<td>Urology</td>
<td>162%</td>
</tr>
<tr>
<td>Pediatrics/Neonatology</td>
<td>203%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>235%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>366%</td>
</tr>
</tbody>
</table>
Impact By Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>ICD-9-CM Codes</th>
<th>ICD-10-CM Codes</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>178</td>
<td>430</td>
<td>2.5x</td>
</tr>
<tr>
<td>Dermatology</td>
<td>172</td>
<td>603</td>
<td>3.5x</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>220</td>
<td>777</td>
<td>3.5x</td>
</tr>
<tr>
<td>Family Practice</td>
<td>229</td>
<td>829</td>
<td>3.6x</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>204</td>
<td>848</td>
<td>4.2x</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>165</td>
<td>836</td>
<td>5x</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>143</td>
<td>5,843</td>
<td>40.9x</td>
</tr>
</tbody>
</table>

Based on diagnosis coding found on 1000s of ambulatory superbills and using GEMs to convert, this is the increase in codes that can be expected.

Source: American Medical Association 2013
Billing Staff

- Plan for:
  - More handwritten diagnoses from providers
  - More clarifying questions for clinical staff
  - More denials, delayed payments
- Impact: Billing staff more reliant on clinical team to get accurate information, more resubmissions and cash flow issues

Billing Staff

- Productivity:
  - Up to 40-50% increase in keystrokes using full keyboard
  - Code lookups/encoders will be completely different in wording
  - GEMS will not be the “go to” resource—must know clinical coding findings and other criteria to derive accurate coding
- Impact: Billing tasks will simply take longer
Billing Staff

- Eligibility and Authorizations
  - More granularity and coding expertise required
  - Process could become more streamlined once systems are updated
    - Payors may still adjudicate using ICD-9
    - Appeals, reconsideration, new treatments for existing patients that occur pre-/post ICD-10
  - Impact: Claims pended or denied based on authorization or benefits coverage

Billing Staff

- Charge entry lag time due to delays
  - Completing EMR encounter to generate charges
  - Pending more detailed information about the patient encounter to code correctly
  - New task/work list categories may help streamline the process
  - Impact: Slow down in cash flow
Billing Staff

- Claims validation and processing
  - New edits based on new Payor proprietary rules
  - On-going builds of new edits increasing as Payors refine adjudication criteria
  - Changes as coding conventions for modifiers, injury codes, V Codes, etc may be replaced with more granular ICD-10 codes
- Impact: Claims edits must be flexible and able to be customized

Coders
Coders

We not documenting terribly now and innovative morbidities or procedures….

… we’re just doing it differently

• Impact: Modifiers, supplemental documentation, HCPCS and local coding may change and the tools you need to manage that have to be flexible and cost effective

Coders

• GEMS typically defaults to “unspecified”
• Not acceptable for coding
• Great starting point for creating listing, converting forms, charge tickets, quality measures, etc.
• Both forward and mapping does exist
Coders

- Impact: Coders will have to understand more about anatomy and physiology and know when to ask for more clarifying information about:
  - Severity
  - Laterality
  - Encounters
  - Location
  - Response to treatment
  - Co-morbidities
  - Risk
  - And more

GEMS Diagnosis Code Mapping

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>≈</th>
<th>ICD-10-CM Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.2 Swelling in head and neck</td>
<td>≈</td>
<td>R22.0 Localized swelling, mass or lump head</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R22.1 Localized swelling, mass or lump neck</td>
</tr>
</tbody>
</table>
Coders

- Compliance for:
  - Coding accuracy
  - Supporting documentation
  - Quality
  - Incorrect versus correct code
- Impact: Learning curve, request for more information, updates and changes to records, lower or denied payment for medical necessity

Documentation

Documentation for ICD-10 will be more detailed and specific 14,500 ICD-9 codes versus 69,847 ICD-10-CM codes
Documentation

- Documentation drives everything…
- Coding…claims submission…..
- Reimbursement…..
- Revenue…………
- Organization health

GEMS is Incomplete

- Approximate Code Example - 1 ICD-10 code required

- 754.30 – Congenital Hip Dislocation
  - Q65.00 – Congenital Dislocation of unspecified hip, unilateral

- Problem:
  - ICD-10 allows for greater specificity in this example by introducing laterality. GEMS converts this code only to the unspecified unilateral ICD-10 code, which will not always be correct.

- 754.30 – Congenital Hip Dislocation
  - Q65.00 – Congenital Dislocation of unspecified hip, unilateral
  - Q65.01 – Congenital Dislocation of right hip, unilateral
  - Q65.02 – Congenital Dislocation of left hip, unilateral
  - Q65.1 – Congenital Dislocation of hip, bilateral
  - Q65.2 – Congenital Dislocation of hip, unspecified
Common Documentation Problems

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- Symptoms, signs and/or working diagnoses were coded when a definitive diagnosis has been established (outpatient)
- Physician orders lack level of specificity necessary for ICD-10 (outpatient)
- All coexisting conditions documented by physician are not being reported (outpatient)
- Unspecified diagnosis codes and specified diagnosis codes of a condition or injury were reported
- Illegible physician handwriting
- All inpatient procedure codes not being reported

Inpatient/Outpatient Coding/Documentation Review Summary

- Physicians are using abbreviations that are not based off the standardized list of abbreviations
- Outpatient encounter/order forms lack the level of specificity necessary for ICD-10
- Co-existing conditions, documented by physician, were not coded
- Diagnosis code assignments were not always assigned to their highest degree of specificity
- Lack of supporting physician documentation to support diagnosis coded and billed
- Signs/symptoms were code when a definitive diagnosis had been established
- Procedure was coded but the documentation did not support that the procedure was performed
Inpatient/Outpatient Coding/Documentation Review Summary

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- Co-existing conditions, documented by physician, were not coded
- Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations

Physician Practice

- Physician documentation was not specific enough for the assignment of ICD-10 codes resulting in the assignment of miscellaneous, non-specific diagnosis codes.
- Co-existing conditions, documented by physician, were not coded
- Lack of supporting documentation to support the codes (CPT & E/M)
- Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations
- EMR-cloned documentation
ICD-10 Superbill – American Academy of Family Practice

Coding and Documentation

Requires new information

Tells a more detailed story
• learning curve for documentation / coding
• significant increase in questions, clarifications
• oversite for all policy and procedure changes, quality reporting
• do-overs for pre-authorizations
• new rules for medical necessity
• hunting and pecking through drop-downs, learning new descriptions / syntax
• loss of muscle memory with new forms / formats
• cash flow degradation

Documentation

Clinical Documentation Improvement

• Expand CDI program to include all patient discharges preparing for ICD-10 and Pay-for-Performance
• Provide formal education and training to acquire CCDS/CDIP certification
• Continue to leverage CDI Measure metrics and identify opportunities/trends
• Include ICD-10 specific metrics in monthly dashboards as education begins

• Engage Physician Advisor(s)
• Increase staffing resources
• Collaboration/Increased interaction with HIM due to ICD-10
• Maximize ICD-10 Education & Training Opportunities
• Coder Career Ladder
• Computer-Assisted Coding System

Critical Success Factor:
Productivity Mitigation
Streamline Quality
Limit Learning Curve
Enable dual-processing environment
• Education practitioners on what they need to document for ICD-10
• Not interested in learning the coding right now
• For the condition, what do they need to specify in their patient encounter
• KISS principle—Keep it Simple

What Can You Do

• Train coders earlier—not later
  • We need to monitor documentation
  • Documentation translates to revenue
  • Perform ICD-10 Readiness Audits Quarterly—Education is Key

What Can You Do
The worst that can happen?

- new technology
- new documentation requirements
- new coding conventions
- requests for clarifying information

physician’s productivity negatively impacted

“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures…. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.”

*ICD-9-CM and ICD-10-CM*
Documentation Example – Pre-eclampsia antepartum with gestational diabetes

ICD-10 Clinical Documentation will need to specify 1) trimester, 2) pre-existing or gestational diabetes, diabetes type, 3) other maternal diseases complicating pregnancy (i.e., anemia, obesity, alcohol use, smoking, mental, digestive disorders) – for obesity, BMI, and the source of obesity (excess calories or due to medication).

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Documentation</td>
<td>ICD-9 Code</td>
</tr>
<tr>
<td>Lisa comes in for her monthly OB check at 30 weeks. She has been having headaches, nausea and vomiting. She thought she was getting the stomach flu. She has no fever, but her blood pressure is 150/90. Blood sugar indicates gestational diabetes. Lisa has also gained over 8 lbs. since her last visit. Cumulative weight gain during pregnancy is over 60 lbs. Obesity prior to pregnancy. IMPRESSION: gestational diabetes with pre-eclampsia</td>
<td>642.43 mild or unspecified pre-eclampsia antepartum 648.00 diabetes mellitus complicating pregnancy, unspecified 278.00 Obesity, Unspecified</td>
</tr>
</tbody>
</table>

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**DOCUMENTATION & QUALITY**

- By analyzing the documentation and conducting medical record documentation reviews, the impact can be assessed.
- The medical practice should utilize an experienced auditor(s) to conduct the audits either internally or externally.
- Random samples should be evaluated and various types of medical records should be reviewed.
- It is important to make sure the current documentation adequately supports ICD-10-CM code.
- A clinical documentation assessment tool should be utilized.
- The baseline review should be part of the impact analysis and ongoing until one year post implementation.

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**DOCUMENTATION & QUALITY**

- Once the audit has been conducted and analyzed,
  - the organization will have a good assessment of documentation deficiencies
  - Will be able to develop a priority list of diagnoses that require more granularity
  - Provide appropriate feedback and education
- The audit will also help identify practitioners who would benefit from focused training to assist in making sure the practitioner will be able to support medical necessity using ICD-10-CM

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**DOCUMENTATION & QUALITY**

1. Implement a clinical documentation improvement program within the organization
2. Monitor the documentation on an on-going basis to ensure improvement
3. Identify areas that practitioners still are deficient and need more assistance
4. As with any type of audit, a report summary should be submitted to senior management
Now What!

It is all About Change

Phase 1: Planning
Impact Assessment
Phase 2: Communication and Awareness
Phase 3: Assessment
Phase 4: Operational Implementation
Phase 5: Testing
Phase 6: Transition
1. Ensure top leadership understands the extent and significance of the ICD-10 change.
2. Assign overall responsibility and decision-making authority for managing the transition.
3. Plan a comprehensive and realistic budget.
4. Ensure involvement and commitment of all internal and external stakeholders.
5. Adhere to a well-defend timeline that makes sense for your practice

Planning

1. Identify tasks based on your practices business processes, systems, and policies.
2. Identify critical dependencies.
3. Conduct a comprehensive impact assessment within all areas or departments in the practice.
4. Develop a project plan with start and end dates.
5. Continue to update the plan throughout ICD-10 implementation and post-implementation.

Implementation Timeline
(October 1, 2015)
Implementation Timeline (October 1, 2015)

6. Contact all vendors including software, hardware, clearinghouses, billing services, payors, trading partners, etc. to assess ICD-10 readiness.

7. Develop a testing schedule with vendors and payors.

8. Review changes in documentation requirements for your specialty.

9. Develop a comprehensive action plan.

10. Develop an ICD-10 budget.

Challenges Ahead
1. Keep stakeholders, steering committee or ICD-10 team members up-to-date on status of ICD-10.
2. Continue to hold monthly executive steering committee meetings.
3. Complete your impact assessment and identify all areas/departments and systems impacted by ICD-10.
4. Conduct a GAP/solutions analysis, identifying who ICD-10-CM impacts, the current state of readiness and where you need to be – the solution.

Take Away Advice

5. Documentation doesn’t contain the specificity to code with ICD-10-CM.
7. Build and execute your communication plan, updating the schedule periodically.
8. Develop the training plan.
9. Develop the action (project) plan and work to identify timelines, duration and responsible parties.
10. Complete and/or update the budget.

Take Away Advice
11. Execute the action (project) plan.
12. Conduct ICD-10 readiness assessments.
13. Upgrade and test systems and processes.
14. Begin dual coding to measure productivity and proficiency.
15. Go-Live.
16. Manage post-implementation challenges.

Take Away Advice

Keys to Success

Assess Risk
- Share Information
- Identify Key Stakeholders
- Rank needs and development Strategy

Transform task force into action team
- Budget
- Schedule
- Train
- Implement

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THE TRANSITION

- The transition to ICD-10 will impact people, processes and technology across all organization which includes:
  - Operations
  - Finance
  - Technology

Questions and Answers
Ms. Grider is a Senior Manager with Blue & Co. with over 32 years of experience in coding, reimbursement, practice management, billing compliance, accounts receivable, revenue cycle management, and compliance across many specialties. Her specific areas of expertise include medical documentation reviews, accounts receivable analysis and coding and billing education. She holds the following certifications: CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, CCS-P, and CDIP. She is an AHIMA Approved ICD-10 Trainer.

Her background includes many years of practical experience in reimbursement issues, procedural and diagnostic coding, and medical practice management. She has provided testimony for the National Committee on Health Care Vital Statistics on ICD-10 Implementation and is considered an ICD-10 expert in the country. She developed the education and training for ICD-10 for the Indiana and Kentucky Hospital Associations, the Illinois State Medical Society and other organizations. She has developed curriculum for coding programs for IU Health and Martin University as well as the American Academy of Professional Coders. She has served on the AMA CPT Editorial Panel from 2007-2009 and is the Indiana Health Information Management Association President.

Ms. Grider is the author of many coding publications for the American Medical Association including Principles of ICD-9-CM Coding, Coding with Modifiers and Medical Record Chart Auditor. She is also the author of the ICD-10-CM Implementation Guide, Making the Transition Manageable, Principles of ICD-10-CM and the Principles of ICD-10-CM Workbook. She holds multiple certifications with the American Academy of Professional Coders as well as the CCS-P credential with the American Health Information Management Association. Her professional affiliations include: the American Academy of Professional Coders, the Indianapolis Chapter of the American Academy of Professional Coders of which she was the founder and President from 1996-2003; past President of the American Academy Professional Coders National Advisory Board; member of the American Health Information Management Association, Healthcare Finance Management Association, and the Workforce for Electronic Data Interchange. Ms. Grider was named one of the Top 10 Health Information Management Professionals in 2009.