ICD-10 - THE COUNTDOWN CONTINUES

Elaine Anderson, SVP and Chief Compliance Officer, Texas Health Resources
Lynn Myers MD, Medical Director Texas Health Physicians Group

ICD10......THE FINAL JOURNEY

× Lets assume........
  + All provider ITS systems work
  + All vendors are ready
  + All codes sail through the systems “end-to-end”
  + Payer systems work

What could possibly go wrong?

What are some of the “non-technical” imperatives for successful ICD10 transition as we enter the “home stretch”?
TOP IMPERATIVES:

**Hospital System**
- Hospital System Hospital System Hospital System Hospital System
  - Inpatient: Identify MS-DRGs most vulnerable to shift
  - Physician & mid-level Education - Uncover the biggest documentation challenges
  - Clinical Documentation - Implement ICD10 documentation concepts in "high risk" areas early (CDI team)
  - End-to-End Testing with vendors and payers
  - Outpatient: Evaluate risk for increased denials (LCDs, MN edits, etc.)
  - Coder Training and dual coding
  - Mitigate risk of staff (coders and others) productivity losses
  - Workforce training
  - Develop ICD10 Dashboard to monitor pre and post “go live”
  - Do “what if” analysis on key revenue cycle components...what if there is a significant slow down, etc.

**Physician Group**
- Physician Group Physician Group Physician Group Physician Group
  - Identify most impacted specialties and practices
  - Physician & mid-level education
  - Nurse education
  - Front Office education
  - Evaluate risk for increased denials (LCDs, MN edits, etc.)
  - End-to-end testing with vendors and payers
  - Coder training
  - Mitigate risk of productivity loss
  - Develop ICD10 Dashboard to monitor pre and post “go live”
  - Do “what if” analysis on key revenue cycle components...what if there is a significant slow down, etc.

**HOSPITAL FOCUS – TIME IS SHORT**

**Congestive Heart Failure**

<table>
<thead>
<tr>
<th>ICD9</th>
<th>ICD10</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

- High volume
- High risk
- ICD revenue opportunity

May not want to focus on this first........

**Malignant Neoplasms**

<table>
<thead>
<tr>
<th>ICD9</th>
<th>ICD10</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>15</td>
</tr>
</tbody>
</table>

- High volume
- High risk
- ICD revenue opportunity

May want to focus on this
### IDENTIFY HIGH RISK - REIMBURSEMENT

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Unspecified code usage</td>
<td>+ Unspecified code usage</td>
</tr>
<tr>
<td>+ Isolate <em>documentation risk</em> by service line and further by diagnosis</td>
<td>+ Documentation risk – Medical necessity</td>
</tr>
<tr>
<td>+ Identify dx codes that have potential to shift DRG up or down (secondary dx)</td>
<td>+ Identify CPT codes that may be vulnerable for denial due to medical necessity</td>
</tr>
<tr>
<td>+ Isolate documentation and “shift risk” risk by physician</td>
<td>+ Identify top dx codes</td>
</tr>
<tr>
<td>+ Prioritize efforts and education (80/20 rule)</td>
<td>+ Translate superbills</td>
</tr>
</tbody>
</table>

Limited time.......limited resources.......how to prioritize

### IDENTIFY HIGH RISK - REVENUE CYCLE PROCESS

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician (CPT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Coder/staff productivity loss</td>
<td>+ Coder/staff productivity loss</td>
</tr>
<tr>
<td>+ Physician productivity loss due to increased documentation</td>
<td>+ Physician productivity loss – many physicians assign codes</td>
</tr>
<tr>
<td>+ Cash slow slowdown</td>
<td>+ Cash flow slowdown</td>
</tr>
<tr>
<td>+ Increased physician queries</td>
<td>+ Increased physician queries</td>
</tr>
<tr>
<td>+ Increased denials</td>
<td>+ Increased denials</td>
</tr>
<tr>
<td>+ Increased time to bill</td>
<td>+ Increased time to bill</td>
</tr>
<tr>
<td>+ Scheduling and Precert</td>
<td>+ Front Office process</td>
</tr>
<tr>
<td>+ ABNs</td>
<td>+ ABNs</td>
</tr>
<tr>
<td>+ More medical record requests</td>
<td>+ More medical record requests</td>
</tr>
</tbody>
</table>

Plans to mitigate the risk and backfill where needed
PHYSICIAN AND MID-LEVEL EDUCATION

× Hospital
  + Opportunities for all medical staff
  + Both web-based and instructor led opportunities by specialty
  + Focus on “high risk/high volume” physicians for instructor led
  + Physician champions and entities assist in getting “high risk/high volume physicians enrolled
  + CME credit
  + CDI team – introduce real time ICD10 concepts early.
    Monitor- re-educate

× Physician Group
  + All providers – mandatory
  + Specialists and high risk physicians targeted for instructor led. Focus on top diagnosis codes
  + Web-based for others
  + CME Credit

Integrated across system – consistent

WORKFORCE EDUCATION

× Awareness – based on job role
  × Awareness and moderate understanding of ICD10 codes (structure and assignment)
    + Pre-registration, scheduling and registration
    + Case managers
    + Finance and decision support
    + Quality
    + Tumor registry/Trauma registry (focused in their area)
    + Physician Office staff/practice managers

× Clinical documentation
  + Physicians
  + Mid-levels
  + Others

× Super-users
  + Coders (IP, OP and Physician Office)
  + CDI Specialists
  + Physicians who assign their own dx codes
END-TO-END TESTING

- Start as soon as possible
- Payers do not have the bandwidth to test with all providers (first come – first serve)
- Interface testing – by March 31st
- E2E testing – April to September
- Clearinghouse testing – in tandem with payers
- Test E2E – to payers and back
- Test all possible scenarios (ICD10 CM and PCS)

EARLY ADOPTION – ICD10 DOCUMENTATION

- Implement ICD10 documentation early
  + Natively code in ICD10 as primary code set for high risk accounts and then dual code in ICD9 for claims filing
  + Query for ICD10 documentation
  + Reinforce documentation requirements with physicians
- Considerations:
  + Systems readiness
  + Availability of tools and resources
  + Timing of physician education
MONITORING AFTER OCTOBER 1 2014

- A few possible ICD10 Dashboard
  + DNFB – work in progress
  + CMI to benchmark
  + Unspecified code utilization
  + Physician response to queries
  + Physician agreement with queries
  + ICD9/ICD10 Agreement Rate w/GEMS MAP
  + % of visits queried
  + Days in AR
  + Cash as % of Net Revenue
  + Days cash on hand
  + Denials
  + Medical record requests