

ICD-10 Critical Pathway for Getting Started - 2012 and Beyond

February 17, 2012

Background

The transition from ICD-9-CM to ICD-10-CM/PCS comes with various unknowns such as quality of coded data, reimbursement rates, and interoperability. Published in January 2009, the HIPAA regulation that required this transition to occur must be implemented within a healthcare environment that has become exponentially integrated; one in which it is difficult to detach and define distinct components.

For those providers who have not yet begun on the transition path, they **must start today and work through a highly-condensed project** to meet the October, 2013 deadline. While little time remains for successful engagement and deployment of the necessary resources, it can be done.

Purpose

HIMSS and AHIMA have partnered to develop a condensed critical pathway with steps needed to guide providers through the process and phases of the implementation. If work is undertaken **immediately**, components such as budget, system testing, assessments, and evaluation can be addressed so providers can focus on the vital imperatives for a successful go-live with ICD-10-CM/PCS.

The HIMSS-AHIMA condensed timeline provides the phases that must be addressed in order to make a successful transition and describes what the people, process, and technology impacts will be.

Project Assumptions

Defining assumptions for this initiative helps to clarify concepts behind the implementation plan and bring to consensus what may be considered true or untrue within a project. Key assumptions for an ICD-10-CM/PCS implementation are the following:

- The phases highlighted within the condensed timeline must be run in parallel and closely coordinated. As of February 2012, there is no opportunity to tackle the phases sequentially.
- Close cooperation must be achieved with vendors and health plans: this work must be completed in partnership.
- The compliance date does not mean the effort is complete. There will still be much effort required to support testing of the people, process, and technology impacts, as well as the need for parallel coding.

For more information on ICD-10 implementation, please visit [HIMSS](#) and [AHIMA's](#) websites.

About HIMSS

[HIMSS](http://www.himss.org) is a cause-based, not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 51 years ago, HIMSS and its related organizations are headquartered in Chicago with additional offices in the United States, Europe and Asia. HIMSS represents more than 44,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 570 corporate members and more than 170 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, research initiatives, and media vehicles designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care. To learn more about HIMSS and to find out how to join us and our members in advancing our cause, please visit our website at www.himss.org.

About AHIMA

The American Health Information Management Association is America's leading professional society whose mission is to "improve healthcare by advancing best practices and standards for health information management and [serve as] the trusted source for education, research and professional credentialing." AHIMA represents more than 64,000 specially educated HIM professionals who serve healthcare and the public by managing, analyzing and utilizing data vital for health system management. www.ahima.org



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Phase	Explanation	Deadline	People Impact	Processes Impact	Technology Impact
Internal Impact Assessment	The purpose of the Internal Impact Assessment is to survey the provider organization's internal, existing people, processes, and technologies that use ICD-coded data and/or code sets and/or support data that will be affected by the new ICD-10 codes and processing requirements. The results of this survey will identify which ICD-related people, processes, and technologies will be impacted as well as how much by the conversion to ICD-10 and what changes need to be made.	3/31/2012	Coders - learn new codes, manage increased queries; Physicians - adopt new ways of documenting in the record; Clinicians - enhance clinical documentation in the record; Information Technology - manage increased workload with more scarce resources; Financial Management - learn new codes, manage reduced revenue cycle productivity.	Technology - Reporting, Data entry, Data warehouse, Decision support, Research; Revenue Cycle - Pre-Authorization, Eligibility, Scheduling, Admitting/Registration, Charges, Coding, Claims/Billing, Collections/Follow-up, Payment Posting, Denials Management, Payer Contracting; Education/Training ; Patient Care - Clinical Documentation, Quality improvement, Case management; Financial Mgmt - Business analytics, Modeling; Others	Information system applications (commercial and in-house developed); Contracts for commercial information system applications; Interfaces ; Inputs (forms & file imports); Outputs (reports & file exports); Biomedical devices ; Data repositories
External Impact Assessment	The purpose of the External Impact Assessment is to determine which systems and organizations that are outside of the provider control (i.e., vendor's health plans, registries, HIE and other trading partners) will be impacted by the transition to ICD-10 and what changes the provider will need to make. The specific focus will be on acquiring readiness plans, obtaining potential costs and minimizing operational disruptions.	5/31/2012	Coders - If CAC or other coding technology is utilized, need to determine what training will be required to use the enhanced system. Business Office - Understand new system upgrades/changes to billing system, clearinghouse, etc. Practice Management - Review implementation plans and potential impact of system changes (case flow disruptions, increased costs, etc.) All key staff - Differentiate internal versus external responsibilities for upgrades/changes.	Depending upon what is outsourced - including but not limited to, claims submission, coding, billing, A/R management, denial follow-up, etc.	Similar to internal assessment - Information system applications billing systems and clearinghouses; Interfaces ; Inputs (forms & file imports); Outputs (reports & file exports); Data repositories
Education	The purpose of the education assessment is to determine which staff will need to gain skills using ICD-10 or mapping tools and what pre-requisite education must occur prior to intense ICD-10 education.	Pre-requisite education prior to year-end 2012; ICD-10 and mapping education by end of 2nd quarter 2012.	Staff from pre-registration through billing will require different types of education; Medical staff and other clinicians may need documentation education to facilitate complete ICD-10 coding.	Documentation coaching may need to be initiated and/or expanded.	Modifications of templates to capture documentation in defined fields; Use of dictation to capture documentation in an electronic form; Use of computer aided coding applications to enhance coding performance; Use of translation tools to support mapping efforts.
Baseline Budget Formulation	The purpose of the budget is to help healthcare providers predict the financial impact of the transition to, and use of, ICD-10. Users can easily see and change the assumptions in the model to conform to their organization's circumstances.	5/31/2012	A budget assumes the transition to ICD-10 will affect four resource areas: coding; revenue cycle, non-IT project management, and IT. Resources will require external training, internal training on new software, time to practice (testing) as well as decreased productivity. Additionally, dedicated resource need to be added to support implementation activities.	A budget assumes the transition to ICD-10 will require modifications to People, Process and Technologies. Process impacts will result from new technology implementations as well as regulatory requirements. Each process change will extend resources, including budgetary for training and testing.	A budget assumes ICD-10 requires a technology upgrade to meet the new code standards. Upgrades will charge for software implementations, vendor support, training and testing.

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Business Process Changes	This phase of implementation involves organization-wide upgrading/changing of business processes, information systems, software applications, health information management systems, education of medical billers and coders, as well as clinical documentation education for medical staff.	12/31/2012	Steering or Governance Committee: provide direction and coordinate all efforts in business/IT process changes in close collaboration with executive sponsors, revenue cycle/finance/HIM/IT/vendors/billers/coders/clinical education team for general staff & medical staff.	Change Management Team, Operations/Senior Management, Revenue Cycle/Finance, Admitting/Patient Scheduling, Clinical Staff, Medical Billers/Coders, Vendors/Contractors, HIM & IT staff, Patient/Outreach, Software Developers, General Staff.	Software Upgrades/Changes - to enable ICD-10 compatibility including admissions/scheduling, EMR/EHR/coding software/DRG Grouper/payment management research/auditing/lab system/pharmacy system/clinical patient management system/report database/cancer reporting/CDC reporting; Information Technology - upgrade/change to enable inter/intra-organizational interoperability, data mining for clinical and business intelligence.
Internal Testing & Validation	This phase includes testing of all business processes and IT systems within an organization. Each individual system (EHR, practice management, reporting, etc.) must be tested. Full testing of all processes working together must occur, from initial patient engagement to creating a claim for the patient service, to assure that the proper codes are included on a claim.	3/31/2013	Everyone involved in the business should be part of the testing to be conducted after training is completed.	All processes must be tested individually and together to assure they will be working correctly for the use of ICD-10 .	Vendor products must be in place. Generally a "test system" is created and "test data" is used. Note that tests are conducted while normal business is also continuing.
External Testing & Validation	This phase allows organizations to test all processes and all areas that send and/or receive information from outside the organization (e.g. a provider sends a claim to a health plan). Test data is exchanged to assure that proper information is sent, correctly received and processed by the receiving organization. Each individual step in a process is tested to ensure accurate and proper function. A complete "end to end" test - from the beginning of a patient experience through claims payment and reporting should be conducted for the most frequent and most important types of services.	9/30/2013	Each individual involved in the business should be part of the testing to be conducted after training is completed.	To occur once all internal testing is completed and processes are deemed to be working correctly. All processes must be tested individually and together to ensure accurate and proper functioning for the use of ICD-10 codes.	To occur once internal testing is completed and systems are determined to work correctly. Vendor products must be in place. Generally a "test system" is created and "test data" is used. Note that tests are conducted while normal business is also continuing.

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Implementation 10/2013	Begin Using ICD-10 Codes				
Follow-up and Evaluation	<p>The ICD-10 Task Force should appoint a Post ICD-10 Committee to review implementation results, evaluate success against established criteria and to identify what works and doesn't work, especially in revenue cycle, HIM, and IT areas. Prior to October 1, 2013 this committee should determine the measures to be tracked and collect baseline information on those measures. Following the go-live date, healthcare professionals will need to employ lessons learned from the 5010 conversion and not become complacent following the go-live phase. There will be significant post-implementation issues, such as claims denials and rejections or coding backlogs. The post ICD-10 Committee must quickly identify these issues, establish feedback loops and work the established solution path to completion.</p>	<p>Start planning for this in April 2013; this is an on-going task</p>	<p>Providers, Coders, HIM, IT, Finance, Patient Financial Services</p>	<p>Coders - productivity will be impacted significantly with more codes and higher complexity in identifying codes from clinical documentation. Providers – will be required to answer more questions from coders for more specific documentation requirements. Revenue Cycle - will need to analyze reimbursement to ensure payment and that organizations are paid accurately as anticipated. Finance – focus on cash and increased cost due to unforeseen circumstances in delayed revenue, decrease in productivity and technology hiccups.</p>	<p>Lessons learned from 5010 implementation suggest that although vendors claim readiness, there will be post go-live adjustments required. Post vendor evaluation – do the products perform (some legacy systems maybe strained with the number of codes / logic)? Do products still provide value (logic /lookups /displays of data may not be useable with the number of codes & length of descriptions)? Did vendors communicate well during the process or were they not "transparent?" How are the workflow tools working? What about payers that did not transition? What is the plan for conversion and how will information be communicated and contracts negotiated once 2 years of claims history is available? Vendors are also subject to limited resources and will be hard pressed to be proactive in the Post Go-Live phase.</p>