

A HIMSS G7 Advisory Report

ICD-10 Transformation: Five Critical Risk-Mitigation Strategies

Launching the HIMSS ICD-10PlayBook, Version 2, with provider-focused strategic guidance that addresses real-life issues of ICD-10 implementation in the context of the healthcare economy, competing federal mandates and limited resources.



TABLE OF CONTENTS

INTRODUCTION 3

FIVE KEY AREAS OF RISK FOR ICD-10 IMPLEMENTATION 4

FINANCIAL RISK & SUSTAINABILITY: IMPLICATIONS & RISK MITIGATION 4

WORK FORCE ISSUES GROWING 6

 THE CHANGING WORLD OF WORK 6

PROVIDER NEEDS AND VENDOR READINESS 8

MITIGATING PAYMENT RISKS TO PROVIDERS 9

FRAUD, WASTE & ABUSE: EDUCATION IS KEY 10

POTENTIAL PATIENT IMPACT OF ICD-10 13

ICD-10 RISK MITIGATION STRATEGIES: FIVE PRACTICE AREAS 16

CONCLUSION 19

APPENDIX/CHECKLIST 21

REFERENCES 26

We want to thank our sponsors:



The HIMSS G7 is a thought-leadership and industry action platform that brings together seven key stakeholder groups—healthcare providers, health plans, banks, information technology firms, government, employers and consumers—to design the healthcare financial network of the future. It was created as the result of the unification of HIMSS and the Medical Banking Project in 2009.

INTRODUCTION

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) nationwide transformation requires enterprise overhaul and an industry-wide synergistic network of support systems capable of providing guidance as we embark on this uncharted path. The path is uncharted because no other country in the world utilizes ICD-10-CM/PCS (Procedure Coding System). Although other countries have been using ICD-10 for the last 10 to 15 years, the United States received special permission from the World Health Organization (WHO) to create a level of specificity appropriate only for a socio-economically advanced nation with a high degree of technology prowess, and diseases that seem to have an unending number of co-morbidities.

The disease trajectory and epidemics facing the United States today demand that the healthcare system update its antiquated processes. The limited or poorly used technology, inaccurate and/or nonspecific reporting of current diseases and procedural codes are significant impediments to healthcare quality, delivery and reimbursement. These must be rectified to remain commensurate with the clinical and business intelligence needed to drive strategies around health promotion, disease prevention, public safety requirements, lower employee/employer insurance rates, and other actuarial considerations that impact healthcare costs.

“Accessing and analyzing clinical and enterprise intelligence is vital to improving healthcare delivery and controlling costs,” said HIMSS President and CEO, H. Stephen Lieber, CAE, at the [HIMSS Leaders and Innovators](#) meeting November 16-18, 2011.

ICD-10-CM is comprised of more than 69,000 diagnosis codes; ICD-9-CM contains about 13,000 and ICD-10-PCS has more than 72,000 codes. It seems daunting, but the reality is that no healthcare organization will utilize all of these codes all of the time. Although the work involved in ICD-10 conversion seems impossible at times, understand that the practice size and facility type are highly correlated to the level of complexity in implementation. A small physician group will only use ICD-10 codes specific and relevant to their particular practice. A large healthcare system with a level one trauma center, proton cancer treatment center, specialized surgical suites, occupational health centers and multiple specialty ambulatory sites will utilize more of the codes from both the diagnosis and procedure coding systems.

The HIMSS G7 Advisory Report is not exhaustive of all risks involved in ICD-10 planning and implementation, but it will focus on five key areas of risks. Left unchecked, these issues could have catastrophic consequences for some providers and institutions. The five key areas of risks include:

1. Financial impacts and sustainability
2. Work force
3. Vendor readiness
4. Provider payments
5. Fraud, waste and abuse

A brief discussion on the possible risk implications to patients also will be covered to a limited degree in this advisory report.

In addition, this report includes specific tips for practice areas that will be directly impacted by ICD-10, including:

1. Small practices—5 physicians or lessⁱ
2. Large practices—more than 25 physicians in a group
3. Acute-care hospitals
4. Safety net entities
5. Health plans

Recommendations on how to best reach healthcare systems and others impacted by the transition through the [ICD-10 PlayBook](#) will be outlined.

It is the intent of this report to raise overall awareness, assist users in minimizing pitfalls and provide strategic guidance to enable informed decisions. The magnitude of the task ahead must drive all healthcare stakeholders to weigh the cost of **not** implementing ICD-10 against critical public-health points, such as better quality care, primary disease prevention and improved service delivery methods intended to decrease hospital stays.

FIVE KEY AREAS OF RISK FOR ICD-10 IMPLEMENTATION

The ICD-10 PlayBook (Version 1) focused on financial risk mitigation strategies helped the industry tremendously. As provider end users reviewed the [G7 Advisory Report](#) in April 2011, it became evident that more questions regarding the specific risks needed to be addressed by the HIMSS G7 Roundtable in order to minimize the impact of an information technology “tsunami” that may result in more claims rejections and delayed payments.

FINANCIAL RISK & SUSTAINABILITY: IMPLICATIONS & RISK MITIGATION

Experts from the Centers of Medicare & Medicaid Services (CMS) estimate ICD-10 will initially result in a decrease in cash flow and loss of revenue.ⁱⁱ It is predicted that denial rates will increase by 100 percent to 200 percent post-implementation, with a corresponding increase in accounts receivable days by 20 percent to 40 percent. Healthcare organizations will most likely be hindered with declining payments for up to two years after the implementation date of October 1, 2013.ⁱⁱⁱ In addition, claims-error rates are anticipated to increase from 6 percent to 10 percent as compared to the current average of about 3 percent with ICD-9.

According to the American Society of Clinical Oncology, an estimated organizational cost by bed size is approximately \$1.5 million to \$5 million for a 400-plus bed institution.^{iv} A hospital bed size of 100-400 is estimated to incur costs between \$500,000 to \$1.5 million for implementation. An institution with fewer than 100 beds is estimated to spend between \$100,000 to \$250,000 to engage in ICD-10.

Pershing Yoakley & Associates, P.C. (PYA) identified seven key areas of the continuum of care revenue cycle that must receive proper attention and planning to integrate ICD-10:^v

1. Budget for potential cash-flow impacts
2. Prepare for delayed payment and claims adjudication
3. Prepare for IT software updates, patches, conversion and testing
4. Adjust accounts receivable reserves as needed
5. Prepare for health information management (HIM) productivity delays and educational expense outlays

6. Prepare for increased denial tracking, trending and reporting needs
7. Right size of staffing in patient access, HIM and patient accounting to handle increased workload and volume

Key preparation activities should include the assessment of current physician documentation patterns and the ICD-9 coding thereof; analysis of current operational processes; staffing requirements and systems impacted; and the determination of the financial impact of this transition.

Risk Mitigation Strategies for Financial Sustainability

- Focus on good documentation, which directly impacts accurate code assignment, billing and payment timing
- Be aware of new documentation guidelines in order to evaluate provider documentation for thoroughness and completeness
- Document services, labs and diagnostics to capture care provided in the inpatient setting
- Promote collaboration, transparency and communication between the provider and the payer
- Train and problem solve through the use of a task force
- Communicate with CMS to continue perfecting payment groupers and mappings
- Collaborate with other healthcare stakeholders to create an industry test bed
- Renegotiate major supplier terms to create a balanced payment schedule
- Aggressively manage inventory and resources to avoid unnecessary costs and expenses
- Manage A/R assertively and minimize denied payments and write-offs
- Work all denials to eliminate the occurrence and ensure more first time payments

Regardless of provider type, ask these questions:

1. Can we forecast working capital?
2. What steps need to be taken now to do so?
3. What additional products or resources are available to assist in the ability to accelerate days in A/R?
4. What credit products are available to assist with unexpected negative impact to working capital during the ICD-10 transition?

With proper preparation, organizations can avoid losses and cash collection delays during ICD-10 implementation. The transition to ICD-10 impacts all facets of the healthcare continuum. Successful outcomes of approaching this initiative proactively include increased efficiency in claims processing; improved claims accuracy; improved data capture for knowledge-based decision making; and reduced unnecessary cash flow issues.

WORK FORCE ISSUES GROWING

THE CHANGING WORLD OF WORK

Addressing the challenges of ICD-10, as well as other mandates and opportunities, require healthcare organizations to focus not just on solutions based on technology, but also on a talented workforce. As Experis, a ManpowerGroup company, explains, in this emerging “Human Age,” it is talent that serves as the true differentiator in organizational success because it is talent that must apply and improve processes, push innovation and enhance patient care. However, businesses and healthcare organizations are experiencing significant talent gaps. Despite a chronic and high rate of national unemployment, employers in all sectors continue to have difficulty finding the talent they need.

According to ManpowerGroup’s 2009 Talent Shortage survey, only 14 percent of US employers said they were having difficulty finding talent.^{vi} In 2010, however, that number jumped to 52 percent. The United States is not alone. Globally, 34 percent of employers surveyed said they were having difficulty hiring the right talent as well.

Why are Employers Having Difficulty with the Workforce?

It seems counterintuitive that employers are having difficulty finding talent in times of chronic and high unemployment. However, the types of skills sought by employers and the availability of those skills in the general talent pool are not aligned. Additional reasons for the talent mismatch include:

- Job candidates are looking for more pay than is offered. While it is in some cases a “sellers’ market,” there may be unrealistic expectations on one or both sides.
- Lack of experience among candidates; lack of “hard job,” or technical skills.
- Lack of right values and mindset.
- Lack of soft skills, or interpersonal and communication skills. As organizations have cut staff, there is the expectation that employees must be able to do more. That often requires enhanced skills in areas such as collaboration, communication, negotiation, group dynamics, etc.

To address the above issues, some employers are outsourcing, offering alternative work arrangements to entice desired talent to sign on, expanding the talent search “ecosystem” and even hiring for general competencies and training. Those solutions may be more difficult in healthcare environments, where specific knowledge is required. The primary issue is that workforce availability, candidate options and personal demands are shifting.

Compounding this issue is a lack of engagement among existing employees. According to research by Right Management, a ManpowerGroup company, as many as 84 percent of employees are planning to look for a new job this year.^{vii} That’s up from 60 percent in 2010. Clearly, there are options in the marketplace for talented individuals. Thoughts of greener pastures may also be spurred by current work levels. Another Right Management survey showed that 71 percent of workers surveyed said their workloads have increased.^{viii} More than half of those said it increased by “a lot.” Even if 84 percent of employees do not make serious overtures for new employment in 2012, the significance of that figure raises important questions about engagement and consequent productivity within their current employment environments.

Just as the talent gap will continue to grow, so will the requirements and stresses put upon healthcare organizations for increased care amid tightened reimbursement and revenue levels. To retain high performers, healthcare organizations will need to ensure that individuals apply and develop their skills; feel a part of the changes happening around them rather than a victim of changes that are thrust upon them; and trust that leadership is successfully driving the organization in a manner that ultimately propels enhanced patient care and supports employees.

Risk Mitigation Strategies Amid ICD-10

The magnitude of the ICD-10 transition holds great potential to cause disruption and frustration for staff members. By involving the right internal and external stakeholders, and creating assessment, education, training and communication plans, the risks of employee disengagement and attrition can be better managed during the transition. Following are critical success factors in the early assessment and implementation phases of ICD-10.

Assessment:

- Carefully select your ICD-10 assessment team
- Define ICD-10 stakeholders and align expectations
- Outline the scope of the transition--define what is in scope and what is not
- Vet everything with process owners
- Approach the assessment from a workflow perspective—work from the coding process outward and follow the process
- Create a streamlined assessment report and document repository for all assessment-related materials

Implementation:

- Select your implementation team wisely. Strong program and project management skills are essential to properly plan, budget and resource the project.
- Start with a defined work breakdown structure and integrate process flow mapping.
- Outline your ICD-10 training program. Getting this outlined early is critical.
- Push to understand upgrade dates/costs, particularly with vendors.

As noted above, training is essential for successful implementation. Even outside of ICD-10 efforts, training is central to not only mitigate medical and safety risks, but also to develop and engage staff appropriately. For ICD-10, the essential steps in outlining an effective training plan include:

- **Communicate:** Introduce the new coding system to the team and key stakeholders.
- **Plan:** Create a training plan and procure buy-in. Coding staff may require five to 10 days of training, depending on skill level and number of specialties involved. Clinical and administrative staff may need up to eight hours of training.
- **Assess:** Determine training needs and target audiences for more intensive training.
- **Educate:** Launch intensive training of coding staff, analysts, key decision makers, and specialty focused training for providers (MD/DO/NP/PA) and nurses. Consider spreading training costs over a multi-year budget period, starting with clinical knowledge and implementation now. Code specific training should be conducted closer to compliance date.

A special note should be made about coders. Many healthcare employees will be affected by ICD-10, but medical coders will need to accommodate major technological and informational changes;

interact differently with healthcare providers who need to alter how information is documented, manage losses in individual productivity, and increases in organizational demand to maintain reimbursement levels. Special attention to engagement and retention plans for coders will be essential to ensure the timely transition to ICD-10.

To engage and retain coders:

- Bring coders into the project plan and invite buy-in.
- Understand competencies of individual coders and individual abilities to manage large amounts of data.
- Ensure sufficient training. This may require staff augmentation while core staff undergoes training.
- Leading up to launch and post-launch, supply coders with additional support systems to ensure appropriate quality control measures.
- Ensure appropriate training for clinical care providers to expedite the release of accurate claims and minimize coder work.
- Provide meaningful recognition opportunities appropriate to the culture of the organization.

PROVIDER NEEDS AND VENDOR READINESS

In October 2011, KLAS published [ICD-10: Preparing for October 2013](#), which reported that fewer than 10 percent of providers have passed the halfway point in their preparations for ICD-10.^{ix} While providers are aware that a lack of preparation could result in a revenue cycle disaster post-implementation, KLAS discovered that most providers are still in the planning and strategy development phase of the implementation process. The research also revealed that many providers have not yet established their ICD-10 budget.

One of the keys to a successful and timely implementation of ICD-10 is an organization's relationship with its vendors. Each vendor will have its own strengths, capabilities and constraints. Selecting an individual within the implementing organization to serve as the person responsible for managing and coordinating all vendor ICD-related projects and activities will ensure an effective and timely ICD-10 implementation.

Hospital System Challenges

To add to the implementation challenge, hospitals typically have between 100 and 200 software systems that must be reviewed. On average, hospitals have at least 30 vendor partners of some type that provide services to manage interfaces, databases and connections for legacy systems that, in many cases, have not been reviewed in years.

It also is important to note that while vendors play a critical role, they are also exposed to a high level of risk. This is partly due to the fact that vendors themselves must hire sub-contractors from time to time to help augment work force shortage issues. It is critical for vendors to ensure that their sub-contractors are fully capable of committing to timeframes outlined in provider-vendor agreements without sacrificing quality of services or products.

In working with vendors, the following recommendations from VitalWare are paramount:^x

- Create a vendor inventory, including products and versions
- Determine processes that need vendor support for ICD-10

- Discuss business needs with vendors
 - If needs cannot be met, determine alternatives
 - If needs can be met, obtain commitment from vendor
- Include vendor tasks and timelines in remediation plans
- Include vendor tasks in project management processes (i.e., issue, requirement, change management)
- Prepare to test and remediate well in advance of the compliance date
- Make a final readiness determination, and if necessary, specify the need for corrective actions and go back to the remediation plan to determine next steps

Risk Mitigation Strategies for Vendor Relationships

- Require dates for deliverables and track to those dates
- Ensure frequent/regular communication updates from each vendor partner
- Prepare for remediation plan with commitment from vendor partner
- Demand a detailed explanation, if the vendor misses or adjusts timelines
- Support an interdependency relationship (“Your success is my success”) with vendor partners, which must be guided by enterprise high level executives to ensure prompt remediation and resources are made available as needed

Product Inventory Challenges

- Is the product affected by ICD-10?
- Does the product generate/receive/forward ICD-10?
- What version is currently in use vs. what version will be ICD-10-compliant?
- Who owns the product?
- Has the product’s name changed?

One of the tools available for vendors to self report on ICD-10 readiness is the HIMSS ICD-10 PlayBook [VitalVendor](#). Vendors wishing to announce their level of readiness to other providers and industry stakeholders can choose to participate by “opting in” and answering survey questions that will lead to a readiness rating scale based solely on their voluntary responses. This tool is helpful to providers, since it allows visualization of available vendors with ICD-10 products and services in the event there is a need to add additional vendors to their current team.

MITIGATING PAYMENT RISKS TO PROVIDERS

Other concerns included in ICD-10 implementation center on provider payments. How will providers get paid? How will this impact revenue? How long will the delays be? How do we test with our health plan trading partners? How does this impact cash flow and revenue cycle? What are the documentation requirements? How do we staff for an increase in rejected claims?

According to United Healthcare, practice sustainability may be at risk due to delayed payments after October 1, 2013, up to 2014, at a minimum.^{xi} It is anticipated that there will be delayed payments due to the new code sets overall transition, which will impact revenue directly. An increase in aged accounts and accounts receivables will impact productivity and staffing. Open lines of communication between payers and healthcare providers will be critical to mutual ICD-10 implementation success.

Provider Payment Risk Mitigation Strategies

- Educate providers about the relationship between ICD-9, ICD-10, CPT codes, revenue, and the importance of financial benchmarks in the implementation and financial processes.
- Establish a solid financial management plan upfront:
 - What does the business look like in an ICD-9 vs. ICD-10 world?
 - Strategic planning in:
 - ✓ Analytics
 - ✓ Trending
 - ✓ Reporting
 - ✓ Revenue forecasting/modeling activities
- Cash flow management:
 - Begin cash flow analysis early
 - Understand the relationship between ICD-9 and CPT today
 - Contact banks and payers as soon as possible:
 - ✓ Establish lines of communication regarding potential financial needs
 - ✓ Determine if payers are offering any contingency plans.
 - Practices should have a minimum of six months of cash reserves to mitigate revenue impacts over the ICD-10 transformation period
 - Investigate contingency plans early, and prepare a system for implementation

Top Five Provider Actions

- Ensure 5010 compliance
 - Carry-over of 5010 implementation work into 2012 poses a risk to ICD-10 compliance
- Communicate with payers and vendors
 - Discussions regarding expected changes in policy, reimbursement, coverage/benefit determinations
- Assess documentation pitfalls
 - Costly to outsource—early planning is critical
- Begin assessing ICD-9 business today
 - Physicians often do not recognize the relationship between CPT, ICD-9 and revenue
- Plan for financial contingencies to include the following:
 - Practice accountant/practice administrator/coder
 - Banks/lenders
 - Begin planning for contingencies early on

FRAUD, WASTE & ABUSE: EDUCATION IS KEY

The FBI estimates that 3 to 10 percent of all healthcare spending goes toward the payment of improper claims.^{xii} An improper claim can be one that is clearly fraudulent—such as a claim for services never rendered—or may represent an abusive billing pattern by the provider or entity submitting the claim. The American Society of Business and Behavioral Sciences estimates that 80 percent of healthcare fraud is committed by hospitals, clinics and medical professions.^{xiii} In addition, according to an April 2000 article published in the *Journal of the American Medical Association*, 39 percent of providers surveyed admitted that they sometimes exaggerate a patient's symptoms, report symptoms the patient did not have, or change the diagnosis so the patient's insurance company will pay the claim.^{xiv} This high percentage of self-reported behavior suggests that in

an era when healthcare practitioners may feel like they have to fight for every penny of reimbursement they receive from a commercial or government payer, their efforts may unwittingly lead them down a slippery slope to fraud.

The associated monetary harm is roughly estimated to be between \$50 billion and \$250 billion per year.^{xv}

Are the following scenarios occurring in your organization?

- Billing for services not performed
- Billing duplicate times for one service performed
- Falsifying a diagnosis
- Misrepresenting procedures (billing for a covered service when a non-covered service was performed)
- Up-coding—billing for a more costly service than was performed
- Accepting kickbacks for patient referrals
- Waiving co-pays or deductible amounts and overbilling insurance plan

According to LexisNexis, the complexities of implementing ICD-10 are further exacerbated by the highly scrutinized environment into which ICD-10 coding is being introduced and by the regulatory firestorm intended to curb improper payments.^{xvi} Recently created regulatory programs and task forces charged with improving efficiencies within the healthcare delivery system and reducing the incidence of improper payments include:

- Zone Program Integrity Contracts (ZPIC)
- Medicare Drug Integrity Contractor (MEDIC)
- Medicaid Integrity Contractors (MIC)
- Medicaid Recovery Audit Contractor Program
- Medicare Recovery Audit Contractor Program (RAC)
- Health Care Fraud Prevention and Enforcement Team Task Force (HEAT)
- Fraud and abuse provisions of Patient Protection and Affordable Care Act of 2010 (ACA) and related administrative rules

Recently enacted legislation includes:

Fraud and Abuse Provisions of ACA: Implications for Providers

- Suspend payments to a provider or supplier where a credible allegation of fraud exists.
- Place a temporary moratorium on enrollment for those categories of providers demonstrating a high risk for fraudulent or abusive claims practices. Payers will be on the lookout for trends that may indicate healthcare fraud; including using advanced predictive modeling software, such as that used to detect credit card fraud. The program can temporarily top enrollment for a category of high-risk providers.
- Terminate providers from state Medicaid programs when previously terminated by Medicare or another state Medicaid program, which also authorizes CMS to terminate providers and suppliers from Medicare when separately terminated by a state Medicaid program.

Expanded False Claims Act (FCA): Implications for Providers

- Any overpayment identified by a provider and not reported and refunded is a violation of the FCA. Identified overpayments must be reported and refunded within 60 days of being identified, or within 60 days of the date a corresponding cost report is due.
- It is currently unclear when a claim becomes “identified.”
- Civil monetary penalties for each FCA offense increased from \$5,500 to \$11,000 per claim, up to \$50,000 per claim.
- Violators are subject to damages and can be fined up to three times the \$50,000 per occurrence.

Amended Federal Sentencing Guidelines: Implications for Providers

- A two-level increase in the offense level for any defendant convicted of a federal healthcare offense relating to a government healthcare program that involves a loss of \$1 million to \$7 million.
- A three-level increase for losses of \$7 million to \$20 million
- A four-level increase for losses of more than \$20 million

This significantly expanded the definition of what can be considered an original source of incriminating information and narrowed the scope of what is considered public disclosure. It is now much easier to build a case for prosecution of healthcare fraud.

ICD-10 Important Alert for Providers

A huge potential for double billing exists if two systems (ICD-9 and ICD-10) remain in use during the transition period. This scenario could potentially create unintentional FCA violations. The shortage of experienced coding professionals also poses a risk since medical coders nearing retirement age may elect to retire rather than learn a new system. In addition, the General Equivalency Mappings (GEMs) do not provide a definitive map from ICD-9 to ICD-10, with only 5 percent having a 1:1 exact mapping relationship with ICD-10 codes. Because ICD-9 codes could map into multiple ICD-10 codes, this risk rises even more. It is important to note that ICD-10 conversions require manual review due to the significant differences in language and structure between ICD-9 and ICD-10.

Mitigating ICD-10 Implementation Risks

- Review existing practice management billing software to ensure its ability to successfully transition to ICD-10
- Train clinical and administrative staff on new code sets, technological changes, as well as fraud, waste and abuse regulations and reporting
- Review third-party agreements to ensure any vendors involved in billing processes will be compliant with ICD-10 requirements
- Ensure clinical documentation procedures reflect the increased level of detail required by ICD-10
- Contract with an outside entity to audit six to 12 months of claims submitted by an organization to identify any activity that might be considered fraudulent
- Take immediate corrective action where necessary

- Augment your provider credentialing/hiring processes with a provider screening service that will identify the level of risk associated with any professional individuals considered for employment

POTENTIAL PATIENT IMPACT OF ICD-10

The HIMSS G7 participants also acknowledge the potential impact to patients, a subject that has yet to be extensively discussed. Because the healthcare industry has a better idea of what challenges lie ahead and the risks posed to providers, it assumed that most of what impacts providers will eventually impact patients. HIMSS challenged G7 participants to stretch their imaginations beyond what may lie ahead.

Potential impacts to patients identified during the November 2011, discussions by HIMSS G7 include:

- Will there be an access to care issue if providers lack financial sustainability post implementation?
- Explanation of Benefits (EOBs) and statements may look different—who should inform patients?
- Will ICD-10 affect patient financial transactions at the point of care (POC)?
- Will HIPAA privacy issues escalate?
- Will there be significant delays between the date the service was provided and the time that a patient receives a bill immediately following the transition?
- Should partnering occur with organizations such as AARP to carry educational messages for their members regarding this change in coding?

These questions must be addressed by healthcare stakeholders in order to mitigate risks to patients as much as possible.

HIMSS G7 on ICD-10 Vanderbilt DesignShop Work Rounds

November 9, 2011: HIMSS G7 on ICD-10 PlayBook Version 2

Scenarios created by Vanderbilt Center for Better Health DesignShop®

ICD-10 PlayBook Effective Levers for Addressing Risks

Risk Mitigation Strategies Fall into One of the Four Categories of ACAT Model:

- **Avoid:** Eliminate, withdraw from or don't become involved with the risk
- **Control:** Optimize processes, tools and workforce to mitigate the risk
- **Accept:** Retain the risk and appropriately budget for when risk occurs
- **Transfer:** Off-load by outsourcing or insuring against an identified risk

For each risk, think through which strategy would work best and the levers (actions) that should be implemented for that particular strategy.

Small Provider Groups: Priority Issues to Address

- Providers must understand the relationship between ICD-9 and CPT codes
- Providers must know causes of payment denials
- Remove provider reluctance in implementing ICD-10 (lack of buy-in)
- Overcome anxiety over enormity of project—ICD-10 is “do-able”
- Discharge the notion that EMRs are the “magic bullet”

ICD-10 PlayBook Functional Gap Analysis

What are the capabilities you would like to see in the upcoming version s of the ICD-10 PlayBook?

Small Group Feedback

- Provide support to ICD-10 PlayBook via virtual groups if possible
- User interface—create a more user-friendly atmosphere
- “Fast track” information that is easy to access and use
- Provide compressed timelines for those already behind in implementation planning
- Remove gated access
- Add sponsors' endorsement
- Add ticking clock for implementation countdown
- Separate content into tracks: small providers, large provider groups, rural, community, multi-specialty, etc.
- Drill-down on how to get started
- Add case studies
- Include survey tool kits
- Include assessment resources
- Provide financial planning guidance
- Include more content on guidelines from health plans
- Include post-implementation financial modeling
- Include Q & A's from webinars
- Put order of information by timelines

Large Group Feedback

- Provide direction on how to use the ICD-10 PlayBook—identify where to start first
- Each content submission must have an expanded abstract for those with little time to read
- Create capability to download content to digital readers
- Separate applicable content into user types: Small providers, large providers, hospitals, safety net facilities
- Improve graphics
- Create checklists out of large documents to improve usability and access to information.
- Include “ICD-10 Briefs” of no more than two or three pages
- Include more bullet-point documents vs. heavy reading

Content Gap Analysis

What educational information is missing from the ICD-10 PlayBook that should be included to help providers in successful implementation?

Small Group Feedback

- More information on implementation “critical issues:”
 - **Correct use of GEMs**
 - **EMRs and ICD-10**
 - **Industry missing tools**
 - **CAC and ICD-10**
 - **Fraud and abuse in ICD-10**
 - **Financial issues**
- Testing information with test case examples, including coding
- Remediation
- Communications with health plans on how providers will be paid
- Include targeted content for small providers, large practices and hospitals
- Documentation guidance
- Separate 5010 from ICD-10
- Pull timelines into separate topics
- Add information on financial neutrality
- FAQs on “pitfalls, tips and traps”

Large Group Feedback

- Include urgent messages: “You have 23 months left...here is what you need to do”
- Include compressed time lines

Support Gap Analysis

What would make it easier for organizations to support the ICD-10 PlayBook as part of marketing and branding?

Small Group Feedback

- Media Kit (already included in ICD-10 PlayBook, Version 1)
- Flyers (included in ICD-10 PlayBook, Version 1)
- Full co-branding with provider organizations/others
- Target specific content to encourage participation
- Borrow best practices from similar organizations in garnering broad based support

Large Group Feedback

- Consider adding a Glossary of Terms

Communication Gap Analysis

How do we get vital information to providers and staff who are not HIMSS members? What format do we use? How do we make the information easy to understand and use? What channels of communication might we pursue?

Small Group Feedback

- Blogging
- Network bulletins
- Inclusion of www.himss.org/ICD-10PlayBook in marketing materials of G7 participants
- Web site link in partner web sites
- Expand HIMSS FAQ
- Leverage HIMSS collaboration with other organizations: add PlayBook link to their sites
- Trade associations; add to industry magazines
- Materials to be more easily usable
- Mobile applications for content

Large Group Feedback

- Health plans to push the ICD-10 PlayBook link to their members and encourage usage
- Pre-approved statement/talking points to be sent to ICD-10 PlayBook participants marketing departments for promotion
- Provider relations communications
- Web site link in marketing materials to clients/members

ICD-10 RISK MITIGATION STRATEGIES: FIVE PRACTICE AREAS

For the most part, small provider practices, large provider practices, hospitals/health systems, safety net entities and health plans will experience varying degrees of impact. Some will even share common priorities. The commonalities in risk mitigation strategies for five areas include, but are not limited to:

STRATEGIES AFFECTING ALL PROVIDER GROUPS

- Understand service payment contracts
- Identify high-volume diagnosis/procedure codes under ICD-9 and focus on these key revenue drivers for ICD-10
- Understand financial impact early
- Establish relationship with banking/financial institution partner for line of credit for working capital in advance of implementation date
- Obtain tax advice
- Plan ahead to control cash-flow disruption
- Align funding source early—recommendation is to have a minimum of six months worth of cash reserves as liquid asset depending on organizational size and overhead
- Make fraud, waste and abuse education a priority for key individuals, such as providers, coders, HIM leadership and practice managers

SMALL PROVIDER PRACTICE

Small-practice providers make up approximately 70 percent of all providers in the United States today.^{xvii} Owners of small practices (five or fewer physicians, NPs or PAs) may experience ICD-10 implementation challenges in relation to their size. Although there are many challenges, some risk mitigation strategies to include are:

- Identify “priority risks”
 - Understand the relationship between ICD-9 and ICD-10
 - Set aside six months of liquid asset at a minimum for operations to offset payment delays post implementation
 - Realize that the EMR is not “the magic bullet” for ICD-10
 - Manage emotional and physical stress to avoid burnout
 - Ensure appropriate level of staff support—appoint practice manager to oversee
- Be proactive vs. reactive—look for resources on implementation
- Understand impacts of ICD-10 claims denials—delayed payment, longer A/R days, possible loss of revenue
- Build up peer network support—share ideas, best practices
- Prioritize time—set aside time daily to work on ICD-10 with staff
- Prioritize competing projects—put at the top of the list those that impact revenue such as ICD-10
- Invest in provider and staff training
- Account for training time and loss of productivity for an unspecified period of time (anticipate slower pace due to having to look up codes vs. rote memory)

LARGE PROVIDER PRACTICE

Large provider practices are in the same boat as smaller provider groups in that they face similar challenges when preparing for ICD-10. One of the differentiating factors is a larger payroll and a higher overhead to manage.

Risk mitigation strategies for this group include:

- Communicate with the health plans early on how to test
- Create an ICD-10 training plan for staff and new hires—must obtain buy in early
- Allocate financial resources for medical billers/coders to be trained in ICD-10, along with practice managers/administrators
- Use practice managers/administrators as “ICD-10 champions” to train other staff
- Align outreach to vendor partners—obtain commitment to finish on time
- Ensure any planned new technology purchases or upgrades encompass ICD-10 plans

HOSPITALS/HEALTH SYSTEMS

Of all provider groups, hospitals will have the most challenges ahead in light of ICD-10 due to the complex nature of its operations and processes.

A few recommendations for mitigating risk when implementing ICD-10 are:

- Conduct IT and vendor readiness
- Conduct a thorough work flow assessment—identify impacts, data processes, technology needs
- Create robust implementation planning using readily available tool kits, timelines, project plan templates, etc.
- Identify gaps early and remediate as soon as possible
- Identify work force issues—may need more coders immediately after compliance date to avoid bottle neck of denials
- Ensure fraud, waste and abuse education as a priority for key individuals such as providers, coders, compliance managers and revenue cycle leaders
- Integrate data capture when possible—enter it once, populate many fields
- Continually improve internal communication—what went well? What should be improved?
- Share regular/constant communications regarding updates, benchmarks, support needs
- Understand financial investment before, during and after implementation
- Invest in provider training on proper documentation
- Prioritize program design and implementation structure
- Consider utilizing new college graduates as “information technology trainers” to implement ICD-10 and Meaningful Use—a creative way to reduce costs
- HR must ask the question to potential hires to address **escalating salary issues**. “Do you want to make more money now, or do you want to have a long term relationship with this company?” This simple question may be a key driver to ensuring financial sustainability during the ICD-10 transition
- Review salaries practices for coders to ensure competitiveness within the market
- Consider participating in an ACO if it proves to be a good business model for the enterprise

SAFETY NET ENTITIES

Among the organizations that maintain the health of the community are the safety net entities. These entities often see the uninsured, under-insured and undocumented workers.

Risk mitigation strategies for this group include:

- Consider aligning with community health systems for education, training and staffing
- Early adoption of work flow tools through batch translation tools (ICD-9 to ICD-10)
- Engage in financial impact analysis early
- Ensure proactive vs. reactive approach in mitigating risks
- Maintenance and adherence to regulatory compliance
- Invest in provider and staff training—outsourcing may be an option, initially, but ongoing training should be provided in-house
- Account for training time and loss of productivity
- Ensure protocols are followed per training via internal audits, use of templates, contracts and EMRs
- Utilize evidenced based medicine (EBM) protocols

- Negotiate with payer sources—consider participation
- Consider population-based vs. physician-based protocols
- Become familiar with payer reimbursement trends
- Ensure pre-authorization is supported by the proper level of documentation
- Establish fraud, waste and abuse benchmarks

HEALTH PLANS

Health plans are not typically top of mind when assessing the highest risk groups for ICD-10 impact. However, although health plans seem to transcend the typical barriers to implementing ICD-10 at times, risk mitigation strategies are always a catalyst for growth, process improvement and network management.

Among the risk mitigation strategies recommended for health plans include:

- Anticipate impact of higher payments, although the industry anticipates revenue neutrality
- Anticipate and account for higher level of reimbursement codes with the aging population and with greater specificity to identify more severe co-morbidities
- Prepare for more informed contract negotiations by providers
- Anticipate and prepare for possible dual system functionality (accepting ICD-9 and ICD-10 simultaneously) in case of another “discretionary enforcement period”
- Account for some quick turn-around time from denials to resubmissions from well prepared entities/providers—ensure enough staffing equipped to process in a timely manner in order to avoid bottleneck
- Improve provider communications on payment structure, testing and remediation
- Prevent network erosions through timely communications with providers and patients
- Improve provider awareness and collaboration across various points of service
- Anticipate request for payment advances—may be easier for larger health plans
- Ensure open communication with providers—educate on payment process
- Provide simple education “tid-bits” for patients about the new ICD-10 codes through EOBs and other forms of communication to build trust

CONCLUSION

The healthcare industry must break down ICD-10 into workable pieces to increase “buy in” among provider groups. In the process of attempting to simplify implementation into tolerable increments, it would behoove the industry to include the high-level risk mitigation strategies outlined in this paper to minimize potential negative impacts of ICD-10.

The overall financial sustainability of each organization is paramount to ICD-10 implementation. It is simply not enough to “finish on time.” Important questions remain: Will providers be prepared to weather the delays in payment post-implementation without compromising access and quality care? How long can small providers, especially those serving in rural areas, continue to operate if payments are delayed? Will there be enough qualified and affordable work force to go around? Will the vendors have the bandwidth to get provider software applications launched on time? Will providers be able to document consistently to support the level of coding and avoid fraud and abuse issues down the road?

More bluntly, perhaps, the industry should be asking: Do providers, from a one-provider practice to the largest health systems, have the initial financial investment required to be compliant with the ICD-10 federal mandate? If not, what are the recommended contingency steps from an industry perspective? These questions demonstrate the need for prudent, thoughtful, high level planning and implementation.

Calmly but surely, providers must be fueled by the quest to maintain revenue neutrality at the very least, if not taking advantage of the prime opportunities to optimize operations. With less than 24 months left before the compliance deadline of October 1, 2013, providers should already be in the implementation phase. If this is not the case, compressed timelines must replace outdated project plans in order to “fast track” providers and institutions to where they need to be at this point in time. Furthermore, CEOs and executive boards across the healthcare industry should be aligning their governance strategies for ICD-10 implementation to reflect utmost prudence and informed decision making to ensure fiduciary responsibility.

APPENDIX/CHECKLIST

**HIMSS G7 Participant List for ICD-10 Transformation: Five Critical Risk Mitigation Strategies
November 9, 2011 at Vanderbilt Center for Better Health Design Shop**

<i>Name</i>	<i>Position</i>	<i>Organization</i>
Anderson, Elizabeth	Manager, Equity Research	Deutsche Bank
Bartley, Joanne, CAE	Manager, Business Centered Systems	HIMSS
Beckwith, Kenn	Director, Healthcare Practice	Experis IT
Bounos, Maria	Manager, Business Development	Wolters Kluwer
Boynton, Annie	Director 5010/ICD-10 Communication/Adoption and Training	United Healthcare
Casillas, John	Senior Vice President, Business Centered Systems	HIMSS
Cooper, Carrie	Associate Director	Optum Health
Hall, Denise J.	Partner	Pershing Yoakley & Associates
Jodock, Pam	Direct Business Development, Commercial Health Care Solutions	LexisNexis
Jorgensen, Kelly	VP, Business Development	VitalWare
Kirsh, Bill MD.	Chief Medical Officer	Sentry Data Systems
Knotts, Randy	Senior Manager	Medtech Media
Lippincott, Ross	Vice President of 5010 and ICD-10 Deployment Programs	United Healthcare
Meisner, Deborah	VP Regulatory Compliance Strategy	ASC X12, WEDI, Emdeon
Meyers, John	VP, Senior Product Manager	Fifth Third Bank
Miller, Joseph	Director of E-Business	Amerihealth Mercy

Mulaik, Melody	President and Co-Founder	Coding Strategies, Inc./HBMA
Santos, Juliet A., MSN, CCRN, FNP-BC	Senior Director, Business Centered Systems	HIMSS
Shah, Paresh	President	Mindleaf Technologies
Sheidy, Dion	Partner, Health Industries Advisory	PricewaterhouseCoopers
Stottlemeyer, Christine, CPAM	AAHAM 1st Vice President, Director of Patient Accounting	AAHAM/Memorial Hospital
Sullivan, Tori E., RHIA, MHA, PMP	ICD-10 Solution Professional	IBM
Tennant, Robert M., MA	Senior Policy Advisor	MGMA
Thomas-Flowers, Dwan, MBA, RHIA, CCS	Sr. HIM ICD-10 Consultant	Deloitte
Victoria Ross-Davis, MD, Sydney	Medical Director	BCBSIL/Healthcare Services Corporation
Zuckowsky, Theresa	IT Program Director, Informatics	Vanderbilt University Medical Center

RISK MITIGATION STRATEGIES CHECKLIST FOR WORKFORCE

Task	Assigned To	Date	Date Completed
Lay the groundwork for success by performing a comprehensive assessment of talent needs			
Define ICD-10 stakeholders and properly align expectations			
Appoint a “coding champion” and work with the Chief Medical Officer to train providers			
Be diligent in outlining the scope of project and responsibilities			
Vet with process owners			
Approach the assessment from a workflow perspective			
Streamline reports and create a document repository			
Select the implementation team wisely			
Start with a defined work breakdown structure: integrate process flow mapping			
Outline the training program			
Bring your workforce into the process of conversion at each phase It is imperative to get “buy-in” from the ground up			
Increase awareness of clinician role in successful ICD-10 transformation			
Project a professional challenge to staff: communicate why ICD-10 is important to implement both from a company perspective and for the industry			
Communicate the importance of each individual’s role			

RISK MITIGATION STRATEGIES CHECKLIST FOR STAFF TRAINING

Task	Assigned To	Date	Date Completed
Communicate: Introduce the new coding system and general terminology to the team and other key stakeholders			
Plan: Create a training plan and obtain “buy-in”			
Assess: Determine training needs and target audiences for more intensive training			
Educate: Launch intensive training of coding staff, educate physicians			

Key personnel training: Coders, analysts, key decision makers and general staff			
Plan for specially focused-training for providers (MD/DO/NP/PA) and nurses			
Establish multiple vehicles for learning: Computer-based training, established courses, classroom, e-blasts			
Keep a record: Implement a tracking course of participation and attendance			

RISK MITIGATION STRATEGIES CHECKLIST FOR VENDOR READINESS

Task	Assigned to	Date	Date Completed
Create a vendor inventory including products and versions			
Determine processes that need vendor support for ICD-10			
Discuss business needs with vendors: <ul style="list-style-type: none"> ➤ If needs cannot be met, determine alternatives ➤ If needs can be met, obtain commitment from vendor 			
Include vendor tasks and timelines in remediation plan			
Include vendor tasks in project management processes (ex issue, requirement, and change management)			
Prepare to test and remediate well in advance of compliance date			
Make final readiness determination and if necessary, specify need for corrective actions, go back to remediation plan to determine next steps			
Require dates for deliverables (Project Managers)			
Ensure frequent/regular communication updates from each vendor partner			
Demand detailed explanation if vendor misses or adjusts timelines			
Have a remediation plan in place with commitment from vendor partner			

RISK MITIGATION STRATEGIES CHECKLIST FOR PROVIDER PAYMENT

Task	Assigned To	Date	Date Completed
Ensure 5010 Compliance: Carry -over of 5010 implementation work into 2012 poses a risk to ICD-10 compliance			
Communicate with payers and vendors: <ul style="list-style-type: none"> ➤ Engage in discussions regarding expected changes in policy, reimbursement, coverage/benefit determinations 			
Assess documentation pitfalls: <ul style="list-style-type: none"> ➤ Costly to outsource—early planning is critical 			
Begin assessing ICD-9 business today: <ul style="list-style-type: none"> ➤ Physicians often do not recognize the relationship between CPT, ICD-9 and revenue 			
Plan for financial contingencies: <ul style="list-style-type: none"> ➤ Practice accountant/practice administrator/coder ➤ Banks/lenders 			

REFERENCES

- ⁱ Centers for Medicare & Medicaid Services. "Provider Size." Accessed at www.cms.gov/ICD10/Downloads/ICD10SmallandMediumPractices508.pdf, p. 8. 2011.
- ⁱⁱ AHIMA. "Analysis of the Proposed Rule: HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS." Accessed at www.ahima.org/downloads/pdfs/resources/AnalysisofICD10ProposedRule.pdf. September 2008, p. 11.
- ⁱⁱⁱ Modern Healthcare. "ICD-10 estimated to cost vendors, providers billions;" August 22, 2008. Accessed at www.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.
- ^{iv} HIMSS. "ICD-9 CM to ICD-10 CM Coding Transition." Virtual Events Power Point Presentation; American Society of Clinical Oncology. 17 March 2011. Accessed at www.asco.org.
- ^v Hall, Denise. "ICD-10 Financial Risk Mitigation Strategies." Power Point Presentation. Vanderbilt Center for Better Health DesignShop®, Nashville, TN. November 9, 2011
- ^{vi} ManpowerGroup. "Talent Shortage 2011 Survey Results." Accessed at http://files.shareholder.com/downloads/MAN/1439749912x0x469531/7f71c882-c104-449b-9642-af56b66c1e6d/2011_Talent_Shortage_Survey_US.pdf. 2011
- ^{vii} Right Management. "Employee Discontent Survey." Accessed at <http://www.right.com/news-and-events/press-releases/2011-press-releases/item22035.aspx>. 2011
- ^{viii} Right Management. "Employee Workload Survey." Accessed at <http://www.rightmanagement.de/de/news-and-events/press-releases/2011-press-releases/item21201.aspx?x=21201>. 2011
- ^{ix} Triggs, Graham. "ICD-10: Preparing for October 2013." Accessed at <https://www.klasresearch.com/Store/ReportDetail.aspx?ProductID=646>. September 2011.
- ^x Jorgensen, Kelly. "ICD-10 Vendor Readiness." Power Point Presentation. Vanderbilt Center for Better Health DesignShop®, Nashville, TN. November 9, 2011.
- ^{xi} Boynton, Annie. "ICD-10 Provider Payment Risk Mitigation." Power Point Presentation. Vanderbilt Center for Better Health DesignShop®, Nashville, TN. November 9, 2011.
- ^{xii} Jodock, Pam. "ICD-10 Fraud, Waste and Abuse." Power Point Presentation. Vanderbilt Center for Better Health DesignShop®, Nashville, TN. November 9, 2011.
- ^{xiii} Atkinson M, Gierlasinski N. "Fraud in healthcare organizations: profiteering at society's expense." ASBBS Annual Conference. Accessed at <http://asbbs.org/files/2010/ASBBS2010v1/PDF/A/Atkinson.pdf>. February 2010.
- ^{xiv} Wynia MK, Cummins DS, VanGeest JB. "Physician manipulation of reimbursement rules for patients – Between a rock and a hard place." JAMA-Journal of the American Medical Association. April 12, 2000. V283:pp.1858-1865.
- ^{xv} Omnibus. "Rampant Medicare Fraud Receives Congressional Attention." Medicare Cuts: Medicare Legislation and Regulation Watchdog. [<http://medicarecuts.com/story/rampant-medicare-fraud-receives-congressional-attention>]. March 24, 2011.

^{xvi} Jodock, Pam. "ICD-10 Fraud, Waste and Abuse." Power Point Presentation. Vanderbilt Center for Better Health DesignShop®, Nashville, TN. November 9, 2011.

^{xvii} Hing E, Burt CW. "Characteristics of office-based physicians and their medical practices: United States, 2005–2006." National Center for Health Statistics. Vital Health Stat 13(166). 2008.