Successful ICD-10 Implementation from a Provider Perspective

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Agenda

- Organizational Overview
- Environmental Scan

(What is happening organizationally that has affected your approach to testing?)
- Approach to Testing
- Challenges
- Mitigation Strategies
- Current Status
- Lessons Learned
- Next Steps

Organizational Overview

- Penn Medicine Chester County Hospital
- One of four (4) hospitals in the health system
- 270 licensed beds acute care community hospital, West Chester, PA
- Sixteen (16) outpatient satellite registration areas

Stats at a glance: (annual*)
- Admissions: 14,982
- ED Visits: 43,240
- Outpatient Visits: 536,485
- Surgical Cases: 7,696
- Employees: 2,456

*Based on FY14 statistics
ICD – 10 Dimensions

- Coding
- Clinical Documentation
- Operational Readiness
- System Remediation
- End to End Testing

Environment Scan

- Independent community hospital – 2012
  - ICD-10 Program Management
- Merged with Penn Medicine - 2013
  - Assimilate with Penn Medicine ICD-10 organizational structure
  - Review ICD-10 implementation status
  - Significant diversity with installed clinical and information systems
  - Accommodate approach to systems remediation and testing
Testing Approach

- Systems remediation
- Internal testing
- Dual Coding
- Claims testing

Challenges

- Competing priorities with merger activities and transformation to enterprise-wide information technology platform
- Testing with payers and initiation of end-to-end testing
- Systems remediation
  - Physician practice migration to ICD-10 compliant systems
Mitigation Strategies

- Payer testing
  - Continue dialog with revenue cycle team and payer regarding ability to conduct end-to-end testing
  - Engage with claims clearinghouse to perform testing

- Systems remediation
  - Complete end-to-end testing
  - Communicate with implementation team regarding status
  - Apprise management of risk if testing is compromised
  - Review alternative options

Lessons Learned

- Initiate testing early
  - Vendor availability

- Maintain stable state with systems
  - Detect any issues within internal systems
  - Software updates / enhancements can result in instability
  - Update potentially “breaks” functionality that was working

- Monitor the environment
  - New strategic initiatives
  - Impact to systems and technology
Our Mission...... is to improve the health of our communities....

Environmental Scan that influenced our plan

- 5010 learning really influenced our commitment to testing
- Payer Population and risk (high-dollar, high-risk, operationally complex)
- Affiliations +2 Current states/EPIC transition
- Competing priorities
Approach to Operational Testing

- Recognize from where we’re starting—added expertise to the team through Avastone Health solutions
- Create detail plan
  - Engage operations front line
  - Pain points today
  - Scope, method, cost
  - Engage our clearinghouse
- Analyze Data: Payer mix, Case mix, etc. / Modeling using actual
- Contingency: language modification with payers as safety net
- 3 phases emerged

Challenges

- With payers
  - “Sell” the importance of testing
  - “Teaching” role (Why important)
  - Concessions to payer level of testing
    - Syntactical vs. end to end
  - Payer resourcing
    - Delay impact
  - Unique processing and testing environments
    - General Plan vs. Plan specific
- For us:
  - With delay, internal burning platform waned
  - Clearinghouse team we worked so closely with changed mid-stream
  - Scope by payer, adjust our plan and goals each time
  - Starting “over” each time due to payer’s plans
  - Tracking our results also had to be customized by payer level of testing
Mitigation Strategies

- Financial Neutrality
  - Operational/Technical Adjustments
    - Training Education
    - Testing
  - Mitigation Matrix
    - Plan

Current Status

- Phase 3 testing to begin in April (pending SGR)
  - Some new payers, some repeat payers
  - Will include large payers, small plans, re-price’s and TPAs
- Goal is to be finished by June 30, 2015
  - Still in queue would be Medicaid and Medicare (July)
- Reviewing options for paper claims
  - Including workers comp/liability
- Stay aligned with clearinghouse (new team members) and internal resources with competing priorities
Next Steps & Lessons Learned

Next steps:
• Continue to work with Epic
  – Embed tools to ease the transition
• Continue refreshing overall program plan
• Start focus on what we need to let patients know about upcoming transition
  – Pre-Auth
  – Referrals
  – Benefit plan impact (will they get a false positive denial, etc.)
• Continue to leverage our CDI program

Lessons learned:
• ICD-10 is not a Sexy Project!
  – Competing priorities
  – Providers do not yet see the value
• Investment in this level of testing builds confidence
• Conversations with payers are changing in a good way
• Revenue cycle improvement opportunities are emerging
• Change fatigue
• Connecting the dots to all levels of the organization
• Ebola helped us!
• Challenging “closet” opportunities re-emerge: like shared problem lists

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**Site** | **Site Size** | **Description**
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UNC Hospitals | 830 beds | Acute care teaching hospital for The University of North Carolina at Chapel Hill. UNC Hospitals consists of North Carolina Memorial Hospital, North Carolina Children's Hospital, North Carolina Neurosciences Hospital, North Carolina Women's Hospital and North Carolina Cancer Hospital.
UNCFP | 18 clinical; 2 affiliated depts.; 2 administrative units | 1,100 physicians who provide a full range of specialty and primary care services for patients of UNC Health Care.
Rex Hospital | Total 660 Beds 433 beds Acute Care 227 Skilled Nursing Care | Provides inpatient, outpatient and emergency services primarily to the residents of Wake County, N.C. Rex Hospital also operates Rex Cancer Center, Rex Women's Center, and Rex Rehabilitation and Nursing Care Center of Raleigh on its main campus. Rex Hospital has additional campuses in Cary, Wakefield (in Raleigh), Garner, Holly Springs, Knightdale and Apex. Rex Hospital owns Rex Home Services.
Chatham Hospital | 25 bed | Critical access facility which operates 21 acute/swing beds and four intensive care beds, along with a complement of surgical suites, emergency room and ancillary services.
UNCPN | 30 community physician practices | UNCPN is a wholly owned subsidiary of the System, but a private employer, that owns and operates more than 30 community physician practices throughout the Triangle (Raleigh, Durham and Chapel Hill), N.C., area.
* High Point Regional Hospital | 351 beds | General acute hospital/facility located in High Point, N.C., to promote and advance charitable, educational and scientific purposes, and to provide and support health care services. Two other affiliated Surgery Centers, High Point Surgery Center and Premier Surgery Center. Also includes sub-entities that cover laboratory services, physicians practices, imaging services and partnerships to provide durable medical equipment, various therapies, home health services.
* Caldwell Memorial Hospital | 110 beds | Acute care hospital with a provider network of more than 50 primary and specialty care physicians and advanced practice professionals.
* Pardee Hospital | 222 beds | Acute care hospital which also has a comprehensive physician practice network, Rehab & Wellness Center, Health Education Center and Urgent Care.
* Johnston Health | 179 medical/surgical beds 20 behavioral health beds 101 patient suites | Provides inpatient, outpatient, emergency services, and several physician offices. There are two sites - Smithfield, and Clayton.
* Nash Hospital | 280 bed hospital 23 bed I/P rehab Center 50 bed behavioral health center | Acute care facility which also includes the Bryant T. Aldridge RehabCenter and the Coastal Plain Hospital Behavioral facility.

*added post-ICD-10 Program team formation
Footprint of UNC Health Care

ICD-10@UNC Program Approach Structure

• So basically…
  – going from multiple programs at each affiliated facility

  ![Diagram showing changes from multiple programs to a single program](image)

  – to a single UNC Health Care System program
Testing Overview

ICD-10 creates the need for a new testing paradigm. Data errors are no longer simply an internal issue resolved by empathetic customer support representatives after the fact. Visibility is required by all healthcare stakeholders into every other stakeholder’s readiness level and required functionality to conduct accurate and efficient clinical and business transactions.

Testing Overview

Objective
To determine the process, resource and revenue risks of ICD-10 compliance by coding clinical events in ICD-10 and evaluating the real payment results.

Desired Outcomes
- Identify gaps in documentation and coding standards
- Understand finance and revenue cycle impacts and determine appropriate mitigation
- Use real clinical events/data to validate payer mapping processes and Impacts
- Fully engaged trading partners and visibility into their readiness challenges
- Create a test data repository to be leveraged during system, integration, and operational readiness testing
Approach

Phased Approach to Testing

• The purpose and objective of this integration is to insure that *people*, *processes*, and *technologies* are fully aligned to optimize testing coverage and resource utilization between the various testing phases prior to ICD-10 Go-Live

• Create a common strategy and execution plan for all phases of testing:
  Regression, Unit or Functional, System Integration (SIT), UAT (User Acceptance Testing), End-to-End (E2E), and IR&E (Implementation Readiness and Execution)
Approach

Principles

• Testing will be primarily focused on high risk / high impact areas related to ICD-10 changes. The scope is a combination of affected information technology systems, reports, and policies and procedures.

• Impacted clinical and business processes will be evaluated for inclusion in testing based on risk. Risk evaluation will take into consideration impact to People, Process, and Technology to ensure proper training and preparedness.

• Un-impacted technical infrastructure, systems and applications, and clinical/business process will require regression testing to ensure completeness and functionality.

Stages of Testing

STAGE 1
INTERNAL UNIT/INTEGRATION
✓ MEDICAL RECORD SELECTION
✓ DUAL-CODING EXERCISE
✓ DUAL-CODED CLINICAL RECORDS
✓ ICD-10 CODING ACCURACY
✓ WORKFLOW PROCES
✓ IMPROVEMENT
✓ ICD-10 TRAINING
✓ COMPUTER ASSISTED CODING
✓ COMPLIANCE TESTING

STAGE 2
SHARED CODING RESULTS
✓ DUAL-CODED TRANSACTIONS
✓ CODING CONSENSUS
✓ ICD-10 CODING ACCURACY
✓ SHARED WITH ALL TRADING PARTNERS (EG. CLEARINGHOUSES, HEALTH PLANS AND VENDORS)
✓ ADDITIONAL CODING REVIEW BY TRADING PARTNERS (IF REQUIRED)
✓ BILLING TESTING
✓ DEFECT RESOLUTION

Clinical ICD-10 Data

STAGE 3
TRADING PARTNER TESTING
✓ BUNDLED MEDICAL RECORDS
✓ DUAL CODING WORKSHEETS
✓ DRG ASSIGNMENTS
✓ 5010 TRANSACTIONS
✓ SHARED WITH ALL TRADING PARTNERS (EG. CLEARINGHOUSES, HEALTH PLANS AND VENDORS)
✓ ADDITIONAL CODING REVIEW BY TRADING PARTNERS (IF NECESSARY)

STAGE 4
END-TO-END TESTING
✓ DUAL-CODED TXN'S
✓ END-TO-END TESTS
✓ COMPLIANCE TESTING
✓ DEFECT RESOLUTION
✓ HELP DESK
## Testing Partners

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<th>Payer Testing Participant</th>
<th>Clearing House Payer Testing Participants</th>
<th># of Claims Submitted</th>
<th># of Claims Accepted</th>
<th># of Claims Rejected</th>
<th># of 835’s received*</th>
<th># of Claims to be Submitted</th>
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## Success Criteria/Lessons Learned

- Engaged executive sponsorship
- Central view of your organizations in-flight activities
- Completed IT systems inventory and remediation
- Identify key operational resources
- Establish a timeline and assign responsibility for tasks
- Establish relationship with channel partners: payers/clearinghouses/vendors
- Leverage relationship with other providers and organizations
- Some payers are not as flexible as this testing requires
- End-to-end testing does not mean the same thing across the healthcare industry partners
- Identifying payers who will partner in testing