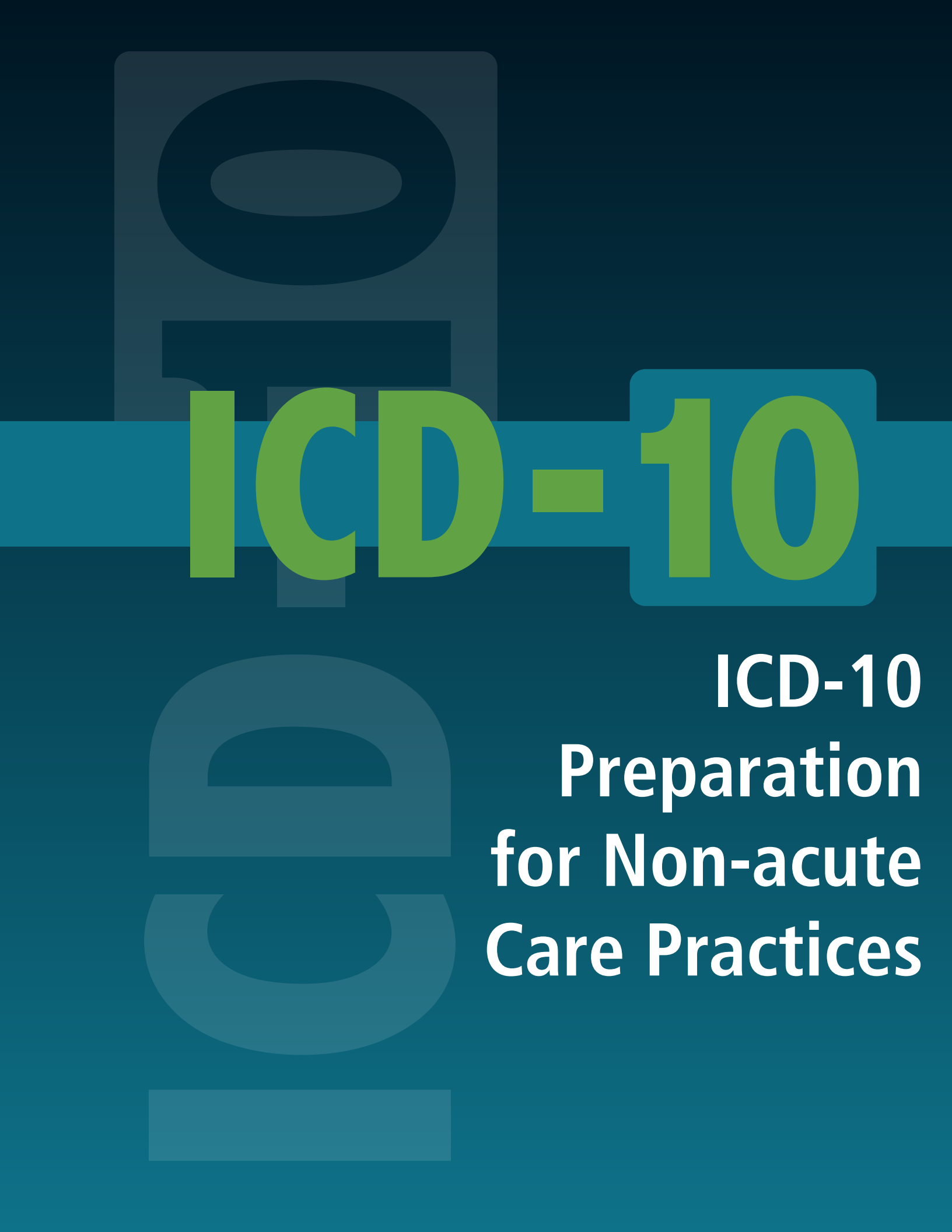

ICD-10 Preparation for Non-acute Care Practices

WHITE PAPER:

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ICD-10 PREPARATION FOR NON-ACUTE CARE PRACTICES

October 1, 2015 is the official transition date for the ICD-10 coding system. This system, published by the World Health Organization, replaces ICD-9, which has been in place for more than forty years. ICD-10 will enhance the healthcare system by enabling physicians to better capture patient visit details and more specifically identify patient problems including their degree and cause. This will ultimately lead to better care coordination and health outcomes. This transition is necessary due to the limited data about patients' medical conditions and hospital inpatient procedures that ICD-9 provides, making specificity of clinical documentation difficult. The focus of this white paper is on ICD-10 preparation for non-acute care practices and the purchasing and planning they will need to complete for the ICD-10 transition. The October 1st, 2015 deadline to transition to the new ICD-10 code set may seem like a long way off, but the planning and preparation along with the testing and training that are required must be in progress now to ensure that claims get paid and you meet regulatory requirements when the transition takes place. All of this work does not happen overnight and it certainly doesn't happen without dedicated staff and the support of your vendors as well as other stakeholders that are impacted by the ICD-10 change. This white paper will cover, at a high level, the administrative, billing, and clinical impacts of ICD-10 on non-acute care practices as well as tips for project planning to ultimately ensure that you have a smooth transition to ICD-10. The topics covered here do assume that most practices already have PM and EMR software. For those that don't, and are still using encounter forms, now is the time to consider moving to automation for your billing side with a practice management software and to electronic medical records for patient tracking and encounters.

WHAT IS ICD-10?

The World Health Organization publishes the International Classification of Diseases code set, which defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. ICD-10 is the tenth edition of the WHO code set. The WHO has authorized the United States to adapt this code set and use it for government purposes. Currently, the United States is using the ICD-9 code set, which was originally published in 1977 and is composed of ICD-9-CM, the Clinical Modification, and ICD-9-PCS, the Procedure Coding System.

ICD-10 also includes a Clinical Modification, CM, and a Procedure Coding System, PCS. ICD-10 includes the level of detail needed for morbidity classification and diagnostic specificity in the United States. It also includes titles and language that compliment accepted clinical practice in the United States. The ICD-10 code set is giving new wording, terminology and diagnostic specificity to coding. The code sets are growing with ICD-10. ICD-10-CM consists of about 68,000 diagnostic codes, while ICD-10-PCS, the hospital focused procedure code set, consists of about 87,000 procedure codes.

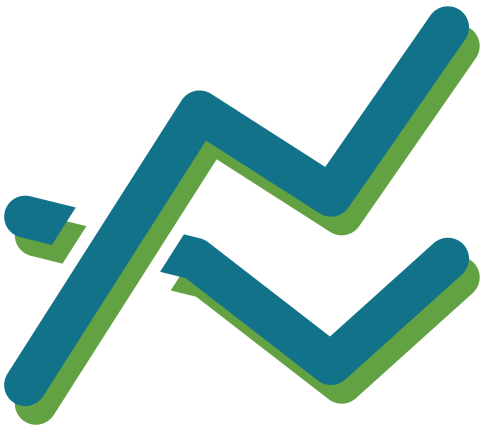
WHY IS IT NECESSARY TO MAKE THIS TRANSITION?

ICD-9 is a nearly-40 year old code set and it is limited. The medical terminology doesn't match today's terminology or the way modern practices operate. There's little room to add new codes based on the code set that's available and limited detail and specificity in terms of not being able to document anatomical descriptions or differentiate risk and severity. Additionally, the parameters to identify disease manifestations and the ability to optimize claim reimbursement with additional detail and specificity are not available in ICD-9. Another issue with ICD-9 is that payors are not able to analyze claims to look at utilization, costs and outcomes to measure performance.

Having all of this additional data, detail and specificity with ICD-10 ultimately allows for better healthcare operations as well as more efficient and streamlined processing and reimbursement of claims. It will increase automation and seek to minimize provider inquiries. The change to ICD-10 also allows for updated terminology and disease classifications to match how providers work today and what's really going on, allowing for new code additions, improved coding accuracy and specificity to include the anatomical site, etiology and severity within the code data. Being able to collect a repository of detailed data and being able to analyze patterns of disease based on the data that's submitted, being able to respond to health outbreaks quickly, and being able to have a way to support alternative reimbursement models such as ACO or case-based patient management are other benefits that will be derived from the use of ICD-10. Payors will potentially be able to develop new pricing and reimbursement models as well as have the ability to more effectively detect fraud.

EXPECTATIONS VS. REALITY

There are a number of expectations related to ICD-10 which are not entirely in line with reality. Many practices are running under the assumption that the deadline date will likely change again. CMS has already changed the deadline twice and it seems they are staunch in the current date and they continue to communicate that staunchness.



Another expectation is, "We have plenty of time to prepare." This is true – if you start now. Do your planning. Understand how this transition is going to impact the practice. Start your training and work on getting your providers and staff up to speed. The longer you can allow for that piece, the more success you'll have with the transition.

Many practices have the idea that, "Vendors will handle the transition for us." Part of the challenge with that is, realistically, ICD-10 impacts so many different systems and likely multiple vendors that you work with so no one vendor would be able to handle the transition for you. For example, it may impact if you have lab interfaces with your EMR. It will impact your practice management system. It will impact your EMR system. It's not just the billing and coding piece. It can impact HIEs, registries, and any number of different areas. So it's not just one vendor, necessarily, handling it for you unless you hire a consultant that manages your whole project for you. But if you're going to be doing it yourself, with your staff and providers, you have to plan your own project and start reaching out to your vendors to understand what will happen on their end.

Another expectation is that the ICD-10 change only impacts coding. It doesn't just impact coding but that is an important part of it. It also impacts clinical documentation. Providers need to be adding specific details to meet the specificity of ICD-10 codes. There are numerous systems within the office that need to be updated, and you will need to determine what those systems are and how you are going to prepare them for the change to ICD-10.

Going along with that idea of limited impact, some practices think, "We only need to know a new set of codes." Well, the new set of codes is quite different and vastly larger. The positive is that you likely won't need to know all of these codes. Each practice still has a standard set of procedures that they need to be coding for. It's a matter of identifying what your most commonly performed procedures are, what your ICD-9 codes for those procedures are and how those codes will translate over into ICD-10.

Some practices believe, "The doctors know that this is required so they'll just do what they need to do." Part of the challenge with this transition will be that it does impact both the billing and coding and operational sides of the practice. It also has a very heavy impact and reliance on doctors documenting the correct information as they're seeing patients so that the most accurate ICD-10 code can be applied and submitted on the claim. Because of the importance of accurate, detailed documentation it is necessary to get your providers into the habit of documenting for ICD-10 as soon as possible.

The final expectation is that external stakeholders will get this right. However, there are a number of different vendors that you might need to be working with and everybody in the industry is impacted by this change. You can't necessarily assume that every external stakeholder is going to get it right and on time. There are going to be growing pains with this transition.

ICD-9 VS. ICD-10

ICD-9-CM	ICD-10-CM
Doesn't identify right versus left.	Identifies right versus left >40% of codes.
Codes are 3-5 digits • First digit is alpha (E or V) or numeric • Digits 2-5 are numeric • Decimal is placed after the third character	7 digits • Digit 1 is alpha; Digit 2 is numeric • Digits 3-7 are alpha or numeric • Decimal is placed after the third character
No placeholder characters	"X" placeholders
14,000 codes	69,000 codes to better capture specificity
Limited Severity Parameters	Extensive Severity Parameters
Limited Combination Codes	Extensive Combination Codes to better capture complexity
1 type of Excludes Notes	2 types of Excludes Notes
Limited available space for new codes Ambiguous overall detail embedded within codes **Sample code:** 813.15, Open fracture of head of radius	Very specific detail embedded within codes (Allows description of comorbidities, manifestations, etiology/causation, complications, detailed anatomical location, sequelae, degree of functional impairment, biologic and chemical agents, phase/stage, lymph node involvement, lateralization and localization, procedure or implant related, age related, or joint involvement) **Sample code:** S52123C, Displaced fracture of head of unspecified radius, initial encounter for open fracture type IIIA, IIIB, or IIIC

Sources: ICD-10 Implementation Guide for Small and Medium Practices & Road to 10

ICD-9 VS. ICD-10	
ICD-9 Procedure Codes	ICD-10-PCS
3-4 numbers in length	7 alpha-numeric characters in length
Approximately 3,000 codes	Approximately 87,000 available codes
Based on outdated technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality
Generic terms for body parts	Detailed descriptions for body parts
Lacks descriptions of methodology and approach for procedures	Provides detailed descriptions of methodology and approach for procedures
Lacks precision to adequately define procedures	Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information

Source: American Medical Association

WHAT WILL ICD-10 IMPACT? EVERYTHING BUT THE KITCHEN SINK

One integral part of planning for the ICD-10 transition deadline is determining what will be affected in your practice. The simple answer is everything. Every part of your practice will be impacted by ICD-10 in some way.

- Do any forms that you use capture an ICD-10 code? You need to make that change. All of your forms, templates, and interfaces which collect proper documentation within the EMR will need to be ready for the transition. This will involve working with your EMR vendor to make sure you are upgraded and understand where in the software all of this additional detail and specificity will be captured.
- Where do you reference codes? Make sure you update your manuals.
- Superbills are critical whether you have a billing company or rely on a revenue cycle management company to handle your billing and you need to make sure you have them ready for ICD-10.
- You'll need to update your labs so that your orders reflect ICD-10 codes.
- For claims submission, you'll need to check with your clearinghouse, or with your individual payors if you submit directly, to find out what will be paid in terms of ICD-10 codes and what documentation will be required to support those codes. If you work with a billing service, make sure that your contract is updated and that they are up to speed on ICD-10 and how they'll be making that transition. It is highly recommended that you rely on a clearinghouse to consolidate all of your claim submissions, claim management, and rejections because they're closely tied to the multiple payors that a single practice may work with and able to streamline that process and help you quickly identify reasons for rejections and speed up the claim resubmission process. Your payor relationships could change considerably. A lot of the ICD-10 changes are geared towards allowing payors to be able to have more data and analyze what's going on in terms

of reimbursements and payments.

- HIEs, registries, and immunization organizations may be impacted as well because of code submission.
- The referral process will also be affected, as you will need to use ICD-10 for authorization and pre-certification forms and processes.
- Research participation could be impacted in that you will need to submit ICD-10 codes to ensure study inclusion.
- Staff needs to be trained and needs to understand how what they do impacts other departments within the practice in relation to ICD-10.

It's clear the impact of ICD-10 will be significant, but this does not mean this transition is insurmountable. With proper planning and execution of those plans, it is absolutely possible to make a smooth transition on October 1, 2015.

WHAT SHOULD YOU BE STARTING NOW?

Your first step is to make sure you're already using version 5010 for your claims submission. This is a step that the majority of practices should already have in place, but if, by chance, you're using 4010, know that you will not be able to use that data to submit ICD-10 claims. You will need to make the transition to 5010 as soon as possible. If you're still submitting 4010 claims to your clearinghouse and your clearinghouse is converting those for you, now's the time to make the change to submit in 5010.

The other thing you should start today is engaging providers and staff. Understand what the impacts are and start creating awareness so that they understand why this is so important. Get their buy-in. Talk to your clinicians, front desk, and owners if you have them. Make sure that everybody is understanding how important this is and that they're on board. Once you engage your whole staff, the next step is identifying your project champions. These are the people that will be leading the charge within the organization both on the administrative side and the clinical side as well as maybe with your vendor counterparts. The champions will be assisting with planning, communicating those plans, getting the buy in, outlining the different tasks that need to occur and making sure that everybody stays on task to get those done. It is incredibly important to make sure everybody is on the same page and knows what the plan is.

Another thing to do today is start an impact assessment. Ultimately what the impact assessment and all of the other steps allow you to do is create a formal project plan. Treat this transition as a business thing. This is something that you have to do and if you can break it down into its individual parts and have somebody leading these, it becomes much easier and much more efficient and effective to have a smooth transition come October 1st, 2015 and beyond.

BEST PRACTICES FOR CREATING PROJECT PLANS

At a high level, here are some basic steps for creating a project plan:.

- First, you want to identify your key stakeholders and project champions. Your stakeholders are anybody that's touched by this change or that needs to assist you in making the transition to ICD-10. Project champions will help to plan and manage the project, making sure everybody stays on track. Communicate the importance of the change and get people engaged, not just your key stakeholders or your main doctors, get all of your staff involved because everybody's going to be impacted by it and your success

depends on everybody.

- Next, perform an impact assessment. Determine how each process and component of the practice could be impacted by the transition to ICD-10 and decide how you will address those impacts to make a smooth transition.
- Now you are ready to develop a formal project plan. Part of your project plan will be what happens at go live and then what do you do after you go live. Communicate your project plan and remember to communicate every time there are changes made to it. Keep people engaged. Oversee the execution of each of the project tasks.
- Make sure your project plan identifies the key milestones. First is engaging your stakeholders, which you've already done. Second is completing an impact assessment, which is also already completed. Third might be executing on your task. Fourth might be testing. Then you have training. Then you have 'go live' and then 'post-go-live. Within each of those milestones, you can then start identifying and building out all of the tasks that need to happen in order to reach each of those key milestones. This will help you monitor your success as you execute your project plan.

Keep in mind that not all of these things will happen one by one. Many things will be happening at the same time and you need to keep those balls juggling in the air and keep an eye on them to make sure that they're moving forward. You want to set a budget that includes training. There could be a cost associated with upgrading hardware if you need to meet certain requirements for your external vendor systems and you'll want to account for this in your budget as well. You may look to purchase add-on tools and services, possibly a code-mapping tool or a reference manual. You also want to budget for any revenue impacts. Finally, take your plan and share it with your stakeholders. Get their buy-in, ask questions, get their two cents and then refine the project as needed and share it again with your stakeholders so everybody is aware of the final agreed-upon plan.

Keep in mind
There could be a cost associated with upgrading hardware if you need to meet certain requirements for your external vendor systems

ASSESSING AND HANDLING RISKS

Doing a risk assessment as part of your project plan is very important. Consider risks such as inadequate training and lack of vendor preparation. Make sure that your vendor has their software versions ready, know when it will be released and what you can expect from them in terms of functionality. Ask about training, the upgrade process and the support that will be provided for you after the go live.

Another risk is that, potentially, you could lose staff. Switching to a brand new code system is challenging. Coders will be in high demand so make sure you have them trained up and completely engaged, helping with the transition. This will create a more positive culture within your practice and keep your coders on board.

If payors or other external vendors aren't ready, that could be a big risk. You have to imagine how many different health plans are out there and all of these health plans and payors have to have everything working like clockwork just like your practice does. The reality is not everybody's going to have it right. There could also be a negative impact on relations with patients and payors, knowing there's going to be more back and forth to talk about why something is delayed or why something is denied. There could be reimbursement impacts. This could slow revenue if the payors aren't ready or claims aren't submitted accurately. There could be increased denials and payment delays for fee-for-service items. There will

be alternative reimbursement definitions from payors for capitation, case-based or ACO payments, so it's important to understand how those would change with your payors. The payors may start doing audits because they have access to additional information and want to make sure that the documentation matches the coding. And remember, there may be an increased focus on fraud detection.

You may experience budget limitations. This is the kind of risk that you want to be able to identify and prepare for so that you don't experience a cash flow shortage unexpectedly.

Finally, trying to get referrals or authorizations pushed through may be a challenge that you should be aware of and have contingency plans for.

The number one concern when considering how you will handle these risks is that you need to create ways for staff to report issues. If they see something that's going wrong or something they're not comfortable with, they should have an easy way to report it. Establish a decision-making chain. If there's an issue, understand who is going to receive it, how it's going to be reviewed and how it will be addressed and resolved.

WHAT SHOULD YOU BE DOING MOVING FORWARD?

Once you have your plan in place, you will need to begin executing it. Regularly update your staff on the progress; good and bad. Everybody needs to know the reality. Begin your training. A good place to start is the provider documentation. Once you've had a chance to talk to your payors and you're able to look at your current ICD-9 codes and translate those into their ICD-10 counterparts, then you can go back and identify what documentation is required for each of those ICD-10 codes. Then start training your doctors, nurses, nurse practitioners, and anybody that assists with documentation to make sure they're capturing the appropriate information or the appropriate code. Get started sooner rather than later.

Start your internal system changes. What documents and forms do you need to update? What processes do you need to overhaul? What policies and procedures do you need to outline and document for the staff? Talk to your vendors to schedule any external system changes. Then begin making those changes. If you need to upgrade your PM or EMR software, do that earlier rather than later. That way when the time comes, you're ready to go.

A couple months before that October 1st date, start training on the changes. Identify who's confident and where others aren't confident so you know where to focus the training. Consider tailoring your training to your audience, whether it's a provider, front desk person or coder, and then maybe tailor to different learning styles. Not everyone learns in the same way. You may have different training tools that are available through outside organizations, a consultant or your different vendors. MicroMD offers webinars, self-help tools, reference tools and a number of different services and consulting type packages with which we're able to assist our clients. So look where you can to find your resources.

Start documenting the changes to policies, procedures and job responsibilities and start testing those systems. As it comes closer to the transition date, you need to be able to test with your clearinghouse, payors, PM and EMR software, and labs. Test your own internal system. Try multiple test cases. Create test cases that would be your high dollar, high risk type items that you risk not getting the documentation right. Try to trigger errors and identify how you're going to prevent those errors. Ultimately, triggering the errors tells you how to prevent them in the future.

Continue staff training. Usually you want to train your coders closest to go-live to retain that information because it's going to be very important. Start the clinical documentation training long before that so the doctors get used to it and it becomes a repetitive thing. There may be training needed for medical terminology for the coders specifically. Will you be using GEMs or other mapping tools? If so, how will you use them? Assist people with where to get information, how the claim submission process changes and monitoring the claims submission especially after the 'go live' so that you know how to look at that and understand where things may be breaking down or working well. Then you want to train on dependencies, meaning sharing with each individual how their job or what they do with ICD-10 codes impacts how somebody else may use it. It's important to know that so you understand how the whole system works and people can understand their part and how important it is.

WHAT SHOULD YOU EXPECT FROM YOUR PM AND EMR SOFTWARE VENDOR?

Number one, vendors are preparing. It might not be that all vendors are prepared or every vendor has a plan, though. Know that it's not quick and easy. Vendors, like practices, have so many things behind the scenes that are touched by ICD-10 codes that need to be reprogrammed and updated and we also have, as vendors, an important duty to our clients to make sure that we are assisting them in making that transition as fast as possible. Contact your vendor and find out how they plan to communicate with you through this transition. If they use email, as MicroMD does, make sure they have your email address. They need to be able to communicate important changes to you. This applies to all external vendors that you're working with, not just your PM and EMR software, but it is important for your software vendors to have the ability to contact you with important information relating to upgrade timelines and other ICD-10 resources.

From our standpoint, at MicroMD, we worked with our clients to ensure PM and EMR release for an ICD-10 version. This came out in late 2014 so that clients could begin to upgrade, start training, and get used to testing the system. MicroMD is also loading the ICD-10 codes into the software and offering a crosswalk tool. We are working to assist our clients with utilizing the software for all the facets that ICD-10 has impacted. And we are doing that through webinars, checklists, self-help tools and a number of other services. We will be doing dual support of ICD-9 and ICD-10 codes. This is very important. We'll be available to schedule the testing for the PM and EMR software and assist in coordination testing with the clearinghouses we work with as well. Those are the things that we're doing and that you should be expecting from your vendors as well.

WHAT HAPPENS WHEN OCTOBER 1ST, 2015 GETS HERE? (AND AFTER THAT.)

Some of the next steps to anticipate would be going live with ICD-10 and putting all those system changes into production. You will be submitting claims that have a date of service before October 1, 2015 using ICD-9. You'll be submitting claims with a date of service on or after October 1, 2015 using ICD-10. This means you'll be running dual systems for some length of time. Make sure you check with your vendor that they will be able to accommodate the dual system.

You want to monitor for issues. Anything else within the organization that utilizes ICD-10 codes, you want to monitor those things and how well they're working and be able to identify and implement improvements if needed. Expect rejections and denials and look at if you are a potential target for a fraud audit. Resolve issues quickly so you can move forward and continue training as needed.

You also want to measure success. Take a look at how you're doing. The success may not always be there but the challenges or break downs give you the opportunities to improve.

Moving beyond October 1st, keep monitoring your progress, success, and areas for improvement. And don't forget to celebrate surviving the transition to ICD-10!