Analyzing the Financial Impact of ICD-10

Practical Considerations to Minimize Losses in Productivity, Cash flows and Profits, and Mitigate Risk for Compliance

CPAs / ADVISORS
blue

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Mitigate Risk…..Documentation Challenges With ICD-10

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Primary ICD-10 Impact

- Three Primary Sections:
  - Operations & IT
  - Reimbursement Impact
  - **Documentation & Coding**

Documentation

- Documentation drives everything……..
  coding…claims submission……....
  reimbursement…..
  revenue……
  organization health

Common Documentation Problems

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- Symptoms, signs and/or working diagnoses were coded when a definitive diagnosis has been established (outpatient)
- Physician orders lack level of specificity necessary for ICD-10 (outpatient)
- All coexisting conditions documented by physician are not being reported (outpatient)
- Unspecified diagnosis codes and specified diagnosis codes of a condition or injury were reported
- Illegible physician handwriting
- All inpatient procedure codes not being reported

Inpatient/Outpatient

Coding/Documentation Review Summary

- Physicians are using abbreviations that are not based off the standardized list of abbreviations
- Outpatient encounter/order forms lack the level of specificity necessary for ICD-10
- Co-existing conditions, documented by physician, were not coded
- Diagnosis code assignments were not always assigned to their highest degree of specificity
- Lack of supporting physician documentation to support diagnosis coded and billed
- Signs/symptoms were code when a definitive diagnosis had been established
- Procedure was coded but the documentation did not support that the procedure was performed

Inpatient/Outpatient

Coding/Documentation Review Summary

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- •Co-existing conditions, documented by physician, were not coded
- •Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations

Example

- Example: **Physician documents partial small bowel resection with no further specificity** To code the appropriate root operation ICD-10 for the procedure being performed, physician documentation needs to identify the exact portion of the small intestine that was removed. If the physician documents removal of an entire portion of ileum or jejunum for example, this would then be coded to resection instead of excision.
- **MS-DRG Reimbursement Impact: ($6,261.27)**

Physician Practice

- Physician documentation was not specific enough for the assignment of ICD-10 codes resulting in the assignment of miscellaneous, non-specific diagnosis codes.
- •Co-existing conditions, documented by physician, were not coded
- •Lack of supporting documentation to support the codes (CPT & E/M)
- •Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations
- EMR-cloned documentation

Clinical Documentation Improvement

- Expand CDI program to include all patient discharges preparing for ICD-10 and Pay-for-Performance
- Provide formal education and training to acquire CCDS/CDIP certification
- Continue to leverage CDI Measure metrics and identify opportunities/trends
- Include ICD-10 specific metrics in monthly dashboards as education begins
- Engage Physician Advisor(s)
- Increase staffing resources
- Collaboration/Increased interaction with HIM due to ICD-10
- Maximize ICD-10 Education & Training Opportunities
- Coder Career Ladder
- Computer-Assisted Coding System

Critical Success Factor:
Productivity Mitigation
Streamline Quality
Limit Learning Curve
Enable dual-processing environment

What Can You Do

- Education practitioners on what they need to document for ICD-10
- Not interested in learning the coding right now
- For the condition, what do they need to specify in their patient encounter
- KISS principle—Keep it Simple

What Can You Do

- Train coders earlier—not later
  - We need to monitor documentation
- **Documentation translates to revenue**
- **Perform ICD-10 Readiness Audits Quarterly—Education is Key**

A layman's view of the impact to your ambulatory operations

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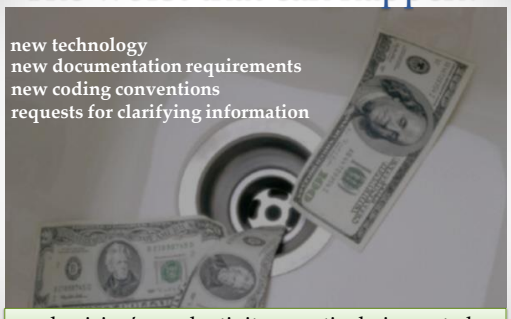
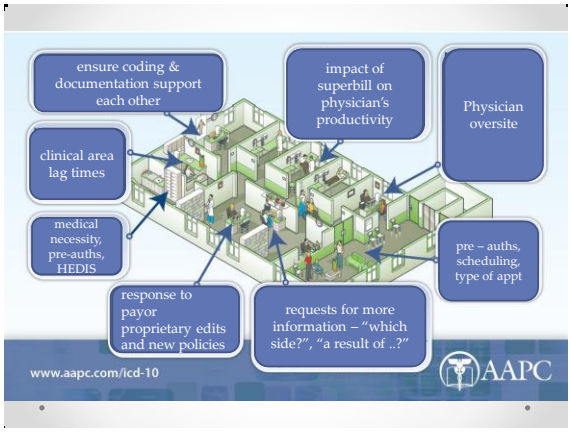
The worst that can happen?



physician's productivity negatively impacted



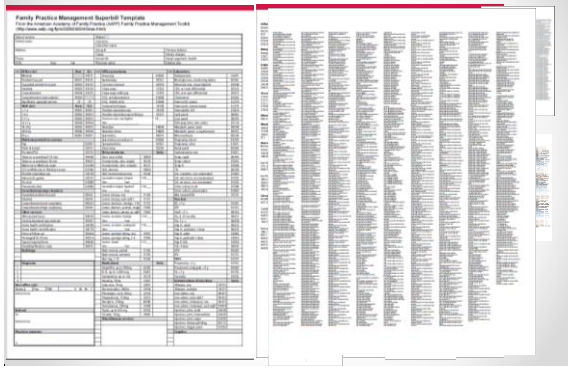
- learning curve for documentation / coding
- significant increase in questions, clarifications
- oversite for all policy and procedure changes, quality reporting
- do-overs for pre-authorizations
- new rules for medical necessity
- hunting and pecking through drop-downs, learning new descriptions / syntax
- loss of muscle memory with new forms / formats
- cash flow degradation

Coding Increase by Specialty

Specialty	ICD-9 Codes	ICD-10 Codes	Coding Increase
Cardiology	178	430	2.5 x
Dermatology	172	603	3.5 x
OB-GYN	220	777	3.5 x
Family Practice	229	829	3.6 x
Ophthalmology	204	848	4.2 x
Pediatrics	165	836	5 x
Orthopedics	143	5,843	40.9

Source: White Plume Technologies, 2012

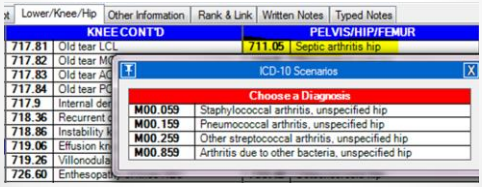
ICD-10 Superbill – American Academy of Family Practice



Coding and documentation

Requires new information

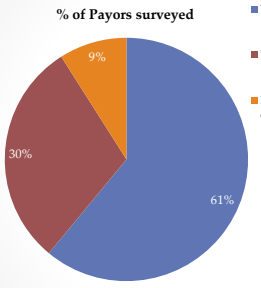
Tells a more detailed story



GEMS is Incomplete

- Approximate Code Example - 1 ICD-10 code required
- 754.30 – Congenital Hip Dislocation
  - Q65.00 – Congenital Dislocation of unspecified hip, unilateral
- Problem:
  - ICD-10 allows for greater specificity in this example by introducing laterality. GEMS converts this code only to the unspecified unilateral ICD-10 code, which will not always be correct.
- 754.30 – Congenital Hip Dislocation
  - Q65.00 – Congenital Dislocation of unspecified hip, unilateral
  - Q65.01 – Congenital Dislocation of right hip, unilateral
  - Q65.02 – Congenital Dislocation of left hip, unilateral
  - Q65.1 – Congenital Dislocation of hip, bilateral
  - Q65.2 – Congenital Dislocation of hip, unspecified

Payor readiness for ICD-10



Source: HealthEdge survey, 2012

"BCBSOK will implement an ICD-10 adjudication system ….using ICD-10 codes through a "Pure" environment. During an appropriate run-out period (the length as yet not determined) we will continue to process ICD-9 claims through our existing environment."

What's on your Payors' Plate?

Adjudication
- Continual changes to payment policies (Denials)
  Backwards mapping from ICD-10 to ICD-9 / Improper payments, carve outs
  Managing commercial, WC and auto claims

Operational changes
- System changes and associated issues
  Slow downs in every area
  Increased demands on help lines and provider relationship managers

Contracting
- Lack of meaningful historical data for contracting with ICD-10

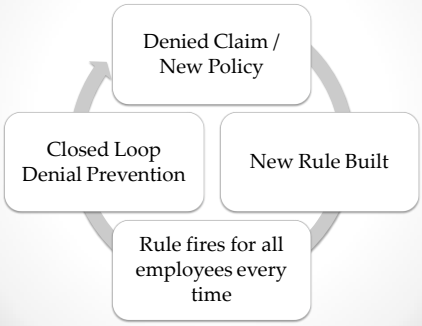
Policy changes
- Pre-authorizations and referral
  Medical necessity
  Proprietary edits
  Coverage policies and formularies
  Appeals and Timely filing – especially for claims prior to the cut off

Payor Proprietary (Black box) Edits

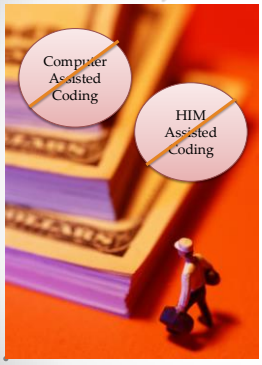
	Aetna	Anthem	Cigna	HCSC	Humana	Regence	UHC
Payer-specific edits	62,335	76,726	1,190	123	5,033	5,000	82,868

Source - AMA 2012 National Health Insurer Report Card

Closed Loop Denial Prevention



Which tools do you need for ambulatory RCM?



- eSuperbill that **preserves muscle memory**
- **flexible tools** that support both WC and HIPAA claims
- **closed loop denial prevention** process