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ICD-10: Ready or Not?

Survey Results Provide an Overview of ICD-10 Implementation and Planning Status

By Jerry Lear, CIA, CISA, and Kirra Phillips, RHIA, CCS

In only a few months, healthcare organizations will make the transition to the International Classification of Diseases 10th revision clinical modification/procedure coding system (ICD-10-CM/PCS) standard code sets for reporting diagnoses and procedures. Proposed legislation to further postpone the implementation deadline of Oct. 1, 2015, has gained little traction. After two implementation delays of its original October 2013 date and years of planning by healthcare providers, vendors, payers, and clearinghouses, the Centers for Medicare & Medicaid Services appears to be ready. Many healthcare organizations have made significant efforts to prepare for the change to ICD-10, including training, testing, and implementing systems. This article will discuss the status of healthcare providers in getting ready for this historic change.

From May 21, 2015, through June 10, 2015, CHAN Healthcare, a subsidiary of Crowe Horwath LLP, and the Association of Healthcare Internal Auditors (AHIA) conducted a survey to understand the readiness of healthcare organizations for the implementation of ICD-10. Forty-one complete responses were received. Respondents included national health systems, multistate health systems, academic medical centers, multihospital health systems, single-site hospitals, and physician groups.

The survey results include respondents from organizations of various sizes. Nearly 37 percent of respondents said their organizations have greater than $2 billion in net patient service revenue (NPSR). Exhibit 1 shows the breakdown of respondents based on their organizations' NPSR.

ICD-10 Governance Structure and Related Elements

More than 95 percent of respondents indicated their organizations have an ICD-10 governance structure in place, and the majority of respondents indicated their governance structure for ICD-10 includes the following elements (see Exhibit 2):

- Program or project charter
- Governance or steering committee
- Executive sponsorship
- Detailed project plan
- Project budget
- Subcommittees
- Project resources, such as internal or external consultants

Training and Preparation

The survey addressed several specific ICD-10 training matters, including whether staff members in certain functional areas have been trained. Most respondents said training is well underway at their organizations but has not been fully completed. Several respondents noted training will be completed over the summer. As seen in Exhibit 3, for personnel involved with care delivery, 22 percent of respondents indicated they are ready now, and 58.5 percent said they plan to be ready.

Exhibit 1: Net Patient Service Revenue of Organizations That Responded

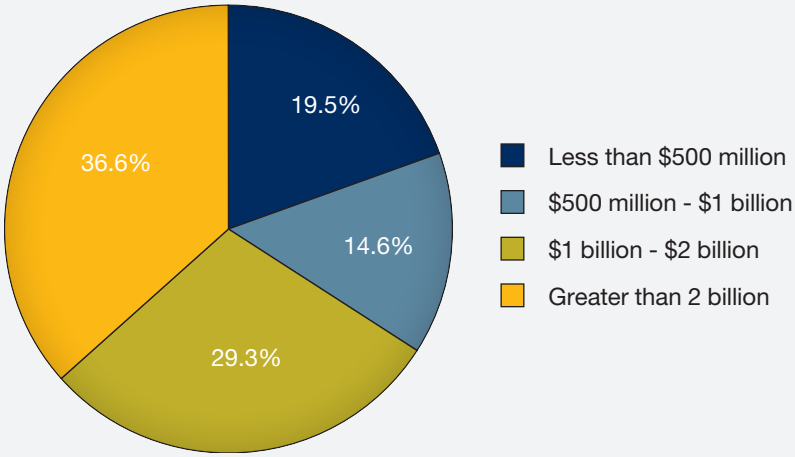


Exhibit 2: Elements of ICD-10 Governance Structure

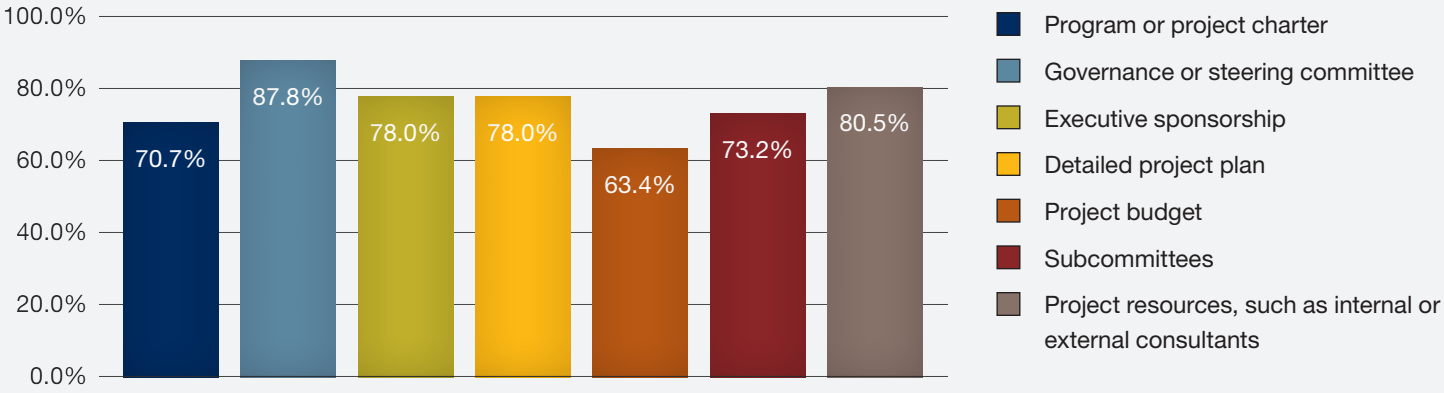
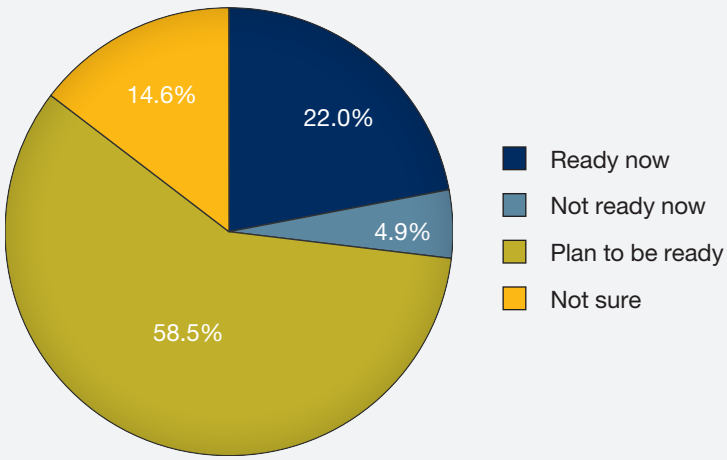


Exhibit 3: Care Delivery Personnel Readiness



Results were comparable for health information management and coding staff, with a slightly greater number of respondents indicating they are ready now or plan to be ready for the transition (see Exhibit 4).

The category of revenue cycle personnel yielded the lowest percentage of respondents who indicated their organizations are ready now for the transition (17.1 percent); the highest percentage (65.9 percent) said they plan to be ready (see Exhibit 5).

Several respondents voiced concerns about whether payers will be ready for the transition, noting that their systems will accommodate ICD-10 codes but that some payers may not be ready to receive ICD-10 codes. Collaboration between providers and payers is a critical step in preparing for ICD-10. Diligence and persistence are needed in working with payers during the short amount of time left before implementation.

While the vast majority of respondents (92.7 percent) said their organizations had conducted training with coders, only 46.3 percent indicated training had been conducted with nursing staff. Seventy-eight percent of respondents said physician training had been conducted in their organizations, while 63.4 percent said their organizations had trained billing personnel (see Exhibit 6).

Several respondents commented that training also is occurring in other functional areas, including general training for administrative personnel as well as for information technology, care management, and quality reporting personnel.

Testing With Clearinghouses

Sixty-one percent of respondents said they have tested with clearinghouses, though many noted that testing would continue into the summer. Because many organizations rely on clearinghouses to process clean claims efficiently prior to submission to the payer, clearinghouse readiness is a vital component of successful ICD-10 implementation. Of the 61 percent of respondents who said they have participated in testing, 64 percent indicated that the clearinghouses appeared to be ready for the transition.

End-to-End Payer Testing

Fifty-six percent of respondents said they have participated in payer end-to-end readiness testing, and 20 percent said they have not participated in the past but indicated plans to test in the future. Respondents who had performed testing said that Medicare and Medicaid were the most frequent payers tested. Several respondents said they have tested with other private payer insurers, but other respondents indicated that not all payers are ready to perform testing. In some cases, testing, particularly with private payers, had been scheduled but not completed. In addition, some respondents noted that testing has occurred only with 837 claims submission data; 835 payment transactions are to be included at a later date. This could mean that electronic explanation of benefits or remittance advice detail may not be adequate to explain denied claims.

Exhibit 4: Medical Record and Coding Personnel Readiness

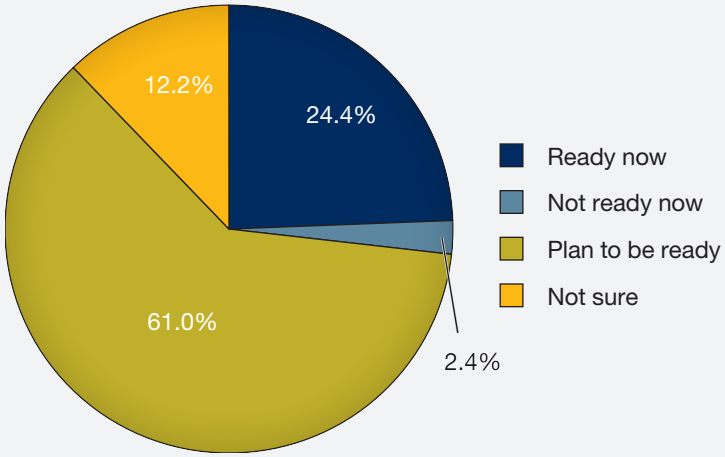


Exhibit 5: Revenue Cycle Personnel Readiness

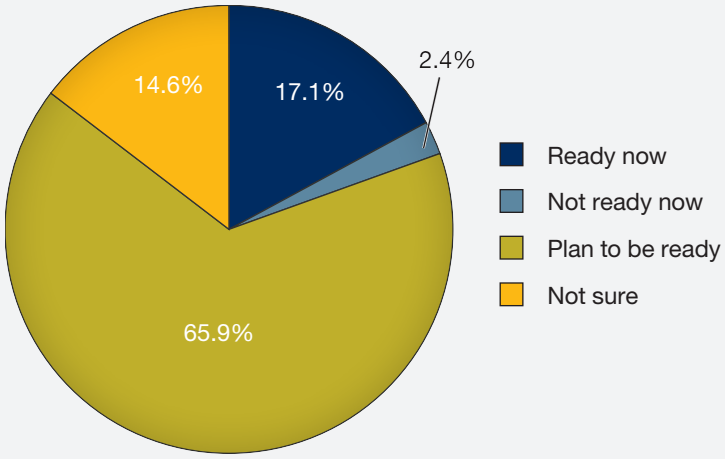
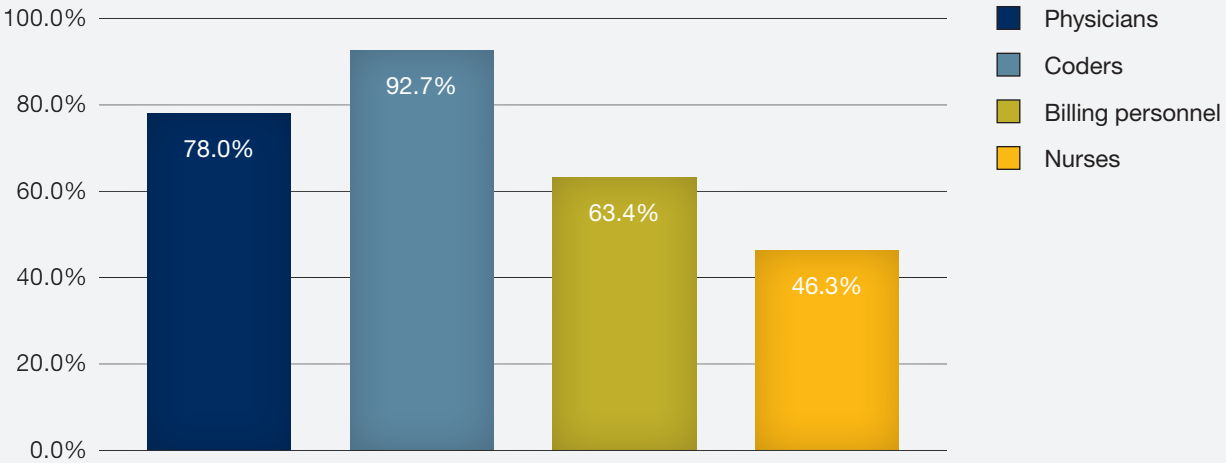


Exhibit 6: Training Conducted, by Group



Of those respondents who said they have participated in end-to-end testing, only 17 percent indicated that their end-to-end testing addressed cutover patients, meaning patients who are pre-certified, pre-authorized, or insurance verified before the ICD-10 transition date but receive services post-transition. Several respondents indicated the payers declined engaging in testing this aspect of the transition. Similarly, only 26 percent of respondents whose organizations had participated in end-to-end testing said they had tested the insurance verification, pre-certification, or pre-authorization process with payers. Several respondents noted they will be making inquiries of payers regarding this testing, with a few specifically indicating that aspect of testing has not yet been considered by their organization.

Of those respondents who have participated in end-to-end testing, 17 percent said that testing has been performed on all payer systems or platforms. Several noted that payers permitted testing of only certain platforms or dictated which platforms were to be tested, resulting in concerns about whether payers would be ready to accept all claims.

Respondents also indicated the number of payers with whom they had conducted end-to-end testing. Exhibit 7 is based only on the 56 percent of respondents (23) whose organizations had conducted end-to-end testing and shows that the majority had tested with one to five payers.

The survey also addressed the respondents' sense of payer preparedness. Again, responses in Exhibit 8 are limited to the 23 respondents whose organizations had conducted end-to-end testing. The highest percentage (39.1 percent) said they were uncertain whether the payers were ready; nearly 21.7 percent indicated that all payers were ready.

Finally, relative to end-to-end testing, the survey addressed issues that have occurred with commercial payer testing. Results include all respondents, because even some of those whose organizations had not yet performed end-to-end testing have encountered issues. Respondents could select more than one choice. Almost 44 percent of respondents indicated that payers were unavailable or unwilling to test. Twenty-nine percent said that they encountered other issues, including inaccurate reimbursements as well as not always getting feedback other than that data was received. More than 17 percent said they encountered no issues with testing (see Exhibit 9).

Exhibit 7: Number of Payers With Which the Organization Has Conducted End-to-End Testing

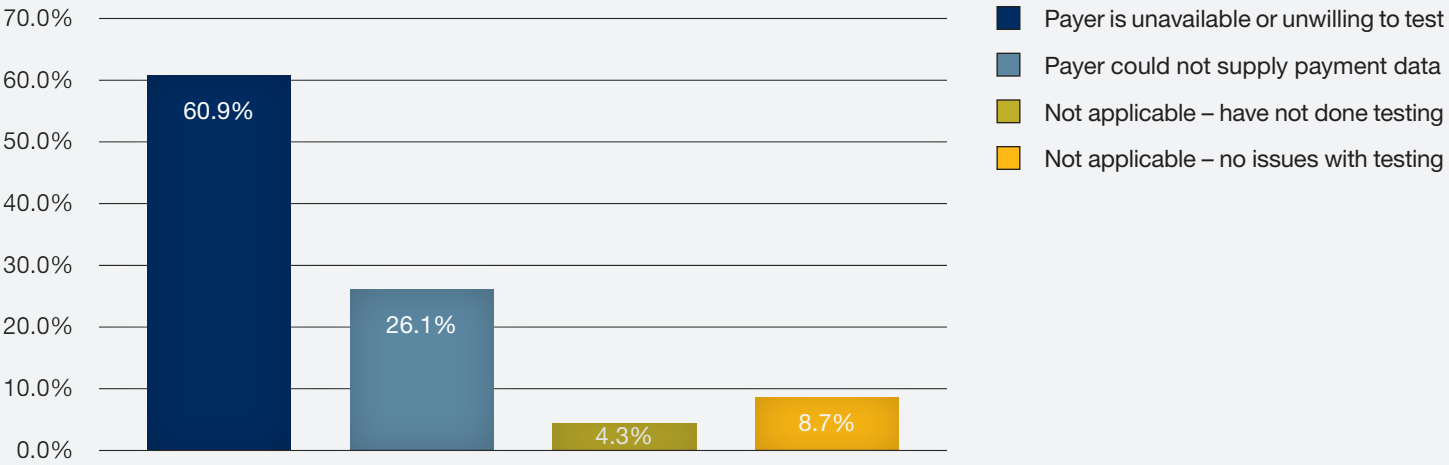


Exhibit 8: Percentage of Commercial Payers Ready for ICD-10

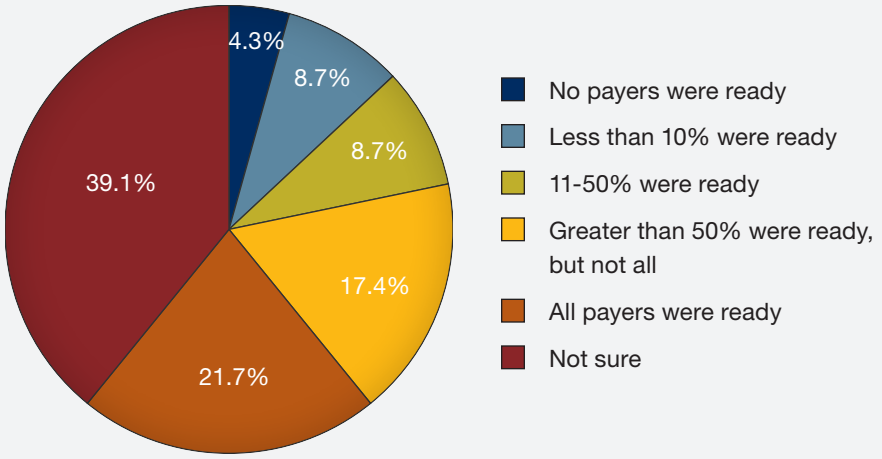
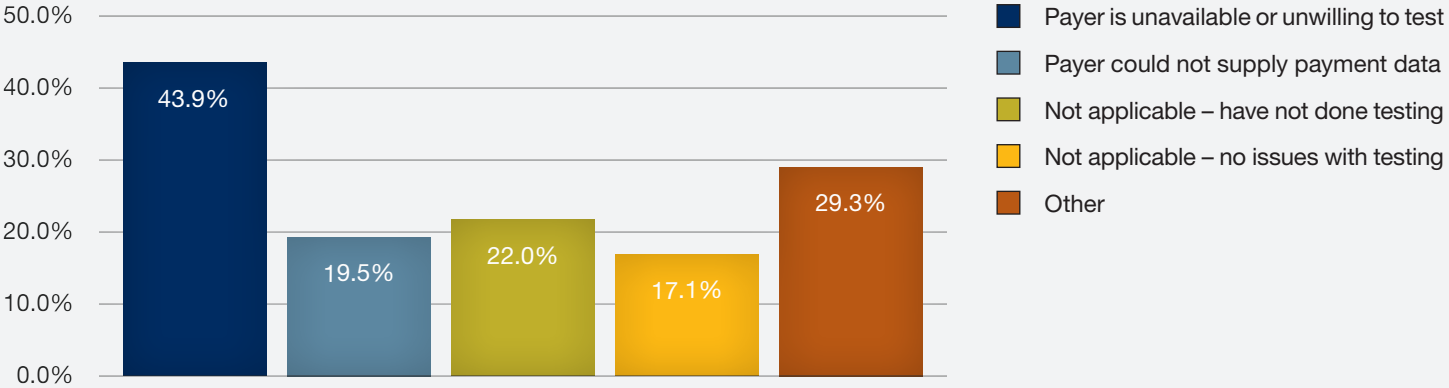


Exhibit 9: Issues That Have Arisen in Conducting Testing With Commercial Payers



Cash Flow and Reimbursement

The next series of survey questions explored cash flow and reimbursement considerations. When asked whether their organizations expect reductions in cash flow from commercial payers, the majority of respondents were not certain. However, 29.2 percent of respondents indicated an expected cash flow reduction of 5 percent or more, half of the respondents indicated the reduction would be more than 10 percent, and many respondents were unable to predict a specific cash flow reduction (see Exhibit 10).

Of the 46 percent of respondents who were able to provide an estimate for cash flow reductions, only 11 percent noted that one commercial payer comprises more than 50 percent of the anticipated reduction. Most of the respondents who expected reductions in cash flow anticipated that these reductions will occur in October through December 2015. Of those who indicated they expect cash flow reductions, only three respondents, or 15.8 percent, expected those reductions to continue beyond January 2016.

The survey also asked how organizations anticipate mitigating the risk of reduced cash flow. About 46 percent of respondents said they expect their organizations to use reserves to address cash flow reductions, as depicted in Exhibit 11.

Forty-six percent of respondents indicated that payer contracts address cash flow interruptions and the timing and amount of gap payments. Gap payments, as used in the survey, pertain to differences between expected reimbursement per the health system's information system and the amount actually paid by the payer. Should payer denials increase or adjudication periods increase, providers may seek additional cash from the payers in the form of gap payments until the payer adjudication returns to "normal." Gap payments typically are anticipated when a payer implements a new payment system, and the payer adjudication rates are reduced until the processing returns to normal volumes. Many respondents indicated they are unsure whether payer contracts address this element or that the analysis and research of the issue is still in process. Several respondents said their organizations are addressing this risk individually with payers.

Forty-one percent of respondents said their organizations have analyzed managed care contracts to determine ICD-10 impact on reimbursement calculations, while another 22 percent said they plan to perform such an analysis. A significant risk in this area is whether documentation will be sufficient to assign the most appropriate code. Training for front-line caregivers is essential to help ensure that the encounter acuity is documented properly and thus coded at the appropriate level. Front-line caregivers must understand the significance of complete and proper care delivery documentation so that coding staff has ample information to code the claim properly.

The survey also addressed whether organizations had been successful in renegotiating contracts, if necessary, or in creating neutrality agreements with payers. While many respondents said they are uncertain whether they are at risk regarding payer contracts and gap payments or if their organizations had chosen not to renegotiate with payers, 34.2 percent said they have successfully negotiated new contracts, are pursuing contract revisions, or have augmented existing contracts through neutrality agreements to mitigate payer reimbursement cash flow risks. Some organizations still are in the process of addressing payer contracts. Exhibit 12 depicts these responses.

Exhibit 10: Expected Cash Flow Reductions From Commercial Payers

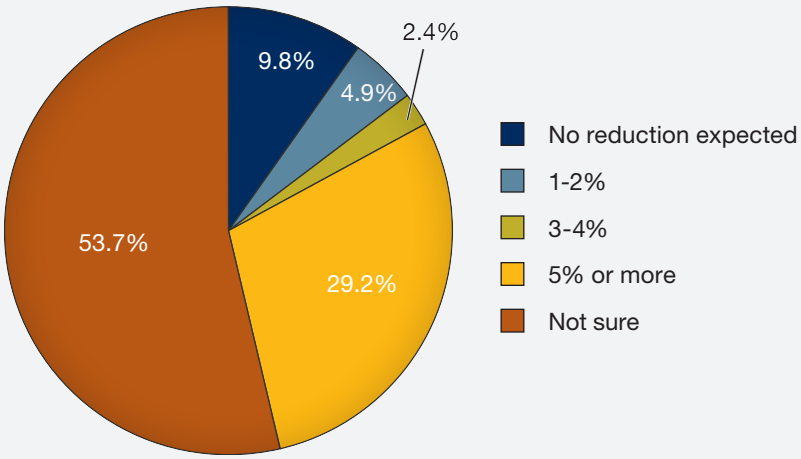


Exhibit 11: Mitigation of Reduced Cash Flow

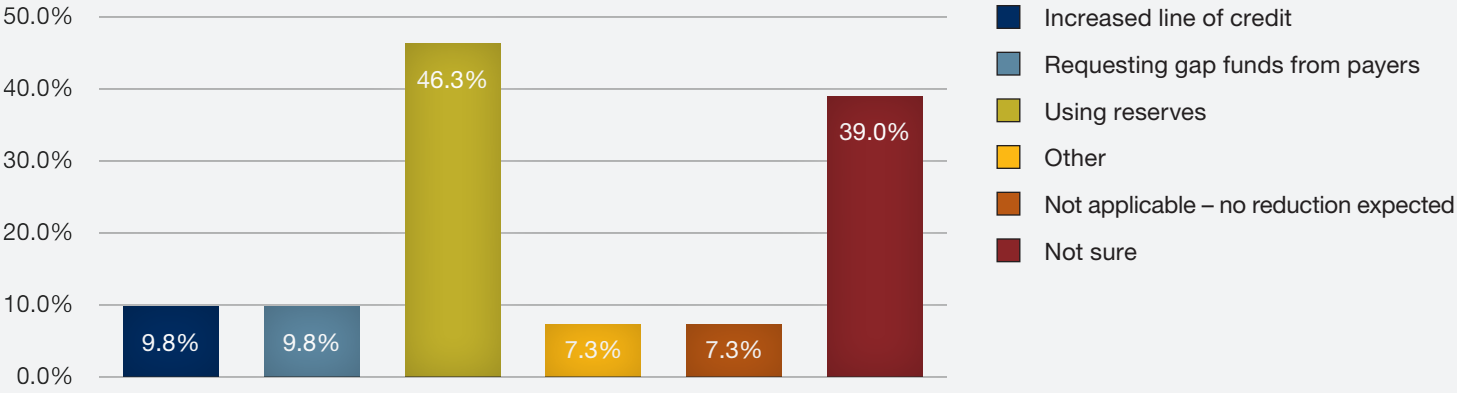
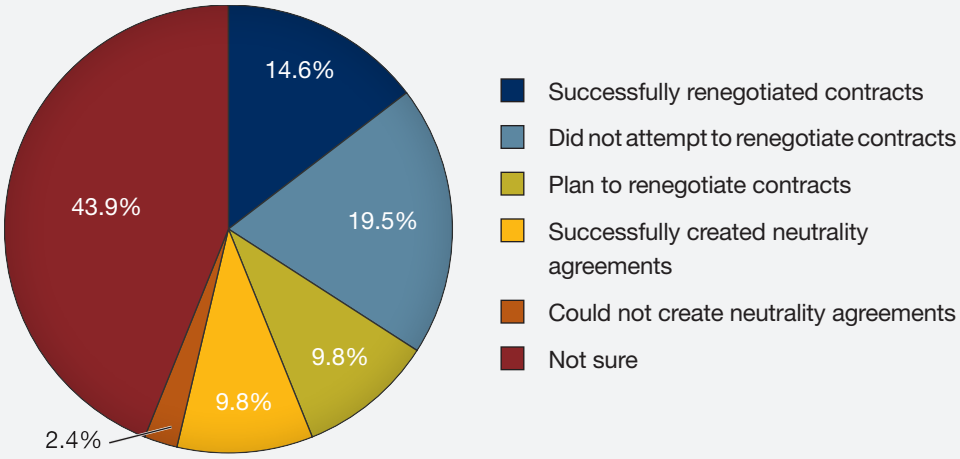


Exhibit 12: Success of Organization in Renegotiating Contracts to Reduce ICD-10 Risks or in Creating Reimbursement and Production Cost "Neutrality" Agreements



The final question in this section addressed any anticipated diagnosis-related-group (DRG) shifts that might affect revenue. Nearly 37 percent of respondents said they do anticipate a shift, while the majority were uncertain or had not yet completed an analysis (see Exhibit 13). The survey requested percentage increases or decreases in revenue for those respondents who said they anticipate a DRG shift. The percentages provided vary widely, ranging from a decrease of 12 percent to an increase of 6 percent.

Other Transition Activities

The next series of questions focused on a variety of topics pertaining to the ICD-10 transition.

Purchase of software. Thirty-nine percent of respondents said their organizations purchased and implemented new software to become ICD-10 compliant, while 46 percent did not. The remainder was uncertain. While no trends in software purchased were apparent, the addition of computer-assisted coding was noted in several cases.

Key performance indicators (KPIs). While 12.2 percent of respondents said their organizations had not established KPIs to monitor during the transition, the majority said they have identified certain KPIs to track. The most common was days in accounts receivable, followed by coder productivity rates, denial rates, and discharged not final billed. Responses are depicted in Exhibit 14.

Resources. The survey also addressed areas where organizations would be adding resources during the ICD-10 transition. Almost 83 percent of respondents said their organizations plan to add coding resources, with 41.5 percent adding clinical documentation improvement resources and 41.5 percent adding computer-assisted coding. See Exhibit 15 for responses. Comments regarding other areas where resources will be increased included training (primarily of physicians), patient access, business offices, and data analytics. Planning ahead for resource needs is critical, as the market for coding talent will be highly competitive in the fall.

Dual coding and physician queries. Eighty-eight percent of respondents indicated that pre-transition activities include dual coding in ICD-10, while 54 percent indicated physician queries in ICD-10 are part of the preparation effort.

Performance reports and analytics. Most respondents said they are uncertain how performance reports and analytics will be handled for the first quarter of ICD-10 implementation, indicating this should be an area of focus as final preparation efforts are made.

ICD-10 affects much more than reimbursement. In today's healthcare environment dictated by outcomes, evidence, accountability, and value-based purchasing, ICD-10 is a significant component in providing an accurate picture of the risk, complexity, and severity of the patient condition. ICD-10 data affects everything from quality reporting to decision-support systems, from clinical tracking via trauma and cardiac registries to population health management. Because ICD-10 is essential to reporting throughout the organization, healthcare organizations need to identify how various reporting mechanisms will be affected and how changes in reporting will be addressed. Eighteen percent of respondents said their organizations plan to create reporting with ICD-10 data and map it for comparison with prior ICD-9 data, while 15 percent said they plan to prepare reporting using dual coding. Ten percent said they plan to create reporting with ICD-10, providing no comparative information.

Exhibit 13: Anticipation of Any Shift in DRG That Will Affect Revenue

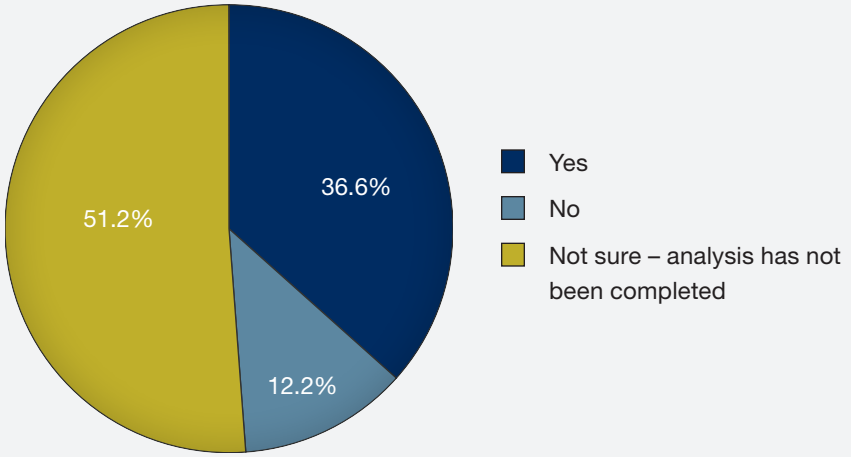


Exhibit 14: Key Performance Indicators

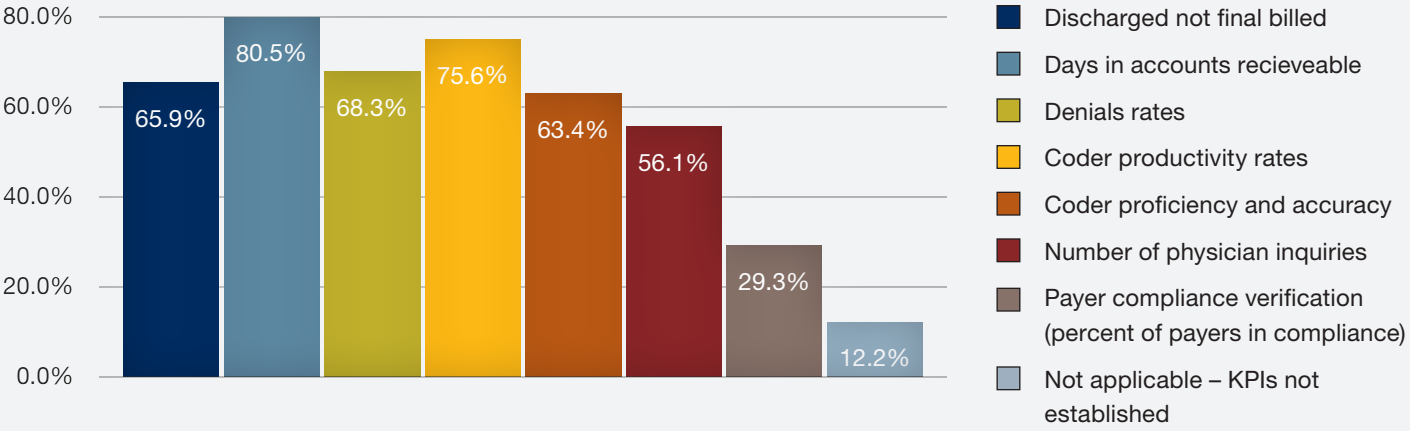
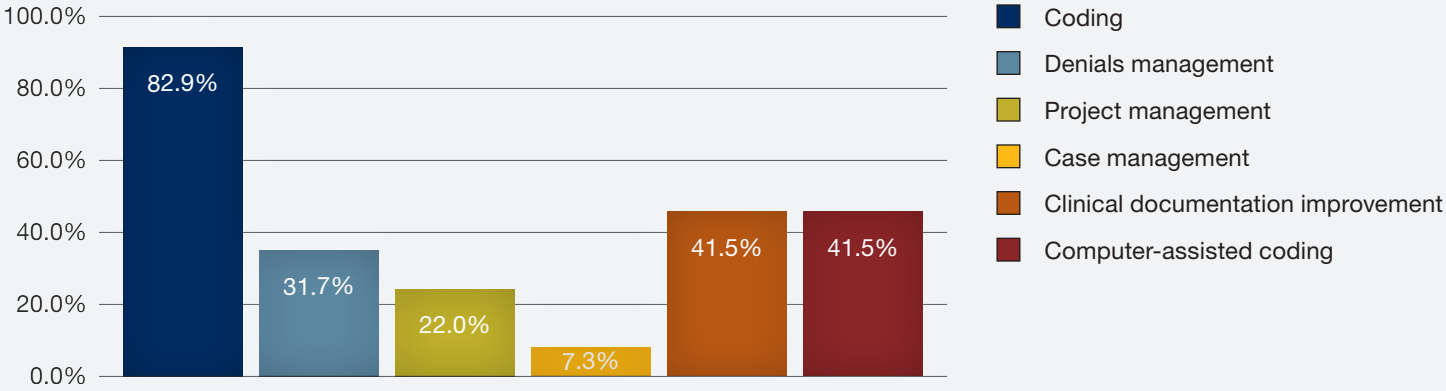


Exhibit 15: Addition of Resources During ICD-10 Transition



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Barriers to Success

The most frequently mentioned barriers to success include these:

- **Physician documentation.** Weaknesses in clinical documentation could affect proper code selection and thus reimbursement. Opportunities exist to engage physicians and further improve the focus on clinical documentation.
- **Training, particularly of physicians.** As with any major health system initiative, caregivers are stretched between the need to support implementation and the need to continue to provide high-quality care. As a result, it is difficult for caregivers to find the necessary time for critical training.
- **Payer readiness.** Several respondents expressed concerns that payers will not be ready or will have varying degrees of readiness. Not knowing the challenges that each of their payers faces causes uncertainty.
- **Resources and competing priorities.** Other marketplace or systems-implementation activities create a distraction, affecting the focus on ICD-10 readiness.
- **Denial management.** Increases in ICD-10-related denials and the management of the denial rates will pose a challenge. Our survey results indicate that 835 payment transactions are to be tested at a later date, which could mean that electronic explanation of benefits or remittance advice detail may not be adequate to explain denied claims.

Key Takeaways for Internal Audit

Leading up to implementation, internal auditors can assist leadership through evaluating processes in place to achieve a successful transition to ICD-10.

- Consider sharing the results of this survey with the ICD-10 leadership team so they can benchmark their progress to date.
- Remain diligent in completing testing with payers and following up on issues identified.
- Assess how performance reports and analytics that management relies upon for decision-making will be handled. End users should be prepared for a lack of comparative information if dual coding will not occur.
- Determine if communications are occurring with everyone affected by ICD-10 so they will know what to expect and so that issues encountered by staff will more quickly reach the appropriate parties for resolution.
- Be ready to monitor the impact of ICD-10 on reimbursement and denials. After the implementation deadline, this information will be critical to assess the financial impact.

CHAN Healthcare and AHIA are grateful to the 41 individuals who took the time to complete the ICD-10 survey to share this valuable information with peer organizations.

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