Centers for Medicare & Medicaid Services
Preparing for ICD-10 Implementation in 2011 National Provider Teleconference
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Implementation Strategies for 2011 – Sue Bowman, AHIMA

Leah Nguyen: Our next speaker is Sue Bowman, Director of Coding Policy and Compliance
at the American Health Information Management Association or AHIMA.
Sue will be speaking with us today in her role as one of the ICD-10-CM
Cooperating Parties. The Cooperating Parties represent a longstanding public
and private sector partnership with AHIMA, CMS, the American Hospital
Association and the Centers for Disease Control and Prevention.

Please note that CMS does not endorse outside organizations' materials or
activities. I now turn the call over to Sue.

Sue Bowman: Thank you, and I'll start on slide 30. I know that many of you are very
familiar with the differences between ICD-9 and ICD-10. But for those of
you who may not and for a little refresher, I thought we would just start very
briefly with a description of the difference in the structure between the two
code sets.

So for ICD-10-CM, the codes are three to seven characters long, whereas we
all know they were only up to five characters in ICD-9. The character one in
ICD-10-CM is always alpha. All the letters except U are used. Character two
is numeric. Characters three through seven can be alpha or numeric.

Just as in ICD-9-CM there is a decimal after three characters. ICD-10-CM
also uses a new concept called a dummy placeholder of X to conserve space to
allow future expansion in some code categories. And the alpha characters are
not case sensitive, meaning that a lowercase letter and an upper case letter do
not have different meanings, they have the same meaning.

On slide 31, just a brief description of the differences between ICD-10-PCS and ICD-9-CM is that as you can see PCS is a much longer code, much more room for expansion and for specificity than we currently have in ICD-9 procedure codes. And every code in PCS always has exactly seven characters.

Each character can be either alpha or numeric. The numbers zero through nine and the letters A through H, J through N and P through Z are used. The letters I and O are not used. Alpha characters again are not case sensitive. As I said, each code must have seven characters. And there is no decimal in 10-PCS. So that's just a little brief background to set the stage for some of the differences in the code set that have to be taken into consideration as we get into implementation planning.

Now on slide 32, as I'm sure many of you have already realized, the transition to ICD-10 presents many opportunities as well as challenges. The scope and complexity of the transition are very significant, coded data are more widely used now than when the U.S. transitioned to ICD-9 almost 30 years ago.

And given all of the places where ICD-9 codes appear or are used in some way, the transition to ICD-10 requires extensive changes that will affect many systems, processes and people. So a key takeaway message from today's session is the absolutely critical importance of not delaying in getting this implementation process started.

A smooth, successful transition by the compliance date of October 1, 2013, requires a very well planned and well managed implementation process. An organization that has planned their implementation strategy carefully and thoroughly and begun the planning process early can expect a smoother transition and earlier realization of benefits from moving to ICD-10.

The implementation planning and preparation process can be thought of as being broken down into several phases. The first phase, which is the one I'm going to focus on mostly today is implementation plan development and impact assessment. And ideally this phase should be nearing completion or at least well underway.

So for those of you who may not have gotten started yet or have just barely gotten started, I urge you to move forward with this phase as quickly as possible. As I'll explain as we talk through some of the steps in this phase, it's critically important to start this phase quickly because it will set the stage for how much work and how much time is necessary for the steps that need to be done in the subsequent phases.

In other words until you know the scope of the impact of ICD-10 in your organization, you don't know how much time and resources are going to be needed to complete the preparation activities. So you don't want to wait too long before making that assessment.

Phase 2 is the implementation preparation phase. It can be thought of as putting into action the tasks for implementation that are identified in Phase 1. Phase 3 is the go-live preparation immediately prior to the compliance state. Phase 4 is actually post-implementation. After October 1, 2013, there will still be follow-up activities, problem resolution and so forth that need to be done.

And these phases are not mutually exclusive timelines. They will very likely overlap. On slide 34, it's sort of a suggested timeline for the different phases with the first phase really having begun once the ICD-10 final rule was issued. I should point out that the quarters referenced in these dates refer to calendar year quarters.

So, for example, first quarter 2011 is referring to January to March of 2011, just for clarification. These dates are only a general guideline. The timeline for the implementation plan development and impact assessment, implementation preparation and go-live preparation will likely be variable to a number of – due to a number of factors including the type, size and complexity of the organization.

However, as I mentioned completion of the impact assessment early is critically important because without the impact assessment an organization cannot reasonably predict the length of time or the amount of resources that are going to be required for the implementation preparation and go-live phases and, therefore, can't plan an accurate timeline or budget for the work involved.

So delayed completion of this impact assessment phase will jeopardize an organization's ability to complete all of the ICD-10 implementation tasks by the compliance dates which will risk increased claim rejections and payment delays.

On slide 35, as I said we're going to focus today on the major steps that need to be done in Phase 1 to help those of you who may be struggling with getting started to understand what these steps are and how to move forward with this planning phase. A key first step is establishing an interdisciplinary steering committee to develop the ICD-10 implementation strategy for your organization and oversee the implementation process.

Essentially this committee will be responsible for overseeing all of the steps in the ICD-10 transition process. Membership on this committee should include representatives from the various business areas impacted by the ICD-10 transition. Now note that in a small organization such as a physician practice or a clinic this committee might just be a couple of people. But it is still some designated people who are responsible for overseeing and managing the transition process.

The steering committee is charged with formulating transition strategies and identifying the goals and this will include development of the organization's ICD-10 implementation strategy and identifying the actions, people responsible and deadlines for the various tasks required to complete the transition.

And ICD-10 awareness education should also be provided to key stakeholders that are identified by the steering committee and I'll talk about this in more detail a little bit later in the presentation.

Change management strategies need to be implemented to empower the stakeholders to accept and embrace the transition to ICD-10 and this is a key step in this phase to overcome resistance to change, get everyone on board and make everybody feel like they're part of the process for moving forward and not resentful of it.

Also during Phase 1 the key ICD-10 transition tasks and objectives should be identified. Next, on slide 37, a detailed project plan should be developed. That includes an internal implementation timeline and specifying the resources required to complete the various identified tasks, articulating all of the stakeholder's roles and responsibilities and spelling out the transition tasks, deadlines and responsible individuals, essentially all of the normal steps that would be part of developing a plan for any large project.

I had mentioned earlier that ICD-10 awareness education should be provided, and this is basically to alert the various key department heads and managers and senior executives throughout your organization about the transition to ICD-10 and some key information that they need to understand in order to move forward with this project.

So, for example, senior management information technology personnel, key department managers, the medical staff need some education on what is the ICD-10 regulatory requirement, the information that Pat presented earlier, what is the value of going to these new code sets. In other words why are we doing this?

What do we hope to accomplish in the end? How does ICD-10 fit with other internal and external initiatives and just some of the overall key differences between the ICD-9 and the ICD-10 code sets and also between ICD-10-CM and ICD-10-PCS?

In addition to educating the medical staff on the general regulatory requirements, the value of the new code sets and how ICD-10 fits with other initiatives. They also need to be made aware of the impact of ICD-10 on their documentation practices.

Coders and other health information management professionals need to begin to become familiar with the structure, organization and unique features of ICD-10-CM and/or ICD-10-PCS, depending on their setting as Pat explained earlier—who's going to implement which system. Only coders in hospital

inpatient settings will need to learn about ICD-10-PCS, whereas coders in all settings will need to become familiar with ICD-10-CM.

Note that the level of education I'm talking about here, this familiarity with the code sets is not the same as the intensive education on actually learning to code with 10-CM and 10-PCS. That needs to be provided closer to implementation and that I'll touch on a little bit later.

Also note that when I refer to coders throughout this presentation this really encompasses anyone who will be doing the actual coding of encounters or services such as physicians who may do their own coding or office managers or other personnel who aren't necessarily called coders but are serving in the capacity of the coder.

If they're doing the coding of an encounter and that's part of their responsibility or what they do, then the timelines we're talking about here for the kind of education coders need to have and when that needs to occur applies to those individuals as well.

Next in Phase 1 needs to be an assessment of the organizational readiness for the transition. This is a big area, a big chunk of the Phase l activities. This includes things like identification of the affected business areas and individuals, identification of all of the affected systems, applications, databases, consideration of current and future organizational plans and acquisitions such as mergers, purchases of physician practices or healthcare facilities, impact on all of the operational processes that currently use ICD-9-CM codes needs to be analyzed as well as those processes for which ICD-10–CM or ICD-10-PCS codes are intended to be used in the future.

In other words where is ICD-9 today and where might those ICD codes need to be used in the future? The impact on documentation processes and work flow needs to be assessed. And you should evaluate the current data flow, work flows and operation processes to identify those impacted by the ICD-10 transition and determine areas where you can make improvements in those processes.

In other words you may not want to just convert all your current processes to ICD-10. You may look at the processes and see that there are some areas that can be improved and made more efficient, and while you're doing the ICD-10 conversion would be a great opportunity to do that. And, as I mentioned earlier, delayed completion of the impact assessment will jeopardize the ability to complete all of the ICD-10 implementation tasks by the compliance date.

So it's critically important to get started on this step if you haven't already done so. Other steps in this area include identifying all of the reports and forms requiring modification for ICD-10, any policies and procedures that need to be developed or revised, and looking at the status of the readiness of your business associates.

This would include people like the systems vendors, payers, other providers that you do business with and communicating with them to see their progress towards ICD-10 preparedness and understand when they expect to be ready for testing. And one point I'd just like to make about this whole impact assessment area is that a lot of organizations we've talked to have indicated a surprise that all of the areas within their organization that they have found are impacted by ICD-10.

I haven't talked to anybody yet who dug into this and discovered that really ICD codes are not used as extensively or infiltrated throughout their organization as much as they expected. Most people are finding that you would be very surprised at some of the places that are impacted by the transition. And so this project is bigger than they expected and so the earlier you understand that, so that you've allowed sufficient time to actually make the changes, the better off you'll be and the more prepared you'll be for the compliance date.

All of the internal and external recording processes that might be impacted need to be identified. These include processes such as registries, quality measures, state data reporting requirements, the impact on coding and billing productivity needs to be assessed, such as figuring out how long it's going to take for coders to achieve proficiency in ICD-10 coding and what the impact

of that learning curve will be on the quality of data due to a temporary decrease in coding accuracy during the learning curve.

The length of this learning curve and the impact on data quality is expected to be less for ICD-10-CM than for ICD-10-PCS due to the similarities to ICD-9-CM . But certainly in both systems there's going to be a learning curve for coders to become proficient in the new systems. ICD-10 implementation experience in other countries has shown that an initial productivity declines should be expected with a gradual improvement over three to six months.

Implementation variables that can affect productivity are the amount and level of dedicated preparation, program management, interdisciplinary team participation, extent of coder education and credentials, coder experience and understanding of anatomy and disease processes, extensive training, documentation status and organizational size and complexity. You also need to start to asking your vendors about their readiness and timeliness for upgrading the software.

For example some of the questions to ask vendors include what systems upgrades are replacements are needed to accommodate ICD-10? What costs are involved and will upgrades be covered by existing contracts? If not, what will be the projected cost and when will the cost be incurred? When will upgrades or replacement systems be available for testing and implementation? What customer support and training will be provided?

And how will their products and services accommodate both ICD-9 and ICD-10 as you work with claims provided both before and after October 1, 2013? The information technology personnel need to be oriented on the code set specifications and pertinent regulatory requirements including the logic and hierarchical structure of ICD-10-CM and ICD-10-PCS.

Some of the things to consider here include the fact that the compliance date is date of service driven. Remember as you look at the different data fields where ICD-10-CM will be a factor and where ICD-10-PCS will be a factor. For example outpatient procedure code fields will not be affected because they will still contain CPT codes. Facility-wide systems audit needs to be

performed which means inventorying all of the systems applications and databases using ICD-9-CM codes.

And this can be a big job if you have a lot of systems. Some of the things to consider here are how many systems will be affected and what types of systems will be – systems changes will be made? Is the system developed and maintained in house or by an outside vendor? Is an application service provider used for any of the applications? How are ICD-9-CM codes used in each system? Where do ICD-9-CM codes originate from? How is the quality of data in the system checked?

A detailed analysis of all of the system changes that need to be made will need to be performed. And then the system changes need to be prioritized and the costs of making these changes estimated. The electronic data flow needs to be mapped to inventory all of the reports that contain ICD-9 codes. For example, who is using these reports?

Are these reports even still needed? Is anybody even reading them? Do the reports contain the information users really need and are completely new or modified reports needed instead?

Again, as I said, this is an opportunity to look at all of the processes and reports that are currently in existence and make sure that what you're producing and what you continue to do is really the best way to go for the organization.

On the next slide, slide 45 – there is a list of some of the systems and applications potentially affected by the transition to ICD-10. This is certainly not an all-inclusive list, but gives you an idea of the scope of the task that you're facing. You need to determine, as part of the overall systems impact, how long both ICD-9-CM – ICD-10 codes will need to be supported, and if system storage capacity will need to be increased.

Will any upgraded or new hardware or software be needed? And be sure you consider any systems currently under development to make sure that it's flexible enough to ensure compatibility with ICD-10. On slide 47, moving

into the coding area of this impact assessment and implementation planning – a gap analysis of coding and documentation practices should be conducted.

This means starting now to measure the coder's baseline knowledge of anatomy, physiology, pharmacology and medical terminology, so that education can be targeted at the areas of identified weaknesses. And, measuring the coder's baseline knowledge now will shorten the learning curve, improve the coding accuracy and productivity, and accelerate the ultimate realization of benefits from moving to ICD-10.

This step involves assessing the coder's knowledge in all of the biomedical sciences, as I mentioned, and then providing any additional training as needed, based on the assessment results. So this is the type of training that can be done now – that doesn't have to wait until the intensive coder training closer to implementation, where you can make sure that the coders are adequately prepared with the expertise in the biomedical sciences arena well before ICD-10 is implemented.

The quality of medical record documentation needs to be assessed and this can involve evaluating samples of various types of medical records to determine whether the documentation supports the level of detail found in ICD-10. And then, documentation improvement strategies can be implemented to address areas where documentation is found to be lacking.

Changes in documentation capture processes might be considered, such as prompts from electronic health records systems to help facilitate improvements in documentation practices. And it helps in this step to designate a physician champion to assist in medical staff education and promote the positive aspects of moving to ICD-10.

And, as Pat mentioned earlier, keep in mind that there will still be unspecified codes available, so the goal here is not to eliminate the use of all unspecified codes – there are times when even the clinician doesn't have the information necessary about the disease process in order to assign a more specific code.

But the goal here is to ensure the medical record documentation is as good as it can be to support the greater specificity in the ICD-10 code sets to the absolute extent possible, and it's best to do that early on, rather than wait for implementation, and then deal with a lot of issues with the documentation at the same time that ICD-10 is also being used – better to have the documentation already improved up front and ready to go when the compliance date arrives.

The training needs need to be assessed, and this isn't just coders. Multiple categories of users of coded data are going to require varying types and levels of ICD-10 education and it's going to be needed at different times. Different people will need different training at a different point in time between now and the compliance date, so you need to determine, who's going to need education in your organization?

What type and level of education do they need, based on their role? And when that education needs to occur – what is the most appropriate and cost-effective method of providing the education to these different categories of individuals? Such as, traditional face-to-face classroom teaching, audio conferences, self-directed learning programs, web-based instruction, et cetera.

Will this education be provided through internal or external mechanisms, or a combination of both? And, of course, the same method of training doesn't need to be used for every group that requires training. Different groups may benefit from different styles and methodologies of training.

On slide 50, as I mentioned earlier, now is not the time to provide intensive coder training, meaning the training to teach people how to learn to code with the system. We recommend that that not be provided until six to nine months prior to implementation – and the main reason for that is, if coders are trained now and they're not using that training until, of course, October 2013, they're going to lose a lot of that knowledge in that interim.

So, while they need to become familiar with the code sets – understand the differences in the systems, some of the key issues involved with coding with ICD-10 – it's really not the time now to provide that intensive training.

When it is time to provide the intensive training, it's expected that – for budgetary purposes – to consider two full days of ICD-10-CM training for those who just need ICD-10-CM and not ICD-10-PCS because ICD-10-PCS is so completely different from ICD-9-CM, it will require more training that ICD-10-CM and, as was stated in the ICD-10 final rule, it's anticipated that approximately 50 hours will be needed to fully train hospital inpatient coders on both ICD-10-CM and ICD-10-PCS .

Slide 51 provides some examples of some of the categories of individuals within your organization that may need some level of ICD-10 knowledge, not necessarily intensive coder education, like the coders will need, but some level of knowledge about the ICD-10 code set in order to understand that the data that they are using in their particular position.

Part of Phase 1 is also developing an ICD-10 budget. This involves identifying all of the ICD-10 transition expenses and estimating if there are associated costs, such as software modification, education, hardware and software upgrades, staff time, temporary or contract staffing to assist with increased work resulting from the transition, such as coding and billing backlogs, IT support, or review of coding accuracy.

The amount of anticipated cost for the ICD-10 transition is dependent on the size and complexity of the organization, as well as the degree of system integration, the need for outside technical assistance, and the number of systems, applications and interfaces that need to be updated. The largest budgetary expenses, however, are generally for the systems upgrades and education.

Other possible transition expenses include consulting services, report redesign or development of new reports, reprinting of paper forms, conversion of data, and additional software or other tools and resources to facilitate the ICD-10 transition or improve operational processes.

And, as part of this process, you need to identify the departmental budgets that will be responsible for each transition cost, including the systems changes –

hardware, software upgrades, and education – where the budget for that is going to appear. So that was really the focus on Phase 1, which was, in a nutshell, assessing the impact, discussing the scope within your organization of what needs to be done to prepare for ICD-10.

Just briefly, I'll touch on Phase 2, implementation preparation, which should ideally start about now or very shortly, and essentially involves completing the tasks that were identified during Phase 1, including implementation of system changes, making the actual changes in policies and procedures, reports and forms that were identified in Phase 1 or developing any new reports, providing education to those categories of individuals I mentioned earlier once you've identified who needs training and when, then some of those groups whose training needs to occur earlier, rather than later, may need to begun – may need to be started during this time period.

Also, as part of Phase 2 – is implementing the documentation improvement strategies that were identified in Phase 1, and continuing to monitor the documentation improvement and making further changes as necessary – completing the internal testing and validation of system changes occurring sort of later on in Phase 2, and then, once systems, vendors, payers, or other business associates are ready for testing, to begin the testing process.

The assessment of medical records documentation and implementing improvement strategies is kind of an ongoing step that appears in every Phase – is sort of never done – you just keep trying to improve it more and more as time goes on. The coding staff should continue to increase familiarity with the ICD-10 code sets, and education on the biomedical sciences and pharmacologies should continue to be provided as identified during the knowledge gap analysis that was done during Phase 1.

Continue to regularly follow up on the readiness status of business associates. Refine the project, a timeline and budget as needed as you go along and as you learn more about the steps and the process and the costs. And also in Phase 2 start developing a contingency plan for continuing operations if critical systems issues or other problems occur when ICD-10 implementation goes live.

Now some of the consequences of not planning well for ICD-10 include things such as increased claims rejections and denials, increased delays in processing authorizations and reimbursement claims, improper claims payment coding backlogs, compliance issues, end decisions based on inaccurate data. But many of these potential problems, in fact all of the potential problems can really be mitigated through proper planning and preparations.

On slide 59 I've just given you some examples of some of the resources that are available on the AHIMA ICD-10 Web page. Many of these resources are free. One of – a couple of the key things on there is the ICD-10 Preparation Checklist which these phases are based on that I just described. And that checklist is actually currently undergoing a revision and the revision should be posted soon.

There are also role-based implementation models for different categories of people including inpatient and outpatient coders, data managers, academic educators and students as well as payers that provide a timeline over the next several years for key tasks for those groups, and there are more role-based implementation models being developed. But those are also freely available.