OPTUM™

Executive Report

Making the Health System Work Better for Everyone: The ICD-10 Collaboration Imperative

By now, the basic elements of the regulatory change from medical classification version ICD-9 to ICD-10 have been recited over and over again. Research shows the conversion will pose an enormous challenge to health care organizations, and while the Department of Health and Human Services has announced its intent to delay the ICD-10 implementation deadline for certain entities, most organizations have already begun their work in earnest.

Everyone in the health business is talking about ICD-10. But what's almost never talked about—or perhaps is only whispered—is that if ICD-10 is to be successful, health care organizations need to do more than change their processes, technologies, and systems. They need to focus on something far more important and far more difficult to change: their attitude toward collaboration with their partners.

Here's why: for ICD-10 to be successful, collaboration is a prerequisite—and collaboration does not come naturally in the health care industry. In fact, if historical precedent teaches us anything, it's that the chance of a *natural* collaboration on the ICD-10 transition is remote. The relationship between payers, providers, and federal and state agencies has often been strained, if not adversarial. To be successful with ICD-10, these stakeholders will need to put aside years—maybe decades—of history and start working together.

In February 2012, HHS announced its intent to delay the ICD-10 compliance date by one year—from October 1, 2013 to October 1, 2014. The normal rule-making process is now in progress, and we are likely to have a final decision on the date sometime later in 2012.

What's at Stake?

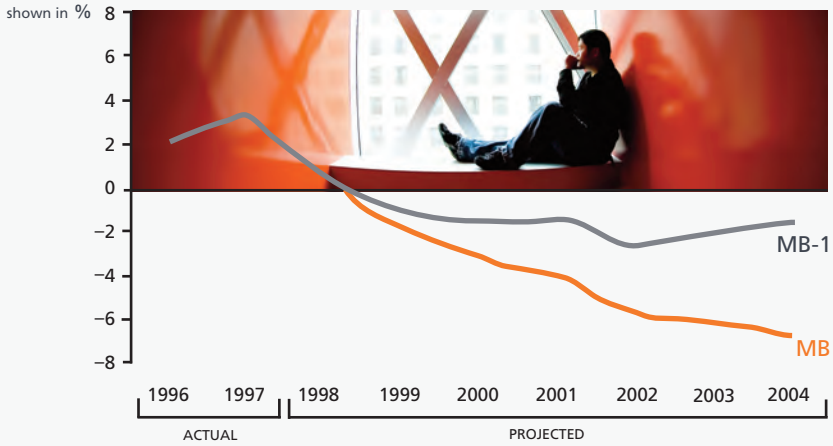
The regulatory change from ICD-9 to ICD-10 coding will have a significant impact on most of the aspects of an organization's operation—and, more broadly, across a wide spectrum of health system partners that share processes and systems. Those affected range from individual providers to large-scale health care delivery systems, to commercial payers and government health care entities such as Medicare and Medicaid—all of them connected to each other via a complex network of systems and processes.

The mere scope of the switch can seem formidable: health care providers, commercial payers, and government agencies will need to modify *every* system that holds, transmits, or analyzes health data. Every record, business rule, and application that currently uses ICD-9 codes will have to be revised or replaced, and every employee retrained. And if that isn't daunting enough, consider the potential impacts throughout the health system. One need only look to historical precedent to understand, for instance, how noncompliance by one single trading partner—or lack of collaboration and agreement on how a transition will be handled—can have far-reaching implications. Such implications could directly affect patient care, payments, and reimbursements and could cause other kinds of disruptions that could generate both direct and associated costs.

Consider for a moment the wide-ranging, systemic impact that the Balanced Budget Act of 1997 (BBA) had on the health care industry. Even though the BBA called for reductions in Medicare spending spread out over several years, according to the American Hospital Association (AHA), by 1999 "many providers were already feeling the pinch." A few years into implementation of the act, the AHA was predicting that the act would have more impact on the financial performance of hospitals than had been anticipated by the government. In an AHA report, the organization found a historical precedence of having payment shortfalls in Medicare, Medicaid, and uncompensated care covered by private payers.

Hospital Medicare margins could drop to negative 6.6% depending on cost growth.

Figure 1 Actual and projected post-BBA total Medicare margins



Source: The Lewin Group, February 2000

In subsequent years, those potential impacts became very real, especially in terms of patient outcomes. A study published by the National Bureau of Economic Research revealed that from 2001 to 2005, hospitals that had faced large payment cuts because of the BBA had increased mortality rates compared with hospitals facing small cuts.

The ICD-10 transition represents industry change with extensive, systemic impact across the health care value chain. Because of the tightly connected processes and critical areas of intersection across payers, providers, and government agencies, joint planning is imperative for all parties to reach ICD-10 compliance. However, while the importance of collaboration may seem intuitive, it's no secret that the relationships between payers, providers, and federal and state agencies have often been strained, if not downright adversarial. In fact, if historical precedent teaches us anything, it's that the chance of a natural collaboration on the ICD-10 transition seems remote.

In a recent survey of providers' attitudes toward collaboration, only half of the responding providers strongly agreed that collaboration with payers was "important to my organization." Providers also described significant challenges to fostering such collaboration. For instance, more than 80 percent of respondents said the complexity of collaborative business models was a "difficult" or "very difficult" challenge to overcome. The majority also cited other collaboration obstacles as equally difficult to overcome: protracted return-on-investment time frames, technical/data integration, sustaining a collaborative relationship over time, overcoming traditional cultural differences, prioritizing the right collaboration opportunities, finding the right partners, and lack of urgency to change.[1]

Anecdotal feedback suggests the scope of the collaboration challenge should not be underestimated. In a recent Optum executive discussion, one hospital's chief information officer (CIO) described the challenge this way: "It's so complex just getting everyone in our own organization engaged, collaborating, and willing to change—never mind managing across our partner organizations." The CIO identified 70 different vendor systems that require review/update/collaboration in addition to the systems that reside within the two hospitals, the clinics, and the physician offices that make up his network.

With such a sizable scope, the different stakeholders involved in health care must recognize that their own success in transitioning to ICD-10 is naturally constrained by the organizations with which they do business, and as such, collaboration is imperative. Failure to collaborate will increase the cost of business for all parties. Simply consider the resources for checks and balances and administration that will have to be put in place to ensure transactions are being coded and reimbursed properly. An adversarial relationship will take more resources and more energy to monitor the process than one in which objectives are aligned and all parties can trust that they're being treated fairly based on contracts and reimbursements.

This paper explores the risks associated with ICD-10 implementation, explains the necessity for parties across the health system to collaborate in preparation for the change, and describes how organizations must modify remediation plans to ensure the needed collaboration occurs.

Anecdotal feedback suggests the scope of the collaboration challenge should not be underestimated.

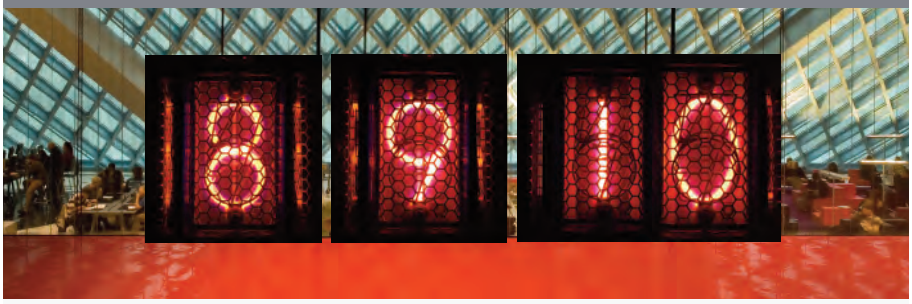
What Does the "Transition" Mean?

The procedure codes contained in the ICD-10-CM (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)) do not constitute simply an expansion or refinement of their ICD-9 counterparts. ICD-10—particularly ICD-10-PCS—represents the wholesale replacement of a decades-old coding system with another that has a fundamentally different structure and logic (see sidebar, page 4).

1 Payer-Provider Collaboration Panel Discussion Survey Results, McKesson Executive Leadership Summit, August 12, 2011, LCI-McKesson-ELS-Collaboration-Survey-Results.pdf.

As such, ICD-10 will affect most aspects of a health organization's operation, from delivery of patient care to management of reimbursement, to analysis of that information against outcomes in order to improve health care quality and delivery. There's also the operational impact of actually assigning the codes. Consequently, ICD-10 preparedness involves a level of complexity that requires deep knowledge of the entire health care spectrum and that has implications that span clinical documentation and coding, business risks (revenue, cost, and productivity), claims denials, customer and beneficiary service delivery, care quality, provider network retention risks, and state government policy.

Extent of the Change



How big a change is ICD-10? The scale of the change varies from one part of the coding system to another. For its part, ICD-10-CM (Clinical Modification) is a major expansion of ICD-9-CM—from 14,000 codes of three to five numeric digits each to 68,000 codes of three to seven characters each—yet much of the chapter structure is similar. On one hand, ICD-10-CM carries forward many of the design principles of ICD-9-CM, although all of the code numbers have been replaced and a new level of detail is required. On the other hand, ICD-10-PCS is fundamentally different in its structure (multiaxial) and design compared with ICD-9 procedure codes. While ICD-9-PCS has 4,000 codes of three or four digits each, ICD-10-PCS contains 72,000 codes of seven characters each.

Beyond technology updates for ICD-10, payers, providers, and government agencies face significant changes in business processes across their organizations. The impact on health plans ranges from claims processing to medical management (policies, authorization, and care coordination), benefits design, contract and network management, and more. Hospitals, clinics, and physician offices will have to make widespread changes in the ways they document and process clinical services. ICD-10's provider impacts range from patient access to all aspects of health information management, clinical and ancillary documentation and coding, patient financial services, and reporting. For government health services, impacts range from Management Information claims payment remediation and eligibility to vendor management, reimbursement, Medicaid policy changes, and more. In addition, organizations need to be able to manage potential impacts from interconnected processes performed by a multitude of health system partners using either software systems or manual processes that still rely on paper.

Figure 2 **Business Process Impacts**

Payer		Provider		Government Entites	
Medical Management	• Identification and stratification • Personal health record medical content • Provider effectiveness	Patient Access	• Central, emergency department, ancillary, and ambulatory registration • Scheduling • Admitting/discharges/transfers • Referrals/authorizations/ precertifications • Bed management	Program Management	• Plan administration • Health plan administration • Health benefits administration • Rate setting • Performance/analysis measures • health care outcomes • Quality assessments • Cost settlement management • Financial reporting
Provider Contracting and Pricing	• Provider contracting • Provider effectiveness • Demographics and payments • Actuarial and analytical systems • Membership and provider portals • Financial payments • Enterprise data warehouse	Clinical and Ancillary	• Physician and nurse documentation • Ancillary and support services documentation • Order entry and results • Workflow within electronic medical record • Case management • Clinical registries and research • Workflow transfers between clinical units	Business Relationship Management	• Coordination and interoperability with other state and federal agencies • Exchange of information (standards, privacy, security requirements)
Membership Contracts and Benefits	• Hospital patient eligibility verification • Contract database • Content management system • Membership • Claims-related reports • Claims-related interfaces • Transaction 270/271 (eligibility) • Transaction 278 (referrals/ authorizations)	Health Information Management	• Coding and abstracting • Deficiency tracking • Claim edit work lists • National Correct Coding Initiative/ Local Medical Review Policies (NCCI/LMRP) edits • Encoding and grouping • Physician query • Clinical documentation	Contractor Management	• Coding and abstracting • Deficiency tracking • Claim edit work lists • NCCI/LMRP edits • Encoding and grouping • Physician query • Clinical documentation
Claims Adjudication	• Adjudication • Claims editing • Diagnosis-related group grouper • Go's program processing • Transaction 837P/I/D (claims: professional, institutional, dental) • Transaction 276/277 (claims status) • Transaction 835 (remittance)	Patient Financial Services	• Charge entry • Payer/clearinghouse edits • Contracting and credentializing • Facility and professional billing • Follow-up and denial management • Claims status	Provider Management	• Enrollment and disenrollment in programs • Communication • Portals • Appeals and grievances
Claims Submissions	• Real-time claims submission • Electronic-data-interchange claims, other transactions • Data collections	Analytics and Reporting	• Quality/outcomes reporting • Financial/revenue reporting • Public health reporting • Federal and state reporting • Data warehouse • Mapping and translation	Operations Management	• Claims adjudication • Service authorization • Payments and reporting • Cost recoveries
Risk Adjustment	• Filtration logic • Prescription-drug-event reconciliation • CMS claim submission • Risk score calculation	Strategic Initiatives	• Implementation of new business or clinical systems • Transition to paperless environment • Opening of new facility • Consolidation of information-technology-vendors' portfolios • Implementation of computer-assisted coding	Care Management	• Report of outcomes • Targeted population management • Disease management • Catastrophic case management • Early Periodic Screening, Diagnosis, and Treatment • Waiver programs • State/national health registries
				Beneficiary Management	• Eligibility determination, enrollment, and disenrollment • Shared eligibility services with health information exchange • Communication (e.g., portals, call center)
				Program Integrity Management	• Program compliance • Auditing • Tracking medical necessity • Quality of care • Patient safety • Fraud/abuse • Administrative anomalies • Provider/member utilization and performance

Financial Risks Inherent in ICD-10 Transition

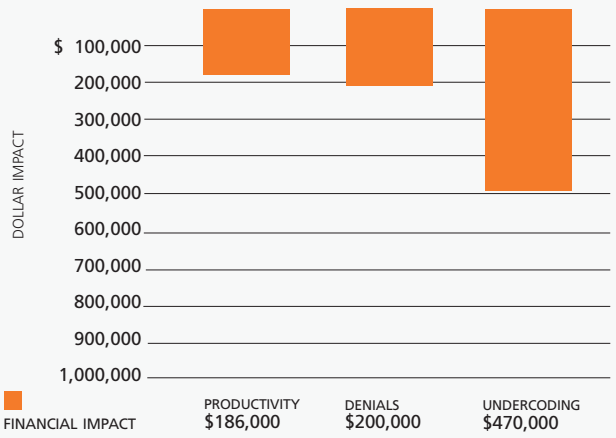
Organizations face numerous financial risks inherent in the complex transition to ICD-10. Failure by all of the affected organizations to manage the ICD-10 transition effectively could result in delayed payments, significant lost revenue, invalid contracts, substantial increases in coverage denials, and an unsustainable increase in the resources needed to provide checks and balances across myriad provider, payer, and government agencies. For example, ICD-10 billing and reimbursement issues have the potential to severely disrupt cash flow; the miscoding of a single transaction can result in tens of thousands of dollars worth of difference in billing and reimbursement (Figure 2); and uncertainty over how to code could lead to a huge backlog and lost productivity. Moreover, the increased complexity of ICD-10 will invariably result in payment errors that all parties will want recovered as part of their program integrity efforts.

An April 2011 survey of payers and providers conducted by the HealthLeaders Media Intelligence Unit reported that organizations anticipate significant financial impact.[2] Just under half (46 percent) of survey respondents anticipated a revenue loss from ICD-10. Of those, 42 percent anticipated their loss could exceed 6 percent of revenue for up to two years after implementation. With most hospitals operating on margins of 1 to 3 percent, a revenue loss of such a size and duration could be devastating.

To scope the potential impact in real-dollar terms, Optum analyzed a variety of public data, estimating that a typical 250-bed hospital is expected to take an annual financial hit of as much as $1.67 million in 2014.[3] This is due to lost productivity, denied claims, and undercoding.

In addition, payers—already challenged to keep administrative costs low due to the Patient Protection and Affordable Care Act—run the risk of increasing administrative costs if not ICD-10 ready. Furthermore, tight government budgets have little room for increasing costs from ICD-10.

Figure 3 **Projected annual financial impact of ICD-10**
Typical 250-bed hospital



Based on recent projections on ICD-10's impact on productivity,[2] denials, and coding accuracy, industry experts estimate a typical 250-bed hospital may lose approximately $850,000 in the year after the ICD-10 conversion.

2 *The 2011 ICD-10 Organizational Impact and Readiness Assessment Survey,* July 2011, http://www.healthleadersmedia.com/content/MAG-268328/ICD10-Revenue-Losses-Loom.

3 Sources for analysis include: Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS, pp. 21-22; Libicki et el; Financial Leadership Council. ICD-10 Transition Success: Launching a Focused and Coordinated Plan Grounded in Expertise. Washington, D.C.: The Advisory Board Company, 2011, p. 4. http://www.mhei.org/programs/documents/ICD-10web.pdf.

Figure 4 **Example: Reimbursement Risk = $4,952**

54-year-old male with attention to ileostomy

ICD-9-CM

Diagnosis

V5.52	Atten to ileostomy
154.1	Malignant neoplasm of rectum
V58.81	Fitting and adjustment of vascular catheter

Procedures

45.62	Part small bowel resect Necrotizing enterocolitis (NEC)
46.51	Small bowel stoma closure
86.05	Removal of foreign body or device from skin

Diagnosis-Related Group (DRG) 330

Major small and large bowel procedures with Complications and Commorbidities

$14,544.87

ICD-10-CM/PCS

Diagnosis

Z4.32	Encounter for attention to ileostomy
C20	Malignant neoplasm of rectum
Z452	Encounter for adjustment and management of vascular access device (VAD)

Procedures

0DT90ZZ	**Resection** of Duodenum, Open Approach
0WQFXZ2	Repair Abdominal Wall, Stoma, External Approach
0DQ90ZZ	Repair Duodenum, Open Approach
0HPPX7Z	Removal of Autol Sub from Skin, External Approach

DRG 330

Major small and large bowel procedures with Complications and Commorbidities

$14,544.87

DRG 330 is higher in the surgical DRG hierarchy than 345 so the grouper logic will stop here when a procedure code is identified.

This Procedure Coding System (PCS) code is listed in the surgical DRG 345 and drives the claim to DRG 345 when paired with the repair small intestine code below it (in the absence of a major bowel procedure code). None of the other PCS codes are listed under DRG 345 or 330.

Diagnosis

Z432	Encounter for attention to ileostomy
C20	Malignant neoplasm of rectum
Z452	Encounter for adjustment and management of VAD

Procedures

0DB87ZZ	**Excision** of Small Intestine, Via Opening
0WQFXZ2	Repair Abdominal Wall, Stoma, External Approach
0DQ90ZZ	Repair Small Intestine, Open Approach
0HPPX72	Removal of Autol Sub from Skin, External Approach

DRG 345

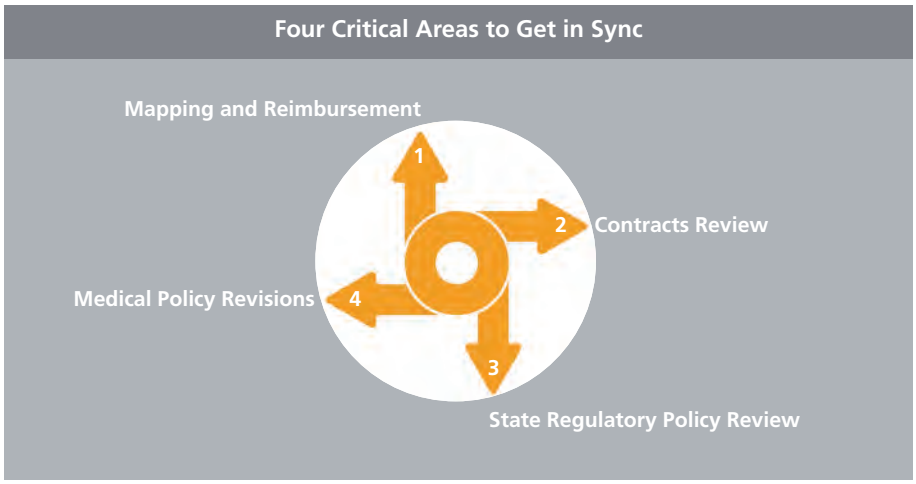
Minor small and large bowel procedures with Complications and Commorbidities

$9,542.41

Excisions of small intestine are not listed in surgical DRG 330 as a major small bowel procedure; however, resections of small intestines are considered major small bowel procedures and drive the assignment of surgical DRG 330.

In addition, the code transition could create significant operational risk and place stress on the entire health care system. For example, each party will need to maintain dual reporting and tracking until all parties are ICD-10 compliant and all ICD-9 claims and billings have been settled—adding complexity and potential disruption to daily operations.

Finally, failure to manage the ICD-10 transition effectively could also result in significant productivity loss. Australia experienced three months of reduced coder productivity after its ICD-10 implementation in 1998. Furthermore, Canada claims to have never regained pre-ICD-10 productivity levels since its 2001 implementation.[4] And within the U.S., Salt Lake City–based Intermountain Healthcare projects that when it transitions to ICD-10, coder productivity will drop 50 percent in the first year.[5] Given the complexity of ICD-10, Optum believes that the demands placed on coder productivity will be so extreme that the industry faces substantial risk of not having enough qualified coders and training services to transition effectively.



Four Critical Areas to Get in Sync

With the financial and operational stakes so high across a health care system of interconnected systems and processes, collaboration is imperative. Successful institutions will work to support their partners in the transition to mitigate the risk of noncompliance, minimize negative financial consequence, avoid disruption of government programs, and ensure the most-efficient investment across all parties. As part of its work with organizations across the health care spectrum, Optum has identified four critical areas of intersection where processes and stakeholders must work in sync to mitigate any negative consequences resulting from ICD-10 compliance efforts. The four areas are mapping and reimbursement, contracts review, state regulatory policy review, and medical policy revisions.

1. Mapping and Reimbursement

Payers, providers, and government agencies need to understand each partner's approach to ICD-10 compliance, particularly in the areas of mapping, billing, and reimbursement. For example, if a health plan intends to do reverse mapping from ICD-10 to ICD-9 to get through systems internally, it's important for providers to understand the reverse-mapping approach and how accurately it will roll to the correct ICD-9 diagnosis-related group (DRG). This is especially important if payers are not using the standard reimbursement mapper of the Centers for Medicare & Medicaid Services (CMS). The CMS mapper lets

4 "Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital," American Health Information Management Association, 2004, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005558.hcsp?dDocName=bok3_005558.

5 "ICD-10: Bring lawyers, guns and money," Inside Edge, Scottsdale Institute, March 2011, www.ingenix.com/~/media//.../InsideEdge_201103%20ICD10.pdf.

providers identify their reimbursements prior to billing. Because there is no one-to-one mapping between ICD-9 and ICD-10 and because codes could roll to different DRGs, health plans' decisions around mapping are fundamental to payment accuracy for providers. Such a reverse-mapping approach will require that providers have monitoring resources and tools to make sure ICD-10 codes are being reimbursed based on accurate ICD-9 codes. Similarly, if a payer is planning to use a clearinghouse to do mapping to ICD-9, this, too, will require extensive monitoring within the provider organization.

Furthermore, even if all parties are fully ICD-10 ready on the proposed compliance deadline date of October 1, 2014, each of them must still code and process both ICD-9 and ICD-10 code formats for some extended period of time for those patients whose care spans before and after the implementation date. How the organizations will crosswalk between the two coding systems should be discussed and evaluated prior to implementation so that provider and payer have a strategy for handling the coding of charts and related claims both pre- and post-ICD-10. Furthermore, testing should continue throughout the process to identify potential changes to the map—before systems and end-to-end testing—so that payers, providers and government agencies can identify financial and operational outcomes that affect the business process.

2. Contracts Review

Contracts also present an area for immediate review across parties. Contracts between payers and providers may contain carve-outs or hard-coded references that are specific to a DRG or ICD-9 code. Thus, contract reviews are required in order to identify such issues, and collaboration will be required in order to make addenda or renegotiate contracts. Also, any new contract negotiations should be completed with consideration for future ICD-10 coding as well as the ICD-9 coding still required for care today. Furthermore, testing should continue throughout the process to identify potential changes to the map—before systems and end-to-end testing—so that payers, providers and government agencies can identify financial and operational outcomes that affect the business process.

With the financial and operational stakes so high across a health care system of interconnected systems and processes, collaboration is imperative.

3. State Regulatory Policy Review

There are also *state* regulations that specifically cover coding structures and diagnosis codes. Modifications, no matter how small, that change regulatory references from ICD-9 to ICD-10 require sign-off by the executive branch—a process that can take several months to complete. And while Medicaid agencies may be moving forward with ICD-10 readiness, multiple other agencies within the government structure, such as a state's office of emergency management or office of vital statistics, may also have policies that revolve around DRG or ICD-9 codes that must be modified. Those policies—as well as any related reimbursement methodologies embedded in statutory, regulatory, or other administrative code—all will require revisions to ensure government payers are not paying inappropriately for critical health services.

4. Medical Policy Revisions

As payers and providers progress in their ICD-10 remediation, they're likely to uncover the need to make medical policy changes that will affect provider care. After all, when one previously covered ICD-9 code maps to 15 different ICD-10 codes, do all of those 15 codes have the same medical necessity and therefore coverage? For instance, a health plan or payer might determine that because it now has more-specific codes, it will cover only four of the six variations of a procedure, all of whose six variations had been covered previously under one ICD-9 code. This would certainly affect provider care—in terms of what requires prior authorization and whether a procedure gets performed at all—and result in changes in processes to mitigate an unanticipated increase in denials and a drop in reimbursements.

How to Enact the Collaboration Imperative

Without a doubt, payers, providers, and government agencies must work closely together and roll up their sleeves around the specific intersections of mapping and reimbursement, contract and state policy reviews, and medical policy revisions. The need for plans and processes to be in sync is so important that collaboration must be embedded throughout the individual implementation plans of each business and agency. Collaboration must begin with the initial readiness assessment and continue through to remediation and trading-partner testing, postimplementation monitoring, and business workflow improvement. Highlights of the places to embed collaboration throughout the payer, provider, and government agency ICD-10 remediation programs are detailed later.

Without a doubt, payers, providers, and government agencies must work closely together and roll up their sleeves.

Readiness Assessment

Government agencies, payers, and providers are each beginning their ICD-10 compliance efforts by assessing their current capabilities, determining their ICD-10 readiness needs, and designing methods to close the gap in ways that best protect against operational and financial disruptions. In addition to assessment of software vendor readiness and technology to bridge the gap, this initial assessment should include an evaluation of the health organization's provider, payer, or government agency network and, specifically, each partner's ICD-10 remediation approach and timeline.[6]

Operationally, each entity should try to determine all of the affected stakeholders but should focus its initial partner assessments on the areas of highest impact. For example, since contracts are written differently between partners, providers should prioritize (1) payers with which they have the highest transaction volume and (2) contracts that are based on DRG reimbursement. This initial assessment is critical to starting a dialogue and building a relationship between parties relative to ICD-10 and to setting an example for teams to emulate as they interact and progress through remediation and beyond. The assessment should include a detailed discussion of mapping, reimbursement approach, and contract review, with subsequent discussions covering medical policy changes, contingency planning, and quality assurance monitoring.

Program Management

Each organization needs a strong project management team to oversee implementation of the transition and to coordinate activities across the enterprise and beyond. To achieve success, it is critical that a transition implementation have resources specifically assigned as the main contacts for each party. And those individuals should be fully knowledgeable about ICD-10 as it relates to the relationship with a specific payer, agency, or provider. These people also should be fully involved in managing the transition and tasks specific to that partner as they move toward readiness and compliance.

A health company should consider having one or more of a significant partner's executives involved within the program leadership team in some capacity. For example, Intermountain Healthcare and SelectHealth (Intermountain's health plan) have found it helpful to closely align on remediation efforts and have assigned a SelectHealth executive to sit on the steering committee for Intermountain's ICD-10 effort. SelectHealth, which represents 30 percent of Intermountain Healthcare's hospital payer mix and 40

6 The Centers for Medicare & Medicaid Services has put together comprehensive ICD-10 guides for states. The guides are available at https://www.cms.gov/ICD10/02b_Latest_News.asp#TopOfPage.

percent for its medical group, initially wanted to undertake its code conversion initiative independent of Intermountain Healthcare. However, the two organizations realized the need for collaboration and are now aligned in their ICD-10 effort. According to Craig Jacobsen, associate vice president of Intermountain Healthcare, the provider is also in discussions with other payers and with information technology vendors about similar alignment.[7] In addition, some payers and providers are establishing a coding center of excellence, or ICD-10 competency center, with a governance model that effectively facilitates rapid and accurate decision making.

The industry's ICD-9 coding system has been in place in the United States since 1979, and the conversion to ICD-10 therefore represents monumental change for employees who've spent their careers operating in the ICD-9 coding environment. Thus, change management is a core task of the program management team. Change management represents an opportunity for a collaborative payer/provider/government team to share resources and change management efforts to effect the change.

Communications

Given the potential of ICD-10 to disrupt relationships between health plans, government agencies, and provider networks, organizations should develop strong communication plans for their partners, and the plans should describe ICD-10 remediation efforts, including testing. The success and effectiveness of an ICD-10 implementation depends on the capacity of its provider network to submit accurately coded claims in a timely manner.

Given the potential of ICD-10 to disrupt relationships, organizations should develop strong communication plans for their partners.

7 "ICD-10: Bring lawyers, guns and money," Inside Edge, Scottsdale Institute, March 2011.

Health plans and government agencies need to support the efforts of their provider network in achieving ICD-10 compliance and vice versa. Communications to the extended network must be planned carefully, sustained strongly, and delivered efficiently through a variety of outreach channels such as portals, bulletins, push e-mails, and education sessions.

Training

Because they rely on accurate diagnosis and procedure coding, health plans and government agencies will want to support ongoing provider education and training. Most health plans employ coding teams that work with provider offices to help employees correctly code charts, records, notes, and claims, because proper coding affects risk scores and premium payments. Plus, most provider organizations have resources assigned specifically to a health plan, a group of plans, Medicare, or Medicaid. These teams will play a critical role in helping navigate the ICD-10 transition by designing and developing new training and technologies as well as auditing documents and standards. In addition to this, organizations should augment internal resources and documentation with addition training through trade associations, professional organizations, and the vendor community.

Education and training programs should highlight the most consequential risk areas in which even a tiny discrepancy can mean loss of significant reimbursement. In addition, to increase accuracy, education programs must be tailored according to clinical category (such as cardiology or neurology) so that each stakeholder will best understand the category's new code set. Based on extensive training experience, Optum experts estimate a six-month learning curve for coders.

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Resourcing and Capacity Planning

With a long learning curve associated with the new coding, another critical challenge for all involved is the matter of coder productivity, capacity, and expertise. AAPC, the largest U.S. medical coding training and certification association for physician provider coding, is advising providers to expect a 15 percent increase in documentation time.[8]

With a long learning curve associated with the new coding, another critical challenge is the matter of coder productivity, capacity, and expertise.

The complexity of ICD-10 will make it challenging to hire, retain, and train enough coders to manage the post-ICD-10 volume without revenue disruption; and a spike in experienced coders leaving the workforce could further exacerbate the current coder shortage. A recent report by research company KLAS Enterprises[9] confirmed this issue. The study explored providers' greatest concerns related to ICD-10 and found that internal organization readiness—namely, staff training and physician/nurse readiness—topped the list. Payers, providers, and agencies should discuss opportunities to collaborate—from the perspectives of resources, education, and training—in order to collectively address that shortage.

Organizations should also consider how such tools as computer-assisted coding help resolve capacity and productivity issues, improve revenue management both short-term and long-term, and limit the impact on hospital clinical documentation improvement

8 "ICD-10: The Maryland Collaborative," Healthcare Financial Management Association, Maryland Chapter, October 2011, Nachimson-et-al-ICD-10-10-07-11.pdf, p. 18.

9 "ICD-10: Preparing for October 2013," KLAS Enterprises, September 2011, https://www.klasresearch.com/Store/ReportDetail.aspx?ProductID=646.

programs. Some organizations must also recognize that they'll need to identify and mitigate clinical, financial, and operational risks without the benefit of in-house ICD-10 experience. This is where analytic skills and clinical coding expertise—shared between parties or brought in from a third party—could be leveraged to benefit a group of collaborative organizations within a trading relationship.

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Testing

Clearly, internal and trading partner testing is a critical element of the successful transition. Organizations will need to be able to process both ICD-9 and ICD-10 codes for an extended period of time beyond the proposed new date of October 2014 and will need to test system and process modifications well in advance of the mandated compliance date.

Many organizations will be performing parallel coding (coding in both ICD-9 and ICD-10) before the deadline to better understand the new reimbursement process, and they'll need trading partners to conduct joint testing. Payers, government agencies, and providers will have to work with each other to determine whether, when, and how they'll become able to accommodate testing and receipt of parallel coding during the time leading up to the ICD-10 launch.

Contingency Planning

The best-laid plans don't always come to fruition. Therefore, backup plans must be in place to make sure that the flow of claims, the timely remittance of payments, and the movement of cash—as well as patient care of course—do not get disrupted. Trading partners need to collaborate to develop contingency plans that could include workarounds to transmit claims, process claims, and accept remittances. In addition, individual payers and providers should have discussions with their lenders on their own lenders' ICD-10 readiness as well as that of their major partners. It's important to communicate contingency plans and make lenders aware in case of the need for a short-term loan to keep operating capital flowing.

Quality Assurance and Postimplementation Monitoring

Payers, providers, and government agencies know this transition will have unexpected impacts. Thus, organizations need to develop a process for quickly coming to agreement on variances that were not experienced prior to ICD-10. Therefore, a significant component of collaborative planning would be to jointly design a surveillance and quality assurance process for monitoring for postimplementation impacts, identifying patterns, and quickly resolving issues as they arise.

Organizations must identify the quantifiable operating and financial metrics that will likely be affected by the transition, and they must build a report structure that will enable them to:

- Monitor those metrics over time
- Understand normal deviations from trend
- Quickly identify aberrant deviations that may warrant further investigation and response

For example, controls might include the monitoring of claims payments to ensure there will be no spikes in key performance categories and no significant fluctuations in claims denials or payment patterns. Potential areas for *payers* to consider include autoadjudication rate, mean medical cost per encounter, hospital inpatient case mix, and average denial rate. Potential areas for *providers* to consider include average bill size by type of service, days in accounts receivable, average denial rate, and percent of claims pended for further review. Such metrics will enable health plans and government agencies to work proactively with provider networks to identify and resolve payment disparities, patient care variations, and other discrepancies that occur during the transition.

The best-laid plans don't always come to fruition. Therefore, backup plans must be in place.

Reaping the Benefits

Successful organizations will take the long view and recognize that the proposed new deadline date of October 1, 2014, is only the midpoint of the transition effort. Clinical documentation—including the things physicians record during patient care and the ways they record them—is clearly the foundation for initiating a coding process that works smoothly across the value chain. But it also creates the data foundation for future steps in the improvement of health outcomes and the reforming of care. The real benefits of ICD-10 can be realized only once payers, providers, and government agencies begin using newly available information to improve the way care is delivered, the way they themselves operate internally, and the outcomes for the people being served.

From a strategic perspective, ICD-10 lays the information foundation for building health communities capable of producing enduring health for people—what Optum calls Sustainable Health Communities. ICD-10's more precise coding specificity is an opportunity to advance clinical analytics and drive improvements in care management programs, actuarial analysis, and benefit design as well as to advance overall industry changes such as value-based reimbursement and quality improvement.

A recent HealthLeaders survey confirms health industry leadership's expectations for ICD-10. The survey found 72 percent of leaders saying ICD-10 will help with their quality initiatives; 53 percent said it will improve evidence-based medicine; and 46 percent anticipated that ICD-10 will improve long-term health care quality. But to achieve those results, today's adversarial organizational relationships must convert to ones in which dialogue changes dramatically between parties and in which continuing partnership relationships are wins for all parties.

By collaborating to optimize ICD-10 readiness and ensure compliance across partners and the extended health network, payers, government, and providers must both mitigate short-term risk and solidify the information foundation to enable the health system to work better for everyone.

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