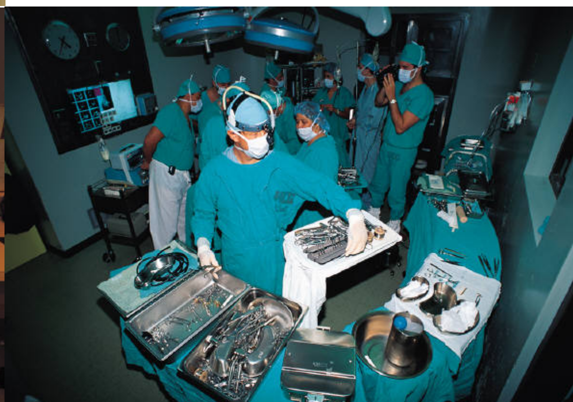
HIPAA Code Set Rule: ICD-10 Implementation

An Executive Briefing



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CEO SUMMARY

HIPAA Code Set Rule: ICD-10 Implementation – An Executive Briefing will help AHA member hospitals and health systems prepare for the ICD-10 deadline of October 1, 2013.

This resource highlights some important implementation issues that should be shared with staff as they prepare for this significant and complex transition. The transition timeline is strict and will require careful coordination across your organization in order to successfully implement the new diagnosis and procedure codes known simply as "ICD-10."

Here is what you can do:

- ✓ Share this document with your senior management team
- ✓ Assemble an ICD-10 Steering Committee
- ✓ Appoint an ICD-10 team leader
- ✓ Monitor the implementation plans as well as the progress made toward ICD-10-CM and ICD-10-PCS over the course of the next few years

Contact AHA Member Relations at (800) 424-4301 with any questions, comments or concerns you may have with meeting the implementation date. You can download and print additional copies of this executive briefing at http://www.aha.org/aha_app/issues/HIPAA/index.jsp.

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SENIOR MANAGEMENT BRIEFING

Summary of the ICD-10 Final Rule

On January 15, 2009, the Secretary of the Department of Health and Human Services released a final rule calling for the adoption of a new edition of the *International Classification of Diseases (ICD)* standards known as the 10th edition using Clinical Modifications (CM) and the Procedure Coding System (PCS). The final rule adopts ICD-10-CM for reporting patient diagnoses and ICD-10-PCS for reporting hospital inpatient procedures - both will replace ICD-9-CM. The final rule, available at http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf, was published in the January *16, 2009 Federal Register*.

The ICD-10-CM replaces ICD-9-CM Volumes 1 & 2 used for diagnosis reporting while ICD-10-PCS replaces ICD-9-CM Volume 3 used for inpatient procedures. The final rule also references the continued use of the *"Official Coding Guidelines*" as the basis for correct use of ICD-10 codes. Note that ICD-10-PCS codes are strictly intended for use by hospitals to report inpatient procedures and would not be used for outpatient or physician billing.

The use of ICD-10-CM and ICD-10-PCS applies to all "Covered Entities," that is health plans, health care clearinghouses and health care providers that transmit electronic health information in connection with the Health Insurance Portability and Accountability Act (HIPAA) transaction standards. The compliance date for ICD-10 is October 1, 2013 (federal fiscal year 2014).

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On a related note, there was another final rule that was also issued on January 15, 2009. It calls for the adoption of an updated version to the current HIPAA electronic transaction standards (Version 5010). The newer versions replace the existing HIPAA transaction standards on January 1, 2012. The newer version (5010) of the electronic standards is necessary in order to distinguish the reporting of the new ICD-10 codes.

Full compliance is expected for claims received for encounters and discharges that occur on or after October 1, 2013 (FY 2014). There is a single implementation date for all users based on the date of service for ambulatory and physician reporting, and the date of discharge for inpatient settings. The date for switching to the new release is consistent with the long-standing practice for inpatient facilities to use the version of ICD that is in effect on the date of discharge.

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SIGNIFICANCE OF ICD-10

Clear and accurate diagnosis and procedure code reporting provides valuable information about patient care. It provides important information for accurate reimbursement such as key Medicare payment and medical necessity determination.

ICD-9-CM has been in use for almost 30 years and because of its structural limitations has not been able to effectively assign new codes for rapidly changing medical treatments and technological growth. An upgrade to the new edition of the coding system is needed to stay current with improvements in medical treatment as well as anticipate future technological growth in medicine.

Clinical codes must be capable of accurately describing diagnoses, illnesses and medical procedures—especially to improve the quality of health care and design a more equitable reimbursement model. The adoption of ICD-10-CM and ICD-10-PCS will enable providers and others to better study the relationship of cost to specific medical conditions. Greater specificity in clinical coding provides an important reference point for improving our understanding of medical treatment and should enable system designers to create new and better health information systems.

Administrative claims data are often used to make decisions not only about reimbursement but also can be used for value-based purchasing, to evaluate the quality of the care and to conduct bio-surveillance and public health research. ICD-9-CM simply lacks the increased level of detail required for handling these emerging needs.

The failure to successfully implement ICD-10 could create coding and billing backlogs, cause cash flow delays, increase claims rejections/denials, lead to unintended shifts

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in payment and place payer contracts and/or market share arrangements at risk due to poor quality rating or high costs. Inaccuracy in clinical coding creates distorted or misinterpreted information about patient care which also results in faulty investment decisions to improve health delivery.

Benefits of Implementing a Modern Classification System

- Improved ability to measure health care services
- Increased sensitivity when refining grouping and reimbursement methodologies
- Enhanced ability to conduct public health surveillance
- Decreased need to include supporting documentation with claims
- Increased ability to distinguish advances in medicine and medical technology
- Provide more detail on socioeconomic, family relationships, ambulatory care conditions, problems related to lifestyle and the results of screening tests
- Facilitate use of administrative data to evaluate medical processes and outcomes, to conduct biosurveillance and to support value-based purchasing initiatives

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Comparison of ICD-9-CM vs. ICD-10-CM

(For Coding *Diagnosis* Only)

ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
3-5 characters in length	3-7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric	First digit is alpha; Digits 2 and 3 are numeric; Digits 4-7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Allows laterality and bi-laterality
Difficult to analyze data due to non-specific codes	Specificity improves coding accuracy and richness of data for analysis
Codes are non-specific and do not adequately define diagnoses needed for medical research	Detail improves the accuracy of data used for medical research
Does not support interoperability	Supports interoperability and the exchange of health data between the U.S. and other countries

Comparison of ICD-9-CM vs. ICD-10-PCS

(For Coding *Procedures* Only)

ICD-9-CM Procedure Codes	ICD-10-CM Procedure Codes
3-4 numbers in length	7 alpha-numeric characters in length
Approximately 3,000 codes	Approximately 72,600 available codes
Based on outdated technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Allows laterality
Generic terms for body parts	Detailed descriptions for body parts
Lacks description of methodology and approach for procedures	Provides detailed descriptions of methodology and approach for procedures
Limits DRG assignment	Allows expansion of DRG definitions to recognize new technologies and devices
Lacks precision to adequately define procedures	Precisely defines procedures with detail regarding body part, approach, any device used and qualifying information

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STRATEGIC PLANNING AND OPPORTUNITIES

Successful transition to ICD-10-CM and ICD-10-PCS requires careful strategic planning and coordination of resources across the entire hospital. Planning for ICD-10 must engage executive leadership, particularly since the coordination challenges span across a wide-range of functional areas, including finance, information services, decision support, compliance and the medical staff. The transitioning process begins by examining every application where diagnosis or procedure codes are captured, stored, analyzed or reported. Your ICD-10 team must also be prepared to address the implications to current information systems, the approaches for maintaining timely reimbursement, opportunities for improving decision support (necessary for quality and compliance reporting), as well as staffing needs and training.

Taking short cuts or providing a minimal effort to achieve compliance without examining the steps or opportunities to maximize the benefits associated with ICD-10 could result in significant redesign costs later on.

The assessment for ICD-10 implementation is an opportunity to review current work flow and medical documentation practices. It will also allow you to make improvements that streamline future processes and strengthen the basis for code assignment.

Another important and recent legislative change relates to the *American Recovery and Reinvestment Act (ARRA).* The ARRA provides financial incentives for hospitals to modernize their health information technology. This funding is provided to hospitals that have adopted and are considered “meaningful users” of electronic health record (EHR) technology. Accurate clinical coding relies on having complete and readily available

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health record documentation. The development of electronic health records is an added benefit that not only supports ICD-10 assignment but also helps to improve the quality of the care by providing better and more readily available patient health information. More information on ARRA and "meaningful use" can be found at: http://www.aha.org/aha_app/issues/HIT.

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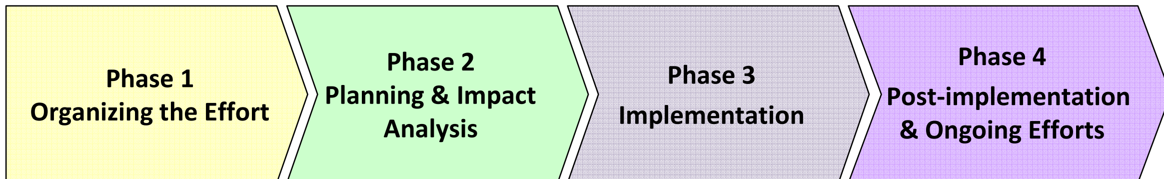
OVERVIEW OF ICD-10-CM AND ICD-10-PCS IMPLEMENTATION PHASES

Implementation is divided into four phases:



Phase 1 - Organizing the Implementation Effort

This phase will involve:

- Organizing your cross-functional Steering Committee
- Selecting a Steering Committee leader
- Developing a meeting schedule
- Identifying required tasks and developing timelines
- Assigning tasks and responsibilities

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Phase 2 – Planning and Impact Analysis

This phase will involve performing an organizational assessment and developing an implementation schedule including:

- Conducting an information systems inventory
- Assessing vendor readiness and support
- Conducting staff awareness sessions
- Assessing and planning for staff training needs
- Identifying necessary tools
- Identifying areas requiring operational and policy changes
- Evaluating health plan contract implications
- Budget planning
- Identifying gaps in health record documentation

Phase 3 - Implementation

This phase will involve executing, monitoring and overseeing the implementation schedule including:

- Outlining specific tasks and monitoring timeline for completion
- Reviewing budget requirements
- Developing metrics and monitoring progress
- Routine reporting of progress towards completion
- Implementing changes to system design and development
- Testing and validation of system changes
- Conducting the staff training
- Conducting physician training to address documentation gaps

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- Monitoring current work flow volumes during the training period so backlogs are a minimum prior to going live. This will result in less time needed to maintain dual coding systems if old accounts are processed prior to the implementation date.

Phase 4 - Post-implementation Evaluation and Ongoing Efforts

This phase will involve an evaluation to determine the success of the implementation, as well as fine-tuning any additional required changes including:

- Evaluating software upgrades
- Reviewing quality of coded data
- Conducting additional staff training
- Reinforcing physician documentation training
- Assessing case mix impact

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Phase I - Organizing the Implementation Effort

Organizing Your Cross Functional Steering Committee

To carefully orchestrate the required changes, convene a cross functional Steering Committee to identify every system application affected and to assign tasks and responsibilities to carry-out the necessary changes.

The approach taken will differ among hospitals based on the level of automation, the number of electronic databases and the functional areas affected.

Below are some of the recommended approaches your organization may consider. It can be customized to fit the needs of your hospital.

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Steering Committee Composition

<table>
<tr><th>Leadership</th><th>Core Steering Committee Members</th><th>Ad Hoc Team Members</th></tr>
<tr><td>Sponsorship and support from a senior level manager to ensure coordination across departments.</td><td>It is recommended that at a minimum the following departments be part of the core Steering Committee:

• Health Information Management
• Information Systems and Technology
• Billing
• Finance
• Compliance
• Revenue Cycle Management</td><td>The following representatives should be involved on an as needed basis once a determination has been made of the functional areas affected.

• Quality
• Registration
• Nursing
• Clinics
• Emergency Department
• Pharmacy
• Medical Staff Affairs
• Outpatient Surgery
• Ancillary services such as:
  – Imaging
  – Laboratory Services
  – Cardiology
• Rehabilitation
• Home Health
• Urgent Care
• Therapies
• Utilization Review</td></tr>
</table>

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Meeting Schedule

Meeting	Frequency	Tasks	Completion Timeline
Organizing the implementation effort	Every 2 weeks	○ Develop implementation goals ○ Develop plan for assessing implementation impact ○ Develop implementation strategy ○ Develop tools to assess impact on affected functional areas ○ Identify Steering Committee's required tasks ○ Develop timelines ○ Assign responsibility for tasks ○ Educate information systems staff on code sets	The end of 2009
Planning and impact analysis	Monthly	○ Launch awareness campaign ○ Conduct a facility-wide information systems inventory ○ Contact vendors to determine plans for readiness and support ○ Assess and plan for staff training needs ○ Identify area's requiring operational and policy changes ○ Develop a "master to-do" list ○ Evaluate health plan contract implications ○ Assist functional areas with budget planning	First quarter 2010
Implementation	Every 2 weeks	○ Review resource requirements ○ Develop metrics to measure implementation progress ○ Review routine reporting of progress toward completion ○ Review updates on changes to system design and development ○ Review reports of testing and validation of system changes ○ Oversee staff training ○ Evaluate systems that may need to be transitioned or replaced ○ Oversee physician training on documentation	Compliance date October 1, 2013
Post Implementation	Monthly	○ Evaluate success of implementation ○ Review reports of coded data quality ○ Evaluate need for continued staff training	Ongoing

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Phase 2 - Planning and Impact Analysis

Performing Your Organizational Assessment

Changing to ICD-10 will impact departments differently. Every department should conduct an internal assessment and report their findings back to the ICD-10 Steering Committee. Based on these responses, a detailed "master to-do" list can be developed for the organization.

Each department should conduct an internal assessment that includes:

- Inventory of their information systems
- Assessment of their training needs
- Identification of areas requiring operational and policy changes
- Identification of necessary tools
- System-wide information systems inventory

Some information system applications utilize only diagnosis codes, while others utilize both diagnosis and procedure codes. It is important that the cataloging of information systems makes the distinction and provides a brief assessment of how the codes are entered onto the specific application. It will be helpful to chart the flow of information, how it is entered and the areas in which the information is shared. A sample assessment form is included on page 18.

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As a starting point, common systems likely to be affected include:

- ☐ Accounting
- ☐ Advanced Beneficiary Software
- ☐ Birth defect registries
- ☐ Billing
- ☐ Case management
- ☐ Claims submission
- ☐ Clinical data reporting
- ☐ Clinical department
- ☐ Clinical protocols
- ☐ Clinical reminder
- ☐ Compliance checking
- ☐ Computerized physician entry
- ☐ Databases
- ☐ Decision support
- ☐ Disease management
- ☐ DRG grouper
- ☐ Electronic processing
- ☐ Encoder software
- ☐ E-prescribing
- ☐ Financial
- ☐ Hospital information
- ☐ Interface engines
- ☐ Inpatient rehab facility patient
- ☐ Assessment instrument data collection
- ☐ Managed care (HEDIS) reporting
- ☐ Medical abstracting
- ☐ Medical Device Registries
- ☐ Minimum data set collection
- ☐ OASIS
- ☐ Outpatient code editor
- ☐ Pharmacy
- ☐ POA
- ☐ Provider profiling
- ☐ Quality management
- ☐ Reports
- ☐ Registration and scheduling
- ☐ Research databases
- ☐ State birth registration
- ☐ State reporting
- ☐ Test ordering
- ☐ Utilization management

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Each department will conduct an inventory of the applications used. This inventory should include determining whether the application is supported by a commercial vendor or developed in-house, as well as a determination of the frequency of updates and whether these updates are included as part of a maintenance contract.

Sample ICD-10 Implementation Department Assessment: HIM Department

Application Name	Vendor	Application Maintainer	Frequency of Regular Updates	Under Maintenance Contract	Diagnosis or Procedure Codes, or Both	Codes Entered Directly Into Application or Downloaded from Other Systems?	Lead Person
Encoder	ABC, Inc.	ABC, Inc.	Quarterly	Yes	Both	Entered directly	K. Jackson
Abstracing System	DEF	DEF	Quarterly	Yes	Both	Downloaded from encoder	K. Jackson
DRG Grouper	GHI	GHI	Annually	Yes	Both	Downloaded from encoder	K. Jackson
Outpatient Code Editor			Quarterly	Yes	Diagnosis	Entered directly	A. George
Present on Admission Database	In-house	IS&T	Annually	No	Diagnosis	Downloaded from abstracting system	B. Todd
Birth Registrations	State	State	Annually	Yes	Diagnosis	Entered directly	P. Kral
Trauma Registry	State	State	Annually	Yes	Diagnosis	Entered directly	P. Kral

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Legacy Systems

Maintaining and upgrading legacy systems is one of the most difficult challenges hospitals face. Updating to ICD-10 means confronting important decisions as your organization examines existing legacy systems and whether to upgrade or replace these systems.

The questionnaire on the next page will help collect information on legacy systems to assist in your organization's decision-making process.

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Assessment of Legacy Systems for ICD-10 Implementation

Department: ________________________________

Name of Application: ________________________________

Question	Answer	Comments
Is the system still currently in use?		
What is the system used for?		
Does the system work satisfactorily?		
Is there another application currently available that can perform a similar function as the current system?		
Is there current staff capable of redesigning the system?		
Is the system documented fully enough to allow another designer to update the system?		
On what hardware does the system run?		
On what software platform does the system run?		
Is the system difficult to maintain or improve?		
Can the system be integrated with newer systems?		
What is the cost of updating the system?		
What is the cost of replacing the system with a new application?		
With what other systems or programs does the legacy system interface?		
What impact would a change in the legacy system have on these other systems or programs?		
With how many legacy systems is your organization contending?		
If multiple systems, what is the priority among the legacy systems?		

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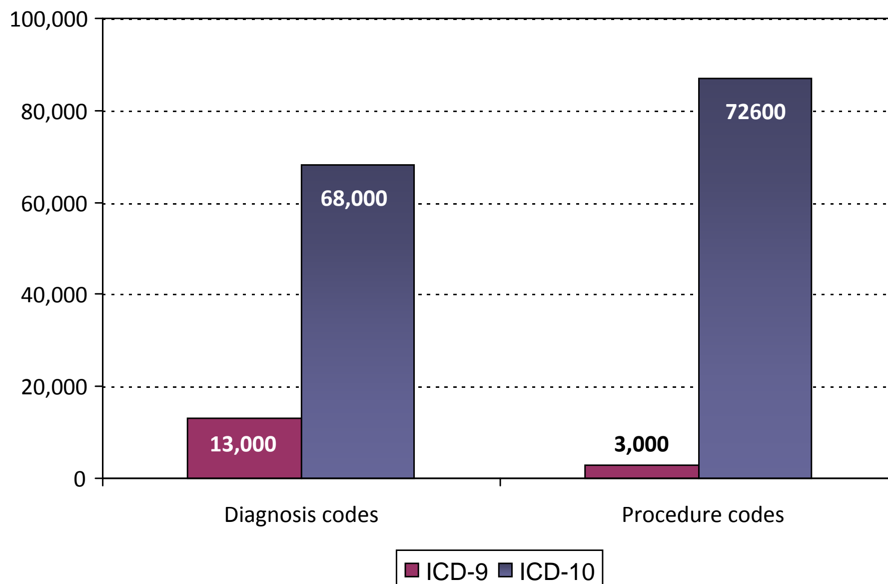
Storage Capability

Consider the storage capability of all systems and your plans for maintaining both ICD-9-CM codes as well as ICD-10-CM and ICD-10-PCS codes for a certain period of time—at least until all pre-implementation claims have worked their way through the system. In certain instances, it may be necessary to maintain historical data in ICD-9-CM rather than converting it to ICD-10.

Another item for consideration is the expanded number of available codes under ICD-10 vs. ICD-9-CM. As shown below, there will be a significant increase in the number of codes with ICD-10 for both procedure and diagnosis codes.

Number of ICD-9 and ICD-10 Codes for Diagnoses and Procedures



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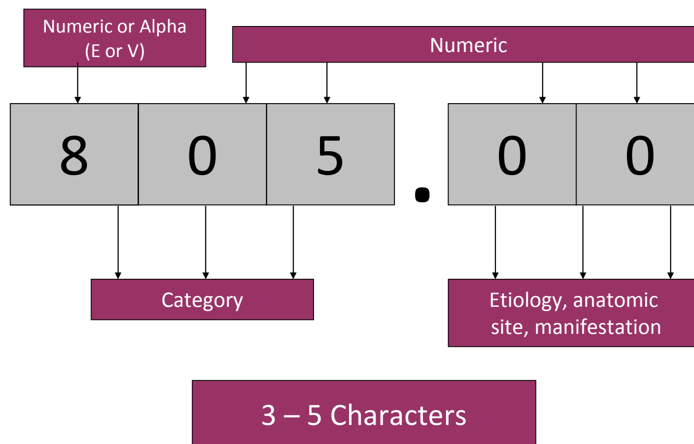
Field Size Changes

The field size changes associated with ICD-10 diagnosis and procedure codes will also impact storage abilities.

Classification System	Field Size – Diagnosis Codes	Field Size – Procedure Codes
ICD-9-CM	Maximum 5 digits	Maximum 4 digits
ICD-10	Maximum 7 digits	All codes 7 characters

Another way to view field size changes is by comparing differences in the structured format between ICD-9-CM and ICD-10. *The format structure as illustrated below contains the "decimal." It should be noted that the HIPAA transaction standards do not allow the transmission of the decimal in the ICD-10-CM code. The decimal is implied in the transmission.*

ICD-9-CM Diagnosis Structured Format



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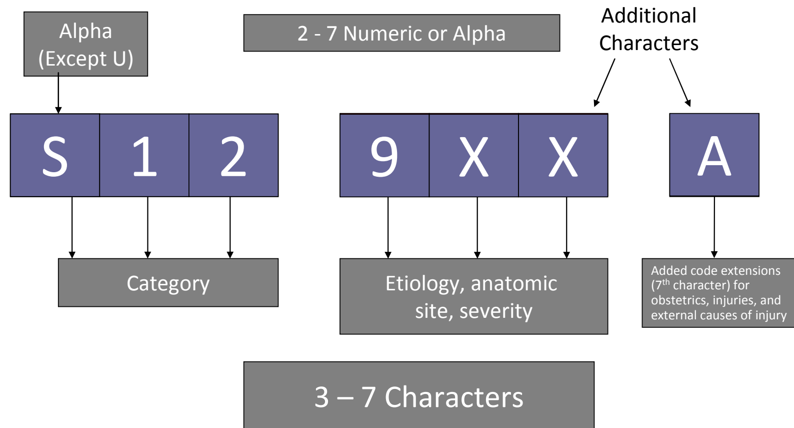
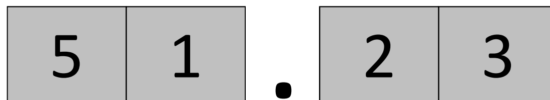
ICD-10-CM Diagnosis Structured Format

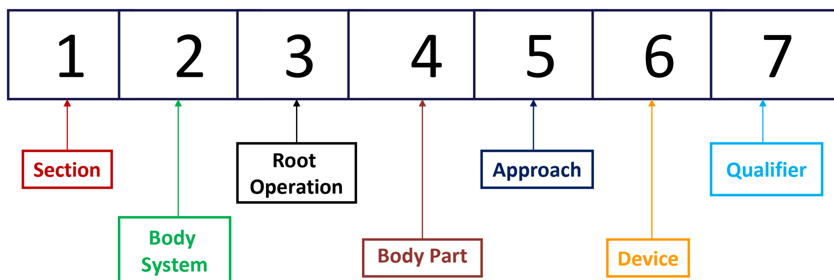


ICD-9-CM Procedure Structured Format



ICD-10-PCS Procedure Structured Format

ICD-10-PCS – Structured Format Characters (Medical/Surgery)



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Vendor Readiness and Support

- Identify which vendor systems are affected
- Develop a master list of all vendors affected
- Contact vendors to determine whether changes to existing systems are forthcoming and when they plan to have available upgrades to support ICD-10
- Determine whether the upgrade to ICD-10 is included with your maintenance agreement
- Ask vendor to share their plans for readiness
- Make certain that the vendor intends to continue to provide support for the application
- Determine whether the application requires any special or custom developed edits
- Identify special terms in contracts to cover custom edits, if any

Health Plan Awareness, Readiness and Plans for Testing

- Prepare a list of largest health plans
- Contact health plans and schedule meetings (can be done collectively with other providers; if possible work with state associations to schedule meetings)
- Share hospital plans for readiness and dates when hospital will be ready to begin external testing
- Host periodic follow-up meetings to share implementation progress and to validate plans for future testing

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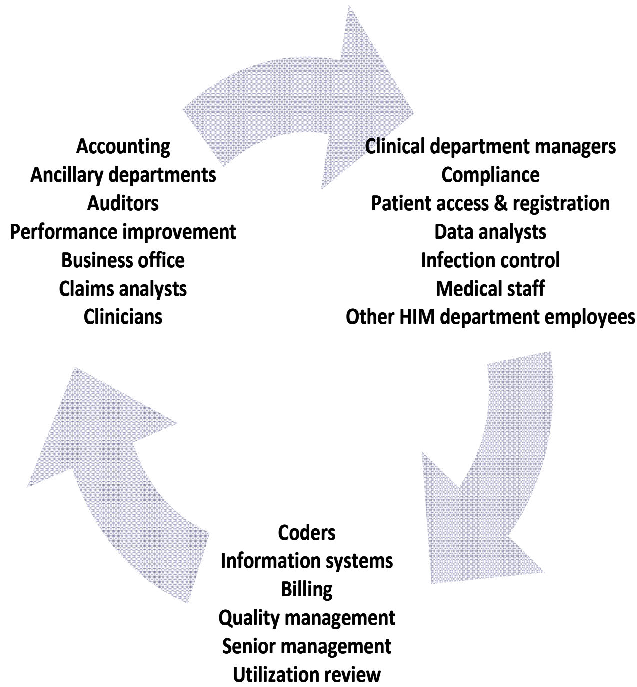

- Determine need for level of understanding

Level	Need	Rationale
Basic	Need to be familiar with major differences between ICD-9 and ICD-10 and be aware of impact of change	Assist in creating ICD-10 implementation plan and identify opportunities for change
Advanced	Need moderate understanding to use and interpret ICD-10-CM and ICD-10-PCS	Assist in planning and evaluating impact on clinical documentation and internal processes (e.g. quality, compliance)
Expert	Need for proficient understanding to select and interpret ICD-10-CM and ICD-10-PCS	Perform code assignment and audit coding quality

Regardless of the level of understanding needed, all affected staff should at least have awareness training during the planning and impact analysis phase.

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Useful Tools

Many commercial vendors are offering or developing new tools to aid in the conversion to ICD-10. (For example, translation or conversion tools, comparative assessment tools, and compliance tools).

An important tool currently available and free of charge comes from the Centers for Medicare & Medicaid Services (CMS). It is called the "General Equivalence Mappings (GEMS)."

The GEMS are designed to facilitate the transition from *ICD-9-CM* to *ICD-10-PCS*, providing backwards and forward mapping between the two coding systems. The documentation and user's guide gives potential users information regarding the structure and relationships contained in the mappings to facilitate correct usage. The intended audience includes, but is not limited to, professionals working in health information, medical research, payment and informatics. The GEMS, as well as the User's guide, may be downloaded from the CMS Web site at:
http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp#TopOfPage.

Besides the electronic mapping or translation tools, there is still a need for data analysis and decision review tools. For example, a translation tool may be used to evaluate revised health plan contracts (decision support, revenue cycle, claims adjudication applications) and the translation tool may convert the vast majority of the codes. **There are, however, a small number of codes that will still require manual evaluation and expert decision making about code list relationships to determine the most accurate mapping. The manual evaluation may require data analysis support and other tools that can look at the provider's patient population, past contracts or other pertinent information.**

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Operational and Policy Changes

As you make your plans for ICD-10 implementation also review existing operations and policies. There may be a need to change these—especially those dealing with coding and documentation instructions.

Health Plan Contract Implications

Many hospitals enter into contractual agreements with health plans and these agreements may be affected if they are structured on the basis of ICD-9-CM diagnosis or procedure codes. It is important to carefully review existing agreements and determine which contracts and health plans will be affected.

- Determine whether ICD-9-CM diagnosis codes or procedures are used to determine reimbursement
- Determine contract renewal dates and whether references to ICD-9 codes in the contract have to be converted to ICD-10
- Discuss with health plans whether they intend to convert existing contracts to reflect ICD-10
- Determine if the health plan is using a standard map to convert to ICD-10 or if they are using customized mapping
- Understand how the health plans are approaching reimbursement and determine if there are significant changes that may require negotiation
- Review accuracy of mapping ICD-9 codes to ICD-10 since it is possible for payers to develop their own reimbursement mappings (based on their historical data)
- Consider a proactive approach—creating a provider-centric customized map to enable payer/provider contracting

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- Verify that they have timelines and plans in place for conversion to the HIPAA 5010 transaction standard and to ICD-10-CM and ICD-10-PCS and when their systems will be ready for testing with providers

Budget Planning

Consider the following areas with regards to budget planning:

<u>Operational</u>

- Training cost
- Productivity loss (possible need for temporary staffing usage)
- Budget for multiple-year implementation steps
- Reassess and revisit budget throughout implementation periods
- New or modification to system software

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Phase 3 - Implementation

Execute Implementation Schedule – Outline of Specific Tasks

Once the information systems inventory, vendor readiness assessment and the training assessments are concluded this will help you to develop an outline of the specific tasks to work on.

A “master to-do” list can be developed with specific timelines for completion. The list also should include responsible individuals as well as any required tools. Be certain to appoint a project manager to ensure timing and interdependent milestones are flawless for “on-time” implementation. The ICD-10 Steering Committee can assist with prioritization of tasks in collaboration with the affected departments.

Budget Requirements

Consider multi-year budgeting and reassess financial support that is needed on an annual basis.

Budgeting requirements should include consideration for the following areas:

- Training and education
- System changes
- Staffing for internal changes
- Updating of existing commercial software applications
- Purchasing replacement applications that will not be upgraded internally
- Data conversion
- Purchasing of electronic tools to assist in mapping or conversions

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Metrics and Monitoring Progress

Establish and monitor timelines and progress. Report the findings to the ICD-10 Steering Committee on a monthly basis. Timelines may need to be adjusted as necessary.

Routine Reporting

Routine reporting on implementation progress should be an integral component of the ICD-10 Steering Committee meetings. In addition, progress should be reported at organization-wide meetings and shared among departments to ensure staff are apprised of progress.

Manager and Department Involvement

Specific tasks for individual departments will be completed by department managers and their staff. Whenever possible, activities should be incorporated into individual performance evaluations.

System Design Development – Testing and Validation Process

Internal

As you design changes to handle the reporting of ICD-10 codes, you should also think about the testing and validation of these system changes. Conceptually, the changes made to your internal systems must ultimately be recognized and interpreted the same way by an external entity or trading partner that is looking at the data coming from the changes you made.

Testing

- Populate files used for testing purposes
- Examine whether all of the format configuration changes have been properly modified

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- Validate whether these changes are properly recorded in the specific section of the HIPAA transaction standard
- Test the accuracy of the changes by creating edits that specifically focus on these changes and how and when they should occur as information flows during the population of data into the files

Validation

- Examine whether supporting documentation is gathered and is available to support the coded information
- Monitor whether appropriate security methods are used including log-in and tracking of individuals
- Ensure that the appropriate communication protocols are being utilized during the transmission of data

External

Once you have completed your internal testing the next phase is external testing.

Testing

- Prepare for external testing by communicating with the health plans
- Register with the health plans for testing
- Establish dates for conducting testing
- Identify the various production scenarios that should be used during the testing period

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Validation

- Consider the results that should be achieved from a reimbursement perspective
- Validate that the results should yield similar reimbursement results to that of using ICD-9-CM
- Ensure that health plans demonstrate they are processing the claim using ICD-10 information rather than relying on the GEMS to convert an ICD-10 code back to an ICD-9-CM and then process the claim for payment. As noted earlier, ICD-10 is a nine-fold increase in the number of codes and includes one-to-many, many-to-one and other configurations of plausible choices. A purpose built map can enable this process
- Verify that health plans have redone their edit logic for reimbursement using ICD-10 as their basis to drive the reimbursement formula. This is important because the GEMS will not be maintained indefinitely. At some point in the near future, the maintenance for these GEMS will cease
- Ensure the production scenarios reflect real-world situations – typical billing scenarios reflecting the most common type of claims
- Generate reports on the results of the external testing process
- Review security and connectivity profiles as well as any additional resulting transaction that is generated from the submitted transaction. That includes the acknowledgment transaction as well as other transactions. For instance, if the claim is submitted and processed using the ICD-10 codes, once processed it produces the remittance transaction to describe how reimbursement occurred. This end-to-end testing is needed to ensure appropriate changes have been made

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Finally, if all goes well, confirm the go-live date with health plans and, if feasible, establish post-live date tracking that includes reports. The reports should monitor transaction volume of successful processing.

Staff Training

Staff training on the ICD-10 will be carried out on the basis of individual staff roles. Many of these individuals will need awareness training early in the process. However, coding professionals will need detailed training close to implementation date to achieve ICD-10 coding expertise.

It is important to include physicians on staff since they are an important component for successful implementation. Engage the physicians and work with them to improve physician documentation as well as responding to coding queries. Some physicians will find training helpful since they will need similar support for their own billing practices.

Training can take different forms: Face-to-face training, audio seminars, webinars, etc. In addition to formal training, regular “quick coding tips” could be provided to users leading up to the implementation date.

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Timing of training

- Basic training: During the initial phase, all departments should receive awareness training to ensure general awareness of the magnitude of the change
- Advanced training: Moderate level training should be conducted, beginning in FY2010
- Expert training: In-depth, detailed training of coding professionals should be conducted six-nine months prior to October 1, 2013. However, it is not too early for them to become familiar with ICD-10 concepts and guidelines earlier (such as starting with FY 2010) in order to ease the transition and allay any potential fears. It is estimated that expert training will require 40 hours for both diagnosis (3 days) and procedure (2 days) coding

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Phase 4 – Post-implementation Evaluation and Ongoing Efforts

Software Upgrades

It is important to evaluate software applications post-implementation to determine that the applications are working appropriately. If necessary, software upgrades or enhancements may be needed to correct any post-implementation "glitches" or system errors.

Training

- Conduct additional training based on findings of quality coding audits
- Conduct physician training based on coding staff identification of high-volume areas requiring additional physician queries

Quality Improvements

- Conduct an audit of coded data post-implementation to identify any potential coding errors or areas
- Work with coding staff to determine the high-volume areas requiring additional physician queries and develop physician documentation training accordingly

Comparative Assessments

- Review coded data to ensure that cases continue to be reimbursed at the same rate or grouped to the same MS-DRG they would have been with ICD-9-CM
- Monitor reimbursements to avoid any unintended consequences of coding change

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ROLES BY FUNCTION

Organizational ICD-1O Sponsor

- Assist in prioritizing ICD-10 activities over other organization-wide initiatives
- Ensure collaboration among departments
- Ensure budgeting issues are considered organization-wide
- Report progress of ICD-10 implementation to CEO and senior management
- Report progress to rest of senior management group

ICD-10 Steering Committee Lead

- Convene ICD-10 Steering Committee meetings
- Set ICD-10 Steering Committee meeting agendas
- Report progress to ICD-10 sponsor
- Keep track of implementation progress

HIM/Coding

- Participate as a member of ICD-10 Steering Committee
- Conduct ICD-10 awareness training throughout organization
- Complete information systems assessment inventory
- Identify training and budgeting issues for department
- Determine physician documentation areas requiring improvement
- Identify areas in coding and documentation requiring operational and policy changes
- Identify gaps in health record documentation

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Billing

- Participate as a member of ICD-10 Steering Committee
- Attend ICD-10 awareness training sessions
- Complete information systems assessment inventory
- Identify training and budgeting issues for department
- Identify areas requiring operational and policy changes

Finance

- Participate as a member of ICD-10 Steering Committee
- Attend ICD-10 awareness training sessions
- Complete information systems assessment inventory
- Identify training and budgeting issues for department
- Identify areas requiring operational and policy changes
- Review current contractual agreements with health plans
- Analyze impact of ICD-10 on health plan agreements

Information Systems

- Participate as a member of ICD-10 Steering Committee
- Attend ICD-10 awareness training sessions
- Complete information systems assessment inventory
- Assess vendor readiness and support
- Review contractual agreements with software vendors
- Ensure ICD-10 implementation is considered in all future software application purchases
- Identify training and budgeting issues for department
- Identify areas requiring operational and policy changes

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Quality

- Participate as a member of ICD-10 Steering Committee
- Attend ICD-10 awareness training sessions
- Complete information systems assessment inventory
- Identify training and budgeting issues for department
- Identify areas requiring operational and policy changes
- Identify areas where physician documentation improvement may be necessary
- Assess opportunities with availability of granular data for quality improvement

Medical Staff Liaison

- Participate as a member of ICD-10 Steering Committee
- Attend ICD-10 awareness training sessions
- Complete information systems assessment inventory
- Identify training and budgeting issues
- Participate in documentation improvement training

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RESOURCES

ICD-10-CM Final Rule
http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf

5010 Final Rule
http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf

5010 Implementation Guides (TR3) – AHA Member Discount
http://www.nubc.org/become.html

AHA Regulatory Advisory on ICD-10 Final Rule
http://www.ahacentraloffice.com/ahacentraloffice/ICD-10/files/Adv_ICD-10_finalrule.pdf

AHA Resources on ICD-10
www.ahacentraloffice.org/ahacentraloffice/html/icd10resources.html

American Health Information Management Association (AHIMA)
www.ahima.org/icd10

National Center for Health Statistics, Centers for Disease Control and Prevention
http://www.cdc.gov/nchs/icd.htm

Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/ICD10/

2009 ICD-10-PCS General Equivalence Mappings (GEMs), Code Tables and Index, Reference Manual, Reimbursement Mapping and Code Descriptors
http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp#TopOfPage

2009 ICD-10-CM General Equivalence Mappings (GEMs), Index, Tabular List, Reimbursement Mappings – Diagnosis
http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp#TopOfPage

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Acknowledgements

The AHA wishes to acknowledge the assistance of the following individuals in the creation of this document:

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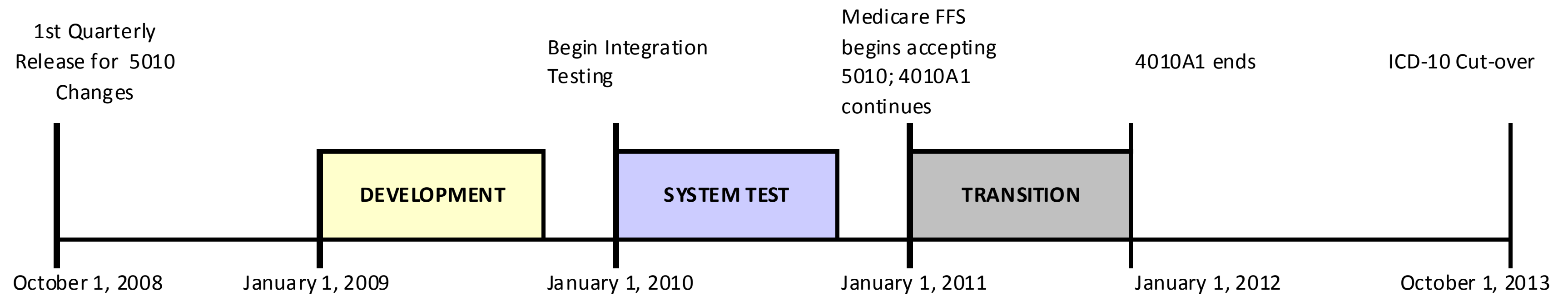
TIMELINES FOR COMPLETION



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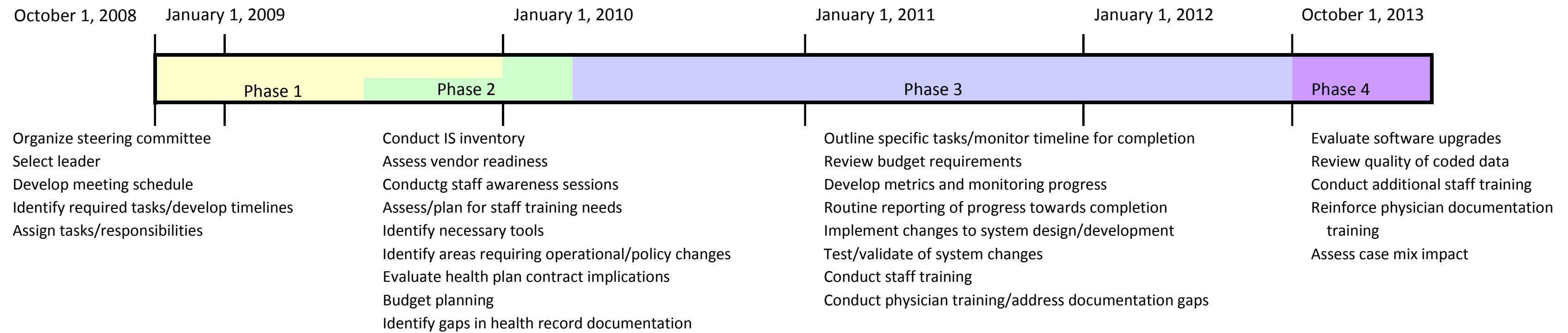
ICD-10 Timeline



Phase 1
- Organize steering committee
- Select leader
- Develop meeting schedule
- Identify required tasks/develop timelines
- Assign tasks/responsibilities

Phase 2
- Conduct IS inventory
- Assess vendor readiness
- Conductg staff awareness sessions
- Assess/plan for staff training needs
- Identify necessary tools
- Identify areas requiring operational/policy changes
- Evaluate health plan contract implications
- Budget planning
- Identify gaps in health record documentation

Phase 3
- Outline specific tasks/monitor timeline for completion
- Review budget requirements
- Develop metrics and monitoring progress
- Routine reporting of progress towards completion
- Implement changes to system design/development
- Test/validate of system changes
- Conduct staff training
- Conduct physician training/address documentation gaps

Phase 4
- Evaluate software upgrades
- Review quality of coded data
- Conduct additional staff training
- Reinforce physician documentation training
- Assess case mix impact

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