ICD-10 Reboot

Getting your agency’s readiness plan back on track

Corinne Kuypers-Denlinger, VP, Post-Acute Care Product Group, Decision Health
Arlene Maxim, RN, Founder/CEO A.D. Maxim
Tricia A. Twombly, RN, BSN, HCS-D, HCS-OC, COS-C, CHCE, AHIMA
ICD-10 Trainer, Senior Director, DecisionHealth

Could this be you on September 30?
Session Objectives

• Refresh our collective memory as to why we’re making the shift to ICD-10
• Transition plan that agency of any size can adopt
• Training guidelines for staff, with an emphasis on coders and clinicians
• Available resources, and know how to validate applicability to and utility for home health and hospice

Why ICD-10?

• The ICD-9 code set is full, no more room for new diseases or new technologies
• Data will be compatible with world health data
• Accelerate development of evidence-based protocols
• Greater specificity of code selection will facilitate
• Cost management
• Reduction in fraud and abuse
• Improved outcomes management
• If you want to get paid, you’ll have to make the change
Industry Readiness

- 59% of agencies believe ICD-10 will be implemented on October 1, 2015
- Some 38% believe it will be delayed again, but are preparing as if it won’t – 3% are doing nothing
- 63% of respondents say ICD-10 readiness is a priority for the remainder of 2014
- Claim delays/denials (45%) and coder productivity (27%) are the two biggest concerns as we make the transition
- 92% of agencies have spent less than $10K in preparation, and 81% plan to spend less than that going forward
Tip: Agencies have underspent and under-budgeted for the transition

Industry Readiness

- General acceptance that productivity will decline as a result of
  - Extra time needed to code (42%),
  - Extra time for OASIS-C1 completion (13%),
  - Additional time and effort required for clinicians to complete documentation (45%)
- Some 70% of agencies either plan to
  - Take a line of credit (26%)
  - Get a loan (9%) or
  - Have a six-month cash reserve, yet
- A frightening 43% do not yet have a backup plan

Tip: Have a back-up plan
I don’t want to transition to ICD-10!

Transitioning is not Optional

- It affects all areas of your business, not just billing
- Failure to implement will cost everyone $$$
  - Billing Backlogs, Cash Flow Delays
  - Increased rejections/denials
  - Training & re-training
- Improper coding can lead to reviews, rejections & revenue loss!
What Does a Transition Team Do?

• Develop a Training Plan
• Assess Readiness of Staff/Billing/IT Systems to Transition
• Develop Process Changes for Intake
• Work with ICD-10 Trainers
• Quantify Lost Productivity during Transition
• Assess Need for Outside Coding Assistance
• Determine Education Needs Among Referral Sources

So How Do I Choose a Transition Team?

• Leaders from each department of the Agency
• Choose those with the skills & abilities to implement significant changes in their areas
Appoint a Project Manager

- Single team member will be responsible for holding each department accountable across the ICD-10 implementation team
- Holds final word regarding policy, business & technical decisions

Where Do We Start?

- Establish regular check-in meetings
  - Meet to discuss & address any issues encountered by the departments during training & implementation
  - Once a month to review planning & impact analysis
- Decide how you will conduct an Impact Assessment
  - Determine how ICD-10 will affect your organization
  - Determine scheduling and budgetary deadlines
- Communicate Regularly – Create a calendar of internal tasks, milestones, deadlines
A Process to Follow

Step 1 – Identify Resources
Step 2 – Create Project Team/Inform Staff
Step 3 – Assess Impact on Your Agency (Ongoing)
Step 4 – Identify Challenges & Create Project Plan
Step 5 – Secure Budget
Step 6 – Contact Vendors, Payers & Monitor Prep
Step 7 – High Level Training for Test Team
Step 8 – Go-Live Preparation
Step 9 – Measurement & Management

Step 1: Identify Resources

• Conduct an information systems inventory
• Assess vendor readiness & support
• Identify necessary tools for the conversion
• Identify areas needing operational & policy changes
Step 2: Create Team / Inform Staff

- Assemble Implementation Team
- Conduct staff awareness sessions
  - What is ICD-10 and why we are required to change?
  - What can you do to be better prepared?
- Assess staff for their level of readiness

Step 3: Assess Impact on Agency

- Identify Stakeholders & Their Unique Needs
  - Referral Sources
  - Software Vendors
  - Clearing houses
  - Etc.
- GAP Analysis of Staff & Systems
- Assess Clinician & Code Set User Knowledge
- Assess documentation practices & begin improvement efforts immediately!!!!
Step 4: Identify Challenges / Create Project Plan

- Communication Plan
- Coding Education Plan
- General Equivalence Maps; Reimbursement Maps
- Be proactive re documentation gaps with physicians

Step 5: Secure Budget

- Plan a Comprehensive & Realistic Budget
  - Should include Resource & System Needs
  - Plan for Stakeholder Education & Training Needs
  - Account for Software Upgrades, System Changes
  - Factor in Productivity Loss (poss. need for temporary staff)
  - Reassess & revisit budget throughout the implementation period
Step 6: Contact Partners / Monitor

• Identify & ensure involvement and commitment of all internal & external stakeholders:
  • Vendors
  • Physicians
  • Clearinghouses
  • Etc...

Step 7: Train Test Team

• Conduct staff training
• Test / Validate system changes
• Monitor work flow volumes during training period to minimize backlogs prior to go-live
• Reinforce physician
• documentation training
Step 8: Prepare for Go-Live

- Coordinate Educational Needs with Meaningful Use, Quality Measures, Patient Outcomes, and Clinical Decision Support Requirements
- Finalize & Test system changes
- Assess case mix impact
- Intensive education
- Monitor Coding Accuracy & Reimbursement Impact

Step 9: Measure and Manage

- Set milestones for each action item and monitor for compliance
- Measure Coding Accuracy, Productivity, and effect on reimbursements
- Monitor Documentation Improvements
- Continued Coding Education/Documentation Education
- Competencies to evaluate knowledge and skills
ICD-10 Project Manager: Required Duties

- Convene Steering Committee Meetings
- Set ICD-10 Steering Committee Agendas
- Keep track and inspire implementation progress

- BE A CHEERLEADER!!!!!
Revenue and Reimbursement Implications

Look for Current Revenue Cycle Weaknesses

• How long are claims sitting in accounts receivable before being submitted to the payer?
• What percentage of your potential claims revenue is being written off due to timely filing deadlines?
• How long is your billing department taking to submit Medicare RAPs and claims?
Suggested Home Health Revenue Cycle Performance\(^1\)

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Poor</th>
<th>Average</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare days in AR</td>
<td>45 days or more</td>
<td>35 days</td>
<td>25 days or less</td>
</tr>
<tr>
<td>Total days in AR</td>
<td>60 days or more</td>
<td>50 days</td>
<td>40 days or less</td>
</tr>
<tr>
<td>Medicare AR older than 120 days</td>
<td>10% or more</td>
<td>7%</td>
<td>3% or less</td>
</tr>
<tr>
<td>Total AR older than 120 days</td>
<td>15% or more</td>
<td>10%</td>
<td>7% or less</td>
</tr>
<tr>
<td>Collections</td>
<td>Less than 100%</td>
<td>100%</td>
<td>More than 100%</td>
</tr>
<tr>
<td>Medicare write-offs</td>
<td>2% or more</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Total write-offs</td>
<td>3% or more</td>
<td>2%</td>
<td>1% or less</td>
</tr>
<tr>
<td>Days to bill RAPs</td>
<td>More than 10 days</td>
<td>7 to 10 days</td>
<td>Less than 7 days</td>
</tr>
<tr>
<td>Days to bill claims</td>
<td>More than 10 days</td>
<td>7 to 10 days</td>
<td>Less than 7 days</td>
</tr>
</tbody>
</table>

\(^1\)M. Aaron Little, CPA, ICD-10 Administrator’s Boot Camp (DecisionHealth)

Staff Overtime / Hiring Additional Staff

- Monitor workflow volumes and make sure that backlogs are being minimized
- Spend money on overtime or new staff now, or:
  - Operations fall behind
  - Claims sit in AR past timely filing deadlines
- Do the math and determine whether it makes more sense for the agency to pay for overtime or hire outside help
Determine Technology Needs and Costs

- Practice Management Software
  - Cost of ICD-10 software update (if applicable)
  - Cost of hardware upgrades (if necessary)
  - Possible change in contract rate
  - Staff time spent on training with the new update
  - Loss of productivity until staff members are as adroit with the program as they were before
- Clearinghouse, Analytical Software
- Payer web portals

All of Your Partners are Affected by ICD-10

ICD-10 will greatly affect the operations of your external partners. Providers are not the only ones bearing the cost in time, productivity, and revenue.

- Possible costs passed down from the partners:
  - Contract rate negotiations
  - Need for fee-based customer help lines usage
  - Software update to ICD-10, with possible hardware upgrades
Identify All External Partners You Work With:

- Payers
  - Medicare
  - Medicare Advantage Plans
  - Commercial Payers
  - Medicaid
  - Medicaid MCOs

- Clearinghouse
- Practice Management Vendor
- Outsourced Coding
- IT Contractors

External Testing with Payers

1. **Create** test claims with ICD-10 codes
2. **Submit** to payers
3. **Receive** responses from payers with test results
4. **Troubleshoot** any errors received and resubmit test claims
External Testing with Payers  (cont.)

Contact your payers and find out when and how they plan on conducting external testing with you:

• When is it happening?
• Where do we input the ICD-10 codes into the software?
• How does the agency identify test claims as such?
• Do test claims have to be based on real clinical data?

Perform Pre-Billing Audits

The Billing Department should be performing comprehensive pre-billing audits to ensure claims are ready to be billed. The following questions should be answered in the affirmative before a bill is submitted to the external partner:

(1) Are all billable visits and non-routine medical supplies accounted for on the final claim?
(2) Were all billable visits performed according to physician-ordered frequencies?
(3) Did all required therapy assessments occur within the required time frames and were all non-billable therapy visits excluded from the claim?
Perform Pre-Billing Audits  (cont.)

(4) Has the cert/recert (485/POC) been received signed and dated by the certifying physician?

(5) Did the qualifying Face-to-Face encounter occur within the required time frame and has the certification documentation been signed and dated by the physician?

Perform Pre-Billing Audits  (cont.)

(6) Did the certifying physician fill out the Face-to-Face encounter form adequately?

(7) Have all interim/PRN orders for additional visits or services been received signed and dated by the physician?

These audits should be used to identify any patterns of error in final claims due to missing or incomplete documentation.

Found trends can be used to determine which staff members or current processes need attention.
Episodes Spanning October 1st
SOC/ROC/Recerts

• If both the date of the RAP and the M0090 date are before Oct. 1
• ICD-9 codes should be used on the OASIS-C1-I9
• The HIPPS code will be generated with ICD-9 codes, even though the final claim will contain ICD-10 codes

Episodes Spanning October 1st
SOC/ROC/Recerts

• If the RAP date is before Oct. 1, but the M0090 date is after Oct. 1
• ICD-10 codes should be used on the OASIS-C1-I10
• ICD-9 codes are reported on the RAP
• The HIPPS code will be generated with ICD-10 payment
• The ICD-9 codes reported on the RAP are only necessary for it to be processed
Episodes Spanning October 1st
SOC/ROC/Recerts

• If the M0090 date is before Oct. 1 but the RAP date is after Oct. 1 (patient is re-assessed before the first billable visit and within the 5-day window)
• ICD-9 codes should be used on the OASIS-C1-I9
• ICD-10 codes are reported on the RAP
• Though both the RAP and the final claim will contain ICD-10 codes, the payment-generating HIPPS code will be based on the ICD-9 codes reported on the OASIS.

How Will PPS Reimbursement be Affected?

• CMS uses the Home Health Prospective Payment System (HH PPS) to determine provider reimbursement
• Based on the information provided in the OASIS, the CMS Grouper program assigns a HIPPS code to the patient
• The characters in the HIPPS code represent the following information:

  • 1st CHARACTER: Number of visits, and whether episode is EARLY or LATE
  • 2nd CHARACTER: Clinical Severity (diagnoses, pain, ulcers, etc.)
  • 3rd CHARACTER: Functional Severity (ADLs, IADLs)
  • 4th CHARACTER: Service Utilization (therapies)
  • 5th CHARACTER: Non-routine Supplies (NRS)
How Will PPS Reimbursement be Affected? (cont.)

<table>
<thead>
<tr>
<th>HHRG</th>
<th>HHRS</th>
<th>Standard PPS Base Rate</th>
<th>Weights</th>
<th>Labor Adjusted Rate</th>
<th>Case-mix Adjusted Rate</th>
<th>Geographic Factors</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0PS1</td>
<td>IFRS</td>
<td>2.1777</td>
<td>0.9886</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
</tr>
<tr>
<td>LIFRST</td>
<td>2.1777</td>
<td>0.8386</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
<td>375.63</td>
</tr>
<tr>
<td>LIFRST</td>
<td>2.1777</td>
<td>0.8386</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
<td>375.63</td>
</tr>
<tr>
<td>LIFRST</td>
<td>2.1777</td>
<td>0.8386</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
<td>375.63</td>
</tr>
<tr>
<td>LIFRST</td>
<td>2.1777</td>
<td>0.8386</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
<td>375.63</td>
</tr>
<tr>
<td>LIFRST</td>
<td>2.1777</td>
<td>0.8386</td>
<td>1740.85</td>
<td>1.274322</td>
<td>0.8992</td>
<td>1.427546</td>
<td>375.63</td>
</tr>
</tbody>
</table>
How will Reimbursement be Affected

• Sequencing changes in the new HHRG sets can result in reimbursement changes
• Diagnoses may find themselves placed in different groups and have different weights assigned to them
• If your agency has a fairly homogenous clientele in terms of diagnoses, the effects of changes in reimbursement will be magnified

Determining Reimbursement Change

1) Begin by identifying the sample size of the census by selecting a specific time frame that you will review (1-3 years is recommended)

2) Using your selected sample, perform the following steps:
   a) Identify the ICD-9 codes AND the applicable case-mix weights
   b) Identify the applicable revenue based on this information. This figure will serve as a baseline, and will represent past revenue under ICD-9
   c) Using the clinical information in the medical record, convert the ICD-9 codes from the above analysis to their appropriate ICD-10 counterparts. Identify the case-mix weights again
   d) Identify the new revenue figure. This number will serve as a projected revenue estimate in the ICD-10 world
Analyzing the Data

The most meaningful way of interpreting your data is on a case-by-case basis.

1) Examine your top 10 to 20 diagnoses and identify revenue changes on a diagnosis-specific level

You may find certain diagnoses are now “less profitable”, while others will bring in more revenue.

Use this knowledge to prioritize your marketing team’s efforts accordingly.

Why is Maximizing Reimbursement Necessary?

Maximizing your future reimbursement under ICD-10 is not about lining your pockets— it’s about recouping loss!

There are two types of ICD-10 costs that your agency faces:

<table>
<thead>
<tr>
<th>One-time costs</th>
<th>Ongoing Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="One-time costs" /></td>
<td><img src="image" alt="Ongoing Costs" /></td>
</tr>
</tbody>
</table>
One-time Costs

- Software/Hardware Updates
- Edits to Forms to accommodate ICD-10 information
- Productivity Loss
  - During Training
    - From lack of familiarity with new systems and processes
- Workflow restructuring

Ongoing Costs

- Training
  - Coder
  - Clinical
  - QI/Compliance
- Productivity Loss
  - Increased Denials (require manual attention)
  - Permanent Coding Outsourcing / New Staff / Overtime
- Slowing of revenue stream due to increase in Denials and Audits (until CMS’s detection algorithms are optimized for ICD-10)
- Payer Contracted Rate Renegotiations
CMS and other industry leaders are recommending that agencies have available enough credit/cash to keep operating for 6 months with no revenue coming in.

This suggestion anticipates a “doomsday” Y2K scenario, which we hope will not happen, but as always—

**BETTER SAFE THAN SORRY!**

Preparing for the Worst (cont.)

**How to prepare:**

- Expand existing line of credit
- Contact a bank/lender who understands the specialized financing requirements of healthcare practitioners
- Contact your Small Business Administration (SBA) office
- Know that banks are unlikely to approve new lines of credit for managing cash flow
Importance of Training All Staff

Recommended Training

- Support to ensure coordination across all departments
- *Not* just the coders!!
- Plan for increased turnover of Clinicians &/or Coders
- Provide training within four learning groups
Training Format

- Pay envelope stuffers
- Posters
- In-services
- Print resources
- On-line courses
- Live education conferences
- Customized webinars
- On-site consultants

Learner Groups

Level 1 – General

- Support staff
  - Administrative assistants
  - Medical records personnel
- One hour high level overview
  - Rationale for change
  - Impact on organization
  - Job responsibility
Learner Groups

Level 2 – Basic

- Administrative Staff
  - Intake
  - Scheduling/Billing
  - Sales/Marketing
  - Senior management
  - Accounting
- Four hour general overview
  - Vendor readiness
  - Budget planning
  - Report review
  - Operations and planning

Learner Groups

Level 3 – Intermediate

- Clinical Staff
  - Clinicians/Therapists
  - Regional directors
  - Case managers
  - Clinical supervisors
  - Agency director/Administrator
- 20 to 30 hours intermediate training
  - Documentation requirements
  - ICD-10 conventions and guidelines
  - ICD-10 Disease specific chapters
  - ICD-10 V,X,Y,Z codes
Learner Groups
Level 4 – Advanced

- Coding Staff
  - Coding specialists
  - Coding supervisors
  - Compliance clinicians
  - QA/QI clinicians
- 30 to 50 hours advanced training
  - Documentation needs
  - ICD-10 conventions and guidelines
  - ICD-10 Disease specific chapters
  - ICD-10 V,X,Y,Z codes

Home Health Coders

- Solo Coder 44%
- 2 Person Team 25%
- 3+ person team 31%
Your Agency

- Who is responsible for the coding?
  - Field clinician
  - Centralized coder(s)
    - clinical
    - non clinical
    - 56% non clinical
    - 44% clinical
  - Outsource coding
- Does the coder also review the OASIS?

ICD-9 Productivity

- Coding responsibility ONLY:
  - 25 assessments per day
- Coding and OASIS review:
  - 15 assessments per day
- Internal quarterly audit results:
  - 90% > accuracy rating
Comparison

• Coder productivity first 12 months:
  - 70% longer to code claims
  - 54% decrease in productivity

*Note: Data suggests initial productivity loss is never fully recovered*

• Coder productivity in the long term:
  - 20% decrease in productivity
  - Maintain a 90% > accuracy rating

<table>
<thead>
<tr>
<th>ICD-9 Current</th>
<th>ICD-10 First 12 months</th>
<th>ICD-10 Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coding:</strong></td>
<td><strong>Coding:</strong></td>
<td><strong>Coding:</strong></td>
</tr>
<tr>
<td>25 assessments daily</td>
<td>11.5 assessments daily</td>
<td>20 assessments daily</td>
</tr>
<tr>
<td><strong>Coding and OASIS Review:</strong></td>
<td><strong>Coding and OASIS Review:</strong></td>
<td><strong>Coding and OASIS Review:</strong></td>
</tr>
<tr>
<td>15 assessments daily</td>
<td>6.9 assessments daily</td>
<td>12 assessments daily</td>
</tr>
<tr>
<td><strong>Internal audit Review:</strong></td>
<td><strong>Internal audit Review:</strong></td>
<td><strong>Internal audit Review:</strong></td>
</tr>
<tr>
<td>90% &gt; accuracy rating</td>
<td>90% &gt; accuracy rating</td>
<td>90% &gt; accuracy rating</td>
</tr>
</tbody>
</table>
Gap Analysis

- Assess employee knowledge gap
- Anatomy
- Physiology
- Pathophysiology
- Pharmacology
- Medical terminology

Pharmacology Example

ICD-9

- Patient admitted with diabetes mellitus with polyneuropathy due to long term steroid use and is taking insulin. Pt. also has rheumatoid arthritis.
- M1020: 249.60 secondary diabetes with neuro
- M1022: 357.2 polyneuropathy
- M1022: 714.0 rheumatoid arthritis
- M1022: V58.65 L/T use steroids
- M1022: V58.67 L/T use insulin
- M1022: E932.0 Adverse event to steroid use
Pharmacology Example
ICD-10

• Patient admitted with diabetes mellitus with polyneuropathy due to long term steroid use and is taking insulin. Pt. also has rheumatoid arthritis.
• M1021: E09.42 Drug induced diabetes with polyneuropathy
• M1023: T38.OX5D Adverse effect of glucocorticoids and synthetic analogues
• M1023: M06.09 Rheumatoid arthritis
• M1023: Z79.52 L/T use systemic steroids
• M1023: Z79.4 L/T use insulin

Pharmacology Example
ICD-10

• T38.OX5D Adverse effect of glucocorticoids and synthetic analogues
  Alpha listing:
  - Anabolic
  - Androgenic
  - Antineoplastic
  - Estrogen
  - ENT agent
  - Ophthalmic preparation
  - Topical NEC
Pharmacology Example
ICD-10
• Z79.52 L/T use systemic steroids
  Tabular listing:
  - Long term use of inhaled steroids
  - Long term use of systemic steroids

Pathophysiology Example
ICD-9
• Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF. Both nursing and therapy will see the patient.
  • M1020: V54.13 A/C hip fx
  • M1022: E88.44 Fall from bed
  • M1024: 820.8
Pathophysiology Example

ICD-10

• Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF.

• M1021: S72.042D Subsequent encounter for a closed displaced fracture of base of neck of left femur with routine healing

• M1023: W06.000D Fall from bed subsequent encounter

Pathophysiology Example

ICD-10

Appropriate 7\textsuperscript{th} Character

D – Subsequent encounter for closed fracture with routine healing

E – Subsequent encounter for open fracture type I or II with routine healing

F – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing

G – Subsequent encounter for closed fracture with delayed healing
### Pathophysiology Example

**ICD-10**

Appropriate 7\textsuperscript{th} Character

- **H** – Subsequent encounter for open fracture type I or II with delayed healing
- **J** – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
- **K** – Subsequent encounter for closed fracture with nonunion
- **M** – Subsequent encounter for open fracture type I or type II with nonunion

---

### Pathophysiology Example

**ICD-10**

Appropriate 7\textsuperscript{th} Character

- **N** – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
- **P** – Subsequent encounter for closed fracture with malunion
- **Q** – Subsequent encounter for open fracture type I or II with malunion
- **R** – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
- **S** – Sequela
Anatomy and Physiology  
ICD-9 Example

- Patient admitted for newly diagnosed type I diabetes with chronic kidney disease. Patient on insulin.

- M1020: 250.41 Diabetes with renal
- M1022: 585.9 Unspecified chronic kidney disease

---

Anatomy and Physiology  
ICD-10 Example

- Patient admitted for newly diagnosed type I diabetes with chronic kidney disease. Patient on insulin.

- M1020: E10.22 Type I diabetes mellitus with diabetic chronic kidney disease
- M1022: N18.9 chronic kidney disease

- Note: Unspecified renal insufficiency is a choice but is not included the list of allowable pairings
Preparation and Impact

Preparation

- 5 areas of training were considered by CMS
- Methodology
- Clinical specialty
- Number of coders
- Number of hours for coder training
- Cost per hour of training
Preparation

• CMS and AHIMA recommend training time line to be no sooner than 9 months prior to implementation (October 1, 2015)
• If training occurs sooner, the agency would need to retrain

• Note: This time line is not referencing the agency ICD-10 trainer(s)

Preparation

• Implementation ICD-10-CM:
• Coders = 16 hours training
• Gap knowledge deficit = 8 hours additional
• Total = 24 hours training time
• CMS estimate $644 per coder

• Note: This time frame and cost is for full time coders only – not other agency personnel who need an overall understanding (i.e. senior management, accounting, quality improvement staff)
Preparation

- Required software changes will affect coding processes
- Testing with vendor and intermediary before the ‘go live’ date is a must
- Duel coding will be required for a period of time
- Lower payment structure for unspecified codes may result

Impact

- New code set will produce a temporary increase in coding errors resulting in rejected claims
- Medicare expects a spike in rejected claims 3 to 6 months following introduction of code set, peaking at 10% of all claims submitted
- Productivity will be directly affected because of the need to learn new codes and definitions
Impact

• Coding clinic guidance will be retired so ‘unlearning’ rules will be as important as learning the new code set
• In 2016, CMS estimates a 9.77 million dollar loss in coder productivity (based on each assessment requiring an additional 1.7 minutes to complete)
• CMS expects the Home Health industry to have an overall transition cost from ICD-9 to ICD-10 of 16.58 million dollars

Impact

• Increased delay in processing claims
• Increased claim rejections and denials
• Improper claims payment
• Coding backlog
• Compliance anomalies
• Decreased cash flow
Impact

- Do I have the right employees on the coding team?
- Do they need remedial education prior to ICD-10 training?
- Should I hire additional coders?
- Should I consider a short term agreement with an outsource coding company?
- Should I outsource all coding?

---

Sample Timeline for Home Health

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>Nov</td>
<td>Dec</td>
</tr>
<tr>
<td>Nov</td>
<td>Dec</td>
<td>Jan</td>
</tr>
<tr>
<td>Feb</td>
<td>March</td>
<td>April</td>
</tr>
<tr>
<td>May</td>
<td>June</td>
<td>July</td>
</tr>
<tr>
<td>August</td>
<td>Sept</td>
<td>Oct</td>
</tr>
</tbody>
</table>

**PLANNING**
- Identify resources
- Create project plan
- Assess effects
- Secure budget

**COMMUNICATIONS**
- Inform staff
- Contact vendors
- Contact payers
- Monitor vendor prep
- Monitor payer prep

**TESTING**
- High-level training
- For teams
- Level 1/Level 2 internal

**COMPREHENSIVE TRAINING**
- Contact your software vendor and NGS for possibilities

**Coding**
- Dual Coding Practice
- Dual Coding Activity Begins

**OTHER ANALYSIS/TASKS**
- Review list of proposed changes
- Additional training on grouper
- Training on GABC C-1
- Evaluate groups for impact
- To payment
- Ongoing quality audits
Take Away Points

• Review medical record documentation on most frequently coded conditions
• Focus on charts that lead to the highest or most common denial rates
• Identify documentation improvement opportunities
• Comprehensive education and mentoring
• Develop coder and clinician interactions

Take Away Points

• Partner with the right education sources
• High quality documentation will increase the benefits of the new coding system
• High quality documentation is increasingly being demanded by other initiatives
• High quality documentation and accurate coding are on the door step of home health in an ICD-10 environment
Take Away Points

• Preparation is the key
• Communication is vital
• Establish a team to implement the transition
• Payment in part, will be linked to precise coding
• Accurate coding depends on thorough documentation
• Both are critical to your organizational success in an ICD-10 environment

ICD-10 Transition Resources

• NAHC ICD-10 Transition Resources Directory
• Centers for Medicare and Medicaid Services
• WEDI CMS Cooperative Exchange ICD-10 Implementation Success Initiative
  http://www.wedionline.org/icd-10/default.aspx
ICD-10 Transition Resources

- General ICD-10 Information
  Provider and HIM Websites
- Find the right tools and training
  Buyer beware
  Be wary of free
  Know the source
- Just because it says home health or hospice doesn’t mean it is
What questions do you have?

Contact Information

Arlene Maxim, RN
Founder/President A.D. Maxim Consulting
www.admaximconsulting.com
900 Wilshire Blvd.
Troy, MI 48084
248 457-9227

Corinne Kuyper-Denlinger
Vice President, Post-Acute Care Product Group
DecisionHealth (www.decisionhealth.com)
9737 Washingtonian Blvd., Suite 200
Gaithersburg, MD 20877
301 287-2363

Tricia A. Twombly, RN, BSN, HCS-D,HCS-O, COS-C, AHIMA Approved ICD-10-CM Trainer
Senior Director, DecisionHealth
301 287-2303