ICD-10—the tenth revision of the International Classification of Diseases—is here. The U.S. Healthcare System has been preparing for this moment for several turbulent years. Beginning October 1, 2015 the Centers for Medicare and Medicaid Services (CMS) instructed the nation’s providers to commence submitting claims utilizing the new ICD-10 code set. The new system carries with it the potential for profound benefits, including opportunities for enhanced quality and coordination of care and improved revenue. But the shift has triggered waves of anxiety among healthcare providers who have seen claims denied and payments delayed because they did not use and bill the new codes properly.

With more than 100,000 new codes, ICD-10 gives providers, payors and researchers access to a wealth of new clinical data. The codes reflect changes in medical technology and treatment and allow for more thorough and precise descriptions of diagnoses, severity of illness and the intensity of care provided to patients. The new code sets carry the potential to improve a healthcare organization’s ability to document patient quality of care, greatly enhance coordination of care by painting a more accurate and comprehensive clinical picture, provide deeper and more meaningful justification of services provided and present opportunities for providers to receive better reimbursement that more closely reflects true severity of illness and utilization of resources.

But the new system is not without intense challenges. To realize ICD-10’s benefits, physicians need to change the way they document care to ensure each record reflects the right information related to laterality, specificity, severity of illness (SOI), risk of mortality (ROM) and additional information about accompanying diagnoses, approach for procedures, use of medical technology and devices, and other clinical and descriptive information they did not previously need to document so fully. Likewise, coders need to be fluent in the ICD-10 coding methodology in order to pick up the right codes to support accurate billing. Clinical documentation improvement (CDI) specialists and physician advisors need to understand ICD-10 documentation and coding requirements in order to draft queries and develop education to ensure that physicians are documenting in a complete, compliant, and ICD-10 centric manner. And billers, revenue integrity staff and revenue cycle personnel need to understand key requirements and financial implications to ensure financial success under ICD-10.

The change has represented a big shift in mindset and operations; it will take some more time to fully take root. Healthcare organizations looking to prevent revenue loss, mitigate compliance risks and ensure success under ICD-10 must be focused, nimble and adaptable. This paper presents some common issues, examples of how differences in documentation and coding requirements under ICD-10 can interrupt revenue, and strategies to help ease the continued transition.

MONITOR DENIALS AND CORRECT ROOT CAUSE ISSUES

Providers have experienced some inevitable claims denials for medically necessary services that were provided and documented but not properly coded and billed using the new ICD-10 methodology. Healthcare organizations must be diligent in monitoring denials and instituting processes to quickly correct coding, documentation, and billing issues caused by improper, incomplete or inadequate use and submission of ICD-10 codes. Despite months—and in some cases years—of preparation, issues inevitably surface through the denials process, so it is critically important to adjust denials monitoring and reporting and staff accordingly. It is also necessary to ensure lines of
communication remain wide open between denial and revenue cycle staff, HIM and CDI personnel, coders, and physicians so that root causes can be identified and corrected. All the monitoring in the world will not help if the information does not flow to the people who can correct the problems.

**OPEN AN ICD-10 LINE OF CREDIT**

As a preventive measure, some healthcare organizations and physician practices opened new lines of credit to guard against cash flow issues that accompanied increased ICD-10 related denials and a longer than average A/R cycle. Some banks even offered special “ICD-10 credit lines” geared specifically towards helping physicians, hospitals, and other healthcare provider organizations keep the lights on while they worked through securing the integrity of their revenue and cash flow.

**IDENTIFY AND PRIORITIZE RISK AREAS**

Conducting timely reviews can help billers, coders, CDI and HIM staff to identify any interruptions that may have gone unnoticed in ICD-9-CM, but began impacting the revenue stream after October 1, 2015. It is important to prioritize efforts and focus on the procedures and treatments for which ICD-10 has the greatest potential for negative financial impact or adverse compliance risks. Can your team identify these procedures and treatments? How many of these are done at your facility every day? Organizations are beginning to discover that a given code is not being reimbursed, or contrarily, that the organization is being over-reimbursed as a result of improper use and submission of ICD-10 codes. Is your organization’s documentation sufficient for coding and billing for these procedures?

Healthcare providers and organizations that were already dual coding and conducting regular ICD-10 compliance, documentation, and billing audits prior to the transition date may have proactively identified the top risk areas. Organizations that had not implemented dual coding and only stepped up auditing and monitoring efforts after October 1 might still be lagging behind, but can take steps to recover quickly. These include focused assessments, communication, education, targeted chart reviews, data analysis, monitoring and reporting on key ICD-10 related metrics.

**PREVENT REVENUE STOPPERS**

What might you look for to identify “revenue stoppers?” One approach is to start with the most common procedures and services your organization provides and bills and then identify the documentation and billing requirements for those procedures and services under ICD-10. Can you find the right notes? Is the right information documented within the notes? Are the physicians documenting with adequate specificity to support coding and billing under ICD-10?

For example, two ICD-10-PCS procedures that are common at many facilities and are prone to risk under ICD-10 are blood transfusion and mechanical ventilation. Here are some examples of items that a coder, clinical documentation specialist, chart auditor or biller might want to consider:

**Blood Transfusion**

Under ICD-10-PCS (procedure coding system), correct coding for blood transfusions requires that the documentation provide the body system/region (character 4). The choices for the blood transfusion are: peripheral vein, central vein, peripheral artery or central artery. Also, documentation must include the approach (character 5) and these choices are: open or percutaneous. This information was not required to code a blood transfusion in ICD-9-CM volume 3, but is required with ICD-10-PCS.

Can you locate the blood transfusion notes in every patient’s chart? Once you locate this note, does the documentation consistently contain the information required to code and bill under ICD-10-PCS (e.g., body system, region, approach)? Inadequate or missing documentation must be remedied through proactive education and communication with physicians. Proactive measures such as chart audits and education will help reduce the number of physician queries after the implementation date.

**Mechanical Ventilation**

Mechanical ventilation can be invasive (e.g., endotracheal intubation or tracheostomy) or non-invasive (e.g., face mask or mouth piece). In ICD-9-CM volume 3, if the mechanical ventilation was non-invasive then duration was not a requirement for code selection. If the mechanical ventilation was invasive, then duration was a requirement for code selection. In ICD-9-CM volume 3, the duration was broken down as follows: unspecified, less than 96 consecutive hours and 96 consecutive hours or more. There are some changes with ICD-10-PCS code selection for mechanical ventilation.

Under ICD-10-PCS, the root operation of a procedure identifies the objective of the procedure. The mechanical ventilation root operations that need to be considered are: assistance and performance. Assistance is defined as taking over a portion of a physiological function by extracorporeal (outside the body) means. Performance is defined as completely taking over a physiological function by extracorporeal means. Does your current documentation reveal whether all or a portion of the patient’s physiologic function is taken over?

Further, the duration in ICD-10-PCS is more precise for both invasive and non-invasive mechanical ventilation, whether a portion or complete taking over of physiological function occurs: less than 24 consecutive hours, 24-96 consecutive hours and greater than 96 consecutive hours. Make sure that your documented duration meets the new ICD-10-PCS criteria. In ICD-10-PCS respiratory ventilation assistance also specifies choices for the type of ventilation: continuous positive airway pressure, intermittent positive airway pressure, continuous negative airway pressure, intermittent negative airway pressure or no qualifier.
are adequately documented. If any information is missing, coding and billing issues will ensue.

**MITIGATE COMPLIANCE RISKS**

The problem is twofold. When viewed through a proactive lens, if coders do not see the necessary ICD-10 related information in the patient charts, they cannot appropriately build and bill the claims. Thus, there will be a need to query physicians and billing will be delayed. Likewise, the possibility for denials is enhanced if bills drop with incomplete information or if the payor requests supporting documentation that the provider cannot produce.

Viewed through a reactive lens (think Recovery Audit Contractors, or investigations by States Attorney General or the Department of Health and Human Services’ Office of the Inspector General) ICD-10 carries with it the potential for risks related to over-coding and over-billing. If there is not sufficient documentation in each patient’s medical record for the billed procedures and services, but those procedures are nonetheless billed and reimbursed, the healthcare organization might find itself in possession of overpayments and subject to repayments, penalties, damages and fines. Compliance and internal audit departments at healthcare organizations are critical links in the ICD-10 coding and billing process. These groups must be engaged and actively monitoring, auditing and educating on the risks. Moreover, it is always important to consult with compliance and legal teams when changing policies and practices related to billing and coding.

**UTILIZE DATA ANALYSIS AND SCORECARDS**

Many organizations utilize data analysis and scorecards to monitor risks and drive performance improvements. CDI, HIM, compliance, internal audit, revenue integrity, billing and revenue cycle leadership should consider collaborating on new ICD-10 scorecards and ensure ICD-10 related metrics have been successfully integrated into existing physician and departmental scorecards. The scorecards should draw attention to the accuracy, completeness and quality of physician documentation and provide tools to engage physicians on documenting with ICD-10 in mind. Likewise, a scorecard might focus on coder accuracy under ICD-10 and be designed to identify areas in which coders need improvement or education. Focusing on these areas is important because documentation drives coding and coding drives reimbursement. In coding and billing, we are all familiar with the old adage “not documented, not done.” In other words, if the documentation is not sufficiently robust, the organization may not be capturing relevant information necessary to ensure compliance and appropriate reimbursement under ICD-10.

**LOOK FOR EXPERT ADVICE**

A wealth of information has been published about ICD-10 by CMS and industry groups. Look for seminars, conferences, webinars, publications and surveys from CMS and from industry groups such as AHIMA, ACIDIS, HFMA, HCCA, HIMSS and the AMA. In addition, professional services firms and experts like FTI Health Solutions can help healthcare organizations update their coding and billing practices for ICD-10, modify related systems, update and validate claims scrubbers, conduct chart audits, run data analyses, update scorecards, dashboards, and reports, identify risk areas, monitor coding, improve claims accuracy, reduce denials, train coders and staff, and provide guidance to help healthcare industry leaders and practitioners avoid mistakes.

**COORDINATE AND OVER-COMMUNICATE**

Your organization’s ICD-10 monitoring plan and infrastructure ideally includes coordination between a team of senior leaders, administrators, physicians, and representatives from health information management, coding, clinical documentation improvement, quality, information technology, data, finance, revenue and compliance departments. Continued communication and coordination is paramount to success under ICD-10. The shift has been monumental. Failure to continue to employ effective change management and change communications strategies will be costly.

Utilize the results of ICD-10 monitoring and auditing efforts to identify areas for improvement. Engage key stakeholders; organize continued discussions and communications strategies; continue to update policies and procedures; tighten internal controls and develop and implement training and education. Prevent ICD-10 revenue stoppers and mitigate compliance risks through chart audits, data analysis and reviews to identify root causes of denials. Sit down with physicians who are consistently not in compliance with the organization’s updated policies related to documentation and ICD-10. Hold discussions to educate on the importance of complete, accurate and compliant documentation that meets the requirements under ICD-10. Finally, realize and share in the clinical and financial benefits promised by ICD-10.

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**ABOUT THE FTI CONSULTING CDCI PRACTICE**

The CDCI practice at FTI Consulting focuses on understanding how data can be used to educate, assist, and transform Clinical Documentation Improvement (CDI) and Health Information Management (HIM) and coding programs within the healthcare environment.

FTI Health Solutions supports healthcare organizations through education, change management, auditing and monitoring programs, analytics and chart reviews. Our experts regularly assess the current state of Clinical Documentation Programs and
help organizations identify gaps, correct issues, and enhance the success of their current coding programs.

Our Physician Scorecard solution provides analysis of hospital claims data, CDI program data, VBP and HRRP related quality and efficiency indicators. We pair the scorecard results with analysis and recommendations from FTI’s physicians, clinicians, and HIM/CDI specialists. We assist clients with communicating the results to their internal physician staff to ensure acceptance and engagement, and provide training to drive improvements in physician documentation.

Our ProTrend™ outcome metrics reporting package provides analysis of APR and MS DRG data and helps organizations to monitor Case Mix Index (CMI), CC/MCC Capture Rates, and overall volume as compared to nationwide benchmarks for similar institutions.

Our Value Based Purchasing analytics monitor all of the metrics within each VBP domain. We pair this monitoring with real-time education to help provider organizations realize improvements to the quality metrics that will be reported to CMS, thus ensuring compliance and maximizing future reimbursements. Additionally, we utilize analytics to validate the CMS-published VBP data and scores against the data the hospital reported to CMS and help to facilitate appeals process triggered by identified discrepancies.

REFERENCES

1. The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010