SIX BUILDING BLOCKS FOR A SUCCESSFUL

ICD-10 Implementation

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ICD-10 BUILDING BLOCKS

Six fundamental building blocks will enable ICD-10 transition teams to structure and lead a sound and cost-effective implementation process. These building blocks include:

1. COMMUNICATION
2. CODING EDUCATION
3. CLINICAL DOCUMENTATION IMPROVEMENT
4. INFORMATION TECHNOLOGY
5. REVENUE CYCLE
6. POST GO LIVE ACTIVITIES

Skillfully executed, they will smooth the transition to ICD-10 and help ensure high quality coding and documentation programs. These foundational building blocks will be essential for programs that must assure the data quality needs of today and tomorrow. This report explores these building blocks in more detail.
Six Building Blocks for a Successful ICD-10 Implementation

1. COMMUNICATION

CMS recently released updated guidelines for ICD-10 Communication Plans. The key elements from these guidelines include:

**Articulate a vision for ICD-10 for your organization.** The importance of a vision statement should not be overlooked. The vision statement provides communication on a shared purpose and clarity for the implementation team to guide them throughout implementation. When expected outcomes and shared vision are included, it is less likely the team will veer off the path to a successful implementation.

**Work with partners and understand their roles.** ICD-10 implementation will not be accomplished by one person and it is vital to communicate with all partners and stakeholders. This includes groups internal to the organization such as IT and Patient Financial Services as well as groups external to the organization such as software vendors and payers. Roles and responsibilities of all parties affected by ICD-10 need to be well defined to facilitate regular collaboration and communication of timelines and milestones.

**Establish a timeline.** Timelines that address milestones, secondary tasks and deadlines help to keep implementation teams on task. They communicate progress to stakeholders and internal and external partners. While not all timelines are formal, visually presenting a timeline is a very effective way to communicate.
1. COMMUNICATION

**Determine communication methods.** A communication plan that includes specific communication methods provides a set of ground rules within which the implementation team will operate. A good rule of thumb is to consider the saying “seven times, seven ways.” Communicating a message multiple times using multiple types of media increases the likelihood the message will be heard and understood. A thorough communication plan will include the following elements:

- Who the communication is coming from and going to
- Who will provide the content for the communication
- How frequently the communication will be sent
- What format will be used (for example, a status report or an action item list)
- What media will be used for delivery (for example, email, verbal updates or project software)
- Messages to be delivered related to the communication

A good rule of thumb is to consider the saying “seven times, seven ways.”
SKILLS ASSESSMENT

Unless an organization has tracked and trended details of coding quality review data by coder, a coder skills assessment is the place to begin coder education. A skills assessment will identify areas of strength and weakness for each coder, and allow an organization to tailor educational programs to the need of the coders. With an assessment of current skill level and training to reinforce strengths and shore up weaknesses, coders can develop a plan to achieve forensic coding skills. Forensic skills go beyond basic coding skills and will be needed more than ever in the ICD-10 environment.

Clinical coders with forensic skills apply their technical knowledge of clinical terminologies and classifications, medicine, and technology to review, analyze, abstract, validate and code the facts of a patient’s story. Their data mining skills are indispensable, as is their competency in the use of electronic documentation sources, computer assisted coding tools and mapping algorithms.
### Coding Education

#### Training Pyramid

ICD-10 training is best organized within five groups, from Group One which begins with a level of awareness to Group Five which includes power users. The training pyramid below identifies the training groups and requirements for each group. Forensic coders are typically in Groups Four and Five, while charge capture specialists who focus on CPT coding rather than ICD coding are in Group One for example.

<table>
<thead>
<tr>
<th>Group</th>
<th>Training Level</th>
<th>Staff</th>
<th>Hours</th>
<th>Training Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Awareness</td>
<td>All employees</td>
<td>Two</td>
<td>Large group presentations, webinar, video</td>
</tr>
<tr>
<td>Group 2</td>
<td>Understanding</td>
<td>Codified data users, physicians, those who reference codes</td>
<td>4 - 6</td>
<td>Workshop, group presentation, video, webinar</td>
</tr>
<tr>
<td>Group 3</td>
<td>CM Proficiency</td>
<td>Employees who assign ICD-10 CM codes</td>
<td>20</td>
<td>Small group workshop, video, webinar, applied training with 1:1 follow-up</td>
</tr>
<tr>
<td>Group 4</td>
<td>Proficiency</td>
<td>Employees who assign ICD-10 CM codes and ICD-10 PCS</td>
<td>50</td>
<td>Small group workshop, video, webinar, applied training with 1:1 follow-up, external review and monitoring</td>
</tr>
<tr>
<td>Group 5</td>
<td>Power User</td>
<td>Designated trainers</td>
<td>80</td>
<td>Workshop, seminar, applied training with 1:1 follow-up, external review and monitoring, video, webinar</td>
</tr>
</tbody>
</table>

The training pyramid describes suggested staff for each level, hours of training and suggested modalities in which to offer ICD-10 training. While we hear debate about conducting ICD-10 training now versus just in time for the October 1, 2014 go-live date we have observed that early fundamental training reduces coding staff anxiety about the transition and improves retention of staff as they are more actively involved in the transition in a positive way. Additionally, building in ICD-10 practice and training of others will actually improve retention of coders’ ICD-10 knowledge. The retention rate is in the area of 70 percent when new skills are practiced, such as a scheduled process of coding at least five records per week in both ICD-9 and ICD-10. When coders train other coders the retention rate climbs to over 90 percent. Another education modality to consider is discussion groups, which demonstrate a retention rate of about 50 percent. All modalities combined provide reinforcement, variety and encourages communication and cooperation among coders.
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2. CODING EDUCATION

CHECKLIST FOR CODERS
An important way to get coders engaged in their professional development is through self-assessment. Using the following self-assessment goals checklist coders can rate themselves in the following areas on a scale of 1 (goal not achieved at all) through 5 (goal achieved) to assess their personal progress in preparation for ICD-10:

- I am aware of my foundational knowledge strengths related to A&P, disease processes, pharmacology, etc.
- I am completing tasks to improve my weaknesses related to A&P, disease processes, pharmacology and other areas.
- I am networking with a subject matter expert and peers.
- I am practicing and applying codes to “real world” documentation.
- I am working to understand the ICD-10 CM/PCS coding guidelines.
- I am gaining a deeper understanding of the clinical documentation improvement protocols.
- I work collaboratively with clinical documentation specialists when a clarification or query is needed.
The success factors for the clinical documentation building block include physician involvement, communicating documentation gaps and other key data findings, agreed upon goals of a clinical documentation improvement process and ongoing focused reviews with feedback. The medical staff, the clinical documentation improvement staff, and the coding staff will need education on the findings from documentation reviews. Findings should include discussion of the documentation elements needed to support ICD-10 codes through use of specific examples. The value of more concise data capture for high quality data should be emphasized.

Evaluating the documentation capture process will yield improvements in documentation practices and may even help simplify and streamline documentation. This is an opportunity for collaboration and development of a shared documentation vision between coders, physicians, and clinical documentation specialists, which increases involvement and satisfaction. The evaluation should include reviewing the use of templates, which ideally are used for specific documentation needs and capturing details – not for broadly capturing data, as that creates a false image that “patients are all alike.” The team should evaluate the use of
alerts to determine their usefulness in capturing important documentation without creating “alert fatigue.” The automatic use of copy and paste is a risky documentation practice and should be discouraged. When electronic health record systems allow copy and paste functionality it should only be used with a careful review by the care provider of the relevancy of content being copied. The copy and paste practice warrants establishing policies, instructing users, and planning for monitoring and feedback to reduce or avoid compliance risk and accurately reflect current patient information. Documentation must be monitored with the goal of assessing compliance and to identify areas where improvement is needed to capture concise data with high-quality and integrity. A physician query process for clarifying documentation is essential in a CDI process.

It is suggested that prevailing query rates range from 10 to 35 percent. With that in mind, it is important that physician query protocols are clearly understood. The majority of physician queries begin while the patient is still in the hospital. Some of these concurrent queries remain unanswered until after the patient is discharged and often, the queries can linger until well after the account has been coded. Queries should be monitored for compliance with the established query policies and procedures and routinely reported to a physician champion or health information committee. If query protocols are not effective, it will be imperative to retool the process.
For the most part, IT plans for the transition to ICD-10 are well underway, due in part to the 5010 compliance conversion. Many organizations have systems that are already ICD-10 compliant; others are not as far along. The important elements of the IT building block for ICD-10 readiness that need to be monitored throughout the implementation process include: communications to and from vendors, testing of system capabilities, the costs associated with IT implementations, necessary upgrades and system maintenance. Additionally, decisions around how ICD-9 and ICD-10 databases will be accessed and maintained will need to be made.

QUESTIONS FOR VENDORS

For Current Vendors
a. Will a mapping or crosswalk strategy be used between ICD-9 and ICD-10 code sets?
b. What is your timeline for system modifications and what do those modifications include? Note: Make sure testing is part of the timeline.
c. Will you continue to support applications or are you discontinuing some products in the wake of the ICD-10 transition?
d. Are there any new hardware requirements associated with ICD-10-related software changes?
e. What are the costs involved? Will modifications and upgrades be covered by existing contracts?
f. Will customer support and training be provided for any new ICD-10-related functionality, and is there a charge?
g. Is there a phased approach for implementing ICD-10?
For Potential Vendors

a. How does your product simplify my organization’s transition to ICD-10?

b. How does the functionality offered by your system compare with my current system?

c. Does your implementation require a complete system conversion?

d. Based on what I already have in place, how much will it cost to convert to your system?

e. What are the costs of maintenance for your product?

f. Who in this area is using your current system?

g. What kind of product quality guarantees do you offer, and are these guarantees included in the contract?

h. What is your timeframe for implementation?

i. Talking to vendors’ existing clientele in your area about their experience with that vendor may help you identify if the vendor’s services are a good fit for your organization.

TESTING

Good IT principles require testing of system functionality throughout the process of implementing upgrades to systems and for installation of new systems. Testing should be a part of every IT project plan. Just as important is testing transactions between systems, both internally and externally. Organizations are at risk if testing with external clearinghouses and major payers is not performed. One approach is to convert claims from ICD-9 to ICD-10 and compare the DRG grouped in ICD-9 to the DRG grouped in ICD-10. By examining the data, one-to-one matches can be identified and DRG mismatches can be identified and further analyzed. This activity may reveal that 10 to 20 percent of the accounts do not map one-to-one and will need analysis. And a word of caution, one-to-one matches do not necessarily mean the claims are coded accurately or reflect the correct level of specificity. However, this testing reveals important information and knowing is the first step to making improvements.
IT COSTS

Estimating system upgrade and new implementation costs is a key component in an ICD-10 Implementation Budget. Other elements to include in the budget relating to IT costs are interfaces, additional or upgraded hardware needs and a contingency. Often, hardware costs can be over 25 percent of the total IT portion of the budget. Depending on the age and complexity of the interfaces, those costs can range from 6 to 15 percent. Contingency budgeting is important to cover unexpected expenses.

DATABASE MAINTENANCE

For financial and operational reporting purposes it is important to understand the databases that hold ICD-9 and ICD-10 data. Some systems will be capable of maintaining both data sets, some may not. Having detailed conversations with organizational IT staff and vendors will clarify the following questions:

- Will the current systems be able to store ICD-9 codes and ICD-10 codes?
- How long will both code sets be supported?
- Does data storage capacity need to increase?
- Will the ICD-9 data be accessible, if so for how long and who will be allowed access?
- Will data be stored outside the system in some other database format such as Excel or Access?

Often, hardware costs can be over 25 percent of the total IT portion of the budget.
Literature research from multiple sources reveals common themes regarding revenue cycle readiness and revenue neutrality. The nine points of advice to organizations described below comes from Government Health IT:

a. Organizations should develop a budget and strategy to provide for additional cash reserves should delays in payment occur.

b. Organizations should conduct financial modeling to understand the impacts of moving from ICD-9 to ICD-10 – the impacts should be looked at by provider, by facility, by service line and by geography if applicable.

c. Managed care contracts should be reviewed and if necessary, renegotiated to decrease negative impacts to the bottom line.

d. The readiness of high volume payers should be assessed to determine their ability to process claims. Many payers are now posting readiness information on their websites.

e. Conduct CDI reviews using ICD-10 code sets to determine if documentation contains the specificity necessary for ICD-10.

f. The potential for backlogs in coding, billing and claim edits should be analyzed and a strategy developed to work the backlogs.

g. A strategy for pre and post ICD-10 denials management should be developed.

h. Assess the readiness of external vendors who support coding, billing, follow up and denials.

i. Any audits currently performed (compliance, RAC, etc.) should be reviewed to determine ICD-10 impact.

j. Additionally, dual coding accounts in both ICD-9 and ICD-10 should be considered. This will provide data necessary for many of the business decisions discussed above.
Perhaps the most important building block for ICD-10 implementation is to plan the activities to undertake following the October 1, 2014 go live date. As Sir Walter Scott said, “I can give you a six-word formula for success: ‘Think things through – then follow through.’” It is important to follow through and monitor coding accuracy and productivity following go live. When problems are identified, strategies should be implemented to address workflow problems, process problems and resource issues. Determine if further education and training is needed and provide it expeditiously to prevent future issues.

Monitor for opportunities to improve data integrity through EHR enhancements, monitoring of alerts, and communication with physicians and clinical documentation improvement staff. Finally, monitor productivity to manage responding to staffing needs. Go live will be a challenging time for all and retention of highly trained, skilled coding staff will be essential.

As Sir Walter Scott said, “I can give you a six-word formula for success: ‘Think things through – then follow through.’”
Kathy M. Johnson, RHIA, is Vice President and General Manager, Data Quality and Coding Compliance for Care Communications, Inc. (CARE) a national health information management consulting company based in Chicago. Johnson joined the CARE team in 1997 as a coding consultant with primary duties of completing coding quality reviews, delivering coding education (one-on-one training as well as small and large group settings), conducting operations assessments and evaluating client coding compliance programs. Accepting a CARE director position in 2003, Johnson oversaw consulting engagements focused on data capture, coding classification, compliance and education. In her present role, she provides strategic guidance as adaptation to the future state of coding and the changing needs in the healthcare industry are underway.

Johnson is a veteran health information management professional with more than 30 years of experience in a variety of positions, including health information management department director, classroom and practicum educator and post secondary health information program director, independent consultant and quality improvement leader in the acute care setting.

Johnson’s articles have been published by the American Health Information Management Association (AHIMA), Advance for Health Information Professionals, HCPro and the Healthcare Financial Management Association, and include:

- Regulatory Alphabet Soup: Financial Implications of RAC, MAC and HAC
- POA Coding Requirements Create a Chilling Effect for Hospitals
- Effectively Managing RAC
- 5010 and ICD-10
- Is It Too Early to Begin ICD-10 CM & PCS Education?

Johnson possesses a bachelor’s degree in health information management and is an active member of AHIMA and has served on the association’s Practice Councils.
Lisa Fink, MBA, RHIA, CPHQ, Senior HIM Consultant, Care Communications, Inc. As a Senior HIM Consultant, Fink has performed multiple ICD-10 engagements to include readiness assessments and implementation planning. She has also supported hospital coding functions and post go live system implementations through interim management.

In previous roles, Fink directed HIM departments, QI departments and managed an IT department. Managing change was inherent in these roles to include complete retooling of medical record filing systems, development and training quality improvement processes, development of a systematic approach to successful accreditation, and implementation and support of electronic documentation systems.

Fink has held adjunct faculty positions in the business college setting, the community college setting, and with two AHIMA accredited schools. Her teaching focus has been ICD-9 coding and other health information management courses.

Fink is a member of AHIMA, the National Association for Healthcare Quality, and the Wyoming Health Information Management Association (WYHIMA). Currently the President-Elect, Fink has held all seats on the Board of WYHIMA multiple times. She received a bachelor’s degree in HIM from Carroll College in Helena, Montana and a master’s degree in business administration from Regis University in Denver.
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Visit us online today to request more information about how our services can help ensure a successful ICD-10 transition at your facility, including:

**Clinical Documentation and Revenue Risk Assessment**
- We determine your facility’s Medicare revenue impact and help define strategies to reduce risk.
- Utilizing CARE’s proprietary ICD-10 Code Predictor™ (GEMs) technology, we identify all cases that may be problematic in ICD-10.
- An all-important case-by-case review to validate documentation needs and develop a customized action plan for clinical documentation improvement.

**Skills Assessments, Planning and Training**
- Analysis of coding staff skills deficiencies.
- Comprehensive and facility-specific coding education and training programs.
- E-learning platform or on-site training options.
- ICD-9/ICD-10 parallel and production coding support and planning for transition staff levels.

**ICD-10 Directors/Leaders**
- Assistance of an ICD-10 expert to ensure thorough planning, project management and efficiency in execution.

Visit our website: carecommunications.com/icd10
For questions and assistance with your ICD-10 implementation, contact Roberta Peters at 800-458-3544, extension 153 or rpeters@care-communications.com.

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**Additional Online Resources.** Here are additional resources that may be useful in making the transition to ICD-10:
- ICD-10 Monitor
- ICD-10 Watch
- CMS ICD-10 web page
- AHIMA ICD-10 web page
- ICD-10-PCS Reference Manual
- ICD-10-CM—National Center for Health Statistics
- AHA Central Office ICD-10 Resource Center