Revenue Mitigation Strategies
Offsetting The Financial Impact Of ICD-10

January 23, 2014
What the industry is saying about the Transition to ICD-10…

- Staff alignment between business and IT is critical to success
- Y2k of healthcare
- Biggest transformation in healthcare to date
- Ticking time clock…or bomb?
- …Will impact your Revenue Cycle!

Sir, your team with the quick fix for our ICD-10 conversion has arrived.
## ICD-10 Leading Practice Strategies

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<tbody>
<tr>
<td><strong>Education</strong></td>
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<tr>
<td>Vendor selected</td>
<td>Coder</td>
<td>CDI/physician champion</td>
<td>All learners</td>
<td>Practice coding</td>
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**Report remediation**

| Report/Form Identification | Crosswalk Strategy | Report/Form Remediation | | | | | |
| Inform | Clarify | Convince | Involve |

**Communication and awareness**

**System remediation**

| System Identification | System Remediation | 360° Testing | | | | | |
| | | | | | | | |

**Revenue mitigation**

| CDI Program Review | Contract Review | KPI Benchmarking | Denials Mgt./Payer Contingency | | | | |
| | | | | | | | |

**Coder productivity/retention**

| Coder Backfill and Retention Strategy | CAC Implemented | | | | | | |

**Compliance Date:** Oct. 1, 2014
### ICD-10 Business Impact Areas

#### People
- Registration (central, ED, ambulatory, ancillary)
- Scheduling
- Admitting/discharge/ transfers
- Prior-authorizations/ pre-certifications
- Medical necessity checks
- Bed management

#### Process
- Physician and nurse documentation
- Ancillary and support services documentation
- Order entry and results
- Workflow within EMR
- Case management
- Clinical research
- Workflow and transfers between clinical units

#### Systems
- Coding and abstracting
- Deficiency tracking
- Claim edit work lists
- NCCI/LMRP edits
- Encoding and grouping
- Physician query
- Clinical documentation improvement

#### Patient access
- Charge entry
- Payer and clearinghouse edits
- Contracting
- Facility and professional billing
- Follow-up and denial management
- Claims status

#### Clinical and ancillary
- Quality/outcomes reporting
- Financial/revenue reporting
- Public health reporting
- Clinical registries
- Data warehouse
- ICD-9 to ICD-10 mapping and translation
- Compliance

#### Health information management
- Implement new business and/or clinical systems
- Transition to paperless environment
- Opening of new facility
- Narrowing of IT vendor portfolio
- Implement computer-assisted coding

#### Patient financial services
- Analytics and reporting
- Strategic initiatives

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**IT System Remediation/Health Information Management**
ICD-10 Financial Impacts

- A/R days grow by 20 to 40%
- Denial rate increase 100 to 200%
- Reduced cash flow
- Coder productivity drops short term 50%, long-term 25%
- Contract reimbursement risk expected vs. actual reimbursement
- Backfill & retention costs
- Payers are not ready to accept ICD-10
- Claims processing time extended additional 10 to 20 days
- Claims error rates 2x’s higher
- Document specificity
- IT system readiness

Sources: CMS and HIMSS
ICD-10 Potential Impact on Reimbursement

• Potential for Denial Rate increase by 100% to 200% post-implementation
  – Incongruities between the two coding systems
  – Coding errors
  – Improper eligibility and authorizations
  – Insufficient documentation
  – Payers will be more diligent to assume miscoding
  – Payer processing errors

• Cash flow will slow for 24+ months
  – Payers must be more diligent to validate appeals
  – Appeals become more complicated, requiring more clinical documentation

• Increase in AR Days by 20% to 40%
  – Payers delay in processing claims and appeals
  – Incorrect payments
  – Retroactive adjustments
  – Mapping issues at both payer and provider
ICD-10 Revenue Mitigation Strategies

- Reimbursement & Coding Analytics
- Coder Productivity
- CDI Improvement
- Payer Readiness/Contingency Analysis
- Denials Management
- KPI Monitoring
- Productivity/Cutover Strategy
- Education
Use of Reimbursement & Coding Analytics

Has your organization conducted a reimbursement and coding analysis?

A comprehensive financial impact analysis should be completed to identify the potential shift in reimbursement for DRG-based claims with the transition to ICD-10.

- Consider consolidating data by:
  - CDRG, MDC, Hospital, MS-DRG

- Anticipated output of analysis:
  - Total Claims in source data for each classification
  - ICD-9 Reimbursement
  - ICD-10 Reimbursement for Minimum and Maximum DRG scenarios
  - Reimbursement Variances
  - % of claims w/Change risk (in total and by increase/decrease)
  - Shift risk for high volume DRG movements

Use of data analytic metrics are the compass to guiding the ICD-10 Program in targeting areas of risk/opportunity and prioritizing remediation efforts accordingly.
Coder Productivity Mitigation

• You can always hire more coders, right?
• Transition to computer-assisted coding
• Be creative — consider a coder career ladder program
• Remote coding (retention vs. productivity mitigation strategy?)
• Considerations:
  – While coders are in training (minimum 40 hours for IP coder, but likely more)
  – Practice coding with real data
  – Post-transition (learning curve)
  – Retention

Anticipated coder productivity impact of ICD-10

- 50% Long-term
- 25% Short-term
Clinical Documentation Improvement (CDI) Program

Does your organization have a Clinical Documentation Improvement Program and/or is in the process of implementing a program?

<table>
<thead>
<tr>
<th>Primary Objectives</th>
<th>Critical Success Factors</th>
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<tbody>
<tr>
<td>• Improve physician documentation</td>
<td>• Executive sponsor and accountability</td>
</tr>
<tr>
<td>• Improve Case Mix Index (CMI)</td>
<td>• Physician liaison</td>
</tr>
<tr>
<td>• Enhance compliance</td>
<td>• Robust reporting and metrics</td>
</tr>
<tr>
<td>• Document for appropriate reimbursement</td>
<td>• Adequately trained clinical documentation specialists</td>
</tr>
<tr>
<td>• Identify and track core and other quality measures</td>
<td>• Effective physician query process</td>
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Mitigate Risk + Leverage Opportunity = CDI a Must for ICD-10
Clinical Documentation Improvement (CDI) Program

- Think BIG — review all DRG payers
- Leverage technology
- Dedicated staff
- Onboard: Physician liaisons
- Work with what you have
Payer Readiness/Contingency Planning

• Review payer contracts, negotiate protective language, identify contracts with potential negative revenue impact

• Will you be able to proactively identify the payers that will not be ready/compliant by Oct. 1, 2014?

• If so, do you want to take a proactive or reactive approach, i.e., let the claims deny or map/code to ICD-9 before submitting?

• Will you dual-code claims or map from l-10 to l-9? Which department will be responsible — HIM or PFS?

• Do you have workflows within your application to support your strategy?
ICD-10 Areas of Focus for Denials Management

**Do you have a strong denials management program in place? Are you planning to adapt the program to being able to track root causes of denials real-time?**

<table>
<thead>
<tr>
<th>Clinicians Role</th>
<th>Executive Level Oversight</th>
<th>Technical Deployment</th>
<th>Denial Risk Mitigation</th>
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<tbody>
<tr>
<td>• Clinical documentation improvement</td>
<td>• Cross-department collaboration</td>
<td>• Clinical documentation improvement</td>
<td>• Existing Denials Trends</td>
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<tr>
<td>• Medical intelligence</td>
<td>• The role of the CFO</td>
<td>• Computer assisted coding</td>
<td>• New Denial Management Technology</td>
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<tr>
<td>• Medical necessity</td>
<td>• Collaborate with existing committees</td>
<td>• Mapping</td>
<td>• Coding Accuracy &amp; Completeness</td>
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<tr>
<td>appeals</td>
<td></td>
<td>• Denials tracking and trending</td>
<td>• Physician Based Denials</td>
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<td></td>
<td></td>
<td></td>
<td>• Denial Resolution Process</td>
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<tr>
<td></td>
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<td>• Financial Reserve Analysis</td>
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</tbody>
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### Education - Curriculum (Levels) By Learner

<table>
<thead>
<tr>
<th>Learner categories</th>
<th>Typical roles/credentials</th>
<th>Education levels</th>
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<tbody>
<tr>
<td>Coders</td>
<td>CCS, RHIA, RHIT, CPC, etc.</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Revenue cycle, IT, reporting/analytics</td>
<td>Claims, appeals, referral/prior authorization, billing, patient accounts, analysts, report writers, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Providers, nurses, CDI specialists</td>
<td>MD, NP, PA, ancillary providers, therapists, RN, case managers, CDI specialists, etc.</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Executives/ key stakeholders</td>
<td>CEO, CFO, CIO, CCO, CNO, COO, CMO, CMIO, etc.</td>
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1. Level 1: Overview
2. Level 2: Knowledge-based/skill transfer
3. Level 3: On-the-job
Education - Revenue Cycle (Example Curriculum)

Level 1: Impact of ICD-10 Overview – Revenue Cycle

- Provide overview of ICD-10 mandate
- Review flow of diagnosis information through the revenue cycle process (patient access, provision of care, coding, billing, denials/follow-up)
- Includes knowledge review

~ 60 min.

Level 2: Coding for Non-Coders - Financial

- Overview of ICD-10 Coding Conventions and Guidelines (General Content)
- Review change in nomenclature and organization of code set
- Review GEMs and pitfalls of mapping and translation
- Specific workflows to be addressed include: prior-authorizations; top services requiring medical necessity; and top diagnosis-based claim edits or denials; other.
- Includes knowledge review

~ 90 min.

Note: Level 2 will only be required for this individuals working with diagnosis information on a regular basis in roles such as: Medical Necessity Verification, Prior-Authorizations, Claims Edits, Denials, Audits, other.
Productivity/Cutover Strategy

Strategy to work-down aged accounts...start ICD-10 with a clean slate

Ramp-up staff to support both I-9 and I-10 accounts and backfill due to lost productivity
KPIs: Creating A Baseline

When should we start benchmarking our data?

What metrics should we be collecting?

Who will be accountable for taking action?

How should we report the information?

Key Performance Indicators

Case Mix Index (CMI)
Coding productivity and quality
Denials
Discharged not final billed (DNFB)
Reimbursement by service line
Key ICD-10 Transition Actions To Mitigate Risk

1. Prepare for HIM productivity delays and educational expenses
2. Enhance denial tracking, trending and reporting needs to isolate ICD-10 root causes
3. Reduce and improve current A/R, DNFB backlog prior to ICD-10
4. Budget for potential cash flow impacts
5. Prepare for delayed payments and claims adjudication
6. Engage with your high-volume payers to perform end to end testing and compare expected vs. actual claim reimbursement
7. Adjust accounts receivable reserves as needed
8. Right size of staffing in revenue cycle services to handle increased workload and volumes
9. Leverage financial modeling/analytics to determine revenue impact by provider, facility, service line; use data to develop physician, CDI and Coder education curriculum, and identification of test scenarios