ICD-10 Executive Action Guide:
A Roadmap to Ensuring a Successful Transition
to a New Coding System

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Transformative change initiatives such as the conversion to ICD-10 require significant planning and careful orchestration to achieve successful implementation. After nearly three years of getting ready for ICD-10, Oct. 1 is rapidly approaching. That's the date all hospitals and health systems must begin using the new ICD-10 coding system, and when Medicare and other payers will reject hospital claims that fail to comply with ICD-10. The federal government in February said that no further delays in implementation will be granted. Therefore, hospital leaders must make the transition to ICD-10 a priority and monitor progress to ensure a successful transition on Oct. 1.

For most hospitals and health systems, the task of converting to ICD-10 should be well under way. It involves thorough strategic planning and coordination of resources across the entire hospital so support from executive leadership is imperative.

To help you manage this effort, this Executive Action Guide highlights four areas that are critical to ICD-10 implementation and provides a roadmap to benchmark progress. It explains how to organize the ICD-10 transition effort; how to plan for implementation; what must be done now to implement the transition successfully; and how to evaluate efforts post-implementation.

Throughout the guide, you will find some questions hospital leaders should ask about their organization's ICD-10 transition, information on what hospital leaders should be doing now in the implementation timeline, and tips for helping physicians and caregivers improve their documentation. It also provides background on ICD-10 and explains why the transition is needed.

Watch for additional information in AHA publications and member resources throughout the year as part of the AHA’s ICD-10 Education Series.

In addition, the AHA Central Office provides extensive ICD-10 resources for medical records and clinical staff, including a training handbook, audio seminars, newsletters, official coding guidelines and other publications. To access these resources, visit www.ahacentraloffice.com.
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Background on ICD-10

In 2009, the Department of Health and Human Services issued a final rule to update ICD-9-CM to ICD-10-CM for diagnosis coding and ICD-10-PCS for procedure coding (jointly referred to as ICD-10). The federal government has delayed the transition a number of times from the first proposed implementation date of Oct. 1, 2011. All indications are that no further delay will be granted, and all providers, payers and clearinghouses must be ready by Oct. 1, 2014.

What is ICD-10?
ICD-10-CM is an upgrade to the current, outdated diagnosis coding system. Diagnosis codes are a way for hospitals, physicians and other providers to efficiently and electronically exchange information with health plans to describe patient conditions. They are embedded in nearly every clinical and billing operation nationwide. Diagnosis codes are an important piece of information to describe patients’ conditions, justify the services provided and demonstrate medical necessity.

ICD-10-PCS is the companion procedure coding system that will affect only hospitals reporting inpatient procedures. It was created by 3M under a contract with the Centers for Medicare & Medicaid Services (CMS) and with the involvement of the AHA and other stakeholders as replacement for the ICD-9-CM procedure codes.

How does ICD-10 compare to ICD-9?
Under ICD-10, the coding system will grow significantly. ICD-10-CM has about 70,000 codes compared to about 14,000 codes in ICD-9-CM. The new diagnosis code set, ICD-10-CM, has retained several conventions and guidelines already familiar to users of ICD-9-CM. Meanwhile, the new procedure code set, ICD-10-PCS, introduces a new format, conventions and application, and it will likely represent the greater challenge to hospital coders affecting training, productivity and accuracy. ICD-9-CM contains about 4,000 procedure codes compared to about 72,000 ICD-10-PCS procedure codes.
While some people note the tens of thousands of new codes included in ICD-10, the expansion will allow for greater coding accuracy and specificity, and will provide a mechanism to capture and fully describe new medical technologies and advances. Certain changes, such as the inclusion of laterality (i.e., left, right or bilateral) and the identification of chronology of encounters for injuries (e.g., initial, subsequent or treatment of related long-term adverse consequence) have a significant impact on the number of codes, but are simple and important concepts for communicating about a patient’s condition.

As noted in media reports, some of the new codes are esoteric, such as being bitten by a shark, and pertain to very rare instances. However, these codes may be relevant to occupational hazards, public health concerns or other risks that medical specialty societies have requested. They do not need to be learned by all physicians, but can be looked up when needed for a specific patient in a rare incident, such as an employee of an aquarium attacked by a shark while on the job.

**How does ICD-10 link to payment?**

Together, the diagnosis and procedure codes are the DNA of diagnosis-related groups (DRGs), which are used by Medicare and other payers for reimbursing hospital inpatient care. While physicians must include the diagnosis codes on their claims, health plans generally use the diagnosis codes as the basis for benefit coverage, but they do not use the diagnosis codes to determine physician payment amounts. Physicians and hospital outpatient departments will continue to use Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System codes (HCPCS) and be paid based on those codes.
What will physicians need to do?
The greater specificity of ICD-10-CM and ICD-10-PCS will require more detailed clinical documentation in some cases. While physicians and other clinicians will need to learn about ICD-10 and ensure that they have provided sufficient documentation for coders to select the correct codes, most physicians will not be responsible for knowing the actual codes. Rather, professional coders or billers will assign them. Some national physician organizations have continued to push for a delay in implementation of ICD-10; however, the federal government has made clear that it does not plan to extend the transition date beyond Oct. 1. More information on how ICD-10 will affect physicians and how hospital leaders can help prepare them for the transition is included on pages 10 and 14.

Why should we move to ICD-10?
ICD-9-CM is more than 30 years old, and has simply “run out of room.” Despite annual revisions, it is not able to keep up with changes in medical knowledge or the demands for detailed administrative data to evaluate the quality of care, implement value-based purchasing, and support biosurveillance and public health initiatives. For example, due to current numbering constraints, distinct procedures performed on different parts of the body and with widely different resource utilization are grouped together under the same procedure code.

Hospitals will be better able to distinguish newer technologies and resource differences with the expanded granularity of the ICD-10-PCS codes, which differentiate surgical approaches, anatomical regions and devices. In addition, the move to ICD-10 will allow more detail on socioeconomic factors, family relationships, ambulatory care conditions, problems related to lifestyle and the results of screening tests. It also will mean better data to monitor resource utilization, improve clinical, financial and administrative performance, and track public health risks. More detailed coding systems also will improve the nation’s understanding of the diseases or illnesses being treated and will provide caregivers and the public with better information to guide future treatment.
The Role of Hospital Leaders

Hospital leaders must take an active role to ensure a successful transition to ICD-10.

Mistakes in the transition can create coding and billing backlogs, cause cash flow delays, increase claims rejections/denials, cause unintended shifts 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 can create distorted or misinterpreted information about patient care. The worst case scenario – your payments will stop if they are not reported with the appropriate code set.

To ensure a successful transition, hospital leaders must ensure that staff resources are adequate to complete remaining tasks, communicate that the transition is a priority for the organization, address any questions and concerns physicians may pose, and closely monitor the implementation progress. In addition, hospital leaders should routinely inform their trustees about the progress being made.

Another important area to monitor is the impact of a likely decline in productivity as coders learn the new coding system. Leadership will need to manage this added time to ensure revenue cycle days are not negatively affected. CEOs should direct their senior management team to assess staffing options to mitigate these effects during the early implementation phase. Management also should assess whether existing financial resources are sufficient and/or whether additional resources should be allocated.
Questions to ask about your organization’s ICD-10 implementation efforts

Hospital leaders should regularly monitor the answers to the following questions to ensure the hospital is on track for a successful transition to ICD-10.

1. How is our ICD-10 transition plan progressing?
   - Do we have the right people on the transition team?
   - Do we have sufficient resources?
   - Are we on track to meet the Oct. 1 implementation deadline?
   - Do we have a solid employee and physician education plan?

2. How can we help physicians and other clinicians to improve their documentation?

3. What is our back-up plan if things do not go as anticipated?

4. How can our hospital leverage the benefits from the move to ICD-10 for strategy development? Think about:
   - Care coordination
   - Population health
   - Internal quality evaluations
   - Internal efficiency evaluations
   - Improving patient safety
   - Enhancing risk management
What you should be doing now to ensure a successful transition

Hospital leaders should ensure that their senior management team fully understands the ICD-10 implementation steps and can report on progress. Here’s what you should be doing now:

- Expand training to include coding staff who have not yet been trained.
- Provide physicians with awareness and education programs about ICD-10 concepts and emphasize the importance of complete documentation and narrative.
- Contact your major public and private sector payers, including Medicare and Medicaid, to schedule testing if you have not already done so. Testing with health plans should include previously paid claims re-coded in ICD-10-CM/PCS so that you can compare the results across coding systems as a guide to whether ICD-10 coding is being done correctly. Select representative samples with:
  - High volume and/or high cost inpatient claims
  - High volume outpatient claims
- Assess whether DRG assignment and/or payment in ICD-10 is consistent with your hospital’s expectations. If not, determine why, and make corrections as needed.
How you can help physicians and caregivers improve their documentation

Hospital leaders must communicate clearly with physicians to emphasize the importance of their cooperation in the move to ICD-10 and address their concerns. You should:

- Highlight the benefits of the physician having more specific information about the condition of patients being treated.
- Ensure medical directors take responsibility for educating physicians about coding documentation requirements.
- Emphasize that physicians will need to work with the medical record department to ensure that the documentation meets the professional coders’ needs.
- Have medical records staff work with physicians to find specialty-specific tools, such as frequently used code lists or tip sheets on documentation needs. Many physician specialty societies and coding organizations are developing these resources.

Stages of ICD-10 Implementation

The transition to ICD-10 includes four phases: organizing, planning, implementation and post-implementation evaluation. The following pages describe each stage, with an emphasis on implementation. This should be the primary focus between now and Oct. 1. A chart on the next page outlines activities that should occur in each phase.

A more in-depth examination of these concepts is available in the AHA's ICD-10 Executive Briefing available at http://www.aha.org/content/00-10/09oct-ICD10briefing.pdf.
Table 1. Key Steps for a Successful ICD-10 Transition

<table>
<thead>
<tr>
<th>Organizing the Effort</th>
<th>Planning for Implementation</th>
<th>Implementation</th>
<th>Post-implementation Evaluation</th>
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<tbody>
<tr>
<td>Assemble team with clear leadership and executive support</td>
<td>Identify all information systems that handle ICD codes (billing, clinical, orders, administrative, etc.)</td>
<td>Conduct training for coding staff and assess need to hire additional coders</td>
<td>Consider how ICD-10 supports analytics such as clinical outcomes review and quality</td>
</tr>
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<td>Raise trustees’ awareness about the scale of the task, timeline and resources required</td>
<td>Prioritize list of system changes that must be made</td>
<td>Make changes to information systems</td>
<td>Evaluate paid claims and documentation and coding processes to ensure that codes are being assigned accurately</td>
</tr>
<tr>
<td>Establish a master “to-do list” of areas impacted by ICD coding</td>
<td>Develop plans for employee training, educational resources and staffing</td>
<td>Complete internal testing of information systems</td>
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<tr>
<td>Set timeline for completion of tasks:</td>
<td></td>
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<tr>
<td>• Information systems modifications</td>
<td></td>
<td></td>
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<tr>
<td>• Staff training and educational plans</td>
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<tr>
<td>• Outreach to physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should be completed</td>
<td>Should be completed</td>
<td><strong>January 2014 to October 2014</strong></td>
<td><strong>October 2014 to 2016</strong></td>
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</tbody>
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Organizing and Planning

The first step in the transition to ICD-10 is to examine every application in which diagnosis or procedure codes are captured, stored, analyzed or reported. This assessment provides an opportunity to review current work flow and medical documentation practices. It will allow the organization to make improvements to not only streamline future processes, but also to strengthen the basis for code assignment.

By now, the organization and planning stages should be complete – including the assessment of system changes. These steps are foundational for successful transition and must be done well and carefully.

Implementation

As hospitals and health systems work to implement ICD-10, a number of activities must occur. For example, hospitals should complete system changes, conduct internal and external testing, train production coding staff, educate physicians about the importance of complete and accurate documentation, and assess financial impacts. Many departments, such as information technology (IT), medical records, finance and clinical areas, such as the operating room and emergency department, play an important role in supporting ICD-10 implementation. While the departments noted below will be most closely involved in ICD-10 activities, broad employee engagement plans, such as general education sessions or employee newsletters or articles, will help ensure a smoother transition.

Information Technology. The IT department should work with individual work units to ensure that the hospital has identified all of the systems that must be updated to accommodate ICD-10. A process should be in place to work with outside vendors on the timing for installation and testing of upgrades.
**Medical Records/Health Information Management.** The medical records or health information management department has primary responsibility for placing codes on claims, and must ensure that members of the coding staff have been sufficiently trained to manage the transition. Hospitals should expect a slow-down in coder productivity, which may slow the revenue cycle unless additional coders are hired, perhaps temporarily, or other steps are taken. Hospitals also should make contingency plans to address the financial impact of possible delays due to any problems that may slow the revenue cycle, or delay or stop payments for a period of time.

**Physicians.** Physicians will need to learn about ICD-10 and ensure that they have provided sufficient documentation for coders to select the correct codes. For physicians, the focus is generally not on learning the actual codes, which professional coders will assign, but learning about any conceptual changes to the subset of ICD-10 codes specific to their clinical area and areas in which documentation will need to be improved.

Physicians will need to be sure to include laterality in notes and may be asked to describe the patient’s diagnosis with more detail than previously documented. For example, under ICD-10 coronary artery disease may be described by combination codes that did not exist in ICD-9, such as: without angina; with angina; with unstable angina; with documented spasm; or with unspecified angina pectoris.

Surgeons and others performing surgical procedures will be exposed to both new diagnosis and procedure codes, and should seek guidance from their specialty societies. For example, some procedures will need more information on whether the basis for the encounter is the initial encounter receiving active treatment, subsequent encounter with routine healing or subsequent encounter with problems affecting healing, such as nonunion of broken bones. Procedure codes will require more detail on the anatomic site and surgical approach. This will result in clinicians having more detailed information about patients, including differences in acuity and severity that can be used to improve care and evaluate costs.
Hospital leaders can expect to hear concerns expressed by physicians. It is important to communicate with physicians to both address their concerns and emphasize the importance of their cooperation and the benefits of having more specific information about the complexities and comorbidities of patients being treated.

Specialty societies have developed many tools to facilitate the transition, such as developing “Top 50” lists by specialty. In addition, the “superbill” of common codes and procedures, updated to ICD-10, will continue to be a crucial tool for physicians and will aid them in learning the segment of ICD-10 relevant to their work.

**Finance.** As results from testing become available, finance staff should be working with coding staff to ensure that the ICD-10 coding is being done accurately. In addition, the finance staff should be assessing how the transition is likely to affect cash flow, and plan accordingly. Medicare contractors have estimated that the transition from the ICD-9-CM version of the Medicare-severity DRGs (MS-DRGs) to the ICD-10 version of the MS-DRGs is expected to result in 1 percent of the patients being assigned to different MS-DRGs.

Medicare contractors also have identified 10 MS-DRGs that are most likely to shift when claims are re-coded from ICD-9 to ICD-10 (see Table 2 on the next page). These are services where differences in the two classification systems will likely lead to differences in MS-DRG assignment. Hospitals should pay special attention to these services in testing and impact analyses.
Table 2. MS-DRGs Most Affected by the Transition to ICD-10

According to 3M, patients who were assigned to the following MS-DRGs under ICD-9 are the most likely to be assigned a different MS-DRG under ICD-10. These shifts are due to systematic differences in the two classification systems. See the full report, available at http://cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html for more detail on why these shifts are likely to occur, which subsets of patients will be affected and what the new MS-DRGs could be.

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. 812</td>
<td>Red blood cell disorders w/o MCC.</td>
</tr>
<tr>
<td>2. 981</td>
<td>Extensive O.R. procedure unrelated to principal diagnosis w/MCC.</td>
</tr>
<tr>
<td>3. 391</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w MCC.</td>
</tr>
<tr>
<td>4. 885</td>
<td>Psychoses.</td>
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<tr>
<td>5. 066</td>
<td>Intracranial hemorrhage or cerebral infarction w/o CC/MCC.</td>
</tr>
<tr>
<td>6. 191</td>
<td>Chronic obstructive pulmonary disease with CC.</td>
</tr>
<tr>
<td>7. 011</td>
<td>Tracheostomy for face, mouth and neck diagnoses with MCC.</td>
</tr>
<tr>
<td>8. 974</td>
<td>HIV with major related condition and MCC</td>
</tr>
<tr>
<td>9. 292</td>
<td>Heart failure and shock with CC.</td>
</tr>
<tr>
<td>10. 037</td>
<td>Extracranial procedures with MCC.</td>
</tr>
</tbody>
</table>

ICD-10 Testing

A crucial piece of ICD-10 testing with major payers is to ensure that claims can be transmitted, and to assess whether the new codes being used are consistent with expectations. The purpose of testing is to identify any unexpected and potentially adverse changes in payment as well as delays if a large number of claims needs to be reprocessed.

Some hospitals already have undertaken a limited volume of testing with some health plans. As previously noted, the testing methodology should include using previously processed claims that were originally coded using ICD-9-CM. The hospital coders would then pull the medical records for these claims and recode the claims using ICD-10 codes.

By design, the newly recoded claims with ICD-10 should yield the same payment group classifications as the previously paid claims using ICD-9-CM codes. A few exceptions may arise where there are inherent changes in the hierarchy of the ICD-10-CM codes (see Table 2 on the previous page). Some hospitals have started asking coders to dually code at least a subset of claims in ICD-9-CM and ICD-10-CM/PCS as practice in order to identify documentation gaps and to assess productivity time of the coders.

Dually coded claims also allow hospitals to assess financial impacts of the transition to ICD-10. Some questions to keep in mind as the claims are coded include:

- How much longer does it take to code the claim in ICD-10 versus ICD-9?
- Are there documentation gaps where there is a need for increased physician queries and where there needs to be physician training?
- Does the greater specificity in ICD-10 codes lead to assignment of a different DRG? (Medicare claims can be recoded and run through a software program called a grouper that will assign the relevant DRG code.)
Two Dimensions of ICD-10 Testing

**Connectivity.** That is, the claim must be capable of passing the front-end edits associated with the transmission of the claim to the health plan.

**Adjudication.** The second, and more critical piece, is the adjudication process, where the claim newly recoded under ICD-10 passes through the adjudication logic to establish payment or the assignment to a payment group. For instance, Medicare hospital inpatient claims go through the grouper logic to create a DRG assignment.

As the test results are made available, senior management should review them with the coding team, examining primarily those claims in which the DRG assignment or private plan payment varied significantly from the original claim. The review team should include coders and a physician liaison. The team should examine whether the documentation that was used to develop the ICD-10 codes was adequate, and, whether the coders assigned the correct ICD-10 codes.

If the documentation was lacking, it may be necessary to educate the physician about improving the narrative in the documentation. Physicians will need guidance from the medical records or clinical documentation improvement team on documentation rules for ICD-10 and the importance of including the clinical narrative within the patient record. If the review indicates that the documentation was adequate and the code development was correctly assigned, then the problem might be the edit logic of the health plan when it applied the ICD-10 codes.

The AHA has advocated that CMS start testing with hospitals in early 2014 and provide extensive opportunities to accommodate all providers who want to conduct testing. Testing must be completed in a timely fashion so that providers, payers and clearinghouses can resolve any issues discovered during testing and complete training well in advance of the Oct. 1 transition date. CMS has announced limited end-to-end testing for ICD-10 this summer.

The document on the next page provides an example of how ICD-10 testing should flow. The AHA will continue to work with CMS to ensure a broad and complete testing timeline that is meaningful for hospitals and others. We encourage all hospitals to consult CMS’s educational materials available on the agency’s ICD-10 website at http://www.cms.gov/Medicare/Coding/ICD10/Index.html.
Hospital pulls representative sample of previously paid claims.

Hospital coders pull documentation and recode test claims using ICD-10.

Hospital test claims resubmitted with ICD-10 codes.

Contractor tests for connectivity –
- Fails – return to provider.
- Passes – goes to next step.

Contractor tests for content – Processes claims using ICD-10 codes.
- Inpatient test claims run through MS-DRG Grouper.
- Outpatient test claims run through APC systems.
- Both claim types adjudicated through assignment of MS-DRG or APC.

Hospital receives results of adjudicated test claims processed using ICD-10 codes.

Hospital compares to original claim.
- Asks if assignments are similar.

Note: Bulk of testing will likely include inpatient claims; there is significantly less volume on outpatient claims. Rationale: inpatient claims are primarily driven by ICD-10-CM and ICD-10-PCS by the Grouper. Outpatient claims are primarily driven first by HCPCS codes, ICD-10-CM is not as important for APC assignment.
Post-implementation Evaluation

After implementation, hospitals should assess how the transition to ICD-10 can be leveraged for strategic analysis and planning. The richer data encompassed in ICD-10 can be used to identify opportunities to improve operations and clinical outcomes. ICD-10 will allow hospitals to assess the resources used to treat patients with a given diagnosis at a greater level of specificity. For example, asthmatic patients could be differentiated into those with mild, intermittent asthma versus those with severe, persistent asthma with acute exacerbation. And rather than looking across all patients with other operations on the heart, the hospital can subset patients into those with repair of cardioverter/defibrillator (automatic) pocket versus ligation of the atrium of the heart.

In addition, hospitals will want to assess whether payment changes have occurred for services in which the ICD-10 codes provide more granular differentiation by patient diagnosis or procedure. It is likely that Medicare also will review claims in the future to assess whether the move to ICD-10 has led to increased payment due solely to coding changes, and not the underlying mix of patients treated and services provided.