Key Strategies for Ensuring Clinical Revenue Integrity with ICD-10

Angela Carmichael, MBA, RHIA, CDIP, CCS, CCS-P
Pyramid Healthcare Solutions, Clearwater, FL

Melinda Tully, MSN, CCDS, CDIP
J. A. Thomas & Associates, Atlanta, GA
This presentation will offer key strategies to help you identify opportunities to preserve, and in some instances, improve case mix index (CMI) during the transition to ICD-10.

After the presentation you will be able to:

- Identify how ICD-10s granularity will impact case mix index and clinical revenue integrity.
- Understand how adequate preparation and management of a CDI program will ensure success with ICD-10.
Outline

• Case Mix Index: A Key Metric For Success With ICD-10
• Understanding ICD-10’s Impact on Case Rate Reimbursement
• CDI Strategies for Success with ICD-10
• Summary
CASE MIX INDEX: A KEY METRIC FOR SUCCESS WITH ICD-10
What is CMI?

CMI is a measure of the diversity, clinical complexity and the need for resources in the population of patients in an acute care hospital.
How is CMI Calculated?

CMI is calculated by summing the DRG relative weights for all Medicare discharges for a specific period of time and then dividing by the number of discharges during the same time period.
Calculating CMI

- Medicare pays each hospital inpatient stay by DRG (Diagnostic Related Group).
- A DRG is a lump-sum payment based on the averages the cost of caring of similar types of patients.
- Each DRG is assigned a numerical weight ("relative weight") that reflects the current national average resource consumption for that patient population.
- Each acute care hospital has a standardized dollar amount assigned to it by Medicare, determined by factors such as the CMI, local wage index, type of facility, the number of low-income patients, type of institution, etc. ("blended rate")
- Hospital payment consists of the DRG relative weight multiplied by the hospital blended rate.
- By adding the weights of the facility’s DRGs for a specific period of time then dividing the sum by the number of admissions during that time you arrive at the CMI.
Why is CMI Important?

- CMI is a barometer of change within an organization
  - Change in surgical or medical volumes
  - Improper admissions (services provided in wrong setting)
    - IP admission for cardiac cath without meeting medical necessity
  - Failure to document complications and comorbidities (CC) and major CCs (MCC)
  - Failure to code, or code correctly, documented complications and comorbidities (CC) and major CCs (MCC)
The Provider’s Choice: Revenue Neutrality vs. Strategic Advantage

- Current Documentation + Accurate Coding
- Improved Documentation + Accurate Coding
- Revenue Neutrality
- Improved CMI
- CMI Stability
- Strategic Advantage
UNDERSTANDING ICD-10’S IMPACT ON CASE RATE REIMBURSEMENT
MS-DRGS, CMS-DRGS, AP-DRGS, APR-DRGS
ICD-10-CM/PCS Challenges

↑ volume of codes
↑ specificity of codes
↑ clinical nature
↑ characters composing a valid code
+ Alpha-numeric structure
✓ Complete overhaul of procedure reporting
✓ Change in coding guidelines
+ New technology
ICD-10-CM Specificity

ICD-10-CM offers increase specificity that can:

- Shift the MS-DRG
- Explain resource consumption patterns
  - May impact future CC/MCC lists, exclusion list, grouping & relative weights
- Report Severity of Illness (SOI), or Risk of Mortality (ROM)
  - May impact future payment in terms of VBP
- Informational purposes
  - May reduce denials for duplicate claims, etc
ICD-10-CM: Identifying Specificity

Etiology
Manifestation or complication
Specificity of anatomical site
Acuity (acute, subacute, chronic, unspecified vs. acute/subacute, chronic, unspecified)
Degree (mild, moderate, severe, unspecified vs total/complete, partial/incomplete)
Type (primary, secondary, unspecified)
Laterality (R/L/unspecified, or R/L/bilateral/unspecified)
Episode of care (3-16 “extension” options depending on code category)
Trimester (1,2,3, unspecified)
Number of fetus (1-5, other)
Inherent vs. Intentional Impact

Inherent Impact

- Many aspects of ICD-10, for both diagnoses and procedures, that inherently allow for strategic advantage for payers and providers who are prepared to exploit these aspects.

Examples:
- Increased use of combination codes
- Increased use of “code first” instructions

Intentional Impact

- The greatest impact on reimbursement is expected to result from intentional & strategic modification to payment methodologies.

- MS-DRGs
  - CC/MCC list & exclusions
  - Grouper changes
  - Relative Weight changes

- Commercial Payers
  - Separate payment rates for laparoscopic vs open procedures
What are your goals for transitioning to ICD-10?

- **Legally Compliant**
  - Capable of submitting ICD-10-CM/PCS codes on 10-1-2014
- **Strategic**
  - Accuracy of MS-DRG Assignment
  - SOI & ROM capture
  - HAC & POA reporting
  - Bullet-proofing documentation against external audits
- **Somewhere in between**
  - Missing shifts in MS-DRG
  - Missing SOI & ROM capture
  - Over-reporting HAC & inaccurate POA indicator reporting
  - Denials attributed to inadequate clinical support for specificity reported

Requires a Robust CDI Program
ICD-10’s Impact on Common Reimbursement Schemes

• Case Rate Reimbursement
  – A payment system in which a hospital is reimbursed for each discharged inpatient at rates prospectively established for groups of cases with similar clinical profile and resource requirements.
  – (MS-DRGs, CMS-DRGs, AP-DRGs, APR-DRGs, MS-LTC-DRGs, IPF-PPS)

• Other
  – IRF-PPS (IP Rehab), RUGs (Skilled Nursing), HHRGs (Home Health)
  – Case Rate Carve-out, pass-through, add-on technology
  – Episode-based Reimbursement
  – Hospital Billed Charges
  – Usual & Customary Reimbursement
  – (Professional services, IP billed charges, MS-DRG Rate)
ICD-10’s Impact on Case Rate Reimbursement

**Short Term**
- Inherent Impact: Moderate
- Intentional Impact: Moderate

**Long Term**
- Inherent Impact: Moderate
- Intentional Impact: Potentially Significant
<table>
<thead>
<tr>
<th>Reimbursement Scheme</th>
<th>Inherent Impact</th>
<th>Intentional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case rate</td>
<td>Moderate</td>
<td>Potentially significant</td>
</tr>
<tr>
<td>MS-DRGs</td>
<td>Moderate</td>
<td>Potentially significant</td>
</tr>
<tr>
<td>CMS-DRGs</td>
<td>Moderate</td>
<td>Potentially significant</td>
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<tr>
<td>AP-DRGs, APR-DRGs, MS-LTC-DRGs, IPE-PPS</td>
<td>Moderate</td>
<td>Potentially significant</td>
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<tr>
<td>Inpatient Rehab PPS (IRF-PPS)</td>
<td>Moderate</td>
<td>Moderate</td>
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<tr>
<td>Skilled Nursing (RUGs)</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>Home Health (HHRGs)</td>
<td>Moderate</td>
<td>Potentially significant</td>
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<tr>
<td>Risk Adjustment (HCC/RXHCC)</td>
<td>Moderate</td>
<td>Potentially significant</td>
</tr>
<tr>
<td>Case Rate Carve-outs</td>
<td>Minimal to moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Episode-based Reimbursement</td>
<td>Minimal to moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Performance based (HEDIS)</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Hospital Billed Charges</td>
<td>Minimal to no</td>
<td>Minimal to no</td>
</tr>
<tr>
<td>Usual &amp; Customary Reimbursement</td>
<td>Minimal to no</td>
<td>Minimal to no</td>
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<tr>
<td>Professional Services</td>
<td>Minimal to no</td>
<td>Minimal to no</td>
</tr>
<tr>
<td>Inpatient Billed Charges</td>
<td>Minimal to no</td>
<td>Minimal to no</td>
</tr>
<tr>
<td>Inpatient MS-DRG Rate</td>
<td>Moderate</td>
<td>Potentially significant</td>
</tr>
</tbody>
</table>

Source: Compiled based on ICD-10 Impact on Provider Reimbursement, Patricia Zenner, RN, Milliman, March 2010
Impact on Reimbursement

- Study predicts a $\frac{1}{2}\%$ increase in MS-DRG payment after transition, but only if coding is accurate.
- Improved clinical documentation & accurate coding can increase payments above & beyond $\frac{1}{2}\%$.
- The majority of current clinical documentation improvement strategies will hold true.
- Additional opportunities based on changes in:
  - Grouper logic changes based on code specificity
  - Changes to the CC/MCC lists & exclusions (SOI/ROM APR-DRGs)
  - Coding instructional notes (“code first”)
  - Official coding guideline changes
  - New diagnoses/procedures not previously captured in ICD-9-CM
CMI the Canary in the Coal Mine

• A dip in CMI is avoidable with preparation and forethought.
• In order to stay on course and ensure a healthy CMI in 2014 and beyond, providers need to understand what strategies will need to change – and which ones need to stay the same to succeed after the transition.
CDI STRATEGIES FOR SUCCESS WITH ICD-10
What are your goals for transitioning to ICD-10?

• Legally Compliant
  – Capable of submitting ICD-10-CM/PCS codes on 10-1-2014

• Strategic
  – Accuracy of MS-DRG Assignment
  – SOI & ROM capture
  – HAC & POA reporting
  – Bullet-proofing documentation against external audits

• Somewhere in between
  – Missing shifts in MS-DRG
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Requires a Robust CDI Program
CDI Strategic Approach for ICD-10

- ICD-10 is not just a “Coding Issue”
- Concurrent clinical documentation improvement is necessary to benefit from the greater specificity in ICD-10-CM and……
- Preserve current reimbursement and case mix levels
- Concurrent CDI a necessity
Avoid the Following

• Do not expect to benefit from I-10 without improving clinical documentation.
• Do not rely solely on a post-discharge query process to improve clinical documentation.
• Do not assume that your current CDI program is adequate to support the transition to ICD-10.
• Do not focus exclusively on coder education
• Do not clarify for additional specificity at every turn.
CDI Success in ICD-10 Transition

- Success is dependent on assessment and preparation of infrastructure, processes and training of the clinical documentation team and coding professionals
- Requires evaluation and assessment of the current clinical documentation program
- Requires robust education
- Integration of ICD-10 preparedness and Clinical Documentation Improvement vital
Assess Current CDI Program

• Ensure Documentation Specialists have the required clinical foundation and critical thinking skills for success

• A higher level of knowledge and application of A&P as well as medical terminology required
  – Testing for clinical competency may be necessary
  – Assess biomedical skills

• Evaluate current CDI staffing, tools and general workflow as well as the interaction with other key clinical/quality departments
Assess Current CDI Program

• Analyze monthly case mix correction both before and after the transition
• Benchmark current CDI program against peer organizations with a CDI program
• Analyze current CDI practices to identify opportunities for improvement
  – Productivity
  – Physician response and concurrence rates
  – Collaboration with HIM professionals
• Evaluate CDI synergy with current coding accuracy and productivity
Assess Documentation Improvement Opportunities

• Identify medical record documentation improvement opportunities in both ICD-9 & ICD-10
• Start by reviewing medical record documentation on the most frequently-coded conditions (Top 20 diagnoses & procedures)
• Look for change in the axes of classification from I-9 to I-10 then verify that the documentation contains this level of detail
• Focus on capturing details that reflect SOI, ROM, quality and patient safety
Evaluate Coding Accuracy

- Contract with an external vendor for annual evaluation of coding accuracy.
- The old adage “You don’t know what you don’t know” is very true for coding.
- It is imperative to validate coding accuracy with ICD-9-CM prior to transitioning to ICD-10.
- Once the transition to ICD-10-CM/PCS is made, continued evaluation of coding accuracy will be paramount to case mix preservation.
CDI, Physicians, and ICD-10

- Assess current physician support for CDI
  - Do you have a physician director of CDI?
- Review physician query response rate
- Review physician query concurrence rate
## Current CDI Assessment (Summary)

<table>
<thead>
<tr>
<th>System</th>
<th>Facility</th>
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<tbody>
<tr>
<td>Leadership and Accountability</td>
<td>Leadership and Accountability</td>
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<tr>
<td>Administrative oversight committee</td>
<td>CDS Staffing</td>
</tr>
<tr>
<td>Physician Leadership</td>
<td>Physician Engagement/Champion</td>
</tr>
<tr>
<td>HIM Leadership</td>
<td>CDI Process &amp; workflow</td>
</tr>
<tr>
<td>IS/IT Support</td>
<td>HIM Support/Engagement</td>
</tr>
<tr>
<td>Case Mix Data Analysis</td>
<td>Administrative oversight committee</td>
</tr>
<tr>
<td>Compliance</td>
<td>CDI team meetings</td>
</tr>
<tr>
<td>Strategic Plan (CDI)</td>
<td>IS/IT Support Electronic Clarification</td>
</tr>
<tr>
<td>Policies and Procedures (CDI)</td>
<td>Review of available data/program statistics</td>
</tr>
<tr>
<td></td>
<td>Interdepartmental communication for CDI</td>
</tr>
</tbody>
</table>
NEXT STEPS AFTER CDI ASSESSMENT
Initiate ICD-10 Documentation Queries Now

Review

Choose

Clarify

Provide

Choose the top twenty documentation opportunities
Incorporate one new ICD-10 query into current CDI program every month
Why Clarify Now?
ICD-10 May be Delayed One to Two years

Which Method Works Best?
Clinical Example

- AMI
  - Type of infarction (NSTEMI versus STEMI)
  - Age of infarction (Four weeks or less = Acute)
  - Specific site of myocardium (anterior, inferior, etc.)
  - Coronary artery involved
  - Initial episode of care or subsequent episode of care
Prioritizing is Key

- Educate Physicians Sooner Versus Later
- Physician support and training is the greatest challenge faced by hospital and health systems (74.3 percent) online survey
- Physicians are finding it hard to see the benefit of ICD-10
- Start peer education now
- Without physician cooperation and understanding, other changes in workflow or systems to accommodate ICD-10 ultimately will fail
Prioritizing is Key

• Thoughtful Use of the Electronic Health Record.
• Develop templates and alerts for physicians
  – achieve specificity by prompting for documentation by type then by complication and then by severity
  – But, this can go overboard
  – Physicians can only deal with so many prompts
  – Work with your EHR vendor to develop the proper amount of prompts and thoughtful analysis of how the EHR can support the ICD-10 transition
CDI ICD-10 “To Do” List

• Provide both clinical documentation specialists and coders with ICD-10 awareness, developmental and role specific education vital to maintaining both case mix and productivity
• And, don’t stop there—continuing education will be vital long after the go-live date of October 1, 2014
• After the go-live date CMI will require close monitoring
  – Subtle changes will require investigation
  – Denials will require evaluation to determine root cause
• Additional training for the CDI and coding teams can be expected
• Keep quality, patient safety, and severity an equally important part of your CDI program
CDI ICD-10 “To Do” List

• Consider performance enhancing tools
  – software driven CDI programs
  – computer assisted coding (CAC) software (retro and concurrent
  – EHR leverage for documentation alerts, and query templates and notifications
• Conduct parallel software testing one year ahead of the conversion
• Work in both current ICD-9-CM and ICD-10 code sets to be acclimated
• Measure success working with new code sets
Post ICD-10 Implementation Monitoring

Monthly Analysis:
• CMI trending and patient mix analyses (medical/surgical ratio)
• MCC/CC capture rates
• Productivity benchmarks

Ask yourself:
• Has the clarification rate or the review rate decreased?
• Are physicians responding as readily?
• Does the concurrent DRG and final DRG match remain the same?
• Is your query rate incessant?
Clarification in ICD-10

- Don’t clarify for additional specificity at every turn
- Incessant clarifications will grind clinical documentation improvement to a halt
- Manage clarifications by focusing efforts to achieve the greatest good
- Focus on clarifying when the greater specificity will shift the MS-DRG and result in appropriate reimbursement
- Clarify when the greater specificity allows data for reporting severity of illness, observed versus expected mortality, core measures, patient safety indicators, hospital acquired conditions and present on admission
Procedural Clarification in ICD-10

• Almost all ICD-9-CM procedure codes will have more than one ICD-10-PCS code option available
• Clarifications for additional information regarding surgical procedures will be far more prevalent than in ICD-9
• Procedural focus
  – ICD-10-PCS root operation definitions
  – Tools such as body site keys and device keys
  – Surgical approaches
  – Specific anatomical sites involved
In Closing

• Ensuring clinical data and revenue integrity under ICD-10 requires a top-notch and fully engaged CDI program

• If you can answer yes to all of the following questions, you will have very little to worry about come October 1, 2014.

• And by the way……. “Embrace specificity”
Ask Yourself…

- Do you have a CDI program in place now—or plan to prior to the October 1, 2014 go live date?
- Are you actively monitoring your CDI program?
- Are you benchmarking yourself to your peers with a CDI program?
- Have you set goals for targeted improvements?
- Are you reviewing all payment schemes that base payment on coded data?
- Are you prepared to manage the clinical documentation improvement opportunities afforded by both ICD-10-CM and ICD-10-PCS?
- Have you determined if your CDI program is adequate for both I-9 and I-10 success?
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http://www.roswellpark.org/partners-in-practice/white-papers/icd-10-cm-transition


Resources

www.ahima.org/icd10
www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm
www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp
www.cms.gov/ICD10
www.who.int/classifications/icd/en
www.cms.gov/ICD10/Te110/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=descending&itemID=cms1246998&intNumPerPage=10
http://content.hcpro.com/pdf/content/268585.pdf
www.asco.org/.../Microsoft%20Word%20-%20ICD_9_CM_to_ICD_10_CM_Coding_Transition.pdf
Thank You!