ICD-10
PREPARATION GUIDE
PART II

More resources to prepare your physicians and staff, and to help work with your vendors to successfully implement the new code set.
A successful transition to ICD-10 — which is set to go into effect on Oct. 1, 2015 — requires coordination among providers and their trading partners, which include billing services, software vendors, clearinghouses and health plans, in addition to internal staff training. MGMA expert, Robert Tennant, MA, MGMA Government Affairs senior policy advisor, offers advice and resources on ICD-10 in his regular column published in MGMA Connection magazine. We compiled more of his columns into an easy-to-use guide to help practices prepare for the new code set. MGMA members can download Part I of the preparation guide at mgma.org/icd10-preparation-guide
Working with your software vendors to achieve ICD-10 success

To experience minimal cash flow disruption following the Oct. 1, 2014, compliance date for ICD-10, practice professionals must reach out to their critical software vendors as early as possible. Asking these vendors the right questions, taking the right steps and planning for contingencies should be key elements of your implementation plan.

Why is your software vendor important?
The move from ICD-9 to ICD-10 will require significant change in every part of a practice, including information technology (IT) systems. In terms of software, practices will need to assess every system that captures or uses ICD codes to determine whether the system needs to be upgraded or replaced.

While many practice professionals will focus their attention on practice management (PM) system and EHR software, other products might need to be assessed, such as case management, quality reporting and clinical trial software.

Since the vendor will supply much of the critical software-related information, practices should consider sending the company a list of questions and request written answers. After receiving this information, practice professionals should create a worksheet that contains, at a minimum, the following information to effectively manage this process:

• Vendor name and purpose of the software
• Contact information, including the name of a company representative who is qualified to address questions and issues
• Readiness risk level to practice (i.e., “red” for critical revenue stream vendors)
• Practice department and/or individual with responsibility over software
• Date vendor was contacted with space for comments, such as when you expect a reply
• Date vendor has indicated upgrade or replacement will take place
• Amount of time vendor anticipates system will be offline during conversion process
• Date vendor has indicated internal testing will take place
• Date vendor has indicated external testing can begin
• Name of practice staff responsible for updating this vendor section of the spreadsheet

Version control
An issue of potential concern is that software vendors might offer a product upgrade that is only for certain versions of the software. For example, if a vendor upgrades to Version 10 and the practice is running Version 5, there could be substantial cost to move to the latest version. More advanced versions of the software could also require faster computers with additional memory or hard drive space, leading to additional costs for the practice.

Meaningful use
Many practice professionals are simultaneously working with clinicians to attest for Stage 2 of the Medicare or Medicaid EHR Incentive Program. Not only does this add stress on practice staff, but many of the vendors that practices use for PM software are the same vendors they use for their EHRs. There are far fewer products certified for the 2014 meaningful use criteria compared with those certified for the 2011 criteria, according to early indications. As practice professionals reach out to their PM vendors to discuss ICD-10, they should talk with the vendor or an EHR vendor about plans to update EHR software to accommodate the 2014 meaningful use criteria.

Clearinghouse issues
With the 2012 implementation of Version 5010, the new HIPAA electronic claim format, many practices were able to rely heavily on their clearinghouse to assist during the transition. In many cases, the clearinghouse was able to convert the Version 4010 format to the new one. However, clearinghouses have limited ability to solve a practice’s ICD-10 issues. In particular, it will be difficult if not impossible for a clearinghouse to convert an ICD-9 code to an ICD-10 code without having access to the complete medical record. In addition, as much as 20 percent of claims submitted to clearinghouses are in Version 4010 — a format that will not appropriately accommodate ICD-10 codes, according to industry reports. Practice professionals should reach out to their clearinghouses to ascertain what ICD-10 services it can provide and at what cost.

Assuming the federal government does not extend the Oct. 1 compliance date, practices will need to maintain their ability to submit both ICD-9 and ICD-10 codes for...
some period after this date for a number of reasons, including the following:

• Several insurance types, including workers’ compensation and auto insurance, are not required by law to adopt ICD-10, which will require practices interacting with these entities to use ICD-9 codes on transactions for the foreseeable future. The Centers for Medicare & Medicaid Services, however, has stated it will encourage these entities to adopt the ICD-10 code set.

• Practices must be able to accommodate both ICD-9 and ICD-10 codes until all claims and other transactions for services performed before Oct. 1, 2014, have been fully processed. Practice professionals are urged to promptly process all claims using ICD-9 codes as the transition date nears to assist in limiting cash flow disruption.

• Practice professionals might find that some of their health plans are not able to accept ICD-10 codes after Oct. 1, although this would not be legally compliant with the regulation. Practices also may lodge a formal complaint with the government against any health plan that is noncompliant.

Determining costs
Once the internal software assessment is completed and software upgrades or replacements have been identified, the practice must accurately determine the costs. Recent MGMA Legislative and Executive Advocacy Response Network (mgma.org/learnresults) research suggests that only about 30 percent of vendor maintenance contracts cover the upgrade expense of the ICD-10 implementation. As a result, many practices will be required to cover these costs. Along with determining the costs associated with hardware and software upgrades, practice professionals should ask if vendors are offering any ICD-10 specific training for the practice’s clinical and administrative staff, and if so, what the cost will be for this service.

Timing is critical
With just a short time before ICD-10 is required, practice professionals should analyze their internal systems and reach out to their software vendors as quickly as possible. If a vendor does not have its product ready or decides not to offer an upgrade, practices will need to review alternative software products; budget sufficient time and money for new software; and purchase, install and train staff on using the new software. The goal for the practice is to have the software installed with sufficient time to conduct both internal and external testing with clearinghouses and health plans.

Healthcare professionals got a reprieve from the impending ICD-10 deadline with passage of HR 4302, the Protecting Access to Medicare Act of 2014, also known as the SGR “patch” bill. ICD-10 has been delayed for at least one year, with earliest adoption scheduled for Oct. 1, 2015. Rather than halt all implementation efforts, practice professionals are encouraged to leverage their ICD-10 related efforts to improve practice performance. As an example, a number of the action steps required for the new code set can be applied to other areas of the organization to improve organizational operations.

Documenting the patient encounter
Enhanced documentation to support the assignment of more granular codes is a critical component of ICD-10. As part of staff training for the new code set, many practices are focusing on improving patient encounter documentation. This improvement can produce benefits beyond simply getting ready for ICD-10, including:

• Providing clinicians in the practice who are involved in a patient’s care with a more complete picture of health status, prognosis and treatment protocols

• Enhancing the quality of care provided during transitions of care, such as when a patient is referred to a specialist; admitted to a hospital; or transferred to a rehabilitation center, skilled nursing facility or long-term care provider

• Facilitating more accurate billing of services

• Improving the information provided to patients themselves. This is becoming even more important as an
increasing number of patients are requesting access to their medical records.

**Upgrading PM software**

The vast majority of practices will have to upgrade or replace their practice management (PM) software to accommodate ICD-10 diagnosis codes. Recent MGMA research (mgma.org/learn) estimates the cost will be about $12,000 per full-time-equivalent physician for those practices required to upgrade or replace software. If the practice is looking at this level of change and expense for a new PM system, it might be a good opportunity to explore options for automating critical revenue cycle tasks, such as patient insurance eligibility verification and claims payment, and take advantage of the administrative simplification provisions included in Section 1104 of the Patient Protection and Affordable Care Act (ACA).

**Automating patient insurance eligibility verification**

For many practices, eligibility verification is conducted by phone through a health plan’s automated voice response system or through a health plan’s website. With this approach, the practice keys in a patient’s health plan identification number and receives the appropriate voice or web response. Although this approach can be effective for a small number of patient eligibility verifications, it is cumbersome and labor-intensive.

The purpose of an insurance verification is to determine if a service is covered, establish the patient’s financial responsibility and reduce claim denials and resubmittals. As practice professionals know all too well, getting patients to pay what they owe at the time of service can be a challenge. Many larger balances are paid over a long period of time, and some balances are never collected. Larger balances are becoming more common with the increase in high-deductible health plans.

From an operations perspective, it is much more efficient to check patient eligibility the day before an appointment, especially if all of the patients with the same health plan are run in one transaction or “batch.” Conducting eligibility in batch mode allows the practice to identify potential problems, such as a lapsed insurance card, and talk to patients before they arrive for appointments.

With the appropriate technology in place, practice staff has the ability to check eligibility at multiple points, including prearrival, check-in and charge entry. This real-time eligibility and benefits verification functionality combined with the claims valuation engine often incorporated into the PM software (or offered on the health plan’s website) permits the practice to calculate the patient’s financial responsibility before or at the time of service.

**Operating rules**

The ACA required that all health plans support requirements of the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I & II Operating Rules. That requirement went into effect Jan. 1, 2013.

The ACA mandated operating rules for eligibility include the following:

- A patient’s financial responsibility for payment of services must be returned to the practice within 20 seconds of the request to a health plan. The practice will collect the copay, co-insurance and patient deductible. The health plan must report the patient’s financial responsibility for providers who are both in and out of network.
- Eligibility inquiries for dates one year in the past and to the end of the current month must be reported by the health plan.
- Health plans must respond to provider requests for the following service type codes:
  - 1-Medicare care
  - 33-Chiropractic
  - 35-Dental care
  - 47-Hospital
  - 48-Hospital inpatient
  - 50-Hospital outpatient
  - 86-Emergency services
  - 88-Pharmacy
  - 98-Professional (physician) visit office
  - AL-Vision (optometry)
  - MH-Mental health and UC-Urgent care
Comprehensive PM systems can automatically generate an estimate of a patient’s out-of-pocket financial obligations after determining the health plan allowance and applying any remaining deductibles or coinsurance. Armed with this information, practice staff can advise patients of amounts due prior to procedures and collect prepayments. Because patient estimates will be more accurate, the number of patient refunds and resubmission of claims will be reduced.

Identifying patient financial responsibility upfront captures payments more efficiently and reduces the need for back-end patient collections. Providing patients with service estimates based on their latest deductibles, coinsurance amounts and benefits information improves the provider-patient relationship while helping the group maximize cash flow and minimize payment delays.

**EFT and ERA**

Electronic funds transfer (EFT) offers an excellent opportunity for a practice to automate a manual process and achieve significant efficiencies. In many practices today, payment in the form of a paper check is received from the health plan in the mail with the practice’s administrative staff then copying the check, manually posting the information and then taking time out during the workday to make deposits at the bank. As the workplace has embraced direct deposit of paychecks, healthcare is now embracing EFT, albeit at a slower pace.

As of Jan. 1, health plans are required by the ACA payments via EFT to practices that request it using a national standard that incorporates new EFT operating rules. In addition, health plans must support the new operating rules for electronic remittance advice (ERA). Health plans face significant fines if not compliant.

The ACA’s EFT and ERA operating rules will facilitate easier enrollment, reassociation and faster payments by:

- Requiring health plans to use a consistent format and form on EFT/ERA enrollment forms, ensuring that the enrollment process is similar across plans
- Requiring health plans to offer an electronic method of provider EFT/ERA enrollment
- Automating the reassociation of EFTs and ERAs
- Requiring the health plan to release the payment and ERA within a reasonable timeframe (e.g., three days or fewer) if the provider has enrolled for both transactions
- Providing practice access to instructions from health plans on how to address late or missing EFTs and ERAs
- Allowing practices to receive key data elements (“trace numbers”) in the EFT and ERA transactions that will facilitate successful reassociation
- Requiring health plans to use a uniform set of code combinations for common business scenarios developed by CAQH CORE to convey details of the claim denial or payment adjustment [Claim Adjustment Reason Codes (CARC)/Remittance Advice Remark Codes (RARC)] to the practice. This operating rule establishes a maximum set of CARC and RARC code sets for use with a number of specific business scenarios.

Although upfront costs for new PM software can be significant, practice professionals must compare the cost of the technology with the cost for staff time required to rework and resubmit denied claims, communicate with patients regarding delinquent accounts, engage with one or more collection agencies, write off bad debt, manually process payments and remittances, and perform other burdensome administrative tasks.

Improving documentation and leveraging the new standards and operating rules for insurance eligibility verification, EFT and ERA will provide a clear return on investment for practices. Although practices might not see a specific return on investment associated with the complex, challenging and expensive transition to ICD-10 itself, the processes practices undertake to prepare for the new code set can be leveraged to improve clinical and administrative performance.

To help practice professionals transition to these new standards, MGMA offers a number of resources at mgma.org.
ICD-10 delay gives opportunity to take low-cost, high-impact steps to prepare for the new code set

The Centers for Medicare & Medicaid Services (CMS) announced Oct. 1, 2015, as the new deadline for implementing ICD-10. It was the most recent extension for physician practice adoption of the diagnosis component known as the clinical modification (CM). After Oct. 1, 2015, outpatient claims will need to be coded with one of approximately 69,000 codes, an increase from 13,000 codes in ICD-9-CM. With the new start date in place, the question is, what should physician practices do now to prepare for the transition?

The delay to the Oct. 1, 2014, date was included in the Protecting Access to Medicare Act of 2014, which included a provision that ICD-10 could not be adopted prior to Oct. 1, 2015. Soon after the bill was signed into law on April 1, CMS announced the new compliance date and stated it would issue an interim final rule in the near future to officially affirm the 2015 compliance date and provide an opportunity for public comment. CMS also indicated that all HIPAA-covered entities (providers, health plans and clearinghouses) would be required to continue using ICD-9-CM through Sept. 30, 2015, even if they were already prepared to move to ICD-10.

In a separate announcement, CMS revoked its offer of end-to-end testing for a sample group of providers with Medicare administrative contractors and indicated that additional opportunities for end-to-end testing will be available, but not until 2015. As part of our ongoing ICD-10 advocacy efforts, MGMA has strongly asserted that comprehensive end-to-end testing is a prerequisite to ICD-10 implementation.

Practice action steps
Practice executives might be justifiably concerned about investing significant organizational resources on a mandate that has been postponed several times. You might consider steps that require minimal financial investment yet can benefit the practice with its ICD-10 efforts and other operational issues.

1. Project management
A critical part of preparing for ICD-10 is managing the changes that must take place. An effective initial approach to project management is the creation of a comprehensive spreadsheet that maps out the tasks required and who will perform them. Of particular importance is identifying what software in the practice will be affected by ICD-10. Consider populating the spreadsheet with this information:
   • Software product
   • Department, division or affected area of the practice
   • Software needs to be upgraded (yes/no)
   • Software needs to be replaced (yes/no)
   • Vendor contact information (not just the sales representative)
   • Vendor contacted (yes/no)
   • Vendor responded (yes/no)
   • Date indicated for upgrade/replacement
   • Estimated cost (including training and hardware)
   • Workflow change required (yes/no)
   • Practice staff assigned/responsible
   • Notes/resolution

The additional time allows practice executives to clearly identify any vulnerable areas of the organizations in terms of software upgrades or replacements. Other tasks that can be added to the spreadsheet include:
   • A listing of staff who will need to be trained in the new code set, preferred method of training and training timetable
   • Internal and external testing schedule
   • Contingency plans should a significant number of claims be pended or denied

2. CDI
The foundation for a successful transition to ICD-10 is the accurate documentation of a patient encounter. Professionals can only code based off of the information they are provided in a medical record. If the record does not contain the necessary elements, coders might not be able to identify the most appropriate code. ICD-10 is far more granular than the current code set and includes elements that might not be captured now by your clinicians, such as:
   • Laterality
   • Encounter type (initial, subsequent, sequela*)
   • Anatomic details
   • Severity
   • Disease relationships
Engaging in clinical documentation improvement (CDI) with your physicians, nurses and other clinical staff is an excellent way to prepare for ICD-10. Enhancing the documentation of an encounter can also:

- Enhance the accuracy of your billing. Practice coders can select the most appropriate level of service performed by a clinician when they have enhanced documentation available. Enhanced documentation will also guard against patient services that are not billed. Coders can only work with the information they are provided. Often times, the result of better documentation is increased revenues that reflect the services provided to patients.
- Guard against audits. The more accurate the clinical documentation, the less likely it is that a practice will fail a billing audit. CDI can help protect your practice in the event of a health plan or other entity reviewing charts for accuracy of billing.
- Improve transitions of care. CDI can ensure the accuracy of documentation that follows a patient to referral specialties or other care settings, such as physical therapy, skilled nursing or long-term care. This can lead to improved performance throughout the patient care cycle.
- Augment your patients’ records. Patients and caregivers are becoming more engaged in their healthcare and that of their loved ones. Patients are permitted a copy of their medical records in an electronic format under federal privacy regulations and as a component of the Medicare and Medicaid EHR incentive program. CDI can provide patients and caregivers with a more complete medical record that they can bring with them if they visit another care setting.

3. Internal CDI testing

If clinical documentation is not complete, the typical office coding process can result in chasing a clinician for the appropriate information. This can delay submission and subsequent payment of the claim. In situations where there is a significant lapse in time between a patient encounter and coding of the claim, it might be next to impossible for a clinician to accurately recall the relevant details necessary to assign a more granular ICD-10 code.

Your CDI efforts can include a number of tests that can provide effective barometers of how your practice will fare following the compliance date, such as:

- Identify your top 25 most frequently billed codes using ICD-9 diagnosis codes with previously and successfully adjudicated claims, and map the claims to ICD-10 codes. Determine whether the records contain the necessary clinical information to support an appropriate ICD-10 diagnosis code. If you determine that one or more of your clinicians is not producing sufficient documentation to support ICD-10 codes, you can work with them on weak or incomplete documentation. In some cases, it might be more effective to use peer-to-peer dialogue — having physicians discuss CDI with their colleagues.
- Use your top 25 ICD-9 diagnosis codes and dual code a selection of live claims by mapping to ICD-10-CM codes. Begin auditing to determine whether the records contain the necessary information to support the appropriate ICD-10 diagnosis code. Consider this exercise with claims from the health plans that compose the majority of your payments. This exercise will be even more effective once health plans release their payment policies.
- Take any opportunity to test with your software vendor, clearinghouse or health plans. Some of these trading partners offer a variety of testing opportunities that could be valuable in determining your overall ICD-10 readiness level.

With Congress mandating a minimum of one additional year for the healthcare industry to move forward with ICD-10, this should be seen by practice executives as an opportunity to take low-cost, high-impact steps to prepare for the new code set. Access more MGMA ICD-10 resources at mgma.org/icd10.

*Sequela: A morbid condition following or occurring as a consequence of another condition or event. Source: medical-dictionary.thefreedictionary.com/sequela
Tracking ICD-10: A guide to internal assessments

With the new ICD-10 compliance date set for Oct. 1, 2015 (less than a year away), it is time once again to turn your attention to transitioning to this new code set. Conducting an internal assessment of how ICD-10 will affect a practice’s organization is an excellent way to jump-start compliance efforts. Even practices that completed an assessment in preparation for the 2014 implementation date will benefit from reassessing the affected areas as vendors and workflows might have changed in the past year.

A practical first step is to create an Excel spreadsheet (or Word document) that captures the critical information related to affected areas, resolutions and contingencies. The following are some general topics you might want to include:

- **Identifying affected areas.** ICD-10 is not simply a claims-submissions issue. The transition could affect the clinical encounter, lab orders, pre-authorizations, clinical trials, quality reporting and other areas. Larger practices might have to assign multiple staff members to oversee areas, such as billing, coding and data analytics.

- **Workflow.** Practices should track if and how administrative and clinical workflows will be affected by the change to ICD-10 and include a resolution to each workflow issue if possible.

- **Dual coding.** Among the many challenges associated with the ICD-10 transition is that some entities, such as workers’ compensation plans, are not required to adopt the new code set. In addition, claims submitted after Oct. 1, 2015, for dates of service prior to the compliance date need to be coded using ICD-9, so practices might need to code claims with ICD-9 and ICD-10 for some time after the compliance date. Practices should document the use of ICD-9 codes and how they will be captured on the spreadsheet.

- **Code assignment.** A key component of this preparation will be determining how the practice assigns ICD-9 codes and how ICD-10 will affect that assignment. There are generally three approaches to code assignments:

  - **Clinician coding.** In some practices, clinicians assign the diagnosis codes at the time of a patient encounter. While effective, it requires clinicians to be well-versed in documentation requirements for ICD-10 and the codes.

  - **Internal professional coders.** Many practices employ professional coders, who code claims based on documentation provided by clinicians. These individuals will need ICD-10 training, and practice clinicians will need to focus on clinical documentation improvement, which is critical to ensure that coders receive necessary information regarding a patient encounter that allows them to assign appropriate ICD-10 codes.

  - **External coders.** For practices that export claims to external professional coders, it is important to gather the following information:

    - Plans to be retrained on ICD-10 codes (some might retire rather than go through extensive training)
    - The date when they expect to receive their ICD-10 certifications
    - When they will be comfortable coding claims in ICD-10
    - Any additional cost for the practice associated with the transition

- **Determining whether ICD-10 will affect software.** Larger practices might use multiple software systems that will be affected by the change to ICD-10. Practice professionals should evaluate each practice system to determine if it uses diagnosis codes and requires an upgrade or replacement.

- **Vendor contact information.** In addition to affecting the practice system and EHR software, the move to ICD-10 might require other practice software to be upgraded or replaced. Practice professionals are encouraged to reach out to vendors with a certified letter requesting answers to critical questions instead of relying solely on communications from local sales representatives and/or information published on websites. Each software system should be tracked individually with the following questions answered:

  - **Software needs to be upgraded or replaced?** When discussing this issue with a vendor, practice professionals should ask if the vendor will upgrade the practice's version of the software. Some vendors might not support ICD-10 with older versions, which would potentially require the practice to incur the expense of moving to a more recent version.

  - **Vendor contacted?**
  - **Vendor responded?**
  - **Will vendor produce an upgrade or replacement?**

It is better to know the answer to this question well in advance of the compliance date. If the answer is no, practices will need sufficient time to identify an alternate plan.
appropriate alternative, install new software and train staff. Completing this well before Oct. 1, 2015, should minimize negative effects.

- **Date indicated for upgrade/replacement?**
- **New hardware required?** Some practices have found that when they upgrade practice management systems and/or EHR software, advanced software requires improved hardware, such as RAM memory, faster CPU speeds and/or larger hard drive space.

- **Date indicated for staff training on the new software (if needed)?** Some vendors offer software training as part of a maintenance agreement; others offer it for an additional cost. It is imperative to train staff members well in advance of the compliance date to minimize any effects on productivity.

- **Costs covered under existing maintenance agreement?** If yes, practices should ensure that the maintenance agreement covers all the costs related to the switch to ICD-10, including the software and associated training. Practices should consider asking their legal team to review the contract terms.

- **Additional staff requirements.** Practices should also assess whether hiring or reassigning staff is necessary. For example, it might be advantageous to train additional staff to assist the revenue cycle management team for the first few months following the compliance date — the time when productivity is most likely to be affected.

- **Estimated cost to practice.** Each task on the spreadsheet should have an accurate cost assigned to it so practice professionals can bring the tally to the budgeting team.

- **Testing.** Practices should include opportunities for testing, which can be classified as:

  - **Internal testing** to ensure that staff, after training and through revised workflows, is able to capture the documentation necessary for ICD-10; that coders are able to assign the appropriate ICD-10 codes; and that software can generate ICD-10 codes.
  - **External testing** with trading partners, such as external coders, billing services and clearinghouses.
  - **Testing with health plan partners** with a focus on the plans that make up the majority of the business for testing purposes. Health plans are taking a number of approaches, from offering no testing to full “end-to-end” testing that includes sending a remittance advice to the practice.

- **Contingencies.** For many of the spreadsheet categories, practices should consider adding a section outlining what contingency plan the practice will employ. For example, has an alternative practice management system software product been identified if a vendor does not have the ability to provide the practice with an upgrade or replacement? If an external coder does not plan to recertify for ICD-10, has the practice identified an alternative? If the state workers’ compensation plan will not transition to ICD-10, can the practice assign an ICD-9 code to these claims?

A comprehensive spreadsheet should help practices manage the task of transitioning to ICD-10. Identifying and tracking the required modifications are critical steps to ensure that the organization is well-prepared and to minimize the chance for significant cash flow disruption.

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**Jump-start your 2015 ICD-10 efforts**

With less than nine months to go before the deadline for the ICD-10 transition, practice leaders will need an aggressive action plan in place to meet the challenge. Although the ICD-10 compliance date has been delayed several times, not taking action and assuming the Oct. 1 date will be moved again might put your practice revenue at risk.

Many practices began their ICD-10 implementation process in 2014, only to put those efforts on hold following passage of the Protecting Access to Medicare Act of 2014 (H.R. 4302, which delivered a minimum one-year delay). However, it is best to dust off that action plan and begin again to prepare for this important challenge.
Take the following steps to help your organization move forward with ICD-10:

- **Assess the effect on the practice.** The first step in your ICD-10 effort will be to accurately assess how the new code set will affect the organization. This assessment includes identifying software in the practice that uses diagnosis codes and ascertaining if a system will need to be upgraded or completely replaced, which clinical and administrative workflow processes will require modification to accommodate ICD-10 and its need for enhanced documentation, and which practice staff will need to be trained. Once the assessment is complete and you have asked your trading partners what costs they will pass on to your organization, you can create a budget for the transition.

- **Improve clinical documentation.** Most agree that the foundation for a successful transition to ICD-10 will be the improvements in the documentation of clinical encounters. Conducting clinical documentation improvement exercises with your clinicians will help ensure that your downstream coders have the information if they need to assist in the assignment of the appropriate codes.

- **Establish trading partner readiness.** Once you have identified external trading partners that will be affected by ICD-10, it is critical to establish their readiness levels. For external coders, find out if they will be retrained and recertified for ICD-10. If they do not plan to, it will be best to identify alternative coders before the compliance date. In the case of software vendors, you will need to know if an upgrade or replacement is necessary, and get a timeline for those changes and the cost to the practice. Similarly, if you contract with a clearinghouse, talk to its representatives about readiness levels; services offered; and, if applicable to your practice, the potential workarounds for handling older claim formats, such as HIPAA 4010. Finally, identify the health plans that compromise the bulk of the business transactions and contact them to find out readiness levels and if they have published their revised payment policies.

- **Test, test and test again!** Take any and every opportunity to test your ability to select the appropriate ICD-10 code, include the code on administrative transactions and successfully submit these codes to a clearinghouse or health plan. While the Centers for Medicare & Medicaid Services (CMS) has announced that it will only offer limited end-to-end testing (which includes receipt of the remittance advice), the agency will be conducting unlimited front-end testing that will help determine technical compliance and adherence to performance processing standards. In addition, discuss testing opportunities with your practice management system vendor, clearinghouse and key health plans.

- **Identify resources.** MGMA members can find a wide array of external resources at the MGMA ICD-10 Resource Center (mgma.org/ICD10) that will help them navigate each of the necessary implementation steps. You will also find links to helpful resources developed by CMS, such as the “Road to 10,” a website (roadto10.org) that outlines the effects of ICD-10 on a number of medical specialties and offers common codes, primers for clinical documentation, clinical scenarios and additional resources associated with each specialty. In addition, MGMA has partnered with a select group of associations and vendors to bring members discounts on effective code selection and staff training products. Learn more about these resources: mgma.org/ICD10.

Despite the uncertainty caused by multiple delays of the compliance date, practice leaders have to move forward with the assumption that the current Oct. 1 date will stay in effect. Implementing an action plan that includes the steps identified here will help safeguard your organization from the impact of not being ready to submit claims with ICD-10 codes.