ICD-10 PREPARATION GUIDE

MGMA resources to prepare your practice and work with trading partners on the new code set.
A successful transition to ICD-10 — which is set to go into effect on Oct. 1, 2014 — requires coordination among providers, trading partners, clearing-houses 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 Connexion magazine. We compiled his columns into an easy-to-use guide to help practices prepare for the new code set.
Implementing ICD-10 in your practice

The government has set a final compliance date of Oct. 1, 2014, for industry adoption of ICD-10. As you attempt to successfully implement the new code set, consider these steps.

Create an implementation team
ICD-10 will impact many areas of your practice, and your team should represent each of them. The size and complexity of your organization will influence which staff members you choose (and how many) for the internal implementation team, but at a minimum, it should include members from the clinical and administrative areas of the practice.

It is preferable to ask a physician with budgetary authority to serve as a “champion” who communicates critical information to other clinicians. Peer-to-peer interaction can be particularly effective when communicating with clinicians. Other members of the medical staff (including nursing staff and nonphysician providers) should be included along with staff from the coding, billing and information systems departments. Larger institutions will want to ensure that staff members from benchmarking and research, clinical trials and other departments that use diagnosis-based data are on this team, too.

It is helpful to identify an appropriate governance structure for the team and communicate roles and responsibilities for executive sponsors, steering committees and smaller groups with specific implementation responsibilities. Staff members are busy with other duties and projects, so consider dividing tasks and assigning them to subteams to avoid overburdening team members. Roles should be well-defined with clear accountability and the authority to make and act on decisions.

Develop backup plans for each implementation and testing milestone to avert potential problems; establish completion dates and monitor progress. For example, what will your practice do if a critical vendor does not produce an upgrade by the expected date? Outline a protocol for identifying implementation issues and correcting them. Each team and subteam should also identify available internal and external tools and resources as well as additional tools and resources that will need to be purchased.

Build internal awareness
The initial staff communications about ICD-10 will most likely focus on what the change is, when it...
will happen and how it will impact the organization. It is wise to include all staff members in these communications, even those who are not directly impacted by the code set. Explaining the potential consequences of inaction, such as an increase in denied claims leading to a significant disruption to cash flow, will be especially important when communicating to senior management. As you create a communication plan, it might be effective to review lessons learned from any previous all-staff efforts, such as efforts to comply with HIPAA privacy regulations, the adoption of an EHR or even moving to a new location.

Select the most appropriate communication method for your practice, which might be a written report posted in common areas, regular oral reports during staff meetings, visual presentations using PowerPoint, timely emails or a combination of approaches. Larger organizations and those with multiple locations might consider hosting webinars to ensure that a consistent message is conveyed to all staff. You might also need to develop different communication vehicles for specific staff and departments. Again, peer-to-peer communication can be an effective approach to conveying key messages to clinical staff, such as budget requirements and the need for revised clinical documentation to accommodate ICD-10 codes. In general, communication to staff should include an explanation of the purpose and expected outcomes of the transition and could take the following approach:

• Provide ICD-10 background information and implementation timeline.
• Raise implementation issues and concerns, and remind staff of the potential consequences of inaction.
• Introduce teams and subteams.
• Identify staff members who are responsible for answering questions about ICD-10 implementation for each department or organization.

Create an external network
Migrating to ICD-10 could prove challenging enough to warrant the assistance of external colleagues to ensure a smooth transition. Networking with peers in similar-size practices or those in the same specialty will provide a valuable opportunity to:
• Share team-building and internal communication strategies
• Discuss implementation successes and failures
• Coordinate communications with external trading partners, such as practice management system and EHR vendors, clearinghouses, billing and coding companies and health plans
• Compare external trading partner responses and concerns
• Discuss implementation updates and changes required in systems and business processes
• Pursue collaborative opportunities for ICD-10 training

MGMA-ACMPE members can leverage the Member Community to share strategies, ask questions and learn from the ICD-10 implementation experiences of their colleagues. Visit mgma.com/code-community to get started.

Resources:
1. CMS ICD-10 resources are available at cms.gov/Medicare/Coding/ICD10.
Implementing ICD-10 in your practice: Internal assessment

Once practice staff understands the basics of ICD-10 and how its structure differs from ICD-9, and an internal team has been established to lead the transition, the next step is to review the impact the new code set will have on the organization. This assessment is critical as practice administrators prepare for the transition. A full understanding of how ICD-10 will affect the practice enables you to take necessary steps to upgrade or replace information technology (IT) systems, arm staff with appropriate knowledge, budget adequately for the change, plan for possible contingencies and avoid significant cash-flow disruption following the Oct. 1, 2014, compliance date.

In general, your internal assessment should review:

- Practice infrastructure, including core clinical and administrative computer systems and key business applications
- Billing workflow processes that use ICD-9 codes
- Information management systems and processes that use ICD-9 codes (including comparative data, extracts and benchmarking reports)
- Links to other internal business areas
- Links to external entities

Creating an impact analysis document or spreadsheet can provide a convenient and effective method of managing the changes associated with ICD-10. After identifying changes to areas including IT, reporting processes, research, clinical documentation, diagnosis code assignment, health plan interaction, staff training and other
areas, identify staff members to work on associated education, trading partner outreach, budgeting and other tasks.

Assessing the specific impact on IT

IT systems represent one of the greatest areas of potential impact associated with the adoption of ICD-10. Practice administrators should take a complete inventory of electronic and manual systems that use ICD-9 to evaluate necessary upgrades and investments in new equipment or software, including:

- EHR/decision support/other clinical systems
- Medical necessity software
- Billing systems (including insurance eligibility verification if you use ICD-9 codes)
- Claims “scrubbing” software
- Encoding software
- Medical-record-abstraction systems
- Disease-management systems
- Performance-measurement systems
- Utilization-management systems
- Scheduling and registration systems
- Accounting systems
- Quality-management systems
- Test-ordering systems

For practices that engage in research and/or clinical trials, the internal assessment should include a review of:

- Statistics/research/historical benchmarking software (any longitudinal data captured by the practice in ICD-9-CM)
- Data-management software
- Trend-analysis software
- Clinical-trials software

Once you determine what vendor applications use ICD-9 codes, identify the contact person and phone number or email address for each vendor, and assign staff to contact each company. The next step is to establish how ICD-9 codes are entered and used in each information system. Are they manually entered or pulled in from another system? Will you need to capture and/or store both ICD-9 and ICD-10 codes simultaneously for some period of time after the compliance date?

Health plan contracts and code assignment issues

Practice administrators should review health plan contracts to determine whether ICD-9 codes are included in the language and, if so, how the codes are used. Certain services provided to patients and covered by insurance could be affected by the move to ICD-10. Similarly, the review should identify how the diagnosis code is selected by clinical staff or internal coders.

For example, does the practice use an itemized list of the most commonly used codes (also called a “superbill”) to report physician charges? If so, it will need to be redesigned and expanded from its current one- to two-page format to five or even 10 pages (depending on your specialty) once the ICD-9 codes on the superbill are mapped to the more voluminous ICD-10 codes. If the clinical staff concludes that lengthy superbills would be unsuitable, the practice will need to identify an alternative approach to diagnosis code selection.

Finally, when you pinpoint the areas of the practice most impacted by ICD-10, it will be helpful to identify critical internal and external resources needed to take the necessary remediation steps.

Next in the series: Assessing the ICD-10 readiness of your critical trading partners.

Implementing ICD-10: Assessing trading partners

Once your practice has determined what information technology (IT) systems will be affected by the conversion to the ICD-10 code sets, you will need to ask vendors when and if these systems will be modified or whether they need to be replaced.

Your practice could have many IT systems that use ICD codes; the two most vulnerable are the practice management system (PM) and the EHR. Software vendors are critical to the practice’s ability to capture and report the appropriate ICD-10 codes, yet they are not “covered entities” under HIPAA and therefore are not required by law to update their software.

Practices should develop a trading partner assessment action plan well before the Oct. 1, 2014, compliance date that includes communicating with vendors and getting answers to a series of critical questions. It is recommended that you request the answers to these questions in writing. It is also prudent to review your current vendor agreements to establish whether they are contractually required to update or replace your software to accommodate the new ICD-10 codes and, if so, what timeframe and costs are stipulated for the upgrade or replacement.

Assuming the current contract does not address all of your trading partner assessment concerns, here are a few suggested questions to ask your vendors:

- Will the company upgrade the software to accommodate ICD-10?
What versions of the software will be upgraded to accommodate ICD-10? If we are behind, how many upgrades will be required to bring the practice’s application up to current standards?

What changes are expected in the software’s screen and reporting formats?

What will be the cost for each upgrade?

Will there be additional maintenance fees? If so, how much will they be?

If the company produces a software upgrade, will it require hardware upgrades? If so, what are the minimum hardware requirements, and what is the cost estimate for the hardware?

Will the company support the ICD-9-CM and ICD-10-CM code sets concurrently in the testing and production stages? If the company offers dual use, how long will the overlap be available to the practice?

Will the product offer any form of code-selection capability?

How will the software handle the issue of ICD-9-CM codes being disabled for dates of service after Oct. 1, 2014, while remaining enabled for dates of service earlier than Oct. 1, 2014?

How will the software accommodate ICD-9-CM legacy data?

How does the software handle ICD-9 to ICD-10 and ICD-10 to ICD-9 crosswalk issues?

Does the software support the government’s General Equivalency Mapping tool and other proprietary mapping tools offered by commercial health plans?

What enhancements of clinical documentation will be made to ensure clinicians have the ability to capture the additional documentation required for ICD-10?

Will the software offer any templates as part of the ICD-10 upgrade?

How will the company support the testing of interfaces between our systems (PM and EHR)? This could prove even more challenging if the systems are from different vendors.

What product support training will be offered and at what cost?

Will the vendor offer any specific ICD-10 training for clinical and administrative staff? If so, what are training style options (for example, web-based, face-to-face), and what is the cost for this training?

Will the vendor outline the steps a practice professional must perform to test (internally and externally) and implement ICD-10 using the software?

In terms of dates:

+ When will the upgrade or replacement be made available to the practice?
+ How long will it take to install and test the software?
+ How long will the practice be “offline” during the installation process?
+ When can the practice initiate internal testing?
+ When can the practice initiate testing with its external trading partners (for example, billing services, clearinghouses, health plans)?
+ Does the vendor offer any automated test plans and clinical scripts to facilitate the testing process?
+ What is the vendor’s contingency plan if the software is not ready for go-live on Oct. 1, 2014?

Determining the readiness level of your software trading partners is an essential component of a successful ICD-10 compliance plan. Simply put, if your vendors are not ready, your practice will not be ready, and that could lead to claims-payment disruption. Reach out early to trading partners and explore alternatives if your current vendors will not be able to support your adoption of ICD-10.

Next in the series: Assessing the ICD-10 readiness of your additional critical trading partners.
Assessing readiness among partners

By Robert Tennant, MA

It is critical for professionals in physician practices to establish processes to ensure that ICD-10 codes can be incorporated into clinical workflow and that practice management system software is on track for upgrades or replacement. Before you can move forward with ICD-10 implementation, you must ensure that your software can accommodate ICD-10 with your transactions or identify alternative methods to assign these codes. Once that process is complete, the next step in your ICD-10 implementation is to determine the readiness level of your key external trading partners.

Many practices use outside billing services (including professional coders) and/or clearinghouses to assign the appropriate codes to claims and submit them for payment. Rather than assume that your service, coder or clearinghouse will be ready for the Oct. 1, 2014, compliance date (or preferably even sooner to facilitate testing), we recommend that you request comprehensive answers in writing to the following critical questions:

• Do you expect to meet the ICD-10 compliance date of Oct. 1, 2014?
• As of today, where are you internally for this ICD-10 transition process?
• On what date will my practice be able to submit test claims to you?
• What is your process for testing claims containing ICD-10 codes and what will be required from our practice to conduct testing?
• Will there be a price increase for your current services due to the transition to ICD-10?
• Will you offer clinical documentation and/or ICD-10 code-identification services to assist our practice?
• If so, when will these services be available, and what are the associated costs?
• Who will be my primary contact at your organization for the ICD-10 transition?
• For the professional coder: When (specific dates) will you be certified for ICD-10?

Clearinghouses might not be in a position to convert your submission to a claim that will be paid by the health plan. A nonspecific ICD-10 code might be insufficient to ensure adjudication and payment, depending on the health plan’s requirements and payment policies. Clearinghouses can be highly effective at converting older formatted claims (4010) to the required 5010 version. However, there is concern that claims submitted without the appropriate ICD-10 code cannot be converted by the clearinghouses, which do not typically have access to the clinical documentation.
used to assign the ICD-10 code — so the claim will be returned to the practice.

The challenge will be to resubmit the claim with a more specific ICD-10 code based on the available clinical documentation. If the documentation did not capture a piece of information, such as the laterality of the medical issue, you might be forced to contact the patient long after the visit to augment the record.

Another critical factor in a successful industry transition to ICD-10 will be a health plan’s ability to update its information technology systems, business processes and payment policies and to conduct testing with physician practices prior to the compliance date. For practices, the first step in reaching out to your health plans is to identify the appropriate website or contact person to discuss ICD-10 issues. Ask those health plans that handle a significant percentage of your organization’s income the following questions:

- When will your ICD-10 upgrades be completed?
- When can I send test claims and other transactions with ICD-10 codes to you?
- Do you offer any automated test plans and clinical scripts to facilitate testing?
- Do you intend to change medical necessity requirements because of the more specific ICD-10 codes?
- When will you tell us about changes to coverage and payments necessitated by ICD-10?
- How will your products/services accommodate both ICD-9 and ICD-10?
- How long after the compliance date will you accommodate both ICD-9 and ICD-10 codes?
- Will you use general equivalence mappings (GEMs) between ICD-9 and ICD-10 for creating files going into the health plan or going out?
- Will you use the specific Centers for Medicare & Medicaid Services’ ICD-10 GEMs/crosswalk?
- Will you provide any support and training services to practices?
- Will extensions be given for timely filing during the ICD-10 transition time?
- How will the ICD-10 conversion affect our reimbursement?
- How will the ICD-10 conversion impact our contracting? For example, will you renegotiate contracts to replace ICD-9 codes with ICD-10 codes?
- What is your contingency plan if you are not ready for the go-live date of Oct. 1, 2014?
- Whom should I contact with any specific ICD-10 questions?

The effect on reimbursement will be the greatest concern for practice professionals during the transition to ICD-10. Many professionals experienced significant and lengthy cash-flow disruptions after the switch to HIPAA 5010 in January 2011, and there is concern that potential payment delays associated with ICD-10 will be more acute. Outreach and regular communication with your external trading partners are important components of a successful implementation plan. With numerous trading partners to contact, we encourage you to begin the outreach process as soon as possible.

Next in the series: Assessing and transforming clinical documentation to accommodate ICD-10.
Implementing ICD-10: Enhancing clinical documentation

In previous articles, we discussed working with external trading partners to make certain they have the ability to support your practice during the ICD-10 transition. It is also critical for clinicians to provide the necessary documentation to assign appropriate ICD-10 codes and potentially identify the correct code themselves while you ensure the readiness of external coders, billing services and clearinghouses to process claims with these new diagnosis codes.

The impact on clinical care resulting from this transition sets this government requirement apart from other HIPAA mandates. With the transition to the 4010 and 5010 electronic claims and other transactions, smaller practices were able to leverage billing services and clearinghouses to convert old formats to new formats and maintain cash flow. However, ICD-10 poses a unique problem because downstream vendors might not be able to convert an ICD-9 code to an ICD-10 code without access to the complete patient encounter documentation. Even if these vendors were willing to offer this service, providing that level of documentation with each claim would be labor-intensive for practice staff and would add steps to the billing service or clearinghouse process with costs shouldered by the practice.

The transition to ICD-10 will, in many cases, require clinicians to capture new, updated or modified information. As a result, it is important to review the way your clinicians document clinical services to address vulnerabilities when you prepare for ICD-10. This will help your internal and external coding staff become accustomed to the more specific and detailed clinical documentation that is needed to assign ICD-10 codes.

The move to ICD-10 should not affect how clinicians provide clinical care, but additional information must be recorded during the patient encounter because ICD-10 gives more specific choices for coding diagnoses. Your clinicians might already collect this additional information from the patient; now you will have to document it. This more-complete documentation will reduce the need to follow up with health plans about pending claims or those that were rejected for an unsubstantiated diagnosis code, saving the practice time and money.

**Internal documentation review**

A good first step toward improving the process of recording a patient encounter will be to examine the current level of clinician documentation to determine whether it is sufficient for ICD-10. As professional coders know, the adage to live by is, “If it is not documented by the clinician, it did not happen and, thus, cannot be coded or billed.”

Review the documentation for a selection of claims using the most commonly used diagnosis codes to determine if the documentation would be specific and detailed enough to select an appropriate ICD-10 code. This could involve leveraging the expertise of your coding staff or potentially contracting with an outside entity.

One straightforward component of many patient encounters will be the laterality of the clinical issue. Laterality is expanded in ICD-10-CM, and clinical documentation for diagnoses that should include information about which side of the body is affected (i.e., right, left or bilateral).

The following are common examples of specific information that coders will need to accurately assign ICD-10 codes on claims:

- Diabetes mellitus: diabetes type, affected body system, complication or manifestation, long-term insulin use, if appropriate
- Pregnancy: trimester now required
- Fractures: site of fracture, type of fracture, laterality, location
- Injuries: external cause, place of occurrence, activity code, external cause status
- Musculoskeletal conditions: ICD-10 includes more codes related to musculoskeletal conditions; for example, there are eight codes for...
pathologic fractures in ICD-9, but there are more than 150 codes in ICD-10.

**Unspecified codes**

ICD-10 offers the tempting choice of using “unspecified” as an option. Many expect that this will be a particularly attractive option right after the compliance date, when there is much confusion among providers or when the patient encounter is not well-documented. However, there are some downsides to this approach. Some health plans might not accept these unspecified codes and could delay adjudication of the claim until they receive additional information or an updated ICD-10 code. Using “unspecified” without a more granular code present will make it difficult for practice professionals to code for reimbursement at higher levels when they review severity and risk scores.

**Internal communication**

Your clinicians might have treated certain patients and documented these encounters for many years, which could make it more difficult to communicate the necessary modifications to their documentation for the ICD-10 transition. A practice champion on the clinical staff can help you promote the changes required before moving to ICD-10. We expect to see a variety of champions in different practices. For example, you might identify a physician champion to lead the efforts with the other physicians in the group and a nurse to take charge of educating the nurses.

Allow plenty of time in your ICD-10 implementation schedule to start the internal review, clinician education and implementation of improved documentation processes. It could take considerable effort for long-term documentation habits to be modified, and you want to have ample time to complete this process well before the ICD-10 compliance date of Oct. 1, 2014.

We know that educating and training clinicians about improved documentation can be challenging, which is why we recommend you begin discussions at staff meetings and in internal communication venues as soon as possible. Focusing on the dual goals of improving patient-encounter recording and avoiding cash-flow disruption should help convince the clinical staff to take the necessary steps sooner rather than later.
Training your staff for ICD-10

For many professionals in physician practices, the transition to ICD-10 will be more similar to compliance efforts with HIPAA privacy and security than with their transition to Version 5010 of the electronic transaction standards. ICD-10, like compliance with the privacy and security regulations, will necessitate that most, if not all, staff in the organization is aware of the new federal requirements, with many employees requiring significant training. If staff is not adequately trained for ICD-10, practices run the risk of rejected claims and the resultant cash-flow disruption in your practice.

As you develop and implement a training plan, consider the following steps:

• **Identify staff and level of training required.**
  The first step is to identify the clinical and administrative staff members who need to be educated and trained on ICD-10. Then you can establish what level of education or training is required. Every staff member should be notified of the change to ICD-10, how it will affect the practice and what steps the organization is taking to implement the new code set. This type of education, sometimes called “level setting,” helps staff members understand why the transition is taking place and their role in that process.

*Practice professionals* might need two types of training, depending on their roles. Start out with a good grounding in the specifics of ICD-10 coding and how it will affect clinician workflow. Then move to project management training to develop a comprehensive plan to successfully implement the code set.

*Clinical staff members* involved in patient treatment or who are involved in the billing process must learn how ICD-10 will affect the claims revenue cycle. In particular, emphasize how ICD-10 might require changes to clinical documentation to ensure that coding staff has sufficient information to assign the appropriate diagnosis code. Practices that have their clinicians identify the diagnosis code at the time of service and use “superbills” will need to significantly retool these to accommodate the larger code set. These revised superbills can be an important component of clinicians’ training. It is important to incorporate this aspect of the patient encounter into the training for practices that will be using alternative methods of code selection in the form of a book, web-based program, mobile device, practice management system or a combination of these solutions. Clinicians should receive 16 to 24 hours of training, according to industry estimates.

*Revenue cycle and data-centered administrative staff members* should receive extensive training in the new code set so they understand how it will affect their job functions. Staff members involved in claim creation, scrubbing or use of diagnostic codes for other revenue or administrative transactions will need to be trained well in advance of the Oct. 1, 2014, compliance date, as they most likely will be involved in the internal and external testing process. Larger practices might have staff members focused on data analytics or other functions that entail using diagnostic codes. These individuals might require software-specific training, which could be offered by individual software vendors. Depending on their job functions, revenue cycle and data-centered administrative staff members are estimated to need between six and 10 hours of training.

*Professional coders* will need the most detailed training and, depending on the practice, specialty-specific training might be the most valuable. You might also consider having your coders professionally certified to help ensure that they are fully prepared for the new code set. Some experts estimate that professional coders will require 40 to 60 hours of training, which is a significant investment for a practice. To protect that investment, strongly encourage and potentially incentivize your coders to stay with the practice. Another option would be to consider including a reasonable noncompete clause that complies with applicable state and local laws.

• **Determine the best training method for each staff member.** There is no one-size-fits-all approach to training for practices or individual staff. Face-to-face training, online courses, webinar-based teaching and hard-copy books are all available, and each method has its benefits and
drawbacks. Some might opt for a short, intense, face-to-face training mode; others might prefer online education that they can access when it fits their busy schedules. In general, a classroom setting with an interactive, hands-on training approach that permits individual claims to be recoded and allows coders to ask questions is preferable for professional coders. Meanwhile, peer-to-peer education might be most effective for clinicians. For example, it might be highly successful to contract with a vendor to have a physician assist your doctors with coding and documentation.

- **Reduce your training costs.** To offset training costs, consider partnering with one or more practices in your area, especially those with the same or a similar specialty. Having staff participate in evening or weekend training sessions will minimize the impact on patient care, and participants can learn from their colleagues. At a minimum, consider networking with your MG-MA-ACMPE professional colleagues to share training experiences and the effectiveness of vendors and methodologies. Practice professionals should also explore whether trading partners will offer ICD-10 training. For example, your practice management system or EHR vendor might include training as part of its maintenance contract or offer it for an additional fee. Similarly, it is worth contacting your health plans, local hospitals and any state or regional health organizations (such as health information exchanges, state medical societies and regional extension centers) to determine whether they offer training.

To a large extent, the success or failure of your ICD-10 implementation will revolve around your staff’s ability to meet the transition challenges. Remember that not only will staff members need to be trained on the new code set but also on any new clinical or administrative software that was upgraded or replaced as part of your ICD-10 implementation process.

Cash flow might be affected if administrative staff cannot incorporate the new codes into their workflow, if clinicians fail to appropriately document patient encounters or if professional coders cannot assign the correct codes. It is critical to create an effective training and ongoing support schedule to meet the needs of your organization while not impeding employees’ ability to complete their work.
Internal and external testing for ICD-10

Testing is a critical step in your ICD-10 implementation process to ensure successful collaboration with your key external trading partners and that all internal systems and business processes are in place prior to the Oct. 1, 2014, compliance date. It is best to identify system issues, workflow obstacles and payment problems well before what industry members call the cut-over date.

Testing can help you verify ICD-10 internal processes, procedures and systems, and it will also help validate alignment between critical external trading partners, such as clearinghouses and health plans. A good testing program starts with the development of a comprehensive strategy and good coordination between practice professionals and their trading partners.

Remember that, unlike the transition to HIPAA Version 5010, ICD-10 is much more than ensuring correct file formats. Your practice’s business performance and health plan payments could be affected and, therefore, need to be tested. Thus, the goal of your ICD-10 testing is to ensure as much payment “neutrality” as possible — including minimal disruption to clinician and coder productivity, practice revenue and business operations.

Internal testing

The foundation for a successful ICD-10 transition is internal testing. Once internal systems are fully ICD-10 upgraded or replaced and working as predicted, practice professionals can begin to initiate external testing. After implementing ICD-10 upgrades or replacing your practice management (PM) system, EHR and/or other software that is affected by the code set change, consider the following two types of testing, which is even more important if two or more of the systems, such as the PM and EHR, interact with each other:

• Information technology (IT) system code testing
• Business readiness testing

In the case of IT systems, you must rely on software vendors to upgrade or replace the necessary software. (Visit mgma.com/5010ICD10 for a list of questions to ask vendors regarding this migration.)

Completion of individual component testing, system testing of integrated components and performance testing of all components must be accomplished prior to any external testing. Many of these tests will be similar to those performed for other IT changes that practice professionals have undertaken for previous standards, such as Version 5010 and the National Provider Identifier. Typically, this testing will be conducted with the assistance of your vendors, and it involves generating ICD-10 codes. In the case of PM systems, it involves generating both ICD-9 and ICD-10 codes on transactions.

The second stage of internal testing ensures that business processes and clinical workflow are appropriately modified. It is important to make sure that staff members are trained on the new software and fully briefed on the new documentation expected as part of ICD-10. Generating both ICD-9 and ICD-10 codes on claims is an excellent method of ensuring that staff and software will be ready for the compliance date and that the clinical workflow will permit the assignment of appropriate ICD-10 codes.

External testing and achieving payment neutrality

Once you complete the internal testing process and are confident that you will be able to generate the appropriate ICD-10 codes with each system, you can begin testing with key external trading partners. The challenge here is straightforward: Engage each of these entities and coordinate how and when you can test with them. Although external testing is not required by law, practice professionals can realize a number of benefits from this type of testing, including identifying practice workflow changes necessary to ensure maximum efficiency. Here are some suggestions:

• Ascertain where in the revenue cycle process your clearinghouse can provide assistance with identifying and submitting ICD-10 codes.
• Target coordination between clinical and administrative systems.
• Determine changes in health plan payment policies with an emphasis on alterations to payment, acceptance of unspecified codes and documentation requirements.
• Identify contacts at clearinghouses and health plans who could be useful if practice professionals experience problems after the compliance date.
• Assist system, coding and documentation issues before practice revenue is at risk.
• Anticipate potential coding and claim submission delays.

By Robert Tennant, MA
• Help avoid disruption of cash flow following the compliance date.

The right external testing approach for every affected business process — including patient eligibility verification, claims payment, medical management, quality improvement, reporting and analytics — can confirm that outcomes after the Oct. 1, 2014, date are consistent with those prior to the compliance date.

Clearinghouses have a unique role to play with the move to ICD-10. Although practice professionals were, in many cases, fully able to leverage their clearinghouse during the Version 5010 conversion, the same is unlikely to happen with ICD-10. It is doubtful that a clearinghouse will have the capability to convert an ICD-9 code to an ICD-10 code due to the tremendous variability between the two code sets. Although there is an established crosswalk between the two code sets developed by the government (the General Equivalence Mapping tool¹), it is not a pure one-to-one match for many codes, and typically the clearinghouse will not have the clinical documentation that would enable it to assign the appropriate code to the claim. We encourage practice professionals to reach out to their clearinghouse to determine what ICD-10 services they can provide.

Professionals moving to ICD-10 also need to be concerned about maintaining equivalent payments for patient services following ICD-10 implementation. Achieving this “payment neutrality” across the vast majority of claims is critical to avoid long-term implications to cash flow. Testing with health plans is one of the most effective methods of determining whether payment neutrality exists. Submitting a selection of test claims using your most commonly submitted combination of CPT and ICD-10 codes is a good way to gauge the health plan payment policies — and thus payment neutrality.

Remember, however, that some health plans might not be accepting test claims. With these health plans, there are still options to help you determine the issue of payment neutrality. Assigning both ICD-9 and ICD-10 codes to a claim that you are submitting to a health plan for payment before Oct. 1, 2014, known as “dual coding” is an effective method of establishing neutrality, albeit without the direct confirmation from the health plan. The other approach is to review the clinical scenarios available publically as part of an industry effort to identify a standardized ICD-10 coding approach. This project, led by HIMSS and the Workgroup for Electronic Data Interchange, is the only national effort aimed at pilot testing ICD-10 codes.² Although there are only a relatively small number of testing scenarios available as part of this pilot, some of them might correspond to the patient services your practice provides. Reviewing these could assist you in better gauging the payment neutrality of your claims.

Although it is unreasonable to expect that all individual payments will be the same between ICD-9 and ICD-10, the overall goal of testing should be to achieve financial neutrality, or close to it, with all aggregate payments received.

Notes:
2. HIMSS-WEDI national testing pilot: himss.org/icd10nationalpilotprogram.
10 action items for ICD-10 compliance

The Oct. 1, 2014, compliance date to implement ICD-10 is less than a year away. The next 12 months will present numerous challenges for physician practice professionals who are transitioning to this new code set, from the readiness of trading partners to the readiness of your own organization.

The following 10 action items will help prepare your practice:

**Understand ICD-10.** Practice professionals can begin the ICD-10 process by arming themselves with information to make the code set adoption as seamless as possible. Although practice professionals do not necessarily need to have the same level of ICD-10 expertise as professional coders, it will be helpful to understand the major differences between ICD-9 and ICD-10, how those differences will affect a clinician’s specialty and how ICD-10 will affect an organization.

**Create an internal implementation and communication team.** Including representatives from the administrative and clinical sides of an organization can increase internal awareness of the change and divide up the work that needs to be accomplished prior to the compliance date. Peer-to-peer communication and education can be an effective method of communicating changes required by ICD-10, particularly with the modifications associated with workflow and clinical documentation.

**Review impact areas and modify processes.** Updating software will only be one part of the implementation process. Practices can have multiple systems and exchange data with numerous other organizations. Electronic and paper-based workflow processes that drive clinical encounters and the billing process should be analyzed to identify the potential impact from the ICD-10 transition. Interfaces between internal systems, interfaces between the practice and external trading partners, and any electronic transaction that uses diagnostic codes must be revised to accommodate the new code set. For each practice, the extent of the effort will also depend on the number of systems in place, whether the software was purchased or developed in-house, the age (version) and flexibility of each system, the number of internal system interfaces and reports, and the number of external data transfers and reporting channels to trading partners and other entities, such as government agencies.

**Reach out to software vendors.** Following an internal assessment, practice professionals will have identified all of the software that needs to be updated or replaced. For many practices, these upgrades will be limited to the practice management system and EHR, although others might be using additional systems with diagnosis codes. You will need to ascertain from the vendor, preferably in writing, the following:
- Will the vendor upgrade software to accommodate ICD-10?
- Will the company upgrade your version of the software?
- Will the software upgrade require a hardware upgrade, too?
- Will the software allow your practice to use ICD-9 and ICD-10 for some period of time following the compliance date?
- What is the vendor timeline for installation/testing/training?
- What, if any, ICD-10-specific training will the vendor offer?
- What is the total estimated cost for the practice?

**Develop a budget.** Implementing ICD-10 will be an expensive effort for most practice professionals. You should consider the following areas when creating a realistic budget:
- Practice management, EHR and other software upgrades or replacement
- Hardware upgrades
- Staff education and training
- Temporary staff during transition
- Changes to superbills (if applicable)
- Additional time for documentation review
- Additional clearinghouse fees (if applicable)
- Lost coder, clinician and/or revenue cycle staff productivity
- Increased number of denied and reworked claims

**Contact clearinghouses and health plans.** Practice professionals should discuss ICD-10 with clearinghouses and major health plans. Critical items to include in this discussion:
- When will they complete internal upgrades to accommodate ICD-10 codes?
- How can they help your practice with this transition (i.e., education or training)?
• When can you send test claims and other transactions with ICD-10 codes?
• Will they provide a list of the data content changes needed?
• Will clearinghouses offer any Version 4010 workarounds?
• When will health plans announce their revised ICD-10-related coverage/payment changes?

Improve clinical documentation. One of the most challenging aspects of ICD-10 is the need to ensure that clinical documentation supplied by practitioners is sufficient to assign ICD-10 codes. There are a number of ways to identify potential documentation issues long before the compliance date. First, professionals can review successfully adjudicated claims in ICD-9 and begin to assign ICD-10 codes to these claims. If the documentation is insufficient (for example, it fails to note the laterality of the issue), your staff will need to be informed. The second approach is to have coding staff assign ICD-9 and ICD-10 codes to current claims. Finally, professionals can contract with third-party vendors that offer claim and/or documentation review services. The goal should be to identify any gaps in the documentation that would prevent a coder from selecting the appropriate ICD-10 code.

Train staff. ICD-10 training for clinicians and appropriate staff is essential. Begin by identifying education needs with these questions:
• Who in the practice requires training, and what type of training is appropriate?
• When and how should they be trained (for example, online vs. face to face)?

Train staff members too early and they might require retraining — too late, and it could be difficult to get the training completed in time. Some recommend training coding staff six to nine months before the compliance date and clinical staff three to six months ahead.

Test. As practices experienced with the recent transition to HIPAA Version 5010, internal and external testing is critical to success. ICD-10 is unique in that it affects administrative and clinical personnel and requires internal and external testing. Internal testing ensures that workflow processes that have been modified to accommodate ICD-10 are working smoothly and that the right codes are being generated at the right time. External testing of ICD-10 codes includes technical and payment aspects. First, can your software generate ICD-10 codes on transactions, and will your clearinghouse and health plan accept this transaction for processing? Second, is the code appropriate for payment, and will the health plan pay the same amount as it did under ICD-9? External testing of ICD-10 codes promises to be problematic, especially if clearinghouses and health plans are unable or unwilling to accept test claims for practices.

Plan for contingencies. Despite the best preparation, practice professionals must still prepare for the possibility of decreased staff productivity, critical software not being upgraded prior to the compliance date, clearinghouses being unable to fully resolve ICD-10 issues, health plans being unprepared to accept ICD-10 codes, and rejected or pending claims. To protect your cash flow and ensure that your group can meet its financial obligations, consider postponing large capital investments close to the compliance date, setting aside cash reserves and establishing a line of credit. Recognize well before the compliance date what functions your clearinghouse can assist you with and create workflows to account for those functions they cannot perform. This will be especially important if your group’s practice management or EHR software will not be upgraded or replaced in time. Finally, whenever possible, determine your health plan ICD-10 requirements and meet them to minimize the chance that your claims will not be paid in a timely manner.

For additional tips to prepare for ICD-10 implementation, visit mgma.org/ICD10.