

Easing the Transition to ICD-10: The Role of Automated Procedure Documentation and Coding Solutions

Deploying clinical information systems and advanced decision support solutions to qualify for incentive funds under the HITECH Act has taken center stage in today's health care environment. But it is not the only daunting challenge confronting hospitals, ambulatory surgery centers (ASCs) and other provider organizations.

A more critical and pressing challenge is meeting the U.S. Department of Health and Human Services' October 1, 2013 deadline for completing the transition to the ICD-10 code set.

Moving from ICD-9 to its more expansive successor is an industry-wide, multifaceted project that will affect multiple systems, business processes, payments and policies. It will be a complex transition that calls for system changes, retraining and lost productivity that Rand Corporation estimates will cost between \$430 million and \$1.19 billion over 10 years.

In return, ICD-10 is expected to generate cost savings of between \$700 million and \$7.7 billion over a 10-year period through:

- More accurate payments, especially for newer, more expensive procedures
- Fewer miscoded, rejected or improper claims
- Better understanding of the value of new procedures
- Improved disease management
- Better health outcomesⁱ

DRIVING THE TRANSITION

The ICD-10 mandate is driven by more than costs and benefits. Developed more than 30 years ago, the ICD-9 code set has simply outlived its usefulness. It lacks the specificity and detail required in today's health care environment and is running out of room for new codes. ICD-9's limited structural design is also unable to accommodate medical advances and future industry growth.

Additionally, ICD-9 does not include the most up-to-date disease processes, terminology or practices. It limits the user's ability to compare costs and outcomes and, perhaps most significantly, cannot support the health

care industry's move to interoperable health data exchange.ⁱⁱ

Recognizing these limitations, the World Health Organization in 1994 updated the system to ICD-10 to better classify recognized diseases and improve compatibility with medical data recording practices. Since then, nearly 100 countries have adopted ICD-10 for mortality and morbidity. Even the U.S. has been utilizing ICD-10 for mortality reporting since 1999.ⁱⁱⁱ

Rapid global acceptance of ICD-10 was driven by several factors. In addition to offering a more comprehensive system of medical information, the expanded code

set provides better data for measuring quality, safety and efficacy of care by enabling the user to capture richer and more specific diagnostic information electronically.

ICD-10 also allows for global consistency among medical diagnosis codes to support patient safety, as well as bio-terrorism monitoring and infectious disease surveillance. It simplifies the global exchange of disease and mortality data, which is critical for protecting worldwide public health. For example, ICD-10 could have facilitated earlier detection and better tracking of SARS and the West Nile Virus.^{iv} It also supports the effectiveness of clinical conditions

and technologies, and aids research by providing greater detail than is currently available.

A COSTLY, CHALLENGING TRANSITION

Hospitals and ASCs must overcome several major hurdles on the path to ICD-10. Among the most significant is the sizable investment in clinical and financial systems the transition will require – an estimated \$713 million and 1,286 work days for WHO. ^{v,vi}

The expanded code set impacts documentation and HIM/coding/billing systems, as well as any systems with which they interface. These typically include registration, CPOE and EMR systems, most of which will require software modifications to accommodate format changes, more specific content and new diagnostic codes.

Because billing and IT vendors, payers and providers will transition to ICD-10 on different schedules, systems will need to function, at least for a time, in a dual ICD-9/ICD-10 environment. This capability is also true post-transition, as providers will need to be able to view historic ICD-9 claims.

In addition to new or upgraded systems and solutions, the transition will require a substantial investment in staff training. Because ICD-10 is more granular and detailed than ICD-9, even professional coders and billing specialists who are comfortable with the existing code set will require training to become proficient with the new one.

While the training needs are considerable for hospitals and other organizations with a dedicated coding staff, the

challenge is magnified in ASCs and other organizations that lack these resources. In those organizations, responsibility for ensuring accurate documentation and code assignment typically falls to billing clerks who rarely have specific coding expertise or are managing billing along with multiple other administrative duties. This makes training and education even more critical.

Rand projects the cost for training full-time coders to be \$100 million to \$150 million, and an additional \$50 million to \$100 million for part-time coders. Coder productivity losses are expected to total \$150 million.

Training is not limited to coders and billing clerks. Physicians and other clinicians will also need to be trained to capture the appropriate level of information in procedure documentation, which is expected to cost \$25 million to \$100 million. Productivity losses among physicians are expected to range from \$50 million to \$250 million before they achieve proficiency.

Finally, IT staff will need to be educated on the differences between ICD-9 and ICD-10. These staffers will need to identify systems and software that must be replaced or modified, as well as to develop interfaces that allow appropriate coding data to be exchanged with downstream and vendor/payer systems. IT staff will also help determine which systems will operate in a dual environment and for how long, as well as who will require access to the ICD-9 system. ^{vii}

EASING THE TRANSITION

Many of the transition challenges confronting hospitals and ASCs can

be eliminated by deploying an electronic documentation and coding solution. Top-tier solutions will accommodate the expanded fields and data required under ICD-10 with little more than a software upgrade. They can also function in a dual-coding environment for as long as necessary.

Most of these solutions integrate automatically with other clinical and financial systems, eliminating the need for major system upgrades or replacements, software modifications or manual mapping – which together constitute the majority of the costs associated with the ICD-10 transition.

Because automated documentation and coding systems are designed for ease of use, they can also significantly reduce the training needed to prepare coders, physicians and other staff members for ICD-10. More importantly, these solutions can accelerate the learning curve and reduce the productivity losses associated with the transition.

What's more, electronic procedure documentation solutions drive compliant, coder-ready documentation. They can eliminate most, if not all, of the expected 15 to 20% increase in documentation activities created by ICD-10's expanded code set. For physicians alone, a permanent workload increase of 3 to 4% is anticipated – without an offsetting payment increase. ^{viii}

As an added bonus, electronic documentation and coding solutions typically result in a rapid return-on-investment, often in 12 to 18 months. Hospitals and ASCs that deploy them and automate these key processes can reap

immediate benefits, including reduced costs, increased revenues and streamlined workflow.

THE TIME IS NOW

Though qualifying for incentive funds under the federal stimulus program may have pushed ICD-10 off many providers' radars, few can afford to procrastinate planning for and initiating the transition.

The magnitude of system and training requirements means the switch to ICD-10 will be a complex, multi-year project that will consume significant time and resources.

Because of their impact on the move to ICD-10, electronic procedure documentation and coding solutions should be an important element of

any facility's transition plan. In addition to easing the process and reducing its cost, these valuable solutions will drive improved productivity and compliance, while enhancing workflow processes – outcomes that will provide immediate benefits for hospitals and ASCs alike.

PROVATION® MD ALLOWS PHYSICIANS TO DOCUMENT PROCEDURES EFFICIENTLY AT THE POINT OF CARE. REPLACING BOTH DICTATION AND TRANSCRIPTION, IT DRIVES STRUCTURED AND COMPLIANT DATA CAPTURE AND PRODUCES COMPLETE, IMAGE-ENHANCED DOCUMENTATION THAT IS READY TO CODE, RESULTING IN GREATER EFFICIENCY, INCREASED PROFITABILITY AND GREATER CLINICIAN SATISFACTION.

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ProVation MD's intuitive navigation also drives revenue recovery and provides greater protection against RAC audits by leading clinicians through the procedure documentation process efficiently, and then automatically tying that documentation to reimbursement coding. Complete documentation, including an e-signature, is available within minutes of a procedure, accelerating billing and improving workflow efficiency. Letters, requests, reports and patient instructions are generated automatically.

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