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Build an ICD-10 rapid response team for revenue emergencies.

By Warren Hansen, Associate Director of Provider Consulting, Optum 360™

Now that ICD-10 is a reality in the U.S. health care environment, providers are finding that October 1, 2015, didn't bring with it the D-Day scenario they thought it might. But they also know ICD-10-related challenges that aren't apparent now might manifest themselves in the coming months.

The latest data from the Workgroup for Electronic Data Interchange (WEDI) revealed larger providers felt confident they would be ready for ICD-10. Readiness, however, is a subjective term. Providers were certainly ready to submit claims come October 1, but are payers ready to receive them? And if not, how many claims will be denied?

ICD-10's enhanced coding guidelines could lead to a higher incidence of denials due to coding errors. Even more likely, ICD-10's greater granularity could result in lower reimbursements if documentation doesn't provide adequate detail to justify higher severity coding and DRGs.

Providers who are truly ready for ICD-10 have conducted end-to-end testing: they have submitted claims based on both ICD-10 documentation guidelines and native coding in ICD-10, and they have received an adjudicated claim from payers. These providers also have analyzed coding effectiveness and clinical documentation adequacy, and where they found gaps, provided coders with additional training and improved documentation. They found their risks and analyzed and addressed them.

Do you need an ICD-10 rapid response team?

Providers who haven't been able to get to that level of preparation run the risk of significantly decreased cash flow. Such providers require a rapid response team watching for coding and documentation gaps, as well as a plan to address those gaps as they are identified. The following are four essential steps organizations must follow to build an effective ICD-10 rapid response mechanism:

1. Make sure HIM and revenue cycle data are easily accessible. Most organizations tracked and reported their top 25 diagnoses and top DRGs under ICD-9, and they should be prepared to track and report the same data for comparison under ICD-10. Other important data points to track and compare include accounts receivable (A/R) days, cash on hand, discharged not final billed (DNFB), discharged not final coded (DNFC), and case mix index (CMI). Organizations should create a dashboard to track each of these key performance indicators.
2. Develop a team of experts that can identify risks using data. While a typical command center approach often seen with large go-lives or rollouts of enterprise systems might not be necessary, having focused teams aware of key indicators of risk is a prudent strategy. Billing experts, knowledgeable coding staff and denials management experts would be an ideal matrix for a rapid response team. Additionally, ensure clear lines of communication with payers to facilitate remediation of unforeseen impacts to revenue.
3. Determine the thresholds at which the ICD-10 rapid response team takes action. Facilities should determine whether a metric fluctuation is an anomaly or true cause for alarm. Certain areas, such as claims data, coding audits and case mix, may need 14–60 days of data to determine whether to take action. Other areas, such as clinical documentation improvement (CDI) queries and denials, may require only a few days of steady differences to know if a problem exists.
4. Determine how the team will respond. With a rapid response team in place, data at their fingertips, and applications at the ready to identify risks, organizations can act effectively. Prepare a dedicated workflow to follow after an issue is identified. Identify key accountable individuals with the authority and ability to manage change.

Develop a team of experts that can identify risks using data.

No matter how rapid, the response must be right.

With decision-makers in place, organizations should provide resources to dedicated denial management teams, CDI teams and coding improvement teams ready to help organizations get their revenue back on track.

Rapid responses to manage denials.

In the early days of ICD-10, it might be useful for organizations to review their top ICD-9 denial reason codes and the associated CCs/MCCs and monitor these daily for trends of increased denials. A mix of people, process and technology are always in order when it comes to limiting denials. Organizations should ensure they have adequate staff, efficient processes and capable technology in place to address increased denials in a timely manner.

Rapid responses to improve clinical documentation.

In a perfect world, all physicians would be up-to-speed on ICD-10, and CDI specialists will have already worked on high-volume, high-impact DRGs affected by ICD-10. If that is not the case, however, CDI activities can serve as validation to providers about the education they have received. They may fall into old documentation habits, but physician queries and discussions with physicians about documentation concurrent with a patient stay can educate physicians in real time about new documentation guidelines for certain DRGs.

Rapid responses to improve coder productivity.

Organizations must track coder productivity, typically measured by the number of charts per day an average coder can complete. Most organizations know what their baseline productivity is — if not, they can easily calculate it with data from most coding systems. Some organizations that have prepared for ICD-10 with dual coding saw minimal productivity loss, while others saw productivity hits similar to what was predicted: 20–50 percent. The hit to revenue caused by a 25 percent loss in productivity could be significant. Hiring more staff coders will be difficult at this point, as will securing contract coders. With the ubiquity of remote coding, organizations are competing regionally, nationally and even internationally for qualified, experienced coders. One solution is to boot-camp train entry-level coders. Give them the training they need to code the simpler outpatient encounters, such as labs and radiology, then shift more experienced coders into more difficult inpatient coding scenarios.

In conclusion, most, if not all, provider organizations could benefit from an ICD-10 rapid response group. By continuously analyzing data and deploying resources to plug revenue gaps, providers can remediate ICD-10-related challenges.

At the same time, don't forget the "blocking and tackling" activities essential to accurate, timely revenue. One such activity is a documentation and coding review. Organizations should audit 10–20 percent of their charts over six months. Why six months? Because that's when organizations should start seeing improvements. Another basic activity all organizations should emphasize is reimbursement analytics. Compare revenue by DRG, year-over-year, from October 2015 to October 2014. Doing so will help organizations find major shifts in reimbursement.

Learn how Optum can help your organization make a successful transition to ICD-10.

Phone 866.322.0958

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Warren Hansen
Associate Director of Provider Consulting

About the Author:
Warren Hansen is an associate director of Provider Consulting at Optum 360. Warren was one of the principal designers of the Optum ICD-10 Consulting solution. His extensive and diverse health care background includes IT management, revenue operations, health information management and project management.

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11000 Optum Circle, Eden Prairie, MN 55344