Mitigating the Financial Impact of the ICD-10 Conversion

There's not always a direct correlation between an ICD-9 and ICD-10 code. So providers should take steps to mitigate risks with the conversion.

Source: Physicians Practice

In August 2012, the HHS announced that the implementation of ICD-10 was going to be delayed from October 1, 2013 to October 1, 2014. Two of the greatest concerns associated with the conversion are the impact on the revenue cycle and accurately detailing the condition to meet the ICD-10 requirements.

As a starting point, physicians and hospitals alike should ask three crucial questions:
1. Is our knowledge of the pre- and post-ICD implementation costs adequate?
2. Is our awareness of the training, productivity, contractual, documentation, and revenue issues adequate?
3. Is there adequate cash-on-hand and cash reserves prior to the ICD-10 deadline to ensure liquidity post-compliance?[1]

In order to assess these areas, a good starting point is accounts receivable (A/R). Because various studies and the experience of other countries has demonstrated that there is a significant potential of a shortfall in net revenue (i.e., a 250-bed hospital could face $1 million to $2.5 million in the months following Oct. 1, 2014; and Australia and Canada found that coder productivity will increase 50,000 hours in the first month of implementation alone).[2] Hence, coding errors, payment denials, inadequate understanding of mapping to ICD-10, and the impact on contracts are all significant landmines to be aware of and navigate during the preparation process.

Let's look at a clinical example – esophageal hemorrhage.[3] Currently, it is identified as a major complication or comorbidity (MCC). ICD-10 has no equivalent code and one mapping identified ICD-10-CM Code K22.8 (other specified disease of the esophagus). This is problematic on two fronts: 1.) the MCC, which receives a higher reimbursement rate, is lost; and 2.) it does not provide the most specific code available. The more appropriate code, K22.11 (esophageal ulcer with bleeding), would still capture the MCC, provide the more accurate condition description and maintain the higher-weighted Medicare severity-adjusted DRG (MS-DRG). Therefore, ensuring that "cat" does in fact spell "cat" and not another animal.

In light of this, physicians should look at ways to mitigate the financial impact of the ICD-10 conversion. Suggestions include:
• Training coders and increasing their vocabulary and understanding of anatomy, physiology and procedures;
• Utilize the "80-20" Rule — assess the most frequently billed or highest dollar claims and curtail mappings, education and clinical documentation to meet these needs;
• Educate clinicians to use the more specific language and, like a contract, place it at the top of the notes, so coders can reduce the amount of time they have to spend scrolling through a medical chart;
• Evaluate contracts with IT vendors and payers to make sure everyone is on the same page and who absorbs liability in the event of an error that has a significant impact on the revenue cycle; and
• Make sure the HIPAA-required Business Associate Agreements are in place.

By focusing on these suggestions now, providers can mitigate the projected adverse impact on the revenue cycle and potentially capture previous inefficiencies in ICD-9 claim related submissions.


**Links:**
[1] [http://www.physicianspractice.com/blog](http://www.physicianspractice.com/blog)
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