ICD-10: Industry Perceptions and Readiness

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INTRODUCTION TO ICD-10

The U.S. healthcare industry is poised to undergo many radical changes in the coming years. One need only look at the newspaper to become aware of the many policy reforms under consideration. One significant policy implication that has been overshadowed by the current healthcare reform discussion is the ICD-10 conversion with its looming implementation deadline of October 1, 2013.

While conventional wisdom suggests this federally mandated change– which will affect all payers and providers–will exceed both HIPAA and Y2K in terms of cost and risk, healthcare organizations do not appear to have taken significant steps to prepare for implementation. The results of a recent study by Milliman, Inc. suggest that many organizations have done little in terms of implementation planning and preparation, and perhaps as a result of this lack of planning, study participants do not appear to view ICD-10 as offering opportunities to gain competitive advantages.

This white paper provides an overview of ICD-10; examines current industry perceptions and levels of readiness for the ICD-10 transition, based on survey responses; discusses some possible misconceptions reported by survey respondents; and provides information about possible transition strategies.

What is ICD-10?

Today, much of the data collection, analysis, and reporting in the U.S. healthcare system relies on the International Classification of Diseases Clinical Modification version 9 coding system (ICD-9-CM), which provides a standardized approach for categorizing diseases and patient conditions and surgical, diagnostic, and therapeutic procedures. Use of ICD-9-CM permeates the U.S. healthcare delivery and payment systems: it is referenced in provider reimbursement contracts, used for billing and claims processing, serves as the basis of trend analysis and reporting, and is used for many of the population and healthcare management functions provided in today's environment.

While the United States uses ICD-9-CM, the rest of the world has made the transition to ICD version 10 (ICD-10). The differences between the two versions are significant. Whereas ICD-9-CM provides approximately 13,000 diagnosis and 3,000 procedure codes, the versions of ICD-10 diagnosis and procedure codes to be deployed in the United States have roughly 68,000 and 87,000 codes respectively. The format and syntax of the two coding systems are also different.

The Final Rule issued by the Department of Health and Human Services (DHHS) on January 16, 2009, mandated ICD-10 use in HIPAA transactions (by health plans, providers, and clearinghouses) for all diagnoses and inpatient procedures effective October 1, 2013.

How will ICD-10 affect my organization?

The implementation of ICD-10 represents the most significant regulatory change in the healthcare industry since the implementation of HIPAA. Use of ICD-9 codes is pervasive throughout the payer and provider environments. One obvious area of impact is information technology (IT) because many system modifications will be necessary to allow for the new code formats and syntax. But this is just the tip of the iceberg. Many other business areas, systems, and processes will be affected, such as:

- Billing and claim payment
- External reporting
- Provider profiling
- Benefits administration
- Medical policies
- Financial reporting
- Underwriting
- Quality management
- Disease/case management
- Population health management
- Provider/insurer contracting provider relations
- Customer service
- Trend analysis
- Insurance product pricing

Only through a comprehensive pre-implementation assessment can organizations identify all affected business areas, and develop strategic plans for conducting the implementation in a manner that makes efficient use of resources and mitigates risk.

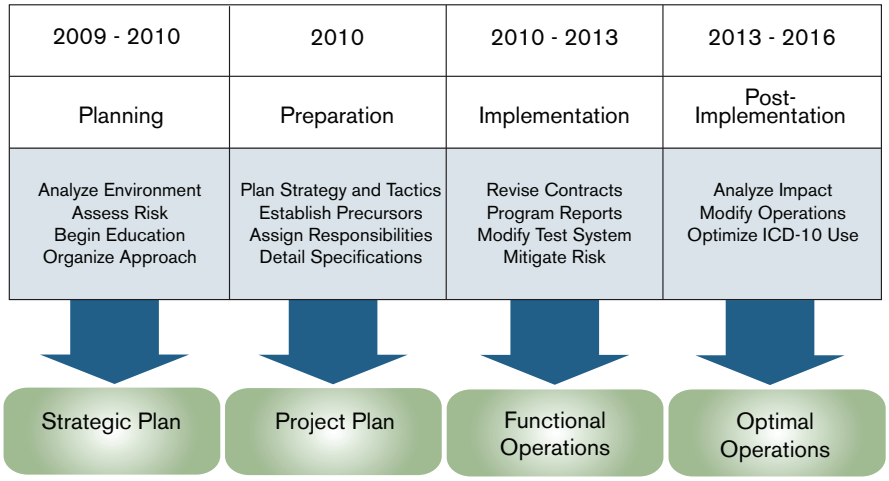
Why should I worry about ICD-10 now?

The deadline for ICD-10 compliance is October 1, 2013. In response to requests from the healthcare industry, the government extended

the compliance period from the originally proposed deadline of late 2011 to the current deadline. Although some organizations might be anticipating additional slippage of the date, the government has signaled that no additional extensions will be forthcoming. In fact, the country's largest payer, the Centers for Medicare and Medicaid Services (CMS), is well on its way to achieving compliance by the deadline and will surely expect the provider community and other payers to be ready as required.

Because the ICD-10 implementation will affect nearly every department and function within operations, a managed multi-phase approach to compliance will be necessary. Milliman recommends a four-phase timeline and approach as illustrated in Figure 1.

FIGURE 1: FOUR-PHASE TIMELINE



Organizations should already be actively engaged in the planning phase, with a focus on assessing the environment, identifying risks, educating stakeholders, and identifying resources. Starting in early 2010, organizations should be focused on synthesizing the output of the planning phase, developing implementation strategies, and developing detailed transition plans. Organizations will also want to start long lead-time initiatives such as contract revisions and negotiations in 2010. Likewise, organizations will want to simultaneously accommodate ICD-10 requirements during the course of other organization initiatives that impact coding. However, the majority of actual implementation work should occur during 2011, 2012, and 2013. Organizations should be ready to accept ICD-10 code sets early in 2013 to ensure sufficient time for testing and remediation in advance of the compliance deadline of October 1, 2013.

At a minimum we expect that additional post-implementation work will continue through 2016, as organizations map between ICD-9 and ICD-10 for reporting and analysis purposes. It is unlikely that organizations will be able to fully complete the transition from ICD-9 to ICD-10 until at least 18 months of ICD-10 experience is accumulated. No doubt, the additional coding specificity will lead to a better understanding of the levels of disease severity and future changes to the groupers, reimbursement, quality reporting, etc., well beyond 2013.

ICD-10 PERCEPTIONS AND READINESS SURVEY

In August 2009, Milliman conducted its 2009 ICD-10 Perceptions and Readiness Survey (see Appendix A) to gauge industry preparedness for the ICD-10 conversion. Milliman conducted the multiple choice survey using a Web-based instrument made available via an e-mail to Milliman clients. Survey responses were provided by 79 respondents representing 69 unique organizations. About 90% of these respondents described their organization as a health plan. Because of this high percentage of health plan representation within the survey responses, we have tailored our discussions to the health plan market.

Despite the unbalanced combination of HIPAA-covered entity types responding, we were able to gain a fairly level representation of different-sized organizations responding to the survey. One-third of respondents described their organizations as large, 38% as medium-sized, and 28% as small. We believe this nearly even representation adds validity to the discussion that follows.

SURVEY RESULTS

The survey results provide some interesting insights into respondents' readiness for and perceptions of the ICD-10 implementation. We present the findings and discussion under three topics:

1. General readiness
2. Industry perceptions of risk
3. Industry perceptions of the ICD-10 opportunity

General Readiness

The first part of the Milliman survey was designed to gather information about organizations' general readiness for the ICD-10 conversion. In general, the results of the survey suggest two major findings:

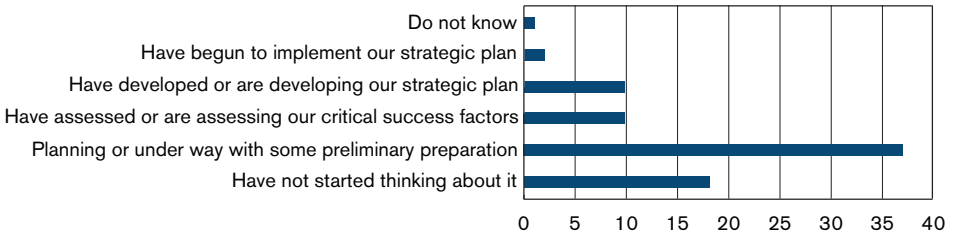
1. The vast majority of respondents (70%) indicated that their organization has done "little or nothing" to implement the new standard.

2. The primary reason why respondents' organizations have done so little to prepare is that 30% of respondents believe external vendors will have primary responsibility for implementing the change.

We question, given the high percentage of respondents who have limited preparatory action, whether these organizations really know if their vendors have the primary responsibility for this transition. The only way to determine levels of responsibility for each unique organization is to perform an in-depth implementation assessment.

The chart in Figure 2 illustrates the level of preparation that has been undertaken by survey respondents.

FIGURE 2: LEVELS OF PREPARATION



Vendors may be able to drive an organization to minimal compliance, defined as essentially using ICD-10 in electronic transactions. But it will take more than compliant transactions for organizations to claim a successful conversion. Most organizations will not want to delegate to vendors the business decisions that, when inadequately addressed, will expose themselves to severe operational and financial risks.

Although not surprising, the large portion of organizations believing they can rely on vendors is somewhat alarming for three reasons.

First, covered entities—not their vendors—are the "owners" of business processes and will ultimately bear the risks of poor or inadequate business considerations. For example, a payer's inability to accept and process claims with ICD-10 codes could halt auto-adjudication, overwhelming claim processing units and exposing payers to massive prompt payment penalties and interest payments, as well as provider dissatisfaction leading to network instability. In another example, while a vendor may set up the payer's system to accept and process claims using ICD-10 codes, there's no guarantee that the modified system will pay the right benefits or the right amount to the providers. Mapping errors or misjudgments about the "most appropriate" code to map to for reimbursement purposes may impact any intent of sustaining budget neutrality. Covered entities will not want these decisions to be made in isolation by third-party vendors.

Second, despite industry perceptions, the ICD-10 transition will affect a broad scope of internal operations, not just vendor systems and services. The conclusion of CMS after conversion of MS-DRGs from ICD-9 to ICD-10 is that any conversion of processes will likely require the use of clinicians and clinical coding experts as well as software programmers. Of those survey respondents indicating that they have begun ICD-10 transition work, 50% indicated that their organization has assigned responsibility of the project to personnel in the IT or claims departments. This may or may not be indicative of the common misconception that ICD-10 will affect only IT or claims. As previously described, ICD-10 may have far-reaching impacts throughout the organization: in actuarial and finance, population and healthcare management, provider contracting, and others. To achieve full compliance and to mitigate risk, all parts of the organization must be involved in the planning, preparation, and implementation phases of the project. Although it is feasible to manage enterprise implementations in the IT or claims departments, organizations must recognize that this transition is much more than an IT or claims project that can be handled by vendors.

Third, notwithstanding current uncertainty in the healthcare industry because of ongoing healthcare reform discussions and the transition time allowed by the extended deadline, planning for ICD-10 implementation should begin now. When DHHS issued the proposed rule, it included three years for implementation. There was so much push back from the healthcare industry that DHHS extended the timeframe to almost five years. With 2009 almost over, there are only four years remaining. It will simply take time to identify and assess all affected areas, processes, and systems, develop plans and identify resources to carry out the changes, check vendor readiness, and test the changes before completing the implementation.

When organizations were asked how long they expected their ICD-10 implementation to take, the responses varied widely. Some organizations thought implementation would take as little as a year while others expected more than five years. With time slipping away, organizations would be wise to complete an implementation assessment as soon as possible to garner a more solid understanding of how long it may take to complete the transition.

Industry Perceptions of Risk

The second part of the survey was focused on identifying respondents' perceptions of risk exposure from the transition. Respondents were asked to rank eight risk factors in order of the magnitude of perceived risk, with the option to manually add an additional ninth factor.

Risk Factors Perceived as High/Medium Risk

The following risk factors were rated as the top three high/medium risk concerns by respondents (i.e., rated 1-4 out of 9):

1. Unknown financial implications to billing and payment schemes, provider billing practices, use of mapping tools, etc.
2. Unknown financial implications to medical policy coding, coding errors, edits, fraud and abuse editing, etc.
3. Systems upgrades needed to accommodate ICD-10 for new code syntax and format

Responses also showed that a significant percentage of respondents believe their highest risk (ranked 1-2) is associated with vendors meeting implementation requirements. However, there was also a significant percentage that ranked vendor reliance as lower-risk (7-9). It appears that respondents believe strongly that vendors meeting implementation requirements presents either a high risk or a low risk.

These findings suggest that most respondents have a reasonable handle on the potential risks associated with the transition and the potential consequences. However, these concerns are in direct opposition to the responses regarding organizational readiness (i.e., respondents indicated they understand the risks, but that their organizations are not actively engaged in mitigating those risks). It is unclear if organizations feel little urgency to mitigate these risks because they feel they have plenty of time, feel they cannot actually mitigate the risks, anticipate that the potential magnitude is not significant enough to warrant action, or if other factors are an impediment.

Industry Perceptions of the ICD-10 Opportunity

The final section of the survey was focused on measuring respondents' perception of ICD-10 as a competitive opportunity. Interestingly, only 41% of respondents indicated that their organizations viewed the conversion as offering many opportunities. Most of the remaining respondents simply do not know what change ICD-10 will bring for their specific organization. Some of these respondents who are unsure of their future with ICD-10 may be thinking they will rely on vendors to make their transitions for them. While this may help them reach compliance, it is not likely to help them maximize the opportunities by innovating with the ICD-10 transition.

The Final Rule implementing ICD-10 identified seven major benefits that are expected to come about as a result of the transition from ICD-9 to ICD-10:

1. More accurate payments for new procedures
2. Fewer rejected claims
3. Fewer improper claims
4. Better understanding of new procedures
5. Improved disease management
6. Better understanding of health conditions and healthcare outcomes
7. Harmonization of disease monitoring and reporting worldwide

DHHS quantified the 15-year financial impact to the healthcare system of the first five benefits, totaling approximately $3.3 billion (discounted 3%) in present value terms. DHHS also quantified expected implementation costs such as training, system changes, and loss of productivity. While the Final Rule projects that the financial benefits of the transition may outweigh the costs, there is clearly some skepticism in the market that these savings will indeed come to fruition.

Although the administrative efficiency benefits of ICD-10 will likely be realized—fewer rejected claims, fewer improper payments, and more accurate payments for new procedures—we believe that the real value and opportunity of ICD-10 will be a direct result of payers' access to more and better data about disease state severity, and improved alignment of healthcare utilization and reimbursement. Those organizations that invest in strategic thinking about how to leverage ICD-10 to their advantage will be the real beneficiaries in this conversion.

CONCLUSION

Milliman's ICD-10 survey suggests that, while many organizations recognize the risks of implementation and non-compliance, few are actively involved in planning and preparing for the transition. The survey also suggests disparity as to the value of the conversion, with more than half of respondents not perceiving ICD-10 as offering opportunity. There are, however, some organizations that recognize the important opportunity not just for compliance, but as a strategic advantage. We believe these organizations that choose to start now and complete the ICD-10 transition in a controlled environment will be able to both more effectively manage their risk and position themselves with a strategic advantage above their competition. Organizations that wait to evaluate their conversion strategy will be left struggling to catch up on October 1, 2013, and are more apt to face financial repercussions post-implementation.

For more information on ICD-10, contact Andrew L. Naugle, a principal in the Seattle office at andrew.naugle@milliman.com or Pat Zenner, a consultant in the Healthcare Management Group practice at pat.zenner@milliman.com.

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APPENDIX A - ICD-10 READINESS SURVEY INSTRUMENT

1. Which of the following best describes your organization's current stage of ICD-10 implementation?

a. Have not started thinking about it
b. Have thought about it and are planning or underway with some preliminary preparation work (skip to question # 3)
c. Have assessed or are assessing our critical success factors (skip to question # 3)
d. Have developed or are developing our strategic plan (skip to question # 3)
e. Have begun to implement our strategic plan (skip to question # 3)
f. Do not know

2. What is the primary impediment to your organization moving ahead with ICD-10 implementation?

a. Nothing
b. Do not know enough about ICD-10 to get started
c. The deadline is 2013; we will worry about it later
d. Too many competing priorities
e. Insufficient human resources
f. Financial constraints
g. External vendors have the primary responsibility (e.g., claims-processing vendor)
h. Do not know

3. How long does your organization expect it will take to complete ICD-10 implementation?

a. 1 - 2 years
b. 2 - 3 years
c. 3 - 5 years
d. > 5 years
e. Do not know

4. Number from most (1) to least (9) what you perceive are your organization's greatest ICD-10 implementation risks.

__ The learning curve related to medical record documentation and coding
__ System upgrades needed to accommodate ICD-10
__ Revisions to provider/ payer contracts needed to accommodate ICD-10
__ Unknown financial implications of initial use of mapping tools
__ Unknown financial implications of the modifications to billing and payment schemes
__ Unknown financial implications of modifications to medical policy coding, coding error edits, fraud and abuse editing, etc.
__ The post-implementation "data fog" in relating historical ICD-9 data to ICD-10 data
__ Reliance on the vendors to meet implementation requirements
__ Other:_____

5. Which best represents your organization's view of ICD-10?

a. It offers many opportunities
b. Do not expect much will change as a result
c. Fear of the unknown downstream consequences
d. Do not know
e. Other:_____

6. What department has taken the lead role in your organization's preparations for ICD-10?

a. Strategic Planning
b. Finance
c. Information Technology
d. Claims
e. Other:_____
f. Have not designated a lead position/ department

7. What topics would you like to hear about in Milliman's October ICD-10 Webex? (check all that apply)

a. Building a strong implementation foundation
b. Assessing and planning for the changes
c. Payer and provider strategic collaboration
d. Implementation planning
e. Effective crosswalk use
f. Understanding, mitigating and planning for the financial impact
g. Effective communication and training
h. Managing vendor relationships
i. Integration/ coordination with other priorities and initiatives
j. Strategic opportunities
k. Other: _____

8. What type of HIPAA 'covered entity' do you represent?

a. Health plan
b. Hospital
c. Healthcare provider
d. Healthcare clearinghouse
e. Business associate to covered entities.
Specify:_____
f. None of the above

9. Compared to your competitors, do you consider your organization size to be:

a. Large
b. In the middle
c. Small

APPENDIX B – SURVEY RESULTS

QUESTION 1	
WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ORGANIZATION'S CURRENT STAGE OF ICD-10 IMPLEMENTATION?	
HAVE NOT STARTED THINKING ABOUT IT.	18
HAVE THOUGHT ABOUT IT AND ARE PLANNING OR UNDER WAY WITH SOME PRELIMINARY PREPARATION WORK.	37
HAVE ASSESSED OR ARE ASSESSING OUR CRITICAL SUCCESS FACTORS	10
HAVE DEVELOPED OR ARE DEVELOPING OUR STRATEGIC PLAN.	10
HAVE BEGUN TO IMPLEMENT OUR STRATEGIC PLAN.	2
DO NOT KNOW.	1

QUESTION 2	
WHAT IS THE PRIMARY IMPEDIMENT TO YOUR ORGANIZATION MOVING AHEAD WITH ICD-10 IMPLEMENTATION?	
NOTHING.	5
DO NOT KNOW ENOUGH ABOUT ICD-10 TO GET STARTED.	6
THE DEADLINE IS 2013; WE WILL WORRY ABOUT IT LATER.	4
TOO MANY COMPETING PRIORITIES.	8
INSUFFICIENT HUMAN RESOURCES.	2
FINANCIAL CONSTRAINTS.	1
EXTERNAL VENDORS HAVE THE PRIMARY RESPONSIBILITY (E.G., CLAIMS-PROCESSING VENDOR).	11
DO NOT KNOW.	1

QUESTION 3	
HOW LONG DOES YOUR ORGANIZATION EXPECT IT WILL TAKE TO COMPLETE ICD-10 IMPLEMENTATION?	
1 - 2 YEARS	26
2 - 3 YEARS	24
3 - 5 YEARS	9
> 5 YEARS	1
DO NOT KNOW	18

QUESTION 4									
NUMBER FROM MOST (1) TO LEAST (9) WHAT YOU PERCEIVE ARE YOUR ORGANIZATION'S GREATEST ICD-10 IMPLEMENTATION RISKS.									
	1	2	3	4	5	6	7	8	9
THE LEARNING CURVE RELATED TO MEDICAL RECORD DOCUMENTATION AND CODING.	5	4	4	5	6	1	5	11	5
SYSTEM UPGRADES NEEDED TO ACCOMMODATE ICD-10.	11	4	4	5	5	2	4	1	6
REVISIONS TO PROVIDER/ PAYER CONTRACTS NEEDED TO ACCOMMODATE ICD-10.	1	4	5	6	12	7	8	5	2
UNKNOWN FINANCIAL IMPLICATIONS OF INITIAL USE OF MAPPING TOOLS.	2	4	8	5	5	7	5	4	1
UNKNOWN FINANCIAL IMPLICATIONS OF THE MODIFICATIONS TO BILLING AND PAYMENT SCHEMES.	3	10	7	9	5	6	4	4	0
UNKNOWN FINANCIAL IMPLICATIONS OF MODIFICATIONS TO MEDICAL POLICY CODING, CODING ERROR EDITS, FRAUD AND ABUSE EDITING, ETC.	3	9	6	7	6	8	5	5	1
THE POST-IMPLEMENTATION "DATA FOG" IN RELATING HISTORICAL ICD-9 DATA TO ICD-10 DATA.	3	6	11	7	8	11	6	4	3
RELIANCE ON THE VENDORS TO MEET IMPLEMENTATION REQUIREMENTS.	12	7	6	5	4	9	12	9	5
OTHER.	8	1	1	2	0	0	0	0	5

QUESTION 5	
WHICH BEST REPRESENTS YOUR ORGANIZATION'S VIEW OF ICD-10?	
IT OFFERS MANY OPPORTUNITIES.	32
DO NOT EXPECT MUCH WILL CHANGE AS A RESULT.	15
FEAR OF THE UNKNOWN DOWNSTREAM CONSEQUENCES.	13
DO NOT KNOW.	14
OTHER, PLEASE SPECIFY.	4

QUESTION 6	
WHAT DEPARTMENT HAS TAKEN THE LEAD ROLE IN YOUR ORGANIZATION'S PREPARATIONS FOR ICD-10?	
STRATEGIC PLANNING	8
FINANCE	2
INFORMATION TECHNOLOGY	24
CLAIMS	15
HAVE NOT DESIGNATED A LEAD POSITION/DEPARTMENT	16
OTHER, PLEASE SPECIFY	13

QUESTION 7	
WHAT TOPICS WOULD YOU LIKE TO HEAR ABOUT IN MILLIMAN'S OCTOBER ICD-10 WEBEX? (CHECK ALL THAT APPLY)	
BUILDING A STRONG IMPLEMENTATION FOUNDATION	27
ASSESSING AND PLANNING FOR THE CHANGES	34
PAYER AND PROVIDER STRATEGIC COLLABORATION	36
IMPLEMENTATION PLANNING	32
EFFECTIVE CROSSWALK USE	44
UNDERSTANDING, MITIGATING AND PLANNING FOR THE FINANCIAL IMPACT	40
EFFECTIVE COMMUNICATION AND TRAINING	26
MANAGING VENDOR RELATIONSHIPS	17
INTEGRATION/ COORDINATION WITH OTHER PRIORITIES AND INITIATIVES	18
STRATEGIC OPPORTUNITIES	28
OTHER	0

QUESTION 8	
WHAT TYPE OF HIPAA "COVERED ENTITY" DO YOU REPRESENT?	
HEALTH PLAN.	62
HEALTHCARE PROVIDER.	5
HEALTHCARE CLEARINGHOUSE.	1
NONE OF THE ABOVE.	1
BUSINESS ASSOCIATE TO COVERED ENTITIES, PLEASE SPECIFY.	7

QUESTION 9	
COMPARED TO YOUR COMPETITORS, DO YOU CONSIDER YOUR ORGANIZATION SIZE TO BE:	
LARGE	26
IN THE MIDDLE	30
SMALL	22

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