Capitalizing on the ICD-10 Coding System: What Healthcare Organizations Need to Know

With a successful transition to ICD-10 behind them, healthcare organizations must now focus on leveraging the system to strengthen their overall competitive advantage.

Executive Summary

Healthcare organizations’ largely successful transition to ICD-10 is only the first step in exploiting the system’s capabilities to drive competitive advantage. They now need a clear strategy and tactical game plan to deepen insights, improve quality and achieve better outcomes.

This involves minimizing revenue leaks, improving outcome and quality measures, and exploring the opportunities made possible by ICD-10’s additional diagnostic specificity and new clinical definitions.

ICD-10: The Journey Has Just Begun

When the final rule for ICD-10 was published in 2009, healthcare organizations were concerned about the massive investment required to transition to the new coding system. Nonetheless, the industry was convinced of its value. Many payers and providers indicated they would make use of the granularity in the ICD-10 code set to remediate their organization’s business processes and IT systems to strengthen their competitive advantage.

Yet conflicting priorities, including the Affordable Care Act (ACA) mandate, the rollout of health insurance exchanges and meaningful use requirements, jostled for position during the industry’s ICD-10 transition. In fact, the ICD-10 implementation deadline was extended twice. Between 2013 and the rule’s final implementation in 2015, many healthcare entities narrowed their focus - limiting their activities to simply achieving compliance with ICD-10 requirements, rather than capitalizing on the coding specificity offered by ICD-10 (see Figure 1).
ICD-10 Investments

In 2010, America’s Health Insurance Plans (AHIP) surveyed health plans to estimate the cost of ICD-10 implementation. By 2013, when compliance became the primary goal, healthcare organizations had made significant investments in ICD-10 remediation, systems and training, which they had initially anticipated based on AHIP’s survey (see Figure 2).

Although these numbers can vary significantly among health plans - based on the number of lines of business, remediation approaches, business processes and IT portfolios - in general, both payers and providers invested heavily in becoming ICD-10 compliant.

The investments initially paid off. On October 1, 2015, years of anxiety and excitement surrounding ICD-10 translated into a largely eventless, smooth transition. ICD-10 claim volume reached 90% to 95% by year-end 2015, and denial rates were well within norms (1.6 to 2%). Today, many plans and providers are dismantling their program-management offices (PMO), task forces and control centers - signaling that their ICD-10 transition is complete.

Yet in reality, the transition to ICD-10 is just the beginning. In order to fully exploit the power of ICD-10 and drive competitive advantage well beyond 2016, healthcare organizations will need to apply their ICD-10 investments to gain actionable insights.

ICD-10 Implementation Costs

<table>
<thead>
<tr>
<th>Plan Size</th>
<th>Member Base</th>
<th>Per-Member Average Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>&lt; 1 Million</td>
<td>$38</td>
</tr>
<tr>
<td>Medium</td>
<td>1-5 Million</td>
<td>$13</td>
</tr>
<tr>
<td>Large</td>
<td>&gt; 5 Million</td>
<td>$11</td>
</tr>
</tbody>
</table>

Source: AHIP Survey of 20 sample health plans in September 2010

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From Transition to Strategic Advantage

Today, healthcare organizations aim to ensure business continuity during the ICD-10 post-transition period (the data fog stage) that will extend into 2017. Simultaneously, they should create...
a strategy for capitalizing on ICD-10 in four key areas: identifying and eliminating financial divergence; reducing revenue leaks in Medicare Advantage; improving HEDIS and CMS Star quality ratings, and enhancing care-management functions.

**Identifying & Eliminating Financial Divergence**

Historically, most health plans and providers performed financial neutrality analysis (FNA). Unlike FNA, financial divergence analysis focuses mainly on coding inaccuracies that lead to diagnostic-related group (DRG) changes and financial divergence.

Financial divergence analysis also uses ICD-10 claims, and enables backward mapping to ICD-9 for payment comparisons. This is expected to reveal any discrepancies that were missed in FNA, which is primarily based on forward mapping.

We highly recommend that health care organizations conduct a financial divergence analysis on a quarterly basis to detect susceptible DRG shifts and payment variances caused by coding errors. This is key to minimizing financial risk, especially given the learning curve required for coders to become ICD-10 proficient and the low percentage of coding accuracy seen during the national pilot program. The analysis should be comprehensive – encompassing financial divergence as well as upcoding, downcoding, provider communications and medical record reviews (see Figure 3).

During the data fog period (2015-2017), we advise health plans to conduct periodic ICD-10-focused provider audits to address gaps in documentation and coding. Findings from these audits can provide valuable inputs/insights to enhance various edits/rules around prospective and retrospective detection of overpayments, and prevent fraud, waste and abuse.

**Reducing Revenue Leaks in Medicare Advantage**

For the first time, Medicare Advantage plans must process both ICD-9 and ICD-10 claims to arrive at population risk scores. One-to-many mappings in ICD-10 and associated complexity in hierarchical condition category (HCC) groups require significant analysis and validation of the risk score. Limited exposure to the new ICD-10 coding system may introduce gaps in diagnosis coding, leading to under-estimation of risk scores and revenue leaks.

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Plans need a statistical, model-driven analysis using historical and current claims to identify susceptible and missing HCC codes and eliminate revenue leaks.

In addition, ACA mandates that insurance entities that offer plans through health insurance exchanges (HIXs) establish a risk-adjustment program. This involves transferring funds from health insurance plans that enroll lower-risk individuals to plans that enroll those at higher risk. Plans need an effective risk-adjustment and data validation (RADV) program – including claims auditing – to ensure that the
clinical conditions of the members (including complications/comorbidities) are captured through proper documentation and coding.

**Improving Quality Ratings**

ICD-10 has a direct impact on HEDIS, physician quality and reporting systems (PQRS) and CMS Star ratings. The CMS Star rating system in particular exerts a strong influence on individual consumers shopping for health insurance. While Medicare Advantage plans that earn at least four stars are eligible for additional incentives from CMS, those that earn low-star ratings are likely to be penalized.

Although payers have remediated their HEDIS systems and data-capture processes to comply with ICD-10, the quality measures and Star ratings will only be as good as the quality of incoming ICD-10 claims. Unfortunately, inaccuracies were as high as 45% in specific claim categories in the ICD-10 National Pilot Program led by HIMSS/WEDI during 2013. Physicians and coders must negotiate a significant learning curve before they can achieve higher coding accuracy. It is therefore critical that health plans use ICD-10 claims received in the fourth quarter of 2015 and throughout 2016 data to audit coding accuracy and ensure proper documentation.

**Enhancing Care Management**

**Population Management & Value-Based Reimbursement**

ICD codes are used extensively in various health-management programs, including care and population management (identifying at-risk populations, disease management, utilization management and care coordination, for example). ICD-10 provides tremendous opportunities to improve these initiatives through its diagnostic specificity and new clinical definitions – particularly regarding chronic conditions such as asthma, diabetes, obesity and heart disease.

The level of detail captured during initial and subsequent episodes of care can eventually yield a clearer picture of the quality of care an individual patient received and the related outcomes. Similar data, once aggregated and depersonalized, can help organizations identify best practices for coordinating care protocols for a particular condition within a specific population.

Additionally, the industry is moving away from the fee-for-service model to outcome-centered or value-based payments. Furthermore, Health and Human Services (HHS) has set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018.

Performance, clinical and quality measures form the foundation for different payment models in the value-based reimbursement continuum. ICD-10 codes will provide a wealth of clinical information – enabling payers to design effective, value-based care programs in the coming years.

**Coding Accuracy & Documentation Review**

It’s important for hospitals to periodically review claims/encounter data to identify coding gaps and issues in order to improve coding-staff accuracy and productivity. Coding accuracy is fundamental to reducing denials, enhancing cash flow and driving incentives through quality-improvement measures. In the pilot program studies conducted by HIMSS and WEDI in 2013, coding inaccuracies for certain clinical conditions reached as high as 45%. In our view, it could take a full year for physician practices and hospitals to achieve 90%-plus accuracy in ICD-10 coding. In light of this learning curve and potential coding errors over the coming months, healthcare organizations must systematically work to improve this critical function. Our advice:

- Establish an effective control mechanism over the next few years to achieve consistency among coders.
- Ramp up auditing – focusing on both pre-bill and retrospective audits to detect coder deficiencies and identify gray areas that can be addressed through education.
- Educate coders on an ongoing basis to improve productivity and accuracy.
- Engage physicians to ensure the adoption of new clinical documentation processes, and the use of specific codes in every possible scenario to collect accurate codes.

Cases for documentation reviews can be identified based on the number of queries to physicians and coder productivity.

**The ICD-10 Journey: Moving Forward**

The focus areas we identified here – arresting revenue leaks, financial divergence analysis and improving HEDIS/Star ratings, for example –
should be viewed as starting points for realizing quantifiable ROI from ICD-10 investments. Looking ahead, organizations can continue to optimize operations and explore the opportunities opened by ICD-10’s rich data sets, which continue to accumulate.

There are key steps healthcare entities can take now to build and sustain momentum for making the most of ICD-10:

- Develop short- and long-term game plans for reaping the benefits of ICD-10.
- Identify an ongoing, ICD-10 strategic initiatives team. (The team should comprise clinical, IT, data analytics, quality and administrative personnel, augmented by external consulting services as needed.
- Target sources of funding for continuing ICD-10 activities. It can be difficult to garner capital funds; it is often easier to earmark operational funding in existing budgets for ongoing reviews and analyses.

The smooth transition to ICD-10 marks a milestone, but not the end of the journey. Plans and providers need a game plan for realizing strategic benefits from their ICD-10 investments. Healthcare organizations that commit to periodic audits and reviews of incoming ICD-10 claims data from revenue-management, quality and care-management perspectives throughout 2016 can realize significant advantages from their treasure troves of ICD-10 data.

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Footnotes


About the Author

Palani Munisamy is a Director within Cognizant Business Consulting’s Healthcare Practice. He has more than 15 years of experience in solution consulting, business development and client relationship management. Palani also has significant experience in managing large transformational and regulatory initiatives, and is a certified Managed Healthcare Professional (MHP) from Health Insurance Association of America (HIAA). Palani has co-authored numerous white papers on healthcare IT and business issues. He can be reached at Palani.Munisamy@Cognizant.com.

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