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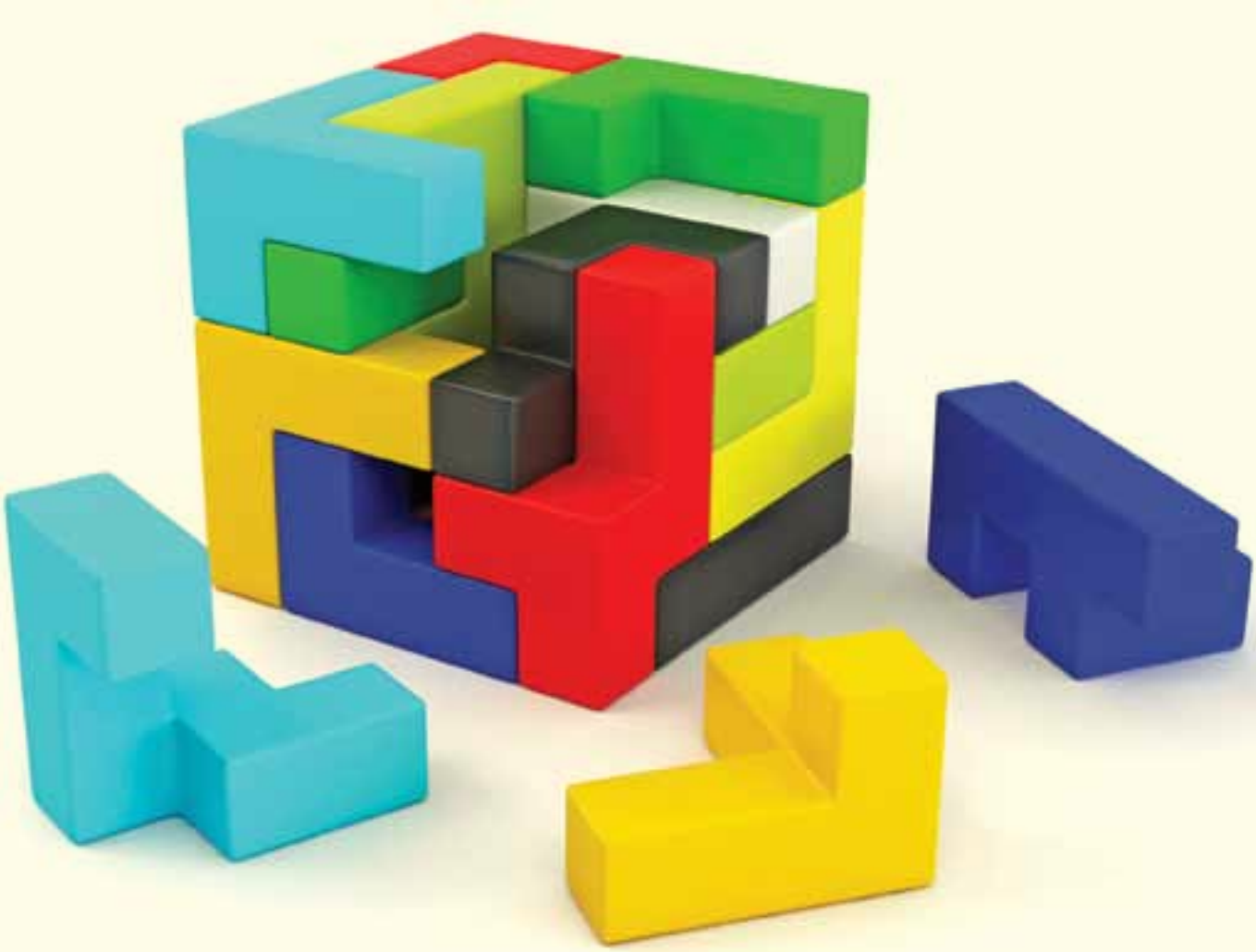
Readying Your Denials Management Strategy for ICD-10



To mitigate revenue loss and manage accounts receivable (A/R), hospital finance leaders are making ICD-10 denials management a top priority. Leaders are recognizing that the transition to ICD-10-CM/PCS is not simply a coding or health information management (HIM) challenge; it is a significant threat to the organization's revenue and cash flow, requiring top-most attention.

To best support revenue integrity, hospital executives should not only appreciate the effect of ICD-10 on denials frequency and type, but also move beyond traditional denials management strategy. For many hospitals and health systems, existing organizational resources, project management competencies, and workflows supporting denials management will not suffice. As discussed in this HFMA education report, sponsored by Optum, preparing for ICD-10 and its far-reaching impact will require new levels of focus in four key areas:

- Clinician role in denials prevention and defense
- Executive-level oversight of denials management strategy
- Strategic deployment of technologies
- Resources devoted to coding support

Revenue and Cash Flow Impact of ICD-10

Before looking at each of these four areas, it's important to first appreciate the impact that ICD-10 will have on the revenue cycle of a hospital. A clear and immediate effect will be an increase in the number of claims denied: The Centers for Medicare & Medicaid Services (CMS) estimates that in the early stages of implementation, denial rates will rise by 100 to 200 percent, and that days in A/R will grow by 20 to 40 percent.

Claims error rates also will go up. CMS predicts that claims error rates will be more than two times higher with ICD-10, reaching a high of 6 to 10 percent in comparison with the average 3-percent error rate with ICD-9 (*ICD-10 Transformation: Five Critical Risk-Mitigation Strategies,* Healthcare Information and Management Systems Society, 2011*).*

Because of the complexity of the new coding system and coders' unfamiliarity with its ins and outs, coding backlogs are projected to balloon by at least 20 percent, impeding the flow of cash. A typical turnaround time for claims processing of 45 to 55 days could end up being extended another 10 to 20 days (Deschenes, J., "5 Potential ICD-10 Financial Issues," *Healthcare Payer News*, July 8, 2011).

In addition, the shift to ICD-10 will change the nature of denials and their management. Claims denials will not strictly be a matter of clarification that can be handled by a nonclinical person in the billing office. Denials will raise questions about medical necessity or the clarity of medical documentation supporting a code; such questions will require input from a physician, nurse specialists, or outside expertise.

The problem will be particularly acute with ICD-10 procedure codes, notes Nelly Leon-Chisen, RHIA, director of coding and classification for the American Hospital Association. "ICD-10-CM/PCS requires coders to understand more specific aspects about clinical procedures," she says. "For example, with insertion of a cardiac pacemaker, a coder will need to be able to indicate on which side of the heart the leads were attached, whether the leads were placed in the right or left ventricle and atrium, and whether an open or percutaneous surgical approach was used. These details may not be apparent from merely viewing the title of the operation; the coder may have to read through the operative report to identify them."

Greater need for specificity will impact both ease and speed of coding. "It is going to take coders longer to go through the medical records to find what they need," says Leon-Chisen. On average, coders took nearly 18 minutes longer to code a record in ICD-10-CM/PCS than in ICD-9-CM, according to a 2012 AHIMA study (*ICD-10-CM/PCS Productivity Study: Early Results Show Big Drop*, UASI Insights & Education, Oct 15, 2012).

With so many challenges ahead, how can hospitals and health systems best prepare their denials management strategies?

As the industry transitions to ICD-10, to maintain revenue and generate cash flow, providers should streamline workflow processes to support accurate coding and get bills out the door. Focusing organizational efforts around denials management, prevention, and defense; strategic deployment of technologies; and resources devoted to ICD-10 implementation will be particularly important.

Clinician Role in Denials Prevention and Defense

Physician participation in denials management will need to increase under ICD-10. Staff and referring physicians—particularly surgeons—should be aware of the depth and types of documentation they will need to provide before claims processing. Also important will be readiness to add clinical perspective and input when denials occur.

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Many experts note that even providers with robust denials management programs should raise the bar by employing a full-time physician as medical director of denials management or by contracting with clinical specialists to address queries and other issues associated with medical necessity, so that providers will be better prepared to go toe-to-toe with payers over denials.

Also key will be minimizing the day-to-day documentation burden on clinicians. To this end, many hospitals are acquiring medical intelligence that provides templates or criteria to guide physicians through the elements of documentation needed to support a diagnosis or procedure code under ICD-10.

The University of Pittsburgh Medical Center (UPMC) has worked toward building the strength of its current denials management processes for more than two years in anticipation of ICD-10. The organization has had a physician dedicated to denials management since 2010, and its leaders have a system in place for advanced tracking and trending of clinical denials.

"It is a highly structured program, enabling our team to address all denials in a centralized process," says Adele Towers, MD, MPH, medical director of health information management. "We maintain information in a database and release monthly reports that provide a snapshot of the number of charts requested, the number of claims denied, the dollars involved, the issues identified, and the top 10 primary and secondary diagnoses."

Although the UPMC denials management process will not change for ICD-10, the health system will shift its attention to the front-end physician charting phase and try to reduce challenges at the back-end denial stage as it prepares for ICD-10 implementation. Automation will support this focus.

The medical center is currently working with a technology vendor to develop computerized clinical documentation improvement tools that will identify critical documentation issues while the patient is still in the hospital. One of these tools will scan an operative report to determine whether all the necessary elements are present to assign an ICD-10 procedure code. "It will flag any missing elements—for example, type of device used or depth of incision—so a specialist can review the report and send it to the surgeon for completion, if needed," Towers explains.

UPMC also will employ another type of technology to review and query clinical notes made by the physician. "The tool will be inserted in the physician's day-to-day workflow," Towers says. "When the physician goes on the floor and opens up the electronic medical record, he or she will see not only notes about the patient, but also any related documentation communications, such as a request to clarify the diagnosis," she says.

Towers believes the new tools, which are now undergoing testing and will become operational within six months, will be a huge advancement toward supporting physician efforts around documentation improvement. "The key is to communicate with physicians as part of their workflows, to make it easy for them to address issues related to coding and medical necessity while the patient is in the hospital," she says.

THE ROLE OF THE CFO IN ICD-10 DENIALS MANAGEMENT

Although most organizations make the director of HIM responsible for ICD-10 implementation, the CFO can help ensure that his or her organization's ICD-10 steering committee is paying attention to the revenue cycle and denials management by assuming the role of executive sponsor, chartering teams to spearhead efforts directed at specific areas of denials management, and selecting metrics to assess progress. Typical questions CFOs may ask to encourage accountability include the following:

- How many educational sessions have been held?
- Have we completed a chargemaster review?
- Have we reviewed all our contracts with our payers?
- Have we performed a risk assessment regarding issues with data integrity?
- How are we retrofitting our report infrastructure to monitor denials?
- Are we engaging not just rank-and-file medical staff, but also referring physicians?
- Have we aligned and assigned budgets for denials management activities?
- Have we tied costs to specific cost centers so we can compare implementation expenditures from fiscal year to fiscal year?

Executive-Level Oversight of Denials Management Strategy

Also important is having the right oversight structures in place to ensure effective denials management. To streamline workflow and support revenue integrity under ICD-10, hospitals should involve all departments in the organization's denials management strategy.

"Cross-department collaboration is key because pieces of information related to denials are collected from many different areas throughout the organization before they are fed into the medical record and made available for coding to complete a claim," notes Leon-Chisen.

To best position for success, many hospitals and health systems are relying on high-level steering committees to oversee the overall ICD-10 implementation strategy, with supporting task-based teams guiding revenue cycle performance and denials management.

As an example, Baptist Health South Florida's organization-wide ICD-10 steering committee has met quarterly over the past year to analyze HIM systems, review mapping and other IT tools, put together an implementation and capital planning budget, arrange for training and recruiting of certified coders, and expand the current clinical documentation improvement initiative to lay the groundwork for more physician involvement in ICD-10. Over the next few months, the committee will start to meet every other month as it begins reviewing the progress of charter groups that are working on specific aspects of ICD-10, such as transitioning physician practices, updating clinical systems, and managing revenue cycle impact. Information about the organization's ICD-10 strategy and progress is communicated throughout the enterprise through an online newsletter.

Similar cross-department collaboration is supported in the oversight structure at Christiana Care Health System in Wilmington, Del., where the organization's steering committee includes departmental stakeholders who review the status of ICD-10 projects and the work streams that will be critical for denials management, such as the use of computer-assisted coding and the detailed assessment of the financial impact of the change in coding for various DRGs. The steering committee meets once a month; project and work stream leaders meet biweekly; and progress reports are distributed widely through a shared information site.

"We are managing ICD-10 as an entire program of work, where every aspect is linked under the program," says Peggy Lynahan, ICD-10 program manager for Christiana Care. "Individual projects, such as crosswalks and mapping, are managed by specific managers, but all of the activities come together at the top at the program level."

Recognizing the importance of executive-level oversight and the reality of other organizational priorities competing for time, some organizations have made use of existing committee structures to advance denials management efforts.

One such organization is Gwinnett Health System in Atlanta, which established a governance structure in 2010 that coordinates the work of ICD-10 project teams related to coding, clinical documentation, system awareness, reporting and analytics, and the revenue cycle under an existing top-tier executive clinical committee.

"We recognized the need to be able to report the denial and cash flow impact related to ICD-10 to the senior leaders who are setting organizational and clinical strategy. To do so effectively, we tapped into the executive clinical transformation committee, which was set up for meaningful use and roll-outs of clinical systems, because it made sense from a clinical perspective," explains Cathy Dougherty, assistant vice president for revenue management. "We wanted to be sure people understood that ICD-10 is not just a coding and IT problem."

Under the guidance of the clinical transformation committee, Gwinnett Health System's executive revenue cycle governance committee meets monthly to assess a scorecard that tracks the completion of tasks related to ICD-10 and denials management, including core and specialized training of coders, implementation of a clinical documentation improvement system, and all system upgrades.

Even though many organizations are reaching beyond traditional denials management oversight structures in the face of ICD-10, the commitment and engagement of revenue cycle leadership remains crucial for success.

Typical tasks led at the revenue cycle level for many organizations include identifying baseline and target measures of coding efficiency and productivity, tracking high-volume or high-value clinical areas that generate the most physician queries, identifying potential impact on discharged not final billed (DNFB), and overseeing training paths. Revenue cycle leaders also are playing a primary role in selecting and tracking metrics to help the organization better identify post-ICD-10 denial trends by payer, procedure, and diagnostic code.

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HOW ARE YOUR PAYERS ADDRESSING ICD-10?

To assess the potential impact of ICD-10 on payment, the American Hospital Association recommends that providers talk with payers to gain better insight into planning. A first step is for providers to review their contracts with top payers. "You need to know if your contracts are based on actual code numbers listed or on DRGs or payment formulas," says Nelly Leon-Chisen, RHIA, director of coding and classification for the American Hospital Association.

Some proactive payers are developing work groups to learn about the support that providers will need during the transition to ICD-10. However, even when such groups don't exist, providers should communicate regularly on the topic.

Christiana Care Health System has been in touch with each of its top 10 payers and has reviewed its contracts with the top three payers. Baptist Health and other providers in the state are having monthly open-line discussions with one of the top payers in Florida about payer and clearinghouse issues and challenges.

Providers should learn how payers plan to conduct end-to-end testing, notes Leon-Chisen. "Many hospitals are worried that they may not be able to get onto the testing schedule with a payer since it may require carefully coordinating when software vendors will have their ICD-10 software ready."

Gwinnett Health System is concerned about testing. "We have been working with our clearinghouse to try to be one of the providers they use to test with payers, but the clearinghouse tells me that payers do not want to perform the full testing for every provider; they want to do testing on one or two accounts with a few providers," says Cathy Dougherty, assistant vice president for revenue management.

In March, Gwinnett will be ready to code in ICD-10 and will have a system for mapping back codes in ICD-9 for billing purposes. "I would like to work with our payers to test the process and have some real accounts adjudicated. But I don't know if I will be able to make that happen," she says.

Realistically, payers will not be able to end-to-end test ICD-10 claims with every provider. The hope for providers is that enough information will be made public to feel confident when testing is absent. "There may be a degree of responsibility for the providers who undergo testing in terms of sharing their findings with others who won't be able to," notes Lynahan. "Knowing what is happening is going to be so important, because it is in the initial testing that you find the gaps between what the hospital thinks and what the payer thinks."

Strategic Deployment of Technologies

Resource needs associated with denials management also are shifting as ICD-10 approaches. In addition to investing in the clinical documentation improvement systems discussed earlier, many hospitals and health systems are acquiring solutions in the following areas to advance efforts.

Computer-assisted coding. Computer-assisted coding (CAC) is widely viewed as an important tool to make up for lost productivity and payment after ICD-10 kicks off. In a nationwide survey by KLAS Research in 2012, 21 percent of facilities had already obtained CAC, and 53 percent reported they would make the purchase by 2015 (*CAC Top Strategy for ICD-10*, KLAS Research, April 23, 2012).

"Providers are paying more attention to automated coding primarily because ICD-10 coding will be much more complex and take more time, and there are concerns about being able to get enough coders onboard," says Leon-Chisen, noting that CAC can be particularly useful for coding deemed easier, more routine, or specific to the outpatient setting

Mapping. Also important to organizations is the ability to model the financial impact of ICD-10. Using specialized software, hospitals are able to take an existing claim in ICD-9, map it to ICD-10, and determine the impact on payment.

Baptist Health South Florida will be using mapping software to help guide its focus on denials management. "We have not started wading through the details of the data yet, but that will pick up in the coming year," says Lee Ratliff, director of clinical business technology. "When we do, we will look at specific DRGs that have a significant revenue impact, either positive or negative, and look for possible reasons behind the change: Is the clinical documentation appropriate? Are clinical specialists documenting correctly? Are we able to code in ICD-10 appropriately?"

Mapping isn't solely about projecting change, Lynahan at Christiana Care adds. "After the go-live date, we will use mapping to examine impact on DNFB and zero in on more specifics about DRG shifts: Where did it shift from, what did it shift to, and what factors were involved in the shift," she says.

Denials tracking and trending. Of course, technology is the key means hospitals use for improving tracking and reporting of denials trends. In addition, many organizations are using these solutions to help create scorecards by payer, identify root-causes for delay or denial, and support communication of payer or clearinghouse issues. The coming of ICD-10 only underscores the importance of these capabilities.

Gwinnett Health System has been focused on advancing its denials tracking, with a key goal of improving 835 analysis. The organization will be exploring external assistance for tracking and trending denials related to ICD-10 in an effort to identify payment barriers and to expedite cash flow. "The added burden of denials post-ICD-10 may be overwhelming," Dougherty says. "I feel we will need additional assistance to keep up with it and make a quick impact."

DENIALS MANAGEMENT READINESS CHECKLIST

How do you know if your facility is on track for successfully managing denials during the transition to ICD-10? Executive leaders are establishing scorecards of metrics for reporting performance and tracking progress with input from HIM and revenue cycle departments. When developing these scorecards and providing planning insights, consider how well the organization is able to do the following.

- ☐ **Identify existing denials trends, including comprehensively and efficiently categorize and stratify the reasons for denial.** Denials have a way of sneaking into an organization through many pathways: utilization review; billing; RAC requests. A first step is to define the denials that are in play and scour the organization to learn where they are coming from so they can be monitored and trended before mapping to the new system.
- ☐ **Track progress in implementing new technology for denials management.** Will the intended selection, set up, and training period associated with implementing the tool align with broader ICD-10 readiness, revenue cycle, and HIM goals? Routine project check-in points will need to be communicated across key stakeholders to minimize and manage potential delays.
- ☐ **Quantify the effects of new technology on the efficiency and productivity of coding and the accuracy and completeness of clinical documentation.** Tracking and trending progress against baseline measures and industry targets will help the organization better understand the opportunities of technology and potential to optimize ROI. Leaders will also gain insight into ways the organization's capacity is shifting to meet ICD-10 demands associated with these functions.
- ☐ **View denials from the physician's perspective.** The organization should be able to identify high-dollar or high frequency clinical procedures and services that are most at risk for denial post ICD-10 and commit resources to work with physicians who perform these procedures or services.
- ☐ **Trace and fix issues with denial resolution processes.** Assess communication between the business office and the HIM department about what is happening in relation to current denials, where they are in the process of management, and how effectively they manage when codes have been changed or documentation is amended. Any bottlenecks, poorly managed hand-offs, or workflow inefficiencies will only be amplified with a surge in denials post ICD-10.
- ☐ **Evaluate new technology from vendors.** Is there a work queue or routing system associated with a denial management tool? If not, what is the plan? How will denials be monitored? How will analytics be delivered to revenue cycle team members? How will the system keep denials moving and provide information to payers? How will the system assign and track accountability?
- ☐ **Evaluate the financial reserve as it relates to denials.** How well is the financial reserve sized and utilized? What strategies will need to be put in place to address shifting needs associated with the transition to ICD-10?

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MITIGATING ICD-10-RELATED THREATS TO THE REVENUE CYCLE

Kyle Pak, senior vice president, Optum Insight, discusses key steps financial executives should take to minimize unintended revenue impact after the transition to ICD-10.

Why is ICD-10 an organizational priority, and what key steps should hospitals take to mitigate revenue disruption?

The challenges of ICD-10 were well-worn topics of conversation even before CMS pushed the implementation deadline to October 2014. Now the talk is turning to action.

The highly detailed coding regimen will unlock a new generation of analytics our health system desperately needs. Still, the volume and complexity of ICD-10 carry tremendous risks to productivity and revenue disruption, particularly through the transition.

Regardless of the state of a hospital's ICD-10 preparedness, it is imperative for financial leaders to realize that their revenue cycle is subject to a butterfly effect due to the interconnectedness of the health system. What may appear to be simple changes in coding and revenue processes can drive wide distortions elsewhere.

For example, if records of patient care lack the requisite specificity and supporting documentation, when coded to ICD-10, they may be eligible for only half the reimbursement of the same episodes coded under ICD-9.

Considering the stakes, hospital finance leaders should brace their institutions today to ensure proper documentation, mitigate potential sources for coding errors, and manage the coming flood of claims denials that threaten their missions and commitment to their communities.

Completing the three A's – Assess, Adopt, and Analyze – will help financial leaders stop distortions within their revenue cycle:

- Assess: Identify all potential points of disruption, including how contracted health plans are approaching ICD-10.
- Adopt: Prioritize projects and align resources – from computer-assisted coding implementations to contracting with managed services providers.
- Analyze: Define appropriate measures for input and optimize revenue cycle management processes under ICD-10.

The ICD-10 deadline is drawing near, but it's not too late to adopt practical strategies to identify interdependencies and mitigate risk.

Source: Optum.

Resources Devoted to Coding Support

For effective denials management in the face of the ICD-10 transition, organizations also will need to understand and anticipate shifting needs associated with coding both prior and post go-live.

The demand for skilled medical coders is already high, and it is expected to grow by another 18 percent over the next three years (*Addressing the Demand for Medical Coders*, Medical Coding Task Force, June 2012). What's more, a nationwide shortage of trained and experienced coders is only one problem facing hospitals and health systems' efforts to gear up for ICD-10. Many hospitals also have difficulty fully staffing their coding departments because of tight budgets and inadequate internal support from leadership.

To succeed during the ICD-10 transition, hospitals and health systems will need to find ways to supplement their coding capacity. Many providers will need to invest in training programs and consider hiring additional FTEs, supplementing efforts with external assistance, and raising salaries and/or providing other financial incentives to support recruitment and retention of high-quality coders. Senior leaders will need to ensure resources are allocated to meet the organization's needs accordingly.

Baptist Health South Florida already has senior coders certified in ICD-10. Also, the organization has developed a career ladder that provides incentives and an avenue of advancement to employees who have some background in coding or an interest in pursuing coding as a profession.

Gwinnett Health System has focused much of its efforts on strategic hiring. It has added four coding auditors—more than double its previous staff of three—to spearhead coder training in ICD-10. The healthcare system also has added four new clinical documentation nurses for its documentation integrity team, and it hopes to add six additional coders this year.

At Christiana Care, leaders are focused on ramping up the use of external resources for coding augmentation. "We have a projected timeline for when we think we will need additional coding help—for example, when coders are away training or when they are practicing what they have learned," says Lynahan.

Calculating external coding support needs will be a straightforward process, Lynahan explains: "Coders will spend four days in training, and we will back-fill with coding augmentation until they come back. Then we will assign 20 percent of coding time for practice. So if I have five people in training who spend 20 percent of their time practicing, then I will need one full-time back-fill coding resource to cover that work."

The Future of Denials Management

Effective denials management after the ICD-10 implementation deadline, October 2014, will depend on the organization's ability to demonstrate new levels of documentation and coding efficiency and expertise. Getting there will take intensive planning, investment in technology and human resources, and new levels of understanding about workflows across the revenue cycle.

No matter the size or the strength of existing denials management processes, hospitals and health systems need to pay attention to the four areas discussed to avoid ICD-10 billing and coding backlogs, cash flow interruptions, and substantial revenue loss associated with shifts in numbers and types of claims denials.

Each organization's approach to managing opportunities and challenges in these areas will be different, largely dependent on its service mix, payer environment, financial position, and existing denials management capabilities. However, one thing is certain: The potential impact of ICD-10 implementation on revenue and cash flow as hospitals face this denials management environment of the future demands top-level prioritization.

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