Whole practice must embrace the challenge

The transition to ICD-10-CM is not just a problem for software vendors. I recommend that you:

- Designate an internal staff member, a physician, a small committee or a temporary outside consultant to rally staff and spearhead ICD-10 until it is up and running.
- Schedule training for everyone, including an average of 16 hours for certified coders; the AAPC, AHIMA and ACMCS Web sites are the best sources of online education.
- Locate every piece of paperwork – internal and external – that includes ICD-9 codes and prepare to say goodbye to the "super bill" and other "cheat sheets" and "encounter sheets," which lack the specificity for more granular ICD-10. Maintain old records containing ICD-9 codes for historical purposes and to resolve old claims.
- Streamline all work processes; consider implementing an EHR.
- Schedule downtime for updating hardware and software.
- Analyze your payer mix, factoring the percentage of delinquent payers and set aside in escrow.

Rex Stanley, CEO, Unicor Medical

Important to identify early opportunities to optimize systems

William Shea, AVP and partner, Cognizant Business Consulting

The conversion to ICD-10-CM is more than a simple update; it will bring fundamental structural changes spanning the entire healthcare delivery system. Throughout this transition, the best ways to reduce claims and coding errors will be through early and comprehensive transition planning; effective code mapping and conversion strategies informed by sophisticated analytics designed to achieve financial, benefit and clinical neutrality and equivalence; thorough end-to-end testing; and training.

How effectively and completely payers and providers perform these critical functions will determine to what extent cost benefits outweigh cost liabilities – and how quickly. It will be important to identify early opportunities to optimize systems and processes to minimize claims and coding errors, and to derive real business value from the new codes. Organizations that plan, analyze, test and train effectively will be best positioned to go beyond mere neutralization strategies and adopt a speed-to-value approach that will improve productivity through better claim auto-adjudication and first-pass rates; increase claim payment and provider reimbursement accuracy; reduce miscoded, improper or rejected claims; automate authorizations and referrals for a significantly larger set of procedures; assess risk, profile patient status and manage length of stay through more informed utilization management; and improve revenue cycle performance through enhanced outcomes management and proactively monitoring key indicators.

Viewing the transition as just another IT project will be a lost opportunity to achieve competitive advantage, reveal process improvements and drive value.

Best approach will start with an impact assessment

Rob Culbert, founder and president, Culbert Healthcare Solutions

The best approach will start with an impact assessment before planning, implementation and optimization efforts occur. The assessment should include an inventory of all related clinical and business functions and the IT applications that support them.

After the impact assessment, organizations must undertake separate functional and vendor readiness assessments. With the exception of those using home-grown IT solutions, most groups will need to rely on IT vendors for ICD-10 updates. Do not underestimate the time and effort vendor coordination and testing will entail; it may well be the most challenging aspect of the transition. Develop a testing schedule with payers and/or vendors for each type of EDI transaction before the Oct. 1, 2013 compliance date to ensure that they all process smoothly.

When it comes to billing compliance and coding errors, however, physician documentation and coding training will be key. The training itself should be performed in the months leading up to go-live, but at implementation organizations should plan to conduct real-time monitoring of clinical documentation, coding productivity, claim edits, claim denials and more.

Tracking performance metrics throughout implementation will be central to identifying and curtailing claims problems, coding errors and a number of other potential issues. Metrics also provide an opportunity to go beyond mere implementation. They should act as a catalyst driving the additional training, workflow redesign and system modifications that can help optimize claims and coding performance going forward.