

On October 1, 2015, ICD-10 became effective for all [HIPAA](#)-covered entities. This fact sheet offers providers tips and resources for:

- Assessing your ICD-10 progress using key performance indicators to identify potential issues that could affect productivity or cash flow
- Addressing opportunities for improvement
 - Troubleshooting issues identified during your assessment
 - Deploying tactics like system enhancements and targeted staff training
- Maintaining your progress and keeping up to date on ICD-10

1. ASSESSING YOUR PROGRESS—Key Performance Indicators

Now that you've made the switch to ICD-10, you can look for opportunities to analyze your progress. By tracking and comparing key performance indicators, or KPIs, you can identify and address any issues with productivity, reimbursement, claims submission, and other processes.

Get Started—Establish a Baseline for Each KPI

The first step in using KPIs is to establish a baseline, or a point of comparison, for each KPI you'd like to track. For purposes of assessing your ICD-10 progress, you'll want to compare KPIs from before the October 1, 2015, transition date with KPIs from after the transition date. The pre-transition KPIs will serve as baselines.

Ideally, you either:

- Already have pre-ICD-10 baseline data for some KPIs from your clearinghouse
- Can generate baseline data practice management system, electronic health record, or other health IT system

If you're a provider in a small practice, you might not have routinely used or tracked KPIs in the past, so you may need to start by developing a baseline. Work with your billing and coding staff to see what data are already available in your systems, reports, and records. Check for data available from outside sources like:

- Clearinghouses
- Third-party billers
- System vendors

If you do not already have reports with KPI data for the year before the October 2015 transition, work with your clearinghouse or vendor to pull the data to create a baseline.

Tip: It's best to compare metrics with past calendar years by month. There's some seasonality to statistics, and you will want to take into account local issues (e.g., impact of staff vacations). Keep this in mind when developing baselines.

ICD-10 Compliance Date: **October 1, 2015**

KPIs to Track

Once you have established baselines, compare your metrics pre- and post-October 1, 2015, to put your current KPIs in context. Tracking KPIs can help you detect problems and opportunities for improvement. Once you have identified problems, you can evaluate them to find the root causes and ultimately improve your KPIs. Be sure to reevaluate your KPIs on a regular basis as you refine your processes.

You don't have to track all of these KPIs—some might not be practical or relevant for you. But even small steps to identify and resolve issues can get you on the road to higher productivity and better cash flow.

Tip: Tracking KPIs separately for each payer will assist in isolating the root cause of issues.

- Days to final bill**—number of days from time of service until provider generates and submits claim
- Days to payment**—number of days from time claim is submitted until provider is paid
- Claims acceptance/rejection rates**—percentage of claims accepted/rejected during payer front-end edits (before entering the payer's adjudication system)
 - » Consider using these criteria to gauge potential issues:
 - Agings - 0-30, 31-60, 61-90, 91-120, 121+ days from time of service; track by payer and dollar value
 - Days in accounts receivable, by payer
- Claims denial rate**—percentage of claims accepted into the payer's adjudication system that are denied
 - » Consider keeping separate tallies of authorization and coding denials
- Reimbursement rate**—cents on the dollar provider receives on claim versus amount billed
- Payment amounts**—amounts provider receives for specific services (focus on high-volume, resource-intensive services)
- Coder productivity**—number of medical records coded per hour; review by individual coder
- Volume of coder questions**—number of records coders return to clinicians with requests for more documentation to support proper code selection
- Requests for additional information**—number of requests from payers for additional information required to process claims
- Daily charges/claims**—number of charges or claims submitted per day
- Clearinghouse edits**—number and content of edits required by clearinghouses, or claims accepted/rejected by clearinghouse
- Payer edits**—number and intended meaning of edits required by payers
- Use of ICD-10 codes on prior authorizations and referrals**—number of orders and referrals that include ICD-10 codes
- Incomplete or missing charges**—number of incomplete or missing charges weekly or monthly
- Incomplete or missing diagnosis codes**—number of incomplete or missing ICD-10 diagnosis codes on orders
- Use of unspecified codes**— volume and frequency of unspecified code use
- Return to Provider (RTP)/Fiscal Intermediary Standard System (FISS) Volumes**—number of rejections in Medicare RTP/FISS system
- Medical necessity pass rate**—rate of acceptance of claims with medical necessity content

Hospital Inpatient Services

For hospital inpatient services, **other KPIs to track** include:

- ❑ DNFB—or discharged not final billed, the number or rate of patients who have been discharged without the hospital issuing a final bill; look at the number of claims in DNFB within 30 days of Timely Filing guidelines
- ❑ DRG volumes (by group) under ICD-9 versus ICD-10

Tip: You may see variations in some KPIs such as DRG volumes that are unrelated to the ICD-10 transition. This document focuses on identifying and addressing ICD-10-related issues.

2. ADDRESSING YOUR FINDINGS—Troubleshooting

Develop a Feedback System

- ❑ Create processes for gathering ICD-10 feedback and questions from staff and for sharing insights throughout your organization.
- ❑ Ask your staff about:
 - » Any specific parts of their workflow that are slowed by ICD-10
 - » Areas where more or different tools or training might be helpful
 - » Where they see opportunities for improvement
 - » Which codes are causing the most difficulty
 - » Specific feedback on issues requiring communication with physicians
- ❑ Create an issues list where staff can document new issues in one location as they arise. Track the system or payer with the issue, steps taken to resolve it, and the current status.

Check Clinical Documentation and Code Selection

- ❑ Look at clinical documentation for services provided before and after the October 1, 2015, transition date. Issues with documentation might result from insufficient clinician training on ICD-10 coding concepts and guidelines. Any lag times in responses to coder questions can further affect related KPIs such as days to final bill and rates of claims denied due to lack of medical necessity.
 - » Are there differences in documentation structure or required content?
 - » Are documentation differences driven by providers, by vendor templates, or by payer requirements?
 - » Does the medical record support selection of a specific ICD-10 code?
- ❑ Understand your organization's processes for selecting diagnosis codes and applying coding guidelines. This will help you to identify the sources of issues and to target remediation efforts.
 - » Who selects diagnosis codes? Who ensures that code selection reflects guidelines? Is it clinicians, billers, certified coders, or vendor software?
 - » Be sure to account for all IT systems involved (e.g., practice management systems, electronic health records [EHRs], coding tools). Keep in mind that EHR upgrades from vendors, for example, can have unintended downstream consequences that affect ICD-10.
- ❑ Provide educational resources for your clinicians and coders:
 - » Share official CMS educational resources with clinicians and coders. See the [Provider Resources](#) page of [cms.gov/ICD10](https://www.cms.gov/ICD10).
 - » Review the [Specialty Resources Guide](#) and [Coding and Clinical Documentation Resources](#) to choose resources that best meet your needs.
 - » Take advantage of training and resources available at no or low cost from state and specialty medical societies, health care trade associations, and payers.
 - » Consider tapping accounts receivable staff to track payer issues, educate coders, and work with front office staff to identify and resolve any problems.

- ❑ Identify a physician champion to:
 - » Help understand issues with clinical documentation
 - » Offer advice on the best ways to implement change with physicians when needed
 - » Suggest effective ways to distribute information
 - » Act as a liaison between health information managers, physicians, and CDI

Check for Systems Issues

- ❑ Verify that all your systems are up to date
- ❑ Check for technical problems with your systems
 - » A range of issues, like outdated qualifiers and patient problem lists, could stem from glitches in your practice management systems, electronic health records, or coding tools. Such issues could lead in an increase in days to final bill and in rates of rejected claims.
- ❑ Be sure your system is set to generate:
 - » Only ICD-10 codes and ICD-10 qualifiers for services provided on or after October 1, 2015.
 - » Only ICD-9 codes and ICD-9 qualifiers for services provided before October 1, 2015.
- ❑ Some providers who experience ICD-10 challenges because of system issues could benefit from [contracting with a clearinghouse](#) to process claims.
 - » Clearinghouses cannot help you identify ICD-10 codes to use unless they offer third-party billing/coding services. Even these services cannot translate ICD-9 to ICD-10 codes unless they also have the detailed clinical documentation required to select the right code.
 - » Many clearinghouses continue to offer ICD-10 testing to help resolve post-implementation issues.
- ❑ Work with your vendor to resolve any systems issues affecting productivity.
- ❑ If your EHR system is not fully supporting ICD-10 documentation or code selection, clinicians can group common codes based on the types of patients they see to help expedite the process.

Resolve Any Medicare FFS or Medicaid Issues

- ❑ The [Medicare/Medicaid Provider Contact List](#) can be useful if you are experiencing issues with KPIs that are specific to Medicare Fee-For-Service (FFS) or Medicaid.

Conduct Hospital Chart Audits

If you work in a hospital setting, here are some considerations around chart audits:

- ❑ Select high-risk cases to audit as well as cases for which there is a diagnosis-related group (DRG) shift between ICD-9 and ICD-10 to identify patterns of incorrect coding.
- ❑ Follow the entire flow for each record type—inpatient, outpatient, same-day surgery, emergency department, and recurring accounts—including Medicare and commercial cases.
- ❑ Review surgical procedures that need clusters of codes for accurate reporting (e.g., removal and replacement of joint prosthetics)
- ❑ Review 7th character use for injuries and musculoskeletal conditions (e.g., use of subsequent encounter D code instead of initial encounter A code results in a different DRG)
- ❑ Review high-risk and resource-intensive DRGs to ensure accuracy
- ❑ Review surgical cases to determine if approach is reported correctly

3. MAINTAINING YOUR PROGRESS—Keep your systems and coding resources up to date

- ❑ ICD-10 updates take place annually on October 1, following the same timeline used for ICD-9 updates. Be sure to keep all your systems and coding tools up to date, and to review the [ICD-10-CM](#) and [ICD-10-PCS](#) General Coding Guidelines on a regular basis. With quality reporting and other requirements, it's more important than ever that you update your coding resources at least annually.
- ❑ Led by CMS and CDC, the [ICD-10 Coordination and Maintenance Committee](#) is responsible for updates to ICD-10. [Suggestions for updates to ICD-10 codes](#) can be made during bi-annual [ICD-10 Coordination and Maintenance Committee meetings](#). If you are interested in making recommendations for modifications to ICD-10, please submit them at least two months before a scheduled meeting.