Preparing for the ICD-10 Transition

March 25th, 2014
Introductions

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Agenda

• ICD-10 Overview / Background
• ICD-10 Key Program Components
• ICD-10 Revenue Cycle Impacts
• ICD-10 Assessing/Managing Risk and Progress
Objectives

1. Confirm a baseline understanding of ICD-10 and areas of impact, especially for those that have not been an active part of a program or workgroup to date

2. Review successful ICD-10 program components

3. Understand specific Revenue Cycle impact areas and key activities to mitigate risk

4. Understand strategies to measure progress of ICD-10 program initiatives
ICD-10

General Overview / Background
ICD-10 Background

• 190 days until ICD-10 is here – 10/1/2014
• Applies to all covered entities under HIPAA
• Does not affect CPT coding for OP services and physician services
• One implementation date for all users:
  o Date of service for OP and physician services
  o Date of discharge for hospital claims for inpatient settings
Why ICD-10?

• ICD-9 is over 30 years old
  o Outdated terms
  o Limited in the number of new codes
  o Limited data about patient’s medical conditions and hospital procedures

• United States is the last industrialized nation to adopt ICD-10 (Canada in 2001 is most recent)

• United is only nation to use ICD-10-PCS codes AND the only nation to use ICD codes for reimbursement
ICD-9 vs. ICD-10

More codes = Greater Complexity

ICD-10 Overview / Background

- New Code Format
- New Documentation Requirements
- Translation Challenges
Focusing on the Benefits

• Improved ability to track and respond to international public health trends
• Higher quality information for measuring healthcare service quality, safety, and efficiency
• Greater coding accuracy and specificity
• Recognition of advances in medicine and technology
• Improved efficiencies and lower costs
• Space to accommodate future expansion
• Alignment of the US with coding systems worldwide
Enterprise Wide Impact

Information Systems
- Broad range of impacted systems
- Coordinated testing of all impacted systems/interfaces
- Reporting

Coding
- Training and backfill
- Drop in productivity
- Talent Shortage

Physicians
- Documentation Specificity
- Increase in documentation time, coding queries

Revenue Cycle
- Increase in denials, inquiries, claims adjustments, and audits
- Payer contract renegotiation
- New authorization processes

Finance
- Increase in A/R days
- Impact to cash flow
ICD-10

Key Program Components, Activities
Key Program Components

• Program Structure
• Coding & Clinical Documentation
• Information Systems
• Reporting & Analytics
• Education & Communication
• Revenue Cycle & Finance
Sample Program Structure

ICD-10 Governance Team

Coding
- Coder Education
- Coder Productivity
- Recruitment, retention
- CAC
- Dual Coding
- Ambulatory

Clinical Documentation
- Chart Reviews
- Forms
- CDI
- EHR Workflow
- Quality
- Case Management
- Ambulatory

Reporting Analytics
- Reports inventory
- Prioritization of remediation
- Change Management
- Ambulatory

Information Services
- System upgrades
- Implementations
- Assist with reports remediation
- System and interface testing
- Ambulatory

Education
- Physician Education
- Coder Education
- All other learners
- Learning Management
- Ambulatory

Revenue Cycle/Finance
- Assess workflow impact
- Policies/Procedures
- Payer contracts
- Financial Risk assessments
- KPI’s
- Ambulatory
## HIM/Clinical Documentation

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insufficient Documentation</strong></td>
<td>• Coder certification</td>
</tr>
<tr>
<td>• Coders cannot code</td>
<td>• Physician education</td>
</tr>
<tr>
<td>• Missed reimbursement</td>
<td>• Dual coding</td>
</tr>
<tr>
<td>• Increase in physician queries</td>
<td>• CDI program</td>
</tr>
<tr>
<td>• Compliance/audit risk</td>
<td></td>
</tr>
<tr>
<td><strong>Coder Productivity (AHIMA)</strong></td>
<td></td>
</tr>
<tr>
<td>• 30 – 60% short term impact</td>
<td>• Queries/results</td>
</tr>
<tr>
<td>• 20% permanent impact</td>
<td>• Coding accuracy %</td>
</tr>
<tr>
<td><strong>Physician Productivity (Advisory Board</strong></td>
<td><strong>and Precyse)</strong></td>
</tr>
<tr>
<td>• 10% - 20% permanent impact</td>
<td>• Chart Reviews</td>
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<td></td>
<td><strong>Staffing</strong></td>
</tr>
<tr>
<td></td>
<td>• Backfill &amp; contract coders</td>
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<td></td>
<td>• Retention strategies</td>
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<tr>
<td></td>
<td><strong>Technology</strong></td>
</tr>
<tr>
<td></td>
<td>• Build or enhance EHR templates</td>
</tr>
<tr>
<td></td>
<td>• Computer Assisted Coding</td>
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</tbody>
</table>

ICD-10 Key Program Components
Information Services

- Varying system timelines for upgrades and testing availability
- Implement detailed IS ICD-10 Remediation Plan

<table>
<thead>
<tr>
<th>System Remediation Timeline</th>
<th>Category</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlas Labworks</td>
<td>Clin Doc</td>
<td></td>
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<tr>
<td>Cerner Millennium</td>
<td>Clin Doc</td>
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<tr>
<td>ComputerMart</td>
<td>Rev Cycle</td>
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<tr>
<td>GE Centricity DMS</td>
<td>Clin Doc</td>
<td></td>
</tr>
<tr>
<td>GE Centricity Perioperative Anesthesia</td>
<td>Clin Doc</td>
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<tr>
<td>GE Centricity Perioperative Manager</td>
<td>Clin Doc</td>
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</tr>
<tr>
<td>GE Centricity RIS-IC</td>
<td>Clin Doc</td>
<td></td>
</tr>
<tr>
<td>McKesson Horizon Patient Folder</td>
<td>Coding</td>
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<td>McKesson Horizon Home Care</td>
<td>Clin Doc</td>
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<td>McKesson Series</td>
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<td>MedAssets</td>
<td>Rev Cycle</td>
<td></td>
</tr>
<tr>
<td>Midas Plus</td>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td>Net Health Systems - WoundExpert</td>
<td>Clin Doc</td>
<td></td>
</tr>
<tr>
<td>Occupational Health Research - Systoc</td>
<td>Clin Doc</td>
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<tr>
<td>OptumInsight - eFR</td>
<td>Rev Cycle</td>
<td></td>
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<tr>
<td>QS/1 Data Systems - NRx</td>
<td>Clin Doc</td>
<td></td>
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<tr>
<td>Wellsoft</td>
<td>Clin Doc</td>
<td></td>
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<tr>
<td>3M Coding and Reimbursement System</td>
<td>Coding</td>
<td></td>
</tr>
</tbody>
</table>

Information Services ICD-10 Remediation Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clin Doc</td>
<td></td>
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<tr>
<td>Rev Cycle</td>
<td></td>
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<tr>
<td>Coding</td>
<td></td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
</tr>
</tbody>
</table>

Total Systems: 35
Compliant Systems: 31
Non Compliant Systems: 4

System Remediation Timeline:

- Phase 2: Testing Preparation (Test system builds, unit testing, etc.)
- Phase 2: End to End Testing

ICD-10 Key Program Components

- Varying system timelines for upgrades and testing availability
- Implement detailed IS ICD-10 Remediation Plan
Reporting & Analytics

• Risks:
  • Any report that touches an I-9 code will need to be updated
  • Reports with pre and post 10/1/14 data will require both ICD-9 and ICD-10

• Mitigation:
  • Develop an inventory of reports
  • Prioritize remediation of reports
  • Education for report writers and report requestors
Education

• **Risks:**
  • Diverse education needs
  • Significant effort to develop content

• **Mitigation:**
  • Consider purchasing content
  • Develop strategies to test competency
ICD-10

Impacts to the Revenue Cycle

Initiatives addressing today’s inefficient processes will be key to the readiness of the Revenue Cycle for ICD-10
Patient Access functions will be touched more significantly than many realize; education and training around authorization and medical necessity will be key.

**Take Action**

- Ensure physician order, scheduling, and registration processes and systems store chief complaints in code format, consistently, with no free text
  - Codes must provide the proper level of specificity
- Establish a strict Scheduling Minimum Data Set (MDS) policy that includes ICD codes **AND** descriptions
- Formalize communication process around missing or incorrect ICD codes (i.e., when a I-10 code is provided but an I-9 code is needed)
- Support staff must be:
  - Trained to understand basic anatomy and physiology
  - Educated on the changes in ICD-10 coding procedures

Communication to physician offices and scheduling departments will increase significantly as physicians and patient access staff get trained on the expanded code set.
Diagnosis codes play a key role in the approval of prior authorization requests; a substantial increase in the number of codes presents multiple challenges for providers and payers.

**Take Action**

- Ensure that support staff receive general ICD-10 training including basic anatomy and physiology.
- Discuss timing and procedure for beginning to authorize dates of service past October 1, 2014.
- Establish an ‘add-on’ policy which limits cases requiring last minute authorizations.
- Create job aids and cheat sheets to help staff track procedures that require authorizations.
- Assemble an “ICD-10 Pre-Cert/Auth Group” to keep up with any changes to payer rules around authorizations.

Due to the increase in code volume, more procedures will require authorization. Providers & payers will have to train their employees on the new procedures (i.e., C-section), which might require prior authorizations.
Added complexity in the authorization process will require increased involvement from clinical resources for retro or extended authorizations.

**Take Action**

- Utilization review staff will need clinical level, GEMS, and ICD-10 education.
- Tightly monitor physician documentation to ensure medical necessity, appropriateness of care, and proper authorization is obtained for completed procedures.
- Payers will focus more heavily on clinical documentation during the appeals process, therefore CM/UR will be required to get more involved in the denials management process.

As payers request more detailed documentation to support diagnosis, Case Management & Utilization Review staff will pay a critical role in the revenue cycle.
Edits within the billing scrubber which reference ICD-9 codes will need to be updated to the appropriate ICD-10 code, but many codes do not have an easy one-to-one match. Given the high number of codes being added, it is likely many new edits will need to be created.

**Take Action**

- Communicate with payers and your clearinghouse; participate in other forums to understand payer state of readiness
- Establish a plan for functional and integrated testing to ensure claims are interfacing properly with both the billing scrubber and clearinghouse
- Complete staffing analysis to understand implications of increase in billing edits; increase in billing edits may require additional staff or increased automation

Centers of Medicare & Medicaid Services (CMS) predicts claims error rates will reach a high of 6% to 10% in comparison with the average 3% error rate with ICD-9.
Claim Follow-up

Implementing a denials management system which takes advantage of automation, collection workflow, and robust reporting will help organizations track and manage the additional volume of denied claims.

Take Action

- Develop strategies to drive billing work-in-process (WIP) buckets as low as possible prior to implementation.
- Deploy stratification principles during AR follow-up focus on the right accounts at the right time.
- Focus on reducing denials and streamlining denials processing as much as possible in advance of October 1, 2014.
- Complete a staffing analysis to understand implications of increased denials.

- According to CMS, denial rates could increase by 100% to 200% post-implementation.
- The turnaround time for claims processing could be extended an additional 10-20 days.
- CMS will adjust ADR (Additional Documentation Requests) limits in accordance with denial volumes.
Key Performance Indicators

Access Management

• Capture the percent of claims requiring medical review by provider, type of claim, and the average turnaround time for each impacted claim
• Consider implementing a robust denials management system to:
  o Track/Monitor authorization denials by denial code, payer, plan code, etc.
  o Communicate denial information to ancillary departments

Reimbursement Management

• Track DNFB associated with coding completed but claim rejected during the billing editing process (e.g. invalid diagnosis code, missing data element, or inaccurate payer designator)
• Track and monitor agings by payer and plan code to understand delays in cash
• Track and monitor AR days by payer and plan code
• Track and monitor clean claim rates

Reimbursement Management

• Implement a monthly Denials Task Force which reviews trends in denials metrics and develops remediation efforts for process breakdowns
• Track and monitor RAC/MIC audit volumes
• Monitor write-offs for spikes in populations effected by ICD-10
ICD-10
Assessing / Managing Risk and Progress
Assessing Financial Risk

Risk Identification
- What are the different operational and financial risks that could occur as a result of ICD-10?

Risk Assessment
- What is the magnitude if the risk occurs (severity)?
- What is the likelihood of occurrence?
- What level of control does the organization have to prevent this risk?

Financial Assessment
- Has the industry projected the potential magnitude of impact?
- What are the best metrics we can use to quantify the potential financial impacts?
- What does our organization’s financial impact look like based on real data inputs?
## Example ICD-10 Risk Matrix

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Risk Assessment</th>
<th>Financial Assessment</th>
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<tbody>
<tr>
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<tr>
<td></td>
<td>Risk Likelihood</td>
<td>Risk Severity</td>
<td>Overall Risk Weight</td>
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<tr>
<td>1</td>
<td>Payer Readiness/Claims Adjudication Delays</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2</td>
<td>Increase in claims denials</td>
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<td>3</td>
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<td>3</td>
<td>Unexpected/reduced reimbursement</td>
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<td>4</td>
<td>Increase in payer scrutiny/audits</td>
<td>3</td>
<td>3</td>
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<tr>
<td>5</td>
<td>Impact to quality reporting/incentives</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6</td>
<td>Physician Documentation</td>
<td>4</td>
<td>5</td>
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<tr>
<td>7</td>
<td>Coder Productivity</td>
<td>4</td>
<td>5</td>
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<tr>
<td>8</td>
<td>Coder Readiness</td>
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<td>5</td>
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<tr>
<td>9</td>
<td>Vendor/Vidant system readiness</td>
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<td>5</td>
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### Legend:

- **Overall Risk Weight** is calculated by multiplying the likelihood and the severity. The higher the number, the greater the risk.

- **Control Level Description**:
  1. Essentially avoidable through selected risk mitigation actions
  2. Highly controllable through organization or program actions
  3. Moderately controllable through organization or program actions
  4. Largely uncontrollable by the organization or program actions
  5. Uncontrollable by the organization or program actions

- **Control Level**:
  1 = Low
  2 = Low/Moderate
  3 = Moderate
  4 = Moderate/High
  5 = High
Measuring Status of Workgroup Initiatives

Why is developing workgroup scorecards important?

• Crucial to track how workgroup initiatives are progressing against timelines and budgets
• Escalate any initiatives that are behind schedule and/or over budget
• Share status with executive leadership and other key stakeholders for appropriate collaboration on any reprioritization and/or risk mitigation tactics
## Overall Workgroup Scorecard Example

<table>
<thead>
<tr>
<th>Team</th>
<th>Team Lead</th>
<th>Exec Sponsor</th>
<th>Overall Team Status</th>
<th>Major Activities</th>
</tr>
</thead>
</table>
| Coding                        |           |              | On Track            | • Coder training remains on track. Auditors have completed training; beginning to practice on 10-coded charts  
|                               |           |              |                     | • Actus CAC upgrade on track for 2/24 go-live (required for dual coding)          |
| CDI                           |           |              | Needs Attention     | • Jvion (financial risk assessment) draft reports to be delivered week of 2/3 with final report due the week of 2/17.  
|                               |           |              |                     | • Charts being selected from highest volume and at-risk codes and DRG’s          |
| Revenue Cycle                 |           |              | Needs Attention     | • Letters have been sent to our largest payers to attend a discussion on readiness and contract amendments for I-10. Expect meetings to be scheduled in Feb, March.  
|                               |           |              |                     | • Rev Cycle sub teams (reg, pre-auth, charging, auditing, billing) re-engaging at next team meeting on 2/18.          |
| Reporting & Analytics         |           |              | Needs Attention     | • Goal is to have all existing I-10 reports inventoried by the end of February |
| IS                            |           |              | Needs Attention     | • Current focus is solidifying upgrade timelines for remaining systems and developing a timeline for integrated testing |
| Education                     |           |              | Needs Attention     | • All impacted learners identified and education plan developed, still finalizing timelines.  
|                               |           |              |                     | • Addressing slow adoption rate of physician training rollout.  
|                               |           |              |                     | • Addressing education and communication needs for IS                            |
What can be done right now to prepare?

- Educate and communicate to physicians
  - Educate physicians on ICD-10 documentation requirements
  - Prioritize by highest volume and/risk diagnosis codes, if possible
- Educate and certify coders
  - Educate and test coders on ICD-10 competency
- Ensure system readiness
  - Inventory systems/applications/interfaces and plan for any that will not be ready for ICD-10
- Test with payers
  - Survey all payers, implement workflow adjustments for any that will not be ready
  - Ask to be included in any testing plans
- Create interdisciplinary ICD-10 Steering Committee
Questions / Open Discussion
Contact Information

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ICD-10

Appendix Slides
Things to think about...

Which Changes are Temporary versus Permanent?

• How are my staff impacted by this change?
  o Do we input ICD-9 codes today?
  o Do we input diagnoses that are converted to ICD-9 codes?
  o Is there a lookup or a pick list for admitting diagnosis or chief complaint? What will it look like under ICD-10?

• What systems need to be updated?
• Which processes will need to change?
• Will productivity be impacted?
• Are there policies that are impacted?
• Do we have any forms that have ICD-9 codes?
• Are there cheat sheets utilized in these areas?
• Do we run reports that require us to identify diagnoses or procedures?
**Example Education Dashboard**

**License Usage**
- 62% have been utilized.

**Users Started**
- 14% of users have started.

**License Usage Distribution**
- No change since Nov.

**User Engagement**
*(based on users that have began training)*

<table>
<thead>
<tr>
<th>User Type</th>
<th>Engagement Rate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (IP/OP/ED)</td>
<td>0.4% of 1840</td>
<td>↑</td>
</tr>
<tr>
<td>Physicians (Owned Phys. Group)</td>
<td>3% of 291</td>
<td>↑</td>
</tr>
<tr>
<td>Coders (IP/OP/ED)</td>
<td>90% of 111</td>
<td>↔</td>
</tr>
<tr>
<td>Coders (Owned Phys. Group)</td>
<td>76% of 33</td>
<td>↔</td>
</tr>
<tr>
<td>All Other Users (IP/OP/ED)</td>
<td>27% of 481</td>
<td>↑</td>
</tr>
<tr>
<td>All Other Users (Owned Phys. Group)</td>
<td>24% of 690</td>
<td>↑</td>
</tr>
</tbody>
</table>

*Example data used for illustration purposes*
Example HIM/Clinical Dashboard

HIM Hospital Coder Staffing & Super Users

HIM Hospital Coder Contract / Backfill Spend

Hospital Coder Queries & Coding Accuracy

Case Mix

*Example data used for illustration purposes
# Example IS Dashboard

<table>
<thead>
<tr>
<th>Build Team</th>
<th>Target Date</th>
<th>% Complete</th>
<th>Status</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIT</td>
<td>9/20/13</td>
<td>100%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Hospital Billing</td>
<td>9/25/13</td>
<td>100%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Interfaces</td>
<td>10/7/13</td>
<td>100%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>ASAP</td>
<td>10/11/13</td>
<td>100%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Ambulatory EHR</td>
<td>12/31/13</td>
<td>89%</td>
<td>●</td>
<td>↑</td>
</tr>
<tr>
<td>Professional Billing</td>
<td>12/31/13</td>
<td>80%</td>
<td>●</td>
<td>↑</td>
</tr>
<tr>
<td>Clin Doc</td>
<td>12/31/13</td>
<td>46%</td>
<td>●</td>
<td>↓</td>
</tr>
<tr>
<td>Orders</td>
<td>1/31/14</td>
<td>44%</td>
<td>●</td>
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</table>

<table>
<thead>
<tr>
<th>Decision Support</th>
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</thead>
<tbody>
<tr>
<td>WebFOCUS</td>
<td>3/14/14</td>
<td>37%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Crystal Reports</td>
<td>3/14/14</td>
<td>6%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Reporting Workbench</td>
<td>3/14/14</td>
<td>0%</td>
<td>●</td>
<td>↔</td>
</tr>
<tr>
<td>Batch Interfaces</td>
<td>TBD</td>
<td>NS</td>
<td>●</td>
<td>↔</td>
</tr>
</tbody>
</table>

**Status Legend:**

- All of the activity is on track.  
- Part or all activity delayed or behind schedule.  
- Critical milestone is delayed/at risk.  
- Activity or target dates to be determined.

**Change Legend:**

- No change in % complete.  
- Increase in % complete.  
- Decrease in % complete.
Sample Revenue Cycle Dashboard

Patient Access Training

Patient Financial Services Training

Procedures Scheduled Post ICD-10

KPI Development Tracking

<table>
<thead>
<tr>
<th>KPI</th>
<th>Status</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR Days by Payer</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Denial Volumes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- By Denial Type</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>- By Payer</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Clean Claim Rate</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Physician Query Volumes</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>DNFB by Area</td>
<td></td>
<td>75%</td>
</tr>
</tbody>
</table>
Financial Risk Assessment

- Resources are limited during this time of massive change for organizations.
- Completing a Financial Risk Analysis enables the organization to focus training and improvement efforts to areas of highest potential impact.

Examples from Jvion, LLC

ICD-10: Assessing / Managing Risk
Helpful resources

• CMS ICD-10 Website:
t=/icd10

• CMS ICD-10 website for physician practices (New):
  • http://www.roadto10.org/

• WEDI White Paper on ICD-10 Critical Metrics:
  • http://www.wedi.org/docs/resources/wedi_impact_assessment_ swg_white_paper_icd10_metrics_revised_111412-pdf.pdf?Status=Master

• HIMSS ICD-10 Playbook:
  • http://www.himss.org/library/icd- 10/playbook?navItemNumber=13480

• AHIMA ICD-10 Playbook:
  • http://www.ahima.org/topics/icd10