hfma arizona chapter
healthcare financial management association

GO BEYOND

Quick Links

To see chapter event photos, Spring Conference posted!
http://www.azhfma.org/events_gallery.cfm

Sponsors are the "Secret Sauce" of the Arizona HFMA Chapter

Matt Cox, Sponsorship Chair

Throughout my career I have had the opportunity to participate in several HFMA Chapters. The Arizona Chapter is unique and provides some of the best educational events available in the Nation. What is the "Secret Sauce" that makes these educational events exceptional AND

(Continued on page 5)

Inside

October 2015

Cactus Clarion

2/2015-16

President's Message

Mike Kennedy

Well, the biggest news is ICD-10 went live on October 1. This event has been compared with Y2K. Everyone knew it was coming and, hopefully, took the necessary steps to make the transition as smooth as possible. Aside from ICD-10, this chapter year is shaping up to be an exciting one.

In August, we had our HFMA Region 10 Conference in beautiful Colorado Springs. We had excellent speakers, interesting topics, and a country western theme night complete with a band and a cowboy chow buffet set against the picturesque backdrop of the Rocky

(Continued on page 2)

Community Questions Proposed AHCCCS Care Program

The Hertel Report

Gov. Doug Ducey is looking to move Arizona's expanded Medicaid program in a more conservative direction, proposing work requirements, copays, HSAs and a five-year limit on benefits.

Called AHCCCS Care, Ducey's plan was recently discussed at several community meetings, where it met great resistance from attendees, who fear it will decrease access to care.

(Continued on page 3)

(President's Message continued from page 1)

Mountains. On September 3, we had Senator Jeff Flake speak to us about the direction and the challenges the U.S. Senate is facing regarding Healthcare and the Affordable Care Act. Additionally, Senator Flake told us a little about himself and his adventures as a survivalist. On September 23 - 25, we had our annual Fall Conference. For those who were not able to attend, the conference was held at the El Conquistador Hotel in Tucson. Our Keynote speaker was Amy Van Dyken, winner of 6 gold medals in swimming. Amy gave an amazing and inspirational presentation. She detailed her struggles to become the first female to win four gold medals in the history of the Olympics and how four years later, she won two more. She went on to describe how a freak ATV accident in Show Low, Arizona, ended her swimming career and left her a paraplegic. Yet despite that, she has an incredible sprit and a determination to overcome all obstacles. She received one of the longest standing ovations I have ever seen at a conference. The motivation didn't stop there. Through humor and insight, Jeff Johnson once again taught us how to "Be Incredible". And to close us out, we had a line-up of timely and immediately actionable educational topics.

Our next conference will be in Scottsdale, April 20 -22. Our theme is Survivor. This will be a fun way to highlight just how difficult it is to navigate the challenges in healthcare. We are all survivor experts of: ACA, ICD-10, system conversions, mergers and acquisitions, and countless others. So breakout your camo gear and see if you have what it takes to be the Ultimate Survivor!

Also, we have our annual HERe Event coming up on November 6. This women's conference has grown every year and 2015 is no exception. To find out more about what is happening in the Chapter, join our Facebook group page and our LinkedIn group page.

In closing, I would like to thank all the Board Members who have been working diligently to make this chapter a valuable resource for you, our amazing members. As we approach the holiday season I think about this quote:

> Balance, peace, and joy are the fruit of a successful life. It starts with recognizing your talents and finding ways to serve others by using them.
> Thomas Kinkade

As busy as we get, remember it's family and friends who bring peace and joy to our lives, not the reports and the meetings that often define our jobs.

I wish everyone a happy and joyful holiday season.

Events

Visit www.azhfma.org for more details

November 5

BKD CPAs & Advisors co-sponsor:
Webinar: What Just Happened to the EMR Program?

November 6th

3rd Annual HERe Event

November 10th

AzMGMA co-sponsor:
AHCCCS Update, Tucson

November 12th

WAHE Networking Event

November 18th

AHCCCS Update, Phoenix

Program Update

Jason Metcalf, FHFMA, Program Chair

The Program Committee finished the Fall Conference at the El Conquistador in Tucson on September 23-25th. Amy Van Dyken was our keynote, and her story was inspiring to all. If you didn't make it you really did miss a great speaker.

The Spring Conference will be on April 20-22 in Scottsdale. Our theme is going to be "Survivor." We have all been through ICD-10, system conversions, and other changes this year. It is time to celebrate our survival and talk about future survival strategies. We are still working on our keynote, but I can assure it will be applicable for future preservation. Of course, we will be delivering relevant educational content based on the member pulse survey, responses from the last conference, as well as local, and national updates as customary.

As a chapter we are still working with other organizations to bring about the "Super Conference" in the Fall of 2016. The vision is to have more collaboration with AHIMA, AHE, HIMSS, MGMA, etc. Each of our organizations has educational content that is helpful for all of us to share, so we will be scheduling a collaborative conference to meet that need.

Happy Holidays and Happy New Year if I don't see you before then!!

(The Hertel Report Community Questions Proposed AHCCCS care program continued from page 1)

The proposed changes could impact 350,000 adults eligible for the Arizona Health Care Cost Containment System (AHCCCS).

Ducey says the program, which includes something similar to a health savings account, allows Arizonans to "take charge of their own health" and rewards personal responsibility. Contributions to AHCCCS Care accounts could be used for services not currently covered by Medicaid, including dental, vision, weight loss and more.

The state's plan to modify its Medicaid program will be submitted by AHCCCS as a waiver request to CMS this fall.

The most controversial provisions of the program, and the least likely to gain federal approval, are the maximum five year lifetime limit on benefits and the work requirement. At least 10 other GOP-dominated states are seeking to tie Medicaid to work.

Adults enrolled in the program would be responsible for:
Co-pays of up to 3 percent of their household income for
- Non-emergency use of ER
- Missed appointments
- Visiting a specialist before seeing a PCP
- Prescribed opioids

Paying 2 percent of their income into an HSA for uncovered medical, dental or vision
Actively pursuing employment
Meeting specified health goals

Attendees expressed concern that some people are deemed able-bodied but due to mental illness, disability or other reasons, are very limited in what they can do for work.

Cost sharing was another point of contention, with attendees questioning whether this population can support even modest payments. The program, for example, would require an individual earning about $15,500 a year in income to pay a monthly premium of about $26.

In the next year, AHCCCS will work with CMS to negotiate the terms of the next waiver. AHCCCS will consider public comments received by Sept. 25 for its final proposal to CMS.

The Hertel Report
www.thehertelreport.com

Leadership: Developing your Revenue Cycle Team for ICD-10

Laura Legg, RHIT, CCS, Healthcare Resource Group

At the AHIMA National Convention in New Orleans last month, there was definitely excitement in the air as we moved into the October 1, 2015, date to begin using the ICD-10 coding system. Remember the song by Barry Manilow "Looks Like We Made It"? That was the feeling among gatherers at the Clinical Coding Meeting.

Our journey here was discussed in many ways: someone said, "it feels like Christmas is 4 days away" and another said, "it is just like giving birth". Without a doubt, and no matter how you are feeling, it has been a long journey. However, keep in mind that the work has just begun. We've gotten through the go-live and the submission of the first claims. Now we are waiting for the next big thing to happen and to see what it might be.

Many predictions have been made as to what the future holds; communication will be key. How are you developing your coding team for ICD-10 challenges? HIM Leaders at Health Resource Group in Spokane, WA, are gearing up in the following areas:

- **Motivation:** Every good leader knows that motivation is key to employee performance, productivity, and having the optimal office culture. Leaders must set a good example. Remember, your attitude is contagious. If you meet the challenges of ICD-10 with an attitude of "we can do it," most of your staff will too. Your positive attitude will make your staff feel needed, appreciated, and valued. If you find yourself in a position where your staff are trying to correct your attitude, you have some work to do. You are the "engine" that drives the direction of your staff.

- **Education:** The education phase of ICD-10 has just begun. The first 14 days have shown us that there is some confusion out there in areas where ICD-10 differs from ICD-9. Seventh character assignment confusion has surfaced regarding initial and subsequent encounters, specifically, between coding systems: CPT vs. ICD-10 PCS and when to use each system. For coding staff, the code categories that produced a lot of questions in ICD-9 will continue to create coding questions in ICD-10. Education sessions, brown bag luncheons, and coding roundtables will be essential to foster continued learning. Healthcare Resource Group recently surveyed their coding team to learn which areas they felt required further education and clarification in ICD-10. Among the top answers were:

    1. Use of seventh character
    2. Fracture coding
    3. Obstetrics coding
    4. Myocardial infarctions
    5. Cerebrovascular accidents

- **Auditing and key performance indicators:** Increased risk for audit comes along with the new coding system. Payers have been very clear that they will no longer accept ICD-9 codes on claims. Monthly auditing is the only way to be confident that your coding staff is assigning the correct ICD-10 codes. Defending our coding choices with payers is just around the corner. Don't let the quiet opening act of ICD-10 trick you into thinking that payers won't be auditing and challenging the codes you are submitting on claims.

  Audit each coder monthly, tracking trends, and circle back with education to meet those challenges. As the industry learns more about ICD-10 codes, be sure that your staff is kept informed. One of the best ways to do this is to make sure coders are reviewing the American Hospital Association's Coding Clinic each quarter. There are some surprising answers surfacing from the ICD-10 coding questions submitted. Among them is the change for coding diabetes mellitus and osteomyelitis. ICD-9 CM allowed the coder to assume a relationship between diabetes mellitus and osteomyelitis. However, Coding Clinic, Fourth Quarter 2013, page 114 instructs coders that ICD-10-CM does not pre-

(Continued on page 6)

Banner, Intel Can't Reach Deal for Connected Care

The Hertel Report

Despite communicating with providers about its participation in a new plan serving Intel employees, Banner Health Network now says it will not be part of Intel's Connected Care program for the Phoenix area in 2016.

"We continue to have a great deal of appreciation for Intel's vision of 'having the healthiest workplace on the planet' and their commitment to seeking the highest level of health care for their employees and dependents," said Banner spokeswoman Jennifer Ruble. "Unfortunately, we were unable to reach contract agreement for the coming year."

Intel would not provide additional details about the plan before its employees receive open enrollment information, but the company says the program, which includes contracting directly with providers, is still moving forward.

Todd Ricotta, executive director of operations for the Arizona Care Network (ACN), said ACN intends to participate in Connected Care and continues to work towards a Jan. 1 launch.

Connected Care is designed to improve quality, convenience and employees' experiences, while also decreasing costs. It is built on the patient-centered medical home model, where a team of professionals led by the primary care physician provides coordinated care.

Intel's program could be a big boon for participating providers. In Portland, Oregon, more than one-third of Intel employees chose Connected Care this year.

Intel has 11,000 employees and 19,000 dependents in the Phoenix area.

The Hertel Report
www.thehertelreport.com

(Sponsorship Update continued from page 1)

affordable? The answer is simple... Sponsors and Exhibitors!

The Arizona Chapter has a long history of successful partnerships with Sponsors and Exhibitors. Being new to my role as the Sponsorship Co-Chair, the recent Fall Conference in Tucson was my first opportunity to see first-hand what a well-oiled machine the sponsorship process is at the Arizona HFMA Chapter. From reminder emails to helping explain the sponsorship and exhibitor opportunities, the Sponsorship Committee helped secure enough sponsors and exhibitors to make the Fall Conference a financially viable event. I would like to thank the Sponsorship Committee, Sponsors and Exhibitors for making the Fall Conference a success. Not only do our Sponsors and Exhibitors make our conferences financially viable, they make them more fun. For example, the Fall Conference sponsors provided entertainment, food & prizes.

With the upcoming Spring Conference there are always opportunities for Sponsors and Exhibitors to continue providing the "Secret Sauce". Watch your email for how you can participate in the Spring Conference!

Matthew E. Cox
CFO Dignity Health Arizona
Sponsorship Chair
AZ Chapter HFMA

Using Analytics to Improve Patient Revenue

Carrie Romandine, VP of Solutions and Services, Apex Revenue Technologies

Patients are now responsible for hundreds of billions of dollars formerly paid to healthcare providers by institutional payers. Struggling to collect, many providers are applying analytical tools to improve the average yield from each patient statement while maintaining positive patient relationships.

In this article, we'll discuss six foundational metrics to track. By carefully monitoring these variables, healthcare providers can conduct controlled experiments to optimize results. But first, what are the preconditions for making this type of patient revenue cycle analytics successful?

To the extent possible, integrating systems and processes is an important preliminary step toward streamlining access to the financial performance data you need to measure results. In our experience, providers will not only experience significant initial improvements in financial results by integrating their patient revenue cycle tools, they will also establish the data framework they need for a clear view of which strategies are having the most positive impact on revenue and cost performance.

These preliminary steps often involve the electronic health records (EHR) system, patient billing platforms, online payment systems, patient portals, and financial communication tools used by patient-

(Continued on page 7)

(Leadership continued from page 4)

sume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.

A lot of metrics are going to change following October 1, 2015, and they will likely be influenced by many processes in your revenue cycle. What are the new coding productivity standards for coding? At this point no one knows, but you want to be watching the productivity of your coding team, weekly. Watch for improvement and growth. Be patient and give coders time to adjust to the many changes. Keep quality foremost in the minds of your team members, and have an ICD-10 expert available to do research and answer coding questions. We all strive for coding quality of 95% accuracy and above. It remains to be seen what the first quality numbers will be in ICD-10.

- **Feedback from/to coding staff:** Provide a mechanism by which coders have an opportunity to note any additional issues specific to the coding process and the work they are doing. This can be a valuable tool for identifying problems with the coding process and/or systems.

  Create positive experiences while giving feedback to your staff. Focus on answering questions and having resources available. Coders need to feel confident that you will provide the education, feedback and support they need to continue the journey of learning ICD-10. Building their confidence and leading them to become experts in the coding workplace will benefit all involved.

- **Communication:** Collaborative relationships may be key to keeping those coders with you as the offers and sign on bonuses circle the HIM job boards. It will be difficult to leave a position where you have a good relationship with your manager and you have confidence that they will provide you with what you need to keep moving forward while learning the ICD-10 coding system. Coding leadership success will be more closely linked to the collaborative relationships that are forged by coding professionals than to the technical expertise they impart. Although both technical expertise and the ability to manage oneself in relationships are needed, expertise without solid, open and honest relationships often fails to result in becoming part of decision-making and finding a place at the leadership table.

Laura Legg, RHIT, CCS
AHIMA approved ICD-10 CM/PCS Trainer
Director of Consulting and Education
Healthcare Resource Group

Welcome New and Transferred Members

Since July 2015

David A. Amos *(transfer from So CA)*
Director of Patient Financial Services
Kingman Regional Medical Center

Jennifer Crawford, CRCR

Somer Goss
Senior Consultant
Price Fass & Company LLC

Casey Hancock
Health Choice

Mike Herth
Keyser

Brandee Kalandyk
Manager - Assurance
Ernst & Young

Sandra Krause
Chief Financial Officer
Pioneer Health Group

Matthew C Langley
Honorhealth

Missy Landaker
Revenue Cycle Specialist
IntegraMed Fertility

Jenny Lewis
Ernst & Young

Jaime Limon
Supervisor
Integrated Health Management Services, LLC

Joanne Paolini
Director National Contracts

Meg Phillips
PFS System Manager
HonorHealth

Leslie Rowans
Decision Support/Process Improvement Manager
North Valley Surgery Center

Mark Charles Thomas
Chief Financial Officer
Cranial Technologies Inc

Cheryl A. Tong *(transfer from So CA)*
Chief Financial Officer
Banner Desert Medical Center/Cardon Children's Medical Center

Chrysynthia M Wilson
Accounts Receivable Manager
Fort Defiance Indian Hospital Board, Inc.

Teresa Wollgast
General Manager & CFO
Arizona Medical Infusion

Claire Zimmerman
Sr. Business Analyst, Clinical Transformation
UnitedHealth Group

(Analytics continued from page 6)

access personnel and call center staff. These early results can serve – in an encouraging way – to bring further institutional focus on meeting patient revenue challenges by analyzing revenue cycle data as a means to improve results.

For example, one large Southeastern health system experienced a $77 million reduction in cash collected from patients from one year to the next, together with an increase in bad debt and charity care from 29 percent of net patient revenues to 38 percent. These figures represented a severe decline in the health system's ability to collect cash from patients. The provider's revenue cycle team worked to streamline systems while adding flexibility. By integrating the way their billing and payment tools worked together, they were able to increase collection yield and lower billing-related costs.

Specifically, in the first six months after implementation, this Southeastern health system experienced a 10 percent improvement in collection yield, due to both e-payment increases and improved statement performance, which equated to an annualized increase of $1.3 million. They also saw a 10 percent de-

(Continued on page 10)

Membership

Leslie Flake, Membership Committee Chair

AZ HFMA Membership committee recently sent out a survey to assess current needs of our members and would like to thank all who participated! We greatly value your feedback and have updated our Stoplight Report detailing action plans based on your comments. Our initial survey was sent out a year ago and we were able to implement action plans this past year based on this survey.

The three main areas that received the most feedback were Networking, Communications and Program Topics. See below for a list of the past year's accomplishments:

- Chapter Networking Activities:
  - Interactive sessions at conferences
  - Networking evening at conferences
  - Happy Hours
  - HERe ~ Women's Event

- Improve Member Communication:
  - HFMA committee involvement opportunities
    - All committees and a brief summary of objectives are listed on the website including a link for becoming involved.
  - Communications committee has been expanded
  - Implemented & actively manage website & social media (Linked In, Facebook)
  - Events posted on HFMA website & Facebook page

- Educational topics addressed at chapter programs:
  - Spring and Fall Conference Content:
    - ICD-10
    - Healthcare reform/ACA/Risk management
    - Legislative activity/ Medicare/ Medicaid
  - Washington Update with Senator Jeff Flake

We are now focusing on the Stoplight Report on the next page based on your feedback from last month's survey.

We look forward to continuing to provide valuable content and networking opportunities this coming year! Please encourage all friends/colleagues who you feel would benefit from AZ HFMA to join us.

Leslie Flake
Chair, Membership Committee
leslie.flake@bannerhealth.com
602-747-3950

STOPLIGHT REPORT

Member Satisfaction (TEAM)

9/21/2015 (DATE)

GREEN / COMPLETE:	YELLOW / IN PROGRESS:	RED / CANNOT COMPLETE AT THIS TIME AND HERE'S WHY:
Increase Networking Opportunities: • Town Hall breakfast with Senator Jeff Flake • Networking at events - Thursday evening Fall Conference • Events: - Arizona Healthcare Executives (AHE) Networking Events - HERe ~ 3rd Annual Women's Event Nov 6, 2015 Improve Member Communication: • Expand communications committee • Facebook • Linkedin • HFMA committee involvement opportunities: - All committees with a brief summary of objectives are listed on the website including a link to become involved. Improve Programing Content: • Fall conference content: - ICD-10 - Healthcare reform/ACA/Risk management - Legislative activity/ Medicare/ Medicaid Continue: • Networking, Conferences, Webinars, Events, Communication	Increase Networking Opportunities: • Happy hours - Communicated via Facebook & Website • Breakfasts • Improve Provider attendance Improve Member Communication: • Implement & actively manage social media (Linked In, Facebook, etc.) Improve Programing Content: • Healthcare reform/ACA/Bundled payments • Legislative activity/Medicare/Medicaid • EMR/Technology • Interactive sessions: - CMO & CFO Panel - Physician Finance Roundtable - Telemedicine Roundtable	

(Analytics continued from page 7)

crease in statement costs, due to an overall decrease in the number of paper statements sent and the average number of cycles in which collection is required.

Once this kind of foundation is in place to provide visibility into the impact billing communications has on payment results, patient revenue cycle analytics becomes most useful. A flexible communication platform is also key, allowing a provider to use the messages within the various billing channels to get the right message to the right patients at the right time. Providers can apply "flexible logic" in the production of statements, eStatements, payment portals, etc., so that patient-relevant messages about payment plans, other payment options, and online payment portals are most likely to have an impact. In addition to taking into account the age of the patient's balance, the healthcare provider can optimize statements based on factors such as: balance due amount, payment plan status, prompt pay offerings, ZIP code, and other demographic information.

As a specific example, the statement message area could be dedicated to alerting the recipient to the availability of payment plans on statements with relatively high balances due. For lower balances, that message area could instead emphasize the availability of an online payment portal.

Analytics reveals the results of this type of fine-tuning. The revenue cycle team can review dashboard reports, identify challenges and opportunities, and continually optimize messaging, segmentation, channel communication strategies, and process changes based on results.

When implementing segmented messages and other patient-specific approaches, it's essential to measure the "before" and the "after." The key to continued progress is to analyze key variables that drive success, which brings us to the six recommended foundational metrics:

1. Cash collected

What's pivotal to patient cash success is measuring cash collections from different angles. Patient cash aging buckets and collection aging buckets will highlight trends and successes in patient billing practices, and patterns in overall cash collected. This provides insight into areas of challenge and opportunity in patient billing and collections versus normal business cycles.

Establishing overall patient financial success in terms of the dollars collected, and dollars collected as a percentage of total dollars billed, is integral. The former may be impacted based on changes in patient volumes, payer mix, and the average value of services provided, and should be benchmarked as such.

2. Statement billing costs

Perhaps the most clear and simple indicator of payment performance is volume-based reduction in your statement print costs. Lackluster eStatement adoption and ePayment performance falls short in offsetting more costly printed communications. And slow payment performance among any or all patient segments drives added print costs incurred through multiple print cycles.

It's important to understand the number of statements sent and the average number of billing cycles required to collect at both a macro level and by patient segment. Improvement tactics include patient seg-

(Continued on page 11)

(Analytics continued from page 10)

mentation, targeted messaging to drive patients to pay earlier, and use of alternative financial communication methods (i.e., patient access staff and text notifications) as part of the billing cycle.

3. eStatement performance
eStatements are important to billing and payment performance for two reasons:

- Adoption of eStatements reduces your billing costs and overall cost to collect.
- Patients who opt in for eStatements tend to pay faster through integrated ePayment portals because of the convenience.

Therefore, key metrics to track include total enrollments, total electronic statements sent, and electronic statements sent as a percentage of total statements. Despite the convenience, adoption won't happen by chance. A multi-touch effort to drive eStatement adoption through one-to-one interactions and messaging on bills and portals is required.

4. Payment performance by channel
Research shows that patients tend to pay faster when they have access to payment options that are appropriate and convenient for them. Yet, not any one channel is right for all patients, so segmentation is a clear factor in this analysis. Patient access staff, printed bills, eServices, mobile devices, and telecommunication channels, such as call center agents and IVR technologies, are all tools in the tool belt that provide different value at different times for different segments.

So what to use and when? By understanding which channels are performing for which patient segments, you can better tailor messaging and present preferred options more appropriately to increase yield and drive down costs. Factors include speed to payment by channel, the percentage of overall payments by channel, and the amount collected as a percentage of total dollars billed by channel.

5. Revenue Performance
As you balance the use of paper versus electronic services appropriately, and target your financial messaging and channels of communication to the right patient segments, you'll begin to see costs go down and the speed to collect increase. The financial rewards are significant! Yet, the greater opportunity comes when you begin to move beyond cost-cutting measures and collection speed, and into overall revenue improvements.

Metrics to track include collection yield, percentage write-offs to bad debt, and percentage write-offs to charity care. Although these are likely metrics you track today, the goal is to watch them with a keen understanding of what strategies you are applying to drive improvements so you can see what's working and further refine your patient financial engagement tactics.

6. Other Billing-Related Costs
As your integrated patient billing and payment strategy pays off in increased revenue, the benefit will be a reduction in the fees paid for in some of the less cost-efficient back-end tactics used for collections, such as collection agency fees and customer service calls. Collection agency fees can be analyzed by patient segment. Customer service calls should be measured on the average fee per billed statement.

In conclusion, healthcare providers can achieve relatively fast improvements in meeting patient revenue cycle challenges by implementing a modern, integrated approach. From there, a combination of organizational focus and careful measurement of key variables brings further progress. The familiar adage, "You can't manage what you can't measure" applies well in the context of the patient revenue cycle. By focusing on key metrics, providers can achieve sustained progress in improving financial outcomes while also connecting with patients in ways that strengthen the patient-provider relationship and improve patient satisfaction.

Carrie Romandine
VP of Solutions and Services
Apex Revenue Technologies
cromandine@apexrevtech.com
www.apexrevtech.com

Arizona Providers Prepare for Oct. 1 ICD-10 Deadline

The Hertel Report

Providers nationwide are bracing for a major shift in how they document medical procedures and diagnoses, a change that could cause significant payment delays, depending on their readiness.

The switch to the new coding system, ICD-10, has been on the horizon for years. It was delayed so many times by the federal government, some providers considered the situation to be like the boy who cried wolf. Now, with implementation just weeks away, those procrastinators could be in for a rude awakening.

Industry experts contend Arizona is a "mixed bag" of preparedness.

"The ICD-10 implementation is tending to hurt the smaller practices and solo practitioners, especially those in the rural areas who were used to doing their own billing and were comfortable," said Phoenix healthcare consultant Jean Rice. "If the practice is a large one, there seems to be more preparation and readiness."

The International Classification of Diseases (ICD) is overseen by the World Health Organization. It is the international standard for defining and reporting diseases and health conditions. Used by more than 100 countries, ICD allows the world to compare and share health information using a common language.

The medical codes used for diagnosis and billing in the United States have not been updated in more than 35 years and contain outdated, obsolete terms. However, the switch from ICD-9 to ICD-10 means providers and insurers are replacing 14,000 codes with 69,000 codes.

Although every provider doesn't use every code, that's still a lot to learn. Medicare claims with a date of service on or after Oct. 1, 2015, will be rejected if they do not contain a valid ICD-10 code.

In July, the Centers for Medicare and Medicaid Services (CMS) offered physicians and other healthcare providers additional flexibility to assuage fears that a lack of ICD-10 fluency would create a landslide of denied claims. "While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family," stated the agency.

Claims already get rejected for a range of reasons due to human error, including incomplete information or incorrect codes. However, providers should expect denial rates to increase after Oct. 1, especially if they handle billing in-house, said Chris Asterino, chief executive officer of revMD.com, a Phoenix-based billing firm that works with 200 physicians in 11 states.

"This is a material change to the reimbursement system," he said. "It is highly likely that claims will be delayed and there will be a higher denial rate after Oct. 1."

The Hertel Report
www.thehertelreport.com