Predictive Modeling and Advanced Analytics to Mitigate Financial Risks of the ICD-10 Transition

HFMA National Institute
June 17, 2013
Speaker Introductions

Christine Armstrong
National Consulting Leader for the Provider ICD-10 service line and the West Coast
Revenue Cycle leader; more than 25 years of experience in health care industry

Chris Schmidt
Specialist Leader with over 11 years’ experience conducting health care claims data
analytics and payer/provider contract modeling. He has spent the last 2.5 years
assisting providers, health plans, and state governments assess the financial
impacts of ICD-10. He is a Fellow of the Society of Actuaries and a member of the
American Academy of Actuaries.

Danielle Reno
Danielle Reno is the Sutter Health ICD-10 Program Director, supporting executive
governance committees, development of implementation strategies, and program
management for system wide education, Computer Assisted Coding (CAC)
implementations, dual coding, vendor & payer readiness, IS systems remediation
and testing, clinical documentation improvement, and communications for the
Program.

Bret Kelsey
Bret Kelsey is the Chief Revenue Officer and Executive Sponsor over Lucile Packard
Children’s Hospital’s integrated ICD-10 program. Bret has over 25 years of Revenue
Cycle experience and has held leadership positions in community hospitals, health
systems, Children’s Hospitals and Academic Medical Centers. He has extensive
experience in revenue cycle transformation, process improvement, cost reduction,
and a track record of maximizing yield and reimbursement.
## Agenda

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<td>Questions for Discussion</td>
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ICD-10 Financial Modeling Introduction
Financial Modeling: What Can Be Done?

The following steps can help determine the claims at risk for moving to different DRGs, the direction and magnitude of the ICD-10 impact, and mitigation strategies for reducing potential risks.

1. Cross Mapping Analysis
   - Gather 12 months of claims data
   - Best results are achieved from using Medicare claims
   - Simulate ICD-10 claims based on CMS general equivalence maps (GEMS) or provider created maps
   - Provide high level reimbursement impact based on MS-DRG base rate x DRG weight formula
   - Illustrate examples of the types of claims that go to different MS-DRGs, the direction and approximation of magnitude of financial impact

2. Contract Modeling
   - Gather 12 months of claims data
   - Simulate ICD-10 claims based on CMS general equivalence maps (GEMS) or provider created maps
   - Use existing contract rate sheets to calculate reimbursement on ICD-9 and ICD-10 data
   - Compare ICD-9 and ICD-10 results to identify financial impact based on actual contract reimbursement terms

3. Documentation and Coding Review
   - Review medical record documentation
   - Identify opportunities for improving medical record documentation
   - Natively code claims in ICD-10 with high likelihood of DRG shifts
   - Identify opportunities for improving ICD-10 coding
   - Use ICD-10 natively coded claims to revise modeling assumptions in Cross Mapping Analysis and Contract Modeling

4. Payer Collaboration
   - Select payers for collaboration and develop initial communication plan for payers
   - Discuss collaboration process with payers and how data will be shared and tested
   - Identify targeted claims that will optimize the results obtained during the collaboration
   - Share natively coded ICD-10 claims
   - Health plan tests claim adjudication and provides claim reimbursement, pay/deny decision, etc.
   - Obtain insights from the claims natively coded and revise Contract Modeling
ICD-10 Modeling Myths

There are many myths surrounding the financial impact of ICD-10 that should be understood to better grasp the problem.

1. **I can “crosswalk” my way to financial neutrality**
   - Through modeling, crosswalks have shown that they will not be both clinically equivalent and financially neutral.
   - Natively coding in ICD-10 and using other risk mitigation strategies will work best.

2. **Contracts with per diems and case rates are not impacted**
   - Many provider contracts use DRGs and ICD-9 codes to identify per diems and case rates.
   - These will be impacted as claims shift to different DRGs and drive different reimbursement rates and as ICD-10 codes replace ICD-9 codes in the contract.

3. **CMS has mitigated the risk with the GEMs and MS-DRG conversion**
   - The GEMs are not comprehensive and require updates to be clinically equivalent. Enhanced maps will require other information and clinical considerations.
   - DRGs may shift when mapping from ICD-9 to ICD-10.

4. **Contract neutrality is intended to eliminate the actuarial need to model**
   - Modeling needs may vary by contract due to timeline for renewal, payment terms, the estimated amount of impact, and population case mix.
   - Modeling and understanding the impact will help identify risk areas, prepare for contract negotiations, and be useful for risk mitigation.

**Contract modeling is an essential way to assess financial impact introduced by ICD-10**
ICD-10 Contract Modeling: Full Cycle for modeling

Below are key steps and considerations for modeling contracts. Contract modeling will likely be an iterative process with the modeling assumptions and data being updated as more information becomes available.

1. Select ICD-9 Claims and Contracts to be Modeled
   - Prioritized based on high-risk, high-volume
   - Compares ICD-9 calculated reimbursement to ICD-10 calculated reimbursement by claim to understand the impact of the ICD-10 transition

2. Validate Reimbursement Logic with Claims and Contracts

3. Calculate ICD-9 Reimbursement

4. Simulate ICD-10 Claims
   - Creation of a test bed of ICD-10 data which can be used for modeling the financial impact due to the change from ICD-9 to ICD-10

5. Calculate ICD-10 Reimbursement

6. Assess Impact

Regroup ICD-9 claims using DRG grouper based on most recent DRG version and calculate reimbursement

Regroup ICD-10 claims using DRG grouper based on most recent DRG version and calculate reimbursement
ICD-10 Financial Modeling Process
Cross Mapping Analysis

A cross mapping analysis uses provider created or CMS published General Equivalence Maps to simulate ICD-10 Inpatient claims, and MS-DRG Medicare reimbursement formulas to assess DRG variances. This analysis focuses on Medicare Inpatient claims and includes estimated reimbursement impacts, along with codes that would be prioritized for the ICD-10 program to investigate.

### High Level Reimbursement

- Uses GEMs or provider created maps to simulate ICD-10 claims
- Highlights areas of greatest potential impact for providers to target their ongoing ICD-10 program efforts
- Provides a high-level reimbursement impact and a potential range of values that a provider may expect, if paid on an MS-DRG base rate multiplied by weight

### Coding Implications

- Identifies codes to focus on for medical record reviews, documentation training, and coder training
- Provides examples of the claims that group to different DRGs when comparing ICD-9 to ICD-10, giving insights into potential documentation gaps or coder training that would be beneficial

This analysis is very informative, but it does not give providers all the information they need for use in their overall ICD-10 remediation program, which is why detailed contract modeling is important.
Contract Modeling Details and Output

The contract modeling uses provider created or CMS published General Equivalence Maps (GEMs) to simulate ICD-10 claims, and Inpatient contract reimbursement formulas to assess DRG variances.

Models are used to calculate multiple reimbursement scenarios to help isolate the change by contract term. The customized models must handle various contract terms including:

- DRG base rate x weight
- Case rates
- Per diems
- Stop-loss
- Carve-outs
- Code Groups
- Outliers
- Line and claim level payments

Claim Simulation Example

**One ICD-9 Claim**

<table>
<thead>
<tr>
<th>D1</th>
<th>D2</th>
<th>D3</th>
<th>D4</th>
<th>P1</th>
<th>DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>562.11</td>
<td>272.4</td>
<td>553.3</td>
<td>530.81</td>
<td>45.76</td>
<td>331</td>
</tr>
</tbody>
</table>

**Seven ICD-10 Claim Possibilities**

<table>
<thead>
<tr>
<th>D1</th>
<th>D2</th>
<th>D3</th>
<th>D4</th>
<th>P1</th>
<th>DRG</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>K5732</td>
<td>E784</td>
<td>K449</td>
<td>K219</td>
<td>0DTN0ZZ</td>
<td>331</td>
<td>1/7</td>
</tr>
<tr>
<td>K5732</td>
<td>E784</td>
<td>K449</td>
<td>K219</td>
<td>0DBN0ZZ</td>
<td>331</td>
<td>1/7</td>
</tr>
<tr>
<td>K5732</td>
<td>E784</td>
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<td>K219</td>
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<tr>
<td>K5732</td>
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<td>K449</td>
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<td>0DBN0ZZ</td>
<td>331</td>
<td>1/7</td>
</tr>
<tr>
<td>K5732</td>
<td>E785</td>
<td>K449</td>
<td>K219</td>
<td>0DBN7ZZ</td>
<td>349</td>
<td>1/7</td>
</tr>
</tbody>
</table>

**Sample Output**

<table>
<thead>
<tr>
<th>I-9 DRG</th>
<th>I-10 DRG</th>
<th>I-9 Allowed</th>
<th>I-10 Allowed</th>
<th>I-10 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Procedure (DRG331)</td>
<td>Bowel Procedure (DRG331)</td>
<td>$89,246</td>
<td>$89,246</td>
<td>0%</td>
</tr>
<tr>
<td>Bowel Procedure (DRG331)</td>
<td>Anal &amp; Stomal Procedure (DRG349)</td>
<td>$44,623</td>
<td>$39,543</td>
<td>-11%</td>
</tr>
<tr>
<td>Bowel Procedure (DRG331)</td>
<td>Digest Disorders (DRG392)</td>
<td>$22,311</td>
<td>$16,403</td>
<td>-26%</td>
</tr>
<tr>
<td>Bowel Procedure (DRG331) - TOTAL</td>
<td></td>
<td>$156,180</td>
<td>$145,192</td>
<td>-7%</td>
</tr>
</tbody>
</table>
As the implementation date nears, collaboration with payers should be a priority as it provides additional value above and beyond what could be done when just creating that data for internal testing purposes.

### Payer Collaboration Steps and Value

#### Suggested Steps in Collaboration

<table>
<thead>
<tr>
<th>Set Up and Outreach</th>
<th>Data Selection and Coding</th>
<th>Share Data with Payer</th>
<th>Claims Analysis</th>
<th>Feedback to Program and Continuation</th>
</tr>
</thead>
</table>

#### Value to Providers

<table>
<thead>
<tr>
<th>Value to Providers</th>
<th>Collaboration with Payer Required</th>
<th>Rationale for Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in medical documentation</td>
<td>No</td>
<td>Identifying gaps in documentation by coding could lead to the correct level of training prior to implementation</td>
</tr>
<tr>
<td>Improved predictability of ICD-10 claims</td>
<td>No</td>
<td>Simulation is a starting point for ICD-10 prediction, but predictive power can be improved with real ICD-10 claims</td>
</tr>
<tr>
<td>Understanding of ICD-10 code-set</td>
<td>No</td>
<td>ICD-10 is a steep learning curve, and coding claims will provide some valuable lessons learned</td>
</tr>
<tr>
<td>Refined assumptions for contract modeling</td>
<td>Yes</td>
<td>Contract reimbursement modeling to date has not been as predictive as will be needed to mitigate risk</td>
</tr>
<tr>
<td>Insights into payer system processing</td>
<td>Yes</td>
<td>Payers are updating rules in their system logic to be ICD-10 ready, which impacts providers, but payers are not required to get provider approval for system decisions</td>
</tr>
<tr>
<td>Informing for other payers</td>
<td>Yes</td>
<td>Not all payers will be as ready as payers who are collaborating, and collaboration will inform providers on nuances that will be similar across all payers</td>
</tr>
<tr>
<td>End-to-End testing partnership</td>
<td>Yes</td>
<td>Providers teaming with payers will be first in line to perform end to end testing</td>
</tr>
</tbody>
</table>

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ICD-10 Financial Modeling at Sutter Health
Sutter Health Overview

Hospitals
- 24 facilities in Northern CA, split across 5 regions
- Integrated delivery system of hospitals, ASCs, medical groups, home health and more
- Services include trauma, transplants, research, cardiovascular and cancer

Sutter Medical Network
- Integrated, patient-centered physician network
  - 5 Medical Foundations
  - 5 Affiliated IPAs
- Over 5,200 primary care doctors and specialists

Employer Organization
- $9.1B Northern CA-based not-for-profit organization
- Annual statistics:
  - 211K discharges
  - 9.5M outpatient visits
- 47K+ employees
- Many large-scale programs in-flight (EMR, new construction, etc.)
# Sutter Health ICD-10 Areas of Focus

## ICD-10 Program

<table>
<thead>
<tr>
<th>Leadership</th>
<th>(Executive Steering Committee, CORE, Enterprise, Regional &amp; Program Leadership)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Technology</strong></td>
<td><strong>Work Groups/Teams</strong></td>
</tr>
<tr>
<td>Application Services</td>
<td>Clinical Documentation Improvement (CDI)</td>
</tr>
<tr>
<td>DOS</td>
<td>Dual Coding</td>
</tr>
<tr>
<td>Computer Assisted Coding (CAC)</td>
<td>Education</td>
</tr>
<tr>
<td>Crosswalk</td>
<td>Employee and Physician Engagement (EPE)</td>
</tr>
<tr>
<td>Reports Remediation</td>
<td>Research &amp; Clinical Operations</td>
</tr>
<tr>
<td>Vendor and Trading Partner Readiness</td>
<td>Revenue Cycle / HIM</td>
</tr>
<tr>
<td>Testing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IS Quality Center</td>
<td>Technical Services</td>
<td>Project Services</td>
</tr>
</tbody>
</table>
Financial Modeling: Progress to Date

Sutter Health began financial modeling activities in 2011 and continues to refine our analysis with refreshed data and various methods.

Cross Mapping Analysis

- Utilized 15 months of historical Medicare Inpatient claims data
- Identified high impact areas of mismatched DRGs and MDCs

Round 1

- Simulated ICD-10 claims using GEMs and grouped using v.26 MS-DRG
- Identified that 16% of the claims mapped to a different DRG

Round 2

- Re-ran analysis utilizing v.28 MS-DRG
- Identified that 8% of the claims mapped to a different DRG

Documentation and Coding Review

- Through the clinical documentation review, a small volume of sampled codes analyzed were assigned an unspecified code in ICD-10
- Provided insight into standardizing existing CDI strategies, methodologies and processes, such as physician queries and dashboard reporting
- Identified existing documentation gaps that can be improved upon by education today

Payer Collaboration

- Surveyed contracted payers to understand their ICD-10 readiness activities and timelines
- Identified top revenue payers across Sutter Health
- Agreed upon targeted, high risk, DRGs to natively code in ICD-10
- Establish early partnerships with partners to prepare for volume testing at a later time
Financial Modeling: Next Steps

Sutter Health is currently working on contract modeling for 4 major enterprise wide payers. 12 months of historical claims are being simulated to create ICD-10 data in order to analyze potential financial impacts after the transition date. We expect the output of this analysis to show:

<table>
<thead>
<tr>
<th>DRG Shifts</th>
</tr>
</thead>
</table>
| • With some ICD-9 codes mapping to many ICD-10 codes, there is the possibility that ICD-10 claims will group to different DRGs  
| • There is also the possibility that some claims that were originally paid by a DRG may be paid per diem (ex: maternity cases that now group to a more complicated DRG) |

<table>
<thead>
<tr>
<th>Areas of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Based on potential revenue shifts, we can determine high areas of risk related to various factors such as Major Diagnostic Category (MDC), DRG, facility, region or contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Areas for Contract Remediation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• By analyzing the model by contract, we will have the ability to identify specific payer contracting nuances that may need to be addressed during the transition to ICD-10</td>
</tr>
</tbody>
</table>
How to Jump Start Financial Analysis

For those organizations that haven’t started financial modeling to understand potential impacts to cash flow, here are some tips to get started.

• Survey contracted payers to understand when payers will be ready for testing and which payers may not be ready by 10/1/14

• Review payer contracts, including carve-outs, to understand what services could be at risk

• Utilize GEMs (or proprietary crosswalk) to understand DRG shifts once claims are mapped to ICD-10

• Evaluate documentation of high revenue / high volume DRGs to understand documentation gaps and address early through clinical documentation improvement education
ICD-10 Financial Modeling at Lucile Packard Children’s Hospital
Lucile Packard Children’s Hospital

About Our Hospital
- Academic Children’s Hospital with 311 beds
- Over 650 physicians many are Stanford School of Medicine Faculty
- Satellite pediatric units and telemedicine services expand our current facility
- 2012 Facts & Figures
  - 4500 births
  - 80,000 inpatient days
  - 13,000 discharges
  - 160,000 clinic visits

About Our Network
- Our patients are babies, children, adolescents and expectant mothers throughout the US and International destinations
- Packard Children’s Health Alliance is a network of community physicians affiliated with LPCH
- The PCHA network extends from Central California to the area North of San Francisco

Awards & Recognition
- 10 of 10 Highly Ranked pediatric specialties in the 2012-2013 US News & World Reports
- Ranked as one of the nation’s best pediatric hospitals by U.S. News & World Report
- Heart transplant patient successes were recently profiled on Dateline NBC in June 2013
LPCH ICD-10 Program Structure & Scope

The ICD-10 program scope addresses the people, process and technology impacts throughout the LPCH Network. Governance supports executive alignment, risk mitigation and decision making at the lowest level.

IS Executive Committee
Executive Sponsor: Bret Kelsey

PMO drives and provides a structured approach to developing, monitoring and tracking ICD-10 implementation

Workgroups & Scope

Executive Leadership provides oversight and decision making

PMO drives and provides a structured approach to developing, monitoring and tracking ICD-10 implementation

Workgroup Leads lead the development of deliverables, provide input and recommendations to the ICD-10 Leadership

Workgroups Members engage and support deployment across all entities

VP Ops Group
Physician Advisor Dr. Jin Hahn

ICD-10 Program Team
Chair: Lin Zhang, HIM Director
Co-Chair: Kathy Dotson, Epic Program Director

CEO Staff Committee
Deloitte Leadership Gerry Allen

HIM / Coding
Native Coding, CAC, Coder Productivity, & Dual Coding

Clinical Operations & Quality
Operational Workflows & Tools

Non-HIM Revenue Cycle
Rev Cycle Workflows, Denial & Epic Worklists, Staff Productivity

Physician Alignment & Clinical Documentation
CDI Program, Epic Templates, Physician Communication

Decision Support (Clinical & Finance) and Managed Care
Cross Mapping Strategy, Reports, Financial Modeling, Contracting

Training
Training Vendor, Plan & Delivery

Information Services
System Remediation, Testing Plan, Test Data and Testing Execution

Lucile Packard Children's Hospital at Stanford

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## Financial & Payer Analysis

### Work to Date
- APR-DRG Impact analysis conducted
- Payer contracts reviewed for ICD-9 carve-outs and potential impact
- Renegotiation of Payer contracts (with ICD-9 specific requirements) initiated
- Conducted payor survey initiative to determine payor readiness

### Key Activities

<table>
<thead>
<tr>
<th>Set Up and Outreach</th>
<th>Data Selection and Coding</th>
<th>Test Planning</th>
<th>Claims Analysis</th>
<th>Feedback to Program and Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natively coding 1,000 test cases</td>
<td>Identify test data requirements</td>
<td>Submit natively coded claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test cases identified by MDC / APR DRG frequency</td>
<td>Identify dates and schedule</td>
<td></td>
<td>Analyze results</td>
<td></td>
</tr>
</tbody>
</table>
| Key test data variables included:  
  - Top DRGs  
  - Dates of service before and after Oct 1  
  - UB Bill types  
  - Visit types  
  - Inpatient, Profee & Ambulatory claims  
  - Paper & Electronic | Test environment Planning | Payer runs claims | Refine contract negotiation plans |
| | Leverage ZirMed to communicate with clearing houses for technical testing | Collaborative analysis conducted | Refine technical testing plan |
| | Define expected outcomes for financial and technical testing | | Refine testing plan and Initiate iterative testing cycles |

- initiated payer surveys with top payers
- Conducted meetings with select payers to communicate desire to conduct financial and technical testing
- Natively coding 1,000 test cases
- Test cases identified by MDC / APR DRG frequency
- Key test data variables included:
  - Top DRGs
  - Dates of service before and after Oct 1
  - UB Bill types
  - Visit types
  - Inpatient, Profee & Ambulatory claims
  - Paper & Electronic

- Identify test data requirements
- Identify dates and schedule
- Test environment Planning
- Leverage ZirMed to communicate with clearing houses for technical testing
- Define expected outcomes for financial and technical testing
Financial Impact for Inpatient Reimbursement Terms

There can be wide variances in code-based payments, particularly inpatient DRG based payments, depending on how providers code

- There is a one to many and a many to many relationship between ICD-9 and ICD-10
- This makes predicting how claims will be coded impossible to know until actually going through the coding process

**ICD-9 to ICD-10 Mapping Examples**

<table>
<thead>
<tr>
<th>ICD-9 A</th>
<th>ICD-10 A</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 B</td>
<td>ICD-10 B</td>
<td>$</td>
</tr>
<tr>
<td>ICD-9 C</td>
<td>ICD-10 C</td>
<td>$</td>
</tr>
<tr>
<td>ICD-9 D</td>
<td>ICD-10 D</td>
<td>$$$</td>
</tr>
</tbody>
</table>

**ICD-9 X | ICD-10 K | $ |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Y</td>
<td>ICD-10 L</td>
<td>$$</td>
</tr>
<tr>
<td>ICD-9 Z</td>
<td>ICD-10 M</td>
<td>$$</td>
</tr>
<tr>
<td>ICD-9 N</td>
<td>ICD-10 N</td>
<td>$$$</td>
</tr>
</tbody>
</table>

The mapping is not 1:1 → Difficult to predict the volume of each coded

The codes do not all pay the same amount → Difficult to predict the influence of coding preferences on total medical cost

Some ICD-10 codes selected by providers will increase or decrease payment, compared to the analogous ICD-9 code-based payment. In many of these cases, the coding will be entirely appropriate and the change in payment dictated by an outside source (i.e. CMS)
## Example - 35 Year-old Male w/ Pancreatitis

The reimbursement risk is $1,900 in the example below.

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Procedures</th>
<th>DRG 439</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM</td>
<td></td>
<td>Disorders of pancreas exc. malignancy w CC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5770 - Acute pancreatitis</td>
<td>None</td>
<td>$6,100</td>
</tr>
<tr>
<td>27789 – Other specific metabolic disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2512 – Hypoglycemia NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Procedures</td>
<td>DRG 440</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disorders of pancreas exc. malignancy w/o CC/MCC</td>
</tr>
<tr>
<td>ICD-10-CM/PCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K850 - Idiopathic acute pancreatitis</td>
<td>None</td>
<td>$6,100</td>
</tr>
<tr>
<td>E803 – Defects of Catalase and Peroxidase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E162 - Hypoglycemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K850 – Idiopathic acute pancreatitis</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>E889 – Metabolic disorder, unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E162 - Hypoglycemia</td>
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</tr>
</tbody>
</table>

Reimbursement risk would vary based on different ICD-10 documentation and coding situations
Mitigating Risk Post Implementation

Providers should include contract language to address potential adverse events that could occur within the first six months to a year that ICD-10 is implemented. The negotiations for these contracts will likely take place in late 2013 and early 2014.

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Contract Language Mitigation Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall payment differences</td>
<td>▪ Inpatient reimbursement amounts are expected to be impacted, and significantly in some areas.</td>
</tr>
<tr>
<td></td>
<td>▪ Place a risk corridor on claims allowed to dispute, such as if payment has changed by +/- X% of previous six month average.</td>
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<td></td>
<td>▪ Specify a payment difference threshold where the contract can be opened up for negotiation if the experience adversely affects one party by a certain percentage.</td>
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<tr>
<td></td>
<td>▪ Outline a dispute resolution process in contracts since more claims will likely be disputed. A time period should be specified to allow for claim disputes and a process such as arbitration through a third party should be specified.</td>
</tr>
<tr>
<td>Delays in claims submission to payor</td>
<td>▪ Providers can expect a 50% reduction in productivity due to staff transition to ICD-10 and a general slow down will occur to ramp up to the new system.</td>
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<td></td>
<td>▪ Review and adjust contracts that have language requiring claim submissions within a specified period.</td>
</tr>
<tr>
<td>Payor delays payment</td>
<td>▪ A general slow down will occur for the payer to process claims.</td>
</tr>
<tr>
<td></td>
<td>▪ An interim payment schedule should be set up before implementation until the slow down period ends.</td>
</tr>
<tr>
<td>Payor implements policy changes</td>
<td>▪ Payers will likely be implementing several policy changes for ICD-10.</td>
</tr>
<tr>
<td></td>
<td>▪ Contract language should be set so that the payer notifies the provider by July 1st 2014 or earlier (at least 90 days prior to implementation) before the policy goes into effect and allows provider to comment on desired changes.</td>
</tr>
<tr>
<td>Payor increases number of records to audit</td>
<td>▪ Due to the increased fraud risk ICD-10 offers, payers will most likely increase the number of records they want to audit.</td>
</tr>
<tr>
<td></td>
<td>▪ Limits should be specified within the contract as to the number of records allowed for auditing.</td>
</tr>
</tbody>
</table>
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