dollars and sense mitigating budget risk for ICD-10

There are 10 challenges hospitals and health systems should consider as they budget resources for ICD-10 and prepare for the financial impact of implementation.

Although the deadline to implement ICD-10 has been delayed, the need to budget resources for implementation over several budget cycles and to anticipate the financial impact remains critical to healthcare organizations’ fiscal welfare. To minimize or eliminate potential risks to their organizations, healthcare leaders should focus their tactical planning efforts in 10 areas.

Potential Budget Risks

A significant number of tasks and activities should be accounted for in an organization’s ICD-10 budget, from assessment to remediation to system/process/policy upgrades to post-compliance remediation. As the budgeting process continues to take shape, with monitoring, management, and oversight of a hospital’s finance team, these 10 areas can help prepare an organization for the work ahead. As healthcare finance leaders delve deeper into the ICD-10 preparation process, this list can be customized for their organizations’ needs.

Risk No. 1: Insufficient cash-on-hand. Because the projected fiscal impact of ICD-10 will be different for each organization, there is no correct answer as to how much cash on hand is required to support the transition to ICD-10. Estimated requirements range from six to 12 months of cash on hand, including unrestricted investments. Bond issuers also will prescribe the days of cash on hand and other required ratios that should be factored into estimates.

Starting now, CFOs should vigorously pursue strategies to enhance cash on hand. These strategies should include decreasing days in accounts receivable (A/R) as well as assessing all processes for obtaining and recording...
patient information required for the revenue cycle that can potentially restrict the flow of revenue. Also, clinical documentation improvement, utilization management, denials management, and improved coding efforts all can contribute to accelerating net revenue and cash on hand.

Another opportunity healthcare leaders should investigate is securing a line of credit from a bank during the transition period, communicating with the bank how the organization will manage the fiscal impact of the transition to ICD-10.

**Risk No. 2: Unexpected depletion in cash reserves.** An Advisory Board analysis predicts that the financial impact of ICD-10 implementation will be staggering: A typical 250-bed hospital could face a projected shortfall in net revenue of $1 million to $2.5 million in the months following ICD-10 implementation (“ICD-10: A High Stakes Transition,” presentation by The Advisory Board Company and faculty for Johns Hopkins University, American Health Information Management Association ICD-10 Summit, 2011). Errors in coding, increases in payment errors and denials, and inadequate mapping to DRGs in contracts are anticipated to cause shortfalls in revenue, according to the analysis.

The Advisory Board analysis also predicts that productivity will decrease for coders by 20 percent and for physicians by 10 to 20 percent due to significant increases in queries following ICD-10 implementation. Over a three-year period, the financial impact of ICD-10 implementation on a typical 250-bed hospital could range from $2.5 million to $7.1 million in lost net revenue, according to the analysis.

Given such projections, it is clear that cash reserves should be identified for the post-ICD-10 period. Sustainability and risk mitigation will require liquidity.

**Risk No. 3: Decrease in productivity.** A RAND Corporation report found that the transition to ICD-10 in Australia and Canada significantly hurt productivity of coders. Research findings cited in the report suggest that 50,000 extra coder hours will be required the first month that ICD-10 is in effect. At a fully burdened cost of $50 an hour per coder, this increase translates into $2.5 million in additional costs the first month.

Assuming a six-month learning curve, over which 60 percent of the difference disappears, RAND notes the break-in costs (the difference between productivity loss in the first few months and long-term productivity losses) could be roughly $5 million, and the additional long-term costs from reduced productivity could be $10 million a year.

Although a comparison with Australia and Canada has value in modeling productivity after ICD-10 implementation, it is important to note that the United States has a significantly greater number of codes than either of these two countries.

The impact on productivity will reach beyond coders. Physicians, case managers, utilization management, revenue cycle staff, decision support, researchers, registration/preauthorization staff, data quality and IT professionals, and many others will require education, reassessment of processes and policies, and support during the transition period. As a result, interim staffing may be needed during preparation for ICD-10 as well as months after the compliance date. Determining those interim labor costs due to productivity impacts should begin well in advance of the actual transition.

**Risk No. 4: Underestimation of scope.** The actual scope of efforts and the resources needed by hospitals and health systems as they transition to ICD-10 will become evident only during ongoing ICD-10 compliance efforts. Although an initial ICD-10 assessment can identify gaps and areas that require specific remediation, much of the enterprise-wide impact of ICD-10 may not be fully understood early in the organization’s efforts. It is important to use the assessment as a baseline and make amendments as efforts progress and even post-compliance.
One area not to overlook is the ways in which ICD-10 will have an impact on data. ICD-10 will affect data collection and analysis in eight areas of hospital operations, including patient registration, clinical care and support, reporting, and health information management, according to a 2011 report (Mancini Newell, L., and Williams, W., ICD-10 White Paper: Data Impact Across the Enterprise, April 2011). IT systems for which data collection will be affected by ICD-10 range from niche systems within departments to enterprisewide information systems, and could affect internal reporting for boards, executive team leaders, and line managers as well as external reporting.

Hospitals also should revisit the effectiveness of processes, skills, and clinical documentation under ICD-9, since improvements can be made in the current coding environment to create net gains.

**Risk No. 5: Personnel and/or skills shortages.** Some industry experts are bracing for attrition of coders who are expected to leave their jobs because they do not wish to transition to ICD-10. The more immediate concern, however, is whether an organization will be able to retain its highly skilled, experienced staff, who could easily find employment with other healthcare organizations or with companies providing services and products in support of ICD-10 compliance.

A few healthcare organizations are reconfiguring workflows to reduce the impact of ICD-10 on healthcare budgets. However, this approach may not work for every organization. As a result, hospitals and health systems should examine the potential for using interim staff to support productivity during and after implementation. It is important for providers to be aware that high demand for experienced professionals may cause higher-than-expected staffing costs for both interim resources as well as new employees.

Developing an internal ICD-10 education and training program is a critical aspect of preparing for ICD-10. Education and training costs should be budgeted both in the time period leading up to the compliance date and the months following to provide remediation, as needed. Finally, a recruitment and retention plan tailored specifically to the organization’s ICD-10 needs is essential.

**Risk No. 6: Interruption in operations.** Providers also should factor in the potential for operational interruptions—expected and unexpected—as they prepare an ICD-10 budget.

The most obvious interruptions typically cited by organizations that have been through the transition are decreases in coder productivity and delays in payment from payers and clearinghouses. Other potential interruptions include delays related to registration and preauthorization, managing claims denials and/or resubmitting claims, physician productivity, and the additional effort required to upgrade IT systems, test and implement systems, and retrain users.

**Risk No. 7: Contractual challenges.** Although there is great interest in tools and services that predict the financial impact of ICD-10, the other impact on revenue will be the method each payer selects to map ICD-9 codes to ICD-10. Providers should work with each payer to understand how the payer’s method of mapping will affect payment and revenue. This process will require considerable effort on the part of finance staff. Regular communication with payers will help providers determine when specific information will be available to compare, by payer, current levels of payment with estimates of payment after ICD-10 implementation.

Once there is an understanding of how payment will be affected by payer, individual contracts should be reviewed and renegotiated, and the organization’s budget should be reassessed.

**Risk No. 8: Unexpected challenges with technology or systems.** One of the elements of an ICD-10 financial assessment should be formal communication with each vendor to determine when the vendor’s applications will be compliant with ICD-10 and
the types of upgrades needed. Updating applications will directly impact the workload of the provider’s IT staff, and unexpected costs can arise throughout this process. Should a vendor be unable to update an application to comply with ICD-10, a system replacement may be required.

In addition, providers may need additional systems and services that complement or support compliance efforts not initially identified within their ICD-10 tactical plan and the corresponding budget for this plan.

Risk No. 9: Inadequate contingency planning. One valuable risk-mitigation approach that providers should undertake is to develop and routinely update a detailed contingency plan. Through scenario planning techniques, providers can detail potential ICD-10 efforts and develop corresponding funding models to support them. A monthly operating and cash-flow budget also should be developed.

Risk No. 10: Inability of strategic partners to achieve concurrent compliance. If the past is an indicator of the future, we know that the HIPAA 5010 initiative required an extension until June 30, 2012, so that providers and payers/clearinghouses could successfully transmit information. Careful monitoring of strategic partners during the transition to ICD-10 should include not only payers and clearinghouses, but also IT vendors that may not be able to update their systems. Should any of these partners be unable to meet the ICD-10 compliance date, a provider’s ICD-10 budget will be affected. This factor introduces a risk that may be difficult for providers to quantify initially.

What the Industry Is Saying About ICD-10 Budget Projections

Developing budget projections for ICD-10 remains a difficult task because of the number of components and the potential variables—both internal and external—involving. There are no conclusive budget estimates for healthcare organizations to rely on as they develop their own budget projections. The few examples available are dated. Articles on this topic published from 2011 through 2012 point to anecdotal evidence of costs exceeding estimates, warning that vigilance is required in developing a realistic budget to support ICD-10 compliance.

Providers should revisit ICD-10 budget variances often through their established governance processes to ensure that new risks and resource requirements can be addressed in the budget. Additionally, regular and timely risk identification, planning, and remediation efforts will help healthcare leaders prepare for the potential impact of ICD-10 on operations, productivity, and revenue.

About the authors

Lucy Mancini Newell, FHIASS, is managing partner, The Kiran Consortium Group LLC, Chicago, and a member of HFMA’s First Illinois Chapter (Lucy.Mancini-Newell@Kiran-Consortium.com).

Joseph J. DeSilva, FACHE, is partner, interim executive services practice, The Kiran Consortium Group LLC, Scottsdale, Ariz. (Joseph.DeSilva@Kiran-Consortium.com).

The authors wish to thank Ronald J. Kroll, formerly CFO, Mercy General Hospital, Sacramento, Calif., for his contributions to this article.