ICD-10 Impact on your hospital

A Belgian Managements' view

September 2013 – Peter Fontaine – COO AZ Delta Roeselare
ICD-10 migration

– History ICD-9-CM Belgium
– Broader view on the Belgian funding system
– Impact on hospital operations
– Impact on hospital budget
– Other impact
– Conclusions
1. History ICD-9 Belgium

- 40 years of coding?

**MEDISCHE REGISTRATIE 1973**

**EEN SYSTEEM TOT BEVORDERING VAN KWALITEITSGENEESKUNDE**
EN MEER VERANTWOORD ZIEKENHUISBELEID

Ziekenhuis : 01
Trimester : JAARAFWERKING
DEEL 1

Administratie Centrum Caritas
Abdijstraat 34
3030 HEVERLEE
1. History ICD-9 Belgium

- ICD-9-CM (1979): Not just a coding language
- Effective use Belgian hospitals
  - Obligation to code in Belgium since 1988
  - First applications in hospital budget
    - 1995: PAL NAL - DRG
    - 1997: MKI
    - 1998: Intensive Care
  -> Merely a correction mechanism on the day price
- Real impact on hospital budget since introduction of Justified beds in hospital budget
  - 2002: start
  - 2006: 100%
- Evolution in the coding services in a hospital
  - Started with very limited staff and mostly one or two coded diagnoses
  - Significant evolution in coding quality over time
  - Especially after the change from AP -> APR DRGs because of the impact of secondary diagnoses
  - Evolution from separate form to coding from the discharge summary
  - To some extent evolution to over coding
    - Introduction of Auditing system
    - Intervision
  - More populations to code – no grouper
    - Hospitalisations
    - Day care – emergency
    - Nursing care
1. History ICD-9 Belgium

- Evolution in the coding services in a hospital
  - Professionalization of the organization
    - Most hospitals have a separate coding dpt
    - Coding staff from administrative profile to (para)medical – norm 1 FTE / 100 beds
    - Specific coding and grouping software
    - Health information management staff
      - Responsible for feedback
      - Meeting with doctors
    - Meeting the Federal deadlines = challenge
  
> professional team in place – trained in ICD-9 coding
- **Arrived in an new era with new logic**
  - Reduction in LOS – reduction in hospitalization capacity needs
  - Evaluating and increasing the efficiency of the care process
  - Margins can be generated through ‘non-production’ (forfait pharmaceuticals, ...)
- **Other factors** (Dana A. Forgine et al. The impact of DRG based payment systems on quality of Health care in OECD countries - Journal of health care finance - fall 2004)
  - Decrease in hospital mortality
  - Less stable patients at discharge
  - Sicker patients at admission
- **Difficult to get active and ongoing participation of doctors**
  - Although they should be the source of information (diagnoses and performed procedures)
  - It should be possible to derive extensive diagnostic and procedure information from the EHR
2. Broader view on the Belgian funding System

- Doctors do not speak the same language as the hospital
  - The language as such (language)
  - Financial language (incentive)
2. Broader view on the Belgian funding System

- Doctors do not speak the same language as the hospital

1) Financing

- Hospitals are financed based on DRGs derived from diagnosis and procedure codes coded in ICD-9-CM.
- (Most) Doctors are financed based on RIZIV/INAMI procedure coding

- There could be some evolution in the financing system
  - A consensus is growing on federal levels about the need to think about a new hospital wide financing system.
  - Studies about all-inn forfait – Taskforce. Based on DRGs (ICD-coding)
2. Broader view on the Belgian funding System

- Doctors and hospitals do not use the same language

2) Language

• Hospitals have to code and provide diagnosis and procedure codes in a structured way through ICD-9-CM coding.
• Doctors capture their diagnoses and procedure information in free and unstructured text with limited interoperability. Also no guarantee that doctors understand each other.
• There could be some evolution through
  – the “RIZIV” language could probably change. Not possible with ICD-9-CM procedures
  – Action plan e-health 2013-2018 in which ICD-10 could play a central role
    » conference end 2012
    » Led to 20 goals to be reached
    » Two with relation to a structured coding process in the EHR.
2. Broader view on the Belgian funding System

- **Action 2: Development of a hospital-wide EPR**
  - Hospital files must be structured and coded.
  - Information must be generated semi-automatic
  - MKG must be filled in semi-automatic
    - By the end of 2017 all registrations must be generated by a system to system communication.

- **Action 13: Realization of a national terminology governance**
  - Medical reference thesaurus based on SNOMED-CT
  - Current codification systems will be mapped (ICD-10?) – deadline 2017
  - Including the systems linked to payment e.g. RIZIV nomenclature.

E-health actionplan should be the basis for administrative simplification (action 15)
2. Broader view on the Belgian funding System
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• Personal conclusion on the funding system
  – Until now - difficult to get Doctors on board
  – Health systems -> multidisciplinary – team play
  – Same rules must apply to all participants
  – Some change expected where ICD-10 could directly or indirectly play a central role

• Evolution Federal funding system
  – ICD-10 has the potential to better understand complications, design clinically robust algorithms and track outcomes of care. K. De Vault in Journal of health information management, march 2009.

• Some evolution to exchangeable structured medical records
  – There is hope...things start to change
While waiting: Build a partnership with your doctors:

- Build a common (financial) interest e.g. responsibility projects
- Shared savings.
- MZG-team
- Continuous Feedback
- Active interaction with doctors
- Auditing of information processes
- IT-link to medical record
- Also in the preparation to ICD-10
3. Impact on hospital operations

- USA: personal experience
  - AHIMA 2004: ICD-10
  - Deadline October 2014?

- Belgium
  - Visible federal preparation and announcement 2011
  - Announcement of initiatives undertaken for the migration to ICD-10 2013
  - Deadline januari 2015
  - A sudden change with insufficient preparation time?
  - Additional costs for the hospitals (limited margins today)

- Convinced about the need to move to ICD-10
  - Limitations of ICD-9 (diagnosis – procedures)
  - Not longer supported
3. Impact on hospital operations

- Professional preparation by the FOD VG based on international experience and partnerships (e.g. Ahima)
  - Label translation
  - Mapping ICD-9 -> ICD-10
  - E-Learning tools !!!
  - ICD-10-PCS license
  - Impact studies
  - Coding Manuals
  - Anatomy and physiology manuals
  - Info sessions
  - ...

3. Impact on hospital operations

- For a hospital: the work starts now
  - Thoughtful, well-planned implementation
  - Early preparation is essential for success
  - Training coders – how to organize this?
  - While finishing current coding in time
  - Prepare ICT systems
  - Analyze potential financial impact
  - Development of a budget
  - Help physicians to prepare
  - ...

- ...
3. Impact on hospital operations

- Main barriers:
  - Delay in ICD-9-coding.
  - Additional costs?
    - Costs of training
    - Productivity costs
    - System changes
  - Coders competence: anatomy and physiology
  - Get doctors involved (ICD-9 -> ICD-10): AP -> APR -> ICD-10
4. Impact on hospital budget

- ICD-9 (DRGs) Relative extensive impact on a hospital budget

- ICD-9 coding through DRGs used in hospital budget e.g. public hospital Roeselare
  - Basic budget – Justified Beds (8 Mio)
  - Forfeit clinical biology (0.5 Mio)
  - Justified beds intensive care (0.25 Mio)
  - Pharmaceutical Forfeit (1 Mio)
  - Forfeit radiology (0.5 Mio)
  - Palliative support team (B4) – ICD-9
  - Reference amounts

-> + 10 Mio € / total turnover of 100 Mio €
4. Impact on hospital budget

- Two unknown factors

  1) Evolution to APR DRG 28.0 is planned (BFM 2014-2015?).

    - Relative significant impact (Dr. Pincé – 2012)
      - Changes in MDC
      - Changes in DRGs
      - Less patients in surgical DRGs
      - Less patients in more severe SI-classes
      - Reduction in combinations DRG/SI with 11%

    - Simulation possible about the impact from APR DRG 15.0 to APR 28.0 based on ICD-9 coding
      - More impact for hospitals with higher Severity classes

    - Also some opportunities
      - Complications of care not present on admission are not taken into account in the determination of the severity of illness.
      - Somehow there are some methodological questions about the POA indicator.
4. Impact on hospital budget

- **Two unknown factors**

  2) Subsequent evolution to ICD-10

     - No view on impact on hospital reimbursement. Are patients with a certain ICD-9 CM coding attributed to the same DRG/SI based on ICD-10 coding?
     - No simulation possible since APR 15.0 does not work with ICD-10
     - Based on mapping FOD ICD-10 versus ICD-9

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- ICD-9  Base SI 003.1 = 4  995.91 = 2
- ICD-10  ?

- Need DRG manuals based on ICD-10 to better understand the impact of the transition.
5. Other impact

– Law changes
  • Some explicit references in the Belgian law to ICD-9 and APR DRG 15.0 e.g. oncology diagnoses ICD-9-CM in forfait clinical biology

– Impact on old data
  • Limited internal analysis on historical ICD-9 data
    – Mostly used as basis for DRG calculation
  • More attention to convert older health information data in the hospital
    – From APR DRG 15.0 APR-DRG 28.0
      » Problem: Older data not coded for APR DRG 28.0 e.g. Present on admission indicator.

• Government provided federal data
  – E.g. used for market share analysis based on DRGs or MDC
6. Conclusions evolution to ICD 10

• Conclusions
  – The transition is unavoidable (EOL) and necessary to get in line with other countries
  – Good preparation is necessary – supported by government support and initiatives
  – The transition to ICD-10 also holds the potential
    • To make hospital records more structured
    • Involve doctors’
    • Create new reimbursement systems with more emphasis on financing quality of care
  – Be the first to be prepared – you buy time to do things good the first time