

## 15-207 ICD Risk Management Strategy Assessment

### EXECUTIVE SUMMARY

International Statistical Classification of Disease and Related Health Problem Version 10 (ICD-10) is used to analyze and track population health statistics including mortality and morbidity. ICD-10 includes the compilation of codes published by the World Health Organization and the Centers for Medicare and Medicaid Services (CMS), and is used to verify medical necessity and authorize medical services, determine reimbursement for services, and report quality metrics.

MD Anderson (MDA) is currently preparing for the federally mandated conversion to ICD-10, scheduled for October 1<sup>st</sup>, 2015. Due to legislation passed in 2014, ICD-10 implementation was delayed causing MD Anderson to enact contingency plans and adjust their original approach in working toward full remediation in preparation for last year's anticipated go-live. Even though ICD-10 is meant to improve reporting, reimbursement, and diagnosis monitoring, the program presents a great deal of challenges for the healthcare industry, and more specifically provider organizations, concerning planning and implementation efforts.

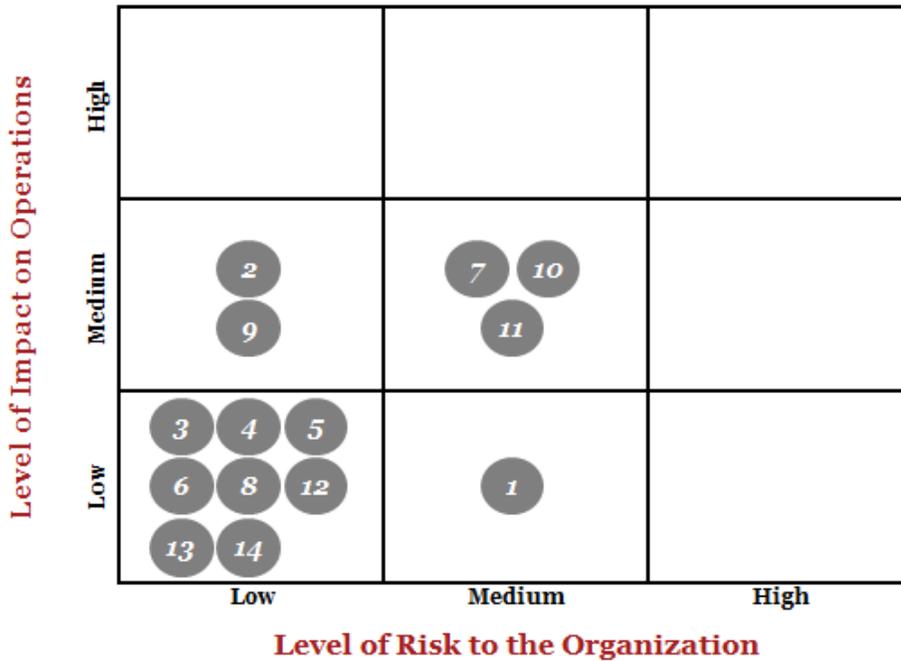
Internal Audit performed a point-in-time assessment to evaluate MD Anderson's ICD-10 project activities to date. This effort specifically assessed MDA's progress since last year's audit completed in May 2014, and their current state of readiness leading up to the October 2015 cut-over date.

### Audit Results:

Based on independent procedures performed, Internal Audit confirms MD Anderson is on target for the successful implementation of ICD-10. Our assessment confirms planning efforts to be in line with leading practices addressing timing and considerations across people, process, and technology functional areas. It should also be noted that management successfully altered their remediation planning in light of last year's delay by instituting contingency plans and maintaining focus across the various work efforts. These continued efforts have put the Institution on track to be prepared for the ICD-10 go-live this October. Based on Internal Audits work efforts, it was concluded that all risks fall within the low to medium impact quadrants of the Risk Evaluation Matrix. See below for the final outcome associated with the major risk areas that were evaluated as a part of this year's audit.

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The University of Texas M.D. Anderson Cancer Center  
ICD-10 Risk & Impact Ratings - Current State



**Risk Descriptions**

1. Lapse in Communication
2. Lack of Education and Training
3. Implementation of Staffing Contingency Plans
4. Workplan Maintenance
5. Work Group Meeting Cadence
6. Enterprise Testing Work Group
7. Provider and Staff Receptiveness
8. Revenue Cycle Process Risk Mitigation
9. Reimbursement Risk Mitigation
10. Clinical Documentation Improvement
11. Provider Incentive/ Discipline
12. Remediation of Applications
13. System Training
14. Integration of EHR Deployment Activities

**Criteria for Level of Impact on Operations Rating**

**High** - The effect would drastically impact our ability to comply with ICD-10 standards.

**Medium** - Compliant activity may be temporarily interrupted.

**Low** - There will be little or no effect on compliant operations.

**Criteria for Level of Risk to the Organization Rating**

**High** - There will be a drastic or long-term effect on public or stakeholder image.

**Medium** - There will be a short-term effect on public or stakeholder image.

**Low** - There will be little or no effect on public or stakeholder image.

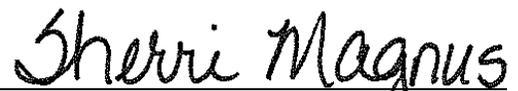
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As a result of completing our assessment, Internal Audit has identified the following key risks for management to consider as the project approaches go-live:

1. Management should consider improving awareness and communication strategies for providers, specifically by:
  - A. Enhancing communication of ICD-10 updates to providers as go-live approaches; and
  - B. Making all training and education for ICD-10 Champion Network staff at Levels 3 (direct interaction) and 4 (documentation interaction) a mandatory requirement.
2. Management should consider instituting a formal feedback program, outlining a formal disciplinary policy, or establishing an incentive/rewards program to govern provider documentation.
3. Management should consider enforcing or updating MDACC policy #ADM1178 to improve provider query response metrics and to effectively address escalation procedures for queries with no response.
4. Management should consider delivering standardized and consistent feedback to coders regarding the results of dual coding test cases.

**Appendix A** outlines the methodology for this project.

The courtesy and cooperation extended by the ICD-10 Project team members was sincerely appreciated.



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Sherri Magnus, CPA, CIA, CFE, CRMA  
Vice President & Chief Audit Officer  
July 15, 2015

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## Observation 1:

**Improved Awareness and Communication Strategies**

Based on conversations with ICD-10 program sponsors, program management, and work stream leaders, it is apparent that MD Anderson is currently experiencing a high volume of Institution-wide changes that include the EHR implementation, go-live of ICD-10, Cerner labs upgrade, ProVation implementation, and stabilization of Financial Clearance efforts. The combination of these Institution-wide events poses risk to the Institution, especially if one initiative fails to execute successfully. The cumulative effect of these events poses risk to the success of the ICD-10 program from an end-user readiness perspective.

**A. Communication of ICD-10 Program Updates and Efforts**

Since the federal government's delay, management has combined and streamlined ICD-10 and EHR implementation resources for go-live; however, when assessing the current status of the ICD-10 program, a lack of consistent communication to providers has caused buy-in and commitment to decline. Despite the continuation of the Provider Ambassador Network, physicians still feel as though they have not received adequate communication and management noted a difficulty with providers attending different ICD-10 related meetings and working sessions.

**Recommendation A:**

Management should consider strengthening communication to providers as ICD-10 go-live approaches. Management should consider enhancing the existing communication strategy/plan by disseminating more frequent updates to providers, and developing a strategy to proactively prompt providers to express their concerns and recognize gaps in knowledge related to the ICD-10 conversion. This can be accomplished by offering more face-to-face interaction (town halls, attending departmental meetings, etc.) with providers and educating them on the criticality of being prepared for ICD-10 and how they can help the organization achieve this goal.

**Management's Action Plan:**

Responsible EVP: Dr. Thomas Buchholz

Owner: Dr. Ron Walters

Observer: Wenonah Ecung, Ph.D.

Due Date: September 4, 2015

*Management acknowledges the finding; however, the program had received guidance to not overload providers with general ICD-10 communications and to focus core messaging closer to go-live. In an effort to accommodate this request, communications have been limited to providers who are currently working in ICD-10, specifically the 75% of providers who have been capturing their professional charges in ICD-10 on the MedAptus system since October 2014.*

*There was also concern of over-communicating in case there was another legislative delay to ICD-10 in the spring of 2015 similar to the one experienced the prior year. However, since the ICD-10 program is now in the 90 day period prior to go-live, and no delays appear forthcoming, a series of communications to clinical providers is planned. Examples include:*

- a. An all-provider email will go out from the Office of the Executive Vice President (EVP)/Physician-in-Chief (PIC) in early August reminding providers of the impending ICD-10 go-live date and highlighting upcoming enhancements to training and educational material*
- b. Department specific training will be developed or enhanced in July and August with general themes and/or audit findings for specific departments, and implemented on a Clinical Documentation Improvement (CDI) home page. These will contain necessary information for each department to become ICD-10 ready*
- c. Targeted, department-specific reminders will go out from the Office of the EVP/PIC starting in August, emphasizing the specific elements and will point to training and educational material sites.*

## **B. Training and Education**

It was noted that refresher training is planned this summer, but it was also noted that these trainings (eLearning and Instructor Lead Training) are not being publicized as mandatory requirements for ICD-10 Champion Network staff at Levels 3 (direct interaction with ICD-9 such as patient access staff) and 4 (documentation-level interaction with ICD-9 codes such as billers and collectors). Although management intends to monitor and follow up with the employees that have not completed the recommended ICD-10 training, management should consider the risk that many staff may not complete the trainings. This gap in training could lead to staff noncompliance with new ICD-10 requirements, negatively impacting processing of claims and reimbursement.

### Recommendation B:

Due to the fact that impacted staff across levels 3 and 4 encompasses a significant portion of users affected by ICD-10 at a medium to high impact, management should consider making level 3 and 4 eLearning and Instructor Led Trainings mandatory requirements and tying completion of these programs back to employee performance evaluations.

### Management's Action Plan:

Responsible EVP: Dr. Thomas Buchholz

Owner: Dr. Ron Walters

Observer: Wenonah Ecung, Ph.D.

Due Date: September 11, 2015

*Management acknowledges the finding and has begun to take corrective action. The Organizational Change Management (OCM) work stream worked with the leadership of impacted departments in spring of 2015 to re-assess employees identified as levels 3 and levels 4. As part of that re-assessment, only level 4 critical employees will have negative impacts on the business if training activities are not completed prior to the ICD-10 go-live (refer to the table below for a description of levels 1 – 4). To mitigate this risk, the team will use clinical and financial leadership to reinforce compliance with ICD-10 education activities for level 4 critical employees.*

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Department Scoping – Level Assignment Guide			
Level	Description	Training	Purpose
<b>Level 1</b>	<ul style="list-style-type: none"> <li>Does not work with ICD codes</li> <li>Needs general institutional ICD-10 transition knowledge</li> </ul> <p><b>Example:</b> Behavioral Science, Anesthesiology and Allied Health</p>	<ul style="list-style-type: none"> <li>No training activities; Levels 1 and 2 will receive institutional communications around ICD-10 only</li> </ul>	<ul style="list-style-type: none"> <li>Provided as a benefit to employees</li> <li>Improve communication, understanding, and efficiency across the institution</li> </ul>
<b>Level 2</b>	<ul style="list-style-type: none"> <li>Does not directly work with ICD codes</li> <li>Needs general institutional ICD-10 transition knowledge</li> <li>May experience some operational impacts of coding transition as a downstream or upstream entity from a Level 4 department</li> </ul> <p><b>Example:</b> Nutrition, Palliative Care</p>		
<b>Level 3</b>	<ul style="list-style-type: none"> <li>May encounter ICD codes in occasional job duties</li> <li>Works regularly with departments who interact with codes</li> <li>Need to understand the transition to ICD-10 and the upstream and downstream impacts to the departments with which they interact</li> </ul> <p><b>Example:</b> Emergency Care, Surgery Scheduling</p>	<ul style="list-style-type: none"> <li>eCourse 1 &amp; 2 Refresher</li> <li>eCourse 3</li> </ul>	<ul style="list-style-type: none"> <li>Provided as a benefit to employees</li> <li>Improve communication, understanding, and efficiency across the institution</li> <li>Shared knowledge reduces confusion and increases employee value and job satisfaction</li> <li>Advances culture with a shared message across the institution</li> </ul>
<b>Level 4 Non Critical</b>	<ul style="list-style-type: none"> <li>These employees are typically assessed as level 3 employees but desire level 4 knowledge and therefore have been included to attend level 4 training activities</li> <li>Works indirectly with ICD codes</li> <li>Desires understanding of transition, code structure and commonly used code sets</li> <li>No measurable operational consequence to only completing Level 3</li> </ul> <p><b>Example:</b> Case Management, Radiology Oncology</p>	<ul style="list-style-type: none"> <li>eCourse 3 Refresher</li> <li>eCourse 4a and/or 4b</li> <li>Attend TTT Presentation (Dept Trainers Only)</li> <li>Attend ILT Presentation</li> </ul>	<ul style="list-style-type: none"> <li>Necessary to ensure the institution experiences minimal post go-live service disruption</li> <li>Important for institutional risk mitigation</li> </ul>
<b>Level 4 Critical</b>	<ul style="list-style-type: none"> <li>Needs Level 4 knowledge</li> <li>Works closely with ICD coding</li> <li>Needs understanding of transition, code structure, and commonly used code sets</li> <li>Poses significant operational risks if Level 4 training is not received</li> </ul> <p><b>Example:</b> Rehabilitation, Financial Clearance Center Associates and Coordinators</p>		

Additional support from clinical and financial leadership, such as Dr. Buchholz and / or Bob Brigham, Brad Gibson or their direct staff will be used to send ICD-10 related communications on behalf of the ICD-10 program to level 4 critical employees reinforcing the importance of completing education activities. These communications include an introductory email to level 4 critical employees outlining the training plan and completion timeline, follow-up communication(s) for non-compliant level 4 critical employees and acknowledgement at the close of training for the completion of training activities.

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## Observation 2:

**Provider Documentation Improvements**

Consistent with prior year, management still has not outlined a formal disciplinary policy, or established an incentive/rewards program to govern provider documentation, at least initially after ICD-10 go-live. This could lead to gaps in processing of claims and a potential delay in reimbursement.

A disciplinary policy or an incentive/rewards program has not been formalized to improve the accuracy of provider documentation and enforce compliance with ICD-10. Management did note that both technical and surgical coders will be directly involved in providing documentation feedback to providers on coding quality to better prepare them for conversion to ICD-10. It was also noted that the MD Audit tool is utilized to deliver provider feedback and keep track of providers that do not meet quality metrics. Although these mechanisms of feedback will help, a process is not in place to track if providers improve their performance based upon the feedback received. These quality control measures would ensure that provider documentation is adequate, appropriate, and consistent upon ICD-10 go-live. Without this formal process, there is a heightened risk that providers will submit incomplete, inconsistent, or inadequate documentation, and subsequently, coders will have difficulty assigning codes, leaving room for delayed claims and potentially reduced reimbursement. ICD-10 management is aware of these concerns but no formal plan has been established to determine the best approach to mitigate documentation quality risks.

**Recommendation:**

Management should consider instituting a formal disciplinary policy, or establishing an incentive/rewards program to govern provider documentation and track performance improvement after they receive feedback via MD Audit or the coders. Tying provider documentation to performance rewards or disciplinary action will help improve overall provider behavior, provide substance to the informal process already established, and hold providers accountable for their documentation thus resulting in better outcomes within the revenue cycle.

**Management's Action Plan:**

Responsible EVP: Dr. Thomas Buchholz

Owner: Dr. Ron Walters

Observer: Wenonah Ecung, Ph.D.

Due Date: August 31, 2015

*Management acknowledges the finding. There is no formal disciplinary policy or incentive program to improve the adequacy and appropriateness of provider documentation for ICD-10. Due to the scale of tracking, reporting, and monitoring required to tie to discipline or incentives, there is not institutional capacity or support to implement a change of this magnitude prior to the ICD-10 go-live.*

*However, management is committed to modifying the medical record sign-off policy from 30 days to a shorter period of time. This would help decrease the lag time between the provision of clinical care and the coding and billing for services. It would also be an incremental step to more quickly see impacts of ICD-10 and to prepare for the EHR OneConnect implementation, which requires significantly faster sign-off. Management will provide an implementation*

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timeline by no later than August 31, 2015 and it will outline approval steps and dates which may include steps such as input from division heads and department chairs, the executive clinical operations team and the executive committee of the medical staff. The implementation timeline would identify a reasonable implementation date for the medical record sign-off policy change in order to mitigate the risk identified for the ICD-10 go-live and stabilization.

With regard to documentation improvement, per consideration 3 in this report, the query escalation policy #ADM1178 will be fully implemented. However, #ADM1178, is an administrative policy and not linked to the Medical Staff Document Completion Penalty Policy (CLN0510), a clinical one which has penalty fines from the PRS SAP account, related to the completion of the medical record. This was a conscious decision made during the development of the query response policy, partly for expediency, and partly for institutional acceptance. Also, at that time, the query process was new and performance tracking could not be provided at the individual level. Provider acceptance of penalties would be challenged unless and until the data was solid. There are no current plans to link #ADM1178 to CLN0510, the Medical Staff Document Completion Penalty Policy. Management may consider modifying CLN 0510 at a future date to support Stage 2 Meaningful Use compliance or to support the OneConnect implementation, but it is considered beyond the scope of this current response.

Auditor's Follow-up Comment:

Management's action plans to modify the medical record sign-off policy and track key performance indicators through the Clinical Documentation Improvement (CDI) process noted in Observation #3 should mitigate the risks to an acceptable level.

Observation 3:

**Improvements to Query Escalation Procedures**

As best practice, coders are directed to submit queries to physicians in order to clarify and address potentially conflicting, incomplete, or imprecise clinical documentation. Queries enable coders to code encounters timely and appropriately.

The "Clinical Documentation Query Policy" #ADM1178 addresses the current query procedures for the Institution, specifically the expected format of queries, procedures to initiate queries, guidelines for responses from providers, and escalation procedures in the event providers do not respond to queries. Per the escalation policy, "if no response [is received] within 48 hours, the Responsible Clinician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN) will be paged. If no response to page within 24 hours, the Query will be escalated and handled in the following manner:

- (1) First level notice to on-call Physician,
- (2) Next level will be Department Chair,
- (3) Next level will be Division Head and Executive Vice President (EVP) if no response has been received prior to or at the time of discharge."

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Based on conversations with ICD-10 program sponsors, program management, physicians, and coding leaders, it was noted that the current escalation process for queries (MDACC policy #ADM1178) has not been implemented effectively or fully enforced. Per inspection of management's Key Performance Indicator (KPI) dashboards from March 2015, Internal Audit noted provider response rates to queries over a 12-month period have averaged at 30%; this percentage is significantly low when compared to 3M's leading practice provider response rates recorded at above 80%. Beyond this metric, Internal Audit also noted that Clinical Documentation Improvement Specialists (CDIS) do not have an effective process or technology to drive additional changes beyond the creation of the initial query. Lastly, management has not established an incentive/rewards program to govern provider query response metrics.

Although management tracks physician query response rates through the Key Performance Indicator (KPI) dashboard, there is no incentive in place to improve the KPI and enforce compliance. Tying provider query response metrics to performance rewards or disciplinary action will help improve overall provider behavior, provide substance to the formalized policy already established, and hold providers accountable for their documentation thus resulting in better outcomes within the revenue cycle.

Recommendation:

Management should consider enforcing or updating MDACC policy #ADM1178 to effectively address and improve query response metrics for physicians. Additionally, management should address the escalation procedures outlined in the policy, including clarification on the timing for when the secondary level parties (Department Chair and EVP) should be involved in the escalation procedures. This clarification should include what this level of involvement signifies related to provider behavior and noncompliance.

Management's Action Plan:

Responsible EVP: Dr. Thomas Buchholz

Owner: Frank Tortorella

Observer: Wenonah Ecung, Ph.D.

Due Date: October 30, 2015

*Management acknowledges the finding and will begin to take corrective action. The current query response policy #ADM1178 is an administrative policy, partially instituted, due to the newness of the query process at MD Anderson and due to the system limitations affecting ease of access and response to queries.*

*In June 2015, members of the clinical leadership team including Dr. Thomas Buchholz, Physician-in-Chief, and Dr. Ron Walters, Associate Vice President and ICD-10 sponsor, met with clinical department chairs to obtain acknowledgement and support for the clinical documentation improvement (CDI) query process. The department chairs have requested that they receive department-specific reports with their providers query response data, so they can create accountability, act as an escalation path, and provide follow-up. This aligns with the actions outlined in MDACC policy #ADM1178 (section 5.3).*

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*The reports are now being re-formatted to include the type of summary statistics that would be useful to the department chairs to identify specific opportunities for improvement. These reports will be available and distributed to department chairs by September 10<sup>th</sup> summarizing data from June and July 2015 to establish a baseline. The escalation process should be fully implemented in October 2015 and subsequent reports should reflect an increased response rate.*

*As a consequence of this risk assessment, further discussion occurred about the role of the on-call physician, who is mentioned in the escalation process of #ADM1178 (section 5.3) and the role of the Quality Officers who are not specifically mentioned in the policy. It was felt that with department chair support, the role of the on-call physician referenced in the policy was likely not needed and that it will be up to the department chair to decide whether or not to include the Quality Officer in the implementation. The policy will be revised to note these changes in process.*

*The CDI department is also making changes that should enable more targeted reporting and escalation including:*

- Reviewing CDI target metrics, including the provider query response rate, and adjusting the metrics to align with peers based on the maturity of MD Anderson's CDI program. The CDI department will take into account technical limitations which cannot be overcome prior to the ICD-10 go-live. Specifically, additional investment will not be made into the legacy system ClinicStation since it is scheduled for replacement in March 2016 by EHR OneConnect. The current system makes finding and responding to queries more cumbersome since it is not integrated into the provider's work flow. Due to this system limitation, the CDI specialists will continue to use the offline process of emails and reminders to direct providers to queries they may have received. This will affect the adoption and ease-of-response for providers.*
- Continuing to track and report on key performance indicators such as the provider query response rate, agree response rate, and case mix index and identifying appropriate action plans for metrics that are outside of acceptable ranges*

#### Observation 4:

##### **Improvements in Coder Feedback**

Based on conversations with a sample of coders, it was noted that inconsistencies exist in the level of confidence coders have in being prepared for ICD-10. When asked about the effectiveness of management's activities to prepare coders for ICD-10, responses ranged from feeling well prepared through dual coding exercises and receiving consistent support and feedback, to feeling ill prepared and voicing that management has not provided consistent feedback on dual coding cases. Management did note that technical coders will be receiving additional training, both web based and instructor led, to help better prepare those coders for Go-live. The inconsistency across the dual coding audits has created a general fear that some coders may encounter a steeper learning curve than others, thus creating a crippling backlog upon ICD-10 go-live.

Management noted that changes have been executed in an attempt to deliver standardized and consistent feedback on ICD-10 dual coding and preparation activities agnostic to the type of coder. The recent changes were instituted in an effort to have the technical coder feedback process mirror the process in place for professional coders. This change will help alleviate the technical coder

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concerns, but it will still be critical to have the various coding managers' work together in providing frequent feedback to ensure their coders are prepared and have an increased confidence level leading up to Go-live. Standardized and frequent feedback will allow coder performance to trend consistently before go-live and mitigate the risk of a backlog and/or delayed claims.

Recommendation:

Management should consider holding joint monthly meetings, inclusive of all professional and technical coders, to ensure they are receiving adequate feedback at the same frequency as well as take the opportunity to learn from one another.

Management's Action Plan:

Responsible EVP: Weldon Gage

Owner: Brad Gibson

Observer: Sue Threlkeld

Due Date: August 28, 2015

*Management acknowledges the finding and has already begun to take corrective action by restructuring the technical coding dual-coding process and related education opportunities to mirror those of professional coding and we believe the coders are more confident in their ICD-10 capabilities.*

*Management has taken the following actions:*

- *Reformatted the cases to focus on the coders ability to identify the appropriate codes from the documentation presented*
- *Increased the number of cases dual-coded to allow for more practice*
- *Increased the time allotted each week for continuing education from 4 hours to 6 hours*
- *Delivered consistent feedback from the ICD-10 dual coding results*

*In addition, management is conducting joint monthly education sessions with professional coding, Patient Business Services, Clinical Documentation Improvement and Radiation Oncology, has engaged a coding auditor to focus solely on auditing inpatient technical coding in preparation for ICD-10 PCS readiness and will be adding additional leadership staff in the next month.*

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## Appendix A

### Strategic Area: Operational

### Risk Type: Operational, Financial, Compliance

#### Objective, Scope and Methodology:

The focus of the assessment was to provide an objective evaluation of MD Anderson's efforts to-date as it relates to the upcoming ICD-10 conversion. Leveraging subject matter professionals, the team performed several high-level interviews across each business unit focusing on functional services related to people, process and technology. The primary goal of the assessment was to identify gaps and make recommendations for additional considerations that should be included in the preparedness efforts.

To accomplish these objectives, Internal Audit gained an understanding of MD Anderson's ICD-10 readiness efforts to date via analysis of the ICD-10 Steering Committee meeting minutes, status reports and outputs, as well as through interviews with the various business unit and functional leaders.

Our internal audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing*.

#### Number of Priority Findings to be monitored by UT System: None

A Priority Finding is defined as "an issue identified by internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole."

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