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# PREPARING FOR ICD-10

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Documentation gaps. Denials. Payment delays. Confusion. Upheaval.

In an industry already renowned for constant and dramatic changes, forward-looking U.S. executives at payers and providers are already bracing and laying the groundwork for what promises to be the most significant overhaul to the medical coding system in the healthcare system: adoption of the new ICD-10 codes to document diagnoses and treatments at far greater levels of granular specificity.

Although many other Western nations have moved to the "International Classification of Diseases, 10 Rev.," as it's formally known, the U.S. has stubbornly remained in the world of ICD-9, despite its limitations. Given the scope and impact of this change, that reluctance is more than understandable. However, after nearly four decades of scientific progress, clinical innovation, and greater demands for transparent reporting and more precise payment processes, the healthcare industry has outgrown ICD-9. With foresight and the right approaches, providers and payers can transform the ICD-10 challenge into an opportunity for improved care outcomes, sharper insights into care delivery, and lower costs at every phase of the revenue cycle.

## BETTER INFORMATION, BETTER CLINICAL OUTCOMES

There are two categories of ICD-10 codes: ICD-10-CM for diagnoses by providers and ICD-10-PCS for inpatient hospital procedures. Structurally, the ICD-10 code is much longer (up to seven characters, as opposed to a maximum of five in ICD-9), meaning that the industry can now make use of up to 68,000 codes for diagnoses and 87,000 procedure codes, compared with a little more than 14,000 diagnosis codes and 4,000 procedure codes in ICD-9. For example, under ICD-10, a clinician can enter a code for West Nile virus or specify that a laparoscopic procedure was performed on a patient (as opposed to a traditional open procedure)—specificity that was previously unavailable. While ICD-9 offered one code for suturing an artery—whether it was a sliced pinkie or a severed aorta—as many as 195 codes exist for the same procedure in ICD-10. (To access a complete list of all codes, visit www.cms.gov/ICD10.)

The Centers for Medicare & Medicaid Services (CMS) says:

> [T]he ICD-10 code sets provide a standard coding convention that is flexible, providing unique codes for all substantially different health conditions. It also allows new procedures and diagnoses to be easily incorporated as new codes for both existing and future clinical protocols. ICD-10-CM and ICD-10-PCS provide specific diagnosis and treatment information that can improve quality measurements and patient safety, and the evaluation of medical processes and outcomes. ICD-10-PCS has the capability to readily expand and capture new procedures and technologies.

From a higher-level perspective, ICD-10 improves the quality of information to improve the efficacy of clinical processes, clarifies diagnoses and procedures, and reduces payer and provider administration. In an article published in the August 2011 issue of *hfm*, "ICD-10: Obligations and Opportunities," Philip Ronning, the principal of Ronning Healthcare Solutions, provides an even clearer picture of

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the benefits that await successful adopters. He notes that ICD-10 will bring the following advantages.

*Support accurate coding and reduce coding errors.* An ongoing improvement effort is reducing coding errors and increasing accuracy. ICD-10 holds the prospect for significant improvement.

*Capture advancements in new technology.* The principal shortcoming of ICD-9 has been its increasing inability to provide codes for new technology. ICD-10 accommodates both implemented new technologies and provides for easy additions in the future for new developments.

*Translate precisely admissions into proper diagnosis-related groups (DRGs).* The specificity of ICD-10 promises improved accuracy in grouping diagnoses and procedures into the proper Medicare severity-adjusted DRG (MS-DRG).

*Offer payment design and contracting innovation.* With improved specificity in coding come innovations in how payment and claims processing systems are designed and managed. This benefit should remove much of the administrative negotiating in claims management and contract negotiation.

*Improve resource utilization management.* Reducing utilization will be an ongoing focus in the future. Better information on the conditions surrounding the relationship between diagnosis and procedure(s) will provide the basis for more effective utilization management initiatives.

## THE BRIDGE FROM ICD-9 TO ICD-10

*General Equivalence Mappings.* The Centers for Medicare & Medicaid Services (CMS) has published the General Equivalence Mappings (GEMs) that contain bidirectional mappings for both diagnoses and procedures (ICD-9 to ICD-10 and ICD-10 to ICD-9). GEMs contain all clinically plausible translation alternatives from one code set to another, including one-to-one, one-to-many, and many-to-one mappings. They are meant to be a general purpose aid to help vendors, payers, providers, and reporting agencies convert their existing ICD-9-based systems to ICD-10. GEMs can be employed in many ways, such as linking ICD-9 and ICD-10 data for long-term clinical studies and analyzing data collected during the ICD-10 transition period and beyond.

*Reimbursement Mappings.* Reimbursement Mappings, released by CMS in December 2008, offer a single recommended mapping of each ICD-10 code to a single ICD-9-CM alternative. This crosswalk is based on MS-DRGs and can be used to help prepare billing systems for the transition and to support the phase-out of ICD-9-based systems after Oct. 1, 2013, when healthcare claims will be submitted to payers using ICD-10 diagnosis codes and, for inpatient services only, ICD-10-PCS procedure codes.

# THE IT IMPACT

Pundits have dubbed the ICD-10 conversion healthcare's own "Y2K" crisis, given the overwhelming impact it will have on the IT portfolio. "It's actually a disservice to use the Y2K analogy, because this is so much greater in complexity,'" notes Torrey Barnhouse, CEO of Springfield, Mo.-based TrustHCS. "This isn't simply changing a two-digit field to a four-digit field. With Y2K there was virtually none of the training or process change that we need with ICD-10."

"The first step is to inventory where ICD codes are used in your entire portfolio of IT systems," says Dean Farley, PhD, vice president, PPS and payment accuracy solutions, OptumInsight. "You'll face so many build/buy decisions. Do those systems need to be changed or replaced? You need to talk through each department and build a systematic plan. The time is now."

At Johns Hopkins Hospital, that inventory was an eye opener. "We found that more than 100 of our applications and databases used ICD-9 codes," says Paul Allen, director of casemix information management and education. "That's a mixture of homegrown and commercial systems. For the internally developed applications, we have a process in place to make the modifications to support ICD-10."

Allen continues: "For the commercial software, the situation is riskier because there are so many uncertainties for every single system and vendor. Will the current version be made ICD-10 compliant? Is there a new upgrade? When will it be delivered? When will it be ready for testing? What will it cost? What additional hardware and software will be needed to support that? Will it integrate with our other systems? That's a lot of risk that we need to manage."

There's a similar level of concern at Catholic Health East in Newtown Square, Pa. "Some of the timelines we're seeing from vendors for their ICD-10-compliant software versions seem awfully close to October 2013," says Cynthia Fry, vice president of revenue. "Some have reported that they won't be ready until Q4 of 2012. Others have no date yet. That might force some health systems to resort to the General Equivalence Mappings—but that's something we want to avoid because so many codes don't map on a one-to-one basis and payers are creating multiple versions of these mappings."

Katie Carolan, vice president of operations and ICD-10 services for Baltimore-based HRS, is blunter: "Software vendors say they'll be ready, but what happens if they aren't?"

## TRAINING PLAYS A PIVOTAL ROLE

Most industry watchers believe that ICD-10 will require exceptionally high levels of training that stretch across the organization. Payers and regulators will be looking for providers to demonstrate that they've trained their coders as part of broader compliance requirements. According to Allen, these initiatives—encompassing class time, computer-aided instruction, pre/post-tests, and careful scoring—will need to begin in 2012. "ICD-10 will require coders to have a much deeper knowledge of anatomy and physiology," he says. "They will need to understand a much more detailed and specific documentation vocabulary to attain a consistent level of accuracy and quality in the coding. So it makes sense to get those courses started immediately. Get that out of the way before you even start ICD-10-specific training sessions."

Terri McCubbin, RN, director of ICD-10 consulting services, 3M Health Information Systems, has an eye on the broader scope of ICD-10 training. "ICD-10 training should be tailored to fit specific staff needs," she says. "First, schedule basic training for administrators who need to understand what's changing and how the organization is affected. These people might not use codes in their daily work, so they don't need in-depth education. A one-to-two hour presentation for nursing managers and staff, for example, should be sufficient."

McCubbin says: "You will need a more advanced course for staffers who actually see or occasionally use codes, such as someone in a scheduling or registration role. People in these roles don't actually create or change codes, but they may interact with codes as part of their job responsibilities. They might require a half-day training session. It's the people who are creating or originating the codes who need extensive training. They might be inpatient clinicians or staff in ambulatory care offices. They might be coders too. These people are heavily impacted by the changeover. Gaining competence and fluency in ICD-10 takes time."

And finding time to train coders can be another drain on providers. "If you're only budgeting 50 hours per coder, I think you'll fall well short of the training that will be required," says Barnhouse. "Coders need an extensive amount of additional biomedical training. They need collegiate-level instruction on anatomy, physiology, pharmacology, and more. Planners should be thinking in terms of hundreds of hours, not dozens. The problem is, how do you carve out as much as 25 percent of a coder's time for continuing education without impacting today's throughput and cash flow?"

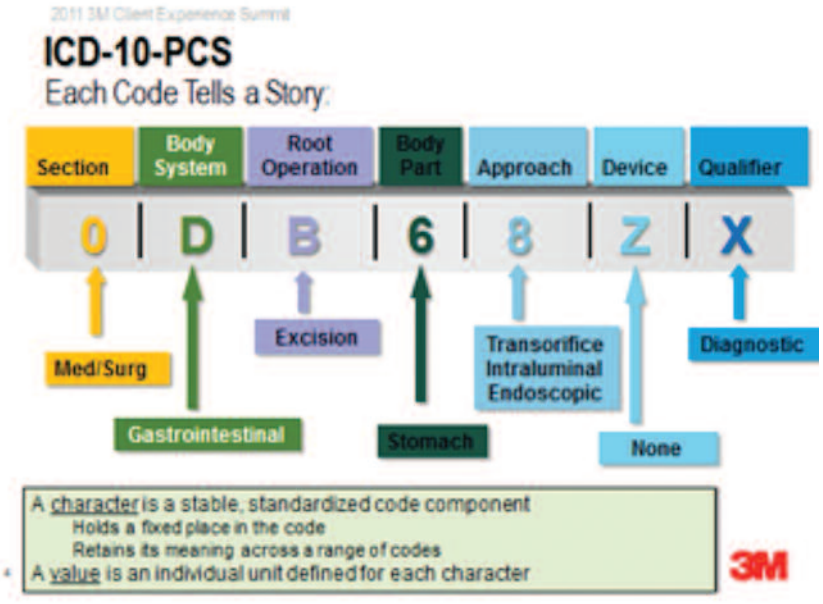
# WATCH YOUR LANGUAGE: A DOCUMENTATION ISSUE

ICD-10 essentially boils down to significant changes in the way that clinicians capture and record information about patient encounters, diagnoses, and treatments. ICD-10 reduces the many general, unspecified codes of ICD-9 and requires the physician to document with greater specificity. Historically, physicians have casually used terms like "excision," "resection," or "extraction" interchangeably. However, in ICD-10, each word has a very specific meaning that correlates with a specific code. A change to one word means a different code.

And a different code means a different level of reimbursement. ICD-10 also requires substantially more documentation detail. For example, in ICD-9, it's completely valid to document a debridement as "excisional debridement of skin and subcutaneous tissue." However, that's not precise enough for ICD-10, where the physician must describe the general system of the body that was involved, the precise action or approach taken, the specific body site where the action was performed, and any device that was used or implanted during the procedure.

Consider a patient who is treated for a second-degree burn on the abdomen. Under ICD-9, the diagnosis code would be 942.23. However, under ICD-10, there is a new distinction between burns and corrosion. Furthermore, if this is the second or third visit to the healthcare facility, ICD-10 requires you to capture and report that too.

"No question, this is a huge learning curve for the doctors," says Paul Allen, director of casemix information management and education, Johns Hopkins Hospital, Baltimore. "But over time, I believe this both feasible and beneficial. And it's also critical. If they submit incomplete documentation, the revenue cycle becomes unnecessarily long and that puts the financial stability of the provider at risk."




Slide: Courtesy of 3M Health Information Systems.

"This isn't just an expansion of codes," says Cynthia Fry, vice president of revenue for Catholic Health East, Newton Square, Pa. "It's changing the way physicians think about documentation in the medical record. This kind of fundamental change will take time. Frankly, this area—getting physicians to change the way that they currently document—is what concerns me the most. We will be unable to produce a claim if documentation fails to meet the ICD-10 requirements."

"There's a greater emphasis on what they document and how," says Torrey Barnhouse, CEO of TrustHCS, a medical-coding specialist based in Springfield, Mo. "If physicians don't comply, there'll be an exponential increase in inquiries from coders—and doctors are already overwhelmed by the queries they're getting today. Fortunately, in our work with health systems, we're seeing broad-based cooperation from physicians. They're coming to us and saying, 'What is the proper way to document this patient episode?'"

According to Suzanne Lestina, FHFMA, CPC, director of revenue cycle MAP for HFMA, a two-step strategy can help bring more doctors into the fold faster. "The smart approach is to work with employed doctors first," she says. "They're a more captive audience and you can also manage their documentation through the electronic health record they use to document. But doctors who aren't employed—that's a much tougher challenge."

"Physician documentation is the foundation for ICD-10 success," says Terri McCubbin, RN, director of ICD-10 consulting services, 3M Health Information Systems. "And enlisting their support means reaching out and engaging them—not dictating new processes

The training issues, staffing requirements, and productivity concerns associated with ICD-10 translate into an enormous set of challenges.

and terms. It's a good idea to get input and ideas from physician leadership about how they can help the coding staff get the specificity that ICD-10 requires. If you emphasize the opportunity for greater accuracy and precision of quality outcomes data that comes with more specific documentation, you have a much better chance of forging a cooperative partnership with physicians."

## THE CODER CRUNCH

Unsurprisingly, experts agree that the greatest impact of ICD-10 will be experienced by coding professionals in the HIM departments of every health system in the country. The training issues, staffing requirements, and productivity concerns translate into an enormous set of challenges.

"Without question, coder productivity is going to be a major issue for every provider," says Allen. "For instance if a coder averages 13 charts a day, what happens if that throughput declines to eight charts?"

"Many of the revenue cycle leaders I've spoken to are telling us that ICD-10 will initially drag productivity down by 40 to 50 percent," Lestina notes. "And we're not expecting that ICD-10 coders will ever get back to the levels of productivity they had with ICD-9. They'll improve, but never reach today's speeds."

In Canada, where ICD-10 has been in use for years, the leading indicators aren't promising. "The data from Canada and other nations that have adopted ICD-10 is quite concerning," says Barnhouse. "Although Australia has achieved far more positive outcomes due to their early assessment and training approach, providers in many other areas have experienced coder productivity shortfalls and staffing shortages. Even if you've never outsourced coding before, you surely will in 2013-14."

"We definitely want to reduce the need for additional coders," says Allen. "So if we can add technologies and streamline coding processe, those are steps we can take now. We don't need to wait to 2013 to make those improvements. Now, maybe technology and process improvements reduce the productivity hit somewhat, but we'll still need more coders. There's no getting around the fact that staffing will be critical during and after the transition to ICD-10. We're working with HR and our training team in a "Retrain and Retain" program to bring our current coding team up to date on ICD-10 and put in HR policies to retain them. We don't want to train them and see them leave."

Allen continues: "We're also considering an initiative to hire people off the street—today—and start training them solely in ICD-10. They'll never learn or code an ICD-9 bill. If we don't have a cadre of coders standing by in the wings, we will be up the creek."

Time is of the essence when it comes to staffing, says Katie Carolan, vice president of operations and ICD-10 services, HRS, a clinical coding consulting firm headquartered in Baltimore. "You need to book these coding resources early," she says. "It's not too early to start that process now, in fact, because everyone is going to need those at the same time. You don't want to be looking for temporary help on Sept. 15, 2013. It will surely be too late by then. These will be rare resources and they will be expensive. But if you're short, it will threaten your revenue stream."

One strategy for addressing coder productivity is the use of technology to automate and accelerate the coding process. Computer-assisted coding tools leverage natural-language processing and text-mining algorithms to automatically read physician documentation and assign the right ICD codes. "This isn't a 'nice to have,'" says Dean Farley, PhD, vice president, PPS and payment accuracy solutions, OptumInsight, a major provider of health information, technology, and consulting services to healthcare organizations. "ICD-10 coding will be nearly impossible without it. There just won't be enough coders in the world to process bills in this more complex environment. Will this remove the human element? No—it can't and it shouldn't. But it will improve coders' throughput and accuracy, almost raising them to the level of an auditor or reviewer."

Unfortunately, ICD-10 adoption won't come without healthy amounts of effort and investment over extended time.

*Facilitate implementation and functionality of the electronic health record (EHR).* Expanded codes make digitizing medical records easier. Converting to ICD-10 before EHR development is generally considered to be easier and less costly than doing so after EHR implementation because many EHR systems will likely not support ICD-9. Therefore, healthcare organizations would not benefit from waiting to stage ICD-10 between EHR implementation and the ICD-10 compliance deadline.

*Enhance quality and population health reporting, management, and improvement.* Anticipation is building around improved quality reporting and management. Among the benefits promised is an increased ability to measure and monitor the effects of hospital care on population health measured longitudinally. Improved information about the population derived from ICD-10 databases will allow a much greater degree of actuarial accuracy in predicting morbidity in a population.

*Employ effective accountable care positioning, including value-based purchasing, bundling, and global pricing.* The sophistication inherent in ICD-10 will improve providers' ability to demonstrate and offer value in the accountable care environment, particularly given its expected applications in population health measurement and management.

*Reduce ambiguities in all aspects of patient-provider interactions.* ICD-10 will offer a much larger dictionary of codes to allow a reduction in the code-based descriptions of both diagnoses and procedures. More available codes will make it easier to find the correct code.

*Protect against fraud and abuse.* Because CMS has identified ICD-10 as a tool for detecting fraud and abuse, hospitals and health systems can use the tool to prevent and protect against fraud as the specificity of the codes eliminates much of the need for judgment, thereby reducing errors and the opportunity for miscoding and fraudulent upcoding.

Moreover, the adoption of ICD-10 will put U.S. healthcare information systems on par with those of nations that have long been using this classification system to document patient encounters, diagnoses, and treatments.

## DANGER: CHAOS AHEAD

With so many advantages to accrue, it might be easy to assume that healthcare executives are eager to embrace the ICD-10 classification paradigm. Unfortunately, ICD-10 adoption won't come without substantial amounts of effort and investment over extended time, far past the Oct. 1, 2013, implementation date.

"It's important to recognize that, ultimately, ICD-10 is an unfunded mandate," says Paul Allen, director of casemix information management and education for Johns Hopkins Hospital in Baltimore. "I'm convinced that there will be a meaningful payback. What we will gain is enormous. But the road to these gains is long and difficult and there are many uncertainties surrounding cash flows and payer contracts."

# HOW WILL ICD-10 AFFECT THE FINANCIAL PICTURE?

For healthcare executives, the tremendous costs of ICD-10 compliance are only a piece of the total financial picture. Perhaps the larger concern stems from the uncertainties regarding the impact of ICD-10 on reimbursement revenue. The expert opinions can vary. Katie Carolan, vice president of operations and ICD-10 services for Baltimore-based, HRS, expresses the concern of many CFOs. "Are we going to endure an enormous amount of work and cost—and receive less reimbursement than we did before?" she asks. "That's certainly the pessimistic point of view. But if we don't do this properly, we'll see even less reimbursement. It's mandated and there's no choice."

"CMS has said that revenue changes under ICD-10 will not be significant," says Terri McCubbin, RN, director of ICD-10 consulting services, 3M Health Information Systems. "However, most private payers aren't saying one way or another. So it's only prudent to be prepared. However, it's possible to offset potential changes in reimbursement under ICD-10 by working now to improve documentation specificity for ICD-9 coding. This may result in more accurate and improved reimbursement, which can help fund your ICD-10 transition."

Dean Farley, PhD, vice president, PPS and payment accuracy solutions, OptumInsight, doesn't foresee as dire a picture. "CMS won't use this as a hammer to lower reimbursement," he says. "But they will use it to allocate their dollars differently based on acuity and resource requirements. They'll put dollars where they'll do the most good."

Torrey Barnhouse, CEO of Springfield, Mo.-based TrustHCS, agrees. "I don't see this cutting reimbursements," he says. "I see it as a way to make our systems better and improve the way we document so that we can get better information and improve patient outcomes. I think this can and should swing both ways. The greater specificity might reduce reimbursements in some instances, but in other cases where coders have previously downcoded out of an abundance of caution, you could see increases in reimbursements under ICD-10."

One way to get a sense of the impact is to perform some "dual coding" experiments. Some health systems are running as much as a year's worth of claims history through an ICD-10 regimen and evaluating the likely effects on reimbursements. "Yes, there's a productivity impact in doing this," says Farley. "But it can show you—ahead of time—where the pitfalls are likely to be: the codes, the physicians, the products, and the payers that are likely to be the source of problems.

Regardless of the reimbursement scenario, it's certain that the lost productivity and slower coding involved in ICD-10 will have a material impact on cash flow. "The timing of the claims and receipt of cash will definitely be affected," says Barnhouse. "If facilities fail to establish cash reserves, they'll struggle. We've seen consultants advise their clients to allocate as much as one year's worth of cash. That might be too much for some systems, but clearly not having ample cash reserves would be imprudent."

At Catholic Health East in Newtown Square, Pa., Cynthia Fry, vice president of revenue, underscores the importance of building partnerships with payers. "It's a good idea to create some risk-mitigation clauses for cash-flow purposes," she says. "For example, if there is one payer whose denials increase from 1 percent to 15 percent, we might successfully appeal some percentage of those cases, but the delay in cash could materially impact us. It's a good idea to collaborate with the payers now so that neither party is unfavorably impacted through the implementation of ICD-10."

## DEADLINE IS COMING

Although nearly two years remain before the implementation date, certain urgency is called for. "The fact is, as an industry, we've frittered away two years," says Paul Allen, director of casemix information management and education, Johns Hopkins Hospital in Baltimore. "There isn't a single executive who shouldn't have his health system immersed in ICD-10 conversion. It's not too late. Washington has made it clear that the date will not get pushed out, so you need to get moving. It will take a year or two post-2013 for payers, vendors, and providers to have sufficient data to truly determine the impact of ICD-10. This is an exciting change, and I can't wait to see what the results are."

Indeed, even the Workgroup for Electronic Data Interchange (WEDI)—the industry consortium that promotes electronic record keeping and information—acknowledges the challenge. WEDI's subcommittee on ICD-10 notes: "ICD-10 … is a massive overhaul of the coding scheme and will require field size expansion, change to alphanumeric composition, and complete redefinition of code values and their interpretation. This will be the most significant overhaul of the medical coding system since the advent of computers."

Industry research firm Gartner is just as emphatic: "The conversion year and the year after will be chaotic. The proper mindset is to plan meticulously and prepare for this to be a crisis, even if the conversion date should move back (and there is no sign that will happen)."

## FIRST STEP: ASSESSING READINESS

Most institutions have already begun their ICD-10 journey. But if you haven't, the best

## FIVE KEY ACTION STEPS TO GET STARTED

*Establish a project management team.* The ICD-10 migration project is a long-term, complex, process. A cross-functional team or migration task force should be established by and under the direction of both senior financial and IT management. The task force should include representatives of finance, revenue cycle, IT, coding, medical staff office, major physician groups, and compliance.

*Create an implementation plan.* A detailed implementation plan prepared by the task force is needed to guide the progress, including subordinate schedules, resource requirements, and budgets by function or system with team member responsibility specifically designated. An agreed-upon initial assessment form should be developed for the creation of this plan. Senior management should review the appropriateness of budget allocations and resource requirements.

*Produce and project a timeline.* A master project timeline in a Gantt Chart overseen by the task force integrating the plans from each department or function is then developed with critical paths identified, particularly for key vendors upon whom timely conversion depends. In other countries where the conversion has taken place, the staff learning curve was six months. Training should not commence before early 2013 to ensure staff will not forget what they have learned by the time they have to use ICD-10, thereby requiring retraining. Physician training for nonclinical activities can be problematic. This is particularly true for nonemployed physicians over whom the hospital has less authority. Generally, physician leaders and physician champions are helpful in encouraging timely participation.

*Prepare a gap analysis for each department or system.* Because successful implementation depends on many individual components, departments should be reporting regularly on their progress and their trading partners' progress. The task force will prepare and manage an analysis of the gaps between current state and full ICD-10 readiness, and monitor the plan to fill the gaps. Problem areas can be identified, and the resources of the group or outside expertise can be called upon to fill those gaps.

*Calculate and prepare for impact on the revenue cycle.* Although there are multiple reasons for and benefits from this conversion, the financial impact can be significant. The task force should assess the potential impact the conversion may have on revenue by payer or contract. Consider potential risks from:

> Claim rejection and denial
> Authorization delays
> Improper claims payment
> Coding backlog
> Key MS-DRG shifts
> Case mix index changes

*Source:* Ronning, P.L., "ICD-10: Obligations and Opportunities," *hfm,* August 2011.

place to start is with a thorough assessment. According to Terri McCubbin, RN, director of ICD-10 consulting services for 3M Health Information Systems, the key is to find the gaps. "Gain an overall view of your entire organization," she says. "What departments are using or creating ICD-9 codes today? Which staff members will need training and to what extent? What information systems hold ICD-9 codes and will need to be updated? Where will you need to focus your transition plan? For example, we're finding many organizations are reviewing coded records to identify documentation that's lacking the specificity required for ICD-10 coding, so they can identify which clinicians will need consultative training for ICD-10. When you get down to it, ICD-10 will affect every paper-based process, every software system, and workflow that uses ICD-9 codes. It's hard to find corners of the organization that won't feel the impact."

Allen at Johns Hopkins agrees with the focus on benchmarking. "The first thing we're doing is putting together a document of all the criteria we want to measure as it stands today," he says. "That might be days in A/R, number of denials, rejects in the billing system. We want to identify and report on as many of these as possible."

"You definitely have to know where you stand today before you can map out a path to the future," says Katie Carolan, vice president of operations and ICD-10 services at the Baltimore-based coding consulting firm HRS. "Where are you with your systems, processes, clinical documentation — and where does all of this need to be for ICD-10? Finding those gaps is crucial. Most hospitals are still putting together these systemic assessments. But in 2012, the plans need to turn into action." ●

## THE FOUR PHASES OF ICD-10 TRAINING

*General awareness.* Training for ICD-10 should be well under way. Every department should be aware of the magnitude of effort required. Organizations should educate and budget accordingly.

*Staff knowledge.* Assess the baseline knowledge of staff in critical areas and pinpoint areas where emphasis is needed. A high level of IT involvement will ensure vendors and systems are ready for the transition.

*Training.* Once that baseline is established, cater your education program to each individual's needs and incorporate different training avenues.

*Post go-live support.* This is a time for organizational agility, especially in revenue cycle, healthcare information management, and IT. Close monitoring will be required throughout the go-live process and afterward.

*Source:* Carolan, K., and Reitzel, D., "Preparing Your Organization's Training Program for ICD-10," *hfm*, October 2011.