ICD-10 | ICD-10 KPIs at a Glance

1 Assessing Your Progress | Key Performance Indicators

Now that you've made the switch to ICD-10, you can look for opportunities to analyze your progress. By tracking and comparing key performance indicators, or KPIs, you can identify and address issues with productivity, reimbursement, claims submission, and other processes.

For more about assessing and maintaining your ICD-10 progress, see the [CMS Next Steps Toolkit](#).

You don't have to track all of the KPIs listed below—some might not be practical or relevant for you. But even small steps to identify and resolve issues can get you on the road to higher productivity and more timely claims processing.

- ❑ **Days to final bill**—number of days from time of service until provider generates and submits claim

- ❑ **Days to payment**—number of days from time claim is submitted until provider is paid

- ❑ **Claims acceptance/rejection rates**—percentage of claims accepted/rejected during payer front-end edits (before entering the payer's adjudication system)
  - Consider using these criteria to gauge potential issues:
    - Agings - 0-30, 31-60, 61-90, 91-120, 121+ days from time of service; track by payer and dollar value
    - Days in accounts receivable, by payer

- ❑ **Claims denial rate**—percentage of claims accepted into the payer's adjudication system that are denied
  - Consider keeping separate tallies of authorization and coding denials

- ❑ **Payment amounts**—amounts provider receives for specific services (focus on high-volume, resource-intensive services)

- ❑ **Reimbursement rate**—cents on the dollar provider receives on claim versus amount billed

- ❑ **Coder productivity**—number of medical records coded per hour; review by individual coder

- ❑ **Volume of coder questions**—number of records coders return to clinicians with requests for more documentation to support proper code selection

- ❑ **Requests for additional information**—number of requests from payers for additional information required to process claims

- ❑ **Daily charges/claims**—number of charges or claims submitted per day

- ❑ **Clearinghouse edits**—number and content of edits required by clearinghouses, or claims accepted/rejected by clearinghouse

- ❑ **Payer edits**—number and reason for edits required by payers

- ❑ **Use of ICD-10 codes on prior authorizations and referrals**—number of orders and referrals that include ICD-10 codes

- ❑ **Incomplete or missing charges**—number of incomplete or missing charges, weekly or monthly

- ❑ **Incomplete or missing diagnosis codes**—number of incomplete or missing ICD-10 diagnosis codes on orders

- ❑ **Use of unspecified codes**—volume and frequency of unspecified code use

- ❑ **Return to Provider (RTP)/Fiscal Intermediary Shared System (FISS) Volumes**—number of rejections in Medicare RTP/FISS system

- ❑ **Medical necessity pass rate**—rate of acceptance of claims with medical necessity content.

TIP Tracking KPIs separately for each payer will assist in isolating the root cause of issues.

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Establish a Baseline for Each KPI

The first step in using KPIs is to establish a baseline, or a point of comparison, for each KPI you'd like to track. For purposes of assessing your ICD-10 progress, you'll want to compare KPIs from before the October 1, 2015, transition date with KPIs from after the transition date. The pre-transition KPIs will serve as baselines.

Ideally, you either:
- Already have pre-ICD-10 baseline data for some KPIs from your clearinghouse
- Can generate baseline data through your practice management system, electronic health record, or other health IT system.

If you're a provider in a small practice, you might not have routinely used or tracked KPIs in the past, so you may need to start by developing a new baseline with current data. Work with your billing and coding staff to see what data are already available in your systems, reports, and records. Check for data available from outside sources like:
- Clearinghouses
- Third-party billers
- System vendors

If you don't have KPI data from before the ICD-10 transition, your clearinghouse or vendor can help create a baseline.

Track Your KPIs

Once you have established baselines for your KPIs, compare the data pre- and post-October 1, 2015, to put your current KPIs in context. Tracking KPIs can help you detect problems and identify opportunities for improvement. Once you know what the problems are, you can evaluate them to find the root causes and ultimately improve your office's productivity. Be sure to reevaluate your KPIs on a regular basis as you refine your processes.

TIP   It's best to compare metrics with past calendar years by month. Seasons can affect statistics, and you will want to take into account local issues (e.g., impact of staff vacations, flu season). Keep this in mind when developing baselines.

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Visit **cms.gov/ICD10** to see the **CMS Next Steps Toolkit** and other official CMS resources"