

CDI and ICD-10 readiness

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During the recent CHIA seminar on “Strategies for Clinical Documentation Improvement and ICD-10” held in May 2012, we found that the audience was very eager to learn and understand more about preparing for ICD-10 implementation whether it be October 2013 or October 2014. Thorough and well-thought out planning and readiness will allow you to be well positioned to minimize the documentation data accuracy and financial risk posed by this massive transformation. This article will share some highlights from that seminar and provide you with a Clinical Documentation Improvement “CDI” ICD-10 readiness list of key strategies for you to use and follow.

Background

CDI programs can help alleviate the documentation burdens associated with ICD-10 initiatives if they focus on securing appropriately detailed documentation in the record now. Correct coding and appropriate reimbursement represent a direct reflection of accurate and complete documentation and this will prove ever more important as ICD-10 becomes the new code structure. In addition, capturing patient severity and acuity through documentation and coding is critical to scorecards, profiles, research and patient care initiatives.

A potential delay in the implementation compliance date began with the following statement made in February this year. “We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead,” HHS Secretary Kathleen Sebelius said in a press release. The Department of Health and Human Services (HHS) on April 9, 2012 announced a proposed rule that would delay the compliance date from October 1, 2013 to October 1, 2014 for the International Classification of Diseases, 10th Edition, diagnoses and procedure codes (ICD-10).

All covered entities must transition to ICD-10 at the same time to ensure a smooth transition to the updated medical data code sets. Failure of any one industry segment to achieve compliance with ICD-10 would negatively impact all other industry segments and result in rejected claims and provider payment delays. HHS believes the change in the compliance date for ICD-10, as proposed in this rule, would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition among all industry segments. Staying on course and on track is vital for those in health care. Let us look further at the CDI impact and the phases or steps that you should be planning for and/or achieving.

Understand coding conventions and guidelines

ICD-10-CM is available for use in all U.S. health care settings. The Clinical Modification (CM) is for diagnosis coding and uses three to seven digits instead of the three to five digits used with ICD-9-CM, but the format of the code set is similar. **ICD-10-PCS** is intended for use in the U.S. for procedure coding in inpatient hospital settings only. ICD-10-PCS uses seven alphanumeric digits instead of the three or four numeric digits used under ICD-9- CM procedure coding. Coding under ICD-10- PCS is much more specific and substantially different from ICD-9-CM

procedure coding. Guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction.

Common diagnoses and procedures that will impact CDI

We know that there are specific areas in documentation TODAY that are problematic, and this will continue to remain true in ICD-10. Below is a short list of areas to focus on and study carefully to prepare you now for ICD-9 and for ICD-10.

Orthopedics	Stroke
Fracture	Diabetes
Asthma	Respiratory Failure
Coma	Pressure Ulcer
Pregnancy	Myocardial Infarction

Some steps to take to assess your documentation gaps are listed here:

1. Identify the top 10-30 surgeries (Map to ICD-10):
 - a. Define the documentation requirements.
 - b. Assess documentation weaknesses.
 - c. Address through documentation improvement.
2. Review reports (canned and customized).
 - a. Size of field.
 - b. System edits for decimal point.
 - c. System edits for alpha numeric characters.
 - d. Testing plan.

Financial impact

Little confirmed information has been provided to date on the financial impact of ICD-10 on all impacted health care facilities. However, the *Medicare and Medicaid Research Review* (MMRR), a publication of CMS Research, Development & Information office recently published a document identifying the Impact of the transition to ICD-10 on Medicare Inpatient Hospital Payments to estimate the impact of the conversion to ICD-10 on Medicare MS-DRG payments to hospitals using 2009 Medicare data. The MMRR used ICD-9-CM DRG version 27 (FY 2010), the converted ICD-10-MS DRG Version 27 and the ICD-10 to ICD-9 CM Reimbursement Map for fiscal year 2010 to estimate the impact on aggregate payments to hospitals and the distribution of payments across hospitals.

The report states that overall, the native ICD-10 MS DRGs relative to the native ICD- 9-CM MS-DRGs increased hospital payments by 0.05 percent. Thus payment increases and decreases

due to a change in DRG assignment essentially netted out. The change in payment was relatively consistent across hospital types with rural hospitals having a 0.01% decrease in payment.

With the implementation of ICD-10, it was also identified that the MCC list and CC list would be changed due to mapping of ICD-9 to ICD-10. The following illustrates the changes to both the MCC and CC lists:

MCC List: 1,592 codes in the ICD-9-CM based version.
Replaced by 3,152 codes in the ICD-10-CM based version.

CC List: 3,427 codes in the ICD9-CM based version.
Replaced by 13,594 codes in the ICD-10-CM based version.

Due to these significant MCC/CC changes, it is expected that extensive education and training will be required. In addition, a comprehensive documentation assessment will need to be conducted to assist in identifying which MCCs and CCs will impact an organization.

Key education and training on ICD-10 for CDI

We use the terms “education” and “training,” almost interchangeably at times. However, we need to be clear that education must come first and then the training can take place. Listed here are some definitions to consider:

Education = the development of knowledge; learning.

Training = the practice and learning to do a particular act, trade, art, or profession.

Keep in mind that not ALL people learn the same way. We have those who are visual learners and they learn best by seeing (reading, pictures). Auditory learners learn best by listening (hearing and repetition). Kinesthetic learners learn best by doing (finding the answers to questions, games, practice or analysis). Then there are those who have a “combination” of learning styles.”

Intensive coder training should not be provided until 8–10 months prior to implementation with the training spread out over time with plenty of actual practice of the code set. Similarly the CDI staff will need education and training. To best prepare for ICD-10, conducting an assessment of your training needs and then follow up with prerequisite foundational health science education and then actual ICD-10 code set education and training. Books and references are already available. Formal classroom settings may not be available in all areas so self directed learning may be the best option. Partnering health information management (HIM) staff with CDI staff will be important to optimize clinical and coding skills best. The HIM profession serves as a resource as well as industry experts of the code set.

Physician engagement

Being proactive and responsive will be key to physician engagement. There are several benefits of ICD-10 that can help the physician and clinician community understand readiness better. Improvement in mortality data and identifying a condition with the proper words permits quicker and more accurate retrieval of mortality data. The execution of care can be positively impacted through the identification of a condition and documentation of the clinical thoughts into words, thus permitting others who follow to understand better just what the provider is thinking. ICD-10 will impact “Quality Scores” by allowing a condition to be more specifically identified and coded allowing quality indicators to be extracted retrospectively. Physician profiles use ICD-9 data today and with ICD-10 greater data mining can occur to allow for insight into the process used for staff privileges. Reimbursement impact, both positive and negative, may occur with ICD-10, but most importantly we want a true picture of the rationale for services/tests to support financial remuneration. Improved clinical data can provide this support.

An assessment of documentation should be conducted. Ask a physician leader to participate in the review and then share the findings with others in the medical staff and leadership. It has been reported that 74% of hospitals believe that training physicians about new documentation requirements was their biggest hurdle to implementing the expanded ICD- 10 code set. Having a strong documentation improvement program to address deficiencies identified in a medical record review will support the new coding system.

Physician query process

The AHIMA Practice Brief on Physician Queries and CDI should be used and followed. Queries should improve documentation of unique clinical situations and provide assurance that if codes are assigned, the documentation in the record is supported. Excessive use of queries may indicate trends of poor documentation that should be addressed. Documentation is also used to evaluate the adequacy and appropriateness of quality care, provide clinical data for research and education, and support reimbursement, medical necessity, quality-of-care measures, and public reporting for services rendered by a health care entity.

The query can list “all clinically reasonable choices regardless of the impact on reimbursement or quality reporting” and give physicians a space to write “other” or “unable to determine.” Not to be forgotten is that the financial impact should not be documented or implied on the query form.

Technology, tools and resources

Computer Assisted Coding (CAC) technology is seen as an asset for ICD-10. CAC automatically generates codes directly from clinical documentation. A computer/engine will “read” electronic text or handwritten documentation AND provide the tentative ICD-9-CM or ICD-10 code(s) ready for validation. The technology can now perform the CAC functions on a concurrent basis benefiting CDI and concurrent HIM coding practices.

There are many great resources available, be sure to check them:

CMS (Centers for Medicare and Medicaid Services)

AHIMA (American Health Information Management Association)
AAPC (American Association of Professional Coders)
HIMSS (Healthcare Information Management Systems Society)
HFMA (Healthcare Finance Management Association)
HCCA (Healthcare Compliance Association)

Summary

The lack of successful preparation for ICD- 10 may lead to: cash flow delays; increased claims rejections/denials; payer contracts, and place market share arrangements at risk due to poor quality rating or high costs. Furthermore, distorted or misinterpreted information about patient care may occur resulting in faulty investment decisions to improve health delivery.

The transition to ICD-10 will bring about higher-quality data, which will result in:

- Improved ability to measure the quality, efficacy, and safety of patient care;
- Increased sensitivity when refining grouping and reimbursement methodologies;
- Enhanced ability to conduct public health surveillance;
- Greater achievement of the anticipated benefits from electronic health record adoption and provide you with the tools to help you implement;
- Measuring the quality, safety, and efficacy of care;
- Reduced need for attachments to explain the patient's condition;
- Improved payment systems and processing claims for reimbursement;
- Better research, epidemiological studies, and clinical trials;
- Improved development of health policy and operational and strategic planning.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. Develop an implementation strategy that includes an assessment of the impact on your organization, a detailed timeline, and budget. A successful conversion from ICD- 9 to ICD-10 depends upon good planning and preparation. Do not wait, even with a possible one year delay. Act now and plan your strategy for ICD-10 and CDI implementation.

Watch your CHIA e-mails and visit the Web site for more information, tips and upcoming educational seminars and programs that address ICD-10 readiness.

References

<http://www.cms.gov/ICD10>; Industry input through ICD-9-CM Coordination and Maintenance Committee;
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<http://www.cdc.gov/nchs/icd/icd10cm.htm#10update>
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