

Q&A

CDI WEEK

ICD-10 preparation

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As part of the third annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Vivian E. Gannon, RN, CCM, CCDS**, clinical documentation improvement coordinator at Chesapeake (Va.) Regional Medical Center, and **Autumn Reiter, RN, BSN, CCDS**, clinical documentation specialist at Chesapeake Regional Medical Center, answered the following questions regarding ICD-10 preparation. Contact Gannon at Vivian.Gannon@chesapeakeregional.com or Reiter at Autumn.Reiter@chesapeakeregional.com.



Q **What has been your biggest obstacle with ICD-10 preparation, and why?**

A *Our biggest obstacle, like many other facilities, is physician education and buy-in.* The physicians' role is crucial to the organization, and changing physician attitudes and behavior is our greatest challenge. Getting them to understand that the greatest benefit of ICD-10 is that it will provide detailed data for analysis, resulting in better patient care and quality physician outcomes, will help pave the way to successful implementation.

volume of codes at risk (of inadequate documentation) in ICD-10 for both principal diagnosis and secondary diagnoses.

We also drilled down to individual physicians within the groups to identify specific individual educational opportunities. Our service lines were evaluated similarly, identifying orthopedics as our initial focus (highest volume, highest risk), followed by pulmonology. Specific areas identified included cerebral artery occlusion, acute/chronic respiratory failure, sepsis, pneumonia, and total knee and hip replacements.

Q **Can you describe your approximate timetable for training and education leading up to the "go live" date of October 1, 2014?**

A *ICD-10 has been a major focus for us since July 2012. We launched our initial opportunity assessment with the assistance of The Advisory Board ICD-10 Compass translation tool.* Over several months we developed our prioritization dashboards based on service lines, physician groups, and individual physicians, and developed our project plan creation in December 2012. Using this tool, we drilled down to specific physician groups with highest volume (Bayview Hospitalists, Chesapeake Hospitalists), and further drilled down to highest

The translation tool provides a plethora of reports—sometimes a bit overwhelming—but we are able to filter through voluminous amounts of current data and pinpoint our known and projected weaknesses, allowing us to develop techniques for proactive and concurrent documentation improvement efforts. Our CDIs and coders have been actively participating in comprehensive education since this time, with CDIs focusing first on our selected top 25 ICD-9 codes at risk in ICD-10 as well as our top 25 DRGs as we roll out those concepts to the physicians. Some of our top at-risk ICD-9 principal diagnosis codes include the following:

- 64891 – Other current conditions ... mother, delivered, with/without mention of antepartum condition
- 43491 – Cerebral artery occlusion unspecified with cerebral infarction
- 41071 – Subendocardial infarction, initial episode of care

- 51884 – Acute and chronic respiratory failure
- 5770 – Acute pancreatitis
- 72402 – Spinal stenosis, lumbar, w/o neurogenic claudication
- 66331 – Other and unspecified cord entanglement ... complicating labor and delivery ... antepartum condition
- 6826 – Cellulitis and abscess of leg, except foot
- 51881 – Acute respiratory failure
- 56211 – Diverticulitis of the colon, without mention of hemorrhage

Each month we select four to six new educational concepts. Our plan is to have a more in-depth anatomy and physiology course review in the spring of 2014. We are preparing for implementation of 3M 360 *Encompass*® in October 2013, integrating computer-assisted coding, clinical documentation improvement (CDI), and quality metrics, and streamlining our clinical documentation and coding workflows so coders and CDI specialists are able to work from the same content, enhancing documentation.



What are you doing now to educate your physicians on ICD-10?

We publish a monthly educational news blast on our physicians' intranet page and create educational information "tips" sheets (which are often placed in a patient's record). Our program is highly interactive, with our CDI specialists working out on the units six-plus hours a day, so our educational interactions are beneficial for both the physician and the CDI. Frequently we pose our questions to allow the physicians to "teach" us first, and then when we explain our request. It is a joint effort in obtaining the requested documentation.

Our medical record is a hybrid one, and will be for another 12 months or so. Taking full advantage of the additional year we were given to prepare for the code set conversion is allowing us to accomplish great strides in incorporating many of the ICD-10 concepts in a nearly seamless fashion.



Are you projecting additional staff needs, or if not, a decline in productivity?

We are indeed projecting the need for increased staff. We hired an additional 1.5 FTEs as part of our initial projected CDI workload increase, giving us 4 FTEs for our 310-bed facility. Currently we are awaiting approval for an additional 2 FTEs. Considering the ongoing educational needs, the anticipated increase in queries to ensure documentation at the highest level of specificity, and the projected expansion of CDI into the emergency department and outpatient arenas, we will certainly be increasing our staff.



What type of training have you provided to your CDI specialists?

ICD-10 education is an ongoing activity. We are utilizing the 3M ICD-10 online training courses and will be participating in an anatomy and physiology course review that is planned for both our coding staff and clinical documentation staff in the spring of 2014. In addition, we have been and will continue to participate in webinars and audio conferences offered by our industry experts at HCPro and AHIMA, as well as other vendors.



Physician education looms as the biggest obstacle to ICD-10 implementation

Donna Smith, RHIA, project manager and senior consultant with the consulting services business of 3M Health Information Systems, says that physician collaboration and dual coding are vital to ensuring a smooth transition to the new code set. Her comments follow.

What are some of the biggest obstacles hospitals are encountering with ICD-10 preparation?

There are a variety of things keeping people awake at night. I think hospitals have addressed and are well underway resolving IT needs, though some vendors have not fully disclosed or committed to when they will be ready for ICD-10. The majority are ready. 3M is ready and will support its customers.

Whenever we've conducted seminars or other training on the topic of ICD-10, the No. 1 concern is always physician documentation. Hospitals, clinics, or physician offices want to have a plan in place to deal with the needed documentation to support ICD-10. Some physicians have raised concerns about transitioning to a new coding system. Examples are cited about having to use "ridiculous" codes, and there are news reports about how bad or unnecessary it is; however, that is not true. The examples cited for delaying ICD-10 or waiting for ICD-11 most often focus on external cause codes that describe injury causes. In ICD-9 we also have external cause or E codes that could be viewed as unnecessary as well. Currently physician offices are not required to report E codes and are not required under ICD-10 to report them, either.

One area to focus on is preparing the physicians for the necessary documentation changes. Hospitals should do so by reviewing what documentation gaps exist in the charts now rather than randomly going out and teaching them about ICD-10. Focus on what needs to be done specifically to address the documentation gaps in your hospital. For example, in children's hospitals, the No. 1 diagnosis is asthma, because the coding has completely changed. If you get physicians used to new specificity/granularity documentation requirements related to asthma, then you can move on to another diagnosis. The key is looking at your current DRG assignments and documentation in the record and determine "where am I lacking?"

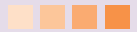
One way to educate the physician is to do it with queries. CDI specialists are already doing this in many hospitals to obtain improved documentation in the record for ICD-9; if you change the queries a little bit for ICD-10, they can also obtain the needed ICD-10 additional specificity now. This is considered passive education to the physicians and it can be effective. An example is that in ICD-9, acute respiratory failure unspecified goes to acute; in ICD-10 it doesn't, it defaults to unspecified. We can query for that acuity now, so it whittles down what you need for the October 1 ICD-10 go-live date.

Another area that hospitals are nervous about is testing: Practice coding, testing their systems to make sure they hold the codes, and passing the claim back and forth with their fiscal intermediary to make sure it works. People are far enough along in their planning to know what they're doing, although I'm surprised how many haven't trained their coders and CDI specialists in ICD-10.

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How far along should hospitals be in their timeline to the "go live" date of October 1, 2014?

Everyone needs to have an awareness to know it's coming, but coding staff should also be well underway on coding training. If not everyone on the coding staff, at least managers and trainers need to be trained to set the goals for the rest of the staff. It's the same in CDI: If CDI specialists are going to train physicians, they need to be in training now and use that knowledge to ask physicians the correct questions.



Physician education looms as the biggest obstacle to ICD-10 implementation (cont.)

CMS put out some really neat guidelines and checklists for hospitals; they actually advocate we start coding training January 1, 2014. We recommend the sooner the better to shorten the learning curve before “go live.”

You have to have a timeline for learning the process, but once you do that, you have to start practicing using ICD-10. We recommend that hospitals practice coding some number of cases in both ICD-9 and ICD-10. It shows the weaknesses in your current medical record documentation. One thing you might notice is that you can't assign a code because you're missing documentation. If that happens, obtain the documentation for that diagnosis or procedure first. For example, to report a cardiac cath in ICD-10, you need the type of contrast used. If it's missing, you need to go to the cardiac cath lab and ask them to revise their report template to obtain this going forward. So sometimes it's a process that must be revised rather than physician education that needs to be provided. Hospitals will not know the weaknesses in documentation or processes or the variances in MS-DRG assignment unless someone codes the records with ICD-10. There are ways to obtain an estimate, but the best way is to code in ICD-9 and ICD-10.

Some of our clients are starting dual coding in October so that they have a year's worth of records. Others are starting three to six months ahead of time. Regardless, it should be a planned approach. If you take all those elements—practice and training—then you can see where to start. For example, if you want to dual code three months out (from October 1, 2014) and need six months of training previously, you can extrapolate nine months out.

Another thing I recommend for physician training is focusing on a particular service line and a particular procedure that is difficult to code in ICD-10. Orthopedic surgery and bowel surgery are two procedures we see where there might be some issues around getting exact documentation. Ask a physician to give a class on the specific details of the procedure, and share with them the new coding system and ask them how it might be applied. The coding tables are very intuitive. Make it a collaborative effort rather than going to them and saying, “This is what we need you to document.” I have seen this approach and it was very successful. Physicians wanted to push the change in their documentation themselves—they took ownership and set up a template op note to set up the elements needed under ICD-10-PCS.

Are you projecting additional staff needs, or if not, a decline in productivity?

The actual results will be varied depending on the amount of prep time put in ahead of time. If you do a good job with dual coding, the productivity decrease won't be as high. Computer-assisted coding (CAC) systems can help to mitigate productivity loss. What we see in the literature is a 30%–50% loss of productivity in the first six months of go-live. Other countries that have gone to ICD-10 never go back to pre-ICD-10 levels of productivity. You can mitigate that with a CAC or additional staff. If you've practiced ahead of time, done process changes, and physician education and collaboration, your productivity drop will be lower. Will queries increase in ICD-10? We've heard that queries could increase 40%, but again it depends on how you roll it out. Do your due diligence and start ahead of time and it might not be that much.



Cerebral Infarction Documentation

Cerebral infarcts are a serious medical condition that affects different patients in different ways. Treatment often requires additional resources such as occupational, physical, and speech therapies to aid in the recovery process. To adequately reflect the impact of the infarct on the patient, specific documentation requirements are needed. Please specify:

Patient's handedness—Right or left. Rehabilitation effects can be affected depending on the hand and/or side affected.

Specific location or vessel—Simply stating “cerebral infarct” is inadequate to reflect severity and patient risk.

Laterality—Right or left.

Sequela—Sequela (aphasia, ataxia, hemiparesis, dysphagia, etc.) should continue to be documented and specified if resolved.

Cause—Thrombosis, embolus, stenosis, or occlusion.

Origin of the cause—Ulcerated plaque, heart, local occlusion, or disease process.

