Ready your CDI staff for ICD-10 implementation

Three years. That’s how long you have to prepare for the implementation of the International Classification of Diseases, 10th Revision (ICD-10).

If you are among those who think there is still plenty of time to prepare, or if you think CDI specialists already understand as much as they need to about the shift, think again.

“The enormity of this change still hasn’t hit people,” says Stanley Nachimson, principal of Nachimson Advisors, LLC, in Reisterstown, MD. “The change is incredible, and the documentation improvement team needs to know about this right away.”

Most CDI staff (52% of 350 respondents to a September ACDIS survey), however, indicated they have only basic awareness of ICD-10 changes. (Basic awareness was defined as an understanding that the new system is coming and why CMS thinks the change is important.) Furthermore, 44% of respondents indicated their facility does not have an ICD-10 training timeline to their knowledge, and another 51% said that CDI staff don’t have a seat at the table when it comes to ICD-10 implementation planning. (View the results of the survey on pp. 22–28.)

Beginning now, CDI specialists “need to be aware of the key components of ICD-10,” says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM at Kaiser Foundation Health Plan, Inc., and Hospitals, in Oakland, CA.

No one’s saying that every CDI specialist in the nation needs full-immersion ICD-10 training, “but now is not too early” to start reviewing the draft ICD-10 coding guidelines, going over CDI metrics, and raising awareness about documentation needs associated with ICD-10, says Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources at AHIMA in Chicago. “In my opinion, CDI staff are going to be near the top in terms of [ICD-10] training needs.”

Understand ICD-10 implications

On January 16, 2009, Department of Health and Human Services published its final rule adopting ICD-10 to replace ICD-9 in healthcare transactions and setting the effective implementation date at October 1, 2013.

“The compliance dates are firm and not subject to change,” CMS said in a recent MLN Matters article (www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf). “If you are not
ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.”

The differences between the ICD-10 and ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. ICD-10-CM contains about 70,000 diagnosis codes compared to approximately 14,000 in ICD-9-CM, and approximately 70,000 ICD-10-PCS (procedure) codes compared to 4,000 ICD-9-CM codes, the MLN Matters article states. ICD-10 codes are also longer and use more alphanumeric characters.

The ICD-10 code sets afford the opportunity for increased specificity in coding classification. Take, for example, diverticulitis of the large intestine with perforation or peritonitis with bleeding. Under ICD-9 coding conventions, there are two codes to assign, one for the diverticulitis with hemorrhage/bleeding and one for the peritonitis. Under ICD-10 conventions, there is a combination code to capture this clinical event, K57.41, says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, CCDS, C-CDI, manager of clinical documentation services at YPRO, Inc., in Madison, WI. The codes not only allow for greater clinical specificity in data recording, but they require greater clinical specificity in physician documentation in order for the new codes to be assigned. Nachimson uses the following example to show the difference:

“Under ICD-9, if a patient is injured while playing sports, the coder assigns a code for ‘injured in sports.’ But in ICD-10, the coder will need to know what sport and what type of injury,” he says.

All providers in all healthcare settings will use the ICD-10-CM diagnosis codes. Each code is three to seven characters long. The first is an alpha character, the second is numeric, and the third through seventh characters can be either alpha or numeric, with a decimal after the third character, the MLN Matters article states. The alpha characters are not case-sensitive.

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. These codes differ from the ICD-9-CM procedure codes in that they have seven characters that can be either alpha (non-case-sensitive) or numeric. The numbers 0–9 are used (letters O and I are not used to avoid confusion with zero and one). The codes do not contain decimals.
As an example, Krauss says the ICD-10-PCS code for dilation of right brachial artery with drug-eluting intraluminal device, percutaneous endoscopic approach, is 037644Z.

In order to report the new codes, the medical record documentation needs to reflect not only the procedure performed, but also how the physician performed it.

“PCS is dramatically different from what we’re used to,” says DeVault. “For example, one of the seven characters identifies the surgical approach for the procedure. This forces you to think and understand the procedure.”

Inpatient coders currently do not need that level of detail to code a patient’s episode of care. And, more importantly for CDI staff, physicians don’t necessarily need to document that level of specificity, DeVault says. “It’s a huge challenge but also a huge opportunity,” she says.

DeVault cites ICD-9 code 39.31, repair of a blood vessel, as an example. Regardless of whether the physician is repairing a blood vessel in the patient’s toe or the patient’s arm, the coder chooses 39.31, she says. Anecdotally, in ICD-10, there could be 200 codes to choose from, since each code represents a different approach and a different body part.

**Join the ICD-10 planning committee**

The transition to ICD-10 will likely require training and organizational meetings over the next three years. The first step for CDI programs is to participate in these meetings, says Nachimson.

Steering committees may include department heads from information technology, HIM, finance, compliance, and more, he says. Meetings may take place quarterly or biannually at this point, with the intention to increase frequency and participation as the implementation date approaches.

Not every meeting will require CDI staff participation. Some sessions may merely address the technological implications of the software compliance needed to enable the transition.

Other meetings, such as those that address documentation workflow or HIM documentation needs, would benefit from CDI specialist involvement, Bryant suggests.
**Complete a staff assessment**

AHIMA suggests that coding staff need additional training in four areas:

» Anatomy and physiology

» Pharmacology

» Disease processes

» Medical terminology

Many HIM directors have begun to conduct assessments of their staff in these main areas. Such assessments help identify training target areas and allow directors to provide specific help to support staff who need it.

However, some suggest CDI specialists need no preparation in these areas since many come from clinical backgrounds. Bryant and DeVault caution against this thinking. “Just as coder proficiency can differ from staff member to staff member, the same can be said for CDI specialists,” says Bryant.

Those with nursing backgrounds may have worked in documentation improvement for a number of years and “may benefit from a refresher course,” says DeVault. “You just don’t want to make any erroneous assumptions about what staff may or may not know.”

Further, many CDI programs incorporate a mix of staffing backgrounds. Team training with both nurses and coders in the room can help build camaraderie and program cohesion, DeVault says. “It will help ensure that everyone in the program is on the same page.”

**Review ICD-10 basics**

As previously indicated, most CDI specialists understand that ICD-10 is on the way, that it is here to stay, and that it will require more specific documentation and, likely, more queries.

Beyond this basic understanding, DeVault suggests CDI staff take a look at the new code set (visit www.cdc.gov/nchs/icd/icd10cm.htm#10update or ask your HIM director whether he or she has a draft version you can borrow) and review the new ICD-10 coding guidelines. Such reviews may help alleviate any unease and further raise staff awareness regarding the change.

“You don’t need to learn the codes, of course,” DeVault says, noting that the codes themselves may still change. “But you can certainly start reviewing the draft codes and guidelines.”

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Analyze CDI program benchmarks

Perhaps the greatest role (and obstacle) for CDI specialists in terms of ICD-10 implementation preparation is physician training, says Krauss.

“Many CDI staff are on the floor communicating with the physician about documentation improvement on an ongoing basis,” Krauss says. ICD-10 preparedness “is just another example of the value of that process.”

Just as CDI staff need not memorize codes, physicians need not know the nuances of the implementation process. But they do need to know where additional specificity will be required in the documentation. So how does the CDI team begin to prepare?

“Know your data,” says Bryant. “CDI staff already know what the documentation trouble spots are, so they can look to the draft codes and determine the documentation challenges and start to build that level of specificity into their repertoire.”

Pick your top five or 10 DRGs and review the guidelines and terminology changes for those in the new code set, DeVault suggests. “Then you can target that terminology in your educational practices.

“The CDI staff already focus so intently on documentation integrity,” she continues. “We just need to tap into what is already happening and gradually introduce concepts related to ICD-10.”

For example, if the physician writes “the area of concern was excised” rather than indicating excisional debridement including the type of instrument used and the depth of the incision, the CDI staff already knows to go back and query for additional specificity, says DeVault.

Analyzing query data can help CDI staff know not only what areas to focus their own ICD-10 education on, but also where and who to focus on for additional physician training.

“The CDI staff needs to understand the documentation requirements that come with ICD-10 since they are the ones

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who will be training the people who do the documenting,” says Nachimson.

Review the new code sets with an eye toward what documentation changes affect which specialty and build that training into regularly scheduled CDI/physician interactions. For example, “if you are already going to speak to the physicians about diabetes or if you are slated to speak with the cardiovascular surgeons, do a little ICD-10 research and work that into your presentation,” DeVault says.

But don’t overwhelm the physician staff, she warns. Keep the focus on ICD-9 and on the documentation specificity. Then, at the end of your program, you can say, “By the way, ICD-10 is coming, and we’ll need even more specificity from you, and these are the items we’ll be looking for.” In that way you can begin to preemptively affect their documentation,” she says.

Develop an ICD-10 training timeline

Three years can seem like an extremely long expanse of time or it may seem like an hourglass of sand slipping swiftly away. Appropriate planning, however, can prepare everyone in the facility for the shift to ICD-10. Consider the following six suggestions as implementation stepping stones:

1. Assess your facility’s current ICD-10 implementation planning process
2. Get involved in the ICD-10 steering committee
3. Assess staff competencies on basics such as anatomy and physiology, pharmacology, disease processes, and medical terminology
4. Review ICD-10 basics, draft code sets, and guidelines
5. Analyze CDI program benchmarks against changes in ICD-10
6. Target trouble spots for additional physician documentation training

It is up to individual facilities to determine when and how they implement their ICD-10 transitions, Bryant says. “They may decide to only do assessments in 2011 and begin ICD-10 coding reviews in 2012.” Whatever your approach, you’ll want to develop a specific plan of attack and keep your team on schedule.

“The CDI team needs to educate physicians regarding ICD-10,” says Krauss. “That’s what we do—physician behavior modification. We need to tell the physicians, ‘If you think we’re asking you for more specificity now, wait until 2013.’ Let’s get a hold of this now and not wait until ICD-10 is upon us.”

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