Q&A ICD-10 preparation

CDI WEEK

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As part of the second Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Katy Good, RN, BSN, CCDS, CCS,*** *clinical documentation program coordinator for Flagstaff (Ariz.) Medical Center and an AHIMA-approved ICD-10-CM/PCS trainer, answered the following questions regarding ICD-10 preparation. Contact her at* Kathryn.Good@nahealth.com.

Q ***Did the anticipated one-year delay of ICD-10 (from October 2013 to October 2014) change anything in your facility? If so, in what way?***

The delay has not had a concrete impact on our plan. Like most facilities, we have a lot of work to do when it comes to ICD-10 and it can feel overwhelming. There are so many small pieces to consider, impacting virtually every department. We have continued our current trajectory, knowing that there will be setbacks. We have several other programs that are also being implemented during this time as well (Dolby Computer Assisted Coding, Advisory Board ICD-10 Compass, etc.), so we know that we will need all the time we can get. I think the delay is definitely in the back of everyone's mind and we are reassured by the additional time, but we are not slowing down, rethinking our timeline, etc.

Q ***Should CDI specialists be more concerned with the codes and coding guidelines, brushing up on anatomy and physiology, or both?***

I think the answer is the same for ICD-10 as it is for ICD-9. In order to do our jobs, it is crucial that we have general knowledge of coding guidelines and the documentation required for proper code assignment. However, most clinical documentation specialists are not required to function as coders. We certainly need to understand the new requirements associated with the transition to ICD-10. However, code assignment should not be high on the priority list in comparison to knowledge of coding guidelines and, more importantly, documentation requirements.

Our role is defined by our ability to recognize clinical indicators of a diagnosis, identify an issue, and communicate this effectively to the physician. For this reason, I would argue that it is absolutely essential that we have a firm grasp of the anatomy, physiology, and terminology that will be expected/used with ICD-10. I suspect that in our facility, we will be asked to provide constant feedback to the physicians regarding the required terminology.

What are some of the common diagnoses that will require more specificity in ICD-10?

From what I've experienced, the following diagnoses are going to require more specificity:

- Fracture
  (open vs. closed as well as episode of care)
- Respiratory failure (hypercapnic vs. hypoxic)
- Specificity for diabetes and related complications and treatment (insulin)
- Laterality for injury/procedures
- Asthma (severity, as well as persistent vs. intermittent)
- Bronchitis (specificity: It has expanded from one code in ICD-9 to 11 codes in ICD-10)

Do you anticipate CDI specialists clarifying surgical reports, due to the additional specificity needed to capture ICD-10-PCS codes?

Yes. I think many CDI programs are already querying for data which has no impact on the DRG or severity of illness and risk of mortality. We already consider it to be part of our job to help minimize the need for retrospective queries as they delay the revenue cycle, and this will not change with ICD-10. We recognize that we will not catch all the documentation needs required for ICD-10-PCS as they are very extensive. However, we will address any that we recognize and attempt to clarify them concurrently if possible.

When do you recommend that CDI departments start querying for additional specificity under ICD-10, given the (likely) new 2014 timeline?

I think this decision is very facility-specific and likely depends on numerous factors, including ICD-10 readiness and CDI staffing resources. It's important that we have a firm foundation from which to begin querying. This includes accurate understanding of the requirements and compliant queries. This may also include identification of potential problem areas. For example, we will be using ICD-10 Compass (from the Advisory Board) to assist with risk identification, and it will be several months before we have access to this data.

Many CDI programs will probably not be at the point where they are prepared to begin querying anytime soon. I know in our case we have recently been very focused on the development of an electronic query process and are in the midst of hiring. We just started the comprehensive education process for the CDI and coding staff last month. This already diverts time away from reviews and adds additional stress to staff. We will be looking more closely at our queries and updating and developing queries for ICD-10 after we have completed our education plan. This realistically will likely be a year from now and will hopefully coincide nicely with the completion of our scheduled physician training. We intend on being prepared (with queries established) to be querying for ICD-10 specificity approximately six months prior to implementation.

One thing we can be doing immediately is making sure that any new query templates that we develop are ICD-10 compliant. For our facility, we like to use established query templates, and they go through a rather extensive approval process. It doesn't make sense to spend time making a new query now only to reformulate it a year later.

I think it is important to consider momentum in this process. We want to give providers time to adjust and hopefully begin including ICD-10 specificity prior to the change, but we also do not want to start too early and lose engagement. I'm sure anyone involved in ICD-10 planning is very familiar with the phrase, "But you are talking about something two years down the road!" Unfortunately, we still get comments from physicians that they do not believe that we will transition to ICD-10 at all. I think we will be most effective in communicating with the physicians soon after they have received their education and when the transition is right around the corner.

Don't halt your ICD-10 training, even though uncertain deadline looms

Barbara Hinkle-Azzara, RHIA, *vice president of operations with Meta Health Technology in New York, encourages facilities to move forward with ICD-10 preparation efforts now to ensure a smooth transition to the new code set. Her comments follow.*

If I could give one piece of advice to facilities regarding ICD-10 preparation, it would be to forge ahead. That seems to be the message from the industry associations as well. Both AHIMA and ACDIS have encouraged their members to continue preparation and implementation plans.

By September 2012, facilities should have been well past the initial institutional reviews and educational efforts, but it turns out many have not completed these basic tasks yet. If CMS had pushed forward with its original implementation date, those facilities would have been way behind instead of just behind at this point.

With the proposed delay, however, some facilities have pulled back on planning and training. I am sure many ICD-10 committees canceled more meetings than they held over the summer, but in my opinion, you can never have enough time to educate people. Facilities should use the extra time associated with the implementation delay to their advantage.

One area to pay extra attention to is vendor readiness and integration. Push vendors for more answers and investigate options regarding ICD-10. Address items you know need work and examine how they will change under the new coding system.

Also, determine if you have segments of the staff with limited awareness of the coding change and start some educational outreach there. Explain the ICD-10 basics and outline how the shift from ICD-9 will affect them.

Remember, CDI specialists do not need training to become ICD-10 coders. Instead, they need to learn how the code system works and what areas will require extensive documentation. Once the CDI specialists understand the basics, they should review how documentation requirements will change for the top-tier DRGs at their facility and start incorporating ICD-10 elements into the query process.

CDI efforts will undoubtedly be an important component of ICD-10 compliance. In fact, I suspect there will be a big influx of CDI programs developed in the coming years due to the additional documentation specificity required. Just as implementation of the MS-DRG system in 2007 caused a spike in CDI program growth, ICD-10 will cause another big jump. So if a facility does not have a CDI program, it should begin the training and implementation process if feasible. Those facilities which do have CDI programs will be in a better position come implementation time, but they should not wait until the "go-live" date to train CDI staff or to start querying physicians for the specificity needed under ICD-10.

ICD-10 is another opportunity. The increased granularity that the new code set contains will support healthcare research and take our data to a much more sophisticated level. Of course, ICD-10 represents a tremendous challenge to facilities. If they do not have a CDI program currently, they should implement one. Facilities will not survive in ICD-10 without a robust CDI effort.

There are a number of other opportunities for expansion of the CDI role, including implementation of the electronic medical record, documentation improvement efforts in the emergency and outpatient services, and private payer record reviews.

The profession itself is a tremendous profession. It brings benefit for the patient and the facility and the physicians. Those who have been in the role for 15 years or more know there is something wonderful, meaningful, purposeful in this. But CDI specialists need to be committed to staying ahead and maintaining awareness of all the changes coming down the line. If I had to provide one piece of advice to CDI specialists, I'd tell them to embrace the changes.