Q&A CDI WEEK ICD-10 preparedness

Elsevier Clinical Solutions

As part of the fifth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***N. Suraj Bossoondyal, MD, CCS, CCDS, CDIP, CHP, CPC, HIT-T*** *is the CDI manager at the University of California—Los Angeles (UCLA). He was a physician for six years, specializing in family medicine, emergency medicine, general surgery, and preventative medicine. Bossoondyal has more than four years' experience in CDI, including management and ICD-10 training leadership. He answered the following questions on ICD-10 preparedness. Contact him at NBossoondyal@mednet.ucla.edu.*

Q With ICD-10 implementation right around the corner, how prepared is your facility?

A: All concerned departments, including coding, CDI, and physicians, are thoroughly preparing for ICD-10. ICD-10 is new for everyone; therefore, it is difficult to say exactly how prepared we will be. We are confident in our preparation and our knowledge, and feel ready for implementation.

We have been assessing our preparations based on discussions and collaboration. We don't have individual assessments. Both coding and CDI have their own systems for measuring preparation. On the CDI side, we have weekly discussions on ICD-10, and we continue to query for ICD-10 specificity and discuss hot topics. Our CDI specialists have open communication with management as well, and can discuss any concerns they might have. Everyone has strengths and weaknesses, so we like to share those with one another and work on the weaknesses, and teach each other.

By the time we got to early September, we wanted to be able to say that everyone is comfortable and ready to go.

Q Can you describe the impact of ICD-10 implementation on your training budget?

A With several delays within the past few years, there tends to be less of a concern in terms of a training budgets because we already had those funds allocated and the training planned. It was simply postponed. We thought of training as something that was inevitable, already budgeted, and it had to be done, just like anything else in our budget.

Q Can you describe the level of ICD-10 preparedness for your physician staff/providers?

A Our physicians have received ongoing training since early 2014, and they are as ready as they can be. This year, we've been focusing on

refreshing what they've already learned and evaluating cases using ICD-10.

Our physicians mostly struggled with how ICD-10 will affect them, and what differences they could expect in the documentation. We've found that you have to show them the specifics in diagnosis writing, and explain the reasoning behind ICD-10 specificity. For the most part, our physicians have a positive attitude. They are receptive to what we have to say and understand that we need to work together. We also encourage our physicians to ask questions and get in touch with our CDI staff.

Q What training methods have you used to educate your physicians/providers and staff for ICD-10 implementation?

A Training programs are based on specialty or department, and covers everything from basic principles to procedure codes. Now that we are so close to implementation, our focus is more on querying in ICD-10, coding in ICD-10, and documenting for ICD-10 specificity, using common cases that they see everyday. We have a combination of onsite training and anytime online/e-learning access for those who couldn't attend a live session or want a refresher. For our live training, we use a hybrid of our own training and training from a third party. Our CDI specialists did the ICD-10 for CDI Boot Camp, and our coders did an ICD-10 Coding Boot Camp as well.

Our physician champions lead all of the inpatient training for physicians together with CDI staff, and our education is tailored for them, focusing on the clinical aspects rather than codes. Similarly, our coders have training that is more specific for them. We also have a physician champion for our surgery department, so it's easier for him to approach the surgery department and discuss those procedure documentation changes in ICD-10.

Our physician champions used Train-the-Trainer with providers, which has been extremely effective because of the peer-to-peer, physician-to-physician aspect. Even though CDI specialists help with training, this option helps providers educate one another. It's more about strengthening rapport between the team.

Almost every day for the past year or so, we have a case study that we distribute via e-mail that goes to CDI and coding. They cover over just about anything ICD-10-related, including procedure codes, excerpts from AHA Coding Clinic for ICD-10-CM/PCS, or examples of specific coding or documentation scenarios.

We try to make all training a collaborative effort.

Q Have you been able to add CDI staff in anticipation of the ICD-10 implementation date? If so, how did you obtain approval from administration?

A Yes, we have been able to onboard a number of new coders and CDI specialists. It's an ongoing process. For us in CDI, hiring new staff isn't just for ICD-10, but rather for our long-term planning and vision for the department. Of course, ICD-10 is one of the main concerns, but it is not the only concern.

You have to be able to analyze and assess your department before you can make your case and get approval for new staff from leadership. We really try to look at our vision—w here we project ourselves to be and what we plan to do with the additional staff. We also try to use national benchmarks to predict productivity for new projects. For example, in terms of ICD-10, you must show your current productivity, how productivity and quality will be reduced, and come up with actual numbers.

All of our new staff will do what our current CDI specialists and coders are doing, but will play an integral role in our ability to expand our coverage across the health system and tackle other projects as a team.

Q How often does the coding and CDI team meet (if at all) to talk about ICD-10-related matters and review problematic diagnoses/difficult ICD-10 coding scenarios?

A: Our CDI and coding teams actually make up one department: medical coding and CDI. We meet twice monthly as a team to improve rapport, increase communication, and perform team building exercises. Physician champions and other leaders are also asked to join us if they can, and we encourage them to chime in with their insights.

It is a great opportunity to take CDI to the physician and coding worlds, and understand the challenges that both groups face. It's about sharing the whole picture. For the most part, we review case studies that both CDI and coding would like to share. Both groups bring examples, present, and then we can give ICD-10 feedback from each side.

We also have open communication with our quality department to discuss potential healthcare acquired conditions and patient safety indicator cases both concurrently and retrospectively so everyone can share their input.

Q: Does your team currently review records for ICD-10 and leave queries for ICD-10-related situations?

A: Yes. ICD-10 queries have been incorporated into our EHR query bundle. This has been ongoing, and we've gradually increased it over the past year. Now, we are fully practicing ICD-10.

Q: Will your CDI team be increasing query efforts related to procedures? Will they learn the PCS portion and identify query opportunities there?

A: Not necessarily. This depends on how much coders and surgeons have been educated on documentation—that will be the deciding factor in whether or not we'll have to increase our query efforts.

As a CDI team, however, we will be paying attention to procedures and learning as much as we can about them, as they are new to us. We do have a query template created for procedures. We will continue to have consistent and constant communication between coders and CDI specialists, in an effort to identify whether there are a high number of documentation deficiencies within procedure notes.

Q: Have you found opportunities where automation in the EHR or other process (e.g., checklists on order sheets or reports) can help with ICD-10 documentation?

A: We are always working with our physician champions to keep our EHR system up-to-date for ICD-10. Our system is great because we can really customize it to fit our needs. Physicians already have an ICD-10 breakdown and tools specific to ICD-10 in the database.

Q: Are your coders dual coding?

A: Yes, our coders started at the beginning of the year. CDI staff communicates with coding when we need ICD-10 feedback on a specific case, and they are very responsive and this seems to be successful thus far.

Deborah Neville, RHIA, CCS-P is the director of revenue cycle, coding and compliance for Elsevier Clinical Solutions in Atlanta, Georgia. She is responsible for all eLearning, including ICD-10-CM/PCS and clinical documentation. Here, she describes the need for continued program monitoring to pinpoint knowledge and skills gaps leading up to and through ICD-10 implementation.

Will Preparedness Lead to Success?

In less than one month, the healthcare industry will be implementing what has become one of the most controversial healthcare changes in recent memory: transitioning from ICD-9-CM to the ICD-10-CM/PCS coding systems.

According to the *2015 CDI Week Industry Overview Survey*, almost 64% of respondents feel that they are prepared for the transition, yet 47% state that they are not fully prepared for ICD-10-PCS, and almost 35% state the same for ICD-10-CM. Physician education still ranks high among concerns.

In recent history, CDI has moved front and center in the eyes of healthcare leadership. ICD-10-CM/PCS may have been a strong contributor to this visibility, but other initiatives—such as meaningful use; audits such as Recovery Audits and Comprehensive Error Rate Testing; the Readmission Reduction Program; and Patient Safety—are also drivers that require more complete and accurate documentation by healthcare providers. The translation of clinical information into usable data is not an easy task, and requires coordination and cooperation between providers, coders, and CDI professionals.

One key take-away: coded data is used for more than just reimbursement.

CDI professionals have a significant role, ensuring that documentation demonstrates medical necessity for all evaluation, services, and procedures provided, at the level of specificity necessary to describe the most granular detail of the patient's condition.

One of CMS' goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. According to the US Department of Health and Human Services, the top three reasons for inaccurate payment of claims can be attributed to insufficient documentation, medically unnecessary services, and incorrect diagnosis coding. The government takes this directive very seriously.

Let's take a closer look at how documentation fits into preparedness. Preparing an organization for the transition to ICD-10-CM/PCS, and to meet required reporting, requires a consistent and ongoing educational program.

Educating and preparing coders, CDI professionals, and healthcare providers up to and beyond the October 1, 2015 deadline will require continued monitoring of healthcare data to pinpoint knowledge and skill gaps to ensure that patients are provided quality care at affordable rates.

From a provider's standpoint, it is important to ensure the viability of the organization is maintained, with strategic plans developed on the back of accurate and complete data. In addition to less than "best practice" patient care, inaccurate documentation may have multiple consequences:

- The movement of healthcare to a more consumer-driven business means that patients, payers, and providers depend on comprehensive documentation to tell a complete story of the patient population's encounters. The value-based purchasing system essentially uses documented and coded patient outcomes to decide whether quality care was provided to a patient.
- The Hospital Acquired Conditions Reduction Program modifies payment for a selective number of conditions if they occur during a hospitalization—when shown not to be present on admission. It is felt that these conditions are preventable if appropriate care is provided and documented.
- A more recent activity is the *Readmission Reduction Program* in which healthcare claims are evaluated for patients that are admitted within 30 days of discharge. The intent is to ensure that appropriate care was provided to the patient and identify extenuating circumstances that require readmission.

As stated previously, coded documentation is much more than an avenue to payment. It is the basis of all healthcare-related activities. Helping clinicians understand key documentation components, and helping them to apply this knowledge to every-day documentation activities [in and out of the electronic medical record], poses a challenging, but rewarding, CDI opportunity. Preparations to evaluate documentation and coding post-October's ICD-10-CM/PCS implementation date will help organizations react quickly to deficits in knowledge and performance.