Q&A

CDI WEEK

ICD-10 delay and preparedness

As part of the fourth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Adelaide M. La Rosa, RN, BSN, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer and Ambassador,** is the initiator, developer, and system director of HIM/CDI/CDM for Catholic Health Services of Long Island (CHSLI). She has 30 years of varied clinical healthcare and leadership experience and extensive knowledge of healthcare revenue cycle, ICD-9-CM/ICD-10 coding rules and regulations, and MS-DRG, DRG, and APR methodology. La Rosa received the 2010 CDI Professional Achievement Award from ACDIS and has been a repeat faculty member at several ACDIS national conferences. She answered the following questions on ICD-10 delay and preparedness. Contact La Rosa at Adelaide.Larosa@chsli.org.

Q *How has the one-year delay of ICD-10 (to October 1, 2015) affected your training and implementation timeline? Have you put anything on hold, or are you still moving ahead?*

A *CHSLI continues to move forward with the training of coding and CDI staff.* The delay has given us more time to reinforce the knowledge of ICD-10 our staff has already obtained. It also allows for time to dual code and to perform data analysis to assess the impact of the new code set.

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

A *We have purchased the 3M ICD-10 Training Tool, which will allow us to provide ongoing training.*

Q *Can you describe the impact of the delay on your physician staff/providers?*

A *The physicians are being informed of the importance of documentation regardless of what ICD version of a code set is in place.* We focus on the communication of care to support medical necessity and promote accurate completion of the medical record.

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

A *We are currently staffed to handle the transition to the new ICD-10 code set. Our CDI team is currently querying physicians to capture the level of specificity required for ICD-10.*

Q: *How confident is your facility that ICD-10 will really take effect on October 1, 2015?*

A: *Extremely confident. We have committees and processes in place to ensure ICD-10 compliance, coding training, physician documentation education, vendor readiness, and claims testing.* Operational leaders have been identified and have been tasked to meet the deliverables for ICD-10 readiness.

. . . .

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

A: *Yes, they do query for the level of specificity expected to be documented for ICD-10 coding.* Regardless of the code set that is in place, CDI captures as much detail about the diagnoses and procedures for that patient encounter. It is about the communication of care that we are getting documented with this level of specificity. This information will also play a role in supporting medical necessity.

. . . .

Q: *What are the most problematic conditions you and your team are struggling with?*

A: *Physicians/MLPs have been educated to put coding aside and to understand the importance of this detail; information about the patient is needed also to support their evaluation and management billing.* We speak in terms of accurate and complete documentation as it provides accurate and complete communication of care.

. . . .

Q: *Are your coders dual coding?*

A: *All of CHS' acute care sites will start dual coding in November 2014.* We will identify the high-volume cases for each acute care facility and build in select cases to dual code into the workload of the coder's day.

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: *There is ongoing communication between the coding and CDI teams.* Formally, once a month, I hold a Web-based meeting to bring all our different staff together to further education ICD-10 and review coding scenarios and documentation opportunities.

. . . .

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

A: *All the CDI staff for all six sites have been trained in ICD-10-CM and PCS.* They currently review operative reports to ensure the extent of the procedure has been documented.

. . . .

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 just went live with our six acute care hospitals with our EMR.* We are now regrouping to find such opportunities where EMR can assist with documentation improvement.

A need for complete and accurate documentation, regardless of code system used

Deborah Neville, RHIA, *is director of revenue cycle, coding and compliance for Elsevier Clinical Solutions in Atlanta, GA. Here she describes the need and the value of good documentation in the health record, regardless of whether one codes with ICD-9-CM or ICD-10-CM/PCS.*

Accurate and complete documentation has always been the basis for quality data and coding but the transition to ICD-10-CM/PCS has brought the need to the forefront. Accurate documentation is no longer just an "HIM" issue—CDI is recognized as a top issue to be addressed by hospitals and physicians alike.

Elsevier has always perceived CDI to be paramount. As a global company with publications such as the "Lancet" and well-known brands such as Mosby's, Grey's Anatomy, and Saunders, Elsevier offers tools such as ClincalKey that, at the touch of a button, can provide the physician the most recent evidence-based information about diseases and disease management. This wealth of information allows Elsevier to provide CDI professionals education on the most accurate and timely information available.

Our CDI education provides a standardized approach to CDI. Whether the CDI professional is a nurse, coder, or even a physician, it is important to understand how to evaluate the entire health record to identify key information that justifies admission, provides specificity to demonstrate accurate patient severity of illness (SOI) and risk or mortality (ROM), determine the timing of the onset of conditions to determine a hospital-acquired condition versus one that was present on admission, and to support medical necessity for all services provided.

The role of the CDI professional is changing and evolving. These professionals must demonstrate extensive problem-solving and communication skills. Not only does the CDI professional need to understand the clinical presentation of a patient, they need to be able to identify clinical documentation to cue them into situations where additional clarification or information is needed from the physician to capture co-morbidities, complications, associated conditions, treatments, and patient responses. The extra year provided by the delay for ICD-10-CM/PCS implementation is advantageous to allow in-depth training for these professionals.

Coding means translating clinical terms (documentation) into classification terminology. The difficulty lies with the fact that physicians don't necessarily "speak" in the same language as used by a classification system. Education must point out when similar terminology may mean something totally different to a clinician than how it is perceived under a coding system and help enable physicians and CDI professionals to understand nuances of different, but similar, clinical terms.

Too many people think that CDI is about getting more reimbursement, but it's not. It's about correctly capturing the presentation of the patient and what is going on at any given point in time. Accurate documentation should lead to appropriate reimbursement, result in better peer-to-peer comparisons of hospitals and physicians, ensure quality data that provides information for a number of clinical or strategic uses, and also decrease compliance risk. Coded data will also allow information, aggregated over time, to help build standards of care for "best practice" treatment of diseases.

Our clients are all going full steam ahead with their ICD-10-CM/PCS implementation efforts. They recognize that a lack of CDI programs in the past may have had a significant effect on reporting patient outcomes and reimbursement. The Medicare Fee-for-Service gross improper payment estimate for FY 2013 is 10.1 % (up from 8.5% the previous year). That translates to $36 billion in inaccurate payments. Two of the main reasons for this high error rate were inaccurate diagnosis coding and lack of supporting documentation.

Good CDI programs can help ensure complete documentation to then allow for better coding and less risk of inaccurate payments. Even though we are concerned with ICD-10-CM/PCS training for future use, we can't forget that this high error rate occurred under the ICD-9-CM coding system. Improvements in documentation today will affect ICD-9-CM data collection as well as ICD-10-CM/PCS. The key take-away is to take advantage of the extra time until ICD-10-CM/PCS implementation, and implement clinical documentation improvements now. Make sure your physicians understand you're not asking them to write a book, but depict the presentation of the patient. Don't embellish, but accurately document so it can be abstracted and translate to quality measure reporting.