Q&A ICD-10 Preparation

CDI WEEK

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As part of the first 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,*** *director of the CDI program at St. Francis Hospital in Roslyn, NY, answered the following questions from ACDIS regarding ICD-10 preparation.*

Q ***Is it too early to start training our coders and CDI specialists in ICD-10 specifics?***

A ***No, but at this time it must be limited to general topics like anatomy, physiology, and some basic changes in ICD-10, which all come down to documenting and coding to a much higher level of specificity.***

An easy example to describe is the changes in documenting CVA—where is the problem? Left or right, cerebral or pre-cerebral vessels, stenosis or embolus, or in situ thrombosis? These changes are general enough and easy to remember, but it's early to introduce the actual coding changes. Remember that retention of new information (at first, before repetition and daily use of the new codes) is measured in hours, or at the best in days.

Q ***What's your overall take on ICD-10? Do you consider it a major industry change, or merely a little additional specificity needed in the record?***

A ***ICD-10 is indeed a major change, both in terms of new details and also in meeting the deadline of October 2013.*** However, it should not be a panic situation! With the correct training at the correct time, it is clearly doable.

It will become obvious that the inadequacies of ICD-9 in uncertain situations like newly developed procedures and technologies will be overcome by ICD-10 rules and coding. Once again, it really comes down to understanding that the ICD-10 changes are only those of documentation requirements, which raise the level of specificity for each diagnostic category.

To me, it's not a major change. The level of specificity is what the physicians should be documenting in their charts without ICD-10. It's communication of care. If it's properly documented, ICD-10 will now allow us to truly show the population of patients we're treating.

Q ***When should physician education efforts start?***

A ***Immediately.*** We have over the past five years been teaching our physicians about accurate documentation and what it really means. Doctors are documenters, not coders. The increased level of specificity required under ICD-10 is valuable in further describing for outside reviewers the level of care being delivered and ultimately reflected in the physician's profile for all to see. The obvious push by the government (and private payers) to know what they are being asked to pay for will be made clear in ICD-10.

Also, physicians need to prepare their office. They need to make sure that the vendor they're using has the Version 5010 transaction ability to submit their claims. They need to identify who in their office needs to be trained. They need to understand their encounter forms/super bills need to be changed.

Begin ICD-10 education and training now

Barbara Hinkle-Azzara, RHIA, *vice president of operations with Meta Health Technology in New York, NY, says that ICD-10 training should begin now. Just don't try to bite off too much at once, she recommends. Her comments follow.*

On training CDI specialists and coders: I certainly think it's not too early [to begin training]. This is such a major change for CDI folks and coding folks as well. If you think about how long ICD-9 has been in place, and how much time it has taken for people to get to a level of expertise with ICD-9, then it makes perfect sense to set the groundwork and the building blocks now for ICD-10.

They need to start understanding the structure of the codes at a minimum. There are so many tools out there now that are available that make it very simple to do a translation, even though we know it's not a 1:1 translation. I think using those translation tools that use the GEMs are a great way to acclimate to what the structure of the codes look like in ICD-10. Try to understand some of the difference in the features—the laterality, the trimester, the episode of care, those types of things that are built into the structure of ICD-10 codes—even if it's just taking a few examples of where they are now in ICD-9 and how it translates to the ICD-10 world.

Get the building blocks down, look at the published timelines that are out there, and decide where you want to be six or eight months from now.

On educating physicians about the change: It's a very tricky perspective [when to begin training physicians]. It's similar to the challenge we had when MS-DRGs began. I think the answer is you have to carve out time. It varies from institution from institution because the cultures are so different. The approach that I recommend for CDI specialists and coders is to determine what physicians need to know for 2011, 2012, and 2013. Right now they need to know that the system is changing. Use whatever communication systems you have in place, whether that's a print newsletter, or face to face, or in their rounds. The beauty is that we already have CDI specialists out there communicating with their physicians, so hopefully they have their ear at some regular place and time.

After physicians know the basics, section off what are the things that will impact their documentation. Use examples, because they speak very loudly and clearly to the physicians. Use examples that are specific to their specialty, and show them what the documentation will look like before and after ICD-10. You have to build on the amount of detail incrementally and work up to October 1, 2013.

Q: How do you incorporate ICD-10 specific physician queries into your program when you're already querying for ICD-9 specificity without overwhelming the docs?

The fear of "overwhelming the docs" was present for the last five years at St. Francis Hospital when we began tackling education in ICD-9. We think we have evolved a program which neutralizes that fear, and by extending its basic method to ICD-10 we are optimistic that the same success will occur. We have used dedicated columns in our medical staff news, a dedicated time slot in an annual mandatory staff meeting (which annually addresses about 500 doctors) and in specialty meetings for both physicians and office staff.

Q: What are some of the big diagnoses that are going to require more specificity in ICD-10?

We have created a list of our most common DRGs, either top 10 or 25. In our hospital, it is clear that the categories which will be under the gun include myocardial infarction, CHF, arrhythmias, CVA, diabetes, malignancies, GI bleeds, and sepsis.

The ICD-10 documentation requirements for these diagnoses are the subject of intensive study and education for both physicians and coders. We have established a very close working relationship with our HIM department and have a monthly educational meeting with HIM and CDIP personnel on-site (with lunch). It usually lasts two hours with vigorous Q&A sessions led by myself and the CDIP director.

La Rosa is the initiator, developer, and director of the CDI program at St. Francis Hospital, which now includes a staff of 18. She has 26 years of varied clinical healthcare and leadership experience and extensive knowledge of healthcare revenue cycle, ICD-9-CM coding rules and regulations, and DRG methodology. She is the founder of the New York ACDIS chapter, whose membership now includes 11 hospitals. She was a recipient of the 2010 CDI Professional Achievement Award at the third annual ACDIS conference. Contact her at Adelaide.Larosa@chsli.org.