Physician Engagement and ICD-10:

The Role of the Physician in a Successful Transition

Wolters Kluwer Health | ProVation® Medical

Conflict of Interest Disclosure

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Are employed by Wolters Kluwer Health, which offers procedure documentation and coding software.

Learning Objectives

Review ICD Updating – WHO, When, and Why

Evaluate how the move to ICD-10 will affect revenue

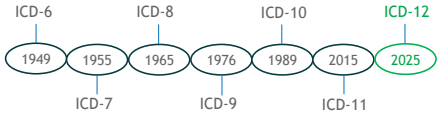
Analyze existing clinical documentation processes to detect and correct weaknesses

Explore the role of clinical documentation and its automation in the successful transition to ICD-10

ICD History

Began in 1893 as International List of Causes of Death, updated to International Classification of Diseases in 1949

Updated about every 10 years since the World Health Organization (WHO) became its custodian in 1948



ICD Update Process

World Health Organization provides the ICD framework

- Every country uses the same basic ICD codeset
  - Framework remains the same country to country
  - 730 Osteomyelitis, periositis and other infections involving bone
- Used for Mortality and Morbidity reporting

Each country can modify the WHO framework

- CA in Canada - *using ICD-10 since 2001*
- AM in Australia - *using ICD-10 since 1998*
- CM in United States

ICD Update Process

Change from I-9 to I-10

- Most significant change since WHO took it over (moving from 5 to 6)
  - Change to alphanumeric
  - From approximately 7,000 codes to more than 12,500 codes

ICD-10-CM has been available for use in the US since 1999

- Revised in 2007 and 2009
- From approximately 13,000 codes to more than 68,000 codes
- From up to five characters to up to seven characters

123.45 A12.34xS

Skip to ICD-11

ICD-10 is a stepping stone to ICD-11

WHO is back on its 10-year update cycle

- ICD-12 in 2025
- ICD-9-CM is out of date
  - Does not allow for clinically robust data
  - Does not allow for exchange of meaningful information/data between health care organizations
  - Organizations are already in the midst of making the switch
  - USA reports ICD-10 codes to WHO for mortality reporting since 1999

ICD-10 and Revenue

The change from ICD-9-CM to ICD-10-CM is budget neutral

- What you are paid for a meniscectomy with ICD-9 should be what you are paid under ICD-10

What to anticipate with the change

- Claims submitted with incorrect codes will not be paid
- Software issues at go live
- Documentation doesn't support code specificity
- Usual October ICD update….but on steroids

ICD-10 and Revenue

Future

- Need ICD-10 for meaningful use data (Stage 2)
- Healthcare industry cannot accurately measure quality of care using ICD-9-CM
- Part A talks to Part B
- Use of specific codes for more…patient safety and outcomes

Essential to be ready to go on October 1 !

Documentation – Assessing Readiness

Physician documentation must be the focal point for assessing ICD-10 readiness

Many common diagnoses and specialized areas will require greater detail than is captured currently

- e.g. fracture of patella – is coded 820.0 (closed) or 822.1 (open) under ICD-9, with no further indicators needed
- With ICD-10, there are 480 codes to choose from. The code requires additional detail: location, laterality, type of fracture & type of visit
  - S82.025A = Nondisplaced longitudinal fracture of left patella, initial encounter for closed fracture
  - S82.041E = Displaced comminuted fracture of right patella, subsequent encounter for open fracture type I or II with routine healing

Documentation – Assessing Readiness

- 7th character "A", **initial encounter** is used while the patient is receiving active treatment for the **condition.** Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
- 7th character "E" **subsequent encounter** is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

Documentation – Assessing Readiness

Insufficient documentation for accurate coding under ICD-10 will impact

- Patient safety and outcomes
- Compliance
- Revenue cycle

Documentation – Assessing Readiness

The best approach to assessing readiness is also the most basic

- Pull and assess random samples of medical records across a variety of specialties
- Identify and draw attention to areas of weakness
- Can be done using internal resources or by bringing in external consultants

Effective Clinical Documentation Improvement

Ongoing training programs

- Introduce training at the outset
- Programs should be ongoing
- Physician Champion
- Training should address potential issues by
  - Physician specialty
  - Individual physicians

Effective Clinical Documentation Improvement

Concurrent documentation and coding initiatives

- CDI specialists work with physicians to close gaps between documentation and coding needs – conduct coding gap analyses to determine strengths & weaknesses
- Enables documentation monitoring and correcting prior to the effective date
- Requires specialists with deep clinical and coding knowledge
- Find out from coders – are there particular areas of needed improvement for specific physicians?
- Focus on highest volume admitters first, or focus on key trends across the board

Effective Clinical Documentation Improvement

ICD-10 training and knowledge

Someone within your office or organization should be educated in ICD-10

- Need an ICD-10 Champion in your organization – someone to lead the charge
- Multiple educational opportunities available
- Distance education, on-line classes or in person workshops

The Role of Automation

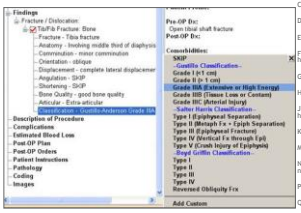
Software that automates the documentation and coding process can ease the transition to ICD-10 and shorten the learning curve for physicians

Look for automated solutions that

- Drive comprehensive documentation
- Capture the high level of detail required under ICD-10
- Guide physicians through the process of documenting with enough specificity and granularity to ensure appropriate coding

The Role of Automation

Example: Displaced oblique fracture of shaft of right tibia S82.231C



Specificity/Granularity Required

The appropriate 7th character is to be added to each code from category S82

A - initial encounter for closed fracture

B - initial encounter for open fracture type I or II

C - initial encounter for open fracture type IIIA, IIIB, or IIIC

D - subsequent encounter for closed fracture with routine healing

E - subsequent encounter for open fracture type I or II with routine healing

F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing

G - subsequent encounter for closed fracture with delayed healing

H - subsequent encounter for open fracture type I or II with delayed healing

J - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing

K - subsequent encounter for closed fracture with nonunion

M - subsequent encounter for open fracture type I or II with nonunion

N - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

P - subsequent encounter for closed fracture with malunion

Q - subsequent encounter for open fracture type I or II with malunion

R - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

S - sequela

The Role of Automation

A professional who is thoroughly schooled in ICD-10 should be involved in the evaluation process from the outset to ensure that:

The software ultimately is prompting for relevant questions

NPL quality is the basis for coding accuracy and consistency – assess to make sure solutions will not require future system reconfiguration

Make sure the software can extract information from documentation from multiple sources used by different specialties or functional areas, outpatient and inpatient, etc.

The Role of Automation

CDI + Automation = Success

The efficiencies inherent in technological solutions to provide significant support are just one piece of the overall ICD-10 readiness strategy

A solid marriage of both CDI strategies and technology is required for a smooth, successful transition to ICD-10

Summary

- Change in coding systems is inevitable
- You learned ICD-9, you can learn ICD-10 too!
- Documentation and code accuracy will play an even a larger role in reimbursement
- Use technology to automate documentation

Questions?

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