ICD-10 documentation: The key to getting paid

With the October 1, 2015 deadline for the transition to the International Classification of Diseases-10th revision (ICD-10) diagnostic coding set looming, most physicians barely have begun grappling with the central challenge of the shift: documentation

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Regardless of how well physicians or their coders understand the new coding system, practices will not fare well on reimbursement unless their providers can document encounters in sufficient detail to support the new codes.

Many physicians are putting off the training they will need to do this because they have so many other challenges absorbing their time: Meaningful Use stage 2, the Physician Quality Reporting System, value-based reimbursement, patient-centered medical homes…the list goes on.

Some doctors are hesitant to put too much effort into ICD-10 because the deadline has been postponed before and they fear it might be delayed again. David Boles, MD, who leads a family practice in Clarksville, Tennessee says, “We don’t have a time set for formal training yet, because we’ve been through this before, where the government delays stuff over and over.”

Nevertheless, Boles admits, the indications are that the transition will occur this October 1. And he wants to be prepared when that happens.

Physicians can derive immediate benefits from learning how to document for ICD-10 now, rather than waiting until the last minute, says Jim Lazarus, managing director, strategy and innovation, revenue cycle solutions, for The Advisory Board Company. “The improved documentation will benefit physicians now in the ICD-9 environment. It will be reflected in their quality and outcome metrics. It will also likely increase their reimbursement.”
Here are some tips on how to approach ICD-10 documentation and where to get training for it. In addition, we share the experiences of some physicians as they prepare for the changeover to ICD-10.

How big a challenge?

There are approximately 68,000 ICD-10 codes, compared to 14,000 ICD-9 codes. That nearly five-fold increase in the number of codes requires more specific documentation than what most doctors provide now in their records. But in most cases the change is not as big as it first appears.

To begin with, 78% of ICD-9 codes map “one-to-one” with an ICD-10 code, either exactly or approximately, according to the American Health Information Management Association (AHIMA). This means that they require no more documentation than physicians enter now for those codes.

Of the ICD-10 codes that do not have ICD-9 counterparts, about half are related to laterality (left, right and bilateral indications), AHIMA says. Another big chunk of ICD-10 codes consists of “external cause reporting” codes, such as what caused a particular injury. While these have been widely mocked by ICD-10 opponents, the Center for Medicare & Medicaid Services does not require providers to use these codes. (Some states mandate certain ones, however.)

Among the new codes that physicians must support with documentation are those related to linked conditions such as hypertension and heart disease, new diseases such as Ebola, and musculoskeletal conditions such as bone fractures.

Because of the expansion of injury and musculoskeletal codes, “orthopedic doctors are going to have a lot more new codes,” says Angie Comfort, RHIA, CDIP, senior director, HIM practice excellence, coding services, for AHIMA.

There are significant differences among specialties in terms of numbers of new codes physicians and coders will have to deal with. “If they’re primary care physicians, they’re going to see a lot more than an endocrinologist or a urologist would see,” Comfort says. “Urology has a very small chapter [in the code book], just a few pages.”
Coding and coders

Physicians employed by hospitals and healthcare systems normally don’t code for themselves, but many independent practitioners do. Those who code must learn the details of ICD-10 coding that apply to their own specialties, perhaps with the help of certified coders in their practices.

But when it comes to documentation, “doctors don’t want to be trained by coders,” Comfort says, because “most of them are not clinicians.” While the coders can help physicians understand what’s appropriate for billing, they can’t show them how to use ICD-10 when they’re trying to care for patients.

Lazarus agrees. “Their perspectives are very different. Physicians are attentive to the documentation, whereas coders are focused on what codes and groupings that documentation translates to.”

Physicians who code for themselves have figured out different ways to locate the ICD-10 codes they need. Boles, for example, says that his e-MD electronic health record provides body diagrams and code lists that he can click on to build the correct codes. James Morrow, MD, a family practitioner in Cummings, Georgia, says he plans to enter ICD-9 codes into his EHR, using the search function to bring up a list of related ICD-10 codes.

Templates and prompts

Some physicians hope that their updated EHRs will prompt them through the ICD-10 documentation process. But not all EHRs include the necessary prompts. The upgrades supplied by some major ambulatory EHR vendors, however, are more related to coding than to documentation.

Even where vendors have rewritten templates for ICD-10, Lazarus says, physicians may not be able to use them to guide their documentation because it’s too cumbersome to document everything using pull-down click boxes. “Organizations have found that if you put in too many click boxes, physicians simply become frustrated with the system and are clicking to get out of it or through it,” he says.

Consequently, healthcare systems usually customize the templates to make them less burdensome for physicians.

In ambulatory care, he adds, the customization needed is not as extensive as in inpatient care. Because there are fewer pathways, “You can use prompts and technology to help a little bit.”
Moreover, he points out, “Physicians may do half of their business each day in similar kinds of interactions, so they’ll see patterns. And with a little attention and effort, you can often get sufficient documentation to support coding in a regularly applicable, non-burdensome way.”

Physicians in small, independent practices tend not to use pre-canned templates at all. William Harrington, MD, a family physician in Midlothian, Virginia, has always built his own. Morrow prefers to customize his templates on the fly to fit the particular patient he is seeing. And Steven Von Elten, MD, a family practitioner in Warrenton, Virginia, says most of the 12 providers in his practice use free text rather than structured documentation. He’s not sure how he and his colleagues will remember all the details they need to document for ICD-10.

Harrington, who doesn’t plan to expand his own EHR templates, is optimistic about his ability to learn ICD-10 documentation. “I don’t want to sound too laissez faire, but I’ve been looking at this for a long time,” he says. “I’ve looked at the ICD-10 codes, and I know the types of things you’d have to put in a chart to justify more detailed codes. So I’m already learning, even though I’m not using it. Every time I code, I see the ICD-10 codes next to the ICD-9 code.”

**Where to get training**

Lazarus advises all physicians to familiarize themselves with ICD-10 by reading overview materials that CMS and other entities (AHIMA and the American Medical Association among them) offer on their websites. Other free resources, he adds, are available from some hospitals and physician organizations, as well as trade publications.

Beyond that, he suggests, physicians should focus on ICD-10 from the perspective of their specialty and practice setting. “If you’re in a small practice and do [hospital] rounds once a week, you’re going to have different concerns than a doctor employed by a healthcare system as part of a multispecialty group,” he says.

Lazarus suggests that physicians seek out physician-specific training, which can be either peer-to-peer or conducted by other clinicians such as nurse practitioners. Some specialty societies offer this kind of information on their websites.
In addition, the CMS “Road to 10” website features peer-to-peer videos on ICD-10 for small practices in several specialties, and CMS is holding local training sessions for physicians. (For a listing of these events, see www.roadto10.org/events.)

AHIMA offers a few coding briefs for physicians on its website, Comfort says. In addition, it provides free, downloadable tip sheets on documenting 74 different conditions for ICD-10.

Some consulting firms offer peer-to-peer educational sessions. While these might be too expensive for small practices, some third party vendors offer training modules and simulators at an affordable price, Lazarus says.

Experts don’t advise physicians to rely on their EHR vendors for training. But many doctors are looking to vendors for help, our interviews suggest, and some companies are providing it.

Hands-on approaches

To get practical experience in documentation before the implementation deadline, Comfort says, AHIMA recommends that physicians take advantage of the dual coding that is available in ICD-10-ready EHRs. By coding some visits in both ICD-9 and ICD-10, she points out, physicians can either get feedback from coders in their practices about what is missing in their documentation, or they can figure it out themselves.

AHIMA also advises practices to perform a “document assessment” to determine how their current documentation will support ICD-10 coding. This requires coding a current chart in ICD-10, and deciding whether there is enough information in the record to capture the necessary concepts for ICD-10.

What if physicians dictate their notes? Although they don’t enter structured data, Comfort says, they must include all of the details required to support ICD-10. “When clinicians dictate, sometimes the documentation gets watered down, and the information needed for coding isn’t there,” she points out.

“Laterality is usually included, whether the note is dictated or entered into the EHR,” she adds. “But sometimes the linking of diseases is not there and the severity isn’t there.”
Real-world challenges

The physicians we interviewed were less concerned with learning how to document for ICD-10 than about two other issues: 1) the degree to which the coding and documentation would slow them down, and 2) the prospect of a cash flow crunch during the ICD-10 transition.

Regarding the first issue, they agreed that the new coding system would reduce their productivity, at least initially. “I’m greatly concerned about how much time I’ll be spending on working through all of these changes as we go from 14,000 codes to 68,000 codes,” Von Elten says. He expects to spend more time on his computer, but doubts that it will improve his documentation.

Similarly, Boles says, “We’re going to spend more time working on charts than working on patients, just like we are now.”

Nevertheless, the physicians we interviewed seem confident that they can rise to the challenge. Morrow and Harrington both believe they’ll be coding and documenting accurately for ICD-10 within three months of the transition date.

Harrington says he views this as a form of on-the-job training. Between self-education and training sessions, he figures, he’ll be 80% to 85% ready by October 1, and he can pick up the rest as he goes along. In fact, he sees no alternative, considering the number of codes involved.

The question is how a less-than-perfect command of ICD-10 coding and documentation will affect practice revenues during the transition period. Boles says he’s very concerned about that, but he’s still not sure what to do about it.

“A three month delay in collections could kill us,” he notes. “So I’ll try to prevent it, but I’m definitely not in control of that. I don’t have a rock-solid plan.”

Overall, physicians expect ICD-10 to be a grind—and an unnecessary one at that—but they’re determined to do whatever it takes. “We have no alternative but to get through it,” Von Elten notes. “It’s going to be a daunting task, no doubt.”
Start preparing now for ICD-10

Transition tips you can use:

Take a financial snapshot

• Begin analyzing the financial health of your practice. Evaluate your payer mix, determine your typical accounts receivable cycle and examine denied claims, both for coding and documentation reasons. Determine what you need to do to survive financially if you encounter a major problem with reimbursements after October 2015.

Gather coding data and identify diagnostic patterns

• Analyze your practice’s coding patterns to determine which codes you use most frequently, which ones make up the largest portion of your revenue, and which ones are denied most frequently, and for what reasons. This should be done for each payer you work with, going back about a year.

Contact vendors and health plans

• Ask your payers and vendors—electronic health records, billing services, clearinghouses—about their ICD-10 readiness. Monitor the preparedness of your vendors and payers and work with them to identify and address gaps.

Improve your documentation

• Providers should begin documenting patient encounters as if ICD-10 is already in place. The goal is to be ready, from a documentation standpoint, for testing and going live with ICD-10.

Begin testing

• Testing ICD-10 claims to ensure that your coding and documentation are working properly is vital, and should begin as soon as possible. The Centers for Medicare and Medicaid Services is holding testing weeks prior to the transition, but waiting for those events is not necessary. Testing is important both within your practice and with the clearinghouses and payers you work with. Make sure you test using records that reflect patient encounters you commonly deal with.