10 tips to accelerate ICD-10 compliance

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Unless you’ve been on another planet, or had your head completely buried in the proverbial sand, you know ICD-10 is here to stay. But is your organization ready for all that it entails?

Here’s a quick look at ICD-10 by the numbers. Physicians will now have 68,000 diagnosis and 72,000 procedure codes to choose from when documenting inpatient encounters—a 678 percent increase in total codes.

While the potential for this added specificity seems positive, too much documentation leads to “note bloat” and possibly reams of paper and/or electronic documentation that people simply can’t access or absorb. On the other hand, too little documentation can create excessive amounts of post-discharge queries by the coding team who need to enter the right codes for MS-DRG assignment and billing. Too little documentation can also lead to poor care coordination and worse, patient outcomes.

In other words, ICD-10 could make it difficult for healthcare organizations to remain compliant and current while still generating revenue. As a result, finding the balance in accuracy and productivity is critical.

But don’t despair. There are a number of best practices you can implement to accelerate your compliance efforts. The following are 10 tips every organization should consider as part of their ICD-10 strategy to provide better patient care through more accurate documentation.
10 tips for ICD-10 compliance

Tip #1: Communicate and collaborate
Remember that any one department can’t set direction or create change for the whole organization. This is why it is so important for senior leaders to communicate all facets of the organization’s ICD-10 strategy. Additionally, they should allocate appropriate resources and make priorities clear.

Collaboration is also critical. To succeed, healthcare organizations must have ongoing collaboration—and 360-degree communication—between physicians, professional coders, and clinical documentation specialists. For example, coders must communicate back to the clinical documentation specialists (CDSs) about the types of post-discharge queries they are writing. Why? So that the CDSs are informed and can begin capturing these as clinical clarifications during the patient’s stay. This improved documentation will have a positive impact on severity, outcomes, and in some instances, case mix. This is especially true if these are impacting revenue, SOI, or ROM.

At the same time, CDSs should monitor coders to make sure they are not over-utilizing post-discharge queries that could have a negative impact on clinicians and harm relationships. This 360-degree communication may be the only way to identify and resolve any gaps that may exist in the current effort and create the plan to strengthen compliance efforts on a go-forward basis.

Tip #2: Assess people, process, and technology
Be disciplined in assessing strengths and challenges of people, processes, and technology connected to ICD-10. For example, if you don’t have the right team in place, doing the right things, it will be an uphill battle to achieve compliance in a sustainable way. Many organizations may have started this process with ICD-9 and dual coding; if so, they may be able to continue to leverage this approach going forward. Assess the technology in place and be sure that you are leveraging the investment made in the EHRs with technology-enabled documentation and CDI solutions.

Tip #3: Monitor reporting and data analytics
Speaking of ICD-9, remember that the same analytics and reporting are just as important in ICD-10. This means that your organization needs to rigorously monitor key performance metrics such as case-mix index. Additionally, they may require more reporting detail at the code level to fully analyze and identify missed-specificity in clinical documentation with the new code set.

Finally, reports must be generated on a weekly basis for the first few months and then on a monthly basis; anything longer than that doesn’t provide the real-time insight the organization needs to improve future results. Today, be sure that your automated CDI, coding, and MS-DRG assignment reporting systems are set up to provide you with the reports.
**Tip #4: Be prepared to provide remedial education**

For some, ICD-10 will seem overwhelming, possibly even intimidating, so be prepared to offer ongoing remedial education as needed. For example, your organization should provide coders with the opportunity to practice using new codes. In the past, ICD-9 might have only included a single code for "atrial fibrillation," but ICD-10 now includes many additional secondary codes for further detail, which provide added depth and clarity to patient records. Providing ongoing training and feedback is important if there are questions early in the process. This is especially true for high-revenue medical services such as cardiovascular.

**Tip #5: Resist the urge to go after all specificity**

Clinical documentation specialists’ and coders’ time is limited and of great value. Healthcare organizations need to avoid over-using these resources in pursuit of code specificity that does not impact revenue or patient care. A pragmatic mindset is best, and you may want to start slow in this area. For example, you may want to suggest a ramp-up plan for specificity queries with the expectation that eventually all specificity be documented.

After monitoring early progress, productivity, and revenue, the organization may then choose to attempt to increase specificity. Again, this is another reason that reporting and data analytics are so important.

**Tip #6: Watch and analyze case mix index like a hawk**

Case mix index (CMI) is crucial for determining the allocation of resources to care for and treat patients. Yet if any dips or variances occur, they need to be identified, classified, and studied. For example, if a review of joint replacement patients shows a decline in CMI, look closer at which physicians are driving the documentation as well as the codes being assigned. Is only one code being used where secondary codes should be used?

Coding errors will happen and will likely be to blame. Healthcare organizations should be realistic about this and expect them early in the process. There is no shame in mistakes; what is shameful is not learning from them.

**Tip #7: Tightly manage Discharge Not Final Billed (DNFB)**

It is imperative to have dedicated staff monitoring DNFB on a daily basis. If this metric increases, make sure to take a closer look and evaluate the reasons causing the delay in individual cases. For example, with the increased amounts of codes, specificity could be the culprit. Are too many cases still waiting on specificity? For how many days? If you are using contracted staff (both CDSs and coders), make sure to monitor their quality and accuracy as well as productivity—especially early in the process—and look to make adjustments required to make the DNFB metric fall back into reasonable thresholds.
Tip #8: Create an ICD-10 audit plan

Have you created an ICD-10 audit plan for evaluating accuracy of ICD-10 coding? Is it daily for every coder? What are your metrics for monitoring, and do you know how they are calculated? Is it manual or electronic? Do you have staff to conduct internal audits, or are you outsourcing this function? Do you have technology-enabled compliance monitoring integrated into your encoder or computer-assisted coding solutions?

Determining the answers to these questions is important. You have 30 days from the October 1, 2015 implementation date to be sure that you have a coding audit project plan with dedicated resources, timeframes, reporting tools, deliverables and that it is budgeted.

Tip #9: Give feedback to the ICD Coordination and Maintenance Committee

It is important to remember that we’re all in this together. This means that everyone has a responsibility to provide early—and ongoing—feedback to the ICD Coordination and Maintenance Committee or similar task force. This may include suggestions on existing codes, asking the committee to consider new codes, or simply providing recommendations for improving specific parts of the process. Do all you can to make the code sets better for everyone.

Tip #10: ICD-10 is not perfect—accept imperfection!

Keep a positive attitude about the change that is coming. To be optimistic, ICD-10 is attempting to improve the entire clinical documentation process. While it will never be a perfect system, this is your opportunity to help your organization make the most of it. Be positive, celebrate early progress, and do all you can to capitalize on early momentum.

Embrace ICD-10!

Clinical documentation improvement has become a strategic imperative at hospitals and health systems across the country as providers look to not only address case mix accuracy, and “bullet proof” clinical documentation against repayment demands. While ICD-10 can seem overwhelming, by following these recommendations and suggestions, your organization can reap the benefits of early adoption and better documentation processes.

To learn how Nuance can help you improve clinical documentation processes—and better comply with ICD-10—please visit www.nuance.com/healthcare or call 877-805-5902.

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