Looking in the ICD-10 rearview mirror

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Did you take the right path?

By Becky Quammen

Currently, many healthcare leaders are consumed with the many technical components associated with ICD-10 implementation: billing system compatibility, scrubber compatibility, coder training, physician education and the like.

Fast forward to Oct. 1, 2015, and ICD-10 has arrived. Instead of implementing ICD-10, leaders will be scampering to focus on managing this new coding system.

Consider yourself warned. Waiting until October to worry about managing ICD-10 is probably not the best strategic choice. Instead, it would be advisable to get out in front of the curve and start focusing on ICD-10 management today. More specifically, the time is now to consider the real goal of ICD-10: actually improving the level of clinical documentation.

By taking such an approach, you won't be looking in the rearview mirror a few months from now and wondering, "How could I have missed that most important turn on the path toward ICD-10 success?"

To start, as a healthcare leader, you need to understand that the move to ICD-10 is all about improving the clinical documentation to substantiate the care that was provided and then receiving timely compensation commensurate with that care delivery. In addition, it's important to realize that the ability to more precisely describe a patient condition has the potential to identify areas for reduction in waste and cost. On top of these core advantages, many other benefits will emanate from ICD-10 such as identifying trends in diagnosis, addressing public health needs, achieving better surveillance of epidemic outbreaks and managing bioterrorism, according to the American Medical Association.

It all starts with clinical documentation. Fortunately, the quality of the documentation is a familiar issue for healthcare leaders, as it has been an integral component of clinical and financial success for many years. Indeed, how many times have you heard that physicians and the care team are doing the work, they are just not accounting for it in their documentation? ICD-10 specificity requirements are just shining a bright light on this age-old concern.

The upshot? Now, more than ever before, healthcare organizations need to enable clinicians and other staff members to focus on the front end of clinical care delivery – specifically zeroing in on good clinical documentation.

To do so, leaders have to understand the depth of documentation data that is needed to perform the detailed level of coding required. What's disconcerting is that many healthcare organizations are not even compliant today with a level of clinical documentation that supports coding, reduces administrative work required to rework claims for submission and reduces denials under the less complicated ICD-9 system. The situation will only get more challenging under ICD-10. Indeed, according to a recent study conducted by the American Academy of Professional Coders (AAPC), a coding education and certification organization, more than 20,000 audits of physicians' clinical documentation revealed that only 63 percent of current documentation is sufficient for ICD-10's specificity levels.

As such, leaders need to hurry up and zero in on implementing the clinical documentation improvement initiatives that can lead to success under ICD-9 today – and more importantly under ICD-10 down the line. This will require a razor-like focus on ensuring that care delivery events start with good clinical documentation. Indeed, if clinicians provide the detailed documentation as they deliver care, then it will become much easier to assign specific codes down the line.

This has always been true, but it takes on a greater urgency with the adoption of the more specific ICD-10 coding system. Consider the following: The increased specificity in ICD-10 codes will mean that clinicians will have to go beyond simply using documentation such as "uncontrolled diabetes," but instead will need to document the difference between diabetes mellitus due to an underlying condition and diabetes induced by drugs or chemicals.

Remember, though, clinical documentation improvement is not a "one-and-done" event, but rather a continual process – or even a state of being. Surely, there are all kinds of ways that clinical documentation improvement can be incorporated into your organization's culture. Many of these approaches involve more products, more expense and more training. For example, using advanced clinical charting tools to ensure details that might otherwise be missed are captured can be especially helpful. However, the most direct and effective route to improved clinical documentation involves simply establishing and enforcing stronger documentation requirements.

As an organizational leader, you need to use what is available to you now: The ability to monitor, audit and enforce compliance to quality documentation of care. That's the first step to success under any coding model – and an essential first step toward ICD-10 success. **HMT**

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