One aspect of your ICD-10 transition plan that must not be overlooked is physician training and education. Provider documentation is as important as coding when it comes to successful ICD-10 implementation. Hospitals need to develop a strategy now to ensure that physicians are ready, willing and able when ICD-10 coding becomes a reality in 2014.

**Introduction**

As the October 1, 2014, deadline looms, hospitals across the nation are preparing for the transition to ICD-10. As most hospital administrators and CFOs recognize, failing to successfully address this important transition can have adverse effects such as reduced reimbursements, denied claims and delayed payments — all of which can imperil the financial health of the hospital and its ability to provide quality care to patients.

The facts are well documented. The move from ICD-9 to ICD-10 will add approximately 137,000 new codes and is considered the most challenging change since the inception of coding. While transitioning to a new set of diagnostic and procedural codes is complex, to say the least, it is expected to deliver long-term benefits such as more accurate and timely reimbursements, better quality of patient care, and improved disease and care management.
As hospitals ready for the transition, much of the focus is on training coders, upgrading systems and attending to the other essentials needed for the ICD-10 switchover. Obviously these fundamentals are critical, but physicians may actually play the largest role in the successful adoption of ICD-10. A recent study that assessed more than 3,000 medical records across the country revealed that, on average, only 37 percent of the current physician documentation would support the newer standards required by ICD-10.¹

Without more specific clinical documentation, accurate coding and proper payments will not be possible. Therefore, as part of their overall ICD-10 strategy, hospitals must develop a physician-focused transition plan that includes communications, training and education, clinical documentation improvement (CDI), and a policy for community physician outreach.

**Physician documentation and hospital financial health**

Physician documentation has a direct effect on the financial health of the hospital. This interdependency will become magnified with ICD-10. If physician documentation does not meet the specificity required for the new code set, the financial ramifications can be severe, and include:

- Reduced reimbursements
- More denied claims
- Increased accounts receivable days and decreased cash flow
- Greater workload for both coders and CDI specialists

All coding and billing begin with documentation. If you don’t get that right, then a significant portion of the money spent on systems and processes in anticipation of ICD-10 will be wasted.

According to Shely O’Laughlin, vice president and national solution leader for ICD-10 and CDI at Optum®, having the correct clinical documentation is analogous to capturing accurate information when registering a patient. “As every CFO knows, having the wrong insurance information at registration leads to problems down the line, such as tracking down patients to get the correct information, delayed billing and potential revenue write-offs due to failure to get proper authorizations. It’s the same with documentation. When you begin with bad clinical documentation, the trickle-down impact across the organization is substantial. It will affect productivity, reimbursements and, ultimately, the bottom line.”

**Engaging the physician**

It is critical that physicians be engaged and understand how ICD-10-compliant documentation benefits them as well as the hospital. In many cases, physicians may not be as motivated by the financial implications of ICD-10 for the hospital as they are by quality care issues.

According to experts, the message to physicians should be that good documentation is a quality initiative. “Physicians are not taught how to complete the documentation in order to accurately assign codes, and physician billing does not require a high degree of specificity,” says Adele Towers, MD, University of Pittsburgh Medical Center. “However, the lack of specificity on a hospital record can affect payment. The key is to engage physicians to correlate how clinical documentation provides an opportunity to demonstrate the quality of care that was provided.”²
Additional issues must be overcome to gain physicians’ buy-in. These include significant demands on their time and a natural resistance to change. According to Dr. Towers, “Physicians are by nature independent thinkers and will expect a very concise, clear reason to change documentation habits.” These considerations should be addressed as part of your ICD-10 transition strategy and plan.

Strategies for a smooth transition

There are several strategies and approaches to consider when constructing your physician ICD-10 transition plan. These include:

Communication program: A good starting point is developing an awareness and communication program that specifically targets physicians. This can go a long way toward diminishing the fear among providers that has been created by the hype and misinformation about ICD-10 and what it will mean for them. A physician communication program can include the use of posters, existing medical memos, department meetings and other physician forums.

Education and training philosophy: As you develop your education and training program, concentrate on the following:

- Physicians should be trained separately from your coding staff.
- Physician education must be concise, relevant and accessible.
- Courses should be tailored to each physician’s specialty. A cardiologist has no interest in how orthopedics gets documented or coded.
- Identify how ICD-10 is different from ICD-9, and teach providers the difference. Physicians do not need or want to be taught what they already know.
- Focus the majority of your efforts on the top 10 or 20 high-impact areas (by frequency or dollars) for which physicians will need to increase the granularity of their documentation to support ICD-10 specificity.

Physician champion: Peer-to-peer communication is one of the most effective ways to reach physicians. That’s why identifying and engaging an interested and respected physician to champion CDI is so important to your ICD-10 transition. A physician champion can conduct formal and informal education sessions at department meetings and other forums and provide one-on-one coaching as needed. In many organizations, a physician champion/advisor is part of the CDI team, bringing expertise and credibility to your clinical documentation improvement program.

CME credits: Many organizations are making continuing medical education credits (CMEs) available to physicians who complete ICD-10 training. Certifying your ICD-10 training will increase participation and be a valuable enticement for physicians.

Phased approach to training

Your physician training program should include three levels of instruction: overview, knowledge-based skills transfer and on-the-job training. A typical curriculum — which could include a mix of eLearning, instructor-led and hands-on training — could include:

- Overview training: impact of ICD-10
- Provider documentation enhancements for ICD-10
• Difference between ICD-9 and ICD-10, by specialty
• On-the-job training, supported by CDI specialists and physician champions

In parallel with physician training, organizations should consider how they could leverage their electronic medical record (EMR) to assist physicians in capturing the required levels of specificity. This could include adding prompts to EMR templates to address the supplemental information now needed for ICD-10.

Once coders, physicians and CDI staff are trained, hospitals should begin dual coding. This will identify gaps in clinical documentation well before the October 1, 2014, deadline. You should create a close communication chain so the trends and/or gaps in documentation identified by coders during dual coding are communicated to both physician champions and CDI staff. This will allow them to zero in on deficiencies in clinical documentation that need to be addressed with further education.

The role of clinical documentation improvement

The number and breadth of hospital CDI programs have increased dramatically over the last decade. These programs, under which dedicated specialists review charts for accuracy and completeness, are designed to improve the clinical and financial performance of the hospital. An effective CDI program can be critical to ensuring that the true patient story is documented, and that the documentation reflects the appropriate level of severity and complexity for the treatment provided. Focusing on the quality of the documentation will naturally lead to appropriate reimbursement (revenue integrity), and is important to managing costs related to rework and inquiries. Without that focus, a hospital could be losing revenue.

While the impending ICD-10 deadline may be kick-starting the CDI initiative for many hospitals, it is the prospective value-based payment models that are making CDI an organizational imperative. According to a Healthcare Financial Management Association educational report: “One reason CDI is receiving new levels of attention is the growing importance of accurate documentation under value-based payment models, which tie payment to the achievement of quality and performance targets. Accurate, complete clinical documentation is important not only for establishing a baseline of patient health, but also in demonstrating the efficacy of the prescribed plan of care in improving the patient’s status.”

If you have an active CDI program now, it should be leveraged to support the transition to ICD-10. Your CDI specialists should act as transition guides for your physicians, actively engaging with them throughout the ramp-up period. Early interaction and working incrementally with physicians to increase documentation specificity and accuracy will make the transition easier. Organizations cannot wait until mid-2014 to start the process. Physicians can begin documenting to the ICD-10 standards today, and a gradual transition plan will be the most successful.

Develop a community physician strategy

Hospitals need to devise a strategy to ensure that all physicians affiliated with the hospital, including non-employed community providers, receive ICD-10 documentation training. If independent physicians or physician groups that practice at your hospital are unprepared, the financial results could be devastating, including lost or delayed revenue and diminished productivity of hospital coders and CDI staff.

Improving clinical documentation through technology

According to a report from KLAS, more than 74 percent of hospitals have purchased or are planning to purchase a computer-assisted coding (CAC) system to help with their transition to ICD-10. In addition, an increasing number of hospitals are looking to technology to help with clinical documentation improvement.

While CAC is obviously a coding tool, a comprehensive CAC platform with a highly sophisticated natural language processing (NLP) engine can support your hospital’s ICD-10 documentation effort as well. Although ICD-10 clinical documentation will require greater specificity, your CAC should support the natural way that physicians communicate their findings, diagnoses and clinical descriptions. Not all NLP engines can do this, nor can they interpret documentation to support an efficient CDI initiative. You need a system that combines linguistic rules and mathematical modeling to identify meaning and context, thus allowing coders to capture diagnoses and procedure codes quickly and accurately from language naturally used by physicians. The most advanced systems will also read non-narrative data like lab reports, and quickly identify additional gaps in information.

Technology is also being used to automate CDI programs. NLP technology can be leveraged to automatically review clinical documentation and identify likely discrepancies, helping CDI specialists prioritize their work. This is an important breakthrough because traditional CDI efforts face several obstacles:

• Manual reviews are time-consuming, which limits the number of cases that can be processed.
• A survey by the Association of Clinical Documentation Improvement Specialists showed that seven out of eight CDI specialists found documentation deficiencies in less than 50 percent of the records they reviewed.
• More than one-third of physician queries do not receive a response or are invalidated.
• Queries after discharge are more likely to be ignored and are less defensible.
Here are some issues to consider when developing an ICD-10 community physician strategy. Many independent physicians and small group practices may not have the capital, time or expertise needed for training. To counter this, many hospitals are going to offer to their community physicians the same ICD-10 education that they are providing to employed physicians, and it will be either free of charge or at a discounted rate. This includes training for ICD-10-PCS used for inpatient care and ICD-10-CM used for billing professional services. This not only presents hospitals with a great public relations opportunity but also ensures that community physicians will be successful in their own practice and will document accurately for cases within the hospital.

If there are multiple hospitals in your area, there is a good chance that your community physicians will have admitting privileges at more than one. Since most hospitals will require ICD-10 training or certification for non-employed physicians, you need to ensure that time-strapped providers don’t have to undergo the same training more than once. This could require collaboration with competing hospitals to understand their community physician training requirements and to coordinate training agendas. Among your options are to:

- Work together as a group to form a regional strategy.
- Consider hiring the same vendor to conduct training at all hospitals so that physicians will have to go through certification and training only one time.
- Review ICD-10 physician training programs across the area and accept each others’ training certificates to eliminate redundancy.

**Nine practical steps for transitioning physicians to ICD-10**

Accurate clinical documentation is the foundation of a successful transition to ICD-10. Hospitals must develop a comprehensive plan to ensure that physicians are well trained and motivated to deliver the level of specificity required for ICD-10 and the coming value-based payment models. Here are nine practical steps your organization can take to address the involvement of physicians in this transition:

1. Develop a strategy and project management plan to ensure physician participation and compliance.
2. Create a coordinated communication program to inform and engage physicians.
3. Leverage the expertise of your existing staff, such as training coordinators and CDI specialists.
4. Engage a vendor/partner to help navigate your ICD-10 transition and provide services/skills as needed.
5. Identify a process for creating content specific to physicians, tailored by specialty and emphasizing role-specific training.
6. Consider a mix of eLearning, instructor-led sessions and on-the-job training.
7. Leverage supporting technology — such as NLP-based CAC and CDI systems — to complement your clinical documentation improvement effort.
8. Develop a program to ensure that non-employed physicians are trained and ready.
9. Develop a monitoring and improvement methodology to support ongoing improvement.

**Automated CDI in action**

- The University of Pittsburgh Medical Center (UPMC) is implementing an NLP-based system that leverages CDI business rules for automating case finding and physician querying. The system reviews hundreds of cases per day and identifies those with a high probability for documentation improvement. This allows CDI specialists to spend their time more productively by reviewing and prioritizing only high-probability cases. It also minimizes the number of cases that physicians need to review to determine clinical relevance. In addition, it addresses the low query response rate by integrating queries directly into the physician’s routine workflow, in most cases while the patient is still in the hospital and the case is top of mind.

- The initial results have been impressive. UPMC has run multiple audits comparing the findings of its CDI specialists with the findings of the automated CDI process. In each test, the automated process found more documentation deficiencies than were identified by human review of the same cases. “The average difference was an increase in estimated reimbursement of $138 per inpatient case. When projected across all UPMC hospitals, this equates to nearly $10 million in additional billable revenue per year.”

3. Ibid.
Successfully implementing ICD-10 in your hospital: Don’t overlook the physician factor

References

1. AAPC website: “Documentation will become critical with ICD-10.”


3. Ibid.