Delay in ICD-10 Allows for Continued Development

Taking a deep breath, many providers have concluded that the delay in the effective date of ICD-10-CM and PCS, which at first seemed disconcerting, may prove to be more advantageous than detrimental to their ongoing operational readiness. Now, with this respite, the key to maintaining momentum in ICD-10 preparation through the coming months will be the continued focus on provider-specific readiness tasks.

Readiness Progress to Date

As hospitals and physicians have evaluated their progress to date toward readiness for ICD-10, most have divided their action plans into specific knowledge and skill milestones for coders, physicians, and clinical and revenue cycle staff members. These readiness milestones have been further segmented according to deadlines for completion. Now, the delay in ICD-10 implementation allows providers strategically to plan the completion dates for these action items in ways that optimize their organization’s readiness.

To use this time wisely, providers should consider completing the education plan by layering the knowledge requirements for each group into additional shared training activities for all involved. This process will allow building of the necessary skills for interdependence and ensure proficiency for all groups.

As an example, consider a physician making a decision for inpatient surgery for a Medicare patient who has been seen in a hospital-based cardiology clinic. The physician’s office calls the hospital’s surgical center to schedule the operative procedure. Before the procedure can go on the schedule, however, the surgery scheduler must review the new ICD-10 diagnosis and procedure code(s) to determine if they meet medical necessity for an inpatient admission. Should the surgery scheduler involve a patient care manager to discuss the planned procedure with the physician’s clinical staff? Or should the procedure be scheduled as requested by the physician with patient status to be reviewed and determined after the completion of the surgery? The current process is somewhat difficult and often results in the patient receiving services in the wrong setting, but ICD-10 will complicate the decision even more if staff members lack the appropriate knowledge and available resources to reach an optimal decision.

Three Areas for Concentration Going Forward

The following three areas of concentration will combine individual learning activities and group attainment of the overlapping knowledge base needed for ICD-10 readiness:
Physicians – Continue with individual physician documentation reviews to determine improvements needed for ICD-9; meanwhile, prepare brief, bulleted “ICD-10 Uptakes” for documentation revisions and/or additions by each physician, if possible (and, if not by individual physician, by medical specialty). Either coding staff members or nurse reviewers (auditors) should assist with chart reviews.

- Continue short (15 minutes or less) presentations to the physicians based on their own documentation and the required documentation changes for compliant coding under ICD-10.

- Track individual physician “scores” on documentation reviews to be shown only to the reviewed physician as his or her ICD-10 achievement. Ensure progress is noted as the physician makes necessary revisions for ICD-10.

- Include coding staff members in evaluating documentation improvements and reviewing with physicians descriptive terms or specificity in disease processes necessary for ICD-10.

Coder – Continue with brief coder training at least every other week (one-hour sessions) to review the ICD-10 documentation needed for the top 25 - 50 diagnoses for hospital or facility patients.

- For example, if the hospital has a “diabetes clinic,” focus on preparing a documentation/coding “Uptake” that outlines requirements for coding all of the ICD-10 diabetes diagnoses. The “Uptake” documentation aide can be utilized for both coder and physician training.

- Consider asking the coding staff members to identify ICD-10-CM diagnoses that may generally meet medical necessity for inpatient admission, and that may be most appropriate for observation placements.

- Focus quarterly review on the hospital’s PEPPER Report and/or RAC/ADR audits to ensure clinical staff (particularly patient care management), physicians, and coders understand obstacles in documentation and coding under ICD-10.

  If these services were denied under ICD-9, they may be even more difficult to support for medical necessity and inpatient admissions under ICD-10.

Identify all uses of ICD-9 throughout the revenue cycle and establish a work flow process to assist with coding resources for ICD-10 implementation.

- Ask patient access representatives, patient care management nurses, and patient financial services billers and collectors where their job tasks are affected by ICD diagnosis and inpatient procedure codes.
- Build decision trees to simplify decision-making for medical necessity by registrars, add electronic tools or aids wherever possible, and ensure resources are user-friendly and understood by billers and follow-up staff to correct claims in ways that comply with ICD-10.

**Continued Knowledge Improvement**

While these recommendations involve simple actions, they focus on basic knowledge gains that will form the foundation for ICD-10-CM and PCS success. Individual training is important; however, as noted earlier, the most beneficial knowledge will be attained through layering skills for interdependent documentation and coding achievements throughout the health practice or system. No staff member works in a vacuum. He or she fills a vital role in the reimbursement process and will be called upon to have the appropriate answer to each overlapping ICD-10 question throughout the revenue cycle. For providers to navigate these complex processes successfully, each physician and staff member must comprehend not only how to complete their individual tasks but also their part in mutually supporting decision-making.