ICD-10 and CDI Implementation: Lessons Learned from the United States

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Objectives

• Examine the myths and facts of ICD-10 implementation
• Review the last days before ICD-10 Go-Live
• Explore the impact of ICD-10 implementation on management and staff
• Tips for a smooth transition to ICD-10
• Benefits of a CDI program
• **Myth:** The increased number of codes in ICD-10 will make the new systems impossible to use.

• **Fact:** Coding professionals who received proper training were able to easily transition from ICD-9-CM to ICD-10-CM/PCS.
Myths and Facts

• ICD-10 was developed without clinical input.

  **MYTH**

• **FACT:** Many clinicians participated in the development of both ICD-10-CM and ICD-10-PCS.
Myths and Facts

• The improved structure of the terminology and the higher level of specificity will make finding codes more intuitive.

• ICD-10-CM and ICD-10-PCS are more clinically accurate and logical than ICD-9-CM.
Prior to Go-Live

• Pre-implementation predictions:
  – Substantial cash flow disruptions and revenue shortfalls
  – Significant increase in claims denials
  – Major payment slowdowns
  – Small physician practices going out of business
  – Reimbursement disruptions
  – Dual coding would be necessary
Prior to Go-Live

• More pre-implementation predictions:
  – ICD-10 is impossible to learn
  – Expanded specificity would make the codes too complicated
  – Level of detail needed in ICD-10 would not be supported by the medical community
  – More claims would be miscoded
  – Widespread denials involving “unspecified” codes
Prior to Go-Live

• More pre-implementation predictions:
  – Government-sponsored insurance companies wouldn’t be ready
  – Testing was inadequate
  – The transition would be prohibitively expensive
  – Organizations would experience major disruptions in business operations
  – ICD-10 would never be implemented
Impact on People

• Negative feelings about ICD-10:
  – Anger: “How am I supposed to learn this new system when I have to see so many patients per day?”
  – Anxiety: “I don’t want to get up in the morning and face this coding monster!”
  – Sadness: “Nothing is like it used to be.”
  – Disorientation: “I’m supposed to be doing WHAT?”
Impact on People

• Positive feelings about ICD-10:
  – “ICD-10 will improve patient care, provide better patient data, and improve public health and safety.”
  – “ICD-10 will allow us to create a comprehensive and thorough picture of a patient’s status and well-being with the help of improved clinical documentation.”
  – “ICD-10 will allow me to code better.”
LESSONS LEARNED
Lessons Learned

• Leading staff through the transition can be difficult! Communication is key!
  – Hold daily 15 minute team huddles or morning emails with updates
  – Acknowledge staff that go above and beyond
  – Be transparent
Lessons Learned

• Schedule short daily meetings with Physician Champion(s), department heads, and managers to update on progress with training and systems

• Review top diagnoses to determine how codes will change with ICD-10

• Coders and clinical documentation improvement (CDI) professionals must work closely with providers on documentation
Lessons Learned

• Post-implementation challenges:
  – Clinical documentation deficiencies
  – Increase in physician queries
  – Inadequate physician education
  – Incorrect claims edits
  – Poorly designed EHR coding tools that caused clinician frustration
  – Physician orders for ancillary services contained ICD-9-CM codes
Biggest Challenge

- Physician documentation
- **Solution:** Clinical Documentation Improvement
What is CDI?

- CDI is the bridge between clinical language and coding language
- Concurrent review of health records for conflicting, incomplete, or nonspecific provider documentation
- Reviews typically occur on patient care units or in outpatient clinics, or can be conducted remotely via the EHR
What is CDI?

• Queries to providers may be utilized to gain greater specificity in documentation
• CDI should be viewed as a tool and not as a hindrance to being able to perform patient care
• CDI provides educational information about specificity in documentation that supports consistency in care and supporting severity of illness and length of stay
The CDI Team

- CDI Manager/Director
- CDI Specialist (CDIP credential)
- Physician Advisor/Champion

- Typically part of the HIM department
  - Case Management
  - Utilization Review
High Quality Documentation

1. **Legible** – clear enough to be read and easily deciphered

2. **Reliable** – trustworthy, safe, yielding the same result when repeated

3. **Precise** – accurate, exact, strictly defined

4. **Complete** – has the maximum content, thorough

5. **Consistent** – not contradictory

6. **Clear** – unambiguous, intelligible, not vague

7. **Timely** – performed at the time of service
1. Perform gap analysis of current documentation
   – Identify points of pain
   – Biggest impact

2. Determine areas of focus
   – Specific service lines?
   – Specific physician specialties?
   – Specific payers?
   – Inpatient? Outpatient? Emergency Room? Clinic?
CDI Program Goals

• Achieving coding compliance
• Increase case mix index (CMI)
• Quality performance improvement
• Patient satisfaction
• Reduction in denials
• Streamlining communication between HIM/Coding, CDI and Physicians
• Other goals
Summary

• Preparation is key for a successful transition to ICD-10
• More provider education is needed
• CDI program helpful in the transition and post-implementation
References

Questions
Thank You!