As healthcare organizations of every size race toward ICD-10 compliance, many are giving insufficient attention to a critical step that is key to mitigating risk and preparing for the change: implementing and sustaining an effective physician clinical documentation improvement program. This step should be the foundation for an enterprisewide approach to preparing for ICD-10.

Many hospitals and health systems across the nation have initiated efforts to improve clinical documentation, yet most of these efforts have not succeeded because they have focused on educating coders, case managers, and health information management (HIM) professionals rather than physicians.

The delivery of patient care is predicated on the accuracy and completeness of the information compiled, assimilated, and documented by physicians. The clinicians charged with supporting care of a physician’s patients rely on such information to guide their efforts, and the information eventually can be used for clinical analytics and population health management. For this reason, organizations should take steps to ensure the accuracy and thoroughness of physicians’ documentation on the “front end” of patient care delivery. Indeed, such efforts will produce far better results than attempting to correct or trace errors, or cajole physicians retroactively, when deficiencies in documentation become apparent to those further down the chain of care delivery.

The elements of clinical documentation are taught in medical school, but medical school students receive little insight into how clinical documentation guides, influences, and controls every aspect of the healthcare delivery system. As a result, these students tend to have underdeveloped clinical documentation skills, and many leave medical school with the impression that clinical documentation is a menial, nonfunctional chore and a necessary evil.

The transition to ICD-10 offers healthcare finance leaders an opportunity to address this problem. In preparation for ICD-10, these leaders should not only evaluate the clinical documentation tools and technologies that are proliferating in anticipation of the Oct. 1, 2014, ICD-10 implementation deadline, but also take steps to ensure that their organizations have in place structured physician clinical
documentation programs. ICD-10 compliance provides both a reason and an opportunity to move forward with improvement processes that will reap both short-term and long-term benefits.

**How to Mitigate Risk Related to ICD-10**

Without early engagement of physicians and an organizational understanding of their pivotal role in documenting each patient’s information accurately, specifically, and thoroughly, initiating a clinical documentation improvement initiative can be difficult. Obtaining buy-in from a hospital’s or health system’s medical staff eases this process by providing a means to identify and anticipate the potential downstream impact—whether positive or negative—of the efforts to enhance clinical documentation.

A clinical documentation improvement initiative that actively engages physicians from the start can mitigate several areas of potential risk related to ICD-10 and its implementation.

**Changes in the very nature of clinical documentation.**

ICD-10 requires changes at the core of healthcare business operations, especially changes in how patient care is documented. ICD-10 is not simply a new way to code, but rather, a new coding schema that requires physicians to be much more specific in documenting the care they provide. The examples in the exhibit below show a clear distinction between the documentation of today and that of ICD-10, which physicians must understand to be able to properly document each patient’s encounter. Having physicians on board from the start offers a tremendous advantage in ensuring that the physicians quickly obtain this understanding.

**Training and education.** Success under ICD-10 requires effective allocation of training and educational resources. This requirement is much greater under ICD-10 than under ICD-9, and it helps to have physicians on board and receptive to the need for increased training and education. Physician education should be ongoing; to be effective, it should not simply consist of a one- or two-hour lecture or a series of lunch-and-learn sessions. Over the long term, physicians will have a direct impact on the productivity of other professionals supporting improved accuracy in documentation. Without sponsorship, leadership, training, and reinforcement for adoption, physicians’ transition to ICD-10 may be more difficult than necessary.

Ensuring the adequacy of training and education also requires a training plan that demonstrates to physicians how improved clinical documentation promotes better care. Such a training plan should highlight the necessity of specific and sufficient documentation.

### HOW DOCUMENTATION DIFFERS BETWEEN ICD-9 AND ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathologic Fractures</strong>&lt;br&gt;10 codes</td>
<td><strong>Pathologic Fractures</strong>&lt;br&gt;Approximately 150 codes</td>
</tr>
<tr>
<td><strong>Required Information:</strong>&lt;br&gt;Document general site such as vertebra, femur, etc.</td>
<td><strong>Required Information:</strong>&lt;br&gt;Document exact location (site and side), cause (e.g., osteoporosis, cancer, long-term use of steroids), initial versus subsequent encounter for care (If it is subsequent, does it involve non-healing?).</td>
</tr>
<tr>
<td><strong>Urosepsis</strong>&lt;br&gt;Default code is UTI</td>
<td><strong>Urosepsis</strong>&lt;br&gt;No default code available</td>
</tr>
<tr>
<td><strong>Required Information:</strong>&lt;br&gt;Note: Although the default code of UTI is not ideal, it is an option.</td>
<td><strong>Required Information:</strong>&lt;br&gt;Urosepsis requires “coding to condition.” Documentation requires a description of the condition, blood pressure of 90/50 (not stated as hypotension), temperature of 95 (not stated as hypothermic), chills, altered mental status.</td>
</tr>
</tbody>
</table>
Some physicians may be convinced that documentation cannot accurately reflect the quality of the care they provide. The challenge—and the potential risk—associated with training physicians lies in developing a training plan that echoes quality-of-care considerations behind clinical documentation improvement.

The need for changes in behavior. Improving clinical documentation under ICD-10 will require physicians to be open to changing their behavior. In general, physicians will be more receptive to such change, and clinical documentation improvement initiatives will be most effective, when the physicians are actively engaged in all phases of documentation. Such engagement allows for ongoing feedback and direction with administrative support that can promote behavioral changes needed for successful documentation under ICD-10. Such feedback provided by team members from other disciplines can further support physician education, training, and engagement.

The need for physician leadership. Leadership and sponsorship from physician executives and champions are critical ingredients for ensuring an organization can achieve the level of clinical documentation improvement required for success under ICD-10. The message that should be conveyed to physician leaders regarding strategies for clinical documentation improvement in preparation for ICD-10 is simple: “It is imperative that we do this and do this well.” At least initially, physician leaders who support the initiative will be needed to provide education related to clinical documentation improvement to their peers. Once this initial peer-to-peer training is completed, it should be followed by continued and consistent learning opportunities that are likewise supported by physician leaders. This approach will set a strong foundation for the initiative.

Legal ramifications of poor documentation. More aggressive pursuit of fraud and abuse and the widespread effort of recovery audit contractors (RACs) to retroactively deny payments deemed improper substantially increase the risk to healthcare organizations posed by poor clinical documentation. The Centers for Medicare & Medicaid Services mandates that medical staff by-laws at all hospitals have a utilization plan in place that ensures high-quality, accurate, and complete clinical documentation. The requirements are similar for clinics, medical groups, and physician offices and apply to care provided in both inpatient and outpatient settings. Incomplete clinical documentation can signal lack of compliance with medical staff by-laws and, specific to Medicare patients, the rules of participation.

The window of opportunity to improve clinical documentation also is rapidly narrowing as the government increases efforts to investigate fraud and abuse in health care. It is well-known and well-documented that a large portion of compliance mishaps are initiated by poor documentation or are not defensible because of a lack of documentation. The core of most allegations of overpayment and/or abuse is inadequate physician documentation; allegations that are most likely to result in loss of revenue for an organization are those based on a retrospective review of documentation one to five years after a claim has been filed.

Physician engagement in the clinical documentation improvement effort from the start ensures that physicians are aware and mindful of all of these risks and concerns related to fraud and abuse and RAC activities.

Action Steps for Success

Hospitals and health systems should take four steps to assess their ICD-10 readiness and better support efforts to improve the quality of clinical documentation.

Confirm that sufficient funds and staff have been allocated to support an ongoing physician clinical documentation improvement effort. Ensuring the physician clinical documentation improvement initiative has adequate funding is essential not only to achieving ongoing success under ICD-10 but also to meeting the requirements of mandatory quality and regulatory initiatives that depend on comprehensive, accurate physician documentation. Enterprisewide resource planning, such as staffing and timeline sequencing, is critical to minimize the negative impact on revenue that will be inevitable with the transition to ICD-10. Given the sheer scope of the effort required for the transition to ICD-10, and number of parties involved, it may not be possible to eliminate every revenue-related risk, but appropriate funding and allocation of staff can make an enormous difference.
The funding and support also should be sufficient to ensure that physicians receive targeted assistance for several months following the ICD-10 implementation deadline to solidify their skills in documenting to ICD-10 standards. Even with training and diligent preparation, improvement levels will continue to vary across service lines and with individual physicians, with some areas requiring more attention, training, time, and resources than others.

Assess the extent to which the physician clinical documentation improvement initiative is generating positive results. One way to evaluate the initiative’s effectiveness is to test samples of physician documentation periodically—currently and as training continues—to ascertain whether physicians’ documentation consistently exhibits sufficient specificity to promote assignment of appropriate ICD-10 codes. These assessments should be performed by staff members trained in ICD-10 or by an outside professional.

The assessment process should begin well before the transition to ICD-10 is completed. Benchmarking the progress of the initiative in today’s environment can have an immediate positive effect on revenue while simultaneously ensuring physicians and staff are well prepared to sustain appropriate documentation under ICD-10. By cultivating the best practices for physician documentation under ICD-9, an organization can greatly reduce the gap between today’s performance and tomorrow’s requirements for ICD-10 compliance.

Establish the physician clinical documentation improvement program as an ongoing initiative. The importance of physician documentation has expanded in recent years. Although much of the focus is on clinical medicine, the corresponding importance of physician clinical documentation remains important to ensure financial sustainability—whether hospital, clinic, practice, or any other healthcare provider—while supporting enhanced patient quality and safety. Documentation also will be subject to further scrutiny through federal audits, so the need for organizations to maintain the highest possible level of physician documentation competency and accuracy will continue beyond the ICD-10 compliance date.

Confirm that documentation improvement is an integral part of the organization’s ICD-10 effort. Because the transition to ICD-10 will require the support of a variety of internal staff—coders, documentation specialists, case managers, office managers for owned practices, ancillary staff, and more—all of these individuals should play a role in the clinical documentation improvement as part of an enterprisewide effort. These professionals can provide valuable assistance in preparations for the testing phase of ICD-10 as well as during go-live and afterward, provided they know the importance of their role and are committed to supporting the success of the transition to ICD-10.

Todd M. Husty, DO, FACEP, is medical director, Medical Audit Resource Services Inc. (MARSII), Eustis, Fla. (tmhusty@himexperts.com).

Lucy Mancini Newell, FHIMSS, is managing partner, The Kiran Consortium Group LLC, Barrington, Ill., and a member of HFMA’s First Illinois Chapter (Lucy.Mancini-Newell@Kiran-Consortium.com).