Cracking the Code: Physician Clinical Documentation and ICD-10

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Introduction

Most executives know the importance of Clinical Documentation relative to coding, billing, quality initiatives, risk management, utilization, medical necessity, and so on. However, it is the practitioners’ documentation, Clinical Documentation, that is the sole source for all these functions. Practitioners’ documentation should also be supported by nursing and ancillary staff documentation.

Improvement in Clinical Documentation (CDI), as an element of a healthcare organization’s broader, enterprise-wide compliance initiatives, is paramount, but, attaining success with CDI programs can be challenging. Although daunting at first glance, ideally, CDI conversations should not create anxiety or nervousness, but rather, inspire an opportunity for a significant positive outcome. The type of opportunities that are generated from CDI include improved patient safety and quality of care as well as enhanced compliance and benefits to revenue cycle efforts. This CDI effort can and should be used to refocus physicians on the importance of improved clinical documentation on operational compliance, and, ultimately, how this directly affects the quality of patient care every day.

The objective of this white paper is to provide some specific approaches to mitigate the potential risks regarding physician clinical documentation improvement, one of the key components of a comprehensive, ICD-10 transition initiative. These efforts should begin early and yield immediate benefits and, with continuous reinforcement, will achieve satisfactory compliance with the requirements of ICD-10 to meet the prescribed, deadline date of October 1, 2013.
Today, the understanding of clinical documentation and its impact on reimbursement has encouraged many healthcare organizations across the continuum-of-care to initiate efforts to improve documentation. While much of the effort is focused on an episode of care in which physician training is followed with intermittent, generalized, educational material and sporadic audits, relatively fewer organizations address this effort by creating a structured program to continually assist physicians to improve their documentation. Case managers, documentation specialists and Health Information Management (HIM) staff receive more training in documentation than physicians, yet they are not holding the ultimate responsibility for the documentation. As a result, the focus must be on the physicians and their documentation.

During medical school, the elements of thorough clinical documentation are taught, but there is limited education and training specific to how clinical documentation guides, influences and even controls every aspect of the healthcare delivery system. Quite frankly, during training the pressures of time and volume of work encourage the abbreviation of thorough documentation. This skill is not only undeveloped but, for many, has been reduced to that of a menial, non-functional chore...a necessary evil.

Because clinical documentation is a complicated topic, the additional “eyes” of other pertinent, healthcare professionals are important to ensure that such documentation supports the actual treatment rendered by the physicians. Both case managers and HIM professionals are important contributors to how physicians can improve their clinical documentation skills.

While many within the healthcare industry advocate a focus of ICD-10 compliance resources on Health Information Management and Revenue Cycle operational areas, a more powerful approach is to do so in conjunction with a physician clinical documentation improvement program. This focused approach will engage physicians to develop the skills to support the changes required to transition from ICD-9 to ICD-10.

Developing a physician clinical documentation program will reap both short-term and long-term benefits. As a result of the required ICD-10 compliance, it provides both a reason and an
opportunity to remedy a long-overlooked effort directly related to on-going, process improvement and best practices efforts that are most often in place. Ultimately, the appropriate Physician Executive and Executive sponsorship as well as a framework to support participating physicians will drive adoption and sustainability for an on-going, physician clinical documentation program.

So how do we begin this process? Without early engagement of physicians and an organizational understanding of their pivotal role in documenting patient information accurately and thoroughly each time, initiating this process can be difficult. By initiating this process at the source, the downstream impacts, both positive and negative, can be identified and incorporated into the development of this process. Today, we know that many other healthcare professionals are expending valuable time and effort on identifying problems with clinical documentation and working to then get adequately updated clinical documentation upon patient discharge. As resources continue to be challenged by growing organizational demand, identifying these problems can directly impact these resources and contribute to further streamlining each phase of the completion of clinical documentation. Finally, ICD-10 will introduce challenges on coding demands that will exceed capacity, therefore, the impetus to address physician clinical documentation improvement rises in terms of relative value to the organization and its efforts to mitigate risk while optimizing operational processes.

*Graphic 1: The Clinical Documentation Process*
What Can Executives and Physician Leaders Do to Mitigate ICD-10 Risk?

As each organization - hospitals, healthcare systems, and medical practices/clinics - engages in planning and executing tasks specific to the ICD-10 transition, we have developed a list of potential risks that might impact your organization’s initiative: As a result, we have identified the seven potential risks that might arise while undertaking improvement of physician clinical documentation:

1. **ICD-10 requires changes at the core of healthcare business**, especially how patient care is documented (Compliance will require *far more effort than learning a new code*),

2. **Inadequate allocation of training and education resources** will have a more significant impact with ICD-10 than it ever did with ICD-9,

3. **Reimbursement losses** due to ineffective, physician clinical documentation will be magnified,

4. Without **sustained physician leadership and sponsorship**, the possibility for negative political impacts related to poor physician clinical documentation will increase,

5. **Training physicians** can be a challenging effort,

6. **Fraud and abuse** is now more aggressively pursued so that poor clinical documentation can pose a higher risk than previously experienced, and

7. **Less than appropriate clinical documentation results in a lack of compliance** within medical staff by-laws specific to Medicare patients, and is applicable to both out-patient and in-patient settings.

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1. **ICD-10 requires changes at the core of healthcare business**, especially how patient care is documented Compliance will require *far more effort than learning a new set of codes.*

If one carefully examines the changes that are required by ICD-10, it becomes more evident that these changes are at the core of our healthcare business. **It is not just a new way to code** but rather a new coding schema. This new coding schema requires physicians to be much more specific in documenting patient care than they do today. The examples below provide a clear distinction between the documentation of today versus that of ICD-10 so that they can properly document his/her patient’s encounter.
2. Inadequate allocation of training and education resources will have a more significant impact with ICD-10 than it ever did with ICD-9

With so much emphasis on other disciplines, such as HIM and case management impacted by the transition to ICD-10, there may not be as much emphasis on the needs of physicians, who remain the originating source of clinical documents. Without sponsorship, leadership, training and reinforcement for adoption, there may be a more difficult transition for physicians to ICD-10 than necessary. Long term, this will have direct impact on the productivity of other supporting professionals that work toward completing an accurate patient record as well as a direct financial impact on the organization.

3. Reimbursement losses due to ineffective, physician clinical documentation will be magnified

There is significant, quantitative information about how reimbursement is positively impacted when Clinical Documentation Improvement (CDI) programs are in place. This type of program becomes even more effective when physicians become integral constituents who are actively engaged in all phases of CDI efforts. Therefore, improvement of clinical documentation by physicians and other clinicians has two financial benefits: (a) minimize future ICD-10 loss AND (b) increase reimbursement.
Based on these two direct benefits, an investment in physician education is a sound financial decision.

4. **Without sustained physician leadership and sponsorship**, the possibility for negative political impacts related to poor physician clinical documentation will increase

At the heart of any effort to improve physician clinical documentation, leadership and sponsorship from physician executives and champions are essential. The message to their colleagues is simple - “It is imperative that we do this and do this well.” Obviously, facts supporting this imperative and a clear path toward improvement must be introduced. In addition, while other healthcare professionals have provided support to physicians, the education relative to clinical documentation should be conducted, at least initially, by physicians. This peer-to-peer type of education has high impact and will resonate very well with the entire physician community. Once this initial peer-to-peer training is completed, it will also be important to provide physicians with a body of knowledge that is followed by constant and consistent, re-learning opportunities. This approach will yield positive results and set a strong foundation for the initiative.

5. **Training physicians can be a challenging effort**

Physicians will readily confirm that this is a true statement. Why might this be a risk? This is highly magnified when the training is in an area that most physicians believe is not important in the practice of medicine. Many physicians believe that documentation is not directly related to patient care, thus it is not very important. These pervasive attitudes define the challenge and inform how to outline the training plan. Demonstrate to physicians that better clinical documentation promotes better care and highlight the necessity of specific and sufficient documentation for the success of the rest of the healthcare delivery system. The challenge and, therefore, the potential risk associated with training physicians points to a training plan that echoes that consideration and also be part of an on-going, sustained effort in support of all physicians.

6. **Fraud and abuse is now more aggressively pursued so that poor clinical documentation can pose a higher risk than previously experienced**

In the last few years, we have seen an increase in the efforts to combat healthcare fraud and abuse. Given this fact, it matters little whether Medicare Recovery
the opportunity to fix documentation issues for many years, the window of opportunity is narrowing since it will only become more difficult as we approach the ICD-10 compliance deadline of October 1, 2013.

7. Less than appropriate clinical documentation results in a lack of compliance within medical staff by-laws specific to Medicare and Medicaid patients, and is application to both out-patients and in-patients.

There is a mandate by CMS that medical staff by-laws at all hospitals must have a Utilization Plan that assures high quality, accurate and complete clinical documentation. There are similar requirements for clinics, medical groups and physician offices as well. Understanding this obligation should encourage physicians to adopt best practices for clinical documentation sooner than later rather than risk a breach in CMS requirements.

A Physician Clinical Documentation Improvement Program is a self-funded initiative.

While each healthcare organization must balance funding numerous concurrent or planned initiatives, a program for Physician Clinical Documentation Improvement is one of a few initiatives that can be self-funded based on the increased revenue that consistently is generated from improved documentation. Why is this true? The cost of a program will initially yield an ROI of a ratio of 1 to 5 or 1 to 4.

Example based on actual returns after a Physician Clinical Documentation Improvement program has been enacted:

Small Hospital (100 beds): Investment in program (external resource) = $25,000 Increase in Revenue = $125,000
Organizing Your Physician Clinical Documentation Initiative in Support of ICD-10 Compliance

While your healthcare organization will be developing a structured tactical plan to address all tasks and activities related to achieving ICD-10 compliance, we would encourage your executive team, Physicians and Administration, to ensure that physician clinical documentation is a relevant and critical element of this compliance initiative. Experience shows that there are a few steps that are recommended to ensure success of the project.

The first step is to engage physician leadership to reinforce the need and importance to support the current documentation guidelines agreed upon by all physicians at hospitals or practices. In addition, physician leadership should advance these key, supportive positions in all medical staff departments and introduce the need for the medical staff to produce consistent, accurate and thorough clinical documentation in support of a mandatory, mission critical activity. The physician leadership will require some education themselves to understand how to manage and sustain this documentation effort. Ultimately, this same clinical documentation is a window to patient safety and quality of care and, as a result, no physician should have the ability to opt-out of this initiative.

Once leadership and sponsorship is in place, the next step is to draft a set of processes that support not only the education and training of physicians, but all complementary activities to promote and sustain a clinical documentation improvement program. These processes are meant to determine “how are we doing today”. The long term objective of this program is to improve existing ICD-9-based, physician clinical documentation so that the gap toward transition to ICD-10-based physician clinical documentation is diminished. Thus, the program will act to minimize potential risk specific to physician clinical documentation. Why? The increased specificity needed for ICD-10 will appear magnified if superimposed on the general lack of specificity in documentation for ICD-9. Without a concerted effort to optimize today’s clinical documentation, each healthcare setting will assume greater risk related to the potential gap created by ICD-10’s documentation differences.

In the early stages of your Physician Clinical Documentation initiative, communications is essential to share information and progress with the entire physician community. Developing concise, meaningful messages as to why this initiative is important for patients and the quality of their care are critical. Previously, there has been no punitive dimension to this type of initiative and, therefore, has realized mixed results. Taking advantage of the existing compliance ICD-10 requirements as a condition for participation with CMS, each healthcare organization can proceed with this program to support compliance and effectiveness. At present, there is no punitive act as long as you follow the rules which have been agreed upon. “If you can’t follow the guidelines, you can’t participate with CMS and, therefore, with this organization.” This is not punishment, it is the reality for practicing medicine for this patient population.

Since tracking progress is important, all efforts related to physician clinical documentation should be benchmarked. These results are helpful for physicians to measure what is done right or what can be improved upon. It is these metrics that will provide a gauge of progress and help to identify those physicians that are encountering greater challenges during this initiative. One other approach to tracking progress is to establish both an internal and external audit effort. These audits will provide the additional “eyes” and experience to validate documentation as it is today and help evaluate how it changes in the future. All of these steps act as reinforcement for improvement or as a vehicle to identify challenges and help develop an approach to correct them.
Training physicians will present its own challenges. It will require more than a lecture and sporadic follow-up. A variety of approaches may be required to ensure the best results. A variety of venues may also be required – recorded podcast, web-based meetings, face-to-face meetings, and so on. Why the concerns about training? Rather than be focused on simply regurgitating ICD-10 codes, it is far more important to train physicians on the structure of this new type of clinical documentation. This effort should not be viewed through the narrow lens of inserting ICD-10 codes. Instead, the more accurate question is whether this new code matches what the physician observed, diagnosed and treated. Once this question is answered, the next question to pose is whether we will be reimbursed for the care and resources appropriately? Understanding these two questions lays the correct foundation as to why clinical documentation matters to achieve ICD-10 compliance.

How does ICD-10 differ from ICD-9? The level of specificity required in the clinical documentation is far more than ever previously documented. Current habits from ICD-9 coding practices allow for more general terms to be used so ICD-9 is code-able. On the other hand, ICD-10 requires a level of specificity that requires information such as left or right as well as subsequent encounter information. No longer is the symptom sufficient information, but rather the most likely diagnosis related to it. If there are two words that define the required ICD-10 documentation effort, it is specificity and sufficiency (i.e. sufficient documentation of what took place; why we came up with a given treatment plan). As your organization prepares for this effort, ask whether there is a large problem in the current ICD-9 physician clinical documentation. If there is, then it will definitely be amplified in ICD-10. It is this very reason that supports the importance of improving physician clinical documentation sooner than later.

The next step in this process is to determine the available resources and how they can be deployed to support the physician clinical documentation program in a cost effective way to attain the desired end goal. Some organizations can leverage their HIM staff and, if available in your healthcare organization, Case Managers, to provide additional, clinical documentation support to physicians. With these two types of healthcare professionals collaborating with physicians, the Case Manager can provide support at front end of the patient encounter, and HIM can provide support at the back end of the process to identify requirements for more specific documentation. The other type of resources to be mobilized will be someone to function as a Physician educator. The role of Physician educator will be important as part of the peer-to-peer approach to provide learning in short increments of time. It is far more beneficial to allocate short bursts of effort such as 5-10 minutes and sustain this type of effort over a defined period of time until a level of competency is sustained. Training should be conducted on a monthly or quarterly basis. Finally, re-training through an interactive review and query process should be available daily to all physicians.
Conclusion

As Physician Leaders and Executives strategize about how to deploy resources that will both facilitate compliance requirements of the upcoming ICD-10 implementation but also provide a positive impact on patients, they should consider proactively embarking on a Physician Clinical Documentation Improvement initiative that will satisfy both key objectives. With a continued emphasis on both the quality of care and streamlining processes through best practices, this type of initiative fulfills both of the strategic goals. Tailor the approach of this initiative so that physicians can best learn and receive sustained feedback will provide a positive and productive training environment since this is the best structure. It is important to note that physician participation must be mandatory. Pairing physicians with peers that champion the clinical documentation improvement initiative is an effective approach that can be complemented by HIM professionals and Case Managers. This proactive initiative will bear significant fruit today while paving a way to decrease the impact resulting from the transition to ICD-10. The memorization of new codes is simply not enough even though this is being advanced by a number of sources. We encourage each healthcare organization, no matter the size, complexity, or setting to introduce their own comprehensive Physician Clinical Documentation Improvement program since it will provide deep and far-reaching impacts with both short-term and long-term benefits for the patient, physician and organization.

Medical Audit Resource Services, Inc. (MARSİ)
MARSİ was founded in 1995 by Dr. Todd M. Husty. The firm provides services in the following areas: Physician and Staff Education, Physician Clinical Documentation Improvement, Compliance Auditing, RAC Audit and Denial Support, and Revenue Cycle Management.
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