Revised ICD-10 training and implementation timeline for CDI

Director’s Note: This white paper is an ACDIS Advisory Board-endorsed timeline of revised training and preparedness recommendations for CDI, based on the anticipated new Oct. 1, 2015 compliance date for ICD-10. It is intended to provide a suggested framework, but is not a one-size fits all solution. Check with your own ICD-10 steering committee before implementing.

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The passage of bill H.R. 4302, or the Protecting Access to Medicare Act of 2014, stunned the healthcare community with its buried-in-the-bill passage of a delay to the ICD-10 code system. But now that the shock has worn off and CMS has confirmed a new compliance date of October 1, 2015, the ACDIS advisory board has issued a revised recommended training and implementation timeline specifically for CDI.

The timeline includes broad training and implementation guidelines for CDI and other affected hospital departments. It is organized into quarters for the remainder of 2014 (quarters three and four), then offers monthly suggestions through October 1, 2015. The timeline begins on page 4 of this white paper.

Michelle McCormack, RN, BSN, CCDS, CRCR, ACDIS advisory board member and director of CDI for Stanford Hospital & Clinics (SHC) in Palo Alto, California, notes that although the revised timeline includes many recommended courses of action, the most important element is fostering facilitywide communication.

“One of the things we’re focusing on at SHC is ensuring an organizational understanding of the impact of ICD-10, continuing our steering committees’ work activities and looping in leadership of all departments in the hospital,” McCormack says. “I don’t know if people are doing that, or if it’s just being put in the laps of HIM departments. It’s important to make sure everyone understands how it affects every step of the documentation, coding, and billing process, as well as upstream and downstream processes.”

Stanford Hospital & Clinics, for example, has a number of ICD-10 focused working committees that meet regularly, on separate schedules, then come together monthly with organizational leadership to review key activities and accomplishments and jointly tackle barriers to progress. “The one I sit on is ‘physician documentation readiness,’ but ICD-10 is a big initiative as reflected by the sheer number of committees and work streams, such as IT, revenue cycle, decision support, quality measurement and improvement, clinical doc-
umentation and physician readiness, and enterprise-wide communication,” she says. “It’s a huge effort here, and it needs to be.”

In McCormack’s case, the regular meetings and interdepartmental communication revealed that ITS application and payer testing was one of the health system’s major challenges, followed by improved provider documentation and effective provider/coder education and training.

“We are fortunate to have a very talented and robust ITS department that has planned to complete all application remediation in August 2014. Payer testing, underway prior to the delay, has now been paused,” she says. “With respect to physician documentation, we’ve already gone live with our ICD-10 update in Epic (in February 2014), and our physicians are already documenting for it. But within the committee discussions prior to the February go-live, we discovered that there were many applications requiring codes, or mapping to codes. We kept finding new roles that were utilizing a list of common ICD-9 codes within their everyday work, especially in clinics. Everyone has their own process and an organizational understanding of this was essential to a successful ITS conversion to ICD-10.”

McCormack says this slow process of investigation through committee has been invaluable to her facility’s preparedness. Hearing that other facilities have not begun a similar fact-finding mission has her nervous, even given the one-year delay.

“When you think there are people that haven’t begun exploring this stuff—it’s really scary. Now is the time to take advantages of the gifts we’ve gotten,” she says.

Don’t be surprised if one of your facility’s greatest documentation deficiencies is procedures (ICD-10-PCS), says Laurie Prescott, RN, MSN, CCDS, CDIP, CDI education specialist with ACDIS/HCPro in Danvers, Massachusetts.

“We expect the largest contributor to decreased coder and CDI productivity will be the PCS codes,” she says. “If there is an increased focus on this now, the CDIs can provide focused targeted education to the surgeons about what is missing and what is present. This information has to be focused for each surgeon—looking at their top procedures and current documentation practices.”

The ACDIS revised training and implementation timeline also includes a heavy emphasis on dual coding, which Prescott thinks is critical to a successful transition to ICD-10.

“I love that the timeline speaks to dual coding practices. I would encourage organizations to assure there is a feedback loop between the coders’ dual coding findings and the CDIs,” she says. “For example, perhaps regular meetings or a formal way to communicate what information is missing and even what information is present that is required for ICD-10. The CDIs should be focusing specific documentation needs to specific physicians. We should not be teaching documentation needs that are already being met. There is nothing more frustrating to the physician then education about a practice that they are already doing.”

Stanford’s HIM/coding department began dual ICD-9/ICD-10 coding in March, but has scaled back some since the delay. Six months ago it contracted an external company to perform a documentation analysis, but McCormack
wasn’t thrilled with the results. “We didn’t glean a lot of useful information from that—they didn’t show us gaps. We did some template and order set revisions from [the analysis], but nothing too actionable.”

While dual coding is a big component of the revised ACDIS timeline, if you haven’t begun dual coding, McCormack says that you can make significant progress by simply revising your electronic templates and query forms for ICD-10.

“By refining your documentation, updating your queries, and modifying your query templates, you can make a lot of headway,” she says.

“This should also be the time to review policies—especially your query policies,” Prescott adds. “They should reflect the fact we will be asking more queries in ICD-10.”

For example, Prescott recommends that your query policy address the following questions:

- How should queries be prioritized?
- How long should queries be allowed to be unanswered?
- Do we differentiate between queries for reimbursement vs. those that provide more specificity but do not affect reimbursement? Or severity of illness?

“We need to be having discussions about that now,” Prescott says. “As for asking queries for ICD-10, I tell my students ‘get on it now.’ The physicians will learn and may adjust documentation now without even understanding it is to meet needs in ICD-10. Anything we can do to change their habits now prior to implementation will assist in the anticipated productivity issues.”

When news of the ICD-10 delay hit, Stanford sent a mass email to its physicians and other affected parties. The objective was twofold: to make sure everyone heard the news from administration, and to assure providers that Stanford’s ICD-10 efforts were not ceasing.

“Because we had already gone live ICD-10 clinical terminology for our providers in Epic in February, they had already had their Web-based training. After the delay nothing changed from them—just an email mass distribution to let them know the country is not going to convert in 2014, but our organization is not taking steps back,” says McCormack.

“We were in a unique position—we couldn’t turn it [ICD-10] back, it didn’t make sense to turn it off within Epic,” she continues. “My goal during this year is that we’ll transfer from calling it ICD-10 training and just call it ‘CDI documentation update.’ I’d like to change the view that ICD-10 is the driver of documentation training.”

McCormack believes the future of CDI is removing coding-specific references and just focusing on increased specificity in the health record for the services provided. Given the unpredictability of party politics and the possibility of future delay, as well as new, post-ICD-10 coding systems, she thinks it’s for the best.

“Healthcare will change, so increasing your specificity will not hurt you. It will mitigate risk, and with healthcare reform additional specificity is needed,” she says.
Stay on course.

Initiate or continue coding, CDI, and provider ICD-10 training. Consider prioritizing higher-dollar and higher-volume cases, but plan to cover all clinical service lines. Recommended training: 8.0 hours/month for CDI and 16.0 hours/month for coding staff.

- Query a selected portion of ICD-10 concepts as a means to provide physician education.
- Purchase adequate reference materials for CDI and coding staff.
- Study ICD-10-CM and PCS coding guidelines, Coding Clinic for ICD-10-CM/PCS, DRG changes, CC/MCC lists, and ICD-10-related documentation opportunities.

August 2014: Review IPPS rule in Federal Register for ICD-10 updates (code revisions, CC/MCC revisions, DRG updates).

Mail letters or otherwise inform physicians of the ICD-10 delay and proposed hospital plan.

Begin dual coding (if it hasn’t already been started) for identification of risk areas and coding familiarity. You may want to begin this process on a small scale. Identify high-volume/high-dollar DRGs.

Review the top 20 most commonly queried items in ICD-9 and identify current problem areas (e.g., urosepsis).

Identify and implement an ICD-10 coding quality audit and feedback system.

Perform coding proficiency analysis, coding accuracy analysis, and DRG validation on a monthly basis.

Perform physician-/specialty-specific chart analysis to identify documentation opportunities related to ICD-10 (i.e., what is not being documented today that is needed to assign ICD-10 codes?). Identify physicians with the most improvement needed.

Consider performing a CDI operational assessment to identify process gaps and pinpoint opportunities for greater efficiency and productivity, staffing analysis, etc.
**Fourth quarter 2014**

- Continue coding, CDI, and provider ICD-10 training. Place a heavy emphasis on procedures/PCS.
- Consider working with similar/like-size organizations to foster information sharing and networking related to ICD-10 findings.
- Initiate internal ICD-10 system testing, if it hasn’t already been started.
- Determine when to begin formal ICD-10 training with physicians, syncing up with dual coding results.
- Develop ICD-10 reference materials (pocket cards, documentation opportunity flyers/posters, etc.)
- Develop/revise physician query forms to include ICD-10 concepts.
- Develop physician education materials.

**January 2015**

- Determine and communicate organizational strategies to identify and prioritize documentation opportunities based on highest risk (financial impact, volume impact, profiling impact, other). These strategies will be used to prioritize education informed by dual coding outcomes.
- Analyze dual coding outcomes to tailor service-specific provider education for high-risk areas. This process will also reinforce the new coding knowledge within your CDI department.
- Expand ICD-10 queries with providers. Monitor ICD-10-specific query responses and assess need for additional education.
- Meet with key leaders/physician leaders/physician advisors to develop a physician education plan.
- Work with IT to identify the status of system testing and map the timeline for completion prior to ICD-10 go-live.
- Develop and/or participate in an organizational ICD-10 transition planning workgroup and/or steering committee (include executive leadership, provider leadership, IT, EHR team, compliance, HIM, CDI, nursing, quality, etc.).
Consider incremental expansion of dual coding scope (increased volume and/or coverage areas); continue to bring back service-specific provider education focused in areas of greatest opportunity (highest dollar and/or volume and/or other impact).

If necessary, outsource ICD-9 coding to maintain revenue cycle performance.

Begin analysis and forecasting of productivity impact and learning curve related to ICD-10 transition.

Review and revise CDI policies and procedures for ICD-10 in preparation for go-live.

Provide fact sharing and status update to ICD-10 transition teams. Identify overall strategy and map out timeline, distribute accountabilities, etc. Initiate ICD-10 internal communication throughout facility.

Develop timeline for training hospital staff (non-coding professionals) on ICD-10. Include staff that currently work with ICD-9 codes or ask for admitting diagnoses from physician offices, but do not read documentation to assign codes (i.e., registration staff, decision support, etc.).

Begin scheduling physician education sessions by specialty (first sessions to begin in summer 2015; begin scheduling no later than March 2015). New resident classes typically onboard in June or July, so you may want to plan to train before or after that time period.

Post ICD-10 signage in physician dictation offices/lounges.

Consider incremental expansion of dual coding scope (increased volume and/or coverage areas); continue to bring back service-specific provider education focused in areas of greatest opportunity (highest dollar and/or volume and/or other impact) and risk. Use external tools, if necessary, to aid in determination.

Continue analysis and forecasting of productivity impact and learning curve related to ICD-10 transition. Evaluate staffing. Secure additional staff, if necessary. Plan for and/or utilize external coding services to meet needs, if necessary.

Create and schedule an ICD-10 “open house” or “skills fair” to increase awareness, knowledge, and engagement.

Provide fact sharing and status update to ICD-10 transition teams; adapt as needed.
**April 2015**

Consider incremental expansion of dual coding scope (increased volume and/or coverage areas); continue to bring back service-specific provider education focused in areas of greatest opportunity (highest dollar and/or volume and/or other impact). Provide 1:1 education with CDI and physicians, when possible. Validate ICD-10 coding quality of internal coding staff.

Continue analysis and forecasting of productivity impact and learning curve related to ICD-10 transition. Plan for and/or utilize external coding services to meet needs.

Consider follow-up/refresher training for CDI. Consider focusing on high-impact services. Utilize external resources to obtain updates on ICD-10 concerns in the industry and adapt training, as needed.

Solidify/confirm provider onboarding training plan in preparation for new resident orientation.

Hand out physician documentation pocket cards/tip cards with ICD-10-specific language.

Develop ICD-10 CDI quality assurance plan.

Provide fact sharing and status update to ICD-10 transition teams; adapt as needed.

**May 2015**

Full dual coding scope, utilizing external vendors to supplement staffing as needed. Solidify and execute staffing plan (internal and external) to meet ICD-10 productivity and quality standards, and maintain accounts receivable.

Continue analysis of dual coding outcomes. Task CDI with tailoring and presenting service-specific education based on the findings.

Develop “go-to” team with coding counterparts in preparation for go-live.

Provide fact sharing and status update to ICD-10 transition teams; adapt as needed.

**July 2015**

Begin provider onboarding training/education and training for other hospital staff and ancillary departments (registration, etc.).

Begin ICD-10 vendor and payer system training.

Provide fact sharing and status update to ICD-10 transition teams; adapt as needed.
August 2015

- Complete provider onboarding training/education and training for other hospital and ancillary departments.
- Provide fact sharing and status update to ICD-10 transition teams; adapt as needed.
- Conduct in-depth organizational analysis of overall ICD-10 preparation status and data, and perform necessary high-priority changes.

September 2015

- Provide fact sharing and status update to ICD-10 transition teams; adapt as needed. This includes all aspects of staff and provider training, system testing, and financial impact.
- Review any relevant FY 2015 IPPS changes with CDI staff.
- Conduct in-depth organizational analysis of overall ICD-10 preparation status and data, and perform necessary high-priority changes.

October 1, 2015

ICD-10 go-live

- Hold on!
- Continue on as planned. Review key process indicators, previously identified data elements, etc.
- Conduct ongoing analysis of staffing, monitor findings from coding outcomes, and adapt ongoing coding, CDI, and provider education/feedback as needed.

October 2, 2015 through December 2015

- Analyze data identifying areas of concern (e.g., decrease in capture rates) and provide targeted education.
- Continue networking and sharing industry findings, best practices, and recommendations.