ICD-10:

A NEW DYNAMIC IN THE RELATIONSHIP BETWEEN CLINICIANS AND CODING PROFESSIONALS

White Paper

ICD-10
Will Change Everything

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THE CHANGING LANDSCAPE

Brief Overview of Relevant Changes in ICD-10: ICD-10 History

There are many changes that are going to affect the way we code for diagnoses with the implementation of ICD-10-CM. The level of specificity contained in the new code set requires all to brush up on skills and pay particular attention to what is found in the details. Clinical conditions that formerly could only be assigned by an unspecified code have expanded to include many new concepts as well. Coders need to have a higher understanding of disease processes to properly assign codes. To accomplish this, the coder and clinician must develop a partnership.

Brief Description of New Documentation Requirements:

We are going to assume the common goal of coding should be to represent as accurately as possible the patient's condition and the procedures performed to maintain or improve that condition. These codes are used to communicate these key aspects of health care for a variety of purposes. In all cases the assumption is that the codes represent reality as accurately as possible. These codes factor into claim processing, quality measures, decision support, risk prediction, policy development, research, and a host of other analytic and operational activities critical for all health care stakeholders.

"The common goal of coding should be to represent as accurately as possible the patient's condition and the procedures performed to maintain or improve that condition."

Clinical documentation is at the root of good coding. Without proper patient assessment and documentation by clinicians, the ultimate goal of coding cannot be realized despite the most proficient technical coding effort. With inadequate documentation and coding, all of the downstream uses of these codes will be flawed.

Under ICD-10, the rich content capabilities supported by these codes provide a new level of shared, unprecedented health care information. This enhancement in health care information, however, requires a more complete level of documentation to support this content. The nature of these codes requires that to code accurately, certain content must be present in the record or coding may be impossible for certain types of conditions. Querying clinicians will be much more common and will increase the challenges for both the professional coder and the clinician.

Overview of Current Relationship of Clinicians and Coders

In most practices there is the invisible divide between the coder and clinician, especially in larger practices or facilities. This divide exists on many levels. In many instances coders feel uncomfortable asking questions of a clinician for fear of looking less than qualified or of being faced with a provider whose time has already been stretched thin and whose patience is running short. Building a relationship with clinicians in a larger facility is sometimes more difficult to accomplish with coders far removed from the day-to-day operations. One other hindrance comes from electronic communication, such as email. Since tone can never be determined in email, it makes relationship building even harder. In some large facilities the coders may have never met the providers for whom they code, so they have no direct relationship.

Requirements for Change

It is clear that ICD-10 creates a new dynamic in the relationship between clinicians and coding professionals, and this requires a significant change for both. Change is always a challenge but generally provides opportunities for improvement of processes that are chronically dysfunctional. We clearly need change to accomplish our stated goals, but change always requires that four key factors are addressed:

1. A shared understanding of the problem—Those involved in the process of change must believe there is a problem needing to be addressed and requires their participation in the process to affect that change.

2. A shared sense of values—Assuming that stakeholders share an understanding of the problem, they need to understand the degree to which they share values that will drive change.

3. A shared vision for change—With aligned values and a clear understanding of the problem, participants in the change process must now assure their plan for change is clearly defined, shared, and that there are not different directions moving forward.

4. The institutional capacity for change—Given the above goals are realized, there still must be an operating environment that can support change and provide the resources needed to meet the requirements for change

Meeting these challenges is a daunting task, as change always is, but ignoring any of these four key factors will guarantee failure. With that in mind let's explore the challenges and requirements moving forward to affect this change.

THE PROBLEM

Perspective of the Coding Professional

Current Environment

Traditionally, coders have struggled to extrapolate the necessary information from a medical record for several reasons. Some of these reasons include legibility issues, missing documentation, or not having a good understanding of what the clinician performed. Assuming good skill sets for extracting information, coders are often fearful to go beyond existing documentation and approach an already busy clinician to ask for clarifications or changes in documentation.

KEY PAIN POINTS

- **Feeling like a "nag"**

  Concern clinician will feel like the coder is constantly telling them to do something different

- **Feeling like they have no value**

  With the transition to EMRs, vendors tell clinicians their systems can code, and they won't need the coder any longer.

- **Afraid to stand up**

  Concern that clinicians will challenge coder's knowledge level (and win).

- **Fear of retribution**

  Fear that if they point out clinicians' mistakes, their job will be in jeopardy.

- **Concern about ambiguity**

  ICD-9-CM is so vague that a patients' specific condition cannot always be spelled out through coding.

Current Relationship with Clinicians

There are varying roles a coder may have affecting the type of relationship they have with a clinician. Coders working in smaller practice normally have a one on one relationship with a clinician with fewer communication concerns. The relationship can solidify due to the direct contact the coder has with clinicians. In larger practices however, there is a divide that deepens as size grows. Coders may have less direct contact with a clinician, instead having to use a go-between or some form of electronic communications. With the advent of Electronic Medical Records (EMRs), more communications are sent electronically which can actually increase the divide. It is hard to determine tone in an electronic communication method, which can cause communication issues and lead to hard feelings or distrust for the long term. Communication is an essential part of developing a good working environment.

Change Under ICD-10

ICD-10-CM has the potential to require fundamental changes in the way coders interact with clinicians. The level of specificity found in the new code set will be a challenge to coders and providers both. Success will only happen when both come together to work as a team in order to be able to assign the new codes. In addition, coders need to be confident in their skill sets and what goes into proper assignment of a code. This can only happen with solid education.

New Coding Requirements for Coding Professionals

ICD-10-CM brings with it a complete change in some coding concepts. The level of specificity found within the code set will mean the brushing up of or learning new skills. A strong foundation in anatomy and pathophysiology is essential to understanding and applying the new codes. There are new concepts found in both ICD-10-CM and ICD-10-PCS. Coders who consider themselves experts in ICD-9-CM need to perform a skills assessment to determine what additional trainings they will need to make the transition. Coders will need to have the

skills to be able to extract clinical information from the medical record to assign the appropriate codes in ICD-10.

For ICD-10-CM the learning process for all coders starts back at the beginning. Although many guidelines remain unchanged, the look-up process is somewhat revised and learning the new book is necessary. Coders need to have detailed instruction on the use of the 7th character extenders and how they differ by code categories. Coders may also be challenged by the expanded index entries for combination codes that include multiple disease processes.

Productivity Concerns

If you ask a coder today what the category is for diabetes in ICD-9-CM, most will immediately answer with "250." Ask them where it is located in ICD-10-CM and you get a blank stare. All coders will be beginners again, learning a new system. Although it is similar in process (looking it up in the alpha index, confirming in the tabular and flowing instructions) it will take longer. ICD-10-CM has almost five times the number of codes that are contained in ICD-9-CM. Coders will never be as fast as they are in an ICD-9-CM world. Without proper training, productivity will suffer. Even using electronic coding systems identifying the correct ICD-10-CM code will be a lengthy process as ICD-10-CM code descriptors are extremely long and truncating is not easily accomplished. No matter what method is used for looking up or assigning codes, it will take time and practice for coders to be brought back up to speed.

Coding Quality Concerns

Codes can only be assigned by documentation in the medical record. A "garbage in, garbage out" issue could surface with the conversion to ICD-10-CM. If most codes are unspecified due to documentation issues, we are going to miss the increased data capture capabilities of the new system. All of the positives of moving to ICD-10-CM (better data, more precise research information, better tracking of disease management, etc) will never be realized. In addition, coders not having a strong foundation in Anatomy and Pathophysiology will struggle to appropriately assign codes. Working with providers on documentation meeting ICD-10 specificity will be crucial.

Operational Impact

There may be new software or entire new systems that are installed due to ICD-10-CM implementation. A coder may be called upon to assist in template development for an EMR to ensure the templates contain the necessary prompts for diagnosis application. In offices not having EMRs, coders may look to make or purchase "cheat sheets" with most frequent diagnoses to assist in code assignment, as encounter forms will probably no longer be suitable. Computer assisted coding or encoders must be evaluated for ease of use under the new system. The drop down buckets for EMR systems will be a consuming process. In many circumstances now coders can automatically input codes quickly without reference to the descriptors. Heavy reliance by coders on books will be necessary long term.

Increased Queries

With the specificity of the system, increased queries will most likely be seen in all practices. In smaller practices, it will be easier as the coder usually has more direct access to the providers. In larger facilities, the manner in which queries are performed may need to be adjusted to accommodate the expected increase. If providers do not improve or meet documentation expectations, it will slow coders down while they search for additional supportive documentation.

Perspective of the Clinician

Current Environment

Clinicians are struggling with the impact of a financially constrained environment impacting all stakeholders both within and outside of the health care industry. The demand for accountability and defined value is increasing. This leads to a dramatic increase in the administrative burden on all aspects of the health care industry, including clinicians. Traditionally, most clinicians view themselves as autonomous and view their participation in health care as focused specifically on the care of one patient at a time. They view the patient interaction as private between them and the patient and do not see a need for others to be involved in influencing this interaction or having visibility into how they treat their patients.

KEY PAIN POINTS

The environment results in a number of perceived pain points from the clinician perspective:

- The close relationship between them and their patient is being eroded.
- Documentation and administrative requirements are limiting the time that they can see their patients.
- They have lost continuity with the overall care of the patient.
- They are seeing a progressive decrease in revenue given the same level of services.
- The concept of professionalism has been compromised by the "requirements" for good business.
- They are coming under increasing scrutiny and are at risk for allegations of malpractice, fraud, waste and abuse.
- They may view hospital or other health care providers as competitors who are eroding market share.

Understanding Coding Importance

Traditionally, clinicians view coding as an administrative task. They generally do not consider that coding helps them take care of their patients and is of lesser importance as compared to direct patient care. They do understand that coding may influence payment either directly or indirectly, but assume that "someone is taking care of that". The connection between coding and research, decision support, policy development, public health and a variety of other activities is lost on many clinicians because they are focused on care for one patient at a time. The tendency for clinicians is to think of the episode of patient interaction as of primary importance while all other activities of health care delivery are considered secondary.

Perception of Coders and Coding

Most clinicians understand that coding professionals are necessary and serve an important business function but do not generally consider them as partners in defining patient conditions and procedures in standard

codes. In many cases, inquiries by coding professionals are considered bothersome and interfering with their direct one on one patient interaction. They lose sight of the fact that the coder can't just make up information, but requires documentation for the codes that they define. Clinicians often don't make the connection between coders and their revenue stream.

Clinicians are also frustrated by the sense that what is obvious to them in the documentation is not acceptable from the coding perspective. For example; if a clinician documents a patient is admitted for a "cardiac ablation" procedure with a history of recurring atrial fibrillation, the coder may say they can't code "atrial fibrillation" because the clinician used the terms "history of". From the clinician perspective the "history of" is a common way of describing the patient's condition for which they are admitted for definitive treatment; "cardiac ablation". The downside of not establishing the right level of communication in this case goes well beyond the frustration of the clinician or the coding professional. If the coding does not reflect the patient's real condition because of this failure to communicate, then much of the data that we rely on to understand costs, quality, outcomes, appropriateness, and variety of other uses of data about "atrial fibrillation" will be wrong.

Change Under ICD-10

Documentation Requirements

ICD-10 introduces a number of concepts that are not new from a clinical perspective, but are new to the content and meaning of codes. These new concepts include:

- More specific anatomical locations
- Laterality and distribution of disease sites
- Classification of certain disease states
- Stages of diseases
- Co-morbidities
- Functional impairments
- Sequelae
- Complications
- Etiology
- Environmental impacts
- A number of other key parameters about the patients' health state and the nature of their health conditions

While the extent of these parameters of care supported by ICD-10 has increased dramatically, almost all of these concepts existed before ICD-10 and are important in understanding the nature of the patient's condition and the nature of care needed to address the variations in these conditions. Based on the practice of good patient care and basic documentation, we should be documenting all of these concepts today. It is hard to make a case this level of documentation is a new and unnecessary burden imposed by ICD-10, but instead it should go well beyond what is required for coding, capturing all medical concepts relating to the patient's condition, that may impact their treatment, or the accurate communication of the nature of their health state to those who need to know.

Nonetheless, we know documentation today is frequently well below the level of documentation needed to support good patient care or accurate coding. This problem will only be magnified under ICD-10.

Increased Queries

There is no doubt that given the current level of documentation and the significant increase in the content supported by ICD-10, queries of clinicians will increase. Even with an increased level of querying, however, there still is a risk of inaccurate coding because, in some instances, the coding professional will not know what to ask if certain concepts are not in the record. For example, if the clinician does not state a fracture involves the growth plate, the coder will not know to query the Salter-Harris classification of the growth plate injury. This increased level of uncertainty and the requirement for clinician queries will undoubtedly lead to frustration for the clinician who already feels overwhelmed and views this as just another administrative requirement.

Greater Accountability

There is little doubt that demands for accountability is increasing and that ICD-10 provides much more information in support of that accountability. From clinicians' perspective, this may be perceived as a threat opening the door to much greater questioning of their performance and puts them at risk for interpretation of improper care. For many it is not that they believe that they provide less than optimal care but that information may be used against them inappropriately with interpretation that may be questionable or lack sound basis. In theory, the increase in the ability to define risk and severity should help address some of these concerns, but clinicians historically have not had a good experience under the microscope.

Operational Impacts

The daily operations in providing care require modification to capture and support ICD-10 codes. Super bills or "cheat sheets" are unlikely to work in an ICD-10 environment. There may be substantial delays in coding because of drops in coder productivity. Payers may delay payments because of challenges in redefining their policies and processing rules under ICD-10. There is little doubt that - at least in the short run - operations in the clinicians' practice will be negatively impacted.

Values

To understand how to address key problems, it is important to look at the values held by clinicians and coding professionals relating to documentation and coding.

Perspective of the Coding Professional

Importance of Coding for Health Care Information

The level of detail found in ICD-10 will be valuable long term for many reasons. Proper use of the codes can allow for quicker claim adjudication by spelling out "who," "what," "when," "where," and "why" of the patient's condition. The codes help support medical necessity and the need to the services provided to patients.

Valued as an Important Part of the Healthcare Team

Coders as key members of the health care team will be extremely important moving forward under the ICD-10 code sets. Coders who master the new code sets will be in high demand and coders with good communication and educational skills will be a valued part of the team.

Quality Coding

To achieve true quality with the new code set, codes should be assigned to the highest level of specificity with limited use of unspecified codes. Besides specificity, codes should also represent as accurately and completely as possible the patient's health state and the procedures or services provided to help maintain or improve that health state. It is only through this level of quality the true level of value can be determined by the implementation of ICD-10-CM.

Perspective of the Clinician

Patient Care

Patient care is the primary directive for the clinician and would generally rank high on the list of items will clinicians would value in this transition. The connection between good patient care and coding is often lost on the clinician. It is easier, however, to establish a case for clinical documentation as an important value that contributes to good patient care. For clinicians it is less about ICD-10 codes and more about documentation for good patient care independent of codes.

Health Care Knowledge

Clinicians value health care knowledge and evidence as to what types of services are most efficacious for different patient conditions. There is clearly a connection between coding as a standard definition of procedures and disease required to develop good health care knowledge. Generally, these standards are assumed and the contribution of the clinician arriving at these standard descriptions may not be as clear to them.

Reimbursement

Obviously, clinicians value reimbursement. Even among the most altruistic clinicians it is well known that without revenue there is no mission. It may be difficult for the clinician to see the connection between coding and his or her bottom line. Many clinicians have removed themselves from what they would consider the "details" and might look at coding as one of those "details" someone else is taking care of. Clinicians need much greater awareness of how documentation and coding impacts their bottom line to value the coding effort. Evolving new models for payment are moving beyond just paying for the quantity of services and are looking more at efficient delivery of quality care needed based on the patient's condition. ICD-10 will factor greatly into these newer models to provide the answer to not just "what" was done, but "why". The goal of high value health care is not just the delivery of goods and services, but rather the improvement, maintenance, or palliation of the patient's health state.

Clinicians already feel buried in "administrivia" and have virtually no value for administrative processes. Anything that can lessen this burden is valued. If clinical documentation can be seen to reduce inquiries

and additional reporting of all types, then there could be some perceived value.

Accountability—Measures of Quality and Efficiency

Clinicians are somewhat skeptical about attempts to measure their performance; however, they have a great deal of interest in how they perform as compared to their peers if there is some assurance that these measures include sufficient information to provide a level playing field for comparisons. Certainly ICD-10 provides much greater definition of both patient conditions and procedures. This increased precision should go a long way in leveling the playing field of analysis assuming proper analytic and statistical principles are followed.

A VISION FOR CHANGE

Confirming the Importance of ICD-10 codes

In the past, ICD-9-CM codes were given lesser importance than other codes used in the coding process in the outpatient environment. This was due to many reasons. ICD-9-CM codes are vague and often, even with concrete documentation in the medical record, an unspecified code was be assigned due to the limitations in the codes. For most outpatient services the diagnosis has little bearing on the amount the clinician was reimbursed since most services are paid through the assignment of Relative Value Units (RVUs).

This will change in an ICD-10 environment. ICD-10 codes contain the details previously missing in our coding system that now allows for much more detailed coding assignment. This should allow for more accurate reimbursements in the coding system. It will be important moving forward for the codes to be assigned to the highest level of specificity available. Trends in health care show more weight being assigned to medical necessity and ICD-10 codes will allow for support of this if used correctly.

Defining a Common Goal for Coding

Developing a new and improved relationship between coding professionals and clinicians requires an alignment with common goals. Clinicians and coders need to realize the goal of coding and documentation is to reflect as accurately as possible the patient health state and the procedures used to maintain or improve that health state. This goal can only be reached by proper patient assessment, clinical documentation, and partnership with coding professionals to assure that codes reflect reality. Clinicians can't just assume that things will get coded correctly and coders can't just assume they have done "their job" by just coding what was documented. "The job" of meeting this goal requires that both coding professionals and clinicians are aligned to the same effort.

Coders need to embrace this new generation and focus on bringing clinicians and others up to speed. By developing a good working relationship with the clinician they can forge new paths.

Changing the Coder/Clinician Relationship

Since accomplishing this overarching coding goal requires a partnership, how do we change the relationship between coding professional and clinicians?

Change on the Coder Side

Effective communication - as well as proactively working with the providers on documentation - is necessary. Coders can work with clinicians on the new code set through documentation improvement initiatives. By working together, the team can unite over common concerns. Through the updating of skill sets, coders are able to work hand in hand with the clinician to make sure ICD-10 is used successfully and the necessary changes are implemented. Coders may need to break out of the box a bit and work with clinician to accept certain language and terms that can be interpreted in a consistent and accurate way but may not fall into rigid traditional guidelines. Guidelines should be just that - "guidelines"; and not a reason avoid coding because the exact words

were not used in a rigid way. Coding is not for coding sake. Coding is to reflect as accurately as possible the patient health state and the procedures used to maintain or improve that health state. If the guidelines are not working on either the clinical or coding side, we should look at changing guidelines where appropriate rather than coding information we know does not represent reality accurately.

Change on the Clinician Side

Clinicians need education about the role of the coding professional and how coding can align with better values to them and their patients. Clinicians need to work with coding professionals side by side for much of the ICD-10 educational effort so they can be better attuned to the challenges coders face and their need for proper documentation to address the common goal of coding. The reality is that there will be more change needed on the clinician side to improve this relationship, but there is definitely room on both sides for improvement.

THE INSTITUTIONAL CAPACITY TO CHANGE

Engaging Clinicians

Despite a shared understanding of the problem, a shared sense of values, and a shared vision for changeunless clinicians are engaged in a meaningful way with the proper leadership, then change will hit a wall. Organizations such as hospitals, clinical practices, medical associations and payers need to combine efforts wherever possible to drive change that is in the best interest of all stakeholders. This requires clinical leadership by one or more clinical champions who are prepared to drive the vision home and assure clinicians are educated and perform as required. Ongoing feedback and additional education is needed. There must be a commitment by coding professional management and clinician leadership to coordinate efforts in line with common goals.

Engaging Coding Professionals

Coding professionals must embrace this change for ICD-10 to be successful. Coders not willing to make this transition, or not willing to hone skills, will be unable to code under the new system and will quickly find themselves unemployable.

Sharing Knowledge

Coding under ICD-10 requires a new level of knowledge for the coding professional, not only to support the basics of coding but also to become more engaged in an understanding of the patient's condition, the nature of procedure, and the pathophysiology and anatomy that relates to these conditions and procedures. Clinicians can help educate coding professionals about the nature and context of diagnosis and treatment in a way that provides greater understanding and appreciation of what they are coding and why it is important. Coding professionals can help educate clinicians about the process of coding and why coding is important to them and their patients. There appears to be a lot of communication by tossing information "over the wall". We need to start taking those walls down to provide a more meaningful dialogue.

Providing an Environment to Support Change

Coders with advanced training will be able to bring clinicians onboard with ICD-10 changes by understanding the changes needed in clinical documentation and having the ability to instruct the clinician on any changes needed. Coders can monitor current documentation and provide education to clinicians and assist them understanding the changes needed. Working closely with clinicians will help to provide quality in the coding system. Beyond coders and clinicians, the health care environment must support this new relationship from the top down. A governance model on the clinical and administrative side must provide leadership and guidance to assure that the goal of accurate and complete documentation and coding is a top organizational priority. Champions on both the administrative and clinical side must step up to the plate to oversee and guide this priority, or needed change will not occur

Monitoring Success and Continuous Quality Improvement

The job is never done until there is evidence of sustainable quality. We need to continually monitor the quality of documentation and coding to assure the common goal is reached and that there is ongoing feedback to continuously improve both documentation and coding to support the accuracy of how we represent the realities of patient care. This requires institutional support to take on this effort within any enterprise.

About AAPC

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