Engaging Physicians in ICD-10 Planning: The Documentation Link

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There is much to do before we reach ICD-10 go-live in our organizations-including engaging the medical staff. Physician engagement is important in all healthcare settings and initiatives, but it will be essential in an organization's successful transition to ICD-10.

Obtaining engagement may be a challenge, but it is a necessity that must be built into readiness and implementation planning. This article takes a closer look at engagement and presents documentation issues and activities to build into engagement plans.

The Value of Engagement

Being able to articulate the benefits of ICD-10 to physicians is a critical step in obtaining their engagement. For physicians, the specificity available in ICD-10 offers the potential for improved patient care, quality, and safety.

Kelly Caverzagie, MD, notes the importance of physician engagement in the success of quality improvement initiatives, defining that engagement as "active enrollment and doing it for the right reason."[1]

Organizations with high levels of physician engagement demonstrate the following positive outcomes:

- Higher revenue and earnings per admission and per patient day
- Increased referrals from engaged physicians
- Reduced physician recruiting costs
- Sustained significant growth and profitability[2]

Some physicians remain unconvinced of the need for ICD-10. Last November, American Medical Association delegates voted to "work vigorously to stop the implementation of ICD-10." While the Department of Health and Human Services reiterated its support of the new code set, in April it proposed a one-year delay for the final compliance date.

There is an obvious need for better communication and increased understanding within the healthcare industry of the widespread benefits of ICD-10-CM/PCS. There are many experts on the new code set that can assist organizations with messaging and communication efforts to engage physicians and their affiliated associations and societies.

Identifying New Documentation Needs

Some physicians already believe that documentation is the number-one issue they face today, even without ICD-10 awaiting them in the future-they know documentation affects patient care, quality, safety, reimbursement, and severity, as well as acuity data. Physicians must engage in the ICD-10 transition, because documentation sits at the center of accurately coded data.

Engaging other physicians around documentation issues is not easy, however, and can require additional effort if they do not see documentation initiatives as a priority for day-to-day patient care functions.

ICD-10-CM/PCS is more robust and granular than ICD-9, and organizations should complete a documentation assessment as part of their ICD-10 implementation plans. The assessment should determine whether current documentation practices will support the level of specificity necessary for ICD-10 diagnosis and inpatient procedures coding.

The assessment can be conducted in a variety of methods and settings. Focusing on either diagnosis documentation or procedure documentation can identify any gaps that may exist. An assessment or audit team with expertise in ICD-10 can

conduct either a random or a focused sampling of current records. The size can range from 50 records to more than 100 depending on the size of the practice, hospital, or organization.

The results of the assessment will offer a good view of any gaps in documentation required for ICD-10 and can develop a priority list of diagnoses and procedures requiring greater documentation detail. The process also helps identify providers who will benefit from focused ICD-10 training efforts.

Specific areas within ICD-10 diagnosis should be brought to the attention of physicians; for example:

- "Coma" to include coding for somnolence and stupor in addition to coma, and it will also identify the Glasgow scale for eye opening, verbal response, and motor response
- The seventh character extension level in some fractures will identify the specific type of open fracture by using the Gustilo Fracture Classification
- Diabetes documentation and coding will need to specify type (Type 1 or Type 2) and cause of diabetes, such as drugs or chemicals, underlying condition, or other specified diabetes. In addition, accurate diabetes code capture will require documentation of the body system complications related to diabetes, such as kidney or neurological complications

There are notable changes within the ICD-10-PCS that may affect code capture. The procedure coding system is comprehensive and expandable, and it has a structure (different from ICD-9-CM) with standardized terminology. Documentation of the muscles, tendons, ligaments, arteries, veins, and general body structures is necessary for accurate code assignment.

In addition, some procedure code assignments require laterality. This, however, may be documented in areas of the physician documentation other than the operative or procedure note-such as the history and physical-so there may not be an issue with this coding element.

Capturing devices within the code set is another enhancement, and this may require additional documentation. The assessment should help determine potential gaps.

Tips for Engagement Efforts

The following strategies may be useful in developing physician engagement and readiness plans:

- Develop a set of "ICD-10 Awareness" slides or materials to share with physicians. Keep it short and simple. Request time at a medical staff meeting to present this information; invite the physician office staff to participate in order to increase an understanding of the scope and impact of ICD-10. Engaging office staff is key for success.
- Create documentation and coding examples with ICD-10 terms and codes. Provide these to medical staff as part of the overall educational plan. Remind physicians that ICD-10-CM is simply an extension of ICD-9-CM with added specificity for laterality and other relevant clinical details.
- Contact the hospital medical staff office and ask to publish regular ICD-10 articles, tips, and information in the medical staff newsletter or bulletin.
- Invite physicians who code to attend educational programs and other offerings.
- Identify physicians to include on the ICD-10 implementation committee. Appoint a physician ICD-10 champion to help with communication to other physicians and lead physician-related activities surrounding ICD-10.
- Share and provide tools with physicians. Review and update the physician query forms and templates. Review the EHR for quick enhancements, electronic templates, or reminders that can aid documentation specificity. If the organization uses paper records, consider templates that might be useful. This work may be an extension of the organization's current documentation improvement activities.
- Offer to conduct a documentation assessment and provide the findings to physicians. Target clinical specialty areas (e.g., orthopedics) to narrow the focus and get to the areas of ICD-10 with the most change.
- Join forces with HIM and clinical documentation improvement professionals in the organization's physician engagement activities and efforts.
- Present the facts and give data. Run reports on diagnosis and procedure codes that are not elsewhere classified and not otherwise specified; this may help illustrate a pattern of a lack of specificity.

- Always be open to suggestions, be responsive to questions, and try to be as available and as accessible as possible. Being known as the ICD-10 resource will help with physician engagement. Include physicians as much as you can in your ICD-10 implementation plans. *ICD-10 expertise lies within HIM so offer to help with physician awareness, implementation plans, and documentation improvement.*

Notes

1. Quinn, Richard. "Physician Engagement." *The Hospitalist*, October 2009. www.the-hospitalist.org.
2. Gallup. "Physician Engagement." www.gallup.com/consulting/healthcare/15385/physician-engagement.aspx.

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