Six Months and Counting: Are You Ready for ICD-10-CM/PCS Implementation?

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With just six months until the implementation of ICD-10-CM and ICD-10-PCS, now is the time for HIM professionals to re-evaluate the state of their facility's implementation plan and make any necessary adjustments to ensure a successful transition. Previous delays may have slowed down training and planning, but this final stretch to October 1, 2015 still provides time for organizational preparation.

The "ICD-10-CM/PCS Transition: Planning and Preparation Checklist" offers a comprehensive plan that can be followed to help foster a successful transition to ICD-10-CM/PCS. This document [...] provides specific guidance that addresses all areas of an organization that are impacted by the transition to ICD-10.

Review of this document indicates that now is the time for "go-live" preparation with training and planning in full swing. Preparation, education, and testing will be beneficial in mitigating potential implementation issues, allowing for a smoother ICD-10 transition. Each phase of this implementation plan provides information for specific target audiences primarily affected by the tasks in that phase.

The focus now is on the necessary tasks related to go-live and final implementation on October 1. While this phase provides information for several target audiences, this article focuses on a few of the more critical areas.

Bringing Coding Staff Up to Speed

Now is the time, if it hasn't yet begun, for intensive education and training for a facility's coding staff. All coders should complete comprehensive ICD-10 education, and it is recommended that this be conducted by an AHIMA-approved ICD-10 trainer. There are multiple ways to complete education and often a combination of methods is the most effective, such as:

- Traditional classroom training
- Distance education courses
- Audio or web-based materials
- Self-directed education with printed or electronic tools

Consider the amount of material to be covered and the best way to provide the training while also maintaining coders' current workload. This will aid in developing the most effective training plan for staff to ensure the comprehensive education needed for ICD-10 implementation is obtained by each coder.

Not all coders will need the same amount of training. It is estimated that hospital inpatient coders will require approximately 50 hours of ICD-10 education due to the complexity of ICD-10-PCS and the need to learn both ICD-10-CM and ICD-10-PCS. For those coders working in settings other than hospital inpatient, the estimated required training time is approximately 16 hours because only ICD-10-CM training is involved. Finally, for those coding staff members working for a physician practice or specialty clinic, the focus should be on those categories of ICD-10-CM most applicable to the particular patient mix.

While education and training is crucial, the assessment of coder proficiency following the training is just as important. Plan for a process to validate coder learning and identify potential areas requiring re-training or additional education. With the complexity of both ICD-10-CM and ICD-10-PCS it should be expected that some amount of additional education will be required.

If an organization utilizes contract coding staff, it is essential that facilities ensure these coders have also received the necessary ICD-10 education. Companies should confirm the content of the training as well as the qualifications of the

educator.

Dual Coding Offers Training Benefits

Dual coding provides the coding staff an opportunity to practice what they've learned during the education process with exposure to cases they encounter on a daily basis. One of the struggles with this, as well as many of the processes associated with the ICD-10 transition, is the balance between providing the dual coding opportunity while still maintaining the current workload. A successful dual coding program gives coders practice in assigning ICD-10 diagnosis and procedure codes while building confidence in working with the coding classification. It also serves several other purposes while beginning the process of building a database of cases coded in ICD-10.

Part of dual coding is the development of a procedure for auditing dual coded records and providing coding staff with feedback and education to continue the training process. Individuals auditing dual coded records should not only give suggestions for code changes, as appropriate, but also provide the reasoning and rationale for any changes or additions. The feedback provides the coding staff with the basis for changes and further develops coding skills. This process gives managers specific documentation with which to evaluate and assess the ICD-10 competency of their staff.

Dual coding is also an opportunity to continue the evaluation of the quality of health record documentation. Often, dual coding is the first time actual health records are coded in ICD-10 and it quickly becomes apparent if there are documentation gaps impacting code assignment. In ICD-10-CM, this often means the assignment of unspecified codes which, long term, can result in decreased reimbursement and an inaccurate reflection of severity of illness. With the specificity of ICD-10-PCS, inadequate or incomplete documentation will often prevent the assignment of a procedure code. Both the coding staff and auditors can provide feedback related to the quality of documentation.

Organizations should track any DRG changes found during dual coding. If the case was correctly coded in dual coding, minor changes to the codes—for example, added specificity—will generally not impact the DRG. There are cases where changing one character in an ICD-10-PCS code can impact DRG assignment; therefore, any DRG changes found during dual coding should be carefully reviewed to determine the validity of the shift.

Finally, dual coding creates a database of cases coded in ICD-10 which can then be used for payer testing and in other areas where data is necessary for a successful implementation.

Clinical Documentation Improvement Key to Success

During these final few months leading up to implementation, organizations should continue to assess the quality of health record documentation and implement strategies for improvement as necessary. Quality documentation is a critical step in realizing the full benefits of ICD-10. Provider education should continue up to and beyond the ICD-10 transition to ensure a clear understanding of the documentation requirements. It is important to remember that most providers will only require training in specific sections and categories of ICD-10-CM, and should focus training to be meaningful to their specialty. Keep in mind that a complete documentation improvement plan must include monitoring to determine the effectiveness of the plan.

While the transition to ICD-10 is a short six months away, there is still much work to be done to guarantee a smooth implementation and to mitigate potential issues. It is imperative that organizations use these remaining months to maximize education and training for staff as well as continue the push for quality documentation.

Reference

Bowman, Sue and Ann Zeisset. "ICD-10-CM/PCS Transition: Planning and Preparation Checklist." May 2014. http://bok.ahima.org/PdfView?oid=300536.

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