Integrating ICD-10, Quality Initiatives and Other Regulatory Mandates into your Clinical Documentation Improvement Program

White Paper
March 2012
The convergence of a number of Centers for Medicare & Medicaid Services (CMS) initiatives will impact all healthcare clinicians; especially coding and reimbursement professionals. Specifically, CMS is driving the meaningful use of electronic health records (EHR), quality reporting, third party audits, and the adoption of ICD-10 to better ensure proper payments while improving patient safety, quality of care and efficiency of care for Medicare beneficiaries.

In this paper, we will discuss how providers can simultaneously address all of these initiatives through clinical documentation improvement, which relies on a solid understanding of reimbursement. We will focus on the connection between clinical documentation, quality measures, audit targets and ICD-10, as each of these topics is integrally linked to the on-going industry move towards electronic health records.

As we discuss the regulatory and documentation requirements associated with these initiatives, we will explore the impact to each of the following workflows:
- scheduling and registration;
- coordination of care;
- delivery of care;
- documentation;
- coding;
- claims submission and adjudication; and
- reimbursement.

Lastly, to be successful at improving clinical documentation within your EHR, which will ultimately deliver better patient care within your facility, we will discuss provider tasks, the importance of a timeline and the resources required.
Meaningful Use of Electronic Health Records

Although the adoption of EHR technology has been a challenge for providers, it is helpful to remember the goal of the program as communicated by Medicare: Patient Quality. In fact, if we examine the core principles of the "meaningful use" program, we can see that patient quality explicitly stated.

Components of “meaningful use” of a certified EHR system include:
• use of the system in a “meaningful manner”, such as electronic prescribing;
• use of the system for electronic exchange of health information to improve quality of health care; and
• use of the system for submission of data related to quality and other measures.

Payments and Penalties

To encourage wide scale adoption of EHR technology by inpatient hospitals and physicians, the American Recovery and Reinvestment Act of 2009 initiated a significant incentive payment program. Hospitals began earning payments under this program in FY 2011, and payments will continue each year until FY 2017. Under the law, a hospital can earn as many as four years of incentive payments if it is deemed a meaningful user of EHRs. The specific criteria were published in CMS’s Medicare and Medicaid EHR Incentive Program final rule.

According to the formula mandated by that rule, MedPac estimates that the Medicare EHR program will distribute approximately $3 billion in payments in 2012 alone. They estimate that the average large hospital (more than 400 beds) will receive payments of $2.7 million in its first year of participation and that the average smaller hospital will receive payments of about $1.6 million in its first year (payments decline from the first year). Physicians may receive up to $44,000 over five years, starting with $18,000 in 2011.

The final rule also stipulates that hospitals and providers that fail to meet the meaningful use criteria by FY 2015 will be penalized, with a reduction in payment for future services.

To successfully demonstrate meaningful use, eligible physicians and hospitals are required to report clinical quality measures (CQMs) as well as meaningful use functionality measures. The quality measures are discussed below.

ICD-10

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. By now, you are likely aware of the increased coding specificity provided by ICD-10 and the associated documentation requirements necessary to support this coding system. This broad-sweeping change will impact registration, scheduling, coding, billing, and reimbursement. It also has significant implications for your payer and vendor relationships, as well as your IT system. CMS has provided a steady supply of guidance for your implementation program, including very specific implementation guides written for practices, facilities, payers and vendors.

Payments and Penalties

Implementation of ICD-10 is mandatory and there is no grace period. All systems transition on October 1, 2014. This unfunded mandate is a significant expense to providers and payers alike. The outpatient prospective payment system and physician fee schedule are not impacted directly because those systems are procedure-based. ICD-10 will impact inpatient reimbursement due to an expected “DRG Shift” in which similar inpatient claims will be paid under a different DRG due to changes in grouping logic, specifically Complication and Comorbidity (CC) and Major CC designations.
Clinical Quality Measures

CMS defines a clinical quality measure as a “specific evidence-based practice that has been shown to give the best results to the most people”. Generally, the electronic health record system itself is meant to be part of the reporting process. Providers must submit either aggregated data through a vendor, or can submit individual patient level data from the qualified EHR system directly.

Each Medicare payment system (inpatient, outpatient, physician, etc.) has a distinct quality reporting program. CMS has generally started each with a voluntary “initiative” pay for reporting incentive, and then shifted to a mandatory program for all providers where payment penalties are incurred for providers who fail to report.

Payments and Penalties

Both the payment impact and the measures themselves have evolved over time. The table on this page summarizes payment and lists the measures for 2012. For a more in-depth understanding, refer to the individual quality measure manuals published for each system.

Quality Measures and the EHR

Meaningful Use and Quality Reporting are interdependent, and the push to report directly from the EHR has evolved as both Congress and CMS have pushed these initiatives forward. Details are provided each year in the Federal Register, in the new CMS manual “Medicare Quality Reporting Incentive Programs Manual” (Pub. 100-22) and in specific quality manuals published for each system.

A brief overview of the three main systems:

- The physician quality reporting system is still in the incentive phase; in the CY 2012 Physician Fee Schedule final rule, CMS established the Physician Quality Reporting System (PQRS) PQRS-EHR Incentive Pilot, allowing eligible professionals a means to meet the criteria for satisfactory reporting both the measures associated with the 2012 PQRS incentive program and the evidence required to achieve meaningful use status for the EHR Incentive Program.

- The Outpatient and Inpatient Quality Reporting Systems were established prior to the EHR Incentive program and are evolving to take advantage of the industry-wide adoption of this technology. A voluntary “Electronic Reporting Pilot” is underway. CMS expects that the submission of quality data through EHRs will provide a foundation for establishing the capacity of hospitals to send, and for CMS in the future to receive quality measures via hospital EHRs for the Hospital Quality Measures programs. This will allow CMS to collect data for measures without the need for manual chart abstraction. The discussion of the transition to direct EHR submission is discussed each year in the OPPS and IPPS Rules.

- The Inpatient Quality Reporting system also has a newly introduced higher than expected admissions penalty for heart failure, acute myocardial infarction and pneumonia patients. That significant penalty will be phased in over time.

<table>
<thead>
<tr>
<th>Inpatient Quality Reporting (IQR)</th>
<th>Outpatient Quality Reporting (OQR)</th>
<th>Physician Quality Reporting System (PQRS)</th>
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<tbody>
<tr>
<td>Reduction to the payment update factor for the applicable payment year 2007 and beyond: 2.0%</td>
<td>Reduction to the OPD fee schedule increase factor for the applicable payment year 2012 and beyond: 2.0%</td>
<td>Voluntary incentive payment for all Medicare Services for reporting providers:</td>
</tr>
<tr>
<td>Higher than expected admissions for HF, AMI &amp; pneumonia penalty • 2013: 1.0% • 2014: 2.0% • 2014: 3.0%</td>
<td>• Acute Myocardial Infarction • Heart Failure • Pneumonia • Surgical Care Improvement Project • Children’s Asthma Care • Venous Thromboembolism • Stroke • Global Initial Patient Population • Emergency Department</td>
<td>• 2009: 1.5% • 2010: 2.0% • 2011: 1.0% • 2012-2014: 0.5%</td>
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<tr>
<td>CMS has specified physician quality core measures and alternate core measures to report:</td>
<td>• Acute Myocardial Infarction • Chest Pain • Emergency Department – Throughput • Pain Management • Stroke • Surgery • Imaging Efficiency • Structural Measures</td>
<td>Penalty on all Medicare Services for failure to report: • 2015: 1.5% • 2016: 2.0%</td>
</tr>
<tr>
<td>• Core Measures</td>
<td>• Core Measures</td>
<td>• Influenza Immunization • Weight Assessment and Counseling for Children and Adolescents • Childhood Immunization Status</td>
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ICD-10 codes must be used to report quality measures on all applicable claims with dates of discharge on and after October 1, 2014.

Since November of 2003, CMS and The Joint Commission have worked together to align common measures, with a goal to minimize data collection efforts for these common measures and focus efforts on the use of data to improve the healthcare delivery process. This effort resulted in the creation of one common set of measure specifications documentation, known as the Specifications Manual for National Hospital Inpatient Quality Measures, to be used by both CMS and The Joint Commission, with common (i.e., identical) data dictionaries, measure information forms, and specific algorithms for identifying cases by measure, with elements such as E/M code, discharge code, encounter date, birth date, principal diagnosis code, arrival/leave time, as well as specifics for given procedures and dates. The Physician Quality Reporting Specifications Manual lists measures where the denominator code for reporting may be a procedure or a diagnosis code.

Because some measures are reported using the principal diagnosis, translating that to ICD-10 will be important. As of the writing of this paper, CMS has not released the crosswalks of quality measure ICD-9 to ICD-10 codes, but these are expected sometime within 2013.

Third Party Audits

The Social Security Act obligates CMS to audit Medicare and Medicaid claims to identify overpayments. To fulfill this statutory requirement, CMS has procured various types of contractors to conduct provider complex and automated audits throughout the country. Audit Medicaid Integrity Contractors (Audit MICs) review Medicaid claims. Recovery Audit Contractors (RACs) focus on Medicare claims with an expansion into Medicaid. Issues under review are pre-published by the RACs.

The Office of the Inspector General (OIG) is also authorized to investigate any provider receiving federal dollars under the Medicare or Medicaid programs. The OIG publishes a Work Plan each year that details the issues they will be investigating, and they publish their findings in subsequent Audit Reports and Evaluation & Inspection Reports.

In addition to these government auditors, providers are also under scrutiny by commercial payers and all organizations should have an internal audit program in place to generally monitor for compliance.

Penalties

To get a general idea of the financial impact of external audit, let’s examine the recent results of the RAC program. The Recovery Audit Program has and continues to uncover overpayments to the Medicare program. In FY 2011, the RAC auditors recovered $797.4 million in overpayments to providers and suppliers, an increase from FY 2010 where auditors recovered $75.4 million in overpayments. With the expansion of the recovery auditor program to include Medicaid under the Patient Protection and Affordable Care Act, CMS anticipates that the Medicaid recovery audit contractor effort will save the Medicaid program $2.1 billion over the next five years. Furthermore, the April—June 2012 Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter, reports collections thru June to be at $1,776.9 millions

Now that you have become familiar with the
Impact of Initiatives on Organizational Workflow

regulatory background of meaningful use of electronic health records, ICD-10, quality reporting and third party audits, let’s examine how these various initiatives impact organizational workflow.

To ensure success with each of these initiatives, start with the common element to each—proper clinical documentation. Proper documentation will support not only future ICD-10 code assignment, but Quality Reporting initiatives and increased third party audit activity.

Although documentation is the key to success, each of these initiatives will require organizations to integrate people, process and technology so organizations will need to address staff needs (resources, education, etc.), refine processes and maximize the utilization of electronic health records. Let’s discuss how the following related processes are impacted by ICD-10, quality reporting and third party audit activity.

Scheduling & Registration

ICD-10

The transition to ICD-10 will radically impact scheduling and registration areas as the collection and use of diagnostic and procedural information (e.g., authorization/ pre-certification processes, diagnosis capture, etc.) is inherent to these processes.

First and foremost, the structural differences between ICD-10 and the current ICD-9 coding system will have a substantial impact from an education perspective. Not only is there a steep individual learning curve associated with comprehending a new coding system, but in many facilities the number of staff involved in scheduling and registration functions is also substantial and often decentralized throughout larger facilities or organizations. Reaching all points of patient access and all associated registration and scheduling staff will complicate the deployment of your education program.

Second, with the increased complexity of ICD-10 code assignment and the anticipated productivity impact that accompanies a complex coding system, it is almost certain that patient scheduling, patient registration and patient wait times will all increase.

Lastly, as greater specificity is needed to appropriately assign ICD-10 codes, if clinical documentation (including outpatient physician orders) is not enhanced, accurate and complete code assignment may be in jeopardy. The downstream effects of inaccurate or incomplete coding are:

• inaccurate authorizations;
• failure to properly notify beneficiaries (ABN) resulting in non-payment;
• inaccurate data used for Quality Reporting initiatives; and
• an increase in Accounts Receivable (AR) Days as the ability to submit claims in a timely manner, claim acceptance and claim adjudication (e.g., payments and denials) will be at jeopardy.

So it is clear, entities should ensure that efficient processes are in place to address situations where additional documentation is needed to appropriately assign the ICD-10 codes (e.g., physician query processes).
Quality Reporting
In addition to the significant impact that ICD-10 will have on scheduling & registration workflows, the ongoing expansion and emphasis on Quality Reporting initiatives will also heavily impact this area. Accurate collection of various scheduling and registration data elements at the point of patient access is critical to its utilization in Quality Reporting initiatives. Furthermore, Quality Reporting initiatives will likely uncover areas where service delivery modifications are needed and will serve as a catalyst to change. As a result, future scheduling of clinical care may be impacted (e.g., allotting the appropriate amount of time to provide quality care in the most efficient fashion). For example, as preventative screening services gain coverage and associated quality measures are developed, consideration might be given to those anticipated patient needs in the scheduling process.

Third Party Audits
As third party audits identify medical necessity and level of service issues, added focus is needed on scheduling of services. It becomes imperative that organizations ensure that the right service is provided in the right setting or level of care. The scheduling areas, along with individuals involved in coordination of care activities, need to work collaboratively in ensuring that detailed diagnostic and planned procedure information is provided at the point of services in support of the level of care being scheduled.

Coordination of Care
Coordination of Care activities will be impacted by these converging issues as well. As with the scheduling and registration areas, detailed clinical information is required:
- at the initiation of care to facilitate diagnostic and procedure code assignment that support authorization and certification processes;
- to clearly demonstrate within the EHR the medical necessity of the services being rendered and support the level of care provided throughout a patient’s stay for continued stay reviews; and
- to justify care provided in the event of a retrospective review.
Poor documentation within your EHR will be a detriment to accurate diagnostic and procedure code assignment with ICD-10, to quality reporting initiatives, and to supporting claims submitted/reimbursement during payer audits.

Specifically in the area of quality, coordination of care professionals should have an up-to-date understanding of clinical best practices, with an eye towards ensuring proper documentation of published quality measures. This should include an awareness of acute care transfer and readmission payment rules and penalties.

Delivery of Care
While the deployment of ICD-10 and ongoing third party audits will not inherently change the delivery of clinical care provided, CMS has specifically aimed to do just that with Quality Reporting initiatives in their efforts to 'promote higher quality and more effective health care'. Perhaps you have noticed changes in your own physician practice, where common preventive care measures originally defined specifically for Medicare recipients are generally applied to all patient populations (for example: preventive care and screening measures for diabetes management, smoking cessation counseling, systematic screenings for blood pressure, certain kinds of cancer or substance abuse problems, etc.). Further changes in delivery of care models are anticipated as these programs progress.

Documentation of Care
From a documentation perspective, both quality reporting initiatives and the deployment of ICD-10 will necessitate and drive similar changes to the EHR.

As CMS fully intends to consider the adoption of electronic specifications for quality reporting in the future, it will be necessary to document compliance with key quality measures within your EHR. This will allow for the capture of quality measures as part of your delivery of care. It will also enable CMS to reduce the administrative burden by streamlining quality measure collection and reporting efforts.

ICD-10 will trigger further enhancements in documentation practices, as greater specificity is required to appropriately assign ICD-10 codes. The need for more detailed documentation with ICD-10 deployment will serve as a driver of documentation improvement initiatives and will facilitate gathering of meaningful clinical information on the front end. This is, of course, something that a well-executed EHR can capture with appropriate encounter screens, prompts and pick lists.

Lastly, current third party audits and associated appeal activity will serve as additional drivers in improving documentation to support the delivery of care being provided and in proactively defining appropriate levels of care for certain services.
The outcomes of such audit and appeal activity will reveal where your facility has opportunity to improve documentation and where care may be more appropriately delivered.

**Coding**

Clear and concise documentation within an EHR is critical to code assignment. The transition to ICD-10 will obviously have a significant impact on accurate and timely code assignment due to:

- the structural differences between ICD-10 and the current ICD-9 coding systems;
- the additional specificity required to appropriately assigning ICD-10 codes;
- increased knowledge of anatomy & physiology required; and
- poorly documented services.

As a result, it is anticipated that facilities will see a significant decrease in coding productivity, an increase in coding backlogs and an increase in physician queries with the transition to ICD-10 necessitating additional trained coding resources to maintain current revenue streams.

Likewise, in preparation for the deployment of ICD-10, time spent on required comprehensive education will impact current coding productivity requiring staffing modifications. Furthermore, as quality reporting initiatives further develop, there will likely be further reliance on accurate coding and abstracting functions to support reporting activities and scrutiny by third party audits. We can also extrapolate that the challenges providers will face if they fail to properly implement ICD-10 will be exacerbated by the increased requirement for quality reporting.

**Claim Submission and Adjudication**

Claim submission processes will also be impacted by the deployment of ICD-10 and the accuracy and completeness of ICD-10 coding. Providers may see claim submission delays if inadequacies exist in:

- documentation;
- coding training provided to coders and/or staff performing coding functions (e.g., scheduling & registration); or
- code assignment.

When documentation does not adequately support accurate/complete code assignments and coder productivity is not at optimal levels, providers will experience an increase in discharge not final billed (DNFB) holds, as well as bill holds impacting claim submission and the risk of reaching timely filing limits. Claim acceptance and adjudication issues may also result. An increase in denials is anticipated and organizations need to brace for impacts to cash flow and increases to overall accounts receivable (AR) days.

Quality reporting, depending on the specific program and submission methodology chosen by the organization, derives directly from claims and EHR data. This means that entities struggling with timely and accurate claims submission will likely face quality reporting challenges as well.

**Reimbursement**

Now that we have seen the impact the deployment of ICD-10 will have on quality reporting initiatives, third party audits and further deployment of EHRs under Meaningful Use, it should be crystal clear that future reimbursement is at risk if steps are not taken to mitigate that risk. Risks include:

- decrease in reimbursement for failure to report quality measures (2% decrease for most settings and a loss of incentive payments for physicians);
- underpayment for failure to update payor contracts historically based on ICD-9 diagnostic coding;
- inpatient DRG shifts;
- denials; and
- increased third party audit activity.

Ultimately, significant losses in reimbursement are detrimental to organizations and undermine their ability to provide quality, state-of-the-art care. This highlights the importance of careful and thorough implementation planning.
ICD-10 will be implemented October 1, 2014, which leaves providers little time remaining to upgrade systems, improve clinical documentation practices, educate and train staff, and brace for the claims and reimbursement challenges inherent to this change.

When we contemplate ICD-10 within the larger context of CMS initiatives—increasing and changing quality reporting requirements, expanding third party audit challenges, and the industry wide rapid adoption of electronic medical records to comply with evolving meaningful use requirements—it becomes obvious that an integrated approach is essential. By now, most organizations have formed an ICD-10 implementation team or task force and begun basic impact assessments. Those efforts should also be informed and driven by quality reporting and audit findings.

An integrated approach that considers these adjacent initiatives is the first step; the next is to integrate implementation efforts within the health care organization itself. These projects give us a unique opportunity to move out of our silos and work cohesively together as a team, which is especially important when we consider the overlap and impact each of the workflow areas have on each other.

As providers prepare for ICD-10, they should use the often-recommended four-phased approach: Assessment, Planning, Implementation, and Evaluation. No matter where you stand today within this approach, you need to understand that the process is fluid and you may need to go back to the assessment phase even if you are deep into the implementation phase. Organizational success will require continuous evaluation of interdisciplinary initiatives combined with the flexibility to respond to the results of that evaluation.

To begin this process, identify the solutions and resources you will need to complement, enhance or replace. Consider which work processes you will handle internally and those you would rather outsource. When considering resource management, make sure you take into account the heavy impact of ICD-10, Quality Reporting and Audit on the following areas:

- managed care and other contracts;
- fee schedules;
- front end registration processes and protocols; and
- coder productivity.

Perform a 360-degree business analysis

You need to gain a clear understanding of the impact of ICD-10, quality reporting, audits and EHR adoption will impact your specific organization in order to develop a successful implementation plan and an education curriculum to support your efforts. Drill down into each specialty/department to both gather feedback from staff to enhance your understanding and educate staff on how these complex concepts impact the organization. Be sure that clinicians, coders, auditors and where applicable IT staff members are each included in the process.

For each specialty, take the time to identify and study the types of patients cared for in your practices and facilities, the services provided, your top procedures performed, and most common diagnoses. Extrapolate this to understand the common reimbursement challenges, such as common denials, physician queries, and other organizational workflow issues inherent to the specialty. Then identify third party audit issues published by the RACs, MICs and OIG that are germane to those services. Take the process one step further and identify the quality measures associated with them.

Understand Past and Future Reimbursement Challenges

As we’ve discussed, quality reporting, audit and ICD-10 are each driven by clinical documentation and each significantly impact reimbursement. Your staff education should include concrete examples of how their workflow impacts the bottom line, but first you must understand the combined impact.

As you do the necessary work to understand third party audits (for instance, MS-DRG and medical necessity validation of inpatient claims to ensure proper billing), the impact of ICD-10 (for instance, historical claims data analysis to predict MS-DRG shift under ICD-10) and quality reporting (the data analysis and abstraction for compiling and submitting your report), consider how an integrated approach will save you time and resources. In fact, for inpatient reimbursement, an analysis related to ICD-10 readiness is quite similar to the reimbursement work related to MS-DRG validation reviews being done by the RACs and MICs.
To analyze your current business on the inpatient side, integrating quality, audit, and ICD-10 factors, create an inventory of the highest risk areas, focusing on published initiatives as well as your specific data. You may want to do this work globally, or specialty by specialty, but insure the process includes these elements:

| Understand key clinical areas where ICD-10 is very different from ICD-9. | Include very different axes of classification, one-to-many mappings, etc.  
Understand the limits and value of the General Equivalency Maps (GEMs) published by CMS, and consider which maps your organization will rely on for which purposes. |
|---|---|
| Examine the issues published by your RAC, Work Plan items (and Audit Reports of findings) published by the OIG and other third party audits. | Develop a general understanding of focus areas.  
Inventory your specific MS-DRG validation reviews which have resulted in significant improper payments.  
Find examples of your specific past complex medical necessity reviews which break down in your existing admission workflow.  
Where you can, quantify the financial impact associated with these audits, both in terms of the cost of the audit work and the repayment amounts. |
| Understand the inpatient (and related outpatient/physician) quality measures. | Calculate the financial impact specific to your organization of failing to comply with quality reporting mandates. |
| Examine existing ICD-9 specificity issues within each clinical area. | Compile a list of most utilized diagnosis/procedure codes.  
Map those codes to related third party audit target areas in each clinical area, noting where greater specificity is required  
Map those codes to quality measures associated with each specialty area  
Catalog the most common medical necessity issues (and compile lists of related LCD/NCDs) |
| Perform a historical claims analysis to find highest risk areas specific to your organization. | Compile a list of top paid MS-DRGs, top-utilized MS-DRGs.  
Perform a mass translation of ICD-9 to ICD-10 to identify MS-DRGs and example patient stays that are vulnerable to MS-DRG shift.  
Find example real-life cases associated with medical necessity and/or other denial/re-bill issues. |
| Use the risk areas identified in the above analysis to do a more in-depth record/claims analysis and self-assessment on a set of exemplar cases: | Confirm that the documentation supports the ICD-9 coding.  
Validate that the principal diagnosis was appropriately assigned.  
Confirm that the CC/MCC secondary diagnoses are well documented.  
Consider a review of “Present on Admission” coding and documentation.  
Natively assign codes in ICD-10 as if it is post-implementation. This is an excellent exercise for your coding and audit staff to underscore areas where current documentation is lacking. Compare to the mass translation above.  
Confirm the ICD-10 to MS-DRG grouping logic to assess if payment is consistent.  
Identify how this case relates to published or prior audits by RAC, OIG, or other entities that were identified in your general review described above.  
Identify how this case relates to the quality measures that were identified in your general review described above.  
Quantify, for this specific case, the financial impact of improper documentation, coding, billing or compliance. |
What Providers Need to Do

While a significant amount of work, this process ensures a 360 degree approach and eliminates duplication of effort. In each case, the regulatory initiatives are one side of the coin—YOUR SPECIFIC DATA are the other.

Once compiled, this combination of general regulatory requirements, benchmarking and trending from your specific organization's history and real-life specific examples will clearly illustrate what types of documentation improvements are required. You can then focus your education efforts on the areas of highest impact. Using a standard audit or survey tool to consistently capture information will facilitate the sharing of information.

Improve Clinical Documentation Workflow

Analysis of this type helps organizations both understand their current performance under ICD-9 and outline their specific requirements in preparing for ICD-10. In a single review, you can glean important lessons regarding medical necessity, coding, documentation, quality, MS-DRG validation, reimbursement and other audit issues. Once you have a 360-degree view of the specialty, you can use this to inform your on-going EHR implementation and customization efforts.

Use this information to design the improvements to your encounter forms and capture screens, with an eye towards streamlining workflow while mitigating both existing and anticipated pain points. This will ensure that clinicians document not only what is necessary for the increased specificity of coding and what is required to meet quality reporting standards, but also that the documentation is compliant for reimbursement.

While most vendors have provided capture screens that encourage proper documentation aimed at the published CQMs (which vary for hospitals and physicians), providers should take the responsibility to verify that those screens have the specificity required by ICD-10, proper reimbursement, and any gaps identified by on-going third party audits such as RAC and internal audit processes. In other words: do it once, do it right!

It is important to note that this work can begin immediately. To avoid procrastination, emphasize to staff that greater documentation specificity impacts each department’s bottom line NOW; there is no need to wait for deployment of ICD-10!

Provide Integrated Education

Education is one of the most important and discussed components of ICD-10 readiness, and clear guidelines about timelines, and workflow-specific education has been published by CMS, AAPC and AHIMA. Increasingly, the industry is realizing that ICD-10 education involves much more than just coding education. Organizations should expand their ICD-10 coder education plan to include general awareness education for all stake holders, and specific education for clinicians, IT, reimbursement, audit and other staff. At the same time, organizations have an opportunity to leverage these ICD-10 education efforts to illustrate to all staff the connection between documentation, coding, patient quality, reimbursement and audit findings. Juxtaposing ICD-10 against these initiatives with specific reimbursement impact examples can improve buy-in, making the case to reluctant staff for working together to improve patient care.

The education should be workflow focused, addressing all initiatives in a coordinated, well thought out program that is on-going, dynamic and responsive. Provide staff with the foundation first, then stay current by asking each staff member to take responsibility as content experts in their own domain. This should include giving staff access to regulatory updates and resources. Assure that the educational program design is collaborative and interactive rather than the traditional top-down approach. This will be a good foundation to improve morale and interdepartmental communication, both of which will be important as the organization during the early stages of ICD-10 implementation when systems behave in new and unanticipated ways and rapid response is required.

Throughout this process, it will be imperative to create a balance between internal and external resources. Education for ICD-10 and the other regulatory initiatives can be extremely costly and it will be important to use your budgetary dollars wisely!
Summary

Through the study of quality reporting results, the deployment of ICD-10 and increased third party audits, the health care industry will potentially see:

- modifications being made to the delivery system with added treatment protocols being defined;
- more specific information and reporting to the consumer regarding cost, outcomes and disease management;
- payers aggregating information about the relationship between services provided and the diagnostic condition to drive future patient care coverage models; and
- caregivers gaining an understanding of the resources required to optimize patient care and outcomes.

Organizations should simultaneously address the impact of this massive change in coding systems and the impact of other converging regulatory initiatives on their specific organizational processes through a thorough documentation improvement program. To achieve success in managing all of these converging issues, now is the time to act!

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