Key Ways to Help Physicians Transition to ICD-10

How to use technology and education to assist your medical practice's physicians with the ICD-10 transition before it happens.

Source: Physicians Practice

The ICD-10 transition on October 1 is quickly approaching. Is your practice prepared? Perhaps a better question is: Are your practice's physicians prepared?

Under ICD-10, health systems and physicians are going to experience "an absolute explosion of the requirements for precision and specificity" in documentation. That's according to Thomas Mercer, president and CEO of Executive Health Resources, a provider of compliance solutions to hospitals and health systems, who spoke about the ICD-10 transition challenges health systems will face during a presentation as part of this year's Healthcare Information and Management Systems Society (HIMSS) Conference in Orlando, Fla., entitled "Using Documentation Technology to Achieve Physician Alignment with ICD-10."

Under ICD-10, the number of codes used for documentation and coding will jump from about 18,000 to almost 155,000, said Adele Towers, Mercer's co-presenter and medical director of health information management at the University of Pittsburgh Medical Center (UPMC). For a more specific example of how that increasing complexity will play out, consider an ankle sprain. Under ICD-9, an ankle sprain has four potential diagnosis codes. Under ICD-10 it has 72. The key will be practices and physicians learning the codes that apply to their specialty versus memorizing all 72 which may not apply.

But increasing complexity is still likely to result in a drop in productivity as coders adjust, and as physicians receive more queries about documentation, said Towers. To help ensure coders and physicians get up to speed at UPMC as quickly as possible, the health system combined a computer-assisted coding solution and a clinical documentation improvement system at three of its hospitals in October 2013. The goal: to use technology to help identify the clinical facts based on the documentation that is present, and to use technology to help identify what's missing. Rather than relying on manual queries to physicians when coding and documentation questions crop up, the new system sends queries to physicians and it enables them to complete the queries electronically with an EHR interface.

"You can do all of the excellent education in the world, you can do all of the coaching in the world, but if you're not making it easy for the physicians to respond to the queries in an intelligent way where they're confident in the response, it will not be nearly as effective," said Mercer.

The results of the new system include:
• Faster responses to queries. The response rate among physicians jumped from around 70
percent to nearly 100 percent at the three hospitals that transitioned to the new system.

- **Faster turnaround for queries.** The average query turnaround time decreased from 15 days to 16 days to about six days to eight days at the hospitals.

- **Faster coding turnaround time to final bill.** Turnaround time to final bill for cases with a query decreased from 29 days to 39 days at the hospitals to 10 days to 14 days.

While technology can help ease the transition for physicians and practices, so can education, said Mercer. "We need to continue to work to educate physicians about what documentation in the new world really means," he said.

To ensure physicians have relevant coding and documentation information at their fingertips, UPMC has created a series of brief videos featuring physicians. In the videos, physicians provide documentation information on disease areas so that physicians can learn directly from their colleagues.

"I think the key with physicians is ... one method is not going to work for everybody," said Towers. "Some physicians like the videos, some physicians just want a pocket card, some physicians demand to have everything on the query form ... We provide it all."


Links: