

# Engaging providers in ICD-10



Patricia A. Zenner, RN

The ultimate goals of engaging providers in the ICD-10 transition are stellar physician documentation and coding. Once those goals are achieved, ICD-10 coding could be beneficial to providers and patient care. There will be accurate and complete patient records that can be used to facilitate care consistency and coordination. The medical records will present an accurate legal representation of the services provided to defend against possible litigation. There will be a complete and accurate database to promote evidence-based practice and, eventually, appropriate reimbursement for services rendered.

Although all HIPAA and affiliated entities, including providers, should share the same goals, a survey by J.A. Thomas & Associates found that 74.3% of respondents identified the greatest challenge they face to be getting buy-in from physicians and then training them.<sup>1</sup> Recent industry readiness assessments from the Centers for Medicare and Medicaid Services (CMS) found that self-preparedness levels for providers were the lowest compared to health plans and vendors.<sup>2</sup>

Thus, while it is clear that ICD-10 coding could be beneficial to providers and patient care, most providers are not yet engaged in the transition. Organizations must plan and implement focused efforts to change superior documentation and coding from lofty goals to practical ones. In this paper, we discuss the emerging best practices to engage physicians in the ICD-10 transition.

## PREPARING FOR PROVIDER ENGAGEMENT

Despite widespread verbalization of the industry's commitment to budget neutrality, tension remains as a result of competing interests between providers and health plans. To help overcome that hurdle, providers have said that they want clear, consistent, and concise messages concerning affiliate and health plan ICD-10 implementation and operational expectations.

### One size does not fit all

In developing provider support plans, organizations need to understand, acknowledge, and accommodate unique provider environments. Larger providers may have their own programs that health plans can support, whereas smaller providers may rely on the health plans. Not only do provider organizational structures and ICD-10 preparedness vary, but providers may also have very

different approaches to claim coding, ranging from a comprehensive infrastructure of certified coders to the physician, office manager, or perhaps the physician's spouse. Medical record format and content also vary widely, as do the sophistication of electronic medical record and billing systems.

### Implementation leadership

- "Do not put HIM professionals in the position of trying to get physician 'buy-in' for ICD-10..."
- "Make physician leadership responsible..."
- "Physician-led coding and compliance programs..."
- "Physician team member responsible for providing feedback to other physicians in the group..."
- "Structure a collaborative approach involving internal physician leaders and ICD-10 experts..."

These quotes from various websites emphasize the point that physicians relate to physicians. In addition to management and coding staff, identify a physician champion for the project and include at least one physician in the implementation process.

### START NOW: TARGETED DOCUMENTATION IMPROVEMENT

Start now to develop and implement programs for physicians to document more specifically.

1. Identify the codes presenting the greatest risk.
2. Educate providers by showing them comparisons between both coding systems.
3. Review several records each week for documentation deficiencies; continue for several months.
4. Compile and share with providers a monthly summary for both ICD-9 and ICD-10 documentation, with a recommendation for improving documentation.
5. Use the tracking to identify physician education needs, and identify risk areas to promote discussion and resolution.

By the time October 1, 2013, rolls around, documentation on those high-risk areas will be greatly improved and staff will be familiar with the high-risk ICD-10 codes.

1 JATA (May 25, 2011). ICD-10 survey shows urgent need for physician education and medical staff buy-in. News Post. Retrieved September 15, 2011, from <http://www.jathomas.com/news/2011/05/24/icd-10-survey-shows-urgent-need-physician-education-and-medical-staff-buy>.  
 2 CMS (August 2011). ICD-10 and Version 5010: Industry Readiness Assessments. Official CMS Industry Resources for the ICD-10 Transition. Retrieved September 15, 2011, from <https://www.cms.gov/ICD10/Downloads/ICD-10andVersion5010IndustryReadinessAssessmentsResults.pdf>.

## PROVIDER ENGAGEMENT AND EDUCATION

Develop a communications plan addressing pre- and post-transition issues, as well as active issues, and incorporate the "7 C's": compelling, creative, continuous, consistent, credible, clear, and concise.

### Who

Although all providers need to be aware of the impending changes, it is most efficient to develop a strategy to target information to the providers that will be most affected. Depending on the organizational structure, ICD-10 education may also need to involve the entire office—office manager, coders, billers, etc. Organizations may also want to include employee unions in communications where applicable.

### What

Content is paramount. Not only should content address "What is in it for me?" from the providers' perspectives, it is also important to acknowledge the administrative overload. Cite specific examples of how more precise documentation and coding can promote quality and improve efficiency and more accurate reimbursement.

Not every provider needs to be educated about every code. To increase receptivity, create programs that focus on a subset of codes that have direct impact on the provider. Conduct intense training on conditions and procedures where capturing the most accurate code may impact costs, reimbursement, and/or identification for clinical pathways or other care management programs. Create scenarios demonstrating the impact of documentation and coding and including which claim types will be involved and how.

**Example:** A patient is seen by an orthopedist in the office for follow-up care of an open fracture of the femur. Which of the following do not need to be documented under ICD-10-CM:

- a. Laterality of the fracture
- b. Whether the encounter is a routine follow-up visit or sequela (e.g., infection)
- c. Type of fracture (e.g., transverse, oblique, spiral, comminuted)
- d. Displaced or non-displaced
- e. Specific location of the femur (e.g., neck, intracapsular, epiphysis, midcervical, base of the neck)
- f. The Gustilo classification or depth of tissue involved
- g. Healing status (routine, delayed, nonunion, malunion)
- h. None of the above

In developing the plan, consider the size range of hospital and physician practices. In smaller organizations cash flow often is a greater concern, yet billing error rates may be higher.

Health plans should publicize specific changes in payment and medical policies, especially those areas in which providers are at greater risk. Communicate with providers on what they can expect regarding medical necessity coding, clinical documentation, and submission of nonspecific diagnoses. Provide estimates of potential financial implications for key areas.

### When

Develop a schedule for when the information will be communicated. Timing is especially important—too early and it will be forgotten, too late and there may be too little time for change. Communicate general information early and provide more detailed information later.

### How

With ICD-10 impacting every HIPAA-covered entity and associate, to avoid ICD-10 overload and unnecessary expenses, to add credibility, and to make effective use of physicians' time, some organizations are facilitating coordination among payors, providers, medical associations, and specialty societies for shared communications and education.

Include multiple engagement approaches, whether it is a combination of on-site training, staff meetings, website information, webinars, newsletters, emails, help lines, online tutorials, or information with explanations of payment. No single approach will work alone.

Consider creating incentives. For participation in training, offer continuing medical education (CME) or continuing education units (CEUs) for clinicians. Build incentive-based quality indicators around clinical areas where correct coding is essential (see also the Milliman white paper "Using ICD-10 for Immediate Quality of Care and Coding Improvement").<sup>3</sup>

### Testing

Communicate and publish the testing schedule and plan, identifying which codes will be tested, steps in the testing process, and when results will be provided.

Include all major payment systems and clearinghouses as testing partners. This may even allow larger organizations to test on behalf of smaller practices.

Make testing available as early as possible and allow providers to submit actual claims as part of the test to identify payment issues.

### After implementation

Develop a mechanism to provide detailed education and feedback on claim problems and denials during the transition. To maintain HIPAA transaction compliance, this may be done through an ICD-10 hotline, mailing inserts, or other means. For example, if a health plan institutes a policy of rejecting certain nonspecific codes, the remittance advice may include:

- Claim Adjustment Reason Code 125: Submission/billing error(s).
- Remark Code M81: Patient's diagnosis code(s) truncated, incorrect, or missing. You are required to code to the highest level of specificity.
- Remittance Advice Remark Code M16 states: Alert: Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.

3 <http://insight.milliman.com/article.php?cntid=8006>

Conduct a periodic audit of medical records to identify documentation deficiencies and provide aggregate and individual feedback to providers. Maintain practitioner anonymity in reports provided. Make any individualized feedback physician-to-physician.

Because every HIPAA entity and affiliate will be simultaneously focused on coding, the ICD-10 transition may be the ideal time to improve documentation and coding. However, it will not happen without a plan that includes best practices and implementation of focused efforts to engage physicians in the ICD-10 transition. Provider documentation and ICD-10 coding may never be perfect. But do not miss this opportunity to make it better.

---

Patricia A. Zenner, RN, is a consultant in the Healthcare Management Group practice of Milliman. Contact her at [pat.zenner@milliman.com](mailto:pat.zenner@milliman.com).

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.

Copyright © 2012 Milliman, Inc.