

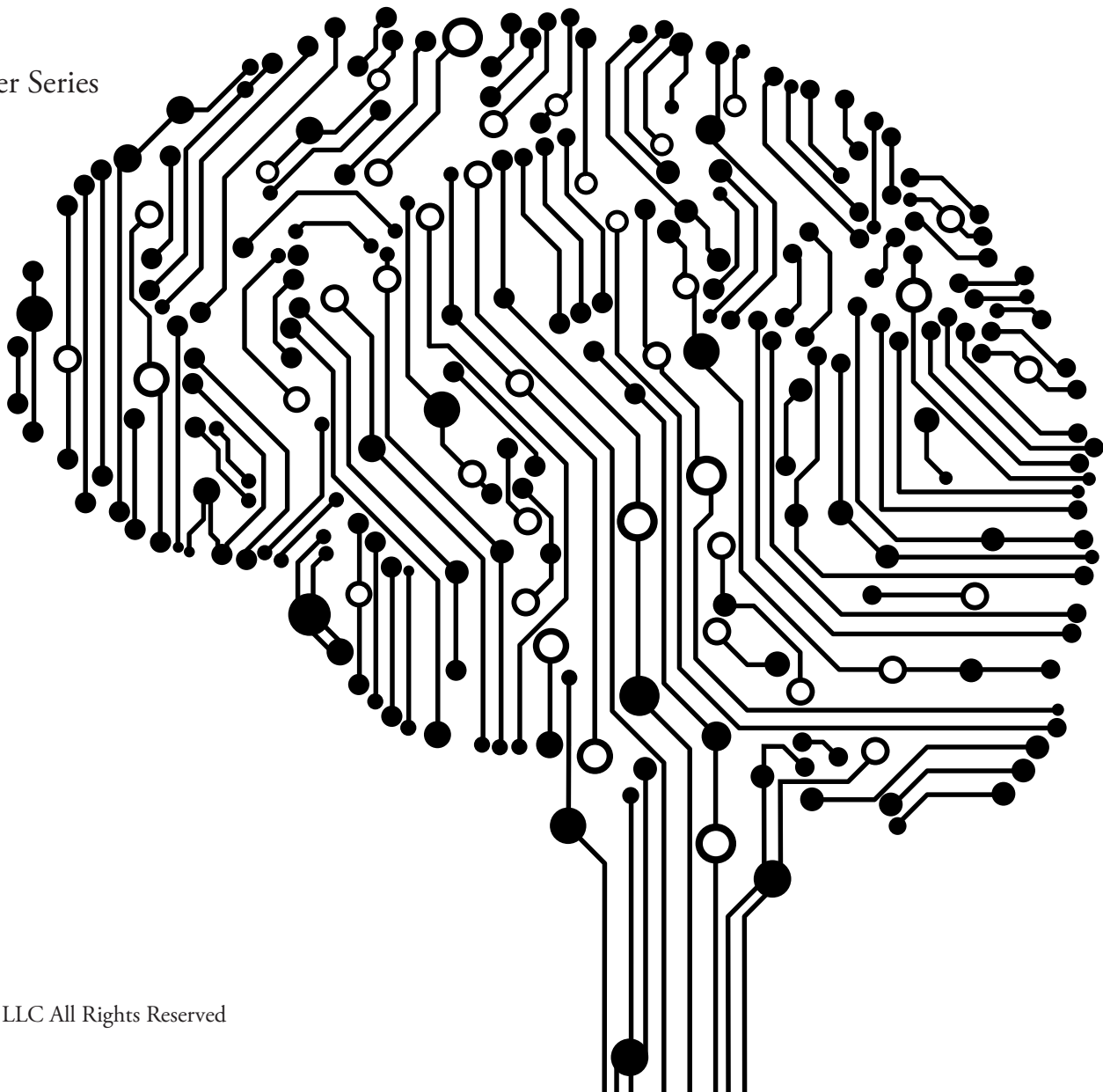


Applying Smarter Technology for Smarter Documentation Improvement

Using new tools, some techy smarts, and a little ingenuity

August 2013

ICD-10 Whitepaper Series
Issue No. 10



Clinical documentation—the information that a doctor/practitioner captures about the patient encounter—serves a critical role in the healthcare system. It is a central component to driving better patient care, provides an audit trail of the care delivered, serves as a legal document, and impacts reimbursement amounts. And now, with the onslaught of healthcare reforms and mandates, the importance of clinical documentation has intensified. The current conversion to ICD-10 is representative of this impact and how large industry changes are forcing providers to reexamine just how they capture and report the care they administer.

Clinical Documentation—a Pillar in Our Healthcare System

The ICD-10 transition (visit www.cms.gov/icd10 for more information) is providing an unprecedented chance to improve clinical documentation across the provider landscape. This is because the act of coding itself is driven entirely by what a provider captures about the patient encounter. With the kind of fundamental change required by the new code set, we get somewhat of a “do-over” to address current documentation gaps or lapses overlooked in today’s ICD-9 world.

Underlying this documentation improvement opportunity is the inherent increase in specificity that comes with ICD-10. A diagnosis that had one code in ICD-9 could have tens of different options in ICD-10 that provide more granular information on location, frequency, and type. This quality sits at the crux of arguments for and against implementation of the new code set. On the one hand, ICD-10—if implemented correctly—will:

- Reduce ambiguity
- Improve our ability to measure the quality of care delivered
- Drive transparency and improve reporting
- Improve our ability to understand, track, and predict public health threats
- Enhance an organization’s ability to monitor the services delivered and the associated reimbursements

On the other hand, detractors argue that ICD-10 will create an undue administrative burden on physicians who are already struggling to keep up with other healthcare mandates.

Regardless of perspectives, ICD-10 compliance is mandated by October 2014. And the increased specificity in the code set will force providers to include more detail and re-examine current documentation practices to comply with the mandate, drive accurate coding, and ensure proper reimbursements. The old adage that if it isn’t documented then it didn’t happen will take on a new meaning in ICD-10; ambiguity and unspecified coding practices will expose a provider to increased scrutiny from regulators, decreased reimbursements, and the potential for possible fraud/abuse allegations.

But the importance of accurate documentation goes beyond correct coding in ICD-10. Proper documentation impacts the quality of care provided by better capturing an episode of care and driving more continuity of care across a patient’s lifetime. For the physician, improved clinical documentation demonstrates accountability and improves the overall administration of care. And for the overall organization, better documentation means fewer denials, reduced AR cycle times, more accurate/appropriate reimbursements, and better protection from audits or other compliance activities. So getting documentation right isn’t an ancillary activity—it is a core component to the entire ICD-10 conversion.

Becoming Smart about ICD-10 Documentation Activities

With ICD-10 effecting every patient encounter, the associated documentation efforts are daunting. Not surprisingly, the documentation discussion has taken center stage as providers work to find solutions and vendors try to capitalize on the market opportunity. But as the industry has matured in its understanding of ICD-10, there is a recognition that it is impossible and unnecessary to include every chart from every corner of a facility in an ICD-10 documentation program. There has to be some level of prioritization to better allocate resources and time.

Theoretical vs. Empirical—Two Approaches to ICD-10 Documentation Prioritization

The Theoretical Approach

To date, most ICD-10 documentation programs have taken a theoretical approach to prioritization. We call it theoretical because it is based on a few basic assumptions and concepts around ICD-10 risk. Its premise is that by looking at current risk in ICD-9 and understanding volatility in the shift to ICD-10, a provider can anticipate potential areas of ICD-10 operational and financial impacts. And based on these perceived impacts, a provider can better focus their ICD-10 documentation program to the service lines and departments associated with the highest levels of risk.

Theoretical Approach

- Resource driven
- Analyzes a subset of data
- Determines risk based on DRG level volatility and current ICD-9 risks
- Provides mid-level visibility into impacts
- Is not repeatable across the conversion timeline

This process typically uses clinical documentation improvement metrics and available ICD-10 mapping information including:

- Current ICD-9 DRG reimbursement information
- Audit results
- Service line revenues
- DRG shift volatility from 1:1 to 1:Many and 1:0

A dedicated resource or team will compile this information and pull together the underlying strategy and plan for the ICD-10 documentation program. Sometimes an outside vendor is brought in to help with the prioritization effort. Adding this external perspective will usually bring in some type of industry-level trend information to help validate or inform which areas within the organization need the most attention. Once all of this information is compiled and assessed, chart review and physician education activities are organized in order of precedence depending on the risk findings.

While the theoretical approach has the most industry traction, there are clear challenges that have been brought to light by new thinking and emerging tools. They include:

- A heavy reliance on resources (internal or external) to compile risk information and develop outputs
- The risk of missing potential impacts because the evaluation process is manually driven and narrowly focused on a subset of a provider's data
- A lack of enough granular detail to make the risk information actionable
- A siloed view of the current ICD-9 world and future ICD-10 world
- No way to monitor the overall effectiveness of ICD-10 documentation efforts across the conversion timeline
- The tendency to misstate potential financial risk when calculated

Empirical Approach

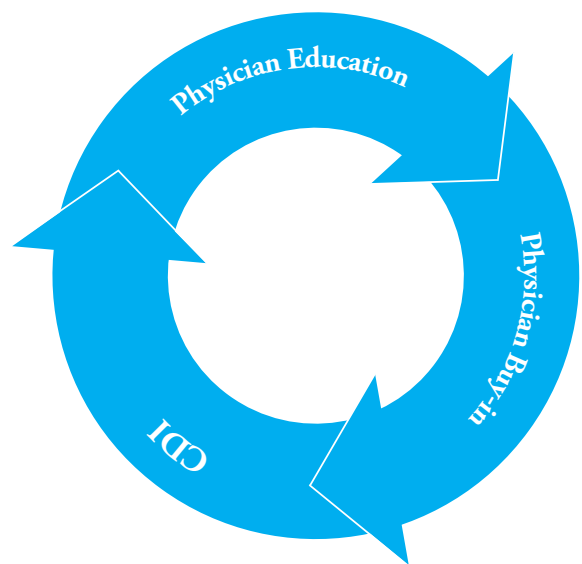
- Software driven
- Analyzes multiple years worth of data
- Determines risk based on statistical relevance and historical data patterns
- Provides granular detail into impacts including physician, coder, and codes
- Is repeatable across the conversion timeline to support dual coding and ICD-9 documentation improvement efforts

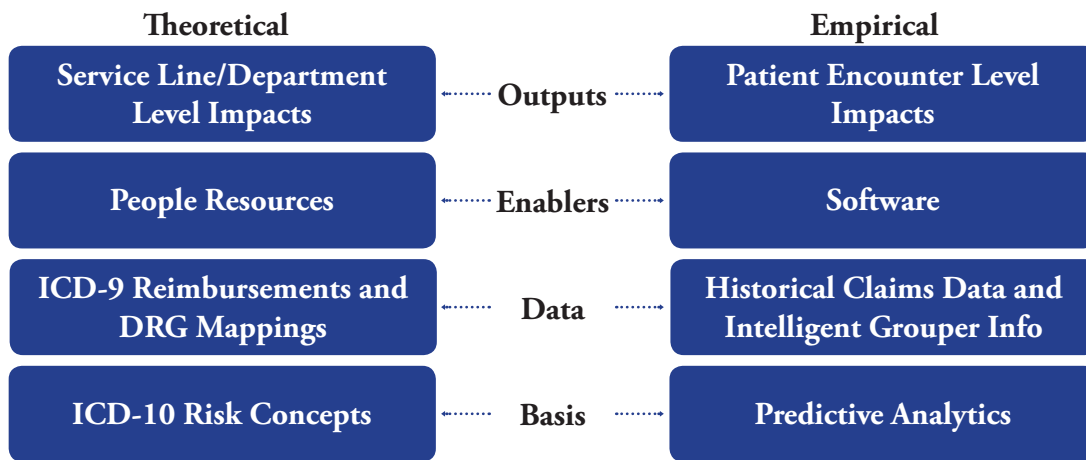
Leading facilities are looking to newer, software-enabled solutions that address the shortfalls in the theoretical approach while driving down cost and improving the quality of the prioritization effort.

The Empirical Approach

Advancements in the area of data analytics are helping ICD-10 documentation programs better focus efforts, engage physicians, and monitor program effectiveness. For the first time, capabilities like Big Data are being made available in an affordable way to providers. These technologies use advanced statistics to find otherwise hidden relationships. For ICD-10, this means that the historical and clinical context embedded within an ICD-9 encounter can be effectively accounted for and quantified in terms of ICD-10 risk.

ICD-10 software solutions have been developed based on these emerging analytic capabilities to deliver an empirical approach to ICD-10 documentation program prioritization. The process leverages machine intelligence (see side bar) to analyze a provider's claims information over multiple years and to calculate ICD-10's financial impact. Millions of claims can be processed within a few hours to deliver specific financial risk information down to the encounter level including physician, coder, and documentation/procedure code. The resulting outputs capture a provider's ICD-10 risk based on current processes more accurately, with greater granularity, and in a way that enables the more effective prioritization of ICD-10 documentation efforts down to the exact physicians who need targeted support.





Using the empirical approach to documentation prioritization, providers can quickly see the patient encounters tied to the greatest amounts of ICD-10 risk. This means that:

- There is a more refined and accurate view into the exact charts that need to be included within the documentation program
- ICD-10 program managers can better drive physician engagement by communicating the amount of ICD-10 financial risk associated with each practitioner
- Resources can be better allocated and budgets can be better managed

The outputs of this approach tend to be more focused, more accurate, and more reflective of current processes than the theoretical approach. Moreover, solutions that use the empirical approach can be used at multiple points along the conversion timeline to measure the effectiveness of ICD-9 documentation improvement efforts, dual coding, and ICD-10 education activities.

A Note about The Actual Documentation Review

The approaches provided above only apply to the prioritization of ICD-10 documentation programs—not the actual execution of documentation reviews. But the advantages of the empirical approach naturally extend into program performance. This is because the greater levels of granularity reduce resource demands

by better allocating reviewers. Instead of covering an entire department, resources can focus on the two or three physicians and relevant charts tied to the highest levels of risk. Education, dual coding, and native coding activities can all be better prioritized thereby reducing the need to hire external resources or backfill support.

But there is a “buyer beware message” for providers as they look to the market for an empirical solution. Not all analytics are alike. Many times vendors will pass off what is little more than a spreadsheet as a full fledged software tool. Before a provider selects a company to help with their ICD-10 documentation effort, they should ask the following questions:

What does the user interface look like?

Can I see it?

Is it an application, a series of spreadsheet models, or something else?

How is it deployed (cloud-based, installed locally, etc.)?

Is the analysis methodology transparent?

How easy are the tool and outputs to read/use?

What do the standard reports look like?

Does the software provide actionable recommendations?

Can we create custom reports?

How easy is it to customize the data that we see within the application?

Is there a charge for customized reports?

Are there graphs or is the information presented in more of a table format?

How easy is it to view the information in different ways depending on the end-user/consumer?

Is the support team easily accessible and responsive via phone or online?

Having the answers to these will help protect a provider from subpar solutions, false promises, and potential cost over runs.

For more information on Jvion, please e-mail us at contact@jvion.com or call us at 678.889.1842

Using the Empirical Approach to Create a Sustainable ICD-10 Program

We started by talking about ICD-10 as a documentation opportunity instead of a challenge. And, while the effort is daunting, there are significant long-term documentation benefits to the conversion including improved physician engagement, more effective clinical documentation improvement programs, and an enhanced organizational understanding of patient care and financial health.

Using the empirical approach to ICD-10 documentation prioritization, a provider can better identify the biggest areas of opportunity that will ultimately lead to greater benefits in the long-term. Think of it as the 80/20 rule. For any situation, close to 100% of the risk is concentrated in just 20% of the people or factors that are in scope. If you focus on the 20%, then you address most if not all of your risk while better leveraging your resources.

The same is true for ICD-10. The large majority of the codes pose very little risk to revenues or operations. Many of these can be easily converted and addressed through automated conversion tools and small updates to standards and procedures. However, there is a minority where the risk is high. These represent the biggest opportunity areas. If a provider uses the empirical approach, they can identify these areas and apply a laser focus on the associated processes, systems, documentation, and people. As a result, they can actually magnify ICD-10's reporting and trending capabilities over the long-term.

This thinking can be further extended to drive a more sustainable documentation program overall. It starts with early physician education. With the encounter-level risk metrics delivered through an empirical solution, physicians can see the exact dollar impact associated with their current documentation practices. An HIM director can demonstrate that, based on current charts

and the related coding, Dr. XX is associated with \$XX risk to reimbursements based on current practices. These metrics serve as a powerful communication tool that makes physicians part of the process and drives ongoing buy-in to documentation improvement efforts. Once physicians are on board, it is much easier to continue the documentation improvement conversation and create an environment of collaboration.

The same concepts can also be applied across all other clinical documentation improvement (CDI) activities. Because the empirical approach relies on software, analytics can be run quickly and cheaply. The solution provides access to close-to-real-time-data that delivers insights into potential denials, reduced reimbursements, and audits. Having this kind of analytic view can help a provider better allocate CDI resources so that they are performing chart reviews and making recommendations that align to the organization's risk. And physician education programs can be better tailored and focused enabling greater levels of compliance and retention.

So the same approach that helps to prioritize ICD-10 documentation programs can ultimately help support ongoing documentation efforts by providing a mechanism that drives physician engagement, focuses CDI efforts, and tailors education based on an organization's financial and operational risks. This better allocation of resources and time translates into a more sustainable and well-grounded documentation program, which ultimately helps improve patient care and the overall health of a provider.

What is Machine Learning?

Machine learning is a type of artificial intelligence that is used to train a system to learn from data and predict meaningful patterns. Based on complex algorithms, a machine can teach itself to become more accurate and relevant in the outputs that it delivers. While the concept sounds like science fiction, this capability has been around for years and used across the healthcare industry to detect fraud, recognize speech, and understand natural language. It's extension to ICD-10 will most likely continue as we harness the power behind the code set to understand and improve health outcomes.

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About the Author

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Surya comes to Jvion with more than 14 years of leadership experience in the healthcare consulting space. Before Jvion, he spent a majority of his career as a Senior Manager at Accenture in the Health and Life sciences practice. He was responsible for delivery of several transformational and IT initiatives architecting, developing and delivering complex solutions with large teams in the U.S. and offshore for large payor and provider clients. Surya is also Sun Certified Enterprise Architect and possesses unique skills to lead and develop innovative IT solutions. He is the Architect of Jvion's icdcomplete and is responsible for product engineering and client services. Surya is a very active member of the HIMSS and AHIMA organizations.

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