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Measure Twice, Cut Once

5 Biggest Lessons in ICD-10 Documentation Success

The ICD-10 transition is providing an unprecedented chance to improve clinical documentation. This is because the act of coding itself is driven by what a practitioner captures about the patient encounter. With the kind of fundamental change required by ICD-10, we get somewhat of a "do-over" to address current documentation gaps or lapses overlooked in today's ICD-9 world.

But taking advantage of this opportunity can be difficult. The conversion itself is daunting, hard to prioritize, and time consuming. Many are finding it difficult to address the needed updates to documentation practices. But the increased specificity in ICD-10 is forcing providers to include more detail and re-examine current processes to comply with the mandate, drive accurate coding, and ensure proper reimbursements. If not addressed, ambiguity and unspecified coding will expose providers to increased scrutiny from regulators, decreased revenues, and the potential for possible fraud/abuse allegations.

So what is a provider to do? We compiled the five biggest lessons learned to driving ICD-10 documentation success. In a nutshell, it comes down to understanding ICD-10 risk in a quantifiable way and then prioritizing activities accordingly. Just like building a house, a successful ICD-10 documentation program starts with measuring twice and cutting once.

1 Look to the past to understand the future

The best starting point for an ICD-10 documentation program is a historical claims analysis. By looking at past coding and reimbursement outcomes, a provider can understand where there are potential gaps and risks that will lead to productivity and financial impacts in ICD-10. But to find real, meaningful patterns, it is important to use the right analytic lens and apply it to at least one year of claims data. The better approach is to go for two or three years to truly capture trends that can be turned into action.

2 Get down into the detail

To deliver meaningful ICD-10 analytics you have to do more than a DRG-level analysis. A provider needs to examine each patient encounter to achieve the most detailed understanding of documentation gaps and opportunities. This is a huge task, which is why providers, more often than not, turn to advanced software solutions. The results take the analysis beyond codes to the practitioners and coders—the people—who are understanding, documenting, coding, and communicating what is going on with a patient. In doing this level of measurement, most providers find that the large majority of their current documentation and coding processes are just fine for ICD-10. It is the 10-20% that comprise the outliers, which really require focus and detailed attention.

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3 Prioritize by risk

With a clear understanding of the exact charts associated with high operational/financial risk and opportunity, a provider can take a laser focus to address documentation needs. Staring with an awareness of the exact potential impact associated with each code, a provider can concentrate efforts on the associated practitioners and charts. Having this level of detailed information also translates into more meaningful and engaging conversations with practitioners because they can see and quantify the potential impact that their documentation efforts have on the organization.

4 Fix what you can today

When analytics are done right, they lead to insights that not only help the future state of the organization, they also help improve how things are done today. In the case of ICD-10, encounter level analytics can lead to improvements in documentation and coding in ICD-9. Unspecified code usage is a great example. Many times there are alternatives in ICD-9 that help address potential impacts in ICD-10 AND drive improvements in the today's world.

5 ICD-10 documentation isn't a one-and-done activity

Documentation improvement is never "over." There are always opportunities to change, fix, and better what is done today. In the case of ICD-10, it is important to continually monitor documentation efforts all along the conversion process and thereafter. Whether through dual coding, testing, training or any other activity, having the ability to make changes and then see the potential impact of those changes is critical to driving documentation success.

When we say "measure twice, cut once," we are talking about a clear and data driven understanding of ICD-10 documentation risks and opportunities that enables the best spend of dollars and time. Taking this approach to the documentation challenge has saved organizations thousands and has led to a mindset that is rooted in actionable data and measured success across the entire ICD-10 conversion.

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About Jvion

Jvion is a healthcare technology company addressing the financial and operational impacts resulting from mandated reforms and compliance activities. We offer a suite of Big Data-enabled software solutions to:

- Reduce the financial impact and burden of the ICD-10 conversion
- Help providers protect their revenues by identifying and predicting clinical and financial waste areas

Jvion's solutions are powered by our proprietary Bonobo Big Data Platform™, which detects otherwise hidden patterns of risk. It is through these predictive modeling capabilities that we help hospitals reduce losses affordably and in a patient-centered way. This means that providers get to keep more of their revenues so they can focus on what they do best—deliver care.

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