Preparing for the ICD-10 Transition

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Agenda

• ICD-10 Code Set Training
  Now is the time
  Who needs training?
  How to retain the information?

• Clinical Documentation Assessments
  Why are they needed?
  What are the biggest problems?
  What are realistic goals?

• Clinical Documentation Training
  What should it cover?
  How much of a commitment is it?
ICD-10 Code Set Training

Now is the time

• We are one year away from being live on ICD-10

• Educational plans should be finalized, and, for large facilities, under way

• In order to work with physicians and other providers to assist in transition, the coders must understand the code set and guidelines
ICD-10 Code Set Training

Who needs training?

• Basically, everyone
  • Level of training will depend on job duties for the practice
ICD-10 Code Set Training

Who needs training?

• Coders/Billers
  • Full code set training is necessary in order to:
    • Code efficiently
    • Provide education
    • Appeal denials
    • Perform internal QA/audits
ICD-10 Code Set Training

Who needs training?

- Physicians and other providers
  - Type of code set training will depend on level of coding required

- Documentation improvement education specific to specialty, with general overview for other sections, may be all that is needed

- If physician/provider in family practice/internal medicine/pediatrics, may need full code set training
ICD-10 Code Set Training

Who needs training?

• Managers
  • Managers need an understanding of the code set in order to:
    • Keep a handle on productivity issues
    • Keep a handle on the A/R
    • Make budget decisions
    • Assess payer contracts
    • Make/update office policies
ICD-10 Code Set Training

Who needs training?

• Nurses
  • The more knowledge they possess, the more they can assist the physicians/providers

• Ancillary Staff
  • If they perform data entry only, an overview may be all that is necessary

• If they assign the diagnosis codes from an encounter form, more in-depth training will be necessary
ICD-10 Code Set Training

How can the information be retained?

• Documentation assessments for physicians and other providers on an ongoing basis

• Coding practice sessions for anyone involved in code assignment

• Dual coding on a continuous basis increasing as we get closer to “live” date
Clinical Documentation Assessments

• Prepared by running a report of your most frequently used ICD-9-CM codes now

• Charts are pulled from the reports and assessed for code assignment in ICD-10-CM

• Education and guidance provided from the findings can be performed internally or outsourced
Clinical Documentation Assessments

Why are they needed?

• Most direct way to show physicians and providers the difference between ICD-9-CM and ICD-10-CM

• Uses their own records

• Can concentrate on specific diagnoses, one at a time
Clinical Documentation Assessments

What are the biggest problems?

• Retention of new concepts that are not being used on a daily basis yet

• Documentation adjustments

• Out with the old, in with the new

• Frustration
Clinical Documentation Assessments

What are realistic goals?

• Depends on size of practice (number of physicians and other providers)

• At least top 10 diagnoses per provider
Clinical Documentation Assessments

What should it cover?

• Not code after code after code after code after code

• Driven to particular specialty, not everything for everyone

• The necessities of documentation to assign codes to the highest level of specificity
Preparing for the ICD-10 Transition

Clinical Documentation Assessments

How much of a commitment is it?

• Will depend on what “hat” the physician or provider wears
  • Physician champion/trainer needs the ins and outs of all areas from a documentation standpoint

• Other physicians and providers may need approximately four hours
Final Thoughts

- Prepare with documentation assessments
- Make adjustments where necessary
- Take advantage of educational opportunities
- Start now
Thank You

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