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## **ICD-10 – Clinical Documentation**

### *The Role of the Clinician in Capturing Accurate Data*

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## Health Information - Role of the Physicians

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Physicians view their primary role in healthcare as the evaluation and treatment of patients for whom they have taken on the responsibility for care. As physicians we have trained many years to fulfill this role, often to the exclusion of nearly any other role in the healthcare environment. Besides direct point of service patient care however, we do participate in a number of other important functions as key participants in healthcare leadership, population healthcare management, business operations, research, public health, health policy and a host of other important activities related to healthcare. While some may participate more directly in some of these activities, virtually all clinicians play a role either directly or indirectly in the broader aspects of healthcare delivery. We all have a responsibility to assure the continuous improvement of the quality, safety and effectiveness of healthcare delivery in this country.

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### UNDERSTANDING THE HEALTH OF THE POPULATION AND THE BURDEN OF ILLNESS

Physicians provide the primary source of healthcare information as a part of the process of caring for patients. This information is critical at the point of care as well as for the continuum of care of patients across time, conditions and providers. It is also critical to monitor the effectiveness, safety and quality of care of populations. Without high quality information, we have no visibility into what works and what doesn't work. While we may take pride in the quality of research done in controlled studies within institutions, we are lacking in our ability to fully understand healthcare delivery in this country across providers, payers, population and regions. The only significant data that we have that is standard, universal and interoperable across organizations is claims data. There are general concerns from physicians that claims data is not reliable to evaluate healthcare, nonetheless, it is the only information that we have about healthcare delivery that crosses industry boundaries.

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### DO WE REALLY PROVIDE THE BEST HEALTHCARE IN THE WORLD?

We often hear the statement that we provide the best healthcare in the world. There is little doubt that we provide the most expensive healthcare in the world, since we do have reliable data about what is spent. But is it the highest quality or the most effective or efficient? How safe is what we do?

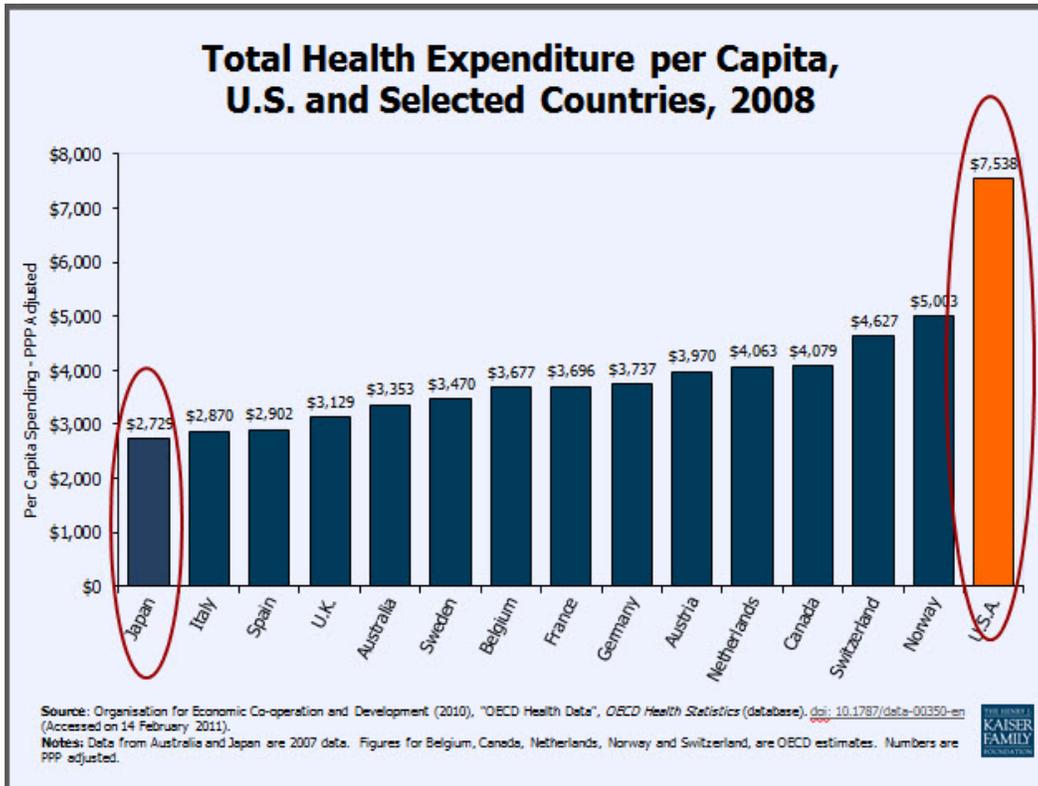
Based on spending and analysis of healthcare spending published by the Kaiser Family Foundation<sup>1</sup> looking at 2008 data We spent 16% of the GDP or about \$7,500 per capita for healthcare as compared to Japan which spent 8.1% of their GDP or about \$2,700 per capita. In addition Japan has universal healthcare while we have 48 million uninsured. It's projected that by 2020, health care expenditures

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<sup>1</sup> <http://www.kff.org/insurance/snapshot/OECD042111.cfm>

will approach 20% of the GDP<sup>2</sup> with no assurance that we will solve the uninsured problem.

As illustrated in this Graph:



Despite this large difference in expenditures, Japan ranks first in terms of average longevity while we rank 38<sup>th</sup>. Infant mortality in the US is 3 times the infant mortality in Japan. Without reliable detailed information on what is done for patients and why, we can't understand how to improve the quality, efficiency, effectiveness and safety of healthcare in this country.

#### WHY DO WE LACK RELIABLE HIGH QUALITY DATA?

Most physicians, and for that matter most payers don't view claims data as an important source of healthcare information. For physicians, coding of data is considered a necessary evil that they believe is a burden and detracts from patient care. They don't see the value of the data produced from the transaction about what they did and why. Most other industries do a far better job at producing reliable data based on standard business transactions. Data captured at the point of

<sup>2</sup> From the Office of Actuary (CMS) – Published by Health Affairs – July 2011



service as a part of the restaurant encounter can reliably drive key business processes like staffing, ordering stock, developing menus, and understanding what works and doesn't work for customers. It is unfortunate that we can rely more on the standard transaction data from our encounter with the local restaurant than we can on the standard transactional data from a healthcare visit. Payers should demand the same level of data accuracy in the claim transaction that any other purchaser should demand of any other vendor in other industries.

## Patient Assessment and Documentation

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It should be obvious that standard, universally reliable data on patient's health conditions and the nature and cost of the services that are intended to improve or maintain those conditions is a requirement to understand and improve healthcare. Getting to the right code to reflect as accurately as possible the nature of that condition and treatment is critically important. Proper coding however depends on complete and accurate assessment and documentation. The best trained coders can only code based on the documentation available to them. Only the physician is trained and licensed in diagnosis and treatment. There is a dependence on the clinician to assess, and document all relevant medical concepts accurately in order to lay the ground work for good data.

As we move to ICD-10, there is an opportunity to significantly improve our ability to capture key parameters of healthcare including, risks, comorbidities, complications, severity, causation, manifestations and other key factors needed to measure healthcare delivery. This opportunity will be lost however if the documentation and coding is not at a level of quality to provide accurate data about what was done and why.

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### DOCUMENTATION – AN ADMINISTRATIVE BURDEN OR JUST GOOD PATIENT CARE?

A frequent complaint heard from providers is that the requirement for documentation to support ICD-10 coding is an “unnecessary administrative burden”. If we look closer at the types of documentation needed to support proper coding in ICD-10 however, the required documentation is an important part of good patient care. If we look at any of the following requirements to support ICD-10 coding, it would be hard to state that the information was unnecessary or an administrative burden.

- Laterality – left, right, bilateral or unilateral
- Trimester of pregnancy and weeks of gestation
- BMI calculation in Obesity
- Which finger, and which level in a finger amputation
- The type of surgical approach for procedures
- The severity of seizures



- The severity of retinopathy or renal disease in diabetics

These examples represent a small sampling of the types of documentation needed for ICD-10 based on different types of conditions. In each case however, this information is needed for good patient care and should be documented regardless of coding requirements.

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*It's hard to claim that documentation required to support ICD-10 coding is unnecessary or represents a burden over what we should be doing today.*

***It's just good patient care.***

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## **Documentation, Coding and the Changing Healthcare Landscape**

There is little doubt that the healthcare landscape is changing. This is driven by a number of factors:

- Dramatic changes in the economy
- The unrelenting increase in the percent of GDP that goes to healthcare
- The continued growth in the uninsured or underinsured population
- The challenge in our ability to compete internationally due to the financial burden of the cost of healthcare services as compared to other nations
- The ongoing concerns about quality, effectiveness and safety
- Billions lost on fraud, waste and abuse.

These factors are key drivers in proposed changes in the direction of the healthcare delivery and financial model that includes:

- Information driven healthcare
- Evidence based medicine
- Value based purchasing
- Episodes based or risk based payment models
- Accountable care
- Increasing focus on patient safety
- Focus on admissions that are potentially avoidable
- Focus on conditions that were not “present on admission”
- Audits and recovery of “inappropriate” payments
- Aggressive focus on fraud, waste and abuse

There is definitely a sense that healthcare spending is out of control. There is also a sense that the data we have to understand healthcare cost, quality and effectiveness is inadequate. There is little doubt that reforming healthcare must be driven by reforming the quality of the information that we have about healthcare.



## Strategies for Engaging Clinicians in the Dialogue

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The biggest challenge in improving the existing landscape of clinical documentation is engaging the clinicians that create that documentation. Many clinicians view documentation as a burden and interfering with care. While documentation is a critical part of caring for patients, it is often relegated to the “unimportant”. Engaging clinicians requires a specific strategic approach. The following are recommendation to improve the level of engagement:

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### DIRECTLY CONFRONT BARRIERS TO CHANGE.

Clinicians have raised a number of issues around the burden of ICD-10 and why they should just be left to focus on good care. It is important to emphasize that good documentation is a requirement to good patient care and that virtually all documentation required to support ICD-10 is documentation need to support care of patients with those conditions.

Many other barriers to change have been voiced related to the number of codes, complexity, unnecessary (silly) codes and a host of other challenges. In a prior HDC paper<sup>3</sup>, *ICD-10; The Case for Moving Forward*, written on behalf of the Advisory Board Company, some of the challenges and the case for moving forward are addressed. The talking points in this paper may be helpful in addressing some of these barriers posed by clinician

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### ENLIST PHYSICIAN CHAMPIONS

Physicians respond best to their peers. Unfortunately educational efforts by other qualified subject matters experts can be discounted by physicians and it often takes a clinician to go head to head on challenges and questions raised by other clinicians. These physician champions will need to be well trained in ICD-10 and the clinical documentation needed. They will need to believe in what they are championing and be able to present the necessity and value of good documentation and good data to their colleagues. These champions may require mentoring by others to help them be successful. Talking to physicians is tough and you need all the support you can get.

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### ELEVATE THE DISCUSSION

Raise the level of the discussion to healthcare delivery on a higher level than the level of the single instance of a patient encounter. Establish the case for better healthcare for all, based on better information about the delivery of care. Discuss the importance of the clinician in the healthcare debate and how their leadership

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<sup>3</sup> <http://healthdataconsulting.com/resources/white-papers/>



will ultimately mean a more effective system based on better evidence. Discuss that without clinician input we will continue to have policies and guidelines that don't make sense from the clinician and patient perspective. Lack of participation by clinicians does not mean the train of health care change will not move forward, it will just move forward without them.

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#### FOCUS ON CARE FIRST AND CODES SECOND.

Most clinicians have no real interest in codes. Their focus is on good patient care, as it should be. Nonetheless, good patient care includes good documentation and if documentation is complete then good coding should follow. If the focus of documentation is on patient care rather than coding requirements, clinicians are more likely to be receptive to the message. While the connection between documentation and proper coding should be made and illustrated, coding is not the driver in the mind of the clinician. Much of the current training available around ICD-10 is coding centric and is not aligned well with the clinician's way of thinking. AAPC (the American Academy of Professional Coders) and other organizations are rethinking their approach to training clinicians around ICD-10 coding and the clinical documentation to support ICD-10, that takes into consideration the different perceptions of clinicians in this area.

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#### ESTABLISH VALUE

Physicians and other clinician struggle to see the value in this migration from ICD-9 to ICD-10 and the documentation required to support this change. It is important to show how ICD-10 and good clinical documentation is important for them, their patients and health of the population in this country. In a prior HDC paper<sup>4</sup>, *ICD-10 – Advantages*, some advantages of ICD-10 are outlined. The clinician must at some point see what's in it for them and their patients.

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#### DEFINE THE VISION OF BETTER INFORMATION IN A VALUE BASED, ACCOUNTABLE CARE ENVIRONMENT

We know that fiscal constraints and the concern about escalating cost are huge drivers in the national debate around healthcare. Costs must be constrained. This constraint should not be a blunt ax, but rather a precise surgical management of service utilization. Key information around risk, complexity, comorbidities, complications, sequela, safety, effectiveness and a host of other analytic metrics is essential to provide a more rational management of healthcare and allocation of limited dollars. In this new environment, payment models will change and accountability will increase. The physician will experience these changes in payment

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<sup>4</sup> <http://healthdataconsulting.com/resources/white-papers/>



adjustment, recovery audits, pay for performance models, quality and effectiveness measures that drive program inclusion or exclusion. Risk of scrutiny in an environment focused on fraud, waste and abuse will increase the need for accurate coding and documentation to support that coding. Providers, as part of an Accountable Care Organization (ACO), may take on the financial risk of care where accountability for cost becomes a significant issue for them directly. There is little doubt that the extended vision of healthcare delivery is focused on healthcare information that will drive all aspects of healthcare delivery moving forward.

#### UNDERSTANDING DOCUMENTATION PATTERNS

Though ICD-10 has thousands of new codes, it isn't because we have thousands of new disease entities. Part of the reason for the increase in the number of codes is that new details of conditions have been captured, but a larger reason for this increase is the fact that these codes are "combination" codes with many healthcare concepts included in a single code. Because of this we see codes that repeat based on only one recurring concept.

For example, of the 69,000 ICD-10 codes, over one third are the same with the exception of the concept of "right" vs. "left". Considering that most of these codes also have an "unspecified side" option, the ratio is even higher. It is this repeating pattern that results in a repetition of many codes that are the same except for one or two concepts. As another example, for every acute fracture code there is a code for "initial encounter", "subsequent encounter" or "sequela". If the encounter is a subsequent encounter, then for each fracture there is a code for "routine healing", "delayed healing", "malunion" or "nonunion". Just looking at the number of repetitions, it is easy to see why there are so many codes. Understanding these recurring patterns is important to identify those concepts which require documentation and the number of codes they impact. The following table illustrates some examples of these concepts and the number of time these concepts are referenced in ICD-10

Concept	Number of codes Impacted
Acute or chronic	1764
Open or closed	10,893
Routine healing, delayed healing, nonunion or malunion	11,290
Right or left	25,230
Initial encounter, subsequent encounter or sequela	47,223

Understanding patterns can help focus documentation efforts to those areas that are common recurring concepts in these codes.

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#### CLINICAL DOMAIN FOCUSED

Different physicians in different specialties see different clinical conditions that may be limited to a more specific clinical area. These clinical domains will be commonly evaluated and managed as a normal part of their practice. Each of these clinical domains is very different in the type of documentation and coding requirements. The musculoskeletal area for example accounts for over 50% of the ICD-10 codes while other areas may be represented by far fewer codes and fewer changes from the current coding pattern. Each area has its own new documentation requirements to support the new ICD-10 codes in these clinical domains. Education around these documentation requirements should be focused around the clinical domains relevant to the clinician.

### Summary

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ICD-10 provides an opportunity to capture much better information about the nature of healthcare conditions and the institutional procedures done to improve or maintain those conditions. A clear definition of the patient's health state however is dependent on accurate and complete documentation of the important medical concepts assessed by a trained clinician as part of the patient encounter. The requirement for documentation that supports this new coding system should not be a burden since the documentation of these concepts required for ICD-10 coding are in almost all instances important in the management and care of the patient.

Engaging clinicians requires recognition of their perceptions about how they view their role in healthcare. Understanding these perceptions is critical to improving the quality of healthcare data that we rely on to understand and improve healthcare delivery.