Case study

Kick off your ICD-10 implementation the right way

Managing the changeover to ICD-10 may be so completely overwhelming for some HIM directors and managers that just getting started is the most difficult part.

According to a poll conducted during the January 28 HCPro audio conference, “ICD-10 in 2011: Your Road Map to Successful Implementation,” many hospitals are, in fact, just beginning their efforts.

One-quarter of attendees are still trying to convince their organization’s leadership that ICD-10 needs attention. Another 25% are still working to form a steering committee.

Less than 5% consider their implementation efforts well under way and anticipate having no problems being ready when ICD-10 takes effect in October 2013.

The good news is that, although there is still much work to be done and nearly everyone is only just getting started, HIM can use this as an opportunity to really shine.

Deborah C. Beezley, RHIT, director of HIM at St. Anthony’s Medical Center in St. Louis, who spoke during the audio conference with Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, chief operating officer of First Class Solutions, Inc., in St. Louis, said that her HIM department will serve as the project lead for ICD-10 implementation.

Beezley said it is a tremendous advantage for the department to head up such a significant effort.

And she’s ensuring that everyone in the department has a chance to get involved.

“We’re using this opportunity as a team project so all can participate in some way, be it through research, implementation efforts or integrated testing, or a variety of other tasks,” Beezley said.

In fact, there are so many tasks that many HIM directors and managers may not know where to begin.

Develop an executive summary

At St. Anthony’s, Beezley began with a road map, an executive summary, and a kickoff meeting.

She distributed the executive summary prior to the meeting. This document really helped in terms of receiving senior-level support.

“It delineated our ICD-10 implementation strategy and included an outline—probably of about 10 pages—of our ICD-10 road map to go-live,” Beezley explained.

“It was an opportunity for senior leaders to review in advance what was coming down the pike.”

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ICD-10 implementation

In her summary, Beezley included:
➤ The reason the change is necessary
➤ An overview of worldwide ICD-10-CM/PCS usage
➤ The benefits of ICD-10-CM/PCS
➤ A brief explanation of CMS mapping and General Equivalency Mappings
➤ An implementation strategy with defined phases
➤ A road map for implementation
➤ A few ICD-9/ICD-10-CM/PCS code examples

Hold an effective kickoff meeting

The executive summary also served as the basic agenda for the kickoff session. The idea is to begin to stimulate thoughts for those who will soon be members of the steering committee, Beezley said.

During the meeting, she and her HIM team covered the following points:
➤ Introduction. Beezley started off with a basic review of the objectives.
➤ Reason for change. Beezley said that she found it best to keep this as simple as possible, but during this section of the presentation they covered topics such as the lack of specificity and detail in the ICD-9 codes, as well as the outdated terminology and disease processes.
➤ Worldwide usage. This information was important to include, Beezley said, as it served as an eye-opener for most of those present at the kickoff meeting. “They really had no idea how many countries worldwide have ICD-10 in operation, from Canada to Australia,” she said.

Questions? Comments? Ideas?

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Medical Records Briefing
Benefits of ICD-10. “We spent a fair amount of time defining the reason for change and the benefits of ICD-10,” she explained. “It was amazing during this kickoff meeting to see how many of these ancillary and support department directors were totally unaware that this change was going to be occurring.”

Stakeholders and tasks to accomplish. “The tasks go on and on,” Beezley said. She provided a specific list of tasks and the stakeholders. “That gave them a better understanding of the multidisciplinary nature of the effort.”

HIPAA 5010. Beezley explained in simple terms how 5010 impacts ICD-10 implementation.

ICD-9 and ICD-10 differences. This was very beneficial, she said, because “people could see it and it became more real.”

Mapping/GEMs. Explain this in the very simplest terms—to the extent possible, Beezley advised.

Impact on outpatient and ancillary departments and urgent care clinics. Discuss how the change will affect them, what they can expect, the training their staff members will need, and how HIM will help them during the transition.

Other considerations. These include:
- Simultaneous efforts to become electronic. “With EHR implementations going on across the country right now, many facilities have really limited information services (IS) resources, so planning well ahead of time is absolutely vital as IS is a key part of this effort,” Beezley noted.
- Budget needs. For HIM, this includes everything from staffing levels (e.g., increased coding staff) to education (e.g., anatomy and physiology, ICD-10 fundamentals) and even the cost of one or more years of new coding manuals, Dunn said.
- Education and training. Many individuals need exposure to ICD-10 education above and beyond a general orientation, and this goes far beyond HIM department staff, Dunn advised.
- Dual systems. Make sure that your use of dual systems doesn’t negatively affect revenue and reporting, Beezley said. St. Anthony’s anticipates using dual systems for four to six months.
- Vendors. This includes partnering and timeliness of response. Beezley warned this could take two to three years to accomplish.
- Complexity of mappings. “This will only magnify over time,” she noted.
- Impact on metrics, quality, decision support, research, reimbursement, compliance, risk, and outside data transfers (e.g., infection control).

Road map for implementation. Beezley presented the HIM team’s overall road map for go-live. “It’s very fluid … it’s going to change. We’re going to have additions and deletions, and those can occur at any time,” she explained. “But you need some kind of direction with overall strategies.” The road map was their starting point. (To see the overall road map Beezley developed for her organization, turn to p. 4.)

Project team. Dunn recommended using an existing revenue cycle team as a base group of people and then adding to it as necessary. “Just supplement it with

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additional members that you believe are necessary to pull this off,” she said.

➤ Next steps. Here, Beezley suggested starting small. For example, begin designing a road map if you don’t have one already. In addition, define your hospital’s stakeholders and form a project team. You should be scheduling a first meeting in early spring. Beezley also recommended beginning to meet with hospital outpatient departments in early 2011, and that IS should start to conduct a system inventory and formally define where changes and upgrades are necessary. Finally, begin making what will be an ongoing list of issues that could be problematic, and develop action plans to resolve them.

Beezley provided everyone with contact information of HIM staff who would serve as contacts for the project, including herself and two other staff members, to provide support and answer questions.

Above all, remember that although things will change, you need to set target dates for when tasks must be completed, as well as assign responsibility for those tasks, said Beezley.

“And continue to stress the impact of not meeting the deadline, which is that claims are going to be rejected as of October 1 [2013],” she noted. “And that’s the bottom line.”

Editor’s note: For more information on St. Anthony’s Medical Center’s approach to ICD-10 and what you should be doing in 2011 to prepare for October 2013, a recording of the audio conference “ICD-10 in 2011: Your Road Map to Successful Implementation” is available on HCPro’s Healthcare Marketplace at www.hcmarketplace.com/prod-9343.

2011 (Phase 1) to-do list

Source: Deborah C. Beezley, RHIT, director of HIM at St. Anthony’s Medical Center in St. Louis. Reprinted with permission.
This month’s idea

Spread the word about physician legibility

Legible.
Complete.
Dated, timed, signed, and authenticated.

That’s what section 482.24 of the Medicare Conditions of Participation requires of your medical records.

But many hospitals struggle to achieve compliance in this area. And falling short doesn’t just affect quality and patient care. Consider the financial effects; auditors can deny claims when orders are missing signatures or documentation is illegible.

Legislation behind legibility

Consider that, per the March 10, 2010, CMS Transmittal 327, “If the signature is missing from an order, [auditors] shall disregard the order during the review of the claim.”

Can your hospital afford to lose reimbursement?

Patti Reisinger, RHIT, CCS, HIM director at Community Medical Center in Missoula, MT, is making an effort to increase compliance with signature and legibility requirements, especially in light of the recent audit activity she has seen on these issues.

For example, Community Medical Center received medical record documentation requests from CMS auditors containing the following language:

Legible physician/clinician signatures and credentials for services provided. Signature logs and attestation statements should be submitted when physician and/or clinical signatures are illegible.

The hospital has also recently undergone a few Comprehensive Error Rate Testing (CERT) audits for missing lab signatures.

Ideas to consider

Reisinger is taking a multifaceted approach to reducing illegibility at her hospital. Consider a few of her suggestions:

➤ Spread the word through a physician newsletter. Reisinger recently submitted a piece to the hospital’s physician/clinician newsletter on legibility, in which she included examples that were not exactly easy to interpret. (See p. 6 for the article and samples she used.) The newsletter was well received, says Reisinger, although the providers who had written the printed snapshots were very confident that their documentation was readable. However, she had received the specific examples from coding staff members who were unable to read the handwriting.

➤ Get your chief medical officer (CMO) involved.

“Work with your chief medical officer to deliver your message to the medical staff committee,” Reisinger says. She has also worked with her CMO to discuss the issue and brainstorm solutions during her hospital’s medical executive committee meetings. For example, they’re currently discussing whether to give additional physicians printed rubber stamps with their names to clarify signatures, or asking—though not yet insisting—that physicians print their name underneath their signatures.

➤ Take a one-on-one approach. Reisinger says having one-on-one conversations with physicians is very important and can be especially helpful if you use the time to show specific examples. She admits it may not be possible to meet individually with all clinicians at larger facilities and organizations, but because Community Medical Center is a smaller hospital, she is able to have the discussions and has seen how helpful they can be.

In addition, to help track the physicians’ progress on this issue, all of the inpatient nursing departments at Community Medical Center conduct audits for legibility and signatures. Each department reviews approximately five records per week.
Can you read what you write?

Until we implement the EHR, we are faced with the challenge of handwritten documentation of our medical records. Joint Commission and CMS both require entries in the medical record be legible.

Illegibility of documentation has several implications.

Risks to patient care. Illegible entries can lead to misunderstandings or transcription errors and serious patient injury. As most of you have read in journals across the healthcare continuum, medication errors are the leading cause of preventable errors.

Legal implications. The patient record may be the most important piece of evidence in defending a claim when your or the medical center are involved in litigation. Our case could be weakened when we are not able to support the facts because the information within the record is not legible. Because of the time lapse of the patient care and when the cases are typically held, the only memory of what actually occurred is in the body of the medical record.

For fun, I’ve attached samples of actual handwriting from our medical records – can you read what you wrote?

Source: Patti Reisinger, RHIT, CCS, HIM director at Community Medical Center in Missoula, MT. Reprinted with permission.
The lost art of data integrity

by Darice M. Grzybowski, MA, RHIA, FAHIMA

Somewhere between the third urgent item on your to-do list, getting your budgets prepared, and responding to the latest auditor’s requests lies the omnipresent responsibility of nurturing the validity of the medical record. HIM professionals have traditionally been the legal custodians of the record. (After all, who else is daring enough to testify in court on the accuracy of the EHR?) Have we also by default become the custodians of data integrity?

Defining data integrity

Data integrity can mean different things to different people. When looking at the content of the medical record, integrity is described as complete, compliant, and current documentation. When clinical documentation has integrity, it provides meaning to those who read the record for patient care. It provides clear, concise information for billing or other decision support activities for those who abstract data from the record. Enemies include illegibility, omissions in data, and late documentation. Integrity issues affecting work flow are a different problem. This type of integrity, the focus of this article, is used to locate a record, access information, and manage processing, release, and coded information. Data integrity issues typically arise from a variety of root causes:

➤ Poor system functionality and design (e.g., inadequate screen flows; inability to identify, manage, or correct errors; lack of edit checks)
➤ Carelessness and lack of staff accountability—sometimes caused by overzealous focus on productivity and turnaround times
➤ Lack of adequate training or understanding of systems or processes
➤ Poor interfaces or integration of data, causing redundant or error-laden data
➤ Lack of definitions causing inconsistent data entry, documentation, or reporting

These errors have become so common in our everyday work, we tend to grow numb and unfortunately accept them as expected outcomes!

Data integrity as a mission

When looking at the information flow around the core medical record, one often thinks of the accuracy of data from the point of registration forward. We all are familiar with GIGO (garbage in, garbage out), and in the past few years, I feel we’ve allowed and even tolerated a considerable amount of “trash” to enter into our computer systems and daily work flow.

Whether it’s a duplicate medical record number, an erroneous verbal order or patient type/status, or other error, we begin to process these events as a routine part of our daily activities rather than try to resolve the problem or process creating the issues. In some cases we even devote full-time staff to cleaning up these errors.

As HIM professionals, we are acutely aware of these errors because of the heavy toll they extract on our staff and the decrease in productive hours when normal work flow is disrupted. HIM staff often become the cleanup crew instead of serving as true data integrity auditors, advisors, and champions of data quality.
Data integrity

We are so busy with the day-to-day activities of managing, processing, and reacting to problems that many of these issues continue to exist and errors continue to accumulate, some of which are simply ignored.

A case in point: I recently became aware of a policy that a facility put in place due to a popular EHR system’s inability to allow caregivers to correct erroneous orders and document that correction as an amendment. Instead, the EHR forced users to cancel the order (even when already carried out) and issue a new one in its place—one that obviously wouldn’t be carried out since the patient was already discharged!

We need to ask ourselves why systems like this, which have a dramatic negative effect on our data quality, are allowed to be implemented in our facilities with these types of problems. I believe it stems from the following:

➤ HIM is not adequately participating in the system selection and functional requirements process (see the October 2010 MRB), so uneducated or untrained staff decide to implement poorly designed systems.

➤ Adequate work flow test cases were not designed or used prior to a system go-live.

➤ We accept system vendor weaknesses and inability to fix problems and develop workarounds rather than insist on remediation of the issue.

➤ The culture is so politically correct that a problem fix, particularly one involving the medical staff, is avoided.

➤ We have lost the mission of protecting the sanctity of the legal health record and quality of data. It’s no longer a priority, as documentation becomes fragmented in an EHR that may not have been designed to manage documents so much as test results or orders.

Data integrity starts at the top

To foster a culture of accountability (i.e., error prevention and doing things right the first time) and data quality, the mission must be embraced at the top of an organization and filter down to the core staff level. This might mean you need to take the following steps:

➤ Identify problem areas where data integrity errors occur. To do so, assess your daily work flow and key indicators that help trend problems over time.

➤ Create a data integrity officer. Nothing is more expensive to a hospital than labor. But devoting time to identifying and preventing errors is a good use of it; devoting resources to fixing repeated errors isn’t.

➤ Embrace process improvement through best-practice identification and gap analyses. Whether using Lean Six Sigma, process mapping, or another work flow improvement technique, it is critical to understand what is best vs. current practice.

➤ Hold staff, vendors, and clinicians accountable. If any one of the groups lets personal preference trump protecting data integrity, the system is at risk of collapse.

➤ Ensure that there is at least one individual whose sole responsibility is to identify, assess, recommend, and facilitate changes to promote data integrity.

Data integrity has always been central to quality documentation in the paper record world. As records become automated and are more intensely complex and interoperable through sharing of data at various levels, the integrity of those data becomes more important. HIM must be diligent in supporting quality from the point of record creation to permanent archival and retention.

Data integrity is as much an art as it is a technical skill. To protect it, get involved in system design and testing, ensure that integrity remains a priority, and above all, drive accountability for decreased errors organizationwide.

Editor’s note: Grzybowski is president of HIMentors, LLC, which focuses on HIM operations, education, best practice, EHR/EDMS implementation, legal health record management, and the provision of strategic marketing services for physician-owned practices, hospitals, and healthcare technology vendors. She is a nationally recognized author, speaker, and expert in automation in healthcare and data management. For more information, go to www.HIMentors.com or e-mail info@HIMentors.com.
Get started on CPOE implementation

by Kristin McCabe

If you are gearing up for a computerized provider order entry (CPOE) implementation, there are some tips and tricks that will help you stay on top of the transition.

First and foremost, a project of this magnitude requires a dedicated core team to plan and carry out a successful implementation. At the core level, team members must have the time to devote to the project and all of the work necessary to implement a functional system.

An ideal CPOE core team includes the following:

➤ **Project manager (PM).** The PM’s job is to identify the critical steps in the implementation process and to keep the project moving. He or she is also in charge of project details: Are we following the project plan? Are we sticking to our timeline? Are we keeping to our budget? How do we promote CPOE? The PM will have his or her hands full managing the details.

➤ **Team leader.** Every good PM needs a sidekick. Call this person what you will—team leader, manager, specialist, expert—it doesn’t matter. He or she needs to know the system inside out and backwards. Where the PM is concerned about the project as a whole, the team leader should dive into the software. This person needs to know the system and its integration better than anyone. He or she needs to know a little about everything and must set aside loyalties from any past work as a nurse, pharmacist, or software junkie. This person is in it for the physicians and physicians only.

➤ **Physician champion.** Where would CPOE be without a physician champion? Unfortunately, it is hard to find one that is 100% devoted to the project; therefore, you can adjust your plan so that your physician champion is only pulled in when decision-making is crucial. While you can excuse the physician champion from most first-round meetings, he or she should have a hand in most project decisions. The physician champion’s input is crucial, and his or her decisions will be a direct reflection on how software functions after it is live. Ultimately, the physician champion will become the poster child for CPOE at your facility.

➤ **Pharmacy analyst.** A pharmacy analyst will play a key role. Most software companies have a disconnect between their pharmacy module and CPOE functionality. It is the pharmacy analyst’s job to review all medications in their current formulary, rename them using physician-friendly terms, and write order sentences to allow ease of use for physicians when they order medications. Keep in mind that there are thousands of drugs on the pharmacy formulary, and every drug needs to be touched, tested, and reviewed at least once.

➤ **Nurse representative.** While this is a CPOE project, nursing representation is vital. This representative should most likely be a nurse informatics team member. Some organizations recruit nurses who may be on medical leave to fill this position. Nurses are essential to capturing work flows, as they have a hand in just about everything done with their patients.

➤ **Training coordinator.** A training coordinator will come in very handy when you go live. This person’s main responsibility is booking rooms for training, gathering training material, putting together a training schedule, and getting everyone trained. And once all that hard work is done, the training coordinator needs to be able to staff a drop-in center or stand in on a training class for someone who couldn’t attend.

➤ **Analyst/worker bee.** Finally, an analyst is needed to help with the order entry details. The analyst serves as a worker bee; he or she knows how the system works and, hopefully, why it was built as it was. The analyst’s knowledge of the current system helps drive future decisions made by the CPOE team. His or her ability to understand the ins and outs of the system makes this person an invaluable resource when it comes to building and tweaking orders in the system.

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CPOE implementation  < continued from p. 9

Once you establish which roles are needed on your core team, start filling them. Each department will need to be involved in the project in one way or another.

The first steps

Once you have your core team assembled, it’s time to make sure all the other pieces are in place. If you’ve done any major projects in your healthcare system in the past, you know how important it is to have a governing body to turn to when decisions need to be made.

Many hospitals form a CPOE steering committee to guide the project in the right direction. This committee should be rich in hospital resources, and its members should be the key stakeholders for the project. The project must have a voice from within the hospital walls. You can say it 100 different ways, but it is essential to the success of any CPOE implementation that the project is a hospital initiative and not an information services initiative. And as this is a physician order entry project, you need to have a strong physician voice on your side.

It is important that you get the word out that CPOE is coming. A good marketing campaign starts early and presents itself often. The change from pen to computer is not always welcome, but if marketed correctly, physicians will see that CPOE is the safe way to go.

Work flow documentation

Begin documenting work flows as soon as you can. Even if your project or project team is off to a slow start, you can always document what is going on. Always have a member of the nursing staff and, if possible, a unit secretary available for meetings. It is also helpful to create a list of departments that you would like to meet with and the key contact person for each.

Uncover all the little nuances that make departments unique. Within each, uncover and document what a day in the life of a physician order looks like. Start with the basics. A physician handwrites an order, then what?

Once you are ready for your future-state work flows, it’s nice to have the same team members present to hear how their work flows might need to shift to make the physicians’ work flows a little smoother. This is easier said than done, but definitely worth the struggle up front rather than seeing departments break down at go-live. The more prepared you are in advance, the fewer surprises come your way on the go-live date.

Tips and pointers

To be successful on go-live, you must know how your hospital was successful prior to it. Note the issues the hospital struggled with prior to go-live to ensure that CPOE is not blamed for previously existing issues.

That said, you can guarantee that switching from paper to electronic will uncover any process issues that exist, whether they are the result of processes not currently followed or processes missing altogether. Regardless of what you uncover, stay on track with your timeline. If you are having a work flow meeting with the ED staff and they realize they don’t have a written policy on nursing staff initiating protocol orders, there’s no reason to stop the meeting because of a missing policy. Document what is happening, not what should be happening. Form a subcommittee to deal with the missing policy at a later time. Place the onus on the department that uncovers the problem to work together to improve the issue on its own.

Remember, the more user-friendly your system is for your physicians, the smoother go-live will be.

Implementing CPOE will not be easy, but with preparation and resources, you are well on your way!
Quiz: Know the ICD-9-CM neoplasm codes

Use this quiz to test staff members’ knowledge of coding for neoplasms.

1. Which ICD-9-CM code should a coder report for a benign neoplasm on the shoulder?
   a. 170.4
   b. 170.5
   c. 216.5
   d. 216.6

2. Which ICD-9-CM code should a coder use to report Hodgkin’s sarcoma of the lymph nodes of the neck?
   a. 201.11
   b. 201.12
   c. 201.21
   d. 202.01

3. Which ICD-9-CM code should a coder report for a malignant neoplasm of the hard palate?
   a. 141.5
   b. 145.1
   c. 145.2
   d. 145.5

4. Which ICD-9-CM code should a coder report for acute exacerbation of chronic monocytic leukemia?
   a. 206.0
   b. 206.1
   c. 206.8
   d. 208.1

5. Which ICD-9-CM code should a coder report for carcinoma in situ of the liver?
   a. 211.3
   b. 211.5
   c. 230.3
   d. 230.8

6. Which ICD-9-CM code should a coder report for a benign neoplasm of the breast?
   a. 217
   b. 233.0
   c. 238.3
   d. 239.3

7. Which ICD-9-CM code should a coder report for a malignant neoplasm of the upper lobe of the lung?
   a. 162.3
   b. 162.4
   c. 174.2
   d. 175.9

8. Which ICD-9-CM code should a coder report for Kaposi’s sarcoma of the skin?
   a. 172.9
   b. 176.0
   c. 198.2
   d. 214.0

Answers:
1. d; 2. c; 3. c; 4. b; 5. a; 6. d; 7. a; 8. b
Happy birthday, MRB!

The more things change …

Editor’s note: As part of our yearlong celebration of MRB’s 25th year, we wanted to take a look back at article excerpts from years past. In some ways, things haven’t changed much—getting physicians to complete documentation in a timely manner is still a challenge—but in others, it is clear that HIM has come a long way.

5 years ago… Establish a relationship with IT to ease the transition to paperless records (MRB April 2006)

You may be lucky enough to already have a working relationship with information technology (IT) staff, but if you don’t, take the time to make sure the lines of communication are open. Otherwise, IT may overlook your needs (e.g., HIPAA compliance, HIM work flow and forms, and JCAHO standards) when you begin the transition to an EHR.

Teresa Hall, MHA, RHIT, CPC, director of HIM and risk management at Billings (MT) Area Indian Health Service, learned this the hard way—HIM wasn’t part of the EHR project until the midpoint.

“The EHR really started to impinge on my program when I learned that the incomplete visit crossed over to the billing package before it was coded and completed,” Hall says. Her group immediately asked for a program change within the EHR so the coders could click a “complete” button once a visit was actually finished.

Regular discussions with the IT department can really make a difference with the transition from paper to electronic records. Take a step back, examine the EHR, and evaluate how internal processes have changed or will change.

Hall alerted the IT and EHR program directors to the havoc the EHR wreaked on HIM functions. Coding, provider documentation, and billing went haywire because HIM wasn’t involved in the process. Physicians were responsible for their own coding in the EHR, and most of them were constantly selecting a generic code, which ultimately appeared on the error report and needed to be corrected by HIM.

To prevent additional problems, Hall organized five conference calls with HIM EHR users. This provided a discussion forum and an opportunity for HIM end users to recommend changes that would improve their work flow.

10 years ago… Fax reminders to physicians to encourage chart completion (MRB April 2001)

This month’s idea uses technology to remind physicians to complete charts and adds a prize incentive to those who master the mission. Susan Miller, medical records coordinator at the 36-bed Dubuis Hospital of Shreveport (LA), says the medical records department tried “all kinds of things” to get physicians to complete patient charts in a timely manner.

“Because we’re a long-term acute care facility, we can have as many as 15 physicians on one case because the patient is here so long,” she says. Having so many people involved in care that extends over a long period of time means the files are lengthy.

Miller’s department sends notification to physicians when a record is 15 days old. But sometimes that isn’t enough. A friend in Arkansas had an idea that was working well, so Miller decided to give it a try in her department.

She set up a program in her computer to send daily fax reminders to physicians. If the physician does not respond to the traditional 15-day notice, the fax machine starts churning out reminders on a daily basis until the record is completed.

“It’s been working,” she says. “They get so irritated at us faxing them and wasting their paper that they come over here and do their charts.”

For every chart completed, the physician’s name is entered into a weekly drawing for a free lunch for the physician’s office staff. Miller says the lunch raffle is
a hit. The office staffs have joined forces with Miller and her coworkers to see that the work gets done.

Lunch is sandwiches or pizza. It doesn’t have to be a fancy affair to get the employees excited.

Miller says the new program has done wonders to reduce the facility’s backlog of incomplete charts.

25 years ago… Cost accounting: What it means to HIM directors (MRB November 1986)

In their efforts to control costs and respond to increased financial pressures, many organizations have begun the lengthy and involved process of implementing a cost accounting system. If your facility is one of them, then you, as medical records director, will probably have a double role to play in setting up that system.

At the very least, you’ll participate as a department head who will analyze, estimate, budget, and monitor fixed and variable costs. But you may also participate as a designer and contributor of key data to make the sometimes significant investment in a cost accounting system worthwhile for your organization.

As a medical records manager, you can help implement a cost accounting system at two levels. Your organization will ask you to develop standard costs in your department and apply those costs to your annual budget.

That critical step involves identifying the activities in your department that control variable costs and developing standards for those labor and material costs. You can expend varying levels of effort in doing so, ranging from “seat of the pants” estimates to engineering studies. Regardless of the technique, you must understand and participate in the process. To do less is to under-represent your department in an important institutionwide activity.

The second way is to become involved in all aspects of the effort. As the keeper of critical, encoded patient information that is necessary to drive the cost accounting system, you can and should be involved in selecting the system that your organization will use, training other department managers, testing, and converting.

Frequently, task groups or committees oversee the implementation process. Make every effort to be a charter member.

EHR beat

Conduct an EHR readiness assessment

Determine whether your organization is ready to make the leap

by Margret Amatayakul, MBA, RHIA, CHPS, FHIMSS

Hardware, software, people, policy, and process must work together to achieve your organization’s EHR goals.

One of the earliest matters that policy must address surrounds organizational readiness for an EHR. In fact, having a policy of regular readiness assessment is an important step toward success. Even if a certain project with a certain group goes smoothly, that doesn’t guarantee success for another project.

You may think a policy that focuses attention on planning is not necessary, but implementing an EHR is a spiral of change, with each cycle repeating itself in many ways, often with new twists and turns.

The College of Healthcare Information Management Executives survey on readiness for meeting the meaningful use of EHR requirements for earning incentives illustrates that many organizations have major concerns.

Close to 75% of CIOs who responded indicated that upgrades or new component implementations were among the top three concerns they had with respect to being ready to earn meaningful use incentives, according to the 2010 summary report, “Survey Finds EHR Implementation Is a Major Concern for Healthcare CIOs in Meeting Meaningful Use Requirements.” Capturing and

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submitting quality measures ranked second, with 60% of CIOs listing it among their top three concerns.

Although this survey did not solicit information on human factors, it did uncover several causes of these concerns, including availability of capital, staff with applicable skill sets, vendor readiness, time for sufficient testing, and compatibility with existing and/or legacy systems.

Your planning policy should include the following considerations:

➤ **Economic.** Do you have sufficient capital and operating funds to fully implement the EHR or the components you need? Will the amount of available funds limit the type of system, scope of system capabilities you acquire, or timing? What are the implications of such limitations? Will limited funds mean less expertise available for system building, less diligence in testing, less training from the vendor, fewer input devices for users, and so on? All of these can derail implementation and adoption if you don’t manage them properly.

➤ **Attitudinal.** What are the attitudes of the major stakeholders (e.g., physicians, nursing staff members, HIM professionals, and users in other departments) toward an EHR? Are they enthusiastic about it? Skeptical? Uncertain? Do they have reasonable expectations? Overall, are they ready to move forward? You should also apply caution when interpreting stakeholder questions and concerns.

Physicians are key stakeholders who are often very challenging. Many involved in EHR implementation assume that physicians don’t want to participate and so do not seek their input. Then, when a physician wants to see the underlying practice guideline used to create a data entry template, the assumption is that he or she is expressing fear or uncertainty, when in fact the physician may have a legitimate request that needs your attention.

Nurses should not be left out of the loop. Whether in a hospital or physician office, nurses are likely to use the EHR at least as much if not more than physicians. Nurses have legitimate questions about how much information they are being asked to enter, why terminology generated from the system is unfamiliar, and myriad other concerns—most of which are not the result of computer literacy issues.

Similarly, HIM professionals who express concern about printing the record for court should not be dismissed as fearful for their jobs; in fact, they are attempting to do their jobs, often in the face of many who see the EHR as primarily a clinical system.

Finally, information technology (IT) professionals also face challenges. EHR should not be viewed solely as an IT project, but obviously IT has a huge stake in correctly implementing the technology.

Alternately, potential users who refuse to participate in system design, who claim that a process is wrong without reviewing it, or who believe the system should be sufficiently intuitive and thus think they don’t need training require attention as well.

Clearly, EHR implementation should be treated as the multi-stakeholder endeavor it is.

➤ **Technical/infrastructure.** In hospitals and large physician practices/clinics, an EHR usually builds on other systems that are already in place (or being developed simultaneously). If you are implementing some of the surrounding systems concurrently with the EHR, you will have a steep learning curve before your facility is ready for the complete system. Areas to consider include the following:

– Are software components that will be EHR “building blocks” (e.g., admitting/registration, master patient index, order communications to ancillary...
departments, results reporting from lab and radiology) already in place? Do they capture the data required for the meaningful use incentives? Do staff use them effectively? It is also important to evaluate how closely you want to stick to the early criteria for meaningful use. For instance, some hospitals implement computerized provider order entry without all of the requisite interfaces, meaning that physicians can place certain orders electronically but must handwrite others. This will meet the first stage of the meaningful use criteria, but physicians may find that such a hybrid process is more burdensome than doing all orders online.

- Is your network and communications infrastructure sufficient to support an EHR? Any perceptible amount of time a physician must wait for a screen to load is too long and will discourage even the most committed potential user. A key ingredient of the criteria for earning the meaningful use of EHR technology incentives is the ability for enhanced exchange of data—with other providers, patients, public health, and quality measure reporting. As such, your network infrastructure may need enhancement and greater attention to security controls.

- Do you need additional IT resources to install and support an EHR? Small organizations, especially, seem to believe that once the vendor installs the system, the job is almost done. EHR systems, however, are very high maintenance. On a continuous basis, you (or your team) will need to connect new devices (physically or logically), build new templates, change clinical decision support, implement upgrades, add new quality measures, and so on. Many of these tasks require skills different from what a typical IT department may have.

- Does the organization have persons with sufficient project management skills to accomplish a big effort? Some organizations now find they need a project management office to handle the ongoing workload as well as the mix of needed skills. You need staff members who can perform contracting and procurement, budgeting, resource leveling, risk management, issues management, highly detailed process mapping and work flow analysis and use, use-case development, screen design, template building, integrated system testing, and ongoing environmental scanning job functions.

➤ Cultural. Last but not least: Is executive management ready to give strong, visible, and enduring support to the effort? Has it done so for other major IT initiatives? How well does your organization support change? How strong is medical staff leadership support for the EHR?

In the past, executive leadership may have looked the other way when a heavy admitter didn’t want to do something, or it may have accepted less than 100% adoption of a change because it could be managed through a workaround. Such positions are no longer feasible. Executive leadership will need to become more engaged in understanding technology and find ways to support the knowledge of workers.

Before moving too far down the path toward acquiring and implementing an EHR, your organization should develop policies to address questions that arise when planning and selecting an EHR. For a sample EHR readiness assessment policy, see p. 16.

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### EHR readiness assessment policy

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#### Scope
This policy ensures that investments in HIT and EHR are supported by organizational readiness.

#### Definition of terms
- **EHR**—a system that captures data from multiple sources and supports clinical decision-making at the point of care
- **Health information technology (IT)**—a descriptive term encompassing different applications of IT in healthcare

#### Policy statements
- [Name of provider] will make it a practice to assess all applicable elements of organizational readiness in its first phase of planning to adopt any HIT.
- [Name of provider] will take specific measures to educate, engage, and coach all applicable stakeholders as it seeks to implement an EHR or any of its components.
- [Name of provider] leadership must be fully committed to supporting an EHR before engaging in planning. This commitment must extend to sufficient financial resources to ensure viability of the system; attitudes and beliefs that realistically promote the vision and goals of the system; technical infrastructure, including hardware, software, and people as resources; and a culture of visible participation and support of positive change.
- [Name of provider] will not attempt to implement HIT or EHR in the absence of requisite resources but will define a migration path that reflects internal and external dependencies as well as organizational strengths and limitations.

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Dear colleagues:

In my February column, I discussed the effect the impending implementation of ICD-10-CM/PCS on October 1, 2013, will have on physicians and their facilities. My colleague, Dr. Robert Gold, reemphasized ICD-10 in his column as well. This topic will not go away; physician definition, diagnosis, and documentation of patient conditions must reflect the language and higher specificity required in ICD-10-CM/PCS if we are to thrive, not just survive. Coders and clinical documentation specialists (CDS) will soon approach you to consider changes to your documentation to reflect the higher specificity required.

ICD-10 diagnosis codes (ICD-10-CM) increase from five to seven digits, allowing room for expansion or increased specificity. Both physicians and hospitals will use the new codes. Facility inpatient procedure codes (ICD-10-PCS) increase from four to seven digits and emphasize anatomic specificity and laterality. These codes are very different from the CPT descriptions physicians report.

While there is a partial freeze in ICD-10-CM/PCS code changes after October 1, their application to MS-DRGs used in bundled payments and physician-hospital profiling is still evolving. Physician feedback to CMS is critical to minimize any inadvertent mischaracterization of patient populations or treatments.

Examples of how ICD-10 will be different include:

▶ **Classification of acute myocardial infarction (AMI).** The default classification of AMI in both ICD-9 and ICD-10 is a ST-segment elevation MI (STEMI) unless the physician explicitly documents non-STEMI, “non-Q wave” MI, or nontransmural MI. Locations (e.g., anterior, inferior) of non-STEMI are not reported in either. While ICD-9 distinguishes initial and subsequent episodes of care for up to eight weeks, ICD-10-CM eliminates the subsequent episode of care designation, using the same AMI code for up to four weeks post-onset. Unlike ICD-9-CM, ICD-10-CM notes the involvement of specified coronary arteries (e.g., left main, left anterior descending) in STEMI and of reinfarctions that occur within four weeks of the initial event. ICD-10-CM requires links to any acute complications of AMI (e.g., cardiac rupture, papillary muscle dysfunction) that occur within four weeks of the initial event. Sadly, both ICD-9-CM and ICD-10-CM classify non-ischemic cardiac myonecrosis as acute ischemic MI. Therefore, carefully consider the clinical significance of troponin elevations in non-ischemic circumstances (e.g., exacerbations of systolic or diastolic heart failure, Takotsubo cardiomyopathy), recognizing that “non-ischemic cardiac myonecrosis” codes to AMI.

▶ **Adverse effects of medications.** ICD-9-CM and ICD-10-CM both report adverse effects of medications taken as directed, but ICD-10-CM also specifies adverse effects due to underdosing. Of course, physicians must explicitly document these consequences and link them to medications to be captured as such. Interestingly, if an inpatient admission is due to an adverse effect that is not the result of underdosing, MS-DRGs group it in ICD-10 to the same DRG used in poisonings, which may increase or decrease its relative weight. Coders and CDSs will need explicit documentation as to the extent a clinical condition results from correct vs. under- or overdosing of a medication, whether it was taken as prescribed, and whether it interacted with alcohol or another medication.
➤ Debridements. ICD-9 and ICD-10-PCS require explicit physician descriptions of debridement, differentiating between excised tissue (i.e., excisional debridement) and extracted tissue (i.e., “sharp,” nonexcisional debridement) and the deepest level affected by the procedure. As a general rule, all procedures require documentation of the exact anatomy operated on; otherwise, a physician query may be necessary.

➤ “Fragility” fractures. When I ask physicians the most common cause of pathological fractures, many cite malignancies or multiple myeloma. However, ICD-9-CM and ICD-10-CM classify osteoporotic fractures as pathological fractures, considering osteoporosis a pathology. ICD-10 introduces the uncommon term “fragility” fracture (i.e., “sustained with trauma no more than a fall from a standing height or less that occurs under circumstances that would not cause a fracture in a normal healthy bone”). This happened to my mother who, upon falling out of bed, fractured her C7-T1 vertebra. Her surgeon said it wouldn’t have occurred with healthy bone. Unlike ICD-9-CM, ICD-10-CM requires differentiation between fragility fractures due to age vs. medications, disuse, previous trauma, oopherectomy, or postsurgical malabsorption.

➤ Acute renal failure (ARF)/acute kidney injury (AKI). The classification and stratification of ARF and AKI is a mess I hope will be corrected prior to the October 1 code freeze. Sadly, while ARF is classified by its underlying renal pathology, AKI isn’t. Hopefully, additional codes for the stages of AKI (e.g., AKI stage 1, 2, 3, or those requiring acute dialysis) will be available in October so that the codes appropriately represent resource utilization, morbidity, and mortality. If so, please stage and document the severity when it occurs. (Learn more at http://ccforum.com/content/11/2/R31.)

ICD-9-CM and ICD-10-CM have codes for renal pathologies causing AKI, but ICD-10-CM requires more explicit documentation of renal pathology. For example, ICD-9-CM classifies “toxic nephropathy” (i.e., due to contrast) as acute tubular necrosis, while ICD-10-CM introduces new codes for drug-induced nephropathies that don’t describe pathologies (e.g., acute tubular necrosis or interstitial nephritis). Both ICD-9-CM and ICD-10-CM classify “vasomotor nephropathy” (a term I’ve never seen documented) as acute tubular necrosis, but neither have a specific pathologic code for nephropathy due to acute ischemia or shock. Given that ICD-9-CM and ICD-10-CM classify AKI by associated renal pathologies (e.g., acute interstitial nephritis, acute cortical, medullary, or tubular necrosis), coders and CDSs will likely ask you when it is best to add these descriptors.

ICD-9 and ICD-10-CM/PCS affect physician profiling and the process of codes submission. Sadly, no physician organization is a member of the Cooperating Parties for ICD-9 or ICD-10-CM/PCS, nor directly influences MS-DRG organization and structure. For this reason, if you find something that doesn’t make sense, encourage your specialty society to investigate and comment so the codes and DRG methodologies can be accurate and clinically congruent. Submit feedback to Donna Pickett, medical classification administrator of the National Center for Health Statistics, at 301/458-4434 or dfp4@cdc.gov, or Patricia Brooks, technical advisor, CMS Office of Hospital Policy, at patricia.brooks2@cms.hhs.gov.

Thank you for your attention to this matter.
With warm regards,

James S. Kennedy, MD, CCS

Editor’s note: Kennedy is general internist and managing director with Atlanta-based FTI Healthcare, which specializes in clinical resource and case management, clinical documentation, and coding improvement. Contact him at 615/479-7021 or james.kennedy@ftihealthcare.com.