Last-minute ICD-10 training tips for documentation

It’s the final weeks before healthcare entities across the United States officially start employing the International Classification of Diseases, 10th Revision Clinical Modification and Procedural Coding System (ICD-10-CM/PCS).

While most understand the ICD-10-CM/PCS acronym easily enough, it’s worth spelling out from time to time to remind ourselves of the code sets’ origins and intent—a unifying numeric data set allowing healthcare workers across the world to compare trends in healthcare.

Experienced CDI professionals now well understand that the new code system contains exponentially more codes than its ninth revision counterpart and that these additional codes allow for more details and greater specificity regarding the acuity of a particular patient’s medical condition.

However, this simple fact requires a sea change of thought and actions throughout our healthcare system—one which advanced facilities and CDI programs have been preparing for, in some cases, for more than a decade.

Nevertheless, even the best prepared have a lot of last-minute to-dos to consider:

■ Update forms and policies
■ Test the systems
■ Make sure staff are educated and prepared

The list goes on and on. As you work to put the final touches on your pre-implementation plan, here are a few things to consider.

Refresh education

By now, facilities should be way past the basic ICD-10 overview education. Now is the time to reinforce ICD-10 knowledge through refresher courses and training methods, says Robin Keeney, CCS, CCDS, director of Revenue Cycle Services at VHC, Inc., in Oakbrook Terrace, Illinois.

Look at the differences in documentation from ICD-9 to ICD-10, and determine any knowledge gaps for both physicians and coders.

“The best use of an organization’s time right now is to take a close look at the data [from dual coding] and identify coding weaknesses and opportunities for higher physician documentation specificity,” says Keeney.
CDI specialists can incorporate a variety of methods to maintain and further ICD-10 knowledge, says Keeney. Webinars, workbooks, and abbreviated ICD-10 courses can be very helpful for facilities that feel they need more formal training. Education at this point, however, should be targeted to address identified weaknesses. Similarly, training for coders and physicians needs to move beyond the basics.

“ICD-10 has so much more detail, in particular in the PCS. Coders need to understand the definitions of root operations, and CDI must work with physicians on achieving the highest level of specificity possible in procedure documentation,” Keeney says.

Networking with and asking questions of CDI colleagues will undoubtedly help facilities as they work through the “nitty gritty” of the implementation process, she says.

Regularly schedule calls with local member hospitals to discuss specific cases that presented coding or documentation challenges, Keeney recommends, and hold meetings where cross-discipline groups can bounce ideas off of one another and ask questions specific to their facility and departmental needs.

“People need to start using networking and group discussions so they get the benefit of everyone’s findings” as the country moves through the implementation stages into active use of the ICD-10 codes, she says.

**Dual coding**

One of the most obvious tips for training has been reiterated time and time again: Practice makes perfect.

By now, facilities should be dual coding not only to learn the ins and outs of the system, but also to identify opportunities for education, says Tina Brooks, RN, CCDS, CRCR, CDI specialist at NCN Revenue Integrity.

“Training can only hit so much,” says Brooks. “What I’ve found is when we are dual coding, that’s when we learn the most because you get into the meat and potatoes of finding the correct code, using Coding Clinic, dual coding summaries, and addressing the physicians’ needs.”

Brooks’ facility focuses its dual coding efforts on identifying diagnoses and surgeries that can’t be coded in ICD-10 based on the documentation, so CDI staff can go back and provide additional information and education to the physician teams. Coders focus on mastering the ins and outs of surgery cases, Brooks says, to avoid a holdup in the overall coding process.

As far as practice goes, Brooks says there’s no such thing as being over-prepared. She suggests going to the CMS website, downloading the Official Guidelines for Coding and Reporting for both the CM and PCS portions, and reading through them extensively. She keeps copies of them on her computer desktop and, whenever she or one of her colleagues has a question, uses the word search feature to find the answer—a much quicker method than flipping through multiple books, Brooks says.

“It’s on every [CDI professional] to do that, whether you read the rules in a book or off of the CMS website,” she adds. “You learn a lot more by going directly to the source.”

**Portable references**

Most facilities anticipate a delay in productivity post-implementation, says Deanne Wilk, BSN, RN, CCDS, CCS, CDI and inpatient coding manager at Good Samaritan Health System in Lebanon, Pennsylvania. The last thing a hospital needs are delays caused by simple questions.

By creating tools to answer commonly asked questions or address identified “problem zones,” CDI specialists can help reinforce coder and physician knowledge and prevent unnecessary delays, Wilk says.

Now that her facility is past initial training and practicing the ICD-10 codes, Wilk started targeting education based on physician specialty and query/educational preferences. Facilities should experiment with what works best for them and their own physicians.

For example, Wilk developed PowerPoint presentations and 8-by-11 code sheets for coders that cater to their specialty. Coders also have access to an online portal where they can complete training and go back for additional clarifications.

“We don’t want coders to mark everything as ‘unspecified,’ ” says
Wilk. “The physician’s diagnosis needs to match with the final codes assigned to a given medical record.”

Pocket cards and posters are another easy method for quick references and tips. These tips can be translated into weekly emails or newsletters and distributed throughout the hospital, she says. Keep pocket cards succinct and focused. Any quick reference should be easy for a physician to navigate, and should not be a burden for them to use.

“While we want to prevent delays if at all possible, make sure your physicians know they can use CDI staff as a resource. If a physician really needs help, even if it is for a simple question, one-on-one discussions can be a huge help for the physician, and can also help CDI identify educational methods or tools on that topic,” Wilk says.

Create a task force

As CDI specialists, it can be difficult to effectively engage and educate coders and physicians without the support of the rest of the facility administration. By having a team of directors and hospital leaders behind you, it will be that much easier to navigate the ICD-10 battle, says Kerry Seekircher, RN, BS, CCDS, CDIP, CDI manager at Northern Westchester Hospital (NWH) in Mount Kisco, New York. NWH put together a task force that meets weekly and includes:

- HIM director
- ICD-10 project director
- CDI managers
- Coding manager
- IT department

The task force works on a variety of projects, Seekircher says. It plans, coordinates, and implements all of the necessary training, ensuring the coding staff, CDI staff, providers, and ancillary staff receive the right combination of boot camps, anatomy and physiology training, and e-learning. After ICD-10 implementation was confirmed, the group worked to bring back refresher boot camps and training for staff.

The task force also reviews forms, templates, and policies for opportunities for increased specificity and works as a team to make the necessary changes. The group members combine their different perspectives to identify the biggest documentation opportunities and top service lines, and to plan additional education or resources as needed. The group is also in charge of testing the software systems.

“We try to bring in the different disciplines as needed to make sure we’re covering all of our bases,” says Seekircher.

Even if you don’t have a designated task force, CDI can work with other departments to identify educational needs and opportunities. “If you can’t make a formal task force, try to set up weekly meetings where representatives from various departments can check in,” she says.

Efforts and analysis need to continue after implementation as well, Seekircher says.

“Begin to consider an additional budget for post-implementation if there are unexpected hiccups. Have a plan in place if you need outside support, contracted coders, more physician training, and the like. We don’t know if we’ve done enough education or if we have the right resources in place,” says Seekircher, “Make sure your organization is prepared, have a planned budget, and be ready to act. We all need to know what we would do in the event of barriers, issues coding records, or bill delays.”

Additional staff

Lastly, as a facility goes through its last-minute training and preparation, a wise thing to do is bring in backup, says George Redd-Hachey, CCS, CCDS, CHDA, former coding and CDI manager at the University of Florida Health Shands Hospital in Gainesville. Having an extra helping hand available in light of the mountain of tasks that ICD-10 has brought (and will continue to bring) could make the difference between a successful or stressful transition.

Shands hired new graduate coders to start in July, August, and September to work exclusively in ICD-10, while existing staff amp up their dual coding efforts more and more as October approaches.

CDI staff can work with leadership to get approval for additional staff if they feel it’s necessary. Since no one can say for sure exactly where coder productivity will be, Keeney says there’s a strong case to beef up your coding and CDI staff with backups. 🕵️‍♀️