New Tools on the Horizon will Facilitate Physician / Provider Training and Improve Documentation Process in Advance of ICD-10-PCS Implementation

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Clinical Documentation Innovation

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As the healthcare industry approaches the October 1, 2014 compliance date for implementation of ICD-10, it's becoming increasingly apparent that almost all of its focus is on ICD-10-CM (clinical modification) and very little attention is being paid to the vastly more complex ICD-10-PCS, the procedure coding system.

As previously noted, the industry at large is focusing more on ICD-10-CM primarily because it is very similar to ICD-9-CM. Additionally, there is much more guidance – particularly official guidance – available for ICD-10-CM. In fact, there are currently 117 pages of official guidelines for ICD-10-CM, but, surprisingly, only 15 pages of official guidelines for ICD-10-PCS from CMS.

This is a problem. As we approach October, the paucity of available guidelines for ICD-10-PCS will unquestionably create a major challenge for medical and coding professionals. In the past, trade associations, education providers and vendors have stepped up to fill this type of void, but until now none have been able to adequately produce a solution that will fit within the workflow of current documentation practices.

How ICD-10-PCS Differs from ICD-9-CM

To briefly recap, ICD-10 Procedure Coding System (ICD-10-PCS) is a system of medical classification used for procedural codes that describe various inpatient health interventions by medical professionals. The World Health Organization (WHO) granted the National Center for Health Statistics (NCHS) permission to create ICD-10-PCS to replace Volume 3 of ICD-9-CM and a clinical modification of the original ICD-10. CMS then contracted with 3M Health Information Systems to design and develop ICD-10-PCS.

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), after 30 years of service, uses outdated and obsolete terminology, codes with imprecise, inaccurate and limited data, and is not consistent with current medical practice. ICD-9-CM provides neither the necessary detail on patients' medical conditions nor on procedures performed on hospitalized patients. The code length and alphanumeric structure of ICD-9-CM limit the number of new codes that can be created, and many ICD-9-CM categories are already replete.

ICD-9-CM's lack of specificity and detail makes it difficult and in many cases impossible for payers and others to correctly analyze data on outcomes, health care utilization, resource use and performance.

By contrast, ICD-10-PCS, which was developed for use in U.S. inpatient hospital settings, is much more comprehensive than ICD-9-CM and is in fact a complete departure from the old inpatient procedural classification system. It is equipped with a redesigned 7 alpha or numeric digits while the ICD-9-CM coding system uses only 3 or 4 numeric digits.

In ICD-10-PCS, the first digit indicates the section of medical practice (surgery, administration, measuring and monitoring, etc.) and the following digits specify the body system, root operation, body part, approach and the device used. The seventh character is a qualifying digit. The first three digits of a code are stored in tables throughout the ICD manual for reference.

In a useful article[1] published in the Journal of AHIMA, Steven J. Steindel provides detailed descriptions and samples of ICD-10-PCS coding. He notes that ICD-10-PCS codes need to be derived based on operative and medical notes. For example, if the operative report indicated a fine-needle aspiration biopsy of the left lobe of the thyroid, a coder would consult a table for Medical and Surgical (0): Endocrine System (G). The coder would then select Drainage (9), note the left lobe of the thyroid gland (G), show it was a Percutaneous Endoscopic approach consistent with a fine-needle aspiration (4), without a drainage device (Z), and conducted for diagnostic purposes (X). The resulting ICD-10-PCS codes would thus be 0G9G4ZX.

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[1] AHIMA. "Learning and Using ICD-10-PCS." Steven J. Steindel, Journal of AHIMA, February 9, 2011.

The Benefits and Challenges of Increased Complexity

ICD-10-PCS offers a unique code for every procedure. Its uniform structure eliminates confusion of meaning when describing health interventions. The system includes standardized definitions and terminology, which means that it accurately captures the complexity of any given procedure. ICD-10-PCS is also expandable, allowing for addition of unique codes for new procedures.

This increased complexity is intended to bring many benefits to providers of inpatient medical procedures, ranging from improving public health tracking to discouraging upcoding and fraud, specifying reasons for patient non-compliance to recommended regimens of care and allowing for detailed data on injuries and accidents, to name only a few.

Increased complexity, however, comes at the cost of a major increase in the number of PCS codes. ICD-9-CM included 3,878 total codes for inpatient procedures, while ICD-10-PCS includes an astonishing 71,923 codes.

Given this major increase, it is easy to see why training in the use of ICD-10-PCS will take longer and be more complicated than most physicians, providers and coding specialists have anticipated. The absence of support by regulators, educators and vendors in this realm is concerning as it suggests that effective solutions are extremely complicated to develop.

If It's Not Documented, It Didn't Happen – And It Can't Be Billed

It will be critical for providers to identify documentation practice inefficiencies as well as inefficiencies in processes, systems and workflow in order to develop a plan to eliminate them in advance of ICD-10-PCS implementation. This will avoid unnecessary delays in coding and billing of claims while maintaining data integrity.

This will be a major challenge in 2014, yet providers who are not adequately prepared to implement ICD-10-PCS by the Oct. 1st deadline risk not being paid, or of not receiving all payments that are in fact due them. The average medical practice or hospital organization has very little cash on hand to meet the anticipated changes in revenue that are inevitable from these regulations.

The Impact of PCS on Physicians

While ICD-10-PCS is mandated for hospital coding and billing of inpatient procedures, those procedures are performed and documented by physicians. Though outpatient physicians will continue to code and bill using CPT, hospitals need the physicians to document in a timely, legible, and comprehensive manner in order for the hospital coding specialists to assign the correct PCS codes. In fact, some hospitals will sanction physicians who have an unusually high volume of incomplete records, and physicians could very easily find themselves with an increased number of incomplete records if there are numerous queries regarding inpatient procedure documentation.

The nature of ICD-10-PCS coding is such that a complete PCS code can't be "assigned" if key procedural specificity is missing from the record, so there will be numerous instances where coding specialists will have to query a physician in order to complete the accurate ICD-10-PCS coding of an inpatient record.

AHIMA Recommendations for ICD-10-PCS Provider Training

In a recent brief,[2] AHIMA argues that the clinical documentation improvement (CDI) community will be vital to ensuring a smooth transition to ICD-10-PCS. CDI programs use CDI specialists with coding and / or clinical backgrounds who focus on the accuracy of clinical documentation.

AHIMA recommends that education in ICD-10-PCS documentation requirements for physicians should consist of short sessions led by CDI staff that cover individual topics and include the following requirements:

- *Utilize real life, practical examples*
- *Compare the difference in terminology between ICD-10-PCS and ICD-9-CM*
- *Create templates*

What is needed is a method of physician training that incorporates or addresses these three requirements. The method should be simple and easy to demonstrate during the brief sessions recommended by AHIMA.

A Cloud-Based Provider Training Tool That Works

Fortunately, a new software company called ICDLogic is developing a cloud-based application that not only serves as a superior ICD-10 documentation training tool for physicians and providers, but also greatly facilitates a smooth overall transition to the ICD-10-PCS environment. ICDLogic's flagship application, called Cypher,™ empowers physicians and other providers to create ICD-10-PCS compliant documents via a simple and easy to understand interface and process, concurrent with patient care, with the potential to minimize or even bypass the need for Clinical Documentation Queries that will be necessary to clarify documentation.

ICDLogic's Cypher™ is a cloud-based application for all desktop computers, tablets and mobile devices that rapidly automates the formulation of physicians' clinical thinking into the accurate, ICD-10-PCS terminology. The resulting documentation is HIPAA-compliant and contains all the clinical specificity necessary to enable efficient coding, billing and reimbursement downstream in the billing process.

Cypher™ utilizes a proprietary ICD-10 and CDI/coding and documentation logic to create documentation guides for all major medical conditions and procedures, for each of the 70,000+ codes included in ICD-10-PCS, and customized by medical specialty.

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[2] AHIMA. "Using CDI Programs to Improve Acute Care Clinical Documentation in Preparation for ICD-10-CM/PCS." Journal of AMIMA 84, no.6 (June 2013): 56-61

The content ICDLogic's documentation guides is generated by medical editors and reviewed by CM and PCS experts. Physicians review and approve the final documentation guides before they are loaded into the application and made available for use. Every documentation guide is based on approved medical evidence, which is cited for easy reference by physicians, other providers and coding professionals.

Cypher™ excels as a clinical documentation training tool for the new ICD-10 environment, providing for each of the documentation training methods recommended by AHIMA:

- *Utilize real life, practical examples* – *Cypher™ documentation guides contain real-life clinical examples that illustrate documentation best practices*

- *Compare the difference in terminology between ICD-10-PCS and ICD-9-CM* – *For many conditions and procedures, Cypher™ documentation guides contain a crosswalk from ICD-10-PCS back to ICD-9-CM*

- *Create templates* – *Cypher™ actually eliminates the need for templates because its programming logic is based on ICD-10 code descriptions and official guidelines*

Cypher's™ ease of use makes it an ideal tool for the physician and provider training sessions recommended by AHIMA. CDI and other coding professionals will be able to conduct efficient sessions that demystify ICD-10-PCS for providers and reduce the concerns associated with the 2014 transition to the new coding environment.

Beyond Training – Best-in-Breed Solution for Users of ICD-10-PCS in 2014

In addition to its value as a training tool for providers and coders, the Cypher™ application is an excellent solution for the new PCS environment for several reasons:

- *Users are not given a long list of PCS code numbers and descriptions to search. Instead, they are given guided navigation panels that walk them through the clinical details that must be documented in order to select and justify the assignment of an accurate and complete 7 character PCS code.*

- *Users are given specialty-specific customized Body Part tables to help them quickly locate and select the correct body part when documenting the anatomical site on which the procedure was performed.*

- *Users are given specialty-specific customized Device Tables to help quickly locate and select the correct device when documenting that a device was inserted and left inside of the patient at the end of the procedure.*

- *The PCS logic of Cypher™ is derived from a customized ICD-10-PCS Index designed to help the users search for procedures using common procedural terms that are well-known in the medical community (not the new ICD-10-PCS terms that are often foreign to physicians, such as "extirpation").*

- *Users are provided with links to National Coverage Determinations and/or Joint Commission Core Measures that are associated with a PCS code.*

Conclusion

The transition to the new ICD-10-PCS environment will prove problematic for physicians, hospital organizations and other providers of inpatient medical services who are not adequately prepared. ICD-10-PCS represents a jump in complexity and precision of several orders of magnitude over the old ICD-9-CM.

While the new system will yield numerous benefits, the right training and tools will be required in order to ensure a smooth transition and minimize unnecessary delays in coding and billing of claims leading to disruptions in the billing cycle.

Fortunately, there are new tools coming online in advance of the transition to ICD-10-PCS that will be available to facilitate both physician training and, ultimately, implementation and use of the new coding procedures by both providers and Coding Specialists.

Chief among these tools is Cypher™, a cloud-based application available to physicians at the point-of-care. It utilizes real life, clinical examples that illustrate documentation best practices and features a thoughtfully designed and easy to understand user interface that guides users through the documentation differences between ICD-10-PCS and ICD-9-CM.

About the Author

Jones is the principal of Lolita M. Jones Consulting Services (LMJCS), founded in October 1998 in Fort Washington, MD. She has more than 25 years of experience in coding and consulting. In April 2013, Ms. Jones launched a new monthly newsletter titled ICD-10-PCS Solutions (MedLearn, Inc., Minneapolis, MN), and in 2011 she wrote the ICD-10-CM/PCS Implementation Action Plan, and the ICD-10 Competency Assessment for Coders, ICD-10-CM & ICD-10-PCS (HCPro, Marblehead, MA).

About ICDLogic

Established in 2012, ICDLogic is a New York City-based technology company founded by healthcare information and technology experts who know how to build smart information-driven applications for physicians. ICDLogic has extensive experience in healthcare regulatory information, billing and coding, and understand the semantic ontologies behind ICD-9, ICD-10, SNOMED CT, MeSH, LOINC and UMLS. We also understand the importance of Clinical Documentation Improvement (CDI) and its impact on DRGs, coding, reimbursement, and health revenue compliance. Most importantly, we understand the need for intuitive user interfaces that make information-rich applications that are easy to use by doctors and other clinicians.

ICDLogic's mission is to provide easy-to-use clinical documentation tools for physicians so they can spend more time with patients and less time on compliance education and busywork.

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