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International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System and Clinical Documentation Improvement

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Abstract

Today, the International Classification of Diseases, Ninth Revision, Clinical Modification is more than 35 years old and there is a great need for the United States of America to implement the International Classification of Diseases, Tenth Revision. The International Classification of Diseases, Tenth Revision has two parts: The International Classification of Diseases, Tenth Revision, Clinical Modification for diagnosis codes and The International Classification of Diseases, Tenth Revision, Procedure Coding System for inpatient procedure codes. Both classification systems incorporate greater specificity, clinical data, and information relevant to ambulatory and to managed-care encounters**.** With the greater specificity, it is imperative for clinical documentation specialists to work side-by-side with physicians and with clinical staff to educate them on the changes from the International Classification of Diseases, Ninth Revision to the International Classification of Disease, Tenth Revision. Clinical documentation specialists are also needed to assist in the rise in physician queries. This can cause delayed coding of medical charts and delayed patient and/or insurance billing. However, with the help from the Clinical Documentation Improvement team, physicians can receive the proper education and training needed for a smooth transition to the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System.

Key words: Clinical Documentation Improvement; CDI; Education; CDI Education; ICD-10-CM/PCS; ICD-10; ICD-9-CM

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Abbreviations

Table 1: *Abbreviations*

AHIMA	American Health Information Medical Association
CAC	Computer Assisted Coding
CC	Complicating or comorbid condition
CCDS	Certified Clinical Documentation Specialist
CCS	Certified Coding Specialist
CDI	Clinical Documentation Improvement
CDIP	Certified Documentation Improvement Practitioner
CDS	Clinical Documentation Specialist
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
eHealth	Electronic Health
HAC	Hospital-Acquired Condition
HCA	Hospital Corporation of America
HHS	Health and Human Services
HIE	Health Information Exchange
HIM	Health Information Management
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
ICD-10	International Classification of Diseases, Tenth Revision
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, Tenth Revision, Procedure Coding System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
MCC	Major complicating or comorbid condition
MS-DRG	Medicare Severity Diagnosis-Related Group
NCHS	National Center for Health Statistics
PAMA	Protecting Access to Medicare Act
POA	Present on Admission
PSI	Patient Safety Indicators
RHIA	Registered Health Information Administrator
RN	Registered Nurse
ROM	Risk of Mortality
RW	Relative Weight
SOI	Severity of Illness
U.S.A.	United States of America
WHO	World Health Organization

International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure

Coding System and Clinical Documentation Improvement

Chapter 1

Introduction

On May 1, 2014, the U.S. Department of Health and Human Services (HHS) released the

interim final rule that stated the new compliance date would require all Health Insurance

Portability and Accountability Act of 1996 (HIPAA) compliant entities to start using the

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

and International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-

PCS) October 1, 2015. The rule also stated that those HIPAA covered entities would continue to

use the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-

CM) until September 30, 2015 (Dimick, 2014). With Congress' verdict to change the

compliance date from October 1, 2014 to October 1, 2015 for ICD-10-CM/PCS, several Clinical

Documentation Improvement (CDI) Programs around the United States of America (U.S.A.)

have also decided to delay training and education sessions. Many physicians and staff are

waiting until next year, 2015, before beginning to start training and transitioning. However, time

will tell if this choice will impact their readiness for the October 1, 2015 deadline. The larger

problem is continuing to use an antiquated system for yet another year.

Background

"The Administrative Simplification provisions of the Health Insurance Portability and

Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human

Services (HHS) to adopt national standards for electronic health care transactions and national

identifiers for providers, health plans, and employers" ("Hipaa – general," 2013). The increase

in health information exchange (HIE) is due to the continued adoption and implementation of

HIPAA standards. For those health organizations that do not adopt and implement HIPAA

standards will be financially penalized ("Hipaa – general," 2013).

The World Health Organization (WHO) developed the International Classification of

Diseases (ICD). It is the "global standard for reporting and for categorizing disease, health-

related conditions and external causes of disease and of injury. In addition to clinical diagnosis,

the classification is also used in the development of health programs, prevention, reimbursement

and treatment" ("World health organization," 2014). ICD is used by a number of countries,

including the U.S.A.

In 1979, the U.S.A implemented a modified version of the ICD, Ninth Revision, called

ICD-9-CM. The ICD-9 version, created by the WHO, was more specific than earlier versions;

however, it did not meet all of the needs for the healthcare settings in the U.S.A. during that

time. Therefore, the National Center for Health Statistics (NCHS) and the Council on Clinical

Classifications created a specific version of ICD-9, called ICD-9-CM, to meet the needs of the

American healthcare settings (Topaz, Shafran-Topaz & Bowles, 2013).

In May 2002, Sue Prophet, American Health Information Medical Association's

(AHIMA) director of coding policy and compliance, explained to Congress that "AHIMA

believes that adoption of a replacement for the ICD-9-CM diagnosis codes is an absolute

necessity, as ICD-9-CM is more than 20 years old and has become outdated and obsolete"

(Hazlewood, 2003). Today, ICD-9-CM is more than 35 years old and the need for the U.S.A. to

implement ICD-10 is even greater. Not to mention, since 2011, the ICD-9-CM Coordination and

Maintenance Committee implemented a partial code freeze. Only codes capturing new

technologies and new diseases would be added to the current ICD-9-CM and ICD-10-CM/PCS classification systems. After October 1, 2016, which is a year after the ICD-10-CM/PCS compliance date, regular updates for ICD-10-CM/PCS will resume, but updates will not be available for ICD-9-CM (as ICD-9-CM will no longer be HIPAA compliant and/or used) ("Icd-10-cm/pcs myths and," 2014).

ICD-10-CM/PCS

There are two parts to ICD-10: ICD-10-CM for diagnosis codes and ICD-10-PCS for inpatient procedure codes. Each part is very specific and ICD-10-CM has several improvements over the later version of ICD-9-CM. It "incorporates greater specificity, clinical data, and information relevant to ambulatory and to managed care encounters. In addition, the structure of ICD-10-CM allows for the possibility of greater expansion of code numbers" (Hazlewood, 2003). The combination codes for conditions and for common symptoms or manifestations, poisonings, and external causes are all ICD-10-CM/PCS code types that have been affected by the specificity increases. The expanded codes, such as, injury and diabetes have also changed and have added to the specificity of ICD-10-CM/PCS (Hall, 2012). Currently, there are about 17,000 ICD-9-CM codes. With ICD-10-CM, the amount of codes will increase to more than 155,000 (Topaz, Shafran-Topaz & Bowles, 2013). There are currently approximately 3,800 ICD-9-CM procedure codes. ICD-10-PCS, which is for inpatient procedure coding, has more than 71,000 codes. ICD-10-PCS will be required for all inpatient procedure accounts and will not have any impact on Current Procedural Terminology (CPT) codes, but will require education for coders. The new codes "greatly increase the specificity of the code descriptions by identifying the specific root operation, body part, approach, and devices used" ("Using cdi programs," 2013).

Rationale for ICD-10-CM/PCS

According to Robert Tagalicod, Director, Office of E-Health Standards and Services, there are four key reasons "Why ICD-10 Matters" (Tagalicod, 2013).

1. ICD-10 Advances Health Care and the Implementation of eHealth Initiatives

    a. ICD-10 is essential to health care reform and the Centers for Medicare & Medicaid Services (CMS) electronic health (eHealth) initiative, and is part of the overall goal – the triple aim to achieve better care, better access and better health while lowering costs.

    b. eHealth programs such as ICD-10, Administrative Simplification, the Medicare and Medicaid Electronic Health Record Incentive Programs and quality reporting programs like the Physician Quality Reporting System are all aimed at accomplishing this goal.

    c. Together, these eHealth programs will provide greater interoperability, easier data sharing, better quality measurement, improved clinical outcomes, and lower costs.

2. ICD-10 Captures Advances in Medicine and in Medical Technology

    a. ICD-10 captures new procedures that lead to innovative health care and to medical breakthroughs.

3. ICD-10 Improves Data for Quality Reporting

    a. Many quality measures rely on ICD diagnosis codes. ICD-10 provides better data for quality reporting and outcomes measurement.

4. ICD-10 Improves Public Health Research, Reporting, and Surveillance

    a. ICD-10 is more effective at capturing public health disease due to its greater specificity. Federal, state, and local officials, including researchers, will use 1CD-

10 diagnosis codes for public health research, reporting and surveillance

(Tagalicod, 2013).

There are several other reasons why ICD-10-CM is important for American healthcare. The content and the format of ICD-10-CM have major enhancements over ICD-9-CM. Some of these improvements include, but are not limited to:

1. ICD-10-CM codes are alphanumeric and include all letters except "U," thus providing a greater pool of code numbers.

2. ICD-9-CM's V and E codes are incorporated into the main classification in ICD-10-CM.

3. The length of codes in ICD-10-CM can be a maximum of seven characters (digits and letters) as opposed to ICD-9-CM's limitation of five digits.

4. ICD-10-CM offers the addition of information relative to ambulatory and to manage care encounters.

5. Conditions that are new or that were not uniquely identified in ICD-9-CM have been assigned code numbers in ICD-10-CM.

6. In ICD-10-CM, some three-character categories are not used in order to allow for revisions and future expansion.

7. Instead of grouping by categories of injury or type of wound, ICD-10-CM groups injuries by site of the injury and then by the type.

8. Excludes notes were expanded in order to provide guidance on the hierarchy of the chapters and to clarify priority of code assignment.

9. Some conditions with a new treatment protocol or perhaps a recently discovered or new etiology have been listed in a more appropriate chapter.

10. Combination codes are used for both symptom and diagnosis, and etiology and

manifestations – for example K50.03 Crohn's disease of small intestine with fistula.

11. Codes for postoperative complications have been expanded. Also, a distinction has been

made between intraoperative complications and post-procedural disorders: for example,

K91 Intraoperative and post procedural complications and disorders of digestive system,

NEC (Hazlewood, 2003).

What is Clinical Documentation Improvement?

"If it was not documented, it was not done." Most clinicians have heard this phrase time

and time again. The reason that they have heard this phrase is because in legal cases, this is the

statement of truth (Hailes, 2012).

Clinical documentation is critical for patient care and for healthcare. It validates that

patient care was completed and it serves as a legal document. Each facility's documentation in

the patient health record has guidelines that are governed. The guidelines ensure that each

facility is meeting compliance standards with local, state, and federal regulatory agencies

("Using cdi programs," 2013). Clinical documentation must also meet certain compliance and

regulation standards for payers, such as, CMS and Tricare. In addition, it has an impact on

coding, on billing, and on reimbursement (Hailes, 2012). Therefore, it is imperative for

physicians to know and to understand the changes that are needed in order to accommodate the

increased specificity of ICD-10-CM/PCS. Their documentation will need to "accurately reflect

the patient's diagnosis and procedures" ("Using cdi programs," 2013).

In an effort to assist medical providers, CDI programs were developed. Each facility's

CDI program varies to meet the needs of their physicians, clinicians and the specific facility's

clinical documentation needs. CDI professionals "are the ideal individuals to work side-by-side"

("Using cdi programs," 2013) with care providers to ensure and to reflect the quality of patient

care, to ensure that the documentation in the patient health record is complete and accurate, as

well as, to ensure that the documentation is detailed enough for accurate ICD-10-CM/PCS code

assignment ("Using cdi programs," 2013).   This will also ensure the accuracy for hospital

reporting (Hall, 2012).

Clinical Documentation Specialists

        CDI programs consist of a wide range of different personnel, often referred to as a

clinical documentation specialist (CDS), depending on the facility. The CDS may have either a

clinical or coding background, but is able to use both sets of skills ("Using cdi programs," 2013).

For one organization, that owns over 160 facilities across the country, their CDI program

consists of experienced Registered Nurses (RNs), and Health Information Management (HIM)

personnel with a credentialed Registered Health Information Administrator (RHIA) and/or a

credentialed Certified Coding Specialist (CCS) (2014, July 29). Another organization, that has

several facilities in Tennessee, CDI department consists of just one kind of healthcare specialist:

RNs (2014, September 24). Other CDSs may hold Certified Documentation Improvement

Practitioner (CDIP) or Certified Clinical Documentation Specialist (CCDS) certifications

("Using cdi programs," 2013). The CDS team "must be able to work cooperatively, building

rapport and trust with providers and other staff" ("Using cdi programs," 2013). Building trust

and rapport with the physicians and other staff will help ease the transition from ICD-9-CM to

ICD-10-CM/PCS.

Clinical Documentation

        The CDI team holds many roles within the HIM Department. They perform chart

reviews, work with physicians with clinical documentation, and are sometimes the liaison

between the coding staff and the physicians. CDSs perform chart reviews concurrently and/or

retrospectively to determine if additional clinical documentation is needed to accurately code the

health record. Several different note types must be reviewed, which may include: 1) Nursing

Notes; 2) Emergency Room Notes; 3) Operating Room Notes; 4) Laboratory; 5) Diagnostics; 6)

Physical Therapy/Occupational Therapy Notes; and 7) Other Disciplines. The CDS reviewing

the notes must compare these notes with the History and Physical, the Physician Progress Notes,

and the Consultation Notes. A physician query is needed for additional information or for

further clarification of the documentation in the health record if, there are any discrepancies in

the health record and/or if, there is incomplete clinical documentation. Some common reasons a

query may be needed include, but are not limited to: 1) legibility; 2) completeness; 3) clarity; 4)

consistency; and 5) precision ("Using cdi programs," 2013).

　　　　According to studies on the impact of ICD-10-CM/PCS, the increased specificity in

documentation will increase physician queries. This will cause delayed coding of charts and of

delayed billing. However, it has been found that the physician queries are increasing in some

areas, but will decrease in other areas. With strategic planning, CDI personnel can make changes

to the existing queries that they use for ICD-9 in order to accommodate the increased specificity

of ICD-10 queries (2014, July 29). This will not impact the amount of queries, but will impact

the physicians. One organization has already been revamping their physician queries. While

doing this, they incorporated the ICD-10-CM/PCS requirements; thereby, starting to train the

clinicians to begin documenting as if ICD-10-CM/PCS was already implemented (2014,

September 24). The CDSs must work with the physicians to educate them on what changes need

to be made (in regards to specificity) in their documentation to avoid additional physician

queries.

Physician clinical documentation must reflect the complexity of the patient's care, comorbid conditions, and treatment. All of these areas impact severity of illness (SOI) and risk of mortality (ROM) and ultimately effect the Medicare severity diagnosis-related group (MS-DRG). The MS-DRG assignment, which indicates the correlated relative weight (RW) associated, results in either a higher or lower reimbursement rate from CMS depending on the needed resources ("Using cdi programs," 2013).   Present on admission (POA), hospital-acquired conditions (HACs), patient safety indicators (PSIs), complicating or comorbid conditions (CCs), and major complicating or comorbid conditions (MCCs) all influence clinical documentation for ICD-10-CM, which ultimately impacts reimbursement for the facility ("Using cdi programs," 2013).

The transition to ICD-10-CM/PCS is very overwhelming for many clinicians. However, CDSs can help ease the transition to make it less stressful for clinicians through education. CDSs must first identify and become familiar with the differences between ICD-9-CM and ICD-10-CM/PCS, especially the coding process. Next, an assessment of the current documentation is necessary to determine any documentation deficiencies. A gap analysis should be completed to establish the areas of opportunity for physicians. CDSs should present the findings and educate the physicians on the areas of opportunity ("Using cdi programs," 2013).

Just like any new policy or procedure that takes place, education is needed to inform staff of those new policies and new procedures. Medical school does not emphasize the key components needed for physician documentation. Therefore, CDSs must provide education to providers, especially in regards to the specificity changes that will be necessary for ICD-10-CM/PCS. Providing a positive learning environment in short sessions is one way to ensure educational sessions have high attendance rates from providers and staff. Explaining the "added

benefits of improved data, and how that data supports better hospital and provider profiles, reduces denials, and ensures timely reimbursement" ("Using cdi programs," 2013). It will help the providers and clinicians understand the importance of complete, of accurate, and of timely clinical documentation. Some examples of methods for training sessions include: 1) Utilize real, practical examples; 2) Compare the difference in verbiage between ICD-10-CM/PCS and ICD-9-CM; 3) Create templates; 4) Distribute handouts; 5) Leverage newsletters; 6) Hang posters throughout the facility for awareness; and 7) Hand out "pocket cards" for quick reference ("Using cdi programs," 2013).

Purpose of the Study

The purpose of this study is to evaluate if healthcare facilities have a CDI team that is currently educating and preparing staff for the transition from ICD-9-CM to ICD-10-CM/PCS, despite the compliance date being delayed. Through the analysis of data from a survey of CDI staff across the country, this study will help determine whether facilities will be ready by the new compliance date, October 1, 2015. Also, this study will determine how many facilities have started dual coding patient accounts to better ensure system and user readiness for ICD-10-CM/PCS's start date.

Significance of Study

This study seeks to gain an understanding of the readiness of facilities and of the readiness of CDI teams transitioning to ICD-10-CM/PCS. Some studies have been conducted on the impact of productivity when switching from ICD 9-CM to ICD10-CM/PCS. However, this study strictly focuses on facilities' current status with ICD-10-CM/PCS staff education. The specificity of ICD-10-CM/PCS over ICD9-CM is so vast that it is vital to organize educational sessions to ensure complete and accurate coding.

HIM professionals will greatly benefit from this research by being able to gage themselves against their peers in their readiness to transition from ICD 9-CM to ICD-10-CM/PCS. If the HIM professionals perceive their departments as inadequate, this study can aid them in organizing the pieces needed to help their staff and team to develop a customized educational plan for their facility. All clinical and professional staffs must be educated and must be ready for the implementation of ICD-10-CM/PCS by the compliance date of October 1, 2015.

Research Questions

This study seeks to inform HIM professions of facility and of clinical staff readiness for the transition to ICD-10-CM/PCS with the increased specificity and the enormous increase in the number of codes. The specific research question is:

- Are facilities and CDI staff currently ready for the transition to ICD-10-CM/PCS despite the compliance date being delayed until October 1, 2015?

The data analysis of the survey will focus on facility size, size of the CDI team, whether there is an educational program for ICD-10-CM/PCS in place, and several other variables. Survey data will be analyzed by computing response rates, frequencies of variables, and cross tabulations.

Chapter 2

Review of Literature

An extensive and lengthy search was conducted of pertinent literature using the search engines of Google Scholar, PubMed, CINAHL, Healthcare Information and Management Systems Society (HIMSS) and AHIMA's Body of Knowledge. A manual search was also performed.

A set of search criteria was followed for each of the databases listed using keywords that reflected ICD-10 and CDI. The keywords, as well as, a combination of the keywords used during the search included: clinical documentation improvement, CDI, education, CDI education, ICD-10-CM/PCS, ICD-10, and ICD-9-CM. This literature review included articles and journals that were published between 2003 and 2014. They also were written in English and included the current status of healthcare facilities and clinical documentation improvement staff on the education and on the readiness for the transition from ICD-9-CM to ICD-10-CM/PCS. Articles that included the revenue cycle and the revenue gap were excluded, as well as, any letters or website blogs.

After extensive research, there were not any articles or scholarly journals that were found to address the current status of healthcare facilities and clinical documentation improvement staff on ICD-10-CM/PCS transition readiness. Two CDI personnel were contacted personally through telephone and e-mail communication in order to gain a better understanding of facility and of clinical staff readiness for ICD-10-CM/PCS.

Findings

      "'On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015'" (Dimick, 2014).

      Due to Congress enacting the bill to delay ICD-10-CM/PCS yet again for another year, many healthcare organizations are being impacted negatively. CDI programs that were working with physicians and with facilities to become ICD-10-CM/PCS compliant are being placed on hold and it is estimated that most facilities will not resume testing and training until six months prior to the HIPAA compliant date of October 1, 2015. Clinical documentation is being impacted because of the need for added specificity. The new code set (ICD-10-CM/PCS) allows for more specific codes, which would allow for higher reimbursement and for improved reporting. The current code set, ICD-9-CM has been on a code freeze for a couple years and is making the need to transition to ICD-10-CM/PCS even greater.

Chapter 3

Methodology

Research Design

In order to understand the ramifications of the new compliance laws in reference to ICD-9-CM converting to ICD-10-CM/PCS and Clinical Documentation Improvement, a survey questionnaire (Figure 1) was developed and distributed. The final data collection tool included the following variables:

1. Medical Facility Primary Type

2. Size of Health Care Facility

3. Size of Clinical Documentation Improvement Staff

4. If you have a Clinical Documentation Team, who makes up the team?

5. What is the skill level of current Clinical Documentation Specialists (CDS)?

6. Is there an educational program to help transition to ICD-10-CM/PCS?

7. Is the CDI staff reviewing and preparing for any of the following areas that may be of challenge for ICD-10-CM/PCS due to increased specificity? Please select all that apply.

8. Is your facility currently dual coding?

9. What types of CDI training sessions are being held for physicians and clinical staff to prepare for ICD-10-CM/PCS? Please select all that apply.

10. Currently, do you feel your facility will completely be ready for the transition to ICD-10-CM/PCS by the new compliance date, October 1, 2015?

Variables and rationale

Medical Facility Primary Type. Survey choices were: (a) Acute care; (b) LTAC/Skilled Care; (c) Rehabilitation; (d) Psychiatric; and (e) Other.

Rationale: The type of facility may be a factor in CDI education complexity. The more services a facility offers, potentially, the greater impact on healthcare staff and system readiness for ICD-10-CM/PCS by the new compliance date of October 1, 2015.

Size of Healthcare Facility. Survey choices were: (a) 50 or less beds; (b) 51 to 100 beds; (c) 101 to 200 beds; (d) 201 or more beds; and (e) Other.

Rationale: The size of the facility may be a factor in the size of the CDI team. A larger facility generally will have a larger number of employees. Are there enough educators ready to help clinical staff in the transition to ICD-10-CM/PCS? Some smaller facilities may not have a CDI team and therefore, will need an alternate plan for education and to ready staff for the increased specificity and complexity of ICD-10-CM/PCS.

Size of Clinical Documentation Improvement Staff. Survey choices were: (a) 5 or less; (b) 6 to 15; (c) 16 to 25; and (d) 26 or more.

Rationale: The size of the CDI staff may have an impact on the transition to ICD-10-CM/PCS. The more CDI staff a facility employs, the more availability the staff would have to help answer any questions, as well as, to help those in need of addition education on ICD-10-CM/PCS.

If you have a Clinical Documentation team, who makes up the team? Survey choices were: (a) Registered Nurses; (b) Certified Coding Specialists; (c) Registered Health Information Administrators; and (d) Other.

Rationale: The educational background of the CDI team is important because it may help physicians and other clinical staff respect and take educational sessions more seriously. When the physicians and other clinical staff can build a rapport with the CDI team, the educational sessions and other encounters may lead to a smoother transition to ICD-10-CM/PCS.

What is the skill level of current Clinical Documentation Specialists (CDS)? Survey choices: (a) Beginner (0-1 year of experience); (b) Moderate (1-5 years of experience); (c) Advanced (5-10 years of experience); (d) Expert (10 or more years); and (e) Other.

Rationale: Again, the skill level of the CDS may be a contributing factor for physicians and clinical staff to build rapport. When a CDS has been with the company and/or within their same role for several years, the knowledge and the experience may be helpful in devising a facility specific plan to ease the education and the transition for clinical staff to ICD-10-CM/PCS.

Is there an educational program to help transition to ICD-10-CM/PCS? Survey choices: (a) Yes and (b) No.

Rationale: Determining whether or not a facility has an educational program to help transition to ICD-10-CM/PCS may be very helpful in knowing if a facility is ready for the new code set, ICD-10-CM/PCS.

Is the CDI staff reviewing and preparing for any of the following areas that may be of challenge for ICD-10-CM/PCS due to increased specificity? Please select all that apply. Survey choices: (a) Acute Myocardial Infarction; (b) Asthma; (c) Cerebrovascular Disease; (d) Coma; (e) Diabetes; (f) Fracture; (g) Orthopedics; (h) Pregnancy; (i) Pressure Ulcer; (j) Respiratory Failure; and (k) Other.

Rationale: The areas listed above are currently a challenge for ICD-9-CM. Knowing whether or not the CDI staff is incorporating the areas into training and into educational sessions for ICD-10-CM may be a benefit to determine the current status of a facility's readiness for the increased specificity that comes with ICD-10-CM/PCS.

Is your facility currently dual coding? Survey choices: (a) Yes and (b) No.

Rationale: Dual coding is a major indicator and tool that can be used to determine areas of opportunity for facilities as they transition to ICD-10-CM/PCS. Knowing if a facility is currently dual coding may be helpful to see if CDI are working with physicians, coders, and other clinical staff to address areas of opportunity.

What types of CDI training sessions are being held for physicians and clinical staff to prepare for ICD-10-CM/PCS? Please select all that apply. Survey choices: (a) Utilizing real, practical examples; (b) Comparing the difference in verbiage between ICD-10-CM/PCS and ICD-9-CM; (c) Creating templates; (d) Distributing handouts; (e) Newsletters; (f) Hanging posters throughout the facility for awareness; (g) Hanging out pocket cards for quick reference; (h) WebEx training; and (i) Other.

Rationale: Each person learns differently. Finding out whether facilities and CDI staff are taking full advantage of a vast amount of different training sessions may ensure that all types of learners will understand the changes that will occur with the transition to ICD-10-CM/PCS.

Currently, do you feel your facility will completely be ready for the transition to ICD-10-CM/PCS by the new compliance date, October 1, 2015? Survey choices: (a) Yes and (b) No.

Rationale: Knowing whether each CDI staff currently feels that their facility will be ready for ICD-10-CM/PCS by October 1, 2015 may determine whether facilities should not

postpone training and educational sessions until next year, but simply continue to strive to keep

momentum and to ensure that each staff member will feel comfortable and confident when the

new code set is implemented.

Database Selection

After reviewing all possible databases, it was determined that *Survey Monkey* would meet

all the requirements of the study and would be used. The data from *Survey Monkey* was then

exported into *Microsoft Excel 2010*.

Data collection instrument

A data collection instrument was developed using the tools available within

SurveyMonkey to incorporate the variables discussed above. The survey was administered using

a random sample through *SurveyMonkey's* web link that provided direct access to the survey

tool. This data collection method was found to be efficient, user-friendly, and easy. It also

allowed for all information to be completely de-identified and confidential.

Population and Sample Design

A random sample of CDI personnel from around the U.S.A. were chosen to participate in

the survey. Each potential participant received an e-mail communication inviting them to

participate in the survey. Each facility was affiliated with Hospital Corporation of America

(HCA) except one, which was affiliated with St. Jude Children's Research Hospital.

Data Collection Procedures

An e-mail communication (Figure 2) with a quick link to the survey tool from

SurveyMonkey was administered to the random population within 57 facilities across the nation

on Monday, October 20, 2014. The deadline to complete the survey was set for Friday, October

24, 2014.

Data Analysis

After the deadline had been reached, the data was organized and transferred into a

Microsoft Excel 2010 spreadsheet. Data was inputted and organized in different tabs. The first

tab contained all data from *SurveyMonkey* including: 1) Question number; 2) Question; and 3)

Response. The second tab contained all the data analysis tables used to determine the percent of

respondents. The third tab contained all pivot tables using the information from the data analysis

tables. The fourth tab contained all pie charts and all graphs.

Chapter 4

Results

Response Rate of Population

After gathering all data, it was determined that 18 CDSs out of the potential 57 responded to the survey. That equates to a 30.58% response rate. After reviewing all surveys, it was found that 2 of the 18 surveys had incomplete surveys. Both failed to answer a couple questions.

Frequency Tables

Tables 2 through Table 11, set one, are a summary of response counts and percentages from the 10 survey questions.   Tables 12 and Table 13, set two, are a summary of the total number of choices selected for areas of increased specificity for ICD-10-CM/PCS and total number of choices selected for the types of training sessions implemented. Table 14 through Table 20, set three, are the cross tabulations of counts and of percentages between variables within the survey questions. In Table 14 through Table 16, they reference background information on the facility and on the CDI team. In Table 17 through Table 20, they reference educational sessions, facility readiness, and dual coding for ICD-10-CM/PCS.

Table 2: *Medical Facility Type*

Facility Type	No. of Respondents	Percent of Total Respondents
Acute Care	17	94.44%
LTAC/Skilled Care	0	0.00%
Rehabilitation	0	0.00%
Psychiatric	0	0.00%
Other (please specify)	1	5.56%
Total	18	100.00%

Table 3: *Size of Health Care Facility*

Size of Facility	No. of Respondents	Percent of Total Respondents
50 or Less Beds	0	0.00%
51 to 100 Beds	2	11.11%
101 to 200 Beds	5	27.78%
201 or More Beds	10	55.56%
Other (please specify)	1	5.56%
Total	18	100.00%

Table 4: *Size of Clinical Documentation Improvement Staff*

Size of Clinical Documentation Staff	No. of Respondents	Percent of Total Respondents
5 or Less	15	83.33%
6 to 15	2	11.11%
16 to 25	0	0.00%
26 or More	1	5.56%
Total	18	100.00%

Table 5: *If you have a Clinical Documentation Team, who makes up the team?*

Clinical Documentation Team's Background	No. of Respondents	Percent of Respondents

Registered Nurses (RNs)	14	77.78%
Certified Coding Specialists (CCSs)	0	0.00%
Registered Health Information Administrators (RHIA)	0	0.00%
Other (please specify)	4	22.22%
Total	18	100.00%

Table 6: *What is the skill level of current Clinical Documentation Specialists (CDS)?*

CDS Skill Level	No. of Respondents	Percent of Respondents
Beginner (0-1 year experience)	2	11.11%
Moderate (1-5 years of experience)	14	77.78%
Advanced (5-10 years of experience)	0	0.00%
Expert (10 or more years of experience)	0	0.00%
Other (please specify)	2	11.11%
Total	18	100.00%

Table 7: *Is there an educational program to help transition to ICD-10-CM/PCS?*

Educational Program for ICD-10-CM/PCS		
Yes	17	94.44%
No	1	5.56%
Total	18	100.00%

Table 8: *Is the CDI staff reviewing and preparing for any of the following areas that may be of challenge for ICD-10-CM/PCS due to increase specificity? Please select all that apply.*

Areas in need of Preparation for ICD-10-CM/PCS	No. of Respondents	Percent of Total Respondents (N=16)
Acute Myocardial Infarction	10	62.50%
Asthma	8	50.00%

Cerebrovascular Disease	9	56.25%
Coma	7	43.75%
Diabetes	8	50.00%
Fracture	7	43.75%
Orthopedics	6	37.50%
Pregnancy	3	18.75%
Pressure Ulcer	8	50.00%
Respiratory Failure	9	56.25%
Other (please specify)	8	50.00%
Total Responses	16	

Note. Respondents were to select all of the above choices that were applicable.

Table 9: *Is your facility currently dual coding?*

Facility dual coding	No. of Respondents	Percent of Respondents
Yes	4	22.22%
No	14	77.78%
Total	18	100.00%

Table 10: *What types of CDI training sessions are being held for physicians and clinical staff to prepare for ICD-10-CM/PCS? Please select all that apply.*

Types of Training Sessions	No. of Respondents	Percent of Respondents (N=17)
Utilizing real, practical examples	4	23.53%
Comparing the difference in verbiage between ICD-10-CM/PCS and ICD-9-CM	3	17.65%
Creating Templates	2	11.76%
Distributing Handouts	4	23.53%
Newsletters	4	23.53%
Hanging Posters Throughout the Facility for Awareness	2	11.76%

Handing Out Pocket Cards for Quick Reference	4	23.53%
WebEx Training	12	70.59%
Other (please specify)	5	29.41%
Total Responses	17	

Note. Respondents were to select all of the above choices that were applicable.

Table 11: *Currently, do you feel your facility will completely be ready for the transition to ICD-10-CM/PCS by the new compliance date, October 1, 2015?*

Current Facility Readiness for ICD-10-CM/PCS	No. of Respondents	Percent of Respondents
Yes	11	61.11%
No	7	38.89%
Total	18	100.00%

Table 12: *Number of Areas That May be of Challenge for ICD-10-CM/PCS on Question 7 of the Survey That Were Selected by the Survey Respondents and the Percent of Respondents Who Selected This Number*

No. of the Eleven Areas with Increased Specificity Selected	No. of Respondents Who Selected This No. of Areas	Percent of Respondents Who Selected This No.
0	0	0.00%
1	6	37.50%
2	1	6.25%
3	0	0.00%
4	1	6.25%
5	0	0.00%
6	1	6.25%
7	0	0.00%
8	1	6.25%
9	4	25.00%

10	1	6.25%
11	1	6.25%
Total	16	100.00%

Note. The mean (average) number of areas with increased specificity selected was 6.38 and the median was 7.00.
Note. Excludes 2 Missing/No Response.

Table 13: *Number of Types of Training Sessions That Are Being Held for Physicians and Clinical Staff to*

Prepare for ICD-10-CM/PCS on Question 9 of the Survey That Were Selected by the Survey Respondents

and the Percent of Respondents Who Selected This Number

No. of Types of Training Sessions to Help Prepare for ICD-10-CM/PCS	No. of Respondents Who Selected This No. of Types of Training Sessions	Percent of Respondents Who Selected This No.
0	0	0.00%
1	10	58.82%
2	2	11.76%
3	0	0.00%
4	3	17.65%
5	0	0.00%
6	1	5.88%
7	0	0.00%
8	1	5.88%
9	0	0.00%
Total	17	100.00%

Note. The mean (average) number of types of training sessions to prepare for ICD-10-CM/PCS selected was 4.20 and the median was 4.00.
Note. Excludes 1 Missing/No Response.

Cross Tabulations of Selected Pairs of Variables

Table 14: *Cross Tabulation of Size of Facility by Facility Type*

			Facility Type					Total
			Acute	LTAC/Skilled Care	Rehabilitation	Psychiatric	Other	
Size of Facility	50 or less beds	Count	0	0	0	0	0	0
		% within Facility Type	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	51 to 100 beds	Count	1	0	0	0	1	2
		% within Facility Type	5.88%	0.00%	0.00%	0.00%	100.00%	11.11%
	101 to 200 beds	Count	5	0	0	0	0	5
		% within Facility Type	29.41%	0.00%	0.00%	0.00%	0.00%	27.78%
	201 or more beds	Count	10	0	0	0	0	10
		% within Facility Type	58.82%	0.00%	0.00%	0.00%	0.00%	55.56%
	Other	Count	1	0	0	0	0	1
		% within Facility Type	5.88%	0.00%	0.00%	0.00%	0.00%	5.56%
Total		Count	17	0	0	0	1	18
		% within Facility Type	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 15: *Cross Tabulation of Types of Training Sessions for ICD-10-CM/PCS by Facility Type*

			Facility Type					
			Acute	LTAC/Skilled Care	Rehabilitation	Psychiatric	Other	**Total Percent of Respondents (N=17)**
	Utilizing real, practical examples	Count	3	0	0	0	1	4
		% within Facility Type	17.65%	0.00%	0.00%	0.00%	5.88%	23.53%
	Comparing the verbiage between ICD-10-CM/PCS and ICD-9-CM	Count	3	0	0	0	0	3
		% within Facility Type	17.65%	0.00%	0.00%	0.00%	0.00%	17.65%
	Creating Templates	Count	2	0	0	0	0	2
		% within Facility Type	11.64%	0.00%	0.00%	0.00%	0.00%	11.64%
	Distributing Handouts	Count	3	0	0	0	1	4
		% within Facility Type	17.65%	0.00%	0.00%	0.00%	5.88%	23.53%
	Newsletters	Count	4	0	0	0	0	4
		% within Facility Type	23.53%	0.00%	0.00%	0.00%	0.00%	23.53%
	Hanging Posters	Count	2	0	0	0	0	2
		% within Facility Type	11.64%	0.00%	0.00%	0.00%	0.00%	11.64%
	Handing Out Pocket Cards	Count	3	0	0	0	1	4
		% within Facility Type	17.65%	0.00%	0.00%	0.00%	5.88%	23.53%
	WebEx Training	Count	12	0	0	0	0	12
		% within Facility Type	70.59%	0.00%	0.00%	0.00%	0.00%	70.59%

Types of CDI Training Sessions for ICD-10-CM/PCS

			50 or less beds	51 to 100 beds	101 to 200 beds	201 or more beds	Other	Total
	Other	Type						
		Count	4	0	0	0	1	5
		% within Facility Type	23.53%	0.00%	0.00%	0.00%	5.88%	29.41%
Total		Count	36	0	0	0	4	40
		% within Facility Type	90.00%	0.00%	0.00%	0.00%	10.00%	100.00%

Note. Excludes 1 Missing/No Response.

Table 16: *Cross Tabulation of CDI Team Size by Size of Facility*

			Size of Facility					
			50 or less beds	51 to 100 beds	101 to 200 beds	201 or more beds	Other	**Total**
CDI Team Size	5 or Less	Count	0	1	4	9	1	15
		% within Facility Size	0.00%	50.00%	80.00%	90.00%	100.00%	83.33%
	6 to 15	Count	0	1	0	1	0	2
		% within Facility Size	0.00%	50.00%	0.00%	10.00%	0.00%	11.11%
	16 to 25	Count	0	0	0	0	0	0
		% within Facility Size	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	26 or More	Count	0	0	1	0	0	1
		% within Facility Size	0.00%	0.00%	20.00%	0.00%	0.00%	5.56%
Total		Count	0	2	5	10	1	18
		% within Facility Size	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 17: *Cross Tabulation of CDI Team Size by Education Program Implemented for ICD-10-CM/PCS*

| | | | Educational Program Implemented for ICD-10-CM/PCS | | |
			Yes	No	Total
CDI Team Size	5 or Less	Count	15	0	15
		% within the Education Program Implemented	88.24%	0.00%	83.33%
	6 to 15	Count	1	1	2
		% within the Education Program Implemented	5.88%	100.00%	11.11%
	16 to 25	Count	0	0	0
		% within the Education Program Implemented	0.00%	0.00%	0.00%
	26 or More	Count	1	0	1
		% within the Education Program Implemented	5.88%	0.00%	5.56%
Total		Count	17	1	18
		% within the Education Program Implemented	100.00%	100.00%	100.00%

Table 18: *Cross Tabulation of Facility Readiness for ICD-10-CM/PCS by Educational Program*

Implemented for ICD-10-CM/PCS

| | | | Educational Program Implemented for ICD-10-CM/PCS | | |
			Yes	No	Total
Facility Readiness for ICD-10-CM/PCS	Yes	Count	10	1	11
		% within the Education Program Implemented	58.82%	100.00%	61.11%
	No	Count	7	0	7
		% within the Education Program Implemented	41.17%	0.00%	38.89%
Total		Count	17	1	18
		% within the Education	100.00%	100.00%	100.00%

			Program Implemented		

Table 19: *Cross Tabulation of Training Sessions for ICD-10-CM/PCS by Facility Readiness for ICD-10-CM/PCS*

Facility Readiness for ICD-10-CM/PCS

			Yes	No	Total Percent of Respondents (N=17)
Types of CDI Training Sessions for ICD-10-CM/PCS	Utilizing real, practical examples	Count	4	0	4
		% within Facility Readiness for ICD-10-CM/PCS	23.53%%	0.00%	23.53%
	Comparing the verbiage between ICD-10-CM/PCS and ICD-9-CM	Count	3	0	3
		% within Facility Readiness for ICD-10-CM/PCS	17.65%	0.00%	17.65%
	Creating Templates	Count	2	0	2
		% within Facility Readiness for ICD-10-CM/PCS	11.76%	0.00%	11.76%
	Distributing Handouts	Count	4	0	4
		% within Facility Readiness for ICD-10-CM/PCS	23.53%	0.00%	23.53%
	Newsletters	Count	4	0	4
		% within Facility Readiness for ICD-10-CM/PCS	23.53%	0.00%	23.53%
	Hanging Posters	Count	2	0	2
		% within Facility Readiness for ICD-10-CM/PCS	11.76%	0.00%	11.76%
	Handing Out Pocket Cards	Count	4	0	4
		% within Facility Readiness for	23.53%	0.00%	23.53%

		ICD-10-CM/PCS			
WebEx Training	Count		7	5	12
	% within Facility Readiness for ICD-10-CM/PCS		41.18%	29.41%	70.59%
Other	Count		3	1	4
	% within Facility Readiness for ICD-10-CM/PCS		17.65%	5.88%	23.53%
Total	Count		33	6	39
	% within Facility Readiness for ICD-10-CM/PCS		84.62%	15.38%	100.00%

Note. Excludes 1 Missing/No Response.

Table 20: *Cross Tabulation of Dual Coding by Facility Readiness for ICD-10-CM/PCS*

Facility Readiness for ICD-10-CM/PCS

			Yes	No	Total
Currently Dual Coding	Yes	Count	4	0	4
		% within Facility Readiness for ICD-10-CM/PCS	36.36%	0.00%	22.22%
	No	Count	7	7	14
		% within Facility Readiness for ICD-10-CM/PCS	63.64%	100.00%	77.78%
Total		Count	11	7	18
		% within Facility Readiness for ICD-10-CM/PCS	100.00%	100.00%	100.00%

Chapter 5

Analysis and Discussion

Ninety-four percent (94%) or 17 of the respondents were from acute care facilities. One respondent or six percent (6%) was from an "other" facility (Table 2).

Fifty-six percent (56%) of the respondents were from facilities that had 201 or more beds. Twenty-seven percent (27%) of the respondents were from facilities with 101 to 200 beds. Eleven percent (11%) of the respondents had 51 to 100 beds at their facility. One respondent was from an "other" size facility. There were not any respondents that came from facilities that had 50 or less beds (Table 3).

Eighty-three percent (83%) of the respondents have a CDI team that consists of five or less personnel. Two facilities, eleven percent (11%), of the respondents have a CDI team of six to sixteen people. One CDI team or six percent (6%) of the respondents have a team of twenty-six or more CDI staff. There were not any facilities to have a CDI team of six to fifteen personnel (Table 4).

Seventy-eight percent (78%) of the respondents have a CDI team that consists of RNs. Twenty-two percent (22%) responded with "other." There were not any respondents to have CDI teams that consist of CCSs or RHIAs (Table 5).

Seventy-eight percent (78%) of the respondents have a CDI team that has moderate experience (1-5 years). Eleven percent (11%) of the respondents have a CDI team that has beginner experience (0-1 year) and eleven percent (11%) of the respondents answered "other" to the skill level of their CDI team (Table 6).

 Ninety-four percent (94%) or 17of the respondents said there was an educational

program to help transition to ICD-10-CM/PCS. One respondent or six percent (6%) said they did

not have an education program (Table 7).

For survey Question 7, seven (7) areas that may be of challenge for ICD-10-CM/PCS due

to increased specificity were selected by fifty percent (50%) or more of the respondents. The

survey choices that were selected by the majority include: 1) Acute myocardial infarction; 2)

Asthma; 3) Cerebrovascular Disease; 4) Diabetes; 5) Pressure Ulcer; 6) Respiratory Failure; and

7) Other. The choices not selected by the majority and which fell below fifty-percent (50%)

include: 1) Coma; 2) Fracture; 3) Orthopedics; and 4) Pregnancy. Two respondents either

skipped or purposefully left this question blank (Table 8).

Seventy-eight percent (78%) of the respondents are not currently dual coding at their

facility. Twenty-two percent (22%) of the respondents are currently dual coding (Table 9).

For survey Question 9, one type of training session to help prepare for ICD-10-CM/PCS

was selected by fifty percent (50%) or more of the respondents. The survey choice selected by

seventy percent (70%) of the respondents was WebEx training. The other eight (8) types of

training sessions were selected less than fifty percent (50%) of the respondents. The other types

include: 1) Utilizing real, practical examples; 2) Comparing the different in verbiage between

ICD-10-CM/PCS and ICD-9-CM; 3) Creating templates; 4) Distributing Handouts; 5)

Newsletters; 6) Hanging Posters Throughout the Facility for Awareness; 7) Handing Out Pocket

Cards for Quick Reference; and 8) Other. One respondent either skipped or purposefully left this

question blank (Table 10).

Sixty-one percent (61%) of the respondents feel their facility is currently ready to

transition to ICD-10-CM/PCS by the new compliance date, October 1, 2015. However, thirty-

nine percent (39%) of the respondents feel their facility is not currently ready to transition to ICD-10-CM/PCS.

In the survey, Question 7 and Question 9 were multiple answer questions. The respondent was to select all that apply to their specific facility and/or CDI team. Table 8 shows the respective number or respondents and their corresponding percentages per area of increased specificity. Table 10 shows the respective number of respondents and their corresponding percentages per type of training sessions held to prepare for ICD-10-CM/PCS. Table 12 and Table 13 summarize the count and the percentage of selected choices of areas of increased specificity and the count and the percentage of selected choices of types of training per respondent, respectively. In Table 12, thirty-eight percent (38%) selected only one area of increased specificity. Twenty-five percent (25%) selected nine areas of increased specificity. One respondent selected the other areas. They include: 1) Two areas; 2) Four areas; 3) Six areas; 4) Eight areas; 5) Ten areas; and 6) Eleven areas of increased specificity that may pose as a challenge for ICD-10-CM/PCS. The mean (average) number of choices selected was 6.38 and the mean number of choices selected was 7.00. Also, two surveys had missing or blank answers for this question. In Table 13, fifty-nine percent (59%) selected only one type of training session held for ICD-10-CM/PCS. Eighteen percent (18%) or three of the respondents selected four different types of training sessions held at their facility. Twelve percent (12%) or two of the respondents selected two different types of training sessions and six percent (6%) selected six and eight different types of training sessions for ICD-10-CM/PCS. The mean (average) number of choices selected was 4.20 and the mean number of choices selected was 4.00. Also, one survey had missing or blank answers for this question.

Cross Tabulations of Various Pairs of Variables

Table 14 through Table 20 show the relationship between two different variables of data collected from the ten survey questions.

In Table 14, fifty-six percent (56%) of the respondents were from an acute care hospital with 201 or more beds. Twenty-eight percent (28%) were from an acute care facility with 101 to 200 beds. One acute care facility had 51 to 100 beds and an "other" facility also had 51 to 100 beds. One acute care hospital had an "other" number of beds.

Seventy-one percent (71%) of acute care facilities are using WebEx Training to prepare for ICD-10-CM/PCS. Twenty-nine percent (29%) are using an "other" type of training that was not listed in the question's answer choices. Twenty-four percent (24%) or four of those respondents are from acute care facilities and six percent (6%) or one respondent is from an "other" type of facility. Twenty-four percent (24%) or four respondents selected the following: 1) Utilizing real, practical examples; 2) Distributing Handouts; 3) Newsletters; and 4) Handing Out Pocket Cards. Three or eighteen percent (18%) of the respondents were from acute care facilities and one respondent, six percent (6%), was from an "other" facility. Eighteen percent (18%) or three of the respondents selected comparing the verbiage between ICD-10-CM/PCS and ICD-9-CM as their means of training. All of those respondents were from acute care facilities. Twelve percent (12%) or two of the respondents chose creating templates and hanging posters. Those respondents were also from acute care facilities. One survey had missing or blank information for part of this cross tabulation (Table 15).

Eighty-three percent (83%) or fifteen of the respondents are part of a CDI team that has five or less people on staff. Out of the eighty-three percent, nine respondents came from a facility of 201 or more beds, four came from a facility of 101 to 200 beds, one respondent came

from a facility of 51 to 100 beds and one respondent came from an "other" facility. Eleven

percent (11%) or two of the respondents are part of a team of six to fifteen people. One

respondent came from a facility of 51 to 100 beds and the other respondent came from a facility

of 201 or more beds. Six percent (6%) or one of the respondents have a CDI team of twenty-six

or more people and came from a facility of 101 to 200 beds (Table 16).

In Table 17, eighty-three percent (83%) or fifteen of the respondents come from a CDI

team of 5 or less team members and they also have implemented an educational program for

ICD-10-CM/PCS. Eleven percent (11%) or two of the respondents have a CDI team of 6 to 15

members. One respondent selected that they did have an educational program and one

respondent said that they did not have an educational program for ICD-10-CM/PCS. Six percent

(6%) or one respondent was part of a CDI team of twenty-six or more staff members that had an

educational program implemented for ICD-10-CM/PCS.

Sixty-one percent (61%) or eleven of the respondents felt their facility is ready for ICD-

10-CM/PCS. Ten of those respondents also have an educational program implemented and one

respondent's facility did not have an educational program. Thirty-nine percent (39%) or seven

of the respondents felt their facility is not ready for ICD-10-CM/PCS, even though those same

responders also stated that their facilities had educational programs implemented for ICD-10-

CM/PCS (Table 18).

Seventy-one percent (71%) or twelve of the respondents use WebEx training for ICD-10-

CM/PCS. Of the respondents that use WebEx training, seven felt ready for ICD-10-CM/PCS and

five did not feel ready. Twenty-four percent (24%) or four of the respondents utilize real,

practical examples; distribute handouts; have newsletters; hand out pocket cards; and have

"other" types of training for ICD-10-CM/PCS. Out of the twenty-four percent (24%) or four of

the respondents, three felt their facilities were ready for ICD-10-CM/PCS and one respondent

felt their facility was not ready to implement ICD-10-CM/PCS. That respondent listed "other"

source of training from the choices listed. Eighteen percent (18%) or three of the respondents

used comparing the verbiage between ICD-10-CM/PCS and ICD-9-CM for their type of training.

Twelve percent (12%) or two of the respondents selected creating templates and hanging posters.

Of the twelve percent (12%) or two respondents, all of the respondents selected that their facility

was ready to implement ICD-10-CM/PCS. One survey had missing or blank information for part

of this cross tabulation (Table 19).

Seventy-eight percent (78%) or fourteen of the respondents are not currently dual coding.

Out of the seventy-eight percent (78%), seven respondents felt their facility is ready to

implement ICD-10-CM/PCS and the other seven respondents felt their facility is not ready to

implement ICD-10-CM/PCS. Twenty-two percent (22%) or four of the respondents are

currently dual coding and feel their facility is ready to implement ICD-10-CM/PCS (Table 20).

Limitations

Several limitations exist that need to be addressed. After extensive research during the

literature review, it was found that there were not any articles related to the current position of

CDI staff and facility readiness for ICD-10-CM/PCS due to the delay of compliance date to

October 1, 2015. The survey had a limited distribution to CDI staff at HCA facilities and St.

Jude Children's Research Hospital. Sending the survey nationwide to multiple organizations and

to multiple facilities potentially would have increased the sample size and perhaps led to a

broader understanding of the status of ICD-10-CM/PCS implementation. Not all respondents

answered all questions. Two respondents left one or more questions blank. Some CDI staff may

not have current facility statuses with regards to all aspects of the implementation of ICD-10-

CM/PCS program, i.e. some CDI staff may or may not know if their facility is currently dual

coding. The survey only yielded a thirty-one percent (31%) response rate.

Chapter 6

Conclusion and Recommendations

Summary of Findings

Evidence from the survey indicates that large acute care facilities are not necessarily

ready to implement ICD-10-CM/PCS by October 1, 2015. The majority of respondents that

indicated they had an educational program implemented for ICD-10-CM/PCS also had fifty-nine

(59%) answer "Yes" to facility readiness and forty-one percent (41%) answer "No" to facility

readiness. Those facilities that use WebEx training for ICD-10-CM/PCS had forty-one percent

(41%) answer "Yes" to facility readiness and twenty-nine percent (29%) answer "No" to facility

readiness. Of the facilities that are not currently dual coding, seven respondents answer that their

facility was ready to implement ICD-10-CM/PCS and seven respondents also answered that their

facility was not ready to implement ICD-10-CM/PCS. Very few facilities were found that have

already started dual coding, which included four respondents.

Based on these findings, it has been found that more education and more training needs to

occur in order for facilities to be ready to implement the new code set, ICD-10-CM/PCS on

October 1, 2015. Even if the facility had an educational program implemented, currently using

WebEx, and/or dual coding, these factors did not indicate complete facility readiness for ICD-

10-CM/PCS.

Conclusions

It is imperative to implement ICD-10-CM/PCS into American healthcare systems, as

soon as possible. The delay to October 1, 2015 gave organizations more time to transition;

however, it also delaying education, training, and testing. In addition, this delay is causing

American healthcare systems to be behind in reimbursement, in measuring, and in reporting

specific health outcomes. ICD-10-CM/PCS is more granular, more specific, and offers more

codes. There is room for expansion as new treatments and methodologies are developed; plus

space for new diagnoses. The current version of ICD-9-CM is very limited. CDI programs and

their CDSs are important to help ease the transition from ICD-9-CM to ICD-10-CM/PCS.

CDSs play a vital role for all healthcare entities to help ensure that physician's clinical

documentation is specific, is accurate, and is complete to lead to higher reimbursement and to

decrease claim rejections for inaccurate or incomplete information. With the transition to ICD-

10-CM/PCS October 1, 2015, CDSs must be able to convey the complex changes and be able to

educate the clinical staff about all variations between the two editions. A CDS must possess

critical thinking skills, be able to interpret clinical documentation in the health record, be able to

understand the disease processes and be able to understand the different procedures performed.

In addition, they must be able to work side-by-side with physicians and other clinical staff in

educating them on the changes from ICD-9-CM to ICD-10-CM/PCS. Physicians will need to

understand that their methods to documentation do not need to change, but that they need to be

more specific when documenting patient care.

Implications of the Study

HIM professionals, including CDI teams, will benefit greatly from this study by having a

better understanding of current facility readiness to implement the new code set, ICD-10-

CM/PCS by October 1, 2015. The results from the study will help guide HIM departments in

determining the next steps to ensure physicians and clinicians are prepared for the transition to

ICD-10-CM/PCS. The results from the survey provide which types of educational sessions may

lead to a better facility readiness. Also, incorporating dual coding into the work load could prove to help ease the transition and allow clinicians to feel more prepared for the new code set.

Recommendations

      The survey conducted included two organizations, where one has facilities all across the U.S.A. However, more facilities and more organizations should be included to have a better understanding of facility readiness in the U.S.A for ICD-10-CM/PCS. The data collected also does not indicate whether or not those facilities that are not currently dual coding will begin or will have plans to dual code significantly before the October 1, 2015 compliance date. A follow-up survey could be conducted in order to determine if more facilities are dual coding and whether or not that is an indicator of facility readiness for the new code set within ICD-10-CM/PCS.

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Appendix

Figure 1

Survey Questionnaire: ICD-10-CM/PCS and Clinical Documentation Improvement

1. Medical Facility Primary Type
    a. Acute Care
    b. LTAC/Skilled Care
    c. Rehabilitation
    d. Psychiatric
    e. Other (please specify)
2. Size of Health Care Facility
    a. 50 or less beds
    b. 51 to 100 beds
    c. 101 to 200 beds
    d. 201 or more beds
    e. Other (please specify)
3. Size of Clinical Documentation Improvement Staff
    a. 5 or less
    b. 6 to 15
    c. 16 to 25
    d. 26 or more
4. If you have a Clinical Documentation team, who makes up the team?
    a. Registered Nurses (RNs)
    b. Certified Coding Specialists (CCS)
    c. Registered Health Information Administrators (RHIAs)
    d. Other (please specify)
5. What is the skill level of current Clinical Documentation Specialists (CDS)?
    a. Beginner (Experience 0-1 year)
    b. Moderate (Experience 1-5 years)
    c. Advanced (Experience 5-10 years)
    d. Expert (Experience 10 or more years)
6. Is there an educational program to help transition to ICD-10-CM/PCS?
    a. Yes
    b. No
7. Is the CDI staff reviewing and preparing for any of the following areas for that may be of challenge for ICD-10-CM/PCS due to increased specificity? Please select all that apply.[1]
    a. Acute Myocardial Infarction
    b. Asthma

       c. Cerebrovascular Disease

       d. Coma

       e. Diabetes

       f. Fracture

       g. Orthopedics

       h. Pregnancy

       i. Pressure Ulcer

       j. Respiratory Failure

       k. Other, please specify

8. Is your facility currently dual coding accounts?

       a. Yes

       b. No

9. What types of CDI training sessions are being held for physicians and clinical staff to prepare for ICD-10-CM/PCS? Please select all that apply

       a. Utilizing real, practical examples

       b. Comparing the difference in verbiage between ICD-10-CM/PCS and ICD-9-CM

       c. Creating templates

       d. Distributing handouts

       e. Newsletters

       f. Hanging posters throughout the facility for awareness

       g. Handing out 'pocket cards' for quick reference

       h. WebEx Training

       i. Other, please specify

10. Currently, do you feel your facility will completely by ready for the transition to ICD-10-CM/PCS by the new compliance date, October 1, 2015?

       a. Yes

       b. No

Figure 2

E-mail Communication: ICD-10-CM/PCS and Clinical Documentation Improvement

My name is Maggie Possel and I am a Master's degree student at the University of Tennessee Health Science Center. I am conducting a survey and your response would be greatly appreciated.

My topic is ICD-10-CM/PCS and Clinical Documentation Improvement. The survey is 10 questions, should only take a few minutes, and completely confidential. All information will be de-identified.

Here is the link to the survey.
https://www.surveymonkey.com/s/G6YX9S7

Please complete the survey by Friday, October 24, 2014.

If you have any questions, please e-mail me at margaret.possel@hcahealthcare.com

Thank you so much for your time.

Maggie Possel