

CLINTEGRITY 360 | COMPUTER ASSISTED PHYSICIAN DOCUMENTATION

Technology to Help Your Physicians with the Transition to ICD-10

In the changing world of healthcare reform,
let Nuance Healthcare and J.A. Thomas show you what
clinical documentation improvement success looks like.



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HEALTHCARE



SUMMARY

Healthcare reform, federal and state quality initiatives, and the move to outcomes-based payments are creating a complex new environment within healthcare. These changes are challenging the way physicians document patient episodes and the way hospitals ensure that physician documentation appropriately captures the level of care provided to each patient.

The complex transition to the ICD-10 coding system will put clinical documentation tools and processes, and Clinical Documentation Improvement (CDI) programs, to an even greater test. Highly specific, exhaustive, and clearly recorded patient information will be critical to maintain existing levels of reimbursement, ensure the accuracy of performance reports, and reap the benefits of this more articulate and flexible coding system.

However, the electronic documentation systems needed to collect this information have had limited success in clinical practice because of the intricacies of structured data entry workflows and the inability of template-driven clinical notes to capture physician narratives. Current CDI programs, which rely on retrospective, manual reviews of patient cases and physician documentation to alert physicians to gaps in their documentation, struggle today to keep up with their existing cases. With the transition to ICD-10, manual reviews will prove inadequate to ensure that physician documentation is as complete and accurate as this new coding system requires.

This paper describes a new system for inpatient clinical documentation and clinical documentation improvement that leverages the combined power of Clinical Language Understanding (CLU)—a unique combination of medical intelligence and natural language processing technologies, and clinically focused CDI strategies to provide a real-time, interactive solution for documenting under ICD-9 today and ICD-10 tomorrow. Clintegrity 360 | Computer Assisted Physician Documentation offers a technology solution to work alongside your physicians as a trusted partner and ensure documentation contains the details necessary for accurate and appropriate quality reporting and reimbursement.

The ability to understand the content of a dictated note in real time, combined with CDI rules, will allow this system to identify gaps and ambiguities in notes and give physicians pertinent and focused suggestions to improve their dictated narratives. CDI specialists will be able to leverage the results to expand their case coverage and focus their work in preparing physicians for the transition to ICD-10.

Clintegrity 360 | Computer Assisted Physician Documentation will allow physicians:

1. To produce more specific ICD-10-compliant clinical documentation in real time
2. To receive fewer queries from coders and CDI specialists for more information or clarification
3. To learn interactively how to document relevant diagnoses properly
4. To use narrative dictation in combination with structured templates and data fields to tell each patient's unique story

Clintegrity 360 | Computer Assisted Physician Documentation will allow CDI programs/specialists and coders:

1. To expand and deepen their CDI case coverage
2. To generate operational and administrative reports to identify persistent documentation gaps and develop focused training programs
3. To streamline the coding process with more detailed and accurate documentation

DOCUMENTATION AND THE PHYSICIAN

Electronic documentation systems have become commonplace in many clinical settings, promising to help physicians produce complete, detailed, and compliant patient records. However, physicians' notes do not yet meet the increasingly demanding requirements for clinical documentation, mostly due to lack of specificity, missing information or unclear associations between relevant findings. The magnitude of the problem is obvious since almost 60% of all acute care hospitals have a clinical documentation improvement program of some kind in place.¹

As the pace of healthcare payment reform initiatives accelerate, hospitals face an ever-increasing burden to ensure that physician documentation meets the requirements of ICD-9 coding today and ICD-10 coding in the near future. Physicians face mounting pressure to produce better, more precise clinical documentation while they continue to work to provide the highest level of care for their patients. Our healthcare system is being transformed into one that rewards and reimburses providers for quality and outcomes. As part of these larger initiatives, new reimbursement models are being introduced, making complete and compliant codes even more critical.

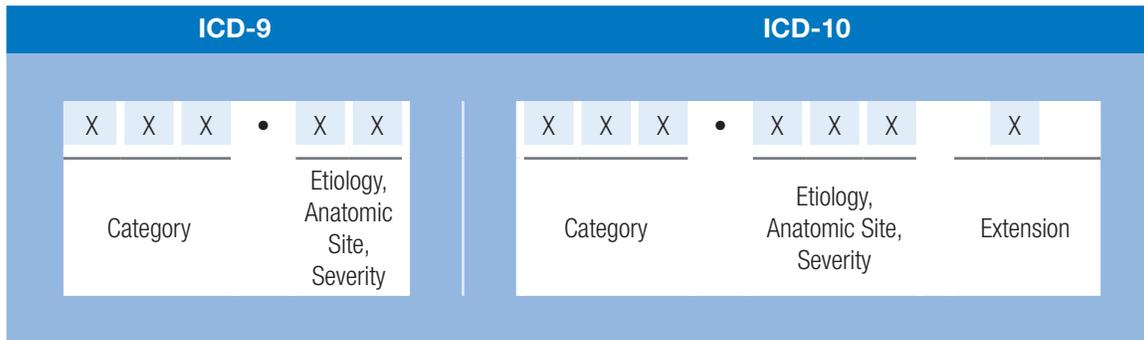
Increasing the accuracy and specificity of physician documentation using a clinically focused technology solution like Clintegrity 360 | Computer Assisted Physician Documentation will help within the new regulatory environment. Complete capture of patient complexity, severity of illness, risk of mortality, complications, and 'never events' not only affects payment, but also determines a hospital's case mix index, which has a direct impact on reimbursement. Accurate clinical data is critical to proactively managing preventable readmissions, negotiating managed care contracts, and for physician profiling and hospital performance reporting. At the same time, federal programs such as the Medicare Recovery Audit Contractors (RACs) are making the documentation process even more complex. Perhaps the greatest challenge comes with the transition to ICD-10, putting physician documentation in the eye of a perfect storm.

Old Problem, New Tools

On October 1, 2014, the ICD-10 classification system will replace ICD-9-CM as the national coding standard used to record, store, and retrieve diagnosis and procedure information for clinical and quality purposes, as well as for healthcare reimbursement. The long-awaited adoption of ICD-10 will drive healthcare improvement by enabling accurate identification and payment of new procedures and better understanding of health conditions and outcomes. However, the transition will not be easy. Many analysts estimate transition costs will total hundreds of millions of dollars nationwide.²⁻⁴ Most of these costs will go into adapting existing processes and tools to meet the new requirements in documentation.

Diagnostic and procedural categories of ICD-10 contain five times more codes than ICD-9, meaning that five times more subtypes of diagnoses and procedures can be captured and billed—as long as they are documented properly. For example, there is only one code in ICD-9 for the suture of an artery, no matter if the physician is repairing a minor cut or a major stab wound. There are more than 180 codes in ICD-10 for the same procedure, making it possible to accurately capture patient acuity in much greater detail.

Furthermore, an ICD-10 code can comprise as many as seven digits; ICD-9 has just five. To compute the additional digits, such details as the laterality and extension of a lesion or the severity of a diagnosis are required.



The following example shows the more detailed information gained through added digits:

ICD-9-CM	ICD-10-CM
Axis of classification:	Axes of classification:
Code: 572.2 (1) (MCC)	Codes: (7) Encephalopathy, hepatic/Failure, hepatic
Axes: Encephalopathy by type, hepatic	Axes: Failure, hepatic
	Type: <ul style="list-style-type: none"> • Alcoholic (No CC/MCC regardless of acuity or severity) • Due to drugs (No CC/MCC regardless of acuity or severity) • Postprocedural (CC-not classified by acuity or severity) • Unspecified by type (MCC regardless of acuity or severity)
	Chronicity: <ul style="list-style-type: none"> • Acute/subacute (MCC regardless of severity) • Chronic (No CC/MCC regardless of severity) • Unspecified (MCC regardless of severity)
	Severity: <ul style="list-style-type: none"> • With coma • Without coma • (Severity does not impact MCC status—only type & acuity impacts)

ICD-10 is a more expressive and flexible language for capturing precise patient information and sharing it among physicians, payers, reporting agencies and, ultimately, the patients themselves. To this extent, ICD-9 codes have proved to be inadequate for representing patients' conditions for any purpose outside of billing. ICD-10 brings greater granularity and richness to coded data, supporting clinical research and outcomes measures, and promoting more accurate reimbursement. However, its complexity will challenge physicians' ability to provide complete documentation. Experience in other countries that have already made the ICD-10 transition demonstrated that training of physicians and staffs, as well as increased documentation time, are significant costs associated with the ICD-9 to ICD-10 transition.

The increasing use of Clinical Documentation Improvement programs in our healthcare system has met with positive results, but traditional CDI programs require labor intensive manual data abstraction and will be put to the test to maintain current levels of reimbursement in ICD-10. Many organizations are turning to Computer Assisted Coding solutions to help make coders more productive. Since coders will still be required to validate codes suggested by CAC, focusing attention on the source of clinical documentation will ensure the transition to CAC is also set up for success. Clintegrity 360 | Computer Assisted Physician Documentation (or CAPD) will supplement current CDI tools available in the market and make a difference by providing real-time documentation support while physicians dictate—and by doing so provide added incentives for physicians to speak rather than do tedious data entry. Navigating lists of diagnoses and picking values for describing such details as status, location, and timing has been the major obstacle to physicians' adoption of electronic templates. Predictably, as the number of diagnoses and their attributes increases, structured data entry tools will become more burdensome.

HELPING PHYSICIANS MEET ICD-10 DOCUMENTATION CHALLENGES

Clintegrity 360 | Computer Assisted Physician Documentation will help physicians capture all the information needed for coding in ICD-10, in real time, at the point of documentation without manual data entry. By enabling physicians to capture detailed, complete documentation upfront, CDI specialists have fewer documentation gaps to address, and coders have the information they need to get to the most appropriate codes for each patient.

One of the components of Clintegrity 360 | Computer Assisted Physician Documentation is Clinical Language

Understanding (CLU), a sophisticated software technology able to parse clinical notes and capture key clinical findings in them, such as diagnoses, medications, allergies, vital signs, or social history items. These are then standardized from narrative expressions into ICD-10 codes in a fully compliant and predictable way by the software.

The other component is Clintegrity 360 | Clinical Documentation Improvement (CDI), a technology that utilizes detailed knowledge of the ICD-10 coding system to identify if more information is needed to assign the most accurate code. The power of these two technologies combined provides a solution that will, in real time, translate a physician's voice into text, analyze it to identify gaps and ambiguities that could affect coding accuracy, and immediately provide targeted feedback to the physician for incorporation into his or her notes.

Clintegrity 360 | Computer Assisted Physician Documentation will automatically detect missing information, unclear associations between relevant findings, or unspecified diagnoses. It then highlights them for physician consideration and correction. Consider, for example, a patient who is admitted to the emergency room with a serious episode of asthma. A busy emergency doctor would typically dictate "acute asthma exacerbation" as the reason for admission. ICD-9 has only one code for this diagnosis. ICD-10, however, has four possible codes, based on the gravity of the asthma episode (mild intermittent, mild, moderate, and severe persistent). Additional information is needed to determine which ICD-10 code is more clinically useful. Computer Assisted Physician Documentation asks the physician—while dictating—to add the severity attribute by dictating the additional text or allowing the physician to select the correct description supplied by the system.

Clintegrity 360 | Computer Assisted Physician Documentation promotes better patient care through more detailed documentation and helps achieve ICD-10 compliance.



COMPUTER ASSISTED PHYSICIAN DOCUMENTATION USE CASE EXAMPLE

The following example highlights several key benefits of the Clintegrity 360 | Computer Assisted Physician Documentation solution: improved quality and content of clinical documentation, positive impact on reimbursement, and subtle transition to ICD-10 through the introduction of ICD-10-related queries long before the 2014 mandate takes effect.

Patient Case

A 65 year old female patient has been on the Adkins diet in efforts to lose weight and lower her cholesterol, admitted with altered mental status, fever and hypotension. During the admission she is found to have increasing SGOT, lethargy, delirium and stupor.

Evidence: Temperature 102.2, Heart Rate 110, WBC 18.8, Urinary Tract Infection due to E. Coli, elevated liver function tests, Blood Pressure 80 – 90 systolic for first 24 hours of admission CT of head negative first 24 hours of admission, CT of head negative for CVA/bleeds, but does reveal vasogenic edema

Treatment: IVF, antibiotics, ICU support, neuro IVF, antibiotics, ICU support, neuro checks

Documentation: Altered mental status with fever, elevated SGOT, Delirium

Action: Clintegrity 360 | Computer Assisted Physician Documentation analyzes the documentation, determines there is high confidence in the evidence and generates a clarification opportunity for severe sepsis, and for toxic encephalopathy. The patient's attending physician responds to the clarification by documenting the additional details in the next progress note

Result: *The additional detail in the documentation properly reflects the principal diagnosis, impacting the patient's care, recovery, and length of stay*

This additional detail will impact ICD-9 and ICD-10 reimbursement as well as the severity of illness (SOI) and risk of mortality (ROM).

THE CASE-BASED APPROACH

Improving physician documentation is tied to helping physicians improve the quality of each document they create. Understanding when to suggest a clarification opportunity to a physician, however, requires knowledge of a patient's entire visit and all related documentation. For any one

dictation performed by a physician, there may not be the requisite information or cues to support a query. When the patient visit is viewed as a whole, however, a broader view of multiple documents and patient information can provide the required background to trigger a query.

The converse is also true, where a specific document created by a physician may trigger a clarification for say, a diagnosis of respiratory failure. If the specificity of that patient's respiratory failure is contained in another document somewhere else in the patient's record for that visit, either from that physician or another physician regarding that patient, it would not be necessary to generate a clarification. Clintegrity 360 | Computer Assisted Physician Documentation has been designed as a case-based model to account for both of these situations. This means the entire patient record for that visit, not just one specific document is analyzed as a whole in order to understand when it is appropriate and necessary to send a clarification to a physician. Once the patient's diagnosis is appropriately detailed somewhere within the patient record, physicians will not be shown clarifications related to that diagnosis unless additional information is provided that triggers a new and subsequent clarification.

Integrating Into Physicians' Workflows

One of the keys to ensuring the effectiveness of Clintegrity 360 | Computer Assisted Physician Documentation as a physician tool is understanding and integrating with physicians' existing documentation workflows. Individual physicians and hospitals have their own unique characteristics and preferences for how they create their documentation. Clintegrity 360 | Computer Assisted Physician Documentation has been designed to accommodate a broad range of physician documentation workflows by seamlessly integrating into these documentation workflows to deliver clarifications before physicians complete and sign their documentation.

For physicians creating documentation through front-end speech recognition, Clintegrity 360 | Computer Assisted Physician Documentation will non-obtrusively query physicians, as they begin their dictation for any outstanding documentation needs associated with that patient, as well as for any new clarifications generated from Clintegrity 360 | Computer Assisted Physician Documentation's analysis of their current document.

For back-end dictation-transcription workflows, Clintegrity 360 | Computer Assisted Physician Documentation will analyze transcribed documents and query physicians during their electronic signature process. The ability to integrate Clintegrity 360 | Computer Assisted Physician Documentation closely within existing workflows increases acceptance by physicians and improves the response rate to clarifications.

Supplementing Existing Documentation Improvement Programs

Concurrent clinical documentation review programs today are often stretched to the limits of their resources in trying to review existing in-patient cases to ensure that documentation adequately supports the care given to each patient. A large percentage of documentation review specialists' time is spent addressing the same, highly repetitive documentation gaps. For documentation review specialists, these are the high-volume, highly repetitive queries that they identify on a daily basis. Many of these queries fall into the category of specificity-related queries, in which documentation does not fully define a patient's diagnosis.

This workload often results in some cases not being reviewed at all, as reviewers are forced to focus only on high-priority cases, with review staff unable to address more complex documentation issues. With the implementation of ICD-10, concurrent review staff and resources will be strained even further as documentation requirements grow much more complex. Under existing documentation review models, only by hiring and training additional documentation improvement staff would an organization be able to keep up with the increased documentation review needs.

Clintegrity 360 | Computer Assisted Physician Documentation addresses this growing gap in documentation review staff resources by automating a subset of the most commonly generated

documentation improvement queries. By automating these clarifications, review staff can move beyond highly repetitive queries. Clintegrity 360 | Computer Assisted Physician Documentation allows review staff to reallocate their time and resources to expand case coverage, provide more in-depth reviews of complex patient cases, and contribute more assistance toward addressing additional quality metrics and patient safety indicators.

Tracking and Monitoring Documentation

As Clintegrity 360 | Computer Assisted Physician Documentation analyzes physician documentation, all clarifications and responses are recorded in a detailed audit trail that can be used to generate operational and administrative reports. These reports range from organization-level documentation quality reports to individual physician usage reports. The ongoing tracking and monitoring enabled by Computer Assisted Physician Documentation can be used to help evaluate organizational compliance and identify challenging areas for additional focused training.

Single Platform—Seamless Workflow

Clintegrity 360 | Computer Assisted Physician Documentation as a documentation improvement tool for physicians can work alongside an existing documentation improvement program. When used with the full complement of Nuance Healthcare solutions including our CDI, Compliance, CAC and Analytics solutions, your healthcare organization is provided with a complete, end to end documentation system, beginning with voice enabled documentation capture through a variety of supported workflows, clinically focused clinical documentation improvement featuring peer to peer education and strategies designed to help physicians document accurate details from the start, computer assisted coding to streamline efficiency and shorten A/R time, and quality measures and reporting capabilities to analyze performance and facilitate continuous process improvement across the entire organization and within in each facility.

A NEW PARADIGM FOR CLINICAL DOCUMENTATION

Achieving documentation best practices can have a profound impact on a healthcare organization's efficiency, quality of care, reputation, and profitability. As cost pressures intensify and the rules governing healthcare payment continue to evolve, meeting such performance objectives is essential to long-term viability and growth. With Clintegrity 360 | Computer Assisted Physician Documentation as part of a clinically focused CDI review program, healthcare organizations will be well-positioned to manage the reimbursement and regulatory challenges of the next decade.

ABOUT NUANCE HEALTHCARE

Nuance Healthcare, a division of Nuance Communications, is the market leader in creating clinical understanding solutions that drive smart, efficient decisions across healthcare. As the largest clinical documentation provider in the U.S., Nuance provides solutions and services that improve the entire clinical documentation process—from capture of the complete patient record to clinical documentation improvement, coding, compliance and appropriate reimbursement. More than 450,000 physicians and 10,000 healthcare facilities worldwide leverage Nuance's award-winning voice-enabled clinical documentation and analytics solutions to support the physician in any clinical workflow on any device.

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