ICD-10 and Physician Documentation
Leveraging Scribes for the Transition
**Introduction.**

With every federal incentive to adopt electronic health records (EHR) systems, every move toward structuring medical data, physicians are faced with more time-consuming digital documentation. Yet very few practicing physicians are trained in medical coding and documentation. Medical schools prepare doctors to treat and cure, not type and click.

And now comes ICD-10.

Physicians who are already frustrated with EHR dropdowns and checkboxes will face even more granular layers of documentation needs. The tenth edition of the International Classification of Diseases requires an unprecedented level of specificity. Once ICD-10 is adopted in the U.S., the current ICD-9 set of 14,000 generalized diagnosis codes will explode by nearly 400% to an exhaustive list of 69,000 comprehensive codes.

Implementation of this complex classification system figures to be greatly impacted by electronic health documentation. This means the biggest issues facing practices today are less about generating the proper ICD-10 codes and more about all the supplemental documentation details that will be needed to accurately select them.

**Despite this fact, practices are at varying degrees of readiness.** Some emergency departments are hiring certified coders and professional agencies to prepare for the transition, while other specialty groups plan to rely on new dropdowns from EHR vendors—only 40% of which had indicated they were ready to support the upcoming change as of April 2015. Many practices have done nothing at all.

The purpose of this document is to provide a synopsis of what’s coming and offer a few possible documentation solutions to help all types of American practice settings prepare for the transition.

**What’s Changing? A lot.**

ICD-10 modernizes older terminology to more consistently and comprehensively catalogue medical conditions. There are codes that combine diagnoses and symptoms, multiple codes that can be used to describe a single condition and “external cause codes” to detail contributing factors. These codes are designed to categorize every possible symptom, injury and illness currently known to man—all with great specificity. To say that those tasked with selecting the right codes will come to rely on highly-detailed documentation would be an understatement.

Tremendous pressure will be placed on already-overloaded physicians:
“This is a permanent increase, not just an implementation or learning curve increase. It is a physician workload increase with no expected increase in payment, due to the increased requirements for providing specific information for coding. Electronic health record systems will not be able to eliminate the extra time requirement.”

—Nachimson Advisors

Consider, for example, an open femur shaft fracture—common in emergency rooms and orthopedic settings. Currently with ICD-9, there are 16 codes to choose from. That number will balloon to 1,530 with ICD-10. It’s not uncommon to have four, five or more ICD-10 codes to submit for one condition, with codes for everything from exact body parts and contributing conditions to precise activities and locations tied to an injury.

Bottom line: Practices will need in-depth documentation that the people coding can consult to select the right codes and ensure proper reimbursement.

“The new code set is so expansive, physicians won’t be able to crosswalk their ways through ICD-10.”

—Courtney Zydron
Chief Medical Officer, eScribe

Right now, the goal for every practice should be thorough documentation. Having a highly specific record of each patient encounter will benefit physicians and help make for a smoother transition to ICD-10. With EHR frustrations already at all-time highs, many administrators will need to look for cost-effective outside solutions for capturing sufficient levels of detail.

Documentation now

In an industry where digital documentation technology is still in its infancy, frustrations are already at all-time highs. The following quote from a cardiology practice is one representation of where things currently stand across America:

“Physicians are beyond frustrated at this point with documentation. I am also concerned about the level of accuracy in their documentation as well as timeliness. Some physicians have adapted better than others to the EHR.”

Documentation with ICD-10

With ICD-9, physicians can get away with vague documentation. That’s not going to work with ICD-10:

- Diagnosis codes will increase 393%, from 14,000 to 69,000
- Procedure codes will increase 1,700%, from 4,000 to 72,000

Without the right checkboxes and dropdowns in medical documentation, practices may not be able to appropriately bill and get properly reimbursed.
Documentation Solutions.

The job of a skilled scribe—one who’s thoroughly trained in medical terminology including your area of specialty—is to comprehensively document each patient encounter, including all events related to current injuries and illnesses. This relieves physicians from hours of clinical work while simultaneously ensuring more thorough and accurate documentation—the very same documentation that will be needed to select proper ICD-10 codes.

Leveraging Virtual Assistants

Virtual medical scribes offer many of the same documentation benefits of on-site medical scribes, but are available to a wider group of practices including rural hospitals and small offices. They’re connected to practices through HIPAA-compliant technology that allows for unrecorded, real-time documentation into the EHR that can be used by physicians selecting ICD-10 codes. (Note: To help ensure virtual scribes supply detailed documentation without increasing security risks, it’s advisable to fully vet suppliers for not only highly skilled employees but also extremely secure technology.)

Leveraging Specialized Transcription Services

Many physicians prefer using dictation devices to record medical record narratives, which are then transferred over to the EHR. The issue with dictation is that it can be difficult to capture data in a structured format when it’s transferred to your electronic system. This can make it cumbersome for physicians to select the correct codes, and can increase the likelihood of errors in ICD-10 selections. Specialized transcriptionists are one possible solution to the shortcomings of dictation: They both allow your physicians to continue with their preferred documentation method and help ensure greater accuracy when extracting and structuring data from their narratives.
To summarize:

- Highly skilled, thoroughly-trained medical scribes and transcription assistants have a deep understanding of medical coding.

- They can help physicians ensure medical documentation is highly specific and capture detailed information within medical coding portions.

- Thorough documentation makes it easier to assign the most appropriate ICD-10 codes for each condition.

While it would not be prudent to have medical scribes and transcriptionists perform ICD-10 coding, their medical documentation expertise can be of tremendous value to administrators and physicians. To help ease into the transition, practices would be well advised to seek the assistance of a consultant specializing in EHR documentation solutions.

About eScribe

eScribe provides industry-leading medical scribe staffing for hospitals and physician-owned groups across the nation in a variety of emergency medicine and outpatient settings. The firm has a proven track record of creating full-service scribe programs that are affordable and produce a sustainable, positive return on investment for its partners.

1 Source: Workgroup for Electronic Data Interchange Survey  

2 Source: The Impact of Implementing ICD-10  

3 This is a verbatim quote from an email inquiry received by eScribe. Names have been to omitted to preserve privacy.