Cut Through the ICD-10 Noise with Documentation Guidelines

By Jon Elion, MD

Physicians have been bombarded with opinions, information and misinformation about ICD-10-CM/PS. This makes it challenging for them to cut through the politics and posturing and focus exclusively on practical and pragmatic approaches to deal with the new coding system. Discussions are often clouded by confusing issues specifically related to an inpatient or outpatient setting, or by focusing on the business aspects of running a medical practice as opposed to the charting and coding requirements of medical documentation.

Physicians should concentrate on writing good, comprehensive clinical notes, rather than varying notes based on inpatient versus outpatient, or based on the payer. Here are some simple guidelines that all clinicians should adapt, regardless of the setting:

- Learn the basic principles underlying how documentation gets coded:
    - Coders cannot use lab data and reports for coding; the findings must be interpreted and described in the physician notes. Saying that the patient has a "K+ 2.3? (or even "Serum Potassium of 2.3?) is not codeable, but if a physician uses the word "hypokalemia" then the documentation can be coded.
    - Information written by physicians and physician extenders (nurse practitioners and physicians' assistants) can be coded, but information contained in nurses' notes cannot.
    - Information in radiology and clinical pathology reports cannot be coded, as the physicians providing that information did not have direct contact with the patient.
- The biggest improvement in the quality of clinical notes is achieved through the liberal—and appropriate—use of the phrases "due to" and "manifested by." For example, it is not sufficient to say that the patient has anemia and a GI bleed; it needs to be stated whether or not the anemia is *due to* the GI bleed. Not only does the clinical note become clearer, but the delineation of cause-and-effect assists with coding as well.
- Coders need to know the "Principal Diagnosis" (the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care). This should be clearly stated (coders should not assume that it is the first diagnosis listed), and is also a helpful concept in the outpatient setting (where it is referred to as the "First-Listed Diagnosis").
- When diagnoses are inconclusive, physicians should use terms such as "probable," "suspected," and "rule out" as appropriate. The rules for how these are handled and coded differ between the inpatient and outpatient setting, but this distinction should be left to the coders; just write the most complete and medically accurate note possible.
- Be very specific in describing radiologic and pathologic findings (remember that the respective reports cannot be used for coding). This is one instance where "copy and paste" can be considered and may be helpful, provided that the source of the quote gets proper attribution and is specifically referenced and commented upon in a clinical note. Saying that a biopsy was "positive" or that there is a "fracture of the right femur" does not provide enough information to be properly and completely coded.
- Be very specific about the details of procedures that are performed. ICD-10 does not have "catch-all" codes for poorly described procedures as ICD-9 has, and this can result in major problems with coding and reimbursement. Most typical operative reports have sufficient detail for coding, but notes charted for office-based encounters need to receive the same attention to detail.
- Pay special attention to entries in a problem list that refer to "history of" or "status post." "Status Post Cholecystectomy" may refer to something in the past that is not relevant to the visit. Carefully consider if such a diagnosis was **M**onitored, **E**valuated, **A**ssessed, or **T**reated (you can use the acronym "M.E.A.T." to remember).

While this has most applicability to reimbursements based on risk-adjustment, this approach is valid and appropriate for all settings and payers.

You don’t need to learn ICD-10 in order to practice good clinical medicine. But the components of documentation that help to support complete and accurate ICD-10-CM/PCS coding are also the foundation of all good clinical notes.

Jon Elion is a practicing cardiologist and founder/CEO of ChartWise Medical Systems.

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