ICD-10 Opens Documentation Gaps

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We studied. We practiced. We prepared. We had extensions—first a year, then two. More time to practice. Then, at long last, October 1, 2015 arrived, bringing with it the much-anticipated new code sets ICD-10-CM and ICD-10-PCS. Despite much hand wringing and nay saying, the implementation day came and went without much commotion—likely thanks to all that hard work and preparation.

In the days and weeks since October 1, 2015, a silent tsunami has been building. Clinical documentation improvement (CDI) specialists and coders alike are working diligently to get all the additional information that is now needed to accurately code records in ICD-10. Despite all the preparations, it's uncertain that health information management (HIM) professionals would have been able to fully imagine the sea of change that is now upon healthcare. Gone are many of the "unspecified" choices. Some remain, but we know that we should really not be using them.

The additional information behind that specificity and granularity that we knew was going to be the bedrock of the ICD-10 code set is still not there for some—despite all the preparation. Now that the time has come to start reviewing records and using the new system, some coders are finding that in addition to the old gaps in documentation and codes that existed, there are even more gaps in the documentation.

Before ICD-10, coders could often rely on "unspecified" to fill in the gaps when the documentation just was not there—but today that is just not always an option. Consider this example of trying to code a "right breast mass." None of the notes, not even the radiology report, give an indication as to where the mass was located. Without the specific location and notation of whether it was benign or malignant, the choices for the coder are few. Would it be coded to N63, Lump in breast? Is there a better option? Without the location of the mass, a coder cannot code the record.

The next step is to query the physician for the "suspected malignancy" that was noted by the radiologist while reading the CT scan. For the purposes of the example, say the coder even went to the Breast Center at the organization to find someone to help determine the location of the tumor. None of the attending physicians or residents had noted its description, however. This key fact was ignored because there would be no biopsy or treatment—the patient opted out and chose to go to hospice care. The fact that this information was needed for accurate and adequate documentation for ICD-10 had been overlooked. If the documentation had instead specified that there was a "suspected malignant breast tumor" that was in the "upper outer quadrant of the right breast," then the detail would be there for ICD-10 and it would be a much more accurate reflection of the severity of illness and risk of mortality for that patient as well.

There is so much that is new with ICD-10-CM/PCS coding and documentation, and there is no way that anyone could have anticipated every aspect of these new details. As the industry moves forward, CDI specialists and coders will need to investigate what new information is needed, item by item, and seek out those with the expertise to help understand what it all means. Was the IABP continuous or intermittent? Was the radiation oncology treatment (IMRT) a proton beam, electron beam, or another method?

So where do HIM professionals go from here? Organizations can facilitate education for staff, with multiple classes, grand rounds, and self-learning modules for the physicians. Even with all this education available, it can be difficult to engage physicians. Some physicians might wait until the last minute to do self-learning modules, or sit in the back of in-person classes and not participate. One of the greatest frustrations for a CDI specialist is lack of physician engagement. Helping physicians understand that the documentation and coding process will have a direct effect upon them and how they are reimbursed is a good approach for getting physicians to become more engaged in the process.

The Centers for Medicare and Medicaid Services (CMS) is moving toward their goal of alternative payment models based upon value and not cost. Value-based purchasing is designed to do just that. Some penalties associated with such programs are

derived from ICD-10 codes, and Medicare spending per beneficiary will be felt by one- and two-physician groups starting in 2017. Those penalties will be calculated based upon data from coded records in 2015. So for now, CDI specialists must continue to educate physicians with patient-specific conversations that emphasize what is needed and why with each new query.

Areas that are emerging with the greatest documentation gaps so far include:

- Laterality (i.e., fractures, injuries, masses, and tumors)
- Location (be specific and as detailed as possible)
- Consistency/conflict/ambiguity (clarify as needed to keep the record accurate)
- Disease type (for atrial fibrillation, is it persistent, paroxysmal, or chronic)
- Disease acuity (acute, chronic, acute-on-chronic)
- Disease stage (for diagnoses such as chronic kidney disease and pressure ulcers)
- Etiology and manifestations (such as diabetes, encephalopathy, anemia, ulcers)
- Details needed for combination codes (instructions in the ICD-10 Tabular list)
- Nicotine, alcohol, and drug use/abuse/dependence
- External causes and circumstances surrounding injuries

Encoders are great tools, but while learning what is needed in ICD-10 it may be more beneficial to go back to the ICD-10 Alphabetic Index and the Tabular to understand what is needed. The instructions in the Tabular are invaluable in determining the correct codes and understanding new directions that apply in ICD-10.

The road ahead may be long and arduous, but this is an opportunity for the CDI specialist to lead—to educate and keep the focus on capturing the most accurate information from each record. Strategies to address the documentation gaps can include: additional educational offerings, presentations at department meetings, and tools such as specialty-based “cheat sheet” lists of targeted information that can be pocket-sized so physicians use them when documenting or dictating information into a health record.

While the gaps may seem large and numerous, when HIM professionals look back this October we will be amazed by what we have accomplished.

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