More Specific Physician Documentation Needed for ICD-10-CM

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The dawn of October also welcomes the official go-live date for ICD-10-CM/PCS—meaning there is absolutely no time left to waste in preparing for the additional documentation requirements necessary for successful ICD-10 implementation. Over the past several years, the healthcare industry has focused efforts across multiple areas of expertise, tapping into physicians, HIM directors, coding managers, coders, and clinical documentation improvement (CDI) specialists in a multi-pronged approach for documentation preparedness. Many organizations have developed a strong team approach to overcoming documentation challenges, and the leaders of these teams have always been—and will always be—the physicians.

Ultimately, the responsibility to meet the rigorous specificity requirements under ICD-10 lies with the physician who is treating the patient. This really isn't a new responsibility, but documentation for ICD-9-CM was much less stringent—and thus the need to include greater specificity in documentation was not nearly as high as what the healthcare industry can expect with ICD-10. There are many supporting roles for documentation improvement, as mentioned above, to guide the physician and offer assistance. But the documentation must always originate from the providers. The entire healthcare team must meet a higher standard to make the transition from ICD-9 to ICD-10 a success.

For those who haven't performed a gap analysis of ICD-9 to ICD-10 for their practice yet—it's not too late. The first approach for performing a gap analysis is auditing physician queries. There may already be a process in place to monitor query activity, but if there isn't, then it's time to develop and implement one. The data collected from the query analysis will help determine the pain points and areas that need to be focused on and improved upon through education.

A second and more traditional approach for a gap analysis is to run a report of the top diagnoses for the practice or facility. Next, take the top 10 most commonly used diagnoses and run another report of patients who had those diagnoses assigned to them. Pull 10 to 20 charts for the most commonly used diagnosis code. Review the history and documentation for the encounter and audit for the following list of items:

- Could be coded under ICD-10-CM
- Need more specific information to code, such as:
    - Laterality
    - Initial or subsequent encounter
    - Site
    - Mechanism
- Could only be coded to an unspecified code

Each provider in the practice or facility should review the analysis or audit findings so they understand what areas of documentation need improvement to support this specific diagnosis in ICD-10. Then, move on to the next diagnosis on the top 10 list, and keep evaluating until the list is complete.

How often these evaluations take place will depend on the number of providers in a practice or facility, the number of different specialties, the type of specialties, and how providers perform. It is recommended to perform these at least quarterly to quickly identify compliance with education and also any new trends that have developed. To ensure a smooth transition and a minimal impact on revenue, these assessments should become part of the regular audit process even after implementation of ICD-10.

While it is possible to code and bill with unspecified codes when documentation is lacking, many diagnoses will require additional information to assign all characters for a complete code assignment. Keep in mind that the insufficient

documentation found in the query analysis often represents a larger percentage of at-risk revenue. Although the Centers for Medicare and Medicaid Services is offering a grace period to allow physicians additional time to become proficient, this grace period will pass quickly. A proactive approach is necessary to prevent lost revenue down the road.

The following list includes a few examples of where documentation changes will likely be needed:

- **Diabetes documentation must include:**
    - Type of diabetes
    - Body system affected
    - Complication or manifestation
    - If a patient with type 2 diabetes is using insulin, a secondary code for long term insulin use is required
- **Neoplasms documentation must include:**
    - Type:
        - Malignant (Primary, Secondary, Ca in situ)
        - Benign
        - Uncertain
        - Unspecified behavior
    - Location(s) (site specific)
    - If malignant, any secondary sites should also be determined
    - Laterality, in some cases
- **Asthma documentation must include:**
    - Severity of disease:
        - Mild intermittent
        - Mild persistent
        - Moderate persistent
        - Severe persistent
    - Acute exacerbation
    - Status asthmaticus
    - Other types (exercise-induced, cough variant, other)
- **Soft Tissue Injuries**
    - Laterality
    - Specificity of location
    - Cartilage tear
        - Incomplete
        - Complete
        - Bucket-handle
        - Peripheral
        - Complex
        - Other
    - Cause
        - Traumatic
        - Non-traumatic: use or overuse, pressure

- General
  - Episode of care for 7th character placement:
    - Initial—active treatment
    - Subsequent—follow-up visit
    - Sequela—residual condition
- Cause of injury (only for the initial episode of care)
  - Mechanism—How the injury occurred
    - Intention
      - Accident
      - Assault
      - Self-inflicted
      - Undetermined
- Place of occurrence—Where did it happen?
- Activity—What was the patient doing at the time of injury?
- External cause status—Military, civilian, work-related, leisure?

These are only a few examples of the more specific documentation requirements. As HIM professionals begin to review the queries and data obtained through the gap analysis, they will find many additional diagnoses that will require improved documentation for specificity. ICD-10 is a new territory for all healthcare professionals and an opportunity to expand and improve the industry's best practices to meet the challenges of today's healthcare.

Reference

AHIMA. "ICD-10-CM/PCS Documentation Tips." http://bok.ahima.org/PdfView?oid=300621.

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