Preparing for ICD-10-CM in the Emergency Department: Approaches to Improve Emergency Department Documentation

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Taking the right steps now will allow hospitals to improve emergency department documentation and adequately prepare for the future implementation of ICD-10-CM coding.

Obtaining the sufficient clinical documentation needed to support code assignment is a challenge in ICD-9-CM today. This challenge is expected to become even more problematic, however, with the increased specificity of ICD-10-CM-particularly for emergency department coding. This article explores multiple steps hospitals can take now to improve emergency department documentation in preparation for coding with ICD-10-CM.

Emergency department physicians focus on addressing acute symptoms; consequently, emergency department documentation reflects signs and symptoms as well as multiple differential diagnoses, but is often vague when it comes to more definitive diagnoses. The outpatient guidelines section of the Official ICD-9-CM Guidelines for Coding and Reporting apply to emergency department visits for patients who are discharged, which means coding professionals cannot code differential diagnoses (possible/probable conditions).[1] For this reason it's important for emergency department physicians to connect signs and symptoms to a definitive diagnosis.

Conversely, for patients admitted to the hospital through the emergency department, coding professionals need clinical documentation from the emergency department that clearly states possible/probable diagnoses, rather than merely listing acute symptoms. Thus, there are known challenges and clinical documentation gaps for ICD-9-CM coding of emergency department visits today. These documentation issues will still be a concern for correct code assignment with ICD-10-CM. In addition, the increased specificity and detail in ICD-10-CM codes is expected to be particularly relevant for the types of conditions treated in the emergency department. For example, the injury chapter in ICD-10-CM is one of the sections that were significantly revised, and the signs and symptoms chapter was greatly expanded to allow classification of symptoms with much more detail. Specific examples are shown in Table 1.

Table 1. Differentiating Documentation for Correct Code Assignment

The Injury chapter in ICD-10-CM was significantly revised and the signs and symptoms chapter was expanded to allow classification of symptoms with much more detail. This table illustrates the resulting difference in coding description from ICD-9 compared to ICD-10.

ICD-9-CM	ICD-10-CM
813.42 Other fractures of distal end of radius (alone)	**S52.502A** Unspecified fracture of the lower end of left radius, initial encounter for closed fracture

Documentation: site, open or closed	Documentation: site including laterality, open or closed, displaced or non-displaced, episode of care
847.0 Sprains and strains of other and unspecified parts of back; neck Documentation: site	**S13.4xxA** Sprain of ligaments of cervical spine **S16.1xxA** Strain of muscle, fascia and tendon at neck level, initial encounter Documentation: site; distinction as to sprain (ligament) or strain (muscle, tendon)

Impact of New Coders

As Table 1 illustrates, increased clinical documentation will be needed to code fractures in ICD-10-CM. Clinical documentation in emergency department records typically includes laterality, but documentation of the site of a fracture is often more vague than ICD-10-CM codes, and the distinction of displaced vs. non-displaced is often not documented. The second example in the table illustrates the differences in the code sets for sprains and strains, another frequent emergency room condition. In ICD-9-CM sprains and strains are classified to the same code; there is no distinction. However, in ICD-10-CM they are classified separately. For example, a *sprain* of the cervical area is assigned to subcategory S13.4, while a *strain* of the cervical area is classified in subcategory S16.1. So it will be important to differentiate sprains from strains in emergency department health records to determine which ICD-10-CM code applies. These are just a couple examples to illustrate the impact of ICD-10-CM on emergency department documentation.

Given the impending documentation gaps for ICD-10-CM coding in the emergency department, hospitals should take steps to prepare for ICD-10-CM and mitigate these documentation concerns. They should begin by analyzing current clinical documentation to identify and prioritize their ICD-10 documentation gaps. This is most easily accomplished by coding a sample of emergency department health records in ICD-10-CM and noting specific documentation gaps as difficulties are encountered during the coding process. The record sample should include emergency department visits that reflect the emergency department's most frequent diagnoses and a sample of each emergency department template that is used to capture clinical documentation. This chart audit will identify specific documentation gaps and help determine where focused interventions will have the greatest impact. To determine approaches to resolve documentation gaps, consider where form changes or system prompts might be employed, what operational changes might impact clinical documentation, and where training might be needed.

Applying Template Revisions to Comply With ICD-10

Physician documentation in the emergency department is commonly captured via templates. Templates can be paper forms, but increasingly are built into emergency department information systems (EDIS) via system prompts. In either circumstance, physician documentation templates are complaint-driven and designed to capture relevant information for common emergency department conditions, such as chest pain, back pain, upper extremity injury, and upper respiratory infection. The templates are effective in helping physicians record a lot of clinical information quickly. They are intentionally designed to capture the specific elements required for evaluation and management code levels, with explicit language for the history, examination, and medical decision-making components. As a result, the templates are efficient and effective in some respects, but they lack details to prompt documentation of definitive diagnoses.

Once emergency department ICD-10-CM documentation gaps have been identified, this information can be used to determine the specific details that could be added to emergency department templates. For example, the upper extremity injury template likely includes a differential diagnosis of fracture, in addition to that of sprain/strain. Consider how to modify the template to prompt the emergency department physician to specify if a fracture diagnosis is displaced or non-displaced, or how to separate

the prompt for sprain from strain. All emergency department templates should be reviewed and analyzed to identify where to build in prompts of additional information that is needed for ICD-10-CM. Once the desired modifications are identified, revise the templates to capture this clinical documentation.

Hospitals with an EDIS should contact the vendor to determine what ICD-10 updates they may already have planned and look for an opportunity to suggest specific changes to emergency department templates. HIM professionals in the hospital should reach out to the director of the emergency department to initiate this exploration of ICD-10 readiness with the EDIS vendor. Collaborate with the emergency department director to fully examine the EDIS vendor's plans for any and all system changes to comply with ICD-10-CM. You'll need to know, for example, what modifications to expect in screens and reporting formats. Use available resources, such as the ICD-10 vendor questionnaire available on the AHIMA website.[2] Also be sure to understand clinical documentation functionality in the EDIS and its capabilities to ensure end users are fully exploiting system functionality to capture clinical documentation.

Operational Impacts and Suggested Preparations

In preparation for ICD-10-CM coding in the emergency department, hospitals should also review outpatient coding policies and procedures with outpatient coding staff. In addition, review the diagnostic coding and reporting guidelines for outpatient services to ensure they are universally understood and applied. The ICD-10-CM official guidelines for coding and reporting are available on the Centers for Disease Control and Prevention Web site, and the outpatient guidelines mirror those that the industry currently follows for ICD-9-CM.[3] For example, outpatient conditions are still coded with ICD-10-CM to the highest degree of certainty, meaning that the working diagnoses or conditions on a list of differential diagnoses are not coded on emergency department outpatient visits.

Coding policies may also need to be updated to prepare for ICD-10-CM in the emergency department. For example, the following guideline is from Section IV.B: "The appropriate codes from A00.0 through T88.9 and Z00 through Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit."[4] It may be helpful to formulate coding policies for consistency in coding and reporting external causes. The codes for external causes were greatly expanded in ICD-10-CM and include codes to describe not only the cause of an injury or condition and the intent, but also much more detail on the place of occurrence and the activity of the patient at the time of the event. Hospitals may want to explore external reporting requirements and set an internal policy on the depth of complexity at which they will capture these codes. This will help identify further potential emergency department ICD-10 documentation gaps. It's important to capture the details surrounding the onset of a condition in the emergency department, as this is the best opportunity to capture this clinical information. Even for patients admitted from the emergency department to inpatient care, details surrounding an event are best found in the emergency department documentation.

Emergency department ICD-10 documentation gaps present a new opportunity for clinical documentation improvement (CDI) specialists to branch into outpatient record review. Established CDI programs are beginning to carve out time specifically for outpatient review. Today, CDI efforts on outpatient records typically focus on areas identified at risk for loss in a charge analysis. For example, injections/infusions and medical necessity documentation to support services provided. But CDI specialists could also assist in meeting ICD-10-CM documentation requirements in the emergency department.

Before launching into outpatient review, the CDI specialist should first spend time in the emergency department to study the clinical workflow. A likely approach is to have CDI specialists schedule time in the emergency department early in the morning to review the charts from the night shift and clarify documentation gaps with the clinical staff before they have completed their shift. This can be repeated again later in the day, at the end of the day shift. In this manner, the CDI specialist can ask for clarification while the clinical staff is still there and the patients are fresh in their minds. For emergency department coding, the focus of the CDI specialist is to ensure clinical documentation suggests a diagnosis, instead of merely symptoms. This offers a great opportunity to begin to build in awareness of the clinical details needed for ICD-10-CM.

ICD-10-CM Training and Understanding

Another approach to prepare for ICD-10-CM and proactively address ICD-10 documentation gaps in the emergency department is to provide training for emergency department physicians. Training should initially provide an overview of ICD-10-CM, highlighting where additional specificity and detail is available in the new codes. Emergency physicians treat a broad spectrum of conditions, from minor infections to major cardiovascular events and trauma. In fact, patients with almost any

condition can come into the emergency department. Therefore, emergency department physicians will need to be aware of the significant changes throughout the new code set that will require clinical documentation. Follow this general overview with more focused training to address the specific opportunities and ICD-10 documentation gap priorities that have been identified. Emergency department physicians should also be familiar with revised emergency department templates or EDIS functionality intended to prompt them for diagnosis details. It's also important to help physicians understand the impact their documentation has on the coding and reporting process.

Preparing for ICD-10

Clinical documentation should be as comprehensive as possible to ensure appropriate reimbursement, quality patient care, and a reflection of severity of illness. While unspecified codes are available in ICD-10-CM, unspecified codes impact the completeness of coded data and thus should only be used when no specific code is available or a more exact diagnosis is not yet known. Capturing sufficient clinical documentation to leverage the specificity available in ICD-10-CM will challenge emergency departments. For this reason hospitals should take proactive steps to identify ICD-10 documentation gaps that are physician- and facility-specific, dependent upon documentation habits and user application of templates and forms. They should subsequently prioritize the documentation gaps and plan focused interventions that will have the greatest impact for more complete coded data. Use multiple approaches, including the form or system prompt changes, operational changes, and focused training described in this article. Because it's difficult to change physician documentation habits, documentation improvement requires sufficient lead time to achieve measurable success. Hospitals should begin working now to improve emergency department documentation in preparation for coding with ICD-10-CM.

Notes

1. Centers for Disease Control and Prevention. "ICD-9-CM Official Guidelines for Coding and Reporting." August 11, 2011. Available online at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm#guidelines.
2. AHIMA. ICD-10 vendor questionnaire available for download free from http://ahima.org/icd10/resources.aspx (scroll down to "tools").
3. Centers for Disease Control and Prevention. "ICD-10-CM Official Guidelines for Coding and Reporting." 2012. Available online at http://www.cdc.gov/nchs/icd/icd10cm.htm.
4. Ibid, p 100 of 113 (2012).

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