Top Documentation Issues for ICD-10

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ICD-10-CM/PCS offers organizations better data about their patient populations and the services they provide them. The code set's greater specificity allows coding professionals to more accurately reflect the details of physician documentation.

However, an organization won't leverage those benefits if the documentation lacks the necessary detail in the first place. That's why an important early step in an organization's ICD-10 implementation plan is ensuring clinical documentation is sufficient for the new code set, said Donna Smith, RHIT, in her presentation "The Top 10 Documentation Issues under ICD-10."

Early education on documentation prepares physicians to capture more specificity in the patient record and helps medical staff adjust documentation practices well in advance of implementation, said Smith, a senior consultant at 3M Health Information Systems.

Smith described the top documentation issues she has already witnessed in transitioning organizations or expects to see as facilities move to ICD-10. She gave her recommendations at the AHIMA ICD-10 Summit in Baltimore, April 12.

Ten Issues to Focus on Now

Some documentation issues will require physicians to capture new information; others involve updated, modified, and otherwise expanded documentation needs.

Smith's top-10 problem areas are:

- Diabetes mellitus
- Injuries
- Drug underdosing
- Cerebral infarctions
- AMI
- Neoplasms
- Musculoskeletal conditions
- Pregnancy
- Respiratory/vents
- ICD-10-PCS-"the whole book," Smith said to laugher

She described the following issues and examples, among others:

Diabetes mellitus. ICD-9 features 59 codes for diabetes, while ICD-10 offers more than 200. The expanded diabetes code set has added a provision of "poorly controlled" to the categories of controlled or not controlled. Coders typically today have to query physicians to code the controlled levels, and adding another measurement will make coding even more complex, Smith said.

Injuries. ICD-10 also features an expanded category for injuries. A seventh character extension identifies the encounter type, with "A" for the initial encounter and "D" for the subsequent encounter. Coding professionals will also code the size and depth of the injury under ICD-10, Smith explained, which may not be captured in physician documentation.

Smith recommends organizations look at their records now to see if the level of documentation is there to support injury codes.

"If you are a trauma center, a good place to start addressing this is by pulling some records and see if they are coding to this specificity already," she said. "If not, you will have to do some education. But learn that need now, before ICD-10 implementation."

Underdosing. Underdosing is a new code in ICD-10. It identifies situations in which a patient has taken less of a medication than prescribed by the physician. The medical condition is sequenced first, with the underdosing code listed as a secondary diagnosis.

"The additional code tells us why the patient isn't taking their medication. Financial reasons are a big example. But whatever brought them into the hospital comes first," Smith said. Since this is new, many physicians will not be in the habit of documenting a patient's reasons for underdosing in the record.

Musculoskeletal conditions. ICD-10 includes more codes related to musculoskeletal conditions; for example, there are eight codes for pathologic fractures in ICD-9, but in ICD-10 there are more than 150 codes.

A Warning against "Unspecified"

Coders may be tempted to take the easy road and code "unspecified" if documentation doesn't support more specific codes. But Smith warned against this.

"Yes, there is an 'unspecified' code in ICD-10, and you can code it all you want. But in two to three years when you review your severity and risk scores you will be in bad shape," Smith said, "because you won't have the specificity in your codes that you need to justify higher levels and better reimbursement."

Some codes require time frames attached to them, such as the respiratory/ventilator codes, which note if a patient has been on a ventilator for less than 24 consecutive hours, 24-96 consecutive hours, or greater than 96 hours.

Smith noted this will be another area of education for some organizations, as she has heard anecdotally that documentation lacks time frames attached to events.

Start Early

HIM departments will need to start training their physicians to improve documentation now. She shared an example she thinks will illustrate the need to update to ICD-10 when HIM makes its case to physicians.

"In 1979, the year ICD-9 was implemented, the Nobel Prize was awarded for the CT scanner. Think about how far we have come in healthcare since then, while our codes have remained in ICD-9," she said.

Reimbursement is also a factor. While CMS isn't changing the way MS-DRGs are calculated now, future changes that require more in-depth documentation are coming, Smith said.

"We want to capture specificity now for when that change happens," she said. "If you are not doing well in ICD-9 specificity, you won't do well in ICD-10 since it is raising the bar.

"Doctors say, 'Our patients are sicker than the hospital down the street.' They may be sicker, but they aren't [to payers] if the documentation doesn't say so," according to Smith.

Direct examples help when educating physicians, Smith said, and she recommended featuring examples in education sessions. One way to do that is to create a chart listing a diagnosis and the ICD-10 documentation specificity needed to show that diagnosis.

For example, instead of documenting "asthma," doctors will need to indicate the severity level of asthma; instead of noting "respiratory failure," physicians will need to document "acute respiratory failure."

The training required to master documentation improvements will take time. Organizations should start now, Smith said. Focus on the top ten problem codes at your facility, she recommended, and begin to tweak physician queries so they reflect the

questions coding professionals will ask on October 1, 2013, when the first services will be reported in ICD-10-CM/PCS.

“Think about how long it has taken you to get physicians to document the acuity of a heart condition,” Smith said. “ICD-10 has hundreds of those specific codes.”

Coding professionals, meanwhile, can start preparing to work with the more specific documentation.

The root operation code is new to ICD-10, and it could hang up coders even if the documentation is present. Smith suggested that coders train on anatomy and physiology now and start pulling charts containing surgery to practice applying the root operation code. Putting in the time on anatomy and physiology will smooth the way for learning and applying ICD-10 later.

“This is a new term for all of us,” Smith said.

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