Implementing ICD-10: Enhancing clinical documentation

By Robert Tennant, MA

Editor’s note: This is the sixth in a series of articles providing assistance for implementing ICD-10. The first five articles are available at mgma.com/virtualconnexion in the November/December 2012, January 2013, February 2013, March 2013 and April 2013 issues.

In previous articles, we discussed working with external trading partners to make certain they have the ability to support your practice during the ICD-10 transition. It is also critical for clinicians to provide the necessary documentation to assign appropriate ICD-10 codes and potentially identify the correct code themselves while you ensure the readiness of external coders, billing services and clearinghouses to process claims with these new diagnosis codes.

The impact on clinical care resulting from this transition sets this government requirement apart from other HIPAA mandates. With the transition to the 4010 and 5010 electronic claims and other transactions, smaller practices were able to leverage billing services and clearinghouses to convert old formats to new formats and maintain cash flow. However, ICD-10 poses a unique problem because downstream vendors might not be able to convert an ICD-9 code to an ICD-10 code without access to the complete patient encounter documentation. Even if these vendors were willing to offer this service, providing that level of documentation with each claim would be labor-intensive for practice staff and would add steps to the billing service or clearinghouse process with costs shouldered by the practice.

The transition to ICD-10 will, in many cases, require clinicians to capture new, updated or modified information. As a result, it is important to review the way your clinicians document clinical services to address vulnerabilities when you prepare for ICD-10. This will help your internal and external coding staff become accustomed to the more specific and detailed clinical documentation that is needed to assign ICD-10 codes.

The move to ICD-10 should not affect how clinicians provide clinical care, but additional information must be recorded during the patient encounter because ICD-10 gives more specific choices for coding diagnoses. Your clinicians might already collect this additional information from the patient; now you will have to document it. This more-complete documentation will reduce the need to follow up with health plans about pending claims or those that were rejected for an unsubstantiated diagnosis code, saving the practice time and money.

Internal documentation review

A good first step toward improving the process of recording a patient encounter will be to examine the current level of clinician documentation to determine whether it is sufficient for ICD-10. As professional coders know, the adage to live by is, “If it is not documented by the clinician, it did not happen and, thus, cannot be coded or billed.”

Review the documentation for a selection of claims using the most commonly used diagnosis codes to determine if the documentation would be specific and detailed enough to select an appropriate ICD-10 code. This could involve leveraging the expertise of your coding staff or potentially contracting with an outside entity. One straightforward component of many patient encounters will be the laterality of the clinical issue. Laterality is...
expanded in ICD-10-CM, and clinical documentation for diagnoses that should include information about which side of the body is affected (i.e., right, left or bilateral).

The following are common examples of specific information that coders will need to accurately assign ICD-10 codes on claims:

- **Diabetes mellitus**: diabetes type, affected body system, complication or manifestation, long-term insulin use, if appropriate
- **Pregnancy**: trimester now required
- **Fractures**: site of fracture, type of fracture, laterality, location
- **Injuries**: external cause, place of occurrence, activity code, external cause status
- **Musculoskeletal conditions**: ICD-10 includes more codes related to musculoskeletal conditions; for example, there are eight codes for pathologic fractures in ICD-9, but there are more than 150 codes in ICD-10.

### Unspecified codes

ICD-10 offers the tempting choice of using “unspecified” as an option. Many expect that this will be a particularly attractive option right after the compliance date, when there is much confusion among providers or when the patient encounter is not well-documented. However, there are some downsides to this approach. Some health plans might not accept these unspecified codes and could delay adjudication of the claim until they receive additional information or an updated ICD-10 code. Using “unspecified” without a more granular code present will make it difficult for practice professionals to code for reimbursement at higher levels when they review severity and risk scores.

### Internal communication

Your clinicians might have treated certain patients and documented these encounters for many years, which could make it more difficult to communicate the necessary modifications to their documentation for the ICD-10 transition. A practice champion on the clinical staff can help you promote the changes required before moving to ICD-10. We expect to see a variety of champions in different practices. For example, you might identify a physician champion to lead the efforts with the other physicians in the group and a nurse to take charge of educating the nurses.

Allow plenty of time in your ICD-10 implementation schedule to start the internal review, clinician education and implementation of improved documentation processes. It could take considerable effort for long-term documentation habits to be modified, and you want to have ample time to complete this process well before the ICD-10 compliance date of Oct. 1, 2014.

We know that educating and training clinicians about improved documentation can be challenging, which is why we recommend you begin discussions at staff meetings and in internal communication venues as soon as possible. Focusing on the dual goals of improving patient-encounter recording and avoiding cash-flow disruption should help convince the clinical staff to take the necessary steps sooner rather than later.