

Road Map to ICD-10-CM

Documentation is the Cornerstone to Successful Implementation

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REMEMBER THAT ICD-10-CM implementation is only a few years away. Think about the specificity in ICD-10-CM and ask yourself the question, “Will the practitioner’s documentation be ‘up to snuff?’”

Since I audit medical records within the scope of my responsibilities, I can tell you that most current documentation practices will not support the higher levels of specificity for ICD-10-CM. Now is the time, if you have not done so already, to perform a baseline ICD-10-CM readiness audit. Why is this so important as the first step? To prepare, it is important to identify current documentation deficiencies when reporting diagnoses in the medical record.

Many of you who conduct audits in your medical practice or routinely have audits performed as part of compliance have undergone this process from a comprehensive coding perspective — now is the time to take a different approach. Review the patient’s chart note to ensure the physician is documenting a complete diagnosis. For example, if a physician makes a medical determination for a patient’s ear pain based on his documented assessment, including a history pertinent to the reason for the visit and an examination, most likely you’ll see the diagnosis documented as “acute otitis media” without further elaboration. The diagnosis code reported in ICD-9-CM would be unspecified (381.00, unspecified acute nonsuppurative otitis media).

However, in ICD-10-CM, the diagnosis of acute otitis media (H65.1, other acute nonsuppurative otitis media) cannot be coded without additional information (such as whether the right or left ear is affected). In addition, the physician will have to identify whether the problem is initial or recurrent. More information must be documented in the medical record to support selection of an ICD-10-CM code. The documentation should look more like this: *Patient has an acute onset of otitis media of the right ear, a recurrent condition.*

Now you can correctly code using ICD-10-CM as H65.114 (acute and subacute otitis media recurrent, right ear).

How do you ensure that the documentation will

be sufficient when ICD-10-CM is implemented? By performing an ICD-10-CM readiness audit, you will be able to identify the problem areas and this will help formulate documentation-training requirements for your practitioners.

I recommend reviewing five or six records per week for each practitioner. Remember that you are just assessing the diagnosis documentation for this audit.

In addition, map or crosswalk your current ICD-9-CM codes to their ICD-10-CM equivalents.

Once you have finished a month of weekly audits and compiled the results, sit down with each physician and review the chart note with the documented ICD-9-CM code versus the ICD-10-CM code (if you can code it). Here is one major issue — in many cases, you will not be able to assign a diagnosis code in ICD-10-CM due to lack of documented specificity in the medical record.

How do you solve the problem?

- Educate the physician using the comparison between both coding systems.
- Encourage the practitioner to begin documenting more specifically for ICD-10-CM.
- Keep your results each week and compile a monthly summary. This summary should identify the percentage of correct documentation for both ICD-9-CM and ICD-10-CM, with recommendations for improving the documentation.

The most important mechanism I have found in working with physician documentation is effective communication. If the physician can see which mistakes he or she made by reviewing the medical record along with the audit results, it helps to clarify confusion.

As you now realize, we have a lot of work to do to get ready for ICD-10-CM. Keep auditing the practitioner’s diagnosis documentation for a period of about six to 12 months and compile the results. Track deficiencies, along with improvement, on a spreadsheet and share it with your practice.

Is there a lot of work yet to do to get ready? Absolutely! But we can do it! ■

