

The one-year grace period for correct use of ICD-10 codes

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Many surgeons welcomed the Centers for Medicare & Medicaid Services' (CMS) decision to give health care professionals a one-year grace period to precisely comply with the 10th revision of the International Classification of Diseases (ICD-10) documentation requirements. Throughout this grace period, which ends October 1, 2016, CMS will remit payment to physicians if the ICD-10 code is at least in the appropriate family of codes.¹

The current roll out of ICD-10 may have left some surgeons feeling disoriented. Although precise ICD-10 documentation is not required for professional billing during the grace period, accurate ICD-10 coding is necessary to support hospital services and for quality reporting. Compliance with ICD-10 not only will benefit hospitals, for which compliance is required in year one, it will also benefit physicians through correct documentation of their patient's clinical condition. Moreover, precise data are necessary to achieve high reliability in health care for our patients in the future. This column addresses some questions and concerns regarding ICD-10 coding that many surgeons share.

Why should surgeons be concerned about precise ICD-10 coding?

This grace period is a far cry from a free pass for the many health care professionals, especially surgeons, whose practices are often intertwined with the hospitals at which they deliver care. Contrary to the obligations for health care professionals, hospitals still are required to submit accurate ICD-10 diagnosis codes generated from physicians' documentation. If the patient's health care record is missing information necessary for proper ICD-10 coding, the hospital will have to ask physicians to provide more detailed information to avoid use of nonspecific codes that may result in the denial of the hospital's Part A claims.

Does ICD-10 coding affect my participation in any reporting and payment programs?

ICD-10's increased granularity provides a more accurate depiction of the patient's severity of illness and should help physicians avoid undeserved penalties and poor ratings on publicly distributed provider report cards.² Proper use of ICD-10 terminology may be useful to surgeons who are seeking to successfully participate

in the Physician Quality Reporting System (PQRS) and the Medicare Value-Based Payment Modifier Program.³ With greater detail and increased ability to accommodate new technologies, ICD-10 has the potential to provide better data for evaluating and improving the quality of patient care.⁴ The data captured by the updated code set may be used to more meaningfully understand complications and track patient outcomes. Furthermore, ICD-10's increased granularity could prove useful in clinical research and public health investigations.⁵

What is the surgeon's role in ICD-10 coding when a hospital and practice have billing and coding staff?

ICD-10 compliance does not mean surgeons have to become coders. The role of the clinician is to document the nature of the patient's condition and services rendered to maintain or improve those conditions as accurately as possible, whereas the job of the coding professional is to ensure that the coding is consistent with the documentation. Lack of appropriate documentation is bad for payors, providers, and patients. The surgeon's focus should be on the language and/or wording that will document

greater detail and specificity of the coded data for a given diagnosis, condition, disease, and/or surgical procedure.

What tips would you offer to surgeons who are trying to accurately document their cases using ICD-10?

Understanding the basics of ICD-10 documentation may help make ICD-10 coding less opaque. Clinical documentation of a patient encounter should include the following information, all of which typically is easy to provide:

- *Episode of care* (initial, subsequent, sequella)
- *Acuity of disease* (mild, moderate, severe, acute, chronic, acute on chronic)
- *Laterality* (right, left, bilateral)
- *Type and cause of a condition, disease, or disorder* (for example, expected acute blood loss anemia after surgery for a gunshot wound to the liver)
- *Underlying condition* (such as essential hypertension, uncontrolled type 1 diabetes)
- *Manifestation of disease* (such as sepsis due to perforated appendicitis)

- *Linking of diagnosis* (for example, diabetic nephropathy, peripheral vascular disease due to smoking, renal calculi due to hypercalcemia from primary hyperparathyroidism, and so on)
- *Causal organism* (identification of the infectious organism)
- *Relationship of drug, tobacco, alcohol to disease* and documentation of use, abuse, or dependence
- *Support medical necessity* with physical findings, labs, or radiologic findings (for example, as indicated by a mass seen in the right upper lobe on computed tomography scan, a thoracotomy and right lung resection will be performed)

Isn't ICD-10 coding more of an issue for hospitals? Isn't Current Procedural Terminology (CPT) coding more relevant to billing for physician services?

Although CPT codes will still be accepted for billing for professional fees and outpatient procedures, nonspecific CPT codes may result in denial of payment for newer procedures.² Furthermore, hospitals will be required to use ICD-10 procedure codes for all inpatient

procedures. ICD-10 requires the following information in the description of procedures:

- *Specific anatomic site or region and body part* (such as right upper lobe of lung, upper inner quadrant right breast)
- *Laterality* (right, left, bilateral)
- *Root operation* (such as biopsy, excision, repair, resection)
- *Approach* (including percutaneous, endoscopic, open)
- *Devices used*, such as biologic (skin graft), synthetic (mesh), mechanical materials (cardiac pacemaker)
- *Qualifiers* are specific to the procedure (diagnostic procedure)

Because physicians are responsible for providing the documentation for these descriptors, we must be able to comply with ICD-10 requirements.

Furthermore, CMS is monitoring postoperative outcomes outlined by the Agency for Healthcare Research and Quality (AHRQ).⁵ To avoid inaccurate designation of poor postoperative outcomes, it is important to document the following conditions as

present on admission or before an operation when applicable:

- Systemic inflammatory response syndrome/sepsis
- Urinary tract infection (urosepsis)
- Veno-thromboembolism events
- Decubitus pressure ulcer
- Respiratory insufficiency/failure (including chronic obstructive pulmonary disease [COPD])
- Renal insufficiency/failure
- Coagulopathy
- Bleeding condition/anemia (such as gastrointestinal bleed)
- Hip fracture
- Wound dehiscence or other complications after another surgeon's operation

What other tips would you offer for complying with ICD-10 documentation requirements?

Some other documentation tips for successful ICD-10 compliance are as follows:

- Eliminate the phrase “postoperative” condition from your documentation

vernacular because it will imply a complication; for example, instead of using “post-op ileus,” document “expected ileus after intestinal resection.”

- State when expected medical conditions emerge after surgery are due to primary disease processes (for example, expected respiratory insufficiency after surgery requiring ventilator support due to COPD).
- Document if a condition is a result of the primary disease (for example, septic shock due to a tubo-ovarian abscess).
- Document when subsequent operations are anticipated (such as second-look surgery being planned to evaluate for progressive intestinal ischemia).
- For professional fee coding, list symptoms in medical terms when the diagnosis is not yet known. Only hospitals are allowed to use terms such as “suspect,” “probable,” or “rule out” in their coding.
- For reimbursement of services provided, diagnoses must be linked with treatment in plain English (for example, a bronchoscopy will be performed to investigate hemoptysis and a lung mass seen on chest X ray).

What is an example of steps an institution has taken to comply with ICD-10, and what have been the benefits?

In January 2014, hospital health information experts, hired consultants, and clinical documentation surgeon champions developed and implemented a clinical document improvement and ICD-10 training curriculum for the department of surgery at the University of New Mexico, Albuquerque. The curriculum began with mandatory lectures that addressed current documentation deficiencies and new ICD-10 documentation requirements for each surgical specialty. A clinical documentation surgeon champion assigned to each surgical specialty reviewed cases at division conferences and highlighted opportunities for better clinical documentation. Surgical health care professionals were given access to ICD-10 Internet and mobile apps. ICD-10 documentation tip sheets created for each surgical specialty were distributed to providers via hard copies attached to workstations and electronic versions made public on the hospital Intranet ICD-10 website. Providers and documentation

specialists reviewed clinical documentation queries during one-on-one sessions.

Severity of illness and risk of mortality levels, case mix illness scores, provider query response rate, documentation delinquency, AHRQ quality measurements, and hospital charges for surgery patients are monitored for each surgery division and shared with providers.

These changes resulted in a 40 percent increase in the surgery department's case mix index and a \$300,000 per month increase in hospital charges.

Are there any resources to consult to aid in implementing a similar program?

Additional ICD-10 educational resources are available at the following links:

- Centers for Medicare & Medicaid Services. Provider ICD-10 Resource Guide & Contact List. Available at: www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf. Accessed November 18, 2015.
- American Health Information Management Association. Choose your path to ICD-10: Quick links to helpful ICD-10 resources. Available at:

www.ahima.org/icd10/. Accessed November 18, 2015.

- American Health Information Management Association. Clinical documentation improvement: ICD-10-CM/PCS documentation tips. Available at: <http://bok.ahima.org/PdfView?oid=300621>. Accessed November 18, 2015.
- American College of Surgeons. Practice management: ICD-10 coding. Available at: facs.org/advocacy/practmanagement/icd10. Accessed November 18, 2015.
- Morse S. CMS appoints Ombudsman. *Healthcare IT News*. Available at: www.healthcareitnews.com/news/cms-names-icd-10-ombudsman. Accessed November 18, 2015.
- CMS ICD-10 Ombudsman, reachable at: icd10_ombudsman@cms.hhs.gov. ♦

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