



The importance of detailed documentation in ICD-10

by Megan E. McNally, MD, FACS | 63

The 10th revision of the International Classification of Diseases (ICD-10) takes effect October 1. The good news is that surgeons still have some time to make changes in their documentation practices to prepare for the transition to ICD-10. Following are some guidelines for ensuring a smooth transition.

Transitioning

Transitioning from ICD-9 to ICD-10 will affect the way many surgeons practice. Most of the information coders will use will come from accurate and thorough documentation in the medical record. The biggest difference between ICD-10 and ICD-9 is the addition of numerous codes. There are 68,000 codes

in ICD-10 versus 13,000 in ICD-9. In addition, the inpatient procedure code set (PCS) will evolve, bringing the entire set of new codes to 141,000.

Clinical documentation implementation

Clinical documentation implementation (CDI) programs can be beneficial in this transition. CDI programs may comprise coding and/or nursing specialists assisting physicians on documentation in order to allow for timely and accurate coding. The success of CDI programs relies on a cooperative effort between physicians, health information management, coders, and clinical documentation specialists. Documentation queries may be

helpful in clarifying diagnosis codes. Surgeons will need to respond quickly and accurately to documentation queries to aid in the transition. In addition, they must become familiar with the increased granularity of these coding sets. For example, documentation should indicate whether one lymph node or an entire chain of lymph nodes was removed; or the documentation should describe whether a patient's anemia is chronic or acute blood loss anemia.

Importance of documentation

The increasing complexity of medicine has been met with a corresponding increase in complexity of medical documentation. The purpose of developing the ICD-10 coding set

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64] was to reflect these intricacies. New devices and advanced procedures are now included and can be accurately coded in the health record. The transition aids in data collection to accurately reflect the condition that is being treated, as well as the outcomes for that treatment. For example, similar injuries on opposite limbs cannot be accounted for in ICD-9. With ICD-10, different injuries or different severities of medical conditions now can be coded.

Thorough, detailed documentation leads to accurate coding, and accurate coding leads to appropriate and timely claims payments for hospitals and physicians. Most importantly, accurate documentation can lead to better, more effective patient care. It can provide more detailed information to other health care providers

performing subsequent care or services on patients.

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Quality and safety measures

Many of our quality and safety measures are risk-stratified. Thorough documentation with the appropriate coding of the problem list will accurately reflect the overall state of the patient. The quality and safety measures affect payments directed to hospitals. As requirements for surgeon-specific data increase, clear documentation with ICD-10 could affect potential future pay-for-performance programs. If

certain conditions were present on admission or certain comorbid conditions exist and are not documented, it could affect the observed-to-expected death ratio for morbidity and mortality. If a surgeon under-codes a case, then the observed ratio may fall below the expected average of his or her colleagues.

If your practice has not yet started the transition, now is the time to get ready for ICD-10. As surgeons, we must enhance our clinical documentation to reflect the more detailed changes with ICD-10. For more information, visit the ACS ICD-10 resource website at www.facs.org/advocacy/practmanagement/icd10. ♦