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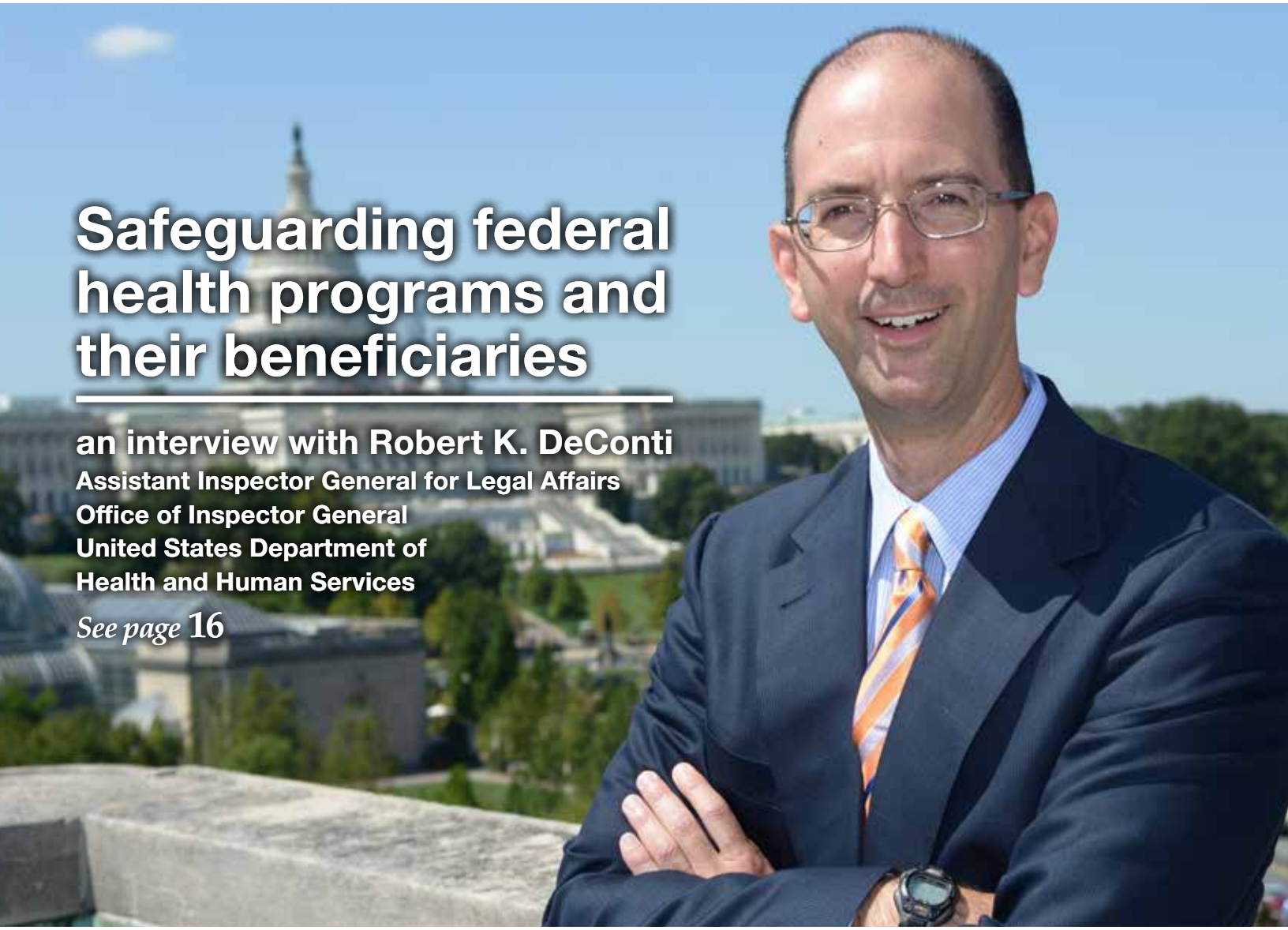

Safeguarding federal health programs and their beneficiaries

an interview with Robert K. DeConti
Assistant Inspector General for Legal Affairs
Office of Inspector General
United States Department of Health and Human Services

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Looking beyond the end of the physician ICD-10-CM coding grace period

» Documentation accuracy is critical in ICD-10-CM coding.

» Teamwork between coder and physician is essential to the success of ICD-10-CM transition.

» Providers remain concerned with decreased productivity due to increased ICD-10-CM documentation requirements.

» With the physician ICD-10-CM grace period ending, audits and claim denials are a concern.

» Preparation for the ICD-10-CM transition is a start; continued efforts are necessary to ensure further success.

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The one-year-long grace period for ICD-10-CM implementation ended on October 1, 2016. This provided the healthcare industry a transition period which allowed providers, coders, and billing staff to get familiar with the new code set. Providers will now have to fully comply with the more specific new documentation requirements of ICD-10-CM. The key to a successful transition involves providers improving their documentation. The enforcement of greater specificity in the documentation requires providers to document more precisely and accurately, and it requires coders to choose the ICD-10-CM diagnosis codes that most closely reflect the complexity and severity of the patient's condition.

Price

There is concern that these higher documentation and coding standards will be too time consuming for providers and decrease productivity for both the providers and the coders.[1] Additionally, there are concerns about increased claim denials and the negative financial impact this could have for physician practices and healthcare systems. This article will focus on ways that the provider and coder billing staff can continue to improve their ICD-10-CM compliance while reducing the risk of audit and government scrutiny.

A key component is documentation accuracy

The purpose of medical record documentation is to paint a picture that tells the story of an episode of patient care. This is best done by recording as much detail and specific information regarding the patient's condition as possible and must be completed by the provider. Many of the new documentation provisions introduced in ICD-10-CM are details that physicians/providers should already be documenting.[1]

ICD-10-CM offers an expansion over ICD-9-CM in that codes define the patient's condition with more specificity. Many of the new codes are combination codes which describe the following:[2]

- The type of care (e.g., initial, subsequent, sequelae)

- The acuity of the disease (e.g., mild, moderate, severe, acute, chronic, acute on chronic)
- The laterality (e.g., right, left, bilateral)
- The type and cause of the condition, disease, or disorder (e.g., acute blood loss after surgery for a gunshot wound to the liver)
- The underlying conditions (e.g., essential hypertension or uncontrolled type 2 diabetes)
- The manifestation of the disease (e.g., sepsis due to a perforated appendix)
- The specific causal organism
- Link more than one diagnosis together (e.g., diabetic nephropathy and peripheral vascular disease due to smoking)
- Document the relationship of drugs, tobacco, or alcohol to the disease and specify use, abuse, or dependence
- Support medical necessity with physical findings, labs, and/or radiologic findings

Teamwork is essential to the transition

Historically, physicians view documentation as a time-consuming burden; they have not seen coding as a method of communicating a patient's condition, but rather as a chore to ensure payment.[1] There has been a disconnect between coder and physician. With increased demand for high-quality documentation, accurate coding, and increased government scrutiny, physicians and coding staff must work together. Teamwork and collaboration between the coder and physician/provider is essential to the success of the ICD-10-CM transition. Because coders rely on the physician's documentation in order to apply the correct code, it is vitally important to have open lines of communication between the two, since coding accuracy will drive reimbursement. Physicians have a large incentive to improve their documentation, and this will improve the coding process as well as the accuracy and effectiveness of claims processing. The more meticulous the provider documentation, the easier it is for coders to accurately code records. If this process is thorough and both teams are working together, the financial outcome will be better.

ICD-10-CM increased documentation requirements may impact productivity

Providers should plan for a decrease in productivity; physicians will have to spend more time documenting and responding to queries, and coders will spend more time eliciting details in the documentation in order to apply the correct codes.[3] In many cases, there will be multiple codes to apply in ICD-10 rather than a single code as in ICD-9-CM. The combination of more specific documentation and greater number of codes to choose from will likely decrease productivity; however, this drop in productivity has not been as large as many had feared. This might be due to the proactive approach many organizations took around ICD-10-CM training, documentation programs, implementation of EHR systems, and Computer Assist Coding (CAC) technology.[4] Hopefully the grace period has allowed providers and coders to get acclimated to the changes, and productivity will continue to rebound with time and familiarity.

Audits/denials: What's the plan of action?

This is an important topic in the healthcare industry today. Since the implementation of ICD-10-CM on October 1, 2015, there has been less of a negative impact than predicted. Now that the ICD-10-CM grace period has ended, concerns for increased denials and audits are reemerging, and

there will be challenges ahead to overcome.[5] Just as with ICD-9-CM coding, there will be some claim denials and government audits. Preparedness for outside audits improves while the likelihood of an audit diminishes when healthcare organizations and physician practices have implemented good documentation practices, internal controls, ongoing monitoring, and auditing programs.[6]

Physicians should focus on the codes and the documentation requirements for their field, because these vary among specialties. For example, orthopedics has more than 17,000 ICD-10-CM codes with about one quarter related to fractures.[1] Self-audits and peer reviews to get feedback and monitoring for accuracy will be important steps to fight off adverse government audits.

Physicians should focus on what they are trained to do: evaluate the patient and then determine and implement a treatment plan based on observation, tests, studies, and collaboration with the patient. This process should be thoroughly documented in the medical record and translated into ICD-10-CM codes by the coder. This will promote accurate reimbursement and provide justification of medical necessity for services provided.

Conclusion

ICD-10-CM is now fully implemented. Now providers must sufficiently and thoroughly document everything they know about their patient's condition. "Document, document, document" is the motto. The best plan of action is for organizations to ensure that physicians provide high-quality documentation—working in partnership with the coder to ensure compliance with the new ICD-10-CM requirements. These best practice efforts will decrease risk, help with audits, and improve reimbursement. Many organizations have implemented clinical documentation improvement programs to help with this transition. On-going training, education, and monitoring of providers and coders is necessary for continued ICD-10-CM coding success.

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