Assess Your Documentation in Preparation for ICD-10

With the upcoming transition from ICD-9 to ICD-10, much concern has been raised about new levels of documentation requirements for ICD-10. Now is the time for your practice to assess your current documentation and how it will support coding for ICD-10.

Keep the following points in mind as you assess on your clinical documentation for ICD-10.

- The documentation for ICD-10 coding may not be that different from your current documentation. It is very likely that the more detailed information in the ICD-10 code is already in your clinical notes. For example:
    - The ICD-10 pregnancy codes are broken down into trimesters, which will be in your documentation.
    - The changes in diagnosis codes and increased level of detail are specific to the different specialties. Orthopedics has the highest increase in codes, but many of the new codes are simply separate codes for "right" vs. "left" and detail about the exact location in the bone of the fracture. This information will already be in your documentation.
    - Some "new" concepts in ICD-10 are not new to medical practice. For example, asthma diagnoses in ICD-9 were categorized as "intrinsic" and "extrinsic." In ICD-10, the more common terms of "mild," "moderate," and "severe" are used.
- Decide if you want to do the documentation assessment yourself or if you want to get outside expertise.
    - There are organizations that offer resources and training programs that will provide you with feedback on your current documentation and whether or not it will be sufficient for ICD-10.
    - Other resources are available that you can use to do your own documentation assessment. An example is mappings of the ICD-9 codes to their ICD-10 counterparts, which are usually specialty specific and for the most common diagnoses. You can use these resources to assess if your current documentation has enough information to support the ICD-10 code. You can then work on any improvements that will be needed.
- You may need to improve the level of detail you document in order to support ICD-10, but it is better to identify this need now instead of after the deadline when you are trying to get reimbursed for the services you perform.
- Using more precise diagnosis codes in ICD-10, and today in ICD-9, can prevent claims denials and better documentation will assist you in the event of an audit.

Documentation improvement activities are an important step for preparing for the October 1, 2015 deadline and will also help you today with your ICD-9 coding.

Visit the AMA's website for more resources on ICD-10
www.ama-assn.org/go/ICD-10

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