RAC's and Medical Necessity ICD-10 will Change Everything

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Medical Necessity

- Medical Necessity determinations not just hot button for the RAC's, MICs, or ZPICs, but also with government auditors
  - Medicare Administrative Contractors (MACs)
  - Fiscal intermediaries (FIs)
  - Comprehensive Rate Testing Contractors (CERT)
  - Clinical judgment based on documentation in the medical record is the best defense
  - Providers should examine any and all medical necessity denials to determine when an appeal is warranted
  - Engage your medical staff in the review process—hospitalists, physician advisors, specialists, and of course, the attending physician—should all be actively involved

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Justifying Medical Necessity

- The issue of medical necessity for the providers' services remains a recurring theme for all of the government's enforcement efforts
- Medical necessity will be one of the main variables in their data-mining hunt looking for irregularities and mismatches

ICD-10 Final Rule CMS-0013-F

- Published January 16, 2009
- October 1, 2013 – Compliance date for implementation of ICD-10-CM and

  ICD-10-PCS (no delays)
- No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes

  http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf

Why is it Such a Big Deal?

Just a version change?

1. A cornerstone of Health Information
   - ICD9/10 diagnosis codes define the health state of the patient
   - ICD9/10 procedure codes define the institutional procedures that patients may receive to maintain or improve their health state
2. Major change in the coding system
   - **14,400** ICD9 codes to **69,368+** ICD10 codes
   - **3,800** ICD9 procedure codes to **72,000** ICD10 procedure codes
   - Major changes in structure of the codes
   - Major changes in coding rules
   - Major changes in terminology
3. Pervasive use through most healthcare systems
   - Many business functions Impacted
   - Many IT systems impacted
   - Paper and electronic

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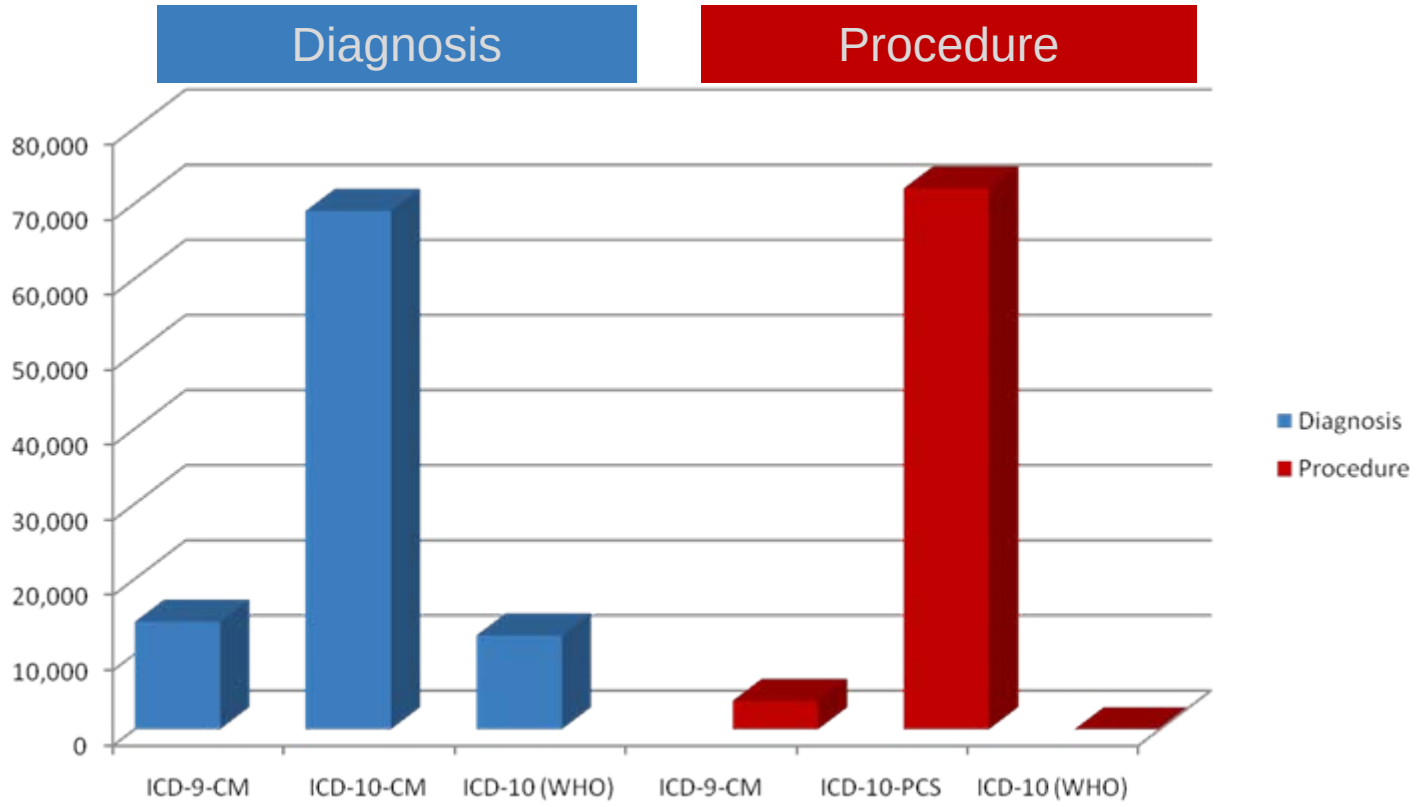
ICD10 Quick Facts



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Why Are There So Many Diagnosis Codes?

- 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
- 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
- ~25,000(36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’

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ICD-10 Compliant Code Set Reporting

	Date of Service	Code Set
Encounters	09/30/2013	ICD-9-CM
	10/01/2013	ICD-10-CM
	Date of Discharge	**Code Set**
Hospital Inpatient	09/30/2013	ICD-9-CM
	10/01/2013	ICD-10-CM & ICD-10-PCS

On October 1, 2013, the usual coding rule for inpatient services will apply. Providers and insurers will use ICD-9-CM edits and payment logic for claims relating to encounters and hospital discharges occurring prior to October 1, 2013. Beginning on October 1, 2013, ICD-10 will be used for all encounters and hospital discharges. For hospital inpatient claims, the code in use on the date of discharge and NOT the date of admission will be used.
HCPC and CPT codes will not be affected.

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The Code Freeze

- On October 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173
  - There will be no updates to ICD-9-CM, as it will no longer be used for reporting
- On October 1, 2014, regular updates to ICD-10 will begin

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Advantage of Moving to ICD-10

- More consistent with the rest of the world
- Considerably more information per code
- Greater expandability in codes
- More logical tabular structure
- Better definition of co-morbidities, complications and disease manifestations
- Improved support for analysis related to:
  - Risk and severity
  - Predictive modeling
  - Quality and cost efficiency analysis
  - Population epidemiologic research

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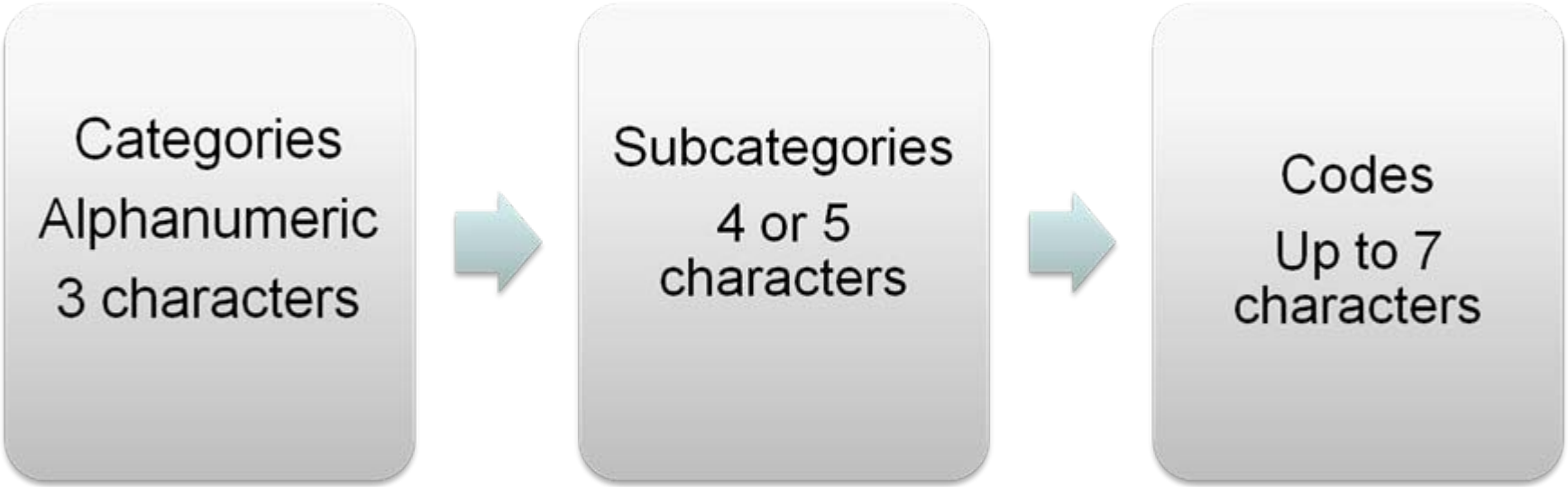
Let's Look at a Snapshot ICD-10-CM

Format and Structure



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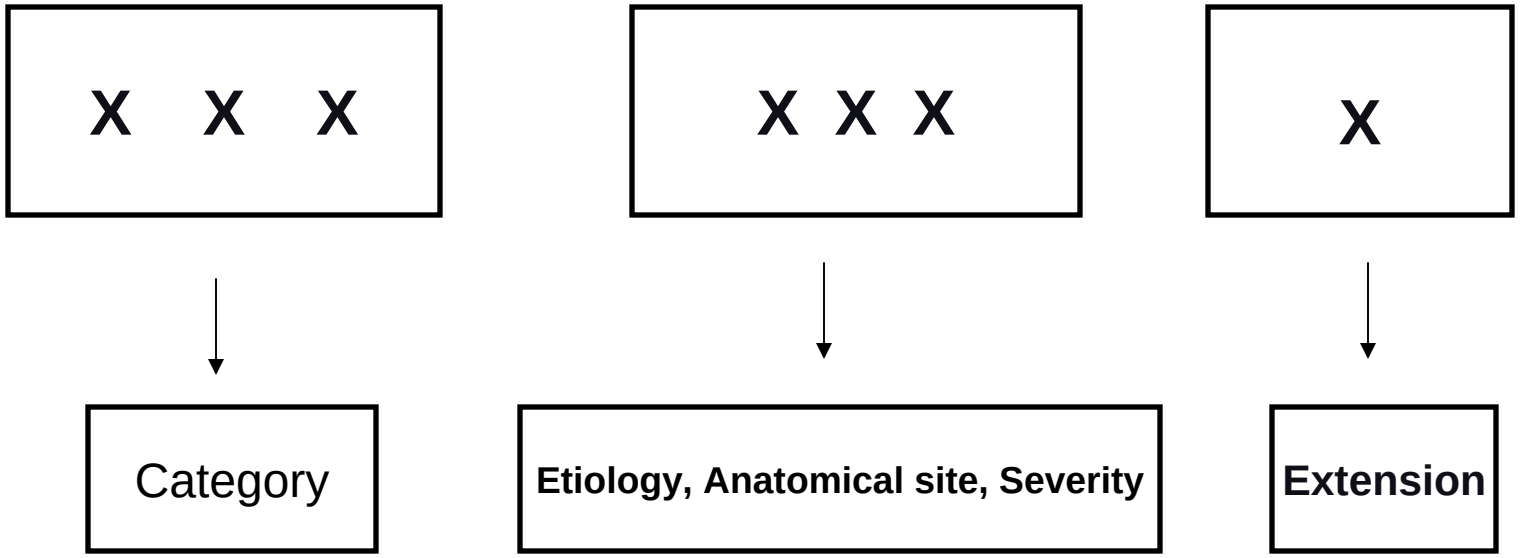
ICD-10 CM Format



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Hierarchy Structure

- Differences in ICD-10-CM
  - Alphanumeric Structure
  - Addition of 6 and 7 digit extensions to provide a higher level of specificity
  - More specificity
  - Reorganizing and adding chapters
  - Diagnostic codes will be more precise
  - Expanded to include health-related conditions
  - Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
  - The new structure will allow further expansion than was possible with ICD-9-CM

Additional Observations and Challenges

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes in which ICD-10-CM groups injuries by site
- Diabetes codes include over 210 choices
- Creation of combination diagnosis/symptom codes which reduced the number of codes needed to fully describe a condition
- The length of codes being a maximum of seven characters as opposed to five digits in ICD-9-CM
- Challenges for OB/GYN with codes beginning with letter “O” which can be confused with number “0”
  - Potential keying errors which could lead to claim denials

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Laterality

ICD-9-CM	ICD-10-CM
• 931 Foreign body in ear	• T16.1xxa Foreign body in right ear, initial encounter • T16.2xxd, Foreign body in left ear, subsequent encounter • T16.3xxq, Foreign body in ear, unspecified ear, sequela

Up to Sixth Character Subclassification

- *A six character sub-classifications represents the most accurate level of specificity*
  - L89.510 Pressure ulcer of right ankle, unstageable
    L89.511 Pressure ulcer of right ankle, stage 1
  - L89.512 Pressure ulcer of right ankle, stage 2
  - L89.513 Pressure ulcer of right ankle, stage 3
  - L89.514 Pressure ulcer of right ankle, stage 4
  - L89.519 Pressure ulcer of right ankle, unspecified stage

Seventh Character Extension

- Certain ICD-10-CM categories have applicable 7 characters
  - The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct
  - If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters

Dummy Placeholders

- The ICD-10-CM utilizes a placeholder character “x”. The “x” is used as a 5th character placeholder at certain 6 character codes to allow for future expansion
- Example*:*
  - 032.1 Maternal care for breech presentation of fetus 1
  - Code requires 7th character
    - Code reportable: 032.1xx1

Note: 7th character 1-9 identifies multiple gestations to report the fetus which the code applies

Combination Codes

- ICD-10-CM consists of greater specificity. Sample
- Examples
  - I25.110, Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris
  - K50.013, Crohn's disease of small intestine with fistula
  - K71.51, Toxic liver disease with chronic active hepatitis with ascites

Complications

7th character
A initial encounter
D subsequent encounter
S sequela

- T81.535-Perforation due to foreign body accidently left in body following heart catheterization
- T81.530-Perforation due to foreign body accidently left in body following surgical operation
- T81.524-Obstruction due to foreign body accidently left in body following endoscopic examination
- T81.516-Adhesions due to foreign body accidently left in body following aspiration, puncture or other catheterization
  - 7th character required

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Code Mapping Example
Maps 2:1

ICD-9-CM	Description	ICD-10-CM	Description
625.6 788.32	Stress Incontinence, Female Stress Incontinence, Male	N39.3	Stress incontinence, female, male

Code Mapping Example
Maps 1:2

ICD-9-CM	Description	ICD-10-CM	Description
454.0	Varicose veins of lower extremity, with ulcer	I83.ØØ9	Varicose veins of unspecified lower extremity with ulcer of unspecified site
454.0		I83.Ø19	Varicose veins of right lower extremity with ulcer of unspecified site

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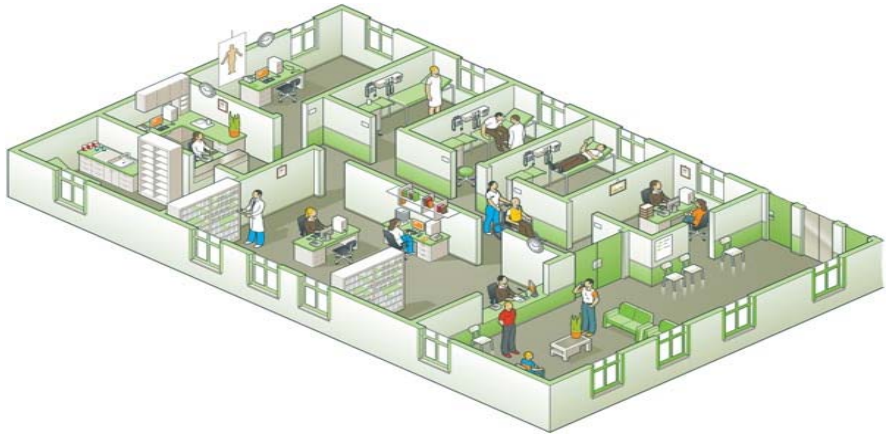

DOCUMENTATION CHALLENGES

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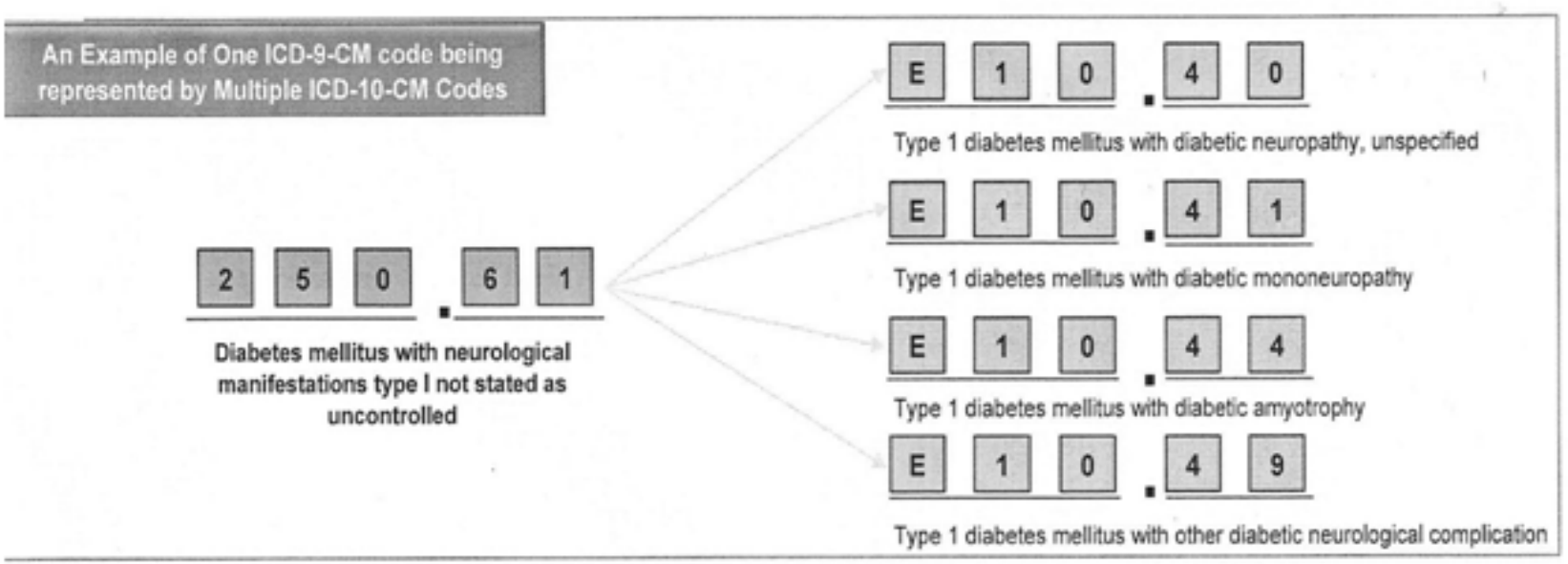
Diabetes Mellitus

- Over 210 codes to identify
- Documentation must include:
- Type of Diabetes (1 or 2)
- Manifestations
- Other mitigating factors

Diabetes Mellitus

- There are six diabetes mellitus categories in the ICD-10-CM They are:
- E08 Diabetes mellitus due to an underlying condition
- E09 Drug or chemical induced diabetes mellitus
- E10 Type I diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus
- E14 Unspecified diabetes mellitus
- Note: All the categories above (with the exception of E10) include a note directing users to use an additional code to identify any insulin use, which is Z79.7. The concept of insulin and noninsulin is a component of the diabetes mellitus categories in ICD-10-CM.

Mapping Diabetes



The industry expects that mapping ICD-9 and ICD-10 codes will be a complex task

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Diabetes with Manifestation

- A 60 year old patient presents with Type 1 diabetes has a **chronic left heal ulcer** with **muscle necrosis** due to the **diabetes**.

- Diagnosis code(s):
  - E10.622-Type 1 diabetes mellitus with other skin ulcer
    - A note underneath the code identifies to “Use additional code to identify site of ulcer
  - Secondary diagnosis-L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

Gestational Diabetes

- A patient with gestational diabetes is seen by the OB/GYN for her routine visit during her seventh month of pregnancy. The patient is doing well and her gestational diabetes is well controlled with diet.

- O24.4 Gestational diabetes mellitus
- O24.41 Gestational diabetes mellitus in pregnancy
- O24.410 Gestational diabetes mellitus in pregnancy diet controlled
- O24.414 Gestational diabetes mellitus in pregnancy insulin controlled
- O24.419 Gestational diabetes mellitus in pregnancy, unspecified control

  - Diagnosis Code: O24.410 gestational diabetes mellitus in pregnancy, diet-controlled

Burns

- Information necessary in documentation:
  - Burn or corrosion
  - Depth of burn (first, second, third degree, etc)
  - Extent burn or corrosion
  - Agent
  - Burn codes used for thermal burns except sunburns that come from heat source
    - Fire
    - Hot appliance
  - Corrosions burns due to chemicals
  - 7th character required
    - A Initial encounter
    - D Subsequent encounter
    - S Sequela

Example

- A patient who has Type 1 diabetes mellitus is treated for a second-degree burn on her left knee which radiated down to her ankle. The patient was burned when a hot skillet fell and hit her left knee causing the burn. She was in her kitchen when the injury occurred.

How it is Coded

- Tabular List: L24.222-Second degree burn of left knee
- When reviewing the tabular list instructions, the instructions indicate a 7th character is required. The choices in category T24 are:
- The appropriate 7th character is to be added to each code from category T24.
- A Initial encounter
- D Subsequent Encounter
- S Sequela

How it is Coded

- In additional the instruction notes instruct the user to select a code to identify the source, place and intent of the burn.
- Since the patient was injured by a skillet which fell on her knee while she was cooking in the kitchen at home, the following needs to also be reported.
  - What injury occurred and;
  - Place of Occurrence

How it is Coded

- Correct diagnosis code sequence and reporting:
  - First listed diagnosis: L24.222-Second degree burn of left knee
  - Secondary diagnosis: X15.3XXA- Contact with hot saucepan or skillet
  - Tertiary diagnosis: Y92.010 - Kitchen of single-family (private) house as the place of occurrence of the external cause
  - Fourth diagnosis:E10.69 – Type1 diabetes mellitus with other specified complication

Fractures

- Documentation required:
  - Anatomic site
  - Laterality
  - Fracture type
  - Displaced or Nondisplaced
  - Open or closed
  - 7th character extension required

Fractures

- S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  - Requires 7th character A for initial encounter
  - **S42.022A**
  - **Site-Left Clavical**
  - **Laterality-left**
  - **Initial encounter**

Fractures

- Fracture codes require seventh character to identify if fracture is open or closed
- The fracture 7th character extensions are:
  - A Initial encounter for closed fracture
  - B Initial encounter for open fracture
  - D Subsequent encounter for fracture with routine healing
  - G Subsequent encounter for fracture with delayed healing
  - K Subsequent encounter for fracture with nonunion
  - P Subsequent encounter for fracture with malunion
  - S Sequelae
- S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  - Requires 7th character A for initial encounter
  - **S42.022A**

Example

- A patient underwent surgery for an open burst fracture of the first lumbar vertebra which became unstable.
  - First listed diagnosis: S32.012B-unstable burst fracture of first lumbar vertebra
    - Seventh character “B” identifies the initial encounter for the open fracture.

A Initial encounter for closed fracture
B Initial encounter for open fracture
D Subsequent encounter for fracture with routine healing
G Subsequent encounter for fracture with delayed healing
K Subsequent encounter for fracture with nonunion
S Sequela

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Injury Coding

- Injury Coding
  - Initial encounters generally require three codes
- External cause codes
  - Are used for the length of treatment
  - 7th digit extender changes with stage of healing
- Place of occurrence
  - Used only once at the initial encounter
  - No 7th digit extender
- Activity code
  - Used only once at the initial encounter
  - No 7th digit extender

Example

- **CC: Hurt left knee-TV fell on it**
- HPI: Patient hurt her knee and it is bruised and it hurts to walk. She was moving a TV in her bedroom last night and she fell into the TV with her knee causing her to collide with it. Her lower back has been hurting since then as well.
- A/P: L knee strain
  - Lumbar strain
- S86.812A—Strain, left knee, initial encounter
- S39.012A—Strain, Back, initial encounter
- W18.09xA—Fall striking other object, initial encounter(activity) Y92.013—House, single family home, bedroom (place of occurrence)

Cardiology

- A 75-year-old male, 2 days post-coronary bypass grafting patient, presents today with unstable angina and shows a fresh thrombus in the saphenous vein graft. A PTCA is performed in addition to a percutaneous intracoronary thrombectomy to remove the thrombus.

Code Comparison

ICD-9-CM	ICD-10-CM
996.72-Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft	T82.817A Embolism of cardiac prosthetic devices, implants and grafts, initial encounter T82.827A Fibrosis of cardiac prosthetic devices, implants and grafts, initial encounter T82.837A Hemorrhage of cardiac prosthetic devices, implants and grafts, initial encounter T82.847A Pain from cardiac prosthetic devices, implants and grafts, initial encounter T82.857A Stenosis of cardiac prosthetic devices, implants and grafts, initial encounter **T82.867A Thrombosis of cardiac prosthetic devices, implants and grafts, initial encounter** T82.897A Other specified complication of cardiac prosthetic devices, implants and grafts, initial encounter T82.9XXA Unspecified complication of cardiac and vascular prosthetic device, implant and graft, initial encounter

Asthma

- Documentation for Asthma includes:
  - Severity of disease (mild intermittent, moderate, persistent, etc.)
- Does acute exacerbation exist?
- Does status asthmaticus exist?

Asthma Codes

J45	Asthma
J45.2	Mild intermittent asthma
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma, with (acute) exacerbation
J45.22	Mild intermittent asthma, with status asthmaticus
J45.3	Mild persistent asthma
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma, with (acute) exacerbation
J45.32	Mild persistent asthma, with status asthmaticus
J45.4	Moderate persistent
J45.40	Moderate persistent, uncomplicated
J45.41	Moderate persistent with (acute) exacerbation
J45.42	Moderate persistent with status asthmaticus

Asthma Codes

J45	Asthma
J45.4	Moderate persistent
J45.40	Moderate persistent, uncomplicated
J45.41	Moderate persistent with (acute) exacerbation
J45.42	Moderate persistent with status asthmaticus
J45.5	Severe persistent
J45.50	Severe persistent, uncomplicated
J45.51	Severe persistent with (acute) exacerbation
J45.52	Severe persistent with status asthmaticus
J45. 9	Other and unspecified asthma
J45.90	Unspecified asthma
J45.901	Unspecified asthma with (acute) exacerbation
J45.901	Unspecified asthma with status asthmaticus
J45.99	Other asthma
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma

ICD-10-CM for Conduction Disorders

The ICD-10-CM codes for conduction disorders will vary depending on diagnosis. In order to code conduction disorders in ICD-10-CM the following is necessary:

- –Type of disorder
- –Site involved

Atrial fibrillation	I48.0	Ventricular fibrillation	I49.01
Atrial flutter	I48.1	Ventricular flutter	I49.02
Atrial premature depolarization	I49.1	Re-entry ventricular arrhythmia	I47.0
Bradycardia	R00.1	Tachycardia	R00.0

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Heart Failure

•Following are the ICD-10-CM codes from the I50 category for heart failure

•The instructional notes for I50.- that if heart failure is due to another condition, that condition is listed first.

Left ventricular failure	I50.1	Heart failure, unspecified	I50.9		
Unspecified systolic (congestive) heart failure	I50.20	Unspecified diastolic (congestive) heart failure	I50.30	Unspecified combined systolic and diastolic (congestive) heart failure	I50.40
Acute systolic (congestive) heart failure	I50.21	Acute diastolic (congestive) heart failure	I50.31	Acute combined systolic and diastolic (congestive) heart failure	I50.41
Chronic systolic (congestive) heart failure	I50.22	Chronic diastolic (congestive) heart failure	I50.32	Chronic combined systolic and diastolic (congestive) heart failure	I50.42
Acute on chronic systolic (congestive) heart failure	I50.23	Acute on chronic diastolic (congestive) heart failure	I50.33	Acute on chronic combined systolic and diastolic (congestive) heart failure	I50.43

Example: Heart failure due to hypertension (I11.0)-first listed
Followed by the type of heart failure

Hypertension

- ICD-10-CM code range for hypertension is I10 – I15. 9
- In order to code hypertension in ICD-10-CM the following is necessary:
  - Essential or Secondary
  - Causal relationship of other conditions
  - Elevated blood pressure versus hypertension

Hypertension

Essential hypertension	I10
Hypertensive heart disease with heart failure	I11.0
Hypertensive heart disease without heart failure	I11.9
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	I12.0
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease	I12.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0
Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I13.10
Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	I13.11
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	I13.2
Renovascular hypertension	I15.0
Hypertension secondary to other renal disorders	I15.1
Hypertension secondary to endocrine disorders	I15.2
Other secondary hypertension	I15.8
Secondary hypertension, unspecified	I15.9
Elevated Blood pressure reading	R30.0

Ulcers

- Information required in documentation:
  - Type of Ulcer
  - Acute or chronic
  - Hemorrhage
  - Perforation
  - Hemorrhage with perforation
  - Without hemorrhage or perforation

Example

K25.0	**Acute gastric ulcer with hemorrhage**
K25.1	Acute gastric ulcer with perforation
K25.2	Acute gastric ulcer with both hemorrhage and perforation
K25.3	Acute gastric ulcer without hemorrhage or perforation
K25.4	Chronic or unspecified gastric ulcer with hemorrhage
K25.5	Chronic or unspecified gastric ulcer with perforation
K25.6	Chronic or unspecified gastric ulcer with both hemorrhage and perforation
K25.7	Chronic gastric ulcer without hemorrhage or perforation
K25.9	Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation

Hernia

- Diagnosis codes range from K40.00-K46.9
  - Documentation required
    - Site of hernia
    - Laterality when appropriate (Unilateral-bilateral)
    - If gangrene or obstruction is present
    - If condition is recurrent
  - Categories:
    - Inguinal (K40.0-)
    - Femoral (K41.0-)
    - Umbilical (K42.0-)
    - Ventral (K43.0-)
    - Diaphramatic (K 44.0-)
    - Other abdominal hernia (K45.0-)
    - Unspecified abdominal hernia (K46.0-)

Hernia Repairs

K40.00	**Bilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent**
K40.01	Bilateral inguinal hernia, with obstruction, without gangrene, recurrent
K40.10	Bilateral inguinal hernia, with gangrene, not specified as recurrent
K40.11	Bilateral inguinal hernia, with gangrene, recurrent
K40.20	Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
K40.21	Bilateral inguinal hernia, without obstruction or gangrene, recurrent
K40.30	Unilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent
K40.31	Unilateral inguinal hernia, with obstruction, without gangrene, recurrent
K40.40	Unilateral inguinal hernia, with gangrene, not specified as recurrent
K40.41	Unilateral inguinal hernia, with gangrene, recurrent
K40.90	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
K40.91	Unilateral inguinal hernia, without obstruction or gangrene, recurrent

Malignant Neoplasm Breast

- 54 choices for male/female breast
- Documentation must include:
  - Laterality
  - Location
  - Use of an additional code to identify estrogen receptor status
  - Example: C50.422 Malignant neoplasm of upper-outer quadrant of the left male breast

Malignant Neoplasm Breast

- Sixth character sub-classification
  - C50.- Malignant neoplasm of breast
  - C50.1- Malignant neoplasm of nipple and areola
  - C50.2- Malignant neoplasm of upper-inner quadrant of breast
  - C50.3- Malignant neoplasm of lower-inner quadrant of breast
  - C50.4- Malignant neoplasm of upper-outer quadrant of breast
  - C50.5- Malignant neoplasm of lower-outer quadrant of breast
  - C50.6- Malignant neoplasm of axillary tail of breast
  - C50.8- Malignant neoplasm of overlapping sites of breast
  - C50.9- Malignant neoplasm of breast of unspecified site

Mapping Examples

INTERPRETIVE FINDINGS: Exam reveals a stable knee under examination under anesthesia. The video arthroscopy examination reveals smooth articular surfaces throughout the entire knee. He has a lateral meniscus which is normal. His medial meniscus shows a locked bucket-handle medial meniscal tear which underwent excision. The cruciate ligament is intact.

Mapping Example

Enter Code: 836.0 Lookup

ICD-9 836.0 > ICD-10

CODE	DESCRIPTOR
S83.211A	Bucket-handle tear of medial meniscus, current injury, right knee, initial encounter
S83.212A	Bucket-handle tear of medial meniscus, current injury, left knee, initial encounter
S83.219A	Bucket-handle tear of medial meniscus, current injury, unspecified knee, initial encounter
S83.221A	Peripheral tear of medial meniscus, current injury, right knee, initial encounter
S83.222A	Peripheral tear of medial meniscus, current injury, left knee, initial encounter
S83.229A	Peripheral tear of medial meniscus, current injury, unspecified knee, initial encounter
S83.231A	Complex tear of medial meniscus, current injury, right knee, initial encounter
S83.232A	Complex tear of medial meniscus, current injury, left knee, initial encounter
S83.239A	Complex tear of medial meniscus, current injury, unspecified knee, initial encounter
S83.241A	Other tear of medial meniscus, current injury, right knee, initial encounter
S83.242A	Other tear of medial meniscus, current injury, left knee, initial encounter
S83.249A	Other tear of medial meniscus, current injury, unspecified knee, initial encounter

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Documentation: Compliance and Quality

- In the clinical area, the largest impact to ICD-10-CM implementation is the documentation
  - Since ICD-10-CM is more robust and has up to seven digits of specificity, will documentation currently be in the medical record to support ICD-10-CM on the “Go-live” date?
  - By analyzing the documentation and conducting medical record documentation audits, the impact can be assessed

How to Approach?

- How is ICD-9 currently used in the clinical setting?
  - Random samples should be evaluated
  - Take an in-depth look at the current level of documentation
  - Running a frequency report of the most used procedures and diagnosis codes before you begin

How Do You Begin?

- Take an in-depth look at the current level of documentation in the medical record
  - Review the lack of specificity in the documentation and analyze how to begin the process of improvement
  - Based on the specialty of the practice, review the most common diagnosis codes used and frequency

Perform an ICD-10-CM Readiness Audit

- Practitioners either have staff that conduct audits in your medical practice or routinely have a consultant audit for appropriate documentation and coding
  - Important element of compliance and many practitioners have undergone this process from a comprehensive coding perspective
    - But take a different approach
      - Review the patient chart note to make sure the physician or non-physician practitioner is documenting a complete diagnosis to support an ICD-10-CM code

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Performing an ICD-10-CM Readiness Audit

- ICD-10-CM readiness audit
  - different than the typical medical record documentation and coding audit
  - Auditor will assess the documentation and make a determination if:
    1. does the documentation support the current diagnosis reported, and
    2. will the documentation support an ICD-10-CM code(s)?
  - The auditor must be familiar with ICD-10-CM codes and guidelines in order to make this determination

Performing an ICD-10-CM Readiness Audit

- Once the audit has been conducted and analyzed:
  - the organization will have a good assessment of documentation deficiencies
    - will be able to develop a priority list of diagnoses that require more granularity
  - Audit will also help identify practitioners who would benefit from focused training to assist in making sure the practitioner will be able to support medical necessity using ICD-10-CM in 2013

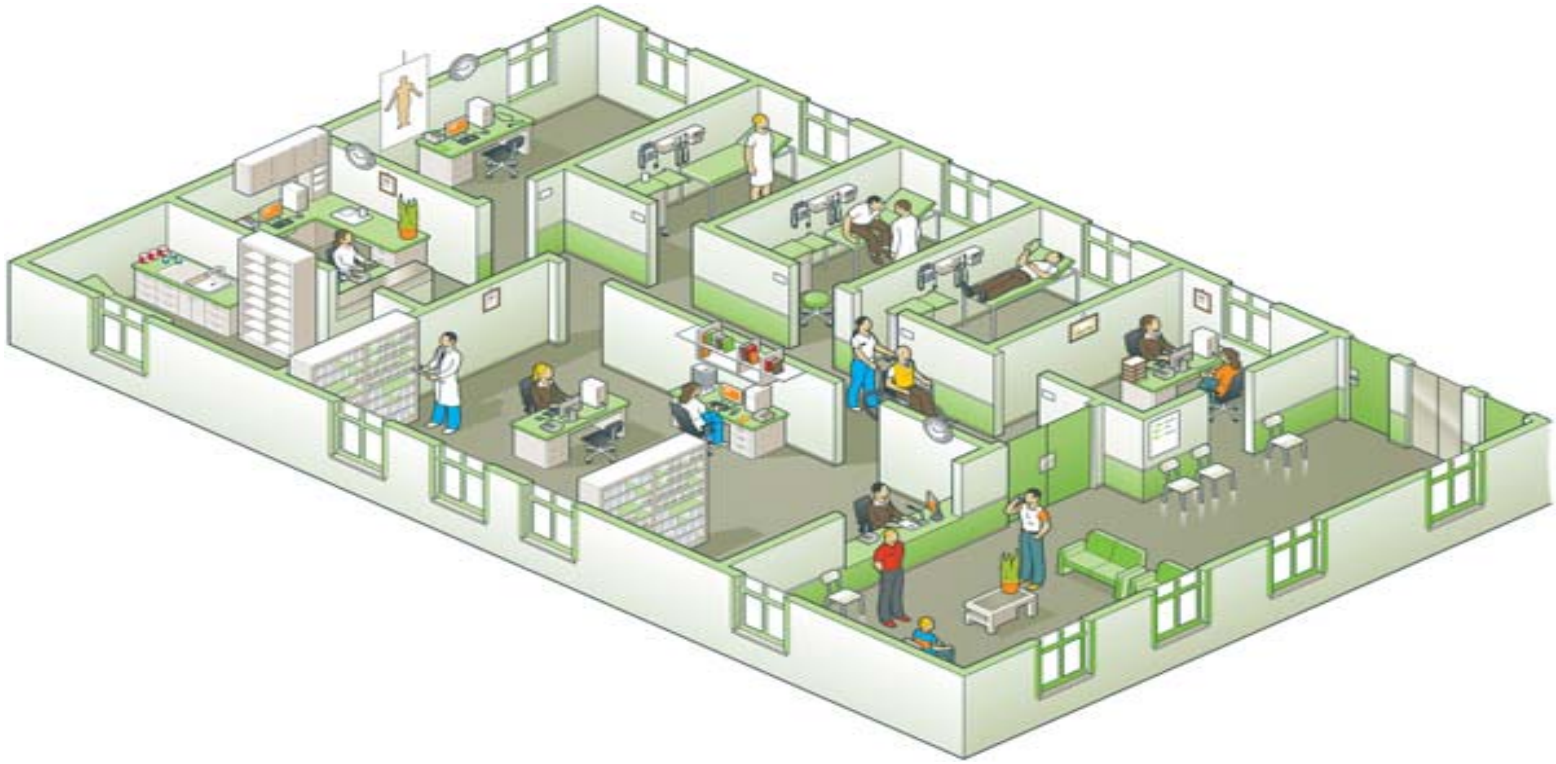
How Do You Solve the Documentation Problem?

- Educate by showing the comparison between both coding systems
- Encourage the practitioner to begin documenting more specifically for ICD-10-CM
- Keep results and comprise a periodic summary
  - This summary should identify the percentage of correct documentation for both ICD-9-CM and ICD-10-CM with recommendation for improving documentation.

Conclusion

- It is evident after reviewing documentation that a lot of work must be completed to get ready for ICD-10-CM
- Audit the diagnosis and inpatient procedure documentation pre and post ICD-10-CM implementation

ICD-10 Will Change Everything



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Questions?

THE COUNTDOWN IS NOW!!!

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