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Eli's Rehab Report

Practice Pointers: Put Your Documentation Under the Microscope for ICD-10 Prep

Get a fresh perspective of the documentation demands that come with ICD-10.

ICD-10 implementation is on halt until at least Oct. 1, 2015, but that's no reason to stop your preparations. Take advantage of this unexpected grace period.

One major concern of ICD-10 experts is that many clinicians just want to use crosswalks or General Equivalence Mappings (GEMs) to generate an ICD-10 code. "Many ICD-9 codes translate to non-specified ICD-10 codes through the GEMs," says Gillian Leene, senior regulatory affairs specialist for the **American Physical Therapy Association.** "This defeats one of the main objectives of the ICD-10 transition, which is to capture greater specificity about the patient's condition through the claim form."

Dead end: "The consistent use of non-specified ICD-10 codes could lead to red flags and potential audits," Leene warns. Clear, detailed documentation and using codes that specifically describe the reason that the provider is treating the patient is essential.

Unfortunately, "the biggest challenge is assisting physicians and other providers improve their clinical documentation to meet the specificity of ICD-10," says **Betty A. Hovey, CPC, CPC-H, CPB, CPMA, CPC-I, CPCD, ICD-10 Development and Training Director for the American Academy of Professional Coders.**

3 Keys Areas in Your Documentation That'll Need a Boost

One ICD-9 code can easily translate to an entire section of ICD-10, so you'll need a solid leg to stand on when you submit your codes and claims for payment. If you inject super-specificity into your documentation now, you can expect fewer denials later.

"The key to treatment notes and other documentation under ICD-10 is ensuring that the specificity of the patient condition described in the ICD-10 code matches the specificity in the documentation," Leene says.

"Many of the new changes can be summed up into three categories," observes **Jeremy Furniss, MS, OTR/L**, coding & payment specialist for the **American Occupational Therapy Association.**

1. Laterality. Most therapists already note the affected side (laterality) in their documentation, but now it'll be a must because the codes are so specific. Furniss offers the example of a patient who is right-handed with flaccid hemiplegia impacting the right side.

In ICD-9, the therapist could code the above condition as 342.01 (Flaccid hemiplegia and hemiparesis affecting the dominant side). The ICD-10 code, however, looks at dominant and non-dominant as well as laterality, Furniss notes. "So the ICD-10 code would be G81.01 – Flaccid hemiplegia affecting right dominant side."

So, now more than ever, you need to specify if the hemiplegia affects the right or left side and if this was the dominant or non-dominant side. Plus, "you will find laterality like this in many other ICD-10 codes equivalent to the diagnoses you currently use," Furniss says.

Be alert: Some ICD-10 codes will dive even deeper into specificity. For example, in ICD-9 you have only eight choices for coding a fractured finger, while in ICD-10 you have about 64 choices. This is because ICD-10 allows you to specify a more exact location of the fracture. A good example is code S62.621 –Displaced fracture of medial phalanx of the left index

finger.

Sound overwhelming? Take a deep breath. "The two remaining changes that may impact documentation relate only to patients being treated for an injury," Furniss says. And they're easy to find because they are all in chapter 19 of ICD-10 and start with an S or T.

2. Episode of treatment for an injury. If you're working with patients being treated after an injury, note that ICD-10 requires a seventh digit for injury cases which means the code is reporting more detailed information.

"The seventh digit is an alpha character describing the treatment episode," Furniss explains. "This alpha character describes if the client is being seen for an initial, subsequent, or complication related treatment episode for the injury."

You should already be documenting if the patient has received prior treatment for the condition or injury, Furniss notes, but "it will be important to explicitly state if the treatment is in an initial episode, a subsequent episode, or if the treatment is related to a complication during the healing of an injury."

Eye opener: To put it in perspective, if you thought S62.621 sounded complex, remember that even these fracture codes have options for a 7th digit (which describe how the fracture is healing). All of this needs to be in your documentation, and remember: "all of this information should be provided by or obtained from the referring physician," Furniss says.

3. Cause of the injury. Get familiar with the workings of the "S" codes in chapter 19. They all require a secondary ICD-10 code from chapter 20 defining the cause of the injury and that cause had better be in your documentation.

Good news: "Occupational therapists typically get to the heart of the cause of an injury when treating someone as they assess the occupational profile," Furniss observes.

However, even if your injury documentation is already up to snuff, "it would be wise to make sure that these items are clearly labeled in the documentation," Furniss says. After all, chapter 20 of the ICD-10 includes a "wild variety" of injury causes.

Test Your Specificity Readiness With an Audit

Good idea: "APTA recommends that physical therapists audit their current documentation to ensure that they are capturing the specificity required in ICD-10 coding," Leene says.

Hovey recommends doing an ICD-10 readiness assessment via your billing/EMR software:

- Have your office staff run a report by diagnosis for each provider (which will be your working list for education).
- Take the number one code for the provider.
- Run another report looking for patients with that diagnosis in the past 1-2 months.
- From that report, pull 10-15 patients.

"From the documentation present, can you assign an ICD-10-CM code?" Hovey asks. "If so, are they codes that are comprehensive, or are they unspecified codes?"

Next, "create a report by patient that shows what, if any, ICD-10-CM code could be assigned and what deficiencies, if any, were present that made the record unable to support a more specific code," Hovey says. "If there were no deficiencies, point that out also."

Suggestion: Establish a QA percentage that your therapists are expected to meet from a compliance standpoint, Hovey says. "If they do not meet QA, then the same condition would be assessed at their next session. The same condition would continue to be assessed with education provided until QA is met for that condition. Once met, the next diagnosis on the list would be assessed, and the process is repeated."

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