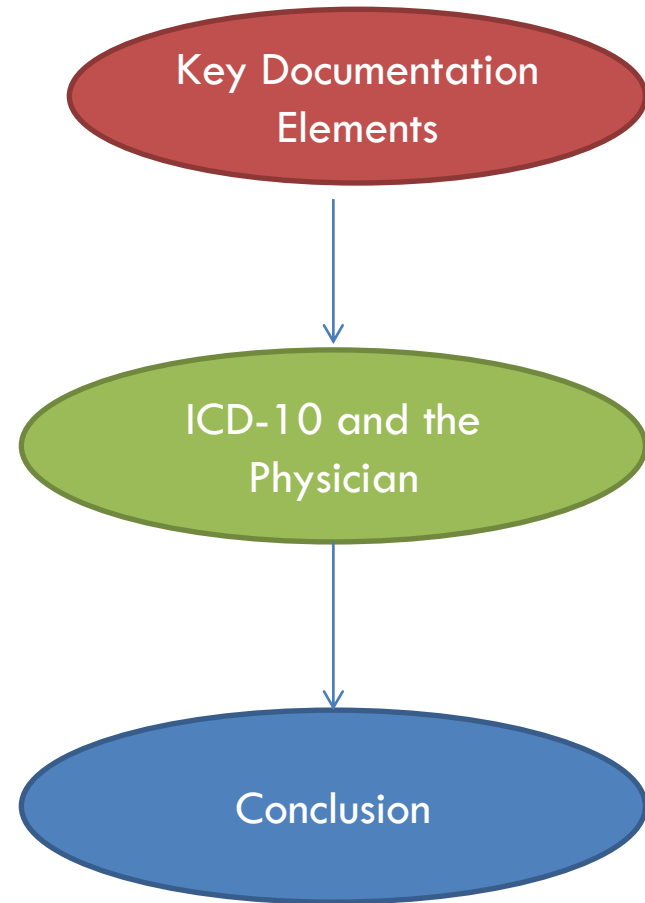
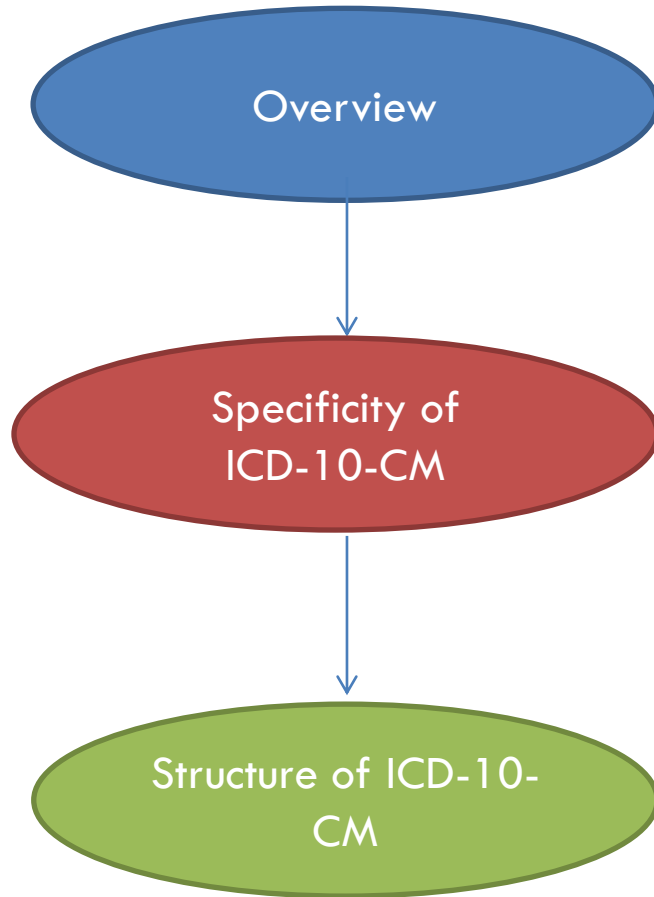


ICD-10 and Primary Care

Community Providers



Training Topics



Overview

- What is ICD-10?
- Why is ICD-9 changing?
- Areas of Improvements

Overview

What is ICD-10- CM?

- The World Health Organization's (WHO) International Classification of Diseases has served the healthcare community for over a century. **The United States implemented the current version (ICD-9) in 1979.** While most industrialized countries moved to ICD-10 a number of years ago, the United States is just now transitioning with a final **compliance date of October 1, 2015.**

Sticky Note:

ICD-10-CM means that each **diagnosis** that a human being may have is given a **code number** designation that describes that **disease, condition, or illness.** ICD-10-CM codes do not describe the **services** performed, just the medical condition.

- The WHO's ICD-10 is a classification system for diagnosis codes only, which does not contain a procedural code set.
- **ICD-10-CM (International Classification of Diseases -10th Revision-Clinical Modification)** is a US clinical modification of the WHO's ICD-10, developed to support US health information needs.
- ICD-10-CM is designed for classifying and reporting diseases in **all US healthcare settings.**



Overview

Why is
ICD-9
Changing?

ICD-9 is **more than 30 years old**

It **cannot be expanded** for new diseases

Payers cannot pay claims fairly using ICD-9, since the classification **does not accurately reflect current technology**

The healthcare industry **cannot accurately measure the quality of care** using ICD-9

Overview

- There are more total code sets in ICD-10-CM, however:
 - 50% are related to the musculoskeletal system
 - 25% are related to fractures
 - 36% distinguish ‘right’ vs. ‘left’

Clinical areas most effected	ICD-9-CM code	ICD-10-CM code
Fractures	747	17099
Poisoning and toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain injury	292	574
Diabetes	69	239
Mood related disorders	78	71



Overview

Greater specificity means improvements in:

Quality Measurement

Greater detail to accommodate new diagnoses, technologies and procedures

Public Health

More effective at capturing health diseases and reporting disease spread

Research

Improvement in classifying nature of injuries

Reimbursement

Better justification of medical necessity, fewer gray areas in coding



Overview

ICD-10 Claims Submission

Sticky Note:

ICD-10-CM claims submission is based on the setting and date of service for which services are provided.

Claims cannot be submitted with ICD-10 codes prior to 10/1/2015.

The table below details which code set (I9 vs. I10) should be submitted on a claim based on the type of setting.

Setting	Date used	ICD-10 Code Set	Claims Processing
Ambulatory	Date of Service (DOS)	ICD-10-CM (diagnosis codes)	DOS prior to 10/1/2015 use ICD-9-CM DOS on or after 10/1/2015 use ICD-10-CM
Physician Services	Date of Service (DOS)	ICD-10-CM (diagnosis codes)	DOS prior to 10/1/2015 use ICD-9-CM DOS on or after 10/1/2015 use ICD-10-CM
Hospital Inpatient	Date of Discharge (DOD)	ICD-10-CM (diagnosis codes)	DOD (through date) prior to 10/1/2015 use ICD-9-CM
		ICD-10-PCS (procedure codes)	DOD (through date) on or after 10/1/2015 use ICD-10 CM/PCS

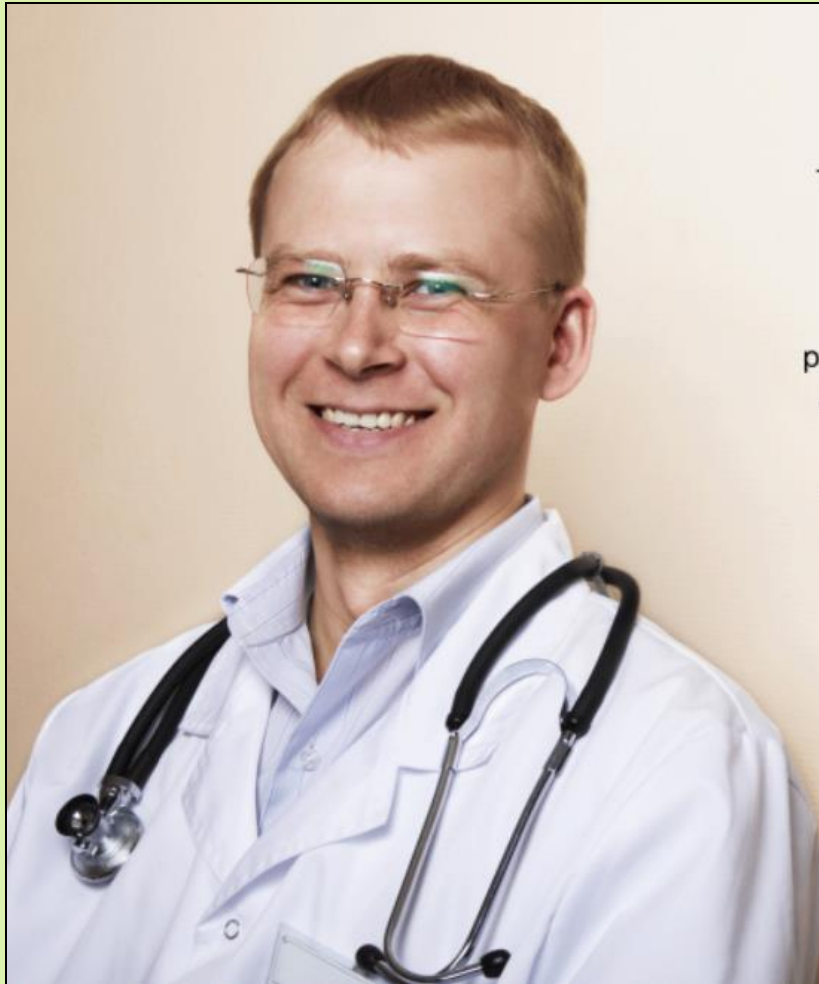
ICD-10-PCS replaces ICD-9-CM Volume 3 to report *hospital inpatient resource utilization*. Does not affect physician CPT reported services



Specificity of ICD-10-CM

- Documentation Impacts

Specificity of ICD-10-CM



Though the healthcare delivery system in America is an ever-evolving enterprise, physicians remain at the center of the system.

It is the physicians who determine the diagnoses, perform the procedures, order the tests, and prescribe the treatments that drive the core of patient care. In 2011, the Centers for Medicare and Medicaid Services (CMS) reported physician and clinical services spending reached \$529.2 billion. This shows health care spending is driven by physician decisions.

It is the physician documentation that undergoes a translation from words into a series of codes. These codes provide the basis for billing, medical necessity decisions, and physician profiling. This is not a new process; however, the words that are now translated to ICD-9 codes will soon be translated to ICD-10 codes.



Specificity of ICD-10

Documentation Impacts

1. Laterality

Laterality has been added to ICD-10-CM codes at the request of many parties in the medical community. However, not all ICD-10-CM codes have laterality added. **The majority of laterality additions are found in diagnoses that are related to neoplasms and injuries.**

In this documentation example, compare ICD-9 and ICD-10 to see why greater specificity of laterality is an improvement.

ICD-9

- Enthesopathy of wrist and hand.

ICD-10

- Other bursitis, not elsewhere classified, right hand.
- Other bursitis, not elsewhere classified, left hand.
- Other bursitis, not elsewhere classified, unspecified hand.



Specificity of ICD-10

Documentation Impacts

2. Disease Pathophysiology

Disease pathophysiology is far more granular in the ICD-10 disease descriptions. In order for the most accurate level of severity to be chosen, documentation must reflect the highest level of known pathophysiology for diseases.

Here is a comparison example of the pathophysiology granularity seen in ICD-9 and ICD-10:

ICD-9

- Other specified transient cerebral ischemias.

ICD-10

- Carotid artery syndrome hemispheric.
- Multiple and bilateral pre-cerebral artery syndrome.
- Other transient cerebral ischemic attacks and related syndromes.
- Middle cerebral artery syndrome.
- Anterior cerebral artery syndrome.
- Posterior cerebral artery syndrome.



Specificity of ICD-10

Documentation Impacts

3. Combination Codes

Combination codes have been created to classify two diagnoses that routinely occur together—for instance, a diagnosis and its most common manifestation or complication.

Here is an example of how complications and site of the disease can be combined in ICD-10:

ICD-9

- Regional enteritis of large intestine.

ICD-10

- Crohn's disease large intestine, w/o complications.
- Crohn's disease large intestine, with rectal bleeding.
- Crohn's disease large intestine, with intestinal obstruction.
- Crohn's disease.
- Crohn's disease large intestine, with fistula.
- Crohn's disease large intestine, with abscess.
- Crohn's disease large intestine, with other complication.
- Crohn's disease large intestine, with unspecified complication.



Specificity of ICD-10

Documentation Impacts

4. Clinical Guidance Scales

ICD-10 incorporates the specificity of many common clinical guidance scales and classifications, such as the **Glasgow Coma Scale, Gustilo-Anderson Classification of Open Fractures, Salter-Harris Fracture Scale, and the Scale for Visual Acuity.**

Salter-Harris Fracture Scale

Transverse fracture through the growth plate.
Straight across.

Fracture through the growth plate and metaphysis.
Above.

Fracture through the growth plate and epiphysis.
Lower.

Fracture through all three elements of the bone (i.e., metaphysis, growth plate, & epiphysis).
Through.

Compression fracture of the growth plate.
Rammed.



Specificity of ICD-10

Documentation Impacts

5. Timing of the Encounter

There are 47 codes in ICD-10 to this one code in ICD-9.

ICD-10-CM requires documentation of the type of treatment that is rendered for specific conditions such as injuries, signs and symptoms, and external causes of morbidity. Documentation must include what stage of care the patient is receiving, such as an **initial or subsequent encounter** or if the focus of treatment concerns the **sequela of a previous injury**.

ICD-9

Sprains and strains of wrist and hand.

ICD-10

Strain of the long flexor muscle, fascia and tendon of the right thumb at wrist and hand level, initial encounter.

Strain of the long flexor muscle, fascia and tendon of the right thumb at wrist and hand level, subsequent encounter.

Strain of the long flexor muscle, fascia and tendon of the right thumb at wrist and hand level, sequela.



Specificity of ICD-10

6.

Acuity

It is critical to include **acuity** in our documentation to identify the severity of a patient's condition.

As an example, "**acute**" and "**chronic**" are key terms that add specificity to the medical record.

Remember that chronic disease management impacts each patient encounter in terms of management and use of goods and services.

example:

Acute vs. Chronic Bronchitis

It is important to identify the acuity of bronchitis to support diagnostics provided and treatment rendered.



Specificity of ICD-10

Documentation Impacts

7. Increased Disease Granularity

ICD-10-CM has expanded many code descriptions to connect complications and manifestations with conditions. Sometimes we do not always make these connections when documenting in the medical record. If we do not start, provider queries will increase dramatically with ICD-10. Some examples are listed below:

Acute bronchitis due to respiratory syncytial virus.

Acute peptic ulcer with both hemorrhage and perforation.

Chronic ulcerative rectosigmoiditis with fistula.

Idiopathic focal epilepsy with localized and intractable seizures and status epilepticus.

Drug induced folate deficiency anemia.



Specificity of ICD-10

8. X Placeholders

In ICD-10-CM, the most common length of a code will be four characters; however, the system is built to support seven. The additional characters were created to allow growth with medical advances and to identify specific details of a patient encounter, such as greater disease specificity, injuries, or care history.

When the seventh character is used, but the fifth and/or sixth are not needed, an X placeholder value is used to allow billing and reporting software to work.

FOR EXAMPLE:

S03.0xxD equates to dislocation of the jaw with subsequent encounter. Because we need to report this as the subsequent visit for this encounter, and due to the brevity of the code, the XXs fill the gaps for electronic reporting.

T43.1x1A equates to accidental poisoning by monoamine-oxidase-inhibitor antidepressants in an initial encounter. The X is used as a placeholder.



Documenting in ICD-10-CM

Note that the characters have been color-coded to show the documentation specificity required:

CONDITION	ICD-9-CM	ICD-10-CM
<p>Initial evaluation of complications involving a femoral popliteal artery graft.</p>	<p>996.74 Other complications due to other vascular device, implant, or graft.</p>	<p>T82.818A Embolism Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.828A Fibrosis Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.838A Hemorrhage Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.848A Pain Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.858A Stenosis Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.868A Thrombosis Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p> <p>T82.898A Other Specified Complication Vascular Prosthetic Devices, Implants & Grafts – Initial Encounter.</p>



Structure of ICD-10-CM

- ICD-9 vs. ICD-10
- Code structure
- New Features

Structure of ICD-10-CM

ICD-9 vs. ICD-10

ICD-9-CM vol. 1 & 2 (Diagnosis Codes)	ICD-10-CM (Diagnosis Codes)
3-5 characters in length	3-7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric	First digit is alpha; Digits 2-3 are numeric; Digits 4-7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality
Example: 453.41 Venous embolism and thrombosis of deep vessels of proximal lower extremity	Example: I82.411 Embolism and thrombosis of right femoral vein

Structure of ICD-10-CM

Sticky Note:

- The ICD-10-CM Code Book has **21 chapters**.
- Each chapter represents a designated **block of codes**, i.e. Neoplasms C00-D49

3-7 Alphanumeric characters

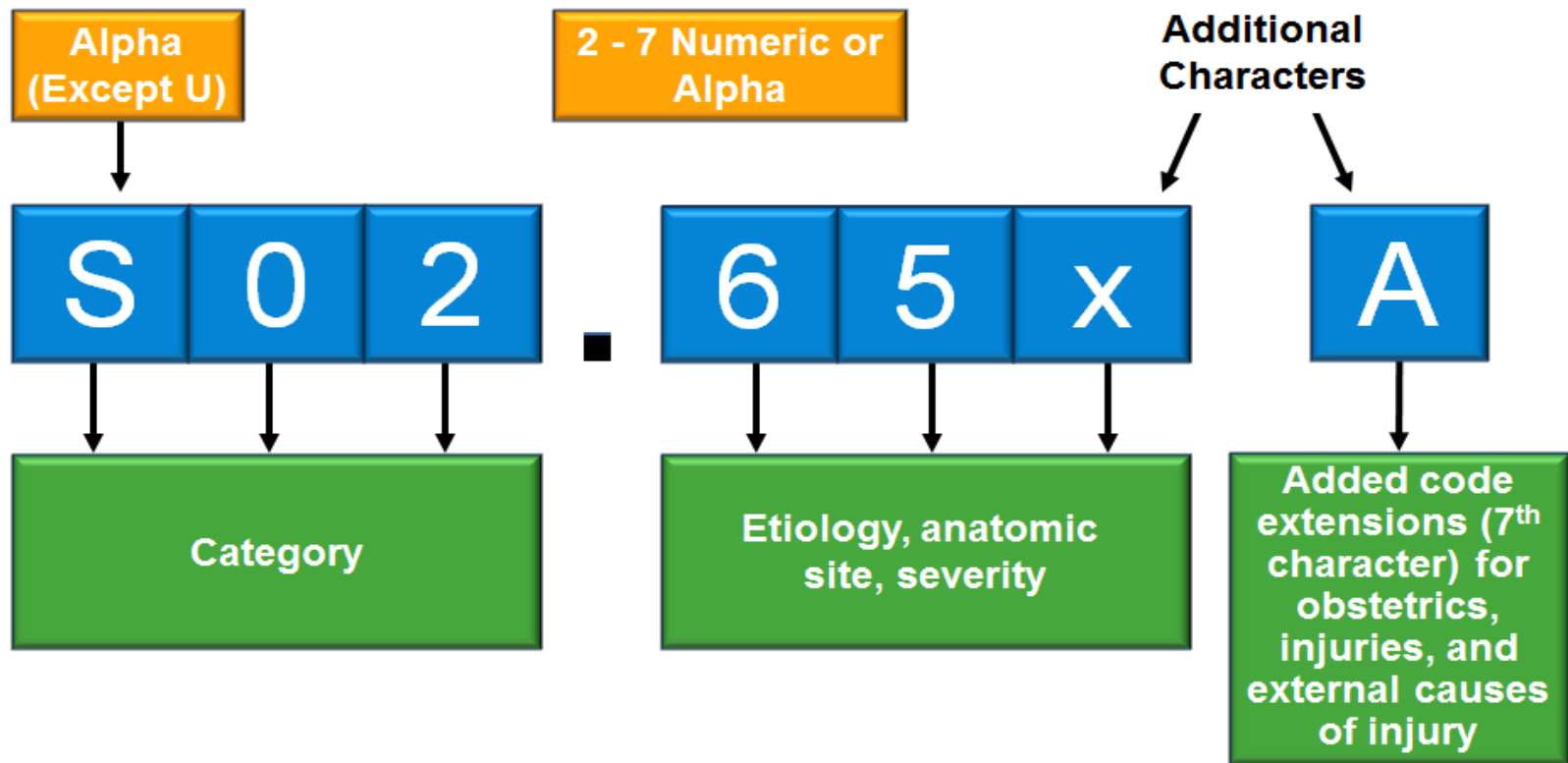


- All letters used except U
- The letters I & O are used *only* in the 1st character position
- Each letter is associated with a particular chapter (except D & H)



Structure of ICD-10-CM

ICD-10 characters and extension



Key Documentation Impacts

- 7 Key Documentation Principles
- Inadequate & Improved Documentation Examples

7 Key Documentation Elements

7 Key Documentation Impacts in ICD-10

1. **Disease or disorder site (location and laterality)**
2. **Acuity and/or encounter status of treatment**
3. **Etiology, causative agent or disease type**
4. **Underlying and associated conditions**
5. **Manifestations**
6. **Complications or adverse events**
7. **Supporting info such as lab or socioeconomic indicators**

Remember: Not all conditions require all seven documentation principles, but these are simply the ones that appear most often in the ICD-10 code set.



7 Key Documentation Elements

1.

Disease Site

Site documentation assists in ensuring accurate code assignment and helps prevent surgical errors.

As an example, documentation of the location of spina bifida assists in proper code assignment.

example: | **Spina Bifida**

In the case of spina bifida, the site (e.g., cervical, thoracic, lumbar) is critical for optimal code assignment, claims adjudication, and avoiding queries.



7 Key Documentation Elements

2.

Acuity

It is critical to include **acuity** in our documentation to identify the severity of a child's condition.

As an example, "**acute**" and "**chronic**" are key terms that add specificity to the medical record.

Remember that chronic disease management impacts each pediatric encounter in terms of management and use of goods and services.

example: | **Sinusitis**

It is important to identify the acuity of sinusitis to support diagnostics provided and treatment rendered.



7 Key Documentation Elements

3.

Disease Type

It is important to distinguish disease **type** within our documentation as this influences treatment selection and outcome monitoring.

Unspecified disease descriptions, such as severe combined immunodeficiency, do not provide enough information about the necessary labor and treatment required to care for this condition.

example:

Severe Combined Immunodeficiency

Severe combined immunodeficiency is classified by several different types (e.g., with reticular dysgenesis, with lower T-and B-cell numbers). Each type adds a different level of intensity to the plan of care.



7 Key Documentation Elements

3.
Cont.

Etiology

Documentation of condition **etiology** ensures coding of severity and tracking of treatment outcomes.

The causative disease, contributory drug, chemical, or non-medicinal substance needs to be documented as these significantly impact treatment.

example: | **Dyskinesia**

Dyskinesia requires identification of the etiology, such as due to stroke or brain injury, drug-induced, or inherited, to achieve granularity in disease identification.



7 Key Documentation Elements

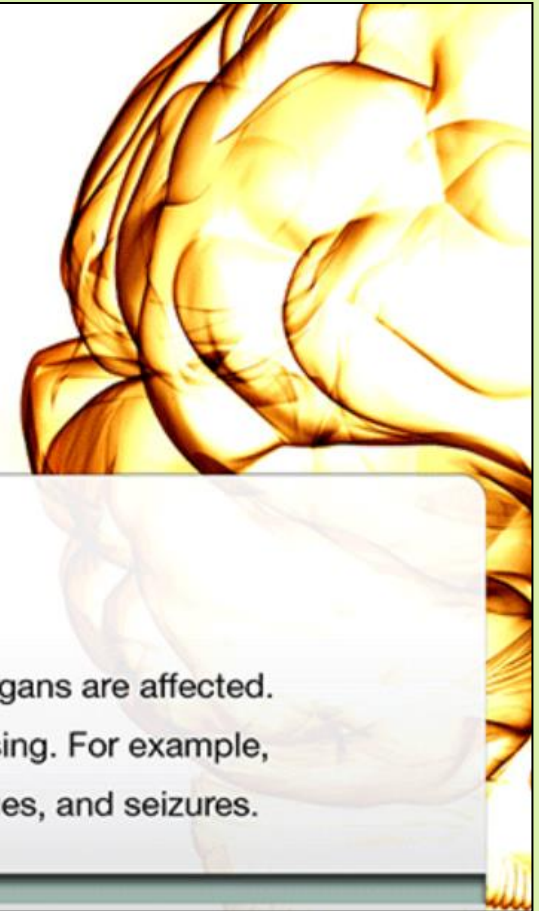
4.

Underlying or associated conditions

Documentation of any **underlying or associated conditions** renders a complete and accurate picture of the child's medical condition. With this documentation, disease progression is easily measured, and treatment adjustments are validated.

example: | **Phenylketonuria (PKU)**

As phenylketonuria (PKU) progresses, different body systems and organs are affected. Documentation should provide detail on how the disease is progressing. For example, PKU is often accompanied by intellectual disabilities, behavioral issues, and seizures.



7 Key Documentation Elements

5.

Manifestations

Documentation of the common **manifestations** for many diseases supports greater specificity in code assignment and a better description of care provided.

example: | **Influenza**

In addition to the etiology of influenza, include any manifestations, such as laryngitis, otitis media, and pneumonia as well as gastrointestinal disorders and neurological complications (e.g., meningitis, postinfectious encephalitis).



7 Key Documentation Elements

6.

Complications or adverse effects

Drug toxicity, considered either a poisoning or an adverse effect, is a major healthcare issue. Documentation should include the child's **intention** when consuming a drug.

The child's drug consumption must be documented as poisoning accidental, intentional self-harm, or assault, an adverse effect, or as underdosing.

Drug administration by the provider is assumed **"therapeutic"** in nature.



example: **Anaphylaxis**

There are many drugs that have a negative effect on the immune system. Anaphylaxis, for example, can be caused by various antibiotics, anti-seizure medications, or pain medications.



7 Key Documentation Elements

7. Supporting Lab or Socioeconomic Indicators

We must document the clinical significance of **supporting lab values**, and any corresponding diagnosis, in order to capture the patient's condition and to substantiate treatment protocols.

This will ensure the diagnostic work performed is recognized, coded, and reimbursed.

example: **Elevated CA-125**

Ensure the clinical significance of any abnormal findings in specimens and organs from the various body systems, such as abnormal levels of hormones, enzymes, biological substances, and immunological, microbiological, and cytological sections, are listed in the medical record.



Epilepsy

Inadequate & Improved Documentation

Here is an example of inadequate and improved documentation for **epilepsy**.



INADEQUATE DOCUMENTATION

IMPRESSION:

1. Epilepsy.



IMPROVED DOCUMENTATION

IMPRESSION:

1. **Well controlled, juvenile, myoclonic epilepsy. Last seizure one month ago, has never been in status epilepticus.**

I

C

D



The following documentation improvements are needed:
type, control status, and status epilepticus presence.



Asthma

Inadequate and Improved Documentation

Here is an example of inadequate and improved documentation for **asthma**.



INADEQUATE DOCUMENTATION

Seven-year-old female with asthma presents in resp distress. Tachycardic & tachypneic, inspiratory and expiratory wheezing. O2 sat 63% on room air.

Mother reports home inhaler and nebulizers used but didn't help.



OPTIMAL DOCUMENTATION

Seven-year-old female with **moderate, persistent** asthma presents in resp distress, **exam consistent with status asthmaticus**. Tachycardic & tachypneic, inspiratory and expiratory wheezing. O2 sat 63% on room air.

Mother reports home inhaler and nebulizers used but didn't help. **Dad smokes near child**.



The following documentation improvements are needed:
type, acuity, exacerbation status, and tobacco status.



Influenza

Inadequate & Improved Documentation



INADEQUATE DOCUMENTATION

Assessment:

1. Influenza.
2. Speech disturbance.
3. Sinusitis.
4. Otitis media with perforated tympanic membrane.



REQUIRED ICD-10 DOCUMENTATION

Assessment:

1. **Influenza A.**
2. **Laryngitis.**
3. **Acute maxillary** sinusitis.
4. **Left** otitis media with **left central** perforated tympanic membrane.



The following documentation improvements are needed for ICD-10: type, site, acuity, manifestations and laterality.



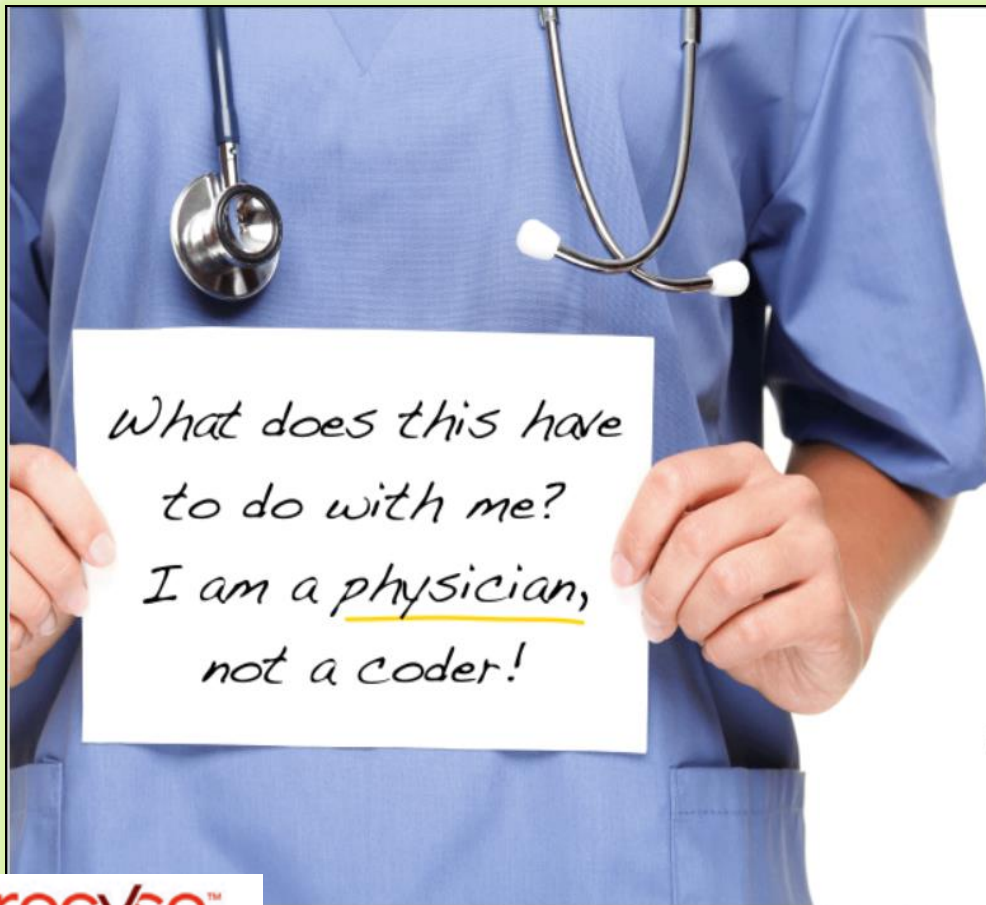
ICD-10 and the Physician

- A Physician's Role in ICD-10
- Changes impacting Primary Care
- Most Common Pediatric Codes
- ICD-10 Physician Benefits



ICD-10 and the Physician

A Physician's Role in ICD-10-CM



As a physician, we are the center of health care delivery. The physician is the driver of patient care, but that's not all.

Physicians, in many cases, are also deeply involved in running a business, driving appropriate reimbursement for care provided, keeping abreast of new technology, and the ever-changing regulatory environment as well as ensuring standards of medical necessity, severity of illness, and quality of care are met. We have a lot to do!

ICD-10 affects all of these areas and requires further work. However, when embraced, we can benefit greatly compared to the inadequacies of ICD-9 today.



ICD-10 and the Physician

Changes for Primary Care

1. Headaches

- ICD-10 includes a whole slew of codes for headaches. For example when a patient presents with a migraine, providers will have to specify whether it's common, hemiplegic, persistent, chronic, ophthalmologic, abdominal, or menstrual. Many of the codes in the headache section also require additional documentation that was not previously required.

2. Depression

- Today, one in 10 people report symptoms of depression to their doctor. As a result, depression codes have been expanded in ICD-10, and providers will have to document in detail additional features such as single episode versus recurrent, mild, moderate, or severe, and in partial or full remission.

3. Ear Infection

- For pediatric and family-medicine providers, earaches are often a daily occurrence. ICD-10 includes various codes to denote specific forms of a middle-ear infection. Physicians must document acute vs. chronic, laterality, and associated perforated tympanic membrane.

ICD-10 and the Physician

Changes for Primary Care

4. Diabetes

- Physicians must now document whether the diabetes is Type 1, Type 2, drug-or-chemical-induced, or due to an underlying condition. They will also have to document the specific underlying, the specific drug or toxin, as well as the use of insulin. ICD-10 gets into the “nitty-gritty” about diabetes, so a careful review of diabetes codes is recommended.

5. Asthma

- Asthma is yet another diagnosis that has been increasing over the years and has been expanded in ICD-10. Physicians must document whether the asthma is mild intermittent, mild persistent, moderate persistent or severe persistent. In addition, they must specify whether the asthma is uncomplicated, with acute exacerbation, or with status asthmaticus.

6. Health Status & Services

- Primary-care providers may want to take note of some new codes related to factors that influence health status and contact with health services. These are not going to show up in a code mapping process but are relevant. For example, codes Z55 through Z65 pertain to health hazard related to socioeconomic and psychosocial circumstances.



Most Common Pediatric Diagnosis Codes (From AAP Coding Newsletter)

1. Encounter routine child health examination

with abnormal findings Z00.121
abnormal finding _____
without abnormal findings Z00.129

2. Acute upper respiratory infection

J06.9

3. Otitis media

nonsuppurative
serous

acute (secretory)

right H65.01

left H65.02

bilateral H65.03

recurrent acute

right H65.04

left H65.05

bilateral H65.06

chronic

right H65.21

left H65.22

bilateral H65.23

allergic

acute and subacute

right H65.111

left H65.112

bilateral H65.113

recurrent acute

right H65.114

left H65.115

bilateral H65.116

chronic

right H65.411

left H65.412

bilateral H65.413

suppurative

acute

w/o spontaneous rupture of

eardrum

right H66.001

left H66.002

bilateral H66.003

with spontaneous rupture of

eardrum

right H66.011

left H66.012

bilateral H66.013

recurrent w/o spontaneous

rupture of eardrum

right H66.004

left H66.005

bilateral H66.006

recurrent with spontaneous

rupture of eardrum

right H66.014

left H66.015

bilateral H66.016

chronic

tubotympanic

right H66.11

left H66.12

bilateral H66.13

atticoantral

right H66.21

left H66.22

bilateral H66.23

4. Acute pharyngitis

J02.9

5. Asthma

mild intermittent

uncomplicated J45.20

acute exacerbation J45.21

status asthmaticus J45.22

mild persistent

uncomplicated J45.30

acute exacerbation J45.31

status asthmaticus J45.32

moderate persistent

uncomplicated J45.40

acute exacerbation J45.41

status asthmaticus J45.42

severe persistent

uncomplicated J45.50

acute exacerbation J45.51

status asthmaticus J45.52

exercise-induced

J45.990

cough variant

J45.998

6. Encounter follow-up examination after other treatment

Z09

7. Allergic rhinitis

due to pollen (hay fever)

J30.1

other (perennial)

J30.89

unspecified

J30.9

8. Sinusitis

chronic

maxillary J32.0

frontal J32.1

ethmoid J32.2

sphenoid J32.3

pansinusitis J32.4

other (multiple sites

not pansinusitis) J32.8

unspecified J32.9



Most Common Pediatric Diagnosis Codes (From AAP Coding Newsletter)

9. Dermatitis

allergic contact, due to	
metals	L23.0
adhesives	L23.1
cosmetics	L23.2
dyes	L23.4
other chemical products (insecticide)	L23.5
food in contact with skin	L23.6
plants, nonfood (poison ivy, oak, sumac)	L23.7
animal dander	L23.81
other agents	L23.89
unspecified cause	L23.9
irritant contact, due to	
detergents	L24.0
oils and greases	L24.1
solvents	L24.2
cosmetics	L24.3
other chemical products (insecticides)	L24.5
food in contact with skin	L24.6
plants, except food	L24.7
metals	L24.81
other agents	L24.89

10. Attention-deficit/hyperactivity disorder

predominantly inattentive	F90.0
predominantly hyperactive	F90.1
combined type	F90.2
other type	F90.8

11. Cough

R05

12. Viral infection

unspecified B34.9

13. Streptococcal sore throat J02.0

14. Bronchitis

acute
 due to respiratory syncytial virus J20.5
 due to rhinovirus J20.6
 unspecified J20.9

15. Conjunctivitis

acute
 atopic
 right eye H10.11
 left eye H10.12
 bilateral H10.13
 follicular
 right eye H10.011
 left eye H10.012
 bilateral H10.013
 viral
 due to adenovirus B30.1
 unspecified B30.9

16. Esophageal Reflux

with esophagitis K21.0
without esophagitis K21.9
newborn P78.83

17. Influenza with respiratory manifestations

unidentified virus
 respiratory manifestations
 other than pneumonia J11.1

18. Gastroenteritis/colitis

unspecified noninfectious K52.9

19. Fever

postvaccination R50.83
unspecified R50.9

20. Constipation, unspecified K59.00

21. Prophylactic vaccination Z23

22. Abdominal pain

epigastric R10.13
colic R10.83
generalized R10.84
 with acute abdomen R10.0
lower
 right quadrant R10.31
 left quadrant R10.32
periumbilical R10.33
upper
 right quadrant R10.11
 left quadrant R10.12

23. Viral diseases

other specified B33.8
infection, unspecified B34.9

24. Pneumonia

viral, unspecified J12.9
unspecified organism
 bronchopneumonia J18.0
 lobar J18.1
 other J18.8
Unspecified site J18.9



ICD-10 and Physician

ICD-10 Physician Benefits:

DATA

- ICD-10 expands the quality of data that is minded and reported, which in turn can help to improve patient care.
- Once ICD-10 data is gathered for a number of years, researches will have information that provides more specifics to compare. This allows conclusions to be drawn that will help improve the care our patients receive.
- ICD-10 provides us a better means to collect data about our patients, which details disease progression and treatment efficacy.

Monitoring

- ICD-10 greater level of specificity may help in the prevention of fraud and abuse. It makes it more difficult for ICD-10 users to assign diagnosis from severe disease categories without proper documentation.

Reimbursement

- Since ICD-10 provides a more accurate clinical picture of the care provided, misinterpretation by third parties, such as auditors, payers and attorney may be avoided.



Conclusion

In today's healthcare industry, improved provider documentation is about more than reimbursement. It is about better care, communication, and a clearer provider report card.

By documenting appropriately, providers can:

- Paint a more accurate picture of a child's condition severity.
- Improve the quality of patient care.
- Enhance communication among all healthcare providers.

