Codify
BY AAPC

Home Health Coding and OASIS Expert

ICD-10: Boost Reimbursement through Better Documentation

Do you know the details required to assign an accurate ICD-10 code?

As a clinician, it's your role to document each patient's condition as accurately as possible on the day of assessment. Without thorough and accurate documentation, your coders can't choose the most specific diagnosis codes, which can have a negative impact on your agency's reimbursement.

Bonus: Good documentation can actually save you time by eliminating phone calls, corrections, and re-work after the fact.

List these Vital Details

Many agencies left field clinicians out of their ICD-10 training efforts because they don't actually assign diagnosis codes, said **Jennifer Warfield, BSN, HCS-D, COS-C with PPS Plus** in Biloxi, Miss.

But field staff hold the key to accurate codes with their documentation, Warfield said during the recent PPS Plus-sponsored webinar "ICD-10 Required Documentation."

Time saver: Keeping in mind the details needed to assign the most specific ICD-10 codes from the moment the referral comes in can reduce calls back and forth between the coder and the clinician.

In general, make certain to document the following for each patient your agency sees, Warfield said:

- The patient's condition. Why are you seeing this patient?
- The onset of the condition. When did this condition arise?
- The etiology or cause of the condition.
- The anatomical location of any injury or wound.
- Laterality. Being able to distinguish which side of the body is involved in the patient's condition is a new feature in ICD-10, so gathering this information will help with the most accurate code assignment.
- The severity of any wounds. Wound severity is key to assigning specific codes for pressure ulcers, non-pressure ulcers, diabetic ulcers, and stasis ulcers in ICD-10.
- Environmental factors. Be sure to note any tobacco exposure or alcohol use which may be related to your patient's conditions. Many codes require additional codes to report these details in ICD-10.
- Manifestations or complications.
- Time parameters required to select accurate codes for conditions such as myocardial infarctions.
- Comorbidities.
- Healing status of wounds or injuries.
- External causes.
- Level of encounter required to select the seventh character for some codes (initial encounter, subsequent encounter, or sequela).

Look Closer at History and Status Codes

Clinicians are responsible for determining which diagnoses to include on the plan of care. But it's not a good idea to always list every comorbidity your patient has.

Take care when listing history codes. You're not likely to use many family history codes in home health, Warfield said. But personal history codes may be appropriate in situations where they are related to the care your agency provides. For example, history of neoplasm, UTI, or pneumonia codes may be appropriate, depending on the patient's current care

needs. In general, history codes should be sequenced lower in your list of diagnoses, she said.

Status codes may also provide some additional information about your patient, but you should consider whether the status has any bearing on the current care you will be providing before including them in your diagnoses list, Warfield said.

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code can be informative, because the status may affect the course of treatment and its outcome.

Follow These Tips for Better Documentation

Good documentation begins with the referral call. Making sure your intake staff knows which information to request, depending on the reason for the referral will save time later on. Once the first call from the referral source is over, it may be a couple of days before the field clinician goes out to do the assessment, Warfield said. By that time, the medical record may be long filed away, and getting copies of X-rays, radiology reports, or EKG reports will be much more complicated.

Bottom line: Include the diagnoses that will affect the current plan of care in your list of diagnoses and make certain you have interventions in place to address them. Be sure to check that the diagnoses have all been documented by the provider.

Note: PPS Plus will be hosting a repeat presentation of "ICD-10 Required Documentation" on Tuesday, Jan. 12th at 1 pm. CST. Register for this event at https://attendee.gotowebinar.com/register/1198683549964099841 . For more information, visit www.ppsplus.com, call (888) 897-9136 or email info@ppsplus.com .