Documenting ICD-10-CM: What’s new?

By Brian Outland

Because of the increased granularity of the new ICD-10-CM codes, which are scheduled to be implemented on Oct. 1, 2015, physicians will need to provide more specific information in their clinical documentation. This specificity will be critical for efficient claims processing, and learning what is needed may require some time and practice.

For instance, physicians will need to note cause of injury and date of onset, which are not details always documented before.

Note the following patient scenario.

An 81-year-old man presents for preoperative evaluation before transurethral resection of the prostate, which is scheduled to take place in 5 days. His surgeon has requested evaluation for hypertension and cardiac clearance. The patient had an inferior-or-wall myocardial infarction (MI) 1 year ago, for which he received thrombolytic therapy with complete resolution of symptoms. His lastjection fraction measurement, 1 month ago, was 50%. The patient’s regular physical activity includes walking and swimming. He reports no shortness of breath on exertion. He does not have cerebrovascular disease, diabetes mellitus, congestive heart failure, renal failure, or angina. He has a history of essential hypertension and was prescribed metoprolol succinate once daily but is not taking the drug because he can’t afford it.

The patient is in no acute distress on physical exam, and his height and weight are appropriate for his age. His blood pressure is elevated at 157/92 mm Hg. His chest is clear, and he has no pedal edema. An electrocardiogram shows nonspecific T-wave changes.

Laboratory values include a creatinine concentration of 1.5 mg/dL, a slight increase from the patient’s baseline that could indicate early renal insufficiency.

The physician plans to monitor blood urea nitrogen and creatinine levels for renal function and nephropathy referral if necessary. He notes that the patient’s hypertension is probably due to nonadherence to metoprolol succinate, and indicates that he will communicate this to the surgeon, who may not be aware of the patient’s financial situation.

The physician changes the patient’s medication regimen to oral prazosin, two 20-mg tablets daily, with the first dose administered in the office. A 30-day supply of free samples is provided. The physician plans to reevaluate the patient’s hypertension in 3 days and will clear him for surgery if it is improving.

When documenting this encounter, the physician should note why the encounter is taking place, since there are different ICD-10-CM codes for a routine visit, a surgery clearance, and an initial visit.

If known, it is important to document whether patients are adherent with their medications. “Underdosing” is a new concept in ICD-10-CM and can be captured along with the diagnoses. When an issue with underdos ing is noted, it should be documented whether the matter is new or has been recurrent. The ICD-10-CM terms provide new detail compared to the previous ICD-9-CM code V15.81, “history of noncompliance.”

The physician in this case documented that the patient’s lab results showed a slight increase in creatinine from baseline, which may indicate early renal insufficiency. Guidelines allow the reporting of an additional diagnosis to support the abnormal test result. (The accompanying table compares the codes for the sample scenario in ICD-9-CM versus ICD-10-CM. Note the codes 794.4 and R94.4 for abnormal renal test results.)

In ICD-10-CM, coders are provided a “Use Additional Code” note for hypertensive diseases (I10-I15). If known, it should be documented whether hypertensive patients have any of the following: exposure to environmental tobacco smoke, history of tobacco use, occupational exposure to environmental tobacco smoke, tobacco dependence, and/or tobacco use. This patient had none of these.

While there are some new things to include in ICD-10-CM documentation for billing and coding purposes, some of these elements may already be in use for purposes of clinical care. Documentation requirements for some conditions may be easier or more difficult for physicians, depending on how they are accustomed to documenting now. Eventually, it is anticipated that the new elements in ICD-10-CM will become second nature, just as ICD-9-CM is now. A good way to prepare for the switch to ICD-10-CM is to conduct a self-audit similar to the above exercise for the more common conditions seen in your practice. It may also be helpful to begin requesting a testing plan schedule from your vendor. Conduct internal testing within your clinical practice as well as external testing with payers and other external business partners after you have completed the planning stages.

More ICD-10 resources are available online at www.acponline.org/ICD10. Also, the Centers for Medicare and Medicaid Services maintains an ICD-10 website at www.cms.gov/Medicare/Coding/ICD10 that has the latest news and resources to help prepare.

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Making patient portals patient-friendly

By Margo Williams

Patient portals are a double-edged sword. Many patients enjoy the ability to look up information about their last visit or e-mail a question to their doctor without getting an automatic attendant, being put on hold, or having to leave a message. For the practice staff, a well-designed portal can cut back significantly on phone calls and often office staff.

There are many barriers to successful use of patient portals, including many on the practice side such as cost, physician and staff resistance, technical obstacles, and more. However, the patient portal helps engage your patients in their care (which has better outcomes) and makes them more satisfied with their care (because they are part of the team). Your practice gets the added benefit of meeting the meaningful use measure. Below are some tips to make it easier for your patients to use your portal.

Make it worthwhile. If patients can contact your office via the portal with a question and get a reply back the same day, then that is more valuable than leaving a voice mail and playing phone tag. If they can see the lab results, ask a simple question, or request a prescription refill, they won’t need to call the office and wait while someone tracks down the information or passes the message on to the physician. Even if the answer is to schedule an appointment, at least the patient is clear on what they need to do. Some patients may also like to know that messages sent through the portal become part of their record, rather than misplaced or forgotten.

Meaningful Use Stage 2, Core Objective 7 requires that the practice “Provide patients the ability to view online, download and transmit their health information,” and Core Objective e7 requires using “… secure electronic messaging to communicate with patients on relevant health information.” If using your portal provides useful information and the ability to take the information to another clinician, then patients will use it and the practice will get credit for those measures.

Make it easy. Ideally, your patients should be able to choose their own user name and password. Many systems assign a password that isn’t logical to the patient. When patients have multiple doctors using multiple systems, they are inundated by how many different user names and passwords they have to remember, particularly if frequent password changes are required. If patients only need to go into the system once or twice a year, and each time they do it takes them 10 minutes to remember how to get in and then they have to change their password, they’ll stop using it.

Another way to make using the portal easy is to include a link to the site every time you send a notification. Patients often get a notification that they have a message from their doctor, but the automatically generated message doesn’t even say who is sending out the notification. Including a link would at least take them to the right place, and hopefully they will be able to remember how to access your portal. Print a business card or flyer with the practice name, the portal URL, and instructions on how to access their account.

Get the Blue Button added to your EHR. The Blue Button lets Medicare patients (or their caregivers) go online and access their records from hospitals, physician offices, laboratories, pharmacies, and anywhere else that bills Medicare. Because many patients don’t know or can’t remember what was done to them last week, last month, or last year, the Blue Button allows them to see their personal health record, which can be used to provide patients with care based on accurate information.

For more information on how patient portals can improve care and how to incorporate them into office work flows, go online to www.healthit.gov/providers-professionals/patient-portal-benefits-patient-care-and-provider-workflow. For more information about using the Blue Button in your practice, go online to www.healthit.gov/patients-families/blue-button/about-blue-button.