



ICD-10

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ICD-10. It's closer than it seems.

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How to Prepare for Documentation Changes and Improvements with ICD-10

Although the final rule on the proposed ICD-10 deadline change has not been published yet, it is important to continue planning for the transition. ICD-10 will require an increased granularity and specificity in documentation of patient encounters. This change will mean that providers and payers need to adjust how they document patient visits but will create more detailed data that can be used to improve patient care. More specific code sets can also assist providers avoid delays in reimbursement payments by identifying why certain claims are being rejected or denied by payers.

You will need to prepare for these changes in clinical documentation by taking certain steps:

- 1. Inventory Systems and Identify Discrepancies:** You should review your systems that currently use ICD-9 in order to identify areas in your revenue cycle, reimbursement rates, health information management, electronic medical records, and clinical systems that will eventually use ICD-10. These systems will be affected by the increased specificity of documentation as well as the increase in number of codes used in ICD-10. Your systems inventory will need to evaluate any potential gaps in clinical conditions or work flow processes that could be affected by increased documentation. Once you have identified any discrepancies, you can update and modify your systems and processes prior to transitioning to the new code sets. This will save your organization time by finding incomplete or non-specific data and ensuring that they do not cause a delay with coding and billing when you finalize implementing ICD-10.
- 2. Evaluate Current Software Systems:** As you conduct your systems inventory, you may realize that some of your systems have become out-of-date or are redundant. You will need to determine if it is more cost-effective and efficient to upgrade these systems or centralize and replace them

before ICD-10 implementation.

3. **Train and Educate Staff:** Your organization should identify staff members, from providers to coders, who currently use ICD-9 codes. Staff who will now be using ICD-10 will need training to become familiar with the increased documentation standards necessary with the new code sets. Training will help staff members become comfortable with both the heightened specificity and increased number of code sets that they will be using frequently.
4. **Test the Documentation Process:** Finally, your organization will need to test each stage of the new documentation process in a trial setting. Staff members should simulate a typical patient encounter in its entirety to ensure that data is being documented thoroughly and consistently. This will also help identify any areas that still require improvement in the coding process.

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