

# ICD-10: IMPROVING CLINICAL DOCUMENTATION

Improving Clinical Documentation means a joint effort by the provider and the coding professional according to the American Academy of Professional Coders (AAPC) and it includes:

- Well-documented medical records that facilitate communication, coordination and continuity of care and promotes the efficiency and effectiveness of treatment.
- Accurate coding is the key to prompt reimbursement, practice profiling and contract negotiations. It is important for both financial and compliance reasons.
- Chronic conditions are important to show not only resource utilization, but also severity of illness for statistical purposes.
- Specificity is important for further research into treatment effectiveness for chronic conditions.
- Showing medical necessity means you are justifying your treatment choice and help support E/M levels.

## 10 Steps to correct coding as published in the ICD-9-CM:

1. Identify the reason for the visit.
2. Always consult the Alphabetic Index (Vol. 2) before turning to the Tabular List (Vol. 1).
3. Locate the main entry term.
4. Read and interpret any notes listed with the main term.
5. Review entry for modifiers.
6. Interpret abbreviations, cross-references, symbols and brackets.
7. Choose a tentative code and locate it in the tabular list.
8. Determine whether the code is at the highest level of specificity.
9. Consult the color coding and reimbursement prompts, including, age, sex and Medicare as secondary payer edits. Refer to the key at the bottom of the page in the ICD-9-CM for definitions of colors and symbols.
10. Assign the Code.

Source: AAPC website

