THE ROAD TO ICD-10

WHY DOCUMENTATION?

It is sometimes a challenge for providers to directly relate documentation to quality of care and the reimbursement process. However, they are directly related.

The main concern of providers is and should always be patient care and treatment. ICD-10 does not change that. In fact, it seeks the same thing, which is improving patient care data in order to support the full clinical story.

The additional specificity in documentation for ICD-10 does not require a provider to do more testing, treatment, or services. It only requires the documentation of the full patient and clinical details that the provider already knows.

The Logic Behind ICD-10-CM/PCS

We all know that we have to increase our knowledge of documentation needs for ICD-10-CM/PCS. But what does this mean?

It means we need to know the specific documentation requirements in ICD-10 that tell the complete biomedical and pathophysiological story, which supports compliant billing and fair reimbursement.

ICD-10-CM/PCS are really more logical and specific; they can report an unambiguous clinical picture to support quality communication and fair compensation for services rendered.

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