

Figure 3

Quotes on Documentation Requirements for ICD-10-CM/PCS

“We did not see a big deficit in our surgical dictation, like type of medical devices. We found that surgeons have been doing a great job in procedure notes and other notes in the chart such as nurse’s notes and other places in the chart.”

“We have not gotten feedback for ICD-10 and in obstetrics/gynecology that would be very helpful.”

“We will get some updated modules online; a panel counting (a message displayed in the EHR; counting down to ICD-10 implementation). Has not been directly addressed to us yet. We have a giant banner of ICD-10 implementation countdown.”

“Feedback from our billing service on how to improve coding and documentation; charts are sent back with a note on how much we could have generated and how much actually we did back up by documentation.”

“I don’t know how it is going to work for ICD-10 (selecting which part of the colon for diagnosis and then selecting the procedure code for that specific spot).”

“We are looking for diagnosis coding patterns; review for billing and for specific codes; we give physicians three scores in three areas (diagnosis accuracy, E/M accuracy, and back-office procedures).”

“I am pretty detailed too; document a lot of stuff in the record so information is all there. Some people cut and paste but this doesn’t help to update the record. I haven’t done any comparisons about what I am going to bill in ICD-10.”