Specific, consistent ICD-10 coding key to timely payments

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(HealthDay)—In order to prevent denials, it is important to code correctly within the *International Classification of Diseases*, Tenth Revision (ICD-10), with specificity matching documentation, according to an article published in *Medical Economics*.

Noting that payers are currently going easy on specificity in coding of ICD-10, but that this largess is not likely to last, the article emphasizes the importance of coding correctly in order to prevent payment delays and possible loss of payment.

A firm providing financial management and support services offered four tips for making sure the right codes are used to prevent denials. They note the importance of not leaving code selection to the electronic health record and checking the selections against the documentation. For

those using encounter forms for billing, the forms should accommodate all the components needed for accurate coding, including laterality, upper and lower, initial versus subsequent encounter, etc. Code selection should be made as specific as possible, but coding should not be more specific than documentation. Payers' coding policies should be researched; these may differ from Medicare reimbursement and they may need addition of specific modifiers or want specific codes to be used.

"It is still best to document what you did, do what you documented, and accurately report what [you] have done that is medically necessary to the highest level of specificity," according to feedback from an ICD-10 Diary physician.

More information: More Information