PREVENT
ICD-10
DENIALS

Verify EHR Coding

Trusting electronic health records (EHRs) should be automatic. But the ICD-10 code selection could be based on mappings that don't result in the most specific or correct ICD-10 code needed. You don't want to leave code selection totally to your EHR. Spot check the EHR's selections against the actual documentation.

Customize Forms

Check encounter forms and superbills. Make sure they have the best options for diagnoses and include details such as encounter and laterality.

Document Well

Medical coders are expected to assign the most specific ICD-10 codes possible. What's possible is defined by the clinical documentation, which means specificity starts with documentation. Documentation needs to support medical necessity to make sure healthcare providers can justify the level of reimbursement. You don't want to have to pay back money on an audit just because you coded more specific than you documented.

Know Healthcare Payer Policies

Payer policies differ in what they cover and how they reimburse. Knowing what healthcare payers want is the kind of knowledge that is most important for preventing ICD-10 denials.

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