CLINICAL DOCUMENTATION ICD-10

Payers and Providers Partnering for Success

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IMPORTANCE OF IMPROVING CLINICAL DOCUMENTATION

- Clinical documentation is at the core of every patient encounter.
- In order to be meaningful it must be accurate, timely and reflect the scope of services provided.
- An accurate representation of a patient's clinical status translates to coded data.
- Coded data is then translated into quality reports, physician report cards, reimbursement, public health, and disease tracking and trends.
- Improving the accuracy of clinical documentation can:
  - Reduce compliance risks
  - Minimize vulnerability during external audits
  - Provide insight into legal quality of care issues.

DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF

- Documentation should **not** include arrows up or down in place of “hyper” or “hypo” as they could be interpreted as elevated.
- Do not use ICD-10 diagnosis codes in place of the actual written/spelled out diagnosis/condition.
- Each progress note must be able to **“stand alone”.**
- **Do not** refer to diagnoses from a prior progress note, etc…
- When diagnosing a patients condition make sure you evaluate each condition and not just list it, for example:
  - DM w/Neuropathy-meds adjusted
  - COPD-test ordered
  - Hyperlipidemia-stable on meds

DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF

- All progress notes **must** be signed by the provider rendering the services and included with signature should be the providers credentials (stamped signatures are no longer acceptable since 1/2009).

- EMR notes must have the following wording as part of the signature and note must be closed to all changes:
  - Electronically signed
  - Authenticated by
  - Signed by
  - Validated by
  - Approved by
  - Sealed by

- Any changes that are to be made to a closed encounter can be added as a separate addendum to the DOS, but must be done in a timely manner.

DOCUMENTATION CRITERA – PHYSICIAN AND STAFF

- Charts are well organized
- All chart entries are dated and signed or initialed
- All handwriting is legible
- No unexplained cross outs, write over, or squeezed in notes
- Reason for visit/chief complaint is noted
- Allergies or "NKDA" noted
- Current medication, RX, OTC or recreational are noted
- Medication orders include and renewals are:
  - –Evidence of dispensed written patient education materials are noted
  - –Significant phone calls are documented (advice, content and decision made)
  - –No unsubstantiated, subjective remarks are seen

THE 10 COMMANDMENTS OF E/M DOCUMENTATION

1. **The Documentation Must be Legible**
   If a record cannot be read or interpreted, it is of little value. However, with a little help, the coder or auditor should be able to handily decipher the provider's documentation. Dictated or computer generated records can be a great benefit in this area.

2. **Every Record Must Contain Basic Data**
   These include patient name, patient birth date, the encounter date and time, vital signs, allergies, and the location of the service. Upon completion, every record must be signed by the provider, whose printed name should also be a part of the record.

3. **The Record Must Be Organized**
   Encounters should follow the format of: chief complaint, history, exam, and diagnosis/plan. The history (HPI) must be broken down into the review of systems (ROS) and the past, family, and social history (PFSH).

4. **Documentation Must Match the Billed Services**
   Every billed service and its corresponding diagnosis code must be clearly documented in the medical record. For example, if the provider is relying upon the evaluation of two stable medical problems to support a level 4 encounter, the pertinent history and exam for each of the problems must be found in the record.

THE 10 COMMANDMENTS OF E/M DOCUMENTATION

5. Medical Decision Making (MDM) Must Match Service Level

MDM is the overriding determinant of the level of service, and a billed service level should never exceed the MDM reflected in the documentation.

6. Addendums or Alterations Must Be Properly Identified

Ideally, an encounter should be fully and completely documented within eight hours, and certainly no more than 24 hours after the service. Additions to a completed record should be clearly labeled as such, and include the date, time and reason for the addendum. When making a late addendum, it is preferable to place it on a separate page from the original document to avoid the impression that the author was attempting to alter the original record.

7. Do Not Clone Medical Records

Cloning medical records refers to the abusive use of boilerplate data, or carrying forward large portions of a patient's prior record to the current encounter.

8. Do Not Abuse Modifier 25

Modifier 25 is proper only when a separately identifiable E/M service is performed, in addition to another procedure or service.

THE 10 COMMANDMENTS OF E/M DOCUMENTATION

9. The Necessity of Ancillary Testing Must Be Clear

When testing or procedures are part of the encounter, the reason and necessity for these items must be clearly documented or intuitively obvious to medical personnel. Although “rule out” diagnoses are not valid to submit for billing purposes, they can be used in the text of the record to explain the need for testing.

10. Note Face-to-Face Time for Time-Based Encounters

When time-based billing is used, a simple statement that over 50 percent of time was spent in consultation with the patient is required, as well as the total number of minutes spent “face-to-face” with the patient. The subject matter of the counseling should also be recorded in adequate detail to support the amount of counseling time

EMR DOCUMENTATION - PITFALLS

- Templates and billing driving care and charting
- Point-and-click mentality vs. accurate and ethical documentation
- Copy and paste forward
- Charting for services that were not performed; use of default entries
- Documentation cloning
- Negatives listed vs. positives- hard to discern what is wrong with the patient
- Failure to review available information
- Inaccurate charting
- Addendums for increased reimbursement vs. for patient care
- Relative value unit (RVU) driven care
- Signing of notes without reading them
- EHR revealing bad practice patterns

EMR DOCUMENTATION - SOLUTIONS

- Limit the copy and paste functions – In an audit, copy and paste functions can be perceived as cloning
- Copy and paste also risks introducing documentation errors
- Document in your own words
- Review before closing notes for accuracy
- Check the meds, test results and all interventions with the patient
- Ensure that you are in agreement with the story you have depicted of the patient's encounter
- Once you close the note, your only option for a correction is an addendum
- Addenda only pertinent clinical information not just revenue based information – Do not get into the habit of adding documentation to support a higher service level unless the documentation is reflective of medical necessity
- Adding information on radiology interpretations or documenting medication or other interventions that can boost a visit level should be done at the time of service to reflect the presenting problem's severity, not as an afterthought.

ICD-10-CM BASICS

SUMMARY OF THE CHAPTERS IN THE TABULAR LIST

Chapter	Code Range	Estimated # of Codes	Descriptions
1	A00-B99	1,056	Certain infectious and parasitic diseases
2	C00-D49	1,620	Neoplasms
3	D50-D89	238	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
4	E00-E89	675	Endocrine, nutritional and metabolic disease
5	F001-F99	724	Mental, Behavioral and Neurodevelopmental disorders
6	G00-G99	591	Diseases of the Nervous system
7	H00-H59	2,452	Diseases of the Eye and Adnexa
8	H60-H95	642	Diseases of the Ear and Mastoid process
9	I00- I99	1,254	Diseases of the Circulatory Process
10	J00-J99	336	Diseases of the Respiratory system

SUMMARY OF THE CHAPTERS IN THE TABULAR LIST

Chapter	Code Range	Estimated # of Codes	Descriptions
11	K00-K95	706	Diseases of the Digestive system
12	L00-L99	769	Diseases of Skin and Subcutaneous Tissues
13	M00-M99	6,339	Diseases of the Musculoskeletal/Connective
14	N00-N99	591	Diseases of Genitourinary system
15	O00-O9A	2,155	Pregnancy, Childbirth and Puerperium
16	P00-P96	417	Certain conditions originating in the perinatal period
17	Q00-Q99	790	Congenital malformations, deformations and chromosomal abnormalities.
18	R00-R99	639	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
19	S00-T88	39,869	Injury, Poisoning and Certain other consequences of external causes
20	V00-Y99	6,812	External causes of Morbidity
21	Z00-Z99	1,178	Factors influencing health status and contact with health services

BENEFITS OF ICD-10 CODING SYSTEM

- It will provide much better data needed to:
  - Measure the quality, safety and efficacy of care
  - Reduce the need for attachments to explain the patient's condition
  - Design payment systems and process claims for reimbursement
  - Conduct research, epidemiological studies and clinical trials
  - Set health policy
  - Support operational and strategic planning
  - Design health care delivery systems
  - Monitor resource utilization
  - Improve clinical, financial and administrative performance
  - Prevent and detect health care fraud and abuse
  - Track public health and risks

OTHER IMPORTANT CHANGES TO NOTE FOR ICD-10

- Importance of Anatomy:
  - Injuries are grouped by anatomical site, rather by type of injury.
- New Definitions
  - In Some instances, new code definitions are provided reflecting modern medical practice (definition of acute myocardial infarction is now 4 weeks rather than 8 weeks).
- Restructure and Reorganization
  - Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters.
- Reclassification
  - Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge.

ICD-10 EFFECT ON CLINICAL DOCUMENTATION

- ICD-10 coding introduces accurate representation of health care services through complete and precise reporting of diagnoses and procedures.
- ICD-10 will yield more thorough data for clinical decision making performance reporting, managed care contracting, and financial analysis.
- ICD-10 includes a more robust definition of severity, co-morbidities, complications, sequelae, manifestations, causes and a variety of other important parameters that characterize the patient's conditions.
- A large number of ICD-10-CM codes only differ in one parameter. For example nearly 25% of the ICD-10-CM codes are the same except for indicating the **right** or **left** side of the body
- Another 25% of the codes differ only in the way they distinguish among "**initial encounter**", versus "**subsequent encounter**", versus "**sequelae**".

ICD-10-CM CODE STRUCTURE

- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th and 6th characters.
- Digits 4-6 provide greater detail of etiology, anatomical site and severity.
- **A code using only the first three digits is to be used only if it is not further subdivided.**

ICD-10-CM CODE STRUCTURE

- A code is invalid if it has not been coded to the full number of characters required.
- This does not mean that all ICD-10 codes must have 7 characters.
- The 7th character is only used in certain chapters to provide data about the characteristic of the encounter.
- Examples of where the 7th character can be used;include injuries and fractures:

Injuries and External Causes

Value	Description
A	Initial encounter
D	Subsequent encounter
S	Sequela

Fracture

Value	Description
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela

ICD-10-CM CODE STRUCTURE

- A dummy placeholder of “X’ is used with certain codes to allow for future expansion and/or to fill out empty characters when a code contains fewer than 6 characters and a 7th character applies.
- When a placeholder applies, it must be used in order for the code to be considered valid.
- Below are specific examples of ICD-10 diagnosis codes. The use of combination codes, increased specificity, and the “X” placeholder is illustrated:

Code	Description
Combination Codes	
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
Increased Specificity	
S72.044G	Non-displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing
Laterality	
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
“X” Placeholder	
H40.11X2	Primary open-angle glaucoma, moderate stage

CONTACTS

If you have any questions or concerns about the information presented here or would like to schedule an onsite presentation for you and your staff, Please contact Mary Ellen Reardon or Shannon Chase and we will be glad to assist you.

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Thank You