Part B Insider (Multispecialty) Coding Alert

ICD-10: Enhanced Documentation Is Key to ICD-10 Success

Every staff member should work toward this shared goal.

As you work toward mastering ICD-10, you're bound to hear over and over about the need for improved documentation when it comes to working with this code set. Why not take advantage of the ICD-10 implementation delay to work on tackling this issue? You may find your ICD-9 coding improving as a result.

Why Good Documentation Is Important

The word "documentation" appears 72 times in the ICD-10-CM Guidelines, says coding expert **Sharon Molinari**, a consultant based in Henderson, Nev. And the guidelines advise querying for additional information 23 times.

Poor documentation will prevent you from being able to select the correct ICD-10 codes. If you want to take advantage of the code set's use of laterality or the detailed information the sixth and seventh characters provide, you'll need excellent documentation.

"Increased specificity means increased communication and improved documentation," Molinari explains.

The increased specificity ICD-10 offers may impact the following areas, Molinari says:

- Reimbursement
- Outcomes calculation (P4P)
- Agency susceptibility to MAC reviews and action
- HHA risk for RAC, ZPIC, and other audits
- Lost revenue or delayed cash flow.

Better documentation will also help you to be a better ICD-9 coder. "This is our opportunity to get it right to manage our processes and documentation to describe the home health patient population as accurately as possible," Molinari says.

Review Your Documentation

With the new ICD-10 target date set for Oct. 1, 2015, you have some extra breathing room to take a closer look at the documentation you currently receive. Start by gathering existing medical record documentation for the top 25 conditions you code most frequently, as well as records for the diagnoses most often involved in denials.

Once you've gathered the documentation, examine it for the following, Molinari suggests:

- How timely and complete is the information?
- How detailed is the information?
- Do you collect enough information to support the diagnoses you report and identify specific codes?
- Does the referral or medical record provide specifics on wound characteristics and the anatomical areas affected by injuries or fractures?
- Are your clinicians documenting communication with any referring doctors and verification of the diagnoses and the plan of care?

When you have the answers to these questions, you can identify documentation improvement opportunities.

Improve Your Documentation

Once you identify areas where your documentation is lacking, you'll need to establish a plan to make it stronger. Be sure to look for improvement opportunities that could impact multiple initiatives, Molinari says.

Keep an open mind and focus on finding the best solution to address each documentation gap. When it comes to improving documentation, one size doesn't fit all, Molinari says. For clinician documentation, you may need to make changes in the following areas, she says:

- Modifications to forms or templates
- Electronic Health Record documentation templates. Consider adding laterality, encounter de-tails, severity, etc.
- System prompts
- Workflow or operational process changes
- Education

Education is especially important when it comes to improving documentation. Be sure to provide comprehensive education and mentoring by partnering with the right education sources. Ongoing education and auditing of clinician and physician documentation is imperative, Molinari says.

Tip: With a little research, you can create a useful ICD-10 documentation training tool, tailored to your needs. Make a list of the top 40 diagnoses your agency codes and convert them to ICD-10, says **Lisa Selman-Holman** of Selman-Holman & Associates, CoDR □ Coding Done Right and Code Pro University in Denton, Texas. Then create a corresponding list of information you'll need to select the most accurate code.

Physician documentation issues are nothing new, but improving the documentation you review from physicians can be tricky. Since the physician must state or confirm all diagnoses, the quality of the physician documentation is critical.

Unfortunately, "We are often limited in coding, due to the lack of documentation or its vagueness, which may result in a negative impact on patient outcomes and reimbursement," Molinari says.