

Outpatient Facility Coding Alert

ICD-10: Maintain 7 Criteria to Keep Your Diagnosis Coding On Track

Follow our experts' advice to turn down the risk of down coding.

You may be able to choose diagnosis codes with the precision of a sharpshooter, but if the clinical record doesn't support the codes you report, you run the risk of down coding, focused medical review, and even fraud investigations. The documentation on which you base your coding is about to get even more scrutiny as the ICD-10 transition date approaches. Make sure your clinicians' documentation techniques will pass muster with these expert tips.

Now's the time to assess clinicians' documentation skills, says **Arlene Maxim, RN**, founder of A.D. Maxim Consulting, A.D. Maxim Seminars, and The National Coding Center, in Troy, Mich. Under ICD-10, clinicians will need to beef up their documentation, she says.

"Documentation will make or break this process," Maxim says. ICD-10 will require a higher degree of specificity. Assessing documentation practices now allows your agency to begin improvement efforts before the added pressure of the ICD-10 deadline arrives.

Clinical documentation is the foundation of every health record, said **Dorothy D. Steed, CPC-H, CHCC, CPUM, CPUR, CPHM, ACS-OP, CCS-P, RCC, CPMA, RMC, CEMC, CPC-I, CFPC, PCS, FCS, CPAR**, AHIMA Approved ICD-10 Trainer, an independent healthcare consultant and educator in Atlanta, Ga. Clinicians may collect documentation only once, but others will use it many times so it's important to make every effort to prevent it from being misunderstood.

Clinicians need to think about how often others will use and access their documentation in the future, Steed said during the recent audio conference "Clinical Documentation Improvement." This critical information is needed for patient care and to help determine coding quality and accuracy.

During the audio conference, Steed outlined seven criteria for quality clinical documentation. Consider how your clinicians' documentation stacks up in each area and provide help in making the changes needed to better support coding choice.

1. Legibility: Documentation should be readable and easily deciphered. A lot of handwritten documentation isn't legible or decipherable, Steed cautioned. Rushed or careless documentation may cause other problems.

Legibility includes being able to read the name and title of the clinician completing the documentation, Maxim adds.

This is an especially important aspect of good documentation, Steed said. Complete and legible entries provide protection for providers. But illegible entries in a medical record may cause:

- Misunderstanding of a patient's condition.
- Jeopardized reimbursement.
- Denied payment.
- Loss of legal appeals.
- Serious patient injury.

2. Reliability: Is the documentation trustworthy? Based on the diagnoses, is the documentation reliable? Does it support the rationale for the diagnoses and for medical necessity?

The reliability is related to every single visit note. Most denials and down coding occur when visit notes don't support the codes you report based on the original assessment, Maxim cautions.

3. Precision: Clinical documentation must be accurate, exact, and strictly defined. Increased detail generally means greater accuracy in documentation, Steed said.

The degree of specificity in documentation that will be necessary with ICD-10 will challenge even the most experienced clinician, Maxim says. Take the musculoskeletal system, for example. There are eight codes for pathologic fractures in ICD-9, but in ICD-10 there are more than 150 codes.

4. Completeness: Good documentation fully addresses all concerns in the record, and includes appropriate validation.

5. Consistency: Documentation shouldn't be contradictory. Are there conflicting statements in the record? Are there conflicting opinions between providers that have not been clarified? Make sure any inconsistencies are addressed.

This is where the coordination of services comes into play, Maxim says. Many times a contradiction occurs when there is a lack of communication between the disciplines. "Get everyone on the same page."

6. Clarity: Documentation should be unambiguous. Vague documentation that does not totally describe a patient's condition won't support the services your agency provides.

7. Timeliness: Documentation must be up-to-date to help ensure optimal patient treatment.

Important: Clinicians should never be tempted to put off documentation until a more convenient time. Every hour away from the visit, a large percent of information is lost. "Our memory for specific information fades quickly. Agencies should begin enforcing requirements of in-home documentation."