OASIS Alert

Diagnosis Coding: Improve Accuracy with Better Documentation

Look to your marketing team as an ally in improving physician documentation.

Documentation can make or break your coding and OASIS accuracy as well as your agency's reimbursement. There's no time like the present to see where you can make improvements.

Know Why Good Documentation is Important for Diagnosis Coding

The word "documentation" appears 72 times in the ICD-10-CM Guidelines, says **Sharon Molinari, RN, HCS-D, COS-C**, a home health 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 sets' 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 says.

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

- Reimbursement
- Outcomes calculation (P4P)
- Agency susceptibility to MAC reviews and action
- Agency 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 of Oct. 1, 2015, you have some extra breathing room to take a closer look at your current documentation. 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 received at the time of referral?

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

When you have the answers to these questions, you can identify documentation improvement opportunities. Be sure to also think about the specificity that ICD-10 codes for these diagnoses will require, Molinari reminds.

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. Don't focus solely on ICD-10.

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. With 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 details, 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 agency's needs. Make a list of the top 40 diagnoses your agency codes and convert them to ICD-10, says **Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O**, AHIMA Approved ICD-10-CM Trainer/Ambassador 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 from the physician or referral source to select the most accurate code.

Improving the documentation you receive from physicians can be tricky. Physician documentation issues are nothing new. Since the physician must state or confirm all home health 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.

Try this: Train your marketing staff on documentation requirements and have them share the information with local referring physicians, Molinari suggests. Marketing staff can discuss documentation and process issues your agency is currently experiencing, what ICD-10 will require, and how to best communicate.

Marketing staff can provide documentation tools and tips on what your agency needs to properly document:

- Face-to-Face encounters.
- Medical history and current diagnoses.
- List of medications.
- Inpatient admissions.