OASIS Alert

Documentation: Master 7 Qualities for Top Notch Documentation

Make sure you're supporting medical necessity and code selection or risk denials.

You already know that when the clinical record doesn't support the OASIS items that impact reimbursement, you run the risk of downcoding, focused medical review, and even fraud investigations. As the Oct. 1, 2014 ICD-10 transition date approaches, attention to the documentation required to support the new code set will only become more focused. Make sure your documentation techniques will pass muster with these expert tips.

Now's the time to assess your 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 tells Eli. ICD-10 will require a higher degree of specificity. Assessing your documentation practices now allows you to begin improvement efforts before the added pressure of the ICD-10 deadline arrives.

Don't go overboard: You may run the risk of downcoded claims when documentation that supports the OASIS assessment is missing, but it's probably not necessary to document supporting information for every item every week. However, you do need to make sure the chart clearly shows why you decided to answer each OASIS question the way you did.

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. You may collect documentation only once, but others will use it many times and you'll want to make every effort to prevent it from being misunderstood.

It's important to think about how often others will use and access your documentation in the future, Steed said during the recent Eli-sponsored audioconference "Clinical Documentation Improvement." This critical information is needed for patient care.

Steed outlined seven criteria for quality clinical documentation. Consider how your documentation stacks up in each area and make the changes needed to be sure you're supporting your OASIS responses.

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 says.

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 your 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 not just related to the assessment (OASIS), but with every single visit note. Most denials and downcoding 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 home care clinician, Maxim says.

4. **Completeness**: Good documentation fully addresses all concerns in the record, and includes appropriate validation. Be absolutely sure every SOC assessment includes the beneficiary's prior level of function.

When records go under review by any contractor, the prior level of function will assist in supporting the need for home health care services, Maxim says.

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**: Your 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.

This includes the need for clinicians to document in the home, Maxim says. Clinicians should never be tempted to put off documentation until a more convenient time. Every hour you're 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."

Watch for Under-Documented OASIS Areas

Be sure your documentation backs up your OASIS responses, especially with these often missed items.

Vision impairment (M1200). Your clinical documentation must be consistent with any problems identified in this item. If your patient's vision scores as partially or severely impaired, you'll want to show evidence of it in the medical record. Good documentation includes details such as "provided large print reading materials," "made suggestions about improving the lighting for safety" or comments indicating that you considered vision problems and their impact on medication management.

It is also important to include any diagnosis- or problem-related issue that causes vision impairment, Maxim says. Good documentation describes why the patient's vision is impaired and just how such impairment will impact the plan of care.

Cognitive functioning (M1700). When caring for a patient who is confused, you should document the patient's mental state on each visit. Your documentation should always reflect the reason you're in the home. You should evaluate and monitor for safety, medication management, and other basic care issues every visit. Be sure to document this.

Bowel and bladder incontinence (M1610/1620). Assumptions that elderly patients are often incontinent lead to this problem being inadequately documented. Be sure to include incontinence in the treatment plan and document it in the record, when applicable.

You may need to address chronic incontinence only once, but you'll still want to include the details in the medical record. Your documentation should include the length of time the incontinence has existed, information about the cause, supplies you are using, and preventive education to avoid skin breakdown. Document new problems such as recent incontinence of unknown origin or incontinence related to mobility issues more frequently as part of the treatment plan.

Be sure to include the details of what you're doing to address the issue.