

Chiropractic Coding & Compliance Alert

ICD-10 Update: Ward Off Your ICD-10 Fears With These Impeccable Documentation Tips

Plus: Take on a 20 minutes a day to master ICD-10 ready documentation.

ICD-10 will require a higher degree of specificity. Assessing documentation practices now will allow your group to begin improvement efforts before the added pressure of the ICD-10 deadline arrives in October.

Though providers collect documentation only once, they must do so keeping in mind that they are creating a blueprint of critical information with far reaching consequences that will pass through the hands of other providers caring for the patient, the coders, the insurance companies, the auditors, and possibly even lawyers. Remember if you do not put clear details of the findings and procedures on paper now, you are losing your chance to claim later that you did perform that procedure.

"What I always teach is if it wasn't documented it didn't happen," tells **Doreen Boivin, CPC, CCA**, with Chiro Practice, Inc., in Saco, Maine. She further explains that, "You need to document during the visit and complete it. Trying to go back and create from memory can cause problems later on with legal issues or reimbursement."

Follow 5 Criteria for Quality Clinical Documentation.

Gauge how your documentation stacks up in each area and start making the changes needed to better support coding choice by watching these five areas.

1. Precision: Ensure that your documentation is accurate, exact, and strictly defined. Increased detail reflects greater accuracy in documentation. The degree of specificity in documentation with ICD-10 will perturb even the most experienced clinician.

Example: Take a case documented as degenerative disc disease of the mid cervical region. The ICD-9-CM code for this would be 722.4 (Degeneration of cervical intervertebral disc). The ICD-9 coding does not require site specification. However, in ICD-10 CM codes, there will be a range available to choose from, making it imperative to report the site of pathology:

- M50.30 (Other cervical disc degeneration, unspecified cervical region)
- M50.31 (Other cervical disc degeneration, high cervical region)
- M50.32 (Other cervical disc degeneration, mid-cervical region)
- M50.33 (Other cervical disc degeneration, cervicothoracic region)

2. Completeness: Does your documentation fully address all concerns in the record, and does it include appropriate validation? Many of the ICD-10 codes will require details that most coders may not routinely consider.

Example: An ICD-9 record could say "tension headache" and the code would read 307.81 (Tension headache), excluding Not Otherwise Specified, NOS, and migraine. This code is used if the psychopathology is manifested by a single specific symptom or group of symptoms which is not part of an organic illness or other mental disorder classifiable elsewhere.

Take a sneak peek at the ICD-10 options and you would be amazed with the variety available:

- G44.2 (Tension-type headache)
 - o G44.20 (Tension-type headache, unspecified)

- G44.201 (Tension-type headache, unspecified, intractable)
- G44.209 (Tension-type headache, unspecified, not intractable)
 - o G44.21 (Episodic tension-type headache)
 - o G44.22 (Chronic tension-type headache).

Avoiding unspecified codes is always a good idea until the documentation leaves you with no options. A more complete note for this case should therefore include at least:

- The type of headache
- Whether it is episodic or chronic
- Whether it responds to medication (intractable or not).

"Always ask yourself, what is the reason for the encounter," stresses Boivin. She has a checklist such as "How did it happen? Is it sudden or chronic? What makes it better? What makes it worse?" You could add these points and create your own checklist.

3. Legibility: No rushed or careless documentation, please. The person looking at the chart should be able to easily read the name and title of the clinician completing the documentation. 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.

4. Reliability: So how much can you bank upon your documentation? Does it support the rationale for the diagnoses and for medical necessity? The reliability is related to every single visit note. "Always try to put it in the patient's words," advises Boivin. Most denials and down coding occur when visit notes don't support the codes you report based on the original assessment.

5. Consistency: Be wary of eradicating any contradictory statements in the record. Are there conflicting opinions between providers that have not been clarified? Make sure any inconsistencies are addressed. Try to get everyone on the same page, and encourage coordination and communication between the disciplines. "The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care," says AHIMA. The generation of a query may arise when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Example of a clinical scenario where a query may arise:

Documentation: Laboratory finding of serum sodium of potassium is 4.5 mEq/L and the attending physician documents hyperkalemia in the final diagnostic statement. This could lead to a query such as:

Query: Please review the laboratory section of the present record to confirm your diagnosis of hyperkalemia. Laboratory findings indicate a serum sodium of 4.5 mEq/L/.

Take 20 Minutes to Ease Documentation Worries



Simply spending 20 minutes a day studying your current records can help keep your ICD-10 worries at bay.

Take on a recent patient record and identify the ICD-9 codes for the service. Next, make use of the General Equivalency Mappings (GEMs) or search for keywords in the alphabetic index of ICD-10 to narrow your ICD-10 choices. Then, check for the final codes in the ICD-10 tabular list and look for the information to report the code to the highest level of specificity. See if you would need to code till the fourth, fifth, sixth or seventh character. Look for the clinical descriptor at the level of each character, paying attention to the excludes1 and excludes 2 notes.

Compare all of this information with the existing details in the patient record and update the record with any missing pieces for assigning an ICD-10 code. Make a ready reference note to use for documentation of similar patients in the future.

Set your goals: Challenge yourself to follow this process for 100 patient records in the coming months. If you do and keep reference notes of what you learn you could find yourself seamlessly transitioning into the ICD -10 coding world.