EDITOR’S NOTE: This is the final installment in a two-part series on clinical documentation improvement.

Claim delays with slowed production means reduction in revenue. It is difficult to determine the amount of change that would be involved with the additional time necessary to document care, but will be based on how the health plan revise their requirements to support medical necessity, the specialty, and the current status of the documentation in relation to supporting the diagnosis.

Studies have indicated that a 15-20% increase of time to document to the level of specificity could be realized. The Electronic Health Record will not be able to eliminate the extra documentation time requirement. Templates will need to be changed to capture additional notes and documentation requiring extra work.

Analyzing the documentation during the impact assessment, along with conducting medical record documentation audits routinely will enable the organization to assess the impact. The organization should have experienced auditor(s) conduct audits either internally or externally. Random samples should be evaluated and various types of medical records should be reviewed. A clinical documentation assessment tool should be used to conduct this audit to be sure current documentation adequately supports ICD-10. By performing an ICD-10 readiness audit, this will identify problem areas prior to implementation, which will avoid denied and suspended claims in the future. This will also help to formulate documentation training needs for the organization.

Take an in-depth look at the organization’s current level of documentation. Review the lack of specificity in the documentation and analyze how to begin the process of improvement. Review the most common diagnosis codes used and their frequency. Once an audit is conducted and analyzed, the organization will have a good assessment of documentation deficiencies, and can develop a priority list of diagnoses requiring more detail. The audit also helps identify practitioners who will benefit from focused training using ICD-10-CM and PCS.

The buzzword right now is clinical documentation improvement related to inpatient and
outpatient services in the hospital setting. But I have to wonder doesn’t the clinical documentation begin with the practitioner?

I do agree we should work diligently in the hospital setting to improve documentation. Especially with the level of specificity we need to reach with ICD-10. But what about in the physician practices? I feel strongly we need Clinical Documentation Improvement Programs within the medical practice setting along with certified Clinical Documentation Improvement Practitioners to assist physicians in reaching specificity in documentation not just for the diagnosis but also the procedure submitted on the claim.

Many medical practices have over the years taken the Office of the Inspector General’s (OIG) advice and implemented compliance in their medical practice. As part of compliance auditing and monitoring is one of the components. However, how often do you audit and monitor? How often do you work with the practitioners on his/her documentation? I would guess for many it is one time per year. But is that enough? As part of Clinical Documentation Improvement and the impending implementation deadline for ICD-10 physicians and non-physician practitioners would benefit by ongoing support. What does this mean? Create a clinical documentation improvement plan within the medical practice. Hospitals have the luxury of many software programs to assist with Clinical Documentation Improvement, but there are few tools and resources that translate to the medical practice.

When creating you Clinical Documentation Improvement Plan, put your plan in writing. For example:

Review documentation for 5-10% of all claims submitted by each practitioner per week. Create a tracking report monthly and share it with the practitioners. This will give you insight as to what assistance each practitioner needs. Some of the practitioners will need help with documenting procedures, while most will need guidance in documenting diagnoses.

In my 20+ years of auditing one of the consistent problems I run across in the physician office record is the assessment and plan does not give us a clear picture of the patient’s condition and management options considered. In addition when you are performing documentation audits, it is important to review the ICD-10 code(s) to make sure the current documentation can support a specific ICD-10 code. In many cases currently with the expansion of the codes and change in terminology you will find a significant deficiency for ICD-10-CM.
This invaluable information will allow you to build training for the practitioners and assist them with improving documentation to support not only the procedure but the ICD-10 codes as well. By beginning the improvement process now, it will allow more accuracy, and will ensure there is not a dramatic decrease in productivity when ICD-10 is fully implemented October 1, 2014.

About the Author

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