# ICD-10-CM Clinical Documentation Assessment

North Carolina Public Health

# Training Objectives

- Understand why performing a Clinical Documentation Assessment is an essential part of the transition to ICD-10-CM
- Understand how each agency could conduct a Clinical Documentation Assessment
- Review findings from the DPH ICD-10 Implementation Team Clinical Documentation Assessment Pilot
- Understand the need for an ongoing Clinical Documentation Improvement Program

# Clinical Documentation Assessment Objectives

- Ensure that clinical documentation is sufficient to assign ICD-10-CM codes at the highest level of specificity
  - ICD-10-CM includes a more robust definition of severity, comorbidities, complications, sequelae, manifestations, causes and a variety of other important parameters that characterize a client's condition
  - Diagnosis codes support medical necessity for billed services
- An ICD-10-CM Clinical Documentation Assessment will:
  - Evaluate a healthcare provider's current documentation in preparation for ICD-10-CM
  - Identify documentation deficiencies and develop documentation improvement strategies (e.g., education) needed to improve documentation
  - Help avoid denied or un-billable claims and reduce the risk of interruption in revenue

# Clinical Documentation Assessment Objectives (cont'd)

- Development of a priority list of diagnoses requiring more granularity or other changes in data capture and recording
- Identification of changes/additions that may be needed in electronic medical records to ensure that the information captured will result in assignment of ICD-10-CM codes to the highest level of specificity and accuracy

# Clinical Documentation Assessment Process

- All DPH stakeholders (DPH, CDSAs, rural health clinics, local health departments) must be ready to transition to ICD-10-CM on 10/1/2014
- To ensure agencies are prepared for the transition, an assessment of current documentation practices need to be conducted **now** in order to implement and monitor document improvement strategies
- DPH ICD-10 Implementation Team conducted Clinical Documentation Assessment pilots in the following agencies:
  - Raleigh CDSA
  - Johnston County Health Dept (EMR)
  - Franklin County Health Dept (Primary Care)
  - Macon County Health Dept (no Primary Care)
  - Office of Chief Medical Examiner

# Clinical Documentation Assessment Process

- Before conducting a Clinical Documentation Assessment, persons conducting the assessment must first be trained in ICD-10-CM
- Determine the type of records to be randomly selected for review
  - Refer to WBS 3.3, Clinical Documentation Assessment posted at http://publichealth.nc.gov/lhd/icd10/deliverables.htm
- Each agency should determine the content within each record that will be reviewed

# Clinical Documentation Assessment Process

- Collaborative review process works well
  - For example, team of 3 individuals (with at least one clinician) review assigned records
  - Review team ascertains if documentation improvements are needed in order to code to the highest level of specificity
- ICD-10-CM Clinical Documentation Worksheet
  - http://publichealth.nc.gov/lhd/icd10/deliverables.htm
- Compile analysis of findings and strategies needed in order to improve documentation before 10/1/14

# Example

- Client presents with severe ear pain. Physician performs and documents an assessment including a history pertinent to the reason for the visit, examination findings and provides diagnosis of Acute Otitis Media
  - In ICD-9-CM, code 381.00, Unspecified Acute Nonsuppurative Otitis Media, is assigned
  - In ICD-10-CM, the diagnosis of Acute Nonsuppurative Otitis Media would be H65.19- which is an incomplete diagnosis and further documentation (e.g., which ear(s) are affected; is the problem initial or recurrent) is needed in order to assign a correct code
  - Documentation such as "Client has an acute onset of nonsuppurative otitis media of the left ear, which is recurrent" is needed to assign an accurate code
    - H65.195 – Other acute nonsuppurative otitis media, recurrent, left ear

# ICD-10-CM Myths

- The increase in documentation required by ICD-10-CM will demand a huge amount of content added to the medical record

- ICD-10-CM requires knowledge of unnecessary and unknown details of a client's illness or condition

# Pilot Findings

- There was information in the medical record that would permit more specific code assignment and/or additional code assignment
- Laterality, infectious agents, type of diabetes, etc. were not always documented so unable to code to highest level of specificity
- Diagnostic code in the record was not supported by the documentation
  - The diagnosis codes that were billed were identified but in the client record, the diagnosis was difficult to find or missing

# Possible Strategies

- Review client record forms or EMR pull down screens to determine if any of the following should be added or terminology needs to be revised
  - Side of dominance (Left, Right, Ambidextrous)
  - Laterality (Left, Right, Bilateral – for all paired organs or structures)
  - Ordinality (Initial or Subsequent encounter; Are symptoms the sequelae [previously known as late effect] of initial event?)
  - Asthma Severity Classification Scale (Intermittent, Mild persistent, Moderate persistent, Severe persistent)
  - Differentiation between general and focal seizures
  - Identification of the substance related to adverse effect, poisoning or toxic effect
- Educate clinical staff about documentation deficiencies identified during the Clinical Documentation Assessment

# Possible Strategies

- Simulate typical client encounters to ascertain that data is being documented thoroughly and consistently
- Form coalitions with other CDSAs
- Implement a Clinical Documentation Improvement program
  - Purpose: To initiate concurrent and, as appropriate, retrospective reviews of client records for conflicting, incomplete, or nonspecific provider documentation

# Clinical Documentation Improvement (CDI) Program Goals

- Identify and clarify missing, conflicting, or nonspecific clinician documentation related to diagnoses and services provided
- Support accurate ICD-10-CM diagnostic and CPT/HCPCS procedural coding leading to appropriate reimbursement
  - The diagnosis codes support medical necessity and are used for medical review, auditing and coverage
- Promote health record completion during the client's course of care
- Improve communication between clinicians and other members of the healthcare team
- Provide education

# CDI Program Policy Content

- General policy declaring the agency's commitment to correctly assign and report ICD-10-CM and CPT codes
- Source(s) used as the basis for code selection (e.g., 2014 ICD-10-CM Coding Guidelines available on the CDC website)
- Designate staff responsible for code assignment
- Procedure to follow when staff assigned responsibility for code assignment are unsure or unable to identify the correct code
- Identification of any payer-specific requirements related to code assignments
- Appropriate methods for resolving coding or documentation disputes with clinicians

# CDI Program Policy Content

- Procedure to follow when documentation in the client record is not clear or complete to assign the correct code (e.g., send query to clinician)
  - Sample CDI Clarification Form is in WBS 3.3 (Appendix D)
  - Queries to a clinician should be:
    - Clearly and concisely written, contain precise language, present the facts and why clarification is needed, present the scenario
    - Individualized to each client and contain clinical evidence specific to the case
    - Non-leading
    - Used to clarify the intent of the clinician
    - Include the option that no additional documentation or clarification can be provided
  - Queries should not:
    - Result in a yes/no answer
    - Be used as a substitute for appropriate clinician documentation in the record
    - Indicate to the provider an increase/decrease in payment
    - Introduce information not otherwise contained in the medical record

# CDI Program Policy Content

- Procedures for correction of inaccurate code assignments in the client record, health information system or to agencies where the codes have been reported
- Defined audit plan for code accuracy and consistency review and corrective action plan for identified problems
- Identification of coding resources available to staff responsible for code assignment
- Identification of optional codes an agency captures for statistical and/or clinical purposes. For Example:
  - Personal history codes
  - Family history codes
  - Clarify the use of External Causes of Morbidity (Chapter 20)

# CDI Program Policy Content

- Procedures for processing claim rejections that are due to code assignment
  - Clarify that codes will not be assigned, modified or excluded for the purpose of maximizing reimbursement or avoiding reduced payment
  - Specify that codes will not be changed or amended for the sole purpose of having the service covered by Medicaid or other insurance
  - If the initial code assignment did not reflect the client's condition or services provided, codes may be revised as long as there is documentation in the client record to support the change
- Policy statement that code assignments must be supported by
  - Complete and appropriate client record documentation including the specific reason for an encounter (e.g., specific diagnoses as well as symptoms or problems that clarify the reason for the encounter)
  - any conditions treated (e.g, physician order for services)

# Questions

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Submit Questions to:

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