Clinical Documentation Improvement

Presented by: Rhonda Buckholtz

No part of this presentation may be reproduced or transmitted in any form or by any means (graphically, electronically, or mechanically, including photocopying, recording, or taping) without the expressed written permission of AAPC.
Agenda

• Benefits of documentation
• Documentation Concepts in ICD-10
• Case examples

Benefits of Proper Documentation

• Improves compliance
• Improves patient care
• Improves clinical data for research and education
• Protects the legal interest of the patient, facility and physician
• Enables proper reimbursement for services performed
Documentation Audits

- Analysis of documentation for content and validity/medical necessity relationship
- Analysis of documentation in relationship to coding and billing
- Identification of patterns and trends in documentation

Identification of risk areas in documentation, i.e. illegibility or improper use of symbols and abbreviations
- Analysis of documentation for compliance issues
- Education and training on documentation improvement opportunities
Supporting Medical Necessity

- Justification of care depends on information found in the medical record
  - Diagnosis codes identify circumstances of patient encounter
  - Medical record documentation must be supportive

Coding/Billing
- Does documentation support code?
- Are there policies in play?

Quality Reporting
- Does documentation support reporting requirements
- Are disease processes well documented

Compliance
- Are operative notes complete in information
- Have all areas of risk been identified and covered by documentation?
Documentation

“Documentation is only good if the next physician who treats the patient can pick up your record and know exactly what happened”

Criteria for Documentation

- Evidence-based
  - Past and present diagnoses easily accessible
  - Appropriate health risk factors identified
  - If not documented, easily inferred
  - Patient progress and response to any changes in treatment or revisions of diagnosis should be documented
Criteria for Documentation

• Evidence-based
  – Each patient encounter should include:
    • Reason for the encounter with relevant history
    • Examination findings
    • Diagnostic test results
    • Assessments
    • Clinical impressions
    • Plan of care

Criteria for Documentation

• Precision
  – Example:
    • Patient is seen for shortness of breath, chest pain, fever and cough; chest xray indicates aspiration pneumonia- physicians assessment states pneumonia
      – Complete, precise documentation would indicate in the assessment that the patient has aspiration pneumonia- further query of the patient should be done to determine the cause of the aspiration, such as food, milk, solids, microorganisms, etc…
Common Traps and Pitfalls

Example: EMR

Assessment #1: 780.52 Insomnia unspecified
Plan:
Follow Up: 6 months
Example: Medical Necessity

CC: Patient presents with no complaints
HPI: Pt here with no real complaints doing well………
A/P:
Diabetic neuropathy
Hyperlipidemia
Hypertension

Example: Legibility
ICD-10’s Greatest Challenge

• Documentation sufficient to support:
  – Specificity
  – Granularity

WORKING WITH PHYSICIANS ON ICD-10
NO ONE likes change….

- Period…
  - It’s not about changing how they care for their patients
  - Empathy is important
    - …. At the end of the day it really should be all about good patient care… the rest just falls into place…

All decisions should be this clear
Unfortunately they are not....
Documentation Concepts

- Approximately 21 unique concepts
  - Breaking down ICD-10-CM into concepts

Clinical Concepts

- Type
- Temporal factors
- Caused by/Contributing factors
- Symptoms/Findings/Manifestations
- Localization/Laterality
- Anatomy
- Associated with
- Severity
- Episode
- Remission status

- History of
- Morphology
- Complicated by
- External Cause
- Activity
- Place of Occurrence
- Loss of Consciousness
- Substance
- Number of Gestations
- Outcome of Delivery
- BMI
Clinical Documentation Improvement

Specificity

- Laterality
- Temporal Factors
- Anatomic Location
- Other issues

Laterality

- The addition of laterality into the code set is one of the reasons for the increased number of codes in ICD-10-CM.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>370.34 Exposure keratoconjunctivitis</td>
<td>H16.211  Exposure keratoconjunctivitis, right eye</td>
</tr>
<tr>
<td></td>
<td>H16.212  Exposure keratoconjunctivitis, left eye</td>
</tr>
<tr>
<td></td>
<td>H16.213  Exposure keratoconjunctivitis, bilateral</td>
</tr>
<tr>
<td></td>
<td>H16.219  Exposure keratoconjunctivitis, unspecified eye</td>
</tr>
</tbody>
</table>
Example A

Patient presents with superficial foreign body in finger of left hand. Piece of glass was removed from finger, antibiotic ointment placed, and Band-Aid put on finger.

S60.459A  Superficial foreign body of unspecified finger, initial encounter

Example B

Patient presents with superficial foreign body in left index finger. Piece of glass was removed from finger, antibiotic ointment placed, and Band-Aid put on finger.

S60.451A  Superficial foreign body of left index finger, initial encounter
Patient presents with a fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.301A Unspecified fracture of shaft of humerus, right arm, initial encounter for closed fracture

---

Patient presents with an oblique fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.331A Displaced oblique fracture of shaft of humerus, right arm, initial encounter for closed fracture
Temporal Factors

- Acute
- Chronic
- Acute on Chronic
- Recurrent

Example A

Joy presents for recheck on her bronchitis. She states she is less short of breath when walking up stairs this week. She says the albuterol is helping her breathing.

J40 Bronchitis, not specified as acute or chronic
Joy presents for a recheck on her simple chronic bronchitis. She states she is less short of breath when walking up stairs this week. She says the albuterol is helping her breathing.

J41.0 Simple chronic bronchitis

Anatomic Location

Many codes in ICD-10-CM have site specificity, including:

• Fracture coding
• Dislocations
• Pressure ulcers
• Burns and corrosions
• Lacerations
• Open bites
Example A

Jon is brought in by his mother for a recheck of his radial Torus fracture of the right arm. Everything is healing well after 2 weeks. Mom will bring him back next week for possible cast removal.

S52.91XD Unspecified fracture of right forearm, subsequent encounter with routine healing

Example B

Jon is brought in by his mother for a recheck of his distal radial Torus fracture of the right arm. Everything is healing well after 2 weeks. Mom will bring him back next week for possible cast removal.

S52.521D Torus fracture of lower end of right radius, subsequent encounter with routine healing
Other and Multiple Concepts

- In some cases, multiple concepts will be present in the same case (temporal factors, anatomic location, laterality).
- Providers need full education on these areas to ensure that unspecified codes will not be used
  - This will prevent multiple provider queries to receive enough information to assign a code.

Example A

Patricia brings in her daughter for ear pain. Jane is 2 years-old and has been pulling at her ears and crying. Patricia noted a fever this morning, so she called to get Jane in to be seen. Upon exam, a bulging, cloudy, immobile tympanic membrane is seen with purulent fluid. Diagnosis: **Purulent otitis media**.

H66.40 Suppurative otitis media, unspecified, unspecified ear
Example B

Patricia brings in her daughter for ear pain. Jane is 2 years-old and has been pulling at her ears and crying. Patricia noted a fever this morning, so she to get Jane in to be seen. **Jane has suffered bouts with acute purulent OM 3 times in the past 5 months. She goes on antibiotics, gets better, then the condition recurs.** Upon exam, a bulging, cloudy immobile **right** tympanic membrane is seen with purulent fluid. Left ear is normal. Diagnosis: **Right recurrent purulent OM.**

H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear

Example A

Linda is in today for a follow-up of her **atrial fibrillation.** Meds: Cardizem. She states her heart rate is up just a little bit today. No chest pains. No shortness of breath. **ECG: AFib with nonspecific ST-T changes.**

I48.91 Unspecified atrial fibrillation
Example B

Linda is in today for a follow-up of her persistent atrial fibrillation. Condition present for more than 2 years. Meds: Cardizem. She states her heart rate is up just a little bit today. She is experiencing more frequent symptomatic AFib recurrence with symptoms lasting for 5 days. No chest pains. No shortness of breath. ECG: AFib with nonspecific ST-T changes.

I48.1 Persistent atrial fibrillation

Example A

CHIEF COMPLAINT: Sinus problems. Symptoms include postnasal drainage, sore throat, facial pain, coughing, headaches and congestion. The symptoms are characterized as moderate to severe. Symptoms are worse in the evening and morning.

EXAM: Exam Nose: Intranasal exam reveals moderate congestion and purulent mucus. Exam Facial: There is bilateral sinus tenderness to palpation.

IMPRESSION: sinusitis

J32.9 Chronic sinusitis, unspecified
Example B

CHIEF COMPLAINT: Sinus problems. The problem began 2 weeks ago and is constant. Symptoms include postnasal drainage, sore throat, facial pain, coughing, headaches and congestion. The symptoms are characterized as moderate to severe. Symptoms are worse in the evening and morning.

EXAM: Exam Nose: Intranasal exam reveals moderate congestion and purulent mucus. Exam Facial: There is bilateral maxillary sinus tenderness to palpation.

IMPRESSION: Acute maxillary sinusitis

J01.00 Acute maxillary sinusitis, unspecified

Fractures

• Contributing factors
• Type
• Underlying conditions
• Anatomic Location
• Complications
• Localization/Laterality
35 year old presented to the emergency department with a painful, right wrist. Upon examination the wrist is swollen and there is pain with palpation of the wrist area with limited grip strength of the right hand. Pain is noted to be in the anatomic snuffbox and upon extension a radial deviation is noted. A mid third scaphoid fracture is confirmed by plain film. Fracture is reduced in office and patient is placed in a long arm cast.

S62.021A Fracture of middle third of navicular [scaphoid] bone of right wrist, initial encounter for closed fracture

Documentation Requirements

- In order to assist providers with clinical documentation improvement, it is necessary that the coder/auditor/educator understand the documentation requirements of the most commonly coded conditions in their specialty.
Hypertension

- Type
- Associated complications
- Severity
- Symptoms/Findings/Manifestations
- Temporal factors
- Contributing factors

Congestive Heart Failure

- Type
- Contributing factors
- Temporal factors
- Associated conditions
Example

Subjective: 75 year old female is seen for follow up for chronic hypertensive heart disease. She has been having ongoing shortness of breath and orthopnea. Recent EKG demonstrates finding consistent with cardiomegaly, but not recent change since a prior EKG. Currently she is on Lasix, Lanoxin and Atenolol.

Objective: BP = 175/95. HR = 100. Chest x-ray show mild pulmonary edema. There is 2+ pitting edema in both ankles.

Assessment: Hypertension – poorly controlled Chronic diastolic congestive heart failure

I11.0 Hypertensive heart disease with heart failure
I50.32 Chronic diastolic (congestive) heart failure

Osteoarthritis

- Type
- Contributing factors
- Symptoms/Findings/Manifestations
- Localization/Laterality
- Anatomy
Example

**Subjective:** 66-yr-old with a history of slowly progressive pain in the left knee. She has noted some enlargement of the knee and considerable crepitance on motion. There has been no significant warmth or redness and symptoms appear confined to that knee. She has difficulty getting out of a chair and can only walk for 2 blocks with a cane. She cannot recall any history of trauma to the knee.

**Objective:** Exam reveals range of motion limited between 15 and 90 degrees. There is severe crepitance on motion and palpable osteophytes. Minimal effusion is noted. There is moderate genu varus on standing. X-rays demonstrate marked joint space loss particularly in the medial compartment with prominent diffuse osteophytes.

Assessment: Primary osteoarthritis confined to the left knee

M17.12 Unilateral primary osteoarthritis, left knee
Subjective: Patient presents with complaint of intermittent headaches. He has had similar headaches for 10 years and comes in now because they used to occur 2-3 times a year and now they are occurring 3-4 times a month. The headaches are so severe that he is unable to work while having one. He describes them as a throbbing pain behind his right eye. The headaches are often associated with nausea and in the last few months he has occasionally vomited with them. Light aggravates his symptoms, but he has no visual symptoms associated with the headaches.

Objective: His neurologic exam is unremarkable.

Assessment: Chronic Migraine

G43.709 Chronic migraine without aura, not intractable, without status migrainosus
Sinusitis

- Anatomy
- Temporal factors
- Contributing factors

Example

**Subjective:** This patient is a 7 year-old female who was seen in the office for discomfort in the **maxillary region**. For the previous **4-5 years** the patient had suffered from **chronic sinus problems** of a similar type. Symptoms included constant nasal congestion, coughing, and snoring. The patient has been **exposed to second-hand smoke from family members**.

**Objective:** An initial exam showed edematous red nasal mucosa and colored nasal discharge. Allergy testing results were negative. A CT scan confirmed **bilateral maxillary blockage and bilateral thickening** of the mucus membrane.
Example

- **Assessment:** Chronic Maxillary sinusitis, Secondary tobacco smoke exposure

- J32.0 Chronic maxillary sinusitis
- Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)

Overweight and Obesity

- Severity
- Contributing factors
- Association
- Symptoms/Findings/Manifestations
**Subjective:** A 49-year old AA woman presented for weight loss treatment. She has attempted to lose weight through a variety of diets but has had no meaningful success. She states that she “loves food” and particularly is “addicted to sweets”.

**Objective:** On exam, she was 64 inches tall and weighed 230 pounds yielding a **BMI of 39.5**.

**Dx:** Severe obesity due to excessive caloric intake

- E66.01 Morbid (severe) obesity due to excessive calories
- Z68.39 Body mass index (BMI) 39.0-39.39, adult

---

**Diabetes Mellitus**

- Type
- Pregnancy-related
- Complications
Subjective: 56-year-old obese male with a long history of adult onset diabetes mellitus. He is seen for a follow up evaluation and currently has no new symptoms. He has been dependent on insulin for 10 years and has stage 2 diabetic chronic kidney disease. He does not keep his calories or diet in range.

Objective: Weight = 245. Height = 5' 10''. Blood glucose = 125. Exam otherwise unremarkable. Calculated BMI = 35.1

Assessment: Type 2 diabetes mellitus with CKD stage 2 Obesity

E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
N18.2 Chronic kidney disease, stage 2 (mild)
E66.09 Other obesity due to excess calories
Z79.4 Long term (current) use of insulin

Mood Affective Disorders

- Type
- Temporal factors
- Severity
- Symptoms/Findings/Manifestations
- Remission status
Example

Subjective: 48 year old male with long history of Bipolar disorder currently being treated with lithium carbonate. He presents with a recent symptoms of sleep deprivations, lethargy constipation and general malaise. He states that he feels hopeless. He also state that he feels he is being persecuted and the victim of a government plot to kill him.

Objective: Appears depressed with slow psychomotor function. Physical and neurologic exam is normal

Assessment: Bipolar disorder, severe, Current major depressive manifestations, Paranoid delusions

F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features

Assisting Providers with Transition

- A real emphasis needs to be made with the practitioners to move away from usage of unspecified codes.
- There is a high risk for denial by payers under ICD-10-CM for certain unspecified code usage.
Assisting Providers with Transition

- Template Assessments
  - EMR
  - Paper
- Update where necessary
- Educate on changes with time enough to become familiar with them

Assisting Providers with Transition

- Documentation Assessments
  - Compares current documentation against ICD-10-CM specificity
  - Run by entire practice
  - Run by clinic/facility
  - Run by provider
Assisting Providers with Transition

- **Documentation Assessments by Provider**
  - Run top diagnosis against recent patient visits
  - Pull 10-15 recent charts with that diagnosis
  - Assign ICD-10-CM code(s)
  - Create a report
  - Meet with provider
  - Re-assess

---

### Documentation Assessment Forms

**Physician Name:** Raymond Smith, MD  **Date of Audit:** XXXX

**Reviewer (Auditor):** Mary Ellen Ellis, CPC, CPC-H, CPMA

<table>
<thead>
<tr>
<th>Chart</th>
<th>Patient ID</th>
<th>ICD-10-CM code</th>
<th>ICD-10-CM code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A244893</td>
<td>L25.9</td>
<td>Unspecified contact dermatitis, unspecified cause</td>
</tr>
</tbody>
</table>

In ICD-10-CM, in order to assign a code for contact dermatitis to the highest level of specificity, documentation needs to include type and causation.

<table>
<thead>
<tr>
<th>Chart</th>
<th>Patient ID</th>
<th>ICD-10-CM code</th>
<th>ICD-10-CM code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>J990356</td>
<td>L24.1</td>
<td>Irritant contact dermatitis due to oils and grease</td>
</tr>
</tbody>
</table>

Code appears to make transition to ICD-10-CM.

<table>
<thead>
<tr>
<th>Chart</th>
<th>Patient ID</th>
<th>ICD-10-CM code(s)</th>
<th>ICD-10-CM code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>K480353</td>
<td>L23.9</td>
<td>Allergic contact dermatitis, unspecified cause</td>
</tr>
</tbody>
</table>

In ICD-10-CM, in order to assign a code for contact dermatitis to the highest level of specificity, documentation needs to include type and causation.
Impact

• Denied claims
• Pended claims
• Medical necessity

Summary

• Understand the unique clinical concepts for your practice/specialty
• Review EMR/EHR to see what additions can be added to assist
• Perform documentation assessments to see where improvements may be needed
• Provide clear concise education on noted weaknesses
• Re-evaluate after implementation