Revenue Cycle Management – Clinical:

Clinical Documentation and Coding

What is clinical documentation and why is it important?

Clinical documentation should be an accurate representation of a patient's clinical status. This information is translated into coded data. Coded data is then translated into quality reporting, physician report cards, reimbursement, public health data, and disease tracking and trending.

According to the Centers for Medicare and Medicaid Services (CMS), medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to better manage the patient's care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations and
- Collection of data that may be useful for research and education

Source: Centers for Medicare and Medicaid Services

Document every step you take. Remember: if it's not documented in the record, it did not happen.

Clinical documentation has a direct impact on patient care and should paint a clear picture of the encounter from beginning to end. Providers should have a working understanding of documentation guidelines and coding principles to capture information that is clear, concise and complete.

In order to be meaningful, documentation must:

- Adhere to CMS Documentation Guidelines and requirements
- Contain proper diagnostic and procedure code assignment
- Be accurate, timely, and reflect the scope of services provided

Where can I find more information about documentation and coding?

CMS and organizations like the National Committee for Quality Assurance (NCQA) have free online resources covering a wide range of topics. They are leading the way towards improving the quality of health care and producing better patient outcomes in the United States. At the core of these efforts is Clinical Documentation Improvement (CDI) and coding.

Documenting Evaluation and Management (E&M) Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Documentation of Evaluation and Management services has been under scrutiny for some time now. Claims sent to Medicare for E&M visits have shown high errors in the following areas:

- Insufficient documentation,
- No documentation, and
- Incorrect coding

These errors lead to documentation that does not support medical necessity and can cause inaccurate billing of E&M services.

It is suggested that all staff who perform charting responsibilities take time to access the CMS Evaluation and Management Services Guide online. The guide explains documentation guidelines in detail, and gives examples for documenting the History, Examination and Medical Decision Making for an E&M visit.

NCQA Guidelines for Medical Record Documentation

http://www.ncqa.org/Portals/0/PolicyUpdates/Supplemental/Guidelines_Medical_Record_Review.pdf?ver=2007-02-08-105600-000

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following 21 elements reflect a set of commonly accepted standards for medical record documentation. An organization may use these elements to develop standards for medical record documentation.

NCQA considers 6 of the 21 elements as core components to medical record documentation. Core elements are indicated by an asterisk (*).

1. *Each page in the record contains the patient's name or ID number.*
2. *Personal biographical data include the address, employer, home and work telephone numbers and marital status.*
3. *All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.*
4. *All entries are dated.*
5. *The record is legible to someone other than the writer.*
6. **Significant illnesses and medical conditions are indicated on the problem list.*
7. **Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.*

NCQA Guidelines for Medical Record Documentation (continued)

8. *Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.*
9. *For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).*
10. *The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.*
11. *Laboratory and other studies are ordered, as appropriate.*
12. **Working diagnoses are consistent with findings.*
13. **Treatment plans are consistent with diagnoses.*
14. *Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.*
15. *Unresolved problems from previous office visits are addressed in subsequent visits.*
16. *There is review for under - or overutilization of consultants.*
17. *If a consultation is requested, there a note from the consultant in the record.*
18. *Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.*
19. **There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.*
20. *An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).*
21. *There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.*

Documentation and Coding Resources

To get more information, please follow the links below.

ICD-10-CM codes:
https://www.cdc.gov/nchs/icd/icd10cm.htm

CPT codes:
https://www.ama-assn.org/practice-management/cpt

HCPCS codes:
http://www.cms.gov/medhcpcsgeninfo/162.99.3.205/Financing/file.axd?file=2010%2F11%2FBackgroundofHCPCScoding.pdf

Center for Medicare and Medicaid Services (CMS)
https://www.cms.gov/

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/