Simple Steps to Improve Clinical Documentation: CMS’ Tips for Documentation

Effective October 1, 2014, your practice and the clearinghouses, payers and billing companies you work with will all be required to use ICD-10 codes. One way to help your practice prepare for ICD-10 is to work on improving how you document your clinical services. This will help you and your coding staff become more accustomed to the specific, detailed clinical documentation required to facilitate the best selection of ICD-10 codes.

ICD-10 Captures Familiar Clinical Concepts

Concepts that are new to ICD-10 are not new to clinicians who are already documenting a patient’s chart with more clinical information than an ICD-9 code can capture, such as:

- Initial Encounter, Subsequent Encounter or Sequelae
- Acute or Chronic
- Right or Left
- Normal Healing, Delayed Healing, Nonunion or Malunion

Take a look at documentation for the most often used codes in your practice, and work with your coding staff to determine if the documentation is specific and detailed enough to select the best ICD-10 codes. Many ICD-10 codes—more than one-third—are identical except for indicating laterality, or whether the right or left side of the body is affected. One of the advantages of ICD-10 codes is that they enable clinicians to capture laterality and other concepts in a standardized way that supports data exchange and interoperability for a more efficient health care system.

Below are examples of the specific information needed to accurately code the following common diagnoses:

**Diabetes Mellitus:**
- Type of diabetes
- Body system affected
- Complication or manifestation
- If type 2 diabetes, long-term insulin use

**Fractures:**
- Site
- Laterality
- Type
- Location
Injuries:

- **External cause** – Provide the cause of the injury; when meeting with patients, ask and document “how” the injury happened.

- **Place of occurrence** – Document where the patient was when the injury occurred; for example, include if the patient was at home, at work, in the car, etc.

- **Activity code** – Describe what the patient was doing at the time of the injury; for example, was he or she playing a sport or using a tool?

- **External cause status** – Indicate if the injury was related to military, work, or other.

Remember, ICD-10 will not affect the way you provide patient care. However, it will be affect the way you document patient care. It will be important to make your documentation as detailed as possible since ICD-10 gives more specific choices for coding diagnoses. This information is likely already being shared by the patient during your visit—it’s just a matter of recording it for your coding staff. Good documentation will also help reduce the need to follow-up on submitted claims—saving you time and money.

**Verifying Your Documentation is ICD-10-Ready**
While ICD-10 should not require providers to change documentation practices; reviewing documentation will help you understand how ICD-10 will affect your practice. Understanding the scope of the ICD-10 transition will reduce the likelihood that you will overlook areas that need updates for ICD-10. Complete testing of your ICD-10 documentation all the way through communication with billing services is vital to making sure you have worked out any snags in the process before the October 1, 2014 transition date.

**Keep Up to Date on ICD-10**
Visit the CMS ICD-10 website, [www.cms.gov/Medicare/Coding/ICD10](http://www.cms.gov/Medicare/Coding/ICD10) for the latest news and resources to help you prepare.