Tuesday, 25 March 2014 00:00

ICD-10: The Burden of Documentation

Written by Joseph C. Nichols, MD

One of the common themes we hear about the level of clinical documentation needed to support ICD-10 is that it is a major administrative burden that results in large cost impacts on providers. We have heard that this “unfunded mandate” is causing undue financial hardship and detracting from good patient care.

This is the first in a series of pieces that will challenge some of the myths that seem to have gained wide acceptance with certain parts of the healthcare industry. These myths may be positive or negative toward ICD-10. In this author’s view, there are myths on both sides that need to be discussed objectively with a few alternative viewpoints.

Documentation is not about administrative burden, it’s about good patient care

While there is a sense that the documentation needed to support ICD-10 is an unnecessary burden to clinicians, there is really nothing new about documentation requirements. Documentation is all about what we were taught in medical school: we were taught that part of evaluating a patient should include observing and documenting key aspects of the patient’s presenting condition. There are many parameters that are important to assess and document, depending on the nature of each condition. Below are just a few examples:

- Is this the initial or follow-up encounter?
- Does the condition involve the left or right side of the body?
- Is the pregnancy in the first, second, or third trimester?
- What was the cause of the illness or condition?
- How severe is the condition?
- Is there an infectious agent involved, and if so, what type?
- Is the condition at some stage or level?
- Is there an underlying problem or comorbidity?
- Is this a recurring condition?
- What part of the anatomy is involved?

- Has the patient had some manifestation or complication of the condition that is relevant to care?

Obviously, the parameters of the patient condition will vary depending on the type of condition, and answers may or may not be available at the time of care, but few would disagree that this type of information is important in the context of providing proper care to the patient. An oft-quoted statement we all have heard as part of our training was: “If it wasn’t documented, it didn’t happen.” Clinicians cannot pretend to remember all of the things that are important to patient care in support of each patient throughout the course of their management. The limited set of condition parameters illustrated above accounts for some part of the documentation required for the large majority of the ICD-10-CM codes.

There is virtually no documentation requirement in ICD-10 that should not be considered important to some aspect of good patient care and reliable healthcare data.

Providers should be leaders in capturing healthcare data that improves healthcare delivery

As clinicians, we have been so focused on every single episode of patient interaction that it seems we can tend to lose sight of the broader picture of healthcare delivery and our role in guiding, capturing, analyzing, and using this data to improve the health of the public. As clinicians, we often complain about the inaccuracy of quality measures, the inequity of payment, or the lack or rational application of healthcare policies based on the data we submit. Many clinicians bemoan the use of claims-based data to analyze healthcare because of the poor quality of the data, but to a large degree, the quality of the data is dependent on them. Providers need to take a leadership role in ensuring that we have good data and that it is used wisely to improve the quality of healthcare for all who become involved in the healthcare system at any level.

Good data is dependent on:

- Complete observation of all healthcare parameters appropriate to the patient problem
- Accurate and complete documentation of these patient observations
- Accurate and complete coding of all the important parameters of the patient condition as can be supported by the documentation and the available codes.

Good data is dependent on clinicians.

Accurate healthcare documentation is as important, if not more important, than documentation in other industries

For most industries, vague documentation and imprecise data is unacceptable. Consider the examples below:

Restaurants:

Imagine ordering a filet mignon (medium-rare), braised asparagus with hollandaise sauce, and a glass of Cabernet Sauvignon, Knights Valley, 2008. If the waiter documents “meat unspecified, vegetable with a sauce, and glass of unspecified wine,” it is unlikely that any physician would pay the $90 bill listing these items.

Air Travel:

Imagine if you are on a plane and the pilot announces that “we will be flying to an unspecified location arriving at an unspecified time. By the way, I didn’t do the flight check list because I hate cookbook flying.”

Contractor:

Imagine if a remodeling contract called for an unspecified number of unspecified lights in unspecified locations.

Plumber:

The plumber’s documentation on a $4,000 bill indicates that an unspecified procedure was done with unspecified hardware for an unspecified problem.

Shoes:

Most shoppers would not buy a pair of shoes of an unspecified color or a brand for an unspecified price.

In almost every other industry, specificity matters. It should matter more in healthcare.

We get what we demand

An analysis by Health Data Consulting of three years of payor data, representing all lines of business for a million patients and including more than 17 million claims, showed that for ICD-9-based data, 5 percent of the 14,000 ICD-9 codes accounted for 73 percent of the charges. The vast majority of these codes were either unspecified codes or codes that simply represented the patient sign or symptom. There is little doubt that poorly specified documentation and coding has plagued the industry for years. For some reason, however, we have been reticent to demand good documentation and data as a requirement of good patient care and appropriate payment. We seem to believe the myth that if we require better observation, documentation, and coding, patient care will suffer.

It’s time to demand that the price we are paying for healthcare is supported by accurate data about what was done and why. We cannot improve what we can’t measure. At the present time we don’t have good data to understand why we spend three times as much per capita for healthcare as Japan[1], why Japan is No. 1 worldwide in terms of life expectancy and we are 38, or why we have three times the infant mortality

rate of Japan. We may have many anecdotal answers to some of these questions, but we don't have reliable, accurate data to understand if we are really getting value for the extremely high price we pay for healthcare.

The bottom line:

- Good healthcare requires complete and accurate observation and documentation.
- Reliable and accurate data requires consistent, guideline-driven coding based on good documentation.
- Good healthcare policy aimed at improving the health of the population at large requires proper analysis of reliable and accurate data.
- Good healthcare information depends on payors and other healthcare entities demanding good data, and providers delivering it.

About the Author

Dr. Nichols is a board certified orthopedic surgeon with a long history in health information technology. He has a wide range of experiences in healthcare information technology on the provider, payer, government and vendor side of healthcare business. He has served in positions in executive management, system design, logical database architecture, product management, consulting and healthcare value measurement for the last 15 of his 35 years in the healthcare industry. He has given over 100 presentations nationally related to ICD-10 over the past three years on behalf of payers, providers, integrated delivery systems, consulting groups, CMS, universities, government entities, vendors and trade associations. He co-chairs the WEDI (Workgroup on Electronic Data Interchange) translation and coding sub-workgroup and has received WEDI merit awards three years in succession. He is also an AHIMA approved ICD-10 coding trainer. He is currently providing consulting services as the president of Health Data Consulting Inc.

Contact the Author

joenichols@healthdataconsulting.com

To comment on this article please go to **editor@icd10monitor.com**

1 Kaiser Family Foundation based on: Organization for Economic Co-operation and Development (2013), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2013)

Read **1780** times Last modified on Monday, 24 March 2014 17:48

Tweet 0 Like Be the first of your friends to like this. g+1

Joseph C. Nichols, MD

Dr. Nichols is a board certified orthopedic surgeon with a long history in health information technology. He has a wide range of experiences in healthcare information technology on the provider, payer, government and vendor side of healthcare business. He has served in positions in executive management, system design, logical database architecture, product management, consulting and healthcare value measurement for the last 15 of his 35 years in the healthcare industry. He has given over 100 presentations nationally related to ICD-10 over the past three years on behalf of payers, providers, integrated delivery systems, consulting groups, CMS, universities, government entities, vendors and trade associations. He co-chairs the WEDI (Workgroup on Electronic Data Interchange) translation and coding sub-workgroup and has received WEDI merit awards three years in succession. He is also an AHIMA approved ICD-10 coding trainer. He is currently providing consulting services as the president of Health Data Consulting Inc.