Carrots and Sticks in Coding: Why Good Documentation Matters

By Kathleen McCarry, MGMA of Greater St. Louis

Editor’s Note:
SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA) which will include sharing information in publications, across websites, through organizational committees, and via joint educational programs. MGMA is committed to providing helpful management information to SLMMS members and their office staffs. The MGMA of Greater St. Louis has over 250 practice manager members representing over 140 local physician practices, as well as over 75 business partner members.

As I facilitated numerous ICD-10 workshops over the past year, some disturbing truths revealed themselves: Too few physicians are compliant in their documentation, and most physicians assign the diagnoses codes themselves without consultation or audit from their billers prior to claims submission. Not only will these realities make the ICD-10 transition difficult, but due to non-compliant coding, physicians may be missing out on many opportunities and exposing themselves to unnecessary risks.

Physicians know their patients and the conditions they’re treating. When asked if their documentation is compliant, the response is often: “It must be; I documented what I did.” However, there are attributes of truly compliant documentation:

- Legible
- Signed with a signature that matches the one on your practice’s signature card
- Complete
- Clear
- Consistent
- Precise and to the highest level of specificity
- Required for any significant reportable condition or procedure

Why does it matter? Here are some of the carrots and sticks:

**Carrots:**
- Better patient outcomes
  - Improved communication with other care providers
  - Error reduction
  - Increased chance of success
  - Pay-for-performance contracts
  - Quality and physician report cards
  - Claims reimbursement
  - Reduction of audit risk

**Sticks:**
- Slow, or no, claim reimbursement
- Audit paybacks and recoupment
- Sanctions and exclusions from health plans
- Malpractice claims (I recently read that office-based incidents account for approximately 28% of claims against physicians. Would your documentation suffice in your defense?)

What’s the Point?

Whether you are motivated by the carrots or the sticks, you must take advantage of the delay in ICD-10 implementation and embark, with your billing and coding team, on a clinical documentation improvement journey.

- Educate yourself on compliant documentation.
- Ask your billing staff to provide you with relevant written coding rules and guidelines from Medicare, your payers, and the coding book, and insist on receiving updates as they occur.
- Encourage your staff to partake in outside education via professional societies such as the MGMA. Open the door for them to create an effective, compliant process by which to query you if your documentation doesn’t meet the criteria, and learn from these queries.

Ultimately, this journey will lead you to the carrots, help you to avoid the sticks, and put you in a much better position for a smooth transition to ICD-10.

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