Physician Documentation: The Main Ingredient for Specificity

Quality physician documentation is the foundation of every patient’s medical record, and accurate coding is driven by timely, consistent, and patient-specific documentation. The implementation of ICD-10 has increased the need for clear, detailed, and specific documentation for accurate coding. This presentation explains how adding details to physician documentation leads to the selection of more-specific ICD-codes that better illustrate the patient’s medical necessity, thereby providing better justification for the patient’s admission and ensuring a lower coding error rate.

Learning objectives:

• Describe the benefits of superior physician documentation and the direct relationship between documentation and accurate coding.

• Describe how nonspecific documentation can affect a facility’s presumptive compliance with the 60% rule.

• Describe methods for engaging physicians to overcome gaps in documentation.

• Describe how physicians can use quality documentation to support the impairment group, etiological diagnosis, and complications.

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