

ICD-10 Implementation Team – Clinical Documentation Work Group Minutes

November 2, 2011

1:00pm – 2:00pm

Conference number: **1-888-363-4734**; Access Code: **2142113#**

<https://dhhs.ncgovconnect.com/histraining/>

Attendees (☑ = present; ■ = absent)

☑ Sarah Brooks (Facilitator) - DPH	☑ Frances Taylor – DPH
■ Taryn Edwards - DPH	☑ Ellen Shope – DPH
☑ Diane Keener – Macon LHD	☑ Brenda Dunn - DPH
■ Kaye Hall – Warren LHD	☑ Leatrice Hamilton – Mecklenburg LHD

Item	Agenda Items	Presenter	Decisions / Action Items	Questions / Comments
1	Purpose of Clinical Documentation Work Group	Sarah Brooks	<ul style="list-style-type: none"> • Prepare recommendations, document drafts and training related to Clinical Documentation Assessment for submission to the ICD-10 Implementation Team to include: <ul style="list-style-type: none"> ○ Clinical Documentation Assessment Process ○ Assessment Tool ○ Clinical Documentation Improvement Strategies • Provide guidance to local agencies, upon request 	
2	Brainstorming Session	Sarah Brooks	<ul style="list-style-type: none"> • The Clinical Documentation Work Group will do an initial clinical documentation assessment, develop and test a tool for local agencies to use, and develop a findings report with recommendations for documentation improvements. <ul style="list-style-type: none"> ○ A pre-requisite for this activity is the completion of ICD-10 coding training by Work Group members (probably Spring 2012) ○ Sarah will research tools that may already exist and will work on a draft tool ○ Brenda and Ellen will send Sarah samples of audit tools currently used for Program and documentation audits. (It was noted that the Medicaid Leveling Tool currently in use evaluates CPT codes rather than diagnosis codes.) DONE ○ Work Group members will go to several local agencies and audit various program documentation onsite in order to test the tool and to acquire examples to be used when training local agencies on the assessment tool (e.g., Using common diagnoses, reflect code used under ICD-9 and code that is appropriate under ICD-10 and assess the clinical documentation needed to support the assigned ICD-10 codes). This must be done onsite in order to have access 	

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			<p style="text-align: center;">to all relevant documentation and meet HIPAA requirements (will be part of health care operations). Onsite will be essential for agencies that have an EHR. This exercise will also be very good training for the nurse consultants.</p> <ul style="list-style-type: none"> • A tool and instructions/training will be provided to local agencies and the local agencies will be responsible for performing their own assessments. <ul style="list-style-type: none"> ○ Local agencies may want to coincide their internal assessment with audits done under the consolidated contract – this will be a local agency decision. ○ These audits are done anywhere from quarterly to annually. ○ Local agencies must do the assessments – DPH staff will not perform this activity for the local agencies. ○ NOTE: Women’s Health does the audit based on local on-going internal audit processes. The OPHN Nurse Consultants in conjunction with other programmatic Nurse Consultants (CH/WH) do coding audits upon request of local agencies. • Sarah will incorporate the outcome of this discussion into the Clinical Documentation Assessment portion of the Implementation Plan. • Sarah will send an e-mail to the Implementation Team suggesting they ignore the Client Record Documentation Assessment Section of the Implementation Plan since there will be many changes to that section. DONE • Sarah will send out recommendations for the purchase of ICD-10 code books ensuring that the books contain the changes approved 10/1/11 (and under code freeze going forward). <ul style="list-style-type: none"> ○ Ingenix 2012 code book not available until Feb 2012 http://www.shopingenix.com/Product/38835/ ○ PMIC is the source of the ICD-9 and CPT code books used by Joy’s staff. Their online catalog does not offer ICD-10 code books and they state that purchasing these books would be a waste of money. ○ Sarah will re-check the Ingenix and PMIC catalogs in Feb 2012 to see what is available and send out recommendations to the Implementation Team. • Sarah will add the following to the Implementation Plan: <ul style="list-style-type: none"> ○ Best Practices section - Recommendations on the use of Computer Assisted Coding (CAC) – this cannot be determined until the Work Group performs the Clinical Documentation Assessments 	

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			<ul style="list-style-type: none"> ○ Client Record Documentation Assessment – Re-work this section based upon decisions made at today’s meeting. Also, add verbiage related to why the assessment is so critical (e.g., potential financial impacts; paradigm shift for local agencies - does the documentation support the coding) 	
3	Next Meeting Date	All	The Work Group will not meet again until they have had training in ICD-10 coding since it will be difficult to perform their tasks until they have gone through the training.	
Next Meeting Date: TBD				