Electronic Documentation Templates Support ICD-10-CM/PCS Implementation (2015 update)

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Editor's Note: This Practice Brief supersedes the October 2012 Practice Brief "Electronic Documentation Templates Support ICD-10-CM/PCS Implementation."

Improving patient care continues to take center stage in the healthcare industry, as demonstrated by an increased emphasis on health IT and electronic health record (EHR) implementation in programs like the American Recovery and Reinvestment Act's (ARRA) "meaningful use" EHR Incentive Program, the Accountable Care initiative, Patient-Centered Medical Homes, and the Medicaid Chronic Care Management program. These, and other initiatives, all require strategic organization-wide planning for ICD-10-CM/PCS implementation.

The implementation of ICD-10-CM/PCS will require organizations to capture detailed information at the point of care. Since ICD-10-CM/PCS provides increased specificity in its code sets, clinical documentation to support that specificity is critical. Specifically, providers don't need to provide a higher volume of clinical documentation, but rather need more precise documentation (i.e., laterality, specificity, anatomic sites, etc.) with the focus on quality, not quantity. Proper documentation can be facilitated through the effective use of EHR templates and prompts and the data repurposed throughout the EHR to support the "collect once, use many times" concept.

The meaningful use EHR standards and certification criteria have enhanced organizations' ability to capture and exchange standardized, structured clinical content. Templates can also help support the capture of clinical content in a standardized and structured manner. Prompts or clinical decision support rules relevant to clinical specialties will result in meaningful patient data as well as improvements in patient care. The added level of specificity in ICD-10 is needed to bolster clinical decision support tools that provide alerts and reminders to clinicians during patient care. This is an important patient safety consideration.

Leveraging these data collection tools will improve clinical documentation, leading to a higher quality of care for the patient through a better understanding of complications, better design of clinically robust algorithms, and better tracking of the outcomes of care. Greater detail and specificity offer many advantages, including the ability to discover previously unrecognized relationships in data and the impact on public health by detecting developing epidemics in their early stages.

Prior to ICD-10 implementation, healthcare organizations will need to communicate with their EHR vendors and identify methods for updating and/or creating templates that facilitate compliance with new documentation requirements and code assignment. In some instances this may require upgrading to a new version of the EHR's software. Providers need to factor in the level of effort required to modify or create the content needed to support the transition process. By employing the features available in custom template design, an organization or physician practice can modify the EHR to better fit their unique workflow needs.

Templates add an advantage by reminding providers to ask patients specific questions. The structured note will assist the physician with reminders to ensure his or her documentation is as complete and accurate as appropriate for ICD-10-CM/PCS coding guidelines. In a physician practice, for example, the ability to utilize different templates will allow the provider to simply choose by specialty (i.e., the "check-up" or "diabetes patient" template) at the start of the encounter. In the hospital setting, reviewing and updating the provider query template/form is just one example of the type of template that will require attention. Determining the "vital" documentation opportunities now will allow organizations to begin providing focused education and training.

This Practice Brief identifies best practices that ensure clinical documentation remains accurate when leveraging data tools like EHR templates and prompts. These best practices are designed to support and guide HIM professionals, providers, physician practice staff, clinicians, and other healthcare stakeholders through an effective transition to ICD-10-CM/PCS documentation requirements that ultimately improve the quality of healthcare.

Defining Templates and Prompts

Templates and prompts can be useful tools to ensure complete EHR documentation at the point of care. A template is an EHR documentation tool utilized for the collection, presentation, and organization of clinical data elements. Prompts are a function of a template designed to trigger the provider to specify required or missing documentation.

Careful, thoughtful design and the ongoing review of EHR templates and prompts is essential to successful implementation. In the facility setting, a collaborative approach that includes health information management services (HIMS), clinical documentation improvement (CDI) and quality staff, providers, and information technology (IT) representatives is recommended when implementing templates and prompts. Utilization of data from the CDI program will place a facility in a better position to design the specific prompts required for the template and result in more complete documentation.

Documentation areas with significant impact may require the design of new templates to capture the new or more detailed information required. Templates should be designed to capture specific information needed for clinical care and accurate reporting of the clinical encounter. This will prevent faulty template design that captures documentation in a way that makes all patients look the same.

There are advantages and disadvantages to using these tools. Templates and prompts can assist in improving the quality of care delivered and the completeness of documentation.[1] Alternatively, providers may feel as though there are additional steps and increased workload as the electronic prompts force their documentation requirements. Proper education, monitoring, and training will help support the use of these tools.

Customized Template Benefits

The ability to utilize different templates allows a single EHR solution to be flexible. Important benefits of template usage include:

- Easy, standardized organization of clinical data
- Single-page views of patient data for quick reference
- Ability to quickly manage an entire patient population
- Time savings versus having to browse through multiple patient files/pages
- Increased percentage of chart completion
- Standardized data capture, which helps to ensure accurate coding and reporting
- More complete data fields, which can lead to fewer under-billed appointments

Source: "EHR 105: EHR and EHR Templates." EMRapproved.com. 2011. www.emrapproved.com/pdf/phs-hitu/emru105_course.pdf.

Streamlining Workflow Processes

There may be ways to streamline the workflow process to mitigate some of the potential productivity losses that are expected to come with ICD-10-CM/PCS implementation. Designing workflows now may reduce the need for coding staff to initiate physician queries for missing or additional information in order to code a patient record. Deloitte published an article that discusses the importance of developing and executing strategies that include physician engagement and adoption of technology-driven templates and code selection tools. The article states:

> [T]he development of enhanced electronic health record (EHR) templates to support clinical documentation needs can help ease provider adoption of the new code set. Finally, many organizations are considering the inclusion of the following "top five" elements in their EHR templates: laterality, devices, episode of care, trimester, and root procedure.[2]

In the outpatient setting, "there are many advantages to creating templates in the EHR, there are also benefits to utilizing an EHR with integrated practice management, billing, and documentation tools. To take full advantage of the EHR's efficacy, a

practice should look to the variety of methods for customization," according to an article posted on EMRapproved.com.[3]

Leveraging the use of tailored elements in a custom template design is a popular method for customizing the EHR. The unique features developed through the customization of EHRs allows practices to create an EHR best suited to their specific needs. Some studies have found that an involved customization is important in order for the adoption of any EHR to be successful for a given practice.[4] Many EHRs allow providers to modify generic templates or to create their own unique sets of templates with ICD, HCPCS, and CPT codes. This process can be labor-intensive, and these templates will need to be updated or replaced to meet the ICD-10 specificity requirements.[5]

When discussing the improvements that will need to be made in preparation for ICD-10, Mike Davis, managing editor for the Advisory Board Company, said in a Healthcare Information and Management Systems Society (HIMSS) article that the "answer will call for the creation of discrete encoded data to support the ICD-10 coding process."[6] Many dictation and transcription services are currently able to produce much of the physician documentation through new technology solutions, such as natural language processing (NLP), which work to mine text from the transcribed documents. Additionally, clinical vocabulary solutions can help code the resulting discrete data to a medical terminology such as SNOMED CT and pass the patient data to computer-assisted coding (CAC) applications, which can assist with coding quality and efficiency.

These workflow enhancements will need to be considered as facilities move toward structured template documentation for physicians. Beverly Dellinger, RN, clinical applications analyst at Wellspan Health, adds, "When clinical documentation workflows are adequately analyzed and weak points properly identified, the implementation of templates can add value by making the documentation process comprehensive, standardized, and produce timely display of documentation results."

Documentation Considerations for ICD-10-CM/PCS

Physician documentation must be more granular to support the increased specificity in ICD-10-CM/PCS. Documentation from the operative report is critical in the selection of the appropriate ICD-10-PCS code. In order to make a code assignment, the following will need to be included in physician documentation:

- **Body System:** Body system in which the affected body part belongs (central nervous system, endocrine system, etc.)
- **Type of Operation:** Provider must clinically describe the procedure performed to the extent necessary for a coder to accurately translate the clinical description of the procedure to the appropriate root operation (i.e., resection, excision, etc.)
- **Body Part:** Specific part of the body and laterality where the procedure was performed (i.e., appendix, liver, right leg, etc.)
- **Approach:** The approach taken to accomplish the procedure (i.e., open, laparoscopic, etc.)
- **Device:** The type of device (if any) that remains in the body upon completion of the procedure (i.e., grafts, implants, etc.)

Documentation areas for consideration when assigning ICD-10-PCS code(s) include:

- **Root Operation:** Selection of the root operation is dependent on properly determining the objective of the procedure (i.e., what will be accomplished through the procedure?) A thorough explanation of the purpose of the procedure is necessary. For example, the terms "excision" and "resection" were used somewhat interchangeably in ICD-9-CM. In ICD-10-PCS, however, these terms represent completely different procedures.
- **Site:** Does the operative report state the specific site of the procedure? The body part selections and laterality are much more specific in ICD-10-PCS. Documentation must specify what body part was affected by the procedure. Some of the specific body parts identifiable in ICD-10-PCS are the anterior tibial artery, abdominal sympathetic nerve, and the thorax muscle, left.
- **Devices:** Devices that remain in the body after the completion of the procedure must be documented. These include devices such as drains, non-autologous tissue substitutes, radioactive elements, and infusion pumps.
- **Qualifiers:** Qualifiers are represented as the seventh character in an ICD-10-PCS code. These will vary depending on the ICD-10-PCS code. Some examples include the types of pacemakers, graft materials, and hip prostheses. Qualifiers can also represent anatomical locations which are relevant to that particular procedure.[7]

Documentation Considerations for ICD-10-CM

ICD-10-CM Concepts	Considerations	ICD-10-CM Concepts	Considerations
Injury	● More specific documentation of the site of an injury, such as a fracture ● Laterality of injury ● Episode of care 7th character: • Initial encounter for care of fracture • Subsequent encounter for fracture with routine healing • Subsequent encounter for fracture with delayed healing • Subsequent encounter for fracture nonunion • Subsequent encounter for fracture with malunion • Sequela ● Categories S52, S72, and S82 are impacted by the Gustilo Fracture Classification ● Fractures delineate displaced or nondisplaced as well as type of fracture, such as comminuted, spiral, segmental, etc. Source: Simmons, Cortnie. "The Musculoskeletal System and ICD-10-CM." *ICD-Ten: Top Emerging News*. April 2011.	**Under dosing**	● New concept for ICD-10-CM that refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction ● May be classified as due to financial hardship or the age-related debility of a patient Source: Leon-Chisen, Nelly. *ICD-10-CM and ICD-10-PCS Coding Handbook*. Chicago, IL: AHA Press, 2012: 501.
External Causes of Mortality	● Episode of care 7th character • Initial encounter • Subsequent encounter • Sequela ● New category for reporting medical devices associated with adverse incidents in diagnostic and therapeutic use Source: Kostick, Karen. "Coding for External Causes of Mortality in ICD-10-CM." *Journal of AHIMA* 82, no. 7 (July 2011): 56-58.	**Obstetrics**	● Episode of care ● First, second, or third trimester of pregnancy ● 7th character to be assigned with multiple gestations; identifies fetus to which the code applies ● Twin pregnancy may be classified as monoamniotic/ monochorionic Source: Barta, Ann. "Obstetric Coding in ICD-10-CM/PCS." *Journal of AHIMA* 81, no. 6 (June 2010): 68-70.
Circulatory System	● Acute myocardial infarction (AMI) time frame is four weeks or less ● Certain AMI codes classify the responsible artery ● Subsequent AMIs require historical time frame (within four weeks) ● Angina terminology changes such as	**Neoplasms**	● Laterality classification is available for some neoplasms ● Significant changes in terms describing forms of lymphoma and leukemia ● Significant changes in terms describing polycythemia vera ● Additional codes for liver cell carcinoma

	"with arteriosclerotic heart disease with documented spasm" Source: Barta, Ann. "The Circulatory System and ICD-10-CM/PCS." *Journal of AHIMA* 82, no. 5 (May 2011): 62-64.		Source: Bielby, Judy. "Coding Neoplasms in ICD-10-CM." *Journal of AHIMA* 82, no. 10 (October 2011): 72-74.

Lack of Specificity Prevalent

Educating providers on clinical documentation is as crucial as it is delicate. Physicians need a range of human and technological support to guide them to the documentation needed for the increased specificity of ICD-10-CM/PCS. There are multiple reasons that the documentation in the record may not be specific enough. Providers can perceive their documentation as clear in its intent. However, they may be missing critical documentation needed for coding. One should note that physicians are taught medicine during their education; documentation is not necessarily a part of their medical curriculum. For example, the physician may state that "the patient was grunting," often meaning the patient was in acute respiratory failure. However, a coder cannot assume a diagnosis using such a general term. There is a difference in acuity by stating the disease more specifically.

Ensuring clear and concise documentation while the patient is still in the hospital is crucial to ensuring high quality care. Utilizing templates and clinical documentation specialists can provide the specificity needed to bridge the gap between the clinical language used in physician documentation and the classification language used in coding.

Stephanie Hays, medical coding quality consultant at Vanderbilt University Medical Center, based in Nashville, TN, says her facility's CDI program, in collaboration with the informatics department, is involved with a project that evaluates clinical documentation templates and then incorporates prompts that capture details required in ICD-10-CM/PCS. "The project will reduce the need to query providers by collecting required details up front, within their existing tools and templates," Hays says. "Improved templates will allow providers to remain focused on patient care during the challenging transition to ICD-10."

HIM's Role in Template Design

While an interdisciplinary team is generally formed whenever electronic template-based provider documentation is considered, HIM professionals are critical to the selection process when looking to develop or revise electronic templates in preparation for ICD-10-CM/PCS and should be involved in the template development and management process. The heightened specificity of ICD-10-CM/PCS will require clinicians to become more precise in their documentation, and the electronic templates and their associated alerts and reminders must support this change. HIM professionals should be involved with the design process to ensure well written templates are developed that focus on documentation specificity. This specificity has the potential to enhance computer-assisted coding accuracy and coder productivity. Refer to Appendix A in the online version of this Practice Brief in AHIMA's HIM Body of Knowledge for more information on policy considerations.

As part of the design process, guidelines for the data entered into each field must be determined, as well as guidelines for allowing a comment area for "yes" and "no" answers. Quality initiatives should also be incorporated. Included with the proposed template, a standardized form signed by the requestor and the department head or service chief must be submitted to the workgroup or committee responsible for the implementation of the template. The request form should include the purpose of the template, proposed implementation timeline, and individuals responsible for testing the usability, training, and dissemination of the new or revised template. Refer to Appendix B online for a sample request form.

The requesting party should submit the formatted template following standardized guidelines approved by the appropriate organizational authority. The use of guidelines will add standardization and clarity when establishing templates. The guidelines should include:

- Requirements of indentation
- Punctuation
- Capitalization
- Headers

- Indication of a required field
- Verification of spelling of terms
- Usage of abbreviations or reference to a legend of abbreviations
- Review for proper grammar and word tense

Default values must be used with great caution to avoid inaccurate information. Coding nomenclature should not be included in a template. Note titles should be mapped to a standardized format for consistency and ease of retrievable documentation. A review process must be established and maintained on a regular basis to keep up a master list of templates, to ensure that the template is being used, that information is still relevant, and to identify needed updates. Templates and note titles no longer used should be deactivated but not deleted so a historical library is maintained for templates existing prior to the classification system update to ICD-10-CM/PCS. Refer to Appendix C online for more information.

Talking with Physicians About Templates

Templates developed using evidence-based medicine should be designed to capture free text as well as structured data to accommodate the multiple specialties and subspecialties of medicine. In this way, the user will be able to identify common data elements with the option of adding significant clinical findings for an individual patient.

With the implementation of EHRs, most clinicians are now accustomed to the direct entry of clinical data into electronic systems. As a result, dictation for transcription of clinical notes and reports has decreased. However, the formats designed by the physicians, medical scribes, and medical transcriptionists for transcribed reports may be a good starting point for the creation of clinical templates in the EHR. A well-designed template will recognize that EHRs are primarily data-centric rather than document-centric.[8]

Working through the health record quality review committee, clinicians can ensure data elements supporting evidence-based medicine and quality care are captured in the EHR. This clinician-to-clinician approach, as well as identifying a physician champion for each clinical service, is an effective way to design and educate clinicians on the use of templates for the EHR. The physician champion should be involved in the review of current patient-specific paper forms to be considered for conversion to electronic versions. Physician champions have been trained and can solicit cooperation from their peers. Physicians need to know that the accuracy of their documentation goes hand-in-hand with their physician profile performance reporting and benchmarking data, as well as profiling for patient care. Improved documentation of diagnoses and procedures that specifically affect ICD-10 code assignment will accurately capture severity, acuity, and risk of mortality data. “Motivating physicians to improve their documentation requires getting physicians to understand that proper documentation aligns with a better understanding of the patient’s history and current status, and this information aligns with better quality care,” says Thomas Payne, MD, in a Healthcare Financial Management Association report.[9]

The Role of the EHR Vendor

Changes in regulations governing documentation, core measures, physician queries, medical necessity, and the implementation of ICD-10-CM/PCS all speak to the need for accurate, thorough, and precise documentation. The desire to meet the meaningful use requirements is expediting the adoption of EHR systems by hospitals and providers nationwide.

EHR vendors utilize a wide number of methods to assist providers with documentation, including templates, macros, cloning of records, and free text entry. Vendor template models also vary significantly, with some instituting ICD codes within templates, while others draw from a core terminology engine like SNOMED CT. Providers are strongly encouraged to engage their vendors as soon as possible to plan and implement an update process that addresses vendor-specific strategies tied to the transition to ICD-10-CM/PCS. In some cases, providers will be required to modify significant numbers of their existing templates to meet the documentation and coding requirements of ICD-10-CM/PCS.

HIM professionals must be involved in the implementation and update of the EHR. For example, if the EHR provides drop-down boxes for ease of documentation of personal, family, social, and historical clinical conditions, HIM would have valuable input in the creation of the selections.

Templates are an ideal documentation tool to facilitate required documentation and, in some models, code selection. However, care must be taken to ensure that the templates are not too prescriptive and are not complicated or time-consuming to use.

Depending on the vendor model, the presence of accurate billing codes may also require validation. To this end, physician participation must take place throughout the template development period.

Patient Considerations

The patient audience is equally important to consider when developing documentation tools. Patients are increasingly experiencing visits where physicians face a computer and work their way through the EHR during the encounter instead of engaging in face-to-face conversation. The careful design of templates and effective physician training may help reduce patient perception that a physician is focused on the computer rather than the individual.

Daily progress note documentation is the responsibility of the medical staff. The documentation should include required elements and updated diagnoses and procedures when applicable. The collaboration between vendor and hospital client base should result in documentation tools that:

- Reduce the amount of duplicative documentation by physicians
- Contain key fields that will assist with accurate and specific code assignments
- Automatically reproduce data on a coding worksheet to assist with coding
- Populate a discharge summary with diagnoses and procedures from progress notes, post-procedure notes, consultations, operative reports, and other specified documentation
- Include required fields for Joint Commission requirements and medical staff rules and regulations for specific documents (i.e., post-procedure notes, discharge summaries, etc.)
- Include “free text” options to allow the healthcare provider(s) to include additional patient-specific information

Vendors traditionally provide a basic EHR system that includes limited design workflows and templates. Ultimately, it is the responsibility of the healthcare provider to enhance and maintain additional workflows and templates. EHR vendors should have an understanding of the importance of documentation for primary and secondary data use, such as:

- Medical necessity
- Continuing care
- Patient safety
- Regulatory requirements
- Coding
- Charge capture
- Quality measurement and reporting

Templates assist with the standardization of essential elements in clinical documentation. This standardization will, in turn, result in the capture of data at the level of specificity needed to support the timely display of results, expedited chart searching, coordination of care among healthcare providers, and improved patient outcomes.[10] Well-formatted templates also support quality programs such as the Accountable Care initiative, the Patient-Centered Medical Home initiative, the Medicare Chronic Care Management program (which requires the EHR to generate and maintain health summaries and care plans), and others.

Documentation templates should be designed to reflect clinical accuracy and ensure documentation integrity. Now is the time for healthcare facilities to merge meaningful use and ICD-10-CM/PCS planning initiatives to develop templates, prompts, and overall systems that facilitate and encourage documentation needed for patient care, severity of illness, intensity of services, accurate code assignment, and reimbursement as well as a variety of healthcare quality and reporting requirements.

Appendices

- Appendix A: Electronic Note Title and Template Policy Considerations
- Appendix B: Request Form for Note Title and Templates
- Appendix C: Checklist for Template Review

Notes

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