Communicating with Physicians: Something to Talk About

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Ask a physician: "Doctor, are your detailed history and physicals comprehensive?" Now ask: "Doctor, are your comprehensive history and physicals detailed?" Chances are, you'll get two affirmative replies. To a physician, detailed workups are comprehensive, and comprehensive workups are detailed--essentially the same in clinical terms. But in regulatory and financial terms, a detailed history and physical is distinctly separate from a comprehensive history and physical.

Welcome to the diverse world of healthcare languages.

Among the different languages of healthcare are **patient, clinical, coding, financial**, and **regulatory languages**. Each has specific nuances that may have profound consequences if improperly translated from one language to another. As a result, "translation errors" produce financial, regulatory, and interpersonal conflicts.

Errors of Our Ways

An outstanding example of healthcare language translation error is the quintessential **admit to observation/admit to inpatient status** question itself.

Go ahead: ask the utilization review (UR) question that really annoys a doctor: "Doctor, are you admitting this patient as an inpatient or outpatient observation?" You know the look we doctors give you in response. We roll our eyes with contempt--it really doesn't matter to us. The patient is in the hospital and already under "observation" in our opinion. Both the physician and UR coordinator automatically assume the other party obviously "doesn't get it." This is where the friction begins.

The UR coordinator is speaking in *financial language*, but the physician is speaking in *clinical language*. The UR coordinator is really saying, "I need to know if we bill Part A or Part B for this admission." The doctor assumes the question was clinical and doesn't realize that the UR coordinator was asking a financial question. Furthermore, neither the physician nor UR coordinator perceives the different focus of the other participant because they believe they are speaking the same language. Here again, translation is necessary.

What's in a Name?

When physicians document the *patient* phrase "bad kidneys" into the *clinical* term "renal insufficiency," every doctor reading the chart understands the meaning. But when a coder looks at "renal insufficiency," there is no appropriate code. Therefore, by default, "renal insufficiency" isn't coded. Furthermore, because there isn't a code, "renal insufficiency" doesn't exist in regulatory or financial language. This means physicians and hospitals don't get paid and don't get any credit or recognition for taking care of patients with "renal insufficiency."

Clinical language has gray areas. Coding language is black and white. The ICD-9-CM code 405.99 just isn't the same as 405.91. The "comprehensive" CPT 99223 or 99222 documentation is different than the "detailed" 99221 documentation for an admission history and physical. The more specific and more correct physician documentation is, the more specific the code for both financial reimbursement and regulatory credit and recognition.

Recognizing the Signs

What can be done about translation errors? Fortunately, physicians are, by nature, curious. Although we despise being "trained," we like being "educated." In medical school, we were taught to recognize signs and symptoms of disease processes we had never encountered before. Once we knew what to look for, we saw clinical examples frequently. The same is true for coding and documentation translation disorders.

A rigorous educational effort to teach physicians the nature of the healthcare language translation process is a good first step. Demonstrating common translation errors will help both physicians and coders recognize the potential problem when certain clinical key phrases are encountered.

A program featuring a monthly short listing of discovered translation errors (with perhaps a reward for both physician and coder when a new translation error is discovered) will underscore the financial repercussion of translation errors and keep it fun. Displaying "wanted" posters of easily misunderstood or incorrectly translated phrases and terms accompanied by a brief explanation of the conflict will help physicians recognize, and therefore avoid, documentation pitfalls.

But how are physicians motivated to change documentation patterns? One of the best ways is to link hospital documentation of multiple diagnoses that directly affect DRG reimbursement by usable comorbid conditions and complications to evaluation and management (E/M) coding. Documentation of multiple diagnoses is part of the integral medical decision-making process of E/M coding. When physicians realize that documentation of multiple diagnoses (each having a valid translation code) helps not only the hospital but also their own E/M coding, they become motivated to modify documentation habits.

Aim for Understanding

As physicians and hospitals struggle to remain economically viable in the "business of healthcare," programs to improve physician documentation as well as communication to others speaking different healthcare languages have developed.

By fostering improved mutual understanding of the differences in healthcare languages, physicians and other participants in the compliance realm of documentation, coding, and billing will communicate more effectively and with fewer interpersonal conflicts.

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