Documentation Rx: Strategies for Improving Physician Contribution to Hospital Records

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Hospitals typically know which physicians need documentation therapy. However, they do not always have a comprehensive care plan. A combination of educational and operational steps can improve physician contributions in the documentation requirements for hospital records.

Identifying Issues that Require Treatment

A hospital's compliance, reimbursement, and patient care practices hinge on accurate and appropriate physician documentation, since this is the primary method of relaying information needed in both clinical and business transactions. And yet documentation continues to be problematic. The Office of the Inspector General reports that 44 percent of errors in fiscal year 2004 were due to insufficient documentation.[1] Other external and internal coding audits show that the cause of improper coding is lack of proper physician documentation to support reimbursement at the appropriate level.

Documentation shortcuts pose risk management issues, since the record must defend the professional judgment and standard of care for both the facility and the practitioner. Failure to write a timely operative note after surgery can compromise the patient's treatment and outcome. Failure to enter a time and date when the note was recorded makes it difficult to defend the timeliness of the action taken to meet the standard of care. Using phrases such as "doing well" implies a lack of medical necessity in some circumstances where documentation should validate the need for continued treatment.

Compliance struggles and improper payments often result when physicians lack time or sufficient understanding of the methodology behind coding and how documentation, or the lack of it, affects coding, billing, and the integrity of the hospital record. In other instances, coders, who should never make clinical judgments in the absence of proper documentation, are hesitant to approach physicians when information is ambiguous or needs clarification.

Physicians must be educated that complete documentation helps both the physician and the hospital with regard to compliance and protection from litigation. The key to appropriate documentation lies in physicians' understanding of coding methodology and its clinical interpretation. For example, abnormal lab tests that are significant enough to be treated should be documented as a diagnosis (e.g., a low sodium count must be documented as hyponatremia in order to qualify as a reportable condition on a claim form). Anemia must be further specified to provide accurate classification and reporting (e.g., acute or chronic blood loss). Physicians must understand that urosepsis is defined as urinary tract infection in coding terms; further clinical specificity is required to distinguish minor infections from those that may be life-threatening. Sepsis must be documented separately to be eligible for code assignment and reporting.

In addition, hospital process or culture can inhibit direct interaction with physicians to amend ambiguous or inadequate documentation. Coding professionals must have access to—and be empowered to—query physicians when necessary.

Tips to Improve Physician Documentation

Documentation improvement programs for physicians must have the support of hospital administrators. The administration must understand that proper documentation is crucial to patient care, risk management, and billing. Medical staff bylaws should reflect timely and proper medical record completion so that hospital administration can work with physician leadership for a common understanding of required standards and the process for handling failure to meet standards.

Communication and Education

Periodic meetings between HIM staff and physicians in each clinical specialty can help improve communication and provide targeted education. The participation of coding professionals boosts the value of these meetings, as they can provide insight into how terminology used by physicians translates into code assignments. Some hospitals present case studies at monthly meetings. Others post documentation tip sheets where physicians typically dictate or complete their records. In-services can be made mandatory for physicians who do not meet identified documentation standards.

HIM managers must develop policies and procedures so that when coders identify documentation deficiencies, the next steps are clearly defined.[2] A standardized physician query sheet or online form can help.[3] The process should determine how clarification from the physician should be both requested and received (e.g., should the physician come to the records processing area to answer the query or should query sheets be faxed to the physician's office along with the progress notes and patient identifiers and the information returned by fax or telephone?).

Queries should improve understanding of unique clinical situations and provide assurance that if codes are assigned, the documentation in the record supports them. When a query results in additional information used as a basis for coding, a late entry progress note or an addendum to the discharge summary is required. Query forms supplement medical record documentation for accurate code assignment and are not considered documentation to support clinical decision making or treatment.

Another effective way to promote better documentation is to appoint a suitable liaison to assist with physician communication, preferably a physician advisor who would come to the HIM department to review documentation problems. The liaison is responsible for contacting physicians when HIM staff have questions regarding documentation. Liaisons can also be charged with physician education and advising on medical staff rules and regulations related to health record issues. A liaison can minimize coders' reluctance to approach physicians.

Hospital newsletters can further educational efforts by stressing the importance of documentation in regulatory compliance and good customer service. It is important to include examples of good physician documentation and illustrate how it enabled the hospital to receive the correct reimbursement and provide optimal service to patients and hospital business associates. Newsletter topics might include the need to:

- Be consistent in terminology (e.g., numerous ICD-9-CM codes describe ischemic heart disease)
- Document all diagnoses that are actively treated, since complications and comorbidities improve DRG reimbursement
- Show all disease relationships (e.g., any condition that complicates a diabetic condition should be clearly documented)
- Document all diagnoses that are identified by a consultant and are actively treated during hospitalization
- Document techniques used in the outpatient setting

Simplifying documentation can help, also. A list of standardized abbreviations and terms should be available to physicians, and the process for correcting errors in patient documentation entries should be standard. Streamlined forms can significantly improve documentation.

Sharing Data

Performing concurrent documentation reviews can be helpful. Utilization and case managers should be encouraged to perform these reviews and educate physicians with the findings. Many physicians learn best on a case-by-case basis. As part of a concurrent review program, it is helpful to use clinical documentation guidelines (CDGs). CDGs are code-based tools listing typical treatment protocols for given conditions. Reviewers use CDGs to justify days of stay to managed care organizations and to identify physician documentation deficiencies. They improve physician documentation by pinpointing specific information needed to support correct diagnoses while patients are still hospitalized. As a result, there is better data quality by the time the record gets to the HIM department.

Accurate report card data and physician performance measurement can help improve physician documentation. In reviewing a clinical specialty, hospitals can produce a documentation performance scorecard on each specialist reviewed. Each medical record is reviewed and scored according to a point system. The sample report card shown above illustrates suggested items to review in a chart audit of cardiologists. Values are associated with each item. Medical necessity denials and missing documentation about specific vessels imaged are scored highly because of the negative cost and reimbursement impact for the

hospital. A cardiologist with a score of 11 or more points on one record needs help with documentation. (If multiple encounters are audited during an audit period, divide the total points by the number of encounters audited.)

If selected physicians are not receptive to report cards, alternate strategies can be employed. Preventive tactics include agreement with the chiefs of staff on minimum documentation standards necessary to retain medical staff privileges. Processes can be established so that poor compliance with proper documentation is reported to the medical record committee, utilization management committee, and the peer review committee. The peer review committee can approve the continued report card monitoring and incorporate the findings into its pertinence reviews. Pertinence review report card failures can be made a part of the credentialing process. Placing the worst offender on the medical record committee can help. There tends to be a sentinel effect from sitting on committees with physicians who believe in the importance of documentation. Any policy developed will be more effective when created with the input of physicians.

Improving physician documentation requires ongoing education, operational processes that facilitate better communication and monitoring against standards, and periodic reporting of documentation audit results to stakeholders. Any audit results specific to an individual physician should be shared with that physician to provide an opportunity for correction. Trends and patterns of deficiencies are appropriate for more general reporting. By implementing effective educational and operational strategies, hospitals will minimize compliance risk, improve financial health, and enhance patient care.

Twelve Questions for Good Review

A checklist of questions can assist physicians with documentation during service so that postdischarge analysis and return to correct documentation deficiencies are minimized. These questions also help identify problematic documentation for reimbursement, and they can be used in any review process and in physician education.

- Is surgery done in the emergency room documented in the final progress note?
- Are symptoms used when etiologic factors are known?
- Is there a summation of the visit or hospitalization in the final progress note?
- Is the source identified for patients admitted with pathologic factors?
- Are indications for transfusions clearly documented?
- Are all cancer sites identified as primary or secondary? If there is metastasis, is the site it has spread to been documented?
- Do all diagnoses on the final progress note agree with those on the discharge summary?
- Are surgical procedures that were omitted from the final progress note on the operative record?
- Do pathology reports have findings that do not appear in the medical record?
- Do medication sheets often show administration of medication without an associated diagnosis clearly documented in the medical record?
- Do diagnoses on the outpatient referral form relate to the ordered test or service?
- Do physicians write “rule out” of certain conditions as the reason for the visit?

Physician Documentation Scorecard: Cardiology

Description	Points
Documentation Meets All Requirements	0
Cardiac Arrhythmias Unspecified	3
Cardiac Conditions Not Clearly Documented	4
Missing Detail on Myocardial Infarction	2
Pacemaker Removals Not Documented	6
Components of Echocardiogram Missing	3
Missing Documentation of Specific Vessels Treated/Imaged	9

Revision of Pacemaker Skin Pocket Not Documented with Pacemaker Upgrade	2
Insufficient Documentation of Physician Presence/Services Provided in Cardiac Rehabilitation Exercise Area	1
Medical Necessity Denial	10

A physician scoring 11 points or higher in a record review needs documentation therapy.

Notes

1. Centers for Medicare and Medicaid Services. "Improper Medicare Fee-For-Service Payments Report, Fiscal Year 2004." Available online at www.cms.hhs.gov.

2. Texas Medical Foundation, Hospital Payment Monitoring Program. "Overcoming Documentation Barriers." Available online at www.tmf.org/pepp/docbarriers.html. Other suggestions for education, procedures, review, and sharing information in this section also come from this report.

3. To obtain copies of sample physician queries and procedures, sample physician query forms, and physician query and medical record addendum forms, visit the Medicare Quality Improvement Organization for Oregon (OMPRO) Web site at www.ompro.org and click on "Coding and Documentation Resources."

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