Performance Improvement for Documentation

by Carol Labak, RRA, CCS

We've all seen it before: that look of bewilderment on a physician's face when a discussion about documentation arises. While this is not the first incidence of this discussion between the physician and the health information manager, neither is it the first time the HIM professional has encountered that look of utter confusion from the physician.

This recurring event sparked a decision by our facility's medical records department to come up with a new approach to improving documentation—one that would get the attention of the approximately 100 physician members in our independent practice association. The decision was made to improve our facility's forfeiture of reimbursement due to poor documentation and our unacceptable range of denials due to incorrect coding. The new approach was to educate the physicians through presentations that showed the issue in terms of reimbursement, rather than documentation. The team chose the reimbursement focus because it was an issue the physicians could relate to (while documentation is considered by physicians to be a problem of the medical records department).

Mission: Not Impossible

Several educational sessions were held. Many questions were asked. The short sessions kept new information at a minimum. Nothing happened. No changes were seen in the documentation of outpatient visits. But that failed to curb our efforts. Another idea led to a second approach—a newsletter. The team decided that a brief, one-page newsletter, directed at physicians and printed on bright paper, would surely get attention. We were sure that concise, to-the-point information would get the message across: accurate documentation + accurate coding = accurate reimbursement.

After three issues of the newsletter, the physicians were surveyed on their impressions of these informational communiques. Not one physician could recollect seeing the shocking pink or chartreuse paper, let alone having read it.

The third approach turned out to be a success, and we learned that nothing takes the place of persistence when it comes to implementing change. The new approach established the health data quality committee, made up of the corporate medical director (for support, authority, and medical expertise), data quality specialist (for coding expertise), ambulatory care manager and health education nurse (both of whom felt accurate documentation in the medical record was important), and (here's where the new approach comes in) two volunteer physicians from our facility's department of internal medicine. Though this method required asking the physicians to participate multiple times and meeting at their convenience, our efforts were successful. We communicated, we educated, and we improved documentation with resultant increased coding accuracy.

Mission: Education and Compliance

The committee's mission was to promote accurate documentation that would ensure quality of care, data integrity, coding accuracy, and compliance with regulatory bodies. The goals were to disseminate information to providers relating to documentation and coding rules and regulations; monitor patient records as required by administration and medical staff (high dollar, high risk, high frequency); perform monthly generic chart audits for compliance to regulatory and legal policies; and ensure compliance with accrediting bodies. Initially, the committee met every two weeks. This provided time to inform the physicians of the documentation guidelines and to perform audits slowly and deliberately as the team began working together.

We used Medicare's "Guidelines for Documentation of Evaluation and Management Services" as our audit criteria. The document became a prototype for simplified reference sheets that showed key components of the various levels of evaluation and management (E&M) services—history, physical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time. These sheets also showed the requirements of each component based on the level of care (i.e., problem focused, expanded, and detailed). Armed with the requirements, the committee began auditing the records of the department of internal medicine's physicians. At each session, one physician was chosen and 10 records were audited.

Although patient and physician confidentiality was maintained by eradicating any identification from the outpatient notes reviewed, the committee physicians were able to identify which physician was being audited by his or her documentation style. A serendipitous bonus for the team, this form of conjecture served to keep the physician team members interested in the committee's goals during the team's developmental stage.

Once audits began, the committee received authorization from the medical director to change the E&M code assigned by the treating physician. If the committee did not agree that the documentation matched the E&M code billed, a letter was sent to the physician explaining why the code was lowered and suggesting how the documentation could have been improved. The physician had 10 days to respond to the change. If he or she did not respond, the changed code became the code used for billing. If the physician wanted to dictate an addendum to the progress note, he or she could do so and resubmit the file to the committee. The letter was then signed by the committee. In these cases, the letters were met with more acceptance by the treating physician due to the presence of the two physicians on the committee.

It took six months of working together for the health data quality committee to become very cohesive. At this point, we began meeting on a monthly basis, and the 10-record audit took less than 30 minutes to perform. The committee's next step was to audit the department of internal medicine's physicians a second time to see if there had been any improvement in documentation. On comparison, there appeared to be a noticeable improvement. The committee, on its first audit, agreed with 60-80 percent of the E&M codes assigned by the physician. On the second audit, agreement with the code assignments reached 75-100 percent.

Our committee then began to make recommendations for documentation on all audited records—even those containing E&M codes with which we agreed. During this time, the real proof of success showed itself in an unplanned, unexpected way. One of the physicians on the committee walked into the medical records department with a medical record under his arm. He went straight to the manager, opened the record to the last progress note and said, "This note is so illegible I cannot read it, and this certainly is not a 99214." At our clinic, when the charges are entered in the computer system, a temporary sheet at the front of the chart is used to document the entry. The specialist whose note was illegible had billed a 99214 (Office or other outpatient visit, established patient, detailed), a code that this physician did not agree with.

Mission: Accomplished

At that point, we realized we had achieved our goals. Right before us stood the proof: a physician who could no longer look at a progress note for its clinical content alone, but for what it does not contain as well. While the physicians on our committee were busy evaluating the documentation of their peers, the importance of guidelines to accurate documentation had taken root.

While the mission remains the same, the plans to carry it out have changed. Now physicians rotate into the committee every six months, enabling all of them to serve, participate, and become familiar with the guidelines. The results? The quality of our medical record documentation has been enhanced and our coding accuracy has improved. Reimbursement has also improved (in other words, denials have decreased). While the health data quality committee cannot take total credit for the decrease in denials (our facility has a reimbursement task force working on these issues), committee members feel that the push for "accurate documentation + accurate coding = accurate reimbursement" played an important role in reducing payment denials. Furthermore, with the focus on fraud and abuse, the health data quality committee has the potential to transform into a compliance committee—changing gears to provide physicians with the latest information necessary to accurately document services.

The committee continues to move forward and is currently preparing for educational sessions with respect to the new E&M guidelines. Thus, it would be a natural progression to charge this committee with the task of creating and monitoring a compliance plan. Other possibilities include expanding educational sessions to include all clinical personnel, instituting a hotline for fraud and abuse questions, and reports. If this occurs, committee membership would be expanded to include billing personnel.

Payers and, subsequently, providers are becoming increasingly aware of the need for accurate documentation and coding. With this new cognizance comes greater interest in improving physician documentation-through participation in informational offerings and assumption of active roles on committees such as the health data quality committee. Documentation is not just a medical record problem anymore.

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