Using Physician Profiling to Improve Documentation

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by Cheryl Hammen, RHIT

In today's competitive market, physician profiling has become a way to provide consumers with a "snapshot" of a physician. It is also used in determining physician participation in various managed care contracts through identification of variations in physician practice patterns. In some instances, physician profiling is being used at the hospital level to identify variations in physician documentation patterns.

By comparing peer physicians using internal hospital data, documentation issues may be identified and addressed. To ensure that a physician's data is accurate, and therefore that hospital data is accurate, the codes assigned by the hospital must be based on complete physician documentation.

Physician profiling is usually performed through use of ICD-9-CM patient care data. In profiling a physician's inpatient care patterns, length of stay (LOS), utilization of services, and charges may be compared for patients classified to DRGs against those of other physicians. If the LOS or utilization of services are significantly higher than those of the physician's peers, and thus, the charges are higher, the physician may be providing care and services for diagnoses not documented in the record.

Two Physicians' Profiles

For example, Dr. Wilson, an internist, was profiled against his peers at City Hospital. His inpatient cases at the hospital were compared against those of 15 other internists who practice at the same hospital.

The results of the comparison for four pairs of DRGs are provided in "Dr. Wilson vs. Peers".

Based on the comparison, it appears that Dr. Wilson's pair ratios are significantly different from those of his peers. It also seems that Dr. Wilson may be overusing services, resulting in increased charges for his patients and longer LOS. If, however, he did not provide specific, complete, and accurate documentation, it may be that his patients were actually sicker than was reflected in the DRG assignment due to incomplete physician documentation leading to inaccurate coding.

Physician profile data, generated on a regular basis, may help the HIM department in identifying physicians who exhibit potentially poor documentation techniques. Using this data, the HIM department may be able to assist in achieving complete and accurate documentation by providing one-on-one education to the physician. If the facility has a physician advisor, he or she can provide peer-to-peer education that usually leads to better outcomes in achieving the desired results.

By presenting the profile data to Dr. Wilson, the physician advisor can explain the variations that exist and the potential causes of those variations. As stated previously, the variations may be due to:

- overutilization of ancillary services
- longer than necessary lengths of stay
- incomplete documentation

Usually, a review of medical record documentation for the cases illustrated through the data will indicate that additional conditions were present or suspected, but the nature of the confirmed or suspected diagnosis was not provided in the physician documentation.

By profiling Dr. Smith, another internist, we can identify potential compliance issues as illustrated in "Dr. Smith vs. Peers".

The goal is not to obtain documentation to maximize hospital reimbursement, but to achieve complete documentation resulting in appropriate reimbursement. Physician documentation must be complete and specific to appropriately reflect the condition

and treatment of the patient. Physician documentation is the basis for the ICD-9-CM coding, which results in DRG assignment, as well as in determining medical necessity in physician office coverage issues. Accurate physician documentation of inpatient cases is more than a hospital issue-it affects physicians, too. Physicians can play a major role in improving not only the hospital's data, but also their own.

Dr. Wilson vs. peers

DRGs	14	15	79	89	174	182	416	320
Wilson # of cases	10	10	1	19	6	18	5	15
Pair ratio (%)	50	50	5	95	30	70	25	75
Average LOS	5	4	7	6.5	4	4	6	5.5
Average charges ($)	8300	7400	9200	9000	9300	7500	9800	8300
Average number ancillary services	7	5	5	4	4	3	6	4
Peers' avg. # of cases	14	6	5	15	10	10	11	9
Pair ratio (%)	70	30	26	74	50	50	52	48
Average LOS	5	3	7	5	4	3	6	4
Average charges ($)	8300	6800	9200	8600	9300	5900	9800	6000
Average number ancillary services	7	3	5	2	4	2	6	2

Numbers and dollar amounts are provided only for illustrating this example.

- **DRG 14** Specific cerebrovascular disorders except TIA (r.w., 1.2070)
- **DRG 15** Transient ischemic attack and precerebral occlusions (r.w., 0.7480)
- **DRG 79** Respiratory infections and inflammations, age > 17, with CC (r.w., 1.6501)
- **DRG 89** Simple pneumonia and pleurisy, age > 17, with CC (r.w., 1.0647)
- **DRG 174** GI hemorrhage with CC (r.w., 0.9985)
- **DRG 182** Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age > 17, with CC (r.w., 0.7922)
- **DRG 416** Septicemia, age > 17 (r.w., 1.5278)
- **DRG 320** Kidney and urinary tract infections, age > 17, with CC (r.w., 0.8621)

Dr. Smith vs. peers

DRGs	14	15	79	89	174	182	416	320
Smith # of cases	14	15	79	89	174	182	416	320
Pair ratio (%)	90	10	50	50	70	30	80	20
Average LOS	4	3	6	5	3	3	5	4
Average charges ($)	7800	6800	8900	8600	8000	5900	8600	6000
Average number ancillary services	6	3	4	2	3	2	4	2
Peers' avg. # of cases	14	6	5	15	10	10	11	9
Pair ratio (%)	70	30	26	74	50	50	52	48
Average LOS	5	3	7	5	4	3	6	4
Average charges ($)	8300	6800	9200	8600	9300	5900	9800	6000
Average number ancillary services	7	3	5	2	4	2	6	2

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