Boost Reimbursement through Improved Documentation: 5 Tips

Here are five tips to ensure better documentation and, along with it, better patient care and improved reimbursement.

**Source:** Physician Practice

1. **Do avoid EHR shortcuts**

In many ways, EHRs have simplified documentation and record tracking. In some cases, EHRs allow physicians to “cut and paste” information from previous patients. Although physicians may view this feature as a timesaver, progress notes are crucial to successfully supporting the reasons for continued hospitalization. Documentation shortcuts can create difficulty in supporting medical necessity for the patient’s continued inpatient status.

For example, if the patient’s improvement/regression is not documented in a dedicated note each day, the payer may appropriately question whether services are medically necessary. If the notes do not clearly indicate the reason(s) for the patient’s continued inpatient status, the payer may deny some of the days as medically unnecessary.

2. **Do be exact when time is a factor**

Time-based codes, such as critical care (99291-99292), require a precise documentation of time. Documented time may include face-to-face time and floor time in the hospital. Floor time may include discussions with family members, reviewing diagnostic tests, and discussions with other providers involved in the patient’s care. The time does not need to be continuous, but any time spent with other patients, or away from the unit on which the patient is admitted, must be deducted from the total time reported.

3. **Do give procedure specifics**

Surgical notes should clearly identify the approach, all procedures performed at the surgical encounter, and any unusual situations that happened during the operative session. For instance, multiple spinal injections necessitate that the provider identify whether the injections are bilateral in the same level or in several levels. Or, if a procedure is stated as “complicated,” the provider should be specific about how the determination was made.

For example, lesion measurements should be stated, and make sure to specify both when the measurement was taken and whether the measurement includes the margins. If the coder is left to rely on the pathology report for information on lesion size, the measurement will not be as accurate as it would be if taken and documented before the tissue was removed from the blood supply.

4. **Do provide full diagnosis detail**

Inpatient hospital claims are reimbursed exclusively on the reporting of codes from ICD-9-CM. The MS-DRG reimbursement methodology groups medical conditions by severity, to include co-existing complications and co-morbidities that either require physician management or affect the physician’s
management during the admission. Complication and co-morbidities are further defined as either “standard” or “major.” Greater severity means a greater level of care, which means greater reimbursement. If the record is unclear regarding the degree of impairment, the coder may not be able to capture the code level that will yield a higher reimbursement.

Congestive heart failure provides a good example of how poorly defined physician statements may reduce expected reimbursement. Congestive heart failure, not further defined, does not equate to a complication or co-morbidity for MS-DRG reimbursement. Further definition as “chronic systolic” and/or “diastolic” congestive heart failure equates to a standard complication or co-morbidity, thereby increasing the reimbursement. A complete descriptor of acute-on-chronic systolic and/or diastolic congestive heart failure equates to a major complication or co-morbidity, increasing the hospital reimbursement even further.

Detailed and clear documentation is useful for more than just reimbursement. Inpatient coders are expected to report all applicable codes that describe the patient’s conditions. Medical accuracy of the patient record is critical to successful care. Furthermore, hospitals use these codes to capture and report statistical data regarding treated patients.

5. Do document E&M elements in full

Evaluation and management services are often unsupported at the level billed. New patient visits, emergency services, consultations, initial inpatient encounters, and observation services require that the provider meet or exceed each of the history, examination, and medical decision-making components for the service level chosen. Often, the review of systems (ROS) section is too weak to support the code level that the provider desires to report.

For example, in order to report a level IV or V service, documentation must substantiate the review of 10 body systems. Or, the provider may discuss all positive findings and pertinent negative findings, finally stating that all other systems are negative. If two-nine systems are reviewed during an outpatient consultation, service cannot exceed 99243.

Based on the current Medicare Physician Fee Schedule, there is a revenue difference of about $60 between 99243 and 99244. The difference between 99243 and 99245 is about $100. Medical necessity should always drive the level of service, but consistently under-documenting the ROS alone substantially reduces revenue.

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