Better Coding through Improved Documentation: Strategies for the Current Environment

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Now more than ever, HIM professionals must ensure that documentation of health information is thorough, clear, and accurate. Here are some strategies to solve problems and improve processes.

Health information managers and coding professionals have always played a vital role in advocating for clear, complete, pertinent, and accurate documentation in the medical record. This role is of paramount importance given today's government focus on fraudulent coding and billing practices. It is clearly necessary for HIM professionals to lead our organizations and providers down a path that results in thorough and clear medical record documentation that describes the care and services provided to patients.

A Starting Point

The foundation for medical record documentation practices exists in a variety of regulations and standards, including the hospital accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations and the Medicare Conditions of Participation. In addition, licensure regulations promulgated by many state departments of health contain regulations for documenting in the medical record.

An initial strategy is to reexamine organization policies and rules and regulations regarding documentation requirements for individual reports and entries in the medical record. Include all types of records (inpatient, ambulatory surgery, invasive procedures, observation, outpatient testing, outpatient clinic services, and emergency). Frequently, policies are out of date or rules and regulations do not address all record categories. Reestablish your baseline expectations regarding content and format for both paper and electronic records. Examine policies from the compliance standpoint to determine if your organization's documentation requirements support coding. Identify where changes, if approved, would provide more complete information at the point of coding.

All organizations accredited by the Joint Commission are required to complete ongoing medical record review "for completeness and timeliness" of information and to determine that required documentation is present, legible, and authenticated. The intent statement of Joint Commission standard IM.3.2.1 delineates those minimum aspects of documentation that must be reviewed. This standard further requires that "action is taken to improve the quality and timeliness of documentation that impacts patient care."

HIM professionals and physicians now have a vested interest in constructively utilizing IM.3.2.1, along with performance improvement strategies, to improve documentation to support accurate, timely, and complete coding.

Work with your organization's medical record committee or equivalent to define and refine appropriate indicators to assess documentation as it relates to coding. Involve a physician liaison, if you work with one on a regular basis, to assist with coding questions and documentation issues. Select priority areas for review that will produce meaningful results. Focus on documentation indicators that coders identify as problematic. Structure the documentation review plan to focus on certain types of cases or DRGs, such as pneumonia, diabetes, septicemia, or anemia or to systematically assess specific types of denials.

In addition to the elements required for review under IM.3.2.1, consider adding the following indicators:

- Documentation explains the reason each medication was ordered

- Documentation explains the reason each test was ordered
- Documentation explains each abnormal test result
- Documentation explains the reason for each treatment provided
- Progress notes are updated to reflect the treatment plan
- Progress notes document the diagnosis(es) related to the treatment plan
- Progress notes document all procedures performed
- A final progress note contains the final diagnosis(es)
- Final diagnoses are specific and stated in complete, descriptive terms
- Final diagnoses statements include the etiology of the condition
- The content of the discharge summary is consistent with the rest of the record

Following review and data collection, summarize and analyze the results in conjunction with your committee or team to determine if performance meets expectation or if there are any findings or trends that warrant improvement. Brainstorm potential action strategies and document plans for improvement. Such actions may include provider education to increase knowledge, development of new medical record forms or tools, or further revision of documentation policies and requirements.

Educating Providers

A workable strategy for physician education is challenging because of physician constraints on time, level of interest, and the need to structure the content of the education so it is viewed as useful by the physician participants. Programs should be relatively short (ideally 30 to 45 minutes) and the subject matter must be directly related to the physician's practice.

Therefore, when presenting results of the documentation review, structure the content for a targeted group of physicians involved in the care of the specific types of cases reviewed. Provide exhibits and examples of complete and accurate documentation and demonstrate specifics on problem areas that impact coding. In addition, explain to the physicians how the coded diagnosis and data translate into a DRG, and how the same data flows to their own hospital practice profile. For example, Figure 1 demonstrates the results of review of 30 diabetes mellitus cases from October 1998. Cases were reviewed to determine the number of cases that reflected specific and complete diagnosis statements relative to the diabetes. The final diagnosis of diabetes mellitus was checked for inclusion of the type of diabetes, a statement regarding control of the diabetes, and the presence or absence of manifestations. Through demonstration of specific documentation examples, physicians will learn more about their role in compliance, how their documentation impacts the quality of coding and data, and how more complete documentation will help the compliance strategy of the organization as well as the accuracy of coding and data collection methods in their practices.

The Coding Process

Coders must often code inpatient medical records within three to five days of discharge. When this requirement is strictly applied, coders may be in the position of relying on incomplete, conflicting, or inconsistent medical record documentation.

To support accurate and complete coding, organizations must enforce their own policies, rules, and regulations for the timely entry of information in the medical record and for timely completion of medical records. These requirements are based on Joint Commission standards, Medicare conditions, state regulations, and standard medical record documentation practices. The only dictated reports that may not be available immediately upon discharge are the discharge summary or an operative report or pathology report if the procedure was performed the day before discharge. These documents should be available on the record or electronically no longer than 48 to 72 hours after discharge. All other documents, including the history and physical, consultations, emergency records, and diagnostic results must be immediately available.

Regulations do not specify what information or documents must be present when coding is performed. However, the OIG Compliance Program Guidance for Hospitals states that "the documentation necessary for accurate code assignment should be available to coding staff." Organizations must establish more firm policies for their coders regarding the minimum documentation that must be present in order to code.

The only question on the table should be whether to code without a discharge summary, since this should be (and usually is) the only missing dictated report. If your organization affirms a policy allowing coding without the discharge summary, there must be a follow-up review mechanism in place to validate the accuracy of the codes originally submitted.

Each organization must also define a mechanism for each coder to communicate with physicians if necessary in order to obtain clarification on conflicting, incomplete, or ambiguous documentation. The defined mechanism should be reviewed with administration and the medical staff to make sure that you have the needed support and that physicians understand that coders will contact them when they need to. There also must be a clear agreement that physicians are expected to respond to questions in a constructive and helpful way, and that requests for information cannot go unanswered.

Physician responses to coder questions must be documented in the medical record. It is always preferable that the physician write a correction or an addendum to an existing report if needed. However, in reality this may not always be possible. As an alternative, consider a formal query or clinical clarification form approved by the medical staff and made a permanent part of the medical record. These forms must always contain patient identification, be dated, must always contain a specific question and the identification of the coder asking the question, and include a signed response by the physician in his own writing. If you are concerned about the risk of using such a form, or if your legal counsel advises against it, your policy can require that the physician must make a correction or addendum to an existing report after responding to the query.

Incomplete and Delinquent Medical Records

According to Joint Commission standard IM.7.6, incomplete and delinquent medical record statistics must be reported at least quarterly as part of the medical record review function. The volume and types of medical record deficiencies and delinquencies are directly related to the organization's ability to effectively implement an effective compliance strategy that supports accurate data collection, coding, and billing practices. All organizations should strive for systems that permit completion of documentation as close to the point of care as possible.

A compliance framework and systems improvement viewpoint must be adopted for review and analysis of data on incomplete and delinquent medical records. In addition to reporting the data to the medical record committee or equivalent, consider also forwarding the data to your compliance committee or officer. This is particularly helpful if you need more support, if performance has not or does not improve, or if medical record committee analysis and actions have not been effective.

Concurrent Strategies

Implementation of a concurrent approach to documentation improvement is an alternative strategy to address missing documentation and clarify conflicting or ambiguous documentation. Concurrent review of documentation requires assignment of HIM, coding, and case management staff or a combined team to review medical records on patient care units from the time of admission and to concurrently assign diagnostic and procedural codes.

Some potential benefits and advantages of a concurrent approach include:

- improvement in timely documentation resulting from identifying and requesting missing reports and information
- in-depth knowledge about patients and their plan of care and/or pathway
- ongoing review of orders, medications, and treatments in conjunction with the stated diagnosis
- increased opportunity to communicate with the physician to seek additional information when documentation is incomplete or ambiguous

- verification that the physician has entered clarifying documentation in the medical record as needed
- heightened visibility with the healthcare team and opportunity to ask questions about the patient, the plan of care, and treatment
- ability to complete and verify final coding on discharge for a majority of the cases
- pportunity to lead the charge for documentation improvement

Some potential disadvantages and barriers to concurrent approaches include:

- lack of available and competent staff who are properly trained in coding and documentation practices
- inadequate or available space to work on patient care units
- legacy systems that do not support concurrent methods
- challenges in changing work practices and processes
- poor acceptance by the medical staff

Outpatient Documentation

In spite of the increased focus on the need for diagnostic information to support the medical necessity of outpatient testing, hospitals continue to experience problems in obtaining adequate diagnosis information from physician offices when outpatient lab tests, radiology procedures, and other ancillary tests are ordered. The lack of documentation places the hospital at risk for a denial (in fact, the hospital can't bill for the test or procedure without a diagnosis). The problem is that once a patient arrives for a test, it is almost too late to seek additional information from the physician. Since the physician must be the diagnostician, it is inappropriate to question the patient about the reason for the test.

Some strategies you can use to solve the inadequate documentation problem include:

- Train and educate all hospital registrars and ancillary department staff who have responsibility for scheduling tests and procedures. Make sure they are knowledgeable about the information requirements and completely understand why the information is needed. Demonstrate complete information flow from physician office to patient registration to testing department to coding to billing. Continue your demonstration through the payment and denial steps
- Provide education sessions for physicians and their office staff covering the regulations and requirements for documentation to support medical necessity for outpatient testing and procedures
- Develop a combination order/requisition form that all physician offices must utilize to order tests and procedures. The content of the requisition should include patient information, diagnosis, the test(s) ordered and corresponding CPT code, physician signature, date, and provision for the advance beneficiary notice
- Implement a "no excuses" policy that information must be complete before testing is performed. Require registration clerks or the testing department to obtain the information on a pre-testing basis
- Analyze claim denials to understand the most frequent reasons they occur. Develop an improvement strategy in the performance improvement sense. Establish a team to review data, including source documents and coding. Make recommendations for improving information flow and the documentation process; follow with appropriate educational strategies
- Consider whether professional coders should be relocated to the registration area to assist in obtaining information and to perform real-time coding

- Look at electronic solutions that link the physician offices with the hospital

Summary

The most ineffective approach an organization can take is one of doing nothing to improve its compliance processes. In some cases, administrators have ignored outpatient documentation requirements in the name of not upsetting physicians; some organizations continue to write off hundreds of thousands of dollars in denials because their information processes are poor. And some organizations require coders to obtain the information after the fact, which does little to improve the process or physician compliance. Nor does it assure that additional documentation is maintained in the medical record with the initial order or requisition.

Clearly, organizations must identify problems with inadequate medical record documentation and begin to address these issues in partnership with their medical staff. Complete, clear, and accurate documentation is the foundation for complete and accurate coding of all types of medical records. Health information managers have yet another opportunity to lead the way to effective compliance in their organizations by making sure policies, rules, and regulations are complete and thorough, by regularly reviewing documentation practices, by encouraging the organization's leaders to adhere to regulations, and by implementing new strategies and practices that support documentation improvements.

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