

Emerging Issues in Physician Documentation and Compliance: All of the Old, More of the New

Programs are Urged to Consider the Benefits Associated with Improved Clinical Documentation

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Complete and accurate documentation by physicians and other caregivers remains a critical concern throughout the health care industry. Quite simply, medical record documentation is the backbone for verifying the medical necessity of — and compliant reimbursement for — all services rendered to patients under care.

Many health care organizations and their compliance programs continue to focus efforts on improving the quality of medical record documentation that impact a wide range of services and issues, ranging from the historically well known such as triage and medical screening examinations in the emergency department and billing, to newer dependencies such as Medicare severity diagnosis related groups (MS-DRGs), direct financial penalties for preventable errors and nonsocomial infections, and pay-for-performance initiatives.

Emerging regulations, operating requirements, and payment mechanisms likely will contribute to the challenges already faced by health care organizations to prepare for new mandates affecting documentation practices. Accurate and appropriate clinical documentation is not only necessary to support the appropriateness of care, reduce claim audits, make an appropriate DRG selection, and facilitate timely patient discharge, but it also indicates success in any program related to quality improvement.

Therefore, as the correlation between clinical records, quality indicator reporting, direct financial reimbursement, and financial incentives grows, the importance of having solid clinical documentation processes increases



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in significance. This expands the opportunities and instances in which compliance can serve a central role for the entire provider organization by directly impacting documentation performance.

The goal of this article is to address ongoing documentation concerns, highlight some less often addressed areas, such as the involvement of case managers in documentation and reduction of compliance risk, describe at a detailed level the implications of the implementation of the Medicare severity DRG, and suggest possible strategies for health care organizations and their compliance programs to address these current and emerging regulatory issues.

The strongest compliance officers recognize the opportunities they have to positively impact performance of their organizations well beyond the most straightforward of regulatory adherence concerns. The issues addressed in this article attempt to provide guidance to such efforts and to raise the awareness of such potential added value throughout the industry.

CURRENT CONCERNS IN DOCUMENTATION PRACTICES

It is easy to start any discussion of documentation performance improvement by discussing the basics of health information management (HIM) and coding department concerns. There is much written on those details, however, and we have attempted to explore other, less often addressed issues in this article. Specifically, recent experiences in consulting with our clients have reminded us of the critical and unique role of the case management department with respect to documentation, compliance, and reimbursement concerns and of the value of case management participation in achieving enhanced documentation through compliance and documentation performance improvement processes.

Case managers play an important role in assuring an appropriate and accurate medical record because they have the primary responsibility to review and identify key

clinical elements that establish medical necessity within the medical record. Moreover, they are often responsible for utilization review, aspects of denials management, and other such related functions.

Although hospital documentation processes may differ slightly from one organization to the next, the goal is usually the same: the medical record should provide a clear, complete, and legible documentation of the case, how the physicians formulated a plan of care, the treatment provided, and ultimately the reimbursable services. The case manager should review available documentation to ensure that it conveys the acute or chronic nature of the presenting condition or chief complaint; measures the severity of the symptoms to the patient's baseline clinical health; and states the physician's plan of care in response to identified clinical problems or those being ruled out.

The challenge to substantiate medical necessity is typically not due to the case being managed at an inappropriate level, but rather that the documentation to support the intensity of the care is missing. Late entries, illegible notes, missing remarks about case findings, and patient progress and/or plan of care considerations have consequences such as higher costs due to duplication of treatment, unreimbursed/uncaptured services, and compliance concerns for potentially unsubstantiated services.

Such documentation deficiencies also can lead to an extension of the length of stay because a discharge plan has not been effectively communicated. The case manager should be assertive when addressing concerns that the medical record may be missing or has miscommunicated information about the case. The case manager also has a huge responsibility to discuss whether the clinical documentation supports the appropriate and clinically necessary admission status of the patient or if the admission is for the convenience of the patient, family, or possibly even the physician. Each of these issues becomes all the more important under MS-DRGs, as discussed below.

Once the case manager is able to substantiate the medical necessity for the admission status, the next step is to ensure that the level of care is appropriate to address any patient risk and the intensity of service required. For example, admission to a telemetry unit may not be fully justified if specific clinical documentation regarding the need to monitor a condition is not in the medical record. The case manager should meet with the attending physician to review the plan of care and discuss key documentation gaps in an effort to promote the most complete factual documentation of the case.

Being able to demonstrate medical necessity at the most appropriate level with accurate and complete documentation of a clinical case does not guarantee payer reimbursement. It is, however, a vital step in a complex process to promote the best chances for correct reimbursement. In addition to the reimbursement implications, it provides more complete data to be used in quality improvement initiatives or pay-for-performance programs, and demonstration of accurate and appropriate medical necessity also puts the hospital and provider in a better position to respond to any payer or compliance audit.

Thus, like the broader view we take on compliance's role, case management's role also can be viewed in a broader light. Organizations are encouraged to capitalize on the opportunities to benefit from this broader perspective and establish processes that create a more inclusive and comprehensive approach to documentation, compliance, and revenue cycle performance management by bringing in those that are sometimes not included in the management of such functions.

EMERGING DOCUMENTATION PRACTICES

Documentation improvement initiatives continue and are not new in the industry. Experience indicates, however, that such efforts often are not fully accepted or sustained to an organization's detriment. As ref-

erenced above, incomplete, inaccurate, and illegible medical record documentation continues to contribute directly to misdirected financial planning, lost revenue, and the coders' inability to identify key information to support billing results. It also can reduce the quality of care, increase compliance risk, and negatively affect payment for services.

Now as never before, however, hospital medical record documentation will be even more determinant of reimbursement. As we evolve toward severity-weighted diagnosis related groups, we are again reminded of how increasingly important it is to ensure and develop processes to promote the most accurate and complete documentation of the medical record — as well as to ensure the coding team is primed and ready for this new challenge.

While responsibility for MS-DRG implementation could be left in the hands of HIM and coding, a broader involvement and understanding of the system from throughout the organization — admissions, HIM, case management, revenue cycle, and finance to name a few — is highly recommended and would be considered a best practice. In light of the importance and timing of this issue and the detailed-level understanding of it that is required to benefit departments such as compliance, we have taken this opportunity to present a thorough discussion of this new reimbursement system and the relevant implications.

The Brave New World of MS-DRG

On October 1, 2007, implementation of the Medicare severity DRG payment system brought with it the greatest impact on Medicare reimbursed hospitals in 24 years. This severity-based hospital inpatient prospective payment system (IPPS) is a refined classification system that represents a comprehensive approach to applying a severity of illness stratification for Medicare patients throughout the DRG system.

Previously, cases were classified into the Centers for Medicare and Medicaid Services (CMS) DRGs for payment under the

IPPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of DRGs, classification was also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information was reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

Under the new severity-based DRG system, CMS consolidated the current DRGs into Medicare severity-based DRGs. Each MS-DRG has been further divided into subgroups based on the presence of a major complication and comorbidity (MCC), complication and comorbidity (CC), and/or a non-complication and comorbidity (non-CC).

This methodology is based on the severity of the ICD-9-CM diagnosis code. As a result of this further refinement within each base DRG, 745 MS-DRGs were created. CMS believes MS-DRGs will represent a substantial improvement over the current CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption. With the implementation of the MS-DRG payment system, patients will be assigned to the subgroup corresponding to the most extreme CC present.

As discussed above, implementation of the MS-DRG payment system will require a coordinated response from many hospital departments, including administration, HIM, patient financial services, medical staff, information systems, quality improvement, and the compliance office. It should not go unmentioned that physician participation, training, and understanding of this system is vital. With CMS raising the bar to identify and adjust payment for the more severe and service intensive cases, inaccurate, vague, and/or incomplete documentation and coding carries a more significant potential financial risk for the health care organization.

To minimize an organization's financial risk, the resurgence or reassessment of a clinical documentation improvement program should be the key initiative to pro-

mote the most accurate and complete coding of a clinical case under the new MS-DRG system. The second key initiative to prepare for MS-DRG changes over the three-year transition period is to promote ongoing and timely training for coders and clinicians, increase current audit quotas, and address any process or systemic barriers to performance improvement in these areas, including case management.

Clinical documentation includes any and all information related to the care of a patient from admission to discharge. In the acute care inpatient setting, the attending physician bears the primary responsibility for all documentation included in the medical record to demonstrate the severity of the case under the MS-DRG system; however, the facility coder has the opportunity to query the physician to better demonstrate the relevance of this clinical documentation if any component is deemed vague, conflicting, or incomplete. The coder also can remind the physician to document the clinical significance of diagnostic results and agree or respond to care-plan entries by other practitioners in order to support a higher severity level as classified by the new MS-DRGs.

Whether the facility procedures allow for concurrent coding or post-admission coding of the medical record, the coder initially will review the history and physical (H&P) as a first point of reference to help identify the reason for admission or principal diagnoses as well as any secondary diagnoses present on admission.

The H&P should contain a chief complaint, which is the presenting symptom or group of symptoms for which the patient required hospitalization and treatment, and the history of the present illness that chronicles the events leading up to the hospitalization. The coder will assess information included in the "Past Medical History" and "Past Family and Social History" sections of the H&P to evaluate the relevance of those conditions on the current case (*e.g.*, if the condition will be treated or evaluated dur-

ing the current admission) and to help support the severity of the admission.

Chronic medical conditions that do not exhibit an exacerbation of that condition will not support the coding of a MCC or CC ICD-9 diagnosis under the new MS-DRG policy. H&P documentation that includes a comprehensive physical exam that includes vital signs and a thorough review of all body systems, detailing those body systems involved based on the presenting chief complaint as well as indications and results of pertinent diagnostic tests, will impact the severity of the admission as well.

If the coder believes a diagnosis or clinical indicator identified in the H&P can appropriately impact reimbursement but the current H&P documentation is insufficient, a query to the physician should be initiated. The same query option should be considered by the coder if the physician's documented impression, list of conclusions, and plan of care do not provide a clear correlation back to the documented information from the H&P.

The complexity of the case should be supported in daily entries by the attending physician (or covering attending) in the form of a medical record progress note. The progress note entry should address any changes in the patient's condition and action taken, new diagnoses and/or complications that have arisen, unresolved problems with status, treatment and response, clinical significance of ancillary testing and results, concurrence or non-concurrence with other clinical documentation, revisions to treatment plan, and medications ordered. The importance of a complete progress note cannot be overemphasized as each entry will have a potential impact on the severity of the case, hence the MS-DRG assignment.

The review of daily progress notes should provide a chronological "story" of the patient's stay and progress, state the physician's agreement or divergence with a consultant's recommendation, eliminate or add working differential diagnoses, and state whether a patient's condition has been ruled out if previously iden-

tified as "probable" or "possible" or "to be ruled out." Deferring to a lengthy discharge summary to state the key points of a clinical case does not support the accurate and complete coding of the medical record or severity level assignment under the MS-DRG payment system.

When an operative procedure is performed, the coder will search the medical record to identify the preoperative and postoperative diagnosis, procedures performed, primary and assistant surgeons, duration, anesthesia, indications, findings, description of procedure, specimen removed, sutures and drains, estimated blood loss, fluids replaced, complication, and disposition of the patient at the end of the procedure. Lack of specificity in any of these details can directly impact the coder's ability to code to the highest and most appropriate level, again affecting severity under MS-DRGs — thus negatively impacting the reimbursement for the case.

The discharge summary should be nothing more than what it sounds like it should be — a summary of the hospital stay. The discharge summary should include the principal diagnosis as defined by the uniform hospital discharge data set (UHDDS): "that condition, established after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Another critical change under CMS's IPPS final rule is the exclusion of complication consideration for increased MS-DRG payment when one of the eight selected hospital-acquired conditions is not coded as being present on admission and occurred during the hospital stay. The coder should look within the medical record and identify any additional secondary diagnoses that have been classified or reclassified as an MCC or CC condition to appropriately impact the MS-DRG reimbursement. The discharge summary also should restate the reason for the hospitalization and include any significant findings, provide a summary of all treatments and patient responses, as well as all tests performed and their findings.

These are some important ways to ensure a complete and accurate medical record that reflects the “true” complexity/severity of the case that will have a direct impact on DRG assignment under the MS-DRG system. Bear in mind that complete documentation, abstracted through proficient coding, has the potential to mitigate the risks of noncompliance and loss of revenue.

Complete and accurate documentation has a direct impact on a facility or provider’s ability to demonstrate the quality of patient care provided and the severity of the case, which can in turn lead to appropriate reimbursement under the new MS-DRG system. In addition, it should produce greater adherence to CMS rules and regulations, better performance on quality measures, and decreased compliance risk as it can offer protection to the health care organization and provider in the event of an audit or legal dispute.

DOCUMENTATION, QUALITY, AND COMPLIANCE

Finally, in this last section we want to address other areas that rely on documentation and that should be considered in addressing today’s myriad documentation needs. We have established that new government and private payer programs are introducing direct and meaningful financial incentives for providers and practitioners to focus on documentation and quality.

Quality deficiencies and their remedies come from many of the same issues that are at the root of compliance activities, and therefore, compliance can truly play an integral role in achieving benefits throughout the organization by encouraging requisite improvement. As compliance officers increasingly become members of senior management, they must be aware of the wide-ranging issues facing their organization, particularly when their work may be affected by such issues.

Many of the activities compliance officers are involved in — such as trying to improve documentation to improve compliance and limit the risk of litigation, submission of false claims, and payer audits

— also have financial implications, as evidenced by the discussions above.

A hospital’s or physician’s performance on CMS quality of care measures or a pay-for-performance program such as those sponsored by CMS, private payers, or organizations such as the Leapfrog Group, Bridges to Excellence, or the Integrated Healthcare Association is determined by the information found in the patient’s medical record and cannot be separated from any of the other reasons to ensure accuracy in these areas.

Pay-for-performance programs such as these serve as ways to encourage higher quality and more standardized care through the provision of financial incentives to physicians and hospitals that adhere to evidence-based guidelines. Programs such as the Reporting Hospital Quality Data for Annual Payment Update, which was included in Section 501(b) of the Medicare Modernization Act of 2003, will reduce Medicare payment to hospitals that fail to submit quality data on a set of 21 measures related to the quality of care within the inpatient setting.

Moreover, CMS continues to develop initiatives such as the “Hospital Compare” Web site, which publicizes individual hospital performance on specific quality indicators and allows consumers to compare hospital performance on care for heart attack, heart failure, pneumonia, and surgical infection. These examples and the increased emphasis on MS-DRGs are only a few areas where there are direct and indirect effects on quality and documentation as hospitals that perform at a lower level on quality measures may receive reduced payment and/or negative publicity.

CONCLUSION

Compliance with newly developed documentation principles, particularly with respect to MS-DRG and the Medicare Physician Quality Reporting Initiative (PQRI) programs, will continue to exert pressure on physicians and other caregivers — and the facilities in which

they work — to devote more time and attention to their documentation practices in acute as well as ambulatory care settings. Such obligations will require increased coordination and education between physicians and other caregivers and their colleagues in compliance, information technology, care management, and financial services.

Compliance officers and programs, given their unique position and responsibility within the organization, are urged to

consider the wide range of benefits associated with improved clinical documentation and its direct and indirect effect on quality, finance, and compliance. Furthermore, as the link between facility and provider reimbursement becomes increasingly tied to documentation and quality, compliance officers will have new opportunities to improve quality of care and documentation within their organizations while helping to make a positive impact on the bottom line.

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