

Improved Documentation

Leveraging staff training, benchmarking, technology,
and process change for accurate payment



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Providing adequate detail in medical records for billing may seem relatively unimportant when compared with the attention physicians must give to providing high-quality patient care. Yet this task isn't one to be taken lightly.

Helping physicians dot the I's and cross the T's has never been more important, as new coding rules are changing the definition and calculation of payment and external groups are comparing and contrasting the performance of individual providers, point by point.

The Need to Improve Clinical Documentation

Concern about the financial fallout from the shift to severity-based diagnosis-related groups is very real, particularly when today's hospitals already are facing payment challenges.

Such is the case at Sun Health Boswell Hospital in Sun City, Ariz. The 501-bed hospital has an 80 percent Medicare population, an average patient age of 70 years, and inpatients with multiple comorbidities and complications (CC). The latest increase from the Centers for Medicare and Medicaid Services (CMS) was less than 1 percent.

"We always seek good quality documentation," says Nancy Burton, CEO of Sun Health Boswell Hospital. "However, when you're faced with stagnant or further possible reductions from major payers, it is critical that you exhaust all opportunities to improve the accuracy of documentation."

But declining payment is not the only reason why hospitals are seeking to improve clinical documentation. The way they appear in public data is another driver.

Groups such as Thomson Healthcare and The HCIA-Sachs Institute scrutinize data from public sources, such as the Medicare Provider Analysis and Review (MedPAR) data set, CMS Standard Analytical File, outpatient data, and Medicare Cost Reports, to identify the top hospitals in the country on the basis of such clinical metrics as risk-adjusted mortality, complications, patient safety, core measures scores, and severity-adjusted average length of stay. And they highlight key differences in performance, including shorter average lengths of stay and lower costs per case, for the top performers.

Also, HealthGrades regularly analyzes data from Medicare discharges from all U.S. hospitals to profile the quality of care at the national, regional, and state levels, and it ranks individual

hospitals from best (5-star) to poor (1-star) for particular disease conditions or surgical procedures.

Hospitals are becoming increasingly sensitive to the story that these public data files are telling managed care companies and consumers. Do the final billing codes that come directly from physician documentation indicate a hospital has patients with less severe conditions, longer lengths of stay, and higher costs than peers? If so, why would managed care companies want to send their enrollees to that hospital when they can find another institution that treats sicker patients in shorter periods of time at less cost and with good outcome results?

"Our need to make sure we are following coding guidelines correctly and capturing every detail we possibly can has been heightened not only by the demands we place on ourselves, but also by external demands for quality information reporting," notes Roland S. Funsten, FHFMA, vice president of finance and revenue cycle for St. Vincent Health, a healthcare system that includes 17 hospitals in and around Indianapolis, Ind.

"There's still the demand for prompt turnaround on payment, billing and processing, and bill payment," he says, "But there is also increased demand for taking the time to make sure we have adequate supporting documentation on file to improve reimbursement to the highest permissible level and to look for opportunities to capture better and more succinct information about the diagnoses or conditions that affect a patient's stay in the hospital or their care."

Hospitals consequently are turning to concurrent documentation programs that evaluate the content of medical records to see how well they assign DRGs, severity of illness, and risk of mortality, to teach physician documenters and inpatient nurse reviewers about Medicare reporting and coding requirements, and to monitor documentation and coding performance, case-mix index, and CC rates. And they are increasing their case-mix index, rate of reimbursement, and DRG-weighted ratios as a result.

Sun Health Del E. Webb Hospital

In late 2006, the Sun Health Del E. Webb Hospital in Sun City, Ariz., (a sister facility to Sun Health Boswell Hospital) was not sure documentation truly reflected the care of its patients. An internal chart review suggested that coders weren't picking up the detailed level of data that was needed to bring the

hospital's clinical core measures up to the benchmarks it had set for itself. The hospital's goal was to be in the top quartile for all CMS core measures. But for some measures, it wasn't even reaching the average for the state or for the nation.

"As we looked at some of those variations, we began to ask ourselves, 'Have we gotten sloppy with the documentation work that we're doing?'" recalls Jo Adkins, CEO of the 332-bed facility. For patients with congestive heart failure, for instance, were they being discharged on angiotensin-converting enzyme (ACE) inhibitors, and if they weren't, why not?

Although the hospital routinely is one of the top 100 cardiovascular benchmark hospitals rated by Solucient and has been ranked in the top 5 percent by HealthGrades for the past four years, it also wanted to take a broad look at its severity of illness in comparison with peer institutions to be sure acuity levels reflected the patients it was treating and the care it was rendering.

A medical record review by an outside consulting firm showed that the hospital was indeed missing documentation of data elements that related to the severity of illness of patients and CCs. External benchmarking showed that the severity of illness of Del Webb surgical patients was lower than the average for the state of Arizona, even though the hospital has a high percentage of elderly Medicare patients who require a tertiary level of care.

A concurrent documentation program launched throughout the Sun Health system in May 2007 placed clinical nurse liaisons on patient care units to work with physicians, nursing staff, and the quality improvement department to assure that clinical language was clear and specific, that coding was accurate and timely, that core measures were properly reported, and that appropriate CCs were picked up and reflected in reimbursement. As a result of the program, Sun Health Del E. Webb has seen its case-mix index grow in one quarter by 1.84 percent and in another by 5 percent, its medical CC capture rate rise, and its severity of illness increase against external database benchmarks.

■ Sentara Healthcare

The seven-hospital Sentara Healthcare system in Norfolk, Va., installed a concurrent documentation program in 2005 when it found that clinical documentation wasn't explicit enough to accurately code for MedPAR and other public data profiling.

The Shift to MS-DRGs

The introduction of the Medicare Severity DRGs (MS-DRGs) in the August 2007 rule (effective October 2007) is the most dramatic restructuring to date of the inpatient prospective payment system. It replaces 538 standard DRGs with 745 severity-adjusted MS-DRGs, which have been grouped into CC (complications or comorbidities) or major CCs. Some diagnoses, such as congestive heart failure, may now fall into one of three MS-DRGs (one with MCC, one with CC, and one without CC or MCC), and payment varies accordingly: \$6,247 for a case of congestive heart failure with major complications or comorbid conditions, \$5,030 for one with complications or comorbidities, and \$4,351 for one with no complicating conditions.

Beginning in October 2008, CMS will reduce payments if one of eight specific CCs or MCCs was not present on admission and developed during the patient's hospital stay: catheter-associated urinary tract infection, pressure ulcers, vascular catheter-associated infection, surgical site infection, and serious preventable events involving an object left in the body after surgery, air embolism, blood incompatibility, and an external injury or burn.

To respond to these changes, hospitals need to be diligent about improving documentation and coding, or they risk having cases assigned to less complex MS-DRGs and their payments will decline.

In 2007, with the introduction of CMS' new MS-DRGs coding requirements (see sidebar, "The Shift to MS-DRGs") the program added another focus, says Marion Swaim, vice president of health information management.

The system's 19 concurrent documentation specialists continue to make sure reporting for external databases is complete and precise. The specialists also scan for information that may significantly affect payment under the new Medicare coding rules, such as present-on-admission diagnoses and specific descriptors that may push a patient's case from one DRG to another.

"Our intent is not to have a fully coded record at the end of a patient's stay, but rather to make sure we capture documentation

The Key to Success

A concurrent documentation program cannot be effective without strong relationships between clinical documentation specialists and physicians as well as coders.

“There needs to be a relationship with the physician that is facilitative and inviting,” says Barbara Minick, vice president of professional services for Sun Health Boswell Hospital.

“There cannot be conflict between clinical documentation liaisons and physicians. There must be a high degree of collaboration, credibility, and respect for one another.”

The same goes for the relationship between the clinical documentation specialists and coders.

“You need to establish a positive relationship between the two groups,” says Minick. “The nurses need to feel comfortable enough to ask the coders questions and be willing to contribute clinical knowledge that the coders don’t necessarily have. There needs to be a lot of sharing back and forth.”

It takes the right kind of person with the right personality to fill the documentation specialist role, explains Roland S. Funsten, HFMA, vice president of finance and revenue cycle for St. Vincent Health, a healthcare system that includes 17 hospitals in and around Indianapolis, Ind.

“These are individuals who like to deal face-to-face with clinicians and who have the clinical background,” says Funsten. “One of the things that frustrates the medical staff is dealing with an individual who can’t follow a case or understand how one case may be different from another for clinical reasons. It takes the right personality plus knowledge and experience.”

that is important for coding at the end of the stay,” says Swaim. Concurrent documentation specialists look primarily at Medicare patients, reviewing the patient records the day following admission and identifying what is wrong with the patient and what some of the comorbid and complicating conditions are based on the history and physical examination

“They then begin to follow those patients every three days to look for interventions that are not clearly supported based on the documentation,” says Swaim. “They work with the

physician through a query process: ‘That antibiotic you prescribed, I don’t see the corresponding diagnosis. Can we talk about what’s going on with the patient?’”

Since the program began, Sentara has reduced the gap between its experience and national benchmarks, increased its cases that are in higher-weighted DRGs, and realized a net benefit of \$1.5 million in additional payment.

■ Physician Involvement

While there is no right or wrong way to structure a concurrent documentation program, what’s common to all of them is the need to get physicians on board. What physicians write in the medical records of their patients directly impacts the hospital’s public profiling scores and payment. If physicians don’t provide information in language that can be coded, a medical condition will go unreported, and the downstream effect will be missed payment and skewed mortality, complication rates, and other quality metrics.

Typically, physicians have not been taught to be specific in their documentation. They commonly use shorthand devices—symbols such as up and down arrows or abbreviations— or they refer to lab work or radiology reports, which may be appropriate from a clinical standpoint but can’t be used by coders. For example, while a down arrow written before “blood pressure 70/50” may mean shock to a physician, coders are required to follow rigid Medicare coding rules and will need a specific diagnosis of “hypotension” or “cardiogenic” or “hypovolemic shock.”

And things just got a lot more complicated with the release of the new severity-based MS-DRG Medicare coding system. Diagnoses that once were taken for granted as a CC that would routinely place a case in a higher-weighted DRG are no longer considered clear routes for payment increase. DRGs that were more heavily weighted simply because of the presence of complications and comorbidities now must be categorized by whether the CCs are major or minor.

A classic example is congestive heart failure, which last year was labeled a CC that would affect DRG assignment. This year, a straightforward diagnosis of congestive heart failure will not be regarded as a CC unless a physician reports it is acute systolic or acute diastolic heart failure. Massive re-education is needed to make physicians aware of the greater specificity that’s needed for documentation.

Physicians need to understand that documentation is not just a hospital reimbursement problem. Physicians need to realize they are partners with the hospital and that what's good for the hospital in the end is also good for the physician.

"There is an urgency for all of us to understand the need to partner for accurate documentation," says Burton of Sun Health Boswell Hospital.

The good news? Physicians are becoming more receptive as they learn about initiatives such as pay for performance, says Barbara Minick, vice president of professional services for Sun Health Boswell Hospital.

"As pay for performance gets talked about in a variety of settings—not just for hospitals but also for physicians—the awareness of the need to collaborate and partner with hospitals is definitely heightened, although you still have the challenge of getting physicians to understand what they can do to help the hospital, which is not necessarily their first priority," she says.

One strategy is to change the overall message, Minick says. In the past, Boswell and other hospitals used reimbursement as a sort of drumbeat. Boswell now is paying more attention to the ways in which documentation affects physicians.

"It's important for us to say to physicians, 'Your patients are sicker, older, more complex. This is your chance to have the empirical data to show that. So when outside agencies profile you, it's clear what type of patients you are truly taking care of,'" she says.

Minick adds: "In our conversations with most of our physicians, we are able to point to such things as, 'Here's a case mix that moves from x to y with accurate and appropriate documentation of the patient's condition.' It was hard at first for us to learn how to speak to that focus, as opposed to continuing the easy thing and talking about reimbursement. But our approach now is to talk to physicians about appropriate documentation of the patient's condition."

At St. Vincent Health, the focus of conversations is similar. "In physicians' quickness to complete a medical record, they may not clearly and succinctly document the acuity of a patient, which may end up reflecting poorly on them and their care," says Funsten.

Therefore, the concurrent documentation program at St. Vincent Health concentrates on helping physicians meet their own external quality indicators. For example, the program illustrates how coders use the information in physicians' progress notes

to distinguish between a complication and a normal or an expected outcome of a procedure. A frequent example is blood loss during implant surgery, which is not a complication.

"There are certain parts of the coding guidelines that, as much as you'd like to think are black and white, really are gray areas that are not clearly defined," Funsten says. "From a non-clinical point of view, you wouldn't have the medical school training or necessarily know the statistics that define what is to be expected following a particular procedure."

St. Vincent Health enlists the expertise of its medical director, who is an internist and hospitalist, as well as surgeons to get input and clarity.

"We want to be sure we don't inappropriately code a normal outcome of a procedure when in fact it's a complication," he says. "But sometimes it's a fine line. The important piece of this is having the avenues to go and get the information and advice."

The struggle is to get physicians to document in a diagnostic language, not just in the clinical language they are familiar with. What concurrent documentation programs try to do is bridge the gap between the clinical and the coding world.

That's where physician champions or advocates come in.

■ The Importance of Training

Concurrent documentation programs rely heavily on training physicians about the demands for greater specificity in their documentation, not only to adhere to new Medicare coding rules but also to provide an accurate picture of their patients for outside profiling agencies and to point out that the documentation that works in the private practice environment doesn't always translate to the hospital setting.

But formal departmental meetings go only so far.

"In any given hospital system, a departmental meeting will capture only about half of the physicians who need to be involved. So you can't just do that and assume everyone will know what's going on," Sentara's Swaim explains.

Sentara—like St. Vincent, Sun Health, and Humility of Mary Health System in Youngstown, Ohio—has cast a wide educational net.

Sentara's concurrent documentation program takes advantage of forums such as grand rounds and subspecialty meetings, and it targets physicians' assistants to help physicians

understand why they are being asked for more information. Early on, the program named a senior medical staff leader as a co-administrative leader of the project, and it made the vice president of medical affairs the point of contact for physicians at each site. The vice president of medical affairs not only helps to introduce the concurrent documentation program to physician specialties, but also works one-on-one with physicians or specific physician groups who do not understand the benefits of the program and why they need to cooperate.

Senior physician leadership is key at the other organizations as well. St. Vincent's medical director for case management plans and coordinates training programs for the system's medical staff and writes white papers as well as articles on documentation. Sun Health has placed at each of its two hospitals a general oversight physician advisor. At Humility of Mary Health System, the chief medical officer fills in gaps in the educational process for physicians and residents in training.

Typically, a second wave of support comes from clinical documentation liaisons or specialists—the frontline staff who deal directly with physicians on a day-to-day basis to identify what's in the medical record and, more important, what's missing.

Clinical documentation specialists on patient care units can provide vital reinforcement and on-the-spot training for physicians. "Physicians can't remember everything, so these are the people who are on the floors to assist and prompt, and leave queries for physicians," explains Minick of Sun Health.

At Sentara, nine concurrent documentation specialists are either registered nurses or licensed practical nurses. The specialists work with physicians to replace implied with explicit medical detail, clarify diagnoses that are present

on admission, and add descriptors that precisely define a condition or procedure.

Sun Health hired six nurses to act as documentation liaisons and conduct concurrent chart review on all 24 nursing units. The goal is to review 85 percent of all Medicare admissions every day. The documentation liaisons pull the lists of admitted patients every morning and within the first day of admission fully review the chart and start the query process with physicians. They also are the link with coders in the health information management department in a tandem approach to make the information as accurate as possible.

"They are chart auditing in real time," says Minick. "They fill out a face sheet of their interpretations of the patient's condition, primary procedures, diagnoses, present-on-admission diagnoses, etc. That face sheet then goes through a prebilling auditor in our health information management department and then to coding."

While Sentara regularly brings in external auditors for both inpatient and outpatient coding as part of its compliance program, the health system does not purchase outsourced labor for coding because of the expense, notes Swaim. Instead, the system employs coders who have more than five and closer to 10 years of experience, and it assigns one or more to work in a specific hospital depending on the needs of the facility.

In the system's general hospitals, coders work on all types of records. But at Norfolk General, Sentara's tertiary care hospital, one coder specializes in obstetrics because of the high number of infants treated in the neonatal intensive care unit and high-risk pregnancies. In addition, some coders specialize in cardiac care. In 2006 and 2007, Sentara added specialty coders for cardiac catheterization and interventional radiology because of the need to tie together documentation, billing, and coding for these areas. With such an arrangement, as soon as a case is documented, then the charges can be assigned and the codes can be matched to charges.

■ Connecting the Feedback Loop

Data gathered through regular monitoring focus further training efforts. A biweekly conference call between onsite clinical documentation liaisons and remote coders for Sun Health flags problematic diagnoses or reporting areas.



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Understanding Public Profiling

Beth Bumgarner, RN, MS, Alumnus CCRN, senior manager, Acute Care Consulting Services, 3M Health Information Systems, Atlanta, describes ways that documenting patient severity can affect payment and perceptions of hospital and physician performance.

Q We hear more and more about “public profiling” related to MS-DRGs and understand consumers can access this information via the Internet. What effect is public profiling having on hospitals? What role should our physicians play in this arena?

A Medicare introduced the Medicare Severity Diagnosis Related Groups (MS-DRGs) System effective Oct. 1, 2007. The system is designed to more accurately portray patient acuity/severity, and only physician documentation can be used for assigning diagnosis and procedure codes for reimbursement and public profiling information. “Public profiling” refers to severity of illness (SOI) and expected risk of mortality (ROM) assignment for each Medicare recipient.

Hospitals are realizing the importance of implementing concurrent documentation review programs because specific, accurate physician documentation is critical to

achieving appropriate reimbursement and accurate profiles. In these programs, nurses work with physicians to translate their clinical documentation into an appropriate “codeable language” before patient discharge so that the information is as precise as possible for each patient at the time of final coding and billing.

Profiling data is used by payers, employers, and patients to evaluate providers. If a hospital and/or physician have higher costs, longer length of stay, and poor outcomes, then payers and employers may not recommend sending their enrollees to them. Likewise, patients “shopping” for healthcare services may evaluate providers based on profiling information. Hospitals that are visionary and understand the dynamics between accurate documentation and the financial and profiling outcomes will be well positioned to survive in the changing healthcare environment.

Source: 3M Health Information Systems

Direct feedback to individual physicians as well as aggregate feedback by product line or service identifies opportunities for additional education at Sentara. From a random sample of inpatient records, St. Vincent Health reports trends and problem areas for nursing units or physician groups or service lines.

“We just grab any and every opportunity across the board,” Funsten says. “We look at every chance to educate, from a hallway chat to a formal 30- to 45-minute training session to a lunch-and-learn session.”

Software programs that track and trend data can help guide training efforts by generating monthly DRG monitoring reports as well as regular severity-of-illness and risk-of-mortality profiles.

But automated systems for alerting physicians about discrepancies or for streamlining the reporting process for the most part are still in the making.

“Any time you build anything with alerts, you have to make it selective enough so it doesn’t become a bunch of white noise. So you have to tread softly to start,” notes Swaim.

Sentara is in the process of launching an electronic health record project; the system just recently went live in its first hospital. The system includes documentation tools and built-in prompts that ask physicians to include certain descriptors as they create their progress notes. For example, they may be asked to describe whether a patient with CHF has left or right heart failure. Also, the system has capability for electronic messaging to allow for improved speed and

rates of response to queries by physicians. In addition, the project incorporates some automated tools to assist coders, such as access to online coding clinics and national coding publications.

Disparate systems give Sun Health access to data elements it can benchmark, including cost, length of stay, complications, and comorbidities. The hardest information to get is discreet data on individual physicians, Minick says.

"I can get a lot of global data, such as the case-mix index for medical DRGs, and I can see how the case-mix index moved for the neurosurgery service line," says Minick. "But I can't easily get information about how Dr. Jones' performance moved from here to there."

And that is a step that's definitely needed to engage physicians in improving documentation.

"Like all of us, when you ask someone to do something and they enter into a relationship with you, they want to know how well they did, they want a report card. I can't currently give one to Dr. Smith and thank him for his great documentation efforts and show how case mix, severity, and mortality risk reporting has improved," says Minick. "This is an important piece to show how a program is working, because if you can't give feedback to physicians at the individual physician level, show them the results, and reward their efforts, then they will wonder why they should be doing this."



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St. Vincent monitors case-mix index for all payers as well as Medicare, compares performance on classic versus the new MS-DRGs, and tracks responses by physicians to queries for additional information.

"We have a myriad of reports and tracking systems that look at how well we're doing," Funsten says.

St. Vincent is working on its own internal electronic health record and hopes to blend in automated processes for soliciting and capturing information for the medical record.

"You have to strike a balance between the effort it takes to submit a request for information and the amount of information you are asking for in the request, etc.," says Funsten. "But I do think that the technology will be the answer."