An Effective Documentation Strategy

With proposed payment changes from the Centers for Medicare and Medicaid Services, hospitals may need to ensure they are recording the severity profile of patients and the true cost of care to obtain the payment they are due. As such, many organizations are placing increased emphasis on their documentation strategies. HFMA, with sponsorship from 3M Health Information Systems, recently convened a meeting of senior healthcare executives to discuss preferred practices. In the following roundtable, several participants describe their organizations' strategies for improving documentation and offer practical advice on working with physicians to improve accuracy of documentation in order to optimize revenue.

How would you rate your organization's overall strategy toward ensuring accurate documentation, particularly those strategies that involve physicians in reflecting the severity profile of their patients and the true cost of care? Where do you think your greatest strengths and weaknesses are?

Hester: Our current strategy will change significantly in the next two years. At the present time, the information in our medical records and in the physicians' notes doesn't always coincide. So we've contracted with a team of certified professional coders to conduct chart analysis, perform in-house auditing, and help physicians with CPT (current procedural terminology) and ICD-9 coding. We also have begun to do more audits on documentation, and we have become more involved with the leadership of the physician groups.

Our strength has come from engaging physicians in charge capture. By involving them in the documentation and chart audit on the back end, they see the actual impact when the documentation in medical records does not justify the assigned level of care. We have physician advocates who bring to their peers examples of how discrepancies between the documentation in the medical record and the physicians' notes affect payment for the physician as well as the hospital. We also show physicians that improvements in documentation benefit overall medical care and service for the patient.

Cornicelli: One strategy that has been very helpful is to share the data and trends that are identified through the audit process with the clinical departments, especially in outpatient areas such as interventional radiology, cardiology, and vascular surgery. The clinicians in those departments can make inroads with physicians and be advocates to help improve physician documentation, especially when you can show that they are providing a certain level of service without documenting it and the hospital is losing reimbursement as a result. Sharing data with specific clinical departments and letting them be our resources is an obvious strategy, but sometimes one that isn't adhered to frequently enough.

Cohn: In terms of obtaining accurate documentation to support the level of care patients receive, an area of opportunity for us revolves around one-day stays and the types of treatment and procedures that are provided. We have placed a coder in the cardiac catheterization lab and in the interventional radiology department to work along with the clinical staff and review both charges as well as documentation about whether the patient belongs in the inpatient or outpatient setting. We have used external as well as internal auditors and conducted training sessions to work on areas where we found difficulties. Probably the biggest area we are still grappling with is in the emergency department, where we are educating physicians about what observation really means and what is needed to justify an inpatient admission.

How successful have you been in improving physician documentation? What are your success stories?

Lopez: One of our greatest successes has been our revenue cycle committee, which looks at different areas of the entire documentation process. We bring in reports from other committees that provide oversight, such as utilization review and case management, and we look at trends or denials or medical necessity issues. We bring in charts from specific physicians and analyze them in detail with the physicians who participate in the case management review. The revenue cycle committee provides case management leadership and alignment with physicians.

Cornicelli: We have a medical-surgical registered nurse in the medical records department who works extensively in auditing all of our target areas, including one-day stays and any other area where we have an increased focus, and who educates coders as well as physicians on the findings. We've received a lot of feedback from physicians who appreciate the level of clinical expertise as well as the coding expertise she brings to the table. We've given her a lot of training in utilization review, which has created a dynamic relationship between utilization review, case management, medical records, the business office, and clinicians.

Hester: We had a problem with denials on the back end from Medi-Cal. So we brought in a nurse auditor to meet with physicians and show that payment for the last few days of a hospital stay was being denied because there was no documentation to support continued hospitalization.

PARTICIPANTS

Kari Cornicelli, FHFMA, CPA, is vice president and CFO, Sharp Grossmont Hospital, La Mesa, Calif.

Augustine Lopez is CFO, Alvarado Hospital Medical Center, San Diego.

Robert Wardwell is CFO, Tri-City Medical Center, Oceanside, Calif.

Anthony Guerra is vice president and CFO, Sharp Coronado Hospital, Coronado, Calif.

Genevieve Nelwan is director of finance, Palomar Pomerado Health, San Diego.

Michael Hester is revenue cycle director, Children's Hospital and Health Center, San Diego.

David Cohn is vice president, revenue cycle, Scripps Health, San Diego.

Reid Hollyfield is director of finance, Tri-city Medical Center, Oceanside, Calif.

Rick King is vice president and CFO, Sharp Chula Vista Medical Center, Chula Vista, Calif.

When the physicians saw the actual documentation and the deficiencies the nurse auditor had found, they changed their mindset. Their charts are much more complete now, not just on the Medi-Cal population but on all patients, from the first to the last day.

We substantially improved coding compliance on our inpatient records through external audits, which also has decreased our rate of payment denials. Typically, payment for 5 out of 25 days was being denied. We are now getting payment for 24 of those days, and when payment is denied, it is usually for an outpatient observation. The external audits have been a huge success with physicians just by showing what we are looking for in terms of documentation and what the real loss is when there is a lack of documentation.

Lopez: We focused on DNFB (discharged not final billed) dollars that were 30 days and older, which totaled close to a million dollars. We set goals and developed a strategy to address that specific area by extracting reports that identified where these accounts were being held. Was it in the outpatient rehab area, or was it in the lab or in radiology? We pinpointed not just the department, but the specific patient accounts and the person responsible for getting documentation from the physicians. We worked with the directors of the departments and asked them to come up with plans to resolve these accounts, and all of a sudden, that million dollars became more like $150,000 outstanding.

Cornicelli: It goes to show how important it is to drill down into the data and know where your accounts are being held up, so you can focus directly on the clinical area that is involved and get some response. I believe clinical departments don't even realize just how a little bit of missing documentation or one or two incorrect charts can hold up accounts and prevent cases from being billed. Focusing in on these processes is important in the business office and in the medical records department.

Wardwell: One of the most successful things we did was to outsource the coding of our emergency department business. Outside coders were already doing 80 percent of the work for the physician component, so it wasn't hard for them to bridge the gap and do the technical side as well. Now we know that codes are in synch for each visit, and we are picking up additional reimbursement in the range of 15 percent to 20 percent.

Cornicelli: At two of the facilities at Sharp HealthCare, we have implemented an automated charge and billing reimbursement module within the emergency department. This automated module has allowed us to link clinical documentation to CPT codes for ED procedures, thereby

generating charges and eliminating data entry of procedural codes. We have seen an improvement in accurate clinical documentation and coding, which has improved our payment and compliance in billing.

What hurdles have you had to overcome? What suggestions do you have to help improve physician documentation?

King: One of the biggest hurdles is getting physicians interested in improving documentation. Until you can provide specifics in relation to their particular patients and what documentation means for them, the topic is meaningless to physicians. Physicians also want to be guided through the process and to know what their options are. So you have to get down to the level of templates and queries. When you start using these, documentation does improve.

Wardwell: A basic thing is to make documentation easy for physicians. Since our hospital did not have computerization, we started using checkboxes and basic templates to guide physicians through documentation, telling them to "check this box for verification" or "give us a specific phrase for this." We are in the process of producing a simple automated program that can be used on a wireless device so that all the physicians have to do to document care is work their way through the templates and checkboxes while they are with the patient.

What processes do you have in place for monitoring the effectiveness of physician documentation, whether for inpatient or outpatient services or the emergency department?

Wardwell: We formed a dedicated denial management unit and provided it with sophisticated software to categorize all denials and feed that information back upstream. As soon as we spot a trend, we bring the information to the front end and get the right people involved—physicians, nurses, imaging techs—depending on where the problem area is. Once we identify the challenge, we try to build templates or scripts, if you will, to help.

Lopez: Tenet has put together a system for tracking the reason for a payment denial, whether it is because of an issue with medical necessity, level or care, or a payer contract dispute. By categorizing denials in this way, you can learn what you're dealing with and then begin to attack the source of the problem, working with physicians if it's related to medical necessity or dealing with managed care if it's a contractual matter. Knowing where your denials are coming from and why payments are being denied allows you to take steps toward prevention.

Hester: Poor denials management of Medicare outpatients was a real issue when I was at an adult facility. Although we were losing a lot of money, nobody was monitoring denials. Physicians were typically using V-codes or rule-out coding, which they thought was acceptable. So we started accruing information and going to the physicians in the departments where denials were occurring. Just by changing the physicians' coding—with no additional charge capture—we improved payment on the outpatient component by about 12 percent.

How do you communicate documentation requirements to physicians and provide them with updated codes and the specific language that is needed?

Guerra: In the past year and a half, our medical staff office started publishing a new chief-of-staff newsletter. The newsletter mainly includes information for the physicians' benefit, but finance is able to include information about documentation needs. It's amazing that there is a very high percentage of physicians on staff who actually read the newsletter. After the documentation information started coming out, physicians suddenly became more receptive because they were more educated about the process. Prior to the newsletter's inception, coder queries to physicians had little success.

Wardwell: We've used brochures produced by our coders with desktop publishing, which gets information out pretty quickly. We also have a monthly newsletter for physicians. It is produced by the medical staff in conjunction with a physician liaison and includes business information along with clinical topics. A bit of business mixed in with the clinical seems to get the physicians' attention.

hfma™

December 2006
HFMA Executive Roundtable
Copyright 2006
Healthcare Financial Management Association
All rights reserved.

For reprints contact
1-800-252-HFMA, ext. 2.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

Do you believe your facility would benefit from using a concurrent documentation system?

Hester: A concurrent documentation system would definitely improve patient care because clinicians would not be relying on their memory of what happened yesterday or the day before. The documentation would be there on the chart for immediate access. It also would give case management and utilization review better advance notice if they needed to work with insurance payers to raise the level of care, and discharge planners would be able to prepare for the release of the patient much more efficiently if they had concurrent documentation.

King: Concurrent documentation is the ultimate model to move to, but it is too difficult to accomplish only with human resources. An electronic medical record is the component that is missing.

That leads to the next question: What role does technology play in improving the documentation process?

Wardwell: Technology is the enabler that provides the templates and guides physicians through the documentation process. Technology also improves patient care. We've all known that for a long time. We just haven't been able to get to an electronic environment that allows for information to be shared instantaneously.

Hester: We have just gone to PACS (a picture archiving and communication system), so we have instant radiological results, and our systems are allowing better patient care. Physicians can be at home and call up information about their patients. They can review notes and radiology exams in the emergency department, and they can make patient care decisions and add documentation immediately.

What processes do you have in place in your organization for improving documentation?

Lopez: We have benchmarks or targets for all the areas that touch the revenue cycle process, and we track them daily. We also monitor the benchmarks in the revenue cycle committee twice a month.

Cornicelli: We review the reports from our information system to discover which accounts are being rejected and why and to find out where our billing errors are. We have been drilling in on those errors and fixing them, then sharing the information with the clinical departments and the physicians. All of these things have made a difference in our revenue cycle. Our DNFB days, for the first time in several years, is down to 3 days. Much of this success came about using reports that already existed. We simply started working on them in a new way, looking at accountability for every single finding. We would tackle each issue and then move on to the next. As we've drilled down on the problems, we have communicated our findings back to the clinical departments and the physicians involved. It has been a slow process, but we've been able to reap considerable benefits as a result.

Lopez: Our DNFB days had been consistently averaging 6 1/2 to 7 days until we replaced management and allowed the director to focus on the entire revenue cycle process. Since then, our DNFB have been 3 or 4 days. We have consistently achieved this target because we have established a process, and people know what they have to do. We hold people accountable. That is the key.

Cornicelli: That's exactly how we've finally been able to break through and get from double digits down to 4 days continually for the past year. It was a change in leadership, with an emphasis and focus by that leadership team on achieving a goal and sustaining it.

Health Information Systems

3M Health Information Systems, part of the 3M Health Care family, is a leading provider of advanced software tools and consulting services that help healthcare organizations capture, classify, and manage accurate healthcare data. As the developers of the widely-used 3M™ AP DRG and 3M™ APR DRG methodologies, our experts leverage unparalleled knowledge and experience with severity- and risk-adjusted data to develop comprehensive solutions to drive quality improvement and ensure proper reimbursement. 3M Health Care is dedicated to improving the practice, delivery and outcome of patient care. 3M Health Care is a leading provider of solutions for medical, oral care, pharmaceutical, and health information systems markets.