Proper Physician Documentation: More than Just Your Bottom Line

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Physician documentation in the medical record helps provide the cornerstone of medical necessity that not only can help validate the level of patient care provided, but also help to ensure proper reimbursement to the hospital.

An increase in denials by Recovery Auditors (RAs), Medicare Administrative Contractors (MACs), Commercial Payers and others have propelled documentation into the spotlight as a critical part of the equation.

The Benefits

I highly doubt that anyone would argue that accurate and complete physician documentation is essential, but there are definitely a number of clear cut benefits – beyond helping to ensure proper reimbursement is received from cases submitted.

Quality of Care. Increased quality tops the list of benefits that comes to mind. A 2008 *Archives of Internal Medicine*[1] article indicated that "medical records for patients with NSTEMI often lack key elements of the history and physical examination. Patients treated at hospitals with better medical records quality have significantly lower mortality … (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care." The article also points out that patients cared for at hospitals that had better medical recordkeeping experienced lower in-hospital mortality compared to patients who did not have this experience.

Increased Patient Safety. Although not as noticeable a benefit at first, patient safety and the quality of physician documentation within the medical record can run hand in hand. According to a recent study published in the September 2013 issue of the *Journal of Patient Safety*[2], between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death. Staggering numbers, such as these, can help stress the need for better documentation to provide a clear picture of the care provided.

Increased Accuracy and Specificity. A third notable benefit as the result of proper physician documentation is the increase in accuracy and specificity within the medical record. In addition to this, timeliness of the information recorded tends to lead to higher accuracy within documentation. With increased proficiency in accuracy and specificity from better documentation comes a better description of services provided to the patient. This outcome can also lead to an increase in quality scores – the

higher the quality scores, the more of a reflection of patient acuity. This can have collateral benefit to 30 day risk adjusted mortality and readmission rates amongst some other metrics being measured.

Potential Roadblocks

Although improvements to the physician documentation process have evolved over the years, the road traveled has been a rocky one, to say the least – with some even claiming that documentation has even deteriorated the more it progresses.

Among these factors, two stand out as the prime culprits impacting physician documentation: the emergence of the electronic medical record (EMR) and the uneasy transition from a source-oriented record to a problem-oriented record.

Electronic Medical Record. The future of EMR holds so much promise that, according to *The New York Times*[3], "the federal government is spending more than $22 billion to encourage hospitals and physicians to adopt electronic health records." But the problems can start basically from the planning stage, as EMRs are typically designed by non-clinicians – i.e., programmers who are not as familiar with how hospitals and clinicians actually function.

As reported in the *Times* article, "cutting and pasting" (C&P), commonly referred to as "copy forward," may allow for "information to be quickly copied from one portion of a document to another, as well as reduce the time that a doctor spends inputting recurring patient data," but it also leaves the window open to potential fraud. In an effort to cut down on C&P abuse by physicians who are performing less work than they actually bill, the Office of the Inspector General (OIG) has named the issue of cloning in the medical record as a priority in 2015, the *Times* reported.

To further muddy the concerns on documentation, the EMR is limited in providing the opportunity for physicians to include their own thoughts and comments. So much within the record is a template, a checkbox, etc., which prevents physicians from documenting their impressions, assessments and courses of action for the patient.

Problem-Oriented Record. The creation of the problem-oriented medical record (POMR) by Dr. Lawrence Weed in the late 1960s provided a disciplined approach for physicians to include proper documentation in the medical record. Through POMR, Weed created the SOAP note (an acronym for "Subjective, Objective, Assessment, Plan"), which gave physicians a structured approach to gathering and evaluating the volumes of information contained in the medical record and provided them with an avenue to better communicate with each other.

Over the years, physicians have essentially abandoned the fundamentals of the SOAP approach to the more straight-forward, but not necessarily well-rounded "Problem List" approach. But in order for this transition to be effective, physicians must be able to successfully address all of the following factors:

- The problem list was actually designed to help with treatment progress. Many times, the initial problem list is copied and pasted, unchanged, from one day to the next with no original thought or comment. This practice can present challenges for Utilization Management, coding, discharge planning, as well as others.
- The problem list may not adequately express the physician's concerns for what is actually going on with the patient.
- The problem list may not connect the risks and acuity with which the patient presents.

The Importance of Quality

Physicians need to lead the charge in documentation improvements in the medical record. As budgets get tighter and resources become fewer, one misconception rears its ugly head – that hospitals are forcing improvements in this area solely to benefit coding and help increase revenue. As a matter a fact, it's just the opposite. Medicare actually encourages hospitals to improve their coding to support proper reimbursement, which may be higher or lower based on the documentation, but also for better reflection of the patient acuity. This improved accuracy can only increase cost measures, such as the case mix index (CMI), over time, as well as the previously mentioned quality scores. Accurate and specific documentation may also favorably impact audit findings and prevent reimbursement delays or take backs, due to incorrectly denied hospital *and* physician claims.

Better documentation can benefit both hospitals and physicians through quality scores that are now readily available in publicly recorded data, such as Healthgrades. The road to improved physician documentation has not been without its bumps and curves over the years, but physicians remain on the front line of this issue, and need to take an active part in ensuring that the quality and thoroughness of their documentation stands as a true record of the care provided.

References:

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