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The Basics of Documentation & Billing for the Hospitalist

Learning Objectives-

- Understand how to properly and effectively provide documentation in admission and progress notes.
- Understand how documentation leads to effective and compliant billing, coding, and revenue capture.
- Understand the interrelationship between third-party payer contracts, hospital reimbursement, and patient care

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Case Example, Part 1

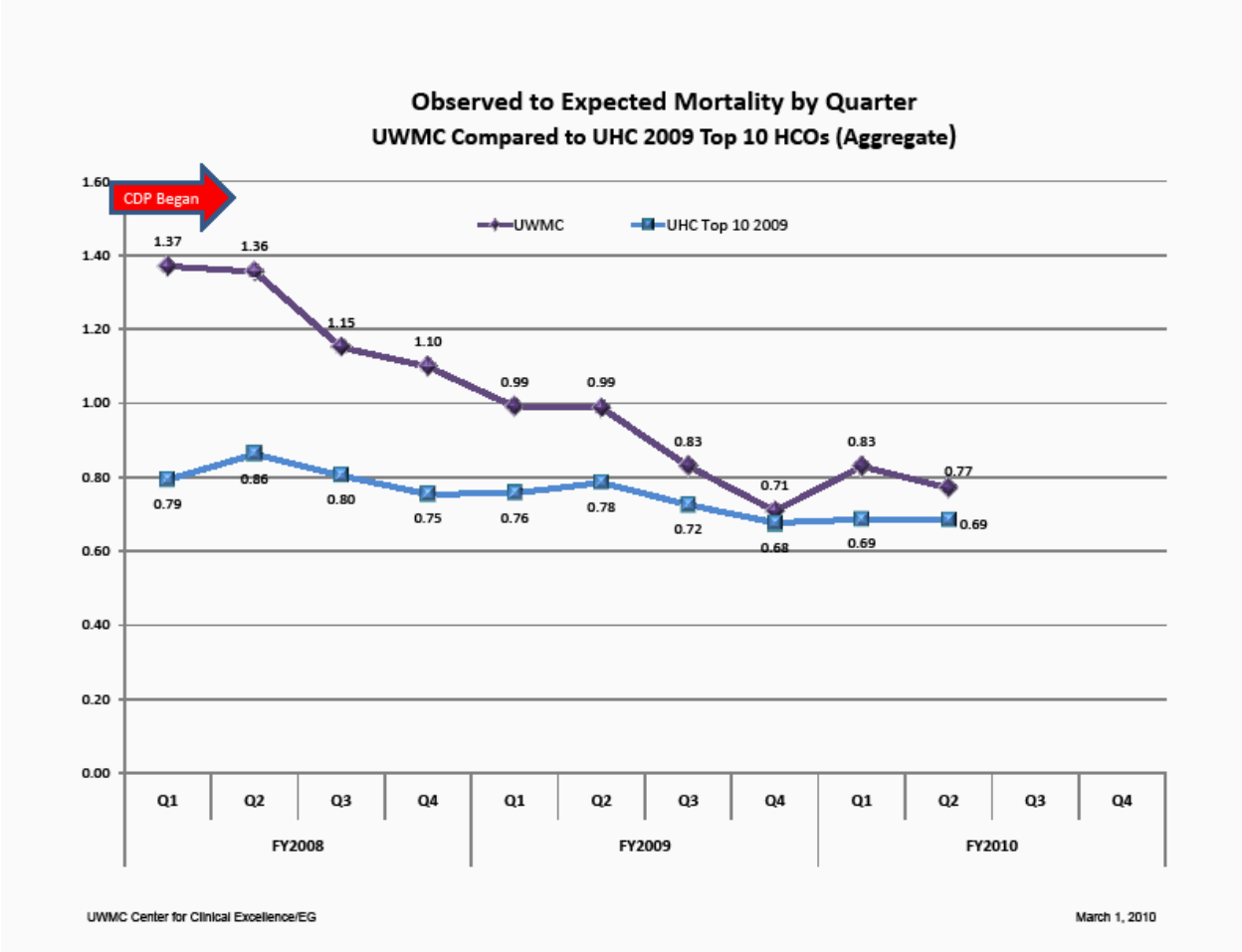
You are admitting a patient found to have a new pulmonary embolism. The main elements of your H&P are as follows:

CC: SOB
HPI: 66 yo woman with multiple medical problems outlined below. Was sitting at home and began to notice worsening SOB accompanied by R sided pleuritic chest pain throughout the day. Felt dizzy when she tried to get out of her chair. No palpitations.
PMH: Previous PEs, unclear etiology, on lifelong Coumadin but not taking consistently; Diabetes type II; Renal insufficiency- baseline Cr 1.5; Obesity; Severe osteoarthritis in hips and knees
Meds: lisinopril, lantus, humalog, Coumadin- not taking these medications consistently
SH: no tob, illicit, etoh use
FH: none
ROS: 10 point ROS is negative
Phys Exam: 37.3 105 130/85 20 87%RA; Gen- appears stated age; HEENT- op clear; Neck- supple, no JVD; CV- tachycardic, no murmur; Chest- CTAB; Abd- soft , obese, nontender; Extr- no LEE b/l; Psych- anxious, but appropriate affect. A&OX3.
Imaging: CT PE protocol—acute R segmental PE with small area of necrosis.
A/P: 66 yo woman subtherapeutic on Coumadin who presents with PE.
PE: Start heparin gtt/Coumadin, place on supplemental O2
Diabetes: Monitor BG and place on home regimen of insulin.
Renal insufficiency: Monitor kidney function. Avoid nephrotoxic medications.

Although you were rushed for time during the admission, you feel like you have initiated appropriate and complete care for the patient. Ultimately, the patient develops a few active medical issues and has a prolonged hospitalization. Despite all of your efforts, you are told that you are billing for a lower level complexity of patient than you thought…

Accurate and complete documentation is important for multiple reasons besides properly detailing a patient's illnesses for you and other staff

- Your documentation is coded to produce the patient's bill. This bill is made up of hospital service charges and physician service charges.
- Medicare now gives reduced payments for certain hospital-acquired conditions and documenting if these were **present on admission** is therefore very important. (See more below)
- The specific diagnoses we give Medicare patients can have a major financial impact for the hospital and may be used to measure quality. When a patient is very sick, accurately documenting the comorbidities and complications aligns true risk of mortality with how sick he/she is, and improves the overall picture of quality of care.
- The following table demonstrates how better documentation compliance through a clinical documentation program can align observed mortality with expected mortality.



How documentation is used to code and bill for a physician's work

- For the physician service charges, Evaluation/Management (E/M) codes are 5-digit numbers assigned to our documentation on the basis of history, exam, and medical-decision making.
- These codes are part of Current Procedural Terminology (CPT) developed by the AMA.
- Luckily, in larger institutions, hospitalists often have the advantage of documentation and coding/billing specialists who look at the elements in our notes and assign codes accordingly. These codes are then used to bill the third party payor (insurance companies including Medicare & Medicaid)
- These CPT codes also translate to a corresponding number of wRVU (work relative value units). Most physicians are expected to generate a certain number of wRVUs and depending upon their compensation program, may help determine incentives/bonuses. A sample table is below:

Inpatient E&M

HCPCS	DESCRIPTION	wRVU	Practice Expense RVU	Malpractice RVU	TOTAL RVUs	Uniform Medical Plan	Medicare	Medicaid
99221	Initial hospital care	1.92	0.71	0.13	2.76	$136.40	$96.66	$54.02
99222	Initial hospital care	2.61	0.99	0.15	3.75	$186.45	$131.43	$74.47
99223	Initial hospital care	3.86	1.45	0.20	5.51	$273.90	$193.31	$109.59
99231	Subsequent hospital care	0.76	0.28	0.04	1.08	$56.65	$39.01	$22.45
99232	Subsequent hospital care	1.39	0.52	0.07	1.98	$101.75	$70.26	$40.46
99233	Subsequent hospital care	2.00	0.73	0.10	2.83	$145.20	$100.78	$57.80
99238	Hospital discharge day	1.28	0.61	0.06	1.95	$100.65	$69.51	$40.90
99239	Hospital discharge day	1.90	0.89	0.08	2.87	$146.30	$101.31	$58.91
99251	Inpatient consultation	1.00	0.32	0.05	1.37	$73.70		
99252	Inpatient consultation	1.50	0.52	0.09	2.11	$114.40		
99253	Inpatient consultation	2.27	0.84	0.11	3.22	$173.80		
99254	Inpatient consultation	3.29	1.23	0.13	4.65	$251.35		
99255	Inpatient consultation	4.00	1.44	0.18	5.62	$306.35		

Optimizing documentation & CPT codes

As hospitalists, we typically encounter inpatient CPT codes as in the table above. A higher number in the last digit of the code (i.e., the "3" in 99223) reflects a higher level of service and higher wRVUs then a lower number in the last digit of the code (i.e., the "1" in 99221). Also for wRVU generation, typically initial hospital visits>subsequent hospital care visits>day of discharge.

All notes need a chief complaint to be billable.

For initial hospital visits (admission H&Ps): Codes 99221- 99223
To bill for a level 3 (or 99223), a complete history and exam is required.

- HPI must have 4 elements
- PMH/FH/SH: each of the 3 elements must be listed & cannot say "none" or "deferred"
- ROS: documentation of a minimum of 10 systems is needed, but how this is stated is important.
    - Note, there are actually a total of 14 systems.
    - The number of systems should not be specified unless you review all 14 or state specifically which 10 of 14 were reviewed, i.e., do not write "10 point ROS negative".

    - Ideally, should provide 10 or more individually stated systems OR documentation of all positives and at least 1 pertinent negative + "all others negative".
- Exam: cannot mix organ systems and body areas and at least 8 organ systems are needed.
    - Gen + vitals= only 1 organ system
    - HEENT consists of 2 organ systems: Eyes AND ears/nose/throat
    - Edema & JVD are part of cardiac system.
    - Extremities & neck do not count as organ systems.
    - To get 8 organ systems in, consider documenting Derm, Psych, and GU (CVA tenderness).

For subsequent hospital care: Codes 99231-99233. Again, documentation reflecting a more complicated patient will receive a level 3. This means that the patient must have high medical necessity PLUS 2 out of 3 of the following:

- A detailed history with 4 HPI elements and 2 ROS
- A detailed exam consisting of an extended exam of the affected system + one other system OR a comprehensive exam consisting of 8 organ systems.
- High complexity of medical decision-making.

For hospital discharge day: Usually codes 99238 and 99239

- If total time spent was <30 minutes, code 99238 is given. If total time was >30 minutes, code 99239 is given, but cannot include time spent by RNs, residents, or students.
- Discharge must occur after the initial date of admission, not on the same day. (For admission and discharge on same day and observed for >8 hours, codes 99234-99236 might be used)
- The discharge summary alone may not suffice! It must be documented by the attending physician that the patient was examined and a discharge diagnosis should be listed. A discharge day physical exam can be clinically helpful and is often the best way to justify that face-to-face time had occurred. This can be included in a separate progress note or in the discharge summary.
- Other important aspects of total day-of-discharge time include discussion with other healthcare providers, preparation of discharge records/prescriptions, coordination of follow-up care, patient/caregiver instruction.

Time-based documentation

- Time can be used as the determining factor for the coders when the majority of patient encounter involves counseling and/or coordination of care. Examples include counseling a patient on a new diagnosis or complicated treatment options in which the history and exam documentation may be less than desired because most of the time was spent counseling. See table below.
    - When billing based on time, it is very important to state the specific diagnoses that were discussed.
    - Only attending time counts and >50% of the visit must be spent in counseling and/or coordination of care.
    - The total visit time and the nature of the time spent must be documented and includes time spent at the bedside, relevant discussion with family, review of data, obtaining relevant patient information, discussing the case with other healthcare providers, and time spent on wards coordinating care (does not include teaching time).

- A sample statement would be “total visit time was 60 minutes of which >50% of the visit was spent in counseling the patient on his new diagnosis of diabetes and necessary lifestyle changes”.

Total Visit Times (Minutes)

Initial Hospital Care	
99221	30
99222	50
99223	70
Subsequent Hospital Care	
99231	15
99232	25
99233	35

- As an add-on to the above “primary” codes, there are inpatient prolonged care codes 99356 & 99357 for additional time spent with the patient. See table of inpatient prolonged services below.
  - Total face-to-face attending physician visit time must exceed the time requirements associated with the primary codes by 30 minutes.
  - Start and end times must be clearly documented and the time has to be face-to-face (per Medicare specifications). Does not have to be continuous time.

E/M base service	Base Time	Min Time for 99356	Min Time for 99357
Admit			
99221	30	60	60+
99222	50	80	80+
99223	70	110	110+
Subsequent Care			
99231	15	45	45+
99232	25	55	55+
99233	35	65	90+

Other important coding points

- Documenting complex medical decision-making:
  - This is often enhanced by indicators such as “worsening”, “uncontrolled”, “new”, or “acute” when appropriate.
  - Indicate severity, i.e., severe O2 dependent or steroid-dependent COPD
  - Documenting management of IV therapies (ie adjusting the rate of heparin gtt based on PTT measurements) supports a higher level of service.
  - State if you have personally reviewed lab data and images and what your findings were.
- Effective 1/1/2010, Medicare and some other insurance carriers will not make payment for consultation codes. Inpatient consultations (previously 99251-99255) will instead be billed as initial hospital care or subsequent hospital care visits as above. “AI” will be used a modifier to indicate an admitting provider. The consultant/specialist still needs to state the reason for the consultation and perform complete documentation.

Case Example, Part 2

On this particular patient, her rocky hospitalization included hypoxia with an O2 sat as low as 85%, elevated blood sugars into the 300 range, worsening creatinine of 2.6. You are contacted by an RN Documentation specialist. She has a few specific queries for you to help capture the severity and acuity of the patient's illness for Medicare since it is unclear from the present documentation in ORCA, such as "Does this patient have acute respiratory failure?".

You have already tried to improve upon documentation of your history, physical exam, and medical decision-making, and you wonder why there is such an emphasis to elaborate on these very specific, yet appropriate, diagnoses.

How the hospital is reimbursed for a patient's hospitalization

- Most Americans over 65 years old are covered by Medicare part A which means huge numbers of hospitalized patients have Medicare coverage. In turn, hospitals are very dependent on Medicare reimbursements.
- Other third party payers work in a similar fashion to Medicare but develop different contracts and reimbursement schemes with a particular hospital.
- Prior to the 1980s, insurance companies paid primary care physicians and hospitals a daily fee for each day a patient was in the hospital.
- In 1983, CMS (Center for Medicare & Medicaid Services) initiated the inpatient prospective payment program (IPPS) which reimbursed hospital care by diagnosis-related groups, or DRGs, classifying a diagnosis into a group where patients demonstrate similar resource consumption and length of stay patterns. This meant that for a patient admitted for a particular diagnosis, hospital reimbursement was given based upon how much it *should* cost to care for the average patient with that condition, not for the number of days he/she was in the hospital.
- The third party payer derives the DRG from the ICD-9-CM (International classification of diseases, ninth revision, clinical modification) codes that we generate. There are over 10,000 of these diagnostic codes. These are inherently related to the CPT codes described above since the diagnoses (ICD-9-CM) must support the service/procedure (CPT).
- Recently, CMS changed DRGs to MS-DRGs, or Medicare Severity-Based DRGs to better reflect severity of illness. So, diagnoses are now classified as being with or without complications/comorbidities (CCs) or major complications/comorbidities (MCCs). A principal diagnosis with a secondary diagnosis of a major complication/comorbidity increases hospital reimbursement.
- Ultimately, the MS-DRG is assigned a relative weight which is multiplied by the hospital base rate (influenced by multiple factors including location, teaching hospital status, percentage of low-income patients, and if the case is an unusually expensive outlier) to help generate the amount of hospital reimbursement.
- In the case above, acute PE would classify as a principal diagnosis with an MCC of acute respiratory failure.
    - So, for example, this could translate to an MS-DRG of 175 and about $12,000 in reimbursement.
    - If there were no MCC, the MS-DRG would be 176 and about only $8300 in reimbursement.

Helping coding specialists decipher your diagnoses

- Coders can use documentation from residents, PAs, or ARNPs, if the attending documents agreement. A formal statement should be used that indicates the attending has seen and examined the patient and agrees with the H&P.
- Avoid phrases such as “decreased sodium” or symptoms such as “dyspnea” and instead state a diagnosis such as hyponatremia or hypoxia.
- Write the assessment for a particular diagnosis; this helps specify what you really mean. For example, diagnosis of “+SOB/fever” with plan to “start azithromycin” could be improved upon by stating “probable community-acquired pneumonia”
- Stating “probable” or “possible” for a possible diagnosis that is being evaluated and empirically treated is acceptable.
- According to CMS, any condition which requires clinical evaluation, diagnostic procedure, therapeutic treatment, extends the length of stay, or requires increased nursing/monitoring is clinically significant. Make sure to include these!

Specific documenting tips for diseases and conditions

Neuro:

- AMS, delirium, ICU psychosis- Document multifactorial encephalopathy (may be toxic, septic, or metabolic)
- + CT or MRI results- Document diagnosis associated w/ findings ie cerebral infarction, cerebral hemorrhage, cerebral edema or hydrocephalus
- Drug/ ETOH Abuse
  - Drug (cocaine) intoxication with continuous dependency.
  - (Opiate) dependency (if use is recurrent or if on chronic RX i.e methadone).
- Avoid vague terms such as “ambulatory dysfunction’’ and ‘‘deconditioning’’ and instead use ‘‘abnormal gait,’’ ‘‘difficulty walking,’’ ‘‘muscle weakness”.

Lungs:

- Pneumonia- Specify underlying/suspected organism i.e. gram neg, MRSA, aspiration, VAP
- Abnormal ABGs- Document the interpretation, i.e. "uncompensated respiratory acidosis"
- COPD/Chronic Bronchitis- Document if stable or exacerbated
- Chronic Respiratory Failure (if on home 02)
- Identify acute respiratory failure

CV:

- Cardiac Arrest- Document cardiac arrest vs respiratory arrest. If cardiac document cause: V-Fib/V-Tach /AMI
- CHF- Specify Heart failure : acute/chronic & systolic/diastolic/combined; include LV assessment

Renal:

- Chronic Kidney Disease (CKD)Stage 1 - 5

- Stage I: GFR >90
- Stage II: GFR 60-89
- Stage III: GFR 30-59
- Stage IV: GFR 15-29
- Stage V: GFR <15

- Renal Failure - ARF, AKI, or ATN

Nutrition/Endocrine:

- Malnourished- Document protein-calorie malnutrition or severe protein-calorie malnutrition if albumin <2.8
- Diabetes, poorly controlled- Uncontrolled Diabetes,(multiple BS>250, Hgb A1c >7)
- Body Habitus- Morbid Obesity, cachetic, emaciation

Skin:

- Skin ulcer- Specify location, & type (pressure ulcer, venous stasis or ulcer 2/2 to PVD or DM). Document if Present on Admission (POA)

Heme:

- Hct 2° GI Bleed/Surg -intra-op or post-op- Document acute blood loss anemia

ID:

- Urosepsis- Document sepsis due to UTI (due to indwelling catheter)
- CAUTI (catheter associated UTI)- Document if Present on Admission (POA).
- Bacteremia- Document septicemia, sepsis or SIRS if the patient is systemically ill. (Sepsis typically defined as SIRS in response to suspected organism)

Case Example, Part 3

Your patient ultimately recovers from all of the above complications after about 10 days. She is about to be discharged to a SNF the following day when the RN tells you that the patient is having dysuria with cloudy urine. She had an indwelling urinary catheter placed during the hospitalization and for one reason or another you had not gotten around to having it removed …

Quality improvement measures that may affect hospital reimbursement:

- CMS gives reduced reimbursement to hospitals for the following hospital- acquired conditions that are considered to be reasonably preventable:
    - Catheter-associated urinary tract infection
    - Vascular catheter-associated infections
    - Mediastinitis following coronary artery bypass grafting
    - Decubitus ulcers (stage III or IV)
    - Object left in during surgery
    - Air embolism following procedure
    - Blood incompatibility
    - Hospital-acquired trauma
    - DVT/PE after total hip/knee replacements
    - Surgical site infection after specific orthopedic procedures
- The following conditions are being considered for 2011: Ventilator-associated pneumonia, failure to rescue, surgical site infection following implantation of devices, *Clostridium difficile*-associated disease, malnutrition

Present-on-admission Indicator: a code that CMS uses to indicate if a condition was present at the time the order for inpatient admission occurs.

- This includes conditions that develop during an outpatient encounter, in the ED, etc.
    - Needs to be explicitly documented by the provider as present on admission OR
    - A long-term condition diagnosed before admission OR
    - A condition "clearly present on admission" but not diagnosed until after admission occurred, such as when a diagnosis is suspected at admission but confirmed sometime later.

Case-related questions:

1) *How might the initial H&P for our patient be better written to include the essential elements that would optimize billing for the physician's and hospital's services?*
2) *What would be important pieces of the subsequent care notes to include, knowing what this patient's hospital course was?*
3) *What do you think happened to the hospital's reimbursement because of the development of the urinary tract infection due to the indwelling catheter?*
4) *If she already had an indwelling catheter prior to admission leading to the urinary tract infection, what specification could be made?*

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