Monday, September 11, 2023

How Better Communication Makes for Better Documentation

Artificial Intelligence (AI) is only as good as the documentation it reads. But what does that mean?

In the realm of doctor pro-fee office billing, if the documentation is unclear, AI cannot magically clarify it. While AI can help us deliver a breakthrough in E/M coding, it cannot fill in incomplete documentation.

At times, coders must remind themselves that seemingly simple things they encounter daily may not align with the standards set by Diagnosis and CPT (Current Procedural Terminology) office/procedure codes. For example, a coder may have worked with a physician for years and understand from experience what they intended to document, even if they did not spell it out. This doesn't mean this is the correct way to handle documentation. To save time, physicians may sometimes be less diligent in including precise phrasing or might take shortcuts depending upon coders to assume they understand what was meant.

This Coffee & Coding is a gentle reminder for physicians to provide clearer documentation. After all, in most cases, the coder's name is on the claims they reviewed and edited. The coder's credentials are the ones on the line, as doctors often defer to coding staff in case of an audit.

Here are some reminders about how to approach clarifying documentation:

- If the provider's dictation includes words such as "rule out," "maybe," "looks like," "could be," or "has differential symptoms only," it's a sign that the diagnosis is inferred rather than fully documented. Inferred diagnoses cannot be coded, and as a result, they cannot be billed.

- If the provider is uncertain or the documentation is lacking, the payer will be unable to interpret or assume to understand what the doctor meant. Incomplete or questionable diagnoses typically reduce the degree of complexity and, therefore, can reduce the level of charges.
- When in doubt, return the documentation to the provider for clarification.
- Labs intended to be conducted at the point of care are typically performed in the office, such as rapid strep, flu, and now rapid COVID tests. These tests yield results within minutes and are documented by the medical assistant (MA) or nursing staff. These practices are not a concern. More problematic situations involve routine or screening labs (PSA screenings, A1C, blood pressure, lipids, cancer tests, etc.) that indicate abnormalities. Remember, these can only be used when considering a diagnosis with confirmation from the provider. Even though these tests may suggest a worsening condition, coders cannot independently make that determination and change the diagnosis to reflect a worsening condition. The provider must explicitly state the change in diagnosis.

Here's an example: If a patient's blood pressure is 150/90 and they do not have hypertension, we cannot necessarily count it as a chronic exacerbation (level 4 diagnosis); anxiety may be the cause of the elevated blood pressure. So, this would be considered a level 3—an acute high blood pressure issue without hypertension. The same applies in the case of tests that show elevated PSA levels—even if you are seeing results from the past six tests, and it is evident that the levels are increasing.

Collaborate and communicate!

In cases where coders are uncertain about the documentation or diagnosis, this creates a great opportunity for coders to clarify the documentation with the physician. During my 30 years of experience in Family/Internal Medicine, I routinely held monthly meetings with physicians, and they appreciated the feedback.

We know that physicians want proper credit and reimbursement for their services and the time they invest in patient care. If a physician makes documentation errors that affect their financial bottom line, they want to be informed and should encourage open communication. Often, physicians may be unaware of guideline changes or have been repeating the same documentation mistakes due to the repetitive nature of their work.

I've discovered that proactive communication consistently fosters better relationships between coders and physicians. With regular collaboration, physicians understood I was looking out for their best interests, including their income, rather than being perceived as an "enemy" who scrutinized every aspect of their work.

Once physicians and coders regularly communicate about the documentation or diagnoses, I guarantee you will see better results and clarity in the dictation.

Got a question about E/M coding? We'd love to hear from you.
Submit your questions by emailing us at coders@calmwatersai.com!

Michelle Sergei-Casiano

CPC, CFPC, CEMC

Senior Manager, Regulatory and Coding Compliance