Part B Insider (Multispecialty) Coding Alert

Know What Constitutes 'Exceptional' Documentation

Keep the 'Five W's' in mind for records that stand out.

Most of us are familiar with the bare minimum requirements necessary for medical documentation--but how many practitioners can say that their documentation is "exceptional?"

TrailBlazer Medicare's **Sherrie Varner** answered the question about how to create exceptional documentation during the MAC's Feb. 8 webinar, "Medicare Documentation and Audits." Read on for her tips about the "Five W's" that make medical records shine.

1. Who. List the performing, supervising, and referring practitioners.
2. What (and how many). Document the services and quantities of services performed.
3. Where. The place of service.
4. When. The date of service.
5. Why. "This is the one where we frequently find more problems, making sure that practitioners are documenting medical necessity and the diagnosis," Varner said.

"We want you to paint us a picture," Varner said. "You know what's happening with your patient, but that information has to be communicated from your head into the documentation that we receive."

You should also ensure that appropriate health risk factors are identified, and document the patient's progress and response to treatment.

Varner offered the following example of poor documentation of a patient's condition, followed by a suggestion on how it could be improved:

Example of sparse a note that only includes a conclusion: "Failed outpatient therapy followed by bilateral knee replacement."

Example of fact-based documentation: "Bilateral osteoarthritis progressing last 10 yrs. X-ray 12/1/11 shows joint space nearly obliterated, marginal osteophytes, and subchondral sclerosis. Previous treatment: Ibuprofen 400 mg QID for the past two years; PT 3 x week 7/15/11-11/30/11. Using cane since August. Knee pain 3/10 continuous (walking=7/10). Pain keeps him awake and can't climb five steps to his front door. Bilateral knee replacement."

Timing isn't written in stone: An attendee to the forum asked how long the physician has to complete a note after the patient is seen in the office. "That is kind of a gray area," Varner said. "There is nothing black or white, but we would generally expect 36 hours, something like that, is the normal time period. Preferably most people would do that on the same day or if it's dictated, maybe it would come back the next day. But usually it ends up being within 24 to 28 hours."