Outpatient Facility Coding Alert

Documentation Tactics: Here's Your Primer on Necessary Documentation for Each Stage of Care

Remember: If it isn't in the chart, it can't be billed.

Every coder knows that your physician's notes should match the codes being billed. Developing and nurturing good collaboration between everyone involved (physicians, billing professionals, and health information management groups) is one of the best steps toward clean claims. Read on for advice on smoothing the information pathway between groups.

Ask 2 Key Questions About the Documentation

Before you can select a code, you need to verify two important things regarding the provider's documentation.

- Does the documentation support the level of service (LOS) billed? The note should include all the elements required to support the LOS selected. The note must include all elements of the history, exam, and medical decision making to justify the visit's level of service. Your provider also should document a clear reason for the visit, and the assessment plan should support the reason for the visit.
- What is the appropriate service level code for the documented care? When considering this, you're looking for documentation of the type, frequency, intensity, and duration of the service. These factors will vary based on the patient's individual needs.

In an ideal documentation process, the provider should:

- Clearly state the patient's clinical condition and indicate factors that impact the physician's decision to provide extra services in addition to any standard therapy provided.
- Use objective measurements to indicate that the patient is recovering or progressing toward goals. The documentation should account for any lack of progress and justification for continued treatment.

Watch for Certain Points at Each Stage

Documentation can be broken into three stages: evaluation, planning, and reporting. Each stage should include certain details, as outlined below.

Evaluation stage: Your provider should list the patient's conditions and any complexities. In cases where it is not obvious, the provider can describe the impact of the conditions on the prognosis and the plan for treatment.

This helps anyone reviewing the record understand that the services planned are appropriate for the individual.

When an evaluation is the only service provided, remember that the evaluation becomes the plan of care. It may contain a diagnosis, or may describe the clinical condition which will help the referring physician or non physician practitioner (NPP) to diagnose the issue.

Planning stage: Be sure that the documentation in this stage is in line with the evaluation documentation. The evaluation and plan may be reported in two separate documents or a single combined document.

Documentation of the plan of care should include:

- Diagnosis
- Type of treatment
- Amount (the number of times in a day the type of treatment provided), duration (the number of times in a week

the type of treatment provided), and frequency of the treatment (number of weeks, or the number of treatment sessions)
- Long-term treatment goal, if any.

Reporting stage: In addition, ensure that the progress report contains:

- An assessment of improvement, including the extent of progress or lack of progress toward each goal
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions
- Changes to long- or short-term goals, discharge, or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

The final piece in the documentation of a patient's care is the discharge note. This is a variation of the progress report that gives details from the last progress report until the date of discharge. Your provider must indicate that he reviewed the notes and that he agrees to the discharge.

Resource: For more on what CMS expects in your documentation, see their "Principles of Documentation" PDF online. Visit www.cms.gov and search for "principles of documentation."