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Documenting the Reasons for Early Discharges May Save Part A Pay

Unless physicians explain why inpatients are leaving the hospital before staying for two midnights, Medicare auditors probably will deny Part A payment. If physicians document the reasons the expectation for two midnights in the hospital didn't pan out, the claim may survive. But physicians tend to document for other physicians and not for the wide range of auditors, coders and others whose ability to understand a patient's story has an effect on payment, experts say.

Under the two-midnight rule, CMS generally presumes Part A payment is appropriate if the hospital stay is expected to cross two midnights and the services are medically necessary, even if patients are discharged early — assuming physicians put the rationale in writing. Unfortunately, that's often not the case, said John Zelem, M.D., senior medical director at Executive Health Resources in Newtown Square, Pa. "In charts I have looked at since the 2014 inpatient prospective payment system regulation [took effect], 95% never have an explanation for earlier-than-planned discharges from an inpatient level of care," Zelem said Sept. 12 at a Finally Friday webinar sponsored by the Appeal Academy.

Auditors want an explanation of why the expectation and reality parted company. Physicians should state something along the lines of "the patient got better than was originally expected and is stable to go home now" and then add an almost magical word — "because" — followed by the reason. Physicians don't have to write much; for example, they can state "patient, who came in with hypertensive urgency, unexpectedly normalized today and is remaining stable. Will be discharged to follow up on an outpatient basis." Or the rationale could be that "the patient is signing out against medical advice," which CMS says does not interfere with Part A payment even when the two-midnight threshold isn't crossed. "Somehow physicians have to let go of the assumption their peers will understand and that's good enough," Zelem said. It was fine for the decades when Medicare claims were barely subject to scrutiny, but that was then and this is now, he says. With so many Medicare auditors, physicians have to spill their intellectual guts on the page, even if it's brief.

And that's not the only information missing from charts, partly because physicians don't write enough down. "Physicians document for other physicians — not for coders, not for reviewers, not for utilization review staff — and they assume others understand," Zelem said. Recently, the vice president of medical affairs at a hospital asked him why physicians have to write that "the patient is stable for discharge" when it's so obvious. "It's not just physicians reading the chart," he explained. "For every physician who reads the chart, there are probably 20 non-physicians and even non-clinicians reading the chart. That's why physicians need to document for a different audience today." One physician complained to Zelem when he was called to the emergency room to document the medical necessity of an admission for exacerbation of congestive heart failure because the patient was obviously quite ill. The chest X-ray and BNP levels w ere bad, lungs were congested and fluid build-

Common Errors in Physician Documentation

A review of 267 hospital charts found significant missing elements from the history and physical, says John Zelem, M.D., senior medical director at Executive Health Resources in Newtown Square, Pa. The weaker the documentation, the less likely claims will survive audit scrutiny. Contact him at jzelem@ehrdocs.com.

History & Physical Statistics

Element	National 267 Charts	% Absent
Chief complaint	224	16.1%
History of present illness	256	4.1%
Past medical history	249	6.7%
Social history	245	8.2%
Review of systems	220	17.6%
Vital signs	221	17.2%
Physical exam	248	7.1%
Labs	170	36.3%
X-rays, EKG, tests	171	36%
Assessment	227	15%
Plans	222	16.9

up was apparent. "I said to the physician, 'Yes, that's a great statement, but does your documentation allow another person reading it to come to the same conclusion about how acute the patient is without seeing him?'" Conversely, Zelem said, stating in a discharge summary that a patient "is stable for discharge" has been called unnecessary by physicians when a patient is admitted with an exacerbation of congestive heart failure because, at discharge, the lungs are clear, the chest X-ray and BNP are better and his or her weight is down because the fluid dissipated. A physician looking at this would understand the stability but "we are documenting for a different audience who cannot reach the same conclusion unless the physician states it." Also this is important from a medical-legal point of view.

Assessment and Plans Must Be More Thorough

Assessment and plans also have to be more thorough than they typically are, Zelem said. It's not enough for the vascular surgeon to say "admit to inpatient status post carotid endarterectomy" or for the neurosurgeon to say "admit to inpatient for laminectomy." The "because" and the reasons why are missing.

It bothers physicians to document for auditors. "They complain that 'the only reason you want me to do this is for hospitals to get paid for it,'" he says. While it's true that hospitals gain from better coding and reimbursement, patients benefit because better documentation means greater accuracy and specificity of diagnoses and treatments and "physicians have skin in the game" with improved quality scores, Zelem said. Various organizations are now reporting quality scores, including CMS's Physician Compare, the Health Care Improvement Incentives Institute (a state report card on the transparency of physician quality information), and HealthGrades.

Imprecise documentation can sabotage physician ratings. For example, when documenting the principal diagnosis, physicians sometimes put "urosepsis," which equates to a simple urinary tract infection, when patients actually have sepsis — blood poisoning — stemming from a UTI. When sepsis patients die, the documentation of urosepsis makes it look like they have a high mortality rate for a relatively innocuous infection. Zelem knows of a physician who was fired by his chief medical officer after several patients with sepsis died and the documentation said "urosepsis."

"That's just one of the consequences that can happen," Zelem said.

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