

MEDICAL DIRECTORS' CORNER**IMPROVING MEDICAL RECORD DOCUMENTATION**

Unless you have been on that deserted island with the cast of *Survivor* for the past year, you know that Medicare has been following the directives from Health Care Financing Administration (HCFA) concerning claims auditing. These audits are of three types: random review, focused service review, and provider specific review. Obviously, this has been much work for all parties. However, I have observed several important points during this process.

First, many physicians have illegible handwriting. While this is not exactly a Nobel Prize winning observation, this problem frequently results in reduced or denied payments to practitioners. We all (and I include myself since I am a practicing physician) must either write legibly or dictate charts which, of course, is very advantageous. Our signatures must also be recognizable.

Second, many times the documentation is just scanty or inadequate. Most physicians do not realize just how poorly they document medical records. I realize that most practitioners are very concerned about their patients and do an excellent job taking care of their medical problems, but frequently documentation is lacking. We must be sure to document our efforts and our findings. This will not only improve reimbursement, but will be invaluable if the patient or family ever institutes malpractice litigation.

Third, if more than one physician in the hospital is seeing a patient, he or she should begin the note with "Attending Note," "Renal Note," "Cardiology Note," or whatever is appropriate. In this way, the reviewers will easily recognize your efforts.

Fourth, no longer can physicians at teaching hospitals merely countersign residents' or fellows' notes. They must show that they personally performed the services for which they are billing.

Fifth, just because a patient is in a Cardiac Care Unit (CCU) or Intensive Care Unit (ICU), this does not mean that all services are Critical Care (99291-92) or the highest evaluation and management codes. The proper code is determined by the service provided, documented, and its medical necessity.

Sixth, if a physician sees a patient initially for a consultation, repeated visits are not Follow-Up Inpatient Consultations (99261-63). They should be coded as Subsequent Hospital Care (99231-33). Also, a consultation requires a formal request from a physician and cannot be a standing order by a facility.

Seventh, many physicians still do not know coding. I strongly advise them to attend any of our *Introduction to Medicare Basics Workshops*, *Beyond the Basics Workshops*, or *Surgery Seminars* that are coming up this quarter. Of course next year, we will have even more courses. These courses are free and very informative. The schedule is in your *Medicare B Bulletin*. In addition, you may contact your specialty society to see what coding courses they offer.

—Stephen D. Boren, MD, MBA
Carrier Medical Director, Illinois