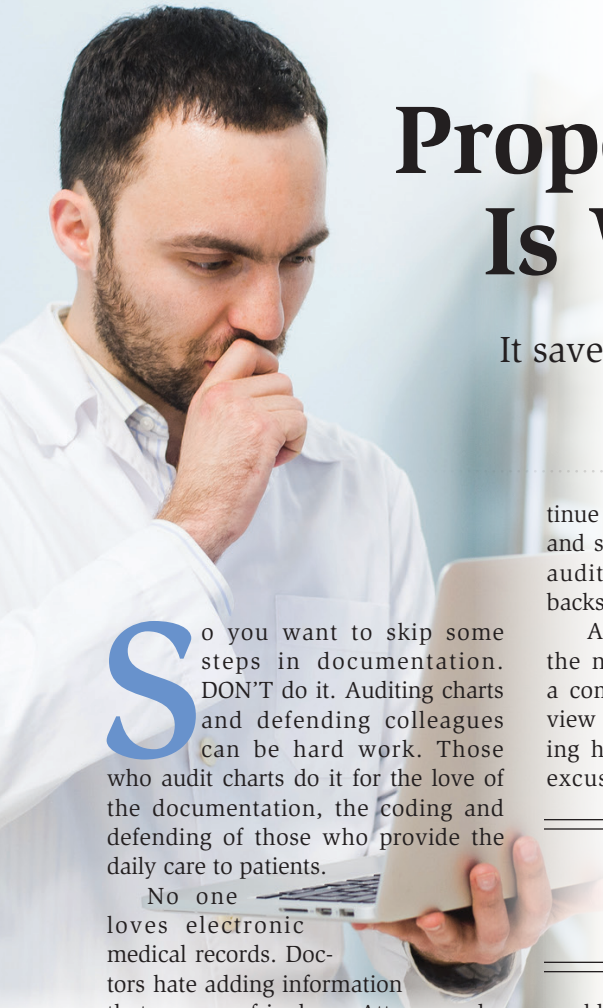

Proper Documentation Is Worth the Effort

It saves you time, money and future aggravation.

BY MICHAEL J. KING, DPM

So you want to skip some steps in documentation. DON'T do it. Auditing charts and defending colleagues can be hard work. Those who audit charts do it for the love of the documentation, the coding and defending of those who provide the daily care to patients.

No one loves electronic medical records. Doctors hate adding information that appears frivolous. Attorneys defending cases hate the fluff and extraneous material one must add to be complete in one's documentation. Auditors must sift through pages of "stuff" to find the pertinent findings, most of the time to get to the meat and potatoes of what the note is really trying to convey.

All that said, don't shortcut to save time or work in your documentation or you will become an outlier. You do not want to be known as an outlier. Auditors who make a living taking back your hard-earned dollars will make a feast of you if you shortcut your notes. Now, that is not to say that templates or macros are bad things, but if you develop them, use them. Cutting down the pertinent findings that are necessary in a note because of the requirements we must add will only make you a target for more audits.

Many don't understand that if you become the target of an audit, and bad patterns are found, they will continue to look at you moving forward, and subject you to even more intense audits with potentially more claw backs.

As painful as it may be, follow the necessary guidelines for having a complete note. Cutting out the review of systems (ROS) because "nothing has changed anyway" is not an excuse, and your whole E&M visit could be denied. Copying and pasting the same note over and over again will not show you to be a good documenter but will show you as an outlier. Simply stating "pulses normal" or "no evidence of neuropathy" will not get you the necessary bullets to bill that coveted 3 or 4 level E&M visit code. It is imperative to understand the necessity to be complete in your record-keeping. If an auditor finds this pattern, reports it, and starts denying your visits, they will happily put you in the queue again for more audits.

Under-coding

Many think under-coding is just fine, or that they don't have to worry about it as the payers will be happy to pay you less for a visit anyway. Yes, it may not be in their best interest to offer to pay you more, but what you are showing them is you are happy to settle for inaccurate coding and that is your modus operandi. They are happy to use all those chips against you; don't let them. Believe it or not, the payers want good accurate coding, reimbursement, and records too. They know that good medicine is best for their subscribers and your patients. It is up to all of us practicing to show them how good your care is through our complete and thorough medical records.

Those who audit in defense of our colleagues are thrilled to see the long note with all the details in it so that we can happily say to that not-so-friendly auditor that they are wrong-i.e., this provider did well.

So use shortcuts like complete macros or complete templates in order to build a better note. Stay away from true shortcuts to simply save time and to just bill what feels right that day. The time you use to do a good note may save you time and money later. As the old Fram oil filter commercial said, "you can pay me now or pay me later." Pay upfront by taking the time to produce good notes. PM

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