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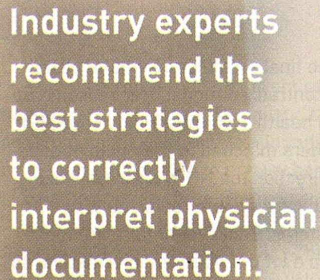

The Mechanics of Inpatient Chart Review

By Judy Sturgeon, CCS

Pressure. All coders know it, feel it, hear it, and live it every day. There is pressure to code faster and pressure to code more information to simplify reporting. For inpatient diagnosis-related group (DRG) coders, add pressure to code for severity of illness and mortality risk and to not code unnecessarily in order to speed production. Code faster, but don't make mistakes. Code everything, except anything that may be a red flag to recovery audit contractors or other payer auditors. "Code it all, code it fast, and make no errors" is the de facto motto. In reality, however, it's a lot tougher to achieve.

One of the most difficult skills to learn is efficient inpatient chart review. Coders must assign the diagnoses and procedures correctly, determine the most accurate DRG for the case, and move on to the next chart in a timely manner. Oddly enough, one of the obstacles that must be overcome to meet this standard is the habit of reading. The chart is not a mystery novel with the tension

building page by page until the final whodunit is discovered at the end.

"The beginning" is so named for good reason—emergency department notes and the patient history and physical are the most likely documents from which to establish the reason for admission. But take a chance, deviate from a normal reading pattern, and skip ahead in the chart. Temporarily put a hold on all the intermediate documentation and go directly to the discharge notes and summary.

An extensive amount of time can be wasted browsing notes and labs in a search for confirmation of a possible diagnosis, only to learn that it had been disproven by the end of the stay. A quick initial review of the final dictated notes may clear up many of the differential diagnoses (or at least make them legible). And in many cases, this is the document of last resort for query responses and for providing last-minute details that may completely reassign the principal diagnosis.

Exercising caution is recommended when reading the dictated discharge summary, though. Cheryl Bowling, RHIT, CCS, CHC, C-CDI, compliance director for Kforce Healthcare, reminds coders that this document "is supposed to be a summary of the patient's stay. Instead, it is likely to be a summation of the last few days of the stay or the last few conditions that were treated. This is only a piece of the puzzle, not the complete picture. For that, the coder must review the entire chart, including conditions as well as treatment."

Charlotte Lane, a DRG trainer and auditor, notes that having a discharge summary is often a mixed blessing. "There are some physicians who document the last thing that they were addressing rather than the reason for admission," she says. "And there are physicians who will include every diagnosis that the patient has ever had in the list of discharge diagnoses. Coders have a tendency to code it all because 'it's in the discharge summary.' But that doesn't mean that all of those meet reporting criteria."

Once the beginning and the end are established, it is still critical to include valid diagnoses and procedures that are documented elsewhere in the chart. The admission order, including the time and date and any documented reasons for admission, could change the whole picture. Was the patient in the emergency department for a cough and bronchitis, but when the lab results came back he or she was found to be in acute renal failure due to dehydration? If so, it is likely that the final DRG will be determined by the kidney failure as the reason for admission, rather than bronchitis. Remember that the reason the patient sought medical care is not always the reason he or she was actually kept in the hospital.

Also consider the patient who has a scheduled outpatient procedure and is admitted the same day. Lane says if the conversion to inpatient status is ordered after the procedure has been completed, the timing of events is key to appropriate code assignment. If the admission was for a complication of the procedure or an unrelated new acute condition, it is not the reason for surgery that will be the principal diagnosis; rather, it will be the reason for admission to the hospital.

Progress notes will be vital to finalizing essential diagnoses. Procedures described in dictated reports as well as in bedside notes may contain the final determination of why a patient was admitted. When cases present more like a medical mystery than a standard hospital stay, it can be radiology, pathology, and even nursing or therapist documentation that provide enlightenment. "While a coder must utilize physician documentation for code assignment, review of other documentation might provide clinical information on which to base a query," says Lane.

As if coders don't already have sufficient challenges to making an accurate DRG assignment, Bowling says even the chart format must be considered when determining how and what to review. "An EMR is more organized; the analysis is electronic. It has ease of access so that more people can use it at the same time. But in other ways it can be disjointed. Portions may be in pathology or radiology; others may be in paper or separate from the main EMR in other electronic systems," she explains.

Bowling says while the old paper methods are certainly familiar and predictable, the resulting ease of audit may not last. When a facility in transition uses a hybrid chart—part paper, part electronic, part scanned, and part missing in action—the problems can escalate exponentially. She advises coders to make sure they have all critical documents and "exercise due diligence to avoid missing procedures along the way."

Once a coder has located all the documents needed for review, the next task is to determine what needs to be read and what can be simply scanned or even bypassed. "Let's face it ... we all want to review the easiest documentation, which are dictated reports," says Lane. "The problem with

consults in particular is that the physician is focused only on the condition for which he or she was consulted. This is also where I find a lot of documentation with the consultant saying one thing and the attending saying something else. The only solution I know to address this problem is to read through the chart, read and consider the entire record."

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Now there is another hurdle to leap: *May* you code it? The mantra of the new coder is too often "the doctor documented it so I coded it." It is still necessary, however, to validate whether the diagnosis is clinically significant to this encounter. Did it affect patient care in some manner? Is there other information in the chart that will allow the coder to select a more specific code? What are the sequencing rules and are there coding directions that totally exclude the use of a particular diagnosis, such as acute pulmonary edema in congestive heart failure or fever and cough in acute bronchitis?

The ability to focus is critical to successful and accurate DRG coding. It is necessary to remember that every chart is different and has its own set of circumstances that can fall under an exception to a basic coding rule. For example, long stays can have bedside procedures hidden within multiple chart volumes. Failure to find and code them can cause a case to lose out on a possible surgical DRG instead of a medical one. A quick review of the surgical consent forms will help identify dates and types of any invasive procedures that were intended to be performed.

Short stays are not necessarily easy to code; these can be some of the most difficult to decipher due to lack of information or ambiguity regarding the true reason for admission. It is not uncommon to lack a final, definitive diagnosis, and the likelihood of a query being required for clarification increases in order to learn a final cause of the presenting symptoms.

After considering all the issues that play into an effective DRG coding review, coders would do well to learn to think like an auditor before finalizing the codes on any admission. According to Bowling, there are several factors coders should take into account before closing out a coding session and moving on to a new chart.

"Check for a CC [complication or comorbidity] or MCC [major CC]," she says. "Take a second look and be absolutely certain that you have done a complete and thorough review of the documentation. Check for clinical significance on the diagnoses that you do have and query the physician if necessary. Get a peer to take a second look; sometimes a set of fresh eyes will pick up additional information. Also, a discharge summary is very helpful for an overall summation of the patient's stay, but many times this is not available in a timely fashion for the coding department. Many facilities institute a process to review the discharge summary to be certain this matches the overall coding and MS [Medicare severity]-DRG assignment."

Bowling notes the importance of assigning correct present-on-admission indicators for hospital-acquired conditions and making sure these codes are appropriate as documented. In addition, validate the principal diagnosis and principal procedure and check the discharge disposition. "For the latter, different groups may be responsible for this function at different facilities, so know where to look for this," she says.

"Too many coders simply code the words without trying to actually read the chart and understand the complete picture of the patient's condition," Lane notes. "Just scanning the chart and picking out words is not effective chart review. But this gets back to the conundrum of productivity vs. quality."

But, Lane adds, "I'm not sure that the issue is really record review." She says the following may be the real issues for some coders:

- They don't understand disease processes and treatments and don't think it is their responsibility to educate themselves.
- They don't know the coding rules and specific instructions in ***Coding Clinic***.
- They do know the coding rules and ***Coding Clinic*** instructions but have been pushed to "code for the money" by their administration.
- They are intimidated by documentation specialists. "The doc specialists often push outside the envelope, and they don't know the coding rules.

But coders will allow themselves to be swayed because these folks are nurses and they are only coders," Lane says.

The coding software used by a facility may have options for electronic reference packages. Other facilities and coders prefer hard-copy references. (A ***Coding Clinic*** subscription is critical if this is the route taken.) Software is convenient, but the original publication can be scoured thoroughly for the latest directives much sooner than many coding software systems can be updated. Remember that the rules and clarifications are effective beginning on the discharge dates listed on the cover, not when the coder gets around to reading them. Continuing education is nonnegotiable.

Coders bemoan the fact that physicians often create a patient chart as though it were a "note to self" instead of a clear and concise documentation of a patient's hospital course. As professionals, coders must realize there is a critical purpose to their input to the permanent record of a patient's care. It is their responsibility to adhere to coding conventions and guidelines and to summarize the encounter without assigning a code to each noun and verb in the chart. It is their duty, as the scribes for electronic data storage and transfer, to continually educate themselves on ever-changing coding rules, disease process and treatment, and procedural techniques as new ones are developed.

If coders cannot speak and understand medical terminology, do not comprehend pathophysiology, and cannot adhere to the logic of nosological systems, they will fail in their endeavors to code accurately for DRG assignment. The ramifications will also be felt as they shift focus to the future and ICD-10. Urban legends claim that a competent coder will need less than a week of training and practice to make the jump to ICD-10. The October 2013 ICD-10 deadline is not that far off and if a coder's skills are not up to par, it may take every day until then to catch up.

As if coders needed a little more pressure.

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