

# Three Small Documentation Changes to Improve Your Billing

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One of the biggest surprises for me after graduating residency was the amount I had to learn regarding billing and coding. It was always something that was in the back of my mind during residency, but like many of us, I focused on patient care more so than the documenta-

tion.<sup>1</sup> Thankfully, I had several good billers and coders in my department willing to give me a few tips on how to maximize my charting.

The first thing I learned was how to document a level V bill.<sup>2</sup>

Someone may assume it's intuitive to checkmark a series of boxes. In actuality, the process is a bit complex. My understanding when I came out of residency, was that I only needed to cover 10 points in the review of systems, two out of three for social history, and nine systems in my physical exam.

In reality, the biller develops a score based on your diagnosis and treatment documentation, your data reviewed, and risk the patient's presentation represents.<sup>3</sup> The actual calculations of these are outside the scope of this article. One important tip is that you can increase your data "points" based on ordering and reviewing laboratory studies, imaging, ECG and echocardiograms. You can "earn" additional points by independently interpreting the ECGs and images in real time. If you obtain outside records, or if you review and summarize older records, this also increases the data portion of your score. In most patient encounters, laboratory studies are ordered, and you review them during the patient encounter, so adding one sentence to your chart referencing this should be fairly easy to implement. You are also interpreting EKGs on patients many times during a shift, so it also should become routine to document your interpretation into the chart. Most electronic medical records will allow smart phrases or text expansion to cover these two very actions. The interpretation of radiographic imaging is a little bit more complicated, and may vary based on your hospital and the hospital's arrangement with the radiology department.

Some encounters, no matter how much documentation you provide, will never be complex enough to warrant a level V bill. The patient who presents for medication refill will most likely not be able to generate enough data "points" to bill at level V. Knowing this, you should focus on making this chart as streamlined and brief as possible, to minimize your time away from patient care.

As a resident, I could not generate critical care billing time, and so I was unfamiliar with the exact definition of critical care time. However, I was made aware that a critically ill patient quickly qualifies for critical care time. CMS defines critical care time as treating a condition which impairs at least one organ system with a high probability of imminent deterioration which may be life-threatening.<sup>1</sup> The first 29 minutes of treatment are included in the initial ED bill, so your critical care time must be at least 30



minutes. This time is cumulative during your care of the patient, so any ECG, chest X-ray, or blood gas interpretations, adjusting the ventilator, obtaining vascular access, calling consultations, discussing the patient's case with the family or the patient, or even documentation are included in this time.

When I met with my billing company, they pulled five random charts of mine and walked me through the scoring system. This helped me to better understand the process. The review meeting lasted longer than the time I spent learning about coding and reimbursement during residency.<sup>4</sup> These three tips, along with continued coaching from my coders and billers, have helped me to document the services I had been providing. I would recommend for you to contact the billing company to ask if they have any suggestions they could offer you in regard to billing and documentation. ●

## References

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