A Resident's Guide to Documentation

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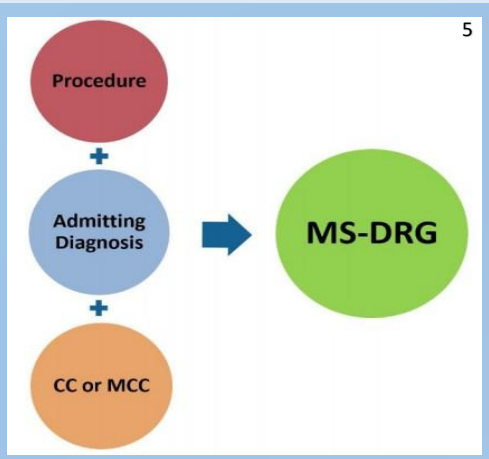
Documentation plays an essential role in hospital reimbursement and physician quality metrics, but most internal medicine residencies have minimal training in this area. Below is a guide exploring how mindful documentation can positively impact our healthcare system and how residents can improve on these skills.

Hospital Payment

Many hospitals depend on reimbursements from the Centers for Medicare & Medicaid Services (CMS) for their financial security. CMS has adopted the Fee for Service payment model, in which Diagnosis Related Groups (DRGs) determine a fixed payment that the hospital will receive for a hospital stay. The hospital is paid at a predetermined, lump sum, regardless of the actual costs involved and the length of stay.

The DRG is determined by the principal diagnosis, procedures performed, and the major comorbid conditions (MCC)/comorbid conditions (CC). The principal diagnosis is the primary clinical focus of the admission, and it often takes several days of care to determine. The principal diagnosis is determined by the coders, and it is imperative that our documentation clearly states the progression of care and the driving medical problems. Coders can only use what is written in a physician's note for billing. For example, a pneumothorax read on a chest x-ray does not count towards billing unless it is included in your note.

Adding MCCs or CCs helps to increase the payment for a given hospitalization. Some comorbid conditions do not affect the payment return and are classified as non-CC. Comorbid conditions increase the perceived complexity of the patient and increase the cost needed to care for that patient. As shown in the examples below, adding MCC/CCs to your documentation can vastly increase the hospital's reimbursement. There are about 3,200 MCC codes available.



[5]

Adding acuity can increase complexity.

- For example, "**acute on chronic** COPD exacerbation"

Professional Fees

Professional fees are another form of reimbursement; they are based on Relative Value Units (RVUs) and subsequent CPT (Current Procedural Terminology) coding. These fees are dependent on the how the documentation reflects the complexity of the patient and their care. These are physician specific and can be used to measure the productivity of an individual physician. Some attending positions will offer incentive payments to the provider based on their RVU productivity.

RVU Quick Tips:

- **Chief complaint:** noted
- **HPI:** 4+ factors
- **ROS:** 10+ systems
- **Past medical/surgical, family, and social history:** 1 element of each category
- **Physical exam:** 8+ systems (must be organ systems, not body areas like "head")
- **Medical decision making:** document patient instructions, consultant input, the request and summary of outside records, additional history obtained from family or caretakers, and any imaging or tracing personally reviewed by you

Examples: ATN and ESRD are MCCs, while AKI, ARF, CKD, hypo/hypernatremia, and acidosis/alkalosis are CCs.

DRG Code	DRG Title	Relative Weight	Payment [3]
192	COPD without CC/MCC	0.7254	$3,990
191	COPD with CC	0.9757	$5,366
190	COPD with MCC	1.3030	$7,166

References

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