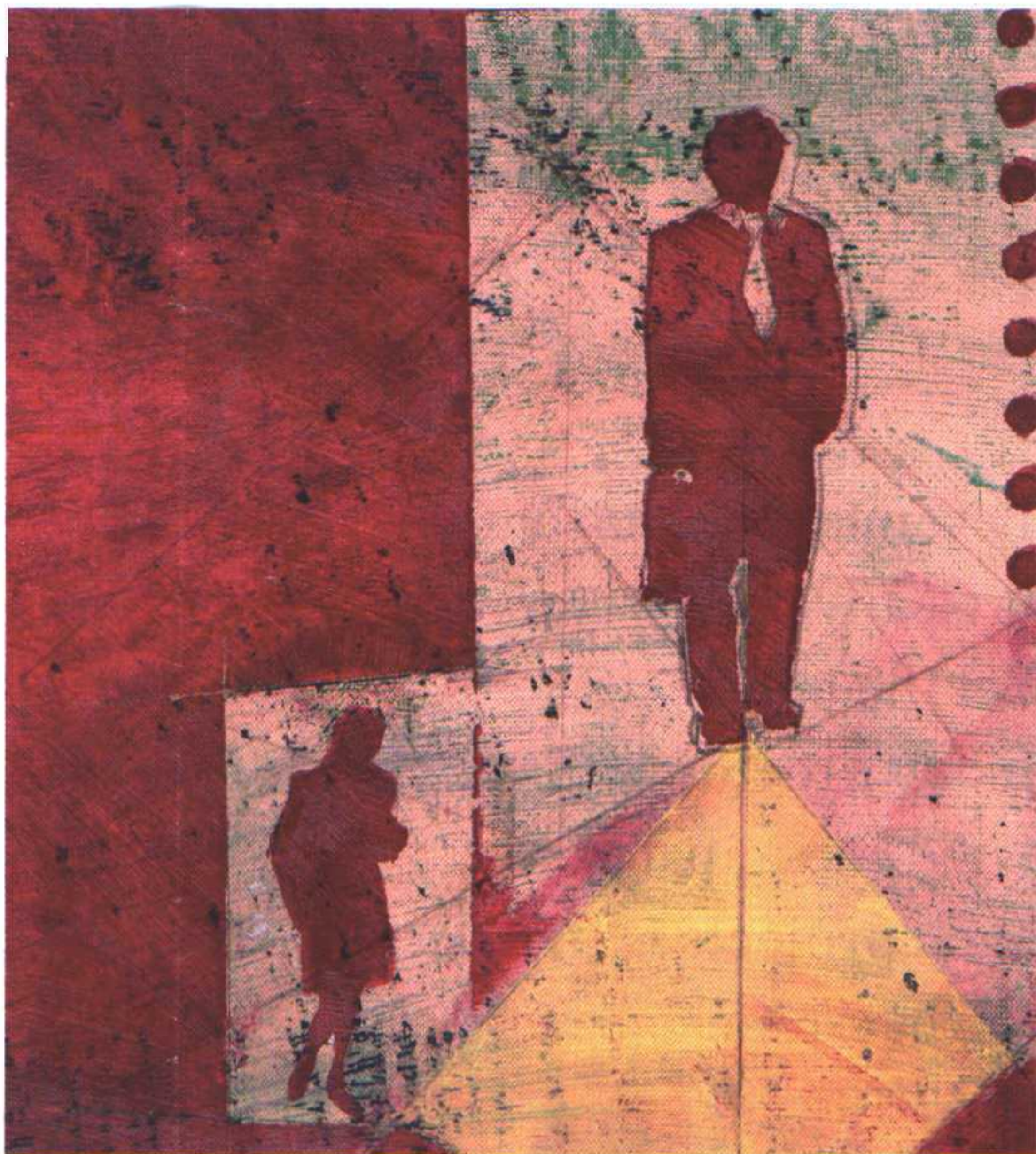


## FEATURE STORY

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# good documentation: what it means for your physicians—and your revenue cycle

The complexity of E/M coding bedevils medical practices to this day. But educating physicians and providing them with customized tools can significantly improve documentation accuracy.

Many medical groups continue to struggle with generating accurate records of what physicians do during office visits, consultations, hospital care, and other evaluation and management patient encounters. This widespread underdocumentation of E/M services not only results in significant revenue losses due to undercoding, but also exposes groups to patient care, malpractice liability, and payer audit risks associated with an incomplete medical record.

Clearly, complete and accurate documentation of physicians' actions in E/M encounters is essential to address these issues. Just as clearly, active physician cooperation is required to obtain such documentation. Nonetheless, physicians often

resist attempts to improve E/M documentation. They may view documentation guidelines as a bureaucratic hassle, particularly when they are presented in an abstract, general way, or primarily to increase revenues. Getting cooperation from physicians whose income does not depend on productivity can be especially difficult.

However, it can be done. The key is to make documentation requirements relevant to the physicians' daily clinical practice, and to provide tools that help efficiently gather information during patient encounters.

Emphasizing the benefits—clinical, risk management, and financial—of accurate documentation often improves physician cooperation. Always the goal is an accurate medical record, not gaming the coding system. Accurate coding is just a side benefit of ensuring the medical record includes all that is needed for optimal patient care. *B*

