

PHYSICIAN ADVISOR DOCUMENTATION REVIEW PROGRAM

PURPOSE:

1. To establish a mechanism for concurrent review of inpatient medical records for accuracy and adequacy of physician documentation
2. To create an environment which fosters the enhancement of communication within the medical record.
3. To improve the education and competence of Health Information Managers for their interpretation of clinical pathophysiology and physician documentation.
4. To support the hospital's overall compliance efforts designed to assure the accuracy of diagnosis coding, procedural coding, DRG assignment, risk adjusted severity and mortality reporting.

APPLICABILITY:

This policy applies to the Physician Advisors, Case Managers, and Health Information Managers (HIM).

PROCEDURE:

A. Retrospective documentation review-pre billing

1. HIM will designate medical records of inpatient discharges for Physician Advisor review based on any of the following criteria:
 - i. need for clarification of physician documentation legibility
 - ii. review and clarification of clinical pathophysiology
 - iii. verification of clinical evidence to support assignment of any ICD-9 diagnosis or procedure code
 - iv. need for clarification of ambiguous or conflicting physician documentation
 - v. discharges for selected physicians as identified by the Senior Vice President of Medical Affairs or her designate
 - vi. discharges within selected diagnosis-related groups as identified by the Senior Vice President of Medical Affairs, Compliance Officer, or other designated hospital official
2. On a daily basis, Physician Advisor will review designated medical records of inpatient discharges and prepare recommendations for review by HIM and Director of Medical Records.
3. Following review, Physician Advisor shall conduct a conference with HIM and Director of Medical Records.
4. Should further clarification be required, Physician Advisor shall assist Medical Records Department in the notification of and discussion with the attending physician or consulting physician(s) as required for timely clarification or completion of documentation as indicated.
5. Medical Records Department shall be responsible for tracking records held for clarification or completion of documentation. This information shall be readily available for review by Physician Advisor.
6. Monthly, Physician Advisor shall conduct 1 hour of education to coding staff with emphasis on new treatments and/or procedures performed at the hospital or clinical topic chosen in advance by HIM director.

B. Concurrent documentation review:

1. The Senior Vice President of Medical Affairs or designate, in conjunction with the recommendations of the Physician Advisors or Case Managers, will identify inpatient records for Physician Advisor review based on any of the following criteria:

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- i. OIG targeted admission diagnoses
 - ii. projected DRG assignment by Case Manager
 - iii. request of Case Manager for purposes of clinical clarification, legibility, or resource utilization
 - iv. no documented working or provisional diagnosis in medical record
 - v. attending physicians with outlier utilization patterns
 - vi. attending physicians with quality of care concerns identified by the appropriate Medical Staff Committee, Department chairperson, or other medical management personnel
2. Information Services Department will provide Physician Advisor with daily census of all inpatients to include patient name, location, attending physician, and admission diagnosis.
3. Physician Advisor will review inpatient record to include review of:
 - i. Emergency Department record (if applicable)
 - ii. Initial Inpatient History and Physical Examination
 - iii. Nursing Admission Assessment
 - iv. Progress Notes
 - v. Consultations
 - vi. Physician Orders
 - vii. Ancillary results
 - viii. Allied Health Professional notes (respiratory, nutritionist, etc.)
4. Should Physician Advisor identify need for clarification and/or additional documentation by Attending Physician and/or consultant(s), Physician Advisor shall independently, or in cooperation with Case Manager, seek clarification or additional documentation by preparing a Documentation Clarification Form to be attached to the inpatient record in the progress notes section for review and action by the Attending Physician and/or consultant(s). Physician Advisor may elect to personally contact the Attending Physician and/or consultant(s) to discuss any documentation, pathophysiology, or utilization issues.
5. Documentation Clarification Forms will contain the disclaimer that they “are not part of the permanent medical record”.
6. Documentation Clarification Forms should be reviewed on a bi-weekly basis to track frequency and quality of physician response.
7. Documentation Clarification Forms should be removed from the medical record at the time of coding in the Medical Records Department.

C. Process improvement

Physician Advisors and Senior Vice President of Medical Affairs shall meet on a monthly basis to review the effectiveness of retrospective and concurrent review programs.

Source: The Association for Clinical Documentation Improvement Specialists (ACDIS) “Tools and Forms Library. For more information, visit www.hcpro.com/acdis/.