

FOR THE Record

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TRANSCRIPTION TRENDS

MAKING BILLING STRIDES BY IMPROVING CLINICAL DOCUMENTATION

By Christopher Rehm, MD



Making strides in the clinical documentation process can result in significantly faster billing and more complete reimbursement for healthcare facilities. With medical transcription costs at major hospitals often exceeding \$1 million per year, it is critical that healthcare providers understand the link between clinical documentation and revenue—especially how improving one can increase the other.

The most apparent relationship between clinical documentation and billing involves speed. The faster documentation is completed, the more quickly the billing process can begin. However, like other important components of revenue cycle management such as coding and accounts receivable management, the accuracy and completeness of patient documents is even more important to ensuring proper reimbursement. After all, in the eyes of the payer, if something is not documented, it did not happen.

To maximize reimbursement, a facility's clinical documentation must be fast, accurate, and thorough. Only after care has been documented can it be billed, so the turnaround time (TAT) of clinical documentation reduces the days to bill. The integrity of clinical documentation is essential when assessing and defending reimbursement rates—so accuracy minimizes the potential for disputed billing. And thoroughness ensures all billable items are included in the patient's record.

Days to Bill

The speed of billing is often directly linked to the efficiency of the clinical documentation process. Investing in new technologies such as speech recognition to increase the productivity

of medical transcriptionists and decrease TAT can also provide a significant boost to the billing process.

If clinical documentation services are outsourced, the medical transcription service organization (MTSO) should work with the facility to evaluate and streamline the internal processes for maximum efficiency. Too often, healthcare facilities assume an outsourcing partner will simply transcribe dictation files when, in reality, the relationship is much more complex and interactive. An MTSO should be equipped with the technology and services to shepherd the entire transcription process from physician dictation to delivery of the completed document into the patient's record.

One of the most important and difficult steps to improving clinical documentation efficiency is proper physician dictation, which has a direct impact on the billing process's effectiveness. To ensure a quick TAT, the dictation process should be as simple and painless as possible.

Painless is the key. If physicians find dictation to be an inordinate burden, they may delay dictating required documentation. They may also take shortcuts that leave out information that does not affect patient care but is necessary for correct billing and full reimbursement.

Integrity and Accuracy

Because payer organizations agree in advance to provide reimbursement or dispute billing within a set time period, faster billing guarantees a more rapid payment. Furthermore, quicker billing reduces the statistical likelihood that payment will be disputed. In other words, the more quickly a bill is issued, the more likely you may be to receive full reimbursement.

The primary reason this is true is because quick billing and high reimbursement percentages are attributes of the same underlying discipline—namely, an efficient clinical documentation process.

If dictation and transcription services are performed efficiently, then the accuracy and quality of the completed documents will be high, and the potential for questions or disputes will be minimized. Once again, physician compliance with proper dictation methods and time frames is critical to achieving this goal. In particular, facilities should make sure physicians use normals properly and only cut and paste information when appropriate. Relying too heavily on these techniques may lead to a physician unintentionally leaving out details of care delivered to a specific patient, resulting in underbilling.

Educating physicians about the relationship between proper dictation and full reimbursement can be an effective method of encouraging compliance with dictation best practices. In addition, if the facility is working with an MTSO outsourcing partner, it is in a position to provide a second set of eyes to review each document for accuracy before billing.

Complete Records

Physicians must thoroughly dictate to ensure that a healthcare facility is billing at the appropriate level for the care delivered. The most effective strategy for achieving this goal is to adopt clear templates that comply with established industry standards. Unfortunately, there is not yet a single standardized template for clinical documentation that has been accepted industrywide, though efforts are underway to establish universal guidelines.

Healthcare providers that comply with industry standards are able to share information effectively and efficiently, which has the potential to reduce delays in patient care, clinical documentation, and billing. It is important to educate physicians on the importance of filling out all the information within a template. Also, invest in technology that retrieves and organizes data automatically within the correct template. This reduces the possibility of human error, decreases the burden on the physician to memorize and comply with specific rules, and signals the physician when certain information is missing from the dictation file.

These electronically generated "red flags" for missing information are extremely valuable because if a physician is not immediately alerted when information is missing, he or she may not remember the information by the time the transcribed file is returned. (It should be noted that quick TAT with transcribed files—less than 24 hours—is also important to reduce this risk.) In these cases, the physician may have to accept the blanks within the clinical document, and certain billable items may be omitted.

In cases of disputed billing, it is also preferable for the patient visit to be fresh on the physician's mind so that questions can be handled quickly and with confidence. If too much time has passed, the physician may not be able to completely remember the necessary information, and the healthcare facility may be forced to accept only partial compensation.

Because billing is directly linked to documentation, healthcare organizations should be proactive about training physicians and adopting technologies that improve the quality and efficiency of the clinical documentation process. For example, a clinical documentation platform should be able to monitor and track a patient's file throughout the entire process, and transcribed files should be electronically available to the physician for review and e-signature immediately after transcription. Also, make certain physicians understand how poor dictation habits can disrupt the clinical documentation process and contribute to inaccurate billing.

Fast and accurate clinical documentation plays an important role in patient care, but many hospitals and healthcare organizations may not fully appreciate its significance to the billing process.

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