Raising the Bar on Documentation Practices: Physicians Beware of Negligent Coding

Timely and accurate documentation is a cornerstone of quality care. It is a topic that has long been the focal point of education by risk management professionals who work with physicians and medical practices.

Inaccurate and untimely documentation practices have been recognized as a factor present in medical malpractice cases. With the looming prospect of non-payment for “never events” and conditions that meet the criteria found in the In-Patient Prospective Payment System for Hospitals (IPPS),¹ there is a financial imperative for physicians to document accurately care and findings in the treatment of patients.

Medical malpractice aside, a Tennessee case² demonstrates the prospective of negligence exposure for inaccurate coding in a computerized record following a diagnostic procedure. The lessons learned from this case point to the need for raising the bar in physician education in coding practices. It also points to the need for careful scrutiny of documentation prior to clicking the “send” button on computerized claims for payment.

The Tennessee Case.
In November, 2002, the plaintiff, R.C., went to her physician, Dr A., with what she thought was a kidney infection. In 2000, Dr. A. had examined R.C. for similar symptoms. Dr. A. sent R.C. to BCMC for an IVP tomography examination. The referral form stated, “R/O [Rule Out] Renal Failure.”³

The test results were reviewed by Dr. J., a board certified radiologist at BCMC. As the facts suggest, Dr. J. did not perform the test and he never met with the patient. Dr. J. dictated his medical opinion regarding the tests, thereby creating a
Radiology Report. Under the “Findings” section of this computerized report, Dr. J. stated that the patient had bilateral renal function, thereby ruling out renal failure. However, at the top of the same computerized document there was a section entitled “Indications.” Completed by a different person, the “Indications” section stated “renal failure.”

Dr. J. indicated that prior to signing a report, he must review the document. However, in this situation he did not notice that the indications section stated “renal failure” before he signed it electronically. The computerized report was sent to Dr. A.

Doctors J and A never discussed the report with one another. Dr. A. then informed R.C. that she did not have renal failure. BCMC and yet another physician, Dr. W. submitted a claim for payment to R.C.’s health insurance company, BlueCross, using the ICD-9 code 586.0, indicating renal failure.

In January, 2004, R.C. obtained different insurance coverage through new employment. She left that position in June, 2005 and then reapplied for insurance coverage through BlueCross. She claimed that she was unable to obtain private insurance as a result of the fact that her medical records indicated she had renal failure in 2002.

R.C. filed a lawsuit against Dr. A., Dr. W. and MCMC. Later, she added Dr. J., claiming that he had a duty to advise Dr. A. and BCMC that she did not have renal failure so that the right ICD-9 code could be submitted to her health insurance provider. R.C. argued that Dr. J. had failed to meet this standard of care and that his negligence was the proximate cause of her damages.

Dr. J. filed a motion for summary judgment. It was his position that there were no genuine issues of material act. The trial court found for the defendant.

R.C. filed an appeal challenging the trial court determination that cause of action was for medical malpractice and not negligence. She also appealed a trial court finding that Dr. J. did not owe her a duty of care with respect to the ICD-9 insurance coding issue.

Because the appeal involved a review of summary judgment, the appellate court explored the evidence “in a light most favorable to the non-moving party” namely the plaintiff, R.C. Using this approach, the court reversed and remanded the trial court decision.
The court first determined that the plaintiff’s claim was for negligence. As the court pointed out:

“When a plaintiff’s claim is for injuries resulting from negligent acts that did not affect the medical treatment of a patient, the claim sounds in ordinary negligence.”11

Here, the plaintiff was not suing for injuries as a result of negligent care. Rather, the source of alleged negligence was the defendant’s failure to notify Dr. A. and BCMC that the “indication” section of his radiology report stated renal failure. The plaintiff’s claim was based on the economic injury she experienced because Dr. J. failed to read the “indication” section of the report that he signed and that had indicated to the plaintiff’s health insurer that she had renal failure.12

The appellate court determined that there was a genuine issue of material fact regarding Dr. J.’s duty to notify Dr. A. and BCMC of the incorrect indication of renal failure.13 The court was careful to point out the physician’s argument regarding the duty of care. In essence, Dr. J. said that

“to the extent that [he] did have a duty to the Plaintiff as a consulting physician, his duty was fulfilled” by reading the test and preparing the report.”14

The doctor went further, pointing out that he was not trained in ICD-9 insurance coding. Further, he stated that he did not owe R.C. a duty of care as to the insurance coding.15

In testimony taken in a deposition, the defendant’s explanation of his obligation regarding the content of the “Indications” section was at odds with that of the plaintiff and an affidavit she submitted from an expert. Of particular import were four numbered paragraphs from the affidavit:

“4. ICD-9 codes are used in the reporting of a diagnosis of a patient when a bill is submitted to an insurance company or Medicare.

...

6. A Program Memorandum issued by The Centers for Medicare and Medicaid Services on ICD-9-CM Coding for Diagnostic Tests (Transmittal AB-01-144) states, “Note that physicians are responsible for the accuracy of the information submitted on a bill.”

7. According to Transmittal AB-01-144, “If the results of the diagnostic test
are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather the interpreting physician should report the sign(s) or symptom(s) that prompted the study.”[W]hen the interpreting physician does not have the diagnostic information as to the reason for the test and the referring physician is unavailable, it is appropriate to obtain the information directly from the patient....

8. [Defendant] therefore had a duty to obtain the clinical information necessary to determine the reason for the requested study and to report the appropriate ICD-9-CM code to the patient’s record and to the Hospital for billing purposes. He further had a duty to follow the ICD-9-CM guidelines for outpatient services in the reporting of the information which prohibit the reporting a code for the condition noted as “rule out”. His failure to make any attempts to determine the reason for the test from the referring physician or the patient and his failure to follow ICD-9-CM guidelines ... resulted in an inappropriate diagnosis code being submitted to the payer.”16

The appellate court noted that in his deposition testimony, Dr. J. had stated that it would be improper to conduct an IVP test on a patient who had renal failure. Taking all the information into account, the court ruled that there was a genuine issue of material fact whether Dr. J. had a duty to alert others that the “Indications” section of his report state renal failure when he knew that RC did not have this condition. The lower court ruling was reversed and the case remanded for further proceedings.17

Observations on the Tennessee Case.
The appellate court ruling highlights a point sometimes overlooked in lawsuits involving healthcare professionals. A cause of action may be premised on negligence rather than medical malpractice. This is not a subtle distinction. Since many states have enacted laws setting specific requirements for pursuing medical malpractice lawsuits, a claim based on “ordinary” negligence may not be as burdensome for a plaintiff. This was true in the Tennessee case. A state law requirement that another radiologist serve as an expert did not apply since the court had found that this was a claim of ordinary negligence, not medical malpractice.

The case is interesting for other reasons. It involved a computerized record. Although the defendant had dictated it, another person had completed the topic
portion that was the focal point of the lawsuit. The doctor did not notice incorrect information in this “Indication” box before signing the report electronically.

Others had an opportunity to “catch” the inconsistency, including the doctor who received the report, and those who filed a claim for services rendered, namely the medical center and the billing physician.

The deposition testimony of the radiologist was interesting in that it was contrary to what the plaintiff’s expert presented as outlined in the CMS ICD-9-M Coding for Diagnostic Tests. As the defendant admitted, he was not trained in ICD-9 coding.

The case did not involve medical malpractice. Instead, it involved negligent coding that result in the plaintiff being unable to obtain health insurance coverage. Once in the “system,” rectifying the errant information may prove a difficult task.

Imagine, however, if the incorrect information had led to improper treatment because a subsequent caregiver quickly scanning the document did not read it correctly or a person entering data into a medical record relied upon the inaccurate “Indications” section. The result could have been patient injury.

**Raising the Bar on Coding Practices.**

The shift to computerized reporting has created many challenges, including format, costs, interoperability issues, and human factors concerns. Physicians who have been accustomed to printed versions of dictated reports may not be as facile with on-screen editions that require an e-signature. That an electronic report may have content “pre-populated” with information may also create a sense of false security that the data is accurate.

Inaccurate coding can have manifold consequences. Fiscal intermediaries may challenge a claim, delaying payment. A sufficient cohort of challenged or “questioned” claims might warrant scrutiny for potential abuse or fraud in billing. With growing concern about proper billing and coding for so-called “Never Events” and the In-Patient Prospective Payment System for Hospital changes, there is ample room for both “upcoding” and “down-coding,” practices that could lead to serious financial and regulatory concerns.

Many physicians feel put-upon by all the changes in the healthcare system. Absent good electronic health system design, intuitive “fail-safes,” training, and proper record review, the opportunity is ripe for serious risk exposure.
Risk Management Strategies for Effective Documentation and Coding

There are a number of practical risk management strategies are to help minimize the risk of negligent coding. These include the following:

1. **Create a User-Friendly Electronic Interface.**
   Ask physicians and other care providers for their recommendations for an electronic record interface. Consider what will work for attending care givers and those who provide diagnostic imaging reports.

2. **Consider Human Factors Analysis.**
   Address the environment in which care providers will use the electronic interface. Take into consideration lighting, the size of a screen, and ergonomics that can help reduce misreading of information and errors in data entry.

3. **Build in Fail-Safe Protocols for Internal Consistency.**
   Work with those responsible for designing the electronic reporting system to incorporate a content consistency checking protocol. Recall the fact that in the Tennessee case there was a contradiction between the “Indications” section and the “Findings” window. Develop a software protocol that will interdict a report with inherent contradictions from being accepted for e-Signature. Design the protocol to address ICD-9 and CMS billing requirements for an interpreting physician. Consider for this purpose “drop down” boxes that can be selected by an interpreting physician.

4. **Establish a Policy and Procedure for Documentation Responsibility.**
   Recall that in the Tennessee case, another individual had completed the “Indications” section of the report. Recognizing that this step may lead to misinformation and inaccurate billing, delineate who has the authority to perform data entry for this purpose.

5. **Provide Care Givers with Necessary Training.**
   Do not assume that care givers know how to use new electronic interface tools. Recognize that many care givers may not know how to manage coding issues and that this may increase with “Never Events” and the IPPS requirements. Offer practical, hands-on training for care giver for this purpose. Consider multiple, focused sessions and regular
in-service programs. Work with medical staff leadership in hospitals and in physician practices to design “demonstrated competencies” testing around electronic documentation practices and coding.

6. **Incorporate a Help Line.**
Consider a Help Line or Help Desk for care givers to utilize in handling electronic record documentation. Think about the same approach for queries on coding issues.

7. **Implement a Process for Monitoring and Surveillance.**
Working with IT, HIMSS, compliance, and coding professionals, implement a practical e-monitoring process to identify opportunities for improvement in coding and billing. Use the information to help those who need further training.

8. **Take Corrective Measures When Necessary.**
Take prompt action to address inaccurate coding on claims that are to be submitted for billing. Utilize an approach consistent with regulatory requirements to correct inaccurately coded claims that have been filed and follow contractual obligations to do the same with private payers. Make certain that those who need notification of corrected information – including health information management and a patient’s care giver – receive the update in a timely manner. Document steps taken to address inaccurate coding information.

**Conclusion.**
The introduction of electronic records, claims, and e-signatures has helped to raise the bar for healthcare documentation. Not only are there risk exposures in terms of patient care, there are liability issues that involve negligent coding. In addition, inaccurate coding could lead to regulatory and contractual risk exposure.

Effective design of “e” systems can help reduce many of these risk concerns. Coupled with good training for care givers and on-going support systems, steps can be taken to thwart the potential for negligent coding practices.

*If you would like assistance with physician education on effective document practices, please contact us at (860) 242-1302.*

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1 Federal Register, 72 (162) 47130-48175, August 22, 2007.
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3 Ibid.
4 Ibid.
5 Ibid.
6 Ibid.
7 Ibid.
8 Ibid.
9 Ibid.
10 Ibid. The court reference two cases to substantiate this type of analysis, Abbott v. Blount County, 207 S.W.3d 732 (Tenn. 2006) and Godfrey v. Ruiz, 90 S.W 3d 692 (Tenn. 2002), both Supreme Court of Tennessee opinions.
11 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.
15 Ibid.
16 Ibid.
17 Ibid.
18 Referring to Transmittal AB-01-144.