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Inpatient (IPPS) Documentation Tips for Physician Advisors, Hospitalists & Providers: [With (OPPS) Outpatient Observation & the 2 Midnight Rule - The Necessities]

Dr. Betty Bibbins

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Inpatient (MS-DRG) documentation can be significantly different from Evaluation & Management (E&M) documentation. Physicians document acute care diagnosis, treatments, patient status & progress in the hospital setting. Coders only take the documented diagnoses and convert them to 7 digit codes (International Classification of Disease-10 [ICD-10]) that are submitted for data processing / reimbursement for services rendered. The 7 digit codes have to correlate to explicitly documented words within the medical record – and be present 'verbatim' when the medical record is reviewed by Auditors. Period. (Therefore a lab result is not a diagnosis.) Repeat: Physicians document, Coders code. This pocket manual is meant to give you the most up to date Documentation Hints that will help you to communicate the quality of care being provided to your patients. It can help you to document the complete severity-of-illness, justify the utilization of resources, and demonstrate medical necessity to 3rd party payers. This can/will correlate to better reimbursements and fewer denials – in both the inpatient and outpatient settings.

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