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The Importance of Documentation Continuity

Did you know?

Unintentionally downgrading the severity of a patient's clinical condition in the medical record leads to insurance company denial opportunities

Example:

- Patient initially admitted to the ICU with diagnoses of "Sepsis due to Pneumonia" & "Acute Respiratory Failure"
- When patient is stable for transfer to the floor, the hospitalist who assumed that patient's care only documents that patient had "Pneumonia" and that the shortness of breath has resolved
- The insurance company then makes the argument that both Sepsis and Acute Respiratory Failure were "ruled out" since they were no longer propagated throughout the remainder of the hospitalization meaning they should not have been coded

The correct way for the hospitalist to document this scenario:

1. Sepsis, due to pneumonia - ***resolved***
2. Acute Respiratory Failure, due to pneumonia - ***resolved***
3. Pneumonia – Continue current antibiotic regimen

Please also remember to document all of these diagnoses in the Discharge Summary!

We simply cannot take care of our patients in the manner to which we have become accustomed if the hospital is not appropriately reimbursed

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