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EP Procedure Documentation | Best Practices

COMPLETE DOCUMENTATION → **CORRECT CODING** → **ACCURATE REIMBURSEMENT**

ACCURATE REIMBURSEMET REQUIRES COMPLETE DOCUMENTATION

Consistent, detailed, accurate and timely documentation in the medical record is the basis for obtaining appropriate reimbursement. With complete information in the record, coders can effectively analyze, code and report necessary information for physician and facility claims.

OPTIMIZE REIMBURSEMENT AND MINIMIZE DENIALS

Timely and appropriate payment for services is important for your institution and your practice. This guide provides recommendations to facilitate accurate claims processing.

APPROPRIATE DOCUMENTATION IS ESSENTIAL

For accurate reimbursement, the medical record must contain documentation that fully supports the procedures performed. Appropriate documentation is essential and will allow:

DETERMINATION OF INPATIENT OR OUTPATIENT STATUS

EP procedures may be performed as either inpatient or outpatient services. Documentation must include sufficient detail to help the coding staff capture all services and to ensure assignment to the correct patient status.

For the inpatient setting, the chart must include a physician order demonstrating medical necessity for inpatient admission, such as the severity of the patient's signs and symptoms, medical predictability of an adverse event, the need for diagnostic studies that appropriately are outpatient services, and/or the expectation of a two-midnight stay.

ASSIGNMENT TO CORRECT DRG

For each admission, the assignment of the MS-DRG is driven by principal diagnosis, secondary diagnoses and procedures performed. To ensure correct MS-DRG assignment, documentation should include:

- All diagnoses, procedures, complications, comorbidities and abnormal test results
- Suspected conditions and any tests performed to investigate these conditions

ACCURATE ASSIGNMENT OF ICD-10-CM / ICD-10-PCS

More detailed and precise information in the record is often necessary to accurately assign codes in ICD-10-CM/ICD-10-PCS. The ICD-10 updates are effective from October 1, 2020 through September 30, 2021. It reflects continued refinement of the new system, with hundreds of new and revised codes. CMS and other reviewers may use coding specificity as the reason for an audit or a denial of a reviewed claim.

PREPAREDNESS FOR THIRD PARTY PAYER AUDITS

In addition to the RAC post-payment reviews, Medicare Administrative Contractors (MACs) and commercial payers also perform pre-payment and post-payment reviews on select claims. Documentation is reviewed to ensure the service meets plan coverage criteria, is properly coded, assigned to the correct patient status, and compliant with documentation rules.

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BEST PRACTICES FOR DOCUMENTATION

Coding and reimbursement for physicians and hospitals is based upon complete clinical documentation. The best records:

- Capture a concise and specific description of services
- Implement a standard dictation format to ensure complete data capture
- Strive for clinical clarity for accurate procedure and diagnosis code selection
- Ensure all records, including admission, procedure report and follow-up progress notes are:
  - Legible, dated, timed, signed and timely
  - Consistent and without internal contradictory statements
- Recognize the EP lab procedure log as supportive procedure information only. The physician's dictation ultimately determines the ability to assign codes
- Maintain a policy that no changes are made to documentation unless approved by the physician

EP PROCEDURE REPORT

Detailed narrative description within the EP procedure report is essential for correct coding and accurate reimbursement. While a summary at the beginning of the report listing procedures performed is a common format, a detailed narrative provides the data necessary for code selection.

- State clear clinical indications including all diagnoses, arrhythmia subtypes, symptoms, prior conservative treatments and therapies.
- Describe procedural approach for accessing the anatomy
- Identify all pacing and recording sites
- Document the rationale when less than a comprehensive study is performed
- Specify sites ablated, including:
  - Ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism
  - Additional linear or focal ablation of Afib remaining following pulmonary vein isolation
- Provide clear identification of techniques used, including:
  - Energy source used
  - Three-dimensional (3-D) mapping
  - Programmed stimulation with IV drug
  - Transseptal puncture, if performed
  - Ultrasound, including key terms for either transesophageal or intracardiac echo
- Indicate catheters and other items used to assist hospitals in reporting C-codes for device dependent procedures
- Confirm diagnostic findings and observations
- Report procedure results
- Summarize planned follow-up and anticipated outcomes

COMMUNICATE AND EDUCATE

A cross-functional team with a common goal that practices open communication is essential for optimizing reimbursement and minimizing denials. Provide coding staff with clinical education and case observation to enhance their understanding of EP procedures. This will improve their accuracy when processing claims. Additionally, provide clinical staff with reimbursement and coding resources to assist with capturing comprehensive product and procedure data.

Communication and education are keys to an effective reimbursement process.

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