How to overcome physician resistance to providing complete and accurate documentation for dying patients

by Trey La Charité, MD

Sadly, there are patients who will not survive their current level of illness regardless of the best efforts of their physicians and their medical facility. The providers caring for these patients are often at risk of under-reporting those patients’ severity of illness and risk of mortality. CDI professionals must educate facilities and physicians about the importance of accurately capturing the entire disease process description because physicians, unfortunately, are frequently reluctant to document additional disease processes in the charts of patients who are obviously about to die. Let’s look at one example before discussing possible causes.

A CDI specialist reviews a case on the floor or in the ICU and notices “prognosis grim” written several times in the medical record. The physician, however, neglected to document one or more strikingly obvious diagnoses from the patient’s record. The CDI specialist queries the physician about the absent disease processes, asking whether those diagnoses are present and how they might affect the patient’s current clinical situation. The queries go unanswered. The CDI specialist follows up with the physician, which proves unproductive. The physician replies, “I’m not going to write that. That patient is about to die.”

There are numerous reasons physicians take this position, and while this is not an exhaustive list, you may have heard some of these excuses at one time or another:

» “I don’t want to ‘penalize’ the patient.”
» “I don’t want to bilk the insurance company.”
» “I don’t want to stick the family with a higher bill.”
» “It just doesn’t feel right.”
» “Why do you need that? They are going to die. How much sicker do you need them to look?”

By examining the faulty and misguided rationale behind these excuses, we can develop an appropriate response when confronted with a similar situation in the future.

1. Your providers are not “penalizing” the patient. When properly documented, the principal diagnosis and the circumstances leading to the current medical situation are firmly established in the medical record. There is no penalty to the patient for accurately describing how sick he or she is.

   On a personal note, I believe patients’ families gain some solace, if they choose to review the records, from the documentation of the severity of their loved one’s illness simply by knowing the full extent of the condition. Furthermore, there is a clear benefit from an epidemiological standpoint to tracking disease processes and identifying the toll those diseases take on our society. Providing diluted documentation related to the severity of a patient’s illness also dilutes our ability to provide that larger societal insight. As providers, our job is to take care of those patients to the best of our abilities. If we do not have a clear and inclusive picture of the various factors that play a role in a patient’s potential recovery, how can we effectively manage that patient in the hopes of providing a reasonable outcome?

2. Your facility and its physicians are not going to “bilk” the insurance company. MS-DRGs were created so that hospitals could be appropriately reimbursed for patients who require more resources for their complex medical care. Patients who are about to die are obviously as sick as anyone can get. Dying patients require an incredible amount of resources to help them and their families’ transition through this difficult time.

   In addition to the medical measures implemented to sustain and prolong life, these patients require other resources such as increased nursing care, comfort care, physician and chaplain time at the bedside, palliative care services, and medications for comfort. These services should be appropriately reimbursed to ensure that they are available for the next patient who desperately needs them.

   Furthermore, under the MS-DRG system, if a provider accurately diagnoses and describes the disease processes that a patient displays, there should be no question as to whether the level of reimbursement obtained is appropriate for that patient’s care. The insurance company is not getting “dinged,” it is covering the legitimate cost of taking care of that patient.

3. The family is not receiving a higher bill from the hospital. As with all health insurance products, patients pay
a fixed annualized premium for their insurance product, regardless of payer. This is set annually, paid on whatever schedule is arranged, and cannot be increased until the following year. Additionally, patients also have standard annualized copay and/or deductible arrangements with their insurance carriers. Once the patient or family has met those required copay or deductible amounts, the insurance carrier picks up the rest of the tab for hospital care. As with yearly insurance premiums, copays and deductibles can only be increased on an annual basis. While the insurance company may get a higher bill based on the DRG submission, the family of the patient who passed away will not.

4. Physicians must obtain a level of comfort with handling the documentation of a dying patient. They need to be reassured when they think they are doing something that “doesn’t feel right,” why such actions are indeed appropriate. While this phenomenon exists among physicians across multiple specialties, resident physicians represent the demographic most prone to expressing this sentiment. I suspect this stems from young physicians’ honest naiveté regarding how their data and their hospital’s data is collected and scrutinized. Resident physicians are also extremely sensitive to anything they perceive as having the slightest chance of being unethical. While these (possibly) young physicians are not acting out of malice or petulance when this unique situation arises, corrective action still must be taken to mitigate this response.

The most important concept to impart to reticent practitioners is that accurate and comprehensive diagnosis descriptions and documentation in these cases is not a financial issue. The reality of why we need our providers to make the charts reflect the imminence of the patient’s death is quite simple: If the patient is about to pass away while on that provider’s service (or their attending physician’s service), the patient’s actual mortality is going to be 100%.

**CDI strategies for documenting mortality**

In order for physicians to keep their report card looking reasonable, it behooves them to make that death (and every death on their service) look as expected as possible. In other words, the expected mortality needs to be made as high as possible.

How can physicians effectively accomplish this? By simply documenting all of those extra diagnoses they were initially afraid to document in the chart. Regardless of the cause or the circumstance, it is never good for a physician’s report card when a patient passes away under his or her care. Fortunately, mortality rates, whether actual or expected, are averages; one single death will not sink a physician’s overall standing in the publicly reported data. However, multiple deaths over time that appear to be relatively unexpected due to a lack of documented comorbidities and significant disease processes will not benefit them or their host facility.

The bottom line is that in today’s environment, a poor image for the doctor or the hospital will mean fewer patients for both.

I do not condone querying for diagnoses that would be considered part of the active dying process. For example, querying for “acute respiratory failure” or “acute encephalopathy” for a patient who has been transitioned to comfort care measures, including a narcotic drip for pain control, would be unnecessary. If these diagnoses did not exist prior to the institution of that drip, I would consider the attempt to secure that provider’s documentation of those diagnoses to be fraudulent and entirely inappropriate.

I am referring to those patients for whom the provider has recognized that a poor outcome is the most likely scenario and to those cases where the patients will obviously not survive their current level of illness regardless of the provider’s best efforts. It is statistically inevitable that patients will pass away inside our facilities’ walls. However, as CDI professionals, our duty is to ensure those patients’ dire clinical conditions are accurately reflected in the medical record.

**Editor’s note:** La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville, and an ACDIS Advisory Board member. He is board certified in internal medicine and has been a practicing hospitalist since 2002. His comments and opinions do not necessarily reflect those of UTMCK or ACDIS. Contact him at clachari@utmck.edu.