Coding Mistakes That Quietly Cost You Money

■ Brad Laymon, PA-C, CPC, CEMC

Every clinician I work with wants to do right by their patients and their charts. Yet across the urgent care systems I consult with, the same quiet leaks show up repeatedly. None of these are dramatic errors. They may never trigger an audit flag. They simply shave a level off the visit, encounter after encounter, until the lost revenue becomes real.

The most common leak I see is an abnormal vital sign that never gets considered for diagnosis. For example, a heart rate of 128 beats per minute gets recorded, noted, and ignored. The clinician absolutely thought about it. They just never wrote down what they thought. Unless that tachycardia is documented as a finding with a plan attached, the chart cannot reflect the clinical reasoning that actually happened, and the encounter defaults to a lower complexity than the care deserved.

Chronic illness exacerbation is another quiet loss. A patient with hypertension comes in for a cough, and their blood pressure happens to be 168/97 mm Hg. If that number never gets acknowledged as a condition that is not at goal, and there is no plan for managing it, the visit looks like a simple cough rather than the dual problem it actually was.

Documented Risk Decision

Prescription drug management may be the single easiest fix to consider. Clinicians manage medications constantly—starting them, adjusting them, continuing them, or deciding not to prescribe at all.[1] Almost none of that gets written down in a way that shows the risk-and-benefit thinking behind it. A sentence as short as, "continued current antihypertensive regimen, benefits outweigh risks given stable readings," turns a generic plan into a documented risk decision. And risk decisions are exactly what move a visit toward a higher level.

Tests considered but not ordered fall into the same trap.[2] A clinician weighs whether to order a chest x-ray, for example, decides the exam does not support it, and moves on. That thinking is real diagnostic work. Guidelines specifically credit a test that was considered and discussed, even if it was never ordered, as long as the discussion is documented. Skipping that sentence to document the thinking means skipping credit for work the clinician already did.

Then there is the independent historian, which is the most overlooked data point in pediatric and altered mental status visits. For pediatric visits, a parent gives the history because the child cannot. For an altered mental status visit, perhaps a spouse engages in the discussion to fill in details because the patient is confused. That conversation took real time and added real complexity to the visit, but if the note does not say where the history came from and why, none of that complexity counts.

None of these suggested fixes add much documentation time. They redirect a few seconds of typing/dictating toward capturing thinking that already happened.

The chart should tell the same story the clinician was actually living through during the visit. When it does, coding accuracy follows naturally, and so does the reimbursement that reflects the real complexity of the care provided. Always aim for documentation excellence! ■

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References

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