



## MEDICAL CENTER

# Clinical Documentation Integrity

# US Modification ICD-10 CM and PCS Collaborative Agencies



Centers for Disease Control and Prevention  
CDC 24/7: Saving Lives. Protecting People.™

☒ NCHS

☐ All CDC Topics

Choose a topic above

A-Z Index [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#) <#>

## Classification of Diseases, Functioning, and Disability

### ICD and ICF Home

ICD-9

ICD-10

ICD-9-CM

► ICD-10-CM

ICF

Classification of Death and

[NCHS Home](#) > [ICD and ICF Home](#)

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## International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

Note: The [2014 release of ICD-10-CM](#) is now available. It replaces the July 2013 release.

- **CDC**

- Responsible for diagnoses

- **CMS**

- Responsible for inpatient procedures

- **American Hospital Assn.**

- Responsible for interpreting ICD-9 or ICD-10 (Coding Clinic)

- **American HIM Assn.**

- Provides input from coding community

# Documentation Basics

Close the Gap between Clinical Language and Codable Language



SNOMED

- National Standardized Clinical Language
- Meditech

ICD-10  
CM/PCS

- Coded numbers obtained by physician documentation **only**.

Coders  
Cannot Code  
from Nurses  
Notes,  
Laboratory,  
Radiology,  
EKG, or  
Pathology  
Reports or  
Symbols ↓ ?

# Different Coding Rules for Inpatient and Outpatient

## Inpatient Setting (Hospital) — Can bill for what you are potentially treating

In the in-patient setting, if definitive diagnosis is unknown, document conditions being worked up as

- Probable
- Possible
- Suspected
- Unable to rule out

Documentation at the time of discharge must include any remaining “uncertain” diagnosis

## Outpatient Setting (E&M)—Can only bill for what you know

### Key Elements for E/M documentation:

- Chief Complaint
- History
- Examination
- Medical Decision

Code diagnosis to the highest level of specificity known (i.e. signs and symptoms)

# Major Terms

**MS DRG—Medicare Severity Diagnosis Related Groups**

**APR DRG—All Patient Refined Diagnosis Related Groups**

**MCC—Major comorbidity/Complication**

**CC—Comorbidity/complication**

**CMI—Case Mix Index**

**GMLOS—Geometric Mean Length of Stay**

**RW—Relative Weight**

Subclass	Severity of Illness (SOI)	Subclass	Risk of Mortality (ROM)
1	Minor	1	Minor
2	Moderate	2	Moderate
3	Major	3	Major
4	Extreme	4	Extreme

# Provider Profiles are Derived From Severity Adjusted Statistics

**Determine by Quality of Care**

**Observed Mortality**

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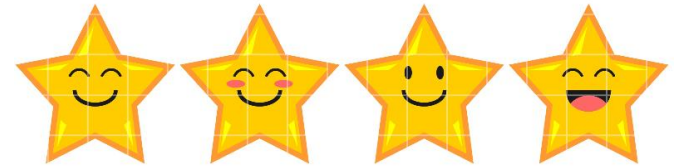
**Expected Mortality**

**Determined by Documentation  
and Assigned Codes**

**Risk Adjusted Mortality**

Patient characteristics (age, principal  
diagnosis, secondary diagnosis,  
procedures)

**< 1 Preferred Provider**



Significantly better

**= 1 As Good As The Next  
Guy**



**> 1 Excessive Mortality**  
**Need to Improve  
Documentation**



# Impact of Documentation

DRG	<b>DRG 293</b> Left Heart Failure w/o CC/MCC	<b>DRG 292</b> Diastolic Heart Failure with CC (Hyponatremia)	<b>DRG 291</b> Acute on Chronic Diastolic Heart Failure/HTN/CKD with MCC (PU R. Heel Stage 3)
GMLOS	2.40 days	3.30 days	4.10 days
RW	0.6656	0.9198	1.3454
SOI	1-Minor	2-Moderate	2-Moderate
ROM	1-Minor	1-Minor	2-Moderate

**\*\*\*Severity Risk Adjusted\*\*\***

Diagnosis ATN

DRG 291 GMLOS 4.6

SOI **3-Major**

ROM **3-Major**

Diagnosis Severe PCM

DRG 291 GMLOS 4.6

SOI **4-Extreme**

ROM **4-Extreme**

# Clinical Documentation Integrity (CDI)





# Physician Resources

## Provider Documentation Educator

Discuss documentation opportunities with Providers:

- One on One Setting
- Focus on individual providers documentation
- Case studies showing changes in SOI/ROM
- Assist with answering queries
- Obtain feedback from providers to improve query process (CDI Education)

# Clinical Clarification Form

## Queries in Meditech by the CDS

- ✱ Present on Admission (POA)—cauti, central line
- ✱ Clarification, Conflicting or Specificity information
- ✱ Validation—No supportive clinical indicators
- ✱ Requires a **response with-in 3 days**
- ✱ Clarifies documentation prior to coding for final billing
- ✱ Ensures documentation supports coding accuracy
- ✱ Clinical Language **is converted to Administrative Language**

## Reporting Diagnoses

- ☐ Clinical Evaluation Diagnosis
- ☐ Therapeutic Treatment
- ☐ Diagnostic Procedure
- ☐ Extended Length of Hospital Stay
- ☐ Increased Nursing Care and/or Monitoring

# Top Queried Diagnoses

## 57% of all CDI Queries sent in CY18

- Sepsis: Ruled In / POA / Link Organism
- Acute & Chronic Renal Failure
- Pneumonia: Type / Ruled In / POA
- Heart Failure: Type & Acuity
- Anemia: Type and Acuity
- Pressure Ulcer: Type / Location / POA

# Sepsis w/ Organism (Linked)

2 SIRS criteria with Infection = **Sepsis**

Sepsis + Organ Dysfunction = **Severe Sepsis**

Severe Sepsis + Hypotension/Vasopressors = **Septic Shock**

## Clinical Indicators

### SIRS Criteria

- ☼ WBC > 12,000/mm or < 4,000mm or > 10% immature neutrophils
- ☼ Temp >101°F (38.3°C) or <96.8°F (36°C)
- ☼ Tachycardia > 90
- ☼ Tachypnea > 20

### Organ Failure/Dysfunction Indicators

- ☼ B/P < 90 systolic
- ☼ Creatinine > 2
- ☼ Bilirubin > 2
- ☼ Platelet Count < 100,000
- ☼ INR > 1.5
- ☼ Lactate > 2

## Undefined Terms Automatic Query

~~SIRS with Infection~~

**Sepsis**

~~Sepsis Syndrome~~

**Sepsis**

~~Urosepsis~~

**Sepsis due to UTI**

# Acute Renal Injury or Failure

Consider either: Acute Kidney Injury  
or Acute Renal Failure due to:

## Etiology

### Pre-renal Causes (reduced blood flow)

- Shock/Hypotension
- Heart Failure
- Cirrhosis
- Renal Artery Stenosis
- Renal Vein Thrombosis

### Renal Causes (damage to kidney)

- Acute Tubular Necrosis
- Acute Cortical Necrosis
- Acute medullary Necrosis
- Tumor Lysis Syndrome
- Acute Interstitial Nephritis
- Rhabdomyolysis
- Drugs/Chemicals

### Post renal Causes (obstruction)

- BPH
- Calculi
- Malignancy
- Neurogenic Bladder
- Catheter Obstruction

		RIFLE criteria				AKIN criteria	
		sCreatinine	Urine output criteria			sCreatinine	Urine output criteria
Increasing severity ↓ Outcome	Risk	↑ sCrea × 1.5	< 0.5 ml/kg per h × 6 h	Increasing severity ↓	Stage 1	↑ sCrea × 1.5 or ↑ ≥ 0.3 mg/dl in sCrea	< 0.5 ml/kg per h × 6 h
	Injury	↑ sCrea × 2	< 0.5 ml/kg per h × 12 h		Stage 2	↑ sCrea × 2	< 0.5 ml/kg per h × 12 h
	Failure	↑ sCrea × 3 or ≥ 0.5 mg/dl if baseline sCrea ↑ > 4.0 mg/dl	< 0.3 ml/kg per h × 24 h or anuria × 12 h		Stage 3	↑ sCrea × 3 or ↑ ≥ 0.5 mg/dl if baseline sCrea > 4.0 mg/dl	< 0.3 ml/kg per h × 24 h or anuria × 12 h
	Loss	Complete loss of renal function > 4 weeks			Patients who receive RRT are considered to have met stage 3 criteria, irrespective of the stage they are in at the time of RRT		
	End-stage	End-stage renal disease					

Avoid Non-specific terms such as:  
“Insufficiency” or “Impairment”

# Chronic Kidney Disease

## Stage:

- 1, 2, 3, 4, 5, or ESRD

Baseline and Current (if worsening)

## Etiology:

- DM • Hypertensive • Other (specify)

## Complications/Manifestations:

- Anemia
- Osteoporosis
- Pulmonary Edema/ Heart Failure
- Cardiovascular disease
- Other

## Dialysis Regimen (Specify Type)

Stages	Description	GFR (mL/min/1.73 m <sup>2</sup> )
I	Kidney Damage with normal or high GFR	≥90
II	Kidney damage with mild decrease GFR	60-89
III	Moderate decrease in GFR	30-59
IV	Severe decrease in GFR	15-29
V	Kidney Failure	<15 (or dialysis)

**Please avoid non-specific terms such as:  
“Insufficiency” or “Impairment”**

# Pneumonia

## Respiratory Infections (DRG 177,178, 179)

- Aspiration Pneumonia
- Klebsiella PNA
- Pseudomonas PNA
- Staph/MRSA PNA
- PNA specified organism—serratia, proteus, or E. coli

## Simple Pneumonia (DRG 193, 194, 195)

- Viral PNA
- Pneumococcal PNA
- Strep PNA
- Mixed bacterial PNA
- **CAP**
- **HAP**

## QUERY OPPORTUNITY

- Antibiotics—not general first line practice use (e.g. Zosyn/Vanco)
- Risk Factors: Dysphagia, CVA, Vomiting, Dementia
- Changes in Antibiotics
- Longer Hospitalization

**Provide documentation regarding reason, such as, probable, likely, suspected, unable to rule out when you cannot confirm the organism.**

# Impact of Documentation

**PDx: Pneumonia, Unspec.  
SDx: Acute on Chr. Dias.  
CHF, Acute Resp. Failure**

**Actual LOS 7 days**

**If appropriate to further  
specify Type of Pneumonia  
as Gram Negative  
Pneumonia or Pneumonia  
due to Gram Negative Bact**

**MS DRG 193 w/ MCC**

**GMLOS 4.60 days**

**RW 1.3860**

**Mortality % 4.76%**

**GMLOS 4.49 days**

**SOI 3-Major**

**ROM 3-Major**

**MS DRG 177 w/ MCC**

**GMLOS 5.90 days**

**RW 1.8672**

**Mortality % 8.68%**

**GMLOS 8.06 days**

**SOI 4-Extreme**

**ROM 4-Extreme**





# Heart Failure

## Identify Type

**Systolic**

**Diastolic**

**Systolic/  
Diastolic**

## State Acuity

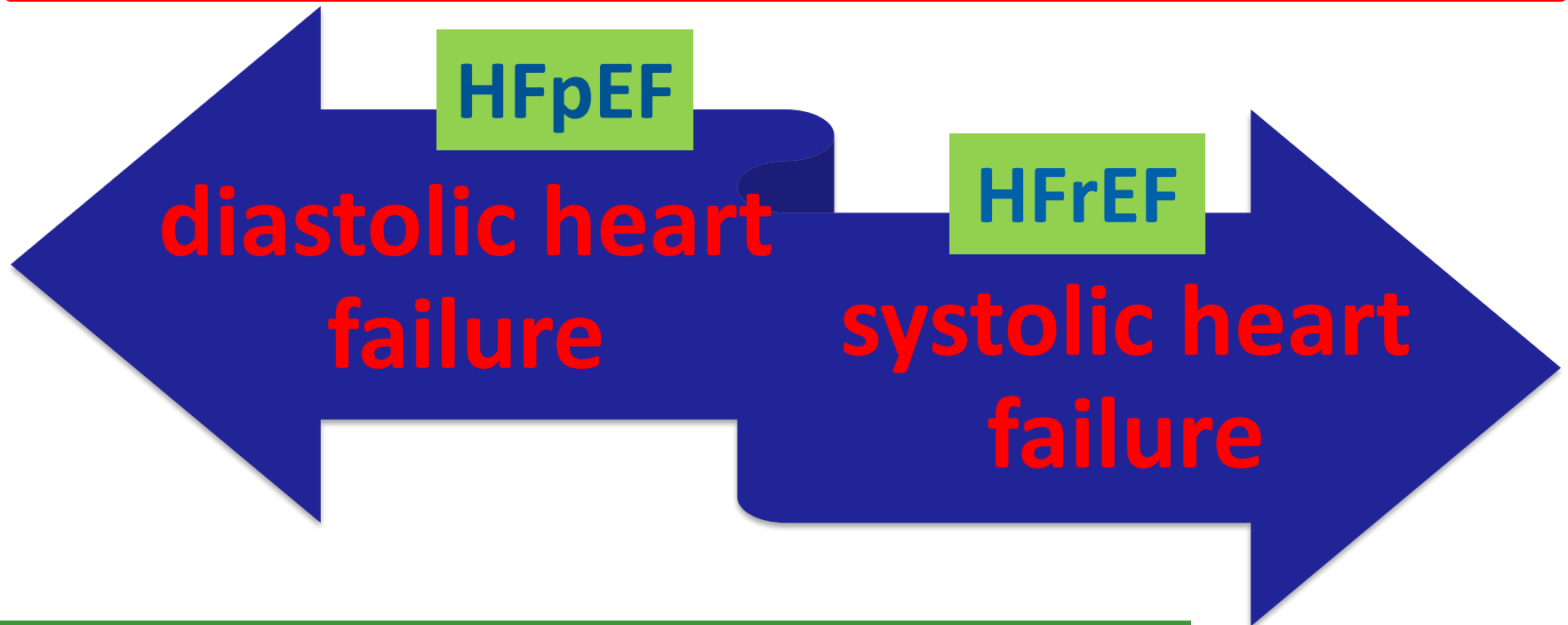
**Acute**

**Chronic**

**Acute on  
Chronic**

# Coding Clinic

American College of Cardiology (ACC), the  
Editorial Advisory Board for *Coding Clinic for  
ICD- 10-CM/PCS*



# Anemia

## Type/Acuity:

- Acute Blood loss

**Acute Blood Loss Anemia – Present on Admission: Yes/No?**

- Anemia of Chronic Disease: i.e. Chronic Kidney Disease
- Iron deficiency
- Bone Marrow Diseases
- Hemolytic
- Nutritional deficiency
- Neoplasm
- Aplastic
- Due to Chemo/Drugs (Specify)

## Treatment:

- Transfusion
- Iron (PO or IV)
- Erythropoietin (Procrit)
- Other: Monitor with Labs

# Protein Calorie Malnutrition

**Education, Total Jk Sjo2**  
 DOB: 9/4/67 49 M  
 Ht: 182.88 cm / Wt: 72.575 kg    BSA: 1.94 m2    BMI: 21.7 kg/m2  
 Allergy/AdvReac: No Known Allergies

AA0000135160 / MM00022408  
 SJO Cardiac Renal A SJM1301-02 ADM IN

Document: Malnutrition Assessment - Malnutrition Identification

**Record List**  
 Other Visit

**Special Panels**  
 24 Hour  
 Vital Signs  
 I & O  
 Notes  
 Medications  
 Order History

**Laboratory**  
 Microbiology  
 Blood Bank  
 Pathology

**Imaging**  
 Other Reports

**Care Trends**  
 Care Activity  
 History  
 Summary  
 Encounters  
 Referrals

**Problem List**  
 Discharge  
 Orders  
 Document  
 Reconcile Meds  
 Sign

**MALNUTR**

**Malnutrition Assessment**

Protein-Calorie Malnutrition	<input checked="" type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Other
In Context of	<input checked="" type="radio"/> Acute Illness/Injury	<input type="radio"/> Chronic Illness	<input type="radio"/> Social/Env Circumstances

**Evidenced by**

Weight loss	<input type="radio"/> 1-2% in 1 week <input type="radio"/> 7.5 in 3 months <input checked="" type="radio"/> >10% in 6 months <input type="radio"/> >2% in 1 week	<input type="radio"/> >7.5 in 3 months <input type="radio"/> 20% in 12 months <input type="radio"/> 5% in 1 month	<input type="radio"/> 10% in 6 months <input type="radio"/> >20% in 12 months <input type="radio"/> >5% in 1 month
Energy intake	<input type="radio"/> <=50% Intake for >=5 ... <input type="radio"/> <=75% Intake for >= 1...	<input type="radio"/> <75% Intake for 1 mon <input type="radio"/> <=50% Intake for >=1 ...	<input type="radio"/> <75% Intake for >7 days <input type="radio"/> <75% Intake for >=3 ...
Loss of Subcutaneous Body Fat	<input checked="" type="radio"/> Mild Depletion	<input type="radio"/> Moderate Depletion	<input type="radio"/> Severe Depletion
Loss of Muscle Mass	<input checked="" type="radio"/> Mild depletion	<input type="radio"/> Moderate depletion	<input type="radio"/> Severe depletion
Gen/Local Fluid Accumulation	<input checked="" type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe
Measurably reduced grip streng	<input checked="" type="radio"/> Yes	<input type="radio"/> Not Applicable	
Malnutrition Comment			

**Provider Responses**

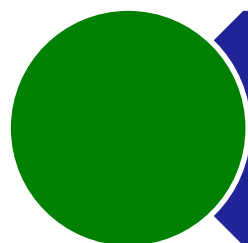
\*I have reviewed these findings ☐ Agree with condition cit... ☐ Disagree (specify other... ☐ Clinically undetermined

Comments

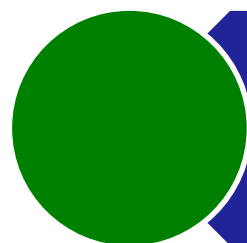
Normals    Add Section    Remove Section    Clear Responses    View Protocol    Preview    Code Visit    Repeat    Save as Draft    Cancel    Save

**Specify: Mild—Moderate—Severe**

# Improve Documentation



Frequently  
seen  
documented



Requires Query  
Specificity

- Aspiration → Aspiration Pneumonia/Pneumonitis
- Hypoxia, on BIPAP → Acute Respiratory Failure
- Home O2 → Chronic Respiratory Failure
- Altered Mental Status → Encephalopathy (specify type)
- Ischemia → Demand, Renal, Cerebral



# Improve Documentation By

- ✿ State **Acuity** — Acute on Chronic
- ✿ **Discharge Summary** should include all **conditions (possible, probable, suspected)**
- ✿ **Clinical Significance** of every abnormal labs/tests
- ✿ Medications used should be justified by diagnosis (always indicate what's being treated)
- ✿ Associated conditions
  - ✿ **Linking** diagnosis—the relationship of two conditions **(due to, with, associated)**
- ✿ Attending should always convey consistent /overall impressions from other providers

# In Conclusion

Thank you for your partnership in providing patient care, and improving the quality of our patient's outcomes.

