CovenantHealth

Levelland · Lubbock · Plainview

MEDICAL CENTER

Clinical Documentation Integrity

US Modification ICD-10 CM and PCS Collaborative Agencies

- **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

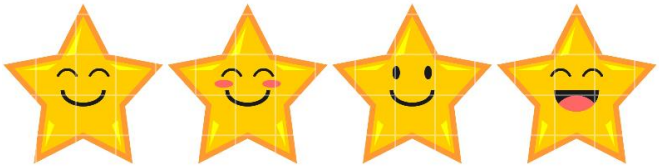
$$\frac{\text{Observed Mortality}}{\text{Expected Mortality}}$$

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	DRG 293 Left Heart Failure w/o CC/MCC	DRG 292 Diastolic Heart Failure with CC (Hyponatremia)	DRG 291 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)

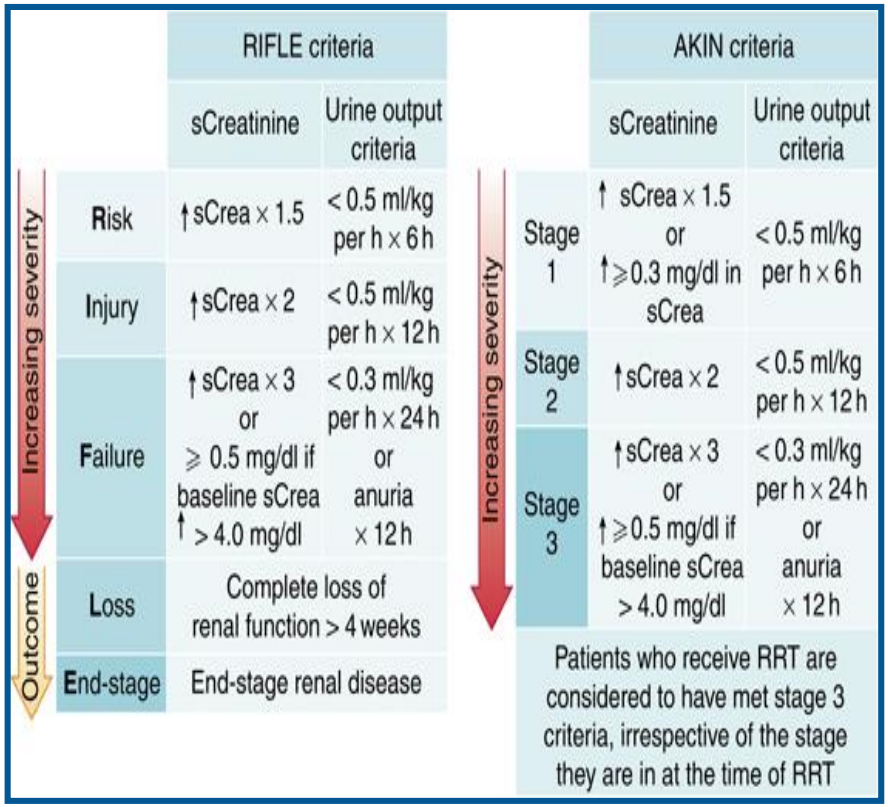
- Shock/Hypotension
- Heart Failure
- Cirrhosis
- Renal Artery Stenosis
- Renal Vein Thrombosis

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



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 m2)
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)	Simple Pneumonia (DRG 193, 194, 195)	QUERY OPPORTUNITY
• Aspiration Pneumonia • Klebsiella PNA • Pseudomonas PNA • Staph/MRSA PNA • PNA specified organism—serratia, proteus, or E. coli	• Viral PNA • Pneumococcal PNA • Strep PNA • Mixed bacterial PNA • **CAP** • **HAP**	• 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	MS DRG	177 w/ MCC
GMLOS	4.60 days	GMLOS	5.90 days
RW	1.3860	RW	1.8672
Mortality %	4.76%	Mortality %	8.68%
GMLOS	4.49 days	GMLOS	8.06 days
SOI	3-Major	SOI	4-Extreme
ROM	3-Major	ROM	4-Extreme

Heart Failure

Identify Type

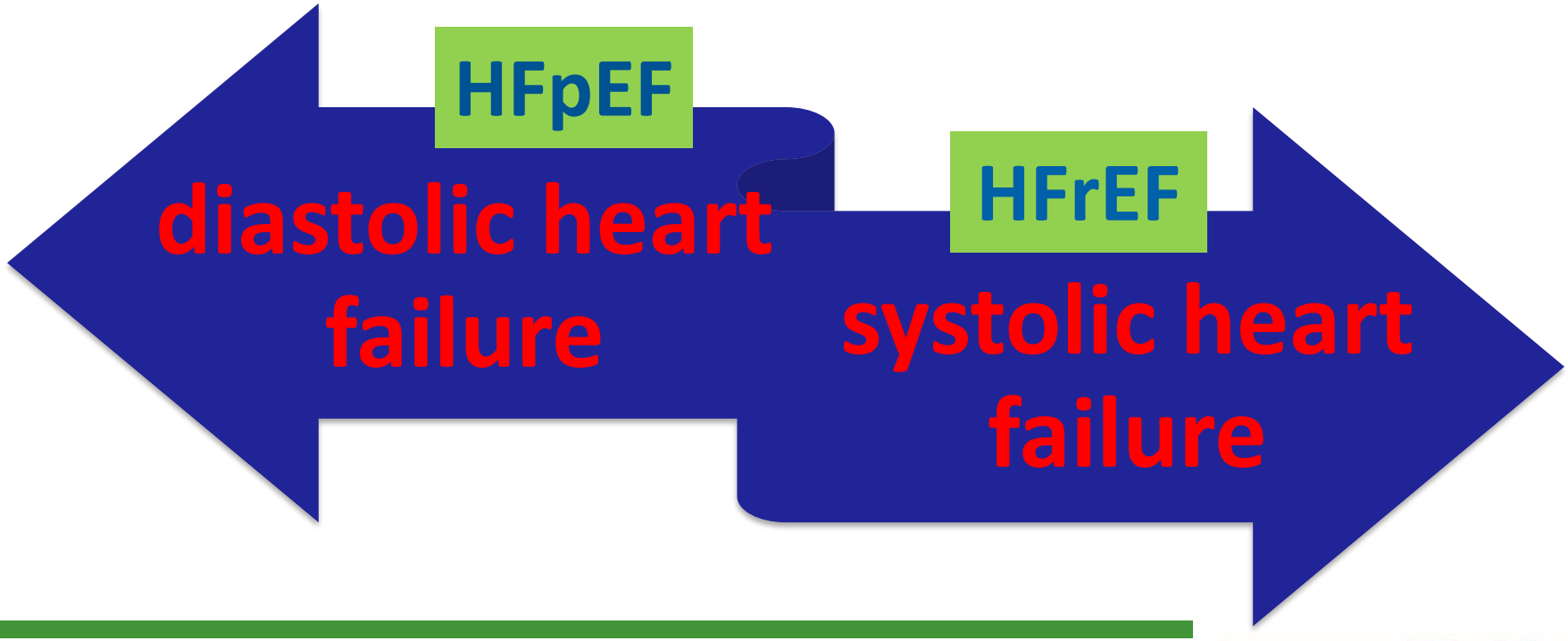
- Systolic
- Diastolic
- Systolic/ Diastolic

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

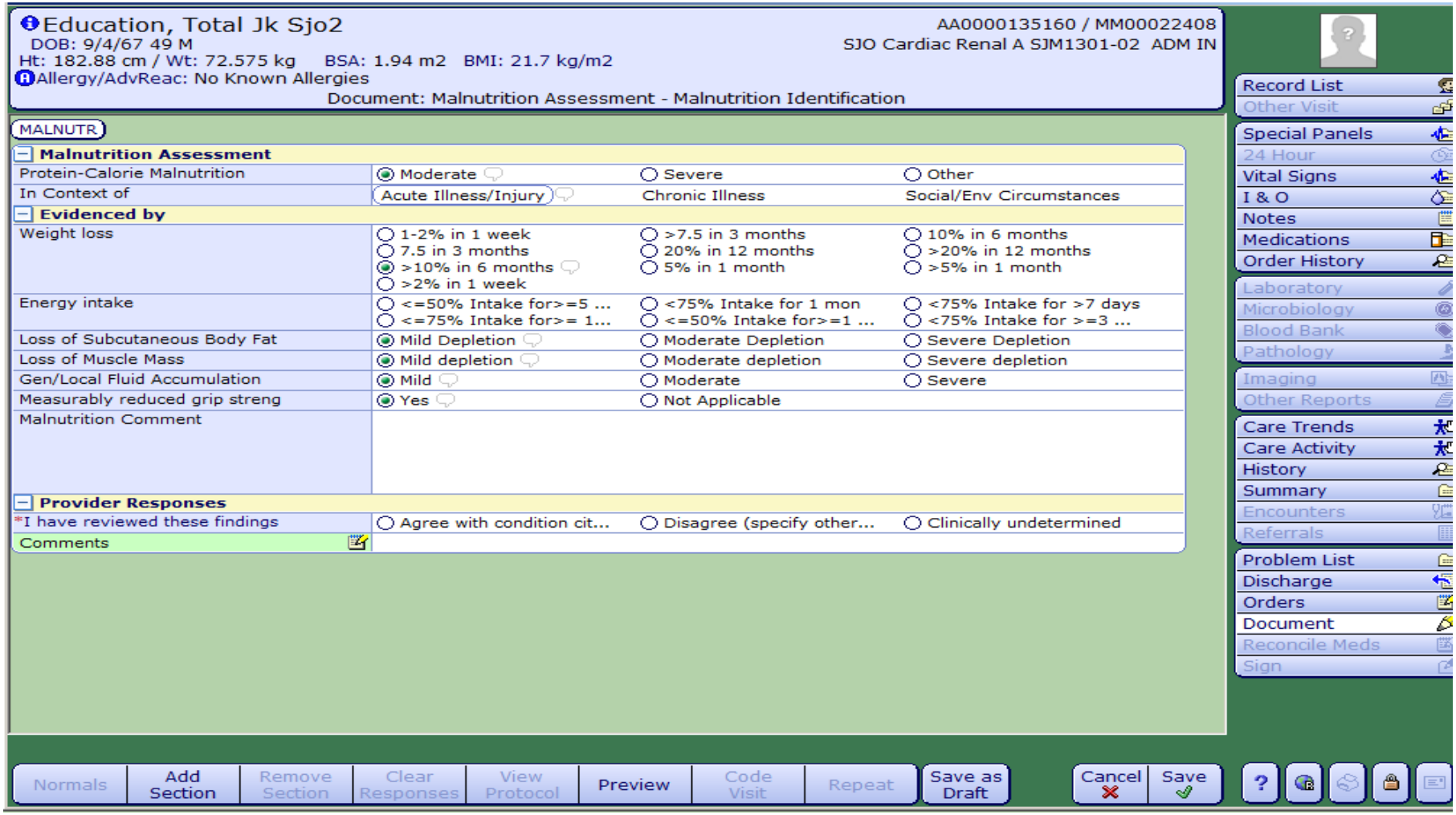
Acute Blood Loss Anemia – Present on Admission: Yes/No?

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

Treatment:

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

Protein Calorie Malnutrition



Specify: Mild—Moderate—Severe

Improve Documentation

- 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.