

CLINICAL DOCUMENTATION INTEGRITY

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OBJECTIVES

- Understand how improving clinical documentation increases:
 - Patient safety
 - Communication between providers
 - Outcome metrics for providers
 - Insurance reimbursement, length of stay, hospital Case Mix Index
- Learn Pediatric specific diagnoses examples and tips

CDI = GET CREDIT FOR WHAT YOU DO!

- Clinical Documentation Integrity provides **accurate and specific documentation** that captures severity of illness (SOI- how sick is the patient) and risk of mortality (ROM- how likely is the patient to die with this diagnosis)
- Helps match resources for providers to care for their patients to the needs and severity of the patients diagnoses

WHY DOCUMENTATION IS IMPORTANT

- Improves patient care
- Ensures an *accurate* medical record
- Credits the providers and hospital for excellent patient care
- Justifies equitable reimbursement for the excellent care provided
- Supports research by providing accurate coding
- Supports the hospital in the national quality arena:
 - Hospital mortality rates
 - Penalties for readmission rates
 - Penalties for hospital acquired conditions
 - Value based contracts

HOW DOES DOCUMENTATION IMPROVE PATIENT CARE?

COMMUNICATION

- **Acuity**
 - "watcher status"
 - ...and WHY
- **Complexity**
 - every care decision must be *thoughtful* or may be unintended consequences
- **Care plan**
 - for seamless care transitions

Provider awareness of complexity/acuity

↓

Increased attention to detail

↓

Enhanced preparedness and improved outcomes

EXTERNAL REPORTING OF OUTCOMES

- National metrics for pediatrics= Quality measures
 - PHIS (Pediatric Health Information System) database/CHA
 - CMS reporting
 - US News & World Report
- Personal
 - National Practitioner Database
 - Credentialing will be based on complications, mortality, length of stay
 - Publically reported online

PUBLICALLY REPORTED MEASURES

- Length of stay
- Morbidity
- Mortality
- Complications
- Patient Satisfaction
- Safety

HOSPITAL VS PROFESSIONAL BILLING BASICS

Hospital Fee	Professional Fee
<ul style="list-style-type: none"> ▪ Facility charge = represents resources/services utilized <ul style="list-style-type: none"> ▪ Pharmacy, radiology, RT, RN, lab, bed ▪ Hospital coders read the chart to assign diagnoses 	<ul style="list-style-type: none"> ▪ Attending physician charge ▪ Represents the skill and training of provider that day and services performed ▪ Attending assigns diagnoses in the charge

BRIDGE THE GAP

Two separate languages

Provider documentation is in **CLINICAL** terms

Documentation for coding, profiling & compliance requires specificity in **DIAGNOSTIC** terms

CDI bridges the gap

HOW CODING WORKS

- Your documentation is used to gather the data
 - Provider notes **ONLY** used for coding
 - Coders **CAN'T** use lab values, path reports
 - Coders **CAN'T** interpret radiology reports, ancillary notes
 - They **NEED** a **DIAGNOSIS** that is explicitly stated

IMPROVING DOCUMENTATION

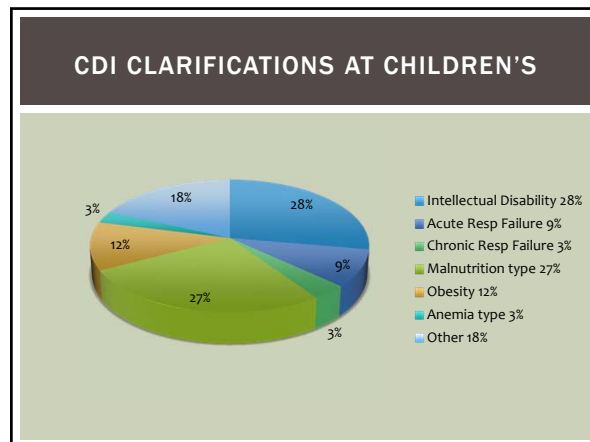
Coders CANNOT code from:	Coders CAN code from:
Nursing Notes	ER Physician Notes
Pathology Reports	H and P
Lab Reports	Progress Notes
Radiology Reports	Consultant Notes
Physical Therapy Reports	Physician/NP/PA Orders*
Nutrition Reports	Discharge Summaries
	Operative/Procedure Notes

SOI AND ROM

- **Severity of Illness** – a measure that allows comparison, within a particular principal diagnosis, of how sick one patient is to another who has *the same* principal diagnosis
 - Minor (1) – Extreme (4)
- **Risk of mortality** – A measure that allows comparison, within a particular principal diagnosis, of how likely a patient is to die relative to another who has the same principal diagnosis
 - Minor (1) – Extreme (4)

CRACK THE CODE

Unable to Code	Able to Code
Multi-system organ failure	Liver failure, renal failure, resp failure
Severe respiratory distress	Respiratory failure: acute, acute on chronic
Hemodynamically unstable	Hypotension, cardiogenic shock
Emaciated, Total Protein/Albumin Low	Protein Calorie Malnutrition
Will rehydrate	Dehydration, hypovolemia
Abnormal Rhythm	Atrial fibrillation, SVT, VTach
"Urosepsis"	Sepsis due to UTI
K = 2.0, will give KCL	Hypokalemia
LLL infiltrate	LLL pneumonia
Bleeding	Hemorrhage, hypovolemia, shock
Hgb 5.2, Transfuse	Acute or Chronic Blood Loss Anemia



- ### INTELLECTUAL DISABILITY
- **What do we use Instead?**
 - Global developmental delay
 - Static encephalopathy
 - Hypotonia
 - Wheelchair-bound/dependent
 - **These terms may mean other delays: speech, gross motor, fine motor**
 - **Why is this important?**
 - **How can you be specific if no IQ testing?**

INTELLECTUAL DISABILITY SPECIFICITY

Mild	Moderate	Severe	Profound
Able to speak and to learn some social skills	Able to achieve elementary school level education	Acquisition of even the earliest motor milestones are delayed	Will generally need full care as adults
Can usually be expected to care for themselves as adults, with some guidance	Language development, ADLs and social skills are often delayed	Able to learn a few words and a few self-help skills	Nursing home environment or round-the-clock nursing care at home
	May need complete supervision as an adult	Will need a protected environment as an adult	
	May be capable of occupations in a supported-employment setting	Living in a group home with increased support will generally be possible	

INTELLECTUAL DISABILITY FOR CHILDREN >= 2-3 YO

Mild	Moderate	Severe	Profound
<ul style="list-style-type: none"> • Able to speak • Some social Skills 	<ul style="list-style-type: none"> • Poor social skills and language • Activities of Daily Living (ADLs) delayed for age 	<ul style="list-style-type: none"> • Few words • Few self help skills • Needs protective environment 	<ul style="list-style-type: none"> • Nonverbal • Requires full supportive care for ADLs

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CLINICAL EXAMPLE

- 9yo ex 23 week premature infant now neurodevastated who presented for elective surgery for hip dysplasia. Documentation states patient has profound developmental delay and is unable to speak. Her upper and lower extremities are spastic and hypertonic.

IMPACT: INTELLECTUAL DISABILITY

	Before Query	After Query
APR-DRG Assignment	309 (Hip/fem for non-trauma repair)	138 (Hip/fem for non-trauma repair)
SOI/ROM	2/1	3/2
PHIS LOS	3.5 days	5.2 days
Relative Weight	1.8	2.6
Reimbursement		↑ \$XX,XXX

- ### MALNUTRITION
- **Terms we use instead:**
 - Failure to thrive (FTT)
 - Growth retardation, failure to grow
 - Difficulty Feeding, Poor PO
 - Poor weight gain
 - Inappropriate weight loss
 - Insufficient weight gain
 - Malnutrition can be a component of FTT
 - Severity is important!
 - Mild
 - Moderate
 - Severe

MALNUTRITION SEVERITY

Z Score	Mild	Moderate	Severe
Weight for Height	-1 to -1.9	-2 to -2.9	-3 or lower
BMI for Age	-1 to -1.9	-2 to -2.9	-3 or lower
Height for Age	n/a	-2 to -2.9	-3 or lower

CLINICAL CASE

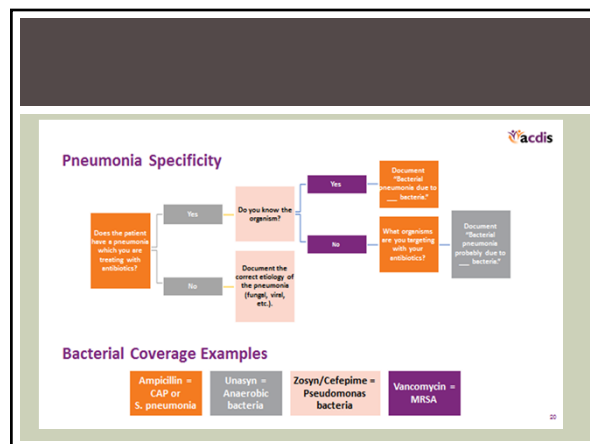
45 day old with laryngotracheomalacia and FTT. FTT thought to be related to poor feeding. Plan for laryngoscopy and speech therapy consult. Nutrition note states patient with weight for height z score of -3.2

What is the best additional diagnosis you as the physician should document in the chart:

1. Malnutrition
2. Mild Malnutrition
3. Mod Malnutrition
4. Severe Malnutrition

IMPACT

	Before Query	After Query
MS-DRG Assignment	DRG 130 MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	DRG 129 MAJOR HEAD & NECK PROCEDURES W CC/MCC
2015 GML0S	2.2 days	3.8 days
Relative Weight	1.26	2.33
Reimbursement		↑ \$XX,XXX



SPECIFICITY EXAMPLES

Good	Better
RUL Pneumonia	RUL Pneumonia secondary to S. pneumoniae
Anemia	Acute Anemia secondary to Upper GI Bleed
Malnutrition	Severe Malnutrition
UTI	Acute Pyelonephritis
Urinary Retention	Acute Urinary Retention
Asthma	Mild Persistent Asthma with Status Asthmaticus

HIGH IMPACT TIP: UNCLEAR DIAGNOSES

- In the outpatient world, a suspected diagnosis cannot be coded. Use **"treating for."**
- In the inpatient world, coders can assign codes to suspected diagnoses....if one of the following terms is used.
 - Treating for** (can be coded that day)
 - Suspected
 - Probable
 - Likely

Can only be coded if the diagnosis is carried to the discharge summary or final progress note.

DOCUMENTATION TIPS

- Use "Due To..." to link diagnosis to pathogenesis, which increases specificity (caused by, secondary to, etc)
- Avoid "Admit for Observation"
 - Instead "admit for continuous/frequent evaluation/monitoring/reassessment"
- Diagnoses should be carried through the medical record
 - Major diagnoses should be in the discharge summary

LINK EVERY ORDER TO A DIAGNOSIS

ORDER	DOCUMENT
RBC transfusion	Acute anemia due to ABO incompatibility
Phototherapy	Hyperbilirubinemia
Acyclovir x 48hrs	Evaluate for HSV, state when ruled out
Ampicillin and Cefotaxime*	Rule out sepsis, state when ruled out
Caffeine	Central apnea

- CDI questions?
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