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?

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acuity</td>
</tr>
<tr>
<td>&quot;watcher status&quot;</td>
</tr>
<tr>
<td>Complexity</td>
</tr>
<tr>
<td>every care decision must be thoughtful or may be unintended consequences</td>
</tr>
<tr>
<td>Care plan</td>
</tr>
<tr>
<td>for seamless care transitions</td>
</tr>
</tbody>
</table>

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 Heath 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
PUBLICLY REPORTED MEASURES

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

HOSPITAL VS PROFESSIONAL BILLING BASICS

<table>
<thead>
<tr>
<th>Hospital Fee</th>
<th>Professional Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility charge = represents resources/services utilized</td>
<td></td>
</tr>
<tr>
<td>Pharmacy, radiology, RT, RN, lab, bed</td>
<td></td>
</tr>
<tr>
<td>Hospital coders read the chart to assign diagnoses</td>
<td></td>
</tr>
<tr>
<td>Attending physician charge</td>
<td></td>
</tr>
<tr>
<td>Represents the skill and training of provider that day and services performed</td>
<td></td>
</tr>
<tr>
<td>Attending assigns diagnoses in the charge</td>
<td></td>
</tr>
</tbody>
</table>

BRIDGE THE GAP

Two separate languages: 
- Provider documentation is in CLINICAL terms
- Documentation for coding, billing, & compliance requires specificity in DIAGNOSTIC terms

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

<table>
<thead>
<tr>
<th>Coders CANNOT code from:</th>
<th>Coders CAN code from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Notes</td>
<td>ER Physician Notes</td>
</tr>
<tr>
<td>Pathology Reports</td>
<td>H and P</td>
</tr>
<tr>
<td>Lab Reports</td>
<td>Progress Notes</td>
</tr>
<tr>
<td>Radiology Reports</td>
<td>Consultant Notes</td>
</tr>
<tr>
<td>Physical Therapy Reports</td>
<td>Physicians/HIMA/Orders*</td>
</tr>
<tr>
<td>Nutrition Reports</td>
<td>Discharge Summaries</td>
</tr>
<tr>
<td>Operative/Procedure Notes</td>
<td></td>
</tr>
</tbody>
</table>

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)
Liver failure, renal failure, resp failure
Respiratory failure: acute, acute on chronic
Hypotension, cardiogenic shock
Protein Calorie Malnutrition
Dehydration, hypovolemia
Atrial fibrillation, SVT, VTach
Sepsis due to UTI
Hypokalemia
LLL pneumonia
Hemorrhage, hypovolemia, shock
Acute or Chronic Blood Loss Anemia
Able to Code
Unable to Code
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

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Profound</th>
</tr>
</thead>
</table>
| • Able to speak
• Some social Skills | • Poor social skills and language
• Activities of Daily Living (ADLs) delayed for age | • Few words
• Few self help skills
• Needs protective environment | • Nonverbal
• Requires full supportive care for ADLs

Acquisition of even the earliest motor milestones are delayed
Language development, ADLs and social skills are often delayed
May need complete supervision as an adult
May be capable of occupations in a supported-employment setting

Will generally need full care as adults
Nursing home environment or round-the-clock nursing care at home

INTELLECTUAL DISABILITY FOR CHILDREN >= 2-3 YO

<table>
<thead>
<tr>
<th>Mild</th>
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INTELLECTUAL DISABILITY

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.
**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

**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**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Before Query</th>
<th>After Query</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR-DRG Assignment</td>
<td>309 (Hip/fem for non-trauma repair)</td>
<td>138 (Hip/fem for non-trauma repair)</td>
</tr>
<tr>
<td>SOL/ROM</td>
<td>2/1</td>
<td>3/2</td>
</tr>
<tr>
<td>PHIS LOS</td>
<td>3.6 days</td>
<td>5.2 days</td>
</tr>
<tr>
<td>Relative Weight</td>
<td>1.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Reimbursement</td>
<td></td>
<td>$XX,XXX</td>
</tr>
</tbody>
</table>

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**Impact: Intellectual Disability**

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<td></td>
</tr>
<tr>
<td>Reimbursement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Malnutrition Severity**

<table>
<thead>
<tr>
<th>Z Score</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight for Height</td>
<td>-1 to -1.9</td>
<td>-2 to -2.9</td>
<td>-3 or lower</td>
</tr>
<tr>
<td>BMI for Age</td>
<td>-1 to -1.9</td>
<td>-2 to -2.9</td>
<td>-3 or lower</td>
</tr>
<tr>
<td>Height for Age</td>
<td>n/a</td>
<td>-2 to -2.9</td>
<td>-3 or lower</td>
</tr>
</tbody>
</table>
SPECIFICITY EXAMPLES

<table>
<thead>
<tr>
<th>Code</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUL Pneumonia</td>
<td>RUL Pneumonia secondary to S. pneumoniae</td>
</tr>
<tr>
<td>Anemia</td>
<td>Acute Anemia secondary to Upper GI Bleed</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Severe Malnutrition</td>
</tr>
<tr>
<td>UTI</td>
<td>Acute Pyelonephritis</td>
</tr>
<tr>
<td>Urinary Retention</td>
<td>Acute Urinary Retention</td>
</tr>
<tr>
<td>Asthma</td>
<td>Mild Persistent Asthma with Status Asthmaticus</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ORDER</th>
<th>DOCUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC transfusion</td>
<td>Acute anemia due to ABO incompatibility</td>
</tr>
<tr>
<td>Phototherapy</td>
<td>Hyperbilirubinemia</td>
</tr>
<tr>
<td>Acyclovir x 48hrs</td>
<td>Evaluate for HSV, state when ruled out</td>
</tr>
<tr>
<td>Ampicillin and Cefotaxime*</td>
<td>Rule out sepsis, state when ruled out</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Central apnea</td>
</tr>
</tbody>
</table>

CDI questions?

- Sheila Snyder MD
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- CDI specialists:
  - Marietta Mordhardt
  - Pam McCall