Appropriate documentation—why it matters

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Disclosures

• Nothing to disclose
Purpose

• Why Clinical documentation is important
• To provide general overview of Clinical Documentation Improvement (CDI)
  • Case Mix index
  • Risk of Mortality
  • Severity of Illness
• A general overview of Medicare payment structure with hospitals
• Discussion of General trends in CDI and ICD 10 implementation
• Physician Engagement Strategies
Some Quotes to start the discussion

“And then the documentation is gone, and all that’s left is a set of numbers.”
Pamela P. Bensen MD, Physician Documentation Educator

“Physicians should maintain accurate and complete medical records and documentation of the services they provide. Physicians also should ensure that the claims they submit for payment are supported by the documentation. Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients’ past medical histories.”
CMS
A case example

68 YO WM past medical hx HTN presents to ED with 3 day history nausea, vomiting and poor po intake with new onset melena. States has been taking 6-8 ibuprofen daily for a year for chronic lower back pain.

Presentation Vitals
Temp 98.7 HR 110, RR 24 BP 180/120
Gen: Laying in bed covered in blood, in obvious distress
HEENT: Conjunctival pallor
Lungs: tachypnea, no accessory muscle usage
CV: Tachycardia no rubs murmurs or gallops
Case continued

- Labs:
  - Hematocrit 21 WBC 6.7
  - Creatinine 3.6, baseline 1.2. Bicarbonate 18

- Patient is started on IVF, Protonix gtt, admitted to ICU and gastroenterology is consulted, type and crossed 2 units, and transfusion started. Patient received IV hydralazine, and ace inhibitor held.

Physician #1 admits patient with Principle problem of UGIB with secondary problems of ARF, anemia and dehydration.

Physician #2 admits patient with principle problem Acute kidney injury secondary to probable acute tubular necrosis, secondary diagnosis of SIRS of non infectious origin with acute organ dysfunction
How Medicare views our patient

Physician 1:
MS DRG 379 G.I. hemorrhage without cc/mcc
Relative Weight/Case mix index 0.7067

Physician 2:
MS DRG 682 Renal failure with mcc
Relative weight/Case Mix index 1.641

Same patient viewed differently by two different providers.
What is the cost to treat the patient?
Which patient to you would require utilization of more resources during their stay?
Which patient would require a longer length of stay?
What is the phenomenon of physicians seeing same patient but labeling different diagnosis called?
What is Clinical Documentation Improvement?

Clinical documentation improvement is not up-coding

Clinical documentation improvement is not about making more paperwork for physicians

Clinical documentation improvement is an accurate reflection of a patient's Severity of Illness, and Risk of Mortality at the time a physician evaluates the patient.

It is a reflection of the diligent care that you, the practitioner, is giving to your patient during their hospitalization.
Why is it important

- 87% of patients would choose a different hospital based upon information on quality
- 82% of patients would choose a different provider based on quality information
- 69% of patients want hospitals to publicize outcomes
- 71% of patients would be influences if a hospital refused to submit data on clinical performance
General tenets of CDI

• Be clear why your patient came in
  • If a diagnosis is underlying cause why the patient is in hospital. Explain why.

• Be specific with your diagnosis

• Label whether present on admission

• Label whether something is expected post operatively or a subsequent complication

• Physical exam should reflect the patients actual status
Diagnosis related Groups-Principal Diagnosis

- Medicare Severity DRGs (MS-DRGS)-used by Medicare
- All Patient Refined DRGS (APR-DRGS)- used by many Medicaid programs, quality metrics
- All Patient DRGS- Used by some payers
- Relative Weight- conversion of diagnosis to numeric form to reflect length of stay, severity of illness, and resource utilization
- Hospital Blended Rate- total dollar amount assigned to a hospital to calculate MS DRG reimbursements (Base rate x Local income variations x Residents/beds x Disproportionate share)
- Geometric Length of Stay- national mean length of stay for MS DRG
- Case Mix index (Total Relative Weight/#Discharges)
Medicare uses a simple algorithm for Medicare Severity Diagnosis Related Groups (MS-DRGs) classification.

**Primary Diagnosis**
- MCC
- CC
- Non-CC

**Secondary Diagnosis**
- MCC
- CC
- No CC

**Relative Weight**
Case Mix index: A comparison between hospitalists

Hospitalist #1

- CMI 2.2
- LOS 5.4 days
- Bounceback rate 3% CHF admissions

Hospitalist #2

- CMI 1.3
- LOS 7.4 days
- Bounceback rate 5% CHF admissions
APR-DRGS

- Proprietary, severity adjusted system used by quality assessment programs such as AHRQ, and database preforming reporting systems.

- Follows Main Driver: Principal Diagnosis
  - Difference is Secondary diagnosis (APR-DRGs) with a 4 tier structure:
    - SOI 1 - Minor
    - SOI 2 - Moderate
    - SOI 3 - Major
    - SOI 4 - Extreme
Severity of illness Levels

APR-DRG

Table 3: APR-DRG SOI Levels

<table>
<thead>
<tr>
<th>Combination of Secondary Diagnosis</th>
<th>APR-DRG SOI Level*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two SOI 4, or One SOI 4 and two SOI 3</td>
<td>4 (Extreme)</td>
</tr>
<tr>
<td>Two SOI 3, or One SOI 3 and two SOI 2</td>
<td>3 (Major)</td>
</tr>
<tr>
<td>One or more SOI 2</td>
<td>2 (Moderate)</td>
</tr>
</tbody>
</table>

*APR rerouting logic, exclusions, and patient age may result in a different SOI level.

MS DRG

Table 4: Severity Impact Using MCC/CCs

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two MCCs</td>
<td>If only one MCC is identified and clinical indicators of another MCC are present, query the physician for this second MCC.</td>
</tr>
<tr>
<td>One MCC + Two CCs</td>
<td>If only one MCC is identified and there are no clinical indicators for a second MCC, search and query for up to two additional CCs.</td>
</tr>
<tr>
<td>Two CCs</td>
<td>If there are no clinical indicators for any MCC, search and query for up to 2 CCs.</td>
</tr>
</tbody>
</table>

Fig.1
AHRQ Quality indicators

- PSI- Patient Safety Indicators
- PQI- Patient Quality Indicators
- IQI- Inpatient Quality Indicators
- PDI- Pediatric Quality Indicators
AHRQ Quality Indicators

Based on UCSF protocol

- Mortality rates for conditions
  - Acute myocardial infarction (AMI)
  - AMI without transfer
  - Congestive heart failure
  - Gastrointestinal hemorrhage
  - Hip fracture
  - Pneumonia
  - Acute stroke

- Mortality rates for procedures
  - Abdominal aortic aneurysm repair
  - Coronary artery bypass graft
  - Craniotomy
  - Esophageal resection
  - Hip replacement
  - Pancreatic resection
  - Percutaneous transluminal coronary angioplasty
  - Carotid endarterectomy

- Hospital-level procedure utilization rates
Hospital Acquired condition

**PSI #90**
- Pressure Ulcer Stage III/IV
- Iatrogenic Pneumothorax
- Post operative sepsis, wound dehiscence, hip fracture, PTE/DVT
- CVC blood stream infection
- Accidental puncture or laceration

**CDC Abstraction**
- CLABSI
- CAUTI
Present on Admission accuracy

Work Setting

Testing in timely fashion

Physician awareness

Present on admission
Present on Admission continued

- POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA;

- Inter-observer variability showed agreement on POA reporting in 74.3 percent of records, with 13.7 percent over-reporting and 11.9 percent under-reporting.

- For-profit hospitals tended to overcode secondary diagnoses as present on admission (odds ratios [OR] 1.96; 95 percent confidence interval [CI] 1.11, 3.44), whereas teaching hospitals tended to undercode secondary diagnoses as present on admission (OR 2.61; 95 percent CI 1.36, 5.03). [3]
A well-known dilemma is called "inter-observer variability" and constitutes a serious impediment in medical imaging.

It has been known since the 1950s. The so-called inter-observer variability is sometimes so drastic that “observers agree on only 50% of the total delineated volume” and in other cases the agreement can even drop to 40% [4].

The same problem also applies to individual experts, who can mark the same image differently when they observe it for a second time. This is called "intra-observer variability"
ICD 10 Coding

- 68,000 diagnosis codes
- 87,000 procedure codes
- ICD 10 will demand specificity from practitioners
- Practitioners can expect to see more coding queries
- Lucky some of the problem diagnosis from ICD9 carry over from ICD 10
ICD 10

- Acute Myocardial Infarction
  - Focus clinical documentation on identifying the date of onset of the MI and duration from onset of MI along with the type, anatomic location, and consequences of the MI.

- Asthma
  - Discuss Severity, timing, and relationship with COPD, Bronchitis.
  - Look for acute respiratory failure

- Cerebrovascular Disease
  - Focus documentation on specific type of hemorrhage or infarction, artery affected, and laterality. Providers can also specify occlusions or stenosis to an artery and laterality.

- Coma

- Diabetes
  - Focus documentation on specific type and subsequent complications
ICD 10 Continued

- Fracture
  - Focus documentation efforts on fracture type, laterality, and type of encounter

- Pregnancy
  - Focus documentation on trimester in number of weeks, counted from the first day of the last menstrual period.

- Pressure Ulcer
  - Focus documentation on specific ulcer documentation such as site, laterality, and stage

- Respiratory Failure
  - Focus documentation on acute, chronic or acute-on-chronic respiratory failure along with hypoxemia or hypercapnia.
<table>
<thead>
<tr>
<th>427.31 Atrial Fibrillation</th>
<th>427.32 Atrial Flutter</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I48.0 Paroxysmal atrial fibrillation</td>
<td>• I48.3 Typical atrial flutter</td>
</tr>
<tr>
<td>• I48.1 Persistent atrial fibrillation</td>
<td>• I48.4 Atypical atrial flutter</td>
</tr>
<tr>
<td>• I48.2 Chronic atrial fibrillation</td>
<td>• I48.92 Unspecified atrial flutter</td>
</tr>
<tr>
<td>• I48.91 Unspecified atrial fibrillation</td>
<td></td>
</tr>
</tbody>
</table>
**Acute Kidney Injury**

- ARF is not a diagnosis.
- Acute Renal Failure is one.
- Prognosis for patients with acute tubular necrosis is worse than compared to pre renal patients
- Dialysis is not required for a diagnosis of acute renal failure and does not impact MS-DRG assignment
- It is important to label causality (I.E. AIN, ATN, GN)

<table>
<thead>
<tr>
<th>Clinical Documentation</th>
<th>Codes to...</th>
<th>SOI/ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;acute renal insufficiency&quot;</td>
<td>593.9 Disorder of kidney and ureter</td>
<td>1/1</td>
</tr>
<tr>
<td>&quot;acute renal failure&quot;</td>
<td>584.9 Acute kidney failure, unspecified</td>
<td>3/3</td>
</tr>
<tr>
<td>&quot;acute kidney injury secondary to acute tubular necrosis&quot;</td>
<td>584.5 Acute kidney failure with lesion of acute tubular necrosis</td>
<td>4/4</td>
</tr>
<tr>
<td>&quot;chronic renal insufficiency&quot;</td>
<td>585.9 Chronic kidney disease, unspecified</td>
<td>1/1</td>
</tr>
<tr>
<td>&quot;CKD, Stage III&quot;</td>
<td>585.3 Chronic kidney disease, stage III</td>
<td>2/2</td>
</tr>
<tr>
<td>&quot;End stage renal disease&quot;</td>
<td>585.6 End stage renal disease</td>
<td>3/3</td>
</tr>
</tbody>
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CDI 2015 goals

• 1. Focus on quality - not reimbursement.
• 2. Expand CDI efforts beyond Medicare.
• 3. Pair CDI specialists with coders.
• 4. Ease transition pains of ICD
Physician engagement strategies

• Discover a common purpose.
• Adopt an engaging style and talk about rewards.
• Reframe values and beliefs to turn physicians into partners, not customers.
• Use “engaging” improvement methods by using data.
• Segment the engagement plan and provide education.
  • Go ahead and identify champions for the quality improvement initiative.
References

1. http://www.who.int/bulletin/volumes/91/10/12-115931/en/
Questions?