Clinical Documentation Improvement at UIHC

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Clinical Documentation Improvement
Clinical Documentation Improvement RN’s

* Also known as CDI Nurses

* Help translate clinical documentation/patient hospital course into hospital coding language
  * Sending queries
  * Participate in rounds and huddles
  * Provide educational resources or LIP teaching

* Cover all inpatient units except: NICU, inpatient psych, or Mother/Baby
Goal of CDI?

* Accurate reflection of severity of illness and intensity of service that results in appropriate MS-DRG assignment

CDI – Clinical Documentation Improvement
CDI RN Role

* CDI RN’s focus on assessing whether all conditions and treatments are documented in “coding language”

* CDI programs bridge the gap between LIP documentation and hospital coding rules

CMS Provides the Following Guidance:

“We highly encourage physicians and hospitals to work together to use the most specific codes that describe their patients’ conditions. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population.”


CMS Provides Further Clarity:

“We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record. We encourage hospitals to engage in complete and accurate coding.”

Current Limitations

- Coding can only be based on MD, DO, NP, PA documentation
- Coders cannot use orders, radiology reports, lab results, medication lists, or nurse’s notes
- Documentation sufficient for clinician communication is not always adequate for coding
- Physicians shouldn’t deal with complex coding!

Provider and Coders *Must* Work Together!
Background: One Example

Patient admitted for bowel surgery

Diuresed, patient does well

Post-op, congestive heart failure is detected, cardiologist is consulted

If note says:

“Heart Failure”

DRG 331
$10,124
ELOS 4.3 Days

“Systolic Heart Failure”

DRG 330
$15,854
ELOS 7.1 Days

“Acute Systolic Heart Failure”

DRG 329
$32,618
ELOS 11.7 Days

MS DRG Category: Major Small & Large Bowel Procedures
Why Should We Care?
Accurate Documentation Drives...

- Accurate reflection of patients’ Severity of Illness (SOI)
- True indication of Risk of Mortality (ROM)
- Appropriate hospital and physician public profiles
- Reduction in denials for medical necessity or reimbursement issues
- Appropriate hospital reimbursement
We Are Being Watched and Evaluated!
Documenting Conditions
Complications/Comorbidities (CCs)

- Chronic heart failure (systolic, diastolic)
- Chronic kidney disease Stages 4 and 5
- BMI > 40 or < 19 (also document clinical diagnosis or condition that corresponds to the abnormal BMI and explains its significance)
- Chronic respiratory failure
- Acute renal failure \textit{without} ATN
- Hypertension (“accelerated”)
- Acute blood loss anemia
- Hemiparesis
Major Complications/Comorbidities (MCCs)

- Stage III or IV Pressure Ulcer
- Acute Respiratory Failure
- Acute Renal Failure with ATN
- Acute Heart Failure (Systolic/Diastolic)
- Encephalopathy
- Severe Protein Calorie Malnutrition
- Brain Death
- Coma
- Cerebral Edema
- Brain Herniation
Whose Patients are Sicker?

* **Not Sick** = No Severity of Illness (SOI) or Risk of Mortality (ROM)

* **Sick** = One or more CC’s (Complications/Comorbidities)

* **Very Sick** = One or more MCC’s (Major Complications/Comorbidities)
Overall Clinical Documentation Concepts

- **Present on Admission (POA)** - being present at the time the order for inpatient admission occurs. This can be updated any time during the acute inpatient visit.
  - POA should be answered with:
    - Y = diagnosis was present at time of inpatient admission
    - N = diagnosis was not present at time of inpatient admission
    - W = clinically undetermined. Provider unable to determine if the diagnosis was present at time of inpatient admission

- **Clinically insignificant/Expected result** – any diagnosis/problem that was monitored, evaluated, or treated during the inpatient stay should be documented

- **Supporting documentation** – every diagnosis/problem needs to be connected to how it was monitored, evaluated, or treated
It’s Okay to Hedge Your Bets

For inpatients (not outpatients):

• Probable
• Possible
• Suspected
• Likely
• Still (yet) to be ruled out

... or any variation thereof can be coded!
For Acute Inpatients

- **Every condition** that is documented as a secondary diagnosis in problem lists or progress notes needs **supporting documentation** on how it is being:
  - Monitored
  - Evaluated
  - Treated

- Regardless of clinical significance—we need to document anything that’s **treated**, **evaluated**, monitored, increases LOS, or RN workload
ACUTE HYPOXIC RESPIRATORY FAILURE:
-although I think a fungal pneumonia is unlikely in the absence of significant
immunosuppression, will continue antifungals. No more than a 10d course, however,
since I overall think this an unlikely source
-continue lung-protective ventilation with low tidal volumes
-ok to start pharmacologic diuresis with lasix as he is coming off pressors

THROMBOCYTOPENIA:
-NTD acutely. Appears to have preceded steroids and PPI

SEVERE PROTEIN CALORIE MALNUTRITION:
-Continue TPN
-if can get a tube post-pyloric, may consider enteric feeds
-watch for refeeding syndrome

HYPOTENSION, PRESUMED SEPTIC SHOCK:
-MAP goal >65
-started steroids empirically yesterday for unresponsive to fluids & pressors. He has had
a dramatic response, so will do a rapid taper over 5d.

MISC:
-full code, but had previously been DNR. Will re-approach family about goals of care &
likely consider palliative care consult
-family updated by resident by phone
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date Noted</th>
<th>Date Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal cancer</td>
<td>05/29/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>S/p LAR with diverting ileostomy 7/21/14</td>
<td></td>
</tr>
<tr>
<td>Postoperative ileus</td>
<td>07/28/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>Monitor, NGT for decompression, NPO</td>
<td></td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>07/23/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>Monitor and replace prn</td>
<td></td>
</tr>
<tr>
<td>Ileostomy status</td>
<td>07/21/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>Monitor, education per enterostomal therapy team</td>
<td></td>
</tr>
<tr>
<td>Postoperative pain</td>
<td>07/21/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>Monitor, treat with IV/PO pain meds prn</td>
<td></td>
</tr>
<tr>
<td>Obesity (BMI 35.0-39.9 without comorbidity)</td>
<td>07/21/2014</td>
<td></td>
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<tr>
<td>GERD (gastroesophageal reflux disease)</td>
<td>07/21/2014</td>
<td></td>
</tr>
<tr>
<td>Overview Note:</td>
<td>Monitor, resume home meds as appropriate</td>
<td></td>
</tr>
<tr>
<td>Medical record says ... (unable to code)</td>
<td>Better to say ... (able to code)</td>
<td></td>
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<tr>
<td>-----------------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>RUL Infiltrate</td>
<td>RUL Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Upper GI bleed, Hgb 5.2, will transfuse</td>
<td>UGI bleed, acute blood loss anemia</td>
<td></td>
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<tr>
<td>Emaciated, poor intake, 40# weight loss</td>
<td>Severe Protein Calorie Malnutrition</td>
<td></td>
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<tr>
<td>ABG ph 7.24, PaCO₂ 36, HCO₃ 14</td>
<td>Uncompensated metabolic acidosis</td>
<td></td>
</tr>
<tr>
<td>Poor skin turgor, mucous membranes dry, will rehydrate</td>
<td>Dehydration</td>
<td></td>
</tr>
<tr>
<td>BP 70/40, requires pressors for support</td>
<td>Hypovolemic Shock</td>
<td></td>
</tr>
<tr>
<td>Troponin and CPK elevated; EKG Positive</td>
<td>Acute MI</td>
<td></td>
</tr>
</tbody>
</table>
Discharge Summary

* **Most** important document from a hospital billing perspective
  * Goal is to summarize conditions and include supporting documentation
  * Don’t rush through it to “get it done”

* Include all diagnoses at the time of discharge even if resolved or unconfirmed but treated, evaluated, or monitored

* Residents or APP’s should create discharge summaries from the start of admission, and resolve problems during the visit
There should be no conflicting information between providers or services

New information should not be introduced in the DC summary

Clarify after testing, any “suspected” diagnoses that are eliminated

Respond to queries on findings from pathology or autopsy reports
Queries from CDI RN’s

* **Purpose:** to ensure LIPs provide the most clinically accurate picture of patient conditions in Epic

* **Goal:** Clarify documentation that was inconsistent, lacking specificity, or missing. Provides the LIP an opportunity to respond and add to medical record

* Queries need to be responded to within 4 business days
  * “Yes” response is to either update the record or tell the CDI RN you disagree

* By law, written queries cannot be leading. Please contact CDI RN’s directly if you have questions