Clinical Documentation Improvement at University of Iowa Hospitals & Clinics: Medical

Deanna Brennan, RN MBA, CCDS
Manager/Director- Clinical Documentation Improvement

Melissa Vermillion, RN BSN
Interim CDI Quality Oversight Specialist

Jan Reighard, RN MSN, CCDS & Linda Myers RN MSN
Clinical Documentation Nurse Specialist
Clinical Documentation Improvement

- Clinical Documentation Nurses:
  - 17 highly experienced nurses with a variety of clinical experience and expertise.
  - 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, Psych, Rehab, Urology and Nursery

We are part of your team
Goal of CDI?

- Accurate reflection of severity of illness and intensity of service that results in appropriate expected length of stay and DRG assignment.

*CDI – Clinical Documentation Improvement*
Clinical Documentation Improvement

Provider Documentation → Principal Dx + Secondary Dx + Principal Pdx + Secondary Pdx

DRG Assigned By CDI

ICD-10 Codes

Severity Level
Risk Adjustment
Quality Metrics
Hospital Reimbursement

Documentation and DRG assignment reflects:
CDI RN’s focus on assessing whether all conditions and treatments are documented in codeable language and bridge the gap as a liaison 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 and DRG assignment can only be based on clinical documentation from an MD, DO, NP or PA.

• CDI nurses review all documentation, including radiology reports, lab results, med lists, and nursing notes even thought not everything can be coded.

• Documentation sufficient for clinical communication is not always adequate for coding.

• CDI nurses bridge the gap between providers and coding teams.

**Provider and CDI Must Work Together!**
Your Role in Documentation Improvement

- Documentation of MCCs/CCs
  - Some secondary diagnoses impact the care given to our patients more than others and therefore impact CDI metrics for severity of illness and risk of mortality. These diagnoses are called CCs and MCCs.
  - Complication/Comorbidity (CC)
    - This is a secondary diagnosis that increases the resources we use to care for the patient. This diagnosis may increase a patient’s length of stay, too.
  - Major Complications/Comorbidities (MCC)
    - These diagnoses have a larger impact on a patient’s stay and always requires additional interventions.
  - MCCs/CCs are drawn from the documentation of secondary diagnoses, and are not the principle diagnosis.
Complications/Comorbidities (CCs)

- Urinary Tract infection
- BMI >40 or <19 (also document clinical diagnosis or condition the corresponds to the abnormal BMI and explains its significance)
- Mild or Moderate Malnutrition
- Acute Blood Loss Anemia
- Hemiparesis
- Chronic Respiratory Failure
- Chronic Kidney Disease or Acute Renal Failure
- Atrial Flutter/ V Fib
- Atelectasis
- COPD with Exacerbation
Documenting Conditions

Major Complications/Comorbidities (MCCs)

- Stage III or IV Pressure Ulcer (POA)
- Acute Respiratory Failure
- Acute Renal Failure with ATN
- Acute Heart Failure (Systolic/Diastolic)
- Metabolic Encephalopathy
- Severe Protein Calorie Malnutrition
- Brain Death
- Coma
- Cerebral Edema
- Brain Herniation
- Shock
Patient admitted for pneumonia

SOB, SPO2 84%, blood gases reviewed and resp status monitored

Patient intubated x2 days for respiratory symptoms

DRG: Simple Pneumonia & Pleurisy
DRG Assignment Example: Surgical

Patient admitted for bowel surgery

Post-op, congestive heart failure is detected, cardiology consulted.

Diuresed & patient monitored

DRG: Major Small and Large Bowel Procedures
Respiratory Infections & Inflammations

- **DRG(177) W MCC**
  - Relative Weight: 1.8912
  - ELOS: 5.5
  - Medicare Payment: $16,105

- **DRG(178) W CC**
  - Relative Weight: 1.2433
  - ELOS: 4.2
  - Medicare Payment: $10,588

- **DRG(179) W/O MCC/CC**
  - Relative Weight: 0.8661
  - ELOS: 3.1
  - Medicare Payment: $7,375

**Common CC/MCCs**

- Acute and/or Chronic Respiratory Failure*
- Encephalopathy*
- Acidosis/Alkalosis
- Acute Renal Failure w/wo ATN*
- Pancytopenia
- Malnutrition with severity*
- Acute/Chronic systolic/diastolic Heart Failure*
- COPD Exacerbation

* Possible MCC
Coronary Bypass without Cardiac Cath

• DRG(235) W MCC
  – Relative Weight: 5.8846
  – ELOS: 8.6
  – Medicare Payment: $50,111

• DRG(236) without MCC
  – Relative Weight 4.0291
  – ELOS 6.0
  – Medicare Payment: $34,311

• Common CC/MCCs
  – Acute Blood Loss Anemia
  – Acute Respiratory Failure*
  – Atrial Fibrillation/Flutter
  – Cardiogenic Shock*
  – Acute systolic/diastolic Heart Failure*
  – Atelectasis
  – Coronary Artery Dissection
  – Pleural Effusion

* Possible MCC
Your Role in Documentation Improvement

Accurate Documentation Drives…

– The patients’ Severity of Illness (SOI)
– Risk of Mortality (ROM) score
– Expected Length of Stay (LOS)
– Accurate hospital and physician public profiles
– Limits denials for medical necessity or reimbursement issues
– Appropriate hospital reimbursement
Supporting Documentation

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
Your Role in Documentation Improvement

• Documentation of Present on Admission (POA)
  – Clear documentation of the presence of diagnoses on admission, is a critical element when determining DRG assignment.
  – If a patient develops one of the specific conditions identified as a hospital acquired conditions or “HAC”, the condition will not be considered a CC or MCC, and will not impact the MS-DRG.
  – POA status for diagnoses such as pressure ulcers, sepsis and DNR status can impact risk adjustment, hospital reimbursement and quality metrics.
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*!
Documenting Malnutrition

- The dietician’s assessment will list a recommended malnutrition diagnosis based on ASPEN criteria. Possible conditions are as follows:
  - Mild (non-severe) malnutrition – First degree (ICD10: E44.1)
  - Moderate (non-severe) malnutrition – Second degree (ICD10: E44.0)
  - Severe protein calorie malnutrition- Third degree (ICD10: E43)

- The malnutrition diagnosis must be documented by the provider, including how the specific type of malnutrition was monitored, evaluated, or treated. The diagnosis cannot be coded without this information.

- The “.malnutritiontext” Epic dot phrase can be used to insert the diagnosis and Present on Admission status from the dietitian consult into your progress notes. The provider must fill out the prompts at the bottom of this section to identify their agreement (or disagreement) and how the condition is being monitored, evaluated or treated.
What we do as a medical team counts!

Remember M.E.T.: Monitor, Evaluate, Treat

- Chronic Medical Conditions
  (Examples: CKD, CHF, DM, HTN, Chronic Respiratory Failure)
  - Did you draw labs that monitor a chronic condition?
  - Did you give a home medication for a chronic condition?
  - Did the patient require more nursing care?
    (Examples: Bariatric, Elderly, Psychiatric cases)
  - Did the patient require a longer length of stay due to a chronic condition?

If you did the work, document it!
Get credit for the work you do!
Queries from CDI RN’s

- **Purpose**: Communication between CDI and Provide to ensure that 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

- **Query Process**:
  - Initial query to lowest level provider via Epic
  - Escalation after two business days
  - Secondary escalation contacts

- Queries need to be responded to within a total of 4 business days
- “Yes” response requires either update of 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
Five ways to minimize query numbers

1. Complete and accurate documentation every time

2. Specify medical diagnoses when you are able
   
   • Acuity (i.e. Acute, Chronic, Acute on Chronic)
   
   • Type (i.e. Systolic or Diastolic)
   
   • Stages of disease or wounds
   
   • If it’s a broad diagnosis like “Anemia” be sure to document the cause (i.e. Acute Blood Loss, Dilutional, Chronic Disease Related)

3. Avoid documenting in purely descriptive terms (i.e. Elevated, Low, High)

4. Complete procedure documentation in a timely manner

5. When you do receive a query, discuss the documentation requirements with the CDI RN to be certain you understand necessary documentation elements needed for the diagnoses you use.
Documentation Tool Kit

- Clinical Documentation Guidelines-
  Available on the point
- Dot Phrases
- CDI Best Practice Lists for your Department
- CDI Nurse Resource Pager #5496 (M-F 0800-1600)
- See your department’s CDI Nurse for details!
Questions or comments?