Lunch and Learn

Clinical Documentation Excellence
Understanding Those Magic Words
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Dr. Wilhelm earned a B.S. from University of Notre Dame in 1999 and spent the following year performing pharmaceutically funded clinical research for the Division of Nephrology at Vanderbilt University. He graduated with D.O. from Lake Erie College of Osteopathic Medicine and completed internship and residency at the University of Mississippi Medical Center (UMMC).

After serving as a chief resident year at UMMC, he moved to Birmingham, AL where he completed a three year fellowship in pulmonary and critical care.

Dr. Wilhelm is board certified in internal medicine, pulmonary medicine, and critical care medicine and currently serves as Assistant Professor of Medicine and Pulmonary/Critical Care at UMMC.

He is the Director of the Medical Intensive Care Unit and Co-chair of the Quality Board.
Shelia Bullock, BSN

Mrs. Bullock graduated with a Diploma in Nursing from Carraway Methodist Hospital School of Nursing and 2 years later from the University of North Alabama with her BSN. She earned her MBA from Belhaven University. Her nursing career spans over 30 years. She has worked as a staff nurse, in hospital nursing management, in commercial insurance as an auditor, implemented a case management and disease management program for a commercial insurance carrier, managed a hospital utilization review department and case management in a prison health system. Currently, she is the Director of the Clinical Documentation Improvement Program at UMMC.

She is a charter member and on the board of the Mid-MS Chapter of the Case Management Society of America, past board member for Association of Clinical Documentation Specialist and a current AHIMA ICD-10 Trainer and Ambassador.

Shelia has presented at MSHIMA state conference, Mid MS chapter of CMSA, Infusion Nurses Society regularly provides education on documentation improvement activities for physicians and mid level providers. She has presented nationally at UHC CDI conference and co-presented on several webinars.

Disclosure Statement

Speakers and planning committee members have no significant financial interest and this presentation does not have any commercial support. There is no investigational or unlabeled uses of a product in this presentation.

The material is designed and provided to communicate information about clinical documentation, coding and compliance in an educational format and manner. The authors are not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding. Every reasonable effort has been taken to ensure that the educational content provided is accurate and useful. Applying best practice solutions, altering work flow, and achieving results will vary with each individual and clinical situation.
Objectives

• List two adjectives that illustrate the acuity of a patient.

• Explain how the word postoperative can be misunderstood as a complication.

• Describe the impact of accurate and complete documentation on quality patient care and reimbursement.

Why is clinical documentation important?

• Critical for Quality & Safe Patient Care
• Serves as a legal document
• Quality Reviews
• Validates the patient care provided
• Research
• Compliance with regulatory and review entities
• Impacts coding, billing and reimbursement
Impact of Clinical Documentation

<table>
<thead>
<tr>
<th>Patient</th>
<th>Physician/Provider</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Quality of Care provided</td>
<td>* Demonstrates accountability</td>
<td>* Quality Measures</td>
</tr>
<tr>
<td>* Continuity of Care</td>
<td>* Performance Management/Quality Measures</td>
<td>* Supporting documentation for treatment and services rendered</td>
</tr>
<tr>
<td>* Non-Payment by insurance for treatment not adequately defined/described</td>
<td>* Reduce or denied payment</td>
<td>* Coding &amp; Billing for appropriate reimbursement</td>
</tr>
</tbody>
</table>

Documentation Matters

CMS (Centers for Medicare and Medicaid Services) requires that ALL medical conditions that are -

- evaluated and/or treated
- the patient’s history, past and present illness,
- outcomes

- be documented in the medical record.
EPIC is our Source Documentation Across the Continuum of Care

- Communication Tool Between Providers
- Ability of physicians and other health care professionals to evaluate and plan the patient’s care
- Accurately and timely claims review and reimbursement
- Collection of data and Resource Management
- Utilization Review and Quality of Care evaluation

Poor quality documentation in a patient’s record has been linked to both excessive healthcare cost and poor quality of care.

National Coalition for Health Care
Charting the Cost of Inaction, 2003
Documentation’s Magic Words

Less Descriptive
- Bacteremia
- Renal Insufficiency
- HIV Infection
- HCAP
- Acute Coronary Syndrome
- AMS
- Respiratory Failure

More Descriptive
- Sepsis
- Renal Failure
- AIDS, AIDS related
- Gram Neg. Pneumonia
- Acute MI
- Encephalopathy
- Hypoxic, Hypercapnic, Post operative
- Systolic, Diastolic, Acute, Chronic, Acute on Chronic

Other Magical Words

- Present on Admission
- Due to
- Suspect
- Probable
- Late effects
- Laterality
- Severe
- Stage of Disease/Condition

Concerning for ≠ suspect, probable
Bacteremia or SIRS

- **Bacteremia** - bacteria in the blood
- **SIRS** - a systemic inflammatory response to anything (effective October 1, 2015 does not include an infectious process - ICD-10)

### SIRS to Septic Shock

<table>
<thead>
<tr>
<th>SIRS criteria: 2 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp: &lt; 97.6°C or &gt;100.4°F</td>
</tr>
<tr>
<td>Resp: &gt; 20 breaths/min</td>
</tr>
<tr>
<td>Pulse: &gt; 90</td>
</tr>
<tr>
<td>WBC: &gt; 12K or &lt; 4K or Bands &gt; 8%</td>
</tr>
</tbody>
</table>

**Key points**
- Septicemia and bacteremia are not synonymous
- Septicemia and sepsis are not synonymous
- Bacteremia defined as presence of bacteria in the blood—does not identify if symptoms are present
- Septicemia defined as systemic disease associated with presence of pathogenic microorganisms or toxins in the blood
- Sepsis generally refers to SIRS (systemic inflammatory response syndrome) due to infection

### Sepsis = SIRS due to infection

- Examples
  - Preexisting system
  - CXR with new infiltrates
  - Spillage of bowel contents
  - Abscess
  - WBCs in a normally sterile body fluid
  - Positive blood culture (not a contaminant)
  - Evidence of infected mechanical hardware
  - Device present – Foley/central line, PD catheter
  - Pneumonitis/empyema
  - UTI
  - Meningitis
  - Bone/joint infection
  - Endocarditis

### Severe sepsis = sepsis + organ dysfunction

- Examples
  - Brain—acute mental status change
  - Lungs—Hypoxia (paO2<90 on Fio2>40, pH<7.32
  - Kidneys—acute oliguria, increasing creatinine
  - Liver—jaundice, variable jaundice
  - Heart—congestive heart failure, thrombocytopenia
  - GI—ileus

### Septic shock = severe sepsis + hypotension

- Examples
  - Endocrine shock
  - Gram-negative shock
  - Systolic BP<90 or 40 below baseline
  - Refractory hypotension
  - IV fluids/vaso
  - Vasopressors

**References**
- Coding Clinic 42 2007 p 544
- Coding Clinic 32 2002 p 54
Case Study

63 year old male with DM Type II presents to ED with infection on his arm. History of fever and states he feels terrible. T. 101.2, RR 35, B/P 95/67, HR 130, WBC 21,000. To OR for debridement of necrotizing fasciitis.

Is there another diagnosis that should be documented?

Respiratory Failure

- Defined as inadequate gas exchange
- Hypoxemic: PaO2 < 60 mmHg
  - Most Common
- Hypercapnic: PaCO2 > 50 mmHg
- Other clinical indicators:
  - Increased work of breathing
  - Intercostal retractions
  - Respiratory rate > 28
  - Unable to speak in full sentences
- Acute, Chronic, Acute on Chronic
Respiratory Failure:
Common Causes

Hypoxemic
- COPD
- Pneumonia
- Pulmonary edema
- Pulmonary fibrosis
- Pneumothorax
- PE
- Pulmonary Hypertension
- ARDS
- Obesity
- Fat embolism syndrome

Hypercapnic
- COPD
- Severe asthma
- Drug overdose
- Poisonings
- Myasthenia gravis
- Polyneuropathy
- Head Injury
- Obesity hypoventilation syndrome
- Alveolar hypoventilation

Is it Acute or Chronic or Acute on Chronic

Post Operative Respiratory Failure

- Clinical Indicators: same as respiratory failure
- Post Operative - is it due to the surgery, anesthesia or other
  - Is Post Operative stated as a time frame?
  - Does Post Operative mean a complication?
- Post Operative Mechanical Ventilation does not equal Respiratory Failure
  - Remains on vent for two staged procedures, prolonged surgery, airway protection, difficult intubation, aspiration risk, chronic lung dx
Case Study

19 y o male involved in an un-helmeted motorcycle accident. GCS 3 at scene and intubated. Arrived at ED and to surgery for splenectomy. Required 4 units PRBCs for blood loss anemia of 1500cc. Admitted to SICU, intubated, on vent with minimal settings. B/P 126/83, now following commands.

Is this post operative respiratory failure?
What other magic word is missing?

ACUTE

Heart Failure

• Supply Demand Mismatch, Troponin bump, Troponemia
  - ? NSTEMI
  - ? STEMI
  - Other: abnl renal function, PE, CHF, Myocarditis...

• CHF
  - Systolic, Diastolic or combined
  - Acute, Chronic or Acute on Chronic
What is magic about Pneumonia?

• CAP - this is considered a simple pneumonia often treated outpatient (Strep, Virus related, H. flu)
  - What requires an inpatient treatment with IVABX
• HCAP - healthcare associated - often seen in patients with renal failure, alcoholism, liver dx, immunocompromised and those from skilled nursing facilities, having frequent hospitalizations or on frequent broad spectrum antibiotics

Pneumonia

• What are you treating?
  - Gram negative bacteria suspected?
  - Is the patient septic - do they meet the criteria?
  - Are they in respiratory failure as a result of PNA?
  - Is the PNA related to another condition?
    ▪ AIDS, Obstructive due to malignancy, Aspiration

• Take credit for your medical decision making and document what you are thinking - remember suspected and probably
Case Study

80 y o female from SNF presents with weakness, fatigue and AMS. VS: T. 101.6, HR 96, RR 24, B/P 96/48, O$_2$ sats 91% on RA, cxr shows RUL consolidation, CBC: WBC 13.4, Bands 20, Lactate 3.2, Cr 1.2, MRSA screen negative.
Treatment: IV Ceftazidine, IVF, O$_2$ at 2L
Dx: HCAP
Is this the most appropriate diagnostic term?

<table>
<thead>
<tr>
<th>MS DRG 195 Simple Pneumonia</th>
<th>MS DRG 179 Respiratory Infection</th>
<th>MS DRG 871 Sepsis with MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMI: 0.6997</td>
<td>CMI: 0.9741</td>
<td>CMI: 1.8527</td>
</tr>
<tr>
<td>LOS: 2.9</td>
<td>LOS: 3.7</td>
<td>LOS: 5.1</td>
</tr>
<tr>
<td>$9,165.20</td>
<td>$11,064.00</td>
<td>$17,143.11</td>
</tr>
<tr>
<td>SOI 1 ROM 2</td>
<td>SOI 1 ROM 2</td>
<td>SOI 2 ROM 2</td>
</tr>
</tbody>
</table>
Shock-ing Magical Terms

- Hypovolemic - hemorrhage, dehydration
- Cardiogenic - loss or damage of pump (heart)
- Obstructive - PE, tension pneumothorax, pericardial tamponade
- Distributive - septic, anaphylactic
- Post op hypovolemic - blood loss anemia with lactic acidosis
- Septic - life threatening, organ failure (lung, liver, kidney)

Case Study

29 y o male body builder became ill after eating potato salad at a picnic yesterday, wife reports began vomiting last night

ED notes: severe nausea and vomiting, abd pain, T. 102, B/P 70/52, RR 26, HR 90, urine cloudy, WBC many, bacteria few

Admit: NPO, IVF, IV ABX, Zofran, flat and upright abd, Bld cx

To OR for appendectomy, on arrival to OR vomited and appears to have aspirated small amount. On entering the abdominal cavity thick purulent pelvic fluid encountered. Wound remains open - wound vac applied.
Case Study Post Op

To SICU post op on vent with wound vac, foley, Central line for IVs, IVABX, CXR shows infiltrates in both lungs, urine and abd culture + e.coli

DX on problem list: Appendicitis, possible aspiration, respiratory failure, and UTI (op note not available)

What is missing?

Final Results

<table>
<thead>
<tr>
<th>As Documented</th>
<th>Adding Magic Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS DRG 341 Appendectomy w/o complicated principal dx with MCC</td>
<td>MS DRG 338 Appendectomy w complicated principal dx with MCC</td>
</tr>
<tr>
<td>LOS 4.6 days</td>
<td>LOS 7.8 days</td>
</tr>
<tr>
<td>SOI 3 ROM 3</td>
<td>SOI 3 ROM 3</td>
</tr>
<tr>
<td>$19,423.06</td>
<td>$25,924.86</td>
</tr>
</tbody>
</table>
Case Study

80 y o female presents to ED with bright red blood from rectum and AMS which is not normal for this patient
PMH: DM, HF, GERD
Vital Signs: T. 99 P 105, R 19, B/P 82/55 O2 sats 90% RA
CBC: H/H 7.8/28.4, WBC 11.3, Glucose 242, A1C 8.4
Cr 1.25, BUN 22.0, Na 128, Echo 25% EF
TX: 2 u PRBCs, IVFs, serial H/H, hold lisinopril and lasix, sliding scale insulin
DX: GI bleed, CHF, DM, dehydration

Case Study

As Documented
MS DRG379
GI Hemorrhage w/o CC/MCC
LOS 2.4 days
SOI 2 ROM 2
Reimbursement: $9,123.70

With Magic Words
MS DRG 378
GI Hemorrhage w CC
LOS 3.3 days
SOI 2 ROM 2
Reimbursement: $12,263.30

MS DRG 377
GI Hemorrhage w MCC
LOS 4.8 days
SOI 3 ROM 3
Reimbursement: $16,522.30
Magic Words Make a Difference

- Improved Quality Care - treatment team better understands the Acuity of the patient
- Continuity of Care to next provider
- Justification for Medical Necessity of the Admission and Length of stay
- Supports Billing
- Impacts Reimbursement
- Meets Compliance guidelines
- Enhances Research

Questions