Deciphering the Tower of Babel: Improving Physicians’ Clinical Documentation Practices

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Objectives

By the end of this presentation, each participant will be able to:

1. Review basic reasons for efforts and benefits of clinical documentation improvement

2. Describe what types of information the physicians need and effective ways to educate the medical staff

3. Understand the physicians’ perspectives regarding clinical documentation
The Goal:
To teach doctors to make entries into the medical record with words that paint the true picture of their patients so the HIM department can paint the exact same picture in codes.

What is CDI?
Clinical Documentation Improvement programs are designed to improve the completeness and quality of patient documentation, resulting in more accurate capture of coded data.
What are the benefits of CDI?

• It leads to the precise assignment of DRGs (It doesn’t matter whether it’s one with a higher or lower weight). When the proper words lead to the proper codes, it leads to the proper DRG—the one that the case deserves, and the one that will be impervious to oversight review. This, in turn, leads to happy compliance officers who realize the notes in the medical record will provide whatever words and clinical justification they need to withstand an Office of Inspector General review.

• Proper DRG assignment means (more) appropriate reimbursement for services provided to patients.
What are the benefits of CDI?

- It leads to the precise severity of illness (SOI) level and risk of mortality (ROM) level. If your doctors don’t know how to express severity appropriately, everyone loses in terms of SOI/ROM and hospital reimbursement.

- Likewise, it leads to the proper reflection of the risk-adjusted mortality index (RAMI) — the denominator of that fraction that determines your hospital’s profiles and your physicians’ profiles. If your program leads to a principal diagnosis and a secondary that is a CC and goes no further, your profiles are miserable because of the physicians’ underdocumenting and your undercoding.
What are the benefits of CDI?

• It leads to coders who can ask a valuable, clinical retrospective question rather than something in HIM jargon that a physician cannot fathom.

• It results in employees/healthcare professionals who, when you provide them with their individual improvements in quality statistics and other measures of success, will ask, “Hey, I have this patient. How can I better express what’s wrong with him?”
What Do the Physicians Need?

They need to know the rules for coding and documentation—NONE OF THIS is taught in medical school or residency!
What Determines the DRG?

- Principal Diagnosis
- Secondary Diagnoses
- Procedures
A key factor in the MS-DRG system is physician documentation within the medical record.

The MS-DRG system contains CCs and Major CCs (MCCs), most of which require much more specific documentation than previously required. The presence of CCs and MCCs greatly affects the DRG assignment. Therefore, it is imperative that physician documentation accurately reflects all clinically significant diagnoses addressed during the hospital stay.
MS-DRGs

Medicare Severity Diagnoses Related Groups (MS-DRGs)

3 levels of severity:

**MCC** – Major Complication or Co-morbidity

**CC** – Complication or Co-morbidity

Non-CC – No Complication or Co-morbidity
It is **CRUCIAL** for physicians to document **ALL** conditions that affect the patient’s hospital stay – of course, using the approved terms!
According to coding rules, the diagnosis of urosepsis may mean:

“(1) generalized sepsis (septicemia), code 038.9, or (2) urine contaminated by bacteria, bacterial by-products, or other toxic material but without other findings, 599.0. If no other information is available, the index defaults to code 599.0 for urosepsis.”

This means if only “urosepsis” is written, an unspecified UTI will be coded - that sure doesn’t show how ill the patient is!
Here are the ONLY choices for coding heart failure:

- Congestive Heart Failure, Unspecified 428.0
- Left Heart Failure, 428.1
- Systolic Heart Failure, 428.20 unspecified; 428.21 acute; 428.22 chronic; 428.23 acute-on-chronic
- Diastolic Heart Failure, 428.30 unspecified; 428.31 acute; 428.32 chronic; 428.33 acute-on-chronic
- Combined Systolic & Diastolic Heart Failure, 428.30 unspecified; 428.31 acute; 428.32 chronic; 428.33 acute-on-chronic
- Heart Failure NOS, 428.9
• **Acute** (or **acute on chronic**) systolic and/or diastolic heart failure = MCC

• CHF specified as **left, systolic or diastolic** = CC

• CHF NOS = nothing!
## DOCUMENTATION of “CHF”

<table>
<thead>
<tr>
<th>Diagnoses (Principal/Secondary)</th>
<th>MS-DRG</th>
<th>Approximate reimbursement to hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute NSTEMI with “worsening CHF – EF 30%”</td>
<td>282 - ACUTE MI, DISCHARGED ALIVE WITHOUT CC/MCC</td>
<td>$3,945 Case weight ~ 0.8</td>
</tr>
</tbody>
</table>

Now, instead of “CHF – EF 30%,” the term “systolic CHF” was written:

<table>
<thead>
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<th>Diagnoses (Principal/Secondary)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Acute NSTEMI with “worsening systolic CHF”</td>
<td>281 - ACUTE MI, DISCHARGED ALIVE WITH CC</td>
<td>$5,830 Case weight ~ 1.2</td>
</tr>
</tbody>
</table>

Finally, here’s how the appropriately documented term “acute systolic CHF” changes things:

<table>
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<th>Diagnoses (Principal/Secondary)</th>
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</thead>
<tbody>
<tr>
<td>Acute NSTEMI with “acute systolic CHF”</td>
<td>280 - ACUTE MI, DISCHARGED ALIVE WITH MCC</td>
<td>$9,055 Case weight ~ 1.9</td>
</tr>
</tbody>
</table>

The specific documentation leads to a more accurate picture of how ill the patient really was – not to mention a difference in reimbursement of over $5,000 between a secondary diagnosis of “CHF” versus “acute systolic CHF!”
A Case from the MICU

ICU admit note A/P:

"CXR with infiltrate, on vent, ↑Cr, positive blood cultures, hypotension requiring pressors, multi-organ failure"
<table>
<thead>
<tr>
<th>What was documented?</th>
<th>What do the physicians think they documented?</th>
<th>What can the coders code?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“CXR with infiltrate”</td>
<td>Pneumonia</td>
<td>Abnormal x-ray finding</td>
</tr>
<tr>
<td>“On vent”</td>
<td>Respiratory failure</td>
<td>Mechanical ventilation code (procedure)</td>
</tr>
<tr>
<td>&quot;↑ Cr&quot;</td>
<td>Acute renal failure</td>
<td>Abnormal test result</td>
</tr>
<tr>
<td>“Positive blood cultures”</td>
<td>Sepsis</td>
<td>Bacteremia</td>
</tr>
<tr>
<td>“Hypotension requiring pressors”</td>
<td>Septic Shock</td>
<td>Hypotension</td>
</tr>
<tr>
<td>“Multi-organ failure”</td>
<td>Multi-organ failure</td>
<td>Nothing!</td>
</tr>
</tbody>
</table>
Options for Educating the Medical Staff

1. **Large group presentations** – good for basic education as to the rationale for CDI – but not very effective in my experience.

2. **Educational e-mails to physicians** – good for limited amounts of information, but after a while, it’s all “spam” to them.

3. **Small group or one-on-one meetings** – the education can be more specifically tailored to the physicians’ specialty, but it may be difficult to schedule these sessions because of patient care duties.
Options for Educating the Medical Staff

“Documentation Rounds”

Joining the physicians for rounds on a regular basis to discuss the patient’s diagnoses and advise about best documentation practices as the physicians see their inpatients in “real time.”

Advantages to this approach:

• Physicians do not have to “find” time for learning documentation
• Helps physicians form good documentation habits
• Since the CDI staff has both medical and coding knowledge, they can make appropriate suggestions for proper documentation
• Improves relationship between medical and coding staff
• Better documentation during rounds means fewer queries after the patient is discharged
Some of the common teaching points I review during rounds:

- Document it now!
- No “SOP” notes please!
- Abnormal lab or radiology results
- Abbreviations and other terms
When you write an order (or plan), please document **somewhere** (such as in the progress notes, H&P, consultation, procedure note, patient discharge instructions, discharge summary OR in your orders) the diagnosis for which you are giving that order. Here are some common examples of this:

<table>
<thead>
<tr>
<th>ORDER/ PLAN</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Nystatin swish and spit QID”</td>
<td>Thrush</td>
</tr>
<tr>
<td>“check CXR – crackles on lung exam”</td>
<td>(Suspect) Atelectasis</td>
</tr>
<tr>
<td>“check AXR – abdomen distended with decreased bowel sounds”</td>
<td>(Possible) Ileus</td>
</tr>
<tr>
<td>“low albumin – add protein shakes”</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>“U/A with &gt;50 WBCs; add Cipro”</td>
<td>UTI</td>
</tr>
</tbody>
</table>
No “SOP” notes PLEASE!!!

It is fine to write “systems-based notes” - as long as there is a **DIAGNOSIS** documented:

Don’t write:

Pulm - check CXR, continue abx  
Heme – S/P 4 units PRBC, recheck H/H  
FEN – PAB 8, adjust TPN

Do write:

Pulm – Pneumonia - check CXR, continue abx  
Heme – Acute Blood Loss Anemia - S/P 4 units PRBC, recheck H/H  
FEN – Severe Malnutrition - PAB 8, adjust TPN
No “SOP” notes PLEASE!!!

PLEASE!

Don’t write “SOP” notes; the coders need an ASSESSMENT (i.e. a diagnosis) in order to code properly.
Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance.

You must write out a diagnosis somewhere in the chart (such as in the progress notes, H&P, consultation, procedure note, patient discharge instructions, discharge summary).

This includes writing out the diagnosis instead of using certain abbreviations; \( \downarrow \text{Na}, \) \( \uparrow \text{Na}, \) \( \uparrow \text{pH} \) are all considered abnormal lab values only; please write “hyponatremia,” “hypernatremia,” and “alkalosis” instead.
### ABBREVIATIONS and other terms

<table>
<thead>
<tr>
<th>DON'T WRITE:</th>
<th>WHAT IT MEANS IN THE CODING WORLD:</th>
<th>DO WRITE (where appropriate):</th>
</tr>
</thead>
<tbody>
<tr>
<td>“↓Na,” “↑Na,” “↑pH”</td>
<td>Abnormal lab values</td>
<td>Hyponatremia, hypernatremia, alkalosis</td>
</tr>
<tr>
<td>“↓Hct”</td>
<td>Another abnormal lab value</td>
<td>Anemia – please specify if due to acute blood loss!</td>
</tr>
<tr>
<td>“positive urine culture” or “pyuria”</td>
<td>Yet another abnormal lab value</td>
<td>UTI</td>
</tr>
</tbody>
</table>
"Physicians are busy. We are pulled in all directions as to meet the demands and expectations of our patients, our families, our facilities, and our governments. To make extra time, we try not to do unnecessary work, taking shortcuts that we believe do not compromise the quality of care that we render. That is how we survive."

“One ‘shortcut’ we take is in medical record documentation. We believe that since we know in our heads what’s going on with the patient that writing all of this down is somewhat cumbersome and obstructive to providing quality care. We’ve learned shortcuts in residency that appear to work, such as calling sepsis due to a urinary tract infection ‘urosepsis’. We use abbreviations that we know the meaning of (e.g. ACS) and sometimes expect others to know of as well..."
The following assessment is written in the H&P: “Pt presents c/o SOB, pain in RLQ. U/A with WBCs, will give Cipro and √ cx. Na ↓ - repeat lytes.” In subsequent notes, there is documentation of “Urine cx → E. coli, cont abx” and “Na still ↓ - adjust IVF, rev√ in AM.”

The rules of coding do not permit for the coders to list the diagnosis without documentation of the proper terms, so the diligent coders will need the physician to document it.

How is this accomplished?
AHIMA defines a query as “a routine communication and education tool used to advocate complete and compliant documentation.”

Typical situations addressed by a query include presenting clinical indicators of an undocumented condition, requesting further specificity or the degree of severity of a documented condition, clarifying a potential cause and effect relationship, and addressing present on admission issues.

How do physicians feel about queries?
Example: The query asks the physician to document the diagnosis written as “↓ H/H” that required treatment with blood transfusions.

Responses:

Clear and helpful:
“This patient had acute blood loss anemia from injuries suffered in a MVA.”

Not as clear or helpful:
“Anemia.”

Frustration all around:
“Isn’t it obvious?”
Agreement with path report:

Hi Dr. Jekyll. My name is Caryn Brenner-Williams, M.D., and one of my duties is serving as a physician liaison between the coders and the medical staff. I am a physician and I have treated patients, so I do understand how frustrating documentation requirements can be. Recently you received a query that probably made you think "this is ridiculous!" - I wanted to explain what the coders need and why.

The query asked you to affirm a diagnosis on a path report. I'm sure you were thinking, “You’ve got to be kidding me! Why am I getting this query? The path report gives the diagnosis!” Personally, I couldn't agree with you more. I'm not the one looking under the microscope! Am I really going to disagree with the pathologist?
Agreement with path report (continued):

Here’s the problem: Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) cannot be coded and reported unless a physician who is providing direct care to the patient indicates their clinical significance. You must write out a diagnosis somewhere in the chart (such as in the progress notes, H&P, consultation, procedure note, patient discharge instructions, discharge summary). In other words, even though it is the pathologist who is looking under the microscope and making the diagnosis, the rules of coding state that “although the pathologist provides a written interpretation of a tissue biopsy, this is not equivalent to the attending physician's medical diagnosis based on the patient's complete clinical picture. The attending physician is responsible for and directly involved in the care and treatment of the patient, since a pathologist's interpretation of a specimen is not the same as a diagnosis provided by a physician directly involved in the care and treatment of the patient.”
Debridements:

The query was asking whether a debridement you performed was "excisional" or "non-excisional." Obviously, this seems like a ridiculous question - what physician has ever performed a debridement that wasn't excisional? Unfortunately, in the coding world (which is occasionally like the Twilight Zone), the coders are required to follow the guidelines to the letter - and this includes classifying debridements as "excisional" or "non-excisional." For coding purposes, the definition of excisional debridement is as follows: "The cutting removal of all devitalized tissue, necrosis, and slough from a wound, infection, or burn of the skin or subcutaneous tissue." According to the guidelines, "Unless the attending physician documents in the medical record that an excisional debridement was performed, debridement of the skin should be coded to 86.28, Nonexcisional debridement of skin. Any debridement of the skin that does not meet the criteria as noted above or is described in the medical record as debridement and no other information is available, should be coded 86.28, Nonexcisional debridement." So, if the physician does not specifically state that the debridement was "excisional," the coders are required to ask you for clarification.
Which patient has the higher risk of mortality?

The first patient was admitted after suffering a “stroke with left-sided weakness and edema.” MERCI retrieval was performed.

<table>
<thead>
<tr>
<th>Diagnoses (Principal/Secondary) &amp; Procedure</th>
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<tbody>
<tr>
<td>Stroke with weakness and edema; MERCI retrieval</td>
<td>24 - CRANIOTOMY W MAJOR DEVICE IMPLANT/ACUTE COMPLEX CNS PDX W/O MCC</td>
<td>$17,105</td>
</tr>
<tr>
<td></td>
<td>Case weight ~ 3.5</td>
<td></td>
</tr>
</tbody>
</table>

The second patient was admitted after suffering a “stroke with left hemiparesis and brain edema.” MERCI retrieval was performed.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Stroke with hemiparesis and brain edema; MERCI retrieval</td>
<td>23 - CRANIOTOMY W MAJOR DEVICE IMPLANT/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT</td>
<td>$24,905</td>
</tr>
<tr>
<td></td>
<td>Case weight ~ 5.1</td>
<td></td>
</tr>
</tbody>
</table>
It is an additional burden on the physicians to have to do this type of documentation, but -

It is essential to the hospital for proper coding and reimbursement, as well as other important factors such as demonstrating severity of illness and risk of mortality.
QUESTIONS??????