CDI for Surgeons: What You and They Need to Know

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Program Notes for ACDIS Conference Clinical and Coding Highlight Series

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- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2018-clinical-and-coding-highlight-series
- Continuing education information
  - Please note: In order to receive your continuing education certificate(s) for this workshop series, you must complete the online evaluation, which can be found in the CE instructions file on the download page. **The evaluation will open after the last event in the *entire* series on August 16, 2018.**

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Understand why surgeons are so important to your hospital and your CDI program's success
  - Understand why surgeons are seemingly so difficult to reach by CDI programs
  - Understand the baseline documentation needs for all surgical specialties
  - Understand the specific documentation needs of the most common surgical subspecialties
  - Develop and employ intervention strategies with your surgical colleagues to affect positive change in their documentation habits

Why Surgeon Documentation Is Important

What Surgeons Mean to Your Facility

- Surgical MS-DRGs reimburse significantly more than medical MS-DRGs
  - Surgery-related resource consumption much higher
- Profit margin for most IP surgeries 20%–35% of charges
  - Despite lower percentage of all admits, surgery is the largest financial driver your facility's revenue
- Much publicly reported hospital performance/quality data directly tied to surgical outcomes
  - How many AHRQ PSIs & CMS HACs are related to surgery?
  - What about the SCIP measures in CMS' VBPP?

What Surgeons Mean to Your CDI Program

- Because surgical MS-DRGs are weighted so much higher, they have disproportionate impact on overall CMI
  - One or two medical doctors dropping the documentation ball may have no appreciable CMI effect
  - What happens to your CMI when one or more surgeons go on vacation?
- CCs and MCCs are weighted much more heavily in surgical cases than in medical cases
  - Capturing just one additional diagnosis in a surgical case much more beneficial to the CMI than in a medical case
- Many surgeons are poor documenters at baseline, so they have the largest opportunity for improvement

What Surgeons Mean to Your CDI Program

- Surgeons have administration's ear
  - Administrators know where the hospital's bread is buttered
- Administrators like happy surgeons
  - Things that make surgeons unhappy tend to get quick attention from the C-suite
    - Perpetually afraid their surgeons will take their surgeries to other facilities
- "Big" surgeons tend to have significant influence within your facility
  - If they don't drink the Kool-Aid, it's hard to get other surgeons to join the movement

Why Surgeons Are Poor Documenters

Surgical Reimbursement System

- Unlike "medicine" specialties, surgeons are reimbursed based on a **global fee system**
  - Single payment for **all care associated with a surgical procedure** which includes three phases:
    - **Preoperative evaluation**
    - **Intra-operative procedure**
    - **Postoperative care for either 0, 10, or 90 days**
- *Therefore*, no impetus for good note quality since not reimbursed on daily E&M charge submissions
  - ***Ex*:** Hospitalists receive a daily fee based on the H&P, each daily progress note, and the discharge summary

Training Experience

- Surgical residency focuses exclusively on making the right clinical call
  - i.e., when you should and should not proceed to the OR
- Little attention given to documentation and billing needs until actually in practice as an attending
- Younger surgeons showing improved documentation practices, but culture change takes time
  - A recent UTMC transitional intern was told by his chief surgery resident to "Follow the Five B's" in his documentation:
    - **Be Brief, Brother, Be Brief!!**

Ego

- *"I can tell you everything you need to know about that patient in one sentence."*
- *"There are two types of doctors in this world: surgeons and those who want to be surgeons."*
- *"I wanted to be a surgeon because I wanted to the best."*
- *"It seems to me that I get paid no matter what I put in the chart."*
- *"Get the medicine people to write what you want in the chart. I operate."*

Misinformation

- *"If I document all of these things you want me to, my complication rates will go up."*
- *"If I don't document anything, the lawyers can't get me."*
- *"Writing more in the chart only helps the hospital. I don't see how that helps me."*
- *"I fail to see how this impacts my patients."*
- *"I don't care about the hospital's bottom line as long as my patients are taken care of."*
- *"Why do I need this? My waiting room is always full."*

Today's Surgeon Lifestyle Reality

- What is the most important commodity to any doc?
  - TIME!!
- Surgeons not immune to the clock
  - All payer reimbursements stagnant or falling, so they feel increasing pressure for high OR volumes
  - Now also grapple with healthcare reform's persistent quality drive to improve outcomes while reducing costs
    - *Surgeons love meetings, right?*
- ***And now you also want them to document more?***
  - Ugh!!

What Does All of This Mean for CDI?

- Any request for improved chart documentation from a surgeon **is a total paradigm shift** in their world order
  - One of the frequently perceived benefits of a career in surgery was less note writing
    - "***Thank God I don't have to write those damn medicine notes again!***"
  - They may see the CDI program and coders as trying to eliminate one of their most coveted perks
- This is a challenge!!

Documentation Needs for ALL Surgeons

Document Everything!

- Surgeons traditionally focused on documentation of the operative indications only
  - Important secondary diagnoses frequently omitted
    - Bad for individual surgeons, surgery service lines, and the hospital's publicly reported ratings/rankings
    - Bad for hospital (*and eventually the individual surgeon's*) reimbursement
- **What are the two most important predictors of surgical mortality?**
  - Patient's age
  - Number and severity of concurrent medical conditions

Document Everything!

- Absolutely critical to **list every diagnosis** affecting the surgical patient
  - There is no way the surgeon can know which diagnoses impact the reimbursement, the SOI or ROM scores, etc.
    - ***Document everything and let the coders and performance improvement programs figure it out***
- ***Note*:** Every surgeon believes they operate on sicker patients than the surgeon down the street
  - Well … PROVE IT!!
  - ***Get every dx label ever hung on your patient in the record!***

Document Everything!

- **Get every diagnosis in the admission H&P or initial consultation**
  - Any diagnosis listed in PMH or first A/P section is POA of "**YES**" which CMS considers a "**comorbidity**"
  - Any diagnosis documented ***after*** admission is POA of "**NO**" which CMS considers a "**complication**"
- **Get every diagnosis in the discharge summary**
  - **Has become the most important document in the chart**
    - The first place the hospital coders look
    - The first place the recovery auditors look

Do Not Describe Diseases as "Post-Op"

- **Implies** to coder and/or auditor that the disease was a **complication** of a procedure/surgery
  - Complication codes negatively impact your surgeons' performance metrics
- ***Note*:** Surgeons still need to establish appropriate **medical linkage** when it exists
  - ***Ex*:** "**expected ileus due to colon resection**" as opposed to "**post-op ileus**"
- *However*, **do not** unintentionally create the inference that a complication exists when in fact there is not one

Do Not Add "Complications" Section to Op Notes

- Surgeons should list **all findings and all procedures** performed in their operative notes
  - *However*, anything labeled as a "complication" by a surgeon must be coded as a complication per Coding Clinic
- ***Note*:** This does not mean you are encouraging surgeons NOT to document what happens in the OR
  - Should encourage them not to hang themselves needlessly
  - *If something happens*, document it and state that it was **unavoidable due to whatever anatomical abnormality**
  - True complications should still be coded as such
    - **Always query if unsure**

Ensure Diagnosis-Physical Exam Congruity

- Can't diagnose patient with **acute encephalopathy** if PE section says "A&O x 3, normal mood, affect, and judgement" and "no focal neurological deficits"
- Can't diagnose patient with **acute respiratory failure** if PE section says "A&O x 3, NAD, lungs CTA bilaterally with good airflow, no increased work of breathing"
  - **Must update/amend pre-populated physical exam templates in the EMR!!**
- ***Note*: Recovery auditors have figured this one out!**
  - ☹ Major source for clinical validation denials

Recognizing Sepsis as Indication for the OR

- How many patients taken emergently to the OR for non-traumatic problems meet SIRS &/or SOFA criteria?
  - ***Ex*:** appendicitis, cholecystitis, ruptured diverticulitis, intra-abdominal abscesses, etc.
  - Is there ischemia, wet or gas gangrene, necrotizing fasciitis, peritonitis, etc.?
- ***Note*:** Must make surgeon CDI sepsis education consistent with critical care/medicine services
  - i.e.: are you using Sepsis 2 or Sepsis 3?

Don't Forget Lysis of Adhesions

- Became popular when separate CPT code created so surgeons could obtain additional reimbursement
  - ***However,*** hospital can submit separate procedure codes as well if surgeon effectively documents
  - ***And*** serves as additional evidence that unfortunate occurrence in OR was expected as opposed to a "complication"
  - ***And*** helps explain increased OR time duration for OR committee through-put efforts

Body Habitus Matters!

- **Obesity** = BMI of ≥ 30–34.9
- **Morbid obesity** = BMI ≥ 35
  - Provider must ascribe clinical relevance to the BMI by documenting the diagnosis of "obesity" or "morbid obesity" in the medical record
    - ***Ex*:** "Morbid obesity w/ BMI = 42"
    - ***Note*:** BMI cannot be taken from EMR calculated value without provider corroboration
  - ☻ **Do not** have to say why or how patient's obesity impacted their care per Coding Clinic

Specific Service Line Documentation Needs

Cardiothoracic Surgery Needs

- All **CABG** operative notes should include
  - The number of coronary vessels bypassed
  - Which internal artery was attached to which coronary artery to make a bypass
  - The origin (i.e. aorta) and termination (i.e. which coronary artery) of a vein graft once implanted
    - From where each vein graft was harvested for a bypass
  - Were any non-autologous or synthetic bypass grafts used?
  - Was the patient on cardiopulmonary bypass during the procedure?

Cardiothoracic Surgery Needs

- Most pneumothoraxes (PTX) are integral and expected with any intra-thoracic procedure
  - Therefore, they are normally not coded separately
- *However*, PTXs **can be coded** if post-procedural care was more than would be normally expected
  - Was the patient sent home with a Heimlich valve?
  - Did you order a follow-up CXR for after D/C to monitor the size/resolution of their PTX?
  - Did you need to see them back in your office sooner than normal to check on the status of their PTX?

Neurosurgery Needs

- How many operative cases have residual neurological deficits from previous interventions?
  - **Hemiplegia/hemiparesis**
  - **Dysphagia**
  - **Ataxia**
  - **Joint contractures**
- Need documented diagnoses for radiological findings they are treating (steroids, mannitol, ICP monitoring, operative decompression, etc.)
  - **Cerebral edema**
  - **Brain compression** as opposed to “midline shift”
  - **Herniation** as opposed to “effacement of cisterns”

OB/GYN & Gyn-Onc Needs

- Perineal lacerations
  - Must make sure stated degree matches the reconstructive procedure subsequently performed
    - 3rd and 4th degree tears are CCs
- Acute post-hemorrhagic anemia after significant blood loss with C-sections, TAHs, etc.
- All organ, lymph node, and omental biopsies need to be documented in the op note
  - Pathology results from those biopsies **need to be added to concurrent documentation as soon as available *or* as post-discharge addendum**

Orthopedic Surgery Needs

- Is that fracture **traumatic** or **pathologic**?
  - There are no ICD-10-CM codes for "fragility" fractures
  - **Osteoporosis** causes spontaneous, "**pathologic**" fractures
- **TKRs** *(& eventually THRs)* **off CMS' inpatient-only list**
  - Surgeon documentation of comorbid conditions critical to justifying IP stay:
    - Age > 75
    - BMI > 40
    - Charlson score ≥ 3
    - ASA score ≥ III
    - RAPT score ≤ 9
    - Pre-op Hgb < 12
    - Poorly controlled DM
    - Cirrhosis
    - Chronic respiratory failure
    - Need for bridging systemic anticoagulation

Podiatry Needs

- Does the patient have just have osteomyelitis or was there cellulitis as well?
- What is the wound/ulcer due to?
  - Pressure
  - Ischemia
  - Diabetes
  - Traumatic injury
  - Previous surgery
- Exactly which joint(s) or location in bone is the amputation performed on?
- If remaining wound is closed with a flap, must state what kind of flap it was and where it came from

Surgical Oncology Needs

- All organ, lymph node, and omental biopsies need to be documented in the op note
  - Pathology results from those biopsies **need to be added to concurrent documentation as soon as available *or* as post-discharge addendum**
- It is always more than just "unintentional weight loss"
  - Chances are the surgical oncology patient meets the recognized criteria for the diagnosis of **malnutrition**
    - Suggest employing dietary/nutritional services to obtain needed history and physical exam findings for provider to interpret

Trauma Surgery Needs

- Must document **every** discovered injury, no matter how seemingly small (including all organ contusions and lacerations)
  - Different injuries from different body sites/systems may combine to place cases in the **M**ultiple **S**ignificant **T**rauma (**MST**) MS-DRGs (955–965)
    - ***There is no way a surgeon can know which diagnoses do and do not count for MST***
  - Hospital coders can take injury specifics from radiology reports **IF** provider corroborated injury in the record

Trauma Surgery Needs

- Review lab results for evidence of additional diagnoses
  - **Anemias** (hemorrhagic or chronic)
  - **Acidoses** (lactic acid levels, serum bicarb levels, anion gaps, ABGs, base excesses)
  - Elevated CPK levels and **rhabdo**
  - Elevated troponin levels and **AMIs**
  - Abnormal ABGs and **acute respiratory failure**
  - Elevated creatinine levels and **chronic kidney disease** or **acute renal failure**
  - Elevated glucose levels and **diabetes**
  - List all **electrolyte abnormalities** as opposed to just correcting them and moving on
    - Suggest only using "hyponatremia" if Na **<** 130 and "hypernatremia" if Na **>** 150

Trauma Surgery Needs

- Were they really "intubated for airway protection" or for "**acute respiratory failure**"?
  - Patients "intubated for airway protection" **cannot be coded** as having "acute respiratory failure"
- Intubating strictly for "airway protection" is rare and should only be documented when appropriate
  - ***In acute trauma patients,* what would pO_2 &/or pCO_2 be if they were not actively, artificially ventilated?**
  - OK to say "intubated in the field" but **not** OK to say "intubated for airway protection" *or* "intubated for unresponsiveness"

Urological Surgery Needs

- There is **no code for "urosepsis"** in ICD-10-CM!!
  - If patient meets criteria for sepsis, it is "sepsis due to UTI" or "sepsis due to pyelonephritis"
  - If does not meet sepsis criteria, it's just a UTI or pyelo
- It is always more than just "hematuria"
  - What about the "**acute post-hemorrhagic anemia**" that the hematuria caused?
- It is always more than just a "renal or bladder mass"
  - What kind of malignancy do you think it is?
  - **Add the pathology results to concurrent documentation as soon as available *or* as post-discharge addendum**

Vascular Surgery Needs

- **4 things** must be found in all procedure notes:
  1. **Anatomical name** of all vessels involved
  2. Specific **types of vessels** involved
     - **Artery**, **vein**, or previous **bypass graft**
  3. **Type of lesion** identified/addressed in each vessel
     - Stenosis/blockage due to **arteriosclerosis**, **embolus**, or **thrombosis**
       - **Note:** Same vessel may have 2 different blockages with 2 different etiologies (i.e. stenting of proximal atherosclerotic lesion followed by extraction of distal thrombus)
  4. **Consequences** of those blockages
     - **Claudication**, **ulcers**, and/or **gangrene**

Strategies to Move the Surgical Needle

Round with Your Surgery Service Lines

- ***After*** they address the medical issues, CDI suggests diagnoses that are present but not yet documented
  - Suggests clearing up any incomplete, outdated, or unrecognized terminology
- Show them the actual codes found within ICD-10-CM
  - Surgeons seem to be more accepting of things actually seen in "black and white"
- Show how capture of these things impacts MS-DRGs
- Show how capture of these things impacts their estimated GMLOS

Participate in Morbidity & Mortality Reviews

- ***After*** surgery service line reviews case from a medical standpoint, CDI then reviews the documentation found in that case and the coding
  - List all missed diagnoses ***and the evidence for the existence of those diagnoses***
  - List all instances of incomplete, outdated, or unrecognized terminology that precluded more accurate disease coding
  - Show how poor documentation habits/patterns precluded accurate principal diagnosis selection by coding
  - **Show how capture of these things would have impacted the MS-DRG &/or APR-DRG SOI and ROM scores**

Participate in Performance Improvement Process

- Review records considered outliers or that negatively impacted the hospital's PSI scores
  - Review disease definitions and diagnostic criteria to ensure accurate data capture
    - ***Ex*: What is **post-operative respiratory failure**?
    - ***Ex*: What is **post-operative sepsis**?
    - ***Ex*: Was that **DVT or PE present on admission**?
    - ***Ex*: Was that an **accidental puncture or laceration**?
  - Suggest different/improved documentation practices to facilitate more accurate data generation
  - Suggest ways to more quickly identify & address documentation inconsistencies negatively impacting data

Show Them Their RA Denials

- Like it or not, surgeons need to know that they are part of your RA defense plan
  - Surgeons can change if shown how to avoid the same problem in the future
- Remind them that money out of the hospital's pocket has to come from somewhere
  - Do they want it to come from the OR, the PACU, the CT and MRI scanners, the nurse-patient staffing ratios, their office space rental rates, etc.?
- Should be done for DRG validation denials (coding-based and clinical validation) ***and*** medical necessity denials (OBS vs. IP, procedural necessity, etc.)

CDI Education at the OR Committee

- Short and recurring presentations regarding problems that CDI and coding are seeing
  - General operative note construction
  - ICD-10-PCS documentation requirements
  - Key procedural omissions
  - Complication documentation and coding
  - DRG validation denials based on operative note documentation
  - Timeliness of operative note completion
  - Conflicts between operative notes and subsequent hospital documentation

Use Few EMR Benefits to Their Advantage

- **Encourage** use of **copy-paste** functionality **for diagnosis list** propagation
  - If they spend time on day #1 note, they'll then spend much less time on subsequent days' notes
    - Just have to update/add new problems
      - **Problem lists should only grow, right?**
    - Makes D/C summary creation much easier
- **Discourage** use of **copy-paste** functionality for the **daily plans** to treat that problem list
  - That is considered cloning

At the Absolute Bare Minimum ...

- Ask them to follow the **Three-Times Rule:**
  1. Get **every diagnosis** in the admit H&P/consult
     - Takes care of POA indicators
     - Prevents being counted as "complication" later
  2. Get **every diagnosis** in one assessment of **one progress note** during the hospitalization
     - Satisfies secondary diagnosis coding criteria since shows problem impacted care
  3. Get **every diagnosis** in the **discharge summary**
     - First place coders look when opening record
     - Prevents recovery auditor denials

Don't Forget "the Help"

- Residents, PAs, and NPs may now do the bulk of (*if not all*) clinical documentation in your facility
  - Therefore, focus your CDI educational efforts on their documentation habits
- Frequently much more compliant
- Frequently much more willing to help
  - They understand their job depends on the fortunes of the hospital or the surgeon who employs them
- *Ideally*, they should all receive their CDI education ***before*** they start their clinical responsibilities

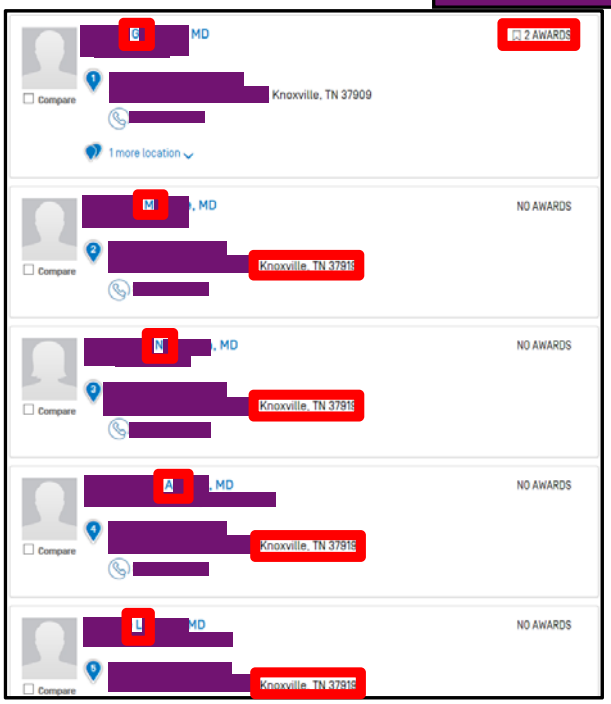
Get CDI Into the Pre-Anesthesia Clinic

- The pre-operative anesthesia H&P is useable for coding purposes (regardless if generated by anesthesia or internal medicine)
  - Takes care of many POA indicators
  - Serves as queued list of diagnoses for surgeon &/or their staff to document in the record throughout hospitalization
  - Serves as source of additional diagnoses that may have been missed by the surgeon's office H&P
  - Serves as cue for CDI staff to query if some relevant disease processes are not documented
  - ***Note*:** Must be signed by pre-anesthesia clinic attending

Review Payer Herding Strategies

- Surgeons achieving lower lengths of stay, complication rates, readmission rates, mortality rates, etc., for same SOI scores cost less to payers
  - Payers "**herd**" patients to surgeons with lower **Observed to Expected ratios** for these metrics
- Which part of this ratio should surgeons focus on?
  - **Numerator management (Observed rate)** involves actual medical care
    - ***While this should certainly be done ...***
  - **Denominator management (Expected rate)** involves improving documentation
    - Providers must accurately reflect their patients' SOI

Payer Herding Ex:



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Notice anything?

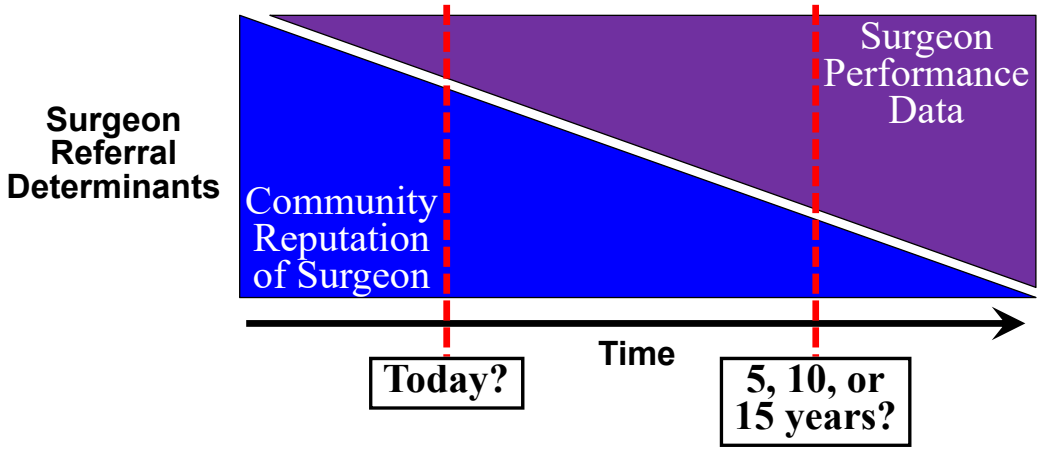
1. First doc listed has "awards"
2. List is **NOT** alphabetical
3. Docs #2–#11 practice ***at same physical address*** (i.e. all are in the same group)

Things that should make you go *HHHmmmmmmmm* ... right?

- **Question**: ***Who makes it to last page of Google search?***

Performance Data Drives New Patient Stream

- Patients and employers becoming more tech/data savvy with HealthGrades, Hospital and Physician Compare, individual payer websites, etc.



Use "Type A" Traits to Your Advantage

1. **Surgeons are extremely competitive**
   - They had to be at the top of their game in everything they ever did to get to where they are
     - How many surgeons ever got a B in anything?
2. **Surgeons are very detail-oriented**
   - *Therefore*, tell them that another surgeon or surgical group does it better then they do!
     - **They will want to know how to fix that perception**
   - Show data that says the hospital down the road or group across the street operates on sicker patients
     - Can get that data from PI/QI/marketing departments

Thank you. Questions?

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To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the

ACDIS Conference Clinical and Coding Highlight Series,

What's in a Review?
Key Factors to Include and Exclude,

will be broadcast live on Thursday, July 26 at 1 p.m. ET.