The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 8th issue of the CA ACDIS journal!

Intracerebral Hemorrhage and its Consequences

Muhammad Taha Farooq, M.B.B.S., ECFMG certified, CDIP, CCS, CCDS
Lead Clinical Documentation Improvement Specialist Optum360, Oxnard

Intracerebral Hemorrhage: Bleeding within the cerebral tissues (epidural, subdural and or subarachnoid) or ventricles of brain. It can be

Traumatic: due to fall

Atraumatic: due to stroke, malignancies

Cerebral Edema: Accumulation of excess fluid in brain tissues due to inflammatory reaction. It can cause brain compression or midline shift.

Treatment: Decadron, Mannitol, intubation or transfer to ICU.

Case scenario: 98 y/o Male presented to ER with the complaint of unable to walk and talk after he woke up from sleep. Head CT showed massive acute hemorrhage from middle cerebral artery measuring up to 7.5 cm resulting in approximately 0.9 cm midline shift towards left side of the brain. Per HNP, patient noted to have intracerebral hemorrhage with midline shift. Patient's family wishes for palliative care. Patient was DNR and expired later at night.

(continued on page 2)

Comment from the California ACDIS Newsletter Team,

It has been a real pleasure, collaborating, and presenting articles pertinent to CDI on a quarterly basis. We truly appreciate support of the Leaders of California ACDIS and ACDIS. We wish good health and success to all our CA-ACDIS members who support the treating teams who provide clinical care to their patients, by ensuring accurate documentation of the medical complexity of the patient's care. The most important customer is the patient and accuracy is the true north of the Clinical Documentation Specialist role.

We hope you had happy holidays and have a Great New Year 2020!

Issue 08
Jan 2020

(cont'd from page 1)

Coding before query

PDX	**I61.9**	Non-traumatic Intracerebral hemorrhage unspecified
DRG	**066**	Intracerebral hemorrhage or cerebral infarction wo MCC
GMLOS 2.1	**SOI 1**	**ROM 2**

Coding after query

PDX	**I61.9**	Non-traumatic Intracerebral hemorrhage unspecified
MCC	**G93.5**	Compression of brain
DRG	**064**	Intracerebral hemorrhage or cerebral infarction w MCC
GMLOS 4.4	**SOI 3**	**ROM 2**

Conclusion:

- We can't use nonspecific phrases like brain swelling, midline shift or mass effects to code. CDI should query for clarification.
- Physician often document in Radiology reports but this documentation can't be use for coding.
- If cerebral edema is mild or without mass effect, CDI should query to physician for clarification if the dx is clinically significant or not.
- Not capturing these diagnosis may adversely affects hospital and physician profiles as it impacts SOI and ROM scores.

Please remind physician for consistent documentation and include in discharge summary.

References

2018 Icd-10 Drg Audit Target Area - Cerebral Edema https://www.providentedge.com/2018-icd-10-drg-audit-target-area-cerebral-edema/ Stroke and Cerebral Edema. [2019].

Exploring quality in Pediatrics and Clinical Documentation Improvement

Rabia Jalal, MBBS, CCS, CDIP, CCDS, RHIA
Clinical Documentation Improvement Specialist, Optum360
Marian Regional Medical Center, Santa Maria, CA

Clinical Documentation Improvement (CDI) has been historically focused on improving DRG by capturing the maximum amount of Comorbid Conditions (CC) and Major Comorbid Conditions (MCC), thereby eventually increasing reimbursements for hospitals which is music to any hospital system's CFO. However, with the focus now shifting to Value-Based medicine, it is no longer enough for CDI programs to focus just on CCs and MCCs, and quality is now a big focus for many programs. Pediatrics is a specialty field that CDI programs are now looking into and implementing in many hospitals that have pediatric departments. In some states, including my home state of California, there is a focus on improving APR-DRGs which focus on Severity of Illness (SOI) and Risk of Mortality (ROM), along with DRGs.

A couple of pediatric conditions that are often not focused on by CDS, but should be from a quality perspective are Neonatal Hypoglycemia and Meconium Staining.

Neonatal Hypoglycemia

Neonatal Hypoglycemia can be defined as lower blood glucose levels in a healthy neonate soon after birth (American Academy of Pediatrics, 2017). Typically, this condition resolves within a short time, but if it persists for more than 48 hours, then it is concerning as a pathological condition. As a CDS, this condition should be looked at especially in babies with whose mothers have gestational or pre-exiting diabetes. Neonatal hypoglycemia is coded using a P code, which fall in the range of P07.1 to P07.4 depending on the circumstances that led to the hypoglycemia in the neonate

Meconium Staining:

Meconium staining is defined as the expulsion of meconium into the amniotic fluid prior to or during labor and delivery. This can be a cause for concern because an infant can develop meconium aspiration or respiratory distress (Ziade, 2019). If a CDS comes across a mother's chart during review indicating meconium staining, it is advisable for to review the baby's chart and query the physician, so it is documented in the baby's chart as well and also look for signs of possible meconium aspiration. Meconium Staining can be coded as P96.83 as per ICD 10 coding guidelines.

References:

Thompson-Branch, A and Havranek, T. Pediatrics in Review April 2017, 38 (4) 147-157; DOI: https://doi.org/10.1542/pir.2016-0063

Ziadie MS. Meconium staining. PathologyOutlines.com website. http://www.pathologyoutlines.com/topic/placentameconium.html. Accessed December 13th, 2019

5th Annual California ACDIS Conference, October 25, 2019

Analyn Dolopo-Simon RN, MPH, ACM, CCDS, UCSD Clinical Documentation Improvement Program

The 5th Annual California ACDIS Conference in UC Davis, started off the night before the conference at the Meet and Greet party in Davis with round of tasty tacos, drinks and CDI comradery. The Meet and Greet was located at the Three Mile Brewing bar and funded courtesy of UC Davis hosts (Tami Gomez). Thanks UC Davis!

UC Davis is great, quaint, college town with good walkability, and a lot of bicyclists everywhere. No feral attack turkeys were spotted during the conference. Cris Gumayagay and team helped set the California tone with the most memorable gold CDI bags and Save the Date UC Davis artwork that accurately resembled the college town feel of UC Davis.

The UC Davis conference hall was packed with attendees who were greeted by the friendly Chairs: Madhu Subherwal, Joel Lipin, and Officer Rani Stoddard and Board President/ Member Emily Emmons. Presentations coordinated by Education Committee lead by Pam Stence, brought stellar presenters who are leaders in the CDI industry. Two of the CA ACDIS Newsletter Committee members, myself (reporter/photographer) and Margaret DeFilippis (presenter) were in attendance at the conference.

Presentations were done by:

- Melissa Varnavas Editorial Director Association of Clinical Documentation Integrity Specialists (ACDIS) “State of the CDI Industry CDI Yesterday, Today, and Tomorrow: Staying Relevant in Changing Times”
- Cassi Birnbaum MS RHIA CPHQ FAHIMA Director UCSD HIM and Revenue Integrity presented “Coding and CDI efforts through a Single Path”,
- Margaret DeFilippis RN, JD, CCS, CPC, CDIP, CCDS presented the Importance of Preventing and Effectively Appealing Denials and Reimbursement”,
- Tami McMasters Gomez CCDS, CDIP, CCS, CCS-P (MHA) Manager, “UC Davis Coding & CDI Services presented CDI Journey at UC Davis Leveraging Analytics to drive CDI Improvement”,

- Victoria M. Hernandez, RHIA, CDIP, CCS, CCS-P Founder, Integrity Coding Solutions presented “Best Practices for Coding Audits and Compliance Strategies”,
- Staci Josten, BSN, RN, CCDS Director, UASI CDI/UR Services “How Does Your CDI Program Measure Up? Analyzing Current State and Taking Future State to a New Level”,
- Monica Leisch, RHIA, CDIP, CCS Director of Compliance / HIM Services Healthcare Cost Solutions, Inc. “Translating CDI into Compliant Coding”,

Memorable quote: It’s All about Quality …If you pursue reimbursement, you will miss the high-quality medical record but ... If you pursue the high-quality medical record, the proper reimbursement will follow.

Source: Jonathan Elion, MD, FACC Outpatient Clinical Document Improvement: A Practical Approach

https://acdis.org/sites/acdis/files/Outpatient%20CDI%20for%20KY-IN%20ACDIS%208-24-2018%20Handouts.pdf

The Importance of Nursing Documentation and the Documentation of Ancillary Providers— A View from the Inside

Maggie DeFilippis, RN, JD, CCDS, CDIP, CCS, CPC,
Managed Resources, Inc.

As a Registered Nurse I spent so much time during and after a shift making sure my documentation accurately recorded what happened to my patients. I was surprised some years later when I became a Medical Coder to learn that nursing documentation was "not important" or "not to be utilized" when it came to medical coding and billing. I was taught, "There are several areas of the medical record that should not be used when assigning a code. Coders should never code from a nurse's note."(1) As the official Coding Guidelines state, "the term provider is used throughout the Guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis."(2)

As a Clinical Documentation Integrity Specialist, my education efforts were focused on physicians, and my queries were sent only to physicians. As a writer of Appeals to Healthcare Denials, I have sometimes determined that the Denial is not appealable because the medical record "lacks sufficient ***physician*** documentation." I have given talks and provided education to many physicians stating, "if you, the physician, did not document it, it did not happen and neither you nor the facility where you provided the care can be reimbursed for that care you provided."

All of these precepts are still generally true. However, in August of 2019, while working in my garden, an insect of some kind bit my left lower leg, which set in motion a course of events that widened my viewpoint considerably. As I applied some ineffective cleansing and a Band-Aid to the site of the bite, and the microbes that insect had injected into my skin began their takeover of my body, I had no idea that my eyes were about to be opened to the origins of some of the missing physician documentation. As a nurse, I usually naively consider myself impervious to the illnesses that ravage my patients. When my fever rose to 103.8 degrees Fahrenheit within 24 hours of that tiny bite, I was sure I had the flu. My leg began to hurt and swell, but I turned a blind eye until my husband stated my choices now lay somewhere between a call to 911 or a "voluntary" trip to the Emergency Department.

In the Emergency Department I was seen immediately. Of course, I would not admit it, but confusion was setting in. I proved the theory that nurses can be annoying patients when I told my healthcare providers that they really should make a note of my Glasgow Coma Score, because I was slipping, and I may not be able to help them eventually get paid for this care much longer. My blood pressure was taken every 15 minutes automatically. I saw the reading of 60 and watched them add another intravenous line and take a legion of vials of blood. On some level I knew I was in trouble, but I persisted, telling my nurses and Physician Assistants and Nursing Assistants they really should document my blood pressure and the fact that my leg was now bright red and swollen to the knee. When they told me I was being admitted with Severe Sepsis due to Cellulitis with Kidney and other organ failures set-

ting in, I was incredulous, but the last thing I remember at that point was telling them to "write it down."

My own story has a happy ending as I did physically completely recover from my illness after a 14 day hospital stay. However, whether the facility and physicians were paid for the expert, curative care I received is another story. When I asked my Infectious Disease specialist, he told me that the payer had downgraded the payment to him and the facility, I looked into the situation. My insurance carrier claimed there was "insufficient physician documentation" to support my diagnosis with Severe Sepsis, so the claim was being paid at a lower rate. I ordered a copy of my medical record.

The diagnosis of Severe Sepsis with associated organ failures was well documented by the physicians and was correctly coded. What was lacking was documentation supporting the diagnosis. There was, in the payer's opinion no objective documentation of my fever, disoriented mental status and hypotension. Further, there was no nursing documentation of the description of the extent of my cellulitis and the impact of antibiotic treatment when they finally found an antibiotic that worked. One Lactic Acid laboratory test was ordered, but the results did not appear in the lab results, so I wondered if that lacking documentation had also impacted the facility's compliance with Sepsis 1 Core Measure reporting, effecting their Compare statistics and possibly their Value Based payment status. If a Clinical Documentation Integrity Specialist had looked at my record who would they have queried to capture this documentation?

While I am grateful for my health, I realized that "insufficient physician documentation" is often based on the physician's lack of access to signs and symptoms that should have been documented by nursing or ancillary healthcare providers. Documentation education is necessary for nursing and ancillary providers as well as physicians. The importance of lacking nursing documentation is also crucial in conditions where "work of breathing" can save a claim for payment of an Acute Respiratory Failure diagnosis. Poor quality and complication diagnoses may be avoided if pressure injuries are described and dated. Physical description and documentation of quantities of food consumed may sustain a Malnutrition diagnosis. Nursing documentation comparing prior mental status with current mental status in the facility may save an Encephalopathy diagnosis. Further, without nursing documentation noting the particulars of increased treatment and monitoring, payment for claims will be frequently denied as failing to meet Official Coding Guidelines, Section III. For facilities to be paid for the excellent care they receive, accurate and complete nursing and ancillary provider documentation is important and does need to be utilized. In fact, such documentation can be vital to the financial health of the practice and or facility.

References

HIM-HIPAA Insider, *Coding from Nurse's Notes* November 24, 2009 ***reported at*** https://www.hcpro.com/HIM-242349-865/Coding-from-nurses-notes.html

ICD-10-CM Official Guidelines for Coding and Reporting (FY 2019) ***reported at*** https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf (First Page, Narrative Text)

Visit our Facebook page:

https://www.facebook.com/

Instagram #caacdis2019

To support our chapter, please send your donations via PayPal using this link:

Paypal.me/CAACDIS

Thank you for your support!

Thank you for all your support in 2019!

PLATINUM SPONSORS

ClinIntell iodine

MedPartners an AMN Healthcare company | PEAK HEALTH SOLUTIONS an AMN Healthcare company | AMN Healthcare | HCPro

GOLD SPONSORS

CHANGE HEALTHCARE | EZDI | HEALTHCARE COST SOLUTIONS | AE & ASSOCIATES, LLC A Healthcare Company Providing You with Excellent Service

UASI Proven. Progressive. Passionate. | UCDAVIS HEALTH | OnPoint HEALTHCARE SOLUTIONS

Want to be a featured member of CA ACDIS? Have a great article and want to get published?

Contact: Analyn Dolopo at adolopo@ucsd.edu

California acdis Official Local Chapter

We hope to see you at future conferences. The next upcoming national conference date to remember is the 13th Annual ACDIS Conference in May 2020 in Las Vegas, Nevada at the Mirage Hotel and Casino.