

CDI AND QUALITY

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OBJECTIVES

- ❑ To explore what motivate surgeons
- ❑ To share effective educational strategies when working with surgeons
- ❑ To explore complication coding
- ❑ To share how having surgery engaged in CDI efforts impacts quality scores at your facility

OBJECTIVES GIVEN TO THE SURGEONS

- To reinforce the need for accuracy in the chart for compliance and to assist with potential audits/other claims.
- To provide a better understanding of the current DRG system used by MCR for payment of inpatient stays
- To allow better understanding of the CDI and Coder Query process utilized to help obtain more accurate data
- To provide insight into quality metrics related to documentation
- To provide a more thorough understanding of how documentation impacts complication codes

TO ERR IS HUMAN.....



Search ID: ear0576

"I DON'T GIVE A DAMN WHAT THE CHART SAYS!
I DID NOT HAVE A HYSTERECTOMY!!!"

APPEAL TO THEIR EGOS!

- Becoming a surgeon is a lengthy and difficult process, generally requiring four years of undergraduate school, four years of medical school and 3-10 years of residency and fellowship training.



KEEP IT SIMPLE AND MAKE THEM LAUGH- OR AT LEAST SMILE

- ◎ The more basic the information is the more likely they will care to pay attention
- ◎ Make sure your presentation is short and sweet-leave time for complaints and questions.



"Try to listen to each other more. It won't be easy. You're not very interesting."

TEACH THE BASICS

◎ DRG

◎ APR

◎ SOI

◎ ROM



OFFER REAL LIFE DATA

- Do screen shots of 3m, or at least set up a scenario which illustrates DRG, ROM and SOI shifts in a surgical patient.



HISTORY AND PHYSICAL

PMH- CHF, Obesity, CA
Presents with Pancreatitis

PMH – HFpEF, Obesity, Prostate CA presents with
pancreatitis

Active Problem List

- ⦿ Acute Pancreatitis
- ⦿ Chronic HFpEF
- ⦿ Prostate CA

Inactive Problem List

- ⦿ Obesity

HIATAL HERNIA REPAIR

K440 diaphragmatic
hernia with
obstruction, without
gangrene

0BQS4ZZ Repair Left
Diaphragm,
Percutaneous
Endoscopic Approach

**DRG 328 RW 1.5357 SOI 1
ROM 1, GLOS 2.53**

K440 diaphragmatic
hernia with obstruction,
without gangrene

0BQS4ZZ Repair Left
Diaphragm,
Percutaneous
Endoscopic Approach

I129 Hypertensive CKD
with Stage 1-Stage 4
CKD or unspecified

DRG 328, SOI 3, ROM 1

HIATAL HERNIA REPAIR

K440 diaphragmatic hernia
with obstruction, without
gangrene

0BQS4ZZ Repair Left
Diaphragm, Percutaneous
Endoscopic Approach

I129 Hypertensive CKD with
Stage 1-Stage 4 CKD or
unspecified

D62 Acute Posthemorrhagic
anemia

K440 diaphragmatic hernia
with obstruction, without
gangrene

0BQS4ZZ Repair Left
Diaphragm, Percutaneous
Endoscopic Approach

I129 Hypertensive CKD with
Stage 1-Stage 4 CKD or
unspecified

D62 Acute Posthemorrhagic
anemia

C50912 Malignant Neoplasm
of unspecified site of left
female breast

DRG 327 RW 2.5899 GLOS 5.5

DRG 327 SOI 3, ROM 2

DRG 328 RW 1.5357 SOI 1 ROM 1 GLOS 2.53

DRG 326 RW 5.3670 SOI 3 ROM 3 GLOS 10.9

K440 diaphragmatic hernia with obstruction, without gangrene

0BQS4ZZ Repair Left Diaphragm, Percutaneous Endoscopic Approach

I129 Hypertensive CKD with Stage 1-Stage 4 CKD or unspecified

D62 Acute Posthemorrhagic anemia

C50912 Malignant Neoplasm of unspecified site of left female breast

I5021 Acute Systolic CHF

K440 diaphragmatic hernia with obstruction, without gangrene

0BQS4ZZ Repair Left Diaphragm, Percutaneous Endoscopic Approach

I130 Hypertensive Heart and CKD with Heart Failure and Stage 1-Stage 4 CKD or unspecified

D62 Acute Posthemorrhagic anemia

C50912 Malignant Neoplasm of unspecified site of left female breast

I5021 Acute Systolic CHF

DRG 326 RW 5.3670 GLOS 10.9

DRG 326 RW 5.3670 SOI 3 ROM 3

YOUR CHART PAINTS A STORY



"Mrs. Hammond! I'd know you anywhere from little Billy's portrait of you."

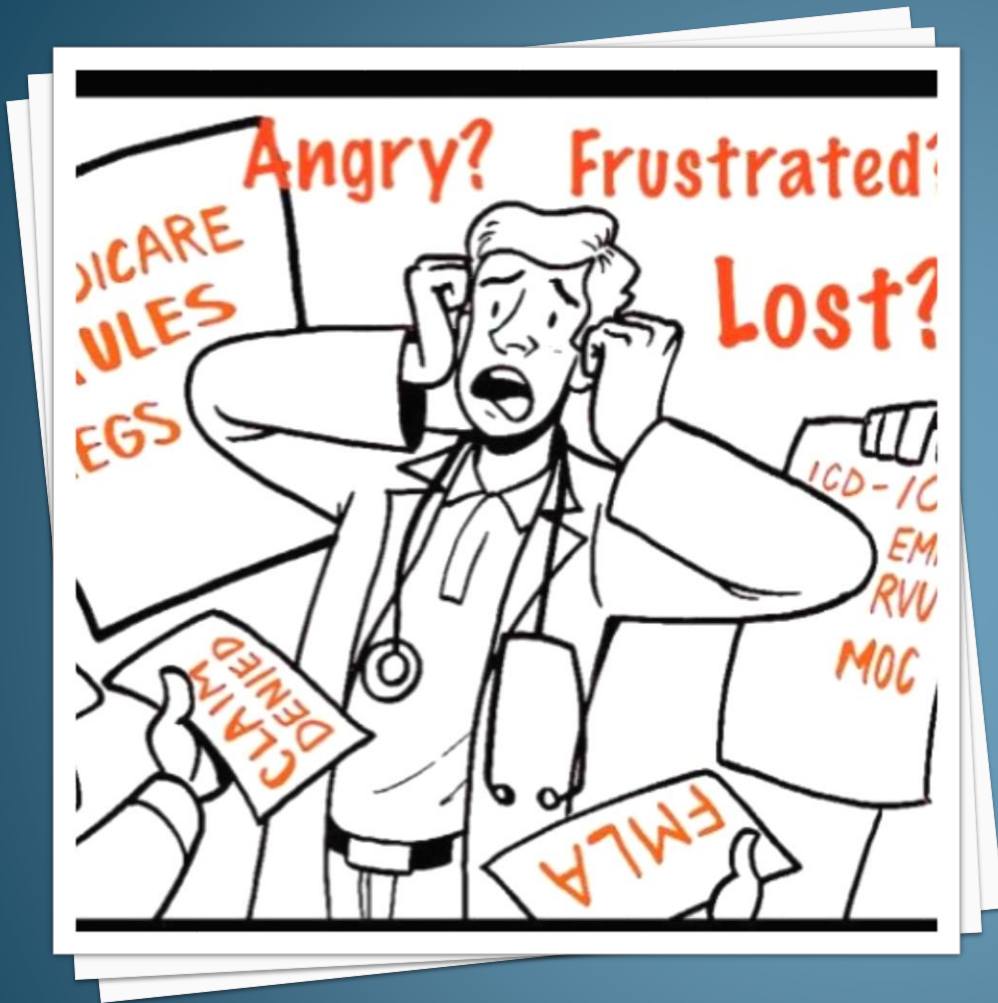


EXPLAIN YOUR CURRENT QUERY PROCESS

- Share the entire process from start to finish including reconciliation
- Seek input to see if there's a way that works better for them
- Acknowledge your CDI Program's focus- is it financially driven or is it quality based? Quality will always pique the interest of a surgeon



"Hip replacement? He was never hip to begin with."



MISERY LOVES
COMPANY



Royal College
of Surgeons

ADVANCING SURGICAL CARE

Improving accuracy of coding to maximise income and data quality

1. Record details of all diagnoses (**including co-morbidities**) and procedures (including those carried out on the ward) clearly in the notes. **Write the primary diagnosis first.**
 - a. For injuries - note the cause.
 - b. For overdoses - note the drugs.
 - c. For infections - note the organism.
 - d. For post operative complications – note the complication.
 - e. For cancelled operations – note the reason for cancellation.
2. If a clear diagnosis has not been reached, make sure you detail the main symptoms in the notes or discharge summary
3. Any 'query', 'possible' or 'likely' diagnosis, or diagnoses preceded by a '?' **cannot be coded**. If a histology result is needed for definitive diagnosis, note this down.
4. **Avoid the use of new or ambiguous abbreviations (e.g. MS – multiple sclerosis or mitral stenosis). Clinical coders are not allowed to make any clinical inferences.**
5. **All relevant co-morbidities MUST be recorded for each current spell**; reference cannot be made to previous spells. Funding is attached to the recording of this data
6. Transfers of care must be recorded.
7. **Details of all diagnoses, co-morbidities and procedures MUST be recorded on e-discharge summaries.**
8. If image control or minimal access approach is used it should be clearly stated.
9. When recording procedures it is **IMPERATIVE** that the **actual** operation is recorded and not the intended operation.
10. The source documentation should be:
 - a. **accurate and complete**
 - b. **reflect the patients episode of care**
 - c. **avoid the use of abbreviations**
 - d. **clear and detailed**
 - e. **legible and in indelible ink**

Emma Fernandez, Standards Manager December 2015

APPEAL TO THEIR CONCERNS

○ Reputation

○ Reputation

○ Reputation

○ Reputation

WHAT DO THESE FACILITIES HAVE IN COMMON?

- ◉ Hospital 1- us
- ◉ Hospital 2
- ◉ Hospital 3
- ◉ Hospital 4
- ◉ Hospital 5
- ◉ Hospital 6

Group A

Group B

Hospital 8

Overall rating :

5 out of 5 stars

Hospital 1

Overall rating :

4 out of 5 stars

Hospital 7

Overall rating :

2 out of 5 stars

Hospital 5

Overall rating :

3 out of 5 stars

Hospital 3

Overall rating :

3 out of 5 stars

Hospital 4

Overall rating :

3 out of 5 stars

◦
<https://www.medicare.gov/hospitalcompare/results.html#dist=25&loc=NEWTON%2C%20MA&lat=42.3370413&lng=-71.20922141.2092214>

Hospital Compare, CMS site

HEALTHGRADES

- ⦿ **Likelihood of recommending doctor to family and friends**
- ⦿ **Office and Staff**
- ⦿ **Ease of scheduling urgent appointments**
- ⦿ **Office environment, cleanliness, comfort, etc.**
- ⦿ **Staff friendliness and courteousness**
- ⦿ **Total wait time (waiting and exam rooms)**
- ⦿ **Experience with the doctor**
- ⦿ **Level of trust in provider's decisions**
- ⦿ **How well provider explains medical condition(s)**
- ⦿ **How well provider listens and answers questions**
- ⦿ **Spends appropriate amount of time with patients**
- ⦿ **Conditions Treated:** Evidence the provider treats a condition that matches the consumer's search (based upon medical claims data or directly sourced from the provider or their representative)
- ⦿ **Procedures Performed:** Evidence the provider performs a procedure that matches the consumer's search (based upon medical claims data or directly sourced from the provider or their representative)
- ⦿ **Patient Volume of Conditions Diagnosed or Treated and/or Procedures Performed:** Total volume of patients this provider has diagnosed, treated or performed procedures on over the past 12 months for this specific condition or procedure (based upon medical claims data)
- ⦿ **Total Patient Volume:** Total volume of patients this provider has seen over the past 12 months (overall - not specific to condition or procedure)
- ⦿ **Board Certification:** Whether the physician has a certification from a board received by Healthgrades

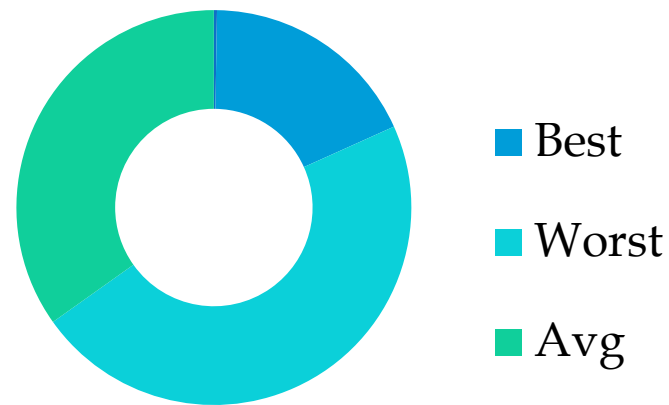
Also use DRG info for severity scores-
we **CAN** help you with that!!

“Sometimes after surgery, patients can develop serious complications while they are in the hospital. They might catch pneumonia, have a heart attack, or lose function in their kidneys or liver. These problems are serious but can be treated by a good hospital team.

If the hospital doesn't manage the patient's complications correctly, the patient could die.”

http://www.hospitalsafetygrade.org/h/newton-wellesley-hospital?findBy=state&state_prov=MA&rPos=6800&rSort=distance#sthash.yoFRNAjC.dpuf

Death From Treatable Serious Postoperative Complications Hospital Safety Grades



LEAPFROG

Accidental cuts and tears

Best Hospital	0.32
Avg Hospital	1.43
Worst Hospital	2.97

“THE FANS ONLY REMEMBER YOUR LAST TIME AT BAT”

MIKE DITKA



DISCUSS LEGAL IMPLICATIONS OF DOCUMENTATION



Documentation Lawsuit Indicator	Incidence
Poor/missing documentation	29%
Poor/missing preoperative assessment	25%
Documentation supports CRNA, no cause	25%
Failure to document adequate monitoring	19%
Perioperative airway documentation	18%
Lack of documentation and/or use of monitors	14%
Lack of position documentation	7%
Lack of informed anesthesia consent	7%
Lack of and/or improper documentation related to regional anesthesia blocks	6%

Lawsuit indicators are contributing factors that support filing a malpractice claim. These indicators can occur concurrently; therefore, the incidence does not equal 100%. Retrieved as part of this study from the AANA Foundation Closed Claims Database.

The Role of Documentation Quality in Anesthesia-Related Closed Claims: A Descriptive Qualitative Study.

Wilbanks, Bryan; DNP, CRNA; Geisz-Everson, Marjorie; PhD, CRNA; Boust, Rebecca; MSNA, CRNA

CIN: Computers, Informatics, Nursing. 34(9):406-412, September 2016.

DOI: 10.1097/CIN.0000000000000270

1. Identifying all personnel who participated in the case and who provided procedures (intubation, regional anesthesia, intravenous access placement, etc)
2. Documenting informed consent and preanesthetic evaluation
3. Documenting that a review of the informed consent, preanesthetic evaluation, and labs/diagnostic tests was performed
4. Documenting patient position, specific positioning aids used, who positioned patient, and position checks to assess pressure points
5. Documenting that neuromuscular function testing was evaluated with a nerve stimulator
6. Documenting confirmation of endotracheal tube placement (ease/difficulty, drugs used, instruments used, amount of air in cuff, etc), documentation of preoperative airway assessment, status of dentition after intubation
7. Documenting regional anesthesia placement (ease/difficulty, drugs used, level of spinal or epidural anesthesia, nerve stimulator use, or ultrasound use)
8. Documenting nasogastric/orogastric tube placement (ease of placement and drainage)
9. Documenting the occurrence of malfunctioning equipment and what was done to rectify the malfunction
10. Documenting complications and what was done to correct them
11. Documenting aspiration risk during anesthesia
12. Documenting the use of low inspired oxygen concentrations for fire risk case
13. Documenting estimated blood loss (must be the same between anesthesia, surgeon, and circulator)
14. Documenting conversion from laparoscopic to open procedure
15. Documenting the rationale for cancelling case
16. Documenting the transfer of care
17. Documenting an explanation for extreme values in physiological vital signs or abnormal drug dosages

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- 1. The quality of care or healthcare professional competence is questioned because of poor documentation.**
- 2. Documentation discrepancies between or within healthcare providers prevents “reconstructing events” for analysis (failure to generate consistent timeline).**
- 3. Poor documentation results in a negative review of a healthcare provider in retrospective analysis (quality assurance initiative or legal review).**
- 4. Poor documentation quality prevents proving the standard of care was met.**
- 5. Poor documentation impairs the ability of other healthcare providers to provide optimal care to the patient because of the presence of inaccurate information to guide clinical care decisions.**
- 6. Poor documentation results in the inability to defend against claims of wrong doing. Frivolous or otherwise unfounded lawsuits might be given merit by poor documentation.**

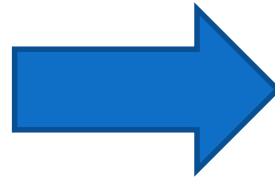
These are the consequences identified during this study that highlight the importance of good documentation.

- 1. Multiple provider documentation of the same event (ie, estimated blood loss) needs to agree, or there may be implications of dishonesty.**
- 2. When adverse events occur, extra attention needs to be given to generation of documentation.**
- 3. Healthcare providers need to appreciate the importance of good documentation.**
- 4. Documentation quality may be assumed to reflect provider quality by chart reviewers.**
- 5. Complications and/or reasons for cancelled cases must be documented to assist in future analysis of the events that occurred.**
- 6. When clinical interventions are performed (eg, emergency tracheal intubation) the healthcare provider needs to document the need/reason.**
- 7. Document as though each case will be reviewed or analyzed by outside entities such as quality assurance auditors, risk management, or attorneys.**

IMPACTS OF CODING & DOCUMENTATION ON QUALITY

Documentation/ Coding

- Complication Coding



Quality Measures

- Patient Safety Indicator



PATIENT SAFETY INDICATORS

- Initially released in 2003 by the Agency for Healthcare Research and Quality (AHRQ)



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

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Patient Safety Indicators Overview

What are Patient Safety Indicators?

The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

How are Patient Safety Indicators used?

The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

WHY SHOULD I CARE ABOUT PSI REPORTING

- Financial penalty
- PSIs are also used by CMS/Hospital Compare and reported publicly as evidence of quality outcomes in hospitals.
- Leapfrog uses this data to assign quality scores to hospitals



PATIENT SAFETY INDICATORS

- PSI 02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)
- PSI 03 Pressure Ulcer Rate - PSI 90
- PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Conditions
- PSI 05 Retained Surgical Item or Unretrieved Device Fragment Count
- PSI 06 Iatrogenic Pneumothorax Rate - PSI 90
- PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
- PSI 08 In Hospital Fall with Hip Fracture Rate - PSI 90
- PSI 09 Perioperative Hemorrhage or Hematoma Rate - PSI 90
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis - PSI 90
- PSI 11 Postoperative Respiratory Failure Rate - PSI 90
- PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate - PSI 90
- PSI 13 Postoperative Sepsis Rate - PSI 90
- PSI 14 Postoperative Wound Dehiscence Rate - PSI 90
- PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate - PSI 90
- PSI 16 Transfusion Reaction Count
- PSI 17 Birth Trauma Rate - Injury to Neonate
- PSI 18 Obstetric Trauma Rate - Vaginal Delivery With Instrument
- PSI 19 Obstetric Trauma Rate-Vaginal Delivery Without Instrument
- PSI 21 Retained Surgical Item or Unretrieved Device Fragment Rate
- PSI 22 Iatrogenic Pneumothorax Rate
- PSI 23 Central Venous Catheter-Related Blood Stream Infection Rate
- PSI 24 Postoperative Wound Dehiscence Rate
- PSI 25 Accidental Puncture or Laceration Rate
- PSI 26 Transfusion Reaction Rate
- PSI 27 Perioperative Hemorrhage or Hematoma Rate
- **PSI 90 Patient Safety for Selected Indicators**

COMPLICATION CODING



ICD-10 OFFICIAL GUIDELINES – COMPLICATIONS OF CARE

Documentation of Complications of Care

- Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a **cause-and-effect relationship** between the care provided and the condition, and an **indication in the documentation that it is a complication**. Query the provider for clarification, if the complication is not clearly documented.
- ICD-10-CM Official Guidelines for Coding and Reporting
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INDICATION FOR COMPLICATION

- Is there a deviation from the normal postoperative course?
 - **Example:** transferred to ICU post op, increased LOS
- Could the condition be considered **inherent** to the procedure? (Occurring routinely in similar cases?)
 - **Example:** Serosal Tear part of adhesiolysis
- Is the condition **commonly expected** after the specific procedure?
 - **Example:** Expected ileus after bowel resection
- Is the condition **present prior to** the procedure?
 - **Example:** Atrial Fibrillation that happened in the post operative setting
 - Is this a pre-existing condition, or did this happen as a direct result of treatment?

CAUSE-AND-EFFECT RELATIONSHIP

Determine whether
condition is:

- ⦿ Direct result of surgery
- ⦿ Result of pre-existing condition
- ⦿ Other cause



Commonly documented terms that may or may not indicate direct relations to surgery:

- ⦿ due to
- ⦿ Associated with
- ⦿ secondary to
- ⦿ caused by
- ⦿ Postoperative
- ⦿ following
- ⦿ after
- ⦿ status post
- ⦿ in the setting of

ACCIDENTAL PUNCTURE/LACERATION

- ◉ Major changes to PSI 15 effective July 2016
- ◉ Previously titled - Accidental Puncture or Laceration Rate
- ◉ Revised title - Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

Numerator

- ◉ Secondary diagnosis of accidental puncture/laceration during a procedure **and** a second procedure ≥ 1 day after the initial abdominopelvic procedure

Denominator

- ◉ Procedure code with an ICD-10-PCS for abdominopelvic.

Exclusions

- ◉ Principal diagnosis of accidental puncture/laceration during a procedure

Secondary diagnosis of accidental puncture/laceration during a procedure - that is Present on admission

Obstetric cases



ACCIDENTAL PUNCTURE/ LACERATION

- Is the puncture/laceration inherent/integral to the procedure due to disease such as adhesions?
- Is the puncture/laceration an unexpected outcome of the procedure?



GUIDANCE - AMERICAN COLLEGE OF SURGEONS

The ACS encourages surgeons to carefully word operative reports to make clear whether a puncture or incision is accidental or expected. If the “injury” to a structure is expected, then the surgeon should use language such as:

- ⦿ “The adjacent organ was densely adherent to the tumor. In order to obtain adequate margin around the malignancy, the serosal surface was necessarily incised and removed, and the defect was closed.”
- ⦿ “Adhesiolysis was difficult. As expected, multiple serosal tears and full thickness enterotomies were created during mobilization of the bowel, then were repaired with....”
- ⦿ “At this point in the operation, entry into the normal adjacent bowel was unavoidable. This segment of bowel was resected and reanastomosed in two layers.”

TIPS FOR SUCCESS

- ◉ Collaboration with surgeons to determine what is expected with specific surgeries and what might be considered a complication
- ◉ Collaboration of Coding & CDI to ensure documentation of complications is clearly documented in the medical record and compliant with coding guidelines
- ◉ Collaboration with Quality to ensure accurate reporting of surgical complications



WHEN IN DOUBT...QUERY!



Was the
puncture/laceration an
incidental occurrence
inherent in the surgical
procedure?

or

Is the
puncture/laceration a
complication of the
procedure?

REFERENCES

[American College of Surgeons -“Reporting Patient Safety indicator-15”](#)

[. http://bulletin.facs.org/2014/05/reporting-patient-safety-indicator-15/](http://bulletin.facs.org/2014/05/reporting-patient-safety-indicator-15/)

Inaccuracy in Hospital Surgical Coding .

The Bulletin 91 (4) April 2009, pp. 142-144

DOI: <http://dx.doi.org/10.1308/147363508X371390>

Published online: June 16, 2015

Wilbanks, Bryan; DNP, CRNA; Geisz-Everson, Marjorie; PhD, CRNA; Boust, Rebecca; MSNA, CRNA

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A Descriptive Qualitative Study. *CIN: Computers, Informatics, Nursing.*

34(9):406-412, September 2016.

DOI: 10.1097/CIN.0000000000000270

Guidelines for Achieving a Compliant Query Practice, Practice Brief,

<http://www.hcpro.com/content/289883.pdf>

3M Coding and Reimbursement System v6.30 Jan SP2 2017

Querying for clinical validation of a diagnosis, *CDI Strategies*, August 29, 2013

<http://www.hcpro.com/HIM-295777-5707/QA-Querying-for-clinical-validation-of-a-diagnosis.html>

NWH PEPPER Report FY 2014-2016

REFERENCES CONTINUED

<http://www.outsourcestrategies.com/blog/2016/08/coding-post-operative-complications-with-icd-10.html>

<http://campus.ahima.org/audio/2007/RB051707.pdf>

<https://engage.ahima.org/communities/community-home/digestviewer/viewthread?GroupId=19&MID=3594>

<http://journal.ahima.org/2013/02/01/physician-query-examples/>

<http://www.icd10monitor.com/enews/item/1599-postoperative-complications-it-s-complicated>

<https://www.cms.gov/icd10manual/fullcode/cms/P0372.html>

<http://www.leapfroggroup.org/compare-hospitals>

<http://www.hospitalsafetygrade.org/your-hospitals-safety-grade>

<https://www.healthgrades.com/>

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/b4-documentationcoding.pdf>

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