Physician Education in Clinical Documentation Improvement:

Accurately Documenting and Supporting Diagnoses in the Delivery of Medically Necessary and Appropriate Healthcare

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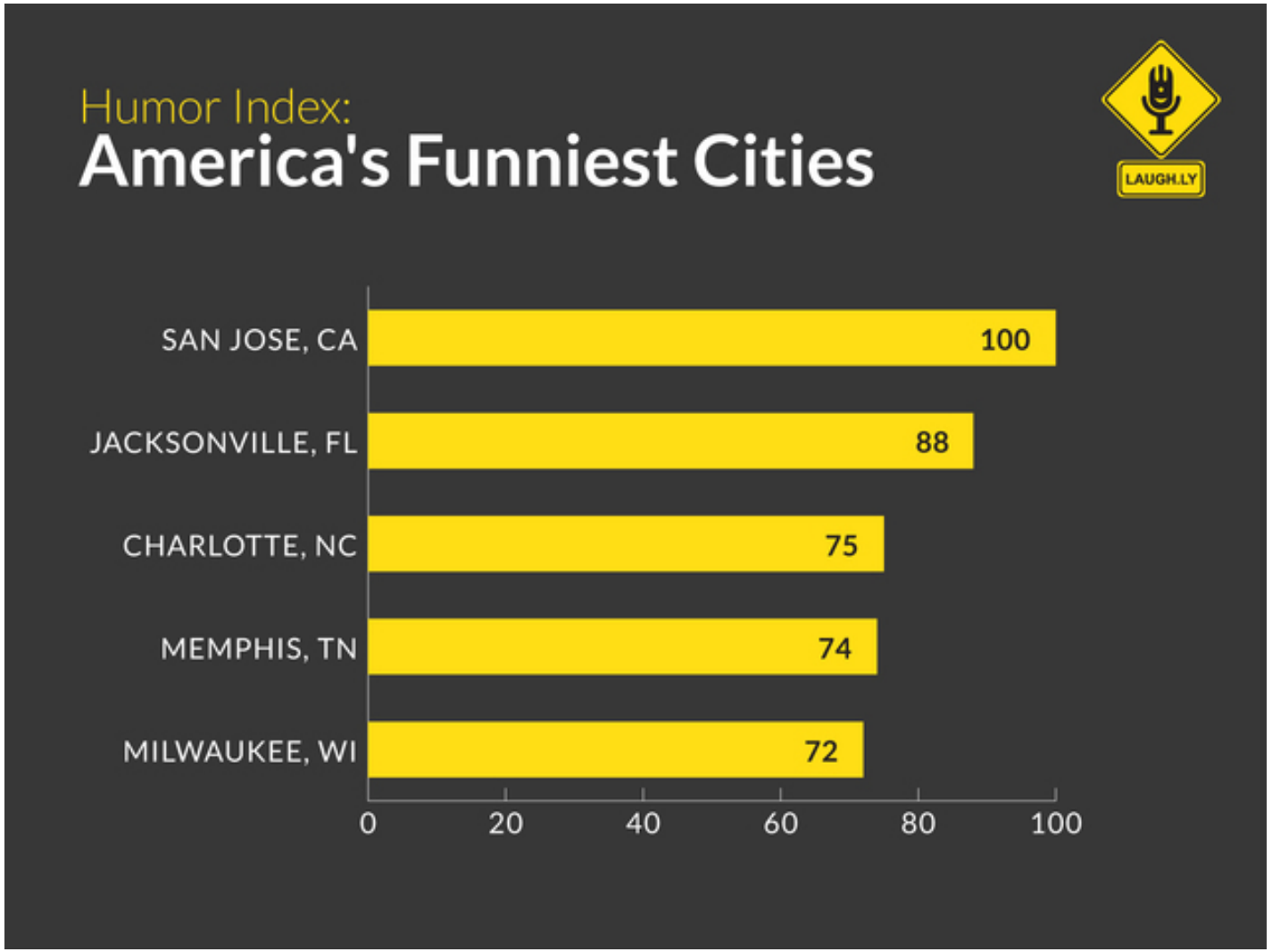
Revenue Cycle and Institute for Population Health

Texas Health Resources®

Lost in Middle America

The Best…


Humor Index:
America's Funniest Cities
LAUGH.LY
SAN JOSE, CA
100
JACKSONVILLE, FL
88
CHARLOTTE, NC
75
MEMPHIS, TN
74
MILWAUKEE, WI
72
0
20
40
60
80
100

The Worse…


Humor Index:
America's Least Funny Cities
LAUGH.LY
WASHINGTON D.C.
29
PHOENIX, AZ
28
MIAMI, FL
23
PITTSBURGH, PA
21
CINCINNATI, OH
19
0
5
10
15
20
25
30

Oh, And We Have Weather TOO…

Identification of Problematic Physician Documentation

1. Internal source THR-specific
2. PEPPER
3. National Data
4. Targeted Audits
5. Denials

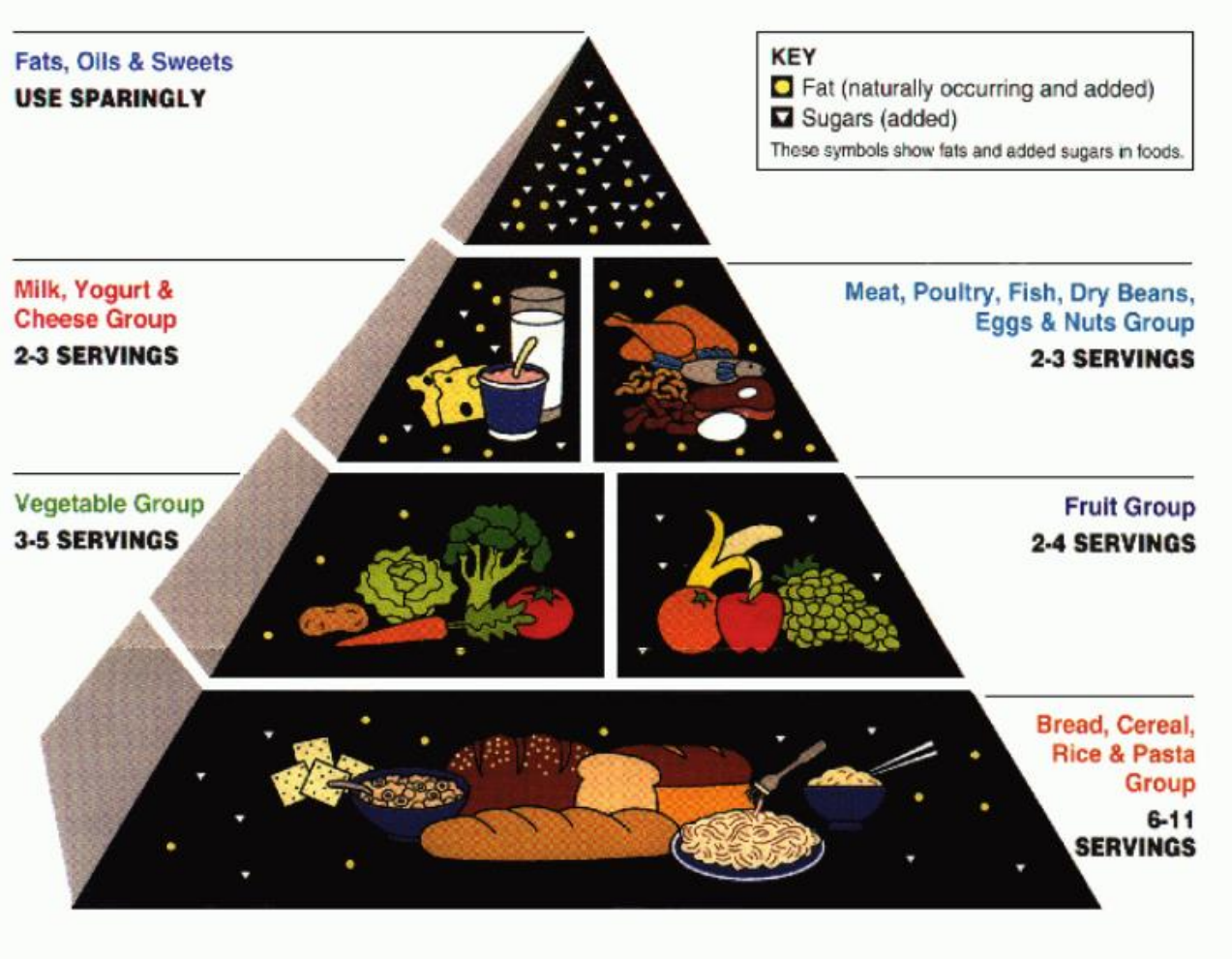
High Risk Physician Documentation

1. Cut and paste
2. Carry forward
3. Voice-to-text and dictation
4. Observation services indications
5. Short stay inpatient admissions

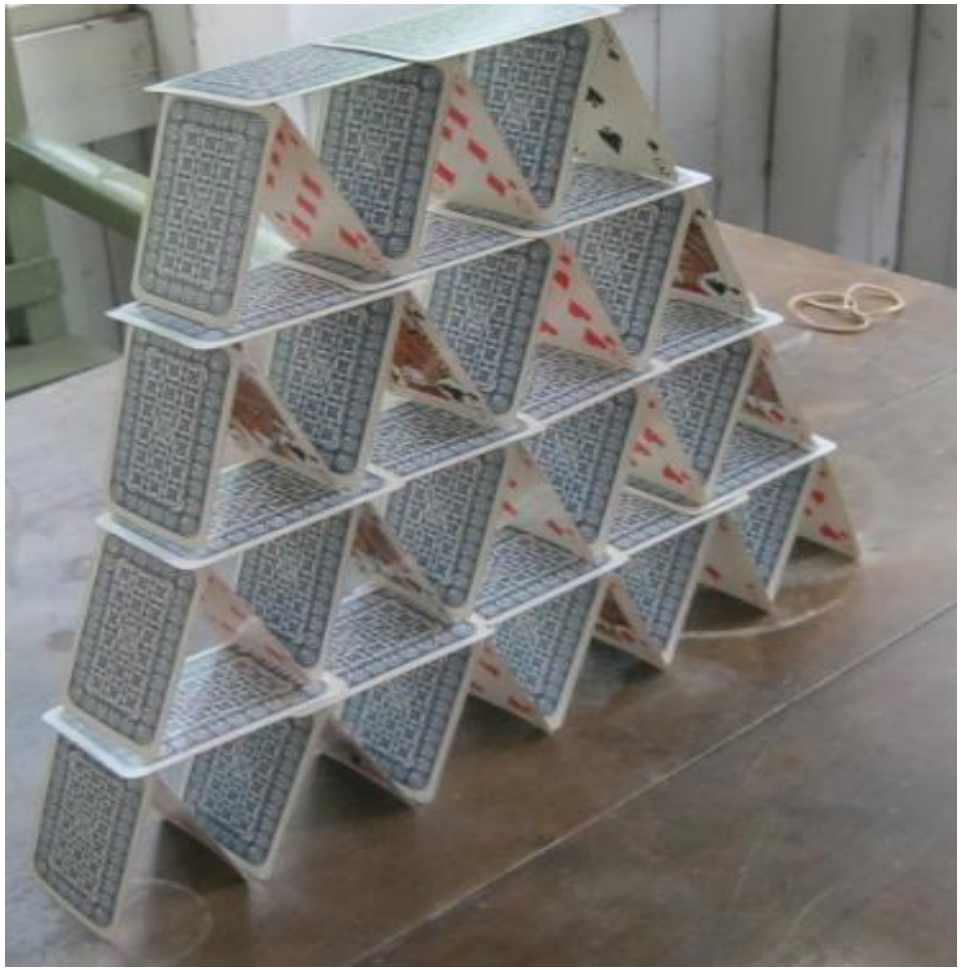
Documentation Connection Between Diagnoses and Medical Necessity

- Supports that services are reasonable and medically necessary to the diagnosis made and/or treatment of that medical condition
- Shows evaluating, diagnosing, or treating an illness, injury, or disease, is in accordance with accepted standards
- Diagnosis reported supports the medical necessity of services

Valid Diagnoses: Foundation of Medical Necessity for Hospitalization - The Bread and Pasta of Medically Necessary Services



Valid Diagnoses



Unsupported Diagnoses = Invalid Diagnosis = Non-Medically Necessary Service

Providing Non-Medically Necessary Services

1. Harm to patient
2. Billing
   - Violation of payer contract
   - Violation of the False Claims Act

Most Common DRG Diagnoses for Hospitalization

1. Heart Failure
2. Pneumonia
3. Sepsis
4. Acute Respiratory Failure
5. Acute Kidney Injury
6. Encephalopathy
7. Chest Pain
8. Syncope/Near Syncope

General Principles for Physician Documentation

1. Differential Diagnoses
2. Physical exam findings for the diagnoses
3. Supported by key objective findings
4. Link the data together
5. Consistent with recognized clinical criteria
6. More accurate and detailed as evaluation progresses
7. Documentation indicates further evaluation and treatment driven by differential diagnoses
8. Avoid irrelevant, static, and non-urgent medical problems not impacting or impacted by diagnoses

Heart Failure

1. Key subjective symptoms reported? Physical exam findings? Targeted lab evaluation? Radiologic exams?
2. POA? Type? Acuity? What cause or condition?
3. Tie it together

Example: Acute decompensated HF with diastolic dysfunction and preserved ejection fraction (or HFpEF) with BNP 0f 2,000. POA due to non-compliance with recently prescribed diuretics and diet.

Acute Respiratory Failure: Details, details, details…

Type?

1: hypoxia without hypercarbia

2: hypercarbia

3: acute post operative

4: shock

Community Acquired Pneumonia

Must have:

- Chest Xray indicating new infiltrate(s), consolidation, cavitation, or diffuse abnormality not explained by HF

AND

Supporting Signs, symptoms, vital signs, physical exam findings:

- SOB, cough, pleuritic chest pain, new onset functional and cognitive decline
- Temp > 100
- Tachypnea
- Crackles, rhonchi, isolated decreased breath sounds

Community Acquired Pneumonia

Supporting:

- Leukocytosis with left shift/bandemia
- Arterial blood gas abnormalities
- Specific urine antigen titers

Not Helpful:

- Procalcitonin
- Routine sputum and blood cultures

Acute Respiratory Failure

1. Suspected, probable, likely: to start
2. Expect more concise diagnosis to evolve as result of evaluation and treatment guided by differential diagnosis
3. Supported diagnosis supports medical necessity

Example: Acute respiratory failure likely due to pneumonia, might later be documented as: 80 year old female with Acute hypoxemic respiratory failure from left lower lobe CAP pneumonia due Streptococcus pneumoniae. CURB-65 score of 3 and PSI of 90: medically necessary hospitalization for treatment.

Sepsis

1. SEP-2 criteria
2. Must identify new infection and likely source(s)

   AND
3. At least 2 SIRS criteria:
   a. Temp > 100.4
   b. RR > 20 or PaCO2 < 32mmHg
   c. HR > 90/min
   d. WBC >12k or <4k or Bandemia > 10%

Sepsis

Tie it together:

Severe Sepsis – SIRS due to E.coli from urinary tract source. Tachycardia, temp of 102.5, leukocytosis with left shift, lactic acidosis with lactate of 4.5. Hypotension of 80 mm Hg systolic responsive to IV NS 2 liters.

Cut and Paste Physician Documentation

1. Leaves doubt that the true clinical picture and/or progress is reflected
2. Can suggest that testing and therapy is ordered and delivered but is not utilized to determine diagnosis or guide therapy
3. Does not reflect complex decision making
4. Targeted by commercial payers and the government
5. Results in quick, easy, and expensive settlements
6. Is not your friend

Problem: Voice-to-Text Dictation Documentation

1. Uncorrected, may not reflect true clinical picture
2. Uncorrected, may not make sense and confusing
3. Uncorrected, can lead to unintended interpretation and inaccuracies
4. Disclaimer even worse

What Are We Doing to Support Improvement in Physician Documentation?

Touch points:

1. Observation reviews
2. InBasket messaging
3. Hospitalist group talks/lectures/discussions with feedback
4. Individual physician discussions
5. Targeted physician outlier interventions/referral to CMO and physician leadership
6. Feedback from DRG validation denials from payers
7. Video podcast series with CME credit available

CDI Video Podcast Series

Purpose Statement:

The Clinical Documentation Improvement video podcast series is designed to review key clinical indicators and other information for healthcare providers, necessary for accurate and concise documentation that reflects and supports valid diagnoses consistent with recognized criteria.

CDI Video Podcast Series

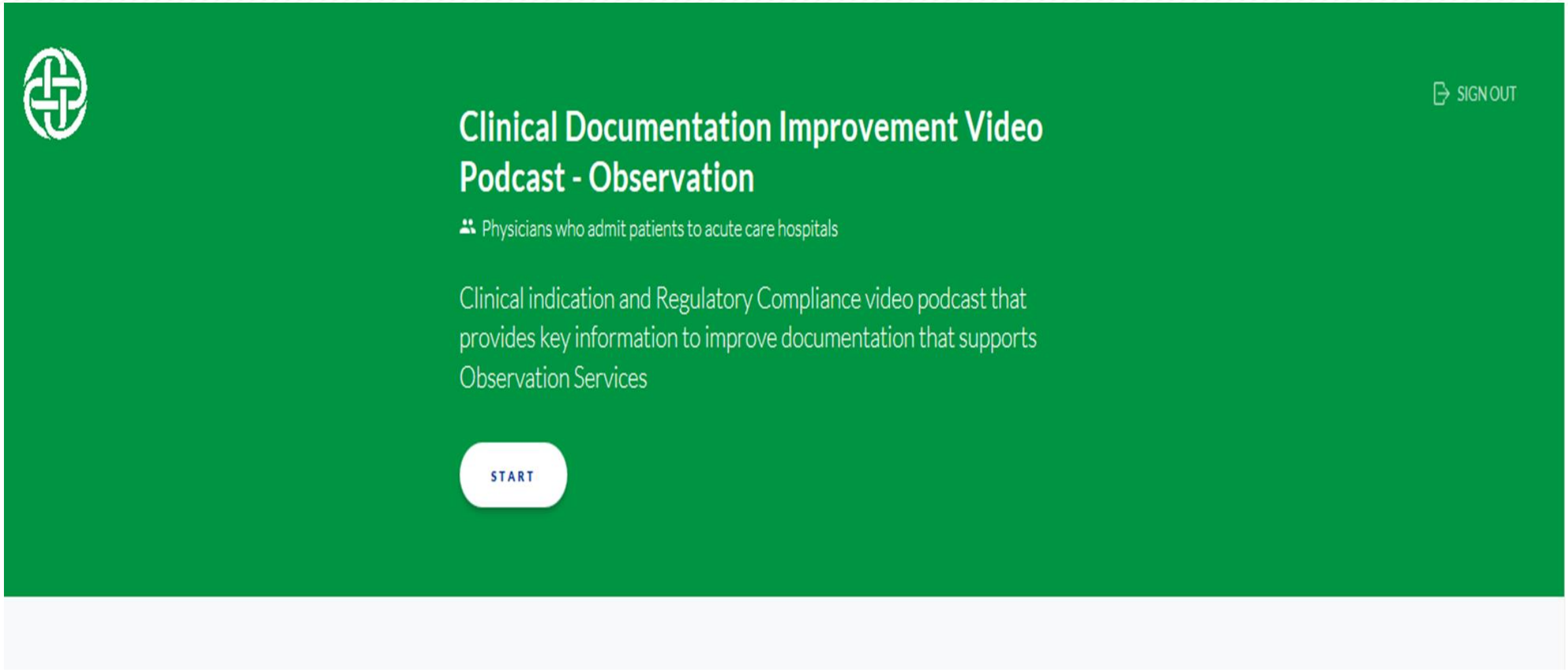
- Topics:
- The most frequently diagnosed medical illnesses of patients who present to an acute care hospital for evaluation and treatment, interspersed with a few key regulatory compliance topics

DRG Diagnoses CDI Podcast Topics

1. Heart Failure
2. Sepsis
3. Encephalopathy
4. Community Acquired Pneumonia
5. Malnutrition
6. Acute Respiratory Failure
7. Near Syncope/Syncope
8. Chest Pain
9. Pulmonary Embolism
10. TIA/Stroke
11. Atrial Fibrillation
12. GI Hemorrhage
13. Anemia
14. Acute Kidney Injury
15. Failure to Thrive
16. Dizziness/Vertigo
17. Renal Replacement Therapy
18. Post-op Respiratory Failure

CDI Video Podcast Series

- What does it look like? Go to TexasHealth.org/CDI
- A few learning objectives
- 13-16 minute video podcast – listen or listen and watch
- CME Credit: Following each 13 to 16 minute video podcast is a unique CME link. Click on the link, answer a few questions, and complete an evaluation to obtain CME credit.
- 0.25 hour free AMA PRA Category 1 Credit™ for each topic.


SIGN OUT
Clinical Documentation Improvement Video Podcast - Observation
Physicians who admit patients to acute care hospitals
Clinical indication and Regulatory Compliance video podcast that provides key information to improve documentation that supports Observation Services
START

Section 1 of 1

Observation Services

Page 1 of 3

Learning Objectives

Upon completion of this activity, the participants should be able to:

- Review the difference between patient status and services
- Explain the limited ability to change the status of an inpatient
- Discuss appropriate methods to stop observation services

Video

Instructions for CME Credit

To obtain .25 hours of CME credit you must complete a short quiz and evaluation. Click **here** to sign in or create a new user account.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Key Physician Education Points

1. Valid DRG Diagnosis is the foundation of further evaluation, treatment, appropriate disposition, and accurate coding.
2. Diagnosis must be reflective of, and consistent with, established clinical criteria
3. Listing of symptoms is not a substitute for a valid DRG diagnosis.
4. Goal is for clinical documentation to accurately reflect clinical status and support valid diagnoses.
5. Changing physician behavior requires multi-modal education, specific and targeted intervention when appropriate, aligned incentives, a lot of time, and it can get messy.