Our CDI Impact on Quality Metrics

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Verbalize agencies that receive quality data
  - List quality committee organizational stakeholders
  - Discuss possible reasons for poor quality scores
  - Describe quality, CDI auditor process
  - Verbalize understanding of reporting exclusions
  - Describe admission types and their impact on quality reporting
  - Write queries that impact quality reporting
  - List components of PSI-90
  - Describe 4 major components of PSI-90

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Quality: More Than Providing Excellent Care

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Quality: Who Gathers Data?

- Hospitals – to ensure quality care
- State agencies – to compare performance data between hospitals
- Insurers – to compare hospital performance and cost
- The Center for Medicare & Medicaid Services (CMS)
  - Hospital Compare website – to assist consumers with making informed decisions for care
  - Hospital Value-Based Purchasing Program
    - Reduces hospital payment by 2% yearly
    - Average performance: 2% back
    - Below average: lose 2%
    - Above average: 2% back + additional 2%
  - Hospital Readmissions Reduction Program
    - Reduces payments for excess readmissions
    - Acute MI, heart failure, pneumonia, COPD, CABG, elective hip/knee replacements
    - ANY readmission to ANY acute care hospital within 30 days
    - Maximum penalty 3% per year
  - Hospital-Acquired Condition Reduction Program
    - Creates an incentive for hospitals to reduce certain hospital-acquired conditions by reducing payment by 1% for those hospitals that rank in the worst performing quartile (worst 25%)
    - CMS PSI-90 **(coded data)**
    - CDC Hospital Acquired Infection (HAI) measures **(abstracted data)**

(Centers for Medicare & Medicaid Services [CMS], 2023)

- The Leapfrog Group – non-profit "watchdog" agency

(The Leapfrog Group, 2023)

The Challenge: Is Our Quality Reporting Accurate?

Quality Metrics Were Not as Expected

- Corporate Chief Medical Officer (CMO) created work group
  - Corporate and hospital CMOs
  - Corporate risk management
  - Hospital quality directors
  - Corporate CDI
  - Corporate coding
- Evaluation
  - Clinical care: Best practice evidence-based procedures in place and monitored
  - Coding: Accurate based on official guidelines for coding and reporting
  - Documentation: Opportunity noted for increased documentation specificity
  - Registration status: Interpreted differently across system

Discovery Phase: Process

- **Case prioritized for CDI review**
  - CDI specialist sends query concurrently to clarify if a complication exists
    - Diverse experience and skill level
  - Physician clarifies diagnosis
    - Appropriateness of responses varies
- **Record coded after discharge**
  - Coders use list of internally selected ICD 10 codes to initiate hold on bill and enter information into database for facility personnel
    - Quality director
    - CMO
    - HIMD
  - Facility personnel review records and give opinion
    - “Coding incorrect”
    - Inherent to procedure
    - Exclusions not consistently considered

Process Challenges

- **Variance!**
  - Inconsistent process across 40 acute care hospitals
    - Some hospitals had regularly scheduled meetings for record reviews
    - Some hospitals had “hit or miss” meetings
  - Inconsistent stakeholders
    - Some included coding, CMO, and quality directors
    - Some included quality director and CMO
    - Some included quality director and physician advisor
    - None included CDI specialists
  - Inconsistent level of understanding of quality reporting requirements
    - Guidelines inconsistently applied
  - Inconsistent level of understanding of coding requirements and guidelines
    - Disconnect between clinical knowledge and code assignment
  - Inconsistent documentation by providers
    - Providers document for communication with other providers
  - No formal procedure for determining registration status

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Corrective Actions: Creating a Cohesive Process

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Corrective Actions

- Include CDI in discussions and process planning
- CDI review of all mortalities
- Adjust CDI prioritization software to ensure second-level review of mortalities
- Institute “CDI-Coder Buddy System”
- “Ask an Auditor” process implemented
- Update list of ICD 10 codes requiring bill hold with automated second level analysis in place
- Research and provide definitions of registration types
- Create new system-wide process for HAC/PSI reviews utilizing available software and FTEs
- Gain buy-in from **all** stakeholders!

Implementation of New Process

- CDI auditors tasked with HAC/PSI reviews
  - Created a group mailbox
  - Schedule crafted
  - Created homegrown database to monitor and trend HAC/PSI referrals
- EDUCATION
  - Coders
  - Quality directors
  - CMOs
  - CDI auditors
  - CDI specialists
  - Business office
  - Registration
- Provider education
  - Onsite
  - Via webinar
    - CME

PSI 90 Sample Results From Eight Facilities

Acute Care Hospitals	2022 PSI Number (Rate per 1,000)	2021 PSI Number (Rate per 1,000)
Facility 1	6 (0.21)	14 (0.40)
Facility 2	6 (0.42)	12 (0.72)
Facility 3	7 (0.46)	14 (0.82)
Facility 4	10 (0.53)	20 (0.76)
Facility 5	9 (0.63)	13 (0.69)
Facility 6	5 (0.27)	16 (0.66)
Facility 7	14 (0.56)	19 (0.56)
Facility 8	13 (0.38)	29 (0.66)

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How to Navigate a PSI Review

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Registration Types

- **Emergent**: An admission where the absence of immediate medical attention could result in a severe life-threatening or possibly disabling condition. Generally, emergent patients are admitted through the emergency department.

- **Urgent**: An admission for a medical condition that could become an emergency if not diagnosed or treated in a timely manner but where the patient's condition is stable enough to slow a short delay. Generally, an urgent admission should occur within 14 days and because of the urgency, the admission is arranged for the first available and suitable accommodation.

- **Elective**: An admission which is scheduled in advance and for which a delay in the delivery of medical treatments or diagnosis would not substantially affect the health or safety of the patient.

- **Trauma**: An admission that results from trauma activation and the patient being admitted for further evaluation and treatment.

- **Newborn**: An admission resulting from delivery either inside or outside the admitting hospital.

(Association of Clinical Documentation Integrity Specialists [ACDIS], 2022)

Present on Admission (POA) Status

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator.
N	Diagnosis was not present at time of inpatient admission. CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.

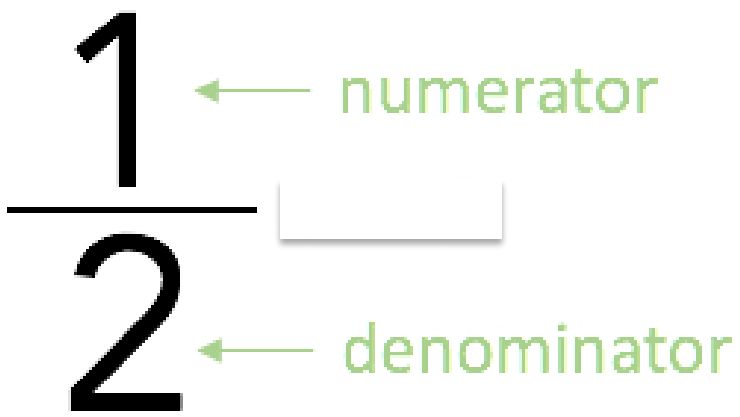
(Centers for Medicare & Medicaid Services [CMS], 2023)

Demographics and Coding: Inclusion Criteria

- Commonly referred to as numerator
- Age
- Major Diagnostic Category (MDC)
- DRG type
  - Medical/Surgical
- Length of stay
- Surgical procedures performed
  - PCS codes
  - Specificity is critically important
- ICD 10 code
  - Accuracy is critically important
  - Ex. Specific vessel identified; site accurate

Demographics and Coding: Exclusion Criteria

- Commonly referred to as denominator
- Present on admission status
- Secondary diagnoses
  - May require query for relationship
  - May require query for additional diagnoses
- Secondary procedures
  - May require multiple procedure codes



- **Very specific to each PSI**
- **Updated annually July 1st**

https://qualityindicators.ahrq.gov/measures/PSI_TechSpec

PSI-90 MEASURES (claims-based):

- PSI-03 Pressure ulcer (13%)
- PSI-06 Iatrogenic pneumothorax (4%)
- PSI-08 In-hospital fall with hip fracture (1%)
- PSI-09 Perioperative hemorrhage and hematoma (4%)
- PSI-10 Postoperative acute kidney injury (8%)
- PSI-11 Postoperative respiratory failure (21%)
- PSI-12 Perioperative pulmonary embolism or DVT (19%)
- PSI-13 Postoperative sepsis (25%)
- PSI-14 Postoperative wound dehiscence (<1%)
- PSI-15 Unrecognized abdominopelvic accidental puncture/laceration (4%)

Four measures responsible for 78% of score

- **Pressure ulcer**
- **Postoperative respiratory failure**
- **Postoperative sepsis**
- **Perioperative PE/DVT**

(Agency for Healthcare Research and Quality [AHRQ], 2023)

PSI 03: Pressure Ulcer Rate

- **Numerator:** Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis code not present on admission for stage 3 or 4 (or unstageable) pressure ulcer (PI~D*), in the absence of a secondary ICD-10-CM diagnosis code present on admission for deep tissue injury or unstageable pressure injury (DTI~EXD) at the same anatomic site.
- **Denominator:** All medical and surgical discharges for patients ages 18 years and older
- **DENOMINATOR EXCLUSIONS**
  - with length of stay of less than 3 days •
  - with a principal ICD-10-CM diagnosis code for site-specific pressure ulcer stage 3 or 4 (or unstageable) or deep tissue injury at the same anatomic site (PI~EXD)
  - with any ICD-10-CM diagnosis code for severe burns (≥20% body surface area) (BURNDX)
  - with any ICD-10-CM diagnosis code for exfoliative disorders of the skin (≥20% body surface area) (EXFOLIATXD)
  - MDC 14 (pregnancy, childbirth, and puerperium)
  - MDC 15 (newborns and other neonates with conditions originating in perinatal period)
  - with an ungroupable DRG (DRG=999)
  - with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
  - with missing MDC (MDC=missing) when the user indicates that MDC is provided

(AHRQ, 2023)

Exfoliative skin disorder diagnosis codes: (EXFOLIATXD)

L492	Exfoliation due to erythematous condition involving 20-29 percent of body surface	L496	Exfoliation due to erythematous condition involving 60-69 percent of body surface
L493	Exfoliation due to erythematous condition involving 30-39 percent of body surface	L497	Exfoliation due to erythematous condition involving 70-79 percent of body surface
L494	Exfoliation due to erythematous condition involving 40-49 percent of body surface	L498	Exfoliation due to erythematous condition involving 80-89 percent of body surface
L495	Exfoliation due to erythematous condition involving 50-59 percent of body surface	L499	Exfoliation due to erythematous condition involving 90 or more percent of body surface

(AHRQ, 2023)

Pressure Ulcer Documentation Considerations for CDI

- Provider must document that a pressure ulcer/injury exists, its location, and POA status

Staging may be coded from wound care notes

  - If provider contradicts, a query is required

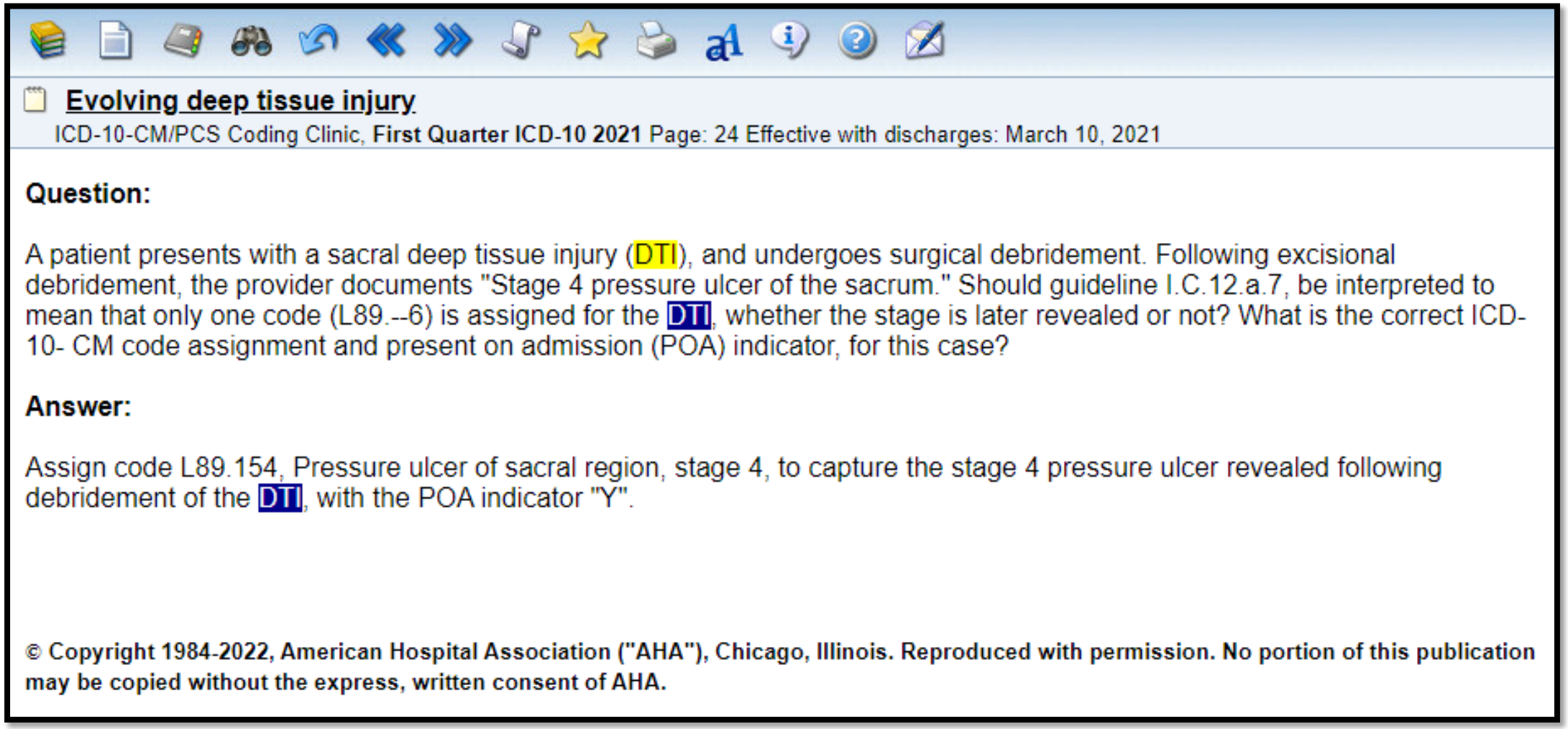
Determine if was POA

  - Look at nursing admission assessment, ER notes, transfer documentation
  - Query if unclear

Evaluate for possible exclusion criteria

  - Burns
  - Exfoliative skin disorder
  - Obstetric case
  - Patient younger than 18 years old
  - Stay less than 3 days

Coding Clinic



Evolving deep tissue injury

ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2021** Page: 24 Effective with discharges: March 10, 2021

Question:

A patient presents with a sacral deep tissue injury (DTI), and undergoes surgical debridement. Following excisional debridement, the provider documents "Stage 4 pressure ulcer of the sacrum." Should guideline I.C.12.a.7, be interpreted to mean that only one code (L89.--6) is assigned for the DTI, whether the stage is later revealed or not? What is the correct ICD-10- CM code assignment and present on admission (POA) indicator, for this case?

Answer:

Assign code L89.154, Pressure ulcer of sacral region, stage 4, to capture the stage 4 pressure ulcer revealed following debridement of the DTI, with the POA indicator "Y".

PSI 11: Postoperative Respiratory Failure Rate

- **Numerator:** Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either:
  - any secondary ICD-10-CM diagnosis code of acute postprocedural respiratory failure (ACURF2D)
  - the last date of an ICD-10-PCS procedure code for a mechanical ventilation for greater than 96 consecutive hours (PR9672P) is zero or more days after the first major operating room procedure, if the dates of both procedures are available
  - the last date of an ICD-10-PCS procedure code for a mechanical ventilation for 24 - 96 consecutive hours (PR9671P) is **two or more days after the first major operating room** procedure, if the dates of both procedures are available
  - the last date of any ICD-10-PCS procedure code for an intubation (PR9604P) is one or more days after the first major operating room procedure, if the dates of both procedures are available
- **Denominator:** Elective surgical discharges (Appendix E: SURGI2R) for patients ages 18 years and older, with any listed ICD-10-PCS procedure code for an operating room procedure (Appendix A: ORPROC) . Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective (SID ATYPE=3).

Denominator Exclusions

- with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) of acute respiratory failure (ACURF3D)
- with any listed ICD-10-CM diagnosis code present on admission for tracheostomy (TRACHID)
- where the only operating room procedure is tracheostomy (TRACHIP)
- where a procedure for tracheostomy (TRACHIP) occurs before the first operating room procedure (Appendix A: ORPROC) , if the dates of both procedures are available
- with any listed ICD-10-CM diagnosis code for malignant hyperthermia (MALHYPD)
- with any listed ICD-10-CM diagnosis code present on admission for neuromuscular disorder (NEUROMD)
- with any listed ICD-10-CM diagnosis code present on admission for degenerative neurological disorder (DGNEUID)
- with any listed ICD-10-PCS procedure code for laryngeal, pharyngeal, nose, mouth, or facial surgery involving significant risk of airway compromise (NUCRANP)
- with any listed ICD-10-PCS procedure code for esophageal surgery (PRESOPP)
- with any listed ICD-10-PCS procedure code for lung cancer (LUNGCIP)
- with any listed ICD-10-PCS procedure code for lung or heart transplant (LUNGTRANSP)
- MDC 4 (diseases/disorders of respiratory system)
- MDC 14 (pregnancy, childbirth, and puerperium)
- MDC 15 (newborns and other neonates with conditions originating in perinatal period)
- with an ungroupable DRG (DRG=999)
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
- with missing MDC (MDC=missing) when the user indicates that MDC is provided

Neuromuscular Disorder Diagnosis **Sample**

Neuromuscular disorder diagnosis codes: (NEUROMD)

G610	Guillain-Barre syndrome	G7289	Other specified myopathies
G7000	Myasthenia gravis without (acute) exacerbation	G729	Myopathy, unspecified
G7001	Myasthenia gravis with (acute) exacerbation	G731	Lambert-Eaton syndrome in neoplastic disease
G701	Toxic myoneural disorders	G733	Myasthenic syndromes in other diseases classified elsewhere
G702	Congenital and developmental myasthenia	G737	Myopathy in diseases classified elsewhere
G7080	Lambert-Eaton syndrome, unspecified	M0540	Rheumatoid myopathy with rheumatoid arthritis of unspecified site
G7081	Lambert-Eaton syndrome in disease classified elsewhere	M05411	Rheumatoid myopathy with rheumatoid arthritis of right shoulder
G7089	Other specified myoneural disorders	M05412	Rheumatoid myopathy with rheumatoid arthritis of left shoulder
G709	Myoneural disorder, unspecified	M05419	Rheumatoid myopathy with rheumatoid arthritis of unspecified shoulder
G710	Muscular dystrophy	M05421	Rheumatoid myopathy with rheumatoid arthritis of right elbow
G7100	Muscular dystrophy, unspecified	M05422	Rheumatoid myopathy with rheumatoid arthritis of left elbow

(AHRQ, 2023)

Degenerative neurological disorder diagnosis codes: (DGNEUID)

F0150	Vascular dementia without behavioral disturbance	F09	Unspecified mental disorder due to known physiological condition
F0151	Vascular dementia with behavioral disturbance	F482	Pseudobulbar affect
F0280	Dementia in other diseases classified elsewhere without behavioral disturbance	G300	Alzheimer's disease with early onset
F0281	Dementia in other diseases classified elsewhere with behavioral disturbance	G301	Alzheimer's disease with late onset
F0390	Unspecified dementia without behavioral disturbance	G308	Other alzheimer's disease
F04	Amnestic disorder due to known physiological condition	G309	Alzheimer's disease, unspecified
F05	Delirium due to known physiological condition	G3101	Pick's disease
F060	Psychotic disorder with hallucinations due to known physiological condition	G3109	Other frontotemporal dementia
F061	Catatonic disorder due to known physiological condition	G311	Senile degeneration of brain, not elsewhere classified
F068	Other specified mental disorders due to known physiological condition	G3183	Dementia with lewy bodies
F070	Personality change due to known physiological condition	G3185	Corticobasal degeneration
F0789	Other personality and behavioral disorders due to known physiological condition	G9382	Brain death
F079	Unspecified personality and behavioral disorder due to known physiological condition		

(AHRQ, 2023)

Postoperative Respiratory Failure Documentation: Considerations For CDI

- Is this an urgent or emergent admission?
- Does NOT include Acute Respiratory Failure codes J96-
  - Must have postoperative/postprocedural respiratory failure documented (J95.821)
- May include procedures done outside of an operating room (Appendix A)
  - Examples of **included** procedures
    - 0FB03ZZ Excision of liver, percutaneous approach
    - 0BBJ3ZZ Excision of left lower lung lobe, percutaneous approach
  - Example of **excluded** procedure
    - 0BBJ3ZX Excision of left lower lung lobe, percutaneous approach, diagnostic
- Clarify if respiratory failure is due to surgery or pre-existing condition
  - COPD, obesity hypoventilation, CHF, etc.
- Check ventilator settings (is it respiratory failure or is it airway protection?)
- Clarify any neurological disorders
  - Dementia, delirium due to known physiological condition, brain death, Alzheimer's
- Clarify any neuromuscular disorders
  - Myasthenia gravis, critical illness myopathy, inclusion body myositis
- Does the pdx fall into the respiratory major diagnostic category (MDC 4)?

(AHRQ, 2023)

PSI 12: Perioperative Pulmonary Embolism or DVT Rate

- **Numerator:** Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with a secondary ICD10-CM diagnosis code for proximal deep vein thrombosis (DEEPVIB) or a secondary ICD-10-CM diagnosis code for pulmonary embolism (PULMOID).

- **Denominator:** Surgical discharges, (Appendix E: SURGI2R) for patients ages 18 years and older, with any listed ICD-10- PCS procedure code for an operating room procedure (Appendix A: ORPROC). Surgical discharges are defined by specific MS-DRG codes.

(AHRQ, 2023)

PSI 12 Denominator Exclusions

- with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for proximal deep vein thrombosis (DEEPVIB)
- with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for pulmonary embolism (PULMOID)
- where a procedure for interruption of vena cava (VENACIP) occurs before or on the same day as the first operating room procedure (Appendix A: ORPROC)
- where a procedure for pulmonary arterial or dialysis access thrombectomy (THROMP) occurs before or on the same day as the first operating room procedure (Appendix A: ORPROC)
- where the only operating room procedure(s) is/are for interruption of vena cava (VENACIP) and/or pulmonary arterial or dialysis access thrombectomy (THROMP)
- with any listed ICD-10-CM diagnosis code present on admission for acute brain or spinal injury (NEURTRAD)
- with any listed ICD-10-PCS procedure code for extracorporeal membrane oxygenation (ECMO) (ECMOP)
- MDC 14 (pregnancy, childbirth, and puerperium)
- MDC 15 (newborns and other neonates with conditions originating in perinatal period)
- with an ungroupable DRG (DRG=999)
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
- with missing MDC (MDC=missing) when the user indicates that MDC is provided

(AHRQ, 2023)

Acute Brain or Spinal Injury Diagnosis Codes **Sample**

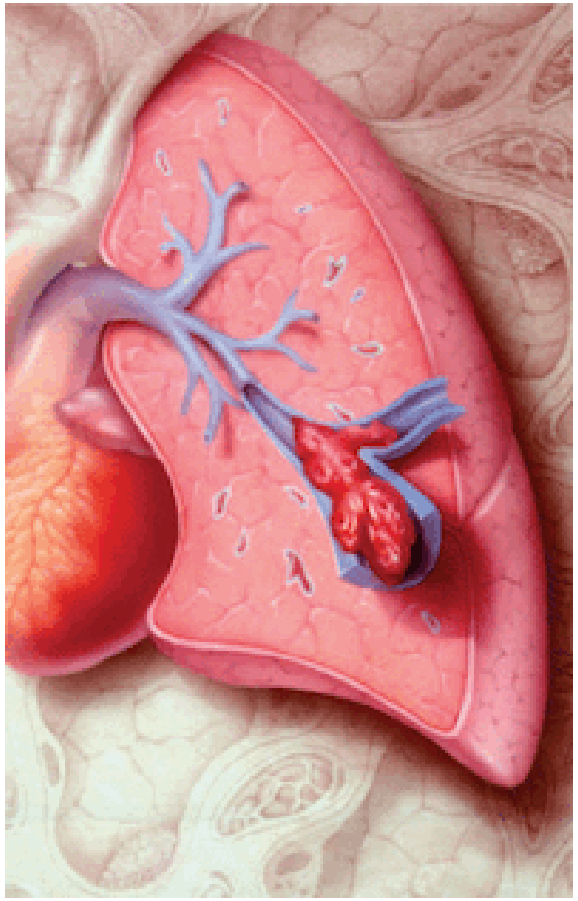
Acute brain or spinal injury diagnosis codes. (NEURTRAD)

G9731	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a nervous system procedure	S064X9A	Epidural hemorrhage with loss of consciousness of unspecified duration, initial encounter
G9732	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure	S065X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter
I6000	Nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and bifurcation	S065X1A	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
I6001	Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation	S065X2A	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter
I6002	Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation	S065X3A	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
I6010	Nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery	S065X4A	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter
I6011	Nontraumatic subarachnoid hemorrhage from right middle cerebral artery	S065X5A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter

(AHRQ, 2023)

Perioperative Pulmonary Embolism or Deep Vein Thrombosis: Documentation Considerations For CDI

- Watch dates and times!
- Ensure procedure is coded correctly
  - Appendix A lists inclusive procedures
- Were there ANY signs or symptoms on admission of DVT/PE?
  - Query if unsure
  - If physician clinically unable to determine, W applied for POA status which acts as a Y
- Does the patient have brain or spinal cord trauma?
  - Must be POA



PSI 13: Postoperative Sepsis Rate

- **Numerator:** Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis code for sepsis (SEPTI2D).
- **Denominator:** Elective surgical discharges (Appendix E: SURGI2R) for patients ages 18 years and older with any listed ICD-10-PCS procedure code for an operating room procedure (Appendix A: ORPROC). Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective (SID ATYPE=3).
- DENOMINATOR EXCLUSIONS
- with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for sepsis (SEPTI2D)
- with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for infection (Appendix F: INFECID)
- MDC 14 (pregnancy, childbirth, and puerperium)
- MDC 15 (newborns and other neonates with conditions originating in perinatal period)
- with an ungroupable DRG (DRG=999)
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
- with missing MDC (MDC=missing) when the user indicates that MDC is provided

(AHRQ, 2023)

Appendix F: Infection Diagnosis Codes Sample

Infection diagnosis codes: (INFECID)

A000	Cholera due to vibrio cholerae 01, biovar cholerae	L89123	Pressure ulcer of left upper back, stage 3
A001	Cholera due to vibrio cholerae 01, biovar eltor	L89124	Pressure ulcer of left upper back, stage 4
A009	Cholera, unspecified	L89129	Pressure ulcer of left upper back, Unspecified stage
A0100	Typhoid fever, unspecified	L89133	Pressure ulcer of right lower back, stage 3
A0101	Typhoid meningitis	L89134	Pressure ulcer of right lower back, stage 4
A0102	Typhoid fever with heart involvement	L89139	Pressure ulcer of right lower back, Unspecified stage
A0103	Typhoid pneumonia	L89143	Pressure ulcer of left lower back, stage 3
A0104	Typhoid arthritis	L89144	Pressure ulcer of left lower back, stage 4
A0105	Typhoid osteomyelitis	L89149	Pressure ulcer of left lower back, Unspecified stage
A0109	Typhoid fever with other complications	L89153	Pressure ulcer of sacral region, stage 3
A011	Paratyphoid fever A	L89154	Pressure ulcer of sacral region, stage 4
A012	Paratyphoid fever B	L89159	Pressure ulcer of sacral region, Unspecified stage
A013	Paratyphoid fever C	L89203	Pressure ulcer of Unspecified hip, stage 3
A014	Paratyphoid fever, unspecified	L89204	Pressure ulcer of Unspecified hip, stage 4

(AHRQ, 2023)

Postoperative Sepsis: Documentation Considerations for CDI

- Ensure sepsis is a clinically valid diagnosis
  - Life threatening organ dysfunction due to a dysregulated host response to an infection
    - SEP 3 criteria
    - SOFA score of ≥ 2
    - Link organ dysfunction to the sepsis
  - SIRS criteria plus infection ≠ sepsis
- Check for any signs/symptoms of infection POA
- Clarify admission status
  - Only applies to elective cases

(Singer, et al., 2016)

Final Thoughts

- Ensure documentation is complete and appropriate for clinical situation
- Query as necessary
- Ensure POA status is accurate and query if uncertain
- Capture and clarify any exclusion diagnoses

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Case Scenarios and Query Examples

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Postoperative Respiratory Failure: Case Scenario

- 45-year-old male admitted for lap assisted gastric sleeve
  - PMHx: Htn, systolic CHF, Type 2 DM, CKD stage 2, COPD
  - Patient counseled to take metoprolol preop and to hold furosemide, metformin, and insulin
- Op note from surgeon reports “no complications” with plans to routinely extubate in PACU
- In PACU: O_2 sats 90% on 50% O_2 by t-piece
  - CRNA notes: patient audibly wheezing with bilateral crackles auscultated
  - Connected back to vent with settings AC 16, TV 500 FIO_2 70% PEEP 5, PS 10
  - Given furosemide IV, in-line duoneb, and solumedrol 125 mg IV
- Admitted to ICU on the ventilator
  - Pulmonology consulted and documented “Postoperative respiratory failure”
  - POD #1 remains on vent but FiO_2 reduced to 40% and mode changed to SIMV
  - POD # 2 extubated to O_2 by facemask and quickly weaned to nasal cannula

Crafting Compliant Queries

- **Treatment**
  - What specific and pertinent treatments are consuming resources (monitored, evaluated, or treated)?
- **Risk**
  - What is the risk to the patient for the diagnosis? What is the risk to the integrity of the medical record if the diagnosis is not specified to the greatest level possible?
- **Indicators**
  - Which clinical indicators are pertinent to the process of making a medical diagnosis?
- **Compliant Question**
  - Is the intent of the question clear…without being leading, presumptive, or directive?

(Duhon, 2018)

Clinical Indicators	Location in Medical Record
"Postoperative respiratory failure…"	Per pulmonology consult 1/21/2023
"…audible wheezes heard, bilateral crackles auscultated, subcostal retractions noted…attached back to ventilator…"	Per CRNA Smith 1/21/2023
Risk Factors	**Location in Medical Record**
"PMHx of htn, systolic CHF, Type 2 DM, CKD 2, COPD…"	Per H&P 1/21/2023
"Surgery performed: lap gastric sleeve without complications…"	Per OP note 1/21/2023
Treatments	**Location in Medical Record**
Furosemide 40 mg IV stat and repeat in 4 hours	Per MD orders 1/21/2023
Duoneb stat and q 6 hours	Per MD orders 1/21/2023
Solumedrol 125 mg IV stat and 60 mg IV q 6 hours	Per MD orders 1/21/2023

TRIC
Treatment: Lasix, nebs, vent, Medrol
Risk: CHF, COPD
Indicators: PMHx, wheezes, crackles
Compliant question: concise with clear explanation of why query sent

Please further clarify the diagnosis and cause of postoperative respiratory failure.

Provider Response Examples:

- Acute hypoxic respiratory failure due to CHF exacerbation not caused by surgery
- Acute hypoxic respiratory failure due to COPD exacerbation not caused by surgery
- Postoperative respiratory failure present and caused by lap gastric sleeve
- Other _____ (please specify)

For continuity of documentation, please document condition throughout progress notes & discharge summary. Thank You

This is a permanent part of the Medical Record

Postoperative Pulmonary Embolism/DVT: Case Scenario

- 75-year-old admitted for ORIF of ankle fracture
  - H&P notes: tri-malleolar fracture occurred last week but surgery delayed due to extensive ankle edema
  - PMHx of DM type 2, HTN, CAD
- ORIF completed without incident and patient admitted to the floor
- POD # 1 c/o chest pain and shortness of breath
  - CTA-Chest notes RLL pulmonary embolism
  - Bilateral doppler US notes DVT right femoral vein
  - Lovenox 1mg/kg sq q 12 hours ordered

Crafting Compliant Queries

- **Treatment**
  - What specific and pertinent treatments are consuming resources (monitored, evaluated, or treated)?
- **Risk**
  - What is the risk to the patient for the diagnosis? What is the risk to the integrity of the medical record if the diagnosis is not specified to the greatest level possible?
- **Indicators**
  - Which clinical indicators are pertinent to the process of making a medical diagnosis?
- **Compliant Question**
  - Is the intent of the question clear…without being leading, presumptive, or directive?

(Duhon, 2018)

Clinical Indicators	Location in Medical Record
"RLL pulmonary embolism…"	Per CTA report 2/25/2023
"…DVT right femoral vein…"	Per US report 2/25/2023
Risk Factors	**Location in Medical Record**
"…trimalleolar fracture occurred last week but surgery delayed…"	Per H&P 2/24/2023
Treatments	**Location in Medical Record**
Lovenox 1 mg/kg SQ q 12 hours	Per MD orders 2/25/2023

Please clarify if these findings were present on admission (POA) or developed after surgery.

Provider Response Examples:

- Unable to clinically determine if PE and DVT were POA
- PE and DVT were not POA
- PE and DVT were POA
- Other _____ (please specify)

TRIC
Treatment: Lovenox
Risk: surgery delay
Indicators: radiology results
Compliant question: concise with clear explanation of why query sent

For continuity of documentation, please document condition throughout progress notes & discharge summary. Thank You

This is a permanent part of the Medical Record

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Thank you. Questions?

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