Obstetrics: A New Beginning for Clinical Documentation

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Learning Objectives

• At the completion of this educational activity, you will be able to:
  – Evaluate if an OB documentation improvement program is appropriate to pursue for your facility.
  – Identify frequently missed secondary diagnosis.
  – Recognize common documentation pitfalls.
  – Define good documentation skills.
  – Apply strategies to measure outcomes

OB at Stony Brook Medicine

• 603-bed academic medical center
• Level 4 (most advanced) regional perinatal center
• Level 1 (most advanced) trauma center and tertiary care center
• 3,651 deliveries in 2011
• State-of-the-art women’s and infants’ center
OB at Stony Brook Medicine

• Obstetrics at Stony Brook underwent a review of:
  – Documentation accuracy
  – CMI: Case-mix index
  – AHRQ Data: The Agency for Healthcare Research and Quality (within the Department of Health and Human Services) conducts research to manage and finance delivery of safe patient care

FINDINGS:
• OB population **increasing in severity** which is often **NOT** being captured
• “A” statements (attestations done by the coders, also known as the coding summary) were reviewed … many secondary **OB diagnosis** were **NOT** being coded
FINDINGS, continued:

• Reimbursement is not the only issue!
• Capturing accurate SOI (severity of illness) and ROM (risk of mortality) is crucial as they influence publically reported hospital and physician data.
• Stony Brook is a member of UHC (University Health System Consortium) which uses payer data (the coded chart) for its reporting.
• UHC provides the data used in popular national and state “report cards” such as U.S. News and World Report’s Best Hospitals and Hospital Honor Roll.

FINDINGS, continued:

• New York state uses APR DRGs (All Patient Refined DRGs) provided by 3M software for coding purposes. This classification system is used by “managed Medicaid” payers in addition to no-fault and workers’ compensation. These APR payers are approximately 40% of our OB patient population.
• APR reimbursement is influenced by severity. Reimbursement varies according to individual contractual agreements made with each institution.
## SOI and ROM
### Severity of Illness/Risk of Mortality

- Based on a scale of 1–4
  1: Minor
  2: Moderate
  3: Major
  4: Extreme

## NYS APR-DRG: Severity and Relative Weight Examples

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Are You an APR State?


Are You an APR-DRG State?

- Payment and reporting purposes: Texas, Maryland, and Massachusetts
- Payment only: Montana, South Dakota, Iowa, Mississippi, New York, Pennsylvania, Rhode Island
- Reporting only: Oregon, Utah, Colorado, Arizona, New Mexico, Tennessee, South Carolina, Virginia
- Check with your institution for updated changes in reporting or payment structure
**FINDINGS**, continued:

- Drill down showed the coders were not understanding the OB terminology and abbreviations, resulting in incomplete coding
- Physician documentation was sparse
- OB has numerous common secondary diagnoses that can be captured with the proper terminology
- In addition to diagnoses, there are procedures that are “implied” and not clearly documented

**Strategies for Getting Started**

- Assign a CDS with OB experience ... terminology, diagnosis, and procedures are very specific. Clinical experience is crucial! It’s a lot to learn for a CDS that has never worked in OB.
- The CDS should “bond” with the department: The physicians should see you as part of their team.
- Learn about the OB population specific to your facility. What are the pertinent issues? Attend daily rounds and staff meetings; learn department workflow.
Strategies for Getting Started

• Compile a list of approved OB abbreviations for your institution.
• Collaborate with a department director and coding supervisor. Once agreed upon, often this may be instituted as a hospital policy and therefore a reference when coding the chart.

Strategies for Getting Started

• Present yourself as an educator, not a disciplinarian!
• Present a documentation improvement plan at a staff meeting.
• Clearly outline expectations for the query process.
• Follow up with consistent, brief, educational sessions. Request 15 minutes at the monthly staff meeting for 6 months (or whatever it takes!)
• Recognize that learning styles vary.
Strategies for Getting Started

Ongoing education is a must!

- Be CREATIVE! Send weekly emails that are brief and witty.
- Use a “Documentation Tip of the Week.”
- Make laminated cards with documentation tips and leave them at the nurses’ station or in the break room.
- Provide positive feedback when documentation is improving and queries are being replied to promptly.

Strategies for Getting Started

Ongoing education is a must!

- Send emails with patient encounter #s citing examples of accurate documentation
- CC all physicians involved with the case
- Use these examples as case studies to present at staff meetings
Strategies for Getting Started

• Don’t forget about what happens after discharge!
• The CDS should review the “A” statements (attestations or coding summaries)
• Have a process in place to ensure that ALL diagnosis queried for and documented were actually coded!

Strategies for Getting Started

• Good recordkeeping is a must!
• Create a template for a daily worksheet organized with key information
• Use this as a communication tool and reference sheet for when the chart is coded
• Record all encounters that have been reviewed and queried, and their outcomes
Strategies for Getting Started

BE AVAILABLE!

Frequently Missed Secondary Diagnoses

Certain diagnoses are REPEAT OFFENDERS:
- Advanced maternal age (mom is 35 or older)
- Anemia
- Electrolyte abnormalities
- Insufficient prenatal care
- Lacerations (and repair of)
Frequently Missed Secondary Diagnoses

- Maternal drug dependence
- Obesity/morbid obesity
- Preeclampsia/hypertension
- Preterm labor
- PROM (premature rupture of membranes) vs. PPROM (preterm premature rupture of membranes)
- Rh incompatibility

Good Documentation

- It all begins with a **thorough H and P**!
- Must include pertinent diagnoses that were treated during pregnancy – not just when her water broke, timing of contractions, dilation, and effacement
- This can be challenging with the EMR (electronic medical record)!
- Not all staff have the same view as the physician, therefore missing diagnoses that could have been coded!
Common Documentation Pitfalls: What Is Missing?

• “Mother is 35” (instead of ADVANCED MATERNAL AGE). Simply stating the patient’s age is not enough to capture this diagnosis.
• “Decrease in H/H: now down to 8.8/27.0 from 10.9/32.0, trend CBC, monitor for symptoms of anemia.” Often this is acute blood loss anemia. If the acuity is not documented, this will code to unspecified anemia (if anemia was even documented!)
• The CDC defines anemia as an H/H less than 11/33 in the 1st and 3rd trimesters, and less than 10.5/32 in the 2nd trimester.

Common Documentation Pitfalls: What Is Missing?

• “Replete K when necessary” instead of hypokalemia. Often seen in hyperemesis gravidarum.
• “Late to care or scant care” instead of insufficient prenatal care.
• Lacerations: Document location, degree, and brief description of how repaired.
Common Documentation Pitfalls: What Is Missing?

- “History of drug abuse” does not capture severity of drug use during pregnancy
- Must state **MATERNAL DRUG DEPENDENCE**
- Abuse and dependence are not interchangeable terms!
- Must specify type of drug and **usage:** continuous, episodic
- Maternal drug dependence also applies to **methadone** and **suboxone** maintenance

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Common Documentation Pitfalls: What Is Missing?

- **Obesity:** BMI = 30–40
- **Morbid obesity:** BMI = 40 or greater (greatly influences severity)
- A second code can be assigned if the BMI is recorded in the chart
Common Documentation Pitfalls: What Is Missing?

Preeclampsia/hypertension:
• If hypertension is preexisting prior to pregnancy, must document as **CHRONIC HYPERTENSION**
• Clarify if preeclampsia is **superimposed** on chronic hypertension
• Preeclampsia must be clarified as **MILD** or **SEVERE**

Common Documentation Pitfalls: What Is Missing?

Preterm labor:
• Cannot be coded by stating gestational age: “35 weeks in active labor”
• Must document **PRETERM LABOR** if 37 weeks or prior
• Preterm labor greatly increases severity!
Common Documentation Pitfalls: What Is Missing?

PROM vs. PPROM:
• Premature rupture of membranes vs. preterm premature rupture of membranes.
• Must spell the appropriate diagnosis out at least once in the chart, then can continue to abbreviate.
• PROM: Rupture of membranes prior to the onset of labor. Often it is not clear if the diagnosis is PROLONGED (greater than 24 hours) or PREMATURE. Must clarify!
• PPROM: Preterm premature rupture of membranes (prior to the completion of 37 weeks).

Common Documentation Pitfalls: What Is Missing?

• “Rh negative, Rhogam given” does not capture the diagnosis of Rh INCOMPATIBILITY.
• “R/O placenta previa or placental abruption”: Clarify which diagnosis in the delivery note or postpartum progress notes.
• All diagnosis must be included in the DISCHARGE SUMMARY! This is the “go to” document for providers and coders!
**Measuring Outcomes**

- Increased **CMI** in one quarter
- Increased capture of **severity of illness/ROM**
- Crucial to reconcile “A” statements!
- Request coders add any diagnoses that were documented but not coded before the bill is dropped

**Difficult Diagnosis**

**Acute blood loss anemia:**

- Physicians reluctant to document this diagnosis and often “**dance around**” defining it
- Many physicians express concern about getting “**dinged**” for a “complication” on their patient outcome reports
Repercussions From NOT Documenting ABL Anemia

- **NOT** capturing a CC
- **NOT** accurately reflecting severity of illness
- **Negative** influence on the CMI

Support for Difficult Diagnosis

- In reviewing the **AHRQ** and **SCIP** data (Surgical Care Improvement Project, sponsored by CMS and **AHA**) this was **not** the case!
- Documenting **expected acute blood loss anemia** was the key to making the physician and CDS happy! ☺
- The use of the term **expected** allows for the capture of ABL anemia that the physician was agreeable to using
Support From the ACP

• In addition to our AHRQ and SCIP data, the ACP (American College of Physicians) issued a statement in the February 2012 issue of ACP Hospitalist stating that “concerned surgeons can be reassured that the code for Acute Blood Loss Anemia is not classified as a ‘complication of surgery.’ This diagnosis will not adversely impact a surgeon’s complication rates or quality scores.”

Support From the ACP

• “In contrast to acute blood loss anemia, a diagnosis of ‘postoperative hemorrhage’ may result in coding of a surgical complication. According to coding guidelines, the complication code for post-op hemorrhage should not be assigned unless a physician specifically indicates that the hemorrhage was due to, or resulted from the procedure. Unfortunately, many coders mistakenly believe this term ‘post-op’ establishes this connection.”
Know Correct Definitions

Let’s clarify the terminology:

• **Complication:** A condition that could be unexpected that will complicate a patient’s care (codes in the 900 category)

• **Expected:** A condition that is commonly associated with a procedure that meets the definition of a reportable secondary diagnosis, but is not clarified or documented as a complication (not coded in the 900 category) and therefore NOT a complication

Know Correct Definitions

• **Inherent:** (referring to a medical condition) A condition that **ALWAYS** occurs in **EVERY** case

• **Integral:** As above, referring to a procedure

Thereby, the difference is that an **expected** condition **MAY or CAN OCCUR** and an **inherent** condition **ALWAYS OCCURS.**
Clarification Supporting Expected ABL Anemia

• Using the term **EXPECTED** in this scenario is appropriate as it is not being said that every patient that delivers a baby (C-section or vaginal) will **ALWAYS** have ABL anemia.

Coding Clinic Support

• *Coding Clinic*, 1st Quarter 2007, p. 19: When postoperative anemia is documented without specification of acute blood loss, code 285.9, Anemia, unspecified, is the default. Code 285.1, Acute post hemorrhagic anemia, should be assigned when postoperative anemia is due to **acute blood loss**.
Thank you. Questions?

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