It’s a Grown-Up World in Pediatric CDI

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Describe the need for/use of CDI programs in pediatric facilities
- Discuss the ramifications of transitioning from per diem reimbursement to the use of a DRG system
- Articulate challenges encountered when coding pediatric-specific diagnoses
- Outline the preliminary outcomes of the CDI program at COA

Children’s of Alabama

- Alabama’s only freestanding pediatric hospital
- Only pediatric Level I trauma center in state
- All pediatric solid organ transplants done at COA
- Several specialties ranked nationally
- Main campus with 360 beds
- South campus – outpatient surgical services/after-hours clinic
- Affiliated with numerous pediatricians and specialists throughout the state
- MDs from COA conduct clinics statewide to ensure children with chronic diseases have access to kid-centered care
Origin of Clinical Documentation Improvement

2010–2012
• CFO recognized national trend of transitioning away from per diem
• Gaps in documentation recognized
• New facility under construction/pediatric cardiology and solid organ transplant services slated to transition to COA
• Medicaid became COA’s largest payer
• ICD-10’s original go-live slated for 10/1/2012
• Medicaid/CDI program research

Children Are the Center of Our Lives

It’s no different in CDE!

Clinical Documentation Excellence

• Unique name – CDE vs. CDI
• A separate department within the finance division of COA
• Program implemented in 2014
  – 8 CDE RNs (including director)
  – All inpatient medical units covered (not currently reviewing psych)
  – 6 weeks of classroom education for CDE RNs, coders, and nurse practitioners, including chart reviews. Simultaneously, management along with CDI consultants conducted introductory teaching for all medical and surgical services.
MS-DRG vs. APR-DRG

• MS-DRGs have limited options to capture the complexities of pediatric patients.
• APR-DRGs better allow secondary diagnoses to have a higher impact on the DRG payment by quantifying the acuity of different patient populations.
• APR-DRGs better represent non-Medicare populations.
• COA had MANY negotiations with payers regarding their upcoming switch to DRG payments for the facility. It was ultimately decided that APR-DRGs would better represent our patient population.

They are NOT little adults!

Admitting Diagnoses Compared

<table>
<thead>
<tr>
<th>Top COA diagnoses</th>
<th>Top area adult diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchiolitis</td>
<td>NSTEMI</td>
</tr>
<tr>
<td>Asthma</td>
<td>Acute on chronic systolic heart failure</td>
</tr>
<tr>
<td>Encounters for chemotherapy</td>
<td>Single live-born infant, cesarean</td>
</tr>
<tr>
<td>Type 1 diabetes with DKA</td>
<td>Sepsis</td>
</tr>
<tr>
<td>DKA</td>
<td>Single live-born infant, vaginal</td>
</tr>
</tbody>
</table>

All COA data current for discharges in 12/2015.
Pediatric-Specific Considerations

- Many differences between pediatric and adult coding
- Coders must have a concrete understanding of the complex medical problems seen in pediatrics
- Coding rules (edits) directly determine which codes can be used in specific circumstances
- Congenital vs. acquired
- Current issues vs. past medical history

Syndromes

- The CDE RNs at COA have interestingly noted much less specificity with syndrome codes in ICD-10 as compared to those in ICD-9
  - Ongoing education on the need to include ALL syndrome manifestations within patient documentation
- Ex: Prader-Willi Syndrome
  VACTERL, formerly known as VADER

When Did It Start?

- Congenital vs. acquired
  - Congenital codes have an entire ICD-10 chapter devoted strictly to them
  - This must be captured in the coding process, as it can affect your DRG
  - Most congenital conditions have their own specific codes vs. acquired or simply unspecified
- Ex: Cardiac valve insufficiency/stenosis
  (Congenital vs. rheumatic vs. non-rheumatic)
Current Issues vs. Past Medical History

• It is important to differentiate between past medical conditions and those that are current, especially for chronically ill children

Ex: NEC vs. short bowel syndrome
Congenital heart disease with palliation vs. repair
Biliary atresia s/p liver transplant
BPD

Coding Rules

Many coding edits are age specific and dictate which codes can be used

Example:
• HIE
• Prematurity
• BPD

APR-DRGs: A Game Changer

• P285, resp. failure of newborn
• J218, acute bronchiolitis due to other spec. org
• P0716, other LBW newborn, 1500-1749 grams
• P0729, premature newborn, 12 week GA
• P0449, newborn affected by maternal drug use
• B9770, coronavirus as the cause of diseases classified elsewhere
• 5A1945Z, resp. ventilation, 24–96 hours
Why Is This Concerning?

- A large majority of our patients stay longer than the average LOS suggested in the APR-DRG system
  - Premies
  - Chronic home ventilator patients
  - Special social situations
  - Immuno-compromised
  - Educational needs of the family
  - Shortage of skilled nursing facilities for children
  - Shortage of medical foster families

Example: 22 weeks born at OSH, develops a grade III IVH within one week of birth and is transferred to CDA for management of post hemorrhagic hydrocephalus including multiple EVDs and shunt placements. Pt NECs and has multiple bowel resections, leaving him with an ostomy, a murmur, failure with short bowel syndrome, and a PDA. Pt is intubated due to multiple surgeries and develops BPD severe enough to render him ventilator dependent. Pt goes on to have a tracheostomy placed and enters the home vent program.

Average LOS for this patient at CDA: ~ 6 months
Average LOS per APR-DRG: ~ 40 days

Why Do Children Tend to Have Longer LOS?

- Congenital syndromes/chronic conditions
- American Society of Anesthesiologists physical status classification (multifactorial)
  - Anyone category 3 or higher or 2 years old or under require a minimum overnight stay per anesthesia
- Plan of care specific to each patient’s development
  - Social issues
    - Custody
    - Legal

Our Approach

- Patients assigned to CDE RN by floor separated by specialty
- Begin review process on 2nd day of admission
- Continue to follow most patients with reviews every other day until discharge to ensure accurate, complete, and compliant documentation
- Patients with both SOI and ROM of 4, reviewed every 2–4 weeks until discharge
- Initially done manually, now electronic
- Reconciliation

***Nothing about our process is concrete, and we change as we feel it is needed***
Query Process

- Originally concurrent only
- Now retrospective PRN as identified by coder
- Only done by CDE RNs
- Informal vs. formal

Education

- Physician
- Midlevel providers
- Coder
- Weekly newsletter

Physician Champion

- Holds weekly conferences open to all interns/residents/attendings
- Runs interference between CDE RNs and MDs when needed
- Handles query escalation process
- Role expanding
Obstacles

- MD engagement
- Private MDs with admitting privileges
- MDs employed by UAB, work at COA
- No clinical indicator policies in place with the start of CDE program
- Office placement
- Finding balance in patient division among CDE RNs
- Reconciliation process – many outsourced/remote coders
- Not enough peer-to-peer education among MDs

Lessons Learned

- Clinical indicator policies are a MUST!
- Caseload cannot be divided by numbers alone
- Rotation of CDE RNs not helpful at this time
- Utilizing both a medical and surgical physician champion is optimal
- Electronic queries within the EMR are more effective for us at COA
- Physician accountability is imperative
- DRG validation process valuable
- RNs must have many years of clinical/bedside experience as well as critical thinking skills

Outcomes

- Increase in query response rates
  - Initially 85%–90% (Sept. 2014)
  - Currently 90%–95% (Nov. 2015)
- More physician engagement – specifically since ICD-10 implementation
- Improvement in CDE/coder relationships
- More continuity in patient care
- Increased case-mix index*
Future Goals

- Increased hospitalwide awareness of CDE and our mission
- Improve reporting and tracking
- Better able to benchmark COA against other pediatric facilities
- Complete the feedback loop between CDE and MDs
- More standardized departmental policies
- Improve query response/agreement rates
- Define role and institute a DRG validator

Thank you. Questions?
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