RWJBarnabas HEALTH | Monmouth Medical Center Southern Campus

Monmouth Medical Center Southern Campus *Clinical Documentation Improvement Program*

updated 3/25/24

Goals of Clinical Documentation Improvement

- Provide accurate data for quality indicators and other hospital metrics
- Improve quality of care
- Reflect true severity of illness and resources consumed
- Comply with CMS regulation
- Allow for appropriate reimbursement of services
- Facilitate complete, accurate, and timely documentation in the medical record prior to discharge

Inefficient and/or missing documentation leads to:

- Unbilled or denied charges
- Lost revenue
- Unexplained continued length of stay
- Poor performance ratings
- Increased liability

DOCUMENTATION

- Whose Documentation Counts
  - Official Coding Guidelines state, “The listing of the diagnoses in the patient record is the responsibility of the Attending Physician.”
  - Coding Guidelines do permit the coder to use documentation recorded by Nurse Practitioners, Physician’s Assistants, and Residents for coding of the chart, as long as they are signed off by their supervising physician.
  - The physician must direct patient care.
    - Consulting provider documentation can be used for coding.
    - Attending may be queried if consulting diagnosis if appropriate for PDX but attending has not included this diagnosis in his progress notes.
  - Radiology findings and pathology findings **cannot** be used for code assignment unless validated and acknowledged by the treating medical team.

- Conflicting Documentation
  - The documentation of the Attending Physician supersedes that of all other providers.
  - If the attending provider documents “renal insufficiency” and the nephrology consult physician documents “acute renal failure,” the attending provider will need to be queried to clarify which diagnosis is to be coded.
  - If the attending provider states “CHF” in his progress notes and the cardiology consult states “acute systolic CHF”, a query will not be generated since the consult only further clarifies the diagnosis, rather than conflicts the diagnosis.

DOCUMENTATION

- Diagnosis Documentation
  - Diagnosis should be carried through to each progress note and the final discharge summary.
  - Diagnoses that are ruled out, should be documented as ruled out, rather than simply deleted from the impression and plan on the progress note.
  - If a diagnosis is not carried through to the discharge summary, coding may send a post-discharge query to determine if the diagnosis in question has been ruled in or ruled out.

- CDS and Coders
  - Coders and Clinical Documentation Specialists/RNs (CDS) at Monmouth Medical Center Southern Campus must follow the AHIMA Standards of Ethical Coding and BH Compliance Policy on Inpatient Coding, and are not permitted to presume diagnoses that are not clear or are not documented by a treating Physician. All missing or conflicting documentation that is needed for thorough coding of the chart will generate a query to the Attending Physician for clarification.

APN/PA/RESIDENT DOCUMENTATION

- Supervising Physician
  - All progress notes and discharge summaries initiated by an APN/PA/RESIDENT must be signed off by the Supervising Physician.
    - It can be difficult for the Coders to determine which physician was supervising him/her for the day when directing a post-discharge query.
    - It can be difficult for the Medical Records Analysts to determine which physician was supervising him/her for the day when requesting a co-signature on a progress note or discharge summary.
  - To avoid confusion, please add a line to all of your progress notes and discharge summaries:
    - **Supervising Physician: _____**

Concurrent Clarifications in Epic

- A concurrent clarification for all patients currently admitted will be generated for the Attending MD in Epic for review and response when:
  - Greater specificity is needed
  - There is conflicting/ambiguous documentation
  - Documentation requires further clarification (cause and effect relationships, underlying etiology of symptom, POA status)

- Nurse practitioners, physician's assistants, and residents can receive concurrent clarifications in Epic.

Concurrent Clarifications for INPTs in Epic

- Clarifications will automatically open on the right of the Epic screen when chart is opened.
- These clarifications are addressed directly to the physician they are intended for.
- If you agree with the clarification, please document diagnosis in the response box and/or carry it through into your next progress note and discharge summary.
- If you disagree with the clarification, please reply directly in the clarification response box and rule out the diagnosis in your progress note if appropriate.

Retrospective Queries

- Post-discharge (retrospective) queries for patients that are already discharged are sent by the Coders and are now completed in Epic.
- Nurse practitioners may now receive retrospective queries or they may be sent to MD who was supervising the nurse practitioner the day of discharge.

- Complete queries as soon as possible so that the account can be coded and the chart completed, no later than 7 days after receiving query.

Document the patient's "reason for the admission"

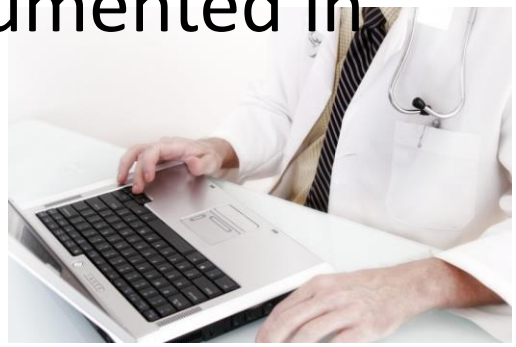
- Link signs & symptoms to etiology (ex. Chest pain, syncope, altered mental status, shortness of breath) once determined
  - Example
    - Chest pain 2/2 PE
    - Syncope 2/2 tachy/brady syndrome
    - AMS 2/2 UTI
    - SOB 2/2 AECOPD

- If patient admitted OBSO and flipped to INPT, document reason for change to INPT status

Specifying your documentation

- Rule Outs
  - SOB r/o Pneumonia – PNA ruled in or ruled out?
  - Chest pain r/o MI – MI ruled in or ruled out?

- Protein-Calorie Malnutrition
  - Mild, Moderate, or Severe (documented in Dietitian consult note)
  - Uses ASPEN criteria



Specifying your documentation

- GI Bleed: specify the cause/site (peptic ulcer, esophagitis/gastritis, diverticulosis, or unspecified and chronicity – acute vs chronic vs acute on chronic)

- Anemia: specify the type (iron deficiency anemia, acute blood loss anemia 2/2…)
  - Expected acute blood loss anemia after surgery is not a surgical complication

- Fractures
  - traumatic or pathologic in nature

Present on Admission (POA)/ Hospital Acquired Conditions

- It is <u>essential</u> to document if any of the following are POA:

  - UTI r/t catheter, stent, etc.
  - Pressure Ulcers (specify stage)
  - Vascular catheter infections
  - Falls
  - Pulmonary Embolism or DVT
  - Surgical site infections (type specific)

Coding Documentation Tips

Sepsis

- Sepsis
  - Sepsis = SIRS plus actual (or suspected) infectious source
    - SIRS criteria:
      - Temperature (<36°C or >38°C (<96.8°F or >100.4°F)
      - Heart Rate >90/min
      - Respiratory Rate >20/min or PaCO2 <32 mm Hg
      - WBC >12,000/mm3 or <4000/mm3 or >10% immature bands
      - 2 of 4 SIRS criteria may clinically support both an infectious process and a systemic process, i.e. Sepsis.
      - Positive blood cultures are not required
  - If Sepsis is diagnosed and SIRS plus infection criteria is not met, CDS will send the attend physician a clarifying requesting the patient's clinical indicators for the diagnosis.

- Severe Sepsis & Septic Shock
  - Severe Sepsis = Sepsis plus evidence of impaired organ perfusion (please link organ dysfunction with severe sepsis)
  - Septic Shock = Severe Sepsis plus hypotension
    - Impaired organ perfusion:
    - Altered Mental Status
    - Oliguria (↑ BUN, serum creatinine)
    - ↑ or ↓ in BP
    - Electrolyte abnormalities
    - Acidosis or alkalosis

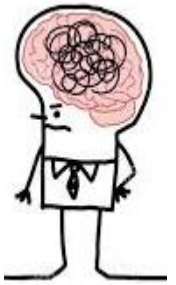
- Sepsis Syndrome
  - CDS and Coding have noticed a re-emergence of the diagnosis of Sepsis Syndrome. From a coding standpoint, Sepsis Syndrome cannot be coded. If possible, please refrain from using this phrase when referring to the subset of symptoms generally associated with Sepsis. If documented, this diagnosis will result in a clarification or query to the attending physician.

~~Sepsis Syndrome~~

Coding Documentation Tips

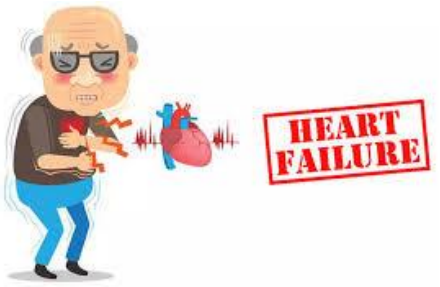
Diseases and Disorders of the Neurological System

- Encephalopathy
  - Altered mental status and Change in Mental Status cannot be coded as Encephalopathy. Please document a diagnosis such as Acute Metabolic Encephalopathy, Acute Toxic Metabolic Encephalopthy, Acute Hepatic Encephalopathy, etc. including the acuity.
  - When known, an etiology for the encephalopathy should also be documented such as Acute Metabolic Encephalopathy secondary to Urinary Tract Infection.
- Encephalopathy with Dementia
  - If a patient has Dementia and also a Change in Mental Status above baseline, please document this so that the coders are clear about the two diagnoses. Otherwise they may end up sending a query for clarification.
  - Example: Acute Metabolic Encephalopathy on top of Dementia secondary to Urinary Tract Infection
- Delirium
  - Many physicians will use the clinical terms delirium and encephalopathy as interchangeable terms. In coding language, delirium and encephalopathy are not considered to be interchangeable terms and delirium is merely coded as a symptom.



Coding Documentation Tips

Diseases and Disorders of the Circulatory System



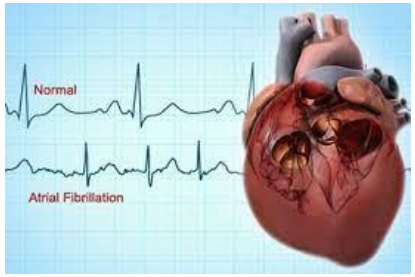
- Congestive Heart Failure
  - Acuity
    - acute, chronic, acute on chronic
  - Type
    - systolic, diastolic, combined systolic and diastolic

- Chest Pain
  - as a working diagnosis will need to have the etiology stated once known or a query will be generated to the Attending Physician asking for the etiology of the chest pain. If all testing is negative and the etiology is undetermined after study, stating this during your final progress note or Discharge Summary will prevent a query.

Coding Documentation Tips
Diseases and Disorders of the Circulatory System

- Syncope
  - as a working diagnosis will need to have the etiology stated once known or a query will be generated to the Attending Physician asking for the etiology of the Syncope. If the etiology is undetermined after study, stating this during your final progress note or Discharge Summary will prevent a query.

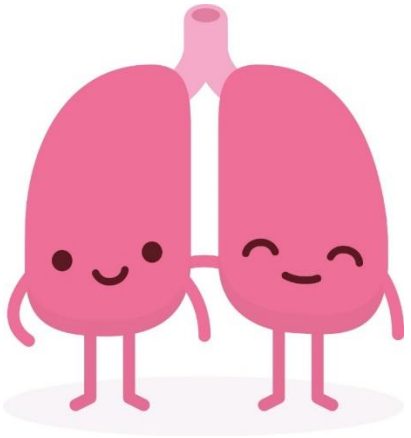
- Atrial Fibrillation
  - There has been an additional requirement for the coding of atrial fibrillation. A diagnosis of atrial fibrillation needs to be accompanied by the type in order to be properly indexed.
    - Chronic Atrial Fibrillation
    - Paroxysmal Atrial Fibrillation
    - Permanent Atrial Fibrillation
    - Persistent Atrial Fibrillation
    - Persistent Longstanding Atrial Fibrillation



Coding Documentation Tips

Diseases and Disorders of the Respiratory System

- Pneumonia
  - When documenting a diagnosis of Pneumonia, the type of Pneumonia also needs to be documented in order to avoid a query.
  - If there is a positive sputum culture, the organism would need to be documented by the Physician in order to avoid a query. The coders are not permitted to "pull" the information from the lab report since the lab is not considered a primary source and cannot be used for code assignment unless validated by the treating medical team.
    - Community Acquired Pneumonia
    - Aspiration Pneumonia
    - Bacterial Pneumonia (please document type)
    - Obstructive Pneumonia due to Neoplasm
    - Ventilator-Associated Pneumonia
    - Viral Pneumonia (please document type)
    - Post-Op Pneumonia
    - Gram negative Pneumonia



- Tracheitis
  - If a patient has a chronic tracheostomy and a diagnosis of tracheitis, please document the relationship, if any, between the chronic trach and the tracheitis.

Coding Documentation Tips

Diseases and Disorders of the Respiratory System

- <u>COPD</u>
  - Conditions that comprise COPD are:
    - Obstructive chronic bronchitis
    - Exacerbation of COPD
    - Emphysema

  - Documentation should state acute exacerbation or compensated in order to avoid a query.
  - As a secondary diagnosis to acute respiratory failure, an exacerbation may be considered to be a comorbid condition which could increase the patient's severity of illness and length of stay and may change the DRG# assigned by the coder.

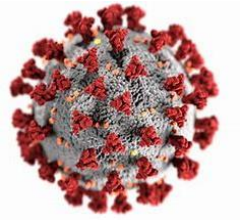
Coding Documentation Tips

Diseases and Disorders of the Respiratory System

- Respiratory Failure
  - A diagnosis of respiratory failure requires an additional notation of acuity and type (when known):
    - Hypoxic, hypercapneic, or both
    - Acute respiratory failure secondary to…
    - Acute on chronic respiratory failure secondary to…
    - Chronic respiratory failure
      - Chronic respiratory failure is rarely documented by providers.
      - Typically applicable when patients are on home oxygen or on CPAP for obstructive sleep apnea which are continued in the hospital setting.
      - As a secondary diagnosis, this may be considered to be a comorbid condition which could increase the patient's severity of illness and length of stay and may change the DRG# assigned by the coder.
  - To code acute respiratory failure, two (2) of the following coding criteria needs to be met:
    - Respirations <10 or >20
    - Pulse ox <90% RA or <95% on O2
    - pH <7.35 or >7.45
    - pCO2 >50 mm Hg (or 10mm above COPD baseline)
    - pO2 <60 mm Hg (or 10mm below COPD baseline)
    - Symptoms such as: Air hunger, Use of accessory muscles, Inability to speak in full sentences, and/or Cyanosis should be documented by physician or nurse

Coding Documentation Tips

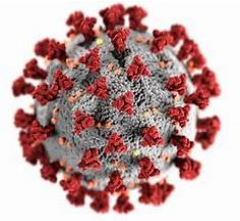
COVID-19



- <u>COVID-19 Documentation</u>
  - Asymptomic COVID-19 (admitted for another reason)
    - Please remember to document the diagnosis of COVID-19 if the patient tests COVID-19 +ve during the admission.
  - Clinical Documentation Specialist and Coders cannot code the COVID-19 lab result from the laboratory records.
  - Document COVID-19 pna or Viral pneumonia 2/2 COVID-19 if viral pneumonia is present.
  - If Sepsis is present, please document Viral sepsis 2/2 COVID 19 or COVID-19 pna.
  - COVID-19 can not be coded without a +ve lab test in the chart, even if diagnosed by the physician.

Coding Documentation Tips

COVID-19



- <u>COVID-19 & HIV</u>
  - Document HIV disease if patient has ever had an HIV-related opportunistic infection.
  - Document HIV+ without previous HIV-related condition (asymptomatic HIV infection status) if patient has never had an HIV-related opportunistic infection.
  - COVID-19 & HIV disease will code the chart to an HIV DRG
  - COVID-19 & HIV+ will code the chart to a Respiratory System DRG.

Coding Documentation Tips

Influenza

- Influenza Documentation
  - Please remember to document the type of Influenza, if known (i.e. A, B, or A & B)
  - Clinical Documentation Specialist and Coders cannot pull the type of Influenza from the laboratory records.
  - Documenting the type of Influenza affects the coding of the chart and the patient's true severity of illness.
  - ***When the patient has additional comorbidities or major comorbidities, the relative weight is affected by the identification of the influenza strain.***

Coding Documentation Tips

Diseases and Disorders of the Genitourinary System

- UTI due to Indwelling Catheter or SPC or Urinary Stents
  - If a patient has a **Foley, Suprapubic catheter, or Urinary Stents on admission** and has a **diagnosis of UTI or Sepsis secondary to UTI**, the infection must be **linked to the chronic indwelling Foley, Suprapubic catheter, or Urinary Stents in the progress notes**, ("or document not due to") or it may end up being considered a hospital acquired condition.
  - The coder cannot assume the relationship; it must be documented by the physician. Otherwise this will generate a query to the Attending Physician.
  - Sample diagnoses:
    - UTI r/t chronic indwelling foley catheter
    - Sepsis 2/2 UTI r/t chronic indwelling foley catheter
    - Multifactorial sepsis 2/2 pneumonia and UTI r/t chronic indwelling foley catheter

- Urosepsis
  - Urosepsis, as a diagnosis, cannot be captured by the coder. The coder needs to capture a diagnosis of **Urinary Tract Infection** or **Sepsis secondary to Urinary Tract Infection**. A diagnosis of Urosepsis will generate a query to the Attending Physician.

~~**UroSepsis**~~

Coding Documentation Tips

Diseases and Disorders of the Genitourinary System

- Chronic Kidney Disease

Stage 1	**Kidney damage and normal GFR**	**>90**
Stage 2	Kidney damage and mild decrease in GFR	60 to 89
Stage 3	Moderate decrease in GFR	30 to 59
Stage 4	Severe decrease in GFR	15 to 29
Stage 5	Kidney failure (dialysis or kidney transplant needed)	<15
ESRD	Chronic Kidney Disease Stage 5 requiring chronic dialysis	

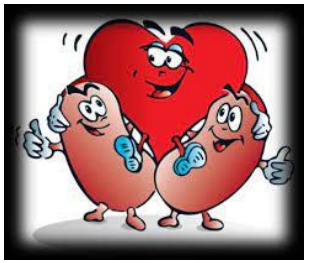
  - **Chronic Kidney Disease Stage 4 and Stage 5** are considered "Comorbid Conditions" (CC) and can change the "Diagnosis Related Group" (DRG) that will be assigned by the Coder; **ESRD** is considered a "Major Comorbid Condition" (MCC); therefore staging of CKD is important and without it, a query may have to be generated to the Attending Physician. When a patient is being treated for a CC or MCC, their Severity of Illness (SOI) and Length of Stay (LOS) may also increase.

Coding Documentation Tips

Diseases and Disorders of the Genitourinary System

- Cardiorenal

  - Documentation of **CKD** and **HTN** history with a diagnosis of Acute on Chronic (Systolic and/or Diastolic) Congestive Heart Failure will code the chart as **Hypertensive Heart and Chronic Kidney Disease** as PDX and **Acute on Chronic (Systolic and/or Diastolic) Congestive Heart Failure** as a major co-morbid condition.
  - This will not only change the Relative Weight (RW) of the chart but may also affect its Severity of Illness (SOI)/Risk of Mortality (ROM) and Length of Stay (LOS).



Coding Documentation Tips

Diseases and Disorders of the Genitourinary System

- Acute Renal Failure (AKI can not be accepted for coding – Acute renal failure or acute kidney injury must be spelled out
  - A documentation of **Acute Renal Failure** or **Acute Kidney Injury** by one physician with documentation of **Renal Insufficiency** by another physician will generate a query to the Attending Physician because this would be considered a conflict.
  - If there is a suggestion of **Acute Tubular Necrosis** without a definite statement of Acute Tubular Necrosis, a query may need to be generated to the Attending Physician since this can change the "DRG" that will be assigned by the Coder.
  - Acute Renal Failure guidelines are built off of the Rifle Criteria and AKIN Criteria. The criteria to be used are:

    - Increase in serum creatinine by 0.3mg/dL or more within 48 hours

    Or

    - Increase in serum creatinine to 1.5 times baseline or more within the last 7

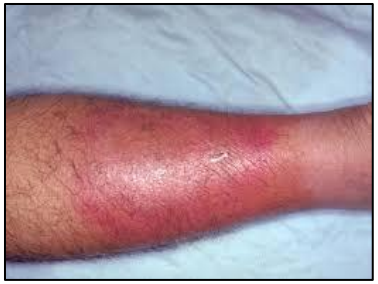
    Or

    - Urine output less than 0.5 mL/kg/h for 6 hours
  - Baseline calculation:
    - The lowest SCr (Serum creatinine) obtained during a hospitalization is usually equal to or greater than the baseline. This SCr should be used to diagnose AKI (acute kidney disease). This is for cases with no evidence or history of CKD (chronic kidney disease).

Coding Documentation Tips

Diseases and Disorders of the Integumentary System

- <u>Cellulitis</u>
  - A diagnosis of cellulitis requires the additional documentation of:
    - Etiology (examples)
    - Secondary to Diabetes
    - Secondary to Peripheral Vascular Disease
    - Secondary to Trauma/Injury
    - Secondary to Chronic Venous Insufficiency
    - Secondary to Animal Bite
    - Post-op Cellulitis
    - Stasis Dermatitis
    - Cellulitis with Gangrene



  - **Whenever the patient has a history of Diabetes, if there is a relationship between the Cellulitis and the Diabetes, this needs to be stated or a query will be generated; i.e. Cellulitis r/t Diabetes**
  - If a wound culture is collected and an organism is identified, please document the type of organism along with your diagnosis of Cellulitis.

- <u>Debridement</u>
  - If a wound debridement is performed, the following criteria must be documented for each debridement site or a query will be generated.
    - Excisional or Nonexcisional (sharply debrided cannot be accepted to mean excisional)
    - Type of instrument used (scalpel, scissors, etc.)
    - Level of excision (subcutaneous, fascia, muscle, bone)
    - Nature of tissue removed (slough, necrosis, devitalized tissue, non-viable tissue, etc.)

Coding Documentation Tips

Diseases and Disorders of the Skeletal/Muscular System

Rhabdomyolysis

When documenting a diagnosis of rhabdomyolysis, please specify the type as traumatic rhabdomyolysis or non-traumatic rhabdomyolysis:

- Traumatic Rhabdomyolysis
  - Traumatic muscle compression - car accident, crush syndrome, fixed position confinement, physical abuse
  - Blood supply to muscle obstruction - arterial thrombosis, artery clamping, embolism, reduced blood supply (as in shock or sepsis)
  - Excessive strain or activity in muscles - Alcohol withdrawal (delirium tremens), extreme physical exercise, persistent seizures (status epilepticus, SE), tetanus
  - Electrical shock - high voltage electric shock (including electroshock weapons), lightning

- Nontraumatic Rhabdomyolysis
  - Autoimmune muscle damage - dermatomyositis, polymyositis
  - Disturbances of electrolytes or metabolism - hypernatremia and hyponatremia, hypocalcemia, hypokalemia, hypophosphatemia, hypothyroidism, increased plasma osmolality, ketoacidosis
  - Infections - Coxsackie virus, herpes virus, Legionella pneumophila, malaria, Salmonella, tularemia
  - Muscle energy supply disorders - carnitine palmitoyltransferase I deficiency or primary carnitine deficiency (CPT type I or II), McArdle's disease, mitochondrial respiratory chain defects, phosphofructokinase deficiency, VLCAD deficiency
  - Poisons and toxins - foodborne toxins, heavy metal, venom
  - Use or abuse of some drugs and medications

Coding Documentation Tips
Functional Quadriplegia

- **Background**
  - Functional Quadriplegia is not a diagnosis of a patient who is a quadriplegic due to paralysis.
  - Functional quadriplegia is not a true paresis.
  - It is the inability to move due to another condition (e.g., dementia, ALS, Huntington's, Parkinson's, severe contractures, arthritis, multiple co-morbid conditions, extreme advanced age, etc.).
  - The patient is immobile because of a chronic severe physical disability or frailty. This is not a diagnosis associated with an acute condition.
  - There is usually some underlying cause. The individual does not have the mental and/or physical ability to ambulate and functionally is the same as a paralyzed person.
  - **Functional Quadriplegia is captured as an MCC because it requires total care for all activities of daily living – increasing the nursing and PCA care required.**

- **Nursing Documentation**
  - Nursing and PCA documentation for ADLs can be found under:
    - Flowsheets
      - Activities of Daily Living Screening
    - Flowsheet
      - ADL assessment

Questions ??

Please contact:

Ruth Linke, RN, CDS, ext. 24934

Thank you.