Physician Education in Clinical Documentation Integrity

Accurately Documenting and Supporting Diagnoses in the Delivery of Inpatient Healthcare

CME

Q4 2025

Objectives

Understand the impact of documentation on various patient, physician, and hospital metrics

Understand the basic concepts that occur when translating clinical language to coding language

Be able to effectively and efficiently document clinical conditions for accurate SOI/ROM

Understand how to use the Tenet tools available to assist with documentation

Reduction in physician documentation clarification query volume

Goals for Participation

- Ensure clinical treatment matches the medical record documentation
- Utilize Tenet tools to assist with clinical documentation
- Reduce queries

Why accurate patient statusing matters

Approach to patient care

Potential diversion of resources required for observation patients (e.g., expedited access to specialists, nurses, MRIs, ECHO or stress studies)

Access to post-discharge care

Access to SNFs: “[Patients] with similar post-hospital care needs have different access to and cost sharing for SNF services depending”[1] on patient status

Physician / hospital quality metrics

Patient status accuracy improves individual physician quality metrics (e.g., LOS, mortality rate, complication rate, etc.)

Reduction of engagement with UR or PA teams

More specific documentation on medical necessity of patient status can reduce time dedicated to UR communication

Reimbursement and patient financial impact

Payers may refuse necessary treatment for patients if medical necessity is not proven in documentation; these denials may lead to incurred costs for patients

1. Medicare Advocacy

Source: Tenet utilization review and physician advisor teams

Observation status

A patient whose care can be safely managed in a setting other than an acute care setting

vs

Inpatient status

A patient whose medical care requirements indicate that they may be appropriate for in-hospital services which should only be provided in the inpatient hospital setting (acute care bed)

From ACMA: American Case Manager Association

Inpatient versus Observation status

Inpatient status

When a Medicare and Medicare Advantage patient is admitted to inpatient status, Attending Physician should certify an anticipated stay across two midnights

- Requires documentation of services that can only be provided in a hospital setting
- List potential risks to patient if discharged (sepsis, death, etc.)

Medicare advantage, Commercial payers rely on commercial guidelines (InterQual, MCG) and their own internal guidelines to determine inpatient status

- Two midnight certification not needed

Observation status

Observation is often appropriate for “signs and symptoms diagnoses” and minor conditions or mild exacerbations of a chronic condition; these may include the following:

Signs and Symptoms Diagnoses

- Chest pain
- Shortness of breath
- Abdominal pain
- Altered mental status

Minor conditions/Mild exacerbations

- COPD/Asthma exacerbation
- Cellulitis without sepsis
- TIA
- Syncope

Source: Tenet Status and Clinical Documentation physician advisor slide deck

How should I be thinking about observation versus inpatient status?

Observation	**Symptom** • Chest pain • Syncope/ Dizziness • Abd. Pain/ Diff. breathing	**Diagnostic testing** • Orders focus on determining the cause of symptoms	**Chronic** • CHF • COPD • Asthma • HTN • Diabetes	**< 24-hour recovery** **Chronic exacerbation expected to recover** • CHF • COPD • Asthma • HTN • Diabetes
Inpatient	**Specific diagnosis** • STEMI • CVA w/residual deficits • Resp. failure/ PE/ Sepsis	**Defined treatment** • Orders focus on specific treatment requiring hospitalization	**Acute** • Pneumonia • Pyelonephritis • Cellulitis	**Clinically ill** **Chronic exacerbation demonstrates illness is severe** • CHF • COPD • Asthma • HTN • Diabetes

Source: Tenet Status and Clinical Documentation physician advisor slide deck

Process to escalate patient status questions

Badge buddy guidance

Leverage your badge buddy for condition-specific patient status guidelines

Utilization review

Actively engage the UR department when they reach out to you on status clarifications / questions

Case management

Work with case management during weekly length of stay meetings to solve through complex cases

Physician advisor

Connect with your facility physician advisor for clarification or guidance on your patient status decisions

Source: Tenet utilization review and physician advisor teams

Badge buddy – Definition of Observation

Condition	Signs & Symptoms
Abd Pain	Pending diagnosis, negative labs, hx of abdominal surgery
ACS	EKG normal/unchanged, negative troponins
Anemia	H&H < 7.0 & 21%, syncope versus presyncope
Arrhythmia: Atrial	New onset Afib/Aflutter & HR < 110. Resolved post ER IV Antiarrhythmic/cardio conversion/ ibutilide
Asthma	Hx of, SABA > 2 doses, wheezing, SX airway obstruction
Cellulitis	Animal/human bite of face/hand/etc. or failed OP anti-infective Tx
CHF	Failed OP Tx, dyspnea after >1 dose diuretics, rates, pleural effusion/ pulmonary edema/ cardiomegaly on CXR
DVT	+US and risk for bleeding requiring monitoring and anticoagulation
ESRD	Missed HD, clotted access, weight gain
General Surgery	Appy/Chole/(scheduled) TKA & THAI Urology/ Most GYN
GI Bleed	IL IVF or blood products prior to decision to admit. H&H >7 % 21%, coffee ground emesis/ hematemesis
Migraine	Failed OP management OR incapacitating/ intractable or focal neurological findings
Syncope	Presyncope/ syncope occurring during exertion or aortic stenosis, EF <35%
Stroke/ TIA	Neuro deficit resolved/ resolving & CT/ MRI performed. Vascular or Carotid US performed pending

Source: Tenet “badge buddy” education

Badge buddy – Definition of Inpatient

Condition	Signs & Symptoms
NSTEMI/Unstable Angina/STEMI	Positive troponins, EKG changes
Anemia	Hemolytic, H&H < 10 & 30%, exertional dyspnea, presyncope/ syncope, blood products transfused
Arrhythmia: Atrial	New onset Afib/ Aflutter requiring continuous antiarrhythmic/ digoxin/ permanent pacemaker or SVTI SX bradycardia
Asthma	Impending intubation or NIPPV, or status asthmaticus. Use of accessory muscles, confusion or drowsiness documented.
Cellulitis	Immunocompromised, located over prosthesis/ implanted device or orbital
CHF	New onset & dyspnea, paroxysmal nocturnal dyspnea & rales/ gallop, pleural effusion/ pulmonary edema/ cardiomegaly
DVT	US confirmed & continuous heparin drip or risk of limb compromise & anticoagulants, etc.
ESRD	NA as a primary diagnosis.
General Surgery	Inpatient Only List (IPO). May discuss with Utilization Review/ Case Mmgt
GI Bleed	GI bleed & IL IVF or blood product transfusion prior to admit. H&H <7 & 21%
Migraine	NA as primary diagnosis
Syncope	NA as primary diagnosis
Stroke	Acute ischemic or hemorrhagic stroke with new onset neuro deficit. TIA is NA as primary diagnosis.

Source: Tenet “badge buddy” education

Case #1: Atrial fibrillation with RVR

62-year-old male with history of hypertension presents with chest pain and palpitations for 2 hours

EKG shows atrial fibrillation with a rate of 145, no ST changes, laboratories normal including troponin, BNP

Patient given diltiazem including infusion in the emergency department with good rate control

Source: Tenet utilization review and physician advisor teams

Case #2: Congestive heart failure exacerbation

72-year-old male with hypertension, CHF with most recent ejection fraction at 35% presents with 2 days of worsening shortness of breath and lower extremity edema

On presentation blood pressure 172/94, pulse 104, oxygen saturations 91% on room air

EKG shows no acute changes with sinus rhythm. Chest radiograph shows pulmonary vascular congestion

Laboratories reveal troponin 0.03, BNP of 1500 otherwise unremarkable

Source: Tenet utilization review and physician advisor teams

Case #3: TIA/CVA workup

81-year-old male with history of hypertension hypercholesterolemia presents with speech difficulty and tingling on right side of the body onset 12 hours prior

Vital signs unremarkable and NIH score assigned to

1 for dysarthria and 1 for sensation

Initial stroke workup including perfusion studies negative

Symptoms are resolving and she is almost back to baseline

Laboratories and EKG unremarkable

Source: Tenet utilization review and physician advisor teams

Case #4: Asthma/COPD

66-year-old male with oxygen dependent COPD on 2 L at home, hypertension presents with 2 days of worsening shortness of breath and nonproductive cough

Patient is not steroid-dependent nor on any recent steroids, using nebulized therapy at home without improvement

On presentation respiratory rate 26, oxygen saturations 86% on 2 L nasal cannula

Patient with diffuse wheezing and scant retractions but speaking 3–4-word sentences

Laboratories remarkable for arterial blood gas on 28% oxygen showing a pH of 7.41, pCO2 of 46 and pO2 of 60

Chest x-ray shows chronic changes

Intravenous steroids, nebulized breathing treatments initiated in the emergency department with no improvement therefore patient admitted to the hospital

Source: Tenet utilization review and physician advisor teams

Case #5: AKI

42-year-old male with hypertension on ACE inhibitor presents with generalized weakness, dry mouth after working outside all day. On presentation blood pressure 90/60, pulse 100 with remainder vital signs unremarkable]

EKG normal

Laboratories remarkable for a sodium of 133, hematocrit of 50, BUN 41, creatinine 1.9 with most recent baseline of 1.2.

Patient given 1 L of normal saline with maintenance fluids in the emergency department and remains weak therefore admitted for serial laboratories and hemodynamic monitoring

Source: Tenet utilization review and physician advisor teams

Case #6: Cellulitis

54-year-old male with chronic lower extremity lymphedema presents with 5 days of increasing redness and warmth in both of his lower extremities

On presentation temperature 37.8, normal blood pressure

Physical exam notable for erythema with warmth symmetrical below the knees bilaterally with no wounds, crepitus

Laboratories revealed white blood cell count of 15,000 with a left shift and Doppler ultrasound negative of both lower extremities

Source: Tenet utilization review and physician advisor teams

Judgement for Inpatient admission

Actual duration of hospital care exceeding two midnights

Expectation of patients exceeding two midnights

IP-only procedures

Complex medical factors

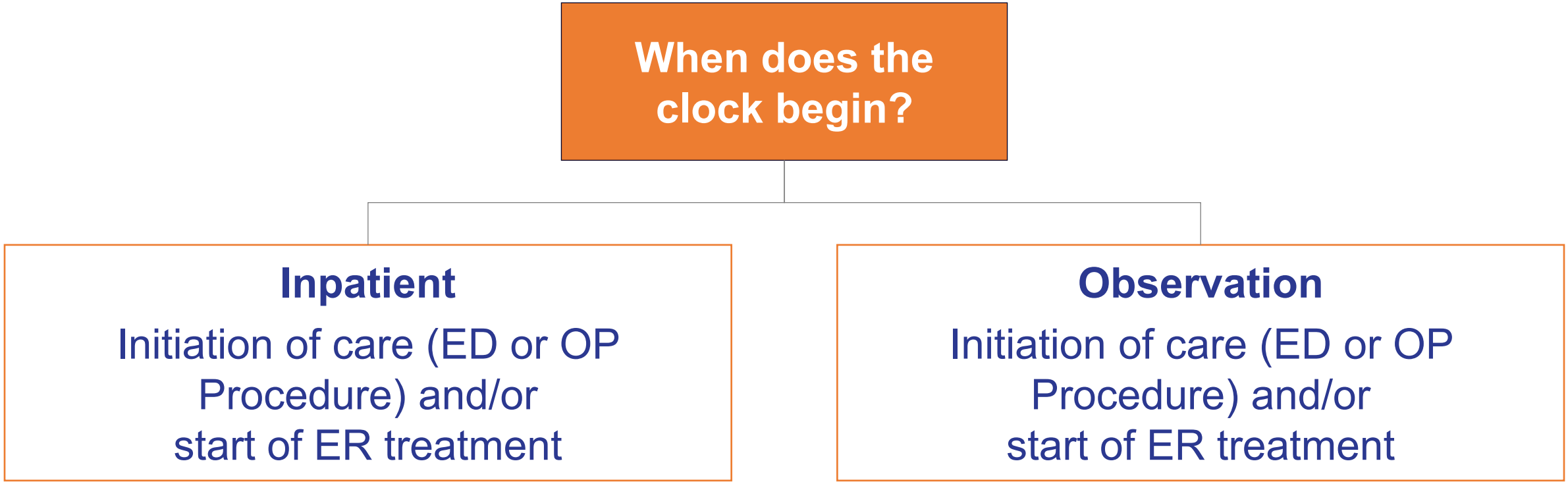
Source: Tenet utilization review and physician advisor teams, Tenet Status and Clinical Documentation physician advisor slide deck

Reasons why a Medicare patient may qualify as inpatient with a length of stay less than two midnights

1. Leaving against medical advice
2. Unexpected recovery
3. Transfer to higher level of care
4. Hospice
5. Death
6. Initiation of Mechanical Ventilation

Source: Tenet utilization review and physician advisor teams

Timing of the two-midnight rule



The two-midnight timeframe starts at midnight of the first calendar day the patient is in the hospital bed and continues to the second night.

Source: Tenet CY 2024 Medicare Advantage Final Rule presentation

For patients being admitted as Inpatient, document that you believe the patient requires a hospital stay crossing 2 Midnights

Key elements of the two-midnight rule

The admission order must include the following:

- Correct syntax to include “admit as inpatient” or “admit”
- **Certification statement of anticipated length of stay** (e.g., a declaration of anticipation that the patient will require two or more midnights of care that can only be provided in the acute setting) **and why** noted in H&P
- Documentation in the record that supports the decision to admit

Admission status may be changed at any time between inpatient and observation status, as long as the patient is still physically in the hospital

Source: Tenet CY 2024 Medicare Advantage Final Rule presentation

Treatment Delays are not included in 2 midnights….

Common complicating issues do not justify inpatient admission

Services not being available due to:

- Weekends and holidays
- Short staffing
- Equipment failure
- Need for outside diagnostics
- Physician unavailability

Delays due to:

- Social issues not related to medical necessity or PAC placement
- Family delays
- Consultant availability
- Test turnaround times

Medical necessity will always remain the key driver

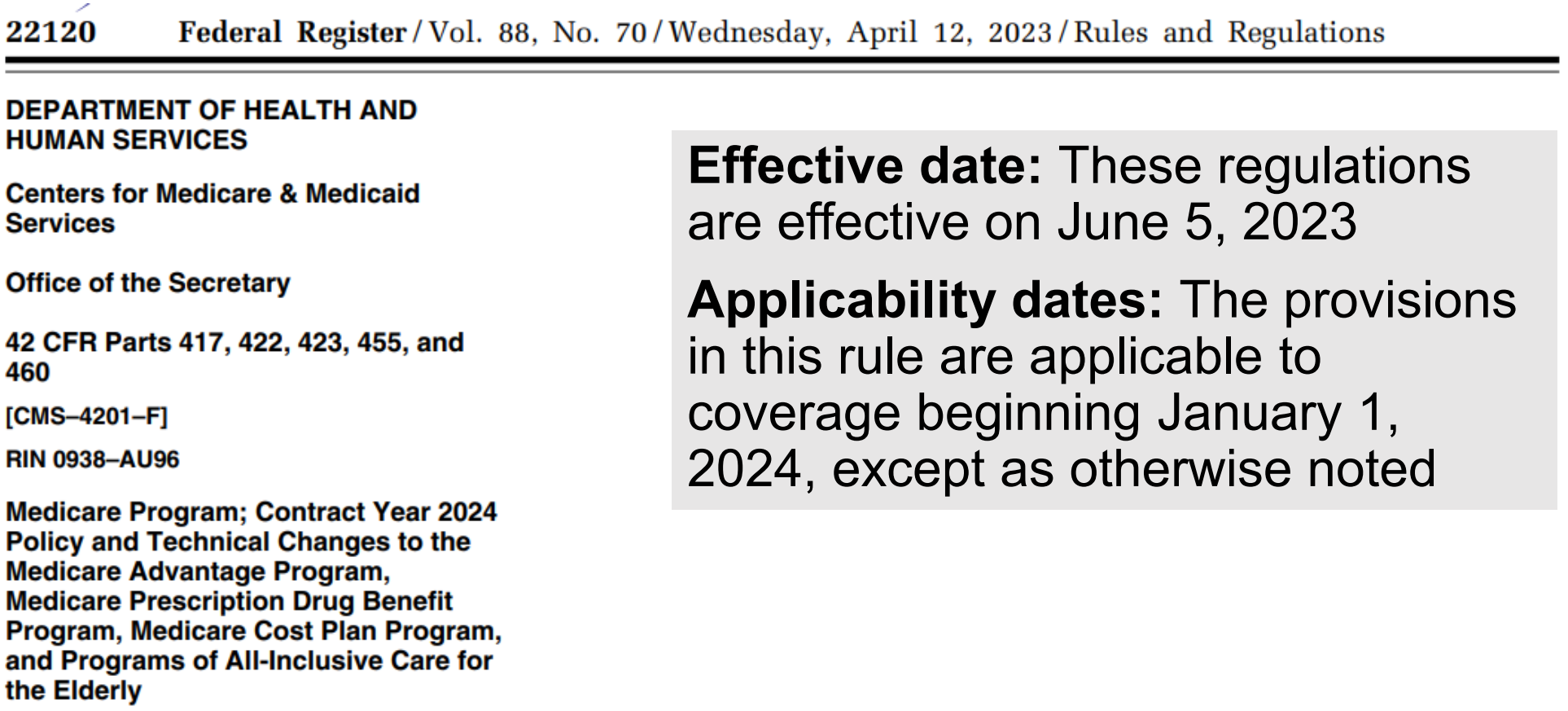
Additional services that do not address the primary reason *for the patient stay* ***will not be deemed as medically necessary*** *and/or may not have been authorized by the patient's insurance, therefore may lead to downstream denials*

Source: Tenet CY 2024 Medicare Advantage Final Rule presentation

Medicare Advantage Plans

What's Changing?

In April 2023, CMS published an update to 4201-F: Medicare Program Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program



22120 Federal Register / Vol. 88, No. 70 / Wednesday, April 12, 2023 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Secretary

42 CFR Parts 417, 422, 423, 455, and 460

[CMS–4201–F]

RIN 0938–AU96

Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Effective date: These regulations are effective on June 5, 2023

Applicability dates: The provisions in this rule are applicable to coverage beginning January 1, 2024, except as otherwise noted

Source: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
Tenet CY 2024 Medicare Advantage Final Rule presentation

Medicare Advantage Plans

What's Changing?

Medicare Advantage (MA) plans are designed to cover the same services as Medicare FFS. They are responsible for the coordination of care for beneficiaries enrolled.

As part of the CMS 4201-F clarification, **CMS made clear that the Two Midnight rule applies to MA plans.**

To reduce potential downstream denials, clinical documentation should outline the presumption of care and support the level of care chosen

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"§ 422.101(b)(2), an MA plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the "two midnight benchmark"); when admitting physician does not expect the patient to require care that crosses two midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the "case-by-case exception"); and when inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2))."

Source: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
Tenet CY 2024 Medicare Advantage Final Rule presentation

Frequently Asked Questions

If I have a simple Chest Pain admission admitted as OBS, but there was an operational delay requiring a total LOS (length of stay) > 2 Midnights (MN), should the status be upgraded?

Depends.

You should only exclude the time of the operational delay. If the care necessitated greater than 2 midnights, irrespective of operational delays, then INPATIENT will be appropriate.

If the operational delay pushed the admission > 2 Midnight LOS when it would have otherwise not, this additional time should not be counted, and the patient will remain is OBSERVATION status.

Source: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
Tenet CY 2024 Medicare Advantage Final Rule presentation

Frequently Asked Questions

What types of delays are considered "operational" or "social", and would not be counted within the 2 Midnight timeframe? *(list not exhaustive)*

- Diagnostic machine (MRI, ECHO, CT Scanner) unexpectedly goes down
- The consultant was never notified of the consult, and takes an extra day to come in
- There is a staffing shortage, and no nurse can accompany the patient to the procedure
- A DC order is placed before the 2 Midnight mark, but the patient's ride breaks down
- A DC order is placed before the 2 Midnight mark, but the patient refuses to be discharged

Source: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
Tenet CY 2024 Medicare Advantage Final Rule presentation

Frequently Asked Questions

What if an ill septic patient anticipated to stay > 2 Midnights and admitted as INPT, rapidly improves and decides to leave AMA after 1 Midnight. Should I change to Observation?

No - maintain Inpatient Status.

In this scenario, the Medicare or MA patient actually meets TWO of the 1 Midnight exceptions that CMS grants:

- Rapid unexpected clinical improvement (with appropriate documentation to support this)
- AMA (Against Medical Advice)

Source: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
Tenet CY 2024 Medicare Advantage Final Rule presentation

Physician ownership of patient statusing

Who is responsible for accurate patient statusing?

Licensed, credentialed clinicians who request and receive approval to admit patients may admit patients to a hospital

Admission status is determined by the admitting physician and is NOT determined by patient, family, nurse, or other member of the care team

Support teams such as physician advisors **can assist physicians in awareness** of guidelines, but cannot make the final determination

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It is the expectation of the admitting clinician to determine the initial level of care for the patient (OBS vs INPT)

It is the expectation of admitting clinicians and supervising/collaborating physicians to ensure the appropriate level of care is selected upon admission

Same applies for attending physicians who oversee resident physician activity

*Further, **physicians are to monitor the clinical course** of the patient and **adjust status as needed***

Source: Tenet utilization review and physician advisor teams

Physician ownership of patient statusing

What are some considerations when through placing a patient in IP versus OBS?

For patients in Observation status:

- It is the expectation that they will be evaluated more than once a day, with continued need to assess for readiness for discharge vs admit to INPT
- Medicare or Medicare Advantage Patients who are in OBS after one midnight and medically need a second midnight of care should be converted to INPT status
- Strong documentation of awareness that patient is in OBS and rationale to keep in OBS or convert to INPT due to medical necessity should be documented in medical record

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Patients who are inpatient after one midnight and being planned for discharge should be carefully evaluated about their appropriateness for INPT:

- Did patient have surgical inpatient-only procedure done?
- Did patient have significant acuity on day #1 and patient unexpectedly recovered rapidly on day #2?
- Was it in hindsight more appropriate for patient to have been placed into OBS status on day #1?
- If so, patient should be downgraded from INPT to OBS (unless Medicare – needs Code 44 procedure done)
- Consider consulting Physician Advisor for very-short stay inpatient discharges

Source: Tenet utilization review and physician advisor teams

Avoidable days

Avoidable days are barriers that stop a patient's throughput through the hospital causing frustration not only to the patient but to the hospital

Avoidable days cause undue denials that take resources to try to amend, however avoidable days can be justified if there is **proper documentation**

Proper avoidable days documentation may also assist in **improving operational efficiencies** to ensure we're adhering to our medical bylaws

Avoidable days include:

- Consulting physician not seeing patient timely
- Procedure delayed not for a medical reason
- PT/OT not seeing patient timely and/or completing follow ups timely
- Discharge planning not completed timely by Case Management
- Family not giving choices for SNF/HH/LTAC
- Payer not giving auth for post-acute services
- Post-acute service not having a bed/person to fulfill requests
- Case Management not following up on the post-acute services

Source: Tenet utilization review and physician advisor teams

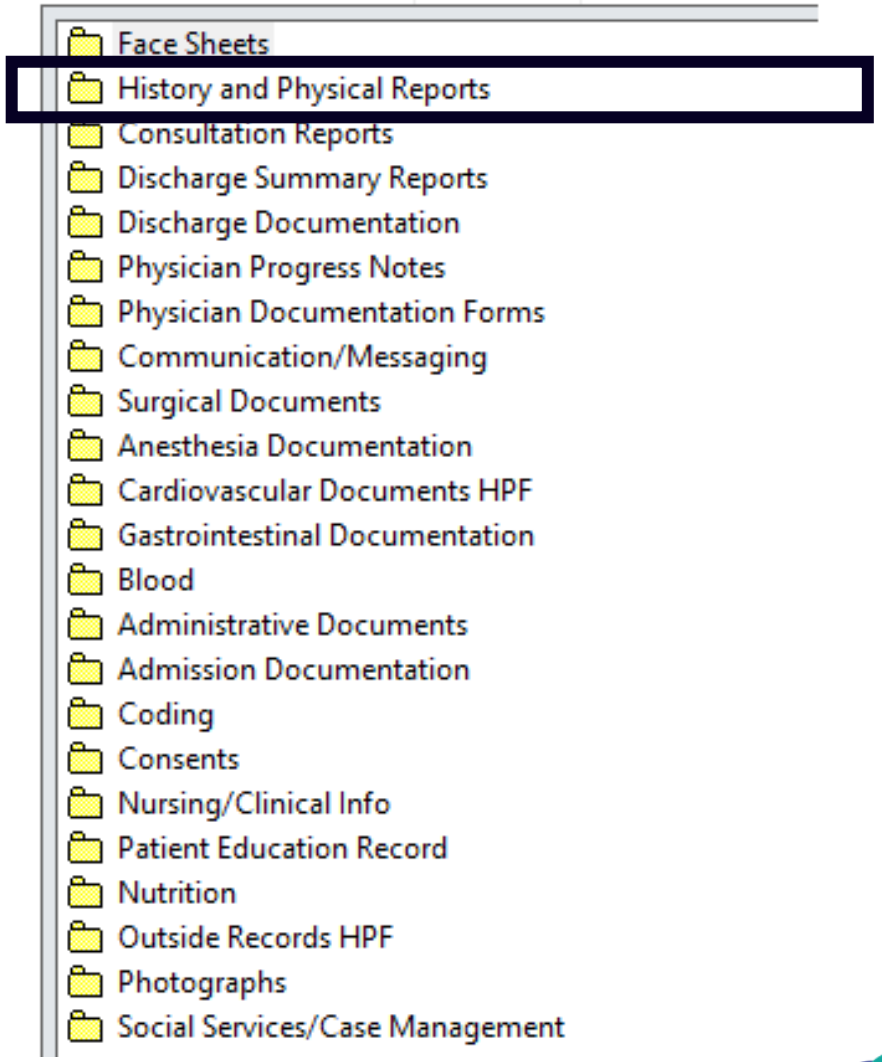
Documentation guidelines

This next section will be focused on documentation expectations and best practices to ensure we are **supporting physician patient status classifications in our documentation**

H&P

The H&P be completed within 24 hrs of admission

The H&P must include a chief complaint, history of present illness, a review of systems, past surgical history, family history, social history, medication list, allergies, and results of a physical examination including vital signs



All physician documentation must be signed in order to be considered valid and used by supporting teams (e.g., UR, physician advisors)

Source: Tenet utilization review and physician advisor teams

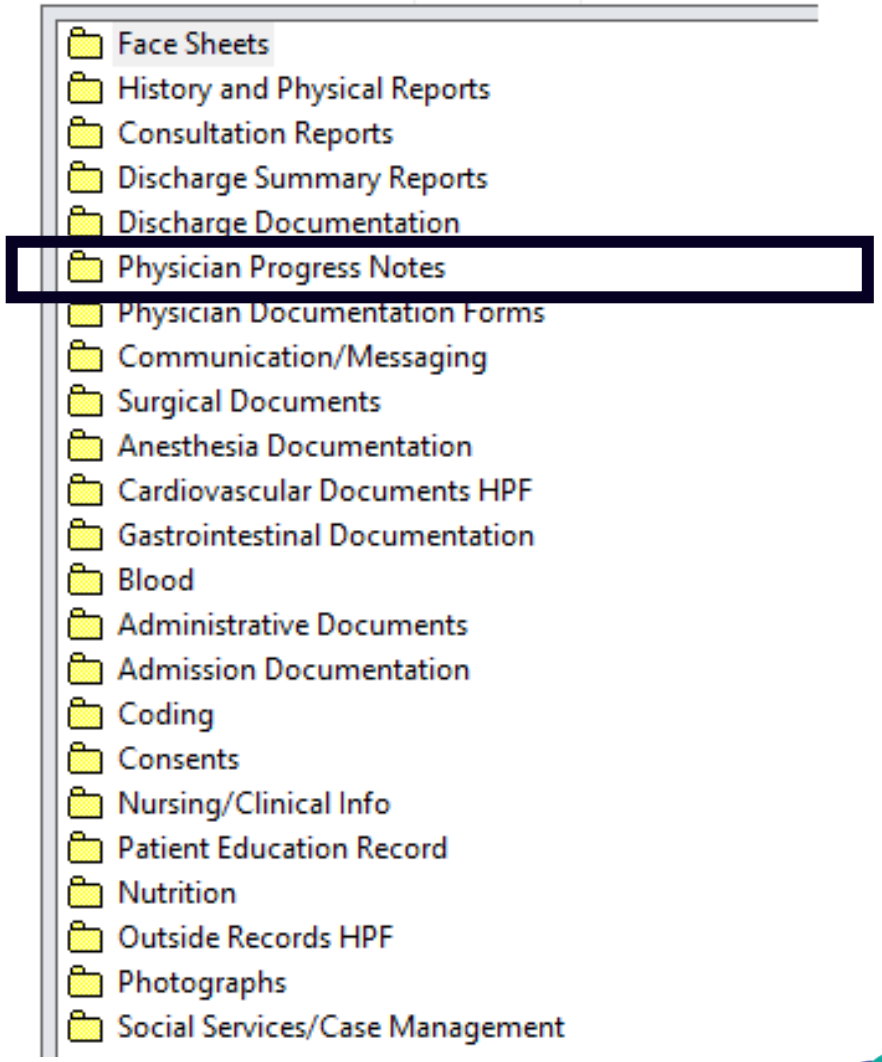
Progress notes

Payers require progress notes to be sent; this requires that information is placed in the progress note concerning new findings/diagnosis

Ensure that your progress note **includes validation of progression of the patient case** as well as the patient status classification

Even if patient is ready to discharge, a progress note must be completed every day to show that the patient is still receiving care

All physician documentation must be signed in order to be considered valid and used by supporting teams (e.g., UR, physician advisors)



Source: Tenet utilization review and physician advisor teams

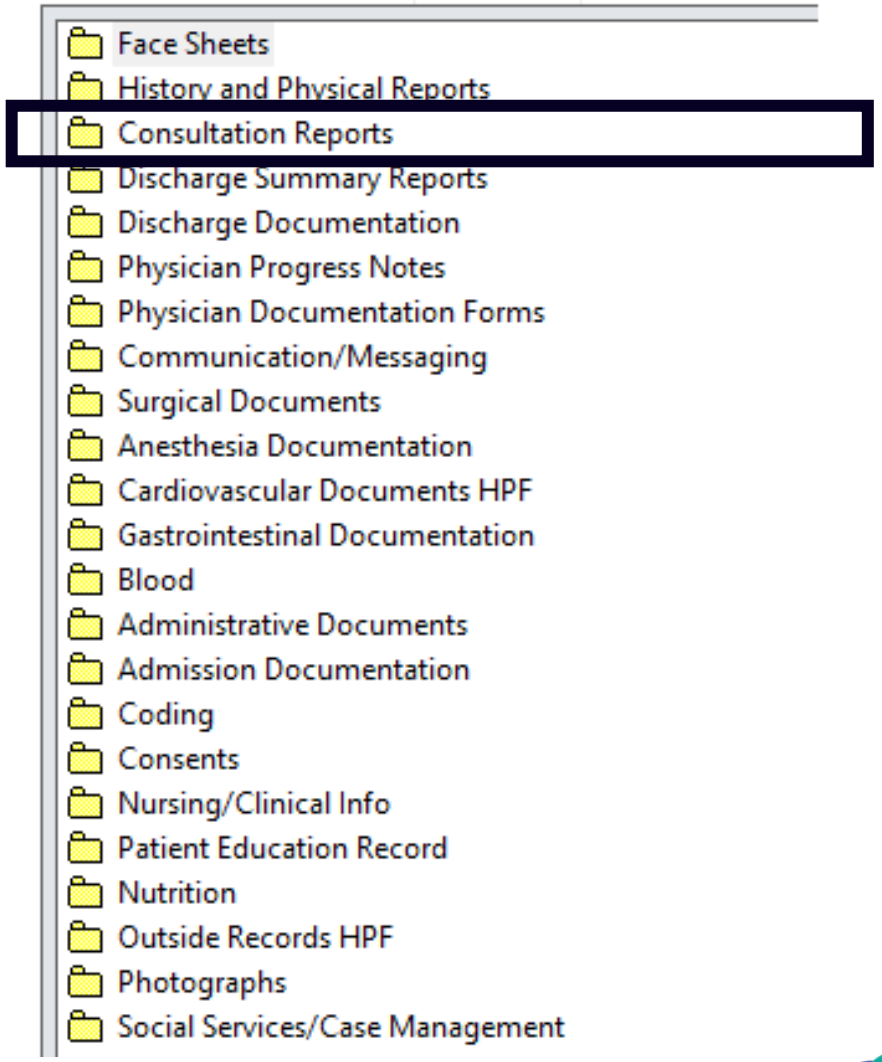
Consultation Reports

Consultation Reports should be completed initially by the consulted physicians i.e., Surgeons/ Cardiologists/ Pulmonologists, etc.

This should be completed within 24 hrs. of order being placed.

Once the initial note has been completed, **progress notes to be completed daily until signing off of case**

All physician documentation must be signed in order to be considered valid and used by supporting teams (e.g., UR, physician advisors)

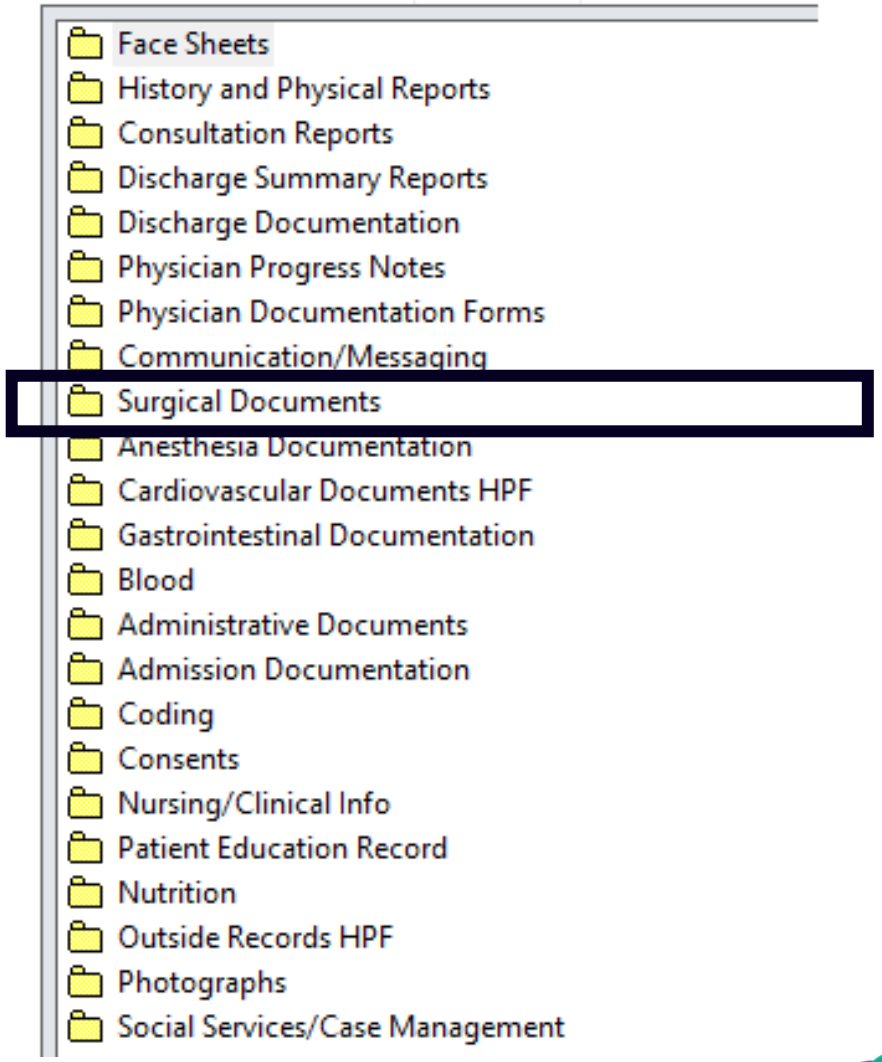


Source: Tenet utilization review and physician advisor teams

Operation/Procedure Reports

These reports should be completed timely

They are needed to ensure that the procedure was completed and if there were no complications during the procedure

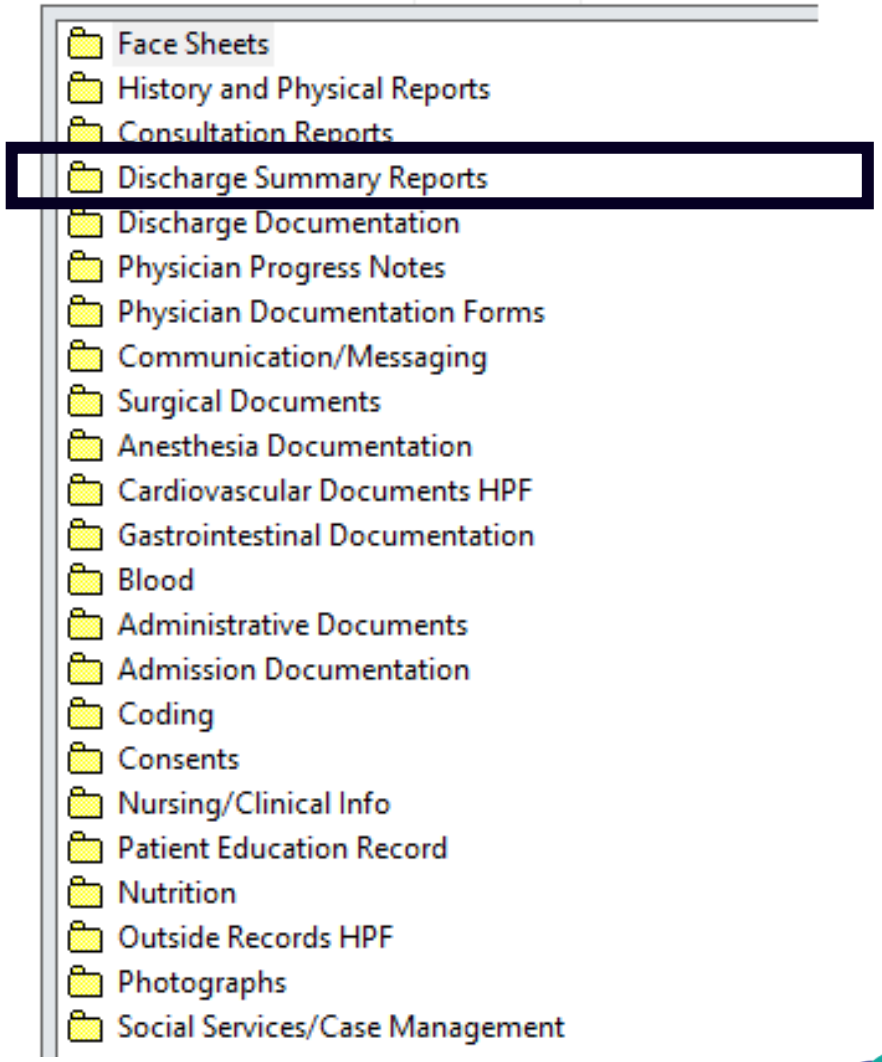


All physician documentation must be signed in order to be considered valid and used by supporting teams (e.g., UR, physician advisors)

Source: Tenet utilization review and physician advisor teams

Discharge Summary

Discharge Summary should be completed when patient discharged, the information should map out the treatment and progress during stay as well as discharge disposition



All physician documentation must be signed in order to be considered valid and used by supporting teams (e.g., UR, physician advisors)

Source: Tenet utilization review and physician advisor teams

APPENDIX

What is CDI?

Clinical Documentation Integrity (CDI). A CDI program is designed to concurrently improve the integrity (i.e., completeness, accuracy and clarity) of the clinical documentation in the inpatient setting. The goals of the CDI program are to:

- Accurately reflect the severity of illness of the patient population
- Ensure accurate payment (i.e., all services provided are captured and patient acuity/complexity is accurately recorded)
- Reduce compliance exposure
- Reduce coding turnaround time and decrease post-discharge questions to physicians
- Prevent audit contractor denials and DRG changes

THE WHY?

- Your documentation reflects the patient in the bed, the necessity of clinical diagnostics, the need for continued length of stay (LOS) and the quality of care provided.

- The final coded record, which is the outcome of your documentation, is shared and available to CMS, data mining agencies and insurers. The information is also used by the hospital to evaluate quality, financial performance and healthcare initiatives for the organization.

The Impact of Clinical Documentation

- *Documentation Explosion*

Documentation Impact

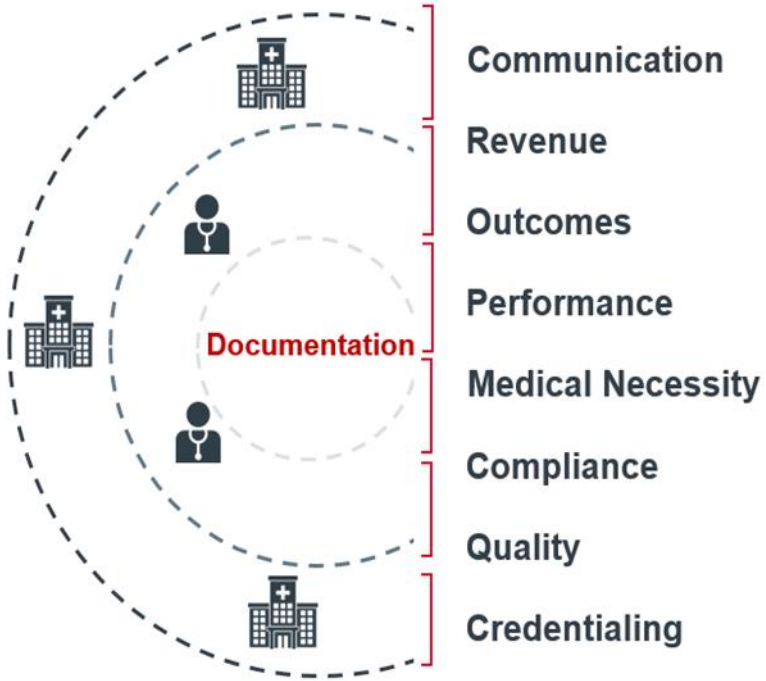
- Payers, Patients, State and Federal Governments
- Professional fees, VBP, MIPS
- Medical necessity, Level of Care, Hospital DRG's

Publiclly Reported Quality Data

- CMS Star ratings, Leapfrog Group, Specialty Societies

Population Health and Chronic Disease Managemer

- Claims data used to identify population groups



Tenet Tools

artifact health	**Physicians can choose to utilize the mobile app to receive and answer queries.**
iodine	**Iodine is a clinical documentation AI platform which assists in identifying documentation opportunities.**
Cerner	**Dragon Medical Advisor (DMA) – Identifies diagnoses and provides advice for specificity.**
Tenet Health Physician Advisors	**Tenet Physician Advisors are available to assist in education and are partners for CDI initiatives.**

The Challenge of Documentation

CLINICAL DOCUMENTATION

Based on historical practices and training, physicians/providers use

clinical terms

CODING REQUIREMENTS

Based on rules and regulations, coding requires specific

diagnostic terms

Coders

submit PDX, MSDRG, CC, MCC

CDS

Review clinical documentation in real-time

MD notes

- Direct patient care
- Communication

Key Documentation - Present On Admission

Critical to document Present On Admission

If a condition is Present on Admission (POA), document

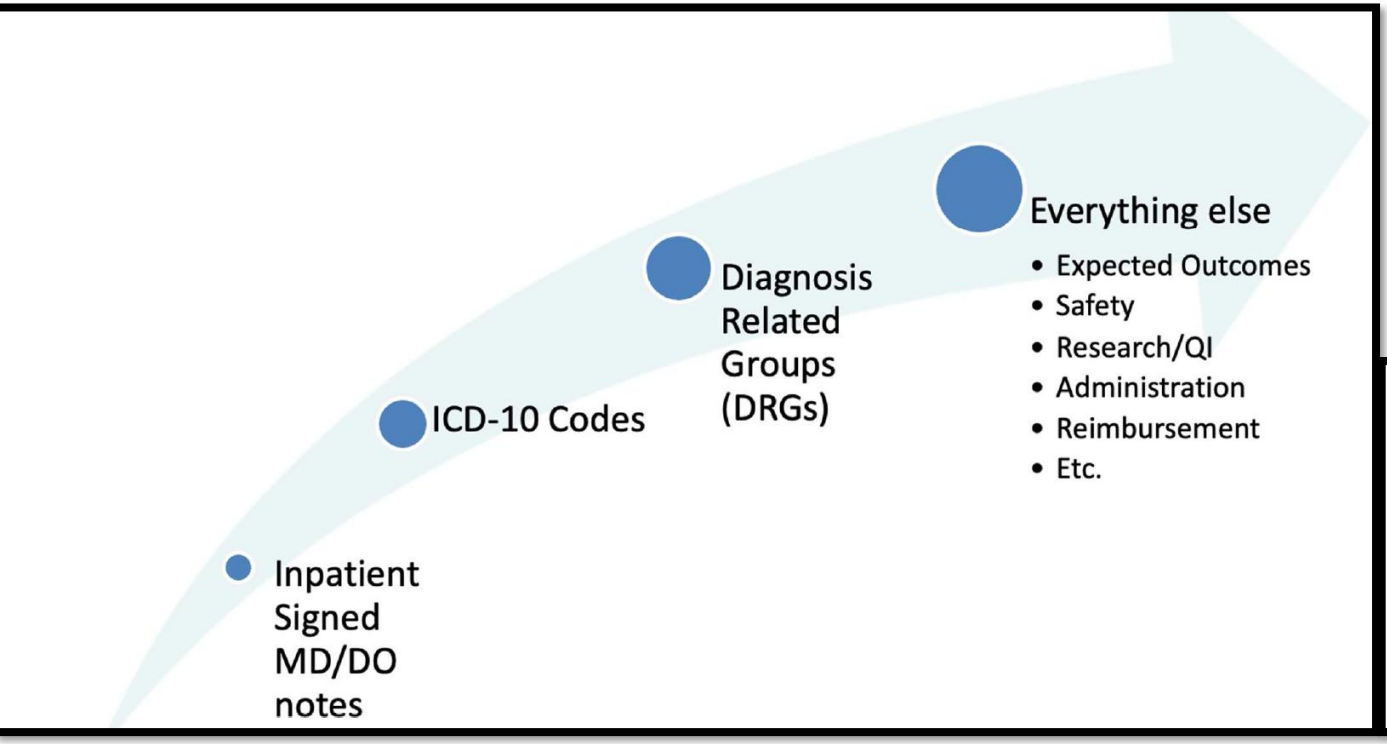
- All known details
- Type of encounter (initial, subsequent, sequelae) for injuries and poisonings
- Link a complication of medical care to its suspected cause
- Document suspected organism, if known or based on risk factors

Present on Admission (POA) status is a significant driver of quality reporting and risk stratification. Some conditions (e.g. UTI or pressure ulcer) when not identified as POA, are considered a Hospital-Acquired Conditions (HACs) and negatively impact quality scores

Note: Make sure infection due to a device is clearly documented as POA if appropriate

Documentation Examples

- UTI due to indwelling Foley, POA
- MRSA infection due to central venous catheter, POA
- Stage 3 Pressure Ulcer to Buttock, POA



Case Mix Index (CMI)

CMI is the average of all DRG relative weights in a given timeframe. It is commonly used as a measure of a Hospital's or Physician's patient population severity of illness.

CMI can also be used by government and other payers for hospital or physician comparison for any number of reasons, such as:

- Profiling
- Pay-for-Performance
- Value-Based Purchasing

What are DRGs?

DRGs: Groups of clinically related diagnoses with similar resource consumption

Two Common Types:

- MS-DRG (Medicare Severity-Diagnostic Related Group)
- APR-DRG (All Patient Refined-Diagnostic Related Group)

Only 1 DRG is assigned per inpatient discharge

CMS releases the updated DRG table on October 1st each year.

Concepts- Defining Diagnoses

Principal Diagnosis

The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

- *Example: Patient admitted with acute on chronic systolic CHF and pneumonia. Patient given IV Lasix and IV antibiotics. Either may be sequenced as principal diagnosis.*
- Best practice: Meet core measures for both diagnoses.

Secondary Diagnoses

All other conditions, either present on admission or that develop subsequently, may qualify as secondary diagnoses if they are monitored, evaluated, or treated during the encounter.

- *Example: Patient admitted with a diagnosis of probable aspiration pneumonia, treated with IV antibiotics. Patient was noted to have a BMI of 45 which indicates morbid obesity and dietary counselling was ordered.*

Concepts- Secondary Conditions Further Defined

Comorbid Conditions (CC)

Complication or comorbidity that has been identified as having impact on severity of illness and/or risk of mortality

Major Comorbid Conditions (MCC)

Major complication or comorbid condition that has been identified as having **significant** impact on the severity of illness and/or risk of mortality

CMS decides what codes are considered CC/MCCs. These codes are reviewed annually and changes to code designations are announced in **the "Final Rule," which becomes effective** October 1st annually.

Case Mix Index

	CMI	Average LOS	Total # Of Case Mortalities 2017
Dr. Smith	1.7	5 days	6
Dr. Jones	2.6	5 days	6

Lower CMI with *same* length of stay?

Lower CMI and *same* mortality rate?

- Which physician looks “inefficient”?
- Which physician appears to give a higher quality of care?
- Which physician has to explain why their “less sick” patients are dying at the same rate?

Risk Adjustment

What is Risk Adjustment?

Risk adjustment is a statistical method used to accurately and fairly predict healthcare outcomes.

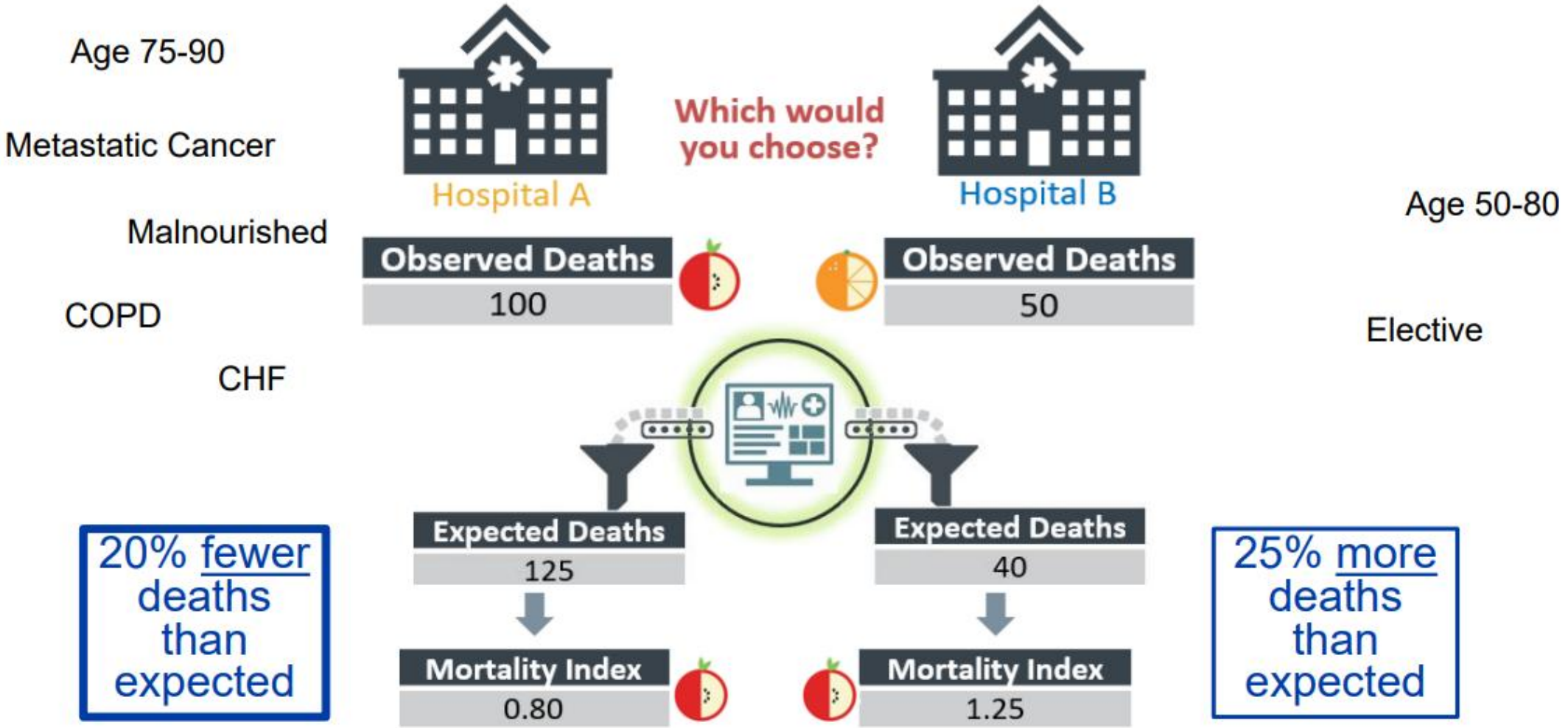
How does Risk Adjustment Work?

Risk Adjustment models take into account underlying health status, as well as other risk factors to 'score' individual patients, providers, and healthcare organizations.

Why Risk Adjust?

Aims to answer the question: "How would performance of various units compare if they had the same mix of patients?"

Why Risk Adjust



Length of Stay (LOS)

Observed vs. expected LOS: Why does it matter?

Observed LOS

The actual number of days the patient is in the hospital.

vs.

Expected LOS

The average number of days patients within a given DRG stay in the hospital.

Best Practice Documentation Supports Accurate Assignment of Expected LOS

	Written Documentation	Assigned DRG	Observed LOS	Expected LOS
Insufficient Documentation	*68 y/o elective admission for planned colectomy due to CA colon, develops SOB post op.*	***331 – Major Small & Large Bowel Procedures w/o cc/mcc***	10.0	4.0
Best Practice Documentation	*68yo elective admission for planned colectomy due to CA colon, develops **acute respiratory failure** due to exacerbation of systolic heart failure following surgery*	***329 – Major Small & Large Bowel Procedures w/mcc***	10.0	11.3

Expected Mortality

Observed to Expected (O/E) Mortality

- The ratio of observed deaths to expected deaths
- Used to assess whether the hospital had more deaths than expected (ratio > 1.0), the same number of deaths as expected (ratio = 1.0), or fewer deaths than expected (ratio < 1.0).
- **O/E ratio** is calculated by dividing the observed mortality by the expected mortality.

$$\frac{\text{The number of actual or 'observed' patient deaths in the hospital}}{\text{The } \textbf{expected} \text{ average of hospitalized patient deaths with a particular illness or condition that are beyond the control of the medical center, such as age, gender and other medical problems}}$$

Quality of documentation has an impact on the "expected" – poor documentation results in lower expected numbers and high O/E ratio , which inaccurately reflects how sick our patients are.

Documentation Impact on Quality Measures

Severity of illness(SOI) and Risk of Mortality (ROM)

- Documentation should reflect the acuity of the patient…
- If a patient dies because he or she was severely ill, but the documentation translates into codes that do not reflect the severity, the adjusted SOI and ROM poorly reflect the care provided
- Publically reported quality metrics are “risk-adjusted” to account for the acuity of illness and care provided
- Categories are determined based on numerous factors including principal and secondary diagnoses, comorbidities, demographics, patient history, treatment and/or procedures provided, etc.
- Mortalities with lower SOI/ROM are subject to peer review

Four Severity of Illness Subclasses	Four Risk of Mortality Subclasses
1. Minor	1. Minor
2. Moderate	2. Moderate
3. Major	3. Major
4. Extreme	4. Extreme

Examples of progression of SOI/ROM

SEVERITY OF ILLNESS (SOI)		SECONDARY DIAGNOSIS OF DIABETES MELLITUS
1	Minor	Uncomplicated Diabetes
2	Moderate	Diabetes with Nephropathy
3	Major	Diabetes with ketoacidosis without coma
4	Severe	Diabetes with Hyperosmolar Coma

SEVERITY OF ILLNESS (SOI)		SECONDARY DIAGNOSIS OF RENAL FAILURE
1	Minor	Acute or Chronic Renal Insufficiency; CKD Stages 1-5
2	Moderate	End Stage Renal Disease(ESRD) ; Acute Renal Failure, unspecified
3	Major	None
4	Severe	Acute Tubular Necrosis (ATN)

RISK OF MORTALITY (ROM)		SECONDARY DIAGNOSIS OF RESPIRATORY FAILURE
1	Minor	Acute Respiratory Distress/Insufficiency
2	Moderate	Chronic Respiratory Failure
3	Major	None
4	Severe	Acute Respiratory Failure; Acute Respiratory Distress Syndrome

RISK OF MORTALITY (ROM)		SECONDARY DIAGNOSIS OF CARDIAC DYSRHYTHMIAS
1	Minor	Premature Beats
2	Moderate	Sick Sinus Syndrome
3	Major	Ventricular Tachycardia
4	Severe	Ventricular Fibrillation

Clinical Case Assessment -Impact of SOI & ROM

	Physician 1	Physician 2	Physician 3
Principal Problem **Associated Comorbidities:**	**Hypotension** Acute renal insufficiency Hypoxia Low Hgb / GIB	**Shock** Acute renal failure/AKI Respiratory distress Acute blood loss anemia	**Hemorrhagic Shock** Acute renal failure/AKI due to ATN Acute hypoxemic respiratory failure Acute blood loss anemia
Severity of Illness	Low	Moderate	Major
Risk of Mortality	Low	Moderate	Major
Expected Mortality	0.2%	0.7%	12.7%

Physician 3's documentation reflects a higher SOI/ROM of the patient , which leads to an accurate O/E representation of the patient we cared for.

Remember: Signs, Symptoms & Test Results Must Be Linked to Related Diagnoses

While important pieces of the medical record, signs, symptoms and test results are not sufficient for coders to assign a diagnosis.

- Linking signs and symptoms to diagnoses may increase SOI and ROM in the inpatient setting. (The terms 'probable', 'likely', or 'suspected' are all acceptable on the **inpatient** record)
- In the ambulatory setting, documentation regarding patient condition should be to the highest level known, treated or evaluated
- Abnormal findings (laboratory, x-ray, pathology and other diagnostic test results) cannot be coded and reported unless the clinical significance is identified by the treating provider *ICD-10-CM Official Coding Guidelines III.E*

Reminder:

The attending physician is responsible for:

- Documenting all conditions in the progress notes and discharge summary
- Resolving conflicts in the documentation

Uncertain Diagnosis

DEFINITION

An uncertain diagnosis is one that is likely or suspected on clinical grounds but cannot be absolutely confirmed with certainty.

Diagnosis of many conditions is dependent on clinical circumstances and professional judgment without a confirmatory test.
Diagnoses and conditions that are uncertain and not ruled out at the time of discharged are coded as if existed or established (for hospital inpatients only).

DIAGNOSTIC CRITERIA

State that the diagnosis remains likely or suspected in the **discharge summary** or **final progress note**. This will avoid ambiguity and confirm that it was not ruled out.

Uncertain Diagnosis

TERMINOLOGY FOR UNCERTAIN DIAGNOSES

- Probable / Possible
- Suspected / Likely
- Questionable
- Consistent with
- Compatible with
- Comparable with
- Suggestive of
- Indicative of
- Appears to be

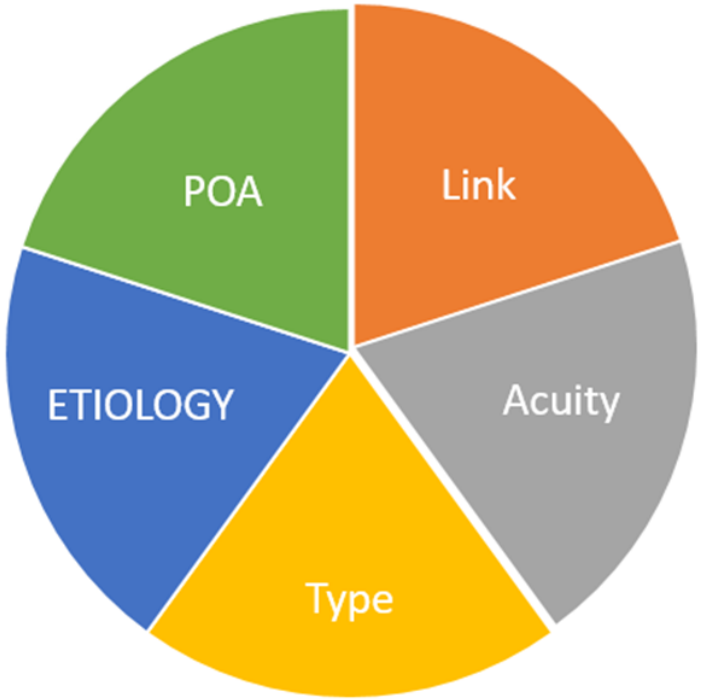
If a provisional or differential diagnosis is determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be documented as an uncertain diagnosis using the above terms.

Physician Documentation Queries

How to get them off your PLATE

- Use the PLATE pneumonic when documenting any principal or secondary diagnosis

- P – Present on admission
- L – Linking conditions
- A – Acuity
- T – Type
- E – Etiology



Discharge Summary

Did you know? **The Discharge Summary is the most important document in the medical record.**

The Discharge Summary is the first document hospital coders review when they start coding any given hospitalization. The Discharge Summary is considered the final diagnostic statement for the entire hospitalization.

- Please include a complete list of every diagnosis or medical issue that impacted your patient's care during their hospitalization.

The Discharge Summary is also the first document Recovery Auditors review in their efforts to deny any given hospitalization and remove important diagnoses.

- There should be no conflicting documentation between what is contained in the Discharge Summary and what has previously been documented in the rest of the medical record.

Please complete the Discharge Summary on the day your patient leaves the hospital.

- Note: Important medical information about your patients and additional significant diagnoses are lost to future providers as all memory naturally diminishes with time.

Studies have demonstrated a trend toward a decreased risk of readmission when the discharge summary arrives before the outpatient follow-up visit takes place. The study, by van Walraven and colleagues (J Gen Intern Med. 2002; 17:186-192), found a 0.74 relative risk of decreased rehospitalization for these patients.

Reference - https://brundagegroup.com/tips/

Physician Documentation Best Practices

Tell the Story

- Diagnoses which are monitored, evaluated, and/or treated should be documented
- Reflect the physician's critical decision making regarding each diagnosis
- "Tell the story" of the hospital stay

Specificity and Acuity

- Documented to the highest degree of specificity and acuity
- Capture with terms such as "acute," "chronic," "acute on chronic," "compensated," "decompensated," or "exacerbated"

Uncertain Diagnoses

- Captured with terms such as "suspected," "likely," or "probable"
- Confirm or rule out within the progress notes
- Use these terms for those conditions that remain uncertain at the time of discharge

Linking Conditions

- Link all symptoms and clinical indicators to underlying diagnoses
- All abnormal lab/diagnostic results of clinical significance need an associated diagnosis, as no diagnosis can be assumed

Discharge Summary

- Summarize the hospital course
- Identify all diagnoses that impacted the encounter
- Complete within 24-48 hours of discharge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