SoutheastHEALTH

Purpose of Compliant Documentation Management Program

- Clinical Documentation Specialist acts as a liaison between concurrent documentation and coding.
- CDS reviews active charts and asks queries of physicians to achieve a quality medical record.
- This will reflect the highest level of severity of illness and risk of mortality of the patient.
- In turn the highest DRG can be achieved which will reflect appropriate reimbursement for the patient's consumption of services.

Role of Clinical Documentation Specialist

Assist Provider with Documentation **which Impacts:**

1. Decreasing LOS
2. Decrease RAC Reviews
3. Increase Revenue / Case Mix Index

Communication between Providers and Clinical Documentation Specialist

- CDS will send queries to providers through Message Center
- Queries will appear in providers box as High Alert with subject line as "Documentation Clarification Query"
- Providers are expected to read queries **and respond**
- If agree with what is being asked, then document response in medical record
- If there is a different cause or diagnosis; document that information in medical record
- If do not agree with query, then send message back to CDS with explanation of why so CDS may learn from that information
- May reach CDS at extension 6101

Documentation Hints

Documents

- POA (Present on Admission) status on all conditions (if not in H/P or on first day Progress notes)
- All diagnosis with severity and type (both Acute and Chronic Conditions)
- Diagnosis (Probable, Possible) for Signs/Symptoms
- Clinical Indicators/Treatment for Each Diagnosis
- Previous physician and consulting physician diagnosis on every progress note
- Current/Probable diagnosis as ongoing, resolving, resolved, or ruled out as appropriate
- ALL diagnosis in Discharge Summary (Both Active and Resolved)
- Laterality as appropriate
- Using only Hospital approved abbreviations

Diagnosis Not Documented or Poorly Documented

- **Acute Blood Loss Anemia** Anemia due to blood loss is not sufficient documentation; **MUST** document **ACUTE** as appropriate
- **Acute Kidney Injury** Renal Insufficiency is not a co-morbid condition; document AKI as appropriate
- **BMI** <19 or > 40 are co-morbid conditions, can be captured from any part of medical record, but the provider **MUST** document **associated diagnosis** (underweight, malnourished, cachexia, Morbid obesity etc.) **and clinical significance** (use of bariatric bed, extra staff for ADLs, difficulty with surgery etc.)

- **CHF** must document both **Severity and Type** –Acute, Chronic, Acute on Chronic Diastolic, Systolic, or Combined
- **Chronic Kidney Disease** document **Stage**1-5 or ESRD If appropriate Acute, or Acute on Chronic Renal FAILURE with Stage *Renal Insufficiency is not considered a co-morbid condition*
- **Malnutrition** read dietician notes and document as appropriate **Severity** and **Type -** Mild, Moderate, or Severe Protein, Calorie, or Protein Calorie
- **Pressure Ulcers** Stage can be captured from any part of medical record, but provider **Must** document **site** of ulcer
- **Respiratory Failure** must document both **Acuity** and **Severity -** Acute, Chronic, Acute on Chronic Hypoxic, Hypercapnic, or both Hypoxic/Hypercapnic CMS recognizes Chronic Hypercapnic/Hypoxic Respiratory Failure if pt has a chronic pulmonary condition and uses continuous home O2 see following specific information
- **Sepsis POA** (present on admission) as appropriate see following specific information

Respiratory Failure

The fact that the patient is not mechanically ventilated does not preclude the use of respiratory failure. Coding Clinic 1990 Q2 p20.

• Respiration <12 or >25 • Air hunger • Use of accessory muscles of respiration • Inability to speak in full sentences • Cyanosis	• Pulse ox <90% RA or < 95% on O2 • pH <7.35 or >7.45 • pO2 < 60mm Hg (or 10mm below COPD patient's baseline) • pCO2 >50mm Hg (or 10mm above COPD patient's baseline)

Sepsis

Sepsis is SIRS plus a documented infection
Severe Sepsis is SIRS plus a documented infection plus Organ Failure

SIRS is documentation of 2 or more	Additional Clinical Indicators for Consideration
• Temperature <96.8 F/36C or >100.4F/38.0C • Respirations >20; PaCO2 <32 mmHg • Pulse >90 BPM • WBC >12K or <4K or Bands >10%	• +/-Altered mental status • Relative hypotension • Oliguria • Metabolic acidosis • Elevated blood sugar in on-diabetic patient

Concurrently the hospital uses Sepsis 2 criteria (listed above) as CMS only recognizes Sepsis 2 criteria and not Sepsis 3 (SOFA scoring)

Documentation Impact

Before	After
Abdominal Aortic Aneurysm, without Rupture Surgical Repair of AAA DRG 254 Other Vascular Procedures w/o CC/MCC LOS 2.3 RW 1.810 = $9,665.40	Abdominal Aortic Aneurysm, without Rupture Surgical Repair of AAA Severe Protein Calorie Malnutrition DRG 252 Other Vascular Procedures w MCC LOS 5.3 RW 3.2598 =$ 17,407.33

Patient was here 5 days