Doc for Docs: Giving "The Talk" to Physicians

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ChartWise BROWN NYHiMA AHIMA Affiliate New York Health Information Management Association

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Some General Guidelines and Hints

- Slides with a light bulb (colored background) are for today's talk
- Slides with *no* light bulb (white background) are for "The Talk"
- Use sparse text mixed with interesting graphics
- Don't read your slides
- Slides with few words are for discussion
- Slides with many words are only for the handout(s)
- Judicious use of self-deprecating humor; be the target
- Use secret visual cues on the slides for topic changes

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Five Things to Know About Jon …

1. **Medical Computing:** Since 1969
2. **Clinical:** Duke-trained cardiologist
3. **Academic:** Clinical Associate Professor at Brown
4. **Administration:** Hospital Boards, Foundation and Finance Committees
5. **Commercial:** Medical software since 1994. Now President and CEO of ChartWise Medical Systems (Computer-Assisted Clinical Documentation Improvement).

I'm MAD!!



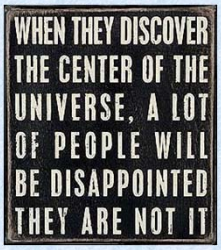

Establish Credibility, Common Ground

- Establish credibility – this is *no time* for humor!
- Establish common ground with the audience
  - ✓ If you are MD, DO, NP or PA you can commiserate that your *own* notes are no longer "adequate"
  - ✓ If you are allied health professional, "This is not why I went to *xyz* school!"
- ✓ Recognize and direct the anger
- ✓ The enemy of my enemy is my friend

Abraham Lincoln (1809-1865)

Make Them Understand and Care

- Make them understand – that's EASY
- Make them care – that's HARD!



Physician Documentation

From OIG and HHS:

*"Physicians should maintain **accurate and complete** medical records and documentation of the services they provide. Physicians also should ensure that the claims they submit for payment are **supported by the documentation**."*

*"The Medicare and Medicaid programs may review beneficiaries' medical records. **Good documentation … helps you address challenges** raised against the integrity of your bills."*

CMS Provides the Following Guidance:

*"We highly encourage **physicians and hospitals to work together to use the most specific codes that describe their patients' conditions**. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population."*

Source: *Federal Register,* Vol. 72, No. 162, Wed. Aug. 22, 2007, Rules and Regulations, pp. 47180–47181.

CMS Provides Further Clarity:

*"We do not believe there is anything inappropriate, unethical or otherwise wrong with **hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation** in the medical record. We encourage hospitals to engage in complete and accurate coding."*

Source: *Federal Register,* Vol. 72, No. 162, Wed. Aug. 22, 2007, Rules and Regulations, pp. 47180–47181.

Physicians & Coders *Must* Work Together

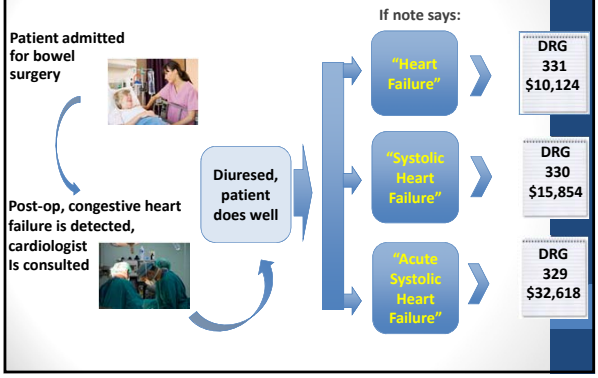
A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures ... ***The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved****.*

Source: ICD-9-CM Official Guidelines for Coding and Reporting.

Current Limitations

- Coding can only be based on MD, DO, NP, PA documentation
- Coders cannot use orders, radiology reports, lab results, medication lists, or nurse's notes
- Documentation sufficient for clinician communication is not always adequate for coding
- Physicians shouldn't deal with complex coding!

Background: One Example



Inadequate Records in the News

Texas Medical Board disciplines 6 doctors
[Wednesday, June 3, 2009]

… **based on inadequate medical records violations …**

Why Should We Care?

Why Should We Care?

- A patient with cholecystitis undergoes a cholecystectomy
- Post-op, the patient spikes a temperature with high WBC
- Abdomen tender, diffuse rebound, pulse 110, respirations 22
- KUB and abdominal CT unremarkable
- IV Cipro started, Infectious Disease consulted
- Patient improves, is discharged on post-op day 6 on oral Cipro

Why Should We Care?

- ✓**Acute Cholecystitis + Laparoscopic Cholecystectomy**
  $8,168, expected LOS 2.4 days
- ✓**Adding Probable Acute Peritonitis and Sepsis**
  $17,477, expected LOS 6.2 days

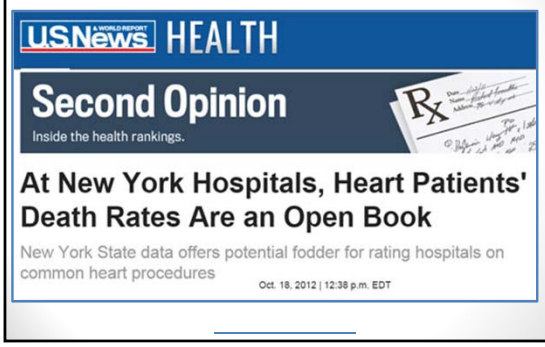
Why Should We Care?


Providence Journal

United Healthcare dropping R.I. doctors from Medicare Advantage network

October 21, 2013

Why Should We Care?


U.S.News & World Report HEALTH

Second Opinion

Inside the health rankings.

At New York Hospitals, Heart Patients' Death Rates Are an Open Book

New York State data offers potential fodder for rating hospitals on common heart procedures

Oct. 18, 2012 | 12:38 p.m. EDT

Make Them Understand and Care

- Don't underestimate the power of the United Healthcare story – hits 'em where it hurts (the wallet)
- Linger and discuss
- Listen for the opening to mimic "*My patients are sicker!*"
  - ✓ *"Has anyone told you that your length of stay is too long, or your resource utilization is too high?"*
  - ✓ *"At my hospital the orthopedic surgeons were not fully documenting how sick their patients were …"*
  - ✓ *"… of course after some training they are now the champs!"*
- This helps to set up the discussion of CCs and MCCs

Complications/Comorbidities (CCs)

- Chronic heart failure (systolic, diastolic)
- Chronic kidney disease Stages 4 and 5
- BMI > 40 or < 19 (also document clinical diagnosis or condition that corresponds to the abnormal BMI and explains its significance)
- Chronic respiratory failure
- Acute renal failure *without* ATN
- Hypertension ("accelerated")
- Acute blood loss anemia
- Hemiparesis

Major Complications/Comorbidities (MCCs)

- Decubitus ulcer
- Acute respiratory failure
- Acute renal failure *with* ATN
- Acute heart failure (systolic/diastolic)
- Encephalopathy
- Severe malnutrition

Present on Admission (POA)

- Y = yes (present at the time of inpatient admission)
- N = no (not present at the time of inpatient admission)
- U = unknown (documentation is insufficient to determine)
- W = clinically undetermined
- Present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

Common POA Conditions

- Peptic ulcer disease, GERD
- CHF, COPD, coronary artery disease
- Dementia
- Diabetes mellitus
- Leg edema
- Renal insufficiency
- Skin breakdown

It's Okay to Hedge Your Bets

For inpatients (not outpatients):

- Probable
- Possible
- Suspected
- Likely
- Still (yet) to be ruled out

... or any variation thereof *can be coded!*

Moving to "Rapid Fire" Mode …

- We are about to enter the most boring part of the talk
- Watch body language and adjust speed accordingly
- Be prepared to move *Rapid Fire* through these
- Remember that text-filled slides should not be read
- Remind the participants that this information is in the handouts

Sepsis Criteria

- Often starts with a patient who looks sick, toxic, or septic
- SIRS: Systemic inflammatory response syndrome (2 or more):
  - Fever over 101°F or hypothermia less than 96.8°F
  - WBC > 12,000 or < 4,000; or bands > 10%
  - Pulse > 90
  - Respiratory rate > 20
- Sepsis is SIRS with a source
- With ICD-10, SIRS can only be used for non-infectious situations (like burns, trauma, etc.)

Sepsis Documentation

- State what sepsis is due to
- The most common causes:
  - Urinary tract infection
  - Pneumonia
  - Cellulitis
- Bacteremia is not the same, not required to document
- There's no such thing as "urosepsis" (use UTI + sepsis)
- Remember to document if sepsis was present on admission!

Documentation Tips: Renal

- *Chronic kidney disease stage I through V,* or *end-stage renal disease* (not chronic renal insufficiency or failure)
- *Acute renal failure:* Creatinine rise 0.5 mg/dl over baseline

Documentation Tips: Renal

Stage is calculated from GFR:

- Stage I = 90 or higher
- Stage II = 60 to 89
- Stage III = 30 to 59
- Stage IV = 15 to 29
- Stage V = < 15
- ESRD = on dialysis

$$\text{GFR} = \frac{(140 - \text{age}) \times \text{weight})}{72 \times \text{serum creatinine}}$$

Documentation Tips: Diabetes

- Specify Type 1, Type 2 or secondary (if secondary, use "Due to"!).
- List all complications and manifestations.
- State whether or not it is controlled.
- State whether or not patient is chronically on insulin.
- When documenting diabetic ketoacidosis, state if it is present on admission (POA). Also applies to hypoglycemic coma and hyperosmolar conditions.

Documentation Tips: CHF

- Always list the ejection fraction (EF)
- Chronic CHF and/or acute CHF
- Use “acute on chronic” rather than “exacerbation”
- Systolic (EF < 40%) or diastolic (normal EF or echocardiographic evidence of diastolic dysfunction)
- For discharge summary:
  - Include the date of the most recent (or scheduled) echo
  - If patient is not on ACE or ARB, explain why

Documentation Tips: Anemia

- List the anemia and its cause
- Example:
  - ✓ Anemia due to acute GI blood loss
  - ✓ Upper GI bleed due to varices

Documenting Post-Op Anemia

- Hemoglobin and hematocrit can change during the perioperative period due to hemodilution, hemoconcentration, splenic “auto-transfusion,” etc.
- It’s important to document anemia, especially if you are going to treat it
- If, in your judgment, surgery results in more than an “expected amount of blood loss” and has anemia, document that this is a complication of the surgery

Documentation Tips: Pneumonia

- Complex pneumonia:
  - Aspiration pneumonitis
  - Staphylococcal/MRSA
  - Pseudomonas
  - Gram-negative
- Simple pneumonia:
  - "Pneumonia," ventilator-acquired, community-acquired, hospital-acquired
  - Community-acquired (viral, Pneumococcal, H. Flu, Mycoplasma)

Documentation Tips: Malnutrition

- Use this diagnosis if there are two or more of the following:
  - ✓Insufficient energy intake
  - ✓Weight loss
  - ✓Loss of muscle mass
  - ✓Loss of subcutaneous fat
  - ✓Localized or generalized fluid accumulation that may sometimes mask weight loss
  - ✓Diminished functional status as measured by hand grip strength
- *Get a nutrition consult!*

Documentation Tips: Other

- Respiratory failure: Distinguish acute vs. chronic (always acute if on ventilator or BIPAP or if $pCO_2 > 50$ or $pO_2 < 60$ or in respiratory distress)

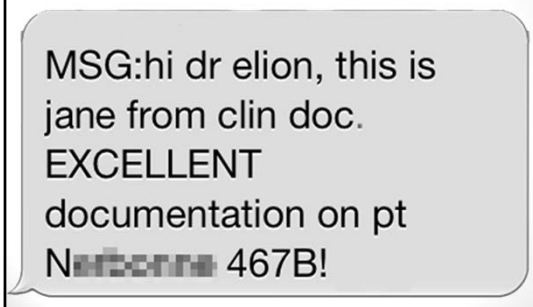
Documentation Tips

- Put *all diagnoses* into the discharge summary
- Use a problem-specific (not organ-specific) approach
- Maintain a complete problem list; review daily
- Write "present on admission" as appropriate
- Okay to use "probable, possible, suspect, or likely"
- *Not* okay to use symbols or arrows (creatinine ↑'d)
- *Interpret all abnormal lab data!*

Phew!

- Phew – made it! Is your audience still with you??
- Take a definitive pause in the presentation, acknowledge that was a lot. Remind them about the handouts.
- We are about to introduce the two most important words of the entire presentation: **DUE TO.**
- But we'll slide into this indirectly with a quick story …

What's Wrong With This Picture?



The Note:

This patient is known to have severe Aortic Stenosis. Her downhill slide is probably due to dietary indiscretion (she does not follow her diet). She is symptomatically much improved after initial diuresis. Her clinical picture is consistent with acute-on-chronic systolic CHF due to Aortic Stenosis.

Improve Documentation With …

- Due to …
- Manifested by …
- Indications include …

The Pay-Off Slide

- The next slide is an entire workshop in CDI reduced to one slide.
- Emphasize that it's a real note. Read the entire note.
- If you have the right audience, you can engage them with an interactive exercise.
- This is equally powerful done as a non-interactive demonstration.
- This is the slide where the "light bulbs" go off – watch the body language!

How Can This Note Be Improved?

1. **Assessment Plan**
2. high k- resolved- I am very worried about gi bleed- needs stolls- ? gi consult
3. esrd- hd for wed
4. avr- on hep> coumadine
5. bradycardia- resolved
6. dm

pt follows diet and goes to dial- he has high k , dropped hb, abd pain>>?? gi bleed????

The "Lightning Round"

- This is usually quite fun and engaging
- Set yourself up as the target – say that these are some examples of *your* notes (if you are a clinician) or notes that you found
- *NOW* audience members usually get engaged and speak up – be sure to show your appreciation

Documentation Tips: Quickies

Medical record says … (unable to code)	Better to say … (able to code)
RUL Infiltrate	RUL Pneumonia
Upper GI bleed, Hgb 5.2, will transfuse	UGI bleed, acute blood loss anemia
Emaciated, poor intake, 40# weight loss	Malnutrition
ABG *ph 7.24, $PaCO_2$ 36, HCO_3 14*	Uncompensated metabolic acidosis
Poor skin turgor, mucous membranes dry, will rehydrate	Dehydration
BP *70/40,* requires pressors for support	Shock
Troponin and CPK elevated; EKG Positive	Acute MI

Documentation Tips: Quickies

Medical record says … (unable to code)	Better to say … (able to code)
No overt CHF; continue diuretics	Compensated chronic systolic CHF
Unable to void; 500 cc when cathed	Urinary retention
Thick green sputum, large number of WBC's and gram-negative Rods; will cover with Ceftriaxone	Gram-negative pneumonia
Infiltrates on CXR, temp 102°F, WBC's 18,000, pulse 102	Sepsis secondary to pneumonia
Poor skin turgor, mucous membranes dry, will rehydrate	Dehydration

Documentation Tips: Quickies

Medical record says … (unable to code)	Better to say … (able to code)
End-stage COPD	Chronic respiratory failure; acute exacerbation of COPD
CXR shows COPD. Diffuse wheezes on exam. Rx with nebulizer, O_2	Acute exacerbation of COPD
RLL infiltrate, swallow study abnormal	Probable aspiration pneumonitis

That's All Folks!

- A final summary slide is not typically needed
- A slide for "Any Questions" is also unnecessary
- Thank your audience profusely and beam at them proudly
- Finish with your favorite humorous image