OFF THE RECORD

BHS NEWSLETTER FOR CDI

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CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

Successful clinical documentation improvement (CDI) programs facilitate the accurate representation of a patient's clinical status that translates into quality reporting, physician report cards, reimbursement, public health data, and disease tracking and trending.

AHIMA (American Health Information Management Assoc)

HAVE WE GOT THE COMPLETE CLINICAL PICTURE?

It is important that the clinical documentation for a patient builds a complete picture of what is impacting on the care and treatment for that individual. For the coding team to translate this to code and incorporate it into the data for a patient this documentation needs to be very clear, not implied or assumed.

A phrase being used commonly in our records is 'on a background of'. For example 'PR bleeding on a background of diverticulosis and warfarin'. In this instance we would just be able to code the **PR bleeding** as we cannot assume that the diverticulosis and warfarin are the underlying cause of the bleeding. The DRG for this scenario would be **G61B *Gastrointestinal haemorrhage, minor complexity*** – for a public patient in for up to 9 days we would get **$3,498**. If however we have clear documentation such as 'PR bleeding likely caused by **diverticulosis** in conjuction with **warfarin**', we could reflect this with our coding resulting in **DRG G61A *Gastrointestinal haemorrhage, major complexity*** and for a public patient staying up to 11 days we would get **$4,372.**

DOES THE PATIENT HAVE COMORBIDITIES?

We often get a well documented medical past history in the admission notes, but it is not always obvious to us which if any of these conditions is impacting on the treatment or care given for us to be able to code them out. For a coder to assign the code, we need to see that one of the criteria below has to be met;

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring

Coders will read all notes relevant to an episode and check the medication charts as well. The medication charts are most useful to us when the 'indication' field for a drug has been completed.

The comorbidities are also vitally important to capture for performance data and comparing patients within a particular diagnosis group. For example you may have two patients, both female aged 65 with pneumonia. One patient has stayed for **3 days** the other for **14 days**. Why so much difference? If the complete clinical picture has been documented, on reviewing what was coded for the two patients, we may see that for the patient that stayed 14 days was nicotine dependent and had COAD with chronic respiratory failure. In addition

to this they had unstable T2DM and are morbidly obese. This goes a long way towards explaining why one patient was far more complex than the other and justifying the increased length of stay.

HAVE THERE BEEN COMPLICATIONS?

When reading through a patient episode there should never be any unanswered questions. If there are then the full clinical picture has not been adequately documented in the record. It would appear that while information may be communicated verbally between treating clinicians, it does not always get written into the patient record. The types of questions we often find ourselves asking as coders are:

- Why didn't the patient get discharged as planned?
- Why was the medication stopped/started?
- What is the 'collection' that keeps getting documented? Is it an abscess? A haematoma?
- Why did the patient go to radiology?
- Why did the patient require a NGT (nasogastric tube)?
- Why does this patient require packed cells?

Anyone who reads the episode whether it be the ED clinician when the patient represents to the hospital, the DHHS auditor or the hospital's lawyers will most probably be asking the same questions if the notes are deficient.

AN EXAMPLE OF DEFICIENT DOCUMENTATION

INCOMPLETE DOCUMENTATION	COMPLETE DOCUMENTATION
82 yr old male – died after 11 days	
E. coli sepsis secondary to UTI Resistance to multiple antibiotics T2DM with CKD Palliation commenced Phx Cognitive impairment, ITP & OA	E. coli sepsis secondary to UTI Resistance to multiple antibiotics T2DM with ***AKI on*** CKD Palliation commenced ***Early dementia (Cognition review)*** ***ITP - platelets noted to dropping, increase frequency of FBE, haematology review*** Phx OA
DRG T60B Septicaemia, intermediate complexity $ 9409	**DRG T60A Septicaemia, major complexity $ 18,321**

In the scenario above having the documentation to enable us to add the codes for dementia and ITP resulted in an increase in funding by $8912. It also adds to the complete clinical picture for this patient for performance data in explaining mortality rates for the septicaemia patient group. This example is from a actual episode in which the coder had to write a query to establish if the dementia and ITP could be coded.

CLINICAL DOCUMENTATION IMPROVEMENT AT BHS

Gemma from the BHS library has kindly provided me with some links for further reading. This particular article although aimed at wound care practitioners is equally relevant to all clinical disciplines and well worth reading.

Yankowsky, K. (2017). Avoiding unnecessary litigation: communication and documentation. Advances in Skin & Wound Care, 30(2), 66-70.
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=toc&SEARCH=00129334-201702000-00000.kc&LINKTYPE=asBody&LINKPOS=1&D=ovft

If you would like further information or have any questions around coding or clinical documentation, please contact:

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