Why Clinical Documentation Matters: The Things You Never Knew

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Objectives

- Understand how your provider performance data is generated
- Understand how a provider’s documentation habits impact hospital and office reimbursement
- Understand what the payers know about your performance as a provider
- Review how payers and employers steer patients to your practices and hospitals
- Review basic clinical documentation practices that effectively reflect your patients’ severity of illness
Purpose of this presentation is to inform providers about the importance and ramifications of their clinical documentation practice patterns.

The hope is to stimulate providers to think about implementing small changes in their clinical documentation practices which can substantially improve their provider performance data.

NOT meant to be a comprehensive review of everything needed to implement a complete inpatient or outpatient clinical documentation improvement program.
Question:

- From where does your individual provider performance data come from?
  - Manual chart abstraction by nurses &/or data analysts
  - Peer reviews by performance improvement &/or insurance company employed providers
  - Patient interviews/reviews

- Answer? **None of the above**
- **Provider performance data generated from insurance company claims **ONLY**
  - What you write in the chart is the sole determinant
Where Does **YOUR** Data Come From?

**Provider** puts dxs in EMR

Diagnoses translated into the ICD system

Billing generates claim w/ dxs now linked to age, race, outcome, LOS, charge, etc.

Only place where provider has any input!

Data now on Healthgrades, Hospital & Physician Compare, individual payer websites, Comparison, etc.

*Mistakenly, most docs believe data generated here*
This is all you ever get to say
Most provider performance data is expressed in terms of **Observed to Expected Ratios (O:E)**

- **Observed** = the actual incidence of a given measurement or outcome
- **Expected** = what was predicted to happen based on certain attributes of the studied subjects

- **O:E above 1.0** = performance worse than expected
- **O:E below 1.0** = performance better than expected

😊 **Translation**: As far as the data crunchers are concerned, **YOU are a bad doctor if your O:E > 1**
How Do **YOU** Influence **YOUR** Data?

- All provider performance data is **Risk Adjusted**
  - While actual formulas are proprietary, **ALL** give some form of statistical credit for the **Severity of Illness (SOI)** and **Risk of Mortality (ROM)** of the patients under your care
  - *In other words*, the sicker **YOU** make **YOUR** patients appear in the record, the **higher** the value of the **Expected** in all O:E calculations **lowering the ratio**

😊 This is **Denominator Management**!
Which Patient is “Sicker”?

<table>
<thead>
<tr>
<th>Patient A</th>
<th>Patient B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MS-DRG 280 = AMI D/C'd alive w/ MCC</strong></td>
<td><strong>MS-DRG 280 = AMI D/C'd alive w/ MCC</strong></td>
</tr>
<tr>
<td><strong>I-10 Code</strong></td>
<td><strong>I-10 Code</strong></td>
</tr>
<tr>
<td>prin dx. STEMI</td>
<td>prin dx. STEMI</td>
</tr>
<tr>
<td>MCC #1 Acute Systolic CHF</td>
<td>MCC #1 Acute Systolic CHF</td>
</tr>
<tr>
<td>CC #1 Acute Kidney Failure, unspecified</td>
<td>MCC #2 Acute Hypoxic Respiratory Failure</td>
</tr>
<tr>
<td>Essential Hypertension</td>
<td>MCC #3 Cardiogenic Shock</td>
</tr>
<tr>
<td>Hyperlipidemia, unspecified</td>
<td>MCC #4 Acute Kidney Failure w/ ATN</td>
</tr>
<tr>
<td>Anemia, unspecified</td>
<td>CC #1 Chronic Kidney Disease, stage 4</td>
</tr>
<tr>
<td>Hypothyroidism, unspecified</td>
<td>CC #2 Mod. Protein Calorie Malnutrition</td>
</tr>
<tr>
<td>Gout, unspecified</td>
<td>CC #3 Acidosis</td>
</tr>
<tr>
<td></td>
<td>Essential Hypertension</td>
</tr>
<tr>
<td></td>
<td>Hyperlipidemia, unspecified</td>
</tr>
<tr>
<td></td>
<td>Anemia, unspecified</td>
</tr>
<tr>
<td></td>
<td>COPD without exacerbation</td>
</tr>
<tr>
<td></td>
<td>Hypothyroidism, unspecified</td>
</tr>
<tr>
<td></td>
<td>Gout, unspecified</td>
</tr>
<tr>
<td></td>
<td>Obstructive Sleep Apnea</td>
</tr>
</tbody>
</table>

• Patient B even if patients A and B are the exact same patient
Why Should **YOU** Influence **YOUR** Data?

1. Patients and employers **choose** providers based on HealthGrades, Hospital & Physician Compare, individual payer websites, Comparion, etc.
2. Payers and Employers “Herd” patients to providers who have lower O:E ratios
   • Providers with lower O:E ratios *cost the payers and employers less*
     • Lower lengths of stay
     • Lower complication rates
     • Higher survival rates
     • Lower readmission rates

😀 **Bottom Line:** *Denominator management protects YOUR new patient stream!*
   - Will patients *choose* you?
   - Will patients be *allowed* to see you?
1. All have “awards”
2. List is **NOT** alphabetical
3. Docs #2–#4 practice at **same physical address** (i.e. all are in the same group)

- What does the patient think when they see this?  
  - **Number one on the list must be the best**
If New Patients Herded Away From **YOU**?

- **No patients = No revenue**
  - Insurance companies/Employers **NOT** required to give notification that you have been rotated to bottom of their available providers list
    - This is the "**Virtual Death Penalty**"
  - Insurance companies/Employers only have to tell you if you have been removed from a plan all together

- **Anyone ever worked at a hospital that closed?**
  - 😞 *Imagine how that conversation would go with your spouse?*
Maybe This Just Applies to Hospital Docs?

- Wrong!
- Although monitored on different metrics, similar processes exist for all office based practitioners regardless of specialty

😊 

PCPs may have it the worst of all

- Most do not practice in the hospital so easily tracked
- PCP is considered the overall patient manager so ALL patient care costs attributed to them regardless of who places the order
PCP Payer Herding Ex:

Notice anything?

1. First doc listed has “awards”
2. List is **NOT** alphabetical
3. Docs #2–#11 practice **at same physical address** (i.e. all are in the same group)

Things that should make you go HHHmmmmmmmmm ... right?

- **Question:** *Who makes it to last page of Google search?*
Specific PCP Data Pressures

- All payers track PCP’s **Medical Expense Ratio (MER)/Medical Loss Ratio (MLR)**

\[
\text{MER} = \frac{\text{Dollars actually spent}}{\text{Dollars available to spend}}
\]

- **Dollars actually spent** includes **EVERYTHING** spent on your patient in the outpatient environment (*and some inpatient costs as well*)
- **Dollars available to spend** dependent on how sick **YOUR** patents are based on **YOUR** documentation

😊 Once again, this is **denominator management**
What Should PCP’s MER/MLR Be?

- PPACA mandated that MAP insurance company products must spend **85%** of collected premiums on direct healthcare of the patient
  - Therefore, most insurance companies want PCP’s MER to be as close to 85% as is possible
    - They want as much of that remaining 15% as is possible for operating expenses and profits
  - However, you look “expensive” to the payer if **YOUR** MER is > 100% and **risk the virtual death penalty**
    - Sound similar to an O:E > 1.0?
What doc wants this?

The UnitedHealth Premium program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality, and with local cost-efficiency benchmarks in the same geographic area. After considering feedback from physicians in our network and the American Medical Association Federation of Medicine, we have enhanced our methodology and our transparency tools to assist you in better understanding and acting on

What could happen?

Is this PCP going to get new UHC patients?

Below 80% on HEDIS
MER >> 85%

Your UnitedHealth Premium Designation Result

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Designation</th>
<th>Effective Date</th>
<th>Status</th>
<th>Assessment Type</th>
<th>Reconsideration Eligible</th>
<th>Reconsideration Due Date Prior to Public Display</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>Did Not Meet Quality &amp; Cost Efficiency</td>
<td>1/8/2014</td>
<td>Pending</td>
<td>Annual Assessment</td>
<td>Yes</td>
<td>12/2/2013</td>
</tr>
</tbody>
</table>

41-1708142. If more than one Tax ID is listed, enter just one.

3. For more information, call 662-270-1588.

To request a reassessment of your designation prior to display of your results, or to be sure to request reconsideration by the date shown in the last column of the table, use the reconsideration process, a form is available to you online. To request Premium re-evaluation, visit UnitedHealthcareOnline.com, select “UnitedHealth Premium” from the top menu bar, select “Your UnitedHealth Premium Program.”

* Colorado and Texas have requirements governing physician measurement programs that differ from standard UnitedHealth Premium program processes. In these states, the Premium program follows different or additional processes for physicians who are measured under the program. For information on these state-specific processes, go to UnitedHealthcareOnline.com and select UnitedHealth Premium.
The Bottom Line?

- If **YOU** are a documentation minimalist . . .
  - You probably do not accurately report how sick your patients are in reality
  - *Therefore*, your O:E ratios are probably > 1.0 and/or your MER/MLR is probably > 100%
  - *Therefore*, patients may choose to go elsewhere for their care needs
  - *And*, you may get rotated to the bottom of the list

😍 **Goal** = Ensure patients **choose you** for their care and that they are **allowed to see you** for their care
Ten Hospital Documentation Tips to Ensure Appropriate Credit Received
1. Document Everything

- If you do not put a label on it, it cannot be coded
  - If it cannot be coded, it **did not exist and is lost**!

- Some diagnoses affect SOI/ROM, some affect reimbursement, some affect both
  - Providers do not know which reimbursement or PI (Performance Improvement) data analysis methodology is being used for any given patient

- There is no way you will learn which diagnoses impact what factors

😊 *Therefore, document everything* and let the coders and program algorithms figure out the rest
2. Get Everything in the First Note

- Anything listed in the **PMH** section or the **A/P** section of admission H&P/initial hospital or office consultation has a POA indicator of “**YES**”
  - Anything that is **Present On Admission** (POA) is a **co-morbidity**
  - **However**, anything that occurs/is diagnosed **after** admission is considered a **complication**
    - **Bad for provider publicly reported data**

- Many reimbursement penalties also tied to POA indicators (**HACs**, **PSIs**, etc.)
3. Maintain Your Daily Problem List

- Update your daily progress notes with additional diagnoses/more specific terminology as new information becomes available.
  - **DO NOT** allow diagnoses to fall off your list!
    - If a problem is corrected, rotate it to the bottom of your list and add “resolved” after it – *think about ICU X-fers*

- Problem lists should only grow during any given hospitalization - *They should never shrink!*

- **Note:** “See previous day’s progress note” will not count for diagnosis propagation **and may not** count for E&M charge justification.
4. Get Everything in the D/C Summary

- Providers should list **ALL** diagnoses in the discharge summary no matter how long the hospital LOS.
- Discharge Summary has become the most important document in the medical record:
  - First place next provider of care looks but also . . .
  - First place the hospital coders look
  - First place the recovery auditors look
  - First place the payers look
- Do the D/C Summary on the day of discharge while all is fresh in your mind:
  - Memory naturally fades with time regardless of age.
5. Use the “Right” Language

- **Providers should** adopt the currently recognized ICD-10-CM system terminology
  - What you learned in training may be different
  - *Ex:* “CKD, stage 4” as opposed to just “CRI” or “CRF”
  - *Ex:* “Chronic Systolic CHF” as opposed to just “CHF”
    - *Learn the actual code names to get credit*
- Use the **diagnosis-specific** approach for all charting
  - There are **no codes** for the organ-system approach
- **Remember:** Your CDI program & coding help you put labels on disease processes you are treating
  - *Your clinical judgement is not being second-guessed!*
6. List Current/Chronic Probs as Such

- Diagnoses qualified as “**history of**” coded in the Z-codes section of ICD-10-CM
  - Z-codes have lower impact on SOI/ROM scores reducing the size of your denominator
  - **Ex:** Patient on 3 BP meds = “HTN” - **NOT** “History of HTN”
  - **Ex:** Patient always has “COPD” - **NOT** “History of COPD”
- “**History of**” should only be used for problems which have been fully treated and resolved in the past
  - **Ex:** “History of breast cancer s/p mastectomy, chemo, and XRT”
7. Clinical Picture Must Match Diagnoses

- Must give **Diagnosis – Physical Exam Congruity**
  - **Ex:** Can a patient really have “Acute Respiratory Failure” if PE says “NAD, CTA bilaterally, unlabored respirations, normal work of breathing, etc.”?
  - **Ex:** Can a patient really have “Acute Encephalopathy” if PE says “NAD, A&O x 3, normal mood and affect, etc.”?

- Brand new problem created with advent of EMR and pre-populated documentation templates
  - **Providers must remember to update the normal physical exam templates in all of their notes!**
8. Pay Attention to Your Consultants

- Adopt your consultants’ more specific terminology
  - **Ex:** You consult Neurology for “AMS”; Neurologist says this is “Acute Encephalopathy”; **YOU** should then document “Acute Encephalopathy” from then on in your notes and **NOT** AMS
  - “If documentation from different physicians conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis.” – AHA Coding Clinic, 1st quarter, 2004
- **On the other hand,** If a consultant says a particular problem is **NOT** diagnosis X, diagnosis X should be removed from your future documentation
9. Establish Appropriate Medical Linkage

- Cause-and-effect relationships critical to the accurate coding of any medical record
  - **Ex:** Diagnosis Reporting Accuracy
    - Is the CKD, stage 3 due to the DM, the HTN, or both?
    - Is the Acute Respiratory Failure due to the sepsis?
  - **Ex:** Principal Diagnosis Selection
    - Is the pneumonia due to their HIV/AIDS?
  - **Ex:** Hospital Acquired Infections
    - Is the UTI due to the Foley catheter?
  - **Ex:** Complication Reporting
    - Is the abdominal wall cellulitis due to the infected mesh?
Tremendous clinical and coding confusion created when different providers use disparate criteria to define the same condition

- **Ex:** KDIGO vs. RIFLE for Acute Renal Failure
- **Ex:** Sepsis 2 vs. Sepsis 3

And, once a “more serious” diagnosis is made, **DO NOT** unintentionally downgrade it to a disease that makes patient appear “less sick”

- **Ex:** H&P says problem #1 = “Sepsis” but progress notes from days 1-3 just say problem #1 = “Pneumonia”
Office Documentation Tips to Ensure Appropriate Credit Received
1. Document Everything

- If you do not put a label on it, it cannot be coded
  - If it cannot be coded, it did not exist and is lost!
- All diagnoses affect YOUR MER/MLR whether you are a PCP or a subspecialist
  - However, providers cannot know how much impact one individual diagnosis code may have
  - And, there are combinations of codes when present on the same claim which increases risk adjustment in addition to the individual codes themselves
However . . . in the office . . .

- The provider *(YOU)* probably chooses which codes actually go on the claim submission for that visit
  - Most office practices cannot afford a coder while hospitals have enough coders to review every chart
- This means the office provider must use the correct language *and* select the most specific ICD-10-CM codes to receive appropriate credit
  - Can be improved with provider effort, appropriate EMR modifications, and office superbill attention
- Must also make sure office staff *DOES NOT* downgrade provider chosen ICD-10 codes to simpler ones which they know got paid in the past
And . . . if you are a PCP . . .

- **YOU** must submit many more codes than believe necessary to justify the office charge if desire appropriate risk adjustment
  - If codes for all diagnoses affecting your patients **not on a claim**, the patient does not have them
- *Oh, BTW* - Diagnoses in problem lists maintained **outside of the assessment and plan section** of the office note **cannot be coded**
  - Can only submit codes on office claims for conditions listed in the assessment and plan sections
    - Different from hospital coding where codes can be taken from anywhere in the chart
**So . . . if you are a PCP . . .**

- **Question:** How many ICD-10 codes can a PCP submit on an office claim for one visit? **Up to 12**
  - *However,* can only submit 4 ICD codes per CPT code
    - The office visit itself is one CPT code
    - *Therefore,* must have at least 2 additional CPT codes if going to submit 12 diagnoses on each claim (i.e. - labs, x-rays, in-office procedures, etc.)

- What if only have the one CPT for the office visit?
  - Can submit non-charge claim (i.e. – no payment implications) with up to 4 additional ICD-10 codes
    - *Exs:* 99429 for Medicaid; 99499 for Medicare
  - Can submit as many of these as are needed
2. Use the “Right” Language

- **Providers should** adopt the currently recognized ICD-10-CM system terminology
  - What you learned in training may be different
  - **Ex:** “CKD, stage 4” as opposed to just “CRI” or “CRF”
  - **Ex:** “Chronic Systolic CHF” as opposed to just “CHF”
    - *Learn the actual code names to get credit*
- If you are a PCP, become familiar with **HCC system**
  - **Hierarchical Condition Categories** = subset of ICD-10 codes used to demonstrate how sick patients are similar to **CCs** and **MCCs** found in MS-DRG system
    - *If know language for one, easy to learn for the other*
3. Support Each Dx in **YOUR** A&P Section

- Cannot submit a diagnosis code on an office claim **unless was addressed** in that day’s documentation.
- **So . . .** each problem must have **one** of the following to be considered eligible for office claim submission:

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitored</td>
<td>Treat</td>
</tr>
<tr>
<td>Evaluated</td>
<td>Assess</td>
</tr>
<tr>
<td>Assessed</td>
<td>Monitor or Medicate</td>
</tr>
<tr>
<td>Treated</td>
<td>Plan</td>
</tr>
<tr>
<td></td>
<td>Evaluate</td>
</tr>
<tr>
<td></td>
<td>Refer</td>
</tr>
</tbody>
</table>

- **Fortunately**, does not have to be much
- **Ex**: “HTN – stable, cont. HCTZ” is plenty
Clinical Documentation Summary

1. All provider performance data based on submitted ICD-10 codes
2. Which ICD-10 codes are submitted based on the quantity and quality of supplied documentation
3. What **YOUR** performance data says about **YOU** is something you can positively manage
4. Poor clinical documentation practices leads to poor provider performance data which will result in fewer patient encounters
Questions?