DOCUMENTATION SAVVINESS

TIPS AND TRICKS FROM A MEDICAL DIRECTOR

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SHM ADULT MEDICINE BOOT CAMP

SEPT 2024

DISCLOSURE

I have no relevant relationships with ineligible companies to disclose within the past 24 months.

I will disclose this is NOT a CDI/Billing coding lecture. ☺

LISA SIMMON

MD MBA SFHM DABFM CHCQM-PHY ADV (SHE GOT A LOT OF LETTERS)

Lisa is a graduate of the University of Sint Eustatius School of Medicine (now AUIS) in Sint Eustatius, NA and the Mercy Family Medicine Residency in Janesville, WI. She has been practicing Hospital Medicine in Phoenix, AZ since 2015 and is recognized by the Society of Hospital Medicine as a Senior Fellow. For the past 3 years, she has worked full-time as a Medical Director Care Coordination for Banner Health and maintains her clinical skills by working per-diem. In 2023, she became certified in Health Care Quality and Management by the American Board of Quality Assurance and Utilization Review Physicians. For fun, she also completed a graduate certificate in clinical ethics.

LEARNING OBJECTIVES

Recognize	Examine	Explain	Develop
Recognize how improved clinical documentation reflects the care rendered to impact communication and clarity with billing/coding/insurances.	Examine the need for clear, concise, yet detailed progress notes.	Explain the benefits and risks associated with cut and paste in medical documentation.	Develop strategies for creating definitive disposition statements to support medical necessity.

AUDIENCE POLL:

I would rank my comfortableness with documentation as:

A. I’m a rockstar, I could teach this class, but I heard Lisa is amazing…
B. I’m pretty good
C. I still feel like a novice
D. I’m just out of school so I feel lost

AUDIENCE POLL:

I deal with denials:

A. All the time

B. Never

C. Not me, but my friends always complain about them

D. What's a denial?

DENIALS ARE THE ENEMY

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- Inpatient Medical Necessity Denials 2021-2023
  - Commercial Payers – 2.4% → 3.2%
  - Medicare Denials – only 0.2%
    - This may increase in 2024 due to new Medicare ruling for Medicare Advantage plans*
- Time taken for administrative conversations with insurances take away from patient care time\
- Your documentation directly affects denials.
  - Specifics from HPI, PE and A/P all are scrutinized

*Commercial payers at the core of denial rate increases and payment delays, report suggests. (June 1, 2023). CDI Strategies 17(22). https://acdis.org/articles/news-commercial-payers-core-denial-rate-increases-and-payment-delays-report-suggests.

AUDIENCE POLL

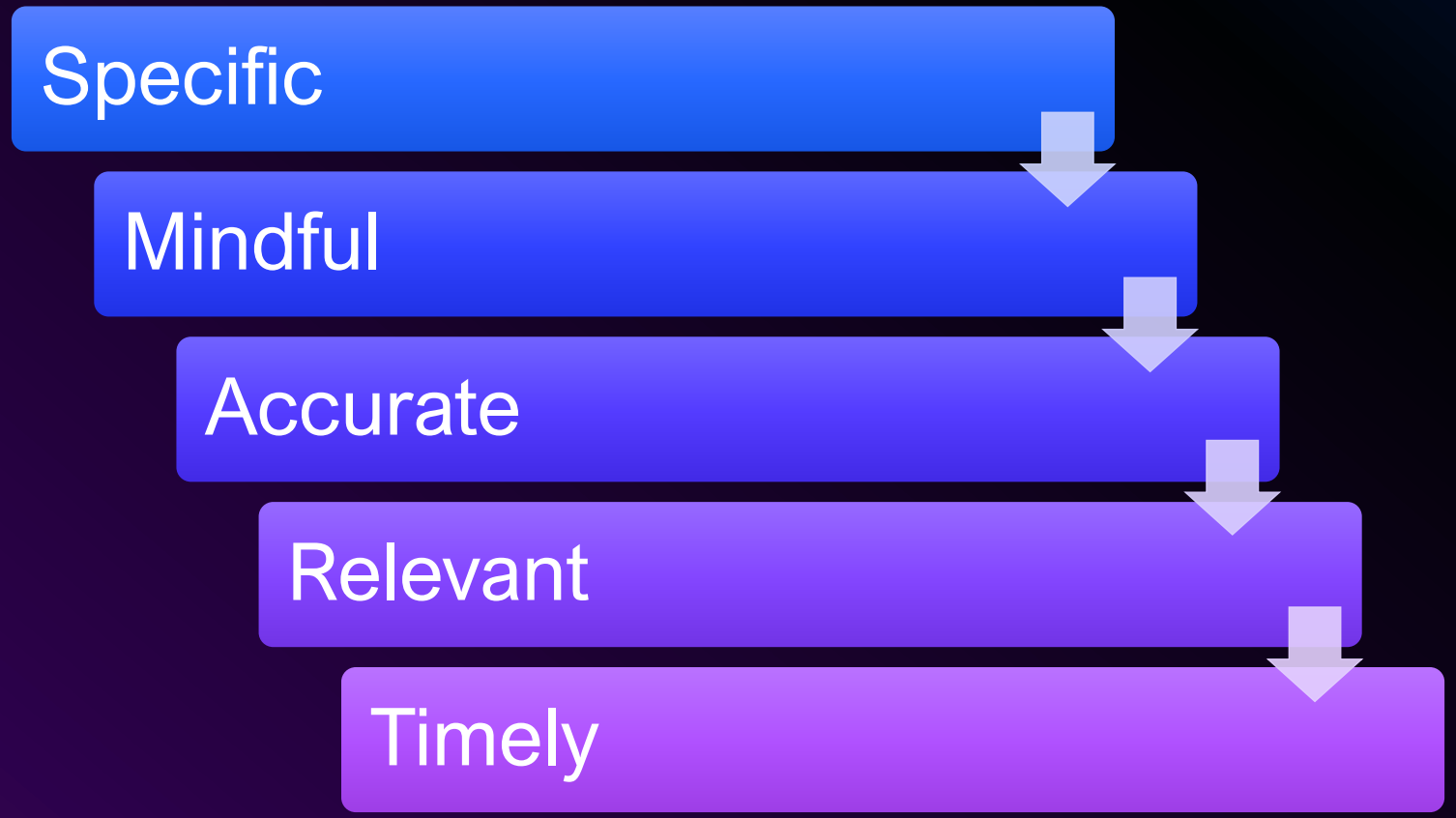
Documentation is needed for:

A. Billing – gotta get the $$
B. Coding – gotta prove my patients are the sickest
C. Insurance – ‘cause they run the world
D. Communication – my colleagues aren’t mind readers
E. All of the above

WHY NOTES MATTERS

- Billing/Coding
- Medical Necessity
- Communication

CHART SMART



*Ansari, A., Astik, G., Kulkarni, N., Landler, M. (2022). Chart SMART: Using Documentation Wisely. SHM Converge.

THE DISPOSITION STATEMENT

YOUR FIRST LINE IN MEDICAL REASONING…

THE DISPOSITION STATEMENT

- Shows Medical Necessity
  - Why does this patient need **this** treatment at **this** time and in **this** location
  - Your 30-second elevator speech
- Important summary for provider hand off and communication with consultants

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LISA, WHY IS "MEDICAL NECESSITY" YOUR FAVORITE PHRASE?

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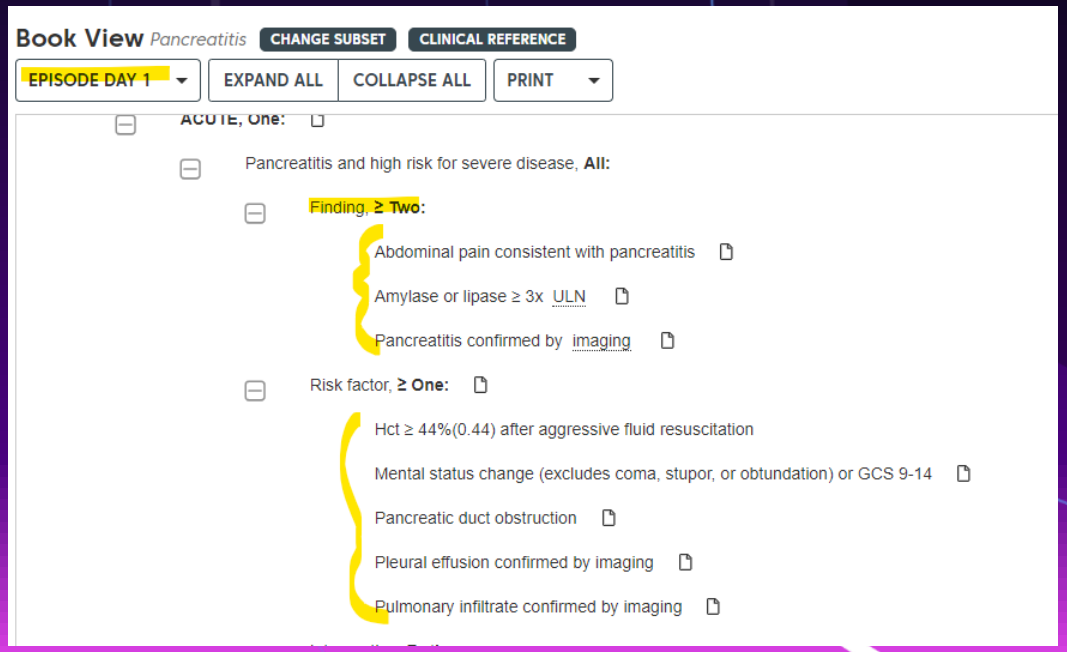
- Commercial insurances base inpatient status on
  - Specific criteria (MCG/Interqual)
  - Medical determinations (RN/MD reviews)
- As of 2024, Medicare **AND** Medicare Advantage, as well as some Medicaid plans base inpatient status on:
  - CMS IPO List for procedures
  - 2-Midnight Rule (but not Medicaid)

MCG/ INTERQUAL CRITERIA

Observation Care	Inpatient Care
• Observation care[A] is indicated for **ALL** of the following: ◦ Abdominal pain suspected to be of pancreatic origin ◦ Clinical need for care beyond emergency department time frame, as indicated by **1 or more** of the following: ▪ Vital sign abnormality ▪ Ability to maintain hydration orally unclear ▪ Pain that persists despite emergency department treatment ▪ Rise in creatinine from baseline (ie, reduction in renal function) ▪ Electrolyte abnormality that persists despite emergency department treatment ▪ Dehydration ▪ Vomiting ◦ Criteria for acute pancreatitis not met (eg, serum lipase not greater than 3 times the upper limit of normal)[B][C][D]	[Expand All / Collapse All] • Admission is indicated for **1 or more** of the following: ◦ Acute pancreatitis,[E][F] as indicated by **2 or more** of the following: ▪ Abdominal pain ▪ Serum lipase greater than 3 times the upper limit of normal, or urinary trypsinogen-2 greater than 50 ng/mL[B] ▪ Findings on imaging indicative of acute pancreatitis (eg, pancreatic inflammation, pancreatic necrosis, peripancreatic fluid collection) ⊟ Pancreatitis (acute or chronic) requiring inpatient care, as indicated by **1 or more** of the following: ▪ Inability to maintain oral hydration (eg, needs IV fluid support) that persists after observation care ▪ Evidence of infection (eg, Fever, peripancreatic abscess) ▪ Severe pain requiring acute inpatient management ▪ Hemodynamic instability ▪ Dehydration that is severe or persistent ▪ Vomiting that is severe or persistent ▪ Acute renal failure (stage 3 acute kidney injury) ▪ Acute kidney injury (stage 2) ▪ Altered mental status ▪ Hypoxemia ▪ Severe electrolyte abnormalities requiring inpatient care



CMS IPO LIST

List of procedures/CPT codes that are INPATIENT

If patient has one of these procedures, and you do not have the patient in the right status, they can deny the entire payment!!

Updated YEARLY

My albatross…

23472 (revision of shoulder) is inpatient but 23474 (arthroplasty) is not…

*https://www.cms.gov/files/document/april-2022-ipo-listening-session-slides.pdf

MEDICARE 2-MIDNIGHT RULE

*Personal Photo – owned by author

- Since 2013, inpatient status is appropriate if patient is reasonably expected to **stay 2 midnights** in the hospital for care that cannot be given outside the hospital
- Financial implications for patient as well as hospital
- What CMS is saying:
  - Accurate documentation is vitally important to this rule
  - Again -- Why **this** patient, **this** location at **this** time?

*https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule

WHICH ONE QUALIFIES FOR A 2MN STAY?

A. 72yo M in hospital for HTN urgency, getting PO med changes
B. 72yo M in hospital with abd pain, got lap chole day 1 and now staying for insulin titration for uncontrolled BGMs (in the 300s)
C. 72yo F with CHF, looks like Pilsbury Doughboy, needing IV Lasix TID and now has a mild AKI after 1 day of treatment
D. 72yo F with acute metabolic encephalopathy 2/2 to UTI, still kookoo after 24hours IV Abx
E. A and B
F. B and C
G. C and D
H. All of the Above

HOW DO I MAKE A GOOD DISPOSITION STATEMENT?

2MN Rule/Timeline?

What am I waiting on?

How is the patient progressing?

Why here?

THE GOOD, BAD AND THE UGLY (NOT MEDICARE)

Bad/Ugly

- Pending clinical improvement
- Continue inpatient
- Pending cardiology clearance

Good

- Patient with significant CHF exacerbation, persistent edema and crackles despite IV Lasix with concern for mild AKI. Needs controlled diuresis in the hospital setting. Expect patient to need at least another 48-72hours for improvement.

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THE GOOD, BAD AND THE UGLY (MEDICARE)

Bad/Ugly

- Patient expected to stay 2 midnights for above
- Pending improvement (no timeline)

Good

- Patient is in the hospital for CHF exacerbation with significant lower extremity edema, orthopnea and DOE while positioning himself in bed. Expect patient to stay in the hospital **at <u>least 3-4 days</u>** for continued, controlled IV diuresis for a significant acute systolic CHF exacerbation.
- Based on my clinical assessment, the intensity of considered treatment and monitoring, the patient meets the medical necessity for inpatient status and is expected to stay in the hospital **at least two midnights** BECAUSE…*

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*Recommended by Banner Health team as an appropriate disposition. CMS looks for 2MN assumption.

YOUR TURN

- Patient is a 23yo male who presented to the hospital on 7/23 with N/V for 3 days. Imaging negative. Labs with mild hypokalemia.
- Patient was changed from observation status to IP on 7/25 due to persistent N/V with inability to tolerate clears. He is using PRN antiemetics at least 3-4 times a day. Also, intermittent IV morphine for abdominal pain. K only 3.1 after IV K 10mEQ x6.

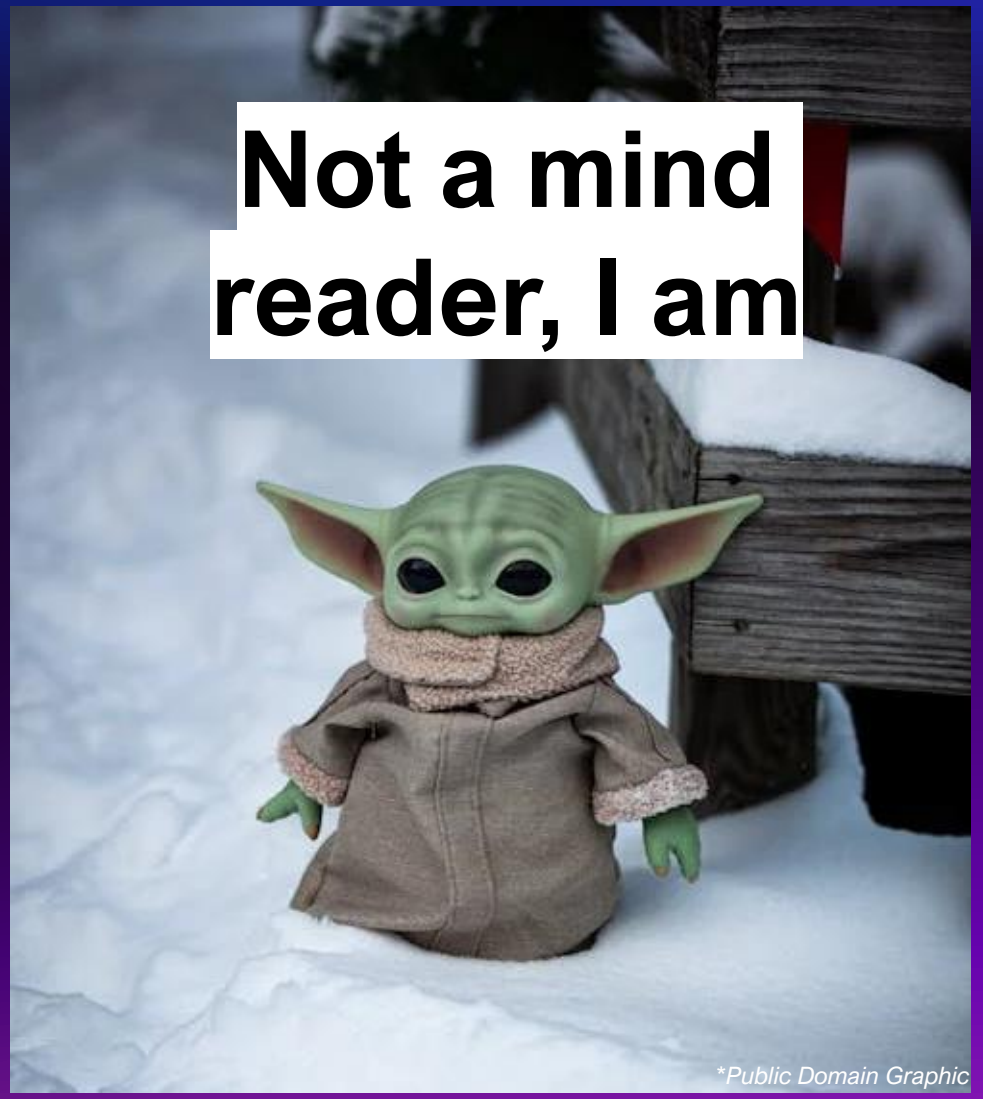
What's your dispo statement???

AND ANOTHER ONE…

- Patient is a 66yo F with hx of COPD, CAD and CKD. She presented to the ED on 8/1 with SOB, cough and wheezing. She was hypoxic to 80% on RA and required Bipap in the ED.
- On day 3 she is off Bipap but still on 3L O2 NC.
  - She complained of cough and said she got SOB just walking to the bathroom. Exam with expiratory wheezing.
  - She is still on IV Solumedrol/Azithromycin. She is using scheduled and PRN nebs with a mild leukocytosis on day 3.

Ok… sell me…

I DON'T KNOW WHAT YOU DON'T TELL ME…



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MAKE A DIAGNOSIS AND BE SPECIFIC

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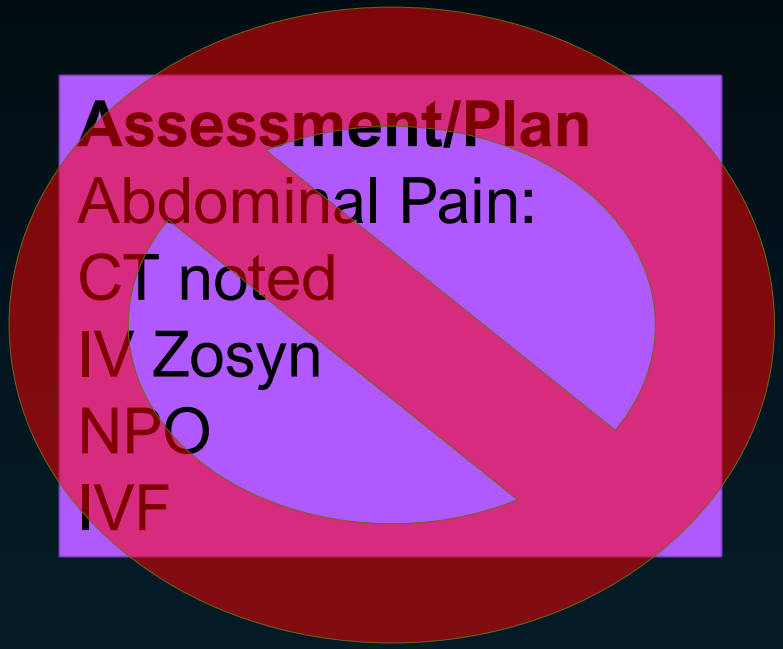
- Part of the chart SMART principle is being specific
- What are you treating?
  - **Do not** be afraid of probable, likely or suspected**
    - **Do** document if something was suspected and then ruled out
- Don’t let others infer what you are doing!

**Uncertain Diagnosis. FY 2024. ICD-10-CM Official Guidelines for Coding and Reporting. Pg 107. https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf.

45-yo female one-week post-op from tummy-tuck surgery presents with abdominal pain. CT shows a 4x3x2cm fluid collection.



Assessment/Plan
Abdominal Pain:
CT noted
IV Zosyn
NPO
IVF

Assessment/Plan
Suspected post-op abscess:
IV Zosyn
NPO for IR drainage vs surgical intervention
IVF while NPO

66 yo male presents to the ED with chest pain. Troponin elevated to 100 with second troponin 200.

Assessment/Plan
Chest Pain:
Cardiology consult
Trend troponins
NPO
IVF

Assessment/Plan
Suspected NSTEMI:
Cardiology consulted from ED
Plan for urgent cath lab
NPO
Heparin gtt

PUT YOUR WORST FOOT FORWARD…

Go big or GO HOME…no literally…

- Give me your heavy hitter diagnosis

Give the newest diagnosis

- We care about chronic issues
  - But not really
- Important for billing

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HOW STINKY IS YOUR FOOT??

55y

dys

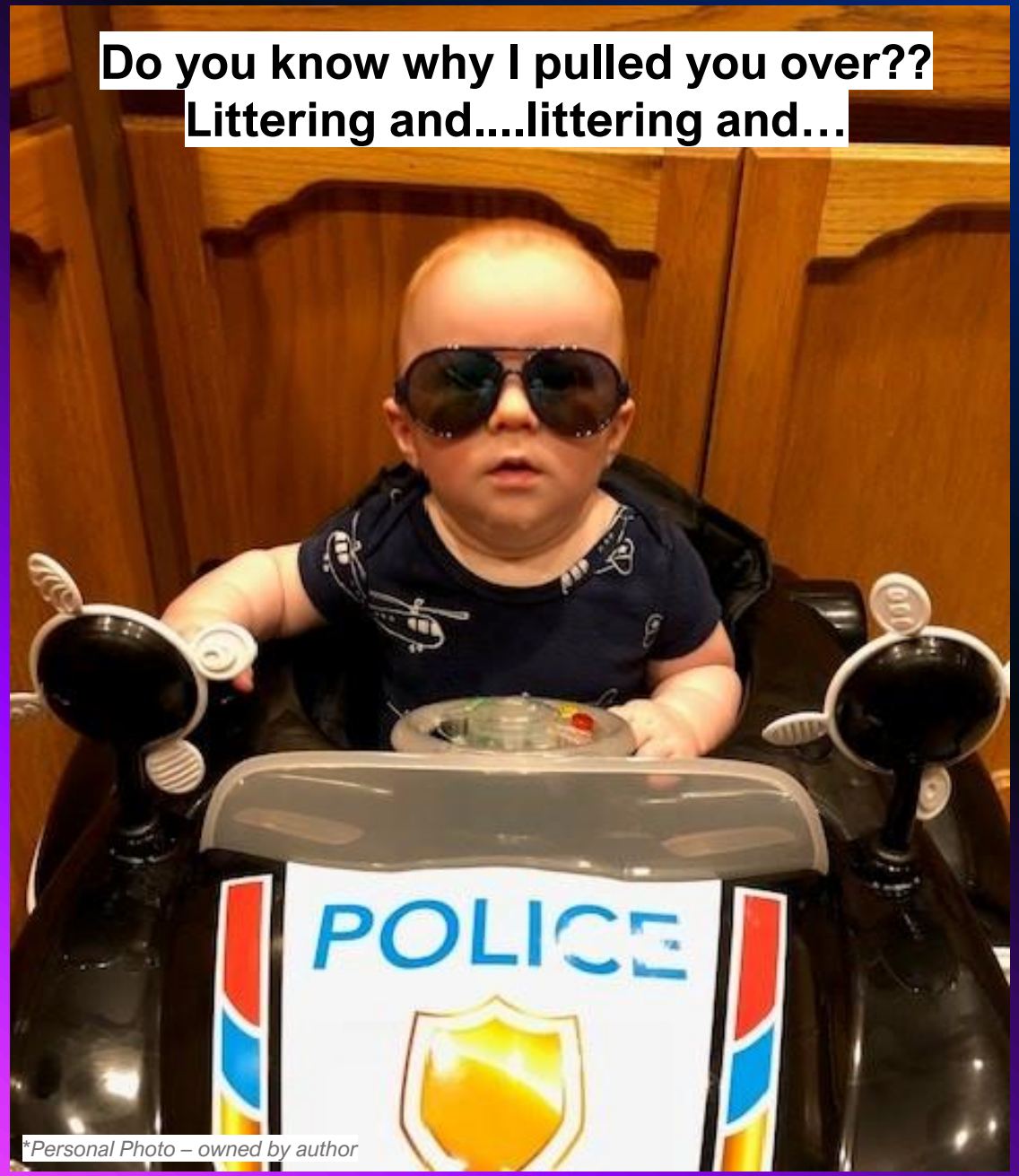
- V
- I
- I

Wh

Wh

Sepsis 2/2 Acute Pyelonephritis
AKI
(or Severe Sepsis noted by AKI 2/2 to Pyelo)
Hypokalemia
Nausea and Vomiting

Do we need:
Tachycardia?
Flank pain?
Fever?



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DOES THE PUNISHMENT FIT THE CRIME?

Common pitfalls in documentation that fail to support medical necessity.

Does the clinical picture match the treatment?

Does the exam match the situation?

Does the patient need to be here?

DOES THE CLINICAL PICTURE FIT THE TREATMENT?

You say:	• Patient needs to stay for CHF exacerbation
BUT	• Your physical exam is normal • The patient is on room air/hemodynamically stable • Patient has no complaints and feels improved
You say:	• Patient needs to continue treatment for cellulitis
BUT	• Your physical exam says skin warm and dry • Subjective says “patient is improved”

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CURB YOUR OPTIMISM

We all want the patient to get better to prove we are doing our job but…

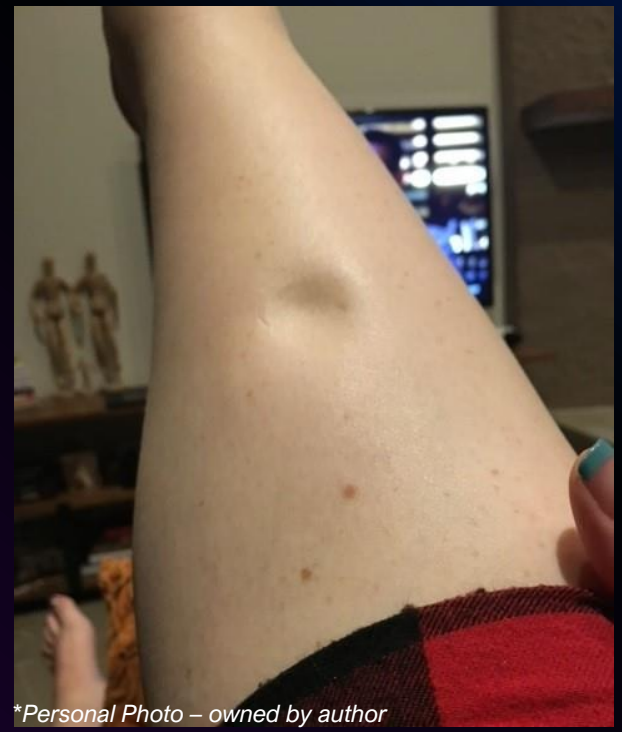
Think glass half empty

- Patient still with SOB when ambulating
- Mentation improving but not at baseline
- Cellulitis only with minimal improvement after 48 hours of IV antibiotics

*Ansari, A., Astik, G., Kulkarni, N., Landler, M. (2022). Chart SMART: Using Documentation Wisely. SHM Converge.

HAVE I MADE YOU A PESSIMIST YET?

- 43yo female with history of nonischemic cardiomyopathy 2/2 to meth use presented to the ED on 5/5/24 for SOB and LE edema.
- She was started on IV Lasix 40mg BID. Echo showed EF 25% (previous 35%).
- She says she feels better, but not 100%, AND her legs look like this after 3 days of IV diuresis with her lungs having mild crackles.



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Give me a disposition statement using exam/symptoms.

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DON'T LET YOUR NOTE FEEL LIKE YOUR STOMACH AFTER THANKSGIVING...

SOMETIMES LESS IS MORE…

[redacted]old M with a PMHx of HFrEF (LVEF 30%), T2DM, CKD stage 3b, a-fib, RLE DVT (2023) 2/2 COVID on Eliquis, HTN, ED, OSA non-compliant with CPAP, h/o MRSA osteomyelitis of right foot previously seen by Dr [redacted] s/p multiple foot digital amputations, podiatrist who presents [redacted] for persistent right foot pain after being seen in clinic by pain management today. In ED, patient w/ leukocytosis to 13.8 and CRP elevated at 74 and foot x-ray c/w osteomyelitis of the 5th metatarsal. Patient given 2gm cefepime and 1 dose of vancomycin and admitted for podiatry evaluation and management of RLE osteomyelitis.

#RLE osteomyelitis of 5th metatarsal
#h/o MRSA osteomyelitis of RLE
#Leukocytosis
- CRP elevated at 74
- s/p 2gm cefepime and vancomycin x1 dose in ED, continue cefepime (2/29-present) and vancomycin (2/29-present)
- Follows with Dr. [redacted] in outpatient setting
- History of MRSA osteomyelitis on 9/2023
- Right foot radiograph 2/28: Interval erosive change involving the CMC joints most pronounced on the base of the fifth metatarsal concerning for osteomyelitis. Several bony amputations
- Lactate wnl

MRI right lower extremity 2/29:Extensive osteomyelitis involving metatarsals and tarsal bone. Packing material within what appear to be abscesses along the dorsal and medial aspect of foot, not optimally characterized in the absence of intravenous contrast.

PLAN
- Podiatry consulted, appreciate recs. Home Eliquis is held for possible surgical interventions
- Oxycodone 5/10 for pain management
- Blood cultures NGTD
-continue cefepime (2/29-present) and vancomycin (2/29-present) for abx coverage

#HFrEF (LVEF 10/2022 30%)
#Paroxysmal a-fib on Eliquis
#h/o provoked RLE DVT
- hold home Eliquis as above
- Continue home Entresto, amlodipine 5mg daily(holding as normotensive), carvedilol 25mg BID, furosemide 40mg BID, hydralazine 25mg TID, isosorbide dinitrate 20mg TID (holding as normotensive)
- Likely add Aldactone at discharge every other day for GDMT

#T2DM
#CKD3b
- Last A1c 11/2023: 7.2%
- Continue home glargine 5 units BID + LRSSI w/ meals and qhs while inpatient
- Blood sugars elevated in 200s recently, will continue to reassess if need to alter insulin regimen if blood sugars consistently stay elevated
- Hypoglycemia protocol ordered

#OSA non-compliant w/ CPAP
- Pt states his CPAP machine was stolen. Will follow-up

FEN: PRN / PRN / Regular

STYLE MATTERS...

Medical Decision Making

Assessment and Plan:
This is a 37-year-old male without significant history who presented due to fatigue and abdominal pain as well as dark urine. He was found to have elevated LFTs. He reports recent daily alcohol use of 2 to 3 cans of beer as well as 1 day of heavy drinking of a 12 pack. Otherwise he does not use alcohol. CT abdomen/pelvis showed no acute abnormalities. He was placed in observation. MRCP showed evidence of CBD obstruction concerning for choledocholithiasis. IEA consulted.

Choledocholithiasis
Elevated transaminases
Alcohol use
Chronic back pain
H/o cholecystectomy.

- EUS/ERCP today per IEA.
- Morphine for pain control.
- Trend LFTs
- F/u hepatitis panel.

DVT Prophylaxis: Lovenox
Code Status - Ordered
-- 03/10/24 0:02:00 MST, Code Status Full Resuscitation

Dispo: Pending EUS and stable LFTs.

The patient seemed to be suffering from **situational depression** but adamantly denied any suicidal thoughts. I discussed this case with the on-call psychiatrist who diagnosed him with adjustment disorder, depression, and insomnia for which he ordered lexapro 10 mg po daily and trazodone 50 mg po qhs.

Copy and Paste = Copy and Fail

ASSESSMENT AND PLAN DAY 1:

D

-
-
-

negative

Why does the patient need to be in the hospital TODAY????

Answer:

The patient is not tolerating adequate PO due to ongoing nausea, remains dehydrated and will be given IVF bolus and requiring multiple doses of IV antiemetics. Plan is to consult GI due to continued poor PO intake

*Ansari, A., Astik, G., Kulkarni, N., Landler, M. (2022). Chart SMART: Using Documentation Wisely. SHM Converge.

Dispo:

Pending nephrology clearance

Nephrology cleared THREE days ago!!!

Dispo:

Pending nephrology clearance

More Fails...

BE LIKE HANSEL AND GRETEL

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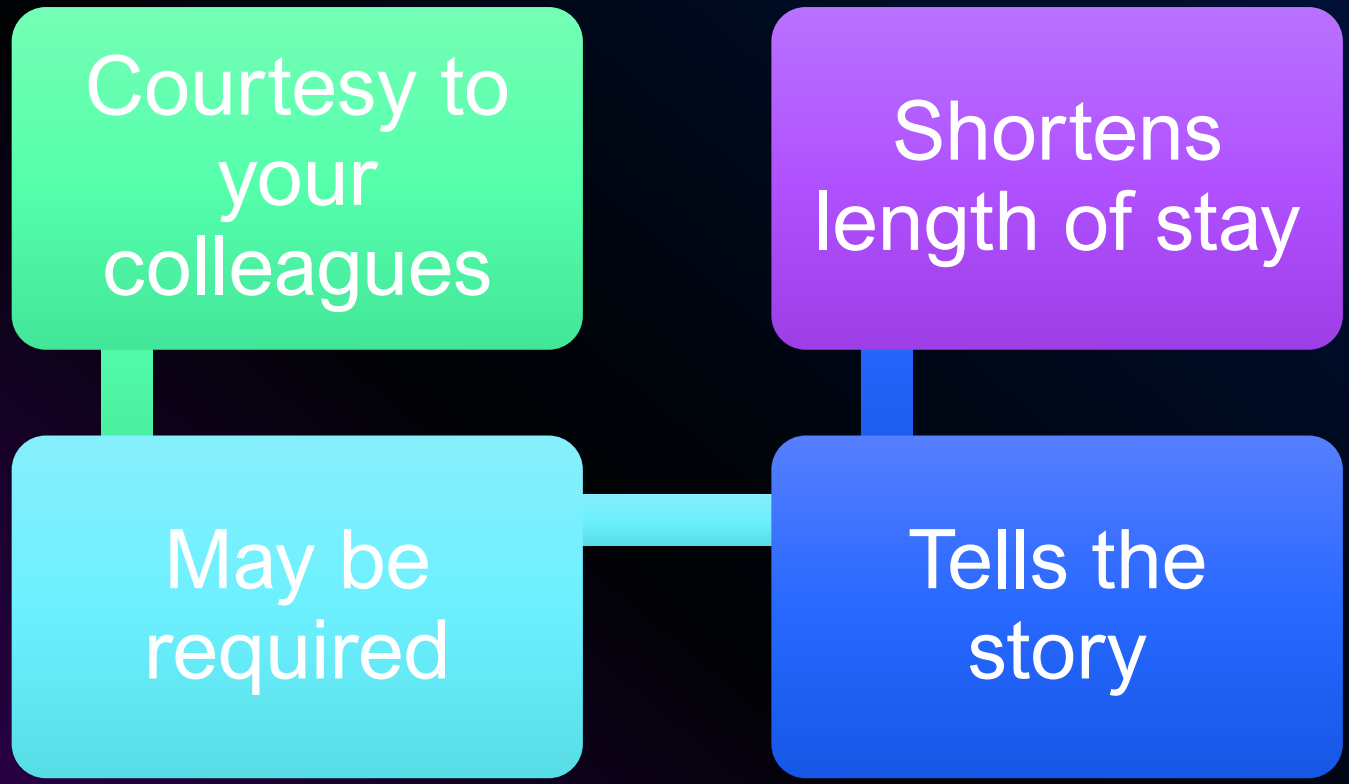
Leave a trail of breadcrumbs…

CONSIDER INTERIM SUMMARIES



THE USE OF AI

- The only way to keep AI from taking your job is to use AI to do your job better!
  - This may be recommended/required by your system
  - It does not substitute your judgement
  - Give feedback!

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FINAL THOUGHTS...

- Does my note tell the story?
- Will I be talking to the medical director later?
- Would this note hold up in court (legal document)?
- Did I tie everything up with a bow with an amazing disposition statement?

LETS RECAP...

Recognize	Examine	Explain	Develop
Recognize how improved clinical documentation reflects the care rendered to impact communication and clarity with billing/coding/insurances.	Examine the need for clear, concise, yet detailed progress notes.	Explain the benefits and risks associated with cut and paste in medical documentation.	Develop strategies for creating definitive disposition statements to support medical necessity.

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QUESTIONS?

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