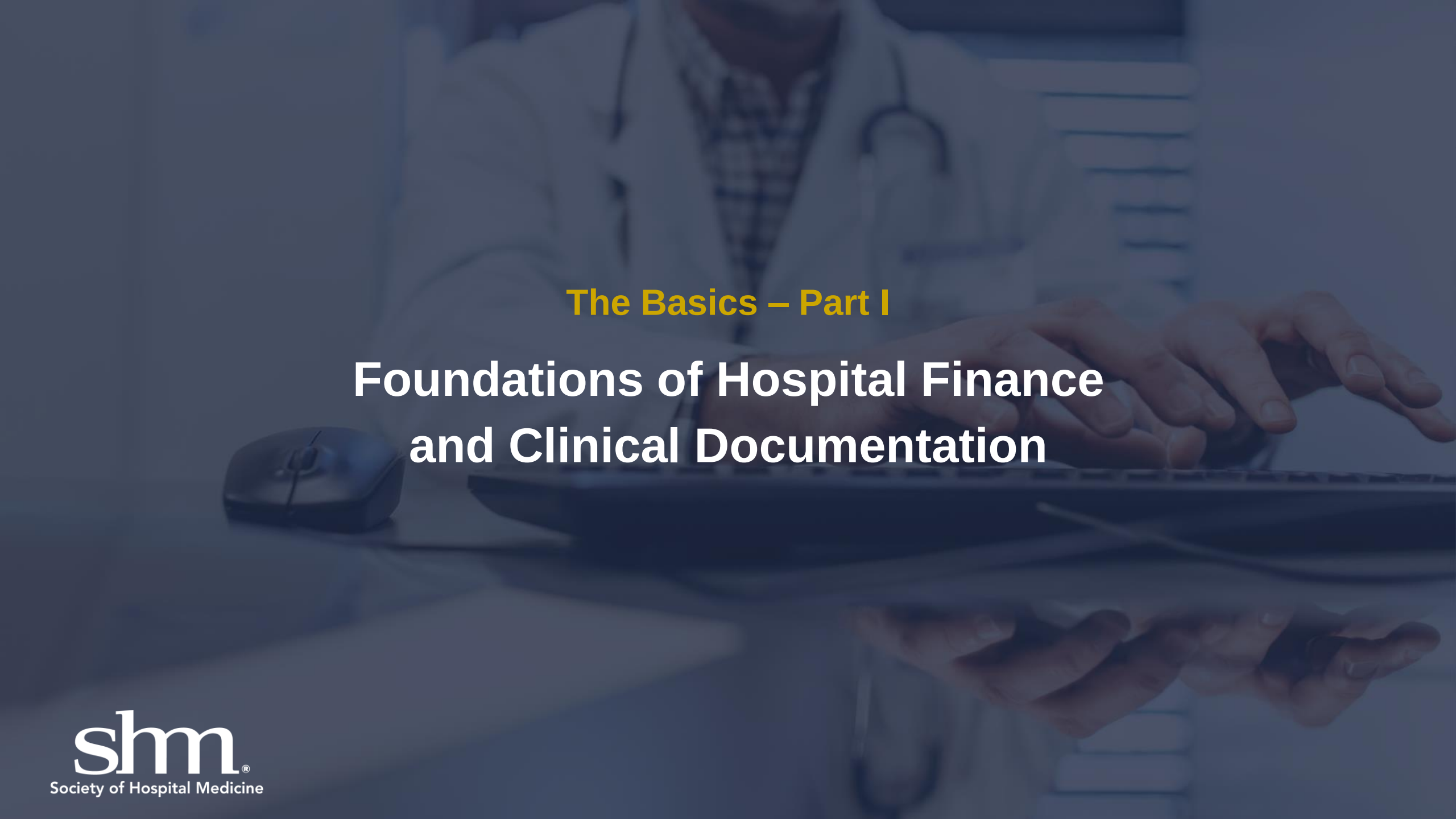
Utilization Management and Clinical Documentation for Pediatric Hospitalists: The Basics



The Basics – Part I

Foundations of Hospital Finance and Clinical Documentation

Society of Hospital Medicine

Amy Sanderson, MD

Boston Children's Hospital

Wendy Arafiles, MD

Phoenix Children's Hospital

Society of Hospital Medicine

Speaker Disclosure

Both SHM and the speakers make no representation or guarantee with respect to the contents herein and specifically disclaim any implied guarantee of suitability for any specific purpose. The speakers and SHM have no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this material, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this presentation. The speakers and SHM make no guarantee that the use of this presentation material will prevent differences of opinion or disputes with Medicare or other third-party payers.

Society of Hospital Medicine

Disclaimer

The contents included in this presentation are for informational purposes only. The coding and documentation guidance provided herein does not replace the Official Coding Guidelines or professional judgment and expertise of the individual performing coding and documentation based on numerous factors including, but not limited to, documentation in the medical record, correct application of coding guidelines, and other industry recognized coding guidance. Coding guidelines and references are updated on an annual basis potentially impacting the accuracy of the content contained within this presentation. Reference official coding resources for up-to-date information. Neither SHM nor the speakers guarantee that the information supplied is without defect. Reasonable effort has been made to ensure accuracy, completeness, and relevance and to ensure that the educational information provided in this presentation is accurate and useful.

Society of Hospital Medicine

Series Schedule

Target Audience

This series is for any pediatric hospitalist who manages patients in the hospital setting.

The Basics

- **Part I – Foundations of Hospital Finance and Clinical Documentation**
- Part II – Hospital Status Determination: Making the Right Decision for Your Patient

Case Studies

- Part I – Common Pediatric Diagnoses
- Part II – Complex Pediatric Diagnoses

Society of Hospital Medicine

Learning Objectives

By the end of this session, participants will be able to:

- **Differentiate** between professional service billing & facility fees.
- **Recognize** common terminology in coding & hospital finance.
- **Appreciate** the role that clinical documentation plays in the current health care environment.
- **Understand** how to include more specificity and less ambiguity in clinical documentation.

Society of Hospital Medicine

Learning Objectives

By the end of this session, participants will be able to:

- **Differentiate between professional service billing & facility fees.**
- **Recognize** common terminology in coding & hospital finance.
- **Appreciate** the role that clinical documentation plays in the current health care environment.
- **Understand** how to include more specificity and less ambiguity in clinical documentation.

Society of Hospital Medicine

Hospital Service vs. Professional Service Billing

Hospital Fee Facility Charge	Professional Billing Attending Physician or Licensed Independent Provider (LIP) Charge
• Represents resources/services utilized by the facility for the *entire stay*. • Hospital coders read through the medical record and assign diagnoses. • If a diagnosis is NOT documented, then it cannot be included on the bill. → **Lost Revenue**	• Represents the skills and training of a medical professional and services performed *that day.* • Providers assign diagnoses when they enter the charge. • If a diagnosis is NOT documented but IS included on the bill. → **Denial & Fraud (compliance)**

Society of Hospital Medicine

Professional Services: E/M Codes

- **Evaluation and Management (E/M) Codes are from the Current Procedural Terminology (CPT) Code Book.**
- **E/M Codes represent the cognitive complexity and intensity of work provided by a medical professional on a specified day of service.**
- **3 Components:**
  - History: CC, HPI, ROS, PFSH
  - Exam: Body Areas or Organ Systems, # areas/systems examined
  - Medical Decision-Making (MDM)
- **Each day of service, a CPT code *with a list of ICD-10 diagnosis codes* is submitted on the bill to the health plan for reimbursement.**

Society of Hospital Medicine

Hospital Services: ICD-10 Codes

- **All ICD-10 diagnosis and procedure codes applicable to the entire hospital stay are collected.**
  - One list of codes is submitted with the bill for the entire hospital stay.
- **The ICD-10 codes justify the resources utilized.**
  - “Non-billable” hospital services
  - Complicated and/or severely ill patients
  - Longer hospital stays

Society of Hospital Medicine

Hospital Services: ICD-10 Codes

- **Principal Diagnosis** **is** **the condition established after study to be chiefly responsible for the admission.**
- **Secondary Diagnoses** **are the** **additional conditions that affect:**
  - Clinical evaluation
  - Therapeutic treatment
  - Diagnostic procedures
  - Extended length of hospital stay
  - Increased nursing care and/or monitoring

Society of Hospital Medicine

Learning Objectives

By the end of this session, participants will be able to:

- **Differentiate** between professional service billing & facility fees.
- **Recognize common terminology in coding & hospital finance.**
- **Appreciate** the role that clinical documentation plays in the current health care environment.
- **Understand** how to include more specificity and less ambiguity in clinical documentation.

Society of Hospital Medicine

History & Evolution of Facility Billing

- Diagnosis Coding System
- Hospital Payment Models
- Hospital Status Determination

Society of Hospital Medicine

ICD: International Classification of Disease

Now in its 10th Edition (ICD-10) in the United States

- **Diagnoses: ICD-10-CM | Procedures: ICD-10-PCS**
- **ICD-10-CM includes codes for:**
  - Diseases
  - Signs, symptoms, and complaints
  - Social circumstances
  - External causes of injury or disease
- **New codes added annually for new clinical conditions or as needed (e.g., COVID, MIS-C, vaping-related conditions)**
- **Used as the standard diagnostic tool for epidemiology, health management, and clinical care**
- **Forms the basis of healthcare payment systems in the U.S**
- **Also used to classify mortality data**

Society of Hospital Medicine

Models of Hospital Reimbursement

Fee for service

Bundled:

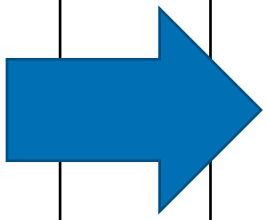
Diagnosis Related Groups (DRG)

Capitation

Society of Hospital Medicine

Cost Containment

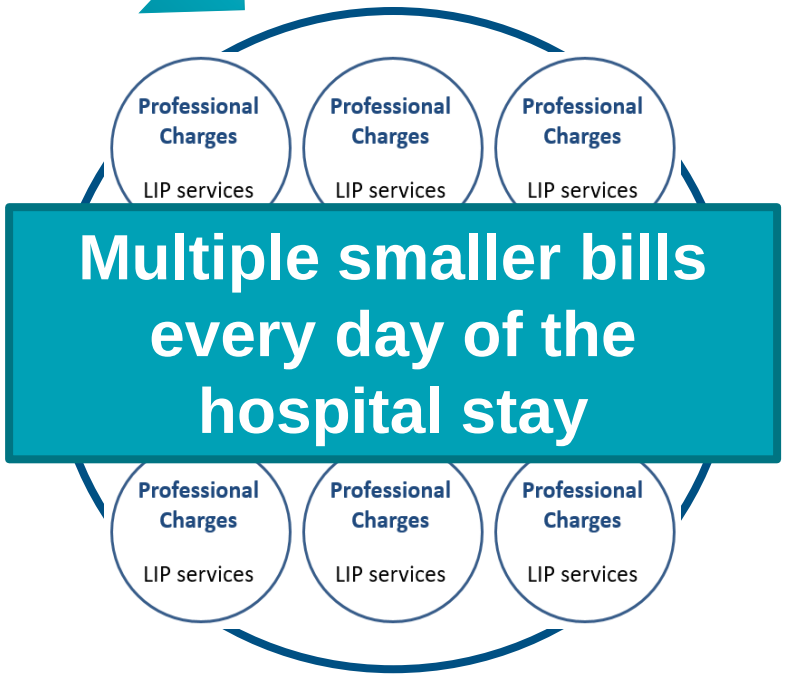
PER DIEM or % OF CHARGE	BUNDLED PAYMENT
• Daily invoice • Not specific to diagnoses • No mandate for supportive documentation • No incentives for cost-effectiveness • No incentives to improve health outcomes of a population	• Incentivizes cost-efficient care • One payment per hospital stay • Diagnoses accumulated during a hospital stay determine facility reimbursement • Documented diagnoses are translated into ICD codes on the hospital bill



Society of Hospital Medicine

Hospital Coders

Professional Coders/Providers



Facility Charges

Nurses and Techs
Unit Coordinators
Respiratory
Therapy Services (PT/OT/SLP)

One BIG bill for the entire hospital stay

Lab and Pathology
Pharmacy
Room and Utilities
Food Services
Materials (supplies, sterilization
EVS, linen)
Waste Management

Diagnosis Related Group (DRG) Systems

DRGs only apply to inpatient status.

- **Primary diagnosis determines the DRG assignment.**
- **Each DRG contains different ICD-10 diagnosis and procedure codes.**
- **Reimbursement model:**
  - Each DRG is assigned a pre-determined base value.
  - Base values depend on contracts with payers.
- **DRG is customized to the individual case.**
  - Each DRG is assigned a relative weight (RW) = multiplier against the base value
  - Some DRGs reimburse more than others because the RW is higher
  - RW can also increase based on additional ICD-10 codes specific for the patient case

Society of Hospital Medicine

DRG Payment System

MS-DRG

Medicare & Commercial Plans:

- **CC**: Complication, Co-morbidity
- **MCC**: Major Complication, Co-morbidity

Payments based on:

- Base DRG **without CC** or **MCC**
- Base DRG **with CC**
- Base DRG **with MCC**

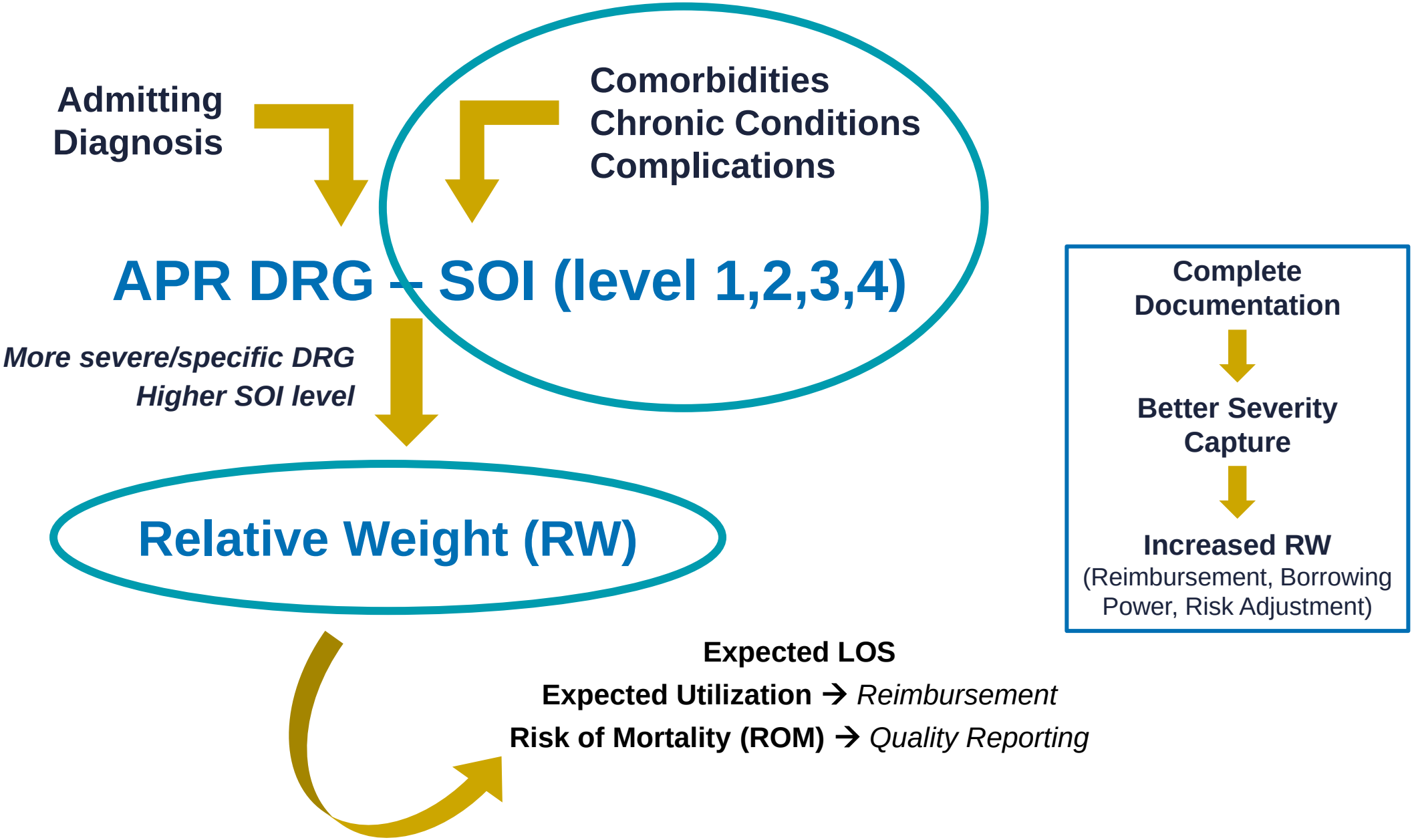
APR-DRG

Medicare & Commercial Plans:

- **SOI: Severity of Illness**
  - "How sick is this patient?"
  - Minor (1), Moderate (2), Major (3), Extreme (4)
- **ROM: Risk of Mortality**
  - "How likely is this patient to die in the hospital?"
  - Minor (1), Moderate (2), Major (3), Extreme (4)

Payments based on DRG with SOI and ROM levels based on documented conditions.

Society of Hospital Medicine


Admitting Diagnosis
Comorbidities
Chronic Conditions
Complications
APR DRG – SOI (level 1,2,3,4)
More severe/specific DRG
Higher SOI level
Relative Weight (RW)
Expected LOS
Expected Utilization → Reimbursement
Risk of Mortality (ROM) → Quality Reporting
Complete Documentation
Better Severity Capture
Increased RW
(Reimbursement, Borrowing Power, Risk Adjustment)

Other Payment Systems

Capitation or Risk-based

Fixed amount of money for each enrollee per year.

- Incentivizes quality healthcare & preventative medicine.
- Incentivizes correct level of service.
- Rates are contracted between hospital & health plan .
- The organization takes on the risk of the balance sheet.

Value-based

Incentive payments (or return of monetary hold-backs) based on performance.

- Linked to PSQ metrics (e.g., HAC rates, readmissions).
- Negotiated terms between hospital & health plan.
- Risk adjustment: higher complexity populations → higher risk for complications, length of stay, cost, etc.

Society of Hospital Medicine

Learning Objectives

By the end of this session, participants will be able to:

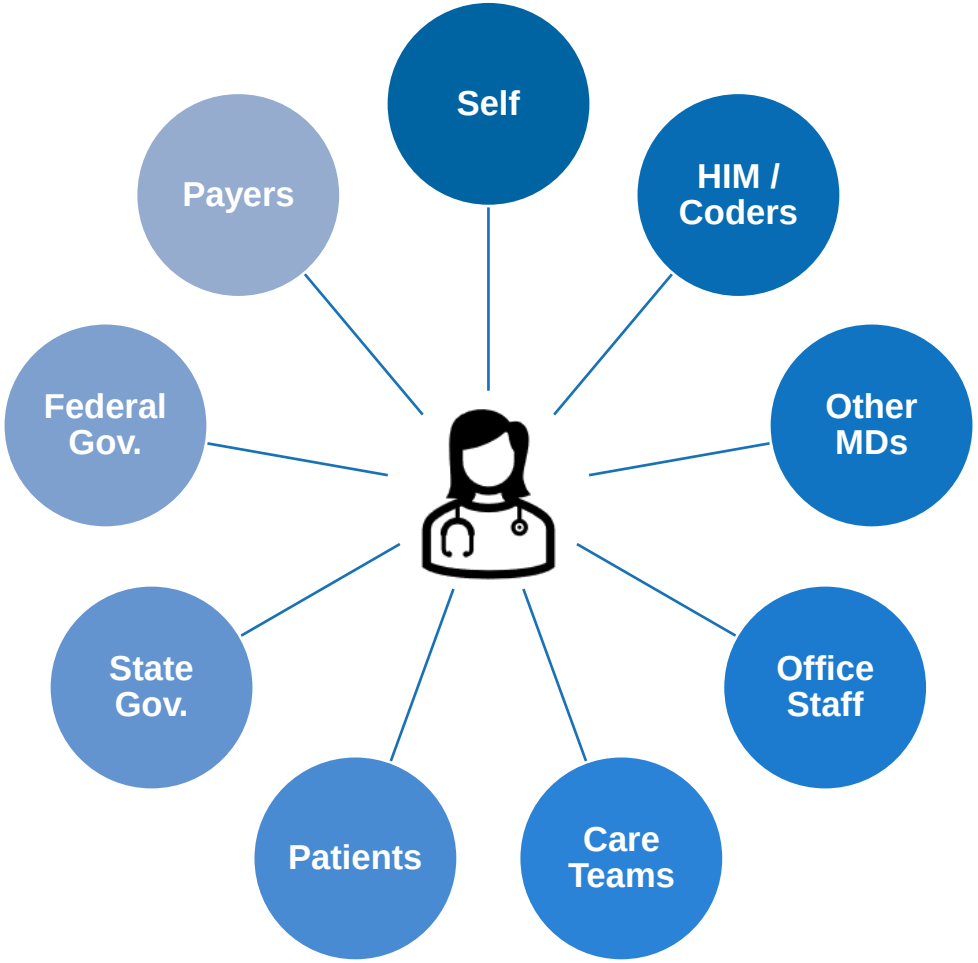
- **Differentiate** between professional service billing & facility fees.
- **Recognize** common terminology in coding & hospital finance.
- **Appreciate the role that clinical documentation plays in the current health care environment.**
- **Understand** how to include more specificity and less ambiguity in clinical documentation.

Society of Hospital Medicine

The Evolution of Documentation

One document serves many purposes.

What was once a tool for physician communication and note-taking is now a primary data source for a massive industry.



- Explain pathophysiology of disease
- Communicate patient care
- Describe professional expertise
- Code accurate and specific diagnoses
- Justify length of stay and charges for utilization
- Avoid fraud and abuse
- Protect from litigation
- Enhance provider and institution public profiles
- Improve risk-adjusted metrics
- Advocate for staffing needs

Why Documentation is Important

- **Documentation improves patient care… Communication!**
- **Ensures an *accurate* medical record**
- **Credits the providers and hospital for excellent care**
- **Justifies equitable reimbursement for the excellent care provided**
- **Supports research by providing accurate coding**
- **Supports the hospital in the national quality arena:**
  - Hospital mortality rates
  - Penalties for readmission rates
  - Penalties for hospital acquired conditions
  - Value based contracts

Society of Hospital Medicine

Documentation & Patient Care

Communication

- **Acuity**
  - "Watcher status"… and WHY
- **Complexity**
  - Every care decision must be thoughtful or else surprise consequences
- **Care Plan**
  - For seamless care transitions

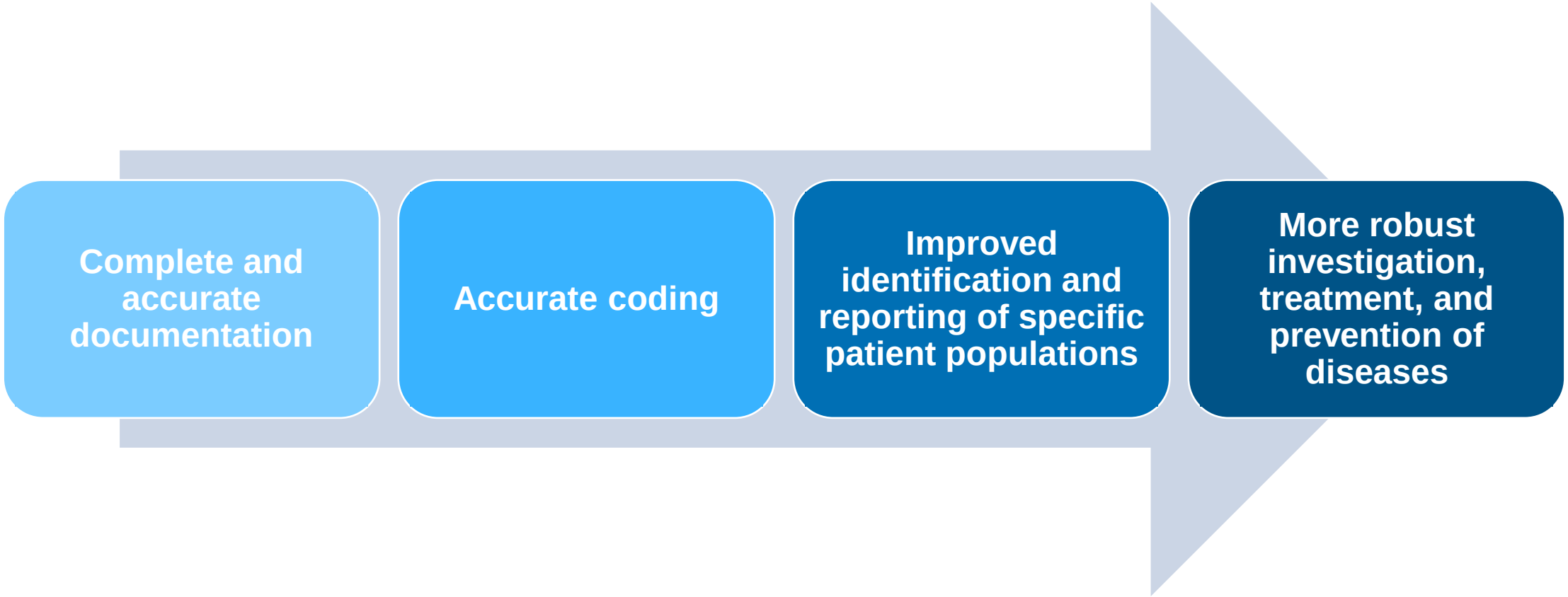
Provider awareness of complexity/acuity

Increased attention to detail

Enhanced preparedness and improved outcomes

Society of Hospital Medicine

Documentation & Population Health



Society of Hospital Medicine

Documentation & Reputation

Hospital Comparisons

- ✓ Length of stay
- ✓ Morbidity
- ✓ Mortality
- ✓ Complications
- ✓ Patient Satisfaction
- ✓ Safety

Physician Profiles

Performance based on cost and quality data

- ✓ Claims-based data (i.e., coded diagnoses)
- ✓ Resource utilization data
- ✓ Outcomes measures (e.g., CLABSI rate, vaccination status, surgical complication rate)
- ✓ Risk adjustments for appropriate peer group

Society of Hospital Medicine

Learning Objectives

By the end of this session, participants will be able to:

- **Differentiate** between professional service billing & facility fees.
- **Recognize** common terminology in coding & hospital finance.
- **Appreciate** the role that clinical documentation plays in the current health care environment.
- **Understand how to include more specificity and less ambiguity in clinical documentation.**

Society of Hospital Medicine

Diagnosis Coding Tips

Coders must follow the rule of the *Official Guidelines for Coding and Reporting.*

- **No assumption coding.**
- **Acuity, severity, and specificity are very important.**
- **If it is not documented, the patient does not have it.**
- **Diagnoses should be carried through the medical record.**
- **Okay to document a diagnosis someone else made.**

Coders CANNOT code from:	Coders CAN code from:
Nursing Notes	ER Physician Notes
Pathology Reports	H and P
Lab Reports	Progress Notes
Radiology Reports	Consultant Notes
Physical Therapy Reports	Physician Orders*
Nutrition Reports	Discharge Summaries
Feeding Team Consult Note	Operative/Procedure Notes

***If the indication for the order is documented (e.g., ampicillin for bacterial pneumonia)**

shm
Society of Hospital Medicine

Documentation Tips

1

Use a disease diagnosis whenever possible.

2

Be as specific as possible.

3

Link a diagnosis to its pathogenesis.

4

Link every order to a diagnosis.

Society of Hospital Medicine

Tip 1: Use a disease diagnosis whenever possible.

CANNOT CODE	GOOD
Right upper lobe (RUL) infiltrate	RUL pneumonia
Hemoglobin 5.6	Anemia
Cachectic, 20lb. weight loss, FTT	Malnutrition
Urine cx: >100,000 CFU E. coli	Urinary tract infection (UTI)
Na+ = 120	Hyponatremia
Home Oxygen	Chronic respiratory failure
SIRS physiology on dopamine & NE	Septic shock
Global developmental delay	Spastic quadriplegia, Intellectual disability
Received 20ml/kg NS overnight	Hypovolemia, hypotension, dehydration

Society of Hospital Medicine

Tip 2: Be as specific as possible.

GOOD	BETTER
RUL Pneumonia	RUL pneumonia due to *S. pneumoniae*
Anemia	Acute blood loss anemia secondary to upper GI bleed
Malnutrition	Severe malnutrition
UTI	Acute pyelonephritis
Unable to urinate, needs bladder catheter	Urinary retention
Asthma	Mild persistent asthma with status asthmaticus

Society of Hospital Medicine

Tip 3: Link a diagnosis to its pathogenesis.

GOOD	GREAT
Dehydration	Dehydration **due to** rotavirus gastroenteritis
Bloody stool, cow milk allergy	Cow milk allergy **resulting in** hematochezia
Status asthmaticus	Status asthmaticus **secondary to** smoke exposure
Acute left pyelonephritis	Acute left pyelonephritis **caused by** E. coli

Society of Hospital Medicine

Tip 4: Link every order to a diagnosis.

ORDER	DOCUMENT
Red blood cell transfusion	Acute anemia due to ABO incompatibility
Phototherapy	Hyperbilirubinemia
Acyclovir x 48hrs	Evaluate for HSV, state when ruled out
Ampicillin and Cefotaxime	Rule out sepsis, state when ruled out
Caffeine	Central apnea

Bonus: Do NOT document diagnoses that do not exist!

- **Urosepsis (no longer exists in ICD-10)**
- **Sepsis/SIRS *physiology* (a physiologic state of being, not a diagnosis)**
- **Asthmonia**
- **Asthmolitis**
- **Asthmonialitis**
- **Kawashocki**

Society of Hospital Medicine

Clinical Documentation Integrity

Clinical Documentation Integrity Program (CDI): any combination of…

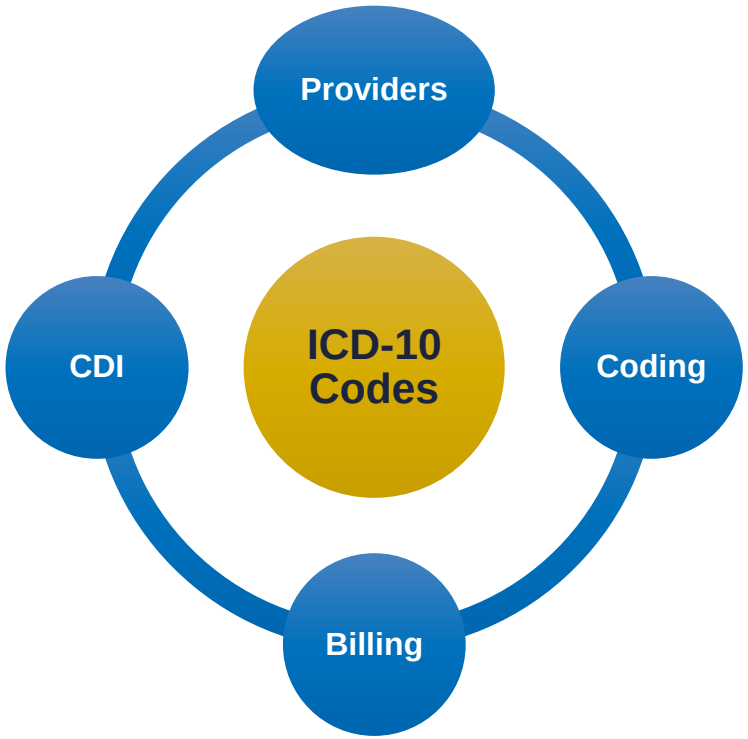
Purpose: facilitate consistent, complete, specific, and accurate clinical documentation for communication, quality reporting, and reimbursement

Interpret clinical language into coding language

- CDI teams submit queries to clarify provider documentation.
- Queries cannot lead providers to a diagnosis.
- Coders cannot change, add, or delete codes without supportive documentation.

shm
Society of Hospital Medicine

Putting it all Together



1. Inpatient documentation reviewed by CDI and hospital coding teams
   - Computer-assisted coding programs
2. All applicable ICD-10 codes are collected
   - Primary diagnosis is determined
3. Missing or conflicting diagnoses are added or clarified by documentation queries to providers
4. Final list of ICD-10 codes and DRG assignment is sent to hospital billing department to include charges and insurance-specific details
5. Final bill is sent to the insurance plan for reimbursement

Society of Hospital Medicine

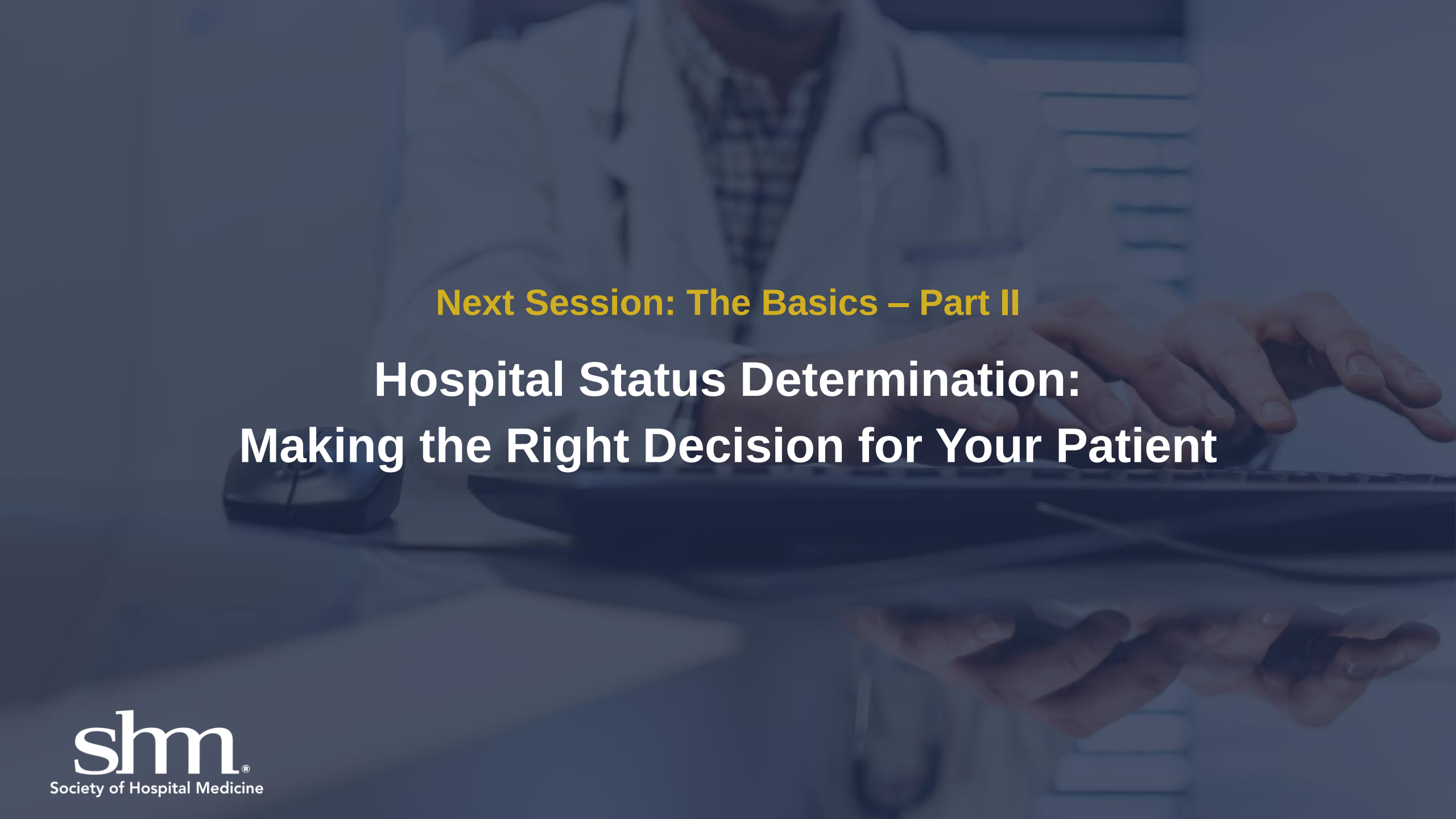
Final Takeaways

- **The most important objective for your note should be to tell the story of your patient.**
- **Use more diagnostic terms and less descriptive terms.**
  - Leads to less confusion regarding patient condition.
  - Accurately captures patient severity of illness and risk of mortality.
- **Diagnoses should be carried through the medical record.**
  - Major diagnoses should be in the discharge summary.

"Paint the picture of your patient with words so the coder can paint the same picture with codes."

– Robert Gold, MD

Society of Hospital Medicine



Next Session: The Basics – Part II

Hospital Status Determination: Making the Right Decision for Your Patient

Society of Hospital Medicine