
NPAC2019
National Physician Advisor Conference
BRIDGING THE GAP BETWEEN CONFUSION AND CLARITY IN HEALTHCARE

Documentation: Spanning Medical Necessity and Beyond

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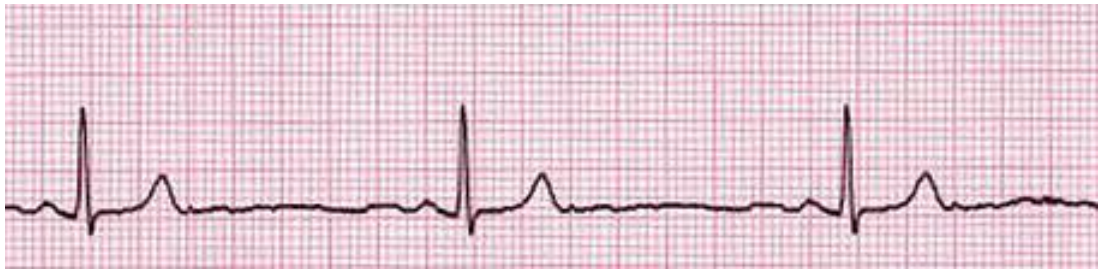
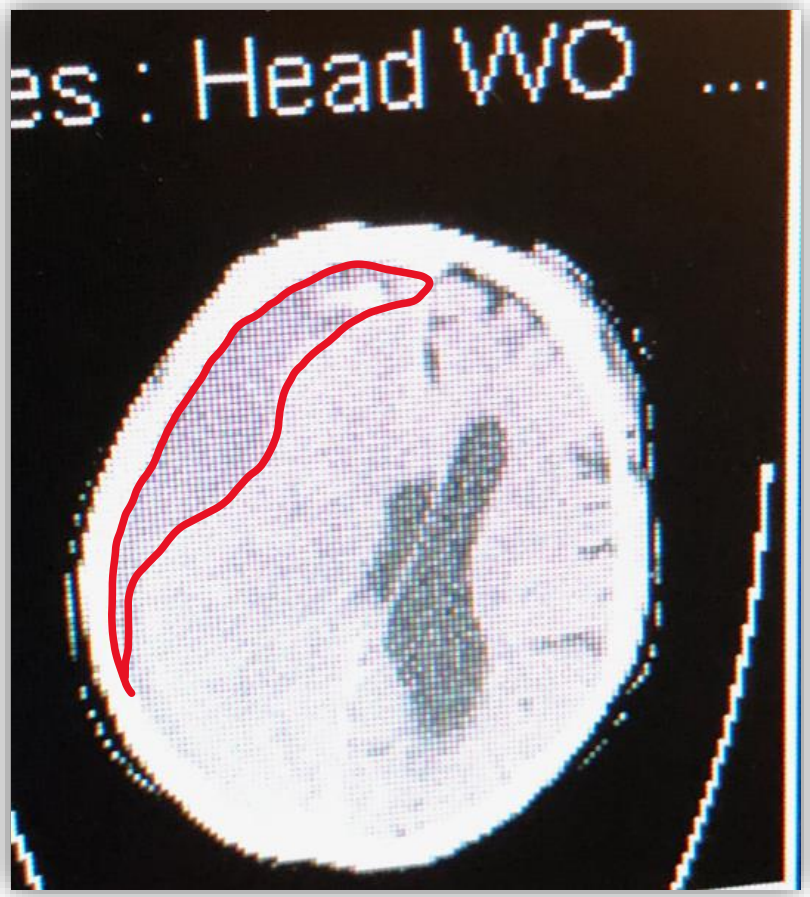
My dad



https://commons.wikimedia.org/wiki/File:Lead_II_rhythm_generated_sinus_bradycardia.JPG

Photograph by Annette Demjanovic

5 weeks later

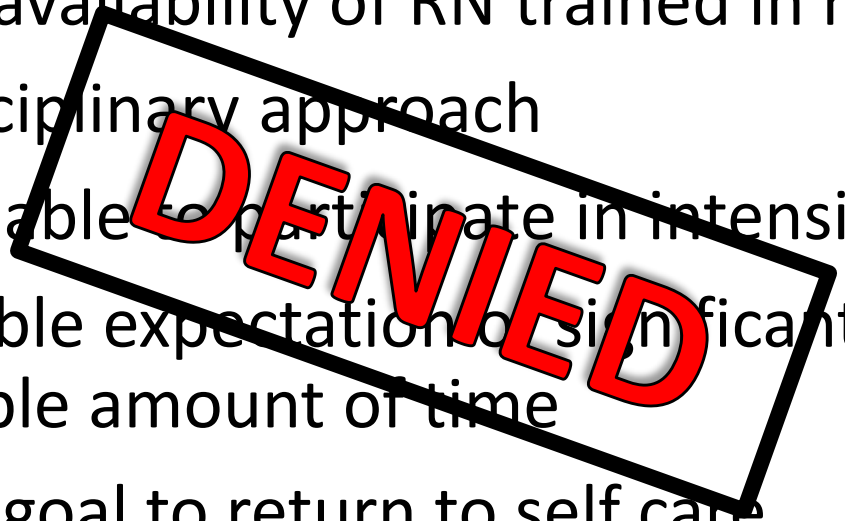


July 30, 2018

Permission granted by Paul Heit; Photograph by Joel Rosenberg

Criteria for Acute Inpatient Rehab

1. Close supervision by physiatrist
2. 24 hour availability of RN trained in rehab
3. Multidisciplinary approach
4. Must be able to participate in intensive PT/OT 3 hr/d, 5d/wk
5. Reasonable expectation of significant practical improvement in a reasonable amount of time
6. Realistic goal to return to self care



THIS is what is known as leading verbiage

Fri 8/3/2018 7:27 PM

Erica Remer

Verbiage

It is imperative that we document adequately to justify medical necessity for the higher level of service. The hospitalist needs to document something along the lines of, “in my medical opinion, this patient needs intensive rehab not able to be provided in an outpatient or subacute rehab setting and needs to have acute inpatient rehabilitation in order to regain his pre subdural hematoma level of function. One hour of physical therapy will be wholly insufficient to achieve this result. He will be best served in an IRF.”

Regards,
Erica Remer

Sent from my iPhone

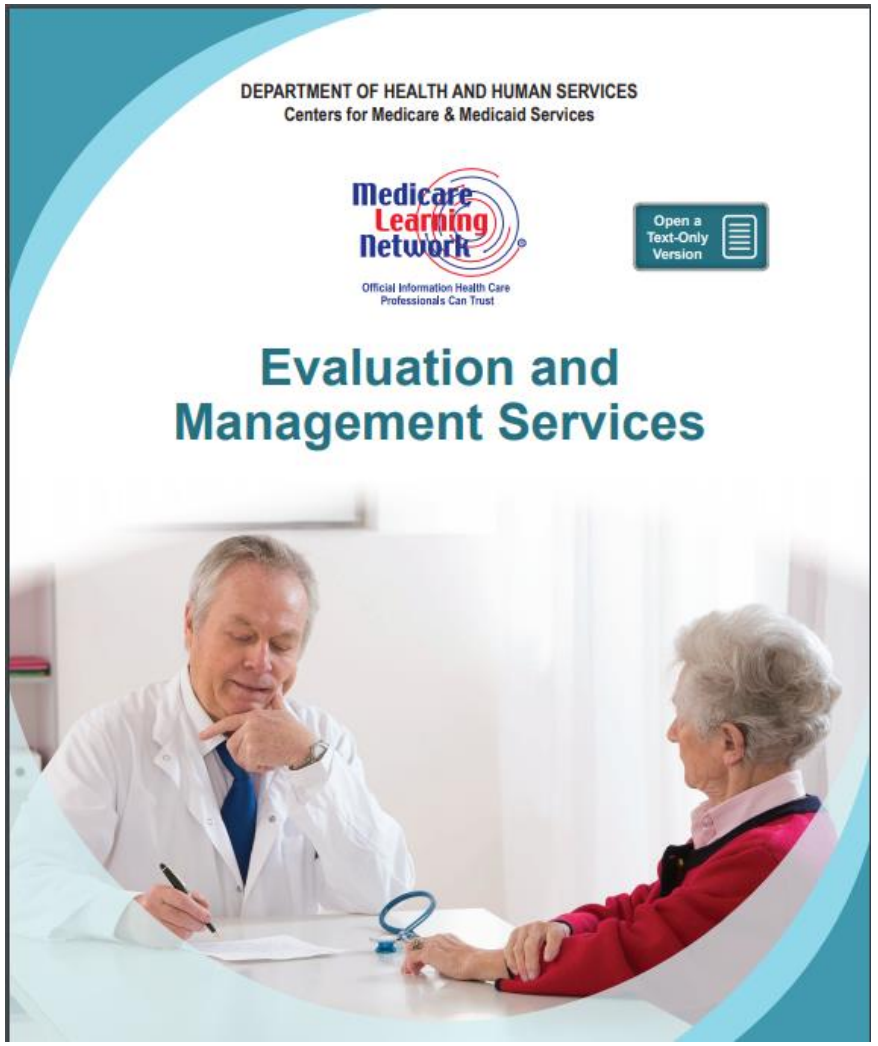
Permission granted by Paul Heit; Photograph by Erica Remer

Permission granted by Paul Heit; Photograph by Erica Remer

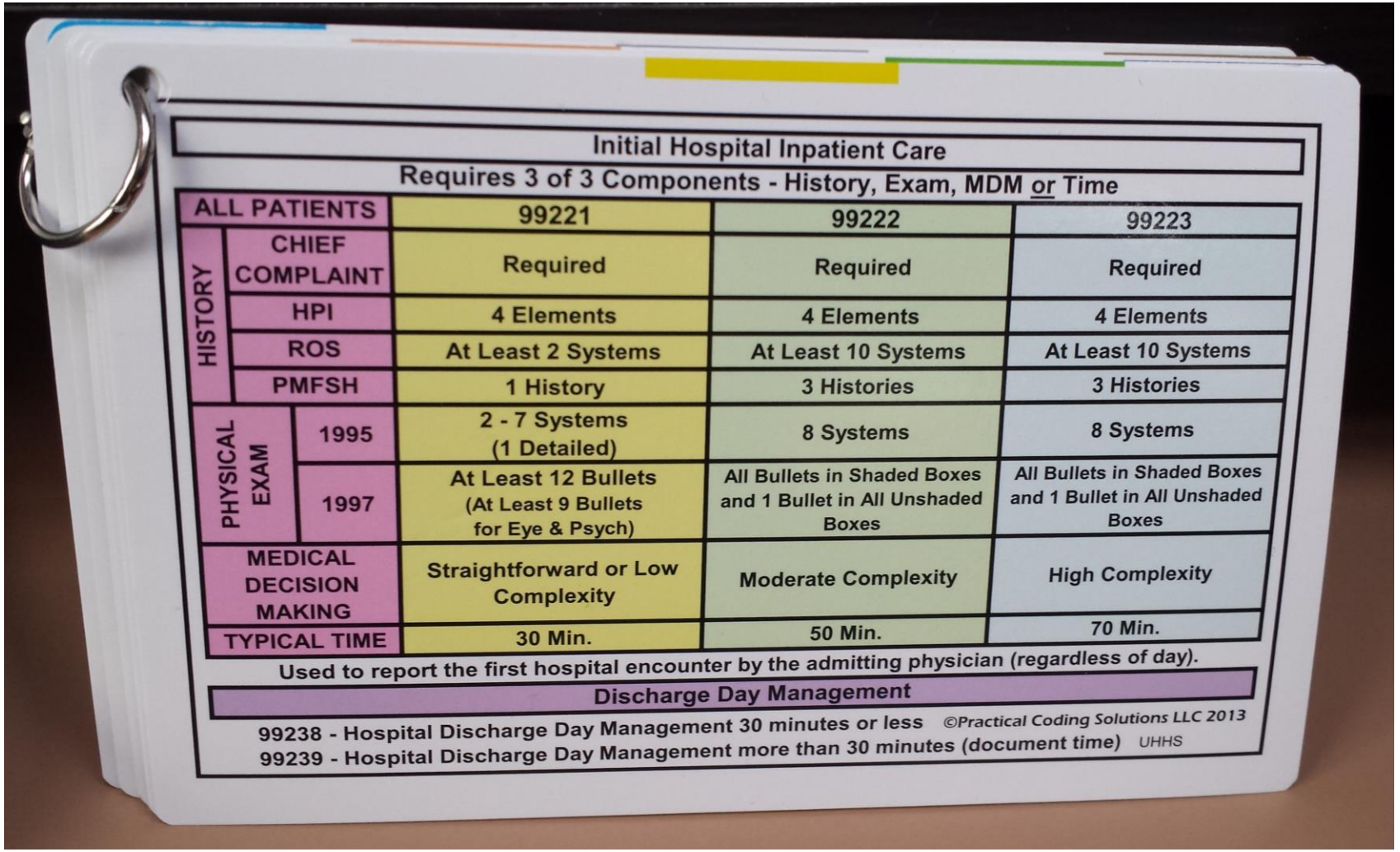
Documentation is a burden?

https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

Documentation for E&M (Pro fee)



Documentation for E&M (Pro fee)



Initial Hospital Inpatient Care

Requires 3 of 3 Components - History, Exam, MDM or Time

		ALL PATIENTS	99221	99222	99223
HISTORY	CHIEF COMPLAINT		Required	Required	Required
HISTORY	HPI		4 Elements	4 Elements	4 Elements
HISTORY	ROS		At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
HISTORY	PMFSH		1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995		2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
PHYSICAL EXAM	1997		At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING			Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME			30 Min.	50 Min.	70 Min.

Used to report the first hospital encounter by the admitting physician (regardless of day).

Discharge Day Management

99238 - Hospital Discharge Day Management 30 minutes or less

99239 - Hospital Discharge Day Management more than 30 minutes (document time)

Permission granted by creator: Sally Streiber, Practical Coding Solutions LLC

From E&M Guidelines:

- If it is not documented, it has not been done.
- Clear and concise medical record documentation is critical to providing patients with quality care and is required to be paid.
- Payers may require reasonable documentation to ensure that a service is consistent with insurance coverage, site, medical necessity.
- The provider must ensure that documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.

It’s part of the job!

https://www.jble.af.mil/News/Article-Display/Article/1041470/

Documentation training

https://www.publicdomainpictures.net/en/view-image.php?image=164552&picture=stethoscope-and-gavel

Documentation for CDI

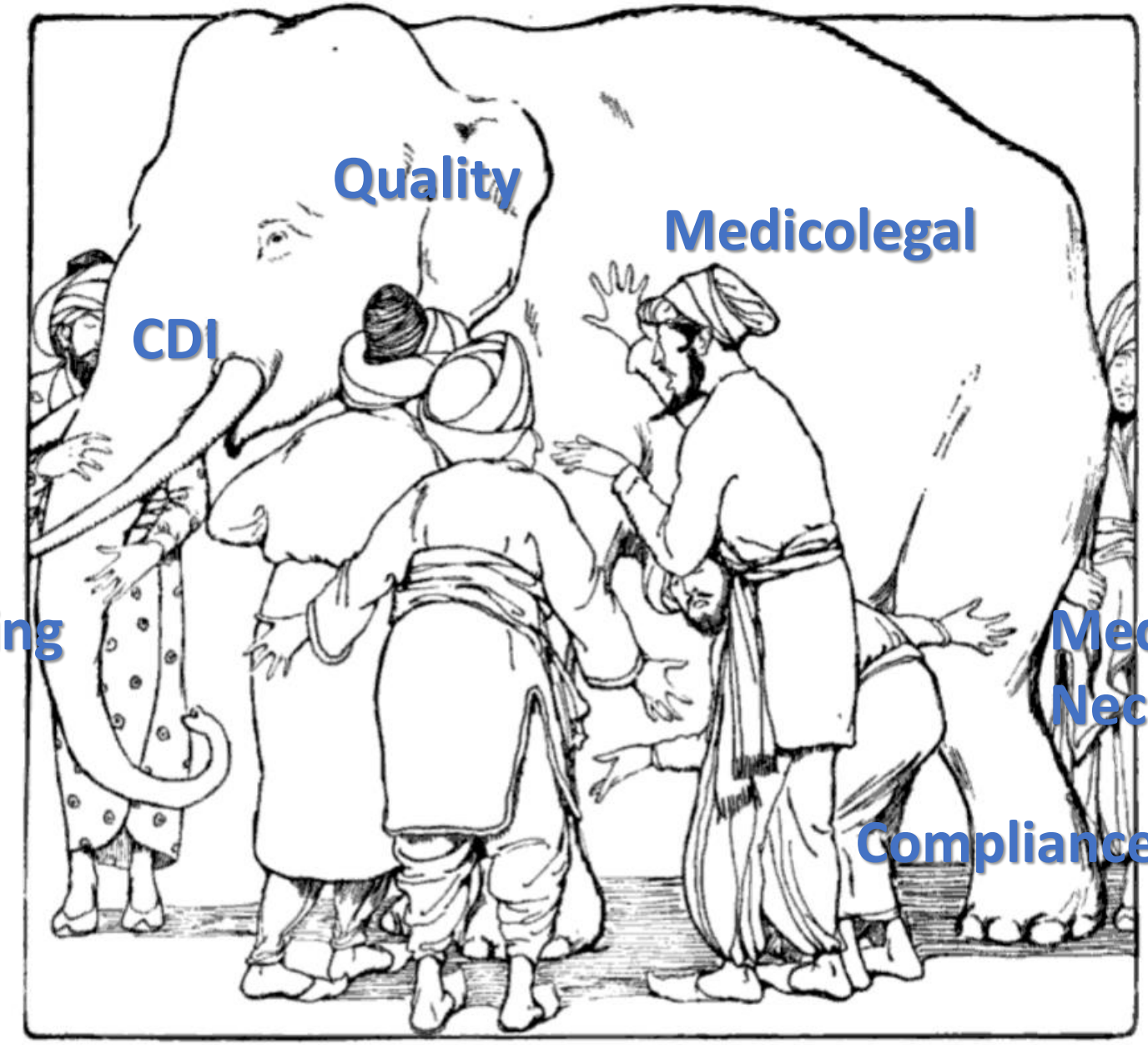
- Traditional CDI: clinical indicators without corresponding codable diagnosis
- Clinical validation CDI: diagnosis which does not seem to have supportive clinical indicators
- Specificity for ICD-10

The elephant in the room…

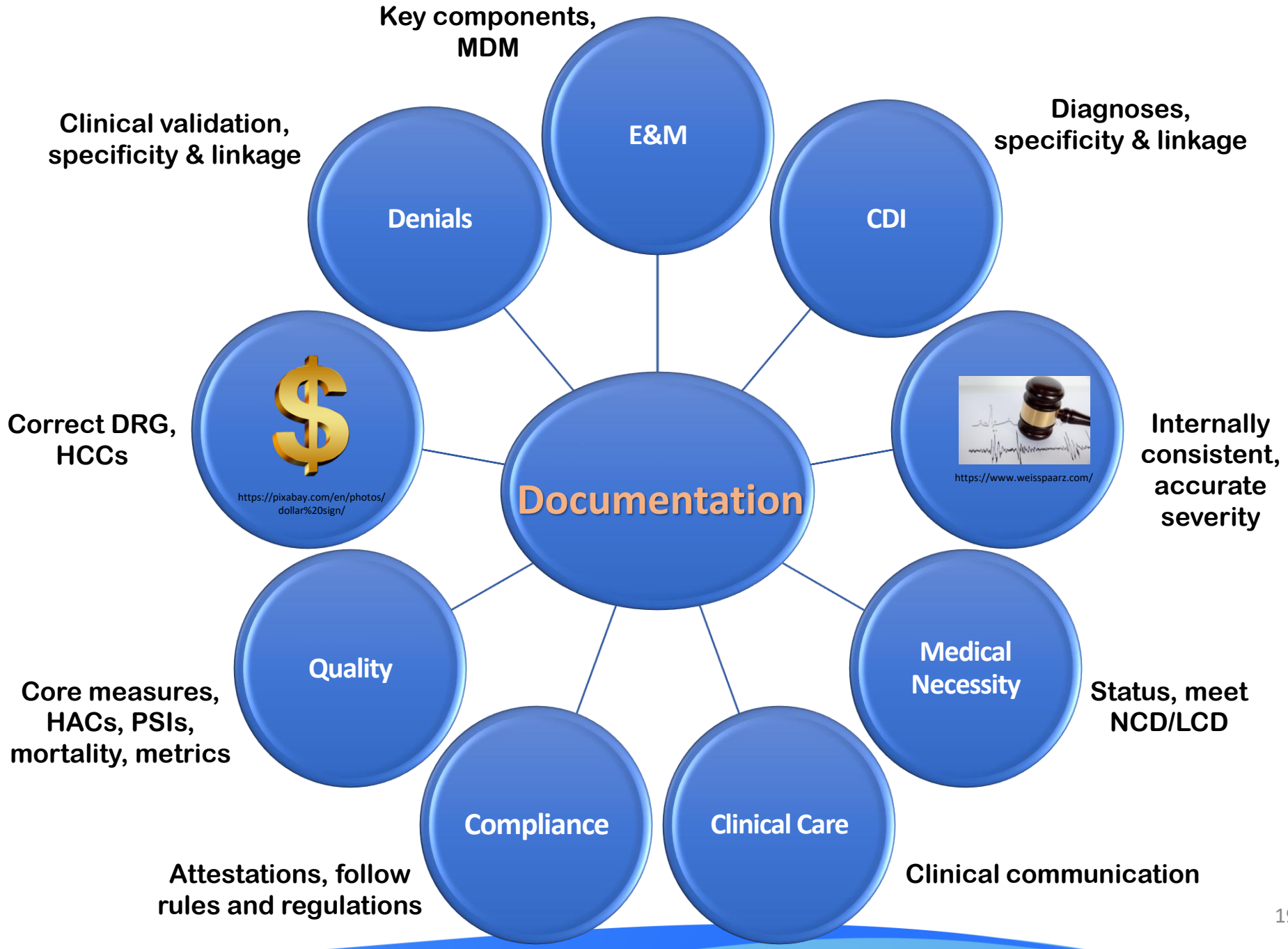
https://commons.wikimedia.org/wiki/File:Origami_(made_from_an_American_1-dollar_bill)_of_an_elephant.jpg

American College of Physician Advisors

Permission obtained from ACPA



https://commons.wikimedia.org/wiki/File:Blind_men_and_elephant.png


Key components, MDM
E&M
Clinical validation, specificity & linkage
Denials
Diagnoses, specificity & linkage
CDI
Correct DRG, HCCs
$
https://pixabay.com/en/photos/dollar%20sign/
Documentation
https://www.weisspaarz.com/
Internally consistent, accurate severity
Quality
Core measures, HACs, PSIs, mortality, metrics
Medical Necessity
Status, meet NCD/LCD
Compliance
Attestations, follow rules and regulations
Clinical Care
Clinical communication

https://pixabay.com/en/objects-squeeze-toy-toy-toys-315453/

Most important to avoid medical necessity denial

Place the patient in the right status and setting

Second most important

Excellent documentation

Similar to medicolegal standard

- Would another ~~medical professional~~ anyone think that the services or supplies used to take care of that patient with that problem in that setting were reasonable, appropriate, and met the standard of care?
  - Status
  - Intensity of Service
  - Avoidable Days

There may be criteria and guidelines, but clinical judgment is paramount.

How can they tell?

https://www.flickr.com/photos/opensourceway/4968547986

Hhhmm, this is a really bad exacerbation of moderate persistent asthma, I think I would even go as far as calling it status asthmaticus. I'm worried about her.

Asthma

https://pixabay.com/en/executive-laptop-business-office-844143/

Asthma

Just another boring patient with asthma. I'll check on her later.

https://commons.wikimedia.org/wiki/File:20130306-OC-RBN-3910_(8576196340).jpg

https://www.flickr.com/photos/dkalo/2902351751

Oxymoron

Care turned over to me at shift change. Pt arrived primarily complaining of severe epigastric abd pain beginning this morning. Indicated pain is entirely resolved. Most of work-up was quite benign however is not demonstrating some T-wave abnormalities inferiorly. Troponin is negative. Troponin repeated and measurable but still in normal range. Associated with some chest pain. No hemoptysis, hematemesis, or DVT risk factors. Given these findings it would be reasonable to hospitalize her for an observational stay.

. in stable condition at time of planned observation hospitalization.

Be clear – IP or OP

- Outpatient status for observation services
  - This clearly defines observation as an outpatient service
  - Make a macro

https://www.flickr.com/photos/shanafin/525187113

Not for convenience

ASSESSMENT AND PLAN:

1. Epigastric abdominal pain
   - Normal liver, normal gallbladder normal pancreas on CT.
2. Ascites, small amount.
3. Midline abdominal wall hernia containing omental fat.

Plan:

- Her presentation sounds like she may be having an intermittent obstruction that would have resolved. However, she is concerned that this is happening about once every 6 months. We discussed possible surgery evaluation although there seems to be no urgent indication for surgery.
- She prefers this be done as an inpatient. Will consult surgery
- Advance diet as tolerated.

IP criteria for abd pain include: surgery which can't be done OP, peritonitis, eval requiring prolonged NPO (> 24 hr), hemodynamic instability, severe pain (q 2-4 hr parenteral meds), complete ileus, signs of obstruction, severe electrolyte abnormalities, significant IVF requirements

Not for constipation (uncertain dx)

Assessment:
Active Problems:
Chest pain

Plan:
Abdominal pain, probable due to constipation. Patient with known chronic constipation.
Start Miralax and senokot
Hypertension: bp elevated; continue BP meds; add hydralazine 25 mg tid.
Sick sinus history of pacemaker
Hyperlipidemia continue statin

MCG Criteria for Gastroenterology Admission:

- Obstipation and **1 or more** of the following(50)(51)(52)(53):
  - Complication of fecal impaction (eg, stercoral ulceration, perforation, venous compression, obstructive uropathy)
  - Fecal disimpaction by digital fragmentation or mechanical disimpaction unsuccessful

Considerations in decision to admit

- Realistic expectation of > 2 MN
- Severity of signs and symptoms
- Medical predictability of adverse event (risk, comorbid conditions)
- Can tests be done on outpatient basis?
- InterQual or MCG can offer suggestions, but are not incontrovertible clinical criteria

Considerations in decision to admit

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Think in ink.

Indicators supporting admission

- Persistent altered mental status (i.e., encephalopathy)
- Hemodynamic instability
- Significant respiratory compromise
- Severe or intolerable symptoms
- Immunosuppression
- Expectation that there will not be a quick resolution with treatment
- Concerning (“dangerous”) dysrhythmias
- Life or limb threatening (think cellulitis)

Indicators supporting admission

- Critical lab values
- Psychiatric risk factors which cannot be managed in an alternate level of care
- Outpatient therapy failure
  - If unclear, place in OP status/OBS services and convert if needed

Good literary technique

- Paint a picture
- Liberal use of qualifiers / modifiers / adjectives / descriptors
  - Severe, intractable, intolerable, persistent, life-threatening, concerning, unrelenting, extreme, excruciating, continuous, constant, significant

This is a 62-year-old male who…

vs.

This is a 62-year-old chronically ill, debilitated male well known to our ED with multiple comorbidities including chronic atrial fibrillation on anticoagulation, alcoholism, and hypertension, with acute onset of severe, stabbing left-sided chest pain…

https://pixabay.com/en/painting-the-hand-paint-hand-brush-1479503/

Medical Necessity in ACDIS Blog

October 23, 2018 CDI Blog, Volume 11, Issue 210

- Q: How can we help our physicians improve their documentation of medical necessity?
- A:
  - **H**&P, HPI need to be thorough and demonstrate complexity
  - **O**rders for services and procedures only safely provided at hospital level of care (diagnosis for every procedure)
  - **P**otential risk if not treated in hospital
  - **E**xpectation of 2 MN stay with “because” clause

2 MN clause (and other attestations)

- “I expect the patient to be in the hospital spanning 2 midnights” is insufficient. Need “because” and a **valid** reason.
- Attestations, disclaimers, caveats should be enterprise-standardized
- You should be part of the development

Progress notes

https://commons.wikimedia.org/wiki/File:Blog_(1).jpg

Progress notes

Subjective:
Interval History:
No complaints

vs.

CHIEF COMPLAINT:Perforated appendicitis

Patient states she feels minimally better since having the NG tube placed. It has put out 400 cc since placement. She denies any nausea. She denies any flatus. She says she has had a quarter sized bowel movement this morning.

Medical necessity documentation

- **Chief complaint** – why is the patient still in the hospital? Do they have any other issues that have cropped up?
- **Physical exam** should address all systems related to the chief complaint/s
- **Assessment and Plan** – should evolve and re-order depending on active problems

Physical Exam - General

- General description is **KEY**
  - Vital signs
  - Pain
  - Distress
  - Nutritional status
  - Hygiene
  - Mental/psychiatric status

- A+O, WD/WN, in NAD…**why is this patient here**?
- Internal inconsistency (e.g., Nontoxic/diagnosis of sepsis)

Progress or non-progress

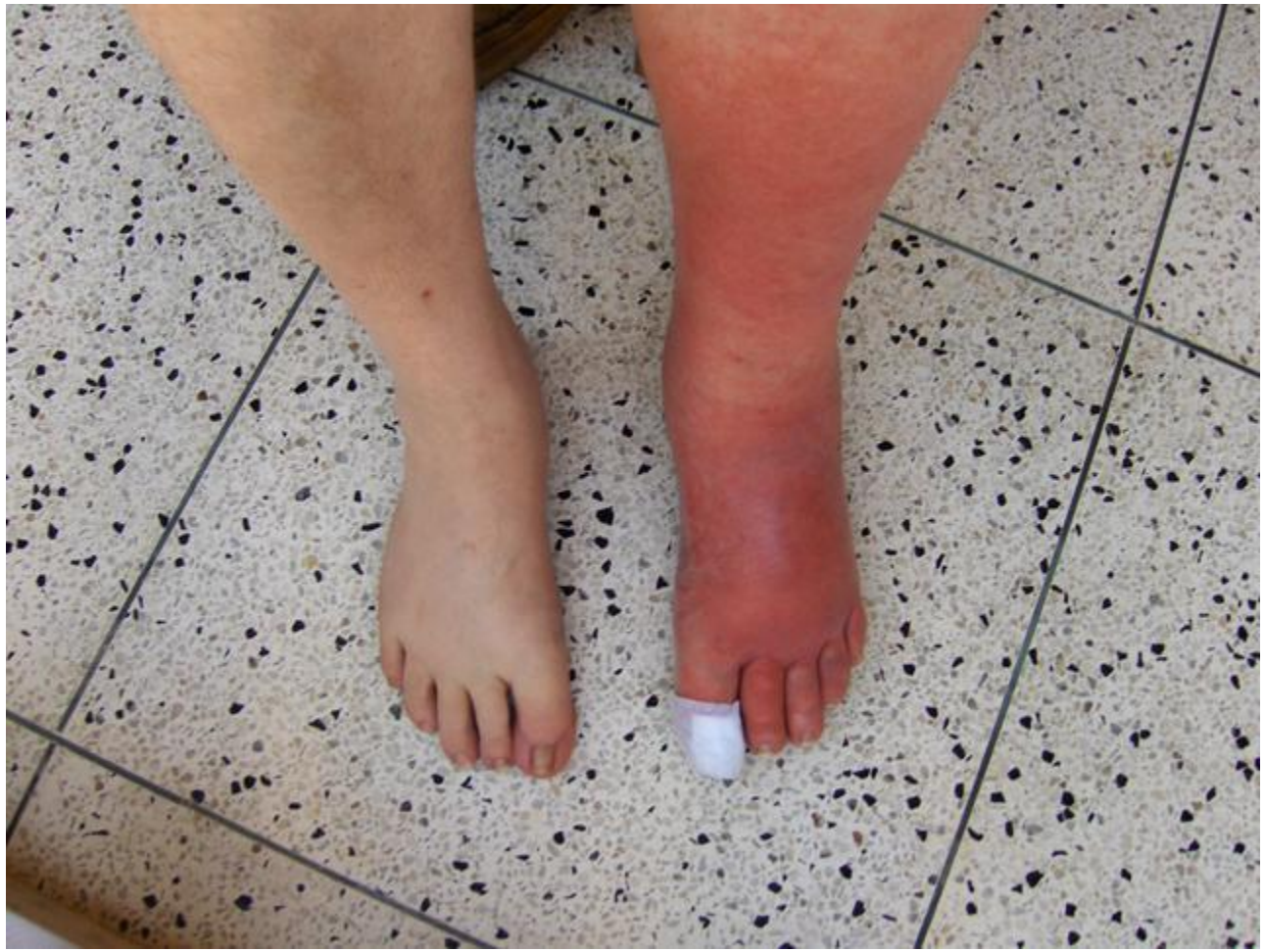
- New complaint – give details, but also address how admitting/principal diagnosis is faring
- Avoid, “Patient is stable.”
  - Better: “improving” or “unchanged”
- “Awaiting stepdown bed,” translates to: “no longer needs ICU bed.”
  - Better to say, “Patient to stepdown soon, when ready,” or “expect continued improvement with transfer to floor bed when indicated and safe.”
- If reason for still being in the hospital can’t be found in progress note, either the documentation needs to be beefed up or the patient should go home!

Documentation Time-out

- When charting (e.g., on rounds)
- Put **MENTATION** into your Documentation
  - WHY is this patient here (not being discharged)?
  - Justify WHERE the patient is (ICU, IP vs. OBS)
  - WHAT is your active plan? WHAT are you doing for this patient currently?

Subjective:
Interval History:
Patient has no complaints at this time.

Medical Necessity Denial



https://commons.wikimedia.org/wiki/File:Cellulitis_Left_Leg.JPG

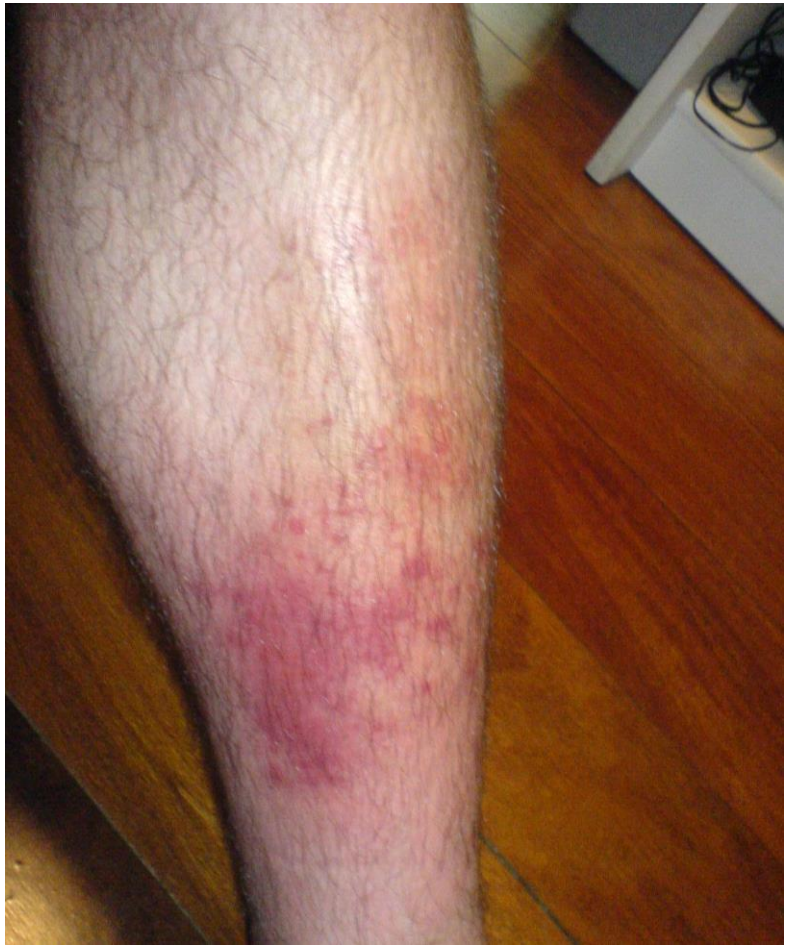
Medical Necessity Denial

- No written denial rationale
- Account narrative: 3 day history of R leg pain which was R leg cellulitis from tinea pedis. Erythema and tenderness to proximal thigh (N.B.: seems like ascending lymphangitis – never documented as such). Febrile with sed rate in 80s and elevated CRP. X-rays to rule out osteomyelitis and subcutaneous gas, ultrasound to R/O DVT. Blood cultures obtained. Admitted on Ceftriaxone and Vancomycin.

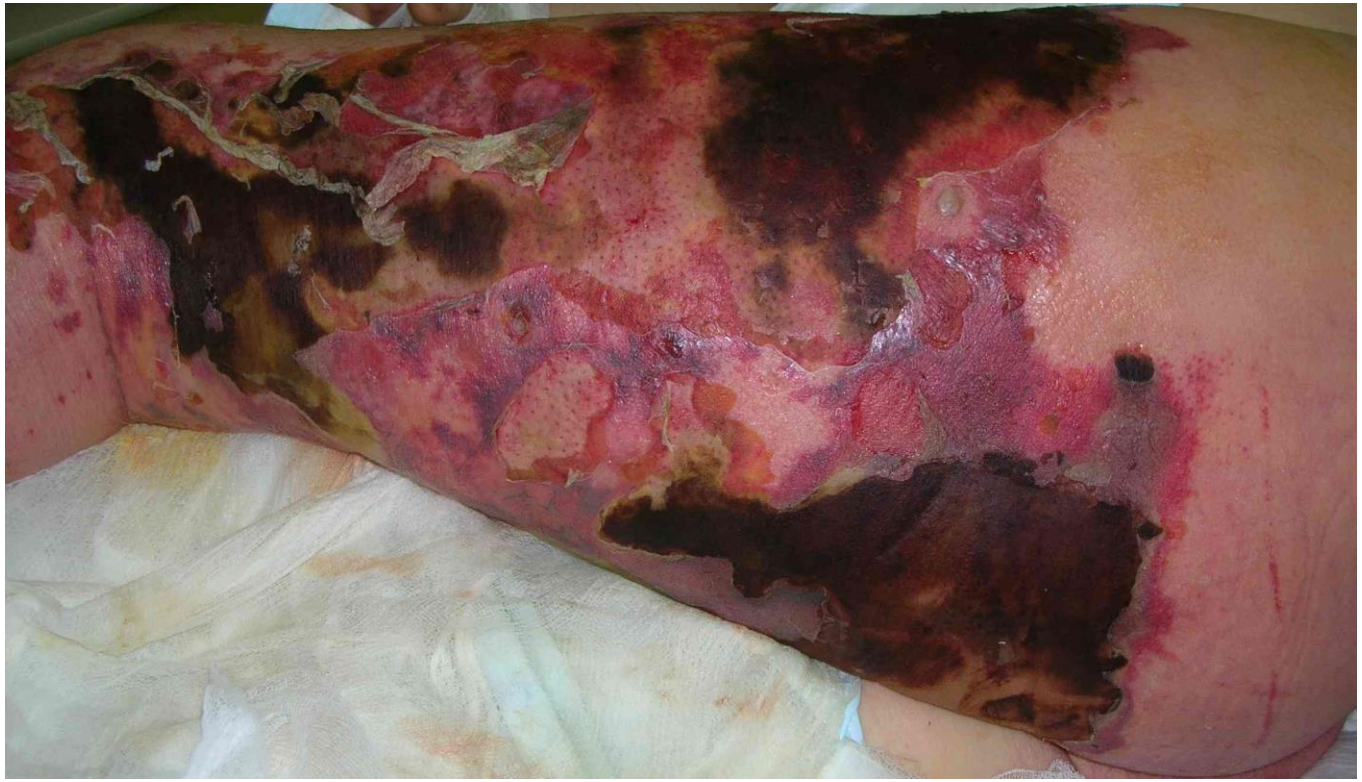
Medical Necessity Denial

- Minimal improvement; Acute Care Surgery consulted to rule out necrotizing fasciitis; Infectious Disease consulted and manipulated medications.
- Described as 47 cm in circumference; wound nurse 12 X 17 cm with large yellow discolored blistering
- 20 day stay with discharge to SNF

Picture can be worth a thousand words



https://commons.wikimedia.org/wiki/File:Cellulitis3.jpg



https://en.wikipedia.org/wiki/Necrotizing_fasciitis

Cellulitis

Inpatient

- Failed OP management
- Bite or implanted device
- Infection spreading
- Immunocompromised
- Uncontrolled DM
- Hemodynamic instability
- Cutaneous gangrene or necrotizing soft tissue infection

Outpatient

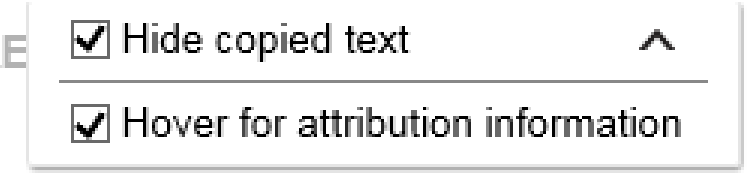
- Rapidly progressing infection
- Perineal infection
- Abscess can be drained OP
- Uncertainty regarding adherence to OP regimen
- Periorbital infection

Medical Necessity denial peril

- Signs and symptoms DRGs (near/syncope, chest pain, back pain)
- Short stays
- Diagnoses which often turn around quickly (COPD, CHF, hypertensive urgency)
- Unspecified diagnoses
- Paucity of comorbid conditions
- Not detailing risk to patient
- Not explaining why inpatient testing is appropriate
- Not describing prior nonsurgical or outpatient therapy

Copy and paste

INTERNAL MED PROGRE



ASSESSMENT AND PLAN:

1. **Bilateral lower extremity edema with cellulitis/dermatitis**. Improved. This most likely is multifactorial however suspicion for possible CHF vs due to also some dermatitis areas in her back with similar rash/erythema type appearance. Ultrasound Doppler bilaterally is negative for DVT.
-Continue with vancomycin for now
-Continue Lasix 20 mg twice daily
-Monitor I and O, so far 500 cc out
-Elevate lower extremities as able
-Monitor for rash/dermatitis including back area
-Consult wound care nurse, appreciate assistance
-2D echo pending to rule out CHF
-CT scan of chest and abdomen showing some loops of bowels air-filled possibly consistent with ileus but no other acute findings

Good documentation practices for medical necessity

- Put most serious, most concerning diagnosis first in your assessment and plan list (Don’t bury the lede!)
- Detail:
  - Specific comorbidities with linkage (cause and effect)
  - Persistent or worsening symptomatology
  - Clinically significant alteration from baseline
  - Functional disability and impairment of activities of daily living
- Explanation as to unexpected rapid recovery

Diagnoses are a hASSLe

- **A**cuity
- **S**everity
- **S**pecificity
- **L**inkage

Medical Necessity Denial

Denial Justification: “This stay does not meet criteria for inpatient admission. The reason is there is no indication of hemodynamic instability, acute renal failure, severe pulmonary edema, persistent dyspnea, or pneumonia. It appears that the needs of this patient could have been met at an observation level of care.”

Medical Necessity Denial – my view

- This is a very complex and chronically ill hypertensive, diabetic woman with tenuous renal function, S/P renal transplant with CKD Stage 3B, on chronic immunosuppression, with chronic hypoxic respiratory failure from COPD, on home oxygen around the clock, who has frequent exacerbations of chronic diastolic CHF.

Medical Necessity Denial – my view

- Presented with significant confusion and hypoxia with desaturation to 70%. Encephalopathy did not resolve with improved oxygenation, and 2 MN stay was anticipated.
- Admitted for diuresis and work-up of encephalopathy which included cultures and brain imaging. Renal consultation for AKI on CKD.
- 8 day stay with discharge to SNF.

Case-PNA

ED:

75 yo male presents to ED with increasing SOB, cough with some production over the last 5-7 days. No hemoptysis or CP. No exposures. Hx of afib, T2DM, HTN, CVA, thrombocytopenia, COPD, and hyperlipidemia.

On several rounds of antibiotics lately with minimal improvement. Also been given some oral prednisone. No orthopnea/PND.

PE: 129/68, P 110, T 36.8, R 18, SpO2 95%
WD/WN, in no acute distress.
Few crackles in RUL. Decreased BS in bases. No wheeze
Irreg irreg with 2/6 sys M

Case-PNA

Labs: WBC 14.4, H/H 11.8/36.9 Plt 323; BUN 35, Cr 1.8

Dx:
1. CAP, RUL. Failed OP treatment
2. Leukocytosis
3. Type 2 DM
4. Afib, anticoagulated. Rate controlled
5. COPD
6. CKD, stage III

Plan:
Admit to medical floor. Empiric antibiotics with Zithromax IC. Has been on multiple other OP abx.

Case-PNA

Admitting H&P:

c/o SOB as well as cough which is mostly nonproductive. No hemoptysis or CP. Has afib and is anticoagulated, has stent. Seen by PMD recently and placed on antibiotics. Did a breathing treatment just prior to arrival. Also on prednisone. More SOB walking distances. No leg swelling. Decreased PO and slight sore throat.

PE: 127/65, P 103, T 36.7, R 16, SpO2 97%
Pleasant, sitting upright in stretcher, no acute distress
Lungs: Normal breath sounds, no resp distress, slight exp wheezing

Case-PNA

Assessment:

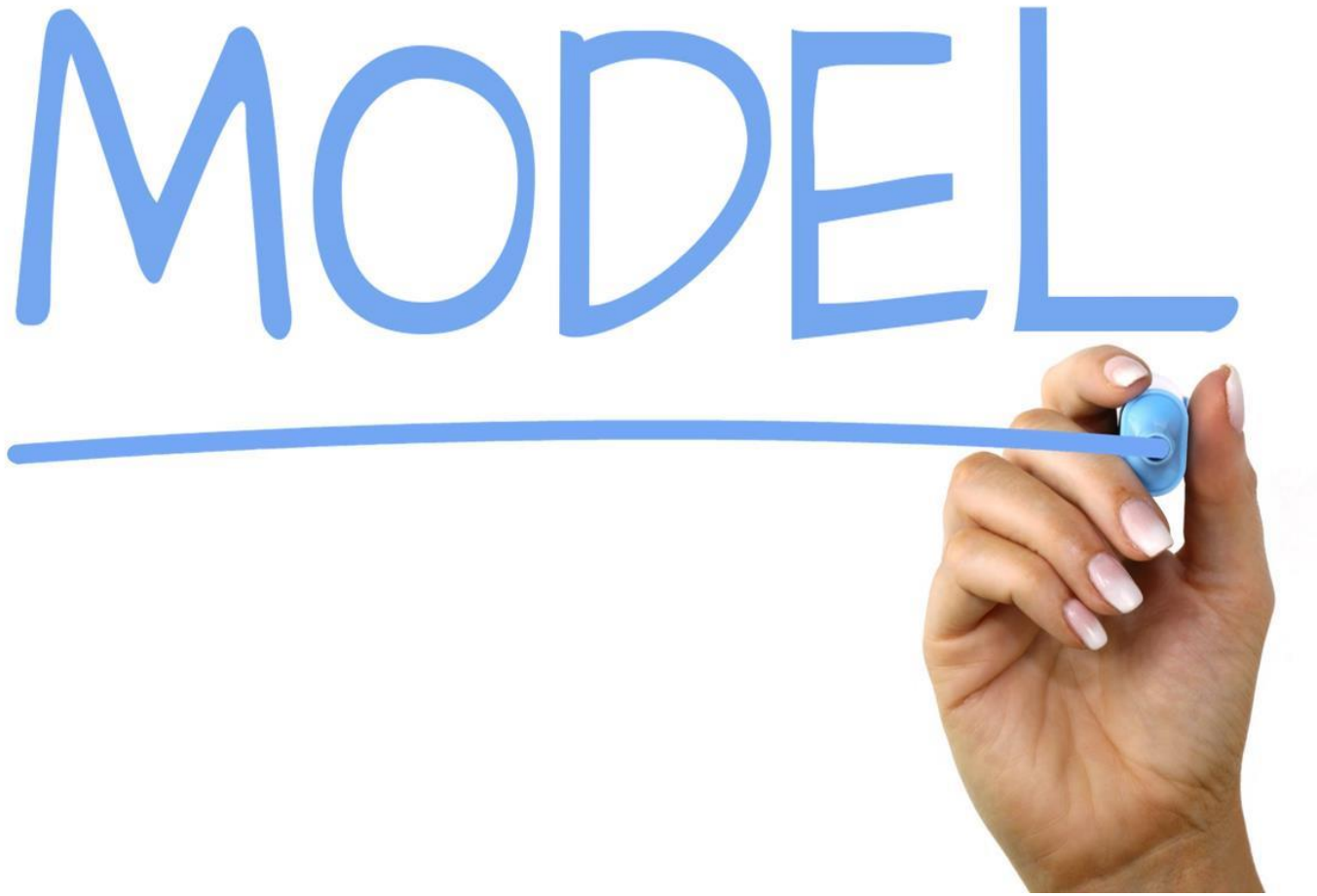
Has been taking Abx given to him by his PCP after he was diagnosed with PNA. He thinks he is not getting much better. Influenza screen negative. CXR infiltrate or atelectasis in the posterior RLL.

Given the patient's elevated white count, complaints of SOB, and recent treatment with PO Abx, I feel it is appropriate to bring him into the hospital for further treatment and evaluation and to place him on IV Abx.

Case-PNA

What do you think?

- PSI/PORT Score 104. Hospitalization is recommended due to a predicted 8.2%-9.3% 30-day mortality.
- CURB 2 points. Moderate risk. 6.8% mortality. Recommendation for IP or OP with close follow-up.

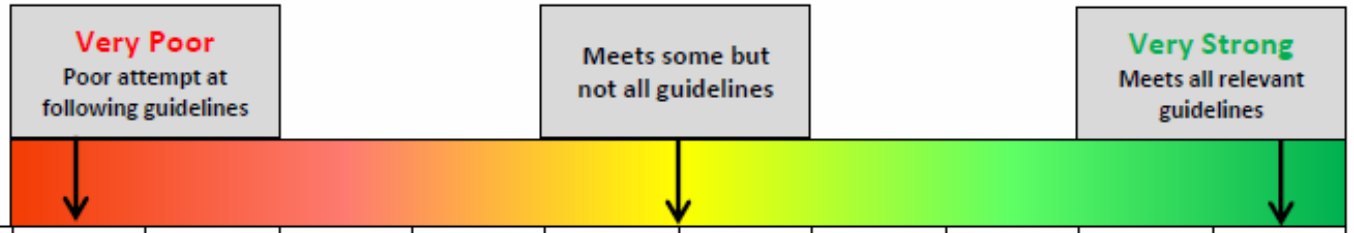


http://www.thebluediamondgallery.com/handwriting/m/model.html

Examples of verbiage

- “In my medical judgment, …”
- “In accordance with generally accepted professional standards…”
- “At high risk of adverse events as evidenced by…
- “In need of intensive treatment beyond the scope of ambulatory or observation care…”
- “Having had extensive experience with Condition X, in my medical opinion, this patient would be best served…”
- YOUR SUGGESTIONS?

Credit to UPMC



Question	1	2	3	4	5	6	7	8	9	10
S = SUCCINCT: Is the note specific and succinct?										
O = ORIGINAL: Have you found plagiarism? Was previously authored material updated?										
A = ACCURATE: Does the note reflect the patient's current clinical status?										
P = PROBLEM BASED Have all relevant co-morbidities and other inputs been considered? For each actively treated problem, is the appropriate complexity to support medical decision making (and the treatment plan) documented?										
Overall impression of the note. All comments are welcome!										

Name of Auditing Physician: _____ Progress Note Identifier #: _____

Feedback!

https://commons.wikimedia.org/wiki/File:Close_the_Loop_-_The_Noun_Project.svg

Documentation is for Clinical Communication

- Convey your thoughts to the other caregivers
- Facilitate information sharing
- Make the patient look as sick and complex in the medical record as he or she is in real life
- Quality, not quantity

Documentation should improve medical care and demonstrate that you provided excellent medical care

Thank You!

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