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Anatomy of the Discharge Summary to Optimize Quality and Revenue Integrity

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Speakers

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Readmission Rate and Care Plan and CDI Impact

ARROWHEAD REGIONAL MEDICAL CENTER

Bio

Sammy Allam, MD, MHA
Physician Manager Quality, CDI
Arrowhead Regional Medical Center

A strategic Hospital Physician Manager and Assistant Professor with 13+ years of experience directing healthcare administration programs and complex managed care hospital operations. A collaborative and adaptable leader skilled in professionally communicating, steering process improvements with innovative solutions, and managing relationships, service quality, utilization, and compliance in fast-paced and dynamic clinical enterprises.

Arrowhead Regional Medical Center provides Inpatient Care and Outpatient Care facilities with over 60 specialty services and preventive programs for children and adults.

Readmission Rate – what we learned?

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Patient

HOSPITAL

- Patients present with 60-85% missing history of pre-existing conditions, which impacts current hospital stay.
- Barriers to the continium of care due to the lack of safe discharge avenues i.e (extended stays)
- The evolution of social determinants of health factors

Examples: lack of health access - patients visit hospital at their breaking point, health literacy, food & shelter, maternal care, psychosocial risk factor

Readmission Rate – what we learned?

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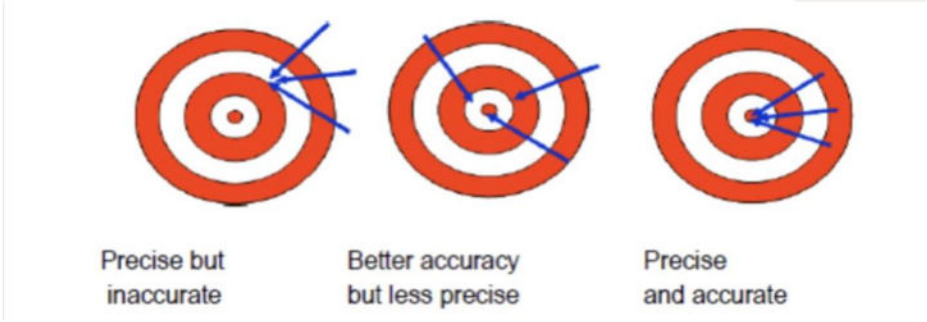
- Hospitals and healthcare facilities have a wide range of departments and verticals. Its smooth functioning is dependent upon their seamless operations through these verticals across functions
- To streamline the processes and exchange of information throughout various functions, healthcare providers are encouraged to increasingly adopting an integrated Health Information Systems
- These are Platforms that integrates various departments in the hospital, streamlines data generation and information flow across the functions, and helps automate processes and systems to reduce redundancies in hospital operations
- From Hospital Admission, throughout Hospital course and towards discharge – precision of data is very important to address populations at risk and prevent Hospital Acquired Complications, also to help with facilitating safe discharge
- Alignment of data precision grew to play an integral role in preventative medicine initiatives and Hospital Quality Metrics such as in “Readmission Reduction” and “30-days Mortality outcome” efforts



Social Determinants of Health and Delayed Discharges

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ICD MENTAL, BEHAVIORAL AND NEURODEVELOPMENTAL DISORDERS

ICD-9-CM	ICD-10-CM
290-294 Organic Psychotic Conditions	**F01-F09** Mental Disorders due to known Physiological condition
295-299 Other Psychoses	**F10-F19** Mental and Behavioral Disorders due to Psychoactive Substance Abuse
300-316 Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders	**F20-F29** Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Disorders
317-319 Intellectual Disabilities	**F30-F39** Mood [Affective Disorders
	F40-F48 Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders
	F50-F59 Behavioral Syndrome Associated with Physiological Disturbances and Physical Factors
	F60-F69 Disorders of Adult Personality and Behavior
	F70-F79 Intellectual Disabilities
	F80-F89 Pervasive and Specific Developmental Disorders
	F90-F98 Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
	F99 Unspecified Mental Disorder

SOURCE: Contexo Media. Best Practices for ICD-10-CMDocumentation and Compliance 2012. Salt Lake City: Contexo Media, 2012. Print.

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INTEROPERABILITY AND PREDICTION ANALYTICS

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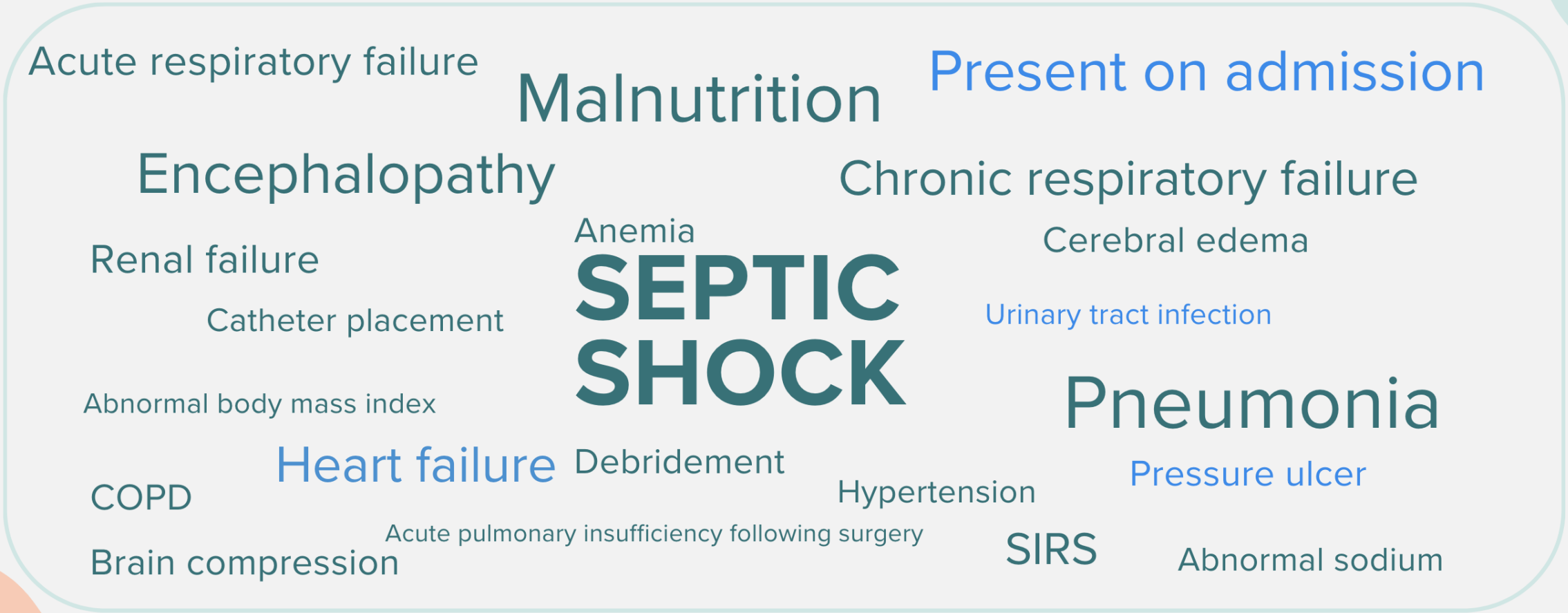
- Monitor DRG, DRG components, Case Mix Index (Acuity) – First line of defense against readmissions, maldiagnoses
- Dwell into etiology – Specify the unspecified diagnoses
- Capture Principal & secondary diagnoses
- Evaluate Severity of Illness & Risk of Mortality
- Dwell on precision of data from admission through discharge
- Highlight Major Co-morbid Conditions MCC or Co-morbid conditions CCs & procedures
- Retrieve missing information via sending clinical queries

Evidence-based guidance for higher quality



Blue = quality-related content

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Examples of Coding the Discharge Summary with Best Practices Commentary

Innova REVENUE GROUP

Bio

Patricia Chua RHIT, CCS, CCDS
President
Innova Revenue Group

Patricia Chua, RHIT, CCS, CCDS, is the COO for Innova Revenue Group. She has more than 20 years of experience in the HIM/CDI/coding industry and is one of the nation's foremost experts in coding and clinical documentation integrity (CDI). She is proficient in all aspects of CDI, revenue optimization, inpatient and outpatient coding, auditing, charge capture, and regulatory compliance.

INNOVA Revenue Group is a small company with the main purpose of assisting organizations to achieve their financial, organizational, and operational goals. INNOVA Revenue Group provides short-term, interim, and long-term end-to-end revenue cycle services for a variety of specialties and facilities that include acute care community hospitals, critical access hospitals, home health facilities, long-term care facilities, ambulatory surgery centers, outpatient clinics, individual provider practices, long-term care hospitals, and psychiatric hospitals. Our cost-effective support/solutions help any size health system or group maximize revenue cycle compliance, efficiency, and productivity.

The Coder/Auditor's Perfect Discharge Summary

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The Perfect Discharge Summary for a Coder/Auditor Includes these elements:

1. **Reason for Hospital Admission:**

- **Importance:** Clearly stating the reason for hospital admission is fundamental. It provides context for the entire hospitalization and helps in understanding the primary medical issue that necessitated the patient's stay.
- **Coding Significance:** This information is vital for accurate coding, as it establishes the principal diagnosis – the condition chiefly responsible for the patient's admission.

2. **All Diagnoses Treated During the Patient's Stay:**

- Importance: Including all relevant diagnoses is crucial for a comprehensive understanding of the patient's health status. This goes beyond the principal diagnosis to encompass all conditions that received medical attention during the hospital stay.
- Coding Significance: Accurate coding of secondary diagnoses is essential for proper reimbursement and provides a complete picture of the patient's health, influencing the severity of illness and risk of mortality metrics.

The Coder/Auditor's Perfect Discharge Summary

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The Perfect Discharge Summary for a Coder/Auditor Includes these elements:

3. **Procedures and Treatment Provided:**

- **Importance:** Documenting the procedures and treatments administered during the hospitalization is essential for conveying the level of care provided to the patient. This includes surgeries, medical interventions, and therapeutic measures.
- **Coding Significance:** Coding of procedures is critical for accurate billing and reflects the resources and services utilized during the hospital stay. It also contributes to the overall understanding of the patient's care journey.

4. **Medications and Discharge Instructions:**

- **Importance:** Including information about prescribed medications and clear discharge instructions is vital for the post-hospital care of the patient. This ensures continuity of treatment and helps prevent medication errors.
- **Coding Significance:** While not directly related to coding, medication information is crucial for overall patient care. It may also be relevant for coding if specific medications administered during the hospitalization impact the patient's diagnosis or treatment.

The Coder/Auditor's Perfect Discharge Summary

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The Perfect Discharge Summary for a Coder/Auditor Includes these elements:

5. **Follow-up Care and Appointments:**

- **Importance:** Providing guidance on follow-up care, including scheduled appointments and recommended tests or consultations, contributes to the patient's ongoing well-being.
- **Coding Significance:** While not directly related to coding, this information is important for understanding the post-discharge care plan and may impact coding decisions if subsequent care is related to the initial hospitalization.

A well-crafted discharge summary not only meets the needs of coders and auditors but also serves as a comprehensive document for the entire care team involved in the patient's post-hospital journey. It ensures a smooth transition of care and supports accurate coding, billing, and reimbursement processes.

Discharge Summary Coding Guidelines

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Inpatient Official Coding Guideline for Uncertain Diagnoses (Section III.C)

"If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

***Note:** This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals."*

- Uncertain diagnoses cannot be reported in the outpatient setting but can be reported in the inpatient setting "**if documented as such at the time of discharge**." "The time of discharge implies the patient has been evaluated, treated, and is ready for discharge from the facility."
- Uncertain diagnoses that are listed on the last progress note for a visit count if it is completed at the time of discharge.

Probable or Suspected Condition in Inpatient Setting (Coding Clinic Advice)

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ICD-9-CM Coding Clinic, Third Quarter 2005 Page: 22

Question:

The attending physician for an inpatient admission has included conditions listed with terms such as "consistent with," "compatible with," "indicative of," "suggestive of," and "comparable with" in the **final diagnosis**. How should these conditions be coded?

Answer:

Code these conditions as if they were established. These terms fit the definition of an uncertain diagnosis. According to the Official Guidelines for Coding and Reporting (Sections II and III), in short-term, acute, long-term care and psychiatric hospitals, if the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," code the condition as if it existed or was established. This advice should not be applied to admitting or interim diagnoses.

Coding Ruled-Out Diagnosis (Coding Clinic Guidance)

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ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2017 Pages:102-103

Question:

There appears to be an increase in physicians documenting uncertain diagnoses on the discharge summary that have actually been ruled out. Some physicians are using the concept of "uncertain diagnosis" to list provisional or differential diagnoses that have been ruled-out on the discharge summary. The fact that the conditions are being worked up and the initial therapeutic approach seems to support this practice, per the guideline for coding uncertain diagnosis. Should diagnoses that are ruled-out at the time of discharge, but were considered during the hospital stay be coded? What is the intent of the guideline pertaining to uncertain diagnosis?

Answer:

The ICD-10-CM Official Guidelines for Coding and Reporting clearly indicate that the "Uncertain Diagnosis" guideline only applies if the diagnosis has not been ruled out at the time of discharge. The guideline "Uncertain Diagnosis" (Section II.H. and Section III.C.) explicitly states, "If the diagnosis documented at the time of discharge is qualified as 'probable', 'suspected', 'likely', 'questionable', 'possible', or 'still be to be ruled out', or other similar terms indicating uncertainty, code the condition as it existed or was established. "At the time of discharge" is a key component of this guideline. If a provisional or differential diagnosis on admission is determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be considered as an uncertain diagnosis. Even if the condition has been worked up and initially treated, once the condition is ruled out, it should no longer be coded. "Ruled out" means that the diagnosis has been eliminated as a possibility.

Discharge Summary Examples

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EXAMPLE 1: PATIENT ADMITTED FROM 4/1–4/7.

Patient is septic from a catheter related UTI, hypokalemic, dehydrated, in acute renal failure and noted to have possible pneumonia. The pneumonia is listed in every progress note as "Possible". On 4/7 the attending physician documents "Possible pneumonia" in the last progress note; however, it is not listed on the discharge summary. The discharge summary does not dispute or rule out pneumonia. Do we still code the possible pneumonia?

YES, WE DO. This was documented on the day of discharge and consequently can be coded.

Discharge Summary Examples

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EXAMPLE 2: PATIENT ADMITTED FROM 5/3–5/6.

Patient is in hypertensive acute on chronic diastolic heart failure with ESRD. The patient receives dialysis daily during the admission. The patient is noted on a 5/3 progress note to have a "Possible NSTEMI TYPE 2 due to the CHF". This documentation is repeated on the 5/4 cardiology consult. It is not listed in the chart again until the discharge summary, dictated on 5/7 where it is listed as "Questionable NSTEMI TYPE 2." Do we code the type 2 NSTEMI?

YES, WE DO. Despite being dropped from the documentation at one point, it is still listed as questionable on the discharge summary. Therefore, it can be coded.

Discharge Summary Examples

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EXAMPLE 3: PATIENT ADMITTED FROM 3/15-3/20.

The patient has diabetic PVD with gangrene of their right foot. A below the knee amputation is performed on 3/15. Because the patient is in chronic stage 3B renal failure, a nephrology consult is ordered. The consultant on 3/16 notes possible acute renal failure. This diagnosis is carried to 3/19 on each progress note but is not documented on the last day of the inpatient stay. The discharge summary makes no mention of acute renal failure— only the chronic stage 3B renal failure. Do we code the possible acute renal failure?

NO, WE DO NOT. The patient was discharged on 3/20, and it was not listed on the 3/20 progress notes or the discharge summary. Therefore, it cannot be coded; however, a query for clarification may be sent to the attending physician. This will confirm if acute renal failure was ruled out or still a suspected condition at the time of discharge.

Discharge Summary Examples

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Question:

There appears to be an increase in physicians documenting uncertain diagnoses on the discharge summary that have actually been ruled out. Some physicians are using the concept of "uncertain diagnosis" to list provisional or differential diagnoses that have been ruled-out on the discharge summary. The fact that the conditions are being worked up and the initial therapeutic approach seems to support this practice, per the guideline for coding uncertain diagnosis. Should diagnoses that are ruled-out at the time of discharge, but were considered during the hospital stay be coded? What is the intent of the guideline pertaining to uncertain diagnosis?

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The ICD-10-CM Official Guidelines for Coding and Reporting clearly indicate that the "Uncertain Diagnosis" guideline only applies if the diagnosis has not been ruled out at the time of discharge. The guideline "Uncertain Diagnosis" (Section II.H. and Section III.C.) explicitly states, "If the diagnosis documented at the time of discharge is qualified as 'probable', 'suspected', 'likely', 'questionable', 'possible', or 'still be to be ruled out', or other similar terms indicating uncertainty, code the condition as it existed or was established. "At the time of discharge" is a key component of this guideline. **If a provisional or differential diagnosis on admission is determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be considered as an uncertain diagnosis. Even if the condition has been worked up and initially treated, once the condition is ruled out, it should no longer be coded. "Ruled out" means that the diagnosis has been eliminated as a possibility.**

DISCHARGE SUMMARY BEST PRACTICES

HITEKS™

1. **Focus on Relevant Information:**
   - Include only essential information that is relevant to the patient's care and post-discharge needs.
   - Avoid duplicating information that is already available in other parts of the medical record.

2. **Use Standardized Templates:**
   - Implement standardized templates for discharge summaries. This helps guide providers in including essential elements and reduces the risk of unnecessary details.

3. **Prioritize Key Diagnoses and Interventions:**
   - Highlight primary diagnoses and significant interventions that influenced the patient's care.
   - Prioritize information that is critical for the understanding of the patient's condition and post-discharge management.

4. **Be Concise in Descriptions:**
   - Use clear and concise language to convey information. Avoid unnecessary elaboration or redundancy.
   - Focus on key clinical findings, treatments, and outcomes without excessive detail.

5. **Avoid Copy-Paste Errors:**
   - Be cautious with copy-pasting information from other parts of the medical record. Ensure that the copied information is relevant and accurate for the current discharge summary.

DISCHARGE SUMMARY BEST PRACTICES

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6. **Limit Repetitive Documentation:**
   - Avoid unnecessary repetition of information already documented in progress notes or other sections of the medical record.
   - Focus on changes in the patient's condition, new developments, and the care plan at the time of discharge.

7. **Include a Summary of Follow-Up Care:**
   - Provide a concise summary of the post-discharge care plan, including medications, follow-up appointments, and any specific instructions.
   - This ensures that the patient and the receiving healthcare providers have clear guidance for ongoing care.

8. **Utilize Headers and Bulleted Lists:**
   - Organize information using headers and bulleted lists to enhance readability.
   - Structured formatting helps providers quickly locate and understand key points without wading through unnecessary details.

9. **Review and Edit:**
   - Encourage providers to review and edit discharge summaries to ensure clarity and conciseness.
   - Eliminate redundant information or details that do not contribute to the overall understanding of the patient's case.

10. **Educate Providers:**
    - Offer education sessions on effective discharge summary documentation to promote awareness of note bloat issues.
    - Provide feedback and examples to illustrate how concise yet comprehensive documentation can be achieved

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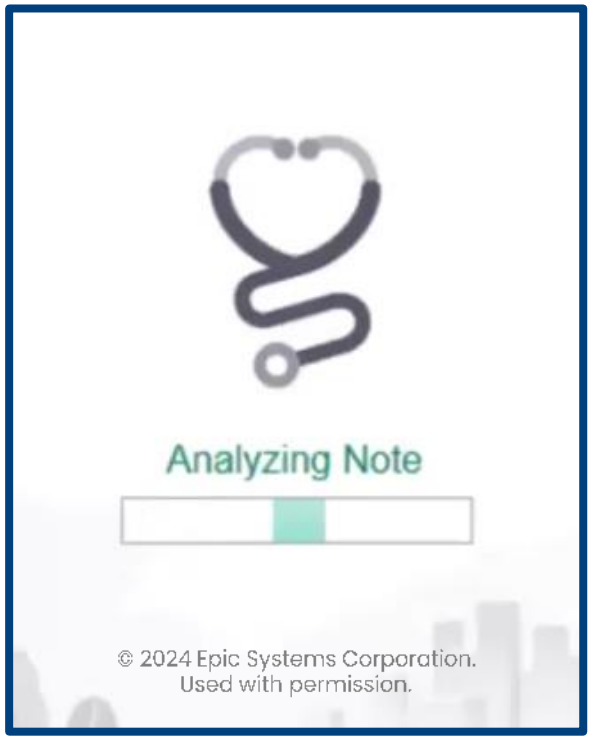
Technology Enablement to Improve Creation of Discharge Summary and Reduce Provider and CDI Burden

Epic

Computer-Assisted Discharge Summary

HITEKS™

1. Consolidates and Summarizes all Care Team Visit Documentation into a Concise D/C Summary for the D/C Physician
2. Avoids Note Bloat
3. Uses Epic's Native Note Editor
4. Applies HITEKS' CDI Query Library to Ensure Full ICD-10 Specificity (acuity, type, etc.)



Epic

CDI Query Library for Revenue & Quality Integrity

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HCC, MS-DRG, MS-DRG Base, APR Base, APR SOI/ROM Impact

Abdominal Pain	Acute COPD/Asthma	Hypomagnesemia
Abnormal CXR on Antibiotic	Cor Pulmonale	Hyponatremia
Acidosis	Debridement	Hypophosphatemia
Acute Blood Loss	Diabete Mellitus Hyperglycemia	Incision and drain
Acute Heart Failure	Diabetic Hyperosmolarity	Malignant Hypertension
Acute Hypercapnic Respiratory Failure	Diabetic Ketoacidosis	Nicotine Withdrawal
Acute Hypoxic Respiratory Failure	Drug Overdose	Pneumonia Specificity
Acute Myocardial Infarction	DVT	Pulmonary Embolism POA
Acute on Chronic Diastolic Heart Failure	Dysphagia Phase	Respiratory Failure
Acute on Chronic Systolic Heart Failure	Elevated lactate with Sepsis (Severe Sepsis)	Sepsis
Acute Respiratory Failure	Elevated Troponin	Sepsis with specific sources of infection
Acute tubular necrosis	Fracture	Shock
AIDS/HIV	Gastroenteritis	Simple Pneumonia
ARDS	Hepatic Failure Severity	SIRS
Asthma Severity	HIV - Symptomatic/Asymptomatic	Spinal Cord Edema
Acute Asthma/COPD	Hypercalcemia	Thiamine Deficiency
Atrial Fibrillation	Hyperkalemia	Thrombocytopenia
Bowel Obstruction	Hypernatremia	Uncontrolled diabetes
Child Abuse	Hyperphosphatemia	Urosepsis
Chronic Heart Failure Type	Hypertension	UTI
Coma	Hypocalcemia	UTI Linkage to catheter
Complex Pneumonia	Hypokalemia	

Elixhauser-Focused Queries

Anemia - Macrocytic	Lymphoma
Anemia - Microcytic	Malnutrition
Brain Hemorrhage	Metabolic Encephalopathy
Cause of Delirium	Midline Shift
Cerebral Edema	Mild/Moderate Malnutrition
Chronic Kidney Disease	Morbid Obesity >35+ & >40
CVA	Obesity BMI>30
Cause of Delirium	Pancytopenia
Drug induced hemorrhage disorder	Portal Hypertension
Encephalopathy	Pulmonary Embolism Specificity
End-Stage Renal Disease	Pulmonary Hypertension
Fluid Overload	Right Heart Failure Etiology
GI Bleeding + Ulcer	Septic Encephalopathy
Hepatic Encephalopathy/Failure	Severe Malnutrition
HFpEF with EF >=50%	Solid Cancer
HFrEF with EF<50%	Subdural Hemorrhage/Hematoma
Hypertensive Encephalopathy	Toxic Encephalopathy
Hypothyroidism	Uncontrolled diabetes
Immobility Status	Underweight
Leukemia	

CAPD360 Insight For NoteReader CDI

Computer-Assisted Physician Documentation

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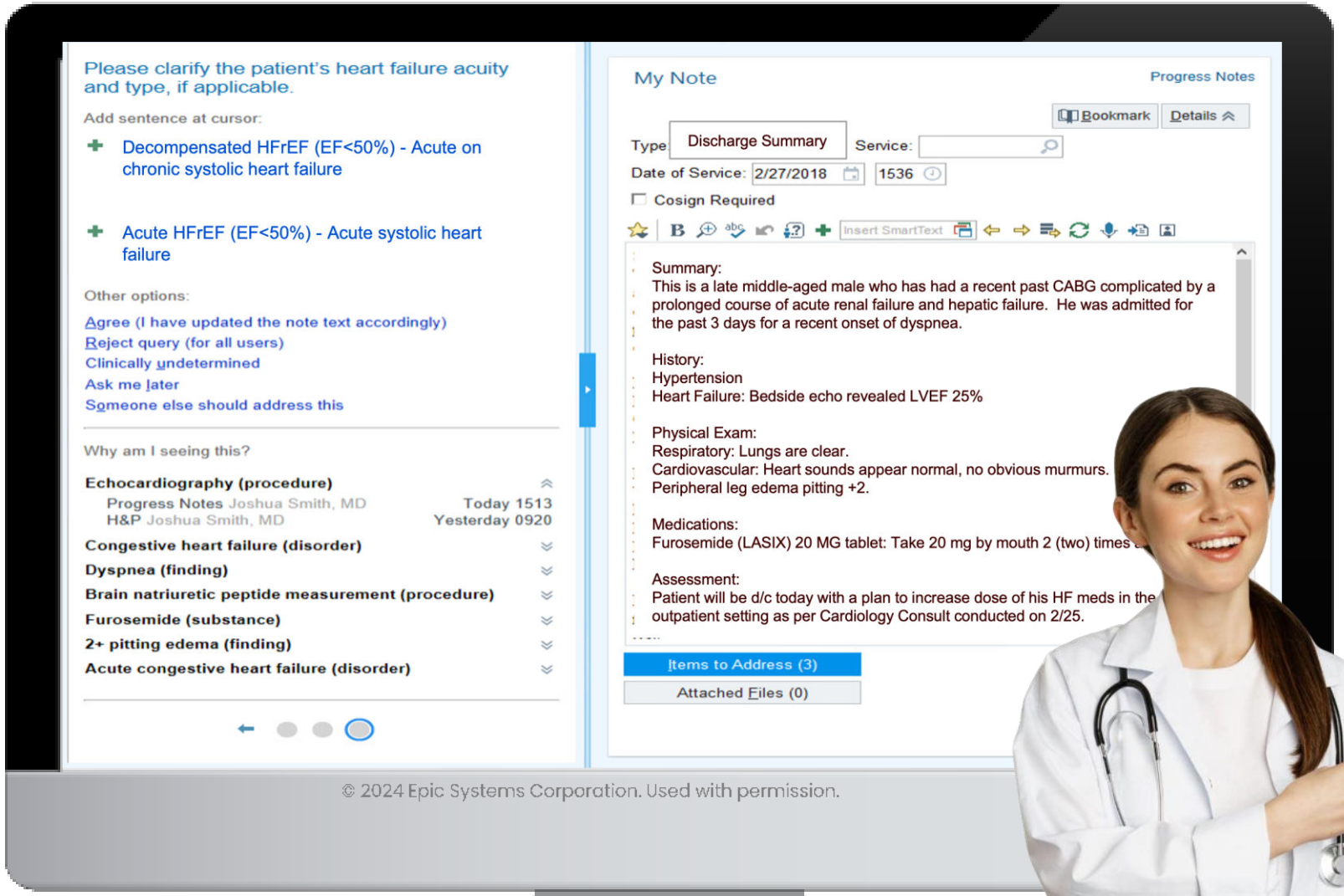

Present

- Present queries as soon as possible while case details are still top of mind

Remain

- Remain completely in Epic so providers don't need toggle between screens

Ensure

- Ensure queries are clinically justified and compliant without over-prompts

Allow

- Allow query logic & workflow to be customized

Cover

- Cover Revenue, Risk and Quality Sensitive Diagnoses

AVAILABLE IN AppOrchard Epic