Describing the 'clinical truth' in clinical coding

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I am concerned about the quality of our clinical coded data. I believe the focus for Clinical Coders (CCs) should be on all conditions that meet criteria for code assignment in order to describe the patient stay fully and truthfully – the 'clinical truth' as per the writings and presentations of Dr Cesar Limjoco, a Clinical Documentation Improvement (CDI) Physician Advisor Consultant from the United States of America (USA) (Limjoco 2014).

For many years, the focus of clinical coding in our hospitals has been on revenue optimisation. Most hospitals do not have the resources to review all episodes, so have concentrated on episodes with the potential to increase revenue. Also, the focus of clinical coding (and clinical documentation queries) has been on a small number of conditions that change the Diagnosis Related Group (DRG) outcome. While the implementation of version 8 of the Australian Refined Diagnosis Related Groups (AR-DRG) classification has broadened the applicable codes, there are still many codes that do not impact DRG outcome and consequently the data remain skewed towards those codes that do.

Factors that impact the quality of clinical coded data

Describing the 'clinical truth' in clinical coding can be impacted by many factors, and we need to think about how we can improve our clinical coding and increase the focus on quality of data. One of the factors that may impact is clinical coding knowledge and application. As well as what CCs learnt in their clinical coding courses, there is a need to keep up-to-date with the changes to the classification and clinical coding rules. For example, there were 83 Coding Rules published in the last financial year that needed to be applied. In addition, for the implementation

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of the International Classification of Diseases and related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and Australian Classification of Health Interventions (ACHI) Tenth Edition, there were 291 diagnosis codes, 362 procedure codes, and 93 Australian Coding Standards that were new, changed or deleted. There are also state or territory-released clinical coding queries to consider. The point being, that clinical coding rules, conventions and standards change a great deal and can significantly impact on the quality of clinical coded data if the changes are not implemented correctly.

Another factor is where there are complex processes and multiple applications to be accessed in order for CCs to obtain the information they need to assign diagnosis and intervention codes. Figure 1 is an example of a clinical coding process map from a tertiary level hospital showing the interactions and data flows. The map does not cover the additional applications that the CCs may need to access for specialised information, such as for radiology, pathology, obstetric and neonatal episodes. In total, the CCs must access at least seven applications in addition to the information held in the scanned medical record. The multitude of places where information may be recorded, and so need information to be abstracted from, increases the potential to impact on quality clinical coding.

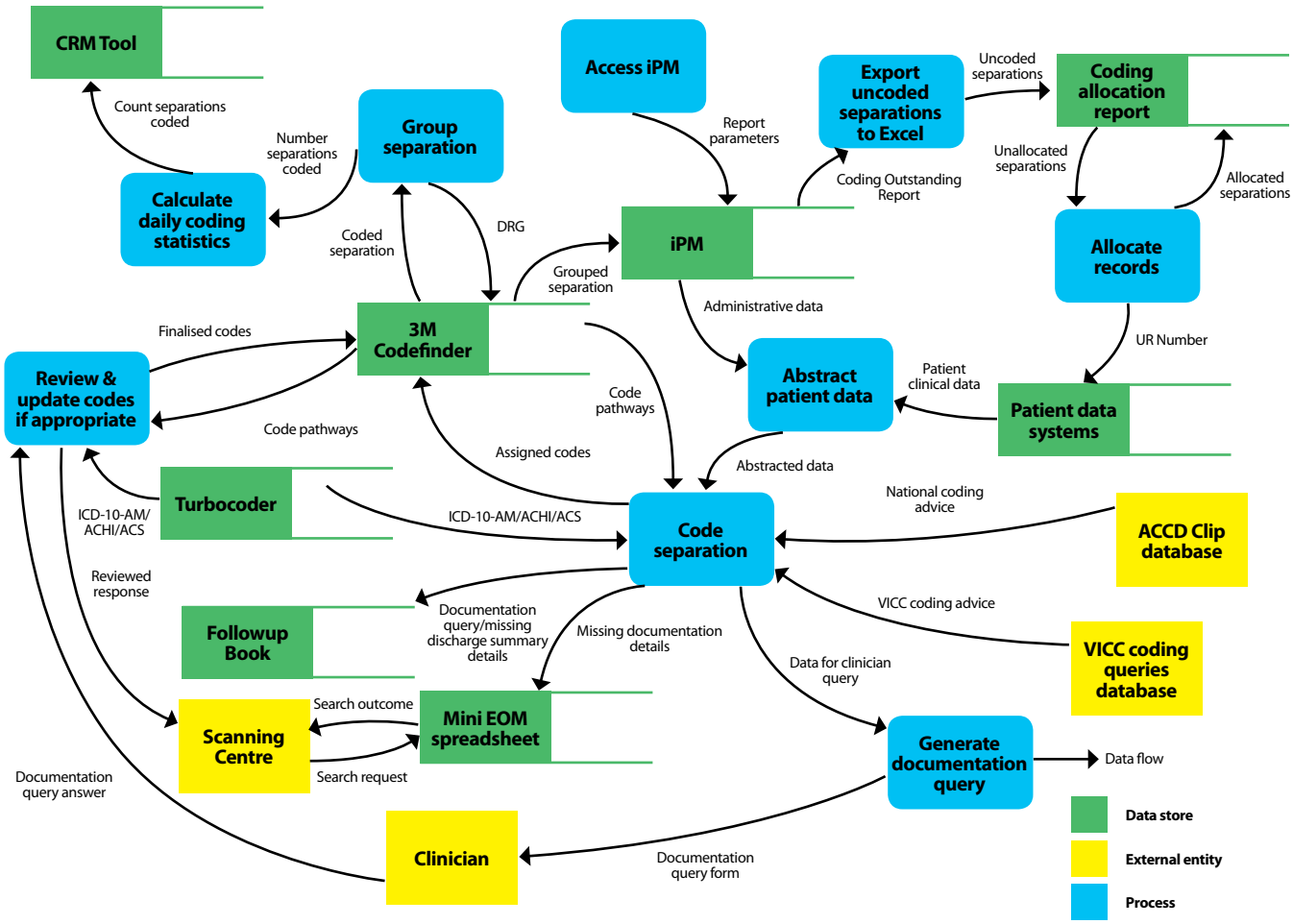

Figure 1: Example of a clinical coding process map from a tertiary hospital

Clinical coding practices can also impact on the quality of clinical coded data. Some CCs say they are pressured to code 'x' condition. Is their management really asking them to code unethically, or are they asking them to optimise within the ethical confines? Are CCs so concerned that an internal auditor will find something they missed, that they would rather 'over code' or raise a query that could be construed as unethical than not meet their key performance indicators? Is it the quantity of episodes expected to be coded by a CC in a session? These potential pressures could impact on the clinical coding quality.

Lastly, clinical documentation has a significant impact. However, how can the clinicians possibly know what words we need and the level of specificity that is required? How would they know that we have 59 different diagnosis codes to describe anaemia? I cannot name them all, so I would not expect a clinician to know them either. We need to guide clinicians in the documentation required to ensure documentation that is suitable for good quality clinical coding, and in describing the clinical truth so that the clinical coding is correct for all its purposes.

Clinical documentation queries

In my experience, there are many good documentation queries written by CCs and Clinical Documentation Specialists (CDS). These queries accurately explain the background and evidence found in the medical record and give the clinician the chance to respond with the clinical truth. I am lucky that I work in both the public and private sectors, so I observe the work of CCs and CDS across a broad setting. However, I am not sure if it is a lack of experience and understanding, or thoughtful (or thoughtless) disrespect or intentional manipulation that leads to some of the types of queries that I have seen in both sectors, for example:

Dear Doctor,

Na+ 132 on 12/9. Patient given intravenous fluids.

Please clarify whether this can be further specified as:

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- *Treatment for hyponatraemia*
- *Other - please specify*
- *Unknown/unable to determine*

This query about hyponatraemia seems reasonable on face value, but on further inspection of the medical record, the intravenous fluids had been ceased prior to the taking of the test that revealed the low sodium, that is, the intravenous fluids could not have been given for the low sodium. Why was this query asked? Why did the clinician not check the facts? Should the clinician have to check the facts? Another example I have seen is:

> *Dear Doctor,*
> *Na 132, repeat urea and electrolytes performed.*
> *Was this increased monitoring of hyponatraemia?*

Again, this query seems reasonable, but on further inspection of the medical record, there were no repeat urea and electrolyte blood tests performed, despite it being key to the query.

Many hospitals have developed query templates to provide CCs with advice on when a query should be written, and to provide consistent wording of documentation queries. However, potentially what we are now seeing is queries that have become 'institutionalised' and CCs are not applying critical thinking to determine if the query is appropriate. That is, they are simply acting on instructions to query 'x' when you see 'y'. As seen in the first example, these two clauses may have existed, but not in a logical way. Unless critical thinking can be applied to the process, CCs should not be writing documentation queries.

Perhaps it is too much to expect CCs to be essentially auditing the medical record at the time of clinical coding. Maybe CCs should code the record as a separate process to auditing and reviewing the record for incomplete documentation. This would allow inexperienced CCs to learn how to code correctly without the stress of trying to learn how to be an auditor and clinical documentation reviewer at the same time. It would also likely improve the clinical coding quality for all CCs who can concentrate on coding what is documented. The development of critical thinking skills to analyse clinical truth and query clinicians appropriately could then be developed over time as CCs progress in their experience.

I have also seen many queries asking if 'x' condition was 'directly related to surgery' , for example, in relation to documentation of nausea and vomiting, hypothermia and hypotension. Perhaps because CCs think this is the right thing to do, the data are full of procedural complications. Unfortunately, by answering these queries in the affirmative, the clinician probably does not realise that a procedural complication will be listed against them and the hospital.

There have been other examples that are clearly not appropriate, for example, where the CC attached a note telling the doctor the answer they wanted: 'we want presumed or likely sepsis, or treated as sepsis'. Another example was found in an article from CDI Strategies (Association of Clinical Documentation Improvement Specialists 2017).

> *We recently reviewed a troubling case related to sepsis which revealed that the patient did not have sepsis and the physicians did not document sepsis as there was no bacterial infection. The CDI specialist, however, queried for severe sepsis twice. Finally, the admitting/discharging physician agreed and signed the query stating severe sepsis was present*

The doctor was seemingly badgered into answering 'yes', despite there being no sepsis. Good documentation queries provide the background and reason for the query being asked. Another example of a query I have seen simply stated that catheter cystitis was a finding, and asked whether it was treated, had a diagnostic procedure or increased clinical care and/or monitoring? The clinician responded saying: 'This is a stupid question and it did not affect his management'. Of course, that is not an appropriate response from the clinician, but you can understand the frustration they must experience sometimes.

Another example had been queried three times. The first query asked if there was a bowel resection with the ileostomy reversal, which gained a 'yes' response. However, then the CC needed to know why the bowel was resected to potentially allow it to be coded so wrote a second query. The clinician responded that it was not suitable to be repaired, but provided no further information, so the CC queried it for the third time. Unfortunately, the response was quite inappropriate by the clinician, indicating that it was his decision to resect it but also adding 'you have no

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training and were not present'. While the response is an unfortunate consequence of pushing for an answer; it does also show how hard it is to get a clinician to understand documentation for clinical coding purposes. No one was questioning his clinical opinion or decision, but the documentation was lacking.

Is our profession pushing the boundaries so far that we are distorting the data, affecting the payment systems or committing fraud as indicated in the following headlines from USA?

- *News & Analysis: Carolinas Healthcare System agrees to pay $6.5 million to settle upcoding allegations (Revenue Cycle Advisor 2017)*
- *News: Charges levied against 412 individuals responsible for $1.3 billion in fraud losses (CDI Strategies 2017)*
- *Five common coding and billing schemes used to perpetrate fraud: #1. Upcoding. (Becker's Healthcare 2012)*
- *MASS-ive settlements for new/established patient coding errors (Part B News 2017)*

I am concerned about the clinical coded data and the story these data should be telling but probably are no longer telling. As a taxpayer and a health fund member, I want to pay for the care that actually happened. We need to stop the misinterpretation, inappropriate queries, clinical coding errors, upcoding (and other similar strategies), intentional or otherwise, that are distorting the clinical truth.

Clinical documentation improvement

Let me get back to the start of my story – is CDI what we need? CDI states it is about documentation excellence and accuracy, to show that appropriate care took place with a positive effect on quality and safety. Robert Hodges (Hodges 2017), a CDI Specialist in Michigan, USA, stated:

> *...the biggest single thing that caught my attention was when I attended the Association of Clinical Documentation Improvement Specialists (ACDIS) conference in San Antonio in 2015 and listened to the presentation by Dr Cesar Limjoco and Kelli Estes on 'Go after the truth, the Clinical Truth—that's what matters at the end of the day!' This really struck me as the heart and soul of CDI. We really are seekers of truth in the health record, weeding out what is not clinically supported, and identifying and bringing forward those things which are hiding or not specific, but which support more precise documentation. I find this to be absolutely amazing, and it's something I now preach every day to my mentees and providers. Our job as CDI specialists is to ensure that the health record is a truthful representation of the care the patient receives, without embellishment……Just the facts.*

Laurie Prescott (Association of Clinical Documentation Improvement Specialists 2017), a CDI Education Specialist at HCPro, USA, stated:

> *My providers often asked me, 'What do you want me to write?'. My standard answer was, 'I want you to write what is true to this patient, this encounter. Nothing more, nothing less'.*

One of my colleagues, Karinne Daley, and I attended the ACDIS conference in Las Vegas in May 2017. There were approximately 2,000 people in attendance, with multiple streams to attend and lots of people to talk to.

We found out that many hospitals now have remote CDS who write their documentation queries and submit them via the Electronic Medical Record (EMR) or email., just like CCs in Australia do. Even CDS working on site are often not on the wards. Also, not all CDI is concurrent, that is, not all while the patient is on the ward. Everything we had read before the conference made us think that CDS were on the ward, putting medical records under doctor's noses and 'talking and liaising' with them. We also found that many hospitals appeared to have little liaison with their CCs, although of course some had very good liaison.

Surely there needs to be a combined approach. There is no point in CDS getting the documentation 'right' if it is not able to be translated into code correctly because, while it may be clinically correct, the wording does not match that used in the classifications. There needs to be reconciliation of data, and discussion between CDS and CCs.

Discussions around 'denials' from funders at the conference was fascinating. Dr Trey La Charite spoke about keeping 'The Barbarians at your gates' (La Charite 2017). He spoke with such intensity against the recovery (funder) auditors and what they find and recover. However, even he was keen to point out CDS

should not stop reviewing the chart just because it is in the top weighted DRG, and CDS should not code (or query) for documentation that is not clinically present. Also, if an overcharge of billing was found, then it needed to be rebilled to ensure the integrity of the data because the 'I' in CDI also stands for integrity.

I have to mention ZDogg MD (Dr Zubin Damania) who did an amazing presentation about healthcare, the EMR and documentation. ZDogg's presentation also included rapping! Not sure I have been to a conference with rapping before, but then our trip also surprised us when 'Donkey' from Shrek (at Universal Studios, on our way home) started talking to us about the EMR!

I believe CDI is the way to improve our clinical coded data quality by having complete clinical documentation in the medical record prior to clinical coding. I have seen the improvement in clinical coding quality through the process at one hospital where they query all relevant conditions for deceased patients to ensure an accurate description of the episode of care. This has resulted in an improved hospital standardised mortality ratio and fewer patients reported on the 'low mortality DRG' list. At another hospital, the CDS is reviewing the medical records towards the end of the patient stay in two clinical units. This has resulted in improved documentation of conditions meeting criteria for clinical coding, improved the content of the discharge summaries and reduced the need for CC generated documentation queries, which has all resulted in less clinical coding time required.

We need to take the best ideas from the current USA programs to implement here and ensure that we take only what is applicable to the Australian scene, not just take everything that is done in the USA. For example, I question whether concurrent review where the same medical record is reviewed over and over again is necessary, or if it potentially wastes a lot of time. Some CDI do not review until towards the end of the patient stay when the diagnosis is clearer. We generally do not have the same billing pressures that USA has where they can rebill but only in a shortened timeframe, and many do not want to rebill for concern of raising a 'flag', so perhaps we could have retrospective review but still prior to clinical coding.

CDI in the USA commenced about 10 years ago with the purpose of improving documentation for revenue optimisation. However, from listening to various presentations at the ACDIS conference, it seems that it has now matured to also be about the quality of documentation and describing the 'clinical truth'. It does not stop when the optimal DRG has been gained. I believe this should be our aim when implementing CDI programs.

Who should be involved in a CDI program? Reading a lot of information from the USA would have you believe that it needs to be nurses. Most people we met at the ACDIS conference were nurses in CDS roles. A few hospitals who have implemented systems in Australia would also seem to say it should be nurses. Then there are a number of physician advisors who say it needs to be doctors.

I have heard of many Australian CDS doing a clinical coding course. I agree that CDS need a good understanding of clinical coding and what documentation is required, but if CDS is about good clinical documentation, then there should be no need for CDS to code an episode to get a DRG.

I believe CDI needs a combination of nurses, doctors and CCs. This is not a competition and should be a collaboration. But I believe our health information management profession should be at the forefront of CDI programs in Australia. Health Information Managers (HIMs) and CCs need to be involved in CDS programs before the opportunity is lost to our profession.

> ***"I believe our health information management profession should be at the forefront of CDI programs in Australia."***

Where to from here?

HIMs and CCs need to take the lead in CDI in collaboration with clinicians such as nurses. We need a team approach, but we have the skills to drive the CDI program. Health services need to review when and who queries the documentation. For example, can it be done concurrently without repetition, and are the right people constructing the documentation queries? HIMs and CCs and CDS need to be involved in EMR implementation to ensure the appropriate documentation can be captured at the time of data entry. In conclusion, HIMs, CCs and CDS need to code and query the 'clinical truth' – 'just the facts'.

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