CHEST Topics in Practice Management

Documentation Tips for Pulmonary Medicine

Implications for the Inpatient Setting

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Clinical documentation improvement is an important aspect to achieve top performance. Clinical documentation in a patient's record includes any and all documentation that relates to the care of the patient during the patient's stay or encounter at the hospital. Documentation is key to accurate clinical coding, validating length of stay, resource utilization, physician profiling, case management, severity of illness, risk of mortality, quality management, risk management, clinical outcomes, critical pathways, regulatory compliance, Joint Commission accreditation, managed care, and reimbursement. Good documentation minimizes coding errors, reduces claim denials, and optimizes reimbursement. Implementing quality improvement strategies that make documentation and coding an organizational priority can positively influence operations, services, and revenue. Other external and internal coding audits show that the cause of improper coding is due to lack of proper physician documentation to support reimbursement at the appropriate level. The purpose of this article is to provide tips for documenting pulmonary diagnoses that not only would ensure appropriate reimbursement but also would accurately represent the severity of a patient's condition.

CHEST 2012; 142(4):1035–1038

Abbreviations: CC = complication/comorbidity; CHF = congestive heart failure; CMS = Centers for Medicare & Medicaid Services; DRG = diagnosis-related group; ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*; MCC = major complication/comorbidity; MS-DRG = Medicare severity diagnosis-related group; RW = relative weight

Hospitals lose millions of dollars in revenue because of incomplete documentation and coding. Hospitals and other health-care facilities index health-care data by referring and adhering to a classification system published by the US Department of Health and Human Services, the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).[1] The Centers for Medicare & Medicaid Services (CMS) mandates that all medical conditions that are evaluated, monitored, or treated should be reported,[1] and this is why the attending physician's documentation is essential throughout the patient's stay. To implement thorough documentation practices, it is important for the attending physician to interpret and confirm documentation of other clinicians and the results of tests. For a hospital to receive the reimbursement that it deserves, there needs to be accurate and complete documentation for proper coding.[2] ICD-9-CM is the national standard data set used for coding diagnoses for care delivered in all settings, including hospitals and physician offices. In the inpatient hospital setting, it is also used for coding procedures on claims submitted by the facility. In contrast, procedures furnished by physicians in all settings and hospitals in outpatient departments are recorded using Current Procedural Terminology codes. Thus, services provided at the same time to the same hospital inpatient would be coded by the physician using Current Procedural Terminology codes and by the hospital using ICD-9-CM codes.

Manuscript received June 1, 2009; revision accepted May 3, 2012.
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DOI: 10.1378/chest.09-1283

For determining payment by Medicare and other payers that rely on diagnosis-related groups (DRGs), patients are placed into DRGs based on ICD-9-CM diagnoses and procedure codes as well as on certain patient demographics reported on the hospital claim. Coding staff relies on medical record documentation by the physician or provider (ie, health-care practitioner legally accountable for establishing the patient's diagnosis) to assign ICD-9-CM codes for the principal diagnosis, secondary diagnoses, and procedures. Medicare severity diagnosis-related groups (MS-DRGs) were implemented in October 2007, which affected many hospitals by removing many of the common comorbidities/complications (CCs) that resulted in higher-weighted CMS DRGs, thus creating a need for more-specific documentation that reveals the severity of care. This change has been the most significant in hospital reimbursement since the implementation of DRGs in 1983. For example, congestive heart failure (CHF) was a CC in the old CMS DRG system, but to be considered a major complication/comorbidity (MCC) or CC with MS-DRGs, the precise type of heart failure must be described as acute, chronic, or acute on chronic and with reference to systolic, diastolic, or combined dysfunction. Each DRG is assigned a relative weight (RW) to represent the resource intensity for the typical inpatient case. On average, an RW of 1.0 results in a lump sum reimbursement of about $5,000, depending on the hospital. The case mix index is the weighted average of the RWs of the DRGs and represents the organization's caseload. The case mix index compares the overall complexity of the hospital's patient population to that of its peers. Cases that have a CC or an MCC are assigned to a higher-weighted DRG.[3]

Coding professionals follow many rules and guidelines when abstracting a record. Principal diagnosis is not synonymous with the admitting diagnosis. The principal diagnosis is defined by the Uniform Hospital Discharge Data Set as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. In other words, an acute condition established after careful examination, laboratory results, and investigation should validate the necessity of admission as opposed to outpatient management. The circumstances of admission, the diagnostic approach, and the treatment rendered are used to determine the principal diagnosis. Additional diagnoses are defined by the Uniform Hospital Discharge Data Set as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and the length of stay. The conditions affecting patient care must require clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, or increased nursing care and monitoring. Inpatient coding rules allow a diagnosis documented at the time of discharge as probable, suspected, likely, questionable, rule out, and possible to be coded as confirmed unless ruled out during the inpatient stay. Abnormal findings (laboratory, radiographic, pathologic, and other diagnostic results) are not coded and reported unless the treating physician indicates their clinical significance and the impact on the patient's care. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or has prescribed treatment, it is appropriate to ask the physician to document the condition that required further testing and treatment. Certified coders are limited by the quality of documentation in the hospital record and the coding rules mandated by the government. Coders are not permitted to interpret laboratory values. For example, if the progress notes state, "Hemoglobin = 6.0," this cannot be coded as anemia unless the physician documents anemia in the record. Pathology, radiology, or laboratory reports presented in the chart but not reviewed and interpreted in the progress notes by the attending physician are not coded.[4]

The purpose of this article is to provide tips for documenting pulmonary diagnoses that not only would ensure appropriate reimbursement but also would accurately represent the severity of a patient. Common pulmonary MCCs are acute respiratory failure, aspiration pneumonia, bacterial pleural effusion, empyema, lung abscess, pneumonia, spontaneous pneumothorax, and pulmonary embolism. Some common CCs are asthma/COPD with acute exacerbation or status asthmaticus, atelectasis, pleural effusion, pneumothorax, pulmonary edema, acute respiratory insufficiency, and tracheostomy complications.

Pneumonia

Pneumonia is defined as an acute inflammation of the alveoli and terminal lung spaces due to infection. Pneumonia is divided into two subgroups: simple and complex. Simple pneumonias include community-acquired pneumonia; unspecified pneumonia; viral pneumonia; bacterial pneumonia, not otherwise specified; lobar pneumonia; *Haemophilus influenzae*; bronchopneumonia; and pneumococcal pneumonia and are assigned to MS-DRGs 193, 194, and 195. Complex pneumonias include Aspiration, *Staphylococcus aureus*, *Pseudomonas aeruginosa*, *Klebsiella pneumoniae*, *Escherichia coli*, gram-negative, and *Candida* pneumonias and are assigned to MS-DRGs 177, 178, and 179. The most important tip in documentation of pneumonia is to document the organism that is being treated or the suspected organism that is empirically treated. All pneumonias

are MCCs in MS-DRGs. Negative blood and sputum cultures do not preclude making a diagnosis of pneumonia. In these cases, documentation of the clinical impression of the bacterial or viral type of the pneumonia, such as gram-negative pneumonia, is needed. It is important to document aspiration pneumonia when aspiration is the known or suspected etiology. When the patient's history and risk factors do not indicate a specific type or etiology, unknown type of pneumonia is documented. Although the term "community acquired" may have significance to clinicians, it does not indicate the causative organism, and in the absence of further information, it is assigned the unspecified pneumonia code.

If a satisfactory sputum culture has been obtained, it must be documented within the progress notes. Coders cannot take a gram-negative culture report and interpret that to represent gram-negative pneumonia. The physician must reiterate the necessary information in the progress notes. When record documentation raises questions regarding the diagnosis of pneumonia, coders are instructed to query the physician. Pneumonia is commonly complicated by sepsis, acute respiratory failure, and complicated pleural effusions. These conditions will affect the DRG and severity scoring and, thus, should be included in the documentation if they occur.[5]

Case 1

A patient is admitted to the hospital with a history of lung cancer, pneumonia, and severe malnutrition. The pneumonia is treated with piperacillin/tazobactum and clindamycin. The final diagnosis listed on the discharge summary is community-acquired pneumonia, severe malnutrition, and lung cancer resulting in DRG 193 (simple pneumonia with MCC) (RW 1.4327). The coding professional queries for the probable organism targeted by the antibiotics selected. The attending physician responds that the patient probably had gram-negative pneumonia and documents this in an addendum to the discharge summary. The final MS-DRG assigned is MS-DRG 177 (respiratory infections and inflammations with MCC) (RW 2.0393).[5]

Respiratory Failure

Respiratory failure must be specified as acute or chronic. Hypoxemia does not equate to a diagnosis of respiratory failure. Although some cases of respiratory failure must be managed with mechanical ventilation support, the absence of mechanical ventilation does not exclude a diagnosis of respiratory failure. It is important to document the underlying cause of the respiratory failure: Coding guidelines require that if the underlying cause is a respiratory condition, such as pneumonia or COPD, then the respiratory failure should be sequenced as the principal diagnosis. However, if the underlying cause is an acute nonrespiratory condition, such as CHF, then the acute nonrespiratory condition is sequenced as the principal diagnosis. If a patient is admitted while in cardiopulmonary arrest, it is important to document whether the underlying cause of the arrest was respiratory in nature.

Patients on mechanical ventilation for a prolonged period of time should have documentation of chronic respiratory failure. Additionally, patients who require home oxygen, such as for emphysema and interstitial lung disease, might also be considered to have chronic respiratory failure. Respiratory diagnosis with ventilator support MS-DRG assignment is according to the principal diagnosis of a respiratory-related condition. The MS-DRG assignment is determined based on whether the patient was on a ventilator for ≥ 96 h (MS-DRG 207) or < 96 h (MS-DRG 208). Assignment of MS-DRG 207 and 208 is appropriate only when the medical record documentation supports the principal diagnosis of respiratory disease and that mechanical ventilation support was provided. The time a patient is on a ventilator should be documented. The time spent weaning a patient from a ventilator is included in the total ventilation time. The type of ventilation should be clearly indicated as life support ventilation, if appropriate. Nutritional problems and nutritional support, such as tube feedings and total parenteral nutrition, in patients who are on prolonged ventilation should be clearly documented, which add to the patient severity scoring. Ventilation during surgery is an integral part of the surgical procedure and is not coded as mechanical ventilation. After surgery, if a patient has respiratory problems and continues on ventilator support past expected extubation, it is important to document the associated respiratory condition.[5]

Case 2

The patient comes to the ED with a history of COPD and shortness of breath with cough for the past 5 days. Symptoms have been worsening. Her initial oxygen saturation is 88% on room air. The ED attending physician notes, "This is the worst exacerbation she has had…ill appearing, mild distress, chest: decreased breath sounds throughout, + wheezes bilaterally, + accessory muscle use." The nurse documents, "acute respiratory distress, audible wheezing on inspiration and expiration, prolonged expiration, placed on bipap, receiving q1h nebs by respiratory." The initial progress note states, "COPD exac; Rx with aggressive nebs, steroids, oxygen, check ABG in few hours."

The coder queried to clarify whether clinical indicators were acute respiratory failure, and the attending physician responded that indeed, the patient had acute respiratory failure and acute COPD exacerbation. The MS-DRG before the query was 192 COPD without CC/MCC (RW 0.7254), and the MS-DRG after the query was 189 pulmonary edema and respiratory failure (RW 1.3488).[5]

Other Respiratory Conditions

Acute exacerbation of chronic conditions such as asthma and COPD should be documented in order to qualify as a CC. Status asthmaticus is a CC, but if the patient develops acute respiratory failure, it is important to have this documentation for an MCC.

Pulmonary infiltrates is a common diagnosis that does not have a specific ICD-9-CM code. However, if the condition necessitates treatment with steroids, a more specific diagnosis is needed, such as collagen vascular diseases; systemic lupus erythematosus, rheumatoid arthritis, or sarcoidosis should be mentioned.

Pleural effusion often is considered an integral component to fluid overload states and their underlying causes. In this circumstance, coding professionals cannot code pleural effusion separately unless the documentation supports additional studies, such as decubitus radiographs, or treatment, such as thoracentesis. It is important to have physician documentation of the underlying cause of pleural effusion. Transudative pleural effusion is commonly found in CHF, cirrhosis, and nephrotic syndrome. The exudative form is most common in bacterial pleural effusions or malignant pleural effusions.[5]

Conclusion

Provider documentation is the cornerstone of accurate coding and billing submission. Assuring the accuracy of coded data is a shared responsibility between coding professionals and physicians and providers. Accurate diagnostic and procedural coded data originate from a collaboration between physicians and providers, who have a clinical background, and coding professionals, who have an understanding of classification systems. Clinical documentation increases the quality and effectiveness of patient care through improved communication among health-care providers. It is important to document all chronic conditions that may be considered comorbid and to remember to link orders to a diagnosis within the progress notes. Many physicians are eager to find ways to improve their quality ratings. Because quality data are based on hospital records and coded data collected by outside agencies, physicians have a more compelling reason to document with the highest degree of accuracy. Documentation improvement is not a new concept in health care but an evolving trend that is critical to both the financial integrity of a health-care institution and the quality of patient care. Through ongoing education, documentation efficiency, and more-effective communication, physicians can help their institutions to become leaders among their peers while improving their ratings. So, the next time you receive a query form or e-mail requesting clarification, just remember that you are helping to make a difference through improved patient care, justification of resources used in treatment, and improved quality outcomes in the quality of care provided.[6]

Acknowledgments

Financial/nonfinancial disclosures: The author has reported to *CHEST* that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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