

Clinical Documentation and Coding

The Clinical Documentation Improvement (CDI) Program at Shands at the University of Florida has been in existence for seven years. The staff consists of registered nurses and certified coders who review records from the clinical perspective to make sure documented diagnoses accurately reflect illness severity. Many times, physician documentation lacks the clarity to accurately capture the true severity of illness and mortality risk. Our program analyzes physician documentation, to ensure alignment of diagnoses with the treatment rendered and that documentation appropriately captures the full range of services. When we send questions to physicians, we are trying to link medical diagnoses with the appropriate “coding world” language – not to tell physicians how to practice.

The diagnosis of “urosepsis” is one example. For coders, “urosepsis” means that the only code they can assign has to do with a UTI. However, when documentation indicates “sepsis related to a urinary tract infection” (when the patient, of course, meets criteria for sepsis), coders can capture the true intensity of resources and services needed. Those could include IV antibiotics, frequent vital signs and increased nursing care.

Information in the medical record is now used for many other areas besides billing: benchmarking, assessing the quality of patient care and of individual care plans, research, and hospitals’ HealthGrades ratings. Right now, documentation improvement programs are the only means by which hospitals can track all these key factors and ensure that publicly reported quality data are accurate.



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