Pediatric efforts offer new CDI opportunities

It was around the time of the ACDIS annual conference when Bonnie I. Epps, RN, MSN, manager of CDI for Emory Healthcare in Atlanta, started researching the effect of expanding her CDI program to include pediatric and neonatal units. When asked why she was interested in expanding, she didn't hesitate in her response. “I’m not,” Epps says, “The pediatricians are.”

In fact, the pediatricians came to her to see whether documentation improvement could help their quality scores and improve their patients’ length of stay (LOS).

“Emory has a large push for reducing length of stay,” says Epps. “And the NICU [neonatal intensive care unit] has an extended LOS. We saw some evidence of patients being discharged sooner than what might have been warranted, and the pediatricians wondered if a lack of documentation may have been at the center of the trouble.”

Her research led her to attend “Leap Frog to Pediatrics: Implementing a Successful Pediatric CDI Program,” by Karen Bridgeman, MSN, RN, CCDS, CDI specialist at the Medical University of South Carolina (MUSC) in Charleston, and David Habib, MD, medical director of care management in the department of pediatrics there, during the 6th Annual ACDIS Conference this past May.

The MUSC CDI program started in 2005 with just two full-time equivalency staff members and a CDI manager for the 700-bed teaching facility. Today, it boasts a staff of 12 and reviews all payers having expanded into its pediatric facility in January 2012.

MUSC’s Children’s Hospital has 186 licensed beds, the majority of which are general medical-surgical, but the facility also has a significant number of Level III neonatal ICU, cardiology, and other intensive care services, Bridgeman says.

“We’re seeing more and more children’s facilities starting CDI efforts,” says ACDIS Advisory Board member Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta. “The largest growth comes from multi-hospital systems that already have CDI programs in place. They see the potential of expanding to their affiliated children’s facility.”

With roughly 500 children’s facilities in the nation, Gold sees both the probable benefit and difficulty inherent in such CDI expansion. Children’s hospitals do not have Medicare patients—the typical starting point for traditional, short-term acute care hospitals, he says. In fact, most are paid on a contract basis related to a certain percentage of the actual charges of the care provided “so there was little financial incentive for children’s facilities to implement CDI,” he says.

Furthermore, children’s facilities do not have the external scrutiny that adult hospitals face. Where typical healthcare facilities turn to HospitalCompare, HealthGrades, and other public quality report cards, children’s programs have few options, says Gold. He notes that Parents Magazine publishes an annual “Top 10” list, but that it is based on anecdotal data from its subscribers and research. So it can be difficult to persuade administration to expand CDI efforts based on physician ego, or quality scores either.

At MUSC, the CDI team started building their case for expansion by examining data from the University HealthSystem Consortium and National Association of Children’s Hospitals and Related Institutions. This data allowed MUSC to compare benchmarks regarding patients’ severity, mortality, and facility case-mix index (CMI). They took the 25 top and bottom DRGs and divided them into two categories—high-volume, low reimbursement and low-volume, high reimbursement—for Medicaid, Blue Cross, and commercial payers.

The data suggested that a higher level of clinical complexity existed than was being depicted in the medical record, Bridgeman says. Asthma and bronchitis, seizures, and neonatal care fell into the high-volume, low yield bucket; that cardiothoracic conditions and Level III neonatal ICU fell into the high-yield, low volume bucket; and that chart review of pediatric patients could help with respiratory failure, cystic fibrosis, sickle cell, and chemotherapy documentation improvement.

“We found the physicians writing respiratory distress, but that just wasn’t clear enough to determine whether it was an shortness of breath or a respiratory failure,” Bridgeman says. “Sepsis and shock weren’t being documented at all.”

Target documentation improvement areas at Phoenix Children’s Hospital include cerebral palsy, chemotherapy complications, and childhood syndromes (of which there are many), says Jill Lindsey, RN, BSN, CCDS, CDI specialist there. The nearly 400-bed facility began a CDI program in

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2010 after a consulting firm determined that their facility had a lower CMI than its neighbors, she says. “That was really the driving factor,” says Nancy Rush, CDI manager at Phoenix Children’s. “Once we started seeing improvements we started seeing improvements in the overall financial health of the organization as well. We just couldn’t believe it.”

In the beginning the three-person team used query templates from the consulting firm but are now revising those forms in collaboration with its coding and physician staff members with an eye toward new challenges, changing clinical indicators, and ICD-10-CM/PCS considerations. “If you aren’t doing this [reviewing pediatric records], get started quick,” says Lindsey. “It is so important with ICD-10.”

Those with experience in pediatric CDI say the most difficult aspect of pediatric expansion, aside from initially making the case to advance into the area to begin with, comes from the clinical and CDI language barriers. “The real challenge is identifying pediatric opportunities,” Lindsey says. “Every time we reach out looking for the clinical indicators it always goes back to those indicative of the adult population. You need to make sure that it [clinical language to pediatric condition] is a true fit every time.” “These are not just little adults,” says Bridgeman. “You just cannot apply the same clinical language to their diagnoses.”

The same is true about the difference between pediatric care and care for neonates, Bridgeman adds. Coding for neonates “is so different from the rest of the population. They are a whole different ball game,” she says. So she advocates starting with the general pediatric population first, and then once the pediatric CDI program becomes proficient, expanding outward. “Take small bites,” she says. “Branch out slowly.”

It’s a model that typical CDI programs know well since many started with consultants’ advice, picked up on improvement efforts related to CMI and the top tier MS-DRGs, then worked toward physician engagement, query revision, and program expansion. “We really worked hard to get the support of the physicians and ensure the success of this program,” Rush says. “So it’s good when you achieve that type of success you can quantify.”

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**Coding guidance regarding V-code use for neonates**

Q: We recently began concurrently coding in our Neonatal Intensive Care Unit (NICU). One of our neonatologists is adamant that the principal diagnosis should not be the V code (i.e., V30.01) for the birth episode. Our coding supervisor explained that the V code is required for all babies born in-house and that the principal diagnosis of babies transferred from outside facilities will be the reason that they were transferred. She gave him the *Official Guidelines for Coding and Reporting* and other articles stating this.

Is there something we are missing here? He’s not satisfied and suggests we call other university hospitals to see how they are coding these babies.

A: He may be confusing physician coding (E/M) rules with the rules for inpatient coding. Your coding manager is correct, the *Official Guidelines for Coding and Reporting* are quite clear and state “For the birth admission, the appropriate code from category V30, Live born infants, according to type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 740-759.” “Should” is interpreted in this instance as “must.” The grouper will require that a V-Code be used as the principal diagnosis in this situation without exception, a function of grouper logic. The V-Code indicates only that a birth has occurred and additional codes would be required for other significant conditions, such as Patent Foramen Ovale, Hemolytic Disease, sepsis, and so forth. Therefore, I would explain to the physician that the opportunity to accurately report the complexity of the cases lies with accurate reporting of secondary codes for this particular group of patients as these distinguish a normal birth from one more complicated, with varying degrees of complexity afforded by the appropriate code sets.

*Editor’s note:* Paul Evans, RHIA, CCS, CCS-P, CCDS, of Sutter Health in San Francisco, answered this question on the ACDIS message and networking board, “CDI Talk.” Evans is the 2012 reviewer of *The CCDS Exam Study Guide.*