Quick tips: *clinicians documenting dementia and delirium*

Purpose of this document

The Statewide Dementia Clinical Network developed these quick tips to improve the documentation of the presence of cognitive impairment, dementia and delirium during an acute admission to provide:

1. **DIAGNOSIS**: clarity of diagnosis
2. **DATA**: better prevalence and incidence data in the acute sector through improved coding of cognitive impairment, dementia and delirium
3. **PLANNING**: better service planning for those with cognitive impairment through more accurate data
4. **MANAGEMENT**: appropriate management through proper condition identification
5. **RESOURCING**: improved funding and resources to better address and manage delirium and dementia in the acute care setting

Why are errors in coding occurring?

1. **LANGUAGE**: Discrepancy between the language used by clinical staff in medical notes and the language clinical coders can accept to document a diagnosis of dementia and delirium
2. **TERMINOLOGY**: Lack of understanding by clinical staff of the particular terms and phrases that must be used consistently for a diagnosis to be captured by coders
3. **IMPACT**: Failure to clearly document in the medical notes the impact of the delirium and/or dementia upon the primary acute general medical condition at time of admission
4. **INTERVENTION**: Clinicians often do not link, in the medical notes, the reason for diagnostic or therapeutic intervention to the condition.
5. **ASSUMPTION**: Clinical Coders cannot assume a condition has been diagnosed or treated based on the intervention or treatment given. Both condition and intervention/treatment need to be documented *and* linked.
6. **DIAGNOSTICS**: Clinicians often do not document their interpretation of the diagnostic test results. Clinical Coders cannot interpret scores to mean a specific diagnosis, even if the form has a table which indicated that a score of ‘x’ means a particular diagnosis (e.g. MMSE, alcohol withdrawal scale).
7. **CONFIRMATION**: Clinicians often do not document whether a suspected diagnosis is either confirmed or ruled out.

What rules must clinical coders abide by?

“The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care”. (Australian Coding Standards (ACS) 0002 Additional Diagnoses)

1. The conditions listed in a discharge summary or admission history *will not be coded* if they cannot be evidenced in other clinical documentation as meeting the above criteria
2. Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
    a. Commencement, alteration or adjustment of therapeutic treatment
    b. Diagnostic procedures
    c. Increased clinical care and/or monitoring

An example: what are the coding rules on confusion or delirium with dementia?

- Confusion NOS (not otherwise specified) and delirium NOS are classified separately in ICD-10-AM
- Confusion NOS is a symptom of dementia and therefore where both of these conditions are documented, only a code for the dementia should be assigned
- A code for delirium should only be assigned when this condition is documented *or* when acute confusional state is specifically documented
- A code for confusion, acute confusion, confusional state and acute confusional state should only be assigned when the condition meets the criteria in ACS 0001 Principal diagnosis *or* ACS 0002 Additional diagnoses

If the documentation in the clinical record is unclear as to whether the patient has confusion or delirium, verification should be sought from the treating clinician. (Extract from Coding Rules, March 2014)

Funding scenario

- 80 year old who falls, fractures humerus and receives conservative treatment during 5 day admission.

Scenario 1: Patient history taken at admission includes documentation of dementia, but no further mention during admission. Some mention of aggressive behaviour noted in nursing notes. However no documentation of additional care, monitoring, or interventions linked to the dementia. Dementia is not coded as there is no evidence that the condition has affected the admission.

Coded as DRG I75B → estimated funding: $2,788

Scenario 2: Patient history taken at admission includes documentation of dementia. Documentation of functional status – limited insight into current function and cognition, can be verbally aggressive from time-to-time, likely secondary to his dementia.

Dementia is coded DRG I75A → estimated funding: $9,033

DRG	DRG Description	DRG WAU	Total Estimated Funding
I75B	Injuries to shoulder, arm, elbow, knee, leg and ankle **without** comorbidity or complication (CC)	0.5963	$2,788
I75A	Injuries to shoulder, arm, elbow, knee, leg and ankle **with** comorbidity or complication (CC)	1.9317	$9,033

Key messages:

Do ✓	*Don't* ✗
Document diagnosis clearly in clinical notes including medical, nursing and allied health documentation	**Do not use short forms or abbreviations for diagnoses**
Interpret investigation results and relate these to the diagnosis and management	**Do not document "Impaired cognition" where a person has a confirmed diagnosis of dementia**
Relate the prior history of dementia to the current acute condition on admission if they are linked e.g. unstable diabetes mellitus due non-compliance from advanced dementia	**Do not document results of tests without attaching a diagnosis or interpretation to the test results e.g. MMSE = 22 versus MMSE = 22 suggestive of impaired cognition**
Document delirium and not the word "confusion" when the person has an acute confusional state	
Proper documentation helps clinical coders collect accurate data: - on dementia and delirium for planning, research and epidemiological use - enabling optimal funding of services	