Three CMS Quality and Compliance Mandates:
One Concurrent Medical Review

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About Huron

Huron Consulting Group helps clients effectively address complex challenges that arise in litigation, disputes, investigations, regulatory compliance, procurement, financial distress, and other sources of significant conflict or change. The Company also helps clients deliver superior customer and capital market performance through integrated strategic, operational, and organizational change. Huron provides services to a wide variety of both financially sound and distressed organizations, including Fortune 500 companies, medium-sized businesses, leading academic institutions, healthcare organizations, and the law firms that represent these various organizations.
Topics

Accurate Clinical Documentation (CDI) can:

- Proactively prepare hospitals for regulatory audits from RAC, MIC, MAC, AND ZPIC
- Promote regulatory compliance that is consistent with CMS regulations
- Support quality care measures
- Assist with accurate hospital and physician profiles
- Validate the patient’s Severity of Illness (SOI) and expected Risk of Mortality (ROM)
- Facilitate accurate coding and appropriate reimbursement

Medicare Reform Initiatives

Medicare Fee-for-Service Program.

- Medicare Administrative Contractors (MACs)
  - By 2010 to become the central point in CMS’s fee-for-service program
  - Replace fiscal intermediaries (FI) and carriers
    - Nineteen MACs with 15 A/B MACs to process both Part A & Part B core claims processing operations
      - Improved beneficiary services
        » Most beneficiaries will submit all their claims to one contractor
        » Integrated and consistent approach to medical coverage across service areas
        » 1-800-MEDICARE answers all claims questions
      - Improved provider services
        » A single interface for Part A and B processing and other services
        » Competition will lead to better services by the MACs to the providers
        » A focus on financial management will foster more accurate claim payment and uniformity in payment decisions

Medicare Reform Initiatives (cont.)

Functional Contractors monitor the relationship within the MAC program

- Recovery Audit Contractors (RACs)
- Qualified Independent Contractors (QICs)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Beneficiary Contact Center (BCC)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
- Administrative Qualified Independent Contractors (Ad QICs)
- Zone Program Integrity Contractors (ZPICs)
- Enterprise Data Centers (EDCs)
- Quality Improvement Organization (QIO)

Medicare Reform Initiatives (cont.)

Zone Program Integrity Contractors (ZPICs)

- Find, prevent, and deter waste, fraud, and abuse in Medicare
- Perform program integrity functions for Medicare A-D, Durable Medical Equipment, home health, hospice, and the Medi-Medi program
- Seven (7) zones implemented in cycles that align with a MAC jurisdiction
  - Cycle 1 (Zones 4, 5, and 7). Contracts awarded to:
    - Health Integrity LLC (Zone 4 - Colorado, New Mexico, Oklahoma, and Texas)
    - AdvanceMed Corporation (Zone 5 - West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, and Louisiana)
    - SafeGuard Services LLC (Zone 7 - Florida, Puerto Rico, and the U.S. Virgin Islands)
  - Cycle 2 (Zones 1 and 2)
  - Cycle 3 (Zones 3 and 6)

Source: https://www.fbo.gov/index?s=opportunity&mode=form&id=3b25ef7cc31e18e67c8dc61d28f1e242e&tab=core&_cview=1

Medicare Reform Initiatives (cont.)

Zone Program Integrity Contractors (ZPICs).

- Duties
  - Performing data analysis and data mining
  - Conducting medical reviews in support of benefit integrity
  - Supporting law enforcement and answering complaints
  - Investigating fraud and abuse
  - Recommending recovery of federal funds through administrative action
  - Referring cases to law enforcement
Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- Purpose
  - Find and correct improper Medicare payments paid to health care providers participating in fee-for-service Medicare.
  - Provide data to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing future improper payments and reduce the Medicare FFS claim payment error rate.
- RACs are paid a contingency fee based on the amount of the overpayments and underpayments that they detect and correct.
- Goal is to have RACs fully in place by 2010.

Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- Four RACs were announced on October 6, 2008
  - Diversified Collection Services, Inc. of Livermore, California, in Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York.
  - CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B, initially working in Michigan, Indiana, and Minnesota.
  - HealthDataInsights, Inc. of Las Vegas, Nevada, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona.
- November 4, 2008 Press Release – CMS imposed an automatic stay on the contract work of the four RACs due to a protest filed by two unsuccessful bidders with the Government Accountability Office (GAO).
- Protest Resolved
  - PRG-Schultz, Inc. – subcontractor to HDI, DCS and CGI in Regions A, B & D.
  - Viant Payment Systems, Inc – subcontractor to Connolly Consulting in Region C.
Proposed 2008 RAC Jurisdictions


RAC Phase In Schedule

Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

• RACs are paid a contingency fee based on the amount of the overpayment and underpayments that they detect and correct. RACs will pay back contingency fees when an improper payment determination is overturned at any level of appeal.
• RACs will be paid the full contingency fee on overpayments identified through extrapolation. RACs did not use extrapolation in the pilot program.
• RACs utilize the same Medicare policies and rules to identify improper payments as the Medicare claims processing contractors. CMS does not mandate or endorse the use of any specific screening product for medical claims reviews.

— HealthDataInsights and Connolly Healthcare signed a five-year license agreements with Milliman Care Guidelines. HDI will use there content and software to review Medicare claims.
Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- The look back period is three years with a maximum look-back date of October 1, 2007
- RACs will implement a Web-based application that will allow providers to look up the status of medical record reviews.
- RACs have physician medical directors and certified coders

Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- RAC medical record request limit
  - Inpatient Hospital, IRF, SNF, Hospice: 10% of the average monthly Medicare claims (max 200) per 45 days per NPI
  - Other Part A Billers (HH): 1% of the average monthly Medicare episodes of care (max 200) per 45 days per NPI
  - Physicians (including podiatrists, chiropractors) Sole Practitioner: 10 medical records per 45 days per NPI
    - Partnership 2-5 individuals: 20 medical records per 45 days per NPI
    - Group 6-15 individuals: 30 medical records per 45 days per NPI
    - Large Group 16+ individuals: 50 medical records per 45 days per NPI
  - Other Part B Billers (DME, Lab, Outpatient hospitals): 1% of the average monthly Medicare services (max 200) per NPI per 45 days
Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- All provider types are available for RAC review once provider outreach has occurred in the state.
- Outreach education must occur before implementation in any state and is underway.
- The RAC Validation Contractors (RVC)
  - Works with CMS and the RACs to approve new issues the RACs want to pursue for improper payments, as well as perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments.
  - Used to provide additional oversight and ensure that the RACs are making accurate claim determinations in the permanent program.

Medicare Reform Initiatives (cont.)

Results of RAC Demonstration: Cumulative through March 27, 2008

- > $1.03 billion of "improper payments" - 96 percent collected from providers; 4 percent repaid to providers

<table>
<thead>
<tr>
<th>RAC</th>
<th>Overpayments Collected</th>
<th>Underpayments Repaid</th>
<th>Total Improper Payments Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connolly</td>
<td>$206.1</td>
<td>$4.3</td>
<td>$270.4</td>
</tr>
<tr>
<td>HDI</td>
<td>$386.1</td>
<td>$20.8</td>
<td>$406.9</td>
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<tr>
<td>PRG</td>
<td>$317.8</td>
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<tr>
<td>Claim RAC Subtotal</td>
<td>$980.0</td>
<td>$37.8</td>
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<tr>
<td>HMS</td>
<td>$13.0</td>
<td>$0.0</td>
<td>$13.0</td>
</tr>
<tr>
<td>DCS</td>
<td>$11.4</td>
<td>$0.0</td>
<td>$11.4</td>
</tr>
<tr>
<td>MSP RAC Subtotal</td>
<td>$12.7</td>
<td>$0.0</td>
<td>$12.7</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$992.7</td>
<td>$37.8</td>
<td>$1,030.5</td>
</tr>
</tbody>
</table>

Medicare Reform Initiatives (cont.)

Recovery Audit Contractors.

- Top Overpayment Items
  - Inpatient Hospitals
    - Excisional Debridement (incorrectly coded)
    - Inpatient Rehabilitation Facility (IRF) services following joint replacement surgery
    - Heart Failure and Shock (medically unnecessary)
    - Surgical Procedures in Wrong Setting (medically unnecessary)
    - Respiratory System Diagnoses with Ventilator Support
    - (incorrectly coded)
    - Extensive OR Procedures Unrelated to Principal Diagnosis
    - Cardiac defibrillator implant in wrong setting (medically unnecessary)

Medicaid Reform Initiatives (cont.)

Medicaid Integrity Program (MIP).

- States have the chief responsibility of controlling fraud in the Medicaid program
- CMS provides oversight, technical assistance, and direction
- Deficit Reduction Act of 2005 established the MIP
  - Goal: To fight fraud, waste, and abuse in the Medicaid Program
Medicaid Reform Initiatives (cont.)

Medicaid Integrity Group.

- Responsible for implementing and managing the MIP
- Goals of the MIG
  - Promote the proper expenditure of MIP funds
  - Improve program integrity performance nationally
  - Ensure the operational and administrative excellence of the MIP
  - Demonstrate effective use of MIP funds
  - Foster collaboration with internal and external stakeholders of the MIP

Medicaid Reform Initiatives (cont.)

Medicaid Integrity Contractors (MICs).

- Review of Provider MICs (Review MICs)
  - Analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities
  - Data mining and analysis techniques to identify provider targets
  - Provide leads to Audit MICs of providers to be audited
  - Contracts awarded to:
    - AdvanceMed Corporation
    - Thomson Reuters
      — Umbrella Contracts Awarded to:
        » ACS Healthcare Analytics, Inc.
        » SafeGuard Services, LLC
        » IMS Government Solutions

Medicaid Reform Initiatives (cont.)

Medicaid Integrity Contractors (MICs).

- Audit of Provider and Identification of Overpayment MICs (Audit MICs)
  - Conduct post-payment audits of all types of Medicaid providers
  - Identify overpayments to these providers.
  - Contracts awarded to:
    - Booz Allen Hamilton
    - Health Management Systems, Inc.
      - Umbrella Contracts Awarded to:
        - Fox & Associates
        - Island Peer Review Organization
        - Health Integrity, LLC.


Medicaid Reform Initiatives (cont.)

Medicaid Integrity Contractors (MICs).

- Education MICs
  - Develop training materials to conduct provider education and training on payment integrity and quality of care issues; and
  - Highlight the value of education in preventing fraud and abuse in the Medicaid program.
  - Umbrella contracts awarded to:
    - Strategic Health Solutions, LLC
    - Information Experts, Inc.

Medicaid Reform Initiatives (cont.)

CMS’s Special Open Door Forum: Medicaid Integrity Provider Audit Program on July 15, 2009.

- CMS recognized that it could do a better job of provider outreach. CMS plans to release
  - Seven to eight pages of frequently asked questions (FAQs) about MIP
  - Procurement timeline so that providers can have better knowledge when contractors are coming
    online
  - Background on the MIP program and its goals
  - Other documents that they call “audits A to Z” will be posted to their website
    (www.cms.hhs.gov/medicaidintegrityprogram)
- MICs will attempt to coordinate with RACs to prevent audits of the same facility at the same time
- What has occurred?
  - 500 Medicaid audits are under way in 17 states – plan to roll out to other states by the end of
    2009
  - 44% of the current audits focus on hospitals
  - 29% are on long-term care facilities
  - 21% of audits are on pharmacies
  - 6% are on physicians, labs, transportation, and other types of providers

Medicaid Reform Initiatives (cont.)

CMS’s Special Open Door Forum: Medicaid Integrity Provider Audit Program on July 15, 2009.

- Some differences in RACs vs. MICs

<table>
<thead>
<tr>
<th></th>
<th>RACs</th>
<th>MICs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look back period</td>
<td>Look back period is three years</td>
<td>Look back period based on what the individual states guidelines are</td>
</tr>
<tr>
<td></td>
<td>Number of days required to produce copies of medical records – 45 days.</td>
<td>Number of days required to produce copies of medical records – Based on individual states rules. MICs will not cover the cost of copying medical records</td>
</tr>
<tr>
<td></td>
<td>RACS will reimburse cost of copying records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical records request limit – 200 per NPI per 45 days</td>
<td>Medical records request limit – No set limit</td>
</tr>
<tr>
<td></td>
<td>Paid a contingency fee based on the amount of overpayments/underpayment discovered</td>
<td>Fee for service based system; eligible for rewards or bonuses based on how efficient and effective they are</td>
</tr>
<tr>
<td></td>
<td>Appeal process is the same across all regions</td>
<td>Appeal process is based on the states’ arbitration rules</td>
</tr>
</tbody>
</table>

Value-Based Purchasing (VBP)

CMS initiative to align payment policy with the delivery of high quality and efficient care for Medicare beneficiaries.

To avoid the two percent reduction in the payment update, hospitals must submit/allow CMS to report quality data.

According to CMS’s press release on 7/31/09, 97% of participating hospitals received the full update last year.

Value-Based Purchasing (cont.)

RHQDAPU Program Quality Measures for the FY 2010 Payment Determination

43 existing measures.

- Acute Myocardial Infarction (AMI)
  - AMI-1 Aspirin at arrival
  - AMI-2 Aspirin prescribed at discharge
  - AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
  - AMI-4 Adult smoking cessation advice/counseling
  - AMI-5 Beta blocker prescribed at discharge
  - AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
  - AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)

- Heart Failure (HF)
  - HF-1 Discharge instructions
  - HF-2 Left ventricular function assessment
  - HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
  - HF-4 Adult smoking cessation advice/counseling
Value-Based Purchasing (cont.)

RHQDAPU Program Quality Measures for the FY 2010 Payment Determination
43 existing measures.

- **Pneumonia (PN)**
  - PN-2 Pneumococcal vaccination status
  - PN-3b Blood culture performed before first antibiotic received in hospital
  - PN-4 Adult smoking cessation advice/counseling
  - PN-5c Timing of receipt of initial antibiotic following hospital arrival
  - PN-6 Appropriate initial antibiotic selection
  - PN-7 Influenza vaccination status

- **Surgical Care Improvement Project (SCIP)**
  - SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
  - SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
  - SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
  - SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery

Value-Based Purchasing (cont.)

RHQDAPU Program Quality Measures for the FY 2010 Payment Determination
43 existing measures.

- **Surgical Care Improvement Project (SCIP) – cont.**
  - SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
  - SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
  - SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
  - SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period

- **Mortality Measures (Medicare Patients)**
  - MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
  - MORT-30-HF: Heart Failure 30-day mortality Medicare patients
  - MORT-30-PN: Pneumonia 30-day mortality – Medicare patients

- **Patients’ Experience of Care**
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey
Value-Based Purchasing (cont.)

RHQDAPU Program Quality Measures for the FY 2010 Payment Determination
43 existing measures.

• Readmission Measures (Medicare Patients)
  – READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
  – READ-30-AM: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
  – READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)

• AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures
  – PSI 04: Death among surgical patients with treatable serious complications
  – PSI 06: Iatrogenic pneumothorax, adult
  – PSI 14: Postoperative wound dehiscence
  – PSI 15: Accidental puncture or laceration
  – IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)

• Nursing Sensitive
  – Failure to Rescue (Medicare claims only)

• Cardiac Surgery
  – Participation in a Systematic Database for Cardiac Surgery
Value-Based Purchasing (cont.)

2010 IPPS Final Rule - Four Measures to the RHQDAPU Program Measure Set for the FY 2011 Payment Determination

• Additions to the existing Surgical Care Improvement Project (SCIP) measure set
  – SCIP Infection (INF) 9 – Urinary catheter removed on postoperative day one (POD1) or postoperative day two (POD2)
  – SCIP INF 10 – Surgery patients with perioperative temperature management

• Addition of two structural measures
  – Participation in a systematic clinical database registry: Nursing sensitive care
  – Participation in a systematic clinical database registry: Stroke care


Value-Based Purchasing (cont.)

2010 IPPS Final Rule – Quality Measures under consideration for FY 2012 and subsequent years

• Numerous measures are under consideration
  – AMI: Statin at discharge
  – ED throughput
  – Complications: Lower Extremity Bypass and comorbidity adjusted complication index
  – PCI: Mortality rate for patients w/o STEMI and w/o cardiogenic shock
  – Stroke measures
  – Venous thromboemobolism
  – Cardiac surgery additional measures
  – Other nursing sensitive measures
  – Several outcome measures, e.g., postoperative respiratory failure, post operative sepsis
  – SCIP: Short Half-Life prophylactic administered preoperatively redosed
  – PCI readmission
  – Hospital acquired infections: Methicillin resistant staphylococcus aureus (MRSA), Clostridium Difficle Associated Diseases (CDAD)

Value-Based Purchasing (cont.)

- 2010 IPPS Final Rule – Hospital Acquired Conditions (HACs)
  - No Changes to CMS’s list of HACs
  - CMS will conduct a joint evaluation of HACs with agencies such as the Department of Health and Human Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Office of Public Health and Science


Clinical Documentation Improvement: A Concurrent Medical Record Review

http://www.photos.com/en/history/purchases
Clinical Documentation Improvement

What is Clinical Documentation Improvement (CDI)?

- A partnership among physicians, concurrent clinical reviewers, and coding professionals to assess whether all conditions and treatments are captured in the medical records to account for the resources consumed by patients
- A concurrent review of the medical record to aide in capturing all appropriate diagnoses to accurately reflect the true severity of illness, expected risk of mortality of patients, and appropriate MS-DRG reimbursement
- A program that seeks to clarify and/or capture conflicting/missing clinical documentation in the medical record

Why is CDI needed?

- Physicians often document in clinical terms, but for accurate profiling, regulatory compliance, reporting of quality measures, coding and reimbursement, diagnoses must be documented.
  - Example #1 – Physician noted in progress note that patient had sodium level of 125 and orders boluses of NaCl. Serum Na+ level is monitored daily. Clarification of appropriate diagnosis for the condition that is being treated and monitored may be appropriate (e.g., hyponatremia)
  - Example #2 – A patient with a history of CHF was admitted with shortness of breath, wheezing and dyspnea on exertion. Chest x-ray revealed pleural effusion and pulmonary edema. Echocardiogram showed LV systolic dysfunction with ejection fraction of 35%. Lasix 40 mg IV twice a day was ordered. Clarification of the type of heart failure may be appropriate (e.g., acute and/or chronic as well as systolic and/or diastolic heart failure)
  - Example #3 - A SNF patient with a history CVA and dysphagia was admitted with bilateral lower lobe pneumonia. The H&P indicated that the patient had a history of aspirating. The swallowing study stated that the patient had frank aspiration during the study. The physician ordered “aspiration precautions” and a mechanical soft diet. Clarification of the type of pneumonia may be appropriate (e.g., aspiration pneumonia)
Clinical Documentation Improvement (cont.)

What are the Benefits of CDI?

- CDI programs assist hospitals with:
  - Compliance with CMS rules and regulations
  - Proactive preparation for RACs, ZPICs, MICs and other healthcare regulatory initiatives
  - Accurate reflection of your patient population severity of illness and expected risk of mortality of for the hospital and medical staff
  - Accurate reimbursement through selection of the appropriate MS-DRG assignment which is driven by capturing the appropriate principle diagnosis, secondary diagnoses, and procedures
  - Determination if a diagnosis is Present on Admission (POA) and with documentation of Hospital Acquired Conditions
  - Validation of medical necessity
  - Support of length of stay, cost, and resource consumption
  - Improved quality of care measurement and outcome studies

Clinical Documentation Improvement (cont.)

What are the Key Roles in CDI?

- Physicians are the cornerstone to accurate and complete clinical documentation. They provide the appropriate diagnoses in the medical record for all conditions that are monitored, evaluated, treated, increase length of stay or increase nursing time. Physicians document procedures they perform

- Clinical Documentation Improvement Specialists
  - Query and communicate with physicians
  - Assist in clarifying ancillary documentation as needed
  - Collaborate with coding staff on all education issues
  - Could be housed in any of the following departments:
    - Case Management
    - Quality Improvement
    - Health Information Management Department
    - Compliance
  - Skills
    - Expertise in clinical nursing and/or coding. Some hospitals use physicians
    - Excellent communication skills with physicians

- Coding Professionals—Code the medical record and determine the final MS-DRG based on the clinical documentation. Coders will retrospectively clarify clinical documentation as needed.
Clinical Documentation Improvement (cont.)

Who are the Other Key Stakeholders?

- Executive Leadership
  - Chief Medical Officer
  - Chief Executive Officer
  - Chief Financial Officer
  - Chief Operating Officer
  - Chief Nursing Officer
- Physician Champion of the CDI program
- CDI Manager
- Director of Compliance
- Director of Health Information Management
- Director of Case Management
- Director of Quality
- Director of Revenue Cycle

Clinical Documentation Improvement (cont.)

Two CDI Approaches.

- Focused
  - Dedicated staff whose focus is on implementing and monitoring the program
  - Communication with physicians by committed staff who are seeking clarification of physician documentation
  - Offer reliability and uniformity in reviews
  - Have a briefer learning curve

- Integrated
  - Incorporated into the duties of preexisting staff within case management, quality, or HIM departments
  - Avoids duplication of medical record reviews
  - One source of contact for the physician regarding clinical documentation, discharge planning, and/or quality issues
  - Typically less add-on staff required upon implementation
  - Typically have a longer learning curve
Clinical Documentation Improvement (cont.)

• Querying.
  – Types
    • Verbal
    • Written
      — Preprinted for common diagnoses with clinical indicators
      — Generic query form
    • e-Mail
  – Queries should be non-leading
  – Adhere to relevant coding authorities’ guidelines such as the American Health Information Management’s Standards of Ethical Coding and the official coding guidelines
  – Utilize appropriate clinical indicators and relevant treatment in the query
  – Request physicians to document the appropriate diagnosis in the progress notes and/or on approved query forms.
  – Follow up with physicians if queries are not answered

Methods to Gain Physician Support.

• Determine the Physician Champion and provide education regarding the role and responsibilities
• Develop customized physician in-services for specialty areas regarding CDI
• Explain the benefits of CDI to physicians
  – Accurate profiling of patient’s severity of illness and expected risk of mortality which are used by a number of entities
  – Collaboration with clinical and coding professionals who are educated in CMS rules and regulation. The CDI staff will serve as a resource to physicians
  – Accurate and complete documentation supports physician professional billing
  – Justification of length of staff, resource consumption, and cost
• Educate physicians regarding healthcare reform/initiatives
Clinical Documentation Improvement (cont.)

Methods to Gain Physician Support.

- Attend key medical staff meetings including Medical Executive Committee and provide education regarding the program
- Invite key physician leaders to participate as appropriate in training sessions with the clinical documentation reviewers and HIM coders
- Involve physicians in educating clinical documentation reviewers and HIM coders on disease processes, new pharmacological agents, technology, etc.
- Provide physicians with quarterly profiling reports that reflect comparison to the established baseline and benchmarks
- Utilize e-mails, newsletters, posters, medical staff meetings, etc. to communicate with physicians regarding the progress of the CDI program

Clinical Documentation Improvement (cont.)

The overall goal is to obtain accurate and complete clinical documentation to reflect patients’ true severity of illness and expected risk of mortality.

CDI assists hospitals in proactively navigating through the many healthcare reform initiatives, profiling, and quality measurements.

Accurate and complete documentation will assist with accurate coding and reimbursement.
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