Improving Reimbursement through Clinical Documentation: A New Beginning

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Value of the CDI Program
Cindy Dennis, MHS, RHIT

Accurate coded data
➢ Tells the patient’s story
➢ Reveals the complexity of their case
➢ Reflects the care the patient received in the facility

Reasons for Poor Quality Clinical Documentation

➢ Clinical documentation practices not taught in medical school or residency programs
➢ Unstructured or inconsistent process
➢ Multiple providers
Criteria for High-Quality Clinical Documentation

Patient record entries should be:
- Legible – clear enough to be read
- Reliable – same result when repeated
- Precise – accurate, exact, strictly defined
- Complete – thorough content
- Consistent – not contradictory
- Clear – not vague
- Timely – at the right time

What to review

- Review data by service line and major diagnostic category (MDC)
- Case mix index (CMI)
- Complications and comorbidity (CC) capture rates
- Major complications and comorbidity (MCC) capture rates
- Severity of illness

Collaboration

- Coding and CDI Specialists work together
- Joint roundtables to discuss cases
- Standardized concurrent/retrospective queries to include ICD-10 codes
What Does CDI Do?

CDS staff review inpatient admissions and assign working/updated diagnosis and MS-DRGs

- Capture and alert clinicians and physicians to potential core measure cases on a concurrent basis
- Resolve coding or documentation challenges prior to patient’s discharge and before final coding and quality reporting submissions

Final Coding Review

Coding/CDI Knowledge Expert

Charts flagged for secondary review prior to billing

- Burdensome
- Coding and CDI education
- Physicians – documentation clarification

Language of Medicine ≠ Language of Coding

What Does it Take to be a CDS?

- Critical thinking skills: analyzing, interpreting
- Technical skills: A&P, Pharmacology
- Staying abreast of regulatory environment
- Understanding and application of coding guidelines
- Collaborative interaction with clinicians
- Communication skills, written and verbal
### Why CDI Program?

- Ensures that provider documentation is accurate and complete at point of care
- Meet Centers for Medicare and Medicaid Services (CMS) "meaningful use" program’s quality measures

### CDI Program

- Collect information at point of care (concurent)
- Educate clinical care providers
- Quality measure impacts:
  - Present on admission (POA)
  - Hospital-acquired conditions (HACs)
  - Major complications and comorbid conditions (MCCs)

### Payment

- CMS will not pay for treatment and care associated with a HAC
- HACs can’t be recognized under MS-DRG system as a cc or mcc:
  - Affects severity of illness
  - Mortality
  - Accurate reimbursement
Benefits of CDI Program

- Reduction of exposure to third-party audits
- Improved publicly reported mortality data
- Appropriate assignments of clinical codes for accurate MS-DRG assignment and case mix index, POA indicators, HAC codes
- Identification of documentation gaps prior to discharge
- Accurate data for CMS quality issues

Medicare Quality Indicators

- Antibiotic selection
- Initial antibiotic(s) within 6 hours after arrival
- Influenza vaccination status
- Pneumococcal vaccination status
- Blood culture performed in ED prior to initial antibiotic received in hospital
- Oxygenation assessment
- Smoking cessation advice/counseling

Joint Commission

Four care measurement areas:

- Acute myocardial infarction (AMI) or heart attack
- Heart failure (HF)
- Pneumonia (PN)
- Surgical Care Improvement Project
Redevelopment of Salem Health CDI Program
Coleen Elser, RN

- Existing program for over eight years - now under HIM
- CDS vs Coder – Benefits of nursing clinical knowledge vs coder ICD-9 knowledge
- Management personality conflicts

Starting Over After the Burnout

- Been there, done that
- New beginnings
- Now great momentum in our new and improved program

Current/Revised Process State

- Brought in CDI consultants
- Added CDI Knowledge Expert
- Have a dynamic 1-2 punch with our two most senior CDIS who add knowledge, experience and fun to the role
### Elevated Level of Interaction with Clinicians

- CDS spends time daily on the units interacting with clinicians
- Experimental two week trial – CDS working directly with hospitalists
- Improved interaction yields increased query response rate

### Collaboration with Coding Department

**Teamwork between CDS and Coders:**
- Weekly huddles
- Monthly in-service during roundtable
- Senior CDS is accessible daily for coders for clinical question interaction

### Reconciliation of CDI/Coding DRGs

Linda Dawson, RHIT

- Upon discharge, the Coder and CDS work together to come up with final DRG for the admission
## Reconciliation of CDI/Coding DRGs

- CDS checks DRG upon discharge.
- Completes retro queries if necessary.
- Sends on to coding.

<table>
<thead>
<tr>
<th>Coder codes the chart</th>
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</thead>
<tbody>
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<td>Sends incomplete CDS queries to physician for completion</td>
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Reconciliation of CDI/Coding DRGs

- Coder or CDI Education done at this point if necessary
- Physician Advisor helps with documentation if necessary
- Physician training in specific areas
- Meeting with specific hospital departments
- End result – receiving the proper reimbursement for care we provided

Reconciliation of CDI/Coding DRGs

- Compliant reporting of DRG for medical necessity and reason for admission
- Accurate documentation for Reimbursement
- Continuing Patient Care
- Severity of illness reporting

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Developing an ICD-10-CM/PCS CDI Training Strategy

The RAND Corporation divides overall ICD-10 costs into three categories:

- Training costs
- Productivity losses
- System changes
Training Concerns
From Different Point of Views

- Coders know the coding rules but don't have clinical expertise
- CDI specialists have clinical expertise but don't know the coding rules
- Current communication processes and team training has helped to build camaraderie and program cohesiveness

Education/Training
Bringing CDI/Coding into ICD-10

- Evaluate coders' anatomy and physiology skills and identify areas for additional training
- Assess CDI specialist coding skills and find the right tools to bridge their knowledge gaps

ICD-10 Training

Conservative Educational Approach:
- Spread out over 21 months
- Allows staff to retain information
- Prevents backlog
February 2013 – January 2014:
- Assessment
- Monthly in-service classes
- Provide continuing coding practice

ICD-10 Training Timeline

January 2014: Dual Coding
- Two or three inpatient charts per day
- Five ED charts per day

Reasons for Dual Coding:
- Coders and CDI specialists education and practice
- Identify trends in physician documentation
- Provide hospitals with valuable data
ICD-10 Training Timeline

April 2014 - October 2014:
- Launch intensive training
- Continue dual coding
- Complete transition of ICD-10 systems to production

ICD-10 Go Live

October 1, 2014
- ICD-10 CM/PCS codes will be required on all claims
- Perform coding audits
- Give feedback

ICD-10 Suggested Resources
- ICD-10 Trainer E-mail Newsletter:
- ICD-10 Audio conferences and Webcasts