# Improving Reimbursement through Clinical Documentation: A New Beginning

***February 21, 2013***


*Presented by Salem Health:*

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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 (concurrent)
- 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 lead CDIS who add knowledge, experience and fun to the roll

# Elevated Level of Interaction with Clinicians

- CDS spends time daily on the units interacting with clinicians
- Experimental 2 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
- Lead 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

# Reconciliation of CDI/Coding DRGs

- Coder codes the chart
- Sends incomplete CDS queries to physician for completion
- Writes own query if necessary
- Enters Coder DRG into CDS Softmed system
- Writes reason for differences in CDS /Coder DRG

# Reconciliation of CDI/Coding DRGs

- DRG matches – CDS closes out process
- Coder drops finalized acct – to billing
- DRG does not match and coder/CDS do not agree
- Case sent to CDI/Coder Knowledge Expert for chart review and final decision
- Retro Query sent if necessary

# 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 Statistics
- Severity of Illness reporting

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

Judy Parker, RHIT, CCS

**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

# ICD-10 Training Timeline

**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

# ICD-10 Training
# Dual coding

**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
- AHIMA http://www.ahima.org/
- CMS http://www.cms.gov/Medicare/Coding/ICD10/index.html
- Association of Clinical Documentation Improvement Specialists http://www.hcpro.com/acdis/index.cfm