Clinical Documentation Improvement
The Physician Champion
ILHIMA 04/30/16

General Background of CDI
CMS Federal Register August 2008 Final Rule
(CMS-1533-FC page 208)

“We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.” “... We encourage hospitals to engage in complete and accurate coding.”


Evolution of MS-DRGs

DRGs were developed in the late 1960s to create an effective framework for monitoring quality of care and the utilization of services in a hospital setting.

Each DRG represents clinically similar patients (CLINICAL COHERENCE) with a similar average use of hospital resources (CASE COMPLEXITY/COST). The hospital, with some exceptions, receives a fixed payment for the DRG, regardless of the services actually provided.

The DRG system allows the hospital to be paid on the type of patient being treated (Prospective Payment System; aka “PPS”) rather than on the actual cost incurred (Accrual cost). The patient classification system links payment to resource usage and not to treatment difficulty and prognosis.

Prior to FY 2008, approximately 78% of patients had a CC assigned. With the advent of the MS-DRG system, only 40% of patients will have a CC/MCC
What is a Clinical Documentation Improvement Program?

Clinical documentation is the foundation of every health record, and high-quality clinical documentation is the goal of every clinical documentation improvement (CDI) program.

The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation.

Good CDI programs identify deficiencies in documentation and provide education ensuring that your facility and you are capturing the acuity of the patient’s condition and reflects the care the patient received.

Programs help keep the medical record in its most effective state.

Purpose of Clinical Documentation Improvement

The purpose of the concurrent CDI program is to facilitate complete and accurate clinical documentation in the medical record—reflective of the true severity of the patient’s illness, intensity of service, and resource consumption required to care for the patient during the hospital stay. The concurrent approach allows documentation issues to be addressed while the patient is in the hospital.

The program also assists in audit defense and supports length of stay, proper coding and billing.

To obtain codeable documentation at the point of care—
What are the physicians’ responsibilities?

**Physician Responsibilities**

To provide legible, complete, clear, consistent, precise, and reliable documentation of the patient’s health history, present illness, and course of treatment. This includes observations, evidence of medical decision-making in determining a diagnosis, and treatment plan, as well as the outcomes of all tests, procedures, and treatments.

This documentation should be as complete and specific as possible, including information such as the level of severity, specificity of anatomical sites involved, and etiologies of symptoms.

Providers are expected to respond to queries. No response does not equal the answer no.

Support the CDI program
Physicians Role

- Primary role of a physician is for evaluation and treatment of patient care
- Participate on other important functions such as:
  a. Healthcare leadership
  b. Population healthcare management
  c. Business operations
  d. Research
  e. Public health
  f. Health policy
  g. Other related activities important to health
- We all have a responsibility to assure the continuous improvement of the quality, safety and effectiveness of healthcare delivery in our great country.

Health of the population & burden of illness

- Physicians provide the primary source of information of healthcare & process of caring
- Physicians see it is critical to monitor effectiveness, safety and quality of patient care
- Lack the ability to understand healthcare delivery across providers, payors, populations and regions
- The only significant standard data we have is claims data- universal & interoperable. But, physicians have concerns from claims data such as:
  1. Not reliable to evaluate healthcare
Is our Healthcare the best in the world?

- How often do we hear our healthcare is best in the world?
- Little doubt that it is the most expensive
- Looking at 2008 spending and analysis, by Kaiser Family Foundation, we spent 16% of the GDP or about $7,500 per capita for healthcare (about 48 million uninsured)
- While Japan spent 8.1% of their GDP or about $2,700 per capita (they have universal healthcare)
- Projected by 2020, that healthcare expenditures will reach 20% of the GDP and no assurance of solving the uninsured problem
- Here are some interesting numbers despite expenditure differences:
  1. Japan ranks first in terms of average longevity: we rank 38th
  2. Infant mortality in US is 3 times that of Japan

Value Based Purchasing

- Fiscal Year 2016 1.75%
- Fiscal Year 2017 2% reduction
- Succeeding years 2% reduction
- Reduction to Base DRG
- Rewards for good performance/penalties for poor performance
- Credit for improvement
- Consistency points only for Patient Experience of care domain
ICD-10-PCS Coding System

- What is ICD-10-PCS? A coding system unique to the United States representing medical interventions that occur in the inpatient hospital setting.
  - Replaces Volume 3 of ICD-9
- It will not be used in the outpatient or office setting
- It is recommended that the Clinical Documentation Reviewer who develop working DRGs become familiar with PCS coding guidelines
Pay for Performance

- P4P is not all about the money
- Raises the standard of care by:
  - Increases public awareness of our commitment and contributions to quality.
  - Promoting a unified healthcare team

Hospital Readmission Reduction Program

- Mandated by the Affordable Care Act
- Unlike value based purchasing, this is a penalty program, you can not acquire additional monies, only lose money
- CMS developed measures with a team of clinical and statistical experts from Yale and Harvard Universities through a transparent process that included input from multiple national technical expert panels and public comments
- Up to 3% reduction of Base DRG
The 30 day readmissions include:
- AMI
- Heart Failure
- Pneumonia
- COPD
- Elective THA/TKA
- CABG
- Stroke

Concerns

- Planned readmissions are not counted as readmissions
- Patients that leave AMA are not included in the measure population
- Measures do not adjust for Socioeconomic Status
HAC Reduction Program

- 1% reduction to amount otherwise payable under IPPS (after reduction for value based purchasing & hospital readmission reduction program)
- Automatic penalty for one quarter of hospitals deemed as having “worst” performance
- No credit for improvement
- HAC measures in Value based purchasing (via PSI 90)

Selection of the Physician Champion
Enlist the Physician Champion

- Physicians always respond best to their peers
- Other qualified subject matter experts can be discounted by physicians and it often takes a clinician to go head to head on challenges and questions raised by other clinicians.
- Need special training for ICD-10 and documentation desired.
- Necessity of good documentation and good data to present to general physician population.
- May need mentoring to help support their championing and communicating with other physicians.

Enlist the Physician Champion

- Who?
- Strong interpersonal skills. Needs to be:
  a. Good leader
  b. Diplomatic
  c. Assertive
  d. Bridge between physicians and CDS
- Broad based clinical understanding with interest in regulation
- Understanding both hospital (administrative) and medical staff
Elevate the Discussion

- Raise the level of discussion to:
  - healthcare delivery on a higher level
  - Establish the case for better healthcare through information documented as to delivery of care
  - The clinician in healthcare debate as a leader, will mean a more effective system based on better evidence
  - Without clinician input the policies and guidelines won’t make sense from both a clinical and patient perspective

Focus on Good Care first, then the Coding

- Focus on good patient care
- With really good documentation, good coding should follow
- Good documentation and proper coding may not be the first thing on a clinicians mind- especially the latter
- ICD-10 is coding centric and not well aligned with physician’s thinking
- Establish value- need show importance of ICD-10 with good documentation and how this impacts the severity of patient care
Physician Champion- The How

- Facilitate and promote the Clinical Documentation Improvement (CDI) program
  - Act as a liaison between the CDI staff and the medical staff and administration
  - Create an environment that:
    - Fosters accurate and complete physician documentation
    - Fosters education and communication between the CDI team and the medical staff
  - Support the hospital’s overall compliance efforts designed to ensure the accuracy of diagnosis coding, procedural coding, DRG assignment, risk adjusted severity and mortality reporting
- Make certain that CDI information and outcomes are shared with the medical staff
- Assist the CDI team in identifying trends and issues along with being the buffer for demanding physicians

Physician Champion- The Where

- Attend regular CDI Steering Committee meetings that were set
  - Evaluate CDI metric reports
  - Represent the Medical Staff
- Attend Task Force meetings- specific to CDI program
- Meet with the Clinical Documentation Specialist team on a regular basis (discussions regarding: documentation issues, trending and training topics)
- Flexibility to members of the CDI team for questions and chart reviews
- Organize Physician Engagement and Education:
  - Agenda for General Medical Staff sessions
  - Present at medical staff meetings
  - Update Medical Staff of CDI outcomes and any outstanding issues
- Work with identifiable physicians as needed to resolve documentation issues as part of the escalation process
- Keep up with CME, regulatory, legal and hospital guidelines for CDI
Healthcare Landscape is Changing

Key factors that are the drivers in proposed changes in the direction of the healthcare delivery and financial model include:

- Information driven healthcare
- Evidence based medicine
- Value based purchasing
- Episodes based or risk based payment models
- Accountable care
- Increasing focus on patient safety
- Focus on admissions that are potentially avoidable
- Focus on conditions that were not “present on admission”
- Audits and recovery of “inappropriate” payments
- Aggressive focus on fraud, waste and abuse

Summary

Having a CDI program with dedicated and highly trained staff to review and monitor documentation adds great value to many aspects of the healthcare industry.

By emphasizing the documentation requirements necessary for the capture of patient severity, acuity, and risk of mortality, healthcare providers can improve clinical data used for research, quality scorecards, and patient safety.

As a result of more thorough documentation, CDI programs more accurately reflect reimbursement for the resources used and services provided.
What about the QUERY process?

Query – The What

An official query is defined as a question presented to a health care provider in an effort to gain additional documentation so the HIM or CDI professional can more accurately assign a code or codes.

The desired outcome of the query is to update the medical record to better reflect the practitioner’s intent and clinical thought process documented in a way that supports accurate code assignment.

The query is a communication tool used to clarify documentation in the medical record.

QUERY = QUESTION
Query – The When

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

*Queries can be done concurrent, retrospective, post-bill or any combination of these.

Query – The Why

Queries help to assure that the clinical documentation can be interpreted in a manner that will gain accurate, appropriate reimbursement for the services provided to each and every patient.

They help with more specific codes, fewer denials, optimal reimbursement, improve quality of reporting and can even have an impact on utilization of resources.

A joint effort between the health care provider and the coding or clinical documentation improvement professional is essential to achieve compete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Only diagnosis codes that are clearly and consistently supported in the medical record, by provider documentation can be assigned and reported.
Query – The Who

The query is directed to the provider who originated the progress note or other report in question. This could include the attending physician, consulting physician, or the surgeon.

Documentation from providers involved in the care and treatment of the patient is appropriate for code assignment; however, a query may be necessary if the documentation conflicts with that of another provider. If such a conflict exists, the attending physician is queried for clarification, as that provider is ultimately responsible for the final diagnosis.

Query – The How

Can be provided in a number of ways these include:
- Paper based and left in the medical record
- Placed in physician mail box
- Faxed physician office
- Electronic health record
- Verbal

A provider’s response to a query can be documented in the progress note, discharge summary, or on the query form as a part of the formal health record. Addendums to the discharge summary or the progress note should include appropriate date and authentication.

Most successful CDI programs employ many techniques to make sure the physicians see and respond to the query.
Physician Champion Training & CDI

The Role of the CDS

- Clinical Documentation Specialist (CDS):

- Review the medical record on a concurrent basis to identify/ensure:
  - Appropriate principal diagnosis selection.
  - Secondary diagnoses evident and consistently documented.
  - Assign a preliminary MS-DRG.

- Engage Physicians:
  - Introduce and/or reiterate inpatient coding guidelines.
  - Develop written and/or verbal concurrent query.
  - Educate physicians to promote documentation best practices.

- Align program goals with coding requirements:
  - Maintain current knowledge of coding guidelines (i.e., coding clinic).
  - Maintain ongoing communication regarding CDI progress with coding team.
  - Serve as liaison between physicians and coding professionals.
The Role of the Coder

- **Health Information Management Professional (Inpatient Coder)**
  - Transform narrative descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations.
    - Review medical record and code from the documentation of healthcare provider.
    - Generate a retrospective query to clarify documentation inconsistencies within medical record.
  - Works in partnership with CDS to guarantee program success:
    - Serves as primary coding resource to the CDS and physician.
    - Informs CDS of coding guidelines and/or updates.
    - Collaborates with CDS to provide ongoing physician education.
    - Verifies preliminary MS-DRG aligns with final MS-DRG assignment.

Secondary Diagnosis

Secondary Diagnosis:
- Uniform Hospital Discharge Data Set (UHDDS) guidelines state that a secondary diagnosis is any condition that is documented by the physician and one of the following:
  - (1) Clinically evaluated, or
  - (2) Diagnostically tested, or
  - (3) Therapeutically treated, or
  - (4) Causes an increased Length of Stay (LOS) or nursing care
- Note: In addition to being documented by the physician, only one of the criteria (from 1 through 4) above must be met in order for a condition to be considered a secondary diagnosis.
Secondary Diagnosis

Secondary Diagnosis:

- Secondary diagnoses can only be included in the patient’s diagnostic statement if the condition is documented by the treating physician (not just included in a lab or other ancillary test).

- Medicare requires the documentation for diagnoses be provided by a healthcare provider (i.e., Attending, consulting physician).

- Definition of Healthcare Provider is determined by the organization.
  - An example would be:
    - Residents (Are all residents licensed in your organization? There are differences for inpatient vs. physician based billing for resident documentation.)
    - NP’s (out East they are licensed to practice)
    - PA’s

Complications and Co-morbidities (CC) & Major Complications and Comorbidities (MCC):

- CC: a significant acute disease, a significant acute manifestation of a chronic disease, an advanced or end stage chronic disease, or a chronic disease associated with systemic physiological decompensation and debility that have consistently greater impact on hospital resources.

- MCC: diagnosis codes that reflect the highest level of severity – leads to substantially increased hospital resource use such as intensive monitoring, expensive and technically complex services, and extensive care requiring a greater number of caregivers.
  - Intensive monitoring (for example, an intensive care unit stay).
  - Expensive and technically complex services (for example, heart transplant).
  - Extensive care requiring a greater number of caregivers (for example, nursing care for a quadriplegic).
What is going on in HIM right now?

HIM Outsourcing Realities

- In September 2015 survey by Black Book found the following:
  - 83% of hospitals now outsource some accounts receivable & collections
  - 58% outsource contract management
  - 55% outsource denials management
  - 68% of the physician groups with more than 10 practitioners now outsource some combo of collections & claims management

- The same survey found 93% of hospitals with more than 200 beds anticipate supplementing their existing Revenue Cycle management software with outsourcing services in the First Quarter of 2016.
Staffing Gaps

- How about staffing gaps for HIM Directors that will face in 2016?
  - So, three things that may take place:
    - Employee transitions
    - Turnover
    - Highly competitive recruitment and retention environment are predicted
  - Demand will continue to outweigh supply with experienced HIM professionals and especially qualified ICD-10 coders
  - In 2016 hospitalists may be forced to hire more coders to perform the same amount of work due to productivity slow downs with ICD-10

Strategies for Relationship Building for HIM

- Each partnership must deliver a value added in the year to come to ensure maximum advantage to an organization. Some suggestions to outsourced HIM partnerships exist, such as:
  - This was provided during the week of September 21st (2015) in conjunction with the CDI education
  - Both on-site and web-ex education was done with positive comments from SCL
  - Limited communication, with both Prism (restricted access to CDIS) and SCL-CDI -HIM reconciliation process, to have overall project impact
  - Continued SCL-CDI and Prism, working goal for 100% reconciliation process from CDIS cases
  - Generation of coding query to be done post discharge only- per SCL
Thank you!

Louis Grujanac, D.O., AHIMA ICD-10-CM/PCS Trainer
louandmara@comcast.net
Cell: 847-840-5440