Improving Reimbursement through Clinical Documentation: A New Beginning

June 28, 2013

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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 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

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
- Severity of illness reporting
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The RAND Corporation divides overall ICD-10 costs into three categories:

- Training costs
- Productivity losses
- System changes

Developing an ICD-10-CM/PCS CDI Training Strategy
Judy Parker, RHIT, CCS

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/
- Association of Clinical Documentation Improvement Specialists
  http://www.hcpro.com/acdis/index.cfm