Clinical Documentation Improvement

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ICE Certified Credentialing Specialist
Chief Executive Officer, Board of Medical Coding and Compliance
Chief Executive Officer, Association of Home Care and Compliance
Senior Director, DecisionHealth

Setting the Table

ICD-9 Productivity

• Coder productivity first 12 months:
  - 70% longer to code claims
  - 54% decrease in productivity
  Note: Canada’s data indicates initial productivity loss is never fully recovered
• Coder productivity in the long term:
  - 20% decrease in productivity
  - Maintain a 95% > accuracy rating
Productivity Comparison

<table>
<thead>
<tr>
<th>ICD-9 Current</th>
<th>ICD-10 First 12 months</th>
<th>ICD-10 Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding:</td>
<td>Coding:</td>
<td>Coding:</td>
</tr>
<tr>
<td>25 assessments daily</td>
<td>11.5 assessments daily</td>
<td>20 assessments daily</td>
</tr>
<tr>
<td>Coding and OASIS Review:</td>
<td>Coding and OASIS Review:</td>
<td>Coding and OASIS Review:</td>
</tr>
<tr>
<td>15 assessments daily</td>
<td>6.9 assessments daily</td>
<td>12 assessments daily</td>
</tr>
<tr>
<td>Internal audit Review:</td>
<td>Internal audit Review:</td>
<td>Internal audit Review:</td>
</tr>
<tr>
<td>95% &gt; accuracy rating</td>
<td>95% &gt; accuracy rating</td>
<td>95% &gt; accuracy rating</td>
</tr>
</tbody>
</table>

What Type of Company Do You Work For?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonProfit agency</td>
<td>25.02%</td>
</tr>
<tr>
<td>Corporate owned agency</td>
<td>18.45%</td>
</tr>
<tr>
<td>Hospital owned agency</td>
<td>12.50%</td>
</tr>
<tr>
<td>Free standing agency</td>
<td>39.12%</td>
</tr>
<tr>
<td>Outsource coding company</td>
<td>4.91%</td>
</tr>
</tbody>
</table>

How has ICD-10 Affected Your Coding Specialists’ Productivity?

<table>
<thead>
<tr>
<th>Answers</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased</td>
<td>1.21%</td>
</tr>
<tr>
<td>Stayed the same</td>
<td>16.36%</td>
</tr>
<tr>
<td>Less than 10% decrease</td>
<td>26.67%</td>
</tr>
<tr>
<td>10% to 19% decrease</td>
<td>23.64%</td>
</tr>
<tr>
<td>20% to 29% decrease</td>
<td>19.39%</td>
</tr>
<tr>
<td>30% to 39% decrease</td>
<td>6.67%</td>
</tr>
<tr>
<td>40% to 49% decrease</td>
<td>1.82%</td>
</tr>
<tr>
<td>50% to 59% decrease</td>
<td>3.64%</td>
</tr>
<tr>
<td>60% to 74% decrease</td>
<td>0.00%</td>
</tr>
<tr>
<td>75% or greater decrease</td>
<td>0.61%</td>
</tr>
</tbody>
</table>
Reasons for Productivity Decline (5 Represents Greatest Impact)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coder Knowledge Deficit</td>
<td>24.29%</td>
<td>30.00%</td>
<td>22.14%</td>
<td>12.86%</td>
<td>10.71%</td>
</tr>
<tr>
<td>Clinical documentation deficit</td>
<td>5.65%</td>
<td>13.19%</td>
<td>26.39%</td>
<td>30.56%</td>
<td>24.31%</td>
</tr>
<tr>
<td>Referral Source Documentation Deficit</td>
<td>6.25%</td>
<td>11.81%</td>
<td>20.83%</td>
<td>30.56%</td>
<td>30.56%</td>
</tr>
<tr>
<td>Software vendor readiness</td>
<td>43.36%</td>
<td>20.98%</td>
<td>19.58%</td>
<td>7.69%</td>
<td>8.39%</td>
</tr>
<tr>
<td>CMS readiness</td>
<td>43.57%</td>
<td>25.71%</td>
<td>22.14%</td>
<td>3.57%</td>
<td>5.00%</td>
</tr>
</tbody>
</table>

How Has ICD-10 Affected Your Clinicians' Productivity?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity has increased</td>
<td>0.00%</td>
</tr>
<tr>
<td>Productivity is exactly the same</td>
<td>60.25%</td>
</tr>
<tr>
<td>Less than 10% decline</td>
<td>17.39%</td>
</tr>
<tr>
<td>10% to 19% decline</td>
<td>14.29%</td>
</tr>
<tr>
<td>20% to 29% decline</td>
<td>4.97%</td>
</tr>
<tr>
<td>30% to 39% decline</td>
<td>1.24%</td>
</tr>
<tr>
<td>40% to 49% decline</td>
<td>1.24%</td>
</tr>
<tr>
<td>50% to 59% decline</td>
<td>0.00%</td>
</tr>
<tr>
<td>60% or greater decline</td>
<td>0.62%</td>
</tr>
</tbody>
</table>

If You Had Claims Rejected – Detail Why the Rejections Occurred

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect ICD-10 codes listed on claim</td>
<td>55.68%</td>
</tr>
<tr>
<td>ICD-9 codes listed on claim</td>
<td>5.68%</td>
</tr>
<tr>
<td>Incorrect codes listed on claims with Oct 1 spanned dates</td>
<td>20.45%</td>
</tr>
<tr>
<td>Claim contained both ICD-10 and ICD-9 codes</td>
<td>13.64%</td>
</tr>
<tr>
<td>Unspecified code used as primary diagnosis</td>
<td>20.45%</td>
</tr>
<tr>
<td>Claim incorrectly rejected due to MAC error</td>
<td>13.64%</td>
</tr>
</tbody>
</table>
If You Had Claims Denied - Detail Why the Denials Occurred

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect ICD-10 codes listed on claim</td>
<td>59.15%</td>
</tr>
<tr>
<td>ICD-9 codes listed on claim</td>
<td>8.45%</td>
</tr>
<tr>
<td>Incorrect codes listed on claims with Oct 1</td>
<td>11.27%</td>
</tr>
<tr>
<td>Claim contained both ICD-10 and ICD-9 codes</td>
<td>23.94%</td>
</tr>
<tr>
<td>Unspecified code used as primary diagnosis</td>
<td>19.72%</td>
</tr>
<tr>
<td>Claim incorrectly denied due to MAC error</td>
<td>16.90%</td>
</tr>
</tbody>
</table>

How has ICD-10 Affected Your Coding Specialists’ Accuracy?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased</td>
<td>0.39%</td>
</tr>
<tr>
<td>Stayed the same</td>
<td>2.64%</td>
</tr>
<tr>
<td>Less than 10% decrease accuracy</td>
<td>5.73%</td>
</tr>
<tr>
<td>10% to 19% decrease accuracy</td>
<td>23.64%</td>
</tr>
<tr>
<td>20% to 29% decrease accuracy</td>
<td>31.39%</td>
</tr>
<tr>
<td>30% to 39% decrease accuracy</td>
<td>28.56%</td>
</tr>
<tr>
<td>40% to 49% decrease accuracy</td>
<td>2.82%</td>
</tr>
<tr>
<td>50% to 59% decrease accuracy</td>
<td>4.64%</td>
</tr>
<tr>
<td>60% to 74% decreased accuracy</td>
<td>0.08%</td>
</tr>
<tr>
<td>75% or greater decrease accuracy</td>
<td>0.11%</td>
</tr>
</tbody>
</table>

What is the Top Reason For Coding Errors?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding knowledge deficit</td>
<td>48.15%</td>
</tr>
<tr>
<td>Clinician documentation</td>
<td>41.67%</td>
</tr>
<tr>
<td>Referral documentation</td>
<td>35.19%</td>
</tr>
<tr>
<td>Physician documentation</td>
<td>33.33%</td>
</tr>
<tr>
<td>EMR issues</td>
<td>6.44%</td>
</tr>
</tbody>
</table>
**Coder Productivity Comparison**

<table>
<thead>
<tr>
<th>ICD-9 Daily Assessments</th>
<th>Survey Percentage Decrease</th>
<th>ICD-10 Projected Decrease</th>
<th>ICD-10 4th Quarter Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>&lt; than 10%</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>10 to 24%</td>
<td>19 to 22</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>25 to 49%</td>
<td>18 to 25</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>50 to 74%</td>
<td>6 to 12</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>75% or &gt;</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>95% &gt; accuracy rating</td>
<td>95% accuracy rating</td>
<td>82% accuracy rating</td>
<td></td>
</tr>
</tbody>
</table>

**Summary of Findings**

<table>
<thead>
<tr>
<th>Error</th>
<th>Percentage</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invalid code(s)</td>
<td>27.49%</td>
<td>Coding Specialist Error</td>
</tr>
<tr>
<td>Inaccurate code(s)</td>
<td>72.51%</td>
<td>Documentation Deficit</td>
</tr>
</tbody>
</table>

**2015 4th Quarter Data**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
Top 10 Diagnosis Categories

- Z47 - Orthopedic aftercare
- I50 - Heart failure
- Z48 - Post procedural aftercare
- E11 - Type 2 diabetes
- J44 - COPD

Top 10 Diagnosis Categories

- I10 - Hypertension
- L89 - Pressure ulcer
- M62 - Muscle weakness
- J69 - Cerebral vascular disease
- R26 - Abnormality of gait

Z47

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>79%</td>
<td>Z47.1</td>
<td>Aftercare joint replacement</td>
</tr>
<tr>
<td>15%</td>
<td>Z47.89</td>
<td>Encounter for other ortho aftercare</td>
</tr>
<tr>
<td>5%</td>
<td>Z47.81</td>
<td>Aftercare surgical amputation</td>
</tr>
<tr>
<td>1%</td>
<td>Z47.32</td>
<td>Aftercare joint explantation of hip</td>
</tr>
</tbody>
</table>
### I50

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>94%</td>
<td>I50.9</td>
<td>Unspecified heart failure</td>
</tr>
<tr>
<td>3%</td>
<td>I50.2</td>
<td>Systolic heart failure</td>
</tr>
<tr>
<td>2%</td>
<td>I50.3</td>
<td>Diastolic heart failure</td>
</tr>
<tr>
<td>1%</td>
<td>I50.4</td>
<td>Combine systolic/diastolic heart failure</td>
</tr>
</tbody>
</table>

### M62

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>M62.81</td>
<td>Generalized muscle weakness</td>
</tr>
<tr>
<td>1%</td>
<td>M62.50</td>
<td>Muscle wasting and atrophy</td>
</tr>
<tr>
<td>1%</td>
<td>M62.82</td>
<td>Rhabdomyolysis</td>
</tr>
</tbody>
</table>

### I69

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>41%</td>
<td>I69.9-</td>
<td>Unspecified sequelae of cerebrovascular disease</td>
</tr>
<tr>
<td>22%</td>
<td>I69.351</td>
<td>Hemiplegia dominant side sequelae of CVA</td>
</tr>
<tr>
<td>11%</td>
<td>I69.398</td>
<td>Other sequelae of CVA</td>
</tr>
<tr>
<td>6%</td>
<td>I69.8-</td>
<td>Other sequelae of cerebrovascular disease</td>
</tr>
<tr>
<td>4%</td>
<td>I69.1-</td>
<td>Intracerebral hemorrhage</td>
</tr>
</tbody>
</table>
### I69

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>I69.31</td>
<td>Cognitive deficits sequelae of CVA</td>
</tr>
<tr>
<td>3%</td>
<td>I69.320</td>
<td>Aphasia sequelae of CVA</td>
</tr>
<tr>
<td>2%</td>
<td>I69.352</td>
<td>Hemiplegia non-dominant side sequelae of CVA</td>
</tr>
<tr>
<td>2%</td>
<td>I69.391</td>
<td>Dysphasia sequelae of CVA</td>
</tr>
<tr>
<td>2%</td>
<td>I69.2</td>
<td>Intracranial hemorrhage</td>
</tr>
</tbody>
</table>

### I69

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>I69.359</td>
<td>Hemiplegia unspecified side sequelae of CVA</td>
</tr>
<tr>
<td>1%</td>
<td>I69.30</td>
<td>Unspecified sequelae of CVA</td>
</tr>
<tr>
<td>1%</td>
<td>I69.321</td>
<td>Dysphasia sequelae of CVA</td>
</tr>
<tr>
<td>1%</td>
<td>I69.322</td>
<td>Dysarthria sequelae of CVA</td>
</tr>
</tbody>
</table>

### Least Profitable Categories

- I87 - Vein disorders
- T81 - Surgical complications
- S81 - Open wounds
- L89 - Pressure ulcer
- I50 - Heart failure
Most Profitable Categories

- R26 - Abnormality of gait
- M25 - Pain/stiffness in joint
- Z47 - Orthopedic aftercare
- M54 - Pain in upper back
- I11 - Hypertension with heart disease

Most Profitable Breakdown

<table>
<thead>
<tr>
<th>Primary Code</th>
<th>Primary Diagnosis</th>
<th>Average margin per episode</th>
<th>Average skill nsg visit per episode</th>
<th>Average therapy visits per episode</th>
<th>Average costs per episode</th>
<th>Average reimbursement per episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>R26</td>
<td>Abn gait</td>
<td>34.8%</td>
<td>3.3</td>
<td>12.6</td>
<td>$2,526</td>
<td>$3,761</td>
</tr>
<tr>
<td>I11</td>
<td>HTN/hrt</td>
<td>33.9%</td>
<td>8.1</td>
<td>4.5</td>
<td>$1723</td>
<td>$2,398</td>
</tr>
<tr>
<td>M25</td>
<td>Joint disorder</td>
<td>33.1%</td>
<td>4.3</td>
<td>10.6</td>
<td>$2,165</td>
<td>$3,428</td>
</tr>
<tr>
<td>247</td>
<td>Ortho a/c</td>
<td>32.4%</td>
<td>4.6</td>
<td>10.3</td>
<td>$2,383</td>
<td>$3,437</td>
</tr>
<tr>
<td>M54</td>
<td>Pain ↑ back</td>
<td>32.2%</td>
<td>4.7</td>
<td>10.0</td>
<td>$2,325</td>
<td>$3,321</td>
</tr>
</tbody>
</table>

Coding and Clinician Touch Points
**Knowledge Gap**

- Anatomy
- Physiology
- Pathophysiology
- Pharmacology
- Medical terminology

**Common Coding Errors**

- 7th character missing
- Incorrect laterality
- Ulcer severity missing
- Sequencing errors
- Inaccurate/unspecified codes
- Invalid codes

**Example**

- Patient admitted for surgical aftercare with right hip joint replacement due to fractured right hip. The documentation states the head of the femur sustained a closed fracture. Patient has a stage I pressure ulcer on the left heel. Therapy and nursing will be seeing the patient.
Answer

• M1021: Z47.1 Aftercare following joint replacement surgery
• M1023: Z96.641 Presence of right artificial hip joint
• M1023: L89.621 Pressure ulcer of left heel

• Note: Available clinical diagnosis points = 0

Answer

• M1021: S72.051D Fracture of head of right femur, subsequent encounter for closed fracture with routine healing

• Note: Available clinical ‘ortho 2’ points = 8

Coding Specialist

• Review 100% of coding specialist codes
• Focus on most common errors
• Affected resource utilization
• Coding education improvement plan
• Facilitate coder and clinician interactions
• Consider developing a mentoring program
Common Documentation Deficits

- General documentation deficits
  - Laterality not documented
  - Ulcer severity not documented
  - Fracture specificity not documented
  - Type of dementia not documented
  - Type of heart failure not documented
  - Reason for therapy not documented

Example

- Patient admitted for surgical aftercare for excision of Merkel cell carcinoma of the face. Radiation to begin when incision site heals.
- M1021: Z48.3 Aftercare following surgery for neoplasm
- M1023: C4A.30 Merkel cell carcinoma of the face
- Note: Available ‘neoplasm’ points = 0

Example

- Patient admitted for surgical aftercare for excision of Merkel cell carcinoma of the nose. Radiation to begin when incision site heals.
- M1021: Z48.3 Aftercare following surgery for neoplasm
- M1023: C4A.31 Merkel cell carcinoma of nose
- Note: Available ‘neoplasm’ points = 7
**Clinician**

- Review 100% of clinician documentation
- Focus on most common documentation deficits
- Affected resource utilization
- Documentation improvement plan
- Facilitate coder and clinician interactions

**Importance of Intake Team**

**Sample Intake Tool**

<table>
<thead>
<tr>
<th>Diagnosis/Condition</th>
<th>Sample Query Questions</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures</td>
<td>Could you provide the radiology report that includes the location and type of fracture?</td>
<td>PCP H&amp;P report, Surgical report, Radiology report, Discharge summary</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Does the CHF have a diastolic or systolic component?</td>
<td>Cardiologist report, PCP H&amp;P report, Ejection fraction, Cath/other procedures report, Discharge summary</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>Is the osteo from a soft tissue injury or blood infection?</td>
<td>PCP H&amp;P report, Radiology report, Discharge summary, Surgical report</td>
</tr>
</tbody>
</table>
Physician Documentation

Documentation

- The physician is legally accountable for establishing the patient’s diagnoses
- Physician practices were given a 12 month grace period
- “If a valid ICD-10 code from the right code family is submitted, Medicare will process and not audit the code selection”

Documentation

- Physicians are not paid from ICD-10 codes
- Physicians utilize ICD-10 codes to establish medical necessity
- Sense of urgency to provide more robust documentation has diminished
- Home health’s reimbursement is dependent on the classification system
Information Governance

- Is an emerging discipline in healthcare that focuses on how an organization ensures information is:
  - Complete
  - Accurate
  - Trustworthy
  - Usable

The goal of information governance is to enable an organization to utilize information as an asset, in supporting the
- Mission
- Vision
- Goals
Information Governance

• Governance of clinical and operational information improves an organization’s:
  ➢ Quality of care
  ➢ Patient safety
  ➢ Population health
  ➢ Increases efficiency and effectiveness
  ➢ Reduces costs and risk

Data Governance

• Data governance is sub domain of information governance
• Data governance responsibilities include:
  ➢ Modeling
  ➢ Mapping
  ➢ Auditing
  ➢ Quality controls
  ➢ Quality management

Enterprise Information Management

• Enterprise information management or (EIM) is a sub domain of data governance
• EIM responsibilities in include:
  ➢ Policies, procedures and processes
  ➢ Managing information across the organization
  ➢ Throughout all phases of its life
Information Phases

- Creation/capture
- Processing
- Use
- Storage
- Preservation
- Disposition
- Information sharing/release/exchange practices
- Chain of custody
- Long term preservation

Clinical Documentation Improvement

- CDI is an integral part of information governance
- Specializing in clinical/operational documentation
  - Policies, processes and procedures
  - Controls to ensure clinical data is specific
  - Complete
  - Precise
  - Timely
  - Legible
  - Consistent
  - Clear

Clinical Documentation Improvement

- CDI as a discipline is specifically a data governance role with responsibilities in place to ensure
  - Compliance with all applicable laws
  - Compliance with all official coding guidelines
  - Substantiate claims
  - Improve revenue streams
Clinical Documentation Improvement

- CDI plays an important part of reviewing information as it begins its lifecycle:
- Prior to being shared outside of the organization:
  - Patients
  - External physicians
  - External clinicians
  - Payers
  - ACO’s

Clinical Documentation Improvement

- Key components of a CDI program are:
  - Integrity
  - Availability
  - Compliance
- Program improves documentation by assuring data elements are:
  - Complete
  - Specific
  - Timely and relative throughout the life cycle

Clinical Documentation Improvement

- CDI has arrived on the doorstep of HH
- Purpose is to review concurrently for conflicting, incomplete, or nonspecific documentation
- The goal of a CDI program is to identify clinical indicators that ensure conditions are supported by the ICD-10 codes
- Documentation is translated into ICD-10 codes
Clinical Documentation Improvement

- CDI processes achieve precise data to:
  - Support the complexity and severity of the patient’s illness
  - Focus on documentation that is used for coding and revenue decisions is accurate
  - Improve documentation quality
  - Improves outcomes

CDI Background

- CDI was originally created because of a lack of data standardization
- CDI initially was to create universal terminology and documentation standards
- To achieve documentation reliability and validity

CDI Background

- CDI programs began in the 1990s to assist physicians in their documentation efforts
- October 2007 CMS implemented severity and risk of mortality to hospital DRGs
- October 2008 CMS required Present on Admission (POA) indicators for all diagnoses
- Hospitals have ramped up their CDI programs
CDI Background

- In 2006 33% of hospitals reported a CDI program
- Current data reflects 81% of hospitals are reporting a CDI program
- 12% of hospitals are reporting plans to start a CDI program within the next 12 months

CDI Background

- Physician participation in hospital CDI programs is required
- Compliance statistics are kept per physician in a hospital setting
- High level provider documentation is required in a hospital setting and it is now on the doorstep in a home health and hospice setting

Getting Started

- Types of CDI programs
  - Case management
  - Clinical Based
  - HIM based
  - Combination
Getting Started

Who is included?

- Physicians
- Clinicians
- Clinical documentation improvement specialists
- Utilization review or quality assurance
- Coding and billing specialists
- External reviewers

Getting Started

- Create a CDI team
- Should not be part of the coding department
- The team member(s) should work closely with the coding specialists, clinicians, physicians
- Direct liaison to physicians
- Develop CDI policies and procedures
- Conduct initial comprehensive chart review

Getting Started

- Review the data by physician and agency clinician for incomplete documentation
  - physician deficit?
  - clinician deficit?
  - identify the HHRG billed
  - determine what the HHRG could have been with additional documentation
- Initial review is basis of a documentation handbook for the CDI professional
**Top 3 Challenges**

**Physician buy in**
- Education of physicians is a prerequisite
- Education should be tailored to specific referral type (cardiology, endocrine etc)
- CDI liaison should emphasize the benefits for the physician including defensible documentation and outcome data

**Top 3 Challenges**

**Physician buy in**
- Medicare sustainable growth rate (SGR) methodology has been repealed
- Replaced with MIPS (merit based incentive payment system)
- Providers will be measured annually in four performance categories

**Top 3 Challenges**

**Physician buy in**
- MIPS eligible professional's score and individual category scores will be available on the Physician Compare website
- Consumers will be able to see their providers rated scale compared to peers nationally
- Brings a new level of transparency and specificity beyond existing programs
**Top 3 Challenges**

**Hiring the right CDI Professional**
- Can come from various backgrounds
- Clinical background
- Strong oral and written communication skills
- Knowledge of coding guidelines and conventions
- Understand the ethics and compliance issue surrounding the query process

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**Top 3 Challenges**

**Hiring the right CDI Professional**
- Who should be a CDI Professional?
- Convergence of skills between coding and clinical
  - Education
  - Skillset
  - Personality

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**Top 3 Challenges**

**Hiring the right CDI Professional**
- Coding/HIM Professional
- 3 – 5 years of HH experience
- Certification in coding
- Regulatory background
  - Knowledge of ICD-10
  - Understanding of HHRGs
  - Revenue cycle process
Top 3 Challenges

Hiring the right CDI Professional
- Clinical professional
- 3 – 5 years of HH clinical experience
- Certification in OASIS
- Nursing background
  - Clinical understanding
  - Documentation knowledge
  - Experience interacting with physicians

Top 3 Challenges

Benefits of Clinician
- Clinical knowledge
- Physician interaction
- Documentation skills
- Basic coding requirements
- 56% of job descriptions require nursing

Benefits of Coder
- Coding skills
- Reimbursement knowledge
- Documentation requirements
- 25% of job descriptions require HIM/Coding

Top 3 Challenges

CDI Specialist
CDI reviews the record concurrently
- Reviews the information available in the patient’s current encounter
- Identifies gaps and seeks clarification
- Initiates queries
- Prior to coding

Coding Specialist
Coder reviews the record retrospectively
- Reviews the information available in the patient’s current encounter
- Closes the loop on any outstanding CDI queries
- Assigns the appropriate codes
Day in the Life of a CDI Professional

- Obtain list of referrals
- Review documentation
- Determine if clarification is needed
- Release documentation to coder for appropriate code assignment
- Physician/Referral responds to query
- Query Physician/Referral Source

Top 3 Challenges

**Bridging the Gap**

- CDI team/agency staff/physicians
- CDI professional is new kid on the block
- CDI role is to communicate with physicians on documentation improvement issues concurrent with the admission
- A role that has been the clinician or coder

**Top 3 Challenges**

**Bridging the Gap**

- The CDI review occurs prior to coding
- CDI professional looks for what **has not** been documented
- The coding specialist looks for what **has** been documented
- Recognize each other's skill sets
**Top 3 Challenges**

**Bridging the Gap**
- Work as partners to accomplish accurate documentation
- CDI is the bridge between the clinical language and the coding language
- CDI assists the physician, coder and clinician in building the bridge between the different roles

**Initial Review**
- Referral diagnoses
- History and physical
- Consulting notes
- Operative notes
- Procedure notes
- Clinical findings

**Follow Up Review**
- Referral diagnoses
- History and physical
- Consulting notes
- Operative notes
- Procedure notes
- Clinical findings
- OASIS documentation
Re-Review
- Referral diagnoses
- History and physical
- Consulting notes
- Operative notes
- Procedure notes
- Clinical findings
- OASIS documentation
- Physician query responses

Productivity Metrics
- HHRG weights/number of admissions
- Number of cases queried/number of reviews
- Number of reviews completed/number of reviews assigned
- Number of query responses/number of queries sent

Productivity Standards
- Number of initial reviews
- Number of follow up reviews
- Query follow up
- HHRG comparison
- Quality scores
Productivity Statistics

• 8-12 initial reviews daily
• ? Follow up reviews
• 12-20 re-reviews daily
• Average query rate = 28%
• Average physician response rate = 85%

Query Process

• A query should occur when documentation:
  ➢ Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
  ➢ Describes a clinical indicator(s) without a definitive relationship to an underlying diagnosis or condition
  ➢ Provides a diagnosis without underlying clinical validation

Query Process

• Communication
  - Paper
  - Electronic
  - Verbal
• Template
• Follow up
• Queries should be part of the permanent record
**Query Format**

Generally includes the following:

- Patient name
- Episode/Admission date
- Health record number/Medicare
- Date of query
- Name/contact information of CDI specialist
- Statement of the issue/Question

**Query Format**

Statement of the Issue:

- Written as a question
- Clinical indicators from the documentation
- Asking the physician to make a clinical interpretation
- Format should not lead physician to a diagnosis

**The Question**

- Can this diagnosis be further specified?
- Can the relationship between these two diagnoses be further specified?
- Please clarify if you agree or disagree with this finding.
- Can a diagnosis be provided to support these findings?
Example

- The patient’s hospital discharge summary notes, that the patient has a history of chronic CHF and a new diagnosis of Afib. The patient complains of SOB with activity. A recent echocardiogram report showed left ventricular ejection fraction of 25%. A recent EKG shows Afib with a HR of 110. The patient’s home medications include metoprolol XL, linsinopril, coumadin and lasix. The admitting physician does not mention heart failure as a diagnosis.

Query Opportunities

- Specificity and type of heart failure
- Specificity of Afib

Leading Query

Leading:
- If you are treating the patient for chronic systolic heart failure and persistent atrial fibrillation, please document this diagnosis in the health record

Problems:
- Presumptive
- Directing
- No clinical factors
Correct Query

• It is noted in the hospital discharge summary that the patient has chronic CHF and a recent echocardiogram states an EF of 25%. Can a confirmation of heart failure and the type of CHF be further specified?
  • Chronic systolic heart failure
  • Chronic diastolic heart failure
  • Chronic systolic and diastolic heart failure
  • Other explanation of clinical findings
  • Unable to determine
  • Findings of no clinical significance

Correct Query

• It is noted in the H&P that the patient has a new diagnosis of Afib and the EKG report shows Afib with a HR of 110. The patient was started on Coumadin and metoprolol XL. Can this diagnosis be further specified?
  • Paroxysmal Afib
  • Persistent Afib
  • Chronic Afib
  • Other explanation of clinical findings
  • Unable to determine
  • Findings of no clinical significance

Example

• Patient was discharged from SNF and admitted to HH for therapy due to exacerbated osteoarthritis affecting his gait. The patient has secondary diagnoses of HTN, osteoporosis and emphysema with long term steroid use. Nursing will also be seeing the patient. The patient complains of hip joint pain with activity. A recent lab report indicates an HbA1c of 8% at 64 mmol/mol. The patient’s home medications include metoprolol XL, linsinopril, Albuterol, prednisone, fosomax, parlodel, and Ibuprofen. The admitting physician does not mention diabetes as a diagnosis.
Query Opportunities

- Presence/type of diabetes mellitus
- Specificity of OA location
- Specificity of gait abnormality

Correct Query

- It is noted in the SNF discharge summary that the patient has a recent lab report indicating an HbA1c of 8% at 64 mmol/mol. The patient was started on parodel in the SNF and is on long term prednisone. Can a confirmation of diabetes and type be confirmed?
- Diabetes mellitus type II
- Drug or chemical induced diabetes mellitus
- Pre-diabetes
- Other explanation of clinical findings
- Unable to determine
- Findings of no clinical significance

Correct Query

- It is noted in the physician H&P that the patient has a diagnosis of osteoarthritis affecting gait. The patient states he has hip pain with activity. The patient is on prednisone and ibuprofen. Can the type and location of osteoarthritis be further specified?
- Bilateral primary osteoarthritis of hip
- Bilateral secondary osteoarthritis of hip
- Bilateral osteoarthritis resulting from hip dysplasia
- Other explanation of clinical findings
- Unable to determine
- Findings of no clinical significance
**Correct Query**

- It is noted in the referral that the patient has an affected gait due to osteoarthritis. The patient states he has hip pain with activity. The patient is on prednisone and ibuprofen. Can the abnormal gait be further specified?
  - Ataxic gait
  - Unsteadiness on feet
  - Other abnormality of gait and mobility
  - Other explanation of clinical findings
  - Unable to determine
  - Findings of no clinical significance

**When not to Query**

- When the information is clinically insignificant
- When the information is from a previous episode and not the current episode
- When the organization’s CDI policies and procedures restrict queries in certain situations
- When the benefit is strictly for increased reimbursement

**CDI Advantages**

- As payment models change and evolve for providers across the healthcare continuum
- The focus must be on quality of care
- Quality of care is shown only by the quality of the documentation
- CDI must play a vital role in the creation and capture of all clinical data
Value Based Purchasing

- Revamps how Medicare pays for home health care services
- Rewards agencies for quality and improvement in health care
- Uses financial incentives to make value based payments
- Holds providers accountable for the quality of care provided

CDI Advantages in a Value-Based World

- Improves quality outcome performance: more accurate case-mix resulting in better severity and risk adjusted outcomes
- Produces outcome data necessary for continuous quality and process improvement
- Increases financial performance in a fee-for-service environment through accurate reimbursement
- Prepares organizations for value-based reimbursement

Pre-Claim Review

- Improve methods for the identification, investigation and prosecution of Medicare fraud
- Reduce expenditures
- Improve quality of care
- Assure clinical documentation requirements are met
CDI Advantages in a Pre-Claim Review World

- Review concurrently for conflicting, incomplete, or nonspecific documentation
- Validates medical necessity documentation prior to pre-claim review
- Identify clinical indicators that ensure conditions are supported by the ICD-10 codes
- Communicates in real time with physician
- Prepares organizations for pre-claim review demonstration

Take Away Points

- Partner with the right education sources
- High quality documentation will increase the benefits of the new coding system
- High quality documentation is increasingly being demanded by other initiatives
- High quality documentation and accurate coding are on the door step of home health in an ICD-10 environment

What Questions Do You Have?