Managing the Clinical Documentation Improvement Program (CDIP)

Audio Seminar/ Webinar

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Faculty

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Kyra Brown, RHIA, CCS, is program manager of documentation and coding outcomes with Methodist Medical Center in Oak Ridge, TN, where her responsibilities included developing a CDIP. Ms. Brown has 19 years of HIM experience, including 8 years of coding in a teaching hospital. She also wrote an online course for AHIMA on clinical documentation improvement.

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# Table of Contents

Disclaimer ................................................................................................................... i
Faculty ...................................................................................................................... ii
Seminar Objectives ........................................................................................................ 1
What is an Effective CDI Program? .................................................................................. 1
Thoughts ....................................................................................................................... 2
The Foundation of an Effective CDI Program is Preparation & Planning ....................... 2
CDI Management Methodologies ..................................................................................... 3
Building Trust & Gaining Respect with Medical Staff ......................................................... 3
CDI Management Methodologies ..................................................................................... 4
Common Misconceptions ................................................................................................. 4
Medical Staff Issues ........................................................................................................ 5
Physicians CAN be your friends........................................................................................ 5
Tips on Cultivating Relationships with Physicians ............................................................... 6
Dealing with Physician's Frustrations ................................................................................ 6
Desired Response to a Query .......................................................................................... 7
Receiving “Buy-in” from Physicians ............................................................................... 7
Presentations by the Documentation Specialists ............................................................... 8
Education ................................................................................................................... 8-9
Suggestions of topics for Physician Education ............................................................... 9-10
What to Include When Educating? .................................................................................. 11
Education & Medical Staff ............................................................................................ 11
How to Disseminate Educational Information? ................................................................. 12
CMS IPPS Regulations .............................................................................................. 12-13
Cardiac Diagnoses ......................................................................................................... 13
Respiratory Diagnoses ................................................................................................... 14
Miscellaneous Diagnoses ............................................................................................... 14
Advanced Planning ....................................................................................................... 15
Accessing Data Integrity .............................................................................................. 15-16
Others benefits of use of the APR-DRG Grouper ............................................................... 17
Other Tools/Processes to Access Data Integrity .......................................................... 17-18
Presenting CDI Assessment Results ................................................................................ 18
MMC's Reporting Process ............................................................................................ 19
Physician “Scorecard” ................................................................................................. 19-20
Considerations for CDIP ............................................................................................... 20
Resolution of Differences ............................................................................................. 21
Considerations ............................................................................................................... 21
Types of Queries ........................................................................................................... 22
Managing a day in the life of a Documentation Specialist ............................................. 22-23
Tracking the work of Documentation Specialists (DS) ................................................. 23
Potential Reports for CDIP ........................................................................................... 24
Documentation Specialist Interactions ............................................................................ 25

(CONTINUED)
Table of Contents

Who are Documentation Specialists? ................................................................. 25
Skills that Enable a Documentation Specialist to Perform Well .................... 26
Interactions of the DS and Inpatient Coder ..................................................... 26
Team Building ............................................................................................... 27
Continuation of Query Process ..................................................................... 27
In Summary .................................................................................................... 28
Resource/Reference List ............................................................................... 28

Audio Seminar Discussion and Audio Seminar Information Online ............... 29
Upcoming Audio Seminars ............................................................................ 30
Thank You/Evaluation Form and CE Certificate (Web Address) .................... 30

Appendix .......................................................................................................... 31
   Resource/Reference List ............................................................................ 32
   CE Certificate Instructions
Seminar Objectives

- Illustrate different approaches and solutions for managing effective clinical documentation improvement programs (CDIP)
- Define CDIP management methodologies and tools to assess the data integrity used for coding purposes
- Review effective communication plans to present CDIP assessment results among physicians, coders and other CDIP members

What is an Effective CDI Program?

- Effective CDI programs:
  - Identify and reconcile deficiencies in documentation
  - Provide education to assure that your facility’s coded data captures the acuity of the patient’s condition and reflects the care the patient receives
Thoughts...

- There is not a “one size fits all” process to CDI Management.
  - Small facilities with little resources can have an effective CDI program.
  - A larger facility with a staff of CDI specialists will likely reap the benefits of clinical documentation improvement quicker.
  - The key is to not let circumstances defeat the process before it gets started.

The Foundation of an Effective CDI Program is Preparation & Planning

- Buy-in of:
  - Hospital Administration
  - Chief of Medical Staff
  - HIM Director
  - Outcomes Management
- Determine areas of opportunity for documentation improvement
  - Baseline audit
  - Meet with inpatient coding staff
CDI Management Methodologies

- Hospital Administrators introduction of the CDI program and staff to the Medical Staff:
  - Adds validity to the process
  - Demonstrates an expectation of their support
  - Kicks off the process of gaining trust and respect of the medical staff
  - Physician “Champion(s)” also add validity

Building Trust & Gaining Respect with Medical Staff

- Consistency, Time, Interaction and Professionalism build trust.
  - Lunch & Learn session with a Physician, CDI staff and Coders provides an excellent opportunity for interaction.
    - Send questions and topics to the physician in advance
    - During the session a discussion of why the question is being asked opens the door of communication
CDI Management Methodologies

- Successful CDI programs build bridges of support instead of alienating others or attempting to have the CDI staff function alone
  - Case Managers
  - Nurses
  - Dieticians
  - Wound Care Staff
  - Anesthesiologists
  - Lab
  - Nurse Managers

Common Misconceptions

- HIM professionals assume that:
  - A physician knows or was taught in medical school the definition of Principal Diagnosis (PR-DX)
  - A physician knows that #1 on the Discharge Summary should be the PR-DX
  - Physicians understand the term “after study” as it relates to the PR-DX
Medical Staff Issues

- Define the process for how to deal with uncooperative, unresponsive physicians
- A consistent venue to “educate” the Medical Staff on documentation and coding issues
  - Orientation of all new physicians, NP & PA’s
  - Focus on “Specialty Education”
  - Communicate with and provide education for physician managers and/or office staff

Physicians CAN be your friends...

- Is this a true statement?
- Reasons physicians are necessary to a successful CDIP
  - Can improvement in documentation be made without them?
  - CORE measure outcome assistance
**Tips on Cultivating Relationships with Physicians**

- Identify the “climate” before you approach
- Do not take their attitude or response personally
- Remain Calm
- Never answer a question unless you are positive the answer is correct.
  - It is OK to say: I need to research and I will get back to you.
- Keep it simple, do not spend a lot of time on educating extensively on coding rules

**Dealing with Physician’s Frustrations**

- Physicians choose their career because they want to treat patients and anything that interferes or interrupts the process causes frustration
  - Some physicians have the ability to see the big picture
  - Some cannot get past their own “picture”
  - A few are just not interested
Desired Response to a Query

- Reiterate over and over that the desired response to a query is to provide accurate and complete documentation of the patient’s health history, present illness, and course of treatment.
  - Documentation is not just needed to support reimbursement
    - Example: The hospital’s MEDPAR data is a reflection on the physician as well as the hospital

Receiving “Buy-in” from Physicians

- Is credibility important?
  - How to gain your physicians’ respect?
    - Coding Clinics as helpful illustrations
    - Stick to the facts...
    - Why maintaining facts are important
Presentations by the Documentation Specialists

- Educate Physicians about annual DRG changes
- Educate Physicians about HACs, RACs, and etc...
- Demonstrate how physicians’ documentation assists in creating change with MS-DRG system
  - CCs vs. MCCs

Education

- Use every opportunity to get the most out of your allotted time:
  - Keep it simple
  - Avoid defining what the physicians already know; but define ambiguous Coding terms
    - (Urosepsis, ACS, Sepsis, SIRS)
**Education**

- Have a main topic but incorporate other documentation needs in the presentation
  - Example: Topic: Urosepsis
    - Explain that Urosepsis codes to UTI
    - The presentation should also incorporate the importance of documentation of a UTI related to foley
    - Was it POA or not
    - And it could be a HAC

**Suggestions of topics for Physician Education**

- Criteria for Reporting Additional Diagnoses
  - Point out for reporting purposes only one of the required criteria has to be met
  - Give an example of each of the criteria
  - Use examples that you know are documentation needs for your facility
Suggestions of topics for Physician Education

- Discharge summary content:
  - Define what “history of” means to a coder
  - Chronic diagnosis that are treated during the episode of care should be addressed in the list of diagnoses
  - Define PR-DX

Suggestions of topics for Physician Education

- Discuss diagnoses that are not codeable (based on those identified during auditing)
  - Examples from MMC:
    - MSOF (Multiple system organ failure) each of these independently have value (MCC, SOI, ROM)
    - Perforated Viscus
    - Hypertensive Urgency
    - Abdominal Sepsis
    - Temporal Wasting
What to Include When Educating?

- Examples of MS-DRGS with MCC, CC and without MCC/CC; with the specific monetary affect of each is the best way to demonstrate the importance of documentation improvement. (Acute verses Chronic diastolic or systolic heart failure and CHF are great examples)

- Examples of Severity of Illness (SOI) and Risk of Mortality (ROM) changes related to documentation improvement is very effective and less controversial.

Education & Medical Staff

- Patience is important:
  - Physician Behavior/Change in documentation will not consistently occur overnight
  - When the census is high and physicians are under stress they tend to revert back to previous documentation patterns
  - After education sessions behavior changes but over time some slip back into old documentation patterns
  - Repetition keeps topics fresh in the physicians minds
How to Disseminate Educational Information?

- **MMC’s Physician Communication Team**
  - Effective communication occurs 3 ways. Options:
    - Formal Presentation
    - Fax a one page flyer to the physicians office
    - E-mail
    - Put flyer in their hospital mailbox
    - Post flyer in physician lounge and dictation areas
    - Pocket cards

CMS IPPS Regulations

- A paradigm shift in the identification of a diagnosis as a CC occurred
  - Previous definition of CC was a diagnosis that extended the length of stay by at least one day in 75% of the cases.
  - CMS change “Our intent was to better distinguish cases that are likely to result in increase hospital resource used based on secondary diagnoses. Using a combination of mathematical data and the judgment of our medical officers, we included the condition on the list if it’s presence would lead to substantial increased hospital resources use”. For example:
    - Intensive monitoring - ICU stay
    - Expensive and technically complex services - heart transplant
    - Extensive care requiring a greater number of care givers - nursing care for a quadriplegic

Reference: Page 99 CMS IPPS Regulations for FY 2008
CMS IPPS Regulations

- Physician’s need to be educated on the level of detail as a result of the changes
  - Acute diseases are designated as CC/ MCC if their impact on hospital resource use was comparable to Acute MI, CVA/ Stroke, Pneumonia, Sepsis, Acute Respiratory Failure and Acute Renal Failure
  - Chronic diagnoses without a significant acute manifestation were removed from the list.
    - Example: CKD Stages I thru III, CKD IV, V remain on list
- The following slides are examples used in physician education to depict the level of documentation detail that is needed

Diagnoses that are no longer a CC:
- CHF, Heart Failure, Unspecified
- Angina Pectoris
- Atrial Fibrillation
- Mitral Valve Diseases
- Aortic Valve Diseases
- Trifascicular Block
- Second Degree AV Block
- Bilateral Bundle Branch Block
- Status Heart Valve Transplant (Porcine)

Diagnoses that will be Major CC’s:
- Ventricular Fibrillation**
- Ventricular Flutter
- Cardiac Arrest**
- Heart Failure, Acute or Acute on Chronic Systolic or Diastolic
- Cardiogenic Shock**

Diagnoses that will be a CC:
- Unstable Angina
- Paroxysmal SVT, Paroxysmal VT
- Atrial Flutter
- Heart failure, Left, Chronic or Unspecified Systolic or Diastolic
Respiratory Diagnoses
(Diagnoses with ** are not counted if the Patient expires)

Diagnoses that are no longer a CC:
- COPD, Emphysema
- Chronic Bronchitis
- Interstitial Emphysema
- Post-inflammatory Fibrosis
- Hypoxemia, Apnea

Diagnoses that will be Major CC’s:
- Pneumonia
- Empyema
- Acute Respiratory Failure
- Acute on Chronic RF
- Respiratory Arrest**

Diagnoses that will be a CC:
- COPD, with Acute Exacerbation
- COB, with Acute Exacerbation
- Asthma, with Acute Exacerbation
- Pleural Effusion
- Atelectasis
- Chronic Respiratory Failure
- Aphasia
- Cheyne-Stokes Respirations
- Hemoptysis

Miscellaneous Diagnoses

Diagnoses that are no longer a CC:
- Multiple Sclerosis
- Alcoholic Cirrhosis
- Biliary Cirrhosis
- Systemic Lupus Erythematosus
- Felty's Syndrome
- Stress Fractures
- Carbuncle & Furuncle
- Impetigo
- Post-Laminectomy Syndrome

Diagnoses that will be Major CC’s:
- Encephalopathy
- Quadriplegia
- Decubitus Ulcer (most sites)
- Shock, cardiogenic or septic
- Kwashiorkor, Nutritional Marasmus
- DIC

Diagnoses that will be a CC:
- Anoxic Brain Damage
- Paraplegia, Hemiplegia
- Candidiasis of the Mouth
- Hematemesis
- Blood in Stool
- Cachexia, Malnutrition
**Advanced Planning**

- When the Medicare proposed changes are published in the Spring review, the changes and planning can start immediately especially related to Code changes.
  - Determine what type of documentation will be needed as a result of the changes
  - Who will need to be educated?
  - Develop a plan of action

**Accessing Data Integrity**

- What is Data Integrity?
  - Data that is consistent, accurate and complete.
- Is the sole focus of your CDI program to capture the appropriate MS-DRG?
  - MS-DRG’s are assigned based on at the most two diagnoses (PR-DX + MCC; PR-DX + CC)
    - Will two diagnoses adequately reflect Severity of Illness (SOI) and Risk of Mortality (ROM)?
Accessing Data Integrity

- The APR-DRG software is the tool that has provided MMC the ability to assess our data integrity.
  - All secondary diagnoses have a “value” that is defined based on their relationship to the PR-DX, Pt’s age and sex.

  **Risk of Mortality**
  **Severity of Illness**
  1 Minor
  2 Moderate
  3 Major
  4 Extreme

Accessing Data Integrity

- How many times have you heard a physician say; but my patient’s are sicker than those seen by another physician.
- Corporate Decision Support provides comparison reports for physicians based on APR software and an APR Norm file
**Others Benefits of use of the APR-DRG Grouper**

- MEDPAR/ Medicare data is still based on 9 diagnoses
  - Our top nine diagnoses are the 9 diagnoses that reflect the highest SOI & ROM.
  - Vendors purchase MEDPAR data to “grade” the quality of care our patients receive.
  - With the use of the APR-DRG as a tool for the CDI Process we feel comfortable that our data appropriately reflects the care the patient receives and the acuity of our patients condition.

**Other Tools/ Processes to Access Data Integrity**

- Auditing & Monitoring of:
  - Expired patient’s records
    - Does the documentation reflect in a diagnosis or symptom what is occurring during the dying process of a patient?
  - Challenging areas to focus on
    - Pt’s admitted as a DNR
    - Oncology patient's with multiple mets or those that have refused further treatment
    - Pt’s that are End Stage in their disease process
  - What is the challenge?
    - The mindset of the physician, due to the disease process my patient is sick enough to die
    - My patient is a DNR, the family wants no further treatment
Other Tools/ Processes to Access Data Integrity

- Audit & Monitor:
  1. Overall MCC/ CC Capture Rates
  2. Medical MCC/ CC Capture Rates
  3. Surgical MCC/ CC Capture Rates
  4. Medicare Rates on 1-4
  5. High Volume Service Rates on 1-4
  6. Special Units (ICU, CCU) Rates on 1-4
  7. SOI & ROM 1-7

Presenting CDI Assessment Results

- Presenting the results of the CDI program will depend on many factors:
  - How many FTE’s are involved in the process?
  - Are you understaffed, or have other duties?
  - Do you have a Manager who serves only in that capacity?
  - Do you have administrative staff to help with the gathering of the information to be reported?
  - Do you have a database to support the process and the time to input the data into the database?
  - What reporting is required by the Director of the Program, CFO, CEO and or other stakeholders?
MMC’s Reporting Process

- Historically, an annual summary was reported on an Excel spreadsheet:
  - The written report was distributed to the Director of Quality, HIM, CFO, & CEO;
  - A PowerPoint presentation was used to summarize the data for the Medical Staff and was presented in January;
  - The PowerPoint Presentation was later presented to the Case Managers and the Coding Staff; and
  - Change of the reporting process is occurring for 2009.

Physician “Scorecard”

- During re-appointment process the Physician receives a scorecard type of report which includes:
  - His/ Her Top 5 MS-DRG’s, Number of cases, Average LOS, GMLOS, Number of all other physicians cases for each of the 5 MS-DRGs and the total LOS of those cases;
  - Risk Adjusted Mortality Index for his/ her patients, Expected mortality for his/ her pts verses the actual;
Physician “Scorecard” (cont’d)

- The Case Mix Index for his/her patients; and
- The same type of process is also reviewed at various times throughout the year by the Quality Director and the Chief of the chair to look at physician outliers on key issues.

Considerations for CDIP

- How will the program “track” Documentation Specialist results?
  - Computer program
  - Paper Tracking
- Track number of reviews
  - Track number of queries
    - Calculate “opportunity” gains from queries
Resolution of Differences

- Coding DRG vs. DS-DRG
  - Which DRG takes precedence?
  - Method for discussing differences
- Does the DS have the opportunity to disagree with the coder?
  - Express Opinions about change in DRG from initial (concurrent) DRG to final (after discharge) DRG
    - Constructive and supportive discussion between coder and DS

Considerations

- What type of reviews should be performed?
  - Medicare Only?
  - All payers?
Types of Queries

- **Written vs. Verbal**
  - Which is more effective
  - Pre-discharge vs. Post-discharge queries
    - Differences
      - Concurrent vs. Retrospective
    - Timelines—how quickly should the query be answered?

Managing a day in the life of a Documentation Specialist

- **Work Assignments**
  - Cover different floors each day
  - Review on the same floors routinely
    - Why this is important
    - Get to be a familiar face
Managing a day in the life of a Documentation Specialist (cont’d)

- Determining number of reviews each day
  - New Reviews
  - Current Reviews
  - Follow-up Query reviews

Tracking the work of Documentation Specialists (DS)

- Computer methodologies
  - Auto reports
- Written methodologies
  - Maintaining a paper trail
Potential Reports for CDIP

- Monthly Statistical Reports
  - Number of Medicare Discharges
  - Number of All Payer Discharges
  - Number of Queries
    - Query Rate
    - Query Response Rate
  - CMI (Case Mix Index)
  - Opportunities achieved

Potential Reports for CDIP (cont’d)

- Query reporting
- Awaiting Attestation Reports
- Finalized Reporting
**Documentation Specialist Interactions**

- Physicians
- Nurses
- OT, PT, RT
- Other Documentation Specialists

**Who are Documentation Specialists?**

- RHITs, RHIA, CCSs
- RNs
Skills that Enable a Documentation Specialist to Perform Well

- Coding Skills
- Clinical Knowledge
- Confidence
- Effective Communication Skills

Interactions of the DS and Inpatient Coder

- Meetings to help promote interaction
- Share knowledge
  - Coding information
  - Clinical information
**Team Building**

- Documentation Specialist role
- Inpatient Coding role

**Continuation of Query Process**

- Pre-discharge
- Post-discharge
In Summary…

- Managing a successful CDIP is a multi-faceted proposition;
- Many players;
- Opportunities for reporting impact are available;
- Buy-in from Administration and Physicians help with validity of CDIP; and
- Documentation Specialists need to be familiar and credible source to physicians and mid-levels (ARNPs and PAs).

Resource/Reference List

Managing an Effective Query Process
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_040394.hcsp?dDocName=bok1_040394

AHI MA Distance Education CDI Courses developed by today’s Audio Seminar faculty are available at:
Clinical Documentation Improvement Issues
https://campus.ahima.org/abo/catalog/ims/Products/DisplayProduct.aspx?ProductId=1632&CategoryId=213&CatalogId=2
Clinical Documentation Improvement: Program Success
Audio Seminar Discussion

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Resource/ Reference List

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