AHIMA Distance Education
Career-building Resources

Concepts of Coding CDI Programs

Audio Seminar / Webinar

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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

James S. Kennedy, MD, CCS

Dr. Kennedy is a Director with FTI Healthcare based in Brentwood, TN. Trained as a general internist at the University of Tennessee in Memphis, Dr. Kennedy's experience includes medical private practice along with successful entrepreneurial healthcare-related startups in the public and private sector. His expertise includes physician-hospital leadership, healthcare systems improvement, healthcare documentation, coding, DRG assignment compliance, and government relations. Dr. Kennedy recently completed the AHIMA book, *Severity-Adjusted DRGs: a MS-DRG Primer*. Contact Dr. Kennedy at 615-479-7021 or James.Kennedy@ftihealthcare.com

Katherine (Kitty) Novak, BSN, RN

Ms. Novak a director with FTI Healthcare and lives near Cleveland, OH. She is a Registered Nurse with over25 years of healthcare provider experience. Her expertise as a clinician includes clinical nursing in the acute care setting, unit, departmental management, and nursing administration. She currently specializes in ICD-9-CM coding, DRG validation, documentation management, and compliance issues surrounding Part A Medicare payment. She has leadership responsibility within the CDI practice for internal curriculum development and ongoing maintenance of client programs.

Ms. Novak's primary area of expertise is inpatient clinical documentation improvement. She has assisted over 200 clients to assess and improve both clinical and financial outcomes due to gaps in medical record clinical documentation. She effectively assists clients with implementing change, and monitoring ongoing results. She has extensive knowledge in ICD-9 coding and APR methodology. Prior to joining FTI, Ms. Novak was an Associate Director at Navigant Consulting where she was responsible for development and delivery of Clinical Documentation Improvement consulting services. Prior to Navigant, she was a Project Leader at 3M where she was responsible for clinical documentation improvement engagements that addressed both inpatient documentation and compliance issues, and addressing provider outcomes, hospital and physician profiling. Prior to 3M, she was a Senior Manager within Cap Gemini Ernst & Young, where she held national responsibility for the clinical development, internal education and ensuring compliance to coding rules and guidelines.

Ms. Novak has assisted community hospitals, hospital systems and large academic medical centers in improving demonstrated patient severity and clinical documentation through the development and delivery of a comprehensive educational and concurrent clinical improvement process. She has performed concurrent and retrospective medical record reviews. She delivers didactic training for broad based and strategic learning to nurses, coders, physicians, physician assistants, advanced practice nurses, ancillary department professionals, and physician office staff.

She instructs clinical documentation staff in concurrent clinical review of inpatient records to challenge adequacy of documentation while supporting appropriate DRG coding and clinical severity, and mitigating potential compliance risks. Contact Kitty at 330-321-1219 or katherine.novak@ftihealthcare.com

Table of Contents

Today's Goals

- **Outline the essential makeup of a clinical documentation program**
- **Identify the departments responsible for implementing and maintaining the program**
- **Learn the responsibilities of a documentation specialist and physician advisor**
- **Review strategies to assure effectiveness and sustainability**

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Poll Question

Which statement below best describes the facility that you represent:

***1 Our physicians document using ICD-9-CM terminology well enough that only a retrospective query process is necessary.**

***2 Our doctors never have done well in documenting illness severity, thus we're looking at improving our ICD-9-CM process for the very first time.**

***3 Our facility has had a Clinical Documentation Program in place at one time but it no longer exists. We are considering implementing a new process.**

***4 Our facility has a Clinical Documentation Program that appears to be functioning well.**

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10 Key Components of a Successful CDI Program

1. **Identify Improvement Opportunities**
2. **Establish a CDI Design Team**
3. **Define Your Expectation/Benefits**
4. **Develop your process model and support**
5. **FOCUS**
6. **Resources and Tools**
7. **Clinician Involvement**
8. **Forms Redesign**
9. **Performance Monitoring**
10. **Executive Sponsorship and Accountability**

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Poll Results

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#1 Identify Improvement Opportunities

1. **Conduct a comprehensive coding and DRG quality review to:**
   - **% coding errors**
     - **Sequencing**
     - **CC and MCC identification and capture**
     - **Clinical interpretation**
   - **% clinical documentation**
     - **Non specific or missing diagnoses**
     - **Language issues (e.g. sepsis vs. Urosepsis)**

Can be randomly selected or focused based on ratio of LOS/costs to DRG assigned (e.g. 75-90 percentile) or at-risk DRG (e.g. without CC)

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#1 Identify Improvement Opportunities: Methodology

- **Reporting Metrics**
  - **DRG Error – Error of ICD-9-CM code assignment (commission or omission), sequencing rules, or interpretation of clinical circumstances of admission resulting in DRG assignment error.**
  - **DRG Opportunity – Code assignment and sequencing compliant with ICD-9-CM; however options exist for a compliant but alternate /higher weighted DRG.**
  - **Physician Documentation Opportunity – Clinical documentation opportunity that, if physician queried and documented concurrently, would compliantly support a higher weighted DRG.**

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#1 Identify Improvement Opportunities: Methodology

- **Reporting Metrics**
  - **Physician Documentation Error – Clinical documentation does not support the final diagnosis assigned:**
    - **Example – Patient stated to have pneumonia with normal CXR**
    - **Example – Patient stated to have sepsis without SIRS criteria**
    - **Example – Patient stated to have anemia with a Hct. of 40**
  - **Coding Error – Error in ICD-9-CM code assignment not affecting DRG assignment**

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#1 Identify Improvement Opportunities:

Sample Findings Medicare

Parameter All Payers	#	MS-DRG CMI
Original	24	0.9429
DRG Error (CMI if all records are corrected)	5 (20.8%)	0.9169
DRG Error – RAC Compliance (CMI if only "overcoded" records corrected)	3 (12.5%)	0.9005
DRG Opportunity (CMI if errors and sequencing opportunities addressed)	0	0.9169
MD Documentation Opportunity* (CMI if DRG errors, DRG opportunities and MD documentation opportunities effected)	11 (45.8%)	1.0206
Total CMI and Financial Impact of Coder DRG Opportunity and MD Documentation Opportunity		**0.1201** **$18,102**

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#1 Identify Improvement Opportunities: CMI Projections

Metric	Medicare	Medicaid
RAC Compliance CMI w/o CDI	**0.9005**	**1.0521**
Coding CDI only CMI	**0.9169**	**1.0672**
Coding and Physician CDI CMI	**1.0263**	**1.1136**
? CMI with and without CDI	**0.1258**	**0.0615**
? CMI w/ & w/o CDI – 50%	**0.0629**	**0.0308**
Annual Volume of Affected Payer	**1,752**	**1,506**
Base Rate	**$6,280.29**	**$6,044.67**
Expected Revenue from 50% CDI effort	**$692,092**	**$280,380**
Optimal Revenue from 100% CDI effort	**$1,384,414**	**$560,760**

Representative sampling of medical records can be extrapolated to help identify potential benefit
Expect about 40-60% results in the first year

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#1 Identify Improvement Opportunities:

Medical Staff Core Issues

- **History and physical examinations, progress notes, and discharge summaries are "cut and pasted" from their office notes and do not necessarily represent the patient's current conditions.**
  - **Inadequate or incorrect review of systems.**
    - **Patient in atrial fibrillation described as having a regular rate and rhythm.**
  - **Progress notes do not demonstrate an orderly progression of the patient's workup.**
    - **Same nonspecific diagnosis used throughout the admission.**

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#1 Identify Improvement Opportunities:

Medical Staff Core Issues

- **XYZ-MC's order sets do not emphasize documentation of physician diagnoses in official ICD-9-CM language.**
  - **Sepsis vs. Urosepsis**
  - **Atypical or "noncardiac" chest pain.**
  - **"Community-Acquired Pneumonia"**
- **Physicians do not know the language that affects hospital or physician-based "Pay-for-Performance"**
  - **Present on Admission**
  - **Severity and Risk Adjustment**

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#1 Identify Improvement Opportunities:

Physician Language Differences

Table 1. Clinical Definition of Sepsis.

Type	Characteristics
Moderate sepsis	Body temperature >38°C or <36°C
	Heart rate >90 beats/min
	Respiratory rate >20 breaths/min or partial pressure of arterial CO_2 <32 mm Hg
	White-cell count >12,000/mm³, or >10 percent immature band forms
	Evidence of infection
Severe sepsis	Sepsis-associated lactic acidosis, oliguria, or acute alteration of mental status
Septic shock	Sepsis-induced hypotension (i.e., systolic blood pressure <90 mm Hg) despite adequate fluid resuscitation. Patients treated with vasopressors or inotropic medications may not be hypotensive at the time of measurement.

Many physicians do not know the diagnostic criteria for sepsis. They use the term "urosepsis" or just document the underlying infection.

New England Journal of Medicine: 351: 159-169, July 8, 2004

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#1 Identify Improvement Opportunities

2. **Review your DRG statistics**
   - **Historical Case Mix Index**
   - **DRG Statistics**
   - **PEPPER Reports**

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#1 Identify Improvement Opportunities: MS-DRG Statistics

- **CMI Statistics**
  - **Total CMI**
  - **Total CMI w/o Pre-MDC**
  - **Medicine CMI w/o OB-Peds**
  - **Medicine CMI w/o OB-Peds, IP Psychiatry, Ventilators, and Rehabilitation**
  - **Surgery CMI w/o OB-Peds**
  - **Surgery CMI w/o OB-Peds, and Pre-MDC**
  - **OB-Neonatal CMI**
- **Medicine RW analysis – compared to all Medicine DRG**
  - **Medicine DRG w/RW > 0.9**
  - **Medicine DRG w/RW > 0.6 but < 0.9**
  - **Medicine DRG w/RW < 0.6**
- **Total CC/MCC Capture Rate**
  - **Total**
  - **Medicine Cases**
  - **Surgery Cases**
- **Service Line CC/MCC Capture Rates**
  - **CV Surgery MCC**
  - **Orthopedics CC/MCC**
  - **Neurosurgical CC/MCC**
  - **Urological CC/MCC**
  - **OB-Neonatal CC/MCC**
    - **Important if private insurance pays on MS-DRG basis**

Metrics in red worth following on a monthly basis

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#1 Identify Improvement Opportunities: CC & MCC Capture

- **CC Capture Rate**
  - **Numerator:**
    - **DRGs with CCs**
    - **DRGs whereby CCs and MCCs equally affect the DRG**
  - **Denominator**
    - **DRGs without CC/MCC whereby a CC can change the DRG**
    - **DRGs without MCC excluded since a CC does not change the DRG**
- **MCC Capture Rate**
  - **Numerator**
    - **DRGs with MCCs**
    - **DRGs whereby CCs and MCCs equally affect the DRG are excluded.**
  - **Denominator**
    - **DRGs without MCC**
    - **DRGs without CC/MCC where a MCC changes the DRG to a higher relative weight than a CC**
    - **DRGs w/o CC/MCC where CC or MCC have equal effect in changing it are excluded**

These metrics show the ability to capture CCs or MCCs and demonstrate the effectiveness of the CDI process

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#1 Identify Improvement Opportunities: Other DRG Metrics

- **Complex to Simple Pneumonia**
- **Pneumonia to COPD**
- **Acute Respiratory Failure to COPD/CHF**
- **COPD to Asthma**
- **Sepsis to UTI/Pneumonia**
- **Stroke to TIA**
- **Pathological Fracture to Medical Back**
- **MI with CC/MCC to MI without CC**
- **Cardiac Cath with MCC to Cardiac Cath w/o**
- **DVT with CC to DVT w/o CC**
- **GI bleed with CC to GI bleed without CC**

Example: Complex to Simple Pneumonia Ratio

$$\frac{\text{Volume of 177, 178, 179}}{\text{Volume of 177, 178, 179, 193, 194, 195}}$$

National Medicare volumes available at:
http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FY2008Table7A.zip

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#1 Identify Improvement Opportunities:

CC Capture in UGI Hemorrhage

MS-DRG Medicare Statistics UGI Hemorrhage		
377	UGI Hem w/MCC	19.2%
378	UGI Hem w/CC	44.8%
379	UGI Hem w/o CC	36.0%

285.1 – Acute Blood Loss Anemia is a CC

Most patients admitted with an Upper GI bleed have acute blood loss anemia

An obvious query opportunity

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#1 Identify Improvement Opportunities:

PEPPER Reports

- **Stroke**
- **Complex Pneumonia**
- **Medical Back**
- **Sepsis**
- **CC Capture Rate**
- **One day stays**
  - **Chest pain**
  - **GI disorders**
- **Three day stays with transfer to SNF**
- **Readmission within 7 days**

PEPPER reports benchmark each hospital's data to statewide data, providing another tool to determine focus areas

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#1 Identify Improvement Opportunities

3. **Review and analyze Severity Adjusted Comparative Reports**
   - **DRG assignment impacts quality and efficiency reporting**
   - **Further identify/support DRG focus areas**
   - **Use to educate the medical staff: "What's in it for me?"**

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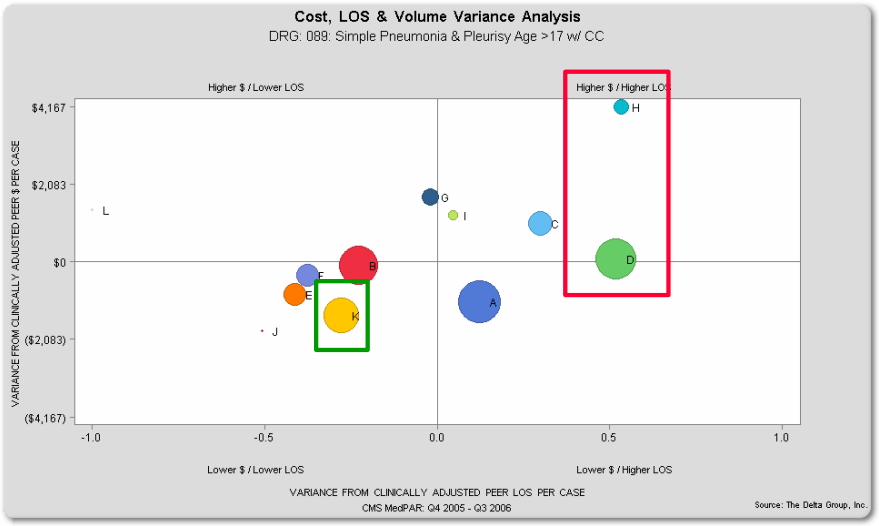
#1 Identify Improvement Opportunities:

DRG 89 - Simple Pneumonia Analysis



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Source: The Delta Group, Greenville, SC – 800-711-8363 - MedPAR 2006

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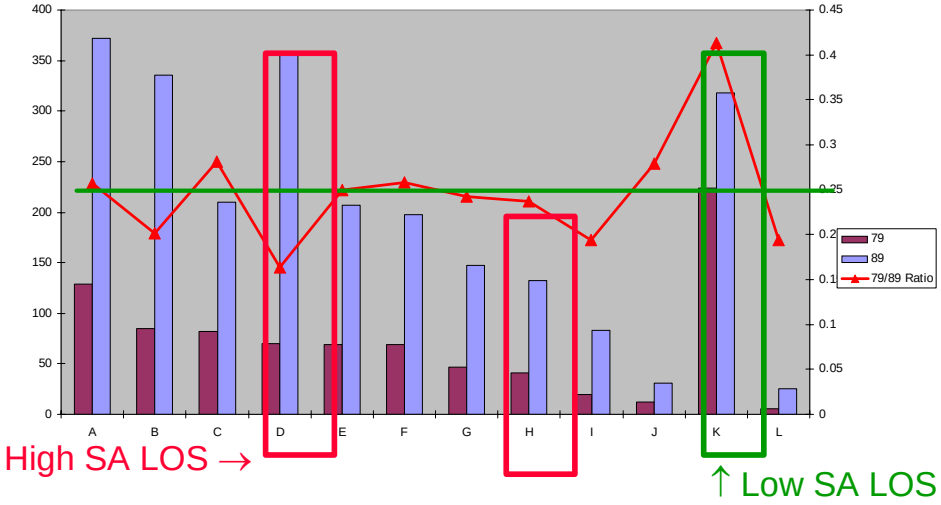
#1 Identify Improvement Opportunities:

Correlate LOS/Cost with DRG 79/89 Ratio



Source: The Delta Group, Greenville, SC – 800-711-8363 MedPAR 2006

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#1 Identify Improvement Opportunities

4. **Analyze and trend retrospective physician queries**
   - **Query trends: urosepsis, anemia due to blood loss**
   - **MD trends: Specific MDs, service lines**

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#1 Identify Improvement Opportunities

5. **Utilize the data to establish:**
   - **Your focus areas**
   - **Baseline statistics for which to compare, at 90 days, 180 days, one year post-implementation**
     - **DRG Audit Results**
     - **DRG Statistics**
     - **Coder Query Volumes**

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#1 Identify Improvement Opportunities:

Typical Focus Areas

- **DRGs without CC/MCC**
  - **Usually in patients over 55 years of age.**
- **DRGs with relative weight < 0.6**
- **DRGs prone to under documentation:**
  - **Sepsis due to infection vs. the infection alone**
  - **Acute respiratory failure vs. acute systolic or diastolic heart failure or exacerbation of COPD**
  - **Pathological fracture vs. fracture NOS**
  - **Fever of Undetermined Origin (FUO)**

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#1 Identify Improvement Opportunities:

Typical Focus Areas

- Stroke vs. cerebral embolus vs. transient ischemic attack
- Acute Renal Failure vs. Dehydration
- Chest Pain
- Symptom code as principal
- Expiring or Expired:
  - Patients on the AHRQ inpatient quality indicator list
    - Available at: http://qualityindicators.ahrq.gov/iqi_overview.htm
  - Patients on the AHRQ Patient Safety Indicator – 2 – Mortality in low risk DRGs
    - http://qualityindicators.ahrq.gov/downloads/psi/psi_technical_specs_v31.pdf - Pages 5 and 6 of the PDF

For expiring patients, assure that they were assigned to the correct DRG (e.g. some pneumonia patients have sepsis) and/or have an APR-DRG Risk of Mortality of 3 or 4

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#2 Establish CDI Design Team

- Must be an organizational initiative, not just a departmental initiative
  - Establish executive leadership involvement, buy-in, and advocacy from the start
  - Medical staff, compliance, HIM, case management, and quality are all involved
- Important to assign responsibility and accountability for CDI Program
  - Who's willing to take the lead and answer the tough questions?

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#2 Establish CDI Design Team

Core Team Members:

- **HIM Director or Coding Manager**
- **Case Management Director**
- **Nursing leadership**
  - **Consider adding Quality to this**
- **Physician Advisor (PA)**
  - **If you do not have a PA for HIM; possibly look to share with Case Management**
- **IT Director**
- **Finance**
  - **Consider adding Compliance Officer**

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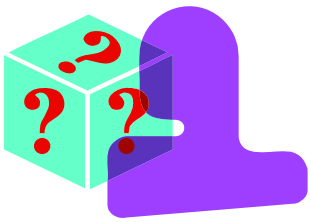
#2 Establish CDI Design Team

Key Questions for this team:



- **What are the expected roles of the CDI design team members?**
- **What do we expect to achieve with a CDI process? What is our ultimate goal?**
- **What model do we want to deploy? Dedicated vs. integrated?**
- **What will be the roles and responsibilities of the documentation specialist?**
- **What role /responsibilities will be expected of the patient care team (case management, nursing, etc.) in the CDI process?**

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#2 Establish CDI Design Team

Key Questions for this team:

- How will we address team (coder/CDS) quality/performance issues?
- How often should we have external coding quality audits?
- How many people do we need based on our improvement opportunities/payer mix
- What are the key CMI metrics we want to track to measure the performance of the program?
- What are the key performance metrics to track and measure the CDS performance/productivity?
- Who will be responsible for generating / analyzing the monthly reports?

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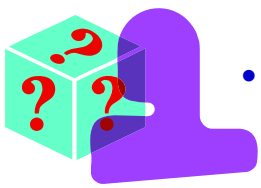
#2 Establish CDI Design Team

Key Questions for this team:

- What will be the executive oversight committee that will recognize CDI successes and address barriers?
- What is our communication education plan? Who do we want to train? Who will do the training?
- Who will address medical staff CDI related issues? Who will be our physician advisor?



- Who will lead improvement opportunities that are physician driven? (ex. Physician order sets, physician response to prompts/queries)

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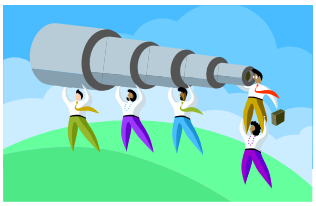
#3 Define Your Expectations/Benefits

- Improve accuracy of final DRG assignment;
- Accurately reflect the severity of illness of the patient population;
- Accurate report cards;
- Reduce compliance exposure;
- Reduce coding turnaround time;
- Decrease post-discharge queries to the physicians



Be sure your focus and processes are in line with your goals!

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#3 Define Your Expectations/Benefits

- CDI does have upfront costs
  - Additional FTEs for concurrent review
    - HR will need to post these positions
  - Physician Advisor
    - Independent contract with physician – usually an hourly rate
  - Support materials
    - Additional encoder licenses, laptop computers, physician prompts
  - External support
    - Can we do it alone or with an outside consultant?
- ROI: CDI programs usually have a 5:1 return on investment.

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#4 Develop your Process Model Physician Advisor

- Critical to long term CDI success/sustainability
- Well respected physician willing and available to negotiate the differences in language
  - Initial time requirement of 5-10 hours a week to start.
  - Will likely require payment for time away from the office.
- Serves as intermediary between medical staff and CDI team. Advocate concurrent and retrospective query
- Willing to learn DRG basics (1° and 2° diagnosis, non CC vs. CC vs. MCC) and help medical staff define terms; e.g. sepsis vs. urosepsis, acute renal insufficiency vs. failure, systolic vs. diastolic heart failure

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Poll Question

Does your facility have a physician advisor to HIM?

*1 Yes, he or she works with us to understand MS-DRGs and advocate us with the medical staff

*2 Case Management has a physician advisor, but we do not utilize him or her for our purposes.

*3 We're doing so well that we don't need a physician advisor

*4 We don't have one but wish that we did.

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#4 Develop Your Process Model Clinical Documentation Specialist

Who is best suited?

- **Coding Specialist**
- **Case Manager**
- **RN/LPN**
- **Other – Social Worker, Respiratory Therapist?**

HIM Professionals are uniquely qualified to serve in the role of clinical documentation, given their years of experience with DRGs and retrospective audits.

A hybrid of coding and nursing is ideal

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#4 Develop Your Process Model Clinical Documentation Specialist

Core Competencies:

1. **Exhibits a thorough knowledge of ICD-9-CM official coding guidelines, clinical documentation requirements, Medicare Severity (MS) DRG reimbursement methodology, and the clinical conditions and treatment needs of the adult patient population.**
2. **Excellent communication skills: Educates members of the patient care team regarding documentation guidelines, including physicians, allied health practitioners, nursing and case management.**

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#4 Develop Your Process Model Dedicated vs. Shared

- **Dedicated Model**
  - Dedicated documentation specialist ensure priority is to improve clinical documentation
  - Primary Responsibility:
    - Facilitates and obtains appropriate and complete physician documentation within the medical record for any clinical conditions and treatment to support the appropriate severity of illness of the patient prior to patient discharge.
- **Shared Model**
  - Shares CDI with other duties, such as inpatient coding or case management
    - Other responsibilities tend to interfere with CDI activities
    - Probably the best for hospitals with less than 100 beds or in manpower shortage areas.

Decide which one works best; don't be afraid to declare if the chosen model is not working.

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Poll Results

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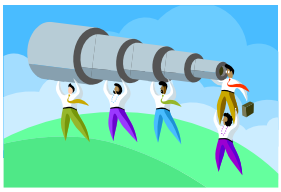
#5 FOCUS

- Define population to be reviewed
  - 80/20 Rule – cannot change everything overnight
  - Try not to address too many things at once
  - # of CDS will be dependent upon this
- Define your hi-risk patient population and focus areas: Medicare, service lines, non-MCC-CC DRGs
  - Base on data!!
  - Be specific to track progress
- Update focus areas frequently



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#5 FOCUS

For Example:

- Phase I – Medicare Population
  - 10 Focus and non-MCC/CC DRGs
  - Expand as the data shows
- Phase II – Other DRG Payers
- Phase III – APR-DRG Impact

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#6 Resources and Tools

1. **Encoder/Grouper**
   - **To provide easy access to most current coding rules and guidelines**
   - **To automatically calculate DRG rather than manual calculation**
     - **Will be necessary for APR-DRGs!**
       Cannot group manually
       May be possible to save CDS diagnoses /MCC/CC codes and working DRG within abstracting for coder review

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#6 Resources and Tools

2. **Utilize your EHR to screen all new admissions in defined pt population:**
   (*Access to in-house chart is often difficult!)*
   - **Assign working DRG**
   - **Follow only those cases:**
     - **Focus DRG List**
     - **Principal diagnosis unclear**
     - **No MCC /CC**
   - **Use EHR to obtain follow-up data reviews whenever possible**

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#6 Resources and Tools

3. Create or purchase standardized documentation prompts

PLEASE DOCUMENT IN YOUR HISTORY AND PHYSICAL, PROGRESS NOTES, AND/OR DISCHARGE SUMMARY IF YOU AGREE.

Dear Dr. _____ Date _____

Your patient appears to have the ACUTE RESPIRATORY FAILURE, manifested by at least two of the following three criteria:

- ☐ **Acute Respiratory Distress** (RR>35, accessory muscle use),
- ☐ **pCO_2 > 50,** usually with acute resp. acidemia (pH < 7.35)
- ☐ **"Significant Hypoxemia"** - SpO_2 < 88%, PaO_2 <60 mg on RA; PaO_2:FI_{O2} ratio < 250 on >50% FiO_2; PaO_2 < 68 on >40% FiO_2, or decreased PaO_2 of 10-15 mm Hg from baseline

requiring close patient monitoring and evaluation, aggressive management usually requiring placement of the patient in a monitored bed, aggressive respiratory therapy, AND/OR mechanical ventilation. (absence of mechanical ventilation does not preclude diagnosis of respiratory failure).

Please document in your H&P, progress notes AND discharge summary if this patient has ACUTE RESPIRATORY FAILURE, whether it was PRESENT ON ADMISSION, its probable underlying cause(s), and all of its complications. Thank you.

Contact: _____ @ _____ if needed.

References: Confalonieri, M, et. al. Acute Respiratory Failure in Community Acquired Pneumonia. Am. J. Resp. Critical Care Med., 160(5), Nov. 1999, p. 1581-1589; Coding Clinic, 3rd Quarter, 1988, p. 7; Coding Clinic, 2nd Quarter, 1990, pp. 19-20.

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To order: 615-223-6971

ACUTE RESPIRATORY FAILURE

PHYSICIAN ALERT

Please respond in progress notes & discharge summary

Unlike post-discharge queries, these are not part of the permanent medical record

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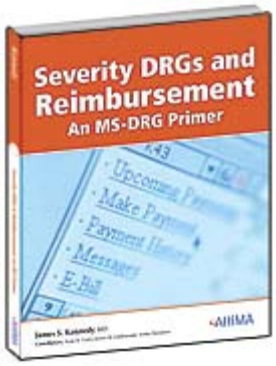
#7 Clinician Involvement

- **Patient Care Staff Education**
  - **Physician Assistants, Nurse Practitioners, Nursing, Case Management**
    - **Can provide specific clinical descriptions /information that will help identify potential documentation opportunities**



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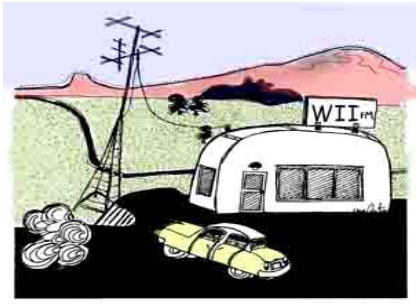
#7 Clinician Involvement

- **Physician Education**
  - **Targeted audiences:**
    - **Medical Executive Council / Department Chairs**
    - **Hospitalists**
    - **Internal Medicine**
    - **Surgery/Anesthesia**
  - **Goals**
    - **"WII-FM" - What's in it for me?**
    - **Include hospital-specific DRG examples of impact of clinical documentation**
    - **Alert the medical staff of the new process and the role of the Documentation Specialist**



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#7 Clinician Involvement

CPT CODE	History	Physical	Med. Dec.	Code	Medicare
99221 99218 99234	Detailed /Comp	Detailed /Comp	SF/LC	99218	$76.59
				99221	$77.74
99222 99219 99235	Comp	Comp	MC	99219	$127.28
				99222	$128.24
99223 99220 99236	Comp	Comp	HC	99220	$179.00
				99223	$178.32

Need 3 out of 3 to qualify

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May 2007, "MedPAC has been conducting research using episode grouping tools for the past two years and has found that they may be a promising tool for measuring resource use among physicians."

Source: MedPAC report to Congress, May 2007

Efficiency = Cost / Severity of Illness

amednews.com
THE NEWSPAPER FOR AMERICA'S PHYSICIANS

GOVERNMENT & MEDICINE

MedPAC starts testing doctor efficiency

The AMA says efficiency measures must be appropriately risk-adjusted before sharing results with physicians becomes useful.

By David Glendinning, *AMNews* staff. July 17, 2006.

Washington -- The panel that advises Congress on Medicare has taken the first steps toward comparing physicians based on how many program resources they use, with the hope that officials some day can identify more-efficient and less-efficient doctors.

In its June report, the Medicare Payment Advisory Commission analyzed 5% of Medicare claims in 13 major metropolitan areas to see how much the program spent on physician services and other medical care for certain types of conditions. MedPAC used commercially available software to organize results into groups based on each episode of care, or single full course of treatment.

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Another item in AMA News

Physician Profiling

http://www.phc4.org

http://www.nj.gov/health/healthcarequality/cardiacsurgery.shtml

http://www.calhospitalcompare.org

http://www.checkbook.org

amednews.com
THE NEWSPAPER FOR AMERICA'S PHYSICIANS

GOVERNMENT & MEDICINE

Group getting Medicare claims data

The consumer nonprofit will compile reports to help patients choose high-quality doctors. Physicians worry about privacy.

By David Glendinning, *AMNews* staff. Sept. 17, 2007.

Washington -- Physicians practicing in four states and Washington, D.C., could start seeing some of their Medicare claims data posted online after a consumer group successfully sued the government for the information.

The U.S. District Court for the District of Columbia ruled Aug. 22 that Health and Human Services must release Medicare physician claims data for the District of Columbia, Illinois, Maryland, Virginia and Washington state to Consumers' Checkbook/Center for the Study of Services. The nonprofit group had sued HHS after the department rejected its initial Freedom of Information Act request.

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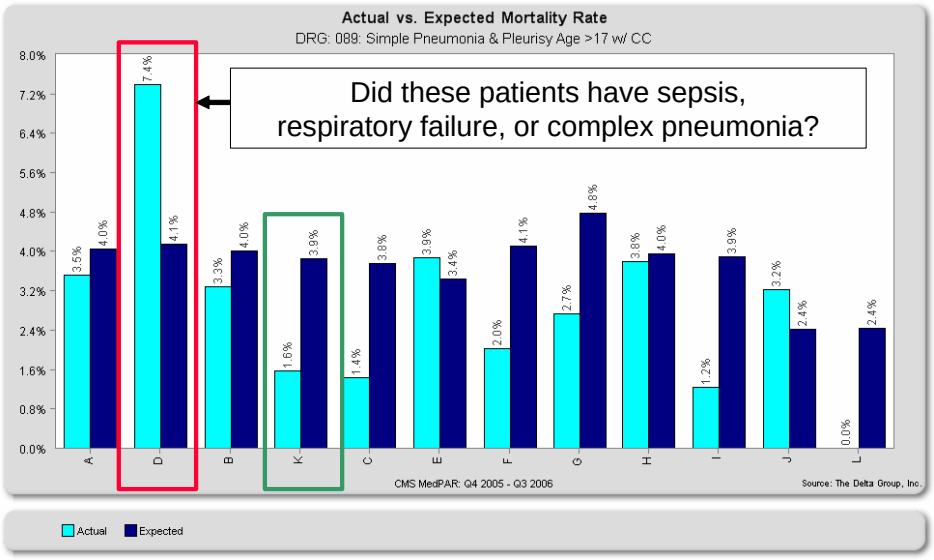
Mortality Tables - "Simple Pneumonia" Were the patients in the wrong bucket?



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#7 Clinician Involvement Altered Mental Status: MUSIC Algorithm

- **M-Manifestation – What type of Altered Mental Status?**
  - **Acute Delirium, Dementia, Stupor, Coma, Mania, Confusion, Psychosis (CC) , Hallucinations (CC) , Delusions (CC)**
- **U – Underlying Cause**
  - **Encephalopathy (MCC) – Toxic, Septic, Metabolic;**
  - **Neurodegenerative Disorders – describe behavioral changes**
    - **Alzheimer's**
    - **Lewy-Body Dementia (associated with Parkinson's Disease);**
  - **Multi-infarct Dementia (CC)**
    - **Alternative: Late effect of stroke**
  - **Bipolar Disorder (CC)**
  - **Schizophrenia (CC)**
  - **Drug withdrawal (CC)**
  - **Seizure – Concussion – Stroke – TIA**
- **S – Severity**
  - **Similar to manifestations. Encourage physicians to use the highest specificity in describing severity**
- **I – Instigating Cause**
  - **Hyponatremia (CC)**
  - **UTI (CC)**
- **C – Complications**
  - **Pathological Fracture (CC)**

Consider developing an order set for this condition!

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#7 Clinician Involvement Heart Failure: MUSIC Algorithm

- **M-Manifestation - Is it heart failure?**
  - Systolic vs. Diastolic vs. both
- **U-Underlying Cause**
  - Congestive Cardiomyopathy **– Pericardial Disease – COPD – Cor Pulmonale – Right ventricular infarct**
- **S-Severity –**
  - Acute vs. Chronic
  - **Decompensated doesn't Count**
- **I-Instigating Cause–**
  - **Noncompliance, ?MI?, ?PE?**
- **C-Complication(s)**
  - Acute Respiratory Failure
  - Nonsustained Ventricular Tachycardia

CHF alone or "Acute CHF" are no longer CCs

EF% do not code to heart failure

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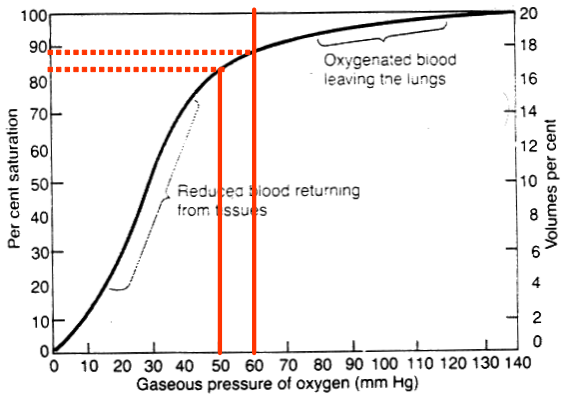
#7 Clinician Involvement Acute Respiratory Failure

Two out of three

- **Hypoxemia**
  - **Classical definition: pO_2 < 60 mm Hg**
  - **Needs to be "significant" hypoxemia"**
- **Hypercapnia**
  - **Defined as pCO_2 >50**
  - **pH usually < 7.35**
- **Respiratory Distress**



pO_2 < 60 corresponds to O_2 Sat < 88%

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#8 Forms Redesign

Redesign physician order sets and other physician documentation forms to support accurate and complete clinical documentation

Keep it simple and make it easy for the physicians to answer concurrent queries and document appropriately in the medical record!

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ORDER SETS

ORDERS AND DOCUMENTATION ALL ON ONE PAGE

DATE/ TIME

PNEUMONIA ACQUIRED IN THE COMMUNITY ORDERS

(ORDERS DESIGNATED BY ☐ THAT ARE NOT CHECKED WILL NOT BE PROCESSED)

Please document the organisms found as the result of diagnostic workup and/or for which therapy is focused.

1. Admit to: ☐ Inpatient Unit; ☐ Observation Unit ☐ Telemetry ☐ Step-down ☐ ICU
   Attending MD: _____
   Notify Above MD of Rm. # and for further orders
2. Condition: Guarded
3. Diet: _____
4. VS on Admit, q2H x 2, then q4H x 1 day, then qid
5. Activity: Ambulate ad lib; Up in chair tid
6. Measure O_2 sat; document in note to the right; Follow O_2 protocol
7. Assess and educate regarding tobacco cessation.
8. IV: ☐ Heplock ☐ ½ NS ☐ NS @ _____cc/hour
9. STAT EKG, CXR PA & Lat, CBC/Diff; Platelet Ct.; PT/aPTT/CMP if not done in the ER.
10. Repeat CBC/Diff every other day for total of 4 days
11. Draw extra tube of serum and hold for one month.
12. STAT Blood culture 5 min. apart x 2, different sites; Must be done within 1-2 hours of admit
13. Ask Resp. therapy to obtain sputum specimen per protocol ASAP. Send for STAT Gram Stain, C&S.
14. Other diagnostic tests (esp. for ICU admissions)
    ☐ Urinary antigen for Pneumococcus
    ☐ Urinary antigen for Legionella Pneumonia
    ☐ Nasopharyngeal ☐ Oropharyngeal Swab for
    ☐ PCR for _____
15. CXR PA & LAT w/ R & L Lateral Decubitus in AM "R/O pleural effusion, change in pneumonia"
16. STAT EKG PRN Chest Pain/SBP <90/ ⇑ dyspnea;
17. STAT ABG PRN ⇑ Dyspnea; Notify MD
18. Social Work Consult to arrange OP antibiotic Rx, home health, and DC Planning.
19. Vaccinations on D/C: ☐ Pneumococcal 0.5 cc IM ☐ Influenza 0.5 cc IM
20. Antibiotic Orders – First dose(s) to be given STAT after the blood cultures are obtained; OK to give if respiratory therapy is not able to obtain a sputum
    ☐ Levaquin® or Tequin® _____ mg IV only qd.
    ☐ Rocephin® _____ grams qd IV with
    ☐ Doxycycline _____ mg IV q 12 hr. or
    ☐ Zithromax® _____ mg qd. IV
    ☐ _____ IV q _____ hour
21. Pharmacy consult for IV to PO conversion at 36

RESULTS OF ER/OUTPATIENT EVALUATION

Circle factors found that determine medical necessity

Unable to take oral meds — Hypoxemia
Unstable living conditions at home — CV Instability
Nursing Home Resident — Confusion
Underlying Neoplastic Dz — Underlying liver dz
Underlying Heart Failure — Underlying Renal Dz
Underlying Cerebrovascular Dz

Other active coexisting Condition that requires hospitalization.

Temp: _____; BP _____; Pulse _____; RR _____

CXR: _____

Hct: ____ WBC _____ Diff:_____% Segs _____%Bands

O_2 Saturation on Room Air: _____%

ABG: pH _____ pCO_2 _____ pO_2 _____ FiO_2 _____

Labs: Na: _____ BUN: _____ Glucose: _____

☐ Drug Allergies: _____

DIAGNOSES REQUIRING PATIENT ADMISSION

☐ Pneumonia, likely due to: _____
☐ Probably Septicemia, likely due to: _____
☐ Sepsis (SIRS* as the result of infection)
☐ Severe Sepsis (Sepsis + organ dysfunction)
☐ Organ disease found: _____
☐ Respiratory Failure** ☐ Acute ☐ Chronic
☐ Dehydration

Other Diagnoses requiring evaluation or treatment:

Plan: Determine the etiology of the pneumonia and implement therapy focused upon this etiology. Assess for complications of pneumonia such as respiratory failure, empyema, or sepsis syndrome.

_____
Admitting or Emergency Room Physician

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#8 Forms Redesign: Progress Notes

Vanderbilt University Medical Center
General Surgery Progress Note

Improving documentation of patient acuity level using a progress note template **Grogan EL, et. al, *Journal of the American College of Surgeons*- 2004 9 (Vol. 199, Issue 10727515)**

Date:_____Time:_____Hospital Day:____POD#:_____Procedure:_____
Comments/Events/Procedures in the last 24 hours:
_____
_____
S:_____
O: VS: Tmax: ____ TC: ____ BP: _____ HR: ____ RR: ____ Sp02: ____
I/O: _____/_____Per Shift:_____Drains: _____Other: _____
Diet:_____ Blood Glucose:_____
PE:
General:_____Neuro: _____
HEENT:_____Resp/CV: _____
Abd/Incision(s)/Wound(s):_____
Extremities: _____
Labs: Studies: _____

Problems/Diagnoses (based upon diagnostics ordered and/or medications/treatments given):

❑ Acute Blood Loss Anemia	❑ Hyperkalemia	❑ Leukocytosis	❑ Respiratory Failure
❑ Atelectasis	❑ Hypocalcemia	❑ Malnutrition Prot/Cal	❑ Septic Shock
❑ Atrial Fibrillation	❑ Hypokalemia	❑ Metabolic acidosis	❑ SIRS due to trauma/burn/pancreatitis
❑ Angina Pectoris	❑ Hyponatremia	❑ Metabolic alkalosis	❑ Subst. Abuse/Dependence
❑ Cardiogenic Shock	❑ Hypophosphatemia	❑ Morbid Obesity	❑ Tachycardia due to:
❑ CHF	❑ Hypovolemia	❑ Pneumonia-prob gram negative	❑ UTI
❑ COPD	❑ Metabolic Encephalop.	❑ Post-Op Fever	❑ Urinary Retention
❑ Diabetes, uncontrolled	❑ HTN-accelerated	❑ Renal Failure	❑ Ulcerations, Peptic
❑ DVT	❑ Alcohol Abuse	❑ PE	❑ Wound Dehiscence
❑ ETOH Withdrawal	❑ Ileus	❑ Renal Insufficiency	❑ Wound Infection
❑ Gram-neg Sepsis	❑ Infection of Vasc. Cath	❑ Respiratory acidosis	❑ Non Q wave MI (↑ Troponins)
❑ Gram-pos Sepsis		❑ Respiratory alkalosis	❑ _____

Assessment/Plan (Must include a treatment plan for each diagnoses checked):

Note the "comorbidities" that are requested on each day's progress note; would require "buy-in" by surgery department

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#8 Forms Redesign: Ancillaries Wound Care, Dietary, and others

BMI ASSESSMENT: BMI<19:___ BMI>40:___
RD:_____DATE/TIME:_____

MALNUTRITION ASSESSMENT
Kwashiorkor
_ Albumin <3.0 gm/dl
_ Weight maintained > 90% IBW
_ Transferrin <180 m/dL
_ Peripheral edema
Nutritional Marasmus
_ <80% UBW and/or significant weight loss of >10% last 6
_ Albumin >3.0 g/dl
_ Poor intake X 3 days with <50% meal consumed or Braden
Severe Protein-Calorie Malnutrition
_ <60% IBW and/or significant weight loss (10% of usual w
_ Albumin <3.0
_ Poor intake X 3 days with <50% meal consumed or Braden
Moderate Malnutrition
_ 60% TO 75% of IBW
_ Albumin 3.0 - 3.5 g/dl
Mild Malnutrition
_ 75% - 90%IBW
_ Albumin 3.5 - 5.0 g/dl
Unspecified Protein-Calorie Malnutrition (labs/anthropomet
unavailable; one or more of the following met)
_ Prolonged period (>7 days) NPO/Clear Liquid diet AND
_ Decreasing weight AND
_ Significant stress factor: i.e. surgery, injury, trauma
RD Signature:_____ Date/Time:___
(Detail assessment submitted in Nutrition Note dated:
__ I have read and concur with this assessment.

__ I have read and concur with this assessment EXCEPT fo

Physician Signature:_____ Date/Time:_

- **Ancillary clinical personnel can make preliminary assessments and describe the clinical picture**
- **Physician signature validates or changes this assessment. Upon his signature, this becomes codeable.**

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#9 Performance Monitoring

Ongoing performance tracking and monitoring is critical to the ongoing success and sustainability of your CDI process:

- **Measure the success of the CDI Program**
- **Identify barriers**
- **Measure CDS productivity and performance**
- **Compares pre CDI to post CDI training**
- **Identify trends and opportunities**
- **Identify specific areas of case mix fluctuations**

Remember to retool focus areas based on data!

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#9 Performance Monitoring Case Mix Dashboard

Dashboard Indicator	NATL AVG	1ST QTR 2006	2ND QTR 2006
Case Mix Index - Medicare		1.5209	1.4829
Case Mix Index - All Payors		1.1244	1.1129
Total Discharges		501	508
Average LOS		6.2	5.8
% All Discharges = Surgical DRGs		23%	18%
Focused Areas			
% DRGs with Wt. < 1.000		35%	40%
DRGs with CC %	40%	35%	42%
DRGs with MCC %	25%	15%	22%
Focused DRGs:			
DRG 61-62-63 vs. 69 - Stroke vs. TIA	55%	76%	80%
DRG 177-179 vs. 193-195 (Pneumonia)	24%	29%	30%
DRG 871-872 vs. 689-690 - Sepsis vs. UT	52%	56%	67%

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#9 Performance Monitoring CDS Productivity & Impact Report

Performance Indicator	CDI Benchmarks	#1	#2
Total # Discharges for Assigned Units		220	200
Total # Reviews	95%	100	120
Total # Cases with a physician query		90	70
% physician query's	30%-40%	47%	37%
% Focused Cases with Prompts		50%	32%
% Query's agree	90%	90%	60%
% Query's disagree	5%	5%	35%
% Queries unanswered	5% or <	5%	5%
% Final DRG Agreement	75%-80%	90%	75%
% Cases with Coder Query		10%	20%

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#10 Executive Sponsorship and Accountability

1. **Identify/Confirm Executive Sponsor**
   - **Confirm and communicate leadership expectations and goals for your program**
2. **Identify Executive Oversight/Steering Committee (Oversight by a multi-disciplinary group of individuals could easily be a pre-existing committee: UM, Revenue Cycle, PI)**
3. **Identify and define the KEY CMI metrics that will be measured and reported on a regular basis**
4. **Establish reporting schedule of the Key CMI and team performance metrics**
5. **Conduct regularly schedule CDS/Coder Team Meetings**
6. **Adhere to the established agreed upon CDI policy and procedure**

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#10 Medical Staff Accountability

- **Physician Report Cards**
  - **Severity and Risk-Adjusted outcomes**
- **Integrity of the History and Physical**
  - **Does it meet the requirements for physician billing?**
  - **Does it adequately describe the severity of illness?**

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Polling Question

As a result of this seminar, what will you do differently?

***1 Nothing at all**

***2 Tweak what we have**

***3 Complete overhaul**

***4 Implement a new program**

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In Summary, to be successful…

- **Identify and communicate the need for CDI**
- **Establish executive and medical staff leadership/ sponsorship**
- **Establish and communicate program goals**
- **Establish clear roles, responsibility and accountability for CDI team up front**
- **Tie-in to coding is critical. This MUST be a joint effort!!**
- **Focus your efforts**
  - **Frequent retooling of focus areas**
- **Educate your docs and patient care team**
- **Track and report your success!**
- **Have FUN!!!!!!**

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Poll Results

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Appendix A – CDS Job Description

Role and Responsibilities:

- **Completes admission reviews of patient records within 24 hours of admission for a specified patient population to: (a) evaluate documentation to assign the principal diagnosis, pertinent secondary diagnoses, and procedures for accurate and optimal DRG assignment, and (b) initiate a review worksheet.**
- **Conducts follow-up reviews of patients as necessary to support and assign a final DRG assignment upon patient discharge.**
- **Prompts physicians regarding missing, unclear, or conflicting medical record documentation and obtains additional documentation within the medical record when needed.**
- **Collaborates with case managers, nursing staff, and other ancillary staff regarding interaction with physicians on documentation and to resolve physician prompts prior to patient discharge.**

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Appendix A – CDS Job Description

Role and Responsibilities: ***continued***

- **Confers with coding staff to ensure accuracy of diagnostic and procedural data and completeness of supporting documentation to assign a working and final DRG.**
- **Participates in the analysis and trending of statistical data for specified patient populations to identify opportunities for improvement. Assists with chart reviews as needed.**
- **Educates members of the patient care team regarding specific documentation needs and coding and reimbursement issues identified through daily and retrospective documentation reviews and aggregate data analysis. Facilitates change processes required to capture needed documentation, such as forms redesign.**

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Faculty Information

- **James S. Kennedy, MD, CCS** is a director with FTI Healthcare and lives near Nashville, TN. Board-certified in Internal Medicine and certified as a CCS by AHIMA in 2001, Dr. Kennedy supports physician education and infrastructure development in Clinical Documentation Integrity. Dr. Kennedy recently completed the AHIMA book, *Severity-Adjusted DRGs: a MS-DRG Primer*. Contact Dr. Kennedy at 615-479-7021 or James.Kennedy@ftihealthcare.com

- **Katherine (Kitty) Novak, BSN, RN** is a director with FTI Healthcare and lives near Cleveland, OH. Kitty has over 20 years of CDI education and implementation experience with FTI, 3M, Navigant, and other consulting firms. Kitty plans to take the AHIMA CCS examination in the near future. Contact Kitty at 330-321-1219 or katherine.novak@ftihealthcare.com

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Resources

***Severity DRGs and Reimbursement: An MS-DRG Primer*; Editor, James S. Kennedy, MD, CCS. Contributing authors: Anita Orenstein, RHIT, CCS, Anne B. Casto, RHIA, CCS and Karen M. Lindemann, RHIT, CCS, CCS-P, CPC, AHIMA publication 2008. Product Number AB215107**

Journal of AHIMA Coding Notes article: "Getting Quality Clinical and Coded Data: How UMHS's CDIP Improved Clinical Coded Data and Clinical Staff Relationships" October, 2007 http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035519.hcsp?dDocName=bok1_035519

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Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
www.AHIMA.org

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or sign on to MyAHIMA
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Join the Documentation Improvement Community from your Personal Page then under Community Discussions you will be able to:

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- Network with other AHIMA members
- Enhance your learning experience

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for information on the seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.

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Career-building Resources

Upcoming Seminars/Webinars

- ***Coding Injections and Infusions***
  Faculty: **Lori Purcell , RHIA, CCS**
  January 31, 2008

- ***EHR Coding Practices***
  Faculty:
  Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA
  February 7, 2008

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Appendix

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You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.