There’s little debate that CDI programs are important. You could even argue that they’re absolutely necessary, particularly in the wake of CMS’ “behavioral offset” or inpatient prospective payment system (IPPS) 0.6% pay cut in fiscal year 2008.

CMS implemented this cut because it anticipates more accurate coding and reimbursement due to improved physician documentation.

This means that if a hospital elects to do nothing to improve its documentation from now until October 1, it will lose 0.6% of its total IPPS reimbursement.

But how do you convince the people that hold your hospital’s financial purse strings that you need a CDI program? Or if you’re just a year or two into a CDI program and are understaffed, how do you make an effective case for hiring another full-time CDI specialist (CDIS)?

Following are some effective strategies for proving a CDI program’s worth and return on investment (ROI):

» Do some number crunching to see exactly where your hospital’s DRGs fall in the big picture.

Audit and compare your hospital’s DRG volume against national averages. This will help you determine where your DRG volume—and potentially, your documentation—stands. If your hospital does not currently have a CDI program, perform an audit of a random sample of 60 charts to determine how well your physicians document their diagnoses overall.

Assign a working DRG based on what a physician actually documented, and then assign the potential DRG based on improved documentation opportunities.

Look at individual diagnoses as well. For example, if physicians only document congestive heart failure and do not include a more specific diagnosis, “right there you know you have a problem,” says Marion Kruse, MBA, RN, managing consultant for Navigant Consulting in Chicago.

CMS published anticipated complication/comorbidity (CC) and major complication/comorbidity (MCC) capture rates in the 2008 IPPS final rule. Given that Medicare Severity DRGs took effect October 1, 2007, run reports to determine how closely your hospital is conforming to this national average, Kruse says. Not including major diagnostic categories 14 and 15 (female pregnancy and newborns), CMS anticipates that an average acute care hospital should meet the following benchmarks:

- MCC capture rate: 22.2%
- CC capture rate: 36.6%
- Diagnoses without a CC or MCC: 41.1%

If a hospital is at or below these numbers, this is a good indicator that it is in need of a CDI program. “[CMS’ benchmarks give] a 10,000-ft view, but it’s the best we have right now,” Kruse says.

Wendy De Vreugd, RN, FNP, senior director of case management for the West Group of Kindred Healthcare, Hospital Division, in Orange County, CA, notes that different types of hospitals (e.g., long-term acute care) should expect a much higher rate of MCC capture than the 22.2% figure above.

» Evaluate your current processes to identify areas in which a CDI program would make a worthwhile investment for your hospital.

Putting your current coding and documentation processes down on paper is the best place to start when analyzing your current processes.

For example, if concurrent coders/HIM staff members perform record review of clinical documentation during the hospitalization, there will be opportunities to query physicians about insufficient documentation during this process, De Vreugd says.

“Medical record coders and CDIS positions can identify and trend information about individual physicians to bring forth, [for example], ‘This physician never documents specificity of anemia or pneumonia,’ ” she says. Gathering these data can bring documentation shortfalls into focus and provide educational opportunities, De Vreugd says.

Determine which DRG categories physicians do not document well. You can also organize these underdocumented DRG categories by specialty. Note that a single absent diagnosis that could add a CC or MCC to a case can make a big difference in the severity weight and the clinical picture of a patient and, therefore, reimbursement, De Vreugd says.
She also notes that physician education is an important part of clinical documentation improvement and that educational needs can vary based on the type of physician.

“Oncologists have different problems than generalists,” De Vreugd says. “Generalists have legibility problems, they don’t understand the principles of diagnostic versus narrative charting, and they write ‘up’ and ‘down’ arrows and lab values that can’t be captured by a coder as a codable diagnosis.”

» Use electronic reports to show financial implications of CDI.

Software is an invaluable tool to help prove ROI, as programs can generate data and reports that show the value of CDIs’ work.

For example, Navigant Consulting uses an electronic CDI Monitor that interfaces with a hospital’s patient registration system and allows hospitals to create customized reports to show the following:

» How many cases a CDIS reviewed
» The types of queries CDISs rendered
» How many follow-up reviews a CDIS conducted

» The physician query rate
» The query agreement rate
» Outstanding queries
» Query answer rates, tracked by individual physicians
» The financial impact

The software converts all of the statistical information into dollar amounts that demonstrate the financial implications. For example, reports show the base DRG, as well as the final assigned DRG after appropriate querying and documentation of additional CCs and MCCs.

“All of it can be put into dollar terms, standardized for the hospital’s own blended rate,” Kruse says.

De Vreugd helped implement a software program that generates Excel spreadsheets. These provide a snapshot of the financial impact an individual CDIS can provide, allowing for an easy means to prove ROI. (See p. 10 for a sample clinical documentation improvement chart.)

“If you’re trying to prove your worth, I recommend using electronic reports,” she says. “They show the benefit of the CDS’ role.”

Consider using a consulting firm

Although the up-front investment is greater, a consulting company can implement a clinical documentation improvement program in a shorter time frame than it may take a hospital. Using a consulting firm could end up saving a hospital money in the long term and help it realize its return on investment.

“The reason outsourcing is sometimes used is because of the specialty knowledge [it brings] to the organization—knowledge that the company may not have internally—or to get a jump start on a complicated subject or project,” says Wendy De Vreugd, RN, FNP, senior director of case management for the West Group of Kindred Healthcare, Hospital Division, in Orange County, CA. “You can invest a lot of time and money trying to put in a [program] when no one has the knowledge base.”

“There’s the time value of money, and a lot of money you’re potentially leaving on the table, when you’re getting a program up and running,” adds Marion Kruse MBA, RN, managing consultant for Navigant Consulting in Chicago.

But not all vendors are created equal. When selecting a vendor, make sure that the company:

» Employs physicians whose role is to educate your hospital’s physicians about documentation requirements. Physician-to-physician interaction is crucial for a successful CDI program, Kruse says.

» Can help with the implementation process. Avoid firms that come in, perform two weeks of education, and then leave you on your own.

» Provides follow-up services as part of its contract. “You don’t want someone who will nickel-and-dime you if they have to come back in the door,” Kruse says.

» Provides a means for statistical measures of success.

» Emphasizes national rules and guidelines during the training, rather than its own interpretation.

» Is tailored to your hospital, not “cookie cutter.”
Key for sample clinical documentation improvement chart

- **DRG-06**: Initial DRG prior to CDI specialists’ (CDIS) review
- **Old weight**: Weight of initial DRG.
- **CDIS-DRG**: New DRG assignment after CDIS review and physician query process.
- **New weight**: Weight of new DRG assignment.
- **Difference**: Difference in case-mix index from initial to new DRG
- **Definition**: Shows whether the patient is at the maximum major complications/comorbidities level, or whether he or she has already been discharged. This allows for better prioritization of patients.
- **CC+**: This number indicates how many additional complications/comorbidities (CC) the CDIS identified in the chart. Sequencing the CCs is important due to billing restrictions on the UB-04. Note that “P” denotes a pending CC (an open query).
- **Max DRG**
- **Max MCC**: The maximum case-mix index from the CDIS’ work (e.g., the total difference in case mix between the original physician documentation and the improved documentation).

This chart demonstrates the effect that a dedicated CDIS can have on capturing missed diagnoses, and potentially obtaining

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Key for sample clinical documentation improvement chart (cont.)

- Bacteremia
- Urosepsis
- Septicemia
- Sepsis
- Severe or generalized sepsis
- Sepsis syndrome
- Septic shock

Understand clinical terminology and indications of sepsis

by William E. Haik, MD

Few conditions cause more chaos for coders than urosepsis/sepsis. Sepsis code assignment demands concise and supportive physician documentation.

Even in the presence of physician documentation, assigning an accurate code is a difficult task due to the vague and overlapping terminology physicians use to denote various degrees of severe clinical infection. These terms include the following:

- Bacteremia
- Urosepsis
- Septicemia
- Sepsis
- Severe or generalized sepsis
- Sepsis syndrome
- Septic shock

Systemic inflammatory response syndrome (SIRS), a relatively new term reported with ICD-9-CM code 995.9x, further compounds the problem of accurate code assignment. SIRS represents a clinical syndrome resulting from either an infectious etiology or a noninfectious condition, including but not limited to pancreatitis, severe burns, or massive trauma.

Another problem coders face arises when physicians document the nonspecific term “urosepsis.” The ICD-9 Manual indexes urosepsis to urinary tract infection, site not specified (code 599.0). However, although the code for urosepsis denotes sepsis from a urinary source, the physician may not have intended this. Instead, he or she may have intended to report sepsis due to a localized urinary tract infection. In this case, when the diagnosis is equivocal, the CDI specialist/coder should review the record for additional documentation. (See p. 13 for a sample urosepsis physician query form.)

According to AHA Coding Clinic for ICD-9-CM, First Quarter, 1998, pp. 1 and 3, “negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition.” Despite this fact, positive blood cultures do not establish a diagnosis of sepsis and may merely represent an isolated laboratory finding. Coders or CDI staff members must obtain additional physician documentation.

Therefore, regardless of blood culture findings, it is imperative that the physician properly document in the record those cases that are clinically consistent with sepsis. If the physician fails to do so, it could result in an incorrect principal diagnosis, which will subsequently result in an inappropriate DRG assignment.

Below are severe clinical infection definitions to aid coding/HIM staff and CDI staff in assigning accurate codes for sepsis:

- Bacteremia, code 790.7: denotes a laboratory finding of viable bacteria in the blood in the absence of two or more signs of sepsis.

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