understand this, then you can get the physician to “buy in” to the idea of CDI.

As part of my business, I create a CDI “tip of the week” that I email to whoever would like it to help educate physicians. I am happy to pass that on as a way of continuing that sharing spirit (email DrBrundage@gmail.com; these are also shared on the ACDIS Forms & Tools Library).

CDI: If you could have any other job, what would it be?
TB: I have found the perfect job for me. I work 15 clinical shifts per month while teaching interns and residents about the art of medicine. I spend the rest of my time lecturing physicians on CDI and helping with UM in the hospital setting. I also use electronic health records to review physician documentation and create a documentation report card for physician educational purposes.

CDI: What was your first job?
TB: I was a lifeguard at the local park in Kalamazoo, Mich.

CDI: Tell us about a few of your favorite things.
TB: When I am not practicing medicine, I enjoy being on my boat. I enjoy fishing and diving, traveling with my wife, and relaxing with my buddies. And, of course, University of Michigan sports—GO BLUE!

Vacation spots: Bahamas, Costa Rica, Grand Cayman Island, Michigan

Hobby: Spearfishing, diving, fishing, running
Nonalcoholic beverage: “Passionate Patty,” which is named after my wife and is V8 Splash mixed with Fresca. It’s our virgin boat drink!

Foods: Any fish caught on my boat, especially hogfish. I also enjoy veggies, my wife’s homemade pizza, and paella. I have a sweet tooth and cannot keep ice cream in the house.

Editor’s note: CDI Journal introduces an ACDIS member in each issue. If you would like to be featured or know someone who would, please email ACDIS Member Services Specialist Penny Richards at prichards@cdiassociation.com.

CDI goal: Documentation for the physician and the hospital
Stop feeding the ‘EHR reimbursement beast’

by Glenn Krauss, RHIA, CCS, CCS-P, CPUR, C-CDI, CCDS

What is the goal of a CDI program? Most of the ones I see still focus on DRG optimization. Unfortunately, they are not preparing for ICD-10 and not supporting the physician with his or her professional billing. Very rarely do I hear about programs that help with the core question, “What’s in it for the physician?” And that’s our biggest problem. We need to make the physicians allies of our CDI programs, and right now they are not. Instead, they are often targets of our queries.

So how do you make the transition? By changing physician behavior one encounter at a time and letting them see that additional documentation helps with their professional billing.

Recently I spoke with a surgeon missing some important documentation from his consult notes. I provided him...
information about history of present illness (HPI) and why it was important to his E/M billing. He thanked me, but his words were more telling than his gratitude: “This is great information. I’ll do better next time so I can continue to successfully feed the EHR reimbursement beast.”

Think about it: Isn’t that what we’re really doing when we’re asking for CCs and MCCs, “feeding the EHR reimbursement beast” with a diagnosis? To change this paradigm, we need to ask about the context, not just the diagnosis. When reviewing the charts, consider asking:

» What is the clinical context in the chart supporting the diagnosis of record?
» Does the HPI in the history and physical support the diagnostic assessment of the physician, corroborated by nursing documentation and chosen plan of care?
» Is the physician’s clinical rationale, judgment, and medical decision-making in arriving at the diagnosis using available diagnostic information clearly depicted in the chart? Or is it instead implied through sporadic bits and pieces of documentation in the electronic health record (EHR)?

Unfortunately, the electronic record and its promotion of the “point and click” and “cut and paste” features often detract from the accurate capture of the physician’s clinical judgment, thought processes, and medical decision-making—all of which validate the physician’s clinical diagnosis. The most recent Recovery Audit Statement of Work highlights the need for this degree of clinical documentation. Take a look at this excerpt:

Clinical validation is an additional process that may be performed [by the Recovery Auditor] along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

Right now there is a lot of controversy in the industry about clinical indicators not supporting the diagnosis. Recovery Auditors are denying claims that have a clearly documented diagnosis but which lack clinical support throughout the medical record. To combat this trend, CDI specialists should ask physicians to document what is going on with the patient. That means the clinical indicators should not only be in the query (per the new ACDIS/AHIMA query practice brief, “Guidelines for Achieving a Compliant Query Practice”), but also be a regular and integral component of the physician’s daily progress notes, history and physical, and discharge summary.

However, frequently there are no valid clinical indicators in the progress note to support the diagnostic information in the chart. Lab values and radiology results are now getting automatically populated by the EHR with little or no indication of their clinical significance mentioned by the physician. Outside reviewers are not able to definitively determine that the physician used the results of the diagnostic tests in the actual clinical management of the patient, resulting in a denial.

Incidentally, interpretation of diagnostic test results and their clinical significance and relevance is a component of E/M medical decision-making that plays a key role in the establishment of medical necessity for any given E/M coding and billing patient encounter. A best practice is to have the physician mention the diagnostic test results in his or her assessment, interpret them, and make a statement about abnormal values relating to the diagnosis or diagnoses that appear in the daily progress notes.

Here’s an example for a sepsis patient: “Temperature trending down to 101, WBC 15, bands are 12, patient still a bit confused but showing marked improvement from admission, respiratory rate now 19, slowly responding to the IV antibiotic regimen recommended by infectious disease. Anticipate discharge when chest x-ray improves and white count comes down a bit.”

Do these clinical indicators and picture paint a picture of a patient recovering from a bout of sepsis? Yes, they do, and they also lend credibility to the hospital and physician reporting a sepsis code.

A chest x-ray might show atelectasis, but the doctor needs to acknowledge it and make a notation. When the physician does acknowledge it, that’s one point on his or her E/M level. For example: “Atelectasis, chest-x-ray still shows increased chest haziness, patient encouraged to use incentive spirometry.”

You don’t need 20 sentences, just a statement of fact of how the doctor came up with the conclusion of atelectasis.

Isn’t this what we as CDI specialists really should be doing? Our goal is to solidify the documentation for medical necessity and the physician’s work. We need to demonstrate efficient and effective treatment measures, which we’ll need under value-based
purchasing. It’s not just about feeding the “reimbursement EHR beast,” which is unfortunately a perceived byproduct of our CDI efforts by a growing number of clinicians.

Ultimately, we should strive to show an accurate clinical picture of the patient’s presentation and response to treatment to complement the documented clinical diagnoses. Describing the patient’s true clinical picture as opposed to generalized diagnostic statements is the key to establishing medical necessity for admission as well as the patient’s continued stay.

Case study
Medical necessity documentation review for patient with nausea and vomiting

Editor’s note: The following case study by Glenn Krauss represents a fictitious account of a plausible instance where CDI specialists may expand their record review to include physician queries for medical necessity components.

Case conditions
A 25-year-old Medicaid patient presents to the ER on a Monday afternoon with nausea and vomiting. Staff administer a proton pump inhibitor as well as antiemetics.

The patient presents two days later in the ER with worsening and relentless nausea and vomiting, and is admitted to the hospital. This history and physical (H&P) states “nausea and vomiting.” Gastroenterology calls for continued proton pump inhibitor and antiemetics and recommends not performing an esophagogastro-duodenoscopy, as the clinical impression was that of cyclical vomiting contributed by untreated anxiety reaction.

Second day progress notes state “nausea and vomiting” again, with no indication of continued patient severity of nausea and vomiting and clinical stability of the patient.

In addition, the H&P mentions a diagnosis of acute renal failure with no likely cause (e.g., prerenal, parenchymal, or post obstructive). Patient receives two boluses of fluid in the ER, yet no potential diagnosis of dehydration is documented. There is no other diagnosis of acute renal failure documented in the chart, including progress notes and discharge summary.

Patient did receive a script for proton pump inhibitor from the initial ER visit, but it is not clear whether the patient was compliant with filling the script, leading to the second presentation to the ER. Discharge summary is a cut and paste of the H&P.

The final diagnoses contained in the discharge summary are cyclical nausea and vomiting related to anxiety with acute renal failure. The DRG worksheet was part of the record indicating MS-DRG 392.

Case analysis
This example is certainly not very beneficial to the overall revenue cycle process. The admission was denied for inpatient on the basis of “clinical picture does not meet medical necessity for inpatient admission.”

There were no clinical indicators for diagnosis of acute renal failure, no degree of nausea and vomiting severity in the initial history of present illness (HPI) documentation to reference as a starting point for patient response to treatment while hospitalized, and no documentation of potential noncompliance with medication contributing to the patient’s bounce back to the ER. In addition, the HPI in the H&P was instead a “history of past illness” versus “history of present illness,” thereby not lending credibility to the patient’s true severity of illness to correlate with the physician’s ordered intensity of service as evidenced in the plan of care.

CDI opportunities
Because the H&P did not establish the severity of the nausea and vomiting, the CDI specialist should have clarified with the physician how he or she identified acute renal failure, since the clinical indicators of such were not documented. The progress notes had no information on stability/instability of nausea and vomiting. That should also have been clarified—for example, “Doctor, was the nausea improving or worsening?”

In addition, the physician’s documentation habits in the EHR warrant a sidebar education session. The discharge summary was cut and pasted from the H&P, and the last day’s progress notes said only “patient discharged stable at 10:34 to home.” A doctor can’t bill an E/M for that last progress note—it’s not even clear he saw the patient.