ACDIS releases EHR position paper

Guidance includes recommendations for various levels of CDI involvement

Although the implementation of electronic health records (EHR) promised to improve productivity, data capture, specificity, and efficiency, there remain a number of reasons for CDI specialists’ concern in this new digital environment, according to a new position statement released by the ACDIS advisory board in this month’s edition of *CDI Journal* (see p. 5).

While CDI professionals play an important role in the implementation and education associated with EHRs, ACDIS warns against making CDI specialists the “wardens at the gate” of the new systems.

“CDI specialists have a specialized skill set and a high level of clinical knowledge and training,” according to the position statement. Yet “many EHR problems are endemic to the software and/or are clerical in nature, and are best addressed by information technology (IT) staff.”

Yet, the paper highlights areas where CDI professionals need to become more involved, such as educating physicians about common EHR documentation missteps, reviewing queries prior to submission, and examining records for trends illustrating “copy and paste” errors.

“We value the importance of incorporating technology into the workflow,” says ACDIS advisory board member Walter Houlihan, MBA, RHIA, CCS, HIM and CDI director at Baystate Health in Springfield, Mass.

“We know it brings value but we also wanted to highlight some of the precautions that CDI professionals need to be aware of. Don’t go blind into the implementation of this important and valuable technology. Know what to expect.”

The ACDIS advisory board meets quarterly to discuss areas of national interest related to the CDI industry and to evaluate ways in which the association may appropriately respond to those challenges.

**E-query use**

- **Yes**: 43.6%
- **No**: 34.2%
- **No, but we are implementing one**: 17.6%
- **Other**: 4.6%

“We knew this [EHR implementation] was an important concern that needed to be addressed,” says advisory board member Dee Banet, RN, BSN, CCDS, director of CDI, for Norton Healthcare in Louisville, Ky. “Many seasoned CDI specialists would agree that the physician query process presented many challenges in the past. With EHR CDI programs are now charged with maintaining current progress while addressing all new challenges that come with the technology. Back then it was comparatively easy; but even then we needed guidance. We knew that we, as the ACDIS advisory board, needed to take a stand on some of these concerns.”

Barbara Hinkle-Azzara, RHIA, an independent Health Information Management specialist in Princeton, N.J., recalls reviewing a relative’s medical record recently and being “appalled” with the errors and misinformation perpetuated by the EHR. “You could tell the physician was using pull down menus. These are the types of misinformation that are being included in your loved-ones medical records, too. Although [EHR systems] can be good for the organization and for our healthcare system overall, EHR implementation can have complicated, unwarranted results. CDI specialists should definitely be involved in the process and be diligent about watching for some of these danger areas,” she says.

**Concerns related to ‘meaningful use’**

To incentivize EHR implementation, CMS provides payments for those facilities which can prove their systems work efficiently. To do this, CMS established a set of goals for Stage 1, including nearly two dozen ‘meaningful use’ objectives—of which facilities need to meet 13 core objectives and five (out of 10) chosen ones. The ACDIS EHR position paper addresses the advisory board’s concerns regarding objectives requiring that EHRs include:

- An up-to-date problem list of current and active diagnoses
- Documentation of the patient’s complaint
- Clinical laboratory test results integrated into the EHR as structured data
- Automatically generated calculations of a patient’s body mass index (BMI)

“The problem with ‘problem lists,’ is that the physician could start typing in a diagnosis and get up to 200 options,” says Mark N. Dominessey, RN, BSN, MBA, CCDS, CDIP,
**Watch for copy and paste problems**

Copying and pasting medical data from one day to another, one admission to another, or one patient to another, represents another frequent problem within EHR systems. While facilities may wish to have CDI specialists hunting for such concerns, the ACDIS position paper cautions against it.

“ACDIS does not recommend that CDI specialists position themselves at the forefront of correcting copy/paste problems,” it states. “Their time is better spent reviewing records to ensure documentation of severity of illness.”

“With all the [potential problems] associated with the EHR, there is an accountability expectation directed at the CDI specialists that may be totally misplaced,” says Banet.

Several other technological methods such as disabling the copy/paste function could help address the problem, says Dominesey, although he doesn’t recommend that option.

“There are a whole host of legitimate reasons that physicians would need to use the copy and paste function. The capability of the EHR needs to address those concerns and the IT department needs to be aware of them as well,” he says.

At Baystate Health, Houlihan and leadership created a

HIT Pro-CP, MCP, director of auditing and CDI services for Trust HCS, in Washington, D.C.

“Technology could make it easier to whittle that list down into probable suggestions that reflect the clinical indicators in the record, but you need to have an awareness of this electronic process and thoughtful record reviews to ensure that those ‘suggestions’ are not leading the physician to an inaccurate diagnosis,” he says.

Although physicians can add to the problem list in the EHR, they often neglect to document whether a condition was resolved or not, leaving patients with a string of possible (and potentially ongoing) concerns, the position paper states. “The EHR often simply allows [physicians] to add a diagnosis to the problem list without evidence that they are managing the condition,” it says.

EHRs also allow physicians to easily carry forward clinical information from previous encounters which may not be relevant to the current situation, the position paper warns.

Although “meaningful use” requires the inclusion of the patient’s complaint, such information frequently turns out to be different from the physician’s determination of the principal (admitting) diagnosis. To avoid erroneous sequencing, CDI specialists should identify any discrepancies between the patient complaint, the principal diagnosis, and the documented clinical indicators for potential query opportunities, according to the position statement.

Furthermore, although “meaningful use” requires the incorporation of data from other providers (laboratory, radiology, pathology, and ancillary care services) it does not mandate that the physician link the information to the treatment plan associated with the patient during the given encounter, the paper states.

All of which seems to undercut one of the CDI industry’s primary objectives—obtaining clear and consistent documentation which best represents the narrative of the patient’s clinical encounter.

“What happens now,” says Dominesey, “is that physicians are forced to point and click their way through the EHR, losing the richness of the narrative of the care.”

“Physician documentation should reflect the progress or regression [of the patient’s condition] ...; and CDI staff should help physicians understand the importance of this fact,” the paper states.

Finally, in regard to “meaningful use” objectives, the ACDIS advisory board warns against wholesale use of automatic configuration of a patient’s BMI, pointing out several citations from the American Hospital Association’s Coding Clinic for ICD-9-CM, which encourage assessment and linkage of the importance of the documented BMI to the current treatment plan for the patient’s condition. The paper also points to several studies illustrating concerns regarding automatically populated BMIs and corresponding diagnoses.

The advisory board recommends that CDI professionals educate physicians regarding the potential obstacles associated with EHR-generated BMIs and to work with dietitians and other healthcare staff to ensure a human element is considered during the evaluation process.

Dominesey calls the section addressing BMI “spot on,” recalling a recent example of a long-distance runner with a BMI of 18. “The CDI queried the dietitian and the dietitian agreed to the diagnosis of malnutrition. The coder coded it. But there was no way that individual suffered from malnutrition,” he says. “The overuse of malnutrition is an audit target. The medical record needs to have stronger clinical indicators which reflect that diagnosis for it to be considered.”

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policy to limit copying and pasting to only necessary items. “The purpose is to establish parameters and minimize the use of copy and paste functionality in our EHR. The provider is responsible for the accuracy and medical necessity of all EHR documentation including any notes,” he says.

The position paper calls on facilities that have the staffing capability to compose a dedicated EHR team for “addressing and correcting this problem.”

A few instances of copy/paste missteps, such as the propagation of inappropriate diagnoses over multiple progress notes or conflicting documentation between the care team (e.g., nurse practitioner or consultant), do warrant CDI intervention, and could require a query to the attending physician for clarification as well as education.

There are compliance concerns associated with these problems, Dominesey says, such as billing for services inadvertently documented throughout the patient’s stay that were only done on the initial day. “If someone uncovers a problem they have to take it to the next level,” he says.

**On-site CDI staff required**

Although many may be looking forward to EHR implementation as their ticket to work from home, the ACDIS position paper warns against completely remote CDI programs. “CDI is not just a process of leaving queries on the medical record, but an ongoing process of education,” it states.

The position paper worries about the potential lack of face-to-face discussion and interactional education that could come with 100% remote CDI programs. “Reviewing records without an educational component leads to CDI becoming a reactive and not a proactive process,” according to the position paper. “ACDIS notes that CDI is not a pre-coding review for accuracy, it is about changing physician documentation habits.”

It also highlights several ways that CDI specialists can actually help educate physicians about how to effectively use EHR systems, and adds that the need for CDI physician education will only increase as the deadline for ICD-10-CM/PCS implementation nears.

“The CDI role is changing physician documentation behaviors and training and that’s really where the subtle difference in responsibilities comes in,” says Dominesey.

Those pining for remote opportunities needn’t worry, though, since ACDIS does support a blend of remote and on-site CDI staff. “Offsite employees can focus on dedicated reviews and maximum coverage of charts. Onsite staff can round with physicians and educate them on the ‘why’ behind the program,” according to the position paper.

Dominesey encourages a staff rotation model, where CDI staff work from home two days a week and on-site three days. The pressures of working from home relate more to maintaining a productivity level while the on-site pressures relate more to interpersonal relationships and on-the-spot problem solving. “Rotating staff helps keep those pressures balanced and keeps everyone engaged with the physicians and the entire scope of the CDI practice,” he says.

**E-query efforts**

Finally, the ACDIS advisory board weighs in on computer-assisted coding and electronic query systems as they incorporate into the EHR. Some sophisticated systems scan the chart for key words, automatically registering phrases such as “congestive heart failure” and then search for related clinical indicators and prepare queries automatically. The position paper suggests that while this and other software may dramatically improve CDI program productivity and flexibility, an actual staff person needs to review any query prior to distribution to ensure compliance.

A “CDI specialist [needs to] review all electronic queries before deciding whether to release them. In addition, all queries should abide by the latest physician query guidance issued by ACDIS and the American Health Information Management Association,” the position paper states.

**Ongoing efforts**

In closing, the ACDIS advisory board indicates that further guidance may be forthcoming.

“We worked on this over several months. While it would have been impossible to capture every nuance of the role of CDI with EHR rollout, we knew there were certain concerns that CDI teams are struggling with, items that they were looking to us to address,” says Banet. “I just hope that others find this position paper provides some direction for them. We’re all making this journey together, and it’s going to be an exciting one.” 🌟
ACDIS position paper

Electronic health records and the role of the CDI specialist

Spurred by incentives in the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, electronic health records (EHR) are now widespread in the healthcare industry. According to a survey from the U.S. Department of Health and Human Services (HHS.gov), more than 50% of doctor’s offices and 80% of eligible hospitals will have EHRs by the end of 2013.¹ As of April 2013, approximately 80% of all eligible hospitals and critical access hospitals in the U.S. had received an incentive payment for adopting, implementing, upgrading, or demonstrating meaningful use of an EHR.

On the whole EHRs represent a positive development in healthcare. EHRs facilitate more efficient documentation collection and storage, promote patient safety and quality initiatives by allowing widespread access to health information, and allow for easier transaction of claims data for professional and hospital billing.

More and more, CDI programs depend on the use of EHRs for querying physicians, capturing more specific and accurate diagnoses and procedures, and even tracking important CDI metrics such as query rates, physician response rates, complication/comorbidity capture rates, and severity of illness/risk of mortality scores.

However, EHRs bring with them potential problems and compliance risks, many of which are only just emerging. For example, CDI specialists report instances of cloned progress notes, copy/paste errors such as gender misidentification (transposing “he” with “she” in a patient chart), and electronically generated body mass indices (BMI) that may be used for coding without a corresponding diagnosis by the physician, which violates the American Hospital Association’s (AHA) Coding Clinic for ICD-9-CM guidances. Other reported problems with EHRs include:

» Inadequate physician and non-provider training related to EHR use
» Lack of onsite expertise to troubleshoot problems
» Physician time constraints, leading to inability to enter sufficient documentation
» Poor physician buy-in
» Physician forms/templates lacking review and signature

Page tagging

Hospitals must address these issues or face payment denials from payers and auditors. Recovery Auditors and other auditing agencies are aware of these and other problems with the EHR and are reviewing records for improper or inadequate documentation as a result of EHR use.

CDI specialists, by the very name of their profession, are often assumed to be the individuals responsible for resolving EHR documentation errors. However, the advisory board of the Association of Clinical Documentation Improvement Specialists (ACDIS) strongly cautions against CDI specialists becoming the “wardens at the gate” of EHRs.

CDI specialists have a specialized skill set and a high level of clinical knowledge and training. Many CDI specialists are registered nurses with 15–20 years or more of bedside nursing experience, and/or advanced chart review and inpatient coding experience as health information management (HIM) professionals. Many EHR problems are endemic to the software and/or are clerical in nature, and are best addressed by information technology (IT) staff, a dedicated EHR response team, or clerical/data entry staff.

On the other hand, some documentation shortfalls and deficiencies are suitable for CDI intervention, such as clarifying the stage and present on admission (POA) status of a pressure ulcer that appears in the middle of a patient’s stay, or asking for supporting clinical indicators for a diagnosis that appears only once in an electronically generated discharge summary.

Following are examples of errors and compliance risks CDI specialists might encounter and the recommendations of the ACDIS advisory board for handling such issues when they arise.

Meaningful use and problem list, patient complaint

According to CMS, the Medicare and Medicaid EHR incentive programs provide financial incentives for the “meaningful use” of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to demonstrate that they are “meaningfully using” their
EHRs by meeting thresholds for a number of objectives. CMS has established the objectives for “meaningful use” that eligible professionals and hospitals must meet in order to receive a Stage 1 incentive payment. For eligible hospitals and critical access hospitals (CAH), there are a total of 23 Meaningful Use objectives. To qualify for an incentive payment, 18 of these 23 objectives must be met:

- 13 required core objectives
- Five objectives chosen from a list of 10 menu-set objectives

One criteria of Meaningful Use of EHRs is the problem list (Core Objective 3: “Maintain an up-to-date problem list of current and active diagnoses”). Although EHRs give physicians the flexibility to update this list electronically, many don’t indicate in their documentation when a condition is resolved; the EHR often simply allows them to add a diagnosis to the problem list without evidence that they are managing the condition.

Some EHRs allow the introduction of a diagnosis from a previous hospital admission to be included in current problem list documentation, even though the diagnosis may be completely resolved from a clinical perspective. The Official ICD-9-CM Guidelines for Coding and Reporting state that you cannot code a condition if it is not relevant to the current episode of care, so it is important to determine whether or not these diagnoses are active and relevant to the present stay: “Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” ²

If CDI specialists see evidence of this problem in the EHR, ACDIS recommends they clarify with the physician whether the diagnosis has resolved or whether it is being actively treated/monitored. CDI specialists should ask the physician to provide the narrative and supporting evidence of the diagnosis in the chart. A physician should update his or her problem list each day. The physician should document when a diagnosis resolves or improves.

Sepsis is one such example. The patient may come to the hospital with sepsis and improve. Conversely, the patient may come to the hospital with sepsis and worsen to severe sepsis or even septic shock. The problem list and the documentation should create a narrative that is easy to follow and shows this progress or regression. The patient is either getting better or worse, and is rarely the same each day. Physician documentation should reflect this progress or regression to support severity of illness, risk of mortality, and evaluation and management (E/M) billing; and CDI staff should help physicians understand the importance of this fact.

Another item related to Meaningful Use is the documentation of the patient’s complaint, as EHRs typically provide a field for physicians to document this data element. A patient’s complaint often turns out to be different from the principal diagnosis, defined by Uniform Hospital Discharge Data Set standards as the condition, after study, that occasioned admission to the hospital. This represents another opportunity for the CDI specialist to clarify the actual principal diagnosis with the treating physician.

Another aspect of documentation risk for the EHR is the inclusion of large amounts of automatically inserted data (e.g., labs, radiology results, vitals, meds, other studies, etc.). Often this data contains no discussion or action on the part of the treating clinician indicating the clinical relevance of these findings. Meaningful Use requires eligible professionals (EP), eligible hospitals, and CAHs to incorporate clinical lab-test results into the EHR as structured data. However, CMS in a Frequently Asked Questions document stated there does not need to be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the laboratory test in order to meet the Meaningful Use standard:

The only requirement to meet the measure of this objective is that more than 40% of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs. ³

In these instances, ACDIS recommends that CDI professionals encourage clinicians to reference results of particular relevance or concern in association with the specific treatment plan documentation.

Electronically generated BMI

Core Objective 8 of Meaningful Use requires the EHR to calculate and display BMI. However, AHA Coding Clinic
for ICD-9-CM, Fourth Quarter 2008, states that you cannot code a patient’s BMI if it is electronically generated and does not have a corresponding diagnosis from a licensed physician or mid-level provider. This was further clarified in Coding Clinic, Second Quarter 2010, which states that BMI code assignment “may be based on medical record documentation from clinicians who are not the patient’s provider… however the associated diagnosis (such as overweight, obesity, or underweight) must be documented by the provider.”

The problems with this official published coding guidance versus Meaningful Use are self-evident: It is difficult to deduce if a patient’s BMI is auto-populated from the medication administration record field or calculated by a dietitian.

In addition, a recent research letter published in Journal of the American Medical Association Internal Medicine reported that primary care physicians failed to record BMI in the EHR in approximately one-third of 213,356 patients in the sampled network. Of the patients who had at least one BMI included in their EHRs, 68.3% had a BMI of at least 25 (overweight) and 34.4% had a BMI of 30, signifying obesity. However, only 17.1% of the known overweight patients and 30.1% of the obese patients were diagnosed by their physicians as being overweight or obese.

Automatically computed BMI levels are fraught with potential problems, from data entry errors to limited knowledge of the patient’s status. BMI documentation should be validated by a human being, otherwise a bilateral AK amputee may be called “morbidly obese” due to his or her height/weight ratio. Similarly, a patient suffering from metastatic cancer may also have malignant ascites and pleural effusion which makes their EHR weight seem normal, yet the patient may be severely malnourished. The evaluation of a patient’s BMI should take into account all clinical indicators and observations regarding the patient to ensure the accuracy of the information in the EHR. Clinicians who validate the BMI need to be aware of the patient’s condition and not just repeat the computed BMI.

The paper recommends CDI specialists provide education to clinical staff to ensure that BMI is calculated by a licensed clinician to enable proper capture of malnutrition and obesity diagnoses and that physicians provide documentation of the related clinical condition, such as obesity. CDI staff should encourage documentation of assessments in progress notes rather than relying on auto-population.

Copy/paste functionality

Copying and pasting of documentation has become a commonplace problem with the advent of the EHR. According to a recent article in the journal Critical Care Medicine, 82% of all residents and 74% of all attending notes contained greater than or equal to 20% copied information. Many physicians, for example, will copy and paste the same progress note from the previous day, even though it might contain important documentation elements like vital signs. EHRs often promote copy and paste functionality as a timesaver, but in reality copy/paste, used inappropriately, can lead to denials and/or allegations of fraud.

ACDIS does not recommend that CDI specialists position themselves at the forefront of correcting copy/paste problems. Their time is better spent reviewing records to ensure documentation of severity of illness. Many mid-size to larger facilities employ a dedicated EHR team, for example, and these professionals are a better outlet for addressing and correcting this problem. CDI specialists must take note of copy/paste errors and bring them to the attention of an EHR or other professional. Some EHRs allow for copy/paste functionality to be automatically disabled.

Should this problem persist, elevate it to an appropriate authority, such as a physician advisor, chief information officer, or chief medical officer, or an accreditation officer responsible for maintaining Joint Commission standards.

However, there are other instances where CDI specialists should be involved in copy/paste problems. For example, if a diagnosis enters the record inadvertently that is not clinically supported, but is then propagated through a series of notes, then the CDI specialist should query the treating physician.

Additionally, copy/paste also increases the risk of having conflicting documentation between an attending and consultant physician or among the attending team (with multiple clinicians—e.g., physician/physician assistant/nurse practitioner, and/or with residency programs). This scenario also warrants CDI involvement.

The inclusion of large amounts of automatically inserted data is a problem for other physicians as well, as they cannot read through the record efficiently when having to parse or ignore useless data. ACDIS encourages that only clinically relevant data is included in the medical record.

Role of the CDI specialist in an electronic setting

Hospitals are rapidly adopting EHR technology and...
many now identify themselves as 100% electronic. The electronic record opens up new opportunities and avenues for CDI specialists, including the ability to quickly scan and review more records, query physicians through emails or other electronic prompts, and perform remote or at-home record reviews. There are benefits to this arrangement, including employing qualified and skilled CDI professionals unable to relocate, and retaining veteran CDI staff members by offering flexible schedules.

While ACDIS embraces and supports the introduction of the EHR and recognizes some of the positive impacts of remote electronic record review, it does not recommend hospitals adopt a 100% remote CDI program. CDI is not just a process of leaving queries on the medical record, but is rather an ongoing process of education. CDI specialists who query the physician remotely do not have the ability to discuss the “why” behind the query, or change patterns of behavior. Reviewing records without an educational component leads to CDI becoming a reactive and not a proactive process. ACDIS notes that CDI is not a pre-coding review for accuracy, it is about changing physician documentation habits. In addition, remote reviews also prohibit deeper, real-time clinical conversations with the provider that can lead to additional opportunities to capture secondary diagnoses and improve severity of illness/risk of mortality scores for the hospital.

A suggested working model in the EHR environment is a blend of on- and offsite CDI specialists. Offsite employees can focus on dedicated reviews and maximum coverage of charts. Onsite staff can round with physicians and educate them on the “why” behind the program, as well as on forthcoming additional documentation needs, such as the additional specificity required to capture diagnoses and procedures in ICD-10. Onsite staff (either permanent or rotating with offsite staff) offers structured and focused efforts, including individual physician meetings and collaboration with physician advisors. Hospitals must provide education for their physicians about the need for accurate and complete documentation in the EHR environment. This can be done in a number of ways, including:

- Providing ongoing education and support in the form of formal education and individualized queries
- Disseminating information in the form of newsletters, flyers, tip cards, signage, etc.
- Employing physician advisors to provide education and peer-to-peer support
- Ensuring upper management support of the process and the necessary resources for success

These issues must be dealt with prior to conversion to ICD-10, or the problems will only continue into the conversion. Demands on physicians’ time will increase with ICD-10, and physicians struggling with the EHR may become overwhelmed. Physicians must receive intense education, support, and follow-through during this time of change, and CDI specialists are perfectly positioned to help provide a successful transition.

**Use of CAC and electronic queries**

Many EHRs allow for the use of computer-assisted coding (CAC) and/or electronic queries to the physician. Some sophisticated systems will even scan the medical record documentation and prepare auto-queries, suggesting clarifications based on the presence of specific terminology or diagnostic test results. ACDIS understands the value of these technologies and supports their use, but urges caution in their adoption. CAC and electronic queries can improve productivity and allow for flexible work-from-home arrangements. However, because diagnoses are determined by both diagnostic testing and a physician’s individual clinical judgment, computer-generated queries are not considered completely reliable. ACDIS recommends that a trained CDI specialist review all electronic queries before deciding whether to release them. In addition, all queries should abide by the latest physician query guidance issued by ACDIS and the American Health Information Management Association.

ACDIS intends to issue further guidance on this subject at a later date.

**References**

3. “FAQ0136,” EHR Incentive Programs, CMS.gov.
5. AHA Coding Clinic for ICD-9-CM, Second Quarter 2010, p. 15.
Another CDI Week has come and gone, but the importance of CDI keeps growing

So another CDI Week has come and gone. I hope you enjoyed the many resources ACDIS prepared, and took the time to celebrate the importance of this profession with your colleagues, physicians, and hospital administration.

Here at ACDIS’ home base in Danvers, Mass., we celebrated with an ACDIS CDI Week cake and orange and purple drinks and snacks. We also played a weeklong game of trivia called “two truths and a lie.” The game plays exactly as it sounds—each participant has to write out two true things about him- or herself, and one false fact, then your colleagues guess which is which.

In the spirit of the game I thought it would be fun to list two truths and a lie about CDI. Ready? Don’t look at the answers below until you’ve had a chance to think these through:

1. CDI specialists cannot survive if all they do is focus on CCs and MCCs
2. CDI is still a relatively unknown profession, and its importance underestimated in the healthcare community
3. The CDI profession will be replaced by technology and the electronic health record (EHR)

And the answers:

1. Truth. The payment landscape is changing and the government is shifting away from pay per service (PPS) to paying for quality. A focused review on CCs and MCCs will soon not be enough in this new environment.
2. Truth. Although most CDI specialists understand their value to their organizations, too many in healthcare don’t even know what “CDI” stands for, or why those annoying queries on the chart are necessary. Those working outside healthcare might know about hospital rankings and physician report cards, but they don’t understand that star ratings are derived entirely from what is documented in the health record.
3. Lie. EHRs and query systems are great, and helpful. But they are also computers, and tools, and not solutions in and of themselves. They are limited by what goes into them, and binary machine thinking. For more information, please see the ACDIS EHR position paper on pp. 5–8 of this quarter’s CDI Journal.

So although CDI Week has come and gone, I hope you don’t stop spreading the news about the importance of CDI in your hospitals, in the broader healthcare community, and to the public at large. Be proud of your profession and the vital role it plays in improving healthcare. Spread the truth and squash the lies!

Take care,

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Meet a member

Teamwork spurs personal and professional growth

Why meet a member when you can meet a team? Here are the folks from MaineGeneral Medical Center. They are all ACDIS members and all six ladies hold the Certified Clinical Documentation Specialist (CCDS) credential. MaineGeneral Medical Center has campuses in Augusta and Waterville.

Cathy L. Seluke, RN, BSN, ACM, CCDS, is the supervisor of clinical documentation compliance. Seluke earned the designation of CDI Professional of the Year in 2012 after receiving multiple nominations from her team and hospital administration.

“I am incredibly fortunate to have an engaged group,” says Seluke. “They are all delightful, have different strengths, are always so professional, and are all great at teamwork. Of course, we are all pretty Type A [personality-wise], but that’s what you get when you recruit intensive care nurses. They’re the cream of the crop.”

A few team members answered questions for this edition’s “Meet a member” feature. The team includes Cheryl McInnis, Susan Brennan, Cathy Rice, Michael Bushey, Martha Mayberry, Mary Orloski, and Seluke. They talked about realizing that CDIs everywhere face the same challenges and how networking helps them solve problems together among other concerns.

What did you do before entering CDI?

Brennan is a former traveling nurse. Her husband was in the military so she traveled with him and worked in many different facilities across the country.

Orloski’s background includes patient education, care management, and utilization review.

Before moving to the CDI team, Rice spent the majority of her 28-year nursing career in critical care, including as a bedside nurse and a nurse manager.

McInnis’ background includes pediatrics, orthopedics, and critical care, plus she served as nursing staff development coordinator and nurse director of medical surgery and telemetry.

Why did you get into this line of work?

Brennan and Orloski migrated into CDI when the role was added to their utilization review roles.

Rice was looking for change in her career and CDI allowed her to use her knowledge while challenging her to grow in her profession.

McInnis injured her right shoulder and left wrist caring for patients. After talking to Brennan, she thought CDI “sounded like interesting work and a way to use my knowledge to benefit the patients,” she says.

For her part, Mayberry “wanted to try something new in nursing, something I’d never done before.” Seluke “lured” her to CDI.

What has been your biggest challenge?

Orloski struggles to overcome some baseline visual deficits and works on a portable ergonomic work station. Lighting affects her ability to read and she finds it difficult to assess handwritten notes. Additionally, she says “the various components of computerized medical records are not constructed to readily allow the type of review we require.”

Rice’s biggest challenge has been learning to reframe the
way she looks at cases. As a nurse, she intuitively “knew” what was going on with the patients. As a CDI, she had to learn to take a closer look and find specific information.

McInnis says learning the coding language and how to craft queries were her two biggest challenges in making the transition to CDI.

How has CDI changed since you began working?

Brennan says that working in CDI means learning and keeping up with an ever-changing new language. She had memorized most of the DRGs, and then MS-DRGs were introduced. Coding rules are updated every October. Because their CDI program helps prevent Recovery Auditor denials, “the team now plays a part in risk of mortality and quality of care.”

According to Mayberry the biggest change comes from the awareness of those in the industry as to the role CDI professionals play. “When I first started and tried to explain the job, very few people understood what in the world I was talking about. Now when I mention it, people understand my contribution to the hospital and have great insight into the CDI role.”

If you could have any other job, what would it be?

Brennan would own and operate a rescue ranch in Montana for homeless, abandoned, and abused animals.

Orloski would be a soil biologist reclaiming contaminated sites.

Rice would be a chef.

McInnis would be in a classroom, teaching history.

Mayberry would be a published author and full-time writer.

Tell us a little bit more about yourselves.

Brennan volunteered at the 1984 Olympic Games in Los Angeles, and went on a trip to Romania with her husband Kevin, who is a minister. Both experiences made the world “smaller” and taught her focus and discipline. She has run the Boston and New York marathons and enjoys her garden and the outdoors. They own Jireh Farm and share it with a horse, two Australian shearers, two Nubian goats, four cashmere goats, and a kitten (who will be tasked with keeping the future barn mouse-free).

Rice and her husband Bob have been married for 30 years and have a son, Dan. She enjoys quilting, cooking, zumba classes, hunting and fishing, and lake-side vacations.

McInnis loves traveling to Disney World, scrapbooking, and camping. She and her husband Dana have two sons, Craig and Chris, a grandson Cameron, and happily await the births of two more grandchildren.

Mayberry is busy editing a young adult novel and enjoys exploring archaeological finds in Central America. She loves vegetables and says her favorite vacation spot is anywhere tropical (“sunshine + blue ocean = happy me”). She is married and has three “fun” children.

IPPS final rule

Payment changes could prompt CDI expansion

Value-based purchasing, readmission reduction, new guidelines for inpatient admission all require CDI involvement

In years past, CDI specialists needed to review the Inpatient Prospective Payment System (IPPS) final rule with an eye toward changes in the documentation and coding adjustment (DCA), CC/MCC designations, and any corresponding MS-DRG changes.

The world of healthcare reimbursement changed significantly over the past few years, however. The coding freeze associated with ICD-10-CM/PCS implementation means limited changes to MS-DRGs and their CC/MCCs, and the once universal outrage at DCA payment reductions (a negative 0.8% this year) has hushed to a mere grumble.

Yet, “don’t let the relative quiet fool you,” says James S. Kennedy, MD, CCS, CDIP, president of CDI MD-Physician Champions in Smyrna, Tenn., “there are big changes in this year’s IPPS final rule, changes that represent a paradigm shift in the way CDI programs work.”

Most people who think of CDI think first about the financial implications (i.e., the role of the CDI specialist as...
being tied to CC/MCC capture and ensuring the highest-weighted MS-DRG gets reported, Kennedy says.

Now, “people need to think in a more global light. There has to be a broadening of scope into all areas of documentation improvement,” he says.

This year, the hubbub is all about the government’s various pay-for-performance measures, which shift the emphasis away from paying physicians and facilities for every service provided toward providing incentives and disincentives according to the quality of care across the healthcare continuum. The big items in the final rule fall into three buckets:

1. Readmissions reduction and hospital-acquired conditions (HAC)
2. Value-based purchasing (VBP)
3. 2-midnights rule

**2-midnights rule**

Forget about watching the clock. Never mind adding up the hours. Say goodbye to the 24-hour or overnight benchmark related to the medical necessity of patient admissions. Instead, welcome in the new 2-midnights rule as the new parameter in justifying inpatient admissions. The way the rule works is that if the admitting physician expects the patient to require care that could span more than two midnights, the admission would be considered medically necessary. (The new language can be found at § 412.3; complete details are available at www.tinyurl.com/2MNrule.)

The new guidelines specify some changes to the order for

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**2014 IPPS FINAL RULE: Sample inpatient order**

What does this mean for you? Adapt this order sheet donated by Alamance Campus of Cone Health in Burlington, N.C., to handle the new 2-midnight rule.

For INPATIENT admissions, the order MUST state either:

- Patient is expected to need inpatient care for greater than 2 midnights
- Rare and unusual circumstances exist requiring inpatient care but patient may not be in house greater than 2 midnights
- Patient here for inpatient-only procedure

If you select inpatient visit status you will need to select one of the options. If you check “rare and unusual circumstances,” you must add a description of the circumstances.

![Order Sheet](image)

**Documentation must-haves:**

- **MEDICAL NECESSITY:** Include medical history and comorbidities, severity of sign and symptoms, current medical needs, and risk(s) of adverse events.
- **WHY** the patient needs to be inpatient for greater than 2 midnights. CMS states, “The factors that lead a physician to admit a particular beneficiary based on the physician’s clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record.”

Source: Vicki S. Davis, RN, CDI specialist, Alamance Campus of Cone Health, Burlington, N.C., vladavis2@armc.com.
inpatient admission including:
» Order must be at or before the time of admission
» Order must include the word “inpatient;” using the words “admit,” or “admit to 4th floor” does not qualify

“They want the physician to be very clear whether they’re admitting to inpatient or admitting to some other kind of status,” said Kimberly Anderwood Hoy Baker, JD, CPC, director of Medicare and compliance for HCPro, Inc., during the September 10 audio conference, “2014 IPPS Final Rule Explained.” (http://tinyurl.com/q7qyc2e) The order to admit to inpatient also requires the physician to document why he or she expects the patient requires that level of care as well as the type of care expected for successful discharge.

“The benchmark is important because that’s how the physician should be documenting—how long they think the patient should be staying in the hospital based on [his or her] medical condition, risk of an adverse event, and severity of illness,” said Marc Tucker, DO, FACOS, FAPWCA, MBA, senior director of audit compliance and education and Executive Health Resources in Newtown Square, Pa., in an article for JustCoding.com.

“I personally know of no physician or admitting process that captures this information; changing this documentation process will be a tremendous shift,” Kennedy says. It’s a shift that CDI programs should spearhead, says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, C-CDI, CCDS, senior manager with Accretive Health in Chicago.

“Effectiveness of CDI in support of the physician’s decision to admit as an inpatient assumes even more importance in light of this change,” he says. “Auditors will be looking for a clear outline of the physician’s clinical rationalization and reasonable expectation of a hospital stay that spans two midnights,” Krauss says.

And it’s one which Alamance Campus of Cone Health tackled already, says Vicki S. Davis, RN, CDI specialist at the Burlington, N.C., facility.

“Our CDI team actually facilitated the discussion and pulled the work group together,” says Davis. The intake and CDI nurses met with the facility’s physician champion and information technology staff to create a new inpatient admission order set which incorporates the necessary pieces of the new requirements. Due to the physician champion’s involvement, the new policy was readily accepted and well perceived,” she says.

The new order set replaces the pre-existing admission orders which are no longer available for use. (See p. 12 for their sample order.) Alamance’s electronic health record will no longer allow an inpatient admission order to be placed without appropriate documentation certifying the need for a stay over two midnights, an inpatient-only procedure, or the “rare and unusual circumstance” that CMS requires in the IPPS rule, Davis says.

“The documentation [now] required to validate inpatient status becomes the documentation we try so vigilantly to help improve on a daily basis. Without realizing it, CMS helped improve CDI programs everywhere,” she says.

### Readmissions reduction, HACs

The IPPS final rule also includes new measures related to the hospital readmissions reduction program (HRRP) and HACs.

Perhaps the most interesting aspect of reimbursement changes is the time periods they cover. Under the HRRP last year, CMS placed 1% of MS-DRG reimbursement at risk (either you met the conditions specified and received the 1% increase in payment or you did not meet the conditions and risked losing that 1%).

For FY 2014, 2% of reimbursement is at risk. However, the data which determines what increase or decrease a facility receives is derived from the three-year period of July 1, 2009, through June 30, 2012, said Kristen Geissler, MS, PT, CPHQ, MBA, director at Berkeley Research Group, LLC, in Washington, D.C., during the September 10 HCPro audio conference. (Tip: To view your facility’s FY 2014 assessments at QualityNet.com, contact your QualityNet administrator.)

It can seem a little like time travel with documentation measures listed in this year’s IPPS final rule counting against reimbursement in years 2015, 2016, and beyond. So, CDI professionals need to ensure that any documentation reflecting those measures gets captured in the record now.

For the HAC reduction program, measures take effect for FY 2015, based on claims data from July 1, 2011, through June 30, 2013, with a rate adjustment of 1%.

“It is pretty important to note that this measurement period is now over,” says Geissler. “What’s going to happen
is the worst 25% of hospitals will lose 1% of Medicare-based DRG revenue. It's a lot of dollars at risk."

CMS only added one diagnosis to the readmission reduction list this year—acute chronic obstructive pulmonary disorder (COPD) exacerbation, citing it as one of the leading causes of Medicare readmissions and the fourth most costly preventable readmission nationally.

CMS will look for coding/diagnoses for principal diagnosis of COPD as well as a principal diagnosis of respiratory failure and a secondary diagnosis of an acute exacerbation of COPD, Geissler says.

The other measure—elective total hip and total knee—accounts for the greatest amount of spending on procedures for Medicare, says Geissler, and the number of such procedures “are increasing steadily. It sounds like something Medicare really wants to get a handle on,” she says.

The HAC Reduction Program expands on efforts associated with the Deficit Reduction Act (which CMS now calls DRA-HACs). The Agency for Healthcare Research and Quality (AHRQ) includes HACs in its inpatient quality reporting (IQR) public data, which it then carries over into the AHRQ patient safety indicator (PSI) composite measure in VBP.

The new program establishes two domains; the first for PSI 90 composite and the second for healthcare-acquired infections, including (see related chart below):

- Central line-associated bloodstream infections (CLBSI) and catheter-associated urinary tract infections (CAUTI) for FY 2015
- Surgical site infections for FY 2016
- Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections for FY 2017

There is mapping available for HACs to ICD-10 on the CMS website, (http://tinyurl.com/blzb57k)

CMS removed a number of IQR measures in FY 2013 IPPS final rule, and this year removed eight measures effective FY 2016. New measures added for FY 2016 (applicable to documentation improvement efforts now) include:

- 30-day COPD readmission
- 30-day COPD mortality
- 30-day stroke (ischemic) readmission
- 30-day stroke (ischemic) mortality
- Acute myocardial infarction (AMI) payment per episode (30 days after index admission)

VBP

CMS created the VBP program in 2011. Items finalized in this year’s IPPS final rule effective FY 2015 include:

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<th>Domain 1</th>
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<tr>
<td><strong>FY15 and beyond</strong></td>
<td><strong>FY15 and beyond</strong></td>
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<td>PSI-90 – Patient Safety for Selected Indicators Composite</td>
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<td>Pressure ulcer rate (PSI 3)</td>
<td>CAUTI</td>
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<td>Iatrogenic pneumothorax rate (PSI 6)</td>
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<td>Central venous catheter–related bloodstream infection rate (PSI 7)</td>
<td>Surgical site infection (SSI) – colon surgery and abdominal hysterectomy</td>
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<td>Postop PE or DVT rate (PSI 12)</td>
<td>MRSA infection</td>
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<td>C. diff infection</td>
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<td>Postoperative wound dehiscence rate (PSI 14)</td>
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<td>Accidental puncture or laceration (PSI 15)</td>
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» CLABSI
» AHRQ PSI Composite
» Medicare Spending per Beneficiary

New measures for FY 2016 include:
» Immunization for Influenza (IMM-2)
» CAUTI
» Surgical site infections for colon surgery and hysterectomy

These measures are included in the IQR for FY 2014 with data collection for VBP beginning in 2012. (See the chart on p. 15, for a visual representation of how measures will be weighed over the coming years.)

IQR, says Geissler, is the “pipeline for VBP” so items added to IQR will likely soon be added to VBP and items removed from IQR in this year’s final rule are “in lockstep” with items removed from VBP.

The bottom line: CDI professionals should be working with their partners in quality to determine what documentation isn’t currently being captured that needs to be.

CDI advancements

The IPPS final rule “is like the tax code, it’s just complicated,” says Kennedy. “You can really get lost in the minutiae.”

CDI professionals have to stay focused on the quality and completeness of the overall documentation from beginning to end, he says.

Those with experience in case management can help with new inpatient admission rules, catching any cases where the documentation may be ambiguous and bringing it to the attention of the case managers, and querying the physician where necessary, Kennedy suggests.

CDI staff should be reviewing records for severity indicators and risk of mortality particularly related to items identified by CMS in this year’s IPPS final rule, he says. “QualityNet should be required reading for anyone in CDI today,” Kennedy adds.

Learn how to conduct outpatient reviews, understand the hierarchical condition code payment method, and understand how documentation of the principal diagnosis drives patients’ overall conditions, he adds.

“CDI professionals need to be part of an army supporting the physician to ensure the entire episode of care of the patient is documented in the record. This isn’t a golf team,” says Kennedy. “We’re a basketball team. We have to pass the ball. We have to set each other up for success. What good is it going to be for the CDI staff to catch an additional diagnosis if it is going to be denied further on down the road?”

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<th>FY2013 final</th>
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We’re not in Kansas anymore!

Questioning the clinical validity of medical documentation

by Trey La Charité, MD

I realized, painfully, early in my career as a physician advisor for CDI that I needed to learn a lot more about coding and the process of translating physicians’ written words into ICD codes. I also needed a more secure footing to successfully appeal the ever-increasing volume of denials my facility faces. So, I decided to go back to school. I enrolled at a nearby community college in the same course many of our coders had taken to earn their coding certificates or RHIT degrees. It taught me how to perform ICD-9 coding. Through that course work, I developed a tremendous respect for coders. If I learned nothing else, I learned that coding is just plain hard. You know why some charts have coding mistakes? Coding is hard!

Lions, and tigers, and bears! Oh, my!

Compounding the difficulty of coding is the underlying fact that the world of the coder is rapidly expanding beyond their traditional classroom teachings. Unfortunately, mastering the intricacies of the ICD system is no longer the only problem coders wrestle with. Like it or not, the demands placed on coders complicate an already difficult profession.

The one refrain repeated to the class during my coding education was that it is not the coder’s responsibility to interpret the physician’s documentation. In the past, the coder was expected to code only what the physician documented: nothing more or less.

The new regulatory environment we face today, however, directly challenges this long-established coding tenet. How? Auditors have a decidedly unfair advantage over coders when they review case submissions. While naturally being allowed to review the correctness of our submitted ICD codes, auditors are also allowed to validate the presence and correctness of the diagnoses documented by our physicians.

For example, if a physician documents “acute renal failure,” the coder is traditionally obligated to code that diagnosis whether or not it actually exists. The auditor, however, sits with his or her definition of “acute renal failure” while reviewing the chart and scours the lab values to see whether the definition was actually met. If the auditor’s threshold for satisfying his or her definitional requirement for a given diagnosis is not reached, that diagnosis is removed and you are faced with yet another denial. If this downgrades the DRG submitted, it is frequently reported as a “coding validation denial.” Unfairly, this terminology implicates the coder as the creator of this error as opposed to the physician who documented something that was not present. In other words, coders are being held accountable for things that are not part of their job description and not in their control.

Follow the yellow brick road

To counteract this inequity, the role of the coder must evolve. If our facilities are going to survive today’s regulatory challenges, our coders can no longer blindly code whatever the physician documented in the medical record. Like it or not, coders need to develop the same diagnostic validation skills displayed by CDI specialists. They need to recognize that some diagnoses written in a patient’s chart may not be clinically accurate or appropriate. More importantly, when the coder recognizes that a documented diagnosis does not actually exist, he or she must display the fortitude to question the provider who documented that diagnosis.

Operationally, this may initially result in decreased coder productivity as the coders will need to send more post-discharge queries to resolve these issues. While the thought of sending additional paperwork to your medical staff is less-than-appealing, it is unavoidable. Provider clarification of questionable or clinically unwarranted diagnoses must be obtained prior to submission for reimbursement. This will probably prove to be an unpopular course of action with your physicians since post-discharge queries require increased provider time for retrospective chart review and analysis. Unfortunately, all doctors feel their time is already overly taxed. CDI programs risk significant backlash as providers bristle at the obvious fact that you are questioning their clinical judgment. Yet, the facility, not the individual physician, is at risk for what the physician incorrectly documented.
Therefore, incurring the wrath of a physician is a required gamble in the constant struggle to keep your facility open.

You can mitigate providers’ response by explaining to your medical staff the potential facility detriments created by the auditors if inaccuracies are discovered. Unfortunately, you need to make contingency plans for physicians who refuse to answer post-discharge queries concerning questionable diagnoses and make decisions regarding whether to code a documented diagnosis that is clearly not clinically present when the attending physician refuses to revisit the case.

In the joint ACDIS/AHIMA physician query practice brief published earlier this year (see the April and July editions of the *CDI Journal*), the two organizations recommend facilities create an escalation policy for just these reasons. The brief outlines two possible policy options (see p. 4 of the July edition) as examples.

**Beware of the flying monkeys!**

To further motivate change, please understand that the government does not care whether an incorrectly documented diagnosis is just a simple mistake. The U.S. Department of Justice (DOJ) and the Office of Inspector General (OIG) have made it clear that documenting something in the medical record that is not clinically present constitutes fraud. Furthermore, they do not require the presence of “intent” to willfully misrepresent a patient’s medical condition as a component of charging a provider with fraud. In the opinion of these regulatory entities, a provider who makes a simple, honest diagnostic inaccuracy that results in an increased reimbursement to your facility is as equally guilty as if he or she intended to defraud the payer.

If your facility’s operating margin is as thin as mine, an unfavorable investigative endeavor by the DOJ or the OIG could be catastrophic. The compliance risk of allowing unfiltered ICD submissions has simply become untenable to allow the continuation of prior coder practice patterns.

**Off to see the wizard?**

This is a very challenging concept for facilities to grasp. First, there is the traditional coding mantra that “it is not the place of the coder to question the physician’s judgment” that must be surmounted. Second, and perhaps more importantly, most coders simply do not have enough clinical knowledge to validate whether a documented diagnosis actually exists.

During training, coders take only one semester of medical terminology and only one semester of pathophysiology. Additionally, coders have no clinical experience as they do not have any direct patient care responsibilities or rotations during their training. However, coders are going to have to cultivate some degree of clinical awareness to help ensure the medical record’s accuracy.

In my facility, we have instituted periodic coder education sessions where I review both the clinical definitions of various disease processes and their pathophysiologies. Our coders submit topics for these sessions if there is anything they feel they do not grasp from a medical perspective. Equipping our coders with the necessary clinical acumen to recognize definitional inaccuracies has become a significant and important educational thrust in our ongoing efforts to maintain the highest possible degree of coding compliance.

**If this author only had a brain**

I am not saying coders should code whatever they feel is appropriate. I do not believe that the coder should make the final decision as to whether an inaccurate diagnosis that is documented by a physician should be coded. The coding quality coordinators, HIM managers, and physician advisors should review charts where this kind of problem is detected. Only then, after a more thorough and comprehensive analysis, should the decision be made collectively to leave a documented diagnosis off of the final coding summary.

Because these supervisors cannot critique every chart, it is becoming the coder’s responsibility to recognize and report any clinical inaccuracies he or she has detected in the medical record. In today’s world, the coder and the CDI specialist need to work as a cohesive unit to ensure that every chart accurately reflects the patient’s complete medical situation.

While this new mind-set involves the clinical documentation specialist learning more about coding, it also necessitates that the coder learn more about medicine. Our facilities simply can no longer afford for this challenge not to be taken up by our coders.

*Editor’s note:* La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville (UTMCK) and an ACDIS advisory board member. His comments do not necessarily reflect those of UTMCK or ACDIS. Contact him at clacharite@utmck.edu.
Complications of care

Take a team-based approach to ensure accurate reporting

by James P. Fee, MD, CCDS, and Garry L. Huff, MD, CCS, CCDS

As we continue to evolve from fee-for-service to performance-driven healthcare, transparent quality and consumer value demand a cooperative integration of all stakeholders. Simply put, quality of care is reflected by quality documentation. All individuals, including coders, CDI specialists, and physicians, must contribute their expertise to mold this new integrative approach. After all, understanding and controlling your data (reflective of care delivery) fosters the development of processes and policies that benefit the patient.

Aspects of patient care that provide insight into performance are complications of medical and surgical care. In fact, such measures as patient safety indicators (PSI) and hospital-acquired conditions are used to define quality by identifying avoidable complications and iatrogenic events. This data, in turn, generates system-level protocols to address such conditions. However, before the compiled data can be appropriately analyzed, the integrity of that information must be ensured. Through an integrative approach, providers should ensure that the clinical database is accurately portrayed within the coding database, from which CMS and other entities formulate benchmarks of quality.

In order to attest to the clinical validity and integrity of the coding database, clinical documentation and quality teams must understand the concepts regarding the definition of complications, appropriate assignment of such ICD-9-CM codes, and their implications regarding profiling and reimbursement. Complications of care delivery are defined as unexpected events or expected/integral conditions with unexpected resource utilization, and are directly linked to medical or surgical care by the treating physician. These conditions possess more than a temporal relationship but rather one of “cause and effect.”

An important distinction must be made regarding a documented condition as being “postoperative.” In fact, most physicians would endorse that a “postoperative” condition is simply one that occurs after the procedure is completed and not “due to” the procedure.

Certainly, the alphabetical and tabular index of the ICD-9-CM codebook assume the “postoperative” relationship as causal, but a CDI specialist should investigate this further within the specific clinical context. That being said, in addition to establishing the conclusive link, the reportability of the condition is predicated on the guidelines established by the Uniform Hospital Discharge Data Set. These include clinical or diagnostic evaluation, treatment, increased monitoring, increased length of stay, and implications of future healthcare needs (newborns only). Following are some clinical conditions and the issues that can impact quality ratings.

Postoperative respiratory failure

An example that often creates havoc among quality and clinical documentation teams is the documentation of “postoperative respiratory failure.” Indexing this condition takes the coding professional to 518.51. However, prior to assigning the code, the documentation team, using the integrative approach, should validate the diagnosis through a series of questions:

» Is there clinical support for the diagnosis?
» Was the condition unexpected?
» If expected or integral, was the care provided beyond routine care?
» Was the condition due to the procedure performed?
» Does the condition meet guidelines for reporting?

The answers to these questions will ensure the validity of the code assignment and the integrity of the coding database. Let us dissect this using some clinical scenarios.

COPD with open colectomy

A patient with known Chronic Obstructive Pulmonary Disease (COPD) undergoes an open colectomy. Postoperatively, the patient develops a respiratory rate of
40, wheezing, intercostal retractions, and a pulse oximetry of 85% on room air. High flow oxygen at 6 liters per minute (LPM) is applied in addition to nebulization therapy and intravenous steroids. The attending physician documents acute postoperative respiratory failure secondary to COPD exacerbation and states that it is not due to the procedure.

Using our methodology (above), we affirm that the diagnosis of acute respiratory failure is clinically supported, the condition was unexpected requiring additional medically necessary and reasonable treatments, and, therefore, the condition is reportable.

However, the “postoperative respiratory failure” is due to COPD exacerbation. The cause-and-effect relationship does not exist between the respiratory failure and the surgery, so 518.51 should not be reported but instead, a coder should report 518.81 (acute respiratory failure) and 492.21 (chronic obstructive bronchitis with acute exacerbation).

**Lung cancer with lobectomy**

A patient with lung cancer undergoes open thoracotomy with lobectomy. Postoperatively on day two, the patient develops progressive shortness of breath, respiratory rate of 32, with pulse oximetry of 82% on 2 LPM, and was found to have a progressive pneumothorax. The patient requires 100% non-re-breather mask and the chest tube was adjusted. The attending documents acute postoperative respiratory failure.

Applying our methodology, we clinically affirm the diagnosis of acute respiratory failure, that the condition was unexpected requiring additional therapy, and it is reportable. Unlike our first case, however, the cause-and-effect relationship is established, and therefore, it is appropriate to report 518.51 (respiratory failure following trauma or surgery).

**CAD with bypass**

Now, let us take a look at a case that haunts every provider and CDI team. A patient with three-vessel coronary artery disease (CAD) undergoes coronary artery bypass grafting. After the procedure is completed, the patient remains intubated and is transferred to the intensive care unit. The critical care physician documents “postoperative respiratory failure” with stated plan to wean as per protocol. The patient is extubated to nasal cannula at 3 LPM after six hours and is weaned to room air after 12 hours. There is no documented increased work of breathing, shortness of breath, or hypoxia.

Once again, using our algorithm, we determine that the diagnosis of respiratory failure lacks clinical indicators, and the condition was expected with routine care provided. However, the documentation reflects “postoperative respiratory failure.” As per the most recent joint practice brief by ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice,” published in February 2013, the CDI team should query for clarification of the diagnosis or use the institution’s escalation policy. This is a crucial step since the diagnosis erroneously inflates hospital reimbursement, but also impacts the institution’s profiling regarding PSI 11: Postoperative Respiratory Failure Rate.

In a recent study published in *The Journal of the American Medical Association* in April 2013, surgical complications increased hospital revenue significantly. This finding reflexively demands the question: Are complications being appropriately reported?

Not only will this assertion end up increasing coding audits for clinical validity by Recovery Auditors, but it will also intensify the focus on pay-for-performance and the associated profiling. In fact, the PSIs, which include various complication codes, are shifting from mandatory reporting within the Hospital Inpatient Quality Reporting program to value-based purchasing program in FY 2015. (Read a related article regarding this year’s IPPS final rule on p. 11.)

With this change, hospitals will see up to a 1.5% reduction in all DRG payments for that FY, if benchmarks are not achieved. Therefore, it is imperative that the CDI team and quality team work together to both prospectively and retrospectively ensure the documentation accurately reflects care delivery and code assignment. By developing an integrative approach involving coders, clinical documentation specialists, and physicians, the clinical documentation team can achieve and preserve the integrity and reliability of the medical record. In doing so, quality of care will become transparent and drive processes for continued improvement.

**Editor’s note:** Huff is president and CEO of Huff DRG Review, in Memphis, Tenn. He served on the Editorial Advisory Board of the *Coding Clinic®* for ICD-9-CM. Contact him at info@huffdrgreview.com. Fee is Associate Director of Huff DRG Review and maintains a clinical practice in hospital medicine. He is also an AHIMA-approved ICD-10-PCS/CM trainer. Contact him at James.Fee@drgreview.com.®
ICD-10 Coding Corner

Recap of Coding Clinic, Second Quarter 2013

Editor’s note: AHA Coding Clinic for ICD-9-CM released its third round of ICD-10 coding guidance in its Second Quarter 2013 issue. HCPro CDI Education Director Cheryl Ericson, MS, RN, CCDS, CDIP, AHIMA approved ICD-10-CM/PCS trainer, says the guidance contains several questions about procedures which may be problematic for coders. Organizations have to decide whether their CDI specialists will query for procedures beyond clarifying excisional from non-excisional debridement as they do today, says Ericson.

Other important updates in this issue include entries on decompensated systolic congestive heart failure (CHF), anticoagulation therapy, and use of sign/symptom/unspecified codes. The following is a recap of the issue with an eye toward what it means for CDI specialists.

General coding updates

The 2014 ICD-10-CM Official Guidelines for Coding and Reporting were published recently (view them on the Centers for Disease Control and Prevention website: www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf) and contain some updates that are cross-referenced in this issue of Coding Clinic, Ericson says.

“Overall, we’re still seeing Coding Clinic providing advice about shortcomings of the ICD-10 code set,” she says.

Some people were hoping that everything would have a specific code, but some of the examples show that you will have to use an ‘other specified’ or ‘not elsewhere classified’ code.”

For example, on p. 31, Coding Clinic states to use “other specified conductive disorders” to report a diagnosis of short QT syndrome. And on p. 32, Coding Clinic states that documentation of acrokeratosis paraneoplastica, Basex syndrome goes to L98.8, other specified disorder of the skin. These entries serve as a broader reminder of the differences between unspecified and other specified codes.

“‘Unspecified’ means [that there is] a lack of documentation [available] to assign to a more specific code, whereas ‘other specified’ means that the physician gave us more detail than the code set can accommodate,” she says. “We’re not going to teach the physician to be more general—you don’t want to do that.”

It will be confusing (and time-consuming) to CDIs and coders alike when they are unable to assign a specific code for some diagnoses as occurs today with the ICD-9-CM code set, Ericson says.

“It will be a trial-and-error process as the CDI staff learns which diagnoses don’t have specific codes within the ICD-10-CM code set,” she says.

It is a concern also seen in pregnancy diagnosis coding, including entries on intrauterine device placement (p. 34), intrauterine pressure monitoring (p. 36), and determining weeks of gestation (p. 33).

“It’s not relevant to traditional CDI efforts, but we’re seeing more CDI staff review pediatric and obstetric populations because of changes in Medicaid payments,” she says. “In ICD-10, older grouper payment systems will no longer be supported, so many payers have to adopt a new payment strategy or begin using MS-DRGs or APR-DRG groupers for claims processing. Whenever patients can be stratified into one or more groups, CDI specialists can have an impact, so we’re seeing CDI expand into other patient populations to ensure patients are classified accurately into the different groups. Doing so can impact reimbursement and quality metrics.”

On p. 31, Coding Clinic reiterates that E codes remain voluntary for reporting, but Ericson says to be wary of thinking that rule of thumb applies in every instance. “Some combination codes such as poisoning and toxic effects traditionally required E codes in ICD-9 for clarification of the circumstances of the event. This information will now be captured using combination codes,” she says. “That means the additional information won’t always be voluntary.”

CHF, anticoagulation therapy

“The big win” in this issue of Coding Clinic is advice regarding decompensated systolic CHF (p. 33). The question references a previous Coding Clinic (Third Quarter 2008,
p. 12) that equated decompensated systolic heart failure to acute on chronic systolic heart failure.

“There is no coding guideline and the ICD-10 tabular list does not carry that concept into ICD-10,” Ericson says. “We didn’t know if this concept would be retained in ICD-10 but someone specifically referenced the 2008 Coding Clinic to see if it applies in ICD-10-CM.”

In response, Coding Clinic clearly states to assign I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure. Be forewarned, however, decompensated is not synonymous with exacerbated, Ericson says.

“We’re still looking for guidance whether the term ‘exacerbated’ will still mean acute on chronic for specified heart failure in the ICD-10 code set,” she says. “As long as the physician documents decompensated, we’re okay, but if he or she says exacerbated, we may still need to query for acute on chronic. So it’s a partial win. Semantics are everything in coding. Provider terminology has to be exact for a code to be accurately applied.”

Coding Clinic also provides additional clarification regarding anticoagulation therapy (p. 34). Ericson says an ongoing source of confusion is that anticoagulation therapy is the same as coagulopathy. Within the ICD-10-CM codes set (as was the case within the ICD-9-CM) a coagulopathy is an acquired condition, whereas if the use of medication is involved it’s either an adverse effect or a poisoning.

Coding Clinic, Second Quarter 2013, pulls this concept forward into ICD-10-CM with an entry on Warfarin-Induced skin necrosis, which codes to I96 (Gangrene), followed by a T code for the adverse effect of the anticoagulant.

“This is consistent with advice we’ve seen through ICD-9 Coding Clinic,” Ericson says. “However, I wish their advice was even more specific and stated that the use of the T code for adverse effect is based on the assumption that the medication was correctly prescribed and correctly administered, as we wouldn’t want inexperienced CDI specialists and/or coders thinking these situations are always adverse effects. This type of over coagulation can also result from a poisoning, which would change the sequencing of the diagnoses.”

**Specified vs. unspecified codes and diagnostic testing**

On p. 30, Coding Clinic discusses the use of specific diagnosis codes vs. unspecified codes, stating that “each encounter must be coded to the level of certainty known for that encounter.”

The entry is critical, Ericson says, as it discusses the balancing act between selecting the most specific code possible—the role of the CDI professional—versus conducting medically unnecessary diagnostic testing to achieve a more specific code. The latter should never be done, Coding Clinic states:

> It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

“They are saying don’t increase the cost of healthcare by ordering a more specific test if it’s not going to help the treatment plan,” she says.

Ericson cites the example of an echocardiogram to diagnose the type of heart failure. Providers often rely on documentation of an ejection fraction (EF) of less than 40% to classify heart failure as systolic. However, Ericson notes that it doesn’t make sense to perform an echo test for every admission if the focus of the admission is not the heart failure just to obtain an EF to specify systolic and diastolic, because an echo from a year ago can still be valid (if the patient is stable, and not coming in because of aggravation of heart failure), she says.

“That’s when CDI specialists look for clinical indicators, including past echo results, to support a query for specificity if the term CHF is documented. We want to be as specific as possible, but you don’t want to perform unnecessary tests. At the same time we need to be sure that the documentation does support coding to the highest specificity allowed within the code set, so a query should be issued if more specificity is available within the code set per coding guidelines,” she says.

Organizations must decide whether it is the role of CDI or coding to query for increased code specificity if it won’t impact reimbursement or other CDI performance indicators. Organizations will not be penalized for the use of unspecified codes, but many industry professionals believe unspecified codes will eventually lose their CC or MCC designation to encourage the use of specificity within the ICD-10-CM code set.

Eventually, “who does this type of querying could change over time,” she says.
Pediatric efforts offer new CDI opportunities

It was around the time of the ACDIS annual conference when Bonnie I. Epps, RN, MSN, manager of CDI for Emory Healthcare in Atlanta, started researching the effect of expanding her CDI program to include pediatric and neonatal units. When asked why she was interested in expanding, she didn't hesitate in her response. “I’m not,” Epps says, “The pediatricians are.”

In fact, the pediatricians came to her to see whether documentation improvement could help their quality scores and improve their patients’ length of stay (LOS).

“Emory has a large push for reducing length of stay,” says Epps. “And the NICU [neonatal intensive care unit] has an extended LOS. We saw some evidence of patients being discharged sooner than what might have been warranted, and the pediatricians wondered if a lack of documentation may have been at the center of the trouble.”

Her research led her to attend “Leap Frog to Pediatrics: Implementing a Successful Pediatric CDI Program,” by Karen Bridgeman, MSN, RN, CCDS, CDI specialist at the Medical University of South Carolina (MUSC) in Charleston, and David Habib, MD, medical director of care management in the department of pediatrics there, during the 6th Annual ACDIS Conference this past May.

The MUSC CDI program started in 2005 with just two full-time equivalency staff members and a CDI manager for the 700-bed teaching facility. Today, it boasts a staff of 12 and reviews all payers having expanded into its pediatric facility in January 2012.

MUSC’s Children’s Hospital has 186 licensed beds, the majority of which are general medical-surgical, but the facility also has a significant number of Level III neonatal ICU, cardiology, and other intensive care services, Bridgeman says.

“We’re seeing more and more children’s facilities starting CDI efforts,” says ACDIS Advisory Board member Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta. “The largest growth comes from multi-hospital systems that already have CDI programs in place. They see the potential of expanding to their affiliated children’s facility.”

With roughly 500 children’s facilities in the nation, Gold sees both the probable benefit and difficulty inherent in such CDI expansion. Children’s hospitals do not have Medicare patients—the typical starting point for traditional, short-term acute care hospitals, he says. In fact, most are paid on a contract basis related to a certain percentage of the actual charges of the care provided “so there was little financial incentive for children’s facilities to implement CDI,” he says.

Furthermore, children’s facilities do not have the external scrutiny that adult hospitals face. Where typical healthcare facilities turn to HospitalCompare, HealthGrades, and other public quality report cards, children’s programs have few options, says Gold. He notes that Parents Magazine publishes an annual “Top 10” list, but that it is based on anecdotal data from its subscribers and research. So it can be difficult to persuade administration to expand CDI efforts based on physician ego, or quality scores either.

At MUSC, the CDI team started building their case for expansion by examining data from the University HealthSystem Consortium and National Association of Children’s Hospitals and Related Institutions. This data allowed MUSC to compare benchmarks regarding patients’ severity, mortality, and facility case-mix index (CMI). They took the 25 top and bottom DRGs and divided them into two categories—high-volume, low reimbursement and low-volume, high reimbursement—for Medicaid, Blue Cross, and commercial payers.

The data suggested that a higher level of clinical complexity existed than was being depicted in the medical record, Bridgeman says. Asthma and bronchitis, seizures, and neonatal care fell into the high-volume, low yield bucket; that cardiothoracic conditions and Level III neonatal ICU fell into the high-yield, low volume bucket; and that chart review of pediatric patients could help with respiratory failure, cystic fibrosis, sickle cell, and chemotherapy documentation improvement.

“We found the physicians writing respiratory distress, but that just wasn’t clear enough to determine whether it was an shortness of breath or a respiratory failure,” Bridgeman says. “Sepsis and shock weren’t being documented at all.”

Target documentation improvement areas at Phoenix Children’s Hospital include cerebral palsy, chemotherapy complications, and childhood syndromes (of which there are many), says Jill Lindsey, RN, BSN, CCDS, CDI specialist there. The nearly 400-bed facility began a CDI program in

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2010 after a consulting firm determined that their facility had a lower CMI than its neighbors, she says.

“That was really the driving factor,” says Nancy Rush, CDI manager at Phoenix Children’s. “Once we started seeing improvements we started seeing improvements in the overall financial health of the organization as well. We just couldn’t believe it.”

In the beginning the three-person team used query templates from the consulting firm but are now revising those forms in collaboration with its coding and physician staff members with an eye toward new challenges, changing clinical indicators, and ICD-10-CM/PCS considerations.

“If you aren’t doing this [reviewing pediatric records], get started quick,” says Lindsey. “It is so important with ICD-10.”

Those with experience in pediatric CDI say the most difficult aspect of pediatric expansion, aside from initially making the case to advance into the area to begin with, comes from the clinical and CDI language barriers.

“The real challenge is identifying pediatric opportunities,” Lindsey says. “Every time we reach out looking for the clinical indicators it always goes back to those indicative of the adult population. You need to make sure that it [clinical language to pediatric condition] is a true fit every time.”

“These are not just little adults,” says Bridgeman. “You just cannot apply the same clinical language to their diagnoses.”

The same is true about the difference between pediatric care and care for neonates, Bridgeman adds. Coding for neonates “is so different from the rest of the population. They are a whole different ball game,” she says. So she advocates starting with the general pediatric population first, and then once the pediatric CDI program becomes proficient, expanding outward.

“Take small bites, she says. “Branch out slowly.”

It’s a model that typical CDI programs know well since many started with consultants’ advice, picked up on improvement efforts related to CMI and the top tier MS-DRGs, then worked toward physician engagement, query revision, and program expansion.

“We really worked hard to get the support of the physicians and ensure the success of this program,” Rush says. “So it’s good when you achieve that type of success you can quantify.”

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**Coding guidance regarding V-code use for neonates**

**Q**: We recently began concurrently coding in our Neonatal Intensive Care Unit (NICU). One of our neonatologists is adamant that the principal diagnosis should not be the V code (i.e., V30.01) for the birth episode. Our coding supervisor explained that the V code is required for all babies born in-house and that the principal diagnosis of babies transferred from outside facilities will be the reason that they were transferred. She gave him the *Official Guidelines for Coding and Reporting* and other articles stating this.

Is there something we are missing here? He’s not satisfied and suggests we call other university hospitals to see how they are coding these babies.

**A**: He may be confusing physician coding (E/M) rules with the rules for inpatient coding. Your coding manager is correct, the *Official Guidelines for Coding and Reporting* are quite clear and state “For the birth admission, the appropriate code from category V30, Live born infants, according to type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 740-759.” “Should” is interpreted in this instance as “must.” The grouper will require that a V-Code be used as the principal diagnosis in this situation without exception, a function of grouper logic. The V-Code indicates only that a birth has occurred and additional codes would be required for other significant conditions, such as Patent Foramen Ovale, Hemolytic Disease, sepsis, and so forth. Therefore, I would explain to the physician that the opportunity to accurately report the complexity of the cases lies with accurate reporting of secondary codes for this particular group of patients as these distinguish a normal birth from one more complicated, with varying degrees of complexity afforded by the appropriate code sets.

*Editor’s note: Paul Evans, RHIA, CCS, CCS-P, CCDS, of Sutter Health in San Francisco, answered this question on the ACDIS message and networking board, "CDI Talk." Evans is the 2012 reviewer of The CCDS Exam Study Guide.*
## Attribution policy takes guess work out of assigning physician documentation responsibility

Years ago, the physician you saw for your annual checkup was the physician in charge of your care should you need to be admitted to the hospital. Today, however, this model has changed. With the complexity of care now required for many illnesses, and the complexity of physician structures at many facilities, determining which physician holds primary responsibility for the patient during a given stay can be much more difficult.

In response to this age of multiple specialties, hospitalists, confusing payment regulations, and public reporting measures, the team at Flagstaff (Ariz.) Medical Center established a policy and decision chart for its HIM/CDI staff to use to help determine which physician owns the responsibility for which portion of the medical record.

After the facility installed a computer-assisted quality assessment program, physicians were able to see their quality data in “real-time” rather than waiting for someone to show them how

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### Sample policy

#### Algorithm for assignment of physician role – inpatients

At the time of chart allocation, it is crucial to assign the appropriate role to each physician involved in the patient’s care. The correct role assignment allows reliable attribution of various aspects of the patient’s care to the appropriate physician, and assists in generating accurate performance, quality improvement, and value metrics. Following are definitions of the various physicians involved in the patient’s care and a chart to aid with proper assignment.

**Admitting physician** – The physician who authors or co-signs the history and physical exam. This will never be the emergency department (ED) physician, even though there may be an ED note/dictation evaluating the patient and the ED physician may write “holding orders.” There is only one admitting physician assigned for each hospitalization.

**Performing physician** – Any physician or surgeon who performs a procedure on a patient. Note: there may be multiple performing physicians.

**Consulting physician** – Any physician who authors a consult note in the patient’s chart and is not designated as an admitting, attending, or discharging physician. There may be multiple consultants. Medical-surgical residents and APPs CANNOT be consultants, according to the Medical Staff bylaws.

**Discharging physician** – The provider who authors the discharge summary. If no discharge summary is present at the time of chart allocation, use the physician who writes the discharge order. There is only one discharging physician.

**Attending physician** – If the patient’s primary DRG is surgical, excluding 004, 011, 012, 013 (tracheostomy codes) – the performing physician for the surgical procedure associated with the primary DRG is the attending physician. This rule takes precedence over all others. If the patient’s primary DRG is medical – use the rules below and the attached table.

The attending physician for medical DRGs is the physician most responsible for the patient’s care. The patient may be attended by multiple physicians during hospitalization but there is only one attending physician at discharge. If the patient has been on multiple services (e.g., critical care, surgery, hospitalist) determine how many days the patient spent on each service (you must use written orders for a change of service), then select the physician who had the most visits from the service that provided the longest care for the patient. In cases where the time in services is equal, select surgical over medical, critical care over general medical/pediatric.

**Questions? Contact your physician advisor.**
their care compares to others via HealthGrades or other reporting mechanisms, says Katy Good, RN, BSN, CCDS, CCS, CDI program coordinator for the facility. “Once they had that data in hand they came to HIM,” Good says. “They didn’t understand why their patients didn’t look as sick as they were.”

So they got a team together comprised of quality, HIM, and CDI, and “hashed it out,” she says.

Ultimately, Flagstaff developed a comprehensive policy identifying different physician types and defining their roles. Good says that the policy aims to more closely account for who provided the most care with the accountability for that care, and also documentation of the care.

For example, if the patient is admitted for a surgery then the primary responsibility for that documentation will likely be the surgeon’s. If the patient spent the majority of his or her time under the intensive care unit, then it will likely fall to the physician there.

“The real reason for this [policy] is to determine who is responsible, to ensure that the documentation of care tracks back to the individual which provided that care,” says Good. “We are obligated to make sure that the data is as accurate as possible.”

<table>
<thead>
<tr>
<th>Division/Section</th>
<th>Admitting</th>
<th>Performing</th>
<th>Consultant</th>
<th>Attending</th>
<th>Discharging provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>No</td>
<td>Yes - e.g., pain management, epidural, regional block</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Adult Critical Care / Intensivist</td>
<td>Physician who authors the H&amp;P</td>
<td>Yes - Bedside procedures such as central lines, chest tubes, etc.</td>
<td>Yes</td>
<td>If ICU LOS &gt; or equal to general med LOS, assign to intensivist with most progress notes. If general med LOS &gt; ICU LOS, follow General Medicine guideline</td>
<td>Physician who authors discharge orders and discharge summary</td>
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<tr>
<td>Emergency Medicine</td>
<td>No</td>
<td>In ED only</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>General Medicine / Hospitalists</td>
<td>Physician who authors the H&amp;P</td>
<td>Yes - outside of the OR bedside procedures (i.e., LP, thoracentesis, paracentesis, etc.)</td>
<td>Yes</td>
<td>Assign attending based on greatest number of progress notes</td>
<td>Physician who authors discharge orders and discharge summary</td>
</tr>
<tr>
<td>Medicine Subspecialities</td>
<td>Physician who authors the H&amp;P</td>
<td>Yes - Outside of the OR cardiac cath, biopsies, endoscopies, etc.</td>
<td>Yes</td>
<td>Assign only if subspecialist did H&amp;P &amp; no order to transfer care to hospitalist/intensivist - assign subspecialist in admitting specialty with greatest number of progress notes</td>
<td>Physician who authors discharge orders and discharge summary</td>
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<tr>
<td>Neurosurgery</td>
<td>Physician who authors the H&amp;P</td>
<td>Yes</td>
<td>Yes</td>
<td>If no surgical DRG, assign attending based on greatest number of progress notes</td>
<td>Physician who authors discharge orders and discharge summary</td>
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### Sample policy (cont.)

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<tr>
<th>Specialty</th>
<th>Who Authors H&amp;P</th>
<th>Delivering/Performing Physician</th>
<th>Attending Based on</th>
<th>DRG Surgical/Proceduralist</th>
<th>Summary Author</th>
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<tbody>
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<td>If no surgical DRG,</td>
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<td></td>
<td>discharge</td>
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<tr>
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<td>Yes</td>
<td>If no surgical DRG,</td>
<td>Physician</td>
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<td>who authors the H&amp;P</td>
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<td>assign attending based on</td>
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<td>on unit procedures such as central</td>
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<td>thoracentesis, etc</td>
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<td>discharge</td>
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<td>progress notes, OR if general</td>
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<td>discharge</td>
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<td>Psychiatry/Behavioral Health</td>
<td>Physician</td>
<td>ECT performed in surgery</td>
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<td>Physician</td>
<td>Interventional procedures</td>
<td>Yes</td>
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<td>Physician</td>
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<td>- must confirm radiology H&amp;P</td>
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<td>summary</td>
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<tr>
<td>General Surgery, ENT, Urology, Plastics</td>
<td>Physician</td>
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<td>Yes</td>
<td>If no surgical DRG,</td>
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<td>summary</td>
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</tbody>
</table>

S:/Dept/Clinical Value/Attribution/Algorithm for attending physician assignment 2-10-2013/KO

If the DRG is surgical, proceduralist is attending

Source: Katy Good, RN, BSN, CCDS, CCS, CDI program coordinator, Flagstaff (Ariz.) Medical Center, Kathryn.Good@nahealth.com.