ACDIS position paper defines CDI role

Guidance describes CDI specialists’ responsibilities

A new position paper written by the ACDIS Advisory Board (see p. 5) seeks to clearly define the CDI specialist’s role and establish professional standards for implementing new programs, redefining an existing department, or hiring new staff members.

“There are so many models of what people consider the CDI role to be. We wanted to describe the ultimate goal—what we see as the overarching intent of CDI—regardless of reimbursement, regardless of specialty,” says Robert S. Gold, MD, cofounder of DCBA, Inc., in Atlanta, and a founding ACDIS board member.

Leadership tool

CDI programs often originate due to fiscal concerns—capturing principal and secondary diagnoses to obtain a CC/MCC and improve the relative weight of a DRG. Administrators then decide to start a program. But frequently they don’t provide guidance on who should staff their CDI departments, nor define the expectations of the CDI reviewers.

“A chief financial officer hears that CDI efforts could help improve their case-mix index and thinks it’s a good idea to start a program, but they really don’t know what is entailed,” says Advisory Board member and CDI Boot Camp instructor Sylvia Hoffman, RN, CCDS, CCID, CDIP, president and CEO of Sylvia Hoffman CDI Consulting in Tampa, Fla.

Often, too, administrators identify a project leader and task him or her with starting the program without providing the leadership tools to do so, Hoffman says. She points to a high-profile hospital group which recently revamped its entire CDI program and hired all-new staff members after the initial lineup simply fell apart.

“Unfortunately, the original team didn’t completely understand the importance of identifying the DRG or following the Official Guidelines for Coding and Reporting when looking to identify principal and secondary diagnoses,” Hoffman says. “There are a lot of people working in CDI who don’t know what they don’t know and don’t know why they need to know it.”

The position paper seeks to address this problem by providing standards that new CDI programs can use to explain to administrators what goals should be set for the program and its staff.

It “seeks to promote a level of professional consistency to safeguard the role and reputation of the CDI [specialist] and promote its value within the healthcare system,” the paper states.

Broad guidelines

The paper’s intent is to “clarify the role,” “provide guidance,” and “promote” CDI value.
while being broad-based enough to apply universally to all CDI programs.

“Every CDIS, regardless of job description, is bound by a similar set of broad guidelines,” the position paper states. Among these are the adherence to ACDIS and AHIMA general principles of ethics, medical ethics, and Official Guidelines for Coding and Reporting. The paper also calls on CDI specialists to adhere to industry guidance, such as physician query practice briefs published in both AHIMA and ACDIS journals, and to stay informed about changes in the industry.

ACDIS is not a government or regulatory body, so the position paper does not set any legal precedent. However, as the only association dedicated to the CDI profession, its papers do carry weight within the industry.

“Of course there have been many different examples of job descriptions and many different opinions regarding what the roles and responsibilities of CDI professionals should be,” says ACDIS Advisory Board member Fran Jurcak, RN, MSN, CCDS, senior director of CDI practice for Huron Healthcare in Chicago. “The ACDIS Advisory Board wanted to be united on its stance and to publish something that not only takes all other official documents into consideration but something that stands as the official opinion of the CDI industry’s leadership.”

“There is a lot being published about what CDI is and what facilities should expect their staff members to accomplish. Unfortunately, a lot of it simply is not realistic,” says Gold. “The board felt like it was time to set the standard and to set the standard high. If you aim for the gold, you may not win gold, but you may end up with silver.”

In that regard, the paper establishes several sets of definitions and identifies reasons for needing “accurate diagnostic and procedural coded data,” noting how CDI efforts help ensure accurate reimbursement, capture patients’ SOI, and improve public quality data reports. The position paper describes coded data as “the lifeblood of both providers and the facilities in which they work.”

To ensure the accuracy of that data, the Advisory Board asserts that CDI specialists have to “apply a broad clinical and coding knowledge base to discern relevant clinical conditions.”

The paper further calls out the unique and “complex” role the CDI specialist plays in the healthcare revenue cycle.

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and in the overall patient-care continuum.

“The CDIS role . . . requires expert knowledge of clinical care and applicable coding guidelines, as well as an ability to communicate effectively with the clinical care team,” the paper states. To do this, ACDIS recommends that CDI specialists have certification as either an RN or a registered health information administrator or technician (RHIA/RHIT) with at least five years’ experience in the acute care/inpatient setting.

“We wanted to emphasize that collaboration between nurses and HIM professionals that has proven so beneficial to programs universally,” says Gold.

Program diversity and effectiveness

CDI department structure and staffing depends on a number of factors, including the number of beds at the facility and annual number of discharges. But despite programmatic differences influencing CDI programs across the nation, the ACDIS Advisory Board “really wanted to delineate that specialized expertise that the CDI specialist has,” says Jurcak.

“There is a sense that administrators see the term ‘documentation’ and think the CDI role encompasses everything that relates to it. We have to do our part to identify the specialized function in which CDI specialists operate,” she says.

This does not mean that CDI specialists should limit themselves to a strictly revenue cycle/HIM-related role. In fact, they should do just the opposite.

“One of the most interesting aspects of the CDI specialist is the ability to serve as the liaison between various departments,” Jurcak says. “It is a position that requires a basic awareness of the ways in which documentation is used and an ability to speak the various languages of that use,” such as clinical dialogue, coding verbiage, and physician language.

The position paper requires staff to have “working knowledge of quality improvement theory and practice, core measures, safety, and other required reporting programs.”

“What's needed for CDI isn't just querying for CC/MCC capture anymore,” says Hoffman. Instead, the paper calls on CDI professionals to become CDI educators, collaborators, and researchers; to “identify patterns, trends, variances, and opportunities to improve documentation review processes.” It challenges CDI specialists to keep abreast of current regulatory changes and to make sure that their department adapts.

“It is important to understand not only what you are doing but why you are doing it and how your efforts are improving over time,” Hoffman says.

As many facilities look to implement new CDI programs in light of ICD-10-CM/PCS, staff members need to know what their top 10 queries are and how those queries will change in light of the new coding requirements, she says. CDI professionals need to understand the effectiveness of their current queries and how to change those efforts to ensure success.

“This isn’t just a task for CDI department managers, but for everyone on the team. That’s why we included [tracking and analysis skills] in this paper,” Hoffman says.

Goals, not dictums

Of course, the ACDIS Advisory Board does not intend its position paper to be used as a strict hiring guideline for new CDI staff. A candidate may have excellent clinical and communication skills but be weak in coding knowledge, or be strong in medical record reviews and queries but weak in providing educational elements; these weaknesses do not necessarily preclude the candidate from becoming an effective CDI specialist.

“If I had to exhibit all of these qualifications [included in this position paper] when I first started as a CDI specialist, I probably never would have been hired,” says Hoffman.

Instead, the position paper represents standards that all CDI professionals should strive to achieve—standards CDI program managers and administrators should use to gauge their program’s growth and progress.

“Not everything is needed from the start, but there needs to be an expectation that they will learn these competencies within a certain amount of time,” Hoffman adds.

Even given her experience and efforts as an instructor, Hoffman consistently identifies new opportunities for her own growth in the industry. “I am still stretching, learning from my students, and attempting to push myself to new boundaries,” she says. “I think that intellectual adventurism is also a key component to what makes a successful CDI professional.” 🌟
**Director’s Note**

**Hard to find a silver lining in ICD-10 delay**

As of this writing, it appears that ICD-10 will be delayed at least another year. Note my use of “at least” because the actual language in the bill does not include a new enforcement date, but says “no earlier” than 2015.

The bill, H.R. 4302 – Protecting Access to Medicare (http://tinyurl.com/l5vrysb), primarily addresses Medicare payments to physicians and the Sustainable Growth Rate. But buried in it is section 212, a handful of lines that call for a delay in implementation of ICD-10 until no earlier than October 1, 2015. The actual language reads:

> The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

I hesitate to call this bill a disaster for hospitals (and, by extension, CDI departments). Some see a silver lining in the delay.

“The one thing that should not be done is to shelve everything completed so far until next year or halt progress in your coding and documentation improvement efforts,” says **Garry Huff, MD, CCS, CCDS**, of Huff DRG Review. “I would recommend you stay the course. You should use this next 12 months to get further acclimated to ICD-10 so that when it does happen, the transition will be seamless. Your investment has not been wasted; in fact, I believe this delay, unlike the first one, will ultimately prove to be a good thing for final implementation.”

But let’s face it: This delay is also harmful. Physicians will have to ultimately comply with the new date, but why should they listen the next time CMS says “no more delays?” It can be hard enough trying to convince them to document thoroughly under ICD-9, let alone a shadowy, oft-moved compliance date for ICD-10.

In addition, many of our member hospitals have already begun training, dual coding, and querying physicians for additional specificity to be ready for the original compliance date of October 1, 2014. Some have even secured additional coding staff or signed contracts with outsourced coding firms to deal with the anticipated backlog. Now all that work will be pushed out another year. Staff will need to be retrained. Implementation plans will be put on hold. CMS estimates that a one-year delay could cost between $1 billion to $6.6 billion, according to a statement from AHIMA officials.

“I was truly saddened to learn of this proposal,” says **Dee Banet, RN, BSN, CCDS**, director of CDI with Norton Healthcare and a member of the ACDIS Advisory Board. “In a time in healthcare when dollars are very tight, our facilities and providers have made sacrifices to allocate resources in preparation for the October deadline. I fear another delay will make it very difficult to sustain credibility when we would need to return to the finance teams asking for the additional dollars that would be needed in the event of a delay. Credibility would also be a challenge when attempting to get buy-in from the physicians and providers who are holding on to hopes of a delay to support their decisions to avoid needed preparations.”

The best advice we can offer is to stay the course and do your job to the best of your ability. Frankly, if you are clarifying diagnoses and procedures to their highest level of specificity, and ensuring that all diagnoses/procedures are supported by clinical indicators in the progress notes and elsewhere, than the codes should take care of themselves, regardless of whether they are reported in ICD-9 or ICD-10.

Try not to be discouraged, and know your job as CDI specialists remains as important as ever.

**Take care,**

Brian Murphy, CPC
Director, ACDIS
Defining the CDI specialist’s roles and responsibilities

Director's note: This position paper seeks to clarify the role of the clinical documentation improvement specialist (CDIS) and provide guidance in developing appropriate policies, procedures, and job descriptions for CDI departments. The CDIS role is complex and requires expert knowledge of clinical care and applicable coding guidelines, as well as an ability to communicate effectively with the clinical care team.

What follows is a generic, ACDIS-endorsed summary of the role of the CDIS, including recommended minimum qualifications, knowledge set, and special skills. This position paper also seeks to promote a level of professional consistency to safeguard the role and reputation of the CDIS and promote its value within the healthcare system.

Basic requirements

Complete and accurate diagnostic and procedural coded data is necessary for many reasons, including the following:

- Accurate reimbursement
- Financial and strategic planning
- Outcomes and statistical analyses
- Epidemiology and research
- Accurate reflection of a patient’s SOI and ROM
- Hospital, specialty, and physician quality of care, including patient safety and outcomes measures
- Communication of a patient’s overall health status to all providers in order to facilitate complete in-hospital and discharge treatment plans

Websites like Hospital Compare and Healthgrades, as well as private payers like Blue Cross/Blue Shield, use this same coded data in formulas to calculate individual physician and hospital profiles and organizational scorecards, all of which can impact a provider’s reputation and ability to deliver patient care. Coded data is, therefore, the lifeblood of both providers and the facilities in which they work.

CDI professionals strive to promote an accurate and meaningful database that clearly demonstrates the resources used in a patient’s care. The CDIS serves as an essential resource to the clinical team and ensures that all relevant conditions requiring healthcare resources throughout the patient’s hospitalization are accurately captured in the final coded data. Complete and specific documentation also promotes better patient care and disease management while appropriately reflecting the acuity, severity, and overall outcome of the patient.

In order to ensure that documentation in the health record contains these critical elements, a CDIS must apply a broad clinical and coding knowledge base to discern relevant clinical conditions. He or she must analyze the quality of provider documentation to understand where gaps and inconsistencies might exist between the clinical information in the health record and the information contained in associated data sets.

A hallmark of the CDIS is experience in complex clinical arenas such as intensive care or the emergency department, which require in-depth clinical knowledge, independent functioning, and high levels of personal responsibility. The focus of the CDIS can cover all patient ages, multiple clinical disciplines, and various settings of care beyond acute inpatient hospitalization; it may also include special attention to areas such as patient quality and safety measures.

Every CDIS, regardless of job description, is bound by a similar set of broad guidelines. These include:

- Adhering to ethical and professional business practices, such as the ACDIS Code of Ethics, general medical ethics, and official coding guidelines (e.g., ICD and CPT®, among others). A CDIS should use appropriate professional papers to support his or her daily processes, including white papers published by ACDIS, AHIMA, and other professional organizations.
- Following internal policies and procedures that are consistent with official coding rules and guidelines as well as regulatory reimbursement policies issued by CMS and other payers.
- Valuing high quality standards as evidenced by reliability, consistency, accuracy, integrity, and validity in CDI practice and process.
- Refusing to participate in illegal or unethical acts or to conceal the illegal or unethical acts of others.
» Respecting the confidentiality of identifiable health information and protected health information.

Summary of role

The CDIS facilitates modifications to clinical documentation through concurrent (pre-bill) interaction with providers and other members of the healthcare team. He or she promotes capture of clinical severity (later translated into coded data) to support the level of service rendered to relevant patient populations. In addition, the CDIS will:

» Clinically evaluate how the health record translates into coded data, including review of provider and other clinician documentation, lab results, diagnostic information, and treatment plans

» Communicate with providers either through discussion or in writing (e.g., formal queries) regarding missing, unclear, or conflicting health record documentation, and clarify the information as warranted

» Educate providers about identification of disease processes that reflect SOI, complexity, and acuity in order to facilitate accurate application of code sets

» Communicate with appropriate healthcare team members to promote accurate and complete documentation of diagnoses and/or procedures in the health record that have direct bearing on SOI

» Demonstrate an understanding of complications, comorbidities, SOI, ROM, case mix, and the impact of procedures on the billed record, as well as the ability to impart this knowledge to providers and other members of the healthcare team

» Gather and analyze information pertinent to documentation findings and outcomes, and use this information to develop action plans for process improvements

Minimum qualifications

Education: The CDIS candidate should be credentialed as an RN with five years of acute care experience, or as a registered health information administrator or technician (RHIA/RHIT) with at least five years inpatient coding experience. He or she should also have advanced clinical expertise and extensive knowledge of complex disease processes with broad clinical experience in an inpatient setting.

Licensure/certification: The candidate should be currently licensed as an RN or possess active RHIA/RHIT. Certified coding specialist (CCS) or other relevant experience is desirable.

Knowledge/special skills

» Clinical expertise with five years of inpatient experience

» Ability to work independently, self-motivate, and adapt to the changing healthcare arena

» Excellent verbal and written communication skills, analytical thinking, and problem solving with strong attention to detail

» Proficiency in organizational skills and planning, with an ability to juggle multiple priorities in a fast-changing environment

» Proficiency in computer use, including database and spreadsheet analysis, presentation programs, word processing, and Internet search

» Knowledge of federal, state, and private payer regulations as well as applicable organizational policies and procedures

» Working knowledge of quality improvement theory and practice, core measures, safety, and other required reporting programs

» Ability and willingness to seek out changes in healthcare reform and coding regulations, then incorporate those changes into chart review and educational responsibilities

Role functions

» Review inpatient medical records on a daily basis, concurrent with patient stay, to identify opportunities to clarify missing or incomplete documentation.

» Collaborate with providers, case managers, coders, and other healthcare team members to facilitate comprehensive health record documentation that reflects clinical treatment, decisions, diagnoses, and interventions.

» Utilize the hospital’s designated clinical documentation system to conduct reviews of the health record and identify opportunities for clarification.

» Conduct follow-up of posted queries to ensure that queries have been answered and physician responses have been appropriately documented.

» Provide or coordinate education related to compliance, coding, and clinical documentation issues within the healthcare organization. This may include rounding with
Identify appropriate sequencing skills for query opportunities

Q: I am a relatively new CDI specialist in a relatively new CDI program. We learned that we should be examining the health record with an eye toward “what bought the bed.” When we raise this concept to our coders, however, they disagreed with the premise, telling us that such a concept was not in line with coding regulations. Can you explain how we may have misunderstood this concept or help us to understand where the difference in perception may lay?

A: Traditionally, coding teams needed to only focus on ensuring proper codes were assigned, following the Official Guidelines for Coding and Reporting for sequencing. They also made sequencing choices that would lead to the greatest reimbursement. As long as the “rules” were followed, they had no concerns. Coders know the definition of a principal diagnosis to be identified by the Uniform Hospital Discharge Data Set as “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

I often explain sequencing for a lesser-paying DRG based on what the patient was actually treated for, or what would have “bought the bed,” rather than assigning a code for a diagnosis that was documented and may be reimbursed at a higher level. The choice of principal diagnosis should be a thoughtful decision reflecting the condition that brought the patient to the facility’s door, the treatment provided, and the care required to stabilize the patient. Consider conducting monthly coder-CDI team meetings to review difficult cases. During these meetings, request examples of medical necessity denials to reexamine as a team. The more discussion and exposure everyone involved in the revenue cycle has in regard to choice of principal diagnosis, the better the outcome on quality measures, potential denials, and payment incentives.

EDITOR’S NOTE
This question was answered by Laurie L. Prescott, MSN, RN, CCDS, CDIP, AHIMA Approved ICD-10-CM/PCS Trainer, is a CDI education specialist at HCPro in Danvers, Mass. Contact her at lprescott@hcpro.com.
I became a physician because I enjoy taking care of sick people. In today’s environment, however, I am subject to numerous unanticipated burdens that interfere with my continued enjoyment of that privilege. In discussions with my colleagues, I clearly have plenty of company. While the list of offending impediments seems to constantly grow, choosing the correct admission status is perhaps the one most despised by physicians.

**New patient status rules**

Recent changes to CMS’ guidance for appropriate hospital status determination, which resulted in the now-infamous “2-midnight rule” effective October 1, 2013, have only deepened the dark loathing physicians harbor for the subject. (Note that as of this writing, a potential delay was a part of Congressional debate.) Understanding the reasons behind providers’ frustration and disdain for the current status system should be helpful to the CDI professional.

Doctors are not blind. Providers know our healthcare system is financially unsustainable in its current form. Providers also understand that the basic tenet for fixing that problem is to pay providers less for their services. So, the decision was made to impose stipulations on the treatment of our patients.

The premise that patients need time to be “observed” before the decision is made to admit is bogus. As physicians, our medical training focuses on answering one fundamental question: Does the patient need to come into the hospital because he or she requires urgent medical attention, or can the patient be safely discharged home to follow up with another provider in the near future?

Physicians also consider the status designation of observation versus inpatient as completely arbitrary. There is no medical reference that cites admission status as a decision point in treatment or disease management. Status is not part of the knowledge base of anatomy, physiology, or disease pathology providers draw from daily. An “observation” patient receives the same level of care, resides in the same hospital bed in the same hospital room, and is seen by the same medical staff as an “admitted” patient. Therefore, why should those patients have a different status designation at all? For providers, it is the patient’s medical condition that dictates the care rendered, not whether the bed they rest on has been designated as an observation or inpatient one.

**Additional considerations**

In addition to these two truths, there are numerous other reasons why the current status determination system is so unpopular with physicians:

> We’re busy. Time is perhaps the most valuable commodity the practicing clinician possesses. We bristle when it is squandered on non-value-added concerns like status determination.

> Confusing criteria. Medical necessity criteria, such as Milliman and InterQual, are extremely confusing and cumbersome. It is unreasonable to expect busy clinicians to learn such a vexing set of rules. Our frustration is compounded by auditors that issue denials even when we meet the criteria. Despite CMS’ official position (requiring physicians to write the order for observation or admission) physicians are not the most qualified people to make a status determination—and we know it. Case managers and utilization review staff are eminently more qualified since they are trained in medical necessity criteria and CMS regulatory requirements.

> Financial implications. The current designations promote a two-tiered approach to patient management. “Observation” has come to mean (falsely) that a patient’s medical situation is somehow not as significant as the situation of someone designated as an inpatient. Since we expect providers to make appropriate clinical decisions regardless of a patient’s ability to pay, do we not have
the same expectations regardless of hospital status? Additionally, observation patients are required to pay for 20% of their costs plus their medications. This absolutely incenses providers. Penalizing patients for a bureaucratic designation that was imposed to reduce hospital payments is unacceptable.

Clock watching. The “observation stopwatch” creates extreme pressure when a provider is making medical decisions. Providers already have plenty of things to worry about.

Admitting a patient should unequivocally answer whether a patient required acute care services.

Patient care

Admitting a patient should unequivocally answer whether a patient required acute care services. Physicians feel that it is unreasonable and superfluous to subsequently require expounded descriptions of all the specific risks associated with a patient’s medical condition in an effort to justify an inpatient admission. And CDI professionals need to know that this is why it is much easier to get a physician to document additional diagnoses in the chart than it is to get that physician to document why a patient had to be admitted.

Physicians cannot reliably predict whether patients will need more or less than two midnights in the hospital. There are simply too many variables to take into consideration. We were not issued crystal balls or tarot cards when we completed medical school.

It is preposterous to add the unobtainable requirement of clairvoyance to something we already don’t understand. What’s more, physicians resent being positioned directly between the perceived needs of their patients and those of the hospital’s. Shouldn’t doctors and hospitals have the same goals?

For all of these reasons, CMS will never generate the desired physician buy-in for a status designation system to be successful.

Policy possibilities

While I do not purport myself to be a healthcare policy expert, in my opinion, there are relatively easy fixes to this problem.

First, I believe we should eradicate status determination from the hospital admission process. Admissions should be based solely on the medical determination of patients either needing to be in the acute care setting or not. Clinicians are comfortable and competent in rendering this decision.

Next, CMS could extend the current MS-DRG system to include coverage for all acute care hospitalizations by simply reducing the current reimbursement levels for inpatients. While hospitals would receive less money for the former inpatients, in return, they would receive more for the observation cases where they were previously taking a financial hit. The total annual reimbursements would average what they were receiving previously, thus initiating hospital buy-in.

Expanding an existing, working system is preferable to the creation of a new, cumbersome, and potentially ineffective system. Additionally, it would allow hospitals to redirect the substantial resources they currently expend on status determination and the appeals process, instead dedicating them to improving patient care and expanding medical services.

Status see-saw

The status designation dilemma is like a see-saw: On one end, the hospitals need observation patients to have a quick disposition due to the limited reimbursement they receive to care for those patients. On the other end, all patients (as well as their families) deserve definitive answers and appropriate care.

The physician is the fulcrum in the middle and is charged with balancing competing objectives while satisfying both the patient and the hospital. This task is unnerving, heartless, and frequently impossible. Physicians want off the see-saw; we just want to take care of our patients.

EDITOR’S NOTE
Dr. La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville (UTMCK) and a former ACDIS advisory board member. His comments do not necessarily reflect those of UTMCK or ACDIS. Contact him at clachari@utmck.edu.
Watch for these ICD-10 coding and documentation traps

by Robert S. Gold, MD

Thankfully, some of the documentation and coding issues I have been screaming about over the past 10 years have been heard with the transition to ICD-10. Some are resolved, some are on the way to being resolved, and some persist in causing me consternation. And, of course, a couple of new concerns have arisen. What follows is a look at some ongoing areas of concern for CDI specialists regarding proper code assignment in ICD-10.

Pneumonias—or not

“Hypostatic pneumonia” represents one of these problem areas. I have written about it previously in other publications. The code for this condition was developed to describe an expired patient found lying in one position for weeks or months, often severely malnourished and with no protein stores to hold fluid in the bloodstream. Frequently these patients’ lungs have turned to the consistency of liver (called hepatization of the lungs) due to settling of fluid in the dependent portions of the lungs.

In ICD-9, the code for this condition was found under pulmonary edema, or congestion of the lungs, as the lungs became severely congested with blood and debris. This led coders to group the diagnosis along with pulmonary edema and respiratory failure. Some consultants taught this as the right code to assign when there was documentation of “pulmonary congestion.”

This condition is no longer found in pulmonary edema and respiratory failure in ICD-10. (That’s a good thing, in my opinion.) Unfortunately, however, it is now found in with the pneumonias—and hepatization of the lungs is definitely not pneumonia, despite some clinical references to lobar pneumonia and red and gray hepatization of the lungs.

Those conditions typically align with cases of patients with terminal cancer, who are cachectic and severely malnourished with ascites and low oxygen saturations due to consolidation of lung tissue with surrounding leakage of pleural effusion. This is real hepatization of the lung in a terminal patient. It represents what the initial intent of the code because, back then, we didn’t have x-rays. Now we do, and we can find the condition. But it’s not pneumonia.

(To read more about the clinical indications, visit http://tinyurl.com/krz4m7q.)

Yes, there are references to the fact that hepatization of the lung, with the red and gray varieties, is seen in pneumococcal lobar pneumonia. But that’s pneumococcal pneumonia, and it has a name and a code. The term is also seen in veterinary literature describing the findings that may supervene in large animals like cows or elephants who cannot get up and who, after time, experience settling of fluid in the dependent portions of their lungs.

Don’t fall for hypostatic pneumonia as a diagnostic entity. If it’s truly pneumococcal pneumonia, code it as pneumococcal pneumonia.

And that’s another issue. In ICD-9, “lobar pneumonia” was assigned 481, pneumococcal pneumonia. Yes, strep or pneumococcal pneumonia frequently presents with a lobar distribution—a whiteout on x-ray of an entire lobe of the lung. But other organisms can lead to a whiteout of a lobe on x-ray, so without culture proof, it is unwise to presume that it was pneumococcal. You should clarify this issue with the physician.

In ICD-10, the Cooperating Parties wisely detached that inappropriate link, and now lobar pneumonia will be assigned J18.1 to depict its x-ray appearance as being pneumonia in a lobar pattern caused by an unspecified organism. But the very next code in the series is J18.2, hypostatic pneumonia, unspecified organism—and it’s still not pneumonia.

Cardiomyopathy

Okay, next let’s take a look at cardiomyopathy, another subject that has disturbed me when it comes to advice on how to assign the various ICD-9 codes in the 425 series. All of the listed conditions are causes of diseases of the heart muscle or codes that are assigned for cardiomyopathy of other specified diseases with 425.8—and I think that’s a good thing. Even though advice on when to assign 425.4...
has been horribly wrong, at least the code set did what it was supposed to do—allow the physician to define the case of the patient’s sick heart, regardless of whether there was heart failure.

With ICD-10, unfortunately we go back to the dark ages. Now we have two codes that describe what the heart looks like and provide no indication as to the cause of the patient’s sick heart muscle—and that’s just plain wrong.

In ICD-9, we had 425.4 and 425.9, which addressed that the physician, in fact, didn’t know which primary or secondary cardiomyopathy a patient had. The rest of the codes were all specific causes or were tied to specific causes.

Now, with I42.0 dilated cardiomyopathy, we seem to be happy that the patient has a dilated heart from whatever the cause, and there’s no need to question the physician as to what the cause was because we have a code that looks like it’s a specific disease—but it isn’t specific. Conditions that can lead to dilated hearts include the following:

» Ischemic heart disease (now I25.5)
» Peripartum cardiomyopathy (now O90.3)
» Cardiomyopathy due to coxsackie viral myocarditis, that happens in children (now B33.24)
» Toxicity from chemotherapeutic drugs (now included in I42.7)
» Alcoholic cardiomyopathy (now I42.6)
» Cocaine use (also I42.7 as a toxin)
» Takotsubo syndrome, stress cardiomyopathy (now I51.81)

With so many possible choices, so long as we get I42.0, you might ask: Who cares? Well, the data cares. The patient cares. Work with your physicians to get these conditions clarified.

Treatment of heart failure or treatment of the patient at risk of progressing to heart failure depends on controlling the “cardiomyopathy.” If we have no idea what the cause is, the patient and the data both suffer.

Dilated cardiomyopathy is a finding with a zillion possible causes. Yes, the physician may never find the specific cause. It can exist without identifiable cause. But don’t ever be satisfied with I42.0 unless the physician truly just doesn’t know.

Further, we now have a code I42.5 for other restrictive cardiomyopathy. Just as with I42.0, all it says is that the heart muscle doesn’t relax well in diastole and often doesn’t do such a hot job in systole. It says nothing about the cause, and again, there are specific causes of restrictive heart disease. It’s a finding on an echo. It’s not a cause of disease. Assigning the code does not help the world’s database of causes of heart disease or heart failure. It may be valuable to know about this dysfunction, but it’s a dysfunction.

Restrictive dysfunction of the heart can be associated with amyloid cardiomyopathy (E85.- plus I43 cardiomyopathy in disease classified elsewhere), known as the worst cause of diastolic heart failure because of the infiltration of the heart muscle with amyloid proteins called prions. Sarcoidosis can do the same (D86.85), as well as scleroderma (M34.-), hemochromatosis (E83.- plus I42.8), pericarditis of lupus or radiation therapy, and even hearts after transplant.

Yes, there can be, after study, no specific cause found, but this “restrictive cardiomyopathy” should be identified by cause or by, as a default, “I don’t know.” And if the physician doesn’t know, that’s okay, but don’t be satisfied with I42.5 unless the cardiologist specifically can say “I don’t know—

Illustrated by David Harbaugh
"Another ICD-10 delay! At least we’ve got more time to query!"
yet—or may never know.”

We have this I43 code to use for cardiomyopathies in diseases classified elsewhere. Maybe this could be subdivided to “dilated cardiomyopathy in diseases classified elsewhere” and “restrictive cardiomyopathy in diseases classified elsewhere,” and then do the same with I42.9 to reflect “I42.91 dilated cardiomyopathy, I don’t know what the cause is” and “I42.2 restrictive cardiomyopathy, I don’t know what the cause is.” That would permit the description of these significant issues of dilation and restriction but outside of the specific causes of heart disease.

Respiratory

The next issue I have with ICD-10 is the fact that the respiratory failure series, 518.8x, has almost—but not entirely—been fixed. Where 518.82 was misdefined and misused, we are close to getting it resolved. No longer do we have an equivalent of 518.82 in ICD-10.

Acute and chronic hypoxic and hypercapnic respiratory failure exist in the J96 group. J80 is now defined as ARDS—acute respiratory distress syndrome in adults and children. “Respiratory insufficiency” points to R06.89, other abnormalities of breathing, where it belongs. “Respiratory distress” now points to R06.00, dyspnea, where it belongs.

There are still inappropriate pointers of “acute respiratory distress” to the ARDS code, however, and almost no case of acute respiratory distress is actually indicative of ARDS. ARDS is ARDS, so don’t ever consider the J80 code for ARDS when the patient is not identified as having ARDS—one of the worst causes of acute respiratory failure that exists. Virtually all of these patients are ventilated or they die. Period.

Having lost ARDS in the respiratory failure category, we now have an inane series of codes in the J95 series, intra- and postoperative complications of the respiratory system, not elsewhere classified. Here we see J95.1, acute postoperative pulmonary insufficiency following thoracic surgery, an MCC; J95.2, acute postoperative pulmonary insufficiency following nonthoracic surgery, an MCC; and J95.3, chronic pulmonary insufficiency following surgery.

There is no identifiable, measureable, definable condition in medicine called respiratory insufficiency. All it means in any medical journal published since the 1850s is that the lungs aren’t doing all they should to oxygenate or to clear carbon dioxide. To have codes for this is unfathomable. And to create a severity status of MCC when you can’t measure it is equally inappropriate.

All patients recovering from anesthesia after a procedure have some element of “pulmonary insufficiency.” They haven’t woken enough to thoroughly do the job, so they’re often left on oxygen for a while.

All patients after chest surgery or upper abdominal surgery have pain when they breathe, so they splint their breathing and they need oxygen. Patients after long procedures, or who have heart failure or COPD or other conditions that have an effect on their abilities to do well without the insult of an operative procedure, will need prolonged respirator support while they reverse from anesthesia, and that’s just what they get.

Some people are sensitive to the sedatives or the analgesics used in these procedures and may need additional support after surgery with oxygen or incentive spirometry.

None of these cases are worthy of being assigned a complication code, nor one that has the financial impact of a major complication, because they do not represent a major complication.

This whole series of codes is ludicrous. Even the physician who led the discussions creating them confessed in private that there is no such thing as chronic postoperative respiratory insufficiency, or chronic postoperative respiratory failure, for that matter.

If the patient, indeed, does have acute respiratory failure as a complication of a surgical procedure, a coder should assign J85.821, acute postprocedural respiratory failure. And it deserves to be designated as a major complication.

As a CDI specialist, ask the physician to name the cause of it, like tension pneumothorax or hemothorax or having removed too much lung tissue or cutting both phrenic nerves. But postprocedural pulmonary insufficiency? Don’t go there. 😞

EDITOR’S NOTE
Dr. Gold is a founding ACDIS Advisory Board member and the CEO of DCBA, Inc., in Atlanta. Contact him at DCBAInc@cs.com. This article was originally published in HCPro’s Medical Records Briefing.

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Ask ACDIS

Parsing documentation for opportunities related to postoperative pneumonia and respiratory complications

Q: What is the correct code assignment for a diagnosis of postoperative aspiration pneumonia? ICD-9-CM's Tabular List under code 997.39 provides the following inclusion terms: “Pneumonia (aspiration) resulting from a procedure.” However, the instructional note under category 997 states, “Use additional code to identify complication.” Should we assign code 997.39, Respiratory complications, Other respiratory complications, along with code 507.0, Pneumonitis due to solids and liquids, due to inhalation of food or vomitus, to describe postsurgical aspiration pneumonia?

I am working on our anesthesiologist’s documentation template in the post-anesthesia care unit. Instead of using “respiratory event,” I had hoped we could identify acute respiratory failure and link the failure to the cause (i.e., chronic obstructive pulmonary disease, congestive heart failure, neuromuscular diseases) or complication of the surgery (i.e., accidental tear to pulmonary organ, pneumonitis due to the anesthesia). My rationale was that if the provider linked the acute respiratory failure to an underlying respiratory condition, it would not be considered a surgical complication.

However, my coding resource states the cause doesn’t matter and that it will still code to a complication due to the fact that the condition occurred in the postoperative period and the ICD-9 Tabular Index takes the coder to 518.51 instead of 518.81 (if linked to other actual cause). My fear is that if I revise the template and add more specific diagnoses, the coding will only reflect complications.

A: Complication codes are tricky. The coding guidelines require documentation of a cause and effect relationship as well as an “indication” of a complication before these codes can be used. Many people disagree about what constitutes an indication of a complication.

We have two possible codes to address the situation in ICD-9-CM. The most accurate code 997.32, post procedural aspiration pneumonia, which can also be described as “chemical pneumonitis resulting from a procedure.” An additional code to specify aspiration pneumonia would not be used. However, code 997.39, other respiratory complications would require another code to further specify the type of respiratory complication. ICD-10-CM has the ability to be more specific about the type of respiratory complication within the code itself. (Read more about this in a related article on p. 10.) It includes following codes:

- J95.1, Acute pulmonary insufficiency following thoracic surgery
- J95.2, Acute pulmonary insufficiency following nonthoracic surgery
- J95.3, Chronic pulmonary insufficiency following surgery
- J95.4, Chemical pneumonitis due to anesthesia (e.g., Mendelson’s syndrome, postprocedural aspiration pneumonia)

Coding Clinic may provide more guidance following ICD-10-CM implementation to ensure consistency across organizations. You may want to change your form to reflect the documentation needed to support ICD-10 coding, as it often takes a while for a new form to be approved and used. You don’t want to have to create another one once ICD-10 is implemented.

It sounds like your facility may have additional concerns here regarding the patient safety indicator of acute postoperative respiratory failure (PORF).

To avoid any negative implications, you need to know which codes trigger this quality metric, and why, to make sure these conditions are accurately reflected when they occur. Codes associated with this measure will become part of the Hospital Value Based Purchasing in fiscal year 2015.

The goal of this metric is to identify postoperative respiratory failure (as a secondary diagnosis), mechanical ventilation, or reintubation cases per 1,000 elective surgical discharges for patients ages 18 years and older and excludes...
the following:

» Cases with principal diagnosis for acute respiratory failure, cases with secondary diagnosis for acute respiratory failure present on admission

» Cases in which tracheostomy is the only operating room procedure or in which a tracheostomy occurs before the first operating room procedure

» Cases with neuromuscular disorders, laryngeal or pharyngeal surgery, craniofacial anomalies that had a procedure for the face, esophageal resection, lung cancer, or degenerative neurological disorders

» Cases with a procedure on the nose, mouth, or pharynx

» Cases with respiratory or circulatory diseases

» Obstetric discharges

CDI specialists should look to ensure the present on admission indicator is accurate on these cases. In the example you provide, for instance, the acute respiratory failure was present on admission so it would not trigger this quality metric.

Revise your query form to reflect diagnoses that can be coded accurately. “Respiratory event,” for example, is not a diagnosis and does not support the use of hospital resources.

Have the provider link the acute respiratory failure to its cause to capture data used in the National Surgical Quality Improvement Program (a surgical quality database) even though it may not be reflected in coding.

Elective surgical discharges are defined by specific DRG or MS-DRG codes with admission type recorded as elective. Often the assignment of a procedure as elective is arbitrarily done by registration so have a process that clearly identifies the type of surgery.

The numerator for this metric (e.g., the volume of cases which can be classified as a PORF) considers discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either:

» Any ICD-9-CM procedure code for a mechanical ventilation for less than 96 consecutive hours (or undetermined) that occurs two or more days after the first major operating room procedure code (based on days from admission to procedure); or

» Any-listed ICD-9-CM procedure codes for a reintubation that occurs one or more days after the first major operating room procedure code (based on days from admission to procedure).

The denominator, or total population being measured, includes elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure.

The reality is that none of these acute respiratory failure codes (518.*) are “complication codes,” as in ICD-9-CM the respiratory complication code is really 997.39, other respiratory complication, which should be reported if the acute respiratory failure is linked to the procedure or 997.32 as discussed above.

The quality metric of PORF is considered a “complication” by the Agency for Healthcare Research and Quality (AHRQ) but is not considered a “complication code,” which is why it is so confusing.

There are specific guidelines of when a complication code can be assigned—there has to be a cause-and-effect link between the condition and the medical intervention, and the provider has to consider it a complication. It cannot be assumed that everything that happens postoperatively is a complication.

The AHA’s Coding Clinic for ICD-9-CM, First Quarter 2011, addresses the matter, indicating that code 997.39 would be reported with the applicable acute respiratory failure code to specify the type of respiratory complication. This is a very complex topic, which will become even more relevant as time goes on.

EDITOR’S NOTE
Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director for HCPro, answered this question. Contact her at cericson@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit www.hcprobootcamps.com/courses/10040/overview.
Disrupting the status quo: Hospital outpatient and ICD-10-PCS

by Andrea Clark, RHIA, CCS, CPC-H

“Sometimes the questions are complicated and the answers are simple.” —Dr. Seuss

This quote seemed an apropos way to begin a discussion about outpatient encounters and ICD-10-PCS. You see, outpatient procedures will still be coded using Current Procedural Terminology®/Healthcare Common Procedure Coding System—the HIPAA-approved code set for reporting hospital outpatient procedures—regardless of when ICD-10 is implemented. Although ICD-10-PCS codes may not be required for outpatient procedures, many payers are expected to begin using them in the outpatient arena. But that’s not the only reason hospitals should plan to assign ICD-10-PCS on outpatient services.

The complicated question in this scenario is: “If ICD-10-PCS is not necessary, why the debate? Why should we bother assigning codes when we don’t have to?” Answering this question simplistically (i.e., “Because CPT/HCPCS is currently the HIPAA-required code set”) reflects short-term thinking.

The ICD-10 system was designed to improve clinical communication via modernization and standardization of codes and descriptions. The ICD-10-PCS side provides additional specificity to describe the science behind the procedures, allowing for exact anatomical specification along with the diagnosis to provide data that is uniquely described and coded. Furthermore, ICD-10-PCS integrates with technology such as electronic health records, CDI tracking software, and computer-assisted coding programs, making it a better fit for advances in these areas.

Those who are interested in using ICD-10-PCS in their outpatient coding may question whether using both code sets simultaneously will decrease coder productivity. It may (in fact, most expect productivity reductions across all departments as teams begin to implement ICD-10), but cross-training outpatient coders on the ICD-10-PCS coding process has a number of benefits, including:

» Inter-coder reliability: This ensures both sides of the coding workforce maintain the high-level skill sets needed for ICD-10 implementation.

» Management of coding schedules and interchange-ability of coding staff: Fully educated coding and CDI teams make it easier to fill in during times of unexpected staffing shortages that many facilities expect to come with ICD-10 implementation. Cross-training also ensures successful cultivation of a fresh coding workforce with primary knowledge of both ICD-10-CM and PCS.

Diverting time and money from outpatient coder training now could require later reinvestment as priorities shift and new ICD-10-PCS expectations arise. However, training coders without expecting them to actually use their skills will end up depleting their abilities to atrophy and, again, might necessitate later retraining.

We all know that ICD-10-PCS is an impressive data set with a high level of detail that will benefit population health. Training our outpatient coders on PCS is in our best interests. Therefore, a decision based on productivity and time cannot be made in a silo. Deciding to train outpatient coders on PCS requires an allied decision with support from the ICD-10 steering committee, medical director and physicians, and others. Below I offer answers to tip the scales in favor of reporting outpatient procedures with ICD-10-PCS, capitalizing on your internal data analytic functions.

It is essential to normalize your internal data within the hospital’s (or system’s) walls for population health management. There was an average of 2,105 outpatient visits per 1,000 people in 2011, according to Irving Levin Associates’ 2012 Health Care Services Acquisition Report. Such a swing in volume from inpatient to outpatient services will play a role in how Hospital Value-Based Purchasing program measures develop over the next few years.

Bundling of Medicare outpatient encounters by claim level through Ambulatory Payment Classification (APC) Comprehensive Payment is becoming an increasing trend, replacing 29 device-dependent APCs in 2015.

Take, for example, Comprehensive APC 0648 Level IV Breast Surgery. In 2015, this will include a single payment for the provision of a primary service and all adjunct services provided to support the delivery of the primary service. This
includes all services, tests, and procedures bundled into one payment of $7,068. This payment includes:

» Diagnostic procedures
» Laboratory and pathology tests
» Other diagnostic tests (i.e., radiology, pulmonary, cardiology)
» Treatments that assist in the delivery of the primary procedure (i.e., preoperative, intraoperative, recovery, post-anesthesia care unit)
» Visits and evaluations associated with the procedure
» Coded and uncoded services and supplies used (i.e., observation)
» Blood and blood products
» Outpatient department services delivered by therapists
» Supplies and devices provided as part of the outpatient service (i.e., implants, tissue expanders)
» Durable medical equipment such as prosthetic and orthotic items and supplies
» Any other components reported by HCPCS codes that are provided during the comprehensive service

Although hospital outpatient departments rely on CPT/HCPCS codes, assigning ICD-10-PCS codes enhances data mining opportunities since each code character describes a specific variable, which can assist with financial predictive modeling. The fourth character indicates right, left, or bilateral; the fifth indicates the approach; the sixth indicates the device; etc.

This data pinpoints financial variables such as resources (i.e., time in operating room, observation, recovery) and implants (type, manufacturer, laterality, cost). Isolating financial outliers, payers, surgeons, type of device/implant, laterality, and other resources will enable hospitals to perform predictive financial modeling for both current and future endeavors. Improved data reporting and analysis by payers and providers will, in turn, improve reporting, mining, and tracking of population health management programs.

Robust procedure data on the outpatient side can be incorporated into hospital quality, safety, and prevention, providing the facility with a better overall performance record as it relates to patient outcomes.

You don’t need to cloud integration of ICD-10-PCS assignments for hospital outpatient encounters with complicated statistics and formulas. The highest outpatient charges, regardless of payer, include same-day surgery, interventional radiology, and cardiology procedures, either electively scheduled or through observation services. With a cohesive approach to a complicated question, it is amazing how simple the answers can be.

“You’re off to great places! Today is your day! Your mountain is waiting, so get on your way!”

EDITOR’S NOTE
Clark is the chairman and founder of Health Revenue Assurance Associates in Plantation, Fla. She has more than 30 years of experience working with hospitals, payers, and other organizations. Contact her via email at aclark@hraa.com.

ACDIS Insight: Outpatient CDI on the rise in facilities

In 2008, only 11% of respondents to an ACDIS poll indicated their CDI program either reviewed outpatient records for documentation improvement opportunities or were looking to expand into outpatient areas (8% and 3% respectively).

How has the climate changed?

Of the more than 400 respondents to the question on the ACDIS website (see the poll at www.hcpro.com/acdis/readerpoll_results.cfm), 35% now say they conduct outpatient reviews and 61% do not (1% say they only review emergency department records, and 2% plan to start outpatient reviews within the next year).

“Outpatient record reviews are evolving,” says Mel Tully, MSN, CCDS, CDIP, VP of clinical services and education at Nuance Communications, Inc., in Burlington, Mass. “I think it is a loop that hasn’t been closed yet but one that can help bridge the gap between hospitals and providers.”

Outpatient reviews, for example, can help demonstrate to physicians that CDI isn’t only for hospital billing and reimbursement purposes—it can also help with professional reimbursement, reduce claims denials, improve medical necessity and quality reporting, and even assist in capturing information necessary for Hierarchical Condition Category (HCC) coding.
ED difficulties

One obstacle to outpatient CDI is the timing, says Laurie L. Prescott, MSN, RN, CCDS, CDIP, a CDI education specialist with HCPro in Danvers, Mass. If the ED is busy, CDI specialists can be seen as a nuisance. “You can’t interfere with the immediate care that’s needed,” she says.

Conversely, on days when the ED activity is slow, there’s little to review. “You have to have patients and conditions to talk about,” she says.

When Kathy Shumpert, MSN, RN, CCDS, CDI specialist at Community Howard Regional Health in Kokomo, Ind., started outpatient reviews she tried a variety of things, including emergency department (ED) reviews, “but because of the pace the best we can do is get whether the diagnosis isn’t of a symptom,” she says.

Part of the problem of implementing CDI in the ED comes from timing

When Prescott initially entered the ED, a couple of physicians allowed her to shadow them and responded to her verbal queries, ensuring they added appropriate wording into the charts. “It worked great for those who would let me,” she says.

Bernadette Slovensky, RN, MSN, is a CDI specialist at Stony Brook (N.Y.) University Medical Center, a level-one trauma care center with 100,000 emergency bed cases per year. Her facility made the leap to outpatient CDI simply because physician leadership asked them to, she says. The physician champions realized the importance of capturing present on admission indicators and obtaining documentation to ensure medical necessity, says Slovensky, who discussed her program’s efforts on the February 2014 ACDIS quarterly conference call (http://tinyurl.com/lk28ohx) and will present on the topic during the May ACDIS Conference in Las Vegas.

“It’s a busy place,” she says. “It is so fast-paced patients may be in the ED for 15 minutes before they’re off to the operating room. We were trying to ensure that those patients’ conditions were accurately captured because once they’re gone, they’re gone.”

For example, a septic patient may come into the ED and receive treatment, but by the time the admitting physician sees the patient he or she doesn’t look septic anymore, so that diagnosis and treatment slips through the cracks, says Slovensky.

“CDI professionals need to educate the clinicians about how to appropriately document these types of things,” says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, CCDS an independent consultant in Madison, Wis.

Take, for example, a case where a patient comes to the ED via ambulance after falling and breaking her foot. The physician notes altered mental status, orders an x-ray and mental consult. In an inpatient-only model, CDI professionals typically do not review the record until the second day of the patient’s stay; when they do, they may discover evidence in the laboratory workup of renal failure but have to chase down the ED physicians for any indications that such a condition was present on admission, says Krauss.
An outpatient CDI program would eliminate that problem. Shumpert’s program focuses on medical necessity. If the ED secretary enters all the diagnoses but the patient condition does not seem to warrant an inpatient admission, the record is flagged and turned over to Shumpert to review. From there, she looks to ensure that any local or national coverage determination requirements were met, and queries when necessary.

Some of these codes and payment systems are foreign to CDI specialists, who may only understand the inpatient prospective payment system and MS-DRGs.

“This was pretty successful because we were able to get items covered that may have been otherwise written off as charity or simply not reimbursable, like a CT scan,” she says.

If insurance does not cover a particular treatment or exam for medical necessity or other reasons, the hospital has a limited window of time in which to explain to the patient his or her payment options (known as an advance beneficiary notice, or ABN). If the patient does not receive this notification, the test may not be covered, the patient may not pay, and the cost for the service may go uncollected by the facility, Shumpert explains.

Payment problems

Payment for outpatient services requires Current Procedural Terminology®/Healthcare Common Procedure Coding System codes and follows outpatient prospective payment system rules. Physicians receive payment for their services partly based on evaluation and management (E/M) codes, which take into consideration the amount of time physicians spend reviewing patient symptoms, body systems, diseases, and treatments, as well as the complexity of the medical-decision making required to care for their patients.

Some of these codes and payment systems are foreign to CDI specialists, who may only understand the inpatient prospective payment system and MS-DRGs. “Certainly, one first step to help CDI expansion into the outpatient services is obtaining an understanding of E/M,” says Prescott.

Shumpert obtained a basic level of E/M knowledge and worked with the physicians to improve their impression and planning documentation, she says.

“I don’t know E/M well, but I did work with them to help them pull in that additional information they need to support their own code assignments, and I think that really helped,” says Shumpert.

At University of Tennessee Medical Center at Knoxville (UTMCK), Trey La Charité, MD, the CDI physician advisor there, has begun expanding his educational efforts to the outpatient realm, taking road trips to associated physician practices and spending roughly 45 minutes on documentation improvement lessons. He brings an outpatient coder with him, hired specifically to audit physician practice records and reinforce documentation improvement information.

On the outpatient side, many physician practices do not have dedicated coding staff, La Charité says. Instead, they have secretaries, depend on their electronic health records (EHR), or simply code the records themselves. This leads to new obstacles.

“Understanding the physician documentation processes in the electronic medical record and paper record systems in the outpatient setting is critical to capturing the appropriate diagnoses and procedures for coding compliance,” agrees Bonnie S. Cassidy, MPA, RHIA, FAHIMA, FHIMSS, senior director of HIM innovation for Nuance Communications. “Most of our focus has been on the acute care side of healthcare and we now have a tremendous opportunity to address clinical documentation integrity and coding compliance in the ambulatory care setting.”

In addition, the rise of HCCs provides additional impetus for outpatient CDI. HCCs are a subcategory of codes based on chronicity, Krauss says, used primarily by Medicare Advantage and managed care companies.

James S. Kennedy, MD, CCS, CDIP, president of CDIMD Physician Champions in Smyrna, Tenn., points to a couple new conditions qualifying as HCCs in 2014, plus their relative weights (RW) and definitions, including:

» Morbid obesity (RW 0.365). A BMI of 40 or more, requiring code 278.01, morbid obesity, or V85.4, BMI > 40.0, defines this condition. Note: ICD-9-CM or ICD-10 does not allow the BMI to be coded from nursing or dietitian documentation unless a provider (e.g., medical
doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant) documents a nutritional diagnosis, such as morbid obesity, obesity, underweight, or malnutrition.

**Consequences of cirrhosis (RW 0.923).** Cirrhosis causes portal hypertension resulting in esophageal varices or hepatic encephalopathy often requiring lactulose or rifaximin, which can be coded only if documented. Even if the varices are not bleeding or if the encephalopathy is stable on medication, if these consequences are monitored, documented, and coded, they count as HCCs. Note: Don’t forget to document any monitoring of chronic hepatitis (e.g., due to hepatitis C), even if it hasn’t progressed to cirrhosis.

HCCs link payment to performance and relative risk of a patient population through analysis of the code set, Kennedy explains. If it typically costs a dollar to treat a particular condition, and one physician spends less than a dollar, that physician will be deemed to provide “efficient” care and could see his quality ratings and reimbursement rate improve.

Conversely, the physician who treats the same patient type but at a higher cost could be deemed “inefficient” and suffer the consequences.

“Physicians aren’t used to anyone reviewing their outpatient records for accuracy of diagnoses in the clinical documentation the way they are used to with inpatient CDI initiatives,” says Cassidy. “They need to understand the long term benefits of clinical documentation accuracy in the outpatient setting.”

Eventually, HCCs may become as important to physician payments as DRGs are to hospitals, Kennedy predicts.

**Volume concerns and expansion solutions**

Since the Institute of Medicine’s November 1999 report *To Err Is Human*, which showed a shocking number of unexpected deaths related to hospital admissions, a new mantra regarding the structure of healthcare delivery and reimbursement has emerged. There has been renewed focus on keeping patients *out* of the hospital.

This has had a negative effect on hospitals’ bottom lines, however. According to an article in *Modern Healthcare*, some of the biggest U.S. hospitals blame weak performance on flagging inpatient volumes. A report in *Healthcare Finance News* states that analysts at both Moody’s Investors Service (in a November 2013 report) and Standard & Poor’s predict a continuing decline in inpatient volumes due, at least to some extent, to a shift toward outpatient care rather than inpatient services. The theory goes that as inpatient volumes decrease, so will hospital revenues. For CDI specialists, this means capturing accurate data for each and every inpatient admission, but it may also mean expanding horizons for the future to offset the drop in inpatient revenue, Krauss says.

Just as hospitals will need to integrate their businesses to provide care across a continuum, so too will CDI departments will need to explore ways to provide value to those various service lines, too, he says.

When Cassidy first joined the coding world, she worked on both inpatient and ambulatory records. “It was one organization, and you had to be familiar with both sides,” she says.

In the ’80s and ’90s, coders became specialized, but now she believes that the tide is shifting again to learning both inpatient and outpatient, and that it will be important for CDI and coding staff to have a firm grasp of both. A majority of the information related to risk adjustment and population health management will come from the physician office—information that never made it to the inpatient side before, she says.

“It has been an inpatient-focused world,” Cassidy says, “and now the volume of care is shifting to ambulatory and outpatient services.”

In short, outpatient CDI is looking more and more like the wave of the future.

**Tip: Look for wound care opportunities**

At Community Howard Regional Health in Kokomo, Ind., CDI is now being incorporated into its affiliated wound care center. Kathy Shumpert, MSN, RN, CCDS, CDI specialist there, discovered that documentation was often incomplete. So she networked with the physicians and nursing staff, conducted focused record reviews, provided education, and worked with the IT staff to amend the electronic health record templates and prompt the clinical staff for the documentation needed.

“We quickly saw an improvement,” she says.
Foreign-born physicians find fulfillment in CDI efforts

Genevir O. Del Mundo, CDIP, CCS, CCA (“Apple” to his friends), a CDI specialist at Kindred Hospital, grew up in the Philippines watching his father help people and save lives. He always wanted to be a doctor, too, to follow in his father’s footsteps.

Transitioning from one country, one culture, to another is difficult enough, but the transition for physicians often presents additional challenges. Foreign medical graduates (FMGs) cannot simply come to America and start practicing medicine. Often they return to school and participate in numerous preparation classes to pass a U.S. certification exam.

Shrijana Basnet, CCS, CPC, CCDS, a CDI specialist at Kindred Healthcare in San Diego, came to the United States from Nepal in 2005. A practicing physician in her home country, she spent two years preparing for her exams, passing several portions of the test. With her final exam pending, she learned she was pregnant with her daughter and put her efforts on the back burner to be with her baby.

Jaysen Lfores, CCS, CDIP, originally from El Salvador, works at Kindred as well. He came to the United States in 2008 looking for healthcare-related opportunities. While many of his physician friends chose to sit for the U.S. medical exams and passed, others opted out of healthcare altogether. “There’s many reasons for not pursuing a U.S. license,” he says. “Some just don’t want to, and some apply their skills in other ways.”

That’s just what Lfores did; he discovered the coding and clinical documentation side of the American healthcare industry, found it fascinating, and decided to see where it would take him.

The experience of Dexter D’Costa, MBBS, MHA, manager of CDI at John Muir Health in Walnut Creek, Calif., was a bit different. The India native found himself fascinated with the business, management, and information technology side of medicine. When he found CDI—like most new to the profession—he wasn’t sure what it was all about. He took the job, received a crash course, and started reviewing records.

A California healthcare system starting a CDI program began to recruit Basnet to join their team in 2007. “I didn’t know what CDI was,” she says, “so I told them I wasn’t interested.” The director was a FMG and planned to create his team from foreign-born physicians. Basnet acquiesced, interviewed, and was won over. She received roughly four weeks of training and struggled with the coding regulations initially. The coding wasn’t the most difficult part of the job, though. “Approaching the physicians was really hard in the beginning,” says Basnet. “Some would just hand the chart back to me and ask me to fix it.”

“Everyone [working in the CDI field] initially finds it challenging to create that connection with the physicians,” says Wendy De Vreugd, RN, BSN, PHN, FNP, CCDS, IQCI, MBA, regional senior director of case management and CDI programs for Kindred Healthcare, Hospital Division, West Region in Westminster, Calif.

With FMGs as CDI staff, however, conversations frequently steer toward the clinical. “A connection between the physicians is already there due to their clinical knowledge and acumen, enabling them to communicate seamlessly across what may have otherwise been a barrier,” notes De Vreugd.

“This is a very interesting move,” says Del Mundo. “One that still makes me feel as though I am caring for the patient, only now I am involved in the quality of their care through appropriate documentation.”

“Working with physicians, working with my peers, applying my medical knowledge and my awareness of a physician’s workflow really made this a perfect fit for me,” says D’Costa.

Conversely, joining the CDI ranks enables FMGs to employ their clinical skills in a way they may not have otherwise envisioned. After presenting an information session for physicians regarding ICD-10-CM, Lfores found the physicians to be particularly receptive.

“Physicians are really open to talking with us. A good physician knows that we are good physicians, too. They understand that we possess the same working clinical knowledge as they do,” he says. “What’s great about the role is our ability to apply that clinical knowledge, of course, and yet [CDI] is such a great field to continue learning and growing in.”
Meet a Member

Wright-Duncan tag team works wonders at Skagit Valley

Kathy Wright is an RHIT and CCDS and was an inpatient coder for 23 years before moving into CDI in 2012. Erika Duncan is a nurse who earned her bachelor’s degree and CCDS credential and came to CDI two years ago after a varied career including time in case management, intensive care, emergency department, and other venues. They both work in the CDI program at Skagit Valley Hospital in Mount Vernon, Wash., and are members of the Evergreen (Washington state) ACDIS chapter.

Under the facility’s case management director Corin Schneider, RN, MN, MHA, this team of two implemented Skagit’s homegrown CDI program. Both agreed they couldn’t pass up the chance to break ground and build a strong program.

Wright and Duncan’s success stems, in part, from the support of their physicians. They have a standing invitation to the hospitals’ medical staff, hospitalist, specialty, and medical resident meetings. The pair recently answered the following questions for CDI Journal:

CDI Journal: What has been your biggest challenge?

Duncan: I think my biggest challenge has been the development of this program. I am grateful to all the CDI professionals I have met since starting on this journey. They have been an invaluable resource to us.

CDI Journal: What has been your biggest reward?

Wright: Seeing documentation changes happening and knowing I had a part in improving the quality of the record which affects our facility and patient care in a positive way.

Duncan: Seeing how the program has grown and how successful and well-received it is can at times be overwhelming. I love seeing how we make a difference.

CDI Journal: Can you mention a few of the gold nuggets of information you’ve received from colleagues on “CDI Talk” or through ACDIS?

Duncan: I so often have an “aha” moment when reading the thoughts of other ACDIS members in the message board “CDI Talk.” Sepsis and encephalopathy are only two of the many subjects we researched through ACDIS. The tidbits of information from the many contacts I have made since being in the field have been so helpful.

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

Wright: Quality control officer for Godiva Chocolates.

Duncan: My dream job would be as a realtor. I love looking at houses, all kinds, all the time.

CDI Journal next asked Wright and Duncan to tell us about a few of their favorite things:

Vacation spots: Wright likes snorkeling in Hawaii, touring wine country anywhere, and walking Oregon beaches. Duncan loves the Cherry Wood Bed & Breakfast in Zillah, Wash., where guests sleep in luxury teepees, shower in open-air showers, and take winery tours on horseback.

Nonalcoholic beverages: Wright loves a double tall nonfat hazelnut latte, and Duncan loves a good latte of any variety—hazelnut, salted caramel, or eggnog.

Retirement plans: Wright plans to rent a beach condo and stay there for a whole month, then do a bit of traveling around the country while Duncan, who hopes to retire in a couple of years, isn’t 100% sure but knows that traveling will be at the top of her list.

Wright added that she has been married to her college sweetheart for 40 years and has a 24-year-old son who is prepping for a career in radiology technology. 🍩
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