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When I was a child, television commercials depicted the elderly population as portly, gray-haired grandparents—cookie bakers and fishermen. However, today’s commercials offer slender, silver-haired gentlemen vitality elixirs, and whitened, pony-tailed women the latest jogging shoes.

When my father retired in his early 60s, a little more than 10 years ago, the first depiction was what he held in his mind. But the second depiction is today’s amazing reality—a good portion of the U.S. population may live, and live well, into their 90s. Much of that longevity comes from advances in science and technology, and much of it comes from changes in healthcare policies and practices. In short, we have evolved.

Consider that coders queried physicians long before CDI specialists became a type of professional. (Read ACDIS Advisory Board member Walter Houlihan’s take on the importance of CDI and coder collaboration on p. 4.) The case could be made that CDI evolved from the need for additional specificity in the documentation—grew out of adaptations required by CMS’ MS-DRG payment methodology. That payment system itself evolved from the need to further stratify the acuity of patient conditions because our understanding of, and ability to care for, certain diseases also evolved.

Today, we are set on yet another evolutionary path, as illustrated in nearly every article in this edition of CDI Journal. The ICD-10-CM implementation date remains October 1, 2015 (read the article on p. 5). Its thousands of new codes will allow greater understanding of common health afflictions. Since all healthcare venues need to use ICD-10, CDI efforts are evolving, expanding into critical access hospitals (see p. 10) and pediatric populations (see pp. 14 and 16).

CMS continues to tie reimbursement to quality as demonstrated in the IPPS proposed rule (see p. 5), so CDI efforts in clinical validation (see p. 20) will no doubt become standard practice soon.

While our CDI evolutionary meme might one day depict a pajama-clad professional (read the article about remote work environments on p. 7), it no doubt will also depict the dramatic effect of CDI professionals’ efforts on our fast-changing healthcare environment.

Finally, perhaps we may one day see a true evolution in the way patient care is delivered and in patient health overall due to your CDI efforts. That’s an evolutionary theory worth believing in. 🧩
The value of CDI and coder collaboration

by Walter Houlihan, MBA, RHIA, CCS

I am privileged to be able to oversee a group of CDI and coder professionals. The knowledge of these two groups is very exciting to see in action, and therefore, I would like to share with you the benefits to healthcare when they have a chance to work together in an interactive environment.

First, there must be respect in both groups for each other’s skill set and overall contribution to healthcare, as well as what they contribute to each individual patient. By demonstrating these skills, they can elevate each other to the next level.

Second, each CDI specialist and coding professional must be open-minded and willing to listen to differing opinions, and be able to contribute positively to the discussion of each case. HIM and CDI leaders need to create and support such environments; they should make it part of their departmental mission to do so.

The HIM and CDI department at Baystate Health (BH) consists of 42 coders and 10 CDI staff. BH is 100% EHR-based, enabling most staff members to work from home. Working remotely is a privilege and earned by each staff member. The criteria for earning that privilege, which staff must achieve and sustain, relate to quality and quantity of work.

Within the department’s applications, CDI specialists and coders can view listings of DRG mismatch cases. After their independent review of the information, they indicate in the application their rationale for the difference (i.e., Official Guidelines for Coding and Reporting, AHA Coding Clinic for ICD-9-CM/ICD-10-CM/PCS, subsequent documentation, etc.), along with any pertinent comments. The CDI assistant director and the coding supervisor review the cases on a regular basis for final reconciliation and to identify group and/or individual educational opportunities. This workflow allows for minimal interruption to CDI and coder productivity. During on-site meetings, the team,
including management, CDI specialists, and coders, discuss data on these mismatches to pinpoint any trends or overall education opportunities.

Every two weeks, all CDI and coding staff are required to work on-site in the HIM department to receive ongoing group training. This group educational day can cover ICD-10, a specific clinical condition, DRG mismatches, coding regulations, or EHR training.

Besides this one on-site day of collaboration, the two groups use instant messaging (IM) during their workday. Through IM, even though the staff works remotely, they have the ability to touch base with each other as if they were sitting side by side. They can pose questions or share interesting cases with their coworkers just by sending a message.

Overall, the value of CDI and coder collaboration cannot be overstated. The benefits are numerous, but most importantly, they affect the patients, the facility, and each member of the CDI and coding staff.

Editor’s note: Houlihan is the director of HIM for Baystate Health in Springfield, Massachusetts. He has worked in HIM for more than 30 years, initially coding medical records at Columbia Presbyterian Medical Center in New York City in the 1970s, then overseeing physician documentation in medical records at academic teaching facilities in New York City and Chicago. At Baystate Health, Houlihan has assisted with developing a CDI program that has improved the quality of documentation and, subsequently, administrative data. He was elected to the ACDIS Advisory Board in 2013 and serves through the end of 2015. Contact him at Walter.Houlihan@baystatehealth.org.

ICD-10-CM/PCS implementation full speed ahead

On Tuesday, April 14, Congress passed the Medicare and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA), which effectively eliminated the more than 17-year battle over cuts to physician reimbursement associated with the Sustainable Growth Rate (SGR).

Known throughout the debate as the “SGR fix,” the new law creates an incentive payment system that works on a merit basis, awarding bonuses or imposing penalties based on physicians’ composite performance scores. This payment system will take effect on January 1, 2019.

It was during the SGR battle in 2014 that Congress slipped in a last-minute amendment delaying ICD-10-CM/PCS implementation to its current deadline of October 1, 2015. No delay language was included in this year’s SGR fix.

On April 30, CMS released its inpatient prospective payment system (IPPS) proposed rule. In it, the agency integrated ICD-10-CM/PCS—adding more insurance against further delays—and added new MS-DRGs for percutaneous intracardiac procedures. CMS also made significant improvements to the ICD-10 MS-DRGs for hip revisions, says James S. Kennedy, MD, CCS, CDIP, president of CDIMD – Physician Champions in Smyrna, Tennessee.

Despite all of this forward motion, on April 30, Rep. Ted Poe (R-Texas) introduced H.R. 2126, a bill seeking to prohibit the secretary of health and human services from replacing ICD-9 with ICD-10 diagnostic coding vocabulary.

In a letter addressed to the representative, James L. Madara, MD, president of the AMA, applauded Poe’s efforts.

Additionally, an article in The American Journal of Emergency Medicine stated that the “ICD-9-CM to ICD-10-CM transition is not straightforward and contains hidden mapping and planning challenges.”
Survey says delays hampered readiness

Repeated ICD-10 implementation delays have negatively affected the healthcare industry’s preparations for the code set change, according to the Workgroup for Electronic Data Interchange (WEDI) February 2015 readiness survey. WEDI has conducted ICD-10 readiness surveys since 2009.

A total of 1,174 health plans, clearinghouses, vendors, and providers answered the February 2015 survey—twice as many as participated in the August 2014 survey—with providers making up the largest group (796) of participants.

When asked about the greatest obstacle in ICD-10 planning and implementation, survey respondents pointed to the continuing uncertainty about the final implementation date as their No. 1 concern, followed by staffing and competing priorities as additional difficulties.

All respondents have started vendor development related to ICD-10. Approximately 80% of health plans have completed impact assessments, and more than half of health plans have begun external testing, the survey said.

CMS continues educational outreach

Meanwhile, CMS continues to mark its ICD-10 advancements by announcing another successful completion of its ICD-10 acknowledgment testing. End-to-end testing, held from April 27 through May 1, had 875 participants who submitted 23,138 test claims. CMS accepted 88% of the claims; rejecting only 2% for incorrect ICD-10 assignment. During March testing CMS accepted 91.8% of the 9,000 test claims submitted by 775 participants.

The claim acceptance rates were higher than previous testing weeks in November 2014 and March 2014. The majority of denied claims were rejected due to unrelated issues, CMS says, including invalid National Provider Identifiers, invalid Healthcare Common Procedure Coding System codes, and invalid postal ZIP codes.

CMS rejected a few claims (8.2%) because testers used future dates, which should not be an issue after implementation. Providers are also welcome to submit acknowledgment test claims anytime up to the implementation date.

MACRA, IPPS continues shift toward quality

Even as ICD-10-CM/PCS paves the way for increased specificity and improved data granularity (more information to data-mine), the government continues its shift from pay-for-service reimbursement to pay-for-performance measures. The IPPS in previous years brought forward hospital value-based purchasing, readmission reduction, and other quality-related payments and penalties.

Proposals for 2016 build on these measures (read more in the CDI Strategies article “IPPS proposal released”), effectively raising operating payment rates to hospitals at 1.1%.

Although physicians previously faced value-based payments as well, MACRA introduces two new pay-for-performance programs, the Alternative Payment Model (APM) and the Merit-Based Incentive Payment System (MIPS), which should be rolled out over the next few years, with full implementation set for 2019.

For CDI professionals, the recent shifts further underscore the importance of complete and thorough record review—not just in light of CC/MCC capture, but also for the detail needed in ICD-10-CM/PCS and to ensure the overall quality of care provided gets captured, for the physician’s sake as well as the hospital’s.

Editor’s note: Portions of this article were compiled from CDI Strategies, JustCoding.com, ICD-10 Trainer Blog, and The HIPAA-HIM Insider.
Ask yourself: Could your CDI program work at home?

It’s no question that CDI specialists have made a big difference while working in hospitals. But a question asked more and more among CDI teams is can the job be done from home?

Charlene Barnes, RN, CCDS, a CDI specialist at Hardin Memorial Hospital in Elizabethtown, Kentucky asked that question in one recent discussion on CDI Talk. Her CDI team is currently weighing their options for accommodating a work-from-home program.

In a recent poll conducted on ACDIS Radio, listeners were asked to respond to this question: “Do you have a remote component to your CDI program?”

- 6% of the respondents answered yes, our CDI specialists are 100% remote
- 24% answered yes, we have a mix of remote and onsite staff
- 16% answered no, but we are considering it
- 47% answered no, our hospital does not permit this option
- 7% answered don’t know/not applicable

What is the appeal?

Convenience and flexibility, for one, answers Juli Bovard RN, CCDS, a CDI specialist at Rapid City (South Dakota) Regional Hospital. Bovard always liked the idea of working remotely, and thinks it would allow her to be more productive with fewer interruptions.

The biggest benefit is flexibility, says Katy Good, RN, BSN, CCDS, CCS, CDI Program Coordinator at Flagstaff (Arizona) Medical Center, who currently works from home with a CDI team onsite at her facility. “I have three small children and the last [few] years have been very demanding career-wise for my husband and me,” she says. “This arrangement allows for an incredible amount of work-life balance.”

The benefits of working from home may be innumerable for the employee, but Good feels employers benefit as well. Having a work-from-home option increases productivity, she says. For one, she doesn’t have to take sick days when she needs to stay home.

She doesn’t have to worry about being late because of traffic. And she doesn’t have to rush out at the end of the day to pick up her kids. Working without the distractions of an office allows her to schedule and prioritize her time, and complete tasks more efficiently.

Remote options work especially well in regions where it is a challenge to fill positions, and find experienced staff—a problem Good often runs into at her facility. The flexibility allows the organization to hire and retain staff members regardless of location.
Organizations should embrace the work-from-home option, says Paul Evans, RHIA, CCS, CCS-P, CCDS, manager of Regional Clinical Documentation and Coding Integrity at Sutter West Bay in San Francisco, California. New technologies, such as electronic health records (EHR) and coding software, and more reliable home internet access, allow CDI staff to review all aspects of a case and issue queries from any location.

CDI managers can also plan ahead, and schedule on-site days where staff come in for team meetings, educational sessions, and present educational materials to physicians.

“If one is strategic,” Evans says, “it may be feasible for a CDI program to be home-based.”

The Mayo Clinic’s CDI program is almost entirely home-based, according to CDI specialist Timothy Weiser, RN, MSN, CCDS. Staff has the option to work from home five days a week.

They use a company-developed EHR system. Queries are done by email and CDI and coding staff interact through email and a company message board. Staff meets online daily at 11 a.m., with occasional meetings at the hospital, Weiser says.

The facility assigns each CDI specialist a primary and secondary focus for cases, says Teresa Hegard, BSN, RN, CDI at the Mayo Clinic. For example, her primary focus is cardiology, and her secondary focus is psychiatry. Cases are filtered into the EHR system based on the CDI specialists’ focus.

Hegard starts by reviewing cardiology cases. If she finishes all cardiology cases, or if none are listed, she reviews psychiatry cases. CDI staff know their responsibilities and are able to go to work without instruction.

Some CDI staff prefer to work in the office, though everyone has the option to work remotely, Weiser says. They also have an onsite staff for education and training, and for chart reviews and clarifications that must be done in person.

Since implementing the remote program at the Mayo Clinic, Weiser says the number of cases reviewed per day has gone up from an average of 18 to an average of 25-26.

**What are the cons?**

Remote CDI limits interactions with providers and other CDI staff, Bovard says. Her team bounces ideas and questions off one another throughout the day, which would be difficult if they worked remotely. CDI staff also already struggle with physician engagement, and effectively communicating and educating physicians could prove challenging, Bovard says.

Working remotely could lead physicians to take CDI less seriously.

Remote CDI specialists face a number of personal challenges, too, Good says. Working from home can be isolating and requires a hefty dose of self-motivation. Setting personal and professional boundaries represents another challenge. At-home CDI staff may find it difficult to stop working at the end of the day, and to focus on work despite distractions at home. Those who work remotely also tend to go overboard and work longer hours to prove they can manage tasks at home.

“When your office is at home, it’s easy to feel like you are always working,” says Good. “I have to force myself to turn off the computer and phone after I am done for the day, or I will be answering emails at 11 p.m.”

Is it possible for a CDI team to work remotely?

The answer falls somewhere between yes and no. The key is finding a balance. Let’s take a look at a few facilities that have successfully integrated working remotely into their programs.

Martin Conroy, RHIA, CPC, director of coding education and clinical documentation improvement at an academic medical center in the northeast (Conroy requested the facility remain anonymous) says his program has two CDI teams. One works remotely, and the other works onsite. Each team has distinct roles, and very different job descriptions.

The onsite staff is all former patient care nurses from within the facility. They know and have established relationships with the physicians,
nurse managers, staff nurses, and most of the ancillary staff.

The remote staff functions as a hybrid coding and CDI team, coding cases and offering suggestions for queries to the onsite staff. The teams are assigned by units and work closely together.

There needs to be someone onsite for a CDI program to be successful, Conroy says. “The physicians and hospital leadership want more face-to-face interaction,” says Conroy. “Someone needs to be in-house to train the physicians and answer questions. But, ultimately, it is important for each facility to find what works best for them and their staff.”

Linda Rhodes RN, BSN, CCDS, CDI manager at New Hanover Regional Medical Center in Wilmington, North Carolina, helped implement a work-from-home program at her facility. Their eight-person CDI staff works from home two days a week and onsite at the hospital for three.

This allows them to maintain connections and interact with providers. Their staff is divided into service line teams, and rotates who works from home and when. At least one CDI from each service line is expected to be onsite each day.

The only issues they experienced were technical, Rhodes says. They stick to a strict, pre-developed set of guidelines.

For example, the staff is expected to meet certain productivity standards, and their duties remain the same whether in the hospital or at home.

By implementing the work-from-home program, staff productivity, teamwork, and employee satisfaction improved, she says. “Working from home should still be a work environment,” says Rhodes. “I hold the staff equally accountable for their work, but ultimately the productivity has improved.”

Overall, find the right balance of working from home and engaging with physicians that suits your program.

Whether hiring two teams, allowing staff to work from home part-time, or transitioning to a completely remote CDI program, the focus should remain on improving documentation and strengthening CDI efforts.

“It’s important to be honest with yourself about what works for you,” says Good. “The decision should be what is best for both the staff and the facility.”

On April 16, CMS introduced star ratings on Hospital Compare, the agency’s public information website that includes reviews and information of nearly 3,500 Medicare-certified acute care hospitals. The ratings are based on data from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures that are included in Hospital Compare.

HCAHPS, which has been in use since 2006, measure patient’s perspectives on hospital care using 11 categories. It focuses on the patient’s experience of care, such as how well nurses and doctors communicated with patients, and how clean and quiet hospital environments were.

The goal of the rating system is to make it easier for consumers to choose a hospital, and understand the quality of care they deliver. It is part of a bigger HHS initiative to build a healthcare system that delivers better care. The ratings help move the healthcare system toward the Affordable Care Act’s call for transparent, easily understandable and widely available public reporting. They also are a part of the Obama Administration’s Digital Government Strategy by providing content in customer-centric ways.

Currently, only 7% of hospitals received a five-star rating, HealthLeaders Media reports. The bulk fell into the three-star range. Consumers will see 12 HCAHPS star ratings for each hospital on the site—one for each of the 11 survey questions, plus an overall average score. The star ratings will be updated each quarter.

For more information, read the CMS announcement, or the HCAHPS website.
Critical components: CDI moves into CAH

In many ways, CDI efforts in the critical access hospital (CAH) setting mirror the typical duties of those working in the short-term acute care world. Just ask specialists to identify their top documentation trouble spots.

“Congestive heart failure [CHF] is our number one, hands down,” says Rebecca Lenz, RN, CDI specialist at Tomah (Wisconsin) Memorial Hospital.

Chronic obstructive pulmonary disease, pneumonia, and respiratory distress top the list for Sara Filas, RN, CDI specialist at Aspirus Medford Hospital and Clinics in Wisconsin.

Janelle Cisneros, CDI specialist at Vernon Memorial Healthcare in Viroqua, Wisconsin, runs down her list: Pneumonia, CHF, COPD, and urinary tract infections round out the top 10. Since the facility has a strong orthopedic program, the list also includes knees and hips, but it generally reflects her CAH CDI peers. (See the related article on p. 12 for additional target areas.)

Although those working in CAH need not worry about a shift from standard clinical definitions for the patient population they serve (like those working with pediatric populations might), the rules governing Medicare reimbursement for the setting differ, and the workload itself presents interesting CDI challenges and opportunities.

**Size matters**

Legislation enacted as part of the Balanced Budget Act of 1997 authorized states to establish a Medicare Rural Hospital Flexibility Program, under which certain facilities participating in Medicare can become CAHs. CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method.

In general, a CAH must:

- Be located in a rural area, or be treated as rural under specific designation rules.
- Furnish 24-hour emergency care services seven days a week.
Maintain no more than 25 inpatient beds that may also be used for swing bed services, if certified by Medicare to do so. It may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds.

Have an annual average length of stay of 96 hours or less per patient for acute care.

Tomah Memorial Hospital has 25 inpatient beds. Aspirus Medford Hospital and Clinics has 25. Vernon Memorial Healthcare also has 25. The small census size in facilities like these makes it difficult to justify the return on investment in CDI—it doesn’t take all day to review less than 25 records, typically. So, those facilities that do hire often add additional duties and specialty projects to specialists’ task lists.

Last February, Vernon Memorial hired Cisneros essentially to prepare for ICD-10-CM/PCS implementation. Then the delay happened, and Cisneros scrambled to obtain a better awareness of the CDI role and prove her worth.

She spends mornings looking through the history and physical reports to ensure physicians include the necessary elements. She examines admission orders and makes sure physicians appropriately sign and date them. She confirms that the patient’s problem list is up to date.

Now that ICD-10-CM/PCS implementation date seems set for this fall, Cisneros re-started educating providers about the new code set’s documentation requirements.

“Every month I go to the clinic providers’ meetings and offer a little ICD-10 education,” she says. “I feel they would rather have a computer program to walk them through it all, but once you explain it to the physicians, they seem to listen.”

In the afternoons, she works with quality and compliance and helps enter information for data abstractions. As needed, she does audits on clinic charts and takes on additional projects.

“I definitely wear multiple hats,” Cisneros says. “I like the variety. I took the job to step outside of my comfort zone, but CDI is really just so vast that it can be hard to wrap your head around it.”

Lenz tells a similar story. She started in October 2014, coming to the role from a nursing career in cardiac and emergency.

“As a nurse, I had no idea that my documentation mattered so much,” she says.

She reports to the quality director and performs quality abstraction and utilization reviews, in addition to some case management work. In the morning, she focuses on concurrent review of all inpatient charts, and then in the afternoon concentrates on quality-related efforts.

“Everyone wanted something different from the [CDI] position,” says Lenz. “So, in the beginning, my biggest role was really understanding what CDI was all about and bridging that gap.”

Now she creates weekly CDI “fun facts” for the facility, works with the coders to develop physician education, performs all concurrent queries, and helps the HIM team when physicians don’t respond to their retrospective query efforts.

And Lenz constantly hunts for additional ways her efforts can help the facility.

For Filas, tasks differ from day to day. “It all depends on what the day holds,” she says, although she too reports to quality and focuses on inpatient admission reviews, looking at the daily census every morning and following up on any opportunities for improvement.

“CDI programs in the rural healthcare area is really about finding a facility’s documentation weak points and adapting that focus,” says Sheila Goethel, RHIT, CCS, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer, coding consultant for the Rural Wisconsin Health Cooperative (RWHC) in Sauk City.

As more CAHs look to implement CDI efforts, RWHC decided to host special CDI roundtable discussions on a quarterly basis to develop best practices and identify common roles and responsibilities for staff members.

Many facilities, Goethel says, “simply weren’t aware of the full responsibility of CDI. They’re learning the process and seeing the benefits.”

**Return on investment**

Facility size isn’t the only difficulty facing CAH CDI staff. CAHs are not subject to the inpatient
prospective payment system or outpatient prospective payment system, as short-term acute care hospitals are. CMS reimburses CAHs at 101% of actual reasonable costs for most inpatient and outpatient services, says Debbie Mackaman, RHIA, CPCO, CCDS, regulatory specialist for HCPro in Danvers, Massachusetts.

Traditional acute care programs start CDI efforts by identifying principal and secondary diagnoses. Doing so allows coders to capture more specific codes, which often equates to a higher reimbursement based on CMS’ Medicare severity diagnosis-related group (MS-DRG) payment method. For traditional hospital settings, this improvement in CC/MCC capture rate means an almost immediate return on investment for CDI efforts.

CAH CDI staff cannot turn to monetary gains to prove their worth, which may actually be a blessing in disguise in terms of obtaining physician support, Cisneros says.

“We are not a very wealthy community. The physicians work hard to keep the costs down for the patients. So, when they hear that the hospital could get more money if the physician would only document X instead of Y, they worry that it will end up adversely affecting their patient, that their patient could end up bearing that additional cost and having to pay more out of their own pockets,” she says.

Nevertheless, CAHs can (and often do) track their case-mix index and look to the annual Program for Evaluating Payment Patterns Electronic Report, specifically for CAH to identify outlier diagnoses. CAH CDI staff can also look to parse data from Intellimed or MedPAR, Goethel says, or look to state and national CAH associations for data sharing within those cooperatives.

CDI staff in CAH also need to look for public quality reporting and delve into such data to identify potential documentation opportunities there. For example, if a particular physician scores low on treatment of heart failure on Physician Compare, the CDI specialist can audit a sampling of the facility’s heart failure patients and compare the documentation and final coding and billing, bringing any identified opportunities and research back to the provider in the end.

“There really isn’t a money component here,” says Goethel. “For us, it’s really about quality documentation.”

Assessing the 96-hour rule

Although CAHs receive the 101% reimbursement rate, “that doesn’t mean the CAH can keep the patient forever,” says Melinda Battaile, MD, PA, FHM, MMCI, CDI reviewer for Vidant Medical Center in Greenville, North Carolina.

Enter the so-called 96-hour rule.

Part of CAH CoP states that patients should have an annual average length of stay of 96 hours (roughly four days) or less. The thinking goes that a patient in a rural setting who requires critical care can

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**CAH DOCUMENTATION IMPROVEMENT POINTS**

The CDI needs of critical access hospitals (CAH) aren’t much different from those of short-term acute care facilities. Yet although the coding and documentation issues that CAHs struggle with are similar, Medicare patients’ coding is not linked to CAH payment as MS-DRGs do not apply in that setting. In general, top concerns include:

- **Sepsis:** A query is needed if the physician states bacteremia instead of sepsis. In addition, a physician might document urinary tract infection when the clinical indicators point to sepsis.
- **Diabetes:** Physicians need to state the manifestation and the etiology, clearly documenting the relationship between the diabetes and any relevant additional diagnoses.
- **Renal failure:** The terms renal failure and renal insufficiency need to be distinguished. CDI should work with facility providers to develop clinical standards and definitions.
- **Orthopedics:** Physicians need to specifically document the fracture type and the location, particularly with the advent of ICD-10-CM/PCS.
go to a CAH for it and be stabilized and discharged. For ongoing critical care, the patient would be transferred to a typical hospital.

The rule has two parts. The first says that the provider must certify the patient will be there 96 hours or less.

For the second part, in order for the hospital to get paid for the patient’s stay, the treating CAH physician needs to assess the patient’s needs and certify that he or she expects that particular patient can be effectively treated within that time period, says Goethel.

The second part takes away the ability to use the average patient length of stay (LOS) over a year’s time and says each patient must be 96 hours or less, Battaile says. The second part was never previously enforced, so CAHs could have an average yearly LOS of less than 96 hours.

Medicare notified facilities last fall that they will begin to enforce the rule for each patient, and “has people really scrambling,” says Battaile. “For rural facilities, sometimes the nearest hospitals can be 35 miles away or more,” she notes. So, transferring a patient on the fourth day of care, when he or she may only need another 12 to 24 hours to stabilize, is “a hardship for the patient and the facility” and a potentially pointless additional expense.

Although the American Hospital Association is lobbying CMS to change the rule, CDI specialists in CAHs can help ameliorate the situation in the interim.

For example, a 40-year-old heart failure patient typically requires an average LOS of two to three days, Battaile says, but if the patient has additional complications, the expected LOS becomes six days. Goethel similarly points to a patient with a gastrointestinal bleed that becomes obstructed. Now that the patient has passed the 96-hour threshold, the CAH needs to decide whether to transfer the patient or keep him or her for another 12 hours to get the condition under control.

In facilities where no CDI program exists, the utilization review staff member might investigate the situation. Where CDI programs do exist, staff can return to the medical record and examine the information to determine what additional data might be needed to illustrate the complexity of the patient’s condition, Goethel says.

“If we’re talking about the same thing that CDI does everywhere—getting good documentation in the medical record. Helping you [the physician] document everything that you do and treat so we can justify that patient’s continued stay,” she says.

Additional opportunities

Just as in the typical hospital setting, CAH CDI professionals continue to look for opportunities to expand their programs’ horizons.

Lenz is working to help develop sepsis protocols and has taken over reviews for present on admission conditions.

Goethel points to efforts focused on capturing the medical necessity of the inpatient admission, and documentation adjustments needed to meet requirements associated with CMS’ 2-midnight rule.

Filas looks to expand reviews into outpatient records.

“I am very new, only one year, so I am still trying to grow and explore, still looking for processes and ideas to improve our program. CDI is definitely a collaborative effort.”

—Sara Filas

The small, community nature of the CAH at Tomah Memorial Hospital was one of the main reasons Lenz decided to work there.

“You can really make a difference here,” she says. “It’s like an episode of Cheers, where everyone knows your name. We all know each other and we all care about each other. We take care of these patients. For CDI, it’s like a big puzzle. My job is to see what I can find out and how I can improve the documentation for these patients and for my facility. It’s a challenge, but it’s a rewarding one."
CLINICAL CORNER

Pediatric efforts critical in quality transition

by James S. Kennedy, MD, CCS, CDIP

The Patient Protection and Affordable Care Act’s (PPACA) goal is for all payers to transition from a fee-for-service to risk-adjusted population payments based on quality and cost-efficiency. CMS’ game plan was outlined in the *Journal of the American Medical Association* (http://tinyurl.com/CMSgameplan).

Pay particular attention to CMS’ timeline (http://tinyurl.com/q6t27vd) and its emphasis on bundled payments, meaning that physician inpatient reimbursements will be tied to hospital DRG systems or outpatient episode grouping, all based on our ICD-10-CM diagnosis codes and treatment descriptions.

Although Medicare serves few children (unless they are severely disabled or have end-stage renal disease), its Medicaid counterpart, which does, is transitioning to a more refined DRG reimbursement system, the all-patient refined DRG (APR-DRG).

Developed in concert with children’s hospitals, APR-DRGs take into account the unique illnesses seen in pediatrics and neonatology and, like Medicare, risk-adjusts according to the language documented by physicians during the hospital stay.

Consequently, children’s hospitals are now paying more attention to how documented pediatric terminology affects APR-DRG assignment and its reimbursement, particularly since bundled payments are part of CMS’ game plan.

Furthermore, as Medicare and Medicaid implement readmission and hospital-acquired conditions penalties (now underway in Texas, Maryland, and Florida), more children’s hospitals are asking their physicians and extenders to be more cognizant of what conditions were present at the time of the inpatient order, given that, if they occur afterwards, they may be reported as poor-quality care.

Areas of opportunity

Ask pediatricians to consider the following documentation opportunities when writing their history and physicals (H&P), consults, progress notes, and discharge summaries, focusing on conditions present at the time of admission.

**Altered mental states:** Specify the nature of the alteration (i.e., acute or chronic delirium, psychosis, vegetative state, unconsciousness, or coma) and, where possible, the suspected underlying brain disease, such as a metabolic, toxic, septic, or hypoxic-ischemic encephalopathy or the late effect of a specified disorder. ICD-10-CM will allow coding of the Glasgow Coma Scale; however, risk adjustment is not affected unless all three elements are documented and reported. ICD-9-CM does not recognize a drug-induced neurotoxicity (e.g., due to ifosfamine or cimetidine) causing sedation, confusion, hallucinations, and the like; thus, the provider must document the term “toxic encephalopathy” instead. Providers must document hypoxic-ischemic encephalopathy as Sarnat stage 1, 2, or 3, and the extent of any neonatal brain hemorrhage. If a child has a static encephalopathy, physicians should document its underlying cause, which may include the late effect of a cerebral hemorrhage or anoxic brain damage.

**Asthma:** Categorize as intermittent, mild persistent, moderate persistent, or severe persistent, and document whether it is exacerbated or in status asthmaticus. If an episode requires high-flow oxygen, or BiPAP, consider if the patient is in acute hypoxemic or hypercapneic...
respiratory failure. Note: Reactive airway disease codes to asthma; thus, physicians should avoid this term unless the intent is to label the child as having asthma. Use bronchospasm instead.

**Azotemia or acute renal insufficiency:** Consider whether any creatinine changes meet the criteria for acute kidney injury as outlined by the pediatric RIFLE (Risk, Injury, Failure, Loss, End-stage) criteria ([tinyurl.com/2007pRIFLE](http://tinyurl.com/2007pRIFLE)) or the Kidney Disease: Improving Global Outcomes (KDIGO) criteria ([tinyurl.com/2012AKIcriteria](http://tinyurl.com/2012AKIcriteria)). If acute kidney injury lasts for more than 48 hours, consider if acute tubular or cortical necrosis occurred.

**Bacteremia:** ICD-10-CM considers bacteremia to be an asymptomatic positive blood culture with minimal impact on resource use. Should the child meet the pediatric sepsis criteria ([http://tinyurl.com/ml2uxqy](http://tinyurl.com/ml2uxqy)), the physician should document sepsis (not SIRS), severe sepsis, and all associated acute organ dysfunctions such as septic shock, even if the blood culture is negative.

**Reduced capillary refill:** If an acutely ill child has a capillary refill time that is more than two seconds, has pallor, or is placed on a shock protocol, query the physician to ensure that shock and its nature (e.g., distributive, cardiogenic, hypovolemic) is documented.

**Pneumonia:** Physicians need to state the likely infectious etiology of the pneumonia (e.g., *Haemophilus influenzae*, pseudomonas, methicillin-resistant *Staphylococcus aureus*, aspiration), particularly if the child is immunocompromised and/or if broader-spectrum antibiotics, like ceftazidime or vancomycin, are used. If a Fungitell assay suggests invasive fungal lung disease with appropriate treatment, the physician can state “likely fungal pneumonia” on the discharge summary. Note: ICD-9-CM does recognize uncertain diagnoses for inpatient coding purposes only if documented on the discharge summary (not the H&P and interim note) and clinically congruent with the patient’s circumstance.

**Congenital versus acquired conditions:** While some newborn (aged less than 28 days) conditions (i.e., great vessel transposition) are always congenital, some are not (i.e., cytomegalovirus acquired postnatal from breast milk or hydrocephalus due to an intraventricular hemorrhage). Specify whether any newborn condition is congenital or acquired (e.g. respiratory syncytial virus RSV pneumonia), since ICD-9-CM considers any condition in a newborn to be congenital unless otherwise documented by the provider.

**Weight loss:** Become familiar with The American Society for Parenteral and Enteral Nutrition (ASPEN) pediatric malnutrition criteria ([tinyurl.com/2013PedMalnutrition](http://tinyurl.com/2013PedMalnutrition)). If a child’s body mass index (BMI) z-score is less than minus one (< -1), consider if malnutrition is present and if mild (< -1), moderate (< -2), or severe (< -3); and, of course, the physician needs to document it when present.

**Heart failure:** Physician documentation needs to describe whether heart failure is systolic, diastolic, or both, and if currently decompensated. Sadly, APR-DRGs do not add additional weight to decompensated heart failure unless the terms systolic and/or diastolic are added.

**Anemia:** State the underlying cause, such as acute blood loss, hemolysis, hemoglobinopathy, or bone marrow aplasia (e.g., due to chemotherapy). If associated with a pancytopenia, document and state its underlying cause (e.g., due to chemotherapy).

**Sickle-cell disease:** State what type of disease and any acute consequences. For children with an acute chest syndrome, describe any reason for prolonged antibiotics, such as a suspected pneumonia.

**Cerebral palsy (CP):** While the Gross Motor Classification System accurately stages CP severity, ICD-9-CM does not use it, and thus requires us to document its etiology (e.g., birth trauma, congenital syphilis, late effects of stroke), the limbs involved (quadriparetic, triparetic, diparetic, hemiparetic), and the muscle tone (e.g., spastic, athetoid, or ataxic).

This is only a sampling of the language we need to use so we can master pediatric risk adjustment. 🎨

**Editor’s note:** Dr. Kennedy is a general internist and certified coder, specializing in clinical effectiveness, medical informatics, and clinical documentation and coding improvement strategies. Contact him at 615-479-7021 or at jkennedy@cdimd.com. Advice given is general. Readers should consult professional counsel for specific legal, ethical, clinical, or coding questions. This article was originally published in **Medical Records Briefing**’s “Minute for the Medical Staff.”
Engage physicians: Lessons from children’s hospitals

If your CDI program needs physician engagement ideas, perhaps tuning into the efforts at your nearby pediatric hospital can help—or, you can just call on Valerie Bica, RN, CPN, CDI specialist at Nemours/ A.I. DuPont Hospital for Children in Wilmington, Delaware, and her teammates. Although many of the group’s ideas may be familiar to seasoned CDI departments, the program employs a variety of tactics to educate not just its facility physicians, but the entire pediatric care team.

At little more than three years old, the CDI program at Nemours manages yeoman’s work. The quaternary care, 204-bed, Trauma 1 facility has 24 pediatric intensive care units (ICU), 28 neonatal ICU beds, and 14 cardiology ICU beds, with roughly 15,000 discharges annually.

The three-person CDI team divides efforts by service line, which allows them to obtain a high level of awareness regarding frequent diagnoses, engage directly with those responsible for the patient’s care, become familiar with particular physician preferences and documentation habits, and tailor CDI educational offerings, says Lisa Adkins, MSN, RN, CPNP, CRCR, CPHM, director of patient authorization, utilization management, and CDI at the facility.

“The team has become very knowledgeable based on their experience with these specific services and diagnoses on these units,” Adkins says.

Measuring success

CMS doesn’t typically cover the cost of children’s healthcare, except in certain circumstances, so facilities aren’t always reimbursed on the MS-DRG model. Although more state Medicaid programs are adopting the all-patient refined DRG (APR-DRG) system, much of the reimbursement for children’s facilities is still primarily contractual in nature. The Neumors CDI team works to improve the accuracy and specificity of the documentation to reflect the true acuity of the children they treat.

“We believe that reimbursement will follow accurate documentation,” Adkins says.

Financial return on investment aside, Adkins points to several metrics to demonstrate the CDI team’s
positive efforts. The case-mix index has moved from 1.65 to 2.14 in its three-year history. The severity of illness and risk of mortality measures more adequately match the complexity of the patients’ conditions. The program consistently falls within the accepted ranges of its peers per statistics from the Children’s Hospital Association. Furthermore, the number of charts reviewed by the CDI staff increased from 75% at the outset to 97% today. The program’s physician response rate was 65%; now it remains a steady 88%.

Finally, one of the most interesting statistics—the number of providers attending CDI education—climbed from 88% to 98%, says Adkins.

The team educates everyone, not just physicians—their purview extends from nurses to nutritionists, behavioral health to rehabilitation therapists, and interns to residents.

“We go through the whole list and educate them all,” Adkins says. “As they understand the purpose of what we do, they improve their documentation and become more involved in the program.”

Multiple times, multiple ways

How do they do it? They train, train, and train again, engaging physicians and other providers almost constantly through a variety of methods. Here’s how they work:

One-on-one onboarding for new attending physicians: Typically, the CDI Physician Advisor Maria Petrini, MD, FAAP, general pediatrician at the facility, provides one-on-one onboarding for any new attending physicians.

Day one training for all pediatric interns: All new pediatric interns who come to the program in July receive CDI orientation on their very first day.

“These guys are very green,” says Bica. “They are shaking in their shoes faced with a kid with cancer who just had a bone marrow transplant and all the complications that go along with that; they’re reporting to a very intimidating physician; and then they have to turn around and face me telling them how to document more specifically. It’s overwhelming for sure.”

Nevertheless, Petrini says, “when you deliver the right information to them from the beginning, you have an opportunity to get it right from the start.”

Offering a guiding, friendly hand seems to have helped earn the CDI team physician support.

“Physicians don’t learn anything about documentation or reimbursement during medical school,” Adkins says. “Their anxiety level is high as they learn the clinical aspects of what’s expected. We’ve been able to merge our CDI message into that medical learning piece to show how interconnected the documentation is to the patient’s care. Now they come to us, and we’re seen as an integral piece of the care team.”

Monthly review sessions: The team circles back to the attending physicians, fellows, residents, and physician assistants on a monthly basis to highlight what documentation seems to be improving, illuminate successes, and point out any continued areas for improvement.

“We try to reinforce what is working and what needs improvement,” Petrini says.

Quarterly service line/department meetings: These sessions bring the business manager, physicians, utilization management, coding, and compliance together to discuss everyone’s documentation needs. Through these sessions, the team identifies opportunities for improvement and can work collaboratively to make the changes needed, says Petrini.

Unit-specific educational sessions: When Bica first started participating in unit-specific meetings, her efforts were so well received in some areas that the physicians decided a CDI team member should join leadership meetings as well. “I now had access to many specialties, and all the people involved in the daily care of the patient,” Bica says. “I quickly saw it as an opportunity to expand our efforts and offer additional ICD-10 education, too.”

Daily multidisciplinary rounds: Although physicians initially may not want another team member hanging on during rounds, participation can provide all sides with integral information, Bica says. Eventually, we were seen as a resource.

“As the CDI team integrates, certain conditions and language use will become apparent. CDI staff can address concerns in real time, with verbal education on the floor reinforced by verbal or electronic clarifications afterwards,” Bica says.

With the family-centric atmosphere at Nemours, it makes sense for the care team to be just as
inclusive. “Without our presence and integration into rounds, I don’t think we would have been as successful,” Adkins says.

**Additional incentives**

Verbal and formal educational initiatives may be the bedrock of Nemours’ CDI success, but Bica points to a number of other softer methods useful in winning physician interest and support.

Positive reinforcement works best for physician buy-in, she says. When someone excels, praise him or her, and do so in public. When someone documents with specificity and granularity, offer up the excellent documentarian for peers to emulate. Doing so not only provides a concrete example to follow, but provides the CDI team with a built-in physician champion of sorts, someone who will carry the CDI message forward and explain what’s needed to the rest of the team, Bica says.

On the back of the computer she uses during regular rounds, Bica tapes several documentation tips, reflecting some salient points from recent educational efforts to reinforce her message. She calls it her “mobile bulletin board,” and the physicians have taken to calling it that too, she says. In addition, the CDI team created specialty-specific documentation tip cards that physicians can refer to whenever they need them.

On her computer’s rolling cart, Bica rests a basket of sweet treats, over time having gotten to know her physicians’ candy preferences. She does out delicious favors while dispensing her CDI information.

“If you do a little pick-me-up from time to time,” she jokes. “Everyone needs a little pick-me-up from time to time.”

**Editor's note:** Portions of this article were adapted from the April 21 webinar “Pediatric Record Review: A Case Study for Physician Engagement and CDI Success.”

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**PHYSICIAN ADVISOR’S CORNER**

**Tips for improving AMS documentation**

Physicians commonly document altered mental status (AMS), but such terminology represents a nonspecific neurological or psychiatric condition, and CDI professionals then need to query to identify the duration and underlying cause of the condition. More specific terms include delirium, dementia, psychosis, stupor, coma, and encephalopathy, among others.

Out of habit, many physicians simply will not write the word encephalopathy, says **Paul Simmons, MD**, Assistant chief medical officer (CMO) and CDI physician advisor at Massachusetts General Hospital in Boston. For other doctors, words like encephalopathy, AMS, and delirium are all synonymous.

“It’s still a big gray area, and every doctor is going to have his or her own way of looking at this, so you have to bear that in mind when you query,” he says.

From its Latin roots, encephalopathy means something bad happening in the brain, Simmons says. Like AMS, encephalopathy is not consistently defined in mainstream medical or neurological literature, so physicians often default to AMS instead.

ICD-10-CM classifies encephalopathy according to its etiology requiring additional specificity with terms such as hepatic, hypertensive, toxic, and metabolic. Additionally, encephalopathic conditions often coexist with an underlying degenerative brain disease of multiple sclerosis.

Through their efforts, CDI staff members may train physicians so well that physicians begin documenting encephalopathy at every turn, says Simmons. Programs need to monitor such common clinical diagnoses (as true for encephalopathy as it is for other diagnoses) to ensure that only the most accurate ones are assigned.

Do a little digging, Simmons says. Pull a sampling of charts and determine how often your facility reports encephalopathy, then compare your reporting rate to...
other similar facilities and national benchmarks. The data in the Program for Evaluating Payment Patterns Electronic Report often provides such information.

If the data reveals a problem, drill down to determine which physicians may need additional or corrective education. Reach out to start a dialogue about the query process and (mis-)perceptions about documenting encephalopathy. With the data in hand, the CDI specialist or physician advisor can work with the CMO and physician groups to improve their documentation. In this regard, no one wants to be an outlier.

**Additional tips for physician support**

In communicating the difficulties of appropriate documentation of AMS and encephalopathy, CDI specialists should first do some research and gather as much information about the various related conditions as possible. Then, they should reach out to their medical and coding staff to discuss the problem areas facing both sides. Consider developing facility-specific clinical standards that CDI staff can use as they develop their queries.

As with any troublesome areas, CDI queries quickly fall short if the overarching program doesn’t follow through with important physician buy-in efforts, Simmons says. Some such methods include:

- **Global education:** Take advantage of every spark of interest from any physician or administrator and strive to provide all physicians within the facility with basic information about who the CDI team is, what the CDI program’s goals are, and how CDI can help physicians. Simmons supports including the CDI staff members’ names, contact information, and even photos on any training materials or queries.

- **Trust and relationship building:** This is the foundation of successful CDI efforts, Simmons says. It means being honest and transparent about CDI program goals, compliant in query practices, and open to dialogue when physicians and administrators seek out CDI professionals’ help.

- **CMO involvement:** Having the CMO’s support can make all the difference to a CDI program’s success. The CMO can help communicate the CDI mission throughout the physician leadership, which in turn trickles down to the physicians themselves throughout the facility, says Simmons.

- **Physician advisor involvement:** Physician advisors represent the CDI team to the rest of the medical staff and offer themselves as an example of how to effectively respond to queries. They may follow up with errant physicians, provide education and clinical support to the CDI and coding teams, and provide documentation improvement tips to physicians. They also help CDI administrators analyze CDI data to identify the most salient pieces of information that can help physicians understand why documentation is truly in their best interests. “If you don’t have a physician advisor or a physician champion, it can be much more difficult to earn the support of the medical staff,” Simmons says.

- **Reward a job well done:** “When in doubt, bring cookies,” Simmons jokes. When a physician does a good job, a simple “thank you” can go a long way. It can be as simple as a handwritten note or a monthly poster featuring documentation superstars of the month. “It makes the individual feel good about themselves and the job they’re doing. It also serves to make others wonder how they can do better to earn accolades. It makes them wonder why they didn’t get a star.”

- **Leverage your networking and education:** Attending local CDI networking events and national conferences arms CDI specialists with additional data to convince physicians of CDI importance. “You can tell them that all the physicians at a rival hospital were documenting additional specificity,” says Simmons. Additional benefit comes from the value inherent in the CDI team’s continued efforts toward their own education and excellence. “That you care enough about the program to seek out CDI best practices and bring that information back to your own physicians and facility says a lot about the value of the program overall,” he says. 🧑‍⚕️

**Editor’s note:** Dr. Simmons spoke at the April 1 Massachusetts ACDIS chapter meeting at Mass General Hospital. Contact him at psimmons1@mgh.harvard.edu.
Clinical validation reviews defense against denials

Historically, organizations—primarily hospitals—tended to focus on diagnosis-related group (DRG) validation and limit their clinical validation to utilization review efforts, says Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director at HCPro in Danvers, Massachusetts, who spoke during the “Defining the Role of CDI Through Clinical Validation” webinar earlier this year.

But the Social Security Act requires CMS to protect the Medicare Trust Fund against inappropriate payments. To do so, it hires contractors to perform not only DRG reviews but clinical validation as well. And these contractors are getting more adept at performing such reviews and identifying errors.

Let’s talk about the differences between DRG and clinical validation.

**DRG validation**

DRG validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim on prospective payment services (PPS), and, as appropriate, reviewing the record’s DRG accuracy. Contractors perform DRG, or coding, validations using certified coders. The contractors base DRG validation on:

- Accepted principles of coding practice, consistent with *Official Guidelines for Coding and Reporting*.

...
The Uniform Hospital Discharge Data Set (UHDDS) data element definitions

Coding clarifications issued by CMS

When performing a DRG validation, the contractor also determines whether the primary diagnosis listed on the claim is the diagnosis that, after study, is determined to have occasioned the beneficiary’s admission to the hospital (as required by the UHDDS). The principal diagnosis, as evidenced by the physician’s entries in the beneficiary’s medical record, must match the reported principal diagnosis. The principal diagnosis should be coded to the highest level of specificity.

Auditors can deny an item or service if it does not meet any of the conditions listed below:

- The item or service does not fall into a Medicare benefit category
- The item or service is statutorily excluded
- The item or service is not reasonable and necessary
- The item or service does not meet other Medicare program requirements for payment

Clinical validation

When performing clinical validation, the contractor determines whether the beneficiary required an inpatient level of care, whether the patient truly possessed the conditions documented in the medical record, and whether such care was medically necessary, reasonable,
The beneficiary must have demonstrated signs or symptoms severe enough to warrant inpatient medical care, and he or she must have received services of such intensity.

During clinical validation reviews, the reviewer considers preexisting medical problems and extenuating circumstances that make admission of the beneficiary medically necessary. Factors existing solely out of convenience to the beneficiary or family (such as admitting an elderly patient because the family is taking a weekend getaway) do not, by themselves, justify inpatient admission.

The medical necessity of a claim supersedes the DRG validation—if the service was not supported by the medical record, the applicable codes are irrelevant.

Then, the reviewer determines whether procedures and diagnoses were coded and sequenced correctly. If the medical record supports the coding, the claim will be paid and billed. If the medical record does not support the coding, the reviewer will use coding guidelines to adjust the claim and pay at the appropriate DRG.

The contractor may determine that the beneficiary did not require an inpatient level of care on admission, but that the beneficiary’s condition changed during the stay and inpatient care became medically necessary (at a later point during the stay). They review the cases in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission
- The diagnosis determined to be chiefly responsible for the beneficiary’s need for covered services on the deemed date of admission is the principal diagnosis

The claim is adjusted according to the diagnosis that made inpatient care medically necessary.

Claims are denied in full when the contractor determines the beneficiary did not require an inpatient level of care at any time during the admission. If the medical record does not support the coding, the claim is denied. Hospitals have the opportunity to appeal claim denials.

**Create defensible claims**

CDI specialists at Catholic Health Services of Long Island, a six-hospital network, perform both types of reviews ahead of government contractors' efforts, says Adelaide La Rosa, RN, BSN, CCDS, its corporate director of HIM, CDI, and clinical data management. The team looks through the record for accuracy of:

- Level of acuity
- Severity of illness
- Clinical indicators
- Utilization of resources

During the DRG validation review, the CDI specialists work with the coders to ensure all diagnosis and procedure codes are supported by documentation in the medical record, resulting in appropriate DRG assignment prior to bill drop.

In the clinical validation review, CDI specialists look for clinical indicators that support the diagnosis and procedure. They generate queries when a diagnosis or procedure is not supported in the medical record and, once again, make sure proper codes have been assigned.

The chief medical officers (CMO) at Catholic Health Services support the CDI team, acting as physician champions and keeping the medical staff at each facility engaged in the CDI program and compliant with CDI requests. Their support was the first step in expanding to more complex reviews, La Rosa says, adding that the CMOs review charts, outstanding physician query reports, and quality metrics with the CDI team on a weekly basis. In addition, the CDI directors can request impromptu meetings with their CMO counterparts.

While many programs may not have the level of support that La Rosa’s does, everyone can rally physician support by exploring how such efforts positively affect the physicians themselves and adjusting query efforts with that in mind. In fact, clinical validation–focused reviews also help with pay-for-performance and quality measures, she suggests.

If a claim gets denied, La Rosa says her team “RACs them back,” appealing as many times as necessary. The staff performs a second
Here is an example where Catholic Health Services of Long Island, a six-hospital network, successfully appealed a denied claim by presenting thorough and accurate records, says Adelaide La Rosa, RN, BSN, CCDS, its corporate director for HIM, CDI, and clinical data management.

**Excisional debridement**

The issue was whether the beneficiary had an excisional debridement of her scalp wounds. The type of debridement was the key determinant of whether the beneficiary’s hospital stay met the criteria for the DRG listed on the claim. La Rosa’s office felt confident the documentation supported medical necessity. Their case was brought before a U.S. Administrative Law Judge (ALJ), who rendered on the following facts:

- The beneficiary was admitted with an “extensive second-degree burn” on her scalp.
- The appeal file contained a “Report of Consultation” that described the performed procedure as follows: “Wounds … debrided, cauterized, and smeared with Bacitracin.”
- The appeal file contained “Patient Progress Notes” that indicated “Multiple scalp wounds … debrided, cauterized …”
- The debridement procedures were code 86.22, excisional debridement of wound, infection, or burn. Removal by excision of: devitalized tissue, necrosis, and slough.
- The auditor revised the procedure code for the debridement procedures to 86.28, non-excisionsal debridement of wound, infection, or burn. Debridement, not otherwise specified. The change in the type of debridement resulted in a change in the DRG.
- The appeal file contained a discharge summary, which indicates the procedures performed include “excisional debridement of wounds by …”
- The appeal file contained correspondence that indicated the treatments performed throughout the hospital stay, including excisional debridement.

The Recovery Auditor felt the clinical indicators did not support the diagnosis, and “excisional” was not used explicitly enough in the report or procedure notes. But La Rosa and her team proved the term “excisional” was used throughout the record. Based on these findings, the ALJ ruled in their favor, stating “the documentation of the beneficiary’s admission to an inpatient stay at their facility … and related evidence and testimony support that she underwent excisional debridement procedures of her scalp wounds by her treating physician.” The Recovery Auditor was directed to process the claim in accordance with the decision.
Drawing a line between coding/CDI roles

Q: In our role as CDI professionals, there seems to be a lot of emphasis on coding. I understand, however, CDI specialists’ principal focus is to clarify the medical record in preparation for coding. How did the emphasis on coding originate, and what was the founding vision? Most of my peers agree that time spent coding might better be used on clarification of the medical record.

A: The role of CDI programs grew out of the coding specialty. Knowledge of coding practices is a very important skill for the CDI specialist. CDI specialists do need to understand the basic tenets of code assignment, and follow the rules and regulations governing the coding process.

Knowledge of the basic coding guidelines assists CDI professionals in identifying reportable diagnoses, sequencing the principal and secondary diagnoses, and identifying a principal procedure, if applicable. CDI professionals use this information to determine a “working DRG,” or a best guess as to what the MS-DRG would be given the current information in the medical record. As a CDI specialist, I did not worry about V or E codes, and I may not have captured all the needed codes to actually capture a situation, but I could combine what I thought would be the principal diagnosis, and any CCs/ MCCs, to form my best guess of the working DRG. I used an encoder, and code books and a DRG Expert were available to assist me in my practice, but I was not as concerned with coding accuracy as I would be if I were the actual coder. My concern was to ensure that the documentation supported all appropriate diagnoses related to this patient.

Reconciliation

Most often my working DRG would “reconcile,” or agree, with the coders’ final assignment. But their listing of codes assigned would always be more complete and accurate than mine.

Reconciliation is an important piece of the process. When disagreement between the CDI and coding staff occurs, it simply points to learning and growth opportunities. There is room for one or both individuals to learn. In my situation, when we disagreed, it was typically due to new diagnoses appearing in the record after my last review or due to Official Guidelines for Coding and Reporting, coding conventions, or Coding Clinic guidance I was not aware of, leading to an error in my sequencing or code assignment. CDI professionals have a lot to learn in this regard, and comparing these answers and working with the coding team can really help.

Concurrent coding

Concurrent code assignment, however, is a bit different. Concurrent coders review the record and assign diagnoses/procedure codes throughout the patient’s stay. In facilities with concurrent coding and CDI efforts, both teams work collaboratively to query the physician.

A coder, completing a concurrent review and code assignment, works with the expertise of a coder to assign codes based on the Official Guidelines for Coding and Reporting and best coding practices. Ideally, then, the final review on the retrospective side requires less time, as the codes assigned concurrently can be applied with little review. Often the individual who completes the concurrent code assignment also retains responsibility to complete the final code assignment and attestation of the record.
CDI focus

Traditionally, CDI specialists do not code the record in any “official” capacity, and many in the industry (including experienced coders now working as CDI specialists, as well as RNs working in the CDI role who took the extra step to earn their inpatient coding certification) warn against blending the two roles together (The January edition of CDI Journal offers a discussion of this in the article “CDI collaboration: Should concurrent CDI also include code assignment?”). Most CDI professionals are not certified coders. Although many have a strong working knowledge of the code set(s), they usually do not complete code assignment for the entire record.

The focus of the CDI is not necessarily accurate code assignment, but moreso complete documentation that will support accurate code assignment. With a goal of capturing vague or incomplete diagnoses, clarifying conflicting information, and perhaps achieving clinical validation of an already documented diagnosis, CDI professionals do not usually take the time (nor do they have the skill) to completely code an entire record.

The CDI focus depends on the mission of the department. Some programs focus on reviews related only to MS-DRG assignment and revenue capture. Others review the record to capture quality indicators, medical necessity, and/or severity of illness and risk of mortality. How the CDI team reviews the record affects which queries are needed.

As for upcoming trends in CDI, the sky is the limit. We are seeing more and more quality measures based on administrative data (claims data and code assignment), which, of course, can be influenced by CDI intervention. As both CMS and commercial payers move to focus on paying for quality versus quantity, examining mortality measures, etc., we are seeing programs begin to shift their focus from the traditional CDI role to one that considers quality of care measures as well. CDI specialists are also shifting their focus from the inpatient population to include the outpatient population related to medical necessity of care and Hierarchical Condition Categories, for example.

Discuss and clarify the mission of your CDI efforts. Understanding the focus helps everyone prioritize their time and efforts. It also helps the team identify the population of records to review and the frequency of repeat reviews. If the CDI team is being asked to perform true concurrent coding, work to ensure that the staff maintains the appropriate certification and knowledge set to do so, and work with the coding and CDI staff members to ensure the best processes, and with hospital administrators to ensure compliance.

Q: Am I correct in understanding that when a complication code, such as 999 or 998 series, happens to be the reason of admission along with another condition also contributing to the admission, the complication code takes precedence over the other condition code?

A: First, refer to the code set’s Alphabetic Index and Tabular List guidelines related to sequencing, with notes that instruct us to code first or code also. There is instruction within the Official Guidelines for Coding and Reporting as to how to interpret the directional notes found here.

Coding Clinic also gives guidance; however, there is a hierarchy for which guidance supersedes the other. Follow first the instructions within the Alphabetic Index and Tabular List (coding conventions) as these are the highest, followed by the Official Guidelines for Coding and Reporting, and lastly the Coding Clinic advice. The Official Guidelines for Coding and Reporting states: When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity... an additional code for the specific complication should be assigned.

Thus, your understanding of how these should be sequenced is absolutely correct, and now you are able to state where you accessed this instruction. ✨

Editor's note: Laurie L. Prescott, MSN, RN, CCDS, CDIP, a CDI education specialist with HCPro in Danvers, Massachusetts, and lead instructor for its CDI-related Boot Camps, answered these questions. For more information regarding upcoming Boot Camp dates and locations, visit www.hcprobootcamps.com/courses/10040/location-dates.
MEET A MEMBER

North Carolina chapter leader recalls industry growth

Formerly the vice president of the North Carolina ACDIS chapter, Brenda A. Harris, RN, CCDS, CCA, has worked in the CDI field for 12 years; she currently is a CDI specialist with Carolinas HealthCare Systems: Carolinas Medical Center University in Charlotte, North Carolina. Happily married with two adult children, one son and one daughter, she enjoys reading, cooking for her family, and sewing (including quilting, which she recently took up).

**CDI Journal:** What did you do before entering CDI?

**Harris:** I was a case manager for a cardiac telemetry unit responsible for arranging home health and communicating with the insurance providers to ensure that the patient’s stay was covered. Prior to that, I was a staff nurse on the same telemetry unit.

**CDI Journal:** Why did you get into this line of work?

**Harris:** Initially, case management and CDI specialist duties were performed by the same person. After one year, we reassessed and decided that [performing two roles] wasn’t very effective, so the CDI department was created. I was very interested in this new opportunity for nursing, especially capturing the severity of illness, although initially that was not the focus.

**CDI Journal:** What has been the biggest challenge?

**Harris:** Definitely getting some physicians to buy into the concept. You have a verbal conversation with a physician, and sometimes they do not follow through with their documentation. Conversely, it is also very rewarding to interact with physicians and those that seek me out to follow up on queries.

**CDI Journal:** How has the field changed since you began working in CDI?

**Harris:** Initially, our principal responsibility was to capture CCs on the chart that would result in a financial gain. We focused on capturing secondary diagnoses only when it affected the DRGs. With the introduction of MS-DRGs, that shifted to the MCCs and CCs. Now, the emphasis is on capturing the severity of illness and intensity of services, with the goal being to have the chart better reflect the true patient condition.

**CDI Journal:** What piece of advice would you offer to a new CDI specialist?

**Harris:** Develop a systematic way to review charts. Using this approach will encourage the CDI specialist to review all disciplines’ notes, including notes from nurses. While we cannot code from nurses’ notes, it may generate an opportunity to query the physician.

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

**Harris:** I think I would be a librarian. This allows you the opportunity to watch students develop a skill set that is so fundamentally important. I would also just love to explore the archives—there is so much to learn there.

**CDI Journal:** What was your first job?

**Harris:** My first job in high school was a youth camp counselor for a summer program at the local recreation center. As a counselor, I was responsible for organizing activities for the kids in the summer program, both games as well as providing academic enrichment.

**CDI Journal:** Tell us a few of your favorite things.

- **Vacation spots:** The mountains, especially walking trails, including Lake Lure, North Carolina
- **Hobbies:** Reading and sewing
- **Non-alcoholic beverage:** Concord grape juice
- **Foods:** Seafood, especially New Orleans–style gumbo
- **Activity:** Zumba 🕺

**Editor’s note:** CDI Journal introduces an ACDIS member in each issue. If you would like to be featured, or know someone who would, please email ACDIS Editor Katherine Rushlau at krushlau@acdis.org.
CODING CLINIC CDI UPDATE

Seventh character defined, more PCS focus

by Sharme Brodie, RN, CCDS

We’re just about six months away from the implementation of ICD-10 CM/PCS, and the AHA Coding Clinic for ICD-10-CM/PCS is rolling right along with advice for the new code set. ICD-10-PCS will be the greatest challenge facing coders this October, so the First Quarter 2015 edition focused on the procedure side once again. I am fairly certain this will be most appreciated come October 1, 2015.

Seventh character application

Starting off, Coding Clinic (pp. 3–21) devoted a lot of time to explaining the application of ICD-10-CM’s seventh character used in Chapter 15, Pregnancy, Childbirth, and Puerperium; Chapter 19, Injury, Poisoning, and Certain Other Consequences of External Causes; and Chapter 20, External Causes of Morbidity. CDI specialists need a clear understanding of how to use the seventh character to ensure all the information is present in the chart, so the coding staff can accurately apply the correct seventh character when applicable.

In Chapter 15, the seventh character accounts for certain complications of multiple gestational pregnancies to indicate which fetus is affected by the condition.

In Chapter 19 and Chapter 20, the seventh character provides specific information about the episode of care (e.g., initial episode, subsequent episode, and sequelae). When used with fracture codes, it provides additional details, such as whether the fracture is closed or open (with type), if there is routine or delayed healing, and whether the fracture was a nonunion or malunion.

The Cooperating Parties (the four organizations in charge of the code set maintenance, including CMS, AHIMA, AHA, and the National Center for Health Statistics) revised the Official Guidelines for Coding and Reporting to clarify how the seventh character is used (changes to the language are indicated in bold below unless otherwise noted).

Most of the categories in Chapter 19 have a seventh character requirement—meaning that, in order for a code to be assigned, it must have a seventh character. There are typically three to choose from:

- **A, initial encounter**: Used while the patient is receiving active treatment for the condition. Some examples include surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

- **D, subsequent encounter**: Used after the patient received active treatment for the condition and is receiving routine care during the healing or recovery phase. Examples of subsequent care include cast change or removal, an x-ray to check healing status of a fracture, removal of external or internal fixation device, medication adjustment, and other aftercare and follow-up visits following treatment of the injury or condition.

- **S, sequelae**: Used for complications or conditions that arise as a direct result of a condition, such as a scar formation caused by a burn.

Categories for traumatic fractures have more available options for the seventh character. However, assignment of the seventh character depends on whether the provider is seeing the patient for the first time, according to the Official Guidelines for Coding and Reporting.

Additionally, when deciding the seventh character for complication codes, the Official Guidelines for Coding and Reporting tells us that “active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem.” The example given to help us better understand this guideline (see Coding Clinic p. 16) is that code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, would be used when active treatment is being provided for the infection, even though the condition relates to the...
prosthetic device, implant, or graft that was placed at a previous encounter.

Aftercare, or Z codes, should not be used for conditions found in Chapter 19, such as injuries or poisonings where the seventh character identifies subsequent care. For example, for the aftercare of an injury, assign the acute injury code with the seventh character D (subsequent encounter).

If the condition warrants a seventh character assignment of S for sequela, coders will also have to assign an additional code—one code for the injury and one code for the sequela itself. The coder assigns the S designation only to the injury code, not the sequela code. The seventh character S identifies the injury responsible for the sequela. The type of sequela (e.g., scar) will be sequenced first, followed by the injury code. Per the Official Guidelines for Coding and Reporting, a sequela is the residual effect after the acute phase of an illness or injury has ended. It can be apparent within hours, days, months, or even years after the illness or injury has occurred, with no time limit on when it can be coded.

Assign the external cause code with the appropriate seventh character for each encounter in which the injury or condition is being treated. Most categories in Chapter 20 have a seventh character requirement for each applicable code. Most categories in this chapter also have three seventh character value options, just as in Chapter 19: A, initial encounter; D, subsequent encounter; and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the seventh character for the external cause should match the seventh character of the code assigned for the associated injury or condition for the encounter.

**Documenting dominance**

New guidelines governing a patient’s dominant versus nondominant side in diseases of the nervous system, such as a cerebrovascular accident, tell coders to assign ambidextrous and right-sided patients to dominant and left-sided patients to nondominant if the physician does not specify and there is no default code. Providers should be educated to include the side of dominance for their patient in their patient assessments and history and physical documentation to avoid default code assignments.

**Defining root operations**

There are 31 root operations (the third character and the objective of the procedure) used in ICD-10-PCS. Coding Clinic gives definitions and examples of a few of them (pp. 27–36), such as:

*Official Guidelines for Coding and Reporting* state “to determine the appropriate root operation, the full definition of the root operation per PCS tables must be applied.” Steps taken during the procedure that are necessary to reach the operative site and to close the operative site (including anastomosis of a tubular body part) are not coded separately. In encounters where multiple procedures were performed during the same operative episode, and each procedure has a distinct objective, coders can assign multiple codes to accurately capture the situation.

However (see p. 29 and p. 35), if the intended procedure is discontinued, code the procedure performed. If a procedure is discontinued before any other root operation is performed, or if the intended procedure is not successfully completed, then the root operation of “inspection” of the body part or anatomical region would be coded.

It will be the coder’s responsibility to determine what the documentation in the medical record equates to in ICD-10-PCS definitions of root operations. The physicians will not be expected to use the same verbiage as used in ICD-10-PCS, nor will the coders be required to query the physician for clarification if he or she does not use the ICD-10-PCS descriptions.

Coders and CDI professionals should familiarize themselves with the definitions of the root operations. The CDI staff may take on additional responsibilities related to surgical chart review under the new code set to ensure all the information is accurate and complete so the coder can accurately build the appropriate procedure codes.

**Editor’s note:** Brodie is a CDI education specialist for HCPro in Danvers, Massachusetts. Contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit www.hcprobootcamps.com.