CDI: WHAT’S IN IT FOR THE PHYSICIAN

Live webcast presented on:
September 17, 2012

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CDI: What’s in it for the Physician

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We will begin shortly!

Live webcast presented on: September 17, 2012
**Presented by:**

Timothy N. Brundage, MD, has served as the medical director for case management and CDI departments for Kindred Hospital Central Tampa since 2004 and became the physician champion for its north and central districts in 2008.

Dr. Brundage acts as a liaison between the case management department and the attending physician and helps to render opinions regarding admission status based on Interqual criteria and sound medical judgment.

**Presented by:**

Trey La Charité, MD, is the physician advisor for the University of Tennessee Medical Center’s clinical documentation integrity project and for coding. Dr. La Charité completed his internship and residency training in internal medicine at UTMCK and is currently an assistant professor in the department of internal medicine and a hospitalist at UTMCK. He also serves on the ACDIS advisory board.
Why does CDI Matter?

Physician documentation in the medical record is an important instrument in the economics of healthcare.

### Why does CDI Matter?

**Medicine Under The Microscope**

- Cost per patient
- Resource utilization
- Length of stay
- Complication Rates
- Morbidity Scores
- Mortality Scores
- Outcome Analysis
- Audits
Documentation and how it affects the entire team

In this World of Documentation

- Your documentation reflects severity of illness (SOI) and risk of mortality (ROM) scores.
- Specificity is vital, a definitive diagnosis must be documented.
- Physician profiles are developed from documented information

Golden Rule: “If it is not written in coding language, it didn’t happen.”
Increased Physician Scrutiny

• Without all factoring conditions documented, profiles will inappropriately reflect higher than expected mortality

• Complete documentation, reflective of the true severity of your patients, helps justify outcomes
  Profiles are used for both commercial and public use
  Future reimbursement methods will likely incorporate profiles in the formula (e.g. pay for performance)

Physician Profiling is Common

• Hospital Report cards
• Healthgrades, Delta Group, Leapfrog
• Medicare Physician Data (since 2007)
• Federal and state regulatory agencies (e.g. OIG)
• The Joint Commission (TJC)
• Centers for Medicare and Medicaid Services (CMS)
• Quality Improvement Organizations (QIO)
Wording Rules

The Centers for Medicare and Medicaid have established rules regarding what wording is acceptable for reimbursement and coding, therefore impacting risk of mortality (ROM), and severity of illness (SOI) scores.
CMS Word Game

- Specificity is paramount
- Lab work, pathology and radiology reports are not usable
- Diagnostic medical/coding language only
- Certain diagnosis must be linked

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Wording Must be Specific

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Acute Blood loss anemia</td>
</tr>
<tr>
<td>Respiratory insufficiency</td>
<td>Acute/Chronic Respiratory failure</td>
</tr>
<tr>
<td>U/A abnormal</td>
<td>UTI</td>
</tr>
<tr>
<td>Urosepsis</td>
<td>Sepsis due to UTI</td>
</tr>
<tr>
<td>Alt. Mental Status</td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>COPD</td>
<td>COPD w/ Acute exacerbation</td>
</tr>
<tr>
<td>Asthma</td>
<td>Asthma exacerbation</td>
</tr>
<tr>
<td>CHF</td>
<td>Acute Systolic Heart Failure</td>
</tr>
</tbody>
</table>
Specific Terms Necessary For Capturing Severity of Illness

- Acute Stable
- Chronic Unstable
- Exacerbated Mild
- Post operative Moderate
- Secondary to Severe
- Due to Uncontrolled

Examples

- Acute Post OP Respiratory Failure (caution!)
- Acute Blood Loss Anemia
- Acute Confusional State
- Acute Diastolic Heart Failure
- Acute Respiratory Failure
- Severe Sepsis
- Acute Exacerbation of COPD
- Pneumonia secondary to Aspiration
- Uncontrolled Diabetes Mellitus type 2
Documentation Concepts

<table>
<thead>
<tr>
<th>Progress Note</th>
<th>Clinical Language and Symbols</th>
<th>Required Documentation Translates to ICD-9 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RLL infiltrate</td>
<td>RLL pneumonia</td>
<td></td>
</tr>
<tr>
<td>Urosepsis, WBC’s 28,000,</td>
<td>Sepsis secondary to UTI due to Staph</td>
<td></td>
</tr>
<tr>
<td>Heart Wall defect</td>
<td>Aneurysm of Heart Wall</td>
<td></td>
</tr>
<tr>
<td>ABG 7.22/68/44; will treat accordingly</td>
<td>Respiratory failure, acidosis, alkalosis, etc.</td>
<td></td>
</tr>
<tr>
<td>Red area on ankle with some skin breakdown</td>
<td>Decubitus ulcer</td>
<td></td>
</tr>
<tr>
<td>BP 68/40 on Levophed for support, CVP = 0-1</td>
<td>Shock: (cardiogenic, hypovolemic, septic)</td>
<td></td>
</tr>
<tr>
<td>MB-CK and Troponin elevated; ST elevation in II, III, and AVF</td>
<td>Acute MI</td>
<td></td>
</tr>
<tr>
<td>Continue Lasix and Lanoxin</td>
<td>Heart Failure (specify acute/chronic/acute-on-chronic and systolic/diastolic)</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Acute Obstructive Bronchitis</td>
<td></td>
</tr>
<tr>
<td>Swallow study positive; Insert NGT and keep patient NPO, for now. RLL infiltrate worsening.</td>
<td>Probable aspiration pneumonia</td>
<td></td>
</tr>
<tr>
<td>H&amp;H 5.6 / 15.8 Type and Crossmatch for 4 Units. Transfuse x 2. Repeat CBC @ 6 PM.</td>
<td>Acute or chronic blood loss anemia</td>
<td></td>
</tr>
</tbody>
</table>

No Use of Symbols

Symbols and numbers do not translate into a diagnosis and cannot be coded!

- \( \text{Na}^+ \ 124 = \text{nothing} \)
- \( \text{U/A} \ = \text{nothing} \)
- \( \downarrow \text{Hgb} = \text{nothing} \)
- \( \text{EF} \ 30\% = \text{nothing} \)
- Symbols = nothing
Why is This Important?

Hypotension
- mortality low

Shock
- mortality rate 50-70%

Respiratory insufficiency
- mortality score low

Acute Respiratory Failure
- 30% mortality rate

Sputum Culture Positive for Pseudomonas
- nothing

Pneumonia due to Pseudomonas
- 40-70% mortality rate

CDI Improves Communication

• How do healthcare professionals convey information about patients to one another?
  — Through the written word!
  — Physicians do not have time to call every other physician involved in that patient’s care to discuss a clinical situation

• The more specific and accurate the medical record, the better the clinical decisions that will be made by the next provider of care
  — Docs can’t make better choices if don’t know everything possible about the patient
Which patient has a longer GMLOS?

A. 84 yo WF w/ R hip fracture *and* type 2 diabetes mellitus (uncontrolled), chronic diastolic heart failure, HTN, chronic kidney disease (stage 3), morbid obesity, and severe malnutrition . . .

**OR:**

B. 84 yo WF w/ R hip fracture *and* HTN, diabetes

*Patient A even if patients A and B are the exact same patient!

CDI Improves LOS

- Small Improvements in diagnosis specificity and accuracy allow physicians more time (days) to safely discharge their patients
  - Meeting GMLOS goals Improves publicly reported data which may lead to increased patient volume
  - Less physician stress if does not feel forced to discharge patients home too early
  - Hospital readmission rates now under intense scrutiny
**CDI Improves LOS**

- CCs and MCCs have substantially more impact on LOS in surgical cases than in medical cases
  - Medical CC may add 1 day or less to GMLOS for the average case while Surgical CC may add 2 to 4 days
- Who are the real financial drivers of your inpatient reimbursements?
  - Surgeons! They like good stats.

**CDI Helps E&M Compliance**

- How many notes (H&Ps, initial consultations, progress notes, and D/C summaries) in your facility actually satisfy CMS requirements for the E&M level billed?
  - Eventually . . . CMS and other auditors will start looking at the individual physician component of “improper payments” or “over-payments”
- *These recoupments will come out of the individual physician’s wallet and not the hospitals’!*
CDI Helps E&M Compliance

- All E&M codes based on a combination of 3 categories:
  - History
  - Physical Exam
  - Medical Decision Making
- More diagnoses & appropriate severity of those diagnoses can only increase the medical decision making component
- **Ex:** Internal audits of our hospitalist group have never shown inadequacy in the medical decision making component

CDI Solidifies Medical Necessity

- CMS/private insurers **aggressively** scrutinizing “Inpatient” vs. “Observation” status through recovery auditing programs
  - Inpatient hospitalizations reimburse substantially more than observation stays
- Currently, only hospital reimbursement effected if inpatient status denied
- Physicians’ individual reimbursement not recouped in status disagreement
  - Position is they are not arguing that patient needed the services provided, just provided in wrong status
CDI Solidifies Medical Necessity

• How does this point help me sell my medical staff on the need for CDI compliance if their wallet is not effected?
• Explain how reduced hospital finances directly effects physicians and their patients
  – May mean fewer nurses on the floor taking care of their patients
  – May mean desired new procedural equipment may not be able to be purchased
• Physicians and hospitals need to be working together as any negative impact on one directly effects the other

CDI Solidifies Medical Necessity

• CMS/private insurers also aggressively scrutinizing procedural medical necessity
  – Ex: “Patient did not meet LCD/NCDs for PTCA w/ stent”
  – Ex: “Patient did not meet NCDs for Kyphoplasty”
• If outpatient procedure denied, payer may go after physician professional fee as well
• Improved physician documentation practices ensure procedural indications are concretely provided and irrefutable
• **Know your LCDs & NCDs!**
  – Best auditor defense is a strong offense!
CDI Improves Reimbursement

• Many physician’s gut reaction is that CDI is solely about the hospital’s bottom line
  – “Why should I help with this project? This only benefits the hospital.”
  – “I don’t care about the hospital as long as my patient is taken care of.”

• MS-DRG system promoted conflict between physicians & hospitals as individual reimbursement systems not aligned
  – Physicians recoil when hear about “hospital’s money”
  – Physicians still believe hospitals have “infinite pockets”

• This old/outdated mindset must be broken!
  – Must do your best to cultivate teamwork between the hospital and the medical staff

CDI Improves Reimbursement

• While CDI programs do have a financial impact on your facilities, must emphasize that this is not primary focus of your efforts
  – Main goal is to make sure patients want to come to your facility and are able to come to your facility for their care

• However, must acknowledge there are financial ramifications to your program
  – Removes this as an argument from med staff looking for reason not to comply
  – Medical staff will never buy in if you try to hide this fact
CDI Improves Reimbursement

- To counteract this financial misperception, must educate & emphasize all other reasons to participate in CDI
  - Bare in mind . . . your new CDI program may be starting from a negative public relations position as CFO most frequently initiates the program
- If they still won’t let this go, emphasize less hospital reimbursement means . . .
  - Fewer nurses
  - No new procedural equipment
  - No new partners
- Would the physicians like to pay for these?

CDI Improves Reimbursement

- If they still won’t let it go, explain to them the pressures your facility faces
  - Every year, hospital reimbursements are reduced by one or more mechanisms
  - Every year, new “must achieve” performance metrics are added
- Reality is that your facility is expected to provide better performance year after year with less and less funds to do so
  - Sound like untenable situation long-term?
- No hospital means no place to practice!
**Future Physician Reimbursement**

• **Bundled Payments** are coming!
  – Currently, for any given hospitalization, the hospital and the physicians send separate bills
  – Eventually, there will be only one check *written to the hospital* for a given episode of care
  – The hospital and the physicians will have to *negotiate who gets what* portion of that check
  – It will behoove physicians to make that check as large as possible!

• Individual physician billing will go the way of the Dodo!

**Future Physician Reimbursement**

• Reduced reimbursements with increasing overhead and regulatory requirements mean fewer physicians can afford to be in private, group practice
  – More and more independent physician practices selling to hospitals
  – Physician’s fortunes now permanently and inescapably tied to hospital’s
    • If hospital does not do well, neither will the physicians
• Must cultivate “*us vs. the world*” atmosphere where “us” = hospital & physician
In The End . . .

• Don’t give up!
• CDI is not a switch that changes from “off” to “on” at your command
• Keep peppering them with all of the reasons CDI is about them
• Eventually, you will find the one reason that resonates with even the most reticent participants

Thank you

For more information about CDI Week and its associated activities and resources, please visit:

http://www.hcpro.com/acdis/cdi_week.cfm

Be sure to register for the next CDI Week FREE webcast:

Introduction to CDI
Thursday, September 20, 2012
at 1:00pm Eastern

http://www.hcpro.com/register/sEN201342
This concludes today’s program.