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Finding new ways to engage

Earlier this year, ACDIS members identified their top concerns for 2016 in a membership survey. Physician engagement, physician education, and physician pushback were listed as struggles one, two, and three. While we may have hoped that providers would come to inherently appreciate the work CDI specialists perform, it’s clearly a hope that’s not yet been achieved.

New physicians join the profession every day. Coding requirements shift annually. (Read the latest news regarding Coding Clinic shift on heart failure with preserved ejection fraction on p. 18.) Government payment rules seem to be in a constant state of flux. (Read more about the inpatient prospective payment system proposed rule on pp. 6 and 8.) Nationally accepted clinical treatments change, too. (Read more about the new sepsis-3 definitions on p. 15.)

With all these constant alterations and augmentations, keeping oneself informed is challenging enough, but communicating—nay, effectively communicating—the necessary information to ensure appropriate action from physicians must seem Sisyphean at times. Surely, the physicians feel this way too—documentation being just another boulder they need to shoulder up the hill in order to care for their patients.

This is why specialists need to keep the CDI tenet close at heart. Generally speaking, that doctrine calls for ensuring the specificity of the documentation in the medical record for a complete and accurate depiction of patient care. However, each CDI program needs to set its own core mission statement according to its values and program focus, and return to it just as a compass needle provides direction for those lost in the wild. (Read more about the importance of the mission statement on p. 20.) With a mission statement in place, CDI staff can begin to build the relationships needed to win physician support.

In experiments that tested how workers responded when explicitly shown the futility of the tasks they were working on, the test condition was referred to as the Sisyphean condition. Those experiments came to the conclusion that people work harder when their work is more meaningful. Perhaps this seems obvious, but the link between meaning and motivation is one that’s often underestimated.

In this edition of the CDI Journal, the ACDIS Advisory Board suggests that leveraging data on an
ongoing basis may not only demonstrate to physicians the inherent value of documentation, but also illuminate documentation’s importance over time on a host of initiatives. (Read more on p. 23.)

Readers can also learn more about how their CDI peers tackle physician engagement at their facilities, including hosting lunch-and-learn events, giving CDI Week gift bags, and holding trivia contests (see pp. 28–30).

In 2013, CCDS Coordinator Penny Richards worked with poster presenters Dawn Mattison and Chelsea Gilbert at the ACDIS Conference in Nashville to create a mock wedding that played on the word “engage” and turned it into a metaphor for the role CDI professionals play in marrying providers’ clinical acumen with coders’ comprehension of the rules governing code assignment. (Although admittedly the quality isn’t great, there’s a video of the event on our YouTube channel—or you can steal the ceremony from the pages of the 2013 conference recap.)

As part of the vows, Richards asked, “Do you vow to support each other through the coding and documentation changes we face?” In this creative ceremony, instead of rings, the physician and the CDI specialist exchanged pens as a sign of the appropriate documentation they promised to write.

Perhaps the wedding concept will work at your facility and the CDI department will blissfully ride off into the sunset with their physician counterparts. If not, try some of these other ideas before you break out the rolling pin.
Thoughts on proposed coding changes

by Sam Antonios, MD, FACP, FHM, CCDS

On March 9 and 10, 2016, the ICD-10 Coordination and Maintenance Committee had a meeting to review many of the proposed changes to ICD-10 coding system.

The agenda for the meeting is available on the CMS website. The ACDIS Advisory Board submitted formal comments to the committee on April 8. (Click here to read them.)

The fiscal year 2017 inpatient prospective payment system proposed rule includes 1,900 new diagnosis codes, more than 3,600 procedure codes, and a host of other changes. (Read the “In the News” article regarding these changes on p. 8.)

Rather than provide a comprehensive list of the proposed changes, I will offer a brief summary of the proposals I feel will have a significant impact and are worthy of note for physician documentation. Most are needed improvements, but they carry with them a need for education and training—both for coders as well as physicians.

Hepatic encephalopathy

ICD-10 has introduced a significant wrinkle in the documentation of hepatic encephalopathy. It required the addition of hepatic coma to the various etiologies of hepatic failure (alcoholic, toxic liver disease, chronic liver failure, viral hepatitis, etc.). The ICD-9 code for hepatic encephalopathy is gone.

The American Academy of Neurology requested the addition of the West-Haven grading system for coding of hepatic encephalopathy. This will be helpful for documenting hepatic encephalopathy in the absence of coma. However, West-Haven is not a very well-known grading system amongst physicians. Certainly, it is known within the neurology community, but obtaining the grading for patients cared for by other physicians may require education and potentially more queries.

Classification of myocardial infarction

Since the introduction of the universal definitions of myocardial infarction (MI), CDI and coders have...
been caught in situations where it is difficult to clearly understand the type of MI because of the coding classification. This is particularly true for what’s known as “Type 2 MI” and the difference between it and NSTEMI. Even physicians have occasionally misunderstood the definitions.

The March meeting included a proposal from the American College of Cardiology and the American Heart Association to incorporate into ICD-10 the MI classification as it was published in 2014 by the Task Force on Clinical Data Standards, which contains five distinct types of MIs. CDI and coders will need additional training to clearly understand the definitions and query physicians when information isn’t clear.

**Lacunar infarction**

Lacunar infarcts are encountered frequently in hospitals. They are the effect of small penetrating vessels in the brain, typically within deeper areas and away from the cortex. Due to their important prognostic value, the American Academy of Neurology requested that they be awarded their own code and specific indexing. This would differentiate them from other types of ischemic strokes. Here, again, education is important to avoid confusion between small peripheral or deep cerebral infarctions.

**Clostridium difficile**

Coincidentally, *Clostridium difficile* (*C. diff*) infections are called “CDI.” They are infections of the gastrointestinal tract, and they can be life-threatening. Treatment and management of a primary episode and a recurrence may be different. In order to differentiate between the two, there is a proposal to create codes for enterocolitis due to *C. diff* that are specified as recurrent. An important clinical nuance is that in order for the episode to be considered a recurrence, the primary or original episode needs to have had a complete resolution with treatment. This will surely introduce some interesting points of conversation about whether the documentation clearly supports one situation versus the other.

**Ectopic pregnancy**

The American Congress of Obstetricians and Gynecologists has historically brought many requests to the Coordination and Maintenance Committee. One 2014 request was for a proposal for new codes to capture gestational pregnancy with coexisting ectopic and intrauterine pregnancies, which has now been updated to include laterality. Although laterality is fairly common in existing documentation of ectopic pregnancy operative reports, it may be lacking in other areas where coding for the diagnosis would be needed, such as progress notes or office notes. Queries and education may be required in this situation as well.

I will try to keep following the information released from CMS regarding changes to ICD-10-CM/PCS and look at its possible clinical documentation impacts. As noted above, there are many other changes in the pipeline, and it’s best practice to keep an ongoing educational effort going within each CDI program to remain up-to-date on the latest clinical criteria and coding changes. 🏆

**Editor’s note:** Antonios is a board-certified internist, CDI and ICD-10 physician advisor, medical director of information systems, utilization management medical director, and HIM committee chair for Via Christi in Wichita, Kansas. He was elected to the ACDIS Advisory Board in 2016 and serves through the end of 2018. Contact him at Samer.Antonios@via-christi.org.
IPPS proposal includes multiple changes

CMS released its fiscal year (FY) 2017 inpatient prospective payment system (IPPS) proposed rule on Monday, April 18. In it, the agency offers its usual collection of payment reductions and increases, estimating an overall spending hike of $539 million. (Read the related article in the April 21 edition of CDI Strategies.)

DCA cuts

One reduction relates strategically to CDI efforts. CMS originally intended the documentation and coding adjustment (DCA) to reduce Medicare payments that were solely due to institutional coding and documentation optimization efforts expected following implementation of the MS-DRG system in 2008. Over the years, the DCA made cuts of varying amounts, but this year’s proposal rests at 1.5%. CMS calculates that roughly $5 billion of the original amount the DCA set out to recoup remains to be collected. Should the cut remain, it could, theoretically, be the last year of DCA reductions.

2-midnight reversal

Another payment adjustment aims to reverse the effects of the 2-midnight rule 0.2% cut—the source of an ongoing legal challenge by the American Hospital Association—with a permanent positive adjustment of approximately 0.2% in 2017 onward, and a temporary adjustment of 0.6% to address the retroactive effect of the rule since 2014, according to a CMS fact sheet.

Coding shifts

CMS included nearly 2,000 recommended additions to the newly implemented ICD-10-CM code set and more than 3,500 additions to the ICD-10-PCS code set. CC/MCC additions and deletions were also included in the proposal.

The volume of changes is likely due to the multiple-year freeze of both the ICD-9-CM and ICD-10-CM/PCS code sets in the run-up to implementation. Changes can be found in Tables 6A and 6B of the proposed rule.

CMS also announced expected changes to MS-DRGs 469 and 470, related to major joint replacement and their relative weights under the Bundled Payments for Care Improvement Initiative. Another shift comes from the current MS-DRG 228–230, other cardiothoracic procedure, in which CMS eliminated the CC-only DRG, according to James S. Kennedy, MD, CCDS, president of CDIMD Physician Champions.

“There’s a lot of great history in the adaptation of ICD-10-CM/PCS to MS-DRGs that is worth reading. I believe once Medicare analyzes FY 2016 MedPAR data (which I suspect that they are doing now), we will see major changes in the CC/MCC table,” Kennedy says.

(Read Advisory Board member Sam Antonios’ discussion of important changes to watch on p. 6.)

Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing Program rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries. It currently includes a host of measures such as catheter-associated urinary tract infections and surgical site infections, essentially rewarding facilities that perform well on the measures and withholding a percentage of reimbursement for those facilities that do not perform as well.

The IPPS proposal seeks to expand the 30-day pneumonia mortality measure and to add two condition-specific payment measures (one for acute myocardial infarction and one for heart failure) beginning in FY 2021. It also seeks to add a 30-day
mortality measure following CABG surgery beginning with FY 2022.

Once the measures are set, documentation and coding for these measures will begin to be collected and analyzed, although the payment for the measures doesn’t take effect until the implementation year. The result can seem a bit like time travel, with penalties in place today for patients seen in years past.

**Hospital-acquired conditions**

The Hospital-Acquired Condition (HAC) Reduction Program aims to eliminate preventable conditions obtained within the hospital setting. This year, CMS proposed changes including:

1. Establish data submission requirements for newly opened hospitals
2. Establish performance periods for the FY 2018 and FY 2019 HAC Reduction programs
3. Clarify data requirements for Domain 1 scoring (in FY 2016, Domain 1 points were assigned for the Patient Safety Indicator 90 composite index value)
4. Adopt the refined PSI 90 (patient safety for selected indicators) composite measure
5. Change the program scoring methodology from the current decile-based scoring to continuous scoring

**Readmission reductions**

Patients with certain diagnoses frequently return to the hospital after a short period of time. CMS seeks to reduce the high cost associated with such readmissions by targeting those patients. The payment reduction is based on a hospital’s risk-adjusted readmission rate during a three-year period. The conditions currently targeted include:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Total hip arthroplasty/total knee arthroplasty
- Coronary artery bypass graft

Although CMS didn’t propose any significant changes to the readmission reduction efforts in the proposed rule, it did indicate a desire to post excess readmission rates to its Hospital Compare website “as soon as feasible following the hospitals’ preview period.”

For more information on the rule, see CMS’ fact sheet. Comments are due to CMS by June 16, and the agency expects to issue a final rule by August 1. Changes will become effective October 1.

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**HACs and POA: Not just alphabet soup**

*by Michelle M. Wieczorek, RN, RHIT, CPHQ*

In 2010 under the Affordable Care Act, CMS linked Medicare payments to healthcare quality, known as value-based purchasing. However, the push for paying for higher-quality medical care goes back a bit further still.

On November 29, 1999, the Institute of Medicine released a report called *To Err Is Human: Building a Safer Health System*, which indicated that medical errors in American hospitals accounted for as many as 98,000 deaths annually. The report proved to be a clarion call.

And so, under the Hospital-Acquired Conditions/Present on Admission Indicator (HAC/POA) program established by the Deficit Reduction Act of 2005, CMS aimed to eliminate payments for conditions obtained in the hospital setting that could have reasonably been prevented. Under the program, CMS essentially said it would no longer pay hospitals for certain conditions that were not present at the time the patient was admitted to the hospital.

CMS identified 11 categories of conditions, including stage 3 and 4 pressure ulcers, falls and trauma, retained foreign bodies, and surgical site infections (SSI). Since 2009, these HACs will not result in the patient
being assigned to a higher-paying MS-DRG if the POA indicator points to the conditions being acquired after admission.

If that isn’t enough, the hospitals in the lowest performing quartile for HACs are penalized 1% of their total Medicare MS-DRG payments. In 2016, 75% of the performance in HACs will be in the abstracted measure domain, and CLABSIs (central line–associated bloodstream infection), CAUTIs (catheter-associated UTI), and SSIs will be targeted.

Thus far, the results have been:

- Approximately 1.3 million fewer patients were harmed in U.S. hospitals between 2010 and 2013, which is a 17% decline in HACs
- Approximately 50,000 fewer patients died in the hospital as a result of this reduction in HACs
- Approximately $12 billion in healthcare costs was saved from 2010 to 2013 due to this reduction

The most recent research information from the Agency for Healthcare Research and Quality indicates that while there is progress, HACs are still a significant source of morbidity and cost, and thus there continues to be a focus on them.

An interim update on HACs (see Figure 1 below) indicates that not only are morbidity and associated cost burden affected by a reduction in HACs, but mortalities are as well. Deaths have been averted as a result of a focus on preventing adverse events in the hospital.

**Poor data or poor care?**

When it comes to success in the various pay-for-performance initiatives, I often remind clients to first be data skeptics and to understand the root cause of why the data portrays particular outcomes.

Quite simply, it is very important to understand whether there is a problem with the data or a problem with the quality of care. In most cases, it comes down to understanding that clinical documentation and coding for a handful of cases has a significant effect on performance.

HACs are especially relevant to this scenario. For example, a 450-bed acute care hospital was penalized

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**Figure 1:**

2013 annual HAC rate and estimates of cost savings and deaths averted from 2010 to 2013

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Adverse drug events</td>
<td>43.8%</td>
<td>11,540</td>
<td>$2,885,000,000</td>
</tr>
<tr>
<td>CAUTI</td>
<td>14.4%</td>
<td>4,427</td>
<td>$190,000,000</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.8%</td>
<td>1,998</td>
<td>$183,600,000</td>
</tr>
<tr>
<td>Falls</td>
<td>3.8%</td>
<td>2,750</td>
<td>$361,700,000</td>
</tr>
<tr>
<td>Obstetric adverse events</td>
<td>0.8%</td>
<td>20,272</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>21.2%</td>
<td>1,297</td>
<td>$4,760,000,000</td>
</tr>
<tr>
<td>Surgical site infections</td>
<td>3.5%</td>
<td>1,150</td>
<td>$966,000,000</td>
</tr>
<tr>
<td>Ventilator-associated pneumonias</td>
<td>0.6%</td>
<td>1,150</td>
<td>$168,000,000</td>
</tr>
<tr>
<td>Postop venous thromboembolisms</td>
<td>0.4%</td>
<td>520</td>
<td>$40,000,000</td>
</tr>
<tr>
<td>All other HACs</td>
<td>10.7%</td>
<td>6,387</td>
<td>$2,397,000,000</td>
</tr>
</tbody>
</table>

Source: *Agency for Healthcare Research and Quality.*
roughly $515,000 in fiscal year 2016 due to four cases of CLABSIs, five CAUTIs, and five SSIs.

So, what can a CDI specialist do? In general terms, one of CDI’s most important roles in an acute care setting is to establish the clinical diagnosis and/or conditions that were POA. A close second is ensuring that patient acuity is clearly represented in the physician documentation so that the true severity of illness and risk of mortality are depicted when codified data is risk adjusted for comparison. Let’s look at a couple examples.

**CLABSI**

The presence of a central line on admission is not always evident to the coder due to the fact that unless a catheter is changed, or obviously infected, it is likely not going to be documented in any detail by the physician in the history and physical.

Therefore, the CDI specialist should review nursing documentation, including ED triage notes, to determine if there is a central line POA. This becomes particularly important if blood cultures have been drawn and on day two or three of the stay they become positive.

The physician must be queried to ascertain if the bloodstream infection was POA and note the clinical indicators that were evident, including the presence of the central line. Failure to clarify the POA status results in the facility being attributed with the CLABSI which has a detrimental effect in pay for performance measures.

Chronic kidney disease, severe protein malnutrition, and diabetes all have a tie to a compromised immune system, making a patient more vulnerable to infection, and thus these diagnoses have an impact on the patient’s predicted risk of mortality and morbidity.

It is as important as ever for the CDI specialist to query the physician for secondary diagnoses that may not have an impact on the MS-DRG assignment but do impact on the depiction of patient acuity. Remember, a handful of patients excluded from a denominator can have a significant effect on financial performance in the HAC Reduction Program.

**Stage 3 and 4 pressure ulcers**

The presence of a pressure ulcer on admission is one of the most frequently occurring physician documentation gaps; as the ulcers do not necessarily drive the acuity of the patient, physicians may overlook documenting their presence altogether, let alone noting their stage and location.

It is often up to the astute CDI specialist to read the skin assessment in nursing or ED triage notes, or refer back to the transfer summary from the skilled nursing facility to look for clues as to the presence of a pressure ulcer.

The role of the CDI specialist in this scenario is twofold. First, the CDI specialist should obtain acknowledgment of the pressure ulcer and its POA status using the clinical indicators found in the medical record, including any staging information that may appear as part of nursing documentation. Second, while stage 3 and 4 pressure ulcers are still considered MCCs (if the POA status is Y) even if the site is unspecified, the CDI specialist should encourage the provider to document the location of the ulcer in addition to the stage so that the most specific ICD-10 code can be assigned.

**Conclusions**

The role of the CDI specialist is extending into the quality and performance domain through alternative payment methods being implemented by CMS.

As we continue to move away from a pure fee-for-service payment mode, legacy CDI programs built on the foundation of strengthening case-mix index performance through improved capture of CCs and MCCs must change to address a new sphere of clinical documentation issues confronting providers.

CDI specialists must sharpen their focus on capturing any and all diagnoses that may impact patient acuity, and must view clinical documentation through a lens of severity of illness and risk of mortality. In addition, provider attribution issues for adverse events must be clarified well before final coding to ensure that hospitals are not flagged for HACs incorrectly.

**Editor’s note:** Wieczorek is a senior manager at Dixon Hughes Goodman Healthcare. Contact her at michelle.wieczorek@dhgllp.com.
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Physician Advisor’s Corner

Medicare reports on 2016 physician value modifier

by Richard D. Pinson, MD, FACP, CCS

The value modifier (VM) is Medicare’s physician pay-for-performance program that rewards or penalizes physicians for the quality and cost of care they provide. For calendar year 2015, Medicare began applying the VM to professional fees paid under its Professional Fee Schedule for physicians in groups of 100 or more providers.

That year, 14 of 106 groups received an upward adjustment of 4.89% to their fees, and 11 groups were penalized with a 0.5%–1% downward adjustment. The 319 groups who did not report quality measures to Medicare were penalized 2.5%.

For 2016, 13,813 physician groups of 10 or more were subject to the VM. Of these, 5,418 groups were penalized the maximum downward adjustment of 4% in their fee schedule because they did not participate in Medicare’s Physician Quality Reporting System (PQRS). Of the remaining 8,395 groups that did report to PQRS, 70 received an upward adjustment of 16% and 58 received a 32% increase. No group qualified for the maximum possible upward adjustment of 48%. There were 59 groups penalized with a downward adjustment in their fees of 1%–2%. (See Figure 2 on p. 14.)

The VM adjustment employs a two-year look-back period, so performance in 2014 determined the VM for 2016. Medicare will apply the VM in 2017 to all physicians in solo or group practice. Similarly, performance in 2015 will determine the 2017 VM, and performance in 2016 will determine the 2018 VM; that means this year, 2016, is the year for immediate action.

Eligibility for VM rewards depends on participation in Medicare’s PQRS. Solo and group practices who did not participate during 2015 will be penalized with a 1%–2% reduction in fees for 2017; they will be penalized with a 2%–4% reduction for 2018 for non-participation during 2016.

Physicians who are members of a group filing claims under a single taxpayer identification number (TIN) that includes primary care physicians are subject to the VM fee schedule adjustment. The VM adjustment of an entire group depends on the performance of only its primary care physicians, who are graded on the quality and cost of care of their patients based on all claims filed during the year by all providers who saw the patient during that year.

Even if providers do not file outpatient primary care claims or are not members of a group that includes primary care providers, they are subject to the PQRS participation requirements, and their diagnostic documentation affects the performance of any other individual or group-practice primary care providers. Those individual practitioners and groups depend on precise documentation by all providers filing inpatient and outpatient claims during the year that accurately reflects the true severity of illness of, and complexity of care provided to, their patients.

How do practices reap the rewards of the VM?

The first essential step is participation in the Medicare PQRS program to avoid the maximum PQRS/VM penalty of up to 4% in 2018 based on 2016 results. Next, ensure the best quality of care and keep costs as low as reasonably possible. Limit low-yield diagnostic testing or evaluation that won’t change management decisions. Consider costly consultations carefully. Take an appropriate, reasonable approach to therapeutic choices. For example, does a high-cost drug or treatment really have significant advantages over a less costly alternative?

Finally, optimum results depend on precise medical record documentation that accurately reflects the true severity of illness of patients and the complexity of care provided as reflected by the ICD-10 codes submitted on the hospital’s inpatient claim.

Quality of care often seems somewhat subjective—just like beauty, quality is in the eye of the beholder. But whether we like it or not, thousands of objective criteria...
have been assigned to outcome and performance measures, with or without clinical validity, to quantify our clinical performance. It certainly helps to employ evidence-based and professional consensus guidelines to meet some of these expectations, but perhaps the most crucial factor in the analysis of quality data is adjustment for severity of illness.

Almost every measure of quality is severity-adjusted based on the number and severity of conditions in a given patient population. Sicker patients with greater comorbidity have higher rates of adverse outcomes; healthier patients with fewer illnesses would be expected to have low rates of adverse outcomes.

So how is this severity of illness measured? It is all based on the diagnostic codes submitted on claim forms to Medicare and other payers. But do the codes assigned actually reflect how sick the patient is? Often they do not, because coding rules can be inconsistent with clinical practice and physician documentation terminology is insufficient to allow assignment of the correct code.

For example, acute renal insufficiency is a nonspecific term that does not capture the severity of acute kidney injury/acute renal failure. The diagnosis of healthcare-associated pneumonia treated with antibiotics for Gram-negative infection will be classified as nothing more than simple community-acquired pneumonia unless the suspected organism is identified to reflect the true severity of illness in the correct code.

In summary, Medicare’s VM is having a greater impact on physician fees, putting all providers in competition for healthcare dollars based on analyses of the quality and cost of the healthcare they provide. Such pay-for-performance programs are growing rapidly both in number and in impact. Winners and losers will be determined not only by the actual cost and quality of care provided, but also by the severity of illness adjustment applied to those outcome measures. To be successful, physicians must demonstrate responsible stewardship of healthcare resources, adopt clinical practices based on evidence and consensus guidelines, and employ precise clinical documentation terminology that translates into the correct codes to fully and completely describe the severity of illness of their patients.

Editor’s note: Dr. Pinson is a certified coding specialist and cofounder of Pinson/Tang Consulting (www.hcqconsulting.com) in Houston. He is coauthor of The CDI Pocket Guide and co-developed the CDI for the Clinician™ cloud-based eLearning program and CDI apps in collaboration with ACDIS.

Figure 2: Distribution of 2016 physician value modifier awards and penalties

<table>
<thead>
<tr>
<th>Tier</th>
<th>VM adjustment</th>
<th>Number of groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality/low cost</td>
<td>32% to 48%</td>
<td>0</td>
</tr>
<tr>
<td>High quality/average cost</td>
<td>16% to 32%</td>
<td>55</td>
</tr>
<tr>
<td>High quality/high cost</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Average quality/low cost</td>
<td>16% to 32%</td>
<td>73</td>
</tr>
<tr>
<td>Average quality/average cost</td>
<td>0%</td>
<td>7,351</td>
</tr>
<tr>
<td>Average quality/high cost</td>
<td>0% to -1%</td>
<td>226</td>
</tr>
<tr>
<td>Low quality/low cost</td>
<td>0%</td>
<td>6</td>
</tr>
<tr>
<td>Low quality/average cost</td>
<td>0% to -1%</td>
<td>644</td>
</tr>
<tr>
<td>Low quality/high cost</td>
<td>0% to -2%</td>
<td>39</td>
</tr>
</tbody>
</table>

Earlier this year, a group of clinicians from around the globe released new standards for diagnosing sepsis. The *Journal of the American Medical Association* published the third international consensus definitions, dubbed Sepsis-3, in February.

The new criteria define sepsis as a “life-threatening organ dysfunction caused by a dysregulated host response to infection.” They define septic shock as “[s]epsis with circulatory and cellular/metabolic abnormalities profound enough to substantially increase mortality.”

Noting “inadequate specificity and sensitivity of the systemic inflammatory response syndrome (SIRS) criteria,” the new definitions discard the concept of sepsis as SIRS due to infection, which has been the diagnostic standard for the last 25 years, according to an article on the ACDIS website by Richard D. Pinson, MD, FACP, CCS, principal of HCQ Consulting in Houston.

The new guidance uses the Sequential (sepsis-related) Organ Failure Assessment score (SOFA) to define organ dysfunction. With SOFA, the function of six organ systems—respiration, coagulation, liver, cardiovascular, central nervous system, and renal—is graded on a scale of 0 to 4, where 0 represents normal function. For each organ system, the baseline SOFA score is assumed to be 0 in patients who don’t have preexisting organ dysfunction. The SOFA requirement is met by a minimum of a one-point increase in at least two organ systems, or by a two-point increase, or more, in one organ system.

Quick SOFA (qSOFA) is a bedside clinical approach used to identify patients who are likely to have a prolonged stay or die in the hospital, but it does not substitute for SOFA for defining organ dysfunction, Pinson wrote. Under qSOFA, the patient must meet two or more of the following criteria: altered mentation, respiratory rate greater than 22, and/or systolic blood pressure < 100 mmHg.

The criteria for septic shock involve “persistent hypotension requiring vasopressors to maintain MAP [mean arterial pressure] > 65 mmHg and having a serum lactate level > 2 mmol/L despite adequate volume resuscitation.”

These definitions may represent a clinical consensus from the participating parties, but they don’t change the ICD-10-CM coding rules, *Official Guidelines for Coding and Reporting*, or various quality-related measures for the condition.

In a letter written to the Sepsis-3 authors on behalf of the ACDIS Advisory Board, Sam Antonios, MD, FACP, FHM, CCDS, CDI physician advisor for Via Christi in Wichita, Kansas, also noted that “the updated definitions also create a direct conflict with the current CMS clinical quality measure for process, SEP-1, which is part of the Inpatient Quality Reporting Program (IQR).”

In his letter, Antonios poses several questions to the definition’s authors (click here to read the letter) and offers ACDIS’ assistance in further addressing inconsistencies.

The ACDIS Advisory Board also released a position paper on the matter, stating that while Sepsis-3 definitions “set forth compelling evidence that cannot be dismissed,” it remains to be seen “how the clinical community will be able to operationalize or change its understanding of sepsis and septic shock.”

ACDIS cautioned against adopting the new guidelines, recommending CDI programs work with leadership regarding next steps. “Avoid blindly following the … recommendations,” it states. ☞
CODING CORNER

Tips for reporting bronchoscopy procedures

by Paul Evans, RHIA, CCS, CCS-P, CCDS

Following are some ICD-10-PCS documentation and coding tips for three of the most common (and commonly misunderstood/miscoded) procedures performed via bronchoscopy.

**Bronchoalveolar lavage (BAL)**

Do not confuse this with the therapeutic procedure whole lung lavage, which is performed to treat pulmonary alveolar proteinosis under general anesthesia. A BAL is performed via a bronchoscope within the lumen of the bronchus, and involves “washing” within the bronchus in order to obtain a sample of fluids. It is coded to the root operation “drainage” because fluids are removed. Lung tissue is not obtained.

According to AHA’s *Coding Clinic for ICD-9-CM*, Third Quarter 2002, the BAL is usually performed under local anesthesia via bronchoscope and “consists of washing out the peripheral airways and alveoli tissue with a rinsing (sampling) solution. About 150–250 cc of saline may be introduced into a subsegment of a lobe and then with gentle suction, retrieved. The BAL specimen retrieved is sent to the laboratory for various analyses. Supernatant fluid and cell pellets from BAL are useful in the diagnosis of neoplastic diseases, infections, and interstitial lung diseases. Bronchoalveolar lavage allows the recovery of cells as well as noncellular components from the epithelial surface of the lower respiratory tract. BAL is sometimes referred to as a ‘liquid biopsy.’ This is not the same as whole lung lavage therapy normally done for pulmonary alveolar proteinosis.”

**Correct coding:** BAL, RLL of bronchus = 0B968ZX. (Note: This does not impact MS-DRG assignment.)

**Biopsy of bronchus**

A biopsy of the bronchus may be obtained via a bronchoscopy. This may also be referred to as “brush biopsy of lung”; however, this is a misnomer, as this lung tissue is not obtained.

According to *Coding Clinic*, Fourth Quarter 1992, p. 27, “[t]he brush biopsy is of the bronchus, not the lung. The procedure is performed intrabronchially and samples are taken from within the bronchus and not the alveolar or lung tissue. Bronchial and/or lung brushings are not performed as an open procedure(s). This is different from a transbronchial biopsy where the bronchoscope biopsy forceps actually punctures the terminal bronchus and samples of the peribronchial alveoli (lung tissue) are taken.”

**Correct coding:** Biopsy, RLL of bronchus = 0BB68ZX. (Note: This does not impact MS-DRG assignment.)

**Biopsy of lung**

A biopsy of the lung tissue may be obtained via a bronchoscopy. The physician should provide documentation in the record of a transbronchial biopsy of lung parenchyma rather than bronchial material. The wall of the bronchus is perforated.

**Correct coding:** Excision of right middle lobe-lung = 0BBD8ZX. (Note: This does impact MS-DRG assignment.)

Consider the following key points when querying for accurate documentation for bronchoscopies and/or assigning the correct ICD-10-PCS code for these procedures:

- Was the procedure confined within the lumen of the bronchus, or was lung tissue obtained in a transbronchial approach?
- Remember, the bronchi have lobes, too, so ensure the correct anatomical location for coding purposes—lung versus bronchus.
- If the intent and scope of the procedure and type of any tissue obtained is unclear, query the physician.!

**Editor’s note:** Evans is manager of regional CDI for Sutter West Bay in San Francisco. He is also a member of the ACDIS Advisory Board and the ACDIS Forms & Tools Library Committee, as well as a frequent contributor to the “CDI Talk” networking group. Contact him at evanspx@sutterhealth.org.
The fundamentals of pathogenic bacteria

by Verona A. Lodholz, DC, MT(ASCP), CPC, CCDS

Microbiology is the study of things that can’t be seen by the naked eye. To the CDI specialist, the term refers to human pathogens and the diseases they can cause. This article discusses some of the fundamentals of pathogenic bacteria and the way they can cause or worsen the disease process, as well as a little about how antibiotic treatment works. As we learned in science class, the human body is made up of billions of cells. Bacteria are single-celled organisms able to survive individually. As such, they don’t have skin holding them together, but instead have cell walls. The cell wall is the key to identification of bacteria and the methods to fight the organisms.

When cultures are performed, preliminary results are often reported as the presence of Gram-positive or Gram-negative organisms. The Gram stain refers to the color of the bacteria noted under the microscope after staining. Purple is Gram positive, pink Gram negative. The organisms go through an identical process; however, Gram-positive bacteria have a single-thickness cell wall that holds on to the initial purple stain. Gram-negative bacteria have cell walls that are made up of a series of thin layers. This allows the purple stain to be washed away, and then the pink counter stain is absorbed.

Normal human flora is composed of a variety of Gram-negative and Gram-positive bacteria that do no harm—in fact, they are often beneficial, as long as they stay where they belong. For example, Gram-negative Escherichia coli bacteria are needed in a normal colon, but cause problems in the bloodstream. Our skin is home to Gram-positive Staphylococcus of a few species, including Staphylococcus epidermidis and even Staphylococcus aureus. Allow these bacteria inside the body, however, and trouble may ensue.

If an infection occurs, antibiotics are employed to block the formation of cell walls. This distinction is important for two reasons. First, the human cells are not as adversely affected as they lack cell walls. Second, the antibiotics don’t kill or maim the living bacteria, only the newly forming organisms.

Antibiotic resistance occurs when the bacteria’s cell wall mutates and it is no longer susceptible to the antibiotic. In the case of MRSA (methicillin-resistant Staphylococcus aureus), it is theorized that the mutated wall itself incites an inflammatory reaction in the patient. Some bacteria are classified as multidrug-resistant organisms (MDRO); according to the World Health Organization, the most frequent MDROs include Enterococcus faecium, Staphylococcus aureus, and Klebsiella pneumonia.

Antibiotics are generally categorized as narrow-spectrum antibiotics, which are effective against either Gram-positive or Gram-negative organisms, and broad-spectrum antibiotics, which are effective against both. Common antibiotics to treat Gram-negative bacteria include streptomycin and nalidixic acid. Antibiotics used to treat Gram-positive bacteria include vancomycin, daptomycin, and penicillins. Levofloxacin is a common broad-spectrum antibiotic, as are moxifloxacin, ampicillin, tetracycline, ciprofloxacin, and chloramphenicol. Each facility should have a local antibiogram, provided by the laboratory, which shows the antibiotics recommended by that organization. This information can assist the CDI staff in sequencing choices in a multiple-choice query.

Editor’s note: Lodholz has 35 years of healthcare experience, including as a certified coder and CDI specialist. Contact her at mytrees420@gmail.com.
CODING CLINIC FOR CDI
Heart failure, obstetrics, and linking language
by Laurie L. Prescott, MSN, RN, CCDS, CDIP

Spring is in the air and the daffodils are blooming. We are more than six months into the transition to ICD-10-CM/PCS, and at times it appears there are more questions than answers. The last few weeks have brought us some direction, though, including the release of approximately 1,900 new ICD-10-CM codes for 2017. (The list can be found on CMS’ website.) We also have a list of approximately 3,600 new ICD-10-PCS codes for 2017. (This is also available on CMS’ site.) Of course, we will also be looking for changes in DRG mappings and the CC/MCC lists, which will likely appear later this summer.

The transition to ICD-10 was not a one-time process that ended on October 1, 2015—it will continue for quite some time. As CDI specialists, we must keep informed of the new information, including the latest guidance offered by AHA Coding Clinic for ICD-10-CM/PCS®. The latest release, First Quarter 2016, focused on ICD-10-CM diagnosis codes, in comparison to 2015, which focused more on the procedure side. One thing remains constant, though: It seems like every Coding Clinic offers some guidance that makes me think, “Finally, it’s about time!” yet also contains other pieces of advice that simply prompt more questions.

Heart failure differentiation
Let’s start with the long-awaited direction related to differentiation of heart failure. Coding Clinic heeded the American College of Cardiology and will now allow the more current descriptions of heart failure with preserved ejection fraction (HFrEF) and heart failure with reduced ejection fraction (HFrEF) to be coded as systolic and diastolic heart failure, respectively. This guidance is highly welcomed.

Obstetrics admission
For those who review obstetrical cases, there is guidance related to selection of principal diagnoses related to an obstetrics admission. The condition prompting the admission should be sequenced as the principal diagnosis for an obstetrical patient. If there is a complication of the delivery, the appropriate code would be assigned as a secondary diagnosis. Coding Clinic provides the example of an admission for premature rupture of membranes with a laceration complicating a delivery. In such a scenario, the principal diagnosis is pregnancy complicated by premature rupture of the membranes, and a secondary diagnosis of laceration would be assigned.

There is also guidance related to ICD-10-PCS code assignment for the repair of obstetrical lacerations; it instructs us to code the body part as related to the degree of the laceration or the deepest level of the repair as described (perineum, perineal muscle, rectal mucosa, and anal sphincter, for example).

Linking language
ICD-10-CM provides many opportunities to assign combination codes, especially those related to diabetes and the many complications associated with this condition. CDI specialists at your facility no doubt have worked diligently with providers to document the relationship using “linking language.”

The question posed in this latest Coding Clinic asks if the provider must document the relationship between the two diagnoses or whether the coder can assume the relationship and assign the appropriate combination code. The answer provided (on p. 11 of Coding Clinic) actually left me more perplexed. It states:

The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves and circulatory system. Assumed cause and effect relationships in the classification are not necessarily the same in ICD-9-CM as ICD-10-CM.

Several examples provided seem to infer that the relationship between diabetes and conditions such as polyneuropathy and ESRD can be assumed, unless of course there is documentation that indicates another identified cause.
Coding versus clinical conventions for ileostomy

Q: When I try to code an ileostomy takedown with small bowel resection and end-to-end anastomosis, I get to code 0DBB4ZZ. Is this not a repair of the ileum and coded to 0DQB3ZZ? Coding Clinic notes the prior code, not the latter, but “repair” means “restore to previous function.”

A: You are absolutely correct that the definition of repair is “repairing, to the extent possible, a body part to its normal anatomic structure and function.” And while the takedown does seem to fit the definition of a repair, Coding Clinic offers the rationale that the repair is the closure of the stoma, and so we must apply two codes, one for the repair and one for the excision of the ileum.

Your question demonstrates the frustrations many feel with the Official Guidelines for Coding and Reporting and Coding Clinic rules we must follow.

The ICD-10 code set was designed to assist with standardization of healthcare data for use with reimbursement and statistical analysis that can be applied to quality measures, research, and demographic analysis. If we each choose to use these codes as we interpret them versus how the Cooperating Parties direct us, the data would be useless. We are required by law to apply the rules consistently. As such, we must do our best to follow the instructions as provided, and the instruction within Coding Clinic is very clear in this case—as it calls for an excision of the ileum versus a repair.

We can challenge this logic by submitting a question to Coding Clinic’s editorial advisory board (they can be submitted at www.ahacentraloffice.org). And Coding Clinic advice does change over time as new concerns are brought to light. The most recent instruction will trump any previous advice, thereby nullifying any conflicting advice given in preceding years. But all that said, until changes are provided, we must follow the instruction that is given.

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Coding Clinic also reinforced the existing understanding that there is no assumed relationship between osteomyelitis and diabetes, as previously stated in Coding Clinic, Fourth Quarter 2013, p. 114.

So, although the direction related to osteomyelitis reinforces previous instruction, the direction related to diabetes and other conditions of the kidneys and nervous/circulatory systems is brand-new and not particularly clear. What conditions are assumed and what are not? Where is “linking” required in documentation? I hope to receive further guidance related to these examples.

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The heart of any CDI department should be its mission. What does the program stand for? What is its purpose? What does the program hope to achieve? If you can’t answer these questions, it may be time for your team to chart a course of action.

Specifically, we’re talking about drafting an official mission statement for your CDI department. The importance of a mission statement cannot be underestimated. A single sentence could help your program:

- Establish value within a larger facility or department
- Define your purpose for providers and executives
- Promote continuity and improvement for CDI team members

At the six-hospital Legacy Health Systems in Portland, Oregon, a CDI mission statement has been in place for several years. It was last updated in 2013, when CDI program managers felt the department needed to play a larger role, says Marjie Aranda, RN, CCDS, interim CDI manager at Legacy.

“We thought that, in order to make the rest of the health system aware of who we were and what we did, we needed to know what our goal and plan was,” Aranda says.

So the CDI team—comprised of both clinical and coding professionals—delved into potential mission statements. Bringing expertise and knowledge from their various backgrounds, the group first established its values. Using the ACDIS Code of Ethics and facility guidelines, they identified five key points:

1. Excellence
2. Integrity
3. Dedication
4. Innovation
5. Confidentiality
The values should describe the qualities your team keeps in mind while conducting daily duties, says Jane Hoyt, BA, BSN, RN, CCDS, CDIP, owner of CDI Nurses, Inc., and a CDI specialist at University of Colorado Health in Denver. These can include the terms listed above, but can also incorporate values such as respect, stewardship, kindness, and honesty. Hoyt also suggests the concepts of humor, to remind staff to enjoy their work and not take themselves too seriously, and growth, to encourage the team to learn from mistakes rather than being afraid of making them.

Next, the team at Legacy identified a series of goals for the department. For example, team goals included reviewing 25 charts a day (new and re-reviews), updating clarification policy and query forms to meet new national standards, and helping reduce Recovery Auditor denials. Previously, the goal list included ICD-10 education for both CDI specialists and providers.

“Goals help us identify what we aspire to,” says Aranda. “As we accomplish them, we can remove them and establish new ones. This keeps our program moving forward with what’s happening in the industry.”

Finally, the mission statement was born:

Collaborate with healthcare providers to ensure complete documentation of the findings, diagnosis, and treatment in the patient health record to reflect the severity of illness and capture accurate codes and statistical data for research, reimbursement, and clinical measures.

That’s it: a simple one-sentence description of what the department accomplishes for the facility through its daily efforts. The statement doesn’t have to be poetic—but it should be comprehensive and specific. It should also include input from all department members, says Aranda, and be reviewed and updated on a regular basis.

A good mission statement can also be accompanied by a vision statement, which details where the CDI department hopes to be in the long term, says Hoyt. This helps explain to providers and other executives why the CDI department performs the work it does, as in this example Hoyt provides:

By securing a thorough, complete, and accurate patient health record, we will achieve the correct reimbursement for resource utilization, the highest quality measures and outcomes, superior communication between providers, and ultimately high patient satisfaction.

At Yampa Valley Medical Center in Steamboat Springs, Colorado, Cari Merlina, RN, BSN, and Jessica Stevenson, RN, BA, both CDI specialists, started to discuss developing a mission statement in March of this year. For their department—which is only six months old—forming a mission statement, policies, and procedures is part of the educational process to help those unfamiliar with CDI (including hospital administration, providers, and new CDI staff) understand the importance of the role. Merlina and Stevenson are currently working with HIM, quality, and revenue cycle personnel to review existing policies and to discuss what a mission statement should look like. The final statement will likely include a combination of reimbursement and quality improvement initiatives, Merlina says.

“We don’t want to hide the fact that we’re working to improve reimbursement, but CDI is not only for monetary gain,” she notes. “We definitely want a quality piece in there.”

A list of goals accompanies their mission statement. These goals put forth that CDI efforts help to do all of the following:

- Ensure continuity of care
- Improve physician and hospital profiles
- Increase case-mix index
- Ensure appropriate reimbursement related to the resources used

Merlina and Stevenson’s efforts illustrate how even newer CDI departments understand that having a mission statement allows a program to truly take off.
“We can speak to physicians and say ‘these are our goals’ in one simple sentence,” Merlina says. “Our hospital places a lot of value on its mission statement. As an organization, CDI having its own mission statement helps establish us as official and is a point of professionalism.”

Alternatively, for those CDI departments that are still growing, Aranda says it’s okay not to rush to create a mission statement. It can be difficult to establish one if the program isn’t initially sure of its focus or how it fits into the larger health system.

If that’s the case, “give it a year and see where you’re going, and then address this,” Merlina recommends.

Having an official mission statement allows a program to achieve accountability and integrity, says Erin Holthusen, RN, CCDS, CDI manager at Allina Health in Minneapolis. However, it’s also important for CDI teams to actively follow the tenets included in the statement.

“We use our mission statement quite frequently, especially when talking to providers,” says Holthusen. “This helps with buy-in and explaining the overall goal.”

For example, when a CDI specialist got pushback from a physician, they referenced the mission statement and were able to clearly define why CDI was necessary for an accurate medical record, opening up an opportunity for further education and building trust with a provider who was new to CDI, Holthusen says. Further, when working through the denial process, CDI specialists can reference the mission statement to determine if they will appeal or accept a denial.

Keeping manageable goals, values, and principles at the forefront of the CDI department is the primary purpose of having a mission statement. “We should be able to readily discuss what our goals are and what CDI is doing,” Holthusen says. “You don’t need a big document to describe what your program is going for.” 🌟
You are your own best teacher,” or so the old adage goes. Sure, goodies and gifts are great for recognizing high-quality documentation, but for CDI teams struggling to obtain physician buy-in, the best strategy may be found in their providers’ own records.

With pay-for-performance and other quality initiatives underway as a part of healthcare reform, physicians need to see how they are performing in real time. Showing them this data in comparison to their peers demonstrates through real numbers how they stack up, says ACDIS Advisory Board member Robin Jones, RN, BSN, CCDS, MHA/Ed, system director for CDI at Mercy Health in Cincinnati.

When physicians see their rate is lower than their peers, they hurriedly find our CDI supervisor.

—Robin Jones, RN, BSN, CCDS, MHA/Ed

Query responses

Until recently, most providers were not interested in seeing how unanswered clarifications or conflicting DRG assignment affected metrics, Jones says. CDI programs traditionally measure overall success by tracking items such as:

- Query rate (overall and by CDI specialist/physician)
- Physician response rate (overall and by CDI specialist/physician)
- Physician agreement rate (overall and by CDI specialist/physician)
- CC/MCC capture rates
- MS-DRG shifts
- Case-mix index changes

This data isn’t often shown to physicians, and yet, since queries...
represent the single most important tool for CDI programs, gleaning patterns of information from them often illuminates opportunities for improved physician support. For example, a lack of response from a particular physician might represent an opportunity for education or a change in approach, or the need for a new method of communication (e.g., notifying the physician of an outstanding query through a phone call rather than email).

Mercy’s CDI program lists physicians’ clarification response rates and places them in physician lounges for all to see, says Jones. To keep the information anonymous, the CDI team assigns each physician a number so they can quickly and safely gauge how they are performing in comparison to their peers. “When physicians see their rate is lower than their peers, they hurriedly find our CDI supervisor,” Jones says.

Mercy also provides physicians with an individualized list of DRGs assigned to their patients, so they can cross-reference that information to their own private billing.

**Case studies**

CDI programs can elevate the importance of data by tying it to case studies—real scenarios relevant to patient care, says ACDIS Advisory Board member Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP, director of education at MedPartners based in Tampa, Florida.

**Additional elements**

Show providers an example of poor documentation, then compare it to the same case with improved documentation and show how the improvement affects a variety of metrics, Newhouser says. Collectively, members of the ACDIS Advisory Board suggest sharing information regarding the following data points:

- Severity of illness/risk of mortality (ROM)
- Length of stay (LOS), average LOS, geometric mean LOS, and expected LOS
- Readmission rates
- Observed over expected mortality ratio

Be transparent so physicians can see the benefits—both financial and quality-related—of precise documentation, Newhouser says. “Physicians need to know that the money is important if they want to have a hospital to practice in, updated equipment, and a paycheck,” she explains. But, “it is imperative to remind them that while money is important, it is quality that must come first.”

For each metric, consider the data for the facility as a whole, and compare it to other facilities within the system or region, says Michelle McCormack, RN, BSN, CCDS, CRCR, director of CDI at Stanford (California) Health Care. Sharing such information with the physicians illustrates how their documentation affects the larger hospital community.

Then, drill down into the data to identify individual metrics, comparing physicians against one another within the facility and within a particular specialty or service line, says McCormack.

**External analysis**

Beyond simply showing physicians the data, CDI teams must teach providers how documentation and coding affects their personal profile as well as their facility’s standing, says Judy Schade, RN, MSN, CCM, CCDS, CDI specialist at Mayo Clinic Hospital in Phoenix. A host of consumer websites cull data and employ a variety of algorithms to rank physicians and hospitals—many of these are well known, such as CMS’ Hospital and Physician Compare sites, Healthgrades, and Leapfrog.

Understand how those practicing within your facility measure up in these reports and share important milestones as necessary, Schade says. When positive shifts occur that correlate with documentation improvement focus areas, tout those accomplishments and acknowledge the role the physicians played in helping to reach those goals.

“Physicians will be engaged if they understand how documentation and coding impacts their personal profile,” Schade says. “Physicians are by nature competitive, and so they aim to be high achievers.” CDI programs can use this to their advantage.
Nuanced details of these reports need analysis, warns Paul Evans, RHIA, CCS, CCS-P, CCDS, manager for regional CDI at Sutter West Bay in San Francisco.

For example, *The San Francisco Chronicle* recently published raw mortality outcomes data for the region. Since the paper did not understand how observed versus expected mortality plays a role in telling the story of a patient’s care, its analysis left a tertiary care center in the Sutter family looking as though it had worse mortality rates than its competitors despite the fact that it treated extremely sick patients, Evans explains.

“You have to be careful to compare apples to apples,” Schade agrees.

With internal data in hand, Evans showed the high-level ROM of that facility’s patients and demonstrated that the facility actually outperformed its competitors.

“Unfortunately, you can’t explain statistics and ROM to the typical lay person, but you certainly can communicate it to your staff and to your physicians,” Evans says.

### Data discretion

Some data discretion may be warranted. Choose data elements that are most relevant to the CDI program’s goals at the time, as well as targeted to the specific physicians in the audience. Remember to share success stories with data elements as they are reached.

“CDI managers should consider all data points and make sure the numbers they present to the physician accurately represents the message they need to convey and targets the needs of the physicians themselves,” says ACDIS Advisory Board member Wendy Clesi, RN, CCDS, director of CDI services at Enjoin.

For example, if a service line that has not been responding to queries begins to consistently increase its response rate, include the improvements in that response rate along with the other metrics you present, McCormack says.

“You want to select metrics that will allow you to see progress as well as areas of opportunity,” she says.

It can be difficult to choose which data points to share, McCormack says, but sharing such concrete analysis leads to greater support from physicians overall.

Physicians will be engaged if they understand how documentation and coding impacts their personal profile.

—Judy Schade, RN, MSN, CCM, CCDS

The Physician Advisor’s Guide to Clinical Documentation Improvement

Physician advisors are not just needed for case management anymore. ICD-10-CM/PCS and the changing landscape of healthcare reimbursement make their input invaluable in the realm of CDI and coding, too. Trey La Charité, MD, physician advisor for the University of Tennessee Medical Center, and James S. Kennedy, MD, CCS, CDIP, president of CDIMD-Physician Champions in Nashville, collaborated on this volume to help physician advisors quickly understand the vital role they play and how they can not only help improve healthcare reimbursement, but also reduce claims denials and improve the quality of care overall.
Physician engagement in three ‘easy’ steps

It’s an age-old question: How do you get physicians to support documentation improvement efforts?

“I first spoke on this topic 26 years ago,” says William Haik, MD, FCCP, director of DRG Review, Inc., in Fort Walton Beach, Florida. “The same points I might have made then are still important, but Medicare keeps giving us additional reasons to make sure the documentation is as specific as possible.”

In the 1980s, when Haik first started practicing as a pulmonologist, he was the only one in his county, so hospitals and other physicians sent their sickest patients to him for treatment. One “sunny Sunday,” as he puts it, the local paper decided to rank hospitals against each other using the region’s outcomes for pneumonia patients.

“I’d scribble ‘pneumonia’ on the discharge summary and not think any more about it,” says Haik of his former self. “I knew they had multiple comorbid conditions and that they needed more expensive antibiotic treatments, but I didn’t understand how my documentation depicted my patients’ conditions to the outside world.”

That changed in a hurry: The newspaper’s report made it appear as if Haik’s patients were twice as likely to expire from pneumonia than patients at any other facility in the county.

“I knew I wasn’t God’s gift to medicine, but I also knew I wasn’t that bad,” he jokes.

Haik began to learn all he could about the payment and coding systems, studied the common lack of congruence between coding language and the clinical world, and approached the AHA Coding Clinic for ICD-9-CM editorial board with discrepancies. They invited him to join the board.

Although no longer a Coding Clinic editorial board member, Haik continues his private practice and lectures on the importance of documentation improvement around the country. Physician support of CDI efforts, he says, depends on “the three P’s: profiles, physician payment, and patient care.”

Profiling

Once upon a time, when someone wanted to determine who was
a good physician, he or she would depend on the advice of family or friends, or that of the larger community, says Haik. Today, good physicians are determined by the hospital length of stay (LOS) for their patients, cost efficiency for treating a given patient or population, and quality parameters set by the government.

“And all of this depends on the codes assigned. And that,” says Haik, “depends on the documentation.”

**Physician payment**

Physicians receive payment based on how much time and clinical decision-making their patients need for effective treatment. To assess this, physicians complete a number of medical record components—the family history, history of present illness, review of systems, etc.—which correspond to a variety of evaluation and management (E/M) codes. The codes are stratified so the more time and medical consideration a particular patient or situation requires, the more the physician is paid for the associated care.

A patient with bronchitis doesn’t require a lot of care, so a physician would report the lowest E/M code, says Haik. But if the patient has bronchitis and COPD, then the physician gets to report a higher-level code. If the patient suffers from bronchitis and COPD and has acute respiratory failure—and all the documentation supports these diagnoses—the physician can report the highest level of E/M code and get paid commensurate with the clinical effort involved for that patient’s care, says Haik.

However, “if I don’t say the magic words and get credited for those codes, it goes back to the lower level of care, and the physician suffers all the consequences that entails,” he says—including possible public shaming such as the kind Haik endured in the early ‘80s.

Payment methods have become more and more complicated over the years, he says. The Affordable Care Act includes cost efficiency measures that effectively penalize high-cost/low-quality care providers by up to 2% of reimbursement. Additionally, Hierarchical Condition Categories (essentially a coding stratification system similar to MS-DRGs) aggregate patients with similar conditions and assess payments based on how efficiently a provider treats that group. Efficacy within norms equates to a normal payment, below average equates to a less-than-optimal payment, and above average equates to higher reimbursement.

“If the provider only documents diabetes but the costs for treatment are higher than other providers’ costs, that physician will receive less reimbursement,” says Haik. “If that same patient also has neuropathy related to the diabetes, that patient is expected to need more resources, and payment will reflect that. The documentation matters.”

**Patient care**

The documentation included in a patient’s medical record (and the codes assigned to reflect that documentation) travels with the patient throughout his or her medical care. The data is then aggregated by any number of private and government agencies and used for population health assessment, research, and changes in payment methods.

Physicians want to provide patients with the best care possible, Haik says, but without precise documentation, the data will not reflect that care. CDI professionals seeking to win provider support need to underline that point.

“Bottom line, I believe that the physician is the very first, and last, patient advocate. Part of our advocacy role is to make sure that our patients get the appropriate level of resources directed to their specific healthcare needs. The only way to do that is through complete and specific documentation to accurately reflect the level of severity of the patient’s illness. And that’s really why documentation is so important.”

—William Haik, MD, FCCP
Bring a physician to lunch: A case study

When Bernice Baker, RN, BS, CCDS, began working as a CDI specialist at Union General Hospital in Blairsville, Georgia, just over a year ago, her hospital’s CEO had one request: “We need more education.”

Physicians were unhappy with the fact that the majority of the educational offerings took place in the evening, according to feedback. They preferred quick meetings during lunch, Baker says. So she brainstormed, then had a eureka moment—why not do a lunch-and-learn program?

The first event took place in May 2015 on a Tuesday afternoon and consisted of two 30-minute sessions with slides and a verbal presentation. The first session started at noon, for those who had an earlier lunch. Then, at 1 p.m., the same information was presented again, for those who had a later break. The half hour in between sessions provided time for physicians to ask questions and relax. And, of course, the facility served a nice lunch.

“Physicians have unpredictable schedules, so we wanted to come up with something where they could choose one session, or come at the end of one session and see the beginning of the next one,” says Baker.

For the first five or 10 minutes, Baker, who is a solo CDI specialist, discusses business and general updates. For the remaining minutes, she delves into a specific topic. The topics are usually based on needs identified by the CDI department. Often, this includes common culprits such as pneumonia and acute
respiratory failure. Other times, the CDI team selects a topic based on the diagnoses or procedures that elicit the most queries. In earlier sessions, CDI staff would spend a few minutes discussing CDI in general—what it is, its mission, and why it exists. (Read the related article regarding the importance of the CDI mission statement on p. 20.)

The CDI team gets physician feedback about their preferences for lunch-and-learn topics.

“The physicians need to be a part of setting [the meetings] up,” says Baker. “They want to see less of me, not more, and they want fewer queries. Having their input helps us tailor education for their needs.”

The CDI department also partners with other departments to discuss more complex topics, like quality scores and public data reporting.

Following each session, Baker creates a bulletin board to highlight informational takeaways. For example, she posts tip sheets and related documentation forms. This encourages a continued conversation as well as ongoing input and feedback.

“The board is good for those who can’t make the meetings, and it gives physicians another chance to see the information and be reminded to ask me questions,” says Baker.

Initially, Baker offered the lunch sessions every two weeks, and attendance was excellent. The cadence became too frequent over time, however, so the team scaled back to monthly sessions. In the future, she plans to offer them

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Quick tips for education and engagement

**Editor’s note**: The following physician engagement suggestions were submitted from ACDIS members.

“We have been sending out little memes with tips of the month to help with our provider engagement. Several of the providers have responded positively towards these and they seem to enjoy the humor. It’s been a good way for our team to keep them engaged with who we are, what we do, & that we are here to help them.”

—*Cheree Lueck, RN, BSN*, CDI specialist at Denver Health Medical Center in Colorado

“We have a quarterly ‘Doc Star’ award we give out to physicians who are engaged with CDI. All CDI staff are encouraged to nominate their physicians. In addition to a certificate, they get a token gift card to use in the hospital cafeteria.”

—*Karen Bridgeman, MSN, RN, CCDS*, CDI educator at Medical University of South Carolina

“Most recently, I baked cookies and placed my ‘CDI bucket of treats’ in the hospitalist office with a ‘thanks for all you do’ card. I have also made goodie bags with chocolates, engraved pens, candles, and other things with a personalized certificate for doctors that are doing an outstanding job documenting and replying to queries.”

—*Claudine Hutchinson, RN*, CDI specialist at Saint Francis Health System in Tulsa, Oklahoma

“During CDI Week, we educate and engage providers by distributing gift bags with the ACDIS logo and theme for that year. Historically, the gift bags have included documentation tip cards, ICD-10 information, and candy. We also have sent out a trivia question to our providers during CDI Week regarding documentation specificity. The first person to respond with the correct diagnosis receives a gift card.”

—*Kerry Seekircher, RN, BS, CCDS, CDIP*, CDI manager at Northern Westchester Hospital in Mount Kisco, New York
quarterly, on both Tuesdays and Thursdays, to allow for even more flexibility with physicians’ schedules. “We want to do whatever works for them considering the limitations of their time,” says Baker.

Physicians need to know that you are their champion and their friend. Let them know that you are there to help them, not change them, and work with them to figure out what needs to be improved and why.

—Bernice Baker, RN, BS, CCDS

Before the lunch program started, Union General Hospital did not have a true CDI program—instead, the program had been an extension of the case management department’s record review efforts. Baker, who had two years’ experience as a CDI reviewer and a background in quality prior to her arrival at the facility, expanded the focus of her reviews beyond the financial perspective to improve quality and capture a more complete clinical picture.

Providers want to put the patient first, so the role of CDI is to help them capture within their documentation the care they’ve provided, says Baker.

“Physicians are open to [improving documentation] for the sake of accuracy and reflecting what is correct so they can give better patient care,” she says. “If our documentation reflects a better and clearer picture for the next provider, we improve care for that patient.”

Each lunch-and-learn session shifted her relationship with the physicians. At first, “I was expecting no one and was so surprised by the buy-in,” she says. Then, “they started finding me more accountable, and they seemed to realize that I did have knowledge, so they started using me more. The key is to come in with open ears and not assume anything.”

She adds, “Physicians need to know that you are their champion and their friend. Let them know that you are there to help them, not change them, and work with them to figure out what needs to be improved and why.”

For those facilities struggling to engage their physicians, Baker has one last thing to say: “Don’t give up! Some physicians love to argue, which is fine. Listen patiently. Keep on trying, and usually they’ll come around.”

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by Laurie L. Prescott, MSN, RN, CCDS, CDIP.

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Northwesterner encourages nurses to join CDI ranks

Coleen Elser, RN, CCDS, has been in the CDI field for nearly nine years at Salem Health in Oregon. For her, it was love at first sight.

Coming from a nursing background, Elser immersed herself in the opportunity to learn and grow in the profession. She joined the Northwest ACDIS chapter and continues to be an active member. On occasion, she finds herself recruiting and advocating for more experienced nurses to take advantage of CDI opportunities. To those who don’t think they can do the job, or that it might be boring, Elser has one thing to say: “Trust me, it’s anything but!”

Married for 28 years, Elser has four children and nine grandchildren, who live as far away as Alaska and as close as right down the street. She and her family enjoy the great outdoors—they live on five acres, and when they’re not working, they spend time traveling, camping, hunting, and fishing.

CDI Journal: What did you do before entering CDI?

Elser: I worked in nursing, starting in neuro-trauma, then as a critical care float nurse, then in home health, and finally with postoperative surgical patients. I started in the first care manager group formed at Salem Health and was part of that group for more than four years.

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

Elser: I wanted to do something that challenged me intellectually. This field does that daily. You have to connect signs and symptoms to real diagnoses, lab values, medications—and then put it all together to create a clear clinical picture.

CDI Journal: What has been your biggest challenge?

Elser: I would absolutely say getting physicians to understand the value of what I do. I want them to know that I’m here to help, not hinder their work.

CDI Journal: What has been your biggest reward?

Elser: Those “aha” moments when you’ve connected with a physician about something that they’ve been struggling to understand. This was a huge surprise recently: having physicians come up to me and thanking me for what I do.

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

Elser: Today, there’s a lot more fine-tuning and looking beyond the clinical picture to the core measures and safety factors that relate back to documentation. There’s more of a focus on the little details.

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

Elser: I’ve encountered new and novel approaches to CDI that I would not have thought about through attending the ACDIS national conference the past two years and meeting other CDI colleagues throughout the country.

I found that we’re all floating in the same sea, and it’s wonderful to learn how they handle some of the situations I encounter on a daily basis. I’ve learned how far we can reach with proper documentation—that it’s not just a document to show how sick a patient is, but also a learning opportunity where we can use the information in ways far beyond the here and now.
**CDI Journal:** What piece of advice would you offer to a new CDI specialist?

*Elser:* Be a sponge. Absorb information from every source because you can never know too much. If you don’t know what something is, look it up or ask for help. You’ll be amazed at how much you’ll learn. Then, share that information with your colleagues so you all can grow together.

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

*Elser:* I would love to be a patient advocate, helping people get through the “system” and giving them straight answers to help them make educated decisions about their care.

**CDI Journal:** What was your first job (what you did while in high school)?

*Elser:* I cleaned toilets for a state park and waited tables at a local restaurant. I often tell people, “I’m still doing the same thing; I just get paid better now!”

**CDI Journal:** What are a few of your favorite things?

- **Vacation spots:** Alaska, Hawaii, and Yellowstone. I live in the Northwest, so they’re all close.
- **Hobby:** Sewing, making quilts, and reading.
- **Non-alcoholic beverage:** Fresh-made apple cider.
- **Foods:** Cookies. I’m a cookie monster. If it’s there, I will find it!
- **Activity:** Walking. I try to put in at least five miles every day; I’ve done several 5K events every year. It’s lots of fun! 🌞