LOSE INCHES AND GAIN DOLLARS WITH IMPROVED CDI
Today’s Presenters

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About NCH Healthcare System

- 713 total beds; 2 hospital system.
- Alliance of 650 physicians & medical facilities. throughout Collier County and SW Florida.
- Extensive inpatient and outpatient services.
- Member of the Mayo Clinic Network
- 36,386 admissions; 93,634 emergency room visits; 3,418 births; 453 open heart surgeries; 11,668 surgical procedures & 3,952 employees.
- HIMSS Stage 7.
Industry Recognition

Pathway to Excellence: Third Hospital in Florida and Only Hospital in Region, 2013

Recognized in Orthopedics, 2013

Recognized as Top 50 Cardiovascular program only one in SW Florida 2013

NCH Cardiac Surgery Services rated 3-Stars and top 10% in the nation 2012, 2013

“A” Rating – Highest “Grade” in Region, 2014

Named a Great Community Hospital in 2013
Learning Objectives

1. Understand how to improve workflow processes, maximize the efficiency of CDI specialists and improve relationships with physicians and coding professionals.

2. Demonstrate improved documentation to enhance the ability to measure quality of care.

3. Discuss how CDI requires technology to drive ongoing effectiveness and success.
Today’s Agenda

Section One
• ICD-10’s Impact on Documentation and Reimbursement
• Examples and Case Studies

Section Two
• Building a Successful Three Phase CDI Program Focused on People, Process and Technology

Conclusion
• Strategies for Success
SECTION ONE:
ICD-10’S IMPACT ON DOCUMENTATION AND REIMBURSEMENT
Key Coding Impacts in ICD-10

ICD-10 will impact how we code and bill for our services.

We have two options:

- Maximize opportunities to show the true severity of our patients’ illnesses.

OR

- Create significant financial and operational risk.

Let’s review three of the six most common examples of coding and billing practices that will be impacted by ICD-10 in order to minimize risk and maximize opportunity.

1. Medical Necessity
2. CPT and Diagnoses
3. Non-Specific Codes
4. Severity of Illness
5. E/M Codes
6. Orders for Diagnostic Rule Outs
Key Coding Impacts in ICD-10

- **Medical Necessity**
  - The most costly, complex type of denial.
  - Specificity in ICD-10-CM supports medical necessity when the provider documentation is thorough.

- **Severity of Illness**
  - Accurately expressing severity of illness is required for quality reporting and optimal reimbursement.

  - Outpatient procedures are better supported due to the granularity of the corresponding ICD-10-CM code(s).
Example of Medical Necessity

A 66-year-old patient with colitis is seen for evaluation of excessive fatigue and rectal bleeding. She has a two-month history of melena and lower right quadrant abdominal pain. Lab tests show mild anemia. A complete colonoscopy is performed via the rectum, and biopsies are obtained. There are findings of hemorrhagic ulcerative colitis in the rectosigmoid area and chronic blood loss anemia.

Diagnoses entered in the chart: anemia
Example of Medical Necessity

A diagnosis of unspecified anemia does not justify medical necessity for a colonoscopy.
Example of Severity of Illness

A 47-year-old patient presents to the ambulatory surgical center for therapeutic uterine artery embolization due to myometrial fibroids resulting in menometrorrhagia and severe dysmenorrhea. Her CBC exhibits anemia secondary to chronic blood loss with a hemoglobin of 9.0 g/dL.

She has a history of migraine with aura, and is not a candidate for oral contraceptive therapy. She has considered a partial hysterectomy, but is not ready to proceed with this option.

Procedure: Therapeutic uterine artery embolization
Example of Severity of Illness

Inadequate ICD-10 coding does not accurately communicate severity of illness to administrators and payers.

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D25.1</td>
<td>Intramural leiomyoma of uterus</td>
</tr>
<tr>
<td>N92.1</td>
<td>Excessive and frequent menstruation with irregular cycle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37210</td>
<td>Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata)</td>
</tr>
</tbody>
</table>
A 70-year-old female patient with a history of hypertensive heart disease with diastolic congestive heart failure, pulmonary hypertension, and persistent atrial fibrillation presents to your office for a preoperative evaluation for an elective hip replacement.

She is currently managing her conditions with diuretics, warfarin, and propranolol.

Her last coronary angiogram was one year ago. Her last chest x-ray was over one year ago.

Preoperative tests ordered: transthoracic echocardiogram, right heart cardiac catheterization and chest x-ray
Example of CPT and ICD-10

**Inappropriate Coding Assignment**

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z01.810</td>
<td>Encounter for preprocedural cardiovascular examination</td>
</tr>
<tr>
<td>Z01.811</td>
<td>Encounter for preprocedural respiratory examination</td>
</tr>
</tbody>
</table>

**Appropriate Coding Assignment**

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I27.2</td>
<td>Other secondary pulmonary hypertension</td>
</tr>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I50.32</td>
<td>Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I48.1</td>
<td>Persistent atrial fibrillation</td>
</tr>
</tbody>
</table>

93306 Echocardiography, transthoracic, real-time with image documentation (2D) with Doppler

93456 Catheter placement in coronary artery(s) for coronary angiography; with right heart catheterization

71030 Radiologic examination, chest, complete, minimum of 4 views

**Preoperative exam encounter codes do not justify non-routine preoperative testing.**

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Case Study

A patient presents with *decompensated* heart failure and asthma.

In ICD-9-CM, a diagnosis of unspecified congestive heart failure results in frequent queries initiated by CDI and coding professionals.

We anticipate the same in ICD-10-CM.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>428.0</td>
<td>150.9</td>
</tr>
</tbody>
</table>

Without further clarification we would be at MS-DRG 293 w/o CC/MCC and APR DRG 194 with SOI 1 and ROM 1
Case Study

As we look deeper into the medical record, the patient is being treated with IV furosemide for generalized edema. An ECHO is performed showing systolic dysfunction with an ejection fracture of < 45%.

The patient has a longstanding history of intrinsic asthma and is currently experiencing an acute exacerbation due to heart failure.

The patient was working strenuously in his garden prior to coming to the emergency room with respiratory symptoms.

He continues to smoke cigarettes daily. He has been counseled on the effects of smoking related to asthma and heart failure during this encounter.
Case Study

With the clinical information provided, how could we obtain greater specificity in our coding for both ICD-9 and ICD-10?

- Query the type of heart failure.
- Query the severity of the asthma.
- Ask the provider to document the cause and effect relationship of cigarette smoking with the asthma exacerbation and heart failure.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>428.21</td>
<td>I50.21 Acute systolic (congestive) heart failure</td>
</tr>
<tr>
<td>493.12</td>
<td>J45.51 Severe persistent asthma with acute exacerbation</td>
</tr>
<tr>
<td>305.1</td>
<td>F17.210 Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
</tbody>
</table>

MS-DRG 292 w/cc  
APR-DRG 194 w/ SOI 2 and ROM 1
SECTION TWO
BUILDING A SUCCESSFUL THREE PHASE CDI PROGRAM FOCUSED ON PEOPLE, PROCESS AND TECHNOLOGY
Clinical Documentation

- Clinical Documentation Improvement (CDI) programs have become a necessity under the Medicare Severity Diagnosis Related Groups (MS-DRG) system, which requires capturing severity of illness.
- Gone are the days where we only had to consider POA, HACs, and capturing “CCs” and “MCCs.”
- As we move forward with Meaningful Use, the Accountable Care Act, ICD-10 and we can’t forget the ongoing RAC initiatives, a CDI program should be a part of every organization’s “SURVIVAL KIT.”
CDI Programs

- 67% of hospitals have initiated a CDI program, but are stifled by insufficient staff and inadequate tracking mechanisms.

- The remaining 33% have no CDI program in place

Source: Advisory Board Financial Leadership Council
Poll Question

What is your top challenge related to clinical documentation improvement?
Maximize Revenue Capture
Letting Nothing Slip Through the Cracks

Accurate Documentation Ensures Appropriate Reimbursement

Blueprint for Implementing Best-In-Class Clinical Documentation

• Make Clinical Documentation Improvement a Finance Priority
• Invest in Adequate Staffing
• Focus on Accurate DRG Assignments
• Prioritize Chart Reviews for Maximum Impact
• Develop Robust Tracking Capabilities
• Hold Staff Accountable for Productivity and Accuracy
• Emphasize Query Compliance
• Leverage Electronic Medical Records

Potential Revenue Benefit of CDI

Average

Best-In-Class

$1.7 M

$3.7 M

Best-in-Class Clinical Documentation Improvement Programs

• Financial Leadership Council study
• Eight tactics for maximizing performance on Clinical Documentation Improvement programs and financial returns

Source: Advisory Board Interviews & Analysis
CDI Impact

Compliance Quality

Risk Administrative Burden

Revenue

CMI: 1.31 to 1.64
CDI Programs

Not Just a Reimbursement Issue

Clinical Documentation Improvement (CDI) programs are designed to “bridge the gap” between unclear clinical documentation and coding practices.

Results:
Improved accuracy of coding, reported outcomes and appropriate reimbursement.
Effective CDI Program Phases

Three phases to optimize your CDI program across your entire organization.

Executing a Successfully Optimized CDI Program

**PHASE I**
- Assess & Design
  - Medical Record Audits
  - Staffing Assessments
  - CDI Process Design
  - Program & Plan Development

**PHASE II**
- Educate & Implement
  - Project Plan
  - Design CDI Curriculum
  - Process Training
  - Mentoring & Best Practices
  - Physician Education

**PHASE III**
- Mentor & Monitor
  - Process Assessment
  - Compliance Audits
  - Monitor CDI Principles
  - Outcomes Measurement
  - Continual Education
THE RIGHT PEOPLE
People

Clinicians

CDI Specialists

Coders
Best Practices: Get Physician Buy-In

- Make it practical
- Make education convenient and mobile
- Use a combination approach eLearning, peer-to-peer, and internal programs
- Communicate the ‘What’s In It For Me’ effectively
CDI Role of the Physician

Use a Myriad of Education

- It is crucial that physicians understand the importance of documentation in ICD-10
- We must find ways to engage them in ICD-10 training and education
Engaging Physicians in Education

- Get to know your physician culture
- Explain the benefits of education
- Provide CDI programs with minimal impact on their daily routine
- Outline how data will be presented back to them so they can follow their progress
- Give them a glimpse of the future
- Stress that CDI is painless and the benefits outweigh any effort
- Be a good steward of physician education
- Appeal to their competitive nature by showing them how they compare to their peers through physician profiles
Empower the CDIS/CDIP

- Clinical Documentation Improvement Specialist role as the most critical to success
- Will be using them to
  - Do face-to-face physician education
  - Integrate documentation education into current practices
  - Rework queries/forms
  - Develop additional education collateral and printable documents
  - Collaborate with coders and case managers
PROCESS CHANGE
Chart Review Processes

• How do we need to change the query process?
• How do we need to change the data-gathering process?
Chart Review Process

ICD-10, hospital acquired conditions, MU, conditions present on admission, readmissions, value-based purchasing and other quality indicators will require more data and play a key role in reimbursement

- Chart review process
- A complete review of the patient record
  - Provider documentation
  - Nursing documentation
  - Ancillary department documentation
The Query Process

• The rate of queries is expected to increase by 55% with ICD-10

• The challenge is to get the query process ready for ICD-10
  – Identify diseases and diagnoses that we document today and determine what their documentation requirements will be in ICD-10
  – This will require more time and more follow-up
  – “I-10 - ivize” your current suite of queries to reflect the specificity necessary for ICD-10
  – Electronic query can be of great value
Example of Asthma Query

Based on your medical judgment of the clinical indicators outlined above, are you treating this patient for a known or suspected:

**ICD-9-CM**
- Extrinsic asthma with acute exacerbation
- Extrinsic asthma with status asthmaticus
- Other, please indicate
- Unable to determine

**ICD-10-CM**
- *Mild intermittent* extrinsic asthma with acute exacerbation
- *Moderate persistent* extrinsic asthma with acute exacerbation
- *Severe persistent* extrinsic asthma with acute exacerbation
- *Mild intermittent* extrinsic asthma with status asthmaticus
- *Moderate intermittent* extrinsic asthma with status asthmaticus
- *Severe intermittent* extrinsic asthma with status asthmaticus
- Other, please indicate
- Unable to determine
Capture Every Dollar, Correctly

- Documentation captures all services provided and level of care, accurately reflects the SOI, and is not in conflict with the diagnosis
- Accurately reflect POA versus HAC
  - a condition not properly documented at the time of admission, but later noted could ding the hospital with a penalty, because it looks just like a HAC based on the documentation, e.g. level II Ulcer
- Services were provided in the right setting and are supported by the documentation
- Coding is complete and accurate
- Correct DRG is assigned
- Can withstand an audit!
As organizations look to “do more with less”, they will look for:

• Fewer vendors
• More creative staffing solutions
• Different ways to access and share information to meet regulatory measures and patient expectations

In order to improve financial/clinical outcomes, our industry requires:

• An enterprise-wide, NLP-enabled HIM workflow solution
• Support of multiple roles within the organization
• Automation and accelerating data transformation
What Does this Technology Look Like?

• Single, integrated workflow platform to support any combination of roles - CDI, Case Management, UR, Coding, Auditing, Abstracting
• Extensible rules framework (Precyse, regulatory and site-specific rules, e.g. abstracting, alerts)
• Patient-centric
• Turn key integration with major EMRs
• Superior ICD-10 coding performance
  – Including E/M coding for OP & facility
  – Embedded encoder
• SNOMED-based NLP
• Predictive analytics
Natural Language Processing

- Intelligence in the form of rules and logic that drives the results of NLP
- Provides knowledge behind the interpretation of the data
- Establishes the clinical relevance of the patient story
- Breaks down data to its SNOMED concepts with tagging of clinically relevant markups
Physician Query w/ Automated Workflow

- Integrated Physician Query application
- Shared by CDIS and Coders
- Automated Workflow
  - Dashboard Alert when Query Completed
  - Auto Release from Pending and Returned to Originator
- Physician Query Tracking & Reporting
CDI Strategies for Success

Maximize efficiency of CDI Specialists
Streamline the entire review process
Improve workflow and automate processes
Enable communication: CDIS, Clinicians, Coders and Management
Engage Physicians and lead to improved documentation
Ensure complete and accurate documentation before downstream coding
Capture patient record for concurrent review
CONCLUSION
Questions?

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