Clinical Documentation Improvement: Implementation and Benefits

The Path to Performance

The Problem:

• There are minimal areas to improve revenue within the health care system that are economically feasible for rural and community hospitals

• Cost Cutting is the focus by:
  – Increased fraud enforcement
  – Down-grading for failure to document Severity of Illness or Medical Necessity
  – Recovery of paid claims with retrospective denials and prospective denials (RAC) (MAC)
  – Payment is linked to quality measures or outcomes
  – Value Based Purchasing Initiatives

  AND

  If it is not documented by a physician, a code cannot be assigned and it cannot be billed
**Denials:**

Title XVIII of the Social Security Act; 1862(a)(1)(A)

... “no payment may be made under Part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

“Medical Necessity” and “Severity of Illness” are captured through physician documentation only.

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**The Physician:**

- Medical School and residency never taught a physician how to document for “Medical Necessity” or for “Severity of Illness”

- Physicians document the treatment and care they provide to the patient

- The terminology a physician uses is different from what a coder uses and wants- they speak a different language and physicians do not know that terminology

- Coders want Diagnosis, not physician terminology (urosepsis, chronic lung disease, uncontrolled blood sugar)
Important Terms

- Principal Diagnosis (Pdx)
- Diagnostic Related Group (DRG)
- Medicare Severity-Diagnostic Related Group (MS-DRG)
- Concurrent/Complicating Condition (CC)
- Major Concurrent/Complicating Condition (MCC)
- Geometric/global length of stay (GLOS)
- Relative Weight (RW)
- Case mix index (CMI)

Principal Diagnosis

- Establishes the base MS-DRG
- "The condition, after study, which occasioned the inpatient admission to the hospital" – CMS definition of inpatient stay
  - Not necessarily what brought the person to the hospital
    - ER Chief Complaint- abdominal pain
    - Admitted for acute pancreatitis (principal dx)
  - Should be a disease process or condition, rather than a symptom, that admits a patient i.e., CAD vs. chest pain.
Principal Diagnosis

• The presenting symptomology necessitating the admission MUST be linked to the final disease process diagnosis by the physician

  – Usually this occurs in the discharge summary; therefore, discharge summaries should be completed as soon as possible following discharge for accurate coding
  – The provider needs to clearly state the diagnosis was present on admission (POA) as evidence by the presenting symptoms

Co-Morbidities (CC/MCC)

Additional conditions that affect patient care in terms of requiring:

• Clinical evaluation
• Therapeutic treatment
  – Continuation or adjustment of home medications
  – Initiation of new medications or IVF
• Diagnostic procedures
• Extended length of hospital stay
• Increased nursing care and/or monitoring
Co-Morbidities (CC/MCC)

CC  (Complication and Comorbidities)
• Patients who are more ill than a “healthy” person with the same principal condition i.e., many chronic conditions add a CC

MCC  (Major Complication and Comorbidities)
• Represent the highest severity of illness to identify the “sickest of the sick”
  • Acute episodes (exacerbation) of chronic conditions (acute on chronic systolic or diastolic HF)
  • Potentially lethal conditions (Acute respiratory failure, shock, encephalopathy, ESRD, open fracture of a major bone)

Example of Documentation

Medical Assessment

“A 65y/o male who has a chronic lung disease presents with fever, chills, leukocytosis, SOB and altered mental status:

These clinical phrases will result in under-coding of the severity of illness
Correct Assessment:

… “A 65y/o with acute exacerbation COPD, along with chronic respiratory failure. This is complicated by acute pneumonia, possible gram negative, and a recent hospitalization. The patient presents today with sepsis and acute septic encephalopathy.”

Coding

• DRG: 204 Respiratory signs and symptoms without CC/MCC
  – Relative Weight  0.6780
  – GLOS  2.1 days

• DRG: 871 Septicemia or Severe Sepsis w /MCC
  – Relative Weight  1.8527
  – GLOS  5.1 days
**Coders:**

- Can **NOT** assume or document a diagnosis without provider documentation, even with clinical indicators
- Can **NOT** guess, interpret, or assume
- Can **NOT** code without a discharge summary
- Can code a **probable, likely, suspected** for inpatient – as long as it is being **treated** and has been documented
- Can code “**present on admission**” and/or “**resolved**” if it has been documented

**MS-DRG**

**MS-DRG – Medicare Severity Diagnosis Related Groups**

- Includes the **principal diagnosis or procedure**
- Some DRG’s have a **CC or MCC** that adds to the severity
- One **DRG per hospitalization**, assigned at discharge
- Each DRG has a **Length of Stay** assigned to it
- Each DRG has a **Relative Weight (RW)**

  - The RW has become the “severity of illness”
Improving Documentation…

• Promotes documentation accuracy, specificity to meet current coding guidelines
• Proactive step towards meeting documentation and coding guidelines with the implementation of ICD-10
• Reduce risks to audits by Third Party Payers and MACs
• Improvement of morbidity and mortality data reported to public agencies
• Collection of accurate data for CMS pay-for-performance programs

Why Do We Need Clinical Documentation Improvement?
OIG Guidance Recommendations

Department of Health and Human Services’ Office of the Inspector General (OIG) guidance recommends the following minimum compliance for health record documentation:

• Health record should be complete and legible
• Past and present diagnoses should be accessible in health record
• Appropriate health risk factors should be identified

AHIMA, Russo (2010)

Criteria for Clinical Documentation

• Good, quality clinical documentation supports evidence-based medicine (EBM)
• Gives details about the encounter including
  – Rationale for physician orders
  – Tests/procedures to be performed
  – Rationale for medical decision making
Defining the Terms

Clinical Documentation

- Clinical documentation is any information documented in a patient’s record by any healthcare provider that can impact patient quality, safety, outcomes and mortality
- Only documentation from a treating physician (attending, consulting, or surgeon) can be used by coding. (*January 2004 Coding Clinic*)

Clinical documentation improvement

- The process to ensure that the information documented (by the provider) is accurate, complete, specific, timely and meets coding guidelines for reimbursement

MCCs and CCs Matter

- Correct capture of MCCs and CCs impacts
  - Length of Stay (LOS)
  - Severity of Illness (SOI)
  - Readmission Rates
  - Mortality Rates
  - DRG Assignment, Weights
  - Revenue
  - Profiles
  - Quality Metrics
MS-DRG System

- Used by CMS to calculate payment for inpatient hospitalization
- Other payors are adapting
  - Blue Cross/Blue Shield
  - Aetna
  - United Health
- One MS-DRG assigned per hospital stay
- Identified by Diagnostic Category
- Severity of Illness reflected by adding comorbid conditions (CCs) and major comorbid conditions (MCCs) being treated

Improving Documentation...

- Improving documentation is cost effective in meeting Federal Quality Measures
  - Information can be collected at the Time of Care
    - Present on Admission (POA)
    - Hospital-acquired Conditions (HACs)
    - Major Complications and Comorbidities (MCCs) and Complications and Comorbidities (CCs) information can be captured
  - Appropriate assignment of MS-DRGs that may affect the relative weight
Clinical Documentation Improvement

• CDS (Clinical Documentation Specialist) will assist with the most compliant, accurate and concurrent documentation for each patient by:
  – MS-DRG assignment from documentation
  – Capture all the CC’s and MCC’s
  – RAC protection
  – Core Measures
  – Value Based Purchasing
  – Clarifying
• CDS will assist physicians in documentation clarification
• CDS will obtain concurrent documentation during the hospital stay
• CDS will query for clarification

Query Benefits

• Establishes evidence to support the rationale for tests/procedures ordered
• Establishes the principal diagnosis
• Support Coding Guidelines for both ICD-9-CM and ICD-10-CM/PCS
• Support of Increase in E/M Level Assignment
• Provides accurate length of stay
• Accuracy in Diagnosis Code Assignment
• Accuracy in Reimbursement
• Decrease in Reimbursement Delays
• Reduction in Payer Audits and Recoupment
Required of Your Physicians:

Medical Necessity and Severity of Illness are required on all patients and CDI Specialist will require Physicians document all conditions that are present on admission. Physicians build a collaborative relationship with the CDI Specialist to ensure best practice in patient care. Physicians document principal diagnosis, co-morbidities and major co-morbidities on all patients and the CDI will assure that all principal, co-morbid and major co-morbid diagnoses are treated and in the discharge summary.

Query Example

80 y/o female with fever/chills, urinary frequency, vomiting. WBC 16.9, 12% bands. Urine 3+ bacteria, urine culture positive. Physician documents “Urosepsis”

690 kidney & urinary tract infection w/o CC/MCC, RW .076, LOS 2.2

Query: “The patient’s WBC is elevated with a positive urine culture for bacteria. What do these findings indicate? ______________________

- Physician Documents: Probable Sepsis
- 872.0 Septicemia or severe sepsis w/o MCC
- RW 1.12, LOS 5.7
### MS-DRG examples

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<thead>
<tr>
<th>DRG</th>
<th>Title</th>
<th>RW</th>
<th>LOS</th>
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<tbody>
<tr>
<td>193</td>
<td>Simple pneumonia w/MCC</td>
<td>1.455</td>
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<td>194</td>
<td>Simple pneumonia w/CC</td>
<td>0.977</td>
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<tr>
<td>195</td>
<td>Simple pneumonia w/o CC/MCC</td>
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<table>
<thead>
<tr>
<th>DRG</th>
<th>Title</th>
<th>RW</th>
<th>LOS</th>
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<tbody>
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<td>329</td>
<td>Small and large bowel procedure w/MCC</td>
<td>5.127</td>
<td>11.9</td>
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<td>Small and large bowel w/CC</td>
<td>2.506</td>
<td>7.3</td>
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<td>Small and large bowel procedure w/o CC/MCC</td>
<td>1.638</td>
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### MCCs and CCs with Reimbursement

#### Diabetes

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<td>637</td>
<td>Diabetes w/MCC</td>
<td>1.3888</td>
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<td>638</td>
<td>Diabetes w/CC</td>
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#### Simple Pneumonia and Pleurisy

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<th>LOS</th>
<th>DRG Amount</th>
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</thead>
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<tr>
<td>193</td>
<td>Simple Pneumonia &amp; Pleurisy w/MCC</td>
<td>1.4550</td>
<td>5.0</td>
<td>$10,685.00</td>
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<tr>
<td>194</td>
<td>Simple Pneumonia &amp; Pleurisy w/CC</td>
<td>0.9771</td>
<td>3.8</td>
<td>$5,620.00</td>
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<tr>
<td>195</td>
<td>Simple Pneumonia &amp; Pleurisy w/o CC/MCC</td>
<td>0.6997</td>
<td>2.9</td>
<td>$4,362.00</td>
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### MCCs and CCs That May Be Missed-Add More

#### Chronic Obstructive Pulmonary Disease (COPD)

<table>
<thead>
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<th>DRG</th>
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<th>DRG Amount</th>
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<td>COPD w/MCC</td>
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<td>191</td>
<td>COPD w/CC</td>
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<td>192</td>
<td>COPD w/o CC/MCC</td>
<td>0.7120</td>
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LOS 5.0 on 192

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#### MCCs and CCs That May Be Missed-Add More

#### Congestive Heart Failure (CHF) & Shock

<table>
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<tr>
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<th>Title</th>
<th>RW</th>
<th>LOS</th>
<th>DRG Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>291</td>
<td>CHF &amp; Shock w/MCC</td>
<td>1.5031</td>
<td>4.6</td>
<td>$11,021.70</td>
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<tr>
<td>292</td>
<td>CHF &amp; Shock w/CC</td>
<td>0.9938</td>
<td>3.7</td>
<td>$6,000.00</td>
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<tr>
<td>293</td>
<td>CHF &amp; Shock w/o CC/MCC</td>
<td>0.6723</td>
<td>2.6</td>
<td>$4,800.00</td>
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</table>

LOS 5.1 on a 292
Clinical Outcomes Measure

- The **Case Mix Index** (CMI) average of all MS-DRG relative weights is the common denominator for clinical outcomes.
- RW is based on **physician documentation**
- RW is based on **MS-DRG** assigned
- **CMS** calculates the CMI for each and every attending physician and each and every hospital.
  - Physician and Profiles can be found on Medicare.gov
  - How severely ill the patients are and the percent mortality of that physicians’ patients.

\[
\text{CMI} = \text{RW} = \text{Severity of illness}
\]

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**Acuity Worksheet**

**Texas Hospital**

<table>
<thead>
<tr>
<th>Payer: Medicare</th>
<th>Admitted: 9/12/14</th>
<th>Discharged: 9/19/14</th>
<th>LOS: 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original MS DRG:</td>
<td>194</td>
<td>Revised MS DRG:</td>
<td>871</td>
</tr>
<tr>
<td>Original MS DRG RW:</td>
<td>.9688</td>
<td>Revised MS DRG RW:</td>
<td>1.807</td>
</tr>
<tr>
<td>RW Difference:</td>
<td>$ 7,627</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes:</th>
<th>Simple Pneumonia with CC</th>
<th>Codes:</th>
<th>Septicemia or Severe Sepsis with MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>486.</td>
<td>496</td>
<td>786.05</td>
<td>496</td>
</tr>
<tr>
<td>263.9</td>
<td>285.29</td>
<td>285.29</td>
<td>443.9</td>
</tr>
<tr>
<td>443.9</td>
<td>729.1</td>
<td>443.9</td>
<td>729.1</td>
</tr>
<tr>
<td>238.71</td>
<td>585.9</td>
<td>238.71</td>
<td>585.9</td>
</tr>
</tbody>
</table>

Query for sepsis: the patient had an increased WBC with bands, low B/P, Tachycardia, increased respirations.
Query for severe malnutrition- albumin was 1.5.
Query for COPD exacerbation- documentation stated it was worsening.
Query for the stage of kidney disease.
## Acuity Worksheet

**Texas Hospital**

<table>
<thead>
<tr>
<th>Payer: Medicare</th>
<th>Original MS DRG: 194</th>
<th>Revised MS DRG: 177</th>
<th>RW Difference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted: 06/02/14</td>
<td>Discharged: 06/07/14</td>
<td>Original MS DRG RW: .9771</td>
<td>Revised MS DRG RW: 1.99</td>
</tr>
</tbody>
</table>

**Codes:**

- Simple pneumonia with pleurisy and CC
- Respiratory infection with inflammation and MCC
- Sepsis Acute respiratory failure

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**Queries:**

1. Type and causative agent was not documented on the pneumonia, sputum shows Citrobacter. Acute respiratory failure in the ER—did it resolve when inpatient? (Query)
2. Has a urinary tract infection, sepsis. Is it treated and is it chronic due to Foley? (Query)

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## TruBridge Record Review Projected Case Mix Index with CDI

**Arkansas Hospital:**

**Sample Record Review**

| RW before TruBridge (50 record sample) | .843 |
| RW after TruBridge (40 records DRG shifts) | 1.35 |

**Percentage Increase:** 38%

**CMI**

Baseline CMI YTD 1.05

Projected CMI (goal) TruBridge CDI Implementation: 1.21 at 20%
TruBridge Record Review for CMI Impact
Arkansas Hospital

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Number of Records Reviewed</td>
<td>50</td>
</tr>
<tr>
<td>Documentation Improvement Opportunities Identified</td>
<td>40</td>
</tr>
<tr>
<td>Clarification RW for CMI Impact</td>
<td>0.510</td>
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<tr>
<td>Coding Opportunities for CMI Impact</td>
<td>40</td>
</tr>
<tr>
<td>Reimbursement billed on 150 charts</td>
<td>$207,628.00</td>
</tr>
<tr>
<td>Potential Additional Reimbursement from DRG, MCC, CC changes</td>
<td>$187,633.00</td>
</tr>
<tr>
<td>Potential Increase in Reimbursement</td>
<td>50%</td>
</tr>
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</table>

TruBridge Record Review for CMI Impact
Arkansas Hospital

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Number of Records Reviewed</td>
<td>50</td>
</tr>
<tr>
<td>Documentation Improvement Opportunities Identified</td>
<td>40</td>
</tr>
<tr>
<td>CDI Opportunity %</td>
<td>50%</td>
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<tr>
<td>Average Reimbursement Per Opportunity</td>
<td>$4,690</td>
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<tr>
<td>Sample Total Opportunity Potential</td>
<td>$187,633</td>
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<tr>
<td>Total Medicare Discharges Per Year</td>
<td>600</td>
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<tr>
<td>Potential Yearly CDI Medicare Opportunity #</td>
<td>480</td>
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</table>
What Clinical Documentation Improvement Can Do
Texas Hospital

Clinical Documentation Report: 10/01/2014 - 12/01/2014

• 60 DAYS post CDI Implementation
• 50 discharged charts audited for clinical documentation improvement:
  • 33 Medicare, 3 United Health, 4 Blue Cross, 3 Private insurance
  • 7 physicians
  • Principal DX: 34 changes
  • CC: 87 added
  • MCC: 19 added
  • Query: 66 sent, 64 returned
  • GLOS: 4.06 average days
  • LOS (hospital): 4.71 average days
  • RW before (CDI): 0.8464
  • RW after (CDI): 1.284

What Clinical Documentation Improvement Can Do
Texas Hospital

• Reimbursement before CDI: $327,478.
• Reimbursement after CDI: $479,606.

• Total billable reimbursement increase: $152,131.
• Per Chart reimbursement change: $3,042.
AHIMA Recommendations

• Abnormal diagnostic test results indicate the possible addition of a secondary diagnosis
• Higher specificity of an already documented condition
• Patient is receiving treatment for a condition that has not been documented
• Abnormal operative or procedural findings are not documented
• It is unclear as to whether a condition was “ruled out”
• Principal diagnosis is not clearly identified

Russo, R (2010), Clinical Documentation Improvement: Achieving Excellence, AHIMA, Chicago, IL

Clinical Documentation Improvement Report
Arkansas Hospital

Clinical Documentation Improvement day: 149

Total # of Charts Audited: 476
Medicare: 376
Blue Cross: 123
Health Advantage: 17
Tricare: 2
USable: 0
United Healthcare: 2

Principal DX Changes
CC: 417 Added
MCC: 152 Added
Query: 249 Sent, 249 Returned

GLOS: 3.52
LOS (hospital): 3.59

RW before (CMI): 0.89
RW after (CMI): 1.05

Reimbursement before CDI: $2,191,709.43
Reimbursement after CDI: $2,700,356.96
Reimbursement Increase: $508,648
Per Chart Increase: $1,068.59
Arkansas Hospital By Physician

### Clinical Documentation Improvement Physicians Report

<table>
<thead>
<tr>
<th>MD</th>
<th>Acts</th>
<th>GLOS</th>
<th>LOS</th>
<th>Query</th>
<th>CC</th>
<th>MCC</th>
<th>Admit RW</th>
<th>Disc RW</th>
<th>$ before</th>
<th>$ after</th>
<th>Diff</th>
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<td>150</td>
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|       |       |       |       |       |     |       |         |         | $2,191,709 | $2,700,357 | Total $508,648 |

TruBridge, Proprietary and Confidential

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Clinical Documentation Improvement Report
Texas Hospital – 10/1/14 – 5/31/15

- 296 discharged charts audited for clinical documentation improvement:
- 260 Medicare
- 9 United Health
- 26 Blue Cross
- 12 Admitting Physicians
- Principal DX: 228 changes
- CC 275 added
- MCC 112 added
- Query 326 sent, 320 returned
- GLOS 4.02 average days
- LOS 4.63 average days (down from average of 6.1)
Clinical Documentation Improvement

- Severity of Illness shown by Relative Weight
  - RW before (CMI)  .865
  - RW after (CMI) 1.26

- Reimbursement before CDI $1,028,849.
- Reimbursement after CDI $1,665,100.

- Total reimbursement increase $1,073,962.
- Per Chart reimbursement change $ 3628.

Value of CDI to Texas Hospital

- Length of Stay was lowered significantly 6.1 to 4.88
- Co-morbid conditions (CC) and Major co-morbid (MCC) were captured
- Severity of illness was captured
- Physician documentation improved significantly
- Reimbursement improved with Medicare and Blue Cross
- Physicians loved having someone to round with them and answered Queries
- Case Managers functioning as CDI specialist blended the jobs
Establishing a CDI Program?”

Getting Started

• Clinical Documentation Assessment
  – Gives a snapshot view of where your facility is currently with its documentation
  – Identifies areas of improvement
  – Identifies potential missed revenue opportunities
• Assemble the Team
• Communicate the Team composition
• Get physician “buy-in”
Required of Your Physicians:

- Medicare sets the trend for insurance companies
- Medical Necessity, Severity of Illness, Present on Admission is required on all inpatients
- Document all conditions that are present on admission
- Build a collaborative effort with the CDI Specialist
- Document principal diagnosis, co-morbidities and major co-morbidities
- Make sure all principal, co-morbidities and major co-morbidities diagnosis that are being treated are in the discharge summary

The Future:

- Physicians will be paid based on documentation and severity adjusted clinical outcomes.
- Physicians will be profiled based on the quality of documentation.
- “Value-Based Purchasing” will be adopted by health care.
- Increase accountability for quality and cost through physician documentation.
- Medicare Risk Assessment for Chronic Care Patients will be in the Clinics
When Do YOU Start?

References

- Russo, R (2010), Clinical Documentation Improvement: Achieving Excellence, AHIMA, Chicago, IL
Thank you

The Path to Performance