Appendix B: Orientation for New CDI Professionals

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Orientation for new clinical documentation professionals should include the nuances involved in diagnosis, procedure, inpatient prospective payment systems (IPPS), and outpatient prospective payment systems (OPPS) capture. Some of these topics include concepts such as major diagnostic categories (MDCs) and common diagnosis related groups (DRGs) within each MDC. MDCs categorize DRGs into groupings by body systems. DRGs, in turn, are often divided into triplets or doublets, and in a few occasional singlets. When CDI professionals are reviewing a record and adding diagnoses, knowledge of opportunities per DRG grouping would aid in accurately capturing severity.

For example, Medicare Severity (MS)-DRG 069 is one of the "singleton" DRGs. A singleton DRG offers no capture of complications and comorbidities (CCs) or major complications and comorbidities (MCCs). A coding and CDI opportunity is to confirm the cause of the transient ischemic attack (TIA) or that the present TIA was in fact a cerebrovascular accident CVA (MS-DRG 066). This allows appropriate DRG capture, with the ability to capture a CC or MCC. Therefore, increasing severity and case-mix index (CMI) capture.

Coding guidelines are the backbone of diagnoses sequencing. Guidelines instruct CDI and coding professionals on which diagnosis should be listed as principal versus secondary. Included is guidance on the capture of poisonings, pregnancy, complications, sepsis, and acquired immunodeficiency syndrome (AIDS) codes. When a CDI professional is educated on coding guidance, they are more likely to accurately capture the correct DRG, become aware of the severity level needed, and reduce DRG mismatches.

Take for example sepsis due to urinary catheter. Following coding guidance, the complication of the urinary catheter would be sequenced as the principal diagnosis. However, some CDI professionals would not be aware of sequencing guidance and would place sepsis as the principal diagnosis.

The publication *Coding Clinic for ICD-10-CM and ICD-10-PCS* is guidance provided by the American Hospital Association. *Coding Clinic* is published on a quarterly basis and answers questions posed by hospitals regarding items not resolved within the coding guidelines. *Coding Clinic* also answers sequencing questions and code capture. For example, guidance on capturing heart failure with pleural effusion educates CDI and coding professionals to code heart failure only, unless the effusion is separately treated. Fluid overload and missed dialysis with heart failure and end-stage renal disease (ESRD) gives guidance on principal diagnosis capture.

Lastly, teaching accurate ICD-10-CM/PCS provides CDI professionals with an understanding of how codes are generated and thus the proper DRG assignment. If coding software is being used that provides a coding pathway in the process of selecting diagnoses and procedures, it would be beneficial for the user of said software to confirm that the diagnoses and procedures generated accurately reflect the diagnoses and procedures they intend to capture. In addition, ICD-10-CM provides notation of Includes and Excludes 1 and 2 notes, which also affect severity capture. For example, a drop in hemoglobin and hematocrit (h/h) should not be captured with anemia. This prompts CDI and coding professionals not to capture drop in h/h when anemia is documented.
