Beyond DRG Shifts: The Diverse Metrics of Inpatient CDI

By Daniel Land, RHIA, CCS

Although inpatient clinical documentation improvement (CDI) programs have traditionally measured their immediate success by financial data gleaned from DRG shifts and the health of their organization's case mix index (CMI), the influence of CDI reaches far beyond revenue enhancement tied to the claim today. Savvy measurement and reporting of the global effects of CDI programs on quality have become particularly important as the investment in CDI resources continues to grow across the nation. Accurate and complete physician documentation is necessary for survival in today's climate of value-based models with financial incentives tied to quality of care, ramifications of accurate hospital-acquired condition (HAC) and patient safety indicator (PSI) reporting, and increased claims denials. Provider documentation must be legible, reliable, precise, complete, consistent, clear, and timely in order to accurately portray the patient's story. Each patient's story is linked to a wide variety of initiatives related to healthcare quality, effective patient care, healthcare economics, policy, and reform. The consumer's perception of healthcare providers and institutions is largely shaped by ready access to a plethora of public data and rankings for physicians, hospitals, and healthcare providers. The accuracy of this data largely depends upon the quality of provider documentation and coding.

Claims Denials

Trending denial rates over time is one method of demonstrating the effectiveness of a CDI program beyond the immediate financial perspective. CDI programs have a remarkable opportunity to review concurrently or prospectively with an eye toward the future. A clinical documentation specialist (CDS) should question if provider documentation accurately reflects the current status of the patient and if documentation supports medical necessity, is sufficient for accurate coding, and will stand the test of time. Since every claim is subject to denial, it is important to get the documentation right on the front end in order to produce a clean claim. Doing so will help ensure that your organization will receive equitable reimbursement and successfully navigate the appeals process.

It is beneficial for CDI and coding professionals alike to understand the medical necessity implications of coding. They should have access to all local coverage determinations (LCDs), national coverage determinations (NCDs), and payer policies. Since management of the appeals process requires a significant investment in human capital, any efforts directed toward reduction of denial rates will directly affect an organization's bottom line. It is helpful to analyze the past six months of your organization's denials in order to identify patterns and trends and understand targeted areas of risk. The continued evolution of ICD-10 will increase the demand for specificity and continue to force physicians to be more descriptive and exact. CDI's role in physician education is far reaching and will ultimately impact denial rates. The value that a CDI program brings to an organization by effectuating a reduction in denial rates is immense and should be quantified and reported accordingly.

Reduction of Coding Queries

Trending query rates over time is another method of demonstrating the effectiveness of a CDI program. Many CDI programs report a reduction in physician queries due to the proactive collaboration of CDI and physicians for accurate and complete documentation. This, in turn, gives time back to coding professionals who have the documentation they need to do their job. CDI and coding professionals bring their own unique expertise to the revenue cycle conversation and their collaboration can potentially reduce query rates by weeding out unnecessary queries.

Patient Safety Indicators and Hospital-Acquired Conditions

CDI programs play a valuable role in helping their organizations capture additional revenue from hospital value-based purchasing (HVBP). This additional revenue capture, if attributable to CDI, should be tracked. It is interesting to note that an

estimated 60 percent of healthcare payments will be based on quality outcomes by 2018.[1] HVBP is a Centers for Medicare and Medicaid Services (CMS) initiative that structures Medicare's payment system to reward acute care hospitals with incentive payments under the Inpatient Prospective Payment System (IPPS), based on the quality of care they deliver—not just the quantity of services they provide.

Patient safety indicators were developed by the Agency for Healthcare Research and Quality (AHRQ) to reflect quality of care by measuring potentially avoidable in-hospital complications and adverse events. CDI programs need to be on the lookout for certain PSIs that are used to measure a facility's quality scores and help ensure HACs and their related present on admission (POA) indicators are reported correctly.

Documentation and coding of all reportable conditions may prevent a patient from being included in the calculations. Many codes that factor into exclusion from reporting are not classified as an MCC or CC, but are important nonetheless. Of course, rules and guidelines must always be observed for reporting of diagnoses. Consistent retrospective reviews of all mortalities, PSIs, and HACs will provide a report card and road map for CDI programs.

CDI Value Transcends DRG Shifts, Case Mix Index

A CDI program's value transcends DRG shifts and CMI. Documentation that impacts risk of mortality (ROM) may not necessarily affect immediate reimbursement. However, this documentation has future implications related to improving the quality and effectiveness of patient care, identifying and reducing preventable conditions, and reducing readmission rates. Another important consideration is consumer perception, which is critical to the overall financial wellbeing of healthcare institutions. Healthcare consumers are becoming savvy comparison shoppers and utilize an arsenal of information at their disposal to make their healthcare provider decisions. Healthgrades, for example, is a US-based company that provides information to consumers about physicians, hospitals, and healthcare providers. Healthgrades evaluates hospitals on risk adjusted mortality and in-hospital complications. Claims data is used to rate and rank doctors based on complication rates at the hospitals where they practice. The fact that quality data is aggregated from coded data places CDI on the front lines of the battle for their institution's market share. CDI programs that review through the lens of quality, think ahead to future reimbursement, and do not focus solely on today's claims greatly contribute to their institution's growth and longevity. Focus on quality and correct reimbursement will follow.

Note

1. "Q & A." CDI Week. 2016.

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