CDI Programs Expanding Outside the Hospital

By Mary Butler

A physician with his own small orthopedic practice is in a hurry to get his charting and documentation done for the night so his wife—the office manager—can send the day's claims out the next morning. Exhausted and in a hurry, he turns to his iPhone for coding help.

"Hi, Siri, what is the ICD-10 code for diabetes mellitus?"

Siri pulls up a number of Google results that combine his search terms, but not necessarily in a way that spits out the exact codes he needs.

"Close enough, right?" he thinks. "What could go wrong?" A lot, says Victor Freeman, MD, MPP, national medical director for clinical documentation improvement for J.A. Thomas, part of Nuance Communications. Freeman says he knows of physicians in the outpatient space who have actually turned to Siri and Google for coding help because they and other non-acute providers are short on time and resources while facing an increase in claim scrutiny. Smaller practices may not have staff adequately trained in coding and billing, and as a result are experiencing a wave of claim denials as they struggle to keep up with new regulations.

"They're losing income… and they're still trying to find ways to catch up, especially as they come through the transition to ICD-10," Freeman says. "I was amazed to discover that many outpatient physicians for a long time have been Googling [to find] the right codes."

Physician documentation is being scrutinized by the government for fraud and abuse—especially evaluation and management (E&M) coding for Medicare—and they soon, if not already, will feel the squeeze from other payment reforms.

While clinical documentation improvement (CDI) programs have long been a staple of inpatient healthcare facilities, increased use of documentation and coding for quality measurement and reimbursement programs across healthcare is causing non-acute care facilities to also adopt CDI programs. Complying with payment reforms promulgated by the Medicare Access and CHIP Reauthorization Act (MACRA), value-based purchasing, hierarchical condition coding (HCC), risk adjustment scores, and ICD-10 means that correct clinical documentation is more important than ever—especially as care delivery moves increasingly to non-acute care settings such as inpatient rehab facilities (IRFs), home health, the emergency room, and long-term care.

Todd Manion, CPC, a senior manager at Deloitte, says ICD-10 and MACRA are driving CDI program growth across sectors, causing these providers to put plans in place regardless of place of encounter.

"Because the data and the diagnoses are all being shared and becoming more transparent, payers, providers, CMS [the Centers for Medicare and Medicaid Services], Healthgrades, and Leapfrog are all utilizing this data to profile and identify risk and identify missed opportunities. And until now, the outpatient documentation has not been the focus," Manion says.

To help physicians meet the newer documentation demands, the American Medical Association is touting a team-based model for physician documentation. This model leans on the use of scribes—in the form of nurses or medical assistants—who round with the physician and do CDI in real time as they record documentation in the chart. This frees up the physician to more actively engage patients, increase their efficiency, and improve revenue.

The Association of Clinical Documentation Improvement Specialists (ACDIS) released a white paper this spring hailing the diversity of backgrounds among CDI specialists and their interdisciplinary nature.[1] "In order to perform CDI responsibilities one must also become proficient in a number of adjacent knowledge domains including medical record review, medical coding and reimbursement regulations, the impact of reportable diagnoses on quality of care measures, risk adjustment methodology,

and both the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). Rare is the person who starts day one with all the required knowledge needed for this role," the white paper's authors write.

While CDI programs have long been a staple of health information management (HIM) departments in inpatient facilities, their stock is rising across the healthcare continuum, giving HIM professionals an opportunity to bring their expertise to the table. However, each new setting comes with a unique set of challenges.

CDI in Inpatient Rehabilitation and Long-Term Acute Care Hospitals

Inpatient rehabilitation facilities (IRFs), long-term acute care hospitals (LTACs), and skilled nursing facilities (SNFs) are all ripe for CDI growth since they are all under pressure from the government and Medicare to meet quality standards just like their acute care counterparts. Each of these settings has its own assessment tools. For SNFs it's the minimum data set (MDS), and IRFs and rehab hospitals have the IRF patient assessment instrument (IRF-PAI).

Rehab facilities, whether they are rehab departments of a hospital or freestanding rehab facilities, are subjected to two major regulations that make accurate documentation absolutely critical—the IMPACT Act and the 60 Percent Compliance Rule.

In IRFs, Medicare reimburses based on diagnoses-driven case mix groups—akin to DRGs in acute care. The 60 percent rule requires that 60 percent of Medicare patients in an IRF fall into a case mix group with more serious conditions, such as spinal cord injuries, traumatic brain injuries, and strokes, while the other 40 percent of the IRF population can have knee or hip replacements and other conditions that require extensive therapy. Additionally, to qualify for an inpatient rehab stay the patient must undergo three hours of therapy per day.

Monica Baggio Tormey, RHIA, CHP, CHC, CHRC, director of HIM and privacy officer at Spaulding Rehabilitation Network, oversees CDI programs in IRFs and long-term care hospitals, and says CDI has been crucial in maintaining compliance with the IRF 60 percent rule and in portraying the acuity of IRF patients. However, CDI is still new in these settings and Tormey says she has had a hard time finding post-acute CDI guidelines for getting started.

"By implementing a CDI program to identify opportunities for more accurate documentation, it improved our ICD-10 specificity which in turn improved our IRF 60 percent [rule] compliance," Tormey says.

CDI is also helpful for harmonizing the quality measures in the IRF-PAI, which takes into account pressure ulcers and catheter-related urinary tract infections, among other quality measures.

"Part of our CDI program is to assist with ensuring accuracy of all of those pieces of data that are documented in multiple places by different colleagues. So physicians might document a pressure ulcer or pressure injury, or our wound care specialist might document a pressure injury. Coders are required to follow coding guidelines when coding pressure ulcer/injury. CDI can oversee documentation consistency—and it has to be as accurate and consistent as possible," Tormey says.

The facilities Tormey works in are experiencing the first year of IMPACT Act compliance, which was enacted in 2014, and standardizes the assessment tools used in post-acute care facilities. For example, SNFs, IRFs, and LTACS all have to carefully assess pressure wound hospital-acquired infections to avoid financial penalties.

"The IMPACT Act has phases where you report and phases where you get penalties if you don't report, and payment adjustments for calendar year 2018 and subsequent years. One of the goals of the IMPACT Act is to harmonize data so that it's consistent across the post-acute sites," Tormey explains.

Denise Parker, RHIT, manager of coding and CDI at Marianjoy Rehabilitation Hospital, says CDI specialists in IRFs often need to check with several different care settings to find out if a patient complies with 60 percent rule criteria. For example, if a patient arrives following a brain hemorrhage, a CDI specialist needs to find out if that patient experienced a loss of consciousness in the process.

"If they didn't have loss of consciousness, they don't qualify. So the rules are very strict. Sometimes the attending doesn't know about it [loss of consciousness] so we will review the acute care record that comes with the patient, or get in touch with the other hospital. Sometimes they don't know, but if there's somewhere we can find it that makes a huge difference," Parker says.

The clinical background of CDI specialists in post-acute vary. At Marianjoy the CDI specialists are HIM professionals, but Tormey works mostly with registered nurses for CDI.

With the goal of helping burgeoning CDI programs in other post-acute care settings, AHIMA recently released a set of CDI tip sheets to help CDI specialists in skilled nursing facilities. CDI professionals in those settings focus on the language that will garner greater details and specificity of the coded data for a given diagnosis, condition, or disease. The tip sheets also offer advice on including information to reflect quality care, frequency of documentation requirements, and documentation sources. The tip sheets are available in AHIMA's HIM Body of Knowledge

CDI in Home Health

CDI is in its infancy in the home health setting and not widely practiced, which is what makes it unique, says Tricia Twombly, RN, BSN, HCS-D, HCS-O, COS-C, CHCE, HCS-C, the CEO of Board of Medical Specialty Coding and Compliance, the CEO for Association of Home Care Coding and Compliance, and senior director at Decision Health. Twombly says CDI in home health has grown, essentially, based on word of mouth, and that up until five years ago she didn't even know what CDI was until she sat in on a session about it at an AHIMA conference.

"CDI is not a big buzzword in home health right now," Twombly says.

She notes that when she talks to home health agencies about it someone usually says, "We already do that, it's part of quality control." But the difference in home health between quality assurance and CDI is that in quality assurance most of the auditing is done retrospectively after a bill is sent in, whereas CDI is done concurrently upon admission to home health.

One key difference between CDI in home health versus other post-acute settings is that home health is reimbursed in 60-day increments since an episode of care can last 60 days or longer. Home health agencies are reimbursed 60 percent up front and 40 percent at the end of 60 days, which means agencies bill twice for the same patient, and for the same episode. The tool used for patient assessments in home health is the Outcome and Assessment Information Set (OASIS). CDI specialists are tasked with improving OASIS scores by auditing the quality of coding and reviewing documentation from the home health nurse that completed the OASIS assessment, notes from the admitting physician, notes from an inpatient stay, or from physical therapists or wound care specialists.

All of this documentation has to be culled from any combination of paper charts and/or electronic health records (EHRs). The CDI specialist is "collecting information from a myriad of sources and you have to have it all collected within five days because that's when you have to mark your OASIS assessment as complete. It's a very accelerated process," Twombly says.

The CDI specialists that work in home health are mostly clinicians (nurses or nurse practitioners) that have a home health certification in coding or an AHIMA certification.

CDI in the ER

Capturing all of a patient's diagnoses, conditions present on admission, and comorbidities during an emergency room (ER) visit —especially if the encounter results in an inpatient stay—can be difficult.

"For CDI it's important, as it is on the inpatient side, to capture the correct information at the point of entry… The ER has such significant throughput that you can impact quite a bit just by focusing on that area," says Amber Sterling, RN, BSN, CCDS, director of CDI auditing services at TrustHCS.

Though she has yet to implement it, Sterling has designed a model of how she thinks a CDI program would work in an ER. Ideally, Sterling would like to see ER CDI specialists with a strong coding background, as well as a strong clinical background, or a nurse with credentials such as a CCS or a CDIP, and they would work onsite due to the pace of an ER. They would also know how to read all the charts that accompany an ER patient and would check in with the patient between one and three times depending on how long the encounter lasts.

An ER CDI specialist would also need to have a deep understanding of the department's workflows.

"Providers work really hard to get patients in a timely manner, so when developing a CDI workflow it's going to be very important to take the time to understand how the patients are seen, what those timeframes are, know when testing will occur. It will be vital to understand so you're seeing patients at an appropriate time and you're not causing a delay. I would never recommend that a chart be held because a CDI specialist hasn't seen the record," Sterling says.

AHIMA's Long Term Care (LTC) CDI Workgroup has developed CDI tip sheets that can be used in skilled nursing facilities. These tips focus on the language and/or wording that will garner greater details and specificity of the coded data for a given diagnosis, condition, and disease. In addition to the focus on coded data, these tips also include information to reflect quality care, frequency of documentation requirements, and documentation sources.

Note

[1] Association for Clinical Documentation Improvement Specialists. "CDI: More Than a Credential." March 2017.

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