Using CDI Programs to Improve Acute Care Clinical Documentation to Support ICD-10-CM/PCS - Retired

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Editor's note: This brief replaces the 2001 practice brief "Documentation Requirements for the Acute Care Inpatient Record, and the 2013 and 2014 versions of the practice brief "Using CDI Programs to Improve Acute Care Clinical Documentation in Preparation for ICD-10-CM/PCS."

The United States transitioned to ICD-10-CM/PCS on October 1, 2015. One of the added benefits of these new code sets is the increased specificity. To assign codes that accurately reflect the patient's diagnoses and procedures, detailed provider documentation is essential. Clinical documentation improvement professionals are the ideal individuals to work side-by-side with medical staff to ensure that the documentation in the patient health record is complete and accurate, as well as detailed enough for accurate ICD-10-CM/PCS code assignment.

Purpose of the Acute Care Inpatient Record

In developing guidance regarding clinical documentation improvement (CDI), it is essential to remember that the primary purpose of the patient health record is for documenting the care of the patient. Regardless of the format of the record-paper or electronic-CDI professionals strive to ensure that the record accurately reflects the severity of illness of every patient.

Adherence to quality of care measures, substantiation of care to external entities, protection from liability, and providing valuable research and educational data are additional aspects to consider with documentation. All of the aforementioned meet the Joint Commission standards of care, which are included in Appendix A of this practice brief.

Every acute care facility must have guidelines that govern documentation in the patient health record. Ideally, these guidelines assure compliance with federal, state, and local regulatory requirements-such as the Medicare Conditions of Participation, compared with the Joint Commission standards of care in Appendix A. Addenda to the record should be carefully addressed within the facility guidelines.

Uniformity of the patient health record must be demonstrated through the use of time, date, legibility, and proper notation of credentials. While every note in the record is permanent, errors in documentation may occur and policy should dictate how the error will be noted in the patient health record. In addition, only approved abbreviations and symbols, as outlined in a clinical staff administrative policy, can be used in the patient health record. The health information management (HIM) department should develop polices related to analysis and completion of the record.

Developing the CDI Profession

Clinical documentation improvement programs utilize professionals who focus on the accuracy of clinical documentation. The CDI professional, often referred to as a clinical documentation specialist (CDS), may have either a coding or clinical foundation but is able to mesh both skill sets. CDSs may come from diverse backgrounds and possess a variety of credentials, such as a Registered Health Information Administrator/Technician (RHIA/RHIT), a Certified Coding Specialist (CCS), a physician, or a nurse. In addition, the CDS may hold Certified Documentation Improvement Practitioner (CDIP) or Certified Clinical Documentation Specialist (CCDS) certifications. A CDS must be able to work cooperatively, building rapport and trust with providers and other staff.

The CDS performs a concurrent and/or retrospective chart review to determine if further clinical documentation is needed to capture the most accurate clinical picture of the patient. In order to accurately code the patient health record, the chart requires clear and specific documentation by the physician. The record review may include notes from diagnostics, emergency room, operating room, nurses, therapy, and other disciplines. The reviewer must compare these notes to the documentation in

the history and physical, consultant notes, and physician progress notes. If the information is not complete or if there is a discrepancy in the patient health record, the CDS should query the physician for additional or clarifying documentation in the record. The CDS may need to query for reasons such as:

- Legibility
- Completeness
- Clarity
- Consistency
- Precision

The focus of CDI is improving the quality of documentation to help ensure an accurate and complete reflection of the patient's care, comorbid conditions, and treatment-which impacts severity of illness (SOI) and risk of mortality (ROM). For example, if the patient has a urinary tract infection (UTI) with kidney insufficiency, the SOI or ROM could be low. However, if the same patient has a UTI and acute kidney failure documented, then the SOI and ROM could be higher due to the greater specificity of the kidney diagnosis. Complexity and severity of illness is reflective of the supporting physician documentation provided.

For an additional example, consider a patient with shortness of breath that expires and has no other specific documentation to support a more clinically complex diagnosis. This case is classified to a Respiratory Signs and Symptoms Medicare severity diagnosis-related group (MS-DRG). However, if the documentation reflects acute pulmonary edema, the patient's acuity is more complex and this is reflected in a different MS-DRG assignment. If this same respiratory patient also has acute renal failure, the MS-DRG assignment will not be affected but the SOI and ROM for the case will be modified.

This increase in relative weight correlates with the potential use of more resources and results in a higher reimbursement. More importantly, the MS-DRG represents the true clinical picture of the patient. This is why the CDS reviews not only the physician documentation, but also the supporting nursing documentation, diagnostics, and other areas in the patient health record.

There are several other factors impacted by documentation, including present on admission (POA), hospital-acquired conditions (HACs), and patient safety indicators (PSIs). Some secondary diagnoses are considered complications/comorbidities (CCs) or major complications/comorbidities (MCCs), both of which affect the MS-DRG assignment. The documentation must clearly indicate whether these CCs and MCCs were POA or HACs. If certain conditions were found to have developed while the patient was in the hospital, the MS-DRG assignment may disallow the CC/MCC condition that was acquired during the hospital stay. Examples of these conditions include:

- Certain fractures
- Catheter-associated UTIs
- Decubitus ulcers

Upon chart review, the CDS may find areas that impact other disciplines. The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) have developed a common set of measurements for specific conditions, known as Core Measures. Core Measures are evidence-based indicators for the clinical outcome of patients and help set a standard for care of these conditions. Some Core Measures include care for a patient who has congestive heart failure, pneumonia, or an acute myocardial infarction. While the CDS may not be responsible for Core Measure reviews, he or she may be the one who first sees the potential Core Measure diagnosis being documented. If the patient has a positive chest X-ray for a pleural effusion, an elevated BNP (brain natriuretic peptide), and is receiving an IV diuretic, the CDS may suspect the missing diagnosis could be congestive heart failure (CHF). The CDS should submit a query to the attending physician for clarification of the clinical indicators.

In addition, as the patient health records are coded, the ICD-10-CM and ICD-10-PCS data are collected and assists in generating the provider's report card. These provider profiles are available through public reporting sites and are used by consumers for a comparison of quality of care within provider services. Report cards can be critical to how a provider is viewed within the community, regionally, and nationally. Complication rates are an example of data being reported that can be easily miscoded and misinterpreted.

Documentation Effects on MS-DRG Assignment

The example outlined below illustrates how documentation can influence the MS-DRG assignment.

Documentation	MS-DRG	FY 2013 Relative Weight
Shortness of breath	204, Respiratory Signs and Symptoms	0.6822
Shortness of breath due to acute respiratory failure	189, Pulmonary Edema and Respiratory Failure	1.2461

The Transition to ICD-10-CM/PCS

The transition to ICD-10-CM/PCS is an across-the-board change for the healthcare industry that has required education from the top down within an organization. Major stakeholders who were involved in the transition vary from facility to facility, and may include senior executives, HIM and CDI staff, medical staff, financial management, information technology, clinical department managers, quality data users, and business associates.

ICD-10-CM is the diagnosis code set that is utilized in all healthcare settings. The structure and format of ICD-10-CM codes is very similar to the previous ICD-9-CM diagnosis codes. However, ICD-10-CM codes include much greater specificity for capturing diagnostic data and also better reflect current medical terminology.

Procedure coding and data differences for hospital inpatient claims are reflected in the increased number of codes that have risen from approximately 3,800 ICD-9-CM procedures to more than 71,000 codes in ICD-10-PCS. The structure and format of ICD-10-PCS codes allows for flexibility to add new codes and greatly increases the specificity of the code descriptions by identifying the specific root operation, body part, approach, and devices used.

ICD-10-PCS code structure is dependent on individual values (Body System, Root Operation, Body Part, Approach, Device, and Qualifier) rather than a fixed code as it was in ICD-9-CM. For ICD-10-PCS coding, in addition to documentation of laterality, an in-depth understanding of these root operations and approaches is critical to determine the objective of the procedure. For detailed guidance on these areas and inpatient procedural coding, refer to the CMS ICD-10-PCS Reference Manual.

CDI and coding professionals-as well as providers-should all be aware of Guideline A11 as outlined in CMS' ICD-10-PCS Official Guidelines for Coding and Reporting:

Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the patient health record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

Example: When the physician documents "partial resection" the coder can independently correlate "partial resection" to the root operation Excision without querying the physician for clarification.

Documenting Specificity for ICD-10-CM

This chart offers a comparison that illustrates the need for detailed and accurate documentation-which translates into data that reflects the patient's specific medical condition. ICD-10-CM requires additional terminology to enable documentation to be consistent, concise, and complete.

ICD-9-CM	ICD-10-CM

427.31 Atrial fibrillation	I48.0 Paroxysmal atrial fibrillation I48.1 Persistent atrial fibrillation I48.2 Chronic atrial fibrillation I48.91 Unspecified atrial fibrillation
427.32 Atrial flutter	I48.3 Typical atrial flutter I48.4 Atypical atrial flutter I48.92 Unspecified atrial flutter

Training CDSs for ICD-10-CM/PCS Documentation Requirements

CDSs already have a good understanding of anatomy and physiology. It is important to remember the application of that knowledge is different in ICD-10-CM/PCS than it was in ICD-9-CM. CDSs need to understand how documentation impacts code assignment in ICD-10-CM/PCS for both quality and reimbursement reasons. ICD-10-CM/PCS brings with it a higher degree of specificity in code assignment, which requires a higher level of specificity within the documentation. The CDS must possess strong critical thinking skills to be able to interpret the documentation provided, have an understanding of the disease process, as well as understand how a procedure was performed, what approach was used, and what type of repair was performed.

An example that illustrates the importance of CDSs understanding the unique coding rules for ICD-10-CM is the coding of an initial acute myocardial infarction (AMI) with a subsequent AMI. ICD-10-CM requires a code from the subsequent AMI category to be used with an initial AMI code when a patient who has suffered an AMI has a new AMI within the four week time frame of the initial AMI. This differs from the eight week time frame that was in ICD-9-CM.

ICD-10-CM/PCS will continue to impact both CDI staff and providers due to the resource-intensive education required to add specificity and granularity to patient information. Provider education will be a primary focus in developing a greater understanding of how ICD-10-CM/PCS affects the documentation process. A critical step for the CDI staff is to be involved in the same level of education as deemed appropriate for coding professionals. Each provider specialty will require the assistance and direction of the CDI staff to ensure the level of detailed information has been documented. The transition to ICD-10-CM/PCS has altered the focus of the CDI program by adding the component of provider education beyond requesting clarification of information through the query format. Together with support from CDI staff, providers are able to improve the quality and completeness of clinical documentation required by ICD-10-CM/PCS, opening the door for resulting positive effects on coding accuracy and quality reporting initiatives.

Providers need to be reassured that they are not expected to change their methods of documentation, only to add detail. Providers must understand the need for specific documentation and diagnoses supporting medical necessity and reducing denials. Furthermore, with the advent of value-based purchasing (VBP) many payers are looking at clinical outcomes to determine payment levels. Documentation will impact the outcome data. With ICD-10-CM/PCS, where complications are more distinctly identifiable, more granular data are available to use when reporting quality results.

Building an ICD-10-PCS Code

This table illustrates the structure of an ICD-10-PCS code describing a skin excision of the left upper arm, 0HBCXZZ.

Section	**Body System**	**Root Operation**	**Body Part**	**Approach**	**Device**	**Qualifier**
Medical and Surgical	Skin and Breast	Excision	Skin, Left Upper Arm	External	No Device	No Qualifier
0	H	B	C	X	Z	Z

Provider Education

Providers should receive ongoing education in short sessions. Documentation habits can be changed incrementally through education during times when it is beneficial to providers. One method is to review a sample of records per specialty on a routine basis for documentation discrepancies. The results would be shared at physician specialty group meetings. Focus on providing one to three important items related to ICD-10-CM/PCS documentation improvement examples. The message should be short, simple, and informative. Focusing on only documentation improvement supports a positive learning environment. Make sure to mention the added benefits of improved data, and how that data supports better hospital and provider profiles, reduces denials, and ensures timely reimbursement.

The following methods may be used to facilitate effective training sessions:

- Utilize real, practical examples
- Give examples of verbiage to support ICD-10-CM/PCS specificity
- Create templates
- Distribute handouts
- Leverage newsletters
- Hang posters throughout the facility for awareness
- Hand out "pocket cards" for quick reference

CDSs should be sincere, confident, cooperative, and able to provide direct communication with case examples illustrating the impact of CCs/MCCs, principal diagnoses, and severity of illness. To gain physicians' trust, the CDSs should be thoroughly educated in ICD-10-CM and ICD-10-PCS.

Physician leadership and involvement is essential to a successful and sustainable CDI program. A physician "champion" (sometimes referred to as a physician advisor or physician liaison) should be a full-time employee of the hospital and must be involved in all formal training provided to physicians, as well as serve in a support role to the CDSs. Physician champions are imperative to documentation improvement, helping to encourage an effective peer-to-peer communication environment. The physician champion can conduct reviews, communicate with other physicians or providers about documentation issues, and promote open lines of communication-particularly when there is a lack of response to queries. The CDSs should work collaboratively with the physician champion to develop resources that can be provided to the medical staff. For example, creating a communication tool, such as a newsletter, to share pertinent ICD-10-CM/PCS information on a regular basis with providers is a great way to build rapport between the medical and CDI staff.

Improving Documentation for Quality in ICD-10-CM/PCS

CDSs should understand how the coding, based on provided documentation, is impacting quality outcomes. A review of what sources of quality information are being used to report the facility and/or provider's results should be conducted. Identify the methodology used by the reporters and evaluate current trends for areas and providers that may be lacking due to documentation issues. CDSs also need to be knowledgeable of Core Measure data extraction, as there may be new impacts to the selection criteria.

It is imperative that CDSs understand how HACs impact the financial status of the hospital and where opportunities exist for more accurate and complete documentation. Finally, educate coders, care providers, and administration on the impact to the data outcomes in ICD-10-CM/PCS and what might be accomplished through improved documentation.

Relationship Between CDI and Coding

Successful CDI programs depend on open communication and respect amongst coding professionals, CDSs and providers. It is paramount that CDI and coding professionals work together to ensure high quality documentation is contained in the patient health record. The role of the CDS is not to "code" the record, but rather to enhance it to the level of specificity needed for final coding and billing.

Appendix A:
Joint Commission and Medicare Conditions of Participation Standards for

Documentation

Documentation Requirements	The Joint Commission	Conditions of Participation
The hospital plans for managing information.	IM.01.01.01	§ 482.24
The hospital plans for continuity of its information management processes.	IM.01.01.03	§ 482.24 (b)
The hospital protects the privacy of health information.	IM.02.01.01	§ 482.24 (b) (3)
The hospital maintains the security and integrity of health information.	IM.02.01.03	§ 482.24 (c)
The hospital effectively manages the collection of health information.	IM.02.02.01	§ 482.24
The hospital retrieves, disseminates, and transmits health information in useful formats.	IM.02.02.03	§ 482.24
Knowledge-based information resources are available, current, and authoritative.	IM.03.01.01	§ 482.24(c)(3) (ii)
The hospital maintains accurate health information.	IM.04.01.01	§ 482.24 (c)(4)(A)(B)
The hospital maintains complete and accurate medical records for each individual patient.	RC.01.01.01	§ 482.24 (b)(c)
Entries in the medical record are authenticated.	RC.01.02.01	§ 482.24 (c)(1)(2)
Documentation in the medical record is entered in a timely manner.	RC.01.03.01	§ 482.24 (c) (1)(2)(3) (iv)
The hospital audits its medical records.	RC.01.04.01	§ 482.24 (c)(3) (iii)
The hospital retains its medical records	RC.01.05.01	§ 482.24 (b) (1)
The medical record contains information that reflects the patient's care, treatment, and services.	RC.02.01.01	§ 482.24 (c) (4)

The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.	RC.02.01.03	§ 482.52 § 482.51 (b)(6)
The medical record contains a summary list for each patient who receives continuing ambulatory care services.	RC.02.01.07	
Qualified staff receive and record verbal orders.	RC.02.03.07	§ 482.24 (c)(2)
The hospital documents the patient's discharge information.	RC.02.04.01	§ 482.24 (c)(4) (vii)

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