Using CDI to Meet Federal Quality Measures

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Clinical documentation is the foundation of every health record, specifically outlining the reasons for treatment and the quality of care provided to the patient. The lack of consistent and standard clinical content within the health record has been an ongoing challenge to health information management (HIM) professionals, especially as their organizations attempt to attest to the "meaningful use" EHR Incentive Program. In order to prove to the Centers for Medicare and Medicaid Services (CMS) that an organization is meeting the program's various quality measures, adequate clinical documentation is needed. Some providers have turned to clinical documentation improvement (CDI) programs to strengthen their documents not only for meaningful use, but several other quality measure programs. Quality clinical documentation is needed for a host of federal initiatives, such as ICD-10-CM/PCS and CMS' patient safety initiative.

A structured approach that develops and maintains quality documentation efforts is essential in today's healthcare environment and is the goal of every CDI program. There are many organizations publishing quality ratings today, such as the LeapFrog Group and Healthgrades. In addition, the government plays a regulatory role in measuring and attempting to ensure a certain level of quality care. These initiatives rely on clinical documentation to compare and trend results.

Meeting the Need for Quality Documentation

The need for high quality clinical documentation-for both quality and patient safety measures-can be met through a successful CDI program. CDI programs are designed to collect information at the point of care, and educate clinical care providers on the benefits of complete documentation during this process. As documentation requirements continue to increase in complexity, so too will the need for skilled documentation improvement professionals who can guide their organizations through the transition.

All of the various quality-related initiatives will challenge organizations to develop and implement clinical documentation improvement strategies designed to promote accurate and compliant documentation. Accurate documentation and clinical code assignments made during an ongoing CDI program will directly link to quality report cards and ratings.

CMS Quality Measure Reporting Tuned with CDI

In particular, CMS has three quality measures that can be immediately impacted by the implementation of a CDI program:

- Present on admission (POA)
- Hospital-acquired conditions (HACs)
- Major complications and comorbid conditions (MCCs)

POA indicators are assigned to every diagnosis code and placed on the mandatory UB-04 form for billing purposes. These indicators were designed to identify those conditions for an inpatient admission that were or were not present on the patient's admission to the care facility. Those conditions that were not POA are considered acquired while the patient was in the hospital, and therefore a HAC. CMS has stated that they will no longer pay for treatment and care associated with a HAC, if the condition could have been reasonably prevented. In addition, CMS has ruled that HACs cannot be recognized under the MS-DRG system as a complication or comorbid condition (CC) or a major complication or comorbid condition (MCC). These decisions can be financially draining on an organization, as they affect severity of illness, mortality data, and accurate reimbursement.

Key benefits of a CDI program include:

- Reduction of exposure to third-party audits such as revenue auditors or contractors or Zone Program Integrity Contractors
- Improvement of publicly reported mortality data
- Appropriate assignment of clinical codes for accurate MS-DRG assignment and case mix index
- Identification of documentation gaps prior to the patient's discharge
- Provision of accurate data for CMS quality issues and pay-for-performance
- Appropriate assignment of POA indicators and HAC codes

Documenting and Coding for Present on Admission

To further highlight the link between clinical documentation and accurate POA assignment, consider the following example:

An 85-year-old female is admitted through the emergency department for a cerebral infarction. She is admitted from the nursing home with the presence of a stage III pressure ulcer of the buttocks, which is classified as MCC. The appropriate POA assignment is "Y" for yes to indicate that the pressure ulcer was present at the time of admission. The MS-DRG is 064 (Intracranial hemorrhage or cerebral infarction with MCC) with a relative weight of 1.8424.

If the patient in the above example did not present with a stage III pressure ulcer, or if the clinical documentation within the chart did not accurately describe the presence of the ulcer on admission, a POA assignment of "N" for no could have been assigned. By changing the POA indicator to "N" on the pressure ulcer codes, the MS-DRG changes from 064 to 066 (Intracranial hemorrhage or cerebral infarction without CC or MCC) which has a relative weight of 0.8135.

Documentation Demands Growing

The CDI professional possesses knowledge in anatomy, physiology, pharmacology, and medical coding classification guidelines. They also have skills in analyzing, interpreting, and evaluating health record clinical documentation as well as communication skills that allow them to interact with the physician and other care providers to ensure that documentation is clear, accurate, and timely.

The need for high quality clinical documentation is moving to the forefront of the healthcare industry. Challenging times are ahead for organizations that cannot meet these new requirements. Organizations can meet this challenge by implementing a CDI program that expands documentation review to include quality and patient safety initiatives as well as accurate code assignment.

The CDI professional is a key influence in the success of meeting meaningful use and other quality programs. Once a program begins, the CDI professional should start real-time education at the point of patient care on the best ways to improve physician documentation.

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Article citation:
Wiedemann, Lou Ann. "Using CDI to Meet Federal Quality Measures" *Journal of AHIMA* 84, no.1 (January 2013): 44-45.