

# Exploring an Integrated Clinical Documentation Improvement & Education Program

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# What does “Integrated CDI” mean- 3 step?

- **Patient status /UR** coming together with **traditional CDI/coding** to create a coordinated, cohesive effort to ensure documentation in the medical record to support BOTH inpt status or observation PLUS the most complete diagnosis to support correct coding and ICD -10.
- **Third step** –include ordering ‘rules’ to match what was documented and billed. (3 step)
- **Cross training = more staff= 1 voice**

# Why have Clinical Documentation Improvement?



- A consistent 'set of eyes' on the record
- Concurrent review, with direct feedback
- Concurrence –
  - Handoffs between ED and the hospitalist – pt status
  - Consistency with the 'reason for admit' throughout the pt's stay/story
  - Continuous feedback loop to the provider, nursing and others documenting in the record
  - Focus on: One integrated voice with providers
  - **A VISION FOR CHANGE...KEY TO THE SUCCESS**

## What efforts are being done to ensure the record can support the pt status and is coded correctly?

- CDI specialist
- Focus: concurrent interaction with providers to ensure co-morbidities and other complications are well documented.
- AND ICD 10 is here.
- Protecting DRG /case mix
- UR/Case mgt
- Focus: work to ensure the patient status is correct and supported by the physician's order (and run reports & insurance work & criteria)
- Clarity of documentation requirements.

Do we have enough resources to do it all well and add charge capture ownership? Any? Some?

With new challenges and demands on documentation – time to think new, creative (even scary thoughts)  
= AN INTEGRATED CDI PROGRAM/TEAM APPROACH

# A Fully Integrated CDI Program

LOOKS AT.....



**Three distinct documentation challenges (Coding/ICD 10, Pt Status and Charge Capture) , incorporate them all into 1 integrated CDI program with focused education for all 'at risk' patterns thru coordinated CDI specialist/trainer(s)**

**WIN WIN WIN- 1 voice of education with the providers/clinical team, cross trained team with more eyes in the record.**

### Correct coding

- Coders back end clean up
- CDI specialist – front end, more interactive
- Tracking and trending patterns?

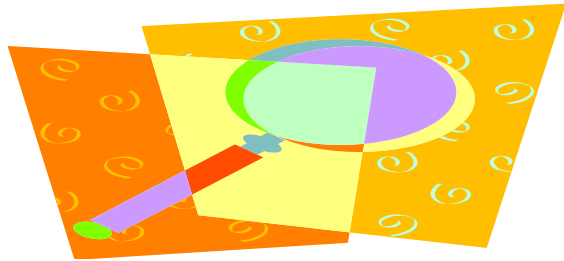
### Pt status

- UR/Case Mgr – both front end and back end
- Auditors – denial /appeals
- Tracking and trending patterns?

### Charge Capture

- Dedicated staff
- Internal auditor – only upon request
- Few individual depts doing
- Tracking and trending patterns?





# Let's look at how and why to implement an integrated approach

- 1) **Limited resources** and still need to do it 'all'
- 2) **Providers** confused, **push back**, lack of buy in, inconsistent message from multiple staff
- 3) **No effective change** in documentation –difficult to sustain – fragmented efforts.
- 4) Too darn **many denials** with no change in patterns
- 5) **IS THE PAIN BAD ENOUGH TO SAY: TIME TO MAKE A CHANGE**

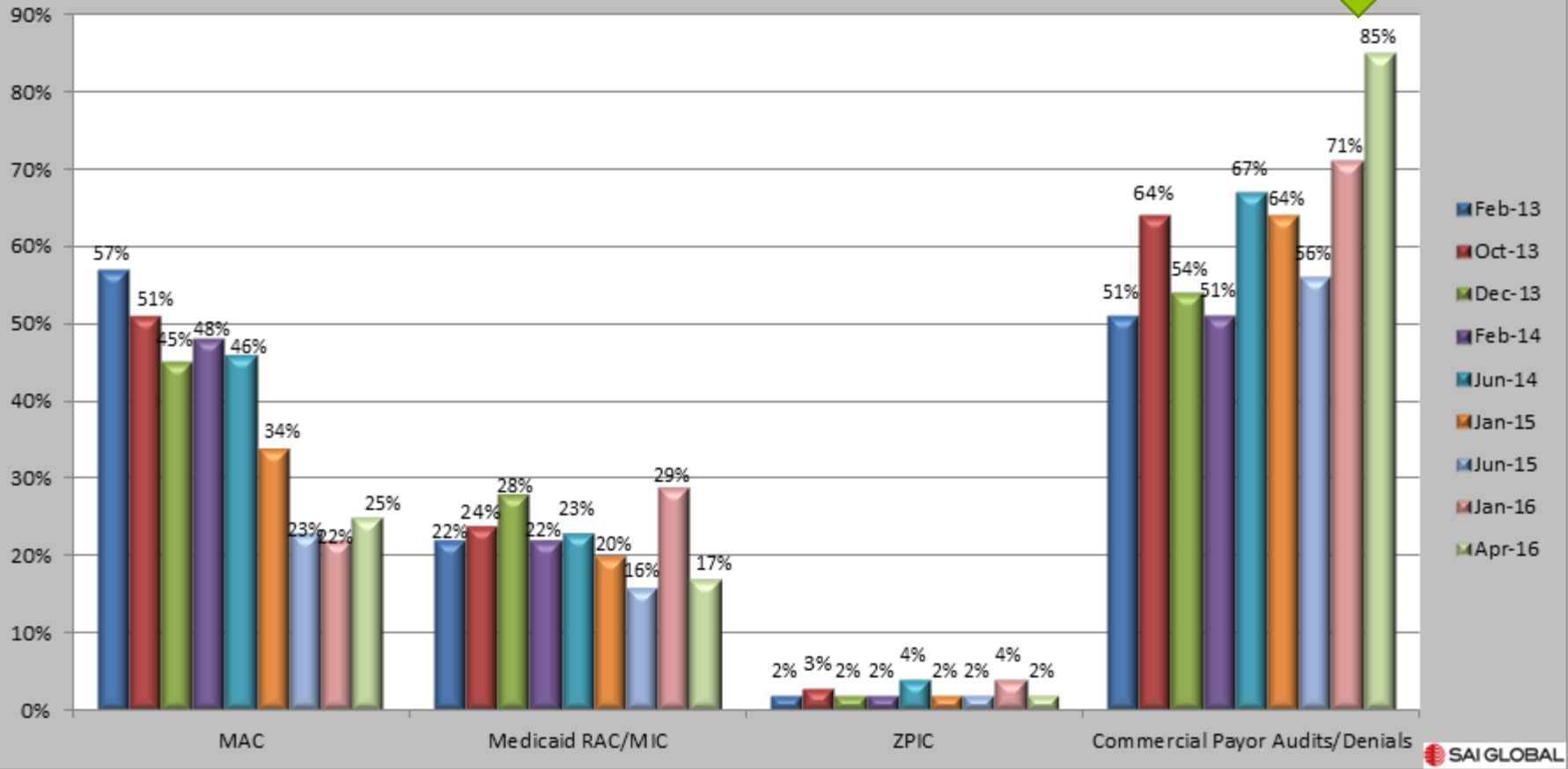
# Step One: Pt Status



# All Payers are auditing...

- Each payer has their own set of 'criteria' for coverage. \*\*What is an inpt?\*\*\*
- Each payer has their own standards for appeals
- Each payer determines if the documentation supports the service that was billed.
- And then the provider community gets to keep the money the payer paid.

## In addition to Medicare RAC audits, which are you seeing an increase of activity? 3 Year Trend



# Key elements for Payers- as ordered by providers

## ALL PAYERS

- Admit to inpatient
- Diagnosis
- Reason for Admit/Plan for why an inpt for dx.
- All part of a pre-determined order set. (Ques in the EMR or paper)

## ● MEDICARE ONLY

- “Clarify” that the LOS is an estimated 2 MN/Presumption
- “Clarify’ that after the 1<sup>st</sup> outpt MN, a 2<sup>nd</sup> ‘in hospital’ MN is required/Benchmark
- After 1-1-15, provider still outlines why the 2 MN, what is the plan that will take 2 MN. No longer ‘certify’ but still needs to clarify the order/signed prior to discharge and rationale for the 2 MN. (Do certify 20 day mark/outlier)
- Critical Access Hospital – must still certify initial 96 hrs and again, at the 96 hr mark.

## Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**

- “Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

Pg

**At the initial admit order – what is the plan that will take 2 MN? Then an early unexpected discharge=short stay**

- **Benchmark of 2 midnights**

- **The new Medicare Inpt**

- “the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt’s total expected LOS.

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**Clearly at the point of conversion- Why does the pt need a 2<sup>nd</sup> MN?**

Education 2017

## Understanding 2 MN benchmark

### MM 8586 1-24-14

- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.
- ER, Observation, outpt surgery = all included in the 2 MN Benchmark.
- Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.

## STILL largest lost revenue – 2 MN benchmark – converting after 1<sup>st</sup> MN

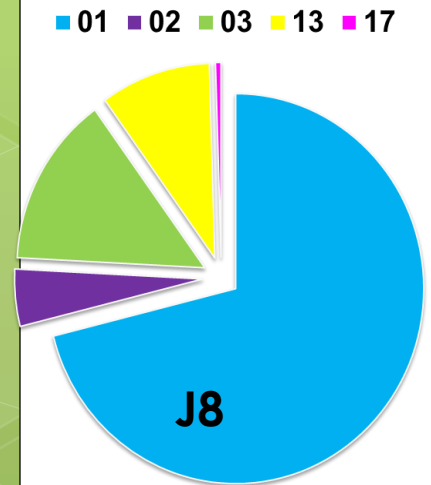
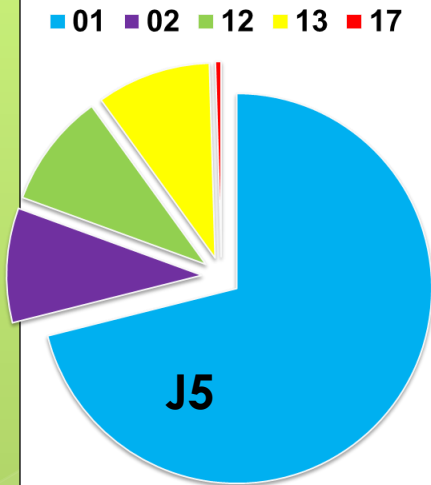
- After the 1<sup>st</sup> MN as an outpt – anywhere – or the first MN in another facility and transferred in –
- “The decision to admit becomes easier as the time approaches the 2<sup>nd</sup> MN, and the beneficiaries in *necessary hospitalization* should NOT pass a 2<sup>nd</sup> MN prior to the admission order being written.’ (IPPS Final rule, pg 50946)
- Never, ever, ever, ever have a 2<sup>nd</sup> medically appropriate MN in outpt..convert, discharge or free...



# Hot Spots for Documentation audits – inpt and obs

- Does the physician clearly state: Why an inpt? What is the plan that will take 2 MN/Medicare? For non-Medicare – why can't the pt be treated safely as an outpt. (Same issues as Medicare-just no 2 MN declaration)
- Medicare/only-If the pt needs a 2<sup>nd</sup> MN after 1 MN as an outpt – what is occurring with the pt's condition that will 'push the pt' to stay a 2<sup>nd</sup> MN? Convert to inpt and include: Why?
- **Mgd Care Medicare/PartC/Medicare Advantage – HIGH AT RISK**. What criteria are they using? Get it in the contract! NOT SUBJECT TO TRADITIONAL Medicare rules
- Commercial Mgd Care or Commercial- who knows? Makes their own rules for disallowed charges.

# Denials by Type – WPS 1<sup>st</sup> and 2<sup>nd</sup> Round P&E



**5PC01** Documentation does not support services medically reasonable/necessary (NO PLAN)

**5PC02** Insufficient documentation

**5PC12** Order missing

**5PC13** Order unsigned

**5PC15** Certification not present

**5PC17** No documentation of 2-midnight expectation

# Top Reasons for Denial – Second Round- Novitas/2<sup>nd</sup> round of P&E

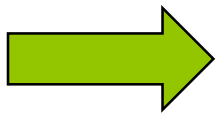
Denial Reason	% Denials JH	% Denials JL
Documentation did not support two midnight expectation (did not support physician certification of inpatient order) NO PLAN	56%	53%
No Records Received	16%	17%
Documentation did not support unforeseen circumstances interrupting stay	4%	3%
No inpatient admission order	9%	15%
Admission order not validated/signed	11%	11%
Other	4%	1%

# P&E findings: First Coast/MAC

## 244 hospitals: FL, PueRico, Virgland

- 1<sup>st</sup> round:
  - 35% denial rate
  - NO Plan
- REASONS:
  - 55% failed to document need for 2 MN
  - 45% failed admission order requirements
    - 48% signed after discharge
    - 39% order missing from the record
    - 13 % order not signed
- 2nd round:
  - 36% denial rate
  - REASONS:
    - 40% failed to document need for 2 MN
    - 60% failed admission order requirements
      - 35% order missing from record
      - 17% order not validated
      - 8% order not signed (as of 2-11-15)
  - MAC recommendations:

Providers document their decision making process. Paint a clear, concise picture of the pt.



# Tell a better, more complete patient story



- Begin with the 1<sup>st</sup> point of contact – ER, direct or Surgery
- Why is the pt not safe to be discharged/ED?
- Why is the surgery an inpt if the CPT is not on the inpt only list? (Medicare only)
- What provider laid out a plan for why 2 MN for a direct admit to the floor? Did the hospitalist see the pt immediately? Did UR talk to the ordering provider?
- Who is validating status for transfers in? Who is asking both the sending and the receiving the 2 MN question? Count 1<sup>st</sup> in sending.

# Key areas to support documentation for pt status

- **Admitting physician** 'starts the pt story' thru use of the clarification of order process – including REASON FOR ADMIT.
- **Internal Physician Advisor**- trainer/champion, works closely with UR and all providers to ensure understanding/compliance.
- **Nursing** continues with the care/assessments/interventions relative to the reason for admit.
- **UR** works with the treating/admitting physician to expand/clarify the documentation at the beginning and conclusion of the patient's stay. Additionally UR closely monitors completion of the certification for ALL payers.
- **Integrated CDI** continually interacts with providers/nursing to ensure all elements are clear /complete . 1 voice of ongoing education...

# Step Two: Coding Focus



## 2) Correct Coding – the 1<sup>st</sup> time

- CDI concurrently reviews
- Receives 'problem/concern' from coders
- Interacts with the providers daily
- Has established relationship
- Eyes of the back end coders
- Reduces queries thru interactive dialogue
- Ongoing education with providers



# And since ICD -10...

- “Easy” ways to show new way of documenting
- Better documentation = ques, auditing to ‘see’ at risk, ongoing support
- Track and trend queries to incorporate into training
- Teach with audited examples, made easy.
- Ongoing audits/concurrent
- Doctors take lead from hospital = positive message

# Continue the Documentation Enhancement Story

- Support team to make this happen:  
Integrated CDI with feedback from coders  
PFS /denial 'busters' with feedback to CDI  
Payer new edits –PFS monitors and advises IT with ability to test, submit, and maintain both ICD 9 and ICD 10 post go live.  
Eyes in the record – nursing/24-7.

# Step Three: Charge Capture



# Golden rule = Billable service

- 3 questions – **the 3 step!**
- Does the order match...
- What was done/documented...
- That matches what was billed?
- Hot spots: **protocols, changes from ordering physician by 'other providers', lost charges due to lack of ownership, wastage documentation for SDV.**

## 3) Charge ownership

- Who owns completeness of the charges?  
Manual and/or electronic?
- Is a daily charge reconciliation process done  
– aligning orders with charges?
- Is there a **dedicated charge capture analyst**  
for certain 'nursing difficulty with accuracy'  
items – like drug adm in an outpt setting?
- Any known hot spots? (Surgery/Drugs,  
supplies, pharmacy)

# **Case Study – how a midwest health system made it work!** Lori Rathbun, VP Financial Services; Deb Chenchar- Theisen, Network Nurse Executive.

Yeahhooo!!





*Sponsored by Catholic Health Initiatives—Englewood, CO and Trinity Health—Livonia, MI*

## MHN Central Iowa Division Results

15 hospitals in MHN's Central Iowa region participated in Clinical Documentation Improvement Request for Proposal.

15 hospitals very satisfied with results and well on their way to improve documentation and tell the story leading to patient safety, quality, and ultimately appropriate reimbursement

# Mercy Health Network

Identified Top Priority among CEO's, CFO's, HIM and Revenue Leaders

Request for Proposal – Team Established to drive proposal

- We had to get real about our CAH realities and craft a proposal that works for our needs
- CDI, HIM, Physicians, Leadership on board for sustainability of program

Education & teaming –

- Clinical Leadership – Top success measure
- Success Measure - identification of CDI specialist
- HIM coders are not the lead CDI specialists

Program Implementations - Audits – November 2014

- CDI Specialist Education November 2014
- Site visits Leadership, CDI, Nursing, HIM and Physician Education – Dec/Jan 2015
- Coding Education - April 2014



# Mercy Health Network

## Clinical Leadership in place across network

- CDI specialists named and working with physicians
- HIM leadership teaming with CDI and providers monthly
- Review of documentation and practicing transition to ICD10

Regardless of delay of ICD10, CDI critical to quality and patient safety – continue education path as a network.

- Sustainability critical to moving to the next level so we practice and make this part of our monthly network meetings for practice

## Feedback from hospitals

- Excellent program design focused on improving CDI, coding, physician understanding and adoption. Well positioned for future transition.

# Audit current inpt and obs:

## 1) Patient Status – Inpatient vs. Observation.

- Audit of existing documentation to determine current understanding of documentation requirements – for the physician as well as nursing. With the new definition of an inpt, this type of auditing and education is timely and critical.
- 5 2MN presumption, 5 2MN benchmark, 5 ER to obs to discharge, 5 Postprocedure to recovery to obs to discharge.

## 2) Audit for at risk coding

- Audit up to 5 records for all providers
- Identify audit sample from a) high volume, b) known weak documenting providers, c) coder feedback d) ICD -10 major change areas.
- ICD -10 accuracy , provider/patient specific.

## Audit order to documentation to UB 04/billing document:

### 3) Charge capture

- Audit of existing 'hot spot' departments – surgery, ER, observation – with a focus on identifying under charges as well as over charges that includes 'challenges of orders matching what was done and billed.
- Line item audit to match order to documentation to UB



## Next – Share results from Audits, UR and Coder Feedback – Sr leaders buy in

- **Time to do education with impacted areas**
- Physician, nursing, dept heads = all owners of an integrated CDI program
- No final decision yet on how to integrate – just learning the current processes

# Finally – brainstorm how to move to 1 consistent message of education

- Leadership facilitates the brainstorming session – sharing the goal:
  - To create a single, integrated system of CDI specialists within the organization.
  - To create a consistent message of how to fix what was broken from the audits- coding/ICD 10, pt status, charge audits.
  - To create a single, training message to providers with the ‘pearls’ from all the audits (as providers are the key in most audits)
  - To ensure no silos exist within the organization
  - To identify EMR enhancements to guide/coach/que and hard stops as necessary.

## **EXCITING Kick Off Education with audit results – who of the UR , CDI, case mgt or others are the best trainers for the integrated team?**

- Within a very short time frame, create a timeline for a 1 day kick off. (All CDI team = 1 trainer/mgs)
- Incorporate:
  - Kick off Physician education:
    - “What are documentation standards and why do I care” –with EASY to implement documentation tools
    - “Attacking the challenges of inpt vs obs- why is it so hard?” -with the tools for enhancing the patient story.
    - Determine if ‘ensuring the order matches what was done’ requires a formal class or individual physician education but share the ‘big message’ of the facility’s commitment to CDI...

# And additional clinical education

- **Nursing, nursing, nursing.... Has been left out of significant documentation training.**
- Ensure the audits include nursing's role in enhancing the pt story. (Obs, inpt)
- Ensure nursing understands how they can compliment the work of a dedicated CDI specialists – they are the eyes of the record 24/7 with immediate alerts.
- Provides Quasi-UR work for after hrs and weekends when volume doesn't warrant dedicated UR Staff.
- Other hot departments? Ensure they meet with the CDI team to determine –next steps.



# Ongoing physician education looks like....

- Integrated CDI team (UR and Coders) and/or (UR, coders, charge capture) meet frequently to discuss – what is broken?
- Develop training outlines to address ‘roll out’ of pearls of training .
- **EX) ICD 10-** Nov/focus on ER; Dec/focus on Cardio; Jan/focus on Ortho with follow up by ALL the team on a daily basis
- EX) **Inpt status** – Dec/focus on Inpt – all payer rules
- EX) **Chrg capture-** Jan/focus on protocols ordered specific to the pt.

## Final steps – roll out

- Identify the ‘**change team**’’: UR, Charge capture analyst, IT, revenue cycle denial team, HIM.
- Invite guests as issues are presented: payer issues, regulatory updates, physician patterns, training developed.
- Identify the primary trainers with all members of the integrated core team cross trained. (More eyes in the record)

Last step: Explore changing reporting relationships while consolidating into 1 **clinical-focused** educational voice- Director of Revenue Cycle with dotted...

### Coding

- ICD 10 audit and ongoing validation
- Coding specialists work with providers
- Option: report to Director of Revenue cycle --dotted line to HIM

### UR

- Daily review of pt status at the time of the original order
- UR documentation specialist work with providers
- Option: report to Director of Revenue cycle—dotted line to Care Mgt

### Charge capture

- Daily review hot spots for lost charges
- Identify lost charges and documentation challenges-doc/dept head
- Option: report to Director of Revenue cycle—dotted line to Dept heads of individual depts

Doing nothing ...is not an option. Be creative in attacking the challenges of documentation to support billable services.

It is darn fun! Move forward with a new, dynamic approach to a challenging environment.

PS Don't forget those pesty EMR's too...they can help with creating 'coaching/ques/queries/forms' – all tools.

# GO TEAM! THANKS A TON



# Thanks for a fun training time!

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Hey join us for the PA/UR bootcamp- July 2016  
RACSummit.com

New web:<http://arsystemsdayegusquiza.com>

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