Challenge, Opportunity, Victory

“Don’t expect to meet the challenges of today with yesterday’s tools and expect to be in business tomorrow”

Ignacio V. Zarate MD, Physician Advisor
Pat Cruz, RN, RAC Coordinator

Objectives

- Background:
- The problem:
- Define CDI:
- CDI’s objective:
- The Caveat:
- The Challenge:

- A winning Strategy:
- Monitoring progress:
- ICD 10 Preparedness:
- Pearls to embrace:
- Pitfalls to evade:
A Snapshot of Healthcare in the United States

- National State of Affairs: CMS is going broke!
  - CBO’s projections in the absence of federal law changes:
    1. USA has a Non-sustainable Growth Rate!
    2. CMS’s business model needs to change!
- CMS implemented a robust business model
  - Their Solution: Our Challenge
- The business model has 3 ambitious expectations
  1. Opportunity
  2. Meet the challenge well
  3. Thrive

CMS New Business Model

- Medicare Prescription Drug, Improvement, and Modernization Act (MMA) 2003
- Deficit Reduction Act 2005 (DRA)

http://www.cbo.gov/ftpdocs/87xx/doc8758/maintext.3.1.shtml
CMS New Business Model (cont.)

MAC Focus:
• Centralize Control
• Data Mining

Improve Quality of Care
• Core Measures
• PSI
• POA/HAC
• HCAHPS / VBP

Reduce Billing Inaccuracy
• Coding Guidelines (AHIMA)
• CDI (ACDIS/AHIMA)

Reduce Waste, Fraud, Abuse
• Medical Necessity (SOI/IOS)
• UM: IP/OP (GLOS)
• RAC
Compliance = PMD crafts a precise clinical picture using CMS approved language

CMS New Business Model (cont.)

MAC Clinical Design

- **QIO**
  Quality Improvement Organization
- **PSC/ZPIC**
  Program Safeguard Contractor
  Zone Program Integrity Contractors
- **QIC**
  Qualified Independent Contractor
- **RAC**
  Recovery Audit Contractor
Elements Affecting Profile and Reimbursement

- Never Events/Serious Reportable Events (SRE)
- Wrong operation
- Wrong patient
- Wrong side or body part
  - Considered complications of care
  - No payment for procedure or related care
- PSI / HCAPHS / VBP

HAC vs. POA

<table>
<thead>
<tr>
<th>HAC</th>
<th>POA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Foreign body post surgery</td>
<td>1. Manifestations of poor glycemic control</td>
</tr>
<tr>
<td>2. Air embolism</td>
<td>2. Surgical site Infections</td>
</tr>
<tr>
<td>3. ABO Incompatibility</td>
<td>3. CABG/mediastinitis</td>
</tr>
<tr>
<td>4. Decubitus ulcer</td>
<td>4. Orthopedic surgeries</td>
</tr>
<tr>
<td>5. Iatrogenic</td>
<td>5. Implantable electronic devices</td>
</tr>
<tr>
<td>Pneumothorax post venous catheterization</td>
<td></td>
</tr>
<tr>
<td>7. Catheter associated UTI</td>
<td>7. DVT/PE post certain ortho procedures</td>
</tr>
<tr>
<td>8. Vascular catheter associated infections</td>
<td></td>
</tr>
</tbody>
</table>
CMS made its largest and most significant change to its inpatient prospective payment system (IPPS)-10/2007

- CMS Introduced Medicare Severity Diagnostic Related Groups or MS-DRG’s: (538 to 751)

- CMS Created New Classifications
  - MCC – Major Co-morbidity / Complication
  - CC – Co-morbidity / Complication

- DRG Change:
  - Before: DRG with CC or without CC
  - After: DRG with CC - or with MCC or without CC

Secondary Diagnosis: Comorbid Conditions

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Increased nursing care/monitoring
- Extended length of stay
DRG Assignment: Coded Data Integrity

- DRG: Assigned based on documentation
- IPPS: Inpatient Prospective Payment System (1983)
  - Fixes payment to DRGs-Relative Weight (RW)
  - Resource consumption associated with each DRG
  - RW is constant for every hospital × Blended Rate
  - 5 DRG Groups
  - Length of stay (GMLOS) is assigned to each DRG
  - LOS exemplifies effective Physician utilization of resources
  - CMI: Patient Severity Index

<table>
<thead>
<tr>
<th></th>
<th>RW</th>
<th>GMLOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF with MCC</td>
<td>1.5174</td>
<td>4.7</td>
</tr>
<tr>
<td>CHF with CC</td>
<td>1.0034</td>
<td>3.8</td>
</tr>
<tr>
<td>CHF without CC</td>
<td>0.6751</td>
<td>2.7</td>
</tr>
</tbody>
</table>

The Difference Documentation Can Make!
Documentation Impact:

- Physician Documentation
- ICD - 9 - CM Codes
- Principal Diagnosis
  - Secondary Diagnosis
  - Principal Procedures
  - Secondary Procedures
- DRG Assignment
  - Length of Stay
  - Severity-Level Profiles
  - Risk-Adjusted Profiles
- Reimbursement
  - Quality Measures
    - (Physicians & Hospitals)

Basic Coding Guidelines

1. Code assignment can be done from:
   - The H&P
   - Any physician's progress note, or orders
   - Discharge summary
   *(If NO conflicting information exits)*

2. Incomplete, vague, or contradictory information must be clarified. (Queries)
3. The PMD is captain of the ship: She/he is ultimately responsible for the final diagnosis! (Clinical Validity)

ERMD Documentation / Diagnoses needs to be reviewed by PMD and clarified
Basic Coding Guidelines (cont.)

1. Abnormal findings are coded only their clinical significance is indicated by the provider i.e.; Labs, x-rays, pathology, EEG and Echo's and other diagnostic results

2. Diagnosis documented and qualified as shown below are coded as if the condition was established:
   *Probable, suspected, likely, questionable, possible or still to be ruled out.

3. If “Rule Out” is used, the provider must clarify if it was indeed ruled out or ruled in!

Basic Coding Guidelines (cont.)

- Acute vs. Severe vs. Chronic
- Decompensated vs. Exacerbation vs. Status
- Quo
- Rule of “3”
- Post op
- History of
- DC summary:
  - Narrate the visit
  - How you deduce a never stated diagnosis
  - Note all diagnosis
Typical Conflicting Documentation

- Attending MD: TIA
  - Neurologist: CVA
- Attending MD: Elevated Trops
  - Cardiologist: NSTEMI
- Attending MD: Renal Insufficiency
  - Nephrologists: AKI/CKD with Stage
- Attending MD: Pneumonia
  - Pulmonologist: Bronchitis/Exac Asthma

- ERMD: R/O Sepsis Syndrome UTI
  - Attending: Urosepsis
- ERMD: Exac CHF Respiratory Fail/BIPAP
  - Attending: CHF Resp Distress

Physicians Document in Clinical Terms

Coding, profiling and compliance must contain Specific Diagnostic terms

Improved documentation bridges the gap. Linking diagnostic terms increases specificity.
Why Learn About CDI?

- Decreased Daily Interruptions
  - HIM, CDI and Case Management – GLOS and (SOI/IOS)

- Accurate Physician Profiling
  - Health Grades, Physician Compare (QA/UM)
  - Severity of Illness & Risk of Mortality (SOI & ROM)

- Decreased Risk: Increase Medical Necessity CDI
  - Audits (ADR/RAC), Denials, Litigation

- Added Value of Proper CDI
  - Improved contract opportunities
  - Perform better in Global Payment Model
  - Improved practice ROI/Efficiency
  - Better understanding of upcoming changes (ICD10)

YOUR PERCEIVED PERFORMANCE IS AT STAKE!

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CMS’s Position on Clinical Documentation Integrity

“We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record”

-Direct Quote, CMS 2008 IPPS Final Rule
Case Example:

**85 YO Female – Admitted with AMS**

**Data:**
- Bun/Creat: 42/1.7
- WBC: 12.7, bands 18, left shift
- Urine: +Ecoli
- BNP: 95

**Documented Diagnoses:**
- AMS secondary to Urosepsis
- Renal Insuff - dehydration

**Events:**
- After hydrating the 1st night – pt gets SOB requires IV Lasix, Transfer to ICU for BIPAP.
- Improves after 24 hours and returns to tele floor on day 3 in the morning.
- Continues to receive IV ABX for next 36 hours.
- Renal function returns to baseline (creat 1.3)

**Documented Diagnoses:**
- Urosepsis
- Renal Insuff - improving
- Resp distress – BIPAP

**Coded:**
- Urosepsis UTI PDX
- Renal Insuff - Dehydration No CC/MCC
- Resp Distress - CHF No CC/MCC

**DRG INFO:**
- 890 Kidney & Urinary Tract Infections w/o MCC

**GMLOS 3.4 SOI 3 / ROM 2**
- Pts actual length of stay was 5 days
- RW – 0.7564

**Documented Diagnoses:**
- Sepsis secondary to UTI
- AKI on CKD III
- Acute on Chronic Systolic CHF

**Coded:**
- Sepsis PDX
- AKI on CKD III MCC
- Acute on Chronic Systolic CHF
- Acute on Chronic Sys CHF MCC

**DRG INFO:**
- 871 Sepsis or Severe Sepsis with MCC

**GMLOS 5.4 SOI 4 / ROM 4**
- Pts actual length of stay was 5 days
- RW – 1.9074

**SEPSIS**

**Bacteremia:** presence of bacteria in blood

**Septicemia:** Presence of any pathogenic microorganism or its toxins in blood

**Systemic inflammatory response syndrome (SIRS)** is defined by the presence of at least 2 of the following:
- Fever (oral temp >38.3° C) or hypothermia (< 36° C)
- Tachypnea (>20 breaths/min)
- Tachycardia (>90 beats/min)
- Leukocytosis(>12,000/µL), Leukopenia (<4,000/µL), or 10% bands

**Sepsis:** SIRS plus Clinical condition of proven or suspected infection

**Severe Sepsis:** SIRS due to Sepsis plus ≥ 1 sign of organ dysfunction

**Septic Shock:**
- Sepsis with hypotension
- arterial BP< 90mmHg or 40mmHG less than pts normal BP for at least 1 hour despite adequate fluid resuscitation - OR
- Need for vasopressors to maintain SBP ≥ 90mmHg -OR- MAP ≥ 70
The Reagent: Constant Training

- Physician advisor and supportive staff: A catalyst for success!
  - PA
  - CDI
  - CM

- Physician Documentation Goals:
  - Clear, Concise, and Complete.
  - Accurate and Specific.

Success is based on physician documentation!
Audit and Fraud Entities and Initiatives

1. Office of Inspector General (OIG)
2. Department of Justice (DOJ)
3. Medicare Recovery Auditors (MCR RA)
4. Medicare Administrative Cont. (MAC)
5. Health Care Fraud Prevention and Enforcement Action Team (HEAT)
6. Comprehensive Error Rate Testing (CERT)
7. Medicaid Integrity Plan (MIP)
8. Medicaid Integrity Group (MIG)
9. Medicaid Integrity Contractors (MIC)
10. Medicaid Inspector General (MIG)
11. Medicaid Recovery Audit Contractors (MCG)
12. Payment Error Rate Measurement (PERM)
13. Program Safeguard Contractors (PSC)
14. Zone Program Integrity Contractors (ZPIC)
The RAC Attack on Healthcare

ADR: Additional Documentation Requests from both the RA and MAC
RAC: Recovery Audit Contractor Requests
CMS/Palmetto: Audits the chart for: Appropriateness of physician documentation, codes and charges
PERM Audits: Payment Error Rate Measurement
Two outcomes:
1. Appropriate
2. Inappropriate

RAC/ADR TARGETED DRG

PIH Top 5 RAC DRG Request
- TIA
- Syncope
- Esophagitis, Gastroenteritis and Misc. Digestive Disorders W/O MCC
- Chest Pain
- Nutritional & Misc. Metabolic Disorders W/O MCC

Prepayment Review Demo (ADR)
- Syncope & Collapse
- Transient Ischemia
- G.I. Hemorrhage
- Diabetes
- Other Vascular Procedures

Top RAC Issue Per Region

Regions A, B & C issues:
Cardiovascular Procedures: (Med Necessity) Medicare pays for inpatient services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.

Region D issues:
Minor Surgery and other treatment billed as Inpatient: (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

Medical Necessity Denials

- CMS denials are primarily based on lack of
  1. Severity of Illness documentation (SOI)
  2. Failure to justify Intensity of Service. (IOS)
- Specific Criteria can show:
  1. SOI Justifies IOS
  2. Inpatient Vs. Observation Status
- Down Coding DRGs
  1. Clinical Validity Scrutiny

*A patient’s share of cost for observation status care is greater than for inpatient status


*March 31, 2013 Data
Medical Necessity Documentation

Example # 1:
Based on the available clinical evidence, this patient’s medical condition, safety and health is at significant risk of deterioration. The patient’s welfare is directly threatened by signs and symptoms of acute and severe...XXX...If further care and work up is provided in a less intensive environment than an inpatient setting.

Example # 2:
Due to the intensity and frequency of the planned treatment...XXX... for this patient, it is imperative it be performed on an inpatient basis for the patients safety and to assure effectiveness of treatment and to avoid an adverse outcome.

XXX= Consistent with Milliman Criteria

Physician Documentation

Physician progress notes should reflect why patient can not return home or be transferred to a lower level of care.

Examples:
- Primary diagnoses has not improved and requires further inpatient treatment.
- New condition developed (describe in detail).
- Chronic condition exacerbation/requires treatment.
- What is the risk to patient’s medical condition, safety or health if discharged.
The Challenges with ICD-10

- **ICD-10**: Will expand from 17,000 codes to 140,000 codes.
- **Clinical Validity**: Evidence in the medical record must support the DRG.
- **Down Coding**: Opportunities for RAC and other auditing agencies to alter service codes to those of a lesser complexity, resulting in less reimbursement.
- **Increased Scrutiny**: Physicians must provide clear, concise, specific and accurate documentation that supports the higher level of specificity of ICD-10 codes.
- **Specificity**: ICD-10 code sets are very specific, providing data that can be analyzed to monitor and measure quality of care for physicians and providers.
  - **Laterality**: ICD-10-Incorporates laterality of conditions or injuries (i.e., left, right).
  - **Site Specific**: ICD-Groups injuries by body area or site of injury and then type.

Recognize the Complexity

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ICD-10 Readiness

- Provide continual education to minimize confusion and loss of productivity.
- Educate physicians and staff about documentation requirements for ICD-10 coding system and provide examples:
  1) Clinical validity  2) Laterality  3) Site specificity  4) CC/MCC
- Review and revise query templates to ICD-10 specifications.
- Support medical record coding to their greatest level of specificity with appropriate CDI language.
- Clarify and correct documentation of diagnoses, CC and/or MCC’s as evidenced by clinical indicators, as it affects the MS-DRG or APR DRG, relative weight’s and length of stay.

CDI Examples:

<table>
<thead>
<tr>
<th>Specific Documentation</th>
<th>Vague Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>•Urinary Retention</td>
<td>•Unable to void</td>
</tr>
<tr>
<td>•Epogen for Anemia of Chronic Disease</td>
<td>•Epogen Order</td>
</tr>
<tr>
<td>•Cachexia</td>
<td>•Waiting, muscle Loss</td>
</tr>
<tr>
<td>•DQ Ulcer and stage</td>
<td>•Decubitus Ulcer</td>
</tr>
<tr>
<td>•UTI Probable 2’ to Foley</td>
<td>•UTI</td>
</tr>
<tr>
<td>•Sepsis probably 2’ to Central line</td>
<td>•Bacteremia</td>
</tr>
<tr>
<td>•HD secondary to ESRD</td>
<td>•HD Order</td>
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CDI Examples: (cont.)

<table>
<thead>
<tr>
<th>Specific Documentation</th>
<th>Vague Documentation</th>
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<tbody>
<tr>
<td>• Head Injury</td>
<td>• Head Trauma</td>
</tr>
<tr>
<td>• Pregnant; Pelvic Pain, Vaginal Bleeding</td>
<td>• Blighted ovum vs. threatened AB vs. complete AB vs. Incomplete AB</td>
</tr>
<tr>
<td>• OB/Pelvic UTZ; for R/O retained Products</td>
<td>• Non OB UTZ for R/O retained Products</td>
</tr>
<tr>
<td>• EKG for Chest Pain</td>
<td>• EKG done without chest Pain documentation</td>
</tr>
</tbody>
</table>

Anatomy of a Successful Strategy

- **Admit Process (CDI + CM)**: Start discharge planning evaluation
- **Post admit review (CDI and CM)**: Thorough screening for criteria
- **Reevaluation of clinical presentation (SOI/ROM)**
- **Reason for status of admit vs. criteria (LOS)**: Reason for continued IP TX vs. DC vs. LLC
- **Assess for coexisting conditions (CC/MCC)**
- **Successful Patient discharge (CM)**: Leads to lower readmission rate and denials
- **Follow up and Rx Medications arranged prior to discharge**
DRG 313 Chest Pain

- CMS Goal LOS: ambulatory -1 day
- Patient will meet Inpatient criteria if experiencing:
  1. Hemodynamic Instability
  2. Pulmonary Edema
  3. Respiratory Distress
  4. Angina with ACS/AMI
  5. Aortic Dissection
  6. Pulmonary Embolus
  7. Tension Pneumothorax
  8. Requires Treatment/Monitoring
  9. Decompensated CC/MCC conditions

DRG 313 Chest Pain (cont.)

- Chest Pain secondary to:
  - Neuromuscular  556
  - Precordial  313
  - Musculoskeletal  313
  - Mid-ternal Chest Pain  313
  - Other Non-Cardiac  313
  - Angina Pectoris  311
  - Pleurisy  204
  - Chest Wall Pain  204
  - Smoke inhalation  206
  - Pleurodynia  195
<table>
<thead>
<tr>
<th>Hemodynamic Instability</th>
<th>Cardiac Arrhythmias</th>
<th>Concerning Rhythms +1</th>
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<tbody>
<tr>
<td>Hypotension/Tachycardia</td>
<td>Post Arrest</td>
<td>Hypotension</td>
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<tr>
<td>Inadequate Hydration</td>
<td>Ventricular Escape Rhythm</td>
<td>Respiratory Distress</td>
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<tr>
<td>Pressor use/poor perfusion</td>
<td>Sustained V-tach</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>Postural VS</td>
<td>(&gt;30 min; HR&gt;100)</td>
<td>Syncope</td>
</tr>
<tr>
<td>HTN (&gt;220/120) or (140/100) +1</td>
<td>Not sustained V-tach</td>
<td>Dizziness</td>
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<td>Encephalopathy</td>
<td>Suspected Cardiac Ischemia</td>
<td>SVT with Chest Pain</td>
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<tr>
<td>AKI/ARF</td>
<td>Or Myocarditis</td>
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<td>Aortic Dissection</td>
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<td>ACS</td>
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<td>LVHF</td>
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<td>Acute Ischemia</td>
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<tr>
<td>Peripheral</td>
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<tr>
<td>Unstable Conduction Defects</td>
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<tr>
<td>Type II 2nd Degree AVB</td>
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<tr>
<td>3rd Degree AVB</td>
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<tr>
<td>New Onset LBBB + Suspected</td>
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<tr>
<td>Ischemia</td>
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General Criteria Affecting SI/IS (cont.)

| COPD Patients                  |                                     |                                     |
| SaO2 < 5% of Base Line (BL)    |                                     |                                     |
| Needs > O2 to Maintain BL      |                                     |                                     |
| PCO2 increase >5% of BL        |                                     |                                     |
| PFR <60% of their prior best   |                                     |                                     |
| Requires >4 TX                 |                                     |                                     |
| Decrease Mobility 2’ to DOE    |                                     |                                     |
| Inability to Eat/Drink 2’ SOB  |                                     |                                     |
| Mental Status Changes          |                                     |                                     |
| Rapid Exacerbation             |                                     |                                     |
| Impending Respiratory Arrest   |                                     |                                     |
Acute Blood Loss (Active Bleeding)
- Hg < 10 g/dL or Hct 30% (Not Baseline)
- Repeat Hematocrit drops ≥ 2%

Severe Anemia +1 “Symptomatic Anemia”
- ALOC/Chest Pain/DOE/Syncope
- Other Findings suggestive of inadequate perfusion

Post Transfusion or Volume replacement doesn't resolve:
- Tachycardia
- Orthostatic Changes (SBP drops >20; DBP drops >10)

High Risk Low Platelets
- Any # < than normal + Severe Bleeding or Hemolytic
- Anemia
- < 20K + any active bleeding
- < 10K + minor purpura
- < 5k

General Criteria Affecting SI/IS (cont.)

Outline the problem:
- Increased scrutiny of medical record documentation
- Clinical vs. diagnostic terms
- Medical necessity
- Clinical validity

Define CDI:
- The process and effort promoting appropriate documentation prior to coding and billing

What is CDI's objective:
- Clear, concise, complete, accurate and specific documentation
- Optimum profile; financial solvency

The Caveat:
- Success depends on physician documentation

The Challenge:
- Physician buy in
### Synopsis 2

<table>
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<tr>
<th>Devise a winning Strategy:</th>
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<tbody>
<tr>
<td>WIIFM</td>
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<tr>
<td>Constant training</td>
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<tr>
<td>Staff support &amp; cross training</td>
</tr>
<tr>
<td>Physician Advisor</td>
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<tr>
<td>ED: CSM/CDI</td>
</tr>
<tr>
<td>Track, trend and target education</td>
</tr>
<tr>
<td>Documentation gap analysis</td>
</tr>
<tr>
<td>Basics of coding rules</td>
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</tbody>
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<tr>
<th>How do you monitor progress?</th>
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<tbody>
<tr>
<td>Decreased queries</td>
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<tr>
<td>CMI</td>
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<tr>
<td>GMLOS</td>
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<tr>
<td>Audits (QA/UM/HIM): Less Denials</td>
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<tr>
<th>ICD 10 Preparedness</th>
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<tbody>
<tr>
<td>General Education</td>
</tr>
<tr>
<td>Gap study: target education</td>
</tr>
</tbody>
</table>

### References:

- Centers for Medicare and Medicaid Services: [www.cms.gov](http://www.cms.gov)
- DRG Expert 2012
- Milliman Guidelines
- ACDIS (Association of Clinical Documentation Improvement Specialist)
- CHIA (California Hospital Information Association)
- AHIMA (American Health Information Management Association).
- [https://www.cms.gov/QualityImprovementOrgs/](https://www.cms.gov/QualityImprovementOrgs/)