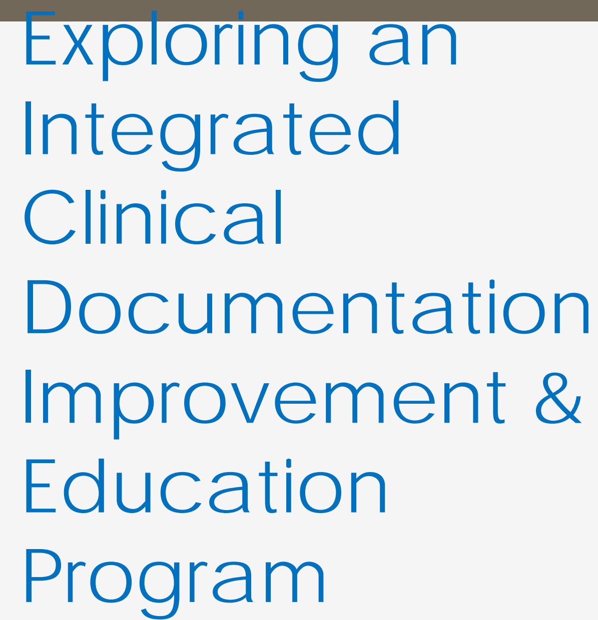
Exploring an Integrated Clinical Documentation Improvement & Education Program



Day, Egusquiza, President
AR Systems, Inc

What does "Integrated CDI' mean- 2 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.
- **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
  - Detailed, diagnosis to avoid queries
  - 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 coming

- 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)

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

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

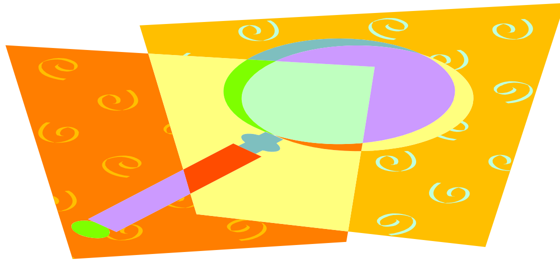
A Fully Integrated CDI Program

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	Pt status	Charge Capture
• Coders back end clean up • CDI specialist – front end, more interactive • Tracking and trending patterns?	• UR/Case Mgr – both front end and back end • Auditors – denial /appeals • Tracking and trending patterns?	• Dedicated staff • Internal auditor – only upon request • Few individual depts doing • Tracking and trending patterns?



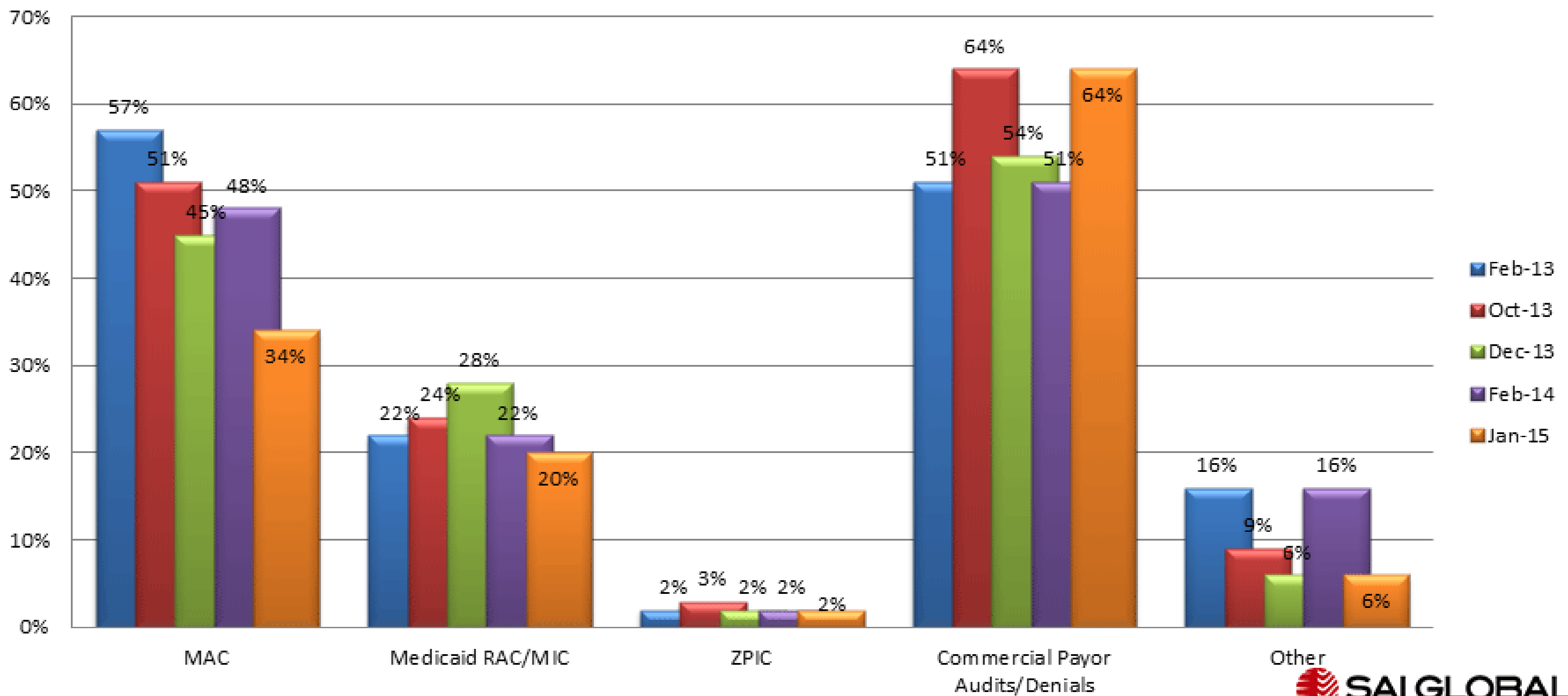
Let's look at how and why to implement an integrated approach

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.
- 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, where are you seeing increase in activity?
2 Year Trend
70%
60%
50%
40%
30%
20%
10%
0%
57%
51%
45%
48%
34%
22%
24%
28%
22%
20%
2%
3%
2%
2%
2%
51%
64%
54%
51%
64%
16%
9%
6%
16%
6%
MAC
Medicaid RAC/MIC
ZPIC
Commercial Payor Audits/Denials
Other
Feb-13
Oct-13
Dec-13
Feb-14
Jan-15
SAI GLOBAL

OPPS 2016 proposed change to definition of an inpt (Budget neutral?)

- 2 MN rule is alive and well
- AND we are looking 'back to the future' with an enhanced definition of '**rare and unusual**.'
- Still use the physician's documentation of 'why an inpt' but if the provider cannot estimate 2 MN /Presumption –then declare an inpt with rationale for 'severity of the condition/intensity of the care' that will require in hospital care. HUGE AUDIT RISK!
- QIO/level 2 appeal group will perform all audits (more peer to peer)
- High volume of 'rare and unusual' flagged for audit = RAC
- RAC lookback to 6 months from date of service/30 days to review=more changes but only with new RACS
- No change to SNF

CMS.gov:Fact Sheet: Two-Midnight Rules 7-1-15

Key elements for Payers- as ordered by providers

ALL PAYERS

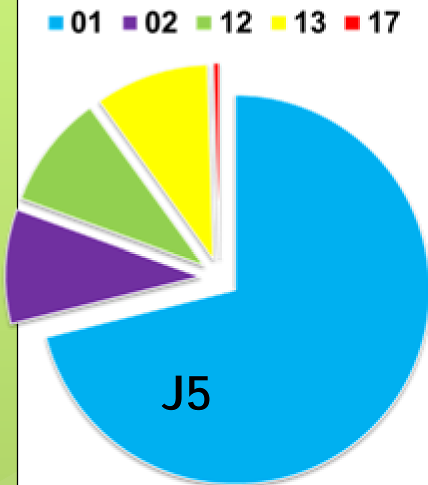
- Admit to inpatient
- Diagnosis
- Reason for Admit/Plan for why an inpt for dx.
- All part of a pre-determined order set.(Ques in the EMR or paper)

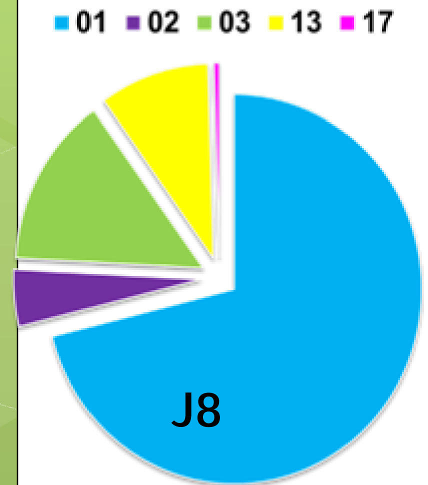
- MEDICARE ONLY
- "Clarify" that the LOS is an estimated 2 MN/Presumption
- "Clarify' that after the 1st outpt MN, a 2nd 'in hospital' MN is required/Benchmark
- After 1-1-15, provider still outlines why the 2 MN, what is the plan that will take 2 MN. No longer 'certify' but still needs to clarify the 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.

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 2nd MN after 1 MN as an outpt – what is occurring with the pt's condition that will 'push the pt' to stay a 2nd 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 1st and 2nd Round P&E





5PC01	Documentation does not support services medically reasonable/necessary
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/2nd 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)	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, VirIsland

- 1st round:
  - 35% denial rate
- 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.

2015

Tell a better, more complete patient story

- Begin with the 1st 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 1st in sending.

Key elements of new 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.

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- **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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- 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.

- 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.

Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

Effective 12-1-13: new use of occurrence span code 72

- National UB committee – Occurrence code 72
  First /last visit dates
- *The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) ……. AND*
- *On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11-20-13)*
- *Per George Argus, AHA, a redefining of the existing code will allow it to be used Dec 1, 2013. CMS info should be forthcoming.*
- *MM8586 ML Matters, Jan 24, 2014 CR 8586*

Key areas to support documentation for pt status

- Admitting physician 'starts the pt story' thru use of the certification 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…

Identify 'place and chase' with UR

- What are the daily hrs of coverage for UR?
- Is there UR in the ER and if so, hrs?
- Have patterns of poor admission orders and action plan to support both OBS and inpt status been tracked and trended? Discharge challenges included.
- What changes have been made to attack the new 2 midnight Medicare rule? Same for all payers?
- Are outpts 'in a bed at midnight' in a dedicated area for ease of tracking? converting if 2nd MN?
- FIND YOUR LOST INPATIENTS!

Step Two: Coding Focus

2) Correct Coding – the 1st 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 then there was ICD -10 CMS – Oct 2015 go live

- "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
- Specialty specific training . EX) Ortho/Jan, ER/Feb, OB/Mar.
- Teach with audited examples, made easy.
- Doctors take lead from hospital = positive message

ICD -10 Continues the Documentation Enhancement Story

- Along with focusing on enhanced documentation to support inpt level of care, the expanded narrative to support ICD 10 conversion continues the 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.

Departments who are impacted by ICD -10 changes

- 1st point of contact =provider offices/dx to get pre-certifications with payers.
- Pre-auth with payers = internal staff, UR
- Medically necessary edit = diagnosis to screen diagnosis against CPT tests to determine if Medicare or other payers will allow. ABN completed with Medicare pts prior to the test.
- Internal IT, scrubber company, payer's IT systems = prior to go live and post go live.
- Concern: Worker's Comp and Liability not covered entities/HIPAA Standard Transaction. Maintain both ICD 9 & ICD10??

More areas impacted by ICD 10

- Lab, Chemo, Imaging, Cardiology, Specialty services = all usually require "medically necessary payer screening" prior to the procedure. Cheat sheets = gone!
- Doctor offices = new encounter forms.
- Rehab = Work comp pre certs. (? ICD 9 & 10)
- PFS = new rejections, new return to provider edits, potential new denials
- HIM/the clean up crew = all payer rejections due to coding, internal issues, more?
- IT decision support = historical to current codes
- Others? = any area tracking by Dx code…more!

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!!

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 2013

- CDI Specialist Education November 2014
- Site visits Leadership, CDI, Nursing, HIM and Physician Education – Dec/Jan 2014
- 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 ICD -10 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 -9 validate while performing ICD -10 readiness , 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.

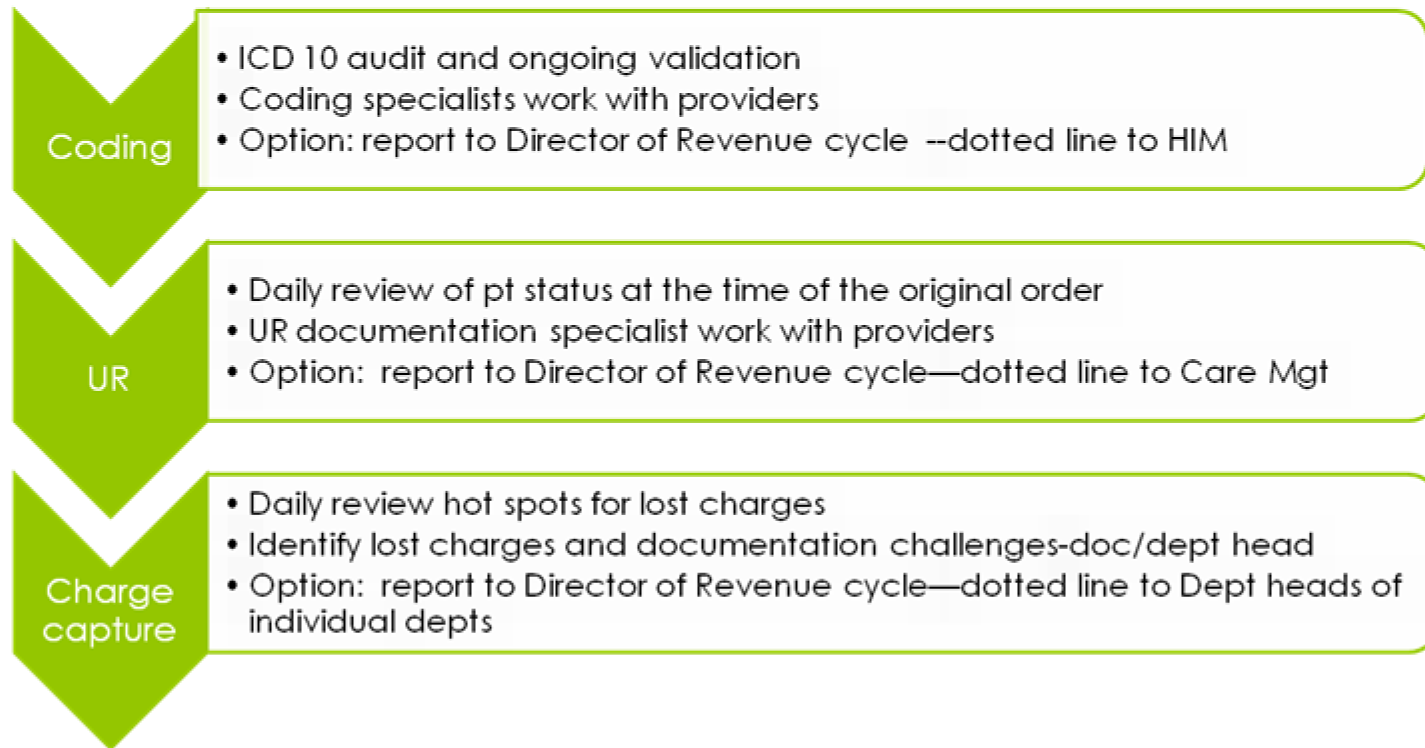
Ongoing physician education looks like….

- 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**- March/focus on ER; April/focus on Cardio; May/focus on Ortho with follow up by ALL the team on a daily basis
- EX) **Inpt status** – Dec/focus on Inpt certification form
- 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



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 2015 RACSummit.com

New web:http://arsystemsdayegusquiza.com

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