OPTUM®

Leveraging a PA with CDI to Tell a Story of Acuity

Learning Objectives

- Understand the PA role with regard to coding accuracy.
- Learn how to ensure acuity is properly documented.

AHIMA Comments on PA role in CDI *

- "In general, the Physician Advisor acts as a liaison between the CDI professional, HIM and Hospitals' medical staff to facilitate accurate coding, DRG assignment and representation of severity, acuity and risk of mortality."

- "The advisor is also in charge of educating specific medical departments (e.g., internal medicine, surgery, family practice) at department meetings regarding the importance of complete and accurate disease reporting for physician performance profiling, physician E&M payment and pay-for-performance and appropriate reimbursement and profiling for patient care."

- "The Physician Advisor should work with the HIM and CDI personnel on a routine basis to review selected health records concurrently or retrospectively. The advisor should explain documentation issues found in chart review including common issues such as congestive heart failure, kidney disease, urosepsis, pneumonia, anemia and respiratory failure."

OPTUM®

* AHIMA. "Guidance for Clinical Documentation Improvement Programs." Journal of AHIMA 81 no.5 (May 2010): expanded web version.

Why a Physician Advisor for CDI?

- If trained extensively in CDI principles:
  - Physicians respond to physicians in a different way – can converse about the case as peers in a non-leading way
  - Physician to Physician conversations - serve to re-inforce solid documentation principles because physicians learn well through case – reinforcement
  - Supports the CDI program

Why a Physician Advisor for CDI?

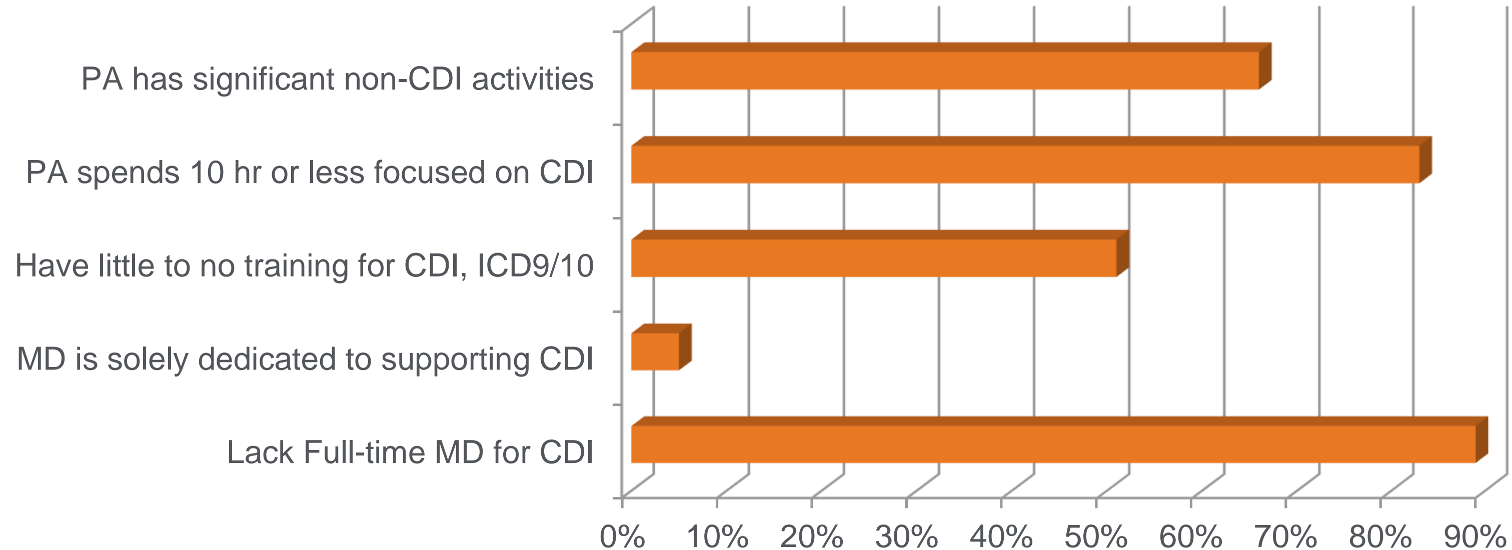
- Help to make sure that documentation can be supportive as RAC, MAC, Commercial Payer DRG Denials are increasing with the reason being "not clinically supported"
  (The fact that the doctor writes a diagnosis does not mean that it is supported in the chart)
- Elevates documentation practices that mitigate vague, incomplete and conflicting information from CDIS to physicians to coders
- Help queries to be more effectively and expeditiously answered as the peer to peer engagement can bridge the gap in documentation interpretation
- Serve as an advisor to Clinical Documentation Specialists and coders
- Aid in ongoing physician education

Value Added by Physician Advisor (examples)

- Physician review adds value:
  - Patient with pneumonia—physician advisor notes history of swallowing difficulties and use of antibiotic with anaerobic bacteria coverage (not typically used for pneumonia)—discussion with treating physician clarifies diagnosis of aspiration pneumonia
  - Patient with acute renal failure—physician advisor notes presence of granular casts in urinalysis (not usually seen in urine)—discussion with treating physician clarifies diagnosis of acute tubular necrosis
  - Patient with gunshot wound—physician advisor notes low blood pressure on arrival, decreasing hemoglobin level, and blood transfusion—discussion with treating physician confirms clarifies diagnosis of hemorrhagic shock

Physician Champion/Physician Advisor for CDI

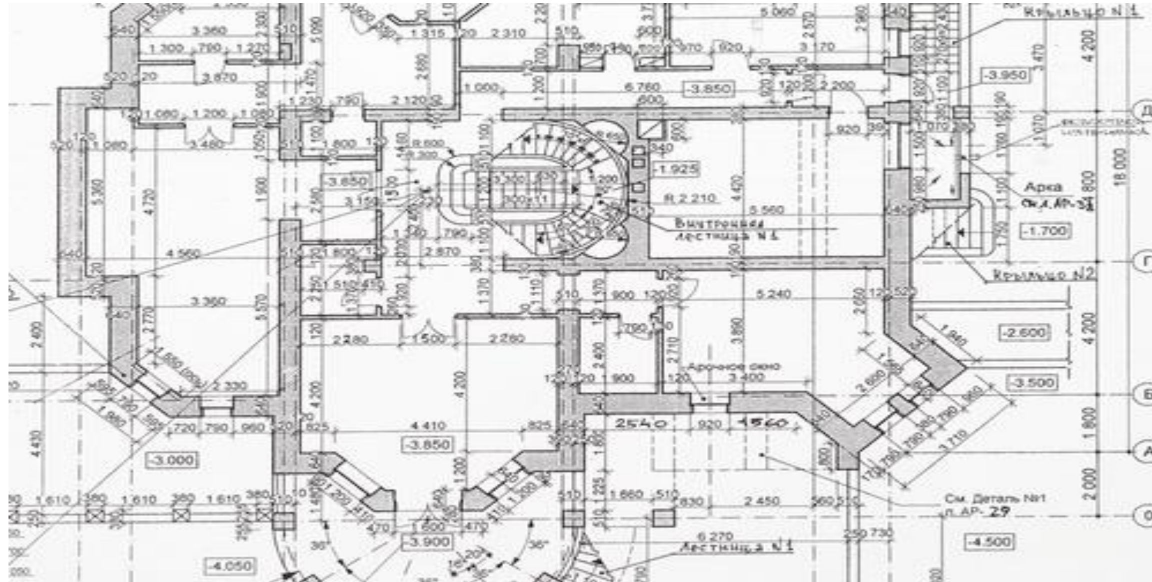
- **Country-wide findings based on survey results**
  - 1088 respondents



The Battle We Face

Setting the Stage

What the Auditors Expect



Accuracy and Specificity

What Typically is Provided

Defining Medical Necessity

- A medical record is considered complete by CMS if it contains sufficient information to
  - Identify the patient
  - Support the diagnosis/condition
  - Justify the care, treatment, and services
  - Document the course and results of care, treatment, and services
  - And promote continuity of care among providers
- With these criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R47SOMA.pdf

Typical Goals for CDI Departments

- The goal of CDI is usually to facilitate clear, concise, clinically accurate information in the medical record through the **identification of incomplete, vague and/or missing diagnoses** allowing "capture" of all applicable diagnoses by codes to reflect:
  - Medical necessity
  - Accurate reimbursement
  - Quality of care/services provided
  - Coding reflective of the provider's intent
  - Patient severity of illness/risk of mortality
  - Appropriate hospital and physician profiles

Conducting the Chart Review

- In order to allow for accurate coding, provider documentation should clearly **identify** those conditions/diagnoses that support the hospital resources provided to the patient:
  - Clinical evaluation
  - Therapeutic treatment
  - Further diagnostic studies, procedures, or consultation
  - Extended the length of stay
  - Increased nursing care and/or monitoring
- Unfortunately, provider documentation typically describes the symptoms associated with a condition, which doesn't translate well into coding nor support inpatient medical necessity

Challenges With Physician Documentation

- Physicians do not document the acuity with which patients present
- Physicians document for other physicians
- The EMR has not been the magic sauce, the answer to the problem
- Physicians assume that others understand
- Many times not aware of affects on quality measures
  - This is significant
- The question always asked: “Did they not learn this in Medical School?”

NO

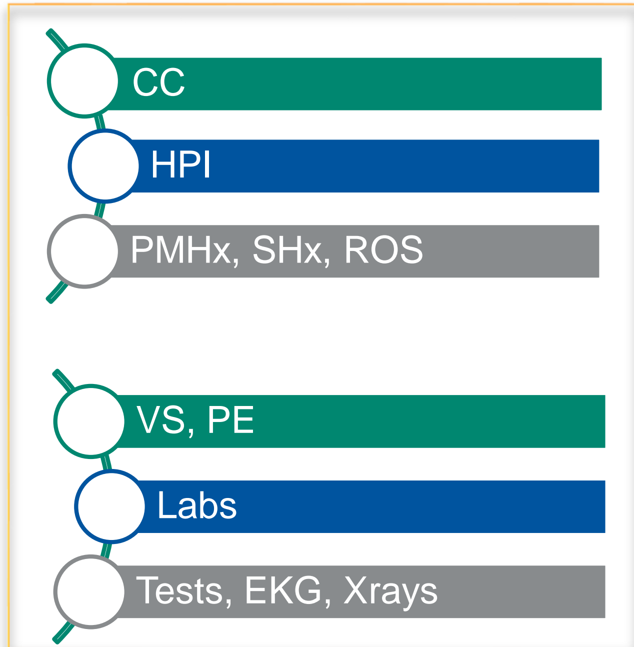
- When is the last time that Documentation Guidelines were updated by Medicare?

1997

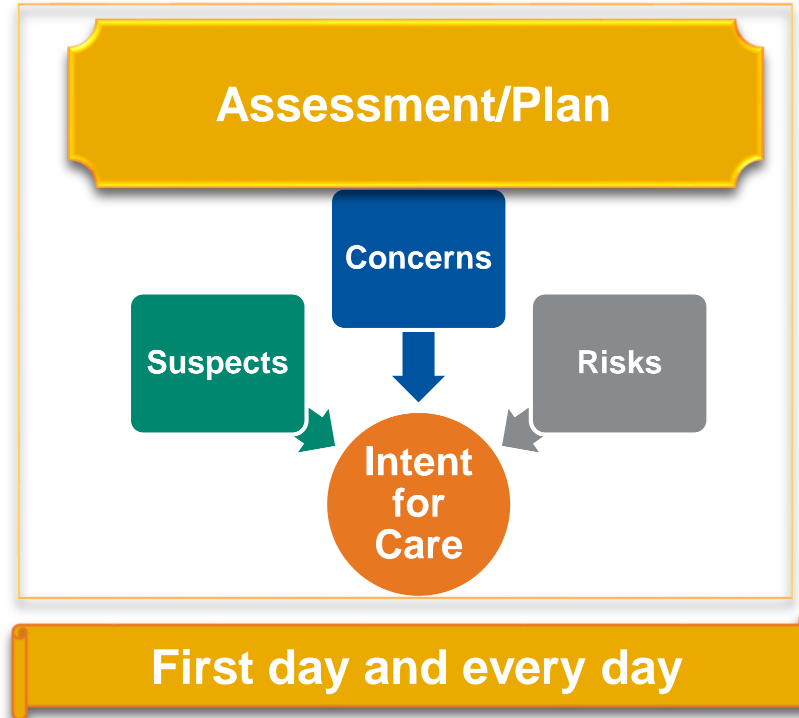
Where Do We Start?

- Right from the beginning:
  - History and Physical
    - Tells the story
    - Sets the acuity
    - Provides the clinical data and story
    - Defines the plan of care
  - But does it really?

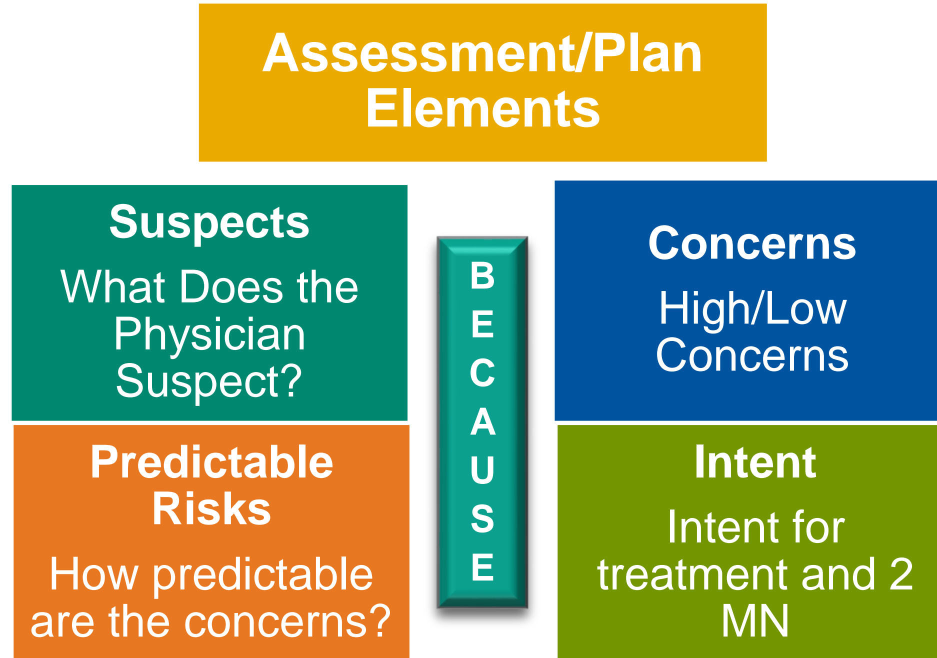
History and Physical – Tells a Story



Physician



A/P – The True Story



Integrated Process Summary

UM

- Is the patient status correct?
- Supported by the appropriate order
- Must be performed in a timely manner

CDI/Coding

- Clinical Documentation to support codes used
- Concurrent reviews
- All the more important with ICD-10 coming

Reasons for a Physician Advisor

- Limited Resources
- Better Documentation looked at from both angles
- Goal to reduce denials on the front end instead of dealing with them on the back end
- Proper documentation is where it belongs in the chart instead of depending on the content of the entire chart

Results

- Increased accuracy and specificity
- Capturing risks and concerns to justify LOC
- Better quality measures as we move to reimbursement for quality and outcomes instead of volume
- Better patient safety and care

OPTUM®

Thank you, questions?

John D. Zelem, MD, FACS

Vice President; Compliance and Physician Education (ACE)

(484) 362-1967

john.zelem@optum.com

Confidential property of Optum. Do not distribute or reproduce without express permission from Optum.