Q&A CDI WEEK CDI & Quality

As part of the eighth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Mindy Davis, RHIT, CDIP, CCS,*** director of HIM and CDI at Rutherford (North Carolina) Regional Health System in Rutherfordton, a member of the North Carolina chapter of ACDIS, and a member of the 2018 CDI Week Committee, answered these questions. Contact her at *mindy.davis@rutherfordregional.com*.

Q Can you describe the relationship of CDI to quality initiatives, and how CDI can make a difference?

A CDI and quality are becoming more and more intertwined. A lot of organizations are realizing that CDI may be in the best position to first recognize quality opportunities within the chart documentation. To that end, CDI can have a profound effect on an organization's quality initiatives.

The most important way CDI can make a difference is to broaden their thinking beyond DRG assignment and CC/MCCs. Not that these topics aren't important, because they most definitely are. However, once CDI specialists are also educated on quality initiatives such as value-based purchasing and how what is being documented (or not documented, as the case may be) can affect overall performance, the CDI team truly becomes even more of an essential asset to the organization.

Q When did your CDI program start getting involved in looking at quality-related documentation concerns, and what was the impetus for the evolution?

A My organization's CDI program has been informally involved with looking at quality-related documentation concerns since early 2016. The initial drive for this was that it was becoming more and more obvious that CDI had the most thorough real-time snapshot of our patients' clinical picture.

Q According to the 2018 CDI Week Industry Survey results, roughly 28% of respondents feel that reviewing for quality measures has hindered their productivity. Has this been the case in your experience? If so, how have you dealt with it?

A It is great to see that only slightly more than one-quarter of respondents feel as if review of quality measures is hindering their productivity, although I am a bit surprised to see it this low. It has been my experience that quality reviews do affect CDI productivity. However, as a CDI program manager, I also think it is my responsibility to consistently demonstrate the

potential positive impact quality review work has on an organization's performance. This is important to communicate not only to hospital administration as it relates to productivity performance and full-time equivalent (FTE) allotment, but it is also important to communicate to the CDI specialists themselves. Everyone appreciates seeing the measurable results of their hard work.

Q Does your CDI department query if it will only affect a quality measure rather than reimbursement? Why or why not?

A Yes. Our CDI program will query on anything significant discovered in the review process which requires further clarification, regardless of whether or not it affects reimbursement.

Q Has your CDI program's mission statement evolved as you've started reviewing for quality measures?

A We haven't had a formal change to our CDI program's mission. It is more fitting to say we are conducting chart reviews from a more holistic perspective rather than from the aforementioned sole focus on DRG/MCC/CC capture.

Q Have ongoing changes in CMS and other payer reimbursement models pushed CDI program involvement with quality forward?

A Yes, most definitely. As the focus intensifies on various pay-for-performance metrics and healthcare quality indicators (value-based purchasing, Hospital Compare, Hospital-Acquired Conditions [HAC] Reduction Program, etc.), the need for CDI involvement also intensifies. I do not anticipate the need for CDI involvement reducing any time soon.

Q Conversely, have recent administrative efforts in CMS lessened the urgency with quality efforts (reductions/consolidation of measures, reduction of administrative burden efforts)?

A No. We haven't seen a decreased sense of urgency. While some of the administrative efforts within CMS may have resulted in consolidation of how certain criteria are measured and reported, it hasn't necessarily resulted in less time being required of the CDI and quality teams in order to accurately capture the needed data. I would love to talk with anyone who has experienced a reduction!

Q What first steps do you think CDI program managers and/or staff members can take to expand into quality?

A The first step is education. Many CDI staff members are newer to the profession and may not necessarily be coming from a background in which they are accustomed to being involved with the various quality metrics.

The same may be true for CDI program managers, too, if their reporting structure does not flow through the quality umbrella. It takes time to understand the sheer volume of the various quality reporting mechanisms that exist and how to move the needle with any of them.

It is also important to mitigate frustration along the way. Since many of the CMS quality measures are reported on old (prior years') data, it can sometimes feel as if CDI specialists' current efforts don't have as great an impact as the immediate financial gains associated with the aforementioned DRG/CC/MCC capture. Again, it takes time!

Q How has your CDI team's relationship with the quality department evolved over time? How do you avoid stepping on each others' toes with reviews?

A Our CDI team's relationship with quality has grown stronger and more effective over time. It is very helpful to work with team members who have a true desire to learn. It also goes a long way when various team members can recognize each other's strengths and when they can add value to certain situations.

For example, when CDI is engaging with a physician over a difficult sepsis case, it is refreshing to hear them say, "let me consult quality. They're experts on sepsis indicators."

Conversations like these reassure me that the best clinical picture of our patients is being captured regardless of who happens to be in the best position at the given moment to provide the information.

Q What was the most rewarding and most challenging aspect of your team's efforts when it comes to quality reviews?

A The most rewarding aspects have been when CDI, quality, and coding have been able to come together as a cohesive team knowledgeable and supportive of each other's objectives.

The most challenging aspect has been the ongoing need for physician education as it relates to what they perceive as nuances in their documentation.

These nuances can at times have a significant effect on quality metrics.

Q How do you see quality in the greater healthcare industry evolving and what can CDI do to prepare?

A The focus on quality within healthcare will continue to increase as more and more data becomes available to both payers and consumers. CDI can best prepare by continuing to focus on education beyond the traditional CDI focus areas, even if their current positions do not currently call on them to use this knowledge in their daily work.

It is also helpful to have a collaborative disposition when working with all other departments. There is always something new to learn within healthcare.

Sheri Poe Bernard, CCS-P, CDEO, CRC, CPC, is the author of the AMA's 2018 publication, Risk Adjustment Documentation & Coding, and a principal consultant at Poe Bernard Consulting based in the Salt Lake City area of Utah. She has 20 years of healthcare information management experience with expertise in Medicare Advantage, CMS compliance, ICD-10-CM/PCS implementation, Current Procedural Terminology® coding, and the healthcare procedural coding system. Here, Bernard discusses the shift from pay-for-service to pay-for-performance reimbursement and how it affects CDI work.

The time for CDI training is now. Underreporting patient diagnoses is going to increasingly pinch physician payments as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ramps up. CMS has replaced the value-based payment modifier payment program with the Alternative Payment Models and the Merit-based Incentive Payment System (MIPS). MACRA looks at Medicare spending per beneficiary (MSPB) and total per capita costs to determine the efficiency of patient services in yet another trend toward risk-adjusted compensation. Diagnoses used in these calculations are based on the CMS-HCC model used in the Medicare Advantage risk adjustment program.

CMS will calculate bonus payments or penalties straight from submitted administrative claims data. While this change simplifies physician and facility reporting, MACRA also increases the burden of documentation and correct code abstraction for physicians.

For example, diabetes with diabetic complications carries triple the risk adjustment weight of uncomplicated diabetes, meaning patients with diabetic complications have historically required significantly more resources than patients without complications. If resources are being expended for a patient with unreported or underreported complications of diabetes, Medicare will assume that the physician has overspent for services based on the patient's health status.

Documenting and reporting severity of illness, always a medico-legal imperative, now becomes essential to protecting a physician's income. Even so, simple changes to physician documentation can capture the appropriate morbidity of a diabetic patient. Streamlined documentation is addressed for risk-adjusting conditions in the AMA 2018 publication, *Risk Adjustment Documentation & Coding:*

Address all complications of diabetes with qualitative language that documents the extent or severity of the complication; e.g., "diabetic neuropathy has progressed to loss of protective sensation (LOPS)." Document any status resulting from diabetes. Ensure that the patient's vision loss, amputation, or dialysis status is documented during the encounter at least once a year.

Hyperglycemia is no longer considered a symptom of diabetes and should be noted in the medical record when it exists, as it is a complication of diabetes that changes the HCC. Similarly, document any hypoglycemia. State the obvious. Do not document "BG of 495." Instead, document, "patient's blood glucose indicates hyperglycemia at 495." Coders cannot code from laboratory values. Documented "poorly controlled" or "out- of- control" DM is reported as hyperglycemia, according to the ICD-10-CM Alphabetic Index. Documented "uncontrolled" diabetes is insufficient information for coding, as it could indicate hyper- or hypoglycemia and defaults to diabetes without complication.

Complete capture of chronic conditions also becomes essential in risk-adjusted programs. For example, if the diabetic patient also has a diagnosis of congestive heart failure (CHF), the CHF should be addressed in the encounter. Not only does CHF carry its own risk adjustment value, but the interaction between diabetes and CHF carries additive weight. These chronic conditions must be carried from the problem list or past medical history into the notes for the encounter being currently documented.

MACRA bonuses are paid two years following the claim data year. Payments in 2020 will be based on this year's claims. CMS has allowed a transition period to ease implementation of MACRA for practices, and risk-adjusted cost has been omitted from calculations for this year.

Beginning next year, and for payments in 2021, about a third of a 7% bonus or penalty (9% in 2022) will be based on MSPB and associated costs. That 7% or 9% potential bonus also translates into a 7% or 9% deficit for underperformers under MIPS, meaning the total bonus risk is closer to 14% or 18%.

Understanding which diagnoses risk-adjust makes sense in today's payment landscape. *Risk Adjustment Documentation & Coding* is directed to physicians seeking to fine-tune their note-taking to ensure risk-adjusting diagnoses are correctly captured and abstracted from the medical record.