Q&A

CDI and quality

As part of the ninth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Keri Miller, RN, BSN, CCDS, a CDI specialist at McLaren Healthcare in Lansing, Michigan, a member of the Michigan ACDIS local chapter, and a member of the 2019 CDI Week Committee, answered these questions. Contact her at *kerimiller2010@gmail.com*.

For more information about CDI quality reviews, read the *2019 CDI Week Industry Overview Survey Report* today.

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

A I have been a CDI specialist for three years, and quality-related documentation has always been a top concern. The severity of illness (SOI)/risk of mortality (ROM) statistic has been a key focus area and program metric, as these help illustrate the true picture of the patient's illness with more specificity. As more patients choose where to get their healthcare, it is important that our publicly reported data reflects the quality of care provided at our institution.

Q According to the 2019 CDI Week Industry Survey results, 25% of respondents feel that reviewing for quality measures has hindered their productivity, and only 18.08% of respondents said their staffing increased with the added responsibility. Has this been the case in your experience? If so, how have you dealt with it?

A CDI, as a profession, must keep evolving to accommodate the ever-changing healthcare reimbursement system. It's a system that is changing to focus not only on the volume of service, but the quality of the services provided. The main goal of CDI at McLaren Healthcare is accurate, complete and compliant documentation. Our productivity goals take queries for quality indicators into consideration. Investing in the education of physicians, spending the time to discuss frequent documentation issues or upcoming changes, can really pay off in the end and help CDI staff save time and improve productivity.

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

A Yes. CDI has the ability to affect so much more than just hospital reimbursement. The quality measures that we can identify and properly report can affect many different areas pertaining to community health. Accurately reporting diseases and Hierarchical Condition Categories (HCC) can help community organizations gain access to grants to further identify and diagnose these issues. Statistics gained from medical

documentation help cities identify the medical needs of the community.

Quality measures are also vital in painting the picture of the health of the individual that was treated. Not every sepsis patient or chronic obstructive pulmonary disease (COPD) patient is the same. The resources used are different depending on CCs/MCCs and severity indicators. The outcomes reported for these patients directly reflects the hospital's ratings, which are available to the public. As more people use these resources to choose healthcare organizations, it is important for hospitals and healthcare centers to accurately reflect the quality of care they provide.

Q More than half (58.65%) of Industry Survey respondents indicated that their CDI program performs mortality reviews separately from their regular chart reviews. Does your CDI team review mortality cases? Why or why not?

A Yes, our CDI auditors do the mortality reviews after the frontline CDI specialist is completed with the chart. They are responsible for making sure all the diagnoses are accurately captured for accurate SOI/ROM and risk adjustment.

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

A Managers need to make sure they stress the importance of capturing documentation for quality-of-care measures and make that a priority for staff. Then they need to provide continual education to CDI staff and physicians that covers quality more in-depth. CDI staff need to not only understand what diagnoses can affect quality, but also be able to identify opportunities to link conditions to better affect risk adjustment and severity of illness to help capture the full picture of the patient's care.

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 aspect of quality reviews is the effect it has on risk adjustment and knowing that you, as a CDI specialist, have the ability to ensure the accuracy of the reported data that reflects the quality ratings of your organization. I am proud to work for a hospital that provides quality care, and I have been a part of helping McLaren report its success through proper diagnosis capture through quality reviews.

The challenge of quality reviews is finding a balance between accurate documentation and over-querying physicians. The best way to avoid query fatigue is to determine if the diagnosis has any effect on SOI/ROM or code assignment. Proactive physician education regarding linked diagnoses and quality indicators can also be helpful.

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

A Pay-for-performance, the Hospital-Acquired Condition Reduction Program, and value-based purchasing are becoming increasingly linked to hospital reimbursement. Capturing quality indicators and HCCs will become increasingly vital to an organization's success, just as CC/MCCs have been for a long time. Also, as denials are becoming more commonplace, it is important that CDI strives to focus on clinical validation and accuracy of documentation.

Sheri Poe Bernard, CCS-P, CDEO, CRC, CPC, is an author of AMA's publication, *Risk Adjustment Documentation & Coding*.

The time for clinical documentation improvement 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 (APM) 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 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.
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> 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 is also 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 a 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 currently documented encounter.

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.