Nuts and Bolts: CDI Program Proficiencies

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Hometown Health – HCCS

Hospital Consortium Project:
Track 1: Nuts and Bolts of CDI Proficiencies

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Disclosure of Proprietary Interest

Learning Outcomes

By the end of this session, attendees should be able to:

- Identify what is CDI and why is it important
- Describe CDI Ethics and Compliance
- Establish knowledge base of CDI; Necessity driven (IP/OP)
- Identify official guidelines for coding and reporting
- Define Medical Record documentation
- Identify contents of the legal medical record

Learning Outcome Standard: This program is based on compliance guidelines set forth by entities like, but not limited to: AHIMA, ACDIS, CMS, The Joint Commission, and Local FI/MACS.
Defining CDI and specifically CDI in rural facilities

The universal question - Why does it even matter?

CDI starting with the basics, and redefining how to benefit your facility

CDI bridges the gap between clinicians and coding

CDI specialists interpret clinical findings, nurses notes, providers to ensure proper coding can take place

Work closely with various departments to identify opportunities

Think translator!

Providers aren’t taught this in school

CDI specialists help fill the gap promoting documentation that is:

- Complete, Consistent, complete, non-contradictory

What does best in a CDI specialist role?

- Level playing field
- Coder background, RN background, other
What is CDI and why is it important

- Issues pushing CDI Specialists to the forefront include:
  - ICD-10-CM/PCS Implementation
  - Government Healthcare Reimbursement Initiatives
  - Pay for Performance
  - VBP (Value Based Purchasing)
  - Medical Necessity Denials
  - ACO’s (Accountable Healthcare Organizations)

Ethics and Compliance

- Why is CDI compliance imperative
- Defining Policies and procedures
  - Adoption of ACDIS or AHIMA Code of Ethics and Best Practices
- Adopting a Query Process and standard Query Template/s
- Using Pepper report tools for CDI
Ethics and Compliance

- Quality Assurance Audits
- What is DRG Creep?
- Cautions of up coding and under coding

Every encounter stands on its own....

CDI; Necessity driven (IP/OP)

CMS provides a specific definition under the Social Security Act:

... no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

- Impacts to Outpatient Accounts
- Impacts to Inpatient Accounts
- The CDI’s role in Medical Necessity
Nuts and Bolts: CDI Program Proficiencies

Official guidelines ICD-10-CM for Coding and Reporting Purposes

Locating the ICD-10-CM Guidelines


ICD-10-CM Guidelines are the rules that govern coding
- Importance for CDI proficiencies
- Updated Annually October 1st
- The "Playbook" Purpose
  - Correct Sequencing Guidance
  - Guidelines and rules
Official guidelines for Coding and reporting

General
ICD-10-CM Guidelines
located here

- Guidelines definition of “Provider”
- Signs and Symptoms
- Combination Codes
- Late Effects
- Possible and Probable Diagnosis

- Complications of Surgery and Care
- Comparative and Contrasting Conditions
- What trumps what; Chapter specific Guidelines vs. General?
- Application of the Principle Diagnosis (PDX)
A. 19. Code assignment and Clinical Criteria
The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Code all clinically significant conditions (IP – UDDS)
All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:
- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs

Documentation for BMI, Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale
For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stages, coma scale, and NIH Stroke Scale, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, the patient’s attending provider should be queried for clarification.

The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.
Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services: H

Uncertain Diagnosis

Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Section III. Reporting Additional Diagnoses: C

Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Chapter Specific

ICD-10-CM Guidelines
Chapter 1a.

Human immunodeficiency virus (HIV)

Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

Chapter 1.a.2.a.

- a. Patient admitted for HIV-related condition
- b. Patient with HIV disease admitted for unrelated condition
- c. Whether the patient is newly diagnosed

Sepsis, Severe Sepsis, and Septic Shock

Starting with SIRS....

- Defining SIRS
- What is it?
- Why is this important for CDI?
- Can’t be first listed DX Code (PDX)!
Sepsis, Severe Sepsis, and Septic Shock

Sepsis or Septicemia...
- Defining Sepsis/Septicemia; what is it?
- Understanding Severe Sepsis

Septic Shock ....
- Defining Septic Shock; what is it?
  Moving onto what the guidelines say....

The systemic infection should be sequenced as the PDX
The localized infection is sequenced as the secondary code
There are exceptions! (i.e. the MD documents the sepsis after admission.
"Urosepsis" term use is out of commission!

(a) Sepsis
For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.
A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.
Sepsis, Severe Sepsis, and Septic Shock

A. (i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

(b) Severe sepsis

The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

Pressure Ulcers

Defining Pressure Ulcers; what are they?

Documentation wise what is needed?

- Site, laterality, stage
- Nurses notes and wound care notes, as documentation source
- What we do need from the MD

Consider Present on Admission indicators, quality initiatives, etc.

Unstageable pressure ulcers

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).
Pressure Ulcers

Documented pressure ulcer stage
Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

Patient admitted with non-pressure ulcer that progresses to another severity level during the admission
If a patient is admitted to an inpatient hospital with a non-pressure ulcer at one severity level and it progresses to a higher severity level, two separate codes should be assigned: one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay.

Sequencing of acute respiratory failure and another acute condition
When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses equally meeting the definition for principal diagnosis (Section II, C.) may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.
Present on Admission (POA) Indicator Guidelines

- Defining what a POA is, and the purpose
- What the Guidelines state:

...The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis...

Present on admission is defined as present at the time the order for inpatient admission occurs—conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

- POA indicator is assigned to principal and secondary diagnoses
- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

Reporting Options

- Y - Yes
- N - No
- U - Unknown
- W - Clinically undetermined
- Unreported/Not used - (Exempt from POA reporting)

Reporting Definitions

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission
- U = documentation is insufficient to determine if condition is present on admission
- W = provider is unable to clinically determine whether condition was present on admission or not
There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. The provider must use their best clinical judgment to determine if the condition was present on admission or not, based on the applicable POA guideline as identified in this document, or on the provider’s best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Official guidelines for Coding and reporting

**Timeframe for POA Identification and Documentation**

Understanding the why……

- CDI can uncover the POA mystery while the patient is still in house
- CDI has the expertise to know when to concurrently query to the correct POA
- CDI can help the hospital lower its complication scores
- CDI can ensure a complete medical record at the time of discharge

**Group Example # 1**

A patient arrives to the ED and is admitted as an inpatient for pneumonia. The patient is bed ridden, and also has a pressure ulcer noted by the MD on the progress notes, and was addressed during the stay, including the discharge summary.

**What query would the CDI professional have?**
Group Example # 2

Clinical Validation is a function of the Coder

True or False; rational...

Group Example # 3

On an inpatient discharge the provider states probable pneumonia.

Would the CDI professional query this based on the guidelines we reviewed?

Group Example # 4

A patient arrives to the ED and is complaining of cough, and chest pain. The MD orders a chest X-Ray and on admission to observation overnight, the MD states probable viral pneumonia.

Is this something the CDI specialist would consider querying?

How would coding interpret this diagnostic statement?
Group Example # 5

In reviewing the medical record the CDI specialist sees the provider noted Urosepsis. The CDI specialist would consider this a documentation issue and provide education and query the provider?

Y/N

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Individual Example # 1

Review Page 14 of 114 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2018; Signs and Symptoms. The patient is discharged with diagnosis of COPD, pneumonia, DM, and was treated symptomatically during the stay. CDI notes cough was noted on the ED physician notes, would this be appropriate as an secondary diagnosis code?

Y/N, rational...

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Individual Example # 2

Review Page 18 of 114 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2018; Use of Sign/Symptom/Unspecified Codes. Consider this, a patient admitted for Emphysema. Patient also is treated for his DM Type 2 (on insulin), Hypertension (on Lisinopril), and Hyperlipidemia (on Lipitor). Knowing that the MD does not state what type of Hyperlipidemia (i.e. mixed, familial, group, etc.), would the CDI specialist query the MD concurrently to obtain specificity?

Y/N, Rational...
Individual Example # 3

Review Page 113 of 114 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2018; POA Reporting Options and Definitions. Consider this scenario; a patient is admitted to the hospital for coronary artery bypass. Postoperatively he develops a pulmonary embolism.

Assign the POA

Individual Example # 4

Review Page 113 of 114 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2018; POA Reporting Options and Definitions. Consider this scenario; after review of this Medicare account, the CDI professional has determined that U POA is most appropriate based on the concurrently reviewed documentation.

What would be the most appropriate action?

A. no action, coding will apply the U POA
B. Assert the MD document Y (yes) POA via query
C. Query the provider to the POA status

Defining the Attending Provider

- Remember what ICD-10-CM Coding Guidelines state!
- What about...?
  - Nurse Practitioners
  - Physician Assistants
  - Physical Therapists
  - Dieticians
  - Nursing

Why is this important to a CDI Specialist?
The medical record is the source document for coding.
- Medical records contain a variety of reports.
- These include the following:
  - Reason the patient came to the hospital
  - Tests performed and their findings
  - Therapies provided
  - Descriptions of surgical procedures
  - Daily records of patient progress
- The discharge summary provides a synopsis of the patient's stay.

Coding Accuracy is based on provider's documentation
- It is important to not only define “who” the provider is defined as,
  but more importantly what parts of the medical record can be
  used for query purposes, and coding alike.
- What parts are important to coding and CDI alike?

Provider Documentation (Primary)
- H&P
- OP Notes
- Progress Notes
- Orders
- Consultant Dictation
- Discharge Summaries

Non-Provider, other Documentation
- Nursing Notes
- Ancillary staff notes
- Radiology reports*
- Pathology*
- Laboratory results
Example # 1

The patient is experiencing muscle weakness and fatigue, and the MD ordered labs to validate the potassium levels. In reviewing the lab values on a patient the CDI professional sees the lab values came back low at 2.5 mmol/L.

Would it be appropriate to assume hypokalemia would be supported?

Test your Knowledge  Test your Knowledge  Test your Knowledge  Test your Knowledge

Example # 2

A nurse documents the patient has CHF and is on long term medications.

Test your Knowledge  Test your Knowledge  Test your Knowledge  Test your Knowledge

Example # 3

Consider this; a patient is transferred from another hospital to a higher level of care. The patient’s outside documentation was sent on transfer. Would it be appropriate to consider this information as part of the record for purposes of CDI and Coding?

Y/N, rational.
Consider this: is it appropriate to see frequently by a certain provider diagnosis only documented within the discharge summary?

Y/N, rational...

A CDI Professional should only focus on Inpatient admissions?

Yes/No; rational...

Learning Outcomes

Now that this session is complete, attendees should be able to:

- Identify what is CDI and why it is important
- Distinguish CDI Ethics and Compliance
- Establish knowledge base of CDI; Necessity driven (IP/OP)
- Identify Official guidelines for Coding and reporting
- Define Medical Record documentation
- Define the attending provider
- Identify contents of the legal medical record
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