Clinical Documentation Improvement (CDI)
Outpatient Services

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Overview

- History & Purpose
- Impact on ICD-10
- Why CDI for Outpatient Services
- SHC Plan for CDI Implementation
  - Assessment/Site visits/Education
  - CDI Focused Reviews and roll out criteria
- CDI on Outpatient Services prior to ICD-10
  - CDI Query TAT
  - # of Queries
- CDI and Coding on Outpatient Services post ICD-10
- Post ICD-10 CDI program implementation evaluation; Query TAT, # of Queries, & Coder Productivity & Quality
- Summaries – Benefits of CDI
  - Impact on Revenue Stats
- Questions

CDI HISTORY & PURPOSE
CDI History & Purpose

• Increased demand for accurate and timely clinical documentation

• Industry initiatives for greater specificity for payers, Meaningful use, Accountable Care Organizations and Compliance requirements

Shriners History

• SHC overview
  ➢ SHC System
  ➢ SHC Specialties
  ➢ New to Revenue Cycle – 2010
  ➢ New to Regulatory requirements

Impact of ICD-10
Impact of ICD-10

- International Classification of Disease (ICD) developed by World Health Organization with substantial physician participation
- ICD-9 has been in use in U.S. since 1979
- ICD-10 was approved by WHO in 1990 and first implemented in the United Kingdom in 1996
  - United Kingdom, Norway, Belgium, Finland, Iceland, Denmark, Sweden, France, Canada, Australia and Germany use it for case mix and some reimbursement

Why CDI for Outpatient Services?
Why CDI for Outpatient Services?

- Better Statistics
- Increasing regulatory and compliance requirements
- Need to improve clinical documentation and physician orders for quality, coding, and compliance
- Without the appropriate level of documentation, encounters cannot be coded and submitted for reimbursement due to ICD-10

SHC Assessment

SHC Plan for CDI Implementation

- Revenue Cycle Initiative
- Assessment
- Hospital Visits and Interviews with key personnel
  - Key findings and takeaways for CDI; education and training needed to be face to face with providers, just in time, and specific to their patient population
- Chart Reviews
- Outpatient record review findings were communicated to the facility HIM manager to communicate, distribute, and begin documentation gap awareness
SHC Plan
• Developed and created standardized CDI/UM model
• Recruitment for Clinical Documentation/Utilization Review Specialists
• Vendor selection for CAC/CDI Tool and challenges
• Implementation of system-wide program
• Monitor effectiveness of the program

Chart Review Findings

Shriners Original OP CDI Reviews 2013-2014

<table>
<thead>
<tr>
<th># Outpatient Charts Reviewed</th>
<th># OP Charts with ICD-10 Documentation Issues/Lacking Specificity</th>
<th>% OP Documentation Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2348</td>
<td>845</td>
<td>36%</td>
</tr>
</tbody>
</table>
SHRINERS HOSPITALS FOR CHILDREN
CDI PROGRAM MODEL AND IMPLEMENTATION STRATEGY

CDI/UM Role at SHC

- The CDI/UM Specialist Will:
  - Be responsible for communicating with physicians and mid-level providers regarding clinical documentation related to the timely and accurate documentation of the diagnosis, co-morbid conditions, plan of care, discharge needs and other relevant documentation required to show need for treatment, etc.
  - Ensure that there is sufficient face to face contact between the CDI specialist and physicians/providers in order to establish solid relationships and trust
  - Be trained on ICD-10 coding guidelines and the specificity of the clinical documentation required for compliance and coding
  - Participate in the Interdisciplinary team at the facility
  - Chart Reviews for Joint Commission
  - Assist with Upfront denials management
CDI/UM Role at SHC

The CDI/UM Specialist will work collaboratively with the:
• UR Specialists to:
  ➢ Verify that status orders are documented appropriately and in a timely fashion
  ➢ Support medical necessity guidelines by verifying that the appropriate level of care has been assigned to each patient
  ➢ Review & address encounters no longer meeting medical necessity
    ▪ Cases referred to the external physician advisor
    ▪ Assist with Peer to Peer set up
    ▪ Communicates a determination with the Attending
  ➢ UR & Care Management to address payer denial management as it relates to documentation of medical necessity

SHC CDI IMPLEMENTATION STRATEGY

CDI PROGRAM IMPLEMENTATION
• Roll out schedule strategy
• Top facility query focus criteria
• Pre-Go Live training
• Onsite training with Executive Summary
• CDI software application training
• CDI report monitoring
• Onsite revisit schedule with follow up visit summary
• Ongoing education plan for both the providers and CDI UM Specialists
Documentation Improvement
Focused Criteria

- Anemia
- Arthrogryposis
- Asthma
- Atelectasis
- Attention Deficit Disorder
- Burn
- Cerebral Palsy
- Cleft Palate
- Congenital Foot Deformities
- Contracture
- Debridement
- Developmental Delay
- Epilepsy
- Fracture
- Gait Abnormality
- Injury External Cause
- Juvenile Osteochondrosis
- Juvenile Rheumatoid Arthritis
- Limb Length Discrepancy
- Limb Reduction Deficit
- Malnutrition
- Neurofibromatosis
- Neurogenic Bladder
- Physeal Arrest
- Postoperative Condition
- Complications
- Scoliosis

Pre ICD-10 Performance
Report Monitoring

Pre ICD-10
Average Queries/Month

2014
2015
Pre ICD-10 Query TAT

Facility Example

Focused Criteria Query Examples
Traumatic Physeal Fractures

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture – femur, epiphysis (separation)</td>
<td>Fracture, traumatic or pathological</td>
</tr>
<tr>
<td>~ lower</td>
<td>~ femur</td>
</tr>
<tr>
<td>~ closed or open</td>
<td>~ lower end</td>
</tr>
<tr>
<td></td>
<td>~ physical</td>
</tr>
<tr>
<td></td>
<td>~ Salter Harris type</td>
</tr>
<tr>
<td></td>
<td>~ Type I and laterality</td>
</tr>
<tr>
<td></td>
<td>~ Type II and laterality</td>
</tr>
<tr>
<td></td>
<td>~ Type III and laterality</td>
</tr>
<tr>
<td></td>
<td>~ Type IV and laterality</td>
</tr>
<tr>
<td></td>
<td>~ Initial, Subsequent, Sequela</td>
</tr>
</tbody>
</table>

Code Comparison Example: Idiopathic Scoliosis

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoliosis –</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>~ idiopathic</td>
<td>~ idiopathic</td>
</tr>
<tr>
<td>~ infantile</td>
<td>~ adolescent</td>
</tr>
<tr>
<td>~ progressive</td>
<td>~ cervical region</td>
</tr>
<tr>
<td>~ resolving</td>
<td>~ cervicothoracic region</td>
</tr>
<tr>
<td></td>
<td>~ infantile</td>
</tr>
<tr>
<td></td>
<td>~ (by spinal region)</td>
</tr>
<tr>
<td></td>
<td>~ juvenile</td>
</tr>
<tr>
<td></td>
<td>~ (by spinal region)</td>
</tr>
<tr>
<td></td>
<td>~ lumbar region</td>
</tr>
<tr>
<td></td>
<td>~ lumbosacral region</td>
</tr>
<tr>
<td></td>
<td>~ thoracic region</td>
</tr>
<tr>
<td></td>
<td>~ thoracolumbar region</td>
</tr>
</tbody>
</table>

ICD-10 Burn Injuries Examples

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Burn</td>
<td>• Burns</td>
</tr>
<tr>
<td>• Site (i.e. Hand)</td>
<td>• Source (i.e. Chemical, Corrosion)</td>
</tr>
<tr>
<td>• Degree</td>
<td>• Degree (First, Second, Third)</td>
</tr>
<tr>
<td></td>
<td>• Site (i.e. Hand)</td>
</tr>
<tr>
<td></td>
<td>• Location on site (i.e. Palm)</td>
</tr>
<tr>
<td></td>
<td>• Laterality</td>
</tr>
<tr>
<td></td>
<td>• Initial, Subsequent, Sequela</td>
</tr>
</tbody>
</table>
ICD-10-CM and Burn Injuries

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T24.322A</td>
<td>Burn of third degree of left knee, initial encounter</td>
</tr>
<tr>
<td>T24.322D</td>
<td>Burn of third degree of left knee, subsequent encounter</td>
</tr>
<tr>
<td>T25.292A</td>
<td>Burn of second degree of multiple sites, left ankle and foot, initial encounter</td>
</tr>
<tr>
<td>T25.292D</td>
<td>Burn of second degree of multiple sites, left ankle and foot, subsequent encounter</td>
</tr>
<tr>
<td>T25.292S</td>
<td>Burn of second degree of multiple sites, left ankle and foot, sequela</td>
</tr>
</tbody>
</table>

Site and degree of burns must be documented for subsequent visits.

Diagnosis: Multiple second degree burns to left ankle and foot with third degree burn to left knee. 10% total body surface involved with 5% third degree. This child fell into open campfire at the local state park where the family was camping.

ICD-10 Cleft Palate Disorders

ICD-9
- Cleft
- Palate
- Unilateral/Bilateral
- Complete/Incomplete

ICD-10
- Cleft
- Palate
- Hard, Soft, Median
- With (i.e. lip, soft palate, lip only)
- Unilateral or bilateral

Post ICD-10
Performance Report
Monitoring Results
Post ICD-10 Queries Trend

Post ICD-10 CDI Query TAT Trend

Conclusion
Summary of Benefits

- Increased quality of documentation that facilitates accurate representation of a patient's clinical status for patient care acuity, severity, and risk of mortality and statistics
- Support for industry initiatives and compliance requirements such as; MU, Joint Commission, ACO's, quality indicators, and physician report cards as a few examples

Questions