

# DOCUMENTATION IMPROVEMENT or Doctor Improvement?

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By Diane Lemire MHA, RHIA, CCS, I10 Trainer  
The L.E. Myre Co.  
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# Learning Objectives

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- ❑ To understand the importance of clinical documentation improvement
  - ❑ To learn best practices for CDI
  - ❑ To gain increased knowledge about the role of CDI, as sites prepare for a new coding classification system
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# CDI = Clinical Documentation Improvement

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- ❑ Heavily promoted program after 2007 with the beginning of MS-DRGs
  - ❑ Some programs prior to this time
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# What is CDI?

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- ❑ To promote the process of Querying
- ❑ To promote accuracy in documentation
- ❑ To assist in correcting discrepancies
  
- ❑ Oh, yes and also to increase reimbursement



# Formal CDI Programs (IP)

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- ❑ “Bought” or brought in to a Facility where Nurses are the CDIs on the floor
  - ❑ CDIs Query on a concurrent basis
  - ❑ CDIs see the physicians on the floor and try to explain “clinically” why particular words are needed
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# CDI Queries – For Outpatients

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- ❑ Try to catch physicians/surgeons to explain the nuances of better documentation, not coding
  - ❑ Severity is a key factor
  - ❑ Medical necessity is a key also
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# Documentation Accuracy

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- ❑ The words “acute” and “chronic” add to the importance of the severity of the patient
  - ❑ Adding a couple of chronic conditions in the history adds to the severity of the patient
  - ❑ Specificity of site/area of surgery is a critical factor
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# Documentation Discrepancies

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- ❑ Is it transcription or the doctor?
  - ❑ Can it be changed, should it be changed?
  - ❑ A coder's MOST important task
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# When to Query?

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- When treatment is being given for a condition that has not been documented
  - Whether a condition was ruled out or not
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# What is a Leading Query?

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- ❑ Does not have enough supporting material in the record to be warranted
  - ❑ Introduces information that is not already in the record
  - ❑ Sounds directing, prodding, or as though physician is being led to make an assumption
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# What is a Leading Query (2)?

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- ❑ Asks questions that can only be responded to by a Yes or a No
  - ❑ Indicates the financial impact of the response
  - ❑ Is designed so that all that is required is the signature
  - ❑ Challenges the physician's judgment
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# When querying does not occur:

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- The following can happen:
    - inaccurate coding
    - lost revenue
    - lost opportunity to educate physicians
    - a pattern of not clarifying may bring a coder's knowledge into question
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# Increasing Reimbursement

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- Querying for more specific information and to clarify information can only aid in increasing reimbursement, even with outpatients
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# Example for Doctors:

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- Eye surgery –
  - Patient came in with a laceration of the globe. Physician did surgery to remove the foreign body that caused the laceration and to suture the globe.
  - **Questions** : What is the globe? What exactly was sutured?
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# Impact of Example:

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## □ Eye surgery –

Case: FB from globe  
Surgery: removal with  
suture

Question: What part  
of the globe?  
conjunctiva, cornea, lens, orbit,  
superficial surface

If unspecified, the APC would  
lead to reimbursement of  
about \$244

## □ Eye surgery –

Case: FB from cornea of eye,  
through incision then  
suture repair

APC with more specific  
information in this case  
may lead to reimbursement  
of \$2638

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# Example for Doctors:

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- Buttock case –
  - Patient came in with severe fistula in anal area, quite deep into the pelvis.  
Physician did a fistulectomy and closed the area with skin graft.
  - **Questions:** Where exactly/how deep into what tissue was the fistula? What was actually closed – skin, soft tissue, perineum??
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# Impact of Example:

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Case: Fistula, anal

Fistula, sigmoid  
perineal

Surgery:

Fistulectomy with  
skin graft, less than 10  
sq cm

Surgery: the same,  
different site

APC reimbursement:  
\$2057

APC reimbursement:  
\$

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# Best Practice?

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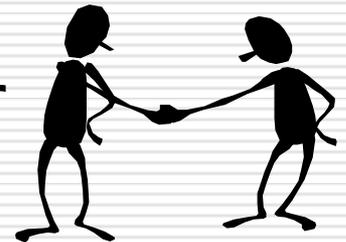
- ❑ Face to face time with doctors
- ❑ Bring expert doctors in
- ❑ Show how better documentation can affect the physician's reimbursement too
- ❑ No payer difference



# Best Practice?

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- ❑ To get along and to work well with the physicians
- ❑ Ask the physicians to do lunchtime education with the cases that are more difficult in their specialty
- ❑ Is there a physician champion? or go between?



# Physicians are not Coders

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- ❑ Best practice is when Physicians or their offices/billers and coders can work together to get a best result
  - ❑ We are not adversaries
  - ❑ OIG looks at both physician office and hospital/clinic bills for matches
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# Clinical Knowledge?

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- ❑ For coders
  - ❑ If it isn't documented, it doesn't exist
  - ❑ RAC reviews are more clinically oriented, even for outpatients
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# It is all in the WORDS

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- ❑ Some entity needs to assist in ensuring that the exact words coders need to assign codes are there
  - ❑ No assuming, please
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# Role of CDI in I10?

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- ❑ It is less about diagnoses than about procedures
  - ❑ Coders need to know their A&P
  - ❑ Outpatient coders are less inclined to be impacted by ICD10PCS
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# Role of CDI in I10?

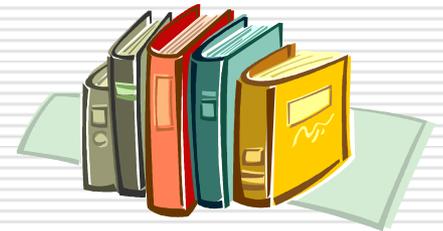
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- ❑ Most of the Querying in I10 will be for the specificity of procedures, the sites of the actual procedures, as noted in the previous examples
  - ❑ For outpatient coders it will still be about obtaining more specificity/medical necessity in diagnostic coding
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# CDI and 2013 (oops 2014)

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- Training and education have begun and are continuing
- Physician education will begin at the end of 2013/beginning of 2014



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# Thank you so much!!



Diane Lemire  
The L.E. Myre Co.  
[www.thelemyreco.com](http://www.thelemyreco.com)  
209.883.1862

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