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By Michelle Martin

Make Your CDI Program a Success

To ensure financial success under MS-DRGs, many facilities now rely on clinical documentation improvement programs.

WITH THE ADOPTION of Medicare Severity Diagnosis Related Groups (MS-DRGs) by the Center for Medicare and Medicaid Services (CMS), proper documentation of patient care in medical records is an important part of maximizing reimbursements for a health care facility. Under MS-DRGs, CMS set higher standards for documentation related to reimbursement, requiring increased specificity to justify a more severe illness. A well-documented record eliminates misinterpretation of the severity of a patient's illness and thus assigns the appropriate reimbursement for services provided.

To ensure financial success under the MS-DRG system, many facilities now rely on clinical documentation improvement (CDI) programs. A CDI program supports thorough and accurate documentation in patient records by working with the physicians, nurses and other staff who document and provide care. The program provides updates to coding guidelines and industry changes that must be adhered to by coders. A successful CDI program will improve reimbursement while supporting high quality patient care and reducing risks from unclear or incomplete documentation.

IDENTIFYING OPPORTUNITIES

In addition to creating a process to review patient documentation and improve the quality of diagnostic and procedure coding, a CDI program identifies opportunities for improved reimbursement. Well-trained clinical documentation specialists (CDSs) review documentation and additional diagnoses to distinguish higher severity. CDS staff must know what to look for and be able to query physicians when necessary to add details to support the lack of documentation they have identified.

Physician support of a CDI program is critical to its success. In times past, doctors often used shortcuts and their own abbreviations to minimize the time they spent documenting. However, if a coder was unable to understand the doctor's abbreviations and the severity of a patient's illness was not noted, the coder was not able to indicate the correct level of reimbursement. Doctors must understand that proper documentation supports a facility's ability to financially support the best doctors and invest in the best equipment.

A CDI physician education program should review coding and reimbursement, demonstrating to physicians how their documentation is being used, and paint a thorough picture of

the patient's clinical status. It should help physicians clearly understand co-morbid conditions (CCs) and major co-morbid conditions (MCCs), a major change introduced with MS-DRGs. These secondary diagnosis codes document higher severity of a patient's illness, allowing hospitals to obtain increased reimbursement associated with these higher-weighted MS-DRGs.

Physicians should understand the importance of describing disease stages and connecting symptoms with their causes. A successful education program will also result in physicians recognizing that responding quickly to queries is critical to completion of the record and assuring the accurate account of the patient's condition for the continuum of care.

DESIGNING A CDI PROGRAM

When a facility decides to implement a CDI program, it's important to first assemble an interdepartmental oversight committee made up of physician champions, a medical director, the chief financial officer, HIM director, coding manager and compliance staff. This group should set goals for the program, determine its structure and decide if it will be introduced initially throughout the entire facility or only in certain areas. It's also important to determine if HIM professionals or nursing staff will run the program. In addition, the committee must develop a process for resolving physician queries and case reviews.

A number of tools will be needed to support the program, including forms for case reviews and physician queries, desk references and pocket tip cards for physicians, statistical reports with benchmarks and goals, and reports on staff feedback.

Health care facilities developing a CDI program should also be committed to reviewing program results on a regular basis to determine its effectiveness. One vital element to review is the physician query response rate to verify if the responses are being documented correctly. Organizations that continually monitor progress and enhance their CDI program will not only enjoy correct reimbursement, but will also be prepared when CMS introduces new changes to reimbursement or coding guideline changes. ■

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