CLINICAL DOCUMENTATION IMPROVEMENT

FOS & BSOF Coding and Reimbursement Conference

January 12-13, 2018
Definition: Clinical Documentation Improvement

“The process of improving documentation to better reflect the severity of each patient encounter”.

What if....
Providers were paid based on the severity of the illness versus the RVU’s (relative value units)
Why Clinical Documentation Improvement is Important

• Provider documentation is important to-
  • Coding and reimbursement
  • Justify medical necessity and support reimbursement
  • Public outcome data (Reputation)
  • Medical-legal issues
  • Satisfy regulatory requirements
The New Value Based World

**CDI Marries Quality Measures & Documentation**

- Value Based Reimbursement - MACRA
- Commercial payer initiatives - BCBS, UHC, Humana
- HEDIS measures
- Risk based contracts for Medicare Advantage
- Bundled joint replacement contracts
The Purpose of Clinical Documentation Improvement

The purpose of a CDI program is to initiate concurrent and retrospective reviews of patient health records for conflicting, incomplete, or nonspecific provider documentation.
Identify Documentation Vulnerabilities
(The Argument for CDI Auditing)

• Look at the OIG work plan for the current year
• Clones notes and assessments
• Medical necessity
• ICD-10-CM specificity
• E&M upcoding or down coding
Quality Reporting and CDI

Domain: Person and Caregiver-Centered Experience and Outcomes

2017 OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS ONLY

MEASURE TYPE: Process

DESCRIPTION: Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.

INSTRUCTIONS: This measure is to be reported at each denominator eligible visit occurring during the performance period for patients with osteoarthritis seen during the performance period. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominating.

Measure Reporting: The listed denominator criteria is used to identify the intended patient population. The numerator-quality data codes included in this specification are used to submit the quality actions allowed by the measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounters.

DENOMINATOR: All patient visits for patients aged 21 years and older with a diagnosis of OA.

Denominator Criteria (Eligible Cases):
- Patients aged 21 years or older on date of encounter
- Patient encounter during the performance period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR: Patient visits with assessment for level of function and pain documented (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, ACOs Hip & Knee Questionnaire).

NUMERATOR NOTE: For the purposes of this measure, the method for assessing function and pain should be up to the discretion of the individual eligible clinicians based on the needs of the patient. The assessment may be done using a validated instrument (though one is not required) that measures pain and various functional elements including a patient's ability to perform activities of daily living (ADLs).

Version 1.0
11/19/2016
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Measure #109: Osteoarthritis (OA): Function and Pain Assessment

<table>
<thead>
<tr>
<th>Performance Met</th>
<th>1006F: Osteoarthritis symptoms and functional status assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Not Met</td>
<td>1006F 8P Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified</td>
</tr>
</tbody>
</table>

• Numerator Patient visits with assessment for level of function/pain documented
Decile Scoring

- Osteoarthritis (OA) Function and pain assessment

<table>
<thead>
<tr>
<th>Meas. 109</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible points</td>
<td>3.0 - 3.9</td>
<td>4.0 - 4.9</td>
<td>5.0 - 5.9</td>
<td>6.0 - 6.9</td>
<td>7.0 - 7.9</td>
<td>8.0 - 8.9</td>
<td>9.0 - 9.9</td>
<td>10</td>
</tr>
<tr>
<td>1 %</td>
<td>80.92 - 94.14</td>
<td>94.15 - 98.67</td>
<td>98.68 - 99.99</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>2 %</td>
<td>5.15 - 14.84</td>
<td>14.85 - 37.78</td>
<td>37.79 - 65.33</td>
<td>65.34 - 88.04</td>
<td>88.05 - 97.81</td>
<td>97.81 - 99.99</td>
<td>-------</td>
<td>100</td>
</tr>
</tbody>
</table>

1- Claims based reporting

2 – Registry based reporting
Measure #47 (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination

2017 OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
The measure is to be reported a minimum of once per performance period for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

Measure Reporting:
The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions allowed by the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claim data.

DENOMINATOR:
All patients aged 65 years and older

DENOMINATOR NOTE: Eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.

AND:
Patient encounter during the performance period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99210, 99213, 99214, 99218, 99190, 99200, 99202, 99203, 99212, 99213, 99221, 99231, 99233, 99234, 99235, 99236, 99239, 99050, 99056, 99070, 99080, 99090, 99100, 99110, 99120, 99130, 99140, 99150, 99160, 99170, 99180, 99190, 99200, 99202, 99203, 99212, 99213, 99221, 99231, 99233, 99234, 99235, 99236, 99239, 99050, 99056, 99070, 99080, 99090, 99100, 99110, 99120, 99130, 99140, 99150, 99160, 99170, 99180, 99190, 99200, 99202, 99203, 99212, 99213, 99221, 99231, 99233, 99234, 99235, 99236, 99239, 99050, 99056, 99070, 99080, 99090, 99100, 99110, 99120, 99130, 99140, 99150, 99160, 99170, 99180, 99190, 99200, 99202, 99203, 99212, 99213, 99221, 99231, 99233, 99234, 99235, 99236, 99239 OR Performance Met:
Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (1123F)

OR Performance Not Met:
Advance care planning not documented, reason not otherwise specified (1123F, with BP)

RATIONALE:
It is essential that the patient’s wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply noting that the issue at all is so much more substantial (Toefl, 1998). It is on the not that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

CLINICAL RECOMMENDATION STATEMENTS:
Advance directives are designed to respect patients’ autonomy and determine what wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in
Measure #47 (NQF 0326): Care Plan

• **DENOMINATOR**
  - All patients aged ≥65 years except when place of service is ED
  - AND 99201-99205, 99212-99215, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99291, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, G0402, G0438, G0439
## Reporting Method Variance

- **Care Plan – Measure 47**
- **High Priority Measure - Process**

<table>
<thead>
<tr>
<th>Meas. 47</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Possible points</td>
<td>3.0 - 3.9</td>
<td>4.0 - 4.9</td>
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<td>6.0 - 6.9</td>
<td>7.0 - 7.9</td>
<td>8.0 - 8.9</td>
<td>9.0 - 9.9</td>
<td>10</td>
</tr>
<tr>
<td>1 %</td>
<td>13.68 - 34.57</td>
<td>34.58 - 62.86</td>
<td>62.87 - 86.91</td>
<td>86.92 - 97.10</td>
<td>97.11 - 99.59</td>
<td>99.6 - 99.9</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>2 %</td>
<td>16.52 - 38.11</td>
<td>38.12 - 59.14</td>
<td>59.15 - 74.99</td>
<td>75.00 - 88.71</td>
<td>88.72 - 96.29</td>
<td>96.30 - 99.17</td>
<td>99.18 - 99.99</td>
<td>100</td>
</tr>
</tbody>
</table>

1 = Claims based reporting  
2 = Registry based reporting
# New Measures for 2018

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Code</th>
<th>Data Source</th>
<th>Data Type</th>
<th>Measure Type</th>
<th>Code</th>
<th>Measure Value</th>
<th>Sub-Measure</th>
<th>Measure Unit</th>
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</thead>
<tbody>
<tr>
<td>Functional Status Change for Patients with Knee Impairments</td>
<td>217</td>
<td>Registry/QCDR</td>
<td>Process</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Functional Status Change for Patients with Hip Impairments</td>
<td>218</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Functional Status Change for Patients with Foot or Ankle Impairments</td>
<td>219</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Functional Status Change for Patients with Lumbar Impairments</td>
<td>220</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Functional Status Change for Patients with Shoulder Impairments</td>
<td>221</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Functional Status Change for Patients with Elbow, Wrist or Hand Impairments</td>
<td>222</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>N</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
Description of the measures

MEASURE TYPE:
Outcome

DESCRIPTION:
A self-report measure of change in functional status for patients 14 year+ with knee impairments. The change in functional status (FS) assessed using FOTO’s (knee) PROM (patient-reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality.

INSTRUCTIONS:
This outcomes measure is to be submitted once per treatment episode for all patients with a functional deficit related to the knee. This is an outcomes measure and its calculation requires submitting of the patient’s functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional knee deficits will submit this measure.
Description of the measure

Definitions:
Functional deficit – Limitation or impairment of physical abilities/function resulting in evaluation and inclusion in a treatment plan of care.
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional knee deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the eligible clinician. A patient currently under clinical care for a knee deficit remains in a single episode of care until the Discharge is conducted and documented by the eligible clinician.
Admission – An Admission is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97161, 97162, 97163 for physical therapy or 97165, 97166, 97167 for occupational therapy) and development of a plan of care by the eligible clinician. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation CPT 97164 for physical therapy, or 97168 for occupational therapy, or Functional Limitation Submitting Discharge Status G-Code (G8980, G8983, G8986, G8989, G8992 or G8995) identifying the close of a Treatment Episode for the same knee deficit identified at admission and documented by a discharge report by the eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current TreatmentEpisode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.
Description of the measure

RATIONALITY:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1873)

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their Guide to Physical Therapy Practice, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.
The Practice of Medicine Going Forward

Outcomes will determine your Income
Coders Role in Clinical Documentation Improvement

Develop a CDI plan for your practice
Job #1 – Coders Role in CDI

Convene a strong multi-disciplinary

- Physician champion
- Nursing
- Other clinical
- Front office
- Billing and coding
- Administration
Items to Address in the Plan

- Use of correct ICD-10-CM codes
- Compliance
- Reimbursement policies
- Quality reporting
- Culture
- Accountability
- Transparency
Goals for Your CDI Plan

• To have a well organized practice where everyone is accountable for success
• Produce reliable medical records
• Promote profitability of the practice
• Develop an effective query process for open communication
• Provide training and guidance for all providers - become their go-to resource
• Audit continuously
• Stay informed with payer rules
Implementation of the CDI Plan

- Assessment
- Implementation
- Maintenance
Step 1 - CDI Assessment

Critical step in determining the current state of your practice

- Evaluate current CDI systems
- Conduct a baseline medical record audit
- Brief providers on findings
- Set goals for providers
- Keep your different types of audits separate: diagnostics, therapeutic procedures, E&M, consults etc.
- Review your bell curve
- Use diagnosis coding to support medical necessity
Step #2 – Implementing the Plan

• Gather all resources and tools
• CDI team collaborates to implement changes
• Accountability
• Customize the plan based on everyone’s baseline audit
• Monitor closely after training
• Evaluate improvement
The Query Process

Queries are a valuable part of the CDI implementation process.

- **Queries should be:**
  - Clinically based
  - Fact-driven
  - Concise and to the point
  - Not leading

- **When to Query**
  - When there is conflicting, ambiguous, or incomplete information
  - Regarding any significant procedure, condition or reportable event.

- **When NOT to Query**
  - Never question a provider’s clinical judgment
Step #3 - Maintenance

• Sustainability of the program requires
  • Monitoring
  • Continual education
  • Performing additional audits
  • Managing adjustments to the program
Documentation Details
Documentation Vulnerabilities Related to Clinical Documentation Improvement

- Documentation lacking discussion of co-morbid conditions
- Validation of all care provided
- Compliance with quality and safety guidelines
- “Code also” additional codes - dislocation and sprain of joints code also any associated open wound
- 7th character (A, D, S)
- Obesity vs. morbid obesity with BMI
- Highest level of specificity
- Status codes - amputations
Coders Role in Clinical Documentation Improvement

Make sure providers document using clinical concepts

- Type
- Temporal factors
- Caused by/contributing factors
- Symptoms/Findings/Manifestations
- Localization/Laterality
- Anatomy
- Associated with
- Severity
- Remission Status
- BMI

- History of
- Morphology
- Complicated by
- External Cause
- Activity
- Episode
- Place of Occurrence
- Loss of Consciousness
- Substance
Sample Documentation Concepts

- **Concept of type** describes a type of condition like primary osteoarthritis or pathologic fracture.

- **Temporal factors** relate a condition to a time parameter, such as acute, chronic, recurrent, etc.

- **Causation or contributing factors** - this concept conveys the patient’s condition is a result of another condition. Often seen with use of drugs, alcohol, or by a physical disease.

- **Associated with** – CKD, diabetes

- **Episode** – Initial, subsequent, sequela, single, recurrent, in remission.
Correct Use of Coding Guidelines

• ICD-10-CM includes Official Guidelines for Coding and Reporting. Adherence to these guidelines is required under HIPAA

• Documentation must show that the conditions was monitored, evaluated, assessed or treated (MEAT)

• A diagnosis code may only be reported if it is explicitly spelled out in the medical record
  • No coding from lab values, etc.
  • Treatment as documented is evidence of a diagnosis – if you treat it, it exists
MEAT the Chronic Condition

- **Monitor**
  - Signs, symptoms, disease progression, disease regression

- **Evaluate**
  - Test results, medication effectiveness, response to treatment

- **Assess/Address**
  - Order tests, discussion, review records, counseling

- **Treatment**
  - Medications, therapies, other modalities
MEAT

• Accurately and sufficiently document all chronic disease processes and manifestations that are both active and/or have a relevant history

• Document all conditions evaluated during every face-to-face visit – that are medically necessary and relevant

• Each progress note must include key indicators:
  • HPI
  • Exam
  • Medical decision-making

• Document every diagnosis reported as an active chronic condition with an assessment and plan of care
<table>
<thead>
<tr>
<th>Not Specific</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Pain</td>
<td>Lumbar radiculopathy</td>
</tr>
<tr>
<td>Pain r/o fracture</td>
<td>L4 and L5 herniated disc with radiculopathy</td>
</tr>
<tr>
<td>Fracture vs. herniated disc</td>
<td>Lumbosacral fracture subsequent with routine healing</td>
</tr>
<tr>
<td>LS fracture</td>
<td></td>
</tr>
</tbody>
</table>
Low Back Pain

Low risk
- No notable history
- No history of cancer
- No corticosteroid use or osteoporosis

High risk
- Fever
- Weight loss
- Nocturnal pain
- Change in bowel and bladder
- Current or history of cancer
## Injuries

<table>
<thead>
<tr>
<th>Episode</th>
<th>Initial, subsequent, sequela</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Be specific to the site of injury and laterality</td>
</tr>
<tr>
<td>Etiology</td>
<td>How did it happen? MVA, fall, fight, etc.</td>
</tr>
<tr>
<td>Place of Occurrence</td>
<td>Where did it happen? Work, sports, shopping, etc.</td>
</tr>
<tr>
<td>Initial encounters – Intent</td>
<td>Unintentional/accidental or intentional/self-harm</td>
</tr>
<tr>
<td>Initial encounters – Status</td>
<td>Civilian, military, etc.</td>
</tr>
</tbody>
</table>
Injury Example

• A left knee injury that occurred on a trampoline

• A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline
# Fracture Specificity

<table>
<thead>
<tr>
<th>Type</th>
<th>Open, closed, pathological, neoplastic disease, stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern</td>
<td>Comminuted, oblique, segmental, spiral, transverse</td>
</tr>
<tr>
<td>Encounter of care</td>
<td>Initial, subsequent, sequela</td>
</tr>
<tr>
<td>Health status, if subsequent</td>
<td>Routine healing, delayed healing, nonunion, malunion</td>
</tr>
<tr>
<td>Localization</td>
<td>Shaft, head, neck, distal, proximal, styloid</td>
</tr>
<tr>
<td>Displacement</td>
<td>Displaced, non-displaced</td>
</tr>
<tr>
<td>Classification</td>
<td>Gustilo-Anderson, Salter-Harris</td>
</tr>
<tr>
<td>Complications and etiology</td>
<td>Direct result of trauma, where did it happen and how</td>
</tr>
</tbody>
</table>
Documentation: Fracture

• Pathologic
• Traumatic

• Type of fracture
• Laterality
• Site
• Encounter
Pathologic Bone Fractures

- **Etiology**
  - Osteoporosis, neoplastic disease, or other

- **Laterality**
  - Right, left, bilateral

- **Site**
  - Femur, hand, foot, humerus, ulna, tibia

- **Encounter**
  - Initial, subsequent, sequela
Traumatic Bone Fractures

- **Type**
  - Routine, delayed, malunion, non-union
  - Open vs closed
  - Displaced vs non-displaced

- **Laterality**
  - Right, left, bilateral

- **Site**
  - Shaft, body, acromial process, neck lateral condyle, ischium

- **Encounter**
  - Initial, subsequent, sequela
Gout

• Cause
  • Idiopathic, drug induced (Niacin), diuretics, cyclosporine

• Episode
  • Acute, chronic, attack, flare

• Location
  • Ankle, foot, hand, elbow, knee, great toe

• Indicate presence or absence of tophi
Arthritis

- Type
  - Osteo
  - Rheumatoid
- Temporal factors
  - Acute
  - Chronic
  - Recurrent
- Caused by or contributing factors
- Symptoms/ findings/ manifestations
- Localization/laterality
- Anatomy
- Associated with
- Severity
Documentation of Complications

- Define the complication
- Identify if it is a procedure or device causing the complication
- Identify if the complication was expected or unexpected
Common Orthopedic Diagnoses

- Bone fractures
- Diseases of the bone
- Diseases of the soft tissue
- Diseases of the joint
- Complications to healing
# Opportunities for Better Documentation

Do not document and report | When you know the patient has...
---|---
“Sciatica” | Lumbago with sciatica, right side
“Right Knee Sprain” | Sprain of ACL, right knee initial encounter
“Unequal limb length” | Unequal limb length (acquired), right humerus
“Vertebral fracture” | Pathologic fracture of vertebrae
“Patient is very obese” | Patient is morbidly obese
“Poorly controlled diabetes” | Uncontrolled diabetes
Considerations for Orthopedic Documentation

• Clearly document the location with specificity and laterality

• Documentation and coding should reflect initial treatment, subsequent encounters, or sequela

• Document the clinical findings/indicators to support the diagnosis documented

• Open bone fractures require additional information related to Gustilo-Anderson Classification of severity
Considerations for Orthopedic Documentation

• Recognize limited availability of “Not Otherwise Specified” options with many orthopedic procedures

• Documentation detail will prevent future queries

• Document related, secondary or causal illness whenever appropriate
Clinical Documentation in the Medical Record

- Complete and Concise
- Accurate
- Timely
- Clear
- Patient Centered
- Legible
Provider

• So what is the providers view?

• Engage providers to perform accurate documentation and capture of primary conditions, as well as presenting co-morbidities
Provider

- Aware of billing codes and ICD-10 codes
- Aware of morbidity and mortality rates
- Medical decision-making versus complexity of the patient
Coding/Billing

- Verify the diagnosis code selected
- Assign a code
- How can they help providers?
Team

• Identify problems
• Prevention strategies
• Coordinate care
• Overall patient health care evaluation
• Communication among the patient’s health care team
Team

- Incorporate CDI in Physician Workflow
CDI and Quality

- Accurate Coding and Quality Measures
- Improved Physician Engagement
- Increased Query Responsiveness
- Increased Audit Defensibility
CDI

- Identify targeted patient populations
- Identify documentation weaknesses
- Review current coding practices
- Educate and continue the process
Clinical Documentation Improvement

A successful clinical documentation program leads to

• Better communication with providers
• Better communication with patients
• Decreased queries from coding and billing department
• Minimize denied accounts
• But most of all – improved clinical documentation!
In Summary

• CDI is more than auditing for billing
• It is a quality initiative
• Improve communications with providers
• Recognize co-morbid conditions
• Overcome barriers of EMR
• Make queries clinically relevant
• Develop a collaborative model
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