The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 13th issue of the CA ACDIS journal!

March 2021 Index

We Stand in Solidarity

"No one person is born hating another because of the color of his skin, his background, or of his religion. People learn to hate and if they learn to hate, they can be taught to love. For love comes more naturally to the human heart than its opposite" --Nelson Mandela

In a recent CDI Strategies publication, the ACDIS Diversity and Inclusion Task Force and ACDIS Leadership published a Zero-Tolerance Policy (https://acdis.org/articles/acdis-update-zero-tolerance-policy). In summary, ACDIS will not stand for any discrimination and/or display of intolerance. In a world that has seen so much tragedy and pain in the last year, the need for love, compassion and inclusion has become more necessary.

The leadership of the CA ACDIS Chapter stands in solidarity with ACDIS in their zero-tolerance stance. Any display of intolerance or discrimination against anybody's race, culture, gender identities, sexual orientation, etc., will not be accepted by our chapter, as we want to strive to be a place where our CDI community feels included and cared for. We take pride in our own leadership being diverse, and we aim to maintain diversity and acceptance in our membership.

The leadership is always open to listening to our members suggestions and concerns. If anyone is feeling or experiencing intolerance due to their personal attributes and beliefs, please feel free to reach out to us or the ACDIS Diversity and Inclusion Task Force.

California acdis Official Local Chapter

Issue 13 March 2021

COVID-19 Vaccines and the Unsung Heroes: Vaccinators!

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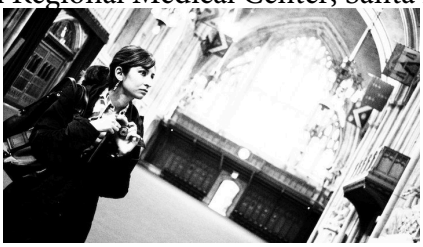

As I write yet another COVID-19 related article, the irony of today's date is not lost on me.
On exactly this date last year, March 11, 2020, COVID-19 was officially declared a pandemic.
The virus has now claimed 26,244,833 lives globally, out of which 530,179 are here in the USA (Johns Hopkins University*).

However, with these dismal statistics and casualties also comes a glimmer of hope: several vaccines have been delivered and administered in the arms of many, and future development of additional vaccines and boosters is in the pipeline. With this medical breakthrough, we can one day put an end to this terrible pandemic!

mRNA Vaccines

COVID-19 mRNA vaccines give instructions for our cells to make a harmless piece of what is called the "spike protein." The spike protein is found on the surface of the virus that causes COVID-19 (CDC.gov 2021).

COVID-19 Vaccine CPT Codes

91300 0001A (1st Dose) Pfizer-BioNTech COVID-19 Vaccine
91300 0002A (2nd Dose) Pfizer-BioNTech COVID-19 Vaccine
91301 0011A (1st Dose) Moderna COVID-19 Vaccine
91301 0012A (2nd Dose) Moderna COVID-19 Vaccine
91302 0021A (1st Dose) AstraZeneca COVID-19 Vaccine
91302 0022A (2nd Dose) AstraZeneca COVID-19 Vaccine
91303 0031A (Single Dose) Janssen COVID-19 Vaccine
** (AMA 2021)

COVID-19 Heroes: "The Vaccinators"

The pandemic has many heroes including frontline healthcare professionals, and an assortment of so many other essential workers. While Clinical Documentation Specialists were not considered frontline workers, we were very much a part of helping keeping our hospitals afloat. As vaccines were developed and were administered to millions, a new hero emerged: The Vaccinators! I was honored to have interviewed one of these heroes, who also happens to be a CDI, CA ACDIS's very own Analyn Dolopo-Simon, Director of the UCSD CDI Program, who served as a volunteer vaccinator and shared her experience with me.

> **RJ:** Can you tell us about the role of a vaccinator?
> **AD:** The role of the vaccinator is determine if there are any potential problems prior to administration the COVID-19 Vaccinations, don PPE, prepare and administer vaccinations, document vaccination manufacturer and lot number on the COVID-19 Vaccination card and the EMR, monitor for signs and symptoms of anaphylaxis following COVID-19 Vaccinations, provide information to patients and families CDC's V-Safe program and answer any questions on vaccine and COVID-19, and provide the orange I Got My COVID-19 Vaccine sticker.

RJ: How does one become a vaccinator?
AD: To volunteer at UCSD, I had to complete the CDC training links, I was provided training on the handling and visual inspection of the Pfizer or Moderna vaccination vials. For example, what temperature the vaccination vials needed to be stored at. How to handle the precious vaccination vials which should not be shook or dropped. I was taught to ask questions that may identify any problems that may defer the vaccination, which I escalated to my charge nurses e.g. recent vaccinations, severe allergic reactions, or active illness. I was taught how to inform patient that they are required to wait 15 minutes post injection in an observed waiting area (30 minutes if they have had previous anaphylaxis to any cause). At UCSD Petco Superstation at Padres' Petco Park Tailgate parking we had 280,000-square-foot site with 42 vaccination tents approximately 300 clinical and administrative staff members from UC San Diego Health to provide vaccines every day from 7 a.m. to 7 p.m. We have volunteers of nurses, doctors, healthcare workers, Observers to notify RN and site supervisors, runners for additional vials and supplies, police, IT support, EMS teams, Pharmacy, security, support staff for traffic and helping people coordinate and sign in. There were ambulances and police cars available onsite. It was a village to help out the vaccination efforts.

> **RJ:** As a vaccinator, how do you dispel misinformation and do much needed vaccine and COVID-19 education?
> **AD:** The CDC links really provide great information on how the vaccinations were created and provide current information on vaccine efficacy and addresses the misinformation e.g. vaccinations do not have live virus, it does not change recipient DNA, etc. Links are provided below, I highly recommend them and you can get CEUs!

RJ: What are the challenges you faced as a vaccinator?
AD: Well, the pace is very fast, there are so many cars and patients, but you learn to adjust, you depend on your support team of runners, charge nurses, IT support and other vaccinators and then…your standard work of vaccination improves in speed and efficiency.

> **RJ:** What are the benefits of becoming a vaccinator?
> **AD:** The people. I saw the joy and relief of patient who were vaccinated. I saw concerned family members bring their beloved elderly parents, grandmas/grandpas, lolos/lolas, abuelos/abuelitas, uncles and aunts to get vaccinated. Some families cried tears of relief and some lost family members to COVID-19. Their stories were heart-warming. The fellow healthcare workers were also so wonderful and grateful. It was incredible experience.

RJ: Why did you volunteer?
AD: I wanted to learn more about these new vaccines. I felt the need to help and at the time priority went to fellow frontline healthcare workers and seniors over 65 years old. I thought the concept was wonderful that we were protecting those healthcare workers who came to work throughout the pandemic and that society really valued our vulnerable senior populations. I wanted to help, as CDS professionals we read about COVID-19 cases daily, but here, we were helping, perhaps, to prevent a future COVID-19 infection. I have elderly parents and family who have chronic conditions, I worry about them. As a UCSD employee, I have received my vaccination as well and I can speak from personal vaccination experience and provide encouragement to patients. Now, I realize not everyone may not want to administer vaccinations, but there are other ways to volunteer during the pandemic and I encourage everyone to try in their own way. As a CDS, we need educate ourselves and those around us (family/friends/acquaintances) and dispel the rumors and misconceptions of the vaccine and give cogent, scientific evidence based advice and resources.

RJ: Finally, I want to thank you for doing this great service and for getting CDI involved in this process and allow us to have a voice as unrecognized "essential" workers!

References and Resources:
-https://coronavirus.jhu.edu/map.html (*Statistics at time of publication)
-https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html
-https://www.ama-assn.org/find-covid-19-vaccine-codes (**Additional codes expected as more vaccines and booster shots are developed)
-https://ucsdnews.ucsd.edu/feature/uc-san-diego-health-helps-launch-san-diegos-vaccination-super-station

The following 3 courses are from the CDC directly on the COVID19 vaccinations. https://www2.cdc.gov/vaccines/ed/covid19/
For CEUs, here is the link: https://tceols.cdc.gov/Account/LogOn
-Create an account
-Click on 9 simple steps to earn CE
-Locate the courses you want CE on and open course thru TCEO
-There is a post test (80% pass rate needed) and complete the survey

Getting ready for our patients at the UCSD COVID-19 Vaccination Super Station
-Analyn

COVID Returns – How to Deal with the Boomerang Effect

Maggie DeFilippis, RN, JD, CCDS, CDIP, CCS, CPC
Clinical Documentation Integrity Specialist, UCLA Health

It is a good thing that CDI and Coders are by nature flexible people willing to constantly update and accept change we have all had to learn to code Novel Coronavirus 2019 ("COVID-19") cases and to capture all associated codes. Now these patients are coming back into the hospital with ongoing COVID-19 manifestations. What's a CDI to do?

> COVID-19 symptoms can last weeks or months after resolution. At least ten percent of all COVID-19 patients will continue to have COVID-19 manifestations long after their acute illness has come to an end. These patients, often referred to as "long haulers" may have had severe COVID-19 and have been hospitalized or may have been patients with very mild symptoms. In one study, 87% of hospitalized patients who had not required ventilation still experienced physician-confirmed COVID-19 related symptoms an average of 2 months after their first symptom emerged. Worldwide, women and healthcare workers have the greatest risk of becoming long haulers, leading some to believe that being a long hauler is related to the volume of exposure to COVID-19 initially experienced by a patient.

Just as acute COVID-19 has been found to affect every part of the body, so, apparently, do its continuing symptoms. Persistent fatigue, difficulty concentrating ("brain fog"), shortness of breath and debilitating muscle aches are the most common COVID-19 sequelae. Loss of taste and smell often continue and respiratory manifestations and viral myocarditis are not uncommon. "Dr. Fauci has noted that some long haulers' symptoms like brain fog and fatigue are highly suggestive' of myalgic encephalomyelitis and/or chronic fatigue syndrome". Some patients who were asymptomatic develop COVID-19 Pneumonia after there is no longer active disease detected. Some patients who never tested positive for COVID-19 or were admitted to the hospital may later became COVID-19 long haulers, who missed a positive testing window.

> Many physicians are now defining "Post-acute Covid-19" as COVID-19 manifestations extending beyond three weeks from the onset of first symptoms. "Chronic Covid-19" is defined as COVID-19 symptoms extending beyond 12 weeks. Since many long haulers were not tested, and false negative tests are common a positive test for Covid-19 is not a prerequisite for post COVID-19 clinical diagnoses.

The increasing incidence of COVID-19 related diagnoses raises many questions as to how to ensure accurate documentation and how to code from this documentation. It will become increasingly important for healthcare providers to accurately capture COVID manifestations; not ust in the acute setting but also for long haulers who continue to re-enter the healthcare system.

*****Future Newsletter will include interview with COVID-19 survivor******

Capturing COVID-19 Manifestations and Sequelae

In general, the simple rule still applies. When there is a positive COVID-19 test, code COVID-19. The United States Department of Health and Human Services firmly states that a positive COVID-19 test is "alone sufficient to diagnose a patient with COVID-19."[1] Also, when the provider definitively diagnoses COVID, even in the absence of a test, U07.1 may still be reported. However, uncertain (likely, probable, etc.) diagnosis of COVID may not be used. COVID reporting is a specific exception to ICD-10-CM Official Coding Guidelines Section for Uncertain diagnoses.

- Patients may continue to test positive for COVID for 3 months after their first positive test. What if the documentation states, " No active virus, ust COVID shedding"?
- Viral shedding can mean either that the patient has an active (current) COVID-19 infection or a personal history of COVID-19. Documentation of "no active virus, ust shedding" may need to be clarified but otherwise should be reported as History of COVID-19 (Z11.52).
- Look for clinical indicators of treatment of COVID 19 (continued medical treatment , isolation etc.) to determine if clarification is needed.
- **COVID will almost always be the Principal Diagnosis code.**

As stated in the AHA Coding Clinics Frequently Asked Questions, "when COVID-19 meets the definition of principal or first-listed diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, except when another guidelines require that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications. However, if COVID-19 does not meet the definition of principal or first-listed diagnosis (e.g. when it develops after admission), then code U07.1 should be used as a secondary diagnosis".

- When the physician definitively documents COVID-19 on admission but a COVID test is not positive until after admission, clarification may be needed, but the COVID diagnosis that meets the definition of Principal Diagnosis will still be sequenced first.
- When there is no active COVID condition, and a manifestation of COVID is present, coders who report a diagnosis of a COVID manifestation are also instructed to code B94.8, Sequelae of COVID
- If the patient has never been diagnosed with COVID and is COVID negative, but is diagnosed with a manifestation "likely due to COVID resolved" the manifestation that meets the principal diagnosis definition is coded first. More frequent manifestations of COVID include:
  - J12.82. COVID Pneumonia
  - M25.81 MIS (Multisystem Inflammatory Syndrome)
  - M35.89 Other Specified Involvement of Connective Tissue
  - D89.833-D89.835 Cytokinin Release Syndrome
  - B33.23 Viral Pericarditis
  - G61.0 Guillain Barre
  - I26.99 Pulmonary Embolism
  - D68.8 Other Coagulation Defects
  - If documentation does not state that a condition is a manifestation, clarification may be needed.

[1]DHHS/CMS Medical and Clinical Laboratory Improvements Amendments 8/25/2020 (meant for retroactive application 42 CFR Parts 410, 413, 414 and reported at https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf

o Note that symptoms such as shortness of breath, fatigue, and cough are integral to the COVID diagnosis and should not be separately coded.
o Note also that when a patient has both Aspiration Pneumonia and Pneumonia due to COVID, both J12.82, Pneumonia due to Coronavirus and J69.0 Pneumonitis due to Inhalation of Food and Vomit, both codes may be assigned. This is an exception to the excludes 1 note. Aspiration pneumonia and pneumonia due to COVID-19 are two separate unrelated conditions with different underlying causes.

- In the absence of active COVID infection and/or documented COVID-related manifestation, the patient who has been confirmed to have COVD-19 in the past should be assigned an ICD-10 code for History of COVID (Z11.52). A personal history code is only appropriate when, as stated in Official Coding Guideline I.C.21.c.4, the code "explains a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring."

o For patients who are clearly receiving treatment for the residual effect of COVID-19, the sequelae (B94.28), and not the history code should be used.
o The requirements for definitive diagnosis by test or physician diagnosis do not apply to the History of COVID diagnosis. The fact that the physician documents that a patient has a history of COVID diagnosis is enough.
o There is no specific time frame for when a personal history code is assigned. If the provider documents that the patient no longer has COVID-19, assign the appropriate personal history code.
o "Post COVID-19 syndrome" is not a defined term in the Alphabetic Index. Usually the meaning of this term must be clarified as it acts as a time-stamp and is not enough to indicate that the current symptom(s) or clinical condition(s) are manifestations or residual effects (sequelae) of COVID-19. "As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, in the absence of Alphabetic Index guidance for coding syndromes, assign codes for the documented manifestations of the syndrome".

Capturing the complexity of care for COVID-19 and COVID-19 related diagnoses is crucial for making sure that COVID cases, that have predominated in hospitals, are accurately and fully reimbursed. Clinical documentation integrity efforts to refine whether COVID is present and active and whether a condition is a manifestation of COVID will be more important than ever. Short of massive payment reforms, maximizing revenue for what care is being delivered through improved documentation will be a key way for organizations to recover from the COVID crisis for healthcare.

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See https://www.healthleadersmedia.com/revenue-cycle/cdc-announces-new-icd-10-cm-codes-covid-19-related-conditions AHA Frequently Asked Questions https://www.aha.org/fact-sheets/2020-03-30-frequently-asked-questions-regarding-icd-10-cm-coding-covid-19#:~:text=However%2C%20if%20COVID%2D19%20does,used%20as%20a%20secondary%20diagnosis.

Ann Marie Gould, MAOM, BSN, RN, CCDS,
CDIP Cristy Zielinski, BSN, RN, CCDS
RN Link

- **Have you ever wondered why insurance companies deny certain diagnoses when billed by the hospital?** Main reason – to save their bottom line! With the coronavirus pandemic, many hospitals have lost money as well as insurance companies. One way most insurance companies may retain capital for their businesses, is to deny specific diagnoses submitted by acute care hospitals. How do they save money – through the process of DRG denials. The DRG denial may be based on a specific diagnosis, like a secondary diagnosis such as a Major Complication/Comorbidity (MCC) or Complication/ Comorbidity (CC) as well as a drop in Severity of Illness (SOI) or Risk of Mortality (ROM).

What are the red flag diagnoses that insurance companies deny based upon the hospital billing?

As a Clinical Documentation Specialist (CDS), it is our role to confirm the clinical evidence in the record supports the provider's diagnosis in order for the Coding and Business departments to accurately code and bill for the inpatient stay. As a CDS, you have two goals: provider education for diagnosis specificity **AND** accurately capture diagnoses for the coders prior to the patient's discharge. With this said, the most common diagnoses that insurance companies will deny include: Acute hypoxemic respiratory failure, acute metabolic encephalopathy, sepsis, and even severe protein calorie malnutrition, to name a few.

How do you prove that the red flag diagnoses are supported within the medical record?

With any Red Flag diagnosis, clinical evidence in the medical record must support the coding of that particular diagnosis. How do we as a CDS prove the clinical evidence is appropriate? Through the use of clinical indicators for the diagnoses listed in the record.

Two of the most common Red Flag Diagnoses that are seen today for insurance company denials include: Acute hypoxemic respiratory failure and acute metabolic encephalopathy. Now, let us take a look at the clinical indicators for each diagnosis.

Acute respiratory failure with hypoxia: Based upon Merck Manual, "acute hypoxemic respiratory failure is severe arterial hypoxemia that is refractory to supplemental oxygen." Main causes that are attributed to acute respiratory failure may include: intracardiac shunting of blood, acute myocardial infarction, sepsis, pneumonia, and heart failure. What are the clinical indicators a CDS will use to confirm/validate the diagnosis of acute hypoxemic respiratory failure within the electronic health record?

- Patient's symptoms may include – dyspnea at rest, tachypnea with respiratory rate > 22 per minute or slowed breathing with respiratory rate < 10 per minute, wheezing/crackles associated with breath sounds;
- Imaging (CXR, CT scan chest) may depict pulmonary edema, pulmonary vascular congestion, COPD/asthma/bronchitis or pneumonia;
- ABG pO2 < 60 mmHg on room air;
- ABG P/F ratio < 300 on room air or nasal cannula oxygen
- If ABG results not available, the CDS may use a SpO2 calculation table as noted below:

SpO2 %	pO2 estimate
86	51
87	52
88	54
89	56
90	58
91	60
92	64
93	68
94	73
95	80

- Treatment provided may include – high flow oxygen, BIPAP or mechanical ventilation; pulmonology consult, bronchodilators, steroids and possibly antibiotics if related to an underlying infection

First of all, is acute hypoxemic respiratory failure documented by the provider?

Second, are there clinical indicators to support the diagnosis?

Lastly, does the treatment performed indicators coincide with the acute hypoxemic respiratory failure diagnosis?

Unfortunately, many insurance companies will deny the 'acute hypoxemic respiratory failure' diagnosis when providers are indicating in their physical exam note that the "patient has no acute distress" or "speaking in full sentences."

In certain acute care hospitals, the CDS may pose a clinical validation query or have an escalation process in place to confirm the "acute hypoxemic respiratory failure" diagnosis is valid.

Please confirm one's hospital policy regarding the clinical validation query or escalation process.

Acute Metabolic Encephalopathy: According to the National Institute of Health PubMed.gov, "metabolic encephalopathy" is defined as: a clinical state of global cerebral dysfunction induced by systemic stress that can vary in clinical presentation from mild executive dysfunction to deep coma with decerebrate posturing." Main causes of metabolic encephalopathy may include electrolyte abnormalities (hyponatremia, hypokalemia, metabolic acidosis, AKI), chronic liver disease, infections (sepsis, urinary tract infections, pneumonia, meningitis), brain tumors, exposure to drugs/solvents over a long period of time as well as nonconvulsive status epilepticus.

What are the clinical indicators the CDS will use to confirm/validate the diagnosis of acute metabolic encephalopathy within the electronic health record?

- Patient's symptoms may include confusion/altered mental state, memory loss, trouble thinking/focusing on specific items, trouble speaking, muscle weakness or twitching, trouble swallowing, sleepiness or seizures;
- Imaging (CT Head/MRI Head) reports negative for any infarction/hemorrhage; EEG results may show diffuse slowing of the brain electricity that may be attributed to a metabolic, vascular, or degenerative condition;
- Laboratory testing may include: Chemistry panel, blood and urine cultures, specific drug levels (based on medications you take routinely) as well as Lumbar Puncture fluid analysis sent for cytology;
- Treatment includes focusing on the underlying etiology.

First of all, is the provider documenting "acute metabolic encephalopathy" within the medical record?

Second, are the clinical indicators listed above found in the medical record?

Lastly, does the treatment performed indicators coincide with the diagnosis of acute metabolic encephalopathy?

Unfortunately, insurance companies will deny this particular diagnosis based upon lack of clinical indicators in the medical record.

Most providers may only document in the physical exam findings, "Alert and oriented x3," instead of some type of confusion.

Also, the providers may document the acute metabolic encephalopathy diagnosis without linking the underlying etiology.

Provider education is key for accurate capture of "acute metabolic encephalopathy" diagnosis

How do you appeal the insurance company denial for the red flag diagnoses?

In some hospitals, specific personnel are utilized for Denials Management. As you may know, Denials Management involves a "village of people," including, but not limited to: Business Office, Health Information Management, coders, CDI specialists, Case Management - to name a few.

CDS teams should be familiar with the DRG denials from their facilities in order to minimize denials of these diagnosis concurrently. There may be specific templates that are used for appeal letters within your facilities. As a CDS, one can assist the DRG denial process with a complete review of the denied diagnosis based upon the clinical indicators as well as the specific escalation or query process one may have in place within one's facility.
Provider education is **KEY** for minimizing DRG denials of specific diagnoses in order to accurately capture the patient's story from admission to discharge and minimize repayment of funds.

Summary

Clinical indicators of a particular diagnosis within the medical record provides HIM/ coding professionals as well as the Business office department in minimizing DRG denials from insurance companies. Hospitals should have established concrete processes when a CDS sends a clinical validation query to a provider as well as a specific escalation process that involves the CDI Physician Advisor. As noted within this article, it takes a "village" to complete any DRG denial process. As a CDS, one has the ability to prevent DRG denials with the concurrent reviews that are performed for all inpatient medical records, thereby minimizing insurance company repayments.

Article written by: RN Link – an educational company to assist RNs, Coders and Foreign Medical Graduates to learn the basics of becoming a Clinical Documentation Specialist - www.rn-link.com - 1-800-853-2810

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Acute inpatient and Acute Rehabilitation CDS

Lori Ballantyne DNP, RN-BC, CCDS
Sharp Clinical Documentation Specialist

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UCSD CDI Director

As CDSs explore other potential job options aside from the Acute Inpatient reviews there is another field, Acute Rehabilitation CDI reviews. In San Diego, I was privileged to interview Lori Ballantyne DNP, RN-BC, CCDS. Lori is a Clinical Document Specialist in Acute Inpatient and in Acute Rehabilitation at Sharp Memorial and Sharp Grossmont in San Diego.

AD: How do you do CDS reviews in Acute Rehab?
LB: The IRF PAI (Inpatient Rehabilitation Facility Patient Assessment Instrument [1]) drives the reimbursement. There are different categories e.g. stroke, traumatic ICH (Intracranial Injury), traumatic injury, cardiovascular, orthopedics and spinal surgery. Reimbursement is dependent on tiered co-morbidities. There is more reimbursement when more complex conditions, e.g., DM with Hyperglycemia or Kidney disorder, are documented. For example, CKD has no weight, but HTN CKD w/Heart failure does. In rehab, potential query opportunities and physician documentation drives complexity.

AD: Sounds similar to HCCs?
LB: There are also IGCs (Impairment Group Codes[2]) from 1 to 16.

AD: I heard there were FIM (Functional Independence Measure) scores?
LB: They don't do FIM scores. Now, Quality Indicators rate how patients can walk and eat, with min-mod-or-max assist, and provide an estimated LOS.

AD: How often do you review?
LB: I do concurrent reviews for Tiered CCs and queries. I can see the Acute Inpatient records from Sharp and OSH scanned, and the Pre-admission screen. I follow up usually 2-3 x week. I use 3M (360) prioritization for all service lines ortho/cardiovascular/general surgery. Acute Rehab reviews are similar to acute inpatient. I monitor the development of any new conditions or query opportunities, e.g., malnutrition.

AD: Thank you! Are there any tips for the CDSs who would like to go into the specialty?
LB: I only review acute rehab 1-2 x week on specific payors. Depending on the size of facility, it could be full-time.

There are great resources for CDSs who wish to go into Acute Rehab CDS on HCPro. Included is an example of the differences for Acute Inpatient versus Acute Rehabilitation from the presentation "Development of an Inpatient Rehabilitation CDI Program" by Andrea W. Johnson, RN, BSN, CCDS[3].

Acute Inpatient Rehabilitation CDI	Acute Care CDI
• Impairment Group Codes—IGC • Etiologic diagnosis – The etiologic problem that led to the impairment for which the patient is receiving rehab – ICD-10 code(s) – Patient Assessment Instrument coding guidelines • Comorbidities—that affect a patient during or after admission, but not including the day before or day of discharge – Tiers/0, 1, 2, & 3 – ICD-10 codes – UB-04 coding guidelines (acute & post-acute care)	• Diagnostic related group-DRG • Principal diagnosis – Condition after study that caused the occasion for the admission – ICD-10 code – UB-04—coding guidelines • Comorbidities – MCC/CC – ICD-10 codes – UB coding guidelines (acute care)

Sources:

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2. http://library.ahima.org/doc?oid=70673#.YE5wGHnsbIU
3. Development of an Inpatient Rehabilitation CDI Program by Andrea W. Johnson, RN, BSN, May 23-26, 2016 HcPro, ACDIS 9th Annual Conference

CDS Spotlight Interview

Lori Ballantyne DNP, RN-BC, CCDS.

What are your favorite things to do in San Diego?
Walking outdoors, I recommend walking in the San Diego zoo.

Favorite restaurants to recommend after pandemic?
Anything Seafood.

Interesting facts about you would like to share?
I am originally from Scranton, Pennsylvania (if it sounds familiar it's where The Office TV show was based). I lived in Minneapolis for 5 years. I was a mechanical engineer and did drawing and analysis. I have a degree in architecture. In 2005, I became an Associate Degree Nurse then achieved my Bachelors. I worked the medical- surgical and telemetry floors from 2005-2015. In 2015, I became an EMR trainer then became a CDS.

What you do you love about your CDI program?
The People, we really have a great group of people!

Pet Co-Worker of the Month

Pets have been such a great source of comfort during this Pandemic. Thank you for your pictures and introducing your four legged coworkers!

For consideration in a future Newsletter please email Analyn

My Motley Crew!
Bennie on the left and Ali on the right
submitted by
Lori Ballantyne
Sharp CDS

Introducing Lexi

Voted Best Hair! In the Long Coat German Shepard Category

submitted by
Sandeep Randhawa
UCSF CDS

Now is your chance to satisfy that urge to write—CACDIS is looking for new writers to step up to the plate and write that article you've always wanted to do!

Don't be shy. We'll give you editing tips and even article suggestions if you're unsure of where to start.

Contact: Analyn Dolopo at adolopo@ucsd.edu

It's time to update your contact information for the CA ACDIS Chapter on the national roster. Doing so helps us identify your interest in volunteering for the leadership committee, speaking, or hosting an event. It also provides you with a discount code off national membership and makes you eligible for occasional deep discounts on ACDIS products and services.

https://www.surveymonkey.com/r/chapter-membership-roster

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