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CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one CCDS continuing education credit for reading the CDI Journal and taking the 20-question quiz. Visit the July/August Journal page on the ACDIS website to take the quiz.
Finding new opportunities where you least expect them

by Melissa Varnavas

When I was growing up, I wanted to be a teacher or a writer. I envisioned a life where I could be both. Those familiar with this column, and others, know that I found fulfillment in those ambitions in my role here at ACDIS, as the conduit between your experiences and the stories of your peers.

In my early 20s, with a bachelor’s degree in English and a minor in communication arts, I worked teaching pre-kindergarten summer school at a daycare center. Eventually, I found a job at Liberty Mutual insurance in their “terms and conditions” division as its only secretary in charge of helping the 30-something-strong department pick up and move its headquarters from one location to another (this was back when computer monitors were literally television-sized).

At our new location, I joined a team of three and helped label chair backs and determine the appropriate ergonomics of each desk; I also delivered mail every day and got proficient at computer solitaire.

One Christmas Eve I had the opportunity to interview for a position at my hometown newspaper. (Seriously, it was Christmas Eve, and I’m sure I’ll tell this story once again on a Christmas Eve sometime hence.) The editor hired me, and I worked my way up from cub reporter to the school beat, to city hall, to community editor, and eventually editor.

After years in the role covering late-night committee meetings, holiday parades, early-morning teacher strikes, and breaking news stories, I gave it up for a new role at a nearby company that focused the talents of reporters on the business of healthcare administration.

It was a gamble. It was an enormous leap. But I did my research. I read up on this HCPro company and figured out how far ahead of the curve it was in providing quality education and information to those working in underserved areas of the healthcare community.

This (overly) long story regarding my professional background isn’t simply an exercise in resume recitation; rather, I’m trying to point out that there are many paths to, and through, our professional lives. Many in the CDI role hail from coding or nursing backgrounds; many come to the role
as foreign medical graduates; others have experience in health information management or utilization review.

Some CDI professionals arrived here after a full career at the bedside, looking for a less physically arduous position. Some came to CDI after years in the coding profession, tired of reading through sparse medical records and intuiting that additional information could make the difference not only in facility and physician compensation, but in the overall accounting of the care provided, in the ripple effects such accounting has on us all.

More to the point, as is the point of this edition of the CDI Journal, there are so many paths that this profession has to offer—so many branches of interest, so many ways the CDI department can collaborate with others and assist in the overall quality of the medical record.

When I joined HCPro, I worked on a newsletter for dialysis facilities and another for stem cell research. I edited books on healthcare corporate compliance and learned about stand-alone radiology facilities’ billing and coding needs. Ultimately, I joined ACDIS and have had the pleasure of being part of this growing profession—of helping this fine body of dedicated individuals identify their principal goals and set a path toward achieving them.

In this edition of the CDI Journal, we welcome our new Advisory Board members as well as thank and welcome our new incoming team. Each of these amazing individuals share their stories here. James Fee’s been in the field for 12 years, Karen Newhouser 13, Judy Schade 15, Anny Yeun, 14. They each bring a diversity of professional history and personal experiences that helped provide a robust leadership team over the past three years. Their efforts produced Postiiont papers, White Papers, and guided this association and its membership toward best practices. Incoming board members have that same breadth and depth of experiences.

In the “Note from the Advisory Board,” Katy Good offers suggestions about how to move the needle on your CDI efforts without getting bogged down or losing ground on productivity goals. In the article “With big health systems come big responsibilities,” CDI program leaders talk about the management skills needed to handle CDI programs and staff across geographical and cultural challenges. In an article exploring CDI software, Julie Geiger offers insight into how new skillsets can help programs not only effectively use the technology available to them but leverage that technology to identify further documentation improvement opportunities and educational gaps for the CDI and coding teams.

As with each edition of the Journal, we set out to provide you with insight and information to help you grow on your own professional journey.

Just as the folks we spoke with for this edition, you, too, have that same opportunity—set your talents into researching and reviewing surgical records, finding ways to foster community across facilities, or reducing claims denials, to name just a few more growth possibilities outlined inside.

And remember, as you grow, we grow with you.
Prioritize your goals during CDI expansion

By Katy Good, RN, BSN, CCDS, CCS

Over the past years, progressive CDI programs have expanded to additional payer sources, begun targeted mortality reviews, and identified hospital-acquired conditions and Patient Safety Indicators, among other initiatives. Despite this, many CDI departments remained behind the scenes, mostly ignored by hospital leadership. We scrambled for visibility, for recognition of the value of our efforts.

Recently, we have seen a shift: Awareness of CDI benefits has grown, margins have thinned, and performance metrics have become increasingly important. Now, CDI programs are involved in documentation integrity across a spectrum of healthcare services. Today as well, many programs are pressured (both by the industry at large and by their own facility) to expand their original scope and achieve an ever greater effect, often without any additional resources.

At this year’s ACDIS Conference, I had many conversations with CDI professionals who were excited yet apprehensive at the prospect of additional responsibilities. These professionals clearly weren’t unwilling to learn; they were simply unsure where to start and concerned about taking on additional responsibilities with limited resources.

No one wants to sacrifice their current successes to chase new initiatives where outcomes are not guaranteed.

Hearing about everything other programs are involved in certainly breeds enthusiasm, but it also can spur anxiety at the prospect of navigating new challenges, confusion about which activities will prove most valuable, and frustration in identifying appropriate resources for implementation of new facility-based CDI initiatives.

Where to start, and how to propose expansion, were common themes that echoed through the convention center in San Antonio this May.

When determining new initiatives to pursue, CDI programs must ensure that potential CDI efforts are assessed for alignment with institutional goals. Even if other programs have had successes expanding into the ED, this doesn’t mean such a use of resources is the best idea for your particular program.

Because of this, it’s essential to clearly identify the challenges and opportunities that your department and hospital is facing. This can be a challenge in itself. Depending on their structure, CDI programs may report to various departments, and many do not have dedicated leadership that fully understands CDI and how it can be leveraged for a facility.

If CDI staff are not included in interdisciplinary meetings, they may not be aware of an opportunity. It may take additional time and effort, but it is important that facility needs drive departmental initiatives.

Prior to making any decisions, discuss current hospital challenges with direct leadership as well as other departments (HIM, care coordination, utilization review, billing, quality, finance, etc.). Identify whether there are hospitalwide goals that CDI might assist with by asking:

It is possible for a facility to look good in one specific type of quality data but fall short in another. Identify which data points leadership is most interested in.

Katy Good, RN, BSN, CCDS, CCS
- Is the facility a part of (or becoming a part of) an accountable care organization?
- Is there a service line currently being expanded?
- Has (or is) the facility expanding their physician practices and employed physician groups?

Become familiar with facility data. Financial metrics should be evaluated for weaknesses by asking:

- What are the areas of concern?
- What are the trends in medical necessity denials?
- How successful has the hospital been in overturning denials?
- Where is the hospital underperforming, according to quality data?

Be sure to assess all types of data—publicly reported quality data utilized by patients/insurers, CMS data impacting value-based purchasing, and any quality data aggregated internally. It is possible for a facility to look good in one specific type of quality data but fall short in another. Identify which data points leadership is most interested in. You certainly do not want to approach leadership to propose performing severity of illness/risk of mortality–based mortality reviews only to find that value-based purchasing readmission and mortality metrics—which are calculated with an entirely different methodology—are the real problem.

After performing a full evaluation of challenges, you can identify various CDI opportunities that could benefit the organization. Now, for each opportunity, you need to assess which initiatives would be required to affect the specific areas of concern by asking:

- What resources will be needed for this opportunity?
- What type of time frame might be needed to effect a positive change (e.g., is this a temporary focused project but an ongoing additional type of review)?
- Does the opportunity require collaboration with other departments?

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**High Impact of Solution**

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**Low Impact of Solution**

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Who will be accountable for the success of the opportunity?
What is the goal and expected outcome of the opportunity?

It can be daunting to look at all the needs and figure out where to start. However, multiple tools exist to help organize and prioritize opportunities. Facilities may make use of a particular methodology but, in the absence of institutional guidance, find a tool that assists in prioritization.

A favorite tool of mine is an impact-effort matrix, which allows you to sort potential initiatives according to how much effort they would require and how much impact their implementation would have. When sorting, think carefully about effort. Anything that involves multiple departments, for example, will likely take more effort than something wholly internal to CDI.

When organized in this way, it is easy to see what initiatives make the most sense. The initiatives in the upper left box are those with high impact and low effort (easy wins!), making them an ideal starting point.

After focus points have been identified, it is time to present them to leadership. Leadership wants (and needs) well-thought-out solutions to problems. A little extra work on the front end helps garner support and buy-in; it also ensures that everyone understands the goals of the new initiative.

Once again, there are many tools that can assist in presenting an initial plan. A simple yet effective tool is SBAR: Situation, Background, Assessment, and Recommendation. Initially developed for quick communication regarding patient status (and probably familiar to many with nursing backgrounds), the tool can also create a simple framework for presentation and discussion.

Once you’ve decided to move forward, other tools will likely be needed to add further granularity, depending on the scope of the project.

Lean tools, Gannt charts, or some other preferred method can be used to build on ideas, organize data, identify metrics for success, and measure your progress as you implement your plan. The important thing is to remain organized, track efforts, and communicate obstacles and successes.

Don’t let yourself be overwhelmed by the prospect of new CDI initiatives. Harness the post-conference excitement and drive your program forward into emerging areas of CDI that add value to your program.

To identify direction, familiarize yourself with institutional goals and challenges and identify areas where CDI can assist in or drive solutions. Then, prioritize potential projects and engage leadership for support. Track your progress and celebrate your successes.

And next year, you’ll be able to share your accomplishments with the rest of your CDI colleagues at the 2019 ACDIS Conference in Orlando!

Editor’s note: Good is a training materials specialist at Enjoin in Baton Rouge, Louisiana, and a member of the ACDIS Advisory Board serving through April 2020. The opinions expressed do not represent a consensus agreement of ACDIS or its Advisory Board. Contact Good at katy.good@enjoincdi.com. Interested in presenting at next year’s conference? Email ACDIS Associate Editorial Director mvarnavas@acdis.org.
Welcome new ACDIS Advisory Board members; farewell and thanks to those stepping down

Serving on the ACDIS Advisory Board is a huge commitment that requires dedication, patience, and expertise. Members serve as the guiding light to the association and to the profession as a whole over their three-year terms. During that time, members participate in ACDIS’ quarterly membership conference calls, hold meetings, write ACDIS position papers and white papers, respond to questions from members, and much more.

Each April, four members step down from the board and are replaced by four new faces from a pool of candidates chosen by the Advisory Board election committee and voted on by the ACDIS membership. The ACDIS team wanted to spend a little time getting to know the folks who have recently rotated off and familiarizing you with the new members. Please take a moment to say thank you to these individuals and introduce yourself to them! (To see a full list of the Advisory Board members, see p. 5.)

**Departing members**

James P. Fee, MD, CCS, CCDS  
CEO  
Enjoin CDI  
Baton Rouge, Louisiana  
James.Fee@enjoincdi.com

How long have you been in the CDI field and how did you get started in the field?

I have been in the field for 12 years and began as a physician advisor for a tertiary medical center in North Carolina. I entered into consulting approximately seven years ago. I entered the CDI field because I felt that complete and accurate documentation was critical for quality patient care as well as accurate reimbursement and performance monitoring of institutions and providers.

What made you decide to apply for the ACDIS Advisory Board?

I applied for the Advisory Board because I wanted to work closely with professionals in the industry to define the future of the profession as healthcare was changing. I also wanted to foster provider/physician participation and help facilities understand and adopt the importance of the CDI mission.

As a practicing physician, incorporating the critical components of complete and accurate documentation and coding into my workflow
helped me guide the organization to the realism of provider engagement.

What’s been your biggest reward/favorite memory in serving on the Board?

Speaking at the ACDIS Conference, collaborating with other leaders in the profession, and providing guidance to members in person, through authorship, and membership calls.

What piece of advice would you offer to a new CDI specialist?

Keep your eye on the big picture of healthcare evolution. In doing so, you will understand how we, as CDI professionals, impact patient care—one record at a time.

James P. Fee, MD, CCS, CCDS

How long have you been in the CDI field and how did you get started in the field?

I’ve been involved in the CDI profession since 2004. It honestly doesn’t seem possible even as I write it because the last 14 years have flown by. I guess it’s true that time flies when you’re having fun!

I was a case manager in the ICU of a Level I trauma hospital when we began to perform CDI reviews along with our case management duties in 2004. It took only a short time before I was hooked on the profession, and when CDI became a dedicated department in 2007, I was the first one to make the leap.

What made you decide to apply for the ACDIS Advisory Board?

The CDI department is typically a very small group in a hospital, and it’s easy to become isolated from the larger events surrounding CDI efforts across the country. I realized that I could effect change on a grand scale by assisting ACDIS in developing CDI best practices and getting the word out about this amazing profession that has become my niche.

What’s been your biggest reward/favorite memory in serving on the Board?

By and large, it has been the people. I’ve met so many wonderful CDI professionals during my tenure on the board and have been in awe of each one of them. I’ve often felt I wasn’t worthy to be in midst of such a knowledgeable group. I’m leaving the board with friends for life.

What piece of advice would you offer to a new CDI specialist?

1. At all times, remember that it is all about the patient.
2. Set yourself up for success by being in a continual state of growth and learning.
3. Enjoy the journey!

Now that you’ve rotated off the Board, what do you have planned for your new-found time?

Aside from my two sons, my passions are gardening and writing. I’m planting my vegetable garden and flower beds on my recently acquired property, and I plan to dust off a book that I’ve been writing and finally get ‘er done! I’m also planning a trip to Australia this summer.

Judy Schade, RN, MSN, CCM, CCDS
Quality and education specialist—CDI
Mayo Clinic Health System
Rochester, Minnesota
Schade.judy@mayo.edu

James P. Fee, MD, CCS, CCDS

Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP
Director of CDI Education
MedPartners
Tampa, Florida
knewhouser@medpartnershim.com

How long have you been in the CDI field and how did you get started in the field?

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Judy Schade, RN, MSN, CCM, CCDS
Quality and education specialist—CDI
Mayo Clinic Health System
Rochester, Minnesota
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perspective from developing a CDI program, performing the daily duties of CDI, and engagement in comprehensive provider education.

The ability to see an issue from different views is very important so the board can serve and advise our entire membership. I have to say I was impressed at the amount of insight and knowledge of the other board members, and even though there were times we disagreed and had lively discussions, we functioned as a united team and respected our diversity.

What’s been your biggest reward/favorite memory in serving on the Board?

One of the biggest rewards was the ability to have a voice in decisions that shape the future of CDI. I will be forever grateful to ACDIS for the information and resources that afforded me the opportunity for growth in my CDI career. Another benefit was all the friends I have made along this journey.

What piece of advice would you offer to a new CDI specialist?

My advice to new CDI specialists would be to take the opportunity to network with others, learn something new every day, embrace the challenges, and focus on how you can contribute to this great profession.

Being a CDI specialist has probably been one of the most challenging positions in my nursing career, however, it’s also been filled with many rewards.

Now that you’ve rotated off the Board, what do you have planned for your new-found time?

“The end has proved to be another beginning.” I am excited to have had the opportunity to serve on the ACDIS Advisory Board and look forward to many interesting and enlightening articles and papers from the current Advisory Board members. A priority for me will be to spend more time with my three grandchildren, which is priceless!

Anny P. Yuen, RHIA, CCS, CCDS, CDIP
Principal
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How long have you been in the CDI field and how did you get started in the field?

I started my career in HIM/revenue cycle, but I have been working in CDI specifically for more than 13 years. I started focusing my career in CDI when I was working as a DRG validator/billing compliance manager. I noticed that many providers were not aware of the difference between clinical and coding language. This lack of knowledge resulted in inaccurate data reporting and affected the provider’s billing and compliance; therefore, I was offered an opportunity to begin educating the providers on the importance of documentation improvement and coding guidelines/coding conundrums.

What made you decide to apply for the ACDIS Advisory Board?

I guess I decided to apply for the ACDIS Advisory Board because of my passion for CDI. I felt strongly that my background in HIM/revenue cycle brought a different perspective to the CDI industry. I truly believe that the success of CDI within an organization is through collaboration amongst a multidisciplinary team.

Unfortunately, many organizations frequently encounter a strain and/or a barrier with the relationship between CDI and coding professionals. As a result, I thought that being on the Advisory Board would allow me an opportunity to share my experiences and provide me a platform to be the liaison between coding and providers in the CDI industry and between AHIMA and ACDIS since I am a member of both organizations.

Furthermore, since I began my career with no tools, I just wanted to give back to my industry and share my knowledge/experiences.

What’s been your biggest reward/favorite memory in serving on the Board?

As I reflect, there are so many favorite memories because I was serving with so many colleagues,
now friends, who share the same passion that I do. But, if I must choose one favorite memory, it would be at the Atlanta ACDIS Conference in 2016. The Advisory Board post-dinner walk back to our hotels where a few of us stopped at this park and some of my dear friends decided to run through a water fountain … need I say more?

Serving on the Board really has been a wonderful and rewarding journey. Who would have thought I could actually write an article and/or book about inpatient/outpatient CDI?

But, all jokes aside, I am so proud of what the Board has accomplished during the last three years. I have personally learned so much from all of my fellow colleagues/friends. I feel the biggest reward is seeing that the members found our work helpful and that the dialogue and collaboration between AHIMA and ACDIS is moving in the right direction.

What piece of advice would you offer to a new CDI specialist?

It takes time to understand the intricacy of CDI. No one becomes a CDI specialist overnight, so you will have to be patient. One day you will reach an epiphany and everything you learned about DRGs, coding, how to query, and when to query will just make sense.

You can continue to build your career in CDI whichever way you want through education, but just remain open-minded—healthcare continuously evolves, so what you learned today may not be applicable tomorrow.

Now that you’ve rotated off the Board, what do you have planned for your new-found time?

Sleep! But, I’m sure I will remain an active member in the CDI community since I am currently on the AHIMA Clinical Documentation Improvement Practice Council and the 2018 ACDIS Symposium Committee.

New members

Fran Jurcak, MSN, RN, CCDS
Vice president of clinical innovation
Iodine Software
Austin, Texas
fran@iodinesoftware.com

How long have you been in the CDI field and how did you get started in the field?

I started in the consulting side of CDI 12 years ago at JA Thomas where I implemented many new programs and provided new-hire training. I moved to Huron Consulting shortly after and became very involved in the professional organization, volunteering to serve on the CCDS Certification Advisory Board, authoring the CCDS Study Guide, and speaking at multiple national and local conferences as well as a number of HCPro webinars.

My passion for CDI and documentation integrity continued to grow as I became more involved with leaders of CDI programs. I often served as a temporary lead for larger systems and realized the huge gap in available resources for managers and directors of CDI to effectively lead their programs.

What made you decide to apply for the ACDIS Advisory Board a second time?

This is the second time I have had the honor to serve on the Advisory Board. The CDI profession has changed significantly since I last served on the board, and the role of the ACDIS Advisory Board has slowly changed with it. I want to be a voice for CDI specialists and their leaders, creating more direct guidelines for practice.

In my application, I wrote that I wish to help support those working in the CDI profession by advocating best practices on a national level and bringing to the board the various perspectives and voices I hear across the country.

What are you looking forward to the most about serving on the Board?

Creating a voice for CDI in national legislation, but also helping CDI specialists to use their voice in their own organizations. Most healthcare providers outside of CDI don’t understand the value of CDI or appreciate their hard work. It’s time we are recognized as a profession of intelligent, compassionate leaders in healthcare and share the value of our work.

What piece of advice would you offer to a new CDI specialist?

Take time to learn something new every day. This profession is constantly growing and changing, and it’s important to take time to absorb
the information, process it, apply it to your practice, and share with others. This is truly a team profession, and only through work with other CDI specialists, coders, and providers will the integrity of medical record documentation occur.

Since you’ve served on the Board before, what was your favorite memory/experience from your last term?

I am extraordinarily proud of the ACDIS/AHIMA query brief and the collaboration that occurred to get that document published. The multiple calls/meetings with shared professional opinions and the resulting quality document that was readily accepted and used by CDI professionals across the country was well worth the effort.

I look forward to the opportunity to update this document in the next year and hope that we can continue to publish other documents that support the CDI profession.

Jeff Morris, RN, BSN, CCDS
Supervisor, CDI
University of South Alabama Health System
Mobile, Alabama
jwmorris@health.southalabama.edu

We all have the same struggles whether you are four miles apart or 4,000, so I always encourage new CDI specialists to network as much as they can.

Jeff Morris, RN, BSN, CCDS

I've been in the CDI field for six and a half years. Initially, our health system hired two CDI specialists (one at each hospital) to serve as the liaison between the coding professionals and the providers. We were tasked with learning the documentation requirements for various disease processes and what specificity would be needed for the ICD-10 conversion. We provided education about documentation specificity, the potential increase in queries with ICD-10, etc., to the provider staff. After numerous ICD-10 delays, we began traditional CDI reviews and built a team of CDI specialists at each hospital.

What made you decide to apply for the ACDIS Advisory Board?

CDI, even though not in its infancy anymore, still has room to expand and improve. Many of us out there in the profession are faced with challenges daily, and I’d like to help steer the future of the profession with input from the membership.

What are you looking forward to the most about serving on the Board?

I am most looking forward to serving the membership of ACDIS by assisting with documents and guidance that will steer our profession and the industry. I am excited to start working on white papers and other tools that will benefit others.

What piece of advice would you offer to a new CDI specialist?

The most important piece of advice is to use the resources that ACDIS provides. Posting questions to the Forum and having conversations with other CDI specialists across the country is how I learned much of what I know today. We all have the same struggles whether we are four miles apart or 4,000, so I always encourage new CDI specialists to network as much as they can.

Erica Remer, MD, FACEP, CCDS
Independent consultant
Erica Remer, MD, Inc.
Cleveland, Ohio
eremer@icd10md.com

How long have you been in the CDI field and how did you get started in the field?

I practiced emergency medicine for 25 years and was always the department expert in documentation and professional billing. My boss showed me a posting for a new position at University Hospitals Health System in Cleveland for a CDI physician advisor, and I took it.

The role expanded and evolved. I trained 2,700 providers in ICD-10, participated in designing query templates, served as the top tier of the query escalation process, interfaced with quality for CDI-related mortality reviews, and appealed numerous denials.

My passion was, and still is, education of residents and healthcare providers, CDI professionals, and coders. In July 2016, I transitioned to being an independent consultant and continue to provide CDI-related education.
What made you decide to apply for the ACDIS Advisory Board?

I wanted a venue to share my knowledge and expertise with other like-minded professionals, and I wanted a way to learn from authorities in the field. ACDIS is the premier CDI organization, and the Advisory Board seemed like the perfect fit. I am grateful to have been selected and want to help shape the future of CDI.

What are you looking forward to the most about serving on the Board?

I look forward to working with the experts and learning from them. I look forward to meeting knowledgeable CDI specialists who share my passion for CDI. I am excited to attend the national conference annually. I want to help explore and disseminate best practices in our field.

What piece of advice would you offer to a new CDI specialist?

Read the documentation and make sure it is telling a cogent story. If it isn’t, there’s something missing. If a traditional or clinical validation query can resolve that issue, generate one and follow up until you get a satisfactory response. Your goal is to have your providers tell the story while they tell the truth.

New CDI professionals come from different backgrounds—usually clinical or coding. CDI requires expertise in both. My advice will be to learn as much as you can about the other field. You cannot be successful without acquiring expertise in both.

Irina Zusman, RHIA, CCS, CCDS
Director of HIM coding and CDI initiatives
NYU Langone Health
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How long have you been in the CDI field and how did you get started in the field?

I started working as a clinical documentation specialist in 2001, but was querying and educating physicians a long time before this since I worked as a coding professional.

What made you decide to apply for the ACDIS Advisory Board?

I am a great enthusiast of HIM and through my years of experience, I mentored many new professionals and helped them to develop their skills. As an HIM leader, I hope that my expertise will be helpful in further aligning two types of professionals that are essential for a successful CDI program—coders and clinicians.

What are you looking forward to the most about serving on the Board?

Working for NYU Health System, I am very focused on the data quality and would like to concentrate my efforts on standardization of reporting. With the element of subjectivism that now exists in coding, we know that facilities report their data differently, and therefore, any organization that compares many hospitals (like Leapfrog, Healthgrades, etc.) usually does not compare apples to apples.

With the help of the other board members, I would like to initiate developing of national policies on reporting of different conditions like sepsis, anemia, and postoperative complications.

What piece of advice would you offer to a new CDI specialist?
Of the 4,840 short-term acute care hospitals in the United States, 3,231 of them were part of a hospital system in 2016, according to the American Hospital Association. Though the 2017 data has yet to be released, one might naturally assume the number would increase, as every day seems to bring new stories of hospital mergers and system acquisitions.

For CDI programs, this prevalence of health systems over freestanding facilities can pose a major problem for uniformity of education and CDI practice. CDI program managers and directors in multifacility systems often struggle to overcome individual hospital culture, create collaborative climates, craft effective (and standardized) query practice policies and procedures, and establish productivity expectations.

When the CDI team is distributed between several facilities of differing types and patient populations in several geographic locations, CDI managers and directors have the difficult role of bringing them together to form a cohesive and successful team.

Since CDI leaders can’t be in five facilities at once, how do they approach managing their team effectively?

Assess the culture

When a new manager or director steps into the role, the job of unifying a distributed team can seem daunting. Even the most stalwart of leaders may not quite know where to start. The best way to begin is by assessing the current cultural landscape across the system—in other words, establishing a baseline, says Tonya Motsinger, MBA, BSN, RN, system director of CDI at Ohio Health in Columbus.

“When I first started, we had five campuses and then one independent campus. They range from a small community hospital to our largest, which has more than 700 beds. They had a nominal cross-campus collaborative effort at the time,” she says. Her 12 staff collaborated about once per month, but their independent processes and cultures were very different.

No matter where the culture stands when you begin, efforts should aim at transparency across the system. This will ensure every facility’s team knows what the other facilities are doing, says Mel Tully, MSN, CCDS, vice president of CDI.
clinical services and education at Nuance, based in Atlanta.

“You have to try to keep consistency of a CDI program to be able to provide the support that each hospital deserves,” she says.

Building that transparency also helps to increase the feeling that, although they’re spread across several facilities, the CDI team is united and can rely on each other when questions arise.

**Standardize processes**

CDI managers and directors need to find ways to build the trust between the dispersed team members. Motsinger says this can only be fully accomplished by maintaining the personality (so to speak) of each facility while streamlining the processes of all the individual CDI teams.

“We immediately started working on putting processes in place across the system. It had to work out, even across facilities, Motsinger says. This could be especially beneficial in instances where a facility within a larger system only has a single CDI professional on staff. When that lone CDI specialist encounters a question, he or she needs to be able to reach out to another facility for answers. This can only happen when the processes are uniform—and only if the team member knows those distant colleagues well enough to reach out.

“If another campus has a question on something, they need to feel safe calling another facility,” says Motsinger. “That was a really big and important goal for our team to meet: to create a very safe environment.”

Systemwide policies and procedures also help ensure cross-coverage for vacations and sick days. According to Tully, CDI program managers and directors need to ask themselves, “Do you have the ability to allocate or assign floaters, or interims, or people who do remote reviews to fill the gaps across the whole system?”

For example, if that lone CDI specialist goes on vacation or gets sick, what happens to the reviews in the interim? If there’s no one to pitch in, there’ll be a mountain of reviews once the specialist returns; patients may be discharged and bills dropped before he or she can get to them. If the CDI processes and policies are uniform across the system, however, a CDI specialist from another facility could easily jump in and, following the same process as always, successfully conduct chart reviews and issue queries in place of the absent staffer.

“We tried to preserve the individuality of each facility, but also make sure things are systemwide so there’s coverage,” says Motsinger. “If someone is off, someone else can effectively jump right into that person’s patient population.”

**Share information**

For those systemwide policies and procedures to be universally implemented, there needs to be some sort of system for sharing information. CDI managers and directors have to ensure that the information disseminated to the various facilities comes from one location, avoiding a telephone-game situation where the end information is a garbled version of the original.

While there are a number of ways to accomplish this, Tully suggests facilities institute a steering committee to develop and disseminate the policies and procedures. That steering committee should include all the key players from the hospitals so that the agreed-upon policies reflect stakeholder goals, she says.

Then, once the policies have been settled, the steering committee should be the governing body to pass along the information to the individual facility leadership, making sure nothing gets lost in translation along the way.
“Information sharing should really begin with the steering committee,” says Tully. “Everyone should do everything pretty much the same, and if there’s a caveat, everyone should recognize that caveat.”

Motsinger also suggests holding regular meetings with the CDI staff from all the facilities in attendance. Not only does this aid the dissemination of uniform information to all the facilities, but it also serves to build a team atmosphere by creating face-to-face learning opportunities and comradery across the program.

“We have a monthly system meeting where everyone comes. If they’re at a farther campus, they can video in, but the important thing is that we

## A CENTRALIZED MODEL FOR SYSTEM-WIDE CDI SUCCESS

Many leading multifacility CDI teams deal with the added difficulty of geographical distance, but at SCAL Kaiser Permanente the CDI team reviews cases at a centralized office, which leads to a team atmosphere from the get-go, says Susan Schmitz, JD, RN, CCS, CCDS, CDIP, the regional director there, based in Pasadena, California.

“They’re not all spread out, and that helps so much,” she says of her 25 team members. “I have the perfect team right now. I have hired some people who obviously weren’t a good fit before, but they tend to weed themselves out.”

With all the team members in close proximity, Schmitz says it’s easy to tell if a new team member is fitting in well with the group as there’s nowhere they can hide. “They tend to complain and they’re unhappy,” she says.

On the flip side, however, the close quarters also allows for more team building activities. One such activity is a biweekly breakfast club, Schmitz says, where all the team members bring in breakfast foods to share. “We try to make it feel more personal,” she says.

Not only do the team members form closer bonds thanks to being around each other, but the model also allows Schmitz to stay constantly involved with her team.

“I think it’s very important to round on your staff frequently, so they know you’re there and they know you’re available,” she says. “With my background in nursing, it’s just part of my personality. I want to know how my staff is doing. I want them to know they’re supported.”

That support doesn’t only come from her, Schmitz points out. Because the whole team uses the same EHR and CDI software, they can easily see where help is needed. “The staff sees all the worklists across all the facilities all at once,” she says. “Once they’ve completed the reviews at their facility, they jump over to one of the other facilities.”

Of course, with the entire CDI staff working remotely—albeit from a centralized location—some tasks do become more challenging. Physician engagement, for example, can be tricky when there aren’t any CDI specialists at each facility (as anyone with a remote team can likely attest). To ensure the education is disseminated to the physicians and that physicians buy into the program, Schmitz takes it on herself to visit each location periodically along with her team lead to talk about documentation and the CDI team’s efforts, she says. In fact, the CDI team’s physician advisors are so engaged that if a query isn’t answered in 24 hours, they reach out immediately to the physician in question and serve as “boots on the ground” for Schmitz and her team.

Though it may have its own difficulties, ultimately, Schmitz says the centralized model works well for Kaiser and the CDI team members.

“Everyone is really well-versed for any kind of condition and diagnosis at any facility,” she says. “They all learn from each other, and everybody works well together.”
can see them and they can see us,” Motsinger says.

Between those in-person meetings, all the information—whether it be an escalation policy, query templates, or educational tools—should be stored in a place that’s easily accessible for all the facilities. That way, even between meetings, everyone has resources at their fingertips. At Ohio Health, Motsinger stores all those documents online for easy access.

“We have a well-developed e-source site for information sharing created by one of our CDI committees,” Motsinger says. “People’s calendars are in there so everyone knows when people are off too. There’s one place everyone can look for everything.”

Get creative

Sometimes a CDI manager or director needs to take a creative approach. Though group meetings and systemized processes will certainly help create a uniform CDI program across the system, it may not have as much success in fostering a true team spirit than other, more creative approaches since everyone still works daily with only their facility team.

“We created cross-campus committees that help people get to know each other and collaboratively work on projects that impact our outcomes for the entire system,” says Motsinger. These committees helped the team recognize that, although they’re responsible for their individual facilities, together the CDI team is working for the good of the whole system, she says.

Those smaller committees could also be segregated to each facility with the enterprise committee comprised of representatives from all the facilities, Tully says. “It’s important to have an enterprise steering committee,” she explains, “but also to have individual committees at each hospital reporting up to the enterprise committee,” to ensure that each individual facility’s voice is heard by the larger whole.

Though forming committees is an approach many CDI managers and directors are familiar with, Motsinger also suggests using some less conventional and more fun methods to instill a team atmosphere across the system.

“We did a summer retreat event. We took the ‘Strength Finders’ survey by Tom Rath because I wanted people to understand that even though people worked differently, it didn’t mean they were working wrong,” says Motsinger. “Everyone took the test and read the books, and I had an HR representative come and talk to us. Then we all did activities to cement the content of the book. It was a time of self-realization to find out how you work and how your neighbors work.”

Though a staff retreat will definitely help team members get to know each other and build relationships across facility lines, employing personality tests can help staff feel that their individual strengths matter to the CDI program as a whole; it can also help the manager or director identify areas in which each individual staff member will thrive. For example, an introverted staff member may not be as adept at teaching groups of physicians as an extroverted one, but they may be quite good at educating on a one-on-one basis.

Motsinger warns, however, that using the personality tests only works with follow-up efforts from the manager or director. If the team members take the tests, talk about them, and then forget they happened two months after the retreat, they won’t yield anything substantial. The staff profiles are also on Motsinger’s bulletin board for easy, transparent reference.

“We went back six months later and I had them break out in their steering committee, and I gave them an exercise that would help them understand their strengths. It wasn’t that we just did it and then forgot about it,” Motsinger says. “It was a really good exercise and shed a lot of light on where people are.”

Having those follow-up meetings and exercises reminds the team of their own strengths and the strengths of their fellow team members. Those reminders serve as a memory jog for CDI staff when they run into trouble in their day-to-day work. And, when questions do arise, they feel comfortable reaching out across facility lines for help and advice.

“We have a lot of people who work really hard,” says Motsinger. “That’s really what has fostered this team-centered environment.”
Many local chapter leaders volunteer due to a sense of excitement about the CDI profession and a desire to learn and network with other CDI professionals. Others simply have a desire to give back.

Regardless, for ACDIS local chapters and networking groups to thrive, each organization needs to foster and mentor a continuous group of potential new leaders. The following article outlines a few ideas to facilitate the involvement of new volunteers and ensure a successful leadership transition.

**First things first**

“When you first start out, you don’t have a broad base of people to choose from in terms of volunteers, so you need leaders (and co-leaders) who can be organized but think on the fly and troubleshoot in situations of difficulties,” says Lori LaFaver, BSN, RN, CCDS, co-leader for the central Pennsylvania ACDIS chapter and a member of ACDIS’ Chapter Advisory Board (CAB).

Founding chapter leaders often don’t give much thought to not being a chapter leader. They focus all their energy on getting the chapter started, finding co-leaders and attendees, identifying speakers, and figuring out how to wrangle a host for the next event.

As a current or founding chapter leader, however, identifying and nurturing possible leaders is as important an aspect of the role as holding the meetings themselves.
Throughout the early months of the chapter (networking) group’s existence, leaders need to pay attention to those inquisitive minds in the group, approaching individuals during breaks or post-session to engage and network. Thoughtful participants often make great leaders.

**Volunteer attributes**

Again, in the early days and months of chapter development, leaders need to play more of a mentoring and nurturing role in bringing potential new leaders into the fold.

This means approaching attendees individually and encouraging them to participate more—maybe by volunteering to host or speak, helping with the setup at the next event, or joining the leadership team for planning calls.

Potential leaders should possess:
- An active ACDIS membership
- Interpersonal, planning, and time management skills
- An ability to delegate and prioritize
- Collaborative expertise
- A passion for the CDI profession

“Leaders should be focused and detail-oriented,” says Aimee Van Balen, RN, CCDS, past chapter leader of the Massachusetts ACDIS chapter and CAB member, because there are “a lot of moving parts” required to maintain the chapter and to organize regular events.

Emily Emmons, RN, MSN, CCDS, CAB member and co-leader for the California ACDIS chapter, agrees. “Leaders really need to be good planners,” she says. “That’s the bulk of leadership responsibilities—planning the next meeting, learning from its successes, and moving on to the next event.”

As leaders get to know their chapter members better, they should seek out those who may have past experience on other boards and committees—either professional experience, with participation in nursing, case management, or coding/HIM associations, or personal experience, serving on student associations, parent-teacher groups, religious committees, or athletic associations.

“Even minor involvement on groups like this can provide context for a new leader,” says Molly Siebert, RHIA, CCDS, past Oregon ACDIS chapter leader and fellow CAB member.

Lillian Dickey, RN, BSBA, a co-leader in the Washington ACDIS chapter and CAB member, had participated on boards and committees in her private life and says the experience helped, but she notes that joining the leadership team of an established, multiyear group is different from joining a chapter that’s just getting started.

“Volunteer leaders should be goal-oriented and reliable to effectively support co-leaders and the local chapter as a whole,” says Alma Yap, RN, CCDS, CDIP, fellow CAB member and co-leader for the Arizona ACDIS chapter.

Volunteers should also understand the time commitment involved, Yap says, and be able to keep competing priorities organized.

“Understand that event planning will take some amount of time and effort that may compete with personal or work priorities. Clear and timely communication with other leadership team members about chapter responsibilities will help in achieving the desired results,” she says. “In addition, having the passion and humility to serve are leadership qualities that will be essential in any volunteer positions.”

In Tennessee, the initial core team of leaders were voted on at the startup meeting, explains Sherri Clark, RN-BC, CCDS, CCS, HT (ASCP), an honorary CAB member and one of the founding core leadership team there.

The “Volunteer State” altered the makeup of its core team over the years based on how interest and desired involvement changed.

“The ‘Volunteer State’ altered the makeup of its core team over the years based on how interest and desired involvement changed. “Continued participation on the core team was based on the desire and ability to actively contribute to chapter business,” says Clark.
Vetting volunteers

Chapters with a history of at least two years of networking activities should have a strong networking group in which leaders and members know one another. With this foundation, current leaders may have strong feelings as to whether an individual would make a good incoming leader or volunteer.

In the absence of formal bylaws defining voting and transition policies, the current leadership team should perform due diligence to ensure a leader/volunteer candidate’s professional status and membership in the national organization.

Current leaders may want to ask for a professional bio, resume, or links to the individual’s professional online profile on sites such as LinkedIn.

Of course, new members should be entering the field and joining the chapter all the time, and leaders should do their best to recognize these individuals and welcome them to the group. Current leaders may wish to encourage new members to volunteer as a helper, speaker, or event host prior to assigning them to core leadership duties.

Be careful not to dissuade such individuals if they’re gung-ho about taking additional responsibility, however, as they could prove invaluable for the continuation of the group in years to come.

Take advantage of the tools and knowledge of the staff at national ACDIS, too. If you need assistance with finding a speaker, professional development, or problem-solving—or if you just need to run something by someone—they are always willing to assist. Contact Associate Editorial Director Melissa Varnavas at mvarnavas@acdis.org or ACDIS Editor Linnea Archibald at larchibald@acdis.org.

Volunteer benefits

ACDIS provides core leadership volunteers (the three principal volunteers required per the agreement form) with a 50% discount off national membership (or a product of their choice) the year following the successful competition of their leadership duties. ACDIS national also often provides additional professional development opportunities to its chapter leaders depending on their needs.

Local chapter leaders also can connect to the national administration through the leadership team’s regular planning calls and with the CAB for advice on related activities.

“The real benefit of being a local chapter leader,” says Emmons, “is that when you are volunteering on the local level, you are giving back to the CDI community—your professional community. It’s not only about providing professional development for the members who attend these local events, but it’s professional development that you are creating for yourself.”

“I have truly learned a ton since I joined the local chapter leadership team,” says Van Balen, “not only about best practices in CDI but about myself, about leadership qualities, and how to incorporate what I’ve learned into my professional career and forge a path for myself.”

“Working alongside my co-chapter leaders as well as with diversified healthcare professionals have been truly rewarding,” says Yap. “The CDI knowledge and involvement gained throughout my volunteer experience has been invaluable. I have met a lot of great people and I have been able to enhance my skills in leading a professional organization.”

Volunteer roles, responsibilities

Each local chapter and networking group decides on the leadership responsibilities and format needed for their events. Some groups have formal bylaws governing local chapter practices, including leadership transitions. Others follow much more informal processes.

ACDIS recommends that any group that has been an official local chapter for three years or more establish a set of bylaws governing the roles and responsibilities of the leadership team and the leadership transition process.

ACDIS does not prescribe these roles but at a minimum it requires that:

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The CDI knowledge ...gained throughout my volunteer experience has been invaluable. I have met a lot of great people and I have been able to enhance my skills in leading a professional organization.

Alma Yap, RN, CCDS, CDIP
Three core leaders from three different organizations serve on the leadership team.

All three leaders be ACDIS members.

Leaders meet regularly to plan events for chapter members.

Leaders hold ongoing educational and networking events for its membership.

Leaders regularly communicate with ACDIS national administrators.

Getting to know your CDI peers on local, state, and national levels is a professional WIN! Since becoming a leader, I have learned so much from my peers on all levels that I wouldn’t have otherwise.

Karen Elmore, RN, BSN, CCDS

For ongoing meetings, the team picks a host and location, and the team member who lives closest to that location takes the lead on organizing the meeting and delegating related tasks (e.g., recruiting speakers, meal planning, and CEU application).

The rotation of chapter meetings around the state ensures that each member of the core team takes the lead responsibilities for at least one event per year.

Some chapters have president, vice-president, secretary, and treasurer roles. These clearly delineated responsibilities are vitally important for groups with nonprofit status, dues collection, and financial obligations.

“Any financial obligations represent a big responsibility, which needs to be owned not only by the treasurer but by the entire leadership team with procedures in place to protect the chapter’s finances,” says Siebert.

Some chapters have a team of co-leaders with additional volunteers serving as “understudies” who shadow current leaders for a year before taking on the leadership duties themselves—that’s the case with the Arizona ACDIS chapter, says Yap, who led the group for three years.

Regardless of how the roles are defined, the simple act of providing clear goals and objectives for the leaders may make volunteering a more appealing prospect for those previously on the fence about stepping forward.

Leaders should clearly and consistently remind members as to when a current leader may be slated to transition off the team, what the responsibilities of that position entail, and the time requirements related to that individual’s duties, adds Van Balen.

“Volunteers need to know what they are getting themselves into,” says Siebert, “so outlining each position within the bylaws can help with this.”

For more information on bylaws and definitions of roles and responsibilities visit the Leadership Toolkit on the ACDIS website.

Transition timing

ACDIS believes formalizing the transition process helps ensure the continuity of the group and the transparency of that process.

The Florida chapter conducts new-board-member voting in the spring, according to past-president Deb Dallos, CDIP, RN, a CAB member.

The president collects volunteers’ bios and other information, presents that information to the chapter members, and creates an online survey that members use to vote in the new leadership team.

At their spring quarterly meeting, the president introduces the new board with a slide presentation. Following the event, the incoming and outgoing teams have a business meeting to discuss the duties and responsibilities of each position (prior to this, all candidates have been sent position responsibilities
NOTE FROM THE CDI PRACTICE GUIDELINES COMMITTEE

CDI software for more than just CC/MCC capture

By Julie Geiger, BSN, RN, CCDS, CDIP

Data in CDI reports should demonstrate the depth of work performed as well as productivity elements. I want to share my experience of personalizing data fields in our CDI software to fully demonstrate our CDI team’s impact beyond moving the DRG.

In our software, the standard drop-down options for query impact contained options for principal diagnosis, MCC, CC, and procedure. The only other options beyond financial impact were “none” and “other.” While such limited options are sufficient for a new CDI program or a program focused solely on DRG opportunity, only having these options available to determine the effect of CDI efforts doesn’t provide any clarity or detail beyond the fact that a query changed the DRG.

As our program matured, there were fewer opportunities for a CDI query response to be the only MCC or CC in a chart. And, if a query response resulted in the only MCC or CC, the CDI specialist’s work was not done. Instead, the specialist would continue seeking an opportunity to query for a second CC or MCC. By going beyond the basics, however, the query impacts were marked as “other” or “none” due to the options available in the software.

As a result, many of my coworkers felt that their query impacts seemed less important. I stressed to them that all queries are important and impactful even beyond the DRG optimization. When reviewing reports, though, I could not effectively demonstrate the depth of the team’s query efforts.

Therefore, I worked with our facility IT resource to learn how to add options to the drop-down menu and set the drop-down options in hierarchical order. The basics be shared with the membership and approved at the nearest event. Leaders should also share updated bylaws with the national staff.

Chapters that decide to take a less formal approach can be successful as long as communication between chapter leaders and members is open and receptive.

“Getting to know your CDI peers on local, state, and national levels is a professional WIN!” says Karen Elmore, RN, BSN, CCDS, chapter leader of Heart of Missouri ACDIS and Missouri State Chapter ACDIS, as well as a CAB leader. “Since becoming a leader, I have learned so much from my peers on all levels that I wouldn’t have otherwise.”
such as principal diagnosis, MCC, CC, and procedure came at the top of the list, followed by new options that more accurately reflected the additional specificity the CDI staff were obtaining.

Utilize your drop-down options to encompass your department’s focus or mission. We updated our drop-downs to reflect priorities related to ICD-10 implementation at the time, and as our query focus evolved over the years, I updated the drop-down list to capture the CDI specialists’ work.

For example, queries are sent for procedure specificity when operative notes are missing details. Adding diagnosis and procedure specificity as drop-down menu options enabled me to share with coding the concurrent work CDI was doing to facilitate the highest specificity of code assignment.

As the team began identifying additional CCs/MCCs to deter DRG downgrades, additional drop-down menu options were added.

I added a diagnosis validity option to illustrate the team’s work related to clinical validation. This option allowed reporting to show how often queries are sent and trend which physicians or specialty groups were being queried for diagnosis validity.

We also added a general category for “record clarity.” There may be times where the outcomes of the query is simply that. To me, it feels far more rewarding to select “record clarity” as the query impact rather than “other.”

Hierarchical Condition Categories (HCC) and quality measures were also added to our drop-downs with updates to the software, and I encourage people to use these options if they fit into your department’s focus or mission statement.

Our team also audits the CDI specialists’ choice regarding the type of query impact issued through the reconciliation workflow. They make sure that the type of query impact listed concurrently remains the outcome of the query after final coding.

Having details on the specific type of query outcomes beyond the DRG optimization can provide better reports to share. The team can receive more detailed, nuanced information about their efforts beyond the financial reports.

CDI leadership can see the expanded work of the team and validate why review time is lengthier as our focus expands. These reports can be shared with coding to show work done concurrently on diagnosis and procedure specificity, since often a facility doesn’t hold a bill to retrospectively query for specificity of a documented unspecified diagnosis.

I have the ability to modify field elements in our EHR and also have a phenomenal resource when I have questions. For those that do not have administrative access to the CDI software, reach out to your information systems or IT contact for assistance.

I am interested in knowing how other CDI programs customize fields in CDI software to make sure the report data captures the depth of the department’s focus.

**Editor’s note:** Geiger is the clinical documentation specialist supervisor at Parkview Health in Fort Wayne, Indiana, and a member of the ACDIS CDI Practice Guidelines Committee. Contact her at Julie.Geiger@parkview.com. Opinions expressed are those of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.

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**SAMPLE INFORMATION SHARED WITH TEAM MONTHLY**

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Agreed and Documented queries

of the agreed and documented queries:

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Queries resulted in DRG change

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Queries resulted in second CC/MCC

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Queries resulted in diagnosis or procedure specificity

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Queries sent for diagnosis validity (clinical validity)

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Queries provided record clarity/POA status, other

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Queries resulted in a SOI/ROM or APR-DRG change
GUEST COLUMN

Tell me again, why was the patient admitted?

By Cesar M. Limjoco, MD

Many CDI and coding professionals continue to be confused about the proper selection of principal diagnosis (PDX) for an inpatient encounter. Back in 2001, I wrote “The Principles of Inpatient Coding: Principal Diagnosis (PDX) and Other Diagnosis (ODX),” for CMS. But, through the years, questions and disputes still keep popping up. In this article, I’ll revisit the issue and provide additional insight.

There are a ton of PDX guidelines, but they can all be simplified into one statement: Like motivational speaker and author Simon Sinek says, “When you know your WHY, you’ll know your way.” Why was the patient admitted to acute inpatient care? Is the admission necessary? Can the patient’s condition be managed as an outpatient (including rehabilitation, assisted living, or nursing home) or at home (with or without home care, or even hospice)?

Answers to these questions are crucial because all the data and case studies consistently show that if a patient can be treated outside of the acute inpatient care space, the risks of inpatient care outweigh the advantages. Thus, the provider needs to demonstrate the need for the inpatient hospitalization. The answers to the above questions rest on a valid PDX. If the documented narrative is nebulous regarding the circumstances of admission, it creates uncertainty about the need for the level of care and opens the encounter to payer denial.

The 2017 Medicare national improper payment report indicated the government spent more than $6 billion unnecessarily due to lack of medical necessity for inpatient acute care, according to CMS. Recent news headlined a healthcare system’s $18 million settlement due to Medicare patients that could have been treated as outpatients. A coherent PDX clarifies what occasioned the admission and makes it easy to validate the medical necessity for an admission to acute inpatient care.

There are times that social and economic reasons preempt proper care at home or as an outpatient. Third-party payers do not pay for social and economic predicaments, but reality may dictate the need to keep the patient in the hospital. Since insurance will not cover the stay, the patient has to assume financial responsibility, but if this isn’t possible, the hospital then eats the cost. These are no-win situations that population health needs to tackle.

The PDX refers to the condition established after study to be chiefly responsible for occasioning the patient’s admission to the hospital, according to the Uniform Hospital Discharge Data Set. Selecting the PDX takes into consideration the circumstances of admission, diagnostic workup, and/or therapy provided, as reiterated in AHA Coding Clinic for ICD-9-CM, Second Quarter, p. 4.

It may take the physician a day or two, or even the entirety of the patient’s stay, to determine the PDX or its probable etiology. Sometimes the physician simply cannot make this determination, and the symptom/manifestation remains the only diagnosis. When this happens, medical necessity is harder to justify, unless there are mitigating circumstances that support the need for inpatient care.

One major misconception in the PDX selection is when coders or CDI professionals assume that the PDX is the same as the reason the patient presents to the hospital. The patient’s chief complaint (reason for presenting to the ED) may not satisfy the need for inpatient care. If the condition can be managed appropriately as an outpatient or at home, the patient does not need to be admitted. When the physician is unsure what the patient has, or that the risk of discharging home is high, the patient can be monitored for a period of time (24–48 hours) as an outpatient observation. Once the patient is cleared of danger, the patient can be discharged. If the underlying issues need a higher level of intervention, the patient can be admitted to acute inpatient care at any time.

So, a patient may come in for a condition that may not need acute inpatient care, but after evaluation, the provider may discover a more serious problem that compels admission. This newly discovered condition may now satisfy the definition of PDX and therefore substantiate inpatient care. Or, a patient may come in for an acute condition that on its own does not need acute inpatient
care, but the patient may still qualify for a higher care level because of concurrent chronic comorbidities. When determining the PDX, the acute condition always trumps the chronic condition(s). A chronic condition only becomes the PDX (in the absence of an acute condition that needs acute inpatient care) when it is the reason for an inpatient procedure and/or when coding conventions (i.e., “code first” rules) says otherwise.

Another scenario is when a patient presents with a benign complaint but while in the ED, they develop an acute condition that necessitates inpatient care. This condition was not what brought the patient to the hospital; it developed while the patient was in the ED. For example, a patient presents with epistaxis, is managed effectively through observation, and is expected to be discharged shortly; suddenly, the patient develops chest pains from an acute myocardial infarction. The epistaxis brought the patient to the ED, but it is the myocardial infarction that will now occasion the admission.

At this point, CDI and coding staff may ask, “What if the patient has two or more acute conditions that satisfy the need for an admission?” This is where the co-equal PDX selection criterion applies—the hospital (and, by inference, the coder) may choose which of the conditions has higher severity that consumed more hospital resources and thus carry an appropriately higher reimbursement. The acute conditions may even be inter-related or have a causal relationship; for example, a patient may come in with acute respiratory failure due to acute-on-chronic systolic left ventricular failure.

According to Coding Clinic for ICD-9-CM, Second Quarter 1990, p. 4: “When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup, and/or therapy provided (and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction), any one of the diagnoses may be sequenced first.”

The physician can provide documentation of the circumstances for the basis for co-equality of the conditions. The coder can then apply the Diagnosis-Related Groups (DRG) algorithm to discern which of the conditions carries a higher severity weight. In these scenarios, it would be pointless to ask the provider to choose which condition necessitated the admission—DRGs are outside most providers’ purview.

For example, a patient presents with multiple problems: shortness of breath, fever, and chest pain. Chest x-ray demonstrates an exacerbated CHF, examination reveals acute bronchitis, and prior history and current EKG findings are consistent with unstable angina (cardiac enzymes are negative). The three conditions were treated with medications. All three diagnoses equally meet the criteria for the definition of PDX, and the hospital can sequence any one of them as such. The aforementioned conditions individually may not satisfy medical necessity for an inpatient admission, but other factors may come into play and require a higher level of care.

Taking the example further, let’s say the above patient undergoes coronary arteriography revealing coronary artery disease (CAD) with 85%–90% blockage of two prominent branches; the patient then undergoes a percutaneous transluminal coronary angioplasty and stent placements. In this scenario, the workup and treatment clearly establish CAD as the underlying etiology of the patient’s unstable angina; it’s the CAD that warranted definitive intervention, and therefore, the CAD is the appropriate PDX. Unstable angina here is a symptom of the CAD. Just an FYI: Unstable angina can also be caused by other conditions that induce ischemia to the myocardium, such as aortic valvular stenosis, cardiomyopathy, or arrhythmia as well as noncardiac (demand) causes like anemia. Definitive treatment is always directed to the pathology to fix the problem, whereas supportive treatment affords symptomatic relief at best.

The complexities of medicine dictate the need for accurate documentation. In the end, everything comes down to the narrative. When there is transparency in the documentation and the record speaks for itself, everything else falls into place and will withstand scrutiny. Documentation showing clinical support of the conditions (including onset) needs to be unimpeachable. The Clinical Truth™️ will always prevail. ‘Nuff said!

Editor’s Note: Limjoco is the chief medical officer for T-Medicus LLC, based in Las Vegas. He has more than 25 years of consulting experience. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries. Contact him at dr_cesar_limjoco@me.com.
Leveraging the NIH Stroke Scale for CDI queries

**Q:** I have a number of questions related to strokes, but essentially, can you describe the clinical definitions of stroke and explain what CDI professionals should be looking for in the medical record?

**A:** Let’s start by discussing who can have a stroke. Unfortunately, the answer is anyone at any time, although having a past medical history of stroke or a family history does put a patient at higher risk.

A transient ischemic attack (TIA), also known as a “mini” stroke, comes from a disruption in the blood supply to the brain. The classical definition of a TIA is based on the duration of neurological symptoms. The current definition is referred to as “tissue-based” because it is based on imaging results, not symptom duration.

The American Heart Association (AHA) and the American Stroke Association (ASA) now define TIA as a brief episode of neurological dysfunction with a vascular cause, and clinical symptoms typically lasting less than one hour, without evidence of infarction on imaging. TIAs can present much like a stroke, but they usually only last a few minutes without causing permanent damage.

Age, gender, ethnicity, and a family history of TIAs can all put a patient at higher risk of having a stroke, along with hypertension (HTN), diabetes, atherosclerosis, and certain types of arrhythmias such as atrial fibrillation and atrial flutter.

There are two main types of strokes. Although they may present with similar signs and symptoms, they have different etiologies. When the etiologies are identified, they can help determine the type of care needed. The first and most common stroke type is ischemic stroke, which accounts for about 80% of strokes. Treatment is aimed at tissue reperfusion by either removing the clot or dissolving it using a clot-busting medication such as tissue plasminogen activator (tPA).

An ischemic stroke occurs when brain tissue is deprived of oxygen-rich blood due to vessel narrowing or blockage. There are a few mechanisms by which this type of stroke can occur. The most common type of ischemic stroke is a thrombolytic stroke, which is the result of a blood clot (thrombus) forming in one of the arteries of the brain, resulting in blockage or near-blockage of the blood supply to that area of the brain. This type of clot is often a result of atherosclerosis.

Another type of an ischemic stroke is an embolic stroke, caused when a blood clot or debris develops in a different part of the body (usually the heart) and travels through the blood stream, lodging in one of the smaller vessels of the brain.

Apart from ischemic strokes, there are also hemorrhagic strokes, which are less common. A hemorrhagic stroke occurs when a blood vessel in the brain leaks or ruptures. The goal for treatment is stopping the bleeding and reducing the pressure it causes. A brain hemorrhage can result from many conditions, including uncontrolled high blood pressure (HTN), overtreatment using anticoagulants (blood thinners), or the integrity of the vessels themselves, such as weak spots or bulges in the wall of a vessel called aneurysms.

There are also different types of hemorrhagic strokes. An intracerebral hemorrhage occurs when an artery in the brain bursts, causing the blood to pool into the surrounding tissue; this damages not only the immediate surrounding tissue but also the tissue beyond the leak as a result of oxygen deprivation. This type of stroke can result in increased intracranial pressure and herniation of the brain tissue. Treatment can include medication and/or surgery.
A subarachnoid hemorrhage is caused when an artery on or near the surface of the brain bursts and spills blood into the space between the surface of the brain and the skull. Often the first symptom of this type of stroke will be a severe headache.

It is extremely important to determine when the symptoms of a TIA or cerebrovascular accident (CVA) started versus the time a patient presents with symptoms, as this will help identify the type of event. In addition to the medical history and demographic risk factors, there are also risks associated with lifestyle choices such as smoking (or exposure to smoke) or alcohol/substance abuse. The effects of a stroke depend on the size of the stroke and the area in which the CVA occurred.

The acronym F.A.S.T. can help you remember the characteristics of a stroke:
- F: Facial drooping
- A: Arm weakness
- S: Speech difficulties
- T: Time—although it’s not a symptom, “T” refers to the time taken to get help because the time untreated equals cell death.

Once it is determined whether the patient has had either a TIA or a stroke, we can determine how the event should be coded. Transient cerebral ischemic attacks and related syndromes are coded to the G45 category; a TIA specifically is coded to G45.9, transient cerebral ischemic attack, unspecified, with inclusion terms of “spasm of cerebral artery,” “TIA,” and “transient cerebral ischemia not otherwise specified (NOS).”

Cerebrovascular diseases are coded using the range of codes I60–I69, found in the circulatory chapter, and traumatic intracranial hemorrhages (S06.-) are coded using the injury codes found in Chapter 19.

Combination codes are plentiful in ICD-10-CM and are used to represent two diagnoses, a diagnosis and manifestation, or a diagnosis and associated complication. For strokes, the combination codes represent not only the type of stroke, but also the side of dominance, location, and laterality, along with common manifestations related to the stroke.

There are also a few instructional notes found under cerebrovascular disease (I60–I69) in the circulatory chapter, including a “code also” note that states to identify the presence of alcohol abuse and dependence (F10.-) and the exposure to environmental tobacco smoke (Z77.22), occupational exposure to environmental tobacco (Z57.31), tobacco use (Z72.0), tobacco dependence (F17.-), history of tobacco dependence (Z87.891), and HTN (I10–I15). Then, we have the Excludes1 note for TIAs and related syndromes (G45.-) and finally traumatic intracranial hemorrhage (S06.-).

Here are a couple examples of the codes for strokes:
- I60, Nontraumatic subarachnoid hemorrhage (these coded identify if the cause of the stroke is nontraumatic, and the location)
- I60.1, Nontraumatic subarachnoid hemorrhage, from middle cerebral artery
- I61, Nontraumatic intracerebral hemorrhage
- I63.0, Cerebral infarction due to thrombosis of precerebral arteries (these codes identify the presence of an infarction and cause along with location)
- I63.1, Cerebral infarction due to embolism of precerebral arteries
- I63.2, Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries
- S06.34, Traumatic hemorrhage of right cerebrum (these codes will have a sixth character that will identify loss of consciousness [LOC] and whether the patient returns to their baseline)
- S06.35, Traumatic hemorrhage of left cerebrum

The National Institutes of Health Stroke Scale (NIHSS, or NIH Stroke Scale) is a 15-item neurological examination performed by healthcare providers to quantify the severity of a stroke in the acute care setting. Each item is used to score a specific ability and is scored on a range from 0 to 4. There is also a modified version of the NIHSS (mNIHSS), proposed to remove poorly reproducible or redundant items, leaving an 11-item neurological examination. Either of these scales
work well in predicting clinical outcomes for the patients. The official protocol rules are as follows:

- Score what you see, and not what you think
- Score the first response, not the best response (except item 9-Best Language)
- Don’t coach

The evaluation of stroke severity depends on the ability of the observer to accurately and consistently assess the patient.

According to AHA Coding Clinic, Fourth Quarter 2016, NIHSS codes (R29.7--) can be used in conjunction with acute stroke codes (I63.-) to identify the patient’s neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute diagnosis code(s). At a minimum, coders should report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

It’s important to note that, according to Coding Clinic, code assignment for the NIHSS may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., a physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient. However, the associated diagnosis (such as a stroke) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or another clinician, the patient’s attending provider should be queried for clarification.

Coding Clinic, Third Quarter 2014 may also be helpful. It states that:

> It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician. Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction.

Editor’s Note: Sharme Brodie, RN, CCDS, CDI education specialist and CDI Boot Camp instructor for HCPro in Middleton, Massachusetts, answered this question. For information, contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit http://hcmarketplace.com/product-type/ boot-camps/clinical-documentation.
Dissecting surgical charts and educating surgeons

For many surgeons, “surgical precision” doesn’t just describe their specificity and prowess in the operating room; it often describes their personality as well. Their fine-tuned accuracy is a point of pride not only in the surgical theater, but in everything they do.

This, of course, can make CDI efforts—which ask questions regarding charting, documentation, and possible outcome complications—more difficult. As a result, CDI specialists often struggle when they begin to review surgical charts.

Yet there are serious ramifications for inadequate surgical documentation, not the least of which is the possibility for erroneous complication codes that will reflect poorly on the surgeon individually and the facility as a whole. Because of this, many CDI teams have branched out to review these records and provide education to the surgeons penning them.

**Chart reviews and query opportunities**

“I think surgeons spend a lot of their training being told that the most important thing is why they’re going to the operating room,” said **Trey La Charité, MD, FACP, SFHM, CCS, CCDS**, the medical director.
for CDI and coding at the University of Tennessee Medical Center in Knoxville, on an episode of ACDIS Radio. “They spend time talking about what needs to be fixed, but they tend to gloss over all the other medical conditions that affect their patients.”

“If you have a surgeon who does the H&P [history and physical] and doesn’t cover all the body systems with documentation of the patient’s comorbid conditions, they really only focus on the one problem they’re treating,” says Rebecca “Ali” Williams, MSN, RN, CCDS, manager of CDI and utilization review services at United Audit Systems, Inc., in Cincinnati.

When this situation arises, CDI professionals need to not only assemble the pieces of the record to formulate a query, but also put two and two together to determine what might be missing, says Williams.

“If you have a patient who comes in and there’s sparse documentation, it takes a lot of digging,” she says. “You have to look at medications, nursing notes—everything. It’s sort of like being a detective.”

Nevertheless, some situations require more frequent CDI intervention—such as postoperative complications, which represent a large sticking point for staff, according to Williams. She adds that coders often assign a code for a surgical complication, when in reality the situation may be an expected part of the patient’s recovery but it wasn’t documented.

“You’ll get an intensivist who documents postoperative respiratory failure. But that’ll give the attending [surgeon] a complication, and it’s not [necessarily] a failure,” she says. “You really have to go to the intensivist and the attending and ask the question.”

Surgeons need to document whether the situation was expected or a “true error,” said La Charité, who pointed out the education around postoperative conditions shouldn’t end with surgeons. Coders, for their part, shouldn’t apply complication codes unless the surgeon specifically states that a specific situation arose as a complication, La Charité said.

“The problem is really twofold: A lot of surgeons document really anything that happens as a complication, and then a lot of coders are also trained in pattern recognition,” he explained.

“You have to take the whole patient clinical scenario into perspective,” says Williams. Patients often have medical conditions that make surgical procedures more difficult and more prone to complications, even when the surgeon performs them perfectly.

Teach surgeons to document any complicating or comorbid conditions, Williams says, because often those conditions may help to exclude the patient encounter from Patient Safety Indicator penalties.

At times, concerns raised by CDI professionals in reviewing surgical charts may result in process improvement opportunities, either in documentation behaviors overall or related to the EHR process, adds Peggy Roddy, RN, the sole CDI specialist at Clarion Hospital in Clarion, Pennsylvania. She points to her own experience reviewing charts for patients receiving pacemaker implants.

“Even though by looking at the operative report I could tell which ventricle they put the lead into, they weren’t telling me the laterality,” Roddy says. “Luckily, our IT person was able to build a template to prompt them.”

Though physician education is certainly a vital part of surgical case reviews, an issue may arise for other reasons too, such as software or miscommunications between multiple clinicians documenting in the record.

**Physician engagement and education**

Approaching surgeons can be tricky, so Roddy suggests entering conversations with a clear mission.
“I’m trying to get all my ducks in a row to see what I need them to do,” she says. “You don’t want to get off on the wrong foot with them.”

When conducting one-on-one education, use surgeons’ own charts to educate them on the reasoning behind CDI efforts, Williams suggests. This will pique their interest and answer the age-old question: “What’s in it for me?” Use a chart from a past case and walk them through it, pointing out the opportunities for improvement as you go.

Such activities also help surgeons understand how documentation gets translated into codes, Williams adds.

“[The surgeons] were very upset to find out that they had complications for things that weren’t actually complications. They thought that the less they documented, the better, which of course didn’t turn out to be the case.”

One-on-one sessions are also a great time to explain how documentation affects surgeons’ quality scores, too, said La Charité.

“I have yet to meet a surgeon who doesn’t believe they operate on sicker patients than the surgeon down the street,” he said. “That may very well be true, but if you don’t document well in the record, if you don’t show me that, well, we can’t prove it.”

Since many of the quality scores are now publicly reported, La Charité suggests pulling up the physician’s profile on a reporting site for a bit of shock value.

Though using their own charts and showing their personal quality scores may go a long way in achieving buy-in, timing is everything when it comes to effectively educating surgeons, Williams says.

“Don’t approach on a surgery day. Maybe just provide education one record at a time,” she says, as this avoids frustrating them with documentation questions at a time when they’re already stressed.

CDI professionals are also well-served to enlist the help of others in reaching the surgeons. By reaching and recruiting even one physician champion, that physician can help spread the “gospel” of complete, concise, and accurate documentation.

“We’re all in this together,” says Williams.

Editor’s note: La Charité’s comments were taken from the April 12, 2018, episode of ACDIS Radio.
FROM THE FORUM

Combining CDI and case management roles

CDI professionals know the situation well. They do excellent work in one area and then are asked to take on additional roles as a result. If they made a difference with X, why can’t they do the same for Y?

Recently, the conversation came up on the ACDIS Forum as to whether CDI and case management/utilization review (UR) could be combined into one role since both groups review charts already, with mixed feedback from Forum members.

“Hutchinson Health Hospital does both UR/CDI,” said Tami Nelson, RN, CDI/UR team lead at the Minnesota facility. “We are a fairly small hospital, so this model works great.”

Often, when CDI professionals work in small, community-based or critical access hospitals, they perform other duties (such as case management/UR) out of necessity.

“Working in a critical access hospital lets you get your feet wet in a lot of different areas,” according to Ellen Shriver, RN, CCDS, who previously worked as a CDI specialist, RAC coordinator, inpatient coder, and auditor for Boone County Health Center in Albion, Nebraska, on an episode of ACDIS Radio. When resources and personnel are sparse, CDI professionals are often expected to pitch in wherever needed.

While this model may be successful for smaller facilities, at larger organizations the combined duties can become unwieldy, leading to one role taking precedence over the other, said Cynthia Mead, RN, CCDS, a CDI specialist at Flagstaff Medical Center in Arizona.

“We found that when CDI and UR were combined that the UR role always took precedence. I think it might work at smaller hospitals when admissions wouldn’t support a full-time staff, but it didn’t work well at our 300-bed system,” she said.

“We had a combined CDI program and had issues with it. All of the department resources and education were geared toward the case managers,” said Jennifer Walts, RN, CCDS, coordinator for CDI at St. Joseph’s Health in Elbridge, New York. “I am sure it can work well, but I think you need management that understands the value of CDI.”

It’s also important to remember the distinct knowledge expertise required of both the CDI and case management/UR roles. Though both groups examine medical record documentation, they come at it from different angles and for different purposes, says ACDIS Advisory Board member Paul Evans, RHIA, CCDS, CCS, CCS-P, the CDI leader at a large healthcare system in San Francisco.

“My belief is that in order to be effective as a CDI, one needs very specific education, support, and guidance,” he said. “Some executives may innocently underestimate the precise nature, skill, and level of education staff need in order to work compliantly as a CDI professional.”

Echoing Evans’ thoughts about compliant CDI, Laurie L. Prescott, RN, MSN, CCDS, CDIP, CRC, CDI education director at HCPPro in Middleton, Massachusetts, also had concerns about how each role—case management and CDI—contributes to patient care differently.

“In my mind, the case manager is considered part of the patient care team—in involved in discharge planning efforts, etc. The CDI should not be an active part of the care team; this could be seen as the CDI influencing the care to manipulate the DRG assignment,” she said. “The roles mirror each other, but they have different focus.”

Ultimately, the thing that helps a CDI team to succeed is leadership understanding of their unique needs and skills, Forum commenters agreed.

“The more one expects from the CDI team,” said Evans, “the more time, support, education, and energy a CDI should be provided to meet expectations.”

Editor’s note: This article’s content was taken largely from recent posts on the ACDIS Forum. To participate in the Forum, click here. If you have any questions regarding this or the Forum in general, please email ACDIS Editor Linnea Archibald at larchibald@acdis.org.
NOTE FROM THE INSTRUCTOR

Managing denials means reviewing for more than clinical indicators and coding guidelines

by Allen Frady, RN-BSN, CCDS, CCS, CRC

More than a decade ago, I received a claim from patient financial services with a denial due to an “incorrect code.” The patient was pre-certified through the insurance company for a femoral popliteal bypass graft. We correctly coded the reported condition as diabetic peripheral vascular disease per the Official Guidelines for Coding and Reporting as related to the physician’s documentation. No error was made. The case manager and physician reviewer had entered the approval code for the pre-certification as peripheral angiopathy with claudication.

The denial reason stated the insurer had not approved the elective procedure to be done on the basis of an endocrine disorder. This most likely reflects a very poor understanding of coding guidelines. Yet it presents an interesting dilemma for us working in CDI.

Payer contracts with commercial insurance companies, in their own way, supersede coding guidelines. How? The contract with the insurance company is a legally binding document. It allows the insurance company to stipulate everything from covered conditions to how the facility needs to report those conditions.

I proudly recited the Guidelines, attempting to prove we reported the condition correctly. I refused to change the code. At the time, I was working as a coding auditor and supervisor. What I lacked, however, was experience in the revenue cycle dealing with payers. This would come back to embarrass me. In a subsequent meeting, with new residents learning about coding, the director of patient financial services said directly to those fledging physicians, “Yes, Allen is a smart guy, but YOU need someone who understands payers.”

As incredulous as I might have been at first, I had to ask myself: Did he have a point? As it turns out, defending code assignment against denials requires much more than determining if the documentation includes best-practice, standard indicators for the diagnosis. It requires more than reviewing the denial to determine if the condition was coded and reported according to the Guidelines.

You can diligently review the patient’s documented clinical indicators versus the reason the insurance company gave for the denial, but it might get you nowhere if, for example, the payer stipulates in the contract that it may deny the claim based on more stringent criteria. It is not uncommon for insurance companies to use out of date, clinically unsound requirements before approving payment for a condition.

For example, a payer may require patients receive an arterial blood gas (ABG) test and be on a ventilator or BiPAP before approving respiratory failure, despite advancements in ventilator-free medicine. The ABG requirement is extremely out of touch with the way medicine is done currently. The test is ordered and drawn much less than it once was, and even patients who don’t undergo the test may still be in respiratory failure.

Such a clinical presentation may not meet medical necessity requirements for an inpatient admission, but it does meet modern standards for a diagnosis of respiratory failure.

The medical necessity isn’t coming from a laundry list of critical care maneuvers required to save the patient; it comes from the need to observe the patient closely to prevent those outcomes from becoming necessary. Patient safety is a priority. It should be very clear in the record—and the documentation therein—that the patient is unsafe for discharge.

Let’s consider a few other areas.

Continuing stay reviews

Insurers also look for evidence that the facility held the patient in the hospital beyond the required time frame. If that was the case, the payer can issue a partial denial for certain days beyond what it considers the “maximum
medical benefit” of a hospitalization. To avoid this, clearly indicate in the progress notes why the patient requires continued stay in an acute setting. When those conditions resolve, a clear discharge plan should be immediately documented.

**Coverage**

In many cases when coding gets blamed for miscoding a diagnosis, the true cause of the denial is simply a coverage determination. There are local coverage determinations (LCD), national coverage determinations (NCD) for Medicare, and—as though things needed to be more complicated—many individual coverage guidelines dictated by commercial insurance companies.

With regard to elective procedures, InterQual®, for example, has a lengthy set of guidelines stipulating all of the medical milestones that must be met before the insurer will pay for a procedure. When I had my own InterQual® copy on my desk, I used to joke that it wasn’t that much smaller than the full set of encyclopedias I grew up with.

Often there is a lack of required documentation for reported alternate therapies related to a specific diagnosis required to trigger the approval. In some rare cases, the documented diagnosis ended up being a non-approved form of the same condition, and in some of those cases, the error ends up being the fault of the insurance company for not having an updated list of codes.

For example, a rash of denials for pacemaker implants from around 2009 to 2013 were apparently due to a failure of hospitals to understand the Medicare coverage determination requirements, or the failure of Medicare to keep their standards up to date with practice—or, more likely, a combination of both of these factors.

**Treatment is king**

At least, it is in the eyes of many auditors.

Unless the treatment would require hospitalization for more than 48 hours, an insurer might deny the claim. Again, you can make a beautiful case that a condition exists, but without proof the condition required inpatient care, you’re looking at potential problems.

Patient safety, however, trumps even treatment. Refer back to my earlier comments regarding the need to demonstrate risk of negative outcomes.

**Beware of intent**

If a pattern of incorrect billing—intentional or otherwise—emerges, it may trigger an investigation from the Office of Inspector General or allegations of False Claims Act (FCA) violations. Having knowledge of hospital procedures that result in incorrect billing is enough to land you in hot water.

You could be a whistleblower or you could file a qui tam lawsuit, but you absolutely must either stop the practice or immediately divorce yourself from the situation, which may require a resignation.

Debating the criteria and current clinical practice guidelines is what we do daily as CDI professionals, but patterns of incorrect billing, where the codes and charges are clearly incorrect (and unsubstantiated), are not to be entertained or tolerated. I run into hospital staff who believe that as long as no one set out to intentionally commit fraud and no one’s pockets were lined directly, all is well. That is simply not true.

According to the FCA, an individual or facility is liable if the entity:

- Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval
- Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspires to defraud the government by getting a false or fraudulent claim allowed

According to the law, the terms “knowing” and “knowingly” mean that a person:

- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity of the information

Proof of specific intent to defraud the government is not required.

**Editor’s note:** Frady is a CDI education specialist for HCPro in Middleton, Massachusetts. Contact him at AFrady@hcpro.com. For information regarding CDI Boot Camps, visit http://hcmarketplace.com/clinical-doc-improvement-boot-camp-1.
By Trey La Charité, MD, FACP, SFHM, CCS, CCDS

Like it or not, provider documentation is the foundation for everything done in medicine. Without it, nothing is accomplished. As healthcare reform progresses (and hospital reimbursement shrinks), the need for excellent provider documentation only increases.

Unfortunately, those in CDI tend to think these documentation pressures apply only to the specific disease terminology used in the ICD system. We determine the impact of the phraseology within the code set on the final MS-DRG submission.

However, we forget that provider documentation is required for justification of all acute care hospitalizations. After all, the payers and Recovery Auditors recoup more by denying an entire hospitalization versus removing one CC or one MCC from an inpatient claim.

Therefore, it is prudent to review some ways your CDI program can help case management, utilization review, and revenue cycle in their ongoing battles against medical necessity denials. Justifying appropriate and accurate hospital status (i.e., observation vs. inpatient) is a critical function of an active CDI department.

First, CDI professionals can educate providers away from listing signs or symptoms as the reason for admission. Providers should always make their best estimate as to what underlying diagnosis is causing the patient's presenting symptomology.

In other words, providers should not admit patients for "dyspnea" or "shortness of breath." They should admit patients for a "probable COPD exacerbation" or a "possible CHF exacerbation." If the provider determines after admission that some other disease process is ultimately responsible for those symptoms, there is no penalty. The provider simply changes the documentation to reflect the diagnosis now believed to be the cause of the patient's complaint.

Unfortunately, insurance plans and Recovery Auditors routinely audit admissions with principal diagnoses that are symptoms as opposed to specific diseases. These entities take the position that, in making a symptom diagnosis, the provider and/or hospital are simply "gaming the system" so they can get paid for a "soft" admission for a patient who really could have gone home. Additionally, even if ultimately approved for an inpatient stay, providers should be aware that the MS-DRGs based on symptom codes reimburse less than ones based on disease-specific codes.

Second, providers should never state that a patient's medical condition is "stable." A patient's overall condition should always be listed as "fair," "guarded," "serious," "critical," "improving," etc. If the patient is truly "stable," the insurance plan will ask why outpatient care couldn't have been provided rather than a hospital bed. Providers should not give a payer the opportunity to use their clinical judgment against them.

Third, don't let providers document that they will "place patient in the hospital overnight," "observe the patient," or "observe them overnight." With the advent of CMS' 2-midnight rule (a regulation under which, to qualify for an inpatient admission, a physician must expect that a patient will require care that spans over two nights), the intent of the provider has become a critical element.

Once again, Medicare Administrative Contractors and Recovery Auditors twist these statements to mean that your provider never thought the patient would need two midnights of care in the first place.

CDI professionals can educate providers away from listing signs or symptoms as the reason for admission. Providers should always make their best estimate as to what underlying diagnosis is causing the patient's presenting symptomology.

Trey La Charité, MD, FACP, SFHM, CCS, CCDS
Providers should simply state that they will “treat the patient in the hospital.” Ideally, if your providers believe the patient will truly need two midnights of care, they should be documenting that in their initial history and physicals in addition to the reason(s) why they believe such care is needed.

Fourth, providers should incorporate disease-specific prognostic tools into their documentation. Examples of these scoring systems include:

- CURB-65 scores and the Pneumonia Severity Index for pneumonia admissions
- TIMI and HEART scores for chest pain cases
- ABCD2 scores for TIs and suspected strokes
- SOFA scores for sepsis cases
- Framingham Criteria for acute CHF exacerbations
- MELD scores for admissions related to liver disease
- Glasgow Coma Scale for encephalopathic patients
- Revised Trauma Score for trauma service admissions

Widely accepted risk-scoring methodologies such as these are extremely difficult for insurance plans to challenge. Additionally, high numerical values for these classification systems strongly support inpatient over observation status. (These and many other tools are free and readily available at www.mdcalc.com.)

Fifth, providers should document if a patient has failed appropriate outpatient therapy for the problem that now needs acute care hospitalization. For example, if a COPD patient was first prescribed oral antibiotics and steroids for an acute exacerbation, but the patient continued to deteriorate, that should be recorded. If that same patient underwent increased metered-dose inhaler and/or nebulizer frequency, but continued to get worse, that too should be documented.

Other factors that further justify an acute care hospitalization include any outpatient care episodes just prior to the hospitalization, such as being seen at another ED or urgent care center, seen in the office by the primary care physician, or recently discharged from another hospital.

Once again, this type of recorded history makes it extremely difficult for the insurance plan to take the position that the patient could have been sent home or managed in observation status as opposed to inpatient.

Providers should also document all interventions instituted in their own emergency rooms prior to the decision to admit the patient. As examples, providers should note that a patient remained short of breath despite X number of nebulizer treatments, or that a patient received an IV diuretic but still had to sit upright to breathe.

This type of documentation allows the hospital to confidently say, “We tried to send them home, but they were obviously just too sick.”

Sixth, providers should note if the patient is immunocompromised. Most providers routinely capture this scenario when the patient is undergoing chemotherapy for an underlying malignancy. However, other situations where a patient should be considered immunocompromised are the routine use of steroids, the growing list of immune modulators for rheumatological diseases, and the immune-suppressant regimens for transplant patients, just to name a few. Immunocompromised patients are clearly sicker than average and have a much higher risk for an adverse clinical outcome, regardless of their reason for admission.

Seventh, providers should not put limitations on their initial treatment modalities and medical interventions. For example, for an acute CHF exacerbation, a provider should not say “will treat with IV Lasix times two doses and then recheck.” Likewise, for an acute renal failure admission, a provider should never say “will give IV fluid times 1 liter and reassess renal function.”

Once again, payers will intentionally take the position that your provider was just “observing” the patient and never intended for the patient to stay two midnights. As an additional consideration, the amount of treatment initially ordered and received may be critical components in appropriate status determinations within the Milliman and InterQual® systems.

Satisfying these criteria may ultimately be the key to a successful peer-to-peer review with an insurance plan’s medical director. It is the next rounding provider’s
responsibility to adjust a patient’s initial treatment regimen as indicated.

For the previous CHF exacerbation example, a provider should simply document “will start twice-daily IV Lasix and monitor closely.” For the acute renal failure example, the provider should simply write “will start aggressive IV fluids and monitor renal function.”

Eighth, providers should not be coerced into admitting a patient based on certain scenarios. Patients should never be admitted to “rule out” something, as payers take the stand that such situations should have been resolved in the emergency room. Terminology like this will never justify an inpatient stay over an observation stay.

Patients should also never be admitted because the family can no longer take care of them. As inhumane as it seems, the Medicare guidelines do not accept family inconvenience as an admission factor. Remind providers that they will be able to treat no one if the hospital closes due to Office of Inspector General financial penalties.

Patients cannot be admitted for nursing home placement. Once again, the Medicare guidelines are quite explicit that this is not an acceptable practice pattern. Assisted living and skilled nursing facility placement can be done from home as an outpatient.

Patients cannot be admitted for nursing home placement. Once again, the Medicare guidelines are quite explicit that this is not an acceptable practice pattern. Assisted living and skilled nursing facility placement can be done from home as an outpatient. Providers should also not admit patients simply because the patient, their family, their primary care physician or another physician insists they need to be admitted.

The bottom line is that patients must have a legitimate medical reason to be admitted to the acute care setting. If one does not exist, the patient must go home.

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While this is not an exhaustive list, it should direct some of your CDI resources and educational efforts to the emergency room arena to help ensure the medical necessity of your hospital admissions and to justify the initial hospital status chosen by your providers.

Excellent provider documentation should begin the moment the provider sees the patient and should build the case for a hospitalization based on every available piece of information. Providers must be more diligent in their documentation to ensure they are allowed to practice the medicine their patients warrant. Poor provider documentation practices at the time of admission leave both the provider and the host hospital vulnerable to future denials. Only through attention to this sort of documentation detail can providers and hospitals immunize themselves from increasing payer harassment.

Editor’s note: La Charité is a hospitalist at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director of UTMC’s CDI program. He is a past member of the ACDIS Advisory Board and the author of three books. La Charité’s comments and opinions do not reflect necessarily those of UTMC, ACDIS, or its Advisory Board. To reach La Charité, email him at clachari@utmck.edu.
CODING CLINIC FOR CDI

Second quarter 2018: Balloon pumps, diabetes, TIAs hypertension, and a host of other CDI concerns

By Sharme Brodie, RN, CCDS

I know everyone is very excited that the newest AHA Coding Clinic, second quarter 2018, is out and ready for review. The great news is it’s only 27 pages in length, and I know with everything else going on (including that it’s summertime), this is good news.

Let’s jump into some of the relevant advice for CDI professionals.

Intra-aortic balloon pumps

I know I usually don’t cover ICD-10-PCS related advice, but this particular Coding Clinic started with discussing intra-aortic balloon pumps (IABP) and how they’re coded so I thought I would follow suit and mention them too.

First, for those who may not know what they are, an IABP is a mechanical device used to increase myocardial oxygen by decreasing myocardial oxygen demand. An IABP provides circulatory support by helping the heart pump blood. Specifically, it’s a polyethylene balloon mounted on a catheter that is generally inserted into the descending aorta through the femoral artery.

The other end of the catheter attaches to a computer console containing a pump that inflates the balloon. The balloon at the end of the catheter inflates and deflates with the rhythm of the heart, helping the heart to pump blood into the body.

At the start of diastole, the balloon inflates augmenting coronary perfusion. At the beginning of systole, the balloon deflates and blood is ejected from the left ventricle, increasing cardiac output. These actions decrease the workload on the heart and allow the heart to pump more blood.

The IABP is driven by a balloon pump console and can be programmed to produce rates as high as 140 beats per minute. IABP therapy was first used for surgical patients, but it’s now being used with interventional cardiology procedures and medical therapy. Some indications for IABP therapy include failure to wean from cardiopulmonary bypass, cardiogenic shock, heart failure, acute heart attack, and support during some cardiology procedures such as angioplasty and stent placement. An IABP may be used pre-, intra-, or postoperatively to support the patient for a few hours up to several days.

On p. 3 of this Coding Clinic, it’s made very clear that an IABP is not classified as a device in ICD-10-PCS and, because it is not a device, using the root operations of “insertion” and/or “removal” for either the placement or removal are not appropriate. The appropriate root operation for when an IABP is used would be “assistance.”

Coding Clinic went on to give some examples for coding an IABP. The first example was for when the IABP is used for support during a procedure and removed at the end of the procedure. How would it be coded? Their answer stated that “typically, auxiliary procedures done solely to support the performance of a surgical procedure are not coded separately. However, cardiopulmonary bypass and IABP are exceptions. When a surgical procedure is performed using IABP, code separately with the root operation ‘Assistance.’”

One of the other examples discussed having a patient transfer from one facility to another with an IABP with the balloon being deflated days later at the bedside. Coding Clinic said that in this situation, as it is not a device, we would not code the removal of the IABP.

Diabetes and the term “with”

Once again Coding Clinic has addressed the usage of the dreaded word “with.” The question asked on p. 6 stated that there is still some confusion about the correct coding of diabetes “with” associated conditions. So, if you thought you were the only one still confused, find solace in the fact that you are not.
The example provided involved a patient with diabetes type 2 and arthritis. The provider in the example did not link the two conditions. The question was whether we could code the conditions as being related without the physician specifically stating they are related in the documentation because there is an index entry for “diabetes with arthropathy.” But, here’s the problem with doing so: the condition is found in the Alphabetic Index as follow:

**Diabetes, diabetic (mellitus)(sugar)**

with

**arthropathy NEC E11.618**

*Coding Clinic* states (p. 7) that

The “with” guideline does not apply to “not elsewhere classified (NEC)” index entries that cover broad categories of conditions. Specific conditions must be linked by the terms “with,” “due to,” or “associated with.” Arthropathy is a general term for any condition that affects the joints, and there are different types of arthropathic conditions that are not necessarily related to diabetes. In order to link diabetes and arthritis, the provider would need to document the condition as a diabetic complication. Coding professionals should not assume a causal relationship when the diabetic complication is “NEC.”

Continued on the same page, a question was asked as to what constitutes “diabetic peripheral angiopathy” and if peripheral arteriosclerosis or peripheral vascular disease in a diabetic patient is considered peripheral angiopathy. *Coding Clinic* responded that peripheral arteriosclerosis is a type of angiopathy and that peripheral arteriosclerosis, peripheral vascular disease, and peripheral arterial disease in a diabetic patient should be linked and coded as “diabetic peripheral angiopathy.”

**Transient ischemic attack**

Now, on p. 9, a question was asked about a patient who was diagnosed with a transient ischemic attack (TIA) due to bilateral carotid artery stenosis with left side symptomatic stenosis. In the scenario, a left carotid endarterectomy with bovine patch angioplasty was performed. The question comes from the fact that there is an Excludes 1 note under category I65-, Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction, that prohibits the reporting of a code from this category with the TIA code.

The stroke team at the question asker’s facility was concerned that if the TIA was not coded separately, their workup was not being captured and they wanted to know whether it would be appropriate to assign codes for both the TIA and the bilateral carotid artery stenosis.

Unfortunately, *Coding Clinic* gave them advice they probably weren’t looking for—in short, they said no. *Coding Clinic’s* rationale was the patient initially presented due to the TIA, after study the underlying condition that caused the TIA and the patient’s symptoms was the bilateral carotid stenosis, which was treated with endarterectomy. The Excludes 1 note under category I65 prohibits assigning codes in category G45, Nonspecific precerebral artery insufficiency, because the cause of the insufficiency is clearly specified as carotid artery stenosis.

**Hypertension**

Also on p. 9, another scenario talked about a patient with hypertension being admitted for suspected acute coronary syndrome, with the physician’s final diagnostic statement listed as “Takotsubo syndrome and HTN.” The question asked how would this case be coded and the asker thought that, based on the Guideline regarding hypertension with heart disease and the Tabular list, that code I11.9, Hypertensive heart disease without heart failure, was appropriate since the provider has not indicated a different cause for the Takotsubo syndrome.

Additionally, based on the Excludes 1 note found at category I51-, Complications and ill-defined descriptions of heart disease, it appears that Takotsubo Syndrome must be coded as hypertensive.

Now *Coding Clinic* came back with the advice to assign code I51.81, Takotsubo Syndrome, as the principal diagnosis and assign code I10, Essential (primary) hypertension, as an additional diagnosis. Their reasoning was that the provider’s documentation of “Takotsubo Syndrome” indicates Takotsubo as the underlying etiology of the cardiomyopathy, not hypertension. Takotsubo syndrome by definition is stress-related. Therefore, it’s
not appropriate to assign code I11.9, Hypertensive heart disease without heart failure. The guideline regarding hypertension and heart disease specifically states, “The same heart conditions (I50.-, I51.4 - I51.9) with hypertension are coded separately if the provider has specifically documented a different cause.”

**Psychoactive substance use**

Pp. 10-12 of this *Coding Clinic* discuss the *Official Guidelines for Coding and Reporting*, Section I.C.5.b.3. pertaining to psychoactive substance use. The first scenario presented involved cocaine use during pregnancy and how it should be coded when the physician has not documented any associated physical, mental, or behavioral disorders.

*Coding Clinic* gave the advice that it would be appropriate to assign a code from subcategory O99.32-, Drug use complicating pregnancy, childbirth, and the puerperium, followed by code F14.90, Cocaine use, unspecified, uncomplicated, for cocaine use during pregnancy. They continued with stating that, per *The Official Guidelines for Coding and Reporting*, codes from Chapter 15 and sequencing priority (15.a.1) state, “It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.”

Next, was a situation where a physician documented “recreational marijuana use” on a patient’s history and physical. The question asked whether or not it would be coded. And, the answer from *Coding Clinic*, was that no, it would not be coded without an associated physical, mental, or behavioral disorder documented by the provider.

I know this particular answer likely has some of you scratching your heads, but the rules are the rules and the rules state that, as with all diagnosis, they first have to meet the definition of a reportable diagnosis and, secondly, the codes for psychoactive substance use are only used when the provider has documented a relationship between the use and an associated physical, mental, or behavioral disorder.

The last situation was regarding a patient who was taking opioids prescribed by the physician for chronic pain. The question asked wanted to know if the code for opioid use could be used and, again, *Coding Clinic* came back with no, not unless the physician documented a relationship between the opioid use and a physical, mental, or behavioral disorder.

**Osteoporosis**

On p. 12, *Coding Clinic* got into another situation we talk frequently about in my classes, which is in regards to a patient who has osteoporosis who sustains a ground level fall, resulting (in this particular situation) in a right displaced mid-shaft femoral fracture.

The question asked wanted to know if it would be appropriate to assign code M80.051A, Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture, for the displaced mid-shaft femoral fracture.

I was very happy to see that *Coding Clinic* gave the same advice I give my Boot Camp attendees: Query the provider as to whether the clinical history is consistent with an osteoporotic pathologic fracture. If the provider confirms osteoporotic pathologic fracture, assign code M80.051A, Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture, or assign code S72.301A, Unspecified fracture of shaft of right femur, initial encounter for closed fracture, if the provider documents the fracture occurred secondary to trauma from the fall.

Remember, *The Official Guidelines for Coding and Reporting*, Section I. C. 13. D. 2. state that “A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal healthy bone.”

**Urinary tract infection and hydronephrosis**

On p. 21, *Coding Clinic* discussed a patient who presented to the emergency department with hematuria, left-sided flank pain, and chills. The CT scan showed a left ureteral stone with hydronephrosis. The patient was admitted to the hospital for treatment and the final diagnosis was listed as acute urinary tract infection (UTI) and hydronephrosis with obstruction due to ureteral calculus. The question asked what the correct ICD-10-CM code should be used in this scenario.
Again, I was glad to see Coding Clinic’s answer for this scenario is exactly what I thought. They said to assign code N13.6, Pyonephrosis, for hydronephrosis with urinary obstruction due to ureteral calculus and acute UTI. No additional code would be assigned for the infection since “obstructive uropathy with infection” are inclusion terms under code N13.6.

**Kennedy ulcers**

Some of you may not have seen a Kennedy ulcer, but for those of you who have, you likely wouldn’t forget it because of how quickly they develop. The next question on p. 21 talks about how a Kennedy ulcer is coded in ICD-10-CM. The advice is to assign a code from the L89, Pressure ulcer, for a Kennedy ulcer.

Coding Clinic went on to say that “a Kennedy ulcer is a type of pressure ulcer that occurs at the end of life and is related to multiorgan failure. Because of its pathophysiology, this type of pressure ulcer does not typically respond to standard treatment. In view of the implications of a Kennedy ulcer for prognosis, and the differences in response from other pressure ulcers, a proposal for creation of a separate code for Kennedy ulcer may be taken to a future ICD-10 Coordination and Maintenance Meeting.”

**Encephalopathy**

The last topic from this Coding Clinic that I’m going to touch on is discussed on p. 22 and p. 25: Encephalopathy. The question on p. 22 asked about the coding of encephalopathy when it is due to a UTI. The question asker wanted to know how the encephalopathy would be coded and Coding Clinic’s advice was to assign codes G93.49, Other encephalopathy, and N39.0, Urinary tract infection, site not specified. The sequencing of the principal diagnosis would be based on the condition found after study to be responsible for the hospital admission.

Then, on p. 25, Coding Clinic clarified some advice previously given by stating that “the advice provided in Coding Clinic, Second Quarter 2017, pp. 8-9 is accurate. When encephalopathy is linked to a specific condition, such as stroke or urinary tract infection, it is appropriate to use the code describing ‘other encephalopathy.’ Therefore, assign code G93.49, Other encephalopathy, when encephalopathy is linked to a condition, but a specific encephalopathy (e.g., metabolic, toxic, hypertensive, etc.) is not documented.”

**Editor’s Note:** Brodie is a CDI education specialist and CDI Boot Camp instructor for HCPro in Middleton, Massachusetts. For information, contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit http://hcmarketplace.com/product-type/boot-camps/clinical-documentation.
MEET A MEMBER

This CDI specialist says there’s nothing else she’d rather do

Kathie McAlexander, RN, CCDS, works at the University of Mississippi Medical Center in Jackson, Mississippi, and has been in the CDI field since 2002.

CDI Journal: What did you do before entering CDI?

McAlexander: I worked in home health, case management, ambulatory surgery, utilization review, and projects management (community-acquired pneumonia and payment error prevention) for a Quality Improvement Organization.

CDI Journal: Why did you get into this line of work?

McAlexander: I was asked if I would be interested in this position and I was ready to grow.

CDI Journal: What has been your biggest challenge?

McAlexander: Ensuring physicians that reviews and queries are not based on dollars.

CDI Journal: What has been your biggest reward?

McAlexander: Though it’s also been my biggest challenge, gaining physicians’ trust is wonderful.

CDI Journal: How has the field changed since you began working in CDI?

McAlexander: Initially, chart review was focused on Medicare patients and reimbursement. I was an advocate of reviewing all DRG payers and am pleased that all payers are now included in review at my facility.

At my facility alone, the changes have been phenomenal. Initially, an outside physician and myself reviewed all Medicare records after discharge. We would review after the accounts were coded, but before they were billed. Now there is a whole CDI department. The additional reviewers perform concurrent reviews, focused audits, mortality reviews, and quality reviews.

CDI Journal: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?

McAlexander: I consider ACDIS itself the nugget as I am appreciative of the support, references, and educational opportunities offered.

CDI Journal: What piece of advice would you offer to a new CDS?

McAlexander: Keep the lines of communication open and remember it is not all about you. A physician I worked with once told me, “Even if the answer is not what you want, at least they answered.”

CDI Journal: If you could have any other job, what would it be?

McAlexander: I cannot imagine not working in the nursing field. I have enjoyed all facets of this profession.
As a CDI specialist, I have increased my knowledge base tremendously. I am so grateful for the opportunity to continue to learn. I tell my co-workers all the time I feel like I am challenged and learn something new every week.

**CDI Journal: What was your first job (what you did while in high school)?**

**McAlexander:** My first job was after high school as a ward clerk at a small town hospital where I grew up. A good friend and I were the first they ever employed. I caught the healthcare fever and have not stopped yet.

**CDI Journal: A few of your favorite things:**

**McAlexander:** I love traveling to new places, music, and horror movies.

**Vacation spots:** The gulf shores of Alabama and Florida.

**Hobby:** Reading and Sudoku.

**Non-alcoholic beverage:** Coke Zero.

**Foods:** Pizza and donuts.

**Activity:** Shopping.

I am married to a wonderful man. His background is telecommunications. We have two sons, one works in a restaurant, the other is a research scientist. I have two beautiful granddaughters and two littles ones I plan on being “Mimi” to as well. So needless to say, time away from work is often spent visiting family.

**CDI Journal: Is there anything else you’d like to add?**

**McAlexander:** Just breathe, keep an open mind, and remember you are not the queen or king of the universe.
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