Opening Healthcare Doors
FEATURES

9 New Official Guidelines for Coding and Reporting
Effective October 1, the new Official Guidelines for Coding and Reporting stir debate over the importance of clinical validation queries and ensuring the treatment matches the diagnosis.

17 Sepsis-3 criteria and the pediatric population
Although the debate over whether to use the new Sepsis-3 criteria in the adult population continues, there’s no one-size-fits-all in the pediatric world.

DEPARTMENTS

3 Associate director’s note
Appreciating membership collaboration, celebrating CDI Week, and taking advantage of the quarterly ACDIS conference call.

4 Note from the Advisory Board
Two RHIA-credentialed board members make the case for inclusivity and the importance of embracing CDI professionals with coding and HIM backgrounds.

6 Ask ACDIS
Advisory Board members weigh in on whether remote nurses need to maintain licensure in the state where they work.

12 In the news
Members of the ACDIS Advisory Board discuss developments related to the latest Official Guidelines for Coding and Reporting.

14 Coding corner
Laurie Prescott, ACDIS’ lead CDI Boot Camp instructor, runs down the highlights of the recent revision to the Official Guidelines for Coding and Reporting.

24 Meet a member
Robin Jones, RN, BSN, MHA/Ed, CCDS, serves as the system director at Mercy Health in Cincinnati, where she oversees the CDI program across 17 hospitals.

OPINIONS & INSIGHTS

7 Nursing license support: A remote CDI dilemma
Wendy Frushon Tsaninos, RN, CCDS, CCS, CMSRN, MSTD, a CDI specialist with Maxim Health Information Services, questions her colleagues about obtaining nursing licensure for remote CDI professionals.

19 Physician advisor’s corner
Sam Antonios, MD, FACP, FHM, CPE, CCDS, offers 10 tips for handling MS-DRG claim denials and winning appeals.

20 Outpatient efforts
Erica E. Remer, MD, FACEP, CCDS, provides suggestions to help physician practices prepare for the closure of the unspecified coding loophole.

23 Exploring the role of a DRG coordinator and CDI liaison
Lori (Cushing) Drodge, RHIT, CCS, discusses how her role at Maine Medical Center evolved.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading this CDI Journal and taking a 20-question quiz. Click here to download the quiz for CCDS credits.
One of the greatest pleasures of my role as the Associate Editorial Director for ACDIS is working alongside such an amazing group of talented, knowledgeable, and generous members. Those working as CDI specialists hunger for education and information, and they are equally hungry for opportunities to share the resources and knowledge they have obtained.

While nothing epitomizes that sharing and networking like the annual ACDIS Conference, it’s also evident in the annual CDI Week celebration, which takes place during the third week of September.

While nothing epitomizes that sharing and networking like the annual ACDIS Conference, it’s also evident in the annual CDI Week celebration, which takes place during the third week of September.

We set aside this week as a time for those in the field to tout the value of the work they perform every day. We encourage staff to print out CDI Week posters and hang them throughout their facilities, to reach out to the ancillary staff that support them, and to thank physicians for their documentation efforts. We also encourage facility administrators to express appreciation for CDI team members through thank-you notes, lunches, or an in-person visit to shake their hands, letting them know how important they are to the institution’s overall success.

This year’s CDI Week theme is “CDI in concert: Your ticket to collaboration.” Some CDI programs have run with that theme and given out “concert tickets” for fun educational events. We’ve already received a number of team photos and suggestions for activities.

One team ordered a photo booth and invited the facility to come and take selfies with the CDI staff. Another group, whose teammates are scattered across the country, created a map with photos of each staff member and a short description of the individual. Others plan presentations and trivia, and one even hosted a CDI specialist from Australia.

We look forward to hearing from as many of you as possible, so please send us your CDI Week success stories, and we’ll feature them on the ACDIS Blog and elsewhere. In sharing your great ideas, we all benefit.
Speaking of which, although they’re perhaps not as jazzy or fun-filled, ACDIS also offers quarterly teleconferences/webcasts free to its members. These calls are informal panel discussions between the ACDIS Advisory Board and ACDIS members.

Participants submit their questions via email ahead of time or type them into the chat pod on the platform. We incorporate these items into an agenda. Often, our calls address the most recent developments in healthcare reimbursement; they also frequently delve into discussions around controversial coding guidelines, changes in clinical definitions, and shifts in expectations regarding documentation and the roles of CDI specialists.

The August quarterly conference call included a number of such topics—changes in the Official Guidelines for Coding and Reporting related to clinical validation queries and coding; Coding Clinic advice related to the use of the word “with” as a linking term for diagnosis documentation; how to handle sepsis denials in light of CMS’ decision to not back Sepsis-3. Many of these topics are discussed within this edition of the Journal, too.

While the Advisory Board doesn’t make formal recommendations on these matters, the conversation does provide a backdrop for members and gives attendees the information they need to communicate concerns facing the larger industry to administrators and decision-makers within their own facilities. In short, these calls help everyone stay well-informed about the latest trends in the CDI profession. If you didn’t have a chance to join us for the live call, you can listen to the recording on the ACDIS website.

ACDIS members have access to the entire archives of these calls. They can also complete the related survey (available just above the recording) to obtain one Certified Clinical Documentation Specialist (CCDS) continuing education credit. Members have up to one year to view the records and download their certificate of attendance.

If you missed the summer call, pencil in our next one, which will be held November 17 at 1 p.m. Eastern time. Talk to you then! 🕵️

NOTE FROM THE ADVISORY BOARD

Collaboration begins with appreciation

by Paul Evans, RHIA, CCS, CCS-P, CCDS, and Anny Yuen

The debate regarding which profession makes the “best” CDI specialist unfortunately continues. Many facilities and consulting firms, initially trained to believe that only nurses could perform the duties of a CDI specialist, continue to propagate such expectations.

Yet we believe other clinicians (e.g., physicians, physician assistants, foreign medical graduates) and nonclinicians (e.g., coders and health information management [HIM] professionals) also perform well in the CDI role with appropriate training.

When considering candidates for an open CDI position, CDI managers need to take a closer look at their initial job descriptions and make sure they accurately reflect not only the current needs of the department and the expanded role CDI specialists need to play, but also changes in industry expectations.

We’ve seen instances where programs take sample roles and responsibilities wholesale, and fail to customize their expectations or include professionals outside nursing. It has
long been ACDIS’ stance that facilities should find the candidate best suited to the particular position. ACDIS has long expressed itself as an inclusive organization, welcoming coders, nurses, physicians, case managers, quality staff, and all who are interested in learning more about the value of complete and accurate documentation in the clinical record.

Further, in order to sit for the Certified Clinical Documentation Specialist (CCDS) credential, ACDIS lists out several levels of required education and skills. Among them, professionals must have an associate-level college degree—as the role of CDI specialist requires a high level of cognitive analysis and the integration of significant clinical acumen and awareness of healthcare reimbursement processes.

On the coding side, educational differences between those holding the Certified Coding Specialist, the Registered Health Information Technician, and the Registered Health Information Administrator® credentials are vast and may include formal college credits, anatomy and physiology, pharmacology, and pathophysiology, among other areas. However, because some facilities do not require coders to have advanced degrees, the conventional wisdom often gets reiterated—that coders in general have no clinical training or knowledge.

As HIM professionals engaged in CDI efforts at our facilities and as active members of the ACDIS Advisory Board, we stand to represent those from the coding side of the house who have effectively leveraged their experience to help advance the CDI mission. We have proven that we can perform duties as CDI specialists and lead successful departments, while promoting the team dynamic between providers and HIM and CDI.

As HIM professionals engaged in CDI efforts at our facilities and as active members of the ACDIS Advisory Board, we stand to represent those from the coding side of the house who have effectively leveraged their experience to help advance the CDI mission.

Not all coders can serve as CDI specialists, and neither can all nurses. Being a CDI specialist takes creativity and strong understanding about clinical documentation and indicators. The first step to true collaboration requires a deeper awareness and appreciation of the talents each individual, regardless of professional background, brings to the table.

---

**ADVISORY BOARD**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Institution</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam Antonios, MD, FACP, FHM, CCDS</td>
<td>CDI/ICD-10 Physician Advisor</td>
<td>Via Christi Health Wichita, Kansas</td>
<td><a href="mailto:Samer.Antonios@via-christi.org">Samer.Antonios@via-christi.org</a></td>
</tr>
<tr>
<td>Wendy Clesi, RN, CCDS</td>
<td>Director of CDI Services</td>
<td>Enjoin</td>
<td><a href="mailto:wendy.clesi@enjoincdi.com">wendy.clesi@enjoincdi.com</a></td>
</tr>
<tr>
<td>Cheryl Ericson, MS, RN, CCDS, CDIP</td>
<td>CDI Education Director</td>
<td>ezDI</td>
<td><a href="mailto:cericson@ezdi.us">cericson@ezdi.us</a></td>
</tr>
<tr>
<td>Paul Evans, RHIA, CCDS, CCS, CCS-P</td>
<td>Clinical Documentation Integrity Leader</td>
<td>Sutter West Bay Area</td>
<td><a href="mailto:evanspx@sutterhealth.org">evanspx@sutterhealth.org</a></td>
</tr>
<tr>
<td>James P. Fee, MD, CCS, CCDS, Vice President</td>
<td>Enjoin</td>
<td><a href="mailto:james.fee@enjoincdi.com">james.fee@enjoincdi.com</a></td>
<td></td>
</tr>
<tr>
<td>Tamara A. Hicks, RN, BSN, MHA, CCS, CCDS, ACM Manager, Care Coordination</td>
<td>Wake Forest Baptist Health</td>
<td><a href="mailto:thicks@wakehealth.edu">thicks@wakehealth.edu</a></td>
<td></td>
</tr>
<tr>
<td>Robin Jones, RN, BSN, CCDS, MHA/Ed, System Director, Clinical Documentation Excellence</td>
<td>Mercy Health, Cincinnati Ohio</td>
<td><a href="mailto:RAJones@mercy.com">RAJones@mercy.com</a></td>
<td></td>
</tr>
<tr>
<td>Mark LeBlanc, RN, MBA, CCDS, Director, CDI Services</td>
<td>The Wilshire Group</td>
<td><a href="mailto:m.leblanc@thewilshiregroup.net">m.leblanc@thewilshiregroup.net</a></td>
<td></td>
</tr>
<tr>
<td>Michelle McCormack, RN, BSN, CCDS</td>
<td>Director, CDI</td>
<td>Stanford Hospital and Clinics Palo Alto, California</td>
<td><a href="mailto:mmccormack@stanfordmed.org">mmccormack@stanfordmed.org</a></td>
</tr>
<tr>
<td>Karen Newhouser, RN, BSN, CCS, CCDS, CCM</td>
<td>Director of CDI Services</td>
<td>MedPartners</td>
<td><a href="mailto:karenmpu@medpartnershim.com">karenmpu@medpartnershim.com</a></td>
</tr>
<tr>
<td>Judy Schade, RN, MSN, CCM, CCDS</td>
<td>Clinical Documentation Specialist</td>
<td>Mayo Clinic Hospital</td>
<td><a href="mailto:Schade.judy@mayo.edu">Schade.judy@mayo.edu</a></td>
</tr>
<tr>
<td>Anny Pang Yuen, RHIA, CCS, CCDS, CDIP</td>
<td>Director, Ambulatory CDI</td>
<td>Enjoin</td>
<td><a href="mailto:Anny.Yuen@enjoincdi.com">Anny.Yuen@enjoincdi.com</a></td>
</tr>
</tbody>
</table>
Remote CDI staff need state-specific licensure

Q

I have a question regarding CDI practice by registered nurses (RN) in states in which they do not have an endorsement of their nursing licenses. Some facilities do not require this, whereas others do.

Obviously, it makes it much easier if the states in which an RN CDI specialist lives and works are in the nursing compact, but this isn’t always the case.

We have had requests (in various states) to have nursing licenses endorsed in the state in which the facility is located, as well as in the state where he or she lives. The rationale escapes me.

A

The issue of nursing licensure has become more pronounced due to the increase in remote RN-credentialed CDI specialists working in the industry.

Remote opportunities will likely continue to expand as more facilities realize that remote CDI reviews/audits are practical and effective, if employed properly.

Some states have had problems filling CDI positions due to cost of living and a general nationwide nursing shortage.

Nursing practice and licensure issues and questions are best handled by the board of nursing in the state in which you are licensed as well as the location of the facility in which you are providing CDI services either via travel or remotely.

Currently there are 25 states operating under the Nursing License Compact (NLC), and its terms require an RN to possess a license in the state in which he or she is a resident.

The terms of the NLC allow an RN to practice in any of the NLC states, even if the RN is not licensed in the particular state he or she is practicing in.

For example, if you possess a Wisconsin RN multistate license and both Wisconsin and Arizona are NLC states, you can practice in Wisconsin, Arizona, or any of the NLC states. You would hold a license only in the state in which you are a resident.

You can view additional details on the National Council of State Boards of Nursing website here: https://www.ncsbn.org/nurse-licensure-compact.htm or through viewing the following video: https://www.ncsbn.org/364.htm.

ACDIS notes that there are 25 additional states operating outside of the NLC, each with their own rules and regulations.

You may wish to begin by consulting your state nursing board for additional information. It is typically a simple process to ask an initial question via a method such as the “contact us” link on the board’s website.

When contacting your nursing board, you may want to provide a complete description of your CDI roles and responsibilities. It is always prudent when holding a professional licensure such as nursing that you work with your employer and institutional legal counsel as well as any related nursing boards.

This is an evolving issue, as evidenced by a July 13 article in Hospitals and Health Networks Magazine “Should Nurse Licenses Hold Across States?”: www.hhnmag.com/articles/7338-should-nurse-licenses-hold-across-states.

Editor’s note: The above answer was drafted and approved by members of the ACDIS Advisory Board.
Nursing license support: A remote CDI dilemma

by Wendy Frushon Tsaninos, RN, CCDS, CCS, CMSRN, MSTD

In the CDI industry, the remote CDI role is highly coveted. One way to attain such a position is to apply for employment with a supplemental staffing agency. Through this process, a candidate can be matched with a variety of clients across the nation, based on the candidate’s skill set, experience, and client needs. A Massachusetts-based hospital may be staffed in part by a CDI specialist working from home in Missouri, for example.

Such a scenario prompts a question: If a registered nursing (RN) license is one of the requirements of the remote CDI position, does the RN CDI specialist need to have her or his nursing license endorsed in the facility’s home state?

Surprisingly, the supplemental staffing industry has had to deal with such a conundrum, and it’s “more common than you’d think,” according to Ben Lawson, a recruitment manager at Maxim Health Information Services, where I work. He cites California as one state in which clients have requested CDI specialists who hold a California RN license.

Reasons behind the endorsement requirement can stem from outdated policies or misunderstanding of the CDI specialist’s role.

“A facility may require the RN endorsement due to a compliance policy drafted prior to CDI being a prominent role and responsibility within the hospital,” says Paul Passaro, co-founder of Intero Group – HIM Services in Fort Myers, Florida.

Clients “typically agree that there is no risk in using an out-of-state RN,” Passaro says. Nevertheless, they have a policy in place requiring the license, and “they need all vendors to comply with hospital policies.”

One reason for the endorsement requirement might be “a clear lack of understanding in the role of what a CDI does from some leadership in the health system,” says Martin Jones, a recruitment manager at Maxim Health Information Services.

Clients and candidates should be aware of the implications of this imposed prerequisite: “With a smaller pool to recruit from, it may take longer to find the right candidate,” Passaro says.

This may mean limiting the candidate search to the client’s state. Preference may also be given to a candidate with a compact RN license or a license in the facility’s state, over one who would need to apply for RN license endorsement or obtain a temporary state RN license while awaiting endorsement.

Candidates who are otherwise well-suited to a client might also shy away from the lengthy process of getting their licenses endorsed.

“Some [CDI staff] are willing to apply and obtain the state license, but some just say, ‘Let’s look at other assignments with less requirements,’ which further limits the pool of candidates for a client, says Passaro.

Those with additional credentials and certifications in the HIM industry, however, may find that they have a competitive edge even if they do not hold an RN credential.

“Most CDI professionals have a coding or CDI certification in addition to their RN license,” Passaro points out, and sometimes that credential will satisfy the requirements of the position (e.g., a candidate must be an RN, CCS, or CCDS).

Jones has seen the downside of such a requirement firsthand, though.

“We had a CDI specialist slated to start, then the human resources team at the hospital flagged that she

Some [CDI staff] are willing to apply and obtain the state license, but some just say, ‘Let’s look at other assignments with less requirements.’

—Paul Passaro
didn’t have a compact state license and halted the process. They ended up not moving forward with that candidate, in order to adhere to the [region’s] board of nursing standards.” Such an outcome can be disappointing to all parties involved.

As RN licensure is governed by individual states, the board of nursing for each state can be viewed as an authority in this discussion. However, these governing bodies may be more familiar with application of nursing bylaws in patient care versus CDI practice.

Donna Kennedy, RN, JD, senior director of CDI consulting and management services at The Advisory Board Company, examines the requirement from the tenet guiding nursing licensure.

“Nursing practice is regulated at the state level in order to mitigate risk to patients who would otherwise have no way to ensure the competency of their providers … requiring documentation specialists to be held to the same standard as a nurse who has patient contact, and who otherwise might pose a risk of harm to that patient, doesn’t make sense,” says Kennedy.

She also draws attention to the typical tasks of a CDI specialist: “None require the skills-based capabilities that a practicing provider must possess to render safe care to their patients. Indeed, HIM professionals would be excluded from this largely administrative role if such skills, or even licensure, were in fact required.”

Two state boards of nursing were contacted via email for official guidance on this topic.

Janeen Dahn, PhD, FNP-C, associate director of complaints and investigations for the Arizona State Board of Nursing, wrote that “if the RN is providing nursing services to a patient, the RN must be licensed in the state in which the patient resides.” Of note, Arizona is one of 25 states that belong to the Nurse Licensure Compact (NLC).

Miyo Minato, supervising nursing education consultant for the California Board of Registered Nursing, responded to the request with relevant California Board of Registered Nursing (BRN) bylaws and the following direction:

The email question posed to the BRN is regarding RN licensure requirement for individuals who may reside in another state and are strictly reviewing patient data recorded in clinical documentation for coding purposes, and there is no direct or indirect activities by the RN related to treatment plans or advice. In this case, there is no requirement for RN license by the board.

California does not belong to the NLC, but it is home to several healthcare systems that use supplemental staffing for remote CDI positions.

“Unfortunately, whether a state licensing board considers the CDI specialists’ non-patient contact role a requirement to obtain licensure in another state is an individual state decision, and I always encourage every person to ask this question of their non-home state board personally,” says Karen Newhouser, RN, BSN, CCM, CCDS, CCS, CDIP, director of education for MedPartners.

Personally asking the question provides the CDI specialist with written (email or paper) evidence, should his or her role in a non-home state be challenged, Newhouser says. It’s better to get it in writing for yourself “instead of going by what someone else claims they were told.” Secondly, “if state boards are deluged with questions, they will more than likely address the issue faster than if only a few ask the question,” she says.

Perhaps in the future, the remote CDI/nursing license endorsement issue will have been resolved through the evolution of CDI practice. Passaro believes that may well happen in the next five to 10 years.

“CDI will continue to move into a remote setting and therefore eliminate the policy that an RN must be registered within the state of work,” he says.

Newhouser is also encouraged by the development of the NLC and its effect on the CDI industry, and she emphasizes that “it is merely moving through the process with a smile—with the hope that change is in the future.” 🌈

Editor’s note: Tsaninos is a CDI specialist with Maxim Health Information Services. Contact her at wfrushon@hotmail.com.
New rules add import to clinical validation queries

The 2016 ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice call on CDI or coding professionals to query physicians if the documentation:

1. Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
2. Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
3. Provides a diagnosis without underlying clinical validation

Such queries aren’t meant to question a physician’s medical judgment, but to ensure the accuracy of the medical record and subsequent code assignment. New recommendations included in the 2017 ICD-10-CM Official Guidelines for Coding and Reporting, however, call on coders to base assignments on the provider’s statement rather than on an independent interpretation of whether a condition exists.

The new Guidelines state:

The assignment of the diagnosis code is based upon the provider’s diagnostic statement that the condition exists. The provider’s statement that a condition exists is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Clinical validation is a somewhat subjective concept, says ACDIS Advisory Board member Cheryl Ericson, MS, RN, CCDS, CDI-P, manager of clinical documentation services at DHG Healthcare.

“Practitioners often disagree on how to define conditions such as severe malnutrition and acute respiratory failure,” Ericson says. “Determining the clinical validity of a reported condition is subjective, which is why denials are plentiful.”

Although it is tempting for CDI and coding professionals to define diagnoses for providers, doing so is beyond their scope, she notes.

In fact, the Guidelines state the provider is legally accountable for establishing diagnoses, so CDI specialists and coders should not diagnose patients.

As for the required threshold necessary to clinically validate a diagnosis, CMS states, “as with all codes,
Clinical evidence should be present in the medical record to support code assignment.”

Additionally, coding guidelines have always required a condition meet the Uniform Hospital Discharge Data Set (UHDDS) criteria before a code can be reported. As such, not every documented condition will, or should, result in a reportable code even with implementation of the new guideline.

CODERS AND CDI PROFESSIONALS must continue to use the query processes encompassing clinically valid criteria endorsed by providers to ensure coding is congruent with clinical truth, says ACDIS Advisory Board member Paul Evans, RHIA, CCS, CCS-P, CCDS, regional manager at Sutter West Bay in San Francisco.

Coding practice should align with widely accepted clinical definitions to the extent possible and work in harmony with CDI practice to produce data sets and billing that are congruent, complementary, and logical; CDI specialists need to continue to work closely with physicians to define and document diagnoses so that the data sets produced are defensible.

“That seems to have been where the industry was headed,” Evans says, but he worries about how the 2017 Guidelines may seem “out of step with that evolution.”

The goal of CDI and clinical validation should be clinical accuracy, says ACDIS Advisory Board member Wendy Clesi, RN, CCDS, director of CDI services at Enjoin. “At the end of the day, medical care, documentation, and coding need to be defendable,” she says. “The best way to do this is through complete and accurate documentation to support coding, quality outcomes, and payment.”

The confusion isn’t necessarily related to identifying the ultimate goal of documentation and coding—as always, that goal is clinical accuracy. Instead, the questions stem from how different players interpret various recommendations, says ACDIS Advisory Board member Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP, director of education for MedPartners.

“If I look at the sentence separately, I see the words ‘clinical criteria used by the provider to establish the diagnosis,’ ” she says.

This means the record needs to have two things:

1. Clinical criteria
2. A diagnosis

Both of them need to be documented by the provider, Newhouser says.

She provides this example: A provider documents criteria for sepsis and clearly and consistently documents the diagnosis and the clinical criteria that he or she feels best fit the patient. When making the diagnosis, the provider chooses to apply the Sepsis-3 criteria and not the SIRS criteria.

“If I were the coder or CDI specialist in this instance, I cannot choose to ignore the sepsis diagnosis merely because the physician used criteria that didn’t align with the belief system of myself, CMS, or the facility,” says Newhouser. “This means I cannot base my code assignment solely on the clinical criteria that the provider used in the record to establish the diagnosis.

In a nutshell, it is up to the physician, as the clinical expert, to decide which criteria he or she uses, not the CDI specialist or coder. We cannot base our code selection on criteria of our choosing.”

The goal of these guidelines is to promote consistency among CDI and coding professionals in identifying diagnoses that appear to lack sufficient clinical evidence.

—Cheryl Ericson Cheryl Ericson, MS, RN, CCDS, CDI-P
Nevertheless, organizations would be well-served to develop internal guidelines that define those diagnoses most vulnerable to denials, says Ericson.

“The criteria should be created in collaboration with the medical staff, CDI professionals, coding professionals, and quality of care professionals,” she says. “The goal of these guidelines is to promote consistency among CDI and coding professionals in identifying diagnoses that appear to lack sufficient clinical evidence.”

After all, says Newhouser, the Guidelines don’t set aside medical necessity requirements. They simply state that coders and CDI specialists do not have a say in which criteria the provider chooses to apply.

Each facility needs to establish its own internal policy for CDI and coding in terms of clinical validation, says ACDIS Advisory Board member Anny Yuen, RHIA, CCS, CCDS, CDIP, vice president of revenue cycle for R3 Health Solutions.

“Sometimes I feel CDI and coding teams need to remember the basics,” she says, like the UHDDS’ definition of a principal diagnosis, which is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

“At the end of the day, the provider is the one who determines the patient’s diagnosis,” says Yuen.

A good practice for performing clinical validation reviews is for CDI specialists to ask themselves whether other providers would come to the same conclusion based on the same information, Ericson says. They should consider whether the diagnosis is a reasonable conclusion based on the totality of the health record.

CDI professionals must let the provider know that they trust the physician’s judgment for a particular diagnosis, but that, as CDI specialists, they are tasked with ensuring the clarity of the record, says Newhouser.

“As a CDI professional, I am merely asking that the physician’s thoughts be put into print,” she says. “One of my favorite sayings is ‘trust but verify.’ I trust the provider, but now I am asking them to verify the diagnoses.”

**Denial dilemma**

The days when a provider could document a diagnosis that would automatically be accepted by payers are gone, says ACDIS Advisory Board member Judy Schade, RN, MSN, CCM, CCDS, CDI specialist for Mayo Clinic Hospital.

Diagnoses affect the DRG, severity of illness/risk of mortality, and now possible risk adjustments, so they are being scrutinized more than ever. This has led to the need for additional documentation to clinically validate the diagnosis and, in a way, prove that the diagnosis is supported, monitored, evaluated, or treated, and that it affected the care of the patient, Schade says.

“I have reviewed records where diagnoses are only mentioned in the discharge summary, and this is suspect as to why these diagnoses were not documented on admission or during the stay,” she notes. “We are asking payers to pay thousands of dollars to care for patients, and the responsibility is on the provider to document a complete and accurate clinical picture, supported by evidence-based practice.”

The healthcare industry as a whole has witnessed an increase in denials where medical necessity is not supported in the record, says Schade.

There are also more denials where clinical indicators and evidence-based practice do not support the diagnosis. Providers are often confused as to why their documentation and diagnoses are being challenged, so Schade offers an alternative approach.

“I ask for clarification, or for the provider to explain a particular clinical scenario as more of an educational intervention,” she says. “This is well-received and less intimidating.”

Facilities are realizing the potential for an increase in denials, so they should be proactive and understand the risks they face, says Schade.

CDI specialists and coders need to collaborate with providers to prevent denials and ensure complete and accurate documentation.

“Personally, I do not like the word “query” or “question” because I am not questioning the provider’s decision to document a particular diagnosis,” says Schade. “I am simply clarifying the documentation to better refine and describe the situation to capture the complete and accurate clinical picture of patient care. That is the CDI specialist’s role.”
IN THE NEWS

ACDIS addresses documentation and coding issues

Editor’s note: ACDIS Advisory Board members Paul Evans, RHIA, CCDS, CCS, CCS-P, and Judy Schade, RN, MSN, CCM, CCDS, in conjunction with former ACDIS Advisory Board member and HCPro Director of HIM/Coding Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, have recently been working on official documentation and coding guidance of concern to ACDIS members. Over the last couple of months, the team has issued questions and commentary on the below two issues to the editorial team of AHA Coding Clinic for ICD-10-CM/PCS, CMS (via the inpatient prospective payment system [IPPS] comment period), and 3M Health Information Systems. Following is a summary of these issues and the responses received.

Minor surgical/therapeutic procedures grouping to surgical DRGs

Earlier this year, ACDIS learned that several minor diagnostic and/or therapeutic procedures, when captured with ICD-10-PCS codes, group to surgical DRGs.

This practice led to significantly higher rates of reimbursement for these procedures and considerable consternation amongst CDI and coding professionals who feared these payments would eventually result in recoupment from CMS and/or private payers.

As a result, some hospitals opted not to code these procedures. Others chose to code them as usual, citing that it was their obligation to do so under HIPAA, the AHIMA Code of Ethics, and the ICD-10-CM/PCS Official Guidelines for Coding and Reporting.

Some of the problematic procedures include the following:

- Paracentesis. Coding this procedure as diagnostic versus therapeutic results in a surgical DRG.
- Esophageal banding of bleeding varices. This procedure now codes to a surgical DRG.
- Fine needle aspiration (FNA) of a lymph node. FNA does not normally code to a surgical DRG, but when performed on a lymph node, it codes to a surgical DRG.
- Insertion of an arterial line. Coding this procedure results in a surgical DRG.
- Pregnancy with a forceps vaginal delivery with a 3rd- or 4th-degree tear repair. Since the vaginal delivery is not a surgical procedure, but the repair of the anus is surgical, these cases are being assigned to a DRG for an unrelated OR procedure to the principal diagnosis instead of a pregnancy DRG.

As a result, ACDIS issued a position paper on this matter in April for its members and the broader CDI community.

ACDIS also issued a comment to CMS in the 2017 IPPS proposed rule outlining these grouping issues, and we are pleased to report that many of these problems have been addressed, as published in the 2017 IPPS final rule.

For example, all of the following codes formerly grouped to OR procedures but have been updated to group to non-OR procedures:

- 0W9G3ZX, drainage of peritoneal cavity, percutaneous approach, diagnostic
- 02H732Z, insertion of monitoring device into left atrium, percutaneous approach
- 06L33CZ, occlusion of esophageal vein with extraluminal device, percutaneous approach
- 06L33CZ, occlusion of esophageal vein with extraluminal device, percutaneous approach
- 079030Z, drainage of head lymphatic with drainage device, percutaneous approach

In addition, 0DQQ0ZZ (repair anus, open approach) and other like codes (e.g., anal sphincter) now group to MS-DRG 774 (Vaginal...
Delivery with Complicating Diagnoses). This indicates that CMS has repaired what was a major payment problem.

Unfortunately, there remains an even more problematic issue for CDI/coding professionals, even after requests for clarification.

**Coding Clinic and use of the term “with”**

Recent AHA guidance, published in Coding Clinic for ICD-10-CM/PCS, First Quarter 2016, and reconfirmed in Second Quarter 2016, creates an assumed relationship for all conditions listed under the term “with” for diabetic manifestations or complications.

Most of these diagnoses may not affect overall payment for inpatient admissions since few are designated as CCs or MCCs. However, the overarching concern regards making such assumptions for patients reimbursed on a risk-adjusted methodology, whereby the relationship between diabetes and basically all coexisting conditions can affect overall risk score calculations.

AHA Coding Clinic for ICD-9-CM published many articles over the years that addressed situations where assumptions could be made between diabetes and conditions such as osteomyelitis, gangrene, and neuropathy.

These assumptions were supported in the Alphabetic Index because they were conditions listed under the word “with,” as seen below:

- Diabetes, diabetic (brittle) (congenital) (familial) (mellitus) (severe) (slight) (without complication) 250.0

  **Note** Use the following fifth-digit subclassification with category 250:

  0. type II or unspecified type, not stated as uncontrolled
  
  Fifth-digit 0 is for use for type II patients, even if the patient requires insulin

  1. type I [juvenile type], not stated as uncontrolled

  2. type II or unspecified type, uncontrolled
  
  Fifth-digit 2 is for use for type II patients, even if the patient requires insulin

  3. type I [juvenile type], uncontrolled

  **with**

  - coma (with ketoacidosis) 250.3
    - due to secondary diabetes 249.3
    - hyperosmolar (nonketotic) 250.2
      - due to secondary diabetes 249.2

  - complication NEC 250.9
    - due to secondary diabetes 249.9
    - specified NEC 250.8
      - due to secondary diabetes 249.8

  - gangrene 250.7 [785.4]
    - due to secondary diabetes 249.7 [785.4]

  - hyperglycemia - code to Diabetes, by type, with 5th digit for not stated as uncontrolled
  - hyperosmolarity 250.2
    - due to secondary diabetes 249.2
  - ketosis, ketoacidosis 250.1
    - due to secondary diabetes 249.1
  - loss of protective sensation (LOPS) - see Diabetes, neuropathy
  - osteomyelitis 250.8 [731.8]
    - due to secondary diabetes 249.8 [731.8]
  - specified manifestations NEC 250.8
    - due to secondary diabetes 249.8

However, in the ICD-10-CM Alphabetic Index, all manifestations (for all types of diabetes E08–E11 and E13) are indented under the word “with,” not just the selected few mentioned in Coding Clinic for ICD-10-CM/PCS, First Quarter 2016, p. 11, which states:

**The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system.**

Refer to the ICD-10-CM Alphabetic Index, “Diabetes, with” to see the complete listing.

It is clearly understood that if the provider documents a condition such as “diabetes with cataracts,” this relationship between diabetes and cataracts can be assumed,
applying the concept that “with” creates the relationship.

However, in the past, if the provider listed the patient’s current conditions, coding professionals assumed that the provider was not creating a relationship but rather providing a list of current conditions, and without further linkage the coder would report both diagnoses as independent conditions and not as cause and effect or manifestations, i.e.:

1. Diabetes
2. Cataracts

But now this relationship can be assumed, and not only for diabetic manifestations, but for any main term in the Alphabetic Index immediately followed by the word “with.” This AHA Coding Clinic guidance has now been codified in the 2017 ICD-10-CM Official Guidelines for Coding and Reporting, effective October 1, 2016, which state:

The word ‘with’ should be interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related. The word ‘with’ in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

This is a tremendous change: If this guidance regarding “with” is truly universal within the Alphabetic Index, then it implies a relationship even without provider documentation—and the scope of the guidance extends well beyond just diabetes mellitus.

For example, it seems that coders could begin to assume that patients who have sepsis with a coexistence of organ dysfunction have severe sepsis, even though the Official Guidelines for Coding and Reporting state “an acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code.”

That’s because the entry “with” appears in the Alphabetic Index under sepsis:

- Sepsis (generalized) (unspecified organism) A41.9
  - ––with
    - --organ dysfunction (acute) (multiple) R65.20

Members of this task group wrote to AHA Coding Clinic about this issue and have received answers indicating that this is indeed the correct interpretation of the term “with.”

ACDIS will continue to monitor this situation and raise the issue of assumed linkages and their implications to the Cooperating Parties.

CODING CORNER

12 new Official Guidelines that affect CDI

by Laurie L. Prescott, RN, MSN, CCDS, CDIP

The last few weeks have been mind-spinning. First and foremost, the 2017 inpatient prospective payment system (IPPS) final rule, which includes Medicare payment system changes, coding changes, and MS-DRG shifts, was released.

The new codes require review. The new quality monitors require review. Coders and CDI professionals need to know how the new codes will map to MS-DRGs. I can’t find enough time in my days (or nights!) to read all the new information.

Additionally, AHA’s Coding Clinic for ICD-10-CM/PCS published groundbreaking direction in the last few months related to diabetes and linking.
While all these changes can be overwhelming, it’s helpful to simplify things and just start at the beginning.

When I teach our CDI Boot Camps, I usually begin with the question, “How many of you have read the Official Guidelines for Coding and Reporting?” Often, nobody raises their hand.

While it’s not the most interesting read, it is a necessary one for those of us working in the field. The Guidelines are only 115 pages, and although they aren’t something you’d take to the beach, I promise they provide a few professional plot twists and turns—some we are aware of, and some that may be surprising.

**Excludes1 notes: Section A.12.a**

Excludes1 notes were not supposed to be used with the term listed above the note. Now, there may be an exception to the Excludes1 definition for circumstances when two conditions are unrelated to each other.

For example, a patient may demonstrate hemiparesis as a sequela of an old cerebrovascular accident (CVA) and also have a code for an acute CVA. If it is not clear whether the two conditions involving an Excludes1 note are related, query the provider.

**The term “with”: Section A.15**

The classification presumes a causal relationship between two conditions linked by the term “with” in the Alphabetic Index or Tabular List.

When the physician documents two conditions as related to one another using this term, coders can view them as linked unless the documentation says those conditions are not connected.

For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related, so in this case a query might be required.

This guidance was reiterated by AHA Coding Clinic for ICD-10-CM/PCS, Second Quarter 2016.

**Clinical criteria: Section A.19**

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient, according to this new guideline. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

This change is important. It tells us that although we should use clinical criteria to identify query opportunities as well as to identify diagnoses that may or may not be present, we must understand that the provider is the only one who can determine the presence or absence of a diagnosis.

We can assist the provider to better document the reasoning related to an identified diagnosis, but we should never choose to not code a diagnosis because we feel it is not clinically supported.

**Documentation from non-providers: Section B.14**

When the corresponding diagnosis is provided, we are able to code further qualifying information from the documentation of non-providers related to items such as body mass index, the depth of non-pressure and pressure ulcers, the Glasgow coma scale, and the NIH Stroke Scale (NIHSS).

We have had this instruction in the past, but now with the addition of codes related to the NIHSS, we can specify the extent or severity of a stroke based on information that is usually documented by nursing professionals.

**Zika virus code assignment: Section 1.f.1**

With the first cases of Zika contracted within the United States appearing in Florida, the Guidelines address the latest virus outbreak and tell us to code only confirmed cases of the Zika virus, as documented by the provider. The physician’s diagnostic statement that the condition is confirmed is all that is needed.

**Long-term use of oral hypoglycemic with diabetes: Section 4.a.1.3**

Assign Z79.84, long-term (current) use of oral hypoglycemic drugs, to indicate the patient uses an oral hypoglycemic on a long-term basis.

We have assigned codes related to long-term use of insulin; now we can recognize those patients who use long-term oral hypoglycemic medications.

**Hypertension, heart disease, and renal disease:**
Section 9.a

The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index.

These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with,” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

Hooray for us, as this results in one less query to ask!

Hypertensive crisis: Section 9.a.10

Assign a code from category I16, hypertensive crisis, for documented hypertensive urgency, hypertensive emergency, or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10–I15). The sequencing is based on the reason for the encounter.

Pressure ulcers: Section 12.a.5 and 12.a.6

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

If a patient is admitted with a pressure ulcer at one stage and it advances to another stage during the encounter, assign two codes: one for the site and stage of the ulcer on admission, and a second for the same ulcer and the highest stage documented during the encounter.

This is a significant change, and will require our attention. I anticipate quality monitors are coming based on a worsening pressure ulcer under our care.

Coma scale: Section 18.e

The new Guidelines suggest that the Glasgow coma scale may also be used to assess the status of the central nervous system for other non-trauma conditions, such as monitoring patients in the ICU.

NIHSS: Section 18.i

The 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 new Guidelines state.

The stroke scale codes should be sequenced after the acute stroke diagnosis code(s). At a minimum, coders should report the initial score documented by the physician. If desired, a facility may choose to capture multiple stroke scale scores, according to the Guidelines.

Open fractures/Gustilo-Anderson classification: Section 19.c.1

In ICD-10-CM, the seventh character designates an open fracture for fractures of the forearm, femur, and lower leg, including the ankle, based on the Gustilo-Anderson open fracture classification. When the Gustilo classification type is not specified for an open fracture, the seventh character for open fracture type I or II should be assigned.

Summary

This list does not include any changes in code assignment related to pregnancy and newborns. If this is an area you review, please refer to the Guidelines.

A number of these changes will have a significant effect on CDI review efforts. These changes reinforce the fact that CDI specialists must keep themselves well-informed and review all upcoming changes—be they included in the code set itself, the IPPS rules, or in the Guidelines as these are.

I always say that change is a good thing, but I have to admit: Part of me wishes all this change hadn’t come at the same time! 🌼

Editor’s note: Contact Prescott at lprescott@hcpro.com. For information regarding CDI Boot Camps, visit www.hcprobootcamps.com/courses/10040/overview.
The Third International Consensus Definitions for Sepsis and Septic Shock published new clinical guidelines for diagnosing sepsis, dubbed Sepsis-3, earlier this year in the Journal of the American Medical Association (JAMA).

Although CMS chose not to adopt the new criteria in a letter to JAMA a few weeks ago, questions still remain about how CDI should approach sepsis claims, particularly in the pediatric realm.

The new sepsis definitions are not applicable in pediatrics for two reasons, says Christopher Seymour, MD, MSc, head of the Sepsis-3 Task Force and assistant professor at the University of Pittsburgh School of Medicine, in a podcast hosted by the Society of Critical Care Medicine:

1. The new sepsis criteria are based on the patient’s Sequential Organ Failure Assessment (SOFA) Score, a severity score not valid for pediatrics.
2. The intent of Sepsis-3 was to identify patients who have sepsis and septic shock, reflecting a mortality of 10% and 35%, respectively. However, since the mortality rate in pediatric sepsis is different in adult sepsis, these rates would not apply to pediatric patients.

While the new definitions cannot be applied to pediatric sepsis, there should still be a set of clinical criteria in place to help providers recognize the diagnosis.

The International Pediatric Sepsis Consensus Conference information defines pediatric sepsis as the presence of, or as a result of, a suspected or proven infection, says Jeff Morris, RN, BSN, a CDI specialist at USA Children’s and Women’s Hospital in Mobile, Alabama.

The clinical criteria for pediatric sepsis are very different from the adult criteria, and they are dependent on the age of the patient. These clinical criteria can include an abnormal temperature and an abnormal white blood cell count. There are also age-specific values for vital signs.

The SOFA tool was developed with the adult population in mind, says Karen Bridgeman, MSN, RN, CCDS, CDI educator at the Medical University of South Carolina in Charleston. Until the development and validation of pediatric-specific definitions and clinical criteria relating to the SOFA score, the Sepsis-3 criteria should not be applied to the pediatric population. Pediatric clinical documentation specialists should continue to use the Surviving Sepsis Campaign guidelines for querying for a potential diagnosis of sepsis in the pediatric population, Bridgeman says.

CDI specialists must recognize the signs and symptoms of sepsis in the pediatric population, as septic shock may develop long before signs of hypotension, says Bridgeman. Children often maintain their blood pressure until they are severely ill, and shock may arise before hypotension occurs, she says.

Septic shock in pediatrics often presents with tachycardia with signs of decreased perfusion. The decreased perfusion can include decreased peripheral pulses, decreased capillary refill, or capillary refill of less than two seconds and mottled or cool extremities. The CDI specialist also needs to review for decreased urinary output and altered mental alertness, which can both be signs of decreased perfusion, says Bridgeman.

When reviewing the medical record, Bridgeman recommends keeping two questions in mind:

1. Has the patient received and responded to fluid boluses?
2. Does the patient have a known or suspected infection?

In addition, CDI specialists need to review for hyperthermia, increased white blood count, deviation from normal age-specific vital signs, and elevated procalcitonin.

Knowledge of normal age-specific vital signs is important in reviewing the pediatric population, as bradycardia can be a sign of sepsis in neonates through 12-month-olds, says Bridgeman.

The query process for pediatric and adult populations remains the same, says Morris. The CDI team will look to see whether the documentation includes clinical indicators for at least two SIRS criteria and a known or suspected infection.

“In pediatrics, you must be prudent when issuing sepsis queries as the majority of our patients technically meet sepsis criteria,” says Morris.

“That’s all you’d be querying for all day long if you stuck to the mentality of ‘they meet criteria.’ We are generally looking for the patient to be described as ill-appearing, meet criteria, and receive an appropriate course of treatment,” he says.

Educating providers on sepsis in the pediatric population is an ongoing challenge, says Valerie Bica, BSN, RN, CPN, CDI specialist at Nemours/A. I. DuPont Hospital for Children in Wilmington, Delaware.

Bica’s team partners with providers and other members of the care team to discuss lab results, vital signs, and what classifies a pediatric patient as having sepsis or septic shock.

The CDI team works closely with the care team to ensure sepsis and septic shock diagnoses are ruled in, or out, clearly in the documentation.

Putting patients first, and educating providers to improve patient care with their documentation, is one way to engage providers and encourage them to improve their sepsis documentation in pediatric populations, Bica says.

“Sepsis and septic shock are concerns for all ages,” says Bica. “I personally believe that the CDI team’s presence [throughout the patient care process] helps to build our credibility because the care team counts us as one of them.”

Additionally, the pediatric CDI specialist should educate the medical staff on the importance of documentation as it relates to the patient’s severity of illness and risk of mortality, says Bridgeman.

Physician documentation needs to be more definitive and inclusive with a diagnosis of sepsis, as this diagnosis is a frequent target for auditors. The use of “concern for” or other language, such as “likely,” “possible,” and “suspected,” should be trigger words for CDI clarification.

In addition, physicians should be educated to document sepsis throughout their progress notes and include the diagnosis in their discharge summaries where it truly exists and affects the treatment provided, says Bridgeman.

“CDI specialists must remember that children are not little adults,” she says. “Children have different physiologies and emotional development.”

And, while the essential role of the CDI specialist remains the same whether reviewing the adult or pediatric medical record, Bridgeman notes that “the pediatric CDI specialist must develop and apply their knowledge of the pediatrics population in their CDI practice.”

Editor’s note: This post was based on a number of threads in the pediatric section of the new ACDIS Forum. Visit the ACDIS website or click here to learn more.
PHYSICIAN ADVISOR’S CORNER
10 tips for appealing MS-DRG denials

by Sam Antonios, MD, FACP, FHM, CPE, CCDS

Over the last 18–24 months, healthcare organizations have seen a surge in MS-DRG denials, sometimes referred to as clinical validation denials.

When reviewers from Medicare Advantage health plans, Recovery Auditors, or other private or contracted health plans analyze a clinical case submitted for reimbursement, they may determine that a particular disease should be removed from the claim. They argue that the clinical documentation in the medical record does not support the diagnosis submitted. In the vast majority of these cases, the removed diagnosis is a CC or MCC, which causes the MS-DRG to shift to a lower payment.

MS-DRG audits are nothing new, but their frequency has significantly increased over the last two years. In some circumstances, the volumes have been overwhelming. There have also been reports of cases where denials have been egregious, unjustified, or made with disregard for the treating physician’s opinion.

Although there is no surefire way to win an appeal, here are some tips to increase the likelihood of overturning MS-DRG denials.

One: If you believe the case has merit, file an appeal, even if the variance in dollar amount is insignificant. It may be tempting to let go of denials that minimally affect the reimbursement, but when the treating provider’s documentation is available, complete, and accurate, and the coding is correct per official coding guidelines, organizations should appeal. This maintains consistency and makes the appeals about data integrity, rather than payment.

Two: Write clearly and summarize first. The appeal reader will likely not want to spend a lot of time figuring out the intent of the appeal. The first few lines need to describe the clinical case and need for appeal succinctly. Additional details can be included in later paragraphs.

Also, remember to reference review articles, clinical guidelines, or other findings to support your appeal.

Three: Learn how to navigate the electronic health record (EHR) to find relevant information. The history and physical and the discharge summary may not capture the entire clinical picture.

Learn where to locate, and how to decipher, emergency department documentation, consultant reports, progress notes, nursing notes, and other provider documentation, which can often include vital information to support an appeal.

Additionally, respiratory notes can reveal the status of the patient, including lung exams, respiratory effort, and need for respiratory treatments. The goal should be to offer a complete and accurate clinical picture of the patient.

Four: If possible, review records from transferring facilities to help describe the patient’s case. These records are likely scanned into the record later in the patient care process, but they should be collected before an appeal. Creatinine levels, electrolytes, and other laboratory findings can help differentiate acute and chronic symptoms and conditions.

Five: Keep track of denials electronically. Preferably, use denial tracking software. If such software is not available, or too costly for your facility, spreadsheets can be just as effective. Remember to update and back up these records regularly.

Six: Keep track of deadlines. Deadlines are different depending on the type of denial and the payer. When a claim is denied and a facility chooses to appeal, note the deadline and develop a plan of action.

Allow an optimal amount of time for appeals to be researched, developed, and written. It would be a shame to lose a denial for missing a deadline, especially when the documentation is present.

Seven: Centralize where appeals arrive in the organization. Denial letters may be sent to the HIM department,
the case management department, the revenue cycle office, or the chief financial officer. Establish a process to funnel all denials to a single team or department, which will facilitate management of the appeals and prevent delays.

**Eight:** Include the attending physician’s opinion. Appeals can carry more weight when the attending physician is able to review the case and provide supporting details and arguments. Review the case with the provider, or have him or her review the case independently and provide feedback.

**Nine:** Become familiar with *Coding Clinic*. This should go without saying, but an appeal can go very differently if its argument has to do with an area where *Coding Clinic* has made a comment. Keep up-to-date with coding and documentation requirements and references to support appeals.

**Ten:** Don’t appeal every case. In some cases, the coding may be wrong or the physician documentation may be weak—and that’s okay. Identify what went wrong and pinpoint opportunities to improve future processes. Strategic appeals ensure CDI efforts remain focused on preserving data integrity. Use these errors as a chance for CDI and provider education and engagement.

**Editor’s note:** Antonios is the CDI and ICD-10 physician advisor at Via Christi Health in Wichita, Kansas. A board-certified internist, he manages the hospital EHR system, works closely with quality leaders to tackle challenging documentation requirements, and engages with physicians on CDI and quality initiatives. Contact him at Samer.Antonios@via-christi.org.

---

**OUTPATIENT EFFORTS**

**Putting the specific into unspecified**

by Erica E. Remer, MD, FACEP, CCDS

The world didn’t end on October 1, 2015. After years of postponement, the proverbial “deal with the devil” made between CMS and the AMA to push ahead with ICD-10-CM/PCS implementation was a year’s grace period during which physician practices could continue using unspecified codes without worrying about Medicare denials or auditor reviews. That grace period ends this fall. No doubt it will be a rude awakening for providers and institutions who took it at face value rather than as an opportunity to educate themselves on the new codes and practice using them.

CMS’ intent was not to permit providers to select unspecified codes for yet another year; the grace period was meant to prohibit auditors from penalizing providers while the providers learned how to navigate the specificity of ICD-10. In fact, “ICD-10 flexibilities were solely for the purpose of contractors performing medical review so that they would not deny claims solely for the specificity of the ICD-10 code as long as there is no evidence of fraud,” CMS explained in a July 6, 2015 joint announcement and guidance with the AMA.

**Specificity hurdles**

So how do CDI specialists remedy the situation and help providers document to the level of specificity that is now needed?

The end results of unspecified documentation differ depending on the setting and focus. Are you considering inpatient DRG calculations or outpatient and professional billing? If you’re a CDI specialist working with physician practices, are you focused on fee-for-service or risk-adjusted capitation methodologies?

Using unspecified diagnoses in the inpatient world results in spuriously deflated quality metrics and decreased reimbursement. Unspecified diagnoses in the fee-for-service arena may result in medical necessity denials, but historically has not had a negative effect on payment, which is why it traditionally fell below the provider’s radar. However, as value-based payment risk becomes more substantial and the professional fee is tied to demonstration of severity and complexity, there may be more incentive for providers to get it right and provide greater specificity in their documentation.
Unspecified codes are not disappearing. Indeed, there will still be times when unspecified codes will be necessary and acceptable. In the time frame after signs/symptoms and before the definitive diagnosis, unspecified codes are still appropriate. Generalists, like emergency physicians, may need to use unspecified codes, but specialists likely will be held to a higher standard.

Even unspecified codes often have some degree of specificity available. “Bronchitis” shouldn’t be diagnosed when it can be qualified as “acute” or “chronic.” And physicians really should know which of the patient’s ears is afflicted with acute recurrent otitis media. In fact, even signs and symptoms have specificity available (where, exactly, is that abdominal pain?). Yet the reality is that physicians will likely never document to the level necessary to get to certain diagnoses’ specificity. They are not going to culture acute bronchitis just to satisfy the maximal granularity of ICD-10 (e.g., J20.3, acute bronchitis due to coxsackievirus).

On the inpatient side, the coder’s challenge is to secure the most specific code supported by the provider’s documentation, often enlisting the help of the CDI specialist to elicit more specificity when there is an impact on the MS-DRG or severity of illness/risk of mortality. On the outpatient side, when healthcare providers (HCP) do their own coding, there are several potential pitfalls:

1. The HCP may noncompliantly bill with a code that is legitimately accurate and specific for the patient’s condition, but that he or she did not support adequately in the documentation. A risk of denial and potential upcoding issues would result.

2. Since it is technically feasible, auditor/payer reconciliation of the coding for the professional and technical bill for the same service may reveal discrepancies if an HCP and a coder are concurrently but independently selecting codes. This could conceivably result in denials.

3. Most commonly, the documentation might support a more specific code, but the HCP has neither the time, expertise, nor inclination to assign that code, so he or she uses an unspecified code. This might result in medical necessity denials, like for testing, but as risk-adjusted value-based quality metrics and payment become more prevalent, the provider’s compensation will be on the line.

With the grace period’s end, we can finally align providers’ interests in documenting and selecting specific codes with those of the institution or medical group. We will finally be able to “show them the money” to entice providers to document in the fashion that we’ve sought for years, but for which they never perceived a direct benefit.

In order to design a plan to effect change, we need to understand the motivation behind the lapse in specificity. There are multiple reasons HCPs document feebly and/or choose suboptimal codes. I think some of the main ones are ignorance, time constraints, inadequate technology, and disinterest. Needless to say, the solution needs to be multifaceted.

Providers became complacent in the ICD-9 fee-for-service environment where they were paid for submitting any old code. Most HCPs received one to two hours of ICD-10 training (which was one to two hours more than the ICD-9 training they received). But anyone basking in the robustness of ICD-10 realizes this isn’t nearly enough.

In the ICD-9 world, many physicians used a paper bill that had a small subset of commonly seen diagnoses, checked off the code that was close enough, and moved on to see the next patient. The language on that paper bill probably did not exactly mirror the ICD-9-CM code language, either.

Physicians may rightly wonder: If “CHF” represented a legitimate code in ICD-9 and got them their reimbursement then, why shouldn’t that be enough now? The HCP probably didn’t know when there was a “not elsewhere classified” or “not otherwise specified” coding option.

CDI specialists need to explain that the quality metrics and risk-adjusted payment methodologies are based on making patients look as sick in the medical record as they do in real life. I use concrete examples like how a patient with “severe persistent asthma in acute exacerbation” seems more sick and complex than a patient with “unspecified asthma, uncomplicated.” Instruct your HCPs that if they can categorize a patient precisely,
ICD-10 more than likely has a specific code to accurately reflect that categorization.

**Problem list conundrums**

Lack of awareness is also a culprit: Providers may meagerly document but then find a precise code when the electronic health record (EHR) walks them there. It is great to use specificity in your EHR’s problem list, but unbeknownst to the HCP, many facilities prohibit coding from problem list documentation. HCPs may think that by choosing that particular code in their billing diagnosis area, they have effectively documented it, whereas their institution may have a contrary internal guideline.

This behavior is most easily addressed by dangling the concept of fraud in front of the provider. The HCP is oblivious of coding regulations, and doesn’t understand that a code must be supported by the documentation he or she has provided in the patient encounter record, but the HCP does understand the serious consequences of medical fraud.

Providers are being given competing tasks—increase their productivity (number of patients seen) and use time-consuming technology that is still, for all intents and purposes, in its infancy. Having to click repeatedly to get to a goal in an EHR is a well-known source of frustration. If HCPs don’t recognize the benefit to them or the patient, they will not want to waste their time clicking to the most granular code just for the sake of the “bean-counters.” Cultivating problem lists that cannot be used for the derivation of codes seems counterproductive to HCPs.

The solution to these impediments is twofold:

1. Educate providers about the benefit to patients and to themselves. Using specific documentation enabling the most precise codes assists in clinical communication. The distinction between “low blood pressure on pressors, getting transfusions” and “severe hemorrhagic shock” is not unmeaningful.

2. Foster the evolution of the electronic environment to make selection of the correct verbiage and code as painless and quick as possible. If physicians searching for “lung cancer” see the option for C61, prostate cancer with lung metastases, they are being misled. The HCP’s EHR search should produce the correct code (or codes) and require as little effort, searching, and/or clicking as possible.

Additionally, all EHRs have some variant of acronym expansion that the HCP may be unaware of. With this functionality, the provider types in a few characters, such as acute tubular necrosis (ATN), and the EHR provides likely choices based on that text entry, such as acute kidney injury due to ATN. Such systems typically employ enterprise-created lookup tools, but they also offer facilities the ability to create a unique set of frequently used phrases, as well as the ability to import colleagues’ phrases. CDI specialists can assist the HCP in designing or stealing acronym expansions; improving the HCP’s efficiency will entice the provider to view you as an ally and not an adversary.

The final barrier is laziness, apathy, or recalcitrance. I posit this will be a very small percentage of your charges. The majority of providers, I believe, want to do the right thing in the optimal way.

For providers who do fall under this last category, though, you may need to escalate and enlist the assistance of administrative superiors. The CDI specialist or physician advisor will not be able to overcome inertia without some form of institutionally imposed incentive or penalty. Physician report cards and transparent public ratings may spur HCPs to get in line with their peers.

In conclusion, we need to get providers to avail themselves of the specificity of ICD-10, not just by October 1, 2016, but as soon as possible. They need to believe it is valuable, important, and worthwhile. We need to help them do it efficiently and consistently. Unspecified codes have a time and a place, but it is our duty to advocate for specificity and for our healthcare providers.

**Editor’s note:** Remer is founder and president of Erica Remer, MD, Inc., Consulting Services. An emergency physician for 25 years, she became a CDI physician advisor and obtained her CCDS in 2014. Contact her at icd10md@outlook.com. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.
My role as a CDI liaison and DRG coordinator

by Lori (Cushing) Drodge, RHIT, CCS

I am the CDI liaison and a DRG coordinator for Maine Medical Center in Portland, the largest hospital in the state with 637 beds. I chose my coding career path in high school, but I had no idea what I wanted to study in college. An “interest study” revealed that the medical field greatly spoke to me. When I explained to my guidance counselor that I didn’t want to be involved in direct patient care, she told me about something called “medical record technology,” now known as “health information management.” (Yes, I’ve been around for a while.)

As time went on and the concept of CDI became known, I started to learn more about it, reading articles and performing remote audits on the side. Today, my role provides me with a rewarding challenge each and every day.

Our team consists of 12 inpatient coders, eight CDI staff nurses, two full-time physician advisors, and two DRG validators.

For me, it sometimes seems like there’s no such thing as a typical day, but every day I enjoy:

- Providing advice when there are coding disagreements and/or documentation inconsistencies
- Sharing a “tip for the day” email that could be a Coding Clinic excerpt, a guideline, a definition, a helpful website, an encoder comparison of DRGs, a screenshot of where to find something in the chart, etc.
- Creating query templates to ensure consistency and compliance
- Reaching out to providers for documentation improvement functions
- Performing DRG audits to identify any missed secondary diagnoses and/or procedures
- Performing audits to identify unnecessary queries created by nurses and/or coders, potential missed query opportunities that may have increased billing time because a post-discharge query is needed, and DRG optimization opportunities
- Researching coding questions
- Monitoring the CMS PEPPER report to identify trends and communicating that information to inform the utilization review committee of any concerns relating to outlier status
- Assisting in ongoing formal education of facility healthcare professionals
- Posting questions and responding to inquiries in the ACDIS Forum

In addition, once a week I meet with a small group of coders, nurses, and a physician to discuss coded cases that have identified Patient Safety Indicators (PSI). We look for exclusions on the AHRQ website (www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx) and provide feedback to ensure the record and codes accurately describe events.

In one instance, we found what appears to be an AHRQ oversight, and the provider addressed this with a letter. We’ve also found that if the admission type is incorrect in registration (i.e., elective vs. urgent), this error affects the PSI as well. We also look at coding for surgical complications, which can be complex and involves trying to decipher things that are complications versus things that are inherent to the procedure.

Another important weekly collaborative meeting is one I have with the CDI nurses. The format includes discussion of a Coding Clinic, a coding guideline, a case study, and helpful resources. Minutes are recorded and placed in a shared document for future reference.

Some monthly events include coding meetings, combined coder and nurse (task force) meetings, and physician advisor meetings. I also attend coding and CDI conferences when possible to gain further knowledge to share with my facility.

My position is challenging, and some procedures are a learning opportunity.
On occasion, both sides of a disagreement seem accurate, and while the situation isn’t often black and white, we can only enforce one side or the other. In the end, it has been very rewarding to respectfully work with others through these challenges, alternately learning and teaching as we go.

I would like to give credit to the late Robert Gold, MD, for being the most prominent mentor in my professional life. Around 2003, I invited him to speak at a Maine AHIMA (MeHIMA) meeting. Attendees loved the wealth of knowledge that he eloquently shared. We became friends, and I would occasionally join him “on the road” to cover for a consultant’s absence.

Dr. Gold loved to cook and instructed my kids on how to smash garlic cloves with a knife blade while he made a delicious garlic-shrimp stir-fry. Sadly, my cutlery did not impress him, and a week later I received a professional Henckel knife in the mail. The clinical knowledge, cooking instruction, and laughter I gained from this surgeon, gourmet chef, and friend has been priceless!

Take my advice: Find your “Dr. Gold.” Make friends. Network at national and local meetings, share feedback with authors, write an article and teach others, remembering that we all have different strengths. Above all, enjoy what you do and strive to do it well!

Editor’s note: Contact Drodge by email at Ldrodge@mmc.org.

MEET A MEMBER
From NICU nurse to CDI director

Robin Jones, RN, BSN, MHA/Ed, CCDS, has a true passion for CDI. She’s been in the field since 2004, beginning her career as a CDI specialist. A few years later, she was promoted to manager. Now she serves as the system director at Mercy Health in Cincinnati, where she oversees the CDI program across 17 hospitals.

“I love putting the pieces of the patient puzzle together,” says Jones, “ensuring documentation is complete and accurate, and doing the right thing for the patients that seek care in the healthcare organization.”

Jones and her husband of 26 years have two children, daughter Megan, who’s 24 years old, and son Tyler, who’s 22. They also have two “fur babies,” Buster and Parker.

She and her husband are getting used to their newly empty nest and are looking forward to traveling, home improvement projects, a future wedding, and grandchildren.

CDI Journal: What did you do before entering CDI, and why did you get into this line of work?

Jones: I worked in the neonatal intensive care unit (NICU) as a nurse for the Children’s Hospital in Cincinnati. Working as a NICU nurse is very emotional and draining.

When Mercy released a job posting saying they would be starting a CDI program at a facility near my home, I became curious about the role and applied. I had no idea what the position was, but was eager to get involved in something outside of the bedside nursing realm.

CDI Journal: What has been your biggest challenge?

Jones: Physician engagement. It is hard to get physicians to engage in the CDI world, due to misconceptions about financial reimbursements for the hospital systems. As we move into value-based purchasing (VBP), physicians need to understand that the documentation effects are much more quality-based, and not solely financial for the hospitals.

CDI Journal: What has been your biggest reward?

Jones: I have had several meaningful moments that are considered “rewards.” However, I would say that taking the stage as a presenter at the ACDIS Conference in 2016 was by far the biggest. I presented as a leader in CDI and was able to represent the team I work alongside every day. I am very thankful!
CDI Journal: How has the field changed since you began working in CDI?

Jones: When I first started working in CDI, administration and physicians didn't understand the program and the potential for the future. Hospital administrators knew that securing the appropriate documentation could affect the reimbursement, but VBP wasn't official yet. Physicians felt like CDI specialists were telling them what to do, though now this position has created a working relationship with providers to ensure documentation is complete and concise for the patient.

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

Jones: There are too many gold nuggets, so it’s difficult to pick just one, though I would have to say listening to ACDIS Radio. I enjoy listening to the different topics brought forward, from diagnosis clarification, changes in documentation and coding guidelines, and future implications regarding gaps in documentation.

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

Jones: Oftentimes, we recruit very proficient, high-functioning nurses with a high level of clinical knowledge, [or extremely intelligent coders with extensive expertise on the coding guidelines and their applications]. In essence, we are taking the best of the best in their respective fields. When transitioning to the CDI role, new CDI specialists may feel like a novice again. My best advice would be to stay calm, get organized, and breathe!

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

Jones: Event planning. I love taking a vision and seeing it come to fruition.

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

Jones: I worked as a housekeeper for the Holiday Inn as a summer job. It was a great job—it helped me become independent, organized, and allowed me to interact with guests. As I travel in my current role, I have a higher level of appreciation of those that keep my life tidy in my home away from home.

CDI Journal: Please tell us a few of your favorite things:

- Vacation spots: Anywhere in the Caribbean. St. Lucia is my favorite place.
- Hobby: Reading, watching reality TV, and spending time with my family.
- Non-alcoholic beverage: Iced tea.
- Foods: I have two favorite foods—pizza and cake (not together).
- Activity: I love going to outdoor concerts, especially Kenny Chesney, and walking on the beach.