



A Physician Advisor Journey from Inpatient to Outpatient CDI

Lessons learned and advice to grow your CDI Physician Advisor program

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Presented By



Yoon Sin Kim, DO, CCDS has been a CDI physician lead for the Baylor Scott & White Healthcare System (BSWH) in Texas for the past seven years. She is board certified in family medicine and an adjunct assistant professor at Texas A&M College of Medicine. Although Dr. Kim did her clinical work in the outpatient setting, she spent her first six years with the CDI program focused on growing the inpatient program. In the last year, she has transitioned her role to assist with the outpatient CDI program. Dr. Kim has created numerous educational publications for providers in her hospital system and presented at ACDIS state chapter meetings in Texas and Ohio. She has also been involved in creating lean workflow processes to maximize data driven results and helps manage pilots and implementation of various software applications used by the CDI program and providers at BSWH.

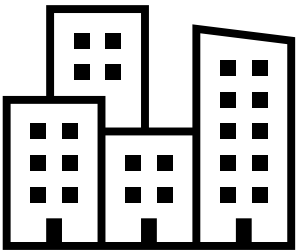
Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Describe how to use physician advisors to bridge gaps between clinical knowledge and coding guidelines
 - Identify two lessons learned while creating education for key outpatient conditions at BSWH
 - Describe two ways to create a successful CDI physician advisor program

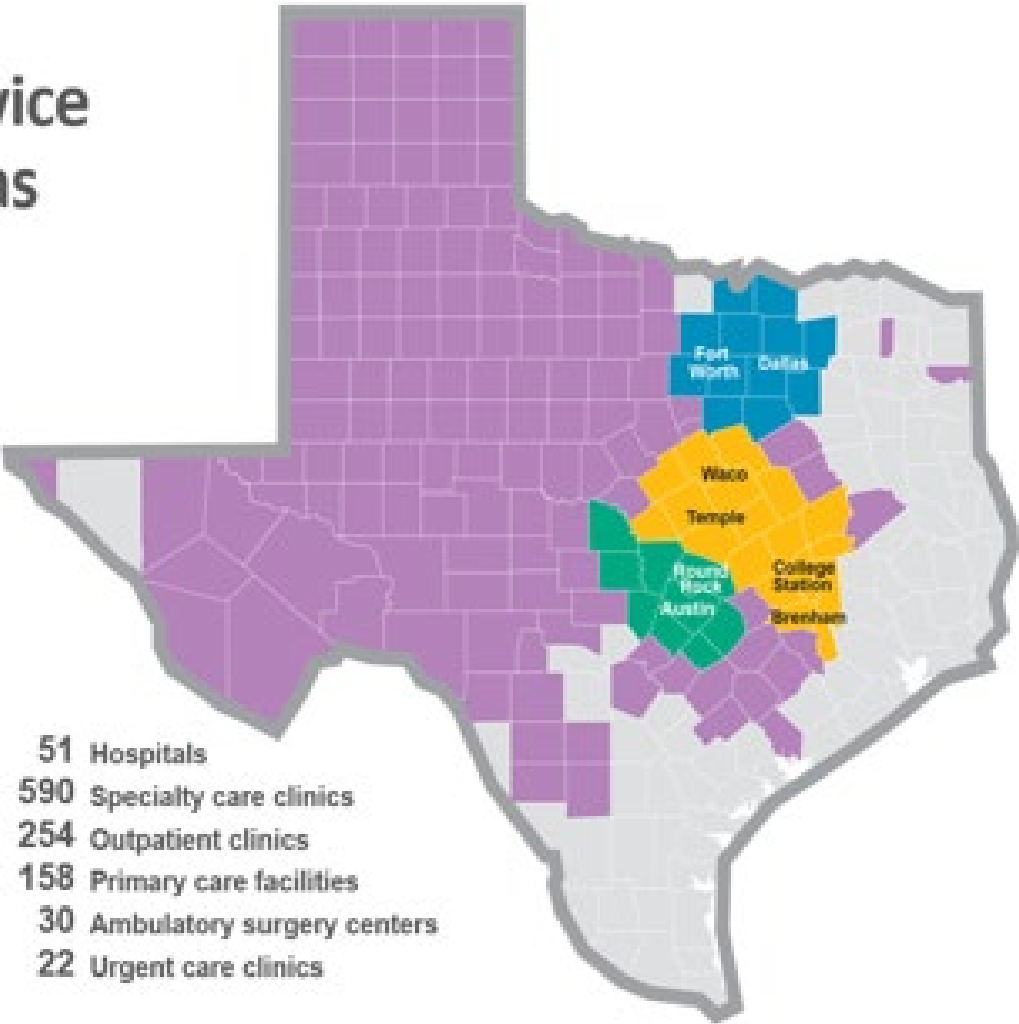
Baylor Scott & White Healthcare System



- 52,000+ Employees
- 7,000+ Physicians



Service areas



DALLAS-FORT WORTH

- 34 Hospitals
- 287 Specialty care clinics
- 178 Outpatient clinics
- 83 Primary care clinics
- 30 Ambulatory surgery centers
- 9 Urgent care clinics

CENTRAL TEXAS

- 8 Hospitals
- 203 Specialty care clinics
- 31 Outpatient clinics
- 39 Primary care clinics
- 6 Urgent care clinics

AUSTIN/ROUND ROCK

- 9 Hospitals
- 100 Specialty care clinics
- 45 Outpatient clinics
- 36 Primary care clinics
- 7 Urgent care clinics

DIGITAL CARE

- 254 Counties (available statewide)

HEALTH PLAN

- 171 Counties



CDI Program Milestones

- **2015 - 2016: started Inpatient CDI for CTX**
 - Inpatient CDI: 5 physicians (3.5 FTE), 2 RNs, per diem weekend coverage with residents/APP covering 7 hospitals
 - Inpatient CDI bootcamp
- **2018 - 2019: Legacy NTX and CTX CDI programs aligned:** 2.25 physician advisor system leads, 1 physician assistant, 60 CDI, 21 facilities
- **2020 - 2021: Pilot & implement new Inpatient & Outpatient CDI software implementation**
- **2022: Increased focus on Outpatient CDI Physician Advisor role**
Inpatient and Outpatient CDI team approx. 120

Evolving Responsibilities

- Chart reviews & queries
- Created query templates: Query alignment team
- Creating & presenting education
- On call for utilization review nurses
- PEPPER meetings
 - Denials data
- CMI meetings with finance
- Delinquent provider query policy
- CDI team: interviews, training materials, orientations, audits, performance metrics
- Lean workflow & query impact flowing into data/metrics
- Software implementation & informatics
- Collaborate on projects with HIM & Quality departments



Physician Advisors: Bridging the Gap

Clinical Knowledge & Relationships

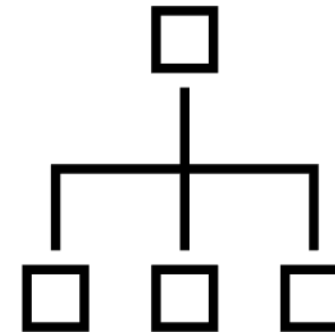
- Resources & official guidelines
- System policies & endorsements
- Provider clinical workflow & processes
- Create education modules for residents, PA's, Hospitalists, Specialists
- Customize education for your audience:
 - Define the issue
 - Provide a solution
 - Show the benefits

CDI & Coding Knowledge

- Coding
- Outpatient vs Profee vs IPPS; PCS
- STAAR ratings
- Hospital-Acquired Condition Reduction Program
- Registries
- OIG
- Denials
- Value Based Care Programs
- HCCs & Risk Adjustment

Highlights of Inpatient Education

- Codes are a form of communication
- Coding 101
- Profee vs CPT vs IPPS vs PCS
- Resources: Standardized guidelines endorsed by the specialty organizations exist?
 - Definitions from coding handbook & coding clinics may be insufficient and/or may not translate accurately to clinicians
- If no standardized guidelines exist, then consider creating experts at your institution (with representatives from major stakeholder regions) to derive consensus definition & policy
- Consult with consultants
- Customize Education:
 - Physicians/APPs:
 - Quality groups, specialty councils, other teams
 - CDI
 - Coding





Lean Into Education Module

- To get meaningful data from these codes, we should be using the same guidelines and criteria for diagnosing the condition
- Teach best practice recommendations
- Look for patterns: compare and contrast
- Don't highlight shortcuts
- Physicians and facilities want to know their data and plans for improvement
 - Foster transparency and competition

Pressure Injury Education Summary

After wound cleansing, performed selective sharp debridement with pick ups and scissors to yellow slough.



PT's scope of practice: can only remove NON-VIABLE TISSUE

(not viable tissue)

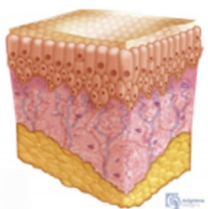
PT uses "selective" to mean only "selected" areas of non-viable tissue

- I&D: Incision & Drainage? Irrigation & Debridement?
- Podiatrists do not use the word excisional or non-excisional
- Wound care governance council: created template for debridements
- "Unstageable" pressure injury for hospitalists did not translate to likely a stage 3 or stage 4 injury (Pepper reports)
- POA status was added on PL by providers but was not transferring into their notes
- POA status can be determined at any time during the admission, especially important for DTPI

Documentation Checklist for Pressure Injuries:

- ☐ POA status
- ☐ Describe the type of ulcer/injury as “pressure”
- ☐ Location & Laterality
- ☐ Stage

Mucosal Membrane Pressure Injury



Found on mucous membranes with a history of a medical device in use at the location of the injury.

These should be documented but cannot be staged















National Pressure Injury Advisory Panel: NPIAP

- Free, downloadable education resources, posters

PRESSURE INJURY STAGES

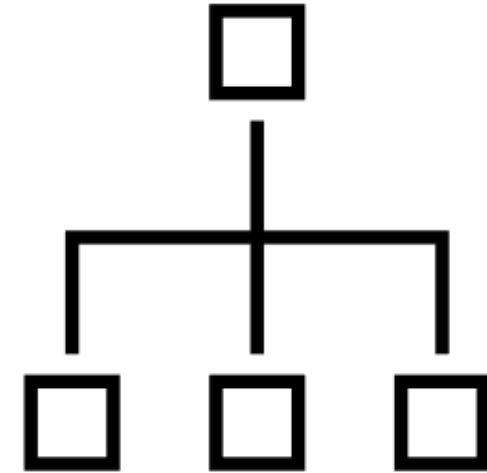
A pressure injury is localized damage to the skin and underlying soft tissue that occurs as a result of intense pressure, prolonged pressure, or pressure in combination with shear forces.

DEFINITION	SCHEMATIC DRAWING	EXAMPLE
STAGE 1 PRESSURE INJURY: Non-blanchable erythema of intact skin <ul style="list-style-type: none"> May appear differently in darkly pigmented skin Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes 		
STAGE 2 PRESSURE INJURY: Partial – thickness skin loss with exposed dermis <ul style="list-style-type: none"> May present as an intact or ruptured serum-filled blister Wound bed is viable, pink or red, moist 		
STAGE 3 PRESSURE INJURY: Full thickness skin loss <ul style="list-style-type: none"> Adipose (fat) visible in the ulcer and granulation tissue Granulation tissue and epibole (rolled wound edges) often present Undermining and tunneling may occur If slough or eschar obscures the extent of tissue loss, then this is classified as an Unstageable Pressure Injury 		
STAGE 4 PRESSURE INJURY: Full-thickness loss of skin and tissue <ul style="list-style-type: none"> Exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer Epibole (rolled wound edges), undermining and/or tunneling often occur If slough or eschar obscures the extent of tissue loss, then this is classified as an Unstageable Pressure Injury 		
UNSTAGEABLE PRESSURE INJURY: Obscured full-thickness skin and tissue loss <ul style="list-style-type: none"> Extent of tissue damage cannot be confirmed because the ulcer is obscured by slough or eschar If slough or eschar removed, a Stage 3 or Stage 4 pressure injury will be revealed 		
DEEP TISSUE PRESSURE INJURY: Persistent non-blanchable deep red, maroon or purple discoloration of intact or non-intact skin <ul style="list-style-type: none"> Discoloration may appear differently in darkly pigmented skin Epidermal separation may reveal a dark wound bed or blood-filled blister Pain and temperature change often precede skin color changes 		

Customizing Education

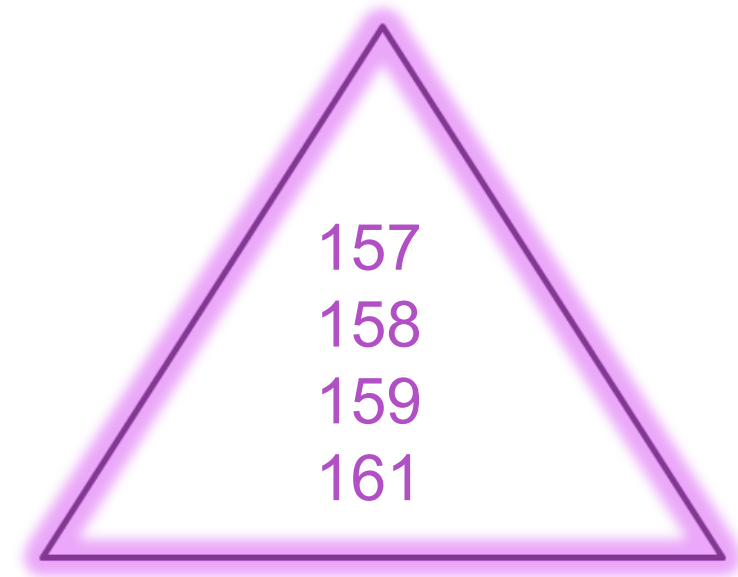
- Query Alignment Team
- Educated Providers Hospitalists & specialists
 - CME credit
- Educated CDI (CEU credit)
- Inclusion terms for L89 Pressure Ulcer:
 - Bed sore
 - Decubitus ulcer
 - Plaster ulcer
 - Pressure area
 - Pressure sore
- Wound Care Governance Council
- Medical Executive Committee Meeting
- HAPI Committee

Remind CDI about codeable like terms...sometimes this can avoid a query



Apply this to Outpatient Education

- HCC 157: Pressure Ulcer to Skin with Necrosis through to muscle, tendon, or bone
- HCC 158: Pressure Ulcer to Skin with Full thickness skin loss
- HCC 159: Pressure Ulcer with Partial thickness skin loss
- HCC 161: Chronic Ulcer of the Skin except pressure



Documentation Checklist for Pressure Injuries:

- ~~POA status~~
- Describe the type of ulcer/injury as “pressure”
- Location & Laterality
- Stage

Malnutrition Education Summary

- Registered Dietician scope of practice includes the ability to diagnose malnutrition in our system policy
- There is no single universally accepted approach to the diagnosis of malnutrition (WHO, ASPEN, GLIM)
- CMS has not officially endorsed any organizational criteria...
- BSWH Registered Dieticians use ASPEN criteria

ASPEN Criteria

STEP 1: Recognize that malnutrition can occur in 3 contexts:

- Acute illness/injury present < 3 months
- Chronic illness present > 3 months
- Social and environmental circumstances limiting access or ability to care for oneself

Bariatric surgery

High BMI

STEP 2: Two or more of the following 6 characteristics are required for malnutrition

—	Insufficient energy intake
—	Unintentional weight loss
—	Loss of muscle mass
—	Loss of subcutaneous fat
—	Localized or generalized fluid accumulation that may mask weight loss
—	Diminished functional status as measured by handgrip strength



NFPE: nutrition focused physical exam

Loss of Subcutaneous Fat	Loss of Muscle Mass	Fluid Accumulation
Orbital	Temples (temporalis)	Ankle edema (Extremities)
Upper arms/Triceps	Clavicles/Acromion & Shoulder (pectoralis mj, deltoid, trapezius)	Scrotal/Vulvar/Sacral edema
Lower ribs/back	Scapula (trapezius, suprasp, infrasp)	Ascites
	Dorsal Hand (interosseous)	Anasarca
	Scapula (lats, traps, delts)	
	Patella & Anterior Thigh (quadriceps)	
	Posterior Calf (gastrocnemius)	

Comparing ASPEN VS GLIM

ASPEN CRITERIA

Insufficient energy intake

Unintentional weight loss

Loss of muscle mass

Loss of subcutaneous fat

Localized or generalized fluid accumulation that may mask weight loss

Diminished functional status as measured by handgrip strength

- Acute illness/injury present < 3 months
- Chronic illness present > 3 months
- Social and environmental circumstances limiting access or ability to care for oneself

GLIM CRITERIA

Reduced food intake or assimilation

Unintentional weight loss*

Reduced muscle mass*

Disease burden/inflammation

Low BMI*

*Phenotypic criteria

ETIOLOGIC CRITERIA		PHENOTYPIC CRITERIA		
Reduced Food Intake or Assimilation	Inflammation/ Disease burden	Weight loss (non-volitional)	Low BMI	Reduced Muscle Mass
< 50% of energy requirement > 1 week or any reduction > 2 weeks or Any chronic GI condition that adversely impacts food assimilation or absorption	Acute disease/injury or Chronic disease related	5% < 6 months or 10% > 6 months	< 20 if < 70 years old or < 22 if > 70 years old	Reduced by validated body composition measuring techniques or physical exam

Metabolic Disorders (No Trumping)

- HCC 21: Protein Calorie Malnutrition
- HCC 22: Morbid Obesity
- HCC 23: Other Specific Endocrine & Metabolic Disorders (>200 codes) such as SIADH, hypoparathyroidism, hyperparathyroidism, classical phenylketonuria

Even though HCC 21 includes unspecified PCM, it is still best practice to recommend that providers document severity

HCC 22:

E66.01 Morbid (severe) obesity due to excess calories

E66.2 Morbid (severe) obesity with alveolar hypoventilation

Z68.41 BMI 40.0 – 44.9, adult

Z68.42 BMI 45.0 – 49.9, adult

Z68.43 BMI 50.0 – 59.9, adult

Z68.44 BMI 60.0 – 69.9, adult

Z68.45 BMI > 70, adult

BMI adult codes are for persons ≥ 21 yo

Classification for BMI

	BMI kg/m2
Underweight	<18.5
Normal weight	18.5 – 24.9
Overweight	25 – 29.9
Obesity (Class 1)	30 -34.9
Obesity (Class 2)	35 – 39.9
Severe obesity (Class 3)	≥ 40

The provider must document a diagnosis associated with BMI in order for it to be captured by coders.

Diagnosis of Morbid obesity:

- BMI \geq 40 or 100+ lbs above your ideal body weight
- BMI \geq 35 plus one or more obesity-related health conditions, such as
 - Hypertension
 - Hyperlipidemia
 - Diabetes Mellitus Type 2
 - Coronary heart disease
 - Abdominal Aortic Aneurysm
 - Osteoarthritis

Diabetes Mellitus

- First education module geared toward inpatient & outpatient providers
- HCC and Risk Adjustment
- Diabetes Registries
- Diabetes Council
- Request for practical advice for providers to add diagnoses to the problem list

Criteria for the Diagnosis of Diabetes

- Fasting Plasma Glucose ≥ 126 mg/dL or
- 2 hour Plasma Glucose ≥ 200 mg/dL during 75g Oral Glucose Tolerance Test or
- A1C ≥ 6.5 % or
- Random Plasma Glucose ≥ 200 mg/dL in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Disclaimer: criteria and recommendations may vary based on different situations and lab values

These are not the criteria for gestational diabetes mellitus

Prediabetes

CRITERIA defining PREDIABETES*

- Fasting plasma glucose: 100-125mg/dL (impaired fasting glucose) or
- 2 hour post load glucose on the 75 g oral glucose tolerance test: 140-199mg/dL (impaired glucose tolerance) or
- A1C: 5.7 – 6.4%

*For all 3 tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at higher ends of the range

American Diabetes Association (ADA) Classification and Diagnosis of Diabetes: Standards of Medical Care in Diabetes - 2021

Criteria Comparison

	PREDIABETES	DIABETES
FPG	100-125	≥ 126
2GTT	140-199	≥ 200
A1C	5.7 – 6.4	≥ 6.5
RANDOM PLASMA GLUCOSE		≥ 200 with classic symptoms of hyperglycemia or hyperglycemic crisis

Diabetes Registries
obtain the diagnosis
of Diabetes from
the following
portions of a
patient's record

Dx on Lab orders

Dx on Medication orders

ED notes

Inpatient and outpatient notes

Problem list (inpatient and outpatient)

Visit Diagnoses

Health Maintenance modifiers

Abnormal findings on examination of blood without diagnosis of diabetes

If your patient does not meet criteria for diagnosis of diabetes but has an abnormal test result, then it is important to document and code an appropriate code to reflect those results and your assessment not only in your notes, but also when adding diagnoses to your orders for labs, studies, and medications.

- Abnormal glucose (R73.0)
- Impaired fasting glucose (R73.01)
- Impaired glucose tolerance (R73.02)
- Prediabetes (R73.03)
- Abnormal non-fasting glucose tolerance (R73.09)
- Hyperglycemia unspecified (R73.9)
should only be coded when not associated with DM or any form of post-procedural hyperinsulinemia)

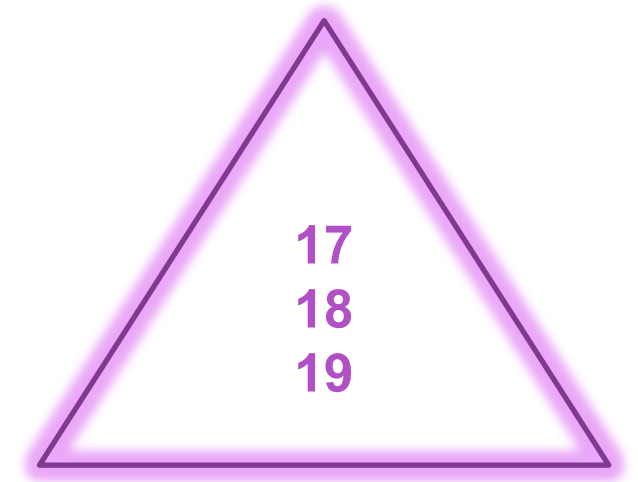
Hierarchical Condition Categories (HCC)

Specifying all of the complications from diabetes that your patient has will help to ensure appropriate capture of risk adjusting diagnoses that reflect how sick your patients really are.

HCC 17 Diabetes with acute complications *RAF 0.302

HCC 18 Diabetes with chronic complications *RAF 0.302

HCC 19 Diabetes without complications *RAF 0.105



** These examples of Risk Adjustment Factor (RAF) values were obtained by using the coefficient for a person living in the community, non-dual eligible for Medicare and Medicaid, aged (CMS HCC v24.0)*

Remember These 3 Key Components of Your Diabetes Documentation:

1

Specify the type
and/or etiology of
diabetes

2

Document the
severity
(hypoglycemia or
hyperglycemia) and
treatment
medications

3

Link any
complications or
manifestations
from the diabetes

LADA According to...

- The American Diabetes Association lists Latent Autoimmune Diabetes in Adults (LADA) as a Type 1 Diabetes Mellitus but other organizations such as World Health Organization (WHO) and the Immunology for Diabetes Society (IDS) have categorized LADA separately

(E13 Other specified DM)

Genetic defects of beta cell function:

- Maturity onset diabetes of the young (MODY)
- LADA or DM type 1.5
- Transient and permanent neonatal diabetes
- Mitochondrial DNA
- Others

Genetic defects in insulin action

- Type A insulin resistance
- Leprechaunism
- Rabson-Mendenhall syndrome
- Lipoatrochic diabetes
- Others

dm

Search

Database Lookup (F7)

External ID	Name	Code	Code Set
378449	DM (diabetes mellitus), type 2 (HCC)	E11.9	ICD-10-CM
369542	DM (diabetes mellitus), Type 2, uncontrolled (HCC)	E11.65	ICD-10-CM

Select additional details:

Glycemic state:

with hyperglycemia

with hypoglycemia

Glycemic state:

with hyperglycemia

with hypoglycemia

Uncontrolled type 2 diabetes mellitus with hyperglycemia (HCC) [E11.65]

Glycemic state:

with hyperglycemia

with hypoglycemia

Uncontrolled type 2 diabetes mellitus with hypoglycemia (HCC) [E11.649]

Clear

100 loaded. More to load.

Accept

Cancel

*Disregard the use of the term 'uncontrolled' in the description name → Instead, utilize the additional details option to specify with hyperglycemia or hypoglycemia

Acute Life-threatening Complications

- **Nonketotic hyperosmolar syndrome or hyperosmolar hyperglycemic state (HHS):** further complications include coma, seizures, and death
- **Diabetic Ketoacidosis:** further complications include cerebral edema, coma, and death

Long-term Complications

Eye: diabetic retinopathy, macular edema; cataracts

Kidney: Nephropathy leading to renal failure

Heart: Atherosclerotic cardiovascular, peripheral arterial, and cerebrovascular disease

Neuro: Peripheral neuropathy, neuralgia, gastroparesis, amyotrophy

Circulatory: peripheral angiopathy, gangrene

Other specified:

arthropathy

skin – dermatitis, ulcer

oral – periodontal disease, other

Morbid obesity or Class 2 severe obesity due to excess calories with serious comorbidity and BMI 35 – 35.9 in adult

Cleaning Up the Problem List

Endocrine

- ✚ Type 2 diabetes mellitus with diabetic chronic kidney disease (HCC)
- Hypothyroidism
- Type 2 diabetes mellitus with hyperglycemia, with long-term current use of insulin (HCC)
- Microalbuminuria due to type 2 diabetes mellitus (HCC)
- Severe nonproliferative diabetic retinopathy of both eyes with macular edema associated with type 2 diabetes mellitus (HCC)

Genitourinary

- ✚ Chronic kidney disease, stage III (moderate) ✓
- ✚ Hypertensive kidney disease with chronic kidney disease → Hypertensive kidney disease = HTN + CKD
- Renal cell carcinoma (HCC) → Is this currently being treated or is this a h/o?

Other

- Pure hypercholesterolemia
- Exudative retinopathy → Diabetic retinopathy already documented
- Acquired absence of right great toe (HCC)
- Hematuria } Has a more definitive diagnosis been established?
- Proteinuria }
- H/O unilateral nephrectomy
- Morbid obesity with BMI of 40.0-44.9, adult (HCC) ✓
- Severe episode of recurrent major depressive disorder, without psychotic features (HCC)
- Anxiety
- Multiple lung nodules on CT

Criteria for Type 2 DM in Remission

Consensus Report: Definition and Interpretation of Remission in Type 2 DM; Diabetes Care 2021

Type 2 DM in remission ↔ “h/o DMT2 ”

Remission is a state in which diabetes is not present but which nonetheless requires continued observation because hyperglycemia frequently recurs.

HbA1c < 6.5% x 3 months in the absence of usual glucose-lowering pharmacotherapy, either spontaneously or following surgical intervention

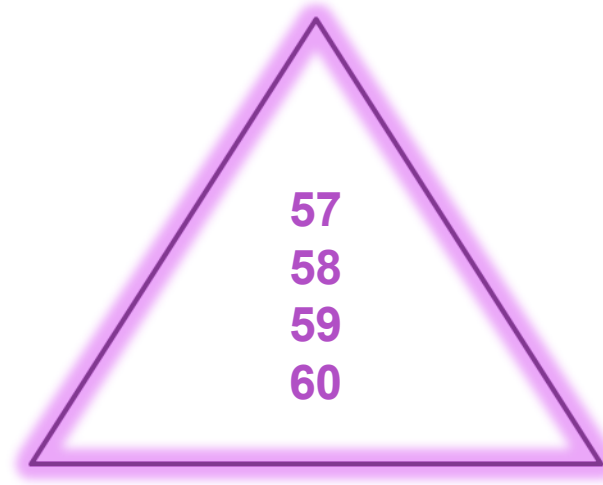
- x 6 months is recommended for lifestyle intervention

Unfortunately, this clinical definition of remission does not translate effectively in codes IF the patient has any continued manifestations/ complications of the diabetes...

Meaning, even if a patient meets this clinical definition of remission, but still has diabetic retinopathy or diabetic neuropathy being monitored and treated for it, then diabetes still gets coded!

Behavioral Health

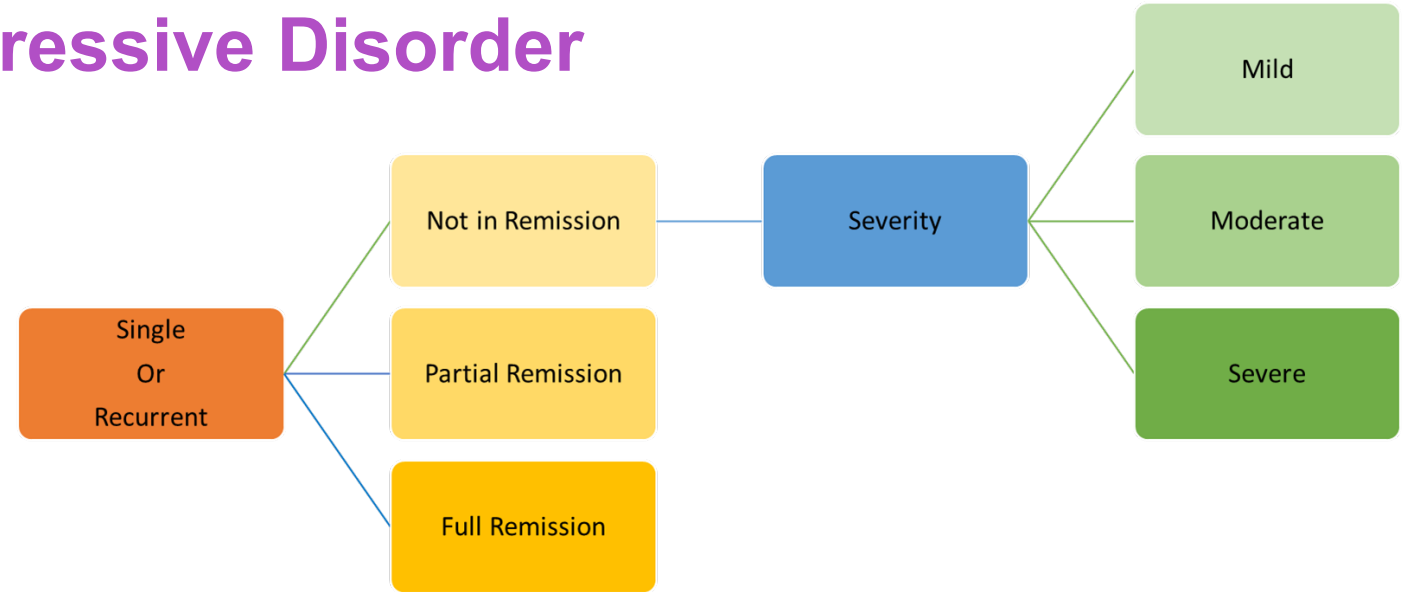
- HCC 57: Schizophrenia
- HCC 58: Reactive and Unspecified Psychoses
- HCC 59: Major Depressive Disorder, Bipolar, and Paranoid Disorders
- HCC 60: Personality Disorders



Major Depressive Episode Criteria

- 5 or more of the following symptoms during concurrent 2 weeks:
 - Depressed mood
 - Decreased pleasure in activities
 - Weight loss
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue
 - Feelings of worthlessness or guilt
 - Decreased ability to concentrate
 - Thoughts of death
- Plus, symptoms cause significant distress in daily function
- Plus, is not related to effects of other substance, medication or diagnosis
- Plus, patient has never had a manic or hypomanic episode

Guideline for Major Depressive Disorder



Not HCC

- Depression
- Depressive disorder
- Major depressive disorder, single episode
- Atypical depression
- Post-schizophrenic depression
- Premenstrual dysphoric disorder



HCC

- Major depressive disorder, single episode:
 - **Mild, Moderate, Severe with or w/o psychotic features**
 - **In partial remission or in full remission**
- Major depressive disorder, recurrent
 - **Mild, Moderate, Severe with or w/o psychotic features**
 - **In partial remission or in full remission**

Severity of Major Depressive Episode

- **Major depressive episode severity:**
 - The PHQ2/PHQ9 tool within Epic can be used to assist in determining severity that is likely present; once calculated, the likely level of severity will be highlighted below the score.
 - PHQ9 Level of Severity
 - Minimal, score 0-4
 - Mild, score 5-9
 - Moderate, score 10-14
 - Moderately severe, score 15-19
 - Severe, score 20-27

Office Visit

PHQ2-9 Depression Screening

Frequency of the following problems over the past two weeks:

Little interest or pleasure in doing things: 2 - more than half the days

Feeling down, depressed, or hopeless: 2 - more than half the days

Trouble falling or staying asleep, or sleeping too much: 0 - not at all

Feeling tired or having little energy: 3 - nearly every day

Poor appetite or overeating: 3 - nearly every day

Feeling bad about yourself - or that you are a failure or have let yourself or your family down: 1 - several days

Trouble concentrating on things, such as reading the newspaper or watching television: 1 - several days

Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that

Thoughts that you would be better off dead, or of hurting yourself in some way: 0 - not at all

PHQ-2 Score: 4

PHQ-9 Score: 14

PHQ Severity Rating: moderate

Columbia-Suicide Severity Rating Scale (C-SSRS)

Mild	Moderate	Severe
Zero-few symptoms present other than those needed to make the diagnosis, minor impairment in daily life	Between “mild” and “severe”	Significant number of symptoms over those needed to make the diagnosis, major impairment in daily life

Clarification of Remission Status

- **Partial remission:** symptoms of the major depressive episode exist but criteria not fully met, or a period without any significant symptoms after the end of an episode, lasting less than 2 months
- **Full remission:** “during the past 2 months, no significant signs or symptoms of the disturbance were present”

Documentation for Major Depressive Disorder

71 y/o F seen for follow up on **depression** and refill of citalopram. Per the patient, there has been improvement in symptoms since adding the citalopram. Specifically, suicidal ideation is absent.

No conditions coded	
71 y/o female	0.386
Depression	0.000
Risk Adjustment Factor	0.386

71 y/o seen for follow up for **major depressive disorder (diagnosed 2017 requiring multiple hospital admissions)**, and refill of citalopram. Per the patient, there has been improvement in symptoms since adding the citalopram, noting there **have not been noticeable depressive symptoms** for last month. Suicidal ideation is absent.

Conditions accurately documented and coded	
71 y/o female	0.386
Major Depressive disorder, recurrent, in partial remission	0.309
Risk Adjustment Factor	0.695

- If the patient is no longer being treated with medication or therapy, then it would be appropriate to document “history of” rather than “in remission”

Adding the Diagnosis to Your Visit and Problem List

- Can type any of the following to add diagnosis to the problem list:
 - MDD
 - Major Depressive Disorder
 - Depression
- Select additional details for each section, for the most accurate diagnosis.

Database Search - Achilles,Delilah-EMER

mdd Search Database Lookup (F7)

External ID	Name	Code	Code Set
709867	MDD (major depressive disorder)	F32.9	ICD-10-CM
714360	MDD (major depressive disorder), recurrent episode (HCC)	F33.9	ICD-10-CM
714358	MDD (major depressive disorder), recurrent episode, mild (HCC)	F33.0	ICD-10-CM
714361	MDD (major depressive disorder), recurrent episode, moderate (HCC)	F33.1	ICD-10-CM
714344	MDD (major depressive disorder), recurrent episode, severe (HCC)	F33.2	ICD-10-CM
714364	MDD (major depressive disorder), recurrent episode, with atypical features (HCC)	F33.9	ICD-10-CM
714373	MDD (major depressive disorder), recurrent severe, without psychosis (HCC)	F33.2	ICD-10-CM
714371	MDD (major depressive disorder), recurrent, in full remission (HCC)	F33.42	ICD-10-CM
714343	MDD (major depressive disorder), recurrent, in partial remission (HCC)	F33.41	ICD-10-CM
714372	MDD (major depressive disorder), recurrent, severe, with psychosis (HCC)	F33.3	ICD-10-CM
714366	MDD (major depressive disorder), recurrent, with catatonic features (HCC)	F33.9, F06.1	ICD-10-CM
714368	MDD (major depressive disorder), recurrent, with melancholic features (HCC)	F33.9	ICD-10-CM
714370	MDD (major depressive disorder), recurrent, with postpartum onset (HCC)	O99.345, F33.9	ICD-10-CM
714345	MDD (major depressive disorder), severe (HCC)	F32.2	ICD-10-CM
714355	MDD (major depressive disorder), single episode	F32.9	ICD-10-CM
714346	MDD (major depressive disorder), single episode with atypical features	F32.9	ICD-10-CM
714347	MDD (major depressive disorder), single episode with catatonic features	F32.9, F06.1	ICD-10-CM
714348	MDD (major depressive disorder), single episode with melancholic features	F32.9	ICD-10-CM
714349	MDD (major depressive disorder), single episode with postpartum onset	O99.345, F32.9	ICD-10-CM
714362	MDD (major depressive disorder), single episode, in full remission (HCC)	F32.5	ICD-10-CM

Select additional details:

Major depression recurrence:

Active/Remission status:

Major depression episode severity:

Psychotic features:

Key Takeaways for Physician Advisor Led Education



- Give your physician advisor a peek into CDI's workflow
- Use specialty specific guidelines as a basis for education and connect with all involved in documentation of that condition
- For providers, stick to best practice documentation recommendations
- CDI Education is not only for providers (monthly PA call with reps from each facility)
 - Coordinate education for providers & CDI ideally at the same time
 - Customize for other councils and teams
 - Use of flyers for highlights to be used at provider huddles
- Understand the provider's documentation workflow in their EHR
- Anticipate future needs and direction of education based on clinical guidelines, upcoming coding changes, denials, etc.
- Use examples of inaccurate documentation, of recommended documentation, problem lists

Future State

- Integrated inpatient/outpatient future/primary care/specialist
- ICD-10-CM is the same INPATIENT or OUTPATIENT
 - Coding of signs/symptoms
- Lunch n Learn for CME credit
- Growing an 'outpatient' physician advisor program modeled after successful parts of inpatient program
- Additional risk models: Rx HCC, HHS HCC
- Leveraging technology for CDI and Provider workflow: BPAs, suspected conditions, queries, problem list,





Thank you.

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the Resource Hub.

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