Expanding the Reach of CDI: CDI in the Emergency Room
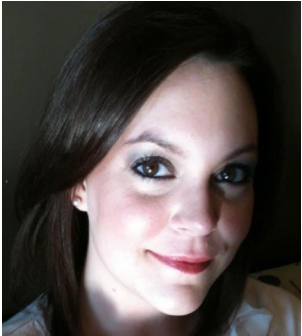
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Autumn Reiter, MBA, BSN, RN, CCDS,CCDS-O, CDIP, CCS, vice president of CDI services and auditing services, a CorroHealth Company in Plano, Texas, began her nursing career in ICU, moving into additional bedside experience in labor and delivery, eventually becoming the clinical coordinator for a CDI program in Chesapeake, Virginia. A 2013 and 2021/2022 ACDIS conference presenter, she served as Virginia ACDIS Chapter leader from 2015 to 2016 and serves on the ACDIS Advisory Board.

Elizabeth Hylton, CPC, CEMC has nearly 20 years' experience in the coding and auditing arena. Her career began at a small community hospital where she reviewed claims submission errors to reduce denials and increase reimbursement. She has spent several years in the varying administrative roles of physician practices across different specialties, including registration, preauthorization, claims submission, and denial review. She has performed reviews and education for many physicians both regionally at one of the largest healthcare organizations in the Southeast and nationwide. Currently, Hylton functions as the supervisor of CorroHealth's profee auditing department, which is responsible for the auditing and education of multiple clients throughout the United States across multiple specialties.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Describe how a CDI program at the point of entry in the ED affects complete and accurate documentation
  - List six strategies to build a successful CDI program in the ED space
  - Identify two challenges to engaging providers in documentation education
  - Describe best practices for starting and maintaining a successful CDI program in the ED setting

CDI in the Emergency Room

Importance of point of entry review of documentation

Shifting Focus - Moving to OP CDI

- Changes in healthcare legislation
  - Affordable Care Act
  - Value-based purchasing
- Changes in physician reimbursement
- Accountable Care Organization
  - Shift to the outpatient setting
- Why start in the Emergency Department?

Emergency Room Statics - 2018

- Number of visits: 130.0 million

- Number of injury-related visits: 35.0 million

- Number of visits per 100 persons: 40.4

- Number of emergency department visits resulting in hospital admission: 16.2 million

- Number of emergency department visits resulting in admission to critical care unit: 2.3 million

- Percent of visits with patient seen in fewer than 15 minutes: 43.5%

- Percent of visits resulting in hospital admission: 12.4%

https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf

National Hospital Ambulatory Medical Care Survey, 2019

- The overall emergency department (ED) visit rate (47 visits per 100 people in 2019).

- The ED visit rate was highest for infants under age 1 year (123 visits per 100 people) followed by adults aged 75 years and over (66 per 100).

- The ED visit rate for non-Hispanic Black people (87 visits per 100 people) was higher than the rate for people from all other racial and ethnic groups.

- The ED visit rate for patients with private insurance was lowest, while the rate for patients with Medicaid or Children's Health Insurance Program/State Children's Health Insurance Program was highest compared with all other primary expected sources of payment.

https://www.cdc.gov/nchs/products/databriefs/db434.htm

Documentation at the Point of Entry- Why Start Here?

- Benefits
    - Documentation integrity
    - Coding accuracy
    - Reportable hospital data
- Focus
    - Medical Necessity
    - Infusions and injections
    - E/M leveling
- Query Process
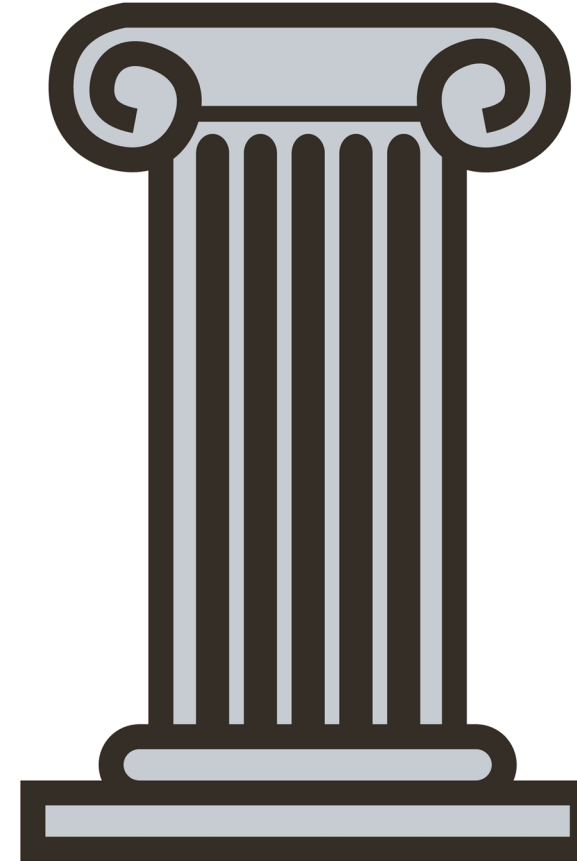   - Real-time vs. retrospective

Developing and Maintaining a Sustainable CDI program in the Emergency Room

Six Pillars of Success

Six Pillars of Success

1. Focus
2. Technology - Data collection and analysis reporting
3. Collaboration
4. Approach and engagement
5. Education and buy-in
6. Implementation

Considerations Before Starting

- Areas of Opportunity
  - Denials
  - Audit findings
  - E/M leveling distribution
- Create a goal
- Develop the appropriate team for success
- Create a plan
  - Start small
  - Be flexible

Pillar 1: Getting Started

What Is Your Focus

- After initial assessments have been completed, chose your focus:
- Quality initiatives
- Documentation to support medical necessity
- Infusion and injection reporting
- E/M leveling
- Correct use of modifiers

Medical Necessity and CPT codes

- The clinical need for the provider to have more diagnostic information doesn't always correlate with payer policy

- Review Local and National Coverage Determinations for common diagnostics performed - determine what, if any, coverage limits exist

- Identify and track denial trends

- Raise compliant queries to clarify diagnoses if conflicts exist

Medical Necessity: Initial Documentation

A provider documents clipping of toenails in the ED setting in addition to the E/M service provided. Other than the patient being diabetic, there is no indication of the reason why this had to be performed in this setting. Medicare appropriately denies this service for medical necessity.

Questions a CDI/coding professional will ask:

- Was the patient incapable of performing this service?

- Are there class findings in documentation that would support medical necessity for otherwise "routine" foot care?

- How many nails were debrided?

- Are there complications to the patient's diabetes (neuropathy, poor vascular function) that necessitated a professional performing this service?
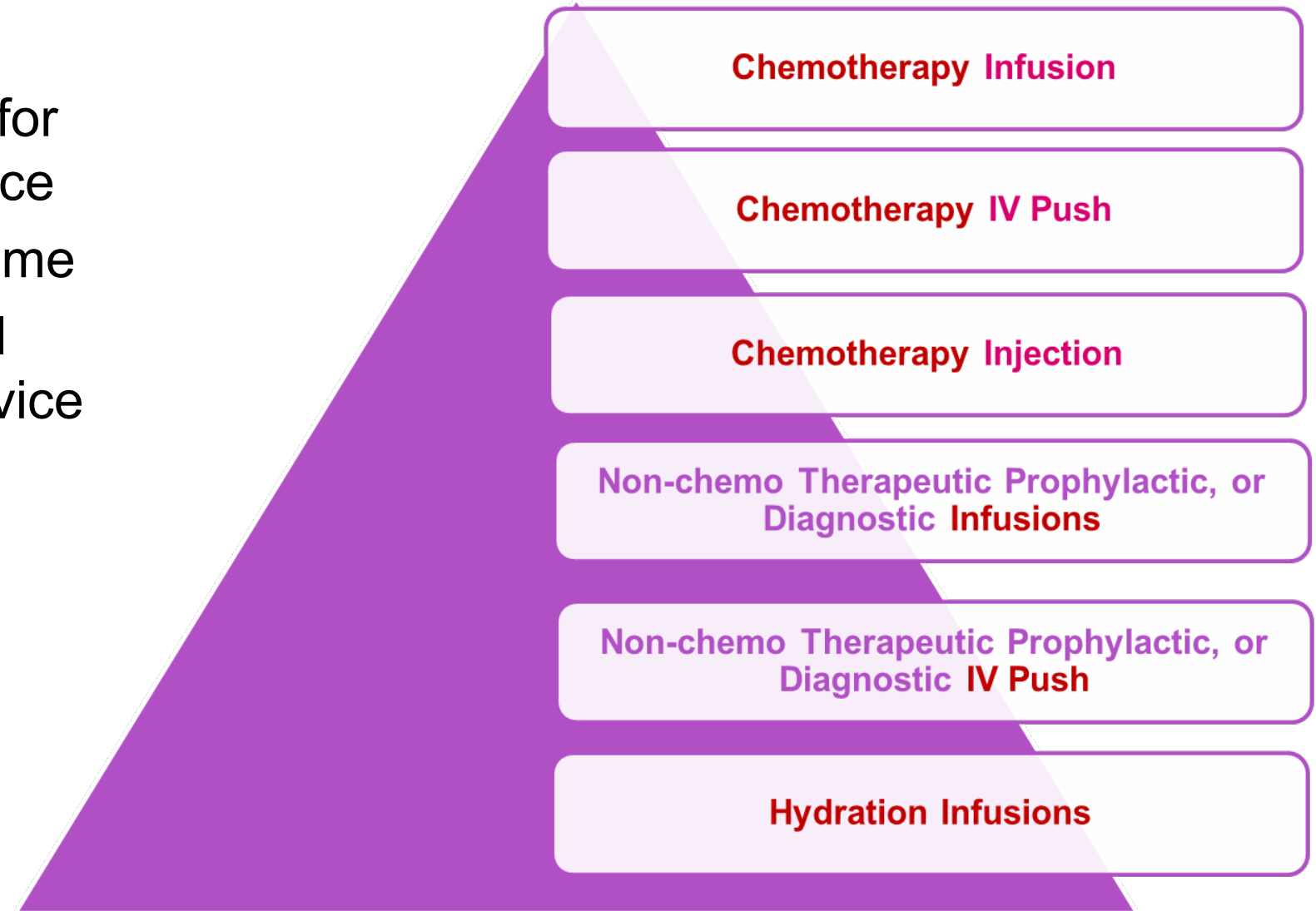
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Medical Necessity: Improved Documentation

Same example, only this time, with improved documentation.

- Provider documents symptomatic diabetic polyneuropathy with a concern for ingrown toenails, along with discolored, thickened nails, thin, shiny skin with no hair growth on the top of the foot, and 1+ edema of the ankles. Provider trims all 10 dystrophic nails, recommends adjustment of insulin dosage to accommodate postprandial blood sugar spikes, and recommends follow up with PCP to evaluate for custom orthotic shoes. A thorough exam of sensation, capillary fill, and overall skin turgor is carried out plus order of labs to evaluate kidney function and A1C levels, as fingerstick glucose of 190 is documented.
- CPT 11721 with modifier Q9 (Podiatry class findings; one Class B and two Class C) is supported by medical necessity.

Injection and Infusion Documentation

- Learn the Hierarchy for reporting Initial Service
- Properly document time
- Substantiate medical necessity for the service

Chemotherapy Infusion

Chemotherapy IV Push

Chemotherapy Injection

Non-chemo Therapeutic Prophylactic, or Diagnostic Infusions

Non-chemo Therapeutic Prophylactic, or Diagnostic IV Push

Hydration Infusions

Injection/Infusion Initial Documentation

- A patient with severe nausea and dehydration presents to the ER, and the provider orders a banana bag. A push of Zofran is also administered while the banana bag is infusing. There is no time of infusion documented in the provider note; however, the nurse documents "42 minutes" in ancillary notes.

- The provider evaluation indicates the patient is a chronic alcohol abuser; however, there is no documentation as to whether the patient is currently intoxicated.

- Pharmacy record indicates an injection of B12 as well; however, there's no documentation by the nurse or provider this was either ordered or administered.

Questions a CDI/Coding Professional will ask:

- Is the patient currently intoxicated? If so, what's the blood alcohol level?

- Infusion start and stop time?

- Were there other services performed but not documented?

Injection/Infusion Improved Documentation

- The same patient comes in with documentation supporting acute alcohol intoxication with delirium, and blood alcohol levels of 0.23. Infusion of banana bag begins at 1115 and concludes at 1143.

- While this infusion is taking place, a Zofran IV push takes place at 1123 given the patient not endorsing immediate relief. The nurse documents the administration of a B12 injection at the conclusion of the infusion as lab work reveals critically low levels.

- The patient is admitted overnight for observation, and lactated Ringers is ordered and run for 6 hours beginning at 0130, till discharge at 0730.

E/M Levels

- Medical Decision Making (MDM) is most closely linked to medical necessity

- Review for the "why" attributing to the level: complexity, amount of data reviewed, risk to the patient

- Do not assume clinical judgment translates to clerical professionals - review for descriptors to justify acuity

- Don't forget to satisfy the history and exam components in addition to MDM
  - All 3 key components are needed for profee E/M leveling in the Emergency Department

E/M Leveling Initial Documentation

A patient presents with a fracture of their thumb. The provider documents a comprehensive history and exam and bills a level 5 Emergency Department level.

Review of the Medical Decision Making indicates an acute uncomplicated injury with one x-ray ordered, over-the-counter Tylenol and ice recommended. This upholds only a level 3 - One new problem with additional workup planned, minimal data, and low risk, for overall low MDM complexity.

Questions a CDI/Coding professional will ask:

- Was a comprehensive history necessary? What bearing does family history have on the current complaint? What about a comprehensive ROS?
- Could the exam be limited to the affected area and general patient health?
- Can additional information be recorded about the type, specific location, and cause of the fracture?
- Was there an underlying comorbidity the provider didn't address that led to the selection of the higher level?

E/M Leveling Improved Documentation

Same example, only this time, with improved documentation.

- The provider documents a detailed history including information regarding the cause of the fracture- sustained while playing varsity football. Past history is not deemed relevant, and ROS is limited to the joints and general well-being of the patient.

- Similarly, exam focuses on the affected area of the body plus vital signs and range of motion for the affected limb. Documentation lists the number of x-ray views obtained along with provider impression- a nondisplaced proximal phalanx fracture of the thumb of the left hand.

- Detailed rationale including rest and ice along with OTC medication use is outlined in the low overall complexity E/M. 99282 is correctly assigned.

Understanding Modifier Sequencing

- There is an order to reporting modifiers and there are three categories that modifier usage fall under. The general order of sequencing modifiers is:

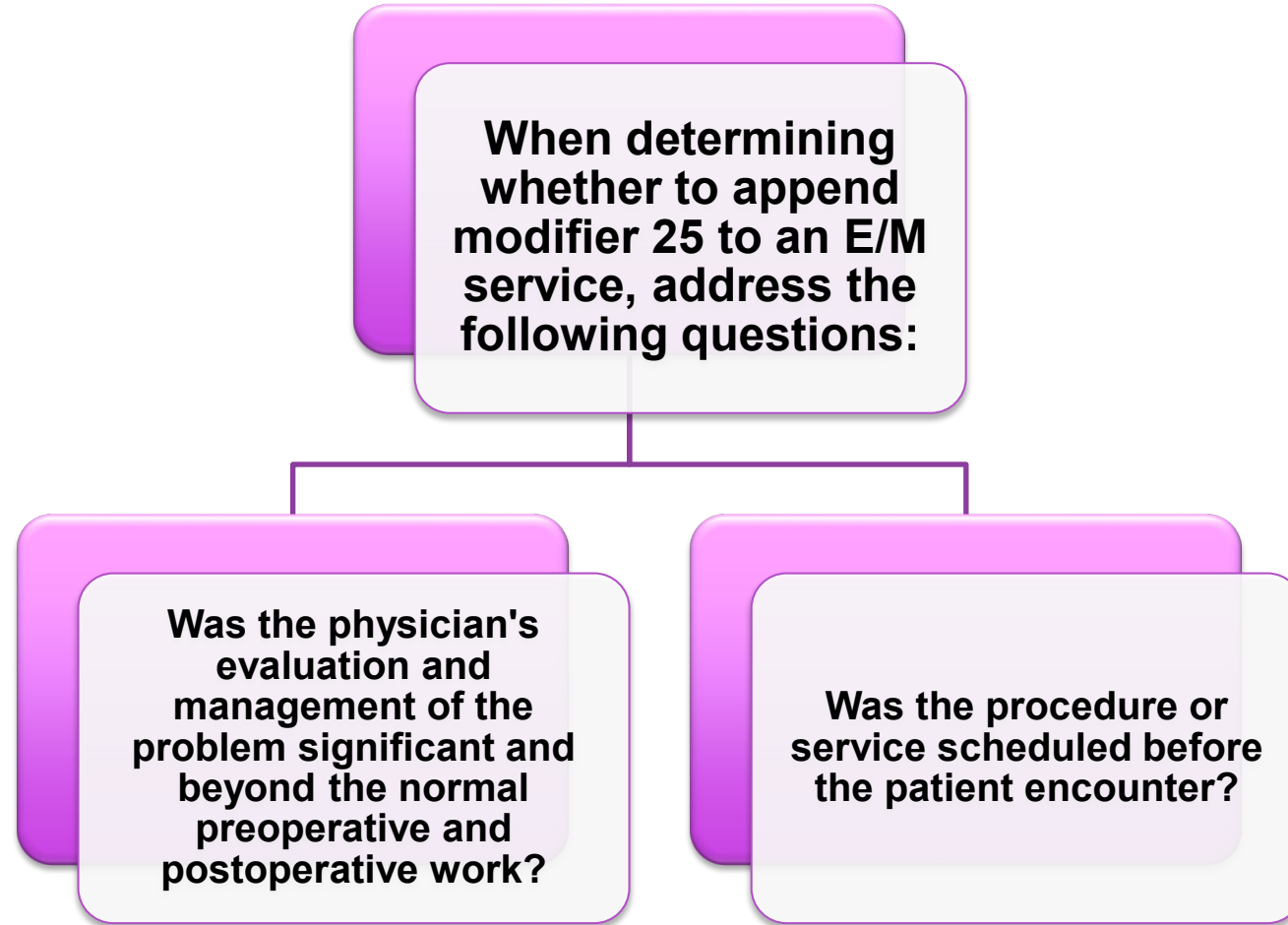| 1. Pricing |
| --- |
| Example: 21, 22, 26, 50, 52, 53, 60, 62, 80, 82 |

2. Payment
Example: 24, 25, 51, 57, 58, 59, 76, 77, 78, 79, AS, 91

3. Location
Example: E1-E4, FA, F1-F9, LT, RT, TA, T1-T9

> Do not add modifiers to Add-on codes

Modifier 25 Usage

When determining whether to append modifier 25 to an E/M service, address the following questions:

Was the physician's evaluation and management of the problem significant and beyond the normal preoperative and postoperative work?

Was the procedure or service scheduled before the patient encounter?

Pillar 2: Technology - Data Collection and Analysis Reporting

Technology

- Take advantage of technology to support your efforts.

- Utilize and build from what you have.

- Will you need additional components to support?

  – Encoder

  – Claims scrubber software

  – Revenue cycle management

Key Performance Indicators

- Denial percentage- Is there a decrease noted?

- "Fleshing out" of documentation – do you see an improvement in amount and type of information?

- Need for query
  - Frequently asked topics
  - Providers queried
  - Response rate
  - Agreement rate

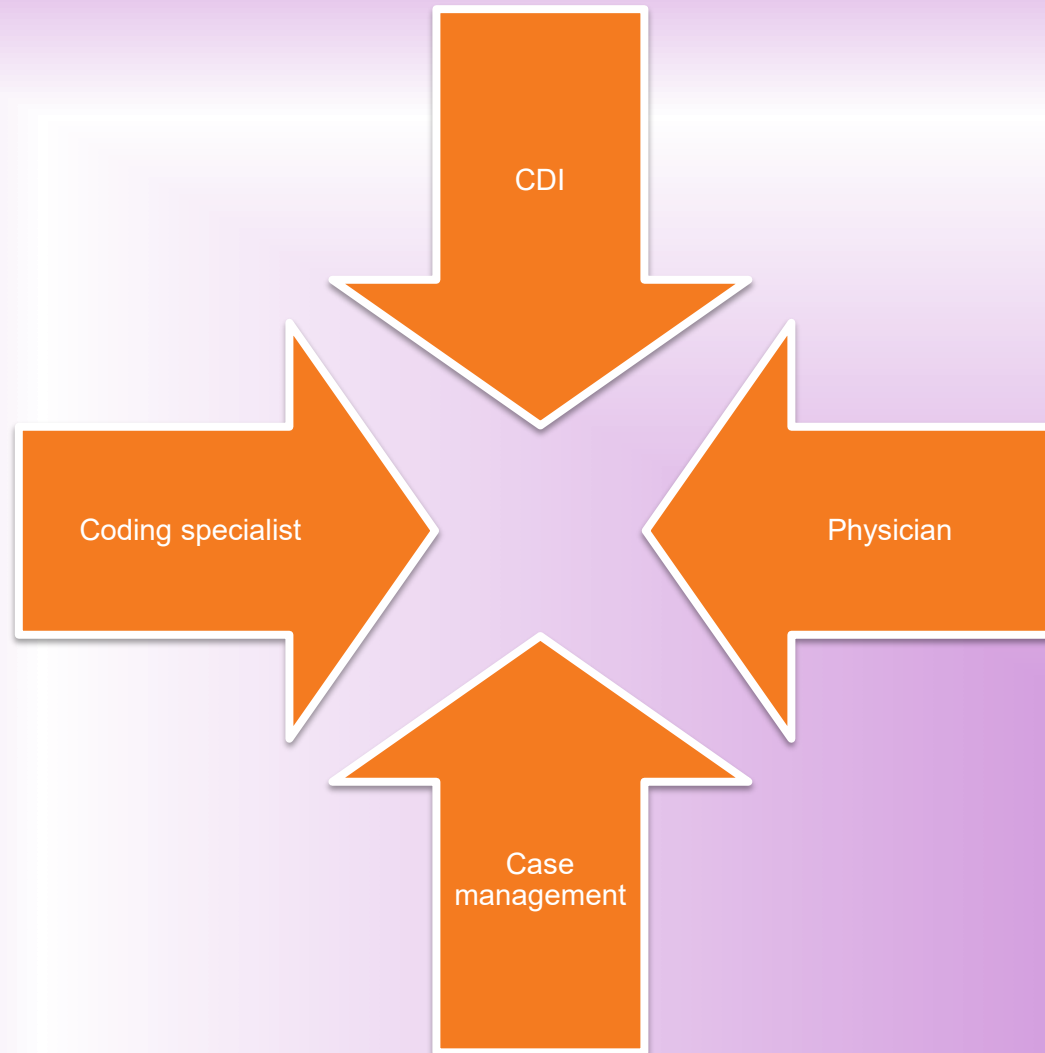- Financial and quality impacts

Pillar 3: Collaboration

Team Approach for Success

Defining Roles

- CDI
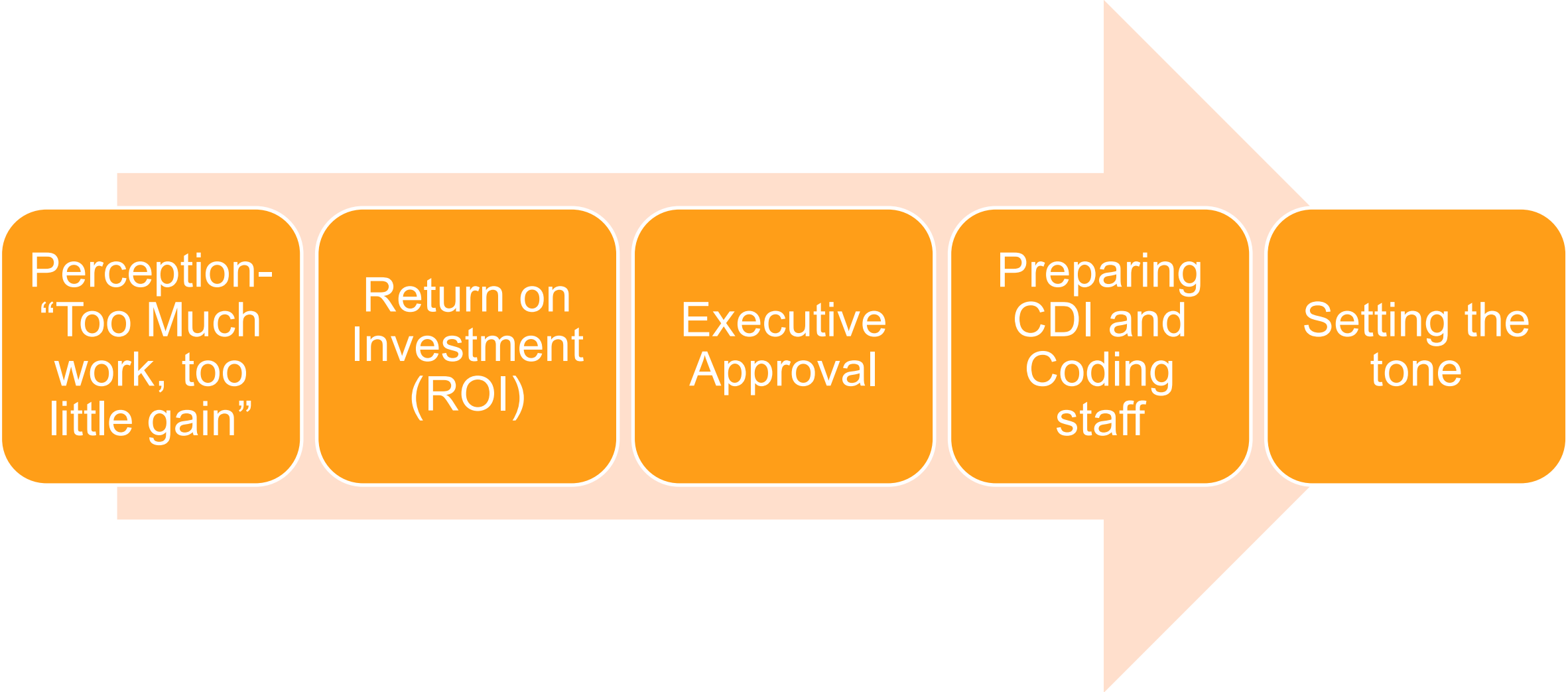- Physician
- Case management
- Coding specialist

Collaboration and Success

CDI

Coding specialist

Physician

Case management

Pillar 4: Approach and Engagement

Roadblocks That You May Encounter….

Perception- "Too Much work, too little gain"

Return on Investment (ROI)

Executive Approval

Preparing CDI and Coding staff

Setting the tone

Pillar 5:Education and Buy-In

CDI and Coder Education

CDI Professional

- OP Coding Guidelines
- NCD/LCD documentation needs
- Leveling methodology
- Injection and infusion reporting
- Query template changes and when to query

Coding Professional

- Understanding CDI Queries
- Familiarity with NCCI edits
- Self-education on disease process
- Collaborative approach with providers
- Knowing the "why" of a CDI initiative

Provider Education

Need for consistent and clear documentation

Medical decision making to clarify need for interventions and testing

Accurate reporting of critical care time

Peer to Peer conversations

- Inpatient hospital admissions
- Physician assistant and physician
- No assumptions

Buy-In from all Stakeholders

Understanding the why:

- ROI will look different
- Initiatives driving the program
- Importance of clear and concise documentation in the ED setting

Benefits for all involved:

- Provider
- Facility
- Patient

Pillar 6: Implementation

Go Time!

Ready, Set, Go!

Queries
- Template
- Policies & Procedures

Monitoring KPIs
- Showing impact of the program
- Month to month changes

What is working/what isn't
- Understanding obstacles
- Promoting successes
- Flexibility is the key to success

Reporting to leadership
- Cadence
- Data collection and impact, showing the value of the program

Wrap-up

- Create your focus-start small
- REMEMBER:
  - Decide on your Focus
  - Understand how Technology can be used to support your program
  - Collaboration will promote success
  - Engagement
  - Education and Buy-in are necessary
  - Implementation

Thank you.

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