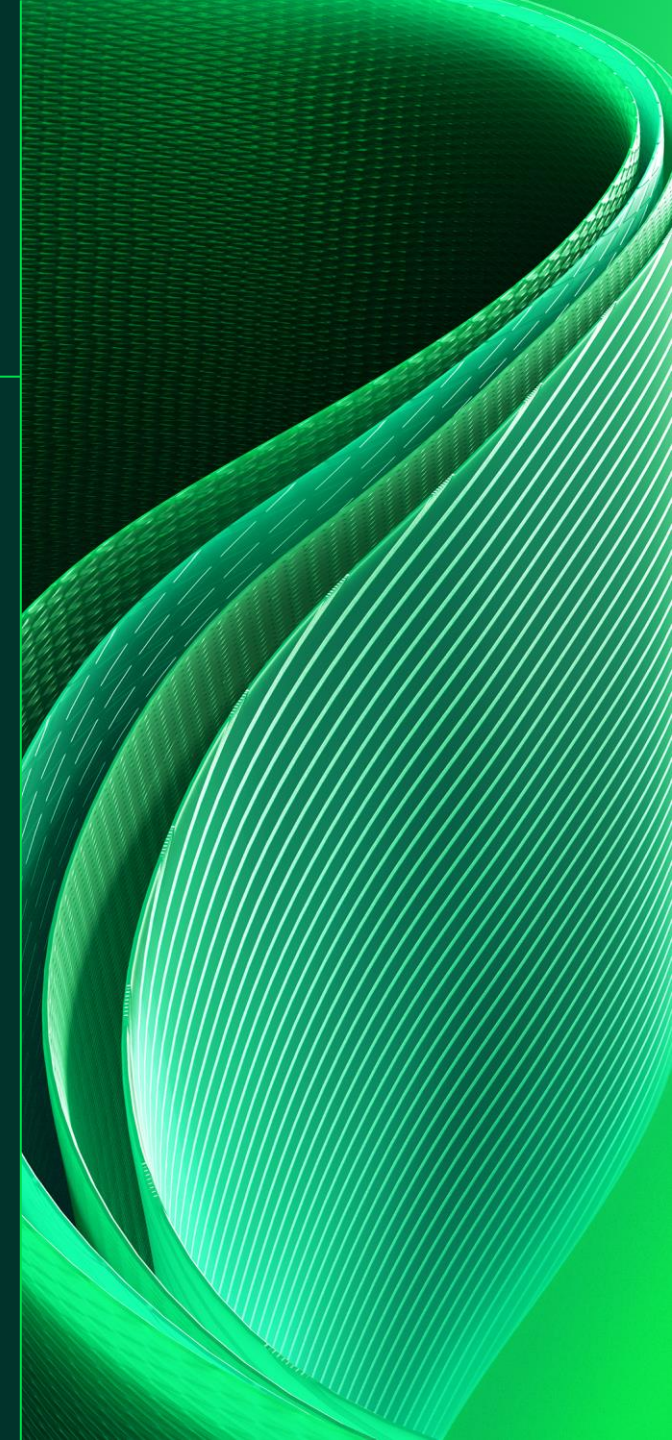solventum

Solventum Advanced CDI Transformation Program

Medical story time: How accurate documentation reflects the patients stay

Stephanie Cantin-Smith

Objectives of this presentation include:

1   Fundamentals of documentation

2   Difference in clinical language versus coding language (ICD-10)

3   Importance of accurate and complete documentation and relation to CMI, severity of illness, risk of mortality, and possible reimbursement

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Documentation and patient care improvement

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Fundamentals of documentation

High quality documentation serves as the story of the patients encounter whether inpatient or outpatient

- Fundamentals of documentation include:
  - Complete description of the patient's reason for admission and any contributing factors
  - Confirming test results which correlate to a treatment being carried out e.g., medication ordered, why?
  - Support for all diagnosis entered into the patient record
  - Accurately documenting signs and symptoms with a corresponding diagnosis
  - Clarity around complications of care or issues that can impact care during treatment

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Improvement with documentation

Accurate documentation improves patient/safety outcomes by:

- Building trust between a patient and provider
- Means of communication between health care professionals
- Enables a smoother transition of care
- Gathers statistical information on disease processes
- Trends data
- Reflection of patient acuity within a health system/hospital
- Ability to focus on patient outcomes and have accountability for quality related initiatives

Advanced CDI Transformation Program
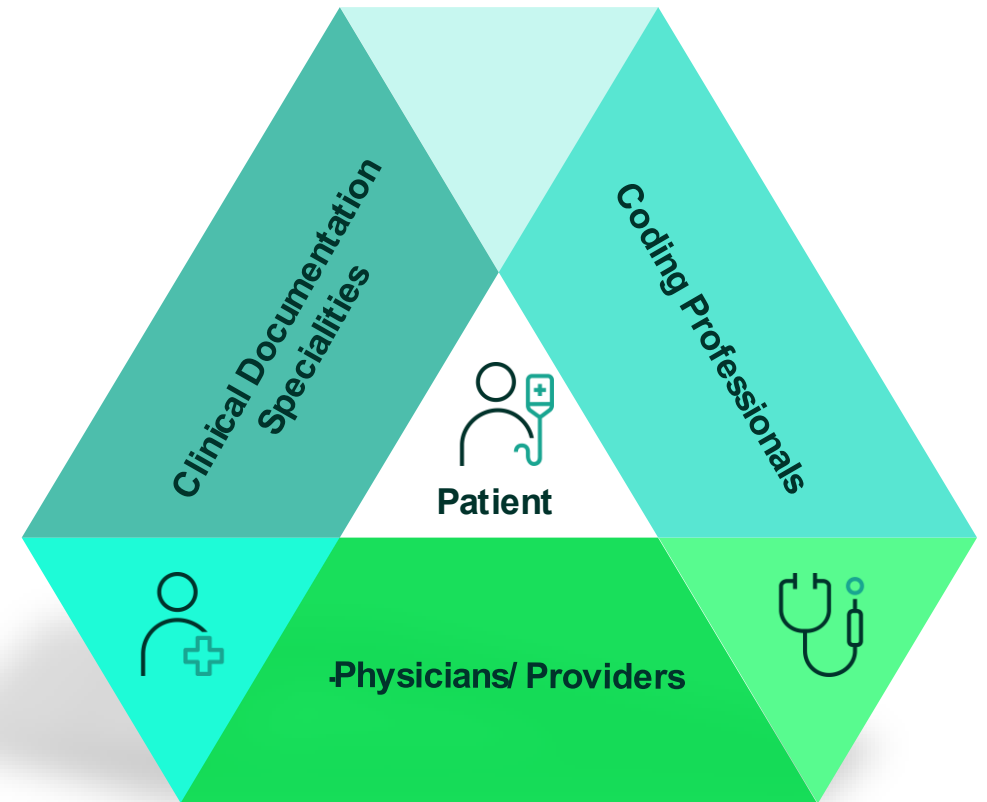
A partnership for documentation integrity

A concurrent review process involving an interdisciplinary team to:

- Assess whether all conditions and treatments are accurately reflected in the medical record

- Address documentation opportunities while the patient is still hospitalized
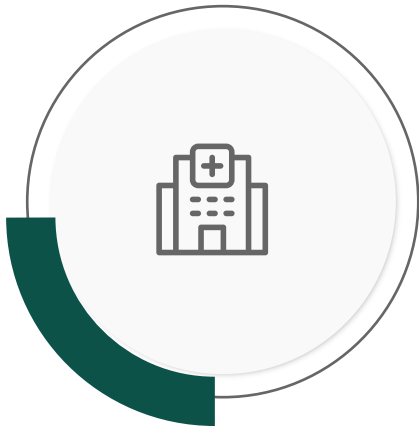
Accurate reflection of patient's clinical picture:

- Severity of illness

- Risk of mortality

- Compliant with rules and regulations

Team members include:

Clinical Documentation Specialities

Coding Professionals

Patient

Physicians/ Providers

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Hospital life today
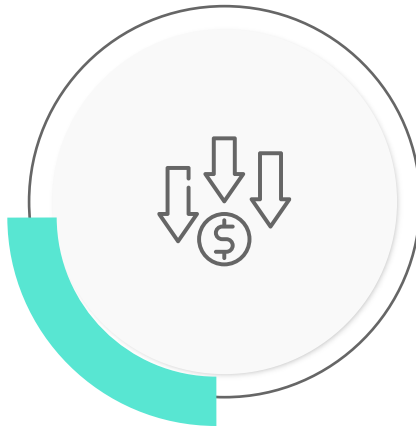
Admission of only sick patients

Deliver high-quality care

Achieve acceptable outcomes

Reduce LOS

Be more cost-effective

Manage it!

Prove it!

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What is Clinical Documentation Integrity (CDI)?

Accurate and complete representation of a patient's clinical condition
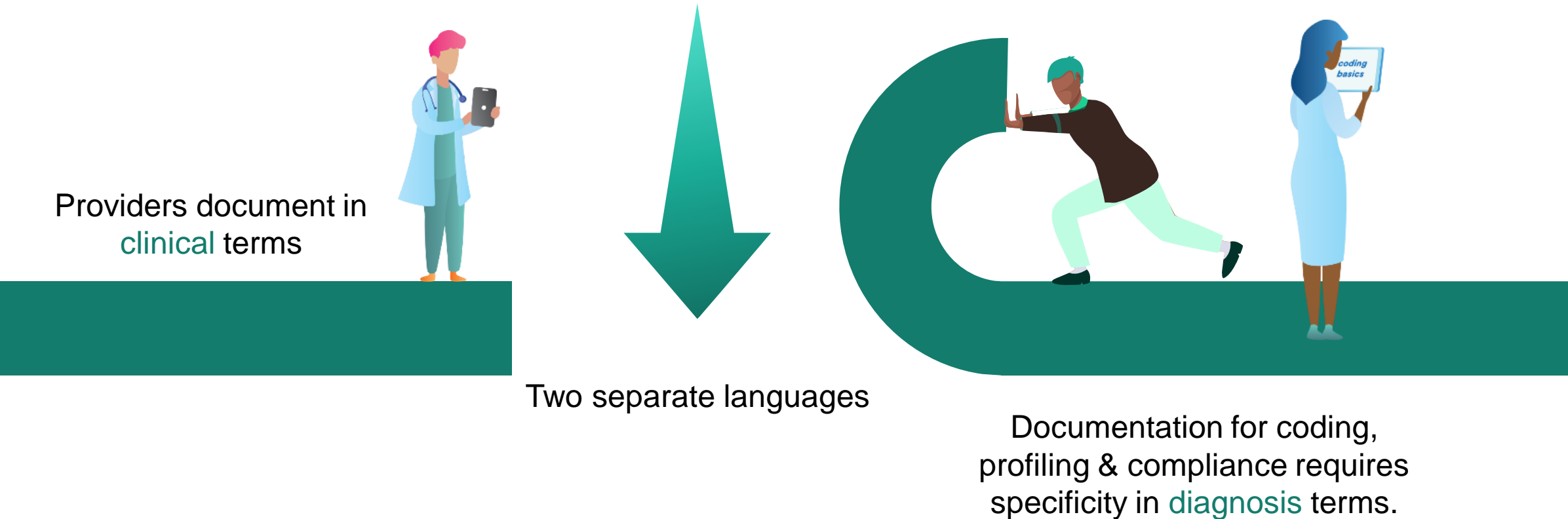
Documentation

- Diagnoses
- Procedures
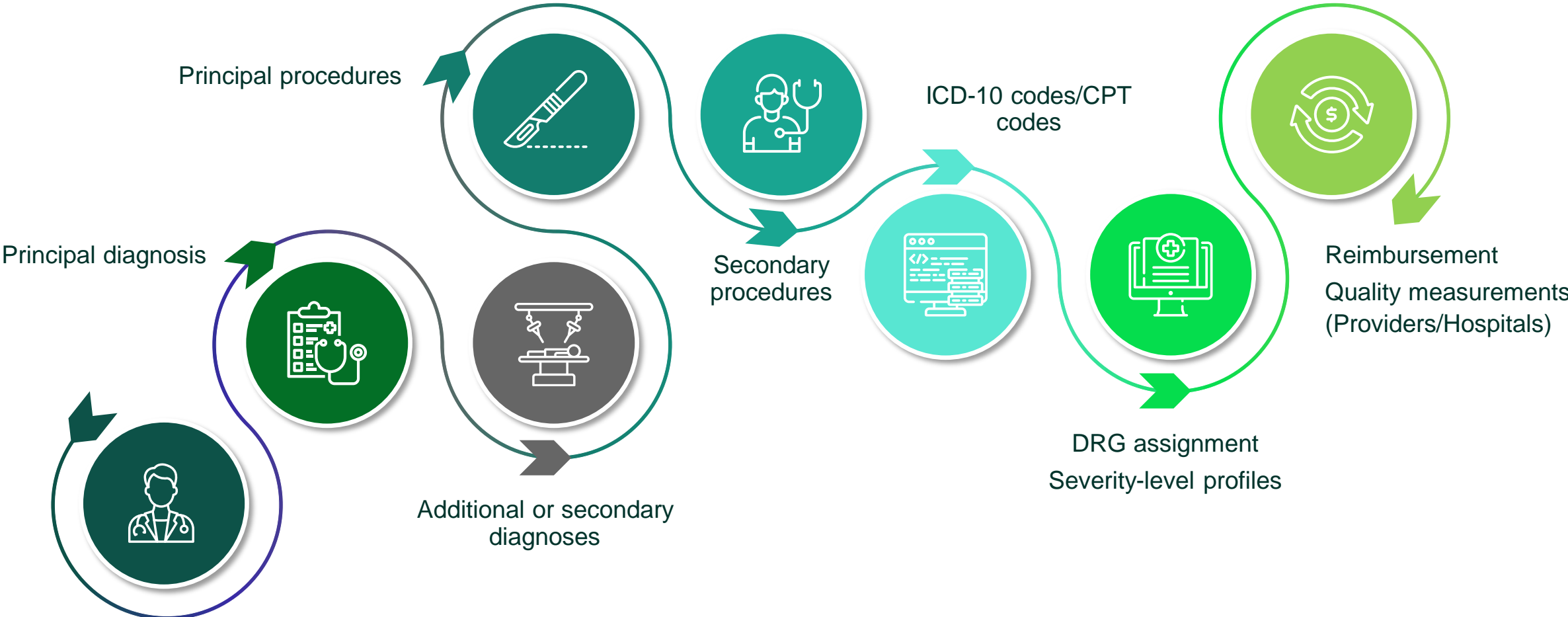- Medical decision making

Coding

Reporting

- Hospital quality metrics
- Physician performance
- Medical necessity
- Clinical decision support
- Reimbursement

- Compliance
- Credentialing
- Public health data
- Disease tracking and trending
- Medical research

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The need

Providers document in clinical terms

Two separate languages

Documentation for coding, profiling & compliance requires specificity in diagnosis terms.

Why is proper documentation important?

Principal procedures

Principal diagnosis

Provider documentation

Additional or secondary diagnoses

Secondary procedures

ICD-10 codes/CPT codes

DRG assignment
Severity-level profiles

Reimbursement

Quality measurements (Providers/Hospitals)

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Why CDI initiative ?

Clear, concise, complete, accurate and specific documentation supports the use of more specific ICD-10 codes and results in more appropriate DRG assignment and reflection of patient severity of illness/risk of mortality

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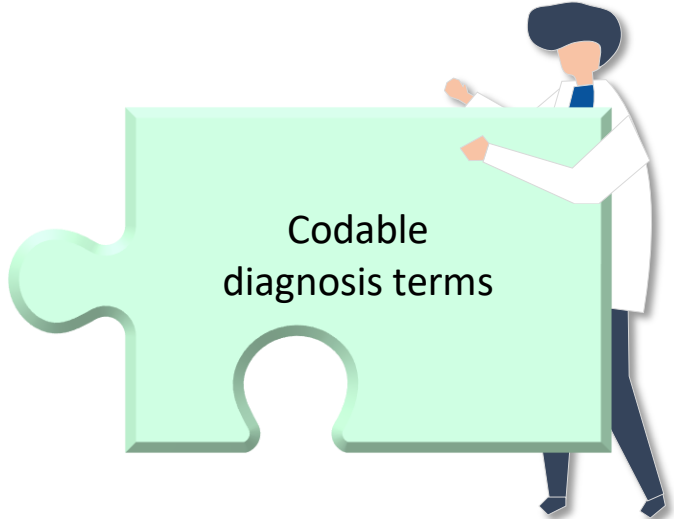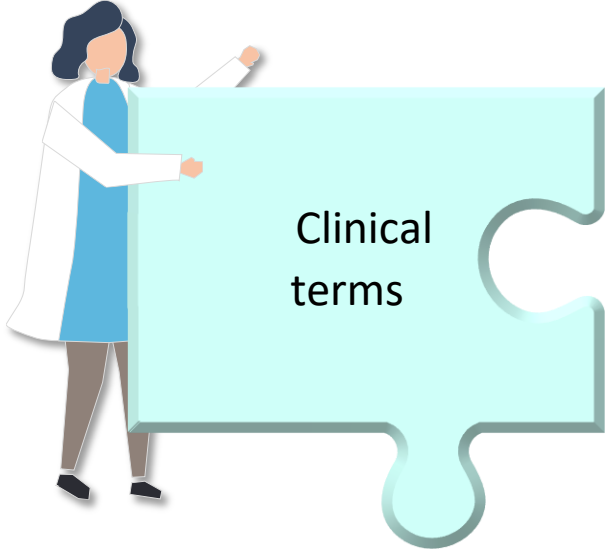# Clinical documentation integrity specialists

- Specialized training
- Review concurrently
- Prioritize the queries
- Ensure a complete and accurate record gets to the coder

Clinical terms

Codable diagnosis terms

Documentation
A reflection of the care provided

Demonstrates the severity of illness (SOI) and risk of mortality (ROM)

Determines . . .

Principal diagnosis

Procedures performed

Secondary diagnosis

Remember
If it is not documented, it never happened.

Review

What is the documentation improvement/integrity program and its goal?

a. A program designed to educate and collaborate with physicians and providers on a concurrent basis to assess and improve medical record documentation, with the goal of attaining complete, accurate and compliant documentation of conditions and procedures

b. A program to assess physician and provider documentation on a retrospective basis for accuracy and to penalize the practitioner that misses the mark

c. A competitive program designed to reward practitioners for improvements in documentation that increase hospital reimbursement

Answer: a

The goal of the documentation improvement/integrity program is to obtain complete, accurate and compliant documentation in the medical record.

Review
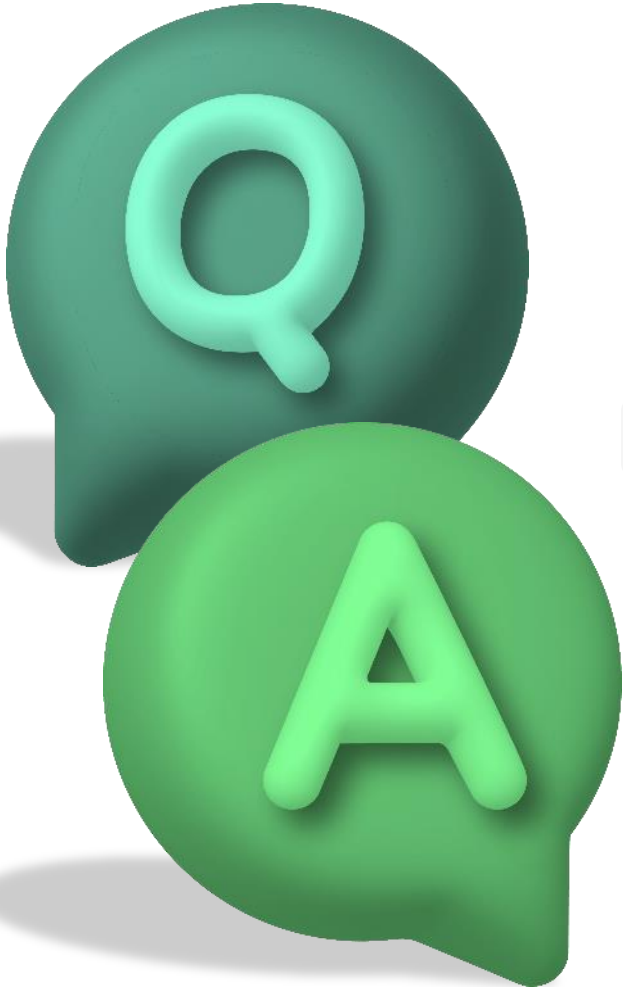
Who are active day-to-day members of the documentation improvement/ integrity team?

a. Physicians and Providers

b. Clinical Documentation Specialists

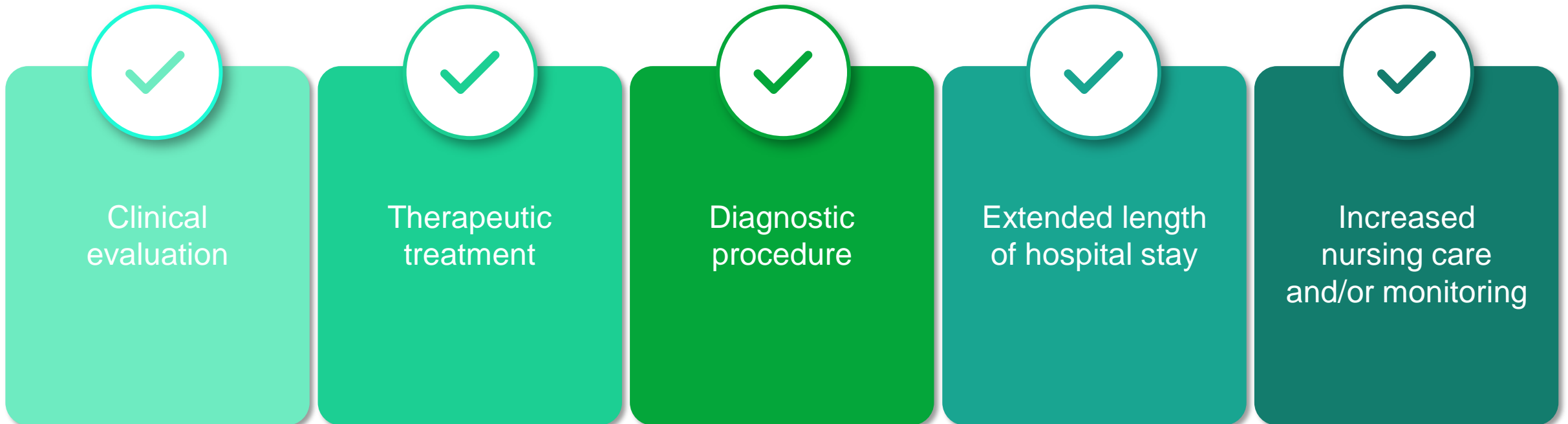c. Coding Professionals

d. All the above

Answer: d

Physicians/Providers, CDS and Coding Professionals are key members of the team. Other clinicians who may also be involved include Case Managers, Infection Control Professionals and Quality Professionals. All team members are subject to the same compliance requirements.

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Severity of illness and risk of mortality

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Additional or secondary diagnoses

For reporting purposes, the definition for "additional" or "secondary" diagnoses is interpreted as additional clinically significant conditions that affect patient care in terms of requiring at least one of the following:

Clinical evaluation	Therapeutic treatment	Diagnostic procedure	Extended length of hospital stay	Increased nursing care and/or monitoring

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What is SOI and ROM?

Severity of Illness (SOI)

SOI: a reflection of how severely ill or sick a patient is due to their disease burden, how difficult he/she is to manage, the types of intervention required, and the intensity of those resources.

Risk of Mortality (ROM)

ROM: the likelihood a patient will die due to their disease burden

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Complication/Comorbidity

Comorbidity

A pre-existing condition present at the time of admission which may cause an increase in the length of stay

Complication

A condition that arises during the hospital stay that may prolong the length of stay

Does not necessarily represent an error in medical care

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Review

What is the meaning of SOI?

a. Summary of illness

b. Severity of illness

c. Symptoms of illness

Answer: b

SOI, or Severity of Illness, reflects how severely ill the patient is due to their disease burden
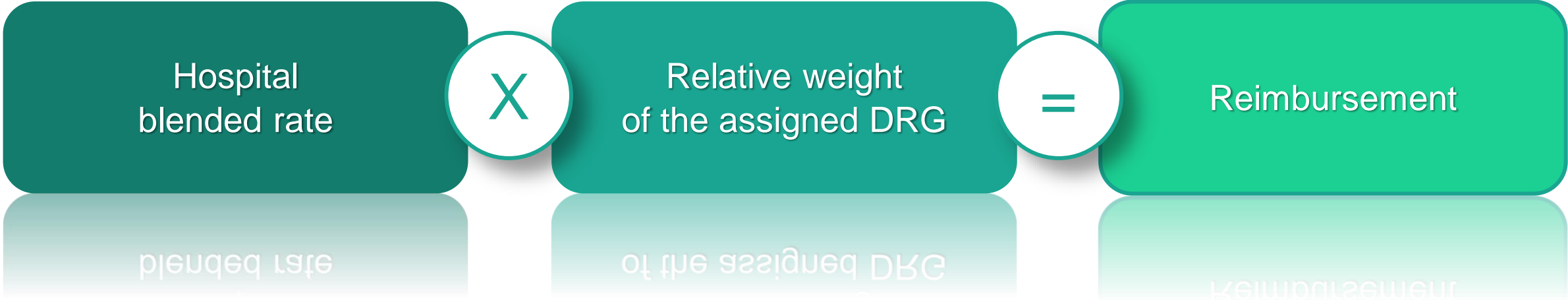
Review

What is the meaning of ROM?

a. Review of Mortality

b. Risk of Morbidity

c. Review of Morbidity

d. Risk of Mortality

Answer: d

ROM, or Risk of Mortality, reflects the likelihood a patient will die due to their disease burden

Calculating reimbursement and CMI

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Calculating reimbursement

Hospital blended rate **X** Relative weight of the assigned DRG **=** Reimbursement

Calculating reimbursement

Example
DRG 189, Pulmonary Edema and Respiratory Failure

Hospital blended rate:	$5348.75
DRG RW	1.2320
Reimbursement	$6589.66

**Hospital blended rate** X **DRG relative weight** = **Hospital reimbursement**
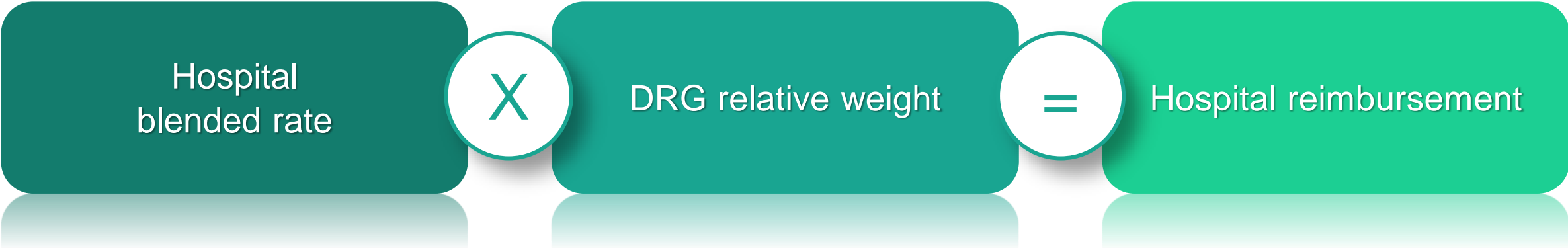
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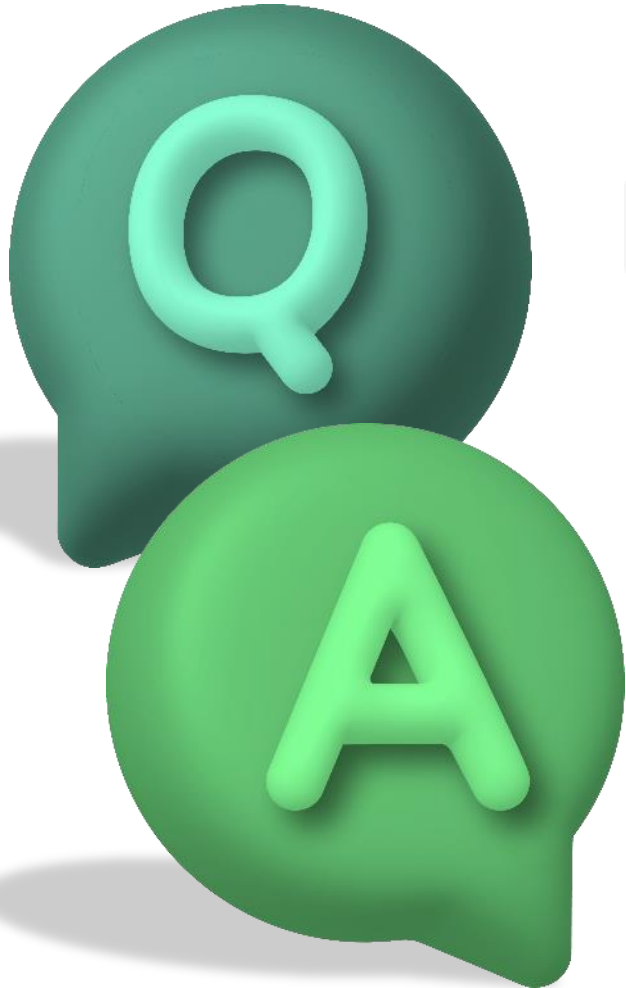
What is the definition of a relative weight?

a. A reflection of the expected resource consumption and severity of diagnoses within each DRG, and is unique to each facility

b. A reflection of the expected resource consumption and severity of diagnoses within each DRG, and is constant across all hospitals within the USA

c. A reflection of the expected resource consumption and severity of diagnoses within each MDC, and is constant across all hospitals within the USA

d. None of the above

Answer: b

Relative weight is one component of the formula to determine reimbursement and reflects the expected resource consumption and severity of diagnoses within each DRG. The relative weight is constant across all hospitals within the United States.

Review
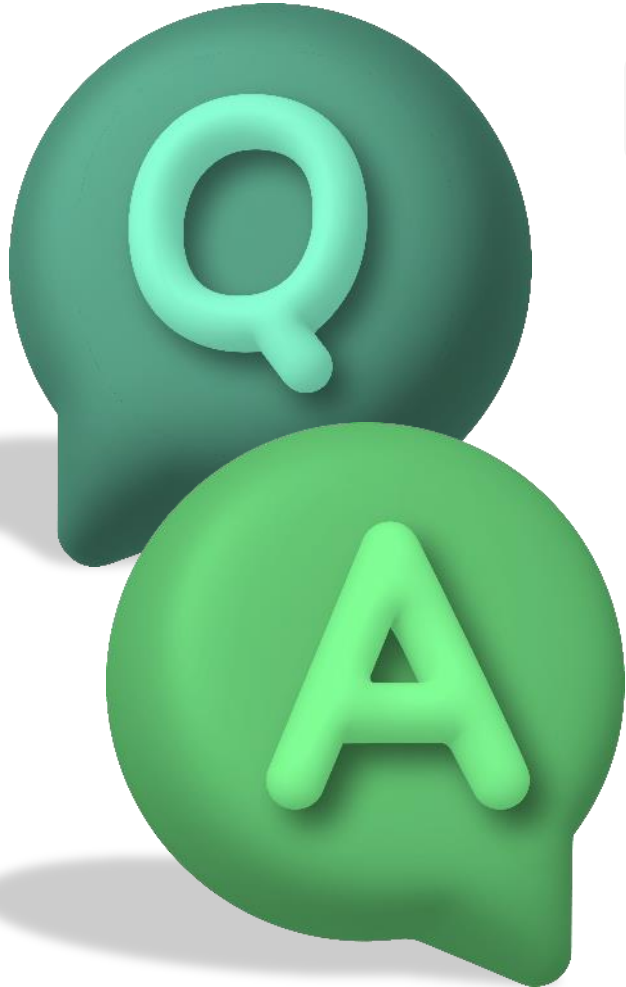
What is the definition of blended rate?

a. A dollar figure used to compute hospital reimbursement determined using a formula issued on an annual basis, and is unique to each facility

b. A dollar figure issued on an annual basis to compute hospital reimbursement, and is consistent across all facilities in the USA

c. A dollar figure used to compute hospital reimbursement which is determined by each individual facility

d. None of the above

Answer: a

Blended rate takes into consideration the type of facility (teaching/non-teaching), the location (rural/urban), and services provided. Blended rate is the second component of the formula to determine reimbursement.

Case Mix Index (CMI)

- CMI is the average of the relative weights of the DRGs in the patient population

  – The sum of all DRG relative weights divided by the number of cases in the time period being monitored

- A low case mix index may denote DRG assignments that do not adequately reflect the resources used to treat patients

- CMI is affected by:

  – Services a hospital provides

  – Medical and surgical case volumes

  – DRG assignments

  – Accurate, complete and compliant documentation
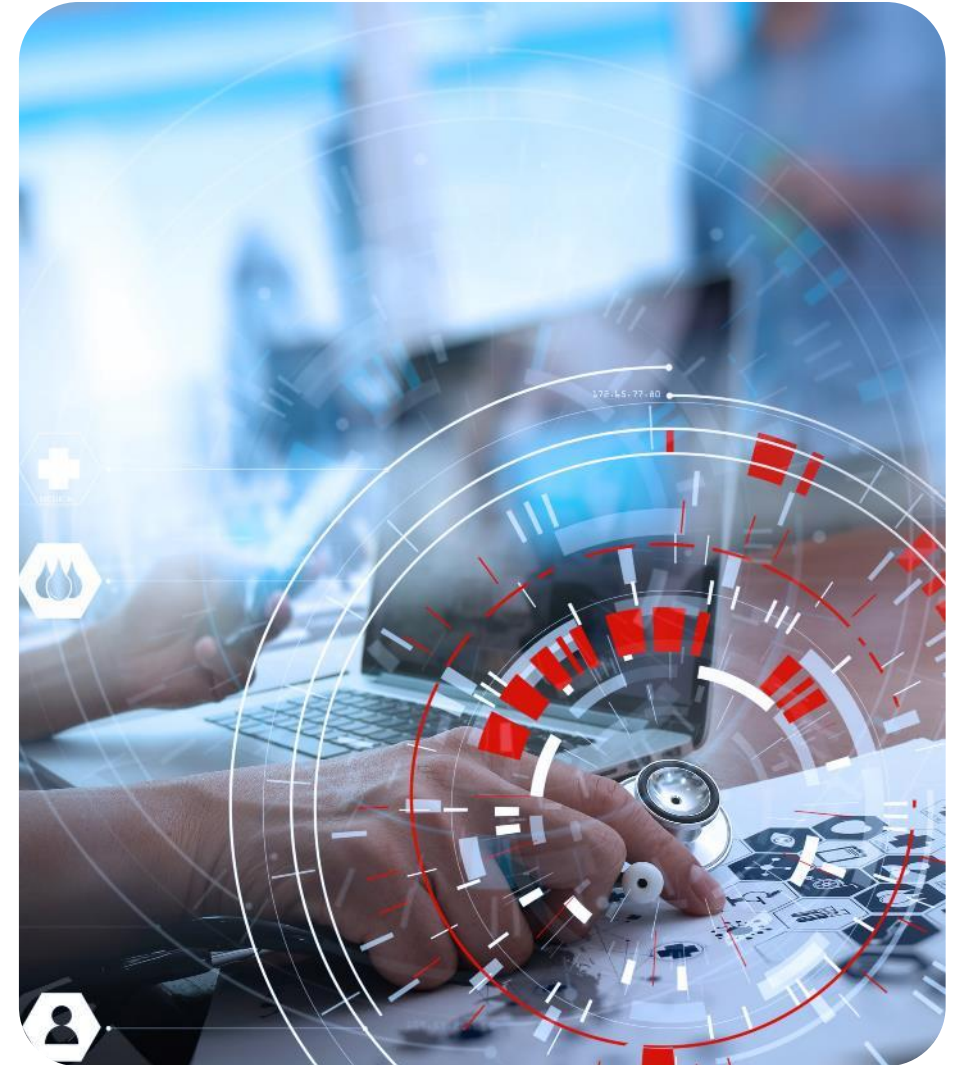
Case Mix Index (CMI)

- Add the relative weight of each DRG and divide by the number of patients:

	DRG	RW
1. CHF w CC	292	
2. Cholecystectomy w CC	415	
3. Sepsis w MV 96+ Hrs.	870	
4. Chest Pain	313	
5. TURP w/o CC/MCC	714	

_____ ÷ 5 = _____ (CMI)

The CMI reflects the severity of illness of your patient population

Are there any concerns with the above patient population?

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Case Mix Index (CMI)

- Add the relative weight of each DRG and divide by the number of patients:

	DRG	RW
1. CHF w CC	292	0.8565
2. Cholecystectomy w CC	415	1.9758
3. Sepsis w MV 96+ Hrs.	870	6.9649
4. Chest Pain	313	0.7236
5. TURP w/o CC/MCC	714	0.9585

11.4793 ÷ 5 = 2.2959 (CMI)

The CMI reflects the severity of illness of the defined patient population

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Review
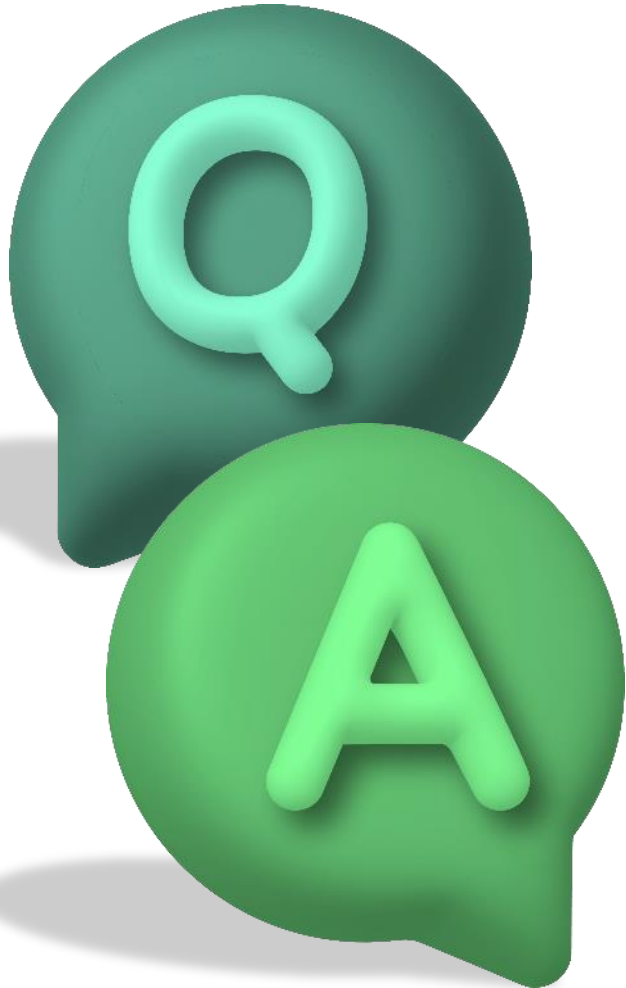
How can the Documentation Improvement/Integrity team impact the Case Mix Index?

a. By working with the Medical Staff to encourage accurate, complete, and compliant documentation

b. By capturing and reporting all pertinent diagnoses and procedures on the final bill for services submitted to the insurance company

c. Through collaborative team efforts of the Documentation Specialists, Coding Professionals, and Physicians/Providers and others involved in the patient care/documentation

d. All of the above

Answer: d

Case Mix Index is impacted through the collaborative efforts of the CDI team by improving documentation patterns and ensuring all pertinent diagnoses and procedures are captured and reported for final billing.

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References

🔗 [Diagnosis-Related Groups: a question and answer guide on case-based classification and payment systems](#)

🔗 [DRG systems in Europe: variations in cost accounting systems among 12 countries](#)

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Thank you

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