# CDI Seen in New Light as OIG is Poised to Validate DRGs

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## New Initiative Is Detailed In The OIG Work Plan

As many of you are aware, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently released a key addition to its work plan announcing an initiative to investigate and validate their concern of hospitals gaming the MS-DRG reimbursement system by engaging in up-coding or mis-coding to receive increased reimbursement (Assessing Inpatient Hospital Billing for Medicare Beneficiaries O1G Work Plan Addition). This initiative consists of two phases, the first an analysis of claims data and data mining to determine and identify patterns of up-coding or mis-coding, the second a drill down further by identifying hospitals that are potentially engaging in questionable documentation, coding, and billing practices that result in a higher-weighted MS-DRG than otherwise appropriate, based upon care provided. When I first read the work plan, my immediate reaction was both positive and negative, recognizing that some hospital facilities will be caught up in the costly activities associated with appealing accurately documented patient care with clinical indicators supportive of the ICD-10 diagnosis and procedure codes assigned.

I am, however, pleased to see the OIG embark on this work project to raise hospitals' awareness of the inherent dangers associated with overly aggressive documentation practices in the name of inappropriately enhancing reimbursement just because they can. I view the OIG's concerns with ongoing up-coding and mis-coding as a signal that the Medicare Administrative Contractor (MAC), the Recovery Auditor Contractor (RAC), and the Beneficiary and Family-Centered Care-Quality Improvement Organization (BFCC-QIO) work to ensure that claims are billed correctly in protection of the Medicare Trust Fund have not been as fruitful in catching the attention of hospitals as would be preferred.

Yes, there have been numerous OIG hospital compliance reviews completed on individual hospitals, with release of reports of findings on the OIG website, to which hopefully all compliance and CDI professionals are attuned. There also was a lawsuit brought by outside data analytics organizations well-versed in identifying potential misdeeds in the financial sector, alleging over-documentation and upcoding perpetuated by a well-known clinical documentation improvement consultancy. This company is seeking $190 million associated with the alleged over-coding, and not surprisingly, the lawsuit points

out that the alleged misdeed of over-coding is widespread, based upon data analysis of other hospitals with which this consulting company has contracted.

Operational Processes Vetted in Real Documentation Integrity
I have written extensively on the pervasively misaligned and misdirected current CDI processes, with the primary measure of performance being calculated by reimbursement. The query process, with the intent of invoking a positive response by the physician in answering the query, is the gist of most CDI programs, especially with those programs that utilize a remote CDI model. There is virtually no sharing of best practices, standards, and principles of documentation with physicians, aside from instruction on appropriate clinical language to use that translates into accurate ICD-10 code assignment. Allow me to share my thoughts and ideas regarding processes that serve as a strong foundation for setting the stage for engagement of physicians in any clinical documentation integrity initiative.

A colleague of mine recently reached out to me to inquire about setting up a clinical documentation integrity program at a community hospital from the ground up, given that the facility had never invested in a prior program. The hospital administrators were somewhat knowledgeable about a CDI program, and a scoping call was scheduled to discuss the project. During the scoping call, in which the administrators as well as the chief of staff and chief medical officer were present, I outlined the basis of a traditional CDI program predicated upon the query primarily for securement of diagnoses and reimbursement.

Integral to any scoping call is the identification of any and all prospective client pain points in the revenue cycle, for the purposes of facilitating discussion and developing potential solutions the consultant can recommend. In this case, a major pain point expressed by the C suite was the sheer magnitude and dollar amounts of managed Medicaid and Medicare denials for inpatient care, something the hospital was ill-prepared to absorb, given its precarious financial situation arising from a large government payor patient mix. In short, the hospital's goal was to validate their intuition that their medical necessity denials were related to incorrect level of care status, either attributable to insufficient (i.e., poor) documentation and/or overzealous Medicare managed care organizations' interest in putting their medical loss ratio and profits first – even over patient care, and fair and reasonable payment for care provided to members. The first phase of the project entailed reviewing a representative sample of denied inpatient claims to identify the root cause, and the findings were not at all surprising. More than 60 percent of the denials reviewed were attributable to insufficient or poor physician clinical documentation, while the remaining denials were attributable to either incorrect level-of-care determination by the physician that was not identified by the case manager, or accounts that potentially could go either way, from a level-of-care perspective.

Based upon the findings and the hospital administrator's forward- thinking commitment to not doing the same thing over and over and expecting different results, they have elected to embark on a unique approach to clinical documentation that endorses the notion of integrity in the communication of patient care beyond diagnosis capture. Documentation integrity, in the hospital administrator's mind, is defined by achieving complete and accurate documentation, beginning in the ED and progressing to the history and physical (H&P), progress notes, and discharge summary, to the extent that stakeholders can fulfill their roles in contributing to the overall healthcare delivery model in an efficient and effective manner. A byproduct of complete and accurate communication of patient care is a record that truly speaks for itself from a perspective of continuity of care, quality of care, and revenue integrity. I am so pleased to finally see a facility that recognizes that solidification and documentation of diagnoses in the record serves little purpose if the quality, patient-centered care provided is not reimbursed by third-party payors, keeping in mind that diagnoses identified through the query process represent a short-term gain without sustainable performance.

## Getting to the Nitty-Gritty: Meeting with Success

Instrumental to documentation integrity is defining a standard of documentation that physicians and other healthcare stakeholders agree to strive for and achieve, acknowledging and subscribing to the philosophy that quality of documentation is the hallmark of quality care and support of the revenue cycle and the mission of the hospital. The first phase of the project that I suggest to current hospital administrators and CDI leadership to consider entails defining this standard and outlining the expectations for communication of care within the ED note, the H&P, and the progress notes. Once this is accomplished, with physicians and case management/utilization review staff working together to draft a document that holds each discipline equally accountable, the real work of improving the integrity of clinical documentation begins. Physicians, residents, case management, utilization review, and the denials and appeals team should engage in several open-door forum workshops where representative cases of actual recent medical necessity denials were reviewed, and documentation insufficiencies identified and discussed. Moving forward, the team should begin to meet on a regular basis to review medical necessity denial cases in real time to ascertain what potential components of documentation require strengthening to best capture the clinical picture of each patient's reason for admission. Attention must be paid to: accurate reflection and reporting of severity of illness in the H&P; components of the physical exam incongruent with the patient's presenting signs and symptoms;

provisional as well as definitive diagnoses with appropriate clinical specificity not well documented; all relevant co-morbidities impacting the complexity and clinical management of patient care not documented; and lack of a rational plan of care congruent with the clinical assessment and judgment, as well as medical decision-making of the physician, including discharge plans. The primary goal in this first phase of the project is to enhance the value of communication of patient care that facilitates and simplifies the case management's and utilization review staff's ability to confidently seek the most clinically appropriate level-of-care status.

Case management and utilization have been empowered by physicians to point out opportunities for enhancement in clinical documentation in real time: this does not necessarily mean more documentation, just better documentation, created before they reach out to the third-party payors for authorization. I need to mention as a side note that documentation of appropriate clinical specificity in diagnoses is an integral part of the chart review process, with feedback provided to physicians and residents as needed. The aforementioned hospital is in the process of hiring a patient care communication facilitator, the title selected for the clinical documentation integrity specialists that is synonymous with communicating patient care, as opposed to merely communicating diagnoses. This individual will be working in tandem with the case managers and utilization staff, as well as the physicians and residents, to affect positive proactive change in patterns of documentation with supportive diagnoses, fulfilling the requirement of the medical record serving first and foremost as a communication tool versus a billing and reimbursement tool. A solid and complete medical record that reports the clinical facts, clinical information, and context of the case, adequately telling and retelling the story, whereby you can actually find the patient in the story, was the driving force behind the hospital's commitment to buck the trend of employing CDI specialists to pump out queries in the hopes of snagging diagnoses for reimbursement purposes only.

## Performance with Purpose

Structuring a CDI initiative to drive meaningful and measurable improvement in documentation that is sustainable over time, with all stakeholders working in tandem for the right reason, achieves real performance with purpose. A truly holistic approach to documentation integrity that puts the patient directly in the spotlight for excellence in communication of patient care circumvents the tendency to become caught up in the phenomenon of clinical documentation integrity processes that foster an environment of chasing dollars.

Chasing dollars with key performance indicators that promote retroactive, repetitive, knee-jerk tasks in the name of money naturally promotes miscoding and upcoding. Case-mix increase targets set yearly for CDI to achieve creates a perverse incentive to create even more queries in the hopes of generating more revenue, which doesn't always necessarily turn into real net patient revenue.

The announcement of the OIG's new initiative to investigate and address any identified systemic hospital specific upcoding or miscoding should be ample motivation to transform current counterproductive, counterintuitive CDI processes that set up compliance risk by unrelentingly focusing upon CC/MCC capture. The OIG's data analysis and data mining techniques to identify aberrant patterns of documentation and coding can result in a costly outcome for any facility.

Res ipsa loquitur, i.e. "the thing speaks for itself.