Clinical Documentation Integrity (CDI) Physician Onboarding
Southeast Region

AdventHealth

What is CDI?

CDI (Clinical Documentation Integrity) is a program developed to assist the providers in documenting the most accurate, compliant, and concurrent documentation for each patient:

- Accurate MS-DRG/APDRG Assignment
- POA Status
- Out comes and statistical analyses
- Accurate reflection of patient's SOI and ROM
- Hospital, specialty and physician quality of care, including patient safety and outcome measures
- Communication of patient's overall health status to all providers to facilitate complete inpatient and discharge treatment plans.

Goals are:

- Compliance
- Improved Patient Care-diagnosis specificity
- Improved Accuracy of Documentation
- Assisting to Protect Provider and Facility Profile.

The Role of Clinical Documentation Specialist (CDIS)

Team of RNs, APRNs, MDs/DOs with a minimum of 5 years of acute care experience.

- To be Clinical knowledgeable
- Understand Medicare rules and regulations
- Understand documentation options, and the impact on severity and mortality ratings
- Review medical records 1–2-day post admission, and thereafter every 24-48 hours.
- Educate on Best Practice Documentation
- To help physicians understand the impact of their documentation
- Provide the support physicians needs to translate their clinical knowledge into terminology which can be coded to document severity of illness

How is CDI support provided?

- Request for specific additional documentation based on the records' current clinical findings, risk factors, and treatment-Clarifications/Queries sent through the electronic medical record, verbal Queries

- **Query type may be for additional documentation regarding:**
  - Principle diagnosis clarification
  - Procedure clarification (i.e., Excisional debridement vs Non-excisional)
  - CC (Comorbid Conditions) clarification
  - MCC (Major Comorbid Conditions) clarification
  - Severity clarification-Specificity
  - Present on Admit status-POA
  - Clinical Validation-Unsupported or inconsistent documentation
  - Conflicting documented diagnosis

Websites like Hospital Compare and Healthgrades, as well as private payers like Blue Cross/Blue Shield, use this same coded data in formulas to calculate individual physician and hospital profiles and organizational scorecards. These can impact a provider's reputation and ability to deliver patient care.

Lab Values

Coders cannot code from lab values alone. The provider must name the associated disorder they are treating such as hypo or hypernatremia, hypo or hyperglycemia, and hypo or hyperkalemia.

It is important to capture these diagnoses as they are risk adjusters and comorbidities that help with LOS, SOI, and ROM. They help with complete, thorough, and accurate documentation of the patient's visit.

- **Hyponatremia and Hypernatremia-** A recent study revealed that patients with hyponatremia (especially older individuals with co-morbid conditions) had an increased risk of death in hospital, at 1 year and at 5 years as compared to patients with normal sodium levels. Incidence of increased mortality was demonstrated even in patients with "mild" hyponatremia (130-134 mEq/dl).

  An example of provider documentation, "Na+ 125 – replace with IV NS", is not enough to capture hyponatremia. The provider must document the word, "hyponatremia" to capture the diagnosis.

- **Diabetes-** Many physicians believe they are providing adequate documentation of a diabetic complication when they document, "Diabetes uncontrolled". There is no default code for uncontrolled diabetes. Effective with ICD-10, diabetes is classified by type and whether it is hyperglycemia or hypoglycemia. If the documentation is not clear a clarification will be sent to the provider so the appropriate code may be reported.

- **Hypokalemia and Hyperkalemia-** An example of provider documentation, "K+ 3.0 – replace with p.o. potassium supplement", is not enough to capture hypokalemia. The provider must document the word, "hypokalemia" to capture the diagnosis.

Documentation Tips

Avoid	Document Instead
• ↓Na	• Hyponatremia
• Sodium 162	• Hypernatremia
• Blood glucose elevated	• Hyperglycemia
• ↑ calcium	• Hypercalcemia

Protecting your profile

- 84 y/o female presented to ER with fever/chills, vomiting, urinary frequency
- VS: HR 98, RR 24, T 102, BP 90/70
- Labs:
  - WBC 13.8, 12% segs
  - Blood culture negative/urine cultures positive
  - Urine 3+ bacteria, WBCs TNTC

MS-DRG	MS-DRG Title	RW	GMLOS
690	Kidney & Urinary Tract Infection w/o MCC	0.80	2.9 Days

"Dr., could you clarify whether this patient had *sepsis due to UTI* at the time of admission?"
Agree. Documentation change:
   "***Probable sepsis* on admission**"

MS-DRG	MS-DRG Title	RW	GMLOS
872	Septicemia or Severe Sepsis w/out MV 96+ hours w/o MCC	1.02	3.6

Interact

Access Methods-Mobile APP

- Login using your AdventHealth network username and password

- Enable a passcode on your mobile device and remain logged in for 90 days

- Receive real-time notifications

- Icon badge indicator for pending clarifications
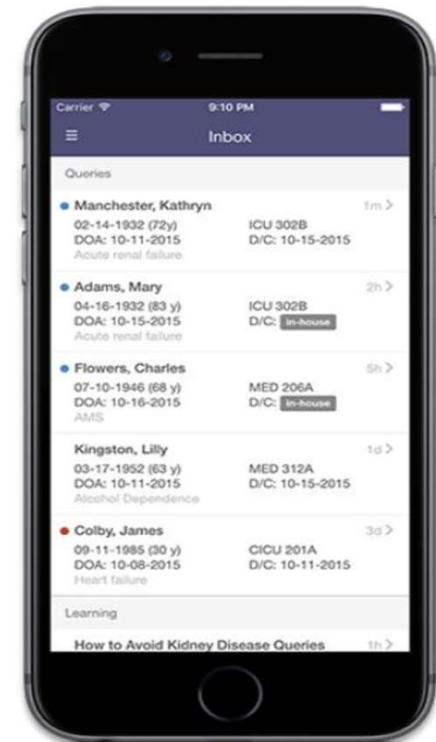
Access Methods - Epic

- If you decide to answer your queries at a different time, you can always click the Interact external link from the Epic toolbar.

- If you are logged into Epic on a desktop computer, you'll see the Interact launchpoint on the main menu.

Access Methods - Epic

- If you are logged into Epic on a laptop, you'll click the yellow carrots, then select Interact from the dropdown list.
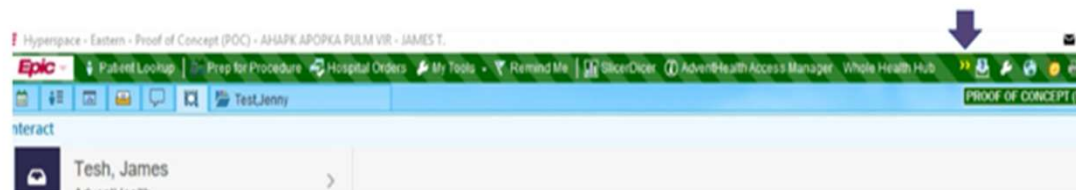
How to contact CDI

- Our Frontline CDI are basically remote. There are some that go onsite a few days/week.

- If you have questions, please reach out. We are available phone, secure chart, or email

CDI Title	Name	Mobile Number	Email
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Extending the Healing Ministry of Christ