THE POWER OF BEING UNDERSTOOD

CLINICAL DOCUMENTATION IMPROVEMENT (CDI) SERVICES

The health care industry is undergoing great change, with ever-growing importance placed on physician documentation. In this era of value-based purchasing, Recovery Audit Contractor audits, quality initiatives and the implementation of ICD 10, the need for explicit documentation depicting efficiency and quality that captures the patient's true severity of illness and medical necessity has never been greater.

Proactively addressing the documentation of present on admission (POA), Medicare severity-diagnostic related groups (MS-DRGs), all patient refined (APR)-DRGs and the significant risk factors involved in every diagnosis with specificity has become imperative for health care organizations like yours, especially in meeting the appropriateness of patient care and justifying the consumption of resources.

Documentation in the health record, whether on paper or electronic, is one of the cornerstones for health care providers. Only accurate, consistent and complete documentation can translate into the data and information necessary to ensure clinical quality, substantiate medical necessity, or the most appropriate reimbursement. The latest regulatory initiative that will increase these efforts is the move from ICD 9 clinical modification (CM) coding system to ICD 10 CM for diagnosis, and ICD 10 PCS for procedures performed in acute care settings. Because of the increased number of codes available and their corresponding level of detail, your documentation efforts must be just as detailed and provide the additional required information.

How can we help?

RSM's health care professionals provide a variety of key services and assistance to address your CDI needs, including:

- Provide education to physician providers and coding staff members to increase their clinical knowledge of the specificity inherent in ICD 9 and ICD 10 and how it necessitates more detailed documentation in the medical record
- Identify and clarify any confusing, incomplete, conflicting or missing information in the medical documentation portion of the health record
- Collaborate communications between members of the coding and CDI team and medical staff

Provider documentation touches a multitude of areas

- Provide continuity of care for the patient by the members of the health care team who rely on the documentation in the health record to determine ongoing treatment decisions
- Provide a more robust and accurate depiction of patients' severity of illness and risk of mortality as supported by APR-DRGs
- Quantify and clarify, within the medical documentation, the resources used during the patient's hospitalization
- Help meet revenue cycle goals, such as submission of clean claims and reduction in days in accounts receivable
- Provide education around clinical documentation to support accurate quality scores with concurrent and retrospective reviews

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