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THE CCDS EXAM *Study Guide*

UPDATED FOR 2012!

Fran Jurcak, RN, MSN, CCDS

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HCPro

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HCPro, Inc.
75 Sylvan Street, Suite A-101
Danvers, MA 01923
Telephone: 800/650-6787 or 781/639-1872
Fax: 800/639-8511
E-mail: *customerservice@hcpro.com*

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ABOUT THE AUTHOR

Fran Jurcak, RN, MSN, CCDS, has more than 25 years of experience as a nurse, nursing professor, and consultant, with clinical experience in critical care and emergency medicine. Currently a director in the CDI Practice at Huron Healthcare in Chicago, Jurcak has helped implement CDI programs in more than 50 hospitals in the past five years. Jurcak taught as an assistant professor of nursing at Madonna University in Livonia, MI, for more than 15 years, and earned recognition as "Faculty Advisor of the Year" in 2006.

Jurcak obtained her CCDS in 2009. She serves on the CCDS Exam Committee, and was recently named to the Association of Clinical Documentation Improvement Specialists (ACDIS) Advisory Board. She is a member of the Michigan chapters of ACDIS and Healthcare Financial Management Association.

ABOUT THE REVIEWER

Paul Evans, RHIA, CCS, CCS-P, is the supervisor for the clinical data integrity/quality department at California Pacific Medical Center in San Francisco. Evans previously served as a project manager at Laguna Medical Systems where he was responsible for a staff of 12 senior auditors performing compliance reviews at more than 30 hospitals.

Evans has a Bachelor of Science degree in business administration from Centenary College and a Bachelor of Science degree in health information management from Louisiana Tech University. A member of both the American Health Information Management Association and ACDIS, Evans has contributed to multiple articles regarding quality and data management and is a frequent contributor to the CDI Talk networking group on the ACDIS website.

PROFESSIONAL ASSOCIATIONS

ACDIS

The Association of Clinical Documentation Improvement Specialists (ACDIS) is a community in which clinical documentation improvement (CDI) professionals share the latest tips, tools, and strategies to implement successful CDI programs and achieve professional growth. Its mission is to serve as the premier healthcare community for clinical documentation specialists, providing a medium for education, professional growth, program recognition, and networking.

Huron Consulting

Huron Consulting Group helps clients in diverse industries improve performance, comply with complex regulations, resolve disputes, recover from distress, leverage technology, and stimulate growth. The company teams with its clients to deliver sustainable and measurable results. Huron provides services to a wide variety of both financially sound and distressed organizations, including leading academic institutions, healthcare organizations, Fortune 500 companies, medium-sized businesses, and the law firms that represent these various organizations.

INTRODUCTION

A Note From the Editor

This study guide has been updated from the 2010 edition to reflect changes in ICD-9-CM codes, coding guidance, industry best practices, and government initiatives. No significant changes have been to the Certified Clinical Documentation Specialist (CCDS) Exam itself, although new and revised questions are introduced on the test annually. Major revisions to the exam and to this study guide are expected to coincide with the implementation of the ICD-10-CM/PCS coding system.

About *The CCDS Exam Study Guide*

The CCDS Exam Study Guide is designed to provide support to individuals seeking the Certified Clinical Documentation Specialist (CCDS) credential based on the criteria established by ACDIS.

As a consultant, I've implemented CDI programs and trained professionals for the CDI specialist's role in multiple hospitals across the country. Frequently, CDI staff members have asked whether an education program or guidebook is available to help them prepare for the certification exam. In this book, I hope to provide you with insight into the theory and regulations that support the CDI role, as such awareness, I believe, provides for successful completion of the certification exam.

Exam Origins

Work on the CCDS credential began in 2008 as a service of ACDIS to answer members' demand for a nationally recognized mark of distinction and professionalism specific to CDI specialists. At the time, ACDIS selected an 11-member volunteer advisory board to help develop the CCDS certification. The board's now 12-member multidisciplinary group comes from diverse backgrounds, including health information management/coding, nursing, case management, quality, and compliance. The board reviews exam questions and content and updates the test as warranted by changes in the industry and CDI best practices.

Applied Measurement Professionals, Inc. (AMP) provides ACDIS with administrative support for the certification process, including exam development, validation, and other administrative tasks. AMP applies industry standards for development of practice-related, criteria-referenced exams to assess competency. It provides practice analyses and development of exam specifications, psychometric guidance to the CCDS advisory board to assist with exam question writing, development of content, and creation of valid exam instruments, scoring, and reporting of results.

Content Focus

The CDI specialist's role is complex and multidisciplinary, suitable for clinically knowledgeable professionals who are proficient in analyzing and interpreting medical record documentation and capable of tracking and trending their CDI program goals and objectives. These professionals possess knowledge of healthcare and coding regulations, as well as anatomy, physiology, pharmacology, and pathophysiology. Further, such professionals possess the valuable ability to engage physicians in dialogue and educational efforts regarding how appropriate clinical documentation benefits patient outcomes and the overall well-being of the healthcare system.

The exam content is based on analysis of the activities of CDI specialists in a wide range of settings, hospital sizes, and circumstances. Through input from ACDIS membership in survey responses and through the research of the advisory board, seven core CDI competencies were identified:

- Healthcare regulations, reimbursement, and documentation requirements related to the inpatient prospective payment system (IPPS)
- Anatomy and physiology, pathophysiology, pharmacology, and medical terminology
- Medical record documentation
- Healthcare facility CDI program analysis
- Communication skills
- *ICD-9-CM Official Guidelines for Coding and Reporting*
- Professionalism, ethics, and compliance

This study guide focuses on content areas identified in the ACDIS *CCDS Candidate Handbook* with particular attention to the *ICD-9-CM Official Guidelines for Coding and Reporting* and identification

of clinical indicators for use in the query process. After completion of the study guide, participants will be able to:

- Understand the IPPS and the impact of appropriate documentation on this system
- Correctly apply coding guidelines and rules to proper assignment of a diagnosis-related group
- Identify clinical indicators requiring more precise documentation for reflection of the severity of illness of the patient
- Accurately measure program success through use of appropriate metrics

CCDS Candidate Requirements

Because ACDIS developed the CCDS credential to recognize individuals with a proven ability to work as CDI specialists, candidates for the CCDS designation are required to have at least one year of experience in the profession. Additionally, candidates must have some college-level education. Successful candidates must achieve a passing score on the certification exam, which tests the candidate's ability to abide by documentation and coding regulations and apply his or her experience and knowledge to typical scenarios that clinical documentation specialists encounter in their profession.

Candidates who wish to take the certification exam must meet all the general requirements and at least four prerequisites; a complete listing is available on the ACDIS website *(www.cdiassociation.com/certification.cfm)* and on p. 7 of the *CCDS Certification Handbook*.

Exam Structure

The exam is an objective, multiple-choice test consisting of 120 questions, 100 of which AMP uses to compute the final score. The exam questions have been designed to test the candidate's multidisciplinary knowledge of clinical, coding, and healthcare regulations, as well as the roles and responsibilities of a clinical documentation specialist. Answer choices will be identified as A, B, C, or D, and the exam will consist of the following question types:

- **Recall questions** test the candidate's knowledge of specific facts and concepts relevant to the day-to-day work of CDI professionals. The exam is an "open book" test; candidates may use reference resources in answering recall questions, as this is the manner in which CDI professionals frequently carry out their responsibilities.

- **Application questions** require the candidate to interpret or apply information, guidelines, or rules to a particular situation.
- **Analysis questions** test the candidate's ability to evaluate and integrate a range of information in problem-solving to address a particular challenge.

According to the CCDS certification website, approximately 40% of the questions can be classified as the recall type, 40% as the application type, and 20% as the analysis type. This study guide provides more than 50 sample questions and answers to help you test yourself and gauge your readiness for the exam. The sample questions included in Appendix A of this book were independently drafted by the author and reviewer. *They are not actual questions from the exam.*

Successful completion of any important exam is based on several factors, one of which is thorough preparation for the exam content. With the preparation work behind you, take some time the night before the exam to enjoy a nice meal, unwind, and sleep well. Relax; the hard work is the day-to-day tasks of the CDI specialist. The exam is simply a test of the abilities you possess.

UNDERSTANDING THE INPATIENT PROSPECTIVE PAYMENT SYSTEM

To understand how clinical documentation influences hospital reimbursement, clinical documentation improvement (CDI) specialists must first understand how the federal government, through the Centers for Medicare & Medicaid Services (CMS), pays for those services. CMS administers Medicaid, Medicare, and other government health insurance programs. The number of Americans receiving Medicare is expected to rise from 46 million in 2010 to 78 million by 2030, according to a Kaiser Family Foundation report.[1] Therefore, many facilities operate primarily on funding from the federal government. CDI professionals need to understand how that reimbursement system works to fully comprehend how documentation improvement influences patient care and facility finances.

Inpatient Prospective Payment System Implications

Hospitals receive government funding for the services they provide through the inpatient prospective payment system (IPPS). Generally speaking, the IPPS pays hospitals on a per-discharge basis for Medicare patients who have received inpatient care. The federal government intended to use the IPPS, which was introduced in October 1983, as a way to influence hospital behavior through financial incentives; in effect, encouraging more cost-efficient management of medical care.

Other insurers also pay for hospital care. While these companies may reimburse facilities for the care of insured patients on a similar system, IPPS rules only apply to Medicare's reimbursement practices. While many CDI programs start by concentrating solely on CMS-related services, common best practices encourage facilities to include all payers in their CDI analysis. The goal of improved documentation and patient care should be consistent across payers and disease type, not just improved healthcare documentation for patients who happen to have government insurance. In addition, the goal of improved documentation and patient care should not focus only on high-cost services such as acute respiratory failure or any other special circumstance.

When there is a lack of consistency in policies and procedures (e.g., reviewing Medicare and not private payers), the risk for potential misuse and abuse increases. A facility that targets only government payers could expose itself to a greater risk of external government audits. A review of all payers will help your facility see how Medicare patients stack up against other national payers. If you look only at Medicare, you skew your data.

Diagnosis-related group definitions

Under IPPS, CMS categorizes the care each patient receives during his or her stay into a diagnosis-related group (DRG) at discharge. In this way, each patient's stay is "summarized" into a DRG based on the principal diagnosis and up to 24 secondary diagnoses that indicate comorbidities and complications treated during the patient's hospital stay. The final DRG may also contain up to 25 procedures completed during the patient's stay.[2]

CMS annually reviews the DRGs to ensure they accurately reflect similar conditions that require comparable resource consumption. For example, the cost for the diagnosis and care of a patient admitted for acute respiratory failure roughly equals the cost of care for a patient with pulmonary edema. Both patients require immediate care with oxygen therapy, nebulizer treatments, and analysis of the cause of their respiratory distress. Such analysis may include radiological tests, pulmonary function testing, and monitoring of oxygen saturation levels. Both of these conditions have a unique International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code, but they "group" to the same DRG, which is 189, pulmonary edema and respiratory failure. (See Chapter 2 for more information on the origins and implications of the ICD-9-CM codes and coding guidelines.)

Further calculations must be made to determine how much money the government pays the facility for its services. Each DRG has a payment weight, a number CMS assigns based on a scale of 0 to 24, that indicates the average resource consumption used to treat Medicare patients in that DRG. This payment weight, or relative weight (RW), is then multiplied by individual hospital base rates. CMS recalculates those base rates annually to reflect differences in operating expenses as well as capital expenses such as property-related costs.

The DRG system, which was originally implemented in 1986, did not allow reimbursement for patients with multiple conditions treated during a single hospitalization. To better account for this population's severity of illness (SOI) and the resources such treatment required, CMS developed the

Medicare Severity DRG (MS-DRG) system in October 2007. MS-DRGs require reporting of comorbid conditions or complications of care. This is the DRG system currently in use. It identifies up to three levels of SOI for specific diagnostic categories:

- Major complication and comorbidity (MCC): the highest SOI indicators
- Complication and comorbidity (CC): a lower level of SOI
- No complication and comorbidity (without CC/MCC): the lowest level of SOI and resource consumption

Like the initial DRG systems, each MS-DRG also has an assigned RW that "ranks" the condition and resource consumption for the care provided. One purpose of the three different levels of severity categories is to encourage complete and accurate documentation in the medical record by providing financial incentives to do so. Thus, cases graded as MCCs would garner higher reimbursement from Medicare.

Take the example of a patient admitted with pneumonia whereby the physician documents only pneumonia in the patient's medical record. Without further information or documentation, the coder identifies this as pneumonia, not further specified, with the ICD-9-CM code of 486. (See Chapter 2 for more information regarding ICD-9-CM.) This code then groups to either MS-DRG 193, 194, or 195 depending on other documented conditions. If the patient has no identified CC, the final reported MS-DRG would be 195, simple pneumonia and pleurisy without CC/MCC. Such a patient would require simple, straightforward treatment including the use of antibiotics, monitoring of chest x-rays, and white blood cell counts.

However, if the patient also has a qualifying CC such as chronic diastolic heart failure, the patient's final reported MS-DRG would be 194, simple pneumonia and pleurisy with CC. This patient's care requires a bit more resource consumption, as the patient will also receive medication and monitoring for the chronic diastolic heart failure. If the patient experienced an acute event of heart failure and the physician documents that treatment appropriately as acute diastolic heart failure, then MS-DRG 193, simple pneumonia and pleurisy with MCC, would be reported. This patient's care would probably require use of IV medications (diuretics) and more monitoring, possibly even telemetry or an ICU bed. The RW associated with each MS-DRG reflects a higher SOI and resource consumption, as you can see in Figure 1.1.

Figure 1.1 | **POSSIBLE PNEUMONIA MS-DRGS**

DRG	Title	CC/MCC	Relative Weight
193	Simple pneumonia and pleurisy	With MCC	1.4378
194	Simple pneumonia and pleurisy	With CC	0.9976
195	Simple pneumonia and pleurisy	Without CC/MCC	0.7095

Remember that Medicare's final reimbursement does not consider the length of time the patient stays in the hospital. Although appropriate reimbursement is important, the CDI specialist's primary role is accurate documentation of SOI. The RW assigned to each MS-DRG should accurately reflect the patient's condition and resource consumption to best indicate the SOI, risk of mortality (ROM), and document appropriate length of stay (LOS). Review of SOI and ROM levels provides a higher level of detail about a patient's condition and the care the facility provided. Improving SOI and ROM indicators strengthens hospital quality data and physician report cards by more accurately detailing the nature of the patient's illness and expected outcomes.

Severity adjustment systems use a structure similar to MS-DRGs, with one global category: the DRG. However, a severity adjustment system differs from MS-DRGs in that it further adjusts the data into four subclass levels for SOI and another four subclass levels for ROM. Both subclasses exist through a numbered ranking system:

1. Minor
2. Moderate
3. Major
4. Extreme

SOI indicates how sick the patient is, and ROM refers to probability of death.[3]

Following the IPPS Formula

Determining a hospital's individual base rate or reimbursement is a complicated process best left for the hospital chief financial officer. However, a quick description is in order to allow for better understanding of the IPPS. CMS describes the following steps on its website, *www.cms.hhs.gov/AcuteInpatientPPS*.[4]

Step 1

Hospitals submit a bill for each Medicare patient they treat to their Medicare fiscal intermediary (FI), a private insurance company that contracts with Medicare to carry out the operational functions of the Medicare program. Based on the information provided on the bill, the FI categorizes each case into an MS-DRG, which determines how much payment the hospital receives.

Step 2

Medicare multiplies the base payment rate by the MS-DRG RW. The base payment rate is a standard amount that is divided into a labor-related and non–labor-related share. CMS adjusts the labor-related share by the wage index applicable to the area where the hospital is located. The non-labor share is adjusted by a cost-of-living factor.

Step 3

If CMS recognizes the hospital as serving a disproportionate share of low-income patients, the facility receives a percentage add-on adjustment for each case paid through the IPPS. This percentage varies depending on several factors, including the percentage of low-income patients served. CMS applies the adjustment to the MS-DRG base payment rate, plus any outlier payments received.

Step 4

CMS pays an add-on amount to approved teaching hospitals for indirect medical education. This additional payment varies depending on the ratio of residents to beds under the IPPS for operating costs and according to the ratio of residents to average daily census under the IPPS for capital costs.

Step 5

CMS also provides an additional payment for cases that include technologies that meet the new technology add-on payment criteria.

Step 6

On occasion, CMS may consider a specific patient's stay as an abnormal situation. Such patients consume a considerable amount of facility resources. CMS identifies these as outliers and increases payments for such situations to protect the hospital from large financial losses due to unusually expensive cases. CMS adds all outlier payments to the base payment rate to determine the final reimbursement payment for the hospitalization.

SUMMARY

The hospital's base reimbursement rate depends on standardized amounts that include provisions for operating and capital expenses. Other reimbursement considerations include:

- Indirect costs for graduate medical education (resident training)
- Adjustments for disproportionate share of low-income patients
- Adjustments for new technology
- Reduced payment for patients transferred to another acute care facility or certain postacute care facilities

Major diagnostic category definitions

DRGs are assigned using the principal diagnosis, secondary codes, surgical procedures, sex of the patient, and the discharge status of the patient. One DRG is assigned for each inpatient stay. A case is assigned to a major diagnostic category (MDC) based upon the principal diagnosis, and each MDC is further divided as either surgical or medical. An MDC is a classification based upon body systems.

Two groups of DRG are not assigned to MDCs, including:

- DRGs associated with all MDCs. These typically have invalid principal diagnoses, have operating room procedures unrelated to a principal diagnosis, or are ungroupable.
- Pre-MDC DRGs. This group is composed of cases classified by surgical procedure rather than principal diagnosis—for instance, organ transplant cases and tracheostomy cases.

Multiple ICD-9-CM codes often group to the same MS-DRG indicating a similar condition or similar resource use. To correctly assign the appropriate MS-DRG, coders must identify the principal diagnosis, or primary condition, that required the patient's admission and treatment. Acute care hospitals use the Uniform Hospital Discharge Data Set (UHDDS) definitions to report inpatient data elements in a standardized manner. UHDDS defines the principal diagnosis as:

> *"[T]he condition established after careful study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."*[5]

Healthcare providers may not always identify the principal diagnosis at the time of admission. For example, a patient admitted with abdominal pain due to an intestinal obstruction may have a primary diagnosis of small bowel cancer that is diagnosed after further testing and analysis.

As identified in the pneumonia example cited previously, MS-DRGs require clear and consistent documentation of all conditions treated during the patient's hospital stay. Additional and secondary diagnoses should be reported when they affect patient care in regard to the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and monitoring

Healthcare providers must clearly document procedures that affect the patient's care to allow appropriate assignment of the final MS-DRG. A patient can have multiple procedures during a single hospital stay, yet according to IPPS rules the hospital may assign only one surgical DRG per patient per admission. Consequently, Medicare groups multiple procedures determined by a surgical hierarchy within the MS-DRG system.

SUMMARY

Factors that affect DRG assignment include:

- Principal diagnosis
- Secondary diagnosis
- Procedure
- Gender
- Discharge status
- Birth weight for neonate

Present-on-Admission Effects

In 1999, the Institute of Medicine (IOM), a nonprofit, nongovernment organization, reported that medical errors represent one of the leading causes of mortality in the United States. In particular, the IOM noted that medical error–related deaths came primarily from complications caused by a patient's hospital stay.

The findings consequently led Congress to authorize CMS to alter its reimbursement to hospitals for patients who suffer a preventable condition. Essentially, CMS stopped paying for conditions caused, even inadvertently, by the care the facility provided. In 2007, CMS implemented this policy by directing hospitals to have coders identify which conditions were present on admission (POA) versus those that occurred or were diagnosed during the patient's hospital stay, identified as hospital-acquired conditions (HAC).[6]

A condition is considered POA if:

- The physician includes the phrase "present on admission" in the documentation
- The condition is included in the patient's past medical history list
- The condition was diagnosed during the admission but was clearly POA (e.g., chronic conditions and cancers)

- The diagnosis was "possible," "probable," "rule out," "suspected," or "differential on admission," and was confirmed at discharge
- The condition developed during an outpatient encounter, such as in the emergency room, physician's office, outpatient surgery, or observation
- The signs and symptoms of the condition were clearly POA, listed later in the record as a diagnosis with a POA[7]

Clearly, if a condition cannot be identified as POA, it will not meet the criteria for a principal diagnosis and cannot be identified as such. However, the guidelines do allow for a condition that was not clearly identified as POA in early notations to be accurately classified as POA in later documentation, particularly if the condition required further analysis or study to be correctly recognized.[8]

The POA indicator is a relatively new element associated with most (but not all) ICD-9-CM Volume 2 codes, and providers have been required to report POA indicators since October 1, 2007. The goal of the POA indicator is to better define clinical conditions or consequences that arise during an inpatient admission. Reporting options include the following:

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission
- U = documentation is insufficient to determine whether condition is POA
- W = provider is unable to clinically determine whether condition was POA
- Unreported/Not Used (or "1" for electronic billing) = exempt from POA reporting

In October 2008, as part of CMS' patient-safety initiatives, the agency announced that it would no longer pay for certain HACs documented as secondary diagnoses. The payment limitation applies to conditions that were not POA (indicator N) or cases in which there is insufficient documentation to determine whether a condition was POA (indicator U).

On January 15, 2009, CMS announced three national coverage determinations (NCD) aimed at protecting patients from having to pay for preventable surgical errors. The new national policies state that Medicare will not reimburse for services related to:

- Wrong surgery or other invasive procedures performed on a patient
- Surgery or other invasive procedures performed on the wrong patient
- Surgery or other invasive procedures performed on the wrong site[9]

These three policies represent recent steps in CMS' initiative to highlight patient safety in hospitals and to reduce the incidence of "never events"—28 serious reportable events the National Quality Forum says should never happen in a hospital.[10]

Although POA, HAC, and never event efforts strive toward the common goals of improving patient care and avoiding preventable medical errors, CDI professionals must keep the following points in mind:

- Medicare covers services related to HACs, although the facility receives only a portion of the typical reimbursement when the claim includes POA indicator N or U
- Medicare will not cover any aspect of service related to the three wrong-site surgery never events specified in the NCDs
- Unlike an HAC, a never event prevents any payment for the hospital and physicians involved in the procedure

CMS now prohibits hospitals from billing the Medicare program for never events and prohibits Medicare payment for these events. Generally, patients with these diagnoses have a longer LOS and use more hospital resources and therefore are often elevated to a higher-paying MS-DRG.

POA INDICATORS

In 2007, CMS announced that it would curtail payments to hospitals for specific conditions that a patient acquires while an inpatient and that can be "reasonably prevented" by following established evidence-based guidelines. Therefore, it is important to identify if the following conditions are POA:

- Foreign object retained after surgery, such as a sponge or needle inadvertently left in a patient after surgery (998.4, a CC)
- Air embolism, which is an air bubble that enters the bloodstream and can obstruct the flow of blood to the brain and vital organs (958.0, a CC)
- Blood incompatibility—that is, a transfusion with the wrong type of blood (999.6, a CC)
- Pressure ulcer stages III and IV, or severe pressure ulcers
- Falls and trauma:
  - Fracture (CC)
  - Dislocation (open is a CC)
  - Intracranial injury (CC)
  - Crushing injury (CC)
  - Burn (CC)
  - Electric shock (CC)
- Catheter-associated urinary tract infection (CC)
- Vascular catheter-associated infection (CC)
- Manifestations of poor glycemic control:
  - Diabetic ketoacidosis (CC)
  - Nonketotic hyperosmolar coma (CC)
  - Hypoglycemic coma (CC)
  - Secondary diabetes with ketoacidosis (CC)
  - Secondary diabetes with hyperosmolarity (CC)
- Surgical site infection (CC) following coronary artery bypass graft
- Mediastinitis
- Surgical site infection (CC) following certain orthopedic procedures:
  - Spine
  - Neck
  - Shoulder

POA INDICATORS (CONT.)

- Surgical site infection (CC) following bariatric surgery for obesity:
  - Laparoscopic gastric bypass
  - Gastroenterostomy
  - Laparoscopic gastric restrictive surgery
- Deep vein thrombosis (CC) (a blood clot in a major vein) and/or pulmonary embolism (CC) (blockage in the lungs) following certain orthopedic procedures:
  - Total knee replacement
  - Hip replacement
  - Fractures of the arm (added in 2010)
  - Ulna
  - Radius and ulna
  - Elbow
- Acute Infection following transfusion, infusion, or injection or blood and blood products

Quality Indicators and Reimbursement

The reporting of quality indicators began as a voluntary collection of 10 specific pieces of hospital quality performance information (see Appendix B). Since then, the program has expanded to include additional quality indicators. Initially, CMS tied the reporting of those indicators to financial incentives; however, beginning in fiscal year 2010, hospitals that fail to submit to CMS information regarding 42 quality measures will receive a 2.1% reduction in their market basket, the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients.

Starting October 2012, Medicare will begin paying hospitals for quality measures, according to a CMS fact sheet released April 29, 2011. The new Hospital Value-Based Purchasing program adopts performance measures under two "domains":

Clinical process, composed of 12 measures

Patient experience, composed of the Hospital Consumer Assessment of Healthcare Providers and Systems survey

Furthermore, beginning in 2013, hospitals with excess 30-day readmissions for patients admitted with heart attacks, heart failure, and pneumonia will see a reduction in payments. By 2015, a portion of Medicare payments will be linked to effective implementation of electronic health records and payment reductions will be punishment for certain HACs.[11]

Because the collection of quality data depends on the final patient diagnosis, the CDI specialist's role is of great value to the quality assurance team. Identification of the principal diagnosis and effective communication between the CDI specialist and the quality team helps identify medical records that the quality team needs to review. Because CDI specialists concurrently review the medical record while the patient remains in the hospital, communication with the healthcare team can help ensure that physicians capture quality indicators in their documentation as well.

IPPS Drawbacks

Unfortunately, medical terminology doesn't always mirror Medicare's coding and billing languages. What a healthcare provider often perceives as a clear medical diagnosis may require greater specificity for appropriate code assignment.

Take congestive heart failure (CHF), for example. Healthcare providers routinely document the diagnosis of CHF and the plan of care used to treat it. However, ICD-9-CM code assignment requires indication of whether the CHF is an acute or a chronic condition and the specificity of the type of heart failure (i.e., systolic, diastolic, or combined). If the professional coder cannot clearly identify the type of CHF, the coder will record the patient's care at a nonspecific code, one that would not accurately identify the patient's SOI.

Clinically, there are many times when the documentation does not clearly identify the patient condition. Healthcare providers often use language that indicates the signs and symptoms the physician treats without documenting the final medical diagnosis. Conversely, healthcare providers may also not clearly indicate a condition that is being treated, requiring clarification before final coding can be completed.

Recognizing this lack of appropriate documentation requires intense scrutiny of the medical record and direct dialogue with the healthcare team to ensure appropriate documentation of the medical conditions the facility provided.

To rectify this situation, a coder could retrospectively query the provider for the required specificity. Because retrospective queries occur after the patient leaves the hospital, they hinder the billing process and increase the number of unbilled charts. The time delay between patient discharge, provider response, final coding, and final billing creates a burden on the facility. Clearly, a more effective process is necessary to ensure accurate and timely response to documentation queries.

A concurrent documentation program supports documentation that leads to:

- Accurate identification of patients' SOI
- A true indication of the ROM
- Support for medical necessity and appropriate LOS
- Clarification of POA diagnoses
- Appropriate hospital and physician profiles
- Reduction in denials for medical necessity and reimbursement issues
- Reduced risk of recovery audit contractor audits and compliance issues
- Appropriate reimbursement

Concurrent queries secure medical record documentation that supports regulatory compliance. Through the query/clarification process, CDI specialists serve as a resource to healthcare providers, nurses, and/or coders to identify clinical indicators of patient conditions that are not clearly documented, and ensure accurate descriptions of the diagnosis so it can be easily coded by the inpatient coder.

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Fran Jurcak, RN, MSN, CCDS

This study guide prepares candidates for the Certified Clinical Documentation Specialist (CCDS) exam. Each section reviews core content established by the CCDS Certification Board and contains sample questions for self-testing.

The CCDS Exam Study Guide reviews:

- Inpatient Prospective Payment System (IPPS)
- *ICD-9-CM Official Coding Guidelines* and selected entries from *AHA Coding Clinic for ICD-9-CM*
- Query processes and procedures
- Common clinical conditions and indicators for query opportunities
- CDI program metrics and data analytics
- Recovery Audit Program and CDI ethics

About the CCDS credential

The CCDS credential is the recognized certification for professionals in the clinical documentation improvement field.

Professionals who obtain the CCDS credential have:

- Demonstrated a clinical knowledge base
- Shown competencies in DRG validation and core coding principles
- Illustrated verbal and written physician query techniques
- Developed concurrent medical record analysis capabilities
- Incorporated compliance initiatives into their CDI programs

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To learn more about prerequisites for taking the exam or to apply, visit *www.cdiassociation.com/certification*.

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HCPro
75 Sylvan Street, Suite A-101
Danvers, MA 01923
www.hcmarketplace.com

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