CORE CDI

February 2018 Newsletter

CDI Tip of the Month:

When opening a record for review, initially focus upon the H & P History of Present Illness. There are eight elements of an HPI with an emphasis upon present illness. The HPI documentation should be concise yet clear and paint an overwhelming picture of the patient's presenting signs and symptoms and other factors represented by the eight elements, accurately reporting and reflecting the patient clinical acuity and need for hospital level of care.

See Link below under Additional Resources below for more information about HPIs.

Read Core CDI's Latest Blog!

"Key Performance Indicators-Revisited" – 02.10.2018

"Staunching The Tide of Medical Necessity Denials" – 02.01.2018

"Medical Necessity to Germane to CDI" – 01.24.2018

Additional Resources

Are You Moving The CDI Needle

E & M Service Guide

Clinical Documentation Improvement-A Path for Success

Clinical Documentation Improvement Specialists have a responsibility to continually advance and grow their careers through self-education, attendance at webinars, in-person conferences and teleconferences, possessing an insatiable appetite for learning and expanding their breadth and depth of knowledge in principles of clinical documentation. Reference to career growth is made towards furthering one's knowledge and understanding of solid principles of clinical documentation beyond methodologies of reimbursement including the MS-DRG system, CCs/MCCs, Hospital Acquired Conditions, Present on Admission indicators, and Severity of Illness and Risk of Mortality reporting

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Evaluation and Management- A Clinical Perspective-The Art of Communicating

Evaluation and Management (E & M) from a clinician perspective versus a coding and billing perspective is distinctly different. A clinical perspective entails resorting to William Osler's thoughts on what the medical record stands for, that is a means for the physician to observe, record, tabulate and communicate the actual care provided. The advent of the electronic health record, the increasing mandates for reporting supposed measures of quality promulgated by CMS, and the increasing focus on "optimizing" E & M assignment and billing has seriously upended the focus and spirit of documentation other than for communication of patient care. This phenomenon is even more magnified given the movement of physician practices selling out to hospitals and health systems and now being "employed," with the employer setting high expectations for physician relative value units generated with patient encounters.

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