Welcome to THIE

Hot Topics Forum
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Voice Products

Voice Products was established in Wichita, KS in June of 1990. We are a multifaceted company that offers a vast array of technological solutions.

We are the leading provider of Voice, Video, and Call recording in the Midwest and provide service and training for industries across the US, Canada, and Mexico.

Customer service is our top priority. Over 85 percent of our staff is devoted to customer service.

Businesses and vendors defer to Voice Products' expertise in Speech Recognition, Digital Dictation, Medical Document Management, Medical Coding and Clinical Documentation Improvement.

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Voice Products

We also provide solutions for legal, law enforcement, child advocacy and E911 agencies providing technology for courtroom and interview room recording, video surveillance, body worn cameras, NextGen 911 and customer interaction recording and analytics.

We have provided installation and training for some of the largest agencies in the nation including Homeland Security, CDC, Border Patrol, and the Federal Bureau of Engraving and Printing to name a few.

CLINICAL DOCUMENTATION IMPROVEMENT

Value Beyond Reimbursement

CDI

Clinical Documentation Improvement

Clinical Document Improvement, also referred to as “CDI”, is one of the hottest topics in the healthcare industry.

CDI is at the core of every patient encounter.

It must be accurate, timely and reflect accurately the scope of services provided.

Successful CDI programs facilitate the accurate representation of the patient’s clinical status that is then translated into coded data.

Coded data is then translated into reimbursement.

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What is CDI?

Clinical Documentation Improvement, “CDI”, is the recognized process of improving healthcare records to ensure improved patient outcomes, data quality and accurate reimbursement.

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Who is Responsible for CDI?

A Clinical Documentation Improvement Specialist (CDIS) facilitates and obtains appropriate physician documentation for any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of care of the patient.

Clinical Documentation Specialists typically come from either an HIM or Nursing background.

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HIM Background

Health Information Management

HIM professionals, through their education, are familiar with compliant documentation rules and regulations, as well as accreditation standards that affect timely billing.

They are familiar with coding rules and regulations.

HIM professionals are also familiar with important areas such as privacy, security and confidentiality that impact sharing of clinical information.

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Nursing Background

Nurses have long played a role in Clinical Documentation Improvement.

Nurses have a strong clinical background which helps them identify gaps in the clinical evidence and documentation.

Nurses typically have strong communication skills when querying providers is necessary.

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CDIS

Clinical Documentation Improvement Specialist

CDIS-Clinical Documentation Improvement Specialists are responsible for collaborating to effectively articulate all the pieces which include:

- Documentation requirements
- Code assignment
- Coding guidelines
- Quality reporting

Successful CDI programs include a myriad of people, processes and technology to be successful.

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CDIS

A Clinical Documentation Improvement Specialist (CDS) facilitates and obtains appropriate physician documentation for any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of care of the patient.

They have a sufficient knowledge of clinical documentation requirements, DRG assignment, and clinical conditions or procedures.

They educate members of the patient care team regarding documentation guidelines, including attending physicians, allied health practitioners, nursing, and case management

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Expectations

They must have an understanding of complications, comorbidities, case mix, and the impact of procedures on the billed record.

They should have the ability to educate members of the patient care team regarding documentation guidelines, including attending physicians, allied health practitioners, nursing, and case management.

They should have sufficient knowledge of clinical documentation requirements, DRG assignment, and clinical conditions or procedures.

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CDIS Workflow

Completes initial reviews of patient records within 24–48 hours of admission for a specified patient population (usually they target certain payors).

Evaluate documentation to assign the principal diagnosis, pertinent secondary diagnoses, and procedures for accurate DRG assignment, risk of mortality, and severity of illness.

Initiate a review worksheet.

Conducts follow-up reviews of patients every 2–3 days to support and assign a working or final DRG assignment upon patient discharge, as necessary.

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Responsibilities

Queries physicians regarding missing, unclear, or conflicting health record documentation by requesting and obtaining additional documentation when necessary.

Educates physicians and key healthcare providers regarding clinical documentation improvement and the need for accurate and complete documentation in the health record.

Collaborates with case managers, nursing staff, and other ancillary staff regarding interaction with physicians on documentation and to resolve physician queries prior to patient discharge.

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Responsibilities

Participates in the analysis and trending of statistical data for specified patient populations to identify opportunities for improvement.

Assists with preparation and presentation of clinical documentation monitoring/trending reports for review with physicians and hospital leadership.

Educates members of the patient care team regarding specific documentation needs and reporting and reimbursement issues identified through daily and retrospective documentation reviews and aggregate data analysis.

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CDI/Coding

The focus for health systems has always primarily been on reimbursement .

As a part of the American Recovery and Reinvestment Act, Electronic Health Records became mandatory January 1, 2014

Over the last 5 or 6 years, providers and health systems have worked diligently to improve their processes.

Technology was introduced to streamline some of those processes.

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Computer Assisted Coding

The health care industry began to embrace and adopt the technology of computer assisted coding to prepare for anticipated revenue loss with the implementation of ICD-10.

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Evolution of CAC

Most early CAC applications were “word spotting” software that consisted of rules that assigned codes. Only 3 or 4 vendors offered Natural Language Processing or NLP

Although the technology was helpful to coders identifying the new code set, they lacked a common space to coders to work.

Only a few were able to integrate with encoders and billing software.

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Coding Challenges

Missing Information
Clarification on Test Results
Diagnoses without supporting lab/diagnostic results
Vague Documentation
Conflicting Information
Documentation supports SOI/ROM
Query Response Rate
Late Arriving Documentation

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Query

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.

Queries are initiated by both, CDIS (Pre and Post Discharge) and coders (Post Discharge) as needed.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

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CAC Today

Computer Assisted Coding has Evolved to include Artificial Intelligence-also known as AI-suggests codes and can help coders identify critical indicators.

Chart Prioritization is automated with flexible workflow. Charts are distributed to coders based on hospital needs making the process much for efficient.

Provides capability to extensively report on data embedded in the record.

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CDI/Coding

Collaborative Role in Reimbursement

CDIS-Clinical Documentation Improvement Specialists have the task of helping identify and communicate opportunities and risks related to documentation inefficiencies in the health record

Coding professionals are devoted to identifying the correct codes to accurately represent patient care, resources consumed, severity of illness, and risk of mortality.

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Technology Challenges

Often the software used between CDI and Coding are different, therefore the information collected, queries, notes and working/final outcomes are in different data silos.

How Can CDI and Coding Professionals work in collaborative space to promote communication and achieve common goals?

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Leverage Technology

Leveraging the same technology used in Computer Assisted Coding, Clinical Documentation can be utilized to provide:

Live feed and capture of CDI data

Customized CDI Worksheets

Automated Assignments

Customized Assignment Priority based Payor, impact, etc.

Integrated Standard Queries

Prioritizing Cases

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CDI
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Better documentation

Improved communication

Optimized accuracy and efficiency

Increased recognition of comorbid condition responsive to treatment

Validated care provided

Demonstrated compliance with quality and safety guidelines

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Prioritize Cases

Clinical Indicators/Diagnosis

- 30 Day Readmission
- HCC Indicators
- CC/MCC Indicators
- Core Measure/PSI/PQRS/HAC Indicators

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HCC Indicators

The ability for CDI software to extract indicators is very significant and will become more significant in the future.

A Hierarchical Condition Category (HCC) is defined as a risk adjustment model that is used to calculate risk scores to predict future healthcare costs.

AHIMA published a very insightful document titled “Ins and Outs of HCCs” by Valerie Fernandez, MBA, CCS, CPC, CIC, CPMA

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HCC Indicators

AHIMA published a very insightful document titled “Ins and Outs of HCCs” by Valerie Fernandez, MBA, CCS, CPC, CIC, CPMA

When it comes to HCCs, all roads lead to clinical documentation improvement. Reimbursement and the level of available health plan services are directly linked to the accuracy, specificity, and overall quality of a physician’s clinical documentation. Quality documentation then enables more meaningful data exchange between provider and carrier.

http://bok.ahima.org/doc?oid=302154#.Wplm8sKWy00

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HCC Indicators

As value-based healthcare continues to expand, HCC coding and an emphasis on its accuracy will become even more important. With the nationwide rise of chronic conditions, the benefits of the HCC risk adjustment model ensures proper allocation of resources to treat high-cost patients while also identifying opportunities for disease management intervention and improving the quality of our nation's healthcare.

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CDI
Beyond Reimbursement

Quality Reporting

Physician Report Cards

Public Health Data

Disease Tracking and Trending

Marketing

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Technology Available

There are very few vendors on the market today that provide the ability to integrate technology in a collaborative manner required for coding, billing, and CDI.

Dolbey has been awarded the prestigious recognition award from KLAS for Category Leader for the last 2 years in a row.

Voice Products is a dealer for Dolbey's award winning Computer Assisted Coding and integrated CDI solution.

We offer 3 CDI options

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CDI Options

Standalone Mode

CDI Standalone

- Minimal Interfaces
- Quick Deployment (60-90 days)
- Offers CDI tools and Financial Impact Reporting

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CDI Options

CDI with NLP

CDI with NLP

- Requires Interface to EMR
- Typical Deployment of 6 months
- Can be added on to the CDI standalone at anytime.
- Offers Standalone Features and Chart Prioritization/Query Opportunities

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CDI Options

CAC/CDI with NLP

CAC/CDI with NLP Unified Solution

- Requires Interface to EMR
- Typical Deployment of 6 months
- Can be added on to options 1 & 2 at anytime
- Offers all features from Options 1 & 2, plus the ability for increased coder productivity, AutoClose and Late Arriving Documentation functionality
- Single application/platform

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Thank You!

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