Clinical Documentation Improvement Programs- Baylor Scott & White Whistleblower Dismissal
Five Key Points- Time for Reflection & Process Transformation
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Last month U.S. District Judge David Ezra in Texas dismissed a whistleblower lawsuit brought against Baylor Scott & White for more than $61.8 million over seven years. The whistleblower alleged the Texas health system engaged in a upcoding scheme to systematically overcharge Medicare led by a health system employed physician. This scheme was not in reality fraudulent in nature; instead the health system was utilizing what is referred to as "clinical documentation improvement programs" where primarily nurse clinical documentation improvement specialists review the medical record while patient is hospitalized, looking for and identifying opportunities to clarify physician documentation in the form of specific diagnoses known as CCs and MCCs that improve reimbursement. Capturing and recording of these diagnoses by the physician facilitates higher reimbursement through assignment of a more resource intensive MS-DRG.

The CDI profession has expressed relief of this dismissal of the whistleblower lawsuit, interpreting the judge's dismissal on the basis of Federal Register IPPS Final Rule that "states the agency does not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to optimize Medicare payment that is supported by documentation in the medical record" to mean continue present CDI practices in the name of maximizing reimbursement. A cautionary approach to CDI is in order given the inherent financial and compliance risk associated with any initiative that strictly focuses upon "maximizing reimbursement without correlating attention to the quality and completeness of supportive physician clinical documentation. Bear in mind the December 2018's OIG addition to its Work Plan titled "Assessing Inpatient Hospital Billing for Medicare Beneficiaries" (OIG Work Plan Addition) in which the OIG previously identified problems and concerns with upcoding, the practice of mis-or-overcoding to increase payment. As a result, the OIG announced a two-part study to assess inpatient hospital billing with the goal of identifying, focusing upon and targeting certain hospitals and ICD-10 codes for a medical review to determine the extent to which the hospital billed incorrect codes. Miscoding or overcoding is a byproduct of "up documentation" and "over documentation" often times perpetuated by overzealous CDI programs with the unrelenting program Key Performance Indicators centering around Case-Mix Index and maximized reimbursement. CDI programs must avoid the temptation to rest on their laurels with the dismissal of the whistleblower lawsuit, convinced of the legitimacy of optimizing reimbursement without concomitant meaningful measurable improvement in documentation and communication of patient care quality and accuracy.

Five Key Points to Consider

- CDI programs should not rest solely on CC/MCC capture as the main goal of the program. Optimal reimbursement that is less prone to denials and external reviewer focus is predicated upon solid complete and consistent clinical documentation.
- Health record documentation must support multiple initiatives within the organization including adequate reflection and depiction of the true patient clinical situation that facilitates and serves as a primary communication tool for all providers.
- A strong high performing revenue cycle is built on a foundation of complete and accurate clinical documentation and communication of patient that withstands the test of retrospective payer denials and external reviewers
- CDI programs must transform into a prospective forward thinking multidisciplinary cooperative approach to educate providers on best practice standards and principles of documentation
- The vision of CDI must embrace patient centric consideration rather than sole optimization of reimbursement.