

## REGISTRATION NOW OPEN!



### **The Partnership**

CHIMA and 3M are proud to announce a new partnership to deliver a Clinical Documentation Improvement (CDI) Specialist Certificate Program that will lead to Advanced Certification in CDI.

### **The Program**

This comprehensive, fully on-line program is being developed by 3M for certified Health Information Management (CHIM) professionals or international equivalents; nurses; and regulated health professionals who meet the eligibility criteria. It will provide an advanced level of competency and specialty for those working in, or wishing to work in, Clinical Documentation Improvement specialist positions. This program, endorsed by CHIMA, will lead to Advanced Certification in CDI.

This program has 12 modules each designed with multiple lessons of online education. The time it takes to complete this program varies based on the learner's previous experience with this content and their learning style. Individuals will have a maximum of 12 months to complete the program.

### **Target Audience**

This program is for HIM professionals, nurses, and regulated health professionals who have a strong foundation in anatomy, physiology, pathophysiology and pharmacology. These individuals would be able to read and analyze all the information in a medical record and identify any gaps. As the goal of CDI is to improve the accuracy and completeness of clinical documentation, these groupings of individuals are best equipped to assess the clinical evidence and carryout the necessary follow-up, including querying and educating physicians.

As this Program will lead to Advanced Certification in CDI, candidates must meet one of the eligibility requirements below:

1. Certified Health Information Management (CHIM) professional and a CHIMA member in good standing or international equivalent with a minimum of 3 years of current HIM work experience in:
  - Coding and/or,
  - CDI and/or,
  - Cancer Tumor Registry and/or,
  - Data Analysis utilizing ICD-10-CA and CCI data.
2. Nurses with a minimum of three years experience working in a health care setting.
3. Other Regulated Health Professionals who have recently worked in clinical documentation improvement for a minimum of 3 years. (Candidates must also have completed course work in Anatomy and Physiology, Medical Terminology and Pathophysiology)

If you have significant experience but do not meet these requirements, please contact us to discuss.

## **Launch Date**

Program registration is open. Please contact [paula.weisflock@echima.ca](mailto:paula.weisflock@echima.ca) with any registration type questions for this professional development opportunity.

## **Why It's Important**

Now more than ever, a strong, highly respected clinical documentation improvement (CDI) Specialist program can make a difference in achieving the goals of improving quality care, improving case mix, and appropriate utilization of resources through quality information. In response to industry demand, 3M in partnership with CHIMA developed the program, which will lead to Advanced Certification in CDI.

## **Number of CHIMA CPE's**

You will earn 30 CPE's for completing this program.

## **Cost**

\$3900.00 + applicable tax (once registration is complete, there are no refunds).

## CDI Applicant Process Guidelines

Potential students should review the CDI Information and eligibility criteria on the CHIMA website found at this url.  
<https://www.echima.ca/professional-development/cdi>

If a potential student meets the admission criteria, they can register at the event link provided. They can pay either by charge card or by cheque. If the potential student has a problem with the processing of the \$3900.00 plus applicable taxes charge card fee, they should contact their bank, as their bank may require confirmation of the expenditure. Potential students are responsible to ensure they meet the criteria. Those who register and do not meet the requirements will not be eligible for reimbursement and may not be eligible for certification, once this option becomes available.

Potential students who are unsure if they meet the criteria can email [paula.weisflock@echima.ca](mailto:paula.weisflock@echima.ca). A review of the individual's application will be conducted. Upon a decision, the individual will be informed of the outcome. The individual will be sent the link to register if they are eligible. If they do not qualify to register, they will be informed of the necessary steps. Once those who meet the criteria have paid the applicable fee and their payment has cleared, the Director of PD at CHIMA will send a message to 3M who will email the individual a user ID and password to access the CDI program hosted on 3M's platform.

Once students are registered for the program and have their passwords, 3M will respond to any system issue questions. Students may contact the Director of PD at CHIMA for any CDI program administration questions. Upon an individual's successful completion of the program, 3M will notify the Director of PD at CHIMA and provide the name, final grade, and their program start and end dates. CHIMA will then send a certificate of completion with CPE credit information.

## **CDI program outline and examples:**

**The CDI program contains 12 modules in total.**

**Module 1** - Describes what CDI is, the importance and the challenges, medical record review and requirements, stages of CDI and the role of a CDI specialist

**Module 2** - Focuses on coding, classification, coding standards, and common guidelines

**Modules 3-11** provide a clinical review of common disorders and diseases, various coding standards and how they pertain to each system and a review of query indicators and opportunities. Specific guidelines and medical record documentation requirements are reviewed to support appropriate code assignment.

Module 3 – Diseases and Disorders of the Respiratory System

Module 4 – Diseases and Disorders of the Circulatory System

Module 5 – Diseases and Disorders of the Nervous System

Module 6 – Diseases and Disorders of the Digestive System

Module 7 – Diseases and Disorders of the Hepatobiliary System

Module 8 – Diseases and Disorders of the Endocrine System

Module 9 – Diseases and Disorders of the Renal System

Module 10 – Infectious diseases

Module 11 – Diseases and Disorders of the Musculoskeletal System

**Module 12** - Focuses on factors affecting or affected by code assignment, how to select charts for review, reviewing a chart, the query process and how to analyze the data

The following are examples taken from various modules:

### **Module 3 – Diseases and Disorders of the Respiratory System**

- **Medical**
  - Pulmonary embolism/edema
  - Pneumonia
  - Acute respiratory distress syndrome (ARDS)
  - Respiratory neoplasms
  - Pneumothorax
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Asthma

- Pleural effusion
- Respiratory distress/failure
- Pulmonary hypertension
- Flail chest/rib fracture(s)
- Acidosis/alkalosis
- Ventilator support
- **Surgical**
  - Tracheostomy
  - Common respiratory/chest procedures
  - Thoracentesis
  - Lung biopsy

In each of the above medical disorders we review the sign and symptoms...why? So the CDI specialist will be aware of or be able to pick up on a condition that was not documented properly or at all.

We review the documentation requirements required by the physician...why? So the CDI specialist we know what is required for coding compliance and therefore know what to query the physician for.

We review basic coding standards and how they apply in different situations? Why? So the CDI specialist will be more aware of what may be missing from a coded abstract, ie. Complication code or how to read a dagger asterisk convention, or the various coding standards that apply to diabetes.

We review clinical examples of lack of documentation for either a diagnosis or specificity and how that impacts the patients acuity once coded properly.

We touch on how an alternate diagnosis can change the MCC or CMG and the significance

We give examples of when and why a query would be necessary.

We have questions usually every third of the way through the modules to test knowledge as we go along. Here is an example from the respiratory module:

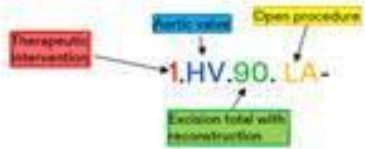
1. A CDI specialist would need to query the physician for pulmonary edema, if not documented in the chart, with a patient who has congestive heart failure. True or False? False. When pulmonary edema is evident with heart failure then coding of pulmonary edema would not be necessary as it is indicative of the heart failure.
2. A CDI specialist can assume a complication that occurs post surgery is related to the surgery itself. True or False? True. If the complication arises within 30 days of the surgery and is an uninterrupted episode of care, a complication can be assumed as due to a surgery/procedure if there are no other indications that the condition was caused by something else.
3. A CDI specialist would look for indicators of sepsis in a patient's chart who has documented ARDS. True or False? True. Look for SIRS or sepsis in the chart as these conditions are often present and associated with ARDS.

We have placed the information in terms that will be easier to learn no matter what the background.

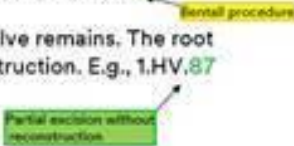
## Module 4 – Diseases and Disorders of the Circulatory System

- Medical
  - Acute coronary syndrome (ACS)
  - Myocardial infarction (MI)
  - Heart failure (HF)
  - Deep vein thrombosis (DVT)
  - Hypertension/hypotension
  - Cardiac arrhythmias
  - Angina pectoris/coronary artery disease (CAD)
  - Chest pain/cardiomyopathy/endocarditis
- Non-Operating Room Procedure Impacting CMG
  - Cardiac catheterization and mandatory coding
- Surgical
  - Coronary artery bypass graft)/valve repairs (CABG)
  - Percutaneous coronary intervention (PCI)
  - Percutaneous transluminal coronary angioplasty (PTCA)
  - Automatic implantable cardioverter defibrillator (AICD) procedures
  - Cardiac pacemaker

this is an example of teaching of CCI works:



- Cardiac valves include: aortic, mitral, pulmonary and tricuspid
- The root operation for a valve intervention is "90", which means excision total with reconstruction. For example, the code for an aortic valve is 1.HV.90.LA
- Different procedures other than "90" (excision total with reconstruction) could include
  - a Bentall procedure which is the replacement of the aortic valve, aortic root and (proximal) ascending aorta. The Bentall procedure is also a root operation of "90;" however, it is identified with a different qualifier than a aortic valve replacement. The qualifier for the Bentall procedure is "WJ" which means "open approach with special excisional technique." E.g., 1.HV.90.WJ
  - a David procedure is when the aortic root is replaced but the existing valve remains. The root operation changes to "87," referring to a partial excision without reconstruction. E.g., 1.HV.87



## Module 5 – Diseases and Disorders of the Nervous System

- Medical
  - Stroke/cerebrovascular accident (CVA)/cerebral infarction
  - Non-hemorrhagic CVA with tPA administration
  - Transient ischemic attack (TIA)

- Spinal cord injuries/fractures
- Brain neoplasms/tumors
- Neuropathy
- Seizure disorder/epilepsy
- Meningitis
- Cerebral edema/brain herniation/coma
- Subarachnoid/intracerebral hemorrhage
- Multiple sclerosis
- Parkinson's disease/Alzheimer's
- Surgical
- External ventricle drain (EVD)
- Clipping of aneurysm
- Spinal fusion
- 

This is an example of a query example:

## Cerebrovascular Accident Query Opportunity

A patient is admitted with a rt. MCA cardio embolic CVA; left sided weakness is documented in the chart. The patient is unable to void, as per nursing notes, the bladder is scanned for 800 ml of urine and a Foley catheter is ordered and inserted. A urine culture is sent to the lab and is positive for E. coli; the patient is placed on antibiotics.

A query opportunity exists for documentation of a diagnosis for hemiplegia, urinary retention and UTI.

	CVA	With urinary retention	With UTI	With hemiplegia
ELOS	4.5	5.9	9.0	14.2
RIW	0.8164	1.0043	1.7482	2.9185
Financial impact	\$4898.40	\$6025.80	\$10,489.20	\$17,511.00

### Module 6 – Diseases and Disorders of the Digestive System

- Medical
  - Digestive malignancy
  - Gastritis
  - Gastrointestinal hemorrhage
  - Peptic ulcer disease/varices
  - Esophagitis and gastroenteritis
  - Hernia
  - Diseases of the liver
  - Dehydration
  - Anemia

- Peritonitis
- Inflammatory bowel diseases
- Surgical
  - Hernia procedures
  - Endoscopic interventions
  - Lysis of adhesions
  - Digestive procedures

Example of a slide pertaining to anemia:

Anemia: Look at lab values of hemoglobin for decreasing values as well as administration of blood or blood products

- Often the physician may need to be queried for a secondary diagnosis correlating to the drop in hemoglobin and transfusion of blood or blood products (and specify the type of anemia)
- In patients with a massive GI bleed, physicians may document hemodynamically unstable
- Review for signs and symptoms of hypotension and hemorrhagic or hypovolemic shock, acidosis and electrolyte abnormalities. Query the physician as required
- For example, if a patient has received ferrous gluconate, question why did they receive it. There should be a correlating diagnosis for every medication a patient receives. Ensure to review the medication documentation record

## **Module 7 – Diseases and Disorders of the Hepatobiliary System**

- Medical
  - Fatty liver disease
  - Cirrhosis and hepatitis
  - Malignancy
  - Liver disease
  - Liver failure/encephalopathy
  - Cholelithiasis
  - Cholecystitis
  - Cholangitis
  - Pancreatitis
- Surgical
  - Liver transplant
  - Cholecystectomy



# Cirrhosis (cont'd)

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- Physician documentation should include the type of cirrhosis, such as

- alcoholic
- biliary
- congenital
- hepatic
- other



- When reviewing the chart look for the type of cirrhosis and any evidence of complications query for clarification, if the conditions met the criteria of significance

## Module 8 – Diseases and Disorders of the Endocrine System

- Medical
  - Diabetes
  - Skin ulcers
  - Hyper/hypothyroidism
  - Electrolyte imbalances
  - Adrenal gland disorders
  - Syndrome of inappropriate antidiuretic hormone secretion (SIADH)
  - Dehydration
  - Malnutrition
  - Cystic fibrosis
  - Blood disorders
- Surgical
  - Thyroidectomy and biopsy

# Diabetes Classification

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- As a review from module two, diseases and conditions can be classified using dagger asterisk conventions, code combinations, “code separately” and “code also” (using additional codes for mandatory assignment). Diabetes is a good example pertaining to these coding standards. We will review each and how they apply
- The established link between diabetes and many other conditions such as PVD, renal conditions, such as CKD, retinopathy, neuropathy, etc., can be assumed and would not need to be queried, as there is a dagger asterisk convention that applies in these cases
- When there is a dagger asterisk convention, the CDI specialist can assume the relationship or cause and effect between the conditions and the physician would not need to be queried. The CDI specialist would need to use a program that classifies the conditions, to know if it is a dagger asterisk convention in these cases. Remember in the dagger asterisk convention a diagnosis type 6 is assigned to the asterisk code when the condition fulfills the requirements for the MRDx
- Combination codes are also used. When classifying a condition, in this case diabetes, and the code title includes a “with” complication then the cause and effect relationship can be assumed. E.g., diabetes with foot ulcer or diabetes with DKA; therefore in this example, a cause and effect relationship is not required by the physician

## Module 9 – Diseases and Disorders of the Renal System

### Medical

- Acute renal failure
- Chronic kidney disease
- Glomerulonephritis
- Hydronephrosis
- Neoplasms of kidney and urinary tract
- Urolithiasis
- Urinary tract infections
- Prostate

### Procedures

- Lithotripsy

### Surgical

- Nephrectomy/nephrostomy
- Prostate interventions

# UTI Concepts, Coding and Documentation

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## **Bacteremia due to a UTI are both coded separately if both receive treatment**

- An additional code for the specific causative organism may be assigned and may reflect a more accurate RIW/ELOS and support length of stay due to a resistant organism

## **Urosepsis is non-codeable**

- If the physician documents urosepsis, it classifies to urinary tract infection; it does not classify it to sepsis
- It is the physician's responsibility to document the specific codeable diagnosis, such as UTI, UTI with sepsis

## **Clarify if the condition is secondary to a device (specify device)**

## **Documentation should specify the associated organism**

- Do not assign a code based on abnormal lab values without physician confirmation of the diagnosis

## **Module 10 – Infectious diseases**

- Medical
  - Bacteremia
  - Septicemia, sepsis, severe sepsis, septic shock
  - Urinary tract infection (UTI) concepts
  - Postoperative/central line infections
  - Fever
  - Drug-resistant microorganisms
  - Human immunodeficiency virus (HIV)
  - Viral illnesses

# Infectious Disease Review

Clinical Terms (Documentation needs clarification)	Diagnostic Statement (Accurate code may be assigned)
SIRS	Identify the source of SIRS such as sepsis, severe sepsis, SIRS due to a noninfectious process (pancreatitis, neoplasm). Documentation should specify both the systemic infection, if present, and the localized infection, if known or suspected and any organ dysfunction
Urosepsis	Documentation should specify the intended diagnosis such as UTI, sepsis or severe sepsis and specify any organ dysfunction and presence of shock. Urosepsis is not a codeable diagnosis
UTI, fever, BP 70/40, AMS, anuria, + blood culture, ↑BUN/Cr, ordered IV antibiotics, IV fluid	Severe sepsis (defined as sepsis with acute organ dysfunction), acute renal failure (document specificity if known or suspected, such as ATN)
Fever, ↓BP, hemodynamically unstable, multisystem organ failure, IV fluid bolus started, dopamine ordered	Shock; documentation should specify the type, such as cardiogenic, septic, hypovolemic

## Sepsis Documentation Review

- Occasionally, the terms “bacteremia,” “septicemia,” “sepsis” and “SIRS” are used interchangeably or indiscriminately in medical records
  - physicians need to clearly document the term that accurately describes the patient’s condition and update the diagnosis if the patient progresses along the sepsis continuum as the condition is treated or resolved
  - if patient has both bacteremia and sepsis, the relationship needs to be clarified (sepsis due to bacteremia, bacteremia with sepsis)
- SIRS due to an infectious process (e.g., SIRS due to pneumonia)
  - additional clarification of the related systemic infection is required
- SIRS due to a non-infectious process (e.g., SIRS due to trauma)
  - documentation should include if there is associated acute organ dysfunction

### Module 11 – Diseases and Disorders of the Musculoskeletal System

- Medical
  - Fractures
  - Arthritis/osteoarthritis
  - Osteomyelitis
  - Spinal stenosis
  - Gout
  - Rhabdomyolysis
  - Intervertebral disc disorder
- Interventions/Surgical
  - Amputation
  - Wound debridement
  - Joint replacements

- Spinal fusions

## Pathological Fractures (cont'd)

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- Other terms for pathologic fracture include
  - chronic fracture
  - collapsed vertebra
  - insufficiency fracture
  - non-traumatic compression fracture
  - non-traumatic fracture
  - spontaneous fracture
  - wedging of vertebra<sup>5</sup>
- Look for these terms as a hint for the fracture type as pathological, and query appropriately for the diagnosis and cause

## Fracture Concepts and Other Injuries

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- Pathological and stress fractures are also reported with specification as to the episode of care the patient is receiving (initial episode, subsequent encounter with routine healing, delayed healing, non-union or malunion, or for sequela from the original fracture)
- Dislocations, sprains and strains are also reported with specification as to the episode of care
- For a fracture to be classified as pathological the physician has to document a cause and effect between the underlying condition and the fracture
  - e.g., for a patient with a history of osteoporosis admitted with a non-traumatic fracture, the physician has to relate the fracture to the history of osteoporosis before it can be coded as a pathological fracture

**Module 12** - Focuses on factors affecting or affected by code assignment, how to select charts for review, reviewing a chart, the query process and how to analyze the data