Dr. Remer's Clinical Documentation for Healthcare Providers learning modules

Introducing the first learning modules explaining best practices in clinical documentation created by a physician for physicians and other healthcare providers. Dr. Erica Remer, a nationally renowned clinical documentation expert, draws on her 25 years of clinical practice to engage fellow clinicians and inspire them to improve their documentation.

The modules were updated or created in 2023 and packaged together in a single comprehensive course. Participants can view any or all modules and claim up to 8.0 hours of *AMA PRA Category 1 Credits*™ as commensurate with their effort.

There are modules focused at hospital-based providers and modules which are applicable to any practice, modules which are aimed at general documentation and ones which suit specialties or are topic-specific. They are excellent for practicing and new/onboarding providers. Institutions can purchase team memberships for their providers, with discounts available for teams over 10 members, upon request. Clinical documentation integrity specialists may also benefit from watching these modules.

These are the available modules and some of the topics addressed in each. Service line and topic-specific modules have asterisks:

1. **Best Documentation Practices: The Good, The Bad, and The Risky (0.5 hours CME)**
    a. Why we document
    b. Clinical communication is most important, but many reasons for documentation
    c. What constitutes good documentation
    d. Medical necessity considerations
    e. Telling the story
    f. History and physical components
    g. Data
    h. Medical Decision Making in Course/Assessment
    i. Best practice diagnoses
    j. Risky practices
    k. Discharge summary

2. **Documentation to Demonstrate Quality of Care and Reimbursement (0.75 hours CME)**
    a. What constitutes Quality in medicine
    b. The concept of risk adjustment
    c. Understanding Diagnosis Related Groups (DRGs) and the associated metrics
    d. Quality programs like Hospital Acquired Conditions (HACs), HACRP, Patient Safety Indicators, and Mortality Metrics
    e. The relationship between metrics and money
    f. MACRA, MIPS, and APMs
    g. Population Health Management and Hierarchical Condition Categories

3. **Clinical Documentation: How CDI Can Help (0.75 hours CME)**
    a. Principles of Clinical Documentation Integrity
    b. CDI is not fraud

c. Good documentation in the context of CDI
d. CDI conditions, such as encephalopathy, functional quadriplegia, heart failure, and respiratory failure

4. **<u>Documentation for Medical Necessity (0.75 hours CME)</u>**
   a. Without medical necessity, no billable service
   b. Understanding what medical necessity is
   c. Who judges medical necessity and by what standards
   d. Status determination
   e. The misunderstanding of observation as a status
   f. The difference between inpatient and outpatient for observation services
   g. 2 midnight expectation
   h. Difference between Medicare and commercial payers
   i. Best practice documentation for medical necessity
   j. Condition Code 44
   k. Copy and paste is not the friend of medical necessity

5. **<u>Documenting for your Dinner: MDM and Time tips (0.75 hours CME)</u>**
   a. Professional billing and Evaluation and Management level of service
   b. Primary need for medical necessity for a billable service
   c. Medically appropriate history and physical
   d. Three elements of medical decision making (MDM)
   e. Problems must be addressed: MEATIeR
   f. What is a chronic problem and how to specify not at goal
   g. Tests and need for interpretation in complexity of data
   h. Prescription drug MANAGEMENT
   i. Risk includes drug therapy requiring intensive monitoring, parenteral controlled substances, de-escalation or not undertaking recommended treatment
   j. Social determinants of health (SDoH)
   k. Choosing level of service based on time
   l. Critical care time
   m. Split/shared
   n. Templates and attestations

6. **<u>Coding for Clinicians: Principles for picking the best ICD-10-CM diagnosis codes (0.75 hours CME)</u>**
   a. Clinicians are not coders, but they are asked to pick ICD-10-CM codes
   b. What is ICD-10-CM
   c. Official Guidelines for Coding and Reporting
   d. AHA Coding Clinic
   e. Coding conventions and guidelines 101
   f. Using signs and symptoms correctly
   g. Integral/inherent to
   h. As many codes as it takes
   i. Specificity to include acuity, linkage, laterality
   j. Z codes
   k. Specific conditions like HIV, sepsis, COVID-19, diabetes

    l. “Personal history of”

7. **<u>Controlled Substances Documentation: Protecting you and the patient (0.5 hours CME)</u>**
    a. Controlled substances, especially opioids, is a huge problem and many providers have issues with their Medical Boards on the basis of their documentation
    b. Documentation of the initial work-up includes:
        i. Medical history (indication, previous work-up and treatment, comorbidities, effect of pain on function, risk factors for substance use disorder
        ii. Physical exam
        iii. Assessment tools
        iv. Review of old records
        v. Baseline urine drug screen (UDS)
        vi. Prescription drug monitoring program inquiry
    c. Agreement/informed consent/pain contract
    d. Documenting treatment plan and goals
    e. “Do not refill until____” prescriptions
    f. Maintenance of medication list
    g. Frequency of follow-up and repeat UDS
    h. Templates
    i. Copy and edit
    j. 5 As of Narcotic prescribing
    k. How to document drug seeking behavior

8. **<u>Sepsis: Aligning practice with principle* (0.75 hours CME)</u>**
    a. The history of sepsis
    b. Definition of Sepsis-2 and Sepsis 3; comparing and contrasting
    c. All that is SIRS is not sepsis
    d. SOFA and qSOFA
    e. Avoiding sepsis-adjacent documentation
    f. Avoiding conflicting documentation
    g. Clinical validation of sepsis

9. **<u>Clinical Documentation in the ED: Helping your hospital, helping your group* (1.0 hours CME)</u>**
    a. What constitutes Quality in medicine
    b. The concept of risk adjustment
    c. Understanding Diagnosis Related Groups (DRGs) and the associated metrics
    d. Medical necessity and status
    e. Diagnoses in the ED
    f. ED-specific CDI conditions, such as encephalopathy, cardiac arrest, Type 2 MI, and trauma

10. **<u>Clinical Documentation: CDI and Quality for Surgeons* (0.75 hours CME)</u>**
    a. What constitutes Quality in medicine
    b. The concept of risk adjustment
    c. Understanding Diagnosis Related Groups (DRGs) and the associated metrics
    d. Patient Safety Indicators
    e. Principles of Clinical Documentation Integrity

f. CDI querying for surgeons
g. Surgeon-specific CDI conditions, such as sepsis, peritonitis, malnutrition, shock, and excisional debridement

11. <u>Clinical Documentation: CDI and Quality for Neurosurgeons* (0.75 hours CME)</u>

a. What constitutes Quality in medicine
b. The concept of risk adjustment
c. Understanding Diagnosis Related Groups (DRGs) and the associated metrics
d. Patient Safety Indicators
e. Principles of Clinical Documentation Integrity
f. CDI querying for surgeons
g. Neurosurgeon-specific CDI conditions, such as brain compression, coma, encephalopathy, residua from brain conditions, and coagulopathy

ROI: Imagine if your providers changed their behavior and improved their documentation and CC/MCC capture rate consistently!

DRG number	DRG name	CC/MCC designation	Relative weight	$, w/base rate $6000	Difference between highest and lowest tier
025	Craniotomy & Endovasc Procedures	w/ MCC	4.5405	$27,243	$12,487
027		No CC/MCC	2.4954	$14,756	
871	Sepsis	w/MCC	1.9572	$11,743	$3,951
193	Simple Pneumonia	w/MCC	1.2987	$ 7,792	

2023 MS-DRG Relative weights

For further questions or to discuss an institutional discount, contact Dr. Remer at icd10md@outlook.com