What's next

Healthcare

What's in the CMS FY2020 IPPS Final Rule?

In August, the Centers for Medicare & Medicaid Services (CMS) released their 2020 Final Rule. Mel Tully, Nuance's VP of Clinical Services and Education, highlights some of the changes and what they represent.

Melinda "Mel" Tully
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With the release of their FY2020 IPPS Final Rule, CMS appears to be sending a clear message: they're working to transform the healthcare delivery system to bring patients better

value and better outcomes. The new policies reflect some historic changes as well as more traditional, expected updates; in all cases, the Final Rule has important implications for clinical documentation improvement (CDI) professionals.

A few highlights:

- First and foremost, the Final Rule encompasses more than 2,000 pages of text that include many changes to co-morbidities (CCs) and major CCs (MCCs), and ICD-10-CM codes. The volume of changes is extensive and calls for the most accurate documentation and coding possible in order to capture appropriate specificity for all procedures and supplemental codes.
- Consider an example: with perioperative haemorrhage or hematoma, is it is very important to distinguish between ecchymosis, which is flat bruising; hematoma, bruising that does have a mass; and haemorrhage, which is excessive blood loss. Some procedures inherently have a large volume of expected blood loss. If this is the case, documentation should reflect whether the blood loss is within limit expected for the procedure. If the clinical documentation does not clearly describe the circumstances of the haemorrhage or hematoma, whether it is routinely expected or inherent to the procedure, or whether it is a complication, it's incumbent upon the CDI professional to ask the question and assure the most accurate documentation possible.
- Second, a range of updates in the FY20 rule accounts for innovations in healthcare devices and pharmaceuticals. In short, CMS does want hospitals to take advantage of innovations that contribute to better patient care and outcomes. Within the Final Rule, new technology add-on payments provide additional dollars to hospitals for each case that uses resources for approved new technology and breakthrough pharmaceuticals. And while some technologies have been discontinued, this is an important opportunity to look at what devices and drugs are in use in your organization, learn about new technologies, and expand your clinical knowledge.

Ultimately, the impact of precision coding and clinical documentation integrity permeates every use of patient information. From clinical care and care coordination to research, quality reporting, and billing, providers and CDI professionals alike must consider the impact of clinical documentation integrity in an environment that mandates better patient care at a lower overall cost. Quality is not a clinical intervention; it's a pervasive approach to all aspects of patient care. The accuracy, quality, trustworthiness, and integrity of clinical documentation have the power to transform healthcare delivery for better patient care and outcomes.

Check out my recent **Nuance in Healthcare** podcast: Achieving Advanced Practice CDI. While the episode does not highlight the CMS Final Rule, it does feature how best-in-class CDI is about building on the facility's current infrastructure and supporting the current staff with the resources and education they need. When this happens, accuracy, outcomes, and patient care are impacted.

Tags: Clinical Documentation Improvement, Clinical Integrity, Patient Safety

About Melinda "Mel" Tully

Melinda (Mel) Tully is the vice president of clinical services and education for Nuance Healthcare, overseeing the development and expansion of clinical documentation programs and clinical education best practices. Mel joined Nuance in 1998 and has more than 25 years of experience in multiple healthcare arenas as a provider, clinical manager in a large academic facility, and as an expert in clinical documentation improvement (CDI). Mel attended Emory University, where she earned her Master's degree in Nursing. She has been certified through the Association of Clinical Documentation Specialists (ACDIS) as a clinical documentation specialist, as well as by the American Health Information and Management Association (AHIMA) as a documentation improvement practitioner.

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