Welcome

LoneStar HFMA

February 19, 2026

Emergency Department Facility Based CDI: The largest Untapped Revenue Lever in the Health System

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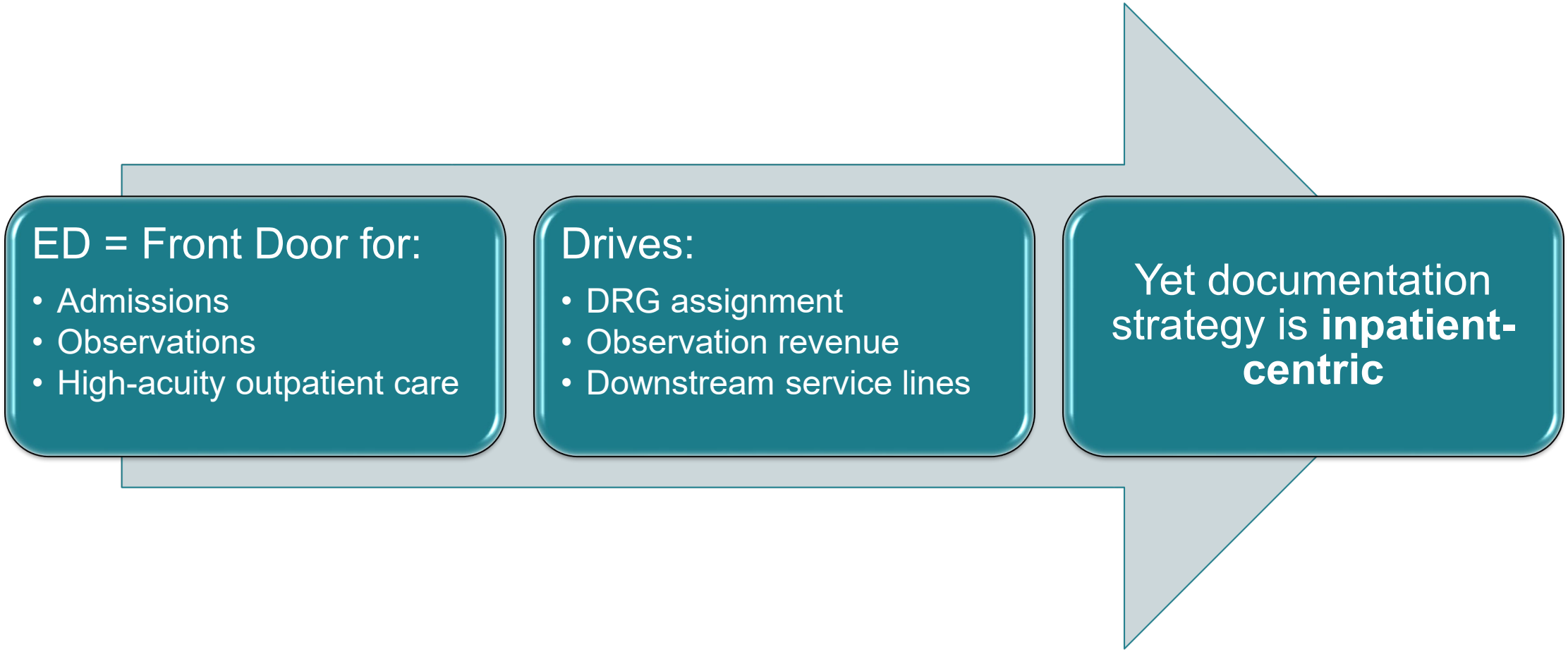
Agenda

- The ED's hidden financial role
- Why inpatient CDI doesn't work for ED revenue
- Where revenue is leaking today
- Facility-based CDI as a business strategy
- ROI model (numbers, not theory)
- Implementation path for CFOs

The ED Is No Longer a Cost Center



Why Traditional CDI Misses the ED

Inpatient CDI starts **after** the revenue decision is already made

ED documentation sets:

- Medical necessity
- Level of care
- Facility E/M level
- Observation vs inpatient trajectory

Most CDI teams:

- Don’t touch ED notes
- Don’t review facility charging
- Don’t engage physicians in real time

This creates **structural revenue loss**

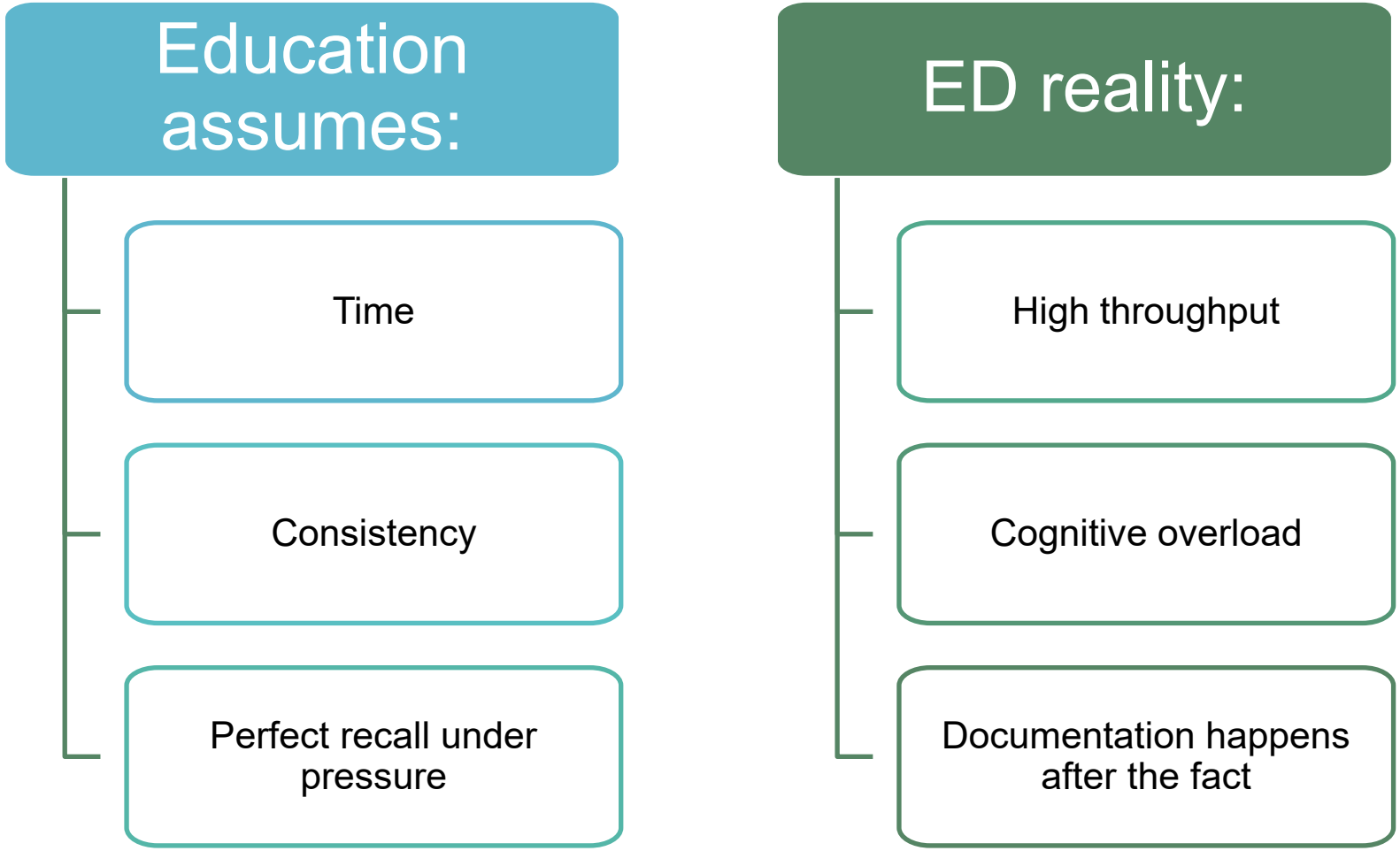
Revenue Reality Check

Do you know your ED denial rate by facility E/M level?

Can you quantify lost critical care minutes?

How much revenue is tied to undocumented medical necessity?

Why Education Alone Fails



The Missed Opportunity

ED sees:

- The sickest patients
- The highest acuity
- The most defensible medical necessity

Yet captures **the least optimized revenue**

Facility-Based CDI Program for the ED

Designed to focus on the unique operational dynamics and financial structures of Emergency Department

- including facility-based leveling, critical care time, and trauma activation
- ensures documentation and coding practices capture resource utilization and care complexity
- reduces risk of audits, denials, and financial penalties due to inaccurate documentation
- supports data-driven decision-making for process improvements

How It Differs from Traditional CDI

Inpatient CDI → retrospective

ED CDI → point-of-care influence

Physician CDI → professional fee

Facility CDI → **hospital margin**

What this **is NOT**:

- Not physician RVUs
- Not HCC chasing
- Not punitive auditing

What it **IS**:

- Hospital reimbursement
- OPPS/APCs
- Audit defensibility

Quality outcome driver

Emergency Department Areas of Opportunity

Point of Care Ultrasound (POCUS) documentation

- Specific documentation and archived U/S pictures
- Performed but not captured
- Documentation vs charge gap

POOR POCUS DOCUMENTATION

Bedside ultrasound performed.

Negative FAST exam.

EXCELLENT POCUS DOCUMENTATION

Point-of-care FAST ultrasound was performed at the bedside to evaluate for intra-abdominal free fluid given hypotension and abdominal pain.

Structures evaluated included the hepatorenal recess, splenorenal recess, pelvis, and pericardial view. No free intraperitoneal or pericardial fluid was identified.

Findings reduced concern for hemorrhagic shock and supported continued medical management rather than emergent surgical intervention. Images were obtained and archived.

Critical Care

Critical care time documentation

- E/M and Facility are different
- Missed minutes
- Poor linkage to instability
- High audit risk

- 68-year-old male
- Shortness of breath
- History of CHF, COPD, CKD
- Hypoxic on arrival
- Requires BiPAP, IV diuretics, continuous reassessment

What the note says:

- Patient with shortness of breath.
- Started on BiPAP.
- Given IV Lasix.
- Patient improved.
- Critical care time: 45 minutes.

Excellent Documentation

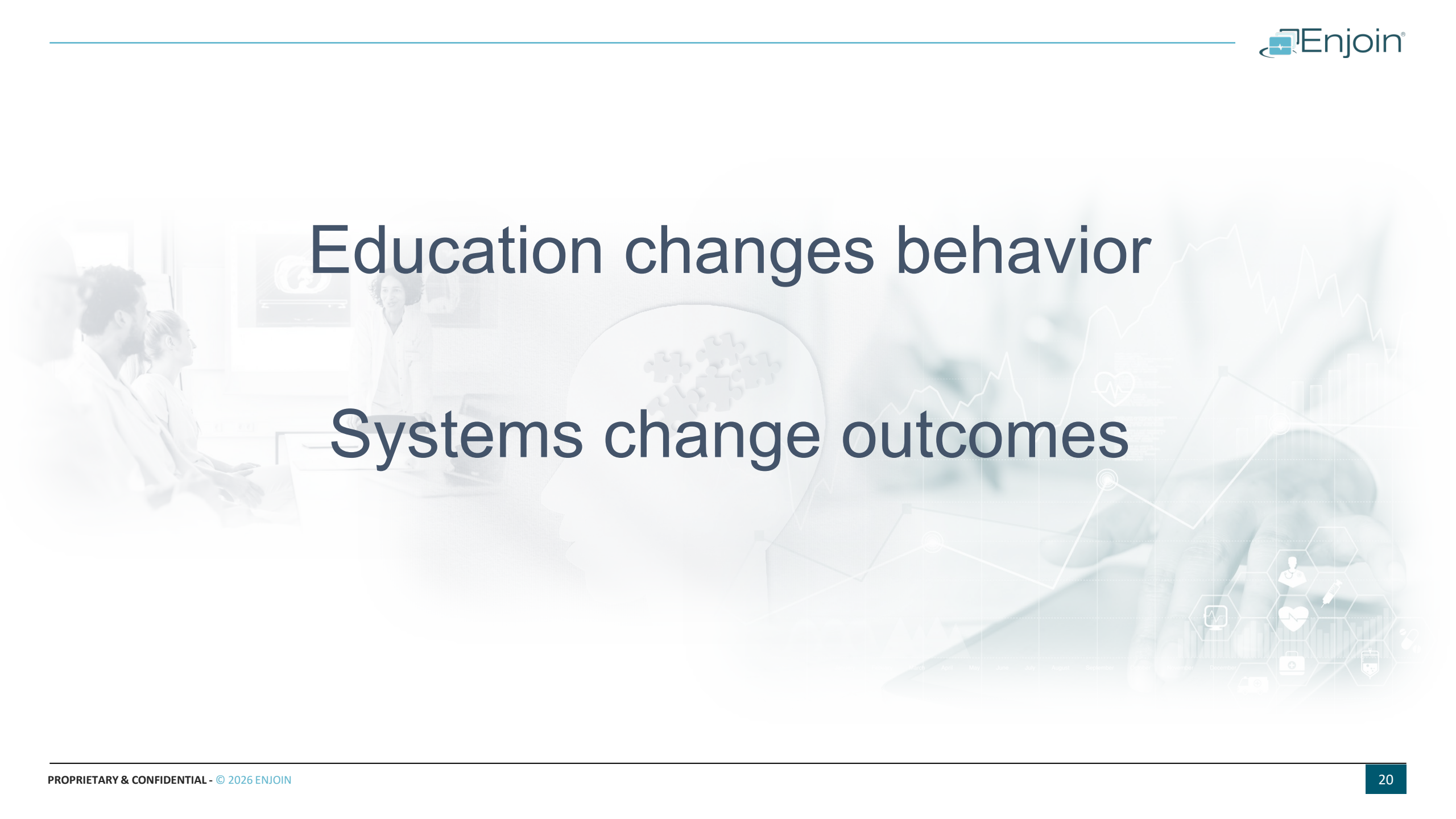
- Patient presented in acute hypoxic respiratory failure with oxygen saturation of 82% on room air, tachypnea to 32, and increased work of breathing. Given underlying CHF and COPD, patient was at high risk for rapid respiratory decompensation and need for intubation.
- Critical care was initiated due to high probability of imminent life-threatening deterioration. Interventions included initiation and titration of BiPAP, IV diuretics for suspected pulmonary edema, continuous hemodynamic and respiratory monitoring, frequent bedside reassessments, coordination with respiratory therapy and nursing staff, and review of diagnostics to guide escalation of care.
- Total facility-based critical care time was 47 minutes, including physician, nursing, and respiratory therapy involvement

Isn’t this just better documentation?

Aren’t we already doing CDI?

Education changes behavior

Systems change outcomes



Measurable Impact of CDI in the ED: Professional Billing

- Increase in average E/M level due to improved documentation specificity by 15-30%

Detailed documentation supports high-level diagnoses that contribute to an appropriate higher E/M visit level

- Leads to optimized reimbursement and more defensible billing

Promotes real-time documentation improvement with targeted education based on frequent misses or vague terminology

- 20% reduction in E/M leveling denials

Supports clean claim submission by ensuring documentation matches coding

Measurable Impact of CDI in the ED: Facility Billing

Promotes Accurate and Comprehensive Documentation

- Supports precise capture of facility-based leveling, critical care time, and trauma activation
- 15% increase in documented critical care time through real-time CDI engagement
- 20% increase in trauma activation coding accuracy due to improved documentation specificity
- 18% improvement in facility leveling accuracy supporting inpatient admissions and facility-based level reimbursement

Reduces Risk of Denials, Audits, and Financial Penalties

- 30% decrease in facility-based payer denials
- 35% increase in successful appeal rates, recouping approximately $200,000 per quarter

Enhances Coding Accuracy and Reimbursement Integrity

- Ensures accurate code assignment and documentation alignment, maximizing appropriate facility-based revenue capture

Leveling the Field: How ED E/M Audits Elevate Accuracy

Encounter Selection	• Targeted review of ED visits (Level 4/5, high-risk conditions, criteria for trauma activation, critical care time, or payer denials)
Documentation Review	• Evaluate provider notes for History, Exam, and especially Medical Decision Making (MDM) per 2023 AMA guidelines
E/M Code Validation	• Assess if the reported E/M level is supported by documentation (problems addressed, data reviewed, and risk)
Discrepancy Identification	• Flag undercoding, overcoding, and documentation gaps
Feedback & Education	• Provide individualized provider feedback and coding education • Identify trends and systemic documentation issues

Benefits to Professional Billing Audit: Why It Matters in the ED

- Ensure Accurate Reimbursement & Revenue Optimization
  - Validate documentation supports the selected E/M level (per 2023 AMA MDM framework)
  - Ensure ICD-10-CM diagnosis codes reflect medical necessity and support procedures, diagnostics, and risk level
  - Improve charge accuracy to ensure appropriate reimbursement from all payers
- Reduce Denials & Improve Cash Flow
  - Identify documentation or coding issues that cause can claim denials (point of care testing/point of care ultrasounds)
  - Strengthen claims for clean submission, reducing rework or denial appeals
- Optimize Emergency Severity Index (ESI) Levels to Strengthen ED Diagnosis Mapping and CMI
  - Improve ED CMI with Stronger alignment of ESI with clinical documentation reflecting the true intensity of services delivered in the ED
  - Enhance resource justification, reimbursement accuracy, and clinical benchmarking for quality and performance metrics

From Symptoms to Specifics: Auditing ICD-10 Coding Accuracy in the ED

Case Selection	Chart Review	Code Validation	Discrepancy Analysis	Feedback & Education
• Random or targeted selection of ED encounters (high volume, high dollar, high denial)	• Comprehensive evaluation of ED documentation: HPI, MDM, final diagnoses, procedures	• Verify accuracy and specificity of assigned ICD-10-CM codes • Confirm alignment between provider documentation and coder interpretation	• Identify missed diagnoses, undercoding, overcoding, and clinical validation issues	• Provide actionable insights to coders and cliniciansTarget documentation improvement opportunities

Aligning Accuracy with Outcomes: The Strategic Value of ED ICD-10 Coding Audits

- Improves coding accuracy and documentation quality
- Identifies missed diagnoses (e.g., sepsis, acute respiratory failure, chronic conditions)
- Strengthens clinical validation and reduces denials risk
- Enhances revenue integrity and risk adjustment capture
- Supports improvement in publicly reported ED quality metrics (sepsis bundle compliance, risk-adjusted outcomes, appropriate ED utilization, stroke or AMI)

A Valued Partnership

- Achieving excellence in emergency department coding, compliance, and performance is not a siloed effort, it is a shared mission.
  - Physician led clinical teams supporting accurate and timely documentation that reflects the true complexity of ED care
  - Coding & CDI Professionals ensuring precise, defensible ICD-10 and E/M code assignment through retrospective review
  - Revenue cycle & compliance driving audit readiness, reimbursement integrity, and risk mitigation strategies
  - Data & Quality leaders leveraging audit insights to improve publicly reported metrics and clinical outcomes

Strategic Overview:
CDI Program Impact

15-30%
E/M Level Increase

$200K+
Quarterly Recovery

20-35%
Denial Reduction

18%
Facility Accuracy

Strategic Value

- Revenue Optimization
- Risk Mitigation
- Compliance Assurance
- Quality Improvement
- Documentation Excellence
- Operational Efficiency

Program Scope

- Professional Billing
- Facility Billing
- E/M Audits
- ICD-10 Coding

CDI delivers measurable ROI while ensuring compliance & documentation excellence.

KEY TAKEAWAY

Measurable Impact of CDI in the ED:
Professional Billing

Increase
15-30%

Documentation Speci

Increase in average E/M level due to **improved specificity**.

Detailed documentation supports high-level diagnoses for appropriate E/M levels.

Secure

Optimized Reimbursement

Leads to **defensible billing** and optimized revenue capture.

Promotes real-time documentation improvement with targeted education on frequent misses.

Reduction
20%

Denial Reduction

Significant reduction in **E/M leveling denials**.

Supports clean claim submission by ensuring documentation matches coding perfectly.

Measurable Impact of CDI in the ED:
Facility Billing

Promotes Accurate and Comprehensive Documentation

Supports precise capture of facility-based leveling, critical care time, and trauma activation

Critical Care — **15%** Time Increase

Trauma Act. — **20%** Accuracy Increase

Leveling — **18%** Accuracy Improvement

Reduces Risk of Denials, Audits, and Financial Penalties

Denials Decrease — **30%**

Appeal Success — **35%**

+$200k / quarter

Enhances Coding Accuracy and Reimbursement Integrity

- Ensures accurate documentation alignment, maximizing appropriate facility-based revenue capture.

Why This Scales & The Cost of Inaction

- Repeatable process
- System-wide impact
- Ongoing leakage
- More audits
- CFOs/ Rev Officers explaining misses retroactively

Why Now?

The Ask

- Pilot
- Measure
- Decide

Questions?

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Thank you!

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