Best Practices for HIM Professionals Managing CDI Programs

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By Kimberly J. Carr, RHIT, CCS, CDIP, CCDS

Though accurate clinical documentation has always been important, the implementation of ICD-10-CM/PCS in October 2015 made accurate clinical documentation critical. Since each character in the ICD-10-CM/PCS code is a specific component of the code, organizations have been challenged with ensuring that providers are documenting clinical details of a patient's condition that were previously not requested or required.

In response to these new documentation challenges, many healthcare organizations of all sizes and complexity expanded their clinical documentation improvement (CDI) programs to bridge the gap. CDI programs are frequently comprised of cross-disciplinary teams which can include physicians, nurses, case managers, and coding professionals. Because of the wide variety of skill sets and expertise, reporting structures for CDI programs vary depending on the organization. Examples may include reporting lines to the chief medical officer, the director or vice president of case management, quality, health information management (HIM), the vice president of medical affairs, or the vice president of revenue cycle.

This article shares insights from three HIM leaders who have direct oversight and responsibility for the CDI program in their organizations. In May 2017, these HIM professionals came together via a virtual roundtable to share their best practices for managing CDI teams. The discussion was moderated by Kimberly J. Carr, RHIT, CCS, CDIP, CCDS, director of clinical documentation at HRS.

HIM's Unique Abilities for Managing CDI

HIM professionals are uniquely equipped to oversee and manage a CDI program because they understand the nuances of documentation, reimbursement, and quality. HIM leaders have the distinct ability to straddle and align these priorities, driving improved financial and quality outcomes for their organizations.

Key components of our panelists' best practices for managing CDI teams include:

- Ongoing education for coders, CDI specialists, and physicians
- Clear communication of expectations and priorities
- Collaboration among all constituents to ensure that program goals are achieved

Carr: How long have you been managing the CDI process as part of HIM department functions? Who did the CDI team report to in the past?

Melinda Patten, MHA, RHIA, CHPS, CDIP, director of HIM at Children's Hospital Colorado (Children's), Denver, CO: Children's is a 486-bed children's general facility that experienced 18,528 admissions in 2016. I have managed the CDI team since its inception in 2014.

Colleen Stalvey, RHIT, associate director of revenue cycle services at Cedars-Sinai Medical Center, Los Angeles, CA: Cedars–Sinai Medical Center (CSMC) is an 885-bed general medical and surgical facility with 45,268 admissions. CDI has always reported up through HIM and ultimately through finance. The program was implemented in 2002 and I have managed the team since 2007.

Kim Wells-Balls, RHIT, CPC, medical record manager/privacy officer at Delano Regional Medical Center, Delano, CA: Delano Regional Medical Center is a general medical and surgical hospital with 100 beds and 3,809 annual

admissions. I have been managing the CDI program for about four years.

Carr: What are the clinical and professional backgrounds of the individuals performing CDI reviews, queries, and related functions?

Patten: We have three CDI specialists (CDISs) who are all registered nurses (RNs).

Stalvey: We have a mixture of professional backgrounds within our team of 17—one foreign medical doctor, three coding professionals trained in CDI, and 13 RNs.

Wells-Balls: Our CDI specialist is an RN credentialed as a CCDS (Certified Clinical Documentation Specialist) with the Association of Clinical Documentation Improvement Specialists (ACDIS) and a CCS with AHIMA.

Carr: If you have RNs or clinicians on the CDI team, have you experienced any challenges or concerns with RNs and other clinicians reporting directly to an HIM professional? If so, please share an example of an issue and how you managed it.

Patten: In the early stages of our program the RNs felt threatened by questions posed by our HIM trainer, manager, reviewers, and coders. They felt they should not be questioned if the person wasn't a clinician, as the RNs were the experts. It took awhile for them to understand the questions were for educational reasons; their knowledge was not being challenged. I have found that any time we build a new team it takes some "adjustment" to the different environment.

Stalvey: As with any team, having a mixture of strengths and skill sets can be a challenge. We made a conscious decision early on regarding the purpose of the program. For CSMC, our mission is to focus on a clear clinical story of the patient within the record. With that as our first priority, it allows for each of our skill sets to be equally relevant.

It takes a deliberate focus to consistently utilize all aspects of the team's knowledge base. The foreign medical doctor is able to look at labs and predict what may come next. The nurse will know what a patient with a certain condition would look like, thus anticipating routine cause and effects. The coder will know what rules and regulations there are around that condition. It takes a constant message of trust and value to each of those components to the team to allow them to work in concert.

One challenge that has just recently happened is in regards to a particular surgery. The coding professionals have weighed in on how this surgery should be coded, coming up with differing opinions. There are also criteria as described by the National Healthcare Safety Network (NHSN) by which facilities are measured against and by which the doctors follow.

We now must leverage our clinical team, the surgeons, and our coding professionals to determine the most appropriate approach. By putting forth the time and focus on the importance of each contributor early on, we have created an environment where we can tackle these challenges together from the clinical, the coding, and the data integrity standpoint.

Wells-Balls: No, I have never experienced any challenges as long as I treat them with respect and value their expertise.

Carr: What is the process for handling MS-DRG assignment differences that occur between the CDI specialists' concurrent or working DRG assignment and the coder's final assignment? What is the course of action? Does this count as an error "against" CDI or coding during their monthly and quarterly accuracy reviews?

Patten: The DRG mismatches are not calculated in the individual's accuracy percentage. The mismatched tool serves two purposes. First, education and understanding for coders, CDI specialists, and reviewers. Second, it ensures the accuracy of the account prior to billing.

Adding the DRG mismatches to the accuracy percentage would be viewed as punitive, which would jeopardize team cohesiveness. For that reason, we are using this tool for educational purposes only. The mismatched report is generated using the CAC/CDI software.

The CDI specialists are given the report for review and may take a quick retrospective assessment of the chart. The education specialist also reviews the report and identifies any issues. The education specialist then suggests a computer-based training module or contacts the coder and/or the CDI specialists to discuss the opportunities for improvement.

This process has helped develop good relationships by creating an opportunity for open conversations with all parties. We make sure everyone is on the same page to ensure understanding of the coding and the documentation.

Stalvey: We currently use identification and communication through our system. When there's a DRG mismatch, the coding team places the account on hold and uses the system to request a consultation with the CDI specialist reviewer. The coder includes reasons for a possible mismatch.

The CDI specialist has the opportunity to review and discuss the case with the coder. If the two disagree following discussion, there is an escalation process they follow. The respective supervisors review the case, collaborate, and provide collective feedback to both the CDI specialist and the coder.

Our goal in this process is to build consensus on the most accurate data set that represents the patient's clinical picture and is in accordance with all regulatory standards. Mismatches are not tracked as errors per se, rather as education opportunities for both. If one or the other has made a negligent error, that would be determined by the respective supervisor.

Wells-Balls: We do concurrent coding, so encounters are typically coded within 24 to 48 hours of admission when sufficient documentation is present and final coded on discharge. Our CDI specialist typically communicates via our system's message center and provides his rationale when he believes a different DRG should be assigned. We have also requested a second opinion from another coding vendor who performs coding audits for DRMC.

Carr: Who provides education for the CDI specialists and coders? Do you educate the CDI specialists and coders during the same session? Do you provide physician education? If so, who provides the physician education?

Patten: We have an education specialist that provides education to both the CDI specialists and coders, and often it is presented to everyone in the two groups on a WebEx at the same time. Physician education is provided by the school of medicine and their billing specialists (not employees of the hospital). The CDI specialists talk with the physicians from the perspective of a specific case. Their goal is to gain or give insights individually; they do not provide group education.

Stalvey: We have several methodologies for education. Both CDI specialists and coders receive routine monthly quality review feedback. We have both a coding and a CDI newsletter that contain hot topics or updated process information. Each team meets monthly individually and will meet together for particular topics. With such large teams, we find it difficult to meet together routinely. In terms of physician education, the CDI team does perform education in many venues both on the floor as well as in a formal setting. They developed a physician documentation boot camp that is put on each month and is open registration to anyone in the organization. The boot camp is also available on demand for any request.

Wells-Balls: Our CDI specialist tries to attend as many online learning opportunities as he can, especially the free webinars presented by Noridian and/or [the Centers for Medicare and Medicaid Services (CMS)], etc. Webinars, along with the information on the ACDIS and AHIMA websites, have given him the opportunity to evolve and expand his knowledge base, which is key to a facility's CDI program success.

Our CDI specialist provides written handouts (newsletters, CDI posters, handbooks) to our physicians, but the most impactful education has been daily face-to-face discussions with them. Those few minutes a day educating the physicians has gone a long way in improving documentation.

Carr: Does HIM continue the CDI specialist's concurrent query if it has not been answered by the time of discharge? If a retrospective query needs to be generated, who is responsible for generating it?

Patten: Upon discharge the query is continued or resolved by the coder and, if needed, another or a different query is generated. The CDI specialists prefer to do quick (couple of minutes) retrospective reviews for self-education.

Stalvey: At our facility the CDI specialists follow their queries for up to seven days post-discharge. If a retrospective query is requested, it is sent to the CDI team for processing.

Wells-Balls: Our providers (mainly hospitalists) are exceptional in addressing concurrent queries. When the clinical picture is not clear, the coders send retrospective queries.

Carr: How often do you meet as a combined group—CDI and coders? What does your common agenda look like and what can you suggest to others trying to make group meetings more effective and productive?

Patten: We usually hold meetings every other Wednesday. The first part of the meeting focuses on any updates or facility or department news. The last part (30 to 45 minutes) is an educational session, presented by the education specialist or a quality reviewer. This is usually not a case review, so only questions regarding the information presented are entertained.

Stalvey: Within the CDI team we have a split presence with most onsite and some working from remote locations. The inpatient coding team is nearly 100 percent remote. Logistics definitely play a part in creating an interactive and effective meeting with the two teams. At this time, the combined meetings are primarily educational sessions. We are looking to create smaller focus groups to better facilitate the collaboration of the two teams.

Wells-Balls: Our coding services are provided remotely by a vendor; therefore, regular meetings are not conducted. Most of the CDI/coder communication is through our system's message center, which has been very effective.

Carr: As the healthcare industry moves forward into value-based reimbursement and alternative payment models, where do you see HIM-CDI collaboration headed? Why do you think it is important for these two professional groups to work together (within the same department)?

Patten: We have an e-mail named "Ask Code" where coders and CDI specialists can send questions regarding challenging accounts. This e-mail is managed by quality reviewers and the coding and compliance specialist. Most often a response is received within the next day. Delays occur when collaboration is required prior to responding.

Stalvey: It is becoming increasingly important for the teams to look at a claim profile in a much different way. Coding is no longer simply about payment. The claim profile has become the basis for data collection, contract negotiations, and patient and physician profiling, quality of care measurements, and payment penalties/rewards. The entire landscape of our industry has changed. The ability of a facility to have a comprehensive claim that represents the patient accurately and completely is the keystone to the success of both programs.

Wells-Balls: Each specialty brings its own skill set to the table. Collaboration between the two is integral to the success of our facility. As diagnostic criteria and coding rules and guidelines evolve, it is crucial that HIM and CDI work together to make the necessary changes as they occur.

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