CDI Opportunities for HIM Professionals

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The HIM field continues to expand and change, opening up more opportunities for HIM practitioners to move out of the HIM department and into other areas of the hospital. Recent initiatives, such as ICD-10-CM/PCS, MS-DRGs, Hospital-Acquired Conditions, and Present on Admission reporting, have brought clinical documentation improvement (CDI) programs to the forefront.

CDI allows coders to move from the cubicle to the floor and perform their craft at the point of care. Clinical documentation specialists concurrently review inpatient charts and clarify physician documentation at the time care is rendered. This enables a more efficient query system and the ability to interact and educate physicians on the complex world of coding.

Clarifying Documentation at the Point of Care

The ability to interact with the physician at the point of care reaps many benefits. Physicians are more willing to discuss a patient while they are providing care. The patient is at the forefront of the physician's mind, assisting communication and facilitating more specific and accurate documentation. The CDI process allows for a more complete and accurate telling of the patient's story during his or her hospital stay.

Documentation specialists are able to educate physicians as to why certain queries are needed that might otherwise seem trivial to a doctor. There are instances when physicians will be confident that their documentation completely reflects what occurred. While this may be true, documentation specialists are able to assist the physician via queries to be even more specific for coding purposes.

A physician who receives a query will sometimes respond that the information already exists in the record. The documentation specialist can read and understand the clinical documentation the physician is using; however, there can be times where the clinical language and the coding language may not result in the same outcome at the time of coding. Documentation specialists can use these instances as teaching opportunities with physicians.

Specialists can explain to the physician the type of wording needed for the most correct and accurate code on the patient's record. They should be ready to present printed examples of *Coding Clinic* explanations when querying the physician, especially in instances where the physician may question why a certain documented response is needed. This is the best opportunity to explain those occasions when the coding language diverges from the clinical language.

CDI programs are oftentimes implemented to improve a hospital's case-mix index; however, CDI can affect more than just the bottom line. The benefits for acute care hospitals include:

- Increased specificity in documentation
- More accurate depiction of patient severity
- Positive communication between HIM and physicians
- Educating physicians on the application of coding guidelines

A documentation specialist is the liaison between HIM and physicians and acts as a catalyst to ensure precise and complete documentation to facilitate the coding process and provide accurate data to regulatory agencies.

The need for CDI programs will increase greatly with the transition to ICD-10-CM/PCS in 2013. The new code set requires more advanced specificity in documentation than the current ICD-9-CM code set, which will necessitate greater collaboration between HIM and physicians to get the appropriate documentation on the chart to facilitate the coding process.

Bridging the Gap between Physicians and HIM Practitioners

A CDI program is also a valuable tool for the HIM department. This is especially true if a hospital places the program under the auspices of HIM. Documentation specialists can be looked upon as ambassadors of sorts for the HIM realm.

Documentation specialists interact with physicians on the floor, an environment in which they are comfortable, rather than within the HIM department. Doctors often visit the HIM department only when they are required to complete paperwork, and many practitioners feel a trip to HIM to sign and complete records takes them away from patient care. A CDI program is an excellent interactive program to help bridge the gap between physicians and HIM practitioners.

Documentation specialists can help educate physicians on the importance of coding and documentation's impact on coding. They can help explain to practitioners that the program is not just established as a method of "gaining" reimbursement or increasing the hospital's case-mix index, but rather a method of ensuring that the severity of their patients' illnesses is accurately collected in the hospital database to provide proof of severity of illness for regulatory agencies.

It is important that specialists be willing to approach physicians, ask questions, and articulate why clarification has been requested. Most physicians are willing to acknowledge the need for specificity, and documentation specialists can help forge a bond that will gain strength in more specific documentation that benefits the hospital and its patients.

Building Rapport with Physicians

Documentation specialists must keep physicians informed of coding changes and the importance of coding clinical documentation. Specialists should ask to be placed on agendas of physician meetings and participate in committees that promote accurate documentation. They must demonstrate the value of complete and accurate documentation. A presentation that illustrates the effectiveness of specific information opens a new world of possibility and willingness to assist in gaining accurate documentation.

Physicians want to see the facts, so documentation specialists should stick to bullet points and give essential information only. Encourage participation and be willing to answer questions clearly and concisely. Documentation specialists should admit when they do not know the answer to a physician's question, and they should let the physicians know that they will do the research and get back to them with an answer.

Participation on committees in which physicians, administration, and documentation specialists can work together helps forge a bond outside of the query realm. This gives physicians an opportunity to learn more about documentation specialists as well as to gain more information about the value of the program.

A Documentation Specialist's Daily Job Responsibilities

A documentation specialist's daily job responsibilities may consist of the following:

- Acquire the list of patients ready for review for the day; take a laptop to the floor to perform reviews if the organization uses an automated review system.
- Locate chart and review progress notes, history and physical, operative reports, and any other procedural reports or labs.
- Place documentation in the CDI computer program, summarizing findings and MS-DRG; schedule next review. If needed, speak with the physician, advanced registered nurse practitioner, or physician assistant regarding any queries based on the chart review. If unable to verbally query, use the CDI computer program to write a query and print and place it on the chart. Document written as well as verbal queries, so those queries are able to be counted in CDI totals for queries.
- Return chart and continue reviewing the list of patients.
- Within the CDI computer program, take care of any discharges from the day before or from the weekend.
- Maintain database with information on final MS-DRG from coding staff and enter into the system.
- Prepare for any future meetings or presentations by reading journals and Internet reports and preparing for ICD-9-CM changes.

Resources

Dimick, Chris. "Leading Clinical Documentation Improvement: Three Successful HIM-led Programs." *Journal of AHIMA* 79, no. 7 (July 2008): 40–44.

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Schade-Boyce, Joanne, Gerri Walk, and Joe Weber. "Clinical Documentation: New Strategies and Methods for Improvement." AHIMA Convention, October 17, 2008. Available online in the AHIMA Body of Knowledge at www.ahima.org.

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