CDI and Coding Make a Winning Team

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by Melanie Endicott

Clinical documentation improvement (CDI) is front of mind in the health information management (HIM) industry these days. Maybe you've seen lots of jobs advertised for CDI specialists lately and have been wondering just what exactly is so hot about this profession. Well, let me tell you all about it!

CDI professionals typically work in inpatient acute care settings, although there is a trend to bring CDI to outpatient and other healthcare settings. The CDI specialist is tasked with concurrent review of clinician documentation in real-time, preferably while the patient is still in the hospital, to determine if there are any gaps in documentation that can be filled in by the physician before the patient is discharged and the chart is sent to coding. CDI specialists must possess very strong clinical, coding, and communication skills.

One of the great advantages of having CDI professionals working hand-in-hand with the clinicians while the patient is still in-house is that they can conduct verbal or written queries to the physician while the patient is still fresh in his/her mind. Facilities without CDI programs must rely on their coders to submit queries to physicians retrospectively to fill the gaps in documentation. Physicians see numerous patients every day, and expecting them to remember every facet of every patient several days or weeks after discharge is unreasonable.

A successful CDI program has the CDI professional(s) team up with the coders so they can assist each other in getting the necessary documentation to accurately code each patient's chart and receive fair reimbursement. Open communication between CDI and coding is of utmost importance.

If this discussion of CDI has sparked your interest at all, be sure to take some time to peruse the AHIMA website for more information about this fascinating field!

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