Clinical Documentation Improvement: Gauging the Need, Starting off Right

by **Genna Rollins**

There's no down side to better documentation, but many organizations have found MS-DRGs and RACs offer the motivation necessary to get their programs started.

During the past several years, clinical documentation improvement (CDI) programs have gone from a leading-edge experiment to a mainstream-must as hospitals grapple with the new Medicare Severity DRG system, ever-more demanding regulatory requirements, and increased public scrutiny of quality and performance improvement initiatives.

"Not only are hospitals that don't have CDI programs behind the eight ball, they will start to recognize a significant loss of revenue," contends Maria Alizondo, MA, RHIT, director of consulting services for Caban Resources, a Lawndale, CA-based HIM consulting firm. Alizondo estimates that as many as two-thirds of hospitals have some type of CDI program, up from less than one-half a few years ago.

For enterprises that do not have programs already, analyzing their case-mix indexes is a good gauge of a CDI program's potential impact on reimbursement. Lining up support and resources gets programs off to promising starts.

Good Motivation: MS-DRGs, Compliance

One of the major drivers for many hospitals to invest in CDI programs has been to maximize reimbursement available through the MS-DRG system, which was implemented on October 1, 2007. The Centers for Medicare and Medicaid Services included an overall 4.8 percent payment reduction in the system—spread over three years—so hospitals have an incentive to achieve all appropriate reimbursement due them.

"The MS-DRG system anticipated that coding would improve after the system was implemented, and that's why the reimbursement cut was included. So hospitals that have not improved documentation and coding probably are receiving less than they're entitled to," explains Cheryl Ericson, MS, RN, clinical documentation improvement manager at the Medical University of South Carolina in Charleston.

A good example of how detailed documentation is tied to coding and reimbursement under the MS-DRG system is the diagnosis "heart failure and shock."

Under the old DRG system, heart failure and shock was one DRG, 127, with a standard FY2007 payment of $5,113.34. Under the MS-DRG system, there are three heart failure and shock DRGs: 291, with major complications or comorbidities (MCC); 292, with complications or comorbidities (CC); and 293 without MCC or CC. FY2008 standard payments for these DRGs ranged from $6,246.74 for MS-DRG 291 to $4,350.63 for MS-DRG 293.

"If the doctor just documents that the patient has congestive heart failure, the coder will only be able to code CHF with no CCs or MCCs," says Eve-Ellen Mandler, MS, RHIA, CCS, director of health information management and privacy officer at St. Clair Hospital in Pittsburgh. However, if the doctor were to add information such as whether the heart failure was systolic or diastolic in nature, or whether the patient also had acute respiratory failure associated with chronic obstructive pulmonary disease, it would enable coders to capture those additional aspects of the patient's condition, thus qualifying the hospital for the higher-paying DRGs 291 or 292, she explains.

Another impetus for starting a CDI program is to ensure that documentation and coding will be aligned, thus enabling a hospital to withstand scrutiny under compliance audits and other regulatory requirements, according to Alizondo.

"Having additional descriptors in the medical record will not only enable coders to assign higher codes, but it will also ensure that the documentation is there for any regulatory audit," she explains.

As an example, Alizondo points to the Recovery Audit Contractor (RAC) program, initiated as a demonstration project in three states and mandated by Congress as a permanent, nationwide program as part of the Tax Relief and Health Care Act of 2006. Slightly more than $357 million—about 96 percent—of improper payments in FY 2007 were overpayments, according to a RAC status document. "These retrospective audits concluded that the hospitals couldn't support the coding used with documentation that was in the medical records," says Alizondo. "Not wanting a RAC take-back has led many hospitals to establish CDI programs."

CDI initiatives also make sense in a world of public reporting of performance indicators. "Beyond reimbursement issues, with all these comparison Web sites, the general public is learning it can shop around. And with the data available online, CDI is a way to demonstrate that you're providing appropriate care," says Ericson.

More on CDI

Blackford, Gwendolyn. "Discover How to Survive Medicare Severity DRGs with a Successful Clinical Documentation Improvement Program and Present on Admission Indicators." AHIMA Convention, October 17, 2008. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

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

Dimick, Chris. "Running a Successful CDIP." *Journal of AHIMA*. Web extra. July 22, 2008. Available online at http://journal.ahima.org.

Dimick, Chris. "Clinical Documentation Specialists." *Journal of AHIMA* 78, no. 7 (July 2007): 44–50.

Pinson, Richard D., and Cynthia L. Tang. "Comprehensive CDI: Making It Happen." AHIMA Convention, October 17, 2008. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

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 FORE Library: HIM Body of Knowledge at www.ahima.org.

The Case-Mix Test

Aside from these general reasons for establishing a CDI effort, a hospital's case-mix index often is a good indicator of whether the organization will be able to benefit from a CDI initiative. Such was the case for Shands Hospital in Jacksonville, FL.

"Our case mix didn't reflect our patient population. We are an inner-city trauma facility and have a large indigent and underserved population," explains Michelle Dragut, MD, CCS, physician advisor for Shands' clinical documentation improvement program. "We did an analysis of the severity of case mix and risk of mortality index and realized they didn't reflect the true status of our patient population."

Mandler agrees that a review of key diagnoses can be very revealing. "If you take the more prominent DRGs that have three levels, and for the cases not coded with MCC or CC, if you determine that if the doctor had documented something different, the case could have been coded as MCC or CC, then you're leaving money on the table," she says. Reviews of internal data looking at the distribution of cases within three- and two-tiered MS-DRGs is a good place to start, but it also helps to compare your hospital to other similar facilities.

That was a step in Dragut's efforts to develop a more extensive CDI program. Many hospitals participate in organizations that provide between-member benchmarking analysis; those that do not have access to this type of information can use Medicare's MedPAR files, she advises.

A successful CDI effort should cause the hospital's case-mix index to rise, according to Mandler. "Changes in volume that impact the case-mix index are not from a CDI program, but if you have about the same volume of pneumonia cases, for example, and your case-mix index increases, it probably means that the doctors are providing more specific documentation," she says.

Mandler also contends that effective CDI initiatives can tighten the billing cycle by cutting down on the number of cases that have been discharged but not final-billed due to outstanding coding-related queries. "It may speed up the process without other major structural changes within coding," she explains. Similarly, a high rate of denials could indicate that coding and underlying documentation are misaligned and that a CDI program could be of benefit.

Another metric for assessing the need for a CDI initiative is Joint Commission ORYX indicators like community-acquired pneumonia. "You can do a focused review and see how many cases followed guideline-recommended care," Alizondo suggests. A disparity does not necessarily mean that care is substandard, just that it is not being well-documented, she says.

CDI initiatives that run smoothly not only provide better information that can be used for a variety of purposes, but also promote cross-departmental collaboration between CDI, concurrent review, compliance review, and performance improvement efforts. "With this sharing of information is where you start really seeing gains being made," says Alizondo.

Where to Start

CDI initiatives often begin with the interest and determination of one or a few staff. But for programs to ultimately address the entire organization or enterprise's needs, a few staff cannot go it alone. Like many significant programs, CDI initiatives require buy-in and dedicated resources to see them through successfully.

Executive and Physician Support

For hospitals that have not implemented CDI programs, some type of analysis of case-mix index presented to senior executives and other key stakeholders is a crucial first step, according to Dragut. Initially she had represented the entire CDI effort at Shands. However, her analysis showed that while the hospital's case mix had improved, it still was not where it should be. So she took the results up the chain.

Presenting the data to hospital leadership won Dragut support for a more extensive CDI initiative. "I alone couldn't make progress. I needed helpers," she recalls. Today, Shands' CDI program is a team of three physicians and a coding expert with 30 years experience. The hospital's case-mix index has increased significantly since, Dragut says.

Early physician buy-in is equally important to the success of any CDI initiative.

"One of the first conversations should be with the chief of staff and hospital medical director. They have to be on board from the beginning," Alizondo advises. Without their crucial support, CDI efforts will falter fast, derailed by frustration and lack of convincing reasons for rank-and-file physicians to document more effectively.

Alizondo experienced first-hand the difficulties involved in winning the medical staff over. "I've had a doctor throw a chart on my desk and ask, 'Who are you to tell me what to do with my patient?'" she says. She recommends talking up the program on physicians' turf—brief meetings over lunch in their offices to review a few cases and show how more detailed information could make a difference in quality reporting metrics as well as reimbursement for the hospital.

Since physician buy-in is so important, many programs feature physician advisors, at least part-time, although there is no magic formula for success.

"It depends on the politics and how strong the managers are who might be involved," advises Mandler. "In our case, we hired part-time physician coaches who review charts and talk to their colleagues. They can say, 'I know you wrote this, but you

ordered this, so were you really thinking of X instead?' Any time you have a doctor talking to a doctor you'll get more out of it," she says. Other models employ nurses, case managers, nurse coders, and coding professionals as the main CDI staff.

Resources for the Short and Long Term

Another early consideration is whether or not to bring in a CDI consulting firm. Consultants can conduct DRG and case-mix analyses, provide training to CDI staff and participating physicians, and supply special query forms and sample documentation. They also typically provide ongoing analysis after the program gets off the ground, which can be helpful in focusing efforts and tracking success.

"Get perspectives of what the different companies can provide," recommends Mandler. "They've all been in place a long time and are all successful in their own way. It's just a matter of what works for your organization."

CDI programs can thrive well without the benefit of outside help as long as the organization can provide the right strengths and talents internally.

"If you have the right person with a strong reimbursement background who understands the healthcare system, you'll do OK," Ericson observes. "The biggest danger if you start with a consultant is how do you decide why and when to stop using them—what happens without that support?"

Mandler seconds the importance of ongoing commitment. "So many of these programs start internally and then fizzle out because people don't work at keeping them going. The monthly meetings, analyses, [and] continuing education of physicians doesn't just happen. Someone has to make it happen," she says.

The AHIMA CDI Toolkit

Look for a toolkit this fall from AHIMA's CDI volunteer work group. The kit offers guidance and resources in six areas:

- Forms and tools
- Steps for starting and maintaining programs
- Metrics for tracking success
- Tips for establishing and maintaining relationships with providers
- Job descriptions, competencies, and ethics for CDI professionals
- Explaining CDI to others

The toolkit will be offered online [...].

Guiding Mission

Regardless of how a program is structured or which department oversees it, the program should have a clear sense of mission, according to Ericson.

"You need to have a clear understanding of what your goals are," she says. "If the department is also doing quality reviews or case management, it can be difficult to balance all those priorities. So it's most important to have a foundation so you know what you'll be reviewing and how often you'll be doing it."

As a CDI program takes root, those involved should gradually be able to refine their efforts, focusing on only certain diagnoses and new doctors or those still having difficulties providing richer documentation.

"The goal of a good program should be to not need as much intervention over time," Alizondo maintains. "If you're doing a good job, the doctors will learn and the need for CDI on a daily basis goes down. Maybe you'll only need to look at high-volume diagnoses, ORYX indicators, or outliers."

However, less day-to-day troubleshooting will not diminish the importance of a robust CDI effort, Alizondo says. “All roads lead to documentation in the medical record.”

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