Clinical Documentation Specialists

by Chris Dimick

Clinical documentation improvement programs are growing, moving some HIM professionals to the clinic floor.

With sharp eyes, clinical documentation specialist Sharnetha White calmly combs through a patient's chart. She isn't fazed by the organized chaos that surrounds her in the heart of Mount Sinai Hospital.

White-coated doctors, nurses, and patients pass on the busy Chicago hospital floor as White hunts through charts in search of missing or cloudy physician documentation.

This is White's working environment. The HIM department that serves as her home office just four floors below couldn't be more different. Where the HIM department offers calm cubicles and murmured conversation, the surgical floor boasts unchecked voices, scurrying nurses, and beeping medical equipment. White is in the middle of the action, and that is where she feels at home.

Although sitting down every once in a while would be nice. "One of the challenges is finding a seat," says White, an RN and RHIA. "Down in HIM it is a quiet environment-the patient has already been discharged when the record is down there. On the floor, you have the challenge of the noise, speed, and trying to capture what you want to capture."

White is one of three clinical documentation specialists (CDSs) at Mount Sinai who concurrently review and query physician documentation. Their work is meant to improve clinical documentation in real time, which in turn allows coders to assign more specific DRGs and better portray a hospital's severity and case-mix index.

Mount Sinai implemented its CDS roles and overall clinical documentation improvement initiative in 2004. The change not only improved the HIM department's coding ability and overall hospital revenue stream, it ensured better patient care through better documentation, says Kathy Sauer, MBA, BS, RHIA, director of health information management at Mount Sinai Hospital and Schwab Rehabilitation Hospital.

The trend started a decade earlier, and the demand is rising for clinical documentation specialists as more hospitals implement programs, according to Mary Mills, RHIT, CCS, president and CEO of Documentation Solutions in Westland, MI. Both registered nurses and experienced coders fit the role well, making CDS an emerging job for HIM professionals, she says.

Seeking out Better Documentation

A clinical documentation improvement program (CDIP) aims to enhance the documentation presented to HIM for coding and DRG assignment. The program puts CDSs like White on the medical floor to review clinical documents for holes in documentation while patients are still in the hospital. CDSs directly query physicians, asking that documentation clarifications and additions be made in progress notes. In some programs, CDSs even suggest coding specifics, like DRGs, before a patient's chart lands on a coder's desk.

"The physicians are not always in tune with what we need in terms of documentation," White says. "We can only go on the documentation that is provided. We can't assume anything; that is a liability. We can't code off of labs, radiology reports, CT scans-we need the doctor to document."

For this reason, facilities often don't realize full reimbursement for their services. Some coders are wary of an audit by the Office of Inspector General or a denial from an insurance company if they code in full, says Mills. Lacking further documentation, they undercode to remain in a "safe zone."

Hospitals with a high percentage of Medicaid patients rely heavily on proper DRG assignments for reimbursement. Better documentation allows coders to record more specific complications/comorbidities (CCs) and DRGs, which pulls in more due revenue for a hospital, says Mills.

A former coder, Mills has helped design and implement CDIPs at several hospitals since founding her consulting company in 2001. The results of a properly run CDIP are immediate, she says, with improved documentation enhancing both ongoing clinical care and reimbursement.

Better Reflecting Real Case Mix

CDIP implementations have accelerated in the last four years as hospitals prepare for impending changes in the Inpatient Prospective Payment System (IPPS) and the increasing government focus on a hospital's severity rate, according to Laura Pait, RHIA, CCS, senior manager at North Carolina–based consulting firm Dixon Hughes.

IPPS is the DRG system used by Medicare to establish payment rates for hospitalized patients. In April 2006 Medicare announced an IPPS overhaul, giving hospitals three years to transition.

Pait formerly worked with consulting firm HP3 implementing CDIPs at various academic facilities. "You are seeing a new energy and wave of interest" in the programs, she says.

The Medical University of South Carolina has a CDIP story similar to many organizations. After a study revealed that the academic hospital was overly conservative in its coding practices and "leaving money on the table," officials implemented a CDIP in 2004, relates Christine Lewis, MHA, RHIA, CCS, CCS-P.

Better documentation led to more accurate reporting of severity to state officials, which in turn better demonstrated the level of resources required at her hospital. "We are treating sick patients, and our profiling is changing because we are documenting better and making sure we are capturing that," says Lewis, health information services manager in charge of coding and record processing.

Mount Sinai Hospital implemented its program in an effort to better communicate with physicians regarding documentation as well as to "make sure we were attaining the correct DRG assignment," Sauer says. An inner-city hospital, Mount Sinai has a very high percent of Medicaid patients.

One year after implementing the program, Mount Sinai had gained an additional $1.5 million in reimbursement. In the second year, the hospital gained $900,000. "Over time the dollar amount you are recovering gets less and less and less," Sauer says. "But that is a good thing, because you know you are picking up everything you can."

Not only does CDIP improve documentation, it improves the coder's job as well. "This program is putting definite answers to our 'maybes,'" says Andrea Bunker, MS, RHIA, CCS, coding supervisor at Mount Sinai Hospital. "Coders say, 'Maybe this patient has diabetes-their blood sugar shows it, but it is not in the record.' A CDS query can answer that 'maybe.'"

Pait sees the potential for a boost in job satisfaction. In facilities with CDIP, a coder has "improved turnaround time, reduced query rates, and has more complete coding at the time of discharge, which gives a better sense of a job well done."

Coders or Nurses as CDSs?

Registered nurses and HIM professionals are both good candidates for CDS jobs. A mix of clinical and coding knowledge is necessary. In the past, Medical University of South Carolina employed both HIM professionals and RNs in its CDS roles. It now has all nurses, but Lewis acknowledges either profession fits the role. "It is just what you feel is best for your culture," Lewis says. "In our facility we felt nurses may be better speaking with physicians."

The debate is ongoing as to which professional is better suited for the role.

Nurses, who are more familiar with the hospital floor and environment, might be better suited for the CDS role, Pait says. "HIM [professionals] historically don't have that presence in a working nursing station," Pait says. "Not to say we can't be

trained and utilized and grow in that, but I think nursing starts off better in that role and relationship when you are staffing your position."

However, experienced coders are more cost-effective and capture more lost dollars than nurses, according to Mills. When working as a coder for a healthcare organization in Dearborn, MI, she conducted a comparison that she says bore this out.

Frustrated that RN CDSs were suggesting incorrect DRGs while on the floor, Mills asked her hospital administration to let her act as a CDS to see who captured more documentation. Mills subsequently helped get information into the record that earned the hospital an additional $245,000 for that one month, she says. In comparison, the RN CDS queried for documentation that led to only an additional $10,000. After six months of similar results, the hospital decided to use coders for the CDS role.

Coders "read a lot of records, we look everything up, we look at the medications," Mills says. The only experience nurses have over coders is working with patients, she notes, but CDSs don't need that piece. "They have the record in front of them that explains everything," Mills says.

Learning Process versus Learning Coding

RNs need to learn CDS processes and coding specifics in order to query for documentation, but coders need only learn the process, Mills says. That cuts the CDS training time in half. "It takes a nurse six months to get on track, just to learn [DRGs and coding guidelines], when a coder who already has that knowledge can just jump right in and start reviewing records," she says. At smaller facilities, CDSs can even code right there on the floor, she notes, shortening the time it takes to produce the bill.

Other facilities look for CDSs who have both nursing and HIM backgrounds. White is an RN and RHIA, and she came into the position with the clinical and HIM knowledge needed for CDS work.

But the job is not for all coders. One must be experienced, have clinical knowledge, and know proper DRG assignments, Mills says. "They have to feel comfortable talking to physicians," she says. "You have to be a people person to do this."

The job is for people who want to get out of the HIM department and interact throughout the hospital, Sauer says. "You get a whole different feeling for how the business of health is done when you are upstairs," she notes.

Exercise also comes with the job. All day, White travels the halls and stairways of Mount Sinai, reviewing patient charts. Sitting down is rare. She usually reads the record standing.

Avoiding a Turf War between CDSs and Coders

Whether a facility uses RNs or HIM professionals as CDSs, it's important to create an environment where CDSs and coding staff can work together. A program cannot succeed without this cooperation, Bunker says.

"If they don't talk to each other, it doesn't work," she says. "They have to work side by side and share their knowledge. There have to be open lines of communication. There can't be turfs."

Territorial CDSs and coders can mean the quick death of a CDIP, according to Bunker. When a coding question arises, some CDSs dig in, saying they know clinical better than coders, while the coders state they know coding better than any CDS.

Mount Sinai took strides from the beginning to combat turf wars, training both the CDSs and the coders on the program at the same time. This demonstrated that their goal was similar, not separate, and that each side should have an open mind, Bunker says.

Coders and CDSs at Mount Sinai also meet regularly to discuss documentation concerns, coding regulations, and other issues. "There is a really good rapport and respect for each other," Sauer says.

Working Fast and on Your Feet

Each morning Mount Sinai's three CDSs mark off which patient charts they will review. Typically they wait until the patient has been in the hospital for 48 hours before reviewing the chart for the first time.

CDSs can't be slow in their reviews. Once they pick up a chart, they are never sure how long they will have possession of it. Although it is important that they see the record, physicians and other providers get first dibs.

"You always have to be looking over your shoulder for someone coming to take your chart," White says. "You learn to share, and it is important to establish a good working relationship with everyone up here. Have an understanding-you have a job to do, they have a job to do."

After CDSs get their hands on a record, their primary duty is to query for additional documentation. If a question is found regarding a physician's documentation, CDSs write a query and place it in the record. The physician is then required to answer the query in the progress notes as soon as possible.

At many facilities CDSs establish a working DRG for each case. CDSs also search the record for any CCs that should be added during coding. "It is like reading a story, and bits and pieces are missing," White notes. "Better documentation allows the telling of the whole story for that patient's length of stay."

While reviewing the chart of a patient admitted for a foot cut on broken glass, White noted that the physician documented that the patient had a history of drug use and was HIV positive. This raised a red flag for the CDS. Physicians tend to use the terms HIV and AIDS interchangeably, but they differ in terms of treatment and reimbursement. AIDS is a different DRG and uses different services at the hospital, and it should be reflected as such in the medical record, White says. Treating the two illnesses can lead to different length of stays and procedures.

Using a customized query sheet, White asked the patient's physician whether the patient was HIV positive or had full-blown AIDS. White planned to check on this query the next day. If the query had not been answered in an update of the progress notes, she would page or track down the physician to get a response.

CDSs also query on the back-end, after the patient has been discharged and the chart has been sent for coding. This is a catch-all for anything missed during the concurrent review, since at times CDSs cannot review a chart due to a short length of stay.

Of course, CDSs can query all they want, Pait notes, but it is up to the physicians to respond if a documentation improvement program is going to work.

Convincing Physicians

Physician cooperation and acceptance is vital to a CDIP's success. "Without it your program will fail," Pait says. "If you do not have an engaged champion selected on the clinical side, you can query till the cows come home and they are not going to answer it."

Convincing physicians comes down to two points. The first: better documentation leads to better patient care. A chart with fine details about a patient's condition and treatment is more useful during subsequent treatment.

"We need a good history and physical on the patient, not just for the capturing of the coding," Lewis states, "but for every healthcare professional looking at the record. They need to have specific and quality documentation for that patient."

Secondly, since better documentation increases a hospital's ability to capture revenue, physicians should be reminded that some of that additional revenue will go toward clinical wish-list items and programs, says Lewis.

Physicians should receive education on the program from the start. It should be clear that CDSs are not querying to influence medical diagnoses or attempting to affect treatment. Their concern is coding, and they ask for clearer documentation to assist in that coding, White says.

A CDIP can take time to grow roots. When Mount Sinai's program was first implemented, physicians answered only 75 percent of CDS queries. Today they answer all of them, Sauer says. Education and acclimation are responsible for the

increase. Classes on the program are given each year to the new resident physicians. This helps physicians know up front what to expect out of the program, and that education has helped boost query answer rates.

A physician champion can be invaluable in generating physician support and can serve as an effective liaison between the clinic and coding. Strong support from a hospital's vice president of medical affairs is also necessary.

Bridging the Gap

In addition to coders and clinicians, people with other C titles-CFOs, CEOs, chief medical officers, and chief nurses-must be on board. It must be clear to all of them that clinical document improvement efforts benefit both care and coding, Pait says.

An HIM director must emphasize CDIP is about more than money, agrees Sauer. "Bottom line, it is all for the patient," she says. "If it were my own mother, father, sister, brother, husband, I would certainly want to know that all of their care was completely documented."

Hospitals have always had the challenge of finding ways to improve reimbursement while improving clinical care. Improving clinical documentation seeks to improve both clinical and financial aspects at the same time, Pait says, which is rare for healthcare.

"We thought the clinical and financial were in two different camps, walked and talked to the beat of a different drummer for all these years," Pait says. "Documentation improvement allows us to bridge that gap and be part of the same team, seeking the same quality outcomes together."

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Article citation:
Dimick, Chris. "Clinical Documentation Specialists" *Journal of AHIMA* 78, no.7 (July 2007): 44-46,48,50.