Document Like This, Not That: CDI Insights from the Physician and CDI Specialist Perspective

By Wil Lo, MD, CDIP, CCA

Many HIM professionals, especially clinical documentation improvement (CDI) program participants, wonder why it can be so difficult for physicians to provide timely, reliable, precise, consistent, clear, and complete documentation in patients' charts. It seems logical that time spent on proper documentation practices on the front end will lead to decreased time spent on responding to queries and audits on the back end. Also, proper documentation will lead to better patient care, better treatment outcomes, better severity of illness (SOI) and risk of mortality (ROM) scores, better patient safety indicator (PSI) scores, better Healthgrades, better University Hospital Consortium (UHC) scores, and decreased Recovery Audit Contractor (RAC) denials.

But the answer isn't as simple as it may seem.

CDI Narrows the Physician-Coder Chasm

In order to shed light on the challenges of CDI, the following case scenario will be used to illustrate the documentation issues that physicians face:

> A 47-year-old male patient presents with a slight fever and a non-productive cough. A chest x-ray reveals bilateral granular infiltrates. The patient's absolute CD4 lymphocyte count is 174 cells/mcl. A bronchoalveolar lavage specimen is obtained and the pathology report states 'Grocott-Gomori Methenamine silver stain reveals organisms consistent with *Pneumocystis jiroveci*'. The attending physician admits the patient and initiates a treatment regimen with aerosolized pentamidine.

The novice coder assigns a retrospective ICD-9-CM diagnosis code for "*Pneumocystis jiroveci* pneumonia" (136.3), but inadvertently misses the diagnosis of "AIDS" (042). In this scenario, the diagnosis of AIDS is evident to the attending physician because a diagnosis of *Pneumocystis jiroveci* pneumonia meets the criteria for the US Centers for Disease Control and Prevention (CDC) AIDS case definition, despite the absence of positive HIV serology. Also, an absolute CD4 lymphocyte count that is less than 200 cells/mcl points to the diagnosis of AIDS.

Ideally, the attending physician should have documented "AIDS" or "HIV disease" and the coder should have been familiar with the CDC's AIDS case definitions. But in this scenario a chasm exists between the physician's documentation practices and the coder's ability to abstract the proper diagnoses from the patient's chart. An effective CDI program will narrow this chasm.

Taking the example above, a CDI specialist could perform a concurrent chart review for physician documentation. Having both clinical and coding skills and knowledge, the CDI specialist could proactively query the physician for the clarified diagnosis of *Pneumocystis jiroveci* pneumonia due to AIDS.

Documentation experts believe that three parties play pivotal roles in the success of a CDI program—physicians, CDI specialists, and coders. In this article, physicians, physician-coders, and CDI experts provide their insights on CDI. Subject matter expert-level coders share their insight in a separate online article (see end box). The hope is any facility, regardless of the type of setting, patient population, or service lines, will glean pertinent information that helps improve their CDI programs.

Various Factors Lead to Poor Documentation Habits

Why are some physicians unable to appreciate the serious ramifications of incomplete, inconsistent, imprecise, unclear, and untimely documentation? The attending physicians of today were not formally trained in proper clinical documentation practices by their predecessors. In turn, today's attending physicians perpetuate this cycle to the medical students, interns, residents, and fellows, who then become the next generation of attending physicians.

Physicians perceive documentation solely as a means of communication of patient care between clinicians. This dogma needs to be challenged by introducing formal clinical documentation training in medical schools and in teaching hospitals. Ideally, medical schools should incorporate formal clinical documentation training in the basic science courses (during the first and second years of the program) or as a required clinical clerkship (in the third and fourth years). Residency programs should include formal clinical documentation training as a required rotation and as part of grand rounds. By breaking the cycle, the next generation of attending physicians will be able to properly document patient care as well as become physician champions who encourage their colleagues to "buy-in" to the CDI programs.

In addition to the lack of formal clinical documentation training, other factors may preclude proper physician documentation practices. "The level of experience is a factor. Understanding the nuances of appropriate documentation is an art that is dependent on the type of hospital as well as the general culture of the medical community in that region," says Baber Ghauri, MD, MBA, FHM, FACP, chief medical information officer at St. Mary Medical Center, CHE Trinity Health. "Time is a factor. Patients with high complexity are inherently more difficult to document on, making more opportunities for non-compliance.

"Also, employment status is a factor. Providers employed by organizations with proper resources are more incentivized to comply with good documentation practices because their organization manages this process, whereas a provider in private practice generally does not have this resource."

Explain CDI by Its Physician Impact

Physicians do realize the importance of accurate clinical documentation and an overwhelming majority of physicians are receptive to CDI training. "With respect to payment and the fee-for-service payment methodologies, physicians are paid on the basis of CPT codes. However, the payment has to be justified based on complexity of decision making," says Garry Huff, MD, CCS, CCDS, president of Huff DRG Review. "An essential component of that is the nature and number of diagnoses that have to be considered. This is essential for getting proper reimbursement for your level of evaluation, getting paid for procedures, ancillary services you provide in the office, etc. The CPT code determines how much you are paid but it is the diagnostic code that determines 'if' you get paid."

Medicare Advantage and other risk-sharing payment methodologies determine their per capita payment by the number and complexity of the diagnoses of a patient. With accountable care organizations, the payment of physician inpatient care is connected with the hospital's payment under the DRG system, Huff says, which is predicated on diagnosis and procedure coding.

Huff explains why profiling and patient care are important to the physicians. "With respect to profiling, data is becoming increasingly available on outcomes such as mortality, patient safety indicators, readmission rates, and cost efficiency. This will be available eventually on the Medicare websites for the public to see. Currently, it is by facility, but the data reporting will be expanded on the physician side," Huff says. "Also, with respect to patient care, without money there is not a mission."

Hospital reimbursement and profitability is dependent on physician documentation and resource utilization. In the not-for-profit facilities, Huff says, the profits are put back into services and the physical plant so physicians can provide quality healthcare. "Being an advocate of fair reimbursement for the hospital is also being an advocate for patient care," Huff says.

Further, physicians appreciate feedback about CDI metrics, especially if the CDI metrics affect them personally. CDI metrics can serve as an excellent tool to engage and instruct physicians in proper documentation practices.

"I think physicians would like to see feedback on the measures that affect them personally, such as physician quality scores," says Lou Ann Wiedemann, MS, RHIA, CDIP, CHDA, CPEHR, FAHIMA, senior director of HIM practice excellence at AHIMA. "Everyone wants to understand, know how CDI will affect them personally and the same is true for physicians. They need to understand how their documentation is used for not just code assignment, but for secondary data uses such as

quality measures, physician report cards, etc." Providing data regarding query rates and volume by physician may also be of interest. "They may like to see how they compare to their peer group in terms of clear documentation," Wiedemann says.

However, the setting may dictate which CDI metrics are emphasized. According to Kathy Hallock, RHIA, CDIP, medical coding quality consultant, medical information services, at Vanderbilt University Medical Center, the CDI metrics physicians would find most helpful are different depending on the setting (i.e., university hospital, community hospital). "In university settings, many of the hospitals are a part of the University Hospital Consortium, which provides benchmarking data on all patient populations," Hallock says. "It has been my experience that these hospitals tend to have a greater interest in SOI & ROM scores, PQRS and patient safety indicators. Many of these metrics are part of the requirements for CMS (the Centers for Medicare and Medicaid Services) and are being identified in the US *News & World Report's* Top Hospitals."

Ghauri offers perspective as a chief medical information officer at St. Mary Medical Center, a community hospital. "Well, any 'good citizen' of the hospital would find this information useful. If these metrics could be delivered discretely and unobtrusively in some sort of easy to understand dashboard with a summative score, it would be welcomed by the medical staff," Ghauri says.

Ghauri listed the following CDI metrics in order of decreasing relative usefulness to physicians: Healthgrades, PQRS and physician quality scores, most common CCs/MCCs, most common DRGs, SOI and ROM scores, CMIs, RAC denials, query agreement rate, query volume, and query response rate. Regardless of the setting, it is evident that physicians value CDI metrics that directly benefit them and that allow them to make comparisons with their peers.

Queries Can Be Contentious

Another contentious topic is the physician query, which serves as an opportunity to clarify the principal diagnoses, present on admission (POA) status and secondary diagnoses, as well as an opportunity to educate the physician on proper documentation practices. The physician query can benefit the physician with respect to patient care, treatment outcomes, patient safety indicator (PSI) scores, SOI/ROM scores, and Healthgrades. But some physicians are habitual query non-responders.

Ginger Boyle, MD, CCS, CCS-P, CDIP, CCDS, associate professor of family medicine at Spartanburg Regional Healthcare System, offers some insight on why some physicians are query-adverse. "Most physicians are trying to focus on the direct patient care in a timely manner. They may feel taking the time to respond to a query will slow them down," Boyle says. "A few physicians may interpret CDI queries as intrusive, or punitive, as if someone is telling them what to do. I feel for the most part the physicians see additional papers on the chart and do not understand what it is for, why it is there.

"They are aware of documentation guidelines and ICD-10 but do not fully understand how it affects their desire to do what is best for their patient."

With so many regulations in effect right now—such as patient-centered medical homes, value-based purchasing, the "meaningful use" EHR Incentive Program, ICD-10-CM/PCS, RACs, MACs, and MICs—some can feel the doctor-patient relationship gets lost, Boyle says. "The doctors are trying to focus on doing the best for the human being for whom they are caring," Boyle says.

Describing to physicians the impact of documentation on the PSI 90 Composite Measure, with respect to the physician query, can be a good way to get the point across. There are several PSIs that comprise this metric, which has a significant impact on Medicare reimbursement, Hallock says. For many university hospitals, 1.5 percent of Medicare revenue is held and hospitals receive this if they meet required quality outcomes. One of these outcomes is PSI 90. Querying the physicians to clarify complications, POA, and other aspects of PSIs is crucial to this outcome, Hallock says. Pre-billing review of the PSIs that make up PSI 90 is a beneficial practice.

"It is valuable education for the physicians in terms of how their documentation affects outcomes," Hallock says. "I think it is also very important that quality reviews are performed for the CDIs to make sure that the queries being sent are not only appropriate but necessary. If physicians get bombarded with queries, they will develop query fatigue and at that point will be less likely to be cooperative," Hallock says.

Documentation Specialists Present their Viewpoint

Clinical documentation improvement programs attempt to bridge the gap between the clinician's language and the coder's language. The apparent gap is related to the difference between "doctor-speak" and "coder-speak," according to Boyle. Coders translate written documentation into numbers and usable bits of data. Doctors and other patient care providers translate signs and symptoms into treatment plans, medications, and procedures. "We share the common goal to provide the best possible care to the patients we serve," Boyle says. "However, the nuts and bolts that we work with on a day-to-day basis are not the same."

Narrowing this gap can be accomplished when "we walk a mile in the other's shoes," Boyle says. "When physicians become coders and coders/nurses/CDI specialists become part of the care team, the documentation is improved."

Physician coders in a residency education program can be an excellent asset to improving documentation at the time the knowledge is first gained. Physician coders within a hospital's administration provide insights into the requirements and the physicians' resistance to fully comply, Boyle says. Coders and CDI specialists within a rounding team can provide on-the-fly, at-the-bedside education before the documentation is part of the permanent record. This is a proactive vs. reactive strategy, and "is key to moving forward," Boyle says.

Hallock offers additional insight to bridge the gap. "I do not believe physicians truly understand the value of a CDI program and [they] believe that it only benefits the hospital," she says. "It is important to educate physicians regarding your CDI program and also make sure they understand that the codes generated by the hospital are used in creating their benchmark profiles, which are used in contract renewals as well as visible by potential patients looking for a physician."

Physicians are being asked to do more tasks that take time away from delivering patient care. This is why it is important for one's CDI query process to be as user friendly as possible, and ideally have it become part of a physician's normal work flow. "For example, if you have the capability of attaching the query to the document in the EHR, this would allow the physicians to answer the query immediately because they are already in the patient's record," Hallock suggests.

Innovative approaches to CDI are being implemented in all types of settings, ranging from large university hospitals to small community hospitals. Marty Conroy, EdM, RHIA, CPC, director of CDI and ICD-10 education, Temple University Health System, describes some innovative approaches to CDI. "We code our accounts concurrently. We then provide physicians with their DRGs and lists of diagnoses codes, procedure codes, and their expected length of stay," Conroy says. "We also alert the treatment team of any Core Measure patients, PSIs, and HACs. Severity of illness and risk of mortality are a focus rather than just reimbursement. The physicians get payer-specific feedback on all of their patients, not just Medicare patients."

Conroy's team works with specialties to identify services that increase cost and extend a patient's length of stay. One focus is oxygen. "We ask the physician to document the reason why a patient requires a nasal cannula 24/7," Conroy says. "Other initiatives focus on when a mass transfusion protocol is initiated or when specific drugs are given that have a single purpose. We have educated physicians and monitor for these interventions to ensure documentation exists to justify them."

EHRs Helping and Hurting Documentation

Many expect that the implementation of EHRs and automation should facilitate the documentation process. Although EHRs can provide drop down menus and clinical decision support, there are some drawbacks to keep in mind. "EHRs will not solve every documentation issue or concern that an organization or provider has," Wiedemann says. "During implementation, careful attention should be given to documentation issues and reviewed against the technology."

For example if a drop down menu or pick list can alleviate some documentation issues, then it makes sense to utilize that technology to assist in documentation efforts. But if the issue is that the physician does not document to begin with, or is late in his or her documentation efforts, an EHR will not address that issue, Wiedemann says. In addition, careful consideration regarding technology such as copy/paste functionality is needed by the organization and provider to ensure that it is being used appropriately. "Some 'easy' electronic documentation methods can result in erroneous documentation," Wiedemann says. The physician, not a state-of-the-art EHR, is the cornerstone of proper documentation practices.

Show, Don't Tell

With respect to training physicians on CDI, Conroy says his team provides most education in small group settings. "We have found large group and general education to be a waste of time," Conroy says. "We have also found education is most welcome when physicians are with their peers. The group interaction has reinforced the learning."

Barbara Lopez, BS, RHIA, data integrity manager at St. Mary Medical Center, says it can be a challenge to get physician buy-in, and has heard about a doctor who wants to flee when he sees a CDI specialist walking his way. "In effect, walls are unintentionally being erected to 'protect' what little time they have to get to see their patients and complete their other tasks," she says. "We wanted to be within their 'walls,' not outside. Rather than 'mandate' a physician, we took the approach of the Servant Leadership Model."

For example, the CDI team aligned themselves with the physicians' mission and the things that matter most to them—memorable customer service, quality patient care, and positive clinical outcomes. Lopez's group has taken an innovative approach to CDI where CDI specialists handle clinical documentation and concurrent Core Measure Quality Review workflows. The collection and review of the patient data occurs at the beginning of the stay and often involves the review of "core measure" or evidenced-based criteria in order to arrive at a working DRG. Second, it "alerts" the physician to the patient. Rather than have two (core measure and CDI) colleagues review the same chart and contact the physician, Lopez's team has combined their functions.

Lopez and her colleagues decreased the number of chest pain diagnoses by showing the physicians how to "link" the symptom to the condition being evaluated and how the length of stay and severity of illness was impacted, she says. "The CDI specialist has become an integral part of the process and the clinician team," Lopez says.

The physicians helped create the query and then tied a metric to query completion in an effort to obtain the correct diagnosis. The CDI team supported the physicians with outcome data that showed the decrease in the chest pain diagnosis, the alternative diagnosis, and the improved severity of illness alongside the names of the attending physician and cardiologist.

Lopez emphasizes the importance of having strong leadership and physician support for CDI programs. "Physicians care about quality. They recognize that their performance scores are tied directly to hospital and public comparative domains and they are being rated," she says. St. Mary's Medical Center found the CMS Value Based Performance Program was a good initiative to focus CDI efforts on. Physicians have started to see the CDI team as content or subject matter experts—who have become the "go to" colleague to support physicians in their overall documentation efforts.

"As a result, we have realized successful outcomes, solid documentation, high compliance rate (more than 90 percent) of answered queries within five days and have a strong physician commitment to move forward together as the healthcare climate shifts," Lopez says. "Our program has taken a new move forward with the identification of 20 physician leaders who will support the ongoing work of CDI specific to discipline."

What helps the initiative is having strong leadership in place that supports the program, such as St. Mary's chief medical information officer (CMIO), "who is a huge advocate of our program and works to improve the electronic capture of approved ICD-9 and ICD-10 diagnostic terms," Lopez says.

By placing themselves alongside each physician, the CDI team has developed a deep rapport and friendship built on trust and an authentic credibility. "We tailored the CDI function for pure clinical documentation review. The actual data abstraction occurs on the back end by the data integrity analyst," she says. "In many ways, the CDI specialist position can be viewed as a clinical documentation practitioner or subject matter expert. As a result, this model goes beyond the 'standard' chart review and actually stands out in the physician's mind because the outcomes are directly tied to his and to the clinical committee performance as a whole."

Although CDI initially may appear to be a daunting task, it is a manageable task. CDI programs should foster collaboration between physicians, CDI specialists, and coders. Physicians can receive ongoing training in proper documentation practices through interactions with CDI specialists and coders. Novice coders, through interactions with physicians, CDI specialists, and advanced coders, can receive ongoing training to deftly navigate through patients' charts, to understand the clinical pathways, and to assign the proper codes. In the end everyone benefits, including the patient.

References

AHIMA. “Clinical Documentation Improvement Toolkit.” 2010.

AHIMA. “Guidance for Clinical Documentation Improvement Programs.” *Journal of AHIMA* 81, no. 5 (May 2010): expanded web version.

AHIMA. “Guidelines for Achieving a Compliant Query Practice.” *Journal of AHIMA* 84, no. 2 (February 2013): 50-53.

AHIMA. “Using CDI Programs to Improve Acute Care Clinical Documentation in Preparation for ICD-10-CM/PCS.” *Journal of AHIMA* 84, no. 6 (June 2013): 56-61.

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

Lopez, Barbara A. “Establishing a CDI Program: How One Organization Leveraged Nursing and Coding Skills to Improve Clinical Data.” *Journal of AHIMA* 81, no. 7 (July 2010): 58-59.

Rollins, Genna. “Clinical Documentation Improvement: Gauging the Need, Starting Off Right.” *Journal of AHIMA* 80, no. 9 (September 2009): 24-29.

Russo, Ruthann. *Clinical Documentation Improvement: Achieving Excellence*. Chicago, IL: AHIMA Press, 2010.

Towers, Adele L. “Clinical Documentation Improvement—A Physician Perspective: Insider Tips for Getting Physician Participation in CDI Programs.” *Journal of AHIMA* 84, no. 7 (July 2013): 34-41.

Read More
Document Like This, Not That—Coders’ Perspective
journal.ahima.org

To prepare for ICD-10, both physicians and coders must be prepared. Physicians need to provide more detailed documentation, and coders need to understand the Official Coding Guidelines for both ICD-10-CM and ICD-10-PCS, as well as have in-depth knowledge of anatomy and physiology. Read an extension of this feature article, focusing on the coder’s perspective of CDI, on the *Journal of AHIMA* website. The piece discusses what coders feel they—and physicians—must improve upon within a CDI program.

Dr. Wil Lo (wil_md@yahoo.com) is a CDI physician consultant.

Article citation:
Lo, Wil. "Document Like This, Not That: CDI Insights from the Physician and CDI Specialist Perspective" *Journal of AHIMA* 85, no.7 (July 2014): 36-40.