Impact of Clinical Documentation Improvement on the International Stage

Save to myBoK

By Tammy Combs, RN, MSN, CDIP, CCS, CCDS

Illness doesn't care what country or region a person lives in, and it doesn't care the race or origin of a person. Since illness is found everywhere around the globe it only stands to reason that providers should also look beyond the boundaries of one country or patient population when researching treatment for the vast array of diseases that impact the human race. This may sound easy, but with numerous languages and documentation standards in play, it can quickly become challenging. Standardization is crucial to a successful integration of diagnostic language into an understandable dialect for all healthcare providers.

The World Health Organization (WHO) is leading the way to bring standardization into realization with the International Classification of Diseases (ICD). This system is managed by WHO to monitor diseases and provide a look at population health in numerous countries.[1] This classification system takes diagnoses and translates them into an alpha-numeric code. This provides the consistency needed to integrate complex medical language. The codes within this complex classification have transformed over the years to not only be used for statistical analysis, but to now guide the reimbursement systems for several countries.

The US has identified that much of the diagnostic documentation recorded by physicians is not providing the details needed in order to assign detailed ICD codes. This discovery has led to the inception of clinical documentation improvement (CDI) programs. CDI professionals are trained in the specific verbiage needed to translate diagnostic terms into the appropriate ICD codes. CDI programs are a valuable resource for physicians to ensure their documentation is of the same excellence as the care they provide. If it isn't, they are not giving themselves credit for the excellent care they provided.

CDI Can Have an International Impact

CDI is becoming very popular in the US, with successes seen in numerous hospitals that have implemented such programs. The success has been evident in fostering appropriate reimbursement, accurate quality scores, and a reduction in insurance payment denials. Statistical analysis also benefits from accurate ICD code assignment, which provides data that has limitless reporting abilities. This level of specificity is not restricted to only one country—several countries report ICD codes. The ICD system has been translated into 43 languages, and 117 countries use the system to report mortality data.[2]

Deborah K. Green, MBA, RHIA, executive vice president and chief innovation and global services officer at AHIMA, explained the value of CDI on an international scale in an e-mail to the author of this article:

> CDI improves the completeness, quality, and specificity of documentation. This is needed without regard to where healthcare is delivered. The same types of initiatives underway in the US which have driven CDI are underway in many countries and regions around the world. These include improving the quality and safety of care, improving the health of populations, and reducing the per capita costs of care. Healthcare delivery system transformation, privatization of care, contracting for care, and even types of value-based purchasing are emerging. I believe all of these are contributing to the level of interest we are seeing in CDI programs and certification outside the US.

CDI Supports Diagnostic Specificity

The level of specificity for an ICD code is determined by the number of characters assigned. The first three characters are considered the category of a diagnosis. The characters that follow the category provide further details about the diagnosis. An

example is femur fracture, which is assigned to category S72, if the documentation gives further detail stating "fracture of the femur shaft" then the code expands to S72.3. By adding the fourth character we have provided the location of the fracture within the femur to bring further clarity to this patient's condition.

With the permission of the WHO, several countries have modified the ICD codes into systems that can provide even greater detail. The US, Canada, Australia, and Saudi Arabia are a few countries who have led the way in using the ICD system to reflect further details to the diagnoses that plague their patient populations. How would the aforementioned femur fracture look in ICD-10-CM, the clinical modification of ICD in the US? Take the level of detail in the documentation a step further by documenting "initial encounter for a non-displaced spiral fracture of the right femur shaft," and then expand the ICD code to S72.344A. This code goes beyond the location and offers the type, laterality, and encounter information. This information can now be used to support medical necessity of payment, quality reporting, and statistical analysis.

Dr. Wil Lo, MD, CDIP, CCA, a CDI physician consultant, has worked with AHIMA in providing international CDI education. In an e-mail to the author, Lo provided an example of growing CDI efforts in Saudi Arabia:

> In the Kingdom of Saudi Arabia, there is a movement toward privatization of health insurance and widespread use of AR-DRGs (Australian Refined - Diagnosis Related Groups) for inpatient reimbursement. With respect to health insurance, facilities will be required to demonstrate medical necessity of procedures by properly documenting the diagnoses. Insurance companies will utilize severity of illness, risk of mortality, intensity of service and length of stay as criteria to determine the level of reimbursement. Facilities will be more accountable and CDI will help each facility meet the stringent standards set by the third party payers… In the Kingdom of Saudi Arabia, and most likely in other countries throughout the world, CDI implementation is viewed as a priority.

CDI Opportunities Abound

Regardless of the country in which care was delivered or the specific code set used, the only way statistical analysis will be reliable is through high quality clinical documentation. "In our work outside the US, we see different clinical coding systems and sets in use," Green says. "But quality documentation is necessary regardless of coding sets used to get to reliable and useable data. I see CDI as a service or practice with 'universal' application."

Physicians are sometimes overwhelmed when they are asked to provide further specificity in their documentation. Training on the verbiage required to gain the detail needed to assign a complete code is not typically included in medical school. That results in physicians who are trying to balance the time they spend caring for a patient and the time they spend documenting that care. CDI is the resource many physicians are turning to in order to make sure the true clinical picture of the care they provided is recognized. This is not only important for the physician, but also for the patients who analyze statistical data when choosing a provider.

Physicians are now publically compared to other physicians, organizations compared to other organizations, cities compared to other cities, states compared to other states, and countries compared to other countries for the healthcare they provide by private entities and the federal government. This comparison looks at the types of diagnosis, care provided, and the outcomes of that care. All of this data must be documented before it can be reported. Accurate clinical documentation is crucial for a fair comparison to be made.

CDI Professionals Wanted

CDI professionals typically spend their days reviewing clinical documentation and translating it into ICD codes, looking for gaps within the documentation. They not only review for specificity, but for the clinical evidence used to support the diagnosis to make sure the documentation reflects the true clinical picture as well. CDI professionals can come from different backgrounds depending on the needs of the organization. Most of these professionals come from either a clinical background, such as physicians and nurses, or a coding background, such as coding professionals and health information management (HIM) technicians/administrators.

CDI is a growing profession that offers the opportunity to impact patient lives by making sure their healthcare journey is expressed in its entirety. AHIMA now offers a credential to recognize these professionals, called the Certified Documentation

Improvement Practitioner (CDIP), which is also recognized internationally. “CDI professionals might be surprised to learn that for those certified there are career opportunities outside the US,” Green says. The CDI profession is growing rapidly throughout the international stage to provide clear diagnostic language to easily recognize the diagnoses that afflict this world.

Notes

1. World Health Organization. “International Classification of Diseases (ICD).” www.who.int/classifications/icd/en/.
2. Ibid.

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