Reinventing CDI: Organizations Relaunching And Reworking Data Integrity Efforts, And Coding Roles, With Clinical Documentation Improvement Programs

By Mary Butler

It's a particularly busy night in the local hospital's emergency department, which is running—as usual—slightly short-staffed. The on-call attending physician goes from room to room treating and diagnosing patients with typical emergency department maladies: influenza, fractured ankle, infant with a high fever and a panicked mother.

Suddenly, a nurse calls a code for an elderly man. As the on-call doctor arrives at the bedside a physician's assistant tells him the patient has uncompensated heart failure. The physician tries three different times to resuscitate the patient—the first two are successful, but on the third, he is unable to revive him.

The physician finishes with his other patients before sitting down with his charts. When he documents his brief encounter with the heart failure patient—with whom he'd had no prior interaction—he documents congestive heart failure as the first listed diagnosis.

But a few hours later he gets a query from a clinical documentation specialist asking for more specific information on the heart failure patient's diagnosis. What he wrote isn't enough to adequately assign a code.

Minnette Terlep, BS, RHIT, vice president, business development, corporate compliance officer for Amphion Solutions, says she heard a physician describe a scenario like this one in an attempt to illustrate the challenges physicians face when working with clinical documentation improvement (CDI) specialists. Even though the doctor provided as much information as he could in the patient's chart, the CDI specialist asked him "Was it 'acute systolic failure,' or 'acute diastolic failure,' or 'acute-on-chronic failure?'"

The physician's response to the queries, Terlep says, was "I don't know. All I know is that the patient had uncompensated heart failure and died from it."

The physician's candor went a long way with Terlep in helping her understand clinicians' frustrations with the ever-increasing specificity that health information management (HIM) professionals are seeking. "We can query physicians forever, but there's a point where they really don't know and they can't give us that level of specificity we'd like from a coding perspective," Terlep says.

It takes a special person—and skillset—to juggle what coders and medical billers need with what physicians can provide, and that's where CDI programs and specialists come in. With the federal government scrutinizing Medicare payments and the eventual ICD-10-CM/PCS implementation looming, healthcare providers need documentation reinforcements to protect their bottom line and ensure they are getting appropriately paid for services—as well as meeting various audit and quality program requirements. CDI programs and specialists can be a provider's first line of defense.

Multiple Mandates Spur CDI Opportunity

Physician queries are not just made by overzealous or picky HIM professionals looking to eat up time. A changing healthcare industry has made accurate and complete clinical documentation essential to meeting new quality measures and payment models, and fostering adequate care. Federal initiatives such as the "meaningful use" EHR Incentive Program and its numerous quality measures, Medicare and private insurance audits, value-based purchasing, accountable care organizations (ACOs), advancements in health IT, enhanced patient engagement initiatives, and the transition to ICD-10 all demand a high volume of clean, granular, accurate, and coded data. The consequences of ignoring these mandates and initiatives come with a

cost—whether it's lost reimbursement, investigations by Medicare's Recovery Audit Contractors (RACs), or poor scores on publicly reported quality measures. Poor documentation can also be hazardous to patient health.

While CDI programs have come in and out of fashion over the last several decades, a revival in the initiatives is underway as a way to help meet the above industry challenges and requirements. The programs have been reinvented using the lessons of past failed attempts to create a CDI program embraced by the administrative and clinical sides of healthcare.

Lisa Campbell, PhD, CCS, CCS-P, owner of Physician Practice Resources, says it's been challenging to help physicians understand CDI's quality and financial benefits. Campbell was scheduled to take the CDIP exam as of press time, hoping the new credential would help demonstrate her expertise in CDI processes.

Physicians see someone reviewing their documentation and giving documentation improvement tips as another thing to add to their plate, Campbell says, noting that physicians also feel constrained by EHRs. She often hears physicians say "I spend all my time typing and not interacting."

"And I get it, but at the end of the day, the government is concerned about quality. They're concerned with the patient's problem, how well you're treating that condition. Sometimes the documentation is not reflective of all they do for the patient," Campbell says.

She adds physicians are also feeling the heat from closer scrutiny of inpatient claims by increased governmental audits—like RACs—and the Department of Health and Human Services' Office of Inspector General (OIG). But, she notes, if "you provide quality care, you have quality documentation, you're less likely to be in situations where you're having what you're paid for questioned."

Donna Wilson, RHIA, CCS, CCDS, CPHM, senior director of Compliance Concepts, whose company helps hospitals and physician practices work through compliance audits by governmental agencies, says CDI can play a major role in proving medical necessity for inpatient stays.

Medicare's controversial new criteria for classifying inpatient stays requires concise clinical documentation in the health record certifying the physician's expectation that the patient's treatment plan will cross two-midnights and ultimately justify the inpatient stay. RACs have put these admissions under a microscope, but Wilson says CDI specialists can be a backstop against denials.

"If CDI is well versed and understands the case manager program review, one of the first things they can do when they get the record is see if they have an admission order," Wilson says, noting this step is frequently overlooked.

"The admission order is very important. It's the missing link that the hospitals are falling behind on. The CDI (program) can definitely help with that," she adds. "CDI professionals can assist utilization review and case management and compliance departments in ensuring a timely, accurate admission order and certification."

Sound CDI practices also contribute to information governance efforts because it involves the creation of reliable, complete, and authentic health information, says Lydia Washington, MS, RHIA, CPHIMS, a senior director of HIM practice excellence at AHIMA. Washington says practices such as copying and pasting within an EHR when documenting an encounter with a patient negatively impacts everyone involved. When used incorrectly, copy and paste can create an incomplete picture of a patient's status and the care treatment delivered by either intentionally or unintentionally creating false impressions.

"I realize that these concepts are not particularly new but as we start to think of them from different perspectives and perhaps more strategically, such as not only the implications for payment but also things like coordination of care or patient engagement (including the increased ability to access their own record), we can see that poor documentation has far reaching implications," Washington says. "This broader view is what makes information governance different from how we may have thought about CDI in the past."

The History of CDI

While the term clinical documentation improvement (CDI) is relatively new, HIM professionals have been retrospectively querying physicians for more complete patient information for years, says Diane Gottlich, MS, RHIA, advisory enterprise risk services manager, covering healthcare providers, for Deloitte & Touche. Healthcare professionals working in utilization review, case management, coding, and quality assurance performed documentation improvement activities before CDI specialist positions became mainstream. The emergence of initial prospective payment systems as a reimbursement structure in the 1980s motivated providers to become more proactive about documentation.

"We've been querying physicians forever," Gottlich says. "I even recall chasing physicians down the hallway with a paper record in my hand saying 'Doctor, can you please write this diagnosis on your discharge summary so that we can code it?"

The difference is that in the last several years, dedicated CDI specialists have focused on documenting care delivery while the patient is still in the hospital or clinic instead of after they're discharged. The new breed of CDI specialists have had to be careful not to repeat the mistakes that documentation consultants and specialists made in the late 1990s.

In 1997, a major OIG investigation found that upcoding—perpetrated by inappropriately manipulating DRGs—was costing Medicare millions of dollars. Upcoding was particularly rampant among providers that hired outside consultants to review claims in a move to maximize reimbursement. Back then, consultants were paid on a contingency basis, a practice OIG came out against strongly in its case against hospital chain Columbia/HCA. In that case the provider/HCA settled the fraud charges for $875 million.

The OIG's legal action spurred reform in the way CDI programs were implemented and maintained. Industry consultants moved toward fee-based services and CDI specialists were taught to avoid querying physicians in a leading manner. Now, strategies for ethically querying physicians are a standard part of CDI training.

"We went into a period after 1997 and really through the 2000 decade where there was a lot of caution, and the coders and HIM directors were always trying to get it right," Amphion's Terlep says.

But with the constant tightening of hospital budgets, Terlep worries the temptation to upcode will resurface—and that's another area CDI specialists can help protect against.

"But I'm very hopeful that we learned our lesson in the late 1990s and we're not going to repeat history," she says.

ICD-10 Transition Major Driver of CDI

Without a doubt the transition to ICD-10 is one of the major drivers behind CDI programs. Nelly Leon-Chisen, RHIA, the American Hospital Association's director of coding and classification, says that for many hospital CEOs educational programming about the new code set was an eye-opener.

"This was an opportunity to realize the documentation wasn't what it should be. There were benefits to them [providers], even in today's world, to look at physician education and create a formal program," Leon-Chisen says. "They realized they were leaving money on the table because the documentation was so bad."

While the code set switch is a major factor in strengthening CDI efforts, CDI's benefits can be realized with ICD-9 still in use. Regardless of the coding system, providers still need to be working on collecting data for quality measures to help their participation in value-based purchasing, or their decision as to whether to enter an ACO.

"They [healthcare organizations] are oftentimes using coded data, and if the codes don't reflect differences in severity because the documentation doesn't reflect that, they're missing out," Leon-Chisen says. "Even for organizations trying to figure out what kind of patients they're treating."

Molly DeMink, BA, CCS, CCDS, CDIP, a consultant for healthcare cost containment firm OmniClaim, says preparing physicians for the documentation required for ICD-10 is a matter of continuing education and making sure they understand what happens when they don't document like they should—such as how it can impact reimbursement and care quality.

For example, under ICD-9 it was enough for physicians to document an asthma patient's diagnosis as just "asthma." "They say, 'I've said asthma for the last 20 years and now I have to say 'persistent asthma.' Are you kidding me?'" DeMink says of physician reaction to a common CDI program query.

Appealing to physicians requires a more nuanced approach. "It's not all about the money. We need to accurately describe these [conditions]," DeMink says. When talking to physicians, CDI specialists need to say, "What are the disease processes so you can advance into medicine from here on out? We try to tie the two together and say 'We need data to improve our medical care.'" After all, CDI programs should not be launched purely to increase reimbursement—which would be a violation of both ethics and federal law if "upcoding" was found by an auditor.

Enter CDI Specialists

Both nurses and coding professionals are competing for spots to meet the increasing need for CDI specialists, the CDI program staff that actually review physician documentation and query for improved documentation when needed. Both are a good fit for the job. However, coders with a CDIP credential arguably have a leg up when it comes to transitioning into CDI roles.

AHIMA's CDIP credential is almost completely clinically based, and adds additional requirements for clinical knowledge and critical thinking as it pertains to reading clinical documentation and associating it with a disease process. The credential is meant to enable CDI specialists to ensure that clinical documentation accurately depicts the patient's story. It also encompasses basic HIM principles such as leadership, confidentiality, privacy, and record keeping.

Campbell, of Physicians Practice Resources, is seeking the CDIP credential to better help her with the metrics portion of a CDI review with her clients. She says the credential will help her to better analyze patient data that will help physician practices identify areas of improvement and areas of success. She's also taking refresher courses in disease process and pharmacology.

DeMink says having a CDIP automatically commands respect from the clients she helps with audits. Coders that are interested in transitioning to CDI need to understand pathology and physiology, pharmacology, biology, and disease processes so that when they query physicians, they can do it more intelligently, DeMink says. Nurses can be a great resource for this; ideally, nurses and CDI specialists should be working as teams.

For coders looking to become CDI specialists, there are several important skills they need to possess. Some coders tend to be shy, and that's something they need to overcome if they're going to be on the hospital floor and working alongside physicians. Additionally, they need to be able to analyze data to assist with payment reform initiatives, according to Campbell.

She adds that with the help of her CDIP credential and experience as an educator, she hopes to start a CDIP training program of her own specifically aimed at HIM professionals.

"I want to continue the mission of HIM professionals moving into CDI roles. I think this is something that has to be done quickly because nurses are getting advanced degrees," Campbell says. "I think they'll continue to try and move into these roles that should be for HIM.

"We are skilled in documentation review. We manage health information. I think this is our area of expertise and we need to take it back, so to speak."

Mary Butler (mary.butler@ahima.org) is associate editor at the *Journal of AHIMA.*

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