Reinvigorating Your CDI Program

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Long gone are the days of "grab and go" coding, finding the CC/MCC to push reimbursement to the next level and then moving on to the next record. Today, in addition to reimbursement, clinical data drives quality initiatives, hospital and physician profiles, and medical necessity. Clinical documentation is the cornerstone of clinical data management. It also represents resources used and patient care rendered when reviewed by external auditors. Another key factor impacting clinical documentation is the adoption of ICD-10-CM/PCS, scheduled for October 1, 2015. Greater specificity in clinical documentation has never been more important.

Since clinical documentation is vital to the success of any healthcare organization, now is the time to step up clinical documentation improvement (CDI) programs. Whether kick-starting a CDI program or reinvigorating one, you will want to build a strong foundation for sustainable success.

Formalize Efforts with a Steering Committee

The first step should be to establish a CDI steering committee that includes key interdisciplinary leadership impacted by CDI. While every organization is unique, most committees should include the following representatives:

- Chief financial officer
- Chief medical officer
- Physician champion
- Director of the clinical documentation improvement program
- Director of health information management
- Director of coding compliance
- Director of continuum of care
- Director of quality
- Vice president of nursing

The first project for the committee should be to clearly define the objectives and expected outcomes of the CDI program. Identify and monitor key metrics and develop dashboards for reporting. At a minimum, the dashboard should include the following:

- Documentation review rate
- Query rate
- Response rate
- Impact
- Case mix index (CMI) trend

Measure Progress to Sustain Momentum

The CDI program head must measure progress, recognize the challenges, and take corrective action as needed. As the CDI program matures, the data captured can be increased to expand the dashboard presented to the CDI steering committee. Other areas to monitor include the query response rate by physician, types of queries generated, and trend CC and MCC capture rate. The metrics can be used to pinpoint opportunities for education.

A physician advisor is paramount to a successful CDI program. The physician advisor serves as a CDI advocate, resource, educator, and a liaison for documentation specialists, coders, and providers. The physician may also participate in reviewing denials and assisting with appeals. Participation as a member of the CDI steering committee should be included in the roles

and responsibilities of the physician advisor since they should be well versed in all aspects of the clinical documentation improvement program. It is also important to cultivate unofficial physician supporters; front-line physician support can speak in support of CDI efforts while interacting with the medical staff.

Don't Make It About the Money

The clinical documentation specialist (CDS) has many roles, but none more important than a complete and thorough concurrent record review. Many CDI programs are implemented for the sole purpose of capturing documentation for reimbursement. While accurate reimbursement is a benefit, the CDS must also understand the far-reaching impact of the clinical documentation on care accuracy and quality. This is typically the biggest selling point—improved patient care—that a CDS has when trying to convince busy physicians to provide better documentation.

CDI programs should start simple. One of the basics that clinical documentation improvement practitioners should know and understand is the "present on admission (POA)" definitions. POA has the potential to impact reimbursement as well as quality reporting. POA categories include:

- Y – condition was present on admission
- N – condition was NOT present on admission
- W – provider is unable to clinically determine whether condition was present on admission or not (Note: "W" will be treated the same as "Y" by the Centers for Medicare and Medicaid Services (CMS))
- U – documentation is insufficient to determine if condition is present on admission (Note: "U" will be treated the same as "N" by CMS)
- E – diagnosis is exempt from POA reporting

POA is federally defined as "present at the time the order for inpatient admission occurs." Conditions that develop during an outpatient encounter, including emergency department, observation stays, and same day surgery are considered to be present on admission. Timing of the documentation does not matter. The physician may document that a diagnosis was present on admission at any time, such as in the discharge summary or in a post-discharge query. If the documentation is unclear, then the CDS must query the physician for clarification.

CMS has a number of quality programs that require complete and accurate documentation as an important reporting component. Claims-based measures originate from clinical documentation and have a vital role in quality initiatives. These programs include:

- Inpatient Quality Reporting (IQR)
- Value-Based Purchasing (VBP)
- Hospital Readmission Reduction Program (HRRP)
- Hospital-Acquired Conditions (HAC)

Work closely with the organization's quality department to better understand the role clinical documentation specialists play in helping meet these quality initiatives.

Spice Up Your Program with PEPPER, Other Tools

Take advantage of the findings from the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The report is published quarterly and includes statistical claims data for MS-DRGs at risk for improper payment due to issues with billing, coding, and/or medical necessity. The report compares data at the national and state level, and identifies a hospital's outlier status of high, low, or in the expected range. The findings from PEPPER can be used to develop auditing, monitoring, and action plans at your hospital or facility as needed.

The Office of Inspector General (OIG) is responsible for protecting the integrity of US Department of Health and Human Services (HHS) programs by detecting and preventing fraud, waste, and abuse. The OIG Work Plan is published annually with an overview of the reviews and activities the OIG plans to pursue. Review the OIG Work Plan to understand the hospital-related policies and procedures and the areas targeted for review. Then, implement an internal data mining process to identify areas of vulnerability included in the OIG plan and develop a corrective action plan.

The importance of collaboration cannot be overstated. The CDS has valuable insight into the clinical documentation beneficial to the revenue cycle team. CDI staff should consider participating on the denials team to understand what is being denied due to documentation and how to proactively assist with documentation up-front. Is the revenue cycle team holding claims due to unanswered queries? Having a good rapport with the medical staff helps facilitate a prompt response to queries. There are many quality initiatives that depend on clinical documentation and the CDS needs to stay informed in order to understand the impact documentation has on quality initiatives.

Partner with coders to build and strengthen the CDI program. Monthly team meetings to review rules and regulations that govern coding, query development and compliance, and record reviews foster team building and provide opportunities to share knowledge and skills. Evaluate which queries are being generated retrospectively and review to determine if the queries can be generated concurrently.

Contribute to the development of query templates and review queries generated to promote compliance. Also, CDS and coding team members can collaborate on data mining projects to identify accounts that may be included in the PEPPER or OIG Work Plan focus. Assess the documentation and the final coding to confirm complete and accurate information. If a trend is identified, it may be beneficial to proactively review vulnerable accounts before the final coding is submitted.

A second-level review by a coder and a clinical documentation specialist can decrease denials. Accounts with HACs should also be referred to the quality department for review prior to the final coding in order to determine if the condition was present on admission or hospital-acquired. In addition, the review should include clinical evidence to support the validity of the diagnosis. A solid CDI program is one that moves out of a silo and develops a team-based approach, promoting efficiency and accuracy.

The CDS must take the responsibility to review every record from a holistic perspective, including for POA and clinical validation. When the patient goes home the record must stand on its own. CDS professionals should ask themselves, “Does this record clearly and accurately reflect the condition of the patient and services rendered?” If the answer is yes, then congratulations on a job well done.

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