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The Complete Guide to CDI MANAGEMENT

Cheryl Ericson, MS, RN, CCDS, CDIP • **Stephanie Hawley,** RN, BSN, ACM • **Anny Pang Yuen,** RHIA, CCS, CCDS, CDIP

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Ericson, who currently serves on the Association of Clinical Documentation Improvement Specialists (ACDIS) advisory board and credentialing committee, is recognized as a CDI subject matter expert for her body of work, which includes many speaking engagements and publications for a variety of industry associations. Prior to joining ezDI, Ericson was the CDI education director for HCPro and associate director of education for ACDIS. She also managed CDI, core measures abstraction, and utilization review departments at a large academic medical center. Ericson has an extensive background in adult education, data analysis, healthcare revenue cycle, and CMS guidelines.

Stephanie Hawley, RN, BSN, ACM

Stephanie Hawley is an RN who holds a Bachelor of Science degree from the University of Nebraska Medical Center and is an accredited case manager. She has worked in various capacities within case management over the past 10 years, including functioning as an RN case manager in intensive care, orthopedics, neurology/neurosurgery, and obstetrics. Hawley has functioned as a case management supervisor and an audit and denials manager and is currently fulfilling the role of director of

case management, auditing & education. Hawley was instrumental in developing and implementing the CDI program at a rural 182-bed regional referral center and one of only three level two trauma centers in the state of Nebraska. Hawley understands the limitations and frustrations encountered in rural facilities and brings the unique ability to overcome many of these obstacles. She has an energetic and enthusiastic personality and enjoys the challenges associated with CDI. She has prepared and executed many hours of education to assist providers in more accurately reflecting their publicly reported data, which also ensures that the facility they work for gets the revenue that it is entitled to.

Anny Pang Yuen, RHIA, CCS, CCDS, CDIP

Anny Pang Yuen, RHIA, CCS, CCDS, CDIP, AHIMA-approved ICD-10-CM/PCS trainer, is the director of ambulatory CDI services for Enjoin. Yuen is a health information management (HIM) and CDI professional who has extensive experience in healthcare and revenue cycle consulting. She has implemented and reinvigorated many CDI programs nationwide and has provided on-site CDI support to major health systems. Prior to joining Enjoin, she was the corporate director of CDI at Penn Medicine. In this role, she was responsible for the oversight of four hospitals and was successful in developing a unified and multidisciplinary corporate CDI process focused on improving provider documentation through specialty-specific education.

Yuen is an active member of the American Health Information Management Association (AHIMA), ACDIS, and the Philadelphia/Southern New Jersey local ACDIS chapter. Yuen currently serves on the ACDIS advisory board as an elected member since 2015. She holds a Bachelor of Science degree in HIM from Temple University, where she minored in business.

Introduction

Welcome to the world of clinical documentation improvement (CDI) and to your role as a CDI manager! If you are reading this book, you are probably trying to wrap your head around the fundamentals of building, sustaining, or revitalizing a CDI department. There are many paths that lead to a manager's role in CDI. Since it is still a relatively new profession, oversight of CDI is often an additional duty for an existing health information management (HIM) or case management manager. Although you may have experience in coding, HIM, nursing, or a combination of these disciplines, CDI is a hybrid profession incorporating elements of all these areas and much more, which can be a challenge for the CDI manager. As organizations grow their CDI programs into CDI departments, a dedicated CDI manager is becoming more common. This role is often a natural progression for an experienced CDI specialist who excelled as a CDI reviewer but may lack managerial and data analysis skills.

Because CDI is a hybrid profession that continues to evolve, there is much variation regarding the role of the CDI department within an organization. As the CDI manager, it will be your responsibility to define or clarify the role of CDI for organizational leadership as well as the CDI staff.

In particular, it is important that CDI efforts are complementary to both the business perspective and the clinical perspective. It might be helpful to think of the business perspective as those duties affecting the revenue cycle (i.e., coding and billing), with a focus on revenue. The clinical perspective considers the impact of coded data and clinical documentation on patient care (i.e., utilization review, case management, and quality).

As the CDI manager, you will need a thorough understanding of:

- Your department's mission and goals, with an ability to translate them into policies and procedures reflected in the daily efforts of the CDI staff
- The fundamentals of translating clinical documentation into coded data

- Healthcare reimbursement methodology and other organizational business practices that affect reimbursement
- Quality of care initiatives affected by coded data while ensuring an accurate clinical scenario and the provider's intent
- Relevant industry guidance and best practices from a variety of sources
- Collaboration with the medical staff, coding staff, and other relevant departments

There are many challenges associated with managing a CDI department. Some are centered on staffing, such as recognizing the best staffing model for your organization; hiring, orienting, and retaining staff; continuing education; assessing competency; and ethical practice. Other challenges are related to workflow, including identifying the departmental mission, determining the review population, ensuring coverage of the review population, distributing assignments, promoting a standardized review process, collaborating with coding and other departments, eliciting provider support, and measuring the impact of CDI. Some areas covered in this book will include:

- Why the CDI mission is imperative for success
- How to hire and educate CDI specialists
- How to evaluate the CDI staff and department performance as well as what data should be reported to administration
- Organizational issues that may have an impact on the effectiveness of CDI efforts

The intent of this book is to serve as a reference during times of challenges and/or transition during your new role as a CDI manager. As you are aware, there is no cookie-cutter methodology to CDI, and each department should be tailored to each organization's specific mission and needs.

Now let the journey begin.

Chapter 1

An Introduction to CDI for the New Manager

An inpatient health record is full of information. This includes nursing notes, provider notes, therapy notes, diagnostics, medications, and so forth. Some would say the health record is a communication tool for those caring for a patient, but increasingly the healthcare industry views the inpatient health record as an invoice used to support payment as well as represent the quality of care. It would be burdensome for the complete inpatient health record to be submitted to support a request for payment, so, to simplify the process, the information within the inpatient health record is translated into diagnosis and procedure codes that are submitted on a claim. Diagnosis codes describe disease processes, while procedure codes describe medical interventions. All that information, pages and pages of medical notes, which is referred to as clinical documentation, is translated into a maximum 25 diagnosis and 25 procedure codes when submitted for payment of inpatient services. The applicable code set varies by setting, a term to differentiate inpatient hospital services from outpatient services, as mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The focus of this book is managing clinical documentation improvement (CDI) services in the short-term acute care inpatient setting.

The translation of clinical documentation describing an inpatient admission into applicable diagnosis and procedure codes is the domain of the professional healthcare coder. Although the phrase *clinical documentation* may imply the documentation of any healthcare professional, diagnosis code assignment is based only on the documentation of independent licensed practitioners (i.e., physicians, physician assistants, nurse practitioners, etc.) who provide direct patient care. We'll refer to these independent licensed practitioners as providers throughout this book. The documentation of other

clinicians, which may include nurses and therapists, can be used to assign a procedure code when the clinician performs the procedure (e.g., debridement).

In this chapter, you'll learn about the evolution of coding from a statistical tool to a reimbursement tool to a quality of care tool. As the value of coded data grows in importance, organizations have looked for ways to support the coding process. One of the most successful solutions is the development of a clinical documentation improvement (CDI) program. Thirty-three percent of organizations report a CDI program in 2006, compared to 81% reporting a CDI program in 2015, according to a recent article published by The Advisory Board that highlights the growth of CDI.[1]

Although many organizations have a CDI program, there is as much variation among them as there is commonality. Perhaps because it is a relatively young industry, CDI is continuing to evolve to meet the growing needs of each organization in regard to the multifaceted uses for clinical documentation and coded healthcare data within the healthcare industry. "Clinical documentation is the foundation of every health record in every setting," according to the American Health Information Management Association (AHIMA) *Clinical Documentation Improvement Toolkit*.[2] Therefore, many organizations are implementing CDI programs, revitalizing those that may not be meeting expectations, or expanding the scope of current CDI efforts.

To define CDI efforts within your organization, it is imperative to understand the role of coding to avoid duplicative efforts and promote successful collaboration. Additionally, depending on your professional background, a better understanding of health information management (HIM) and the role of the professional healthcare coder will assist when making decisions regarding the composition of the CDI staff. Future chapters will delve into the specifics of staffing in CDI and how to grow a CDI program into a CDI department.

The History of Coded Data

Although the exact origins of the CDI specialist role are unknown, the HIM profession played a vital role in its development. The field of HIM has been a recognized profession since the 1930s, when its membership was mostly medical record librarians who were tasked with clinical recordkeeping in hospitals. There are many different types of information found within a health record. Some of the information is referred to as administrative (i.e., name of the patient, gender, date of birth, etc.), which is often demographic in nature. However, the majority of the information is clinical. Clinical data are frequently unstructured, because the elements of each field are not clearly defined, so the data can't easily be placed into a database—making it difficult to analyze. One of the responsibilities of the HIM department is the translation of the clinical information within a health record into a standard nomenclature or classification system to create what most refer to as coded data.

The Uniform Hospital Discharge Data Set

The primary classification system for administrative data in the hospital setting is the Uniform Hospital Discharge Data Set (UHDDS), which also contains definitions applicable to coded data (e.g., principal diagnosis, other diagnosis, principal procedure). It was adopted for use with data collection for the Medicare and Medicaid population in 1974 and incorporated into the rules and regulations of the prospective payment system (PPS) during its enactment in 1983.

The UHDDS is a list of 47 patient-specific data elements routinely required for claims processing. Although developed for the short-term acute care hospital setting, its use has been expanded to the outpatient setting, as a complementary data set has yet to be adopted for that setting. It is referenced within the 10th revision of the *International Classification of Diseases, Clinical Modification (ICD-10-CM) Official Coding Guidelines for Coding and Reporting.*

Prior to 1983, the health record was translated into coded data for the purpose of morbidity and mortality reporting (i.e., health statistics, referred to as "indexing"). To make the process of indexing hospital data more efficient, the International Classification of Diseases (ICD) was adopted in the 1950s. The ICD system was created by and is maintained by the World Health Organization (WHO). The ICD is the standard diagnostic tool for epidemiology, health management, and clinical purposes, according to WHO.[3] It is used to monitor the incidence and prevalence of diseases and other health problems, providing a picture of the general health situation of countries and populations. Basically, the process of coding healthcare information is simply applying a classification system to create standardization among different clinical data elements, which is a process that is more difficult than it sounds.

The international version of the ICD code set required modifications to fit the needs of American hospitals. This became the responsibility of the U.S. National Committee on Vital and Health Statistics. As interest in use of the ICD for hospital indexing increased, its viability began to be studied while in its sixth revision. Those involved included the American Hospital Association (AHA) and the American Association of Medical Record Librarians, which later evolved into AHIMA. These organizations, in addition to the Centers for Medicare & Medicaid Services (CMS), would later become known as the "cooperating parties." The cooperating parties remain responsible for the maintenance of the ICD code set, including the procedure classification system (e.g., ICD-10-PCS).

The international community was also making efforts to revise the ICD code system to better meet the needs associated with hospital indexing, as evidenced by the eighth revision released in 1966. Although improvements were made in the latest revision, additional modifications were still necessary for the code set to be applicable to the U.S. population. To differentiate the revised (i.e., modified) version from the original WHO version, it was referred to as the "International Classification of Diseases, Adapted, 8th Revision" (ICDA-8).

In 1968, the ICDA-8 became the basis of coding diagnostic data for reporting official morbidity and mortality statistics in the United States. This version remained in use until January 1979, when ICD-9-CM was introduced.[4] Not only did ICD-9-CM reflect the ninth revision of the ICD code set, but the acronym *CM* (clinically modified) replaced the *A* (adapted) to reflect that the U.S. version differed from the international version developed by the WHO.

Periodic revisions to the classification system continue. The 10th revision of the ICD has been available for use since 1994. It is currently used by 117 countries, including the United States, to report mortality data. However, unlike other countries, which use the system only for statistical purposes, the U.S. also uses coded data for the purpose of reimbursement. Efforts to replace ICD-9-CM with ICD-10-CM in the U.S. to report claims data were ongoing since October 1, 2012, but due to a variety of circumstances, its implementation was delayed until October 1, 2015.

Meanwhile, the WHO has been working on an 11th revision to ICD, with a planned release in 2017. Because it took so long for the U.S. to adopt ICD-10, some thought it might be best to wait until ICD-11 is available to transition from ICD-9-CM, skipping the ICD-10 version altogether to catch up with the rest of the world. However, such a drastic measure was not supported by the HIM industry.

As a CDI manager, it is important to understand that your staff and the coding staff may have different frames of reference depending upon how long they have been working in CDI or the coding industry. Most who are new to these professions are unfamiliar with ICD-9-CM. Many newly graduated coders were trained only on ICD-10-CM/PCS. In fact, being an experienced coder (i.e., having worked with the ICD-9-CM code set for an extended period of time) may even be initially detrimental to coding well in ICD-10-CM/PCS. As such, the concept of coding experience takes on a whole new meaning.

The Medical Coder

Historically, the medical coder was a degreed professional with either a bachelor's degree in registered health information administration (RHIA) or an associate degree as a registered health information technician (RHIT). Formal education was followed by a credentialing exam to demonstrate competency. Coding was one of the many responsibilities performed by the RHIA or RHIT professional. In an effort to increase the pool of professionals able to perform the coding function, several certifications were created that focused exclusively on the coding function within the RHIA/RHIT scope of work. These certifications did not require a college degree or college-level coursework.

The certified coding associate (CCA) is a credential granted to an entry-level coder who has demonstrated the knowledge needed to code a health record. The next step on the coding career ladder for the hospital-based coder is usually the certified coding specialist (CCS). This position is reserved for a coder who has demonstrated proficiency in classifying medical data from the health record into

diagnosis and procedure codes for both the inpatient and hospital outpatient settings. Coders who hold this certification are not only experts in coding but also knowledgeable about medical terminology, disease processes, and pharmacology. However, coders usually lack clinical experience, which can make accurate translation of a complex health record difficult without this frame of reference. Since there are a variety of programs that prepare an individual for a career in healthcare coding, the level of comprehension of clinical information varies greatly among credentialed coders, which can be problematic as the complexity of the typical inpatient continues to grow.

The coding process is usually a postdischarge function that typically begins within a few days of discharge even though the provider often has up to 30 days to complete the health record (i.e., complete the discharge summary according to most accreditation standards). Many organizations allow the coders to release or "drop" a claim without the discharge summary, which can be problematic if new or different information appears in it that conflicts with the rest of the health record. The urgency to complete the coding process is based on a key coding department metric that monitors how many days it takes for the average record to be coded (ready for billing) following discharge, which is referred to as *DNFB* (discharged not final billed). Organizations seek to keep the time between patient discharge and billing to as few days as possible, because they are paid on a prospective basis (i.e., following the provision of services). If an organization does not have adequate resources, it may not be able to continue to provide care while awaiting payment for services rendered. Consequently, the coder must balance speed with accuracy during the coding process.

Coding is a very exact process where provider documentation must exactly match terminology available within the code set in order for code assignment to occur. However, healthcare is very complex and fluid, so the terminology used by the medical staff often does not match to the possible classification terms required by the code set. It is one thing to understand the mechanics of how to assign a code using ICD, but if the exact terminology necessary for code assignment is not found within a health record, representing the clinical scenario through coded data becomes much more difficult. Coding expectations exist based on an ideal world with the expectation of precise, cohesive documentation that follows consistent standards, but provider clinical documentation frequently reflects the real world, which is often imprecise and convoluted.

Limited clinical understanding by professional coders can lead to misunderstandings and misrepresentation of the clinical scenario within the health record when translated into claims data. Unfortunately, even when the coder realizes the mismatch between the clinical scenario and the available codes, he or she is not allowed to infer the provider's intent. Reconciliation can be made only through the physician query process. A query is a formal process asking the provider to clarify his or her documentation to support precise code assignment. It is a time-consuming process that requires great finesse to craft a question that meets both industry guidance and resonates with the provider.

One of the most difficult aspects of the query process is avoiding queries that could be considered "leading." A query is not allowed to "lead" the provider to a particular conclusion (that is, cause

him or her to document a particular diagnosis). The problem is that *leading* is a vaguely defined concept, so there is much disagreement within the industry as to what is and is not leading. Providers are often frustrated by the query process; they often ask the CDI specialist to tell them what to write and don't understand when the CDI or coder responds they are not allowed to do so. Querying is an important process that will be discussed in an upcoming chapter, and there are a couple of key performance indicators (e.g., provider query response rate and provider query agreement rate).

Although the official guidelines for coding and reporting, as well as CMS advice, often encourage queries when the documentation is not clear, there is much variation as to what someone considers "unclear" documentation. The coder's discretion is a major factor in choosing between querying for additional information and potentially incorrectly applying coding conventions or guidelines resulting in the assignment of inaccurate codes. A best practice is to ask if others would come to the same conclusion based on the same information. The goal of CDI should be that all those who review the record come to the same conclusion. If there is room for interpretation, then a query is likely necessary to clarify the documentation.

Physician queries

As a cooperating party for ICD-10-CM/PCS, and a leading organization for HIM professionals, AHIMA establishes professional practice related to coding processes. One such process for which they provide guidance is querying. It is described as "a routine communication and education tool used to advocate complete and compliant documentation." Query guidance is often confusing and frustrating, so many have attempted to avert AHIMA guidance by referring to the process of asking a provider for clarification of their documentation by a term other than "querying." AHIMA responded to these attempts in their 2010 practice brief, "Guidance for Clinical Documentation Improvement," as follows, "CDI programs may use different names, such as clinical clarification, documentation alerts, and documentation clarification. Regardless of what the communication is called, the query should adhere to the guidance outlined in the 2008 practice brief 'Managing an Effective Query Process' and this current (2010) practice brief." Those who perform the query function, regardless of their professional background, are expected to follow AHIMA's guidance, which includes strict guidelines regarding when and how a query can be issued as well as the composition of the query itself. The guidance has been updated several times by AHIMA, the most recent occurring in 2013 through collaboration with ACDIS in the practice brief "Guidelines for Achieving a Compliant Query." The collaboration highlights the impact the CDI profession has made on the query process as it increasingly becomes a concurrent process and the domain of the CDI staff.

Even if providers document the terms exactly as required by the code set, in today's healthcare environment, there are multiple providers caring for a patient through the proliferation of team medicine. The concept of team medicine describes a situation where one physician, usually the hospitalist, coordinates the care of the patient by deferring to consulting providers who specialize in different disease processes (e.g., cardiology, infectious disease, neurology, nephrology, etc.). The documentation from so many providers can create a lot of "static" within the health record. The lead provider, defined as

the "attending" provider within UHDDS, often fails to create a comprehensive note that accurately references all findings by all other providers and clearly outlines the continued course of action and response to treatment. Theoretically, this documentation should be reflected in defined elements of the health record, like the discharge summary, but these are rarely comprehensive documents.

Although there are guidelines that instruct coders on how to prioritize documentation by various providers within the health record, the providers, including the attending provider, are often unaware of these coding guidelines, so documentation within the health record usually fails to meet these coding requirements. As such, the coder needs to be able to effectively and efficiently interact with the medical staff, which can be challenging when the two entities speak different languages. This "language" barrier supported the need for an intermediary or translator who understands both the coding world and the clinical world; hence, the CDI specialist role was created. "The primary purpose of CDI is concurrent review of the medical record to increase the accuracy, clarity and specificity of provider documentation," according to the Association of Clinical Documentation Improvement Specialists (ACDIS) CDI Road Map.[5] Therefore, as the CDI Road Map notes, "a CDI specialist must have knowledge of coding conventions combined with a strong clinical background and excellent interpersonal skills. Coding is not the primary objective of CDI; rather the CDI specialist works to provide coding staff with a complete and unambiguous medical record through communication with the treating medical team."[6]

The Prospective Payment System

Coded data are most useful when they can be grouped into meaningful categories or standardized. The concept of diagnostic-related groups (DRG) was created by Yale University in the early 1970s.[7] The basis of most DRGs is grouping patients together according to their anticipated resource consumption reflected by the severity of their condition as captured by coded data. The DRGs were created to leverage available data resources, such as demographic data obtained during the registration process and coded data obtained during hospital indexing. Specifically, the inclusion of coded data allows DRGs to group patients with a similar pattern of resource usage and who are comparable from the clinical perspective, upon which hospital payment is based.

The importance of coded data changed significantly in 1983 when the PPS was created under the Social Security Amendment Law (Public Law 98-21).[8] The PPS evolved into the inpatient prospective payment system (IPPS), which is currently in use. The PPS required the Health Care Financing Administration (HCFA), which later became the CMS, to use DRG methodology when paying inpatient claims for Medicare "fee for service" beneficiaries. Although the term "fee for service" is being used in regard to Medicare beneficiaries, it is important to note that all Medicare beneficiaries were fee for service in the 1980s, because Medicare Advantage Plans (Medicare Part C) had yet to be established. Under current Medicare benefits, the clarification of fee for service refers to those Medicare beneficiaries who receive their Medicare benefit through Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

Prior to implementation of PPS, Medicare used the private health insurance sector's reimbursement methodology of retrospective cost-based reimbursement. Hospitals filed an annual cost report, and interim payments were reconciled with Medicare allowable costs.

Types of payment systems

The Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to use a common data set, which in the inpatient setting is ICD-10-CM/PCS. Although inpatient hospital claims must report their services using ICD-10-CM/PCS coded data and all health insurance providers must accept these codes, the payer is free to reimburse services for their beneficiaries using any methodology they choose. CMS employs IPPS methodology. State Medicaid plans employ a variety of methodologies including all patient refined diagnostic-related groups (APR-DRG). In other words, the basis of reimbursement may not be coded data for all commercial payers.

The IPPS is a global prospective payment, a type of fee-for-service method of reimbursement. In addition to a global prospective payment, which is designed to cover the entire hospital stay, prospective payments can be paid per diagnosis or per day (per diem). The per-diagnosis approach means payment is determined based on the reported diagnosis without consideration to secondary diagnoses or other contributing factors. Per diem payments usually vary according to the type of bed being provided (i.e., medical, surgical, intensive care, etc.). Other fee-for-service methods are cost based and charge based. The cost-based method is just as it sounds: The payer agrees to pay the costs (or portion thereof) associated with providing the service. Charge-based payments are when the payer agrees to pay what is charged (or a portion thereof), which is usually determined by both the organization's chargemaster (rate schedule) and what is usual/customary within the industry (i.e., the average charge).

The basis of PPS/IPPS reimbursement methodology is a fixed payment determined by the discharge DRG as established by the diagnosis and procedure codes reported on the inpatient claim. The fixed payment is intended to cover all costs related to the short-term acute care admission based on the costs associated with treating a typical patient for that specific DRG assignment. The PPS payment is irrespective of the hospital's charges for services provided during the inpatient admission. It was implemented in response to growing costs due to rapidly increasing charges so Medicare could cap their payments.

A key element in determining the prospective payment rate is the relative weight (RW), which is a factor assigned to each DRG. For example, when a claim is billed in fiscal year (FY) 2016 using DRG 292: Heart Failure and Shock with CC, the RW is 0.9707. If the claim was billed to DRG 291: Heart Failure and Shock without a CC or MCC, the RW would be 0.6737.

The RW is updated annually through a process referred to by CMS as recalibration. The revised RW is effective each October 1 and can be referenced as part of the annual IPPS Final Rule in Table 5. The RW of DRG 292 changed from 0.9938 in FY 2015 to 0.9707 in FY 2016, resulting in a lower RW

and less reimbursement. In contrast the RW of DRG 291 increased from 0.6723 in FY 2015 to 0.6737 in FY 2016, resulting in a slight increase in reimbursement. Fluctuations in the RW may occur annually because it is based on the cost of caring for an average patient within a particular DRG based on prior Medicare claims data.

Even though the same RW is used for all inpatient claims submitted for payment under the same DRG, each organization receives an individualized payment amount when the RW is multiplied by an organization's operational rate (base rate). There are many factors that can affect an organization's operational rate, such as setting (i.e., rural or urban, cost of wages, residency program, technology costs, etc.). The creation of the PPS for use with Medicare beneficiaries established a relationship between coded data and reimbursement, which has since become the most prevalent type of payment system employed by both private and government healthcare insurance programs, even though the ICD was not developed for such use.

Calculating hospital reimbursement

The formula for calculating an organizations payment for an inpatient admission under Medicare Severity DRG (MS-DRG) reimbursement methodology is

MS-DRG RW X Base Rate = Hospital Payment ($)

If a claim is submitted that supports the billing of DRG/MS-DRG 292: Heart Failure and Shock with a CC, the associated RW is 0.9707.

If a hospital's base rate is $5,000, which is also updated annually, the expected reimbursement for the claim is

0.9707 x $5000 = $4,853.50

If a claim is submitted that supports the billing of DRG/MS-DRG 291: Heart Failure and Shock without a CC or MCC, the associated RW is 0.6737.

If a hospital's base rate is $5,000, which is also updated annually, the expected reimbursement for the claim is

0.6737 x $5000 = $3,368.50

The RW varies by billed DRG during the applicable FY, but the hospital base rate is constant throughout the FY.

DRGs are separated into major diagnostic categories (MDC), which correspond to body systems (e.g., circulatory, respiratory, neurological, etc.), for the most part with a few exceptions, like HIV and multiple significant trauma. An important component of DRG methodology is the principal diagnosis, because that determines into which body system (MDC) the claim will be placed, thereby defining the realm of possible medical DRGs. For example, a principal diagnosis of an acute myocardial infarction (AMI) will result in a medical DRG found in the circulatory body system. The technical term for placing a case into an MDC is *grouping*. Incorrect assignment of the principal diagnosis can lead to an error in DRG assignment. Another exception to classification by body system is the pre-MDC group, where classification is based on the assigned procedure code rather than the principal diagnosis. The pre-MDC MS-DRGs include solid organ transplants, bone marrow transplants, and tracheostomy.

The *principal diagnosis* is defined within the UHDDS as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." Although the principal diagnosis is defined by the UHDDS, its assignment is central to the inpatient coding process. To assist the coder with identifying the principal diagnosis, coding conventions built into the code set can provide sequencing direction (that is, they instruct the coder to list one code before another code). If the coding conventions don't provide sequencing guidance, there are also official guidelines specific to the assignment of the principal diagnosis that address a variety of scenarios. Even though there are standard definitions and coding guidelines, the assignment of the principal diagnosis is a subjective process that is influenced by the perspective of the coder and an auditor. As such, there can be a disconnect between what a coder and the utilization review (UR) staff and the admitting provider consider to be the condition responsible for occasioning the admission. Although recommended by coding guidelines, CMS guidance, and the AHA's *Coding Clinic* advice, most coders rarely validate the principal diagnosis with the provider when they perceive more than one diagnosis could be classified as the principal diagnosis.

In regard to professional reimbursement (i.e., reimbursement of physician services) for each encounter (or daily visit) during a hospital admission, the provider will report a diagnosis to "justify" the services delivered during the encounter. This is referred to as the first-listed diagnosis. The first-listed diagnosis (the most important diagnosis during the episode of care) will likely be different for subsequent days during a patient's admission. As one health issue is addressed, another one may become more prevalent. On the other hand, the hospital inpatient admission is only one episode of care in regard to hospital reimbursement, so only one diagnosis (the principal diagnosis) is reported to classify the patient into the appropriate MDC/DRG even though other diagnoses may be addressed during the admission. The principal diagnosis may be modified during the course of the admission as more information becomes available during "study," particularly when a patient is admitted for a symptom. In contrast, the principal diagnosis associated with surgical patients usually doesn't require additional modification.

Once the MDC is determined, additional modifications, like procedure and additional diagnosis codes, can affect the final DRG assignment. MDCs are subdivided into surgical DRGs and medical DRGs. Procedures that treat a condition, as opposed to a symptom, usually result in the assignment of a surgical DRG. This is usually in the same MDC as established by the principal diagnosis. However, there is occasionally a mismatch between the body system associated with the principal diagnosis and that of the principal procedure. There is a special MDC to deal with these types of cases. Since the RW (payment factor) is based on the typical patient and not all hospital patients require surgery, surgical DRGs are associated with a higher payment to account for the additional hospital resources required to perform surgery and care for the postsurgical patient. Procedures that are diagnostic in nature (e.g., colonoscopy, cardiac catheterization, spinal tap, etc.) usually do not affect the DRG assignment, which leaves the case in a medical DRG, as would be expected, because it is typical to perform diagnostic interventions on patients.

The DRG methodology sometimes allows stratification within the patient population when a particular patient deviates from the typical patient because of the complexity of his or her diagnoses. As previously discussed, the principal diagnosis, as captured by a diagnosis code, groups the claim to a "base" DRG within a particular MDC. Some DRGs, but not all, are classified as a *pair,* which separates patients into two groups. The paired groups differentiate a typical patient from those who require more resources, which results in different reimbursement. Diagnoses reported in addition to the principal diagnosis are referred to as *secondary* diagnoses and defined within UHDDS as "other" diagnoses. An additional/secondary diagnosis is a condition that coexisted at the time of admission (e.g., a comorbidity) or a condition that developed during the admission (e.g., a complication) that affected patient care in terms of requiring one or more of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

CMS has reviewed all diagnosis codes, and those that require additional hospital resources are classified as a complication or comorbidity (CC). The difference between a comorbidity and a complication is when the diagnosis is reported. A diagnosis that is present on admission is a comorbidity (i.e., the patient has the condition when they arrive at the hospital). A condition that develops during the admission is referred to as a complication. The abbreviation *CC* is associated with terms like *complicating condition, comorbid condition,* or *concurrent condition,* but within IPPS, CMS simply refers to the list of these conditions as a complication or comorbidity.[9] This can be confusing because, as stated above, UHDDS defines any secondary diagnosis as a comorbidity or complication depending on when it occurred in relation to the admission; however, not all secondary diagnoses are classified as CCs.

The sequencing of the diagnostic terms determines how a diagnosis classified as a CC contributes to the final MS-DRG assignment. If the condition classified as a CC is the principal diagnosis, then it affects reimbursement only through the DRG grouping, making its classification as a CC irrelevant.

Let's explore this concept with the diagnosis of urinary tract infection (UTI). When the UTI is classified as the principal diagnosis, it will cause the DRG to map to the MDC associated with diseases and disorders of the kidney and urinary tract. The "value" of the UTI and the resources used to treat the UTI will be captured by the realm of possible medical DRGs associated with a principal diagnosis of UTI. If, however, the UTI was a secondary diagnosis, then it would complicate the care of a patient admitted for another condition, such as stroke. The potential additional cost for treating a patient who *also has* a UTI is captured by its classification as a CC.

As discussed earlier, some DRGs can differentiate patients into two different groups. Those without a CC represent the typical patient admitted for a particular condition, and those with a CC represent the more complex patient who required more hospital resources. Because a diagnosis code can be reported on a claim only once, a diagnosis code would never be both the principal diagnosis and a secondary diagnosis.

Complications

Many providers and healthcare professionals equate the term "complication" with medical wrongdoing. The term *complication* in regard to PPS refers to a condition that was not present on admission and that complicates the care of the patient; however, it does not assume medical misadventure. The CDI specialist needs to educate providers that a CC is not necessarily a reflection of the quality of care they provided.

In terms of reimbursement, a CC is a broad term that represents any condition that develops during admission regardless of its cause and is a condition that CMS has determined results in the expenditure of additional resources.[10] Medical misadventure is only one possible cause of a condition classified as a CC.

Again, although a secondary/other diagnosis can be a complication or a comorbidity, not all diagnoses are classified as CCs. The volume of diagnoses doesn't impact reimbursement under PPS; rather, it is the reporting of a **particular** diagnosis in combination with a particular principal diagnosis that positively affects reimbursement.

A CC could potentially affect the reimbursement of both surgical and medical DRGs. Those cases where the claim includes a CC are expected to consume more hospital resources, so their associated DRG has a higher RW. A surgical DRG that can be affected by the presence of a CC usually results in the highest reimbursement compared to a typical patient who isn't a surgical patient and doesn't have a secondary diagnosis classified as a CC.

Adding Severity Into DRG Methodology

Initially, DRG reimbursement methodology was used only for Medicare patients; however, the state of New York desired a similar payment methodology for their non-Medicare population. 3M developed an "all patient" DRG (AP-DRG) for use with any patient type, which was adopted by the state of New York and other payers, including state Medicaid and commercial payers. The AP-DRG methodology is still used by some state Medicaid programs. Unfortunately, AP-DRG is not being updated with ICD-10-CM/PCS, so many state Medicaid programs are transitioning to other types of DRGs.

As such, the original DRG system was revised into a variety of groups that better reflect "severity of illness" (SOI) within a patient population. The concept of risk of mortality (ROM) was added to the grouping process in 1990 by 3M with the development of the APR-DRG. The APR-DRG methodology is able to differentiate patients into four different subgroups within each DRG for both the SOI and the ROM. This level of differentiation is consistent within all the DRGs. Every discharge APR-DRG will have a value ranging from minor (1) to extreme (4) for both SOI and ROM. The applicable RW for reimbursement is usually based on the final SOI value. The formula for determining the APR-DRG is complex and proprietary to 3M.

Mortality index

The mortality index is an organizational metric often monitored by academic medical centers and other tertiary care providers. In its most basic form, it is a ratio comparing expected mortality, which is derived from coded data (most often using APR-DRG methodology), to the volume of actual deaths for a comparable time frame. Because provider documentation has an impact on the expected mortality rate through the SOI/ROM value, many CDI departments are tasked with elicting documentation to support the highest possible SOI/ROM rate for a discharges due to death while the quality department focuses on the volume of actual deaths.

A ratio of 1.0 would mean the volume of deaths was as expected. As such, a ratio above 1.0 is indicative of more deaths than expected, so the goal of most organizations is for their ratio to be as much below 1.0 as possible. The lower the ratio, the more "successful" the organization is at treating very ill patients. Because most providers believe they treat the "sickest of the sick," educating providers about how their documentation affects their mortality profiling is often an effective way of obtaining their support for CDI documentation efforts.

The APR-DRG methodology is preferred for these types of calculations because it is more sensitive than MS-DRG and applies to a broader population. The goal of "mortality reviews" by CDI staff is to ensure that any expired patient is reflected as the sickest of the sick, with an SOI of extreme (4) and an ROM of extreme (4). Additionally, all other patients with the same primary diagnosis who survive should also accurately reflect the highest applicable SOI/ROM value to demonstrate that many of the sickest patients also survive. This is how a ratio under 1.0 is achieved.

Many state Medicaid plans that used the AP-DRG system are converting to APR-DRG. Even organizations that don't receive reimbursement under APR-DRG often perform this grouping in addition to any required for reimbursement because it can be useful in evaluating an organization's mortality index.

Rather than adopt the APR-DRG methodology, on October 1, 2007, CMS implemented its updated DRG methodology designed to better reflect patient severity, called the MS-DRG. This is why the terms *DRG* and *MS-DRG* are often used interchangeably. Implementation of the MS-DRG methodology introduced the major complication and comorbidity (MCC) as a secondary diagnosis. An example of an MCC is end-stage renal disease (ESRD) or HIV disease. These are usually very serious conditions that consume a lot of healthcare resources.

Classification of CCs and MCCs

The list of diagnoses classified as a CC or MCC is updated annually as part of the IPPS update. Currently, those diagnoses that were CCs or MCCs in ICD-9-CM retain their same classification in ICD-10-CM as long as the code exists. However, there are many CCs that have been lost in the transition to ICD-10-CM, such as malignant hypertension. For example, when you look up hypertension in the ICD-10-CM Alphabetic Index, you will notice the documentation of "malignant" will no longer impact the code assignment of hypertension as it did in ICD-9-CM. ICD-10-CM also introduced the principal diagnosis with its own CC and the principal diagnosis with its own MCC. This new classification was necessary due to the prevalence of combination codes within ICD-10-CM, where both a diagnosis and its manifestations (or associated symptoms) are captured within the same code.

CMS is not able to adjust the CC/MCC classification lists accurately until it has collected claims data using ICD-10-CM. As such, many industry experts predict significant changes regarding the classification of diagnoses in the FY 2017 IPPS update.

The addition of the MCC allowed some MS-DRGs to subdivide patients into to as many as three different groups, often known as triplets. The first group represents the typical patient, one that uses the least amount of hospital resources when admitted for a particular condition (i.e., without a CC or MCC). The next group often includes those with chronic conditions; they use more resources than a "healthy" patient with only an acute issue but are not the sickest of the sick (i.e., with a CC). The final group is the sickest of the sick, those patients within a grouping that will be the most resource-intensive, and this is represented by an MCC as a secondary diagnosis.

A key factor regarding IPPS reimbursement methodology is it takes only one diagnosis classified as an MCC to maximize the reimbursement for a particular admission. The combination of multiple CCs and MCCs does not affect the reimbursement. As such, once an MCC is captured as a reportable diagnosis, the CDI review process is often complete. But even though only one CC or MCC is required to move to the next MS-DRG level (resulting in higher reimbursement), many organizations have self-imposed requirements that a claim must include two or more CCs or MCCs so there is a backup in case one is denied during the DRG validation process. It is a myth that claims with only

one MCC or CC are more vulnerable to denial compared to those with multiple MCCs. Cases with multiple MCCs are just as likely to be audited if they are associated with a vulnerable MS-DRG (i.e., one that is prone to payment errors).

As the CDI manager, you will likely be determining when the CDI review process is complete. Depending on your staffing levels, it might be beneficial for staff to complete initial reviews and follow-up reviews on cases that aren't maximized before reviewing cases in hopes of identifying an additional MCC. The success of finding an additional MCC will vary depending on the type of organization. Large, tertiary care regional medical centers and academic medical centers are the most likely to have patients with multiple MCCs. However, even within these types of organizations, the sickest of the sick patients are usually found within intensive care units (ICU), so it may be futile to continue to review patients at a lesser level of care for an additional MCC.

CDI departments that perform DRG validation only on Medicare patients (i.e., review those diagnoses that affect the MS-DRG assignment as a principal or secondary diagnosis) usually require the least amount of follow-up reviews. Many records will be "maximized" and have no additional opportunity to change the DRG assignment following the initial review. In other words, it is a "one and done" process where the CDI staff likely completes more initial reviews than follow-up reviews. This type of review process requires the least amount of training, because the CDI specialist can memorize the list of those diagnoses classified as a CC or MCC. Theoretically, the CDI specialist doesn't even need to know how to assign a working MS-DRG, as he or she can review records for evidence of missing, vague, or incomplete diagnoses that would be reported as a CC or MCC regardless of the associated working MS-DRG. As a result, the CDI specialist is able to limit the scope of his or her reviews by focusing only on documentation related to these diagnoses. This is often a good starting point for the new CDI specialist so he or she doesn't feel too overwhelmed by the complexity of the reimbursement system.

In contrast to IPPS methodology, the volume of secondary diagnoses can affect the grouping under APR-DRG methodology and subsequently the reimbursement. Under APR-DRG, *any* diagnosis can potentially impact the SOI and/or ROM value, so *every* diagnosis potentially has significance. These types of reviews are often more in depth, as documentation efforts include obtaining the highest specificity of all diagnoses rather than focusing only on those that are classified as a CC or MCC. As expected, it is also harder to "close" these reviews than it is for MS-DRG reviews, because only a small proportion of cases (between 5% and 15% depending on the type of organization) will reach a value where both the SOI and ROM are extreme (4). Since any diagnosis can potentially impact the SOI and/or ROM value, a CDI specialist may continue to review these cases until the patient is discharged. Best practice is for CDI review efforts to be supported with technology similar to that leveraged by the coding department so the findings associated with each review are retained and additional reviews enrich and clarify the existing information (i.e., add diagnoses). It would be very time consuming for the CDI specialist to enter all the associated diagnoses to generate the working APR-DRG with each review.

Clinical Documentation Improvement

Although coders within the HIM department have always translated clinical documentation into associated codes using the ICD code set, it has become increasingly difficult for coders to meet all the competing demands associated with accurate claims data while maintaining productivity standards. This challenge became more difficult with ICD-10-CM/PCS implementation; the HIM industry expects initial coder productivity losses in the range of 40%–80% depending on the volume of procedures and sustained productivity losses of 10%–20%. Most agree that coder productivity will never return to pre-ICD-10-CM/PCS levels even with the support of computer-assisted coding (CAC) and other technology.

As CMS changed its reimbursement methodology, hospitals discovered the need for an intermediary or interpreter to bridge the gap between provider documentation and coded data due to the growing negative impact on reimbursement when improper DRG assignments occurred. This gap supported the introduction of a new process into the revenue cycle where clarification of clinical documentation became a concurrent process—while the patient was in the hospital—rather than a postdischarge process. The CDI specialist performs this function within many organizations. Because most organizations at first only employed a few CDI specialists as an experimental process, the effort was often referred to as the "CDI program" because it lacked organizational infrastructure (i.e., a manager, an independent budget, etc.) necessary to be considered a department.

Some organizations were early adopters of CDI programs, implementing them under the DRG system. Often, the goal of the CDI specialist was to ensure the documentation supporting a diagnosis classified by HCFA as a CC was sufficient to allow code assignment. The success of the CDI program was often measured by its return on investment (ROI), because it had to demonstrate its worth through revenue capture that would otherwise be missed. Since the focus was on clarifying clinical documentation, the CDI specialist needed to understand which documentation was needed to support code assignment as well as how code assignment affected hospital reimbursement. Initially, many organizations staffed their CDI programs with experienced coders, because coders traditionally performed the query function of asking for clarification regarding provider documentation. However, many organizations discovered that even among veteran coders, their clinical knowledge varied, as did their ability to identify documentation gaps. As a result, many organizations found registered nurses to be the best candidates to fulfill the CDI specialist function while working collaboratively with both coding and the medical staff. The introduction of nurses as CDI specialists allowed coders to focus on what they do best, code assignment, rather than trying to interpret clinical documentation to ensure the coded data can accurately reflect the clinical scenario.

A 2005 study published in the *Journal of Health Services Research,* "Measuring Diagnoses: ICD Code Accuracy," determined the following:

> *Increased attention to code accuracy has occurred both as a result of the application of ICD codes for purposes other than those for which the classifications were originally designed (reimbursement) as well as because of the widespread use for making important funding, clinical, and research decisions. Code accuracy, defined as the extent to which the ICD nosologic code reflects the underlying patient's disease, directly impacts the quality of decisions that are based on codes, and therefore code accuracy is of great importance to code users.*[10]

Specifically, the study found that "many sources of error are interposed between a person's disease (as it is in truth) and the word label (the diagnosis) applied to it by a clinician, and between the diagnosis and the nosologic code applied to it by a medical coder."[11]

The CDI specialist, especially one with a clinical background, can be the bridge between the world of the clinician and the medical coder. The CDI specialist is able to address many sources of error identified by the study, such as understanding the diagnosis documented by the provider, because variances often exist in the provider's description of a diagnosis due to the number of synonyms that can exist for the same condition. The same study cites:

> *In their written or electronically entered record, clinicians often use synonyms and abbreviations to describe the same condition. For example, synonyms for "stroke" include cerebrovascular accident, cerebral occlusion, cerebral infarction, and apoplexy, among others. The variance in terms is problematic, as each diagnostic code should represent one and only one disease entity. From the clinician's recorded diagnosis label, the coder must select the ICD code that best seems to match the clinician's terminology. The use of synonyms leads to imprecision.*[12]

Another potential error source that is minimized by including a CDI specialist in the revenue cycle is related to the ever-changing criteria associated with assigning a diagnosis. Although the 2013 AHIMA query practice brief "Guidelines for Achieving a Compliant Query Practice," that was co-authored by members of ACDIS, cited clinical validation as a coding responsibility in regard to the query process (asking a provider for clarification of their documentation within the health record for the purpose of code assignment), CMS reserves that role for clinicians (i.e., nurses) and specifically instructs its audit contractors that it is beyond the scope of a medical coder. As such, most coders are not "qualified" to perform this function, which is why querying is often performed by the CDI specialist with a clinical background.

In the "Statement of Work" for the recovery audit program, CMS states:

> *DRG Validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in* Coding Clinic.

> *Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.*[13]

The CDI specialist does not need to be a coding expert; rather, he or she needs to understand the documentation requirements associated with code assignment to focus on assisting the coders and addressing some of the areas of clinical documentation that are most prone to error. For example, there is great pressure for the coding process to be completed as close to a patient's discharge as possible to minimize bill hold times. However, delays in record completion, including responses to an outstanding query, can delay the coding process.

Leveraging CDI specialists, who are tasked with the responsibility of addressing ambiguity within the health record prior to coding, can expedite the coding process and improve provider satisfaction. Moving responsibility for querying to a CDI department often results in improved provider responsiveness, because CDI query efforts are often concurrent with the admission of a patient rather than subsequent to the admission. Providers may be more engaged in the query process when they are still directly involved in caring for the patient for whom clarification is sought. Additionally, the study described above found coders often fail to realize when additional information is needed and may not be persistent at obtaining it, which can also lead to errors.

More and more organizations are moving responsibilities for querying to CDI specialists rather than a dual function including both CDI and coding. The background of CDI staff can also affect the query process, which we will discuss more in Chapter 3. Those with a clinical background are often better adept at identifying relevant clinical information to support the clarification effort as well as provide reasonable choices when a multiple-choice format is used in a query. Verbal queries (directly asking the provider) is becoming the preferred method of querying, because it is often less disruptive for the provider and allows immediate resolution of the documentation question. A CDI specialist with a clinical background is often more comfortable verbally interacting with providers in a collegial manner. In contrast, because most coders often have limited face-to-face interactions with the medical staff, it can often be intimidating for them to verbally ask a provider to clarify or amend their documentation.

Another "boom" in the CDI profession came when CMS transitioned to MS-DRGs. The shift to MS-DRGs gave code assignment an even greater impact on revenue because the MS-DRG is based upon two different secondary diagnosis values (CCs or MCCs), rather than the previous CC model. And more DRGs were differentiated by the presences of a CC or MCC compared to what was available under the original CMS-DRG methodology. The present on admission (POA) indicator, which signifies whether a condition was present prior to admission or occurred during the admission, was also introduced under MS-DRG methodology. POA assignment affected reimbursement through the hospital-acquired conditions (HAC) initiative.

HACs

HACs were introduced for use with the IPPS under the MS-DRG methodology for discharges occurring after October 1, 2008, as part of the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of the DRA requires the identification of conditions that: (a) are high-cost, high-volume, or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

The POA indicator is used to indicate when a condition is a HAC. When a HAC is identified, the hospital does not receive additional payment that would have normally resulted from the associated CC or MCC. In other words, the case is paid as though the secondary diagnoses were not present, even though they are still reported on the claim.

(See the appendix to download a list of HAC ICD-10 codes.)

The healthcare industry is in the midst of another CDI growth cycle as organizations are implementing CDI programs, revitalizing existing CDI programs, or graduating their CDI programs into CDI departments to reflect the increasing value CDI brings to the revenue cycle. The recent boom can be attributed to implementation of ICD-10-CM/PCS as well as the impact of indirect revenue associated with CMS quality initiatives (e.g., Hospital Value-Based Purchasing, the Hospital Readmission Reduction Program, HAC Reduction Program) that can be associated with a penalty or a reward based on organizational performance.

As CMS continues to align payment methodology with the quality rather than the quantity of care, the role of CDI is expanding beyond its HIM origins. As a result, in some organizations, CDI is a distinct department within the revenue cycle, reporting directly to the VP for finance, or it may be part of the clinical/patient care/quality division, reporting to the medical director. Additionally, CDI may assume responsibility for releasing, or "dropping," claims to ensure the clinical perspective is reflected in the coding. In many organizations, CDI is becoming the glue between the revenue cycle and physician relations, coordinating all the departments within the organization affected by coded data. One of the key responsibilities of the CDI manager is to ensure that the mission of the CDI department is clear, because the mission affects staffing and resource requirements, workflow, performance analytics, and much more.

Summary

The world of healthcare reimbursement is very complex and frequently changing. One might wonder, "Why do I, as a CDI manager, need to know all this history?" A general understanding and awareness of the intricacies in healthcare reimbursement will help provide you and your CDI specialists a great foundation to grow professionally as a department. Since clinical documentation impacts many areas, from quality of care to reimbursement, this level of understanding will help you

evaluate and strategize your department's focus areas. Additionally, it will provide some groundwork to help support your department's mission and goals. A CDI manager with a strong understanding of the needs required by the world of coding, quality, and clinical documentation is very important during this time of change in healthcare. Your understanding will help take the department to the next level by effectively building that bridge between the clinical documentation and coded data.

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The Complete Guide to CDI MANAGEMENT

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Managing a CDI department can be a daunting task for new and seasoned managers alike. ***The Complete Guide to CDI Management*** provides CDI program managers and directors with insight into the most common issues associated with implementing, staffing, running, and growing a CDI department. The book also covers core skills such as auditing and metrics, and provides strategies for overcoming challenges related to electronic records, changing regulatory landscapes, and resource limitations.

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