

Laurie L. Prescott, MSN, RN, CCDS, CDIP



The
Clinical Documentation
Improvement Specialist's

COMPLETE TRAINING GUIDE

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Improvement Specialist's**

**COMPLETE
TRAINING
GUIDE**

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Online Materials

Editor's Note: The following materials are located online at the following URL:

www.hcpro.com/downloads/12289

Introduction

- Sample Orientation Schedule
- Sample Orientation Checklist
- Sample Mentor and Preceptor Roles
- Sample CDI Job Description

Chapter 1

Government at Work ICD-10 Delay RecapACDIS Code of Ethics

Chapter 2

Coding Clinic Exercises

Chapter 3

DRG Assignment Exercises

DRG Decision Tree

Crossword Puzzle

Crossword Puzzle Answers

Physician Documentation Tip Sheet

CMS HAC Fact Sheet

Chapter 4

Escalation Policy Addendum

Coding Clinic Query Guidance

Official Guidelines for Coding and Reporting Query Guidance

Chapter 6

Record Review Checklist

Tandem Record Review Checklist

Chapter 7

MDC Crossword Puzzle

MDC Crossword Puzzle Answers

MDC 5 Matching Game

MDC 5 Matching Game Solution

Chapter 8

Physician Education Discussion Scenarios

Physician Preference Tracking Sheet

Chapter 9

Sample Auditing Checklist

Test Your Knowledge Questions and Answers

Additional Reading Suggestions

CDI Journal

“Mentors Provide CDI Staff the Gift of Knowledge” www.hcpro.com/content/293852.pdf

“Comprehensive Training Helps New Staff Adjust to CDI Role” www.hcpro.com/content/285112.pdf

“Training New Staff? Consider the Following Tips” www.hcpro.com/content/261413.pdf

“Government at Work: The ICD-10-CM/PC Delay; A Civics Lesson” www.hcpro.com/content/306272.pdf

“ACDIS Comments to CDC on Proposed Changes to FY 2012 ICD-9-CM” www.hcpro.com/content/264297.pdf

Forms & Tools Library

Presentation: CDI Training on Query Next Steps

This PowerPoint presentation takes typical documentation improvement targets and offers tips for CDI program next steps, and illustrates common focus areas/opportunities regarding mortality and severity targets. www.hcpro.com/content/284909.ppt

About the Author

Laurie L. Prescott, MSN, RN, CCDS, CDIP

Laurie L. Prescott, MSN, RN, CCDS, CDIP, is a CDI education specialist for HCPro in Danvers, Massachusetts. In 2007, Prescott implemented a clinical documentation program at a community hospital in North Carolina. The majority of her nursing career has been spent in acute care, primarily medical surgical, with experience in intensive care, post anesthesia care unit, endoscopy, and one-day surgery. She worked as unit manager, served as an adjunct professor for an associate degree in nursing program, and later stepped into the role of director of education and clinical support of nursing staff. Prescott's 30 years of nursing experience encompasses large academic medical centers, small community hospitals, and physician offices. In addition, she has experience with both regulatory and compliance issues.

Introduction for Managers

Clinical documentation improvement (CDI) programs are growing. Healthcare consulting firms tout their effect on hospital finances. Industry associations such as the American Association of Professional Coders (AAPC), Association of Clinical Documentation Improvement Specialists (ACDIS), and American Health Information Management Association (AHIMA) have long professed the importance of improved clinical documentation accuracy as a cure for many of the healthcare industry's ills—the balm for everything from improved case-mix index and capture of complications and comorbid conditions (CC) and major CCs (MCC) to more accurate depiction of public quality reporting metrics.

Facilities are listening, waking up to the reality that physicians need help discerning why their existing documentation does not necessarily translate seamlessly into a healthcare code. Physicians need help understanding how their documentation affects organization and professional profiling. Any healthcare documentation classes physicians may have taken during their extensive educational careers frequently fall away as more pressing patient care concerns take precedence (particularly following frantic residency days and overwhelming patient case loads).

CDI programs take the physician's clinical acumen and break it down to its underlying components—translating all that is (and is not) included in the medical record—to determine what additional documentation may be required for accurate coding and reporting required by various healthcare transactional code sets, such as the International Classification of Diseases 10th Revision, Clinical Modification and Procedure Classification System (ICD-10-CM/PCS), or Current Procedural Terminology code sets as required by the Health Insurance Portability and Accountability Act.

As a CDI manager or director of a CDI program, you most likely know these nuances well. In fact, you argued your case to administrators for additional CDI staff using just these points and more. Now, your new staff members' arrival is imminent. Now, you need to determine how to train your

Introduction for Managers

new CDI specialist, identify his or her strengths and weaknesses, adapt your facility orientation program, and draft a schedule for the new team members to shadow experienced CDI and coding professionals. (A sample orientation schedule and checklist is available in the Online Materials section of this book, www.hcpro.com/downloads/12289.)

Every new CDI training program should be tailored to the individual facility's specific needs and should follow its specific facility's mission and guiding principals, as well as its CDI programs' goals and culture. However, some basic overarching governance does exist within the CDI profession, and awareness of these industry essentials helps provide new CDI specialists with a groundwork of support and information from which they can grow professionally.

These include:

- An understanding of the current healthcare reimbursement system
- An awareness of fundamental coding rules, guidance, and governance
- Knowledge of core CDI program responsibilities and determinants for success
- Incorporation of key query industry guidance and compliance implications
- Analysis of common clinical pathologies for potential query opportunities
- An interpersonal capability to identify educational opportunities and work across multidisciplinary teams to effect change¹

Whether you provide additional training for your staff via a consultant, boot camp, online learning, or other method, this book is intended to help your new CDI specialist understand these vital concepts. This book includes Test Your Knowledge questions, quick tips, definitions, sample word games, queries, and case scenarios throughout the chapters. Where applicable, it recommends additional reading assignments and resources that may take the CDI specialist out of the book to review online materials. If possible, access to the ACDIS website and membership to the national association are strongly recommended.

Use this book as a secondary, supportive educational guide to augment ongoing training. Give the book to your new staff member, have them read a chapter or two per week, and plan learning activities that reflect the material reviewed. At the end of each week, you (or a staff mentor or preceptor assigned to the new employee) can set aside an hour to review the lessons he or she has learned and answer any questions he or she may have. An explanation of expectations for internal staff as mentors and preceptors is included in the Online Materials section of this book.

Many of you came to the CDI profession as green as spring grass, as green as your soon-to-be new hire. Many CDI specialists receive little if any training and are essentially left on their own to learn as much as possible about documentation improvement and attempt to implement an effective process. This book draws on similar encounters, takes those hard-learned lessons, and extends the hand of experience to help you educate your new CDI staff. Just as the day-to-day effort of CDI requires

building effective relationships and sharing knowledge and education across multidisciplinary teams, so too does on-boarding new team members. You are up to the challenge; and with your guidance your new staff member will be, too.

1. American Health Information Management Association. "Recruitment, Selection, and Orientation for CDI Specialists." *Journal of AHIMA*, (July 2013).

Letter to Managers

Dear CDI Manager,

When I was a manager, two of the biggest challenges I experienced were hiring the right person for the job and establishing a plan for orientation to ensure the new hire had all the tools and support he or she needed. In many programs, this is a constant endeavor.

Experienced CDI specialists are few and far between—just visit the ACDIS job board, LinkedIn, or other professional networking site. Everyone is looking to hire experienced CDI staff. Maybe you'll be lucky enough to have an experienced CDI candidate apply for the position, and maybe he or she will be the perfect fit. More likely, however, you and your existing CDI team will need to train and mentor your new CDI specialist into the exemplary staff member you need.

This challenge may appear even greater if you as the manager or CDI director have little experience in CDI yourself. CDI programs are often housed within the health information management (HIM), case management, or quality departments. If you are a department director, you may understand the concept of CDI but might not have the day-to-day experience with how it functions. Not to worry; this manual will help.

Many organizations use outside programs to train new CDI specialists. This may involve bringing consultants into your facility, or it may mean sending your new staff to in-service education sessions, such as ACDIS' CDI Boot Camps. These are wonderful resources, and while such options provide a wealth of knowledge about the essential tasks a CDI specialist needs to perform, they shouldn't take the place of on-the-job learning and mentoring.

Although first trained by a consulting company, I later concluded that such education would have been so much more valuable if I had received an introduction to the role and some mentored guidance prior to the formal, sit-down classroom education I received. Those first few days of formal education set my head spinning. I had so many questions and was so overwhelmed by the information I didn't know where to start. I also know that I missed key advanced information while my brain was trying to understand simple issues like:

- What exactly is an encoder?
- What do coders actually do?
- How does a code lead to a DRG?
- What are “coding guidelines” and how do I find them?
- What is a “*Coding Clinic*”?
- Who determines what is a CC or MCC?

Letter to Managers

The words “query” and “increased specificity” were not part of my daily vocabulary. I was new to the organization; I had not yet looked at a record, spoken with the coding staff, or met a single physician when I found myself sitting in that classroom discussing chart audit results and listening to the consultants identify documentation opportunities. To be honest, at that moment I barely even knew where my own office was.

A manual such as this one could have been a lifeline for me at the time. I would have loved to have gotten my feet wet before being thrown off the highest diving board.

When it came time for me to train a new CDI specialist, I remembered that early experience and provided a series of homegrown educational components about the CDI role, complete with clear-cut expectations and exercises before the formal education piece occurred. This manual is designed with that early education in mind.

It is difficult to find someone who has the diverse background needed for CDI endeavors. You may find a great HIM candidate, well versed in coding practices, guidelines, and regulatory issues, who requires clinical background and pathophysiology training. Or you may hire a nurse comfortable with physician-to-nurse dialogue, clinical conditions, and etiologies but requires training on coding nuances and reimbursement issues.

Also, hiring a nurse does not guarantee he or she has the clinical expertise needed for CDI review. For example, if the CDI is expected to review pediatric records, a lack of experience as a pediatric nurse may be identified as a learning need. If the nurse has never worked in the intensive care environment, the review of such patients may require more of a focus than a more familiar patient population.

The manual is not meant to be all-inclusive. The specific chapters were chosen based on the basic learning needs of a new CDI specialist, including an understanding of how provider documentation influences the health of an organization both financially and publicly based on quality monitors and how the CDI can influence documentation practices within the organization. Much of the suggested learning activities within the manual are items such as reading assignments, shadowing experiences, etc.

Often, the most important piece of knowledge a new hire can learn is to research information or know who to call when they cannot find an answer to a pressing question elsewhere. No one can be expected to know all there is to know at the end of a three-month or six-month orientation, but by supplying the right introductions and learning experiences at the start, your new hire will be able to critically think his or her way through and seek further clarification when needed.

Identifying mentors

Depending upon the size of your organization and the maturity of your CDI program, you may lack in-house resources to serve as preceptors or mentors. Inventory your staff and identify those best to help your new staff member get up to speed, keeping in mind more than one person may be needed to fill this role due to the wide range of knowledge required.

The choice of preceptor should not only be based on knowledge and experience. Sometimes, the most experienced person on your staff may be the most *inappropriate* person to fill this role (he or she may be the busiest individual or may lack the skills needed to be a mentor). The individual you choose should first and foremost enjoy the process of teaching. This person is more apt to be open and approachable for questions and insight. He or she may be well respected within the organization and able to help the new team member network and foster relationships that are so important in the CDI role. Lastly, your choice for preceptor should be well versed in the policies, procedures, and practices within your department and organization. (Descriptions of the mentor and preceptor expectations are available in the Online Materials section of this book, www.hcpro.com/downloads/12289.)

Now that you have the new hire and you have identified the preceptor, where do you start?

Think back to your first day of work, especially if you were new to the organization. Often the most stressful issue is finding a restroom. No doubt your human resources department will have a host of paperwork for your new staff member. There will also be facility protocols that require review. While the first day is not the day to start loading on the assignments, introductions, expectations, and so forth, it can be a day of welcome and celebration for the new staff member and the rest of the team. (As mentioned earlier, a sample orientation schedule for your new staff member's first day is also included in the Online Materials section.)

If you have a new staff member coming in, it most likely means a shift in priorities and workload for the rest of the team. Creating a celebratory atmosphere can ease everyone's tensions and foster a collaborative environment. Consider a pizza lunch for the first day or an after-hours event at the end of the week to toast the new staff and new group endeavor.

That first week, make team introductions and show him or her the lay of the land. Review your training timeline and your expectations for his or her orientation period. Review the departmental mission as compared to your organization's overarching mission. Discuss how the CDI role supports that mission. Perhaps schedule some shadow time with a CDI specialist to see the chart review in action. (Don't make it too complicated.)

The preceptor or mentor should use this time to complete a learning needs assessment of the new CDI. This can be in official, written question-and-answer form or a discussion. The goal is for the preceptor to understand which areas require more focus and which may require little to no focus.

The preceptor should also understand what types of learning experiences will prove most valuable to the learner.

Suggested Assessment Questions

- What professional background are you primarily experienced in? (Coding, nursing, medical, etc.)
- What types of patient populations are you most experienced with? (e.g., inpatient, outpatient, surgeries, medical, cardiac, etc.)
- What exposure have you had to hospital reimbursement?
- Do you have much experience with face-to-face interaction with medical staff?
- What areas of the CDI specialist role do you feel strong or weak about?
- What type of learner are you? (i.e., do you prefer one-on-one instruction, classroom, or self-study type of learning?)
 - There are many learning style inventories that can be found online, to assist in determining the best methods for an individual to learn. An example can be found at www.learning-styles-online.com/inventory.
- What time of day are you most focused?
 - Would you prefer activities that are more active in the morning or afternoon?
 - Would you prefer passive activities (self-study) in the morning or afternoon?

The CDI manager or mentor can use this information to plan the new CDI specialist's educational path. For example, experienced coders or HIM professionals may skim over Chapter 2 in this book, or a nurse with a cardiovascular background can skim through the documentation improvement opportunities listed in that section. If his or her learning style is independent, have him or her read a chapter and explore a record on his or her own before working together. If the individual is not familiar with the noises and activity of the hospital inpatient unit, plan the first record review in a quiet area, away from the mayhem.

Do not simply hand this book to your new staff member and expect him or her to return in a week or two ready to go. Think how you would feel if you were handed a book and told on your first day to read it. The book should be used as a tool/resource by both the CDI specialist and the preceptor or manager. One additional note of caution: If you do have a dedicated mentor assigned responsibility for training your new staff member, make sure to schedule ongoing meetings with both individuals to evaluate the progression of the training, and to identify outstanding needs and celebrate successes.

Each day should be organized with varied activities that support learning. Mix it up, assign some readings, shadow experiences, record review practices, introductions to key players within the organization, policy/procedure review, etc. Make it fun.

Remember, first let the new CDI specialist get his or her feet wet. There will be plenty of time before he or she should be expected to fully execute a back flip, tuck into a somersault, and dive splash-free.

No orientation will be 100% perfect, but a little focus on the details can make the experience better and more efficient for all concerned. As the manager, be involved. The investment you make up front on this person will be returned with a satisfied, reliable, and successful team member.

Sincerely,

A handwritten signature in black ink that reads "Laurie L. Prescott". The signature is written in a cursive, flowing style.

Laurie L. Prescott, RN, MSN, CCDS, CDIP

Introduction for New Staff

Who are Clinical Documentation Improvement (CDI) specialists?
What do they do?
Why does this work matter?

If L. Frank Baum wrote this book, he might depict a new CDI specialist as Dorothy caught in the throes of a tornado, soon to land in a strange new environment, leaving Kansas long behind. Like Dorothy in the MGM film version, once you land in the world of CDI, your understanding of the importance of the medical record could very well be like suddenly seeing in Technicolor.

Welcome to the wonderful world of CDI.

Whether you hail from a coding, health information management (HIM), nursing, or physician practice background (or from the corn fields of Kansas), this book will help you gain an awareness of the basic tenets of the role and provide you with the background you need to review records for CDI opportunities.

At their most elemental, CDI staff members serve as intermediaries between the clinical and coding teams. CDI specialists work as interpreters, translating a physician's documentation, ancillary laboratory findings, or nursing or nutritionist's notes into possible diagnoses that can be coded.

Few medical schools offer instruction on healthcare reimbursement methodology. Physicians rarely have the opportunity to attend Coding 101 classes. What lessons physicians receive regarding medical record documentation are frequently forgotten in the hectic, harried days and nights of residency as they hurriedly scratch out patient orders and discharge summaries.

Introduction for New Staff

Imagine trying to speak Spanish when you've only had a few lessons? Imagine trying to say how embarrassed you are in Spanish using the cognate "embarazado." You'd actually be telling the world you're pregnant—which is not exactly what you meant. This is how physician documentation frequently gets translated. Clinically, the physician documented what they thought was needed, accurate, and adequate but which frequently remains insufficient.

CDI programs help by promoting consistent, complete, precise, reliable, noncontradictory documentation integral to the compliant submission of Health Insurance Portability and Accountability Act transaction (code) sets. CDI programs take the physician's clinical acumen and break it down to its underlying components—translating all that is and is not included in the medical record—to determine what additional documentation may be required for accurate coding and reporting required by the government as defined by various healthcare code sets.

If you are a coder or a HIM professional, you are likely familiar with the language of medical coding. Terms like *Official Guidelines for Coding and Reporting*, compliance, diagnosis-related groups (DRG), complications and comorbid conditions (CCs), and major CCs (MCC) probably roll off your tongue. Yet, perhaps you become marble mouthed when it comes to communicating clinical indicators to support a sepsis diagnosis when all the physician wrote was urosepsis.

Conversely, nurses coming to the CDI profession may have a distinguished clinical acumen and tremendous rapport with physicians but haven't the foggiest of notions how the healthcare reimbursement process works or how medical coding affects a host of additional outcomes—from patient safety to public quality report cards and even medical research and professional safety standards.

Regardless of your background, we will explore the fundamental ways both knowledge sets come to bear in this role. It is now your job to investigate the medical record in search of clues that point to conditions that may not be explicitly stated and to question the physician (using a query) to either obtain additional specificity or to solicit documentation for a diagnosis.

Healthcare professionals have been performing CDI-like tasks for more than 20 years, ever since the Centers for Medicare & Medicaid Services (CMS) developed DRGs in 1983, with many more CDI programs emerging since the implementation of the Medicare severity DRG (MS-DRG) in 2007.

And the profession continues to grow. If you are reading this book, you are a testament to that fact.

The transition from the International Classification of Diseases, ninth revision (ICD-9), to the 10th revision, Clinical Modification and Procedure Classification System (ICD-10-CM/PCS) code set, is one reason for that growth. Healthcare consultants and media organizations tout the importance of

CDI efforts, repeating the mantra everywhere. “Extra ICD-10 Time: Focus on Clinical Documentation Improvement Now,” reads one magazine headline; “Recognizing the Value of Clinical Documentation Improvement,” reads another. References to CDI programs’ inherent value are embedded in dozens of industry articles and nearly every ICD-10-CM/PCS implementation plan.

ICD-10-CM/PCS implementation isn’t the only reason for CDI implementation and expansion, however. Government healthcare reimbursement initiatives, such as pay for performance, value-based purchasing, and accountable healthcare organizations, represent additional incentives for CDI programs’ proliferation throughout a range of healthcare environments.

Don’t worry, we’ll go over all the details of CDI development and definitions of common terms later in the book. We will describe the various reasons for CDI efforts in depth to give you a better understanding of not only how to perform the tasks associated with your new job but also to help you understand the inherent value in it, so you can explain to those around you why the CDI role is such an important one.

In fact, one of the largest portions of the job includes building relationships with various facility departments to identify problem areas, brainstorm solutions, and educate coworkers about these concerns. Some people say that all life is about relationships. Some are good. Some are bad. Some are mediocre. “Negotiating these relationships successfully allows us to manage our own lives, support others in their personal growth, and reasonably enjoy or accept the life we have before us,” wrote James S. Kennedy, MD, CCS, in the introduction of the first edition of *The Physician Queries Handbook*.

In fact, the *Official Guidelines for Coding and Reporting* suggests that bridging relationships between physicians and coders is essential to ensuring complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. Failure to adequately foster this relationship frequently proves detrimental. It may lead to disparagement between departments, reductions in physician query response rates, or increased auditor scrutiny. CDI professionals need to remember that, in healthcare, lives really are at stake—even if it is in terms of understanding coded data or accurately interpreting physician documentation (or lack thereof) in the medical record.

Those new to CDI frequently refer to the role in artistic terms, likening the capture of accurate data to painting a complete picture of the patients’ conditions or telling the whole story as to how the patient came to be in the hospital and what care was provided. Just as L. Frank Baum composed an image of the Emerald City so all his young readers could see it in much the same light, so too must multiple physicians and entities clearly see the picture of a given patient encounter in the same manner in order to accurately and appropriately provide follow-up care, obtain reimbursement, and provide statistical analysis to the healthcare industry.

You’ve landed in Oz. Ready to begin your adventure? C’mon, let’s follow the yellow brick road.

Letter to New Staff

Dear CDI specialist,

I remember my first day as a new CDI staff member very well. I had been through an extensive interview process: three interviews, a written test, and a meeting with the consulting firm that trained me. At the time, all I understood was that I was going to review records and help medical staff meet documentation needs. After more than 20 years of nursing experience, and time spent as a nursing school clinical instructor and in management, staff development, and healthcare compliance roles, I figured this would be an easy jump for me. It was a jump that felt like I had leapt right off a cliff.

I spent my first day training with two inpatient coders and the consultants. These two ladies were an interesting pair. One had been coding for more than 25 years, and I concluded she could diagnose most disease processes better than a number of physicians I knew. The second was new to the inpatient process, having coded in outpatient and clinic settings for a few years. We were implementing a new CDI program. Everyone looked to me to make this program a success. I soon understood this was much more of a challenge than I ever imagined.

Our instructor made several assumptions as she began instruction. She assumed the coders had a much better understanding of anatomy and pathophysiology than they did. She mentioned lab and diagnostic tests that one or both of the ladies found confusing. When she looked at me, she assumed a person with my experience understood the confusing world of hospital reimbursement.

The conversation fell to rules of reimbursement. I took a ton of notes, not knowing what was important and what was not. I watched my new coder friends and found they were doing much the same thing. We all felt lost.

We sat through two weeks of education. I still have those notes, although they make little sense. The consultants left town, and we were left to implement our new CDI program. Fortunately, for those now entering the CDI field, there are now a number of resources available for the new CDI specialist, including a national advocacy and education collaborative in the Association of Clinical Documentation Improvement Specialists (ACDIS) and more than 40 related local chapter networking groups, as well as books, webinars, annual conferences, and additional guidance from the American Health Information Management Association (AHIMA).

A decade ago, however, I had little available, as CDI was not a common practice then. The coding resources were a bit intimidating, and there was no CDI program nearby that I could even go visit. The benefit of that struggle was that I grew close with the coding team; we taught each other and supported each other through the effort.

Letter to New Staff

I also began to understand the skills and interpersonal qualities needed to succeed in the role when it came time to hire a new CDI for our growing department. The first lesson was to never assume. People enter the CDI specialty from many different avenues. Within the ACDIS ranks, there are HIM professionals, coders, quality staff, nurses from all specialties, and physicians. Each of these experiences brings different skills to the table, but rare is the CDI candidate who brings it all. So no matter which background you come from, there will still be a good deal of foundational knowledge you will need to successfully carry out your day-to-day functions in this role.

Later, when I hired my own new staff members, I did bring in consultants to provide formalized training, but not until after our existing coders and internal staff worked directly with the new employees mentoring and guiding them for several weeks. This allowed the new team member to see us in action, complete reading and anatomy assignments, and begin the process of record reviews. This preliminary work allowed them to take full advantage of the consultant's education without the sense of overwhelming confusion I had experienced.

Now you are the new CDI specialist, and you have this book here to act as an introduction to CDI. It is meant to introduce you to the basics involved in this role. We will cover a number of subjects I have found extremely valuable, from the history of healthcare reimbursement to the purpose of healthcare coding.

This is not meant to be the end-all be-all of your education—this is only the beginning! The idea is to provide you (no matter how you got here) a foundation on which to build your experience. As you explore the impact that clinical documentation can have for your organization's success, you will conclude there will always be new concepts to learn.

When I entered the specialty, I quickly knew that the learning curve for this role would be the steepest I ever experienced. Throughout my years in nursing, I had sought out a variety of roles and specialties, as I enjoyed new and challenging roles. I am so proud I stuck with it, as every day it offers me new challenges. It has allowed me to take those years of experience in those many different roles and meld those skills into a new and stronger knowledge base.

You will accomplish this, too; I promise.

Sincerely,

A handwritten signature in cursive script that reads "Laurie L. Prescott". The signature is written in black ink and is positioned above the typed name.

Laurie L. Prescott, RN, MSN, CCDS, CDIP

Chapter I

CDI Specialist Roles and Responsibilities

The tasks set before you now aren't as complicated as separating grains of wheat or spinning gold from straw. It will be difficult, that's true. And there will be a learning curve; but the roles and responsibilities of clinical documentation improvement (CDI) professionals—the ones you have just committed to perform—may very well be some of the most varied and interesting of your career.

Why? Because soon you'll understand how clinical care must be documented; soon you'll learn how that documentation gets translated into a series of alphanumeric codes and used for a host of reasons.

As you gain experience, you'll begin to see how—as American Health Information Management Association (AHIMA) states in the foreword of its 2014 *Clinical Documentation Improvement Toolkit*—“clinical documentation is the foundation of every health record in every setting.”¹

Defining CDI

When you first saw the CDI specialist opening posted on your facility's job board, you may not have known what the job entailed. Perhaps you heard from a colleague that you'd be perfect for the role or you saw other CDI professionals making the rounds, reviewing records, and thought you'd give it a shot.

Now that you're here you really need to know: What is this thing called CDI anyway?

AHIMA defines clinical documentation as “any manual or electronic notation made by a clinical care provider” and states that the “rapidly changing healthcare environment” and the “variety of uses and users of clinical documentation” has led to the ever-increasing importance of CDI program implementation.²

According to the Association of Clinical Documentation Improvement Specialists (ACDIS) “[t]he primary purpose of [CDI] is concurrent review of the medical record to increase the accuracy, clarity, and specificity of provider documentation.”³

Everyone knows the anecdotal illegible physician signature, the scrawl that’s more akin to a scribbled *x* than a name. Traditionally, physicians’ responsibilities lie with assessing the patient’s needs, diagnosing the patient’s condition, developing a treatment plan, and caring for the individual until he or she can be safely discharged from the hospital. All of this care and more—from laboratory tests to nursing and dietitian notes—needs to be documented in the medical record to demonstrate the assessments and care provided.

As mentioned in the introduction (and as you may know from personal experience), few physicians receive training about how such documentation gets used and why it matters. In medical school, physicians typically review each other’s documentation. When they become residents, staff members review their documentation to ensure appropriateness of care—period.⁴

If you come to the role from the ranks of coding and health information management (HIM), you know how difficult it can be to match documentation in the medical record to a code from the International Classification of Diseases (ICD) needed for billing and other purposes.

If you come to this position from the nursing or clinical side of healthcare, you may well understand the physicians’ shorthand for clinical disease processes. To physicians, a (down arrow) Na means hyponatremia, but it could also mean a decrease in the patient’s sodium level; or (up arrow) K means the patient may have hyperkalemia. Yet coders cannot assign an ICD code to such documentation for a variety of reasons, chiefly because only physicians can diagnose a patient, and any interpretation of a physician’s documentation could unintentionally assign an inappropriate diagnosis.

Colloquially considered translators or educators, CDI specialists are specially trained individuals charged with bridging the gap between physicians and coders to clarify at-risk documentation prior to claim submission.⁵ When documentation is illegible, incomplete, imprecise, inconsistent, conflicting, or unreliable, the coder or CDI specialist is expected to communicate with the physician to obtain the necessary information to clarify the medical record.⁶ The CDI specialist must eventually hold a general proficiency within both the clinical and coding skill sets.

According to the ACDIS *CDI Road Map*:

*[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.*⁷

While coders previously sought clarification from the physician during the coding process (retrospective, pre-bill), a new emphasis on clarifying the record *in real time* (concurrently) emerged as new coding and documentation requirements under the Medicare severity diagnosis-related groups (MS-DRG) took effect in 2007 (which will be discussed in more detail in Chapter 3).

Often, the disconnect between the coding and clinical requirements leads to friction and frustration between physicians and coders. With the advent of CDI, a new role emerged, one in which team members worked alongside both departments serving as translators for the needs of both. This cross-discipline expertise requires a fully integrated team approach and the participation of various stakeholders—from both the revenue cycle management and clinical sides of the facility. It is why ACDIS and AHIMA both endorse a variety of professional backgrounds as effective staff members for the position.⁸

According to AHIMA's *CDI Toolkit*:

*Depending on the structure and design of the CDI program, the program may be staffed entirely by HIM coding professionals, entirely by nurses, or a combination of both. In some programs there may be dedicated physician liaisons or physician champions who conduct reviews and communicate with other physicians on documentation issues. And in other organizations, the CDI program may have staff that come from several professions and work together in daily collaboration.*⁹

CDI programs play an integral role in the hospital revenue cycle and quality assurance. The risks associated with incomplete documentation are too high—ranging from inaccurate treatment to inadequate payment—and too far reaching. Incomplete documentation obviously can lead to unsafe or inadequate patient care or treatment, but it can also lead to inadequate reimbursement. Furthermore, tomorrow's healthcare insurance payment models are based on documentation submitted today (this concept will be discussed further in Chapter 3).

Capturing nuanced, specific documentation will help ensure a smooth transition to the new ICD, 10th Revision, Clinical Modification and Procedural Coding System (ICD-10-CM/PCS) as much as it will help with healthcare reimbursement initiatives such as pay for performance, value-based purchasing, and other efforts. The rapid expansion of CDI in short-term acute care, outpatient services, pediatric populations, critical access, and long-term care illustrates how successful such efforts are.

Concepts to Remember

Complete and accurate diagnostic and procedural coded data are necessary for many reasons, including:

- Accurate reimbursement
- Financial and strategic planning
- Outcomes and statistical analyses
- Epidemiology and research
- Accurate reflection of a patient's severity of illness and risk of mortality (SOI/ROM)
- Hospital, specialty, and physician quality of care, including patient safety and outcome measures
- Communication of a patient's overall health status to all providers to facilitate complete in-hospital and discharge treatment plans¹⁰

Roles of Supporting Staff

The essential CDI team includes CDI specialists, coding staff, and physicians. These three professionals, and the expertise they represent, are the three-legged stool supporting medical record accuracy. All three elements need to work collaboratively for CDI efforts to be successful.¹¹

However, all who document in the record (ancillary staff, nursing, therapists, dietitians, etc.) and all who depend upon the data within the record for justification of medical necessity and statistical analysis play a role in ensuring medical record accuracy.

Before we look deeper at your new role, let's first explore some of the basic responsibilities of your new coworkers.

Coding role

The ICD codes are the standard diagnostic tool for epidemiology, health management, and clinical purposes, mandated by the Health Insurance Portability and Accountability Act of 1996. These codes have become the basis of healthcare payment systems in the United States.

To assign a code, the coders follow rules contained in the *Official Guidelines for Coding and Reporting*, developed and approved by four vested agencies known as the "Cooperating Parties" (which will be discussed in Chapter 2). These codes and their resulting MS-DRGs must weather the test of time, support the documentation in the record, and hold up to any retrospective scrutiny from outside auditors.

So when a coder is uncertain about what diagnosis the physician treated, he or she must go back and ask the physician formally through a query process (or ask for the CDI team's assistance depending on the procedures of the institution).

Discussion Point

Coding/HIM staff typically query physicians *retrospectively*, after the patient has been discharged and before the bill is submitted to the payer. CDI professionals typically query physicians *concurrently*, while the patient is still in the hospital, still receiving care. (The query process will be discussed in more detail later in this book.) What happens when a concurrent query remains unanswered at the time of discharge depends on the policies and procedures of your facility. In some facilities, the coding team then takes on the responsibility for that outstanding query. In other facilities, the CDI specialist maintains ownership of any queries left unanswered.

Additionally, coding/HIM staff will still have retrospective query opportunities, either due to ambiguous information or last-minute additions to the record. Some facilities have begun handing over all query efforts to the CDI team to help with productivity concerns related to ICD-10-CM/PCS implementation.

Talk with your manager or mentor to determine how your program handles retrospective query efforts. Ask him or her to go over the query process flow with you to determine how your role will fit in with that of your CDI and coding teammates. Obtain access to query policies within your organization and review these with your mentor.

Although queries can help obtain clarification, it is always the treating physician's responsibility to assign a diagnosis (and accurately document that diagnosis) in the medical record, and it is always the coder's responsibility to determine which codes are finally submitted based on rules contained in the *Official Guidelines for Coding and Reporting*.

Coders have significant insight into the rules and regulations governing code use and should be considered an asset to the CDI team. In some cases, facility-specific HIM/coding policies, such as those related to when documentation from an attending or resident physician may be used, may also affect the policies and procedures of the CDI program and help protect the facility against auditor claim denials. Both the coding and CDI staff need to mutually recognize and adhere to such policies. Each cannot function independently from the other nor can they adopt separate practices and policies.

Physician advisor

The physician advisor role varies depending on the needs of the facility, the structure of the CDI program, and the availability of the physician. Smaller hospitals may appoint a single individual on a part-time basis, whereas larger facilities may employ one, two, or more physicians, to support CDI efforts.

A single physician advisor, at a minimum, should have an interest in revenue cycle management, understand the importance of coded data on hospital and physician reimbursement and quality

metrics, and have a good working rapport with other physicians at the facility. This individual could be expected to:

- Work with the HIM and CDI personnel on a routine basis to review selected health records concurrently or retrospectively
- Meet weekly/monthly with the CDI team to identify target topics for physician, CDI, or coder education
- Explain documentation issues found in chart review, including common issues such as congestive heart failure, chronic kidney disease, urosepsis, pneumonia, anemia, and respiratory failure to various stakeholders
- Help develop clinically appropriate and compliant provider queries to further clarify documentation
- Help craft organizational clinical guidelines based on industry literature for use in identifying query opportunities

Discussion Point

Not all CDI programs have a physician advisor on the CDI team. Those that do often share them with the case management or utilization review teams. If your program employs a physician advisor, work with your manager or mentor to set up a time to talk with him or her. Work with your manager or mentor to develop a series of appropriate questions for you to ask in order for you to learn more about the physician advisor's role in helping the CDI team. The discussion should also help you better understand some of the clinical and querying concepts you face as a new CDI specialist. Some of these questions may include:

- How do you define CDI?
- How do you support the CDI effort?
- Can you give me some examples of when I, as a CDI specialist, can use your expertise or intervention?
- What process should I follow if I feel a colleague or physician requires education or intervention?

Physician champion

The physician champion role differs from that of the physician advisor. Although many programs use the terms interchangeably, the physician champion often takes on a mentoring or coaching role. Informally, one might consider the champion a cheerleader of sorts for CDI efforts. These individuals may have received CDI assistance on a particularly thorny concern and have seen the proverbial light regarding the importance of documentation improvement. They frequently want to help advance CDI efforts and advocate for CDI applications.¹²

Unlike the CDI physician advisor, the champion is not typically reimbursed for his or her assistance nor does he or she have formal duties related to the CDI team. Nevertheless, these individuals are an asset to the program and can be of help to you as a new CDI professional. Ask your mentor

or manager to introduce you to any CDI champions or any other particularly helpful/responsive physicians.

Additional staff

Other professional caregivers provide vital documentation, too. For example, wound care nurses may document the depth or degree of an excisional debridement or a pressure ulcer. Documentation from respiratory therapy may provide clinical indicators that support a query for a more specific diagnosis. Dietitians may provide insight as to how physicians use their documentation for malnutrition diagnoses. Effective CDI programs avail themselves of these staff members, calling on them for advice and including them on query template creation as appropriate.

You will find as you work through the material in this manual and explore medical records that such documentation offers clues to undocumented diagnoses. This information can be used to support your physician query, medical necessity, and even code assignment in certain cases.

Discussion Point

Work with your manager or mentor to arrange to meet professionals in various departments. Take this opportunity to discuss how they document and where you can access their assessments and treatment plans. This not only helps you understand all that goes into the medical record but also begins to help you build relationships.

You probably won't remember everyone or all the information they'll share with you, so consider asking your manager or mentor to help you establish a follow-up meeting within the next six months to one year, as appropriate.

As you grow in your role, you will become a resource to them, too, and they'll be allies in your efforts.

CDI Program Variances

Different CDI programs often have different core responsibilities. New CDI programs typically focus on clarifying the medical record to identify the patient's principal and secondary diagnoses. Accurate capture of these conditions often leads to a shift in the MS-DRG assignment with a correlated shift in a patient's expected length of stay (LOS) in the hospital and the relative weight (RW) or reimbursement for resources expended.

Many programs get their start by improving the facility's direct reimbursement and case mix index, due to the improved capture of these conditions. Later, however, programs expand to a broader focus, one which aims to ensure the accuracy of the entire medical record for a variety of purposes, including more robust quality metrics, public profile review, and other concerns.

Discussion Point

CDI programs have different foci. It is important for you to understand the mission identified for your program. Talk to your manager or mentor to identify overarching goals of the CDI program and how those goals are measured.

Program reporting structure

According to a January 2014 ACDIS survey, nearly 50% of respondents indicated their CDI programs are housed under HIM, followed by little more than 20% that indicated their programs were housed under case management. Other respondents indicated their CDI programs fell under either finance or quality. Those results shifted somewhat from the early years of CDI implementation, where, according to a 2010 survey published in the *CDI Journal*, 45% reported to the HIM department, 27% reported to case management, and 23% reported to finance.¹³

Common best practice, as these surveys seem to indicate, is for the CDI team to report to the HIM department since their efforts serve the primary goal of ensuring a complete and accurate medical record. Additionally, the alignment of the CDI and coding staff under the management of the HIM department director typically means that staff members will be able to engage each other openly and that staff will receive clear communications regarding common goals and objectives.

However, many programs report to the case management department. The common thinking here relates to the experience of the CDI staff members, as many employees make the transition to CDI from the case management ranks. Such shifts make it easier for these professionals to wear two hats during difficult staffing times and allows for some integration of CDI efforts toward capturing the documentation needed to ensure medical necessity and reduce readmissions.

CDI specialists can help case management by providing the geometric mean length of stay (GMLOS) associated with the working DRG to identify the expected timeline of patient discharge and identify those who may be outliers in resource consumption and LOS. Every MS-DRG has an associated RW, GMLOS, and average length of stay. A key component of MS-DRG reimbursement is the inclusion of anticipated room and board charges based on the GMLOS associated with the principal diagnosis and applicable comorbid conditions. When reviewing a patient without a complication/comorbidity (CC) or a major CC (MCC), the CDI specialist (in conjunction with case management) can assist in determining whether the extended LOS is possibly due to an incomplete, vague, or missing diagnosis, as opposed to discharge planning issues.¹⁴

Still other programs report to finance or to quality.

Regardless of your CDI program's structure, you should have clearly established duties as differentiated from the roles of coders, case managers, or others, since the CDI specialist looks to interrogate the patient's medical record to identify any ambiguous diagnoses and clarify any clinical indicators in the medical record prior to the patient's discharge.

When CDI professionals have dual roles, it can be confusing as to which hat you need to be wearing for which tasks. Careful consideration should be made when CDI specialists are assigned a variety of roles or expectations. If the role becomes all encompassing, it may result in a lower level of achievement of identified goals due to the variety of foci in effort.

Although you may always consider yourself a nurse or a coder or other professional, once you take on the CDI mantle, that is the role that must take precedence. Many defer to the role they find most comfortable. For example, those experienced in case management or utilization review may lean on their skills in that area, focusing their record review toward their area of expertise at the expense of the CDI program's actual mission: typically record accuracy and reimbursement. Similarly, many new to the CDI role, especially nurses and physicians, find it difficult to move from caregiver or provider role to CDI specialist. The CDI specialist, even if he or she is a physician, is not considered part of the treating healthcare team. CDI specialists, just like coders, cannot freely interpret or add documentation with assessments or evaluations of their own. Only the treating physician can diagnosis the patient, since it is his or her clinical opinion that guides the treatment and care of the patient.

All program reporting structures can prove effective, it just depends on the overall goals of the program, support of the facility leadership, and the ongoing evaluation, support, and effort of the CDI team.¹⁵

Discussion Point

Discuss with your CDI manager or mentor how your CDI program reporting structure came to be what it is today. Many CDI programs undergo an evolution, reporting to case management in the beginning phases and moving to HIM as the program grows, or vice versa. Ask how this evolution or existing program structure affects your roles and responsibilities. Discuss how your specific talents fit into the picture of the program's structure.

Test Your Knowledge

Editor's note: The following exercises are meant to assess your retention of information included in this chapter. The answers to these questions are located in the Online Materials (www.hcpro.com/downloads/12289).

1. What are physicians expected to know about medical coding and billing?
 - a. How the ICD code set affects hospital reimbursement
 - b. How to code for their own services and resources
 - c. Basic clinical definitions taught in medical school and documentation fundamentals picked up during residency
 - d. How medical codes can be translated for use in a wide variety of both medical and social research

2. Which of the following traditionally held the responsibility for querying the physician if the medical record was illegible, incomplete, or conflicting?
 - a. Accounts payable
 - b. HIM
 - c. Coding
 - d. Chief of the medical staff or department chair
3. What is the typical goal of a new CDI program?
 - a. To review patient medical records for incomplete, illegible, conflicting, or ambiguous documentation
 - b. To identify quality or liability issues related to patient care
 - c. To review the patient medical record for severity of illness/risk of mortality
 - d. To make sure the hospital receives the most reimbursement it can for the care provided

Roles and Responsibilities of the CDI Staff

One may assume that you possess a number of the necessary qualifications of the CDI role, such as:

- Clinical knowledge
- Familiarity with healthcare payment systems and methodologies
- Awareness or working knowledge of coding concepts and guidelines
- Knowledge of healthcare regulatory compliance
- Work experience in the hospital acute care setting or other setting
- Strong verbal and written communication skills¹⁶

The primary responsibility for day-to-day program efforts falls to you, the CDI specialist. Every day, you will be asked to review a collection of medical records, searching for clues that point to more specific clinical diagnoses. In some facilities, this will be automatically generated for you; at other facilities, you will manually pull records to review.¹⁷

During initial reviews, you will identify the principal diagnosis and any potential secondary diagnoses in order to establish a working MS-DRG. This DRG may change as the physician begins to identify underlying causes or etiologies for treatment. To identify the working DRG, you will need to review the history and physical, any pertinent historical patient information, emergency room or transfer records, and the physician's treatment plan. For a new CDI specialist, like yourself, this could take

anywhere from 15 to 30 minutes or longer.¹⁸ (Chapter 6 will walk you through the record review process.)

Additionally, as outlined in the ACDIS position paper “Defining the CDI Specialist’s Roles and Responsibilities,” your daily job may eventually require you to:

- “Review inpatient medical records on a daily basis, concurrent with patient stay, to identify opportunities to clarify missing or incomplete documentation.
- Collaborate with providers, case managers, coders, and other healthcare team members to facilitate comprehensive health record documentation that reflects clinical treatment, decisions, diagnoses, and interventions.
- Use the hospital’s designated clinical documentation system (electronic health record, encoder, or e-query tools) to conduct reviews of the health record and identify opportunities for clarification.
- Conduct follow-up reviews to ensure queries have been answered and physician responses appropriately documented.
- Provide or coordinate education related to compliance.”¹⁹

Defining queries

When you see an opportunity to provide additional specificity or to clarify a given record, you will reach out to the physician of record to discuss the clinical indicators and coding guidelines and request inclusion of particular documentation within the medical record. AHIMA defines a query as a “routine communication and education tool used to advocate complete and compliant documentation.”²⁰

Composing a compliant query that is easily understood by the provider requires a bit of skill and practice. Many new to the CDI role find this piece a bit difficult. (Conducting record reviews and creating compliant queries will be discussed in Chapter 4.)

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 industry guidance from the AHIMA, ACDIS, Centers for Medicare & Medicaid Services (CMS), and other governing bodies. These rules help protect facilities from fraud allegations and the patient from being incorrectly diagnosed.

Ethical obligations

It is worth noting here that by accepting your new role as a CDI professional, you have also accepted some ethical obligations applicable to that role. Ethics can be defined as a set of moral principles that govern a person’s or group’s behavior, essentially a set of rules for a particular culture or group that discerns appropriate activities. As CDI professionals operate within the world of healthcare, many of these moral obligations may already be familiar to you. They include:

Chapter I

- Appropriate use of medical record documentation
- Protection of patient privacy and confidentiality
- Advancement of the profession of CDI through education and professional support of coworkers and other staff members
- A commitment to lifelong learning
- Respect for coworkers
- Participation in and contribution to decisions that affect the well-being of patients by drawing on the perspectives, values, and experiences of those involved in decisions related to patients²¹

According to the 2008 ACDIS *Code of Ethics*:

*Both handwritten and computerized medical health records contain many sacred clinical stories—stories that must be protected on behalf of the individual and the aggregate community served in the healthcare system. Ethical obligations are central to the [CDI] professional's responsibilities, regardless of the employment site or the method of collection, storage, and security of health information.*²²

Additional Reading

Read the ACDIS *Code of Ethics* (available to all CDI specialists on the ACDIS website and additionally located in the Online Materials www.hcpro.com/downloads/12289). Highlight any areas that resonate with you personally, then highlight any areas that confuse or concern you. Bring this with you to your next meeting with your manager or mentor for discussion.

One of the principal reasons to read and follow the ethical standards is to remind yourself (and protect yourself) from potentially fraudulent practices.

The *Code of Ethics* states that CDI professionals must:

- Refuse to participate in or conceal unethical practices or procedures
- Be aware of organizational policies and procedures for handling concerns about colleagues' unethical behavior
- Not participate in, condone, or be associated with dishonesty, fraud and abuse, or deception
- Act with integrity; behave in an honest, trustworthy manner, abiding by ethical principles; elevate service to others above self-interest; and promote high standards of practice in every setting
- Ensure that the working environment is consistent and avoids any conflict of interest

Concepts to Remember

Actions may sometimes seem ethical but in retrospect, or in the light of a new awareness or alternative perspective, prove detrimental: as true in life, so too for CDI. Chapter 5 discusses how query practices may be deemed fraudulent and cause for investigations and even prosecution, leading facilities to pay millions to the federal government in reparations.

AHIMA released its “Ethical Standards for Clinical Documentation Improvement Professionals” in November 2010, which was intended to:

- Assist in decision-making processes and actions
- Outline expectations for making ethical decisions in the workplace
- Help CDI professionals demonstrate their commitment to integrity²³

AHIMA’s “Ethical Standards” contain nine elements, each with component parts.

The first element states that CDI programs/specialists should “facilitate accurate, complete, and consistent clinical documentation within the health record to support coding and reporting of high-quality healthcare data.”

The second element states that CDI programs/specialists should “support the reporting of all healthcare data elements ... required for external reporting purposes ... completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.”

The third element reiterates query directives.

The fourth element indicates that CDI and coding staff should:

Refuse to participate in or support documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or distort data by means that do not comply with federal and state statutes, regulations, and official rules and guidelines.

The fifth element addressed the interdisciplinary nature of CDI (mentioned earlier in this chapter). The ethical standards were said to apply to all CDI professionals regardless of whether they are AHIMA members. Such inclusionary language was meant to bring an end to the debate over whether nurses needed to abide by the rules that govern HIM and the healthcare revenue cycle.²⁴

Simply put: they do. When CDI specialists (regardless of whether they hail from medical or coding backgrounds) think about the medical record, they must consider it clinically and investigatively and yet have a firm understanding of the rules governing code assignment without taking either impulse too far.

Elements six through nine reflect more general guidance for behaviors, such as the directive to “advance professional knowledge through continuing education” and to “protect the confidentiality of the health record at all times.”

These final considerations mirror items from ACDIS and from earlier and broader AHIMA “Code of Ethics” and “Standards for Ethical Coding.”

Productivity Expectations

Generally speaking, facilities hold CDI specialists to a productivity measure of about 20–30 reviews per day. The number of expected reviews must be considered in relationship to how many follow-up reviews and new-patient reviews are needed, as well as the expected area(s) or focus of review. (Productivity concerns and professional assessment will be discussed in Chapter 9.)

As of this writing, most CDI programs expect their specialists' and coders' productivity to diminish significantly in the months after the ICD-10-CM/PCS implementation date, and most expect the number of queries to increase to accommodate the need for additional specificity.²⁵

It takes time to review the medical record. How much time depends on the complexity of the case. It takes time to craft a query, too, particularly for new staff members. Not only does it take time to create, disseminate, and track, but CDI staff also need to seek out physicians to verbally follow up about the query. Physicians often are quite elusive; as you become more comfortable in your role, you will soon develop methods of communication with the providers. Some prefer email or text; others do better with the face-to-face approach. Success often requires adjustment to their schedule or preferred method of communication. (Additional tips in this regard will be discussed in Chapter 8.)

Discussion Point

Members of the CDI and coding team should be able to help you learn how best to interact with specific providers. Ask your CDI mentor or manager whether a list exists outlining how each provider prefers to be contacted. If a list does not exist, keep a cheat sheet with you as you round with various coworkers that you can use once it is time to go out on your own. (A sample tracking sheet is included in the Online Materials for Chapter 8, "Physician Education.")

Follow-up or re-reviews could take more or less time depending on the complexity of the case, since there can be much more documentation to review. For example, if the patient experiences a decline in status and becomes more complex, or multiple providers become involved, you may find it more difficult to review the record, and there will likely be opportunities for clarification.

Organizations that rely on a paper query process require the CDI specialist to review the medical record on a daily basis to check for query responses; they have to leave paper queries on the record and imagine creative ways to get the physician's attention and response. And many CDI programs remain (at least in part) on paper.²⁶ All this takes additional effort and time. However, most facilities are either already completely electronic or else soon will be due to government incentives for electronic health record implementation.

Discussion Point

Many tools provide automation to code and assign a DRG (such as an encoder) or assist in query construction and tracking. The important piece to remember is that such software is a tool used to assist the CDI, but the process of chart review, identification of documentation needs, and physician education cannot be automated. These skills will be perfected as you grow in experience and knowledge in your role.

Ask your manager or mentor to help you learn what software and other electronic record systems the department uses on a daily basis and establish an education plan to be proficient with these computer applications. Many program vendors offer online tutorials or training manuals that can help you. In many instances, your ability to work within these programs will be imperative to your success in the role.

Electronic tools can make a difference in productivity, but they often present their own unique problem areas, too. CDI specialists need to be aware of poor documentation habits, such as copy and pasting clinical information from the previous day's notes. They also need to be constantly (and consistently) involved with workflow discussions between other department staff and the information technology department to ensure that physicians can easily see and easily respond to the CDI queries. CDI programs with encoder access may be more productive than those without it, and those programs with electronic query and assessment tools can be of further help.

Concepts to Remember

A CDI specialist's productivity (his or her ability to review a set number of medical records per day) varies based on a number of considerations, including:

- CDI specialist's experience level
- Focus of the CDI program (CC/MCC capture or additional foci)
- ICD-10-CM/PCS implementation and training/awareness of associated documentation needs
- Complexity of the medical case/medical record being reviewed (it takes longer to review a case for a patient with multiple complications/comorbid conditions)
- Use of electronic tools (EHR, e-queries, encoder, etc.)
- Retention of queries in the medical record
- Service line specialization

Additional productivity, efficiency measures

Your effectiveness in the CDI role will be measured on more than simply how many cases you can burn through in one day. The effectiveness of the entire CDI endeavor depends on a host of variables that your CDI department manager, senior staff, or program director monitors on a regular basis.

Management will be looking to determine whether the program has a financial return on investment (ROI) and whether improved documentation helps to address medical necessity and prevents denials and so forth. Some measurements you may expect to be evaluated against are:

- Number of records where an opportunity for DRG movement was observed, e.g., from DRG 193-195, Simple Pneumonia, to DRG 177-179, Respiratory Infections & Inflammations
- The number of clarifications (queries) placed by a CDI specialist that affected the DRG (either positively or negatively)
- The number of clarifications that resulted in a severity change
- Rate of physician response to your CDI queries
- Rate of queries submitted for a given diagnosis
- Rate of queries submitted to a given physician
- CDI specialist/coder DRG match
- Volume of post-discharge queries versus concurrent queries
- DRG payer denials on cases followed by the CDI program, negatively and positively²⁷

Discussion Point

Don't worry too much about this right now; however, these will become factors of your assessment later on down the line. Later in this book (see Chapter 9), we'll talk more about how to measure overall CDI program success and your role in that assessment. We'll remind you at that time to talk with your coworkers and managers about how your CDI program goals are assessed and what measures you should strive to attain versus those which will be beyond your control.

Team meetings and group expectations

Developing and maintaining a good working relationship requires a lot of effort. A strong team is built on respect and trust, and we suspect (if you are reading this book) that your CDI program has made a commitment to you and the rest of its CDI team to foster these qualities throughout its program.

To this end, you may be asked to participate in a number of different meetings and/or assist with a variety of projects. Such tasks may include:

- Regular one-on-one sessions with your immediate manager to discuss difficult cases, assess your development, and exchange ideas about new initiatives
- Weekly or biweekly team meetings where CDI and coding staff discuss cases that were either difficult to review or difficult to code (often physician advisors play a role in these meetings to identify and educate staff on disease processes, etiologies, and clinical pathways)
- Quarterly peer reviews/audits of physician queries to ensure query compliance
- Regular cross-discipline review of query templates to ensure forms capture the latest clinical references and adhere to the latest industry query guidance

- Creation of (or assistance with the creation of) regular CDI newsletters and documentation tips
- Creation of (or assistance with the creation and/or review of) regular physician education presentations and supporting documentation
- Participation in utilization review, quality, case management, or denial committees
- Attendance to medical staff meetings, rounds, or continuing education offerings

Other Responsibilities (As Defined)

Discussion Point

Discuss your specific productivity expectations with your CDI manager or mentor to determine how many records you should be able to review and re-review in a given day. Ask your manager or mentor to help you plot out how these expectations should change as you continue to learn more about the role and gain experience in it. Also make sure to ask how the program accounts for time spent on one-on-one physician education, verbal query efforts, team meetings, etc. This will help you better understand whether you are on the right track and in line with team expectations.

Most job descriptions come with the caveat “*and other responsibilities as needed or defined.*” Undoubtedly, the same will be true of you and your position. Priorities will shift as new payment methods are introduced and new documentation improvement opportunities come to light. You will be asked to wear multiple hats. Whichever background brought you to this profession, no doubt you will be asked to share your specific expertise in new ways as you become proficient in your new role.

All this may seem overwhelming at the moment—heck, we’ve just spent roughly 20 pages outlining your job description—but know that this is a profession filled with supportive, caring individuals typically willing to hold out a hand and help lead you along.

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