Clinical Documentation Improvement (CDI) Overview

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Agenda

• Define CDI
• ACDIS
• Credentialing for CDS (Clinical Documentation Specialists)
• Importance of Accurate Clinical Documentation
• CDI benefits for Providers
• Define SOI/ROM (Severity of Illness/Risk of Mortality)
• CDI Program Overview
• CDI Query Process
• Key Elements of a successful CDI Program
• Example of a CDI Program Implementation
• CDI and ICD-10
Definition of Clinical Documentation Improvement

- ACDIS (Association for Clinical Documentation Improvement Specialists) Definition of Clinical Documentation Improvement (CDI):
  - “A service that Physicians can use to help their quality of care— not how they provide it, but how they project it (in their documentation).”
  - A CDI program can be described as a service that assists providers in obtaining accurate, specific, complete, quality documentation
    - CDI reviews are performed concurrently, Queries are initiated real-time, while patient is in-house and may asked verbally or electronically

ACDIS

- ACDIS was created in 2008 to gain recognition and support for the growing CDI field
- From the ACDIS web-site:
  - (http://www.hcpro.com/acdis)
- “The Association of Clinical Documentation Improvement Specialists is a community in which CDI professionals share strategies for successful CDI programs and achieve professional growth. Its mission is to bring CDI specialists together”
ACDIS (con’t)

- ACDIS works closely in conjunction with AHIMA and AAPC
  - Adapted (with permission) Code of Ethics from AHIMA and AAPC
  - Adherence to AHIMA Query Practice brief
  - Official coding guidelines and AHA Coding Clinic guidelines are followed

- ACDIS activities and references:
  - Clinical Documentation Improvement week (9/14-9/20/14)
  - Annual ACDIS Conference
  - Bi-weekly newsletters, Quarterly Journal, free webcasts, quarterly conference calls for members
  - Networking opportunities including a CDI blog and forums

Credentialing for CDI: AHIMA

**AHIMA:** CDIP
Certified Documentation Improvement Practitioner

**From the AHIMA website: Eligibility**
Candidates who would like to sit for the CDIP exam must meet one of the eligibility requirements below:
- An RHIA®, RHIT®, CCS®, CCS-P®, RN, MD or DO and two (2) years experience in clinical documentation improvement
- An Associate’s degree or higher and three (3) years of experience in clinical documentation improvement (candidates must also have completed coursework in Medical Terminology and Anatomy and Physiology)
**Credentialing for CDI: ACDIS**

**ACDIS:** CCDS  
Certified Clinical Documentation Specialist

*From the ACDIS “CCDS Candidate Handbook”:*  
- Candidates must demonstrate that they meet one of the following requirements:  
  - An RHIA, RHIT, CCS, CCS-P, RN, MD or DO and two (2) years experience as a concurrent documentation specialist.  
  - An Associate's degree (or equivalent education) in an allied health field and three (3) years of experience as a concurrent documentation specialist. The education component must include completed coursework in medical terminology and anatomy and physiology.  
  - Formal education (accredited, college-level course work) in human anatomy and/or physiology, plus medical terminology, and disease processes, and a minimum three (3) years experience as a concurrent documentation specialist.

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**Quality of Provider Documentation Impacts Key Areas of Performance**

- **Severeof Illness**  
- **Accurate Clinical Coding**  
- **Risk of Mortality**  
- **Physician Profiling**  
- **Case Mix**  
- **Provider Documentation/ICD Codes**  
- **Utilization of Resources**  
- **Validation of Length of Stay**  
- **Case Mix Index**  
- **Audit (RAC, MAC)**
**Need for Accuracy in Clinical Documentation**

- Accuracy is *essential* for:
  - Providing safe, appropriate patient care and treatment
  - Justifying medical necessity of inpatient status and length of stay
  - Complying with NYS DOH, Federal CMS, and Joint Commission regulations
  - Appropriately reflecting severity of illness and risk or mortality scores
  - Reflecting true physician and hospital performance in publicly reported data (profiles)
    - Influences consumer perceptions
    - Affects competitive strength/reputation in the marketplace
    - Impacts CMS ratings
  - Ensuring proper billing, reimbursement, and revenue

**Documentation that can be utilized for Hospital code assignment**

- Any Provider managing the patient
  - Attending, Consultants, Anesthesiologists, ED physician
  - Residents, PAs, NPs
- The following documentation *cannot* be used for code assignment (but should be reviewed for clues for query opportunities):
  - Nursing, Nutrition, RT, PT
  - Path Reports, Imaging Reports
  - Labs, EKG, ECHO Reports
    - Pertinence of potential diagnosis must be documented by the provider in progress notes
  - Documentation from physician office notes or prior admissions
CDI Benefits for Physicians

- Improve physician’s public profile
- Accurately reflect severity of every patient illness
- Accurate calculation of Mortality Index
- Minimize retrospective queries and deficiencies
- Improve patient care and quality
- Ensure accurate hospital billing and reimbursement
- RAC Readiness
- ICD-10 Readiness
- Assist with appropriate provider E&M level of service and reimbursement under Value Based Purchasing

SOI and ROM Defined

- Severity of Illness (SOI) and Risk of Mortality (ROM) scores are based on four levels:
  - 1 Minor
  - 2 Moderate
  - 3 Major
  - 4 Extreme
- Severity of Illness (SOI) and Risk of Mortality (ROM) are assigned by the DRG grouper, utilizing a complicated algorithm
  - Basically the more co-morbidities present, generally the higher the SOI and ROM
- CMS uses these scores to determine average SOI and ROM for patient’s of individual physicians and hospitals
RGH/NWH CDI Specialists: Who We Are, What We Do

Who We Are, What We Do....
• Team of RNs and coding professionals with acute care inpatient expertise (Part of HIM Department)
• Review Medicare inpatient acute care medical records concurrently, assign working DRG, and calculate SOI/ROM (Severity of Illness/Risk of Mortality scores assigned by the APR-DRG grouper) for the stay
• Generate real-time Provider Queries when documentation is inaccurate or incomplete:
  – Obtain verbiage for greater specificity
  – Clarify discrepancies or conflicting documentation
  – Obtain specification of a diagnosis based on clinical findings

Clinical Documentation Improvement (CDI) Team Here to Help

Our Goals at RGH/NWH CDI Program:
• Assist our providers with:
  ➢ Documentation requirements and ongoing changes
  ➢ Obtain documentation clarification in patient’s chart and help with query responses
  ➢ Accurately reflect severity of illness to improve hospital/physician performance profiles
• Help ensure accurate coding and billing by obtaining documentation clarification concurrently
• Reduce post-discharge Coding Queries and Provider deficiencies
• “Document for quality, and the appropriate revenue will follow.”
CDI Queries

- CDI Queries may be verbal or electronic
  - Verbal query require provider follow-up by documenting the response within the chart
- All queries, verbal or written must follow the AHIMA Query Practice Briefs, must be non-leading, and must include the following in order to be considered compliant:
  - Supporting risk factors, clinical indicators, treatment
  - Generally contain multiple choice selections
  - Contact information for CDS generating query
- Individual Hospital Policy must specify if a written query is considered a permanent part of the medical record
- A successful CDI program should include an escalation process for assistance as needed in obtaining query responses

Example of a CDI Query

Dear Dr. Zents,

Date: 10/21/13

Please review the following information and exercise your independent professional judgment in responding to the query. If you concur, please document on the problem list first. If you do not agree with the query, please indicate below. Based on the following documentation, please provide your intended diagnosis. This documentation will become part of the patient’s medical record.

**CDI Specialist/Coder Assessment**

**Clinical Indicators:**
- SOB, dyspnea located in ER Documented on 10/20/13, Peripheral edema located in History and Physical on 10/09/13 and elevated DTR located in lab on 10/09/13

**Treatments:**
- Diuretic Administration route: IV

**CDI Specialist/Coder Additional Comment Section**

Based upon the above clinical indicators and treatment, please clarify, in physician documentation section, if you are treating any of the following:

**Congestive Heart Failure that is:**
- Acute and/or chronic
- Systolic and/or diastolic
- And left and/or right

Or one of the following:
- The options above are not clinically significant for this patient. The correct diagnosis is:

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**PHYSICIAN’S DOCUMENTATION SECTION**

Based upon my clinical review the patient diagnosis is as follows:

(CD HF:22064)
Example of an “Agree” Query response with an Impact

- 83-year old female admitted with systolic CHF exacerbation
  - Respiratory rate of 30, Oxygen saturations 86%
  - Provider documentation: “would need oxygen around the clock”
  - CDS queried for Acute respiratory failure, Provider agreed and added

  **Working DRG:**
  - Heart Failure and Shock without CC/MCC, Relative Weight: 0.6723
  - Reimbursement: $3,958.12
  - SOI and ROM: 2/2

  **Final DRG:**
  - Heart Failure and Shock with MCC, Relative Weight: 1.5031
  - Reimbursement: $8,849.40
  - SOI and ROM: 3/3

Key Aspects of a Successful CDI Program

- Support of higher level administration
- Designation of Physician Champion
- Creation of a CDI Steering Committee to include key members from Upper administration, coding, HIM, finance, physician champion(s)
- Reporting of key CDI program benchmarks
- Adequate staffing:
  - Suggested (1) FTE/1700 discharges
  - For ICD-10 productivity impact: (1) FTE/1500 discharges
- Regular communication in a newsletter, educational posters, hand-outs, and tip-cards for providers
Key Aspects to a Successful CDI Team

- Initial and ongoing training: clinical knowledge and coding related
- Implement, track, and report productivity standards:
  - Industry standard benchmarks:
    - 8-10 new reviews daily (medical), 10-12 (surgical)
    - 12-15 Follow-up reviews daily
    - Perform Reconciliations daily (review final coding on discharge accounts, facilitate communication with coder when DRG do not match)
- Establish open, effective working relationship between CDI team and coding team:
  - Regular (weekly to monthly) joint meetings to discuss cases
- Provider education through daily interactions, and group presentations
  - CDS Predominantly work on units to facilitate interaction with providers
    - Maintains a CDI presence and recognition with goal to have providers come to CDI as needed
    - Allows for verbal query and in-person educational opportunities in daily interactions with providers and other health care personnel (nursing, dietary, care managers, social work, etc.)

Example of Implementation of CDI Program

- RGH established CDI program 2008:
  - Was not fully staffed, therefore reviews and education limited to mainly medical units
  - Missing necessary elements (no physician advisor, or steering committee)
  - Basic data entry in an Excel file, no formal reporting
- June 2011 began a year long “revitalization”:
  - Contracted with Huron Healthcare Associates:
    - Performed 3 onsite training sessions including 2-week classroom training, 2-4 weeks mentoring on units
    - 1st session: existing team, 2nd: Inpatient coders, new CDS, 3rd session: 4 new CDS
    - Assisted in interviewing and hiring new CDS, updating job descriptions
    - Assisted in benchmarking, data entry, and reporting
    - Roll out presentations to key provider groups
    - Resource for questions, perform follow-up audits and quarterly visits, and team assessments
  - Designated a Physician Champion
  - Created CDI Steering Committee
  - CDI Manager presented CDI Introduction and query completion demonstration to each provider group
  - Created a CDI Program Dashboard which is presented monthly to steering committee
Rochester General Health System: RGH
Clinical Documentation Improvement Program - Provider Dashboard

**Provider Education and ICD-10**

- **Remember providers don’t need to know “how to be a coder”**
  - Most do not need education on coding conventions or why a code requires a 7th digit
  - Need education on how and what to document for the coders to get to the desired code

- **On-going CDI reviews and queries ensures greater specificity in provider documentation overall**
  - Identify documentation gaps and areas for targeted provider education specific to ICD-10
CDI and ICD-10

- Greater focus on CDI with ICD-10 implementation
  - CDI Specialists on front-line for in-person provider education and assisting with obtaining complete documentation for the coding process
  - Assist in feedback loop to providers with information derived from dual coding
- CDI must understand differences between ICD-9 and ICD-10 identify documentation gaps, and recognize query opportunities
- CDI and Coding Queries are another education tool for providers

ICD-10 Training for CDI

- Some CDI programs not require CDS to have in-depth coding proficiency
  - Potential difficulty in identifying additional documentation needs under ICD-10
- Recommended CDI model:
  - CDS undergo complete, formal training of ICD-10
  - Full understanding of coding guidelines under ICD-9 and 10
    - Identify common diagnoses required additional documentation
    - Query providers for the additional specificity
    - Provide one-on-one provider education
RGH CDI Training Plan for CDI

• RGH/NWH utilized Precyse University for system wide training
  – Mandatory, specialized training/module selections based on job title
  – Could be as simple as one module to promote awareness of ICD-10 for non-affected team members
  – Physician training anywhere from 2-20 hours depending on specialty

• HIM Coding and CDI teams:
  – Up to 120-hours of training (including A&P refreshers)
  – Inpatient Coders and CDI: assigned maximum of 120 hr.
  – Training completed by 12/31/13 for existing team members

RGH Dual Coding Plan

• HIM Dual Coding for all encounter types:
  – Began March 2014
  – Ramp up phase with targets for productivity and accuracy
  – Utilized contractor assistance on auditing and feedback to coding team

• CDI dual coding began June 2014
  – Ramp up period
  – Dual coding two accounts (1 Medical, 1 Surgical) per day, Tues-Fri
  – Will begin utilizing contractor assistance in auditing and feedback to CDI team

• Query templates updated for ICD-10 November 2013
• Tracking of volume and type of ICD-10 specific queries
Provider Education and Dual Coding

• Physician Advisory Board implementation October 2014
  – Assist Physician Champion
  – One key Physician Advisor (80% advisor, 20% patient care)
  – One Physician Advisor from each service (20% advisor, 80% patient care)
• Role to work closely with HIM and assist with:
  – CDI Query escalation
  – Contact to relay dual coding feedback
  – Assist with ICD-10 education for their service
  – Assist with payer denials and quality reviews

Status as of October 2015

• To have coders and CDI team fully trained, practiced, and proficient in ICD-10
• Prevent the “Productivity Cliff” as of 10/1/15

• Seamless transition from ICD-9 to 10
  – For providers, CDI, and coding
QUESTIONS?