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
- CDI and Pay-for-Performance (P4P)
- CDI and PSI 90
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 be 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 (9/14-9/18/2015)
  – 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: 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.
Credenialing 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)

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**Quality of Provider Documentation Impacts Key Areas of Performance**
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/Unity 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/Unity 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 requires 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

When to Query (?)

- When the Medical Record Documentation:
  - Is conflicting, imprecise, incomplete, ambiguous or inconsistent
  - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
  - Provides a diagnosis w/o underlying clinical validation
  - Is unclear for POA indicator assignment

AHIMA Practice Brief – Guidelines for Achieving a Compliant Query Practice
Query Process Standards

• Do not indicate the impact on reimbursement
• Must include relevant clinical indicators that show why a more complete or accurate diagnosis or procedure is needed
• Not leading – meaning can not direct a provider to a specific diagnosis or procedure
• Multiple choice query formats should include clinically significant and reasonable options as supported in the health record. In addition, “clinically undetermined” and “other” so as to allow the provider to add free text.

Leading vs Nonleading Query Example 1

• Clarification for Specificity of a Diagnosis
  • Obtunded patient admitted with three-day history of nausea and vomiting. CXR revealed right lower lobe (RLL) pneumonia. Clindamycin ordered.

  • Leading query: Is the patient’s pneumonia due to aspiration?
  • Nonleading query: Can the etiology of the patient’s pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.
Leading vs Nonleading Example 2

• **Clarification of a Missing or Vague Diagnosis**
  • Patient admitted with COPD exacerbation. H&P notes respiratory distress. Oxygen saturation on admission is 86 percent on room air, respiratory rate of 28, and arterial blood gas (ABG) results of pO² 45, pCO² 50, pH 7.34, with Bipap and oxygen ordered.
  • **Leading query:** The patient has abnormal ABGs and your documentation reflects respiratory distress. If you mean acute respiratory failure, please document on this form or the progress note. Thank you.
  • **Nonleading:** Can your documentation of respiratory distress be further clarified:
    • Acute respiratory insufficiency: __________________
    • Acute respiratory failure: _________________________
    • Acute on chronic respiratory failure: ______________
    • Some other cause of respiratory distress: ________
    • Undetermined: _________________________________
    • Not applicable: _________________________________
  • **Rationale:** It is noted in the H&P this patient admitted with acute exacerbation of COPD with oxygen saturation on admission of 86 percent on room air, respiratory rate of 28, and ABGs of pO² 45, pCO² 50, pH 7.34, with Bipap and oxygen ordered.

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

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 do 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 requiring additional documentation
    - Query providers for the additional specificity
    - Provide one-on-one provider education
RGH CDI Training Plan for I-10

• 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

CDI & Pay-For-Performance

• CMS Hospital Value-Based Purchasing Program implemented in 2013 (HVBP)
  – MS-DRG payment adjustment
    • Penalty (or)
    • Incentive
  – Pay-for-performance (P4P)
    • Claims based – diagnosis codes submitted on claims
• CDI Team are on the front line for accurate documentation by the Providers
Patient Safety Indicator (PSI) 90

- PSI 90
  - CMS claims-based P4P quality measure
  - In-hospital complications and adverse events
  - Developed by the Agency for Healthcare Research & Quality (AHRQ)
- Included in two P4P programs
  - Hospital Value Based Purchasing Program (HVBP)
  - Hospital-Acquired Condition Reduction Program (HACRP)

PSI 90 Composite

- PSI 03 Pressure ulcer
- PSI 06 Iatrogenic pneumothorax
- PSI 07 Central venous catheter-related bloodstream infections (CLABSI)
- PSI 08 Postoperative hip fracture
- PSI 12 Postoperative PE or DVT
- PSI 13 Postoperative sepsis
- PSI 14 Postoperative wound dehiscence
- PSI 15 Accidental puncture or laceration
CDI Team’s Role

- Identify documentation issues for each PSI
- Develop queries pertinent to the PSI measures
- Provide documentation education to Providers
- Understand the “Includes” and “Excludes” of each PSI ([www.qualitynet.org](http://www.qualitynet.org))
- Knowledge of risk adjustment variables

PSI 03 – Pressure Ulcer

- Includes -
  - Stage III, IV or unstageable when **not** present on admission
- Excludes –
  - Any stage Pressure Ulcer present on admission
  - Hemiplegia, quadriplegia, anoxic brain damage
  - Transfers from another facility (SNF, hospital)
- Risk adjustment variable -
  - Restless leg syndrome
    - Positive risk adjustment impact of 10%
PSI #7 - CLABSI

• Includes –
  – Infection secondary to Central Venous Catheter
    • Blood stream (bacteremia, septicemia)

• Excludes –
  – Present on admission
  – Less than 2 day stay
  – Immunocompromised state
    • ESRD, CKD V, Hx kidney transplant
  – Cancer

• Risk Adjustment
  – CHF, malnutrition

PSI 15 - Accidental Puncture or Laceration

• Develop a Query when documentation of accidental cut or tear is present
  – ? Complication of the procedure
  – ? Integral to the procedure
  – ? Not clinically significant

• Educate physicians on terms that are indicative of an accidental puncture or laceration

• Educate physicians on terms that suggest non-accidental puncture or laceration
Querying for Accidental Puncture/Laceration

- **Compliant Example**
- **Clinical scenario**: During the removal of an abdominal mass, the surgeon documents in the description of the operative procedure, a “serosal injury to the stomach was repaired with interrupted sutures.”
- **Query**: In the description of the operative procedure a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:
  - A complication of the procedure
  - Integral to the above procedure
  - Not clinically significant
  - Other
  - Clinically Undetermined

- **Rationale**: This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

AHIMA - Guidelines for Achieving a Compliant Query Practice