

The Physician Advisor's Guide to Clinical Documentation Integrity

SECOND EDITION

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Introduction

If you are reading this, you have probably been asked to serve as a physician advisor or champion for your facility’s clinical documentation integrity (CDI) efforts. Perhaps you were chosen due to your experience as a physician advisor with case management or utilization review. Perhaps you have been asked to take on this role due to your previous help with CDI efforts. Or perhaps you are known for your excellent documentation habits.

Regardless, the role of a CDI physician advisor (or as titled in some facilities, medical director) is a unique one and requires the specific insight you have as a clinician. Additionally, the analytical skills you possess to translate documentation trends into meaningful information for your fellow physicians and to maintain awareness of how healthcare data are used in this country—including healthcare reform, reimbursement, and quality improvement efforts—are valuable attributes.

While some CDI programs have been in place since the Centers for Medicare & Medicaid Services (CMS) developed diagnosis-related groups (DRG) in 1983, many more have emerged since the implementation of the Medicare Severity DRG (MS-DRG) in 2007.

What is a DRG and why did this development spur the growth of an industry? Coding and DRG determination will be discussed in more detail later on in this book; suffice it to say, however, that too often the stringent rules governing code assignment confuse or frustrate clinicians. For example, the term “urosepsis,” which means “sepsis due to a urinary tract infection” in most clinicians’ minds, has no code in the International Classification of Diseases 10th Revision (ICD-10). If there is no code for a disease, it does not exist.

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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. Hurriedly entering orders through computerized order entry to improve patient throughput, allowing the electronic medical record to auto-populate every possible field for a given note, and over-relying on the cut-and-paste function does not promote the excellent, long-term documentation habits desired or needed.

CDI programs can help. CDI is the process of promoting consistent, complete, precise, reliable, nonconflicting, and legible provider documentation integral to the compliant submission of 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 ICD-10-CM/PCS or Current Procedural Terminology® code sets. The CDI specialist's role is to ensure the ICD-10 codes reported for any given medical encounter accurately reflect the severity of illness with which a given patient presents through consistent and regular provider education as well as queries when necessary.

CDI professionals, who frequently come to the role from either nursing or health information management (HIM) backgrounds, work with both physicians and coders to define and document the complete story of the patient's medical needs and the care provided in the language ICD-10 requires. Essentially, CDI professionals serve to bridge the translational gap that exists between physicians and coders. While this is ideally performed concurrently—in real time, while the patient is in the hospital—it may also occur after the patient leaves the acute care setting.

Clearly, there is an inherent need for cooperation between physicians and coders. In fact, the *Official Guidelines for Coding and Reporting* states that “a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved.

Essentially, the implementation of the DRG and subsequent MS-DRG systems helped spur the growth of CDI because acute care facilities (hospitals) faced losing valuable reimbursement if unable to capture the clinical specificity needed to code principal and additional diagnoses or procedures to illustrate the

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patients' severity of illness. The DRG and MS-DRG systems spurred the growth of CDI because the gap between physicians' clinical language and the regulatory language of coding required a translator. The implementation of the MS-DRG system in 2007 substantially increased the importance of complete and accurate documentation by all providers, resulting in the explosion of the CDI profession.

CDI programs require a fully invested team effort to be successful. That means CDI specialists must work in complete synchrony with their HIM and coding counterparts. It means they must work tirelessly and diligently with physicians to ensure accurate disease capture. It means they must work with their chief medical officer and senior management team to demonstrate how their efforts benefit the facility, the physicians, and, most importantly, the patients. That is a lot of support and a lot of balls to juggle. You can help.

A strong physician advisor can greatly increase the success of your CDI program and your organization. Surprisingly, the role of the CDI physician advisor remains underappreciated and underutilized. Twenty-five years ago, few hospitals thought of using a physician as a regular resource even for case management or utilization review purposes. However, as clinical issues gained greater prominence in revenue cycle management, many facilities recognized the need and added this role. The question becomes how to ensure that your facility obtains the maximum benefit from your CDI program's efforts.

Organizations often struggle to obtain resources for a full-time physician advisor because there are few road maps to chart responsibilities, provide job descriptions, and outline demonstrable goals associated with the position. Hospital leaders often shortsightedly focus on the all-important immediate return on investment (ROI) of such positions, failing to grasp the larger, positive impacts on publicly reported performance data, patient herding, and contracting. Facilities need to determine what structure best suits their programmatic goals and how to best use their physician advisor.

For example, it may make sense for a facility to hire a physician advisor specifically to address case management concerns related to readmission reductions and for that individual to also work closely with quality assurance to determine whether patient safety indicators are accurately reported. Alternatively, it may make sense for a physician advisor to wear dual hats, one for case management and another for utilization review, to ensure that patients meet medical necessity requirements for inpatient admission and that the services provided are appropriate to the patients' severity of illness (Michelman, 2008).

More than half of CDI programs have a dedicated physician advisor, but only a quarter of those solely support CDI and coding departments. Although most do double duty as case management or utilization

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review advisors, there has been an increased effort from industry activists to ensure their dedicated responsibility for defense of the medical record. As awareness about medical record documentation and coded data ties to physician and facility quality metrics, medical research, claims denials, and reimbursement, many facilities find focused physician advisor assistance in CDI efforts indispensable.

As you will learn throughout this book, a dedicated physician advisor will have to play multiple roles. They will most likely be called on to provide documentation education for fellow medical staff, resident physicians in training, nurse practitioners, and physician assistants in addition to clinical education sessions for coders, HIM staff, and clinical documentation specialists. CDI team members will seek out their assistance on difficult clinical cases and ask for input on the creation or revision of standard query forms.

As a physician advisor, you may be asked to manage a difficult physician or mentor a timid CDI specialist. You might also be asked to act as the disciplinarian, to confront a physician who repeatedly ignores queries or documents inappropriately. You will also need to work closely with the CDI manager or director, the HIM director, the chief financial officer, the chief quality officer, and the chief medical officer to identify trends and spot solutions.

Will it be difficult? You bet. But it is also one of the most rewarding roles you will play. Why? Because not only will you be helping improve the quality of care patients at your facility receive, but you will also be helping all the staff—from your physician coworkers to coders to managers—ensure that your facility gets the credit it deserves for the exemplary care your facility provides.

As a practicing clinician, you impacted the lives of the relatively limited number of patients for whom you were responsible and only on those days you were rounding in the hospital. As a CDI physician advisor, however, you will impact the lives of every patient in your facility every day of the week. CDI keeps your facility's doors open and ensures your medical staff has the necessary resources to provide the medical care to which they are accustomed. Where will your patients obtain the medical care they need if your facility is forced to close?

We know you are up to the task, and we are here to help you get started.

REFERENCES

Michelman, Michael S. *Optimizing the Physician Advisor in Case Management*. HCPro, Danvers, Mass., 2008.

1

Foundations of CDI

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. Unfortunately, the documentation of all these things being done frequently lies at the bottom of the average physician's daily priority list. Like it or not, this traditional view of a physician's responsibilities must change as medical record documentation has become paramount to that physician's ability to attract new patients and to provide the services they think those patients require.

Few physicians, however, are taught in medical school how their language and documentation affects various other departments, reimbursement (both their own and their hospital's), quality data, or other data uses. To their knowledge, when their documentation is reviewed, it is to ensure appropriateness of care by another member of the medical staff.

On the other hand, coders simply do not have the extensive clinical training that physicians have received. Their role is to translate what physicians have documented in the medical record into International Classification of Diseases (ICD) and Current Procedural Terminology (CPT®) codes.

Based solely on what physicians specifically say in the record, coders must discern the patient's principal diagnosis and capture any and all extenuating conditions and treatments provided. If the documentation is illegible, incomplete, imprecise, inconsistent, conflicting, or otherwise unreliable, the coder's job is exponentially more difficult. Coders are not allowed to infer, extrapolate, deduce, or interpret in any way what a physician intended to say. Therefore, physicians must be explicit in their documentation to ensure coders have complete clarity for accurate code assignment.

2

Coding Rules and Guidance

“If it wasn’t documented, it wasn’t done.” Coders frequently use this adage to represent the limits of their ability to interpret a physician’s documentation for code assignment. While the coder may review provider documentation and assign codes in light of International Classification of Diseases 10th Revision (ICD-10) or Current Procedural Terminology® nosologies, their clinical interpretations are limited to determining the need for and initiating provider queries that clarify illegible, incomplete, imprecise, inconsistent, conflicting, or clinically unreliable entries. Furthermore, what may seem clinically intuitive or plain to a physician may as well be a foreign language to the individual coding the care provided (Kruse, 2012).

This limitation may appear strange to practicing clinicians.

For example, when a physician documents “patient with ventilator dependent respiratory failure, will perform vent weaning trials as tolerated,” he or she may be surprised that the coder cannot assume the type (hypoxic or hypercarbic) or status (acute or chronic) of the respiratory failure even though this appears obvious to the provider. If a patient is hypotensive in the emergency department with a leukocytosis and free air on x-ray and taken emergently to the operating room for a laparotomy, the diagnosis of septic or septic shock cannot be inferred. It must be documented. This is frustrating to many clinicians. It can be helpful and illuminating to educate physicians on how many times they speak in “symptoms” rather than “diagnoses.” Terms such as “hypotensive, pressor dependent, vented, abdominal pain, etc.” are not familiar to coders. Physicians must be taught to replace them with “shock, respiratory failure, peritonitis” and so on.

3

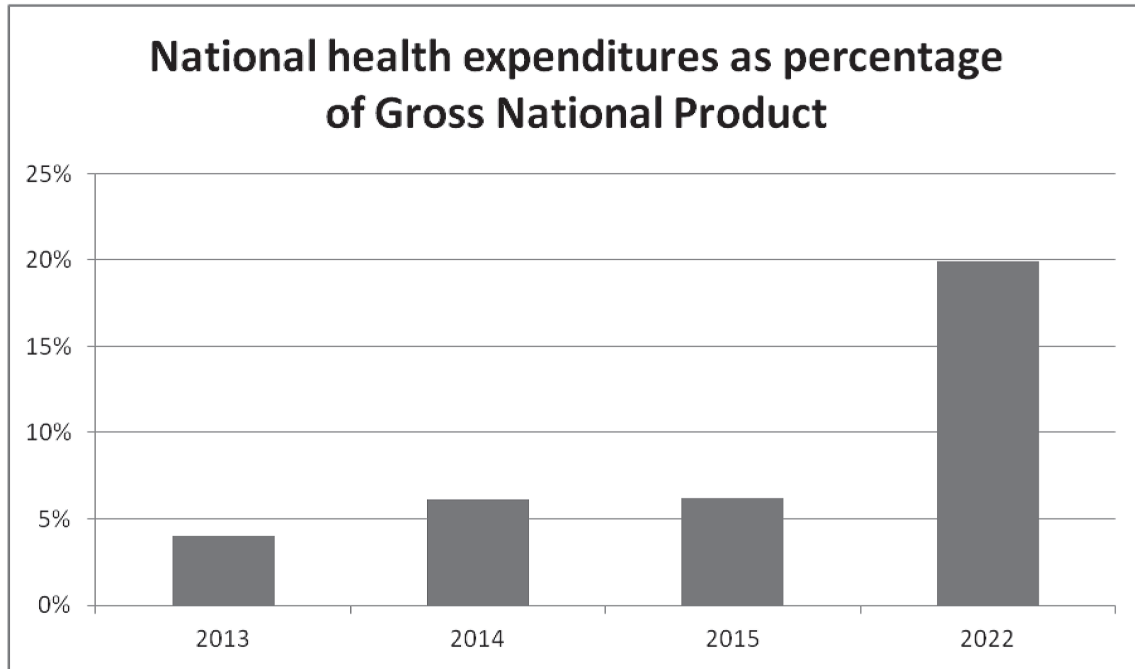
Multiple Coding and Reimbursement Systems

The United States' International Classification of Diseases (ICD) codes are not the only ones used for data processing, reimbursement, and other reasons. The Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS), the American Medical Association (AMA) Current Procedural Terminology (CPT®), and the U.S. Department of Health and Human Services (HHS) National Drug Code are also transaction sets required by the Health Insurance Portability and Accountability Act when covered entities (e.g., physicians, clinics, hospitals) report clinical information. In addition, Systematized Nomenclature of Medicine (SNOMED) is a computer-processable collection of medical term that cover anatomy, diseases, findings, procedures, microorganisms, substances, etc. used in many electronic health record (EHR) systems. It allows a consistent way to index, store, retrieve, and aggregate medical data across specialties and sites of care.

Some of these coding systems apply to all circumstances, such as ICD-10-CM for diagnosis assignment (though there are different rules for inpatient, outpatient, and physician encounters), and some, such as CPT, apply only to physician and outpatient facility services, whereas ICD-10-PCS applies only to inpatient facility procedure billing.

Regardless of which code set is used, where the patient is cared for, or how various agencies use coded data, the accurate depiction of patient conditions and rendered services begins with provider documentation. After all, if the care provided is not documented, how can the appropriate follow-up care be provided? Too frequently, physicians interpret this aspect of patient care as an administrative burden rife with complicated rules. Too often, physicians are overwhelmed by the constantly shifting expectations regarding their documentation efforts.

The CDI team can parse through the layers of documentation information and coding guidance to identify the various reasons physician documentation matters. Individuals respond positively to requests for assistance or changes in their environment if they understand the implications or reasons behind the requests.



Source: CMS. *National Health Expenditure Projections 2012–2022 Forecast Summary*, Office of the Actuary, National Health Statistics Group.

Government reimbursement

Prior to 1983 (the “good ole days”), Medicare reimbursed inpatient healthcare based on actual charges—you received what you billed for. The more the physician did at a facility, the more the facility was paid. While ICD-9-CM codes were used for inpatient admissions, rules for assignment were loose, and coders were allowed to clinically interpret the record for code assignment (or at least were not disciplined when they did).

This all changed when, in 1983, CMS implemented the Medicare inpatient prospective payment system (IPPS), which tied inpatient facility reimbursement to provider diagnoses and treatment descriptions but still allowed physicians to apply their usual fee-for-service codes. The change, policymakers hoped, would encourage hospitals to more effectively manage medical care and limit the government’s financial exposure. CMS publishes subsequent adjustments to its payment rates and methodology annually in a “proposed rule,” allowing those who are vested in the healthcare industry to offer their comments and

CHAPTER 3

suggestions on the proposal. The agency takes some of these concerns into consideration, generates adjustments, and publishes a final rule typically every August in the *Federal Register*. Items within the new rule take effect each October 1 unless otherwise noted.

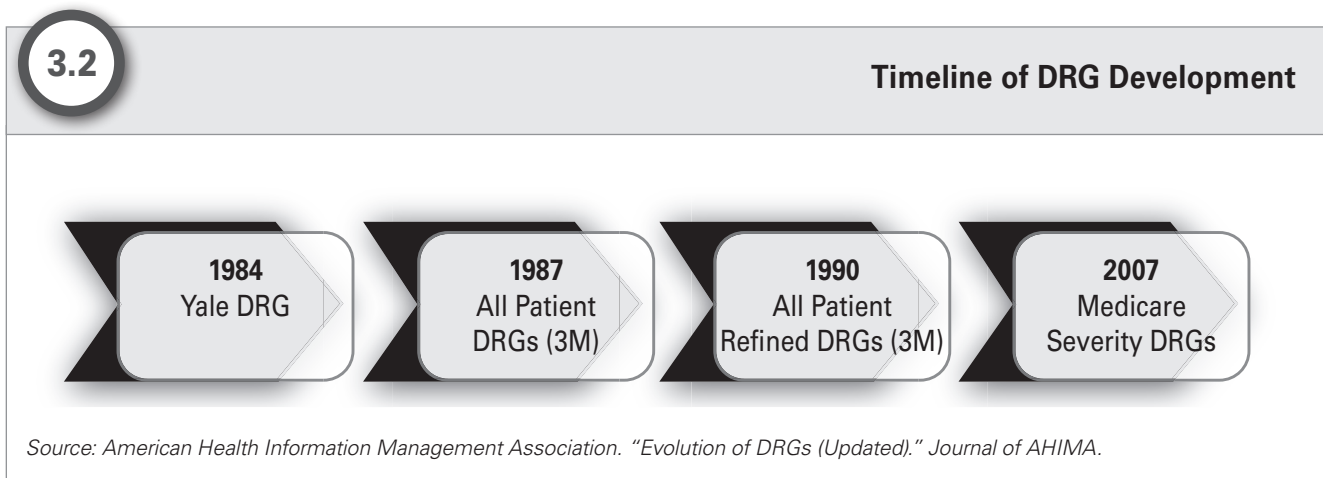
Advance of the diagnosis-related grouping system

Under the IPPS, CMS categorized patient care into a diagnosis-related group (DRG). The original DRG system, developed at Yale University, aimed to categorize similar patients with theoretically similar treatments and charges based on the patient's principal diagnosis (PDX) and up to eight secondary diagnoses. Age and discharge status also influenced the categorization of the approximately 538 DRGs (AHIMA, 2010).

Figure 3.2 illustrates a timeline of the DRG system changes.

The following elements comprise the components of most inpatient DRGs:

- DRG number
- DRG title
- DRG type (e.g., medical or surgical)
- Major diagnostic category assignment
- Severity of illness indicator (APR-DRG only)
- Risk of mortality indicator (APR-DRG only)
- Relative weight (based on resource intensity subject to payment)



4

Physician Queries and Coding Compliance

The physician query represents the CDI specialist’s primary tool to ensure complete, accurate, and codeable information within the medical record. It is the CDI specialist’s job to see what information the record contains and, like a crime scene investigator, pick up clues within the medical record to recognize conditions that are clinically present but not yet documented. When they find such instances, they ask the physician if they are on the right track. If so, they ask the physician to clarify the record by documenting the diagnosis that those clues have elucidated. In a nutshell, this is the query process.

In the course of their duties, CDI specialists cannot simply walk up to a physician and say what they think the diagnosis should be or what they should write. For example, a CDI specialist cannot say to a physician who has documented congestive heart failure (CHF), “Hey, Dr. XYZ. I was looking at the chart for this patient and it looks to me like they might have acute-on-chronic diastolic heart failure. You should add that to the record.”

But why not?

Simply stated, the CDI specialist does not have direct patient care responsibility. All diagnosis and treatment decisions must originate with the treating providers and be documented in the medical record by those individuals. The American Health Information Management Association (AHIMA) and ACDIS provide clear direction on this issue: “diagnosis codes are only assigned based on the documentation of those licensed, independent providers *who render direct patient care.*”

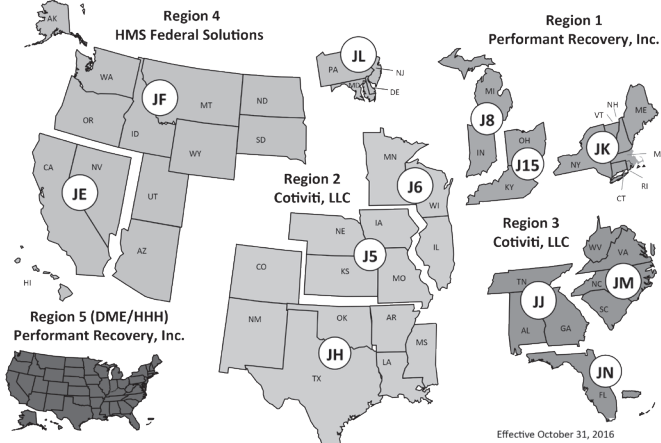
Additionally, the above anecdotal scenario represents what most coders and CDI specialists understand to be a “leading” query—one in which the physician was asked or directed to document a particular diagnosis that often affects reimbursement or quality metrics. While many clinicians facing ever-increasing administrative

PHYSICIAN QUERIES AND CODING COMPLIANCE

4.4

Illustration of Recovery Auditors by Region and by Priority

Medicare Fee-for-Service RAC Regions



	Percent of Hospitals Nationwide	Percent of Participating Hospitals by Region
Region A: Performant Recovery	15%	16%
Region B: CGI Federal, Inc.	19%	23%
Region C: Connolly, Inc.	40%	35%
Region D: HealthDataInsights, Inc.	26%	26%

Source: CMS.

MACs, MICs, UPICs, and ZPICs

While MACs, MICs, UPICs, and ZPICs are also independent, nongovernmental companies, they all have governmental authority to audit healthcare providers in search of overpayments or potential fraud.

Medicare Administrative Contractors (MAC) are the fiscal intermediaries between CMS and healthcare providers. They are the “go-betweens” collecting payment information from hospitals and then processing the payment transactions for CMS. They are responsible for ensuring inpatient claims (Part A) as well as outpatient claims and physician services (both of which comprise Part B) are executed. MACs also serve as an appellate venue when facilities or physicians do not agree with rulings made by RAs. There are 23 MACs that serve as the providers’ primary point of contact for the receipt, processing, and payment of claims. Of these 23 groups, 15 process both Part A and Part B claims (A/B MACs), four process DME claims (DME MACs), and four process home health and hospice (HH) claims (HH MACs).

What makes the MACs interesting is the fact that they can request documentation from a third party (a physician office, for example) while simultaneously requesting information from a billing provider or supplier. If neither party responds within 45 days, the MAC may deny the claim in part or in full. Therefore, the payment of the claim depends on both parties responding. MACs can conduct post-payment reviews up to four years after payment (in contrast to the three-year limit for the RAs), impose severe

5

Identifying Clinical Indicators

As mentioned earlier, physician responsibilities in CDI center on three elements:

- Definitions of terms, what clinical indicators define or differentiate the clinical terminology used by physicians or incorporated into the code description
- Diagnoses or descriptions of clinical conditions made at the bedside or clinical procedures performed in the operating arena
- Documentation of these defined, diagnosed, and/or described conditions in the medical record (especially in the discharge summary, procedure notes, history and physical [H&P] examinations, and other provider notes) in a language that can be coded into clinically congruent and complete ICD-10-CM/PCS codes

This chapter focuses on clinical indicators of conditions or treatments that frequently require greater completeness or specificity in ICD-10 for which concurrent or retrospective query is often required. Documentation improvement opportunities essential to ensuring the integrity of Medicare Severity Diagnosis-Related Groups (MS-DRGs) or All-Payer Refined DRGs (APR-DRGs) will be emphasized.

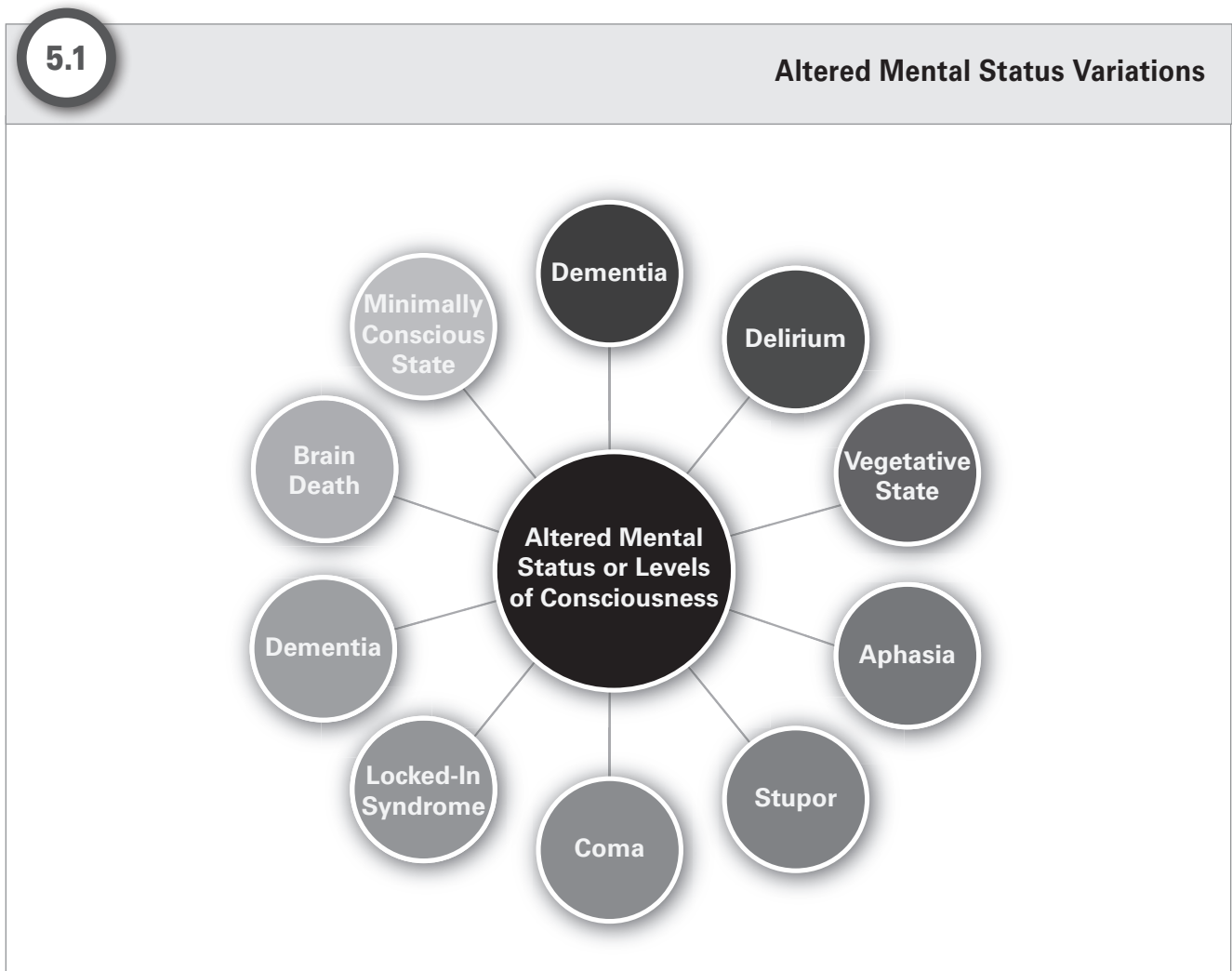
All ICD-10-CM codes are classified into at least one major diagnostic category (MDC) (e.g., MDC 1, Nervous System; MDC 5, Circulatory System; MDC 8, Musculoskeletal System and Connective Tissue) or disease category (e.g., MDC 15, Newborn and Other Neonates [Perinatal Period]; MDC 22, Burns; or MDC 25, Human Immunodeficiency Virus Infections). In most circumstances, the ICD-10-CM code must be a principal diagnosis as (PDX) to qualify for a particular MDC, but there are some exceptions, such as with B20 (HIV disease).

IDENTIFYING CLINICAL INDICATORS

Altered mental status (AMS)

AMS is a commonly used nonspecific neurological or psychiatric term that often requires queries for specificity, duration, and/or underlying or precipitating causes. ICD-10-CM does not always consider the symptom to be integral to the underlying cause, so coding of the nature of an altered mental state or level of consciousness and its related conditions requires physicians and coders pay close attention to the ICD-10-CM instructions when documenting and coding.

Figure 5.1 illustrates the variations in AMS diagnoses.



6

Medical Staff Engagement

Congratulations. You have just become an expert in why clinical documentation integrity is so important and know everything about it. Hopefully, you are equally enthusiastic about sharing with your colleagues all the things you have now learned about CDI. However, do not let your exuberance impulsively override common sense. Without a solid, methodical action plan to encourage and maintain provider engagement, the time you have just spent enlightening yourself will be for naught.

As the CDI physician advisor, it is your job to get your medical staff to support CDI efforts. To be blunt, that means they need to drink the CDI Kool-Aid you are selling and do what you tell them. However, a CDI program and its physician advisor will only achieve such a response when the medical staff wants to participate in CDI program goals. It is a common misconception that people do not like or are afraid of change. The reality is that people do not like being changed. In other words, if a person grasps why a proposed change directly benefits them, they are much more likely to agree. In contrast, if people are told to do something new without being provided the why or the potential reward, they will resent the request and possibly rebel.

To this end, CDI physician advisors must understand that what initially motivated them to improve their documentation behaviors may not carry the same impetus for all members of the medical staff. Therefore, the physician advisor needs to find and communicate as many different reasons as possible that demonstrate the value of CDI. In other words, the search for that one spark that serves as the genesis for change in one or many medical staff members is constant. By continually searching for and reminding providers of all the reasons CDI is important, the physician advisor will eventually uncover the one enticement that resonates most with each individual provider.

7

Evaluating CDI Success

Murphy's law states that if anything can go wrong, it will. A popular corollary to Murphy's law is if anything can't go wrong, it will. As a CDI physician advisor, these adages are undeniably true.

When it comes to CDI programs, the best-laid plans frequently go awry. Yes, there will be unforeseen events for which there is no way for any physician advisor to prepare. More commonly, there are two principal reasons a CDI program goes off the rails: a lack of accountability (i.e., poor oversight and follow-through) and/or a failure to sustain program priorities and results. In short, CDI programs (just like any other program) need to be regularly audited on a variety of metrics to ensure the goals and priorities set for it by program staff and hospital administration (typically via the CDI steering committee) are met and perpetuated.

It sounds simple, doesn't it?

Step 1: Set goals.

Step 2: Measure staff and the results obtained against those goals. Repeat to effect.

Changing healthcare system and facility stressors, CDI program and C-suite turnover, and constant mission creep pressures make this seemingly simple process complex. Factor in the unpredictable evolution of healthcare reform periodically revising the various metrics by which your organization and programmatic success are judged, and the difficulty level may be exponentially compounded.

The physician advisor plays a key role in the ongoing assessment process and the maintenance of long-term programmatic success. However, he or she should not be solely responsible for data collection, assimilation, nor communication of the results to the powers that be.

EVALUATING CDI SUCCESS

7.1

Illustration of Reconciliation Pros and Cons

Common query reconciliation issues	Responsible party	Pros	Cons
<p>Concurrent query not answered that affects the DRG</p> <p>Discharge summary nullifies a concurrent query (dissonance in the medical record)</p> <p>Concurrent query results in a diagnosis without a clear indication of whether it was POA</p>	HIM	<p>Allows CDI staff to focus on new cases.</p> <p>Better response rate from physicians if they are accustomed to HIM asking queries after discharge.</p>	<p>May take longer to obtain an answer, which will negatively affect DNFB (discharged not final billed).</p> <p>The CDI staff may not be as diligent in obtaining an answer concurrently as others will take care of it on the back end.</p>
	CDI	<p>Generally allows for a quicker answer, which lessens the impact on DNFB (discharged not final billed).</p> <p>When performed immediately, will promote more accurate physician responses.</p> <p>Ensures that CDI staff members own their queries and work to improve their processes.</p>	<p>May take time away from concurrent charts.</p> <p>Physicians may be annoyed at being asked to clarify a discharged case.</p> <p>If chart is taken to the floor by CDI, will need to ensure that regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 are followed.</p> <p>May be disagreement between HIM and CDI as to what is a CDI type of query and what is a coding issue type of query.</p>

Source: *The Physician Queries Handbook, Second Edition, p. 89.*

Physician agreement rates

An important statistic to closely follow is the percentage of submitted queries to which a provider responded. Ideally, this would routinely be 100% across all service lines on a monthly basis. After all, if the CDI specialist thought the situation was important enough to formulate a query, it was probably

CDI Audit Form—DRAFT

Demographic Information

CDS	Admit date	D/C date	Encounter #	Reviewer	
Date of review	Final working DRG	Billed DRG			
General CDI process items					
1	Initial review conducted <48 hrs		Yes	No	
2	Adequate re-reviews (dependent on clinical condition and documentation status; anywhere from daily to 2x weekly)		Yes	No	
3	Final working DRG (after any query resolution) matches billed DRG		Yes	No	
3A	Appropriate PDX and procedures recognized		Yes	No	N/A
3B	ODX influencing DRG assignment recognized		Yes	No	N/A
3C	Significant ODX influencing ROM/SOI/LOS recognized		Yes	No	N/A
4	Relevant clinical factors were identified during reviews (pertinent positive & negative/ normal) and relevant trends in documentation were recognized		Yes	No	
General CDI process items					
5	No missed query opportunity (details in comments) (alternative diagnoses were recognized, considered, and either queried or appropriately refrained from query)		Yes	No	
6	Comments:				N/A
Query specific items (N/A if no query posed) Each query contains or complies with:					
7	If query forms utilized: appropriate form used AND form content was customized to the specific case documentation, circumstances, and data		Yes	No	N/A
8	Nature of query (PDX, proc, CC/MCC, 2nd CC/MCC, SOI/ROM/LOS, clarify, POA, etc.) is identified and recorded appropriately		Yes	No	N/A
9	Reason(s) for query: * The clinical symptoms, indicators, or information are included; * The specific documentation issue is described (legibility, consistency, etc.) * Treatment is described that lacks a diagnosis * Other:		Yes	No	N/A
Query specific items (N/A if no query posed) Each query contains or complies with:					
10	The clinical indicators firmly support the query (i.e., not stretched) (including recognition and use of broadly recognized clinical literature standards)		Yes	No	N/A
11	Succinct, clear wording of the query with a clear question posed		Yes	No	N/A
12	Formatted in a user-friendly manner (appropriate use of bullets, avoidance of run-on sentences, etc.)		Yes	No	N/A
13	Timely presentation (i.e., adequate time for workup results to be in the record; initial physician documents must be in record prior to the query posed)		Yes	No	N/A
14	Working DRG at time of query is appropriate to existing documentation		Yes	No	N/A
15	Suggested answer options are presented appropriately (Note: If was to confirm or rule out a diagnosis documented as possible/etc., then format of options may be appropriate to differ from standard multiple choice)		Yes	No	N/A
15A	Open-ended question posed		Yes	No	N/A
15B	Multiple choice: At least 2 clinically reasonable options for this patient diagnosis presented		Yes	No	N/A
15C	Multiple-choice answer format: includes other _____ and clinically undetermined		Yes	No	N/A
16	Provider's response was appropriately recorded in tracking software or tool		Yes	No	N/A
17	Final result/impact of query appropriately recorded		Yes	No	N/A
18	Inclusion of required data elements (patient identifiers, person posing query, contact phone #, etc.)		Yes	No	N/A
19	Overall, query was non-leading		Yes	No	N/A
20	Other query comments:		Yes	No	N/A

Source: Donald Butler, RN, BSN, CDI program manager at Vidant Medical Center in Greenville, N.C.