Insights and Best Practices for Clinical Documentation Improvement Programs

In the face of alarming predictions about ICD-10's administrative impact and its veritable explosion of new codes to wrangle with, and despite the proven positive impact on improving the accuracy of DRG assignment and quality metrics, some hospitals still lack a formal clinical documentation improvement (CDI) program.

Reasons vary. Smaller hospitals may not be staffed to support CDI and can't justify the resources given the time, training, and ongoing investment required. Some are waiting for the ICD-10 implementation delay to expire. Others have implemented CDI narrowly in a way that impacts a very small number of cases.

Some facilities don't know where to start.

For hospitals, fully implementing CDI is daunting in terms of the cost, training, and education required. The key players – physicians, coders, and CDI specialists – very often are at odds and don't work well together and, in many cases, have a limited understanding of what each other does. All the while, hospitals have a myriad of other challenges competing for their attention and threatening their budgets.

What is it?

The American Health Information Management Association (AHIMA) recently offered the following definition of clinical documentation improvement (CDI):

> "The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation. These reviews usually occur on the patient care units or can be conducted remotely (via the electronic health record).
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> The goal of these reviews is to identify clinical indicators to ensure that the diagnoses and procedures are supported by ICD-9-CM codes. The method of clarification used by the CDI communications are also methods used to make contact with physicians and other providers. These efforts result in improvement in documentation, coding, reimbursement, and severity of illness (SOI) and risk of mortality (ROM) classifications."
> *AHIMA, Clinical Documentation Improvement Toolkit* [1]

Under this definition, CDI is essentially an interface between physicians and coders designed to promote greater accuracy and specificity of clinical documentation, especially for complex cases. This may result in more appropriate reimbursement to hospitals for services provided. But even when it doesn't, it reinforces the acuity of these patients, which is reflected in future quality scores impacting both hospitals and physicians.

According to the 2015 Clinical Documentation Improvement Trends Survey from The American Hospital Association in conjunction with Executive Health Resources – a survey of more than 1,000 CDI, coding, HIM, and other hospital professionals – most hospitals have some form of a CDI program. These programs generally feature dedicated CDI resources, reviews on mostly Medicare cases, and some focus on quality measures and metrics. But what about hospitals without CDI or those that want to improve their CDI programs? What follows are insights, resources, and best practices with those facilities in mind.

Implementing CDI – The Physician Challenge – Critical to a Successful CDI Program

In the 2015 Clinical Documentation Improvement Trends Survey, 98.5 percent of the survey respondents noted that their physicians could improve their documentation practices, and that 66.5 percent of these physicians had a lack of understanding of the importance of strong documentation.[2]

Hospitals may not have a fully functional CDI program due to lack of staff, funding, or technology. But by far, the greatest impediment to fully implementing CDI is lack of physician engagement.[2] Physicians typically document for other physicians, not for coders, payers, or auditors. They may not see the value in documenting for other audiences. As a result, clinical documentation of acuity is often inadequate.

Hospitals rely on medical coders to translate physician documentation of the patient's diagnosis and the treatment and procedures performed during their visit into ICD 9/10 codes. If a doctor writes a diagnosis, a coder can use it, but this process does not ensure adequate clinical validation to support those codes along with complete, accurate documentation.

Without proper documentation, hospitals cannot capture the appropriate codes to be adequately reimbursed for the services they provide. To bridge the gap between physicians and coders, many hospitals have hired CDI specialists, typically nurses, who examine documentation for incomplete, ambiguous, or conflicting information. These specialists alert the treating physicians to these cases who may adjust their documentation accordingly.

But this fix also has limits; physicians have to respond to CDI specialists' queries timely and completely. Without this active physician engagement, CDI's goals of improved accuracy and specificity won't be realized. In fact, according to the 2015 Clinical Documentation Improvement Trends Survey, 78.4% of respondents said active participation from treating physicians is one of the most important factors that will lead to a successful CDI program.[2]

How Successful CDI Programs Engage Physicians

How do CDI programs convince physicians to place a higher value on strong documentation when they haven't been trained or encouraged to do so? One key, according to John Zelem, MD, FACS, Vice President; Compliance and Physician Education at Executive Health Resources, is to dispel the harmful misconception that hospitals are forcing improvements in this area solely to benefit coding and help increase revenue.

> "As a matter a fact, it's just the opposite," Zelem said. "Medicare actually encourages hospitals to improve their coding to support proper reimbursement – which may be higher or lower based on the documentation – but also for better reflection of the patient acuity."

Successful CDI programs may also have the collateral benefit of improving quality of care rendered. Studies show a positive link between strong documentation and higher quality. A 2008 Archives of Internal Medicine[3] article indicated that "medical records for patients with NSTEMI (a type of myocardial infarction) often lack key elements of the history and physical examination." As noted in the article, "Patients treated at hospitals with better medical records quality have significantly lower mortality… (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care."

CMS has taken note of the documentation/quality connection and is moving toward payment models based on outcomes and quality measures, not volume of how much care was provided. Health & Human Services Secretary Sylvia Mathews Burwell recently said, "Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they can provide – and do it by 2016."[4]

Along these lines, CMS has mandated incentivizing or penalizing hospitals by using quality-based programs and measures such as value-based purchasing (VBP), readmissions reduction program (RRP), and hospital-acquired conditions (HAC). Many of these factors are based on quality scores associated with diagnosis-related groups (DRGs) data that was recorded two years ago. What gets documented today will reflect in these measures two years from now. These same quality scores (described in detail on page 4) are also important in assisting with risk adjustment for acuity.

As Medicare moves toward an alternative payment system, physicians need to change the way they document. But according to 66.5% of respondents in the 2015 Clinical Documentation Improvement Trends Survey, a lack of understanding of the importance of strong documentation is a barrier preventing physicians from being effectively engaged in CDI.[2]

Better documentation can also have a significant positive impact on the quality measures of Severity of Illness (SOI) and Risk of Mortality (ROM). These measurements don't just affect hospitals, they are also used to reflect the quality of physicians when compared to their peers and are featured on public websites like healthgrades.com and Medicare's Physician Compare. Through solid documentation, physicians have a means to positively impact the way the care they deliver is perceived and measured.

However, the traditional methods of education are likely not the most effective way to educate physicians. Based on the recent 2015 Clinical Documentation Improvement Trends Survey, real-time, one-on-one, patient-specific conversations are the most effective education strategy to make physicians aware of how to improve documentation (84.3% of survey participants agreed) and some of the most prevalent approaches that hospitals use to educate physicians were deemed ineffective.[2]

A way to address this is by employing a physician-to-physician model, in the form of a physician advisor or physician champion. In this approach, these physicians and attending physicians interact concurrently to clarify gaps in documentation and also expedite responses in a timely fashion – while the patient is still in the hospital. The physician champion confers with the treating physician about key clinical indicators and risk factors in the case. During the discussion, the treating physician establishes a diagnosis or requests further specificity if appropriate. The physician champion can also use this opportunity to educate the treating physician in a non-leading manner on general industry indicators for specificity of diagnosis.

Through this approach, CDI helps provide missing clinical support, which may result in better quality and outcomes. CDI can help physicians (in an objective manner) to document this acuity and specificity. This will become even more important once ICD-10 arrives which will require greater specificity in coding.[5]

This approach is also popular because the hospital and physician see immediate results. The hospital is better protected against auditor scrutiny—without having to align additional hospital staff to the task. The physician is better informed as a result of a peer-to-peer interaction with minimal impact on their patient-care time. Resulting benefits also include:

- **Accurate Coding and Quality Measures** – A robust CDI program can produce a dynamic regulatory and coding environment that requires physician-to-physician documentation education. This, in turn, can help reduce physician queries that remain unanswered or improve quality of responses.

- **Improved Physician Engagement** – Real-time reinforcement supports accurate and thorough documentation practices, while conversations occurring concurrently serve as another layer of physician education to improve documentation skills.

- **Increased Query Responsiveness** – Concerns should be addressed while the patient is still receiving care. Reviewing concurrently with a peer physician can assist in identifying vague and/or conflicting documentation, as well as potential gaps in documentation. Providing a summary to the CDI team of the physician-to-physician documentation conversation helps the hospital coding specialist ensure the medical record documentation is complete prior to coding.

• **Increased Audit Defensibility** – The physicians working within the CDI program must leverage an extensive knowledge of the regulations from CMS to drive specific and accurate CMI capture – even in complex cases – and documentation improvement, thereby helping withstand the scrutiny of audit programs.

Getting the Most from Your CDI Program

According to the 2015 Clinical Documentation Improvement Trends Survey, many CDI programs that are just starting primarily target Medicare Fee-for-Service and some Medicare Advantage cases, while most hospitals (82.8%) are unable to ensure ALL complex cases go through CDI review.[2] Governmental and commercial denials frequently happen because the diagnosis used is not clinically supported in the documentation. Therefore, a robust CDI program should target all payers. All complex cases should benefit from CDI regardless of payer.

Proper physician documentation provides the cornerstone of medical necessity that not only can help validate the level of patient care provided, but also help to support appropriate reimbursement to the hospital for services provided, and defend against audits. So along with the need for general physician documentation improvement, new CDI programs also need to include physicians at some point in the process. According to a CDI Week industry survey, only 17 percent of hospitals with CDI programs have policies in place to mandate physician compliance.[6] The lack of active physician participation can lead to unanswered queries, as well as untimely and delayed responses.

Most importantly, providers need to embrace CDI for the right reasons. The American Health Information Management Association (AHIMA) has created guidance by defining purposes, goals and roles, as well as policies and procedures, to further outline the benefits of thorough documentation.[7] Although the content contained within these guidelines is offered more as professional advice, the message is clear:

> "The focus of most CDI programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably, the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures… Improving the accuracy of clinical documentation can **reduce compliance risks, minimize a healthcare facility's vulnerability during external audits, and provide insight into legal quality of care issues.**"

By keeping these guidelines in mind, hospitals and physicians can reap the benefits of a solid CDI program.

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