Taking your next step: CDI professional development
Connect with CDI experts like you. From wherever you are.

Your work as clinical documentation integrity professionals has never been more essential, or more challenging. You play a vital role in the financial health of your organization and the quality of care it delivers.

3M is here to support you through in-depth webinars on CDI best practice, COVID-19 implications and complex quality issues.

These webinars include live Q&A and polls so you can see what your peers think. Plus, you’ll receive webinar recordings, transcripts and slides—whenever you need them.

Click here to join the conversation or visit us at 3M.com/his/webinars.
FEATURES

6 Starting out in CDI (B)
CDI professionals come to the field from a myriad of backgrounds. No two paths are the same, even if they end in the same location.

10 Case study: Taking physician education virtual (B, I, A)
When the COVID-19 pandemic began, the CDI team at Legacy Health decided to center their focus on physician education instead of putting those efforts on hold.

15 Expanding your CDI department (A)
In order to secure FTEs, leaders need to know when to hire, how to recognize a solid candidate, and how to interview candidates.

23 CDI analyst positions (I)
Unique CDI positions not only cater to people's strengths, but can also aid in overall organizational success.

32 CDI career ladders (I)
For many maturing programs, creating a CDI career ladder has become an integral part of their long-term plan.

OPINIONS & INSIGHTS

19 A home health CDI primer
Sharon Litwin shares the ways CDI professionals can benefit home health agencies.

30 Clinical validation research from the field
Audrey Mobley discusses the difference between how clinical validation plays out in theory versus how it plays out in the real world.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking this 20-question quiz.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978-750-8400.

CDI Journal (ISSN: 1098-0571) is published bimonthly by HCPro, 35 Village Road, Suite 200, Middleton, MA 01949. Subscription rate: $165/year for membership to the Association of Clinical Documentation Improvement Specialists. • Copyright © 2020 HCPro, a SimplifyCompliance Healthcare brand. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center at 978-750-8400. Please notify us immediately if you have received an unauthorized copy.

• For editorial comments or questions, call 781-639-1872 or fax 781-639-7857. For renewal or subscription information, call customer service at 800-650-6787, fax 800-639-8511, or email customerservice@hcpro.com. • Visit our website at www.acdis.org. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of CDI Journal. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.
Professional development while stuck at home

By Linnea Archibald

The ACDIS team has been working remotely from home since March 16. At the time of this edition’s publication, we’ve been home for 169 days. Of course, the ACDIS team aren’t the only ones who’ve been social distancing and working remotely. As of ACDIS’ May survey, nearly 70% of CDI professionals who had previously worked on-site had been sent home to work 100% remotely as a result of the COVID-19 pandemic.

While some areas of the country and the world have begun opening up—returning to some semblance of normalcy—some of us are still home and are expecting to remain so for several more weeks or even months.

Recently, I heard someone say that the surefire way to burn out during this strange time is to continue using the phrase, “By X month/date, we’ll be back to normal.” As those dates fly by with few everyday changes, it’s easy to get discouraged. Instead, they recommend it’s better to adjust our expectations, for how things really are right now and then further adjust as necessary when the time comes, recognizing that we may never return 100% to the way things used to be.

One of the ways we’ve had to accommodate our new reality concerns is in education and personal professional development. Before COVID-19, most of us leaned on in-person avenues—attending conferences and local chapter meetings, plus collaborating in meetings and impromptu interactions with colleagues in the office. Now, however, most of those options are gone or moved to virtual platforms. It’s required a fair amount of adjustment.

Just because the landscape has shifted, however, doesn’t mean our professional development has to be put on hold until we return to “normal.” That’s why we’ve dedicated this edition of the CDI Journal to professional development and career opportunities. Most of the ideas found in this edition’s pages are not limited to the in-person space. You can accomplish a lot while sitting in front of your computer at home.

As we did in the May/June edition, we’ve marked this issue’s feature-length stories as “B” for beginner, “I” for intermediate, and “A” for advanced in the table of contents. This will help you choose the most relevant advice for your immediate personal and professional needs.
For those who are just starting their journey in CDI, take a look at the article from Associate Editor Carolyn Riel on p. 6 about jumping into a new role. For those at the midway point in their career, take a look at Riel’s article on p. 10 about unique positions and p. 32 on career ladders and next steps. For those in manager or leadership roles, I put together an article on staffing concerns—from knowing when to hire, to interviewing potential candidates—that can be found on p. 15. We also have education-centered articles suited for all stages on p. 9 and 10.

This edition also features some topic-focused articles that will broaden your horizons and give you ideas for how your CDI program can expand. On p. 19, Sharon Litwin, RN, BSHS, MHA, HCS-d, provides a home health CDI primer. Howard Rodenberg, MD, MPH, CCDS, and Audrey Mobley, MD, MMS, CCDS, discuss Mobley’s recent clinical validation research on p. 30. In her recurring “Things coders wish providers knew about …” series, Sarah Nehring, RHIT, CCS, CCDS, shares 10 CDI truths geared toward surgeons; her article can be found on p. 41.

Plus, this edition includes items suited for the concerns of the moment. On p. 36, Alba Kuqi, MD, CICA, CCS, CDIP, CCDS, CRCR, CSMC, discusses COVID-19 kidney injury clinical indicators and documentation concerns. And, on p. 38, members of our ACDIS Regulatory Committee unpack the clinical nuances related to COVID-19 in the pediatric population.

Though we all hope for the day when the pandemic and the challenges it’s brought are a distant memory, we hope that this edition will help you in your life and work right now. All of us at ACDIS are here to help you grow in your CDI careers. As always, please don’t hesitate to reach out to us.

Stay well.

Linnea Archibald
Starting out in CDI: Learn as much as you can

By Carolyn Riel

CDI professionals come to the field from a myriad of backgrounds. While ACDIS’ previous survey data shows that most of our members arrive at CDI from a clinical background beginning in bedside nursing, the ranks are filled out by those from coding/health information management (HIM) and other clinical fields. No two paths are the same, even if they end in the same location.

For Angelica Naylor, MBA, BSN, RN, CCDS, CDI consultant with TrustHCS Healthcare Consulting Services based in Springfield, Missouri, her career began in critical care nursing.

“I then moved to working in insurance,” she says, “then as a performance improvement leader, and then utilization review before finally coming into CDI.”

“My journey started as a physician in Manila, then I came to the United States for a dermatology conference,” adds Rhoda Galang, RHIA, CDIP, system-wide CDI corporate manager with Scripps Health in San Diego, California. “For some extra income I got a part-time job as a researcher with other oncologists in a cancer research center. They then offered me a HIM director position, and finally I moved into CDI.”

While Brian Simpson, MS, RRT, CCDS, CDIP, CCS, CCS-P, CCDS-O, CRC, CDI and risk adjustment specialist at Penn Highlands Healthcare in DuBois, Pennsylvania, started his career in a clinical field like many others, his path to CDI was anything but typical.

“I worked as a clinical analyst in revenue integrity fighting denials and writing appeals, then wanted a change so got hired as a transition of care coordinator for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) patients,” he says. “I have a lifelong severe lung disease condition that had a flare-up and I had to go back on oxygen 24/7 after being in this position for a while. It was apparent to my boss that I wasn’t able to have patient exposure anymore, so she had me help her with denials and appeals, then she asked if I would be interested in cross-training for CDI.” Within a few months, Simpson was working full time as a CDI specialist.
Though Naylor, Galang, and Simpson each traveled a different path, they all have one thing in common: As Galang says, they sort of “fell into it.” For many CDI specialists, their career path was formed by repeatedly taking the next right step in front of them. They didn’t seek out a role in CDI, but instead happened upon it when they were ready to take a new path.

As the CDI profession becomes more well known in healthcare organizations, though, individuals are beginning to seek out CDI as a career, rather than coming upon it by chance. Those looking to step into a CDI role need to come to the table equipped with the right skills and knowledge, showing their dedication and interest in the profession.

**Traits and background**

Regardless of someone’s background or credentials, there are certain personality traits and knowledge bases that set great CDI candidates apart from their peers. Galang says the most important trait for a new CDI professional is willingness to learn on the job. “It’s not for everyone; you need to fit basic requirements and learn a lot on your own,” says Galang. “There’s no school for it; everything is based on what you learn on the job and what you’re taught.”

Beyond a love of learning, most organizations have additional backgrounds and credentials they prefer to see in a potential staff member. Scripps Health looks for candidates who come from a clinical care background, and prefers a CDI-specific credential when possible (CCDS, CDIP, etc.) and/or an RHIA, according to Galang.

While some organizations limit their candidate search to individuals from a critical care background, according to Naylor, this may exclude some excellent candidates.

“I know some places recommend nurses going into CDI come from a critical care background, but I can’t say I always agree with that,” Naylor says. As a hiring manager, Naylor looked for nurses who came from a utilization review background because these individuals are accustomed to reviewing records. The same, of course, could be said for those from a coding/HIM background. (To read about ACDIS’ stance on the inclusion of all professional backgrounds—both coding/HIM and clinical—check out this position paper.)

Apart from previous work experience, personality makes a huge impression on CDI managers.

“You need a strong desire to learn and analyze data, but also analyze personalities,” says Naylor. “A huge part of CDI is engaging with providers, so this means you have to be personable and have the intuition to pick up on each physician’s personality. You need to know when to ask questions and how.”

**Preparing for an interview**

“The first thing I do during an interview for a potential new specialist is listen to what they already know about CDI before even proceeding,” says Galang. “Sometimes people will talk about CDI as if it’s coding or case management, so when they refer to these jobs it’s easy to tell that they don’t fully understand. This doesn’t mean that they aren’t qualified, but they have to know what the job really is in order to explain why they should be considered.”

“I already knew a bit about CDI from the start, but I did a lot of my own research beforehand,” adds Simpson.
“I already knew some coding guidelines because of my past experience with CHF patients, but I wanted to make sure I really understood the position I was applying for.”

Before going in for your interview (or even applying for the job at all), start by doing a deeper dive into what CDI really means.

“You already know that things need to be clear, concise, and compliant, but make sure you do your research,” Simpson says. For those coming from nursing or some other clinical background, don’t rely solely on that background—dig deeper into the nuances of what CDI specialists really do and why they do it, he recommends.

“Your best initial resource is looking at the ACDIS website,” Naylor suggests. “What we do as CDI specialists and who we are, all of that basic information, is free on the ACDIS site and open to everyone.” (For a comprehensive list of the free non-member resources, click here.)

You can even seek out education right within your organizational walls, Naylor adds. To start, try reaching out to the CDI department and asking about job shadowing.

“A lot of hospitals now allow for in-house shadowing because they would much rather keep an internal employee than hire an external person,” she says.

**Setting expectations**

“The biggest surprise to me once I was in the specialist position was the importance of coding guidelines,” says Simpson. Because of his prior work experience, Simpson already had a good working knowledge of basic coding guidelines, but the CDI field relies heavily on these guidelines as well as keeping up to date with frequent coding and regulatory changes.

On the other side of things, the CDI field also relies heavily on clinical indicators. “You have to quickly gain that understanding that if you have a diagnosis, you need to have all of the information there to clinically validate it,” Simpson says. “It’s extremely relevant to the admission and need of resources.”

The initial learning curve for CDI is a steep one, and new professionals often take months to fully grasp the profession. For most, there is an epiphany moment where all of the puzzle pieces fit together and CDI makes sense.

“You’ll make the same mistakes a few times, so be prepared for that,” says Simpson. “But one day you’ll realize that you’ve finally gotten it.”

Though it will take time to learn the ins and outs, the CDI profession is worth the effort, and those who are dedicated to it will find it immensely rewarding, Naylor says. It’s not an easy career move for those looking to coast into retirement, though.

“If you’re looking for a career step between bedside and retirement, CDI is not that, unless you are dedicated to self-education and keeping abreast with the constant change,” she says. “People come in thinking it’s a desk job and we just press buttons on a computer, but that’s so far from what we do. If you are looking for a laid-back job or one that doesn’t require much work, that is not CDI,” she says, partly because of the career-long learning necessary to stay on top of the coding, regulatory, and clinical updates.

For those who are not near retirement but need a change, though, a step into CDI may be the lifeline they need to keep going, Simpson says.

“If I wasn’t given this opportunity, I would have had to go back on disability because of my illness,” he says. “CDI and the goals I’ve had for myself in this career have given me things to strive for and a will to continue fighting forward. […] You really don’t have to be an RN or from HIM. Lots of allied health staff can add to the profession as long as you don’t have tunnel vision. The best advice I can give to anyone is learn as much as you can.” 🌿
CDI rounding with providers

Q: What’s the best way to approach CDI rounding with providers? We are considering implementing this practice and are looking at processes, outcomes, lessons learned, etc.

A: Many programs have had to put rounding with physicians on hold due to COVID-19, as Deanne Wilk, BSN, RN, CCDS, CDIP, CCDS-O, CCS, CDI manager at Penn State Health in Hershey, Pennsylvania, explained in a recent conversation with ACDIS Leadership Council members.

Each service line at Penn State Health did rounds differently, Wilk said. Some rounds went to more than one floor. Some took a short time, others took hours. Some rounded and then remained on the floor to make themselves available to the medical staff. Others set up rounding huddles, some of them with case management.

“What I can say is providers commented that they miss the staff being there on the floors with them and being able to communicate with them. We were able to obtain much more engagement working closely with them, learning from them as well, and providing ongoing education to both attending physicians and residents. I am hoping we can return on-site at some point, but considerations are being given to remain permanently remote,” Wilk said.

Previously, CDI staff at Essential Health in Duluth, Minnesota, also had an informal rounding process due to the varying sizes of the different facilities, according to CDI Manager Tracy Boldt, BSN, RN, CCDS, CDIP, CCDS-O. Some CDI staff rounded three times a week, others just once per week with the focus not necessarily on getting the query answered but in having CDI seen as a part of the patient care team.

“To some, rounding may have seemed like a waste of time; however, rounding was/is the building block to reinvigorating the CDI department. Prior to rounding (three years ago), practitioners did not have a clear understanding of the role CDI plays. I am a firm believer in partnering with providers along with relationship development to further both CDI and providers’ knowledge. We have often engaged practitioners to present to the CDI team (most providers love to teach), which empowered the relationship further,” Boldt said.

The CDI team at Memorial Hermann Health System in Houston, Texas, participated in weekly discharge rounds with case managers, charge nurses, and physicians for about two years, but stopped about a month before the pandemic sent everyone home, according to CDI System Director Joy Coletti, MBA, RN, CCDS.

“We found it time-consuming with minimal benefits to CDI,” Coletti said, with the value depending on which providers showed up to rounds. Furthermore, case management directors viewed the conversations as interrupting the team’s flow. Attempts to pilot more intense rounding also yielded lackluster benefits, she said.

At WVU Medicine, service line chairpersons chose the best method of interaction between the CDI staff and the providers, said C. Dawn Diven, BSN, RN, CCDS, CDIP, CCDS-O, CDI enterprise director at the West Virginia organization. Those who did choose rounding only did so for a short time, she explained.

“We found it too time-consuming and not the most efficient use of CDI time in the long run. Pre-COVID, everyone was remote and only came in-house for provider education sessions,” Diven said.

Now, each CDI staff member is responsible for reporting and providing education to individual service lines, either monthly or quarterly depending on the preference of the service line chiefs.

“We have found this has worked best for us,” she said. “We hope to someday return to face-to-face education sessions, but we are currently doing this virtually.” 🌐
Each year when ACDIS conducts our annual membership survey, the number one concern CDI professionals tell us they struggle with is physician engagement and education. Without engaged physicians, CDI efforts will languish with unanswered queries and subpar documentation.

The COVID-19 pandemic hit the whole healthcare field in different ways. Many CDI professionals had to put their physician education and engagement plans on hold to allow physicians to focus their attention on COVID-19 patients. Most CDI departments sent their staff home to work remotely, and some put query practices on hold.

The CDI team at Legacy Health in Portland, Oregon, however, decided to center their focus on physician education instead.

**Provider dashboards**

“Before the pandemic even hit, we were already trying to get into [providers’] regular staff meetings, but it wasn’t working very well,” says
Treva Vetter, RN, MSN, BSHI, CDI manager at Legacy Health. “They always have so many things going on, the need to discuss CDI was at the very bottom of their list.”

For a while, the CDI team was making progress and taking a seat at the table during those meetings, having some one-on-one discussions, and providing new clinician orientation about their documentation and the CDI program. But COVID-19 put a stop to those in-person meetings.

Initially, the CDI department paused all physician education for a month. But during that time frame, they realized that the world was not going to go back to normal any time soon and that their processes needed to adjust accordingly.

“I had to figure out ways to continue provider education,” says Vetter. “One of the first things we did was create provider dashboards.”

The dashboard reports can include physician query–specific information, or if appropriate, slides on how the hospital gets paid, how the coding team decides what DRG to code, how the DRG affects reimbursement, or how the exact wording of a diagnosis affects the final codes assigned.

Behind the scenes, Vetter assigns each CDI staff member to a different service line. Each month, Vetter goes into the dashboards and assigns each staff member four doctors for the month, equaling out to one per week. Each specialist goes into the system and fills in a provider dashboard. Then, their CDI Auditor Kaitlin Loos, RN, BSN, accesses the system and runs reports for each provider. The CDI team then reaches out and gives them their dashboard.

“We have every query they’ve been asked for that time period, and we take a look at what they were being queried on, such as malnutrition or sepsis,” says Vetter. Based on this query information, the CDI department then creates education tools for physicians based on those trends. “We have so much education that we’ve started putting all of it on a slide deck with our dashboard for what the queries were on,” she says.

Each provider’s dashboard also displays that provider’s query trends compared to their colleagues. This helps instill some friendly competition among coworkers, Vetter adds.

When providing clinicians with their dashboards, the CDI specialists also reach out to the clinicians by their preferred means of communication. This way the CDI team can ask the provider if they want to review the dashboard together.

“A fundamental principle for physician education is to provide feedback that is data driven and affects [the physicians directly],” says Molly Siebert, RHIA, CCDS, CDI specialist with Legacy Health. “Once they understand how the complexity and complete detail of their decision-making affects things, they can use CDI education as a tool to assist in their personal quality score improvement. It’s all about getting them to see the bigger picture of what we all do.”

Virtual education meetings

Aside from provider dashboards, Legacy Health has also tried using virtual platforms for educational meetings with providers.

In her first and only virtual meeting so far, Loos was able to work through a provider’s concerns related to malnutrition queries and clarify what documentation the provider needed to supply. If nothing else, the meeting helped the provider put a face to a CDI name.

“It was a short meeting, just 15 minutes with one of the providers. But it was nice to connect with her, because so much of the time as CDI specialists we are just a name,” she says.

One of the main concerns with sending CDI professionals home to work remotely is that physician engagement will suffer from the lack of face-to-face interaction. With the current availability of video chat solutions, however, things are much easier than they once were.

“I thought she was definitely engaged, and possibly more engaged than I’ve experienced from physicians before in the hospital setting,” says Loos. “She had her video set up, so it was nice to see her face and be able to talk to her.”

While virtual one-on-one meetings fill the need for specific educational sessions, Vetter wants to leverage video capabilities for more widespread education as well. Eventually, Vetter wants to make...
educational videos for physicians to watch on their own time.

“We could do some of our trouble topics, such as malnutrition,” she says. “I’d like to set up a video database of a lot of this obviously needed information or commonly asked questions.”

**Platform problems**

For virtual meetings and educational sessions, the CDI department uses Microsoft Teams® as their chosen means of communication. As with any new technology, however, they’ve run into some problems as they get up to speed on the new platform.

“With [our old platform, Skype®] everyone was super comfortable and familiar, and a lot of times during meetings people would write in and ask questions,” she says.

Now that they’ve made the switch, however, her team has stopped submitting written questions almost entirely.

“We’re at the point where nobody is asking questions right now, because questions stay in the chat even when the meeting is over and people don’t want someone to look back and take their question or comment out of the context of the meeting,” says Vetter.

Because of this concern, Vetter has been holding more one-on-one meetings with her staff outside of Teams to get the basic day-to-day questions answered.

“I had originally wanted to have a provider team set up so I could start adding doctors into those chats, but I’m thinking now that using Teams to try to have those ongoing conversations with CDI from a provider’s perspective might not work,” Vetter says. “It’s something that we’re going to need to think about more.”

Though the team has been reluctant to jump on board, Siebert says the immediacy of the Teams chat functionality has been helpful and she can see it benefitting staff further as they get accustomed to it.

“I think sometimes people might just need a reminder that this is the time to ask questions,” she says. If they’re reminded they can ask real time questions, perhaps this will increase the staff’s platform use.

“I think eventually people will start asking questions; it’s just going to take some encouragement and getting used to the platform.”

While the new platform may not be the best solution for provider education and discussion, or even more sensitive CDI staff questions, Vetter says that it does offer other benefits for the team.

“We are doing some teambuilding in the platform without the boss in there,” says Vetter. “We’ll have one of our CDI specialists run a lunch teambuilding session with just the CDI team, not me or physicians. They’ve swapped recipes, played Jeopardy—just things to make everyone feel connected.”

**Early successes**

Since Legacy Health only implemented virtual education options a few months ago, Vetter says they’re still collecting the data to prove their success.

“I’m hoping that the query rate will go down,” she says. “That is one key indicator I’ll be looking at as we move farther down the road to see how well this is working or what we might need to change.”

“Specifically, with query rates, I’d like to see the query topics we’re educating on go down,” Loos adds. “Our top query is always heart failure, so I hope if we educate enough that those specific queries will go down.”

As with any new program or project, there’s always room for evaluation and improvement. Start with one thing, Vetter suggests, and then reevaluate and adjust as needed—whether that means adjusting your expectations, the platforms you’re using, or the frequency of your meetings.

“For now, with so much going on, we’re really just doing one-on-one education as needed,” she says. “As things continue and when we have some more hard data, that’s when we’ll stop and reevaluate to see what’s working and what we can do better.”

Judging the success of virtual education is not just based on hard data, however. Sometimes the biggest proof of success is physicians’ anecdotal responses.

“We are doing more than just trying to improve numbers,” she says. “We’re building the foundation for ongoing relationships with our physicians.” 💫
NOTE FROM THE ASSOCIATE EDITORIAL DIRECTOR

Ongoing education by sharing and learning from each other

by Melissa Varnavas

Our efforts to provide vital information related to CDI activities look a little different this year. No doubt yours do too.

With the cancellation of in-person events, ACDIS’ principal concern is how to reinforce and reinvigorate its mission “to serve as the premier healthcare community for clinical documentation specialists, providing a medium for education, professional growth, program recognition, and networking.”

We know that the excellent materials we provide on the ACDIS site represent one way to provide that education and networking, but networking from in-person events also includes moments of serendipity—casual connections made over coffee or by sitting with someone at lunch that you might not have previously met.

That’s why, when we learned that our annual in-person conference needed to be canceled, we created the Staying Engaged: ACDIS presents virtual education and networking three-day event, which took place in June. We didn’t know how it would go. I worried that we wouldn’t get many attendees, or that those who did attend wouldn’t engage with us in online conversations or share their experiences.

I needn’t have worried. We had more than 500 participants. Of those, 98% said the information offered was very important or important to their daily CDI activities, and 95% said the program was excellent or very good. Attendees found the experience, well, engaging. Yet so much of that response was due not only to the excellent speakers featured but also to the attendees for their real-time participation. If you didn’t get to attend live, you can still purchase the sessions on-demand.

ACDIS’ educational offerings haven’t slowed since June. In July, we held an ACDIS Online Summit, Back to the Hospital: COVID-19 Transition to a New Normal, which included a panel discussion with several CDI program leaders and ACDIS Director Brian Murphy followed by two additional sessions thanks to the generosity of our sponsors Nuance and 3M M*Modal.

And we’ve continued with our traditional educational paths, including the benefits associated with ACDIS membership such as this Journal, rolling membership discounts, and quarterly conference calls with the ACDIS Advisory Board.

Since the outset of the pandemic, ACDIS has offered COVID-19 resources to both members and non-members, such as:

- A COVID-19 CDI toolkit covering common clinical indicators, cytokine storms, physician documentation needs, pediatric inflammatory multi-system syndrome, and benchmarks

- Extensive COVID-19 news, updates, and documentation and coding updates in our weekly eNewsletter, CDI Strategies

- A comprehensive survey on how CDI programs are handling activities related to the pandemic

- Offering raffle prizes to those willing to share their face-mask selfies with the ACDIS community in solidarity with the American Hospital Association and American Nursing Association

- Offering free ACDIS-branded face masks to any who need or want them

ACDIS local chapter volunteers have gone above and beyond during this time, too, to provide locally focused insight, education, and networking for folks in their communities. The North Carolina ACDIS chapter offered free membership for the year during its membership drive earlier this spring and has been working on online educational sessions. Georgia ACDIS offered a three-plus-hour event via Zoom® where attendees could chat with one another, view the presentations, and even see
the panelists. New England ACDIS chapters joined with NYHIMA and MAHIMA to offer members four free hour-long educational sessions through the month of August. These leaders have been amazing and innovative in the face of their own personal and professional challenges to meet the needs of their CDI neighbors.

New events coming soon!

Shortly after our June Staying Engaged event, with COVID-19 outbreaks continuing to spread across the country, it became evident that we needed to also cancel our in-person ACDIS Symposium: Outpatient CDI previously scheduled for November. So, we convened a new events committee pulling together members of the 2020 main conference committee, members of the 2020 outpatient symposium planning committee, and a handful of volunteers from ACDIS’ other boards.

Together, we’re working to re-envision our events, creating brand-new educational offerings such as ACDIS Online Education Presents Curtain Call: Behind the Scenes of Star-Studded CDI Programs, which will take place on the heels of this year’s CDI Week celebrations Wednesday, September 23 through Friday, September 25. The 2020/2021 events committee will also be helping us to develop a new outpatient-focused online event for this coming December and establish a comprehensive speaker lineup and alternative formats for our 2021 main event slated for Dallas, Texas, next May.

To that end, we opened the call for speakers for the 2021 event in late July.

We know folks might be leery of putting effort into a presentation where the future of COVID-19, travel, and even our own health and professional status are uncertain. The ACDIS administration will be working with the 2020/2021 events committee and our extended events team to not only plan for the in-person event, but also establish contingency plans should the pandemic continue to prevent travel into next spring.

So, if you’ve been interested in speaking, start putting your ideas down on paper. To apply to speak, you need only email me at mvarnavas@acdis.org, with the subject line “2021 Speaker Proposal.” Include three to five learning objectives, a short description of what you’ll be discussing, and a one-paragraph bio for yourself and any co-speakers. The committee will begin reviewing proposals starting in September.

Just like the June event—just like every exchange over the past 13 years, be it a best practice shared in the Journal, an experience shared on the national stage, a question put forth on the Forum, or a story told on the ACDIS Podcast—our CDI community grows and thrives by sharing our experiences and learning from each other. We continue to look forward to serving as your premiere platform for such growth and look forward to showcasing your unique stories.

Melissa Varnavas

Editor’s note: Varnavas is the associate editorial director for ACDIS in charge of events. Contact her at mvarnavas@acdis.org.
by Linnea Archibald

Organizations are beginning to realize the value of a well-oiled CDI program and the benefits it brings to the organization as a whole, from correct reimbursement, to accurate quality scores, to decreased risk of denials and better communication about patient care. With this, there is also a growing increase in the areas CDI professionals are asked to review. Once organizational leadership understands the positive impact CDI professionals bring to these new review areas, however, it may be in the cards to hire new staff members. In order to secure these coveted full-time employee (FTE) allotments, CDI leaders need to know when to hire, how to recognize a solid candidate, and how to interview those candidates to ensure they hire the best individual for the job at hand.

Knowing when to hire

One of the most straightforward ways to realize the need for additional FTEs is acknowledging when your staff cannot keep up with the amount of reviews on their plates and are taking on additional duties stemming from program expansion. For Rachel Cross, RN, BSN, director of case management and CDI at St. Vincent’s Health System in Birmingham, Alabama, the COVID-19 pandemic gave her team an opportunity to see what other areas would benefit from CDI reviews.

Like many organizations at the outset of the pandemic, St. Vincent’s patient census declined, freeing up some CDI time. Cross and her team opted to take on observation reviews and medical necessity for some outpatient services in their slower time. Based on their early findings and successes, she says they’ll likely continue these reviews post-census increase, but that won’t be possible with their current staffing model.
“What COVID gave us was an opportunity to try out some new objectives,” says Cross. “We were able to get into things that we didn’t have time to get to with higher census numbers. The goal before the second half of fiscal year (FY) 2021 will be to support the added staffing.”

We took someone off the assignments at the main facility and assigned them for two weeks to the smaller hospital. Even if we only earned 50% of what we were bringing in those first two weeks, extrapolated out, we could show the impact we could have.”

Rachel Cross, RN, BSN

With a staff nearly half the size of the consultants’ recommendations, Donohue says the staff were sure that they were missing documentation opportunities in their reviews. “Our coverage is about 35% to 40% of all discharged patients, and that 60% to 65% is where all those missed opportunities are happening,” she says. “It’s not just financial, it’s quality, risk adjustment, Hierarchical Condition Category opportunities, Patient Safety Indicators, and hospital-acquired conditions. We’re also putting ourselves more at risk for clinical validation denials.”

In order to better understand what opportunities they were missing, Donohue says Lakeland consulted with their affiliate, Mayo Clinic, and collaborated with them on an audit. The purpose was to determine if there were missed opportunities to identify patients that may have sepsis. While the Mayo Clinic CDI specialists didn’t find an outrageous amount of missed opportunities, they reiterated what the 2018 consulting firm’s report had already established: Lakeland’s team was understaffed and could make a bigger impact with additional personnel on the team.

Based on Mayo Clinic’s assessment, Lakeland Regional Health’s CEO is considering having their lead quality physician and Donohue observe Mayo Clinic’s CDI program in Minnesota.

Gaining support for hiring

A CDI leader may be confident that they need additional staff members, but ultimately, they won’t have the end-all-be-all say in the matter. In order to add staff members, CDI leaders need to make the case to organizational leadership that budgeting for those staff members will be worth it in the long haul.

Start by determining the cost that would be incurred by hiring a new staff member, Cross suggests. That number should include their starting salary, benefits, and the cost of education to get them up to speed. Then, if possible, provide data surrounding the potential impact they could bring to the organization. For Cross’ organization, they leveraged one of their smaller facilities to do a focused two-week study with a CDI professional on their existing team reviewing records at the facility—a sort of mini-pilot program to prove the value of a full-blown program expansion.

“We took someone off the assignments at the main facility and assigned them for two weeks to the smaller hospital. Even if we only earned 50% of what we were bringing in those first two weeks, extrapolated out, we could show the impact we could have,” she says.
Facilities that are not part of a larger system can enlist the support of groups within the hospital that could benefit from CDI’s intervention as well, says Lindsay Reich, BSN, BSHS, RN, CCDS, CDI manager at University of Tennessee Medical Center (UTMC) in Knoxville.

“Our program has been evaluated by consultants who recognized the need for additional staff given the size of our facility and we’ve had meetings with senior leaders to discuss staffing and coverage issues,” she says. “UHN [University Health Network], an accountable care organization that includes UTMC decided to participate in bundled payments and felt that we weren’t capturing enough information on the inpatient side.”

The solution to UHN’s problem ultimately was adding two FTEs to the CDI department to aid in capturing bundled payment information, Reich says. On top of their support, Reich was able to lean on her experiences from her last organization to put together an example of the type of impact they could have. This helped to justify both the expanded staffing and a new software platform for providing better reporting and data collection, proving their return on investment and illuminating new opportunities.

“We were trying to talk about new software plus new bodies, and we were talking about the data we needed and how we could get the information,” Reich says. “I was able to come up with examples of things we could do based on my experience at [my previous organization].”

**Recruiting candidates**

Once you have the support of organizational leadership and your new CDI positions have been budgeted appropriately, the next step is to begin the recruitment process. First, you need to determine what you’re looking for in a candidate to help craft the job description. This means deciding the professional backgrounds you’ll look for (clinical, coding/HIM, etc.), the number of years of experience necessary, whether you’d like to hire from within or from outside the organization, and educational background (bachelor’s versus associate’s degrees, etc.). (For more information about starting your CDI career, check out the article on p. 6.)

For example, Donohue looks for individuals with a bachelor’s degree in nursing and five to seven years of direct patient care, or a coding background with at least seven years of inpatient coding experience. Reich, on the other hand, opted not to make bachelor’s degrees a requirement because she already had a successful staff member on the team with an associate’s degree.

Outside of writing the actual job description, make sure to have conversations with your human resources (HR) department or recruiter about the type of candidates you’re looking for. For instance, some nurses see CDI roles as a way to leave the bedside as they approach retirement. According to Reich, this notion needs to be squashed with HR to ensure the résumés you receive are from individuals genuinely interested in the CDI field as a long-term career path.

“People still think of this as a retirement job, but I had to tell HR that I really wasn’t looking for that,” she says.

**Interviewing candidates**

Once you’ve reviewed the applications and résumés and have selected a few candidates to interview, decide up front what you’ll ask them and what you want to see from an interviewee. While it’s not the main deciding factor, according to Cross, it’s a good sign if your candidate shows up dressed professionally and prepared for the interview. A candidate who arrives at the interview in casual apparel, is late, or doesn’t bring their résumé may end up being great for the CDI department, but a sloppy presentation gives the wrong first impression.

“I want candidates to be professional and I want them to bring a copy of their résumé,” she says. “Sometimes internal applicants can be just a little too comfortable. The culture we’re cultivating is professional.”
Another marker of a serious candidate is the amount of research they’ve put into the role, Donohue adds. The ACDIS website has a wealth of free information available that can be found from a simple Google search, but doing that legwork shows that a candidate is interested in the position, rather than just wanting a job change.

“I like when they have done research into what CDI is and what a CDI specialist does,” Donohue says. “It’s a type of specialty you can Google, but you won’t totally understand until you’re actually in it.”

Regardless of their professional background, CDI leaders are wise to ask questions about disease progression and clinical nuances during the interview as well, Cross says. These questions—even if the candidate needs further education—will help the interviewer understand the candidate’s ability to critically think through a problem and see any discrepancies (query opportunities) in the clinical story.

“I want someone who has the ability to see something and understand what could happen next,” she says. “That ability to critically think about the disease pathways; [...] we ask a lot of questions during our interviews about those.”

It’s also helpful to ask about how candidates receive criticism and feedback on their job performance, particularly if they come from a long career in nursing, Reich says. Much of their early CDI career will involve constructive criticism through chart audits and the like, so a successful team member needs to be comfortable with that reality and understand that it’s not a personal attack on them.

“I ask them how they respond to constructive feedback about their job performance,” she says. “If you’re a nurse on the floor, you might get your charts audited maybe once a month, but here you’re evaluated all the time and it’s a learning opportunity, it’s not punitive.”

“We’re trying to recruit someone who’s really good at their job, and it’s hard to be criticized when you’re good at your job. [...] You have to be OK with being wrong and being uncomfortable for about a year,” adds Cross.

Truly outstanding candidates won’t shy away from asking questions of their interviewer either—in fact, that’s one of the attributes that makes them stand out from the sea of candidates, Cross says.

“I really like it when people ask what our mission statement is,” she says. “And when people ask how we show our growth and value. [...] No one wants to be part of a program that’s going to lose their funding in a year.”

These questions show that a candidate has done the work of learning about the profession and cares enough about their potential new role to ask about the driving forces behind it.

Perhaps most importantly from a departmental stability standpoint, Donohue also suggests asking that age-old interview question: Where do you see yourself in five years? While it’s a cliché question, a candidate’s answer will help interviewers gauge whether pouring time, energy, and finances into training that person will be worth it in the long run. Candidates have to be willing to learn, and they have to be willing to put in the time.

“CDI has changed since I’ve been in it, and that’s why I love it,” Donohue says. “If they don’t want to put in the time to learn, they won’t succeed.” 🌟
A home health CDI primer

by Sharon M. Litwin, RN, BSHS, MHA, HCS-D

The CDI acronym in the home health industry is new to many, but the process is not. That’s because home health staff understand the importance of capturing documentation to support coding, outcomes, quality initiatives, patients’ needs, and reimbursement; to ensure compliance and avoid denials; and perhaps most importantly to improve patient outcomes. Therefore, home health agencies (HHA) have been doing many aspects of CDI work for years, but have not formalized this into a CDI program per se. Instead, CDI activities are distributed among many roles in the office, including the administrator, quality assurance and performance improvement (QAPI) coordinators, clinical managers, coders, and billers.

Yet, CDI efforts can be instrumental in helping HHAs capture accurate Outcomes and Assessment Information Set (OASIS) and comprehensive assessment data that supports patients’ need for skilled care and homebound status which can be used to support the face-to-face physician information, diagnosis coding, and Conditions of Participation (CoP) compliance. In addition, CDI professionals can combine operational and financial factors in order to hit key metrics important to an HHA, such as days to billing, low utilization payment adjustment (LUPA) percentages, and timeliness of documentation.

A formal CDI program can improve many of the challenges that HHAs face, even if executed via a shared position. Unless an agency is very large, it likely won’t be able to hire a full-time CDI professional. However, by understanding functions of the role, a person in the HHA could be the CDI coordinator. A CDI task force is recommended in order to have all departments represented—intake, financial, billing, QAPI, and clinical. In this article, we’ll explore some of these opportunities.

Regulatory surveys

A CDI program would help to continually ensure compliance with CoPs and other regulations. There have been an increasing number of condition-level deficiencies from regulatory surveys, up to and including Immediate Jeopardy findings, which can lead to sanctions. The new CoPs that took effect in January 2018 include complex conditions for patient rights, plan of care, quality of care, coordination of care, and aide services, plus new conditions such as QAPI, infection control, and emergency preparedness. Agencies still struggle to implement many standards and so are vulnerable to condition-level deficiencies. By ensuring continued survey readiness, CDI will look at compliance with all regulations, including CoPs.

Denials

Increased denials have threatened the viability of many HHAs. The additional development request (ADR) process is used by many CMS contractors—the MACs, RACs, and UPICs—for denial purposes. Targeted probe and educate (TPE) efforts have been going on for several years in the home health industry, focusing on face-to-face visits, medical necessity, and homebound status. Agencies that fail the audits go further into review and are at risk of having UPIC audits looking for fraud and abuse, and potentially undergoing pre-payment reviews.

PDGM

Patient Driven Groupings Model (PDGM) began in January 2020. With it came a dramatic change to HHAs’ payment system for Medicare patients. There are five categories placing a patient into one of 432 payment categories, similar to MS-DRGs or Hierarchical Condition Categories. In this new model, diagnosis coding is critically important as it affects two of the five categories:

- Clinical grouping, based only on the primary diagnosis
- Comorbidities, paid as an adjustment, impacted by any one of the 24 secondary diagnoses
Under this new model, OASIS continues to factor into payment, although significantly less so—only activities of daily living (ADL) and hospitalization risk assessment items lead to a functional impairment adjustment. Payment periods are now 30 days rather than 60 days, although the patient’s certification period remains 60 days.

In addition, therapy tiers (getting reimbursed for certain numbers of therapy visits) no longer exist under PDGM, causing therapy visits to be an expense—another paradigm shift.

Given the impact of PDGM on the function of a CDI program, an HHA will need a tight intake process, coding expertise, and timely documentation, including signed physician orders.

Clinical episode management

HHAs continue to struggle with managing patient episodes, and this has become so much more important with the advent of PDGM. Since therapy visits no longer lead to reimbursement, those disciplines must be managed like nursing, aide, and social work visits, as they always should have been. Managing the number of visits per 30-day payment period and per 60-day certification episode is critical.

HHAs need to employ a case or team management model to manage a patient episode as the team works together on a patient caseload to ensure appropriate visits for the patient. This model leads to goal-oriented rather than task-oriented care. The clinical manager can drive the team, which includes all services ordered for a patient, and can ensure that visits provide “value over volume,” as CMS Administrator Seema Verma has stated, when implementing patient-driven care in home health CoPs and PDGM.

Coordination of care is so important. There may be fewer visits per discipline when appropriate based on patient needs and physician orders, but the disciplines can be each other’s eyes and ears.

Sharon Litwin, RN, BSHS, MHA, HCS-d

Coordination of care is so important. There may be fewer visits per discipline when appropriate based on patient issues to prevent emergent care visits and hospitalizations. This not only leads to financial viability, but also improves patient outcomes, including publicly reported star ratings and Value-Based Purchasing pilot programs. It is the goal of home health to keep the patient home, without emergent care and hospitalizations, during the home health admission.

As the CDI program ensures implementation of this case or team management model, data can be derived more clearly on visits per diagnosis, visits per discipline, etc. If LUPA percentages are high, then having this data will help the HHA drill down to identify how appropriately disciplines are used.

CDI and QAPI

CDI is part of the QAPI program, but it is not solely the QAPI program, as CDI involves metrics, financials, and operations in addition to clinical care. Home health is so integrated across clinical, financial, and operational worlds that to have each area in its own silo can be detrimental to the HHA. Therefore, CDI can ensure that all areas are addressed using key metrics with dashboards for easy identification of underperforming areas. For example, the CDI team can help identify negative trends in the HHA’s case-mix index, visits per episode, LUPA percentages, and patient outcomes.

CDI can lead to performance improvement projects (PIP) under QAPI as many areas will involve all departments, taking up to a year to improve processes, monitoring, knowledge deficits, etc.

The CDI coordinator will have reasons to analyze Certification and Survey Provider Enhanced Reports (CASPER) on OASIS outcomes, particularly the Agency Patient-Related Characteristics Report as this gives information on the HHA’s operation compared to the prior period and to national benchmarks. Also, the outcome report includes a recent measure of Medicare spending per beneficiary that shows expenses for the agency compared to national benchmarks.
QAPI will be very involved with the clinical outcome reports, but the CDI team can develop metrics with the areas of the CASPER reports noted above.

**CDI projects integrating clinical, operational, and financial**

One CDI quality metric is to identify by diagnosis the number of visits per discipline in 30/60 days that led to the most improved outcomes. Since the goal is improved outcomes while remaining financially viable, this could lead to care management by diagnosis. Also, it is important to drill down on the data to identify if better outcomes with appropriate visits vary by team or by agency.

LUPAs can be broken down by diagnosis and outcomes as well. Upon analysis, an HHA can identify if an episode is just under the LUPA threshold, yet the patient did not improve to the level projected on the start of care comprehensive assessment, such as improvement in ambulation. By identifying areas that tie together clinical, operational, and financial concerns, the CDI professional can develop the most optimal action items.

**CDI and intake**

As the referral is key in giving home health the foundation needed to plan a patient’s care, code the diagnoses, and ensure the face-to-face visit is compliant, the intake process can be a CDI project.

The information that agencies receive from referral sources is often lacking when it comes to coding under ICD-10 and PDGM. Unacceptable diagnoses in PDGM have made this process more difficult, and a patient must need skilled care under home health, rather than home health simply assessing the patient or “checking on them.”

**Unacceptable Diagnosis under PDGM**

Many commonly used diagnoses in the home health industry can no longer be primary diagnoses under PDGM. Diagnoses used often for therapy-only cases would be given as referrals to the HHA, such as muscle weakness or gait abnormality. Additionally, many symptom codes, such as shoulder pain, can no longer be the primary reason for home health. CMS states that the underlying reasons for the symptom or condition—for example, muscle weakness or shoulder pain—must be coded. This has been and remains a big adjustment for the industry.

**Face-to-face**

A particularly challenging area for home health is face-to-face visits. Many denials still occur due to face-to-face, and even when there aren’t denials, agencies struggle to comply, as many of the requirements fall into the physician’s hands.

It is critical that the intake department ensures that a compliant face-to-face is in place or that the patient is scheduled to visit the home health certifying physician soon after start of care. A face-to-face can be done up to 90 days prior to the start of home health care or up to 30 days after the start of care; however, the plan of care cannot be signed by the physician prior to the face-to-face. Therefore, it is important to have the face-to-face done as early as possible.

To avoid denials, CDI professionals can make face-to-face a priority project.

**Skilled need**

If Medicare eligibility is questionable on referral, an initial assessment should be made prior to the comprehensive assessment admission visit to determine if a patient is eligible for home health care. Agencies have seen denials on patients that did not really have a skilled need at the time of referral.

The CDI department will want to identify any of these vulnerabilities that are occurring in the intake department, drill down to identify particular challenges, and develop an action plan. The query process is often a key portion of the plan.

**Queries in home health**

All of these areas under intake may cause the agency to query the referral source and physician. Many HHAs are not proficient in querying and may send queries that lack specific information or do not arrive in a timely manner.

CDI professionals can meet with the referral sources to help identify the best method for querying. That
will decrease the number of queries that the nurse or physical therapist will have while admitting the patient. It is critical to take care of these issues on the front end rather than discovering them during the course of home health care or after a denial.

**CDI and the EHR**

Agencies do not always maximize their EHR use. By understanding such areas as reports and locations for documentation, using an EHR can increase compliance and efficiency while decreasing denials.

The CDI team should assess the agency’s EHR use in order to develop an action plan. A key area is to ensure that all clinicians and aides have specific locations for documentation. Coordination of care is particularly important. The EHR must have a designated area for coordination of care documentation so that all team members are able to view information on patients in real time. This is often a weak area in home health, which makes it an excellent project for CDI.

Metrics can be established when the functionality is maximized, and the CDI department can continue to monitor them as the program matures.

**Other initiatives**

Home health has many challenging areas for a formal CDI program to delve into, including:

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act, which is an initiative to improve care coordination and continuum in postacute settings. The home health OASIS-E will have more postacute assessment items than the current OASIS-D1.
- Review Choice Demonstration, which is a pre-claim review process.
- Value-Based Purchasing programs, which are currently in their fourth pilot year in nine states.

A formal CDI program with a coordinator and task force will combine clinical, operational, and financial expertise to help an HHA be financially viable and improve patient outcomes.

**Editor’s note:** Litwin is a senior managing partner at 5 Star Consultants in Camdenton, Missouri. Contact her at slitwin@5starconsultants.net. Opinions expressed are those of the author and do not necessarily represent those of ACDIS, HCPro, or any of its subsidiaries.
The bakers and the decorators: CDI analyst positions

As the CDI field grows, so do the jobs and opportunities within the profession. More people are actively pursuing a career in CDI instead of simply falling into it or viewing it as an escape from the bedside. Some facilities are creating CDI-specific career ladders and growing their department to dozens of CDI specialists. (For more information on career ladders, see the article on p. 32.)

With departments swelling with new recruits, there’s an opportunity to branch out of the typical reviewer, educator, and manager roles. While some folks may love and be extremely successful in these positions, not everyone has the same strengths, and sometimes people’s unique desires and abilities can be used to create new and specialized roles. Such CDI positions not only cater to people’s strengths, but can also aid in overall organizational success.

As a CDI program grows, benchmarking and analyzing data becomes more important to set the course of the department and secure additional resources based on past performance. Because of this need, some departments have started adding CDI roles specifically focused on data, systems, and analytics. While these may not be the jobs people think of when they conjure the image of a CDI professional, they are extremely valuable and rewarding nevertheless.

“It’s kind of like we all work in a bakery,” says Carlena Forsha, MSHCA, BSN, RN, CCDS, lead CDI specialist at HonorHealth in Phoenix, Arizona. “It doesn’t matter who is in the limelight, who is doing the chart reviews or analytics. As a motivational speaker once said, it doesn’t matter who is doing all the pretty decorating on the cakes and who is baking it behind the scenes—each task is critical to success. In the end, we are still all one team working towards the same common goal: the best product for our customer.”

By Carolyn Riel
CDI systems specialist

“Prior to CDI, I worked in bedside nursing for 15 years,” says Beth Simms, BSN, RN, CCDS, CDI systems specialist with Banner Health in Phoenix. “I worked in the ICU, and that can be very stressful, so after so long I needed to step back.”

Simms says she worked with human resources at her facility to find a new role that would be suited to her needs and abilities. They set her up to shadow a CDI specialist for a short time to see that professional’s workflow.

“I walked out after those few hours and absolutely knew this is what I wanted to do,” she says. “It was like being a detective, reviewing charts and finding the puzzle pieces for how to make it better and make everything fit.”

After a few years working in CDI, a new specialized career opportunity came along when Simms’ organization developed a CDI career ladder. The department created a robust structure of new jobs, including the position of systems specialist. (For more information on the career ladder at Banner Health, see the article on p. 32.)

“We had different workgroups in the department that you could be part of, and I was part of the workflow workgroup,” says Simms. “We would look at the workflow process of procedures, the computer systems, and other things. Having this insight I think is what made them decide to place me in charge of overseeing all of the IT-related things.”

When Banner Health set out to build its CDI career ladder, it was important for the organization to have one person in charge of keeping track of IT tickets, updates, and system tests. To fill that need, the systems specialist role was created.

“I look at every computer system we interact with,” says Simms. “I work with IT, vendors, finding out all of their features and figuring out what is best for our workflow. I also help with testing computer systems and have meetings with the vendors to discuss new features.”

Beth Simms, BSN, RN, CCDS

Lead CDI specialist

While Forsha might not have the most unique job title, her daily responsibilities are anything but traditional chart reviews.

“This role developed because the timing was right,” says Forsha. “We had two different hospital networks going through a merger with one CDI manager on each side, so that created some duplicated efforts.”

Both Forsha and the other manager from the merged hospital were looking at case-mix index (CMI) and patient volume data. “The organization wanted to take a closer look at patient volumes and CMI,” she says. “The other manager and I didn’t want to duplicate efforts, so we just had one person (me) run the reports rather than each doing half.”

In running these reports and performing analysis, Forsha was able to show the chief financial officer the differences CDI was making for the organization. “She asked me if CDI could do a deep dive into some more of this data analysis, and that was the birth of my role as it is today,” she says.

Throughout the month, Forsha receives updates from the analytics department, such as patient volume per DRG and CC/MCC capture rates.
“Everything I do is retrospective,” says Forsha. “I have my own spreadsheets where I change information from basic numbers to how the information pertains to logical DRG groups.”

She can then take her spreadsheets and put together reports at the facility level and for the network as a whole. Her reports go all the way down to the DRG level to show the CDI department’s impact and the change in CMI over time. “This is the culmination of everything I do,” she says.

Forsha gives these reports to her manager and the senior director of HIM and coding, who is also over CDI. This gives higher-ups reporting to show how CDI impacts the HonorHealth network overall, and demonstrates what is happening and why at the DRG level.

“I will still do some chart audits and other tasks as well, but this data is my main focus,” says Forsha. “I’m looking to see if we miss something and what the correlations are.”

The why behind specialized positions

From an organizational standpoint, having specialized roles in CDI allows for a deeper dive into the back-end and billing information that affects the facility’s bottom line. CDI specialists rely on a series of computer and technical programs to get their work done, whether that means sending an electronic query or accessing EHRs.

“At this point, a lot of the folks working in CDI are coming from a bedside nursing background, [so] learning how to properly use and leverage technology has not been a driving force in their career so far,” says Simms. “It is so important to have someone overseeing all of the IT stuff and teaching people.”

“Doing this data analysis is so important because you can’t know what you’re missing without knowing where you’re starting from,” adds Forsha. “A lot of the things I found, I didn’t know I was looking for until I stumbled upon them.”

Now that she’s in this position, Forsha sees the risk incurred by not having this type of role.

“If you aren’t keeping up on this data and one day realize you have a problem, it’s going to take you much longer to backtrack and figure it out. It’s so much better to be proactive and dive deep to find how to make your organization as successful as it can be.”

In her role, Forsha has found areas of missed opportunities with chart reviews. HonorHealth’s CDI educator was then able to create specific lessons on some of these missed opportunities and present them at the next staff meeting, making for less missed opportunities in the future.

On a more granular level, not only do specialized positions help the organization and department as a whole, but they also play to the strengths and interests of individual CDI professionals, offering them a way to advance professionally within their department.

“Not having unique and specialized positions means you can’t use the players you have to the best of their ability,” Forsha says. “I know a lot of people would try to do the work I do and their eyes gloss over, but for me it gives me the warm and fuzzies. Not everyone is like that with numbers, or technology, or analysis. But some of us are.”

“It just makes sense to use people’s unique strengths and knowledge of what they love to help everyone else in the department,” adds Simms. “More goes into CDI than just chart reviews. Help people stop seeing the limited roles and find what they really like.” 🌟
OCTOBER 2020

VISIT THE ACDIS BLOG WEEKLY TO FIND OUT WHAT EVENTS ARE COMING UP IN YOUR AREA!
CDI WEEK 2020 PREVIEW

Stroll down the CDI walk of fame

By Carolyn Riel

CDI Week 2020 starts in two weeks and runs September 14–18. This year’s theme is ACDIS Cinema–CDI: Coming to an Organization Near You!, celebrating the CDI superstars and their wide range of skills that are starting to be seen at the forefront of facility efforts as well as in the hard work done behind the scenes. Aside from celebrating CDI efforts within our own community, CDI Week is also a time to help other departments understand what CDI is, what these professionals do, and why CDI is so important in our healthcare system.

The 2020 CDI Week Committee has been working hard (but still having fun!) coming up with ways to make this year as great of a celebration as every year prior, while highlighting our CDI professionals and the classic Hollywood theme. A few things you can expect are:

■ Daily discounts emailed to CDI Strategies subscribers that you can use throughout CDI Week
■ Free resources that would ordinarily only be accessible to ACDIS members
■ In-depth analysis of the CDI Industry Survey
■ Daily Q&As with industry experts published on the ACDIS Blog and sent to Strategies subscribers
■ A free webinar taking the pulse of the CDI industry with a panel of experts on September 17
■ Free printable materials and games, including an official CDI Week poster, plus crossword and word find puzzles

ACDIS is a home for CDI professionals, and that is no different during CDI Week; we’ll be hosting events and interacting daily with all of you for these celebrations. We also encourage individual CDI teams to host celebrations of their own! Whether you’re working back in the hospital or remotely from home, here are a few suggestions straight from the 2020 CDI Week Committee:

■ Nominate your facility’s CDI superstars. Winners can get their name on your organization’s CDI Hollywood Walk of Fame hallway if they are on-site, or receive their own digital star or a cut-out Oscar if they are remote.
■ Hold a face mask decorating contest themed after Hollywood or old cinema. Masks could be decorated to look like the face of your favorite movie star or with cinema-themed icons such as gold stars and movie reels. Get creative!
■ Set up teams within CDI and other departments, then assign each a classic movie. Each team should dress up to the theme and take photos, then submit them to the contest organizer. After everyone votes, the winner can be recognized during a virtual or in-person award ceremony.
■ Have other departments earn their CDI star on the Walk of Fame! Create a set of CDI-related questions to test their knowledge, and give those who get them all correct a gold star certificate to print and display.
■ Get crafty and make movie-themed thank-you cards for the physicians who’ve championed CDI’s cause. Alternatively, make a signature book scavenger hunt where physicians sign CDI staff members’ books taking an oath to better document. The physician who signs the most oaths can win a prize.
■ Create Hollywood-themed chart review games, such as actor patient charts, where participants must figure out what’s missing or how to code the case—with bonus points if they can figure out the actor the chart is based on! Or use a theme of old Hollywood detective movies, such as “Murder on the CDI Express,” where each level or chart review becomes an increasingly difficult case.

No matter what you do to celebrate CDI Week, know that we are celebrating you all here at ACDIS too. We would love to hear your plans, so please submit your activity ideas through our online form. And don’t forget to send us your celebration pictures to be included in our post–CDI Week slideshow! 🎥
“CDI Week”
COMING TO AN ORGANIZATION NEAR YOU
SEPTEMBER 14-18, 2020

© 2020 HCPro, a Simplify Compliance brand
Clinical validation research from the field

Contributor’s note: Clinical validation is a major focus of CDI efforts. So, in continuing his exploration into CDI research and pulling forward experiences shared during various ACDIS poster presentations, Howard Rodenberg, MD, MPH, CCDS, reached out to his colleague Audrey Mobley, MD, MMS, CCDS, to discuss the difference between how clinical validation plays out in theory versus how it plays out in the real world. The following are Mobley’s updated thoughts and data related to her poster presentation “Clinical Validation: The Final Frontier,” from the 2019 ACDIS annual conference.

by Audrey Mobley, MD, MMS, CCDS

Growing up, I remember my mother baking tirelessly during the holiday season. Our home was filled with the aromas of cookies, cakes, and pies. I helped by measuring out the precise amount of brown sugar needed to prepare her great concoctions. Over time, I tried to recreate those childhood memories in my own home, quickly realizing that things never come out exactly as expected. Clinical validation is a lot like baking. You can start with a very specific recipe, but the end product sometimes comes out far different than you thought it would.

Since July 2018, the CDI department at Baptist Health in Jacksonville, Florida, has been navigating the somewhat foreign and rocky terrain of clinical validation. Our introduction to clinical validation was through presentations at professional meetings. Those sessions gave us the impression that clinical validation was mostly a matter of asking the physician if they “meant what they said” in their progress notes. Our experience showed otherwise, and it was this disparity between expectation and observation that led us to dig deeper to uncover where there might be new opportunities related to clinical validation in our institution.

Our process of clinical validation begins with a list of post-discharge coding/CDI mismatches that are referred to the physician advisor for review. Documented diagnoses are also compared with institutional definitions as an objective standard, and if diagnoses and definitions do not match, or if there are other questions of clinical validity, these records are also referred to the physician advisor. If the physician advisor determines that an additional query is needed, the CDI lead develops and submits the query, and both the lead and physician advisor review the responses before a final coding decision is made. Queries that are not answered after a 28-day period of escalation and follow-up are closed. In the past two years, 877 records have been reviewed for 976 diagnoses as part of this process.

We found several critical points where our experience differed from expectations we’d been educated on. First, we were able to identify three categories of charts that came through the clinical validation process. Two of these categories were expected: records with a diagnosis in question that could be passed through as is (43%), and those that would require a clinical validation query (8%), seeking additional information to support the diagnosis in question. We also found that 49% of records fell into a third category: records with diagnoses in question that were unsalvageable even with query. This latter group of records had not been previously identified within the spectrum of clinical validation, as virtually all presentations we had seen only described records where a query might be in order and (understandably) did not discuss cases where there is nothing to be done.

The diagnoses in this category span a range of topics. The most common diagnoses in question were sepsis (38%), acute respiratory failure (38%), and acute encephalopathy (8%). Other diagnoses were reviewed in the remaining 16% of cases.

We found two types of queries needed for this process—objective and subjective. Objective queries seek additional data (physical exam findings, vitals, labs) that would clinically support the diagnosis in question. Subjective validation queries seek additional information to support a diagnosis that may already meet objective criteria but does not “paint the picture”
of illness commensurate with the severity of diagnosis. This latter group represents the majority of our queries.

Subjective queries can be further broken down into two groups. The largest group includes those records lacking subjective data to support the documented diagnosis—no notation of respiratory distress in a patient with acute respiratory failure, for example. A smaller group includes records where the subjective diagnosis directly contradicts objective information.

We also recognized that clinical validation queries must not be designed to question physician judgment, but rather to seek additional information that would further support the diagnoses in question. We already know that physicians sometimes consider the query process to be intrusive, and in order to promote cooperation, we felt it was necessary to approach physicians with the idea that clinical validation was helping us to defend their work to the outside world rather than forcing the physician to justify their efforts to CDI and coding staff.

With this idea in mind, we recognized that traditional query language might seem adversarial. We therefore modified our query language in support of physician advocacy, as seen in the sample query on p. X in support of the diagnosis of sepsis.

We believe this language to be fully compliant with practice standards, as it does not lead the physician to a specific diagnosis or to any particular sign or symptom, does not offer new diagnostic possibilities, notes no financial impacts, and offers only a “free-form” response option for maximum flexibility. This format simply asks the clinician to offer further support for their current documentation with a clinically based explanation of need.

This approach to the physician—assuming their diagnosis is truly “correct” and using the query to support them—has found that not only do physicians often have additional information to contribute, but they are actually willing to do so, often more expeditiously than with the standard closed-ended queries. Our overall response rate to clinical validation queries has been 93%. However, not all queries were fully able to resolve the issues noted within the chart. Only 54% of the diagnoses in question were able to be accepted for final coding after query.

In summary, just like my mother’s cookies, the recipe for clinical validation is much different in practice than in theory. Only a minority of charts with diagnoses in question are amenable to validation queries. The diagnoses in question during clinical validation typically fall into high-frequency categories, and the queries that are written most often request subjective descriptions of patient appearance supporting the diagnosis.

---

SAMPLE QUERY

Dear Dr. [INSERT PHYSICIAN NAME]

In the medical record of your patient [INSERT PATIENT NAME or MEDICAL RECORD NUMBER], you’ve documented the presence of sepsis. Outside auditors often require documentation of the severity of illness, including patient appearance and signs and symptoms of illness, injury, or distress, to give you credit for the care you provide.

[INSERT CLINICAL INDICATORS]

Could you further describe and document the additional signs, symptoms, and/or clinical appearance that suggests the presence of severity of illness in regard to sepsis?

Please provide supplemental description of clinical diagnosis below:

Physician Response:

______________________________________
______________________________________
______________________________________
______________________________________
______________________________________
______________________________________

---
One rung at a time: CDI career ladders

By Carolyn Riel

Right now, starting a career in CDI isn’t something that is very fluid for a lot of people,” says Jessica Risner, BSN, RN, CCDS, director of CDI at over 18 hospitals in the Banner Health Network, based in Phoenix, Arizona. “A lot of people just stumble upon it. I think this will change in the future as the CDI industry grows.”

The CDI field as it exists today hasn’t been around much longer than 20 years, meaning that it’s a brand-new path and concept for a lot of people who find it as their second career—whether they’re coming from a clinical or HIM/coding background. CDI programs generally have chart reviewers, a manager or director, and—if a facility is lucky—a dedicated educator. As the profession grows, however, so does the need for more job stratification and opportunities for professional growth. For many maturing programs, creating a CDI career ladder has become an integral part of their long-term plan.

Getting started

“Getting the career ladder developed was a process,” says Risner. “When I became the CDI director, I noticed that our foreign-trained physician staff were signing the same job description as [CDI specialists from a nursing background]. The problem is they aren’t the same, so it’s really a misrepresentation of credentials.”

Risner first started expanding the titles for CDI specialists, ensuring that the foreign-trained physicians and registered nurses were working under the correct job descriptions that applied to the work they were doing as well as their training and credentials.

“We looked at the registered nurse CDI description, retitled it, and then rewrote it,” she
“We went through the position description page within our company and pulled similar job descriptions, such as auditors from coding, or open jobs on the ACDIS Career Center page.”

Risner and her colleagues took what they liked from their research and built their new CDI job descriptions. Then, once they had the descriptions written, they took the documents to the senior director and on to the human resources (HR) department for review and approval. HR then looked at other comparable positions in their healthcare system and did some market research to make sure the salary was appropriate for the job title.

“They came back with the suggested salary, and we felt it fit accordingly,” says Risner. “After that, the career ladder was approved, and it took about six months to get the entire ladder built out to what it is now. Now the foreign-trained physicians are signing the correct job descriptions and have a clear career ladder.”

Risner says that having a good relationship with HR and building that rapport is a gateway to having conversations with them in the future about new CDI roles, something that Tamara Hicks, BSN, MHA, RN, CCS, CCDS, ACM-RN, CCDS-O, director of CDI at Wake Forest Baptist Health in Winston-Salem, North Carolina, also found to be true.

“When we first began working on our CDI ladder at Wake Forest Baptist Health, we started spending a lot of time with our HR folks,” she says. “They started advising us on how the nursing program built a career ladder and [we decided to] take what we could from that.”

An important part of building a career ladder, she says, is that you must be able to show the difference from one job level to the next and support the different pay grades for each.

Wake Forest Baptist Health has a robust metrics system for justifying its pay scale. “Our CDI-1s and CDI-2s are audited by their managers and get points for their reviews,” says Hicks. “We look to see if these points are not meeting our metrics standards, meeting, or exceeding them.” (More on these job levels a little later.)

For creating rungs of the career ladder, Hicks recommends taking a look at what each job level’s responsibilities look like compared to each other.

“If a reviewer has a certification, what do we expect them to do that’s different from someone who does not?” she says. “We might call second-level reviewers to help with physician education or do new employee orientation for providers.”

When deciding what position someone will be and what their job responsibilities will include, take their unique skills into consideration.

“Some people are really good at creating presentations; others are good at putting together bulletin boards or handouts or giving ideas about which specific cases we can use for education,” Hicks says. “Use everyone’s strengths to create new jobs and find good fits for them—that’s really how we put our career ladder together, then as long as HR was good with it, we were pretty golden.”

**Building a ladder**

There is no right or wrong way to build a career ladder, and its structure will look different from facility to facility depending on individual needs. At Banner Health and the hospitals Risner oversees, the CDI career ladder is robust. For each job title, there’s a job description for a nursing-credentialed individual and a non–nursing credentialed individual. Each of those categories also has a subcategory to specify whether the individual works in the Arizona or Western region.

For example, “you’d have an RN clinical documentation specialist for Arizona, an RN clinical documentation specialist for Western region, a clinical documentation specialist for
Arizona, and a clinical documentation specialist for Western region,” Risner says. “This helped address the initial issue I found as director of foreign-trained physicians and registered nurses signing the same job description.”

Banner Health’s ladder includes the following “rungs:”

- Clinical documentation specialist
- Clinical auditor and data specialist
- Clinical documentation educator
- Clinical documentation system specialist
- Clinical documentation quality and education senior manager
- Clinical documentation senior manager
- Clinical documentation director

For Wake Forest Baptist Health, the CDI career ladder is still fairly new and was only developed about a year ago. “The need for a career ladder at our organization was born out of bringing on other hospitals, each at a different state of their CDI program,” Hicks says. “We learned quickly that each new hospital that was coming on was doing something different for training their CDI staff.”

Some of the hospitals did not have the same background requirements for their CDI specialists that Wake Forest Baptist Health had (a bachelor’s degree plus five years of bedside nursing experience, preferably in critical care). “We took this as a good opportunity to create a career ladder and set prerequisite experiences for our new CDI staff,” she says.

The first rung of Wake Forest’s career ladder—CDS-1—is for team members with no background in CDI or related certifications. “This person will have the baseline ability to review charts and learn CDI,” Hicks says.

For Wake Forest Baptist Health, there was a time where they hired a few new people for the outpatient CDI team and worked to get them certified. “Some of them left and took consulting jobs because they could work remotely and make a higher salary doing that,” she says. “Creating a career ladder was a way to reward them for getting certified and allowing them to make more money working for us—this means staff retention.”

But creating a CDI career ladder can come with some obstacles. “At first, no one wanted to be the test subjects for these new roles,” says Risner. “We tried to make it very clear for those folks stepping into the roles that we all know it is new...
SPECIALIZED ROLES

Sometimes when developing a robust career ladder, specialized roles need to be created in order to use everyone’s strengths to their fullest extent, which will ultimately help the organization.

When Risner became CDI director at Banner Health in Phoenix, Arizona, the department had a very basic career ladder structure of reviewers, educators, senior managers, and a director. “We had 80 people and didn’t have much bench strength in the quality and education space, so I put a huge focus on developing those areas,” she says.

After noticing that the managers and program director were being left to do most of the IT-related work, Risner prioritized creating a position for these tasks. “CDI is very dependent on IT, and there wasn’t one person in charge of keeping track of tickets, system updates, running tests, or staying up to date on what new technologies were coming,” she says. “So, we created a very unique position called a systems specialist.”

The systems specialist, explains Risner, is a hybrid between a clinical informatics nurse and a CDI specialist. “The person we have in this position monitors and interacts with all of our platforms,” she says. “She does all the education on the CDI platform for new folks coming in, or for the whole department on any changes that need to happen with IT.”

According to Risner, the systems specialist role has become integral in allowing the Banner Health CDI department to leverage their technology. (To learn more about developing unique CDI positions, read the article on p. 23.)

While the department hasn’t branched out into additional specialized roles yet, Risner says there’s room for that possibility in the future, particularly in the denials management space.

“Perhaps a denials liaison,” she says. “Or have an interdepartmental liaison to combine quality and denials; there’s always opportunities to bridge gaps in communication.”

and they have the opportunity to mold the roles and give us feedback on what is working and what isn’t.”

Hicks experienced some similar hesitation at her facility. “At first, the CDS-2s didn’t realize that getting a raise and promotion meant more work,” she says. “We told them they were welcome to go back to being a CDS-1 if they wanted, but if they wanted the extra pay, they had to do extra work.”

Once it was made clear that the promotion meant more work, most of those who had moved into CDS-2 roles were on board. “It was a lot of getting over the mindset of ‘I already have so much to do, how can I do more?’ and realizing ‘well, we are paying you to do more.’ ”

Overall, Hicks says, the CDI team has been happy with the career ladder. “It’s a good job, and they work hard and have to keep up with the latest standards, so as long as they are doing this, we want to recognize and reward them for it,” she says. You have “to give people in CDI the opportunities to move up without having to leave the career path.”

While a career ladder may seem like the golden ticket to retaining and engaging your staff, Risner recommends that leaders take the time to build a structure that works for their particular team.

“In hindsight, we might have gone too fast with implementing our career ladder and could have taken a slower approach,” Risner says. “Create one rung, then wait six months and do another one instead of doing them all at once.” But, she notes, “now that we have the career ladder successfully up and running, we don’t just feel like we’re along for the ride anymore. We grabbed the steering wheel, leveraged our strengths, and can better navigate not only our own department’s metrics but also our own career development.” 💪
COVID-19-related kidney injury

by Alba Kuqi, MD, CICA, CCS, CDIP, CCDS, CRCR, CSMC

The initial approach to kidney disease record reviews requires CDI professionals to assess the cause and severity of renal abnormalities. According to a May 14, 2020, article from Johns Hopkins Medicine, approximately 30% of patients with COVID-19 have acute kidney injury (AKI). Furthermore, patients with acute respiratory distress syndrome and AKI are at higher risk for poor outcomes.

Risk factors for in-hospital mortality include:

- Age
- Male sex
- Symptom duration before hospital presentation (per day)
- Hypertension
- Chronic cardiac disease
- Diabetes
- Body mass index greater than 40
- Interleukin (IL)-6 (per decile increase)
- D-dimer (per decile increase)

Multiple mechanisms for AKI in COVID-19 have been developed, including:

- Direct infection of renal tubules by SARS-CoV-2
- ACE-II target mediated injury (this has prompted the study of Angiotensin II receptor blocker as potential treatment)
- Collapsing glomerulopathy
- Other immune-mediated injuries

A May 2020 National Kidney Foundation (NKF)-Harris Poll Survey on COVID-19 and kidney health showed surprisingly low levels of awareness on both the risk of developing AKI as a result of COVID-19 and the long-term effects of kidney damage. According to a June 2020 article from The Lancet, contributing factors include:

1. Acute tubular necrosis (ATN) with septic shock
2. Micro inflammation
3. Increased blood clotting
4. Probable direct infection of the kidney

Initial reports from Wuhan, China, found approximately 3%–9% of hospitalized patients with confirmed COVID-19 developed AKI. Incidence rates have now increased to 15% of all hospitalized patients and 20% or more of ICU patients, with many requiring dialysis treatments. Most patients with COVID-19-related AKI who recover continue to have low kidney function after discharge from the hospital.

As the general incidence and underlying mechanisms of severe COVID-19-related kidney injury remain poorly understood, epidemiological, clinical, and biological investigations are necessary to inform hospital preparedness strategies and development of targeted preventive and treatment interventions. (See the Lancet article referenced above.) The majority of patients who develop severe AKI may require renal replacement therapy (RRT) during hospitalization, and this could have considerable implications for resource allocation, given the limited supply of RRT machines.

Physicians treating patients with COVID-19-related AKI need to manage the patient’s fluid intake. Early in the presentation of AKI, the physician may consider:

- More aggressive fluid resuscitation
- The standard approach, like what is used in sepsis,
- Delayed presentation (patients more likely to be volume depleted)

However, as the illness progresses, the goal changes to minimize fluid overload, aiming for net-even or net-negative fluid balance, particularly related to improving oxygen delivery in damaged lungs.
this point, general management for AKI must also be employed, such as avoiding nephrotoxic medications, managing hypotension, and ensuring early nephrology consultation, which allows for planning when resources may be limited due to the high volume of patients needing RRT.

RRT may be required for patients who suffer progressive renal dysfunction in the setting of ongoing critical illness related to COVID-19. Decisions regarding intermittent hemodialysis versus continuous renal replacement therapy (CRRT) depend on local protocols, availability of resources, and patient stability. For patients undergoing CRRT, several things must be considered, including:

- High rates of filter loss (clotting and clogging)
- Consider modification of prescription to include:
  - Increase in prefilter replacement rates
  - Anticoagulation
  - Other modifications to decrease filter hematocrit

Additional complications of COVID-19-related AKI might also include extensive deep vein thrombosis and presence of heparin-induced thrombocytopenia antibody. As such, inflammation and coagulopathy may complicate the delivery of CRRT.

CDI professionals need to review the entire medical record and focus on reviewing diagnostics and trend results to save time. Both normal and abnormal results may be relevant. Relevant abnormal trends might include creatinine, GFR, and the BUN/creatinine ratio.

Reviewing the medical record takes time, patience, and skill. Furthermore, CDI staff need to apply critical thinking to the facts of the case and formulate an appropriate clarification to the physician.

Alba Kuqi, MD, CICA, CCS, CDIP, CCDS, CRCR, CSMC

Additional complications of COVID-19-related AKI might also include extensive deep vein thrombosis and presence of heparin-induced thrombocytopenia antibody. As such, inflammation and coagulopathy may complicate the delivery of CRRT.

Addressing the present on admission (POA) status of ATN mentioned later in the chart is important because it can clarify if the condition developed during hospitalization or was POA. AKI with ATN (POA-N) could provide an MCC that contributes to severity of illness/risk of mortality and triggers a quality measure. CDI specialists can find a great deal of clinical evidence for POA conditions in the notes from the emergency department or from emergency medical services.

Editor's note: Kuqi is the CDI supervisor at Prime Healthcare in Philadelphia. Click here to read the first part of this series. Contact her at albakuqi88@gmail.com. Opinions expressed are those of the author and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.
As the COVID-19 pandemic progresses, CDI specialists play a crucial part in the effort to accurately track the public’s health. As the link between clinicians and coders, CDI professionals are uniquely positioned to provide support to both services for coding COVID-19’s impact. As the pandemic has evolved here in the United States, CDI teams have risen to the challenge of staying up to date with literature describing the various patient presentations and new ICD-10-CM codes for COVID-19.

CDI professionals have been busy educating and querying clinical teams to get clear documentation of COVID-19 as well as the secondary diagnoses in the disease cascade. They have also worked with coding teams to ensure that the coded data submitted to the various state and federal agencies accurately reflects their health systems’ patient population. Up to now, public health data collection has been mainly focused on adult COVID-19 patients, but we are beginning to see data indicating that COVID-19 is impacting children’s health as well.

According to the COVKID Project, as of August 16, 2020, the United States has reported 486,016 COVID-19 cases in children and teens, with 105 of these cases resulting in death. Unfortunately, these numbers are probably inaccurate because there are significant problems with how states report pediatric COVID-19 data to the federal government.

(Let’s pause here to give our pediatric CDI colleagues a moment...)
to shout at the screen that there is a general failure to recognize the unique characteristics of the pediatric population when it comes to defining ICD-10-CM codes and reporting data here in the United States. OK—let’s continue.)

The first issue is that there is no federal definition of “child” for data reporting purposes. This means that each state can define “child” differently, which leads to large discrepancies in data that the United States uses to make comparisons and define trends during the pandemic. For example, Alabama reports COVID-19 cases in two groups: ages 0–4 and ages 5–24; Ohio, on the other hand, reports COVID-19 cases in children in just one large group of 0–19. Alabama’s pediatric COVID-19 data actually contains adults, and Ohio’s data does not allow us to see the differences in COVID-19 impact by age group.

Secondly, few states are submitting data on COVID-19 infections in children that include the setting of the infection, the percentage of children tested, whether the child was asymptomatic or required hospitalization, and whether the child died from a COVID-19-related illness. The inconsistencies in the data reporting for pediatric COVID-19 infections will have an impact on our ability to identify public health trends that could influence both treatment of pediatric patients and public policies like reopening schools.

To further complicate matters, children with COVID-19 infections have a totally different presentation then their adult counterparts, called multisystem inflammatory syndrome in children (MIS-C). (Again, let’s pause out of respect for our pediatric CDI colleagues and acknowledge that they have been right about so many things all along.)

MIS-C is described by the American College of Rheumatology as “a condition characterized by fever, inflammation, and multiorgan dysfunction that manifests late in the course of SARS-CoV-2 infection,” with the epidemiologic link between MIS-C and COVID-19 defined as any of the following:

- Positive PCR COVID-19 test
- Positive COVID-19 serology
- A history of preceding COVID-19 like illness
- Close contact with a confirmed or suspected COVID-19 case in the last four weeks.

Presenting signs and symptoms are rash, gastrointestinal symptoms (diarrhea, abdominal pain, vomiting), edema of hands and/or feet, oral mucosal changes (red and/or cracked lips, strawberry tongue, erythema of the oropharyngeal mucosa), conjunctivitis (bilateral), lymphadenopathy, and neurological symptoms (altered mental status, encephalopathy, focal neurological deficits, meningismus, papilledema).

The Centers for Disease Control and Prevention (CDC) began tracking MIS-C cases in May after New York, an early epicenter of the pandemic, reported 15 cases of an inflammatory condition in children that appeared to be linked to COVID-19. They used the coding of the listed MIS-C signs and symptoms to identify potential cases. As of August 6, 2020, the United States has reported 570 confirmed cases of MIS-C with 10 confirmed deaths, according to the CDC.

Again, though, it’s likely that these numbers are inaccurate. It is not our habit to list codes for signs and symptoms in the final coding summary, and provider documentation of MIS-C is not codable since there is no code for MIS-C in the ICD-10-CM code set. It’s likely that these numbers are inaccurate. It is not our habit to list codes for signs and symptoms in the final coding summary, and provider documentation of MIS-C is not codable since there is no code for MIS-C in the ICD-10-CM code set. There wasn’t even a code for COVID-19 until the CDC activated U07.1 in the April 2020 ICD-10-CM set update.

The CDC does not seem inclined to activate a new code for MIS-C in the October 2020 ICD-10-CM update as it did previously with COVID-19. In lieu of a new code for MIS-C, the American Hospital Association (AHA) Coding Clinic recommends using ICD-10-CM code M35.8, other specified systemic involvement of connective tissue, to capture provider documentation of MIS-C.
According to Coding Clinic, coding professionals should assign code U07.1, COVID-19, as the principal diagnosis, and code M35.8, other specified systemic involvement of connective tissue, as a secondary diagnosis, for MIS-C that is documented as due to active COVID-19. Per the instructional note under code U07.1, COVID-19 should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations. As a secondary code, M35.8 is ranked as a CC in the MS-DRG system and has a severity of illness of 3 in the APR-DRG system. If MIS-C is thought to be a residual of COVID-19, code instead M35.8 with B94.8, sequelae of other specified infectious and parasitic diseases, as a secondary code.

If the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection versus a residual effect from a previous COVID-19 infection, CDI professionals should query the provider. As stated in the Official Guidelines for Coding and Reporting, the provider’s documentation that the individual has COVID-19 is sufficient for coding purposes. Refer to ACDIS Advisory Board Member Erica Remer, MD, FACEP, CCDS’s article for help in composing these queries.

So, what can CDI professionals do to help with the accurate capture of MIS-C? Familiarize yourself with the list of signs, symptoms, and testing commonly performed in the setting of MIS-C (see the resource box below). Educate your coding team to help them identify potential MIS-C patients when reviewing provider documentation. Educate your clinical staff on the documentation of MIS-C and the need for strong, consistent documentation of the link to COVID-19. Recognize query opportunities when providers are describing the condition of MIS-C without using the exact term in their documentation. Consider making this a performance improvement project for your department. This will allow you to dedicate resources for clinical education.

Define what signs and symptoms should be included in the final coding summary for MIS-C patients, retrospective chart review, and construction of query templates. Consider reaching out to your infection control team to find out how your health system is reporting MIS-C data to your state health department. This may offer your CDI team an opportunity to build a partnership and resource network with other departments that are impacted by the final coding summary.

If you’re feeling particularly motivated, find out how your state collects and reports COVID-19 public health data and review your findings with your clinical staff. There may be an opportunity for you and your team to implement some changes that are long overdue and would greatly benefit both children and their families in your community.

The COVID-19 pandemic has reinforced how crucial accurate data collection is for public health policy. It has also reinforced the impact that CDI teams have on data collection. CDI teams must continue to work with both the clinical and coding teams to ensure that final coding summaries are accurate and reflect the current state of the public’s health.

Editor’s note: ACDIS would like to thank the members of the ACDIS CDI Regulatory Committee for authorship of this paper. Particularly, a special thank you to Candace Blankenship, RN, BSN, CCDS, CDI specialist at Mayo Clinic in Jacksonville, Florida, for principal authorship. To learn more about the Regulatory Committee’s work and goals, please visit the ACDIS website.

CDI RESOURCES FOR MIS-C

- The COVKID Project
- The CDC resources on MIS-C
- The CDC and World Health Organization definitions of MIS-C
- Download and listen to the August 12, 2020, episode of the ACDIS Podcast: Talking CDI. The podcast features Dr. Kevin Friedman from Boston Children’s Hospital speaking about MIS-C and its impact on the pediatric patient population.
CODING CORNER

10 things coders wish surgeons knew about documentation and coding

By Sarah Nehring, RHIT, CCS, CCDS

As a coding educator, most of the questions I address are about two things: ICD-10-PCS coding and queries. While coding procedures can be challenging, the lack of complete documentation is more frustrating. The following are just 10 of the things coders wish surgeons knew about their documentation and why we query.

10. Coders do not assume that everything that happens in the postop period is a complication.

It seems to be a common misconception that things documented in the postop period are going to be coded as complications, but coders only code conditions as complications if they are documented as complications. If a provider documents “postop period complicated by atelectasis,” he or she has documented a complication and a postop respiratory complication code will be assigned.

If a provider documents “expected atelectasis treated with incentive spirometry and nebs,” we may code the atelectasis if it meets the definition of a reportable secondary diagnosis for that admission, but it will not be coded as a complication.

If the documentation regarding a condition is conflicting or unclear, we may query to determine if there is a link between a condition and the procedure that was performed.

Documentation of “wound infection” is unclear. Even if we know the patient had a surgical procedure a week prior to the admission, we cannot assume the two things are related. We will have to query and ask if the wound infection was likely a surgical or postop wound infection.

If “postop infection” is documented, we may query to ask if the infection is due to a device, involves an internal organ/space, or was a superficial wound infection.

If a provider documents “fluid collection noted on imaging” in the postop period and is treating the patient with antibiotics and/or a drainage procedure is performed, we will have to query. There is not a code for “collection, fluid.” Providers can prevent the query by documenting more specifically what was suspected/being treated: postop seroma, postop hematoma, postop abscess.

One final note about complications: For every code we assign, we must indicate if the condition was present on admission or not. Conditions that are present on admission are considered comorbidities. Conditions that are not present on admission are perceived complications regardless of whether coders assign complication codes or not. If a condition is not recognized until day two or three but was likely present on admission, we may need a physician to document that it was likely present on admission.


Coding chronic conditions such as diastolic or systolic heart failure, chronic atrial fibrillation and atrial flutter, diabetes and its complications, chronic kidney disease, dementia, and autism can increase reimbursement, severity of illness (SOI), risk of mortality (ROM), and expected length of stay (LOS), as well as contribute to risk adjustment.

However, we cannot code them if they are not documented, and that means the costs associated with the comorbidities appear unjustified. Underreporting of the chronic conditions being treated can also negatively affect quality scores.

Just including a list of chronic conditions in the patient’s history and physical may not be enough to support code assignment. Ideally, the progress note documentation will include any conditions that:

- Were being treated (with medication)
- Were being considered when making care decisions
8. We think about significance differently.

Some of the things that surgeons consider inherent or expected in the postop period have significance from a coding standpoint. Just because certain conditions are expected in some—or even most—postoperative patients does not mean the condition didn’t happen or that it didn’t increase resource consumption for the patient.

The expected cerebral edema, ileus, atelectasis, hypotension, or acidosis that was monitored or treated needs to be documented so we can code it, especially if the LOS was longer than expected.

7. Morbid obesity is always significant.

From a coding standpoint, morbid obesity is always significant. Morbid obesity can increase nursing care and resource consumption, and it increases the risk of poor outcomes for the patient. Documenting morbid obesity—and the codes that are assigned as a result—can increase reimbursement to cover the increased costs of caring for the patient and can risk-adjust certain quality measures.

The Official Guidelines for Coding and Reporting allow coders to use dietitian and other nonphysician documentation to support assignment of accurate body mass index (BMI) codes. However, we cannot code BMI unless a physician or midlevel provider documents a diagnosis associated with it. If we see a BMI greater than 40 documented in the nursing flowsheets but no diagnosis associated with it, we will likely query for one.

6. Malnutrition, cachexia, and underweight status are also important.

Just as we cannot code BMI without a diagnosis from a provider to go with it, we cannot code malnutrition documented by the registered dietitian unless it is confirmed in the provider documentation.

Severe malnutrition can affect reimbursement, SOI, ROM, and expected LOS, and it’s considered an immunocompromised state and excludes cases from wound dehiscence and central line–associated bloodstream infection Patient Safety Indicator (PSI) calculations.

Severe malnutrition is also a frequent target for payer denials, so it really needs to be well supported clinically.

Lesser degrees of malnutrition—mild and moderate malnutrition—have a lesser degree of impact but are still important diagnoses from a coding standpoint.

Pulmonary and cancer cachexia are both underdocumented and can have significant impact, especially on ROM for elderly patients.

Underweight status is also rarely documented. When the patient’s BMI is 19 or less, documenting underweight status can affect reimbursement and expected LOS.

5. Acute post-op pulmonary insufficiency is a gem.

Acute postop pulmonary insufficiency is a gem because it is rarely documented. If documented precisely as acute, as pulmonary (not respiratory), as insufficiency, and as postop or “following a procedure,” this diagnosis can increase reimbursement and expected LOS, and it is not a PSI.

CDI specialists and coders may consider a query for acute postop pulmonary insufficiency when a patient is morbidly obese or has obstructive sleep apnea or a chronic lung condition such as chronic obstructive pulmonary disease, and when this patient has low oxygen saturation that requires maintenance on oxygen or when the patient is difficult to wean off oxygen in the postop period.

Acute postop pulmonary insufficiency should not be documented to avoid a PSI “ding” when acute postop respiratory failure really is the appropriate diagnosis.

If the patient does have acute respiratory failure in the postop period due to underlying comorbidities, documenting this clearly can preempt a query as to whether the respiratory failure was a complication.

Similarly, if the acute respiratory failure was due to anesthesia, documenting this clearly can preempt a query as to whether it was due to the procedure itself.
4. Delirium is a component or symptom of encephalopathy.

“Delirium” codes as disorientation, a symptom. It is a nonspecific term that has little value from a coding standpoint. Coding literature indicates that delirium is usually a symptom of some other condition—either a mental disorder or a nervous system disturbance.

“Postop delirium” codes as a mental disorder and is a comorbid condition. It has some value from a coding standpoint.

Toxic and metabolic encephalopathy are nervous system disturbances and major comorbid conditions. That means they have significant impact on reimbursement, SOI, ROM, and LOS.

If the patient has a change in mental status from baseline that improves with change in medications or treatment of an underlying metabolic cause, we look for documentation of the nervous system disturbance—toxic or metabolic encephalopathy—rather than the symptom of delirium.

3. Acute blood loss anemia has value, but so does drop in hemoglobin.

Surgeons have likely been queried about acute blood loss anemia so many times that it becomes tempting to document it after every surgery just to avoid a query. Unfortunately, that doesn’t work. Acute blood loss anemia is a target for payer denials, and certain criteria do need to be met to support coding it. Overdocumenting it may result in clinical validation queries.

Sometimes hemoglobin drops after a procedure, and it isn’t anemia. It isn’t due to the minimal intraoperative blood loss, either, but providers are monitoring with repeat lab work and watching for accompanying evidence that there might be ongoing bleeding. “Hgb 14.4➔11.7” can’t be coded, but “Hemoglobin dropped from 14.5 to 11.7, monitoring” can, and it adds value.

2. We are going to query about the path results, often post-discharge.

Outpatient coders can code directly from the pathology report, but the Official Guidelines for Coding and Reporting prohibit inpatient coders from doing so.

To complicate matters further, the Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

The “after study” diagnosis is often the diagnosis documented only in the pathology report. This means CDI specialists or coders ask physicians to document the clinical significance of pathology findings in the discharge summary even if the results were not available until after discharge.

Surgeons may be concerned about legal risk or the compliance of these queries. This concern is understandable and admirable, but unfounded.

It is compliant and necessary that the pathology findings be documented in the discharge summary, even if they became available after discharge, because the specimen was collected during that admission and the pathologic diagnosis is the diagnosis after study.

Unfortunately, copying and pasting the pathology findings into the discharge summary is not enough. We need a physician’s clinical interpretation of those findings.

1. We are concerned about more than reimbursement.

Another misconception I have encountered is that queries are only about reimbursement for the hospital. Reimbursement is a consideration. But our queries are about more than that.

We must follow all the coding rules, which means we may have to query for certain things to be documented in specific ways. We cannot assume much.

We also keep in mind things that affect hospital and physician quality scores. We pay attention to the expected to observed LOS and to SOI/ROM, and we’re concerned about PSIs and risk adjustment.

Queries take time to write and time to respond to, and time is as valuable as money. When we query, we focus on the things that affect your ability to care for your patients.

Editor’s note: Nehring is the inpatient lead coder at a large teaching hospital in central Illinois. Contact her at nehrings4@gmail.com. Opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries.
“Don’t be afraid to ask questions”

Danielle Forni, RN, BSN, is a CDI specialist at Brigham & Women’s Hospital in Boston and a member of the Massachusetts ACDIS local chapter. She has been in the CDI field for a year and four months.

**ACDIS: What did you do before entering CDI?**

**Forni:** I worked in clinical research for more than 10 years in both senior and managerial roles, which entailed the medical review of cardiovascular events/outcomes in both pharmaceutical and medical device clinical trials. Prior to that, I was a staff RN for nearly nine years at both a major academic medical center and a smaller community hospital working in different specialty areas/units: thoracic surgery step-down, hematology/oncology-bone marrow transplant, and medical-surgical telemetry. I also worked as a staff RN in a Coumadin®/anticoagulation clinic/cardiovascular specialist office.

**ACDIS: Why did you get into this line of work?**

**Forni:** I wanted to explore new challenges and opportunities within the healthcare industry, and I came across a job listing for a CDI specialist. The role of a CDI specialist sounded very intriguing to me and I wanted to learn more about how medical record review ties in with coding/billing, education, and improvement of medical practices. Also, it seemed from the job description that some of the skills that I had learned from clinical research could be applied to the CDI role. A former colleague of mine had a friend who is a CDI specialist in Texas, and she then put me in touch with him to get advice on how to pursue a position in the CDI industry.

**ACDIS: What has been your biggest challenge?**

**Forni:** I would have to say educating others both in and out of the medical field about the role of a CDI specialist and demonstrating the importance of our role in the healthcare industry.

**ACDIS: What has been your biggest reward?**

**Forni:** Working with an amazing group of healthcare professionals and leaders who encourage us to bring new ideas to the table and value our input on ways to improve CDI processes.

**ACDIS: How has the field changed since you began working in CDI?**

**Forni:** There’s been a shift to not only focus clinical review on DRG accuracy, but to also look at quality metrics and initiatives. Also, seeing more expansion of CDI programs to include outpatient reviews.

**ACDIS: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?**

**Forni:** Since I became an ACDIS member, I really enjoy the ACDIS Podcast: Talking CDI. I always try to listen live or on-demand as there has been great information on everything CDI such as news, current issues, best practices, etc.

**ACDIS: If you have attended, how many ACDIS conferences have you been to? What are your favorite memories?**

**Forni:** I was able to attend my first ACDIS conference back in May 2019 in Florida. I had an amazing time and really enjoyed meeting/networking with others who were new to CDI as well as seasoned CDI specialists/leaders. It was very interesting to get each
other’s perspectives on CDI and how their programs differ from where I work.

ACDIS: What piece of advice would you offer to a new CDI specialist?

Forni: Don’t feel overwhelmed; it will take time and effort before feeling comfortable in the role. Don’t be afraid to ask questions and develop a good relationship with clinicians as well as HIM/coding professionals.

ACDIS: If you could have any other job, what would it be?

Forni: I think I would have a job in archaeology as I am always fascinated with history and finding artifacts from the past.

ACDIS: What was your first job?

Forni: I got my first job at age 14 working in a warehouse for a small wig company. There were less than 10 employees, so everyone that worked there had to be a jack of all trades—from answering phones, processing/shipping orders, and mailing catalogs, to even styling wigs!

ACDIS: Can you tell us about a few of your favorite things?

- **Vacation spots:** Maine, Bermuda, Egypt, Greece, Italy, Spain, England.
- **Hobbies:** Collecting antiques/memorabilia, reading, crafts, watching football/hockey.
- **Non-alcoholic beverages:** Tea, flavored seltzer.
- **Foods:** Love Mexican and breakfast foods!
- **Activities:** Traveling, going flea markets/antique stores/shows, gardening, crafts, baking, attending concerts/musical theatre.

ACDIS: Tell us about your family and how you like to spend your time away from CDI.

Forni: I live on Cape Cod and have been married for almost eight years. My husband and I have two fur-babies, a golden retriever named Cassie and a Somali cat named Raj. Both my husband and I love to travel and go to flea markets/antique stores/shows.

ACDIS: Is there anything else you’d like to add?

Forni: Anyone that knows me knows that I am an avid Peanuts/Snoopy fan! 🐩