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What are the similarities and differences between CDI audits and coding compliance audits? Are both necessary? It’s our collective responsibility to provide the insight that defines the two specialties and the critical efforts both bring to the table.

A CDI audit may incorporate clinical validation within its scope of practice. Clinical validation audits are typically completed by a clinical practitioner, nurse, physician, or other medical provider. An article referencing coding audit trends in the Journal of AHIMA, June 2017, noted, “It is not the coder’s responsibility to decide whether to assign a code based on their interpretation of clinical criteria [...] ensuring required documentation and code assignment requires strong collaboration with HIM, CDI team, and physician liaisons.”

CDI audits identify when possible diagnoses aren’t specified but are clinically evident within the clinical data (lab reports, etc.) and medical record documentation. On the other hand, coding audits identify the accuracy and compliance of coded data, acuity level, and linking conditions as established by CMS and the ICD-10-CM/PCS Official Guidelines for Coding and Reporting.

While those auditing for CDI practices need to abide by the same code assignment rules as outlined within the coding conventions, Official Guidelines for Coding and Reporting and Coding Clinic, they aren’t required to code the record (although many hold coding credentials). Additionally, CDI audits often have a focus on patient quality, safety, and risk measures documentation capture. The October 2017 Official Guidelines for Coding and Reporting included the following comment:

“The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

Further, CMS distinguished between coding audits and CDI/clinical validation audits performed by clinicians (internal or external auditors) in the following summary:

“Coders must assign what is documented in the record by the provider. Clinical auditors identify what is clinically indicated and not captured in the documentation or if the diagnosis is noted, it is without identified clinical support to validate coding on the claim encounter.”

CMS provides MedLearn Matters fact sheets pointing to insufficient documentation typically triggered for a Recovery Auditor (RAC) denial, calling on CDI specialists and coders to query providers and rectify documentation deficiencies. Auditing and monitoring CDI and coding efforts uncovers potential RAC targets and offers insight into the documentation integrity and educational needs.

There aren’t distinctions between clinicians practicing as CDI auditors for a facility, practice, or provider, and those who perform the role as RACs for CMS or third-party payers. We’re clinical practitioners who clarify unspecified diagnoses when clinical signs, symptoms, and ancillary tests reveal additional severity, an acuity type, or a link to another diagnosis. Clinical practitioners who meet the criteria set forth by CMS may query the provider and supply education related to documented diagnoses lacking integrity, clinical validation, and/or enough detail for accurate code assignment.

Coding audits enable facilities to identify opportunities to improve code assignment and compliance with CMS guidelines. CDI audits identify chances for enhanced queries and missed opportunities. Both are needed to ensure our medical records are complete and accurate.

The blended model of CDI and coding audits promotes the highest documentation integrity and coding accuracy for inpatient and outpatient practices. Access to both resources and a defined process provides return on investment in patient safety and resources for care.

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