RACs request queries as complex reviews roll out
Clarify CDI policies about query retention

A June poll on the ACDIS website shows that only about 30% of facilities maintain their queries as a permanent part of the medical record, whereas 70% say they remove the queries once the physician clarifies the documentation in the record. The percentage of hospitals that retain their queries is up from a 2009 poll in which the split was closer to 20% retention vs. 80% non-retention.

The question of whether to retain queries as a permanent part of the medical record increased in importance this spring as recovery audit contractors (RAC) included queries on the list of records they requested as part of complex audits.

“Once upon a time, there were no query police, But times change,” said Catherine O’Leary, RN, BSN, managing director at CSG Health Solutions, LLC, in Mamaroneck, NY, during her June 3 presentation, “Making Sense of the New Integrity Auditors: RAC, MAC, MIC, and ZPIC,” at the third annual ACDIS conference in Chicago.

Board acknowledges RAC query requests

Two ACDIS advisory board members, Tamara Hicks, RN, BSN, CCS, CCDS, manager of care coordination at North Carolina Baptist Hospital in Winston-Salem, NC, and Heather Taillon, RHIA, manager of coding compliance at St. Francis Hospital in Beech Grove, IN, have both received RAC requests for their queries.

In January, CGI, Inc., the RAC for Region B (one of four RACs), requested documents related to 19 medical records on topics ranging from sepsis and extensive unrelated operating room procedures to aspiration pneumonia, Taillon explained during ACDIS’ February 18 quarterly conference call. “Their letter had a list of documents, and physician queries were included,” she said.

Connolly Consulting Associates, Inc., the RAC for Region C, requested a total of 46 medical records, Hicks said during the same call. Connolly’s requests were primarily DRG validation reviews on concerns similar to those Taillon described. (See “ACDIS members share RAC target topics” on p. 4.) Connolly also requested copies of related queries.

“If it is your hospital’s policy to include [queries] as a permanent part of the medical record, and [a RAC] requests the record, then obviously you’d have to surrender the query. Then what about those facilities who chose not to include...
the query as a permanent part of the medical record? Would you then still be obligated to submit your queries to the RACs?” Taillon asked.

After consulting with the facility’s legal department as well as its consulting firm Executive Health Resources, Hicks’ facility opted not to send the query forms to Connolly.

Deciding whether to include queries as a permanent part of the medical record “is controversial,” James S. Kennedy, MD, CCS, director of FTI Healthcare in Atlanta, said as part of a follow up conversation during the May 27 ACDIS quarterly conference call.

Some believe the whole point of CDI programs is to get the physician to document appropriately in the medical record. These facilities frequently design their query forms to reflect this by including a sentence asking the physician to respond to the query and document his or her response in the record. Such is the situation at North Carolina Baptist, says Hicks.

“Our policy is that the queries are not a permanent part of the medical record,” Hicks said. “We ask the physicians to document in the medical record and [then] we take those query sheets out.”

Leading questions cause concern

Some worry if the facility considers the query to be a part of the permanent medical record, it could cause compliance trouble due to continuing confusion regarding the definition of “leading queries.” (Read more about this problem in the director’s note on p. 5.)

If a governmental audit of queries reveals leading or misleading queries designed for financial gain, it could lead to larger-scale audits and governmental financial recoupment or, at worst, charges of False Claims Act violations.

“Once upon a time, there were no query police. But times change.”
—Catherine O’Leary, RN, BSN

“In my view, this is why facilities should include the queries as part of the permanent medical record,” says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance at HCPro, Inc., in Marblehead, MA. “That way auditors can see right in the medical record what documentation helped the coder get to a particular code. “The answer is to get your process right, not hide your query,” she says.

A July 2009, $2.75 million settlement between the government and Johns Hopkins Bayview Medical Center...
in Baltimore illustrates how leading queries can get facilities into trouble, Kennedy explained in his presentation, “Gray Areas in CDI: Negotiating the Relationship,” during the 2010 ACDIS conference in Chicago. (Read the report from the Department of Justice.)

CMS considers queries permissible. In a 2001 memorandum to its Quality Improvement Organizations (QIO), CMS stated that the physician query form was acceptable “to the extent that it provides clarification and is consistent with other medical record documentation.”

“If everyone is submitting compliant, non-leading queries that support the documentation in the medical record, then what does it matter if the RAC looks at them? If you wouldn’t want to send your query into the RAC, then you probably need to ask, ‘Why not?’ ” Hoy says.

Answering Hoy’s final question means taking a closer look at CDI processes for auditing facility queries, says Lynne Spryszak, RN, CPC-A, CCDS, CDI education director at HCPro, Inc., in Marblehead, MA.

“Facilities who do not currently have a written query policy and well-defined processes or those who do not have an audit system for their queries could take a hit under RAC review,” Spryszak says.

A CDI program may seem to be progressing well and working effectively, but “without an internal query auditing process, a facility could suffer at the hands of a ‘Lone Ranger’ out there writing random queries that are non-compliant,” says Spryszak.

Facilities should examine their query policies and processes and determine the best solution for their own program after consulting with their compliance department and their legal council. A number of sample policies and procedures have been posted by ACDIS members on the association’s website.

**CMS guidance murky**

CMS has been holding a number of open forum calls on the RAC program. Dubbed “Nationwide RAC 101 Calls,” these sessions cover the basics of RAC reviews, each focusing on a different provider area.

The first call on April 28, which was intended for all acute care facilities, offered some interesting insight as to CMS and RAC policy regarding recovery of the physician query during audits, says Hoy. Of particular interest were questions raised at the end of the program. (A transcript of relevant questions was included in the May 13 CDI Strategies.)

Callers expressed confusion over conflicting information from CMS regarding whether facilities were obligated to turn over their physician query forms to the RAC.

The agent explained that RACs may request any documentation “they feel is necessary to conduct the review.” However, “[i]f you don’t believe the physician query helps to support the claim that was billed, then you don’t need to submit it.”

The question and answer session left many with more questions than answers, Hoy says. Although CMS does not prescribe what documents RACs can or cannot seek, CMS says providers should submit any pertinent documentation that would support the claim.

“A simple decision from them as to whether the query is part of the medical record or not could alleviate that confusion,” Hoy says.

“But they didn’t say that during this call. Instead, CMS seems to have indicated that if the facility does not include the query as part of the permanent medical record, and if the query doesn’t support the claim, then the facility doesn’t need to submit the query to the RAC.”

### Are your query forms a permanent part of the medical record, or do you remove them?

- **We remove them after the physician clarifies**: 69%
- **We don’t have a policy on this**: 3%
- **They are a permanent part of the record**: 28%

*Source: ACDIS.*

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ACDIS members share RAC target topics

For most of 2009, while still in its demonstration phase, the Recovery Audit Contractor (RAC) program conducted automated reviews, which included an analysis of claims data that contained clear errors in payment, such as billing twice for a procedure that could be completed only once (e.g., removing a gallbladder).

But beginning in fall 2009, RACs began complex reviews of medical records likely to have been improperly paid due to lack of documentation or improper coding.

In December 2009, Connolly Healthcare, the RAC for Region C, announced its first targets—a list of 24 MS-DRGs—for complex review. (Read the related article in the January CDI Journal.) Other RACs released similar lists, and throughout the spring, reports of RAC record requests trickled in.

“We’ve been waiting by the mailbox to get these RAC [record request] letters, and they didn’t come, and they didn’t come, and they didn’t come, and finally they came,” Catherine O’Leary, RN, BSN, managing director at CSG Health Solutions, LLC, in Mamaroneck, NY, said during her presentation, “Making Sense of the New Integrity Auditors: RAC, MAC, MIC, and ZPIC,” at the third annual ACDIS conference in Chicago. “The chart reviews are in progress and medical necessity reviews are coming.”

During the May 27 ACDIS quarterly conference call, one Maine resident said she received a request for seven charts for DRG validation. All but one requested records for DRG 189, principal diagnosis of respiratory failure. “I think the reason they requested these was because acute respiratory failure was the secondary diagnosis but it was the only MCC,” she said.

A North Carolina CDI specialist said his RAC requested 87 charts from his facility. Records requested included those for common CDI concerns, such as sepsis related to one- and two-day stays, and, similar to the individual from Maine, cases in which only a single MCC was reported.

A Michigan CDI specialist said her facility received a request for 20 records related to extensive operating room procedures, a variety of respiratory system DRGs, and major joint replacements.

“As you get these RAC requests, there’s bound to be the fear—the ‘Oh, I’m not perfect and we’re going to fail’—insecurity,” James S. Kennedy, MD, CCS, director of FTI Healthcare in Atlanta, said during the call. But CDI specialists should take solace in the fact that their primary role is to improve the physician documentation and related coding that the RACs are reviewing now, he said.

“We’ve been waiting by the mailbox to get these RAC letters, and they didn’t come, and they didn’t come ... and finally they came.”
—Catherine O’Leary, RN, BSN

“This is why we are—why CDI—is so important. We’re looking at the record directly. We’re helping physicians with definitions of terms. We’re making certain that what they write in the record is supported by credible literature that supports that definition of terms. We’re helping standardize the language, get it documented in the record, and code it correctly. All this is absolutely crucial to our mission in CDI,” Kennedy said.

In her presentation, O’Leary warned against complacency, and not just with RACs but with a host of governmental audits. Medicare administrative contractors (MAC), Medicaid integrity contractors (MIC), and zone program integrity contractors (ZPIC) all have governmental authority to audit facilities in search of overpayments or potential fraud.

“Okay, we’re ready for the RAC; now we need to be prepared for the MAC,” said O’Leary. CDI programs can help if they remember to focus on “the right things—appropriate documentation in the medical record. ... Remember, the correct coding and appropriate reimbursement will follow when the documentation is as complete and accurate as possible,” she said.
Hello ACDIS members,

Since the last issue of CDI Journal, an important development has occurred in the industry: the release of the AHIMA documents “Guidance for Clinical Documentation Improvement Programs” (commonly referred to as the CDI Practice Brief) and the Clinical Documentation Improvement Toolkit.

These documents provide an overview of critical elements of a successful CDI program and help establish a baseline for compliant queries (see the related article on p. 7). Since the release of these documents, I’ve received many questions from the ACDIS membership, including whether CDI professionals are obligated to follow the AHIMA guidance and what ACDIS’ official response or position is. Previously, I noted that although four ACDIS advisory board members participated in the work group (and I remain very grateful to AHIMA for the opportunity to include ACDIS’ input in the process), this did not imply our association’s blanket approval.

On June 2, prior to the third annual ACDIS conference in Chicago, 13 members of our 20-member advisory board met to discuss the work of the AHIMA CDI Work Group. We reviewed comments from the membership and aired our own concerns and thoughts. In general, I and the ACDIS advisory board support the work of AHIMA, including its practice brief. The advisory board voted 12-0 (one member was absent during the vote) on behalf of our membership to support the AHIMA CDI Practice Brief in the following counts:

» AHIMA is a member of the four ICD-9-CM cooperating parties (the other three members are the AHA, the National Centers for Health Statistics, and CMS)
» ACDIS had representation and leadership on the committee that created the CDI Practice Brief
» The brief recognizes that CDI is a collaborative process of clarifying ambiguous, conflicting, or incomplete clinical documentation; thus, it is not limited to a particular profession
» The brief acknowledges and affirms the equal role of multiple disciplines in CDI, including physicians, nurses, and HIM/coding professionals

ACDIS believes that the CDI profession is multidisciplinary and that CDI specialists serve to bridge the gap between physicians and coding staff (i.e., clinical language and the language of ICD-9). Ideally, they should clarify documentation in the medical record, regardless of its impact on reimbursement, across all payers. Our board reaffirmed that ACDIS is not a nursing organization or an HIM organization. It is an association for CDI specialists, irrespective of their backgrounds. All that matters is whether the CDI specialist has the training and education to do the job.

Leading vs. non-leading remains unsettled

The debate over what constitutes a leading vs. non-leading query still exists, and ACDIS is still working on the issue.

continued on p. 6
In its “Guidance for Clinical Documentation Improvement Programs,” AHIMA describes a non-leading query as follows:

Regardless of format, a query is never intended to lead the provider to one desired outcome. The query must provide reasonable clinically supported options, include clinical indicators, and must not result in a yes/no answer (with the exception of present on admission status). They must include the option that no additional documentation or clarification can be provided.

The majority of the board believes that no one, regardless of their level of expertise, should ask a physician to confirm whether a patient has a single diagnosis using the format of a yes-or-no answer. Therefore, a direct question that can be answered in this manner is never permissible.

However, other CDI specialists, including some members of the ACDIS advisory board, maintain that a CDI specialist may ask a physician a direct question leading to a yes-or-no answer as long as clinical indicators and supporting evidence of the diagnosis are documented in the medical record. Their interpretation of a leading query is asking a physician to put a diagnostic term in the medical record that has no basis in fact. The debate over what constitutes a leading query continues, but we’ll keep working on that. It may require petitioning the Office of the Inspector General or CMS for more guidance on the issue. It may be decided in the courts.

Know that ACDIS will continue to bring this issue to the forefront and seek clarity for the benefit of its members. In the meantime, the ACDIS advisory board strongly encourages the membership to consult legal counsel to ascertain whether their query processes would survive a rigorous review by an outside auditor. As always, please feel free to call or e-mail me with any questions you may have.

Respectfully,

Brian J. Murphy, CPC
Director, ACDIS
bmurphy@cdiassociation.com
781/639-1872, Ext. 3216

AHIMA’s CDI Work Group

The following individuals participated in a yearlong collaboration with AHIMA to create guidance and programmatic tools for CDI programs:

1. Maria Alizondo, BBA-HA, RHIT  
2. Rhonda Anderson, RHIA  
3. Danita Arrowood, RHIT, CCS  
4. Sheila Bowlds, MBA, RHIA  
5. Elizabeth Brady, RHIT, CCS  
6. Glorianne Bryant, RHIA, CCS, CCDS **  
7. Christine Catalan-Butvich, RN  
8. Kathy DeVault, RHIA, CCS, CCS-P **  
9. Michelle Dragut, MD, CCS  
10. Rose Dunn, RHIA, CPA, FACHE  
11. Cheryl Ericson, MS, RN **  
12. Paula Frost, RN, CTR  
13. Gail Garrett, RHIA **  
14. Susan Garrison, CHCA, CHC, CCS-P  
15. Chad Guidry, RHIA, CCS  
16. William E. Haik, MD, FCCP **  
17. Robin Holmes, MSN, RN **  
18. Marilyn Jones, MBA, MN, RN, CCS  
19. Jenna Jordan, RHIA  
20. Christine Karaman-Meacham, MAS, RHIA  
21. Collette LaClair, RN, CPC  
22. Eve-Ellen Mandler, RHIA, MS, CCS **  
23. Gail Marini, MM, RN, CCS *  
24. Carol Osborn, PhD, RHIA  
25. Sheila Peterson, RHIA, RN, CPC  
26. Richard Pinson, MD, FACP, CCS  
27. Chuck Terzian, MD, MPH, MJ  
28. MeChelle Walker  
29. Kathleen Wall, MS, RHIA  
30. Susan Wallace, MEd, RHIA, CCS  

* Indicates ACDIS board member  
** Indicates practice brief committee
AHIMA releases new CDI guidance, offers tools for programs

Two new publications from AHIMA offer guidance and best practices for CDI programs. The Clinical Documentation Improvement Toolkit, released in April, and the “Guidance for Clinical Documentation Improvement Programs” (aka the CDI Practice Brief), released in the May Journal of AHIMA, outline CDI job descriptions, provide examples of leading and non-leading queries, and suggest policies for verbal and written physician queries.

With the releases, AHIMA aimed to create solid guidelines for the CDI profession, including adding further specificity to the gray area of physician queries. The guidelines needed to be specific enough to be useful but broad enough to allow facilities to make necessary adaptations, says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM (NCAL revenue cycle) for Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA. Bryant, an ACDIS advisory board member, served as AHIMA CDI Work Group cochair and as an author of AHIMA’s CDI Practice Brief.

Project genesis

When AHIMA first released a draft of its proposed guidance for physician queries in summer 2008 for public comment, the response was tremendous, says Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources at AHIMA. AHIMA took the comments it received at the time under consideration when it released “Managing an Effective Query Process” that September.

The public’s feedback illustrated the need for additional resources in the industry, DeVault says. So in January 2009, AHIMA sought volunteers to sit on a new CDI Work Group aimed at discovering what additional support industry professionals required.

More than 100 volunteers applied. To choose who ultimately joined the Work Group, DeVault reviewed volunteers’ résumés, sought ACDIS’ recommendations, and weighed input from AHIMA’s own staff.

“We wanted to be sure we had a diverse group and some fresh voices,” DeVault says. Ultimately, AHIMA chose 30 CDI-related professionals, including physicians, HIM managers, and CDI specialists.

AHIMA initially hoped to compile the volunteers’ research into a large volume or book, but “settled on a number of different venues to disseminate the results of their year’s worth of collaboration” for a variety of reasons, DeVault says.

First, the volunteers felt strongly that the advice be provided openly and freely on the AHIMA website. Second, they wanted to deliver the information quickly, and book projects can take a year or more to reach fruition.

So the group of 30 divided into subgroups to concentrate on specific tasks. Some worked on the toolkit; others worked on proposed ethical guidelines for CDI, yet to be released.

The document “Guidance for Clinical Documentation Improvement Programs” came from the efforts of a seven-member committee, which included DeVault and three members of the ACDIS advisory board (see the complete list of participants on p. 6).

“The energy of this group was just like a ball rolling downhill; they just kept gathering momentum. They were so enthusiastic,” DeVault says.

The 41-page AHIMA CDI Toolkit offers sample job descriptions for CDI specialists and physician advisors to CDI,

continued on p. 8
provides definitions for documentation clarifications and sample queries, and offers guidance on how to establish the structure of a CDI program and measure CDI success.

Much of the guidance and toolkit contents echo commonly held CDI best practices regarding program structure, staffing, and query policies. The releases complement AHIMA’s previous query guidance “Managing an Effective Query Process” and its 2001 “Developing a Physician Query Process” but do not replace those documents.

Program staffing

Both the toolkit and guidance suggest that HIM professionals, physicians, nurses, and others with clinical and coding backgrounds make good candidates for the CDI role, and that depending on the needs of the organization, CDI programs can a mix of professional backgrounds.

DeVault notes that the guidance went through a thorough vetting process, earning approval from the volunteer board that created it, the AHIMA leadership, and the AHIMA practice councils, which include HIM volunteers.

During its June 2 meeting in Chicago, ACDIS advisory board members voted to support the majority of the contents of the CDI Practice Brief, in particular its emphasis that CDI is a multidisciplinary profession. (Read more on ACDIS’ position on the releases in the director’s note on p. 5.)

“CDI is a collaborative effort,” says Robin Holmes, MSN, RN, CCDS, manager of CDI at DCH Health System in Tuscaloosa, AL. “We need to show respect for [all] disciplines.”

Query consensus

The practice brief takes up the issues of leading vs. non-leading queries, offers a checklist for conducting compliant written and verbal queries, and acknowledges the importance of the verbal query process.

“I still struggle with the verbal query process myself,” DeVault says. “CDI programs need to know how to measure and manage the verbal process, and that’s somewhat ambiguous.”

Many worry that without the verbal query tool, an important aspect of the CDI specialist’s role could be lost. As the AHIMA guidance states:

“The advantage of a verbal query is the [CDI specialist’s] ability to interact with the provider to facilitate understanding of the issues that need to be addressed. However, caution must be used to ensure that the provider is allowed to make his or her own conclusions regarding the appropriateness of a particular diagnosis or service.

The practice brief recommends that CDI managers train their staff on the verbal query process, track instances of verbal queries, and review verbal query policies as part of CDI program quality assurance measures.

The guidance suggests that organizations should create a verbal query policy that includes the following:

- When verbal queries are appropriate
- A process for documenting verbal queries
- A quality assurance process for verbal queries, including:
  - Who will monitor the verbal queries
  - How many queries will be reviewed for compliance and how often
  - Feedback and corrective action needed
  - Reporting documents for CDI quality assurance processes

Although debate still continues about the definition of leading vs. non-leading queries, Work Group members expressed a measure of pride regarding the work it accomplished on the matter.

“It is easy to cross that line into potentially leading the physician to a particular diagnosis when you are in the hallway having a conversation. So I’m really happy for the leading and non-leading query examples. We worked really hard on those to make sure we offered clinically valid presentations of both,” DeVault says.

Guidance implications

As one of the four cooperating parties in conjunction with the AHA, National Center for Health Statistics, and CMS, which work together to clarify ICD-9-CM medical coding guidelines, some perceive that AHIMA’s CDI guidance possesses additional regulatory weight.

It’s one reason “people take our releases pretty seriously,” DeVault says. “But this isn’t meant to be a standard like a release from Coding Clinic would.”
ACDIS comments to CMS on FY 2011 IPPS proposed rule

Editor’s note: The ACDIS advisory board submitted the following comments to CMS June 15 regarding three issues in the FY 2011 IPPS proposed rule.

June 15, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1498-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Ms. Tavenner:

The Association of Clinical Documentation Improvement Specialists (ACDIS) is pleased to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed changes to the Medicare hospital inpatient prospective payment system (IPPS) and proposed fiscal year (FY) 2011 rates, as published in the May 4, 2010, Federal Register (CMS-1498-P).

ACDIS is a professional association representing more than 1,800 clinical documentation improvement (CDI) professionals nationwide. Their backgrounds include registered nurses (RN), health information management (HIM) professionals, case managers, quality improvement personnel, and physicians.

CDI professionals work to ensure complete and accurate documentation in the medical record, which is integral to accurate assignment of ICD-9-CM diagnosis and procedure codes and the Medicare Severity diagnosis-related groups (MS-DRG) discussed in this proposed rule. Their work also helps to ensure the accurate reporting of quality measures, medical necessity of inpatient admissions and procedures, hospital and physician profiles, and other publicly available data.

Our detailed comments and rationale on the FY 2011 IPPS proposed rule are below.

Proposed FY 2011 MS–DRG documentation and coding adjustment (p. 23872)

ACDIS understands but does not support the concept of the documentation and coding adjustment (DCA). We also believe that the calculation of the DCA, based upon MedPAR data and not chart reviews, is faulty.

ACDIS believes that the current methodology of a uniform, across-the-board reduction unfairly penalizes hospitals with true rises in patient severity and actual case mix. For example, a facility may implement a new surgical service line that leads to an appropriate increase in actual case mix. We also believe that the DCA is antithetical to CMS’ statement in the 2008 IPPS final rule that improved documentation and coding practices are not only legitimate, but encouraged:

We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record. In its public comments, MedPAC recommended an adjustment for improvements in documentation and coding and also noted that hospitals’ efforts to improve the specificity and accuracy of documentation and coding are perfectly legitimate.

In addition, entities such as recovery audit contractors are already responsible for recouping improper payments and, coupled with the DCA, hospitals in effect must pay back monies twice to CMS.

If CMS does intend to move forward with the DCA, ACDIS would support a more refined DCA methodology that does not penalize hospitals with compliant, ethical CDI programs that promote improved documentation throughout the medical record.

ACDIS asks CMS to consider a governed DCA, which allows hospitals an allotted case mix increase in a given year, but if the hospital’s case-mix index (CMI) increases too much, CMS will attenuate it (i.e., regulate the increase).

A similar approach is currently used by Maryland under the All Patient Refined® (APR)-DRG system.

continued on p. 10
The system is explained here: http://tinyurl.com/Maryland-DCA-Methodology.

ACDIS believes the Maryland system takes into account individual hospitals’ documentation and coding practices and that CMS should consider adopting its tenets on a national basis for FY 2011.

ACDIS is not advocating that CMS adopt the APR-DRG system, but that it should consider a similar tiered approach to limiting CMI increases that occur without a corresponding change in service line or an increased utilization of resources.

Proposed change to the severity level for acute renal failure, unspecified diagnosis code (p. 23907)

ACDIS strongly opposes CMS’ proposal to reduce the classification of ICD-9-CM code 584.9 (acute renal failure, unspecified) from an MCC to a CC. We note that the current definition of 584.9 is inadequate to identify true MCC cases and the cost of the resources used to treat these severely ill AKI patients.

To reclassify code 584.9 as a CC would penalize tertiary facilities that accept severely ill AKI patients that require expensive resources, such as dialysis.

ACDIS agrees that the definition of conditions assigned to code 584.9 is inadequate, as it encompasses patients with small or large elevations of creatinine that still meet the definition of acute kidney injury (AKI) within the RIFLE/AKI network criteria. Furthermore, code 584.9 does not identify severe cases requiring dialysis, given that the assignment of a dialysis procedure code does not affect CC or MCC assignment.

ACDIS proposes that CMS postpone this reduction in classification until the existing code set is refined to encompass patients in various stages of acute renal failure. ACDIS plans to petition the National Center for Health Statistics (NCHS) to expand 584.9 to include a fifth digit to account for the stage of renal failure, which would allow for different gradations of the stage of the change. For example, NCHS/CMS could consider the following:

- 584.90 – AKI, unspecified (not a CC)
- 584.91 – AKI, stage 1 (a CC)
- 584.92 – AKI, stage 2 (a MCC)
- 584.93 – AKI, stage 3 (a MCC)

Alternatively, AKI could be staged with the 5th digit of category 584, with the 4th digit representing the underlying renal pathology. If the renal pathology is not specified, then 584.9x would be appropriate.

Expanding 584.9 to account for the various stages of acute renal failure encourages specificity in physician documentation and supports appropriate reimbursement for hospitals that treat patients with very severe levels of renal damage.

While some AKI patients are only treated with IV fluids and are not dialyzed, encompassing the largest cohort of AKI patients in the United States, studies have shown that these specific patients still carry an overall mortality risk of 2.8 to 13%—a much more severe risk of death than any other existing complication and comorbidity (CC).

While other AKI patients may not require dialysis, they do require considerable additional care and monitoring. Other AKI patients require full dialysis, either temporary or permanent, the costs of which would not be covered given that dialysis does not affect CC or MCC assignment.

Published mortality data for AKI shows a range from 2.8 for stage 1 to 77% for stage 3 AKI. For example, in the following study published by Shock, “Injury, Inflammation, and Sepsis: Laboratory and Clinical Approaches,” hospital mortality was 34% (18/53) for non-AKI patients, 40.6% (13/32) for RIFLE-R, 73.7% (14/19) for RIFLE-I, and 76.5% (13/17) for RIFLE-F (chi-square for trend; P < 0.001). In all patients, RIFLE severity correlated with mortality.

You can view the report here: http://journals.lww.com/shockjournal/Fulltext/2009/02000/Rifle_Classification_for_Predicting_in_Hospital.6.aspx.

Acute Kidney Initiative Network definition

In the following article by Renal and Urology News, AKI cases were identified from laboratory data using an adaptation of
the Acute Kidney Initiative Network definition. AKI events were classified by stage (1, 2, or 3).

Of 864,933 hospitalizations, 82,711 involved AKI (stage I: 52,338; stage II: 19,771; stage III: 10,602). A total of 17.4% of patients died (29.8% with AKI and 16.1% without), reported investigators at the Canadian Society of Nephrology Annual Meeting in Edmonton, Alberta. AKI was associated with a 41% increased risk of death after adjusting for confounders. Mortality risk rose with increasing AKI stage: 36%, 46%, and 59% greater risk with Stage I, II, and III AKI, respectively.


ACDIS notes that chronic kidney disease (CKD) codes were recently expanded from chronic renal failure (585) into CKD stages I–V (585.1–585.5); CMS should adopt the same approach with AKI. It is premature to penalize hospitals for the deficiencies of ICD-9-CM with a downgrade of 584.9 from an MCC to a CC. Changes to the ICD-9-CM system (p. 23912)

ACDIS strongly opposes the proposal to freeze changes to the ICD-9-CM coding system effective for fiscal year 2012. Accurate, specific code assignment is a prerequisite for accurate physician and hospital profiling and value-based purchasing.

Since hospitals will have their risk-adjusted outcomes measured, and physicians will have their efficiency measured, CMS needs to work vigorously with the ICD-9 cooperating parties to encourage higher specificity of diagnoses.

ACDIS notes that the Institute of Medicine will soon publish its recommendations influencing how CMS will implement its hospital and physician value-based purchasing program.

Kathleen Sebelius’ letter announcing this report may be viewed here: www.wsha.org/files/SebeliuslettertoQualityCareCoalition.pdf.

In a listening session regarding physician value-based purchasing sponsored by CMS last fall, ICD-10’s weakness in establishing an episodic grouping methodology was fully discussed.

A transcript of this discussion is available on the CMS website: www.cms.gov/PhysicianFeeSched/downloads/Listening_Session_Files.zip.

ACDIS notes that ICD-10-CM is an imperfect system and that refinements to ICD-9-CM should be carried over to ICD-10 prior to its implementation date of October 1, 2013.

For example, ICD-10 has only one code for coronary artery disease and not separate codes for one, two, or three vessels. This harms the ability to predict risk-adjusted outcomes in patients with ischemic coronary artery disease. ICD-10 also does not account for uncontrolled diabetes or malignant hypertension, for example.

The best interest of the United States is a code set which allows providers to capture this and other critical data. ACDIS is on the ground working with coded data as it relates to quality, coding, case management, and compliance. Upgrades should therefore be made to both code sets simultaneously. A code freeze would deny that opportunity.

ACDIS urges CMS to continue to work on refining ICD-9 and mapping those changes to ICD-10. We encourage CMS to continue to be proactive in refining ICD-10 for the purpose of physician and hospital value-based purchasing.

Conclusion

ACDIS wishes to thank CMS for the opportunity to provide commentary on the proposed changes to the Medicare hospital IPPS for FY 2011.

If ACDIS can provide any additional information or answer further questions or concerns, please contact Brian Murphy at 781/639-1872, Ext. 3216, or by e-mail at bmurphy@cdiassociation.com.

Sincerely,

Brian J. Murphy, CPC
Director, ACDIS

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Case study

Alternative staff schedules offer CDI opportunities

When the University of Medicine and Dentistry of New Jersey (UMDNJ) hired Melanie Halpern, RN-BC, MBA, CCDS, CCRA, to implement a clinical documentation and coding integrity (CDCI) program, administration allotted three full-time positions to staff the 550-bed academic medical center.

When Halpern conducted interviews, she thought she had found the perfect candidate. But there was a catch: The individual lived three hours away, which was too far of a commute to make the typical nine-to-five, five-days-per-week schedule feasible. So Halpern asked the advice of Atlanta-based FTI Healthcare Consulting, which UMDNJ hired to establish its CDCI practice.

Case study

Alternative staff schedules offer CDI opportunities

“How can someone be on top of their game after eight hours on duty?”
—Melanie Halpern, RN-BC, MBA, CCDS, CCRA

“At the time, we didn’t have any clients that used an alternative scheduling program,” says Marion Kruse, RN, MBA, director at FTI. So Kruse and Halpern started exploring various options.

A sound CDI program can’t be built on the needs of a single staff member, regardless of his or her qualifications, says Kruse. Thus, “you have to build the business case for a flexible schedule based on the program’s overarching needs and the benefit of that role to the facility,” she says.

“The question became, ‘Can we break free from the Monday-through-Friday regime and maybe get six days of coverage or find another benefit to help the overall program?’” Halpern says.

Halpern developed three options to illustrate how the CDI program might function. (See the scheduling tool on p. 14 or download Halpern’s spreadsheet from the Forms & Tools Library on the ACDIS website.) These options are as follows:

» Three full time equivalent (FTE) staff working four 10-hour days
» Three 12-hour shifts
» A typical five-day, 7.5-hour-per-day schedule

Pros

Fluctuations in census and length of stay made Halpern’s argument for an alternative staffing schedule somewhat easier. Furthermore, she discovered that Tuesdays through Thursdays were the busiest times of the week at the facility.

Patients may feel sick over the weekend but wait until Monday to call the doctor, Halpern explains. The patient sees his or her primary care physician on Tuesday and comes to the hospital either Tuesday afternoon or Wednesday. Any observation status cases could complicate that timeline, she says.

“That pushes us to Saturday,” says Halpern. “If I have someone there during one of the weekend days, it gives me a big head start when the rest of the staff comes in on its regular Monday routine.”

“If you are advocating coverage six days a week, then it would be a no-brainer to go with a 12-hour shift [three days working and four days off],” Kruse says. “There’s a business case to be made for capturing Friday afternoon admissions and surgery cases on Saturday or capturing cases that might otherwise be missed.”

Furthermore, a CDI program may decide to employ an alternatively scheduled staff member to, as Kruse describes it, “act as a sweeper on a soccer team” to work the facility’s busiest days and “pick up the cases that the rest of the team can’t get to.”

Under such a scenario, a CDI manager or director would need to carefully review the facility’s census patterns and physician rounding habits to accurately determine the department’s needs.

Since a 12-hour schedule can be grueling, Halpern suggests breaking up the monotony by diversifying CDI specialists’ tasks to include physician education and assessment of query trends. So rather than review case after case, hour after hour, this person could review cases for eight hours per day and attend to other responsibilities during the remaining time.
“They could look through the previous month’s sepsis or congestive heart failure queries, for example, and identify documentation trends or missed query opportunities and bring those back to the team for discussion,” says Halpern.

Early morning or evening hours can be ideal times to connect with typically overscheduled staff such as physicians and coders, Halpern says.

“You can have a great conversation with a physician at 7 a.m. when it’s quiet in the hospital before he or she gets too busy,” she says.

In addition, CDI specialists may find it easier to meet with coding staff during their off hours.

**Cons**

Each staffing model has its drawbacks. For example, in option one (CDI staff working 10-hour shifts four days per week) staff members cover floors every other day, and documentation reviews of short stays could be missed, Kruse says.

Additionally, if a CDI specialist submits a query on Monday but does not return to that floor until Wednesday, he or she could miss an opportunity for a beneficial physician interaction or assurance that a query has been answered, Kruse says. On the other hand, this model allows the facility to have a CDI staff member available seven days a week.

Under option two (a 12-hour, three-days-per-week schedule), the biggest concern is staff fatigue, Halpern says.

“Clinical documentation improvement requires a lot of attention to detail. Specialists need to be able to review a lot of information, analyze what they’ve read, and ask the appropriate questions using the specific clinical indicators to back them up. How can someone be on top of their game after eight hours on duty?” Halpern says.

In addition to brain fatigue, Kruse worries about CDI specialists’ ability to complete their work. She advocates for CDI staff to “own” a patient record once they’ve started looking through it to prevent passive diffusion of responsibility. If a specialist were to work a three-day schedule, the other team would have to pick up the specialist’s cases on day four if the patients were still in the facility.

“As that [specialist] moves in and out of the facility, do they end up leaving CDI work for the next CDI specialist to cover?” Kruse asks.

The answer to that problem may be added monitoring. A CDI manager would need to perform due diligence and be vigilant in conducting regular monitoring of operational and outcome measures.

“We’ll have to go back and look at these cases in a more analytical way to make sure that nothing is being missed,” Halpern says.

Kruse says that programs choosing this method should pay careful attention to the following warning signs:

» Decreases in the number of initial and follow-up reviews
» Increases in the number of cases without a CC or MCC in the face of decreasing query rates
» Changes in the case assignment to DRGs within the key pairings/triad that the Office of Inspector General has traditionally monitored
» Decreases in the number of expired cases that do not have a severity of illness and risk of mortality score of three or more

“**You can have a great conversation with a physician at 7 a.m. when it’s quiet in the hospital.**”

—Melanie Halpern, RN-BC, MBA, CCDS, CCRA

“That’s the quickest way to see if your staff is doing a thorough job,” Kruse says.

Additional assessments used to determine staff efficiency include:

» Retrospective query rate (post-bill)
» Open queries

“If staff members working alternative hours fall outside of the expected productivity benchmarks, then you may need to address those concerns one-on-one with the employee,” Kruse says.

A manager should retain the right to revoke flexible scheduling or amend schedules if the work isn’t being performed in an acceptable manner, Halpern says.

“But I hope that the discussion, that putting the options out there, will help to break the mold,” she says. “It could be a real opportunity under the right circumstances.”
Scheduling tool

For [Your Hospital Name Here]

CDI flex scheduling tool

Flex schedule template assumptions:
The purpose of this assessment is to analyze the feasibility of allowing [X number] CDI staff to opt for flex scheduling, based on cases reviewed and days/hours worked.

1. Supervisor/director retains decision/discretion to approve flex schedules on the basis of caseload and staffing requirements.
2. Utilizing flex scheduling may allow CDI staff to increase availability to physicians for questions/support over more day(s) per week compared with a traditional five-day schedule.
3. CDI staff with flex scheduling (either four 10-hour shifts or three 12-hour shifts) agree to work as needed on a weekend day, at the discretion of the supervisor/director, in order to cover caseload, physician questions, support, and training.
4. CDI supervisor’s time devoted to concurrent chart review/queries is established as 0.4 FTE (as shown by reduced hours and caseload).
5. Wednesdays will be designated as full staff days when possible (for CDS training, communications, meetings, etc) at the discretion of the supervisor/director.
6. Productivity assessment using quantitative chart review is but one measurement in the CDS responsibility pool; it may be more important to use time to educate physicians.

Option 1: 3 CDI staff on four 10-hour shifts plus 0.4 FTE. Supervisor: 2.18 charts per hour (per CDI staff).

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Total hours per week 157.5
Total cases per week 344
Option 2: Three CDI staff on three 12-hour shifts plus 0.4 FTE. Supervisor: 2.13 charts per hour (per CDI).

**Week ending: 7/17/10**

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**Total hours per week**: 150

**Total cases per week**: 320

Source: Melanie Halpern, RN-BC, MBA, CCDS, CCRA, UMDNJ, The University Hospital, Newark, NJ

Option 3: Traditional model: 3 CDI staff on seven 7.5-hour shifts plus 0.4 FTE. Supervisor: 2.16 charts per hour (per CDI).

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**Total hours per week**: 150

**Total cases per week**: 320

Source: Melanie Halpern, RN-BC, MBA, CCDS, CCRA, UMDNJ, The University Hospital, Newark, NJ
The art of physician communication

by Steven Robinson, RN

Most physicians want to provide an accurate written picture of their patients, and many believe that they document effectively and consistently. However, when queried by a CDI specialist, physicians often require help to understand exactly what needs to be further explained in their documentation and why.

This presents an opportunity for the CDI specialist to explain CMS’ inpatient prospective payment system (IPPS) documentation regulations and the effect physician documentation has on data collection and reported patient care. It is Maxim’s belief that CDI specialists, hospitals, and physicians share a common goal—to accurately reflect true patient acuity, which includes MS-DRG relative weight, severity of illness (SOI), and risk of mortality (ROM).

As many CDI specialists know, physicians often struggle with regulatory methodology compliance mandated by CMS and the AHA to demonstrate accurate patient SOI. MS-DRGs, APR-DRGs, AP-DRGs, and APS-DRGs are examples of payment bundling systems that categorize coded diagnoses depicting a severity profile. The physician/documentation disconnect comes when the physician’s perceived “complete and accurate clinical picture” does not equate to the required documentation needed in the IPPS severity profile. As a result, CDI specialists may have difficulty demonstrating how clinical documentation can directly affect:

» The physician’s individual, practice, specialty, and hospital current and future SOI/ROM profiles and process acuity (case-mix index, CC capture rates, diagnostic ratios, etc.)
» Placement of the patient in the appropriate venue of care according to medical necessity guidelines (i.e., qualifying for inpatient vs. outpatient vs. observation status)
» Accurate reimbursement for the care provided and resources consumed

If physicians can grasp the fundamental purpose behind the CDI specialists’ questions, they will be more understanding of the CDI process, more deliberate in the documentation they provide, and more accepting of the queries generated by CDI staff.

Build relationships proactively

To enlist the cooperation of the physician, a personal introduction will go a long way. CDI specialists should be sincere, confident, and cooperative when initiating a relationship with the physician.

Relationships are built through trust in what is said and actions that are observed, and physicians are great observers. CDI specialists should be sure their actions are always professional with physicians, fellow colleagues, and the patient population. In addition, the more succinct and targeted CDI staff can be with physicians, the more they will entrust them with their time.

Gaining physician cooperation requires the CDI specialist to be strategic. Sometimes it takes several attempts for CDI specialists to clarify a diagnosis or garner documentation on a particular case. The physician may respond, but may not do so completely or with adequate specificity. In such instances, CDI specialists should follow up with the physician by providing direct education (factual, prepared, and intentional information) and by providing focused communication demonstrating how documentation clarity can influence profile accuracy and more appropriate E/M levels. Such actions represent what Maxim considers an industry best practice.

Private, one-on-one discussions reviewing case examples of CDI process outcomes (CC/MCC capture, principal diagnosis, principal procedure influence, severity profiles, and E/M level changes) can be a successful method to help build a strong IPPS foundation and educate physicians.

The goal is to create a relationship in which the physician seeks out the CDI staff once he or she finds value in the CDI work. Valued communication is information that the physician cannot get elsewhere, including profile results, comparative study data, specific rules around documentation, and E/M facts that coincide with DRG queries.

Be prepared when talking with a physician about a specific patient’s documentation. Physicians need to understand that the CDI specialists’ questions are legitimate and that
their responses will influence their private practice as well as the SOI/ROM for the patient. Therefore, it is best to have the medical record readily available to directly point out documentation that is not complete.

Furthermore, talk facts. If you have scheduled a meeting with a physician concerning a specific issue (e.g., query response rates, specific CC/MCC capture rates, or specific criteria surrounding a diagnosis), use internal comparisons of colleague data (with names omitted). Use recent internal metrics reports, including DRG reports, query reports, and PEPPER reported data, that can help the physician gain a greater understanding of the potential benefits of documentation clarity.

The best action plan does not dwell on the past. If you schedule a meeting, be proactive and think about the next step in the discussion. Have your suggestions for improvements in place, but be open to modification.

**Employ multifaceted educational tactics**

There are many ways to address and educate physicians about documentation best practices. They include:

- **Grand rounds.** Build credibility by discussing specific cases from a CDI perspective while making rounds with the physician. CDI staff can explain how specific documentation can help justify resources, demonstrate a higher SOI/ROM, and improve patient care.
- **Posters.** Visual posters on performance grab attention. Display a poster in the nurses’ or physicians’ lounge describing documentation for specific diagnoses that frequently creates challenges for your physicians.
- **Group meetings.** Schedule data report presentations for physician sub-sectional meetings that demonstrate successes and challenges (physician names are usually omitted in these presentations). Physicians tend to respond positively to clearly illustrated trends.

Participation of the CDI specialist in patient care rounds, clinical patient care teams, or patient conferences are all avenues to teach medical staff about specific documentation that affects the patient’s SOI. Grand rounds, patient care conferences, and resident lectures are of benefit to the CDI specialist, too: They can help enrich the specialist’s knowledge of disease and appropriate diagnosis classifications.

Introduce documentation education in meetings, lectures, and medical staff presentations that are already on the schedule. Ask to be involved in identified medical education gatherings. In private or community hospitals, CDI staff can take advantage of medical staff interactions by requesting to be put on the agenda for medical and surgical sectional meetings and medical staff quarterly meetings.

In addition, consider scheduling one-on-one meetings in the physician office or office staff meetings. Offer to round with physicians and review their documentation with them.

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**16 questions to assess physician communication effectiveness**

Honest answers to the following questions can help evaluate the current state of your physician communication process:

1. What actions should we take to employ effective CDI communication with physicians?
2. What can we do to assist hospitals and physicians with accurate profiles?
3. What am I doing to stimulate better communication with my physician staff?
4. Is my communication fresh and new?
5. Who among my physician staff supports my CDI efforts?
6. Am I able to be a consultant to physician staff regarding CDI?
7. Do physicians approach me with questions, or am I always going to them?
8. How many hospitalists does my hospital employ?
9. Are hospitalists receptive?
10. Have hospitalists become my advocates?
11. What process metrics are being measured, and are they reported back to the physician groups?
12. Which metrics are being reported to physicians?
13. Are action plans written around the metrics? Why/why not?
14. Do I have a monthly/quarterly dashboard that I can depend on?
15. What are my dashboard metrics, and do I refresh them? If so, how often do I do this, and who do I share them with?
16. How are metrics outside my objective benchmarks acted on?
Identify physician trends

Identify trends by tracking data and the issues that are illustrated by that data. These trends may affect more than one physician; alternatively, you may uncover a consistent issue with a physician that warrants group interaction.

CDI managers and their team should evaluate CDI operational process metrics and CDI physician query process metrics each month at the beginning of a new CDI program, and then on a quarterly basis once the CDI process is finalized.

In an academic healthcare facility, residents generally dominate medical record documentation, at least in the written medical record. However, if residents do not have strong written documentation skills, their responses to CDI queries may not always be accurate and complete. Most residents are not aware of CDI methodologies or the importance of addressing diagnoses/procedures in a compliant manner. Provide specific examples of resident cases and outcomes to demonstrate the benefits of improved documentation.

Some resident programs allow the concepts surrounding documentation accuracy to be taught in their classes, and hospitals are involving residents more and more in their CDI programs. One Texas hospital system invites residents to learn inpatient and outpatient coding applications by employing them as coders, allowing them the option to moonlight in the HIM department as opposed to the ER.

You should also focus your CDI education on hospitalists. Usually, hospitalist groups comprise a relatively small number of physicians who are responsible for providing care to a large percentage of the inpatient population. Typically, hospitalists are willing to embrace learning opportunities.

Hospitalist groups may also be receptive to patient care rounds and educational sessions on specific disease documentation.

Ask the right question the first time

CDI specialists need to ask questions of the physician when appropriate and warranted, but those questions must be compliant and non-leading. In turn, physicians must be willing to cooperate with the CDI query process.

Questions submitted by the CDI specialist should always be valid, clear, legitimate, and complete (but concise). If questions are easily understood and display an applicable snapshot of the supporting clinical evidence, the CDI program will achieve a higher percentage of physician responses.

Maxim agrees with the AHIMA Practice Brief “Managing an Effective Query Process,” published in the October 2008 Journal of AHIMA. The brief states, “The entire record should be reviewed to determine the specific reason for
the encounter and conditions treated.” It also states, “The importance of consistent, complete documentation in the medical record cannot be overemphasized.”

You should incorporate the following components into each query:
- **Clinical indicators:** signs, symptoms, and clinical evidence that could support a definitive diagnosis
- **Treatment plans:** medications, treatments, and prescriptions to treat or identify diagnoses
- **Clinical monitoring:** serial labs, x-rays, vital signs, neurochecks, or any serial/repeated diagnostics
- **Physician questions:** Ask about diagnostic options pointing to the clinical indicators and treatment plans

When a query is depicted correctly, it paints a picture of the patient’s quality of care and allows the physician to choose a diagnostic statement using the clinical indicators identified.

**Evaluate the physician communication process**

Hurdles and challenges exist in physician education, monitoring, and tracking, but you can support your hospital metrics outcomes as well as the physician’s profile through effective communication with the medical staff. Maxim’s clients state that their CDI specialists’ ability to communicate with inpatient physicians is gradually becoming easier and that physicians are becoming more approachable.

As more and more hospitals implement CDI initiatives, many physicians have become professionally involved in the CDI process as physician champions or advisors. Others are more involved in utilization review, quality, case management, and HIM committees.

Remember that it is always necessary to offer physicians education on documentation compliance. CDI specialists should support physicians by providing queries as needed and by continually making them aware of changing rules and regulations regarding documentation compliance.

CDI is an involved process, and it can be challenging to produce the results you desire. However, collaborative communication between the CDI specialist and physician is not only the first step, but the “concurrent step” to success.

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**About the author**

Steven Robinson, RN, has successfully managed CDI services for more than 200 acute healthcare hospitals, medical centers, and health systems over the past 19 years. An RN and physician assistant with a master’s degree in health management, Robinson currently serves as the senior director of CDI at Maxim Health Information Services (MHIS) in Cleveland.

Prior to working at MHIS, Robinson served as vice president of clinical consulting services at a CPA healthcare firm acquired by 3M, senior vice president of clinical consulting at HP3, and director of forensic healthcare consulting at KPMG, LLP. He is committed to providing clients across the country with quality CDI services.

**About Maxim Health Information Services**

MHIS provides CDI services nationwide. MHIS offers CDI services that are tailored to your facility’s unique needs and allow you to proactively support your medical record staff to minimize incomplete documentation, increase medical record quality, enhance care communication, and receive more accurate reimbursement.

MHIS delivers CDI services in a series of four comprehensive phases: a client interface phase, evaluation phase, education phase, and metrics and process follow-up phase. By choosing MHIS for your CDI needs, you can expect quality customer service, customized results reporting, and a commitment that MHIS will support your long-term CDI success. To learn more about MHIS’ CDI services, visit [www.maximhealthinformationservices.com](http://www.maximhealthinformationservices.com) or call 866/265-0589 (East) or 866/316-8773 (West).
2010 Third Annual Conference
Dear ACDIS members;

Since the conference is over now, I guess I can let the cat out of its proverbial bag—I’m not a big fan of Chicago. I know! I know! How can anyone not love Chicago? The art, the lake, the music, the fantastic food?

But prior to the Third Annual ACDIS Conference, held June 3–4, I’d been to Chicago twice, both times for other healthcare conferences. The first time I flew solo. The second time we were so busy we barely left the hotel.

I’m not saying I wasn’t busy this time, of course—I was. (Who wasn’t? It took me a while to realize that the blurry object buzzing by was ACDIS Director Brian Murphy!) But there was so much going on by way of networking and education and munchies and lunches and fun, I swear there were times I forgot how busy I was and got caught up in the enjoyment of it all.

All told, there were more than 500 of you at the 2010 conference, nearly two dozen exhibitors, and more than 20 educational sessions to choose from. In addition, a number of local chapters arranged to hold breakfasts or lunches or after-hours events with their members. If that wasn’t enough, there was Navigant’s panel discussion and cocktail reception, NHS Solutions’ cruise on the Mystic Blue, and FTI’s bowling night, among other events offered by ACDIS vendors for their clients and customers.

Programmatically, this year’s conference speakers emphasized the importance of regulatory compliance. General session speakers Gloryanne Bryant, RHIA, RHIT, CCS, CCDS; Catherine O’Leary, RN, BSN; and James S. Kennedy, MD, CCS, offered their perspective on government scrutiny of documentation and coding practices. This year’s program expanded to include three tracks of sessions—clinical chart review, program management, and new initiatives and ideas—for participants to choose from. I picked the program management track and learned a lot.

For those who think professional conferences are all about boring lectures, ACDIS speakers shook the dust off that stereotype. Lynne Spryszak, RN, CCDS, CPC-A, and Margi Brown, RHIA, CCS, CCDS, CPC, got into character portraying Laverne and Shirley to help illustrate how HIM and CDI may come from different backgrounds but share the same ultimate goals. And Friday morning, Monica Dancu, RN, BSN, and Sylvia Hoffman, RN, showed participants how to make physician education sessions actually fun. The two explained how they set their CDI training to various television or movie themes and walked their audience through their “CDI-CSI: Documentation Investigation” presentation complete with theme music, lab coats, and pen lights!

I would be remiss if I didn’t also mention the fantastic effort of those chosen for this year’s first-ever poster session. There were 11 volunteers who offered to share their experiences on topics ranging from physician education to local chapter initiation, program inception to CDI next steps. And they did all this during their lunch break the second day of the conference. I was so impressed by their knowledge, generosity, and dedication.

The most enjoyable part of the entire program, however, was meeting so many of the members I’ve come know over the past year. So now when I talk about Chicago, I’ll speak of it with a new affinity. But perhaps that will be true of any city I have the pleasure of visiting as long as I am accompanied by the tremendous people who make up our ACDIS membership!

Next year’s program is April 5–8, 2011, at the Hilton Walt Disney World. On to Orlando!

All the best,

Melissa Varnavas
Associate Director, ACDIS
mvarnavas@cdiassociation.com

Kathy Pagana, PhD, RN, had ACDIS attendees energized during her keynote address, “Using Momentum to Maximize Your Leadership Potential,” June 3.
Beatty earns 2010 CDI Professional of the Year award

Editor’s note: Sandra Beatty, RN, BSN, C-CDI, clinical documentation specialist at Columbus (IN) Regional Hospital, received the 2010 ACDIS CDI Professional of the Year award during the Third Annual ACDIS Conference in Chicago. The following was excerpted from her nomination form.

Sandy Beatty was the first clinical documentation improvement specialist hired at Columbus (IN) Regional Hospital (CRH) in August 2002. She was responsible for taking the concept of improving documentation and developing a strategy to make the program a reality. For her many accomplishments, as well as the initiatives and outcomes listed below, we believe Sandy should be considered for the CDI Professional of the Year award.

At CRH, we consider high performers people who come to work on time, bring a positive attitude, problem-solve, and provide a positive influence to those around them. But Sandy sets the bar higher. Sandy works directly with the medical staff and care team providing feedback, direction, innovative ideas, and support to improve patient care and the documentation of the care our facility provides. She provides education to the medical staff and care team via one-on-one interactions, newsletters, and meetings. She eliminates inefficiencies. For example, Sandy developed worksheets, order sets, operative notes, and progress notes to support accurate clinical documentation that helps to facilitate appropriate coding. These documents support real-time, accurate documentation and help prevent the need to document elsewhere.

The results from her work are demonstrated with a positive 55.4% improvement in the risk of mortality (ROM) and a 17% improvement in severity of illness (SOI) since the inception of the program through April 2009. Sandy is now working closely with the hospitalists who began in November 2008. Since that time, there has been an additional 36% positive improvement in SOI. CRH is privileged to have Sandy as a member of our organization.

Additional comments

“Sandy is a visionary. Her work is partially responsible for CRH being named a Thomson Reuters Top 100 Hospital in 2009 as well as being a recipient of the 2010 HealthGrades Patient Safety Excellence Award. I think it would be difficult to find a more professional role model for the ACDIS to hold up as the CDI Professional of the Year in 2010,” writes Kathy Wallace, RHIA, director of medical quality management.

“Sandy’s ability to quickly form successful relationships with physicians has led to the success of our program. Sandy is a role model for this position,” writes Tom Sonderman, MD, vice president and chief medical officer.

“As a physician, working with Sandy Beatty has been a joy,” writes Rick Shedd, MD, chief of staff. “She works effectively to bring accurate knowledge to the table in a collaborative manner. I truly learn more from her than she will ever learn from me!”
Editor’s note: Adelaide M. La Rosa, RN, BSN, CCDS, director of clinical documentation improvement at St. Francis Hospital in Roslyn, NY, earned Recognition of CDI Professional Achievement honors during the Third Annual ACDIS Conference, held June 3–4 in Chicago. The following was excerpted from her nomination form.

Mahatma Gandhi said, “You must be the change you wish to see in the world.” Any great leader has taken this quote to heart, no matter how big or small the change that they wish to bring. And for her part, Adelaide M. La Rosa has been a proponent of arduous change at St. Francis Hospital in Roslyn, NY, for nearly five years. St. Francis is noted for top performance in patient satisfaction due to the care that is given to its patients. However, this care was not documented to the extent it should have been to reflect our severity of illness (SOI) and intensity of service.

The Clinical Documentation Improvement Program went into full operation on October 1, 2007, and has not stopped seeing growth and success. Under the leadership of Adelaide and physician advisor Dr. Howard Weiss, the program has expanded from a staff of two to a staff of 15.

Leading by example is one of La Rosa’s specialties. Not one to preach and not practice, she maintains her presence on the clinical units alongside her staff, being sure to interact with physicians and other St. Francis team members all while making documentation improvement a hot topic.

Knowing that change is the name of the game, she constantly thinks about the future, what she can do to aid future change, and how she can assist her staff in coping with said change. With new guidelines and ever-evolving duties, La Rosa takes a proactive approach to implementation and sees obstacles as stimulation to learn something new and to complete a challenge.

Furthermore, what is a leader without aiding those in need? Neighboring facilities of South Nassau Communities Hospital and Mercy Medical Center asked to share how she established the CDI program at St. Francis. Since then, she has held conferences with representatives from both hospitals to assist them in setting up similar programs from the ground up. This past December, she began and chaired the first meeting of the Long Island/New York Local Chapter of ACDIS.

All these attributes make Adelaide to be not only a very special leader, but a very special person. She combines these two halves of her to succeed as the director of clinical documentation at SFH and in life!

Additional comments

“Those of us familiar with Adelaide know that she leaves no stone unturned and strives for perfection in all that she does. She is a highly motivated individual who works tirelessly to pursue goals that others might deem unattainable. Her willingness to share her knowledge has not only benefitted her facility, but surrounding institutions as well. I consider myself fortunate that our paths have crossed,” wrote Deborah Stelling, RN, CCS, appeals coordinator at South Nassau Communities Hospital in Oceanside, NY.

“Adelaide is a true team player who never shies away from being involved. She serves as the co-chair of our ICD-10 Steering Committee, and is a member of several committees including our clinical standardization workgroup, Hospitalist Steering Committee, Forms Committee, and countless other initiatives. Adelaide La Rosa is the epitome of a leader and role model deserving of [recognition],” wrote Jack Soterakis, MD, FACP, FACC, vice president of medical affairs and medical director at SFH.
Love tapped for CDI recognition honors

Editor’s note: Jennifer Love, RN, BA, CCDS, manager of clinical documentation improvement for four facilities under Novant Health based in Winston-Salem, NC, earned Recognition of CDI Professional Achievement honors during the Third Annual ACDIS Conference in Chicago, held June 3–4. Although she was unable to attend in person, her staff member Leah Taylor, RN, CCDS, clinical documentation improvement specialist at Forsyth Medical Center, accepted the award on her behalf. The following was excerpted from her nomination form.

Jennifer Love has been the manager of CDI at Medical Park Hospital, Brunswick Community Hospital, Thomasville Medical Center, and Forsyth Medical Center since the inception of the program at Novant in 2008. With a rapidly growing department looking to expand to payers other than Medicare, Jennifer has definitely had her work cut out for her.

First, she has the challenge of “remote management.” The largest hospital, FMC, has more than 900 beds, and BCH is geographically the furthest distance from the others, roughly four and a half hours worth of time driving.

When asked about the hardest part of her job Jennifer says, “Knowing that I can’t be out there daily with you guys rounding and asking queries.” She adds, “I’m envious at times. I see in your eyes how exciting it is to land a big query.”

Jennifer looks to raise CDI awareness. In 2009, Novant released an internal video about our facilities’ CDI efforts. With Jennifer’s vision and the help of various Novant staff, the video came to life. It can be viewed on the ACDIS Blog as Jennifer and her hospital have agreed to share it with ACDIS. The video is short in length, but its strong message hits home.

Another project she undertook recently was creating CDI brochures to distribute in heavily frequented areas within the hospitals. And in 2009, Jennifer was elected vice president of the North Carolina Chapter of ACDIS. She continues to encourage her staff to become more involved in ACDIS as well.

For the 2010 ACDIS conference, Jennifer stepped aside and let two of her staff come in her place. Jennifer considers clinical documentation improvement a new and exciting field. She is frequently heard saying, “Guys, we’re making history … By ensuring accurate and specific documentation in the medical records, we do our part to deliver the most remarkable patient experience, in every dimension, every time.”

Additional comment

“Jennifer has been able to show a significant increase in case mix within our Medicare population in the short time the program has been here. She has now gotten approval to expand to some of the commercial payers. I think this is a huge accomplishment,” wrote Susan H. Belanger, RHIT, CCS, coding manager at Forsyth Medical Center.

“As the coding manager here at FMC, I had heard all the horror stories of other CDI programs. Most coders feel CDS’s infringe on their territory and the two departments fight each other. It is not that way working with Jennifer.”

“Jennifer has to be the most patient person I have ever had the pleasure of working with. She stepped into the role of manager for a brand-new program and put her heart and soul into making it a successful program.”

Love tapped for CDI recognition honors

2010 Award Winners

Jennifer Love, RN, BA, CCDS, from Novant Health in North Carolina, could not attend the conference to pick up her award, but her coworkers attended in her stead.

ACDIS Director Brian Murphy stands with Leah Taylor, who accepted the Recognition of CDI Professional Achievement award on behalf of Jennifer Love, RN, BA, CCDS, from Novant Health in North Carolina.
The Third Annual ACDIS Conference in Chicago featured nearly two dozen exhibitors from consultants to software vendors, human resource firms to communications experts. All had interesting information to share with the more than 500 ACDIS attendees.

They included the following:

- Transcend Services of Atlanta talks with ACDIS participants about the company’s CDI solutions.

- An ACDIS participant makes a stop at Meta Health Technology Booth 115. Meta Health is a full-service provider of health information management solutions based in New York City.

- Morrisey Associates of Chicago works with customers to provide comprehensive Web-based documentation improvement tools.

- Transcend Services of Atlanta talks with ACDIS participants about the company’s CDI solutions.

- Representatives from J.A. Thomas greet ACDIS conference-goers during packed sessions in the exhibit hall.

- NHS Solutions President John Jager and Conference Coordinator Amanda Jager welcome ACDIS guests aboard their sunset cruise on the Mystic Blue.
2010 Exhibitors

More than 500 attendees converged on the conference rooms at the Hyatt Regency in Chicago for the Third Annual ACDIS Conference to learn the latest about the CDI profession—and have a little fun.

Maxim Health Information Services National Director Lance Lowery offers an ACDIS attendee some take-home information about his company’s consulting and human resource offerings.

MedPartners and FTI joined together for a bowling night the first night of the conference.

ACDIS Gold Sponsors 3M demonstrate their CDI solutions software.

Cesar Limjoco, MD, and Robin Dyke from DCBA, Inc., greet customers during the busy breaks in the exhibit hall.
ACDIS board members met prior to the start of the Third Annual ACDIS Conference to discuss a number of association initiatives and industry developments. Those in attendance included: Robert S. Gold, MD; Lena Wilson; James S. Kennedy, MD; Wendy De Vreugd; Lynne Spryszak; Sheila Bullock; Colleen Stukenberg; William Halk, MD; and ACDIS Director Brian Murphy. In the front row are Gloryanne Bryant, Shannon McCall, Robin Holmes, Gail Marini, and Glenn Krauss.

*Lena Wilson, RHIA, CCS, offers tips on how to manage CDI staff across multiple hospital campuses.*

*Photo by Melissa Varnavas*

A St. Francis Hospital’s poster session depicted various methods used by its CDI program to help train physicians. Shown from left to right are Adelaide M. La Rosa, RN, BSN, CCDS; Joan LoMonaco, RN, CDS; Colleen Stukenberg; William Halk, MD; and ACDIS Director Brian Murphy. In the front row are Gloryanne Bryant, Shannon McCall, Robin Holmes, Gail Marini, and Glenn Krauss.

*St. Francis Hospital’s poster session depicted various methods used by its CDI program to help train physicians.*

*Photo by Melissa Varnavas*

Darice Grzybowski, MA, RHIA, FAHIMA, left, and John Trusten take a minute for a photograph with their client Alesha Andrews, RHIT, CCS, following their presentation “The Role of Process Mapping in CDI Program Improvement.”

*Photo by Melissa Varnavas*

ACDIS advisory board members Robert S. Gold, MD, and Gloryanne Bryant enjoy a meal at Buca di Beppo in Chicago.

*ACDIS advisory board members Robert S. Gold, MD, and Gloryanne Bryant enjoy a meal at Buca di Beppo in Chicago.*

*Photo by Melissa Varnavas*

Lynne Spryszak and Margi Brown won over ACDIS attendees as Laverne & Shirley during their conference presentation on how to bridge the gap between coding and clinical departments. The two continued to show off their costumes well into the evening.

*Lynne Spryszak and Margi Brown won over ACDIS attendees as Laverne & Shirley during their conference presentation on how to bridge the gap between coding and clinical departments. The two continued to show off their costumes well into the evening.*

*Photo by Lynne Spryszak*

Catherine O’Leary, RN, BSN, warns conference participants that governmental audits beyond the threat of the recovery audit contractors loom on the horizon during the June 3 general session “Spotlight on Compliance.”

*Catherine O’Leary, RN, BSN, warns conference participants that governmental audits beyond the threat of the recovery audit contractors loom on the horizon during the June 3 general session “Spotlight on Compliance.”*

*Photo by Lauren McLeod*
Those sitting for the CCDS certification exam at the Hyatt O’Hare didn’t let the rain outside dampen their test-taking spirits.

Photo by Melissa Varnavas

Marion Kruse, MBA, RN, director at FTI Healthcare, and Christi Sarasin, CCS, CCDS, CPC-H, FCS, president of Sarasin Consulting Group celebrate their bowling championship. FTI Healthcare sponsored a bowling night for invited guests on June 3.

Photo by Melissa Varnavas

ACDIS attendees enjoy the buffet aboard the Mystic Blue, a sunset cruise sponsored by NHS Solutions, on the first evening of the conference. Look for more photos and video from the cruise on the company’s website.

Photo by Melissa Varnavas

ACDIS Associate Director Melissa Varnavas and Melissa Thacker, director of case management, take a moment to sneak a photo during a session.

Photo by Melissa Varnavas

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2010 CDI Program Benchmarking Survey
Dear ACDIS members:

We are pleased to present the results of a survey regarding CDI program structure. In response to a 30-question survey, 482 CDI professionals provided data about the number of staff they employ, the number of queries they generate, and the number of chart reviews their staff perform. They offered information on the focus of their CDI programs and to whom their CDI specialists report. The results illustrate where seasoned programs are expanding their documentation efforts and also provide guidance for new CDI programs just getting off the ground.

The report shows some interesting trends. For example, most programs indicated that they report to either HIM or case management and that they employ between two and four RNs. Respondents also indicated that CDI programs continue to focus on Medicare patients, CC/MCC capture rates, and documentation as it relates to code assignment and quality/core measures. But many programs are increasingly taking on reviews of additional payers and tackling duties such as examining the record for indications of severity of illness and risk of mortality.

The intent of this report is not to prescribe protocol or establish hard parameters as to how CDI programs should be run. Such decisions must be the result of a comprehensive analysis of each individual facility’s needs, made in cooperation with various departmental leaders within an individual organization. Rather, we encourage the use of the results as a type of ruler by which CDI programs can measure themselves against industry trends.

“I looked at this survey thinking about how I do things here and about whether the priorities we’ve chosen are indicative of the rest of the country,” says Shelia Bullock, RN, BSN, MBA, CCM, CCDS, manager of clinical documentation services at University of Mississippi Medical Center in Jackson.

Self-analysis of your CDI program structure and processes is a best practice for all CDI managers, says Gail B. Marini, RN, MM, CCS, LNC, manager of CDI at South Shore Hospital in Weymouth, MA.

“I need to establish where am I [against] the benchmarks [and determine] if there is a part of the program I should strive to implement or something else that we could be doing better,” Marini says.

CDI staff members want to know how their work matches with others in their profession, says Bullock. “They want to know if they are reviewing the same kinds of records as their peers or if they are being asked to perform work that’s really outside of the scope” of typical CDI responsibilities, she says.

“I was pleased to just see what other programs across the country are doing,” says Joann Agin, RHIT, regional manager of data quality at Carondelet Health in Kansas City, MO.

On behalf of ACDIS, we hope you find value in the results of this report as well.

Sincerely,

Melissa Varnavas
Associate Director, ACDIS
Staffing statistics

One-third of respondents indicated they work in a smaller hospital (101–250 beds). Respondents saying they work at facilities with 100 or fewer beds or hospitals with 401–550 beds each made up 12% of the total. (See Figure 1.)

The results indicate that CDI is still a newer profession: The largest percentage of respondents, 33%, indicated that their program is one to two years old, followed by 23% whose programs are three to four years old. Eighteen percent of respondents said their CDI program is less than a year old. (See Figure 2.)

Most facilities (46%) employ between two and four full-time equivalent (FTE) staff members, 23% employ only one FTE, and 14% employ between five and seven staff members. (See Figure 3.)

» For data regarding CDI staffing per patient discharge data, see Figure 4 below.
» For data regarding staffing size compared to facility size, see Figure 5 on p. 34.
» For data comparing staffing ratios to total number of cases reviewed monthly, see Figure 6 on p. 34.
**Figure 5: CDI staff compared to facility size in raw numbers**

How many FTE CDI specialists does your facility employ?

- None*
- 0.5
- 1
- 2–4
- 5–7
- 8–10
- 11–13
- > 13

*They have other duties in addition to CDI (e.g., case management)

**Figure 6: Ratio of FTE staff compared to total cases reviewed monthly in raw numbers**

How many FTE CDI specialists does your facility employ?

- None*
- 0.5
- 1
- 2–4
- 5–7
- 8–10
- 11–13
- > 13

*They have other duties in addition to CDI (e.g., case management)
Reporting structure

The survey indicates that most CDI programs employ RNs who report to an HIM director or are embedded in an HIM department. In addition, 45% of respondents said their CDI program reports to HIM. Forty-two percent of respondents said they employ between two and four CDI specialists with RN backgrounds, whereas 12% of respondents said their facility employs between two to four staff with HIM/coding backgrounds. (See Figures 7–9.)

At South Shore Hospital in Weymouth, MA, Gail B. Marini, RN, MM, CCS, LNC, manager of CDI, employs a coder and three RNs. Each CDI team member benefits from the professional experiences of the other, she says.

For example, it can be frustrating for the coders to interpret the nuances of clinical language and for the nurses to understand the coding rules and guidelines when it seems as though the diagnosis and treatment are clear. “Such decisions are not always as black and white as one might suspect,” Marini says.

"This is a team effort and everyone needs to work as a group. They have to see themselves that way, as a team.”

—Marion Kruse, MBA, RN

“Coders have anatomy and physiology knowledge, but some programs look for staff with more clinical expertise. They’re looking for clinically based people who can understand the relationship between diagnostic results and the treatment plan and communicate with the physicians during the patients’ admissions to correlate these to diagnostic terms that can be coded,” says Shelia Bullock, RN, BSN, MBA, CCM, CCDS, manager of clinical documentation services at University of Mississippi Medical Center in Jackson.

The debate over which professional background best suits the role of CDI stems from the dual nature of the job. CDI specialists operate between the worlds of clinical documentation and coded data. Knowledge of both spheres is required for optimal CDI effectiveness. (Read a related article regarding the release of AHIMA’s CDI Practice Brief in the July CDI Journal.)

continued on p. 36
“Sometimes there can be tension between the two departments,” says Joann Agin, RHIT, regional manager of data quality at Carondelet Health in Kansas City, MO.

That is one reason Marion Kruse, MBA, RN, director of FTI Healthcare’s corporate finance practice in Atlanta, says, “If you can’t be a stand-alone CDI program, then HIM is a nice place to report.”

When CDI programs were first implemented in the 1990s, many facilities made CDI part of case management (CM) or utilization review, Kruse recalls. “That wasn’t a bad place for it either, but it wasn’t ideal,” she says. Programs which embed CDI in CM sometimes lose focus on documentation initiatives in favor of other tasks such as discharge planning, she says.

The survey shows that CM remains the second most popular place for the CDI program, with 27% of respondents reporting to CM, followed by 15% of respondents who indicated they report to the quality improvement department. (See Figure 9 on p. 35.) Older programs seem fairly evenly divided in their reporting structure. Of the 30 respondents with seven to eight years of CDI program history, about 20% said they report to CM, compared with 30% who said they report to HIM. Of the 18 respondents with nine to 10 years of experience, 33% said they report to CM, 33% said they report to HIM, and 22% said they report to quality improvement. (See Figure 10.)

Regardless of which department oversees documentation improvement initiatives, CDI success depends on two things—the culture and support of the institution and the establishment of good relationships between departments, says Kruse.

“This is a team effort and everyone needs to work as a group. They have to see themselves that way, as a team,” she says.

![Figure 10: Program reporting structure compared with age of CDI program](image-url)
Review priorities

When asked about the type of payers their programs review, 35% said they review records for Medicare, 30% said they review Medicare and some private payers, and 30% said they review all payers. Others indicated that they review any payer who uses the DRG reimbursement system. (See Figure 11.)

These results seemed typical to Agin. “Reviewing Medicare and some payers was where we started too,” she says, “but now we’re moving on to reviewing all payers.”

“It takes time to get a program up to speed,” Bullock says. “You have to start somewhere, so most start with their largest DRG payer group, and that’s frequently Medicare.”

However, an analysis of the survey data shows a fairly even division between those programs who review solely Medicare and those who review all payers. (See Figure 12.)

When asked about their program’s primary focus, 88% said they focus on documentation improvement related to code assignment; 46% said they only review documentation for proper code assignment, and 42% indicated they review charts for documentation related to both code assignment and quality measures. (See Figure 13 on p. 38.)

Figure 11: Which payers represent your program’s primary focus?

Figure 12: Program payer focus compared with program age

Figure 13: What types of payers does your CDI program focus on?
Review priorities
continued from p. 37

As Figure 14 illustrates, 72% of respondents indicated CC/MCC capture and DRG optimization as top priorities, followed by 38% who said their priority was overall improvement of case-mix index. (Note that respondents could select multiple responses, so the results do not add up to 100%.)

Although Figure 15 (on p. 39) shows nearly 78% of programs with more than nine years of experience still query for CC/MCC and DRG accuracy, the results also illustrate an increased emphasis on case-mix index (55% for programs nine to 10 years old) and severity of illness (SOI)/risk of mortality (ROM) (nearly 40% for those nine- to 10-year-old programs).

“Many programs start out with a focus on capturing CC/MCC data,” Bullock says, “but as programs mature they’re moving out of that mind-set and focusing more on quality documentation.”

Programs that do decide to focus solely on DRG optimization should be wary of potential compliance risks and the impression of impropriety that comes with emphasizing financial gain as the sole reason for documentation improvement, Kruse says. So she was pleased to see the low response rate on focused reviews, 11% (see Figure 14), which tend to target only high-dollar lines of service or patient records. A comprehensive approach to record review that examines some elements of quality such as SOI/ROM helps the program avoid the perception of being purely financially focused, which can be problematic from a compliance perspective, she says.

“I’m pleased to see the results on the SOI/ROM reviews, but I wish it were higher. Examining the records for all these items makes it less likely for the recovery audit contractors [RAC] to pull the charts, as they are more likely to have multiple CCs or MCCs. Also, it does not make your program look hypocritical to the physicians since you are maintaining a quality focus when collecting data and measuring outcomes,” says Kruse.

When asked what additional documentation initiatives their programs adopted, 72% said they review documentation for present on admission (POA) indicators, 34% said they...
review records searching proactively for RAC target areas, and 25% said they incorporate utilization management, CM, or core measure collections into their reviews. (See Figure 16.)

CDI programs should establish clear expectations regarding reviews that include quality assurance, core measures, POA, SOI/ROM, and other data elements, Kruse says.

Such complexity can create problems for a CDI program, says Laura J. Werner, MSN, RN, clinical documentation specialist at Carson Valley Medical Center in Gardnerville, NV, a critical access hospital. “Some people get confused when they’re asked to take on too many roles,” Werner says. “Am I measuring for medical necessity criteria on that pneumonia case or am I looking to see that the physician documented all the details related to the treatment of that particular patient while he was in the hospital? Personally, as a CDI professional, I look to see if the physician documented all the care and all the reasons that care was provided.”

The bottom line: When combining different review initiatives, make sure to provide auditing and oversight to ensure that no initiative suffers at the expense of another, Marini says. “These additional responsibilities could affect their program ratios of staff to their numbers of records reviewed, so it’s important to keep that in mind,” says Kruse.
Roles and responsibilities

Many CDI specialists have a wide range of job responsibilities. Their focus depends on specific facility needs, staffing availability, and capability. However, medical record reviews and physician queries—prospective (72%), concurrent (95%), and retrospective (40%)—dominated the respondents’ lists of responsibilities. (See Figure 17. Note that respondents could pick multiple answers, so the results do not add up to 100%.)

Keeping physician queries under the purview of CDI specialists represents best practice, according to Kruse, who encourages staff to follow up on and submit queries for outstanding issues even after discharge.

“If someone cleans up your mess on the back end, then you might be less likely to do a thorough job on the front end. Conversely, if you know that the chart is going to keep coming back to you for review every time there is a question, you are less likely to let something slip,” she says.

Other responsibilities included physician education (88%), post-bill inquiries (29%), and documentation audits and analysis (29%).

“Training physicians is just such a vital part of the position,” says Werner, who spent time with as many physicians as possible. She even shadowed surgeons in the operating room to better understand their work flow and to help them get to know her better.

“Anything you can do to help build that rapport can make a huge difference to your outcomes,” Werner says.

Marini was somewhat surprised by the low number of respondents who said they conducted documentation audits. “I think everyone should be taking a look at the...
Productivity considerations

So how many cases do staff members review for documentation specificity? Between 11 and 20 new cases per day, according to 50% of respondents. Another 38% said they review between one and 10 new cases, and 9% said they review between 21 and 30 new cases per day. (See Figure 20.)

CDI specialists conduct fewer rereviews; 46% of the respondents said they take another look at between one to 10 charts per day, followed by 38% who reexamine between 11 and 20 charts, and 12% who rereview between 21 and 30 cases per day. (See Figure 21.)

“This all seems reasonable to me,” Bullock says. “If you are working 40 cases a day, it could be too much. I’m not saying records to be sure that CDI staff are catching everything they can in terms of medical record documentation,” she says.

As illustrated in Figure 18, most of those who completed this particular survey identified themselves as CDI specialists. The ACDIS CDI Work Group presented the results of its CDI staffing survey in the April CDI Journal. Those results, while similar to the findings of the data included here, specifically targeted CDI department managers on a wide range of questions concerning CDI department staffing.

Most programs (48%) assign CDI specialists by unit, followed by 32% who assign staff by the census and the number of available reviewers, and 14% who reportedly assign staff members based on clinical specialty. (See Figure 19.)

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that you couldn’t do it, but I’d question the effectiveness of
the CDI program that had much larger numbers than that.”

The total number of cases reviewed by a CDI depart-
ment every month varies widely, with the greatest number
(22%) indicating they review between 151 and 300
records. (See Figure 22.) Most CDI specialists leave fewer
than 100 queries per month, according to 51% of respon-
dents. Another 21% said they submit 101–150 queries per
month, and 11% said they submit between 151 and 250.
(See Figure 23.)
When tracking query rates, administrators should exercise caution and be prepared to dig deeper into the data, says Agin. “The more you train your physicians, the better their documentation gets and the less you should have to query,” she says. “There will always be documentation issues, but you can’t necessarily judge whether your team is doing a good job based solely on the number of queries they file.”

Figure 24, however, shows that of the 84 respondents who stated that their program was less than a year old, 65% submit fewer than 100 queries each month and about 5% said they submit more than 350 queries in an average month. Among the nine respondents who said their programs were more than 10 years old, 44% leave fewer than 100 queries each month, and 22% said they submit more than 350 queries monthly.

**Electronic queries**

Ask different CDI staff members to talk about the benefits of electronic medical records (EMR) and the incorporation of electronic query system (EQS) processes on their productivity and answers vary widely. (See Figures 25 and 26.) Respondents were almost evenly split in reporting whether they actually have EMR/EQS, so it is difficult to make any conclusions regarding the impact of those systems on CDI specialists’ productivity.

Most of those who checked “other” regarding EMR said they either currently work in a hybrid environment or are in the process of switching to EMR. The majority of those who checked “other” regarding electronic query tracking said they use software provided by their consultant or are in the process of researching EQS.

**Verbal vs. written queries**

Debate over the value and legality of the verbal query continues throughout the CDI profession. When Agin started her program, her CDI staff did not leave written queries at all, but now her staff perform mostly written queries and keep the queries in the chart as a permanent part of the medical record.

Werner also keeps queries as a permanent part of the medical record.

“When it comes to documenting and tracking query effectiveness and compliance, the verbal query becomes problematic,” she says.

Others believe that verbal queries provide valuable one-on-one educational opportunities. Rather than an impersonal note or form in a chart, a CDI specialist can pose his or her question, explain the reason for the question, and resolve any other follow-up issues that might be needed. One need look no further than AHIMA’s “Guidance for Clinical Documentation Improvement Programs,” published in the May Journal of AHIMA, which states:

> The advantage of a verbal query is the ability to interact with the provider to facilitate understanding of the issues that need to be addressed. However, caution must be used to ensure that the provider is allowed to make his or her own conclusions regarding the appropriateness of a particular diagnosis or service.

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**Figure 25**

Does your facility use electronic medical records?

- Yes: 50%
- No: 30%
- Other: 20%

**Figure 26**

Does your facility have an electronic query system?

- Yes: 44%
- No: 52%
- Other: 4%
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Bullock suggests that respondents may have guessed at the number of verbal queries in responding to this survey which would account for the verbal query ratios seen in Figure 28. Many facilities have more concrete statistics for written queries and may have considered any verbal interaction with the physician a verbal query.

“We sometimes let [verbal query tracking] slip by because we may be rounding with the physician at the time. With the new AHIMA CDI guidance, we will have to make sure we document these interactions,” Bullock says.

The AHIMA guidance states:

For CDI professionals, not all verbal interactions with providers are queries. In many CDI programs staff accompany the medical team on rounds as they discuss patients. These interactions are not considered verbal queries because the provider team determines which patients are discussed and the CDI professional is usually providing general education rather than addressing documentation issues. ... One of the main challenges of a verbal query is accurate documentation of the interaction. What, where, and how it should be documented are all issues to be addressed by policies and procedures.

Survey conclusions

The results of the survey “[are] indicative of trends present right now in the industry,” Kruse says. “That doesn’t mean that CDI won’t change, that specialists won’t find a better way of doing things. For right now, however, I am very pleased to see this. These are results that I can share, information I can take back to demonstrate best practices to prove I’m not just making this stuff up.”

“We have opportunities to learn from each other and improve our programs based on that information,” adds Marini.

Figure 27

Of the total number of queries you submit, how many are written?

- 1 - 100: 4%
- 101 - 200: 4%
- 201 - 300: 13%
- 301 - 400: 19%
- > 400: 60%

Figure 28

Of the total number of queries you submit, how many are verbal?

- 1 - 100: 1%
- 101 - 200: 5%
- 201 - 300: 9%
- 301 - 400: 1%
- > 400: 93%