cdiJournal

January 2012
Vol. 6 No. 1

Physician advisor role requires development

Survey says most remain semi-ineffectual

More than half of CDI programs employ physician advisors, but those that do typically find their efforts ineffectual, according to the *2011 Physician Advisor Benchmarking Survey*.

More than 300 people responded to the survey, with nearly 60% indicating that their CDI program employed a physician advisor (see Figure 1). Of those, 73% (178 individuals) indicated that their physician advisor spends five hours or less dedicated to CDI efforts (see Figure 2 on p. 2), and 54% described their advisor as either moderately effective or ineffective (see Figure 5 on p. 4).

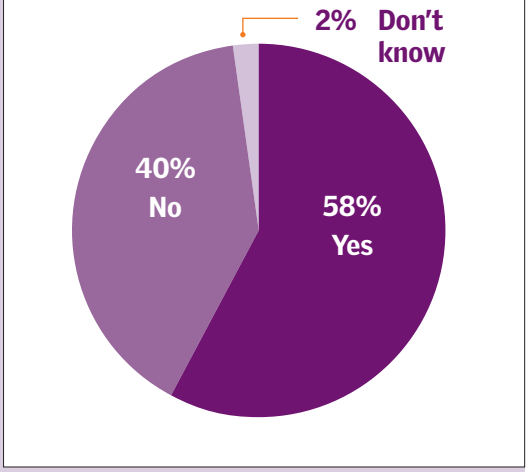
"It looks like physician advisors really are not part of the process right now," says ACDIS Advisory Board member **Trey La Charité, MD,** physician advisor for CDI at the University of Tennessee at Knoxville.

Juggling responsibilities

La Charité serves as physician advisor for CDI and coding, a trend followed by only 25% of respondents (see Figure 3 on p. 3). Most physician advisors also serve as advisors for the case management (51%) or utilization review (47%) departments. Others indicated that their physician advisor also works on claim audits and denials, and a few indicated that their physician advisor also serves as the chief medical officer.

Facilities frequently hire physician advisors to work with case management, La Charité says, because there is a clear and consistent financial return on investment associated with matching conditions to their geometric mean length of stay.

Figure 1: Does your CDI program employ a physician advisor?



"Facilities still make money based on volume—the 'get 'em in and get 'em out' mentality," says La Charité. "As the pendulum swings to a quality of care payment model you'll see more emphasis on core measure and quality reporting" and potentially more focus on physician advisor roles in CDI.

That's the situation at Lehigh (PA) Valley Health Network, says **John Pettine, MD, FACP, CCDS,** director of the CDI program there. Lehigh primarily employs physicians and physician assistants as CDI specialists. It has one full-time RN and 30 part-time physician advisors on a large campus with 900 beds over two sites. The physician advisors concurrently review records, and coders perform retrospective reviews and queries.

"I just don't know how much success you can possibly have in a CDI program without a dedicated, trained physician advisor," says Pettine. "If you only allow one to five hours [for the physician advisor to spend on CDI efforts], that is just not enough time."

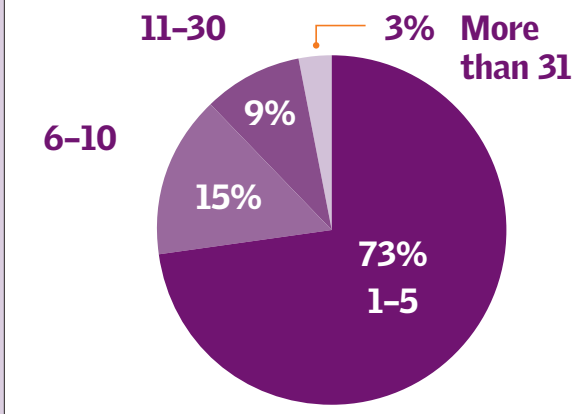
When Pettine first took on CDI duties, he dedicated one day per week to the task. That one day quickly turned into 50% of his time. Now he estimates that he spends roughly 80% of his efforts on CDI.

"I am able to engage more people, and teach more people, and provide more data on DRG performance, and explain face-to-face what physicians need to know," says Pettine.

"More organizations find justification for physician advisors in utilization review and case management. As time goes by, however, they will see an increasing role for them in CDI programs," agrees **Mark Michelman, MD, MBA,** medical director of case management at Morton Plant Mease Health Care System in Clearwater, FL.

Michelman serves as advisor to CDI staff as well as case management and utilization review, "but I've been working

Figure 2: How many hours per week is your physician advisor dedicated to CDI-related efforts?



CDI Journal (ISSN: 1098-0571) is published quarterly by HCPro, Inc., 75 Sylvan St., Suite A-101, Danvers, MA 01923. Subscription rate: $129/year for membership to the Association of Clinical Documentation Improvement Specialists. • Postmaster: Send address changes to **CDI Journal,** P.O. Box 3049, Peabody, MA 01961-3049.

as a physician advisor for more than 20 years now," he says. "The typical physician advisor does not have the experience in CDI and cannot perform all these different roles."

Providing training

Further, the survey illustrates how little training and support most facilities provide to physician advisors. Only 40% indicated that their physician advisor received CDI-specific training, and only 12% indicated they received specific coding training (see Figure 4).

La Charité came to his facility's CDI program from case management. He then received an afternoon's worth of one-on-one CDI training from a CDI consulting firm. Although the facility did not provide coding training, La Charité sought additional education on his own and took a semester-long course at a local community college.

"It was a lot of work but it really helped me learn the lingo," he says.

Pettine also educated himself on CDI via various ACDIS offerings. "It is a great resource for self-education," he says. But obtaining ACDIS membership is not an activity mirrored by most. Respondents indicated that only 7% of their physician advisors were members.

While Pettine definitely encourages his staff to join ACDIS (he told a potential new hire that obtaining CCDS certification is an expectation of the job), he does not believe that physician advisors should be solely responsible for their own CDI training.

> "I just don't know how much success you can possibly have in a **CDI program without a dedicated, trained physician advisor.**"
>
> —*John Pettine, MD, FACP, CCDS*

"If they don't even have CDI training, how are they going to be successful? Whoever hired the physician advisor for the role should be the one to make sure that the physician advisor gets the CDI training he [or she] needs," says Pettine.

Outlining duties

With so little time and support afforded to them in their CDI role, it didn't surprise Pettine to find that a majority of respondents dubbed their physician advisors as either ineffective or only moderately effective in their duties.

Figure 3: Does your physician advisor also serve as physician advisor to any of the following additional departments?

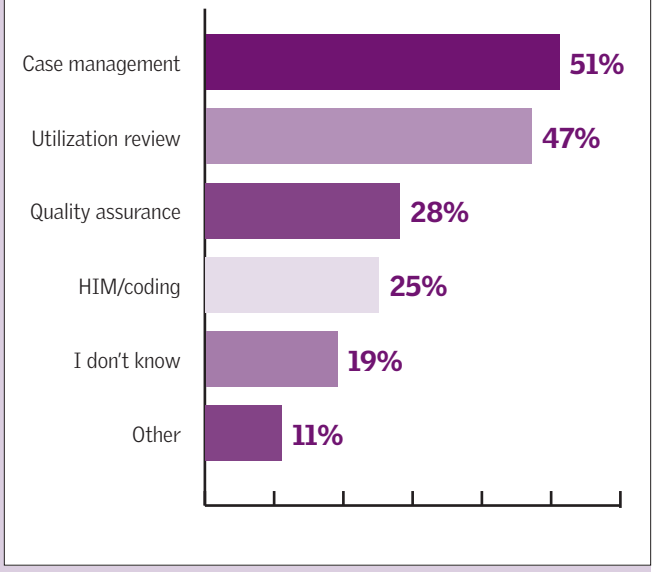
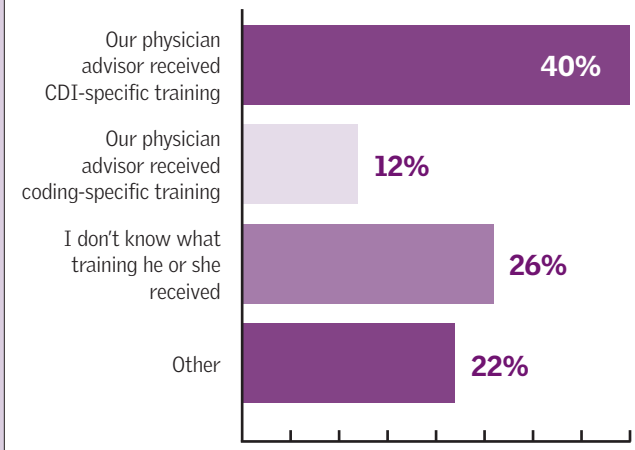


Figure 4: Does your facility provide CDI-related education to its physician advisors?



And what do those duties entail? According to the survey, everything from providing pre-/post-bill clinical documentation support (22%) to assisting with Recovery Audit Contractor (RAC) appeals and drafting appeals letters (33%) to reviewing charts for medical necessity of inpatient admissions (33%) (see Figure 6).

Many of the tasks listed in the survey should be "critical" responsibilities, Michelman says, wishing more respondents indicated that their physician advisor helped to close queries (42%), draft queries (16%), and even query other physicians themselves (17%).

"It is critical for physician advisors to help in drafting queries along with the coders, also. This helps ensure the queries include the most accurate clinical and coding information, which is the whole purpose of the CDI program after all," he says.

Figure 5: Please rate the effectiveness of your physician advisor(s).

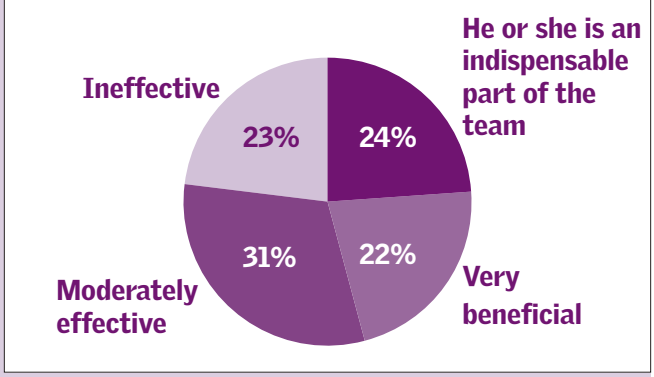
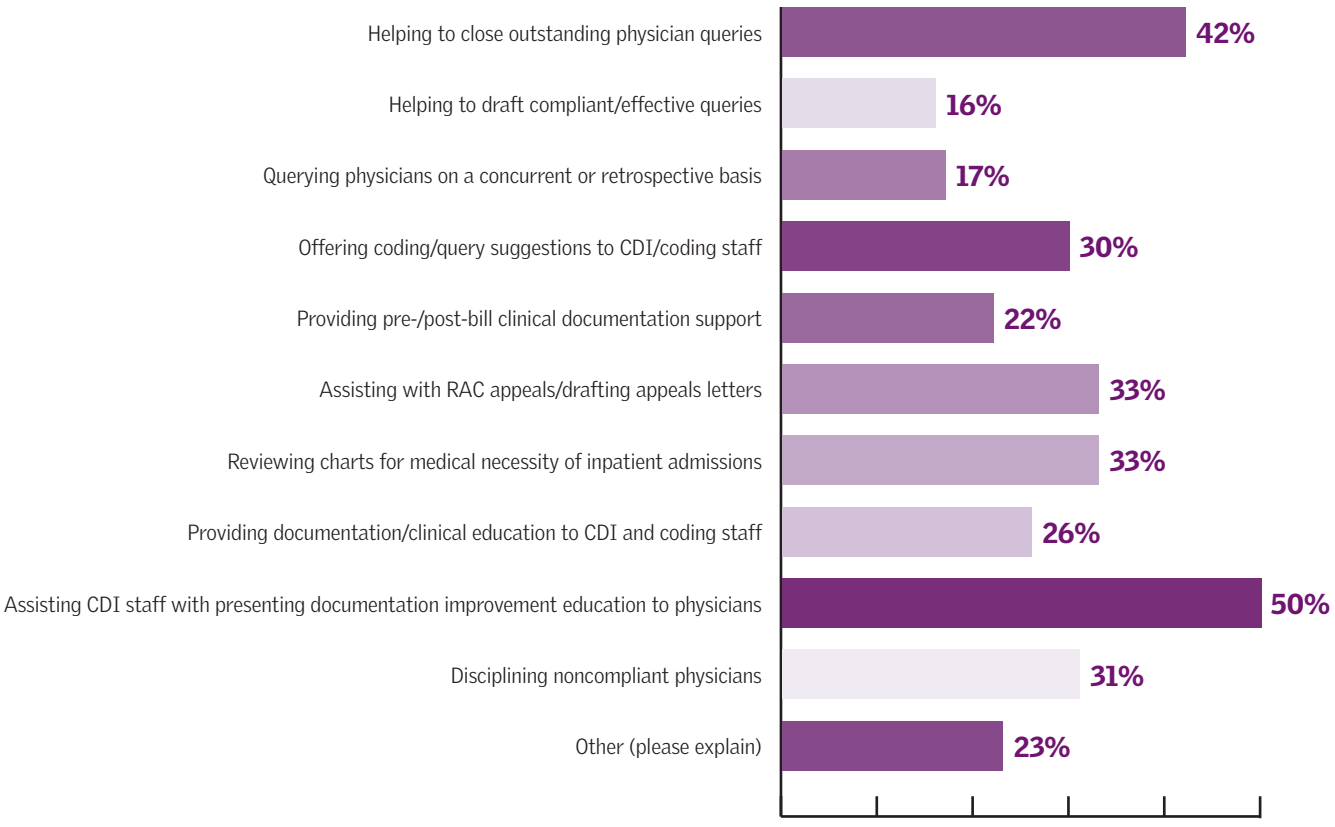


Figure 6: What are your physician advisor's responsibilities?



However, the majority of respondents indicated they refer less than 5% of their total cases to their physician advisor for review (see Figure 7).

The physician advisor role is "different from just going to another physician and trying to put out a fire," says Pettine. "When educated properly, physicians will want to learn this stuff. [CDI] requires a multifaceted approach with the end goal of teaching the physician and changing their behavior."

Yet only 26% of respondents listed providing documentation/clinical education to CDI and coding staff as part of their physician advisor's duties, and 50% listed presenting CDI education to physicians (see Figure 6).

"If the physician advisor doesn't have any education in CDI themselves, then how are they supposed to educate other physicians?" asks Michelman.

"Are the physician advisors just there to get the nonresponding physicians on board? If so, that's pretty disappointing," says Pettine, who attends division meetings and provides analysis regarding how physician documentation affects patient outcomes and provider report cards.

Queries alone won't change a physician's documentation behavior, says La Charité, who also found the results of the survey disheartening. "If you don't preach the gospel to them, if you don't show them the error of their ways, you don't educate them," he says.

Analyzing physician advisor efforts

Don't give up on potential physician advisor involvement, says Michelman. Programs that consider their physician advisor ineffectual should go back and reevaluate their contracts, roles, and responsibilities.

Ideally, a CDI physician advisor should not have to juggle responsibilities for case management and utilization review as well, says Pettine. "Although we indirectly touch all these other areas, we need to keep our focus," he says.

Clearly describing expectations within the contractual agreement can help, but the CDI program needs to understand how a physician advisor can best help them, too. (If you don't have these expectations in place, consider adopting the roles and expectations outlined in the "Physician liaison contract and sample job description" and the "Physician advisor job description" located in the ACDIS Forms & Tools Library.) on the website *www.acdis.org*.

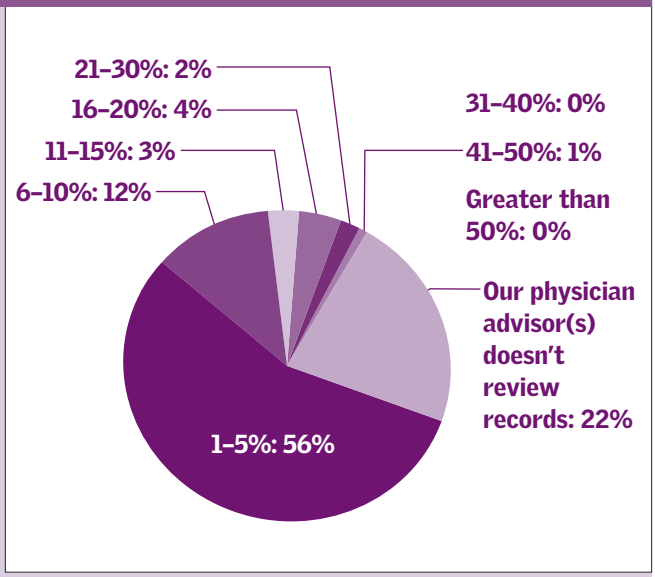
"You need to log what you are currently using the physician advisor for and you need to track how successful your physician advisor is for those uses," Michelman says.

For example, if your CDI program only uses the physician advisor to help with CC/MCC capture rate, then how will the rest of the medical staff appreciate the larger role of the CDI staff and its effect on their performance and financial statistics, asks Michelman. "You need to have the physician advisor focus on the improvement of the clinical picture and have that individual working toward educating the physicians about how their documentation affects that picture," he says.

It is that type of clinical documentation connection that won Pettine's support for the program when he made the career move to CDI effort back in 2007.

"I feel really badly for physicians that are not getting credit for taking care of very sick patients because they simply do not know the right words to use. I don't think that's right. So I try to help. In the beginning, I had no idea what this role was all about; I had no idea that I would really like doing this, but I do. I just think that if you are going to teach and educate physicians you have a better chance if you are a physician yourself," Pettine says.

Figure 7: What is the average referral rate of cases to your CDI physician advisor for review (% of total reviews)?



Director's note

What's in it for the physician? A lot

The bane of many CDI specialists' existence is trying to get physicians to buy into good documentation practices. Most CDI specialists can list a few reasons to answer the eternal physician question, "What's in it for me?" but reasons like publicly available profiles are often nebulous. Because hospitals are paid under Part A and physicians under Part B, it's hard to provide a compelling reason for CDI, as there's no real skin in the fire for the physician.

But a recent notice issued by TrailBlazer Health Enterprises, LLC, put in about as plain words I've seen that contractors are now going to be comparing Part A (hospital) with Part B (physician) claims and looking for any discrepancies between the two. The notice is called *Part A/B Cross-Claim Medical Review: The Impact It Will Have on Physicians* (visit *www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=14572*).

I really like this statement (emphasis mine):

> *"Appropriate claim payments for many services, including inpatient hospital services, require physicians and facilities to ensure proper documentation of medical necessity for the hospital care and related services.* ***At a minimum, physicians must never consider hospital record-keeping to only be perfunctory. Physicians and hospitals must understand that both outpatient and inpatient records should each be able to stand alone to demonstrate medical necessity for related services."***

I will caution that TrailBlazer is just a single Medicare Administrative Contractor (MAC) covering Part A and Part B payments for Colorado, New Mexico, Oklahoma, Texas, and the Indian Health Service. But it is one of the largest MACs in the country, and it's likely other MACs will follow its lead. Even if your hospital is unaffiliated with TrailBlazer, this notice is very much worth sharing with your physicians.

Here's another important piece from the notice (again, emphasis mine):

> *"CMS transferred responsibility for Part A inpatient medical review to MACs and fiscal intermediaries in 2009. With maturation of the Comprehensive Error Rate Testing (CERT) program,* ***the federal government has made reduction of the combined Part A/Part B inappropriate claim payment rate (i.e., CERT error rate) a priority for the Medicare program****. CERT error rate reduction combined with inpatient medical review authority has reshaped TrailBlazer's Medical Review strategy somewhat and has led TrailBlazer to implement A/B cross-claim data analysis and claim review. Though this paradigm and its implementation is currently in its initial phase, TrailBlazer envisions in the near future simultaneous review of all Part A and Part B claims related to inpatient care episodes."*

As you can see, TrailBlazer is right now comparing physician claims directly against hospital claims. For doctors reporting level 3 inpatient E/M services for multiple visits when all they've written in the chart is "admit for chest pain," the problems are obvious. MACs will be taking back money from the doctors unless they start demonstrating how sick their patients really are in the medical record.

I want to thank ACDIS Advisory Board member Glenn Krauss for bringing this to my attention. Glenn has been a champion for linking the work of the CDI specialist to the physicians' business of medicine for as long as I've known him, and this latest notice underscores the message he's been repeating for many years: We're all in this together, physician and hospital.

Take care,

Brian D. Murphy

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Meet a member

Kentucky-based member finds rewards in learning 'broader picture' of patient care

Editor's note: **CDI Journal** *presents a new feature introducing an ACDIS member in each quarter. If you would like to be featured in this section or know someone who would, please e-mail ACDIS Member Services Director Penny Richards at* prichards@cdiassociation.com.

Featured member:

Rita Fields, RN, BSN, clinical documentation specialist at Baptist Hospital East in Louisville, KY, is a member of the Kentucky/Indiana ACDIS chapter.

CDI Journal: **How long have you been in the CDI field?**

RF: Three years.

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

RF: I was working as a case manager and this position became available. I was looking for a new challenge and thought the CDI job looked interesting. I'd been working in patient care and management for 30-plus years. I was a nurse manager in the emergency department [ED]—a job that was 24/7—and then I did ED case management. I loved it, but I needed a change. CDI was something I had never done and it looked challenging. Healthcare changes constantly, and I felt I had some knowledge from previous experience to bring to this new area.I'm glad I made the change. I've learned so much and have a broader picture of things now. I can see what goes on behind the scenes—not just in direct patient care.

CDI Journal: **What has been your biggest challenge?**

RF: My biggest challenge has been dealing with physicians who don't understand the CDI function and what my job entails. They can become defensive when they feel we're trying to tell them how to do their jobs.

It can be difficult to explain how our job is to focus on capturing the severity of illness and risk of mortality to provide more detail about the patient's condition and care provided. It can be hard to then help them understand how this, in turn, strengthens the hospital's data and physician report cards.

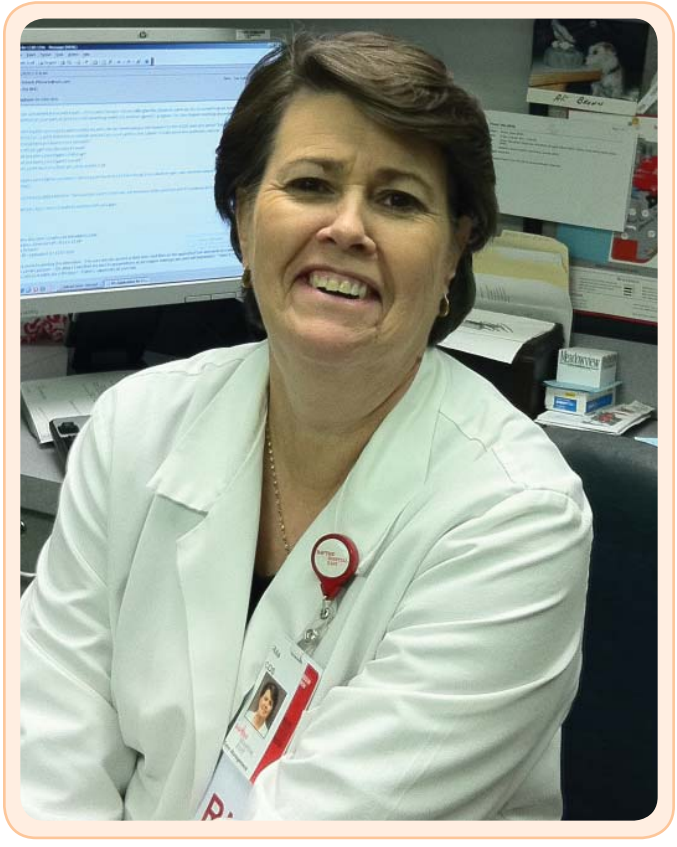
This job requires constant communication with physicians and education.

CDI Journal: **What has been your biggest reward?**

RF: The tremendous satisfaction that I can learn a new job and that learning is a continuous process. I'm proof that you *can* teach an old dog new tricks! My involvement with our ACDIS local chapter has been rewarding because of all the people I've met and the networking opportunities I've found.

A few of Rita's favorite things:

- Vacation spots: Sedona, AZ, and Santa Fe, NM
- Hobby: Collecting Native American art
- Non-alcoholic beverage: Dr. Pepper®
- Foods: Chinese, Mexican, and pizza with all the toppings
- Activity: Water sports, with whitewater rafting at the top of the list



Outpatient CDI efforts offer documentation opportunities

High-cost procedures, medical necessity represent best potential

With the advent of Medicare Administrative Contractors (MAC), which review both Part A (hospital) and Part B (physician) billing, payers are now looking to ensure that physician and facility billing match, says **Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, C-CDIS, CCDS**, an ACDIS Advisory Board member and independent consultant based in Madison, WI. This combined review could mean new vulnerabilities for hospital and physician reimbursement, but it also represents a new opportunity for CDI specialists: outpatient record review.

"We [as CDI specialists] are trying to get buy-in, support, from physicians," Krauss says. "But we don't explain how documentation affects their business. Outpatient documentation review is a good segue for helping physicians understand the importance of documentation in the medical record."

Expanding ED efforts

At Advocate BroMenn Medical Center in Normal, IL, coders identified a number of concerns with outpatient, emergency department (ED), and nursing documentation, says **Avery E. Trickey, RHIA**, manager of the HIM department there. Trickey spoke to ACDIS members about ED/outpatient reviews during the association's Quarterly Conference Call on November 17, 2011 *(www.hcpro.com/acdis/quarterly_conference_calls.cfm)*. Trickey also answered a CDI Week special Q&A on the topic *(www.hcpro.com/content/271005.pdf)* in September 2011.

"Our CDI program was plugging along, and as time went by, we decided we should look at these different areas," says Trickey.

Advocate BroMenn's CDI program employs four full-time equivalent (FTE) staff members, all of whom are RHIAs. The team reviews neurology, intermediate care, critical, surgical, rehabilitation, and cardiology, as well as ED records.

Because coders at Advocate BroMenn assign charges, they were aware of how much the facility might have been able to garner had the documentation been complete. Armed with this knowledge, the team audited 100% of records for two weeks and established a figure for what would have been recouped in charges had the appropriate documentation been included. The team then extrapolated that figure out over a year, noting an estimated $350,000 in potentially lost reimbursement.

To get ED reviews started, Trickey pored over the ACDIS website, reviewed conference PowerPoint® presentations regarding outpatient/ED CDI efforts, and started conversations with the ED leadership. Each CDI specialist spent time in the ED to study the patients and staff and work flow. They established relationships with the nurses and physicians and determined how documentation reviews might be conducted.

Now two CDI specialists spend dedicated two-hour shifts in the ED during the week, in addition to tending inpatient units for reviews. Staff members switch off every other week, so if someone goes on vacation or is absent everyone understands the process and can fill in if need be, Trickey says.

"We're [in the ED] from [roughly] 5–8 a.m. to look at any charts from the overnight shift before the nurses leave, and then again from 1–3 p.m. before the next shift comes in," Trickey says. "That way we can ask for clarification while they're still there."

Adding outpatient opportunities

Although Trickey hasn't rolled out CDI efforts as they relate to medical necessity, Advocate BroMenn's patient accounts department approached the CDI team looking for help in that regard, she says.

Outpatient care includes both high-volume and high-cost procedures, says Krauss. As a result, you may wish to establish medical necessity reviews as well. "Physicians' orders account for approximately 90% of healthcare spending through their pen, through ordering of diagnostic tests and other patient services such as rehab, radiology tests to name just a couple," he says.

Medicare releases national coverage determinations (NCD) while its contractors issue local coverage determinations (LCD), which explain under what circumstance a

certain treatment/procedure will be reimbursed. The conditions can be complex and require more than simply capturing the diagnosis on the claim.

Getting started: First steps

To start reviews on the outpatient side, conduct a retrospective review of your facility's top 20 denials for outpatient procedures, Krauss says. Then determine what the NCD and LCD documentation requirements are for those procedures.

Next, pull a selection of records for each of the top denials and compare their documentation against the requirements, taking note of areas where the medical record falls short. Also note whether deficits in documentation stem from one particular physician or whether the problem exists across a particular service line, Krauss says.

Armed with your audit research, approach key staff members such as a department chair, medical staff director, or HIM director to share the information you've gathered. Illustrate the potential losses and have a plan ready to help resolve the concern, says Krauss.

Such a plan might include creating a new physician order form or documentation tip sheet to make it easier for physicians to document their orders in the most appropriate and compliant manner. It might also include additional educational efforts from the CDI team or one-on-one interventions with particular physicians.

If you receive approval to conduct additional education sessions, do so armed with specific data, says Krauss. Have examples of lacking documentation and appropriate documentation using actual copies of physician medical record documentation.

Bring examples of coverage determinations and key provisions of the LCD/NCD including *Indication* and *Limitations of Coverage* as well as specific medical record documentation requirements. Show physicians where the rules are located. Illustrate how documentation improvement isn't just a program to boost facility reimbursement—demonstrate how it helps physicians' business as well.

Focusing efforts

For example, an analysis of denials at one hospital revealed a high percentage of denials for blepharoplasty procedures for ptosis of eyelids. Often these are considered cosmetic in nature. Cosmetic procedures for the most part are not considered a Medicare-covered benefit and, as such, are statutorily excluded. According to National Government Services (NGS), a MAC:

> *"Based upon specific definitions ... surgery of the upper eyelids is reconstructive when it provides functional vision and/or visual field benefits or improves the functioning of a malformed or degenerated body member, but cosmetic when done to enhance aesthetic appearance. ... Any procedure(s) involving blepharoplasty and billed to this contractor must be supported by documented patient complaints which justify functional surgery. This documentation must address the signs and symptoms commonly found in association with ptosis, pseudoptosis, blepharochalasis and/or dermatochalasis ..."*

Krauss ran a report of the denials encountered for all blepharoplasty procedures performed at the outpatient surgery center for the past year, identified trends by physicians, and selected a representative sample of these denials by physicians.

He then reviewed the dictated operative note identifying clinical documentation deficiencies as defined by the NGS. Krauss met with the outpatient surgery nurse director, reviewed the documentation as compared to the requirements, and asked for her advice about how to communicate to the physicians.

Krauss then made appointments to meet the four physicians who had a disproportionate share of denials for blepharoplasty and showed them their dictated reports against the NGS guidelines and the Wisconsin Physicians Service Insurance Corporation, Part B Medicare carrier's LCD, to illustrate how similar both guidelines are.

"The physicians are busy trying to stay in business," says Krauss. "They can't keep up with all the documentation requirements. Now, along comes the CDI specialist who offers to help them stay on top of the different documentation requirements. Don't you think that will help make a difference in the physician's involvement with the CDI program?"

Editor's note: You can contact Krauss via e-mail at glennkrauss@earthlink.net.

Ask ACDIS

Functional quadriplegia: Including definitions on query forms

Q Is it okay to include a definition of "functional quadriplegia" when we query the physician for this condition? I was surprised when I approached a physician to discuss this diagnosis and he had not heard of it. However, when I gave him the definition, he agreed with it and documented it.

A We are not aware of any prohibition to the practice of adding thoughtfully researched definitions of terms that have been agreed upon by the medical staff to query forms. Sadly, given that there appears to be no case law involving this practice, we can only guess what a judge or jury would rule.

It makes sense to provide definitions to physicians given that the Office of Inspector General, Recovery Audit Contractors, Medicare Administrative Contractors, Medicaid Integrity Contractors, and other reviewers are using their nurses and physicians to clinically interpret records to determine whether the clinical circumstance supports the code assigned based on the provider documentation.

Rules and opinions supporting this method of clinical review include:

- *MLN Matters* article MM6954, "Clinical Review Judgment"
- *Medicare Program Integrity Manual,* section 3.14, "Clinical Review Judgment"
- *MLN Matters* article SE1121, "Recovery Audit Program DRG Coding Vulnerabilities for Inpatient Hospitals"

Using reasonable literature to support these definitions helps facilities defend their queries by ensuring that they are clinically and foundationally sound. It also helps physicians apply evidence-based and consensus-driven diagnoses to their patients' conditions.

However, these definitions should not serve as a substitute for provider documentation, as cited in the AHA's *Coding Clinic for ICD-9-CM,* 2nd Quarter 2004, p. 13, which stated that the medical executive committee may not define "urosepsis" as a substitute for physician documentation.

Regarding the definition of the term "functional quadriplegia," PubMed (*www.pubmed.gov*) did not reference this term during a recent search.

The ICD-9-CM Coordination and Maintenance Committee offered the following information in 2007 (see p. 11):

> *Laura Powers, M.D., representing the American Academy of Neurology (AAN), provided clarification that functional incontinence refers to a person who cannot get to the bathroom perhaps due to staff not responding quickly to their call. Functional quadriplegia is not paresis. It is the inability to move due to another condition (severe contractures, arthritis, etc) and functionally you are the same as a paralyzed person.*

Coding Clinic for ICD-9-CM, 4th Quarter, 2008, defined functional quadriplegia as "the inability to move due to another condition (e.g., dementia, severe contractures, arthritis, etc.)" and not as a true paresis. However, you should exercise caution when using this or any other *Coding Clinic* definition in supporting or defending code assignment.

Coding Clinic, 3rd Quarter 2008, p. 16, emphasizes that you cannot use background material published in *Coding Clinic* as clinical criteria for code assignment, but only to provide clinical clues that may establish a foundation for query.

Furthermore, *Coding Clinic,* 1st Quarter 2008, p. 3, emphasizes that:

> *"[T]he establishment of clinical parameters for code assignment is beyond the scope of authority of the editorial Advisory Board for Coding Clinic for ICD-9-CM. All code assignment is based on provider documentation."*

Consequently, we recommend that you gather expert opinions or credible literature when offering definitions of terms to physicians, especially since they will come in handy if they are challenged in a retrospective audit.

Offering definitions may make a query appear leading or prodding, especially if a definition is offered for only one diagnosis. Have your legal counsel review these queries for appropriateness. Some additional considerations include the following:

- Provide a definition of all the terms included on the query to avoid the perception of leading. Otherwise, it could appear to an outside auditor that you are encouraging the use of a particular diagnosis, especially if it has a more extensive explanation than the others.
- Consult the definition of "functional quadriplegia" from credible sources, such as authoritative literature or expert opinions. Keep these references readily available in the event an outside entity challenges the documented diagnosis and the assigned code.
- After developing the query containing this definition, start one-on-one physician education and build on that education. Depending on the depth of the educational need, set up a meeting with the chief of that specialty to come together on the need for clarification and/or definition. Then present the definition at your facility's next departmental meeting.

Note that not all facilities choose to offer definitions on their query forms. In the case of unusual terms such as "functional quadriplegia," instead of developing a standard definition to use on query forms, you may wish to provide global education and then focus more one-on-one education to a target group of physicians that are most likely to treat the condition.

Editor's note: This question was answered by the ACDIS Advisory Board and is general in nature. Please seek legal counsel for definitive guidance.

Cardiomyopathy: Understand the intent behind the codes

by Robert S. Gold, MD

The goals of coding should always be ensuring data accuracy and capturing a patient's true clinical picture.

Knowing the intent of an ICD-9-CM code is crucial. However, coding guidelines and official coding guidance sometimes conflict with these goals, putting coders and CDI specialists between a rock and a hard place.

Cardiomyopathy (CMP), a disease that affects the heart muscle, is an example of a diagnosis that is frequently misreported due to inaccurate guidance.

First and foremost, coders and CDI specialists must understand that when cardiologists document the term "CMP," it usually denotes their awareness that the patient has a sick heart. The physician may evaluate the heart as being dilated and as having a low ejection fraction. However, they don't always evaluate pathophysiology. Without this evaluation, documentation of CMP can be deceiving. When coders see this documentation, they report ICD-9-CM code 425.4 for the CMP even when the patient may have something else.

Causes of CMP

A quick Google search yields a variety of causes of CMP. There are specific ICD-9-CM codes in the 425 code series for each type of CMP. For example, codes 425.11 and 425.18 denote idiopathic hypertrophic CMP with or without obstruction, respectively.

Code 425.5 denotes alcoholic CMP. Code 425.7 denotes nutritional CMPs, such as due to amyloidosis and beriberi. Some very rare CMPs are also specifically named in this section. Two examples are endocardial fibroelastosis (code 425.3) and obscure CMP of Africa (code 425.2).

Code 425.8 denotes other specified CMPs in diseases classified elsewhere that can also affect the heart muscle and its function. These include Friedreich's ataxia, progressive muscular dystrophy, sarcoidosis, and myotonia atrophica.

Other specific causes of CMP are not included in the 425 code series.

If you look for hypertensive CMP in the Alphabetic Index of the *ICD-9-CM Manual*, it leads you to hypertension with cardiac involvement. This leads you to

the 402–404 code series. Hypertensive CMP is a type of CMP; however, it doesn't exist in the 425 code series. *Coding Clinic*, 2nd Quarter 1993, p. 9, instructs coders to assign both the 402 (or 404) series code and code 425.8 to designate CMP in diseases that are classified elsewhere.

Similarly, ischemic CMP (code 414.8) is not listed under CMP even though it is a cause of heart disease that can lead to dysfunction. No advice exists for the addition of code 425.8 even though it is among the most frequent causes of CMP in the United States. This represents an error in the coding system. ICD-9-CM code 414.8 denotes ischemic heart disease just as codes 403 and 404 denote hypertensive heart disease. They each require code 425.8 to capture the complete description of the condition.

Several *Coding Clinic* references cite code 425.4 (other primary CMPs) for CMP. These references state that coders should report this code for CMP that includes such terms as "congestive," "constrictive," "familial," "idiopathic," "restrictive," or "obstructive." However, these references are incorrect. Code 425.4 should be used only for primary CMPs not otherwise specified or when physicians document one of the aforementioned nonessential modifiers.

When a patient has CMP that is secondary to another condition (and the cause is unknown) coders should report code 425.9 (secondary CMP, unspecified).

When the cause is known, they should report code 425.8. These codes (i.e., 425.8 and 425.9) should be used when documentation includes any one of the nonessential modifiers listed under code 425.4 and when the CMP is due to another condition.

The term "idiopathic" means that the physician cannot determine the cause of the CMP despite extensive workup. If the physician can determine the cause, then by definition it's secondary CMP.

Ischemic heart disease is a disease classified elsewhere. Similarly, hypertension is a disease classified elsewhere. Therefore, code 425.8 should be added to 414.8 (other specified forms of chronic ischemic heart disease) for ischemic CMP.

But it's ischemic heart disease. Wait a second.

Beware of encoders

What about a patient with left ventricular hypertrophy due to increased work caused by aortic stenosis? Physicians refer to this as valvular heart disease. In their minds, it's a CMP. However, coders input "disease, valvular, heart" into an encoder and are directed to endocarditis, which is incorrect. Why does this occur? It occurs because encoders interpret words literally and as being part of one context. This means that a valvular disease of the heart must be endocarditis.

> [Physicians] don't always evaluate pathophysiology. **Without this evaluation, documentation of CMP can be deceiving.**

Instead, coders should report code 424.1 (aortic valve disorders) and 425.8 for valvular CMP. If a patient has advanced to chronic diastolic failure due to the valvular heart disease resulting from aortic stenosis, coders should add code 428.32.

Know the bottom line

In summary, consider the following:

- Code 425.8 should accompany all identifiable and codeable diseases that affect the function of the heart and that don't have a specific designation within the 425 code series
- Assign code 425.4 to all primary or idiopathic conditions of the heart that cause functional change
- Assign code 425.9 to all dysfunctions of the heart that you know are caused by an unidentifiable source
- Report code 425.4 only for primary CMP, which is intrinsic disease of the heart muscle not caused by other conditions

Editor's note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician clinical documentation improvement programs, and is also a member of the ACDIS Advisory Board. Contact him at 770/216-9691 or via e-mail at rgold@DCBAInc.com.

This article was originally published in the December 2011 edition of **Briefings on Coding Compliance Strategies.**

ICD-10 prep: Dig into documentation

Start by reviewing your most frequently reported conditions

With all of the attention around the increased specificity of ICD-10-CM codes, facilities are concerned that documentation will lack sufficient detail. And as CDI specialists know, physicians don't always provide enough information for coders to choose the most specific ICD-9-CM code.

Instead of panicking, determine which conditions the providers most often treat, says **Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS,** director of HIM and coding at HCPro, Inc., in Danvers, MA. Then evaluate the documentation to see what additional information providers will need to document with the added specificity for ICD-10-CM.

"Identify the information that providers can document now," McCall says. The additional information may not help with ICD-9-CM coding, but providers will already be documenting those details when ICD-10-CM rolls around.

"You can't use the new codes now, but you can look to see what additional documentation you will need," McCall adds.

Some things that weren't important in ICD-9-CM will be needed in ICD-10-CM. For example, if a patient comes in with acute pancreatitis and is also identified as being alcohol dependent, coders can assign separate codes in ICD-9-CM for acute pancreatitis (577.0) and a code for alcohol dependence (303.xx or 305.xx) with no need to identify whether the conditions are interrelated.

However, in ICD-10-CM, if coders get this same documentation it will prompt a query to the provider because there is a more specific combination code that can be assigned to identify the conditions being related—code K85.2 (alcohol-induced acute pancreatitis).

Physicians may not be accustomed to being asked for correlation of some conditions because in the past it wasn't relevant to appropriate code assignment. But coders can report certain conditions in ICD-9-CM that will no longer have a default code in ICD-10, which will prompt CDI specialists to go back to the physicians for clarification, says **Jennifer Avery, CCS, CPC-H, CPC, CPC-I**, senior regulatory specialist at HCPro.

"Physicians are used to being questioned about urosepsis as to whether they mean a urinary tract infection (UTI) or sepsis of a urinary source, but they also know that if they don't clarify that coders can assign 599.0 for a UTI because in ICD-9-CM the term urosepsis defaults to a UTI," Avery explains. However, in ICD-10-CM, coders cannot assign a code for urosepsis as the Alphabetic Index directs the coder to code to condition, which requires the coder and/or CDI specialist to go back to the physician for additional documentation, forcing a query.

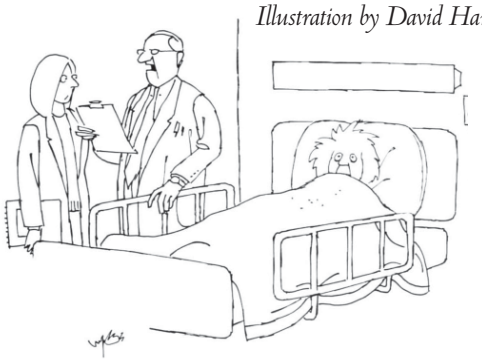
"If we begin to educate the physicians now that urosepsis will no longer be a codeable diagnosis, it may actually assist us with one of our longest running coding conundrums," Avery says.

The way CDI specialists present information to a physician will also be important, Avery adds. If physicians know why the additional documentation is required, they are more likely to make the changes. If the physician simply receives a query asking for additional information, they may not change how they document in the future and the need for further queries on the same conditions will continue.

"If they know that the specificity is necessary in order to code the condition in ICD-10, then it will make a difference," Avery says.

Be sure to share this information with your physicians. "When physicians know what to put in the record, everything else works," says **Robert S. Gold, MD,** CEO of DCBA, Inc., a consulting firm in Atlanta.

Illustration by David Harbaugh



"The new ICD-10 code set will include more than 155,000 codes and greater specificity from physicians' documentation ... She's a CDI specialist, not a patient."

Outgoing members of the ACDIS Advisory Board offer thoughts on association and CDI profession growth

As four new Advisory Board members step forward each year to lend leadership to the ACDIS membership, four trusted members take a step back from their roles. This January, outgoing Advisory Board members include:

Shelia Bullock, RN, BSN, MBA, CCM, CCDS, *director of clinical documentation services at the University of Mississippi (Jackson) Medical Center*

Garri L. Garrison, RN, CPC, CMC, CPUR, *director of acute care services at 3M Health Information Systems Consulting Services*

Robin R. Holmes, RN, MSN, *director of case management at DCH Health System in Tuscaloosa, AL*

Colleen Stukenberg, MSN, RN, CMSRN, CCDS, *clinical documentation management professional at FHN Memorial Hospital in Freeport, IL*

Bullock, Garrison, Holmes, and Stukenberg shared their thoughts on the growth of ACDIS and the CDI profession as a whole during their three-year tenure on the board.

Discovering community

Bullock's facility began its CDI program in March 2007, months before the implementation of MS-DRGs. The career change prompted her to learn more about the industry online. That's where she found ACDIS.

"When you start in a program like this, you research what's going on. I wanted to learn. I wanted to help bring our program up to where other, more established programs were," Bullock says.

Other outgoing board members echo her story.

Stukenberg discovered ACDIS shortly after she accepted her position and just a few months prior to the first annual ACDIS conference at Caesars Palace® in Las Vegas.

"There were about 400 attendees. I don't think anyone expected that kind of turnout," Stukenberg says. "There was this tremendous feeling of opportunity and growth that pervaded the whole event. I just knew I had to get more involved."

Some say that leadership is an innate part of one's being. "There are leaders and there are followers," as the axiom goes. Those contemplating advanced participation with the national association, however, need not feel anxious about volunteering, says Stukenberg.

"National-level involvement can be intimidating," she says, "but everything you do for the first time can be intimidating."

Stukenberg volunteered to serve on the ACDIS Advisory Board and then volunteered to help lead the Northern Illinois CDI Networking group.

"When I joined we [as an organization] were in our infancy stage. Now, we're in the toddler stage. Compared to other organizations we have come so far, so quickly. Nevertheless, ACDIS is a small enough organization that you can really have a voice and make your influence count," says Stukenberg.

Because Bullock "learns by doing," she volunteered wanting to expand her own knowledge of CDI best practices.

"I never thought that I would get picked to be a part of such an experienced group. I wanted to be a part of guiding

this organization. I wanted to connect with others who are also leaders and to expand my knowledge. And I've done all those things. It has been amazing. It has been wonderful."

Similarly, Holmes struggled to find her way as a nurse filling the CDI specialist role. "It was all foreign," she says. "As soon as ACDIS came about, I became involved as a member. I was desperate for it. Finally, someone out there was talking my language."

Energized after attending her first ACDIS conference in Las Vegas, and from additional information offered via membership, Holmes decided she wanted to participate even further. "I just knew that this was something I wanted to be as involved in as possible," says Holmes. "I would encourage anyone who has a passion for CDI to apply for leadership roles within the organization."

Garrison had been working in documentation improvement since 1993. "I must have worked with more than 500 facilities over the years doing CDI," she says, "but it wasn't a skill set that was really recognized by the healthcare industry."

Excited about the opportunity to participate in a fledgling organization, Garrison sought to serve on the ACDIS Advisory Board to help shape how the industry views the roles and responsibilities of CDI professionals.

"There was a skill set for nurses. There was a skill set for coders. But CDI specialists need a skill set of both these professions. At the time there wasn't a group that recognized CDI professionals. ACDIS is really filling a need."

Collaborative measures

That collaborative focus/mission of the association represents one accomplishment all four board members cite as a success. While disagreements still exist regarding which type of professional is best suited to the CDI role, ACDIS maintains that any professional background may perform the job well, as long as the individual exhibits the skills to accomplish the required tasks.

Some nurses and coders want ACDIS to endorse one profession over the other as having the essential aptitude for CDI tasks, says Holmes. The Advisory Board, however, refused to veer from its professed stance of inclusiveness.

"We really want to unify these teams. The bottom line is that anyone can do this job" if they have the training, communication skills, and experience, says Holmes.

"CDI is not one profession type," says Stukenberg. "By being a member of ACDIS (and by being a member of the ACDIS Advisory Board), you really get an opportunity to understand the different perspectives of the various roles. This overall inclusiveness of the association really allows all of us to learn from each other's experience and makes us stronger professionally."

In fact, ACDIS Advisory Board members have been active participants across professional lines, Holmes points out. She participated on a seven-member cross-disciplinary committee (along with fellow ACDIS board members Cheryl

New elections process

When ACDIS began in 2007, the Advisory Board included 12 at-large members—HIM professionals, nurses, and physicians from the industry—who volunteered to help get the association off the ground. Each subsequent year four new Advisory Board members were added until the group swelled to more than 24. Last year, the original 12-member panel stepped down from their posts allowing a new election and rotation process to commence.

Previously, existing members of the Advisory Board selected the four incoming members of the board. Starting in 2012, the process of voting in new Advisory Board members will include a combination of a nomination committee and a vote of the ACDIS membership. Here's how the process will work:

Each fall ACDIS will open the nomination period. Interested individuals will complete a nomination form and submit it to ACDIS. A nomination committee consisting of four current board members and an at-large local chapter member will review the applications, conduct telephone interviews, and narrow the final group to a smaller number (eight to 12) of qualified candidates. Then the entire ACDIS membership will elect their choice of four individuals to serve a three-year term by a vote conducted through the ACDIS website.

As of publication, the committee has begun these reviews. Voting and final appointments are expected to take place in January.

Erickson, Gloryanne Bryant, and William Haik) to draft the AHIMA *Guidance for Clinical Documentation Improvement Programs*, published in May 2010. The entire ACDIS Advisory Board then acknowledged the efforts and intent of the *Guidance* during a special meeting of the board that year.

"We all may not have agreed 100% with everything contained in the AHIMA *Guidance*," says Bullock. "But it was important for us to acknowledge that advice; advice which members of our association helped to draft and which was being disseminated by one of the four cooperating parties."

Although the ACDIS Advisory Board took "a conservative approach" in its support, Garrison says the acknowledgment of AHIMA's various query and CDI publications illustrates a connection to the larger healthcare and health information industries.

Still, opportunities for additional cross-disciplinary growth exist.

For example in spring 2011, the Advisory Board provided commentary on the Centers for Disease Control and Prevention's (CDC) proposed changes to the fiscal year 2012 ICD-9-CM codes. It provided input on items such as malnutrition, acute kidney injury, postoperative respiratory failure, and drug-induced pancytopenia, among others. And in 2010, ACDIS Advisory Board members sent comments to CMS regarding the 2011 inpatient prospective payment system proposed rule.

"We are not a fly-by-night organization. We are not a fly-by-night profession. There are well-thought, well-discussed, well-supported reasons behind the opinions we express. We can/should do more outreach along these lines," says Stukenberg.

'Phenomenal' growth

In their three years of service, Bullock, Garrison, Holmes, and Stukenberg stood at the helm of tremendous association growth. As Stukenberg indicates, attendance at early ACDIS national conferences was roughly 400 or so participants. Nearly 800 participants are expected at the 2012 meeting in San Diego.

The number of vendors exhibiting at the conference has also doubled.

Overall ACDIS membership has grown to nearly 3,000. There are nearly 12,000 subscribers to the free bimonthly e-mail newsletter *CDI Strategies*. Local networking groups have grown from just three in 2008 to more than 30 across the continental United States. There is even a chapter in Hawaii.

"The growth of ACDIS membership is a phenomenal thing," says Garrison. "It is due to the quality of its publications, the conference, the quarterly conference calls. This is the place to go for a tremendous collection of extended resources that come with membership, and this is a place where to go to reach out to others, to find peers in the profession."

> "As soon as ACDIS came about, I became involved as a member. I was desperate for it. **Finally, someone out there was talking my language."**
>
> *—Robin R. Holmes, RN, MSN*

There's always room for additional growth, though.

Holmes wishes for a new local chapter in Alabama and additional opportunities for nursing continuing education credits associated with ACDIS-sponsored events.

Bullock also hopes to help develop a networking group in Mississippi. She looks forward to the continuing advancement of CDI responsibilities in light of various healthcare reform initiatives such as ICD-10, pay-for-performance, value-based purchasing, and readmission reduction.

Programs need to shift away from the earlier focus of CDI targets solely for reimbursement purposes "to a focus on patient safety," Bullock says. "Reimbursement is going to be tied to quality and patient care. ACDIS and the new Advisory Board will have to stress these concerns as we move forward as an organization. This is a fantastic opportunity for CDI to advance."

"The industry is just swamped with changes," agrees Garrison. "Government initiatives and the industry push toward technology is changing our world. Pay-for-performance models are merging coding, CDI, and quality activities. We need to ensure we are doing the right things for our patients and that the data is really telling the whole story."

Garrison also hopes that the ACDIS Advisory Board and association maintains its mix of perspective.

"I think it's an important aspect of [our] success," she explains.

> "By being a member of ACDIS (and by being a member of the ACDIS Advisory Board), you really get an opportunity to understand the different perspectives of the various roles. **This overall inclusiveness of the association really allows all of us to learn from each other's experience and makes us stronger professionally."**
>
> *—Colleen Stukenberg, MSN, RN, CMSRN, CCDS*

As for her aspirations for ACDIS, Stukenberg's are numerous, including additional cross-industry partnerships, increased educational opportunities for ACDIS members, expansion of local networking efforts, accreditation of the Certified Clinical Documentation Specialist (CCDS) credential, as well as increased activity and involvement from the ACDIS membership themselves.

Maybe most of all, Stukenberg wishes she could remain on the board for another three years.

"I'm sort of sad about leaving, to be honest," she says. "It has been such an amazing, exciting time. I would tell those who are coming onto the board and remaining on the board to stay motivated, to appreciate the role and responsibility of the position you've accepted. Participate. It is a lot of work, but it has been an honor to serve. If I could stay longer, believe me, I would."

Networking focus

Oregon/SW Washington group expands organization

New leadership, new blog reinvigorates chapter

More than 30 people attended the October 21, 2011, Oregon/SW Washington ACDIS chapter meeting. Such attendance is exciting enough for a somewhat fledgling networking group (they've been meeting for roughly three years now), but it isn't what leaders **Janet Barber, BSN, RN, MBA,** clinical documentation specialist at Providence Portland (OR) Medical Center, and **Nancy Seebert, RN, BS, MA,** clinical documentation specialist at Legacy Mt. Hood Medical Center in Gresham, OR, raved about.

It also featured the group's first live webinar attempt featuring Cesar Limjoco, MD, of DCBA, Inc., "all the way from Indianapolis."

Exciting enough, to be sure, but that wasn't the highlight of the meeting either, to hear Barber and Seebert talk about it.

Just take a peek at their blog at *http://oregonswwashingtonacdischapter.blogspot.com)*:

> *"NOW TO THE EXCITING NEWS,"* it exclaims, *"The chapter will grow tremendously this coming year with 9—count them—9 volunteers who have committed to lead in 2012."*

"You can't imagine how it feels to go from that first meeting, which essentially was just a gathering of sorts, to where we are now," says **Eileen Pracz, RN, CCDS,** clinical documentation specialist at Oregon Health & Science University in Portland, who led the chapter in 2010.

"This has really grown," she says. "We have a whole committee now that should help our chapter continue to grow."

Pracz gives Barber and Seebert credit for pushing the networking group to its current level of involvement, but it's worth examining the chapter's origins to fully appreciate how far the CDI specialists in this region have taken their group and how far they still want to grow.

A simple start

Linda Haynes, RHIT, documentation specialist for Legacy Health System's Meridian Park Hospital in Tualatin, moved to Portland, OR, in 2006. Her youngest daughter had moved there and Haynes saw an opening for a CDI specialist.

"I'd never heard of CDI before," she says. "My career has been in HIM. I was a director for many, many years."

New to the region and new to the profession, she struggled to find her way.

"In my previous role, I had done a lot of networking, but that was with people back east. I felt like I was stumbling onto information and stumbling into [professional] trouble spots," says Haynes.

In 2007, she attended a meeting about CDI by the World Research Group in Chicago, and while Haynes learned a lot, "it made me realize that there was a lot I didn't know."

Once back in Portland, Haynes picked up the phone and started calling neighboring hospitals searching for other CDI programs.

She didn't have much success.

"I had a hard time finding them, to be honest," says Haynes. "The front desk didn't know who, or what, I was talking about. I didn't know where [the CDI programs] were located: case management, quality, HIM."

With a little investigative effort and perseverance, however, Haynes gathered enough of a crew to hold an initial meeting. The first session was held in September 2009 at Meridian.

"It was just an informal meeting; just a get-together to introduce ourselves and talk about what we do and how we do it and how to get a program started," she says.

That first meeting had about a dozen attendees. A physician gave a presentation or two, but mostly participants just talked. It evolved into a business meeting of sorts, says Haynes, as the group tried to decide how to continue. Seeing all the progress they've made, Haynes is glad they did.

"And [this past] October we had more than 30 attendees," she says. "The excitement and participation has just grown tremendously."

Former Oregon/SW Washington ACDIS Chapter secretary Nancy Seebert welcomes guests during the group's February 2011 meeting.

Secondary steps

At that first meeting, Haynes gathered attendees' contact information and the group discussed meeting "rules," such as frequency and duration of the sessions, whether officers would be elected, and what those roles would look like, says Pracz, who volunteered and was elected president of the group supported by **Karen Maritano, RN,** a CDI specialist at Legacy who volunteered to serve as the group's secretary.

During their tenure, meeting locations rotated among volunteer hosts. The individual or group which hosted the meeting was required to develop the agenda, find the speakers, and provide any additional amenities. Pracz served as a conduit to ACDIS National and Maritano served to communicate announcements and minutes to the members of the group.

"It was really a lot of work during my reign," says Pracz. "Putting together the day was like putting together a wedding. It was difficult to get people to RSVP, to volunteer to host, or offer to present. Not all hospitals have money for training and not all hospitals will allow staff members the time off to come to group meetings either."

Regardless, the two leaders persisted, organizing meetings regarding emergency department documentation, heart failure, and ICD-9-CM coding changes.

And the group continued to grow.

"We've had lots of great presentations and lots of great speakers. Networking on a local level is important because you really share the same challenges," says Maritano.

At a meeting in October 2010, the group decided it would hold a meeting annually at that time to discuss changes to the inpatient prospective payment system (IPPS) and ICD-9-CM code sets.

They also determined that during the October meeting the group would conduct chapter business such as electing new officers, creating potential agendas for the following year's meeting, and discussing possible changes to the structure of the organization.

Leaps ...

Barber changed careers to become a CDI specialist in July 2010. Like many CDI specialists, an Internet search for clinical documentation introduced her to ACDIS, and she found the Oregon/SW Washington chapter through its website and associated blog.

"That first meeting there was a discussion about heart failure, and ACDIS, and primary diagnosis coding rules, and changes to the code set, and the IPPS system," she recalls. "I thought, 'I made the right choice coming to this profession,' " says Barber. "I was thrilled. I liked the meeting and I liked the potential. I knew from experience how important these groups are for your professional and intellectual growth."

Seebert also came to that October 2010 meeting fresh from a nursing career change. "Whenever you take a new job you should immediately look to the association supporting the profession."

She joined ACDIS the day she started her new job. She saw the information regarding the upcoming meeting and called Pracz to learn more.

As a member of the American Association of Training and Development, Seebert had experience serving on volunteer committees as well as working at the local chapter level.

When the call came for volunteers to serve as secretary for the Oregon/SW Washington ACDIS chapter, she raised her hand.

"I learn more by doing," Seebert says, "so I saw this as a great opportunity to learn about my new role and to become more involved."

Barber, it turned out, remembered working with Seebert previously. When she saw Seebert's name, Barber decided to volunteer, too. "I didn't know why no one wanted to be president," Barber says, laughing. "Nancy and I worked together briefly previously and so I stepped in not knowing what I was getting myself into. Luckily, [what I got myself into] was all good."

Stumbles ...

The duo set ambitious goals for themselves. They hoped to collect membership dues, establish the group as a nonprofit entity, and develop job descriptions for group officers. They also hoped to create a website or blog as a place where the community could house photos, meeting invitations, minutes, and presentations.

"We wanted to bring this chapter to a different place, to formalize the process, and we wanted that process to be seamless and transparent. Mostly we wanted to develop a community that people could be excited about," says Barber.

Traditionally, the group held meetings three times a year and so Barber and Seebert set out to do the same. But the June meeting fell through as the two struggled to develop worthy sessions.

"Past procedure was the hosting facility ran the meetings, but when difficulties came up," the chapter leaders needed to resolve problems and ensure the meetings did take place. "It really became overwhelming at times with just the two of us," says Barber.

Although they tried several solutions, the group ended up canceling one meeting. They asked for volunteers to step in but didn't receive much response.

"We were asking for help," says Barber, "but people weren't responding."

In hindsight, says Seebert, "we should have asked for help regarding the meetings right from the beginning. We should have sent out a request for help and we should have been specific about what we needed."

Barber also found that due to changing economic and regulatory climate, hospital funding to support hosting a conference was not as readily available.

"We are in a new paradigm or evolution in regard to what is happening in healthcare. It has been a surprise to see how much has changed just from last January to October," Barber says.

Earlier in the year, facilities supported CDI education efforts, allowing Seebert and Barber to make copies and provide handouts for meetings, but by October such efforts required prior management approval. "We changed our tone after a while," says Barber. "We told the group that we really did need their help."

"We asked for someone to help with speakers and we asked for someone to help with audiovisual. We asked someone to help with food and someone to help with materials," says Seebert.

"You really have to be specific and target your request for assistance," says Barber. The group's most recent meeting stands as testament to the success of that revelation. When October rolled around and it came time for new volunteers to step forward—they did.

The new leadership board includes:

- Juanita Carriveau, president-elect
- Christy Brown, secretary
- Marjie Aranda, treasurer
- Tami Robinson, member services director
- Mikala Iris, communications officer
- Cindy Fessler, BarDee Pattle, and Julie Walsh, at-large committee members

... and bounds

With its new influx of volunteers the group will be able to evolve further to meet its members' needs.

From left to right, 2011 Oregon chapter president Janet Barber and secretary/treasurer Nancy Seebert give founding leader Linda Haynes an award acknowledging her efforts and making her an honorary lifetime member of the group.

For example, it discussed the possibility of extending the meeting duration to 3:30 p.m. and incorporating lunch-and-learn sessions. At the most recent meeting, the group discussed the possibility of shifting to a biannual format and the feasibility of conducting an all-day meeting one Saturday.

Barber and Seebert further developed the chapter member list started by Haynes. They hope new leaders will develop it even further to incorporate members' specialty areas and years of experience, making it even easier to network.

Seebert took it upon herself to develop the chapter blog despite not having any particular previous blogging experience. "She didn't know how to do it but she learned," says Barber. "And now we have it up and running."

They did begin to collect dues, $30 annually, and have $900 in the bank now to help with 2012 meetings. They researched becoming a nonprofit but determined it wasn't warranted due to the small sum being held in their account.

They applied for (and received) continuing education credits for the Certified Clinical Documentation Specialist credential. They created an evaluation form that attendees were required to fill out prior to receiving their certificate of attendance at meetings.

When Barber and Seebert handed over the reins to the new officers in December, they held a leadership meeting to discuss outstanding issues and will be available in an advisory capacity to the new board during 2012.

"It is not over," says Barber. "Good leadership doesn't simply come to an end. You have to make yourself available to continue the conversation." That's why they've recommended establishing parameters for a president, president-elect, and past-president to ensure continuity and to help disburse responsibilities.

"There are a lot of logistics to consider when you step forward to lead a local group like this. It's like planning a big 'ole wedding," Barber says, echoing Pracz's earlier sentiments.

"We learned this year that it really does take a village to run the group effectively. But we also learned that there is so much energy and excitement around this profession. People are very passionate about it and about the association. You just have to ask for help."

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Clinical Documentation Improvement Week

Director's note

CDI Week celebrations bring tales of success

It is hard to believe that the first-ever Clinical Documentation Improvement (CDI) Week is now little more than a pleasant memory for most. It was definitely something to be marked in the annals of ACDIS' history. Almost since the inception of the association, back on October 1, 2007, ACDIS members have clamored for a special day or week to celebrate this unique profession. A committee of volunteers stepped forward to create a blueprint for CDI Week events, and developed ideas and resources to help CDI specialists and their colleagues celebrate.

Their efforts resulted in a date and a name, a logo, a list of suggested activities, sample PowerPoint® training tools, a poster, and CDI Week and ACDIS-branded items. They also reached out to other associations and news publications to spread the word. As news of the first CDI Week celebrations spread, more individuals volunteered to help. Wendy DeVreugd and her Kindred Healthcare colleagues went the extra mile, producing a high-quality video regarding the value of CDI to physicians, the profession's indispensable partners in ensuring accurate and complete documentation in the medical record. The video is still available on the CDI Week home page on the ACDIS website. In fact, all the materials are still available there, free to all.

At our Danvers headquarters, we asked our colleagues ACDIS-related trivia questions daily via e-mail and gave out CDI-related products to the winners. We hosted a cartoon caption contest on the ACDIS Blog and gave book prizes for the most clever responses. We posted trivia questions to the CDI Talk group and offered a variety awards to those who played along. We also solicited stories of your CDI successes (see pp. 22–28).

Externally, we heard about CDI programs hosting potluck lunches for their coding, case management, and physician team members. CDI specialists sent us pictures of the posters they created and showed us the knickknacks they gave away to physicians in honor of the event. We heard about local chapter meetings and multi-facility CDI education sessions. And we enjoyed perusing through the photographs of your CDI teams (see pp. 22–28).

ACDIS owes a special thanks to its sponsors MetaHealth and ChartWise. It also owes a debt of gratitude to all of you who made CDI Week so special at your facilities and on the national level.

Remember, CDI Week is not a one-time special event. We're going to do this ***every year on the third week of September.***

The first CDI Week may be over, but the days of recognizing this unique, vital profession are just beginning.

Bragging rights

CDI programs share stories in celebration of CDI Week

Editor's note: The first annual Clinical Documentation Improvement Week was celebrated September 18–24, 2011. A work group organized and supported by ACDIS convened over several months to plan and organize the event and to develop resources and promotional events, including an industrywide survey and a series of Q&As, which remain available on the ACDIS website (visit www.hcpro.com/acdis/cdi_week.cfm).

CDI specialists need a week of recognition to:

- Recognize the unique skills and expertise of CDI specialists
- Increase public awareness of the CDI profession
- Positively affect the personal and organizational performance of CDI specialists
- Provide broader education on the importance of the quality connection of documentation of care

We are so proud of the outpouring of support and energy from ACDIS members revolving around the week. We heard from those who hosted potluck lunches and after-hour events, those who developed CDI Week posters, and even those who developed CDI videos.

We asked ACDIS members to send in stories about their CDI Week celebrations and successes. Here is a compilation of what we heard.

Poster power

My practice administrator approved my recommendation to have our clinical department participate in CDI Week.

I created a flyer using the logo supplied by ACDIS. The flyer was approved and we posted it in all six clinical physician pods and everywhere else our staff could see it. As part of the compliance team, I felt this week was a great opportunity for our providers and other clinical personnel to clean up their documentation and get ready for future industry changes. I will be performing fourth quarter audits soon, so we will see how this event affected our progress note records. Hopefully for the better!

Marilu Perez Sumner, ACPAR, CBCS, RMC, CPC
Billing, Auditing, and Coding Specialist
Pinnacle Orthopaedics & Sports Medicine Specialists
Marietta, GA

Blue ribbon efforts

I took the basic idea for this from the ACDIS website and went a little further with it. I developed excellence certificates for various documentation issues we deal with. The first certificate was for proper documentation of principal diagnosis. I put the winning physician's name on the certificate and hung it in the physician mailroom where everyone could see it. One of my "problem" physicians asked what he needed to do to get a certificate and has documented well since then.

For those who earn repeated monthly certificates, I award a blue ribbon for most improved. The first recipient was so excited to have this blue ribbon.

Tracy M. Peyton, RN, CCDS
Case Management
Bradford Regional Medical Center
Upper Allegany Health Systems
Bradford, PA

Superstar documentation

We initiated a physician recognition program, dubbed "Documentation Superstars." Every other month we recognize a physician or nurse practitioner who consistently demonstrates excellent clinical documentation. The winner receives a "Certificate of Excellence," a goodie bag (movie tickets, pens, candies, and other assorted items), and has their photo taken. We post their photo on the "Superstar Board" in the physicians' lounge and on the physician home page on our hospital intranet.

We discovered an air of competition among the physicians and, interestingly enough, they often educate each other about what to do to earn the award. As CDI nurses we seize this moment: interjecting additional information, taking full advantage of this physician education opportunity.

Vivian E. Gannon, RN, CCM, CCDS
Clinical Documentation Specialist
Health Information Services
Chesapeake Regional Medical Center
Chesapeake, VA

Next-level education opportunities

Our CDI team offers continuing medical education credits for staff physicians and physician assistants and continuing education unit credits for nurse practitioners who attend CDI education. The team is in the process of obtaining education competency credit for residents/fellows and medical students who complete CDI training. The team has also developed online (eLearning) CDI education for medical and surgical specialties with the hopes of expanding on these offerings in the future to continue to meet education competency and organizational quality goals.

Tim Weister, MSN, RN
Clinical Documentation Improvement Specialist
Department of Quality and Compliance
Mayo Clinic
Rochester, MN

Rounding benefits

A physician asked if I would be interested in rounding with their service. With the approval of the division chair, we developed a plan and scorecard for them which included:

Linda Steinhoff, RN, CDI specialist at Chesapeake (VA) Regional Medical Center, sent this photo of the Virginia ACDIS chapter's fifth quarterly meeting, which featured guest speaker Robert S. Gold, MD, in October.

Groenhagen's efforts earn CDI Week reward

Editor's note: As part of the inaugural CDI Week activities, ACDIS Director Brian Murphy asked members to submit personal anecdotes of their CDI program's successes. Two respondents received prizes for the most inspiring stories.

The following submission from Andrea Groenhagen, BSN, RN, CCDS, proves that moving from the bedside to CDI can lead to its own rewards.

Painting the clinical picture

After 19 years as a bedside nurse (med-surg), I was getting restless for a change. I didn't want a lateral move or managerial position. I was looking for a position that was challenging but where I could use my clinical experience and knowledge.

I found an opening for "clinical documentation specialist." I read the job description to get a general idea of the role and applied for it. Meeting the facility's qualification expectations was not easy. The interview was nerve-wracking. It was with a panel that included two physicians. One of the physicians asked, "How do you approach a busy physician on the floor if you have a query?"

When I was offered the job, I went from being a veteran nurse to a novice CDI specialist. I had those nervous feelings I remembered from when I was a new nursing graduate and giving my first shot to a patient, inserting my first NG tube, urinary catheter, and doing my first venipuncture. I wondered: Had I made the right move? Will I miss bedside nursing?

Here is what I found out: I miss that adrenaline rush I got when I went to a code blue. Now I equate my code blue rush fix to whenever I get a reaction from a difficult physician. As a nurse that compassion never goes away. I know I helped and got satisfaction when patients and families thanked me for the excellent care I provided. As a CDI specialist, I may not get "thank yous" from the physicians as often as I would have as a bedside nurse, but I know in my heart only a great CDI specialist can paint that "clinical picture" accurately and in bold color.

Andrea Groenhagen, BSN, RN, CCDS
Clinical Documentation Specialist
Lawrence Memorial Hospital
Lawrence, KS

- Round with each physician on the team for two days in a row on the week they were at the hospital
- Listen for clues as to what diagnoses could be documented in the medical record
- Review those cases after rounds
- Create a spreadsheet of diagnoses that the physicians captured in their documentation and potential additional diagnoses not captured
- Develop a scorecard for each physician with diagnoses documented/potential diagnoses = % of captured diagnoses
- Meet with each physician individually to discuss findings

We shared results with the division chair, who then showed them to the group.

I plan to repeat this process again this year for a comparison of continued documentation improvement.

The individual meetings gave the physicians an opportunity to ask questions they may not have had an opportunity to ask otherwise. It also provided us with an opportunity to begin developing a relationship with this physician group and the division. From this project, I am now doing quarterly education with the residents, fellows, nurse practitioners, and physician assistants.

McLuckie's successes earn CDI Week honors

Editor's note: As part of the inaugural CDI Week activities, ACDIS Director Brian Murphy asked members to submit personal anecdotes of their CDI program's successes. Two respondents received prizes for the most inspiring stories.

The following submission from Lisa McLuckie, RN, demonstrates that the work of a CDI specialist is like classroom teaching and that patience and good educational strategies go a long way.

Lunch and learn

I have two successes that I have experienced as a CDI specialist.

In an attempt to educate physicians on documentation, I have tried various avenues including one-on-one and e-mail newsletters. My greatest success is with the "lunch-and-learn" programs presented to our hospitalists.

I am the only CDI specialist at my 140-bed facility in a rural community. We have three hospitalists here during the day shift and, although there have been some changes in staffing, we have finally gotten a core group of physicians to attend our educational sessions.

In setting up the lunch-and-learn programs, I review the staffing schedule and select two weeks where I can present to at least the six main physicians. I do the presentations twice (once one week and then again the next week). I present these about every three months and select topics based on diagnoses that coders and I have had to query frequently and/or any new information in the field of CDI that would expand documentation specificity. Our dietary department caters the lunch. Although it can be tough for physicians to break away, I have had complete attendance at all meetings. The topics often result in discussions amongst the physicians as they help each other decipher what they know and translate it into the diagnoses that I am presenting. I also learn a lot from their discussions and debates. I find that, following these lunch-and-learn programs, the hospitalists answer my queries more frequently and the specificity of their documentation improves. They appreciate the education and, after each session, I have at least one physician tell me that they found it helpful and that they learned something new. That, to me, is success.

The other success was relayed to me by one of our hospitalists. This individual has been very attentive to everything I have presented to her. She is very thorough in her documentation and is very receptive to answering my queries. She explained to me that she moonlighted at another facility for a short time a few months ago and was approached by someone from the billing office. They complimented her on the thoroughness of her documentation and were shocked by all the information she had included.

"It was because I had a great teacher," she told them, referring to her experiences with me. I thought that was a great compliment.

Lisa McLuckie, RN
Clinical Documentation Specialist
Wooster Community Hospital
Wooster, OH

Jeanne Hardy, RN, CCDS
Clinical Documentation Improvement Specialist
Quality & Compliance
Mayo Clinic
Rochester, MN

Helping to be helped

We have had our CDI program for a little longer than three years. When it began, many of our medical staff members were supportive of the program but, as with any new process, we encountered those resistant to change. We believe that our success has been wholly attributable to the attitude we adopted—help the physicians help us. As a result:

- One of our physicians was extremely resistant to answering our queries because it required him to write the response in his progress notes. We decided that creating a physician-friendly checklist query that could became part of the medical record was more likely to receive an answer.
- Another physician would not stage chronic kidney disease as there was no glomerular filtration rate (GFR) available in the lab reports. Our director worked with the lab and the GFR is now a part of all chemistry panels.

CDI specialists from the California ACDIS chapter gathered for informal meet-and-greet after-hour events in various locations throughout the state, including this group in San Diego. The 5th Annual ACDIS Conference will be held in San Diego in May 2012.

A number of CDI specialists chose to celebrate the first CDI Week with after-hours events, including this group, which gathered at the Yard House in Los Angeles.

Members of the California ACDIS chapter celebrated CDI Week with informal events across the state, including this one that took place in San Francisco.

George Klimis, director of CDI and DRG validation services for MedPartners HIM, invited members of the Florida ACDIS chapter to an after-hours event in honor of CDI Week.

» An internal medicine physician on our staff rounds very early in the morning. By the time we placed a query he had already come and gone but his consults usually have not. Many times, the query would be buried in progress notes the next morning when he would see the chart again. We worked with him to determine the best way to get a query response from him and ultimately agreed to fax it to his office.

By being flexible and adapting to the physicians' individual preferences, we are happy to report that we now have a physician response rate of greater than 90% on concurrent queries.

E. Lisa Oro, RCP, CDS
Methodist Hospital of Southern California
HIM Department
Arcadia, CA

Feeding success

At Greenville Hospital System University Medical Center, we had celebrations every day during CDI Week. We had potluck lunches, catered lunches, team-building exercises, gift giveaways, and lunch-and-learn times.

Ellen Chang of Alexian Brothers Health System (ABHS) in Arlington Heights, IL, sent this photograph of her team's efforts to thank physicians for their support. Chang created a poster and put out a basket of treats in the physician lounge.

We are affiliated with the HIM department and work closely with the coders. They were invited to one of our potluck lunches and they presented us with several cards, a plant for the department, and a poem written especially for us that was placed in a nice frame. Here is the poem:

To Our Friends in Documentation Integrity

We want you to know How much you mean to us
We hope this poem tells you so.

We know our "Coding World"
Makes no sense to you
That is why we're here
To help you figure out the clues.

Clear documentation cannot be stressed enough
If it is not written in the record
We couldn't code the stuff
That is why this week is so cool
It lets HIM tell you what it means
To have nurses like you on OUR team!

Thank you for all you do!!
It could not be done without you!!!

Happy CDI Week September 2011

We have a great relationship with the HIM department.

The CDI team at Shands at the University of Florida includes Patty Zeile, CPC; Wendy Walther, RN; Sharon Boulware, RN; Edna Betances-Harold, LPN, CCS, CCDS; Heather Festa, RN; Donna Fisher, CDI coordinator, CCS, CCDS; and Jill Cerjan, RN.

We have great respect for each other and for each other's opinion. It has been a work in progress for several years—nevertheless, we have made it work together.

We celebrate HIM week with them and now they have celebrated our first CDI Week with us. What a great week it has been!

Juanita "Nita" B. Seel, RN, CCDS
Certified Clinical Documentation Specialist
Documentation Integrity Supervisor
Greenville Hospital System University Medical Center
Greenville, SC

Advancing CDI program efforts

I live in a very rural area of South Dakota and work in one of the largest hospitals for a multistate area (we are a 300-plus-bed facility). We have several surrounding clinics, but for the most part, we see and handle every patient within a five-hour radius of travel.

I had five-plus years of staff nursing experience when I started this position. There were three of us in the CDI program and we saw an average of six to eight patients a day. Our queries were very basic, all in paper format, and the physicians had no idea about our role. Our program was mainly DRG driven and it seemed our responsibility was to ensure our DRGs matched the coders. (One of the things I used to repeat over and over was, "I am not a coder!")

We had no way to audit physician query responses and all data was manually input to the computer. We often felt overworked. We often felt like our job made little difference in the reimbursement or quality issues.

Over the last two years, however, we have implemented several ideas which helped the program grow by leaps and bounds. In December 2010, we hired an independent consultant group and are now a quality-focused CDI program. We do all of our work on computers and there is no longer a "paper worksheet." This allows us to use resources more effectively and appropriately. We are able to monitor daily/monthly/annually needed parameters such as physician query response rate, geometric length of stay versus actual length of stay, and reimbursement amounts. We now see between 15–20 patients daily.

Doing these daily routines more effectively showed us how outdated our query process was. It was a paper process and those pages were not a permanent part of the medical record, and too often those paper queries went overlooked or unanswered.

We have expanded the query process by rewriting our query policies, making queries a permanent part of the medical record. Physicians can answer on the query, making it easier for them to respond.

We educate hospitalists on a monthly basis, as well as medical residents at other facilities. We are much more visible and our query response rates (as well as actual number of queries) have increased.

The Northern Illinois CDI chapter met during CDI Week at Delnor Hospital in Geneva and passed along this photograph of attendees.

At our last hospitalists meeting we made round sugar cookies decorated with a red circle with the line through it (to signify "No") and wrote "UROSEPSIS" on them (urosepsis documentation is one of our institutions' issues). It went over well and certainly lightened the mood. We added a physician champion to aid the process and reinforce education of physician outliers.

We joined ACDIS for information, education, and support, and it has proved very insightful for further improvements to our program.

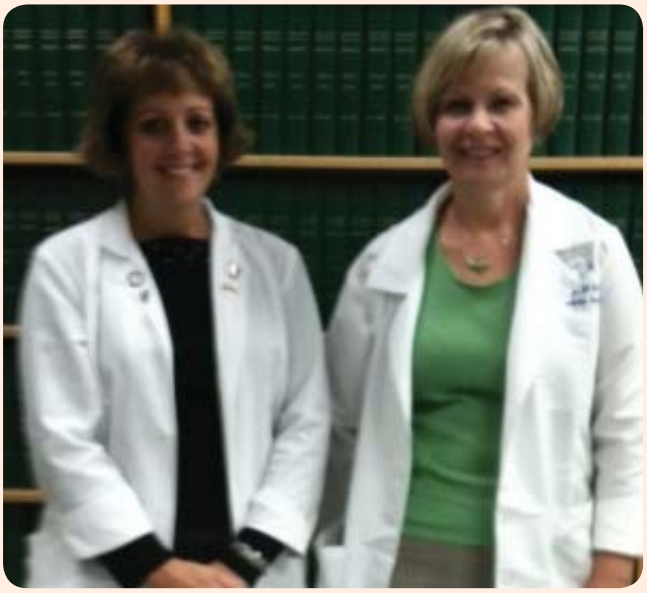
In just two short years, our program has grown considerably. We feel better about our positions; our work flow is much more consistent and allows for review of more patients.

I just wanted to pass along our successes and show that with enthusiasm and hard work, even in a rural institution like ours, CDI specialists can be effective and institute positive change.

Juli Bovard, RN, CDS
Clinical Documentation Specialist
Clinical Effectiveness/Clinical Quality
Rapid City Regional Hospital
Rapid City, CD

Kathryn Lynn Brown (top) and Londa Samuel (bottom) are the proud two-woman CDI team at Saint Joseph's Hospital of Atlanta.

From left, Sandy Plummer, Dawn Vitalone, and Kris Shocaroff, CDI specialists at Community Hospital in Munter, IN, were so excited to learn about the first annual CDI Week celebrations that they posed for a photo in front of the sign announcing the event. The sign (and the week) were unveiled during the 4th Annual ACDIS Conference in Orlando in 2011.



The CDI program at Saint Mary's Hospital in Waterbury, CT, is run by the two-woman team of Barbara Lefevre, RN, BSN, CCDS, and Karen Dollinger, RN, BSN. The two submitted their photo prior to CDI Week celebrations and were featured on the ACDIS Blog photo slideshow.