Charting a course to CDI career success
Discover how breakthrough technology and a coordinated CDI program can strengthen your performance. Leveraging our clinically-based algorithms and LifeCode® NLP technology, Optum™ CDI 3D reviews 100 percent of your records to identify those with the greatest opportunities for improvement. With review concurrent to the patient stay, CDI 3D enables more timely documentation improvement. Ultimately, this streamlines the CDI process, enhances compliance, and most importantly, allows for better quality of care.

See how our CDI solutions enable cutting-edge performance.

Visit: optum360.com/CDI3D
Call: 1-866-223-4730
Email: optum360@optum.com
FEATURES

11 One step at a time: Career tips from the top rung
CDI managers offer suggestions about what qualifications new CDI professionals should possess, and what experienced CDI specialists can do to advance their careers, with sample CDI career ladder suggestions.

17 Six steps to help you join the CDI ranks
Experts share their recommendations for those looking to make a career shift and become CDI specialists.

DEPARTMENTS

4 Associate director’s note
Something to be proud of: ACDIS insight and thought leadership released through position papers, informational white papers, and industry guidance.

6 Note from the Advisory Board
Judy Schade, RN, MSN, CCM, CCDS, describes the benefits of interdepartmental reconciliation process collaboration.

8 In the news: Code of Ethics released
The updated ACDIS Code of Ethics provides new insight into changing compliance concerns surrounding CDI efforts.

19 In the news: IPPS measures matter
The inpatient prospective payment system’s fiscal year 2016 final rule contained much for the CDI staff to focus on, including new patient safety indicator elements and value-based purchasing measures.

27 Ask ACDIS
Query retention policies have been a matter of debate for some time; facility efforts should be consistent across departments and take into consideration the latest industry guidance.

29 Radio Recap
ACDIS Radio guests offer insight into ICD-10’s post-implementation world.

33 Meet a member
A recent master’s-degree grad finds her professional calling in CDI efforts.

OPINIONS & INSIGHTS

22 Clinically speaking
Tips for accurately capturing accidental puncture lacerations.

24 Outpatient efforts
ACDIS Advisory Board member James P. Fee, MD, CCS, CCDS, discusses new Medicare measures that could push CDI efforts into the physician practice setting.

31 Physician advisor’s corner
Trey La Charité, MD, explores some faults other departments may find with CDI program efforts, and explains how to combat the misperceptions.
Healthcare delivery in the United States is changing—some say seismically. As the ground shakes, however, take a moment to get a firm footing, look around, and realize that everyone and everything within this bizarre snow globe bears the same fate—we’re all required to change.

At AHIMA’s national convention in New Orleans, ACDIS Director Brian Murphy joined AHIMA CEO Lynne Thomas Gordon, American Medical Informatics Association President Douglas B. Fridsma, MD, PhD, FACP, FACMI, and AMA Board of Trustees President Steven J. Stack, MD, on stage as part of the convention’s general session “luminary healthcare panel.” During the discussion, the panel discussed the different challenges facing the healthcare world today—and each member offered insight into how various professionals will be integral in responding to such changes.

Of course, we believe that the CDI profession may be well poised as the architects of the sturdy infrastructure needed in this new landscape. After all, the profession was built on change, coming of age as CMS implemented its MS-DRG methodology and bearing the ground swells associated with the advent of electronic health records, value-based purchasing, hospital-acquired condition reduction, ICD-10-CM/PCS implementation, and more.

Within this turmoil, we can take pride in finding ourselves among the ranks of truly amazing CDI thought leaders—individuals willing to reach out and aid those around them, not only to help with daily query compliance concerns but also to offer solid advice about how to grow and adapt in the field. This edition of the Journal is filled with such advice—from Judy Schade’s recommendations on CDI/coding reconciliation processes to Shiloh A. Williams’ suggestions about how to get into the CDI ranks to Katy Good’s suggestions on improving documentation for accidental puncture lacerations.

Such advice isn’t limited to the pages of the Journal, however. This fall, the ACDIS Advisory Board released a revised Code of Ethics. Its publication represents the culmination of several months of research, and we hope the document will be used as scaffolding to support compliant CDI practices. While you can get the highlights on p. 8, we strongly urge everyone to read the Code in its entirety and to review existing CDI practices to ensure they fall in line with recommendations.

This isn’t the only guidance from ACDIS, either. Avid Journal readers may be familiar with the recent efforts from the ACDIS Advisory Board to improve compliance and reduce errors and denials. We encourage you to explore these resources and consider sharing them with your colleagues and teams.
Board to define professional expectations for its members through position papers, such as the CDI specialist’s roles and responsibilities, as well as how the CDI specialist is affected by electronic health records. Readers will likely also recall the Advisory Board’s collaborative work with AHIMA on the 2013 physician query practice brief “Guidelines for Achieving a Compliant Query Practice.”

Over the past year, Advisory Board members have also delved into the concerns of the day by authoring in-depth white papers you may have missed, including:

- Cornerstone of CDI success: Build a strong foundation
- Ten things you need to know about ICD-10—and tell your physicians
- Physician queries and the use of prior information: Reevaluating the role of the CDI specialist

The most recent white paper regarding use of prior information takes no definitive stance on whether CDI professionals can, indeed, take information from a previous encounter and pull it forward to formulate a query for the current patient interaction.

The Advisory Board does, however, review a compendium of industry guidelines—from AHA Coding Clinic for ICD-10-CM/PCS to the Official Guidelines for Coding and Reporting—to give ACDIS members the information necessary to reassess their existing practices in a compliant manner. It also cites specific examples where use of such information might help clarify conditions without additional, unnecessary tests, such as using a prior echocardiogram to help query for type of congestive heart failure, or previous laboratory values to determine the baseline renal function in a query for the type and severity of kidney disease.

In that white paper’s closing, the Advisory Board states that “[w]hen history meets a new era, challenges are inevitable. As an organization, ACDIS partners with the CDI community to provide insight and awareness regarding such issues. However, as a CDI profession, we must work together and interrogate the present to prepare for the future.”

I couldn’t agree more. We certainly have a firm foundation to build on and an amazing team of CDI professionals to work with.

© 2015 HCPro, a division of BLR®

ADVISORY BOARD
Create a CDI/coding reconciliation process

by Judy Schade, RN, MSN, CCM, CCDS

Reconciliation is the process of reviewing medical record documentation and comparing this information to the coding summary: principal diagnosis, secondary diagnoses, present on admission indicators, procedure(s), and discharge disposition. Documentation and coding inpatient reconciliation practices exist as a second look at both the CDI specialist and coding reviews after the patient is discharged and the record is complete. During concurrent record review, all the information needed for accurate code assignment (discharge summary, lab and diagnostic results, pathology findings) may not be available, which could lead to documentation opportunities and significantly affect coding and follow-up care.

During the 2015 ACDIS Conference, I had the opportunity to discuss many aspects of CDI programs. Some programs had reconciliation processes in place and others did not. Generally speaking, however, there was a consensus that reconciliation encouraged open dialogue and collaboration between CDI and coding, presenting learning opportunities for both.

Two of the more common types of reconciliation processes are:

- Reviewing concurrent cases after coding, prior to billing, to ensure CDI/coder agreement
- Specific MS-DRG edits identified as high audit risk or other facility-specific focus area

I developed the CDI program at Mayo Clinic Hospital in Arizona and have continued working there in the inpatient setting. Both of the above-mentioned reconciliation processes have been practiced at Mayo since our CDI program began. The specific MS-DRG edits were initiated because of limited time for concurrent reviews. The current staff consists of five CDI specialists, and reconciliation remains a valuable method to ensure complete and accurate documentation and coding.

Develop an effective process

At Mayo, our reconciliation process includes comparison of the final MS-DRG assignment as determined by the CDI specialist with that of the coder and identification of any documentation or coding opportunities for a complete and accurate clinical picture.

During the concurrent record review, the CDI specialist enters a principal diagnosis, secondary diagnoses, procedure(s), and an initial DRG based on provider documentation. All of the information, including queries/clarifications, is entered in a data collection system. As the hospital stay is reviewed and additional information is added, the CDI specialist adjusts the initial DRG to a working DRG and then to a final DRG.

Mayo Clinic Hospital uses a data collection system that generates specific work lists for each CDI specialist. One of these work lists is “DRG present,” which notifies the CDI specialist when a case has been coded and is ready for reconciliation. These cases are considered a priority in order not to hold the claim any longer than necessary. The holds and edits are closely monitored by the billing staff.

The CDI specialist uses the documented information in the concurrent review process to identify any missed documentation and/or coding opportunities by comparison of data with the coding summary.

In the case of MS-DRG edits, if the stay had not been previously reviewed, a complete review of the
When documentation opportunities are identified, the CDI specialist clarifies the issue retrospectively with the provider and obtains documentation in the record. When a potential coding opportunity is identified, the CDI specialist notifies a coding staff lead to review the case and discuss it with the coder. This communication is usually done via email or verbally.

It is important to note that really, the first step in the reconciliation process is to have a method of holding the accounts after they have been reviewed and coded, prior to billing. This involves the revenue department as any account holds can affect filing the claim.

Coding

All diagnoses that meet the Uniform Hospital Discharge Data Set definitions need to be coded for a complete and accurate clinical picture. If the CDI specialist and coder agree, the case is re-coded. For those instances when the CDI specialist and coder do not agree, a quality review coding team member or a physician advisor reviews the record.

In some cases, chosen codes may appear inaccurate to the clinical CDI specialist; however, upon review, coding conventions and other requirements take precedence. All clarifications and coding changes are recorded, so statistical data is available for educational purposes.

Reconciliation involves CDI and coding colleagues working closely together and having opportunities to discuss cases. This procedure requires time and effort, but it gives participants an opportunity to gain insight and understanding of cases’ clinical and coding aspects, as well as to learn from each other.

Reconciliation outcomes

Coding and revenue cycle administrators often resist the idea of reconciliation, as these accounts are held until reviewed and in some cases sent back to the coder for revisions to resolve the situation and drop the bill. However, the data collected from this process and resulting discussions often proves beneficial as it reveals statistical outcomes and higher MS-DRG assignments; improves severity of illness and risk of mortality scores; supports resource consumption, risk adjustments, and quality care; and can even help substantiate medical necessity. In addition, data can be compared between service lines, individual providers, and coders for feedback and education.

The goal of reconciliation is complete and accurate documentation and coding. Collaboration and partnership between CDI and coding are essential to have a successful CDI program. Accurate coded data is critical to an organization’s quality and outcome measurements.

Recommendation

If your current CDI program does not include reconciliation, my recommendation is to start the process with one MS-DRG edit, which may be a Recovery Auditor target or a DRG outlier in your organization. Another option is to have an edit in place to review all expiration records, focusing on severity of illness and risk of mortality scores. Remember, however, to involve coding and revenue cycle administrators in the process as reconciliation is a team effort and could impact coder productivity and claim submission.

In light of the changing landscape of risk adjustments and varying methodologies, secondary diagnoses are vital factors in the equation. Accurate and complete documentation and coding has a profound impact on reimbursement and quality—possibly saving an organization millions of dollars.

Editor’s note: Schade is a CDI specialist at Mayo Clinic Hospital in Phoenix. A nurse with more than 30 years’ experience, she has been an ACDIS member since 2008 and was recently elected as co-leader of the Arizona ACDIS chapter. In 2013 she received the CDI Professional Achievement award, and in 2015 she was elected to the ACDIS Advisory Board. Contact her at Schade.judy@mayo.edu.
ACDIS releases new *Code of Ethics* for CDI

In response to the question “Have you ever been asked to perform a task which concerned you ethically?” 50% of nearly 900 people said they had, according to a spring 2015 ACDIS poll.

Although ACDIS created a *Code of Ethics* for its members shortly after its inception back in 2008, as the industry guidance changed and expectations of CDI professionals shifted, changes in the Code were needed to better reflect the day-to-day encounters CDI specialists face.

So the ACDIS Advisory Board embarked on a serious update to the document, asking its members to share their ethical conundrums and respond to a multi-dimensional survey on the topic.

When confronted with a potentially questionable task, 35% brought their concerns to their manager, 31% used guidance from either ACDIS or AHIMA to open a dialogue regarding the request, and 13% brought the matter to the attention of their compliance officer, according to the respondents to that more detailed survey. (See the illustration on p. 10.)

In open comments, one respondent stated that their denials manager insinuates to others that the CDI team writes unethical and leading queries. Another respondent said they completed a fraud report form on CMS’ website, and another said her facility would not listen to concerns and “are turning their heads away.”

**ACDIS responds**

In response, the new *Code of Ethics* “is based on core values and broad ethical principles that professionals can aspire to, and use, when making a decision or choosing a course of action.” (Emphasis added.)

“The membership has been asking questions about situations they were involved with and wanted guidance that wasn’t currently available within our existing Code,” says advisory board member Mark LeBlanc, RN, MBA, CCDS, senior consultant with The Wilshire Group, who co-led the *Code of Ethics* update project with advisory board member Michelle McCormack, RN, BSN, CCDS, CRCR, CDI director at Stanford (California) Health Care.

“As with any industry, as we grow, we need to go back and re-examine the guidance documents which lead us,” LeBlanc says.

All ACDIS members and CDI professionals are expected to abide by the Code, and any CCDS applicant must testify to the fact that he or she has read, and will adhere to, the Code.

**Scope of practice**

The Code defines CDI professional values as honesty and integrity, acting in a manner that brings honor to oneself and one’s peers as well as to
the profession, and being committed to ongoing education and professional achievement.

It lists 11 core ethical principles, such as supporting the “reporting of all healthcare data elements” and facilitating “accurate, complete, and consistent clinical documentation within the health record.”

**Defining elements**

Each of these 11 elements is further explained to provide CDI professionals with step-by-step guidelines for application.

For example, the second ethical principle, which states that CDI specialists shall “refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts,” further states that CDI professionals “shall be knowledgeable about organizational policies and procedures for handling concerns about colleagues’ unethical behavior.” It also states that CDI professionals shall “always conduct their work in a manner that supports and encourages clinicians to use their clinical judgment …”

Additional information regarding the seventh ethical principle states that CDI professionals shall develop CDI staff are asking specific questions about ethical behavior. The new code is founded on the real-life concerns of CDI professionals.

—Michelle McCormack

**ETHICAL PRINCIPLES GOVERN NEW CODE**

The following 11 elements make up the core of the newly revised ACDIS Code of Ethics. Those working in the CDI field can use them as guideposts to ascertain whether potentially questionable actions require further analysis, development of internal policies, or outside investigation. At their most elemental, the items call on CDI specialists to examine the medical record without bias for the benefit of the patient, physician, and facility.

1. Advocate, uphold, and defend the individual’s right to privacy and the doctrine of confidentiality in the use and disclosure of information. Preserve, protect, and secure personal health information in any form or medium and hold in the highest regard the contents of the records and other information of a confidential nature, taking into account the applicable statutes and regulations.

2. Use only legal and ethical means in all professional dealings, and refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.

3. Put service and the health and welfare of persons before self-interest, and conduct themselves in the practice of the profession so as to bring honor to themselves, their peers, and the CDI profession.

4. Support the reporting of all healthcare data elements (e.g., diagnosis and procedure codes, present on admission indicators) required for external reporting purposes (e.g., reimbursement and other administrative uses, population health, quality and patient safety, measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.

5. Refuse to participate in or conceal unethical practices or procedures.

6. Advance their specialty knowledge and practice through continuing education, research, publications, and presentations.

7. Facilitate accurate, complete, and consistent clinical documentation within the health record to support coding and reporting of high-quality healthcare data.

8. Facilitate interdisciplinary collaboration in situations supporting CDI practice.

9. Respect the inherent dignity and worth of every person.

10. Avoid participation in, condone, or be associated with dishonesty, fraud and abuse, or deception.

11. Manage CDI departments and practices collaboratively and honestly, avoiding engagement in unethical practice and ensuring thoughtful decision-making processes.
and comply with internal policies and procedures, as well as with reimbursement regulations and coding guidelines. It also states that CDI professionals shall not “participate in the alteration, suppression, or improper preparation of health record documentation” or “participate in CDI practices that result in either undercoding or overcoding” of any medical record under review.

**Practical applications**

In the early days of CDI program implementation, financial efforts were often top of mind. “We’ve moved away from that,” says LeBlanc, “and there are some concerns around that, particularly where organizations haven’t moved as quickly as the industry has.”

The appendix of the new Code includes case examples of potential ethical questions, and specifically points to the related guidelines for CDI specialists’ reference.

One example discusses a CDI department that captures and analyzes the program’s overall financial effects, as well as CDI staff members’ financial outcomes according to their reviews, and includes that analysis as part of each CDI staff member’s performance review. The Code says to apply ethical principles 4, 10, and 11, and that a potential concern may exist. In such a situation, CDI staff may be motivated to submit inappropriate queries to ensure they meet the facility’s expected monetary goals. The example states:

*All CDI professionals should promote accurate documentation and avoid issuing queries solely to meet financial expectations. In order for an organization to ensure the success of CDI, an effective monitoring process must be established, along with department-specific KPIs [key performance indicators]. Each department’s established KPIs may routinely need to be reevaluated or revised due to specific variable changes (for example, the number of years a CDI program has been in existence, levels of experience amongst its staff, facility size, and assignment of coverage). In addition, all performance metrics and expectations should be applied consistently throughout the department, not to just some CDI specialists.*

McCormack agrees that CDI, as a profession, has evolved. “CDI staff are asking specific questions about ethical behavior,” she says. “The new code is founded on the real-life concerns of CDI professionals.”

LeBlanc says the Code is meant to take those concerns and hone in on the values and core ethics of the profession. “We really wanted to ... help people working in the field to apply these items to their working lives.”

---

### ETHICS IN CDI 2015

If you have felt that you were asked to act in an unethical or noncompliant manner, what action did you take?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contacted ACDIS for advice</td>
<td>4.9%</td>
</tr>
<tr>
<td>I spoke with my manager/director</td>
<td>34.4%</td>
</tr>
<tr>
<td>I spoke to my coworker</td>
<td>11.5%</td>
</tr>
<tr>
<td>I used formal guidance from ACDIS/AHIMA to open a dialogue regarding compliance and ethics</td>
<td>31.1%</td>
</tr>
<tr>
<td>I raised my concerns to our compliance officer</td>
<td>13.1%</td>
</tr>
<tr>
<td>I contacted our human resources director</td>
<td>1.6%</td>
</tr>
<tr>
<td>I said nothing</td>
<td>6.6%</td>
</tr>
<tr>
<td>Comment</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

**answered question** 61

**skipped question** 79
At some point, our culture adopted the metaphor of climbing a ladder to represent career advancement—each rung a step up, a position closer to the elusive goal of ultimate success.

To be sure, it’s a ladder everyone is trying to climb. Yet many CDI programs start without much thought for how their staffing responsibilities might change, how the programs themselves might grow. At the onset of CDI efforts, perhaps administration thought of CDI as a project rather than a program—one whose staff would simply be reabsorbed into their previous roles. CDI programs and their staff have continued to advance, however, proving their return on investment not only financially but in a host of other ways.

And CDI programs are growing—hiring new team members and expanding beyond basic CC/MCC capture. That means CDI managers need to create a comprehensive set of job descriptions and professional expectations. This added structure will help the program not only hire the right person for the job, but also train that individual effectively, as well as nurture the existing CDI team so its members can take on advanced responsibilities—and better compensation—further down the line.

Basic qualifications

Start by defining a CDI specialist’s basic qualifications as appropriate to your facility’s needs. If your CDI program needs help understanding coding rules and regulations, then perhaps adding a professional with coding or HIM background might be beneficial. Alternatively, if your CDI program is struggling to get orthopedic surgeons on board with documentation improvement efforts, then perhaps a nurse with that background would be of the greatest benefit to existing CDI efforts.

Despite the ongoing debate over which professional type makes the best CDI specialist, many in the industry support a blended model.

“Obtaining a clear record [that reflects the clinical conditions of a particular patient] requires a team effort between coding, HIM, informatics, quality, and physicians,” ACDIS Director Brian Murphy, CPC, told attendees of the 2015 AHIMA convention in New Orleans. “As an association, we have long supported the idea that those
coming to the CDI role need to have specific qualifications and that an individual’s ability to communicate amongst the various stakeholders regardless of backgrounds is one of the most important.”

Over the years, both ACDIS and AHIMA have released numerous pieces of guidance and sample job descriptions, worth reviewing as CDI programs begin to draft new staff expectations.

In its 2010 CDI Toolkit, AHIMA states that:

“Individuals qualified to serve in these roles include, but are not limited to, health information management professionals, physicians, nurses, and other professionals with a clinical and/or coding background. Depending on the makeup of the CDI program, the program may be staffed entirely by HIM coding professionals, entirely by RNs, or a combination of both. In some programs there may be dedicated physician liaisons or champions who conduct reviews and communicate with other physicians on documentation issues.”

Similarly, the ACDIS 2014 position paper “Defining the CDI specialist’s roles and responsibilities” states that:

“The CDI specialist candidate should be credentialed as an RN with five years of acute care experience, or as a registered health information administrator or technician (RHIA/RHIT) with at least five years inpatient coding experience. He or she should also have advanced clinical expertise and extensive knowledge of complex disease processes with broad clinical experience in an inpatient setting.”

The CDI Road Map includes a sample CDI job description, which states that professionals seeking to join the ranks have to hold a RN, RHIA, RHIT, CCS, or combination thereof, with experience in nursing or another clinical area, coding, process improvement, or utilization review/case management in an acute care facility. Additionally, the CDI Road Map states that CDI programs should seek out those with coding skills and knowledge of the Official Guidelines for Coding and Reporting as well as AHA Coding Clinic for ICD-10-CM/PCS (ICD-9-CM).

As Murphy stated, the CDI Road Map also points out that new CDI professionals should possess “effective interpersonal skills in order to interact effectively with all levels of hospital personnel,” and that new staff members should have excellent organization and prioritization skills, effective written and verbal communication skills, and proficiency in analyzing data and conducting public presentations.

“You can train people on the technical aspects of the job, but teaching a person to think critically can be difficult, so it is incredibly important to hire the right person,” says Angelisa “Lisa” Romanello, RN, CCDS, senior consultant with Prism Healthcare Partners in Chicago.

That’s why Jane Hoyt, BA, BSN, RN, CCDS, CDIP, CPC-H, director of clinical documentation integrity for SCL Health Systems in Lakewood, Colorado, looked for “soft skills” such as personal interests and achievements to see that a potential new hire was “well-rounded” and “involved” when she hired four new staff in the summer of 2015.

“You really need to identify the right qualifications to fit your facility’s needs,” Hoyt says.

Transitional troubles

Although the industry standards indicate that either nurses or coders can effectively perform the CDI role, pay scales for these professional backgrounds may differ, with coders/HIM professionals potentially earning less than those with a nursing background.

Alternatively, nurses coming to the field may no longer be eligible for step increases (salary increases associated with longevity, degrees, and certifications) typically applied to the nursing role.

They also frequently lose out on overtime and differential pay, since most CDI programs follow a nine-to-five, 40-hour, salaried pay structure, says Denise Tinkel, RRT, MHA, CCDS, manager at Prism
Healthcare Partners. This is one element CDI programs need to address with their chief financial officer and human resources department, she says.

“We have to honor and provide career satisfaction for both professional classifications, since it is critical to have both nurses and coders working together in this era of change in healthcare,” says Tinkel. “If we don’t keep them satisfied in these new positions—either by compensation, benefits, or some type of career advancement—we’re at risk of losing these staff, and then we’re at risk of not being able to keep our doors open.”

A look at the ACDIS job board shows that many organizations prefer to hire those with existing CDI experience and, ideally, certification in the role—either the Certified Clinical Documentation Specialist (CCDS) from ACDIS or the Certified Documentation Improvement Practitioner (CDIP®) from AHIMA.

But such experience and expertise can be difficult to find. That’s why many programs seek out those with the appropriate skill sets and train their new staff in the technical aspects of concurrent record reviews according to their facility’s specific needs.

It can take six to nine months for a new CDI professional to become proficient in the role, says Romanello.

That’s why CDI programs need to develop an effective on-boarding program with mentoring, self-study, job shadowing, and productivity expectations, says Hoyt.

“You have to have a real hunger for learning to do this job well,” she says.

Managers need to be mindful of an individual’s specific background and skill set during this training period.

“We’ve had excellent staff really struggle in the beginning,” Hoyt says. “Those with nursing backgrounds are used to excelling in patient care in an area where anything less than excellent care could mean an adverse effect for a patient.”

While CDI isn’t a life-or-death profession, as Linda Renee Brown, RN, MA, CCDS, CCS, CDIP, director of CDI for Tanner Health System in Carrollton, Georgia, put it in the ACDIS Blog post “Primer for new CDI staff: Take it easy on yourself,” it can be additionally difficult for nurses to adjust to CDI programs that focus principally on financial goals.

“Hospitals get focused on the finances and ignore the bigger picture about how CDI efforts can help improve quality scores and other components. For nurses, that’s a dissatisfier,” Tinkel says. “Even though they are no longer laying hands on the patient, we are still doing what’s in their best interest (as well as in the best interest of the facility)—making sure we get credit for taking care of some very, very sick patients.”

So Hoyt recommends CDI managers reassure new staff members and set reasonable goals, assessing their productivity over time.

“You have to reassure them that their feelings are acceptable and show them their success and opportunities for growth through their own data so they can see their progress along the CDI road,” Hoyt says.
If we don’t keep [CDI staff] satisfied in these new positions—either by compensation, benefits, or some type of career advancement—we’re at risk of losing these staff, and then we’re at risk of not being able to keep our doors open.

—Denise Tinkel, RRT, MHA, CCDS

Advanced offerings

Once a facility successfully hires and trains a new staff member, the next task is offering experienced employees options for professional growth.

When a client asked Tinkel to help them create a career ladder, she dug in and started to research the topic, finding a wide range of possible next steps but limited formal guidance. Yet recruitment and retention of qualified CDI staff can be a major challenge for CDI managers, Tinkel says.

“Staff turnover is a costly issue … [so] it is imperative that hospitals have the ability to attract and retain new hires,” according to the sample advancement ladder Tinkel ultimately created for Prism and its clients (see p. 15). “It is of equal importance that hospitals reward and recognize current staff for their expertise and involvement in professional activities. Hospitals offering clinical or professional ladders may have higher levels of satisfaction among CDI team professionals than hospitals with no method for career advancement.”

Facilities that hire and train individuals may offer bonuses at various benchmarks according to a preset timeline or competency expectations, says Romanello.

For example, a new staff member may earn a small sign-on bonus or other form of compensation that he or she contractually must refund the organization if he or she leaves the position within two years. Such a bonus incentivizes potential hires to accept the position but also insures against the risk of staff departure after the organization makes a steep educational investment in them.

CDI programs should also consider recognizing staff for each additional certification or credential obtained, Romanello says. “In the beginning, human resources didn’t recognize the CCDS credential, but this is a big step in the progression of a CDI professional’s advancement.” Those programs who do hire and train their CDI staff should expect such employees to seek out their own certification within a set period of time.

While Romanello remains neutral about whether facilities should compensate staff for testing and maintaining their CCDS credential, she does say that facilities should compensate employees appropriately for any certification they obtain.

CDI staff may also seek advancement through various proficiency levels, such as developing physician education or serving as a mentor to new CDI professionals, Tinkel says. In her sample career ladder, she outlines three levels of professional steps and the requirements of those roles.

“As CDI professionals become experts, they should be expected to be comfortable educating physicians, educating peers. And any time they achieve the next level, they should get a minimum pay increase,” she says. 🌟
CDI staff turnover is a costly issue that hospitals and medical centers will continue to deal with as healthcare delivery resource use cost increases. It is imperative that hospitals have the ability to attract and retain new hires in the field of CDI. It is of equal importance that hospitals reward and recognize current staff for their expertise and involvement in professional activities. Hospitals offering clinical or professional ladders may have higher levels of satisfaction among CDI team professionals than hospitals with no method for career advancement.

XXX Hospital supports an environment that promotes professionalism and excellence among clinical documentation specialists (CDS).

The following are some areas of clinical practice and professional excellence that are recognized in this clinical ladder program:

- Competence in CDI, including but not limited to:
  - Medical record review
  - Identification of physician query opportunities
  - Collaboration with professional inpatient coding professionals
  - Reconciliation of assigned cases
  - Accuracy in reporting of CDI program metrics
  - Coverage rate
  - Physician query rate
  - Query response rate
  - Query agreement rate
  - Case-mix index change
  - Financial benefit resulting from physician queries

**Objectives**

XXX Hospital will promote, recognize, & reward excellence in CDI program performance by:

- Promoting exceptional CDI performance in the following arenas:
  - Face-to-face interactions with physicians, to foster relationships for trust of clinical skills and information sharing
  - Accurate and timely chart review with identified skills of identifying missing, vague, or unclear physician documentation
  - Ability to write queries that are concise and easily understood by the queried provider, in order to garner additional necessary documentation in the inpatient medical record
  - Timely reconciliation of all cases, to include accurate recording of DRG or SOI impact based on physician query, as well as physician response to all queries

- Providing clear delineation of CDI competence levels by:
  - Ensuring that all education for the new CDS has been successfully completed
  - Monitoring CDS performance to assess ability to identify physician query opportunities, diagnoses not supported by clinical indicators, and function on par with other CDI team members

- Encouraging excellence in practice to ensure quality reporting of CDI program performance to senior leadership, including:
  - Financial impact of physician participation
  - Improvement in severity of illness as a result of physician participation
  - Improvement in case-mix index as a result of physician participation

- Championing recruitment and retention of qualified CDI team members, including but not limited to:
  - Clinicians such as registered nurses
  - Minimum of bachelor’s degree in nursing or related field
Professional coders
Minimum of bachelor’s degree in health information science or related field
Required coding credentials (CCS/CCS-P)

**Advancement ladder levels**

**Clinical Documentation Specialist I**
- Entry level position for newly trained clinical documentation specialist
- Demonstrates competent performance in chart audit
- Correctly identifies physician query opportunities > 90% of the time
- Interacts directly with the physician to discuss queries > 80% of the time
- Is proficient in query writing so that the question is easily understood by the physician
- Escalates non-response by physicians immediately according to query escalation policy
- Accurately reconciles all cases in CDI database >95% of the time

**Clinical Documentation Specialist II**
- Experienced clinical documentation specialist with minimum of 2 years recent experience in CDI role
- Demonstrates all skills of CDS I with < 5% error rate
- Attains clinical documentation specialist certification through ACDIS or AHIMA
- Volunteers for special projects in CDI such as developing physician education materials or CDI Week advertisements

**Clinical Documentation Specialist III**
- Functions as subject matter expert and actively participates in CDI department meetings as problem-solver
- Demonstrates all skills of CDS II
- Serves as CDI department liaison for physician and administrative meetings
- Serves as database manager for CDI tracking tool, including DRG validation for accurate and timely reporting of CDI-generated reimbursement and case-mix index improvement
- Serves as reports specialist for any data not obtainable by canned reports from CDI tracking tool
- Serves on internal hospital committees such as utilization review committee
- Participates in senior leadership level meetings and is responsible for preparation and reporting of CDI program metrics to senior leadership level

**Financial compensation for advancement**

Financial reward for ascension through the advancement ladder levels serves as a possible retention mechanism for clinical documentation specialists, who are currently in high demand. XXX Hospital will award the following financial incentives for CDS II and CDS III:

**5% pay raise for promotion from CDS I to CDS II**
- In addition to merit raises based on performance
- In addition to cost of living raises

**5% pay raise for promotion from CDS II to CDS III**
- In addition to merit raises based on performance
- In addition to cost of living raises
Six steps to help you join the CDI ranks

There is a lot of discussion about how to be a good CDI specialist, but as the profession grows and facilities look to hire new CDI team members, many more people are looking to get into the field.

A few months ago, we received an email asking us what we would recommend to CDI hopefuls. After combing through our resources, consulting with our Boot Camp instructors and Advisory Board members, and interviewing working CDI specialists, here are six simple steps to help you set your feet on the CDI career path.

1. Learn as much as you can

When Shiloh A. Williams, MSN, RN, CCDS, CDI specialist at El Centro Regional Medical Center in Holtville, California, initially applied for a CDI position, she knew nothing about CDI, coding, or the revenue cycle. She did a Google search before her interview and read up on DRGs, codes, and common diagnoses. Her research, coupled with her prior nursing experience and clinical knowledge, won her the position.

“I scoured the ACDIS website for information, ideas, and best practices,” Williams says. “Now that I’m doing the job, I am constantly turning to ACDIS resources for staffing and department metrics.”

Regardless of the field or position, any candidate who learns as much as possible about the role and company prior to sitting for an interview will have a distinct advantage. You may not have hands-on experience as a CDI specialist, but that doesn’t mean you can’t learn as much as possible about the field.

Review the materials on the ACDIS website—much of it is free—and take lots of notes. Read the ACDIS Blog and the CDI Strategies e-newsletter for timely tips and news updates. The ACDIS Helpful Resources page and ACDIS Radio are also fantastic free options to learn about the field and the industry.

It’s also a good idea to look through CDI job postings to see what facilities are looking for in terms of knowledge and experience. Some noteworthy topics to research include:

- DRG basics
- ICD-9 and ICD-10 codes
- How to read a medical record and research a chart
- Hospital quality initiatives

2. Attend a local chapter meeting

If you have a local chapter in your area, call or email the leadership
and ask if you can attend a meeting. This is a great opportunity to network with local CDI specialists, learn about the job from working professionals, and discuss timely topics and issues relevant to the field.

Networking may also lead to potential mentorship and job shadow opportunities that you wouldn’t have otherwise. Williams relied heavily on her mentors early in her CDI career.

“I was able to work alongside Marion Kruse, a well-known clinical documentation improvement and Medicare expert,” she says. “My passion for my work was fueled by her knowledge and expertise.”

Check the Local Chapter page on the ACDIS website for more information and meeting schedules.

3. Job shadow CDI staff

If you have a CDI program at your facility, ask the program staff if you can shadow them for a day to learn more about the work they do.

If your facility doesn’t have a CDI program, reach out to neighboring hospitals and see if their program would host you for a morning or afternoon.

Job shadowing is one of the most important things a prospective CDI specialist should do before applying for a job in the field, says Mark LeBlanc, RN, MBA, CCDS, director of CDI services at the Wilshire Group, and ACDIS Advisory Board member.

“Job shadowing is one of the most important things a prospective CDI specialist should do before applying for a job in the field,” LeBlanc says. “It’s a great opportunity to watch a CDI specialist work, ask questions, and see the work in action,” he says. “It’s also a chance to see how you have to interact with staff on the floor. You need to be outgoing, and you have to be able to speak to all different levels of professionals, from providers to coders, so you can get things done.”

Also take advantage of other networking opportunities, such as reaching out to members of the ACDIS Advisory Board. “The board would definitely be willing to spend a few minutes with someone to talk about CDI,” LeBlanc says.

4. Analyze your skills

Typically, the most important attributes for a top-notch CDI specialist are extensive clinical knowledge and awareness of disease processes and complications, comorbid conditions, medical coding, and Medicare reimbursement.

A balance of clinical expertise and coding knowledge makes a candidate ideal, says Bonnie Epps-Long, MSN, RN, CDI director at Emory Healthcare in Atlanta.

“I think [CDI] work would be easier if we all were proficient in coding,” says Epps-Long. “If someone is interested in CDI, they should try and learn something about what coding is and why it’s important.”

Those with clinical backgrounds wishing to enter the field need to understand that CDI specialists have little to no contact with patients. Although their clinical acumen will definitely be put to use, they will no longer have any sway over the patients’ day-to-day care.

CDI work is based solely on what is written in the clinical documentation. For former bedside nurses, this requires a novel way of thinking and a willingness to learn new skills, Epps-Long says.

“[An applicant] should be able to pick up the skills to read the chart, analyze the chart, and learn the coding rules and language,” says Epps-Long. “You must be willing to learn these things and think in new ways.”

Communication skills (both written and verbal), imagination and creativity, and analytical and problem-solving skills are also a must.
“You have to be willing to work with others and collaborate,” says Epps-Long.

5. Train yourself

Programs typically train new CDI specialists for three to six months through in-house mentoring, job shadowing, and formal classroom learning. They often send new staff members to a CDI Boot Camp and/or have consulting training available.

However, if you are serious about getting a job in the field and want to expand your knowledge, it may be a good idea to sign up for an online learning program or a CDI Boot Camp on your own time. You'll receive a comprehensive overview of the job and required knowledge, which will make you a more competitive applicant for prospective employers.

If you would like to work on training yourself, here are some helpful resources:

- The Clinical Documentation Improvement Specialist’s Complete Training Guide
- The Clinical Documentation Improvement Boot Camp
- The CDI Essential Skills Online Learning Library

LeBlanc says prospective CDI specialists should also brush up on their anatomy and physiology—especially important with the advent of ICD-10.

6. Apply for the job

You’ve done the research. You’ve decided the job is a good fit for your personality and skill set. Maybe you’ve even job shadowed a CDI specialist or networked with CDI professionals at a local event. Now it’s time to apply for the job. There are plenty of facilities out there that will hire new staff even if they do not have CDI experience. Highlight any related training and skills in your resume and during interviews.

Keep in mind, you do not need to have the Certified Clinical Documentation Specialist (CCDS) credential to become a CDI specialist. The CCDS represents a mark of distinction for those who have been working in the field for a number of years. In fact, you must be a working CDI specialist for at least two years before you can sit for the exam.

IN THE NEWS

IPPS final rule continues to focus on quality

Quality. It’s been CMS’ mantra over the past few years. Traditionally, the inpatient prospective payment system (IPPS) final rule’s release marked changes in MS-DRG assignment, creation of new ICD codes, and payment and regulatory measures. Such items essentially vanished of late due to the code change freeze associated with ICD-10-CM/PCS implementation delays.

That left the fiscal year (FY) 2016 IPPS open to include elements related to CMS’ recent value-over-volume mission, adding numerous measures to the various programs therein.

“The final rule includes policies that advance the vision and commitment to increasingly shift Medicare payments from volume to value,” says Shannon Newell, RHIA, CCS, director of CDI quality initiative for Enjoin in Eads, Tennessee.

Hospital Inpatient Quality Reporting (IQR) Program

Originally mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the IQR essentially pays hospitals that successfully report designated quality measures a higher annual update.
In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their healthcare. Some of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website at www.hospitalcompare.hhs.gov.

The 2016 IPPS final rule added seven new measures to the IQR, including:

1. Hospital Survey on Patient Safety Culture
2. Kidney/UTI Clinical Episode-Based Payment
3. Cellulitis Clinical Episode-Based Payment
4. Gastrointestinal (GI) Hemorrhage Clinical Episode-Based Payment
5. Hospital-Level, Risk-Standardized Payment Associated With an Episode-of-Care for Primary Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)
6. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
7. Excess Days in Acute Care after Hospitalization for Heart Failure

All of the new measures are claims based except for Hospital Survey on Patient Safety Culture.

Three of the new clinical episode-based measures—kidney/UTI, cellulitis, and GI hemorrhage—will impact payment in FY 2019, says Newell.

CMS finalized removal of six topped-out measures:

1. STK-01, Venous Thromboembolism (VTE) Prophylaxis for Patients With Ischemic or Hemorrhagic Stroke
2. STK-06, Discharged on Statin Medication
3. STK-08, Stroke Education
4. VTE-1, Venous Thromboembolism Prophylaxis
5. VTE-2, Intensive Care Unit Venous Thromboembolism Prophylaxis
6. VTE-3, Venous Thromboembolism Patients With Anticoagulation Overlap Therapy

It also removed:

- IMM-1, Pneumococcal Immunization
- SCIP-Inf-4, Cardiac Surgery Patients With Controlled Postoperative Blood Glucose

**Hospital Readmissions Reduction Program (HRRP)**

CMS also finalized changes to the pneumonia HRRP measure. In the past, CMS defined the pneumonia cohort for mortality and readmission to include various pneumonia codes as a principal diagnosis, excluding cases where sepsis, aspiration pneumonia, or respiratory failure served as the principal diagnosis. This year’s IPPS final rule opted not to add cases with acute respiratory failure as the principal diagnosis and excluded sepsis cases if there is a secondary diagnosis of severe sepsis, amending the cohorts to include patients with a principal discharge diagnosis of:

- Pneumonia
- Aspiration pneumonia
- Sepsis with a secondary diagnosis of pneumonia present on admission

“CMS listened to provider comments … and scaled it back significantly to a more reasonable cohort,” says James S. Kennedy, MD, CCS, CDIP, president of CDIMD-Physician Champions in Smyrna, Tennessee.

“Hospitals must be diligent to identify pneumonia patients who had sepsis on admission to determine if they meet ICD-10-CM’s administrative definition of severe sepsis (acute organ dysfunction, not failure, due to sepsis) which may differ from those of the Surviving Sepsis campaign,” Kennedy says.

The revised pneumonia cohort is expected to increase the number of discharges included in the measure by 50%, and to increase the number of hospitals (which will now meet the minimum case threshold of 25 eligible discharges).

CMS expects the revised definition to also affect the excess readmission rates for some hospitals, so Newell recommends CDI programs work with their quality departments to analyze and address performance improvement opportunities for all populations included in the HRRP.
The quality of documentation and coded data has a direct impact on measure performance and associated financial penalties, says Newell, so CDI and quality programs could also revisit the definitions used to capture “severe sepsis,” which—if present—disqualifies discharges from inclusion in the measure.

**Hospital Value-Based Purchasing Program (HVBP)**

CMS removed IMM-2, Influenza Immunization, because it determined the measure was topped out and removed AMI-7a, Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival, because few hospitals have the minimum number of cases necessary to report the measure.

Because CMS finalized the removal of these two measures from the Clinical Care-Process subdomain, the agency finalized its proposal to move PC-01 (Elective Delivery) from Clinical Care-Process to the Safety domain. CMS will eliminate the Critical Care-Process subdomain and rename the Clinical Care-Outcomes subdomain as simply the Clinical Care domain.

Analyze and address performance improvement opportunities for associated new and/or modified measures, Newell says.

“For claims-based measures, it is important to address documentation and coding vulnerabilities that impact the population included in the measure, referred to as the ‘cohort,’ as well as the risk-adjustment variables which impact the mortality, complication, and efficiency measures,” she adds.

**Hospital-Acquired Conditions Reduction Program (HACRP)**

Although CMS is not adding or removing any HAC categories for FY 2016, it estimates that 19.4% of all hospitals will be penalized with a 1% reduction in MS-DRG payments for all traditional Medicare discharges in FY 2016 due to HACRP performance.

CMS finalized the 24-month period from July 1, 2013, through June 30, 2015, as the time frame for Domain 1 measure—Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI)-90 Composite measure, and decreased the Domain 1 weight from 25% to 15%, as well as increased the Domain 2 weight from 75% to 85% for FY 2017.

“CDI departments should analyze and address data quality opportunities to improve PSI 90 measure performance and assess their vulnerabilities,” Newell says.

CMS also finalized an expansion of data for Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) measures.

The agency will include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations, in addition to data from adult and pediatric ICU locations for the CLABSI and CAUTI measures, beginning in FY 2018.

CMS acknowledged IPPS comments regarding overlapping quality measures included in both the HVBP and the HACRP, but stated that the measures “cover topics of critical importance to quality improvement in the inpatient hospital setting and to patient safety.” It added that the two programs have different purposes and policy goals.

**2-midnight postponed**

Although the IPPS final rule didn’t include much discussion regarding short stays or the so-called 2-midnight rule (which essentially states that physicians need to certify within their patient assessment that the patient could require care which spans at least two midnights), the outpatient prospective payment system (OPPS) proposal did.

The FY 2016 OPPS proposal—typically finalized in mid-November—says that CMS will approve short admissions on a case-by-case basis, based on the physician’s judgment and the documentation justifying the stay.

Beginning January 1, 2016, Quality Improvement Organizations (QIO) will incorporate any changes to the 2-midnight rule finalized in the OPPS rule to conduct the patient status reviews.

**Editor’s note:** This article was adapted from the August issue of *Briefings on Coding Compliance Strategies.*
Accidental puncture laceration: Complication or not?

One of the biggest documentation problem areas pertaining to patient safety indicators (PSI), particularly related to PSI 90, stems from accidental puncture and laceration (APL), says Katy Good, RN, BSN, CCDS, CCS, clinical documentation program coordinator at Flagstaff Medical Center in Arizona, which recently implemented a new comprehensive PSI review process. When Good audited a collection of cases from the previous year, she found a number of APL-related issues, including:

- Lack of queries from CDI for clarification
- Lack of physician documentation
- Lack of proper code assignment for every puncture and laceration as a complication

CDI specialists need to decide whether to query when the physician doesn’t state that the laceration is a complication; what constitutes a complication; what terminology should be used when documenting a laceration that is a complication; and how to effectively educate both coders and physicians.

“The biggest challenges for us so far is what is and what is not a complication, and what doesn’t need to be coded versus what does,” says Good.

The first step is creating a review process. Good’s team—which includes six CDI specialists and a manager—try to catch everything concurrently. Both coders and CDI have their own set of PSI-related duties: CDI should be tackling any potential documentation issues related to PSIs, such as whether the present-on-admission status is unclear, or whether a complication exists. As coders work through the record, when they come across a potential PSI, they put the chart on hold and send it to Good, who then reviews the record within 24 to 48 hours.

“Usually my response is ‘it’s fine,’ but sometimes there may be more of a discussion and a learning opportunity,” says Good.

Every Tuesday and Friday, the CDI team reviews a report that includes PSI-related codes. “Right now, we have a lot of people reviewing PSIs, even though the volume isn’t that high,” she says. “In the long run, this hopefully won’t need to happen, but since it is new to the team, we want as many eyes on the records as possible to make sure we don’t miss anything.”

APL case study

Now let’s walk through the query process. Take this scenario, which Good provided in a recent discussion on “CDI Talk.” The physician documentation stated:

“There was great care taken to avoid injury to the bowel that was directly underneath the skin. The patient did have a chronic wound that had been present since her last surgery in the left anterior abdominal wall. This, in fact, was the serosa of a small intestine. There was no way to avoid injury and serosal tear. This enterotomy was over-sewn using 3-0 Vicryl suture. She had extensive dense adhesions. Lysis of adhesions using Metzenbaum and electrocautery required over two hours. Once this was done, there was another enterotomy that was made. Decision was made to resect these two areas. This was done using an Endo GIATM 75 Stapler. Two side-to-side anastomoses were performed using the GIATM 75 Stapler and then a TA™ 60 stapler was used to close the enterotomies. Of note, the central portion [of the bowel] was dilated consistent with prolonged obstruction. The patient had been having significant abdominal pain preoperatively as well as some nausea.

—Kerry Seekircher, RN, BS, CCDS, CDIP
CDI specialists need to keep in mind that complications should be coded for the patient, not the physician, says Deanne Wilk, BSN, RN, CCDS, CCS, CDI and inpatient coding manager of the HIM department at Good Samaritan Health System in Lebanon, Pennsylvania.

“The fact that it is a quality indicator or the physician may get ‘dinged’ because of it doesn’t mean you don’t code it,” Wilk says. “If the physician says it was unavoidable, that doesn’t mean you should not code it because it was still an issue for the patient.”

The important phrases for CDI staff to watch for, and query for, in this situation are “was this expected or is this to be considered a complication?” says Wilk, and to ask the physician to indicate if this occurred postop and/or intraoperatively.

Had it just been a serosal tear, it might not get coded as an APL, says Robert S. Gold, MD, founder of DCBA, Inc., in Atlanta. However, the issue is the second enterotomy and the unplanned, unexpected resection, he says. “When something unexpected and unplanned occurs that creates tremendous risk so that a resection has to be done, that’s an event and should be coded,” Gold says.

Had the surgeons noted that they “had to resect this stuck segment of bowel to avoid getting into it and potentially contaminating the abdominal cavity” and then did the resection, that would convert it to a planned procedure and alleviate the APL consideration, Gold says.

In response to a high complication rate at her facility, Julie Cruz, RN, CDI specialist at St. Joseph Health in Eureka, California, says her chief medical officer (CMO) requires both CDI and coding to watch for potential complications and to place a query when applicable. If CDI misses the opportunity to query, it becomes the coder’s responsibility to place a retrospective query for clarification.

Anna Rozhkovskaya, RHIT, CCS, CCS-P, CDI manager at Memorial Healthcare System in Miramar, Florida, requires coders to place all cases with potential complications on hold until one of the HIM directors reviews it. If they agree that it is a “true” complication, they send it to the medical affairs director, who then reviews and provides their point of view.

The CDI team then has the opportunity to place a query for the physician or surgeon, if needed. If everyone agrees that it is a complication, the coder will drop the chart.

“It is a very comprehensive process,” says Rozhkovskaya. “Since we now have this process in place, coders don’t just assign complication codes without anyone looking at the chart.”

Kerry Seekircher, RN, BS, CCDS, CDIP, CDI manager at Northern Westchester Hospital (NWH) in Mount Kisco, New York, says CDI reviews these cases in conjunction with the NWH quality department. All cases flagged for having a potential PSI are held for a joint review by CDI and quality. If a determination cannot be made as to whether or not a complication occurred, the physician is queried to provide clarity in the medical record.

“It is best practice for the physician or the surgeon to document if [the laceration] is integral/inherent, necessary, and/or unavoidable,” says Seekircher. “The surgeon should make it crystal clear whether the puncture or laceration was a complication or if it was an expected outcome so that the case can be coded accurately and reflects the care provided.”

As far as education goes, Good includes physicians and surgeons along with CDI and coding.

“Our goal is to reduce and eliminate us being tagged with [inappropriate] APLs, and to be consistent so similar conditions are described the same way,” says Good. “It’s important to be clear with our policies, but also for surgeons to understand that the goal isn’t to get rid of APLs. Every surgeon has a complication rate. The main focus is for us to be consistent with industry guidance and as accurate as possible in the description of what happened to a particular patient.” 📜
More importantly, are your physicians ready?

More than a decade of debate and instability within Medicare’s Physician Fee Schedule (MPFS) came to a historic end with the Sustainable Growth Rate (SGR) repeal in April of 2015.

The SGR formula attempted to curtail Medicare Part B spending (Medicare’s physician payment system) since 1997. The repeal, as a national milestone, not only averted a 21% reduction in provider reimbursement, but it offered assurance that a streamlined incentive payment program would emerge, uniting fee-for-service with value and quality.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides stable updates for five years (0.5% annually) and ensures that no changes are made to the current payment system for four years.

What does that mean today?

The current payment incentive programs will sunset at the end of 2018, including the current 2% penalty for failing to report Physician Quality Reporting System (PQRS) measures, risk-adjusted cost and quality within the Physician Value-Based Modifier (VBM), and the 3% penalty for failure to meet EHR meaningful use requirements.

Defining the composite

MACRA identifies four weighted categories in which the Merit-Based Incentive Payment System (MIPS) composite will reflect the provider’s overall performance in care delivery. These include:

1. Quality (50% in 2019 to 30% in 2021)
2. Resource use (10% in 2019 to 30% in 2021)
3. Clinical improvement (15%)
4. EHR use (25%)

The detailed measures included in each category will be selected based on an annual review by the Secretary of U.S. Department of Health and Human Services. However, preliminary measures will include PQRS, VBM, and the EHR use program.

A key point to be made is that the first benchmark in 2019 will be based upon data collected in 2017. Individual provider payment adjustments, based on performance against these selected MIPS measures, increase annually through 2022.

Providers could see adjustments ranging from negative 4% to positive 12% in 2019, and from negative 9% to positive 27% in 2022. The program is designed to be budget neutral with high performers eligible for additional bonuses. In other words, providers face a potential 36% income margin in 2022. Finally, performance against MIPS measures will be published on Physician Compare.

MACRA incentivizes successful provider participation in APMs with an exclusion option from the MIPS assessment and EHR meaningful use requirements. In addition, those providers qualifying for the APM track will receive a 5% annual lump sum bonus.

In order to qualify, participants must receive 25% (in 2019) to 75% (in 2023) of their revenue from a qualifying APMs. These qualified APMs are those that take on a greater financial risk, report quality measures, and use EHR technology.

Redefining the CDI role

So what does all this mean for CDI? Simply stated: “CDI without walls.” Documentation improvement programs need to become patient-centered and follow documentation improvement opportunities across the care continuum, including ambulatory, inpatient, and postacute care.
programs need to become patient-centered and follow documentation improvement opportunities across the care continuum, including ambulatory, inpatient, and postacute care.

As a profession, CDI’s evolution is critical to ensure the population under treatment is accurately and completely represented in documentation and coding. With the hallmark and extension of risk adjustment beyond the inpatient setting, the importance of provider engagement in all settings is imperative. It may seem a daunting task for any program, but a methodical approach will certainly help ensure success.

MIPS, as required by MACRA, will define populations in the “resource use” category using the current CMS risk methodology of VBM, but with enhancements including public input and “additional processes that directly engage professionals.”

VBM uses Hierarchical Condition Categories (HCC) for risk standardization. As noted previously, baseline data for the 2019 “go live” of MIPS begins in 2017, so the time is now to learn HCCs.

As a CDI program, when considering initial expansion into the ambulatory setting, consider the impact of HCCs on VBM and Medicare Advantage as well as its inpatient infiltration in the Medicare Spending per Beneficiary measure within the Hospital Value-Based Purchasing Program and accountable care organizations.

Unraveling VBM

Section 3007 of the Affordable Care Act mandated that CMS begin applying a value modifier under the MPFS by 2015. The value modifier provides for differential payment to a physician or group of physicians based on the quality of care furnished compared to the cost of that care during a performance period.

This program is an extension, and incorporation, of the PQRS; however, like the hospital measures, it is risk adjusted looking at expected cost of care and quality measures, but on a physician level.

The risk adjustment methodology uses HCCs, which require annual updates of both inpatient and outpatient conditions/diagnoses.

The value modifier becomes the foundation for a quality-tiered reimbursement model reflected in payment adjustments (increase, decrease, no change) based on high-quality cost-effective care. The outcome of the value modifier program impacts both physician reimbursement and profiling, and the data is published on Physician Compare.

Examining HCCs

HCCs began in 2004 to adjust capitation payments to Medicare Advantage healthcare plans for the health expenditure risk of enrollees. HCCs contain diagnostic codes that are grouped into clinical condition categories with similar disease characteristics and costs.

These groupings have an established hierarchy, used to prioritize diagnoses that are clinically related with variable associated costs. In other words, the higher-ranked...
categories are more severe and have a higher cost associated with the disease manifestation.

The HCC model is used in various government programs to predict future costs based on disease, demographic, and insurance factors from the previous year. Therefore, HCCs are used to define the complexity and severity of the population under treatment.

For example, HCCs include high-cost medical conditions (e.g., atherosclerotic coronary artery disease with unstable angina, primary lung cancer), common conditions that require a high frequency of care (e.g., uncontrolled Type 2 diabetes with stage 4 chronic kidney disease), and conditions that define long-term disease complexity (e.g., status post amputation of right leg due to diabetic peripheral vascular disease).

The HCCs with associated assigned weights compile to determine a Risk Adjustment Factor, which reflect overall complexity and resource consumption.

In summary, just as in the inpatient setting, the provider must document to the highest level of specificity to truly illustrate the disease complexity within the HCC model.

**Identifying ambulatory CDI efforts**

Regardless of the setting, the core mission of CDI is constant: Complete and accurate documentation will define the population with specificity across the care continuum.

Certainly, the scale of ambulatory encounters will require prioritization based on program resources and needs. Advancing technological solutions will help CDI and physician efforts, of course, but absence thereof need not paralyze progress.

CDI programs should set manageable goals (beginning with service lines that affect inpatient quality measures) with related metrics to define success.

For example, targeting primary care and preoperative orthopedic evaluations to prepare for the comprehensive care for joint replacement model, beginning in January 2016, is one focused starting point option. Additionally, mining professional billing data for unspecified codes will certainly parcel out the need for improved risk adjustment within the HCC model.

In turn, improved patient data through physician, nursing, office staff, and coder education will appropriately define the population and enhance risk adjustment in MIPS, VBM, and beyond. Keep in mind, the concept of ambulatory CDI is vast, but an early focus lays the foundation for future expansion.

**Collaborating for change**

The repeal of SGR marked a historical milestone for the future of physician pay-for-performance. MACRA touts the most impressive healthcare movement to align physician reimbursement with high-quality cost-effective care.

However, as with current models, like the Hospital Value-Based Purchasing Program, that assess quality, we must ensure that the clinical database is accurately represented in the coding warehouse. CDI professionals are charged to ensure clinical documentation defines care with necessary specificity through education and process development across the continuum. Evolution is now; let’s promote change! 🌟

**Editor’s note:** Dr. Fee is vice president of Enjoin (formerly Huff DRG Review) and an ACDIS Advisory Board member. Contact him at james.fee@enjoincdi.com.
How long to retain paper queries?

Q: How long should we keep paper queries? Our present hospital policy states that our queries are not part of the medical record. We have several years’ worth of queries and was wondering if you have a policy on what to do with those that are at least three years old.

A: Although there are no industry or governmental requirements regarding query retention, the 2001 AHIMA physician query practice brief “Developing a Physician Query Practice” states that:

“Any decision to file this [query] form in the medical record should involve the advice of the facility’s corporate compliance officer and legal counsel, due to potential compliance and legal risks related to incorporating the actual query form into the permanent record (such as its potential use as evidence of poor documentation in an audit, investigation, or malpractice suit, risks related to naming non-clinicians in medical record, or quality of care concerns if the physician response on a query form is not clearly supported by the rest of the medical record documentation).”

The Joint Commission, in RC.01.05.01, states that the retention time of the original or legally reproduced medical record needs to be “determined by its use and hospital policy, in accordance with law and regulation.”

So, each organization must develop policies to ensure consistent practice regarding medical record—and query—retention across all departments. Concurrent and retrospective queries should both follow the same retention process. Many organizations have chosen to allow physicians to respond on the query form itself and to maintain this form within the formal medical record.

In most instances, hospital policies will address the retention time frame too (for example, a policy may require a six-month retention of the queries, and then the queries are shredded). Organizational policies should also specifically address query retention consistent with statutory or regulatory guidelines.

### AHIMA Recommended Retention Standards

<table>
<thead>
<tr>
<th>Health Information</th>
<th>Recommended Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic images (such as x-ray film) (adults)</td>
<td>5 years</td>
</tr>
<tr>
<td>Diagnostic images (such as x-ray film) (minors)</td>
<td>5 years after the age of majority</td>
</tr>
<tr>
<td>Disease index</td>
<td>10 years</td>
</tr>
<tr>
<td>Fetal heart monitor records</td>
<td>10 years after the age of majority</td>
</tr>
<tr>
<td>Master patient/person index</td>
<td>Permanently</td>
</tr>
<tr>
<td>Operative index</td>
<td>10 years</td>
</tr>
<tr>
<td>Patient health/medical records (adults)</td>
<td>10 years after the most recent encounter</td>
</tr>
<tr>
<td>Patient health/medical records (minors)</td>
<td>Age of majority plus statute of limitations</td>
</tr>
<tr>
<td>Physician index</td>
<td>10 years</td>
</tr>
<tr>
<td>Register of births</td>
<td>Permanently</td>
</tr>
<tr>
<td>Register of deaths</td>
<td>Permanently</td>
</tr>
<tr>
<td>Register of surgical procedures</td>
<td>Permanently</td>
</tr>
</tbody>
</table>

**Source:** AHIMA. “Retention and Destruction of Health Information. Appendix C: AHIMA’s Recommended Retention Standards.” Updated August 2011.
AHIMA also published Recommended Retention Standards (see p. 27) which states:

If the query is part of the permanent medical record “…it is very important for the CDI department to know where their queries are housed. If queries are scanned into the medical record, then consider creating a policy to address destruction of the paper queries and the inclusion of a copy located within the medical record. It is also very important to confirm with HIM on whether or not a policy already exists and if not, to involve your compliance department to create a policy addressing this issue. If you choose to make your query forms part of the medical record, make sure the forms are properly labeled with patient information (identifiers) and are dated and timed, as these forms will be considered part of the progress notes. No matter how the query forms are retained (i.e., within the medical record, or as part of the business record of the account) your query process, templates, etc., must be written in a compliant manner.”

As an organization, you must develop and follow your own policies with the guidance with direction from the query practice briefs and Official Guidelines for Coding and Reporting.

The 2013 joint query practice brief from ACDIS/AHIMA, “Guidelines for Achieving a Compliant Query Practice,” suggests that organizations review their query practices and policies on a regular basis to ensure compliance. Review every query template to ensure compliance as well.

Auditing agencies and CMS are fully aware that hospital staff—whether they are HIM/coding professionals or CDI specialists—query physicians. Many reviewers, therefore, ask to see the query forms.

The 2007 IPPS final rule (as published in the Federal Register) instructs hospitals to make attempts to improve all aspects of clinical documentation. It states:

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 within the medical record.

There should be no fear of transparency with your query practices if you consistently follow ethical and compliance standards. We strongly advocate that CDI specialists always develop queries with the thought that someone is going to find and read them. That means that compliance in their presentation, proper clinical support for the query, etc., is paramount. If an auditor requests the queries and your policy states you keep them for six months, then your facility must be able to produce six months’ worth of queries.

Before you choose to make a change to place your query forms as part of the medical record, make sure that you discuss this change with leaders of your medical staff, your organization’s compliance and quality teams, and those who supervise the coding practices within your organization.

These discussions should be part of a thorough review of all policies related to physician documentation queries. We also suggest that those who review the policies be well versed with all the various industry query practice briefs.

Editor’s note: ACDIS Advisory Board members Anny Pang Yuen, Donald Butler, and Walter Houlihan collaborated on this Q&A along with ACDIS/HCPro CDI education specialist Sharme Brodie. The entire ACDIS Advisory Board reviewed and approved its contents.

It is also very important to confirm with HIM on whether or not a policy already exists and if not, to involve your compliance department to create a policy addressing this issue.

The Physician Queries Handbook, Second Edition

The second edition of the Physician Queries Handbook is the authoritative source for defining policies, procedures, and best practices for physician queries. Take a walk through the evolution of query practices and discover how government and industry guidance has changed through the years. Learn how to develop query policies and procedures that take into account the latest query practice brief information. Discover how to update your CDI practices to meet the challenges of ICD-10-CM/PCS implementation, Recovery Auditor challenges, and other payer initiatives.

It includes:

- Sample queries
- Regulatory impact on query practices
- Query process infrastructure
- Re-defining query formats

The Physician Queries Handbook, Second Edition

© 2015 HCPro, a division of BLR.
“The sky didn’t fall,” Erica E. Remer, MD, FACEP, CCDS, clinical documentation integrity officer of University Hospitals in Cleveland, told ACDIS Radio listeners during the October 14 broadcast.

In fact, 75% of the broadcast’s listeners indicated they either had no problems or merely minor slowdowns related to the new code set implementation go-live date.

For many, the switch was reminiscent of the so-called Y2K bug—a technological glitch which many feared would cripple our computer-centric society at the moment the calendar turned to the year 2000. Such devastation never came, and the world continued, as computer-focused as ever, to spin.

Ensuring a smooth ICD-10-CM/PCS transition required appropriate planning, education, staffing, and communication, explained founding ACDIS Advisory Board member Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer, national director of coding quality, education, systems, and support for Kaiser Permanente (KP)–National Revenue Cycle in Oakland, California, during the September 30 ACDIS Radio program.

“We’ve been hearing that folks feel ready for the change,” Bryant says. “Yes, it has been a long road—for some of us it has been 20-plus years in the making—and so the really positive news is that the code set is finally here.”

Keep focusing on the positive, Remer agrees, calling ICD-10-CM/PCS implementation an “opportunity” for the healthcare industry.

“I think we all really should take advantage of the amazing opportunity that ICD-10 is giving us to capture the attention of the physicians and to open a dialogue” about the importance of their documentation within the medical record, she says.

As a physician herself, Remer thinks of the new code set as one designed by scientists and doctors, and communicates that to the physicians she serves.

Physicians may think the code set represents another hoop to jump through imposed by the government, but “we have to remember that they got zero training in ICD-9, and this is a great opportunity to remediate that fact.”

Assess and reassess program basics

Now, nearly a month into the implementation, facilities need to have an ICD-10-CM/PCS command center to collect and communicate any concerns with the new code set, including coding and CDI productivity,
software and technical concerns, and billing and denial problems, Bryant says.

Remer’s program hired new CDI staff as part of its implementation strategy. “Everyone anticipated huge productivity decreases, but we haven’t seen that yet,” she says.

There could even be room for improved productivity amongst coders and CDI professional in the immediate future as dual coding efforts end and teams slowly decrease ICD-10-CM/PCS-specific training in favor of more typical day-to-day documentation awareness efforts amongst physicians, Remer explains.

“The biggest problems will be related to the submission of claims and payment of bills,” says Laurie L. Prescott, MSN, RN, CCDS, CDIP, CDI education coordinator and lead CDI Boot Camp instructor with HCPro in Danvers, Massachusetts, told listeners of the October 14 show.

Yet, these concerns won’t be evident until roughly a month or two post-implementation.

So, potential shifts in MS-DRG assignment should be watched, Bryant says. CDI programs need to understand the effect of the code shift on the facility’s case-mix index and be able to explain what is happening when any sudden drops or increases occur.

Also, make sure to get any backlog of ICD-9-CM cases billed out and focus on pushing the new ICD-10-CM/PCS cases through to billing as soon as possible.

One of the quirks of the new code set relates to MS-DRG assignment, Remer says. So CDI specialists and coding teams need to watch for these cases.

“If we look at the DRG that we end up in and it isn’t where we thought we should be, then the individual will need to go back and look at the case again with ICD-10 eyes.”

Additional focus areas continue to be the procedure coding change, disease linkage, and advanced CDI efforts such as psychiatry, physician practice, and outpatient record review, Remer says.

At some facilities, surgeons have 30 days to complete their operative notes. Under ICD-10-PCS, however, every element of the code needs to be complete for that bill to get dropped. If the surgeon takes 30 days to complete the report and then needs to be queried for additional information, the bill could be held even longer.

Remer suggests CDI specialists query for the operative note while they are reviewing the record concurrently— not only reminding the physician about outstanding documentation requirements but explaining what pieces of information are specifically needed to avoid having to query the surgeon twice.

“Nothing is perfect, but the big thing is that we are going live,” Bryant says. “If there’s problems, there will be solutions too. Look at both sides of the clouds there.”

“It’s not the next zombie apocalypse,” Prescott jokes.

Editor’s note: ACDIS Radio is a free, bimonthly Web-based discussion with industry experts and stories from practicing CDI specialists. For information, visit www.acdis.org/radio.cfm.
Tips for navigating unexpected CDI effects

by Trey La Charité, MD

No new hospital initiative operates in a vacuum. And there is no way to anticipate every consequence of your CDI program. Even with the best intentions, there will be downstream consequences to navigate.

Let’s start with the first place your program’s effects will be noticed: the medical records department. If you didn’t know, your medical records department maintained a Discharged Not Final Billed (DNFB) or Discharged Not Final Coded (DNFC) list before the advent of your CDI program.

The DNFB is a list of all of the charts that cannot be final-coded and submitted for reimbursement until missing documentation has been secured and reviewed. (In my facility, it is called the waiting on documentation or WOD file.) Generally, your DNFB file size is fairly consistent month after month, missing the same procedure notes, operative reports, and discharge summaries from the same group of doctors.

When the size of your DNFB list suddenly increases, it won’t go unnoticed. And, rest assured, your CDI program will increase the size of your hospital’s DNFB list. Why?

Because unanswerable concurrent queries means information vital to accurately capturing your patients’ severity of illness is still missing, and you are obligated to convert those concurrent queries to post-discharge queries. Can the coding of a record that has an outstanding query be completed? No. Therefore, you just increased the number of records on your hospital’s DNFB list.

Did I mention all of the additional post-discharge queries your coders will be sending due to the implementation of ICD-10? That’s certainly going to add to the number of DNFB cases. Since your director of medical records typically gets called on to explain such matters, he or she isn’t going to be happy with your CDI department. Congratulations! You’ve just alienated the person who should have been your first colleague, the medical records director.

Revenue cycle troubles

Unfortunately, the second place your CDI efforts will be felt also revolves around the DNFB list. In this case, however, the effects of your program will be felt by those who run your facility’s revenue cycle. To these colleagues, the DNFB list means delayed cash flow because any record that can’t be sent to a carrier can’t be reimbursed.

Additionally, your facility is losing the potential accrued interest on these reimbursements since the money remains in the carriers’ bank accounts as opposed to yours. To the bean counters, even “insignificant” amounts of lost revenue matter. If your hospital’s operating margin is tight, any slowing of the cash flow or reduction in the operating margin is problematic.

Ironically, CDI programs are often initiated by chief financial officers. I suggest you reduce their angst by reminding them that the increased revenue from a higher hospital case-mix index (CMI) and an improved publicly reported observed-to-expected mortality ratio far outweigh a slowing of cash flow.

To simultaneously fix things for your CDI program and for these two departments, resolving documentation and coding issues while the patient is still in the hospital is the key. This requires a three-pronged approach.

First, spend more time in provider and service line education. While your providers may have figured out that they have documentation issues, they don’t know how to prevent them. Showing them examples of why they keep receiving query after query will provide them with the tools to prevent future queries.

Second, ask your hospital’s administration to take a stronger stance on those providers who never answer their queries. It is likely that it is the same group of offenders for the medical records department.

Third, make sure your concurrent reviewers complete every chart in the hospital before the patients go home.
While that may be impossible with current staffing levels, generally, additional CDI staff are an easy sell to hospital administrators. Not only will your CMI increase, but chances are the additional interest earned from a smaller DNFB volume will cover the cost of at least two new concurrent CDI reviewers. This results in a “win” for both the revenue cycle and medical records departments.

Compliance influence

The compliance department is charged with ensuring your hospital follows established regulatory guidelines. One of the things they consistently monitor is your facility’s quarterly PEPPER results (Program for Evaluating Payment Patterns Electronic Report). PEPPER compares the relative volumes of the various MS-DRGs your facility submits to the same statistics for all of the facilities within your region and the nation. If your volumes for certain MS-DRGs are significantly higher than your region or the whole country, you are considered an outlier.

Every government-employed or contract auditor looks for outliers. Like it or not, an auditor automatically interprets outliers to mean that your facility is admitting patients who do not need acute care services, performing procedures that are not medically necessary, or upcoding for the sole purpose of increasing revenue. If your CDI program is run correctly, your facility will develop outliers for certain MS-DRGs that are monitored in the PEPPER report.

However, you can significantly reduce your compliance officer’s anxiety by assuring that person that your facility is not upcoding. You simply discovered previously unrecognized or incompletely described cases. If the documentation is present to support the diagnoses that were coded and if the accepted clinical criterion for those diagnoses is also present, you will satisfy even the toughest compliance officer.

Positives for performance improvement

The last department your new CDI program will impact is performance improvement (PI)—sometimes called quality assurance or quality improvement. While CDI programs ultimately have a significantly positive influence on a facility’s overall performance metrics, the few negative effects may grab your PI director’s attention first. In my facility’s case, our PI department suddenly noticed that the rates of postoperative sepsis, postoperative respiratory failure, and postoperative anemia increased above the national average.

After investigation, the PI staff determined that the increase was caused by our new CDI program actively encouraging our providers to document these things. To solve the problem, they suggested the CDI program stop querying for some diagnoses in certain circumstances.

Fortunately, after explaining the inappropriateness of the suggestion, I was able to show that physicians needed to work on a few quality issues rather than reverse our CDI program’s efforts. Once again, the increased awareness of the clinical definitions of certain disease processes unearthed more cases where these things were previously unrecognized and unreported.

In full disclosure, the overall improvement in my facility’s CMI played a significant role in defeating the PI team’s unwise suggestion. In the long run, however, the positive effects of the CDI program did ultimately win the day, and our CDI and PI efforts now work in concert. In this case, the positive effects took longer for the performance team to appreciate—since we all had to wait until publicly reported data was available for review.

Patience makes perfection

While by no means complete, this list should give you an idea of where initial CDI vulnerabilities lie and some idea of how to effectively defuse situations. Unfortunately, in any given organization, most people tend to concern themselves with only their particular domain. In the hospital setting, however, CDI tends to influence them all in some form or fashion. Any given hospital represents an ecosystem, and your new program will change that ecosystem. To ensure that change remains a positive one, playing nicely with others is a required skill for today’s CDI professional and will be essential for any physician advisor working with them.

Editor’s note: Dr. La Charité serves as the physician advisor for University of Tennessee Medical Center at Knoxville CDI program, coding, and RAC response, and was a member of the ACDIS Advisory Board from 2011 to 2013. His comments and opinions do not necessarily reflect those of UTMC. Contact him at Clachari@UTMCK.EDU.
MEET A MEMBER

From trauma chart sleuthing to CDI

San Francisco resident creates training videos

Shannon Huth, MSN, RN, CCDS, was working as an emergency department nurse in Southern California when she discovered her talent for chart reviews. She was asked to enter trauma data for county reporting, and realized how much she enjoyed analyzing the charts and learning the codes. As she was getting ready to move to San Francisco for graduate school, a full-time clinical documentation position opened up at a local hospital. The job advertised for nurses with a knowledge of ICD-9 codes—so, naturally, Huth applied. Three and a half years later, Huth continues her work as a CDI specialist at San Francisco General Hospital (SFGH), in a CDI program she helped build from the ground up. She recently became the education manager for the electronic documentation system at her facility, and creates educational videos and handouts to help with training. She recently graduated from the University of San Francisco with a master degree of science in nursing, with a focus on clinical nurse leadership. She is also a member of the California ACDIS chapter.

In her free time, Huth enjoys baking and spending time with her friends and family, including her mother, a licensed vocational nurse; her father, a CNC programmer; and her grandmother, a retired registered nurse. She also has a 13-year-old teacup Chihuahua named Max.

CDI Journal: What did you do before entering CDI?

Huth: I was a registered nurse in the ED in a small community hospital in Southern California. I’ve worked almost every healthcare position in the hospital, including as an ED technician, a certified nursing assistant, a licensed vocational nurse, and a clerk.

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

Huth: While working as a registered nurse in the ED, I was asked to enter the trauma data for county reporting. This was something I only did a few times per month, but I really enjoyed reviewing the charts and cataloging the findings. Over time, the codes began making sense, and I would inquire why certain diagnoses and injuries were coded differently. A few years later, I was getting prepared to move to San Francisco with the goal of starting graduate school and finding a job. SFGH had advertised a full-time position for a clinical documentation specialist. I was more than excited to interview and, ultimately, build the first-ever CDI program at SFGH, with another nurse and a physician. The more traditional daytime hours allowed me to work full-time and complete my master’s degree over the last two years.

CDI Journal: What has been your biggest challenge?

Huth: Starting any new program in a large academic institution can be challenging. As initiatives come and go, we have made the effort to make sure that CDI is involved and aligned as much as possible. Also, working at a public hospital and trauma center means a diverse range of services and patient populations. We spend a lot of time researching the specific needs of the services and customizing education, which goes a long way.

CDI Journal: What has been your biggest reward?

Huth: Any time a provider uses “severity of illness” or “mortality index,” I am a happy CDI specialist. As the CDI program has grown, we have been able to expand into many other areas of interest, such as implementing a new electronic documentation system and quality projects. We have presented a poster at a national quality conference and received an award from the San Francisco Health Commission. Throughout my master’s program, I was able to discuss CDI and its importance in healthcare to my professors and classmates. My final project was code monitoring and education for PSI 15, which was a very unique topic at a nursing school.
**CDI Journal:** How has the field changed since you began working in CDI?

**Huth:** When we started our program, many of the materials found on ACDIS and other sites were focused on CC/MCC capture and reimbursement. While that is an important foundation for CDI, I am happy to see more quality-related materials becoming the focus. I look forward to seeing the impact of ICD-10 and begin reviewing data for additional improvement.

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

**Huth:** ACDIS has been my go-to for all things related to CDI. The quarterly (now bimonthly) journal is my favorite, and I usually read it the same day it is published. I review the “CDI Talk” board daily for any interesting concerns or issues in our field. I don’t have the time to read the entire IPPS report or other reports—ACDIS makes it easier for me to stay up to date on things happening that impact my work.

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

**Huth:** You don’t have to know everything. That’s impossible. Take the time to understand your resources: people, books, ACDIS, Coding Clinic, etc. The coding staff I work with have amazing experience and expertise that I could never match, [so avail yourself of the expertise that already surrounds you]. But as a nurse, I do bring a different and valuable perspective to the table. The key is working together. It is also important to be flexible. Your hospital or organization’s needs may be different than the standard, but know the foundation of CDI to begin the process. The climate of healthcare is changing drastically, and so will your job.

**CDI Journal:** If you could have any other job, what would it be?

**Huth:** I would be a baker! I enjoy baking and decorating cookies and cupcakes for my family and friends. My mother and I have had our Christmas cookie tradition for many years now, and they are a hit. I would love to own and run a food truck focused on desserts.

**Shannon Huth, MSN, RN, CCDS**
Shannon Huth and her parents celebrating her recent graduation from University of San Francisco, where she earned her master’s degree in nursing.

**CDI Journal:** What was your first job (what you did while in high school)?

**Huth:** I worked at McDonalds. I learned many customer service skills!

**CDI Journal:** Tell us about a few of your favorite things.

- **Vacation spots:** Yosemite is my new favorite, but I also love Costa Rica and Nicaragua!
- **Hobby:** I’m working on this one … my hobby is figuring out what hobby I like.
- **Non-alcoholic beverage:** Iced coffee. Black Medicine, based out of Oakland, is my current fave.
- **Foods:** I love anything from The Chairman—it’s the best food truck in San Francisco. Almost all food trucks here are amazing.
- **Activity:** Hiking in the Redwoods, exploring the Bay Area, reading books for fun, and watching Netflix.