Benchmarking CDI Efforts
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For a period of time, my husband and I forsook New Year’s Eve festivities in favor of low-key evenings of noshing on cheese and crackers while the ball dropped on TV. Just before the strike of midnight, I would run around the house opening all the doors—letting the new year enter on a clear, crisp burst of New England winter air that pushed the stagnant breath of the past year out through the back door.

No matter your holiday traditions, we all seem to share the almost mystical belief that this simple turning of the clock, this flip of the calendar, represents a magical reset button on our lives. We can suddenly envision a healthier, happier, more professionally rewarding life for ourselves that’s easily attainable.

Yet there’s really no magic to it. You lose weight by eating more broccoli and getting back to daily walks with the dog. You experience happiness by giving yourself time for the things that bring you joy—being with your family, baking, reading a good book, connecting with old friends. Similarly, a more professional and rewarding life comes from actively engaging in your work and seeking out opportunities to help others.

Setting CDI program goals for the coming year doesn’t require a cleansing burst of cold air, either. In this edition of the Journal, you’ll learn some simple ideas to help you raise the bar for your program.

We often gaze at the year stretched out ahead of us and tick off our lists of plans, but while doing so, it’s important not to neglect the accomplishments of the past. What did you make happen in 2015? Maybe you took the leap, studied your head off, and passed the Certified Clinical Documentation Specialist examination. Maybe you spent a little extra time chatting with a physician who simply didn’t want to let go of the term “urosepsis” and ultimately helped her have a change of heart. Give yourself the much-needed accolades you deserve. Each and every step you take leads you down the path to both personal and professional achievement.

Congratulations on all that you’ve done, and our best wishes for a happy and productive new year!
Set and assess core competencies continuously

by Sylvia Hoffman, RN, CCDS, CCDI, CDIP

The job description for a clinical documentation improvement (CDI) specialist involves more than simply leaving queries. The role takes many different forms depending on the size of the hospital, the size of the department, and the varying responsibilities assigned to the individual.

However, standard competency elements do exist—competencies CDI staff must achieve in order to perform their job well. In 2014, the ACDIS Advisory Board created a position paper outlining its recommendations for CDI standards, titled Defining the CDI Specialist’s Roles and Responsibilities. A CDI supervisor, or other department head, needs to determine whether his or her CDI team is functioning properly and upholding these standards.

In my opinion, one of the most important skills for a CDI specialist is the ability to read the medical record and identify where incomplete, unclear, inconsistent, or missing documentation exists. This requires a firm knowledge of medical indicators and medications, as well as an understanding of medical reports. The CDI specialist must also have a basic knowledge of coding conventions, the Official Guidelines for Coding and Reporting, and the AHA’s Coding Clinic for ICD-10-CM/PCS.

It is equally important for CDI program managers to regularly assess their CDI team on a transparent set of basic statistical measures to determine their effectiveness on both individual and departmental competencies. Many hospitals measure the following for their CDI specialists:

- Record review rates
- Query rates
- Query answer rates
- CC/MCC capture rates

In 2010, AHIMA published a paper titled Guidance for Clinical Documentation Improvement Programs as well as its “Clinical Documentation Toolkit.” The “Toolkit” stated:

CDI programs can be staffed by nurses or other clinicians who may be unfamiliar with the standards applied to coders, and that since CDI is still a relatively new program, it is important for
facilities to have a system of checks and balances in place to ensure a high level of integrity.

These basic measures of success, however, may not be enough to determine if a CDI staff member is competent in his or her day-to-day role. Documentation specialists should be monitored and tested on a periodic basis to determine their professional knowledge and skill sets. Depending on the type of orientation and training they receive, and the ongoing education provided, CDI specialists (and the departments they work in) can either flourish or flounder.

Assessing core competencies

How does a department head or supervisor evaluate the effectiveness of his or her department, or the competency of individual documentation specialists?

CDI departments should develop a method to track and measure individual CDI specialists’ strengths and weaknesses, and have an escalation process in place if an individual CDI falls short of the preset baseline. The basic skills and knowledge CDI staff must possess include:

1. Assigning the principal diagnosis (defined by the Official Guidelines for Coding and Reporting as “the diagnosis, after study, to chiefly be responsible for occasioning the admission to the hospital”)
2. Identifying secondary diagnoses (defined by the Uniform Hospital Discharge Data Set standards as “a diagnosis that is evaluated, monitored, or treated, or increases the length of stay or need for nursing care”)
3. Identifying missing or incomplete documentation in the record
4. Assessing when more specificity is needed in documentation
5. Formulating a concise and correct query following the rules set forth by ACDIS and AHIMA in their industry guidance and practice briefs
6. Assigning the correct DRG
7. Knowledge of hospital-acquired condition (HAC) and present on admission documentation (POA) requirements
8. An understanding of hospital policies and procedures as they relate to the specialist’s job functions
9. Knowledge of work processes and data entry
10. Using resources available to assist in work processes, such as DRG Expert®, ICD-10 Expert for Hospitals, Official Guidelines for Coding and Reporting, the AHA’s Coding Clinic for ICD-10-CM/PCS, the 2013 ACDIS/AHIMA Guidelines for Achieving a Compliant Query Process, etc.

ACDIS published surveys of CDI programs throughout the United States that found a learning curve when it comes to CDI practice. Most new hires take approximately three months to learn the basic information needed to perform the role, and most CDI professionals become proficient—capable of functioning independently with a sound base of knowledge—around the six-month mark. In addition, a second year is needed to attain a mastery of the profession. At that time, the CDI specialist should be refining skills, learning complex concepts, and mentoring fellow team members. The time it takes to obtain that additional level of expertise is one reason that ACDIS requires CDI specialists to have at least two years of experience before taking the Certified Clinical Documentation Specialist (CCDS) exam.

With all this said, new documentation specialists should not be held to the same standards as seasoned staff members. The CDI department should develop a worksheet and perform periodic reviews of a novice CDI specialist’s work. Use of this worksheet can be discontinued once a preset probationary time period has elapsed. (See a sample worksheet on p. 6.) The worksheet can also be used for annual record review assessments of all CDI staff.

Adding record review complexities

These are not the only proficiencies that CDI specialists need to have, however. Due to the changing climate
of medicine, healthcare reimbursement, and ongoing government audits, CDI specialists need to continually evolve with any changes and new requirements pertinent to their profession.

Take, for example, the 2-midnight rule, and the Recovery Auditor denials based on medical necessity and lack of documented inpatient admission criteria. CDI specialists should be aware of Recovery Auditor vulnerabilities in general and know which diagnoses were previous denial targets for their facility. They should understand which diagnoses need closer scrutiny and why, and be able to prioritize reviews accordingly. CDI specialists are increasingly being asked to review records with these concerns in mind, so documentation specialists must keep themselves up to date.

There are a number of other factors that determine the success of a CDI department and reflect the work being done by the CDI team. An often unappreciated metric is the POA capture rate. This can have a huge effect on the coding of HACs and the correct selection of the principal diagnosis. Don’t forget the importance of those standard metrics, too—the total daily number of chart reviews, the query rate, the query answer rate, and the change in CC/MCC capture rates.

Other statistics that should be measured and evaluated are the severity of illness (SOI) and risk of mortality (ROM) scores. Many CDI specialists discontinue their review once they obtain a CC/MCC to increase productivity. However, this may be self-defeating when it comes to establishing the correct SOI/ROM for a patient since it may take several CCs or MCCs to change the SOI/ROM scores. CDI must be aware of how these scores affect the hospital, as well as their impact on the treating physician.

CDI specialists also need to understand how the coding department operates and its effect on the facility’s finances—everything from “bill drop” time to the number of records on “bill hold.”

Still other factors to watch include the case-mix index (CMI) and the geometric mean length of stay (GMLOS). CDI staff should be alert for records with long lengths of stay or stays lasting less than two days. They must

<table>
<thead>
<tr>
<th>SAMPLE TOOL</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Able to identify the principal diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Able to identify the relevant secondary diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Able to identify CCs/MCCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Able to correctly assign the DRG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Able to assign the principal procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Able to identify needed documentation clarification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Able to correctly form a written query</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Able to correctly form a verbal query</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Uses correct indicators in formulating query</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Knowledgeable of diagnoses on HAC list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Knowledgeable of high-risk diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Knowledgeable of quality indicators and effect on revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Knowledgeable of SOI and ROM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Attends multidisciplinary rounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Performs presentations or provides individual education to physicians and staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Works in an organized fashion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Able to prioritize work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Contributes to the CDI team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Keeps up to date on current CDI trends</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
understand how length of stay may affect hospital revenue and the risk for auditor denials.

CDI specialists need to be aware of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) and understand the information it provides. Unfortunately, many CDI staff members have never heard of this important document. In it, CMS provides specific data associated with Medicare improper payments due to billing, DRG coding, and/or admission concerns. CMS provides this data free of charge on a quarterly basis to facilitate the prioritization of auditing and monitoring efforts. The PEPPER may provide the CDI team with an understanding of under-reported or over-reported diagnoses, as well as diagnoses that may need closer documentation scrutiny.

Quality indicators are a new and critical part of how hospitals and physicians are reimbursed. Departments are expanding the CDI role to review records for documentation that affects Patient Safety Indicators (PSI). The CDI specialist needs to be aware of where quality penalties reduce revenue now, and where revenue will likely be reduced in the future. CDI staff may need to focus on improving documentation for certain high-priority quality metrics. Sadly, many programs are singularly focused on DRG payments.

Management should provide continuing education for their CDI specialists to ensure they are up to date and knowledgeable concerning the latest trends and “hot topics” in CDI.

To evaluate the skills and knowledge base of the CDI staff, create a flow sheet for periodic audits on the queries being created and the principal diagnosis and DRG assignments generated. CDI managers need to complete yearly competency testing and provide staff with summaries of their own statistical data, along with overall group information regarding progress with CMI, GMLOS, bill hold time, etc.

CDI managers also need to develop a method to assess individual CDI specialists’ ability to communicate with and engage physicians, provide education, work together with other departments, and contribute to their department as a whole.

The CDI staff should be aware of what is being measured, how it is being measured, and why such measurements matter. CDI personnel should also understand what the consequences of poor performance will be (for example, additional education or job shadowing). Such preemptive discussions helps keep staff from feeling that they are being singled out or treated unfairly. All this information should be incorporated into the facility’s CDI department policies and procedures.

Too often, unfortunately, I hear about inappropriate and outdated query practices within a facility. Sometimes, it’s simply due to outdated education—a consulting team came in some time ago and helped establish a process, and years later the team continues to follow the same practices even though new industry benchmarks exist.

Other times, it’s because CDI staff are not encouraged to continue their training on their own or allowed time to attend local educational events. I once encountered a program whose CDI staff were unable to identify a principal diagnosis. They had used an encoder from day one, were randomly entering incorrect information, and had to start from scratch to relearn the basic tools needed to perform their jobs properly.

Often, it’s due to a lack of transparency or a lack of assessment of the CDI program. Managers collect data regarding the overall progress of the CDI team, but the information is only shared with upper management. In fact, 40% of nearly 300 respondents to a recent ACDIS poll say their program’s data simply isn’t available.

As I previously stated, CDI programs can flourish or flounder based on the amount of ongoing education and support the CDI team receives, and the level at which the team performs. Supervisors cannot be effective if they do not know what their staff are doing.

It’s the responsibility of effective managers to assess and review staff performance and to communicate those results for the overall benefit of the program and CDI staff.

Editor’s note: Hoffman is president and CEO of Sylvia Hoffman CDI Consulting in Tampa, Florida. She served as a CDI specialist in a 1,000-bed teaching hospital, worked as an educational consultant with DocuComp, LLC, and served as a senior associate in the forensic division at KPMG before starting her own Tampa-based CDI consulting practice. She has 15 years’ acute care hospital experience and 10 years of case management experience. Contact her at sylvia@sylviahoffman.com.
“A graph is worth a thousand words,” says Matthew Bohl, business analyst for the CDI program at Baystate Health in Springfield, Massachusetts.

And yet, clinical documentation data was all but non-existent when Baystate Health first implemented its CDI program. Fresh out of undergrad, where he studied biology, Bohl joined Baystate working per diem in the HIM department as the “scanning tech.”

Although he loved his undergrad work, he didn’t see himself counting and cultivating bacteria for a living. Thankfully, Bohl quickly found an opportunity to define a new career for himself within the facility’s growing CDI department—and with that, he transitioned from cutting open sharks to slicing and dicing CDI statistics.

He worked on his computer skills, teaching himself Microsoft Excel—“I’d been using Excel since I was 12, but didn’t know the power of it,” he says—as well as Visual Basic and Microsoft Access. These programs help him manipulate data to cull useful information and illustrate it in helpful ways. (You can see an example of Bohl’s monthly reports on p. 11.)

While it may not be the science of his undergrad years, Bohl, who’s currently working on his master’s degree in public health, treats his business analytics efforts like an investigation or a scientific experiment: pushing through the information to see what opportunities it illuminates.

CDI programs are “more than just coding, more than just HIM or medical documents,” he says. “It affects more than just one department and really was a boon for the [facility]. CDI is a frame of mind.”

**Elemental data**

Baystate worked with a consultant to get its CDI efforts off the ground, pulling benchmarking information from ACDIS and MedPAR data to establish expectations for query rates, query response rates, and productivity volume such as
number of records reviewed per day per CDI specialist, says Jennifer Cavagnac, CCDS, assistant director of CDI/HIM at Baystate.

“The data just exploded out from there,” says Bohl. “It’s like an onion: Once you start pulling back the layers, you discover more and more layers beneath. To continue to be successful, you have to grow with your data. Once you see a trend, you investigate it and see what opportunities it leads you to.”

For example, one data point Baystate focused on in the first year was physician response rates, says Cavagnac. The team expected a response rate of about 90% and was able to increase that to about 95%, she says.

“We knew that data point wasn’t going to get a whole lot better,” Bohl says, so the team started to look at what other elements related to physician responses could be available.

They started to measure how quickly the CDI team received a response, and examined physician response rates by service line and by individual physician.

“We examined the data and then determined why a particular data set looks that way. Then we talked about how we can improve or address those concerns which the data brings to light,” says Cavagnac.

Steering the data

Information is only useful if “you can get it into the hands of those who need it,” says Bohl.

At Baystate Health, Bohl creates any number of reports based on any number of requests. The CDI program essentially maintains an open door policy and makes all its data readily available, welcoming feedback to further enhance outcomes.

Someone from nursing or dietary may have an interesting new idea that the CDI staff hadn’t thought about before, says Cavagnac. So if the team can identify the needed data elements and do some analysis for growth opportunities, everyone wins.

In the beginning, however, the newly created CDI team needed to establish some basic metrics and structure for its reporting. Baystate Health’s CDI steering committee met frequently to establish those parameters.

The steering committee consists of representatives from:

- Finance
- Quality
- Case management
- HIM/CDI
- Clinical team members from both the medical and surgical sides of the house

The meetings are also open to any other hospital department or administrative team wishing to learn more about the CDI program’s efforts, Cavagnac says.

The committee meets monthly to share program information and discuss new focus points. Currently, it looks at:

- Program financial outcomes such as CC/MCC capture rate, case-mix index, and MS-DRG shifts
- Query rates
- Physician response times by medical and surgical service lines
- Data analysis by facility

“In a casual environment they wanted to see each other’s data,” says Cavagnac. “They wanted to see how they were doing against other hospitals within our system and frankly talk about the challenges we face as a group.”

Soon, the steering committee members themselves became catalysts for change. Its members deliver the CDI program’s message out to the rest of the system, and its clinical leaders share the CDI team’s
documentation guidance information with members of each of the clinical service departments, Cavagnac says.

**Setting performance**

“Whatever data we gather needs to be useful,” says Cavagnac. “It needs to show a snapshot in time, or it needs to illuminate cumulative data to enable an ongoing conversation.”

That’s as true for information shared with the steering committee as it is for the information shared with the team of CDI specialists during one-on-one meetings with Cavagnac.

When data shows a trend of opportunities for additional physician education, for example, she picks up the phone and talks with the physician or passes the information along to the appropriate individual.

The Baystate CDI team is 99% remote, but staff come on-site once every two weeks. Items such as an individual CDI specialist’s productivity and query rates or the financial effect of an individual’s query activities are shared with the specialist in question, Cavagnac says, while discussion of program trends takes place during regular group meetings.

The open sharing of information makes individuals feel good about the work they’re doing, says Bohl. When trends are going down, it gives them an opportunity to see that, too, and to express their own thoughts about how to reverse that trend. In short, he says, it’s empowering.

Through their CDI and coding data entry system, staff add sticky notes to share their thought processes and ask questions of each other. If the final MS-DRG assignments don’t match, the coder reaches out to the CDI specialist and a conversation ensues.

The system includes customizable query templates. CDI staff copy Cavagnac on all their queries, and she picks two from each staff member (20 queries in total) for the team to review during group meetings.

“It’s a great learning tool,” she says. “Inevitably someone comes away with a new insight about how to approach a topic.”

**Gathering information**

CDI program directors need to remember two important things as they investigate their own metrics, Cavagnac says.

“One: Try to justify a full- or part-time CDI business analyst so you do not need to use a manager’s or CDI specialist’s time for analytical development. (I’m so very lucky to have a business analyst.) Two: If you do not have a business analyst, make sure you do devote time and effort to develop some sort of data analysis to demonstrate your CDI program’s growth.”

This ongoing collection and dissemination of information allowed the Baystate Health CDI program to add six staff members last year, increasing the total team to 10 CDI specialists. With a full team on board, Cavagnac looks forward to expanding the group’s efforts into severity of illness and risk of mortality reviews, and Bohl is examining how to effectively analyze that APR-DRG-type data.

“We really want to transition those metrics in a direction that can show severity changes by the CDI team,” he says.

Regardless of whether a business analyst is in place, and regardless of whether there are electronic systems in play, CDI programs need to get in front of their own data and use it to empower both their staff and their administration, Cavagnac says.

“Keep it simple, keep it meaningful, and it will go a long way,” she says.
CLINICAL DOCUMENTATION IMPROVEMENT

...ensures clinical documentation is accurate, timely, and reflects the severity of the patient and scope of services provided.

AUGUST 2015: Baystate Medical Center

Reviews per Person
16
The reviews that an analyst is able to do in a work day

Query Volume
301
The volume of queries issued when the month ends

Query Rate
26%
Percentage of patients with a review that are issued a query

Response Timeliness
2.1
Avg. days between date of query issue & date of query

Coverage Rate
50%
Percentage of inpatients reviewed by CDI

Response Distribution
Volume of queries vs. the days between query issue and response

Response Rate
98%
Percentage of queries with a physician response

Documentation Tip
ICD-10 Transition

Future Roadmap
Preparation for ICD-10 Transition & Integration of 10th CDI

Comments
Greater than 95% response rate for 12 consecutive months

Bayside Health || Health Information Management || Clinical Documentation Improvement
Query audits provide growth opportunities

It’s a glass half-full kind of result—40% of “ACDIS Radio” listeners (of the October 28, 2015, broadcast) say their CDI program has an established query auditing process in place.

But there’s definitely room to add more milk to the glass: Another 29% say they have some query review practices established but they only informally or occasionally take the time to examine the efforts of CDI specialists. Meanwhile, 18% don’t have any process in place, and 14% say they either don’t know or the question isn’t applicable to them.

“I would have thought that more than 40% would have something in place,” says Karen Chase, MS, BSN, CCDS, associate director of CDI for Stony Brook University Hospital in Long Island, New York, who developed an auditing process for her team to assess their basic skills and help move more experienced CDI professionals on to complex review efforts.

Chase, and those programs with regular reviews in place, may be ahead of the curve, says ACDIS Advisory Board member Mark LeBlanc, RN, MBA, CCDS, director of CDI services at The Wilshire Group, who co-hosted the October broadcast.

“It’s great that 69% of respondents are getting some type of feedback,” he says. “I think that number will grow. It’s definitely something the industry need to push for as a best practice.”

Stony Brook’s process didn’t happen overnight, says Chase. She initially tracked her CDI specialists’ productivity with metrics such as number of queries, number of records reviewed per day, and number of physician responses, among other items.

She explains, though, that a productivity deficiency didn’t necessarily mean a deficiency in the quality of the review taking place. For example, one CDI specialist had a 95% physician response rate, a number that none of the other specialists could seem to reach. Upon closer investigation, Chase learned that many of the queries issued by the high-production specialist were fairly basic in nature and easy for physicians to respond to. She found that some CDI professionals with lower productivity metrics actually had higher overall case-mix index results due to the effect they were having on the physicians they queried.

“Maybe they were spending more time digging into the records, conducting more rounding with the physicians, engaging physicians with more education and outreach, or conducting more research on a particular topic area that required more time but also had a greater overall effect,” Chase says.

She still requires a “certain amount” of productivity from her staff and expects them to touch at least eight to 10 charts per day, but Chase considers these measures as the basic elements required to “monitor something that’s difficult to monitor.

“These staff members are out on the floor or, if you manage a multihospital system, out at different institutions. The only way for managers to see what they are doing is to measure how many records they get through during the course of the day; it’s the only way to make sure they weren’t going to the beach all day,” she jokes.

Detailing the audit process

The 11-person CDI staff at Chase’s 603-bed academic facility reviews charts through discharge, even in situations where no query is warranted. At the end, the CDI specialist reconciles the chart against the
coding summary and works with the coding staff on any outstanding concerns.

Each CDI specialist generates a basic worksheet summary of his or her review efforts and submits it to Chase on a monthly basis. Chase then audits about 10% of the specialist’s work against a standard checklist for compliance, efficiency, and effectiveness. (See the sample tool below or download it from the ACDIS Forms & Tools Library.)

“I really found that staff members were on different levels of expertise and record review focus,” she says. “Some were doing severity of illness and risk of mortality, while others were still focused on the CC/MCC capture. I needed to know what people knew and what they didn’t know. That’s when my review process became more elaborate.”

Chase ensures CDI staff use appropriate clinical indicators in queries and examines the medical record to make sure no opportunities were missed. Every month, Chase meets one-on-one with her staff to review audit results and talk about opportunities identified. The overall results help her track staff members’ improvement over time and are used in annual performance reviews.

The information isn’t intended to be punitive, however. “It’s not just me saying ‘You missed something on this one,’” says Chase. “It’s an open dialogue where they can bring any concerns they have, as well.” Sometimes that means discussing new tactics to engage with a particularly reticent physician; other times it means providing the CDI specialist with additional objectives or education to improve a particular aspect of his or her skill set, she says.

“I think it’s really important to have a comprehensive audit process in place to really understand what type of work is being performed and ensure the integrity of the work that’s being done,” Chase says. “In God we trust. Everyone else needs to bring me data.”

### SAMPLE TOOL

<table>
<thead>
<tr>
<th>Query audit:</th>
<th>Encounter number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date completed:</td>
<td>CDI specialist:</td>
</tr>
<tr>
<td>Auditor:</td>
<td></td>
</tr>
<tr>
<td>1. Does the query include accurate patient data and significant clinical indicators?</td>
<td>Y</td>
</tr>
<tr>
<td>Patient data?</td>
<td></td>
</tr>
<tr>
<td>2. Was the query composed in accordance with physician inpatient query process policy and procedures?</td>
<td>Y</td>
</tr>
<tr>
<td>3. Was there follow-up of the query?</td>
<td>Y</td>
</tr>
<tr>
<td>4. Was there a proper reconciliation of the chart done with follow-up on changes?</td>
<td>Y</td>
</tr>
<tr>
<td>5. Missed opportunities</td>
<td></td>
</tr>
<tr>
<td>5a. The missed query opportunity was based on: (Complete sections A/B/C/D/E/F.)</td>
<td></td>
</tr>
<tr>
<td>A: Clinical indicators of a diagnosis but no documentation of the condition</td>
<td></td>
</tr>
<tr>
<td>B: Further clarification/specificity of documented diagnosis required</td>
<td></td>
</tr>
<tr>
<td>C: A cause-and-effect relationship between two conditions or organisms needed</td>
<td></td>
</tr>
<tr>
<td>D: An underlying cause required when patient was admitted with symptoms</td>
<td></td>
</tr>
<tr>
<td>E: Only the treatment is documented (without a diagnosis documented)</td>
<td></td>
</tr>
<tr>
<td>F: Present on admission (POA indicator status)</td>
<td></td>
</tr>
</tbody>
</table>
Assessing staff, verbal queries, and fiscal outcomes

Q How long does it take for new CDI specialists to become proficient in the role?

A: “Programs really need to give some thought to how long they give new staff to get up to speed,” says ACDIS Advisory Board member Donald Butler, RN, BSN, CDI manager at Vidant Medical Center.

While some CDI specialists come to the role with experience, many come from nursing, case management, coding, or HIM. These new specialists need to not only learn the day-to-day function of the role, but also grasp the complicated process of how clinical documentation gets translated into codes and, in turn, how codes are used for everything from reimbursement to quality assessments.

“Thats a lot to take in, and it takes a long time to get to that level of competency,” Butler says.

He points to data in the ACDIS Poll archives, “CDI Talk” discussion threads, and the 2014 CDI Program Productivity and Program Structure Benchmarking Report, which all generally indicate that a six-month onboarding process should be expected for a new CDI specialist, followed by a two-year window for expanded learning and growth.

CDI program managers need to set reasonable expectations and assessments, not only for their staff but also for their program, says Butler. “From a metrics perspective, I am a proponent for thoughtful and deliberate assessment of the metrics for the program and for the individual CDI specialist as a part of an ongoing annual evaluation process.”

That said, managers should steer away from collecting data simply for the sake of having it, he says.

“Establish ahead of time which data sets you want to look at, watch it, trend it, and identify those data sets which fall outside the average. For those elements, you then need to figure out what’s happening,” says Butler.

For example, a low physician query response rate may point to an unresponsive physician, or it may mean an opportunity for a particular CDI specialist to receive additional education regarding verbal queries.

“Nevertheless, in my opinion, hard numbers in an employee’s evaluation is a good thing, and it certainly helps to focus where a CDI program moves,” Butler notes.

Q Our CDI program does a lot of verbal queries. Do you have any suggestions for how to assess query etiquette and how we should be tracking those?

A: The 2013 ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice state that verbal queries need to be memorialized in some manner, says ACDIS Advisory Board member Cheryl Ericson, MS, RN, CCDS, CDI-P, CDI education director with ezDI.

Although the practice brief does not dictate exactly how verbal queries need to be retained, it does indicate that the key facts of the interaction between the physician and the CDI specialist should be documented in some manner, as should the outcome of the interaction, she says.

“You want to make sure you’re as transparent as possible,” says Ericson. “Sometimes its difficult to capture the whole conversation that you had, but at a minimum I would include the clinical indicators that led the CDI specialist to believe there was an opportunity for clarification.”

CDI programs should have a robust set of policies and procedures and spell out exactly how...
verbal queries are to be memorialized, how the physician is expected to respond to the verbal query, and the difference between a verbal query and physician education, says Ericson.

“When we do a verbal query, we document everything that we would have included, just as if it were a written query, and then simply indicate that the question was asked verbally,” says ACDIS Advisory Board member Judy Schade, RN, MSN, CCM, CCDS, clinical documentation specialist at Mayo Clinic Hospital.

In terms of CDI etiquette while conducting verbal interaction with physicians, Butler recommends enlisting the physicians’ assistance. He likens the process to a “secret shopper” experience where shoppers report back to the retailer with details about their experience in the store.

CDI managers can follow up with a particular physician after an interaction and simply ask his or her opinion about the exchange. Keeping detailed notes and conducting such interviews on a regular basis may reveal some interesting opportunities for the staff in terms of improvement, and may lead to overall program improvement ideas as well.

The 2010 Clinical Documentation Improvement Toolkit from AHIMA calls on CDI supervisors to regularly assess staff, says ACDIS Advisory Board member Sylvia Hoffman, RN, CCDS, CCDI, CDIP, president and CEO of Sylvia Hoffman CDI Consulting.

As part of that assessment, the “supervisor should shadow CDI staff periodically to hear them interact with physicians in real life and to make sure that everyone is following the rules the way they should be.”

We track how our query efforts affect MS-DRG assignment. Should we (individual CDI specialists) take credit for a shift in assignment even if the query or queries we left didn’t really affect that assignment?

A: “You can really drive yourself crazy worrying whether you’ve contributed to the increase in reimbursement for a particular case,” Ericson says.

Instead, programs need to look at the larger picture—the overall effect of CDI efforts on physician documentation.

“When you’re querying, you’re also educating the provider, you’re encouraging changes in their documentation habits, and that affects documentation on the next case. So after querying and educating the physician over time, you shouldn’t have to query for the specificity of that heart failure,” she says.

There needs to be a shift away from examining how an individual CDI specialist’s efforts affect reimbursement, says Kelly Gates, RN, MHA, CCDS, CDI 3D software product manager for Optum 360.

“There’s a powerful story that can be told with regard to giving yourself credit … for capturing severity of illness and risk of mortality. Your queries help capture risk adjustment,” and CDI programs really need to get credit for how a query “affected the continuity of the medical record documentation and code assignment,” she says.

Look at financially based metrics on a program level, suggests ACDIS Advisory Board member Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP, director of education for MedPartners.

Butler agrees. “A really successful CDI program may have fewer queries, but if that’s in the setting of overall sustained case-mix index, sustained strong physician and hospital profiling scores, that lower query rate isn’t a problem. There are lots of ways to measure impact, not just financial. Don’t take [financial] credit when you didn’t earn it.”

Queries should never be monetarily driven, says Newhouser.

“Remember, it’s for the greater good,” she says. “The bottom line is answering the question of whether we are doing the right thing for the patient. Does that medical record accurately reflect the conditions of their entire hospital visit?”

Editor’s note: These questions and answers were compiled from the November 2015 ACDIS quarterly membership call. Listen to a recording of the call on the ACDIS website, www.acdis.org.
ACDIS Advisory Board considers industry advances

There isn’t an aspect of ACDIS that Donald Butler, RN, BSN, CDI manager at Vidant Medical Center in Greensville, North Carolina, has not been associated with over the years. An active “CDI Talk” group participant, he later elaborated on the concepts raised within that networking community for articles on the ACDIS Blog and CDI Journal. He’s spoken at the annual ACDIS Conference several times and served on its conference committee, helping identify salient topics and competent speakers. So perhaps it was only natural that he applied to sit on the Advisory Board and that the members elected him wholeheartedly in 2013.

Each year, four new Advisory Board members step forward and four trusted members take a step back from their roles. Each board member brings unique expertise and insight to bear on the board and on the direction of the overall association. For those stepping back from board duties as 2015 draws to a close, their three-year tenure included intensive collaboration on a number of new initiatives, offering those working in the field a set of established recommendations from which to build and advance their CDI programs.

“I’ve really enjoyed being a part of this growing organization,” says Butler, who sees an shift in focus since ACDIS’ early years and the efforts of its board from the basic mechanics of association offerings toward a greater professionalism and leadership within the industry.

“There is a maturity process within the organization and an ongoing maturity of the CDI industry, too,” he says.

For its part, the Advisory Board has pushed that growth forward by publishing more thought leadership. In the past few years, such leadership included:

- 2015 revision to the ACDIS Code of Ethics
- White paper: Physician Queries and the Use of Prior Information: Reevaluating the Role of the CDI Specialist
- White paper: Ten Things You Need to Know About ICD-10, and Tell Your Physicians
- White paper: Cornerstone of CDI Success—Build a Strong Foundation
- Position paper: Defining the CDI Specialist’s Roles and Responsibilities
- Position paper: Electronic Health Records and the Role of the CDI Specialist

“We (as a CDI industry) want to have a voice, want to make a difference and have a place at the table in healthcare,” Butler says.

Early on, Sylvia Hoffman, RN, CCDS, CCDI, CDIP, president and CEO of Sylvia Hoffman CDI Consulting in Tampa, Florida, knew she’d
have a voice within the association. She always wanted to be a nurse, and came to CDI at the request of the head of finance at Tampa General Hospital following a stint in case management there. To learn more about her new profession, Hoffman found ACDIS and started reading the blog and email newsletter. After a response to a blog post received multiple replies, Hoffman decided to get more involved and started writing for the association.

“I was astonished by the number of people who responded to my [blog] posts. At that point, I knew I’d found a community I could grow with,” she says.

Hoffman joined the Florida ACDIS chapter, and less than a year later she was elected president of the group. Although this was a professional achievement in its own right, she set her aspirations high.

“Back when I first started writing for the blog, I set my long-term goal to join the ACDIS Advisory Board,” she recalls. And once elected, she “sat down and cried. It was such an honor.

“I’ve been a part of some of the most interesting conversations with the most intelligent people in this field, and when I look around the table, I see that I am one of them. If I don’t do another thing in my field, I’ll be happy,” Hoffman says.

Having a seat at that collaborative table spurred Walter Houlihan, MBA, RHIA, CCS, FAHIMA, HIM director at Baystate Health in Springfield, Massachusetts, to volunteer.

At his first meeting, the board discussed the effectiveness of remote CDI efforts. While some members cautioned against it, others took up the debate and looked for solutions to presumed problems, Houlihan recalls.

“We challenged each other and pushed each other and gave our opinions and discussed our different perspectives,” he says. “If someone offered an idea, we looked for the different points of view and incorporated that difference to advance the profession forward.”

Such inclusiveness is a unique attribute for a midsized association, says Houlihan—an attribute which may stem from its relative youth.

“Perhaps it’s because the profession is younger, and not set in its ways, that makes it and its advisory board so hungry for innovation, so ready to tackle new projects,” he says. “It embraces new ideas and isn’t shackled to tradition.”

It may also be due to the inclusive nature of the profession itself, Houlihan adds. CDI professionals need to work with and through the various stakeholders involved with medical record documentation and coding. That means having an awareness of, and openness to, the concerns and opportunities of a wide range of professionals—physicians, coders, case managers, information technology, dietitians, and more.

“ACDIS’ niche may very well lay within that collaboration,” Houlihan says. “Just as CDI specialists rely on the intersection of various professional types, so too the association must collaborate within the larger industry, always pushing its members to consider and reconsider the perspectives of the professionals they serve.”

The ACDIS Advisory Board is a “collection of great people, of caring professionals coming together to see good things happen within the industry, and I’m proud to have been a part of it,” says Thomas W. Huth, MD, MBA, FACP, vice president of medical affairs at Reid Hospital & Health Care Services in Richmond, Indiana.

As his organization expanded its CDI efforts a few years ago, Huth was “pulled heavily” into the field. He attended the ACDIS Conference, joined the association, and sought additional avenues to serve and learn from the organization.

“ACDIS is a great organization,” says Huth. “The problem is (and it’s a good problem to have), there are not enough hours in the day to tackle all the topics the board would like to. Nevertheless, ACDIS and the Advisory Board has done a good job of leaning in and identifying those opportunities for growth—both for itself as an organization and for CDI as an industry. There is a set of dots that ACDIS can connect for people and help them when they lose their way.”

This is an ongoing mission, a long-term goal, for the Advisory Board, says Butler. “We’re in a new transition into an ever-greater state of professionalism where
ACDIS is seen as the standard bearer for the profession.”

Incoming board members will need to roll up their sleeves to not only continue the work of crafting position statements on a variety of emerging concerns, but also to work with the ACDIS administrative team to reach out to like-minded industry associations such as AHIMA, the Case Management Society of America, the Healthcare Financial Management Association, and others in identifying areas for potential collaboration, says Houlihan.

The real role of the Advisory Board, says Hoffman, is to give back. “That’s really how I see my position here.”

And a lot of effort does go into the work. Advisory Board members field questions from ACDIS members, participate in quarterly membership conference calls, contribute to its publications, and help in a variety of other ways.

“I have a real sense of responsibility and of obligation to the board and to the CDI community that I have agreed to take on by volunteering for the board,” says Butler.

“We’ve done a lot of good things, and I’m very proud of it,” Hoffman says. “But you have to be committed to it. We’re still moving forward. We still have a lot of work to do.”

**PHYSICIAN ADVISOR’S CORNER**

**Tips for gaining physician support for I-10**

*by Sam Antonios, MD, FACP, FHM, CCDS*

October 2015 marked one more landmark change: the shift to ICD-10. Physicians worried about the transition and likely dreaded the loss of familiar terms, efficiency, or income. Explaining some basic ICD-10-CM/PCS information can help.

When ICD-10 became a reality, the first thing everyone focused on was the number of new codes. Although it is true that the number of codes increased, the increase can be explained in the context of the concepts added to each coding element. About one-third of the increase is due to added laterality. Also, a single additional concept for a combination code will have a multiplicative effect. As an example, Crohn’s disease can be of the large intestine, the small intestine, both the large and small intestine, or an unspecified intestine (four locations). Adding one of seven complication concepts to each location of Crohn’s disease will multiply these four codes by seven, resulting in 28 codes. Yet Crohn’s disease did not change, nor did ICD-10-CM add 24 new types of Crohn’s disease pathology.

ICD-9-CM’s design limits the ability to include new diagnoses. Instead of intra-cardiac thrombus, a condition diagnosed with a modern echocardiogram, ICD-9-CM provides “certain sequelae of myocardial infarction, not elsewhere classified.” ICD-10-CM will provide a much better code descriptor. ICD-10-CM also better incorporates specificity coming from clinically validated scales such as the Glasgow Coma Scale or scale of visual acuity, as well as basic classifications such as pregnancy terms.

These improvements resonate with providers. It’s more important than ever to explain the underlying goal of the new code set: Better documentation will mean more accurate data, which will mean better risk adjustments for quality measures and a more appropriate DRG assignment that justifies the length of stay or resource utilization for each patient.

If we are to succeed in the transition to ICD-10, we need to dispel all myths about the new code set, be empathetic to physicians, and always offer support.

**Editor’s note:** Antonios is director of medical information and ICD-10 physician advisor for Via Christi Health in Wichita, Kansas. This article was originally published in the HIM Briefings newsletter.
Tis the season: CDI skirts working major holidays

Many CDI specialists coming from the bedside nursing background are used to working weekends and holidays. It comes with the territory—hospitals are open 24/7, 365 days a year, and doctors, nurses, and the like have to be on-site at all times. Those transitioning to the CDI field do so for a number of reasons, including a more flexible schedule. But when it comes to working on major holidays, is it necessary for CDI specialists to be on the clock?

The initial response to the idea of working the holidays was shock, says Juli Bovard, RN, CCDS, CDI specialist at Rapid City Regional Hospital in South Dakota, questioned the rationale.

“When we come in on Mondays [or after a holiday], we have a CDI specialist who reviews and completes all the reviews for the discharged patients from the weekend [or holiday],” says Bovard. “I can almost guarantee [the cases] would not be coded by then.”

There is no such thing as a documentation emergency, says Katy Good, RN, BSN, CCDS, CCS, CDI program coordinator at Flagstaff Medical Center in Arizona. At her facility, CDI staff do not work weekends or major holidays.

“We catch all of those charts regardless,” says Good. “Queries can wait one [or two] days.”

Anna Rozhkovskaya, RHIT, CCS, CCS-P, manager of CDI at Memorial Healthcare System in Miramar, Florida, says her facility used to work holidays, but created a policy giving CDI specialists major holidays off.

The concern for many managers is productivity, but for record reviews, queries, and other CDI duties, working weekends and holidays may not be necessary to get the
job done, says Renee Meyer, RN, CCDS, a CDI specialist in northern California. Her hospital observes seven holidays annually, and CDI specialists also get weekends off. “[Even with the days off,] we have a review rate of over 90%,” she says.

Even with weekends and holidays off, LeeAnn Conaway, RN, CCRN, CCDS, CDI coordinator at UPMC Altoona in Pennsylvania, says her staff still has a high review rate.

“The small percentage of records we miss will be reviewed by our coders and, if they see an opportunity, they have a CDI review it and ask a question post-discharge,” says Conaway. “The rest of our queries are done concurrently.”

The major holiday season marks the end of the year, and while this is often a busy time for hospitals, the census for many facilities usually drops, says Karen Bridgeman, MSN, RN, CCDs, CDI educator at Medical University of South Carolina in Charleston.

“By the time the actual holiday arrives, our census will usually drop significantly between Christmas and New Year’s,” she says.

At Flagstaff Medical Center, Good noticed the same thing—the census is lower around the holidays. During this season, productivity remains unchanged, with a review rate of 98%–100%.

“Honestly, I think for the hospital, financial impact should be considered as well,” says Good. “Paying staff holiday pay when the same outcomes could be attained without this added cost is certainly a factor.”

If productivity is an issue, CDI specialists should come up with a plan to ensure reviews will be completed, says Kay Blue, RN, BSN, ACM, director of CDI at the Carolinas Healthcare System in Charlotte, North Carolina.

Her CDI team does not work the three major holidays—Thanksgiving, Christmas, and New Year’s Day. They make sure to provide a minimum of 50% CDI staff coverage the day before and the day after each holiday.

At least one person is required to work the other holidays during the year, Blue says, though that has not been an issue. “Sometimes staff prefer to work the holiday to avoid traffic, or because a spouse is available to care for the kids,” she says.

It’s also a good idea to keep track of reviews missed during weekends or holidays, so CDI can prioritize when they come back to the office. “We review all payers, and we do have a discharge without review list that is monitored for reviews [older] than one day,” says Bridgeman.

The CDI staff can collaborate, too, when it comes to scheduling days off around the holidays. “Our team is generally happy to cover other team members so that everyone can have a couple extra days off,” says Good.

At many facilities, the CDI position is considered a privilege for seasoned professionals because the work does allow for flexibility. Many consider holiday time off and flexible schedules a perk of the job, says Conaway.

“We require at least five years of critical care experience [for our CDI specialists], and our least senior person has 15 years,” she says. “As far as I am concerned, not working weekends or holidays is one of the benefits of being offered a CDI position.”

Do Your CDI Specialists Work the Holidays?

- No, the CDI department is closed on major holidays
- Yes, we are fully staffed
- Yes, but staffing is reduced/minimal

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QUERY CONSIDERATIONS

When to query unspecified diagnoses

Over-querying is a common concern in CDI. It can influence productivity and workflow. It can cause delays in documentation and coding processes. It can also overwhelm and frustrate physicians, who in turn may be less likely to support or engage with CDI program efforts.

The transition to ICD-10-CM/PCS has brought a number of documentation challenges, including an increase in unspecified diagnoses. This means the number of queries will likely increase as well. It’s up to CDI specialists to have a sufficient degree of knowledge in their toolkits so they know when it’s appropriate to query and when it isn’t.

Each facility should have a specific plan in place between CDI and coding for how to handle unspecified diagnoses, says Katy Good, RN, BSN, CCDS, CCS, CDI coordinator at Flagstaff Medical Center in Arizona. Her facility opted to focus primarily on two things when it came to ICD-10 specificity–related queries:

- Diagnoses where additional specificity will add or change severity of illness/risk of mortality scores
- Specificity that is required for coding (i.e., needed to accurately assign a code)

“Over time, as our comfort with ICD-10 increases, I predict that we will expand the areas that we query,” says Good. “However, we are cognizant of the impact of queries on providers and want to make sure we are not overwhelming them. Initially, we will focus on the ‘needs.’ As documentation issues resolve in certain areas, I am sure we will begin focusing on other [opportunities].”

The CDI specialists at Sutter West Bay in San Francisco issue a query if additional information is needed to provide clarity in order to compliantly bill, and if that additional information will impact reimbursement, says Paul Evans, RHIA, CCS, CCS-P, CCDS, manager of regional clinical documentation and coding integrity.

“This includes diagnostic coding as well as PCS if the bill can’t be dropped due to lack of specificity,” he says.

CDI specialists also issue queries if any quality metric could be affected, such as SOI/ROM, sepsis survival rate, value-based purchasing, and any other metric affected by risk-adjusted methodology, Evans says.

For example, if a physician performs a vascular bypass, should the CDI specialist query the physician to obtain information regarding the specific vein that was harvested for the procedure? What about the type of joint surface—do you default to synthetic if it is not specified? Evans says no. The precise materials are needed to assign a code. If the documentation does not allow for that level of specificity, there could be an opportunity to query the physician.

Unspecified codes in ICD-10 should be used when “it most accurately reflects what is known about the patient’s condition at the time of that particular encounter,” according to CMS.

Choosing a more specific code when documentation in the record does not support such action would be inappropriate, CMS says. “Each healthcare encounter should be coded to the level of certainty known for that encounter.”

So now that we know that we should always query for unspecified diagnoses and document to the highest level of specificity possible, let’s look at a few other diagnoses.

Principal and secondary conditions

First, let’s refresh and discuss principal diagnoses and secondary diagnoses.

The principal diagnosis is defined as “the condition, after study, which occasioned the admission to the hospital,” according to the ICD-10-CM Official Guidelines for Coding and Reporting, FY 2016. It is not necessarily what brought the patient to the emergency room, but rather what occasioned the admission.

In a recent blog post, Laurie Prescott, MSN, RN, CCDS, CDI education director for HCPro in Danvers, Massachusetts, presented the following scenario:
A patient is admitted for a total knee replacement for osteoarthritis. The patient is brought to the preoperative holding area to prepare for surgery and suffers a ST-segment elevation myocardial infarction (STEMI) before the surgery can begin. Instead of going to the operating room for the knee replacement, the patient goes to the cath lab for a stent placement.

The principal diagnosis in this instance is the osteoarthritis. Acute myocardial infarction (the STEMI) is not the principal diagnosis because it was not the “condition that occasioned the admission,” says Prescott.

Finally, let’s take a look at “other” or secondary diagnoses. The Uniform Hospital Discharge Data Set defines “other diagnoses” as:

All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

According to the ICD-10-CM/PCS Official Guidelines for Coding and Reporting, to be considered a secondary diagnosis, the condition must require any of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic studies
- An extended length of stay
- Increased nursing care and/or monitoring

Secondary diagnoses include diagnoses the patients bring with them that must be considered when treating the principal diagnosis, as well as diagnoses that develop subsequently and will affect the patient care for the current admission.

To further expound on the example above, the patient admitted with the principal diagnosis of osteoarthritis also has a history of Type 2 diabetes, chronic obstructive pulmonary disease, and coronary artery disease. These conditions would be coded as secondary diagnoses because they will require treatment and monitoring during the patient stay, says Prescott. The acute STEMI that developed subsequently will also be coded as a secondary diagnosis because it developed after admission.

CDI specialists should know the criteria for the chronic systematic conditions that should be reported regardless, such as diabetes or chronic obstructive pulmonary disease, says Gloryanne Bryant, BS, RHIA, CDIP, CCS, CCDS, AHIMA-approved ICD-10-CM/PCS trainer. “The presence [of such conditions] alone will impact the care.”

**Whatever condition, disease, or problem the patient has, it must be documented so it can be properly coded.**

-Gloryanne Bryant, BS, RHIA, CDIP, CCS, CCDS, AHIMA-approved ICD-10-CM/PCS trainer.

**Family of codes**

This leads us to another issue prevalent in ICD-10: families of codes.

For the first year of ICD-10 use, CMS will not deny or audit claims based solely on the specificity of diagnosis codes, as long as the codes on such claims are from the correct “family of codes.” But this doesn’t extend to hospital reporting, which leads many to question whether or not payers will reimburse claims that include unspecified codes.

Hospitals are allowed to use unspecified codes. According to the ICD-10-CM/PCS Official Guidelines for Coding and Reporting:

*While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter.*

There are plenty of cases where unspecified codes are justified. The bottom line is the documentation has to accurately reflect the patient diagnoses and the care provided. “Whatever condition, disease, or problem the patient has,” says Bryant, “it must be documented so it can be properly coded.”
CLINICALLY SPEAKING

Check CDI efforts related to functional quadriplegia

by Richard D. Pinson, MD, FACP, CCS

Quadriplegia is a very familiar condition that would never go unnoticed and undocumented in the medical record. The causes are typically catastrophic damage to the upper spinal cord due to trauma, vascular injury, or neoplasm. It could be described as structural or spinal quadriplegia to distinguish it from functional quadriplegia.

Functional quadriplegia, however, is defined as the inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord. It is comparable to spinal quadriplegia in its consequences because patients require total (or near-total) care. The effect of functional quadriplegia on intensity and complexity of care, severity of illness, and costs of care is equivalent in every respect to spinal quadriplegia.

The most common cause of functional quadriplegia is advanced brain and/or neuromuscular degeneration from such things as dementia, hypoxic or traumatic brain injury, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington’s disease, profound intellectual/mental disability, and similar conditions. Some birth defects or advanced musculoskeletal deformity, including severe, progressive arthritis, may result in functional quadriplegia. Most, but by no means all, patients with this condition exhibit extreme cognitive and mental disability.

Common consequences of functional quadriplegia are pressure ulcers, flexion contractures, recurrent aspiration, malnutrition, alimentation support (including G-tube feeding), urinary and fecal incontinence, and catheter drainage of the bladder.

The Braden Scale, assessed by nurses and used to predict the risk of developing pressure ulcers, has two objective indicators useful for recognizing and confirming functional quadriplegia with additional subsets, such as:

Activity and mobility:
- Mobility
  - Completely immobile
  - Very limited
- Activity
  - 1 - Bedfast

Likewise, nursing assessments of the basic activities of daily living (ADL) will indicate a high degree of disability or dependence for such measures as:
- Communication
- Ambulation
- Transferring
- Dressing
- Eating
- Swallowing
- Toileting
- Bathing

An assessment of simply “needs assistance” does not support a diagnosis of functional quadriplegia.

In order to explain functional quadriplegia to physicians, CDI specialists first need to acknowledge that the term itself does not originate from clinical sources but from the ICD-10-CM coding classification system to provide a code that describes the debilitating nature and severity of non-spinal quadriplegia—a condition which requires almost total care of the individual suffering from it.

Some neurologists use the term functional quadriplegia to describe patients who, for emotional or other reasons, pretend to be paralyzed. They may describe patients who require total care for non-spinal reasons as quadriparetic even though quadriparesis has historically been used for patients with spinal injury. Either term allows code assignment to accurately portray the patient’s condition.
From a coding perspective, spinal quadriplegia and functional quadriplegia are both considered serious comorbid conditions that contribute substantially to the severity of illness, complexity of care, and hospital reimbursement for the costs of caring for such patients.

Imagine the intensity of nursing care, monitoring, and length of stay required in these circumstances. Both functional quadriplegia (complete paralysis) and functional quadriparesis (partial paralysis) are coded as the same condition; this code, R53.2, is an MCC in MS-DRGs and has a severity of illness of 3 in APR-DRGs.

In summary, look for patients who require total or near-total care in association with profound, advanced, debilitating medical conditions. Identify physical findings that are characteristic of functional quadriplegia and comorbidity commonly associated with it. Verify by reviewing nursing records of the Braden Scale and ADLs that provide objective evidence of extreme disability and functional impairment.

Editor’s note: Pinson is a physician, educator, and healthcare consultant. He practiced internal and emergency medicine for 25 years, and has trained thousands of physicians and other healthcare professionals nationwide. He is the co-author of the best-selling CDI Pocket Guide and the CDI for the Clinician™ e-learning training solution, and writes for the American College of Physicians’ Hospitalist magazine.

In order to explain functional quadriplegia to physicians, CDI specialists first need to acknowledge that the term itself does not originate from clinical sources but from the ICD-10-CM coding classification system to provide a code that describes the debilitating nature and severity of non-spinal quadriplegia—a condition which requires almost total care of the individual suffering from it.

SAMPLE DOCUMENTATION CLARIFICATION FORM

Date: 
Time: 
CDI specialist: 
Dear Dr. ______________,

The medical record indicated the following symptoms/description/diagnoses:

- Dementia
- Contractures
- Total care/max assist
- Immobility/debility
- Chronic illness ________________________
- Other __________________________________

Please indicate if one of the following accurately describes any associated additional diagnoses for this patient:

- Functional quadriplegia: Complete immobility due to severe physical disability or frailty
- Critical illness myopathy: Intensive care myopathy
- General debility/deconditioning
- Other _______________________________
- None of the above

Physician signature: ___________________________
Date of response: ___________________________

Editor’s note: This sample was taken from the ACDIS Forms & Tools Library and was donated by Katy Good of Flagstaff (Arizona) Medical Center.
Talk about ICD-10: Focus on five tricky diagnoses

From a CDI standpoint, ICD-10-CM/PCS implementation seems to be going relatively well. In fact, in a recent poll on the ACDIS website, 53% of respondents say they are not experiencing any real problems, while 27% say they are only experiencing a couple of minor issues.

As CDI programs move deeper into the post-implementation world, staff are identifying those changes that are having the greatest effect on DRG assignments, and those they are struggling with. Here are a few documentation issues that stand out.

**Atrial fibrillation (AFib)**

There is little guidance for documenting and coding AFib as a principal diagnosis when it is a new onset. The ICD-10-CM definitions are not specific for a patient who has not had AFib previously. In addition, some CDI specialists question whether or not they should query for every AFib diagnosis that is unspecified. (Read a related article regarding unspecified diagnoses on p. 21.)

It’s been an ongoing issue, says Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta, who notes that CMS’ ICD-10-CM/PCS Coordination and Maintenance Committee does have the matter on its radar screen. New onset or initial episode of AFib could have a code soon, and it could read “AFib, initial episode” and then “chronic AFib” with its three models:

- Paroxysmal
- Persistent
- Long-standing/Permanent

Hopefully CMS will also include a digit for association with mitral valve disease or not as these are treated differently, says Gold.

For now, CDI specialists should stay tuned and watch for updates. If they review a case with a new onset or initial episode of AFib, they should work to clearly identify it as new onset, says Laurie L. Prescott, MSN, RN, CCDS, CDIP, CDI education director at HCPro in Danvers, Massachusetts. Although we do not have a code for this in ICD-10-CM, CDI should query to specify it as not a chronic issue. The physician, she says, should discuss possible etiologies and document the patient’s symptoms or complications as well as response to treatment to support the need for inpatient care.

**Peripherally inserted central catheter (PICC)**

There’s been a handful of concerns around documenting and coding PICCs, including:

- What procedure code to use if the catheter tip ends up in the cavoatrial junction (CAJ), the joint between the superior vena cava and the atrium
- What procedure code to use if both fluoroscopy and ultrasound are performed, as the code set only allows for one or the other

Sharon Salinas, CCS, HIM manager at Barlow Respiratory Hospital in Los Angeles, says her facility has been using the code for superior vena cava (SVC). If the catheter tip ends up at the junction, it is not actually in the atrium, which she says justifies this code selection.

Prescott agrees with Salinas and says the CAJ describes the point at which the superior vena cava meets the superior wall of the right atrium. This meeting point, she says, is located at the inferior end of the superior vena cava; if the catheter travels below that point it would enter the heart.

“This is a perfect example of how coders and [CDI specialists] can work together,” says Prescott. “CDI specialists with a clinical background likely will offer more experience related to anatomy questions, especially those related to procedure codes.”

As for the fluoroscopy and ultrasound, the concern is whether or not coding both will make it appear as if two PICC lines were placed. Some say there isn’t an option to choose both, while others say you should be able to code radiologic guidance. Since the insertion would only be coded once, it should be possible to code both.
“A guidance code would be used twice, one for each type used,” Salinas says.

Prescott suggests this question be posed to Coding Clinic. “The choice will not impact the MS-DRG so likely should not be a huge CDI issue,” she adds.

**Gastrointestinal bleed (GI bleed)**

The existing codes for hemorrhagic shock lead to two routes: traumatic or post-procedural. The question CDI specialists face is whether or not the shock secondary to GI bleed should be documented, or if this case should be documented as hypovolemic or other shock.

Back in ICD-9, there was no specific code for hemorrhagic shock, though many groupers offered that description as an option that mapped to the all-purpose code 785.59 (shock without trauma), says Judy Riley, RHIT, CCS, AHIMA-approved ICD-10 trainer and CDI/coding manager at LRGHealthcare in Laconia, New Hampshire.

However, in ICD-10, there is the more specific option of coding R57.1 (hypovolemic shock), if it is documented, or R57.8 (other shock) when associated with hemorrhage.

“R57.8 would be my choice if the hypovolemia were not documented,” says Riley, “but I would query for that documentation to get to the more specific [code].”

If the physician only stated as “shock” or “shock due to GI bleed,” Prescott would “query for the type of shock and likely offer as a choice hypovolemic shock.”

**Debridement**

Many of the debridement documentation issues from ICD-9 have continued into ICD-10-PCS, such as whether the debridement is excisional or non-excisonal.

You can’t presume that “sharp” equals “excisional,” says Judy Sturgeon, CCS, CCDS, clinical coding/reimbursement compliance manager at Harris Health System in Houston.

The coder has to know how deep the debridement went, and it’s critical to know of what tissue, not “to what tissue,” Sturgeon says. “In the old days, ‘excisional debridement to the bone’ was coded as ‘of the bone,’ but [that is no longer true in ICD-10].” (Read the related article regarding the latest edition of Coding Clinic on p. 28.)

In addition, CDI specialists should look for additional procedures performed, or additional objectives of the procedure, says Sturgeon. In ICD-10, the objective of the procedure can change the code to something else.

CDI teams should also structure educational efforts to target aspects of debridements that physicians struggle with, to ensure the physician identifies the debridement as excisional and describes a cutting away of tissue.

Teach your physicians to state “down to and including,” says Prescott. “For example, ‘an excisional debridement, using a number 10 blade, was performed with removal of necrotic tissue down to and including the bone.’”

**Sepsis**

The transition to ICD-10-CM/PCS has introduced some new sepsis-related documentation concerns, including the fact that “systemic inflammatory response syndrome (SIRS) due to pneumonia” does not automatically translate to “sepsis” in ICD-10-CM.

CDI specialists should query for the diagnosis of sepsis if there is clinical support for the condition in the chart, or risk missing the ability to code the SIRS component entirely, says Sturgeon.

When the patient might have sepsis, or the documentation states “sepsis” and cultures come back negative, query to find out if the sepsis was ruled out or resolved, says Sturgeon.

“We must be alert to the fact that sepsis and SIRS can no longer be coded together,” Prescott says. “If either terms are used, or the provider documents ‘SIRS due to an infection,’ a query will be required.”

Other sepsis-related concerns haven’t changed, Prescott says.

“We must still capture the presence of severe sepsis and septic shock as appropriate, and we must make sure the status of present on admission is well documented,” she says. “Lastly, as this diagnosis is a high focus for auditors, so documentation should clearly support the presence of sepsis as supported by the appropriate clinical indicators and treatment plan.”
ICD-10 challenges in the neonatal world

by Karen Bridgeman, MSN, RN, CCDS

ICD-10-CM/PCS brought some new challenges in coding neonatal records. The term “newborn” has replaced the term “fetus or newborn” in the ICD-10-CM code set. This change ensures that these codes will only be used on the neonate’s records.

Gestational age is only captured in the preterm (36 weeks or less) or the post-term neonate (40–42 weeks). The mapping of gestational age uses the keywords “preterm,” “prematurity,” or “post-term” as the term “gestational” is no longer recognized.

The encoder mapping has changed in ICD-10-CM/PCS, which has made locating the appropriate neonatal codes problematic. Many CDI specialists depend on their encoder, which may not lead down the appropriate pathway for code assignment. Therefore, CDI specialists should develop their knowledge of the ICD-10-CM code set and use the Tabular List of Diseases to ensure accurate code assignment.

Some congenital abnormalities have been further specified in ICD-10-CM, which assists in capturing the appropriate code. Propionic acidemia, an inherited metabolic disorder, was difficult to capture in ICD-9-CM, as it mapped incorrectly to acidosis as opposed to a disorder of inborn errors of metabolism. ICD-10-CM maps to the correct code assignment of E71.121, propionic acidemia.

Chapter 16, Certain Conditions Originating in the Perinatal Period, brought some new codes into ICD-10, including:

- P29.0 Neonatal cardiac failure
- P27 Chronic respiratory disease originating in the perinatal period
  - P27.0 Wilson-Mikity syndrome
  - P27.1 Bronchopulmonary dysplasia originating in the perinatal period
- P27.8 Other chronic respiratory diseases originating in the perinatal period
- P27.9 Unspecified chronic respiratory disease originating in the perinatal period

- P92 Feeding problems of newborn
  - P92.1 Regurgitation and rumination
  - P92.2 Slow feeding of newborn
  - P92.3 Underfeeding of newborn
  - P92.4 Overfeeding of newborn
  - P92.5 Neonatal difficulty in feeding at breast
  - P92.6 Failure to thrive in newborn

- P84 Other problems with newborn
  - Acidemia of newborn
  - Acidosis of newborn
  - Anoxia of newborn NOS
  - Asphyxia of newborn NOS
  - Hypercapnia of newborn
  - Hypoxia of newborn NOS
  - Mixed metabolic and respiratory acidosis of newborn
  - Excludes late metabolic acidosis of newborn

- P29.89 Other cardiovascular disorders originating in the perinatal period, which includes possible systolic ejection murmur

- P00–P04 Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy

Codes from these categories are also for use for newborns that are suspected of having an abnormal condition, resulting from exposure from the mother or the birth process, but without signs or symptoms and which, after examination and observation, are found not to exist.
These codes may be used even if treatment is begun for a suspected condition that is ruled out.

Chapter 17, Congenital Malformations, Deformations, and Chromosomal Abnormalities, also has some additional codes, including:

- Q20.4 Double inlet left ventricle

ICD-10-PCS coding of congenital heart repair has been problematic due to lack of codes to capture some of the appropriate procedures. Luckily, the AHA Coding Clinic for ICD-10-CM/PCS, Third Quarter 2014, addresses some of the issues relating to the repair of congenital heart defects, including:

- Blalock-Taussig shunt
- Fontan completion procedure, stage II
- Repair of tetralogy of Fallot

Additional issues of Coding Clinic have been released to address other congenital problems, including:

- Vascular ring and double aortic arch
- Congenital hyperbilirubinemia versus transient hyperbilirubinemia
- Craniosynostosis with cranial vault reconstruction

The Official Guidelines for Coding and Reporting state that the Z38 codes may only be assigned once to a newborn at the time of birth. This differs from physician billing as the physician may assign the Z38 code for each visit during the birth admission.

As ICD-10-CM/PCS evolves, CDI specialists need to stay up to date on the official coding advice offered to ensure that we are capturing the most appropriate codes and procedures.

Editor’s note: Bridgeman is the CDI educator for the Medical University of South Carolina, a past ACDIS Conference speaker, and the author of the CDI Essential Skills online learning library. Contact her at bridgema@musc.edu.

CODING CLINIC FOR CDI

Reassessing debridement documentation

The AHA’s Coding Clinic for ICD-10-CM/PCS, Third Quarter 2015, opens with a discussion of the differences between excisional and non-excisional debridement—diagnoses with a long history of causing coding and clinical documentation confusion.

The new code set hasn’t made it any easier, as this edition of Coding Clinic includes eight questions on the matter on pp. 3–8, and an additional question regarding non-excisional debridement of cranial wound with removal and replacement of hardware.

The bottom line, really, is that just because a physician documents use of a sharp instrument to remove devitalized tissue does not necessarily mean that an excisional debridement was performed.

There are times when a physician may need to clean an area for a procedure or perform an excisional debridement that is not integral to the procedure itself. In such cases, the documentation in the medical record needs to be as clear as possible regarding what the physician did and why he or she did it. If a cleaning was performed as part of an overall procedure, it may not be coded separately. However, if a provider performs a true excisional debridement, it could require separate code assignment.

This issue of Coding Clinic emphasizes that a code is assigned for excisional debridement when the provider documents “excisional debridement” and/or the documentation meets the definition of the Excision root operation.

Excision is defined in ICD-10-PCS as cutting out or off, without replacement, a portion of a body part. Excisional debridement is considered a surgical procedure that results in a surgical MS-DRG and a higher relative weight, which translates into a higher reimbursement.
Root operations that employ cutting to accomplish the objective allow the use of any sharp instrument, including but not limited to scalpel, wire, scissors, bone saw, and electrocautery tip.

Elements that must be documented in the medical record to support an excisional debridement include:

- Technique used by the provider (cutting, scrubbing, trimming)
- Instruments used (scissors, scalpel, pulse lavage, or curette)
- Nature of the tissue removed (slough or necrosis, devitalized tissue, or non-viable tissue)
- Appearance and size of the wound (fresh bleeding tissue or viable tissue)

Last but not least, the physician needs to document the depth of the debridement. Teaching providers and non-providers to use the verbiage “down to and including” removes any uncertainty as to the exact depth of the excision.

I often teach new CDI specialists to think of the mnemonic device “TINA D.,” which stands for technique, instrument, nature of tissue, appearance, and depth. This makes remembering all the information needed for appropriate code assignment a little easier.

Excisional debridements can be performed by nurses, therapists, physician assistants, or physicians, and must be documented as such by the person who performed the debridement. An excisional debridement can be performed in many areas in a facility. The location of where the procedure is performed has no bearing on whether it is considered excisional or non-excisional. External auditors require explicit documentation to support an excisional debridement, so CDI professionals need to make sure they have all the proper documentation in the chart.

Non-excisional debridement is the non-operative brushing, irrigation, scrubbing, or washing of devitalized tissue, necrosis, slough, or foreign material. Non-excisional debridement does not result in a surgical DRG payment. If the documentation indicates a non-excisional debridement was performed, it will be classified to the root operation Extraction, defined as pulling or stripping out or off all or a portion of a body part by the use of force.

The ICD-10-PCS Official Guidelines for Coding and Reporting (A11) state, “[M]any of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation equates to in the PCS definitions.”

The provider is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the provider when the correlation between the documentation and the defined PCS term is clear.

When multiple layers of the same site are debrided, only a code for the deepest layer will be assigned. Coders cannot assume that the debridement of bone, fascia, or muscle is always excisional. ICD-10-CM/PCS does not provide a default if the debridement is not specified as excisional or non-excisional; for this reason, provider education should include use of verbiage such as “down to and including” so the subject is not left open to interpretation.

As mentioned, it is the coder’s responsibility to determine what the documentation equates to in ICD-10-PCS to determine code assignment for a procedure. It is also important for the CDI specialist to have knowledge of the different definitions used in ICD-10-PCS, including root operations, surgical approaches, devices, and qualifiers, so coders have all the information needed for proper code assignment.

Per the ICD-10-PCS Official Guidelines for Coding and Reporting (B3.3), “If a procedure is discontinued before any other root operation is performed, [assign] the code for the root operation of ‘inspection’ for the body part or anatomical region inspected.”

If, for any reason, the documentation in the medical record is unclear about what was done, a query should be generated to clarify the procedure with the physician. As coders and CDI specialists, we cannot assume anything—the documentation needs to clearly reflect what actually happened to the patient.

Editor’s note: Brodie is a CDI education specialist for HCPro in Danvers, Massachusetts. Contact her at sbrodie@hcpro.com.
In the past 15 years at Sarasota Memorial Health Care System in Florida, there were two unsuccessful attempts to implement a CDI program. So when Joannie Crotts, RN, BSN, CPC, took on the project back in 2011, shortly after accepting her first CDI position, she had her hands full. Nearly four years later, the program still stands.

“As they say, the third time’s the charm!” says Crotts, who also served as president of the Florida ACDIS chapter in 2015.

When she’s not immersed in CDI, Crotts enjoys spending time with her family and friends, the great outdoors, and Friday pizza nights. Crotts has two children, a daughter and a son, but now she and her husband are “empty-nesters.” Crotts’ daughter graduated college this past spring and lives close by; her son lives in Nashville.

“I now appreciate the time we get to spend together more,” she says. “I am so thankful for my family.”

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

*Crotts:* I started out in CDI a little more than four years ago. Our team has grown since our inception in 2011 from four to 10 CDI specialists. I believe this is largely due to the dedicated staff who perform the CDI function, administrative support, and a well-rounded CDI team where each member brings with them unique talents and clinical expertise.

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

*Crotts:* I worked as a revenue integrity analyst prior to my transition to CDI. My duties and responsibilities focused more on the outpatient side of healthcare; on current procedural terminology codes, ambulatory payment classifications, modifiers, and Recovery Audit Contractor denials. I had limited exposure to the inpatient side. I was interested in learning more about what drives a DRG, and the nuances of the inpatient perspective payment system, and my CDI experience has helped me achieve that goal.

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

*Crotts:* My favorite subject in college was calculus. I love numbers, and solving problems, and puzzles. I was searching for a job where I could use both my clinical skills from my nursing background and my analytic skills. CDI and revenue integrity is a good fit for me.

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

*Crotts:* I think the biggest challenge for most CDI teams is physician engagement. We constantly seek ways to engage our physicians. We have seen an increased interest in clinical documentation integrity from physicians, due to quality reporting requirements and the availability of the quality data on sites like Healthgrades, Hospital Compare, and Physician Compare. Physicians often say “but my patients are sicker” [than what the data shows]. We challenge them to show us that in their documentation.

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

*Crotts:* We collaborated with our clinical nutrition department to initiate a multidisciplinary approach to identify and diagnose malnutrition using best-practice, evidence-based criteria approved by our medical executive committee. One of our goals was early identification and intervention for patients with malnutrition. It has been rewarding for the CDI team to know our efforts with this initiative have a direct effect on our patients. An added bonus was the positive working relationships we established with our registered dietitian team.

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

*Crotts:* CDI is not just about capturing CCs and MCCs anymore. It’s about ensuring the documentation paints an accurate picture of the patient and accurately reflects the patient’s severity of illness and risk of mortality. Our quality scores are driven by physician documentation. Like most programs, our focus is shifting to align with
the ever-changing healthcare environment. This year, we decided to change our title from clinical documentation improvement to clinical documentation integrity to support our mission of accurate reflection of the patient’s story in the medical record documentation.

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

**Crotts:** Over four years ago, we explored the ACDIS website for information on CDI job descriptions and policies and procedures as we initiated our new program. As our program has matured, we have used ACDIS resources like “CDI Talk” and the Forms & Tools Library to keep up to date on CDI news and developments. Most recently, one of our CDI team members used the resources available through ACDIS to research clinical validation queries and found articles and sample queries to assist her.

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

**Crotts:** The CDI profession is growing and evolving. Due to healthcare changes such as new quality initiatives and the ICD-10 transition, the role of the CDI specialist is expanding. This is an exciting time to be involved in clinical documentation improvement. The opportunities are endless.

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

**Crotts:** I enjoy my job, so this is a hard question for me. I think I would like to work as a preschool teacher. I love kids and watching them discover new things. They are little sponges, full of energy and life.

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

**Crotts:** My first job was at Morrow’s Nut House at the mall when I was 16 years old. I hated telling people where I worked—the nut house! We sold candy and nuts, and I was required to wear a hair net.

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

- Vacation spots: Bar Harbor, Maine, and Napa Valley, California.
- Hobby: Reading, biking, hiking—anything outdoors.
- Non-alcoholic beverage: Diet Coke.
- Foods: Pizza! Friday night is pizza night in our household.
- Activity: Enjoying time with family and friends.

**Editor’s note:** CDI Journal introduces an ACDIS member in each issue. If you would like to be featured or would like to nominate someone who would, please email ACDIS Editor Katherine (Katy) Rushlau at krushlau@acdis.org.