CDI Documentation Standards: A Health System Story

WHITE PAPER

Summary: This paper provides a case study of one organization's record review process development and implementation. For more information about developing your own process, read the related 2018 ACDIS white paper "How to conduct a medical record review."

FEATURES

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Recently, there have been several discussions within our staff at Legacy Health System (LHS) in Portland, Oregon, related to the following concerns:

- Variability in the detail of review documentation
- Variability or inequality of productivity measurement directly related to quality (detail) of CDI documentation
- No information available for the CDI reviewer taking over the case
- Inability to enforce minimum review documentation elements without departmental standards

The discussion participants have been passionate about their idea of what CDI reviews should look like, ranging from clinical efficiency to health information (more detailed) abstract viewpoints. Over the months, we reached out to other CDI teams across the country and via ACDIS, but we discovered that there were no formal recommendations for CDI documentation review standards. To further complicate matters, CDI reviews nationwide are evolving: rather than just reviewing for DRGs, CCs, and MCCs, they are expanding to include risk adjustment and quality reviews. This is a welcome evolution, but it necessitates a more detailed CDI review and more detailed documentation regarding those reviews.

In addition, CDI queries are currently under consideration to become a permanent part of the medical record in LHS. This consideration could further increase the need for standardized CDI documentation/tracking to validate those queries. From an outside perspective, having the query as part of the medical record enhances the attending physician's medical decision-making and connects the missing dots related to the queried information. The query could strengthen the physician's documentation, and potentially increase the hospital's and physician's quality scores.

While we were researching and developing our own CDI documentation review standards, ACDIS published a white paper, *How to Conduct a Medical Record Review.* It is a worthwhile read for every CDI department because it provides national CDI documentation standard recommendations for the first time (pp. 12–13). We were glad to see the white paper aligned with our own process of determining our CDI documentation standards at LHS. Here is our story.

Documentation perspective

The HIM department facilitates the flow of patient and nonpatient care data between hospital and service departments, providers, caregivers, and third-party entities. From HIM's perspective, the CDI specialists' efforts in medical record review facilitate the flow of patient care data from clinical language into codes. CDI specialists focus on the collection of accurate and consistent data to ensure successful outcomes for patients and maintain the financial and public standing of the institution.

From the standpoint of HIM, the most important documentation requirements CDI professionals need to track during their review are:

- Diagnoses and data that validate (clinically support) the diagnoses
- Open questions that may need to wait until all pertinent data are available
- Concerns requiring queries and the reasoning behind those concerns

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The *Official Guidelines for Coding and Reporting Section* 1.A.19 titled "Code Assignment and Clinical Criteria" states: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. … Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."

This guideline has turned into the HIM mantra for physician documentation: "If it's not documented, it didn't happen." This philosophy is the substance of the American Health Information Management Association's (AHIMA) HIM principles. In an October 2013 article published in the *Journal of AHIMA*, "Medical Records' Dynamic Nature: If It Isn't Written Down, It Didn't Happen. And If It Is Written Down, It Might Not Be What It Seems," authors Gary David, PhD, and Erik Vinkhuyzen, PhD, write that:

> *Only once it has been recorded is an event official and practically relevant, and can be acted upon in other parts of the organization. A "record" is exactly that—a recording of some event. … It transforms the events into actionable objects that can span organizational boundaries. … Unrecorded events cannot be counted for reimbursement or care because they are not verifiable through the documentation itself. Thus, documentation serves the essential organizational function of creating evidence of medical encounters. Without such documentation, there is no evidence and in essence no medical encounter in the eyes of the institution.*

HIM professionals are trained to ensure the documentation of the medical record will meet facility, state, federal, and Medicare guidelines and pass the scrutiny of external auditors. Some audits collect data, trends, and patterns for seven to nine years. Because of this, from a HIM and quality point of view, data must be accurate, consistent, and complete. External auditors may have nursing or coding backgrounds, or be professionals with a focus on quality, reimbursement, Medicare, or legal issues. What may be clinically sound in terms of documentation to a nurse may not be sound to a nonclinical professional or auditor.

The CDI review of documentation is the link between physician documentation and code/DRG assignment for revenue purposes. CDI staff often serve as the final reviewer prior to billing. Even though CDI efforts do not constitute direct patient care mandated by state and federal law, they do represent another layer to support the patient care provided. Therefore, CDI teams need to establish minimal documentation standards, recordkeeping processes, and tracking procedures to ensure efficient communication across the care continuum as well as compliance with industry best-practice standards, regulatory guidelines, and facility policies.

Clinical perspective

Before implementing changes to CDI tracking and documentation processes, facilities need to research current practices and establish a baseline to evaluate effectiveness.

From a clinical perspective, documentation constitutes what is written in the legal medical health record. So programs need to first ask whether their CDI efforts are considered part of the legal health record by matter of facility policy. At LHS, CDI documentation is not currently part of the legal medical health record. That fact framed the standardization of our CDI documentation templates. Had CDI documentation been part of the medical record, the quest to standardize documentation would have been more urgent and the resulting template more restrictive. Note that LHS is currently considering making CDI queries part of the permanent medical record, and should such changes be implemented, the CDI team will again review policies and procedures to ensure compliance.

Where a HIM professional may look at the documentation to ensure it meets facility, state, federal, and other guidelines, a clinician may look at the documentation to ensure it accurately describes the patient's clinical picture. CDI professionals may need to query the provider for clinical validity or to obtain a more specific diagnosis based on the clinical indicators contained within the medical record to ensure an HIM/coding professional can accurately translate the documentation into codes, but they must do so according to the latest recommendations related to compliant, non-leading query submission.

From a clinical perspective, CDI documentation may resemble a SBAR (Situation, Background, Assessment, Recommendation) handoff in the clinical setting and an informal note the reviewers leave for themselves.

Background research

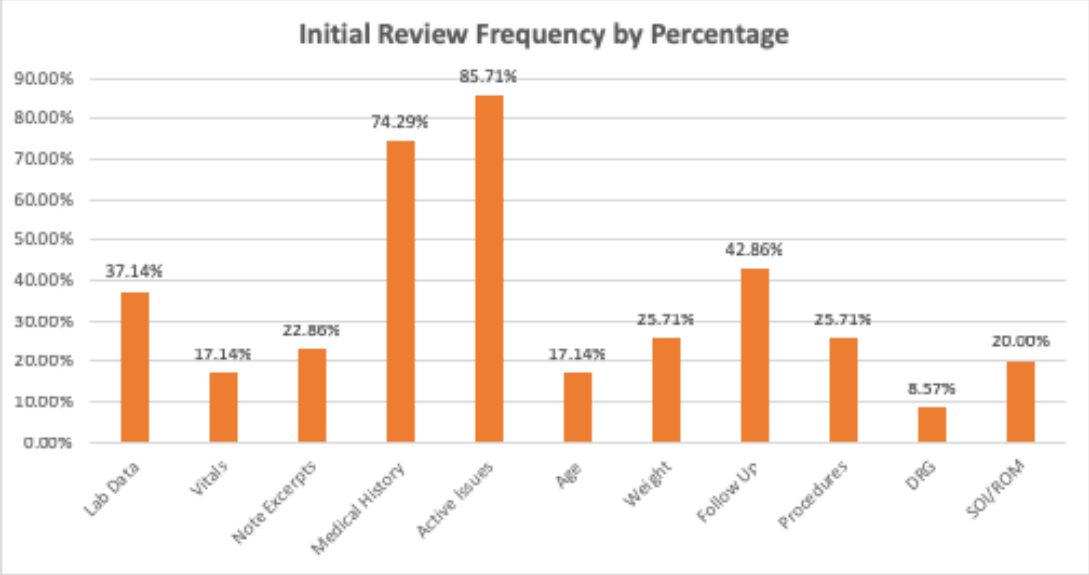
Before implementing changes to CDI tracking and documentation processes, facilities need to research current practices and establish a baseline to evaluate effectiveness. To accomplish this at our health system, a CDI auditor reviewed everyone's documentation in the department, examining at least two cases per staff member—one initial review (the first time the reviewer saw the case), and one continued-stay review (the subsequent time the reviewer saw the case). Each audit element received either a yes or no designation to determine if that item was identified as part of the CDI specialists' review. The data elements included:

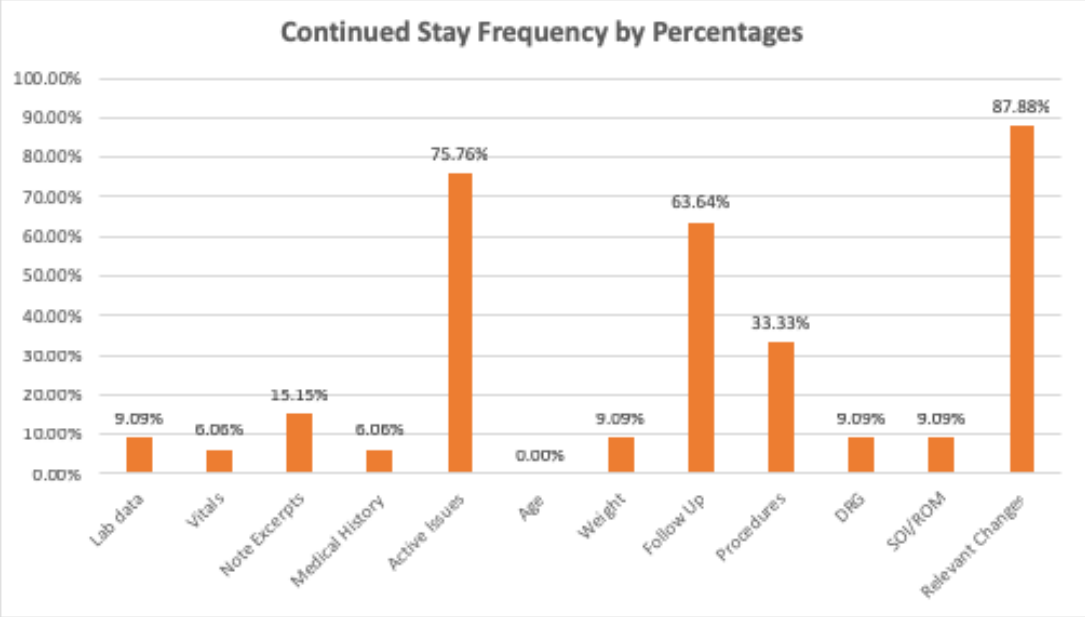
- Lab data
- Vitals
- Note excerpts

- Medical history
- Active issues
- Age
- Anthropometric data
- Follow-up
- Procedures
- DRGs
- Severity of illness (SOI)/risk of mortality (ROM)
- Relevant changes

The audit team was surprised to learn that some specialists were not including basic information such as active issues, follow-up, and relevant changes.

The following two charts illustrate the information captured by CDI specialists regarding their reviews. The project workgroup was satisfied that the majority of specialists were including the same basic information in their review documentation. The audit team, however, was surprised to learn that some specialists were not including basic information such as active issues, follow-up, and relevant changes; the team used this information to steer the project further.





It seemed the most pressing need was a basic minimum standard for documentation. We reasoned that it would be very difficult to cover for staff members who were not documenting active issues or follow-up items—covering for a case like this would require the CDI specialist filling in for an absent colleague to essentially start over from the beginning. With this in mind, we set forth on our documentation standardization quest.

Minimum documentation template

Initial review

- Active issues (Why is this patient currently in the hospital?)
- Procedures (if applicable)
- Queries (if applicable) (What queries were sent, and what queries were considered and ruled out?)
- Follow-up (What should the CDI specialist be looking for in the next review? What conditions are currently under study?)

Continued-stay review

- Relevant changes since last review (Did the patient's condition change? Are there any new diagnoses? Were any previous follow-up items addressed?)
- Procedures (if applicable)
- Queries (if applicable) (What queries were sent, what queries were answered, what new queries were needed [if any], and what queries were considered and ruled out?)

- Follow-up (What should the CDI specialist be looking for in the next review? What conditions are currently under study?)

LHS decided to develop a template that would include the minimum CDI documentation needed for each review. This would allow each CDI specialist to include more details in their reviews if desired, while still ensuring a baseline. Some CDI specialists copy the template into their documentation. Others use it as a guide to ensure that each element is included in some way in each review.

The new employees found the template to be useful in enhancing their reviews and their documentation.

Implementation

Once the project workgroup came up with the documentation standardization template, it set out to implement the process changes needed. The team hosted a roundtable discussion with all stakeholders (including CDI staff, auditor, manager, etc.) in a department meeting and presented background research, the process for upcoming template development, and the template itself. Most importantly, the project workgroup requested feedback from the team in order to further improve the documentation template and to increase stakeholder support.

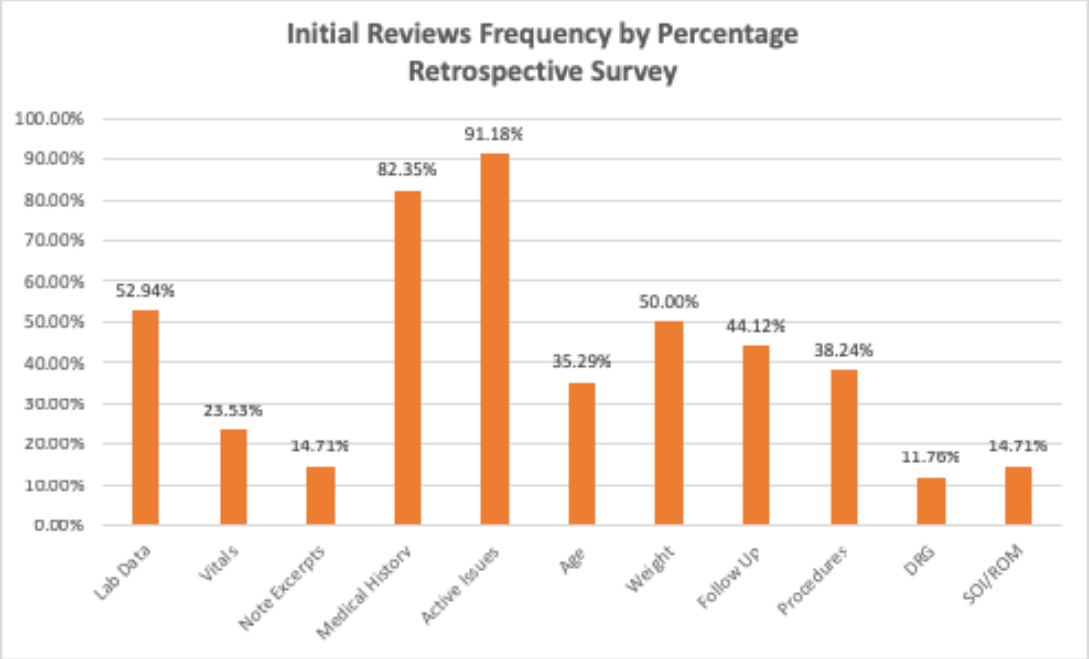
After a discussion, the minimum standard template was distributed to everyone. This template was then discussed further with two new employees who were still on orientation, and used as a training tool to both encourage documentation of minimum standards and guide the reviews of new staff. The new employees found the template to be very useful in enhancing their reviews and their documentation. It is now included in our training materials for any new staff that may be hired in the future.

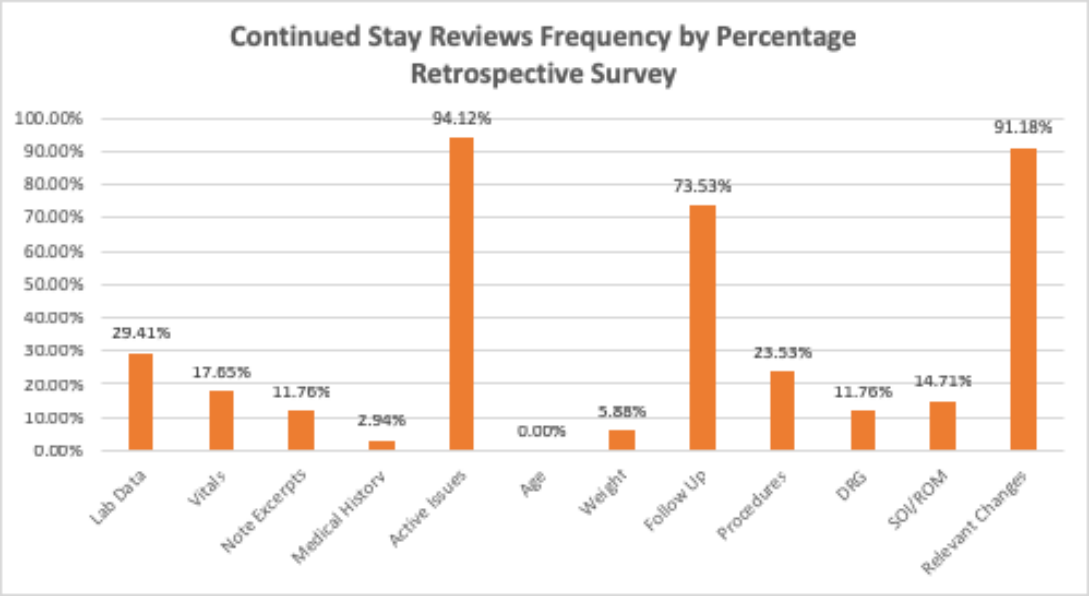
Retrospective survey results

Approximately two months after the implementation of the minimum standard template, a retrospective survey was conducted to evaluate any additional opportunities for improvement and to plan next steps. Since the template was meant to be a *minimum* standard, the survey results were judged with that in mind. The workgroup decided certain items should be in every review: active issues, applicable procedures, query information, and follow-up. So the team first looked for an increase in the frequency of these data points, specifically active issues and follow-up.

The retrospective survey was conducted in the same way as the initial survey. This survey included the two new staff members. It did not include one staff member who was part of the original survey.

There was modest improvement in the frequency of capture of active issues on initial reviews and relevant changes on continued-stay reviews, illustrated in the charts on the following page. The auditor was able to narrow down the remaining documentation deficiencies to certain staff members. With the minimum standard template in place, the auditor and manager can now counsel these staff members on what needs to be included in the documentation.





The current plan is to conduct the survey quarterly, thereby evaluating whether individual counseling of staff members has been successful. The survey will also monitor continued adherence to the minimum standards by the entire department.

Conclusion

In effect, LHS pursued this project to:

- Align CDI review and documentation to improve the flow of patient care data and translate it into successful reimbursement data
- Strive for organizational success in view of the evolving payment shift from volume to quality in which the number of encounters reviewed becomes less important than the generation of valuable, valid queries, as stated in the aforementioned ACDIS white paper *How to Conduct a Medical Record Review*

Every program has different focuses and philosophies. Because of this, we highly recommend including multiple staff members of varying ideologies in the workgroup.

Overall, this project identified data by which LHS can show improvement in key areas of CDI documentation. Additionally, the team now has a minimum standard that can be used in new employee training and in performance evaluation of current employees.

One potential future endeavor would be to assess efforts related to more focused reviews such as clinical validity reviews, second-level reviews for certain diagnoses such as sepsis, psychiatric inpatient reviews, outpatient CDI reviews, etc. The program hopes to develop a minimum standard for all reviewer and review types.

LHS recommends using this method to create a minimum standard that will work for your CDI team. Having baseline data to measure the success of your template is essential. Every program has different focuses and philosophies, as do individuals within a program's department. Because of this, we highly recommend including multiple staff members of varying ideologies in the workgroup. This will ensure a thorough discussion and a balanced outcome.

Editor's note: Loos is the CDI auditor and Siebert is a CDI specialist at Legacy Health in the Portland area. Contact Loos at kailoos@lhs.org and Siebert at msiebert@lhs.org. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.

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An ACDIS white paper discusses CDI best practice, advances new ideas, increases knowledge, or offers administrative simplification. It can be written by an ACDIS Advisory Board member or a smaller subset of the board, or written by external sources subject to board approval. It is less formal than a position paper.