acdis
Association of **Clinical Documentation Integrity** Specialists

2022 MASTERMIND HOT TOPIC GUIDE: PART 1

SUPPORTED BY 3M | M*Modal

TABLE OF CONTENTS

3 Intro
This multitopic report, produced in partnership with 3M Health Information Systems, shares takeaways from the first half of the 2021/2022 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, from the delicate and necessary process of internal staff audits to the perils of CDI scope creep, to the challenges of clinical validation.

4 Internal staff audits
Even a mature CDI staff has opportunities to improve their skills. Whether it's strengthening query compliance, honing clarity when communicating with physicians, or identifying missed opportunities, an internal staff audit process ensures a team is operating to its highest potential.

6 Internal staff quality assurance
Often, expansion requests don't come with additional staffing and resources. CDI leaders must judiciously choose which projects their team can and which they should tackle to avoid spreading themselves too thin.

8 Outpatient CDI expansion
The rate of clinical validation denials has long been on the rise, and there's no indication it will decrease anytime soon, so many CDI professionals find themselves in the denials defense trenches.

2022 MASTERMIND HOT TOPIC GUIDE: PART 1

CDI leaders' responsibilities are varied and far reaching. Rather than going the journey alone, leaders can gain valuable insight by connecting with peers outside their organizations to collaborate, trade advice, and share challenges and successes. The ACDIS CDI Leadership Council serves the purpose of connecting leaders across the country for conversations about the hot topics and industry trends in CDI. But a smaller subset of the Council, the Mastermind group, provides participants with an opportunity for focused brainstorming and problem-solving.

This multi-topic report, produced in partnership with 3M Health Information Systems, shares takeaways from the first half of the 2021/2022 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, from the perennially popular topic of CDI/coding relationship building, to the key management concern of quality assurance, to new frontiers with outpatient CDI expansions.

INTERNAL STAFF AUDITS

Even a mature CDI staff has opportunities to improve their skills. Whether it's strengthening query compliance, honing clarity when communicating with physicians, or identifying missed opportunities, an internal staff audit process ensures a team is operating to its highest potential. Though some organizations may choose to outsource CDI team audits to an external vendor or consulting firm, many find that keeping those reviews in-house leads to more learning opportunities for both the auditor and auditee.

At her organization, **Jeanne Johnson, RN, MHA,** CDI director at Premier Health in Dayton, Ohio, asks her CDI specialists to review five cases in a peer-to-peer audit every month. The experience, she says, has been overwhelmingly positive.

"The focus is on education and seeing that they learned; it's not about finding the problems and dinging them and proving that they've done something bad."

—Chana Feinberg, RHIA, CDI product specialist at 3M Health Information Systems in Silver Springs, Maryland

"Even our new staff members talk about how it's interesting to learn what they see in someone else's cases and how they worked them differently than [the other person] would have," she says. "It's a requirement that we do every month, but it's also a learning opportunity for them."

While asking staff to audit their peers' work may seem like a relatively simple way to begin a quality assurance process, it's important to be clear up front about what you expect from the auditors and the staff members being audited, according to **Ann Zierden, RN, CCDS,** CDI director at CentraCare Health in St. Cloud, Minnesota. Before you launch an audit process, leaders should set forth guidelines for what a good review actually is. That way, the auditors have objective guidelines upon which to base their findings.

"[Before launching the process,] the CDI educator and I got together and we reviewed the ACDIS white paper about how to review a medical record, the ACDIS Code of Ethics, and the Guidelines for Achieving a Compliant Query Practice," Zierden says. "We've determined our goals; we've identified steps to implementation; we have looked at standards for query, format, and content. We're currently updating our tools to reflect that

before we actually start the peer-to-peer implementation."

Though the peer-to-peer structure may work well for some teams and present opportunities for education, other leaders choose to delegate the auditing responsibilities to a designated CDI auditor or educator, or to one of the CDI managers, team leads, or supervisors. This structure also helps to give CDI professionals an opportunity to move from staff-level positions into auditor- or leader-level positions.

In her experience, **Sheila Duhon, MBA, RN, CCDS, CCS, A-CCRN,** national CDI director at Steward Healthcare in Montgomery, Texas, says that designated auditors may also be able to identify trends and educational opportunities for specific staff members because they're regularly reviewing the work of those members. In a peer-to-peer-only structure, reviewers may be rotating and reviewing different staff members' work each month and never see the overall picture.

When her auditors do see a pattern emerging, Duhon says they emphasize immediate education rather than waiting for performance reviews or formal conversations to address issues.

"If the auditors find the same issue recurring, they need to stop the audit right there and reach out to the CDI specialist's manager, and the two of them will discuss, and then either the manager or the auditor [will have the discussion with the staff member]," she says. "We stop; we educate; we then give them time to implement that new process or to correct the issue."

"The focus is on education and seeing that they learned; it's not about finding the problems and dinging them and proving that they've done something bad," echoes **Chana Feinberg, RHIA,** CDI product specialist at 3M Health Information Systems in Silver Springs, Maryland. "[When you treat it as education] it's a very good, clear message to staff."

Over the years, CDI has proven itself an invaluable part of an organization's revenue cycle process. Because of the positive impact CDI professionals have had on their organizations, coupled with the increasing

complexity of reimbursement systems, CDI leaders often find themselves asked to expand their footprint into a myriad of areas. Often, those requests don't come with additional staffing and resources. CDI leaders must judiciously choose which projects their team *can* and which they *should* tackle to avoid spreading themselves too thin.

According to **Kelli Hill, BSN, RN, ACM, CCDS,** CDI manager at North Mississippi Health Services in Tupelo, one way to stop unchecked scope creep is to think long and hard about what CDI's mission actually is and how it interacts and intersects with the organization's mission as a whole.

"I think we've all heard someone say, 'Well, you're already in the chart,' " she says. "But CDI can only do so much with the resources we have, so knowing what your mission is will help set boundaries around what you actually can help with."

Though the specifics of a department's mission may differ from organization to organization, Johnson says filtering everything through one simple rubric can make all the difference. Instead of asking whether CDI *could* help on a specific project (chances are they could, with the right resources), ask whether the issue stems from documentation or something else.

"This is a place where I think technology can really help you," she says. "You may not have the staffing or the resources to do everything that your organization is asking of CDI, so using your technology to take care of some of the 'low-hanging fruit' opportunities can help free up CDI's time to focus on some of those bigger issues that require more critical thinking skills."

—Kelli Hill, BSN, RN, ACM, CCDS, CDI manager at North Mississippi Health Services in Tupelo

"We always have to ask ourselves whether the request actually has to do with a documentation concern," she says. "Because if it does, it might fall into CDI's purview and it might be something we can help with while still staying inside our scope of work. If it's not related to a documentation issue, then it's probably not something CDI can or should be involved with."

Even when you do decide that a project is within CDI's scope and mission, that may not be the end of the struggle. Without adequate staffing, CDI can quickly feel stretched too thin. If this is the case, it's worth investigating what your software tools can do to eliminate (or at least lessen) the simpler tasks that nonetheless take up valuable CDI time. Physician-assisted documentation and prioritization can both be powerful tools to extend CDI's reach, Feinberg says.

"This is a place where I think technology can really help you," she says. "You may not have the staffing or the resources to do everything that your organization is asking of CDI, so using your technology to take care of some of the 'low-hanging fruit' opportunities can help free up CDI's time to focus on some of those bigger issues that require more critical thinking skills."

While scope creep can pose obvious issues for a CDI team, the fact that CDI is constantly evolving to help with new projects and initiatives can also be seen as a good thing. Unlike other professions, CDI is rarely stagnant and there are always opportunities for growth and learning. This, according to **Kerry Seekircher, BSN, RN, CCDS, CDIP,** CDI director at Northern Westchester Hospital/Phelps Hospital-Northwell Health in Westchester County, New York, is a very good thing when it comes to staff satisfaction in the long run.

"Evaluating new opportunities is instrumental to team and program development,

Seekircher says. "It is important to take into consideration if the new initiative is within the scope of the CDI professionals practice, whether it is adding value, and if it is in alignment with the goals of the department and organization. At the end of the day, we are in healthcare to be able to make a meaningful difference, and it goes a long way with the team to find new ways to connect and do just that."

The rate of clinical validation denials has long been on the rise, and there's no indication it will decrease anytime soon, so many CDI professionals find themselves in the denials defense trenches. Much of the problem arises from the coding guideline that states that coders must code the diagnoses that physicians document, regardless of the presence of clinical indicators. Payers, however, are fully allowed to *deny* those diagnoses on the back end due to a lack of clinical indicators in the record.

While some of the clinical validation issues can be cleared up during the concurrent review process, many CDI teams have developed post-discharge checks and balances to avoid sending out claims with unsubstantiated diagnoses. This process often includes a concerted effort between the coding and CDI teams.

"The coder will bring it to their CDI buddy and say, 'What do you think?' And the CDI specialist will then say, 'Let me write a clinical validation query,' " says Duhon. "We'll get it clarified prior to billing."

Since clinical validation can be a touchy topic with some physicians, enlisting the help of a physician advisor through a formal escalation policy can go a long way toward streamlining the process.

"One gap I've identified is not having the physician advisor more involved in the clinical validation query process," says **Schimanya Sullivan, RHIA, CCDS, CCS,** CDI director at Prisma Health in Columbia, South Carolina. "Currently, when a provider responds to a clinical validation query 'unfavorably,' we go ahead and code the record based on current documentation. I agree with having a

"We have a designated CDI specialist who does the clinical denial validations. The reason that we separate that our from front line staff is because we have CDI specialists on the front end who sometimes won't ask questions they need to ask because they fear a denial. In order to take that fear away from them, we choose to have a designated CDI specialist do those payer clinical validation denials."

—Janice Cromer, BSN, RN, CCDS, CDI director at AdventHealth in Apopka, Florida

policy to say we're going to escalate those responses to the physician advisor to have a peer-to-peer discussion with provider of record as appropriate."

Janice Cromer, BSN, RN, CCDS, CDI director at AdventHealth in Apopka, Florida, also suggests that leaders consider appointing one CDI professional (or a subset of their team) to work on the clinical validation appeals process. These individuals, however, should not necessarily be your same frontline staff members who are concurrently reviewing records. Keeping clinical validation separate not only gives these professionals the space to focus fully on denials, but it also prevents them from changing their query practices due to anticipating negative results.

"We have a designated CDI specialist who does the clinical denial validations. The reason that we separate that our from front line staff is because we have CDI specialists on the front end who sometimes won't ask questions they need to ask because they fear a denial," she says. "In order to take that fear away from them, we choose to have a designated CDI specialist do those payer clinical validation denials."

Of course, clinically validating every diagnosis as part of the concurrent or retrospective process—while an excellent aim—may not be possible from a staff bandwidth perspective. According to Zierden, choosing your battles and targeting the diagnoses that are highly vulnerable to denials will give you the biggest payoff for your efforts.

"We're just starting a new process and we're targeting really some of our highly denied diagnoses—sepsis, acute respiratory failure, HAIs [hospital-associated infections], malnutrition, encephalopathy, etc.," says Zierden. "We want to make it so we're not getting feedback from our coders when something isn't supported or is only documented in the discharge summary."

If you have identified at-risk diagnoses already, Feinberg suggests leveraging your technology to further your reach and prioritize the records you need to clinically validate.

"This could be a great place for AI to come in as well," she says. "If a diagnosis is stated in one place and there's no indication of it anywhere else in the record, an AI tool could certainly help in identifying that and being able to pull it into a work queue for CDI to review before it goes to final coding." ■