

# Clinical Documentation Improvement: The Foundation for Revenue Cycle Management

*White Paper*



Business Advisors for the Healthcare Industry

**ELLIS "MAC" KNIGHT, MD**

Senior Vice President/CMO

**ANNETTE SULLIVAN, RHIA**

Senior Manager

July 2015

## TABLE OF CONTENTS

Introduction .....	3
Basic CDI Elements.....	3
Staffing .....	3
Technology .....	4
Innovative CDI Elements .....	5
CDI Integration .....	5
CDI Performance Monitoring.....	5
Case Studies .....	6
Summary .....	8

## INTRODUCTION

The revenue cycle of any modern American hospital starts with and is critically dependent on accurate clinical documentation. Efforts to improve this process through clinical documentation improvement (CDI), therefore, have been implemented in most hospitals throughout the country.

Many of these programs, however, are woefully inadequate as to their performance. Barriers to successful improvement of clinical documentation include inconsistent processes that are haphazardly applied, poor communication between coders and clinical documentation specialists, and the seemingly omnipresent challenge of engaging physicians and other front-line providers in the CDI process.

Furthermore, with the advent of value-based reimbursements, many healthcare systems and hospitals are realizing that CDI must be a collaborative effort between the health information management, finance, and quality departments. Failure to adequately document clinical reality in a way that allows for accurate severity and risk adjustment and quality scoring can be more costly to hospitals than failing to appropriately document the information necessary for accurate coding and billing.

This paper will define the elements required to operate a successful and comprehensive hospital CDI program. It will describe those components that are basic to any CDI effort, and it will introduce more innovative techniques and technologies that can be used to take an existing program to the next level. Finally, it will provide case studies that establish the value of having a strong CDI program in place.

## BASIC CDI ELEMENTS

Staffing and technology—people and tools—undergird CDI efforts and are the two basic elements of the program.

### STAFFING

As with most healthcare operations, a successful CDI program is critically dependent on its staff. While many aspects of clinical documentation can now be supported by technology and automation, knowledgeable and capable staff to operate the program is an absolute necessity.

The effort ideally should be run by a health information management (HIM) expert who understands the nuanced complexities of documentation integrity, especially in the modern era since the widespread adoption of electronic medical record (EMR) systems. This individual

should have the managerial expertise necessary to supervise and manage a staff of clinical documentation specialists, the analytic capabilities necessary to accurately monitor the program's success, a strategic vision for the end goals of the program, and the tactical leadership skills required to accomplish these goals.

Although it is not imperative that the CDI program leader be a professional coder, it is certainly beneficial for the lead person to have that background and knowledge. The planned introduction of the ICD-10 coding system in October of 2015 will significantly increase the documentation required to accurately code diagnoses. Therefore, it will be an advantage for any CDI program to be led by someone fully trained in this area.

Well-trained clinical documentation specialists (CDSs) are the most critical staffing component of any CDI program. These individuals, who usually have a clinical background in nursing or other allied health professions, must have a strong grasp of clinical disease processes. With appropriate training, they can then become equally familiar with the nomenclature used by professional coders and then serve an essential translator role between the clinical and coding professionals.

Strong communication and interpersonal skills are highly important criteria to consider when hiring individuals for CDS positions. The translational process mentioned can be difficult and often runs the risk of resulting in contentious encounters, especially with members of the medical staff. The specialist who can manage this process tactfully and professionally is a valuable addition to any CDI program.

## TECHNOLOGY

Technology is available that can significantly assist with the CDI process. This technology ideally should interface with the electronic medical record system and proactively prompts the clinician to provide documentation that supports the level of care, severity of illness, treatment provided, and risk of mortality. The technology queries the provider based on documented clinical indicators, treatment, outcomes, diagnoses, and procedures and then facilitates the provider's efforts to document appropriately by suggesting critical phraseology that is necessary to support the specificity required for coding.

These software systems utilize ICD-10 compliant methodologies that support accurate clinical documentation, providing physicians and other front-line clinical users with information that potentially allows the clinical team to focus on providing quality care while monitoring the length of stay and outcomes of treatment. This "learn-by-using" method of training physicians on ICD-10 is likely to be much more effective than other laborious ICD-10 training sessions, where providers are asked to listen to didactic lectures on ICD-10 or, even worse, memorize by rote ICD-10 documentation requirements.

## INNOVATIVE CDI ELEMENTS

Innovation through integration and monitoring of quality of care are essential elements of improvement efforts in clinical documentation.

### CDI INTEGRATION

The name of the game in healthcare today is integration, i.e., coordinated care that drives higher quality and cost efficiency. The same holds true for CDI programs. Coordination of these efforts between health information management, financial, and quality improvement departments with the integration of CDI activities into the workflow of these departments can result in an up-to-date and sophisticated CDI program.

Quality improvement activities are especially important in this regard as hospital financial performance increasingly depends on clinical quality outcomes. Undocumented or poorly documented clinical conditions that can effect severity adjustment of quality metrics and/or eliminate penalties for conditions, such as pressure ulcers, that were present on admissions can dramatically impact a hospital's quality scores. This anomaly, then, can impact a hospital's reimbursements through programs like CMS's value-based purchasing program and others. Bringing the quality improvement (QI) team to the table when building a comprehensive and integrated CDI program, therefore, can benefit both the hospital's reputation and reimbursements.

### CDI PERFORMANCE MONITORING

Monitoring of key performance indicators (KPIs), such as the case mix index (CMI), the percentage of no responses to queries by physicians, CC and MCC, (complication and comorbidity and major complication and comorbidity), capture rate, query rate, and physician agreement rate with queries. Certain quality metrics, like the patient safety indicator 90 (PSI 90) and other clinical core measures can help a hospital to justify a CDI Program since most of this data is based on coded data and under-documenting results in data that misrepresents the performance of the hospital and its providers. These indicators can even be quantified in dollar amounts and used to track the return on investment (ROI) for building a comprehensive and sophisticated CDI program.

Technology can help in the monitoring of KPIs and software systems that assist with accurate coding and documentation can also track and quantify these measures so that hospital leaders can keep abreast on a near-real-time basis of their CDI program's activities and performance.

## CASE STUDIES

Following are four illustrations of the positive effect that CDI programs can have on the management of a hospital's revenue cycle.

1. This hospital had just undergone the tedious and expensive process of transitioning their clinical coding system from ICD-9 to ICD-10 standards. Soon afterward they noted, especially in clinical areas such as orthopedics, that their coding accuracy, as measured by internal audits, had fallen off considerably. A deeper analysis of this issue revealed that the orthopedic surgeons had received no training on ICD-10 documentation requirements and were still documenting using the requirements they were historically using for ICD-9. This documentation was wholly inadequate to support the new ICD-10 codes and, therefore, resulted in coding inaccuracy and compliance risks to the hospital. The problem was corrected by installing a software system that was able to interface with the EMR and identify probable working diagnoses. These presumptive diagnoses and their associated documentation elements were then electronically conveyed to the orthopedic surgeons for their consideration and use in the medical record, as appropriate. This action had the effect of both improving the accuracy of coding for orthopedic cases within the hospital, but also helped the surgeons get up to speed on ICD-10 terminology and documentation requirements. Over time, the hospital noted that the software system prompts were required less and less frequently, and the surgeons were able to document accurately with less input from the CDI staff or technology.
2. This hospital had just received a copy of the latest Healthgrades® rankings, which gave them a one-star (out of four) ranking for their care of patients with acute myocardial infarctions (MI or heart attack). The hospital had always prided itself on its cardiac service line and, in fact, had invested significantly in promoting and advertising the care delivered in its new heart center. A deeper analysis of the one-star ranking revealed that the problem was not with the care itself but, instead, with the documentation of the severity of illness for patients admitted to the heart center. Many of these patients had multiple co-morbidities, such as diabetes, renal failure, and chronic lung disease, which increased their risk of an MI. Without proper documentation of these co-existent conditions, the risk projections of patients admitted to the hospital were underestimated, and the hospital's overall outcomes for patients with heart attacks looked much worse than predicted. Once the CDI program kicked in and the cardiologists were prompted more vigorously to appropriately and more accurately document their patient's overall clinical status, the outcome scores improved, and the hospital's star ranking jumped from one to four. The hospital could now justify proudly touting the quality of care delivered in the heart center. Likewise,

patients or referring physicians using systems like Healthgrades® to guide their choice of a facility could use these rankings more reliably.

3. The physicians at this hospital loathed the CDSs and usually ignored their electronic queries in the medical record. They derided the CDI staff, calling them "chart police", who had little understanding of clinical parlance and wanted to waste the physician's time "nitpicking" the way they were documenting in the EMR. One day, a new CDS was hired, an RN by training. Having worked there before, this employee was well-familiar with the medical nursing unit where she was assigned as a CDS. This familiarity extended to the hospitalist physicians assigned to this unit who knew, admired, and trusted this individual's clinical acumen. One of the first cases the new CDS encountered was a patient with septicemia due to a urinary tract infection. The hospitalists had been documenting in the medical record that this patient's diagnosis was "urosepsis", which physicians commonly understand to mean a UTI with sepsis. But this is translated by coding professionals as a bladder infection, which usually does not even warrant hospital inpatient care. When this discrepancy was pointed out to the attending physician, she gladly changed the wording in the medical record from urosepsis to UTI with sepsis. This simple modification of the clinical documentation resulted in the hospital receiving appropriate payment for the clinical severity of the case and the care rendered. Perhaps more importantly, the case was not rejected as being inappropriate for admission, and the patient avoided being held responsible for paying the hospital out of pocket.
  
4. The hospital in this situation felt they had a major problem with pressure ulcers or bedsores on their geriatric inpatient unit. Month after month, the incidence of these "never events" (i.e., clinical events that should theoretically be 100% preventable) were rising. The quality department was mobilized, and tens of thousands of dollars were spent increasing staff training on the prevention and treatment of pressure ulcers, all to no avail! Unfortunately, the matter was that the hospital was receiving a large number of nursing home transfers to their geriatric unit—patients who had developed skin breakdown and pressure ulcers at the nursing home prior to transfer. The skin problems, however, were not appropriately documented as being "present on admission." Therefore, they were attributed to poor care during the patient's inpatient hospitalization. With the documentation problem identified, the incidence of true pressure ulcers developing in the hospital fell to zero, and the quality issue went away. Unfortunately, the hospital invested much time and money chasing after a non-existent problem before resolving the matter.

## SUMMARY

The development of a comprehensive, integrated clinical documentation improvement program can benefit hospitals and healthcare systems in many ways, as described in this paper. The advent of sophisticated IT systems to support clinical documentation efforts can help existing CDI programs to attain a higher level of performance. This outcome will prove true especially after the introduction of ICD-10 coding standards in October of 2015. CDI programs, once introduced, call for close monitoring and ongoing adjustments to keep key performance indicators within target ranges to assure that the hospital is getting the maximum return on investment for their efforts in this area.