Why Everyone Needs a CDI Plan

BY CINDY PARMAN, CPC, CPC-H, RCC

While many valid reasons exist for physicians, midlevel providers, and other healthcare staff to document in the medical record, the healthcare organization can lose money when clinicians undervalue patient treatment through a lack of medical record documentation. To address this ever-present need, many cancer centers have initiated clinical documentation improvement (CDI) programs. A CDI program does not solely apply to the inpatient hospital setting; the plan is also a necessary survival tactic in both the hospital outpatient and freestanding setting.

Clinical documentation improvement has been a healthcare initiative since 1999[1] and an effective CDI plan can improve the billing cycle by ensuring that all services are coded correctly and charged promptly. In addition, a high rate of denials for services could indicate that coding and documentation are not properly aligned and that the provider could benefit from a CDI program. Last, while individual physicians are not publicly identified as quality providers by the Centers for Medicare & Medicaid Services (CMS) to date, they soon will be:[2]

In a continued effort to improve Physician Compare and to prepare the site for the eventual inclusion of quality of care information, CMS is currently in the process of completing a Physician Compare website redesign.

Better documentation leads to better care and higher reimbursement. For example, Borgess Health, a health system based in Kalamazoo, Mich., uncovered more than $6 billion in reimbursement by getting physicians to improve their documentation.[3] As part of the Ascension Health network, Borgess Health includes more than 120 care sites in 15 southern Michigan cities, as well as five owned or affiliated hospitals, a nursing home, ambulatory care facilities, home healthcare, physician practices, a cancer center, and an air ambulance service.

Defining CDI

A CDI initiative is a targeted program of producing, protecting, examining, and posting documents that contain accurate and clinically acceptable information regarding a patient's medical conditions.[4] Any deficiencies in medical record documentation can be addressed, which theoretically leads to a more complete medical record, allowing medical coders to apply concise and correct diagnosis and procedure codes.

During the past several years, CDI programs have moved from the hospital setting to a mainstream requirement for all practice settings. Current estimates find as many as two-thirds of hospitals have some type of CDI program.[5] For most institutions, CDI is an initiative of a Performance Improvement Committee or similar taskforce. This cross-departmental team holds monthly meetings, performs ongoing analysis, and ensures that there is continuing physician education on documentation requirements.

However, the cancer center itself may be organized as a freestanding facility, a remote provider-based department, or an on-campus hospital department. Regardless of the structure or physical location, the use of a unique electronic medical record (EMR) for cancer patients may require that the radiation oncology department or infusion center take full responsibility for their medical record documentation. This process includes developing a clinical documentation improvement program that supports the cancer program's unique EMR requirements.

As a CDI program takes root, those involved should gradually be able to refine their efforts, focusing only on certain diagnoses and new physicians or those individuals still having difficulties providing complete documentation. Thorough documentation supports:

1. The types of patients under treatment
2. How patients respond to a course of therapy
3. Patient acuity (by documenting and reporting diagnosis codes for comorbidities)
4. Complexity of the case.

A series of surveys conducted by 3M in August, October, and December 2012 indicated that clinical documentation improvement issues topped the list of ICD-10 concerns.[6]

Physician Engagement

For a CDI program to be successful there must be stakeholder buy-in and dedicated resources. Effective implementation of a CDI program requires showing physicians where they are missing documentation and involving medical coders or documentation

specialists to improve documentation of the clinical services performed. There is typically resistance during this phase of the process, primarily because extra physician time is required to achieve the necessary outcomes. However, physicians must be part of the team and work with medical coders or other staff to ensure that services are documented, coded, billed, and correctly reimbursed.

Since physician engagement is key, many CDI programs feature physician advisors, such as physician coaches, although there is no magic formula for success.[5] Other models employ nurses, case managers, nurse coders, and coding professionals as the primary CDI staff. Most cancer programs use a nurse reviewer or coding professional to fill the clinical documentation specialist role and these individuals have good communication skills and a basic knowledge of anatomy, oncology, and pathology.[7]

CDI programs can thrive without the benefit of outside help, such as a consulting firm, as long as the cancer center can provide the right strengths and talents internally. Both one-on-one education and group meetings may be necessary to correct any detected documentation deficiencies. At one hospital, clinicians took part in nearly 20 sessions during their specific staff meetings in order to prepare them for the coming documentation questions.[7]

A number of metrics can be used to demonstrate that clinical documentation that supports language to facilitate medical record coding can increase reimbursement. Essentially, if the extent of the patient's illness and/or multiple medical conditions is not included in the documentation, the medical record does not accurately reflect the patient care provided. Since cancer programs will likely one day be paid based on outcomes, now is the time to engage physicians in a CDI initiative.

Accurate documentation links directly to strong financial performance. Remember: a CDI program does not necessarily focus on *more* documentation; instead, the focus is *better* documentation. For example, a physician could document 10 pages of notes for a single encounter, but there may still not be sufficient documentation to code all services provided. As a result, CDI metrics can be incorporated into individual physician profile reports and management reports relating to quality and efficiency. Last, CDI also impacts data for continuity of care, regulatory requirements, accreditation, and quality scores.

1 More Reason to Document

Documentation requirements will continue to increase in complexity with ever changing rules and regulations, new reimbursement methods, and the transition to ICD-10. In addition, clinical care is judged on medical record documentation. Physician documentation is what supports or fails to support the clinician and the facility when a question arises relating to the necessity or competency of care. Medical record documentation has four primary objectives:

1. To document that the service was medically necessary for the patient
2. To demonstrate that the standard of care was met
3. To assist clinicians who will perform subsequent care
4. To justify billing the service performed.

Michelle Dougherty, AHIMA Foundation Director of Research, testified at the Office of the National Coordinator for Health IT's HIT Policy Committee meeting in February 2013; her statement included, in part:[8]

If clinical documentation was wrong when it was used for billing or legal purposes, it was wrong when it was used by another clinician, researcher, public health authority or quality reporting agency. It's crucial to address data quality and record integrity now before health information exchanges become widespread.

Establishing a CDI program will help align documentation and coding, which will enable the cancer program to withstand scrutiny during compliance audits and other regulatory actions. The overall goal of CDI is to make sure the information in the medical record accurately documents the severity of the patient's illness, as well as detailing the care provided to the patient. CDI initiatives that run smoothly not only provide quality information that can be used for a variety of purposes, but also promote cross-departmental collaboration between the CDI team, concurrent review, compliance review, and other performance improvement efforts.

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References

1. Eramo LA. CDI: it takes commitment. *For The Record*. 2012;24(1):14. Available online at *www.fortherecordmag.com*. Last accessed May 24, 2013.
2. CMS. Physician Compare Initiative. Available online at *www.cms.gov*. Last accessed May 24, 2013.
3. Minich-Pourshadi K. Clinical documentation for higher reimbursement. *HealthLeaders Media*. Available online at *www.healthleadersmedia.com*. Last accessed May 24, 2013.
4. Clinical Documentation: Improving Clinical Documentation. *www.clinicaldocumentation.org*. Last accessed May 24, 2013.
5. AHIMA. Clinical Documentation Improvement: Gauging the Need, Starting Off Right. Available online at *http://library.ahima.org*. Last accessed May 24, 2013.
6. 3M. Clinical Documentation Improvement. Available online at *http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Clinical-Documentation-Improvement/*. Last accessed May 24, 2013.
7. AHIMA. Leading Clinical Documentation Improvement: Three Successful HIM-led Programs. Available online at *http://library.ahima.org*. Last accessed May 24, 2013.
8. AHIMA. Testimony of Michelle Dougherty, MA, RHIA, CHP, on Behalf of AHMIA to the HIT Policy Committee Hearing on Clinical Docmentation. Available online at http://ahima.org. Last accessed June 28, 2013.