# Strategies for implementing a CDI program

By Shea Lunt, RHIA, CPC, CPMA, PMP

Clinical documentation is at the heart of every patient encounter, whether the encounter is inpatient or outpatient. Since their inception, clinical documentation improvement (CDI) programs have focused on inpatient encounters and hospital stays.

Although there are inherent differences between inpatient and outpatient CDI due to shorter encounters, patient population and reimbursement methods, the same principles of good documentation apply. CDI programs can be beneficial to physician practices.

In the past, improving documentation in physician practices has largely been the responsibility of coding specialists or office managers. They often communicate with providers directly on a case-by-case basis, seeking greater detail in clinical documentation to support accurate CPT codes. With the emergence of quality programs and reimbursement methods focusing on ICD-10-CM diagnoses to demonstrate risk, there is increased motivation for practices to start outpatient CDI programs, utilizing a formal query process.

Before implementing a CDI program, it is important for practices to understand the benefits, goals and guidelines set forth by the industry.

## Benefits of a CDI program

The CDI specialist must keep in mind that the provider's clinical notes not only affect patient care, but also that the documentation of a patient's medical information is translated into coded data. The coded data then can be used for quality improvement reporting, reimbursement, public health statistics, disease trending and research.

A CDI program can positively affect a physician practice by improving:

- **Patient care**: Accurate and complete documentation in the record ensures that all providers have detailed information regarding the patient's conditions, treatment and course of care. Good documentation can help improve quality of care and efficient coordination of resources.
- **ICD-10-CM code assignment**: Assigning diagnosis codes at the highest level of specificity involves choosing the codes based on documentation and supported by clinical evidence in the medical record. ICD-10-CM codes support medical necessity of services provided. They also play an important role in Hierarchical Condition Category (HCC) assignment, which in turn can affect payment in reimbursement models using a risk adjustment factor (e.g., Medicare Advantage plans).[1]
- **CPT code assignment**: Detailed procedure notes include the specificity necessary to capture the appropriate CPT code. This guarantees appropriate reimbursement for the service provided and ensures against any negative outside audit findings that rely on documentation to support payment for the services.
- **Quality scores**: In many outpatient programs, quality scores are derived from coded data that's dependent on accurate documentation.

## CDI program basics

CDI programs are most commonly headed by CDI specialists with experience in health information management (HIM) or nursing. HIM professionals are familiar with coding and reimbursement rules as well as documentation compliance regulations, while nurses have a clinical background that's useful in identifying discrepancies between clinical evidence and documentation. This experience helps CDI specialists to effectively integrate documentation requirements, code assignment, coding and billing guidelines and quality reporting.

When implementing CDI programs, practices should:

- **Determine goals**: Is your practice trying to improve risk adjustment scores, reduce medical necessity denials or improve support for E/M levels?
- **Establish scope**: Depending on the goals, the CDI specialist may focus on coding as it relates to risk adjustment or on codes with high rates of medical necessity denials. Should your scope include CPT and modifier review? Will "copy and paste" documentation issues be addressed?
- **Identify gaps in documentation and coded data**: Does E/M documentation support the level of service coded?
- **Define the process**: Will your CDI reviews be concurrent or retrospective? Are they performed on site or remote (via EHR)? What are your staffing and training needs? Enlist the help of

experienced inpatient CDI specialists to learn from their successes and failures.
- **Gain support from providers and staff**: Explain what's in it for them. Ensure they understand expectations regarding the query process, timeliness and goals.

### Best practices

A CDI specialist should maintain the integrity of the documentation in the health record and, in turn, ensure the accuracy of coded healthcare data. Because provider queries are the main method for improving documentation by CDI programs, it's vital to understand best practices. The Centers for Medicare & Medicaid Services (CMS) states that queries are appropriate in certain situations if they are not "leading" the provider and do not introduce new clinical information not previously in the record.[2]

The American Health Information Management Association (AHIMA), along with the Association of Clinical Documentation Improvement Specialists (ACDIS), provides "Guidelines for Achieving a Compliant Query Practice (2016 Update)," which is regarded as the recommended industry standard for provider queries.[3]

Examples of when to generate a query include but are not limited to the following:
- Documentation is conflicting, vague, illegible or inconsistent
- Documentation includes clinical indicators without a relationship to an underlying diagnosis
- Documentation provides a diagnosis without related clinical indicators to support it
- Documentation includes clinical indicators, diagnostic evaluation and/or treatment not related to a specific condition or procedure

To refrain from leading providers with queries, an open-ended or "yes/no" query format is preferred.

Whether written or verbal, queries should always be accompanied by relevant clinical information and maintained as part of the permanent legal medical record.

### Measuring effectiveness

Organizations must be able to measure program effectiveness. Overall improvement in the number

## Open-ended query example

**Clinical scenario**: A patient is seen in a primary care clinic and is noted to have DM Type 2. The examination reveals paresthesia, numbness, cramping and antalgic gait. The patient has also undergone recent EMG testing for which the results are available.

**Nonleading query**: Based on your clinical judgment, can you provide a diagnosis that represents the clinical indicators listed below?

In this patient with type 2 diabetes mellitus, the history, physical examination and lab results reveal the following:

- Abnormal EMG results
- A1C of 9.3 with insulin adjustment
- Irregular examination findings

Please document the condition and the associated chronic complications in the medical record.

## Yes/no query example

**Clinical scenario**: A primary care physician documents heart arrhythmia as an impression based on EKG findings. However, previously this condition was noted to be atrial flutter by Dr. Smith, who is part of the same practice and has also seen the patient.

**Yes/no query**: Do you agree with Dr. Smith's impression from 6/8/2018 that the patient has atrial flutter? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

of clean claims, higher quality scores and increased reimbursement are the intended outcomes of CDI activities.[4]

Because the practice of providers amending their documentation based on queries issued by CDI specialists relies on appropriate and timely queries, effectiveness of the query process itself must also be evaluated. Metrics based upon provider response rates, number of queries sent and conditions most frequently queried are valuable when offering feedback and education to providers. However, more direct measures of query effectiveness, as shown in the examples below, can demonstrate the success and efficiency of a CDI program and ensure that each CDI intervention adds value.

Support from providers regarding query format and response expectations are important when implementing a CDI program. Once these are established, query effectiveness can be quantified in different categories, as demonstrated below in Figure 1.

While not all queries achieve the intended outcome, tracking all query results can reveal opportunities for process improvement. Consider additional query measurements such as:

- Lack of response from the provider
- Agreement with the query but coding not revised
- Agreement with the query but provider documentation not amended

**CDI impact**

When implementing a CDI program, you should ensure that the program is headed by an individual(s) with appropriate background and experience to translate documentation into coded data. Establishing clear goals and expectations based on measurable outcomes are essential to maintaining an impactful CDI program, as well as following current industry best practices to ensure accuracy in medical record documentation. As healthcare delivery models continue to evolve, and with the growing impact of value-based reimbursement methods in physician office settings, CDI programs can pave the way for operational efficiency and positive outcomes. ■

*Contact Shea Lunt at slunt@thehaugengroup.com.*

Notes:

1. "Risk adjustment." Centers for Medicare & Medicaid Services. Available from: go.cms.gov/1ciQ92T.
2. "CMS Manual System Pub 100-10 Medicaid Quality Improvement Organizations." Centers for Medicare & Medicaid Services. July 11, 2003. Available from: go.cms.gov/2O75zKo.
3. "Guidelines for achieving a compliant query practice (2016 update)." AHIMA Practice Brief. January 2016. Available from: bit.ly/2naMQ5k.
4. "Outpatient clinical documentation improvement (CDI): An introduction." ACDIS white paper. May 2016. Available from: bit.ly/2KoTtdf.

## **Figure 1.** Quantified query effectiveness

| Query measures | Definition | Examples of deficient documentation triggering a query |
|---|---|---|
| Query was appropriate | Does the query demonstrate a clear intent to improve documentation? Was it supported by clinical indicators? | *Nonspecific diagnoses that did not reflect severity:*<br>• e.g., obesity, intellectual disability, malnutrition |
| Query affected accurate clinical coding | Does the query result in amended documentation that improves the clinical accuracy of coding? | *Further specificity of conditions:*<br>• e.g., stage and laterality of ulcers, stage of CKD |
| Query had a positive affect on final coding including reimbursement and severity | Does the query result in amended documentation that positively affects final coding, resulting in increased reimbursement or risk adjustment scores? | *A higher value code is assigned:*<br>• e.g., CPT with higher RVU value, ICD-10-CM code that is an HCC |