



THE  
Clinical  
Documentation  
Improvement  
Specialist's  
*Handbook*

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Colleen Garry RN, BS



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# Dedication

*I want to thank:*

*Jenny, my sister and best friend, who has encouraged me to do more and think big.*

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*Last, but certainly not least, my dogs, Boodah, “Big” Sam (Pickos), and Miss Fontella Bass,  
who sacrificed many weekend outings for me to write this handbook.*

# About the author

**Colleen Garry, RN, BS**, has implemented and managed a successful clinical documentation improvement (CDI) program at the Medical University of South Carolina for more than three years. She has recently accepted an Assistant Director Clinical Documentation position with New York University Medical Center.

Garry graduated from Marist College in New York and has a baccalaureate in business marketing as well as a registered nursing license. She has a varied background in nursing with more than 17 years of work experience as a critical care nurse, transplant coordinator, ESRD educator, and outpatient program director.

Prior to her career in healthcare, she was employed with IBM Corporation and NBC Television in NY.

She is a member of the American Health Information Management Association and the American Nurses Association, and serves on the board of the Association of Clinical Documentation Improvement Specialists.

Garry has written articles for HCPro's newsletter, **Medical Records Briefing**, and the Healthcare Finance Management Association newsletter, **The Business of Caring**. She has spoken at various professional organizations about CDI programs.

# Introduction

I hope this book and the accompanying prescriptive tools offered within these pages inspire you to embark on your own journey into the new and exciting world of clinical documentation improvement (CDI).

This book is designed to:

- Serve as a blueprint for the leadership team that is entrusted with the role of implementing a CDI program
- Serve as an essential guide to everyday practice for the CDI specialist

I cannot stress enough the need for collaboration and respect among the many professional work groups that a CDI program affects. The next several years promise to be challenging and potentially very rewarding for CDI specialists. I encourage specialists to network and get involved. And my hope is that in time, hospitals nationwide will come to learn the true value and worth of a CDI program.

# How to use the CD-ROM

The accompanying CD-ROM includes the following sample tools and forms that are discussed in various chapters of *The Clinical Documentation Improvement Specialist's Handbook*. Note: The chapters listed in parentheses refer to the chapters in which these tools and forms are referenced]:

- CC pocket guide (Chapter 8)
- CDI manager job description (Chapter 2)
- CDI specialist job description (Chapter 2)
  
- Query for abnormal tests (Chapter 7)
- Query for malnutrition (Chapter 7)
- Query for severity of illness (Chapter 7)
  
- Query for symptoms as principal diagnosis (Chapter 7)

To adapt any of the files to your own facility, simply follow the instructions in the next section to open the CD.

If you have trouble reading the forms, click on "View," and then "Normal." To adapt the forms, save them first to your own hard drive or disk (by clicking "File," then "Save as," and changing the

system to your own). Then change the information enclosed in brackets to fit your facility, and add or delete any items that you wish to change.

## Installation instructions

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This product was designed for the Windows operating system and includes Word files that will run under Windows 95/98 or later releases of Windows. The CD will work on all PCs and most Macintosh systems. To run the files on the CD-ROM, follow these steps:

1. Insert the CD into your CD-ROM drive.
2. Double-click on the "My Computer" icon, and then double-click on the CD drive icon.
3. Double-click on the files you wish to open.
4. Adapt the files by moving the cursor over the areas you wish to change, highlighting them, and typing in the new information using Microsoft Word.
5. To save a file to your facility's system, click on "File" and then click on "Save As." Select the location where you wish to save the file and then click on "Save."
6. To print a document, click on "File" and then click on "Print."



# Building a CDI program

CHAPTER

1



# Building a CDI program

## *Learning objectives*

- **Identify data sources that will demonstrate the need for a clinical documentation improvement (CDI) program**
- **Identify the advantages and disadvantages of different CDI models**
- **Identify how organizational needs affect model selection**
- **Explain the impact of medical code assignment on data quality**
- **Identify the “must have” components of a strong CDI program**

## **The need for CDI**

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In October 2007, the Centers for Medicare & Medicaid Services (CMS) instituted a major change in the way that it reimburses hospitals, moving from traditional diagnosis-related groups (DRGs) to a severity-based system involving Medicare Severity DRGs (MS-DRGs). MS-DRGs require more clinical specificity than ever before, and CDI programs are becoming increasingly popular across the country as a way to respond to the increased clinical level of detail required for accurate coding.

CMS intends that the increased specificity of patient diagnoses will better capture the patient's true severity of illness and resource consumption. The demand for increased specificity makes a compelling argument for implementing a CDI program. But despite the fact that this may be a logical reason to implement such a program, you'll still need to prove its return on investment.

### Using comparative data

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The first step in justifying the need for a CDI program is to benchmark how your hospital compares to others of similar size and location. HealthGrades.com offers free publicly available data. Ask the following questions when benchmarking your data:

- Does your data accurately reflect the level of care that your facility provides? For example, select the mortality score for patients with a principal diagnosis of sepsis. How does your facility score?
- How do your competitors score? If the smallest local hospital in town (one of your competitors) has the best results, and it also has the highest number of cases, your hospital may have an internal problem relating to the quality of coding or the level of detailed documentation that your physicians provide. This documentation helps coders capture the appropriate diagnosis codes and DRGs. When there is a discrepancy between your hospital's true performance and the performance that your coded data reflects, pull the data, verify the results, and use the information as a baseline to track performance. Perform this analysis using a variety of sources, such as *www.healthgrades.com* and *www.hospitalcompare.hhs.gov*.

#### **Program for Evaluating Payment Patterns Electronic Report**

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a quarterly report that the Office of Inspector General publishes

as part of its compliance program. The report reviews target areas typically containing payment errors, such as billing, coding, and utilization. The data compares each individual facility to statewide averages and is a good way to identify and track outliers and trends. PEPPER tracks various DRGs, such as simple and complex pneumonias and sepsis, as well as CC capture rates. The report also provides benchmarks for the 10<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles for specified DRGs.

#### **University HealthSystem Consortium**

Another great source for data to use when trending your hospital's performance is a quality association. For example, the University HealthSystem Consortium (UHC) is an alliance of 97 academic medical centers and 153 affiliated hospitals that represent approximately 90% of the nation's non-profit academic medical centers. UHC publishes a yearly impact report broken down by product line. Using this report is an excellent way to set internal service line benchmarks.

### Importance of audits

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From a compliance and quality standpoint, internal and external coding department audits are essential. Audits are important for the following reasons:

- They allow hospitals to track performance and compare performance with expected outcomes.
- They help to validate coding quality and identify documentation improvement opportunities.

- They are the only valid way to track opportunities and success.
- They demonstrate the close collaborative efforts between CDI and health information management (HIM) staff members. If the audit reveals a quality issue, hospitals should make educational efforts a priority. When the audit reveals a documentation opportunity, CDI specialists should seize that opportunity. They may not be aware that coders have been receiving a record that is subpar.

Working with external auditors and consultants can be valuable because they are impartial and often have helpful insight pertaining to process improvement. Because they have often had the luxury of working with a variety of hospitals, they can speak from a benchmarking point of view.

When performing internal audits, focus on high-volume DRGs—in particular, your top 20. Does your top 20 list include any symptom DRGs, such as chest pain, syncope, or altered mental status? Symptom DRGs are those in which the symptom—rather than the definitive diagnosis—is listed as principal. These DRGs ideally should not make the top DRG tier; however, if they do, this makes a strong case for a need for documentation improvement.

Excessive symptom DRGs may also indicate a utilization issue related to misappropriation of patient status (i.e., inpatient versus observation status). This “mismatch” of patient status will result in a denial of claims, lost revenue, and dilution of the case mix index (CMI)—a hospital-specific calculation that considers an inpatient

facility’s patient volume and acuity. The CMI is the average (mean) relative weight, resource utilization, and payment per case. It provides a quick reference with which to gauge the hospital’s financial health.

The best way to analyze the CMI is to review trends over time. Many factors influence the CMI, several of which the CDI specialist or coder cannot control. When analyzing the CMI, consider the following questions:

- Have you noticed any changes in the DRGs that drive the CMI? For example, how have the percentages of medical versus surgical DRGs changed over time? Remember that your percentage of surgical DRGs is more likely to be higher.
- Is there a shift in market share?
- Has your physician staff changed recently?
- Is your hospital less likely to perform a certain procedure now that medical technology has improved?
- Has there been a major shift in patients who are admitted as inpatients or admitted to observation status?
- Has your CC capture rate differed from anticipated capture rates?
- Has your hospital recently employed a new coder?
- What is your overall employee retention rate?

## Chapter I

CMS provides every hospital with its own set base rate. CMS then multiplies the base rate by the DRG relative weight to determine the hospital's payment. The combination of the DRG relative weights and patient volume determines the facility's CMI. The higher the CMI, the more acute the level of care. Consider the following example: A hospital has the busiest heart transplant program in the country because it employs the most successful heart transplant surgeon. Suddenly, that surgeon decides to work for another hospital that is one of your competitors. As a result, your hospital receives fewer patients, and the volume of cases in MS-DRG 01 (Heart transplant or implant of heart assist system with an MCC) decreases. This also causes a sharp decline in your hospital's CMI. Although a CDI specialist could make great strides to improve documentation, the surgeon's absence will continue to have a negative effect on the CMI. Without tracking your CMI and asking the right questions, this fact would have gone unnoticed and unaccounted for.

In addition to focusing on high volume DRGs, your audit should also review:

- Depth of coding
- Severity of illness
- Risk of mortality

These elements are critical because they are necessary to fully capture your facility's patient acuity. Lack of in-depth coding, that is, not assigning all relevant codes to the greatest level of specificity, can result in perceived poor performance. When a coder codes a record, he or she factors all of

the diagnosis codes into developing a predicted mortality statistic. Omitting ICD-9 codes will lead to an inaccurate patient profile that will result in incorrect computation of predicted mortality. Lack of in-depth coding is also responsible for poor data. Undercoding, or the assignment of a less specific diagnosis or procedure than what could be assigned, is actually an illegal activity. One could argue that when a record is undercoded, it misrepresents the actual cost and resources used to treat the patient. Some view undercoding as an unethical way to entice insurance companies to contract with a facility for certain diagnoses and procedures. In theory, if a hospital treats a patient and does not capture all relevant conditions and procedures, it will most likely be charging less to treat that patient. This may make that hospital more likely to obtain managed care contracts. Undercoding skews the cost data and possibly the outcomes data as well. For example, if a coder omits a CC, he or she jeopardizes reported patient quality outcomes. CMS also uses coded data to amend the current IPPS. CMS uses this data to evaluate relative weight assignments and reimbursement for CCs.

Do not implement a CDI program to correct coding deficiencies. A quality problem related to coding is a separate issue. We will discuss remedying coding problems in a later chapter.

### Compiling audit results

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When compiling audit results, be sure to consistently report key elements. The department should have an overall accuracy score, which it can determine by reviewing best practice coding accuracy rates. Departments should drill down into each

individual coder's performance results. Track scores regardless of whether the scores are high or low. If scores are already high, determine whether they are on target, as well as whether they exemplify best practice. If scores (CC capture rate) are too high, there may be a compliance problem, or the coder may be engaging in upcoding, which is the assignment of codes that are more specific or severe than what the documentation reveals. If scores are low, coder education is warranted. Initiate an action plan to improve accuracy. This is more or less a quality improvement project for the coding department. CDI specialists should support coders in this endeavor. Continuous monitoring for accuracy is needed. Audits should include appropriate depth of code assignment.

If the coding manager has determined that a coder's clinical knowledge is deficient, the manager may need to turn to CDI specialists to help coordinate conversations between physicians and coders. In some cases, the CDI department may be equipped to provide educational support for the coders.

Once you provide this education, monitor your CC capture rate, as well as severity of illness and risk of mortality indicators. Your CDI program should demonstrate a financial impact as well as a quality impact. Financial outcomes are very black and white; however, the quality impact may not be as straightforward. Poor quality outcomes have larger ramifications because they affect reputation, the ability to obtain research grants, and the sustenance of your bottom line.

## **Administrative support**

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It is crucial to have administrative support when implementing a CDI program. Having the support of the chief financial officer (CFO) and medical director is one of the "must-haves" for a successful program. Without visible support from administration, the program will fail. Refer to the Appendix for a CDI "recipe for success" that outlines several other "must-have" components of any profitable CDI program.

To achieve proper buy-in, communicate with administrators to determine what they perceive as the CDI priorities/opportunities. Meet with administrators prior to rolling out the CDI program to ensure that everyone is on board. Quarterly meetings with key personnel are imperative. Meetings should include medical examples that explain concepts related to the importance of severity of illness and risk of mortality from a quality-of-care standpoint, as well as financial examples that discuss the financial implications of improved documentation. Conveying the financial aspect of a CDI program is fairly easy to do. Explain that CDI specialists query cases that have working DRGs that they feel can benefit from documentation improvement. When the physician improves his or her documentation, this can potentially lead to a more accurate DRG. The financial variance between the relative weights of the two differing DRGs (i.e., the working DRG versus the final DRG) is the variance that you can credit to the program's success.

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Explaining the quality ramifications of a CDI program is more difficult because the results are less tangible than a dollar amount and they pertain more to patient acuity of illness profiles, resource intensity, mortality statistics, utilization review, length of stay, and quality-of-care performance measures. Public data and organizational reputation are also tied in with a bigger piece of the financial puzzle (i.e., research dollars). Dollars go where the reputation is, and coded data plays a large role in public perception.

Coded data affects future CMS decisions that impact patient care, quality report cards, and financial outcomes. Track, validate, and report your data in a timely manner. Validation is very important. If you use a vendor database, audit the reports for authenticity. This may seem absurd, but it's actually crucial. The last thing you want to do is report inaccurate financial data to your CFO.

### CDI model selection

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Once you've justified the need to implement a CDI program, the next step is to choose the model that's right for your facility. If you are involved with the model selection, consider yourself very fortunate. Oftentimes, the model is already in place when the CDI manager begins working there. Note that in Chapter 12, we provide several case studies that outline the advantages and disadvantages of certain models, as well as the implementation process for several hospitals. We've also provided an executive summary of an ACDIS CDI survey in which 849 HIM professionals answered various questions related to their programs and

documentation improvement efforts. See Chapter 13 for more information.

There are three basic CDI models that are structured based on which department the CDI specialists report to. These models include:

- **The HIM/coding model:** This model worked particularly well with CMS-DRG version 24. This version included 40% more secondary diagnoses that qualified as CCs that could potentially optimize a couplet DRG pair to the "with CC" category. Version 24 also required less specificity and less clinical interpretation.

Many of the older CDI programs (i.e., pre-MS-DRGs) are multidisciplinary and include HIM/coding professionals or nurses who have received training regarding coding principles. These programs often function without collaboration with outcomes management or case management. CDI specialists under this model are responsible for reviewing/analyzing the inpatient record, determining the appropriate DRG, and capturing secondary diagnoses in a format from which coders can assign a code. The goal of this model is to "clean" the record and decrease both coding time and the need for retrospective queries, thereby decreasing denials, decreasing the bill-hold, and increasing efficiency. Under this model, CDI specialists do not address quality performance measures because some feel that it falls outside of their role.

- **The case management model:** This model is built on the principle that the case manager is a healthcare team member who is knowledgeable about the patient's condition and has the respect of the patient care team as well as easy access to the team for a more efficient query response/resolution process.

The difficulty with this model is that the CDI specialist also has many other job responsibilities that compete for first priority. Undeniably, the number one priority is, and will always be, patient education and discharge needs. This model stresses continuity of care and is most beneficial when there are enough case managers serving as CDI specialists to manage the patient volume and when each case manager/CDI specialist receives adequate coding training. Under this model, it is crucial that case managers/CDI specialists develop a good working relationship with the coding department.

- **Quality outcomes model:** This model requires CDI specialists to review clinical documentation from the quality perspective, focusing in particular on clinical outcomes and statistics. Outcomes managers are often familiar with coding, and they also have the clinical expertise. Most quality outcomes specialists are very detail-oriented individuals who are adept at data analysis and process improvement. The difficulty with this model is similar to the case management model. Outcomes managers who serve as CDI specialists are often pulled in multiple directions, making it difficult to focus exclusively on CDI.

## MS-DRGs and the future of CDI

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With the implementation of MS-DRGs, I believe there is a need to redesign and merge the models discussed in the preceding section. Programs under the HIM/coding model should focus on clinical detail to achieve more widespread success. There is also an organizational need to deconstruct the idea of the "CDI model" and use a collaborative approach involving coding, case management, and outcomes management. The MS-DRG system requires more clinical depth/interpretation, and it is more focused on quality patient care/outcomes. Because of these increased requirements, CDI specialists should analyze DRGs to capture all appropriate secondary diagnoses. They should also strive to decrease denials and streamline the retrospective process so coders can code more efficiently.

Once the CDI program is successful, consider incorporating the CMS core measures into your CDI program. However, don't incorporate the measures until the program has demonstrated a proven track record with supporting data. Ensure that the program has fostered strong working relationships between coders and physicians and that the CDI staff is stable and seasoned. Do not include the core measures when implementing a CDI program for the first time. This is more suitable for older programs that have been in existence for quite some time.

CMS expects that the core measures will have financial benefits associated with best practice models. This added responsibility will require additional CDI staff members, so your hospital must assess the return on investment before

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implementing it. If your organization is presently in CMS' top tier for core measure requirements, adding this to your CDI specialist's function may purely serve to ensure clinically accurate docu-

mentation and continuity of care. If your core measure performance reveals an opportunity for documentation improvement, there may be a financial benefit to this additional role.