AHIMA releases new CDI guidance, offers tools for programs

Two new publications from AHIMA offer guidance and best practices for CDI programs. The Clinical Documentation Improvement Toolkit, released in April, and the “Guidance for Clinical Documentation Improvement Programs” (aka the CDI Practice Brief), released in the May Journal of AHIMA, outline CDI job descriptions, provide examples of leading and non-leading queries, and suggest policies for verbal and written physician queries.

With the releases, AHIMA aimed to create solid guidelines for the CDI profession, including adding further specificity to the gray area of physician queries. The guidelines needed to be specific enough to be useful but broad enough to allow facilities to make necessary adaptations, says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM (NCAL revenue cycle) for Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA. Bryant, an ACDIS advisory board member, served as AHIMA CDI Work Group cochair and as an author of AHIMA’s CDI Practice Brief.

Project genesis

When AHIMA first released a draft of its proposed guidance for physician queries in summer 2008 for public comment, the response was tremendous, says Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources at AHIMA. AHIMA took the comments it received at the time under consideration when it released “Managing an Effective Query Process” that September.

The public’s feedback illustrated the need for additional resources in the industry, DeVault says. So in January 2009, AHIMA sought volunteers to sit on a new CDI Work Group aimed at discovering what additional support industry professionals required.

More than 100 volunteers applied. To choose who ultimately joined the Work Group, DeVault reviewed volunteers’ résumés, sought ACDIS’ recommendations, and weighed input from AHIMA’s own staff.

“We wanted to be sure we had a diverse group and some fresh voices,” DeVault says. Ultimately, AHIMA chose 30 CDI-related professionals, including physicians, HIM managers, and CDI specialists.

AHIMA initially hoped to compile the volunteers’ research into a large volume or book, but “settled on a number of different venues to disseminate the results of their year’s worth of collaboration” for a variety of reasons, DeVault says.

First, the volunteers felt strongly that the advice be provided openly and freely on the AHIMA website. Second, they wanted to deliver the information quickly, and book projects can take a year or more to reach fruition.

So the group of 30 divided into subgroups to concentrate on specific tasks. Some worked on the toolkit; others worked on proposed ethical guidelines for CDI, yet to be released.

The document “Guidance for Clinical Documentation Improvement Programs” came from the efforts of a seven-member committee, which included DeVault and three members of the ACDIS advisory board (see the complete list of participants on p. 6).

“The energy of this group was just like a ball rolling downhill; they just kept gathering momentum. They were so enthusiastic,” DeVault says.

The 41-page AHIMA CDI Toolkit offers sample job descriptions for CDI specialists and physician advisors to CDI,

AHIMA CDI Practice Brief: What it Says and What it Means for Your Program

Join ACDIS Director Brian Murphy Wednesday, July 14, at 1 p.m. (EST) for a live audio conference featuring Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, and William E. Haik, MD, FCCP, as they discuss AHIMA’s recently released CDI Practice Brief. During this 90-minute live audio conference, they will explain how the brief was developed, what it contains, and how hospitals can incorporate the principles into their CDI programs. They will also discuss AHIMA’s position on leading vs. non-leading queries and offer examples of both.

For information, call toll-free 800/650-6787 or e-mail customerservice@cdiassociation.com.
New CDI guidance/tools
continued from p. 7

provides definitions for documentation clarifications and sample queries, and offers guidance on how to establish the structure of a CDI program and measure CDI success.

Much of the guidance and toolkit contents echo commonly held CDI best practices regarding program structure, staffing, and query policies. The releases complement AHIMA’s previous query guidance “Managing an Effective Query Process” and its 2001 “Developing a Physician Query Process” but do not replace those documents.

Program staffing

Both the toolkit and guidance suggest that HIM professionals, physicians, nurses, and others with clinical and coding backgrounds make good candidates for the CDI role, and that depending on the needs of the organization, CDI programs can a mix of professional backgrounds.

DeVault notes that the guidance went through a thorough vetting process, earning approval from the volunteer board that created it, the AHIMA leadership, and the AHIMA practice councils, which include HIM volunteers.

During its June 2 meeting in Chicago, ACDIS advisory board members voted to support the majority of the contents of the CDI Practice Brief, in particular its emphasis that CDI is a multidisciplinary profession. (Read more on ACDIS’ position on the releases in the director’s note on p. 5.)

“CDI is a collaborative effort,” says Robin Holmes, MSN, RN, CCDS, manager of CDI at DCH Health System in Tuscaloosa, AL. “We need to show respect for [all] disciplines.”

Query consensus

The practice brief takes up the issues of leading vs. non-leading queries, offers a checklist for conducting compliant written and verbal queries, and acknowledges the importance of the verbal query process.

“I still struggle with the verbal query process myself,” DeVault says. “CDI programs need to know how to measure and manage the verbal process, and that’s somewhat ambiguous.”

Many worry that without the verbal query tool, an important aspect of the CDI specialist’s role could be lost. As the AHIMA guidance states:

The advantage of a verbal query is the [CDI specialist’s] ability to interact with the provider to facilitate understanding of the issues that need to be addressed. However, caution must be used to ensure that the provider is allowed to make his or her own conclusions regarding the appropriateness of a particular diagnosis or service.

The practice brief recommends that CDI managers train their staff on the verbal query process, track instances of verbal queries, and review verbal query policies as part of CDI program quality assurance measures.

The guidance suggests that organizations should create a verbal query policy that includes the following:

» When verbal queries are appropriate
» A process for documenting verbal queries
» A quality assurance process for verbal queries, including:
  – Who will monitor the verbal queries
  – How many queries will be reviewed for compliance and how often
  – Feedback and corrective action needed
  – Reporting documents for CDI quality assurance processes

Although debate still continues about the definition of leading vs. non-leading queries, Work Group members expressed a measure of pride regarding the work it accomplished on the matter.

“It is easy to cross that line into potentially leading the physician to a particular diagnosis when you are in the hallway having a conversation. So I’m really happy for the leading and non-leading query examples. We worked really hard on those to make sure we offered clinically valid presentations of both,” DeVault says.

Guidance implications

As one of the four cooperating parties in conjunction with the AHA, National Center for Health Statistics, and CMS, which work together to clarify ICD-9-CM medical coding guidelines, some perceive that AHIMA’s CDI guidance possesses additional regulatory weight.

It’s one reason “people take our releases pretty seriously,” DeVault says. “But this isn’t meant to be a standard like a release from Coding Clinic would.”

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