A CDI program’s purpose: Documentation for care quality
Adjust your CDI practices to meet the changing face of healthcare

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The overarching goal of a documentation improvement program is not to improve reimbursement for the hospital, but to effect a positive change in the behavior of those who document in the medical record. These can include:
- Treating physicians
- Consulting physicians
- ER physicians
- Nutritionists
- Floor nurses
- Wound care nurses
- Respiratory therapists
- Physical/occupational therapists

The medical record should accurately depict the acuity of the care provided. It should demonstrate whether all tests and procedures were medically necessary and ordered and performed based on sound evidence-based medicine. It should explain why more resources were spent to treat one particular patient, compared to another patient with a similar diagnosis who was managed and treated with less resources and intensity.

Most CDI specialists focus purely on CC/MCC capture by asking for clarification of specific diagnostic statements, often a single word such as “diastolic” or “sepsis.” Their efforts should be on educating physicians to document a holistic picture of a patient’s illness and the reason for admission to the hospital, not single words in isolation.

A CDI specialist’s focus should consist of educating the physician on the merits and necessity of including the clinical judgments that lead to these diagnostic statements of record. It is not enough from a third-party payer perspective for the physician to merely list diagnoses or a CDI specialist’s driven “buzzwords” to increase hospital reimbursement. Instead, the physician should incorporate in the daily progress note documentation of how he or she arrived at the specifics of the diagnosis or diagnoses, as well as status of the acute clinical conditions being managed (e.g., whether the aspiration pneumonia is clinically improving, worsening, or improving slower than expected).

Value-based purchasing and other initiatives

This change in documentation detail and scope is necessary because healthcare is gravitating toward value of services, rather than the traditional model of paying for volume. It’s quality divided by cost. Spending more money on a patient does not mean the care provided is any better, as evidenced by the work of the Dartmouth Atlas project (visit its website at www.dartmouthatlas.org). It boils down to the patient and how much “medically necessary care” as supported by the physician’s clinical documentation is required to treat that patient, and the efficiency of the physician in managing the patient’s clinical condition.

The CMS proposed rule on value-based purchasing (VBP) is handwriting on the wall for the CDI profession. (Read the VBP proposed rule on the Federal Register website at http://edocket.access.gpo.gov/2011/pdf/2011-454.pdf.) Currently, hospitals are paid for reporting data; under VBP, CMS proposes to reduce payment 1% if the data hospitals report does not support the quality of services provided. This change is scheduled to take place in October 2012.

CMS is also directing a pilot project known as the Physician Feedback/Value Modifier Program. (Read about the program on the CMS website at www.cms.gov/PhysicianFeedbackProgram.) This program uses claims data to create confidential reports measuring the resources and quality of care furnished to Medicare patients. These reports include quantification and comparisons of patterns of resource use/cost among medical professionals and medical practice groups.

VBP and the Physician Feedback/Value Modifier Program are just a few examples of the shift in healthcare toward paying for quality rather than quantity. CDI specialists can seize the opportunity or wait to react when change is thrust upon them. The smart solution is the former.
Screening criteria and history of present illness

Focusing on overall quality of documentation rather than diagnostic statements and case-mix index increases requires a sea change in thinking, but the first step is losing the CC/MCC capture mind-set. Look at the entire record from the beginning and ask, “What’s missing?”

What’s typically missing from most documentation is the physician’s description of how sick the patient looks. Medicare has stated that InterQual criteria is a screening tool but is not the end-all be-all for determining an admission. What is most important is the overall clinical picture of the patient.

The key is getting the physician to document a thorough history of present illness (HPI). The HPI should speak to the true acuity of the patient’s severity of presenting signs and symptoms—for example, how severe the patient’s chest pain is, what are the patient’s associated signs and symptoms, modifying factors of the chest pain, and duration of the chest pain.

There are eight elements of the HPI, and the physician should describe as many of these elements as clinically relevant. Doing so results in an accurate portrayal of the patient’s severity of illness and the medical necessity of the work the physician performed.

More documentation is not needed, just enough to show the physician’s thoughts on paper that reflect how sick the patient truly is. Any words that don’t directly relate to acuity can and should be replaced by ones that do.

HPI and H&P

If resources are available, you may wish to place a dedicated CDI specialist in the ER with a background in nursing and/or case management. These dedicated specialists can start the process of documentation of proper acuity that will carry throughout the patient’s stay. They can also recognize when documentation does not support the acuity necessary for admission and engage in a proactive approach to improving clinical documentation at the point of service, thus preventing a potential costly denial of the entire case.

For example, if a physician documents “hypoxia,” the dedicated ER CDI specialist could observe the patient in the ER and note how sick he or she is, note that the physician spent 90 minutes with the patient to manage a life-threatening condition, and then educate the physician that writing “hypoxic” in the record does not reflect the patient’s true severity of illness or the physician’s management of a potentially critically ill patient with acute respiratory failure.

By the way, a life-threatening condition of acute respiratory failure may warrant the physician billing for a critical care E/M code provided there is adequate documentation to meet the billing guidelines.

Regardless of whether you can place a CDI specialist in the ER, all CDI specialists should make efforts to examine the HPI as outlined above. The following are recommended best practices:

» Look at the signs and symptoms exhibited by the patient as documented by the physician
» Evaluate the extent and results of the physical exam
» Review the physician’s clinical impression/assessment
» Determine whether the HPI paints the picture of a chief complaint that clinically supports the physician’s assessment/clinical impression and associated plan of care

The HPI demonstrates the medical necessity for the physician—severity of signs and symptoms plays an integral role and governs the establishment of medical necessity of admission, per Medicare guidelines.

If you don’t capture the acuity of the patient in the ER, there is little sense in capturing CCs/MCCs, as the entire stay will likely be denied if reviewed for validation of medical necessity by one of CMS’ various audit contractors.

Although many CDI programs focus on Medicare patients, physicians do not differentiate their documentation based on payer type. They document the same way regardless of patient. The goal of CDI should therefore be to effect positive change in documentation patterns and reinforce behavior with immediate feedback.

After reviewing the HPI, examine the history and physical (H&P) reports. For example, during a GI review in a chest pain patient, a physician might document possible anxiety or costochondritis. If the physician documents the diagnosis just one time, it creates an inviting Recovery Audit Contractor (RAC) target for denial and/or downcoding on the premise of “it only appears once in the record,” which runs contrary to official coding guidelines.

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Ask the physician to document his or her clinical impression of the patient. Request the physician to update each daily progress note with relevant information as to the status of the patient’s condition(s), as well as to the diagnoses still under active workup/management, even if each is in a “rule out” status.

As the provisional diagnoses are ruled out, ask the physician to document in his or her progress notes only those diagnoses that remain provisional and are still being considered as possible diagnoses. This materially benefits both the facility and the physician’s E/M billing.

Ask the physician to list all of the provisional diagnoses in the H&P and progress notes if they are clinically relevant to the physician’s applicable plan of care for each. Each one counts toward the number of diagnoses and management options under the medical decision-making part of the E/M code.

The physician may whittle down some diagnoses and add two or three others with plans for continued management or further workup. Ask the physician to document these diagnoses in his or her progress notes and discharge summary. This shows the acuity of the case and substantiates the reason why the patient was in the hospital.

Even though physicians can’t bill these diagnoses (they’re a rule out, and not allowed for physician E/M billing), instruct the physicians that the diagnoses help his or her physician profile and represents the appropriate use of hospital resources in the management of the patient while hospitalized.

Outcome studies are predicated upon accurate clinical documentation translated into clinically specific diagnoses as opposed to less severe symptoms, complemented by risk adjustment through reporting of other clinically relevant diagnoses that impact risk of morbidity and mortality.

Physicians need to be educated on the role of true diagnoses versus symptoms in the realms of outcomes studies and measures of physician efficiency.

To the extent the physician understands and appreciates the role of documenting provisional diagnoses in the medical record, both the hospital and the physician benefit from a business standpoint.

And the end product is the clinically relevant documentation necessary for accurate and appropriate coding.

**Increase accountability**

Some CDI specialists avoid taking a holistic approach to record review. They believe some aspects are the responsibility of other departments or staff.

“Physician billing? That’s up to his or her office staff.”

“The medical necessity of admission? That’s case management’s and utilization review/management’s problem.”

Other CDI specialists prefer CC/MCC capture rates and case-mix index measures because they are easy to calculate and can often be done with the click of a button. In contrast, how can you quantify the impact of good documentation in the H&P and HPI if you can’t run a report? Or documentation that reduces financial exposure to takebacks from the RAC?

The answer is to increase accountability for everyone who documents in the record. To do this, focus on denials, not CC/MCC capture. Perform a baseline of current denials from the RAC or other auditing agencies based on medical necessity or insufficient documentation of assessment of the patient.

Check the progress of your CDI department by monitoring denial frequency. A dip in denials could mean the holistic approach has had an overall positive effect.

A rich target for RACs are diagnoses that only appear once in the record and are not supported by clinical criteria. Many of these single CCs/MCCs are the result of a query by a CDI specialist.

For example, the examination of DRGs 190–192 by Noridian Administrative Services, LLC, is due to a spike in the recurrence of COPD with CC, MCC, or no CC/MCC (read the report at [www.noridianmedicare.com](http://www.noridianmedicare.com)). When these diagnoses are denied by the RAC based on CDI issues, the CDI specialist should accept responsibility. CFOs look at how much money goes into the bank—they’re not looking at how much is recouped. If you get credit for increasing the case mix, you ought to get credit for decreasing it, too.

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