Background/introduction

Clinical documentation improvement/integrity programs (CDIP) have been around for several years. A small percentage of hospitals implemented programs back in the 1990s and more facilities added programs in the early 2000s. The switch from the CMS DRG system, which had remained essentially unchanged since its inception in 1983, to the MS-DRG system in October 2007 translated into a surge in the development of new CDI programs. It was at this time that hospitals sought to minimize the anticipated negative financial impact of Medicare reimbursement under the revised DRG system. In 2008, when CMS announced the permanent Recovery Audit Contractor (RAC) program rollout schedule, those facilities that were still without CDI programs jumped on the CDIP bandwagon in an effort to minimize denials and recoupments based on insufficient or missing provider documentation.

The proliferation of CDI programs has grown exponentially over the past several years. According to HCPro’s January 2011 Clinical Documentation Improvement Program Survey, 79% of 708 participants responded that they have a formal CDI program in place.

Of those facilities that have a CDI program, 83% of programs have been launched within the past five years. According to the chart below, 77% of respondents indicated that revenue enhancement was their organization’s impetus for implementing a program.

Figure 1: What was your organization’s impetus for implementing a CDI program? (Check all that apply.)

Source: HCPro’s January 2011 Clinical Documentation Improvement program survey.
CDI program focus

Prior to the permanent RAC program, the majority of CDI programs were focused on obtaining documentation of those diagnoses that affected the DRG: a different principal diagnosis, a co-morbidity/complication (CC), or a major comorbidity/complication (MCC). As recently as January 2011, 54% of respondents indicated in the HCPro Clinical Documentation Improvement program survey that this is still a top priority for their reviews.

In July 2010, 72% of respondents to an Association for Clinical Documentation Improvement Specialists (ACDIS) CDI benchmarking survey concurred that this is still the priority for their reviews. As the RACs post an exponentially growing number of issues approved by CMS for investigation, the hospitals that responded to the survey are implementing changes to their CDI programs. As the chart below—which contains data from the July 2010 ACDIS CDI Benchmarking Survey—shows, 34% of CDI programs are now reporting that they are reviewing records with an eye toward RAC protection.

**Figure 2: CDI program review priorities**

Which of the following best describes your CDI program’s priority when reviewing charts?

- CC/MCC capture and DRG optimization
- Focused reviews (e.g., service lines, target DRGs)
- Overall case-mix index improvement
- Severity of illness/risk of mortality improvement
- Quality measures collection
- Other (Most who chose “Other” listed all of the above. Participants were allowed to pick more than one response.)

What additional documentation initiatives do you review and/or clarify? (Check all that apply.)

- None. We are dedicated to documentation for purposes of final code assignment.
- Utilization management/case management opportunities and core measure review
- RAC protection
- Present on admission
- Other

**Source:** July 2010 ACDIS CDI Benchmarking Survey.
RAC focus areas
The December 2010 RAC Ready Preparedness Benchmarking Report (www.revenuecycleinstitute.com, and click on “white papers”), published by HCPro’s Revenue Cycle Institute, identified the areas that facilities are focusing on as part of their RAC readiness, shown below.

Figure 3: RAC preparation focus areas

It is clear that from a RAC perspective, the majority of facilities surveyed are focusing on medical necessity and one-day stays, historically the responsibility of the utilization review committee. Yet it’s the documentation of the provider — not the clinical interpretation of the record -- that often results in denials and recoupment. So what kind of return can your CDI program guarantee in terms of RAC preparedness?

CDI and RAC readiness
Since the RACs are expanding their focus into areas other than inpatient records, it’s important to not only be aware of the approved issues, but to do some internal data mining to assess your facility’s risk in these areas. Since CDI programs have typically been focused on inpatient record reviews it’s important to identify strategies employed by your organization to identify and analyze potential problems in outpatient records, now that these are RAC targets. One suggestion for identifying those outpatient RAC targets is to visit the individual RAC contractor’s website. Some areas that may be of interest to CDI specialists are ensuring that start and stop times are documented for infusion services and that the medical diagnosis supports the medical necessity of outpatient services.

If your inpatient CDI team is performing to expectations, now is the time to provide them with the education needed to review outpatient records. The outpatient prospective payment system (OPPS) differs from the inpatient prospective payment system (IPPS), so your reviewers will need to get up to speed with outpatient coding guidelines and documentation requirements.
For example, OPPS services are billed using CPT codes and HCPCS Level II codes as compared to ICD-9 diagnosis and procedure codes with IPPS. Instead of referencing Coding Clinic (published by the AMA) for coding guidance, coders reference CPT Assistant (published by the American Medical Association). While the principles of CDI apply to both environments, the rules governing the coding and billing process are somewhat different.

If you have hospital-owned physician practices, you may want to assess whether the records support the billed evaluation and management CPT codes. Processes for record review, physician clarification, and coding turnaround times will need to be established, similar to what should already be in place for the inpatient process.

Following are five recommendations to ensure that your organization is making the most out of its CDI program.

**#1: Involve your CDI team in medical necessity reviews**

If the current focus of your CDI program is DRG optimization, then your CDI specialists probably spend little time analyzing the record for documentation that substantiates the medical necessity of the inpatient stay—a RAC issue that was implemented for many diagnoses and procedures in 2010. During the concurrent review process, many clinical documentation specialists (CDS) ask themselves why a patient is in the hospital, since the documentation and resources being used often do not appear to support inpatient services. If your utilization reviewers have no understanding of the documentation and coding requirements, you may indeed have records denied for lack of medical necessity.

A typical example is the patient who is admitted with chest pain. Two or three days go by as the physician orders and analyzes the results of the medical workup. On the day of discharge, the provider writes “chest pain due to angina versus GERD” (gastroesophageal reflux disease). Upon admission, the initial note may have read “chest pain, rule out MI” (myocardial infarction), and based on this diagnosis the patient was admitted as an inpatient. A clinician may look at the test results and treatments and determine that the angina or GERD will be assigned as the final diagnosis. However, based on coding rules, the final principal diagnosis—that which determines the DRG—will be “chest pain” (MS-DRG 313), which has been selected for both DRG validation and medical necessity reviews. This is a good example of the difference between clinical interpretation and coding interpretation. The record must be analyzed from both perspectives to minimize medical necessity denials.

If your facility is working to minimize the number of RAC medical necessity requests, have you included your CDI staff in this process? Many facilities focus on the clinical aspects of a case and overlook the fact that it’s the reported ICD-9 codes that trigger the record requests. Many hospitals have internal or external physician advisors helping them establish the medical
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Ensuring that the medical record supports medically necessary inpatient services should be an area of expertise of your CDI team. Include the CDI team in the RAC readiness process and your RAC defense will be more robust. This collaboration (utilization review, coding, CDS) will address both the clinical and the coding aspects of the medical record.

Questions to consider:
1. What is your process for analyzing the types of records being requested by the RAC? Are you able to identify any trends?
2. Is your CDI team aware of which records are being requested by your RAC?
3. How do you ensure that your CDI team is aware of the approved RAC issues?
4. Are you sharing this data with the CDI team and developing a process to target these records for additional or focused analysis?

#2: Develop a CDI—case management collaborative process

Many hospitals that implemented a CDI model combining the roles of utilization reviewer and CDS did so based on the rationale that since the case managers were already looking at the record, they might as well look at the documentation aspect. This model may be true if your reviewers are adequately trained in utilization review and/or case management, documentation improvement, and coding rules and guidelines, and are adequately staffed to handle these competing responsibilities. Facilities that implemented such blended models of case management and CDI found that documentation improvement opportunities took a backseat to utilization review and/or discharge planning priorities.

This finding is validated in a study released by The Advisory Board Company in 2010, which says that CDI professionals—who often lack the time to fulfill case management and CDI responsibilities—prioritize traditional care management tasks over concurrent chart reviews, which causes CDI to suffer accordingly.

It’s important to acknowledge the value of qualified, specialized CDSs. One situation to consider: The average fixed payment for MS-DRG 313 (chest pain), a RAC focus for both DRG validation and medical necessity, is $2,839.74 per case based on figures provided in the 2011 DRG Expert® published by Ingenix. In MLN Matters SE1027, CMS stated that claims for MS-DRG 313 were denied because the demonstration RACs determined that the documentation submitted did not support that the services provided required an inpatient level of care, and the services could have been performed in a less intensive setting. The total estimated cost of the cases...

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The cost for qualified CDI staff versus projected lost revenue makes a strong case for adequately designing and staffing your CDI team. In addition to improving the overall quality of the documentation in the medical record—which everything is based upon—an educated and fully staffed CDI team may decrease the risk of RAC denials based on inadequate documentation as mentioned above.

#3: Expand your CDI efforts into the outpatient setting
Many facilities have CDI programs whose primary focus is reviewing inpatient Medicare records. But consider that CMS has approved several outpatient issues for RAC audit, among them injection/infusion charges. Denials for these claims are due to more than one cause, but a common problem is poor or insufficient documentation. Missing or incomplete start and stop times for infusions could be corrected through a concurrent, prebill review process, thus preventing denials, downgrading of codes and/or recoupments. During the RAC three-year demonstration project, which ended in March 2008, outpatient overpayments represented 4% of the total claims, or $44 million. While this was significantly less than inpatient overpayments, which accounted for 85% of the total (or $828.3 million), the figure is significant enough to warrant ongoing audits and potential recoupments.

**Figure 4: Overpayments collected by provider type:**
Cumulative through March 2008, claim RACs only

- Inpatient hospital: $828.3 million
- Durable medical equipment: $6.3 million
- Ambulance/lab/other: $5.4 million
- Physician: $19.9 million
- Outpatient hospital: $44 million
- Inpatient rehabilitation facility: $59.7 million
- Skilled nursing facility: $16.3 million

Source: CMS: Recovery Audit Contractor (RAC) invoice files and RAC data warehouse.
Perform an analysis of the number of weekend short-stay inpatient discharges to assess staffing needs.

From a medical necessity standpoint, concurrent or prebill review of outpatient services would provide the benefit validating that the services were supported by the specific, appropriate medical diagnoses and ensure that documentation requirements are met: start and stop times for infusions, appropriate drug dosages entered, etc. Ensuring an accurate and complete outpatient record would also provide clinical support for those patients who are then admitted to an inpatient bed from the outpatient services department.

#4: Ensure that the CDi team reviews the discharged weekend short-stay records

Prior to the implementation of the permanent RAC program, many CDI consulting firms recommended that the financial return of reviewing weekend short-stay records did not justify adding additional CDI staff to provide weekend coverage. According to a staffing survey of 86 participants conducted by ACDIS in June 2010, 89% of CDI programs do not provide coverage on the weekends.

Because a number of current RAC issues that result in recoupments often occur on the weekends, it is clear that this recommendation is no longer valid. Examples of these DRGs include:

- Chest pain (313)
- Syncope (312)
- TIA (transient ischemic attack) (069)
- Dehydration/failure to thrive (640–641)
- Arrhythmias (308–310)

One approach is to augment CDI staffing to address documentation issues that concern both reimbursement and RAC issues. Perform an analysis of the number of weekend short-stay inpatient discharges to assess staffing needs.

The weekend CDS’ responsibilities might be limited to review of the new Friday and Saturday admissions and follow-up of unanswered physician queries. Close collaboration between the weekend utilization reviewer and the weekend CDS should ensure that all the weekend short-stay admissions have been reviewed for documentation and medical necessity.

An alternative approach to hiring additional staff would involve analyzing the assignments and work flow of current CDI team members to assess productivity. Many CDS spend several hours per week on data entry and non-review activities. Reassignment or realignment of responsibilities may allow the implementation of a weekend rotation staffing model.

#5: Invest in continuing education

We’ve all heard the admonition about being “penny-wise and pound-foolish.” Sadly, when it comes to providing resources for CDI programs, this is often the case. Facilities strapped for cash may be willing to invest dollars in the initial training of their CDSs (nurses and/or coders) but overlook the importance of providing their physicians and other healthcare practitioners
with not only initial, but continuing education relative to documentation needs. To the detriment of many new, “homegrown” CDI programs, CDI efforts are launched without the delivery of any provider education.

Physicians and other healthcare providers receive little or no education related to the coding and reimbursement process during their training. Since providers are ill-informed about documentation and coding requirements, it’s no wonder that their documentation—which is used for both billing and reporting—is so lacking.

Many facilities implement a CDI program only to find that their outcomes are less than they desired. It is imperative to ensure that the “owners” of the patient medical record—the healthcare providers—are adequately prepared and educated.

Prior to initiating a CDI program or expanding into another area, such as the outpatient or emergency department, all practitioners responsible for documenting in the record should receive instruction on the basics of diagnosis code assignment, medical necessity documentation, and CMS requirements. Since changing regulatory issues often require additional documentation, a continuing education plan for providers is an essential component of any successful CDI program.

Closing thoughts

CDI programs are often implemented with the goal of receiving additional DRG-based reimbursement rather than focusing on the impact that a well-staffed and well-trained CDI team can have on all areas tangential to provider documentation.

Facilities must be cognizant of the return on investment for any initiative that requires financial funding: salaries, technology, training, etc. Integrating the expertise of your CDI team into your RAC preparedness model provides additional return on investment, over and above DRG payment, since a well-documented record will provide a strong bulwark against the RAC and those other agencies charged with identifying overpayments.