Audit your CDI program to avoid pitfalls

A variety of recent resources, including online ACDIS polls and the 2010 *Physician Query Benchmarking Report*, seem to indicate a lack of CDI program auditing and monitoring. Of course, there is a large variation in program design, structure, size, and resources, but although differences between CDI programs exist, there are enough similarities to provide a foundation for regular evaluation. Every CDI program should objectively evaluate the outcomes, processes, and compliance of their CDI efforts.

The following white paper will examine some basic auditing principles and review specific elements CDI programs should monitor.

**Establishing policies and procedures**

To ensure consistent CDI practices across staff members and over time, facilities should establish policies and procedures for their program. Doing so is a vital preliminary step. How can you assess whether staff members understand how to deliver a compliant query if your facility has not defined or communicated what that process entails?

AHIMA’s 2008 practice brief *Managing an Effective Query Process* and its 2010 *Guidance for Clinical Documentation Improvement Programs* call for facilities to establish a uniform physician query policy. But only 75% of respondents to ACDIS’ 2010 *Physician Query Benchmarking Report* said they either fully or partially follow AHIMA’s recommendations, and 12% of respondents admitted to not being familiar with these documents at all.

AHIMA’s *Guidance for Clinical Documentation Improvement Programs* contains several references to the importance of policies, procedures, and review processes. It states that such policies can help delineate the processes for:

- Query quality assurance
- CDI clarification
- When and how to format an appropriate physician query
- Conducting audit and monitoring activities

While AHIMA guidance encourages facilities to use a standard query policy for both written and verbal queries regardless of which professional performs the query, 7% of the 2010 *Physician Query Benchmarking Report* respondents said they have separate query policies for CDI specialists and HIM staff, 67% have a policy for written queries, and 39% have a policy for verbal queries.
Although AHIMA guidance is not considered regulatory in nature, AHIMA is one of the four cooperating parties, along with CMS, the AHA, and the National Center for Healthcare Statistics. As such, many CMS contractors look to AHIMA publications when performing medical record examinations for audits. CDI programs should, too. All these various industry guidance points to getting your CDI program’s policies and procedures in place.

**Auditing trends in CDI**

Auditing and monitoring provides oversight for the CDI program, insight into physician documentation and collaboration, and objective evaluation of the performance and effectiveness of individual CDI staff members as measured against your facility’s policies and priorities.

AHIMA’s 2010 *CDI Toolkit*, several books from ACDIS, and the AHIMA query practice briefs include recommendations for auditing and monitoring practices. For example, AHIMA’s *Managing an Effective Query Process* states:

*Healthcare entities should consider establishing an auditing and monitoring program as a means to improve their query processes.*

Let’s review the current state of practice as revealed in a selection of ACDIS polls. When ACDIS members were asked in July 2009 who performs their query audits, 35% of respondents said they do not perform audits. (See Figure 1 below.)

**Figure 1: Who do you use to perform quality audits on your CDI staff?**

Source: ACDIS weekly poll, July 20, 2009.
Further, in an ACDIS weekly poll conducted June 28, 2010, 52% of respondents indicated they do not audit queries for compliance. (See Figure 2 on p. 5.) And in a February 2010 poll, 36% said they do not audit queries for compliance, effectiveness, and completeness. (See Figure 3 on p. 8.)

As Figures 2 and 3 illustrate, 50% of respondents don’t have any sort of audit structure. Figure 2 shows that only 26% have a consistent process in place (20% review all queries and 6% have an outside auditor).

The 2010 Physician Query Benchmarking Report presented several questions that provide further insight on the auditing and monitoring practices of the CDI community. According to the survey:

- 30% don’t monitor queries for quality
- 12% don’t review/audit query forms for compliance
- 28% review queries “as needed”

Everyone occasionally falls into a pattern of reviewing at random (i.e., when they have time). Many of us have CDI program auditing somewhere on our to-do list. But this kind of prioritization gives no assurance that all CDI specialists are reviewed equally because there is no structure to reviews that are done randomly.

**Examining outside oversight**

A variety of sources—benchmarking surveys, anecdotal information, conference materials, and CDI Journal articles—illustrate differing opinions on best practices for physician queries. This is particularly true among consulting firms; each firm subscribe to its own philosophy and corporate mission but must also meet the contractual obligations set for it by the hiring organization.

Facilities which rely too heavily on consultants (or those who rely on consultants without overseeing their methods) may find their programs under government scrutiny. As the adage goes, “Ignorance of the law is no excuse.” If inappropriate practices and inaccurate data are promulgated, it is the facility’s responsibility to investigate the processes that led to the inaccuracies and to apply corrective actions.

If a facility employs a consulting firm or other external source to audit data, it is incumbent on the facility leadership to know where that firm’s priorities and philosophies fall. Having consultants oversight that are either too aggressive or too conservative may be worse than having no oversight at all.

Some CDI programs are much more aggressive than others in terms of obtaining a financial return on investment; others are, no doubt, overly conservative. These varying approaches constitute yet another reason for CDI programs to develop an internal audit plan and maintain their own
monitoring system because your program’s approach may not match those of external auditors. After all you know your own program best.

**Defining audit elements and creating audit tools**

An important part of devising an audit process is determining what elements to examine. I recommend constructing a checklist with a series of yes/no/not applicable options attached to each element. Each element should be based on an understandable concrete definition and should not solicit opinion; in other words, the elements need to be as objective as possible.

Ideally, this checklist will provide a method of data collection, standardize the audit, and create an objective foundation based on guiding documents. If constructed properly, the findings of the audits can be aggregated, analyzed, and compared over time. (ACDIS members can find sample audit tools online in the Forms & Tools Library.)

While such formalized reviews may have stronger statistical validity, many CDI programs struggle to maintain them over the long term. Be pragmatic about time and resource availability. An audit program needs to be effective and simple to maintain, and the entire audit cycle (review and data collection, data analysis, results reporting, and action planning) must only require a modest amount of time and energy.

**Mapping audit steps**

Auditing methods are primarily data collection techniques. For CDI programs, this means evaluating the way your facility drafts, delivers, and responds to its queries against available industry guidance. Results of auditing activity can also be used to:

- Identify a program’s strengths and weaknesses
- Illustrate program successes to facility administrators
- Provide insight into educational opportunities for coders, CDI staff, and physicians

No matter which issues you intend to address, define the focus of your audit and outline the questions and tasks associated with it. You may decide to do this by posing the audit focus as a hypothesis. For example: *CDI staff members consistently use clinical indicators from the patient chart as reference points in their physician queries.*

You can also frame your audit as a question you want to answer. For example: *Do our surgeons understand the importance of documenting expected complications?*

Additionally, consider adding audit hypotheses as either your program or the broader CDI landscape changes. The purpose of this is to help you define your audit to find out whether a hypothesis can be proven or a question answered.
Next, you’ll need to select sources for your data. As with a research study, auditing establishes precise means to collect and analyze data; these data will test your hypothesis or answer your question. In the example audit frameworks above, the data would come from a review of physician queries.

You will also need to decide which queries to review and how you will track your analysis. In many situations a simple Excel® spreadsheet can do the trick, although many facilities rely on electronic query systems or vendors to supply the raw data.

To create a statistically valid audit, you’ll need to pull a reasonably wide selection of queries to review. For example, to figure out how frequently clinical indicators are used on queries, pull five charts from each staff member.

Based on ACDIS benchmarking surveys, a monthly volume of 150–250 new cases and a query rate of 20% provide 30–50 queried cases. If a 10% random review rate is established as a goal, then five cases per CDI specialist per month should represent a reasonable audit plan.

You may decide to choose five queries from five cases or days at random. This protects your review and the staff member from the risk that an
outlier event (e.g., an unexpected illness or ill temper) will skew overall findings.

To illustrate the above approach, let’s assume we have a CDI department with five staff members. Out of the 25 charts pulled (five charts for each staff member), 10 queries (less than half) include clinical indicators. Upon examination, let’s assume those 10 queries came from two staff members—five from one and five from the other.

Clearly, these two specialists understand the importance of including clinical indicators in their queries; the remaining staff members could probably use additional training. Armed with this information, the CDI manager may decide to acknowledge the efforts of the staff members who included clinical indicators by inviting them to develop a training program for the others, asking them to perform future audits, or seeking their help with annual reviews of query templates for compliance. Conversely, if the audit results illustrate that all 10 queries including clinical indicators came from the same individual, the CDI manager may need to provide additional training for the entire team.

However the audit turns out, once the CDI manager has results in hand, he or she should provide recommendations for corrective actions. The manager should also provide a timeline for corrective action and follow-up reviews/audits to ensure appropriate progress toward program goals.

Auditing responsibility
Auditing and monitoring need not be a strictly managerial task. The individual responsible for conducting audits may be a CDI specialist, CDI manager, HIM manager, compliance officer, coding auditor, physician advisor, or external consultant. Decisions regarding who performs audits should include several considerations. At a minimum, however, the individual performing the audit should:

- Have a strong understanding of AHIMA guidelines
- Appreciate the realities of CDI practices
- Exhibit a solid understanding of clinical and coding guidelines
- Be objective and impartial

Involving CDI staff members in the process will not only help avoid any potential claims of unfair practices, but should also help elicit support for any actions the results require. Further, it reassures staff members that the organization is there to help them advance their own careers as well as the efforts of the CDI program.

Query compliance audits
At a minimum, CDI programs should be audited for compliance with published query guidelines. In its various recommendations, AHIMA suggests queries may be submitted to a physician for:
- Clinical indicators of a diagnosis but no documentation of the condition
- Clinical evidence for a higher degree of specificity or severity
- A cause-and-effect relationship between two conditions or organisms
- An underlying cause when admitted with symptoms
- A treatment documented without a diagnosis
- Present-on-admission (POA) indicator status
- Conflicting, ambiguous, or incomplete information regarding any significant reportable condition or procedure
- Legibility, completeness, clarity, consistency, or precision

Therefore, consider auditing your queries for evidence of the following:
- Unnecessary queries
- Leading queries
- Timeliness
- Poor choice of wording/clarity
- Missed query opportunities
- Noncompliance with query standards (AHIMA or internal policies and procedures)
- Inclusion of clinical indicators
- Inaccurate information on the query form
- Appropriateness/application of working DRG
- Adequacy of re-reviews

When auditing, track the reason for query submission against AHIMA’s list. In this manner, you will be able to identify both program and individual trends. For example, you may find that a particular CDI specialist tends to query only on cases where an underlying cause is not documented and never seems to catch POA indicators.

Financial impact monitoring
Many programs monitor elements related to DRG assignments and financial impact, often more frequently than they monitor for quality and compliance. According to the 2010 Physician Query Benchmarking Survey, respondents tracked the following financial-related elements (definitions added are what I believe to be common usage):
- Final DRG—the last DRG assigned by the CDI specialist, usually at discharge, which incorporates CDI interventions (76%)
- Financial impact of query (73%)
- Initial DRG—the DRG that the CDI specialist determines is supported by existing documentation without any CDI intervention (63%)
- CDI/coder DRG agreement—many programs have a reconciliation process when the CDI specialist expectation does not agree with the coding DRG; (58%)
- Potential DRG—the DRG that would be supported if the medical provider supplies the requested additional documentation (57%)
Working DRG—the DRG supported by documentation at the time of CDI specialist review; this may or may not include the influence of CDI intervention (51%)

Although these elements are important for monitoring your program’s return on investment, they offer limited value in terms of tracking individual staff effectiveness and overall program performance. So be sure to track these items, but do not do so in a vacuum. Everything, including auditing and monitoring, has its context.

Evaluating staff performance
In addition to conducting audits for compliance and financial effectiveness, a CDI program should audit as a means to reasonably evaluate CDI specialists’ performance. According to the 2010 Physician Query Benchmarking Survey, programs audit queries for:

- Physician agreement (84%)
- Percentage of positive and negative query responses (75%)
- Origin of queries (71%)
- Rate of queries from individual CDI specialists (70%)
- Focus of queries (CC/MCC, principal diagnosis, procedure, SOI/ROM, etc.) (64%)
- Rate of queries to individual physicians (58%)
- Method of queries (verbal or written) (58%)
These survey results do not indicate whether this data is analyzed by individual physician and/or by service line or department—which is very valuable information to aid education and outreach collaborative efforts.

It seems more common for CDI programs to monitor for process elements, such as physician response or possible DRG. This points to a need for more robust auditing and monitoring of a variety of elements, with focus on improving outcomes, fashioning compliant queries, and capturing appropriate documentation in the medical record.

Auditing templates
Once you have developed your list of audit target areas, consider creating an annual schedule for auditing/monitoring tasks. This can help alleviate the administrative burden, as can the involvement of other CDI staff.

For example, consider scheduling an annual audit of standard query templates every October. The 2010 Physician Query Benchmarking Survey shows that 67% of respondents always or frequently use templates, with an additional 16% saying they occasionally use templates. However, only 52% audit query templates at least yearly; 28% review them as needed, and 12% do not review them at all.

Auditing templates is needed for several reasons. The first and most obvious reason is to determine whether their use is compliant with your facility policy. In addition, as coding guidelines and medical science change and as lessons from external auditing sources accumulate, your templates must be updated.

Consider assigning an HIM professional and CDI specialist to review the query templates against new or deleted coding guidance and changes to the inpatient prospective payment system. Next, have staff review any questionable templates with the program’s physician advisor. If no physician advisor exists, have them review each form with the most appropriate medical staff members.

Risks of not auditing
CDI programs can have a large influence on the patterns of provider documentation and coding practices. They have the potential to increase understanding and communication between coding and clinical professionals, but they also have the potential to present misinformation.

Because of this, CDI programs without solid footing may present significant risks to healthcare organizations. These risks include:

- Influence from aggressive outside entities, resources, personalities, or other factors, may lead to increasingly noncompliant practices.
- Changing coding guidance, medical science, or CDI practice standards that may not be incorporated into daily practice or query
templates. This can cause activities to be ineffective (at best), counterproductive, or noncompliant (at worst).

- Overly enthusiastic providers may simply agree to every CDI specialist query, which could result in clinically unsupported documentation. Such claims, when filed, will likely be denied by payers at best and could possibly trigger a detailed audit or investigation, at worst.

**Excuses for lack of monitoring**

So why have CDI programs not fully instituted careful auditing and monitoring practices?

Over time, CDI managers may move to other positions, CDI best practices may be forgotten, new consultants may offer alternative perspectives, and financial pressures may be brought to bear on CDI program priorities. All this makes it difficult to maintain a consistent set of program priorities.

But—as if the above factors aren’t enough—consider also that most CDI programs employ nurses or nurses who may or may not have case management backgrounds (66% of respondents indicated they employ staff with such backgrounds according to the July 2010 CDI Program Benchmarking Survey). Further, most programs have staffs of one to four people and are one to four years old, also according to the survey.

Imagine, then, a series of fledgling, potentially understaffed programs, operated by nurses with limited experience in CDI efforts, coding rules and regulations, or auditing techniques. Focused primarily on physician education and the day-to-day act of querying, how would these programs begin to craft an audit process on their own?

**Auditing importance**

We, as a profession, need to establish policies and procedures as well as auditing and monitoring systems that adhere to available guidelines—and we need to accomplish this task soon.

I’d like to especially challenge all of us with management responsibilities to change the poll results shown in this white paper over the next year. Can we aim to raise the frequency of auditing practices from 70% (or less) to 95%? I think we can, and I think we should.

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