CDI collaboration with CM/UR evolves
Programs find additional opportunities to work together

While the majority of CDI programs report to the director of HIM, a good number (27%, according to the 2010 CDI Program Benchmarking Report) fall under the supervision of the director of case management (CM). CDI programs that report to CM face a number of challenges but may also take advantage of the multiple opportunities such structures present, says Joann Agin, RHIT, regional director of data quality for Carondelet Health, St. Joseph Medical Center, in Kansas City, MO, and St. Mary's Medical Center, in Blue Springs, MO.

Defining roles

Before CDI became a profession in its own right, concurrent documentation improvement duties often fell onto the CM or utilization review (UR) team's to-do list. “These [fledgling CDI] programs started with great initiatives and enthusiasm but splitting the days between different job functions led to many program failures,” says Gail B. Marini, MM, RN, CCS, LNC, CDI manager at South Shore Hospital in Weymouth, MA.

When Agin began working in CDI, her job description included UR tasks. These efforts quickly eroded the priority of other duties, she says. “I'd be hesitant to have anyone who is performing CDI activities to also have case management or utilization on their task lists too,” she says.

UR and CM staff discussions with physicians are very different from those initiated by CDI specialists. UR focuses on patient status (whether a patient's condition requires inpatient, outpatient, or observation care) and whether a patient's condition meets medical necessity for inpatient admission. CM, meanwhile, typically worries about the opposite end of the spectrum: family requests, insurance phone calls, and discharge planning.

The CM team also needs to know how a particular patient's SOI/ROM, length of stay (LOS) and when the patient will be ready for discharge or transfer to another facility (geometric LOS [GMLOS]), Marini says.

While appropriate documentation of the diagnosis affects the decisions UR and CM staff make, CDI staff typically focus on the
documentation of care provided within the hospital walls and how that documentation ends up being represented by ICD-9 codes and MS-DRG assignment.

“It can be very cumbersome for case managers to try to take on CDI efforts,” says Marini. “It is easy for them to get pulled into matters of patient care. One second you would be asking [the physician about] the type of pneumonia listed in the documentation, and then you’d be talking about discharge planning.”

Today, few CDI or CM staff find themselves in the predicament of dual roles. According to the 2010 CDI Program Benchmarking Report, only 1% of respondents now seem to integrate CM responsibilities with CDI duties.

Instead, those CDI programs reporting to CM have more clearly defined CDI roles and a program structure that’s separate from those of CM or UR. For example, while Marini started as a CDI project manager under CM, the CDI program eventually moved out onto its own. It now falls under the chief finance officer, whereas CM reports to the vice president of nursing.

### Exploring opportunities

Some facilities have found ways to synergize the efforts of CDI and CM/UR. For example, the two-member CDI team at 660-bed Medical City Dallas Hospital reports to CM. There, the CM director holds a medical necessity meeting every other week to discuss issues where “CDI folks are out front and center,” says Beverly Cunningham, MS, RN, vice president of clinical performance improvement at the facility.

Cunningham’s CM team all subscribe to the e-newsletter CDI Strategies—“not so they will become experts in CDI,” she says, “but so they will be aware of items to watch for in terms of documentation improvement.”

Certain documentation requirements simply do not make sense to CM staff from a clinical perspective, notes Cunningham. “If the CDI specialists can help the case managers understand the role of documentation improvement, then [in turn case managers] can underscore the importance of CDI in their interactions with other clinicians.”

Cunningham suggests that CDI programs tailor special
education sessions for the CM team by taking the top five DRGs at the facility and walking CM through the various documentation requirements. “I don’t want my case managers to be CDI specialists or coders,” she says. “But we do all need to work together.”

For example, when looking at postoperative complication rates, Cunningham’s team discovered that rates were higher at one facility than at all the others. She gathered CM, CDI, and quality teams together to explore different scenarios and determine the root cause of the discrepancy. The group identified a particular standing order for IV fluids as the problem, got the orders changed appropriately, and kept the different departments on alert to catch any continuation of the problem. “The turnaround on this was really amazing,” Cunningham says.

Integrating UR in CDI efforts

Likewise, the CDI staff at Carondelet Health’s St. Mary’s Medical Center is invited to the CM/UR team meetings, says Agin. Monday through Friday her CDI team reviews Medicare admissions and assigns a working DRG, which is handed to the UR staff.

Marini sits on the UR committee as well. “There are plenty of questions that come up that I can help explain,” she says. For example, documentation of symptom DRGs may not support an inpatient admission. “If you have an observation patient that changed to inpatient status, having the diagnostic reason in the chart as to why that decision was made will clarify the reason for the admission and more accurately represent the medical needs of the patient,” Marini says.

Identifying the DRG/LOS connection

At South Shore Hospital, all the CDI specialists start their day at 4:30 a.m. Each team member looks at more than 25 charts per day, Marini says—generally before the time when most physicians do their rounds. That way the CDI specialists have an opportunity to read through the chart and understand the admission before they speak with the physician about a query or outstanding issue.

“In a hospital with community physicians, it can be very time consuming to page, text, or phone physicians once they return to the office,” Marini says.

Because Marini and her team share the working DRG with physicians and CM, the complexity of care and length of stay (LOS) become shared information. For example, when a physician admits a patient for a urinary infection the working DRG is 690, kidney and urinary tract infections without MCC, which has a GMLOS of 3.5. However, the patient has been in the hospital for six days. In this case, the LOS becomes a possible indicator that the patient’s illness may be more than a simple UTI. Although this is only a working DRG, it is another piece of information which can reflect SOI/ROM in acute care, says Marini.

“This can be a difficult area for people who do not understand how the DRG reflects resource use and expected LOS,” says Marini. In such situations, CDI staff can provide education on broader concerns related to LOS.

“Sometimes,” says Agin, “case management can exist in a bubble.” She recalls one CM program which used an average LOS for all its patients regardless of an individual’s principal diagnosis. “That’s flawed thinking and causes inaccuracies,” she says. “Facilities should try to open communication between CM and CDI to raise awareness about areas of overlap. Are they curious about what changes the DRG and how the DRG affects LOS? If they aren’t, they should be.”

Ann Giuli, BSN, MPH, CCDS, CDI specialist at the 305-bed Stamford (CT) Hospital, has worked under CM for the past four years. The director of CM supervises the facility’s CDI, CM, social work, and UR teams. No matter where the CDI program falls in the reporting structure, the roles and responsibilities of the staff must be well defined, Giuli says.

Although most experts agree that CDI, CM, and UR have distinctive roles to play in patient care as well as in meeting medical necessity and coding requirements, there is plenty of room for collaboration.

“CDI is connected to all these other roles,” says Marini. “It is like a Tiffany window; we are each a different part of this beautiful thing.”

Editor’s Note: Read a case study about how CDI efforts improve LOS in the article “The Problem List Project: Managing Post Acute Care Transfer DRGs,” by Michele D. Johnson, RN, BSN, documentation specialist supervisor at Wellspan Health in York, PA, on the ACDIS Blog and download a patient problem list from the ACDIS Forms & Tools Library.
First CDI Week was one for the record books

By the time you’re reading this note, the first-ever Clinical Documentation Improvement Week will be in the record books. I hope you made the most of it.

Almost since the start of ACDIS back on October 1, 2007, our members have been asking (“clamoring” might be a better word) for a week to recognize this unique profession. CDI is not an HIM/coding function, nor is it a profession exclusive to nurses. So very early on, a committee of dedicated volunteers (see list on right) decided that ACDIS needed to develop its own week to help get the word out and to properly recognize the efforts of these hard-working professionals. The committee also decided that we needed ideas and resources to help people celebrate.

Their efforts resulted in a date and a name, a logo, a list of suggested activities, sample PowerPoint™ training tools, a poster, and CDI Week— and ACDIS-branded items. The volunteers also reached out to other associations and news publications to spread the word.

I'd like to give special thanks to Wendy De Vreugd, whose Kindred Healthcare colleagues went the extra mile in producing a high-quality video that preaches the value of CDI to physicians, the profession's indispensable partners in ensuring accurate and complete documentation in the medical record.

CDI Week is not a one-time special event. We’re going to do this every year on the third week of September. Our committee identified this time as the peak season, right before new education begins on changes and updates to MS-DRGs and the inpatient prospective payment system.

Please note that we now have ACDIS and CDI Week items for sale year-round. They're a great way to remember the week, to boost morale at a team meeting, to use as door prizes for a local chapter gathering, or to buy now and set aside for next year. You can find them at www.hcpro.com/acdispromos.

The first CDI Week may be over, but the days of recognizing this unique, vital profession are just beginning. I’m already looking forward to next September!

The 2011 CDI Week committee:
» Donald Butler
» Reta Caputo
» Wendy De Vreugd
» Jolene File
» Glenda Hebert
» Eileen Hickey
» Glenn Krauss
» Adelaide La Rosa
» Thenia Nesbeth-Blades
» Colleen Stukenberg

Take care,

Brian J Murphy, CPC
bmurphy@cdiassociation.com
781/639-1872, Ext. 3216
Body Mass Index and malnutrition: Interrelated comorbidities

by Richard D. Pinson, MD, FACP, CCS

Documentation of both malnutrition and body mass index (BMI) affects MS-DRGs’ assignment as CCs or MCCs and can clarify the patient’s SOI as well as the complexity of care required to treat him or her. Understanding the interrelationship between BMI and malnutrition as well as the clinical criteria and coding rules applicable to both of these concepts is a fundamental skill for CDI specialists to master.

Defining BMI

Except for extremely muscular individuals, BMI is a relatively accurate measure of an individual’s body fat content. The higher a person’s BMI, the greater the health risks. For example, conditions such as diabetes, hypertension, cardiovascular disease, and increased cancer risk are directly related to the degree of obesity as measured by BMI. Conversely, low BMI (less than 19 kilograms per square meter [kg/m²]) is also associated with increased morbidity and mortality; the lower the BMI, the greater the risk.

BMI is calculated using a person’s height and weight and the following equation: BMI = (weight in pounds) ÷ 2.2 = kg/m² [height in inches ÷ 39.6]².

BMI as significant comorbidity

For inpatient coding purposes, a BMI less than 19 (V85.0) or greater than or equal to 40 (V85.4X) is considered a significant comorbidity which may contribute to SOI and impact DRG assignment. To qualify for code assignment, the BMI must be documented in the medical record by the physician, or by a clinician (e.g., a nutritionist or nurse).

There must also be a clinical diagnosis or condition documented by the physician that corresponds to the abnormal BMI and thereby explains its significance, according to AHA Coding Clinic for ICD-9-CM, Second Quarter 2010, p. 15, and Fourth Quarter 2008, p. 191. A nutrition note may be the only place in the medical record where BMI is documented, and it may also provide clues to the underlying condition. Certainly, the presence of a nutrition note implies that an underlying condition is likely present.

Electronic medical records typically offer an excellent opportunity for documenting BMI. Electronic records automatically populate the BMI as calculated from the

Malnutrition query opportunity

Editor’s Note: The following physician query scenario and sample was provided by Richard D. Pinson, MD, FACP, CCS.

Mr. Smith is a 72-year-old male with esophageal cancer who is admitted for aspiration pneumonia. The documentation includes the following:

» Nutrition consult indicates a body mass index (BMI) of 15.9 and weight loss of 25 pounds in the last three months

» Lab shows albumin = 1.8, prealbumin = 4.7, and hemoglobin = 9.0

» Physical exam notes temporal wasting and muscle atrophy

» GI consult ordered for possible PEG tube

What are the query opportunities in this case?

Answer: A BMI less than 19 qualifies as a CC if there is an associated condition documented that makes it clinically significant. Esophageal cancer may qualify, but Mr. Smith has multiple clinical criteria for severe malnutrition, which would be an MCC.

Sample query to Dr. Jones

Dear Dr. Jones,

Mr. Smith was admitted with esophageal cancer and aspiration pneumonia. Other information in the medical record indicates that he has a BMI of 15.9, weight loss of 25 pounds, albumin 1.8, prealbumin 4.7, temporal wasting, muscle atrophy, and may need a PEG tube.

Based on your professional judgment, can you further clarify in the progress notes the clinical significance or condition that these findings represent, if any, and its severity?
patient’s height and weight—especially if the BMI is incorporated into the provider’s history and physical.

**Abnormal BMI-associated conditions**

While the clinical definition of morbid obesity is a BMI greater than or equal to 40, documentation of “obesity,” “overweight,” or similar terms should suffice. For a BMI less than 19, a diagnosis such as “malnutrition,” “underweight,” or “nutritional risk” should do, especially if the physician requests a nutrition consult. The conditions typically associated with specific BMI ranges are listed in the table below titled “Clinical descriptions associated with BMI.”

Conditions such as obesity, morbid obesity, overweight, and underweight are not classified as CCs themselves—typically because they are often used subjectively by clinicians in contrast to the more specific BMI calculation.

**Malnutrition**

Although BMI is a clean, precise mathematical calculation, the concept of malnutrition is inexact and somewhat subjective. First, there are no authoritative definitions of malnutrition or the severity of malnutrition, although some are expected soon from the American Dietetic Association. Furthermore, the diagnosis of malnutrition is a complicated, multifactorial clinical determination (see the table titled “General classification of malnutrition” at right) that requires more than simply finding a low albumin or prealbumin. Malnutrition includes such criteria as:

- Physical findings like emaciation, cachexia or muscle/adipose wasting, or atrophy (e.g., temporal wasting, thenar atrophy)
- Presence of risk factors such as cancer, chemotherapy, AIDS, alcoholism, end-stage disease, malabsorption syndromes, or other gastrointestinal and pancreatic disorders
- Biochemical markers including low albumin, prealbumin, cholesterol, transferrin, blood urea nitrogen/creatinine ratio, and/or anemia
- Recent or progressive weight loss, low body weight, or low BMI

The ultimate diagnosis of malnutrition and its severity depends upon the physician's clinical judgment based on a constellation of the above findings in each individual case. No particular finding is required or definitive.

As summarized in the “General classification of malnutrition” table, the severity of malnutrition should be classified as mild (code 263.1), moderate (code 263.0), or severe (codes 260, 261, 262). Therefore, “unspecified” malnutrition (263.9) really has no clinical meaning, but it is a coding convention used when the severity of malnutrition has not been documented by a provider.

For MS-DRGs, severe malnutrition is considered an MCC that contributes to a higher SOI. It’s interesting to note that coding rules consider the term “emaciation” to be severe malnutrition (code 261)—an MCC. However, the term “cachexia” (code 799.4) is only a CC, even though physicians sometimes document emaciation and cachexia interchangeably.

If the provider documents cachexia, it may be worth a query to determine if the true condition is emaciation or severe malnutrition, as long as the appropriate criteria are present. Malnutrition, unspecified (code 263.9) is classified as a CC, while malnutrition specified as mild or moderate is neither a CC nor an MCC.

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<tr>
<th>Clinical descriptions associated with BMI</th>
<th>BMI</th>
<th>Associated condition</th>
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<tr>
<td>40–40</td>
<td>Morbid obesity</td>
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<tr>
<td>30–40</td>
<td>Obesity</td>
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<td>25–30</td>
<td>Overweight</td>
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<td>19–25</td>
<td>Normal</td>
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<td>&lt; 19</td>
<td>Underweight/malnutrition</td>
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<tr>
<th>General classification of malnutrition*</th>
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<tr>
<td><strong>Criteria</strong></td>
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<tr>
<td>Albumin (gm/dl)</td>
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<tr>
<td>Prealbumin (mg/dl)</td>
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<td>Ideal body weight (IBW)</td>
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<td>Usual body weight (UBW)</td>
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<td>BMI (kg/m²)</td>
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*The diagnosis of malnutrition is multifactorial and includes other clinical criteria. Ultimately it is based on a provider’s professional judgment. No particular finding is required or definitive.
**Marasmus and kwashiorkor**

The exotic terms marasmus (code 261) and kwashiorkor (code 260) have been used for almost a century to describe two distinct clinical manifestations of severe malnutrition in children living in underdeveloped countries.

The term “kwashiorkor” was first used in 1933 by Dr. Cicely Williams to describe severe protein deficiency with some degree of preserved caloric (carbohydrate) intake among children in Africa. The most striking and characteristic finding is severe edema associated with malnutrition. Other symptoms include retarded growth, changes in skin and hair pigment, immune deficiency, and pathologic changes in the liver. Kwashiorkor was never meant to apply to adults, and such severe protein deficiency alone is an extremely rare condition in America.

The word “marasmus” has more ancient origins, coming into use during the mid-17th century and derived from Greek and Latin words meaning “to wither or waste away.” Since that time, marasmus has been commonly used to describe severe malnutrition or starvation. Only more recently did it become specifically associated with severe childhood protein-calorie malnutrition without edema—in contrast to kwashiorkor, where protein deficiency and edema are hallmarks of the disease.

While kwashiorkor and marasmus continue to capture academic interest and still have pertinence in describing childhood malnutrition in underdeveloped regions of the world, these terms have no clinical application to malnourished adults in America. Seeing either of these conditions in American children would likewise be a most unusual event indeed. The classification of malnutrition as severe, moderate, and mild is a much more appropriate and scientific approach for healthcare in America and other developed nations.

**Obesity as malnutrition?**

Defining obesity as a form of malnutrition is an area of great controversy, with vocal adherents on both sides. Certainly, the word “malnutrition” in its broad, literal sense of “bad” (“mal-”) nutrition could be applied to obesity. On the other hand, the historical context and clinical application of the term has always implied “undernourishment.” In either case, even obese patients can be malnourished (based on the criteria discussed above) if they become severely ill.

**Summary**

In summary, if a patient has an abnormal BMI less than 19 kg/m² or greater than or equal to 40 kg/m², a CDI specialist should ensure that the patient’s BMI is documented in the medical record as well as the clinical condition associated with it. Both of these are assigned as CCs under MS-DRGs.

The recognition of malnutrition and its severity is crucial for proper patient management. It should be classified as mild, moderate, or severe. Diagnosis requires the provider to consider multiple clinical variables.

Since there are currently no authoritative guidelines, each hospital should develop its own multidisciplinary criteria for malnutrition (and its severity) to be used by nutritionists, physicians, and other clinical staff. Such institutional criteria will support the correct and compliant coding of malnutrition.

*Editor’s Note: Dr. Pinson is a principal of HCQ Consulting, which specializes in CDI program implementation, restructuring, and education of physicians, documentation specialists, and coders. He is coauthor, with Cynthia L. Tang, RHIA, CCS, of The 2012 CDI Pocket Guide, published by HCPro. The content of this article is adapted with permission from HCQ Consulting.*

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**The 2012 CDI Pocket Guide**

Richard D. Pinson, MD, FACP, CCS, and Cynthia L. Tang, RHIA, CCS, created this 200-plus page pocket manual to help CDI and coding professionals focus on the most common high-volume, high-yield opportunities to improve clinical documentation, coding, and DRG assignment. The 2012 CDI Pocket Guide helps you take clinical findings, dig deeper, and look for additional details—such as medications and other factors—to develop the most accurate picture of the patient’s condition.

To purchase a copy for yourself and your staff, call toll-free 800/650-6787 or e-mail customerservice@hcpro.com.
It did not take Bonnie I. Epps, MN, RN, manager of the CDI department at Emory Healthcare, Inc., in Atlanta, long to realize that staff physicians were not quite chomping at the bit to answer her team’s queries. To raise awareness, she quickly created a multifaceted educational approach and launched an action plan for CDI outreach efforts.

As teachers head back to school this September, they worry about how to keep their students interested and engaged. Although physicians are far from high school students, a few tried-and-true methods used in secondary education may help when offering CDI education.

**Online efforts offer education options**

Since Emory is a teaching hospital, Epps has the luxury of catching physicians early before they begin their residencies. Although it took some time to secure necessary approval and develop the material, each new Emory resident now must pass an online course on CDI fundamentals prior to his or her start date. The course offers examples of different forms of required physician documentation, including the history and physical (H&P), the progress note, the discharge note, and so forth.

Those who have worked in healthcare for some time may think these items are common knowledge for physicians, but Epps says most new physicians “know little about documentation in the beginning. Maybe they have learned that they need to write a H&P and that they need to write a discharge note, but that is as far as it goes. For many physicians this course can be an eye-opener.”

The roughly hour-and-a-half computer session not only covers documentation requirements and information about the roles and responsibilities of the CDI staff, it also includes basic information about CMS and the government’s various payment methods. It explains how coders interpret physician documentation notes and translate them into codes, and it explores the various ways different agencies manipulate coded healthcare data for quality, reimbursement, and other purposes.

Where appropriate, Epps highlights Emory’s own specific policies and procedures regarding these larger documentation concerns.

“Essentially, the course explains why their documentation is important for both business and quality purposes,” says Epps. “We tell them what resources are available to help the residents with their documentation needs and discuss the CDI process. With this course in place, the residents come into the facility with at least a basic familiarity of CDI and its role.”

It works, she says, because residents already take similar courses on infection control, blood borne pathogens, and safety. Other modules include concepts such present on admission, core measures, and hospital-acquired conditions.

When Epps presented information about her program’s online education effort during the ACDIS 2011 Conference poster session in April in Orlando, she thought her idea would appeal primarily to those who also work in teaching facilities.

“I thought that without the ‘stick’ of the grade book behind it that programs would have a difficult time getting their physicians interested. But I received a number of calls from people who were interested in hearing more about the idea. Now I really do think this is something that other programs could incorporate into their training,” she says.

**Variations on a theme aid training**

At the 325-bed St. Francis Hospital in Roslyn, NY, physicians receive a blitz of CDI education every fall, just before the new ICD-9 codes and IPPS rules take effect, says Adelaide M. La Rosa, RN, BSN, CCDS, CDI director at St. Francis Hospital in Roslyn, NY, and her CDI team host a daylong educational conference for more than 500 facility-affiliated physicians every fall.

“To make it more engaging, we include a lot of hands-on activities and group discussions,” says La Rosa. “It’s an intensive one-day course designed to help physicians understand the basics of CDI.”

The session touches on topics such as documentation, coding, and reimbursement, but it’s all in a package that’s hard to ignore. La Rosa says her team’s approach is building on the success of previous efforts to educate physicians about CDI.

“We’re seeing more and more of our physicians coming to us with questions,” she says. “They’re realizing that CDI is a natural fit for their work.”
Adelaide M. La Rosa, RN, BSN, CCDS, CDI director at the facility.

La Rosa and her 18-member CDI team hosts an educational conference for more than 500 facility-affiliated physicians. The meeting is mandatory; physicians receive an invitation in the mail from the facility chief medical officer as well as a follow-up e-mail and/or facsimiles invitation from La Rosa and the CDI team.

In addition to administrative support for her summit, La Rosa credits her team’s ingenuity and creativity as draws for the event. Last year the meeting theme was “We’ve got you covered for ICD-10.” La Rosa gave out rain jackets and created posters that featured umbrella-toting CDI staff protecting medical records from a cloudy sky. The previous year revolved around the theme of staying in shape with documentation improvement; physicians received gym bags and water bottles, and posters featured weight-lifting physicians with CDI specialists as spotters.

“The themes really get things going,” La Rosa says. “It creates a common concept that people can relate to.”

The team keeps the theme a mystery until the day of the meeting so everyone looks forward to the surprise, says La Rosa.

“It really helps rally the troops and keeps the concepts memorable. I’ll walk down the hall and a physician will ask me a question based on the theme. When they do, it is a really great feeling.”

Additional efforts reinforce CDI concepts

Epps does not end her educational efforts with the pre-residency course, however. Just like a typical classroom teacher, she understands that engagement and reinforcement of essential information helps not only residents but all physicians grasp the CDI mission and improve their documentation of patient care.

During her four-year tenure as Emory’s CDI manager, Epps estimates that she has presented more than 50 formal education programs to physician groups and even more to other clinical staff such as nursing, case management, or quality improvement. Epps also attends physician orientation every month, where she gets roughly 10 minutes to explain CDI ideas. When her CDI staff see a new physician on the floor, they introduce themselves and give a quick explanation of their roles.

“We just pull new physicians aside, say hello, and tell them how CDI programs can help them,” says Epps.

Epps has also developed laminated documentation improvement tip cards and posters to remind physicians about linking disease processes to their manifestations. She distributes helpful articles to the physicians whenever warranted and offers CDI education sessions by service line.

La Rosa’s team takes photos of physicians posing with CDI staff and posts a slide show during CDI Week celebrations interspersed with documentation improvement tips. Her team contributes a CDI column to the monthly medical newsletter sent to the physicians as well as a column included in a newsletter specifically for physician office managers. La Rosa meets with specialty groups each month in addition to the annual CDI education event.

Engaging physicians early on and embracing their concerns and priorities helps to open lines of communication, says La Rosa. After that the CDI team needs to keep that communication going.

“Every time the physician puts their pen to paper, [he or she] is telling the outside world about the care they provide to that patient. For some physicians a pen is more difficult to handle than a scalpel. That’s okay, that’s why we’re here. We’re not the police. We’re the safety net. We’re here to help them.”

As for those new residents, Epps and her team make sure to welcome them when they arrive at the facility. “We follow up with them and introduce ourselves. We remind them that we are the people they learned about in that online course,” she says.

At the residency level, new physicians are really interested in doing a good job, Epps says. They are young and enthusiastic and open to new ideas.

While physicians may be far from their high school experiences, CDI specialists—just like teachers—need to address a myriad of topics, scale information to a variety of proficiency levels, and engage physicians’ different interests, Epps says. 
Accolades: Give physicians credit when credit is due, said Trey La Charité, MD, physician advisor for the CDI program at the University of Tennessee at Knoxville, during his 2010 ACIDIS annual conference presentation “Strategies for Achieving Medical Staff Compliance.” Specific acknowledgement of work well done shows physicians you support and appreciate their extra effort. He recommends that CDI staff mail a quick thank-you note to physicians who have improved their documentation specificity.

Bulletin boards: If you haven't staked your CDI department's claim on at least one strategically placed bulletin board with documentation tips, posters, and announcements, do so as soon as possible. Try to snag one near the physician lounge or documentation station. Many programs use a board to post examples of effective documentation.

Collaboration: Promote the CDI program as a team effort, said La Charité. At his facility, the physician advisor attends weekly CDI core team meetings where everyone in the room has equal status to address problematic queries and generate new ideas.

Dashboard: A dashboard is a means to benchmark your CDI program efforts. Use dashboards to track specific data elements such as physician responses to queries over time and the effect of queries on case-mix index, SOI, or other factors to illustrate your CDI program's success. When you include these dashboards as part of your ongoing educational efforts, you demonstrate the value of CDI to your physicians and facility.

Examples: You have 10–15 minutes allotted for CDI education at the next medical staff meeting; don't waste them with platitudes. Use specific examples of both good and bad documentation from your facility—de-identified, of course.

For example, at the time of admission Dr. A documents cellulitis with no mention of sepsis or severe malnutrition. However, Dr. Z, with a similar patient, documents that the patient was septic from cellulitis present on admission and had a serum albumin of 1.9, indicating that the patient had severe malnutrition as well. Take this example one step further and illustrate how Dr. A's documentation affects the patient's expected mortality rates, length of stay (LOS), and relative weight as opposed to Dr. Z's.

Food: Consider splurging on a pizza party or bagel breakfast as a physician/CDI staff icebreaker. “If you corner physicians and feed them, then you'll have them,” jokes Janet M. Gentle, RN, BSN, MSN, CCDS, CDI specialist at Northern Michigan Regional Hospital in Petoskey. All humor aside, don't discount the power of kindness. Linda Renee Brown, RN, CCDS, CDI specialist at Banner Good Samaritan Medical Center in Phoenix, found that KitKat™ bars helped her connect with a particularly difficult physician (read her post on the ACDIS Blog). Candy alone won't do the trick, but paying attention to physicians' needs can go a long way.

Gratitude: It doesn't cost anything to say thank you. When physicians take five minutes to listen to what you have to say, that's five minutes in which they are not attending to other tasks. Tell them that you appreciate their time.

Handwriting: According to AHIMA's October 2008 practice brief “Managing an Effective Query Process,” legibility is one of five main reasons that coders and CDI professionals should query physicians. AHIMA defines illegible documentation as “handwriting that cannot be read by two other individuals.”
Furthermore, CMS requires either a handwritten or electronic physician signature on all orders for healthcare services. If the physician signature is illegible, CMS instructs contractors to deny reimbursement for the submitted claim (see CMS Transmittal 327).

Physicians may consider complaints about their handwriting to be simply stereotypical nagging, so let them know that illegibility not only has the potential to harm patients (especially when other caregivers cannot read their orders), but also has payment implications.

**Items:** CDI Week (held annually during the third week of September) is a perfect time to provide items as a reward for physicians. Programs with a larger budget may be able to purchase CDI Week products for their medical staff, for example, or pens embossed with a documentation tip. Although these things alone won’t ensure physician support for your CDI program, they go a long way toward reinforcing the CDI message.

**Justify:** Not so long ago, CDI programs were essentially foreign entities, strange new programs that might just as easily disappear as provide any long-term value. Within the past four years, however, hospitals across the nation have seen how CDI programs affect quality scores, CC/MCC capture rates, case-mix index, and mortality rates. You can justify the existence of your CDI program by incorporating benchmarking data from ACDIS Program for Evaluating Payment Patterns Electronic Report, MedPAR data, and more. When these items coincide with concerns expressed by your physicians and administrators, incorporate them into your training and provide the items as feedback, justification that your CDI efforts are part of a nationwide trend to improve healthcare.

**Kwashiorkor:** Among certain CDI circles, this one word has taken on an almost comic significance. That’s because while most physicians acknowledge decreased albumin as a marker for malnutrition, without specific documentation regarding the type of malnutrition the resulting code frequently maps to this extremely rare disease. As Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of HIM and coding at HCPro, Inc., in Danvers, MA, wrote in a January 20 Q&A for *CDI Strategies*, “If you cannot obtain information that accurately classifies the malnutrition as mild or moderate, … report ICD-9-CM code 263.9 (unspecified protein-calorie malnutrition) … Coding Clinic states that coders should not report ICD-9-CM code 260 when the provider does not specifically document Kwashiorkor.”

As this is a frequent topic of contractor scrutiny, be sure to keep malnutrition on your annual CDI education list.

**LOS:** Typically the purview of the case management and discharge planning teams, accurate documentation of the patient’s principal diagnosis can dramatically affect the expected LOS. At Wellspan Health in York, PA, Michele D. Johnson, RN, BSN, and her team made some interesting discoveries about how documentation affected LOS statistics for coronary artery bypass graft patients and valve replacement patients. (Read more of her account on the ACDIS Blog, and read a related article on p. 1.) With new payer initiatives and increased quality reporting on the horizon, be sure to explain the effect of documentation on LOS not only to physicians but to the case management team as well.

**Medical necessity:** CDI specialists play an active role in the establishment of medical necessity through clinical documentation, wrote Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, CCDS, an independent consultant based in Madison, WI, in a recent article on the ACDIS Blog.

In order for the facility and physician to receive reimbursement for a procedure, the patient’s record must contain documentation that fully supports the medical necessity for the service. This documentation includes, but is not limited to, relevant medical history, physical examination,
and results of pertinent diagnostic tests or procedures.

**Newsletters:** Write a monthly CDI note to include in your facility physician newsletter. Better yet, take a tip from La Rosa and find other possible newsletter recipients, such as physician office managers or case managers, and submit CDI information to them. Check out samples on the Forms & Tools Library such as the pneumonia documentation newsletter donated by Gina Spatafore of Waterbury (CT) Hospital.

**Orientation:** Add the CDI department to the list of new staff orientation stops. Along with understanding where the lunch room is located and how to handle dictation, new employees should receive a basic 10–15 minute overview of the CDI program’s roles and their responsibilities to the program, says Bonnie I. Epps, MN, RN, manager of the CDI department at Emory Healthcare, Inc., in Atlanta.

**Photographs:** Take a photograph of your CDI team members and place it on an introductory letter to new physicians, says Nancy R. Ignatowicz, RN, MBA, CCDS, system manager of clinical documentation at Provena Health in Frankfort, IL. Include team members’ names and phone extensions as well. Ignatowicz has the photos placed on mugs and gives them as gifts; she has also put the photo on place mats surrounded with documentation tips. The CDI team uses the place mats during special physician education sessions, she says.

**Queries:** Enlist physician assistance on annual reviews of query templates to ensure they remain clinically relevant and accurate. Get the physicians involved by service line. As you enlist their assistance with clinical criteria, instruct coders and CDI staff on the review team to explain the reporting and coding guidelines. With all parties involved, everyone learns something new and everyone owns a piece of the query process’s success.

**Reimbursement:** Documentation improvement is not just about capturing CC/MCC and improving a facility’s case-mix index. In short, it’s not only about the money. At the same time, don’t hide the fact that appropriate documentation equals appropriate reimbursement for services rendered, not just for the hospital but for the physician as well.

**Support:** Most successful CDI programs point to administrative support as the backbone of their success. “In the beginning, no one understands what you do or where to put you in the facility. Our [chief medical officer] had started CDI programs at other facilities so he supported the program right from the start. It is really important to know that the administration has your back,” says Susan Tiffany, RN, CCDS, CDI supervisor at Robert Packer Hospital in Sayre, PA, and Corning Hospital in East Corning, NY.

**Tip sheets:** Many CDI programs have developed their own tip sheets based on documentation best practices at their programs. There are a few samples located on the ACDIS Forms & Tools Library, such as one donated by Jeannie Bellamy, director of documentation improvement and Recovery Audit Contractor coordinator at Skyline Medical Center in Nashville.

**Urosepsis:** Provide routine education regarding the different definitions for sepsis, urosepsis, and septicemia. Many physicians are not aware that the *ICD*-9 *Manual* indexes urosepsis to urinary tract infection, site not specified (code 599.0). Although urosepsis denotes sepsis from a urinary source, the physician may not have intended such a meaning. Instead, he or she may have meant to report sepsis due to a localized urinary tract infection, wrote William E. Haik, MD, director of DRG Review, Inc., in Fort Walton Beach, FL, in an article in *CDI Journal*.

**Validate:** Most physicians do not know about CMS’ reimbursement or documentation requirements. The business of healthcare is frequently the furthest topic from their minds as they struggle through school, residency, and patient care. What they do know might incorporate misinformation, myth, and hype regarding fraud or malpractice, Pamela P. Bensen, MD, MS, FACEP, CEO of Medical Education Programs, Inc., in Buffalo Junction, VA, said in her 2011 ACDIS annual conference presentation “Dealing With Difficult Physicians and Thorny Query Situations.” Be sure to validate their concerns. Tell them that you don’t expect them to know the requirements but that you are there to help them with the task.

**WIIFM:** Answering the question “what’s in it for me” engages individuals in problem-solving efforts, writes Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS, in *The Physician Query Handbook*. Unless physicians understand why CDI programs are important, they most likely will view them skeptically and see them as an additional bureaucratic burden—just one more piece of paperwork that needs to be filled out.
X-rays: Radiology reports, such as CT and MRI scans, x-rays, and ultrasounds, frequently contain detailed information that can lead to more specific code assignment, writes Lynne Spryszak, RN, CCDS, CPC-A, in this edition of CDI Journal (see p. 15). Specific information often found in CT or MRI scans can assist with diagnoses of cerebral edema or compression of the brain, for example, and x-ray radiology findings can be used to query the physician for additional information regarding the coding of the specific site of fractures.

Your responsibility: While CDI programs exist to help bridge the gap between clinical and coding documentation requirements, ultimately it is the physician’s responsibility to document the care he or she provides in the patient’s medical record. CDI specialists need to emphasize this not only during group education sessions with physicians but also during daily interactions. When frustrated physicians demand that CDI staff simply “tell them what to write,” remind the physicians that it is their responsibility to render clinical judgment and appropriate documentation.

Zero tolerance: Some facilities have taken the additional step of implementing a zero-tolerance policy for unanswered physician queries. While that’s not usually the case for concurrent queries, it is 100% mandatory for any retrospective queries that physicians receive at Lehigh Valley (PA) Health Network, says John Pettine, MD, FACP, CCDS, the program’s CDI director. “They don’t have to agree; they just have to respond. It is a unique program that I think is very successful,” Pettine says.

Ask ACDIS

Use of tumor board notes post discharge

Q: Some physicians are uncomfortable making addendums to the discharge summary to include the pathological findings (e.g., malignancy). Instead, they dictate a tumor board note to summarize the course of treatment and final pathological diagnosis. However, the tumor board note is usually dated a few days after the patient is discharged. When a condition meets guidelines for the inpatient admission, is it appropriate to use documentation dated outside the inpatient admission for coding purposes?

A: You may report an ICD-9-CM code for uterine cancer if the tumor board note:

» Qualifies as a “cancer staging form” as outlined in Coding Clinic, Second Quarter 2010, pp. 7–8

» Is part of the permanent medical record for that encounter

» Is signed by the attending (not a consulting) physician for that admission

Refer to the above Coding Clinic and your facility’s medical staff bylaws or HIM or coding policies and procedures for further clarification. If the scenario meets these requirements, report ICD-9-CM code 625.8 for the uterine mass and ICD-9-CM code 179 for the additional diagnosis of uterine cancer. If the pathological report was present on the chart before final coding without a cancer staging form signed by the attending physician and there is no documentation in the record of its findings by any treating physician, then query the physician. Consider the following query:

Dear Dr. Staging:

According to Coding Clinic, Third Quarter 2008, pp. 11–12 and the ICD-9-CM Official Guidelines for Coding and Reporting, we may not report and code abnormal findings on the pathology report unless the provider indicates their clinical significance. Now that the pathology report is available, if appropriate, could you please clarify the patient’s diagnoses in your documentation based on these findings?

The coder or CDI specialist should include the findings or pathology report for the physician’s inspection with the query. Refer to Coding Clinic, Third Quarter 1992, p. 7 for additional guidance.

Editor’s note: James S. Kennedy, MD, CCS, managing director of FTI Consulting in Atlanta, and Sandra L. Sillman, RHIT, PAHM, DRG coordinator at Henry Ford Hospital & Health Network in Detroit, answered this question in the August 14 issue of JustCoding.

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Use baseline DRG, CMI as metrics for success, with caution

by Jonathan Elion, MD, FACC

While many CDI administrators try to measure the effect of their program and staff, there is still confusion in the industry over how this is best measured. Consultants are eager to show that their efforts benefit the hospital, and CDI program managers are similarly motivated to show benefits to upper management.

Inappropriate use of baseline metrics may be inadvertent, but it can result in reports that show an inflated and unrealistic effect of the CDI program on overall facility performance. Furthermore, many CDI programs leave the data analysis to an outside organization or software package without understanding the origin or meaning of the data they receive in return. A CDI program's goal should be to assist in creating medical documentation that most completely and accurately reflects the diagnoses, findings, treatments, and outcomes of each patient. To fully measure and understand the workings of their CDI program, managers must strive to produce, and report, metrics that are brutally honest and insightful with regard to their department's activities.

Baseline DRG

This article focuses on the baseline metrics against which a CDI program can be evaluated. The first concept to explore is that of the baseline DRG. The baseline is defined as the DRG that would have been coded and billed if no CDI specialist reviewed the chart. You can best determine the effect of a CDI specialist by measuring the difference between the baseline DRG and the billed DRG. (Note that while the final billed DRG produced by the coder may differ from that achieved by the CDI specialist, we will assume they are the same for the purpose of this particular discussion.)

While the baseline DRG may seem like a simple concept, it can at times be difficult to determine. Consider the following clinical case:

A patient is admitted through the emergency department (ED) after presenting with undiagnosed abdominal pain. While not optimal, this single symptom has a corresponding ICD-9 code (789.00), which would result in DRG 392, with a reimbursement at a representative hospital of $5,008.

Further testing, however, reveals that the abdominal pain is the result of acute cholecystitis (ICD-9 575.10); this would result in DRG 446 (disorders of the biliary tract without complication), which is reimbursed $5,175.

The CDI specialist notes an increased creatinine and a decreased glomerular filtration rate and queries the physician regarding the patient’s renal status. If the doctor provides proper documentation, it could be possible to assign a complication for Stage IV chronic kidney disease (ICD-9 585.4), which would result in DRG 445 (disorders of the biliary tract with CC), reimbursed a total of $7,464.

The patient undergoes a laparoscopic cholecystectomy (ICD-9 51.23), changing the DRG to 418 (laparoscopic cholecystectomy with CC), with a resulting reimbursement of $11,868.

Next, the patient develops shortness of breath, and the consulting cardiologist documents acute-on-chronic congestive heart failure (ICD-9 428.23), changing the DRG to 417 (laparoscopic cholecystectomy with MCC) with a resulting reimbursement of $17,478.

So what is the baseline DRG, and what impact did the CDI specialist have on this case? In my opinion, it is not fair to conclude that the value of the query was $12,470, the difference between the first scenario shown above and the last. At my hospital, the “admitting diagnosis” is entered by an admissions clerk. This does not qualify as proper data on which to base any calculation of the CDI team's importance. Regrettably, however, sometimes the admitting diagnosis is used as the baseline.
Furthermore, you have to consider that the surgeon did not take the patient to the operating room based on the CDI specialist’s query about the patient’s renal status. Additionally, the MCC that ultimately drove the reimbursement level was provided independently by the cardiology consultant, with no prompting from the CDI staff.

Would it surprise the CDI director, then, to learn that the true financial impact of the CDI specialist in this instance was $0? The documentation of the chronic kidney disease is, of course, important to the completeness and accuracy of the record on this patient, and SOI or ROM may be affected. But claiming any direct financial benefit from the CDI specialist’s involvement with this patient’s documentation is not warranted.

Baseline case-mix index

So, the baseline DRG is the DRG that would have been coded and billed without the intervention of the CDI specialist. The average weights of the actual baseline DRGs can be used to compute a case-mix index (CMI) in an analogous fashion to using the average weights of the billed DRGs, even though most hospitals don’t use this metric.

In the sample chart on p. 14, the baseline CMI is shown with the red line, and the billed CMI, the one traditionally reported, is shown with the blue line. In the early stages of this CDI program, the difference between the two values appears to be due to the impact of the CDI staff, as one might expect. But notice that the baseline CMI increases over time—this implies that the physicians have learned to document better. While the gap between the two lines narrows over time, the benefits seen in the billed CMI continue to be positive. A rise in the baseline CMI reflects the “training effect” of having a CDI program, which cannot be discounted.

Conclusion

Selection of the baseline DRG should be done carefully, honestly, and precisely. Make sure that you have control over the designation of the baseline DRG, or at least fully understand how it was defined if you are using a software program or consultant.

Doing so will help you ensure that your reports are not artificially inflated by incorrect metrics or spreadsheet calculations. Similarly, comparing the baseline CMI to the billed CMI can provide valuable insights into potential training effects on the physicians, and can help to identify opportunities for further education.

If you don’t understand this component, you won’t have a firm grasp of your program’s value at its most basic level.

Editor’s note: Elion is founder of ChartWise Medical Systems, Inc., in Wakefield, RI. He has more than 40 years of experience in computing and more than 25 years of experience in medical computing and information standards. Contact him at jelion@chartwisemed.com.

Radiology findings can help support your physician queries

by Lynne Spryszak, RN, CCDS, CPC-A

A patient’s medical record contains a wealth of information about his or her hospital encounter, including diagnoses, treatments, operative reports, and ancillary notes. Unfortunately, much of the detailed information found in a patient record is not codeable—in other words, it is not information that may be used for diagnosis code assignment. Coders may only use documentation contained in select portions of the record—that which is provided by “hands-on” providers (i.e., those providers legally accountable for establishing a diagnosis).

Radiology reports, such as CT and MRI scans, x-rays, and ultrasounds, frequently contain detailed information that can lead to more specific code assignment. Coding Clinic advice supports the use of radiology findings to obtain additional information regarding the coding of the specific site of fractures. See the following references for more information: Coding Clinic, First Quarter 1999, p. 5 (fracture site specified in radiology report), and Coding Clinic, Second Quarter 2002, p. 3 (ED coding using the...
radiological findings). Note, however, that this guidance does not pertain to assigning diagnosis codes for conditions that the treating provider does not specifically identify or document.

**Clues in the documentation**

Specific information often found in CT or MRI scans can assist with diagnoses of cerebral edema or compression of the brain. These two diagnoses, when reported, add severity to a record because they are considered MCCs in the MS-DRG system. They also represent increased ROM in other classification systems. These two diagnoses frequently trigger the following interventions:

- Intracranial pressure (ICP) monitoring
- Surgical intervention (e.g., evacuation of an intracranial hemorrhage or insertion of a drainage device)
- Insertion of a shunt and/or treatment with medications to reduce intracerebral pressure

According to St. John Ambulance, brain (or cerebral) compression:

> ...Occurs when there is a build-up of pressure on the brain. This pressure may be due to one of several different causes, such as an accumulation of blood within the skull or swelling of injured brain tissues. Cerebral compression is usually caused by a head injury. However, it can also be due to other causes, such as stroke, infection, or a brain tumor. The condition may develop immediately after a head injury, or it may appear a few hours or even days later. For this reason, you should always try to find out whether the casualty has a recent history of a head injury.

Compression of the brain and cerebral edema are both serious conditions that can lead to herniation of the brain, brain cell death, and long-term deficits. These conditions often go undocumented because providers assume that a diagnosis of cerebral hemorrhage, brain tumor, or stroke includes anything related to the focal diagnosis. Providers also assume that because these conditions may be evident from findings summarized in the CT and/or MRI scan, there is no need to document these conditions in their own notes.

This is where a thorough review of radiology reports provides the clinical information to support a provider query for appropriate additional secondary diagnoses such as cerebral compression or cerebral edema. Not every patient with a cerebral hemorrhage or stroke has cerebral edema or compression of the brain, which is why it is appropriate to report these conditions when present.

**Queries for secondary conditions**

Review the Uniform Hospital Data Discharge Set guidelines for reporting secondary diagnoses before querying the provider. For example, before submitting a query, determine whether the condition is the subject of clinical evaluation, diagnostic testing, therapeutic treatment, or increased nursing care, or whether it caused an increased length of stay (LOS). If so, then it would be appropriate to query for the potential secondary corresponding diagnosis.

When reviewing radiology reports, take the following approach:

- Look for terms such as “midline shift,” “compression of the fourth ventricle,” or “space occupying lesion” (often used to describe intracranial tumors).
- Look for any surgical treatments provided, such as ICP, decompressive craniectomy, lumbar puncture, or insertion of a subdural evacuating port system drain (interventions designed to reduce intracranial pressure). Physicians perform some interventions at the bedside and often do not document them. These may be overlooked if a thorough review of the progress notes is not performed.
- Review the medication record for administration of IV steroids, IV mannitol or Osmintrol®, diuretics, or hypertonic saline designed to reduce edema. Patients with complex brain injuries may be followed by a neurologist, neurosurgeon, intensivist, or all three. Their documentation may include specific diagnoses, but coders should not assume that if the condition is not listed in the physicians’ notes, it is insignificant.
- Assess for additional resources such as surgical intervention or physical/occupational/speech therapy. Coders should review these notes for evidence of neurologic deficits that provide additional support for reporting higher-acuity diagnoses.

**Sample scenario illustrates query opportunity**

Consider a patient who is on your census in the medical ICU of a large tertiary center. The admitting or principal diagnosis is “non-traumatic intracerebral hemorrhage.”
The patient’s wife found him unresponsive on the living room floor on April 6 and called 911. The patient has a history of hypertension, and his wife states that the patient “always forgot to take his medications.” A CT scan and MRI confirm an intracerebral hemorrhage with evidence of a midline shift.

Upon arrival to the emergency department (ED), the Glasgow coma score total was 8 (eye 2, verbal 2, motor 4). One day later, the score is 3 (eye 1, verbal 1, motor 1). The patient requires emergency surgery for evacuation of the intracerebral bleed.

When deciding to query for the additional diagnosis of “compression of brain,” consider that the size of the skull is finite—it cannot expand to allow the uninjured brain tissue to “get out of the way” of the hemorrhage, which is increasingly taking up space. As the hemorrhage progresses, brain tissue is compressed against the rigid skull because it has nowhere else to go.

Documentation of “midline shift” indicates the brain tissue is shifting across the hemispheric midline. Not every patient with a subarachnoid hemorrhage needs surgical intervention. Physicians may monitor and treat small hemorrhages only with medication, so a diagnosis is needed to explain why this patient required additional resources.

Currently there is only one ICD-9-CM code available for reporting non-traumatic intracerebral hemorrhages: 431. This code includes intracerebral hemorrhages by general location (e.g., cerebellar, cerebral, cortical, and subcortical) but does not include or incorporate additional conditions, such as cerebral compression or cerebral edema.

Traumatic cerebral hemorrhage, ICD-9-CM code set 853.xx (other and unspecified intracranial hemorrhage following injury), does include the sub-term “cerebral compression due to injury.” Coders should also report a code for the specific injury when possible. This represents a query opportunity. The codes from the 853.xx category also include fifth-digit specificity as to reporting loss of consciousness.

Sample query form

Consider the following query example for additional diagnoses for the scenario described above (please refer to your facility’s specific query policies regarding compliant query verbiage):

Dear Dr. __________:

A review of the documentation in the record shows that the patient was admitted on 4/6/11 with a Glasgow coma score of 8 with a repeat Glasgow score of 3 on 4/7/11, an admitting diagnosis of “intracerebral hemorrhage” (H/P of 4/6/11), as well as being described as “unresponsive” (progress note of 4/7/11). Note the findings of the CT and MRI (4/6/11) scans, and subsequent physician documentation of “intracerebral hemorrhage with considerable midline shift at the level of the lateral ventricles.” Note orders for IV steroids and emergent surgical evacuation of the hemorrhage to “reduce intracranial pressure” (progress note of 4/7/11).

If one (or more) of the following accurately describe any associated additional diagnoses for this patient, please provide this documentation in your progress notes and discharge summary:

No additional diagnoses indicated

Cerebral compression/compression of brain

Cerebral edema

Coma

Other condition (please indicate): __________________

Clinically unable to determine

A final word of caution: The proliferation of external auditors (e.g., Recovery Audit Contractors) to identify fraudulent practices in the Medicare and Medicaid systems has led to increased scrutiny of diagnoses that, when reported, result in additional revenue. When querying a provider for an additional diagnosis, such as cerebral edema or compression of brain, make sure that your query incorporates the clinical findings from the radiology report and the treatments rendered, and that the documentation remains consistent throughout the record, including the discharge summary.

Editor’s Note: Spryszak is CDI education director for HCPro, Inc., in Danvers, MA. Her areas of expertise include clinical documentation and coding compliance, quality improvement, physician education, leadership, and program development. E-mail your questions to her at lspryszak@hcpro.com.

In addition to open registration classes, ACDIS also offers the Clinical Documentation Improvement Boot Camp as an on-site program. To explore the possibility of bringing Lynne Spryszak to your facility for a CDI Boot Camp or other training program, call 800/780-0584 or e-mail bootcamps@hcpro.com.
The interim CDI specialist: Understanding the different roles, rewards, functions, and perspectives of traveling CDI staffs

by Steven Robinson, MS, PA-C, RN, CPUR

Over the past few years, Maxim Health Information Services has identified a definitive need for interim CDI specialists in the acute care setting.

In this article, we will:

» Present a solid composite discussing our overview of CDI specialists and their typical role in acute healthcare facilities
» Offer the Maxim CDI program foundational statement, which includes the need for well-trained CDI specialists in any successful and sustainable CDI program
» Demonstrate the uniqueness of the traveling/interim CDI role
» Provide results of a survey of our internal CDI specialists and perspectives on their role, jobs, and travel experiences

The role and need

CDI specialists are the backbone of the CDI program. They are primarily responsible for facilitating and delivering appropriate documentation clarity in the medical record in order to accurately capture the severity of patient illness and recognize corresponding financial outcomes. CDI specialists typically have responsibility for a number of related activities, such as:

» Identifying opportunities for documentation clarification
» Knowing when it is appropriate to ask the physician a question
» Knowing how to ask a compliant question of the physician
» Measuring physician communication efforts
» Designing and measuring metrics that will determine best practice
» Communicating to hospital leadership and medical staffs the outcomes of previous activities
» Identifying future documentation improvement opportunities

Some CDI specialists take on additional functions, including communicating with the quality management team regarding core measure–related queries, or performing case management and utilization review duties.

Acute care facility fiduciary impacts and severity profile standings can be directly attributed to the CDI program. Through physician queries, CDI specialists communicate valid questions to physicians regarding the clarity of their documentation, or ask for direct links between more causative conditions to outcome conditions. Physicians’ written responses to those questions allow coding professionals to accurately code and assign MS- and APR-DRGs accurately.

Each clarification by the physician can have an impact on the MS- and/or APR-DRG and corresponding relative weight for reimbursement or severity. These relative weight increases (or decreases) all play a part in the bottom line calculation for reimbursement or severity profiling.

In order to concurrently review the record for the clarification opportunities, specific staffs that are knowledgeable in this concurrent review methodology are assigned for record review responsibilities. In a mature CDI program, the staffing is generally one CDI specialist for every 100 beds. For each appropriately staffed CDI program, this process is estimated to, on average, impact the bottom line of the hospital’s revenue by an additional $25,000 to $125,000 or more each month (this figure has many variables, but is calculated by determining the impact of positive query responses and is dependent on payer types of patients reviewed).

Query activities, appropriateness of query types, physician response rates, and coder/CDI specialist collaboration and acceptance rates certainly vary among hospitals, but the common message is that CDI staff play a formative role as part of the healthcare communication team.

CDI foundations

Maxim considers certain functions as foundations for a successful and sustainable CDI program (noted on p. 19). Among these is the ongoing support of the CDI specialist.
As hospitals recognize the positive outcomes of CDI specialists, their role is increasingly recognized as an essential component of their revenue cycle rather than an option. As such, facilities are also turning to interim CDI staffing measures. Maxim has heard from clients that there are three distinct types or groups of interim CDI specialists that could help fill their current needs:

» **Temporary CDI specialists**: For acute care inpatient facilities which have an existing, active CDI program, Maxim provides temporary, fill-in staff for as little as eight weeks or as long as the facility has a need.

» **Pre-CDI, phase II CDI staff**: As Maxim helps facilities with their CDI program implementation and education, it can fully staff the program with interim CDI specialists to begin the concurrent review and query process (physicians would be provided with an overview of communication and query expectations). In such situations, the Maxim CDI specialists would be contracted until the internal facility staff are trained and transitioned to concurrent review full time.

» **Outsourcing CDI**: Under this type of program, Maxim provides all areas of CDI concurrent review. CDI staff and management become the responsibility of Maxim.

Note that each of these models can be customized to the facility's individual needs. Similarly, all programs offer oversight supervision, especially if more than three CDI specialists are initiated and either the second or third option mentioned above is chosen.

Also, all programs require a source to monitor CDI metrics depicting CDI specialist quality outcomes.

### Successful CDI interim staff

In drafting an interim CDI staffing plan, facilities should understand three essential points:

1. **Need of the facility vs. deliverables**
   - What will be the responsibilities of the facility?
   - What are the expectations of the CDI specialist?
   - What are the expectations of Maxim?

2. **Managing the interim CDI specialist**
   - What role will the facility management play?
   - What role will Maxim leadership play? (Is there a need for an on-site Maxim CDI manager? If so, for what duration?)

3. **Logistics and outcomes of the CDI staff**
   - What other activities will be required of the CDI specialist?
- What are the quality methods that will be used to measure the CDI specialist’s success and productivity?
- Who will be responsible for monitoring and reporting the metrics?
- What is the longevity of the project?
- If the length of the CDI specialist’s interim contract is extended, what process will ensure that it happens seamlessly?
- What volumes of records will the CDI specialist be expected to review?

Traveling CDI specialists

Identifying CDI specialists with qualifying skill sets and the ability to travel is a challenge. As a recruiting and placement firm for all types of healthcare employees, we believe that Maxim is certainly the place to develop this unique service. Having worked with hospitals that lost staff and were in danger of keeping their program afloat, we developed a system to meet their unique needs.

In developing a plan for this service, we placed highly qualified and motivated CDI candidates looking for just the right place, wanting to see what other hospital CDI programs were like, and with an itch to travel and see the country.

Survey of interim staff

Below is a composite of 11 questions Maxim posed to 13 of its interim CDI staff. We hope this overview offers some perspective regarding the Maxim interim CDI specialists, their role, their commitment, and their life expectations as professionals.

Of the 13 staff, seven previously served in CDI management positions and six were CDI staff members. Seven had never traveled for a profession prior to taking on the Maxim interim CDI specialist role.

According to our survey, five candidates chose to enter this role in order to combine travel with their profession, four were interested in exploring how other CDI programs worked, three decided to make the switch due to changes in their circumstances, and one sought more professional flexibility.

The work schedule of interim CDI specialists typically mirrors traditional staff, with a Monday-through-Friday, eight-hour workday being the norm (seven staff members are on this schedule). Additional schedules included those individuals which work 10-hour days on a rotating basis; six individuals indicated that they return home weekly, five said they return home every other week, and two said they return home monthly.

When asked about the challenges traveling CDI staff face as opposed to those faced by traditional CDI specialists,
five people indicated that getting to know the different facility routines posed the greatest challenge, while four indicated the most difficult aspect was getting to know new physicians. Three respondents said that they missed the educational opportunities offered in a traditional facility setting, and one indicated that it can be difficult to get used to different programs’ electronic systems.

While resolving such difficulties can be a challenge, the 13 staff surveyed managed to establish some routines that help. Five respondents said that they identify “hot points” in the facility; three indicated they familiarize themselves with the names, faces, and roles of various individuals; three said they make a point to introduce themselves to various personnel; and two indicated that they get to know nurse managers and physicians.

As is the case in any job, the interim CDI specialist role comes with some terrific aspects and some not-so-great ones. See the charts below for a listing of items staff identified as the best and worst aspects of their job, as well as a chart listing items they found most and least rewarding about traveling.

When asked if they would recommend the interim role to friends and colleagues, all 13 respondents said yes. To those who wish to enter the role, however, these practicing interim CDI staff had some advice. Five said experience counts and that a command of all things CDI is necessary for success, and two said a strong sense of flexibility is needed. Other responses included:

» Experience in HIM
» Travel experience
» Exposure to electronic medical records/systems
» Flexibility
» Respect
» Efficiency

Supplying a new outlet for these growing and passionate healthcare professionals is exciting for Maxim. We find challenges everyday, as we do with any service offered, but the rewards are great. Every day our clients complement our CDI staff members on their experience and leadership in the industry. The role of a CDI specialist is important and becoming more so with the needs, mandates, and regulations CMS and other industry entities put before us. Maxim continues to look forward to addressing these needs with a solid foundation of CDI services and solutions.

About the author

Steven Robinson, MS, PA-O, RN, CPUR, has successfully managed CDI services for more than 200 acute healthcare hospitals, medical centers, and health systems over the past 19 years. An RN and physician assistant with a master’s degree in health management, Robinson currently serves as the senior director of CDI at Maxim Health Information Services (MHIS) in Cleveland.

Prior to working at MHIS, Robinson served as vice president of clinical consulting services at a CPA healthcare firm acquired by 3M, senior vice president of clinical consulting at HP3, and director of forensic healthcare consulting at KPMG, LLP. He is committed to providing clients across the country with quality CDI services.

About Maxim Health Information Services

MHIS provides CDI services nationwide. MHIS offers CDI services that are tailored to your facility’s unique needs and allow you to proactively support your medical record staff to minimize incomplete documentation, increase medical record quality, enhance care communication, and receive more accurate reimbursement.

MHIS delivers CDI services in a series of four comprehensive phases: client interface phase, evaluation phase, education phase, and metrics and process follow-up phase. By choosing MHIS for your CDI needs, you can expect quality customer service, customized results reporting, and a commitment that MHIS will support your long-term CDI success. To learn more about MHIS’ CDI services, visit www.maximhealthinformationservices.com or call 866/265-0589 (East) or 866/316-8773 (West).