Physician Advisor’s Corner

Keep on the straight and narrow path: Achieving (and maintaining) CDI compliance

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Compliance represents one of the most important yet underappreciated goals of a CDI program. While my facility’s eight-year-old CDI project did not start out with compliance as an initial objective, we were able to identify and resolve its unintentional oversights.

Whether your program is in its infancy or is fully matured, you need to address compliance concerns to shield your facility from substantial, and completely avoidable, risk. Failure to follow certain tenets of CDI practice puts your facility at risk for financial penalties from those that audit its operations—penalties that ultimately can lead to a reduction in services offered to your patients.

Program origins

First, understand the probable origin of the CDI program. Most likely, a senior staff member (someone from the C-suite—chief financial officer, chief medical officer, CEO, etc.) was having lunch with another senior leader, lamenting reduced reimbursements resulting from healthcare reform, when that other leader mentioned how the new CDI program at his or her facility had garnered a substantial increase in the facility’s case-mix index. Your senior leader was dazzled by dollar signs, convinced that your hospital desperately needed a CDI program to accomplish the same results. Unfortunately, the most important reasons for starting a CDI program were likely ignored.

Understanding the probable origin and intent of your CDI program helps make your program’s structure make sense, too. Odds are that your CDI program started out only reviewing Medicare patients—it may still only review Medicare charts to this day. Why? Medicare patients represent the largest single proportion of MS-DRG payers in your hospital. Some facilities are fortunate enough to have adequate staff to review all MS-DRG payers, but most are not. My organization followed this initial path.

Eventually, though, I became aware that our government does not look favorably on organizations that only apply their CDI efforts to Medicare patients. Such limited scope of practice, in fact, looks suspicious to the enforcers of Medicare rules and regulations, such as the Office of Inspector General (OIG).

Expansion opportunities

You, as the leader of your CDI program, should explain to senior management that your program needs to expand its efforts to all MS-DRG payers, if not all patients. Setting the precedent that your organization is not solely targeting Medicare beneficiaries reduces the chance that the hospital will come under unwanted scrutiny.

The ideal scenario would be for your program to review every chart that comes through its doors—yes, even the totally uninsured. Why? There is a group of people within your facility whose sole job is to get uninsured patients health insurance, and they do a better-than-expected job of getting them some kind of coverage. When this occurs, your facility will eventually get some form of reimbursement (albeit many months later). This reimbursement will probably be subject to some risk adjustment methodology like the MS-DRG system. Additionally, the coded ICD data from these newly reimbursed cases will be included in a publicly reported database.

My organization has about a 49% success rate in this endeavor. This means that there is about a 50/50 chance that my CDI program positively affects both the reimbursement and the reported performance metrics for any given uninsured patient. I like those odds, and so does my hospital.

Continuing with the betting analogy, I would double down on a second probability: I bet your program only reviews records for those diagnoses considered to be...
CCs/MCCs. Since money was the initial motivator, why would your CDI personnel review records for any diagnosis that did not carry a financial implication?

Once again, it is up to you, the CDI professional, to gently guide your senior leadership to a more compliant and rewarding path. First, explain how querying for every diagnosis not documented in the medical record has substantial implications for your facility’s publicly reported performance data. While your senior leadership is aware of this on a conceptual level, they probably have not made the connection that your CDI program can positively affect these items.

Educate senior management about how metrics (outside of the MS-DRG system) calculate how sick a patient is based on the documented diagnoses. Also explain how those methodologies take into consideration substantially more diagnoses than the ones CMS has designated as CCs/MCCs. The APR-DRG system is probably the most widely known of these and can serve as a perfect example of how all diagnoses matter.

Once again, you will have to explain that reviewing for only CCs/MCCs looks suspicious to CMS and the OIG. Reviewing a record for all missed diagnoses sets the precedent that accurate portrayal of your patients’ severity of illness is the goal of your program as opposed to financial gain. At my facility, the “I” in “CDI” stands for “integrity.”

**Compliant queries and materials**

A third mandate for CDI compliance is that no financial or performance implications should be included on any CDI promotional materials. While this includes CDI pocket cards, flyers, posters, and preprinted documentation templates, the single most important item to discuss here is queries.

Leading queries are highly frowned upon by CMS, the OIG, and our profession in general. Supplying providers with the knowledge that the targeted diagnosis of your query is a CC/MCC, or listing the severity of illness, length of stay, or potential reimbursement outcomes of a positively answered query, can only be construed as leading. Being accused of writing leading queries is undesirable—and expensive, if proven by governmental watchdogs. Not supplying this type of information to your providers at the point of service sets the precedent that diagnostic accuracy is the goal, not financial reimbursement.

It is perfectly permissible and necessary to teach your providers—through your educational efforts and presentations—which diagnoses are CCs and which are MCCs, and to communicate that proper documentation of these diagnoses improves severity of illness, length of stay, and reimbursement. But supplying those distinctions at the moment physicians are contemplating what to write in the medical record appears fraudulent and greed-driven.

Lastly, queries must be compliant with industry standards (the 2013 ACDIS/AHIMA practice brief “Guidelines for Achieving a Compliant Query”)—queries constructed outside of these parameters may be considered leading. Following these guidelines helps show that your program follows accepted industry practice standards and that you are not leading your providers to answers they would not arrive at on their own.

Compliance is the unrecognized purview of the CDI professional. Keeping your CDI program on a straight and narrow path avoids potential ramifications that will harm your facility’s patient care efforts. While “selling” compliance can frequently be difficult since you are marketing prevention of things that might not happen, you do not want your program to be an unrecognized liability and an unanticipated risk factor.

Unfortunately, many solutions for increased compliance require adding more CDI personnel to your program. However, this should be an easier sell to your chief financial officer since reimbursement increases generally accrue from reviewing more records. I encourage involvement from your compliance department, as they too have a vested interest in flying under the radar and staying off the grid.