IMA Insights

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Clinical Documentation Improvement - Worth the Investment?

To Our Healthcare Clients and Friends:

In this edition of *IMA Insights*, we will discuss the importance of ensuring accurate, specific and timely clinical documentation and the related challenges facing hospitals. Clinical Documentation Improvement (CDI) is a major focus of the Centers for Medicare and Medicaid Services (CMS). We see this focus with Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC) and other audit and review initiatives. In order to guarantee appropriate documentation, hospitals must work together with Health Information Management (HIM) staff, case management, clinical staff, and physicians. A robust CDI program has never been more important. Not only is it essential to fend off millions of dollars in government fines, penalties and take-backs, but, it is also critical as new payment models and their related incentives and penalties are implemented (i.e., bundled payments & planned readmission status code utilization).

Successful CDI programs help to generate a true picture of the severity and acuity of the patient's illness, measured by the case mix index (CMI), the severity of illness (SOI) and risk of mortality (ROM) scores. It also affects reductions in clinical denials for medical necessity, improved clinical outcomes and continuity of care. It allows for the capture of all diagnoses and procedures supported by the documentation.

Having a robust CDI program process in place can ensure that:

1. Your CMI is accurate and you are receiving the appropriate reimbursement.
2. You are managing your claims by sending out accurate and clean claims and avoiding unnecessary denials.
3. You are managing readmissions and avoiding present on admission (POA) denials.
4. You are in compliance with CMS regulations thus ensuring accurate, real-time clinical documentation in order to avoid unplanned audit pitfalls, huge fines and significant financial remediation.

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BACKGROUND

The American Health Information Management Association (AHIMA) describes clinical documentation as "the core of every patient encounter" and stress that, "in order for clinical documentation to be meaningful, it must be accurate, timely, and reflect the scope of services provided". According to the AHIMA, a successful CDI program "will facilitate the accurate representation of a patient's **clinical** status that translates into coded data".

Clinical documentation should provide an accurate picture of the patient and the quality of care provided to that patient. It is believed that better clinical documentation promotes better patient care. Clinical documentation can support quality and performance, reimbursement, severity-level, risk adjustment profiles, POA diagnoses and hospital-acquired conditions (HAC).

Providers must assess their CDI initiatives even in the face of numerous clinical documentation and coding challenges. Some of these challenges include:

- Physician Engagement
- Workflow Disruption
- Resource Management

CHALLENGES

CDI programs can lead to both improved profitability and compliance but they are not without some challenges. Hospitals may not have a CDI program due to lack of staff, funding or technology. A CDI program requires much in terms of cost, training and education. In addition, hospitals have many other challenges competing for attention and threatening budgets. A few of the struggles providers face when trying to fully implement a successful CDI program are expanded on below:

Physician Participation

Physicians document for other clinicians. Failure to properly understand the importance for strong documentation to support payer requirements and auditor expectations is a challenge preventing physicians from effectively engaging in CDI.

Obtaining buy-in from physicians can be difficult. Regardless, it is necessary to provide a clear and concise reason for them to change their documentation habits. For example, how can coders properly assign one of the new planned readmission status codes if the physician hasn't documented that he is expecting the patient back in the next 30 days? This can help facilitate willing participation in the CDI process. Successful CDI programs must be able to correlate clinical documentation and quality of care.

Promoting greater accuracy and specificity of clinical documentation, especially for complex cases, may result in more appropriate reimbursement to hospitals for services provided. It also reinforces patient acuity that is reflected in future quality scores, CMI and can help support POA and HACs.

Workflow Disruption

The disruption of clinician workflow is also a barrier to improved clinical documentation. Incorporating documentation in the clinician's workflow is a way to ensure accurate capture of diagnoses. It is imperative that hospitals build electronic clinical documentation systems that make it easy for clinicians to provide more specific documentation (e.g. diagnoses or conditions chosen from a pick list instead of free text options).

Providers must engage all clinical providers in the CDI process. Nursing and ancillary clinical staff can assist with documentation of POA status, staging of pressure ulcers, initiation of nutrition assessment and admission assessments that include Braden scores, nursing intervention care needs and activities of daily living (ADL) needs. Nutritional assessments and recommendations can help capture significant nutritional comorbidities while therapy assessments can help capture ADL status.

The CDI staff must be trained on how to present queries to the clinician. More importantly, CDI programs must incorporate queries into the clinician's daily workflow. The query needs to be easily accessible. Ideally, the physician should be able to answer the query electronically and route the answer back to the CDI department. The answer should be reviewed by a Clinical Improvement Specialist (CDIS) to ensure that the documentation requested by the query is complete. It is best practice to ensure that this is done real time, while the patient is still in the hospital, and not post-discharge.

Today's interns and residents are tomorrow's attending physicians and there is a need to educate these individuals on specific documentation. They are usually the first line of inquiry. However, it can be difficult to instruct an intern or a mid-level provider on good documentation skills without buy-in from the attending physician. If possible, try to have a senior attending present during house-staff, mid-level or specialty service education sessions. This can help set the expectation of the goals for documentation. In addition, the presence of a physician resource or physician advisor would be beneficial as this individual would act as a liaison between the CDI department, HIM and the medical staff.

Resource Management

Allocating appropriate resources for a CDI program is major a challenge. Limited resources result in a sampling of cases being targeted based on payer type (i.e. only Medicare, Medicare Fee-for-Service, Medicare Advantage or Medicaid). This leaves complex cases from Commercial health plans under-represented or ignored. Patient volume and acuity, as well as the availability of experienced staff, are factors that may influence an organization's CDI staffing choice.

INSIGHTS

Recommendations for CDI physician challenges include:

- Know your physician audience. Such audiences include, but are not limited to, academic physicians, private practice physicians, mid-level providers, interns and residents. Each subset requires different approaches to education and training with regards to CDI;
- Incorporate CDI training into physician education sessions on a regular basis;
- Educate clinicians on why CDI is important especially as it relates to hospital revenue and quality measures;
- Make CDI part of the clinician workflow;
- Ensure that documentation queries are consistent with clinical practice and consistent with the patient's care;
- Ensure that queries are consistent with evidence-based guidelines;
- Provide meaningful data and feedback on an ongoing basis;
- Have a physician champion;
- Ensure that in-person communication provides the opportunity for education and immediate feedback;
- Provide routine education directed toward specific clinical specialties to address specific diagnoses, and;
- Provide physicians with clinical documentation pocket guides for easy reference.

Strong clinical documentation will improve communication, increase recognition of comorbid conditions, validate the care that was provided and show compliance with quality and safety guidelines.

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SUMMARY

As Medicare moves toward an alternative payment system, physician documentation needs to change and become stronger. More accurate documentation can have a significant impact on quality measures, SOI and ROM. These measures are used to reflect the physician quality scores when compared to their peers and are featured on public websites for patients/consumers to see.

A strong CDI program can help providers improve patient outcomes; accurately capture the length of stay (LOS), core measures, hospital-acquired conditions and patient safety indicators; better recognize comorbidities; and decrease the risk of incorrectly coding observation cases.

Hospitals can incorporate CDI into practice contracts. Doing so would encourage buy-in, especially if outcomes data is incorporated into practice contracts. It can also be a part of the Joint Commission standards that require medical staff to engage in ongoing professional practice evaluations (OPPE) to monitor for quality and performance.

Finally, a strong CDI program will enhance profitability because physicians and coders are capturing data that would have gone without reimbursement.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance with evaluating your hospital's exposure to the information presented above, please do not hesitate to contact me at (610) 314-5194.

Truly yours,

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Mary Ellen has over 20 years of healthcare experience, with a focus on Medicare and Medicaid compliance including but not limited to billing and coding rules as well as Stark and Anti-Kickback.

Mary Ellen has served as an interim compliance director for several healthcare systems in Pennsylvania and New Jersey. Additionally, she has served as the Assistant Corporate Compliance Officer for a multi-state healthcare service organization catering to older adults and also served as the Assistant Compliance Officer for an East Coast university healthcare system. She has been involved in the auditing process, performing audits as well as managing the audit and compliance departments of several hospitals and health systems.

Mary Ellen earned her Master Science of Public Health and Certification in Gerontology from The West Chester State University. She has a Bachelor of Science in Nutrition from The Pennsylvania State University, where she also achieved Paralegal Certification, with distinction. Mary Ellen is certified in Healthcare Compliance by the Compliance Certification Board and is a Certified Professional Coder by the American Academy of Professional Coders.

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