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Association of Clinical Documentation Integrity Specialists

THE CDI DIRECTOR'S CUT

A Guide for Effective Program Management

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Mindy Davis, RHIT, CDIP, CCS

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Contents

About the Authors

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Johanne "Jo" Brautigam is the manager of the clinical documentation integrity department at Roper Saint Francis Healthcare, in Charleston, South Carolina. Brautigam, her husband, and her two daughters have lived and worked in many places as a military family, from the United Kingdom to Anchorage, Alaska, before finally settling in Charleston. Brautigam graduated with an associate degree in nursing from Santa Ana College in California in 1986, and she earned her critical care RN certification in 1989 and her BSN in 1999 from the University of Utah. After 25 years in critical care, Brautigam took the leap into clinical documentation in 2011. She became Roper's first certified clinical documentation specialist (CCDS) in 2012 and took on the manager's role in 2013. Brautigam currently manages a team of 11 specialists covering four hospitals and serves as president of the South Carolina chapter of ACDIS. She also serves on ACDIS' inaugural Leadership Council and is part of ACDIS' Scholarship Committee.

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Author Welcome Letters

Congratulations—you have taken the job as a clinical documentation integrity (CDI) manager! Whether you are new to this role or a seasoned veteran, you will begin to have a different view of medicine as it will now include regulations and reimbursement. With all the variances to the CDI profession, this book should help you come up with ideas to develop and advance your CDI team and keep your key stakeholders apprised of what your team is doing for your organization.

Clinical documentation structures can vary widely. Most teams fall under the health information management (HIM), quality, or case management umbrella. There is no right or wrong place for CDI, and workflows will vary depending on where the department reports. You will develop important management skills on your journey that you will use to identify and engage your audiences, understand your system's culture and, most important, maintain morale and keep your CDI team's identity as you focus on documentation improvement.

Managing a diverse team of documentation specialists means keeping the group united in moving forward with regulatory changes and market patterns. As varied as CDI personalities are, stressing the team effort keeps the focus on the common goal and reduces the competitiveness that many CDI specialists experience. No matter what the documentation structure looks like, we all strive to work with the providers to tell the patient's story accurately.

This book will assist you in navigating CDI management. Maybe you will find something you have already done, thereby validating that you are on the right track. We hope you will also learn plenty of new techniques and strategies for managing a CDI staff. While it may be challenging to pilot a new process or concept, that is how you grow. Understand that you are a valuable asset to your organization. Now let's increase your value!

Know we are in this together.

Johanne "Jo" Brautigam, RN, BSN, CCDS
Clinical Documentation Manager

Welcome, CDI leaders! This is an exciting profession, and you now have the opportunity to serve a group of dynamic people in a leadership capacity! There is no better time to be joining the CDI profession or advancing within your already established CDI career. The industry is experiencing rapid growth, and opportunities abound. The structure of your CDI department and the role it plays within your organization can vary greatly. There is no one-size-fits-all approach to CDI leadership. The upside of this is that you are in a unique position to create a CDI program that can truly make a profound difference to your organization. The challenging aspect of this is that there are many different ways to lead a successful CDI team, and you may be coming into your role feeling a bit overwhelmed as to where you should start. This book will guide you as you get started in your CDI leadership position.

The organizational and reporting structure of CDI departments is as diverse as the profession itself. If you are reading this book, you may have leadership responsibilities for other areas, such as case management, HIM, or quality. Conversely, CDI may be your only responsibility. No matter your scope or reporting structure, each variation has its own set of unique challenges and opportunities. For example, if the CDI department reports through the revenue cycle (typically to the chief financial officer or vice president of revenue cycle) you may face challenges in garnering support for the clinical aspects of CDI that do not result in a tangible revenue impact. Alternately, if the CDI department reports through more of a clinical-based chain of command (i.e., vice president of quality or chief medical officer), you may encounter obstacles in obtaining their buy-in to change documentation patterns that you know are costing the organization revenue. Each different reporting structure will to some extent guide the mission of the CDI department as well as your goals as the leader.

Whether you are coming into the role of CDI leader as a veteran employee of the health system for which you work or you are a newly hired employee to the health system, your organization will likely already have an established reporting structure for the CDI department. In the case of a new CDI department, organization leadership likely will have strong opinions as to where CDI fits. As a leader within the organization and as a CDI professional, it is wise to assess the strengths of the organization by which you are employed and advocate for a reporting structure that you deem will lead to success for the CDI department if you are given the opportunity to provide input. Understanding up front the influence of the reporting structure as well as any preconceived notions your organization may have about the role of CDI will not only assist you in building a CDI team to counteract any existing biases within the organization but will also help you guide the success of the CDI department.

The CDI leadership role is both rewarding and demanding! There is a lot you need to know. This book will not only explain the basics of CDI program creation and ongoing development, it will also help you determine how best to manage the CDI department to navigate toward a successful future for your team and for your organization. The book will discuss the following:

- Developing the CDI mission and stakeholder involvement

- CDI job descriptions, career ladders, onboarding, evaluations, audits, and the challenges of a remote workforce

- The expansion into quality, clinical validation, and outpatient CDI

- Navigating technology implementations, physician advisors, and interdisciplinary rounding

- Data reporting, key performance indicators, and communication and presentation

Let's get started!

Mindy Davis, RHIT, CDIP, CCS, CCDS
Director, Health Information Management and Clinical Documentation Improvement

Chapter 1

CDI Fundamentals: Establishing a Mission and Getting Started

Healthcare professionals are familiar with the old adage "If it wasn't documented, it wasn't done." But as healthcare continues to grow in complexity, additional pay-for-performance programs are becoming the norm and the technology capabilities of electronic health records (EHR) are becoming more sophisticated. This makes it more challenging for the provider to document what in fact was done. In its most simplistic state, this is a way to view the purpose of clinical documentation integrity (CDI)—a way to assist providers in meeting the documentation requirements for illustrating the care they provided. In reality, CDI is much more complex!

While the formalization of CDI programs and individualized departments is relatively new, the concept of seeking accurate, complete, and more specific clinical documentation is not. Health information management (HIM), case management/utilization review, and quality professionals have been tasked with obtaining additional documentation from providers for many years. The introduction of prospective payment systems for hospital reimbursement in the 1980s increased documentation needs, as did the Centers for Medicare & Medicaid Services' (CMS) implementation of diagnosis-related groups (DRG) in 1983 and the eventual shift to Medicare Severity-DRGs (MS-DRGs) and present-on-admission (POA) assignment in 2007.

However, the emergence of CDI as an established profession was largely yet to come. Medical coders were mostly in charge of checking documentation needs in the format of a postdischarge query. During this time, organizations struggled to meet the ever-increasing documentation demands while also maintaining sufficient revenue flow. CDI programs began with a large focus on major comorbid

Staff Onboarding and Development

It is difficult to know what to look for when selecting new clinical documentation integrity (CDI) specialists. There are many options to investigate, such as licensure, certification, or clinical background. For example, is it a requirement to have a registered nurse (RN)? Requirements depend on the organization and job description. If licensure is required, there are very smart pharmacists, but they could be cost-prohibitive. Some CDI teams consist of certified coders or foreign-trained physicians.

A top requirement for a documentation specialist should be an ability to understand pathophysiology as well as a rounded clinical experience. Too much specialization may be an issue because it limits the type of patients reviewed. Another trait that benefits any CDI team is a specialist who works well with others, meaning he or she understands the give-and-take of the team and helps the team utilize each other's strengths.

Some of the skills best suited for a CDI specialist include:

- Ability to read and interpret a patient medical record
- Clinical knowledge and experience
- Strong verbal and written communications skills
- Creative and analytical thought processes

Figure 2.1: Sample orientation checklist

Topic	Date Reviewed	Orientee Initials	Preceptor Initials	90-Day Performance Rating: S (Satisfactory) N (Need Reinforcement) U (Unsatisfactory)	Comments
Review Job Description					
Overview of Diagnosis-Related Grouping (DRG) Program					
Definitions (DRGs, case-mix index, etc.)					
System access					
CDI boot camp					
ICD-10 Manual					
Able to locate diagnoses/procedures					
Identify comorbid condition (CC)/major comorbid condition (MCC)					
Identify surgical vs. medicine DRGs—diagnoses, procedures					
Identify DRGs within Major Diagnostic Categories (MDC)					
Identify DRGs requiring CC/MCC					
Review CC/MCC list					
Review MDC guides					
Disease progression tables					
CC/MCC references					
Online Coding Reference Guides					
Coding Clinics					
Coding Handbook					
CDI Guide					
CC/MCC lists					

Figure 2.1: Sample orientation checklist (cont.)

Chart Review Process					
Software					
Computer-Assisted Coding					
CDI review worksheet					
Organized chart review process					
Adheres to policy and procedure re: chart review process					
Query Process					
AHIMA/ACDIS query compliance document					
Query escalation process					
AHIMA guidelines followed when querying physicians					
Utilizes preprinted query forms correctly					
Communicates effectively/appropriately with physicians					
Software Navigation					
Physician portal					
Encoder standalone					
IT help desk					
Printing census/worklist					
Team meetings (monthly)					
Biweekly meetings with Management					
Additional Comments					

The orientation booklet should also include the following:

Policies

- Organization-specific professional standards of appearance
- Organization-specific professional standards of conduct
- CDI ethics policy (if the department has one)
- CDI query policy

Procedures

- Chart review process
- Escalation process
- DRG baseline impact instructions
- Chart reconciliation process

Other

- CDI team phone numbers
- Orientation schedules
- Important articles
- AHIMA/ACDIS compliant query practice brief

Allow new CDI specialists to shadow a coder so that they can observe the coding process and familiarize themselves with the coding staff who work with the CDI team. In addition, CDI specialists can learn about the interconnection between coding and CDI by following a second-level reviewer. This process can also illustrate the life a chart has after the patient is discharged.

Make sure to orient the CDI specialist with the providers. It might be helpful for new staff to do an elevator speech about who they are. An elevator speech is a practiced, 30-second introduction, explanation, or question that is succinct and usually directed to providers while riding an elevator, as that is a place where there is a captive audience. But the elevator is not required, as it is most important to introduce a CDI specialist and briefly discuss his or her background with providers so that they will recognize the CDI specialist down the line. It is also good to introduce new employees to the facility's administration. Many new CDI specialists have never had any interaction with administrators, so make sure to introduce new staff, as face-to-face interaction helps welcome new employees and shows they have support throughout the organization.

Another helpful tool is a subscription to a year of involvement with a CDI professional organization. Not only is a membership an excellent resource but joining the CDI community is supportive too.

would not be effective. Frequently this is seen in reportable data that can be rewarded years after the collection period.

Along this line, consider the amount of time the team spends on additional duties or projects. This includes looking at a specific order to make sure it is documented, DRG reconciliation, and learning opportunities for mismatched DRGs. Regular education such as WebExes or provider teaching with preparation will also take time out of the productivity of the specialist reviews.

Queries

In assessing queries, look at compliance. As a queried provider, how would you understand the query? Does the query stand up against the latest AHIMA/ACDIS *Guidelines for Achieving a Compliant Query Practice*? Although provider agree rates may be worth considering, a 100% agree rate could indicate that the CDI is hitting only the low-hanging fruit. Or could the queries be leading?

Query rate

The query rate opportunity for certain service lines is negligible. For other service lines, opportunities can cause a glutton of queries that will eat up a lot of the CDI efforts. This means that certain statistics, such as query rate, should be relative. Reporting queries as group effort and in a larger time frame will stabilize the query rate.

The tables in Figure 2.6 illustrate how query rates are not necessarily reflective of productivity.

Figure 2.6: Which CDI specialist works harder?

CDI A

	Queries	Charts	Query rate
Week 1	10	20	50%
Week 2	8	20	40%
Week 3	5	20	25%
Week 4	20	20	100%
Monthly Totals	43	80	54%

CDI B

	Queries	Charts	Query rate
Week 1	10	30	33%
Week 2	8	25	32%
Week 3	5	25	20%
Week 4	20	50	40%
Monthly Totals	43	130	30%

Chapter 3

Clinical Validation

Recently, both government and commercial payers have begun using a new tactic in reducing reimbursement. They now declare that diagnoses must be clinically valid despite a directive from the *ICD-10-CM Official Guidelines for Coding and Reporting* instructing that what the provider documents is what should be coded. The coding guidelines specifically state:

> *The assignment of the diagnosis code is based upon the provider's diagnostic statement that the condition exists. The provider's statement that a condition exists is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.*

No matter how many times this statement from the official coding guidelines is used in appeals, payers continue to deny diagnoses that they don't deem clinically valid. This puts coding and clinical documentation integrity (CDI) in the middle because while the official guidelines say one thing, the payers operate differently.

This in turn negates all the hard work the CDI specialists spend in improving documentation. It raises the question of what to do with diagnoses that are codable but not clinically supported. By essentially forcing clinical validation of diagnoses, payers' behavior also solidifies CDI's contribution to hospital finances now in two ways: by improving reimbursement and by reducing the amount paid back from denials because of CDI's work in clinical validation.

Before these statements about clinical validation first appeared in the *2017 Official Guidelines for Coding and Reporting*, diagnoses without clinical support were left off the coding summary because it was not clear how to deal with clinical validation. The 2017 guidelines forced everyone to code the unsupported diagnosis and figure out how to get around payer denials. The Association of Clinical Documentation Integrity Specialists (ACDIS) then produced a white paper in 2017,

Figure 3.1: Example of a sepsis validation query

Reason for query: Sepsis confirmation—typical clinical criteria are not documented

History:

Admission Assessment/Plan:

Clinical Indicators:

Underlying/localized infection:

Admission VS:

Admission exam:

Glucose in the absence of diabetes:

White blood cell count:

Lactic acid:

Procalcitonin (remove if not pneumonia):

Treatment:

Sequential Organ Failure Assessment (SOFA) Variables (done on admission unless otherwise noted):

P/F ratio (PaO2/FiO2):

Platelet count:

Total bilirubin:

Mean arterial pressure:

Glasgow coma scale:

Creatinine:

Urine output:

Question: Please provide additional supporting evidence for the diagnosis of sepsis.

Consider SOFA criteria if appropriate. If citing Sepsis-2, please clarify what variables represent a systemic response to infection, exceed the expected findings in a localized infection, and are not easily explained by other conditions.

- Sepsis was present with supporting evidence of _____ (please specify)

- Sepsis was determined to not exist, only the localized infection of _____

- Other (please specify): _____

- Unknown

(Include present-on-admission [POA] clarification in options above if applicable.)

As manager of an outpatient CDI department, comparing the beginning RAF with the final RAF after CDI intervention will show the financial impact for the team. Multiply that times the number of practices covered, and it demonstrates the need for a separate CDI team for outpatient CDI.

Evaluation and management services (E/M)

E/M reimbursement is mostly for the face-to-face services the practices provide. The documentation required for this type of billing is based on a medical decision-making perspective. Levels of E/M coding depends on a new or established patient, and there are also differences between office visit and inpatient E/M coding. CMS outlined documentation practices for E/M services as follows (CMS, 2017):

General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, these general principles help ensure that medical record documentation for all E/M services is appropriate:

- *The medical record should be complete and legible.*

- *The documentation of each patient encounter should include:*

  - *Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results*

  - *Assessment, clinical impression, or diagnosis*

  - *Medical plan of care*

  - *Date and legible identity of the observer*

- *If the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred.*

- *Past and present diagnoses should be accessible to the treating and/or consulting physician. Appropriate health risk factors should be identified.*

- *The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.*

- *The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.*

- *To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter.*

How to approach key stakeholders

Start by looking at the organization and enlist the denials department. Talk to the professional services coders. Get familiar with common acronyms used in the outpatient setting, such as *pay-for-performance, value-based purchasing, HCCs, RAF, per member per month,* and *accountable care organizations*. These are in the primary care provider's language these days. Analyze where CDI can make a fast win. This will get the momentum going for creating a program.

Chapter 4

CDI Communication and Relationship Building

Leaders in healthcare have typically attended networking conferences or classes. Networking seems to be one of those skills that either comes very naturally to some or is completely unnatural and therefore avoided by others. But networking is essential in the clinical documentation integrity (CDI) profession. Team members who are natural networkers will be assets in building the success of a CDI team. But for those who are not natural networkers, it is still possible to learn networking techniques over time and implement them in ways that benefit CDI professionals.

Improving Communication and Building a Network

Good communication skills foster CDI success. Although many are aware of how essential good communication is, it can still be difficult to create a communication improvement plan for a CDI team that both is practical for the team but also holds them accountable for measurable results. It is one thing to set a goal to improve communication. It is a completely different thing to be able to demonstrably prove communication has gotten better across a team. One of the challenges with building great communication skills within CDI is that the different ways in which CDI specialists must communicate to various parties who are vital to CDI's success are as diverse as the CDI specialists themselves! Let's break down these different relationships, how communication styles may differ, and how these communication skills are key to building both an internal and external network.

CDI communication

The ways in which CDI specialists communicate among themselves and how the CDI leader communicates to a team will impact the overall success. Just as there is no one-size-fits-all CDI department,

there is also no one-size-fits-all communication style. Three factors affecting the communication within the CDI department are the size of the team, whether there is a remote work option, and whether members of the CDI team are all from similar backgrounds. In this case, *similar backgrounds* refers to whether the CDI team is composed of professionals from a given specialty or type of position. This could mean the CDI team is composed of only RNs. A more diverse CDI team may have RNs, medical doctors, or midlevel providers (e.g., physician assistants or nurse practitioners) on the team.

Additionally, a CDI leader's background as well as the reporting structure (whether the CDI department reports to an executive level or whether there is a more complex reporting structure through health information management, quality, case management/utilization review, or another clinical avenue) will likely affect the communication style. One example of the impact reporting structure may have on communication is the comparison between a CDI leader who reports directly to an executive level and is only responsible for CDI vs. a CDI leader who is also responsible for departments such as case management and utilization review. A leader who is responsible for multiple departments is going to have multifaceted goals that intersect with the CDI mission. This type of leader may have a CDI team whose goals focus on impacts for departments beyond just CDI (e.g., the impact of the working diagnosis-related groups [DRG] on length of stay). One type of leadership is not necessarily easier than the other, but these differences will likely impact communication methods.

This is important to keep in mind as CDI leaders or the organization evolve and consider additions to the team, different reporting structures, and various goals.

Three important communication standards for CDI

First, although complaining within the workplace may have seemed to reach an all-time high, it will get specialists and CDI teams nowhere. It is inevitable that staff will complain, and it will be difficult not to take it personally. After all, leaders have invested their professional energy and expertise into building a CDI team. It is a reasonable expectation to want the team to be happy in their work, but it is unreasonable to expect them to always be happy. Any leader in any position will hear some complaints at some point. In CDI, the most likely culprits will be CDI specialists who think that the expected metrics are unreasonable or unattainable, or those who think that "physician X always avoids me" or "physician Y always answers queries with less-than-optimal responses." It is important to redirect this type of conversation to highlight what the team or individual CDI specialist has been able to accomplish in terms of metrics. Challenge those individuals who are complaining about physician engagement to research this topic on industry professional organization forums. They will find that generally all CDI specialists and CDI programs face the same challenges. CDI leaders should acknowledge the frustration but also lead staff to constructive ways of dealing with frustration rather than allowing unproductive complaining to continue.

Second, there is no hierarchy in the perceived value of CDI team members. While this should go without saying, it is never okay to permit an environment in which there is a perceived hierarchy of the

Chapter 5

Data Analytics, Key Performance Indicators, and CDI Return on Investment

At this point, this book should have provided a good understanding of how to structure a clinical documentation integrity (CDI) department, the committee involvement and interactions the CDI team has with other departments, and the software the team utilizes to enhance CDI efforts. It is now important to focus on ways to determine a CDI team's success.

As each healthcare organization prioritizes differently, every CDI leader will likely be told at least to some degree the metrics that will determine not only the leader's level of performance but also how the CDI team's performance will be evaluated. This core set of metrics and the significance placed upon them likely will be attributed back to the reporting structure. For example, reporting through the health information management department and ultimately to a chief financial officer (CFO) will likely mean that a CDI leader will be routinely reporting and being evaluated on measures such as comorbid condition (CC)/major comorbid condition (MCC) capture rate, overall financial impact, increase/decrease in case-mix index (CMI), and query rate. Conversely, for those who report through a quality chain of command and ultimately to a vice president of quality or medical affairs, there may be greater emphasis placed on CDI's perceived impact on mortality scores, hospital-acquired conditions (HAC), and patient safety indicators (PSI).

Figure 5.1: CDI reconciliation process

Process: Upon receipt of the current query report:

1. Each chart will be opened and compared with the final DRG.

    a. The query impact will be corrected as necessary.

    b. The baseline DRG impacts will be set in association with the final DRG.

        i. Medical:

            1. Whatever has been documented before CDI queries is the doctor's DRG.

            2. After CDI queries, then the viable DRG is the CDI DRG.

        ii. Surgical:

            1. If the patient goes to surgery, then the surgical DRG that correlated to the principal diagnosis (PDX) and principal procedure (PPx) is the baseline DRG.

            2. Take out the CC/MCC that CDI got, put in the PPx, and complete the encoder.

            3. Make that the baseline DRG.

            4. Then go back to the encoder and add in the CC/MCC that was queried. This is the CDI DRG.

        iii. Caveat:

            1. If you have queried and got a CC/MCC but the doctor also adds a new CC/MCC, you lose your gain.

                a. Example:

                    i. DRG 282 acute myocardial infarction (AMI) discharged (d/c) alive without CC/MCC.

                    ii. CDI queried for congestive heart failure (CHF) specificity and gets acute systolic heart failure.

                    iii. Now the CDI DRG is 280: AMI d/c alive with MCC.

                b. Patient goes for coronary artery bypass graft (CABG):

                    i. New DRG BASELINE: 236 Coronary bypass w/o cath, w/o MCC.

                    ii. New CDI DRG: 235: Coronary bypass w/o cath w/ MCC.

                    iii. In the encoder, put in the CABG and take out the CHF. Code it, reset the baseline, then recode with the MCC.

        iv. Queries that make an impact:

            1. MCC, CC, PDX, POA, PPx

2. Reconciliation

    a. If yes:

        i. Check the CDI reconciliation complete.

    b.   If no:

        i.   Do not check the CDI reconciliation complete.

        ii.   Escalate to the second-level reviewer.

        iii.   The second-level reviewer will communicate with you via email/phone as necessary.

3. Frequency of reporting will be Tuesdays and Thursdays. It is a rolling list, meaning the records from the prior report are not reconciled and they will return to the current report.

4. All efforts to complete the past month's reconciliation are to be done prior to the new month (e.g., January must be completed before March 1).

Once the CDI specialist has worked out the correct baseline DRG vs. final DRG with the query impact during the reconciliation process as shown in Figure 5.1, it is up to the manager to make sure that the reconciliation is correct. This may mean double-checking the specialist's work. Sometimes the specialist struggles with reconciliation because of the complexity of the concept. Sometimes the specialist can't bear to lose the query impact when other CCs or MCCs that nullify the impact of the original query show up naturally in the chart. Then there are times the specialists just mark the chart reconciled without working through the process, which is a different issue that needs to be dealt with. This may mean the manager has to look at every chart depending on how it is set up, and there are examples of what to look at while reviewing a query report.

Most financial impacts are a couple thousand dollars, apart from excisional debridement. If there is an outlier for a financial impact, such as one around $65,000, that may indicate a medical baseline DRG to a surgical final DRG. It would be best to check over that chart. The same thing should happen with tracheostomies. This is a very high-paying DRG, and sometimes a CDI specialist will forget to reset the baseline to accommodate for that.

Case-mix index

CMI is the sum of all DRG RWs divided by the number of patients for a specific period. Most healthcare facilities calculate CMI both monthly and annually. List each DRG billed during the calculation period as well as its corresponding weight. Total all of the RWs and divide that number by the total number of individual DRGs. The result is the hospital's CMI for the calculation period. For example, if a hospital billed 35 DRGs for a one-month period and relative weights totaled 40, the CMI for one month is 35/40, which equals 0.875.

CMI can be volatile from month to month because it is affected by other factors, such as a surgeon leaving a practice, an increase of medical cases and less surgeries on the whole, or a service line of physicians who go to a conference. Because of the wide difference in RWs, it is helpful to state the medical and surgical CMI and then the combined CMI. CMI is then multiplied by the facility base

Chapter 6

Vendor Involvement and Technology Tactics

Once the clinical documentation integrity (CDI) team is working like clockwork, do not fall into the trap of thinking it is time to settle back and get into a routine. Instead, it is time to plan for the CDI worst-case scenarios.

Vendors and Staffing

It is always difficult when a CDI specialist leaves, because all that training and mentoring is going somewhere else. In the current CDI climate, finding specialists can be difficult because demand outweighs the supply. It can take six months to a year to get another specialist to replace the caliber of the one who was previously employed.

There are many vendors who can supply temporary or permanent specialists to help maintain CDI productivity, but there are considerations to be made with this type of solution. Take into consideration pay differences between the temporary specialist and the resident CDI team, return on investment (ROI) between the cost of the contracted CDI specialist and the financial impact of his or her work, and the effect on the rest of the team for morale, competitiveness, and territorial tendencies of the resident specialists. Make sure to vet these specialists for their skills and experience. Consider if this will be a temporary Band-Aid or a permanent replacement, which makes a difference when it comes to replacing a specialist. A temporary replacement will only fill in the gaps until a permanent specialist is hired, so any issues with the replacement specialist are only temporary.

strengths and weaknesses of documentation for an individual organization. It reflects length of stay, CC/MCC capture rates, mortality rates, and readmission rates. The data is mainly inpatient and short stays divided by state. Because MedPAR data is abstracted from the UB-04 claims forms used for Medicare billing, the only population represented in the MedPAR data is the Medicare population.

Look at the time frame for a comparison: Were there any changes or events that made an atypical difference in billing? Compare organizational and MedPAR data in the same DRG group, such as 193 to 195, as an example. Observe the organizational percentage of each DRG for the group, and if the organizational percentage is lower than the MedPAR percentage at the higher-paying DRG 193, calculate the difference between these two data points. Vendors often take that difference between data points to demonstrate the percentage of reimbursement the organization misses out on for the change from DRG 195 to DRG 193. Be wary of 100% capture of MedPAR for that DRG, meaning the organization matches or exceeds reimbursement for the higher DRG, because it is a red flag for auditors and could be investigated. Auditors will look at how 100% capture happens by investigating whether queries are compliant or whether there are fraudulent practices going on. Figure 6.1 demonstrates how MedPAR data can be used for these comparisons.

Figure 6.1: Example of MedPAR data use

DRG	Claims for this DRG	Reimbursement based on $5,000 blended rate (Relative weight [RW] x Claims x Blended Rate [BR])	Percentage of DRG	MedPAR percentages for DRG	Projected DRG claims captured on MedPAR levels	Projected MedPAR level reimbursement (RW x MedPAR x BR)
195	536	$1,840,624	53.6%	15%	150	$515,100
194	314	$1,413,314	31.4%	30%	300	$1,350,300
193	150	$987,535	15.0%	55%	550	$3,620,925
Total	1000	$4,241,463	100%	100%	1000	$5,486,325

2019 RW: DRG 195 - RW 0.6868; DRG 194 - RW 0.9002; DRG 193 - RW 1.3167

This MedPAR data is only an example for illustrative purposes. Please visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/MEDPARLDSHospitalNational.html *for current data.*

In Figure 6.1, capturing all simple pneumonia DRGs (195–193) at the same rate as the MedPAR data would lead to an increase of $1,244,862 in reimbursement. That is a lofty goal for a CDI team, but not insurmountable. Because MedPAR covers all DRGs, this could lead to discovering tens of millions of dollars that CDI appears to be leaving on the table. Keep in mind that 100% capture of MedPAR data is not always feasible. If the team is advanced and on top of the principles of DRG management,

THE CDI DIRECTOR'S CUT
A Guide for Effective Program Management

Johanne Brautigam, RN, BSN, CCDS | Mindy Davis, RHIT, CDIP, CCS

When individuals are asked to step into CDI leadership roles, they often have little to no guidance on the skill set needed to lead effectively. But given that documentation integrity is vital to reimbursement and quality initiatives, CDI leaders must be able to leverage their staff's talents to achieve the best results for their health system.

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