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The Physician Advisor's Guide to Clinical Documentation Improvement

Trey La Charité, MD | James S. Kennedy, MD, CCS, CDIP

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About the Authors

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James S. Kennedy, MD, CCS, CDIP, is a general internist trained at the University of Tennessee in Memphis in the 1970s, practiced in multispeciality groups (including Vanderbilt) near Nashville during the '80s and '90s, and has been designated as a certified coding specialist and clinical documentation improvement (CDI) practitioner by the American Health Information Management Association since 2001. As a seasoned advocate and consultant since 2000, Kennedy served on the advisory board of the Association of Clinical Documentation Improvement Specialists (ACDIS) and has been a speaker at multiple national conferences as well as author of numerous books and newsletter articles on the application of clinical documentation to the world of coding.

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Introduction

If you are reading this, you have probably been asked to serve as a physician advisor or champion for your facility's clinical and coding documentation improvement (CDI) efforts. Perhaps you were chosen due to your experience as a physician advisor with case management or utilization review. Perhaps you have been asked to take on this role due to your previous help with CDI efforts. Or perhaps you are known for your excellent documentation habits.

Regardless, the role of a CDI physician advisor is a unique one and requires the specific insight you have as a clinician. Additionally, the analytical skills you possess to translate documentation trends into meaningful information for your fellow physicians and an awareness of how healthcare data are used in this country—including healthcare reform, reimbursement, and quality improvement efforts—are valuable attributes.

While some CDI programs have been in place since the Centers for Medicare & Medicaid Services (CMS) developed diagnosis-related groups (DRG) in 1983, many more have emerged since the implementation of the Medicare Severity DRG (MS-DRG) in 2007.[1]

What is a DRG and why did this development spur the growth of an industry? Coding and DRG determination will be discussed in more detail later on in this book; suffice it to say, however, that too often the stringent rules governing code assignment confuse or frustrate clinicians. For example, the term "urosepsis," which means "sepsis due to a urinary tract infection" in most clinicians' minds, has no code in the International Classification of Diseases 10th Revision (ICD-10).

INTRODUCTION

Few medical schools offer instruction on healthcare reimbursement methodology. Physicians rarely have the opportunity to attend Coding 101 classes. What lessons physicians receive regarding medical record documentation are frequently forgotten in the hectic, harried days and nights of residency as they hurriedly scratch out patient orders and discharge summaries.

CDI programs can help. CDI is the process of promoting consistent, complete, precise, reliable, nonconflicting, and legible provider documentation integral to the compliant submission of Health Insurance Portability and Accountability Act transaction (code) sets. CDI programs take the physician's clinical acumen and break it down to its underlying components—translating all that is and is not included in the medical record—to determine what additional documentation may be required for accurate coding and reporting required by the ICD-10 or Current Procedural Terminology code sets. Although Congress included language in its 2014 regulations governing implementation of the Sustainable Growth Rate postponing implementation of ICD-10 until at least October 2015; querying providers now for the specificity that will be needed will help the entire system make a smooth transition. Throughout this book the reader will receive instruction using examples from both code sets, althought the authors of this book intend to focus on ICD-10.

CDI professionals, who frequently come to the role from either nursing or health information management (HIM) backgrounds, work with both physicians and coders to define and document the complete story of the patient's medical needs and the care provided in the language ICD-10 requires. While this is ideally performed concurrently—in real time, while the patient is in the hospital—it may also occur after the patient leaves the acute care setting.

Clearly, there is an inherent need for cooperation between physicians and coders. In fact, the *Official Guidelines for Coding and Reporting* states:

- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved.[2]

Essentially, DRGs implementation helped spur the growth of CDI because acute care facilities (hospitals) faced losing valuable reimbursement if unable to capture the clinical specificity needed to code principal

and additional diagnoses or procedures to illustrate the patient severity. DRGs spurred the growth of CDI because the gap between physician's clinical language and the regulatory language of coding required a translator.

CDI programs require a fully invested team effort to be successful. That means CDI specialists must work with their HIM and coding counterparts. It means they must work with physicians to educate and assist them. It means they must work with their chief medical officer and senior management to demonstrate how their efforts benefit the facility and the physicians. That is a lot of support and a lot of balls to juggle. You can help.

A strong physician advisor can greatly increase the success of your organization. Surprisingly, as new as CDI may be, the role of the physician advisor is relatively new, too. Twenty years ago, few hospitals thought of using a physician as a regular resource even for case management or utilization review purposes. However, as clinical issues gain greater prominence in revenue cycle management, many facilities have added this role. The question becomes how to ensure that your facility obtains the maximum benefit from your efforts.

Organizations often struggle to obtain resources for a full-time physician advisor because there are few road maps to chart responsibilities, provide job descriptions, and outline demonstrable goals associated with the position. Facilities need to determine what structure best suits their programmatic goals and how to best use their physician advisor. For example, it may make sense for a facility to hire a physician advisor specifically to address case management concerns related to readmission reductions and for that individual to also work closely with quality assurance to determine whether patient safety indicators are accurately reported. Alternatively, it may make sense for a physician advisor to wear dual hats, one for case management and another for utilization review, to ensure that patients meet medical necessity requirements for inpatient admission and that the services provided are appropriate to the patients' severity of illness.[3]

More than half of CDI programs have a dedicated physician advisor, but only a quarter of those solely support CDI and coding departments. Although most do double duty as case management or utilization review advisors, there has been an increased effort from industry activists to ensure their dedicated responsibility for defense of the medical record. As awareness about medical record documentation and coded data ties to physician and facility quality metrics, medical research, claims denials, and reimbursement, many facilities find focused physician advisor assistance in CDI efforts indispensable.[4]

As you will learn throughout this book, a dedicated physician advisor will have to play multiple roles. They will most likely be called on to provide seminars for fellow physicians and clinical education sessions for coders and HIM staff. CDI team members will seek out their assistance on difficult clinical cases and ask for input on the creation or revision of standard query forms. As a physician advisor, you may be asked to hold the hand of a difficult physician or timid CDI specialist. You might also be asked to act as the disciplinarian; to confront a physician who repeatedly ignores queries or documents inappropriately. You will also need to work closely with the CDI manager or director, the HIM director, the chief financial officer, and the chief medical officer to identify trends and spot solutions.

Will it be difficult? You bet. But it is also one of the most rewarding roles you will play. Why? Because not only will you be helping improve the quality of care patients at your facility receive, but you will also be helping all the staff—from your physician coworkers to coders to managers—ensure that your facility gets the credit it deserves for the exemplary care your facility provides.

We know you are up to the task, and we are here to help you get started.

ENDNOTES

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2. Centers for Disease Control. ICD-10-CM Official Guidelines for Coding and Reporting. *www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf.*

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CDI Foundations

Traditionally, physicians' responsibilities lie with assessing the patient's needs, diagnosing the patient's condition, developing a treatment plan, and caring for the individual until he or she can be safely discharged. All of this care needs to be documented in the medical record by the physician.

Few physicians, however, are taught in medical school how their language and documentation affects various other departments, reimbursement (both their own and their hospital's), quality data, or other data uses. When their documentation is reviewed, it is typically reviewed by another member of the medical staff to ensure appropriateness of care. Period.

On the other hand, coders assigning International Classification of Diseases (ICD) and Current Procedural Terminology (CPT®) codes, generally speaking, do not have extensive clinical training. Their role is to read through the various notes and documents to cull the patient's principal diagnosis and any extenuating conditions and treatments provided and to assign codes based exactly on what the provider documented. If the documentation is illegible, incomplete, imprecise, inconsistent, conflicting, or unreliable, a provider query is warranted or, in some cases, mandated.[1]

Team Composition

Enter the clinical documentation improvement (CDI) specialist, a specially trained individual charged with bridging the gaps between providers and coders to clarify at-risk documentation prior to claim submission.[2] Because they work as translators and because complete and accurate clinical documentation is used by so many different venues for so many different reasons, a fully integrated team approach is vital.

It's why your help, as the physician advisor, is needed, too. It is why CDI programs require the participation of various stakeholders—from both the revenue cycle management and clinical sides of the house.

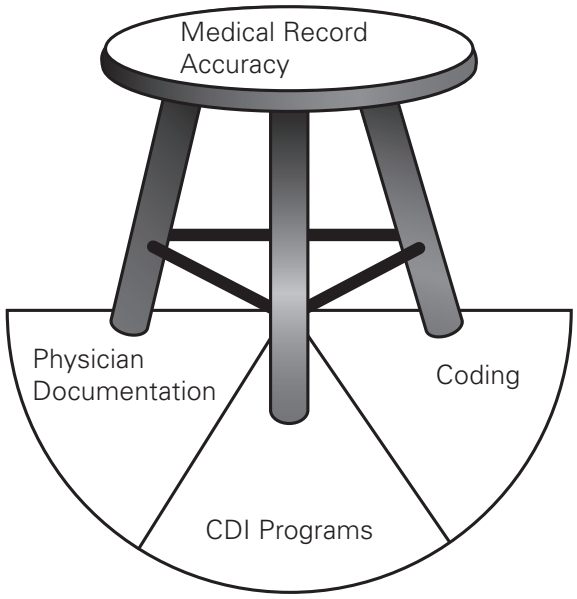
The elemental CDI team includes the CDI staff, the coding staff, and the physician advisor/medical staff. Since the most basic CDI program conducts concurrent reviews to ensure the accuracy of the clinical information in the medical record to enable compliant code assignment, these three aspects represent the three legs of the stool that supports medical record accuracy, as illustrated in Figure 1.1.

Steering committee

Prior to CDI program implementation, various department leaders need to create a steering committee to determine the priorities and goals of the CDI effort. On this level, the team includes the very top administrators, including (but not limited to) the:

- Chief financial officer
- Chief medical officer

1.1 Three-Legged Stool Supporting Medical Record Accuracy



- Health Information Management (HIM) director
- Chief compliance officer
- Director of case management or quality

Together, these individuals can set priorities such as ensuring the integrity of physician quality reporting metrics and the case-mix index or preparing physicians for the transition to the ICD 10th Revision (ICD-10) clinical modification (CM) and procedural coding system (PCS). This high-level team also ensures the program implementation is compliant and that support for its efforts trickles down to other professionals once the program is implemented.

More advanced CDI programs may include additional team members. Programs with five or more years' experience frequently focus on more robust quality metrics (e.g., all-payer refined diagnosis-related groups [APR-DRGs], Centers for Medicare & Medicaid Services [CMS] public profile improvement, Agency for Healthcare Research and Quality [AHRQ] patient safety indicators), denials management, and other concerns as they relate to the capture of documentation.

In this vein, the CDI administration may begin to meet monthly or quarterly to review data trends with ancillary department staff, such as case management or quality. They may even connect the various staff members on a regular basis to discuss how their focus areas dovetail and to provide insight on how each facet may compliment the efforts of the other.

For the purposes of this book, let's look at the responsibilities of our core team members.

Core Responsibilities

CDI role

The primary responsibility for day-to-day program efforts generally falls to the CDI professionals themselves. These CDI staff members are generally tenured registered nurses, though strong coding professionals or physicians also serve. They frequently come to the position after multiple years of clinical or coding experience, drawn to the idea of regular, if not flexible, hours, decreased physical labor, and increased analytical challenges associated with the role.[3]

Typically, facilities train new CDI staff either on the job, through a consulting firm, or by sending them to intensive classroom workshops where they learn basic coding and risk-adjustment methodologies associated with documentation improvement strategies.

The CDI specialist delineates documented diagnoses or treatments in the context of the patient's presentation and treatment within the limitations of coding requirements. When they see an opportunity to provide additional clarity, they contact the physician to discuss the clinical indicators and request additional specificity.

Conducting concurrent medical record reviews and physician queries are CDI specialists' primary responsibility. To do this, he or she must fully understand the industry guidance regarding compliant query practices as well as industry codes of ethics from the American Health Information Management Association (AHIMA) and the Association for Clinical Documentation Improvement Specialists (ACDIS). Simply asking physicians to clarify their documentation isn't their only role; they must ensure the validity of the answer they receive as well.

In fact, many now believe that an attainable goal for CDI departments would be to become "query-free," educating physicians about changing documentation requirements and querying only in tandem with teachable moments and effective educational elements. CDI specialists frequently serve as a touchstone source for coding information and query composition and support. They can also provide a higher level of awareness to physicians regarding the importance of the various pieces of the documentation process, including the history and physical, the operative note, and the discharge summary.

Facilities in the process of implementing electronic health records (EHR) may use their CDI team to help provide physician training as to its use, work with their information technology teammates on process flow concerns, and serve as a resource to team members on items related to the patient problem list and EHR drop-down menus.

CDI specialists must regularly work with their coding counterparts to identify trouble spots and trends in physician documentation and new coding concerns. Similarly, they must regularly meet with utilization review and case management staff when they spot areas of concern. CDI efforts may lead individuals to work with quality data interpretation to improve the facility and physician risk-adjusted mortality levels, patient safety indicators, and facility and physician quality scorecards. Often, CDI programs work with

the denials management team, as well, to identify documentation trends in recovery auditor claim denials, areas where additional specificity may be all that's needed to keep a claim from being denied.

Finally, they need to regularly review their work to ensure not only efficiency but also compliance and accuracy. For example, they need to ensure the queries they submit do not lead a physician to document a certain condition, that the query offers a variety of options to clarify the care provided and the clinical thinking of the physician. In this vein, the CDI team may also regularly work with their compliance and auditing department to monitor these efforts.

The appendix includes a sample CDI specialist job description and the online tools include the 2014 ACDIS position paper regarding expected CDI responsibilities.

Coding role

The ICD codes are the standard diagnostic tool for epidemiology, health management, and clinical purposes. In the United States, the Health Insurance Portability and Accountability Act of 1996 requires the use of the code set for particular types of claims in order to standardize all healthcare transactions. As such, ICD codes have become the basis of healthcare payment systems in the country. The codes are also used to classify morbidity data from hospital inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys. A clinical modification of ICD-10, known as ICD-10-CM, could be implemented for clinical use in the United States on October 1, 2015, alongside a new procedural classification system, known as ICD-10-PCS.

To assign a code, the coders follow rules contained in the *Official Guidelines for Coding and Reporting*, which are developed and approved by four vested agencies known as the "Cooperating Parties." They are:

- The American Hospital Association (AHA)
- AHIMA
- CMS
- NCHS

These codes and their resulting Medicare Severity DRGs (MS-DRGs) must weather the test of time, support the documentation in the record, and hold up to any retrospective scrutiny from outside auditors.

So when a coder is uncertain about what diagnosis the physician treated, he or she would ask the physician either informally or formally through a query process. Since the proliferation of CDI programs, CDI professionals have endeavored to clarify information in the health record concurrently, while the patient is still in the hospital, to alleviate the need for extensive queries during the coding process.

Although CDI professionals can help obtain clarification, it is always the treating physician's responsibility to diagnose and accurately document that diagnosis in the medical record and it is always the coder's responsibility to determine which codes are finally submitted.

As experts, coders have significant insight in the rules and regulations governing code assignment that can be used to defend a particular code assignment should an auditor deny a claim. In some cases, facility-specific HIM/coding policies, such as those related to when documentation from an attending or resident physician may be used, may also affect the policies and procedures of the CDI program and help protect the facility against auditor claim denials.

The HIM/coding staff may be called upon to maintain ownership of the record reconciliation process. In situations where the CDI staff and the coding staff assessment of the principal and secondary diagnoses do not match, the team would discuss the concerns and if necessary escalate the record review to the HIM manager and/or the physician advisor. This helps ensure the correct coding of cases and allows for specific feedback regarding potential miscommunication of what occurred clinically, what the physician documented, and what the coder can apply.

A discussion of query policies and procedures as they relate to industry expectations on the matter occurs later in this book; however, it is worth noting that the 2013 ACDIS/AHIMA physician query practice brief, "Guidelines for Achieving a Compliant Query Process," calls on facilities to create an escalation process that may include the physician advisor for situations where a diagnosis is documented but limited clinical support for the diagnosis exists.

At many facilities, coders own the responsibility for post-discharge (after the patient has left the facility but before the case is coded and billed) and retrospective queries (any follow-up questions that may remain

after the patient has left the building). Due to expected coder productivity decreases associated with the implementation of the ICD-10-CM/PCS code sets, however, many CDI programs are taking another look at their processes and considering whether CDI specialists would best serve as the owners of all queries regardless of where they fall in the patient's time line. This requires clear lines of communication between the two teams and may work best in a program where no departmental distinction exists between the CDI and coding staff members.

At any rate, because the coding staff has the knowledge regarding the nuanced coding rules and regulations, they should be frequently consulted and considered teammates in the CDI work flow.

Physician advisor

The physician advisor role can vary depending on the needs of the facility, the structure of the CDI program, and the availability of the physician. Smaller hospitals may decide to appoint a single individual on a part-time basis, whereas larger facilities may employ one, two, or more physicians, to support CDI efforts.

A single physician advisor, at a minimum, should have an interest in revenue cycle management, understand the importance of coded data on hospital and physician reimbursement and quality metrics, and have a good working rapport with other physicians at the facility. This individual could be expected to:

- Work with the HIM and CDI personnel on a routine basis to review selected health records concurrently or retrospectively
- Meet regularly with the CDI team to identify target topics for physician, CDI, or coder education
- Explain documentation issues found in chart review, including common issues (e.g. congestive heart failure, chronic kidney disease, pneumonia, respiratory failure) to various stakeholders
- Help develop clinically appropriate and compliant provider queries to further clarify documentation
- Help craft clinical guidelines for query processes
- Work with physicians and CDI professionals to resolve outstanding queries
- Analyze query trends and documentation data to identify trouble spots

- Provide targeted education to physician groups and/or one-on-one guidance to difficult physicians
- Relay data trends and other information to department chairs and hospital administration
- Facilitate complete health record documentation by addressing admission denials, DRG modifications, and repetitive queries
- Communicate with third-party payers regarding admission denials, DRG changes, and other issues; aiding in quality assurance, core measures, and other initiatives also comes under the purview of the physician advisor

The appendix includes a sample physician advisor job description.

In the early days of CDI program development, employment of physician advisors seemed optional. Those facilities that employed a physician advisor often used their acumen minimally to address concerns related to outstanding queries and difficult (non-compliant) physicians. Today, it is widely understood that physician advisors to CDI programs play a far more integral role. Today, physician advisors are frequently called upon to address such concerns and many more—from reviewing claims denials from a documentation perspective to providing trending reports, CDI program analysis, and so forth.

For example, today a physician advisor might be expected to understand how CDI supports higher evaluation and management (E/M) billing levels (how physicians bill for their professional services) and more accurate public profiling. They could be asked to explicitly illustrate to individual physicians how their public report cards compare to their peers. They could also be asked to audit CDI specialists' query forms to ensure compliance and work with those CDI or coding professionals who appear to be having difficulty with particular clinical concepts.

Some facilities employ physicians as their CDI professionals. In these situations, physicians review records, query, reconcile outstanding concerns, and more. In such circumstances, physicians could be assigned by service line to work with their peers, or they could follow a more traditional model. These physicians may receive a stipend for their efforts and maintain their general medical practices, or they may be hired outright as full-time CDI specialists.

To be effective, physician advisors need to have:

- **Credibility with the medical staff:** They should be known to their medical staff associates, be fairly well respected, and be able to work well with others.
- **Leadership experience**: Frequently, meeting the above objective means this individual has already played a leadership role within the hospital or medical staff, although not necessarily so. One may have great credibility among one's peers without having been in a leadership position. However, those who have served in previous leadership roles come to the CDI physician advisor position with an awareness of potential aspects of the job, such as interdepartmental relationships, meeting requirements, reporting and analysis responsibilities, among other items.
- **Active clinical practice**: Those physician advisors who opt to maintain their clinical practice may be an asset to the CDI team. In dealing with day-to-day patient care concerns, these individuals have real-life clinical experiences to draw from and share with their CDI and medical staff teammates. They can argue in support of the CDI mission without being negatively labeled as an arm of the hospital administration, and can support the medical staff when CDI requests or processes become too onerous or burdensome.
- **Credibility with hospital administration**: Those with previous leadership experience may well have credibility with the hospital administration, but this is not a foregone assumption, either. What CDI physician advisors need to have is an awareness of the overall goals of the institution and how the different departments serve not only their individual specific goals but also each other and the overall mission of patient care. An effective physician advisor will understand the importance of effective communication with the hospital administration while being flexible to its changing needs.
- **Generic insight about clinical documentation and regulatory oversight**: Clearly, a physician advisor who is already well versed in the nuances of healthcare regulations would be a boon to any CDI program. While that is rarely the case, strange mythical creatures do exist (look no further than the authors of this book), so you should snap them up if at all possible. That said, even those without explicit knowledge of healthcare and coding guidelines should be aware of the role such regulations play on both the business of healthcare and on the delivery of the care itself. Such individuals must be interested in pulling at the threads of why such rules exist and how to best adapt to them rather than be confused, frustrated, or overwhelmed by them.[4]

Physician advisors may well be asked to participate in a host of other duties as well, from helping CDI specialists verify diagnoses/comorbidities to reviewing query templates and working with other physicians to solidify clinical indicators for significant diagnoses.

One of the principal roles is serving as a negotiator between all parties vested in CDI. Typically, the right question, phrased the right way, with the right tone, can make all the difference. The following are a few examples:

- "Could I get you guys to write it this way from now on? Here's why ... "
- "Is there any way you could use this form when performing this particular procedure?"
- "Is there any way your staff could document this for us in the patient's chart?"
- "If you are willing to write it this way, you will get more credit for the work you do."

New physician advisors should understand that progress takes time and the more that's learned, the more you'll discover there is to do. Initially, plan on attending to CDI interests between five to 10 hours per week, but remember to be flexible. An effective physician advisor should be willing (and able) to assist clinicians, CDI staff, and coders when the need arises (within reason, of course). Definitely set an agreed-upon response time with the team and applicable "office hours" when your CDI physician advisor hat is securely donned.

Of course, professional compensation must be a consideration. If the physician advisor receives an hourly rate, determine your expectations based on how many office visits you might otherwise receive during that period. Alternatively, salaried physician advisors should review rates for various medical, director-type positions and the compensation such positions earn.

Physician champion

The physician champion role differs from that of the physician advisor. Although many programs use the terms interchangeably, the physician champion often takes on a mentoring or coaching role. Informally, one might consider the champion a cheerleader of sorts for CDI efforts. These individuals may have received CDI assistance on a particularly thorny concern and have seen the light regarding the importance

of documentation improvement. They frequently want to help advance CDI efforts and advocate for CDI applications.

In an informal manner, such individuals can be a particular asset to CDI efforts. They can mentor new physician staff members, walk them through the query process, and explain its importance. They can be a resource for CDI specialists on clinical concerns when they are available. In short, a physician champion can be a provider who understands and supports the mission of CDI, serves as an informal resource for the CDI staff, and promotes the efforts of the CDI staff among their colleagues.

The physician advisor or CDI team may choose to identify co champions, as well, to advocate CDI efforts to various specialties. In academic medical centers, co champions may be residency program directors who work to ensure new residents understand CDI basics prior to entering the facility. Alternatively, facilities that work with private physician groups may choose to identify a physician champion to help connect the CDI team with those groups to identify more opportune avenues of communication and education.[5]

Again, the difference between an advisor and a champion can be more than just the identifier. The role of the advisor requires a dedicated amount of time specifically allotted to analyzing and advancing the mission of CDI and educating various staff members about the clinical documentation needs associated with particular diagnoses. These individuals will have set goals and responsibilities and should be regularly assessed by them. The champion, on the other hand, serves a largely voluntary role, assisting and advocating as he or she is willing and able to do so.

Limitations of physician responsibilities

It is important to note, however, that neither the CDI physician advisor nor champion can document in the medical record of patients for whom they have not provided direct patient care. It is unacceptable for the advisor/champion to add documentation or order services for the purpose of reimbursement/metrics for those under the care of another provider. Just because a physician advisor/champion is an independent licensed practitioner, does not mean he/she can render a medical opinion on all patients nor change the documentation within the health record for a patient not in his/her care.

The treating physician is the individual in charge of that particular patient's care, and all documentation integral to that care needs to be supplied by that physician and must be representative of that physician's clinical thinking and decision-making processes. Additionally, their opinion does not supersede that of

the attending provider when they are consulting, as their documentation would be treated the same as that of any other consultant. If their documentation conflicts with that of the attending, a query for clarification may be warranted. When acting in the role of advisor/champion, he/she must abide by industry standards for communication with the medical team (e.g., querying), just like coding and nursing/CDI staff.[6]

Role of ancillary staff

Aside from coders, CDI specialists, physicians, case managers, quality staff members, and administrators, other professional caregivers can help the overall CDI mission, too. For example, wound care nurses may document the depth or degree of an excisional debridement or a pressure ulcer. Documentation from respiratory therapy may provide clinical indicators that support a query for a more specific diagnosis. Dietitians may provide insight as to how physicians use their documentation for diagnosing malnutrition.

Effective CDI programs will avail themselves of these staff members. Efforts should include basic education regarding the role of the CDI team at a minimum. Additionally, such staff members could be called to participate in regular query reviews or contacted when clinical concerns arise that are associated with a given specialty area.

Organization of CDI Programs

According to a January 2014 ACDIS survey, nearly 50% of respondents indicated that their CDI programs are housed under HIM, followed by little more than 20% that indicated their programs are housed under case management. Other respondents indicated that their CDI programs fall under either finance or quality. Those results shifted somewhat from the early years of CDI implementation, where, according to a 2010 survey published in the *CDI Journal*, 45% reported to the HIM department, 27% reported to case management, and 23% reported to finance.[7]

Common best practice, as these surveys seem to indicate, is for the CDI team to report to the HIM department since their efforts serve the primary goal of ensuring a complete and accurate medical record. Additionally, the alignment of the CDI and coding staff under the management of the HIM department director typically means that staff members will be able to engage each other openly and that staff will receive clear communications regarding common goals and objectives.

However, many programs still report to the case management department. The common thinking here relates to the experience of the CDI staff members, as many employees make the transition to CDI from the case management ranks. Such shifts make it easier for these professionals to wear two hats during difficult staffing times.

Effective programs will have clearly defined lines as to how the duties of CDI professionals differ from those of their case management counterparts. Case managers aim to safely and effectively discharge patients to the best available care center once their acute condition has resolved. They also look for effective ways to eliminate the possibility of a patient's imminent readmission to the hospital due to lack of care or other concerns. Meanwhile, the CDI specialist looks to interrogate the patient's medical record to identify any ambiguous diagnoses and clarify any clinical indicators in the medical record prior to the patient's discharge. These two missions, although they operate in tandem, have very different foci. When CDI professionals have dual roles, it can be confusing to the physicians which hat the individual is wearing. Physicians may begin to see this as a conflict of interest and become disillusioned or disinterested.

CDI programs that report to finance may conceivably need the assistance of the physician advisor more than programs that report elsewhere. Once physicians understand the CDI program as an arm of the hospital finance department, they frequently condemn its mission as one that seeks to game the system to obtain additional reimbursement. In such cases, the physician advisor can act as a counterbalance to such perceptions. Physician advisors can illustrate how documentation improvement can have a positive effect on hospital reimbursement but that it also has a positive effect on physician reimbursement. Physician advisors can illustrate how the documentation improvement team's efforts can improve both the physician and facility quality reporting information, too. Furthermore, they can theoretically illustrate how one physician fares against another and how your facility compares to the one down the street to underscore the value of CDI programs from more than just a financial viewpoint.

Finally, some CDI programs have made the switch to the quality department for the primary goal of gaining support from the overall physician staff. Just as physicians may perceive that CDI programs housed in finance aim to reap primarily financial outcomes, they often frequently perceive CDI programs housed in quality as having outcomes related to quality improvement. Similar to programs housed in case management, however, CDI administrators need to guard against mission creep. That is, CDI professionals need to maintain the interrogation of the medical record for complete, accurate, codeable documentation as their primary goal and not be overloaded with duties typically assigned to the quality team.

All these various program reporting structures can prove effective. It simply depends on the overall goals of the program, support from the facility leadership, and ongoing evaluation, support, and effort of the CDI team—of which the physician advisor is an integral part.

END NOTES

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The Physician Advisor's Guide to Clinical Documentation Improvement

Trey La Charité, MD | James S. Kennedy, MD, CCS, CDIP

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