

# Optimizing Clinical Documentation Improvement

For most hospitals, clinical documentation improvement (CDI) remains a top priority. With the move to value-based care, healthcare organizations recognize that better documentation can improve quality, lessen risk and raise reimbursements.

Accurate, complete, compliant and specifically relevant clinical documentation is critical to comply with regulations, as well as for physician and hospital profiles, payment for services delivered and exposure to liability. The transition to ICD-10 and the utilization of the MS-DRG and APR-DRG coding methodology makes precise, comprehensive documentation and coding even more imperative.

## Outpatient Claim Denials Grow, CDI Must Catch Up

A comprehensive CDI program should improve coding documentation for:

- Hospital outpatient services
- Physician practices
- Hospital-based physician services
- Multispecialty physician services
- Emergency services

The dynamics of patient flow through the care continuum have created even greater urgency for accurate documentation in the outpatient or ambulatory setting as hospitals experience fewer admissions and shorter lengths of stay. Many inpatient procedures, surgeries and tests are steadily moving to the outpatient setting.

A typical CDI program occurs in the inpatient setting, but as more physicians become employed by hospitals and hospital-owned practices, it creates a demand for outpatient CDI. An ambulatory/outpatient CDI program is imperative to ensure compliant documentation for optimal reimbursement so hospitals can recoup the expenses/resources used to provide their services and so physicians/providers can get paid for their professional services.

A focused review of each of the following elements helps guarantee accurate charge capture in the ambulatory/outpatient setting:

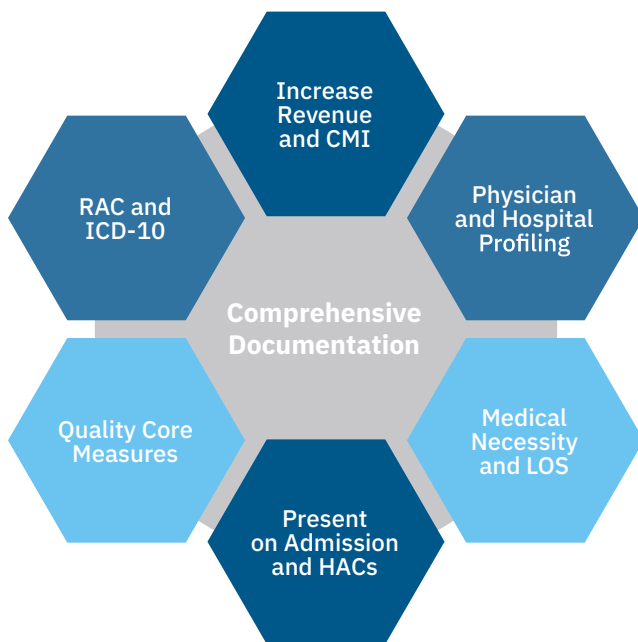
- Clinical documentation and billing records for correct assignment of all Professional CPT- 4 Procedure Coding to include the correct application of modifiers
- Facility process for identifying opportunities to improve the capture of procedures
- Enabling technology and its ability to support efficient processing

The number and complexity of ambulatory services, along with inpatient clinical documentation, should

provide more reimbursement opportunities. Yet, organizations are still trying to catch up.

Often, the lack of optimal clinical coding resides in the sheer volume of outpatient departments, while others may experience a lack of understanding of the financial risk in these areas.

### Comprehensive CDI Impact



## Comprehensive CDI Impact

In a [2019 survey](#) of Association of Clinical Documentation Improvement Specialists (ACDIS) members, 53% of respondents reported that their CDI program reviewed outpatient records for documentation improvement opportunities. In 2018, 14.52% of respondents indicated they had an outpatient query policy in place; in 2019, that number rose to 18.73%, indicating more formalized processes are being developed as outpatient CDI programs mature.

According to the American Hospital Association annual survey, Medicare and Medicaid [underpayments totaled \\$76.8 billion](#) in 2017.

Across the industry, reimbursement environments are more complex than ever, and denials from commercial and public payors are steadily increasing.

The way physicians are reimbursed in the ambulatory setting is another significant issue. Improper payments happen when physicians bill certain services with the incorrect place of service. Performing certain services in their offices can incur additional expenses, and to account for this increase, Medicare reimburses them at a higher rate. However, when they perform these services in settings such as an ambulatory surgical center, Medicare reimburses the overhead expenses to the facility and a lower reimbursement rate to the physician.

As hospitals employ more group practices, they find themselves responsible for the claim denials caused by these improper payments. And, if Centers for Medicare & Medicaid Services (CMS) red-flags a coding error that involves a particular physician, scrutiny can follow that physician into a variety of potential care settings. As Medicare reviews both hospital and physician billing, payors want to ensure that physician and facility billing match. This combined review makes hospital and physician reimbursement vulnerable but presents an opportunity for CDI specialists.

## Physician Engagement: Barrier to CDI Success

ACDIS reports that physician engagement is the most common self-reported challenge among CDI professionals. [In the 2019 ACDIS membership survey](#), 63.74% of respondents said their medical staff is either highly or mostly engaged and motivated in CDI. Hospital leadership vacuums, collaboration issues and lack of ongoing physician training often prevent physicians from improving documentation practices.

Administrative support is key to managing resistant physicians. The 2019 ACDIS survey shows a direct correlation between those reporting strong or moderate administrative support (75.51%) and those with highly engaged physicians in CDI efforts

(77.23%). Physician advisers/champions make good resources for encouraging more engagement with clinicians, with 63.37% reporting they maintain a full- or part-time physician champion.

Whether for outpatient or inpatient care, clinical documentation is at the heart of every patient encounter. The internal auditing function and education provided by a CDI program ensure that a patient's medical record is complete and free of conflicting information. When it is not, CDI specialists and coders seek clarification from the medical team.

However, a broad gap exists between the terminology used by clinicians and the terminology of coding and billing systems. The CDI liaison role must then expand to reflect the complexity of an industry increasingly focused on regulatory compliance, managed care profiles, revenue and reimbursement, and mitigation of risk. According to the ACDIS, all of these factors are increasingly dependent on the integrity of complete and specific clinical documentation in the medical record.

## Overcoming Physician Engagement With CDI

While reviewing physician cases one-on-one is critical to successful CDI, this process is often labor- and time-intensive for hospitals. Managing physician engagement and training can be challenging. Physicians often do not view CDI as a priority, and change management can be difficult, as many consider administrative meetings to be time taken from providing direct patient care. In a [survey of ACDIS members](#), formal group education by service line is used by more than 76% of respondents. Physicians often respond better to peers or third-party educators who can get to the point quickly about the slippery slope from faulty documentation to inaccurate coding and, ultimately, to reimbursement deficit.

The time and resources needed by CDI and coders to interact with clinicians is compounded by the timeliness of resolving any documentation problems

while the patient encounter is still fresh. In 2018, 52.26% of respondents indicated that they currently have an escalation policy in place; in 2019, that number increased significantly to 75.7%, according to the 2019 ACDIS membership survey.

Patient population, payor and technology issues are also important. Resource-strapped CDI programs find themselves having to target cases based on payor type, leaving hospitals unable to ensure that all complex cases get through CDI review. In many organizations, Medicare fee-for-service, Medicare Advantage and Medicaid cases take priority, leaving commercial health plan cases underrepresented. The electronic health record (EHR) has helped organize and stratify clinical information, yet the use of copy-forward, copy and paste, and other documentation shortcuts makes it easier for clinicians to respond to a query before proceeding within the health record. And many details crucial to accurately representing a case's complexity do not fit neatly into the EHR template.

## Best Practices Take a Team Effort

Starting a CDI program or challenging the status quo to optimize an existing program requires executive, physician and clinical staff agreement on what is best for a hospital and its revenue cycle management.

Preimplementation often begins with assessing your team and its responsibilities, followed by determining program objectives, a communications process, training objectives, timeline to completion and more. Baseline data is also important. Questions to ask include:

- What types of metrics are available?
- What are the organization's current and past claims denial rates?
- Has the organization experienced any governmental audit issues?
- What other CDI reports are available?
- What are the organization's financial targets?
- What are the organization's quality metrics?

- Is the organization meeting their length-of-stay targets?

Beginning with an evaluation, a best-in-class redesign process typically moves strategically through three detailed phases — assessment, hands-on implementation and postimplementation monitoring. Documentation and knowledge transfer experts ensure that all areas of hospital staff understand the importance of accurate documentation and have the skills to chart, code and bill every case properly.

Maximizing reimbursement under value-based payment models requires a highly precise and accurate documentation effort. Emphasizing CDI helps contribute to an organization's bottom line. When done right, CDI also accurately represents the quality of the care you deliver.

## Key Takeaways

In today's healthcare environment, leaders must take significant action to ensure that CDI programs operate successfully throughout the organization.

### Think differently.

Understand why precise, comprehensive documentation and coding are more important than ever as organizations shift to value-based payment models.

### Plan differently.

Take a metrics-driven approach to addressing CDI-related issues.

### Act differently.

Evaluate and redesign CDI programs with an emphasis on ambulatory settings and physician engagement.



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