Clinical Documentation Improvement—A Physician Perspective: Insider Tips for getting Physician Participation in CDI Programs

By Adele L. Towers, MD, MPH

The following is likely not a surprise to those clinical documentation improvement specialists (CDS) working day in and day out improving physician documentation. But for the record-clinical documentation improvement (CDI) is not taught in medical school. The truth is that most physicians have no idea what CDI means and why it should be important to them. But it is important.

CDI programs have increased significantly over the past 10 years due to changes in reimbursement and increased scrutiny by third party payers. As a result, hospitals have invested a significant amount of time and resources to hire CDSs to review charts and identify conditions that were evaluated, monitored, or treated during the hospital stay but were not documented in a way that can be coded. Physician participation and buy-in can be difficult since some physicians feel that CDI programs exist only to benefit the hospital and just add more work. But some insider tips-provided by a physician-can be used to promote CDI programs to members of the medical staff and engage their willing participation in the process.

Make CDI about Quality

The main message to physicians should be that CDI is a quality initiative. When asking physicians why good clinical documentation is necessary, they will most likely say that it is to document the care of the patient and to communicate with other providers. Physicians understand the need to make documentation legible, timely, complete, precise, and clear. They understand that the documentation is the legal health record. They understand the common phrase “If you didn’t write it, it did not happen.”

Physicians are not taught how to complete the documentation in order to accurately assign codes, and physician billing does not require a high degree of specificity. A diagnosis of congestive heart failure, not otherwise specified (CHF NOS), is perfectly acceptable for physician billing. However, the lack of specificity on a hospital record can affect payment. The key is to engage physicians to correlate how clinical documentation provides an opportunity to demonstrate the quality of care that was provided.

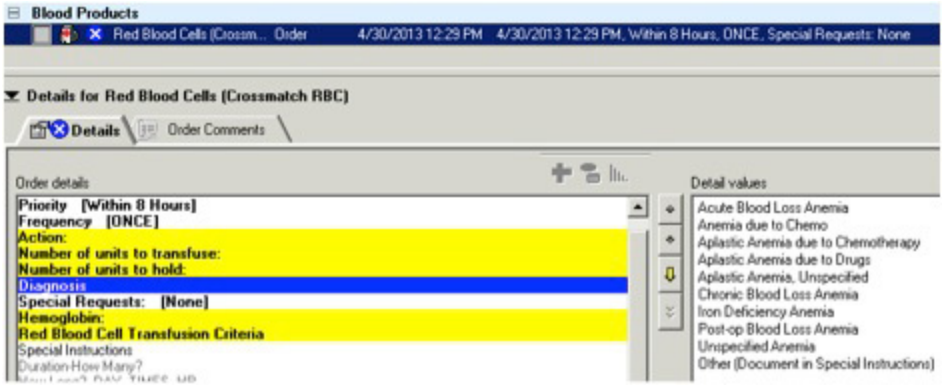
The message to physicians should be simple-good clinical documentation will improve communication, increase recognition of comorbid conditions that are responsive to treatment, validate the care that was provided, and show compliance with quality and safety guidelines. Although the message is simple, there are some challenges when trying to present this information to physicians. Physicians are by nature independent thinkers and will expect a very concise, clear reason to change documentation habits.

Recommendations for how to address CDI with physicians include:

- Know your audience-academic physicians, private practitioners, mid-level providers, and students should each be approached differently
- Incorporate CDI training with ICD-10-CM/PCS-this reduces the number of messages for clinicians
- Tell them why CDI is important
- Make CDI part of the clinician workflow
- Documentation queries need to be consistent with clinical practice
- Queries must be consistent with evidence-based guidelines
- Provide meaningful data and feedback to facility clinicians

Figure 1

Screen shot of UPMC's EHR system requiring a physician to document a diagnosis that justifies the transfusion of packed red blood cells. This additional documentation helps coders apply the proper code.



Know the Audience

Physicians who are employed by a hospital are more likely to be receptive to incorporating CDI if outcomes data are incorporated into practice contracts. In addition, the Joint Commission requires that medical staff undergo ongoing professional practice evaluations (OPPE) to monitor for quality and performance.

At the University of Pittsburgh Medical Center (UPMC), physicians receive data regarding admissions, average length of stay, readmissions, severity of illness, and risk of mortality scores. It is a common trait among physicians that they think they care for the sickest patients. Proper documentation can help support or debunk that claim. Educate physicians that hospital coding determines the severity of illness and risk of mortality. Thus, good clinical documentation benefits the physician as well as the hospital.

Non-salaried or private physicians at UPMC also receive OPPE data and are receptive to the message that the clinical documentation directly affects quality scores. Yet they can be less receptive to "helping" the hospital since it is not easy to see any direct benefit to their practice. If this is brought up or suspected by CDI staff, it is useful to remind these physicians of the costs of care being provided in the hospital. An example that could be raised: Do they think it is fair that a hospital has to provide a large bed or wheelchair for a patient with morbid obesity, but not receive extra reimbursement? The physician needs to be reminded that these patients require extra care, and the way the hospital receives that reimbursement is through the physician documentation.

Interns, residents, fellows, and mid-level providers are often ignored in the CDI effort since they are not the attending of record. At UPMC, the CDI staffs' philosophy is that the house-staff of today are the attendings of tomorrow, and there is a need to educate these individuals on specific documentation now. It is sometimes difficult to influence a trainee or a mid-level provider on good documentation skills unless the attending physician also stresses the need for good documentation. If possible, try to have a senior attending present during house-staff or mid-level education, in order to set a clear expectation of the goals for documentation. Enlist the clinical chairs of the department to carry the message to faculty. In UPMC's case, the best advocate was the Chair of Medicine, who regularly brought up common documentation issues during the morning report with the residents.

Explain Why if Questioned

Physicians are taught to ask "why" as part of diagnostic training and need to understand the reason for a change in clinical documentation in order to fully embrace the concept. So if a physician challenges a CDI recommendation, make it an opportunity to explain why CDI is necessary. Explain the concepts of the MS-DRGs and how they are designed to increase reimbursement for care of complex patients. Explain how a severity of illness and risk of mortality score is derived from the

codeable diagnoses. Have a short, cogent explanation available either verbally, written on a card, or as part of your physician education.

Once the physician understands that documentation has to be specific, program staff should then move on to the most common scenarios for documentation improvement. Share the "top 10" diagnoses that are most frequently not documented or poorly documented at the facility. Examples of frequently queried diagnoses for many facilities include:

- CHF specificity
- Sepsis
- Acute kidney injury
- BMI (low or high)
- Acute blood loss anemia
- Pressure ulcers and debridement
- Hyponatremia
- Chronic kidney disease
- Malnutrition specificity
- Acute respiratory failure

It is also important that physicians understand the process of audits and denials and the financial impact on the hospital. At this time, most physicians have not felt any repercussions from a recovery audit contractor (RAC) denial, but the impact on a hospital is very tangible. Not surprisingly, the top 10 RAC-denied diagnoses are often similar to the top 10 queried diagnoses. Hence, good documentation done concurrently will only help to improve the outcome of a RAC audit.

Incorporate CDI in Physician Workflow

How physicians use and document in the electronic health record (EHR) can have a big impact on CDI. EHR technology has clearly improved the legibility and timeliness of clinician documentation. Physicians can use structured templates to input documentation, or they can dictate into a standard progress note format. But along with all of the benefits of electronic documentation, there are also some significant challenges with electronic documentation. These include:

- Cutting and pasting prior documentation into new records, which can obscure new information and increase audit risks
- When doctors type, they don't include much information
- Symptoms, not diagnoses, are often documented
- Doctors can't find correct diagnosis from pick-list
- Some physicians only look in the EHR for information/communication, which can cause a lack of communication in their workflow

Many of the new generation's physicians have embraced electronic documentation since it allows them to quickly complete the daily note. Some physicians like to keep a daily log of events in their notes, so if a colleague has to cross-cover the patient they only need to read the last note in the chart. This is great for a cross-covering colleague, but it presents a challenge to any CDS or coder who has to review the chart. Reading the same cut-and-pasted documentation can significantly decrease productivity and increase the chance for missed opportunities for coding or documentation clarification.

Physicians are not trained in coding, yet many physicians know the codes that are important to their physician billing. If the physician chooses a nonspecific diagnosis code to include in the note, it can potentially make it more difficult for a hospital to code the case with a more specific diagnosis. Having physicians include codes in their notes may facilitate physician billing, but can come back to haunt a hospital if the case is reviewed by an auditor. For example, a doctor will often document an unspecified code such as "CHF NOS," when the hospital needs "Acute Systolic CHF" in order to have more accurate coding and billing. It is tough to argue with an auditor who says that the physician has mentioned CHF NOS 10 times, but you queried for acute systolic heart failure and got the documentation once. This conflict of the diagnosis codes is hard to defend.

The EHR creates the opportunity to assist physicians with clinical documentation and to provide a means of communication. Whenever possible, build clinical documentation systems that make it easy for physicians to provide the codeable diagnoses. For example, the diagnosis of "acute blood loss anemia" is not how most physicians were taught to document anemia from GI bleeding. If physicians are not familiar with this diagnosis, make it easy for the physician to provide the correct diagnosis. At

UPMC, whenever a physician orders a transfusion of packed red blood cells, the EHR ordering system requires the physician to provide a diagnosis that justifies the transfusion (see Figure 1). The order cannot be signed unless a diagnosis is chosen from a pick-list of choices.

Of course, the pick-list must be compliant and must not lead the physician to choose only a diagnosis that will change reimbursement. CDI tools should be vetted through a compliance department or committee to ensure integrity. It is also important to educate clinicians on how to choose the appropriate diagnosis, again with an emphasis on choosing the correct clinical diagnosis and not the diagnosis that will increase reimbursement. Incorporating documentation in the physician workflow is an easy way to assist clinicians and also provide accurate capture of the diagnosis.

Diagnoses such as decubitus ulcers or malnutrition are often found in documentation from other clinical providers such as nurses or clinical dieticians. Engage nursing staff to assist with documentation of present on admission (POA) status for lines, catheters, staging of pressure ulcers, and initiation of a nutrition assessment. The clinical dieticians can capture significant nutritional comorbidities. The challenge is how to get the documentation from these providers to the physician for review and validation. At UPMC a paper process was utilized so that the nurse or dietician completed an assessment on paper and then placed it in the chart for the physician to review and sign. This process had nearly 100 percent compliance because signing these documents was required as a part of the medical record completion policy.

With UPMC's EHR now in place, dieticians and nurses are completing clinical documentation electronically. If pressure ulcers or nutritional deficiencies are noted, then these assessments are available for review in the hospital record. However, unless there is a specific note to the physician, physicians may not be aware of these significant findings. By accurately identifying these conditions in clinical documentation, staff can ensure physicians are aware of these risks and can include plans to mitigate these conditions.

UPMC plans to create a process that automatically routes assessments to the attending for their review and attestation. While some physicians get annoyed when asked to verify their clinical diagnoses, if the process is simple and clinically relevant physicians will be more responsive.

Keep Queries Consistent with Clinical Practice

If a CDS is going to take the time to query a physician, it is important to ensure that the query is clinically consistent with the patient's care. For instance, never query for a diagnosis of hyponatremia if the serum sodium is 130meq/dl, but the serum glucose is 800mg/dl. The elevated serum glucose causes a "pseudo-hyponatremia" but the corrected serum sodium is in the normal range. It is important for the CDS to have a strong clinical background or to be a highly experienced coder in order to identify scenarios that are not clinically relevant.

One should only query for diagnoses that are clinically meaningful to the patient and the care delivered during the hospital stay. As part of query policy and procedures, it is important to include the Uniform Hospital Discharge Data Set (UHDDS) guidelines for coding and reporting secondary diagnoses. UHDDS guidelines for coding and reporting secondary diagnosis allow the reporting of any condition that is clinically evaluated, diagnostically tested for, therapeutically treated, or increases nursing care or the length of stay of the patient.

Best Way to Query Physicians

Another tip to remember is that when querying a physician, try to incorporate that query into the physician workflow. It is ideal to be able to round with physicians or participate in the morning report, but not every facility has the resources to provide a CDS on the clinical floor. The key to any successful CDI program is the ability to communicate with physicians. In-person communication is very effective, since it provides an opportunity for education and immediate feedback. Many CDI programs utilize the physician query as the method of communication. Queries can be verbal, on paper, or electronic, but the challenge is how to monitor, track, and trend the response to the query.

When using paper queries, try to include the query within the progress note or order to ensure that it will be seen by the physician. Electronic documentation lends itself better to tracking the data, but getting the documentation into the electronic

health record can be more of a challenge. The ideal solution would be an electronic query form that could be easily accessible to the physician, preferably while they are reviewing the clinical record. The physician should be able to answer the form electronically and route it back to the CDS. Once the electronic form is completed by the physician, it should be reviewed by the CDS to ensure that the documentation is complete. Physicians do make mistakes, so it is prudent to review all queries before making them a permanent part of the health record.

Evidence-based Guidelines Keep Queries Consistent

Evidence-based guidelines are essential to ensuring a compliant CDI process. Physicians will have a greater respect for a CDI program that cites standard clinical guidelines as the basis for the query. Queries should be presented to the physician in the context of clarifying the clinical documentation to ensure compliance with evidence-based guidelines. While *Coding Clinic* guidelines are useful from a coding perspective, most physicians will not feel comfortable using *Coding Clinic* guidelines as the basis for determining a clinical diagnosis. Physicians are familiar with resources from standard medical textbooks or journals, or online resources such as UpToDate. Use these resources when querying physicians, both to educate and provide justification for the query.

Sepsis is an excellent example of a diagnosis that has new guidelines to assist physicians who are caring for a patient with sepsis or severe sepsis. Physicians may be completely unaware of the *Coding Clinic* guidelines for the documentation of sepsis, so presenting this information is unlikely to yield a significant change in documentation practice or identification of sepsis.

The journal *Critical Care Medicine* recently published a consensus statement from a committee of 68 international experts on the diagnosis and management of sepsis. Presenting this information to physicians is far more likely to increase the recognition and documentation for sepsis. In this consensus statement, sepsis was defined as “the presence (probable or documented) of infection together with systemic manifestations of infection.” Severe sepsis was defined as “Sepsis plus sepsis-induced organ dysfunction or tissue hypoperfusion.”

When formulating a query to the physician regarding sepsis, first confirm that the clinical scenario is consistent with sepsis and that it will meet some of the clinical variables outlined in the table. Physicians may ask if there are a strict number of diagnostic criteria which must be satisfied in order to make the diagnosis. This is an opportunity to emphasize the clinical judgment and the need for physician interpretation as to when these clinical findings are truly meaningful. However, if the patient does not have any of these clinical findings, then it is inappropriate to query for a diagnosis of sepsis. It is impossible to come up with a strict definition of sepsis, so use these criteria as a guideline. Physicians may not be aware of these clinical criteria, so having them available at the time the physician is reviewing the query will assist in educating the physician and provide justification for the query.

CDI programs often use clinical guidelines to assist with identifying diagnoses that were not documented. CDI programs can also assist in validating diagnoses that have been documented. If a physician documents “acute renal failure,” but the serum creatinine increases from 1.2 to 1.4, can the diagnosis be clinically justified? Given the increased scrutiny of secondary diagnoses by external auditors, it is critically important to assist the coders and CDSs to determine if the diagnosis is truly present or whether the physician needs to be queried for clarification.

When developing the policies and procedures for a CDI program, include the evidence-based guidelines as part of the query development process and in the training for the CDSs, coders, and physicians. Identify physician champions in the fields of infectious disease, nephrology, neurology, cardiology, internal medicine, and surgery to assist in collecting the evidence-based criteria to support the queries for commonly queried diagnoses. These physician champions are often the best resource at educating colleagues on the need for recognition, documentation, and intervention of these diagnoses. Ensure that a regular review process is in place for evidence-based guidelines as recommendations can change.

Why Clinical Documentation Improvement is a Quality Effort

- Better recognition of patient comorbidities and severity of illness
- Improved patient outcomes
- Decreased risk of conversion to an observation stay

- Preparation for ICD-10-CM/PCS
- Physician quality scores and how coding defines the expected LOS, core measures, hospital-acquired conditions, and patient safety indicators
- Performance metrics-utilization of the severity of illness and risk of mortality

Provide Meaningful Data and Outcomes to Clinicians

At UPMC, the following policy regarding physician completion of queries has been proposed. If the CDSs create a physician query that is clinically relevant, consistent with evidence-based guidelines, and the query process is incorporated into the physician workflow, then completion of the physician query should be mandatory and included as part of medical record completion. This would hold physicians accountable to complete the query or risk the penalty outlined in the hospital medical record completion policy. The key point is that the physician has to complete the query, but they do not necessarily have to agree with the query. UPMC does not mandate a specific diagnosis selection but only requires that the physician respond.

So far, this proposal has found widespread acceptance at UPMC facilities since physicians have grown to accept and trust the CDI program. For a new CDI program, this proposal may generate significant concern among the medical staff leadership. It will be essential for the CDI program to demonstrate careful adherence to querying only for clinically relevant conditions. This approach would require approval from the Medical Executive Committee and would need to be clearly spelled out in a policy for medical record completion.

Physicians are inherently competitive and tend to be high achievers. A CDI program should provide timely feedback to physicians and hospital administration regarding the results of the process. Suggested metrics that would be meaningful to physicians would include:

- Volume of queries by physician
- Distribution of query type
- Response rate to queries
- Most common CC/MCC diagnoses
- Most common DRGs
- Severity of illness, risk of mortality scores
- Case mix index
- Denials from auditors

Physicians appreciate the opportunity to compare their performance to their colleagues, but use caution as not all physicians have the same practice patterns. Some physicians may have a low frequency of queries, but that does not always mean that the physician has high quality documentation. If possible, try to compare physicians based on specialty type. Trending information, and not just the volume of queries, often leads to a meaningful measure of quality. A physician may only get two or three queries a month, but if the physician is being queried for the same diagnoses each time, then there may be a documentation quality concern.

Do not emphasize the financial impact of the queries, but rather focus on the impact to the severity of illness and risk of mortality scores. Case management often appreciates this approach as the documentation of the comorbid conditions helps to support the need for medical necessity. Also consider incorporating auditor denial information to the clinicians, since this provides a sense of how clinical documentation is reviewed by an external source.

Deliver One Message that Includes ICD-10

ICD-10-CM/PCS has received a lot of publicity, and this is an opportunity to combine the need for ICD-10-CM/PCS education with CDI. It is essential to design the ICD-10-CM/PCS education with a CDI perspective. Take advantage of time spent educating physicians to drive home the top 10 CDI documentation issues. It is important to do specialty-specific analysis for the most common queries in ICD-9 as well as the diagnoses that could potentially have an impact in ICD-10-CM/PCS. The message is that good clinical documentation today should not be any different than when ICD-10-CM/PCS goes into effect.

Listen: Day-to-Day for a CDS

Clinical Documentation Specialist Amy Gardner discusses her daily work and what it takes to become a CDS. http://journal.ahima.org

Reference

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Adele L. Towers (TowersAL@upmc.edu) is an associate professor of medicine and psychiatry at the University of Pittsburgh School of Medicine, and the medical director at UPMC Health Information Management.

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