Clinical Documentation Integrity Week

2019

Industry Overview Survey

Association of Clinical Documentation Integrity Specialists | www.acdis.org

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About the CDI Week survey advisor

Chinedum Mogbo, MBBS, MsHIM, RHIA, CDIP, CCDS, CCS, is a CDI manager at Tenet Healthcare in Dallas. Mogbo has successfully managed various teams, including CDI specialists and coding auditors. She actively participates in the CDIP and RHIA exam item writing with AHIMA. She has been involved in the successful development of in-house curricula for training CDI specialists and serves as co-chair of the AHIMA CDI practice council working on many projects that provide guidance to the industry—the most recent being the ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice." She co-authored an AHIMA practice brief on "Physician Engagement in CDI" and co-authored the AHIMA practice brief on "Physician Office Queries" in July 2018. Mogbo was elected to the ACDIS Advisory Board in 2019, serving through April 2022.

2019 CDI WEEK INDUSTRY OVERVIEW REPORT

Now more than a decade removed from CDI programs' widespread adoption, CDI professionals have an effect on nearly all aspects of healthcare—from reimbursement, to quality reporting, to denials prevention and appeal writing, to patient care. That's what the 2019 CDI Week theme celebrates—"CDI Superheroes: The Heroes Hospitals Deserve." This year's Industry Overview Survey supports that claim to superhero-hood, showing just how much potential good CDI can bring to an organization.

"There's so much value in reviewing the survey results because it gives you a better sense of what's going on in the industry as a whole," says **Chinedum Mogbo, MBBS, MsHIM, RHIA, CDIP, CCDS, CCS,** CDI manager at Tenet Healthcare in Dallas, a member of the ACDIS Advisory Board, and this year's CDI Week Advisor. "You're able to see trends in the industry and see how we can be better CDI professionals. […] It gives us ideas on how to create policies to stop negative outcomes and encourage good trends."

Each year, ACDIS asks its members and the broader CDI community to weigh in on the state of the CDI profession. This year's survey garnered 639 responses, up slightly from last year's 605. Although this report will not discuss every survey question in detail, readers can examine all the responses beginning on p. 10.

The respondents represented a number of positions and titles, with CDI specialists the most common at 48.67%, followed by CDI managers at 13.30%, CDI directors at 7.82%, and CDI leads at 5.63%. (See Figure 1.) Most (83.88%) of the respondents work in traditional, short-term acute care facilities. (See Figure 2.)

The largest portion of respondents (16.59%) work in organizations with 201–300 beds, followed by those who work at organizations with 101-200 beds (12.68%), those with 301–400 beds (11.27%), those with more than 1,000 beds (9.39%), and those with 401–500 beds (9.08%). (See Figure 3.) This year's survey also asked those who work at health systems about the size of their organization, finding that most (41.46%) work for health systems with more than 1,000 beds. (See Figure 4.)

Like in years past, this year's respondents spanned several experience levels. The best represented group was CDI professionals with between three and five years of experience (29.11%), followed closely by those with more than 10 years of experience (26.13%) and those with six to eight years of experience (21.91%). Those with zero to two years of experience made up 13.46% of respondents, followed by those with nine to 10 years' experience (9.39%). (See Figure 5.)

When it comes to credentialing, the majority of respondents (71.83%) hold an RN license. The next most common credential was the Certified Clinical Documentation Specialist (CCDS) (64.01%), followed by the Certified Coding Specialist (CCS) credential (18%). It's important to note that many CDI specialists hold more than one credential. (See Figure 6.)

Continuing prior years' trend, this year's survey showed CDI programs' further diversification into areas of healthcare beyond traditional inpatient acute care, such as outpatient services and denials management.

Denials management

Information related to claim denials can be extremely valuable in identifying patterns of provider behavior. Denials data can uncover issues from a documentation standpoint, but to leverage that information in a way that engages physicians, you need to explain

how it benefits them. Organizations need programs to determine the underlying cause of denials, identify patterns of behavior, and provide education where necessary. That education should include how the denial may trigger inaccurate data on physician report cards or reduce the level of severity for their patients. What's not meaningful is saying, "If we continue to get these types of denials, the hospital is not going to get paid."

—Anne Robertucci, MS, RHIA, director of strategic product management at Optum360

More than half of the respondents to this year's survey (56.51%) said they're currently involved in denials management at their organization, and a large portion of those who answered "other" for their involvement said that they're currently developing a process to get involved. (See Figure 7.) Most respondents have been involved in denials managment for one to two years (34.04%) followed by those who've been involved for less than a year (23.71%) and those who've been involved for three to four years (20.42%). (See Figure 8.)

Though a small portion of the respondents (4.06%) indicated that they don't know whether their department is involved in denials management or appeals, this may be because the denial reviews seem to frequently go through the CDI manager, director, team lead, or a specific team member; others on the team may not be aware of CDI's involvement, according to Mogbo. This is illustrated by the fact that, when looking at only CDI/HIM lead, supervisor, manager, director, and denials specialist titles, 64.79% said they were involved in the denials management process and only 1.41% indicated that they didn't know whether their department was involved.

"Some facilities will say, 'If the denials department has an issue, just reach out to the CDI manager or CDI leadership and they'll deal with it,' rather than going to the CDI staff," Mogbo says. "Those who don't know may have been shielded from being pulled into new initiatives and departments. CDI can feel like a child with many parents—everyone's pulling them in different directions."

More than half of those involved (65.97%) said they're directly involved through appeal writing (27.77%), reviewing specific diagnoses for denial prevention (21.71%), and sending post-discharge queries and/or conducting mortality reviews for denial defense (16.49%). Another 39.67% said that they're involved informally on a case-by-case, as-needed basis, 9.6% said they are involved only when the CDI team reviewed the denied claim while the patient was in the hospital, and 9.39% said their physician advisor or champion works on the appeal letters. (See Figure 9.)

Regardless of whether CDI program involvement is formal or informal, many of the open-ended responses within the survey indicated that the CDI team takes denial trend information back to physicians and CDI staff for educational purposes. This practice can ultimately help defend the documentation on the front end because, if you can avoid a previous pitfall, the payer won't (at least in theory) be able to deny payment for it again. (For more information about CDI efforts related to the denials management and appeals process, read the *September/October edition of the CDI Journal*.)

Choosing which CDI team members should assist with denials management or appeal writing can be a challenge, particularly with limited staffing and high productivity standards. The survey indicates that to tackle the issue of scope creep, most of those involved in denials management (37.17%) designate the responsibility to the CDI team leads or managers, freeing up staff CDI professionals to focus on chart reviews and physician education. The next most common models were those who have designated denial or appeal specialists in their CDI department (26.28%), those who have physician advisors/champions tackle denials (18.89%), and those who give the responsibility to their CDI second-level reviewers (12.32%). (See Figure 10.)

"At our organization, we do have a denials team, but they reach out to CDI if they want us to take a second look. We have physician advisors who are directly involved with those cases," Mogbo says. "If CDI and coding say they stand by what they queried and

coded, the physician advisor can provide some clinical backup for whatever we're arguing in the appeal letter."

Anecdotally, it seems that clinical validation denials have been on the rise in recent years, often spurring CDI teams to involvement. This assumption is borne out with the survey data, at least in part. The majority of CDI teams involved in denials management (77.39%) assist with clinical validation denials, followed by those who assist with DRG/coding-based denials (56.64%) and medical necessity denials (25.10%). (See Figure 11.)

"Medical necessity is traditionally a case management or utilization review concern, but many organizations need their CDI staff to wear multiple hats," says Mogbo. "Again, we often get pulled in multiple directions depending on different departments' goals."

Excluding those who said they don't know how many denials their organization receives in total each month, 41.42% of respondents said that they receive one to 10 denials monthly, and 25.76% receive 31 or more denials monthly. (See Figure 12.) Of those who have access to the data, 65.23% said the majority of their denials originate from private payers—though the open-ended answers encompassed quite a few payers. Aetna, Blue Cross Blue Shield, UnitedHealthcare, Humana, and Anthem were frequently cited as the companies contributing the bulk of the denials. (See Figure 13.)

"The common theme with denials right now is that the payers are playing games," Mogbo says. "If they're not denying this, they're denying that. There has to be a standard established at some point."

Unsurprisingly, the most common condition cited in respondents' top denied diagnoses was sepsis, garnering 69.18% of respondents, followed by respiratory failure (57.23%), malnutrition (46.33%), and encephalopathy (44.23%). These diagnoses mirrored those most frequently prompting a clinical validation query as well. (See Figures 14, 38.) Much of the increase in sepsis denials may be tied to the now-infamous Sepsis-2 versus Sepsis-3 debate, especially since *UnitedHealthcare announced that they would use sepsis-3 criteria to validate claims*.

"Two of our commercial payers are now denying sepsis if it doesn't meet Sepsis-3 criteria," one survey respondent wrote.

Overall, the open-ended responses regarding the changing denials landscape indicate that denials are on the rise and the clinical criteria employed by private payers are in constant flux.

"The payers have all the power, changing the rules as we go along," wrote another. "They cherry-pick the criteria to invalidate our DRGs."

Many CDI teams have combatted these ever-changing payer criteria sets by creating organizationwide clinical indicator lists for commonly denied diagnoses that can be employed in the appeals process and even the renewal process for payer contracts. (For more information regarding organizationwide clinical criteria development, see this article in *the September/October edition of the CDI Journal*.)

"Developing evidence-based clinical definitions with facility medical staff support has been very successful for our denial overturn rate," wrote one respondent.

CDI technology

This year, nearly 89% of respondents said their CDI program uses assistive software or electronic tools, such as case prioritization, computer-assisted coding (CAC), and electronic groupers. The majority who use these software solutions use a CDI chart review prioritization queue (53.86%), followed by those who use CAC or natural language processing (NLP) (52.78%) and those who use an electronic grouper (46.32%). (See Figure 16.)

Overall, this year's survey respondents have a positive outlook toward CAC/NLP and prioritization tools, with only 6.64% reporting that the software has made their review process cumbersome. (See Figure 17.) In comparison, 21.05% of last year's respondents indicated that the software has hindered their CDI workflows. This drop may indicate that CDI professionals are becoming better acquainted with these solutions and are therefore able to leverage them more effectively, according to Mogbo.

"I wasn't surprised about this. That's the way a lot of organizations are going now for the sake of performance improvement. CDI's work can be made a lot easier by using the CAC/NLP," she says. "Folks are steadily going away from the traditional chart review

model and using more technology. […] People are becoming more and more accepting of these tools, the tools are becoming more and more refined, and people are starting to recognize their value."

While technology can certainly make aspects of CDI more difficult, one of the major benefits of the move away from paper or hybrid medical records comes in the form of remote work options.

This year, more than 68% of respondents indicated they have some form of remote work option at their organization, with the most popular model allowing staff to work a set number of days per week from home (25.49%). (See Figure 18.)

Remote options, whether they encompass going 100% remote or simply being at home for a set number of days, have become increasingly prevalent in the CDI world—partly, according to Mogbo, to increase staff satisfaction and retention.

"We allow staff to work one day a week at home. Usually it's a weekend day, and then we let them take a weekday off for any appointments or anything," she says. "It's a win-win situation because our organization has weekend coverage and the CDI staff get to take that weekday off without using up their PTO [paid time off]. […] It helps with staff retention as well."

With remote capability comes great CDI responsibility, and many CDI leaders worry that allowing their staff to go remote will have a negative effect on performance metrics such as query response rate, physician engagement, and overall productivity.

Those fears, however, may be unfounded, according to this year's survey, as respondents reported that the majority of their remote staff performed at the same level or better as those on-site across all metrics. Additionally, responding to most professionals' biggest concern about remote work, only 10.85% said that their remote staff had worse physician engagement than those on-site. (See Figure 19.)

"With things going more electronic, my staff love the option to go remote," says Mogbo. "I haven't seen any abuses of that privilege, and it's definitely helped with their productivity for sure. When you're at home, you're able to concentrate and you have that flexibility to get errands done when you need to."

Physician engagement

The first step up for advanced practice CDI in the clinical model is to hire the right people. You need professionals that have a very strong clinical acumen, understand physiology processes as well as the interaction of drugs. This makes it very easy and compelling to interact with a physician and talk about what is documented in the medical record. Putting together the clinical presentation which includes the treatment and risk that the patient brings to the hospital with them—the foundation to asking a clarification or a query to the physician. And most of the time, you're right on point, the physician agrees, and documents that.

—Mel Tully, MSN, CCDS, CDIP, vice president of clinical services and education at Nuance

Since ACDIS' beginnings, the number one self-reported challenge among CDI professionals has been physician engagement. This year's results remain fairly similar to last year when it comes to perceived physician engagement/buy-in, with 63.74% of respondents saying their medical staff is either highly or mostly engaged and motivated in CDI (compared to 62.59% in 2018 and 63.40% in 2017). (See Figure 20.)

"Physician engagement is always going to be a hot topic and it's always going to be a bit of a headache," Mogbo says. "Everybody has bad days, and sometimes even the most engaged physicians many not want to talk to CDI at all. […] The best way to improve things is to help the CDI specialists educate the physicians and help change their thought processes. It's going to be difficult, but it's important."

In addition to physician engagement/buy-in, most CDI professionals can attest to the importance of administrative backup—after all, administration controls staffing budgets and can often get a CDI program's foot in the door with even the most resistant physicians. This anecdotal knowledge was verified in the survey, which

found that of the 75.51% of respondents who said their administration was either strongly or moderately supportive, 77.23% also said their physicians were highly or mostly engaged with CDI efforts. In contrast, of those who said their administration was only somewhat or not supportive, only 20.17% said their medical staff was highly or mostly engaged. (See Figures 21, 22.) While there's certainly a correlation, sometimes the physician engagement issue can't be traced to the administrative team, Mogbo says.

"Sometimes you have to realize that you may have a physician issue rather than an administrative team problem," Mogbo says. "Even if you have a really supportive administrative team, your physicians still may be disengaged."

Physician advisor support can also have a big effect on physician engagement in CDI efforts, according to the survey. Mirroring ACDIS' *May 2019 physician engagement survey* findings, 63.37% of respondents have either a full- or part-time physician advisor or champion (compared to 64.29% in May), and another 9.91% are planning to engage an advisor in the near future. (See Figure 23.)

Similar to administrative support, employing the help of a physician advisor or champion also increases the level of physician engagement, according to the survey. While nearly 64% of the general respondent population reported their medical staff as highly or mostly engaged, 72.38% of those who have a full-time advisor and 67.95% of those with a part-time advisor reported the same high levels of engagement. (See Figure 24.)

When it comes to the number of days given to providers to respond to a query, the most common answer was two days, accounting for 31.78% of the respondents. Overall, the majority of respondents (65.61%) said physicians at their organization have seven calendar days or less to respond to outstanding queries. (See Figure 26.) Similar to years past, most respondents (51.03%) have a query response rate of 91%–100%, with only 4.30% falling below a 61% query response rate. (See Figure 27.)

Looking at query agree rates (meaning that the physician provided a written response to the query that provided clarity to apply a new or more specific ICD-10 code or provided clinical validation of a documented condition), the largest group of respondents (61.87%) reach an 81%–100% agree rate, with only 7.85% falling below the 61% agreement rate threshold. (See Figure 28.)

And regarding provider accountability for query response, it seems that more and more organizations are instituting query escalation policies. This year, 75.7% of respondents indicated that they currently have an escalation policy in place, up from 52.66% last year. (See Figure 29.)

Additionally, 79.26% of those with escalation policies had a response rate of 81%–100%, and 65.29% had an agree rate in the same range. In contrast, only 64.29% of those without an escalation policy reached a response rate of 81%–100%, and only 52.38% had an agree rate over 81%. (See Figures 30, 31.)

"Sometimes you have situations where you do have a policy in place, but there's no accountability to hold physicians to the policy," Mogbo says. "You need backup from our administrative team and CDI leadership to be successful."

Quality

CDI specialists advance quality by ensuring that the correct diagnoses are assigned to each patient. This is often a problem of translation: Physicians need to understand that if they aren't specific in their documentation, the conventions of ICD-10-CM will fill in the blanks and may add specificity they did not intend. For example, if the medical record notes "sinusitis," coders will abstract "chronic sinusitis." A list of diagnoses including impotence, alcohol abuse, and insomnia will be interpreted as cause-and-effect (impotence due to alcohol abuse and insomnia due to alcohol abuse) unless another cause is identified. If a patient admits to smoking cigarettes during weekend parties and the physician documents "mild tobacco use," the patient is labeled with "uncomplicated nicotine dependence." These interpretations of

language are hard-wired into ICD-10-CM, and physicians must understand this to ensure patient diagnoses are coded as intended. CDI's end goal is disambiguation of the record to improve coding accuracy, quality of care, and patient outcomes.

—Sheri Poe Bernard, CCS-P, CDEO, CRC, CPC, author, AMA's publication, risk adjustment documentation and coding

Gone are the days when quality-focused reviews represented an expansion opportunity for CDI programs: This year's survey found that only 10.38% of respondents don't review for quality measures (down from 12.73% in 2018). The most commonly reviewed quality domain for this year's respondents was present on admission indicators/hospital-acquired conditions (74.62%), followed by severity of illness (SOI)/risk of mortality (ROM) within the APR-DRG system (65.96%). (See Figure 32.)

"A lot of the CDI programs are beginning to understand that they have to look for more than just CCs/MCCs," says Mogbo. "SOI/ROM gives a much better picture of the condition of your patient too, which is really helpful."

In addition to reviewing for quality measures, 58.65% of respondents also conduct mortality reviews separately from their regular chart reviews, which is down slightly compared to 2018 when 62.91% indicated they conduct mortality reviews. (See Figure 33.) According to Mogbo, this could be because the mortality reviews are being covered by the CDI manager or team lead to avoid taking time away from CDI specialists' normal chart reviews.

"We don't pull our CDI specialists away from their chart reviews for mortality reviews, but we keep it at the manager-to-manager level," she says. "It can be really distracting for CDI specialists to keep getting pulled away from their chart reviews. Everybody wants to get their agenda pushed out to CDI. […] We tried to streamline it so that, if there are issues with the mortality reports, they reach out to the CDI manager for review."

Regardless of the type of quality measures reviewed, a quarter (25%) of respondents said that reviewing for quality measures has hindered their traditional CDI chart review productivity, which is slightly down from 27.61% who indicated the same in 2018. Additionally, only 18.08% of respondents said their full-time equivalents (staff) increased with the additional quality review responsibilities. This may indicate that more CDI programs are viewing quality reviews not as an expansion effort or outside of traditional CDI reviews, but as an integrated part of CDI work. (See Figures 34, 35.)

After an increase to 86.20% last year, the percentage of respondents who said that their CDI department still queries even if the outcome only affects a quality measure rather than reimbursement decreased back to the 2017 range (77.31% in 2019; 76.42% in 2017).

While this may be concerning at first glance, many of the open-ended responses indicated CDI specialists do, in fact, send queries only related to quality concerns, but often under specific circumstances. For example, many respondents indicated that they send these queries specifically on sepsis cases. (See Figure 36.)

"At my organization, we transitioned completely away from querying only for CC/MCC and SOI/ROM capture, to querying for the integrity of the medical record," Mogbo says. "It took a lot of mindset change for the CDI specialists [to get used to querying when it doesn't change the MS-DRG]. But it helps when talking with physicians to be able to say that we're querying for the integrity of the medical record documentation, not because it makes an impact on reimbursement. The physicians responded really positively to the change."

As seen in last year's survey results, the majority of respondents (91.15%) now conduct clinical validation reviews and send clinical validation queries (i.e., queries for clinical support of a documented diagnosis). (See Figure 37.)

Overwhelmingly, respondents indicated that sepsis is their top diagnosis that prompts a clinical validation query (88.32%), followed closely by respiratory failure (85.04%). These results, unsurprisingly, mirror those diagnoses cited as common denial targets. (See Figures 14, 38.)

When it comes to tracking the frequency of clinical validation queries, most respondents (42.31%)

said they have software that tracks query frequency. Another 40.38% of respondents indicated that they don't track clinical validation query frequency, but that may be because they don't differentiate query types when tracking query rate. (See Figure 39.)

Similarly, while 42.31% of respondents said that they have a policy for clinical validation querying, another 38.65% indicated that they do not. (See Figure 40.) According to Mogbo, this is also likely because the organization lumps all queries together when tracking query rates and setting policies, rather than differentiating between types.

Outpatient CDI

While less than 2% of survey respondents indicated that they work in an outpatient or physician practice, more than half of all respondents (53.41%) indicated that their CDI program currently reviews some kind of outpatient records (such as hospital-based outpatient services, physician practices, outpatient rehab, etc.), the most popular of which is risk adjustment for hospital outpatient services. (See Figure 41.)

Unsurprisingly, given the preponderance of respondents reviewing for risk adjustment, most respondents indicated that their outpatient reviews' primary focus is Hierarchical Condition Category (HCC) capture (46.97%), followed by a focus on denials prevention (34.29%), and evaluation and management coding (24.12%).

The survey also indicates an increase in respondents reviewing for medical necessity/patient status concerns. While not the top review focus, this may indicate an element of scope creep. (See Figure 42.)

"CDI specialists often wear a lot of hats and get pulled into a lot of different areas," says Mogbo. "More and more facilities are getting CDI specialists involved in the utilization review and case management side of things too."

When it comes to timing for outpatient CDI chart reviews, both prospective (before the physician sees the patient) and retrospective (after the appointment has happened) reviews garnered the most support (14.85% each). (See Figure 43.)

Typically, retrospective reviews are conducted primarily for the purpose of physician education to prevent the same mistakes in the future, whereas prospective reviews would be used to proactively capture HCC diagnoses, which have to be reported annually.

As the outpatient CDI field matures, organizations are slowly adopting more formalized processes and policies, as evidenced by the increase year-over-year of respondents who currently have an outpatient query policy in place (18.73% in 2019 versus 14.52% in 2018). (See Figure 44.)

This may be another instance, according to Mogbo, where organizations are trying to use one query policy and extend it across both inpatient and outpatient teams. This practice, however, doesn't account for the differences in the settings.

"[Outpatient reviews] are not the same as the ones typically conducted in the inpatient setting, where time is less of a factor and volumes are lower," says the ACDIS position paper "*Queries in outpatient CDI: Developing a compliant, effective process*" Nonetheless, "CDI professionals must adopt compliant practices."

Overall, while this year's survey shows similar trends to previous years' results, it does illustrate the CDI industry's continued expansion into new review areas, particularly related to outpatient services, and to denials prevention and appeal writing.

As these areas mature, new avenues for advancement will open for enterprising CDI professionals, allowing them to use their superpowers for the good of their organization in new and exciting ways. Survey data can help set the course for these initiatives, Mogbo says.

"The world is a global village, really," she says. "Surveys like this one allow people to learn from each other and we're able to see the impact of CDI and where we're headed."

2019 CDI INDUSTRY OVERVIEW SURVEY
CDI Superheroes: The Heroes Hospitals Deserve

1. Please indicate your title/role:

Answer Options	Percentage
CDI specialist	48.67%
CDI manager	13.30%
CDI director	7.82%
CDI lead	5.63%
CDI supervisor	3.13%
CDI educator	2.82%
HIM/coding director	2.82%
Consultant	2.19%
CDI second level reviewer	1.72%
CDI auditor	1.56%
HIM/coding supervisor	0.78%
HIM/coding professional	0.78%
HIM/coding manager	0.63%
CDI physician educator	0.47%
CDI informaticist/analyst	0.47%
CDI quality specialist	0.47%
Hospital executive	0.47%
CDI-coding liaison	0.31%
CDI denials specialist	0.31%
Physician advisor/champion	0.31%
Other (please specify)	5.32%

Other responses:

- Senior manager of physician education and advocacy
- Enterprise director, coding and CDI
- Assistant vice president (VP)/VP of CDI
- Clinical outcomes analyst
- Operations manager, CDI and coding
- Clinical validation denials coordinator/auditor
- Coding compliance auditor
- CDI coordinator
- CDI mortality reviewer
- Director of CDI, coding, and population health
- Recovery Audit Contractor (RAC) coordinator
- Administrative director/VP, revenue cycle
- CDI QA analyst
- Office manager
- Clinical program manager
- Clinical coding specialist

2. Please indicate your facility type:

Answer Options	Percentage
Acute care hospital	83.88%
Consulting firm	6.42%
Outpatient/physician practice	1.72%
Children's hospital/pediatrics	1.41%
Critical access hospital/rural healthcare	0.31%
Long-term acute care	0.31%
Rehab (inpatient or outpatient)	0.16%
Other (please specify)	5.79%

Other responses:

- Health system (academic and non-academic)
- Payer
- Government veteran's association
- Health plan
- Private hospital group (Australia)
- Legal office

3. Please enter the number of beds in your facility.

Answer Options	Percentage
100 or less	7.36%
101-200	12.68%
201-300	16.59%
301-400	11.27%
401-500	9.08%
501-600	8.14%
601-700	6.10%
701-800	3.60%
801-900	3.60%
901-1,000	3.13%
More than 1,000	9.39%
N/A	12.68%

4. Please enter the number of beds in your health system (if applicable).

Answer Options	Percentage
100 or less	2.54%
101-200	2.71%
201-300	3.38%
301-400	4.40%
401-500	3.72%
501-600	5.08%
601-700	3.38%
701-800	3.89%
901-1,000	4.47%
More than 1,000	41.46%
N/A	24.70%

5. How long have you been in your current profession?

Answer Options	Percentage
0-2 years	13.46%
3-5 years	29.11%
6-8 years	21.91%
9-10 years	9.39%
More than 10 years	26.13%

6. What credentials do you hold?

Answer Options	Percentage
Register Nurse (RN)	71.83%
Certified Clinical Documentation Specialist (CCDS)	64.01%
Certified Coding Specialist (CCS)	18.00%
Clinical Documentation Improvement Practitioner (CDIP)	11.89%
Registered Health Information Administrator (RHIA)	9.08%
Certified Coding Professional (CPC)	3.13%
Certified Risk Adjustment Coder (CRC)	2.97%
Master of Healthcare Administration (MHA)	2.97%
Doctor of Medicine (MD)	2.35%
Bachelor of Medicine, Bachelor of Surgery (MBBS)	1.41%
Certified Clinical Documentation Specialist-Outpatient (CCDS-O)	0.78%
Nurse Practitioner (NP)	0.31%
Other (please specify)	28.17%

Other responses:

- Accredited Case Manager (ACM)
- Bachelor/Master of Nursing (BSN/MSN)
- CCRN-K
- Certification in Infection Prevention and Control (CIC)
- Certified Billing and Coding Specialist (CBCS)
- Certified Case Manager (CCM)

- Certified Coding Specialist-Physician-based (CCS-P)
- Certified Documentation Expert Outpatient (CDEO)
- Certified Emergency Nurse (CEN)
- Certified Health Data Analyst (CHDA)
- Certified Healthcare Constructor (CHC)
- Certified Healthcare Technology Specialist (CHTS)
- Certified in Health Care Quality Management (CHCQM)
- Certified in Healthcare Privacy and Security (CHPS)
- Certified Legal Nurse Consultant (CLNC)/Legal Nurse Consultant Certified (LNCC)
- Certified Medical Transcriptionist (CMT)
- Certified Medical-Surgical Registered Nurse (CMSRN)
- Certified Outpatient Coder (COC)
- Certified Patient Account Representative (CPAR)
- Certified Professional in Healthcare Information and Management Systems (CPHIMS)
- Certified Professional in Healthcare Management (CPHM)
- Certified Professional in Healthcare Quality (CPHQ)
- Certified Professional Medical Auditor (CPMA)
- Certified Revenue Cycle Representative (CRCR)
- Certified Tumor Registrar (CTR)
- CNOR (Certified Perioperative Nurse)
- Doctor of Business Administration (DBA)
- Licensed Vocational Nurse (LVN)
- Master of Business Administration (MBA)
- Master of Education (MEd)
- Master of Health Services Administration (MHSA)
- Master of Jurisprudence (MSJ)
- Master of Science in Health Informatics (MSHI)
- Nurse Executive-Board Certified (NE-BC)/Nurse Executive Advanced-Board Certified (NEA-BC)
- Public Health Nurse (PHN)/Master of Public Health (MPH)
- Registered Nurse Certified-Neonatal Intensive Care (RNC-NIC)
- Registered Respiratory Therapist (RRT)

7. Is your CDI team involved in the denials management or appeals process?

Answer Options	Percentage
Yes	56.51%
No	33.33%
Don't know	4.06%
Other (please specify)	6.09%

Other responses:

- We're just starting to get involved.
- We were responsible for denials management/appeals, but now it's been centralized at corporate.
- Only on an as-needed basis.
- Our physician advisor is involved with the appeals process.

8. How long has CDI been involved with denials management?

Answer Options	Percentage
Less than a year	23.71%
1-2 years	34.04%
3-4 years	20.42%
5-6 years	13.15%
7-8 years	3.05%
9-10 years	1.88%
More than 10 years	3.76%

9. In what capacity are you involved with denials management?

Answer Options	Percentage
Informally on a case-by-case basis	39.67%
Informally—only when the CDI team had previously reviewed the denied claim	9.60%
Indirectly—our physician advisor/champion works on the appeal letters	9.39%
Directly—we help write the appeal letters	27.77%
Directly—we review specific diagnoses for denials prevention	21.71%
Directly—we send post-discharge queries and/or conduct mortality reviews for denial defense	16.49%
Other (please specify)	18.79%

Other responses:

- We provide education to the providers.
- We do quality reviews, second-level reviews, and mortality reviews.
- We consult on clinical validation denials, but coding writes the letters.
- Our manager writes the appeal letters, not the CDI staff. We just assist with the diagnoses and reasoning behind an appeal.
- We're responsible for reviewing and writing appeal letters for denials that pertain to a clinical diagnosis.
- We only review cases referred to CDI by the denials team.
- A former CDI specialist writes the appeals. Their full-time role is in denials management, but they have a CDI background and report up through CDI leadership.
- We educate the CDI specialists on denial trends and suggest queries to avoid denials.

10. Who in the CDI department is involved with the denials management/appeals process?

Answer Options	Percentage
The team leads/managers	37.17%
A designated denials or appeals specialist in the CDI department	26.28%
Physician advisor/champion	18.89%
CDI second-level reviewers	12.32%
CDI educator/auditors	10.06%
A group of CDI team members sit on a denials committee	8.21%
Other (please specify)	27.93%

Other responses:

- The CDI specialist who reviewed the chart.
- The entire CDI team/we all take turns.
- Coders, CDI specialist, and the HIM supervisor.
- Management writes the appeals and reviews the denied cases along with us.
- Staff with more seniority/experience.
- Revenue cycle team leads/managers.
- Someone from case management.
- A member of the inpatient CDI team on the inpatient denials; the outpatient CDI supervisor on the outpatient denials.

11. What type of denials does your CDI team help with?

Answer Options	Percentage
Clinical validation	77.39%
DRG/coding-based denials	56.64%
Medical necessity	25.10%
Other (please specify)	13.69%

Other responses:

- All of the above and RAC denials.
- Charge validations.
- Level of care.
- Risk adjustment.
- We only review denials for physician education purposes.
- CPT®—surgical.
- Target and probe audits, surveillance, and utilization review denials.

12. How many denials (of all types) does your facility face per month?

Answer Options	Percentage
1-5	8.51%
6-10	8.12%
11-15	4.16%
16-20	3.37%
21-25	3.17%
26-30	2.97%
31-35	0.99%
36-40	0.79%
41-45	0.20%
46-50	0.59%
More than 50	6.34%
Don't know	60.79%

13. Where do the majority of your denials originate from?

Answer Options	Percentage
Private payers (please specify which payers)	36.77%
Medicare Administrative Contractors	11.52%
Recovery Auditors	8.08%
Don't know	43.64%

Specify which payer:

- Advantra
- Anthem
- Assume Managed Care
- Blue Cross Blue Shield
- BNC
- Cigna
- Cotiviti
- Equicare
- EquiClaim
- HAP
- Harvard Pilgrim
- HealthCare Partners
- Highmark
- Humana
- Key First
- Managed Medicaid payers
- MDPC
- Multiple, but Aetna is the most notable
- NGS
- OmniClaim
- PacificSource
- Priority Health
- Priority Partners
- Superior
- Tufts
- UnitedHealthcare
- UPMC
- Varis

14. What are your top denied diagnoses?

Answer Options	Percentage
Sepsis	69.18%
Respiratory failure	57.23%
Malnutrition	46.33%
Encephalopathy	44.23%
Kidney disease	15.72%
Acute blood loss anemia	12.79%
Pneumonia	11.74%
Congestive heart failure	11.53%
Acute myocardial infarction	5.66%
Altered mental status	5.24%
Chronic obstructive pulmonary disease	2.94%
Other (please specify)	21.17%

Other responses:

- Acidosis
- Acute kidney injury
- Ambulatory RAC for cataract extractions
- Cellulitis
- Cerebral or spinal edema
- Cholecystitis with abdominal abscess
- Congenital cardiac anomaly
- C-sections
- Electrolyte imbalance
- Gastrointestinal bleed
- Hydration therapy
- Hyperbaric oxygen therapy
- Hyponatremia
- Just about any CC/MCC that's the only secondary diagnosis coded (to downgrade the DRG)
- Morbid obesity
- Neonates with positive drug screening
- NICU, usually around meconium staining
- Outpatient denials related to infusion and cardiac testing
- Pulmonary embolism
- Shortness of breath
- Small bowel obstruction
- UTI

15. How have you seen the denials landscape/trends change over time? (Free text answers)

- AKI and acute respiratory failure were the first targets and then sepsis and malnutrition. When new definitions are published, insurance providers find loopholes to apply new and use old criteria to deny diagnoses.
- Two commercial payers are now denying sepsis if it doesn't meet sepsis-3 criteria.
- When we get on top of one thing, the insurance companies change course and focus on something else.
- Increased significantly due to more private payers reviewing charts for denials. Some tend to deny everything in hopes we won't have time to keep up with them and then lose money because we run out of time to review them all.
- Medicare managed care payers have increased the number of reviews as well as the number of denials based on physician documentation. Which is ironic, because the majority of these physicians are contracted by the payer to manage the patient and the documentation.
- It has become a nightmare.
- Medicare Advantage does not follow CMS guidelines. It is very difficult to overturn the denials as they don't follow specific criterion for conditions such as sepsis, acute respiratory failure or AKI.
- Payers denying more and using more creative ways to say no. Lack of education on payer side. Increased denials prevention on CDI/denials side.
- A huge increase in diagnosis, DRG, and clinical validation denials. Some but not all are denied by staff not qualified and therefore we're faced with unnecessary denials and continued denials as they don't understand the clinical rationale provided. Payers are using random clinical definitions that aren't evidence-based.
- Coding denials are mostly clinical validation. They don't use scientific resources they just send the denial because they don't think it meets the criteria. Clinical validation appeal letters are not going to physicians, they go to the coding auditor.
- Payers are becoming more aggressive and using non-clinical staff (e.g., non-nurses, APPs, MDs, etc.) to deny claims. Rationales seem like moving guidelines based on their opinion rather than current medical literature, standards of care, guidelines, etc.—essentially they will make criteria fit their denial need.

16. What type of assistive software or electronic tools do you use in your CDI department/practice?

Answer Options	Percentage
CDI chart review queue	53.86%
Computer-assisted coding and/or natural language processing	52.78%
Electronic grouper	46.32%
Query tracker (CDI and/or physician)	37.70%
Chart prioritization	28.90%
Computer-assisted physician documentation	21.72%
Quality database (e.g., Vizient, etc.)	16.16%
None/manual processes and tools	6.82%
None, but some EHR modifications	4.49%
Other (please specify)	8.98%

Other responses:

- We're using a very outdated tool and systems, but due to upcoming Epic upgrade, there are no plans to invest in an interim solution.
- We have built our own databases utilizing Access.
- Computer-assisted/automated physician queries.
- Computer-assisted query potential.
- Self-developed tracking tool.
- RISK tools.
- HCC solution in Cerner EHR.
- While not strictly CDI software, we use a proprietary DRG validation tool.
- Coders recently lost their CAC program, so we're researching products to replace it.
- We use a query process that sends the query to the provider's cellphone. When they answer on the phone, it immediately sends it to the EHR via a wi-fi connection. The CDI specialists get an immediate email alert that it has been answered.
- Currently we utilize three different tools throughout our healthcare system, but in July we are standardizing the CDI tool across the system.

17. If you use CAC/NLP/prioritization tools, has it been beneficial for your CDI specialists? (Year-over-year)

Answer Options	2018	2019
Yes, it has improved our efficiency and we are more productive	57.60%	25.85%
Yes, it has improved the quality of our queries	—	9.87%
Yes, it has streamlined our workflow	—	23.34%
Yes, it has improved the clinical depth of our reviews	23.98%	10.41%
Not sure yet	32.16%	15.62%
No, it has made our review process cumbersome (please elaborate in comments)	21.05%	6.64%
N/A	—	41.29%

Comments:

- We tried it and discontinued it.
- It slows down the CDI process and our coders don't want to review the EHR anymore, just the CAC, which is often missing important info.
- It's helpful, but still needs more utilization by the staff.
- It turns CDI into coders. They're not focusing on quality and the clinical aspects of the record.
- It seems to focus on a limited set of diagnoses that are high financial target rather than complete documentation. It may be beneficial for those that are short in resources or have a large inexperienced staff.
- I am not sure the prioritization tool is truly effective. The CAC helps to identify CC/MCC or other diagnoses that may have been missed. The CAC is not always correct and therefore flawed; it cannot recognize the pneumonia or MI was on a prior admit and not a valid diagnosis for this admission.
- It will auto suggest conditions that are not supported and many CDI/coders will rely on this tool without reading the entire chart. In some instances, the CAC will not auto suggest conditions that are present.

18. Do CDI staff at your organization have remote (work from home) opportunities?

Answer Options	Percentage
Yes, we are 100% remote	11.49%
Yes, but only a portion of the staff is remote	10.41%
Yes, but staff split onsite and offsite duties	13.64%
Yes, staff are allowed to work a set number of days per week remotely	25.49%
No	31.78%
Other (please specify)	7.18%

Other responses:

- Yes, we are allowed to work remote after certain productivity standards are met. I work in a hospital system of 50 hospitals. We can have a hospital with CDI 100% remote if the team has met standards. If not, they are onsite. Due to the increase in remote CDI, CDI is now looked at by administration as a remote job.
- It's based on performance and we can acquire two work from home days per month.
- One staff member works remotely every weekend, and the other three days are onsite.
- CDI staff can work from home occasionally, on an as needed basis.
- We can work remotely one day weekly if monthly production metrics are met.
- We can work remotely during inclement weather and under special circumstances.
- No and we have asked for it. Many have left the organization to work remotely.
- Staff rotate weeks.
- We're 95% remote, but we come in as needed for physician education, meetings, etc.
- The hospital employed CDI staff work onsite twice per week, but the contract CDI staff are 100% remote.
- One staff member is 100% remote and works between two facilities. The remaining staff can work up to two days per week from home.
- Our level 1 CDI specialists are 100% remote; Levels 2 and 3 are 50% remote.
- Our CDI team used to work remotely, but the team decided to work onsite instead. If really necessary, we can still work remotely.

19. If you have a hybrid program, please compare the effectiveness of your CDI specialists working offsite vs. those onsite. If your team is 100% remote, please rate their effectiveness before remote implementation and since then.

Answer Options	Better than onsite	Same	Worse than onsite	N/A or all work onsite	Don't know
Query rate	17.78%	39.26%	2.77%	24.02%	16.17%
Query response rate	7.93%	48.72%	3.96%	24.01%	15.38%
Productivity	33.33%	25.46%	3.01%	23.61%	14.58%
Physician engagement/buy-in	5.77%	42.03%	10.85%	24.25%	17.09%

Comments:

- We have dedicated support roles of CDI physician educators, who do all interfacing with physicians. Even if CDI isn't remote, they still do not go to floors, our physician educators do that.
- Our response rate is better when we have a physician advisor.
- All CDI staff must meet the same production requirements, whether or not they're remote.
- It depends on the role. Second-level reviewers or auditors that do not interact with physicians or clinical staff can be 100% remote.
- Overall all the CDI staff is more productive at home with fewer interruptions.

20. Please rate the engagement and collaboration of your medical staff in CDI. (Year-over-year)

Answer Options	2017	2018	2019
Highly engaged and motivated	10.89%	12.06%	12.71%
Mostly engaged and motivated, with some exceptions	52.51%	50.53%	51.03%
Somewhat engaged and motivated	31.28%	32.62%	31.78%
Mostly disengaged and unmotivated	5.31%	4.79%	4.49%

21. How supportive is your organization's administrative team of your CDI department? (Year-over-year)

Answer Options	2017	2018	2019
Strongly supportive	38.27%	45.57%	48.41%
Moderately supportive	32.12%	29.43%	27.10%
Somewhat supportive	23.74%	20.39%	19.25%
No apparent support	4.75%	3.37%	2.99%
Other (please specify)	1.12%	1.24%	2.24%

Other responses:

- Very poor support. We only have one physician as our advocate and administration only looks at the money, I'm not sure how we can bulletproof the chart or prevent HAC penalties.
- Supportive, but the communication is weak.
- Administrative team wants results but doesn't provide appropriate resources and support to meet program outcomes.
- Our CMO is totally disengaged. There has been no improvement noted from physicians who always indicate "unable to determine."
- Minimally supportive (no physician advisor, don't hold physicians/hospitalists accountable, no pediatric CDI software, no program expansion in nine years, etc.).
- With the many administrative team changes (new CMO every few years, no COO, rotating CNO) there's no consistent support. The team has to regroup each time, explain the process/aim/goal of CDI, and then leadership changes. Unable to make any appreciable steps forward.
- Minimal support; no in-hospital office space, housed off-site in a basement, only the MD lead interacts with physicians.

22. Correlation between administrative support and medical staff buy-in.

	Strongly supportive administrative team	Moderately supportive administrative team	Somewhat supportive administrative team	No apparent support from administrative team
Highly engaged medical staff	22.39%	4.83%	0.97%	6.25%
Mostly engaged medical staff	61.00%	61.38%	20.39%	6.25%
Somewhat engaged medical staff	15.83%	33.10%	69.90%	37.50%
Mostly disengaged medical staff	0.77%	0.69%	8.74%	50.00%

23. Does your department have a physician advisor or physician champion?

Answer Options	Percentage
Yes, we have a full-time physician advisor/champion	19.63%
Yes, we have a part-time physician advisor/champion	43.74%
No, but we plan on engaging one in the near future	9.91%
No, we have no plans to engage a physician advisor/champion	14.58%
Don't know	1.50%
Other (please specify)	10.65%

Other responses:

- Our physician advisor is our CMO.
- Some sites have part-time physician advisors and others don't.
- We have a physician who helps if we ask, but not a dedicated advisor.
- We have lead physicians per specialty.
- We have physician champions at each hospital and at the institute level.
- We share two full-time physician advisors with quality management and care coordination.
- We have a few physician champions for service line specialties and the physician advisor for utilization review helps as needed to help with difficult cases. We don't have a dedicated CDI physician champion/advisor.
- It varies by hospital in our health system.
- We have a physician advisor, but she's not involved with our program. She just has the title.
- We have six physician advisors who rotate time with us.
- We use an outside company.
- It depends on the hospital. In our system about 75% have a physician advisor and about 50% of those are engaged with CDI (the system's goal is 100% and they will address by adding CDI support to the conversation during contract renewals).
- We have an unpaid volunteer physician.
- Our physician champion was "forced" into doing this with no engagement whatsoever.
- We had a volunteer physician advisor for roughly a year, but he left the organization.
- We have 27 physician champions that are service-line driven. I don't believe they are paid for the role.
- We have three and pay 10% of time for each. I've never met or spoken with them.

24. Correlation between physician advisor/champion involvement and medical staff buy-in.

	We have a full-time advisor/champion	We have a part-time advisor/champion	We plan to engage an advisor/champion soon	We do not have an advisor/champion	Don't know
Highly engaged medical staff	22.39%	21.90%	5.66%	7.69%	25.00%
Mostly engaged medical staff	61.00%	50.48%	47.17%	38.46%	25.00%
Somewhat engaged medical staff	15.83%	23.81%	47.17%	47.44%	37.50%
Mostly disengaged medical staff	0.77%	3.81%	0.00%	6.41%	12.50%

25. If you have a part-time physician advisor or champion, do you share their time with another department?

Answer Options	Percentage
Yes	33.27%
No	9.53%
Don't know	5.79%
N/A	40.37%

26. How many days do physicians have to respond to a query in your facility (i.e., the required time frame in which they are supposed to answer)?

Answer Options	Percentage
One	9.72%
Two	31.78%
Three	12.90%
Four	1.50%
Five	2.62%
Six	0.56%
Seven	6.54%
Eight-14	5.98%
Within 30	5.23%
We don't have a set timeframe for query response	12.90%
Don't know	2.80%
Other (please specify)	7.48%

Other responses:

- 48 hours, but queries can be out up to 30 days.
- We wait two days, then contact the physicians. If we don't get a response, we'll go to the physician champion for help. We'll close it out if no response comes in seven days or by discharge. Post discharge queries are held for five days and then closed.
- CDI queries: Two days; Coding queries: 14 days.
- Two weeks, then they get fined. Most respond quickly.
- If they don't answer the query in 48 hours, they get a deficiency list and suspended after two weeks.

27. What is your physician query response rate within your facility's required timeframe? (year-over-year)

Answer Options	2018	2019
0-25%	1.95%	0.75%
26-50%	2.13%	2.62%
51-60%	1.95%	0.93%
61-70%	2.66%	2.99%
71-80%	8.16%	5.79%
81-90%	21.10%	23.74%
91-100%	44.50%	51.03%
Don't know	12.06%	9.72%
We don't track this metric	5.50%	2.43%

28. What is your physician query agree rate (i.e., written response on a query form or in the record that provides clarity to apply a new or more specific ICD-10 code or provide clinical documented condition)? (year-over-year)

Answer Options	2018	2019
0-25%	1.77%	2.24%
26-50%	3.19%	2.99%
51-60%	1.24%	2.62%
61-70%	2.30%	2.80%
71-80%	8.87%	9.91%
81-90%	35.28%	32.34%
91-100%	27.13%	29.53%
Don't know	15.43%	13.46%
We don't track this metric	4.79%	4.11%

29. Does your organization have an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications? (Year-over-year)

Answer Options	2018	2019
Yes	52.66%	75.70%
No	34.40%	15.70%
Don't know	7.80%	4.11%
Other (please specify)	5.14%	4.49%

Other responses:

- It's an informal process—we use our physician advisor to get queries answered.
- Yes, but it's still a work in progress. We just implemented it a couple months ago.
- We leave sticky notes in Epic for unanswered queries.
- The director of CDI reviews the case and then determines if a physician needs to review it. We don't have a formal policy.
- If queries aren't answered by the next billing cycle, the physician gets a letter for our CMO.
- We have an escalation policy but no requirements for the providers to answer queries. Makes no sense, but we have a 98–99% response thankfully.
- Yes, we have one in inpatient, but not in outpatient.
- We have one for adult CDI and physicians, but not for our pediatric CDI and physicians.
- Each site in our health system develops their own escalation process.

30. Correlation between escalation policy and physician query response rate.

Query response rate	Yes, we have an escalation policy	No, we don't have an escalation policy
0-25%	0.25%	2.38%
26-50%	1.98%	5.95%
51-60%	0.49%	2.38%
61-70%	2.47%	4.76%
71-80%	5.93%	5.95%
81-90%	24.20%	21.43%
91-100%	55.06%	42.86%
Don't know	8.15%	9.52%
We don't track this metric	1.48%	4.76%

31. Correlation between escalation policy and physician query agree rate.

Query agree rate	Yes, we have an escalation policy	No, we don't have an escalation policy
0-25%	2.22%	3.57%
26-50%	3.70%	0.00%
51-60%	1.98%	3.57%
61-70%	1.98%	4.76%
71-80%	8.15%	16.67%
81-90%	36.54%	25.00%
91-100%	30.62%	27.38%
Don't know	11.85%	11.90%
We don't track this metric	2.96%	7.14%

32. Which of the following quality measures and/or quality related items does your CDI program review on a concurrent basis?

Answer Options	Percentages
Present on admission indicators (POA)/ Hospital-acquired conditions (HAC)	74.62%
Severity of illness (SOI)/Risk of mortality (ROM) (APR-DRG methodology) concurrent to stay	65.96%
Patient Safety Indicators (PSI)	57.50%
SOI/ROM (APR-DRG methodology) retrospective mortality reviews	49.23%
HAC reduction program	42.50%
SOI/ROM (not specific to APR-DRG) methodology	36.73%
CMS Inpatient Quality Measures, i.e. "core measures" (not specific to Hospital Value-based Purchasing [HVBP])	26.54%
PSI only (not specific to HVBP)	18.65%
Hospital readmissions reduction program (HRRP)	17.12%
Surgical Care Improvement Project (SCIP) or other quality specialty database	6.73%
We don't review quality measures/metrics	10.38%
Other (please specify)	7.50%

Other responses:

- Potentially preventable complications (PPC).
- We assist care coordination.
- We're planning to expand to look at PSIs and HRRP later this year.
- We review Vizient length of stay risk adjustment.
- We don't review for PSIs and HACs, but we send them to the quality review nurses if we identify them.
- We assist quality as needed.
- We review for the Quality Payment Program (QPP) and the Merit-based Incentive Payment System (MIPS).
- We have a dedicated staff member that does these types of reviews; not all my team members do it.
- We review some PSIs, but not all.
- The coding team does these reviews, not CDI concurrent reviews.

33. Does your CDI program perform mortality reviews separately from their regular chart reviews?

Answer Options	2018	2019
Yes	62.91%	58.65%
No	34.00%	36.92%
Don't know	3.09%	4.42%

34. Has reviewing for quality measures hindered traditional CDI chart review productivity? (Year-over-year)

Answer Options	2018	2019
Yes	27.61%	25.00%
No	43.82%	37.12%
We don't track productivity	9.27%	4.81%
Don't know	19.31%	15.58%
N/A	--	17.50%

35. If your department has expanded to include quality-based reviews, were your FTEs (full-time equivalent) increased?

Answer Options	Percentages
Yes	18.08%
No	41.92%
Don't know	12.50%
N/A	27.50%

36. Does your CDI department still query if the only outcomes relate to a quality measure, not reimbursement? (year-over-year)

Answer Options	2017	2018	2019
Yes	76.42%	86.20%	77.31%
No	17.91%	7.37%	14.81%
Don't know	2.99%	4.35%	5.58%
Other (please specify)	—	2.08%	2.31%

Other responses:

- Only on sepsis cases.
- It depends on the measure and impact.
- At times; it depends on the case.

37. At your facility, do you send clinical validation queries (i.e., queries for clinical support of a documented diagnosis)? (Year-over-year)

Answer Options	2018	2019
Yes	90.73%	91.15%
No	6.46%	4.62%
Don't know	1.09%	1.92%
Other (please specify)	1.82%	2.31%

Other responses:

- Yes and no. We're still working on what the line is between questioning a physician on a diagnosis versus validating a diagnosis. Currently, our approach is if something is documented, but there are no signs of that diagnosis, we send a clinical validation query.

38. If you answered yes to the last question, which of the following diagnoses commonly lead to a clinical validation query at your facility?

Answer Options	Percentages
Sepsis	88.32%
Respiratory failure	85.04%
Encephalopathy	47.54%
Malnutrition	52.05%
Acute renal failure	42.83%
Other (please specify)	5.74%

Other responses:

- Cardiogenic or non-cardiogenic fluid overload, demand ischemia relationship.
- Acute myocardial infarction.
- Heart failure.
- ABLA.
- Pneumonia.
- Morbid obesity.
- Every single diagnosis that is a CC/MCC or increases the SOI/ROM or is a quality/risk related issue.
- Clarify complications with the term "post-op" in front of the diagnosis.
- Cerebral vascular accident.

39. Does your CDI team track the frequency of clinical validation queries?

Answer Options	Percentages
Yes, we possess CDI software that tracks clinical validation query frequency	42.31%
Yes, we track clinical validation frequency manually/we do not have CDI software that does this	11.35%
No, we do not track clinical validation query frequency	40.38%
No, we do not perform clinical validation queries	5.96%

40. Does your facility have a policy (written or unwritten) on clinical validation querying?

Answer Options	Percentages
Yes	42.31%
No	38.65%
Not sure	15.77%
We don't send clinical validation queries	3.27%

41. Does your CDI program currently review (or plan to expand to review) health records for any of the following outpatient settings or services?

Answer Options	Percentages
Hospital outpatient services: Risk adjustment	11.50%
Hospital outpatient services: Emergency department	10.53%
Hospital outpatient services: Ambulatory surgery	8.58%
Physician practice/Part B services	6.24%
Hospital outpatient services: Medical necessity of admissions	5.65%
Hospital outpatient services: Quality measures	5.07%
Hospital outpatient services: National and local coverage determinations	3.90%
Rehabilitation (outpatient)	1.95%
We don't review outpatient records	60.23%
Don't know	14.23%
Other (please specify)	5.26%

Other responses:

- High risk and high cost drugs and procedures.
- We're in the discussion and assessment phase.
- Medicare and Medicare Advantage plans for now.
- Observation services.
- We stopped our outpatient review program.
- We review our physician clinics.
- We don't have enough staff or budget to expand.

42. What is the primary focus of your reviews? (Year-over-year)

Answer Options	2018	2019
Hierarchical Condition Category (HCC) capture	35.06%	46.97%
Denials prevention	6.37%	34.29%
Medical necessity/patient status	3.19%	26.51%
Evaluation and management coding	3.98%	24.21%
Emergency department reviews/observation	2.39%	6.92%
Don't know	31.87%	6.92%
Other	17.13%	17.00%

43. When do your CDI specialists perform outpatient chart reviews?

Answer Options	Percentages
Prospectively—before the physician sees the patient	14.85%
Concurrently—while the patient	8.18%
Retrospectively—after the appointment has happened	14.85%
Don't know	33.03%
Other	40.91%

44. Does your facility/CDI program have a set policy governing the outpatient query practice?

Answer Options	2018	2019
Yes, we have a policy based on the recent ACDIS position paper "Queries in outpatient CDI: Developing a compliant, effective process"	4.29%	8.36%
Yes, we have a policy based around the ACDIS/AHIMA query practice brief, "Guidelines for Achieving a Compliant Query Practice"	7.59%	6.05%
Yes, we have a policy that was homegrown within our program	2.64%	4.32%
No, but we're developing one	15.18%	9.51%
No, we do not have an outpatient query policy	38.61%	34.29%
Don't know	21.45%	23.63%
Other (please specify)	10.23%	13.83%

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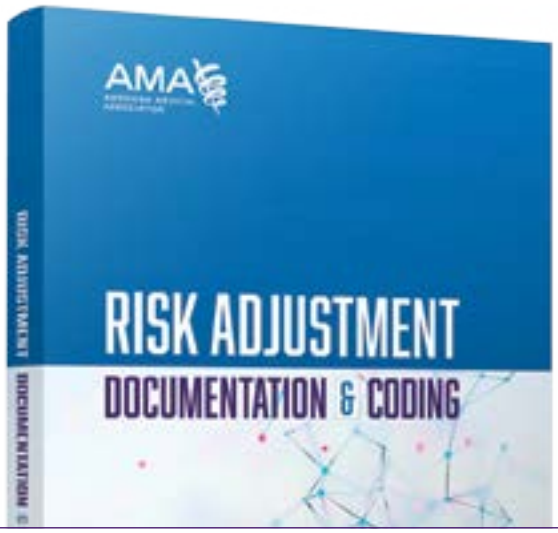

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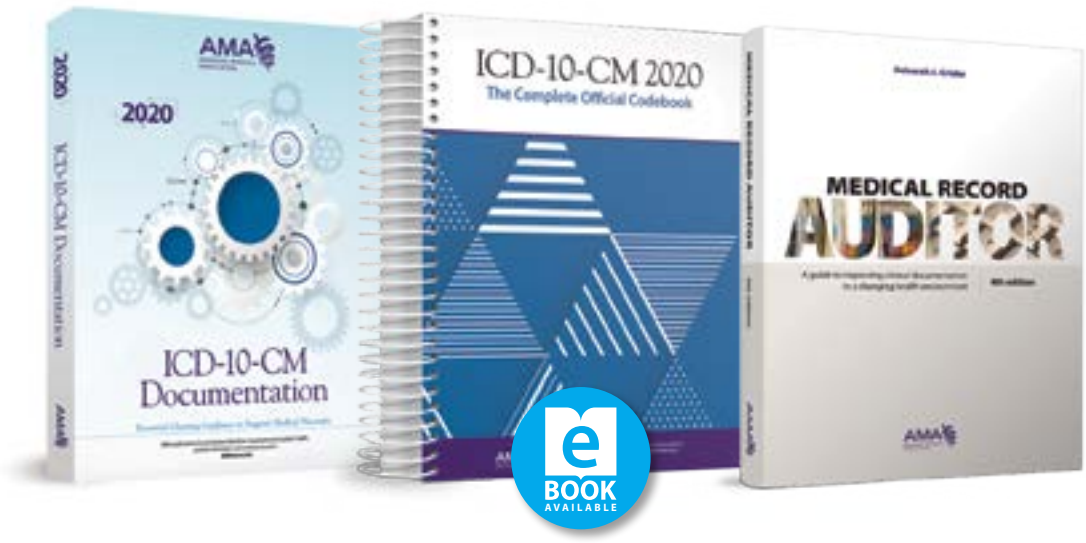

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