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About the CDI Week survey advisor

Aimee Van Balen, RN, BSN, CCDS, is the lead clinical documentation specialist at Lifespan Corporate Services in Providence, Rhode Island. She has clinical experience in medical, surgical, and cardiac care, and has been in the CDI field for almost 11 years. In her current role, she reviews both concurrent and retrospective charts for documentation best practices, query opportunities, mortality/length of stay risk adjustment, hospital-acquired conditions/Patient Safety Indicators, and other quality measures. Of utmost importance, she also provides ongoing physician education in both formal and informal settings. Van Balen orients new staff and is passionate about CDI education for both CDI staff and providers. Van Balen served as co-chair of the Massachusetts ACDIS local chapter from 2013 to 2017 and has been an active member of the Chapter Advisory Board since its formation in 2017. She has been featured on the *ACDIS Podcast* twice to promote local chapter involvement and was a speaker at the 2017 and 2018 ACDIS national conferences. In addition, she recently was published with her colleague in the *Journal of Interprofessional Workforce Research and Development*. Van Balen was elected to the ACDIS Advisory Board in 2020, serving through April 2023.

CR-3809

2020 CDI WEEK INDUSTRY OVERVIEW REPORT

Every year, ACDIS celebrates clinical documentation specialists with a full week of activities, education, and fun. This year's CDI Week theme is *ACDIS Cinema—CDI: Coming to an Organization Near You*, which aims to bring CDI professionals from behind the scenes and into the limelight, recognizing them for the superstars they are.

Leading up to CDI Week, ACDIS releases a survey giving insight on the state of the CDI industry. This year's survey included questions about physician engagement, key performance indicators (KPI), quality reviews, outpatient CDI, and denials management.

"These survey results provide a true window into the day-to-day life of our profession," says **Aimee Van Balen, RN, BNS, CCDS**, lead clinical documentation specialist at Lifespan Corporate Services in Providence, Rhode Island, and this year's CDI Week Advisor.

This year's survey garnered a whopping 849 respondents, up more than 200 respondents from last year's 639. Although this report will not discuss every survey question in detail, readers can examine all the responses beginning on p. 11.

Survey respondents represented different positions and titles within the field, with CDI specialists the most common at 49.82%, up only 1% from last year's count. Following behind were CDI managers at 14.72% and CDI directors at 10.6%. Just shy of 4% of respondents were CDI supervisors, 3.3% were CDI leads, and 2.71% were educators. The survey also contained options for more specific positions, such as CDI-coding liaison or physician advisor, though fewer respondents selected those options. (See Figure 1.) Most respondents (85.28%) work in traditional acute care hospitals. (See Figure 2.)

The largest portion of respondents (15.19%) work in facilities with more than 1,000 beds; organizations with 201–300 beds and 301–400 beds were nearly tied, with 12.25% and 12.49% respectively. (See Figure 3.) This varies drastically from last year's results where most respondents (16.59%) worked in organizations with 201–300 beds, and only 9.39% had more than 1,000 beds.

This year's survey also asked those who work at health systems about their organization's size. It found that most who work in a health system (26.32%) work for one with more than 3,000 beds, followed by 17.85% working in systems with 1,001–1,500 beds and 14.07% in systems with 500 or fewer beds. (See Figure 4.)

As with past years' Industry Surveys, the 2020 edition also had respondents from various experience levels. The most represented group was CDI professionals with between three and five years of experience (23.32%), followed very closely by those with six to eight years of experience (22.5%). Next, coming neck-and-neck, were 15.55% of respondents with between zero and two years of experience, and 15.43% with between 11 and 15 years of experience. Those with nine to 10 years of experience made up 10.13% of respondents, 7.77% had over 20 years of experience, and 5.3% had between 16 and 20 years of experience. (See Figure 5.)

"When I first started my CDI career 11 years ago, I was very concerned to leave the bedside and worried that this profession may not have been a long-lasting career choice. I am so grateful that my concerns were unwarranted," says Van Balen. "I do think that the length of CDI careers also speaks to the dedication of our profession. ACDIS is filled with so many dedicated CDI and coding professionals who pour their hearts and souls into their work each and every day."

As for credentialing, the majority of respondents (75.74%) hold an RN license. The next most common credential was Certified Clinical Documentation Specialist (CCDS) (59.48%), followed by Certified Coding Specialist (CCS) (14.72%). It's important to note that many CDI specialists hold more than one credential, and 28.74% of respondents wrote in additional credentials not listed as survey options. (See Figure 6.)

"Having worked in CDI for a long time now, it no longer surprises me that the overwhelming majority come from an RN background, but I was happy to see many coding backgrounds as well. I do think many people are capable of holding a CDI title, not just nurses, so I hope that we continue to see more integration with other backgrounds," Van Balen says.

For reporting structures, 38.52% of respondents said their CDI departments report to the HIM/coding department. Following that, 13.07% report to the quality department, and only 11.43% of respondents have a stand-alone CDI department. (See Figure 7.)

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

Denials management

The vast majority of denials result from documentation, whether from a clinical condition that's clearly present not being documented or a documented condition with insufficient support in the record. Not only do CDI professionals have the right skill sets to support denial prevention, but they're already reviewing the same attributes of charts that may trigger denials. Aided by the right, clinically intelligent technology, CDI specialists can bring their skills to bear to avoid denials and further preserve revenue.

—Anne Robertucci, MS, RHIA, director of strategic production management for enterprise computer-assisted coding (CAC) and CDI, and Krystal Haynes, RHIA, CCS, CDIP, strategic product manager for CAC and CDI, Optum360

According to this year's survey, nearly 60% of respondents said that their CDI department is currently involved in the denials management process. (See Figure 8.) Of those who are involved, most respondents (15.18%) have been involved for three to four years, 11.98% have been involved for one to two years, and an additional 9.37% have been involved for five to six years. While 8.42% have been involved for less than a year, 7% have been involved for over 10 years.

For those involved directly with denials management, 36.21% assist in writing appeal letters, 26.38% review specific diagnoses for denials prevention, and 21.58% send post-discharge queries and/or conduct mortality reviews for denial defense. Still more respondents are involved indirectly on a case-by-case basis (35.25%), only step in when the CDI team has previously reviewed the denied claim (12.71%), or are involved through the physician advisor/champion working on appeal letters (9.35%). (See Figure 9.)

For the 40.81% of total respondents who said their CDI departments are not working in denials management, Van Balen urges their organizations to begin as soon as possible.

"CDI can have a big impact on denial management, both from a preventative position as well as a retrospective one once denials have been claimed," she says. "CDI specialists have a great deal of knowledge to offer from a clinical validation viewpoint."

Van Balen warns that to not involve CDI in any manner potentially misses a huge opportunity for preventing denials concurrently with medical record documentation clarification and real-time education. As a starting point, if clinical validation queries are not already part of your CDI program, Van Balen suggests putting them on your radar.

"If CDI targeted the top denial diagnoses and providers are given real-time education, we could potentially mitigate some of these issues. There will always be audits, regardless of education and concurrent queries for clinical validation. However, they could be fewer and they could be easier to fight if the diagnosis was validated concurrently," she says.

Once a CDI team decides to take the leap into denials management, deciding who on the team will be

involved is another hurdle. Of respondents tackling denials, 38.37% designate the denials responsibility to CDI team leads or managers, and 26.38% have a designated denials or appeals specialist in their CDI department. Other models include having a physician advisor/champion handle denials (20.14%), giving the task to second-level CDI reviewers (19.18%), giving the task to CDI educators/auditors (13.43%), and assembling a denials committee with members of the CDI team (8.63%). (See Figure 10.)

It's also important to choose which aspect of denials to focus on. Nearly all survey respondents involved with denials management (90.36%) said their CDI team helps with clinical validation denials. An additional 48.19% work with coding-based denials, and 27.71% look at medical necessity. (See Figure 11.)

On average, respondents answered that 46% of their denials fell into the clinical validation category. Respondents also said that roughly 26% of denials were coding-based and 23% were based on medical necessity. (See Figure 12.) Unsurprisingly, the level of involvement in each category reflects this data.

Unfortunately, of those involved in denials management, nearly three-quarters did not know what percentage of their inpatient claims resulted in a denial. However, 11.51% said that 1%–5% of their inpatient claims resulted in a denial, 6.24% said 6%–10% resulted in a denial, and 2.16% said 11%–19% resulted in a denial. Only 1.68% said that 20% or more of their inpatient claims resulted in a denial. (See Figure 13.)

For those who have access to the data, 91.78% of respondents said the majority of their denials came from private payers. Only 4.11% said the majority of their denials originated from Medicare Administrative Contractors, and 4.11% said they came from Recovery Auditors. Though there was quite a bit of variation in the open-ended answers as to which private payers were the worst offenders, Aetna, Blue Cross Blue Shield, UnitedHealthcare, Cotiviti, Humana, and Anthem were frequently cited. (See Figure 14.)

Unsurprisingly, the most common condition cited in respondents' top denied diagnoses was sepsis, with 74.81% of respondents noting it as a top denied diagnosis. Coming close behind sepsis was respiratory failure (listed as a top diagnosis by 66.67%), followed by malnutrition (54.96%) and encephalopathy (44.27%). Among write-in responses, the most common diagnoses were acute kidney injury (AKI) and morbid obesity. (See Figure 15.)

"I have seen both of these topics becoming problematic and I think they deserve to be on CDI departments' radar to at least be aware of," says Van Balen. With AKI, she says the issue is likely the different criteria auditors can use. "I suggest facilities create a policy or guidelines with which criteria they follow to assist in audit appeals," she says.

Van Balen also says that she struggles with the fact that auditors are going after obesity and morbid obesity. She says that nutrition status arguably impacts all aspects of health and medical decision-making.

Unsurprisingly, according to the free-text answers, many respondents feel that the denials landscape is becoming more aggressive with time. (A selection of these free-text answers can be found in Figure 16.)

"I strongly believe that the state of healthcare and reimbursement is, and has been, a huge issue, so it correlates to the aggressiveness of payers," says Van Balen. While clinical validation efforts will help prevent denials on the front end, a strong appeals process has also become essential. "Strong and concise information is necessary to successfully fight denials. Departments should review past denials that were overturned or did not fare as well and draw from those to help create effective appeal letters. […] Payer denials are unfortunately not going away; denials management should spend some time now compiling information and data to save time in the long run."

Key performance indicators

Leaders use KPIs to judge a CDI program's work and success. These indicators can be a slew of data points, from query rates to readmission rates. The metrics leaders choose to monitor, however, can vary from facility to facility based on the needs and mission of the organization. The survey results suggest, though, that there are some patterns for CDI programs nationwide.

According to this year's survey, 85.6% of respondents rated chart reviews per day as an important

KPI, followed closely by 84.22% rating query response rate as important. Also in the top list were query rate (70.6%), CC/MCC capture (69.26%), severity of illness (SOI) and risk of mortality (ROM) scores (64.34%), and query agree rate (60.06%). (See Figure 17.)

"I do believe the query response rate is an important KPI and can help gauge the level of provider engagement," says Van Balen. "Chart reviews per day also can vary greatly depending on the type of facility that the CDI professional is a part of. [For example,] level 1 trauma charts can be lengthy and time consuming to review, whereas a community hospital may have charts that are quicker to review; therefore I personally put less stock in that metric."

Not all KPIs are created equal. In fact, 33.44% of respondents said their facility does not monitor Hierarchical Condition Category (HCC) capture, 32.95% said they do not capture denial rates, and 27.47% do not track readmission rates at all.

"I was surprised that almost 33% of respondents noted that they do not capture denial rates," says Van Balen. "CDI professionals can greatly impact their facilities' denials by being aware of targets and high-risk diagnoses concurrently, before the denials even become an issue."

According to the survey, 89.21% of respondents said that their organization at least somewhat encourages tracking and reporting non-financial as well as financial KPIs, showing a stark shift away from CDI focused on reimbursement and a greater focus on overall documentation integrity. Just under 20% of respondents said that non-financial KPIs are emphasized over financial KPIs, while 38.97% said both types have equal weight. Just under 31% said that while they track non-financial KPIs, financial KPIs are the most important. (See Figure 18.)

"I truly think financial and non-financial KPIs go hand in hand," says Van Balen. "All data is important, and I am not sure that one should be viewed as more important than the other."

Non-financial KPIs can help demonstrate the educational needs and productivity of a CDI specialist. In theory, however, the non-financial KPIs should impact the financial KPIs, Van Balen suggests.

"They support and build off of each other, one leading to the other in my experience," she says. "For example, if your chart reviews per day are low and you work with the CDI staff to help increase reviews, that could lead to more queries, some of which lead to an increased financial gain. The hope is always that provider education will flow to charts not reviewed by CDI and therefore will lead to overall documentation best practice, financial gain, and improvement in quality metrics."

From a reporting perspective, respondents report their KPIs to a range of departments and individuals, regardless of the department to which they report formally. The majority of respondents (54.43%) share KPIs internally with the CDI department staff, and 53.3% report them to the chief financial officer. Nearly 37% share KPIs with physician leadership, 35.27% share them with the chief medical officer, and 33.33% report KPIs to the revenue cycle director. (See Figure 19.)

For sharing data, more than half the respondents said they use Excel® spreadsheets to present. Just under 48% said they use dashboards built into their software service, and 37.36% use in-person PowerPoint® slides or other presentation tools. (See Figure 20.)

While most respondents (45.73%) do not prepare KPI presentations, most of those who do (16.59%) said they spend between three and five hours each month on this project. Another 14.17% of respondents spend between one and two hours monthly, 9.82% spend between six and 10 hours, and 6.76% spend less than an hour preparing KPI presentations. (See Figure 21.)

As with all aspects of CDI, the software tools and solution a department employs will affect their KPI performance, even if only slightly. The tool respondents said most significantly improved their KPI performance was the electronic grouper (33.98%), followed by 31.72% of respondents who said that electronic querying tools significantly improved their performance. Nearly 27% said computer-assisted coding brought significant improvement. Very few respondents said that any software tools negatively impacted their KPI performance, other than 2.26% of respondents who

said natural language processing had a somewhat or significantly negative effect. (See Figure 22.)

While some KPIs are more widely used than others, the choice of what to monitor is facility dependent.

"I think it's important to note that these KPIs are an ever-moving target and the importance of them [is] so subjective and can change depending on the data that the C-suite is looking for or focusing on [in] a given moment," says Van Balen.

Physician engagement

Organizations may need to focus on improving physicians' workloads or expanding how care can be delivered to boost cost-effectiveness, and to a higher standard of care and quality. Executive sponsorship is a key starting point, as are collaboration and communication with clinical leadership, with a concentration on targeted service lines that match the community's needs. I reiterate the importance of including clinical leadership and governance.

—Robert Budman, MD, CMIO, Nuance

Since the first CDI Week Industry Survey, physician engagement has remained a top selt-reported challenge. For the last three years, respondents' perceptions of physician engagement remained basically the same, with roughly 63% of respondents saying their medical staff was either highly or mostly engaged in 2019, 2018, and 2017. For the 2020 results, however, 70.42% of respondents said physicians were highly or mostly engaged. (See Figure 23.)

While not a huge increase from last year, it still shows improvement after three years of stagnation. And though this change could be attributed to the long-term work CDI professionals have done toward earning physician buy-in, the increase is especially exciting this year as many CDI teams have gone from at least partially on-site staffing to fully remote in response to the COVID-19 pandemic.

Whether as a response to the pandemic or because of technological advancements, CDI teams have begun using new virtual education tools more heavily over the last few years. In some cases, CDI teams have actually had greater success gaining physician engagement through virtual mediums that allow physicians to engage with CDI education on their own time. (For more insight into this topic, *check out this article* in the September/October edition of the *CDI Journal*.)

"While I believe the standard of provider engagement remains at the core value of a CDI department, I do think the ways that providers are open to receiving this education has evolved," says Van Balen. "With complex electronic medical records, we now can quickly message the providers and notify them of queries that they can check at their convenience. Many providers are quite tech savvy and prefer education via communication tools, webinars, and on-demand video."

Still, even with the advent of new electronic tools, a physician advisor or champion's help still ranks highly when it comes to physician engagement. According to this year's survey, 63.56% of respondents said that their CDI department had either a full-time or part-time physician advisor or champion, and an additional 9.8% plan to engage one in the near future. However, 12.91% of respondents still do not have a physician advisor and do not have any plans to get one. (See Figure 24.)

"I think a physician advisor is a huge asset to a CDI department as they are invaluable in helping to facilitate provider-to-provider understanding of CDI," says Van Balen. "My facility also utilizes our physician advisor to assist in CDI education of problematic diagnoses and is available to give a second-level review on cases that may be particularly challenging from a clinical perspective."

For those respondents who have a part-time physician advisor, three-quarters of respondents share the physician advisor with another department. Among respondents' write-in answers, many say the CDI department shares with case management, utilization review, and the department in which the physician clinically practices. (See Figure 25.)

One concrete measure of physician engagement is response rate to queries and the amount of time (on average) it takes for physicians to provide a response. Most respondents (33.66%) expect their physicians to respond to queries within two days, 14.71% give their physicians three days, and 9.64% allow one day for a response time. Nearly 11% of respondents do not have an expected time frame at all. (See Figure 26.)

Most respondents (55.72%) said they have a 91%–100% response rate within the time frame set by their facility. Whether respondents give their physicians between one and three days to respond to a query or between seven and 30 days, however, roughly 58% of respondents said their response rate was still 91%–100%. (See Figures 27 and 28.)

Physician response rate isn't the only metric that CDI teams monitor, however. Many also monitor their physician agree rate, which is the percentage of queries resulting in a written response (on the query or within the record) that provides clarity to apply a new or more specific code or provides clinical validation of a documented diagnosis. Most respondents (67.97%) have an 81%–100% physician agree rate, according to this year's survey. (See Figure 29.)

Perhaps unsurprisingly, those with higher query response rates also tend to have higher agree rates. Just under three-quarters (71.97%) of respondents with a response rate between 81% and 90% said they have an agree rate of 81%–100%, and 83.87% of respondents with a query response rate of 91%–100% have an agree rate of 81%–100%.

Similarly, respondents with a lower response rate are more likely to have a lower agree rate. For example, 33.33% of respondents with a response rate of 0%–25% also had an agree rate of 0%–25%, and 30.77% of respondents with a query response rate of 26%–50% also had an agree rate of 26%–50%. (See Figure 30.)

Even the most established CDI programs with excellent physician engagement occasionally encounter a resistant physician, though. When these situations arise, most survey respondents (82.35%) said their organization has an escalation policy in place to hold physicians accountable to their expected time frames. (See Figure 31.)

"I think it's necessary to understand the why behind lower physician response rates," says Van Balen. "Is it a lack of physician understanding in what CDI does? Are the queries inconsistent and unclear, leaving the provider unsure of what the query is asking? Is there a lack of support and engagement from the C-suite? In order to effectively work on the response rate, you must understand the root cause so as not to spin your wheels fruitlessly. Taking time to truly drill down and evaluate the trends will potentially save not only time but frustrations in the long run."

Van Balen suggests taking a deep dive into the query response and agree rates as well as specific provider statistics to identify trends and find the root cause for the lack of engagement.

"Try to figure out if there is a specific department that seems to be struggling with response rates and prioritize them in your educational efforts," she says. "And if you have a physician advisor, use them to tackle the root issues that may be inhibiting the engagement."

Quality

Over the last few years, the industry surveys have shown that many CDI programs are increasingly focusing on quality reviews. This year's survey found that only 8.26% of respondents don't review for quality measures, as compared to 10.38% in 2019 and 12.73% in 2018. The most commonly reviewed quality domain for this year's respondents was present on admission (POA) indicators/hospital-acquired conditions (HAC) (78.02%), followed by SOI/ROM within the APR-DRG system concurrent to the patient's stay (69.09%), then Patient Safety Indicators (PSI) (67.27%). (See Figure 32.)

In addition to reviewing for quality measures, 65.01% of respondents also conduct mortality reviews separately from their regular chart reviews. This percentage dipped a bit in 2019 down to 58.65% and now more clearly mirrors the percentage reviewing mortality charts in 2018 (62.91%). The fluctuation, while fairly small, could be due to the ebb and flow of CDI specialists' normal chart reviews based on patient censuses and shifting departmental goals. (See Figure 33.)

Regardless of the particular type of quality review, 25.5% of respondents said that reviewing for quality measures has hindered their traditional chart review productivity, which is almost identical to the 25% who gave the same answer in 2019. (See Figure 34.) In addition, only 18.38% of respondents said their full-time staff increased with these additional review responsibilities, which is also almost the same percentage as 2019. (See Figure 35.) While this data may show that CDI departments are viewing quality reviews as an integrated part of CDI work, facilities aren't hiring more staff year-over-year to compensate for the additional workload.

"A holistic quality review takes time, well-thought-out queries take time, and education and physician engagement take time," says Van Balen. "Hospital budgets are scaled back throughout, so it's not altogether surprising that there is added responsibility without increased staffing, and unfortunately with ever-growing costs that hospitals are facing in light of the recent COVID-19 pandemic, I unfortunately predict this may still be an issue on the 2021 Industry Survey."

Despite the majority of respondents reporting that they review for quality measures, just under 20% say they do not query if the query outcome only affects a quality measure rather than reimbursement. This year's survey results show that 81.46% of respondents query in these scenarios, which is up from 2019 (77.31%) and 2017 (76.42%), but down slightly from 2018 (86.2%). (See Figure 36.)

"My approach has always been that a well-rounded, holistic CDI program should be focused on accuracy and completeness of the medical record, and in such should be clarifying diagnoses to the highest level of specificity possible regardless of [their] financial impact," says Van Balen. "If we focus solely on reimbursement, we could lose track of the end goal of a CDI department, which should be documentation best practice and a record that reflects the true severity of illness and risk of mortality of the patient."

Outpatient CDI

Information related to HCC reviews can be a valuable foundation of patient care, especially as healthcare organizations transition to a risk-adjusted payment model. Organizations need solutions, both technology-driven and educational, that will help capture HCCs by documenting and coding patient diagnoses across the continuum of care for an entire year, ensuring healthcare organizations realize the benefits of appropriate risk-adjusted calculations. The key to capturing this data is to engage physicians with a proactive clinician workflow as part of their initial care process, integrating with the outpatient CDI review. HCCs will help the organization understand the patient's complexity, ultimately improving clinical outcomes [and] the risk adjustment factor score and provide appropriate reimbursement for the patient care delivered.

—Keri Hunsaker, 3M marketing manager

Similar to last year's survey results, only 2.47% of this year's respondents indicated they work in a non-hospital-based outpatient or physician practice setting. Nearly 20% of respondents, however, said that they do perform outpatient reviews of some kind, and another 25.87% said they have plans to expand to outpatient. (See Figure 37.)

The most common outpatient service or setting that respondents review is outpatient hospital services for risk adjustment factors (31.21%). Outpatient CDI teams also notably review for physician practices/Part B services (21.99%), emergency departments (19.15%), and ambulatory surgery settings (18.44%). (See Figure 38.)

Among top priorities for outpatient reviews, more than half of respondents (55.8%) noted HCC capture as a primary focus. Roughly 20% also focus on medical necessity/patient status, 19.57% concentrate on denials prevention, and 18.84% of respondents focus on evaluation and management coding. (See Figure 39.)

According to Van Balen, even if a CDI team isn't officially reviewing outpatient records, a working knowledge of HCC capture can be a valuable tool. HCCs, which are used to report primarily chronic conditions

monitored and treated in the outpatient setting, help CMS (and other payers using similar methods) determine the necessary funding to care for a particular patient in the future.

Though the conditions grouped in HCCs are often seen in the outpatient setting, patients with chronic conditions may end up admitted to inpatient care as well. Getting those conditions documented properly not only helps the payers determine the appropriate resources needed for the patient's care, but also helps clinicians provide the best care possible.

"While I do not personally perform outpatient CDI reviews, I do know that the HCCs play an important role in outpatient endeavors," says Van Balen. "Inpatient CDI specialists should also be aware of these diagnoses as well."

Outpatient visits, especially in the primary care space, are much shorter than inpatient admissions, which gives the CDI team little time to review the record and query the physician for any necessary clarification. Because of this, most respondents who perform outpatient reviews do them prospectively before the physician sees the patient (38.13%). Not far behind, though, 33.09% review them retrospectively after the appointment has happened. Only 14.39% review concurrently while the patient is with the physician. (See Figure 40.)

The majority of outpatient survey respondents (45%) have a set policy governing their outpatient query practice. For the basis of the policy, 23.57% use the ACDIS position paper "Queries in Outpatient CDI: Developing a Compliant, Effective Process," while 17.86% use the ACDIS/AHIMA query practice brief "Guidelines for Achieving a Compliant Query Practice." Only 3.57% of respondents said that they have a home-grown policy created in their own facility. (See Figure 41.)

Overall, the 2020 CDI Week Industry Survey continues the trends seen over the last 10 years of surveys. While some things remain the same (such as sepsis being a top denied diagnosis), responses show how the CDI industry continues to expand and mature—from branching out into outpatient CDI reviews, to steady improvements in physician engagement.

With 10 years of industry survey data, the results are increasingly important in advancing the CDI industry, according to Van Balen.

"In the current world that we live in, with COVID-19 making face-to-face interactions and networking with other CDI departments more challenging," she says, "I am willing to believe that these types of surveys will be a main source of that professional window for some time to come."

2020 CDI INDUSTRY OVERVIEW SURVEY

ACDIS Cinema–CDI: Coming to an Organization Near You!

1. Please indicate your title/role.

Answer Option	Percentage
CDI specialist	49.82%
CDI second level reviewer	1.06%
CDI lead	3.30%
CDI supervisor	3.89%
CDI manager	14.72%
CDI director	10.60%
CDI auditor	1.53%
CDI educator	2.71%
CDI physician educator	0.24%
CDI informaticist/analyst	0.35%
CDI-coding liaison	0.12%
CDI quality specialist	0.71%
CDI denials specialist	0.47%
HIM/coding supervisor	0.12%
HIM/coding manager	0.12%
HIM/coding director	2.00%
HIM/coding professional	0.82%
Physician advisor/champion	0.47%
Hospital executive	0.47%
Consultant	1.53%
Other (please specify)	4.95%

Selected other responses:

- Director of revenue operations
- Quality director
- Vice president of HIM/CDI/EMPI/DRG appeals
- CDI reconciler
- Risk adjustment documentation educator
- Revenue cycle auditor
- Compliance auditor
- CDI appeals specialist
- Outpatient coding auditor
- HCC analyst
- Case manager

2. Please indicate your facility type.

Answer Option	Percentage
Acute care hospital	85.28%
Consulting firm	3.65%
Outpatient/physician practice	2.47%
Children's hospital/pediatrics	1.77%
Critical access hospital/rural healthcare	0.24%
Long-term acute care	0.12%
Rehab (inpatient or outpatient)	0.24%
Home health	0.12%
Other (please specify)	6.12%

Selected other responses:

- Multihospital health system
- Acute care and behavioral health
- Academic medical center
- State psychiatric hospital
- Not working due to COVID-19 layoffs/furloughs
- Insurance company
- Vendor

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

Answer Option	Percentage
100 or less	6.83%
101-200	9.89%
201-300	12.25%
301-400	12.49%
401-500	8.48%
501-600	8.48%
601-700	5.65%
701-800	4.71%
801-900	2.24%
901-1,000	3.18%
More than 1,000	15.19%
N/A	10.60%

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

Answer Option	Percentage
500 or fewer	14.07%
501-600	5.45%
601-700	5.60%
701-800	4.99%
801-900	3.78%
1001-1500	17.85%
1501-2000	8.47%
2001-2500	7.41%
2501-3000	6.05%
More than 3000	26.30%

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

Answer Option	Percentage
0-2 years	15.55%
3-5 years	23.32%
6-8 years	22.50%
9-10 years	10.13%
11-15 years	15.43%
16-20 years	5.30%
More than 20 years	7.77%

6. What credentials do you hold?

Answer Options	Percentage
Register Nurse (RN)	75.74%
Certified Clinical Documentation Specialist (CCDS)	59.48%
Certified Coding Specialist (CCS)	14.72%
Clinical Documentation Improvement Practitioner (CDIP)	11.31%
Registered Health Information Administrator (RHIA)	6.12%
Certified Coding Professional (CPC)	4.48%
Certified Risk Adjustment Coder (CRC)	2.24%
Master of Healthcare Administration (MHA)	3.18%
Doctor of Medicine (MD)	1.88%
Bachelor of Medicine, Bachelor of Surgery (MBBS)	0.82%
Certified Clinical Documentation Specialist-Outpatient (CCDS-O)	3.18%
Nurse Practitioner (NP)	0.94%
Physician Assistant (PA)	0.24%
Registered Health Information Technician (RHIT)	3.53%
Other (please specify)	28.74%

Selected other responses:

- Accredited Case Manager (ACM)/Certified Case Manager (CCM)
- Accredited Case Management Association Registered Nurse (ACMA-RN)
- Bachelor of Business Administration (BBA)
- Bachelor/Master of Nursing (BSN/MSN)
- Certified Interventional Radiology Cardiovascular Coder (CIRCC)
- Certification in Infection Prevention and Control (CIC)
- Contract and Insurance Credentialing Analyst (CICA)
- Certified Billing and Coding Specialist (CBCS)
- Critical Care Registered Nurse (CCRN)
- Certified Coding Specialist—Physician-based (CCS-P)
- Certified Clinical Research Professional (CCRP)
- Certified Documentation Expert Outpatient (CDEO)
- Certified Emergency Nurse (CEN)
- Certified Health Data Analyst (CHDA)
- Certified Healthcare Constructor (CHC)
- Certification in Healthcare Revenue Integrity (CHRI)
- 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-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)
- Doctor of Business Administration (DBA)
- Fellowship in the American Academy of Case Management (FAACM)
- Legal Nurse Consultant (LNC)
- Licensed Practical Nurse (LPN)
- Master of Business Administration (MBA)
- Master of Health Services Administration (MHSA)
- Master of Public Administration (MPA)
- Master of Science (MS)
- 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. To whom does your CDI department ultimately report?

Answer Options	Percentage
Standalone CDI department	11.43%
HIM/coding	38.52%
Quality	13.07%
Nursing/clinical	1.06%
Case management	8.36%
Utilization review	1.18%
Other (please specify)	26.38%

Selected other responses:

- Administration
- Clinical informatics
- Clinical operations
- Clinical review cycle
- Compliance and audit
- Enterprise revenue cycle
- Revenue management
- Finance
- Medical records
- Revenue cycle
- Revenue integrity
- Revenue management

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

Answer Option	Percentage
We're not involved with the denials management/appeals process	40.81%
Less than a year	8.42%
1-2 years	11.98%
3-4 years	15.18%
5-6 years	9.37%
7-8 years	3.91%
9-10 years	3.32%
More than 10 years	7.00%

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

Answer Option	Percentage
Informally on a case-by-case basis	35.25%
Informally—only when the CDI team had previously reviewed the denied claim	12.71%
Indirectly—our physician advisor/champion works on the appeal letters	9.35%
Directly—we help write the appeal letters	36.21%
Directly—we review specific diagnoses for denials prevention	26.38%
Directly—we send post-discharge queries and/or conduct mortality reviews for denial defense	21.58%
Other (please specify)	12.71%

Selected other responses:

- Each CDI program is involved differently; most are informal while some write appeals.
- We oversee the entire DRG appeals process.
- The CDI team writes and processes Level 1 and 2 appeal letters and we assist on cases the hospital challenges in the federal court system.
- We have two denials physicians who review all the accounts that are denied and engage the CDI team. We don't write the appeal letter; we just help them if need be on a case-by-case basis. They also provide us with education on the denials received.

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

Answer Option	Percentage
The team leads/managers	38.37%
A designated denials or appeals specialist in the CDI department	26.38%
Physician advisor/champion	20.14%
CDI second-level reviewers	19.18%
CDI educator/auditors	13.43%
A group of CDI team members sit on a denials committee	8.63%
Other (please specify)	26.38%

Selected other responses:

- Everyone on the team.
- Each CDI specialist responds to denials on cases they reviewed, then we take turns on non-reviewed denials.
- Coding auditors.

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

Answer Option	Percentage
Clinical validation	90.36%
Coding-based denials	48.19%
Medical necessity	27.71%
Other (please specify)	6.51%

Selected other responses:

- DRG downgrades
- Second-level reviews
- All inpatient denials
- Pre-review for physician advisor referral
- Age restriction
- Outpatient
- Diagnosis specificity

12. What percentage of your denials fall into each category?

Answer Option	Percentage
Clinical validation	46%
Coding-based	26%
Medical necessity	23%
Other	23%

13. What percentage of your inpatient claims result in a denial (of any kind)?

Answer Option	Percentage
1%-5%	11.51%
6%-10%	6.24%
11%-19%	2.16%
20%-30%	0.96%
30%-40%	0.48%
40%-50%	0.24%
50% or more	0.00%
Don't know	74.43%
N/A	4.08%

14. For those with access to data, where do the majority of your denials originate from?

Answer Option	Percentage
Private payers (please specify which payers)	91.78%
Medicare Administrative Contractors	4.11%
Recovery Auditors	4.11%

Specify which payer:

- Aetna
- Blue Cross Blue Shield
- UnitedHealthcare
- Cotiviti
- Humana
- Anthem

15. What are your top denied diagnoses?

Answer Option	Percentage
Sepsis	74.81%
Respiratory failure	66.67%
Malnutrition	54.96%
Encephalopathy	44.27%
Kidney disease	16.54%
Acute blood loss anemia	13.99%
Pneumonia	16.28%
Congestive heart failure	13.74%
Acute myocardial infarction	8.40%
Altered mental status	3.31%
Chronic obstructive pulmonary disease	2.04%
Other (please specify)	15.01%

Selected other responses:

- Acute kidney injury
- Acute respiratory distress syndrome in neonatal/pediatrics
- Cerebral edema
- Dementia
- Endocrine
- Hyponatremia
- Inpatient-only procedures for commercial payers
- Lactic acidosis
- Morbid obesity
- Podiatry procedures within global surgical period
- Pressure ulcer
- Stroke

16. How have you seen the denials landscape/trends change over time? (Selected responses)

- "Payers are becoming more aggressive with denials. Frequently now denying multiple diagnoses on one case to move the DRG."
- "Once we implemented Sepsis-3 criteria, our sepsis denials went to virtually zero."
- "Payers are denying more and targeting specific diagnoses."
- "The insurance companies have their own set of criteria for each diagnosis, regardless of coding guidelines."
- "Increase in sepsis denials based on private insurance companies using Sepsis-3 and Sequential Organ Failure Assessment (SOFA) criteria and us still using Sepsis-2."
- "Commercial payers have turned into the number one denial pain."
- "Significantly fewer during the COVID-19 pandemic."
- "Pediatrics is just now starting to see some clinical validation denials."
- "The payers have gotten more aggressive. Our volume decreased as we began to fight back."
- "The payers will use different criteria when they are sending denials on the same diagnosis."
- "Insurers not using CMS guidelines in regards to clinical validation of certain diagnoses. Often, it appears the letters we write are read by a machine since they make glaring omissions in their second-level denial."

17. For each of the below KPIs, please indicate the level of importance to your CDI department.

	Important	Somewhat important	Unimportant, but we monitor	Do not monitor
New/re-review chart reviews per day	85.60%	10.03%	1.46%	2.91%
Query rate	70.60%	20.84%	5.98%	2.58%
Query response rate	84.22%	11.76%	1.77%	2.25%
Query agreement rate	60.06%	31.82%	4.55%	3.57%
Financial query impact	56.54%	29.58%	7.84%	6.05%
Quality measure query impact	49.27%	32.52%	6.02%	12.20%
Hierarchical condition category (HCC) capture	23.93%	30.49%	12.13%	33.44%
CC/MCC capture	69.26%	20.39%	2.75%	7.61%
Denial rates	26.69%	33.11%	7.25%	32.95%
Case mix index changes	52.36%	29.27%	9.11%	9.27%
Severity of illness (SOI)/risk of mortality (ROM) scores	64.34%	25.77%	3.08%	6.81%
Discharged, not final billed days	32.02%	26.44%	11.49%	30.05%
CDI-coder DRG mismatches	37.66%	35.55%	13.15%	13.64%
Organizational performance on) public scorecards (e.g. Leapfrog, U.S. News & World Report, etc.	46.13%	29.65%	8.73%	15.49%
Readmission rates	29.61%	29.28%	13.65%	27.47%

18. Does your organization encourage tracking/monitoring/reporting of non-financial KPIs?

Answer Option	Percentage
Yes, these are emphasized above financial KPIs	19.32%
Yes, these have equal weight with financial KPIs	38.97%
Somewhat – We track them, but financial KPIs are of principal importance	30.92%
No, our focus is purely financial	10.79%

19. Who do you report your department KPIs to? Check all that apply.

Answer Option	Percentage
Audit/compliance	13.04%
CDI program staff	54.43%
Chief financial officer	53.30%
Chief information officer/HER support	5.15%
Chief medical officer	35.27%
Health information management officer	26.41%
Other C-suite	21.90%
Physician leadership	36.88%
Quality director	28.34%
Revenue cycle director	33.33%
We don't share KPI data with organizational leadership	4.99%
Other (please specify)	13.37%

Selected other responses:

- Vice president of revenue cycle
- Case management/HIM committee
- Steering committee
- Director of coding
- Utilization review committee
- Vice president of operations

20. Please indicate whether you use each of the following tools to present KPI data to organizational leadership. Check all that apply.

Answer Option	Percentage
Excel spreadsheets	52.82%
Dashboard built into software service	47.83%
In-person PPT or other presentation tool	37.36%
Consulting service	12.08%
We don't share KPI data with organizational leadership	7.41%
Other (please specify)	11.11%

Selected other responses:

- 3M
- Analytic services
- Epic
- Tableau
- Vizient

21. On a monthly basis, how long do you spend preparing and presenting KPI data?

Answer Option	Percentage
Less than one hour	6.76%
1-2 hours	14.17%
3-5 hours	16.59%
6-10 hours	9.82%
11-15 hours	1.77%
16-20 hours	1.45%
20 hours or more	3.70%
N/A (I don't prepare materials or present)	45.73%

22. Please indicate which of the following CDI software solutions your program has adopted and their corresponding impact on your existing program KPIs.

	Performance improved significantly	Performance improved somewhat	Performance didn't change	Performance declined somewhat	Performance declined significantly	N/A we have not adopted this tool
Case prioritization	19.97%	23.03%	11.92%	0.64%	0.48%	43.96%
Computer-assisted physician documentation	13.20%	22.38%	10.79%	0.64%	0.48%	52.50%
Electronic querying tool	31.72%	30.27%	10.47%	0.81%	0.32%	26.41%
Computer-assisted coding	26.57%	28.99%	9.50%	0.97%	0.16%	33.82%
Natural language processing	17.07%	23.03%	11.59%	1.45%	0.81%	46.05%
Electronic grouper	33.98%	25.60%	14.17%	0.32%	0.16%	25.76%

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

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Highly engaged and motivated	5%	4%	4.70%	6.40%	9.80%	10.89%	12.06%	12.71%	20.42%
Mostly engaged and motivated, with some exceptions	35%	31.60%	44.60%	43.20%	46.40%	52.51%	50.53%	51.03%	50.00%
Somewhat engaged and motivated	46%	48.90%	40.50%	36.80%	34.70%	31.28%	32.62%	31.78%	25.49%
Mostly disengaged and unmotivated	13%	15.50%	10.10%	13.50%	9.10%	5.31%	4.79%	4.49%	4.08%

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

Answer Option	Percentage
Yes, we have a full-time physician advisor/champion	23.04%
Yes, we have a part-time physician advisor/champion	40.52%
No, but we plan on engaging one in the near future	9.80%
No, we have no plans to engage a physician advisor/champion	12.91%
Don't know	2.78%
Other (please specify)	10.95%

Selected other responses:

- We have a team of doctors that help us with query escalation, but no physician advisor.
- We have an advisor, but there is no dedicated time or involvement.
- We have an advisor that helps us out "as needed."

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

Answer Option	Percentage
Yes	75.40%
No	14.92%
Don't know	8.06%
N/A	1.61%

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 Option	Percentage
One	9.64%
Two	33.66%
Three	14.71%
Four	1.96%
Five	2.78%
Six	0.33%
Seven	8.50%
Eight-14	6.21%
Within 30	4.58%
We don't have a set timeframe for query response	10.78%
Don't know	1.63%
Other (please specify)	5.23%

Selected other responses:

- We encourage a timely response prior to discharge.
- Depends on the type of doctor; our hospitalists are on one week, off one week.
- Depends on concurrent versus retrospective reviews.
- Up to 48 hours post-discharge.

27. What is your physician query response rate within your facility's required timeframe?

Answer Option	Percentage
0-25%	1.47%
26-50%	2.12%
51-60%	1.96%
61-70%	1.31%
71-80%	3.43%
81-90%	21.57%
91-100%	55.72%
Don't know	9.48%
We don't track this metric	2.94%

28. Correlation between query response timeframe and query response rate

Response rate	1- to 3-day response time	7- to 30-day response time
0%-25%	1.69%	0%
26%-50%	2.82%	0%
51%-60%	1.97%	1.69%
61%-70%	1.69%	0.85%
71%-80%	2.82%	4.24%
81%-90%	22.53%	20.34%
91%-100%	58.03%	58.47%
Don't know	6.20%	13.56%
We don't track this metric	2.25%	0.85%

29. What is your physician query agree rate?

Answer Option	Percentage
0%-25%	1.63%
26%-50%	2.45%
51%-60%	1.31%
61%-70%	2.78%
71%-80%	5.39%
81%-90%	35.29%
91%-100%	32.68%
Don't know	13.40%
We don't track this metric	5.07%

30. Correlation between query response rate and physician agree rate

Agree rate	0%-25% response rate	26%-50% response rate	81%-90% response rate	91-100% response rate
0%-25%	33.33%	0.00%	1.52%	1.47%
26%-50%	0.00%	30.77%	2.27%	2.05%
51%-60%	0.00%	0.00%	1.52%	0.59%
61%-70%	0.00%	7.69%	3.79%	0.29%
71%-80%	0.00%	0.00%	8.33%	4.69%
81%-90%	11.11%	7.69%	50.00%	39.00%
91%-100%	44.44%	38.46%	21.97%	44.87%
Don't know	0.00%	15.38%	6.06%	4.99%
We don't track this metric	11.11%	0.00%	4.55%	2.05%

31. Does your organization have an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications?

Answer Option	Percentages
Yes	82.35%
No	11.76%
Don't know	2.45%
Other (please specify)	3.43%

Selected other responses:

- Not currently standardized across the system.
- Our policy is in the review process to be implemented in the coming months.
- Currently being developed.
- Yes, but not enforced.
- Hospitalists do, but private physicians are harder to manage.

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

Answer Option	Percentages
CMS Inpatient Quality Measures, i.e., "core measures" (not specific to Hospital Value-based Purchasing)	28.60%
POA/HACs	78.02%
Hospital readmissions reduction program	19.67%
PSIs	67.27%
HAC reduction program	46.12%
SOI/ROM (APR-DRG methodology) concurrent to stay	69.09%
SOI/ROM (APR-DRG methodology) retrospective mortality reviews	54.88%
SOI/ROM (not specific to APR-DRG methodology)	35.70%
Surgical Care Improvement Project or other quality specialty database	9.59%
We don't review quality measures/metrics	8.26%
Other (please specify)	6.28%

Selected other responses:

- Vizient beat coefficients
- Clinical validation
- Home health quality measures

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

Answer Option	Percentages
Yes	65.01%
No	29.02%
Don't know	5.97%

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

Answer Options	2019	2020
Yes	25.00%	25.50%
No	37.12%	44.87%
We don't track productivity	4.81%	5.13%
Don't know	15.58%	12.25%
N/A	17.50%	12.25%

35. If your department has expanded to include quality-based reviews, were your FTEs increased? (Year-over-year)

Answer Options	2019	2020
Yes	18.08%	18.38%
No	41.92%	47.85%
Don't know	12.50%	10.60%
N/A	27.50%	23.18%

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

	2015	2016	2017	2018	2019	2020
Yes	75.40%	69.60%	76.42%	86.20%	77.31%	81.46%
No	9.30%	21.10%	17.91%	7.37%	14.81%	10.75%
Don't know	4.80%	5.30%	2.99%	4.35%	5.58%	5.96%
Other	10.50%	3.90%	2.96%	2.08%	2.31%	1.82%

37. Does your CDI program currently have an outpatient component?

Answer Option	Percentages
Yes, we have a standalone outpatient CDI department with dedicated outpatient reviewers	16.58%
Yes, our inpatient reviewers also review some outpatient records or provide education	3.15%
No, we don't have an outpatient CDI department but are planning to expand	25.87%
No, we don't have an outpatient CDI department and have no plans to add one	46.27%
Don't know	4.15%
Other	3.98%

38. Which of the following outpatient settings or services do you review? Check all that apply.

Answer Options	Percentages
Hospital outpatient services: Ambulatory surgery	18.44%
Hospital outpatient services: Emergency department	19.15%
Hospital outpatient services: Medical necessity of admissions	11.35%
Hospital outpatient services: National and local coverage determinations	7.80%
Hospital outpatient services: Quality measures	11.35%
Hospital outpatient services: Risk adjustment	32.21%
Physician practice/Part B services	21.99%
Rehabilitation (outpatient)	2.13%
We don't review outpatient records	12.77%
Don't know	21.28%
Other (please specify)	12.06%

Selected other responses:

- Observation cases
- Clinic
- Home health
- Cancer center

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

Answer Option	Percentages
Hierarchical Condition Category (HCC) capture	55.80%
Evaluation and management coding	18.84%
Denials prevention	19.57%
Medical necessity/patient status	20.29%
Medical necessity/coverage of drugs/procedures, etc.	10.14%
Emergency department reviews/ observation	13.77%
Don't know	15.22%
Other (please specify)	12.32%

Selected other responses:

- Documentation completeness
- Coding

40. When do your CDI specialists perform outpatient chart reviews? Check all that apply.

Answer Option	Percentages
Prospectively—before the physician sees the patient	38.13%
Concurrently—while the patient is in the office	14.39%
Retrospectively—after the appointment has happened	33.09%
Don't know	30.94%
Other	11.51%

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

Answer Option	Percentages
Yes, we have a policy based on the recent ACDIS position paper "Queries in outpatient CDI: Developing a compliant, effective process"	23.57%
Yes, we have a policy based around the ACDIS/AHIMA query practice brief, "Guidelines for Achieving a Compliant Query Practice"	17.86%
Yes, we have a policy that was homegrown within our program	3.57%
No, but we're developing one	7.86%
No, we do not have an outpatient query policy	7.86%
Don't know	32.86%
Other (please specify)	6.43%

Selected other responses:

- We do not do outpatient queries. Our outpatient program is retrospective education focused only.
- A consulting company developed a policy for us.
- Varies by customer.
- Use the same policy as inpatient.

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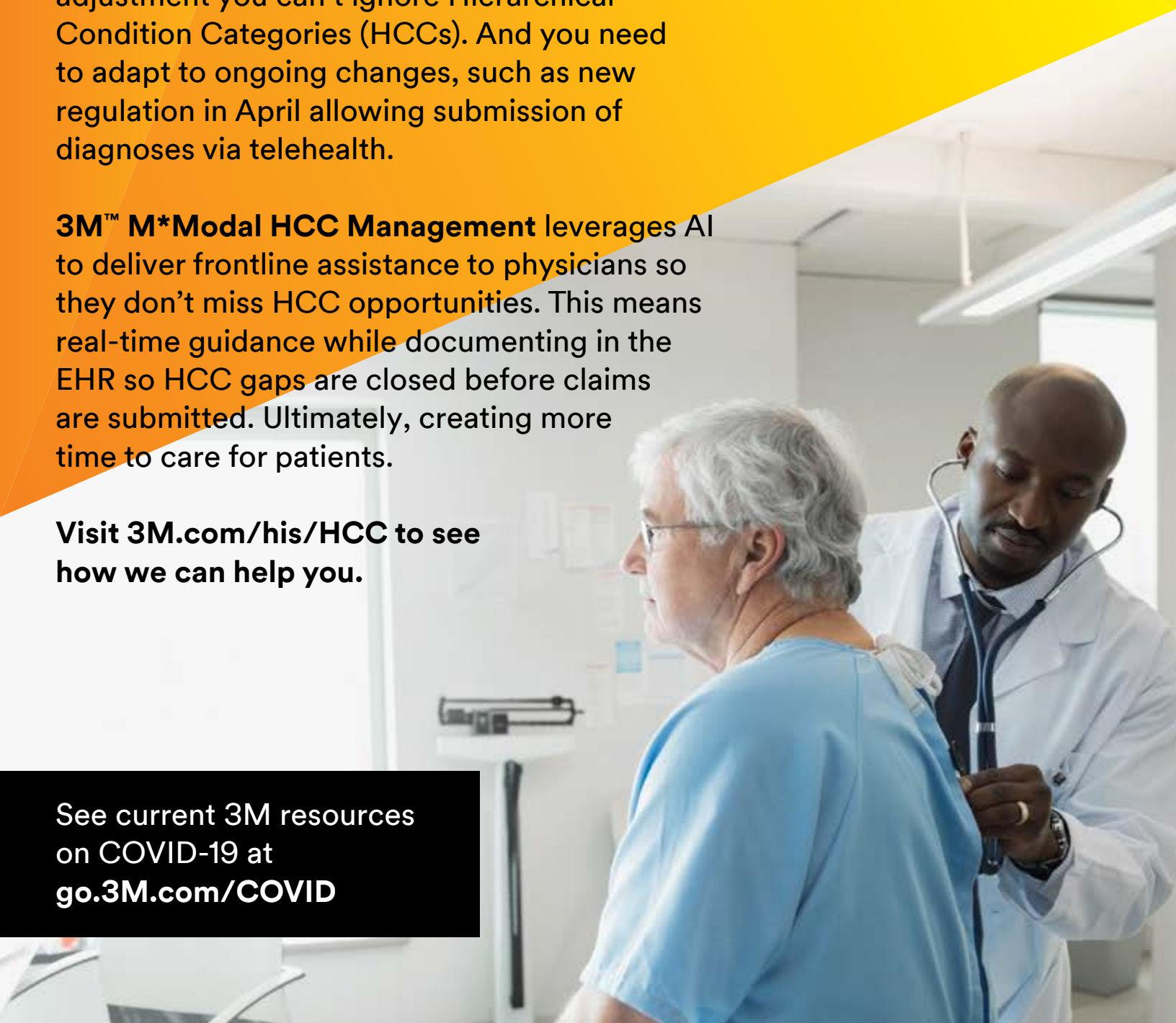

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