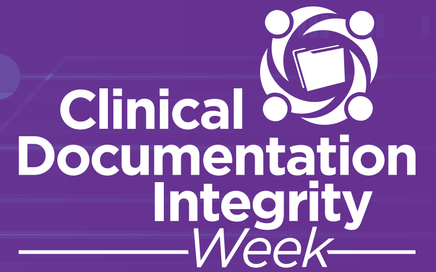

2022 Industry Overview Survey

Association of Clinical Documentation Integrity Specialists
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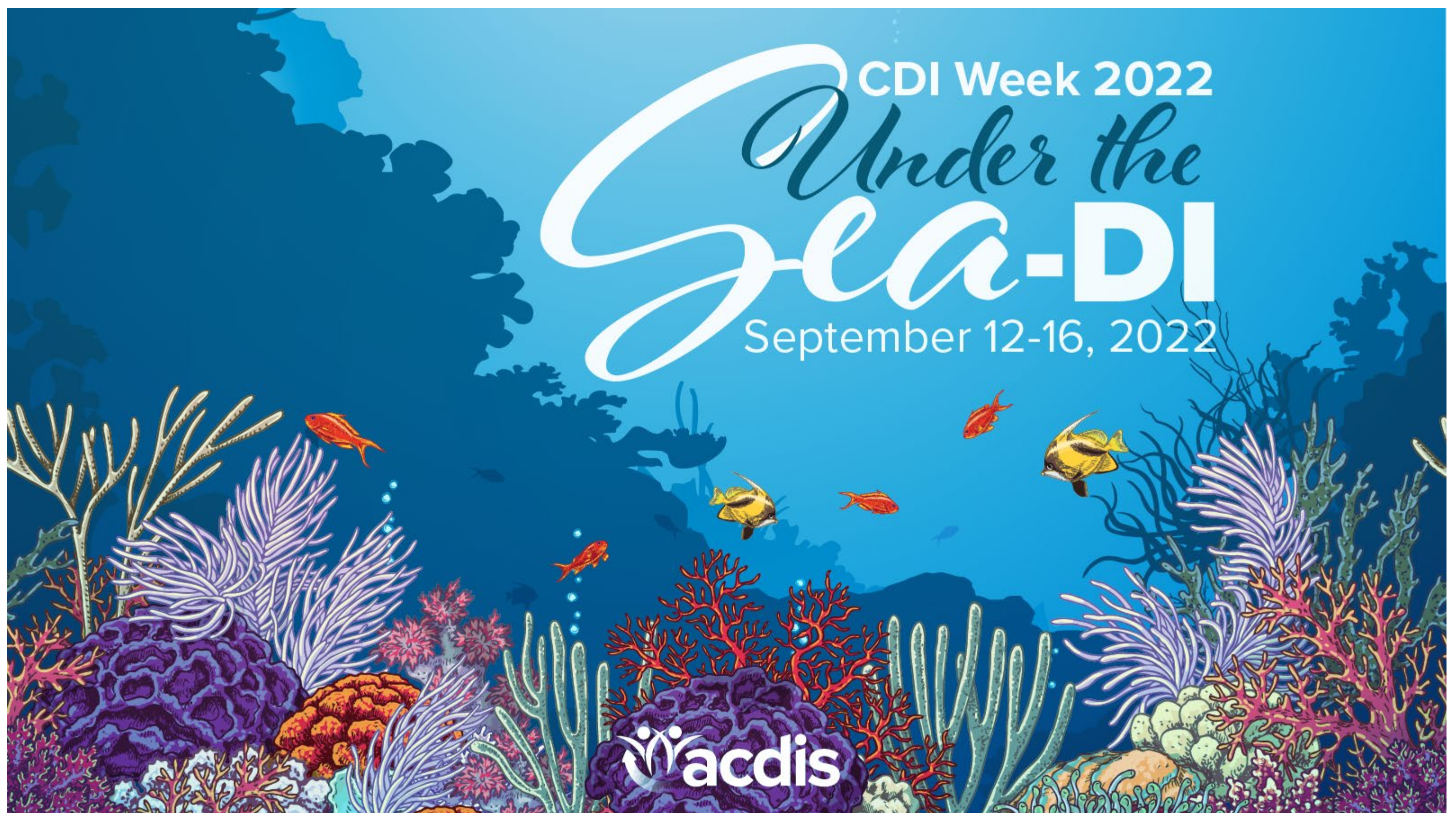

CDI Week

2022 CDI Week Industry Overview Survey

ACDIS celebrates CDI professionals annually with a full week of recognition for the profession through activities, education, and fun. This year's CDI Week theme is *Under the Sea-DI*, celebrating the often underappreciated and unseen efforts CDI professionals contribute to their organizations.

Each year leading up to CDI Week, ACDIS releases a survey to gain insight into the state of the industry. This year's survey includes questions about productivity, staff engagement in the remote environment, provider engagement, outpatient CDI and risk adjustment, and denial trends and CDI involvement. It marks the 12th annual CDI Week Industry Survey, continuing more than a decade of industry evaluation.

"The CDI profession continues to evolve, and the surveys that ACDIS compiles aid us in knowing not only where pain points may be for other programs, but also those areas of success as well," says **Lena Wilson, MHI, RHIA, CCS, CCDS,** RCS specialized manager of CDI and ICD-10 clinical education at Indiana University Health in Indianapolis.

This year, 711 respondents took part in the survey. Although this report will not discuss every survey question in detail, readers can examine all the responses in table format beginning on p. 12.

Survey respondents were asked their title and role to get a picture of the various positions within the field. Similar to last year's results, CDI specialists make up the largest group, with 43.32% of respondents fitting into this role. This number, however, is down slightly from last year's 44.39%. The change is likely due to more 2022 respondents who are CDI managers (18.28% versus 17.37% in 2021) and directors (12.66% versus 11.44% in 2021). The shift from respondents in CDI specialist roles to those in higher positions likely demonstrates individuals growing within their careers. (See Figure 1.)

In comparison to 2021, the percentage of respondents working in an acute care hospital (45.29%) decreased slightly (from 48.09%). (See Figure 2.)

About the 2022 CDI Week Industry Survey advisor

Lena Wilson, MHI, RHIA, CCS, CCDS, is the RCS specialized manager of CDI and ICD-10 clinical education at Indiana University (IU) Health in Indianapolis. She began her career as an inpatient coder and grew from there, expanding her skills into quality auditing and then into various leadership roles in HIM/coding/CDI. She now has almost 20 years of HIM, coding, and CDI experience and has been at IU Health for the last 16 years. During her tenure, she has worked in various roles supporting the CDI team, including direct leadership/program oversight as well as solely focusing on physician documentation education leading up to and through the ICD-10 code set conversion.

The IU Health inpatient CDI program was implemented in 2005/2006, and Wilson has been involved since the inception of this program in every aspect and in its continued growth. Over the last 15 years, the program has expanded to cover 16 inpatient and critical access facilities across the health system with 24 team members and one team lead. Wilson has worked with others to support the implementation of a computer-assisted CDI tool as well as production and quality monitoring programs.

The IU Health CDI program is continuing to expand into the professional space. The professional CDI program will focus on the documentation of HCC diagnoses in the physician office. This program is still in the pilot stage and will continue to evolve.

Wilson is a current member of the ACDIS Advisory Board, serving through April 2024.

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Only 13.64% in 2022 said that they have been in their current profession for over 20 years. That's down drastically from 33.47% in 2021, which could be due to the influx of new CDI professionals into the profession evidenced in the *2021 CDI Salary Survey.* Additionally, 20.68% have been in the profession for six to eight years, and 19.97% selected 11–15 years. Most respondents (60.62%) have been in their current role between zero and five years, an increase from 2021 (56.36%). An additional 16.74% have been in their role for six to eight years, and 1.69% of respondents have been in their role for more than 20 years. (See Figure 3.)

When respondents were asked how long they intend to stay in CDI, their answers were spread across the board. Most respondents said they intend to stay for more than 20 years (19.13%), and an additional 10.55% said they intend to stay for three to five years, while 12.80% of respondents picked the middle road and answered nine to 10 years. (See Figure 3.)

"It is great to see that there is a distribution of those of us in the CDI profession—those who are early on in their career with zero to 10 years in the profession, but also those that are more tenured in their careers with 11+ years in the field," says Wilson. "As a leader and knowing that the bulk of respondents are CDI specialists, it is great to see that there are about 42% of the respondents that are looking to stay in the CDI profession for 11+ more years."

Most respondents (30.66%) indicated their facility has between 101 and 400 beds, and 28.27% said the total number of beds in their health system is 3,000 or more. (See Figures 4 and 5.) These numbers are comparable to those in the *2021 CDI Week Industry Survey* (34.22%, 25.53%), as are the respondents with more than 2,000 beds in their healthcare system (from 37.29% in 2021 to 36.43% in 2022) and those who answered they were not part of a healthcare system (from 14.62% in 2021 to 14.77% in 2022).

Folks in the CDI field come from different educational and professional backgrounds, including nursing, coding, and health information management (HIM). Because of this, it is not uncommon for CDI professionals to hold a vast array of credentials. Most respondents (72.01%) noted that they hold an RN credential, and 61.88% of respondents hold ACDIS' Certified Clinical Documentation Specialist (CCDS) credential. All other credential options offered on the survey had lower response rates. For example, 16.88% of respondents noted holding the CCS, 9.28% hold the CDIP, and 5.63% hold an RHIA credential. (See Figure 6.)

"Given my background in HIM/coding, I personally would like to see more representation by coding professionals," Wilson says. "I believe that a CDI team comprised of RNs and those with a HIM/coding background will foster a more collaborative relationship amongst the entire CDI team. So much of what we do is combining the skill sets of our individual backgrounds/degrees, and the knowledge shared only continues to strengthen the overall knowledge of the team."

About 30% of respondents said their CDI department reports to revenue integrity/cycle, and 21.38% of respondents report to HIM/coding. Finance garnered 13.08% of responses, quality got 12.10%, and 7.88% of respondents indicated they have a stand-alone CDI department. (See Figure 7.)

Productivity

ACDIS routinely receives questions from members regarding CDI productivity standards, and for good reason. Because no two departments are exactly alike, productivity standards can be difficult to systematize. From organizational goals, to review focuses, to patient populations reviewed, the variations between CDI programs can make setting an "expected" productivity for CDI staff like trying to catch a cloud and pin it down.

Because of these difficulties, *ACDIS has long held* that there can really be no industry *standard* for productivity. Trends, however, do exist nationally and can help

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CDI leaders set reasonable expectations for their staff members. Like in *2021*, this year's CDI Week Industry Survey includes a deep dive into these difficult metrics to give professionals an idea of where they fall in relation to average productivity levels.

According to the survey, most respondents (61.37%) said they review six to 10 new records each day and 38.46% said they conduct 11–15 re-reviews or subsequent reviews per day, giving a total average of 17–25 records per day. (See Figure 8.) These numbers seem to mirror the amount of records CDI professionals are expected to review as well, showing an alignment between reality and the "ideal" expectation. Most respondents (56.24%) said they're expected to review six to 10 new records per day, and 36.75% said they're expected to conduct 11–15 subsequent reviews as well. (See Figure 9.)

"Productivity is always a measurement that programs like to utilize, but it is one that is not as straightforward as it could be," Wilson says. "In order to come up with a productivity metric that is meaningful, analysis should be done with the initial and follow-up reviews of the team members."

Of course, even if the expected and actual review numbers tend to be in sync, there may be instances when a CDI professional doesn't meet their productivity metrics. Respondents noted a variety of consequences for such occurrences, including one-on-one meetings with the CDI manager or leader (68.21%), one-on-one education with the department's educator (38.80%), and losing remote work privileges for a time (16.58%). More than 28% of respondents also noted that if the issue persists for an extended period of time, the staff member may be let go. (See Figure 10.)

According to Wilson, it's important to track and trend team members' production from month to month to get an idea of whether a person's dip in productivity is consistent or an aberration. She also recommends building downtime into your productivity expectations to account for any activities staff may be involved in beyond their regular reviews and to recognize that sometimes, particularly in the remote setting, personal issues may arise that impact productivity for a day.

"If there is an ongoing issue with their production, I would just have the discussion with the team member to inquire what barriers that they perceive are present and why they are unable to meet production metrics. I would provide feedback to them as to areas that they may adjust to help to improve their production metrics. I typically would have another follow-up meeting with them in a couple of weeks to see if the recommendations that I had provided had improved their workflow," she says. "The next step would be to connect the team member with a peer. They can shadow a fellow team member and see their workflow process and vice versa. The fellow team member may be able to provide recommendations to help improve/streamline the workflow process. After the team member with the lower production has time to implement/adjust their process, I would meet with them to see how they felt things were going and review their production numbers with them again."

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Part of the reason productivity metrics are difficult to pin down is that they're so dependent on outside factors, including patient census, limited staffing, review types, the individual staff member's knowledge and experience, and more. According to respondents, the experience of the reviewer has the biggest effect on productivity (63.59% ranked it in the number one spot and 15.38% ranked it in the number two spot), followed by the complexity of the case under review (15.04% ranked it as number one and 30.43% ranked it as number two). On the other end of the spectrum, 22.05% said that the format of queries (verbal versus written) had the least effect on productivity standards. (See Figure 11.)

Technology use and remote work, of course, also impact CDI productivity. According to survey respondents, electronic querying had the biggest positive effect on productivity upon its implementation, with 22.39% saying there was an immediate improvement and 39.66% saying they saw an improvement after an adjustment period. Statistically, very few respondents said any technology solution listed on the survey had a negative impact on productivity when implemented, but some newer solutions have much lower adoption rates in general. For example, 59.83% said they don't have computer-assisted physician documentation and 41.37% said the same of natural language processing. Regarding remote work, 48.03% said they saw an increase in productivity upon going remote and 36.24% said their productivity remained the same as when they were on-site. (See Figures 12 and 13.)

Staff engagement in the remote setting

"It takes innovation and creativity to have a highly engaged remote workforce. What was once considered a perk has now become the norm, with a predicted 70% of people working remotely at least five days a month by 2025, according to Forbes. Stay interviews are a proven strategy to increase engagement in a remote workforce as well as help you recruit top talent and retain your most valuable resource: your people. Understanding your employees' 'why'—their aspirations and what gives them purpose—and listening to their honest feedback with an open mind will foster solid, long-lasting relationships. As Sir Richard Branson said, 'Train people

well enough so they can leave. Treat them well enough so they don't have to.' "

— Daniel Land, RHIA, CCS, director of RCS business innovation, AMN Healthcare Revenue Cycle Solutions

The COVID-19 pandemic impacted nearly every industry, but healthcare weathered the biggest blows for obvious reasons. CDI, though not part of the direct patient care team, also felt the impact. According to survey respondents, only 13.43% were 100% remote prior to the pandemic and another 44.00% had a hybrid program with some remote options, leaving 42.57% fully on-site. In contrast, 77.68% said they were fully remote during the pandemic and another 15.94% had a hybrid program with remote options. (See Figure 14.)

Looking at program operations today, 26.91% of respondents said they're entirely remote with no on-site option and another 34.99% said they're completely remote but have an option to go on-site as needed/desired. Another 32.15% said they have a hybrid program of some sort, leaving only 5.95% of respondents fully on-site. Clearly, the CDI world has undergone a drastic change when it comes to remote work options post-COVID-19. (See Figure 15.)

"With the COVID pandemic, it truly changed the way in which most of the workforce (even outside of healthcare) performs their jobs. We are fortunate to have many technological tools to support our operations, and a remote option would not have even been available to most of us 15 years ago as many of us were

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still utilizing a hybrid (paper and electronic) medical record," Wilson says. "During the pandemic, programs were able to support their operations remotely as we saw in the COVID impact to remote work question, and it was a proven method to conducting CDI operations."

Despite pre-pandemic fears that remote work could harm staff engagement, survey respondents overall feel that going remote either improved staff engagement (33.03%) or had no detrimental effect (51.89%). (See Figure 16. To see a chart comparing engagement levels for respondents who went remote temporarily and returned on-site, see Figure 17.) Additionally, remote work—either fully or in a hybrid model—is not correlated to any perceived decrease in provider engagement. (See Figure 18.)

The preservation of staff engagement levels could be partly due to the availability of departmental engagement opportunities, which respondents cited a number of. These activities include regular virtual staff meetings (84.60%), instant messaging platforms (74.05%), flexible schedules (62.32%), reimbursement for CDI education (42.67%), and special project committees (34.16%). Some respondents also mentioned in-person activities, raises based on seniority and accomplishments, organization-sponsored CDI Week activities, and more. All these engagement opportunities have likely led to the overall low turnover rates respondents reported, with 54.84% saying they have a turnover rate of 0%–5%. (See Figure 19 and Figure 20.)

"A 100% remote team does pose some unique challenges in order to ensure that team member engagement either stays the same or increases. It may require some creativeness on the part of teams' leadership to ensure that their teams have access to not only their leadership but also their team members," Wilson says. "I believe sometimes as leaders we may overlook the simplest way to identify the solution: ASK YOUR TEAM. What may work for my individual team may not work for others. They will tell you what they need or what they think would help. Attempt to implement your team's recommendations when you can and keep an open mind. Their recommendations may need some adjustments in order to make the best fit for your overall team."

Additionally, while previous ACDIS survey data showed an overall hiring boom within the industry, the majority of respondents (69.65%) said they have no plans to seek alternative employment in the near future (likely making CDI leaders everywhere breathe a sigh of relief). In fact, only 10.12% of respondents said they were definitely going to look for a different opportunity (more than 20% reported they were unsure). (See Figure 21.)

When it comes to the reason CDI professionals first entered the profession, nearly half (44.72%) said they wanted to grow professionally and saw that opportunity in CDI, followed by 16.42% who said they were working in another department and asked to fill a CDI position; meanwhile, 15.25% said they needed a role with more consistent hours due to family or personal reasons. (See Figure 22.)

On the flip side, when asked what would make them leave the CDI profession, the number one reason was general burnout (52.19%), followed by required overtime (51.43%) and lack of remote work opportunities (51.34%). When asked what would make them leave their specific position, respondents said management failure (91.27%), lack of raises/low compensation (90.45%), and inadequate staffing (89.18%). Encouragingly, several respondents noted in the comments that they plan to remain in CDI until retirement. (See Figure 23.)

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Provider engagement

"Physician engagement takes many forms from a CDI perspective, from lunch-and-learns to computer-assisted physician documentation and beyond. Improving documentation integrity is a multiyear team sport that should be aimed at time-saving efficiencies and simplified workflows. Real-time, in-workflow AI is integral to achieving this while supporting quality improvements (SOI, ROM, GMLOS) and appropriate revenue capture. The use of analytics and dashboards can further augment the use of AI to drive better organizational effectiveness and provider performance. When numbers don't meet expectations, teams have options to improve results through remedial training, incentives, condensing content, and focusing support. Much of this can be achieved via virtual models to boost view and response rates for CDI assistive processes and reduce denials."

— Robert Budman, MD, CMIO, Nuance Communications

Every year, when ACDIS conducts its annual membership survey, respondents report that provider engagement ranks in their top three concerns and challenges. With the pandemic and the advent of more and more remote work opportunities, some CDI professionals have grappled with the even greater challenge of engaging providers without the face-to-face interaction they once relied on.

This year, 12.09% of Industry Survey respondents said that their medical staff are highly engaged and motivated, 46.72% said they are mostly engaged and motivated, and 30.75% said they are somewhat engaged and motivated. Only 7.61% said their medical staff are mostly disengaged, which is still relatively low, but higher than in 2021 when only 5% said the same. The 2022 percentages more closely mirror those seen in 2019, which could indicate a leveling out of the pandemic-induced irregularities. (See Figure 24. For a breakdown of perceived administrative team support year-over-year, see Figure 25.)

Those struggling with provider engagement, particularly CDI teams working remotely, will need to get creative with their approach as provider burnout levels are at an all-time high. Wilson recommends CDI leaders step up and start conversations with the provider leadership on behalf of their teams to show why documentation improvement and integrity matters.

"For those that have programs with a somewhat engaged or mostly disengaged [medical staff], this may be a time to have a conversation with the senior leadership of your CDI team and asking them to reach out to the service line/quality leadership," she says. "Having engagement from the top down along with individual service line leaders is invaluable. Maybe there has been turnover of the individual service line leaders. Meeting with them to explain CDI and why your teams are looking to partner with them to improve documentation may also aid in addressing engagement."

One of the most effective ways to increase provider engagement is leveraging the help of a physician advisor or champion who can approach providers at a peer-to-peer level. For the first time in Industry Survey history, ACDIS chose to separate out the questions related to physician advisor versus physician champion involvement. This delineation is important because, while the role of a physician advisor is typically more formalized and may include an official job description, pay scale, etc., the role of a physician champion is typically more

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informal. Often CDI departments choose the most engaged physicians within a specific group to hold the honorary title of physician champion and ask them to, as the name suggests, champion the efforts of the department with other providers.

According to the survey results, more respondents have a physician advisor (28.21% have a full-time advisor and 33.58% have a part-time advisor) than have a physician champion (15.67% have a full-time champion and 23.88% have a part-time champion). This may be because the advisor role is more formalized and comes with an official title (and sometimes reimbursement), making it more appealing to the physician asked to fill the role. Nearly 40% of those who have a part-time advisor or champion said they share that person with another department, and respondents frequently commented that their advisor/champion either was shared with the case management department or also carried a patient case load. (See Figure 26, Figure 27, and Figure 28.)

When it comes to compensation for those in physician advisor roles, most respondents (besides those who said they weren't sure about the compensation structure) said that their physician advisor receives a set salary for their CDI-related work (21.65%). Most respondents said that their physician champion is not compensated for their work with CDI (12.50%). (See Figure 29.)

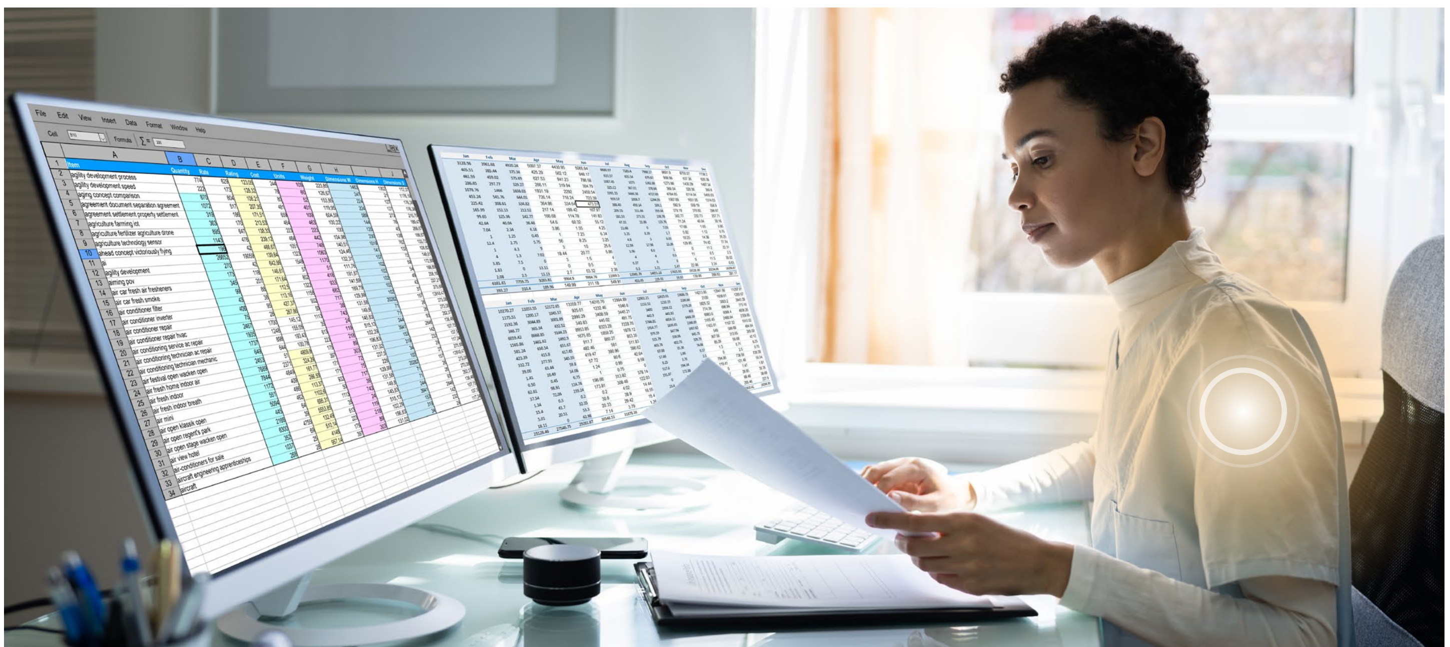
Regarding the query response timeline, most respondents (39.40%) said they expect providers to respond within two days, followed by 13.28% who said they expect a response in three days, which is consistent with 2021's results. Query response rates generally remained high among 2022 respondents, with 55.97% reporting a 91%–100% response rate and 18.36% reporting an 81%–90% response rate. Reported agreement rates remained nearly flat year-over-year as well, with 34.38% reporting an agreement rate of 91%–100% and 34.18% reporting a rate of 81%–90%. (See Figure 30, Figure 31, and Figure 32.)

"It is great to see that there was almost 56% of respondents who have a 91% response rate or greater. Even those with response rates from 81%–90% are good as well considering that there has been quite a bit of provider burnout over the last couple of years," Wilson says.

The percentage of respondents who reported having an escalation policy in place remained nearly flat, with 80.15% saying they have such a policy in place in 2022 compared to 81.66% in 2021. In general, having an escalation policy in place positively affected the overall query response rate as well: 61.08% with an escalation policy reported they had a 91%–100% response rate compared to only 39.76% of those without an escalation policy. (See Figure 33 and Figure 34.)

Outpatient CDI and risk adjustment

"CDI programs are an essential extension of the patient care documentation process. This role continues to evolve as healthcare organizations



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require documentation that spans new care settings, quality metrics, and payment models. More complete and compliant information is essential to capture an accurate patient story and to provide quality patient care. The role of the clinical documentation specialist, traditionally focused on inpatient care, needs a forward-looking perspective, closer engagement with physician practices, and outpatient services and care. Organizations that take a more holistic and proactive approach, investing across the continuum of care, are well positioned to address these evolving patient care needs."

— Keri Hunsaker, marketing manager, 3M HIS

Despite the buzz surrounding outpatient expansion, just under a quarter of 2022 Industry Survey respondents (24.70%) currently review outpatient records, which is nearly flat with 2021's results. Another 23.67%, however, say they plan to expand into outpatient in the near future, so the prevalence of outpatient review is likely to rise in the coming years. Excluding those who don't review outpatient records or didn't specify a review area, the most common outpatient service or setting reviewed is hospital outpatient services for risk adjustment (23.60%), followed by physician practice/clinic/ Part B services (23.17%), ambulatory surgery (18.45%), and the emergency department (17.59%). (See Figure 35 and Figure 36.)

"I think the pandemic caused many CDI programs to reevaluate work efforts and determine the place where their teams could provide the most impact and the focus remained on the inpatient work," Wilson says. "Even if you do not have the CDI team resources to conduct chart reviews, you can still analyze HCC diagnosis code capture and provide education to the providers. Education could be as simple as pushing out a one-page document that includes those diagnoses that are most prevalent for your respective facilities and what is needed in terms of documentation along with an overview of MEAT criteria."

Unsurprisingly, given the overall focus on risk adjustment seen in Figure 36, most respondents who review outpatient records said they focus on Hierarchical Condition Category (HCC) capture (58.52%). The next most popular review focus area (medical necessity/patient status) only accounts for 5.19% of the respondents. (See Figure 37.)

As in years past, CDI most commonly conducts outpatient reviews prospectively (before the physician sees the patient) with 40.74% of respondents falling into this category, followed by retrospectively (after the appointment has happened) with 31.85%. (See Figure 38.)

Encouragingly, more respondents than ever before reported having a query policy governing outpatient query practice. Twenty percent of respondents said their policy is based on the ACDIS position paper *"Queries in outpatient CDI: Developing a compliant, effective process"* and 21.48% said their policy is based on the ACDIS/AHIMA query practice brief, *"Guidelines for Achieving a Compliant Query Practice,"* up from 12.85% and 19.28% respectively in 2021. (See Figure 39.)

"For our outpatient/professional pilot, it was a mind shift on the queries that you are sending the provider, so that process felt a bit foreign in the beginning," Wilson says. "The queries that we send in the inpatient space will have multiple data points/references that we pull together, but the outpatient/professional query is more streamlined: You may be simply asking the provider if that diagnosis that was previously documented was present, or if the medication that the patient is on could have a diagnosis provided."

One of the biggest challenges in outpatient CDI has always been tracking impact. This is largely due to two reasons. First, fewer technological solutions are specifically designed for outpatient CDI efforts, and second, many payment and risk adjustment methodologies are prospective in nature, which means CDI departments may not see their impact reflected in risk scores and reimbursement for a year or more. This remains an issue, according to survey respondents, as 28.89% said they use a spreadsheet to track their impact and 22.22% said they have no way to track their impact at all. (See Figure 40.)

To make the outpatient CDI undertaking more manageable, Wilson suggests measuring your baseline, then monitoring your progress for a small subset of outpatient clinics or other settings.

"My recommendation for those looking to get into the outpatient/professional CDI space is to start small. The analogy of you can't boil the ocean comes to mind. We

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are a large health system with several thousand providers across our state. It would be unrealistic to expect that you could begin an outpatient/professional CDI program that would support all of those providers," she says. "You also need to analyze your coded data to determine where the best fit is for your team's efforts—ED, ancillary, same-day surgery, observation, professional office space, etc."

Denial trends and CDI involvement

Since the last time ACDIS included a section on denials management in the Industry Survey (*2020*), the percentage of respondents involved in the denials or appeals process rose by nearly 10 percentage points to 67.91%. Most respondents involved in the process said they've been involved for three to four years (17.91%), followed by those who've been involved for more than 10 years (15.67%) and those who've been involved for five to six years (11.19%). (See Figure 41.)

Part of the reason for the increase in CDI denials involvement may be due to the fact that hospitals, especially after COVID-19-related financial hits, are looking to protect their bottom lines.

The increased CDI denials involvement "may be due to the fact that we had a reduction in elective procedures and work efforts of CDI programs may have shifted from concurrent reviews to assisting in denials and ensuring that the facilities are recouping as much of the billed amounts as possible," Wilson says.

Adding to their already busy schedules, most respondents (39.57%) said their team leads and managers are the ones involved in the denials management process from a CDI perspective. The next most popular structure was to have a designated denials/appeals specialist in the CDI department (25.90%) or to have CDI educators/auditors take on the responsibility (20.14%). Most commonly, CDI departments are involved with clinical validation denials (74.82%) and DRG validation denials (51.08%). (See Figure 42 and Figure 43.)

Most respondents (66.19%) said they don't know how many of their inpatient claims result in a denial, followed by 11.51% who said 1%–5% of their claims are denied. On average, respondents said that roughly 32% of their denials fall into the clinical validation category, 22% are coding-based denials, and 21% are DRG validation denials. Echoing trends seen in the 2020 Industry Survey, 30.22% of respondents said the majority of their denials come from private payers. In the free-text comments, respondents most frequently mentioned UnitedHealthcare, Humana, and Blue Cross Blue Shield as the top offenders. (See Figure 44, Figure 45, and Figure 46.)

Consistent with 2020's findings, sepsis tops the list of respondents' most frequently denied diagnoses (69.78%), followed by respiratory failure (52.52%) and malnutrition (47.48%). (See Figure 47.) According to Wilson, these top diagnoses shouldn't surprise any CDI professionals since they've basically been the top queried diagnoses for decades as well.

"They have been in our top 10 query reasons for almost two decades now," she says. "Sepsis seems to always be an ongoing topic in every aspect of CDI operations, from the documentation by providers, to the queries that we are sending in order to address documentation concerns, to questions from the coding team where they may need additional clarity on sepsis, to billing and ultimately denials. I believe that a good portion of why this is an ongoing CDI topic is that there are numerous definitions/criteria for sepsis and lack of consistency on the definition for this diagnosis, in particular with payers. With payers utilizing different definitions, it makes it increasingly challenging to ensure that your documentation meets the requirements for all of the various sepsis criteria."

When it comes to how CDI departments are involved in the denials management process, nearly half (46.88%) said they clinically validate high-risk diagnoses concurrently, followed by those who review denials on a case-by-case basis upon request (39.24%), those who conduct mortality reviews for denial defense (30.90%), and those who provide education to physicians based on denial trends (30.03%). (See Figure 48.)

According to Wilson, even if your CDI department doesn't have access to your organization's denial trends, you can still make an impact.

"If your teams do not have insight into denial information, we know from surveys and various articles where the typical focus areas are in terms of documentation, so we can work to educate our CDI team and providers and query concurrently," she says. ■

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2022 CDI Industry Overview Survey

1. Title/role, year-over-year

Answer Options	2020	2021	2022
CDI specialist	49.32%	44.39%	43.32%
CDI second level reviewer	1.06%	1.06%	1.83%
CDI lead	3.30%	4.13%	3.52%
CDI supervisor	3.89%	3.28%	3.66%
CDI manager	14.72%	17.37%	18.28%
CDI director	10.60%	11.44%	12.66%
CDI auditor	1.53%	2.01%	1.13%
CDI educator	2.71%	3.07%	3.09%
CDI physician educator	0.24%	0.64%	0.28%
CDI informaticist/analyst	0.35%	0.53%	0.28%
CDI-coding liaison	0.12%	0.42%	0.28%
CDI quality specialist	0.71%	0.85%	1.13%
CDI denials specialist	0.47%	0.42%	0.28%
HIM/coding supervisor	0.12%	0.11%	0.28%
HIM/coding manager	0.12%	0.74%	0.56%
HIM/coding director	2.00%	1.17%	0.98%
HIM/coding professional	0.82%	0.64%	0.14%
Physician advisor/champion	0.47%	0.64%	0.84%
Hospital executive	0.47%	0.95%	0.98%
Consultant	1.53%	1.59%	1.69%
Vendor Note: This was not an option on the 2020 or 2021 survey.	N/A	N/A	0.14%
Other (please specify)	4.95%	4.56%	4.64%

Selected other responses:

- CDI manager and ACNO
- CDI second level quality reviewer
- DRG validator
- Medical coding quality manager
- Revenue cycle professionals
- CDI apprentice
- RN
- Supervisor of charge description master
- Compliance auditor
- Clinical analyst
- AVP
- Clinical performance nurse
- NP currently trying to switch careers into CDI
- CDI solutions trainer
- HCC coding RN
- DRG and clinical validation auditor
- VP of revenue cycle
- Director of CDI analytics
- Utilization management nurse
- Vice president of HIM/CDI/EMPI/DRG appeals
- HIM quality improvement manager
- Senior director of HIM
- CDI senior advisor

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2. Organization type, year-over-year

Answer Options	2021	2022
Acute care hospital	48.09%	45.29%
Academic medical center/ teaching hospital	16.53%	16.88%
Healthcare system with multiple sites	26.27%	26.44%
Outpatient/physician practice	1.59%	1.97%
Children's hospital/pediatrics	0.64%	1.27%
Critical access hospital/ rural healthcare	0.21%	0.00%
Rehab (inpatient or outpatient)	0.32%	0.00%
Home health	0.00%	0.14%
Long-term acute care	0.53%	0.14%
Consulting firm	3.07%	3.09%
Vendor organization Note: This was not an option on the 2020 or 2021 survey.	N/A	2.11%
Other (please specify)	2.75%	2.67%

Selected other responses:

- Staffing agency
- Revenue cycle management vendor
- Independent contractor
- Behavioral health hospital
- Health plan
- Revenue cycle company
- VHA
- Medicare Advantage payer
- ACO
- Software company

3. Time in role and profession

Answer Options	In profession	In current role	Intend to stay in role
0-2 years	7.88%	28.41%	5.77%
3-5 years	16.74%	32.21%	10.55%
6-8 years	20.68%	16.74%	9.85%
9-10 years	12.38%	7.74%	12.80%
11-15 years	19.97%	9.85%	12.10%
16-20 years	8.44%	2.81%	10.83%
More than 20 years	13.64%	1.69%	19.13%
Unsure	0.28%	0.56%	18.99%

4. Number of facility beds

Answer Options	Percentage
100 or less	4.50%
101–200	8.72%
201–300	12.94%
301–400	9.00%
401–500	9.70%
501–600	7.45%
601–700	4.50%
701–800	5.91%
801–900	3.66%
901–1,000	3.66%
1,001 or more	12.94%
N/A	17.02%

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5. Number of systemwide beds

Answer Options	Percentage
500 or less	12.66%
501–600	3.52%
601–700	3.09%
701–800	4.36%
801–900	3.94%
901–1,000	4.36%
1,001–1,500	9.99%
1,501–2,000	6.89%
2,001–2,500	3.38%
2,501–3,000	4.78%
3,001 or more	28.27%
N/A; I don't work in a healthcare system	14.77%

6. Credentials held

Answer Options	Percentage
Accredited Case Manager (ACM)	1.97%
Certified Clinical Documentation Specialist (CCDS)	61.88%
CCDS-Outpatient (CCDS-O)	2.95%
Certified Case Manager (CCM)	3.23%
Certified Coding Specialist (CCS)	16.88%
Certified Professional Coder (CPC)	4.78%
Certified Documentation Expert Outpatient (CDEO)	0.70%
Clinical Documentation Improvement Practitioner (CDIP)	9.28%
Certified Professional in Healthcare Quality (CPHQ)	1.55%
Certified Risk Adjustment Coder (CRC)	3.52%
Licensed Practical Nurse (LPN)	0.84%
Bachelor of Medicine, Bachelor of Surgery (MBBS)	1.13%
Doctor of Medicine (MD)	3.23%
Master of Healthcare Administration (MHA)	3.94%
Nurse Practitioner (NP)	0.98%
Registered Health Information Administrator (RHIA)	5.63%
Registered Health Information Technician (RHIT)	4.50%
Registered Nurse (RN)	72.01%
Registered Respiratory Therapist (RRT)	0.70%
Other (please specify)	26.86%

Selected other responses:

- BSN
- MSN
- MPA
- MPH, MSHI, PhD
- DNP
- Certified emergency nurse
- LNCC, CFN, NLCP
- CCA
- MSHCI, CAHIMS
- Certified inpatient coder (CIC)
- Certified Revenue Cycle Representative (CRCR)
- Certified pediatric nurse (CPN)
- Doctor of chiropractic (DC)
- MBA
- Family community nurse (FCN)
- Medical-surgical ANCC board certified (RN-BC)
- CCS-P
- Critical care nurse (CCRN)
- Masters in nursing informatics
- Licensed social worker
- Certified rehab nurse (CRRN)
- Certified nurse educator
- Certified in healthcare compliance (CHC)
- CPUR
- CPSO, CPPS
- Maternal neonatal nurse, board certified
- CCRN-K
- Cardiac vascular certified nurse

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7. Reporting structure, year-over-year

Answer Options	2021	2022
Stand-alone CDI department	6.89%	7.88%
HIM/coding	23.31%	21.38%
Finance	14.19%	13.08%
Revenue integrity/cycle	27.44%	30.24%
Quality	11.65%	12.10%
Nursing/clinical	1.38%	2.11%
Case management	7.42%	5.34%
Other (please specify)	7.73%	7.88%

Selected other responses:

- Care coordination/medical resource management
- Working on contract and unsure about reporting structure
- Informatics and technology
- Care management
- Varies by client
- Population health
- Unsure
- Chief medical officer
- Ambulatory reports to quality, hospital-based reports to HIM/coding
- Patient access
- IT
- Directly to the CEO
- Plan operations
- System chief clinical officer
- Risk and quality
- Payer initiatives
- Data quality
- Business office
- Office of patient experience
- Clinical effectiveness
- Performance excellence
- Compliance

8. Number of reviews per day in reality

Answer Options	New reviews	Re-reviews
0-5	5.81%	6.67%
6-10	61.37%	29.23%
11-15	19.32%	38.46%
16-20	3.59%	11.79%
21-25	1.71%	3.08%
More than 25	1.88%	1.03%
Don't know	2.74%	4.62%
N/A	3.59%	5.13%

9. Number of expected reviews per day

Answer Options	New reviews	Re-reviews
0-5	4.44%	3.76%
6-10	56.24%	25.98%
11-15	18.63%	36.75%
16-20	3.42%	12.82%
21-25	1.71%	2.74%
More than 25	2.05%	0.68%
Don't know	4.10%	5.30%
N/A	9.40%	11.97%

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10. Consequences for failing to meet productivity expectations

Answer Options	Percentage
The CDI manager/leader meets with them for one-on-one discussion.	68.21%
They undergo one-on-one education with the department educator or other leader.	38.80%
They lose their remote work privileges until they meet their productivity expectation consistently for a set amount of time.	16.58%
If it goes on for an extended period of time, they may be let go.	28.55%
N/A; we don't have a productivity expectation for CDI staff members.	13.50%
Other (please specify)	13.68%

Selected other responses:

- Unsure
- This hasn't been an issue because those who've fallen behind quickly improve
- Annual pay raises are tied to meeting productivity
- Audit results are emailed to the staff member
- We don't have an official policy
- Handled on an individual basis
- Performance improvement plan
- Not currently enforcing productivity due to system quality projects

11. Productivity impacts (1=greatest impact, 2=second greatest impact, etc.)

	1	2	3	4	5	6	7	8	9	10
Experience of the reviewer (seasoned versus inexperienced)	63.59%	15.38%	7.01%	3.93%	2.74%	1.71%	1.20%	1.54%	0.68%	2.22%
Reviewing for financial metrics only (CC/MCC) versus quality elements	2.74%	13.68%	11.97%	12.48%	11.97%	12.48%	9.74%	7.86%	7.35%	9.74%
Technological solutions that flag nonspecific documentation versus no access to such technology	3.42%	6.32%	14.53%	11.45%	11.11%	8.89%	12.48%	10.09%	11.62%	10.09%
Technology solutions that include prioritizations/evaluating cases with perceived opportunity	3.59%	9.23%	12.65%	14.02%	12.14%	10.09%	9.40%	10.43%	10.09%	8.38%
Composing free-text queries versus using preformatted query templates	1.03%	6.32%	11.11%	15.04%	17.78%	14.02%	11.45%	10.09%	7.52%	5.64%
Verbally querying physicians versus electronic queries only	0.68%	2.74%	4.27%	5.13%	8.03%	15.56%	11.97%	12.65%	16.92%	22.05%
Complexity of the account and/or diagnoses under review	15.04%	30.43%	15.21%	10.77%	8.21%	4.96%	8.21%	3.93%	2.22%	1.03%
Remote working environment versus on-site	7.01%	7.86%	10.60%	7.52%	8.38%	8.89%	9.74%	14.87%	9.91%	15.21%
Physician education responsibilities versus dedicated chart review	1.54%	3.93%	4.96%	10.60%	9.57%	9.40%	15.04%	15.38%	22.05%	7.52%
DRG or coding reconciliation responsibilities	1.37%	4.10%	7.69%	9.06%	10.09%	14.02%	10.77%	13.16%	11.62%	18.12%

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12. Technology's effect on productivity

	It increased our productivity immediately upon implementation	It increased our productivity after a period of adjustment	It made no change to our productivity	It negatively impacted our productivity	It's too soon to tell (we implemented recently)	We don't have this technology
Computer-assisted physician documentation	5.98%	14.02%	14.02%	2.05%	4.10%	59.83%
Computer-assisted coding	13.68%	37.09%	15.56%	2.56%	2.56%	28.55%
Natural language processing	9.40%	24.79%	17.78%	3.59%	3.08%	41.37%
Electronic querying	22.39%	39.66%	18.63%	1.71%	2.05%	15.56%
Electronic grouper	22.39%	31.11%	21.88%	1.03%	2.05%	21.54%
Chart prioritization	12.31%	26.67%	23.93%	3.93%	5.64%	27.52%
Quality database	4.10%	15.90%	23.59%	3.93%	3.76%	48.72%
Some internally developed EHR modifications	7.52%	23.08%	21.54%	1.88%	2.91%	43.08%

13. Remote work's effect on productivity

Answer Options	Percentage
It increased productivity	48.03%
Productivity remained the same	36.24%
It decreased productivity	3.08%
Don't know	6.50%
N/A, we do not work remotely	6.15%

14. How COVID-19 changed remote work

Answer Options	We were fully onsite	We were a hybrid	We were 100% remote program
Prior to the pandemic	42.57%	44.00%	13.43%
During the pandemic	6.38%	15.94%	77.68%

15. Current state of remote work

Answer Options	Percentage
100% remote with no onsite option	26.91%
100% remote with the option to come onsite if needed/desired	34.99%
Hybrid—some staff are onsite and others are 100% remote	11.05%
Hybrid—staff members are allowed to work a set number of days remotely	21.10%
100% onsite	5.95%

16. Staff engagement pre- and post-remote work (those who stayed remote)

Answer Options	Percentage
Increased	33.03%
Stayed the same	51.89%
Decreased	15.08%

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17. Staff engagement pre- and post-remote work (those who returned to onsite work)

Answer Options	Percentage
Increased	2.44%
Stayed the same	17.07%
Decreased	12.20%
N/A, we never offered remote options	68.29%

18. Remote work and provider engagement

	Providers are highly engaged	Providers are mostly engaged	Providers are somewhat engaged	Providers are mostly disengaged	Don't know	N/A
100% remote with no onsite option	15.08%	47.49%	25.14%	8.94%	1.12%	2.23%
100% remote with the option to come onsite if needed/desired	11.72%	48.95%	30.13%	6.28%	0.84%	2.09%
Hybrid—some staff are onsite and others are 100% remote	10.00%	45.71%	32.86%	5.71%	2.86%	2.86%
Hybrid—staff members are allowed to work a set number of days remotely	11.27%	45.07%	33.80%	8.45%	0.70%	0.70%
100% onsite	7.50%	37.50%	45.00%	10.00%	0.00%	0.00%

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19. Staff engagement opportunities

Answer Options	Percentage
Regular in-person team meetings	17.16%
Regular virtual team meetings	84.60%
Instant messaging (e.g., using Microsoft Teams)	74.05%
Special project committees	34.16%
Career ladder opportunities based on seniority (e.g., CDI level II)	16.28%
Career ladder opportunities based on specialization (e.g., CDI educator)	16.28%
In-person team lunches/social gatherings	26.98%
Departmental newsletters	19.35%
Virtual team lunches/social gatherings	20.38%
Department-sponsored in-person CDI Week celebrations	11.00%
Department-sponsored virtual CDI Week celebrations	22.87%
Raises/bonuses for earning CDI-specific certifications	14.37%
Raises/bonuses based on seniority	4.40%
Raises/bonuses based on advanced degrees in related fields	4.11%
Reward program for kudos earned (e.g., earn points that can be redeemed for prizes/gifts)	14.52%
Management and leadership training for i nterested staff members	15.54%
Reimbursement for CDI education (e.g., webinars, conferences, boot camps, certification costs)	42.67%
Team retreats	7.48%
Flexible schedules	62.32%
Other (please specify)	3.81%

Selected other responses:

- CDI enrichment team with monthly activities
- Career ladder
- Chat in Google every day
- We meet with cameras on
- There's no micromanaging and we're trusted to do our jobs well
- Unlimited PTO and yearly bonuses
- Ongoing educational webinars
- We did a virtual CDI Week celebration last year and are planning to meet in-person this year
- Conference travel
- Texting system with the providers
- Biweekly open office hours

20. Turnover rate

Answer Options	Percentage
0%-5%	54.84%
6%-10%	10.12%
11%-15%	5.13%
16%-20%	5.72%
21%-30%	3.23%
31%-40%	2.20%
41%-50%	0.59%
51% or more	1.76%
Unsure	16.42%

21. Plans to seek other employment opportunities

Answer Options	Percentage
No plans in the near future	69.65%
Yes, in the next 12 months I hope to be in a new position at a different facility/organization	6.45%
Yes, in the next 1-2 years I hope to be in a new position at a different facility/organization	3.67%
Unsure	20.23%

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22. Reason for entering the CDI profession

Answer Option	Percentage
I wanted to grow professionally, and CDI offered me a chance to do so	44.72%
I needed a less strenuous job after direct patient care	14.22%
I needed a job with predictable hours due to family/personal reasons	15.25%
I was involved in a different department (e.g., case management, utilization review, HIM/coding) and was asked to fill a CDI role	16.42%
N/A; I'm not in the CDI profession	1.17%
Other (please specify)	8.21%

Selected other responses:

- I wanted to work on improving documentation for the care of the patients
- CDI looked interesting
- I was working in risk adjustment and had a terrible experience, but wanted to stay involved with coding
- Needed a less stressful position after working in leadership
- Didn't have a license to practice in the state I was moving to, so I took a CDI position and then fell in love with it
- I'm the director of case management and CDI was moved under my purview
- I was looking for a desk job where I could still use my clinical expertise
- Needed a lifestyle change
- It was a brand-new position and an opportunity to build it from the ground up
- My friend recommended it to me, and I ended up loving it

23. Factors that could lead to leaving the position and profession

Answer Options	Current Role	The CDI Profession
Lack of advancement opportunities	87.32%	39.79%
Lack of raises/low compensation	90.45%	41.96%
Lack of remote work options	88.36%	51.34%
Management failure	91.27%	34.39%
Required overtime	85.14%	51.43%
Unrealistic expectations for productivity and other metrics	88.30%	48.60%
Inadequate staffing	89.18%	32.99%
Lack of educational resources	84.68%	44.14%
Lack of appreciation from organizational leadership	88.85%	34.08%
High turnover in the department	83.47%	33.88%
Burnout generally	86.53%	52.19%
None of the above	70.40%	79.20%

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24. Perceived provider engagement, year-over-year

Answer Options	2019	2020	2021	2022
Highly engaged and motivated	12.71%	20.42%	14.44%	12.09%
Mostly engaged and motivated, with some exceptions	51.03%	50.00%	50.89%	46.72%
Somewhat engaged and motivated	31.78%	25.49%	26.78%	30.75%
Mostly disengaged and unmotivated	4.49%	4.08%	5.00%	7.61%
Don't know	N/A	N/A	0.78%	1.04%
Not applicable	N/A	N/A	2.11%	1.79%

25. Perceived administrative support, year-over-year

Answer Options	2021	2022
Strongly supportive	52.89%	46.27%
Moderately supportive	30.22%	31.34%
Somewhat supportive	13.89%	18.06%
No apparent support	1.78%	3.13%
Other (please specify)	1.22%	1.19%

Selected other responses:

- We have no idea because of a lack of communication
- Enthusiastic without understanding of the actual specifics of the job, so there are unrealistic expectations
- When we answered to the CFO, they were very supportive, but we haven't had as much support since we started reporting to the HIM director instead
- Too new to assess this

26. Physician advisor involvement

Answer Options	Percentage
Yes, we have a full-time physician advisor/champion	28.21%
Yes, we have a part-time physician advisor/champion	33.58%
No, but we plan on engaging one in the near future	8.36%
No, we have no plans to engage a physician advisor	17.16%
Don't know	4.63%
Other (please specify)	8.06%

Selected other responses:

- We have one but they're not as involved as we'd prefer
- Physician who works with denials is available for questions
- We're trying to get administrative approval
- Our main facility does, but not the partner hospital
- We have two advisors
- We have a physician advisor at the corporate level, but not individual sites
- We partner with a team of physicians but they're not specifically advisors/champions
- Varies by site
- Our CMO is our physician advisor and also the advisor for case management
- We have an advisor in name only as they're too busy to actually help
- Hospital is unwilling to fund the position
- We have a consulting service that provides advisory services

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27. Physician champion involvement

Answer Options	Percentage
Yes, we have a full-time champion	15.67%
Yes, we have a part-time champion	23.88%
No, but we plan on engaging one in the near future	9.40%
No, we have no plans to engage a champion	31.94%
Don't know	11.19%
Other (please specify)	7.91%

Selected other responses:

- It's hit or miss because it's not their primary role
- Our HSP director acts as our champion without compensation
- Our advisor is our champion
- Varies by site
- Informally only
- Unable to find someone to fill the role
- We have department champions
- We have a champion but it's not their assigned role or paid
- Many service line-specific champions
- Only on an as-needed basis

28. Parttime physician advisor/champion sharing

Answer Options	Percentage
We share our advisor/champion	39.55%
We do not share our advisor/champion	7.91%
Don't know	17.61%
N/A, we don't have a part-time advisor or champion	34.93%

Parttime advisors/champions are shared with:

- Fulltime practicing physician
- Utilization management, sepsis, mortality
- Many other departments
- Quality and the emergency department
- Hospitalist medical director
- Case management
- Social services
- Private practice provider
- Performance improvement
- VP of medical management
- Appeals
- Dietitians
- Revenue integrity
- Denials
- Coding
- Advisor covers multiple sites

29. Physician advisor and champion compensation

Answer Options	Physician Advisor	Physician Championn
Yes, they receive a set salary for their CDI-related work	21.65%	10.55%
Yes, they receive an hourly rate for their CDI-related work	8.57%	4.29%
No, they are not compensated for their CDI-related work	6.77%	12.50%
Unsure about their compensation	35.49%	30.47%
N/A, we don't have this position	27.52%	42.19%

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30. Required timeframe for physician query response

Answer Options	2021	2022
One day	10.91%	7.31%
Two days	34.20%	39.40%
Three days	14.06%	13.28%
Four days	2.81%	1.79%
Five days	2.70%	3.73%
Six days	0.22%	0.75%
Seven days	5.06%	5.22%
Eight-14 days	5.74%	5.22%
Within 30 days	5.74%	5.52%
We don't have a timeframe for query response	10.69%	9.10%
Don't know	2.25%	3.13%
Other (please specify)	5.62%	5.52%

Selected other responses:

- Varies depending on client/site
- Up to 72 hours
- Before the patient is discharged
- We don't send queries (health plan setting, outpatient setting)
- Two days from time of discharge, 30 days for a retro-spective query
- Two weeks
- 48 hours of being on service
- Initially two days with escalation process after that up to seven additional days
- Five is the max, but fewer is preferable
- 21 days before they are reported, but not sure what the recommended time frame is
- Deficiency starts after two days, but ultimately they get suspended at 15 days
- Hospitals are held to 36 hours, but all providers have up to 14 days

31. Query response rate

Answer Options	Percentage
0%-25%	1.34%
26%-50%	2.24%
51%-60%	1.64%
61%-70%	1.34%
71%-80%	4.78%
81%-90%	18.36%
91%-100%	55.97%
Don't know	9.85%
We don't track this metric	4.48%

32. Query agreement rate

Answer Options	Percentage
0%-25%	2.09%
26%-50%	2.69%
51%-60%	1.79%
61%-70%	2.09%
71%-80%	7.76%
81%-90%	34.18%
91%-100%	34.48%
Don't know	10.45%
We don't track this metric	4.48%

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33. Escalation policy use, year-over-year

Answer Options	2021	2022
Yes, we have an escalation policy	81.66%	80.15%
No, we don't have an escalation policy	10.57%	12.39%
Don't know	3.94%	2.69%
Other (please specify)	3.82%	4.78%

Selected other responses:

- We used to have one, but it was discontinued
- Varies by client/site
- Our policy is currently in development
- One of our sites has one and one does not
- No formal policy, but the CDI specialist is responsible for escalating by emailing, texting, calling, and leaving messages
- Yes for mortality, patient safety indicators, hospital acquired conditions, and coding queries, but not for general CDI queries
- We do, but it's inconsistent
- We used to have one, but stopped because of physician burnout

34. Escalation policy use and physician response rate

Answer Options	We have escalation policy	We don't have an escalation policy	Don't know
0%-25%	1.12%	1.20%	0.00%
26%-50%	1.68%	4.82%	5.56%
51%-60%	1.12%	6.02%	0.00%
61%-70%	1.12%	2.41%	5.56%
71%-80%	4.47%	7.23%	5.56%
81%-90%	18.62%	15.66%	16.67%
91%-100%	61.08%	39.76%	5.56%
Don't know	9.50%	7.23%	50.00%
We don't track this metric	1.30%	15.66%	11.11%

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35. Outpatient expansion, year-over-year

Answer Options	2020	2021	2022
We have a standalone outpatient CDI department with dedicated outpatient reviewers	16.58%	20.61%	21.27%
Our inpatient reviewers also review some outpatient records or provide education	3.15%	3.60%	3.43%
We don’t have an outpatient CDI department but are planning to	25.87%	21.85%	23.67%
We don’t have an outpatient CDI department and have no plans to add one	46.27%	44.37%	42.54%
Don’t know	4.15%	5.63%	4.97%
Other (please specify)	3.98%	3.94%	4.12%

Selected other responses:

- We’re in the process of launching
- Our main campus does
- Our facility has dedicated outpatient trainers
- We have outpatient coders, but no real CDI process
- Varies by client/site
- Unsure about our plans
- Our outpatient program is on hold until further notice
- A different ambulatory group within our system has just started outpatient CDI reviews as part of the population health department
- It’s currently handled by our physician network
- We only review outpatient records

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36. Outpatient settings/services reviewed

Answer Options	Percentage
Hospital outpatient services: Ambulatory surgery	18.45%
Hospital outpatient services: Emergency department	17.59%
Hospital outpatient services: Medical necessity of admissions	10.73%
Hospital outpatient services: National and local coverage determinations	7.29%
Hospital outpatient services: Quality measures	9.87%
Hospital outpatient services: Risk adjustment	23.60%
Physician practice/clinics/Part B services	23.17%
Rehabilitation (outpatient)	3.43%
Don't know	37.34%
Other (please specify)	14.59%

Selected other responses:

- Unsure
- We're in the process of creating an outpatient program
- Vendor
- Observation cases
- HCCs on inpatient records
- Oncology outpatient infusions and medication

37. Outpatient review focus

Answer Option	Percentage
Hierarchical Condition Category (HCC) capture	58.52%
Evaluation and management (E/M) coding	3.70%
Denials prevention	3.70%
Medical necessity/patient status	5.19%
Coverage of drugs/devices/ procedures, etc.	1.48%
Emergency department review/observation	2.96%
Accuracy of current procedural terminology (CPT) codes for expensive surgeries/procedures	1.48%
Don't know	11.11%
Other (please specify)	11.85%

Selected other responses:

- Accurate documentation of observation cases
- We have plans to start reviewing ED records
- All are planned focuses

38. Outpatient review timing, year-over-year

Answer Options	2021	2022
Prospectively—before the physician sees the patient	33.33%	40.74%
Concurrently—while the patient is in the office	15.66%	12.59%
Retrospective;y—after the appointment has happened	30.92%	31.85%
We don't perform chart reviews/ focus is on education	5.22%	9.63%
Don't know	31.73%	9.63%
Other (please specify)	6.43%	14.81%

Selected other responses:

- We do pre- and post-visit reviews

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39. Policy for outpatient query compliance, year-over-year

Answer Options	2021	2022
We have a policy based on the ACDIS position paper “Queries in outpatient CDI: Developing a compliant, effective process”	12.85%	20.00%
We have a policy based around the ACDIS/AHIMA query practice brief, “Guidelines for Achieving a Compliant Query Practice”	19.28%	21.48%
We have a policy that was homegrown within our program	9.64%	6.67%
We do not have a policy, but we’re developing one	5.22%	9.63%
We do not have an outpatient query policy	8.84%	12.59%
Don’t know	39.36%	20.74%
Other	4.82%	8.89%

40. Tracking outpatient CDI impact

Answer Option	Percentage
We use outpatient-specific CDI software	11.85%
We use a modified version of our inpatient-specific CDI software	2.96%
We track impact manually using a spreadsheet	28.89%
We contract with an external company to monitor our performance	8.89%
Our internal IT department created a tracking tool or us	13.33%
N/A; we don’t have a way to track our impact	22.22%
Other (please specify)	20.00%

Selected other responses:

- Unsure
- Conversion of observation to inpatient based on CDI queries
- We get feedback from insurer and ACO that are part of our health system
- We use our EHR along with partnering with our MA payers

41. Length of time involved with denials management, year-over-year

Answer Options	2020	2022
We’re not involved in the denials management/appeals process	40.81%	32.09%
Less than a year	8.42%	3.73%
1-2 years	11.98%	10.45%
3-4 years	15.18%	17.91%
5-6 years	9.37%	11.19%
7-8 years	3.91%	2.24%
9-10 years	3.32%	6.72%
More than 10 years	7.00%	15.67%

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42. Individual(s) involved in the denials management process

Answer Option	Percentage
A group of CDI team members sit on a denials committee	10.79%
A designated denials or appeals specialist in the CDI department	25.90%
CDI second-level reviewers	13.67%
CDI educators/auditors	20.14%
Physician advisor/champion	17.27%
The team leads/managers	39.57%
Other (please specify)	26.62%

Selected other responses:

- Unsure
- CDI review and then sent to a third party vendor for appeals
- Separate denial staff under the quality department
- Separate department
- Sole CDI specialist, so partner with the physician advisors
- CDI quality reviewers
- Coder and CDI RN
- Advanced coders
- CDI specialists may be asked to review denials if they reviewed the case initially
- CDI provider education lead and coding compliance specialists
- Managed care CDI RN

43. Type of denials reviewed by CDI

Answer Option	Percentage
Clinical validation	74.82%
Coding-based denials	35.97%
DRG validation	51.08%
Medical necessity	23.74%
Other (please specify)	13.67%

Selected other responses:

- Unsure
- Readmissions
- We clinically validate concurrently, but don't help with denials specifically
- Observation to inpatient and vice versa
- Outpatient infusions

44. Percentage of inpatient claims resulting in a denial

Answer Option	Percentage
1%-5%	11.51%
6%-10%	6.47%
11%-20%	5.76%
21%-30%	0.72%
31%-40%	1.44%
41%-50%	1.44%
51% or more	0.00%
Don't know	66.19%
Not applicable	6.47%

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45. Average percentage of denials in each category

Answer Option	Average Answer
Clinical validation	31.53%
Coding-based	22.11%
DRG validation	20.58%
Medical necessity	17.21%
Other	17.19%

46. Length of time involved with denials management, year-over-year

Answer Options	2020	2022
Don't know Note: This option was not included on the 2020 survey	N/A	43.17%
Medicare Administrative Contractors	4.11%	15.83%
Recovery Auditors	4.11%	10.79%
Private payers (please indicate which payer)	91.78%	30.22%

Selected private payers mentioned:

- UnitedHealthcare
- Highmark
- Cotiviti
- Humana
- Blue Cross Blue Shield
- Cigna
- Different payers depending on the state
- Aetna
- Medicare and Medicaid HMO plans
- Priority Health
- Anthem
- Wellcare
- Florida Blue

47. Top denied diagnoses, year-over-year

Answer Options	2020	2022
Congestive heart failure	13.74%	12.23%
Sepsis	74.81%	69.78%
Respiratory failure	66.67%	52.52%
Malnutrition	54.96%	47.48%
Kidney disease	16.54%	15.83%
Acute blood loss anemia	13.99%	10.79%
Pneumonia	16.28%	9.35%
Altered mental status	3.31%	3.60%
Encephalopathy	44.27%	39.57%
Chronic obstructive pulmonary disease	2.04%	2.16%
Acute myocardial infarction	8.40%	5.76%
Other (please specify)	15.01%	28.06%

Selected other responses:

- Unsure
- Any obstetrics CC/MCC
- Acute kidney injury
- Medical necessity
- Testing
- Specifically type 2 MI
- Substance abuse

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48. Type of CDI involvement with denials management

Answer Option	Percentage
We review denials on a case-by-case basis upon request	39.24%
We review denials when the CDI team had previously reviewed the claim	17.53%
Our physician advisor/champion works on the appeal letters	16.67%
We help to write the appeal letters	23.09%
We clinically validate high-risk diagnoses concurrently (e.g., malnutrition, sepsis, etc.)	46.88%
We clinically validate high-risk diagnoses retrospectively	21.01%
We conduct mortality reviews for denial defense	30.90%
We work with other organizational stakeholders to develop organization-specific clinical criteria for high-risk diagnoses	14.58%
We provide education to physicians based on denial trends	30.03%
We work with our payer contracting team to review contracts	8.33%
We collaborate cross-departmentally on denial defense (e.g., with the case management team on medical necessity denials)	18.75%
None of the above	18.40%
Other (please specify)	11.46%

Selected other responses:

- Our new manager (who doesn't have CDI experience) currently handles denials
- Unsure
- We have a vendor for denials management
- Our CDI lead writes the appeal letters
- We have a person/team that does denials
- We manage denials via a work queue
- Varies based on client/site

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