

Defining the CDI specialist's roles and responsibilities

Director's note: *This position paper seeks to clarify the role of the clinical documentation improvement specialist (CDIS) and provide guidance in developing appropriate policies, procedures, and job descriptions for CDI departments. The CDIS role is complex and requires expert knowledge of clinical care and applicable coding guidelines, as well as an ability to communicate effectively with the clinical care team.*

What follows is a generic, ACDIS-endorsed summary of the role of the CDIS, including recommended minimum qualifications, knowledge set, and special skills. This position paper also seeks to promote a level of professional consistency to safeguard the role and reputation of the CDIS and promote its value within the healthcare system.

Basic requirements

Complete and accurate diagnostic and procedural coded data is necessary for many reasons, including the following:

- » Accurate reimbursement
- » Financial and strategic planning
- » Outcomes and statistical analyses
- » Epidemiology and research
- » Accurate reflection of a patient's SOI and ROM
- » Hospital, specialty, and physician quality of care, including patient safety and outcomes measures
- » Communication of a patient's overall health status to all providers in order to facilitate complete in-hospital and discharge treatment plans

Websites like Hospital Compare and Healthgrades, as well as private payers like Blue Cross/Blue Shield, use this same coded data in formulas to calculate individual physician and hospital profiles and organizational scorecards, all of which can impact a provider's reputation and ability to deliver patient care. Coded data is, therefore, the lifeblood of both providers and the facilities in which they work.

CDI professionals strive to promote an accurate and meaningful database that clearly demonstrates the resources used in a patient's care. The CDIS serves as an essential resource to the clinical team and ensures that all relevant conditions requiring healthcare resources throughout the

patient's hospitalization are accurately captured in the final coded data. Complete and specific documentation also promotes better patient care and disease management while appropriately reflecting the acuity, severity, and overall outcome of the patient.

In order to ensure that documentation in the health record contains these critical elements, a CDIS must apply a broad clinical and coding knowledge base to discern relevant clinical conditions. He or she must analyze the quality of provider documentation to understand where gaps and inconsistencies might exist between the clinical information in the health record and the information contained in associated data sets.

A hallmark of the CDIS is experience in complex clinical arenas such as intensive care or the emergency department, which require in-depth clinical knowledge, independent functioning, and high levels of personal responsibility. The focus of the CDIS can cover all patient ages, multiple clinical disciplines, and various settings of care beyond acute inpatient hospitalization; it may also include special attention to areas such as patient quality and safety measures.

Every CDIS, regardless of job description, is bound by a similar set of broad guidelines. These include:

- » Adhering to ethical and professional business practices, such as the ACDIS Code of Ethics, general medical ethics, and official coding guidelines (e.g., ICD and CPT®, among others). A CDIS should use appropriate professional papers to support his or her daily processes, including white papers published by ACDIS, AHIMA, and other professional organizations.
- » Following internal policies and procedures that are consistent with official coding rules and guidelines as well as regulatory reimbursement policies issued by CMS and other payers.
- » Valuing high quality standards as evidenced by reliability, consistency, accuracy, integrity, and validity in CDI practice and process.
- » Refusing to participate in illegal or unethical acts or to conceal the illegal or unethical acts of others.

- » Respecting the confidentiality of identifiable health information and protected health information.

Summary of role

The CDIS facilitates modifications to clinical documentation through concurrent (pre-bill) interaction with providers and other members of the healthcare team. He or she promotes capture of clinical severity (later translated into coded data) to support the level of service rendered to relevant patient populations. In addition, the CDIS will:

- » Clinically evaluate how the health record translates into coded data, including review of provider and other clinician documentation, lab results, diagnostic information, and treatment plans
- » Communicate with providers either through discussion or in writing (e.g., formal queries) regarding missing, unclear, or conflicting health record documentation, and clarify the information as warranted
- » Educate providers about identification of disease processes that reflect SOI, complexity, and acuity in order to facilitate accurate application of code sets
- » Communicate with appropriate healthcare team members to promote accurate and complete documentation of diagnoses and/or procedures in the health record that have direct bearing on SOI
- » Demonstrate an understanding of complications, comorbidities, SOI, ROM, case mix, and the impact of procedures on the billed record, as well as the ability to impart this knowledge to providers and other members of the healthcare team
- » Gather and analyze information pertinent to documentation findings and outcomes, and use this information to develop action plans for process improvements

Minimum qualifications

Education: The CDIS candidate should be credentialed as an RN with five years of acute care experience, or as a registered health information administrator or technician (RHIA/RHIT) with at least five years inpatient coding experience. He or she should also have advanced clinical expertise and extensive knowledge of complex disease processes with broad clinical experience in an inpatient setting.

Licensure/certification: The candidate should be currently licensed as an RN or possess active RHIA/RHIT. Certified coding specialist (CCS) or other relevant experience is desirable.

Knowledge/special skills

- » Clinical expertise with five years of inpatient experience
- » Ability to work independently, self-motivate, and adapt to the changing healthcare arena
- » Excellent verbal and written communication skills, analytical thinking, and problem solving with strong attention to detail
- » Proficiency in organizational skills and planning, with an ability to juggle multiple priorities in a fast-changing environment
- » Proficiency in computer use, including database and spreadsheet analysis, presentation programs, word processing, and Internet search
- » Knowledge of federal, state, and private payer regulations as well as applicable organizational policies and procedures
- » Working knowledge of quality improvement theory and practice, core measures, safety, and other required reporting programs
- » Ability and willingness to seek out changes in healthcare reform and coding regulations, then incorporate those changes into chart review and educational responsibilities

Role functions

- » Review inpatient medical records on a daily basis, concurrent with patient stay, to identify opportunities to clarify missing or incomplete documentation.
- » Collaborate with providers, case managers, coders, and other healthcare team members to facilitate comprehensive health record documentation that reflects clinical treatment, decisions, diagnoses, and interventions.
- » Utilize the hospital's designated clinical documentation system to conduct reviews of the health record and identify opportunities for clarification.
- » Conduct follow-up of posted queries to ensure that queries have been answered and physician responses have been appropriately documented.
- » Provide or coordinate education related to compliance, coding, and clinical documentation issues within the healthcare organization. This may include rounding with

the multidisciplinary healthcare team.

- » Act as a consultant to coding professionals when additional information or documentation is needed to assign coded data.
- » Collaborate with HIM/coding professionals to review individual problematic cases and ensure accuracy of final coded data in conjunction with CDI managers, coding managers, and/or physician advisors.
- » Gather and analyze information pertinent to documentation findings and outcomes.
- » Contribute to a positive working environment and perform other duties as assigned or directed to enhance the overall efforts of the organization.
- » Develop provider education strategies to promote complete and accurate clinical documentation and correct negative trends.
- » Identify patterns, trends, variances, and opportunities to improve documentation review processes.
- » Assist in the development and reporting of performance measures to the medical staff and other departments and prepare physician-specific data information.
- » Enhance expertise in query development, presentation, and

standards (including understanding of published query guidelines and practice expectations for compliance).

- » Conduct independent research to promote knowledge of clinical topics, coding guidelines, regulatory policies and trends, and healthcare economics.

Other

- » Aid in identification and proper classification of complication codes (patient safety indicators/hospital-acquired conditions) by acting as an intermediary between coding staff and medical staff
- » Participate on departmental and hospital committees and assigned task forces, including denials management
- » Advise and consult with the electronic health record development team to ensure the enabling of CDI efforts
- » Comply with HIPAA and code of conduct policies
- » Interact with appropriate resources that support growth and education of the CDI team
- » Promote and be involved locally, regionally, or nationally with professional development of the CDIS role
- » Participate in CDI-related continuing education activities to maintain certifications and licensures. 🌸

Ask ACDIS

Identify appropriate sequencing skills for query opportunities

Q: I am a relatively new CDI specialist in a relatively new CDI program. We learned that we should be examining the health record with an eye toward “what bought the bed.” When we raise this concept to our coders, however, they disagreed with the premise, telling us that such a concept was not in line with coding regulations. Can you explain how we may have misunderstood this concept or help us to understand where the difference in perception may lay?

A: Traditionally, coding teams needed to only focus on ensuring proper codes were assigned, following the *Official Guidelines for Coding and Reporting* for sequencing. They also made sequencing choices that would lead to the greatest reimbursement. As long as the “rules” were followed, they had no concerns. Coders know the definition of a principal diagnosis to be identified by the Uniform Hospital Discharge Data Set as “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

I often explain sequencing for a lesser-paying DRG based on what the patient was actually treated for, or what would have “bought the bed,” rather than assigning a code for a diagnosis that was documented and may be reimbursed at a higher level. The choice of principal diagnosis should be a thoughtful decision reflecting the condition that brought the patient to the facility’s door, the treatment provided, and the care required to stabilize the patient.

Consider conducting monthly coder-CDI team meetings to review difficult cases. During these meetings, request examples of medical necessity denials to reexamine as a team. The more discussion and exposure everyone involved in the revenue cycle has in regard to choice of principal diagnosis, the better the outcome on quality measures, potential denials, and payment incentives. 🌸

EDITOR’S NOTE

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