It's Time for Improvement
in Clinical Documentation Improvement

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Introduction

Healthcare reform driven by the Affordable Care Act (ACA) has placed hospitals and health systems under intensifying financial pressure. The result is that many healthcare organizations have one foot on the dock and one in the boat, as they grapple with both fee-for-service payment arrangements and risk-sharing agreements that offer bundled or global payments. In addition, they face growing regulations – such as MACRA/MIPS – that require increased transparency and documentation specificity in order to be reimbursed fairly, to avoid penalties and to glean any incentives that may be available for efficient, cost-effective care.

More than ever, healthcare provider organizations need support from the health IT industry to smoothly transition to value-based care from volume-based care. But hospitals and physician practices continue to rely on outdated Clinical Documentation Improvement (CDI) solutions that do little to improve the way care is documented, and instead merely focus on improving reimbursement.

This short-sighted strategy often ignores the reality of growing denials in the absence of sufficient documentation for these optimized claims. The result is a revolving door of endless queries to physicians as well as denials and appeals that delay justified payments. None of which does anything to improve the quality of documents to avoid denials in the first place The healthcare ecosystem doesn't just need another technology product or more high-dollar consulting. Instead, it needs to re-think what CDI means. Only then can real improvements be made to elevate the level of detail and specificity captured in clinical documentation, resulting naturally in more and faster revenue capture, fewer denials, lower administrative costs, reduced clinical and financial risk, and ultimately better patient care.

Origins of CDI

Clinical Documentation Improvement came into being in 1982, initially to help hospitals get the most out of prospective Medicare payments. There were automatic payments for the principal diagnosis, but attaching additional clinical codes meant hospitals would receive optimized, higher reimbursements. Revenue optimization companies sprung up to help healthcare organizations cash in on this opportunity, working on a contingency basis that enabled them to reap a percentage of those increased reimbursements. Hospitals were eager for the help, since it didn't cost them anything. The past three and a half decades have seen increased sophistication to CDI software solutions, but little change in techniques.

The typical CDI program today focuses on certain types of care episodes that are commonly underpaid in order to increase reimbursements for those claims. One such care episode is heart failure, since reimbursements can vary widely depending on the type and circumstances surrounding the condition. CDI programs have continued to focus on the same "low-hanging fruit" such as heart failure for years, instead of addressing why this condition is routinely under-coded and seeking to eliminate this problem once and for all.

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Image Source: http://www.publicdomainpictures.net/hledej.php?hleda=doctor

Shortcomings of CDI

The current approach to CDI focuses primarily querying physicians after the documentation has been submitted to find ways to increase revenue. For example, CDI professionals may look to increase the acuity of cases by adding more specific codes to patient records. But this process does not address the core issue. It is also a losing strategy, because in a fee-for-value healthcare landscape providers can no longer improve their net patient revenue by simply providing additional services.

Instead, the focus should be on working with the physicians to improve the documentation at the source. It's not that anyone is questioning their medical judgment. It's simply a matter of ensuring that the reasons behind that judgment have been documented properly to show conclusively that the right care was provided at the right time, in the right place, by the right practitioner using the right medical judgment. It must be clearly reflected in the patient's charts, including their history and physical documents.

The true mission for CDI programs should not be to inflate bills and case mix index to achieve higher reimbursements—a strategy ripe for denials—but instead to carefully match codes to strong evidence for eligibility and medical necessity that will proactively ward off denials. It's all about ensuring healthcare organizations are paid accurately and completely for the care they deliver. When that occurs, an increase in reimbursement is the natural result.

Here are four key shortcomings of current approaches:

1. Reactive

A typical hospital CDI program begins reviewing charts 48 hours after a patient visit. This is much too late to capture necessary detail from the visit that will corroborate a medical necessity finding for clinical codes. CDI professionals should review charts, including the history and physical forms, before they are signed by the physician. By identifying areas of insufficient documentation, CDI programs can head off one of the most common reasons for claim denials

2. Singular focus on codes

In the old world of fee-for-service payments, it may have made sense to simply identify additional codes to indicate additional services performed or greater patient acuity to increase reimbursements. However, in the new world of value-based payments, hospitals won't simply be paid more for doing more. They will receive optimum reimbursements only if they prove that each procedure is medically necessary, the patient is eligible for all these services, and the services have not already been paid for as part of a bundled payments arrangement. As payment arrangements become more complex, they require more qualitative explanation. But most CDI programs do not focus on improving the physicians' habits in terms of adding specificity to charts that will result in reimbursement for the appropriate codes.

3. No long-term ROI consideration

Most CDI programs are currently measuring ROI by how much they are billing –the gross patient revenue. But this doesn't reflect how much they are getting paid—the much more important net patient revenue that will determine whether a hospital achieves a positive margin. The problem is that most CDI programs rely on a "Query, Drop and Run" approach, where they ask a doctor to answer yes or no questions about specific cases to attach additional codes to increase the acuity of certain cases. These are typically "low-hanging fruit" types of cases that often involve a significant amount of complications that may not have been reported initially by the physician

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4. No process improvement

The reason that CDI programs continue to target a certain set of claims for reimbursement improvement is that they continue to be coded inaccurately again and again. Typical CDI programs do not address the root cause of under coding, which is physicians.

Capabilities for success

To move from a paradigm of Clinical Reimbursement Improvement, which typically grows gross patient revenue by increasing case mix index and claim billing – to Clinical Documentation Improvement, which maximizes appropriate claims billing and minimizes claim denials to increase NET patient revenue – healthcare organizations must emphasize the qualitative content of the charts, not simply the attached codes. This new emphasis on improving the specificity and accuracy of patient documents must move away from the "query, drop and run" mentality in favor of a continuous improvement posture which seeks to educate physicians on how to chart correctly in the first place, versus hounding them with endless query requests to fill in the blanks of a poorly written document.

Here are three key capabilities for a CDI program that can really improve hospitals' bottom lines and patient outcomes:

1. Data Analytics and Mining

Before a claim is sent to a payer, hospitals should have the capability to use natural language processing tools to scrub claims and identify any content that historically has been denied, or which conforms to a pattern of under-coding or over-coding. This real-time 24/7 review process is different from an audit because an audit is a sample. New analytics capabilities allow hospitals to comb through every claim, rather than conducting a random audit or focusing only on certain types of claims that historically yield significant missed upside to case mix index.

It's important for provider organizations to understand that CMS and other payers are increasingly focused on spotting fraud, waste and abuse. Hospitals should equip themselves with equally sophisticated analytics to make sure they are sending well-documented claims the first time to avoid denials that can take months or even years to resolve.

2. Proactive Denial Avoidance Tool

Hospitals should expend greater energy on "denials avoidance" rather than on appeals after the fact – especially in the face of statistics that show 90 percent of denials are avoidable. This thinking is in line with the way healthcare organizations have approached other issues, such as programs to avoid patients falling while they are in the hospital. By identifying which patients are most at risk for falling, hospitals can target resources towards the vulnerable patients who need them, rather than waiting for a fall to occur and treating a fracture, which is far more expensive for the healthcare system and damaging for the patient.

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New tools apply this same approach to claim denials. Hospitals can use these tools to predict denials based on the previous year of claims data (highlighting denials) at their hospital, or even compare their claims to those at hospitals around the country to identify claims at high risk for denials. Hospitals then have an opportunity to take a second look at these high-risk claims before sending them to payers.

Automating this pre-submission review process, and using it to identify problems, can help hospitals identify the root of the problem. For example, perhaps 70 percent of knee replacement denials can be traced back to a single physician, who may simply be unaware that she has not been providing enough specific information to prove medical necessity for the procedure.

These kinds of actionable insights are the first step in creating a continuous quality improvement environment in a CDI program. A natural consequence of this is that there will no longer be static CDI "hotspots," i.e., areas such as heart failure which are chronically under-coded and are popular targets for legacy CDI programs. Instead, the "hotspots" will be a moving target, as they are systematically investigated and resolved, resulting in better coding and better documentation to avoid denials and glean the maximum justified reimbursement for those claims.

3. Physician Training

Engagement with physicians is essential for moving toward true Clinical Documentation Improvement that produces clear, concise and consistent documentation which clearly indicates medical necessity. The next generation of CDI programs must rely on both software products and services to improve documentation at the source.

CDI vendors can offer services such as developing a scorecard at discharge to help ensure that charts are complete and specific enough to prevent denials before the patient leaves the hospital. Vendors can start by coming in and giving a snapshot of the hospital's strengths and weaknesses when it comes to clinical documentation. They can offer documentation scoring and flag coding anomalies that could trigger a denial. They can also work one-on one with physicians who may have a pattern of under-coding or providing scant evidence for medical necessity for certain procedures.

Righting the Ship

The focus on a new approach to CDI is to get the chart right the first time. It's not about physicians changing the way they practice medicine or increasing their administrative burden. It's about training them about the level of specificity in documentation that will provide sufficient evidence for medical necessity for each type of claim. This upfront engagement will reduce the number of queries physicians receive in the future requesting that they fill in the blanks. Physicians need to understand that this is essential for the hospital to get paid for all the care the doctor provides, and to protect patients against denials that could hit them, as well as the hospital, in the wallet.

A successful CDI program should not be measured on gross patient revenue – the dollar value of the claims it sends to payers – but on net patient revenue, the cash that is coming in to the organization. Successful CDI programs should see denial rates fall dramatically as documentation improves, and should also see query rates for the same condition diminish substantially as physicians learn to improve their documentation for these coding "hotspots".

The time to begin a CDI program overhaul is now. Hospitals can step off the hamster wheel of launching the same queries to the same doctors about the same procedures repeatedly. Instead, they can get a clear picture of their current CDI performance, identify their weaknesses, deploy tools to optimize reimbursements while avoiding denials, and resolve these weaknesses permanently.