

Coding: Clinical Documentation, Part II: Clinical Documentation Improvement Programs

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The SONPM Coding Committee recently presented a Coding Workshop and a Deep Dive into Coding at the 2024 Perinatal Practice Strategies meeting in Scottsdale, March 22-24, the latter of which included topics related to clinical documentation. The first article of this two-part series was dedicated to clinical documentation, emphasizing the importance of clinical documentation and reviewing common errors. This article will focus on clinical documentation improvement programs.

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As noted in Part I, inaccurate documentation can impact patient care, quality metrics, administrative databases, and perceived patient complexity. Improper or poor documentation can result in adverse patient outcomes, communication gaps, revenue loss, and incorrect case-mix indexes. Examples of the challenges clinicians face include choosing the correct ICD-10 diagnosis and/or Current Procedural Terminology (CPT®) codes and timely, accurate documentation. This may result from insufficient education, uncertainty related to the precise definition of the diagnosis, questions of the clinical significance of a diagnosis, and burdens related to the electronic medical record (EMR).

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Clinical documentation and proper coding can be improved! Traditional interventions may include didactic presentations, utilization of templates, and other learning aids. Emerging technology, such as artificial intelligence, speech recognition, and scribes, may im-

prove clinical documentation. Healthcare systems and/or physician practices can integrate multiple techniques, such as the ones noted above, as part of a Clinical Documentation Improvement (CDI) program.

The literature is replete with examples of CDI programs in adult medicine; however, pediatric CDI programs are emerging to enhance the case mix index and improve reimbursements. In many ways, a successful CDI program should mirror or incorporate similar quality improvement methodologies. The ultimate aim is to achieve accurate and thorough medical record documentation.

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In building a CDI program, the initial step is defining the complement and governance of the team. The team should include stakeholders with complementary skill sets. Members from clinical, administrative, health information management, quality, case management, utilization review, and revenue cycle departments should be considered. Specific roles can be defined for coders, clinical documentation specialists, physician advisors, and physician champions. Clinical documentation specialists serve as a conduit between the clinician and the coder and review the medical record to collect and validate ICD-10 codes, amongst other roles. A physician advisor provides documentation education for clinical colleagues and trainees and education for coders, ancillary staff, and administrative personnel. A physician champion who understands the goal and mission of the CDI program can encourage colleagues and provide a link between the healthcare provider and the CDI team. An administrative sponsor provides leadership and support and is critical in developing a successful CDI program.

Like any quality improvement project, the next step is to evaluate the current state once the team is assembled. The initial assessment is critical to assessing provider documentation's accuracy, specificity, and completeness. Reviewing a sample of records may highlight areas upon which to focus efforts; this should include a review of the documentation processes, ICD-10 codes, and CPT® codes, focusing on the completeness and accuracy

of the documentation and coding. The CDI team should provide background information for providers to demonstrate the magnitude of the problem prior to defining interventions.

In addition to reviewing a sample of records, developing a process flow diagram, related to EMR documentation, coding, charge capture, record review, and inquiries may be useful. This will help determine what the CDI program's workflow and processes might look like and what interventions may be necessary. Is the current workflow for documentation, coding, and charge capture efficient? When are medical records and charge assignments analyzed? What is the process for provider inquiries?

“This is followed by a design phase, where the team develops an equivalent of the “AIM” statement, defines the program scope and approach with clear metrics for measuring successful outcomes, and creates SMART goals. Measurable metrics might include key performance indicators, the case mix index, length of stay, complications or comorbidities, revenue, denials, and/or other benchmarks.”

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The cornerstone of any CDI program is education. Audit findings should be communicated to the individual provider. Education components should include didactic components, as well as simulation-based training. Demonstration of best practices in clinical documentation should be mandatory for new clinical staff. Due to the changing nature of coding and documentation, periodic updates should be provided to experienced providers. For example, new CPT® evaluation and management guidelines focus on medical decision-making (MDM) and time, creating a new standard for clinical documentation. While education is an essential program component, interventions may expand beyond educational activities to encompass technology such as natural language processing and computer-assisted coding.

Clearly defining goals and measuring specific progress indicators are required to obtain “buy-in.” A communications plan should be developed as an essential part of the CDI program to provide timely updates to providers and stakeholders. This plan should include sharing objectives, best practices, timelines, desired outcomes, ongoing reviews, and, perhaps most importantly, program benefits. Ensuring sustainable progress requires continuous monitoring of program compliance, coding changes, and new carrier guidance while communicating successes and establishing new goals.

A CDI program should be ongoing. The CDI's performance data will reveal improvements in documentation and coding and eliminate interventions with limited results. Eliminating waste is a foundation of quality improvement methodology and will positively impact the CDI program itself. Ultimately, a well-designed CDI program will succeed in ensuring proper documentation and coding.

References:

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