# AHIMA Clinical Documentation Integrity (CDI) Toolkit Beginners' Guide



Copyright ©2021 by the American Health Information Management Association (AHIMA). All rights reserved. Except as permitted under the Copyright Act of 1976, no part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, photocopying, recording, or otherwise, without the prior written permission of AHIMA, 233 N. Michigan Ave., 21st Fl., Chicago, IL, 60601

(https://www.ahima.org/education-events/academic-center/resource-pages/reprint-permissions/).

ISBN: 978-1-58426-866-6

**Production Staff:** 

Michael Bittner, Media and Communications Manager

Candy Ramos, Graphic Designer

Anne Zender, Senior Director of Communications

Limit of Liability/Disclaimer of Warranty: This toolkit is sold, as is, without warranty of any kind, either express or implied. While every precaution has been taken in the preparation of this toolkit, the publisher and author assume no responsibility for errors or omissions. Neither is any liability assumed for damages resulting from the use of the information or instructions contained herein. It is further stated that the publisher and author are not responsible for any damage or loss to your data or your equipment that results directly or indirectly from your use of this toolkit.

The websites listed in this toolkit were current and valid as of the date of publication. However, webpage addresses and the information on them may change at any time. The user is encouraged to perform his or her own general web searches to locate any site addresses listed here that are no longer valid.

CPT<sup>®</sup> is a registered trademark of the American Medical Association. All other copyrights and trademarks mentioned in this toolkit are the possession of their respective owners. AHIMA makes no claim of ownership by mentioning products that contain such marks.





## TABLE OF CONTENTS

Authors	4
Acknowledgements	4
Introduction	5
Working With CDI Technology	5
Working With Multi-Disciplinary Teams	6
Organizational And Provider Leadership	7
The Provider Role In CDI	7
Benefits Of The Provider Advisor Role	7
Selecting A Provider Advisor	8
Role Of The Provider Advisor	8
Interdepartmental Collaboration	9
Queries	10
Compliant Queries	11
Electronic Health Record Prompts	11
Query Management	12
Quality Measures	12
Audits And Denials	13
Notes	16
Appendix A: CDI Online Resources	17
Appendix B: AHIMA CDI Articles	19
Appendix C: CDI Glossary	21
Appendix D: Process Examples	27

#### **AUTHORS**

Sandra Bundenthal, RHIA, CCS Karen Carr, MS, BSN, RN, CDIP, CCDS Tammy Combs, RN, MSN, CDIP, CNE, CCS

#### **ACKNOWLEDGEMENTS**

Kathy Alberson, RHIA, CPHRM Roberta B. Baranda, MS, RHIA, CHP John Barrilleaux, MME, RHIA Sue Bowman, MJ, RHIA, CCS Patricia Buttner, MBA/HCM, RHIA, CDIP, CHDA, CPHI, CCS, CICA Gretchen Catlett, RHIA, CHPS, HCISPP Maggie Foley, PhD, RHIA, CCS Shannon Houser, PhD, MPH, RHIA, FAHIMA Alina Hughes, MHA, RHIA, CDIP, CCS Cheryl Ericson, MS, RN, CDIP, CCDS Carole Liebner, RHIT, CDIP, CCS Anny Pang Yuen, RHIA, CCS, CCDS, CDIP

Donna S. Lehner, RHIA, CDIP, CCS Sharon C. McGee, MS, RHIA Melissa Potts, RN, BSN, CCDS, CDIP Kelly Randell, BS-HIM-T, CCS Jaime Richling, RHIA Donna J. Rugg, RHIT, CDIP, CCS-P, CICA, CCS Laura Shue Robyn Stambaugh, RHIA





#### INTRODUCTION

Clinical documentation integrity (CDI) programs help facilitate the precise representation of a patient's clinical status. This is accomplished by reviewing health records to assure they meet high-quality clinical documentation standards that will translate into the appropriate coded data. AHIMA's 2018 <u>CDI Survey Report</u> indicated that of the 157 professionals who responded, 89.81 percent had a CDI program within their organization.<sup>1</sup> A variety of healthcare settings were represented in this survey; however, the largest percentage (78.98 percent) were hospitals. The information from this survey reflects the need for a CDI toolkit to guide new CDI professionals as they develop their CDI practice.

A CDI toolkit is beneficial to healthcare professionals including CDI professionals, providers, hospital administrators, health information (HI) professionals, nursing staff, and others in a variety of healthcare settings. Understanding the background, purpose, and functionality of a CDI department will be key to the success of a department and will contribute to the true reflection of a patient's severity of illness and risk of mortality, by ensuring the health record's data integrity.

Improving the integrity of clinical documentation has many benefits and positive results beyond reimbursement. Clinical documentation is central to every patient visit. As noted in the AHIMA Practice Brief "<u>Guidelines for Achieving a Compliant Query Practice (2019 Update)</u> (ahima.org)," for documentation to be meaningful, it must be clear, consistent, complete, precise, reliable, timely, and legible.<sup>2</sup> This is necessary to accurately reflect patient acuity and complexity, severity of illness, risk of mortality and scope of services and resources provided.

This toolkit will discuss many of the topics that new CDI professionals need to be aware of to develop a strong CDI practice. These topics include working with CDI technology, multidisciplinary teams, leadership, providers, quality measures, and compliance.

#### WORKING WITH CDI TECHNOLOGY

As the use of EHRs have become widespread, many functions, such as copy forward, cut and paste functionalities, use of templates, dot phrases, and SMARTLinks have been implemented to assist with provider documentation. Used properly, these various documentation functions can enhance documentation integrity. However, many CDI professionals have recognized that the improper use of these functions lead to diminished documentation integrity. The role of the CDI professional continuously evolves to ensure providers are communicating with each other and reporting accurate data for the organization's EHR central repository storage of data. All this effort is necessary when timeliness is essential for acute patient care.

Historically, CDI professionals wrote paper queries and placed them in the health record for the provider to review in the inpatient setting. Many CDI professionals processed their reviews manually and required multiple follow-ups to ensure the provider's response was captured. With the implementation of the EHR, all patient information is now readily available for a documentation review. In many cases, this results in streamlining the CDI review process and increases productivity.

The emerging developments of EHRs also allows CDI programs to re-invent how providers receive electronic queries/clarifications. This may include in real-time queries based on clinical evidence in the health record by utilizing text messaging platforms, which can significantly decrease the turnaround time for the clarifications to be answered. This advancement in technology has also opened the door for more outpatient CDI initiatives to be implemented.



Outpatient CDI involves a higher volume of encounters that are seen within a shorter timeframe. Having an electronic process to review health records and send queries provides a process to support this fast-paced environment. To learn about outpatient CDI initiatives and leading practices, see the <u>Outpatient CDI Toolkit</u>.

CDI professionals may leverage a multitude of technology choices based on their job functions and areas of expertise. For example, an inpatient CDI professional may use an encoder or a computer-assisted coding (CAC) tool during their review process. With proper training and implementation, CAC tools can be leveraged to help improve record review prioritization, documentation, code assignment, data extraction, and ultimately patient care. It can also assist in identification of diagnoses requiring further clarification. With the advent of CAC and other natural language understanding (NLU)/ natural language processing (NLP) applications, EHR documents can be scanned for key phrases that may warrant a CDI review. CDI professionals typically review unstructured notes in the health record that are recorded by clinicians treating the patient. Therefore, with the consideration of other pertinent clinical data available in the health record, the goal of a CDI professional is to clarify the documentation in real-time with the attending provider prior to discharge. This will help facilitate more accurate coding for data analyses and better reimbursement outcomes.

In recent years, new technologies have emerged where the use of NLU/NLP is "flagging" potential query opportunities based on current and/or previous documentation. With that in mind, it's important for CDI professionals to look for evidence required to support the reporting of such diagnoses as defined in the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, specific to the inpatient and/or outpatient setting. Many of these tools still require a subject matter expert to decipher whether the items identified by the NLU/NLP are accurate. Since NLU/NLP is driven by existing documentation, there is a potential for erroneous diagnoses driven by templates, questionnaires, misspellings, and abbreviations. These errors can create a lot of "noise" if documentation opportunities are pushed to the providers for confirmation without CDI review. This can result in inappropriate reporting of a condition and could result in a denied claim.

When it is determined a query is warranted upon the completion of a CDI review, CDI professionals may leverage the EHR to create a compliant provider query. These queries may be generated using templates within the EHR. These templated queries, along with specific dot phrases and SMARTLinks used by CDI professionals, should be assessed on an ongoing basis to ensure compliance. It is best practice, as outlined in Guidelines for Achieving a Compliant Query Practice (2019 Update), to customize every query to include specific clinical indicators, documentation and/or treatment that is specific to the patient, and to avoid generically templated queries.<sup>3</sup>

## WORKING WITH MULTI-DISCIPLINARY TEAMS

To achieve documentation excellence in the ever-changing landscape of healthcare, CDI teams will benefit most from a multi-disciplinary team approach. A multidisciplinary team may consist of clinical, coding, and billing backgrounds. This will help ensure that both inpatient and outpatient CDI can be assessed from a multitude of experiences, especially with methodologies and documentation requirements and guidelines for each setting.

In staffing a CDI team, it is important to understand the scope of the department (inpatient versus outpatient). This will help narrow and identify what skillsets are needed and/or missing within the department. Furthermore, with quality in the forefront of many CDI initiatives, there is a need for collaboration outside of CDI to include HIM/coders, providers, and other departments like quality and case management to achieve maximum results. Another important collaborative relationship is between CDI and public/population health management professionals. The health record documentation can support public/population health initiatives.



## ORGANIZATIONAL AND PROVIDER LEADERSHIP

The key to success for many CDI departments has been gaining full support from organizational leadership and medical directors. Without their support, regardless of what the multi-disciplinary CDI team is promoting, initiatives towards documentation integrity may not gain the traction or succeed due to the lack of buy-in. Many providers are not aware of the ramifications of poor documentation, especially now in the age of technology where copying documentation and "note bloat" have increased.

Often, many providers challenge CDI efforts due to their lack of understanding of core CDI principles. These can include DRG assignment, coding, the role of CDI in ensuring the most accurate reflection of patient acuity, and the correlation to provider reported data. Therefore, organizational policies and accountability expectations may help CDI teams achieve documentation excellence by minimizing resistance. Many departments within an organization often work in silos and since documentation touches so many areas from patient care, data/quality reporting, provider reimbursement systems, and billing compliance; it is vital and beneficial for the leaders and medical directors within an organization to deliver a uniform and united message related to the importance of documentation integrity.

## THE PROVIDER ROLE IN CDI

Accurate reporting of classification codes, MS-DRGs, and APR-DRGs requires precise analysis of the health record and application of coding guidelines. A provider who understands the complexities of coding, prospective payment, and third-party audits can be an asset to bridge the gap in communication between CDI professionals, HIM professionals, and medical staff. As more providers become involved in the role of "provider advisor," these guidelines are presented for prospective candidates and as a general tool for development of existing provider advisors. For purposes of this toolkit, the term "advisor" encompasses other terms, such as champion, liaison, or similar terminology.

## BENEFITS OF THE PROVIDER ADVISOR ROLE

Provider leadership is essential to successful documentation integrity efforts. The provider advisor should have sufficient clinical and leadership experience consistent with the needs of the organization. Incorporating the role of provider advisor in the CDI department can benefit the organization by:

- Providing in-service education regarding medical conditions, to support documentation integrity
- Serving as a liaison between clinical excellence and revenue cycle and quality reporting functions throughout the organization to encourage provider cooperation for complete and supportive documentation reflecting the patient's condition
- Providing education to the medical staff regarding payment methodologies, documentation requirements for medical necessity, and provider profiling
- Assisting the hospital in reviewing and appealing denied claims



## SELECTING A PROVIDER ADVISOR

Ideally, a provider advisor should be someone who communicates well and has the clinical respect of their peers. The needs and situations for each healthcare facility will vary. In healthcare systems where there are multiple hospitals, a single provider might serve as the CDI provider advisor to more than one organization. Sometimes, a provider who already works in a contractual capacity (such as a utilization review provider advisor) might also assume the responsibility of CDI provider advisor. An organization may consider appointing more than one provider to this process. The hospital should develop a contractual agreement with the provider to define responsibilities and compensation.

Desired attributes for a provider advisor include:

- Able to devote a minimum of 6 to 10 hours per week to review charts, consult with coding professionals, and meet with the CDI professional and providers regarding specific health records
- Willing to serve on revenue integrity and quality improvement meetings/committees
- Willing to conduct in-house education and training medical departments related to proper documentation practices, prospective payment systems (PPS), and review processes
- Optimally, possessing leadership skills and respected in the medical community

## ROLE OF THE PROVIDER ADVISOR

In general, the provider advisor will act as a liaison between CDI and coding professionals, quality professionals, and providers. They facilitate complete and accurate documentation to support the diagnoses, treatment, medical necessity, and severity of illness. They may provide education to providers and intradisciplinary teams to substantiate accurate code assignment, quality reporting, and correct reimbursement. Sample education topics include:

- · Correlating between clinical language and coding guidelines
- · Reflecting the accuracy of the patient's severity of illness
- · Capturing service/treatment/utilization for the organizations
- · Translating classification codes to individual provider profiles
- · Ensuring that documentation supports code assignments
- · Interpreting coded data in quality measures and reporting
- Payment methodologies
- Work in collaboration with HIM coding and CDI professionals to:
  - Review medical record documentation on a concurrent and retrospective basis
  - Discuss clinical documentation opportunities identified in the record review activities, such as lack of specificity of congestive heart failure
  - Discuss clinical criteria for disease processes, such as sepsis or respiratory failure
  - Assist in the development of appropriate and compliant provider queries
  - Review hospital-acquired conditions and/or treatment complications
  - Review diagnosis specificity needed to capture accurate risk adjusted scores



## INTERDEPARTMENTAL COLLABORATION

Multiple departments play an important role in documentation integrity. A strong working relationship with medical staff and other departments promotes documentation integrity and the coordination of care for the patient. Strong professional relationships within the organization are vital to the success of CDI initiatives. Some examples of effective relationships are:

- > Health Information (HI)/Coding: A uniform message related to documentation requirements (example: acuity/chronicity and specificity) for accurate coding and reporting can be achieved across an organization through the collaboration of HIM/coding and CDI departments. HIM/coding professionals can share coding trends and current documentation practices that are impacting coding/reporting with the CDI team. The CDI team can then leverage this information and create tailored provider education throughout the organization. HIM/coding can also educate CDI professionals on annual coding changes and new AHA Coding Clinic<sup>®</sup> newsletters that may impact code assignments.
- > Quality: A variety of reimbursement methodologies are impacted by quality initiatives e.g., hospital acquired conditions and patient safety indicators. The information used to report these quality measures is abstracted from the patient's health record and is driven by documentation. The collaboration between the quality department and CDI can ensure the accurate reporting of these quality measures. The CDI team can review patient health records for complete documentation and query the provider when there are opportunities for improvement. There may also be opportunities for the collaboration between quality and CDI to identify areas of documentation deficiencies related to specific quality measures that impact health outcomes.
- > Compliance: The compliance department can share billing and compliance findings from both internal and external audits related to unspecified documentation and/or lack of documentation with the CDI team. Similar to the collaboration with HIM/coding, CDI can further provide tailored provider education relating to documentation integrity.
- > Case Management: CDI and case management collaboration can help promote effective communication related to patient care and outcomes (Example: improved provider documentation may help justify the length of stay and/or reporting of the patient's true severity of illness and accurate discharge disposition).
- > Information Technology (IT): CDI professionals can help shed light on current documentation gaps and needs. Therefore, having CDI professionals at the table during any technology implementation can help benefit an organization. Often technology is implemented without end users' feedback and/or subject matter experts who are familiar with clinical language and documentation requirements. For example, CDI professionals can provide insight on current documentation practices and identify areas where providers may benefit from technology enhanced processes, such as having IT add a flag to the coder of the use of specific treatment (medication that qualifies for add-on payment) on the case. This will help reduce the amount of post-implementation provider grievances.
- > Revenue Integrity: The revenue integrity team can share denial trends related to lack of and/or insufficient documentation. Similar to the collaboration with HI/coding and compliance, CDI can also leverage these trends and create a focused education for the providers. Denials management requires a team effort, therefore the collaboration between CDI and revenue integrity can only benefit an organization.
- > Patient Access/Central Scheduling: CDI can provide education on the importance of capturing the admitting diagnosis for each encounter. There have been an increase in telehealth encounters and the potential role of CDI in telehealth encounters.



#### **QUERIES**

Improving documentation accuracy through data analytics has significant clinical, compliance and financial impacts. The healthcare industry is beginning to measure quality across the full patient stay, from beginning to end, measuring processes and all services involved in the patient's care. It is important that a multi-disciplinary team be involved in this end-to-end process. This team must be educated on the most recent version of the following AHIMA Practice Briefs:

- <u>Guidelines for Achieving a Compliant Query Practice (2019 Update) (ahima.org)</u>
- <u>Guidelines for Achieving a Compliant Query Practice FAQs (ahima.org)</u>
- Guidelines for Achieving a Compliant ICD-10-PCS Query (2019 Update) (ahima.org)
- Clinical Validation: The Next Level of CDI (January 2019 Update) (ahima.org)
- Recruitment, Selection, and Orientation for CDI Professionals (ahima.org)
- <u>Best Practices in the Art and Science of Clinical Documentation Improvement (2018</u> <u>Update) (ahima.org)</u>
- Guidelines for Physician Office Query Practice (ahima.org)
- Impact of Physician Engagement on Clinical Documentation Improvement Programs
  (AHIMA Practice Brief)

A variety of tools should support the documentation integrity process of a CDI department. Organizations may customize these tools to meet their particular needs. For the purposes of this toolkit, the term "query" will be used to identify the provider communication tool used concurrently or retrospectively to obtain documentation clarification. Other terms synonymous with "query" include clarification, clinical clarification, documentation alert, nudge, push, and documentation clarification.

The query process is a key component in ensuring complete and accurate documentation. It is appropriate to generate a query when the documentation is incomplete, conflicting, unspecified, or ambiguous within the health record. The organization should define how queries will be developed and maintained in its CDI program (such as concurrently, retrospectively, prospectively, or a combination).

To meet the increased demands to produce accurate and timely coded data, many organizations choose to use query forms as a type of formal communication to ensure data integrity. In some organizations, these queries become a permanent component of the health record, that is, discoverable and often requested as part of an internal and/or external audit review. Responses to queries should be within the permanent health record, such as a progress note or discharge summary if the query is not part of the permanent health record, to support code assignment.

To support the request for documentation, CDI professionals should provide clinical indicators and/or medical evidence that prompted the request for clarification. Organizations may choose to use standardized templates specific to certain diagnoses (such as heart failure) whereby the CDI professional checks the indicators, their location within the health record, and supporting data. If templates are used, the titles of the queries should be compliant and not lead the provider to a particular response.



## **COMPLIANT QUERIES**

All queries presented to the provider should follow guidelines set forth in "<u>Guidelines for Achieving</u> <u>a Compliant Query Practice (2019 Update</u>)" and should be written in a compliant manner. Format examples are especially useful to new CDI departments and staff as templates, which can standardize the query process.

The EHR system can impact the format of the query form. The query format is generally electronic and/or paper. The paper query is a manual process that may use a template to seek documentation clarification or diagnosis specificity from the provider. Historically, paper queries were used throughout the CDI industry. Paper queries may still be used during the startup of a CDI department, in organizations with paper or hybrid EHRs, and/or during downtime of EHRs as a backup process.

Similar to a paper query, an electronic query is a process in which the provider can provide documentation clarification by creating an electronic document that is linked to the patient's EHR. These can be made available as a permanent part of the health record. Electronic queries allow the provider to answer the query remotely or onsite in the organization, providing greater flexibility in their process workflow.

Depending on system functionality, the organization may choose to utilize a different software platform to document the provider query. Some EHR systems may utilize features and functions that can be utilized to store and maintain queries for a department's determined period of time, per the organization's policy. It is important for HIM and CDI professionals to understand the system functionality and where the queries will be stored and retrieved in the case of an audit.

The electronic query should be easy for the provider to locate and complete, regardless of the system used. No two organizations are alike, and no two healthcare facilities will use the same systems the same way. This is due to the various ways organizations structure their processes and systems. It is important for HIM and CDI to be a part of system development and discussion so that the appropriate location and compliant components for queries are identified and used prior to implementation. This collaboration will help ensure compliance with practice briefs on the phrasing of the query and the circumstances in which it would be generated to ensure compliant non-leading queries.

## ELECTRONIC HEALTH RECORD PROMPTS

Many organizations are further developing the EHR to include data prompts when a provider documents a specific diagnosis to obtain additional specificity. For example, an organization may design a cardiac note that prompts the provider, once CHF is documented, to provide additional specificity, such as acuity or type in real-time when supported by the clinical evidence. An organization may also design a prospective system review of the previous encounter before the patient is seen by the provider to identify potential acute and/or chronic conditions. This would allow the system to prompt the provider to address those conditions that require additional specificity for accurate assignment and reporting for the current encounter.

It is important for HIM and CDI professionals to assist with the development of policies and procedures regarding when prompts would be generated, responded to, updated (current code sets and documentation standards), and maintained to ensure compliance.

To learn more regarding guidance for such prompts please review the following publications:

- AHIMA 2021 Practice Brief <u>Prospective Clinical Documentation Integrity (CDI) Review and Query/</u> <u>Alert Practice Best Standards</u>
- Journal of AHIMA article How Do You Distinguish Clinical Documentation?



## QUERY MANAGEMENT

Organizations are free to determine the amount of information, or clinical indicators, needed to support the request for clarification to the health record. Organizations should seek the advice of legal counsel pertaining to the retention of queries. Regardless of how the query is created (electronically or on paper), the organization must determine where to place the query within the health record and if the query will be a part of the legal health record or designated record set.

Increases in third-party audits continue to cause concerns with query compliance. When fulfilling audit requests, organizations should always submit all documents believed to have supported the claim, which may include the entire legal health record, such as late entries and addendums. Organizations must determine the best approach when submitting queries as a part of a third-party audit and include a review of applicable local, state, and federal payment guidelines when considering submission.

To support the consistency of clinical documentation and accuracy of reporting, organizations can request the provider to document answers in the progress notes or as an addendum to the discharge summary. It is important to have a robust CDI department capturing documentation concurrently rather than retrospectively. It is recommended that organizations follow internal policies and procedures for retrospective documentation clarification.

## **QUALITY MEASURES**

Quality healthcare is a high priority for the healthcare industry, specifically for the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). Quality measures have been implemented to improve the quality and transparency of healthcare in the US. The agency uses quality measures through a variety of departments, such as value-based purchasing and public reporting that ensures accountability, public disclosures, and secondary data use.

Quality measures are used to track and quantify the quality of healthcare processes, outcomes, patient satisfaction, and organizational structures. All of the quantifiable measures are associated with the organization and provider's ability to offer high-quality, cost-efficient care and relate to one or more goals. CMS strategic goals include measures for effective, safe, efficient, patient-centered, and timely patient care. Data collection and reporting of quality measures occur a variety of ways, such as claims submission, assessment instruments, manual chart abstraction, and registries. Many data collection agencies focus on the submission of quality measures electronically.

It is critical that the clinical documentation accurately reflect the patient's severity of illness and quality of care. Incomplete or inaccurate documentation can impact various healthcare initiatives including patient care, reimbursement, and quality outcomes. Organizations must ensure that data submitted for quality measures is accurate and complete.





CDI can play a critical role as clinical documentation forms the basis for public reporting of quality of care. When reviewing publicly sourced quality reporting, it is important to understand the data source, types of measures, and performance period utilized for the scoring. Examples of public reporting includes CMS Hospital Compare, Leapfrog Safety Grade, Healthgrades, IBM Watson, US News and World Report, Rand Healthcare, etc.

Public reporting can be impacted by several variables, such as:

- Completing a survey
- Patient claims data
- Non-claims data
- Patient reporting
- Risk adjustment methodology
- Volume of diagnoses

Coding professionals translate provider documentation into coding classifications such as ICD-10-CM, Current Procedural Terminology (CPT®) for outpatient services, and ICD-10-PCS for inpatient procedures. This data is then used for a variety of purposes. Healthcare continues to move forward with initiatives such as quality-driven reimbursement and clinical quality measure reporting. Organizations and providers are required to reflect, in their documentation, the medical necessity for the care provided and the patient's severity of illness.

#### AUDITS AND DENIALS

CMS, the largest single payer of healthcare claims in the United States, and commercial payers (e.g., private insurance) have audit processes to monitor the integrity of the claims they receive. These audits can result in a full or partial payment denial related to a particular claim. Sometimes, these audit findings can be extrapolated across all similar claims, resulting in huge financial losses for a healthcare entity. Although each payer will have their own polices for the audit methodology, which may or may not be fully transparent, many follow the same general processes as Medicare.

According to CMS, "the Medicare Fee-for-Service Compliance programs prevent, reduce, and measure improper payments in FFS [Fee-for-Service] Medicare through medical review."<sup>4</sup> Components of the Medicare Compliance program include:

- Medical Review and Education
- Recovery Auditing
- Prior Authorization and Pre-Claim Review
- Outreach and Education
- Improving Provider Experience

Claim reviews can occur on either a prepayment or post-payment basis. A prepayment review is one that occurs prior to payment and these result in an initial determination.<sup>5</sup> A post payment review occurs after payment and can uphold the initial determination or result in a "revised determination, indicating an underpayment or overpayment."<sup>6</sup>



The compliance areas most relevant to understand are medical review and education, as well as recovery audits. Under the umbrella of medical review and education, CMS has a Targeted Probe and Education (TPE) program to help reduce claims denials by preventing future claims denials. The Medicare Administrative Contractors (MACs) (see table below) are the main contractors for targeted probe and education activities. These types of reviews focus on a specific provider for a particular service and those being audited "have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers."<sup>7</sup>

A recent example of this type of probe activity included a review of claims with the diagnosis of malnutrition. According to CMS, "TPE typically involves the review of 20-40 claims per provider/ supplier, per item or service. This is considered a round, and the provider/supplier has a total of up to three rounds of review. After each round, providers/suppliers are offered individualized education based on the results of their reviews. Providers/suppliers are also offered individualized education during a round when errors that can be easily resolved are identified."<sup>8</sup> Although rare, if an audited healthcare entity does not improve after three rounds of education sessions, the organization will be referred to CMS for next steps, which could include 100 percent prepay review, extrapolation, or referral to a Recovery Auditor.<sup>9</sup> These types of audits are not a surprise to the healthcare entity. The MAC will notify those included in the TPE process and communicate through each round of the audit process.

Contrast these efforts to recovery audits performed by the recovery audit contractors, who review claims on a post-payment basis to "detect and correct past improper payments."<sup>10</sup> In addition to data mining, CMS often receives referrals of potential improper payments from the MACs, unified program integrity contractors, and Federal investigative agencies such as the Office of Inspector General or Department of Justice. A list of approved RAC topics is located on CMS.gov (<u>https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics</u>).

MACs and recovery auditors are not the only type of Medicare claims contractors. The Medicare Learning Network has published this table of Medicare contractors and their responsibilities, most of whom perform what are referred to as complex claims reviews (claims that require a licensed professional who reviews additional documentation associated with the claim):<sup>11</sup>

Contractor	Responsibility
Medicare Administrative Contractors (MACs)	Process claims from physicians, hospitals, and other healthcare professionals and submit payment to those providers according to Medicare rules and regulations (includes identifying and correcting underpayments and overpayments)
Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)	Perform investigations that are unique and tailored to specific circumstances and occur only in situations where there is potential fraud and take appropriate corrective actions
Supplemental Medical Review Contractor (SMRC)	Conduct nationwide medical review as directed by CMS (includes identifying underpayments and overpayments)
Comprehensive Error Rate Testing (CERT) Contractors	Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment rate
Medicare FFS Recovery Auditors	Review claims to identify potential underpayments and overpayments in Medicare FFS as part of the recovery audit program



Because a complex medical review examines both the documentation and associated claims data (e.g. ICD-10-CM/PCS codes), CDI and HIM professionals should be an integral part of the audit and denials process within a healthcare organization. Knowledge of what types of services are being denied can help guide provider education as well as help CDI professionals better understand when a query is necessary to clinically validate a diagnosis or what criteria should be used to support a query requiring the addition of a diagnosis.

It is important for an organization to have checks and balances in place to ensure the highest level of integrity as CDI departments mature. External audits will scrutinize health records closely for documentation. When developing a CDI department, a strong quality assurance (QA) process can aid in achieving a successful and compliant department.

Currently, there are no industry standards regarding how often these reviews should be completed or what volume of cases should be reviewed. The frequency and volume of QA review may be greater for a new CDI staff member or when initiating a CDI department.

Ongoing internal monitoring is recommended to determine the skill level of CDI staff, appropriateness of queries placed, and educational opportunities. Organizations may also choose to have a more formal external audit to validate internal findings. Each organization's departmental policy should identify the qualifications required of the auditor, the frequency, and the volume of audits. The audit results can then be utilized to deliver provider and CDI education to promote documentation integrity.



#### **NOTES**

- 1. AHIMA. "2018 CDI Industry Survey Report." https://bok.ahima.org/doc?oid=302713
- 2. AHIMA. "Guidelines for Achieving a Compliant Query Practice (2019 Update)." <u>https://bok.ahima.org/doc?oid=302674</u>
- 3. Ibid.
- 4. CMS.gov. "Medicare Fee-for-Service Compliance Programs." <u>https://www.cms.gov/</u> <u>Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-</u> <u>Programs/Overview</u>
- 5. CMS Medicare Learning Network. "Medicare Claim Review Programs, ICN 006973." September 2016. <u>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MCRP-Booklet-Text-Only.pdf</u>
- 6. Ibid.
- 7. CMS.gov. "Targeted Probe and Educate (TPE) Q&A's." <u>https://www.cms.gov/files/document/updated-tpe-gas.pdf</u>
- 8. Ibid.
- 9. Ibid.
- 10. CMS.gov. "Medicare Fee-for-Service Compliance Programs."
- 11. CMS Medicare Learning Network. "Medicare Claim Review Programs, ICN 006973."



## APPENDIX A: CDI ONLINE RESOURCES

#### Organizations

AHIMA: www.ahima.org

(AAPC): www.aapc.com

American Hospital Association (AHA) Coding Clinic: <u>www.ahacentraloffice.org</u>

Association of Clinical Documentation Improvement Specialists (ACDIS): www.acdis.org

Centers for Disease Control (CDC): <u>http://www.cdc.gov</u>

Centers for Medicare and Medicaid Services: www.cms.gov

Medicare Quarterly Provider Compliance Newsletter Archive: https://www.cms.gov/Outreach-and-Education/Medi- care-Learning-Network-MLN/ MLNProducts/down- loads/MedQtrlyCompNL\_Archive.pdf

Joint Commission: https://www.jointcommission.org/measurement/

MAC/FI (Medical Administrative Contractor (MAC)/Fiscal Intermediary (FI): https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors

OPPS: <u>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/</u> HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1589-P

IPPS: https://www.cms.gov/search/cms?keys=ipps

Recovery Audit Department: <u>https://www.cms.gov/research-statistics-data-and-systems/</u> monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program

Hospital Acquired Conditions: <u>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-</u> Payment/HospitalAcqCond/Hospital-Acquired\_Conditions.html

Conditions for Coverage and Conditions of Participation: <u>http://www.cms.gov/Regulations-and-Guidance/Legisla-tion/CFCsAndCoPs/index.html</u>

Policy Manuals: <u>https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-</u> Only-Manuals-IOMs



## **Provider Compliance**

MLN Matters Articles: <u>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/MLN-Matters-Articles-List</u>

Risk Adjustment Model: <u>https://www.cms.gov/Medicare/Health-Plans/</u> MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Official ICD-10-CM/PCS information: https://www.cms.gov/Medicare/Coding/ICD10/

ICD-11 Information: https://icd.who.int/en

## Reports

Medicare Compare Find Healthcare Providers: <u>https://www.medicare.gov/care-</u> <u>compare/#search</u>

The Department for Evaluation Payment Patterns Electronic Report: <a href="http://www.pepperresources.org/">http://www.pepperresources.org/</a>

## **Report Cards**

Healthgrades: <u>http://www.healthgrades.com/</u> Joint Commission: <u>https://www.jointcommission.org/measurement/pioneers-in-quality/</u>

Leapfrog Group: <a href="http://www.leapfroggroup.org/">http://www.leapfroggroup.org/</a>



#### **APPENDIX B: AHIMA CDI ARTICLES**

AHIMA Practice Brief. "Best Practices in the Art and Science of Clinical Documentation Improvement (2018 Update)." January 2019." <u>http://bok.ahima.org/doc?oid=302653</u>

AHIMA Practice Brief. "Clinical Validation: The Next Step of CDI (January 2019 Update). AHIMA Practice Brief. (February 2019)." <u>http://bok.ahima.org/doc?oid=302678#</u>

AHIMA Practice Brief. "Measuring the Value of the Clinical Documentation Improvement Practitioner (CDIP) Credential (2018 Update)." <u>http://bok.ahima.org/doc?oid=302618#</u>

Bailey-Woods, Linda. "Natural Language Processing: A Promising ICD-10 Transition Solution." AHIMA CodeWrite newsletter, July 2015. <u>http://bok.ahima.org/doc?oid=301113#</u>

Butler, Mary. "'CDI: Miami' Hunts Down Documentation Offenders." *Journal of AHIMA*, Oct. 23, 2015. <u>http://bok.ahima.org/doc?oid=301474#</u>

Butler, Mary. "Querying Through the Chaos: How to Get Docs' Attention Amidst the Digital Healthcare Haze." *Journal of AHIMA* (July 2016). <u>http://bok.ahima.org/doc?oid=301740#</u>

Chtourou, Helen. "CDI Departments Used to Improve Quality Reporting Accuracy." *Journal of AHIMA* (July 2013). <u>http://bok.ahima.org/doc?oid=106665#</u>

Combs, Tammy. "Documentation Detective: Seven Steps to CDI Foundational Success." *Journal of AHIMA* (January 27, 2016). <u>http://bok.ahima.org/doc?oid=301638#</u>

Combs, Tammy. "How Do CDI Departments Impact the Patient." *Journal of AHIMA* (July 27, 2016). <u>http://bok.ahima.org/doc?oid=301975#</u>

Combs, Tammy. "How to Help Providers Accept CDI Programs." *Journal of AHIMA* (September 28, 2016). <u>http://bok.ahima.org/doc?oid=301989#</u>

Combs, Tammy, and Endicott, Melanie. "Impact of Provider Engagement on Clinical Documentation Improvement Departments (AHIMA Practice Brief)." *Journal of AHIMA* (July 2017). <u>http://bok.ahima.org/doc?oid=302187#</u>

Combs, Tammy. "Measuring CDI Productivity. "Journal of AHIMA (March 23, 2016). <u>http://bok.ahima.org/doc?oid=301649#</u>

Combs, Tammy. "Recognizing the Characteristics of Quality Documentation." *Journal of AHIMA* (May 2016). <u>http://bok.ahima.org/doc?oid=301440#</u>

"Guidelines for Achieving a Compliant Query Practice." *Journal of AHIMA* (February 2019). <u>http://bok.ahima.org/doc?oid=302674#</u>

Geissler, Kristen, and Joni Dion. "Reinvigorating Your CDI Department." *Journal of AHIMA* 86, no.7 (July 2015): 24–27. <u>http://bok.ahima.org/doc?oid=107691</u>

Gurrieri, Joseph J., Cassie Milligan, and Paul Strafer. "Closing the Loop on Quality and CDI: Refocusing Departments to Ensure an Accurate Picture of Clinical Care." *Journal of AHIMA* 86, no.7 (July 2015): 28–31. <u>http://bok.ahima.org/doc?oid=107692</u>

Murphy, Brian. "New CDI Challenge: Adjusting to Quality, Not Quantity." *Journal of AHIMA* 86, no.7 (July 2015): 44–45. <u>http://bok.ahima.org/ doc?oid=107696#</u>



Towers, Adele L. "Clinical Documentation Improvement—A Provider Perspective: Insider Tips for getting Provider Participation in CDI Departments." *Journal of AHIMA* 84, no.7 (July 2013): 34–41. <u>http://bok.ahima.org/doc?oid=106669</u>

Watson, Monica M. "Documentation and Coding Practices for Risk Adjustment and Hierarchical Conditions Categories." AHIMA Practice Brief (June 2018). <u>http://bok.ahima.org/doc?oid=302516#</u>

Wieczorek, Michelle M., and Jill S. Clark. "Curing Inherited EHR Ailments: EHR Remediation Fixes System Issues and Better Aligns Clinical Workflow with Clinical Documentation." *Journal* of AHIMA (September 2014). <u>http://bok.ahima.org/doc?oid=107445#</u>

Wiedemann, Lou Ann. "Clinical Documentation Improvement's Main Ingredient: 'Physicians First.'" *Journal of AHIMA* 86, no.7 (July 2015): 40–41. <u>http://bok.ahima.org/doc?oid=107690</u>

Wiedemann, Lou Ann. "Strategizing Clinical Documentation Improvement: Tracking the Right CDI Measures, Data Can Impact Multiple Healthcare Areas." *Journal of AHIMA* (July 2013). <u>http://bok.ahima.org/doc?oid=106664#</u>

Wiedemann, Lou Ann. "Using CDI to Meet Federal Quality Measures." *Journal of AHIMA* 84, no.1 (January 2013): 44–45. <u>http://bok.ahima.org/ doc?oid=105918</u>



## APPENDIX C: CDI GLOSSARY

#### Α

Acute care prospective payment system: The Medicare reimbursement methodology system referred to as the inpatient prospective payment system (IPPS). Hospital providers subject to the IPPS use the Medicare Severity Diagnosis Related Groups (MS-DRGs) classification system, which determines payment rates

**Addendum:** A late entry added to a health record to provide additional information in conjunction with a previous entry. The late entry should be timely and bear the current date and reason for the additional information being added to the health record

**Admitting diagnosis:** A provisional description of the reason why a patient requires care in an inpatient hospital setting

All patient refined diagnosis-related groups (APR-DRGs): An expansion of the inpatient classification system that includes four distinct subclasses (minor, moderate, major, and extreme) based on the severity of the patient's illness

Amendment: Alteration of health information by modification, correction, addition, or deletion

**Autocoding:** The process of extracting and translating dictated and then transcribed free-text data (or dictated and then computer-generated discrete data) to automatically apply ICD-10-CM, ICD-10-PCS and CPT codes for diagnoses and services; See also Computer Assisted Coding

#### В

**Benchmark:** The systematic comparison of the products, services, and outcomes of one organization with those of a similar organization; or the systematic comparison of one organization's outcomes with regional or national standards

**Business record:** A record that is made and kept in the usual course of business, at or near the time of the event recorded

## С

**Case management:** 1. The ongoing, concurrent review performed by clinical professionals to ensure the necessity and effectiveness of the clinical services being provided to a patient 2. A process that integrates and coordinates patient care over time and across multiple sites and providers, especially in complex and high-cost cases, with goals of continuity of care, cost-effectiveness, quality, and appropriate utilization 3. The process of developing a specific care plan for a patient that serves as a communication tool to improve quality of care and reduce cost

**Case-mix index (CMI):** The average relative weight of all cases treated at a given organization or by a given provider, which reflects the resource intensity or clinical severity of a specific group in relation to the other groups in the classification system; calculated by dividing the sum of the weights of diagnosis-related groups for patients discharged during a given period by the total number of patients discharged



CDI: See clinical documentation integrity

**Centers for Medicare and Medicaid Services (CMS):** The division of the Department of Health and Human Services that is responsible for developing healthcare policy in the United States and for administering the Medicare program and the federal portion of the Medicaid program and maintaining the procedure portion of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM); called the Health Care Financing Administration (HCFA) prior to 2001

**Clinical documentation:** Any manual or electronic notation (or recording) made by a provider or other healthcare clinician related to a patient's medical condition or treatment

**Clinical Documentation Integrity (CDI):** The process an organization undertakes that will improve clinical specificity and documentation that will allow coders to assign more concise disease classification codes

CMS: See Centers for Medicare and Medicaid Services

**Compliance: 1.** The process of establishing an organizational culture that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal, state, or private payer healthcare department requirements or the healthcare organization's ethical and business policies **2.** The act of adhering to official requirements **3.** Managing a coding or billing department according to the laws, regulations, and guidelines that govern it

**Computer-assisted coding (CAC):** The process of extracting and translating dictated and then transcribed free-text data (or dictated and then computer-generated discrete data) to automatically apply ICD-10-CM, ICD-10-PCS and CPT codes for diagnoses and services; See also autocoding

**Core measure/core measure set:** Standardized performance measures developed to improve the safety and quality of healthcare (for example, core measures are used in the Joint Commission's ORYX initiative)

**Current Procedural Terminology (CPT®):** This is a numeric coding classification system that represents services delivered by medical providers. These services include medical, surgical, and diagnostic services

## D

**Dashboards:** Reports of process measures to help leaders follow progress to assist with strategic planning; Also called scorecards

**Diagnosis-related groups (DRGs):** A unit of case-mix classification adopted by the federal government and some other payers as a prospective payment mechanism for hospital inpatients in which diseases are placed into groups because related diseases and treatments tend to consume similar amounts of healthcare resources and incur similar amounts of cost; in the Medicare and Medicaid programs, one of more than 500 diagnostic classifications in which cases demonstrate similar resource consumption and length-of-stay patterns. Under the prospective payment system (PPS), hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual



## Ε

**Electronic health record (EHR):** An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization

**Encoder:** Specialty software used to facilitate the assignment of diagnostic and procedural codes according to the rules of the coding system

#### Н

**Health information management (HIM) professional:** An individual who has received professional training at the associate or baccalaureate degree level in the management of health data and information flow throughout healthcare delivery systems; formerly known as medical record technician or medical record administrator

**Health record:** 1. Information relating to the physical or mental health or condition of an individual, as made by or on behalf of a health professional in connection with the care ascribed that individual 2. A medical record, health record, or medical chart that is a systematic documentation of a patient's medical history and care

**Home health prospective payment system (HHPPS):** The reimbursement system developed by the Centers for Medicare and Medicaid Services to cover home health services provided to Medicare beneficiaries

**Hospital-acquired conditions (HAC):** Certain conditions recognized by CMS that occur during a hospital admission that have a high cost and/or volume, have an assignment of a DRG with a higher payment when present as a secondary diagnosis, and could have been reasonably prevented by applying evidence-based guidelines.

**Hospital Outpatient Prospective Payment System (OPPS):** The reimbursement system created by the Balanced Budget Act of 1997 for hospital outpatient services rendered to Medicare beneficiaries; maintained by the Centers for Medicare and Medicaid Services (CMS)

## I

International Classification of Diseases, Tenth Revision, Clinical Modification Procedural Classification

System (ICD-10-CM/PCS): A coding and classification system used in the United States to report diagnoses in all healthcare settings and inpatient procedures and services as well as morbidity and mortality information

#### L

Legal health record (LHR): Documents and data elements that a healthcare provider may include in response to legally permissible requests for patient information

#### Μ

**MCC/CC:** acronym to describe major complication/co-morbid and complication/co-morbid conditions in reimbursement methodology

**Major Diagnostic Categories (MDCs):** Under the diagnostic-related groups (DRGs), 25 mutually exclusive categories grouped by similar diagnostic-related conditions that affect a specific organ system or systems of the body and in general are associated with a particular medical specialty



**Medicaid:** An entitlement program that oversees medical assistance for individuals and families with low incomes and limited resources; jointly funded between state and federal governments and legislated by the Social Security Act

**Medicaid Integrity Contract (MIC):** CMS contracts with eligible entities to review and audit Medicaid claims to identify overpayments and provide education on department integrity issues

**Medical necessity:** 1. The likelihood that a proposed healthcare service will have a reasonable beneficial effect on the patient's physical condition and quality of life at a specific point in his or her illness or lifetime 2. Healthcare services and supplies that are proven or acknowledged to be effective in the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms and to be consistent with the community's accepted standard of care. Under medical necessity, only those services, procedures, and patient care warranted by the patient's condition are provided 3. The concept that procedures are only eligible for reimbursement as a covered benefit when they are performed for a specific diagnosis or specified frequency; Also called need-to-know principle

**Medical scribe:** An individual who enters information into the medical record at the direction of a provider

**Medicare:** A federally funded health program established in 1965 to assist with the medical care costs of Americans 65 years of age and older as well as other individuals entitled to Social Security benefits owing to their disabilities

**Medicare Advantage (Medicare Part C):** Optional managed care plan for Medicare beneficiaries who are entitled to Part A, enrolled in Part B, and live in an area with a plan; types include health maintenance organization, point-of-service plan, preferred provider organization, and provider-sponsored organization

**Medicare Provider Analysis and Review (MEDPAR) database system:** A database containing information and files submitted by fiscal intermediaries that is used by the Office of the Inspector General to identify suspicious billing and charge practices

**Medicare severity diagnosis-related groups (MS-DRGs):** The US government's 2007 revision of the DRG system, the MS-DRG system better accounts for severity of illness and resource consumption

MEDPAR database system: See Medicare Provider Analysis and Review database system

Metric: A performance indicator used to track and trend performance

#### Ν

**Need-to-know principle:** The release-of-information principle based on the minimum necessary standard

#### 0

**Office of the Inspector General (OIG):** Mandated by Public Law 95-452 (as amended) to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions performed by OIG components



#### Ρ

**Pay for performance (P4P):** 1. A type of incentive to improve clinical performance using the electronic health record that could result in additional reimbursement or eligibility for grants or other subsidies to support further HIT efforts **2.** The Integrated Healthcare Association initiative in California based on the concept that provider groups would be paid for documented performance

**Performance improvement (PI):** The continuous study and adaptation of a healthcare organization's functions and processes to increase the likelihood of achieving desired outcomes

**Performance measure:** A quantitative tool used to assess the clinical, financial, and utilization aspects of a healthcare provider's outcomes or processes

**Provider champion:** An individual who assists in communicating and educating medical staff in areas such as documentation procedures for accurate billing and appropriate EHR processes

Present on admission (POA): A condition present at the time of inpatient admission

**Principal diagnosis:** The disease or condition that was present on admission, was the principal reason for admission, and received treatment or evaluation during the hospital stay or visit or the reason established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

**Prospective payment system (PPS):** A type of reimbursement system that is based on preset payment levels rather than actual charges billed after the service has been provided; specifically, one of several Medicare reimbursement systems based on predetermined payment rates or periods and linked to the anticipated intensity of services delivered as well as the beneficiary's condition; See acute care prospective payment system; home health prospective payment system; hospital outpatient prospective payment system; skilled nursing facility prospective payment system

#### Q

**Quality assurance (QA):** A set of activities designed to measure the quality of a service, product, or process with remedial action, as needed, to maintain a desired standard

**Query:** The process by which questions are posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record

**Quality improvement organization (QIO):** An organization that performs medical peer review of Medicare and Medicaid claims, including review of the validity of hospital diagnosis and procedure coding information; completeness, adequacy, and quality of care; and appropriateness of prospective payments for outlier cases and non-emergent use of the emergency room. Until 2002, called peer review organization

**Quality management:** Evaluation of the quality of healthcare services and delivery using standards and guidelines developed by various entities, including the government and independent accreditation organizations

Quality measures: See performance measure



## R

RAC: See recovery audit contractor

**Recovery audit contractor (RAC):** A governmental program whose goal is to identify improper payments made on claims of healthcare services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments

Reimbursement: Compensation or repayment for healthcare services

**Relative weight (RW):** Assigned weight that reflects the relative resource consumption associated with a payment classification or group; higher payments are associated with higher relative weights

**Retention:** 1. Mechanisms for storing records, providing for timely retrieval, and establishing the length of times that various types of records will be retained by the healthcare organization 2. The ability to keep valuable employees from seeking employment elsewhere

**Revenue cycle: 1.** The process of how patient financial and health information moves into, through, and out of the healthcare organization, culminating with the organization receiving reimbursement for services provided **2.** The regularly repeating set of events that produce revenue

**Risk of mortality (ROM):** A medical classification to estimate the likelihood of an in-hospital death for a patient. The ROM classes are minor, moderate, major, and extreme.

## S

**Scorecards:** Reports of outcomes measures to help leaders know what they have accomplished; also called dashboards

**Secondary Data:** Information that has been collected from a primary source and is available for researchers to utilize in their own studies

**Secondary diagnosis:** A statement of those conditions coexisting during a hospital episode that affect the treatment received or the length of stay

**Severity of illness (SI or SOI):** A classification that asks what the extent of physiologic decompensation or organ system loss of function of a patient in the hospital. The SOI classes are minor, moderate, major, and extreme

**Skilled nursing facility prospective payment system (SNF PPS):** A per diem reimbursement system implemented in July 1998 for costs (routine, ancillary, and capital) associated with covered skilled nursing facility services furnished to Medicare Part A beneficiaries

**SMARTLinks:** Software that allows users to access data through system interfaces, which is unique from a hyperlink. For example, Dot phrases may be used in the provider note to auto populate specific clinical information from another module within the EHR

**Strategic plan:** The document in which the leadership of a healthcare organization identifies the organization's overall mission, vision, and goals to help set the long-term direction of the organization as a business entity

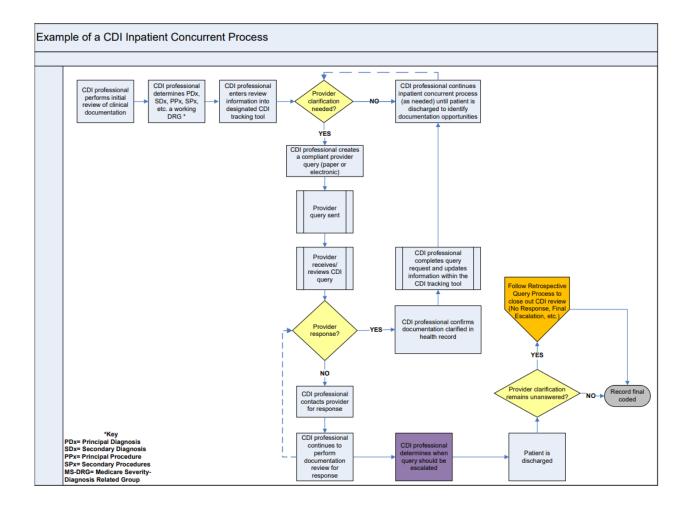
## Ζ

**Zone program integrity contractor (ZPIC):** A CMS program that replaces the Medicare Program Safeguard Contractors (PSCs). ZPICs are responsible for detection and prevention of fraud, waste, and abuse across all Medicare claim types by performing medical reviews, data analysis, and auditing



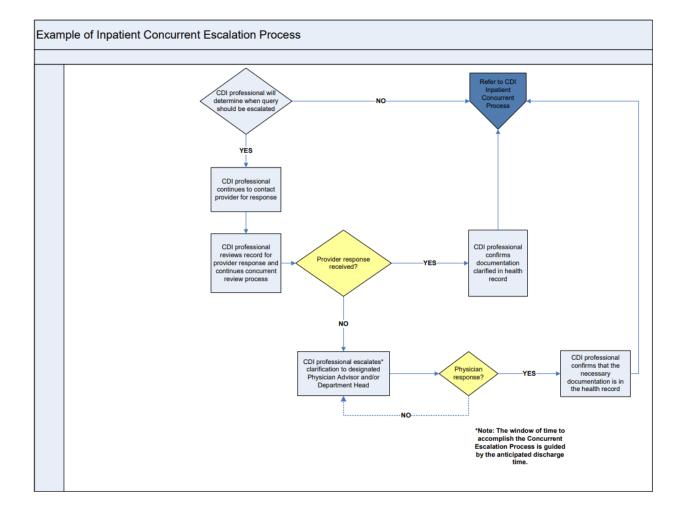
## APPENDIX D: PROCESS EXAMPLES

(Developed by the authors of this toolkit)





# **CDI Toolkit Beginners' Guide**









©2021 AHIMA. All rights reserved. Reproduction and distribution of the AHIMA Clinical Documentation Integrity (CDI) Toolkit Beginners' Guide without written permission of AHIMA is prohibited.