DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Clinical Documentation Improvement (CDI) - Implementation Requirements
PAGE: 1 of 3	**REPLACES POLICY DATED:** 7/1/08, 10/1/10, 5/1/11, 9/1/13, 1/1/18
EFFECTIVE DATE: February 1, 2020	**REFERENCE NUMBER:** REGS.DOC.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated facility/Health Information Management Service Center (HSC) personnel responsible for performing, supervising, or monitoring clinical documentation improvement efforts, including particularly the following:

CDI Director/Manager/Specialists
Corporate Regulatory Compliance Support
Case Management/Quality Resource Management
Physician Advisors
Nursing
Facility/HSC Health Information Management Administration
Ethics and Compliance Officer
Parallon Business Performance Group HIM
External Certified CDI Vendors

PURPOSE: This policy addresses the required processes that should be followed for implementing, and/or maintaining a Clinical Documentation Improvement (CDI) Program that appropriately identifies the diagnoses, conditions and/or procedures that are representative of the patient's severity of illness, risk of mortality, and resource consumption during an inpatient hospitalization.

POLICY:
Company-affiliated facilities/HSCs will follow appropriate processes to:
1. Utilize external vendors that have been certified for CDI purposes, as applicable;
2. Establish processes for qualifications, training, and the approach of the program;
3. Clarify conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent documentation within the medical record to improve the accuracy, integrity and quality of patient data on diagnoses, conditions and/or procedures;
4. Minimize variation in the process;
5. Mitigate potential compliance risk; and
6. Improve the quality of the physician documentation within the body of the medical record.

PROCEDURE: When a facility undertakes clinical documentation improvement efforts to clarify conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent documentation as it relates to diagnoses, conditions and/or procedures within the medical record, it must follow these procedures:

1. If an external vendor is used to assist in the development, implementation or maintenance of a CDI program, the vendor must be approved prior to engagement by Regs and Corporate CDI.

2. Clinical Documentation Improvement must establish and document processes that address the qualifications, training, and the approach to the CDI program. At a minimum, the written approach to the documentation improvement program must include the following parameters:
    a. Purpose: The process must specify that the purpose of the CDI program is to improve the quality of the physician documentation within the body of the medical record in order to accurately and completely represent the diagnoses, conditions and/or procedures, which will ultimately support the appropriate severity of illness, risk of mortality and the intensity of inpatient services provided,
    b. Scope: The scope must specify the patient mix and service lines that will be included

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within the CDI program. Examples of other items the scope may include are MSDRGs, percent of charges, symptoms with high length of stays, inpatient conditions typically treated on an outpatient basis, or any other hospital specific quality measure.

c. Frequency: The frequency must specify the parameters for how often the record will be reviewed. It must include impact to frequency with extended lengths of stay through discharge.
d. Volume: The volume may be impacted by staffing and patient population fluctuations and your procedures/process should outline how the fluctuations will be addressed.

3. Documentation Query Process
   The personnel responsible for performing and supervising the CDI program must understand and adhere to the requirements outlined within REGS.DOC.002.

4. Education and Tracking
   a. All facilities should educate their physicians on the importance of concurrent documentation within the body of the medical record.
   b. Communication should be provided to the medical staff that individuals responsible for documentation improvement efforts will initiate requests to support accurate and complete documentation in the medical record.
   c. Facility leadership must support this process to ensure its success.

5. Facility Compliance Monitoring
   Routine and periodic reviews should be completed by internal facility-directed staff to confirm adherence with this policy. The logistics of these reviews such as frequency, volume, etc. are a facility decision that should be based on each individual CDI program in order to ensure compliance.

6. Company-Wide Compliance Monitoring
   a. Compliance with this policy will be monitored by the Corporate Regulatory Compliance Support Department, Parallon Business Performance Group, and/or Internal Audit.
   b. It is the responsibility of each facility's administration to ensure that this policy is applied by all individuals involved in the documentation improvement efforts for inpatient records.
   c. Employees who have questions about a decision based on this policy or wish to discuss an observed activity related to the application of this policy should discuss these situations with their immediate supervisor in an effort to resolve the situation.
   d. All day-to-day operational issues should be handled locally at the facility; however, if confidential advice is needed or an employee wishes to report an activity that conflicts with this policy and is not comfortable speaking with the supervisor, the employee may call the Ethics Line at 1-800-455-1996.

For questions regarding this policy, please contact the Regs Helpline at http://trinysis.app.medcity.net/regshelpline.

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2. *Guidelines for Achieving a Compliant Query Practice,* American Health Information Management Association (AHIMA), Chicago, Illinois, February, 2019
3. *Practice Brief on Continuous Clinical Documentation Improvement,* American Health Information Management Association (AHIMA), Chicago, Illinois, May, 2010
4. Query Documentation for Clinical Documentation Improvement (CDI) & Coding - Compliance Requirements, REGS.DOC.002