Clinical Documentation Integrity (CDI) is an essential function for hospitals during routine operations. The purpose of CDI is to review physician documentation for hospitalized patients to ensure pertinent medical diagnoses and surgical procedures are documented completely and accurately in the medical record.

The impact of COVID-19 has been and continues to be brutal on the financial health of every health system. Service-mix shift from high-margin elective surgeries to costly chronic care management requires even more focus on comprehensive documentation that is inclusive of all chronic conditions to ensure health systems receive the appropriate level of compliant reimbursement. Because accurate billing is critical, CDI team members must support physicians through the query process, as provider focus has shifted to COVID-19. Continuing to query for comprehensive documentation in the medical record is vital and will ensure complete and accurate accounting of the patient’s disease processes and complexity of care.

Immediately post-COVID-19, the CDI team must prioritize cases where accurate documentation is necessary. As hospitals restart essential services, they will need to capture all due and proper reimbursement through timely coding and billing. The CDI team often prioritizes its daily assignments by payer (i.e., reviewing all Medicare charts before other payers, etc.). During the time of hospital services ramp up, CDI staff should alter their process to review patient records based on diagnosis-related group (DRG) assignment. Prioritizing surgical procedure cases for review over patients with medical conditions may be appropriate, in addition to prioritizing those cases with a sign-and-symptom admitting diagnosis rather than a confirmed medical diagnosis.

At the time of discharge, the inpatient coder assigns ICD-10 codes for diagnoses and procedures documented in the medical record. Timely billing is another critical hospital function; when the medical record is complete and accurate upon discharge, coding of the record is a routine task. If there is vague, incomplete, or conflicting documentation in the record at discharge, coding and billing could be delayed until physician documentation is complete.

The purpose of CDI is to work with physicians while the patient is hospitalized to confirm physician documentation is specific, accurate, and complete. This work eliminates the need for retrospective queries or those questions asked of physicians after the patient has been discharged and is no longer under acute care.

Clinical Documentation Integrity is essential to accurate hospital reimbursement. Prioritizing the work assignments for the CDI team will help to ensure accurate and complete documentation, which will ensure appropriate DRG assignment as the hospital restarts routine operations.

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