



Dear Provider...
A Provider Engagement Story



Speaker



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Learning Objectives:

Integrating CDI into Provider Onboarding:

Participants will learn how the integration of Clinical Documentation Improvement (CDI), with a focus on CDI initiatives brought into the onboarding process can enhance provider engagement and contribute to the success of CDI programs.

Facilitating Clinically Meaningful Conversations:

Discover how Clinical Documentation Specialists (CDSs) can engage providers through meaningful interactions, translating complex coding rules and regulatory guidelines into actionable insights, with a spotlight on CDI efforts.

Addressing Common Documentation Errors:

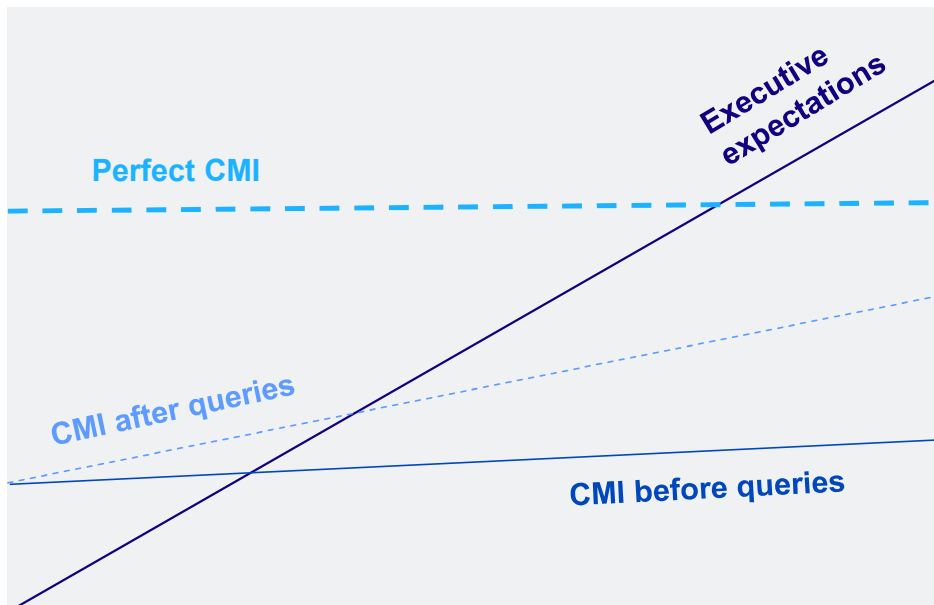
Attendees will gain insights into frequent documentation pitfalls, and explore strategies to overcome these challenges, ensuring precise and effective clinical documentation.

CDI landscape today



CDI programs often succumb to systemic industry headwinds

Consulting firms often *pitch* \$50M+/year in annual CDI revenue opportunities without signing up to deliver ROI



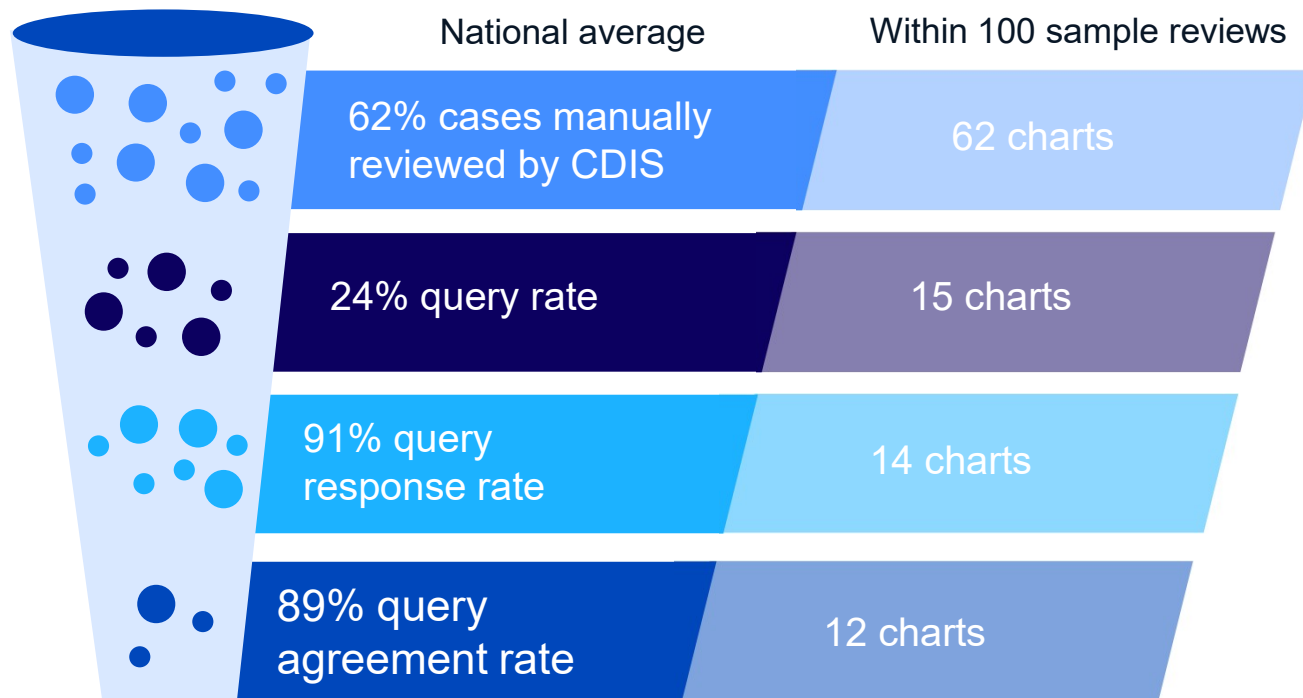
Source: The Natural History of CDI Programs: A Metric-Based Model. National Library of Medicine

Signs of a challenged CDI program

- ⊗ Program ceases to exist
Cost saving measures, staff deficiencies, poor initial implementation
- ⊗ Significantly misses performance targets
Unrealistic or undefined goals, metrics are not rigorously and transparently reviewed
- ⊗ Cannot withstand audit scrutiny
RA, MAC, MIC, CERT reviews
- ⊗ Lacks medical staff engagement
Lack of administrative support, ineffective communication of CDI program mission

Source: Finding a definition for failed CDI programs. ACDIS

Over 80% of traditional CDI efforts do not result in additional documentation opportunity, average



Many CDI programs face similar challenges

Top 4 reasons CDI programs at many health systems are incomplete and leave money on the table:

Lack adequate staffing

70% of CDI programs are currently understaffed

Source: ACDIS

Poor physician experience

Frustrations related to EMR documentation is the single biggest **driver of physician burnout**

Source: AHIMA

Lack capable technology resources

80% of organizations fail to adopt more advanced CDI technology

Source: RAC Monitor

Misaligned priorities between CDI and physician leaders

CDI KPIs often emphasize financial metrics, which are misaligned with clinical priorities

Source: RAC Monitor



„My industry has probably been transformed again just since we started this session.“

Focusing on the Provider

- Effective *clinical* documentation is vital for a successful Clinical Documentation Improvement (CDI) program to support reporting of clinical outcomes & patient data.
 - Not just for the hospital....the patient and provider are impacted
- The importance of provider education in CDI success through early engagement during onboarding to the organization is a critical success factor.
- Providers need to be provided clarity regarding the "why" behind queries and the importance of timely responses.

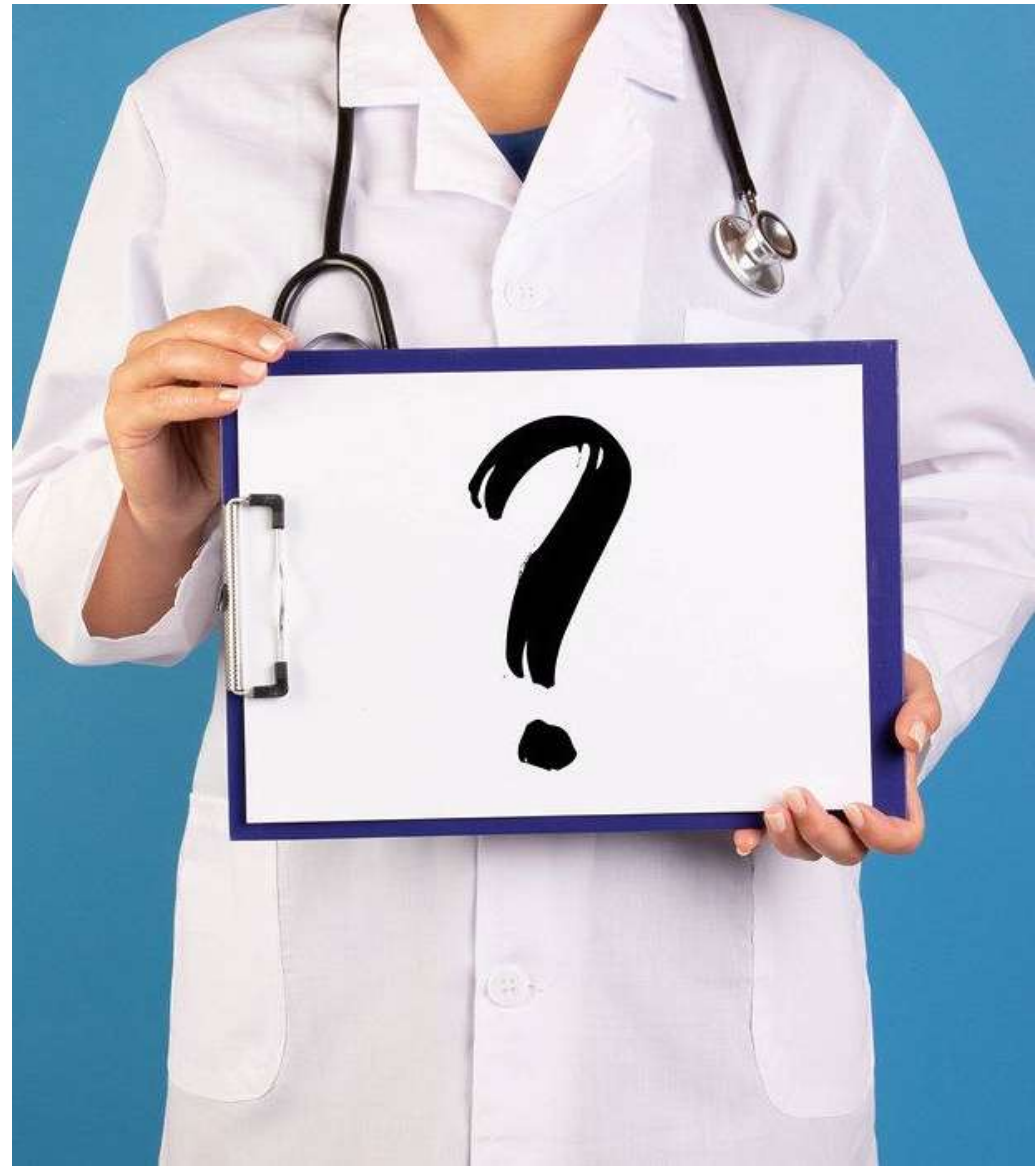


HOW DO YOU DO THAT?

Dear Provider,

Provider education is paramount to CDI program success and starts day #1:

- Ensure CDI is engaged in onboarding of new providers/ groups/residents
- Share the “why” for CDI queries
- Explain the need for timely responses to queries
- Provide the response workflow to the providers
- Offer contact information for any questions/concerns
- Leave them understanding, “What’s in it for me and my patient?”



Clinical Documentation Integrity: *What Is Our WHY?*

Reflecting an accurate Patient Story

By accurately capturing the patient's clinical story concurrently, we:

CODING PERSPECTIVE

- Provide accurate documentation to support ability to finalize coding of encounters without delay in timely billing.

FINANCIAL PERSPECTIVE

- Provide support of appropriate reimbursement for the excellent care that has been delivered through improved documentation with:
 - accuracy
 - integrity
 - compliance in our practices.



PROVIDER PERSPECTIVE

- Reflect the delivery of excellent care & services by Caregivers & Providers to treat our patients' conditions
- Ease the burden on Providers regarding the need for retrospective documentation clarification with concurrent processes/practices

PATIENT SAFETY/MORTALITY PERSPECTIVE

- Ensure accuracy in reporting of PSIs/HACs, O:E, and other data to support trending in public health and ensure your organization's reputation as a trusted source of healthcare delivery for your communities.

Dear Provider.....Clinically Meaningful Conversations



The importance of documentation is not taught in medical school....they learn to save lives and deliver safe/effective care to patients.

As a CDS, we:

- Serve as the **clinical navigator/translator** regarding coding rules & regulatory guidelines
- Engage with the provider in conversations that are **clinical meaningful**
- Must explain how our role is to help support the provider & ensure accurate reflection of the great care that they are delivering
 - Leave the Provider understanding, **“What’s In It For Me and My Patients?”**

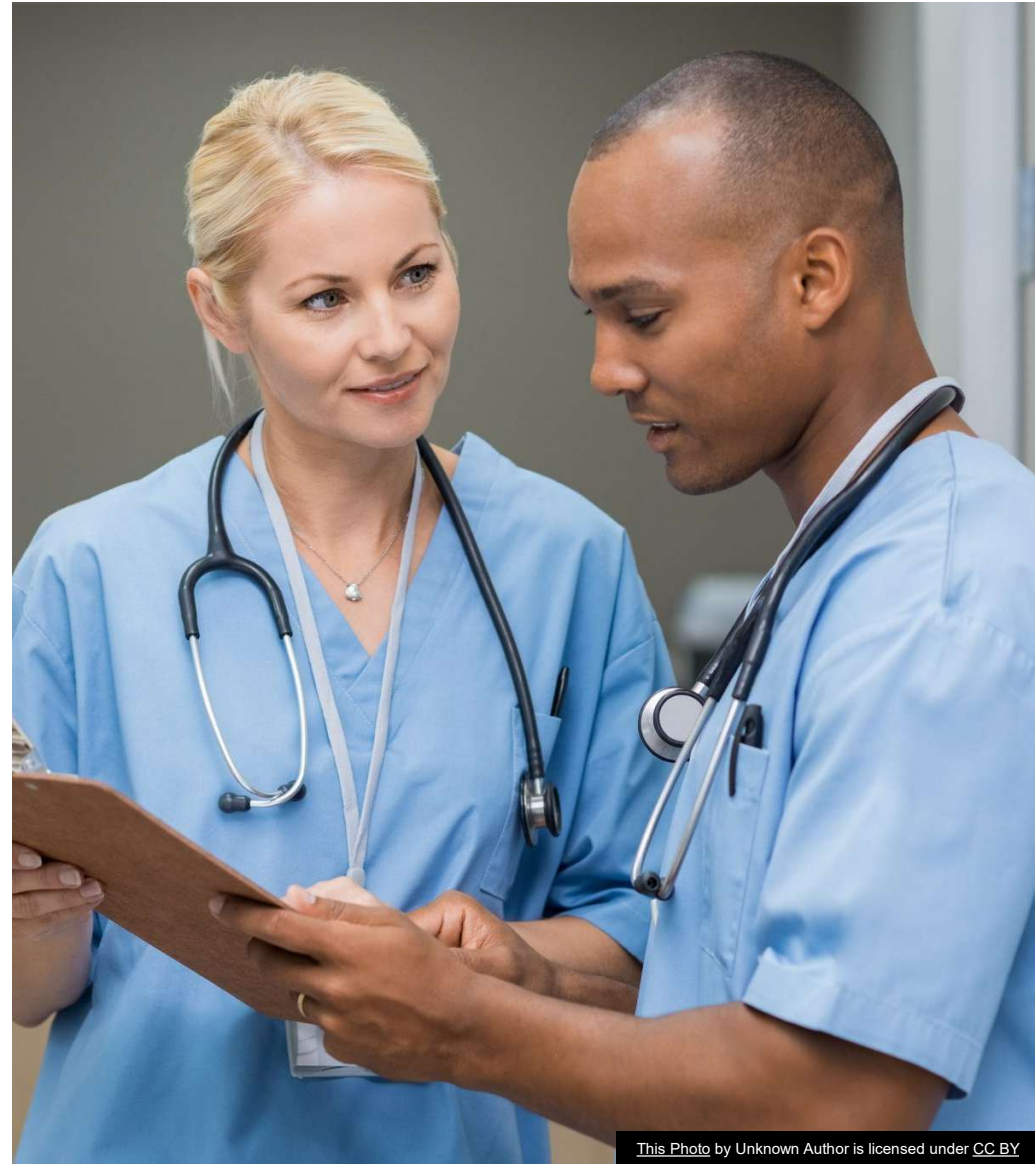


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"Skip all that medical mumbo jumbo
and just give it to me straight, Doc.
What's the ICD-10 code for this?"

Dear Provider....Let Us, Help YOU

- **Direct education to common documentation mistakes:**
 - Dropped documentation
 - Linking diagnoses/treatments/conditions
 - Possible/Probable/Likely in IP vs. OP documentation



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Implementing to Success



Identify a CDI Provider Advocate to champion the work that is done

Serve as a champion of the concurrent nature of the work vs. retrospective—concurrent is less disruptive of provider workflow and patient care



Engagement of Facility Leadership for support of physician engagement success

Engage leaders in a support process for physician response

Setting expectations regarding timeliness of responses through med exec committees and physician bylaws

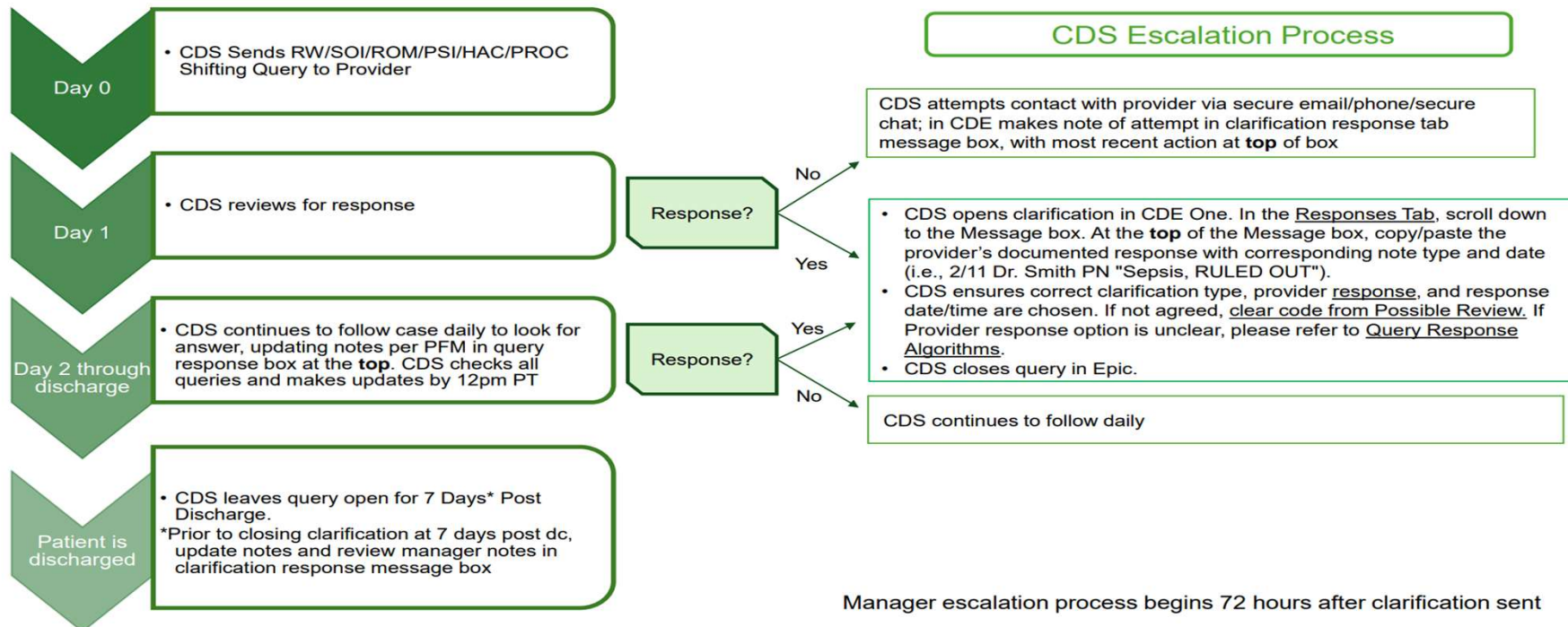
Communicate with leadership regarding issues/concerns regarding physician response, education needs, and compliance concerns



Collaborate with coding and case management/UM leadership

There may be another engagement issue for this provider that would be better addressed globally vs. CDI focused

Develop a Clearly Defined Process....and Communicate It



Last Updated: 02/24/2025
Last Reviewed: 02/24/2025

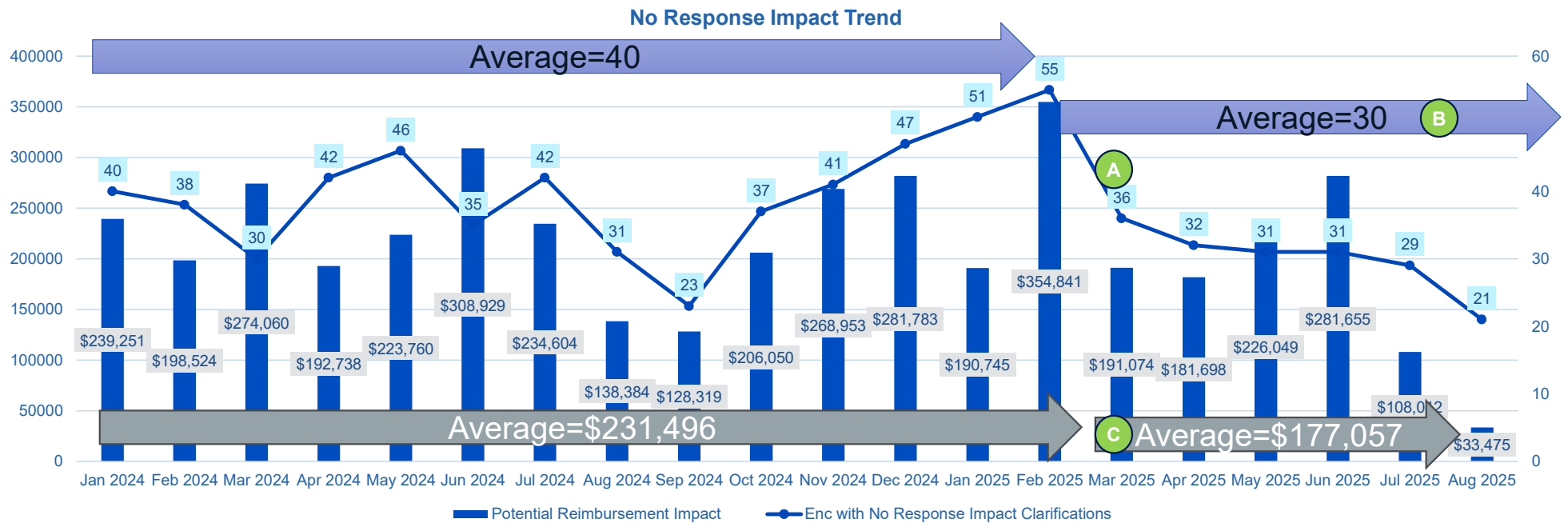
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How are you going to measure success & report it?

- A** 3.4.25—Rollout of Physician Engagement Escalation Process Across R1 Sites
- B** March-Aug—No Response Impact Query Volume Reduced by 25%
- C** March-Aug—Reimbursement Lost from No Response Impact Decreased by 23.5%



CDI Queries Are Placed to Help, Not Harm

- Concurrent queries are within the continuum of inpatient care delivery
- Create less disruption to providers than retrospective queries
- Safeguard the patient encounter from payer downgrades and denials for medical necessity
- Supports ensuring that providers get credit for the excellent care delivered
- Provides an accurate clinical picture to reflect the patient's story



Clinical Documentation Journey

A Tale of Documentation



Emergency Department notes

Coding for the IP stay starts from entry into the ED.

Chief complaint: Short of breath

This starts our patient's IP journey...

...and it appears that we are going to be working the patient up for a new onset of CHF.

Let's see what the attending says...

Once admitted, the attending's notes will drive the coding of the patient's IP stay.

ED HPI: Presents with **shortness of breath for 3 weeks, some swelling in feet**

PMH: DM, **HTN**, no Hx of COPD, asthma, CHF

Physical Exam: BP 160/90, HR 82, RR 16, **92% on RA, BMI 34**
General A&O x3

Resp: **Bilateral bibasilar crackles**

Extremities: **2+ edema bilaterally**

Labs: ↑ BNP, ↓ **Na**, glu 230, **Cr 1.8**, UA 1+ protein, other labs WNL

Assessment: **New onset dyspnea with elevated BNP, pulmonary congestion. Rule out CHF.** Admit to hospitalist.

Slide 19

EW1 [@Abby Guetzlaff] I really like the notebook graphic you have on slide 5 - could we use that here for this copy as well (lines ED HPI... thru Assessment...)?
Cc [@Celina Kurani]
Ellen Warila, 2025-08-26T21:56:08.940

IP admission: H&P

Pertinent Clinical Background (CDI-Focused):

- **PMH:** HTN, DM
- **H&P Impression:** elderly diabetic female with obesity presents with **dyspnea**. ED eval c/w **new onset heart failure**; on ARB. **Start Lasix, get ECHO, repeat labs**

The rules of coding for this scenario:

- **The Principal Diagnosis (PDx) is the condition that after careful study that occasioned the admission of the patient to the hospital.**
- **Per Coding Clinic 1Q2017, p 35:**
 - For a patient with hypertension and heart disease (CHF), there is an assumed link between the two condition unless the provider documents that they are **UNRELATED**.
- **Code Level Notes:**
 - **I50 Heart failure**
 - **Excludes2:**
 - cardiac arrest (I46.-)
 - neonatal cardiac failure (P29.0)
 - **CodeFirst:** ←
 - heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
 - heart failure due to hypertension (I11.0) ←
 - heart failure due to hypertension with chronic kidney disease (I13.-)
 - heart failure following surgery (I97.13-)
 - obstetric surgery and procedures (O75.4)
 - rheumatic heart failure (I09.81)



Principal diagnosis DRG 305

Pertinent Clinical Background (CDI-Focused):

- **ED:** Assessment- **New onset dyspnea with elevated BNP**, pulm congestion. Rule out CHF. Admit to hospitalist.
 - *Low Na documented, **but not a codable diagnosis**—cannot code Hyponatremia, and cannot query for Hyponatremia without lab value, risk factors, and treatment*
 - *Cr=1.8...what is baseline Cr? eGFR? No treatment documented. Unable to query for Acute Kidney Injury or assume CKD linkage to HTN & Heart Failure*
- **PMH:** HTN, DM
- **H&P Impression:** elderly diabetic female with obesity presents with **dyspnea**. ED eval c/w **new onset heart failure; on ARB**. **Start Lasix, get ECHO, repeat labs**

Hypertensive Heart Disease

MS DRG: 305 - HYPERTENSION WITHOUT MCC
 MDC: 05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
 MS DRG WT: 0.7507 Reimb: \$7.51 AMLOS: 2.6 GMLOS: 2.1

APR DRG: 199 - Hypertension
 APR DRG WT: 0.5104 SOI: 1 ROM: 2
 Reimb: \$0 GMLOS: 1.69

Hypertensive Heart Disease (CC)

MS DRG: 305 - HYPERTENSION WITHOUT MCC
 MDC: 05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
 MS DRG WT: 0.7507 Reimb: \$7.51 AMLOS: 2.6 GMLOS: 2.1

APR DRG: 199 - Hypertension
 APR DRG WT: 0.5104 SOI: 1 ROM: 2
 Reimb: \$0 GMLOS: 1.69

Hypertensive Heart Disease (CC) & Acute Renal Failure (CC)

MS DRG: 305 - HYPERTENSION WITHOUT MCC
 MDC: 05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
 MS DRG WT: 0.7507 Reimb: \$7.51 AMLOS: 2.6 GMLOS: 2.1

APR DRG: 199 - Hypertension
 APR DRG WT: 0.6 SOI: 2 ROM: 2
 Reimb: \$0 AMLOS: 2.73 GMLOS: 2.3

ADDED BONUS:
 If we had a refined Principal Diagnosis...
 Two CCs = Less Risk of Targeting by Payer for DRG Downgrade Denial

DRG 305	1/2 SOI/ROM	2.1 days GMLOS	0.7507 RW
DRG 305 w/ARnF and Hyponatremia	2/2 SOI/ROM		



DRG 305 day #2

Hospital day 2- Feeling better. Still **mild SOB. Weight down 6 lbs.** No fever, phlegm. **Pulse ox 88% with walking halls.** UO not measured. Exam- **faint crackles at bases, edema 1+.** **ECHO with LVEF 30%.** **Na improved to 138, Cr unchanged 1.8.** Glu 130, no insulin needed

Systolic heart failure- new onset. Cont iv Lasix, meds, add Jardiance for HF. Dietician consult.

- Documentation progressed to include type of CHF, no acuity still—*new onset does not count for “Acute” from a coding perspective*
- Renal Status: Still unclear if acute/chronic and cannot query due to limited historical data and treatment
- Na “improved to 138”....still cannot query for hyponatremia without initial abnormal lab value
- Pulse ox 88% with walking in halls...possible query for acute respiratory failure? No treatment, “mild SOB”.

Hypertensive Heart Disease w/ Hyponatremia (CC) and Acute Renal Failure (CC) and Chronic Systolic Heart Failure (CC)

MS DRG:	305 - HYPERTENSIVE HEART DISEASE WITH CONGESTIVE HEART FAILURE	DRG WEIGHT:	0.7507	GMLOS:	2.1		
MDC:	05 - DISEASES OF THE CIRCULATORY SYSTEM	APR DRG:	199 - MILD TO MODERATE ACUTE HEART FAILURE	APR DRG WT:	0.7507	GMLOS:	2.3
Reimb:	\$0						

No Change in RW/SOI/ROM/GMLOS but... IF we had a refined Principal Diagnosis, there are now 3 CCs = Less Risk of Targeting by Payer for DRG Downgrade Denial

DRG 305 **2/2** SOI/ROM **2.1 days** GMLOS **0.7507** RW

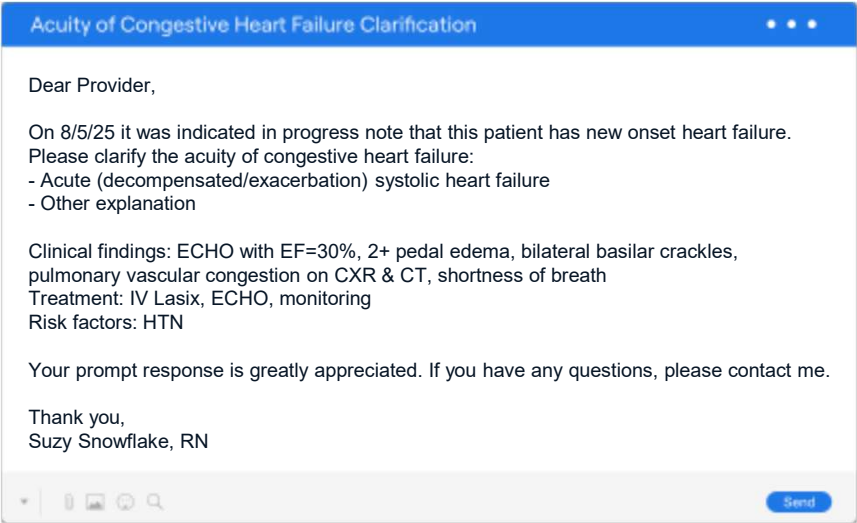


Principal diagnosis DRG 305 → DRG 291

Pertinent Clinical Background (CDI-Focused):

- **ED:** Assessment- **New onset dyspnea with elevated BNP**, pulm congestion. **Rule out CHF**. Admit to hospitalist.
- **PMH:** HTN, DM
- **H&P Impression:** elderly diabetic female with obesity presents with **dyspnea**. ED eval **new onset heart failure; on ARB**. Start Lasix. Labs
- **Progress Note Day #2:** **Weight down 6 lbs.** No SOB. **walking halls.** UO not at to bases, edema 1+. ECG to 138, Cr unchanged 1.1
- **Systolic heart failure** add Jardiance for HF. L

**If Provider Agrees with Query and Documents:
 Hypertensive Heart Disease Becomes Principal Diagnosis,
 Acute Systolic CHF MCC**



MS DRG: 291 - HEART FAILURE AND SHOCK WITH MCC			
MDC: 05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM			
MS DRG WT: 1.3048	Reimb: \$13.05	AMLOS: 5.1	GMLOS: 3.9
APR DRG: 194 - Heart failure			
APR DRG WT: 0.6421	SOI: 2	ROM: 1	GMLOS: 3.32
Reimb: \$0	AMLOS: 3.94		

DRG 305	2/1 SOI/ROM	2.1 days GMLOS	0.7507 RW
DRG 291	2/2 SOI/ROM	3.9 days GMLOS	1.3048 RW



A tale of heart failure... day #3

DRG 305: Hypertension w/o MCC

DRG 291: Heart Failure & Shock w/ MCC

Day #3 Clinical Background:

- Hospital day 3- Patient confused, reported seeing bugs on walls and gown open. Rapid response called by Benadryl given for confusion. Not sure where she is, not at rest and with exertion.
- Delirium due to Benadryl at bedside, CT head if possible.
- Systolic HF- stable

**ADDED BONUS:
IF Provider Documents...
Two MCCs=Less Risk of Targeting by Payer for DRG Downgrade Denial**

Treatment and Evaluation Clarification

Dear Provider,

On 8/6/25 it was indicated in progress note Please clarify whether the following has been documented:

- Toxic encephalopathy due to Benadryl
- Other explanation

Clinical findings: Patient confused, reported "seeing bugs on walls", "in hallway with gown open"
 Treatment: Neuro monitoring, recheck labs, family at bedside
 Risk factors: Benadryl for sleep per request, DM, Creat 1.8, "low Na"

Your prompt response is greatly appreciated. If you have any questions, please contact me.

Thank you,
 Suzy Snowflake, RN

[Send](#)

• Metabolic encephalopathy due to.... Could have queried if better supporting documentation for Cr 1.8 and low Na

MS DRG: 291 - HEART FAILURE AND SHOCK WITH MCC			
MDC: 05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM			
MS DRG WT: 1.3048	Reimb: \$13.05	AMLOS: 5.1	GMLOS: 3.9
APR DRG: 194 - Heart failure			
APR DRG WT: 1.0474		SOI: 3	ROM: 1
Reimb: \$0		AMLOS: 6.1	GMLOS: 4.99

DRG 291

2/1 SOI/ROM

3/1 SOI/ROM

3.9 days GMLOS

1.3048 RW



A tale of heart failure... day #4

DRG 291: Heart Failure & Shock w/ MCC

Day #4 Clinical Background:

- Hospital day 4- **Patient confusion better. Alert and oriented x 3. HF stable. DOE resolved.** Walking in halls without dyspnea. VS reviewed.
- **Delirium due to Benadryl- resolved**
- **Systolic HF- stable**
- DM- stable
- **Discharge home-** refer to PCP for further treatment, consider cardiology eval. **Advise avoid Benadryl.**

Through Improved Documentation:

- 1 Principal Diagnosis moved from an at risk DRG for denial for lack of medical necessity (DRG 305)
- 2 Improved Severity of Illness Scoring to accurately reflect acuity and intensity of services delivered
- 3 GMLOS increased to accurately capture the need for the longer IP stay
- 4 RW increased and helps to reflect the intensity of services, severity of illness, and supports accuracy of reimbursement for care delivered

Accurately demonstrated the patient's clinical picture and the care delivered!

1 DRG 305
DRG 291

2 1/2 SOI/ROM
3/1 SOI/ROM

3 2.1 days GMLOS
3.9 days GMLOS

4 0.7507 RW
1.3048 RW



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Reflecting an accurate Patient Story

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Questions?



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