Stop Playing Documentation Whack-a-Mole

Best Practices for Coding and CDI

🌺 Hawaii HFMA Revenue Cycle Seminar 🌺

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Objectives

1. Identify at least three common root causes of recurring coding and documentation issues.

2. Evaluate one recurring coding or documentation challenge within their organization and determine whether it is best addressed through education, workflow changes, clearer accountability, or improved collaboration.

3. Develop one practical action they can implement within 30 days to strengthen alignment between coding, CDI, and other revenue cycle stakeholders.

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The Underlying Complexity of the Mid-Cycle

Myriad of Clinical Documents

- Clinical documents
- Nurse's notes
- Lab data
- Imaging reports
- Medications
- Risk factors
- Flowsheets
- Vital signs
- Prior medical history
- and more



Inpatient Encounter

59 Clinical documents per encounter

ICD-10 codes **150k**

19 Average Dx and PCS codes per encounter



- **45%** of medical records contain poor quality documentation
- **414 million** patient record entries annually contain poor quality documentation

AGS Health

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More to Review, Fewer Charts Covered

2007: MS-DRG era

~2,000
annual discharges per CDS

8–10
new reviews per day

10–15
follow-up reviews per day

Focus

Revenue (DRG)

2024: ACDIS

~1,200–1,500
annual discharges per CDS

6–10
new reviews per day

15–29
total reviews per day

Focus

Revenue | Quality | Risk | PSIs | HCCs

The job didn't get smaller. The scope got bigger.

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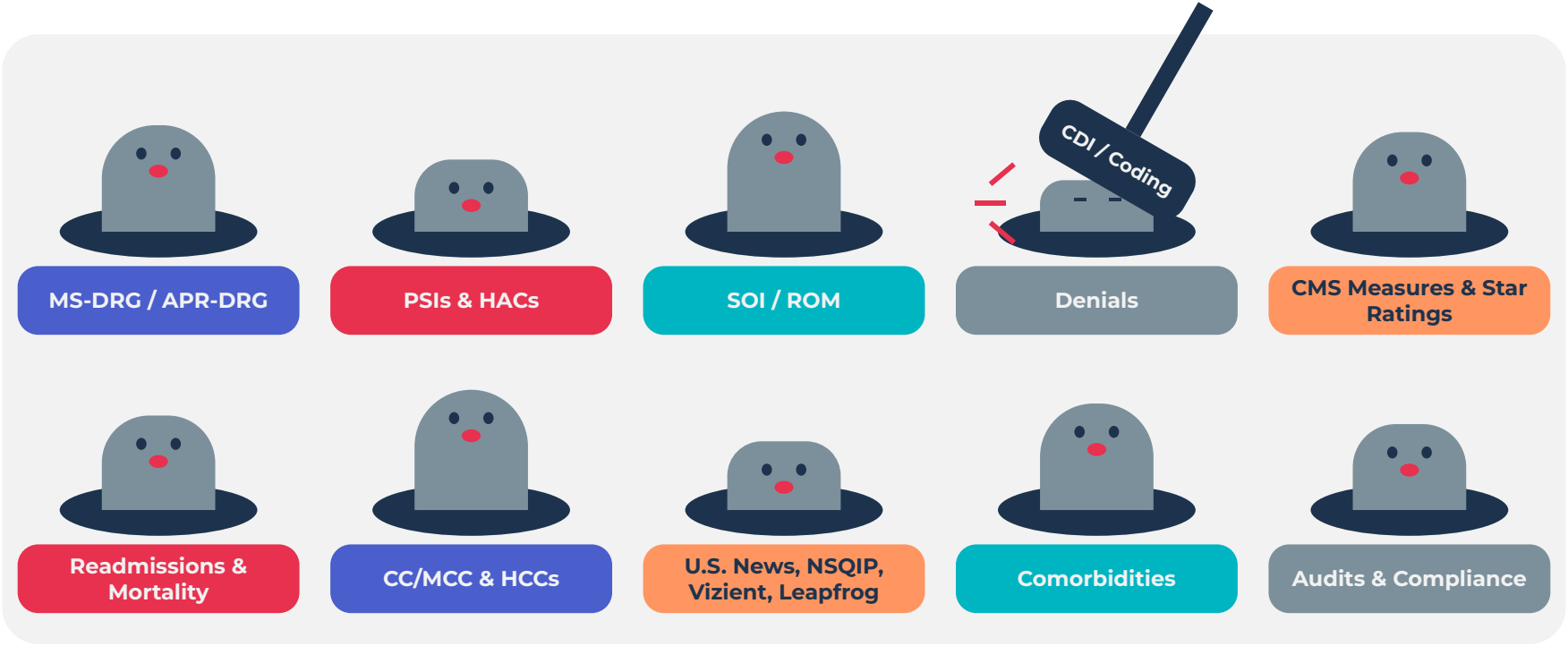
The Whack-a-Mole Problem



Fix one, another pops up...until we fix the root cause.

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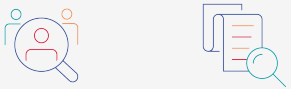
Why Current Approaches Haven’t Solved It

TECHNOLOGY



- Encoders, computer-assisted coding (CAC), CDI query tools
- Built for coding/CDI tasks, not outcomes
- Rules can’t capture full clinical context

ADD-ONS + CONSULTING



- Rules-based algorithms and staff augmentation
- Limited transparency
- Hard to scale across all DRGs

MANUAL



- Chart reviews, audits and education
- Labor-intensive
- Hard to scale across all DRGs

Each approach solves part of the problem, but none addresses the root causes on its own.

That takes people, process and technology working together.

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Same Words, Multiple Meanings

Clinical scenario: Elective CABG patient admitted to ICU on a ventilator. O_2 increased to 70%, extubated 3 hours later, on room air by day 2.

Discharge summary: *"Acute hypoxic respiratory failure, increased O_2 needs post-op on the vent, weaned, resolved, on room air."*

Role	How they read "post-op"
Provider	A time stamp: it happened after surgery, not because of it
Coder	A possible complication. A complication code requires documented cause and effect, so query if unclear
CDI	Two questions: is the diagnosis clinically supported, and is it linked to the surgery or just timing?
Quality	If coded as postprocedural respiratory failure on an elective surgery, it counts toward PSI 11
Finance / HIM	Respiratory failure can add an MCC, which can raise the DRG and attract clinical validation denials

Same words, five interpretations. One clear query aligns them all.

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Common Documentation Pitfalls



EMR templates

Default text, missing specificity prompts, and checkboxes that contradict the narrative

Ask: Who owns template design? Do your templates help or hurt capture of what's required for diagnoses, procedures and levels of service?



Problem list

Stale, never reconciled, carried forward with no clear owner

Ask: How many problems sit on a typical patient's list? Are there duplicate, conflicting or resolved acute conditions still listed?



Copy-paste

Outdated conditions, conflicting notes, compliance risk

Watch for: An assessment and plan that isn't updated to match current findings, and progression of care that isn't documented

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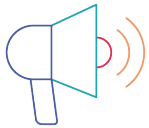
Provider Burden



Alerts

Alert fatigue: when there are too many prompts, providers start ignoring them

Conflicting alerts: CDI, quality and EMR prompts (BPAs) asking for different things

Ask: How many documentation prompts does a provider see per encounter, and who owns them?



Queries

Pajama time: queries answered after hours, on top of a full clinical day

Delays: late responses hold up final coding and billing

Ask: Are your queries concise, compliant and sent at the right time?



Education

Content: TALE (Type, Acuity, Link, Etiology)

Cadence: how often, and in what format

Messenger: peers, CDI or physician advisors

Leadership: visible physician leadership support

Ask: Is education targeted to the gaps in your data, or the same for everyone?

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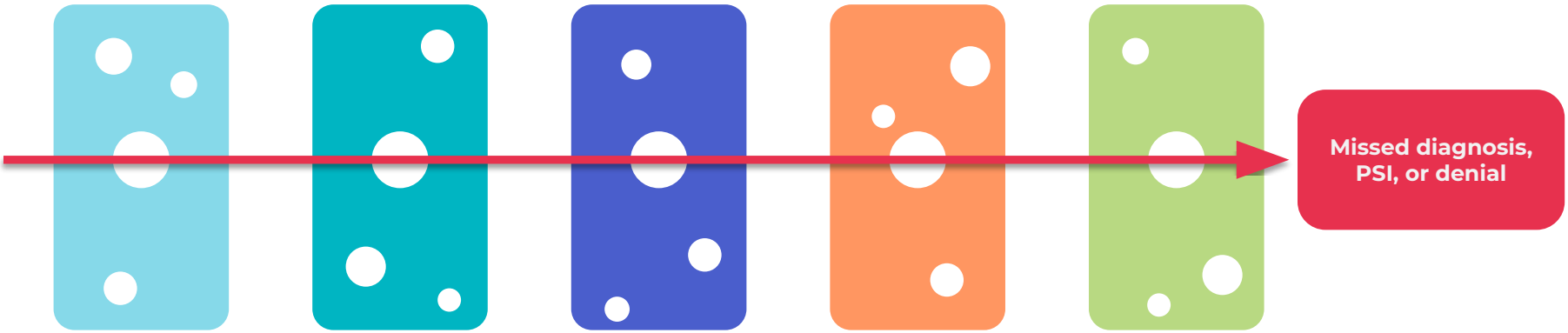
The Swiss Cheese Model

There's no lack of effort between CDI and coding. But every chart passes through many layers, tools, and handoffs. And each one has holes.



EMR templates & alerts
Default text, conflicting prompts

Provider documentation
Copy-paste, unanswered query

CDI review
Chart never reviewed

Coding
Unclear or conflicting documentation

Quality & pre-bill review
Rules miss clinical context

Adding another layer won't help if the holes still line up. Close the holes.

Ask: *How many tools and handoffs does one chart touch before it's billed?*

Model adapted from James Reason, *Human Error* (1990)

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Condition Deep Dives

Malnutrition · Respiratory Failure · Sepsis

Let’s Look at Malnutrition

Root cause: **Workflow**

Where it breaks down

1. Identify: A registered dietitian (RD) assesses the patient using ASPEN and/or GLIM criteria

2. Inform: The provider is notified through EMR alerts (BPAs), CDI prompts or a CDI query or any combination of the three

3. Document: The provider has to document the diagnosis and its severity for it to be coded

Pitfalls

- Multiple disconnected ways of trying to capture the same diagnosis
- Multiple touchpoints that interrupt patient care and add to burnout
- Providers often don’t read or address the RD note, or don’t see why it matters clinically

What helps

- **One pathway**: a streamlined route from RD assessment to provider documentation
- **Fewer touchpoints**: agree on which alert, prompt, or query is used, and when
- **Provider education**: why the RD note matters, and that the diagnosis must come from them

Why it matters: Severe protein-calorie malnutrition (E43) is an MCC and a frequent target of clinical validation denials

The RD finds it. The provider has to say it.

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Let’s Look at Respiratory Failure

Root cause: **Accountability**

Where it breaks down

- **No single standard:** Commonly cited indicators include $pO_2 < 60$ mmHg or $SpO_2 < 91\%$ on room air, and $pCO_2 > 50$ with pH < 7.35, plus increased work of breathing. Organizations and payers apply them differently.
- **Mixed messages to providers:** UR and case management may treat the diagnosis as support for inpatient admission, while CDI and providers disagree on what qualifies
- **High denial risk:** Payers often argue that numbers alone don’t prove failure without matching symptoms and treatment

What helps

- **One criteria set:** a single, organization-wide clinical definition, approved by physician leadership
- **Same message from every team:** UR, CM, CDI, and providers all use that definition
- **Document the whole picture:** values on room air vs. supplemental O_2, work of breathing, and the treatment given
- **Close the loop:** feed denial patterns back to CDI and provider education

When every team defines it differently, the payer’s definition wins.

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Let’s Look at Sepsis

Root cause: **Collaboration**

Where it breaks down

- **Competing definitions:** Sepsis-2 (SIRS-based) and Sepsis-3 (SOFA-based, 2016)
- **Quality vs. payment:** the CMS SEP-1 quality measure uses SIRS-based criteria, while many payers use Sepsis-3 for clinical validation
- **Payer-specific rules:** many payers apply their own internal guidelines
- **“Technically meets” vs. clinical picture:** hitting the criteria thresholds doesn’t always show the patient was clinically septic

What helps

- **One definition**: approved by the medical staff and applied the same way across CDI, coding, and quality.
- **Document the clinical story:** the source of infection, organ dysfunction and how it links to sepsis
- **Bring managed care to the table:** track denials by payer, and address clinical criteria in contract negotiations
- **Joint review:** CDI, quality and the denials team review sepsis cases together

Meeting criteria isn’t the same as telling the clinical story.

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Measuring What Matters



Lead measures: process, for directors and end users

Review coverage, query rate, query response rate, and time



Lag measures: outcomes, for the CFO and executives

CMI, CC/MCC capture, denial rate, quality and PSI scores



Ask yourself

- What are you monitoring today, and why?
- Does every metric have an action plan if it underperforms?
- Do your metrics cover productivity, quality, financial impact, and provider engagement?

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From Data to Action

1. Spot the pattern
2. Find the root cause
3. Put it in a bucket



4. Assign an owner
5. Measure it

Every metric needs an owner and an action plan, or it's just a number.

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Case Study: Pneumonia Etiology

Scenario: The CDI team wasn't querying for pneumonia etiology unless a sputum culture came back positive.

Step	What happened
1. Spot the pattern	The client's volume in DRGs 177–179 (respiratory infections) was about half of the peer cohort's, compared with DRGs 193–195 (simple pneumonia)
2. Find the root cause	Sputum cultures are often not obtained, or are drawn after antibiotics start. Coding guidelines don't require a positive culture to code the etiology
3. Bucket	Education for CDI and providers
4. Assign an owner	Escalated to CDI leadership and the CFO
5. Measure it	**An estimated $100K** in potential missed revenue over 90 days. After education, DRG volumes moved closer to the cohort, and both revenue and quality capture improved

One unwritten rule cost an estimated $100K in 90 days. The data found it.

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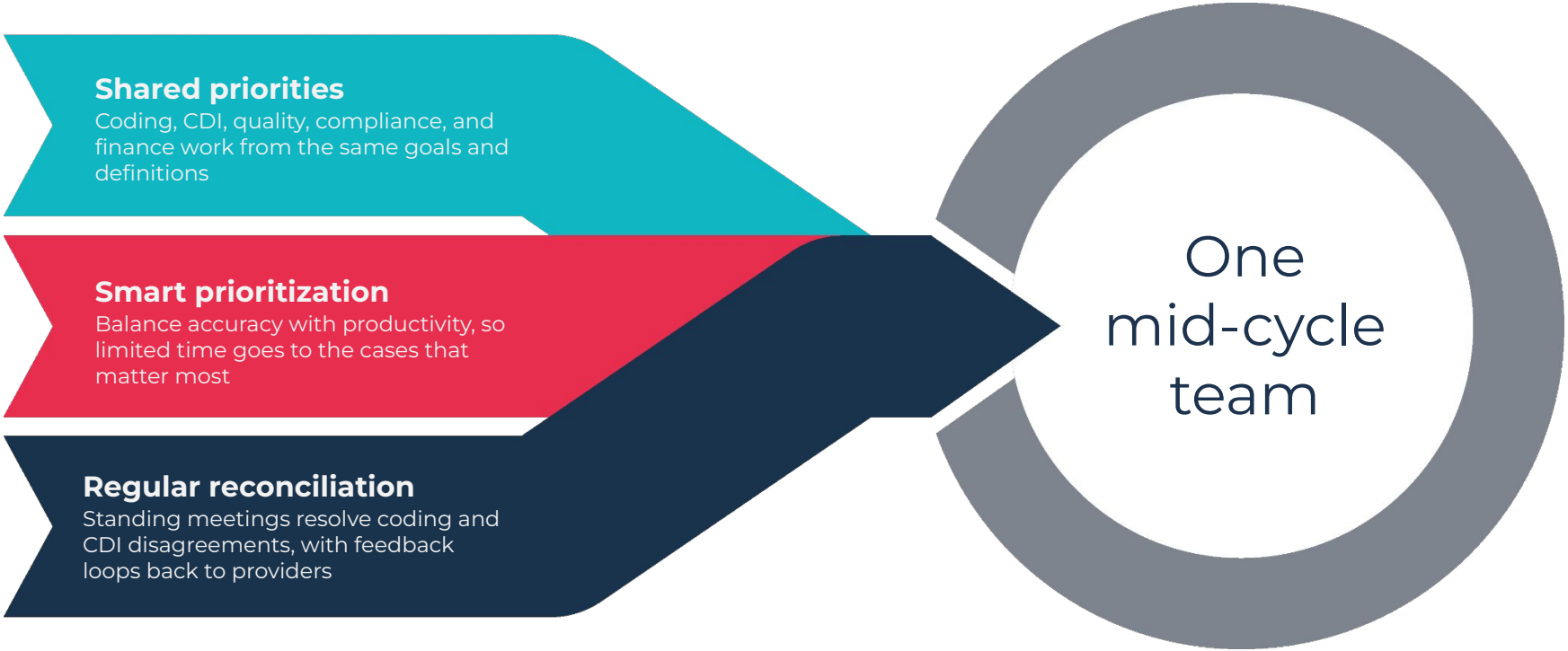
Aligning Teams



Stop whacking moles. Fix the root causes together.

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Your 30-Day Action Plan



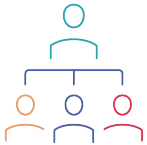
1. Pick one

A recurring coding or documentation issue in your organization



2. Bucket it

Education, workflow, accountability, or collaboration?



3. Own it

Who needs to be at the table?



4. Act

One step you'll take in the next 30 days

3 minutes to write • 5 minutes with a neighbor • 2–3 volunteers share

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Key Takeaways

1. **Recurring issues are symptoms**
   Stop whacking moles and find the root cause.

2. **Align the definitions**
   The same words mean different things to providers, CDI, coding, quality, and payers.

3. **Bucket it and own it**
   Every problem is about education, workflow, accountability or collaboration, and every one needs an owner.

4. **Let the data lead and start small**
   One pattern and one action in 30 days.

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Thank You! Questions?

Please feel free to reach out at linda.schatz@akasa.com

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