STI
Service. Technology. Innovation.

Clinical Documentation Improvement Program

Clinical Documentation Improvement (CDI) is a prevailing topic in the healthcare industry. Clinical documentation is the catalyst for coding, billing, and auditing and it is the conduit for and provides evidence of the quality and continuity of patient care.

As reimbursement models shift from fee for service to quality of care and patient outcomes, there is a need to efficiently communicate the quality of care provided and patient outcomes associated with that care.

Most providers document reasonably well for medical care but are unaware of the details needed for accurate code selection for billing, reimbursement, quality measure purposes and HCC coding. The basic CMS documentation guidelines for E/M services include the least expected documentation to support an encounter. Quality is going above and beyond the basic information.

There are several reasons to begin looking at improving clinical documentation:

- **Patient Involvement – Visit summaries are provided to the patients as part of the Promoting Interoperability category of the Merit-based Incentive Payment System (MIPS).**
- **Increasing regulatory demands for evidence-based patient care; e.g., ACO, MIPS, CPC+ and other CMS approved quality programs**
- **More frequent audits performed with the intent to recover payments**
- **The healthcare industry, with the use of the electronic resources, can now afford to aggressively investigate and enforce compliance through audits, recoupment, and denial of payments**

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- **Incomplete documentation can lead to under-coding or over-coding a service.**
- **Details in a well-documented note are a provider's best defense in any legal situation.**

Records are scrutinized by multiple entities. Providers and facilities are being challenged to put their best foot forward in many ways. The only evidence the providers have of their veracity and the quality of care provided is the medical record. Medical record documentation should be patient centered. The basic premise of medical record documentation is to promote the highest standard of continuity of care.

Documentation improvement is an ongoing process and becomes more manageable with each step.

Take your 1st step with STI's Clinical Documentation Expert (CDE)

To begin, you will have a remote meeting to discuss what processes you have in place for documentation review, coding/billing and to address any concerns you currently have regarding these topics.

Next, the CDE will do a formal review of your patient's charts, focusing on:

- Documentation to support codes selected
- Review current E&M Progress Note template
- Proper use of ICD-10 coding
- Risk Adjustment & HCC Coding
- Documentation supporting chronic conditions & Medicare Wellness Visits

After the formal review, your CDE will create a CDI (clinical documentation improvement) plan based on any deficiencies identified and concerns discussed during initial meeting.

A remote meeting will be scheduled to discuss findings of the review, provide provider and/or staff education and assist in establishing policies/procedures affecting the documentation process. Each plan will be tailored to meet the unique needs of the office/specialty. Adhering to state, federal and individual payer mandates is paramount; however, patient care is the overarching objective for CDI.

STI Clinical Documentation Improvement (CDI) Investment Review

The minimum commitment to begin the program is the auditing and review of 20 patient charts at a cost of $55/chart. Additional charts are $55/chart. The program is applicable for practices using the STI ChartMaker Medical Suite only. For RCM clients, the cost is an additional 1% of monthly collections for a minimum period of 3 months in which we will review 10 charts/month.

For additional information contact:
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