CONCEPT

Clinical Documentation Improvement (CDI): Record Review, Physician Queries and DRG Accuracy

20 – 24 September 2027
London - Central London four-star



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Ref: 528_17053 **Date:** 20 – 24 September 2027 **Location:** London - Central London four-star **Fees:** 23000 SAR

Introduction:

Clinical documentation improvement CDI matters because incomplete or vague provider notes lead to unspecific ICD codes, understated case mix, missed severity and quality signals, and payer denials that are hard to defend at audit. This Core Concept course equips HIM professionals, clinical coders and CDI specialists to review inpatient records concurrently and retrospectively, spot documentation gaps, write compliant non-leading physician queries and report CDI performance. Each participant produces a CDI Programme Design and Record Review Pack with worked queries for a set of sample records.

Course Objectives:

- Assess health record completeness and precision against the documentation quality characteristics used in HIM practice
- Trace how provider wording changes ICD diagnosis and procedure code specificity, DRG assignment, case mix index and severity indicators
- Conduct concurrent and retrospective record reviews that identify clinical indicators and documentation gaps
- Write compliant, non-leading physician queries in open-ended, multiple-choice and yes/no formats following professional query practice guidance
- Reduce clinical validation denials and audit exposure through query audits, clinician education and escalation routes
- Report CDI performance with KPIs such as query rate, response rate, agreement rate and case mix index impact

Target Audience:

- Health information management staff who maintain the completeness and integrity of inpatient records
- Clinical coders who assign diagnosis and procedure codes and raise documentation questions
- CDI specialists who review records and query treating clinicians
- Revenue-cycle and claims staff who handle denials rooted in documentation
- Quality and audit staff who check documentation for coding and reporting accuracy

Course Outline:

Day 1: CDI Purpose, Record Standards and Current-State Review

- CDI Purpose: Complete, Precise and Valid Provider Documentation
- Health Record Components: History, Progress Notes, Operative Reports and Discharge Summary
- Documentation Quality Characteristics: Accuracy, Consistency, Timeliness and Legibility
- CDI Roles: Specialist, Coder, Physician Advisor and HIM Manager Interfaces
- CDI Current-State Assessment Checklist for an Inpatient Service

Day 2: Documentation, ICD Coding Specificity and Case-Mix Grouping

- ICD Diagnosis Coding: Principal Diagnosis Selection and Sequencing Rules
- ICD Procedure Coding: Approach, Body Part and Device Detail Captured in Notes
- DRG Grouping Logic: Complications, Comorbidities and Relative Weight Shifts
- Case Mix Index Movement Traced to Documentation Specificity
- Severity of Illness, Risk of Mortality and Hospital-Acquired Condition Indicators

Day 3: Record Review Workflow and Compliant Physician Queries

- Concurrent Review Workflow: Case Selection, Review Timing and Follow-Up Visits
- Retrospective and Pre-Bill Review: Second-Level Checks Before Final Coding
- Clinical Indicator Gathering from Laboratory, Imaging and Medication Records
- Compliant Query Formats: Open-Ended, Multiple-Choice and Yes/No Use Cases
- Non-Leading Query Wording Against Professional Query Practice Guidance

Day 4: Clinician Engagement, Denials, Audit Risk and Data Integrity

- Clinician Engagement: Specialty Tip Sheets, Feedback Sessions and Physician Advisor Escalation
- Clinical Validation Denials: Root Causes and Appeal Letter Structure
- Audit Risk Controls: Query Audit Sampling, Upcoding Red Flags and Record Amendment Rules
- CDI KPIs: Review Rate, Query Rate, Response Rate, Agreement Rate and CMI Impact
- Data Integrity and Privacy: Copy-Paste Risk, Access Controls and Minimum Necessary Use

Day 5: CDI Programme Design and Sample Record Review

- Case Study: Sample Inpatient Records Reviewed for Documentation Gaps
- Case Study: Compliant Physician Queries Drafted and Peer-Checked
- CDI Programme Charter: Scope, Staffing Model, Escalation Policy and Review Priorities
- CDI Performance Dashboard Build with Monthly Reporting Pack
- CDI Programme Design and Record Review Pack Presentation to an HIM Review Panel

Skills You Will Gain:

- Health Record Gap Analysis
- Principal Diagnosis Sequencing
- DRG Impact Analysis
- Clinical Indicator Extraction
- Compliant Query Writing
- Clinical Validation Denial Defence
- CDI Metrics Reporting
- Documentation Integrity Control

Why Attend This Course:

- Return with a CDI Programme Design and Record Review Pack, including worked queries, built for your own service
- Practise reviewing sample records and wording queries that clinicians answer without being led
- Show finance and clinical leaders how documentation specificity moves case mix, severity and denial figures
- Compare CDI and coding practice with HIM, coding and revenue-cycle staff from public and private providers in several health systems

Conclusion:

Documentation that is complete, specific and clinically supported gives coders what they need and gives the organisation defensible data. The course moves from CDI purpose and record standards, through the link between documentation, ICD coding, DRG grouping and severity indicators, to concurrent and retrospective review and compliant query writing, then to clinician engagement, denials, audit risk, KPIs and privacy. The final day applies this to sample records and produces a CDI Programme Design and Record Review Pack for review by an HIM panel.