DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 181 CDI - A great opportunity for physicians with and without US residency

With guest Dr. Cesar Limjoco

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HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hi there, and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 181. We have a very special guest today who is going to talk about a great career area open to physicians with and without U.S. residency training.

But before we start, I have two announcements to share. First off, I'm excited to reveal our very first sponsor of the podcast. You may recall an episode I did a while back with

Dr. Stephanie Pearson, number 75, titled "A Career-Ending Injury Leads to a New Direction." In this episode, Dr. Pearson tells the story of how an injury sustained while delivering a baby ended her career as a doctor, and how she did not have the disability coverage she thought she did.

The ensuing challenges led Dr. Pearson to co-found PearsonRavitz, a disability and life insurance company that provides coverage with integrity to healthcare professionals like you. You can learn more and schedule a consultation by going to pearsonravitz.com or click on the link in the show notes.

The other announcement I have is an upcoming webinar I'm doing on How to Rock Your Career Using AI. This will be on Wednesday, May 22nd at 06:00 P.M. Eastern Standard Time. For more information and to sign up, there is a link in the show notes, or you can reach out to us at team@doctorscrossing.com. Now, without further ado, on to our episode for today.

We are diving into an area called CDI, Clinical Documentation Integrity, with our wonderful expert guest, Dr. Cesar Limjoco. Dr. Limjoco has been involved in health care consulting and CDI for over 30 years, including his current role as CMO for T-Medicus, where he helps bring teams together to optimize patient care through accurate coding, documentation, and billing.

He is considered a leader in CDI and known for his overarching principle to have the clinical truth of each patient be the North Star for all CDI endeavors. Dr. Limjoco will be helping us better understand the roles for physicians and CDI, how there are entry points for those with and without residency training in the U.S., what the work entails, steps to get started, compensation, and more. It is my absolute honor and pleasure to welcome Dr. Cesar Limjoco to the podcast. Hi, Cesar. Welcome.

CL: Thank you, Heather. Thanks for having me.

HF: I am delighted. I love this topic of CDI because there are opportunities for physicians who maybe decided after medical school they didn't want to go on to residency. There are opportunities for international medical graduates and for physicians who are board certified and licensed clinicians. And you're going to help us understand how this all works. So, thank you for coming on the podcast.

CL: I'll try.

HF: All right. Can you give us a bit of an understanding of what exactly CDI is?

CL: Clinical documentation integrity is the bridge between the physician, taking care of the patient and the information that he or she has generated and how that is transmitted and translated into codes.

HF: And it obviously has big implications for revenue and payment and reimbursement.

CL: Yes, it does. And it's very important. And some people actually may think it's the most important thing, which I would say not. Really, it's about making sure that the patient story is told accurately.

HF: Would you like to give us an example of a physician working in CDI and how they might be working with the coding and working with the documentation and the physicians taking care of the patient?

CL: Well, there are a couple of areas where a physician that's not taking care of that patient can be of help in clinical documentation integrity. The first, of course, the entry level would be as a CDI specialist, clinical documentation integrity specialist. And that means he or she will be going through the cases that are admitted into the hospital on a daily basis and looking for areas wherein there's the need for clarification.

That is the entry level. You don't have to have a license for that. We don't even need to have medical school training for that. In fact, in the past three decades, we have had nurses, coders, respiratory therapists, nutritionists that have filled that role. What's important is to be able to understand the patient's story and where there are gaps in that patient's story that is not able to be translated into codes.

HF: They are reviewing what's going on in the record. Are they often doing this as the clinical case is developing?

CL: Yes, they're there from the outset. Once the patient is admitted, then, of course, first thing is you need the HNP. You can't start without the HNP. You need the HNP in place to see where the starting point is and then how it develops through the hospitalization.

HF: What might be an example where the CDI specialist is looking at the clinical information and then they might see where there could be a gap or maybe something that's left out or maybe even something that doesn't look accurate? And then what do they do next?

CL: Let me start off this way. Once the patient is admitted to hospital, there's a narrative. And I think it's really important that we need to figure out one big thing which is not really looked at by many of the CDI programs in the country right now, which is medical necessity. Is there a need for this patient to be in this level of care? And that will be apparent in the documented HNP and the ED notes.

We need to be able to ask the liaison between the decisions that are looking at the patient and how they are documenting this need, this medical necessity for the inpatient stay. Why is the patient being admitted? What is it for? Does this patient need to be in-house or can they be taken care of on an outpatient setting? That's first and foremost. And that also it answers the question as to what's the principal diagnosis. They go hand in hand.

And then with that principal diagnosis, what are the other comorbid conditions that the patient brings to the table that presents that will affect how they're being managed, that will affect medical necessity for the inpatient stay?

HF: Obviously, you need to have a good understanding of medicine and what's going on with patient care. If someone's coming in as a MD, DO graduate, they're obviously doing some training ahead of time, in addition to what they learned in medical school, I assume, to be able to start at this job. How does someone get that initial training if they say are not a licensed clinician?

CL: Mostly on-the-job training. Just like how the other CDI specialists that are not medical school graduates. You don't expect coders or even floor nurses to fully understand clinical nuances. But by repetition, by seeing cases day in and day out, and being mentored as to what to look for, what are the important things that need to be clarified? Those are the things that you acquire as time goes on.

HF: Now, I did a podcast a bit ago with Dr. Jingyi, she works for a CDI company whose clients are hospitals, and they actually are paired with a coder. So, the physician works with a coder, and they don't need to have any coding experience. And they're a partner in looking at the clinical documentation and making queries on what might be missing or what might not be appropriate. Obviously, in this whole area of CDI, there is different requirements for what your background is.

If someone is coming in more at the entry level, like CDI specialists, as you described, let's say they graduated from medical school, they've heard about this area, and they want to apply. Would it be good for them to take a coding course first or do something to be a more competitive applicant? Or is it just knowing somebody inside the hospital who might help them get in front of the hiring manager? Because this is what everybody wants to know, is how do I actually get one of these positions or even learn more about what would make me qualified?

CL: All of the above. But first of all, I would say that if you really want to get leg up is to be a member in one of the associations, like AHIMA or ACDIS. They have programs, continuing education programs, where you can be trained in the art of clinical documentation integrity, which involves also understanding, learning about the coding requirements. That's the entry level.

You had mentioned about medical director of a private company. That's different. They are licensed, they are board certified, and they really don't have to have a deeper understanding of coding because they have coding experts within as a resource, and they will provide that to them. As medical directors, what they're in there for is to have the clinical acuity, the medical acuity in understanding diseases and disease management. That's a different level altogether.

The CDI specialist comes in as an entry level position, and they're expected to know more about not just the coding side. They don't have to be expert, but they also need to understand the clinical side, and they don't have to be expert at it either.

HF: That's very helpful, and I'll make sure to link to ACDIS and AHIMA in the show notes. Would you say that this is an area where there's pressure to increase revenue through CDI? It's something that you and I were talking about before we recorded this podcast is how the pendulum has swung where before there was undercoding, underdiagnosing, underbilling, but because there's such a revenue incentive to bill more, code more, diagnose higher level conditions that the pendulum has swung, and are the CDI specialists getting caught in the middle of this?

CL: Oh, definitely. I'm sad to say that that's what's happening, and that's given impetus to my mission and my vision, which is to make sure that we put the pendulum back to the middle, and that middle is the clinical truth. We need to make sure that as practitioners, as professionals, the CDI folks are going by that North Star.

HF: What have you seen in terms of the ability to really help those working in CDI respect the clinical truth and also have all the other stakeholders and players in this area honor this mission that you so vehemently and passionately carry the torch for?

CL: It takes a whole village, as I would say, and it needs a symbiotic relationship with all the stakeholders, and it starts from the top, from the administration, from the C-suite, to the department heads, and down to the physicians and CDI specialists and coders and other ancillary departments. It really does. It's working in silos, it don't work. It's never worked, whether it's CDI or other departments in the hospital.

HF: What have you found makes people most receptive to this message, to heed this warning of if we don't follow the clinical truth, it's ultimately really not going to work?

CL: That's an understatement. It really is. If you're going with a different North Star, it's not going to work. You're going to divide all the stakeholders because everyone has their own agendas. And if you're not going with the clinical truth, it's going to go against what the others are going for. Whether it be quality, whether it be utilization, whether it be denials and appeals management, they're all linked together. And if you're not going with the right North Star, it's just going to fall apart. You're just going to incur more waste and less financial feasibility.

HF: Well, when we were talking earlier, before we recorded the podcast, you were talking about how not representing the clinical truth was creating more denials and more work because so many people were adding on sepsis at the diagnosis when it wasn't really substantiated. And this was causing true cases of sepsis to be denied and then have to be appealed. And so, it's creating a situation now where there is a lot more work because insurance companies are much more skeptical about what's being put forth.

CL: It's not just a lot more work, but a lot more waste. A lot of wasted health care dollars on something that is a “he said she said” situation. If all the stakeholders, not just in the hospital, but in the healthcare industry, meaning payers and other agents of payers, if

they were all going by the right thing, which is the clinical truth, then there will be less waste in appeals, denials and so forth.

HF: And now you never have to justify the truth. You just tell the truth. That will work.

CL: Definitely.

HF: I'd love it, Cesar, if you could paint a picture of what someone might be doing in a day to day job in CDI, how their day starts, what kind of cases they're working on and how they actually do this job.

CL: At the entry level as a CDI specialist and most hospitals now have electronic health records, they have a queue of patients to see on the electronic health record and they go through it. They look at the documentation, the H&Ps, the progress notes, the laboratory findings, the consultation notes and see if all the pieces fit together. If the narrative is smooth and there are no gaps in the information.

With that in mind, they have to figure out if this is the right time to clarify or not. This is crucial because you might be generating lots and lots of queries, which is just going to increase moral injury on the physicians and it's not going to help anybody at all. You will just polarize the physicians and the CDI specialists and the coders. And that happens.

If you're doing it with the right mission, the right vision, then instead of polarizing, you're getting everyone together, all the stakeholders together. Because you're painting the patient's picture correctly and accurately.

HF: That sounds like it takes a degree of emotional intelligence and also experience too to know "When do I ask about something that may be missing or may look like it's overdone and look like I'm helping versus pestering somebody who's already very busy and likely feeling stressed?"

CL: Yes, it takes a person with all of that emotional intelligence and acuity to understand the nuances, the personalities. Yes, definitely.

HF: And what might be something that a physician at a different entry level point is doing versus the entry level CDI specialist?

CL: Well, if you are a licensed physician and have completed residency, of course, and even board certified, then the type of physician that you'll be looking for is one of the things that you mentioned earlier. As a medical director of a private company that is looking over the hospital's shoulders, you can be an actual provider within the hospital, the health system, and working as the liaison between the CDIs and the coders and helping the other physicians to, like you say, get in line, make sure that the true story of the patient is being told. It's very important. That level of leadership is important within the hospital and health system.

HF: It sounds like you might be doing some education too, in this role.

CL: Definitely. You have to have this level of leadership. You can call it physician advisor or medical director or even a department chair. You can fulfill that role also. But you're really becoming the arbiter between all of the stakeholders that are involved. Education, you had mentioned, is very important. Education is what keeps everybody on the same page.

HF: I know one thing that physicians I know who do this CDI work mention that they really enjoy is they see a whole variety of cases. They often say they see things and learn about conditions that they didn't when they were in clinical practice. And they like the ongoing education ability to use their clinical knowledge and also to keep growing and learning.

CL: Definitely. In addition, I want to say that there are three pillars that are important in addition to the overarching principle that you mentioned before that I had written about. The overarching principle is, of course, the clinical truth. That is the main mission of the CDI. But the three pillars that are important to make this work is a symbiotic relationship between all the stakeholders, coding, quality, utilization, finance, physicians, all the departments. These are important, the symbiotic relationship.

Secondly is what you just talked about, the continuing education, because everybody has their own perspectives, have their own understandings. And we need to make sure that everybody is looking at it with the same lenses, with the same eyes, so that everybody is talking the same language, if you may.

We have symbiosis. We have continuing education. Technology is the third pillar. Because with AI nowadays, all of this technology, when done correctly, in the right way, with the right mission, with the right controls, it will help ease the burden of everybody, of all the stakeholders, from physicians to CDIs to coders, if done correctly.

HF: Yeah, it's a very powerful tool, and I could see how it could be very helpful in this area. I want to talk a little bit in a minute about compensation, because that is important, obviously, to everyone, and ask a few more questions about steps to explore to get started. But first, I want to share a quick message from our sponsor. Don't go away. We'll be right back.

You can learn more about their services and book a consultation to discuss disability and life insurance. The link will also be in the show notes. Once again, that's PearsonRavitz to safeguard your future.

We are back here with my wonderful guest, Dr. Cesar Limjoco. I wanted to ask you, Cesar, could you give a little guidance about compensation, perhaps talk about some of the different entry points that physicians can have and what they might expect in terms of salary?

CL: Entry level would be the CDI specialist. They can start off below six figures and go beyond six figures depending on their level of seniority and experience. Then you will have the physician advisors, and they will, of course, be compensated as a physician in the six figures. And it goes up from there as a medical director, as a department chair, as the chief medical officer, of course, as you well know.

HF: Someone who'd say a foreign medical graduate, they can enter in, it might be a bit below six figures, but then with experience, they can earn six figures.

CL: I've been involved with a program, actually, that started off with nurses and coders and slowly developed into a whole cadre of foreign medical graduates. There are several systems throughout the country that have a lot of international medical graduates in there. But again, just like any groups of professionals out there, they have to be indoctrinated with the right thing, the right way, which means you have to have the right North Star.

HF: Right. Follow the principles. And then for medical directors or physicians who are licensed and board certified, what I've seen is some starting salaries around $200,000-ish, somewhere around that area, and physician advisors can be around there, and then they can go up higher than that. Would you agree?

CL: Yes, that's how it goes.

HF: Okay, perfect. Just before I wrap up, would you like to go over a few more steps that physicians can do who might want to explore this area and see if it might be a possibility for them?

CL: Definitely. Reach out to AHIMA, the American Health Information Management Association. They have training with CDI, as well as the ACDIS association, the Association for Clinical Documentation Integrity Specialists. They also have training in CDI, network through those associations. I would say in both associations. The more resources that you can network with, the better. I think that's the best thing that you can do.

HF: Excellent. Well, I've also seen some physicians posted in physician Facebook groups, so that can be another good thing to do, because physicians already in these jobs often will recruit other physicians to join them, and so they may post something, and they can also be a great resource if you want to learn more.

Cesar, are there any last words you want to share for physicians who may be feeling a bit lost and struggling to know what they can do with their training and their skills and knowledge?

CL: My story goes back to the 1980s. I was in New York City in a nursery hospital center, which has since closed. I don't know if you've heard of the St. Vincent's Hospital Medical Center in southern Manhattan, between 11th and 12th Street and 6th and 7th Avenue. It's a big hospital. It's about a thousand bed hospital, and I sort of became the unofficial liaison between the medical staff and medical records department. And that's how I got to learn the coding issues, the documentation issues, and I became the go-between for coding and the physicians.

So, that's where it all started. It was unofficial. It wasn't structured. It just arose from it. And from there, I worked for the Greater New York Hospital Association and just

followed up on that because I had started the skill of working with physicians and coders, and they used it in their consulting arm. They peddled us to all the hospital membership to help make sure that the documentation and coding is accurate.

So, that's how it all started. It was all organic. The hospital started asking, "Oh, can you do this? Can you do a one-hour presentation to my medical staff and then to my surgeons, to my pathologists?" That's how it all started. It was all organic.

HF: I love that story because it is often when we are called to solve some type of problem and then we just say, "Yes, yes, answer that call." If we have the energy to do that, it can often be an inclination towards something that could become bigger later on. And like for you, a whole new career area that has become a mission.

CL: A whole new career. And from the beginning, direct patient care was something that wasn't really that was my burning mission in life. I like the learning. I like about medical conditions and what have you. But it provided me with an opening, really an opportunity to go somewhere to utilize this and do it for something good, not just for money, but something good. As a physician, you're taking care of one patient at a time. At my level, I'm looking at multitudes of patients because I'm looking at multitudes of hospitals and health systems that I've helped with across the country.

HF: That is beautiful, Cesar. You followed your own North Star and it led you to a passion career for sure.

CL: Exactly.

HF: Thank you so much for coming on the podcast, sharing your wisdom, your knowledge, and also encouragement for those who want to try something in this area.

CL: Thank you for the opportunity. I love sharing stories.

HF: You're so welcome.
Thank you so much for listening. I always love sharing these episodes with you. And I wanted to remind you about our sponsor, PearsonRavitz. If you'd like to schedule a consultation regarding your disability and life insurance needs, you can do so at pearsonravitz.com or go to the link in the show notes.

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Podcast details

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