Evolving Roles in Clinical Documentation Improvement: Physician Practice Opportunities

In order to effectively discuss clinical documentation improvement (CDI) opportunities in physician practices, it is important to first understand the drivers and goals of a physician practice CDI program. Historically, diagnosis codes have had little impact in regard to physician practice payments made under Medicare Part B, which was based on the reported CPT procedure codes, including evaluation and management (E/M) codes. Providers could report an unspecified diagnosis code such as E11.9, Type 2 diabetes mellitus without complications, and it was sufficient to meet the medical necessity of the service. However, the relationship between reimbursement for professional services and diagnosis codes began to change with the establishment of the Medicare Advantage Program, paid under Medicare Part C, within the Balanced Budget Act of 1997. Medicare Advantage payment is based on the "risk level" of the beneficiary. In other words, higher payments are made to providers who care for "sicker" patients.

To risk-adjust the beneficiary population, the Centers for Medicare and Medicaid Services (CMS) leveraged the Hierarchical Condition Category (HCC) model. Each HCC includes diagnoses that are clinically related within similar cost implications. The hierarchical nature of the methodology allows the most severe form of the disease process to be used when determining risk. For example, if a patient with type 2 diabetes without complications develops diabetic neuropathy, which translates into diabetes type 2 with a complication, a higher weighted factor is applied to the risk-adjustment calculation and the value associated with diabetes without complication is replaced by the value associated with more severe diabetes with a complication.

Accurately reflecting the complexity of the Medicare Advantage patient requires thorough documentation that allows for precise code assignment to the highest available specificity within the code set. The fact that all relevant diagnoses should be reported as the interaction of diagnoses is also reflected in the risk adjustment methodology; for example, if the interaction between heart failure and chronic renal disease is documented, the total risk adjustment factor (RAF) is increased. Providers should be validating and updating all documented conditions at each visit. Not only does the Medicare Advantage methodology require annual documentation of conditions used for risk-adjustment, but the practice of substantiating these diagnoses encourages the provider to continually monitor chronic conditions and increases awareness of possible medication interactions, thus improving the patient's overall health.

CMS announced in 2015 its intent to transform fee-for-service payments, in all settings, into a value-based strategy as well as their intent to develop alternative payment models (APMs). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula and is designed to encourage providers to focus on making patients healthier through a value-based framework. The most common APM strategy is the Medicare Shared Savings Program, also known as accountable care organizations (ACOs), which was established under the Affordable Care Act (ACA). It encourages coordinated care by allowing providers and facilities to partner in offering services across the spectrum of healthcare needs. MACRA offers two quality tracks: one for those who participate in an Advanced APM and the other for providers who do not, called the Merit-based Incentive Payment System (MIPS). Both tracks offer monetary incentives to providers who demonstrate high quality, efficient care through their performance on measures in a variety of categories, including quality and cost. As the Quality Payment Program (QPP) matures, providers will also be financially penalized for poor performance. Consequently, payments made to those who work in the physician practice setting will be

impacted by the diagnoses associated with each claim.

Physician practices are likely to need CDI support to successfully transition to these new reimbursement methodologies and/or maintain their current revenue stream under existing methodologies. The outpatient coding professional is uniquely qualified to assist in this endeavor through their understanding of CPT code requirements, especially E/M codes, as well as the documentation necessary to support accurate diagnostic code assignment beyond simply checking off boxes on a billing sheet that includes ICD-10-CM codes. The role of the physician practice CDI professional will vary depending on the type and size of the practice as well as the type of beneficiaries served. Since CDI is a relatively new concept for many physician practices, it may be necessary to educate physician practice leadership on the need for, and value of, incorporating CDI practices into the documentation workflow.

CDI Core Components in a Large Physician Practice

This graphic represents the core components of a large physician practice CDI program, consistent with a broader set of goals for the program.

Source: Graphic originally provided by e4 and published in its original form in the following article: Wieczorek, Michelle M. and Jill S. Clark. “Curing Inherited EHR Ailments: EHR Remediation Fixes System Issues and Better Aligns Clinical Workflow with Clinical Documentation.” *Journal of AHIMA* 85, no. 9 (September 2014): 56-58.

CDI Professionals in the Physician Practice Setting

In a physician practice setting, the CDI program should be executed with a specific set of goals in mind that support the entity's objectives, whether it is an individual, multi-group, or specialty practice network. These goals may include improving medical coding quality and accuracy, meeting regulatory requirements, adherence to clinical guidelines, meeting documentation requirements for quality payment/incentive programs, and/or leveraging technology in support of improved patient care and clinical productivity. As such, the CDI professional role can be filled by a variety of professionals with skills and credentials consistent with the practice's goals.

The graphic on page 55 represents the core components of a large physician practice CDI program, consistent with a broader set of goals for the program.

Given the broadness of the skill sets required to cover all the various aspects of the physician practice CDI program, organizations may choose to break up the responsibilities into several different roles, each highlighting a different expertise. Key responsibilities for a CDI program in a large physician practice include:

- Perform concurrent reviews and offer providers feedback to improve completeness and specificity in documentation in support of ICD-10-CM, CPT, and HCC coding
- Conduct chart reviews and any necessary provider education for compliance with quality reporting initiatives
- Perform retrospective chart reviews for coding compliance and quality
- Collaborate with team members to aggregate findings from clinical documentation reviews (both retrospective and concurrent) and design educational content and remediation strategies for both individual providers and provider groups
- Coach the provider on opportunities for improving clinical documentation based on annual compliance review findings
- Collaborate with team members on ways to improve electronic health record (EHR) functionality in support of clinical documentation coding trends and requirements
- Translate feedback from providers, CDI professionals, coding professionals, and compliance into content enhancements in the EHR
- Design, test, and implement revised drop-down menus and other enhancements to assist providers in improved documentation and coding completeness
- Collaborate with providers to improve existing standard note and template functionality
- Manage support requests and tickets with the EHR vendor
- Collaborate with the EHR vendor to validate that the embedded clinical terminology system within the EHR is appropriately mapping to the correct ICD-10-CM codes

Example CDI Workflow in a Physician Practice Setting

This flow chart provides an example of a clinical documentation improvement (CDI) workflow in a physician practice.

Patient Encounter Observed by CDI Professional

- Patient assessment
- Evaluation & Management code selection

- Diagnosis specificity
- Hierarchical Condition Categories (HCC)

Clinical Documentation Improvement Process

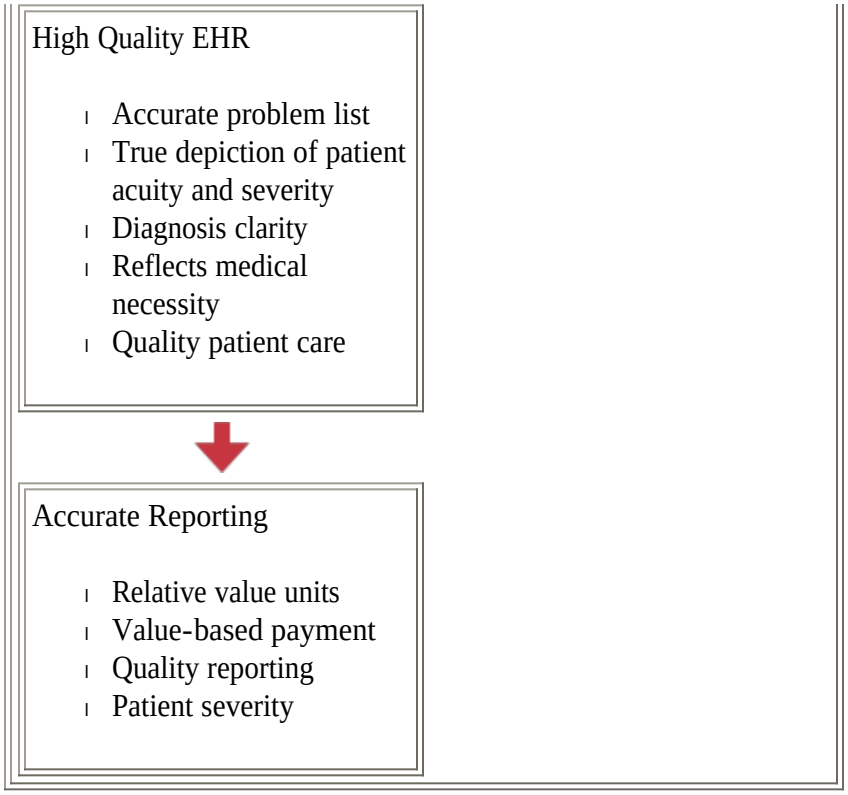
- EHR templates observed for remediation
- Review for documentation gaps
- Review problem list
- Initiate queries
- Provide education/coaching

EHR Remediated

- CDI works with IT
- Enhance available diagnosis selections
- Synchronize templates to provider workflow
- Validate the maps between clinical terms and ICD-10-CM codes

Coding, Abstracting, Billing

- Improved productivity
- Accurate ICD-10-CM and CPT code assignment
- HCC Assignment
- Decreased unspecified codes



Workflow and Process

There are a variety of services offered in the physician practice setting. The CDI workflow will likely differ depending on the size, location, and type of physician practice. The size of the practice may affect its ability to staff the CDI role. In that circumstance, the role may be shared with other responsibilities, such as coding. The location differentiates independent practices from health system-based practices. Often, health system-based practices have more access to resources, which are often purchased by the health system; however, this may also cause them to have less input on those resources. Both the size and type of practice affect the reporting of quality measures.

It is essential that the CDI process begins with an initial review of the health record to validate inclusion of all required components. Specifically, the encounter should be reviewed for seven criteria of quality clinical documentation:

1. Legibility
2. Reliability
3. Precision
4. Completeness
5. Consistency
6. Clarity
7. Timeliness[1]

This step can be performed by a health record technician/clerk, clinical documentation analyst, medical scribe, or other personnel. If any components are missing, the record is returned to the provider for completion.

Once the record is complete, the review by the CDI professional can focus on identifying potential query opportunities, such as diagnosis specificity, medical necessity, validating E/M levels, ensuring that quality performance measures are met and documentation is present to support coverage as required by national coverage

determinations (NCDs) and local coverage determinations (LCDs). Depending on the type of practice, validation to support HCC risk adjustment may be necessary—in addition to meeting quality program requirements.

In order to support reported diagnosis codes, the provider's documentation and any additional clinical indicators derived from laboratory, pathology, and radiology reports should be reviewed. Section IV.J. of the ICD-10-CM Official Guidelines for Coding and Reporting states the following about coding all documented conditions that coexist: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist." If any of these factors are not met, a query should be initiated to clarify the status of a documented condition.

There are two methods used to validate the reporting of a documented condition. The most common method is considering whether the documentation supports a diagnosis that has been monitored, evaluated, assessed, and treated (MEAT). Another newer method is referred to as the TAMPER™ criteria (created by Brian Boyce of ionHealthcare), which stands for treatment, assessment, monitor/medicate, plan, evaluate, or referral. At least one of these elements must be documented for each coded condition. The TAMPER approach is useful when performing HCC coding and examining the patient's comprehensive care. Coding and CDI professionals should avoid automatically coding conditions noted in the patient's problem list or medical history unless the condition passes MEAT or TAMPER criteria. When a condition does not pass this criteria, a query may be warranted to clarify if the diagnosis is an active diagnosis or just a history of the condition. The Diagnostic Coding and Reporting Guidelines for Outpatient Services found in Section IV of the ICD-10-CM Official Guidelines for Coding and Reporting are also helpful in guiding the coding professional on proper code assignment.

The medication list will be a great resource for the CDI professional validating diagnoses for HCC beneficiaries. Providers should be encouraged to document the condition being treated by each medication, demonstrating its relevance as a current and reportable condition. Educational efforts should also encourage providers to specify the acuity of every diagnosis, especially those only mentioned in the history of current condition section of the history and physical. Specifically, documentation should describe each condition as acute, chronic, exacerbated, or resolved to clearly convey its current status and relationship to the current episode of care.

Writing a Compliant Query

A proper query process ensures providers add appropriate documentation to the health record in support of accurate code assignment. Personnel performing the query function should maintain a compliant query process. Although verbal queries may be prevalent in the physician practice setting due to the close working relationship, it is important to follow guidance requiring their recording. When writing a query in the physician practice setting, the CDI professional must adhere to the following guidelines:

- Do not lead the provider to a certain diagnosis
- Include appropriate clinical indicators to support the query
- Format the query as open-ended (preferred), multiple choice, or "yes/no" (or "rule in/rule out")

Refer to AHIMA's January 2016 Practice Brief "Guidelines for Achieving a Compliant Query Practice (2016 Update)," available online in AHIMA's HIM Body of Knowledge at bok.ahima.org, for additional details on writing compliant queries, including query examples.

Provider Engagement

In every setting, obtaining a timely response to a query can be challenging. It's important to determine how and when

to engage the provider. The particular culture of a physician practice will drive how best to engage with providers to ensure timely review and response to queries. Every provider has a unique personality and the CDI professional must determine how to best work with each individual provider to obtain buy-in to the CDI program. Some providers may prefer one-on-one coaching as needed, whereas others might prefer regularly scheduled group education, and others may want a weekly/monthly newsletter with documentation tips. There is no "one-size-fits-all" approach to provider education.

The technology available within the practice will also impact the CDI workflow. Physician practices that are affiliated with a health system are likely to have a robust EHR, possibly with electronic queries built in. Conversely, the EHR found in smaller and individual practices may not support the electronic query function, necessitating a manual process. Whatever process is used needs to be clearly delineated so that all users understand their role in the CDI workflow process. The graphic on page 56 provides an example of a CDI workflow in a physician practice.

The success of any CDI program relies heavily on its key stakeholders and the way in which they communicate. Physician engagement is crucial in this process. It is recommended that CDI professionals provide ongoing education to providers in the form of quick huddles, tip sheets, shadowing, one-on-one consultations, and group education in a time-conscious manner. This process will allow providers to focus on what is most important: the patients.

Note

[1] Hess, Pamela. *Clinical Documentation Improvement: Principles and Practice*. Chicago, IL: AHIMA Press, 2015.

References

AHIMA. "Guidelines for Achieving a Compliant Query Practice (2016 Update)." HIM Body of Knowledge. Updated January 2016.

Bonner, Dari and Karen M. Fancher. "Expanding CDI to Physician Practices: Five Documentation Vulnerabilities to Address in 2016." *Journal of AHIMA* 87, no. 5 (May 2016): 22-25.

Centers for Medicare and Medicaid Services. "ICD-10-PCS Official Guidelines for Coding and Reporting." 2017.

Centers for Medicare and Medicaid Services. "The Quality Payment Program Overview Fact Sheet."

DeVault, Kathryn; Easterling, Sharon; and Kim Huey. "Role of Coding and Documentation in the Quality Payment Program." *Journal of AHIMA* 88, no. 1 (January 2017): 52-55.

Resource Initiative and Society for Education. "Is There a Grey Zone in HCC Coding?"

Wieczorek, Michelle M. and Jill S. Clark. "Curing Inherited EHR Ailments: EHR Remediation Fixes System Issues and Better Aligns Clinical Workflow with Clinical Documentation." *Journal of AHIMA* 85, no. 9 (September 2014): 56-58.

Prepared By

Erin Barnette, CCS, CPC
Melanie Endicott, MBA/HCM, RHIA, CDIP, CHDA, CCS, CCS-P, FAHIMA

Cheryl Ericson, MSN, RN, CDIP, CCDS
Michelle Wieczorek, RN, RHIT, CPHQ

Acknowledgements

Maria Barbetta, RHIA
Aurae Beidler, MHA, RHIA, CHC, CHPS
Patty Buttner, RHIA, CDIP, CHDA, CCS
Dan Christopher, RHIA
Tammy Combs, MSN, RN, CDIP, CCS, CCDS
Angie Comfort, RHIA, CDIP, CCS
Ann D'Arcy-James, RHIA
Lesley Kadlec, MA, RHIA, CHDA
Carole Liebner, RHIT, CCS
Beth Liette, MS, RHIA|
Laurie Miller, RHIT, CCS-P
Chinedum Mogbo, RHIA, CDIP, CCS
Donna Rugg, RHIT, CDIP, CCS
Nilgun Sezginis, MPH, RHIA, CCS-P
Nicole Van Andel, MS, RHIA, CHPS
Lou Ann Wiedemann, MS, RHIA, CDIP, CHDA, FAHIMA
Joan Wilder, MSHI, RHIA, CPC
Holly Woemmel, MA, RHIA, CHPS

Article citation:
Barnette, Erin; Endicott, Melanie; Ericson, Cheryl E; Wieczorek, Michelle M.. "Evolving Roles in Clinical Documentation Improvement: Physician Practice Opportunities" *Journal of AHIMA* 88, no.5 (May 2017): 54-58.