

Proceedings of AHIMA's 2017 Summit on Clinical Documentation Improvement: Advancing the Documentation Journey

AHIMA held a clinical documentation improvement (CDI) summit on July 31–August 1, 2017. The summit is an annual AHIMA event that brings together speakers with expertise in advancing the documentation journey in today's complex healthcare environment. Speakers discussed their experiences with advancing mobile query technology, documentation nuances, the relationship between the physician and the electronic health record (EHR), and federal recoupment initiatives. Additional topics focused on program improvement efforts and leadership, outpatient CDI, physician engagement and education, coding and CDI synergy, clinical validation, CDI in specialty areas, and regulatory issues. The summit is an excellent venue for the sharing of best practices, challenges and issues affecting CDI oversight and management. This paper summarizes the speakers' presentations and the key takeaways from the summit as shared by the 2017 CDI Summit Program Committee.

Keynote Presentations

Transforming Query Delivery and Tracking with Mobile Technology for Providers

Speakers: Melinda Kantsiper, MD, and Teri Gruenberg, RN

Accuracy in documentation and coding leads to positive clinical outcomes, such as integrity of the record, quality measures, patient safety, continuity of care, and population health. The financial implications include optimal reimbursement, case mix index, present on admission/hospital-acquired condition classification, rankings/reputation, and risk avoidance. The physician query response directly affects the quality of documentation and the accuracy of coding.

Howard County General Hospital conducted a pilot study of mobile query technology from September 2016 to January 2017. The study included 70 hospital medicine and intensive care unit providers and 25 CDI and coding staff. The study investigated whether mobile querying (via text message notification) would reduce the burden on providers, make the query process easier/faster, and possibly motivate providers to respond to queries. The pilot study led to some conclusions. Mobile query technology was successful because it was efficient (providers could

respond in less than a minute), convenient (accessible from smartphone, desktop, or EHR), easy to use (intuitive design; the provider's response would appear as a separate progress note in the chart in the EHR), and motivating (providers could view individual scorecards, view peer comparisons, and engage in friendly competition).

The mobile query technology pilot streamlined the query process by reducing the number of steps involved. It included automated query tracking, provider notification, and delivery of reports. It was convenient, and providers were not "chased down" for every query. The simple design included an intuitive user interface for the query author and responder. There was a collaborative, team approach. Reporting increased the visibility and accountability of providers and clinical documentation specialists (CDSs). Also, the individual scorecards and peer comparisons spurred increased query response rates from the providers. The CDI productivity improved, with CDSs periodically reviewing greater than 20 percent more charts. Most importantly, a result was increased provider happiness, which was priceless.

Clinical Case Studies to Illustrate Documentation Nuances, Query Opportunities, and MS-DRG/APR-DRG Analyses

Speakers: Wilbur Lo, MD, CDIP, CCA, and Melissa Koehler, RHIT, CHDA, CDIP, CCS, CCS-P

Five clinically complex case studies were evaluated using an interactive format drawing on the audience's participation. The focus of these studies aimed to minimize the gap between clinical language used by medical providers and the terminology of ICD-10-CM/PCS code sets relied upon by coding professionals. The case studies that were discussed allowed the audience to learn how to efficiently navigate through the documentation to identify query opportunities, generate effective queries, and analyze working and targeted MS-DRGs (Medicare Severity Diagnosis Related Groups) and APR-DRGs (All Patients Refined Diagnosis Related Groups), as well as severity of illness (SOI)/risk of mortality (ROM) scores.

The seven characteristics of high-quality clinical documentation include legibility, reliability, precision, completeness, consistency, clarity, and timeliness (Hess, 2015). These characteristics were analyzed in each case study from both a physician and coding approach when performing CDI health record reviews. The first step is delving into the assessment results of diagnostic and laboratory studies as well as prescribed treatment modalities and medications before reviewing provider narratives of the patient's conditions. With that approach in mind, the next step is to assess the descriptions of the patient's presenting signs and symptoms, followed by the lists of diagnostic tests and prescribed treatments. The documentation is then dissected into differential diagnoses. This step identifies the working DRG, query opportunities, and the target DRG. A DRG analysis is performed by identifying separate examinations of the working and target DRGs and providing comparisons of relevant weights as well as SOI and ROM scores. The interactive format of the discussion energized the audience and left them eager to explore the complexities of CDI documentation analysis with new tools in hand.

The Doctor and the EHR: Diagnostician or Document Manager

Speaker: Marie T. Brown, MD, FACP

Some positive perspectives on the EHR include e-prescribing, clinical decision support, virtual consults, and patient portals. However, the EHR also has many negatives, such as physicians spending too much time doing clerical work, which reduces face-to-face time with the patient.

One study revealed that for every one hour of face-to-face time, physicians are spending two hours on the EHR. Physicians are getting burnt out at a staggering rate.

[STEPS Forward](#) is a website that offers numerous free toolkits for physicians to assist them in improving their workflow and removing some of the administrative burdens that they currently face. One suggestion is to have the patients fill out a checklist in the waiting room that asks them to validate medications, list the issues they would like to discuss, and so forth. These solutions will allow physicians to spend more quality time with the patients, rather than staring at the EHR screen and checking off boxes. Other solutions include reviewing the record with the patient (looking at the screen together), having a printer in every patient room, and practicing “team documentation.” An example of team documentation is to have two medical assistants (MAs) assigned to each MD and have the MAs do the majority of the documenting so that the physician can spend more time with the patient.

These improvements can save physicians three to five hours per day in administrative work, which enables them to see more patients, all while spending more face-to-face time with these patients.

Clinical Documentation Improvement as a Response to Federal Recoupment Initiatives

Speaker: Barry S. Herrin, JD, CHPS, FACHE, FAHIMA

The concept of “low-hanging fruit” is a motivational factor in Recovery Audit Contractor (RAC) audits. The following diagnoses are some of the most common areas of recoupment activity: renal and urinary tract disorders, surgical cardiovascular procedures, acute inpatient admissions for neurological disorders, and outpatient services billed as inpatient encounters. The application of overpayment recoupment provisions under the Patient Protection and Affordable Care Act as well as Medicare Conditions of Participation provisions were illustrated with specific examples seen in practices. Some reasons for queries include ineffective practices of resulting from having the practice’s utilization review department being absorbed into the case management function, creation of workarounds for physician satisfaction, submission of noncompliant (leading) queries, assumptive actions by coders, and misconceptions of providers.

It is important for CDI professionals to focus on revenue integrity, understanding that the outcome of such an approach may not be an increase in billing, but rather keeping more of what has been billed. Correct coding may mean lower initial reimbursement but more certainty in the revenue picture. To ensure success, revenue integrity initiatives can be initiated, such as creating teams of internal experts, which may include health information management (HIM), case management, nursing, medical staff, billing, and corporate compliance. The continuous training of staff is important and can include teaching physicians the basics of coding and teaching coders about clinical documentation processes. One way to provide this education is by having CDI professionals involved in reviewing health records for content on the floor during episodes of care. Coding is a HIM function, not a business office function. Some postulates that can be beneficial to follow include “just because you have a code doesn’t mean it’s covered,” “just because you’ve been paid once doesn’t mean you’ll get paid again,” and “not knowing the rules can land you in jail.”

Program Improvement and Leadership Track

Jump-starting an Established CDI Program

Speaker: Sandy Pearson, MHA, RHIA, CHDA

As clinical documentation programs mature, one of the major concerns becomes “what’s next?” After one achieves initial ongoing success, it becomes easy to maintain the status quo. The quick answer is to explore internal operations. The lengthy answer is to *carefully* examine internal operations including staffing, internal leadership, CDI, and physician education. This case study demonstrated how Catholic Health System, a large multihospital network, reviewed its internal practices and created a potential road map for other organizations to improve their operations for continued growth. Also included in their internal review was a SWOT (strengths, weaknesses, opportunities, and threats) analysis.

As a direct outcome of their study, the CDI director noted that a much-needed investment in their staff, on all levels, was necessary for attaining continued growth. The areas of focus included enhancing automated staff productivity metrics, refining CDI skills, and improving staffing. The program increased feedback and accountability regarding individual and team productivity metrics, reinforced education for CDI staff in weekly educational sessions and monthly staff meetings (coding collaboration, etc.), and standardization of workflows (query templates) across the department, including onboarding. A robust physician education program was also implemented. Lastly, as part of a retention and staff development initiative, a CDI career ladder was implemented.

As a result of all their investments, the program now has an improved query rate, exceeded executive leadership’s goals as a “blue chip” program, and improved staff performance.

Building Stronger CDI Leaders across the Enterprise

Speakers: Andrea McLeod, RHIT, BAS, and Judy Moreau, RN, BMA

Despite the vast resources that exist for building CDI programs and developing professionals, somewhat less information is available for ensuring that CDI leaders are trained to adequately manage the workforce. Ideally, through proper training and development, CDI leaders will be able to develop and manage the talent within the department, and not leave because of overwhelming or unclear expectations. Trinity Health, a 22-hospital system, sought to enhance its leadership over two years.

Among the first steps was to determine the barriers to increasing the quality of their leadership. The barriers that were discovered included competing priorities from other responsibilities (HIM and case management), lack of comprehension of CDI workflows (case reviews, software, and metrics), limited engagement, and no previous experience managing CDIs.

After conducting this research, they educated their CDI leaders on the importance of high-level metrics (dashboards and associated tracking tools), the effect of individual productivity on the department, and the assessment of trending metrics over time. This education also included how to generate reports and give feedback on productivity to CDI professionals. Some of the education was more granular, such as teaching directors when a CDI professional should review the record, what encompasses a case review, and how to review auto-suggested codes and spot-

check work. The efforts led to overall improvement in the visibility and recognition of CDI leadership among executive leadership, an understanding of how to track the quality of work and management, and an increase in engagement.

Beyond the Inpatient CDI Track

Outpatient Clinical Documentation Improvement (CDI): Practical Lessons Learned in an Emergency Department (ED) Assessment

Speakers: Betty Stump, MHA, RHIT, CCS-P, CDIP, CPC, CMPA, and Stephanie Cantin-Smith, RN, MSN, CCDS

Outpatient CDI programs have not been utilized by many healthcare organizations. However, accurate and complete documentation that reflects patient care is the ultimate goal, whether care is provided in an outpatient or inpatient setting. Although outpatient and inpatient settings have differences and similarities, documentation drives coding in both settings. When reviewing medical records, the coding professionals and the revenue cycle team do not focus on documentation improvement; their goal is to have the visit/service coded and the claim submitted. Thus, an outpatient CDI program needs to be established to close the gap between the clinical care provided and documented, and the accuracy of codes submitted for reimbursement for the services provided.

A big driver of outpatient CDI is the Affordable Care Act (ACA). The ACA was innovative in some of its provisions in terms of shifting the environment from fee-for-service to pay for quality. There is going to be a tremendous outreach of value-based programs because of the ACA. Furthermore, we will see an increase in care delivery improvements through innovations and transparency. In addition to the government agencies, many commercial payers, such as United Healthcare, Humana, and Kaiser, are reviewing submitted claims for supporting documentation for services they are asked to reimburse.

Nontraditional outpatient practice settings face some challenges in implementing CDI programs. Different documentation improvement strategies need to be used in alternative settings. However, complete and clinically accurate documentation that supports accurate coding is necessary in both settings, and reimbursement is the same rule for both settings. Accurate documentation results in decreased denials and better-quality reporting.

Emergency department services, ambulatory services, diagnostics, clinics, rehab, observation, and physician practices are some of the areas that could benefit from establishing an outpatient CDI program. When establishing a new outpatient CDI program is being considered, potential outpatient areas that are going to benefit from the program and the key stakeholders need to be identified, and more needs to be learned about their documentation and billing process. Therefore, the best practice before establishing the program is to meet and interview the stakeholders and dedicate time to review the revenue cycle from registration through billing. Furthermore, it is important to focus on educational needs of physicians and ancillary staff regarding complaint documentation, medical necessity, and chargemaster descriptions. By working proactively on outpatient documentation, accurate documentation can be used to prevent outpatient claim denials and adverse audit outcomes, and outpatient facilities can be prepared for value-based and risk-adjusted payment methodologies.

Risk Adjustment and Quality Measures for Outpatient CDI

Speakers: Pamela Hess, MA, RHIA, CCS, CDIP, CPC, and Michael Marron-Stearns, MD, CPC, CFPC

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a Medicare program that pays physician practices that deliver high-quality care at a low cost. Providers have two reporting pathways under this program: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The MIPS program will assign a MIPS score to providers and groups based on their performances. Providers who are engaged in a Medicare-approved APM do not have to participate in MIPS. Providers in an APM will receive an incentive payment of 5 percent for their part B payments for the first six years. The role of CDI professionals will need to be expanded to outpatient settings to capture all of the documentation requirements associated with MACRA.

Several strategies are essential for outpatient CDI programs. The first strategy is in-line documentation that prompts providers to capture certain measures within their notes. Some key components of outpatient CDI programs include an overarching governance structure, data and analytic reporting, case reviews, a redesigned CDI workflow, and ongoing provider education. In redesigning the workflow, certain steps can be taken to support success. First, meet with stakeholders such as providers and clinic managers to obtain buy-in for the program. Then discuss the process, such as which cases will be reviewed, where the case review will take place (on-site or remote), when the review will occur (before, during, or after the encounter), and what the query process will be. A tracking mechanism will need to be set up to monitor the success and opportunities of the program. Finally, a schedule should in place to deliver trend reports to the stakeholders.

Coding/CDI Synergy Track

DRG Reconciliation: Improving Collaboration between CDI and Coding

Speakers: Kristen Bates, MBA, RHIA, CCS, CDIP; Susan E. Belley, MEd, RHIA, CPHQ; and Audrey G. Howard, RHIA

DRG reconciliation is a process of second-level prebill review for mismatch between a CDI working DRG and the final coded DRG. By definition, the process involves clinical and coding professionals, and the mismatch is triggered by disagreement between these two professional groups, requiring further review. The ultimate purposes of the DRG reconciliation process are to validate that the final coded data reflect the overall severity of the patient, verify that the assigned codes accurately capture the clinical documentation while complying with coding guidelines and other regulatory requirements, assess for query opportunities, ensure accurate and appropriate payment, and reduce denials. The challenges in the DRG reconciliation process include revenue cycle pressure, time, staffing, and the feedback loop.

To illustrate the process of DRG reconciliation with its challenges and to offer solutions for a more efficient process, the DRG reconciliation process revitalization project at the University Hospitals of Northeast Ohio (UH), an 18-hospital network serving 1 million individual patients,

was examined. UH's CDI program was established in 1995, and the DRG reconciliation process was started in 1997. The lack of a centralized, systemwide prebill DRG mismatch reconciliation process with data tracking was identified at UH. The hospital contracted with consultants to provide a six-month full-time auditing resource with weekly status reporting, educational feedback, and process improvement recommendations. The results of the audit allowed them to identify missed opportunities for both the CDI and coding teams and offered solutions for greater collaboration between the two teams, including separate weekly huddle meetings between the two teams, additional communication between the teams, immediate individual feedback, and additional education for each team.

Benefits Realization from Collaboration: Embracing and Integrating the Focus on Clinical Data Integrity

Speaker: Bonnie Cassidy, RHIA

Clinical documentation integrity has never been more vital to healthcare, because performance-based payments are now linked to quality measures. Health information governance (IG) and clinical documentation integrity are changing under the new MACRA legislation. Patient-to-payment workflow is illustrated by using the following steps:

1. Patient access,
2. Charge integrity and compliance,
3. Health information management,
4. Claims and billing,
5. Contract and episode management, and
6. Recovery and collections.

Collaboration is the key to having a system in place that produces clinical documentation integrity. This collaboration will also assist in improving patient care, revenue, and compliance.

As in other industries, IG is important in healthcare because of the need for trusted information. IG should be considered the "source of truth" for health information. With the implementation of MACRA, the Medicare Sustainable Growth Rate ended and the Quality Payment Program began. MACRA will likely result in HIM and CDI professionals finding themselves in the center of these quality efforts because documentation and coding are the key components of quality reporting. Ongoing monitoring of performance measures is also needed to determine the organization's success. Some key actions that can be taken to ensure the integrity of clinical information at the point of care include being champions for CDI, embracing population health management, implementing an IG infrastructure, excelling in accurate documentation and coding, being data stewards, and initiating collaboration.

Physician Engagement/Education Track

Documenting to Reduce Denials

Speaker: Timothy Brundage, MD, CCDS

CDI experts as frontline support can educate providers on the key points to include in documentation consistently throughout the chart. If providers are properly educated and reminded to document the clinical criteria as specifically as possible, the CDI team will be able to capture the accurate Present on Admission (POA) indicators, Hierarchical Condition Categories (HCCs), and severity and risk indices needed to classify the patient's care and condition. Helpful reminders, pocket cards, placards, and flyers in nursing stations, doctors' lounges, and offices provide helpful reminders and point-of-care tips. Lessons should be kept short, succinct, and as specific as possible to the provider. Lessons can focus on thinking about key medical history elements such as "not sick, sick, very sick" rather than "non-CC, CC, MCC" (complication or comorbidity; major complication or comorbidity).

CDI professionals can advise providers to use the physical exam to support the acuity and severity of the chief complaint or principal diagnoses; use the Assessment and Plan documentation to list all possible and confirmed diagnoses with statements of the type "if A, then 1, 2, 3; if B, then 4, 5, 6." Online resources and diagnosis-specific cards are available from specialty societies or consulting companies that help outline diagnosis-specific criteria in clinical terms; providers should be encouraged to use these for patient notes. As providers include more detail in their notes and hand off patient care between providers, they must avoid simple "copy and paste" notes; the documentation needs to be updated to reflect the unique elements of care on that date.

Revolutionizing the Clinical Encounter: It's About Time

Speakers: Christina Meyers, RHIA, and Sandra Fuller, MA, RHIA

Documentation challenges include more stringent requirements in the changing landscape of value-based purchasing with the MACRA legislation, which instituted the Quality Payment Program, MIPS, and APMs. Also, the levels of evaluation and management (E/M) hinge upon documentation of the history, physical exam, and determination of the complexity of medical decision making. Risk adjustment and HCCs necessitate reporting of conditions that were measured, evaluated, assessed, and treated during face-to-face encounters. Chronic conditions should be documented in the record at least once annually.

Systemic documentation issues include "note bloat," which leads to abundant data with minimal information. Factors contributing to note bloat include the practice of defensive medicine and unnecessary utilization of the copy/paste function. If several physicians copied and pasted the same information throughout the record, there might be a problem with attribution, in which the source and authenticity of data would be questioned.

Because of advances in technology, patients are becoming more clinically aligned. Patients may measure, record, or transmit data about medications and treatment. Patients may monitor blood sugar, blood pressure, and breathing via electronic applications. The evolution of patient-generated data leads to issues such as data analyses and integrity.

Solutions for documentation issues include EHR 2.0 tools, such as groupware that uses mobile and ambient listening tools to support teams of caregivers focused on value while treating patients. Medical scribes are emerging in ambulatory care settings and should be familiar with medical terminology, pathophysiology, and pharmacology and the treatment of conditions prevalent in their respective facilities. An extension of the medical scribe is voice-enabled CDI, which allows a physician to dictate the patient's history, examination, diagnoses, and treatment

while the patient is in the office. A CDI/coding expert will listen to the dictation in real time and will interact with the physician to provide documentation guidance and capture the patient's narrative.

Medical Residents as Key Players in Documentation

Speaker: May Ladrillono, MD, MBA-HM, CDIP

Residents are the first line in documentation for many hospital systems. They do not learn CDI or the importance of documentation in medical school, so they must learn it as they become practicing physicians in residency. The connection of CDI to residency programs can be started by identifying a physician champion within the core faculty of each residency program. CDI specialists can best help the residents by finding access points for initial and follow-up education, providing frequent verbal and written reminders to improve documentation.

CDI specialists can initiate the relationship during the residents' orientation and continue on a periodic basis. The timing of repeat/additional education is based on the identified common documentation issues, top 10 to 20 diagnoses, or query topics. They can seek reinforcement for documentation issues, unresolved queries, and incomplete documentation by learning the hierarchy of the specific residency program and working within that hierarchy to achieve compliance and success. The physician champion, chief residents, program director, and/or department chair can include CDI education in rounds to achieve better clinical documentation consistency, completeness, and compliance.

Out of the Darkness into the Light: A Surgeon's Perspective

Speaker: Daniel Catalano, MD

Physicians are often overwhelmed by the many requirements of patient care and administrative responsibilities. Increasing pressures to produce in higher quantities or higher quality may appear to the provider as a reason to ignore CDI. However, this challenge is shared among providers, HIM professionals, and CDI specialists, which can provide the common-ground starting point for provider education. CDI is easily overlooked or lost in the frustration of daily practice. HIM and CDI professionals can influence providers by offering statistics about the effect of CDI on their patient care, quality statistics, and comparative data. Providers will understand specifics and data better than generalities.

To improve provider compliance, CDI specialists should focus more on the improvement to patient care and the ability to make documentation more efficient, rather than on the financial effect on the hospital. CDI specialists should first get to know their providers and establish a relationship with them through department meetings, grand rounds, and medical staff meetings. Charts, tables, and statistics that translate patient severity of illness, acuity of care, and risk of mortality into their quality indicators are helpful for visual learners. One-on-one sessions during rounds, while providers are documenting on the floor or in the emergency department, are a good way to educate certain auditory learners.

Clinical Validation Track

Clinical Validation: What Does It Mean for Coders?

Speaker: Laura Legg, RHIT, CCS, CDIP

The goal of a CDI program is to have any documentation issues resolved before final code assignment. To prevent clinical validation denials, CDI and coding professionals need to identify gaps in documentation and send relevant queries, know what the payer targets are, know the deficiencies and how to correct them, and do prebill audits. Providers must establish defined criteria for target diagnoses and be educated on best-practice documentation, which includes stating the diagnosis along with clinical indicators to support the diagnosis, and describing the treatment plan.

The attending physician is ultimately responsible for determining which diagnoses are appropriate, and the provider can base the decision on any clinical indicators that he or she determines to be relevant. Coding professionals with strong clinical knowledge (either through education or experience) should feel confident reviewing documentation for clinical validation. They must have solid knowledge of medical terminology, anatomy, pathophysiology, and pharmacology. Coding professionals should be applying clinical knowledge alongside the coding rules and guidelines as they are making code assignments. They must improve their oral and written communication skills and be able to effectively interact with clinical staff.

Clinical Validation: The Real World

Speaker: Richard D. Pinson, MD, FACP, CCS

According to the Centers for Medicare and Medicaid Services (CMS) RAC Statement of Work, “Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record...and is beyond the...skills of a certified coder.” While this position is controversial, it does not exclude seasoned coding professionals from performing clinical validation.

Another layer of complexity in clinical validation was provided by *Coding Clinic* (Fourth Quarter 2016, pp. 147–49): “Clinical validation is a separate function from the coding process” and “Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.” This guideline reaffirmed the long-standing position that physician documentation serves as the basis for coding. Only a qualified provider can “diagnose” patients, and *Coding Clinic* does not establish diagnostic criteria.

The updated practice brief “Clinical Validation: The Next Level of CDI,” in the December 2016 *Journal of AHIMA* provided a nice synopsis of clinical validation: “It appears clinical validation may be most appropriate under the purview of the CDI professional with advanced clinical education and a background in conducting clinical reviews...Facilities need to establish their own criteria for the credentials, education, and experience required...The goal of clinical validation is to ensure that the health record is not only coded accurately, but also accurately reflects the clinical scenario...and...requires collaboration among providers, CDI professionals, and coding professionals.”

Coding is based on provider documentation. Widely accepted, authoritative, consensus, and evidence-based diagnostic criteria are the standard for clinical validation. Coders with a strong clinical foundation and a background in conducting clinical reviews are suitable candidates to perform clinical validation for CDI programs. Moreover, clinical validation requires collaboration between providers, coders, and documentation specialists. Facilities should establish policies and procedures for compliant documentation, coding, and clinical validation.

CDI in Specialty Areas Track

Tale of Two ACOs: Deploying a Centralized CDI Model across ACO Physician Practices Speakers: Kimberly Hopey, PhD, RN, and Stacey Torturica, CPC, CPMA, CRC, AAPC

Accountable care organizations (ACOs) are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated, high-quality care to their Medicare patients. The goal of this care coordination is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves from the Medicare program.

The HCC model is being used to “risk adjust” the payments to ACO facilities. HCC coding is prospective in nature—the diagnoses that are reported in this year for a patient set the Risk Adjustment Factor (RAF) score and affect payment for the following year. Every chronic, nonresolving diagnosis must be reported at least once during the calendar year to be included in the patient’s RAF score. For these codes to be accurately assigned, they must be supported by coding guidelines and must show evidence that they have been monitored, evaluated, assessed, or treated. The capturing of these diagnoses sometimes requires an increase in provider documentation, which is where CDI comes in.

Outpatient CDI is very different than inpatient CDI. Some of the challenges in the physician office are that the focus of documentation is often on supporting E/M billing alone, there is a lack of understanding of risk-adjustment methodologies, some physicians do not think beyond the chief complaint, and the chronic conditions may be listed in the problem list but not mentioned or discussed in the current documentation. CDI can have a huge influence in the physician office by educating physicians on best practices for documentation, prompting providers to state the diagnosis to the highest level of specificity, and ensuring compliance.

Pediatric Diagnosis Specificity: Distilling Diagnoses to Their Core Attributes, Making CDS Communication to Physicians Concise and Consistent

Speaker: John Glatthorn

It is important to involve physicians in the CDI process of obtaining greater specificity in documentation. In defense-oriented charting, the documentation is defending the care that was provided. The process of distilling the documentation occurs by educating providers on documentation requirements. To start, looking at the raw code set can help to identify any patterns. These are characteristics that influence the problem’s specificity.

An example of distilled documentation is in regard to traumatic fractures. Rather than telling the provider to understand all of the codes that are related to this condition, the education should focus on the characteristics that need to be brought into the documentation. The characteristics for this condition include open/closed, with/without displacement, type, laterality, bone, site on bone, healing status, and episode of care. Another example is the scoliosis family of diagnoses, which includes the characteristics of infantile, juvenile, or adolescent; scoliosis, lordosis, or kyphosis; and the spinal region.

A pediatric consideration with the surgery codes is that they are still largely based on adult anatomy rather than congenital malformation. CDI success can be measured by utilizing dashboards and scorecards for providers, creating policies, and correlating unspecified documentation to denials.

Regulatory Hot Topics Track

The Role of Risk Adjustment in Value-based Purchasing

Speaker: Angela Carmichael, MBA, RHIA, CDIP, CCS, CCS-P, CRC

Value-based purchasing (VBP) has become an integral part of revenue capture opportunity. Over time, it behooves most healthcare institutions to have a robust VBP program. An essential aspect of VBP is risk adjustment, especially HCCs. HCCs are diagnostic categories or “buckets.” Each of the 79 HCCs is based on reported claims data (inpatient, outpatient, and physician). HCCs set payments to Medicare Advantage programs, and a predetermined methodology creates a patient risk score, which provides accurate performance targets for physicians who treat a more acutely ill population.

The patient risk score is based on the CMS HCC score from all claims submitted for one calendar year. Each chronic condition needs to be reported at least once a year during a face-to-face interaction with an acceptable provider, in an acceptable setting. If at all possible, diagnoses should not “fall off” a claim. A diagnosis falling off a claim is an indicator of documentation gaps or a lack of stakeholder awareness. Provider education (emergency room, inpatient, outpatient, physician practices, etc.) with reinforcement of the importance of continuity of diagnoses, completeness and accuracy, and documentation with clinical support will likely reduce documentation gaps and enable program success.

Coding versus Auditing: Does It Boil Down to Medical Necessity?

Speaker: Shannon DeConda, CPC, CPC-1, CPMA, CMSCS, CEMC, CMPM

The EHR system was developed to improve documentation and quality of services provided; however, since its implementation, it has affected the quality of documentation, and it is taking humanity out of the clinical notes because of the templates and bullets that need to be addressed to complete each patient’s visit. Clinicians are therefore experiencing difficulties in complying with complex documentation guidelines. Physicians are advised to print out and review the final product so that they can compare the information they entered and the E/M level that is being billed.

Three key people are involved in documentation, and all three of them look at the documentation from different perspectives. The physician values the medical work and would like to get paid for the work performed. A coding professional is trained to look for the documentation and is not taught to review for medical necessity. However, auditors are trained to look for medical necessity and the complexity of the care provided. Documentation of the complexity of medical decision making should be based on the patient's presenting problem. Therefore, there is a need for professionals who are experts in E/M guidelines to train physicians; these experts usually are not physicians, who are trained to take care of patients, not to understand the E/M guidelines. No measuring stick is available to measure medical necessity; rather, it is driven by the patient's presenting problem and how that presenting problem was treated during the visit.

Coding professionals play an important role in the billing process, and they should be defensive in assigning E/M codes. They need to make sure that they are being compliant before claims are submitted for billing and reimbursement; otherwise, the practice can end up in a legal battle and be asked to pay fines. For example, the average office visit E/M code for a physician is 99213, and the average reimbursement is \$73. In one clinic day, the office can make \$2,336 if the physician sees four patients per hour in an eight-hour clinic day. If the physician's office is audited because of a bad claim and is found to violate the False Claims Act, the office can be asked to pay \$40,000 in fines. Some Medicare payers do not pay for modifier 24 until after they audit the documentation. Therefore, practices should be proactive and audit claims with the modifier 24 before they submit them for reimbursement.

Conclusion

In conclusion, the 2017 CDI summit delivered educational sessions on the hot topics affecting the CDI profession. One of the key takeaways from this summit is the importance of outpatient CDI with the new MACRA legislation. Another hot topic that was discussed in several presentations is the impact of CDI on clinical validation. A track was dedicated to the topic of clinical validation, with experts providing guidance in this controversial topic. Other important themes discussed during the summit included medical necessity, audits, value-based purchasing, physician education, the expansion of CDI programs into specialty areas, and federal regulations that govern CDI.

The need for CDI programs is on the rise. This expansion brings opportunities for CDI programs to grow and improve processes. It is crucial for all healthcare organizations to ensure that their clinical documentation across the healthcare spectrum meets high quality standards.

CDI Summit Presenters

Melinda Kantsiper, MD, is an Assistant Professor of Medicine at the Johns Hopkins School of Medicine.

Teri Gruenberg, RN, is the Clinical Documentation Program Manager at Howard County General Hospital.

Wilbur Lo, MD, CDIP, CCA, is an AHIMA-Approved ICD-10-CM/PCS, and faculty member for the AHIMA World Congress, consultant for AHIMA Domestic CDI Initiatives, and CDI consultant for Jzanus.

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