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PRACTICE BRIEF

Prospective Clinical Documentation Integrity (CDI) Reviews and Query/Alert Practice Best Standards

AHIMA

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Introduction

Clinical documentation integrity (CDI) and technology continue to evolve across the continuum of care, including both the inpatient and outpatient settings. The expansion of CDI and advancing technology has resulted in the need for prospective CDI health record reviews.

CDI professionals are trained to perform concurrent, prebill, and/or retrospective reviews that may result in queries for documentation when further clarification is needed. A concurrent CDI review occurs during an encounter/visit; a prebill review occurs prior to claim submission; and a retrospective CDI review is performed after an encounter/discharge.

Traditionally, these types of reviews were performed by CDI professionals, but technology and automation have significantly augmented or replaced CDI efforts.

Technology is being leveraged to alert providers of an opportunity to be more specific in their documentation or "remind" them to document chronic conditions based on previously documented diagnoses in the patient's health record. The uniqueness of a prospective review, whether performed by a CDI professional or a computer automated review, necessitates the need for guidance and best practices to ensure adherence to industry query practice standards.

A prospective review is performed before a patient is seen by the provider. It involves a review of previous encounter(s) to identify potential chronic conditions in order to prompt the provider to address those conditions that require additional specificity for accurate code assignment and reporting.

For example, a prospective review may identify the use of insulin per the patient's medication list and a recent telephone refill note, but no documentation of an associated diagnosis. The provider is presented with a "documentation alert," prior to the patient's arrival.

These documentation alerts can take a variety of forms, such as a notification alert within the electronic health record (EHR) or a query by a CDI professional. Some providers may identify these as friendly alerts and/or clarifications, but since this is a new area of opportunity for CDI professionals, it is vital for the CDI and coding industry to clearly establish a streamlined query and alert process. As defined in the AHIMA/ACDIS Guidelines for Achieving Compliant Query Practice Brief (2019 Update)[1]:

> A query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment for an individual encounter in any healthcare setting. Synonymous terms for "query" include clarification, clinical clarification, and documentation clarification. Documentation queries (referred to as "queries" in this Practice Brief) are used by coding professionals, CDI professionals, and all professionals responsible for documentation clarification or who have oversight and/or involvement in the query process".

The AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice Brief (2019 Update) also provides guidance regarding when including previous encounter information on a query.[1]

When considering whether a query could be issued using information in the prior record, carefully consider the "General Rules for Other (Additional) Diagnoses" that states: "For reporting purposes the definition for 'other diagnoses' is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring," according to *ICD-10-CM Official Guidelines for Coding and Reporting, Section III*. It would be inappropriate to query for a diagnosis that, if documented, would not satisfy this criteria. A query cannot be based solely on the information from a prior encounter, there must be relevant information within the current encounter to substantiate the query.

The Guidelines for Achieving a Compliant Query Practice Brief (2019 Update) also notes[1]:

> Regardless of the credential, role, title, or use of technology, all healthcare professionals (whether or not they are AHIMA or ACDIS members) seeking to clarify provider documentation must follow compliant query guidelines.

The Guidelines for Achieving a Compliant Query Practice Brief (2019 Update) also recognized that there are professionals who may be "educating providers to document a certain way" outside of the CDI department that are also supporting organizational objectives related to documentation integrity.1 These professionals may not realize that "their interactions meet the definition of a query."[1] Since "their practices could alter coded data, they must ensure that their practices meet compliance standards."[1]

This same concept applies to current and future technology that may be marketed as a CDI tool and/or a non-CDI tool that leverages Natural Language Understanding (NLU) or Natural Language Processing (NLP) technology to identify documentation opportunities; for example, specific codes flagged as a Hierarchical Condition Category (HCC).

These tools leveraging NLU or NLP technology can create an inappropriate scenario where a provider is "led" to document an unsupported diagnosis, especially if these documentation alerts are not validated by a CDI professional and/or supported by current documentation. These tools may provide a documentation alert and/or recommendations for a code and/or query opportunity after reviewing the patient's entire health record and claims data. It is up to the CDI professional to determine whether these documentation alerts are relevant based on their knowledge and understanding of that specific patient before the next steps can be determined.

Alerts by definition are considered a prompt that acts as a communication tool to bring important information to someone's attention so that it can help with decision making. It is important for CDI professionals to understand that EHR "clinical alerts" should not be classified the same as documentation alerts that may fall under the definition of a query issued within the EHR or by an external tool.

The EHR may issue providers clinical/critical alerts that are used to help support clinical decisions (for example, abnormal lab values, common medications used to treat condition, allergies, infectious disease status, etc.) related to the patient's care and treatment plan. Therefore, these clinical alerts are not the same as the "documentation alerts/notifications" that should be monitored and reviewed by CDI professionals during their prospective review/query process.

For example, a tool may issue a documentation alert/opportunity for both pulmonary hypertension and acute stroke after the software reviewed all available documentation within the health record, along with historical claims data. A CDI professional would evaluate these documentation alerts and determine whether they are appropriate or not supported.

The CDI professional in this scenario might determine that the acute stroke was from a previous year and the condition resolved, so the alert is not appropriate. Investigation may reveal the pulmonary hypertension alert was suggested due to use of the medication Sildenafil that was recently refilled by the primary care provider.

Based on the CDI professional's experience, they know this medication can treat both pulmonary hypertension and erectile dysfunction. Upon further review of the record, the patient was documented to have erectile dysfunction for which Sildenafil was prescribed. The record did not contain any evidence to support the diagnosis of pulmonary hypertension.

This is an example of NLU/NLP driving an inappropriate documentation alert. It is vital for CDI professionals to review these potential documentation alerts prior to a provider receiving them. This will help minimize the amount of "noise" that providers receive from myriad EHR alerts.

In the event that the patient didn't have erectile dysfunction documented for the current encounter, the CDI professional may follow the guidelines mentioned in the practice brief and issue a compliant query for clinical significance and/or associated diagnosis related to the prescription of Sildenafil.

Technology-driven documentation alerts not reviewed by a CDI professional may increase the risk of documenting a clinically unsupported diagnosis or selecting a non-reportable diagnosis within the EHR for billing and reporting.

Many EHRs currently allow the provider to select/report their own diagnoses with hierarchical condition categories (HCC) identified in parentheses next to International Classification of Diseases (ICD) diagnosis codes. This additional designation may draw a provider's attention to these codes due to their awareness of its impact to a specific reimbursement methodology, without the consideration of whether there are clinical indicators and/or treatment supporting this diagnosis.

It is important for both providers and CDI professionals to remember the following coding guidelines: According to the ICD-10-CM Official Guidelines for Coding and Reporting, in the inpatient setting, "for reporting purposes, the definition for 'other diagnoses' is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring."[2]

As for outpatient services, it is appropriate to "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.

However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment." In addition, "chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."[2]

The goal of this practice brief is to provide best practices relating to prospective reviews and to recognize that there is a difference between documentation alerts/notifications designed to influence a provider's documentation versus a clinical alert/notification for clinical decision making at the time of charting by a provider. In most instances, these terms may be used interchangeably without realizing that they are two very different things.

When a Prospective Review and Documentation Alert Is Needed

As CDI professionals review records prospectively, a documentation alert may be required to obtain the accurate and complete provider documentation.

For example, a patient scheduled for their annual wellness visit may rarely visit their primary provider for additional care throughout the year. As a result, a CDI professional may conduct a prospective review prior to this annual visit to identify any potential documentation opportunities, so the provider is alerted to all of the patient's chronic conditions that may still be active, especially those that may be classified as an HCC.

The CDI professional may issue a compliant (non-leading) prospective documentation alert to the provider prior to the patient's scheduled visit as long as it complies with current query guidance. See examples of compliant documentation alters in the **Appendix** of this document.

To achieve compliance and avoid non-leading documentation alerts, "prior encounter information may be referenced in queries for clinical clarification and/or validation if it is clinically pertinent to the present encounter."[1]

However, it is inappropriate to mine a previous encounter's documentation to generate queries not related to the current encounter.[1] Mining would be defined as looking for previous information to generate an alert/query that is not supported by the current encounter. An example would be using previous encounter information to send an alert/query for pneumonia on a patient who had pneumonia one month ago, but is now presenting with GI symptoms and has no signs or symptoms of respiratory distress.

Documentation alerts should follow the same non-leading query guidelines as all other types of reviews by including clinical indicators (e.g., reference the location and writer of the relevant documentation, medication name, refill telephone notes, etc.) to support why a documentation alert is necessary.

Furthermore, "all clinically supported options should be included as well as additional options that permit the provider to craft their own alternate response. Options may include other, unknown, unable to determine, not clinically significant, integral to, or other similar wording."[1]

Below are some opportunities where a prospective review and documentation alert(s) may be warranted and sent to the provider prior to a patient's scheduled visit.

Chronic/Life-long Conditions

CDI professionals working in the outpatient setting need to be able to translate the provider's documentation into a format more readily conducive to code assignment. Just like the inpatient setting, there is a disconnect between how providers document in the health record and what is required for accurate code assignment. For example, the concept of a chronic condition.

ICD-10-CM Official Guidelines for Coding and Reporting state, "chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s) (FY 2020, page 114)."[2]

However, the guideline does not specify how the provider should denote a condition as chronic and what qualifies as treatment. Providers may think documenting a "history" of a "life-long" condition is sufficient for a coding professional to classify it as "chronic" condition, but this is not the case.

To support accurate code assignment, some conditions require the provider to clarify the condition as "chronic," while other conditions will default to the code for a "chronic" condition, if not specified. These conditions must meet specific criteria e.g., Uniform Hospital Discharge Data Set (UHDDS) which is highlighted in the following acronyms of MEAT/TAMPER.

Specifically, the documentation should demonstrate monitoring, evaluation, assessment, or treatment (MEAT); or treatment, assessment, monitoring/medicine, plan, evaluate or referral (TAMPER) to be reported as a codable diagnosis on a claim. MEAT/TAMPER are two of the common acronyms used by risk adjustment coding professionals to assist them in validating adequate clinical evidence and support for conditions in the health record. These acronyms provide guidance for the coder to assign ICD-10-CM codes or generate a prospective query.

A documentation alert for a chronic condition may ask the provider to clarify if, for example, atrial fibrillation remains a chronic condition and if it can be further specified as persistent, etc., or if the condition has been resolved by the recent ablation procedure. However, the health record for the current encounter must also support reporting requirements. It is not enough

for the provider to state the patient has "persistent atrial fibrillation" without meeting MEAT/TAMPER requirements.

Providers are likely to be receptive to documentation alerts to clarify the status of diagnoses as chronic or resolved. To support the billed evaluation and management (E/M) level, when time-based methodology is not used, providers must document medical decision making (MDM). MDM includes the number of diagnoses or chronic conditions that must be considered and how these conditions or comorbidities increase the complexity of care. Traditionally, professional billing focused on accurate depiction of E/M criteria, but due to the impact of chronic conditions on risk adjustment methodologies, that will be addressed in the next section, many professional coders have also become certified in risk adjustment. Many commercial insurers require additional criteria beyond "treatment and care" to justify the reporting of chronic conditions on claims data.

Adding to the complexity of defining chronic conditions, Medicare has its own criteria classifying chronic conditions.[3] A Medicare beneficiary is considered to have a chronic condition (CC) if the CMS administrative data includes a claim indicating that the beneficiary received a service or treatment for one of 27 different conditions as specified by ICD-10-CM codes.[3] This data is maintained in the Chronic Conditions Data Warehouse (CCW), which can be found here: www2.ccwdata.org/web/guest/home/#:~:text=The%20CMS%20Chronic%20Conditions%20Data%20Warehouse%20%28CCW%29%20provides,the%20files%20in%20preparation%20for%20their%20study%20analysis.

Hierarchical Condition Categories

Risk Adjustment Payment Methodologies use CMS-HCCs to assign a risk adjustment factor (RAF) to members participating in Medicare Advantage Plans and Affordable Care Act Health Plans (HHS-HCCs). The CMS-HCC model is based on accurate and complete documentation of ICD-10-CM codes that describe the severity and burden of illness for these patients.

Regarding the Medicare Advantage plan, CMS-HCCs accumulate annually on a per calendar year cadence. Prospective reviews are a primary method of validating prior year conditions that remain applicable in the current year by reminding the provider to address these conditions during the patient's annual visit.

In the Inpatient Prospective Payment System (IPPS), CMS-HCCs accumulate for the 12 months prior to a qualifying admission (e.g., an admission with a principal diagnosis of heart failure, pneumonia, myocardial infarction, COPD, etc.), for the purpose of risk adjustment.

Many health plans, provider group organizations, and vendors use some form of prospective CDI program to help improve the documentation of adjustable risk diagnoses to support coding data and quality of care for Healthcare Effectiveness Data and Information Set (HEDIS) and STAR measures and to reflect reimbursement accurately. Please reference the AHIMA Documentation and Coding Practices for Risk Adjustment and Hierarchical Condition Categories article for additional information: http://bok.ahima.org/doc?oid=302516#.X6rjekBFyUk.

Documentation alerts to support the reporting of HCCs may require clarification of the status of a diagnosis which is not classified as a chronic condition by coding guidance. It may also require additional specificity of a diagnosis that has been previously reported. These types of documentation alerts may also include clarification of health status codes such as a below the knee amputation (BKA). The provider should not only state the patient has a BKA but should also evaluate the stump and include other components of clinical indicators to support its reporting.

National Coverage Determinations/ Local Coverage Determinations

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for nationwide Medicare coverage for a specific medical service, procedure, or a device. NCDs generally outline medical necessity criteria by describing the conditions for which a service is covered or not covered. A Local Coverage Determinant (LCD) is developed by a Medicare Administrative Contractor (MAC) when there is not an NCD or additional guidance is required. In rare instances, if there is contradicting information in the NCD and Local LCD, the NCD overrides the LCD. (Source: Noridian)

Documentation requirements for NCDs and LCDs vary based on the type of service and can be categorized into four groups:

- NCDs/LCDs requiring one covered diagnosis coded in the claim
- NCDs/LCDs requiring two covered diagnoses from two groups to be coded in the claim
- NCDs/LCDs requiring documentation that is not captured by coding
- NCDs/LCDs requiring covered diagnoses (either one code or two codes from two groups) *and* additional documentation requirements not captured by coding

Due to the complex and varying documentation

requirements of NCDs and LCDs, existing coding and CDI practices are often inadequate to address these documentation requirements. Therefore, it is vital to analyze NCD/LCD requirements and their impact on the provider, prior to implementing preventive strategies. The most common reasons for documentation deficiencies are listed below.

- Documentation deficiencies due to lack of awareness in NCD and LCD requirements: As per NCDs/LCDs documentation requirements of some services are not limited to a single covered diagnosis. Most of the time providers, CDI specialists and coders are unaware of these additional requirements
- Deficiencies and process gaps in outpatient CDI processes/practices
- Most of the covered diagnoses listed in NCDs/LCDs have a minimal impact on DRGs. Therefore, there is a tendency to overlook these conditions during regular coding audits, DRG validations, and case management reviews
- Documenting and coding "unspecified" diagnoses, which are usually not covered in NCDs/LCDs
- Some services are indicated because of failed conservative therapy, inadequate response to less invasive methods or severe progression of existing chronic conditions. To prove the provision of these services or disease progression, either the provider needs to extensively document past management or past medical records must be added
- The claims can be denied based on NCD/LCD diagnosis even if the documentation and coding are accurate. This occurs when the number of coded diagnoses exceeds the number of form locators in UB04 (19 diagnoses codes and six procedure codes) or CMS1500 (12 diagnoses codes) and the covered diagnosis is listed at the end of the code sequence. Inpatient claims are more susceptible to this due to the increased number of diagnosis codes. In addition, there is a tendency to sequence health status codes (Z codes), and codes not impacting DRGs at the end, which will not be captured in the claim

These gaps in documentation and coding practices will have a detrimental impact on providers. If there are no concurrent processes to mitigate gaps, deficiencies will surface only after a claim denial. Since NCD/LCD requirements must be 100 percent fulfilled to receive payment (i.e., "all or none") almost all denied services will not be paid. It is challenging to correct documentation issues retrospectively, which will also raise red flags for Medicare. In addition, continuous denials based on NCDs/LCDs can increase the risk of government audits, which can result in recoupment based on extrapolations.

Even though the impact of improper management of NCD/LCD documentation can be detrimental, the existing practices are inadequate to address these concerns. Instead of implementing strategies to address all aspects, many providers are implementing retrospective measures ignoring the importance of prospective reviews. Best practices should start from the time the service is planned, ideally from the provider's office.

Targeted provider education must be coupled with the provision of better tools to improve documentation. These tools include but are not limited to prompts in the EMR, documentation templates, alerts, and hard stops. There are more than 1,500 NCDs and LCDs, many will have updates after two to three years, which emphasizes the importance of continuous monitoring and training of CDI professionals.

Infusions

Infusion can be defined as the administration of diagnostic, prophylactic, or therapeutic intravenous (IV) fluids and/or drugs given over a period of time.[4] Documentation requirements for infusions are based on NCDs/LCDs, coding guidelines or a combination of both. Therefore, the above discussion on NCDs/LCDs is applicable to infusions as well. However, there are also documentation concerns inherent to infusion services.

Hierarchy of the infusions is one of the main differences compared to other outpatient services.[5] Two types of hierarchy systems must be considered when assigning codes. According to CPT guidelines, chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services respectively, while all of these are primary to hydration services.[5] Infusions have the highest hierarchy and primary to pushes, which are primary to injections, which is depicted in the following list: [5]

I. Chemotherapy Infusion > Chemotherapy IV Push > Chemotherapy Injection
II. Non-chemotherapy Therapeutic, Prophylactic or Diagnostic* Infusions
III. Non-chemotherapy Therapeutic, Prophylactic or Diagnostic* IV Push
IV. Non-chemotherapy Therapeutic, Prophylactic or Diagnostic* Injections
V. Hydration Infusions

(*arranged in hierarchical order)

These encounters are often scheduled in advance which could lead to the need for documentation reviews/alerts to include the following information: the provider order, dosage, time duration of the infusion service (>15 minutes) and number of units are the key elements

required to assign appropriate codes for infusion services.

However, these may not be captured by the coder either due to lack of documentation, or lack of awareness of the correct practices. This documentation is available in nursing notes and medication administration records, and there is a possibility to overlook these documentations while relying heavily on provider documentation, which may lack correct details regarding drug administration.

Another concern is the difficulty in verifying start and stop times to calculate the total duration of the infusion. Errors in reporting the exact number of units and reporting wastage can also be challenging and should be supported in the documentation.

Comparing Inpatient and Outpatient Coding Guidelines

Section IV of the ICD-10-CM Official Guidelines for Coding and Reporting is dedicated to diagnostic coding for outpatient services, the 2021 guidelines can be found at www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf. Of note is that these guidelines do not supersede any chapter specific guidelines found within the guidelines, as well as the guidelines for use of abbreviations, symbols, punctuation, and other conventions found in ICD-10-CM. The terms "encounter" and "visit" are interchangeable, and the outpatient guidelines do not distinguish one from the other and consider these terms synonymous.

The outpatient guidelines differ from the inpatient guidelines in several ways.[6] First, the UHDDS definition of principal diagnosis is not applicable in the outpatient setting. The outpatient setting uses first-listed condition. The reason for this differentiation is because definitive diagnoses are not always established at the time of an outpatient visit, it may take several encounters before a diagnosis is confirmed.

Codes that describe signs and symptoms are acceptable for code assignment in the outpatient setting when a definitive diagnosis has not been made, although whenever possible, it is preferable to have a diagnosis documented, rather than a symptom. This also speaks to the "Uncertain Diagnosis" guideline for inpatients, which says if an uncertain diagnosis is documented at discharge it can be coded as if it exists in the inpatient setting.

In the outpatient setting, uncertain diagnoses are not coded. In the outpatient setting, the coder should code to the highest degree of certainty at the time of the encounter. For example, if a patient is being seen for a cough, extremity edema, and echo ordered, then the coder will assign the code for the cough and lower extremity edema.

A prospective review may reveal an echo showing EF of 35 percent, patient started on Lasix. The lack of specificity during prior encounters may support an alert during the impending encounter to indicate if a definitive diagnosis can be provided, such as chronic systolic congestive heart failure (CHF).

Another important outpatient guideline to be aware of, is when there is an outpatient encounter for diagnostic testing. When the results have been interpreted by a provider and the final report is available at the time of coding, the coder can code any definitive diagnoses documented in the interpretation.

Prospective Reporting/Compliance

Healthcare data impacts an organization beyond reimbursement purposes. The reputation of an organization is impacted by accurate reporting of the quality and efficiency of care provided to its patient population. Population health analysis and reporting; disease treatment and response; and research projects all depend on the accuracy of healthcare data.

CDI professionals can assist in the documentation of the true and accurate picture of the health status of the patient and support of the resources utilized to care for and treat the patient.

In addition to traditional queries generated by coding or CDI professionals, software is available to review the entire medical record and generate provider alerts, prompts, or queries for documentation.

Thus, CDI professionals, at a minimum, should interact and collaborate with the coding, information technical services, safety, quality, informatics, and data analytics departments to ensure prospective alerts along with concurrent and retrospective queries are compliant and will result in accurate data for reporting.

Improving documentation accuracy through data analytics has significant clinical, compliance, and financial impacts. The healthcare industry is beginning to measure quality across the full patient stay, from beginning to end, measuring processes and all services involved in patient care. It is important that a multi-disciplinary team be involved in this end-to-end process. This team would benefit from receiving education on the most recent versions of the following AHIMA Practice Briefs:

- Guidelines for Achieving a Compliant Query Practice
- Guidelines for Achieving a Compliant ICD-10-PCS Query
- Clinical Validation: The Next Level of CDI

The query process is a key component in ensuring complete and accurate documentation. It is appropriate to generate a query when the documentation is incomplete, conflicting, or unspecified for a quality measure. To ensure the query adheres to the practice briefs and is not leading, the query can only be generated by team members trained to generate queries.

Any alerts that are included in the implementation of software for provider documentation should also include team members who are subject-matter experts (SMEs) in the alert and query process to continuously monitor for compliance. Any query and or alert that is generated must never indicate its impact on a quality measure or reimbursement that may impact the provider's medical decision making.

It is important to recognize that the space involving queries and alerts is ever evolving with technology and it is possible that queries and alerts may be generated by automated software such as in the computer-assisted coding process, provider documentation software prompts or within quality software. This software often utilizes clinical artificial intelligence. From a compliance standpoint, query and/or alert guidance within the practice briefs applies for all queries and/or alerts whether auto-generated or manually by subject matter experts. Prior to the implementation of the software a query SME must review to ensure compliance with practice briefs on the phrasing of the query as well as situations in which an alert would be generated.

As the healthcare industry strives towards transparency it has become critical for documentation to accurately reflect the patient's clinical condition and quality of care. Incomplete or inaccurate documentation can not only impact reimbursement but also quality outcomes. The potential impact to important programs such as HEDIS, Patient Safety Indicators (PSIs), Hospital Acquired Conditions Reduction Program (HACRP), Hospital Readmissions Reductions Program (HRRP), Merit-Based Incentive Payment System (MIPS), Potentially Preventable Complications (PPC), Sepsis Core Measures, Risk Adjustment, VBP, Total Performance Score, and any local and publicly available quality programs must be evaluated. Claims data accuracy will impact the multiple sources of quality reporting that are sourced from both regulatory/government data as well as the public sources and paid options in the private sector.

The measurement of quality can be directly impacted by CDI efforts and collaboration. This is where inter-professional collaboration can make the greatest impact for all key stakeholders. The CDI and quality teams should have regularly scheduled meetings to discuss trends and challenges and to determine how each team can help support the other as well as provide education on processes, policies and procedures impacting both teams.

There are many sources for quality reporting which have similarly titled measures but not necessarily the same outcomes for the same facility due to lack of industry correlation. When reviewing publicly sourced quality reporting, it is important to understand the data definitions, methodology, data source, measures and performance period utilized for the scoring.

Examples of public reporting include CMS Hospital Compare, Leapfrog Safety Grade, Healthgrades, IBM Watson, US News and World News, Rand Healthcare, etc. Public reporting can be impacted by patient surveys, facility reputation, patient claims data, non-claims data, patient reporting, risk adjustment methodologies such as HCC capture, and the volume of diagnoses as well as the inclusion or omission of some or all PSIs.

There is an important need to be able to collect, organize and analyze diagnosis codes and the large amount of data that has been collected in healthcare. Large amounts of data can be transformed by highly skilled data management professionals into very useful information such as forecasting and predictive analysis in risk-adjustment coding. It is important to understand the logic and circumstances for which any of the codes or documentation prompts would be system generated. Knowledgeable and trained health information (HI) and data management professionals should be skilled in the use of data management and data analysis that improves the quality of documentation. Beyond reporting, data has the power to be impactful and support medical decision making when analyzed, managed and shared. Data is simply raw facts until it is organized into meaningful information.

Provider Perspective

Providers may wonder why queries and alerts are needed and feel they are an administrative burden. CDI professionals in the inpatient and/or outpatient setting, have struggled with how best to educate providers on the value of high-quality clinical documentation and its impact on patient care.

Providers may bring up a good point, that a query and/or alert does not change how they provide care to their patients. However, when we take a step back, queries and/or alerts do serve as an avenue to the most accurate documentation, which will assist in capturing the accurate severity of illness (SOI) and

risk of mortality (ROM) of the patients, which captures the quality of care provided and the patient's disease burden.[7]

Providers are under regulatory pressure, laced with policies and procedures to provide quality care. In order to have more accurate coding and billing, it is important for providers to see CDI efforts as a resource rather than a burden. The EHR creates an opportunity to assist providers with clinical documentation as a means of communication. Whenever possible, build clinical documentation systems that make it easy for providers to provide documentation that results in diagnoses that can easily be classified into ICD-10-CM codes. Including providers in the CDI process and procedure planning can help develop buy-in and result in more effective process that fits within the provider workflow.

Data-Driven Planning

As more organizations are leveraging technology for clinical care, it is important for CDI professionals to understand the source of information when performing their reviews and know how to validate the source of information. There are tools within the EHR that look for information to recommend and guide CDI and coding professionals to identify a query and/or alert opportunity for specificity/missing diagnosis and/or code assignment based on existing documentation and/or prior health record documentation.

Some EHRs automatically "pull" in from all encounters. A great example of this phenomenon is the problem list. If the problem list is not being reviewed and updated by the providers during each encounter, there is a risk that a listed condition has been resolved and not an active condition under treatment, yet this information is still being captured by the EHR as a current condition. It is important for organizations to be mindful that documentation across all settings, especially on the same EHR platform, is utilized by all providers for clinical decision-making purposes along with statistical reporting purposes that may result in reimbursement implications.

In addition to internal data review, available external data should also be considered for review and incorporated into the process of data review. It is important to acknowledge there is CMS-HCC and HHS-HCC and their data points are different. It is also beneficial for organizations to review Risk Adjustment Factor (RAF) scores at a global level as well as granular level. From the facility to the provider practice and then individual providers to eliminate silos within an organization to support the ongoing efforts to obtain high-quality clinical documentation.

Conclusion

In conclusion, the need for documentation alerts are being seen throughout the healthcare industry to support the delivery of high-quality clinical documentation. Traditional queries are sent by CDI teams to clarify existing documentation, documentation alerts have been developed to support provider documentation through the notification of information that is relevant to an upcoming encounter, as a resource for medical decision making and the delivery of documentation. The efforts, that have been discussed in the practice brief, by CDI teams will help healthcare providers and organization delivery high-quality clinical documentation that represents the care provided and the patient's disease burden.

Appendix

Example Scenarios

Scenario 1: Implementing CDI Alert Software

A facility has purchased software from a vendor to assist providers with documentation. The software provides prompts to the provider by prospectively and concurrently generating documentation alerts. The system has the ability to utilize clinical information to determine when an alert is needed. The software has been designed to generate an alert every time the diagnosis heart failure has been documented to provide the following information to the provider "Please specify acuity and type." The software has also been designed to generate clinical questions in the presence of specific clinical indicators such as noting unspecified condition when the patient has abnormal temperature, tachycardia, hypotension, elevated WBCs to prompt "Can an associated diagnosis be provided, such as sepsis, SIRS, septic shock or other?"

Best Practice Process:

- Involve CDI and coding professionals as well as providers in the planning and development of the alerts. They can assist in developing compliant alerts that are generated with defined clinical indicators and provide reasonable options such as specific types and acuity for heart failure related to the clinical indicators associated with each patient. Each query must be based on the unique attributes of the patient and documentation within the referenced encounter(s)
- Establish an audit trail to generate any alert that was presented to the provider within the system, that is not on a provider query form, but embedded within the prompts
- Develop clinical criteria to support high-risk diagnoses (e.g., Sepsis-2 criteria, Sepsis-3 criteria, etc.) the organization will utilize for generating an alert, as well as any additional criteria that should be considered
- Develop compliant language for the alerts that is reviewed and approved by applicable department

Scenario 2: Building CDI Alerts into the EHR

Prospective alerts have been built into the EHR system to inform providers when the diagnosis and/or specificity for malnutrition may be supported by the clinical evidence. Neither coding, CDI, nor providers were included in the development of the clinical criteria for prospective prompts for provider documentation. The volume of malnutrition cases and denials had a significant increase post-implementation.

Best Practice Process to Address Increase in Denials:

- Include providers and CDI/Coding professionals to provide expertise in the development and implementation of documentation alerts
- Develop transparent and logic-based clinical sources for the alert

Scenario 3: Prospective Review Leading to a Documentation Alert for an Associated Diagnosis Related to Medication

A patient is scheduled to see their provider for their annual wellness visit. Upon reviewing the record, the patient's last primary care visit was six months earlier, for a sick visit. During this visit, the primary care provider documented major depression not otherwise specified (NOS) under the past medical history (PMH). The patient has a PMH of a mental health disorder. Patient's current outpatient medication list includes Abilify. Per a telephone note from a month ago, the patient had left a message requesting a refill for Abilify.

How to write a compliant documentation alert Option 1:

- Xx/xx Office note documented "major depression NOS" under the PMH section. The patient was documented to be on Abilify
- Xx/xx Telephone note indicated that the patient left a message requesting a refill for Abilify
- Please clarify the clinical significance of the above documentation by providing an associated diagnosis to the highest level of specificity related to the medication Abilify, including supporting clinical criteria (as applicable)

How to write a compliant documentation alert Option 2:

- Xx/xx Office note documented "major depression NOS" under the PMH section. The patient was documented to be on Abilify
- Xx/xx Telephone note indicated that the patient left a message requesting a refill for Abilify
- Please clarify the clinical significance of the above documentation by providing an associated diagnosis to the highest level of specificity related to the medication Abilify, including supporting clinical criteria (as applicable), such as:
  - Major Depression/Major Depressive Disorder (Please specify episode, acuity, with or without psychotic features as applicable)
  - Other condition (please specify)_____
  - Unable to determine

How to write a compliant documentation alert Option 3:

The diagnosis of "major depression NOS" was documented (when/by whom). The patient is continuing to take Abilify (refill request). Please clarify if major depression is a current diagnosis being treated with Abilify that can be further clarified as:

- Single episode (if so, please specify is mild, moderate, or severe)
- Recurrent episode (if so, please specify is mild, moderate, or severe)
- Major depression remission (if so, if full or partial)
- Major depression has been resolved
- Other condition (specify)
- Unable to determine the status of major depression

Scenario 4: Prospective Review Leading to a Documentation Alert for an Associated Diagnosis Related to Documented BMI

A patient is scheduled to see their provider for their annual wellness visit. Upon reviewing the record, the patient's last primary care visit was on one month ago for follow-up status post an inpatient stay for a femur fracture status post fall. The patient was documented to be 5'5" tall and weighs about 276 lbs with a BMI= 45.97. The patient was noted to be counseled regarding their BMI.

How to write a compliant documentation alert:

- Xx/xx Office Visit Note documented the following: 5'5" tall ,weight=276 lbs and BMI= 45.97. The patient was noted to be counseled regarding their BMI
- Please clarify the clinical significance of the above documentation by providing an associated diagnosis related to the documented BMI during this encounter, including supporting clinical criteria (as applicable), such as:
  - Morbid Obesity
  - Severe Obesity
  - Other (please specify)
  - Unable to Determine

Scenario 5: Inappropriate Identification of a Potential Documentation Alert by NLU technology

NLU software identifies the documentation of Reye's syndrome in the discharge instructions where it explains some negative effects of a certain medication like "Do not give children aspirin since aspirin has been linked to Reye's syndrome."

Best Practice Process

CDI professional and/or designated professional to validate documentation alert/notifications prior to a provider's review. The review would flag this as an inappropriate NLU finding with no clinical indicator supporting this additional diagnosis, therefore avoiding the possibility of incorrectly reporting this diagnosis within the EHR by the provider.

Scenario 6: Inappropriate identification of a potential documentation alert by NLU technology

NLU technology suggests documentation opportunity for "ostomy" statuses due to wound care templates having specific categories. For example, the Wound Care Note consist of the following categories where providers are to document:

- Burn
- Wound
- Scar
- Colostomy
- Ileostomy

Best Practice Process

CDI professional and/or designated professional to validate these documentation alert/notifications prior to a provider's review. The review would flag this as an inappropriate NLU/NLP finding with no clinical indicator supporting this additional diagnosis, therefore avoiding the possibility of incorrectly reporting this diagnosis within the EHR by the provider

In addition, the identification of these blank/non-applicable sections are education opportunities for the providers to clean up these sections by deleting sections that are not applicable and/or work with the developers of the NLU/NLP software to avoid capturing these documentation alerts/notifications driven by a header within a document in the health record.

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