AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

Outpatient Clinical Documentation Improvement (CDI) TOOLKIT

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FOREWORD

The concept of clinical documentation improvement (CDI) has grown significantly over recent years. With the current healthcare industry shifting reimbursement methodology from fee-for-service to value-based models, the need for CDI programs has grown beyond the inpatient setting. Successful CDI programs are realizing it is vital for existing programs to expand their documentation reviews to cover severity of illness/risk of morality (SOI/ROM), readmission rates, and other Centers for Medicare and Medicaid Services (CMS) quality measures. Additionally, CDI departments are beginning to expand their scope across the continuum of care to include unchartered territories like outpatient settings, long-term acute care hospitals, and skilled nursing facilities.

This toolkit will examine the various aspects of starting an outpatient CDI program. The information in this toolkit is beneficial to CDI programs who want to start a new outpatient CDI team or an inpatient CDI program that wants to expand into the outpatient setting. There are many healthcare settings in which outpatient care is delivered; we will not discuss every setting in this toolkit. Some of the outpatient settings that will be discussed include physician clinics, emergency departments, hospital observation, home health, and ambulatory surgery.

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THE NEED FOR OUTPATIENT CDI PROGRAMS

The documentation in a patient's health record is used as a communication tool between healthcare providers. The health record is also used for billing and reimbursement, evaluation of quality care, hospital and physician ranking, reporting communicable diseases, registries, and research.

As reimbursement for healthcare shifts from fee-for-service to value-based models, it relies heavily on quality measures and data from programs like the Physician Quality Reporting System (PQRS) and Hospital Inpatient (and Outpatient) Quality Reporting. The quality of patient care and the provider's ability to manage costs for the hospital and professional services is evaluated by these programs. Healthcare organizations now acknowledge the importance of accurate documentation of patient care, regardless of the healthcare setting in which that care was provided.

As a result, many organizations are now looking to their existing clinical documentation improvement (CDI) department for outpatient coverage and/or creating an outpatient clinical documentation improvement (OP CDI) program. In theory, a CDI department that covers both inpatient and outpatient settings will help improve the accuracy of risk scores and reporting of diagnoses. Most importantly, it will help mitigate risks associated with inaccurate coding and reporting. Regardless of the patient care setting, ICD-10-CM is used to report patient diagnoses.

Due to recent changes in CMS payment methodologies, including the implementation of quality measures and the evolution of technology, outpatient payment represents a larger piece of overall hospital revenue. Advancements in healthcare and technology have resulted in a shift of services that were once performed in the inpatient setting to the outpatient setting. The Medicare Payment Advisory Committee's Report to Congress in 2016 showed a drastic shift from inpatient to outpatient services since 2006, including an increase of 44.2 percent outpatient visits per fee-for-service Part B beneficiary compared to a decrease of 19.9 percent of inpatient discharges per fee-for-service Part A beneficiary.[1]

The Medicare Benefit Policy Manual states:

> Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature and other services that aid the physician in the treatment of the patient.[2]

According to rules in the Outpatient Prospective Payment System (OPPS), CMS pays for outpatient encounters under Medicare Part B. The Healthcare Common Procedure Coding System (HCPCS) is used to bill OPPS services provided and must meet medical necessity. A working knowledge of the coding and payment methodologies associated with outpatient encounters is necessary for CDI departments expanding into outpatient services. Outpatient CDI is a very broad concept and can describe any CDI effort not associated with an inpatient claim.

STRUCTURAL DIFFERENCES BETWEEN OUTPATIENT AND INPATIENT CDI PROGRAMS

One of the biggest challenges for OP CDI programs is the quick turnover of visits. Other than outpatient hospital observation encounters, outpatient visits occur in one day, which makes it challenging to perform a concurrent review of cases. The objectives and processes of an individual program will be impacted by the time associated with the outpatient documentation process.

A main focus of inpatient CDI programs is the concurrent assignment of MS-DRGs or APR-DRGs and the associated documentation improvement opportunities. In the outpatient setting, CDI programs have several potential areas of focus to consider, including the elements of the OPPS, diagnosis specificity for risk adjustment, and improvement of E/M levels based on documentation enhancements.

These all require focused documentation improvement activities in many different outpatient settings. Consider evaluating specific needs of different outpatient departments in the organization as well as provider-based clinics. It's not "one size fits all" for OP CDI, as each department will have different needs related to documentation improvement. Examples of OP CDI focus may include payment denials for lack of medical necessity due to insufficient health records, concern for increased compliance risk due to inadequate documentation, or documentation deficiencies for outpatient surgical procedures impacting appropriate code assignment. All these documentation situations impact coding quality and overall reimbursement.

OUTPATIENT REIMBURSEMENT

The major component of the outpatient prospective payment system (OPPS) is Ambulatory Payment Classifications (APCs). The APC code is driven by Current Procedural Terminology (CPT®) code assignment, and single encounters may have multiple APCs assigned. The APC algorithm is complex and there are multiple status indicators that impact overall reimbursement. With CPT procedure codes, there are also two-character modifiers that may also impact reimbursement. Modifiers represent additional information regarding the CPT code, but do not change the definition of the code. In this reimbursement system, there are opportunities for compliance issues based on insufficient documentation, and this is an area where a robust outpatient CDI program can have a significant impact.

CMS has developed a new outpatient quality payment program established by the Medicare Access and CHIP Reauthorization Act (MACRA). At the time of this publication, this system provides two tracks for providers to choose from when submitting quality data. These include the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). If a provider is part of an APM, they are exempt from MIPS reporting. The MIPS program repeals the sustainable growth rate and consolidates aspects of the PQRS, value-based modifier, and the electronic health record (EHR) incentive programs.

With the increased focus on quality care in the outpatient setting and programs such as risk adjustment, Hierarchical Condition Categories (HCCs), and MACRA, attention is now turning to diagnosis coding specificity and accuracy. This is an area where CDI expertise can have a significant impact on the documentation as providers traditionally haven't documented to a high level of specificity in this setting.

CODING GUIDELINES DIFFERENCES—ICD-10-CM OUTPATIENT VERSUS INPATIENT

The Official Guidelines for Coding and Reporting are a companion document to the official edition of ICD-10-CM and have been approved by the four organizations that make up the Cooperating Parties for ICD-10-CM (CMS, the American Hospital Association, AHIMA, and the National Center for Health Statistics).[3]

The coding and sequencing instruction in the Tabular and Alphabetic Index take precedence over the Official Guidelines for Coding and Reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under HIPAA and has been adopted under HIPAA for all healthcare settings.[4]

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.[5]

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Sections II and III apply to non-outpatient settings, and Section IV is for outpatient coding and reporting.

Section IV says: "These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines should also be applied for outpatient services and office visits."[6]

It continues for the selection of first-listed condition: "In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines."[7]

In the outpatient setting, guidelines surrounding selection of diagnoses vary depending on the specific outpatient setting.

For outpatient surgery: "When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication." For observation stay: "When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis. When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses."[8]

Section IV includes other pertinent guidelines:

- Use codes from A00.0 through T88.9, and Z00-Z99 to identify diagnoses, symptoms, conditions, problems complaints, or other reason(s) for the encounter/visit
- For accurate reporting, the documentation should describe the patient's condition, including specific diagnoses, symptoms, problems, or reasons for the encounter
- Codes of symptoms and signs are acceptable for reporting when a diagnosis has not been established by the provider
- ICD-10-CM codes should be assigned to the greatest level of specificity, including assignment of fourth, fifth, sixth, and seventh characters as appropriate
- List first, the ICD-10-CM code for the diagnosis, condition, problem, or other reason for the encounter as the reason for the services provided. List additional codes that describe any coexisting conditions
- 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)
- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management[9]

One of the most significant differences between the Outpatient Guidelines and the Inpatient Guidelines is the coding of uncertain diagnoses. In the outpatient setting, do not code diagnoses documented as "probable," suspected," "questionable," "rule out," "working diagnosis," or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit.[10]

Section IV also says: "For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses. This differs from the guidelines in the hospital inpatient setting regarding abnormal findings on test results."[11]

Note: HCC is a type of risk adjustment, and this rule doesn't apply to HCC, per CMS guidelines on HCC reporting.

DRIVERS AND SETTINGS FOR OUTPATIENT CDI

Numerous and significantly varied clinical settings for ambulatory care create unique challenges and opportunities in the implementation of outpatient CDI practices. The following information is intended to highlight common drivers and their complexities potentially impacted by CDI efforts. While identifying common documentation, coding, and billing considerations, this list may not cover all possible applications. Healthcare organizations and senior leadership must carefully consider individual practices and needs in determining the best use of documentation improvement strategies. The overall complexity of outpatient service reporting and billing practices allow for documentation improvement activities to initially be directed at specific identified targets such as Evaluation and Management (E/M) code assignment or HCC code capture with further or additional targets subsequently added to the OP CDI program.

DRIVERS FOR OUTPATIENT CDI

Evaluation and Management (E/M) Level of Service

E/M codes, a subset of the larger CPT code nomenclature, are used to report the intensity of care provided during a patient encounter. E/M codes are used primarily by physicians to report services such as office, hospital and observation visits, and other related patient encounters including consultations, wellness/preventive medicine visits, and telephone or telehealth encounters. In general, E/M codes for physician services are assigned as supported by the documentation of key elements of history, examination and medical decision making or, under certain circumstances, codes may be assigned based on the amount of time required for the encounter. E/M codes for physician visits must have documentation in the clinical record to adequately support the care rendered and level of service billed.

E/M codes are also used by hospitals and in other healthcare settings to report the institutional or facility resources utilized during an ambulatory care encounter. Facility use of E/M services codes is designed to report the intensity of resource utilization and are often referred to as "clinic visit codes" to distinguish their use for facility reporting. The April 2000 OPPS final rule instructed hospitals to report facility resources for clinic visits based on the development and application of internal hospital guidelines to determine the level of service to report for each patient encounter. The 2008 final rule (42 CFR Parts 410, 411, 412 et al.), published on Nov. 27, 2007, further instructs hospitals that "each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes."[12] Facilities should have a consistently applied methodology for determining the appropriate clinic visit code for patient encounters based on the documented intensity of care rendered.

CPT and HCPCS

The Level II Healthcare Common Procedural Coding System (HCPCS) is a set of codes and descriptors that represent procedures, supplies, products, and services provided to patients in outpatient and ambulatory care settings. CPT codes are used to report procedural services including surgery, therapeutic treatment, diagnostic testing, and other medicine services. Level II HCPCS codes, 5-character alpha-numeric codes, are used to report medical supplies, items, and non-physician services not represented in the CPT code set. CPT and HCPCS codes may be used by physicians and healthcare facilities to report the services provided to a patient during an encounter. This differs from the inpatient setting where procedures are reported with ICD-10-PCS codes. Accurate and appropriate assignment of CPT and HCPCS codes requires an understanding of the specific rules and guidelines associated with their use. Chargemaster-driven codes are at risk as well, so efforts need to be in place to ensure accuracy. Complete, accurate, and timely documentation is necessary to ensure services are captured and reported using the most specific codes.

ICD-10-CM Codes

ICD-10-CM codes are used in all healthcare settings to report the diagnosis/es, circumstance(s) or reason(s) for the visit or care. While the same codes are used in all healthcare settings, there are specific and distinct guidelines directing accurate and appropriate coding practices for acute inpatient stays versus hospital-based outpatient encounters, observation services and provider-based office visits. CDI professionals may find it challenging to learn and apply the guidelines for outpatient services when transitioning from an inpatient work environment due to the varying guidelines specific for the care setting. Further, physicians often don't receive in-depth education or training on proper diagnosis code selection or the rules governing correct code assignment. The widespread use of EHR systems could also contribute to incomplete, incorrect, and inappropriate diagnosis code assignment reporting in outpatient settings. Complete, thorough, and accurate diagnosis reporting is becoming increasingly important as the healthcare industry shifts its focus to quality measures best captured through the diagnosis code assignment.

Medical Necessity

Medically necessary services, as defined by CMS, are "services or supplies that are proper and needed for the diagnosis or treatment of a patient's medical condition, are provided for the diagnosis, direct care, and treatment of the patient's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the patient or the physician."[13] Clinical documentation in the health record must clearly communicate the care provided during a patient-physician encounter is medically reasonable and necessary to support proper coding, billing and reimbursement purposes. Medical necessity concerns span all aspects of outpatient care and apply in all settings. Medicare Administrative Contractors and private payers rely on coverage policies such as CMS National Coverage Determination and local coverage determination policies to inform healthcare practitioners of appropriate or covered diagnosis codes associated with specific procedures. Clinical documentation that clearly and completely supports the necessity for medical services can be challenging for healthcare professionals, and the opportunity for documentation professionals to work collaboratively with the providers helps to ensure the capture of quality documentation.

Risk Adjustment

Risk adjustment refers to accounting processes and tools used to predict healthcare costs based on relative actuarial risks including demographic and health-related factors. Payers employing risk adjustment methodologies utilize diagnosis data obtained through claims reporting to calculate a patient's degree or severity of acute and chronic illness to predict potential healthcare-associated costs. Critical to the overall financial success of risk adjustment methodologies are healthcare providers who actively assess, monitor, and manage the overall status of a patient's health and accurately and compliantly document conditions specifically tied to a risk adjustment model. These models rely on hierarchies that group related conditions based on the overall severity of the condition. As an example, uncomplicated diabetes is at the bottom or low end of the diabetes grouping, while diabetes with an associated manifestation is of greater severity and rates a higher position within the category, effectively replacing the less severe condition with a more complex illness or condition. Improved documentation and reporting allows physicians and healthcare providers to correctly report a patient's overall severity of illness and risk of mortality and, in doing so, allows for accurate assessment of the overall potential for health resource utilization. CDI professionals can assist to ensure patient care episodes fully and compliantly capture underlying chronic conditions and factors influencing the patient's health that may otherwise be under-reported. A dedicated section covers risk adjustment in this document.

SETTINGS IN OUTPATIENT HEALTHCARE DELIVERY AND DOCUMENTATION IMPROVEMENT

Physician Clinics

Physician offices, whether owned and operated as part of a healthcare organization or as an independent valued partner to a healthcare system, provide significant opportunity for the introduction of CDI processes. The increasing use of diagnosis codes to drive payment models such as HCCs, changes to CMS quality reporting metrics such as MIPS, and APMs, and prevalence of EHR systems that rely on provider input alone for the assignment of diagnosis and procedure codes provide ample entry points for documentation improvement. Improving the quality of documentation in the clinical record supports accurate procedural and diagnosis code assignment, decreases the amount of time needed to complete the billing process, and will reduce the risk of claim denials or delays.

Emergency Department

The Emergency Department (ED) is a fast-paced, high-volume care setting designed to provide patient care 24 hours a day by shifts of healthcare professionals. The extreme variety of patient conditions treated in the ED, ranging from the most insignificant to life-ending illness and injury, coupled with supporting staff who must provide care around the clock, create numerous opportunities and challenges to obtaining complete quality documentation and coding. ED coding includes reporting for both professional and facility levels for services,

procedures, and medical supplies. The introduction of CDI practices can assist in many areas, due to the complexity and variety of services provided and coded. Patient transfers from the ED to observation and inpatient status also create opportunities for CDI facilitation of accurate and compliant documentation by capturing the present on admission status of diagnoses and maintaining the clinical severity of illness from the initial entry point through to care in other settings, as well as assisting case management staff in determining the correct patient status.

Hospital Observation

Observation status is an outpatient service utilized when the patient requires additional monitoring/observation beyond what should be provided in the emergency room or an office visit. Providers place patients into observation status most often from the emergency room or, on occasion, directly from their offices. Providers may need additional time to assess the patient's response to the treatment of symptoms or clinical evaluations of serial lab results to determine the appropriate discharge plan, or to make a decision for an inpatient admission. CDI professionals can help ensure the documentation clearly states the conditions for which the patient is being admitted, as well as ensuring the observation order is dated and timed because the observation start time begins after the order is written. They can help facilitate the documentation bridge between the outpatient observation record and the admitting history and physical (H&P). The H&P should include a summary of the events that occurred during the outpatient encounter, the working diagnoses, and treatment plan at the time of admission.

Home Health

Home health agencies (HHAs) are available for a continuation of healthcare in a patient's home. Some of the services HHAs provide include wound care, intravenous (IV) therapy, injections, therapy, and monitoring of a serious illness. HHAs are crucial within the continuum of healthcare. Patients who are stable enough to be discharged from a facility but are not capable of leaving their home for their follow-up care rely on HHAs for their continuation of healing. Without these agencies, the length of stay in hospitals might be longer for this group of patients.

HHAs use the Outcome and Assessment Information Set (OASIS), an assessment tool that drives their documentation. CDI professionals can assist HHAs in reviewing all documentation to ensure all data elements are present to complete the OASIS. The OASIS focuses on the patient's conditions, expected therapy needs, and outcomes. The assessment must be completed within five days of the admission into HHA, again at a 60-day follow up, and at discharge.

Ambulatory Surgery Centers

Ambulatory surgery centers can be free-standing facilities or hospital-based centers that perform same-day scheduled surgical procedures not requiring an overnight stay. Key areas of documentation include the pre-surgical history and physical, the anesthesia evaluation, the intra-operative notes, the procedure/operative note, and the post-operative assessment and re-assessments. CDI professionals can assist providers in capturing the patient's complete clinical picture to support the diagnostic statements for medical necessity for tests and the surgical procedures along with describing the complete medical history and any intra-operative or post-operative complications.

Other Areas of Opportunity

The broad array of patient care settings for outpatient services provides opportunities for CDI too numerous to include in this toolkit. When considering the introduction or expansion of OP CDI activities, leaders should carefully evaluate their individual organization to determine which areas may provide the most significant opportunities for documentation improvement actions.

Services such as radiology, laboratory, cardiovascular, and pulmonary diagnostic testing and therapeutic treatments may benefit from the inclusion of OP CDI activities to ensure compliant ordering and intake processes along with accurate documentation to support billing and reimbursement. Organizations may consider implementing software which allows ease in access to local or national coverage determination policies to ensure medical necessity is met with proper coding and documentation.

Notably, facilities providing specialty care for specific services such as cardiac catheterization labs, dedicated wound care centers, rehabilitation services, or hospice care should consider the introduction of OP CDI activity in these areas. Specific documentation and coding guidelines, as well as regulatory and payer-specific issues, require CDI professionals to learn and apply an assortment of strategies and recommendations to achieve intended outcomes for these unique care settings.

RISK ADJUSTMENT

CMS-HCCs

The CMS Hierarchical Condition Categories (CMS-HCCs) is the most recognized risk adjustment methodology for the Medicare Advantage patient population. This methodology utilizes prospective data to determine the cost of medical care based on the risk of the beneficiaries enrolled in the Medicare Advantage plan.

The CMS-HCC methodology is organized by categorizing specific ICD-10-CM (diagnosis) codes into categories of diseases. Each disease category includes diagnosis codes that are clinically related and/or share similar costs. The most recent version has more than 9,900 plus ICD-10-CM codes mapped to approximately 79 CMS-HCCs.[14] Each CMS-HCC diagnosis has an associated relative factor that changes annually. The relative factor weights, combined with the patient demographic information, are used to calculate each member's risk score. Therefore, providers must submit all applicable diagnosis codes, including those for ongoing chronic conditions, as specified by the Official Guidelines for Coding and Reporting, to ensure risk score accuracy. CMS-HCC qualified diagnoses used to determine the beneficiary's overall risk score can be obtained from any provider face-to-face encounter documentation over the course of that year. CMS-HCCs are not impacted by ICD-10-PCS (procedures) codes, as CMS-HCCs are driven only by the diagnoses.

CMS-HCCs contain two components: the hierarchy and the condition category. The hierarchies are the compilation of all the condition categories (CCs). The hierarchy determines reimbursement and consists of families of diseases that are assigned a cost based on severity and projected use of resources. In theory, as a beneficiary's chronic condition becomes complex, the beneficiary will require more healthcare services and/or treatment. For example, a diabetic patient with complications will require more healthcare services than a patient with only uncomplicated diabetes, therefore the beneficiary with the diabetes with complications will have a higher overall relative risk factor.

While the CMS-HCCs reflect hierarchies among related disease categories, a patient can have more than one HCC category assignment. Each CMS-HCC category is factored into the beneficiary's overall risk profile, which will include acute and/or chronic disease processes along with their manifestations, to capture the patient's risk adjustment factor (RAF) score. The risk adjustment factor score is used to forecast future healthcare costs for the beneficiary. In principle, the higher the RAF score is, the sicker the patient. Conversely, a low RAF score may indicate either a healthier population and/or an indication of a documentation and coding issue.

In summary, the CMS-HCC methodology requires all Medicare Advantage-accepting providers to capture each beneficiary's HCCs at least once every 12 months. For example, a face-to-face wellness visit for a 72-year-old male with congestive heart failure, type II diabetes, and prostate cancer will have at least three separate reportable HCCs, and his predicted cost will be reflected by these reportable diagnoses/HCCs if the provider documents these diagnoses. All CMS-HCCs must have supporting documentation to indicate that all diagnoses are monitored (e.g., documentation of signs/symptoms), evaluated (e.g., test results), assessed (e.g., ordering of additional tests), and/or treated (e.g., medication).

Rx-HCCs

The Basic "HCC" approach was used to create the RxHCC model and is similar to the Part C CMS-HCC Model. The RxHCC methodology relies on certain conditions/diagnoses to predict the prescription cost for those conditions/diagnoses.

For example:

- Part C Model HCC 18 "Diabetes w/ chronic complications" has a relative factor of 0.378
- Part D Model RxHCC 14 "Diabetes with complications" has a relative factor of 0.276

If the Medicare Advantage Plan covers both Parts C and D, a member of the Medicare Advantage Plan with Diabetes with complications would capture an additional relative factor (0.378* Part C bid rate + 0.276* Part D bid rate).

HHS-HCCs

The Health and Human Services Hierarchical Condition Categories (HHS-HCC) were developed specifically for commercial insurance plans. This risk adjustment methodology was created to protect against potential effects of adverse selection[15] and was finalized in the HHS Notice of Benefit and Payment Parameters for 2014 final rule (78 FR 15410). This final rule was published in the *Federal Register* on March 11, 2013. Unlike the CMS-HCC methodology, the HHS-HCC model will calculate a plan's average risk score for each covered plan based upon the enrollees' relative risk. A payment transfer formula is then utilized to identify risk adjustment payments between the plans. Funds will be transferred from plans with relatively low risk enrollees to plans with relatively high-risk enrollees.

Concurrent risk adjustment models are established in the HHS-HCC methodology, consisting of age groups (i.e., adult, child, infant) and "level of metal" (i.e., platinum, gold, silver, bronze, catastrophic).The HHS-HCC risk adjustment model addresses the following: newly insured population; plan metal level differences and rating variation, and the need for risk adjustment transfers that net to zero.[16]

The HHS-HCC methodology utilizes concurrent diagnoses to calculate the patient risk score and is further refined to reflect the expected risk adjustment population. The HHS-HCC risk scores represent members' health status and selection of their benefit plan. Previously reported diagnoses for the HHS-HCC methodology do not flow between plans when a member changes program enrollment.

Documentation of HCCs

Documentation must be from acceptable physician specialty types and the date of service must be a face-to-face visit. Documentation must be legible and from a valid provider type. Furthermore, credentials and/or physician specialty must be clearly documented.

HCCs can consist of acute and chronic conditions; therefore, it is important that all diagnoses are documented to the highest level of specificity that is supported by the clinical evidence. When reviewing documentation, it is vital to review for the seven characteristics of high-quality clinical documentation. These characteristics include documentation that is clear, consistent, complete, precise, reliable, legible, and timely, as discussed in greater detail in the next section.

Queries

Queries are a valuable tool to support the communication between the CDI professional and the provider. The responsibility of a CDI professional is to identify gaps within clinical documentation and to send queries to clarify documentation when these gaps are identified. Some synonymous terms seen with "query" include clarification, clinical clarification, documentation alert, and documentation clarification. In this toolkit, "query" will be used as the term to identify the communication tool used to send both concurrent and retrospective clarifications for documentation.

Each organization should develop clearly defined policies and procedures outlining their query method including the process used in developing and maintaining queries. There should also be a procedure to outline the course of action providers should follow when responding to queries. Queries may or may not be part of the permanent health record; however, all responses to queries should be included within the permanent health record to support code assignment. When developing a query policy and determining the query procedure, it is important to include all members of the CDI team to ensure every perspective of the steps within the query process are considered. The CDI team members may include CDI and HIM leaders, physician leaders, CDI professionals performing the record reviews, providers, and the coding professionals.

It is crucial that the query process is compliant. The components of a compliant query will be the same in all healthcare settings. Please access the AHIMA practice brief "Guidelines for Achieving a Compliant Query Process" to review all the components of a compliant query process. Some organizations may use query templates for certain diagnosis. When using query templates, all of the information on the query should be specific for each individual patient. All queries should include the clinical evidence from the health record that prompted the request for clarification. The titles and content for each query should never lead the provider to a particular response.

In the inpatient setting, queries should only include information from the current admission. In the outpatient setting, this standard is vague, as some of the information impacting an encounter may come from an order from a previous encounter or workup that was ordered in preparation for the current visit. The documentation in each encounter, whether inpatient or outpatient, should stand on its own. Adding to the complexity of the outpatient setting are all of the variables that impact the different outpatient settings. The review of previous visit documentation will depend on the outpatient setting.

For example: In an ambulatory surgery visit, the documentation for the episode of care (e.g., H&P, pre-op clearance consultants, work-up tests, procedure note, and postoperative care) should provide valid sources of information to gather information for a query. However, for an office visit, the CDI professional may need to review the total record (e.g., past medical, social, and family history) to identify all active diagnoses. If a chronic condition or coexisting condition has no bearing on the current encounter, it should not be coded.

It would never be appropriate to "mine" previous encounter documentation simply to generate or to support a query. The clinical indicators should be present in the current episode of care with past documentation providing additional support for a query.

The seven characteristics of high-quality clinical documentation are the foundation of health record reviews. When CDI professionals understand these characteristics, they can easily identify gaps within clinical documentation across the healthcare spectrum.

High-quality clinical documentation is defined by the presence of documentation that is:

- **Complete**—This is documentation that is detailed and has the maximum content. This means that the physician has fully addressed all concerns in the patient record. For example: if the patient has blood drawn and the results show low sodium and the patient is started on sodium tablets but the documentation only states low sodium, there is not a diagnosis to support the clinical abnormality and treatment plan. A query may be needed to determine if a diagnosis can be provided.
- **Consistent**—This is documentation that does not contradict itself. An example would be having conflicting diagnoses, such as one provider note stating the patient has chronic diastolic heart failure and the next note stating the patient has chronic systolic heart failure. In this scenario a query may be needed to determine the type of heart failure.
- **Timely**—This is documentation that is prepared, signed, and dated by the provider at the time the care was provided. An example is a note in which the content may have all the characteristics of high-quality documentation, but it was never signed or dated by the physician. A query may be needed to request a signature and date.
- **Clear**—This is documentation that thoroughly describes what is occurring with the patient. CDI professionals always review documentation for a definitive diagnosis but in the outpatient setting, symptoms may be all that is known at the time of the encounter. In this case, the documentation should include a note stating the etiology of the signs and symptoms are unknown at this time. The documentation should also include the work-up plan for the symptoms to determine if a diagnosis can be identified.
- **Precise**—This is documentation that is clearly defined by including the highest level of specificity that can be determine from the clinical evidence. An example of precision is documenting the specific type of gastroenteritis, such as infectious or non-infectious gastroenteritis. If infectious, the organism would also need to be documented if known.
- **Legible**—This documentation that is clear enough for the reader to easily interpret. If the documentation cannot be interpreted, then a query may be needed.
- **Reliable**—This is trustworthy documentation. For example, if a stage 4 chronic kidney disease (CKD) patient is started on Epogen, the stage 4 CKD is not a trustworthy diagnosis to support the treatment of Epogen. This is because the Epogen is not used to treat stage 4 CKD, but most likely prescribed to treating an associated anemia. In this example a query may be needed to identify the diagnosis being treated to ensure the documentation is trustworthy.

One area that may be more challenging when sending queries in various outpatient settings is sending them concurrently with the delivery of care. When a patient has been admitted as an inpatient, they are usually in the hospital for a few days. However, this is not the case in most outpatient settings. A provider clinic may see more than 20 patients per day and clinicians document while the visit occurs. One possible solution is using a medical scribe as part of the CDI team. With the rise in documentation demands, more providers have been turning to medical scribes to help ease their documentation burden. However, professionals who have traditionally filled these roles have not been trained in CDI. This real-time relationship may support a concurrent review and query process that has made inpatient CDI programs so successful.

OP CDI programs may have their CDI professionals perform a pre-visit assessment of the patient's problem list prior to encounter (i.e., prospective review). CDI professionals may use this information to monitor documentation after the encounter to ensure the problem list was updated. CDI professionals may also develop a reminder to providers to review and update the problem list; however, a query would not be warranted prior to an encounter. Such a query could encourage providers to document conditions that have no bearing on the current encounter, which could lead to overcoding and violation of the Official Guidelines for Coding and Reporting.

It is important for CDI professionals to understand the nature of a patient's presenting problems. The chief complaint should be the driver for the extent of work that is performed and coded. The need for a query can only be validated after the provider completes the documentation for an encounter.

STARTING AN OUTPATIENT CDI PROGRAM

The successful development and implementation of an outpatient CDI program requires strong executive support and provider buy-in. Because outpatient services have a significantly higher volume of encounters when compared to inpatient stays, it is vital for an organization to recognize there is no "one size fits all" or cookie-cutter approach. When considering an outpatient CDI program, different organizations will have unique opportunities and priorities.

Identifying all areas rendering outpatient care is a logical first step. Once identified, each of the areas or departments can be evaluated with respect to type of services, patient volume, and financial impact of the care delivered. Organizations will need to establish specific focus areas and realize that the outpatient CDI team cannot do it all. It is very important for the outpatient CDI team to establish a clear mission statement that includes the overall purpose of the program. This mission can be modified and tailored as the program continues to transform and grow.

It is important to know the organization's data. All organizations considering an outpatient CDI program should perform their own due diligence in evaluating the significance of the clinical documentation, coding, and revenue for each area under consideration. Pertinent questions may include:

- What is the current documentation process?
- How is the coding and billing process performed?
- Are there concerns or potential issues with denials, compliance, or suspected under-performance for new service lines?

Healthcare organizations will need to determine specific areas of information to consider as a part of the initial process development. As an example, consider where data analysis begins and does someone within the organization already have this information (e.g., denials, top diagnoses/charges that are being denied, etc.). These questions will help avoid any duplication of efforts and/or re-creating unnecessary wheels within an organization.

Once a data analytics is performed, best practice is to perform internal audits to validate the data analysis findings. Some organizations may begin with a post-bill audit and then find that a pre-bill audit is more effective, therefore it is important to determine what type of internal audit (post-bill versus pre-bill) is appropriate for each organization.

Upon the completion of an internal audit, an important next step is trending the findings from the data analysis and internal audit. This analysis will help identify more specific problems in the outpatient process including but not limited to:

- Areas of improvement related to the capturing and reporting of HCC diagnoses
- Areas of improvement related to other documentation improvement opportunities
- Bottlenecks and/or breakdowns within the revenue cycle process (e.g., is there a lag time in re-submitting claims that are denied due to lack of staff to process denials, etc.)
- Determine if specific education is needed (e.g., medical necessity for the registration and OP CDI team, etc.)
- Review a sample of outpatient claims using OIG focused topics as the monitoring tool
- Evaluate operational or process changes to streamline workflow

Identifying OP CDI opportunities can be achieved by understanding the organization's data. Utilizing existing reports and/or identifying useful reports will help a developing OP CDI program identify issues that are related to outpatient documentation. This will help the CDI team identify areas of provider education and/or CDI focus /coverage areas.

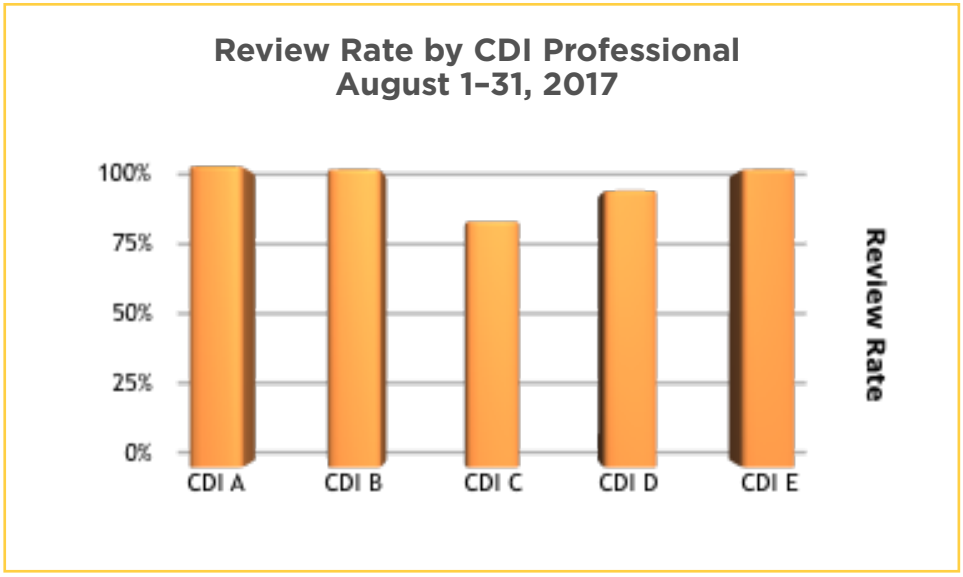
OP CDI METRICS

Monitoring the success of an outpatient CDI program can be determined by developing a metric dashboard to monitor key performance indicators. This data can identify both the success of the program and the opportunities for improvement. There are some general metrics that are monitored by most CDI programs. These include review rate, query rate, query response rate, and denial rate. This data can also be used to monitor productivity standards for the CDI staff. This will help identify staff strengths and educational opportunities for ongoing professional growth. Benchmarking can also be done to determine and monitor expected outcomes for the CDI program.

REVIEW RATE

Each organization will need to develop a review rate goal that is realistic for their setting. This metric measures the number of records that were reviewed compared to the number of health records that were assigned to be reviewed. The time it takes to review a health record will be dependent on the acuity of the patient and the size of the health record. A patient with several co-morbid conditions and an extensive work up will take longer than a patient with one co-morbid condition and routine work up. When determining a realistic review rate goal, it is best practice to perform a pilot study of the time it takes to review the health record. This information can be used to determine an average of the reviews that were performed.

Sample Review Rate Graph

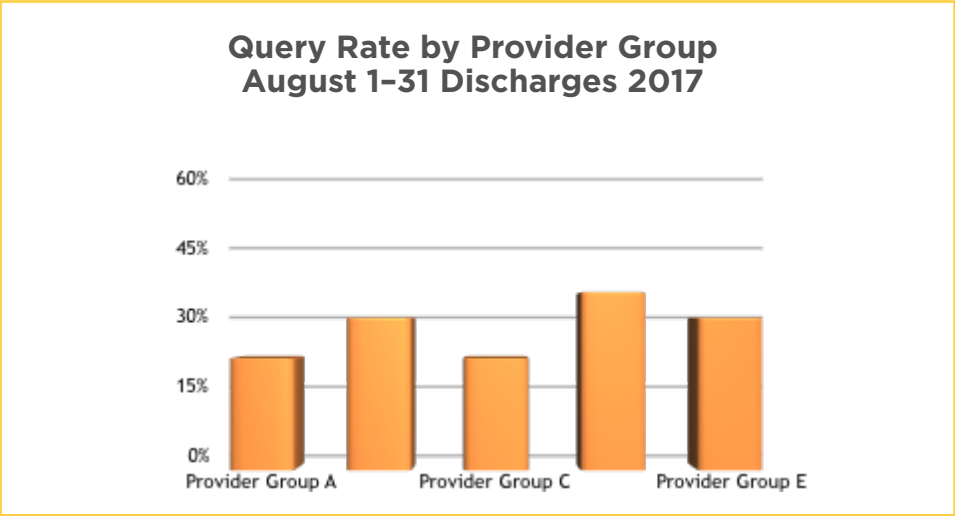


QUERY RATE

The query rate measures the number of health records that resulted in a query to the number of health records that were reviewed. This measure will change as the program matures. When a program first starts it is normal to see a high query rate. As providers learn high-quality documentation standards from the CDI professionals, this rate will begin to decrease. This is not a metric frequently monitored in CDI professionals' productivity expectations, because of the variations in the query rate. If a query rate is part of productivity and is unrealistically high, it could result in inappropriate queries being sent to reach the goal.

This metric can be beneficial in determining educational opportunities for providers. For example, if a provider receives a higher number of queries for a specific diagnosis than other providers, that provider may need one-on-one education regarding the documentation requirements for that condition. This measure can also be used to measure provider engagement. Review the "Impact of Physician Engagement on Clinical Documentation Improvement Programs" practice brief to learn more about using metrics to measure physician engagement.[17]

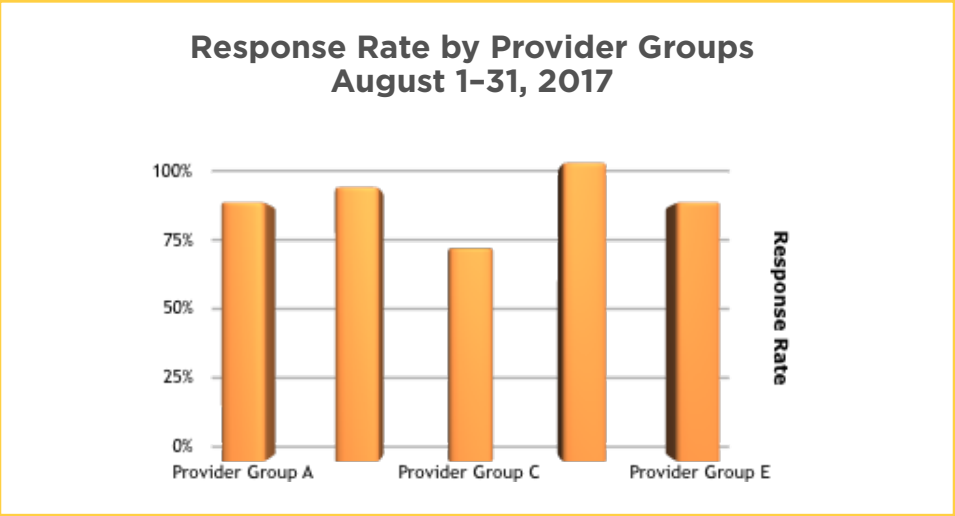
Sample Query Rate Graph



QUERY RESPONSE RATE

This measure reviews the number of queries that have a response against the number of queries that were sent. This measure can help determine the level of provider engagement with the CDI program. It is normal for a new CDI program to have a lower response rate, but as the providers are educated on the need for high-quality documentation, the response rate should increase. If the response rate does not increase, then the providers either need more education or they do not understand how to respond to the query. When developing a query process, it is crucial to include providers to determine a method that fits into their workflow. Review the "Impact of Physician Engagement on Clinical Documentation Improvement Programs" practice brief to learn more about using metrics to measure physician engagement.[18]

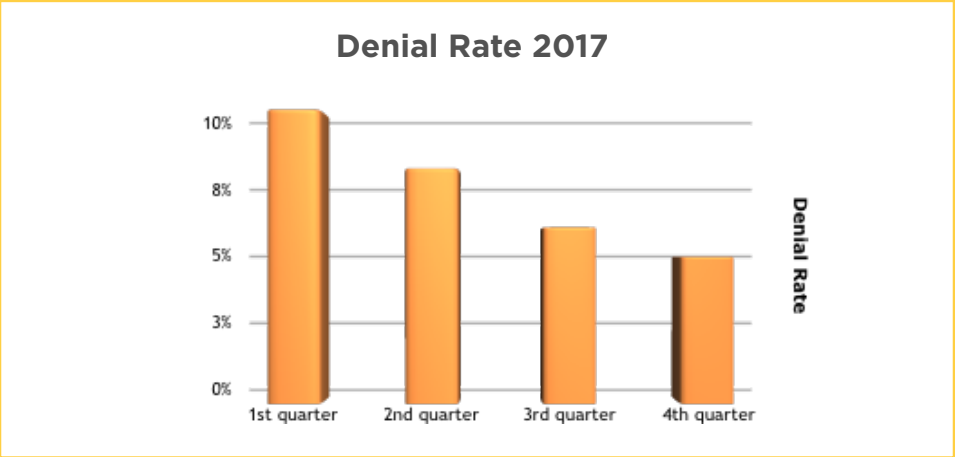
Sample Query Rate Graph



REDUCTION IN DOCUMENTATION RELATED DENIED CLAIMS

It stands to reason that when the documentation within the health record is of high quality then the number of claims denied for missing or inadequate documentation will also decrease. The denial rate is measured by comparing the number of denied claims to the number of claims submitted. When developing a denials management team, many organizations are bringing CDI professionals into the process of determining if a denied claim should be appealed. The reasons for denials can also be used as educational opportunities for providers and staff. Denials data should also be a clue to the CDI staff on what areas of specificity to focus on in the documentation.

Sample Query Rate Graph



STAFF PRODUCTIVITY

When developing productivity standards for CDI staff, it is important to set quantitative and qualitative expectations. It is also important to incorporate a learning curve for new CDI professionals. This curve should gradually increase as their experience grows until they reach the team expectations. It typically takes one year of experience for a CDI professional to become proficient in all the CDI goals. The measurements for productivity should be specific for each organization.

Quality productivity for CDI programs may include both health record review and query compliance. A qualitative audit tool can be developed that assigns a numeric value to each component reviewed (e.g., compliant queries, thorough record review) to provide a measurable data score. When the auditors perform quality audits on health record reviews, they may pull records that did and did not result in a query. Records that did not result in a query will be reviewed by the auditor to identify any missed query opportunities. Records that did result in a query will be reviewed by the auditor to ensure the queries are compliant. The Sample Quality Productivity Audit Tool below is just one example of an auditing tool. Each CDI program should develop internal audit tools specific to its needs.

Sample Quality Productivity Audit Tool

Measure	Score instructions			Score
Record Review (standard is to start review within 2 hours of the encounter)	Score 3 for a review that was initiated within 2–4 hours from the encounter	Score of 2 if the review was started within 4–6 hours from the encounter	Score of 1 if the review was started >6 hours from the encounter	
Query Opportunities	Score of 3 if there were no missed query opportunities identified in the audit	Score of 2 if there were 1–2 missed query opportunities identified in the audit	Score of 1 if there were >2 missed query opportunities identified in the audit	
Total Score				

Action Plan:

Total Score 5–6 Successfully met quality productivity standards

Total Score 4–5 Action plan to be developed to address concerns with a follow-up audit to be performed four weeks after action plan is implemented

Total Score < 4 Action plan to be developed to address concerns with a follow-up audit to be performed two weeks after action plan is implemented

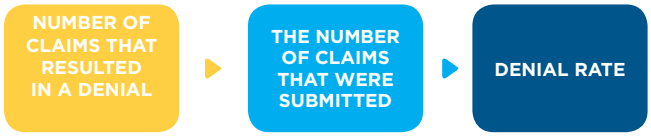
Quantitative productivity is easier to measure because there is a numeric value that can be measured. The components measured for these usually include the review rate and the response rate. As mentioned above, the query rate may be monitored but not always included in productivity. Since this is a number that will vary depending on the maturity of the CDI program, it could create unreal expectations for the CDI team if it is part of the productivity expectations.

Review Rate Calculation:

Query Response Rate Calculation:

Query Rate Calculation:

Denial Rate Calculation:



Benchmarking

When developing benchmarking standards, it is important for organizations and providers to compare themselves to peers that deliver the same level of services. Several benchmarking surveys are publicly available. Some of these include Hospital Compare, Physician Compare, Healthgrades, and the Leapfrog Hospital Survey. The information obtained from benchmarking efforts can assist the outpatient CDI programs to determine the program's expected outcomes.

EXPECTED OUTCOMES

CDI programs focus on having high-quality, complete, and accurate documentation that tells the true story of the encounter and patient's conditions. Many CDI programs have three general expected outcomes that govern their programs. These include appropriate reimbursement, accurate quality scores, and a reduction in denied claims related to the missing or inadequate documentation. The elements that support these outcomes will vary by setting. For example, if the CDI program is focused on HCCs, then the program may monitor the risk adjustment scores. Each setting will have specific quality measures that should be shared with the CDI team to evaluate those elements during the health record reviews. These scores can then be monitored to determine the impact the CDI program has on these measures.

Physician Engagement

Physician engagement is crucial to the implementation, success, and sustainability of any CDI program, whether it be inpatient, outpatient, or any other healthcare setting. Early and continued involvement of key stakeholders and physician champions will contribute to the ongoing collaboration with CDI and coding. Suggestions for focus in this endeavor are to start with a small scope focus of opportunities where the results of documentation improvement efforts will show higher return and value from effort. Sharing these results among the global CDI team will promote engagement and encourage other areas of focus that will contribute to continued success. An additional reference for more details and insight around physician engagement can be found in the "Impact of Physician Engagement on Clinical Documentation Improvement Programs" practice brief.[19]

The table below shows how the query rate can be used to determine the level of physician engagement at a facility.

Physician Engagement Levels[20]

Level of Engagement	Associated Query Rate
Apprehension	>45%
Interest	35–45%
Understanding	25–35%
Commitment	<25%

Level of Engagement	Associated Response Rate
Apprehension	<70%
Interest	70–80%
Understanding	80–90%
Commitment	90–100%

EDUCATION AND PROCESS IMPROVEMENT

It is vital that CDI professionals educate providers on medical necessity requirements to reduce the risk of claim denials. Providers may be unaware of the need to submit a diagnosis code with each CPT code. In a physician clinic, it could be a medical assistant or a nurse who is transcribing orders from the providers. If education has not been provided on the medical necessity requirements, an order could be generated with a primary diagnosis that is unrelated to the provider order. It might be difficult to reduce medical necessity denials without specific education being delivered to providers. This is also true for outpatient surgery denials; when the office obtains an authorization for one procedure and a different one is performed and coded, there is a higher risk for a claim denial.

The importance of continuing education and assessments for process improvement needs is an ongoing task. Continuing education is critical to the startup of any new CDI program; it is also equally important and crucial to successful CDI programs. The specifics of these areas should be a customized to the needs of the individual facility and focus of the organization; these may fluctuate over time. It is beneficial to have ongoing metric reporting for a continual assessment of the program's performance. These reports may be presented at staff meetings, quarterly meetings, or a one-on-one meeting.

Opportunities for ongoing CDI education from AHIMA include:

- AHIMA Annual Convention
- CDI Summit
- CDI Academies
- Webinars
- Online Education
- "Documentation Detective" (CDI blog at the *Journal of AHIMA* website)
- *Journal of AHIMA* articles

NOTES

1. Medicare Payment Advisory Commission. "Chapter 3: Hospital Inpatient and Outpatient Services." *Report to the Congress: Medicare Policy*, March 2016. http://medpac.gov/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatient-services-march-2016-report-.pdf?sfvrsn.

2. Centers for Medicare and Medicaid Services. "Chapter 6: Hospital Services Covered Under Part B." *Medicare Benefit Policy Manual*, Rev. 215, 12-18-15, p. 7. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.

3. Centers for Disease Control and Prevention. "ICD-10-CM Official Guidelines for Coding and Reporting FY 2018." https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf.

4. Ibid.

5. Ibid.

6. Ibid.

7. Ibid.

8. Ibid.

9. Ibid.

10. Ibid.

11. Ibid.

12. Ibid, p. 212.

13. Centers for Medicare & Medicaid Services."Glossary: Medically Necessary." https://www.cms.gov/apps/glossary/default.asp?Letter=M&Language=English.

14. Pope, Gregory, et al. "Evaluation of the CMS-HCC Risk Adjustment Model." March 2011. http://www.nber.org/risk-adjustment/2011/Evaluation2011/Evaluation_Risk_Adj_Model_2011.pdf.

15. CMS. "HHS-Developed Risk Adjustment Model Algorithm 'Do It Yourself (DIY)' Software Instructions." https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-Instructions-2017.pdf.

16. Ibid.

17. Combs, Tammy, and Melanie Endicott. "Impact of Physician Engagement on Clinical Documentation Improvement Programs (AHIMA Practice Brief)." *Journal of AHIMA* 88, no. 7 (July 2017): 42. http://bok.ahima.org/doc?oid=302187.

18. Ibid.

19. Ibid.

20. Ibid.

REFERENCES

AHIMA. *Pocket Glossary of Health Information Management and Technology*, fifth edition. Chicago, IL: AHIMA Press, 2017.

Department of Health and Human Services. "Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates." Final rule. 42 CFR Parts 410, 411, 412 et al., Nov. 27, 2007, p. 212. https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1392fc.pdf.

National Bureau of Economic Research. "CMS Risk Adjustment." August 2, 2014. http://www.nber.org/data/cms-risk-adjustment.html.

Palmetto GBA. "Risk Adjustment Processing System Acceptable Physician Specialty Types Effective Payment Year 2017." https://www.csscoperations.com/internet/cssc3.nsf/files/AcceptablePhysicianSpecialtyTypes%20PY2017.pdf/$FIle/AcceptablePhysicianSpecialtyTypes%20PY2017.pdf.

ADDITIONAL OUTPATIENT CDI RESOURCES

AHIMA. "Clinical Documentation Improvement." http://www.ahima.org/topics/cdi. Also, Read the "Documentation Detective" (CDI blog) at the *Journal of AHIMA* website: http://journal.ahima.org/category/blogs/documentation-detective.

AHIMA. "Clinical Documentation Improvement Toolkit." 2016. http://bok.ahima.org/PdfView?oid=301829.

AHIMA. "Guidelines for Achieving a Compliant Query Practice (2016 Update)." (Updated January 2016) http://bok.ahima.org/PB/QueryCompliance.

AHIMA. "Physician Coding Toolkit." 2015. http://bok.ahima.org/doc?oid=301211.

AHIMA. "AHIMA Query Toolkit." 2017. http://bok.ahima.org/doc?oid=302140.

Combs, Tammy. "Benefits and Barriers for Outpatient CDI Programs." *Journal of AHIMA* website, May 27, 2016. http://journal.ahima.org/2016/05/27/benefits-and-barriers-for-outpatient-cdi-programs.

Association of Clinical Documentation Improvement Specialists. "Outpatient Clinical Documentation Improvement (CDI): An Introduction." May 2016. https://acdis.org/system/files/resources/outpatient-cdi-intro.pdf.

Barnette, Erin, et al. "Evolving Roles in Clinical Documentation Improvement: Physician Practice Opportunities" *Journal of AHIMA* 88, no.5 (May 2017): 54-58.http://bok.ahima.org/doc?oid=302135.

Denton, Debra Beisel, et al. "Clinical Validation: The Next Level of CDI (December 2016 update)." *Journal of AHIMA*, December 2016. http://bok.ahima.org/PB/ClinicalValidation.

Gibson, Harold. "Clinical Documentation Improvement is critical for Private Practices." M-Scribe Medical Billing blog, April 1, 2014. https://www.m-scribe.com/blog/bid/340943/Clinical-Documentation-Improvement-is-critical-for-Private-Practices-too.

Hailes, John. "Truly Understanding Clinical Documentation Improvement for ICD-10." Indian Health Service. https://www.ihs.gov/california/default/assets/File/GPRA/BP2012-ClinicalDocumentationImprovement-Hailes.pdf.

Robinson, Steve. "Outpatient CDI: Priorities, Barriers and Where to Begin." *Advance for Health Information Professionals*, January 18, 2017. https://health-information.advanceweb.com/Columns/CDI-Insights/Outpatient-CDI-Priorities-Barriers-and-Where-to-Begin.aspx.

Smith, Donna. "Sponsored: HCC Accuracy is a Crucial Factor in the CDI Value Equation." *CDI Strategies* vol. 11, issue 20 (May 11, 2017). https://acdis.org/articles/sponsored-hcc-accuracy-crucial-factor-cdi-value-equation.

OUTPATIENT CDI TOOLKIT GLOSSARY

(adapted from the *AHIMA Pocket Glossary of Health Information Management and Technology*, fifth edition. Chicago, IL: AHIMA Press, 2017.)

A

Ambulatory Payment Classifications (APCs): Classification systems used for the hospital outpatient prospective payment system (PPS)

Advanced Alternative Payment Models (APMs): A payment model that allows providers to be exempt from MIPs reporting and earn incentive payments for delivering quality care

Ambulatory surgery center: A center that provides outpatient surgeries that does not require an inpatient hospital stay

B

Benchmarking: A method of comparing one's performance to industry standards

Best practice: Professional procedures that are accepted as being correct or the most effective process

C

Case management: 1. The ongoing, concurrent review performed by clinical professionals to ensure the necessity and effectiveness of the clinical services being provided to a patient 2. A process that integrates and coordinates patient care over time and across multiple sites and providers, especially in complex and high-cost cases, with goals of continuity of care, cost-effectiveness, quality, and appropriate utilization 3. The process of developing a specific care plan for a patient that serves as a communication tool to improve quality of care and reduce cost

Centers for Medicare and Medicaid Services (CMS): The division of the Department of Health and Human Services that is responsible for developing healthcare policy in the United States and for administering the Medicare program and the federal portion of the Medicaid program and maintaining the procedure portion of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM); called the Health Care Financing Administration (HCFA) prior to 2001

Clinical documentation: Any manual or electronic notation (or recording) made by a physician or other healthcare clinician related to a patient's medical condition or treatment

Clinical Documentation Improvement (CDI): The process an organization undertakes that will improve clinical specificity and documentation that will allow coding professionals to assign more concise disease, procedure, and service classification codes

Compliance: 1. The process of establishing an organizational culture that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal, state, or private payer healthcare program requirements or the healthcare organization's ethical and business policies 2. The act of adhering to official requirements 3. Managing a coding or billing department according to the laws, regulations, and guidelines that govern it

Clarification: The action of making a statement or situation less confusing and more comprehensible

Clinical validation: The act of reviewing the health record to ensure there is enough clinical evidence and treatment provided to support a documented diagnosis

Current Procedural Terminology (CPT®): An outpatient coding system that is focused on services that were provided. CPT level one codes are managed by the American Medical Association (AMA)

D

Dashboards: Reports of process measures to help leaders follow progress and assist with strategic planning; also called scorecards

Denied claim: Submitted insurance claims that were denied for payment

E

Electronic health record (EHR): An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff

Encoder: Specialty software used to facilitate the assignment of diagnostic and procedural codes according to the rules of the coding classification system

Evaluation and Management: CPT codes that describe the level of care that was delivered by a healthcare provider

F

First-listed diagnosis: The medical diagnosis that occasioned the outpatient encounter

H

Healthcare Common Procedural Coding System (HCPCS): Level II CPT Codes are managed by CMS and cover healthcare equipment and supplies that are not covered in CPT codes

Health information management (HIM) professional: An individual who has received professional training at the associate or baccalaureate degree level in the management of health data and information flow throughout healthcare delivery systems

Health record: 1. Information relating to the physical or mental health or condition of an individual, as made by or on behalf of a health professional in connection with the care provided to that individual 2. A medical record, health record, or medical chart that is a systematic documentation of a patient's medical history and care

Hierarchical Condition Categories: A payment model that identifies individuals with acute and chronic conditions that assigns a risk factor scored based on the conditions and certain demographic details

High Risk Diagnosis: A diagnosis that is at a higher risk of being flagged for an audit than most diagnoses

Home health agency: An organization that provides home health services, such as: skilled nursing care, physical/occupational therapy, and personal care

Hospital observation: An admission to the hospital to receive services as an outpatient rather than inpatient admission

I

International Classification of Diseases, Tenth Revision, Clinical Modification Procedural Classification System (ICD-10-CM/PCS): A coding and classification system used in the United States to report diagnoses in all healthcare settings and inpatient procedures and services as well as morbidity and mortality information

Inpatient Quality Reporting (IQR): The quality reporting system for inpatient healthcare systems

L

Legal health record (LHR): Documents and data elements that a healthcare provider may include in response to legally permissible requests for patient information

Licensed/Certified Medical Professionals (LCMPs): These are individuals who have successfully completed programs of study in a healthcare field and obtained a license or certificate declaring the person's competency.

M

Medicare Access & CHIP Reauthorization Act (MACRA): A law establishing a quality payment program for providers that repeals the Sustainable Growth Rate (SGR)

Medicaid: An entitlement program that oversees medical assistance for individuals and families with low incomes and limited resources; jointly funded between state and federal governments and legislated by the Social Security Act

Medical necessity: 1. The likelihood that a proposed healthcare service will have a reasonable beneficial effect on the patient's physical condition and quality of life at a specific point in his or her illness or lifetime 2. Healthcare services and supplies that are proven or acknowledged to be effective in the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms and to be consistent with the community's accepted standard of care. Under medical necessity, only those services, procedures, and patient care warranted by the patient's condition are provided 3. The concept that procedures are only eligible for reimbursement as a covered benefit when they are performed for a specific diagnosis or specified frequency

Medicare: A federally funded health program established in 1965 to assist with the medical care costs of Americans 65 years of age and older as well as other individuals entitled to Social Security benefits owing to their disabilities

Medicare Advantage (Medicare Part C): Optional managed care plan for Medicare beneficiaries who are entitled to Part A, enrolled in Part B, and live in an area with a plan; types include health maintenance organization, point-of-service plan, preferred provider organization, and provider-sponsored organization

Medicare Benefit Policy Manual: The Medicare policy manual that provides information on covered services

Merit-based Incentive Payment System (MIPS): An incentive payment system that consolidates Physician Quality Reporting System (PQRS), the Value-based Payment Modifier, and Electronic Health Record Incentive program

O

Office of the Inspector General (OIG): Mandated by Public Law 95-452 (as amended) to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions performed by OIG components

Outcome Assessment and Information Set (OASIS): An assessment tool for home health agencies that incorporates data elements from a comprehensive assessment

Outpatient Prospective Payment System (OPPS): The prospective payment system utilized in the outpatient setting

Outpatient Quality Reporting (OQR): The quality reporting system utilized in an outpatient healthcare setting

P

Pay for performance (P4P): 1. A type of incentive to improve clinical performance using the electronic health record that could result in additional reimbursement or eligibility for grants or other subsidies to support further HIT efforts 2. The Integrated Healthcare Association initiative in California based on the concept that physician groups would be paid for documented performance

Performance improvement (PI): The continuous study and adaptation of a healthcare organization's functions and processes to increase the likelihood of achieving desired outcomes

Performance measure: A quantitative tool used to assess the clinical, financial, and utilization aspects of a healthcare provider's outcomes or processes

Physician champion: An individual who assists in communicating and educating medical staff in areas such as documentation procedures for accurate billing and appropriate EHR processes

Present on admission (POA): A condition present at the time of an inpatient admission

Principal diagnosis: The disease or condition that was present on admission, was the principal reason for admission, and received treatment or evaluation during the hospital stay or visit or the reason established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

Prospective Payment System (PPS): A type of reimbursement system that is based on preset payment levels rather than actual charges billed after the service has been provided; specifically, one of several Medicare reimbursement systems based on predetermined payment rates or periods and linked to the anticipated intensity of services delivered as well as the beneficiary's condition

Physician Quality Reporting System (PQRS): The quality reporting system utilized by eligible providers

Q

Query: The process by which questions are posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record

Query rate: The number of records that resulted in a query divided by the number of health records reviewed

Query response rate: The number or queries with a response divided by the number of queries sent

Quality improvement organization (QIO): An organization that performs medical peer review of Medicare and Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy, and quality of care; and appropriateness of prospective payments for outlier cases and non-emergent use of the emergency room. Until 2002, called peer review organization

Quality management: Evaluation of the quality of healthcare services and delivery using standards and guidelines developed by various entities, including the government and independent accreditation organizations

R

Readmission rate: An admission to subsection hospital within 30 days of a discharge from the same hospital or another subsection hospital

Reimbursement: Compensation or repayment for healthcare services

Relative weight (RW): Assigned weight that reflects the relative resource consumption associated with a payment classification or group; higher payments are associated with higher relative weights

Retention: 1. Mechanisms for storing records, providing for timely retrieval, and establishing the length of times that various types of records will be retained by the healthcare organization 2. The ability to keep valuable employees from seeking employment elsewhere

Revenue cycle: 1. The process of how patient financial and health information moves into, through, and out of the healthcare facility, culminating with the facility receiving reimbursement for services provided 2. The regularly repeating set of events that produce revenue

Review rate: The number of health records reviewed divided by the number of health records that were assigned for review

Risk adjustment: An adjustment made to payment methodology based on a level of risk associated with the severity of a patient's condition

Risk of mortality (ROM): The likelihood of death

S

Secondary diagnosis: A statement of those conditions coexisting during a hospital episode or office visit that affects the treatment received or the length of stay

Severity of illness (SOI): This refers to the extent of physiologic decompensation of a patient

APPENDICES

All the examples provided in this toolkit are meant to be guides. Each organization should create documents specific to their facility and following their organization's policies and procedures.

APPENDIX A: OP CDI QUERY EXAMPLES

Example 1: (Treatment without definitive diagnosis)

Patient presents to the physician clinic with coronary artery disease and a high blood pressure reading and was started on Lopressor 50 mg daily.

Query

Dear Doctor,

"Start Lopressor 50 mg daily", was documented within the clinic note from 7/12/17.

Clinical Indicators: Blood pressure reading of 185/92, tachycardia of 92, and coronary artery disease are also documented within the note.

Based on the clinical indicators and your professional judgment, can an associated diagnosis be documented? Please complete by selecting one of the options below.

- Hypertension
- Elevated blood pressure reading without the diagnosis of hypertension
- Other explanation of clinical findings _____.
- Unable to determine
- No further clarification needed

Example 2: (Risk Adjustment)

An established patient covered under a Medicare Advantage program is seen in follow-up for previously diagnosed diabetes mellitus, type 2. Physician documents patient has been noncompliant with their diet and exercise program and the patient's home glucose monitor consistently reports random morning glucose levels exceeding 300 mg/dl. The documented plan of care is to begin the patient on insulin injections to control their blood glucose levels. The physician assigned diagnosis code for the visit is E11.9, Type 2 diabetes mellitus without complication. Upon CDI review, the CDS notes the patient weight is documented as 413 lbs. and the calculated BMI is noted as 59.3.

Query #1

Dear Doctor,

Type 2 Diabetes is documented in the encounter note on 9/27/17.

Clinical Indicators: noncompliant with diet and exercise program, home glucose reading consistently exceeds 300. Patient to begin taking insulin injections.

Based upon your professional judgment and the clinical evidence, can this diagnosis be further specified?

- Type 2 Diabetes complicated by hyperglycemia
- Type 2 Diabetes without complications, abnormal glucose findings without clinical significance
- Unable to determine
- Other explanation of clinical findings_____.

Query #2

Dear Doctor,

The calculated BMI is noted as 59.3 in the lab findings on 9/27/17.

Clinical Indicators: Patient's weight is noted to be 413 pounds, noncompliant with diet and exercise program.

Based upon your professional judgment and the clinical evidence, can an associated diagnosis be provided?

- Obesity
- Morbid Obesity
- Overweight of no clinical significance
- Unable to determine
- Other explanation of clinical findings _____.

Example 3: (Relationship between device and diagnosis)

A patient with an indwelling urinary catheter comes into the emergency department with abdominal pain and has a positive urinalysis and is diagnosed with a UTI.

Query

Dear Doctor

UTI was documented on the ED note dated 7/10/17.

Clinical Indicators: abdominal pain, urinalysis shows +3 bacteria, patient has suprapubic catheter, Bactrim was started and the patient was told to follow up with their primary care physician.

Based on the clinical indicators and your professional judgment can the relationship between these two diagnoses be further specified? Please complete by selecting one of the options below.

- UTI is secondary to the suprapubic catheter
- UTI is unrelated to the suprapubic catheter
- Other explanation of clinical findings
- Unable to determine
- No further clarification needed

APPENDIX B: POLICIES AND PROCEDURES

Sample Policy and Procedure for CDI in a Provider Clinic

[Enter Name of Provider Clinic]	[Enter Policy Name/Number]
Prepared by:	Approved by:
Effective Date:	Revised Date:
Purpose Statement: The purpose of this policy is to provide direction to the CDI program for this provider clinic. The focus of the CDI program is to review health records for high quality documentation that supports appropriate reimbursement and accurate quality scores.	
Scope: CDI professionals will work with providers to perform concurrent and/or retrospective health record reviews of the clinical documentation. Clinical documentation will be reviewed for the seven characteristics of high quality clinical documentation. When a gap within the documentation is identified, the CDI professional will follow the Query Policy and Procedure.	
Procedure: 1. Each new CDI professional will follow the same orientation schedule, as follows: a. Classroom education will be provided during the first week of employment. b. The new CDI professional will then have an experienced CDI professional as a preceptor to work with for the next 4 to 6 weeks or until the preceptor feels the new professional is ready to review health records on their own. 2. Health record reviews are to be performed at the time of the patient encounter, or within two hours of the encounter. 3. If no gap is identified in the clinical documentation, the CDI professional will make a note in the CDI computer system and mark the health record review as complete. If a gap in the documentation is identified, a query will be submitted according to the organization's Query Policy and Procedure. 4. Providers are expected to respond to the query before the end of the business day. If the query is sent within 1 hour of the end of business, the provider will respond by 10 a.m. the following business day. 5. If there is no response to the provider query by the defined timeframe, the CDI professional will follow the No Response Policy and Procedure. 6. When all queries have been responded to, or labeled as a no response, the CDI professional will make a note in the CDI computer system and mark the health record review as complete. 7. Ongoing CDI education will be provided each month at the monthly staff meetings. CDI professionals are required to attend 10 out of the 12 trainings each calendar year.	

Sample Query Policy and Procedure for a Provider Clinic

[Enter Name of Provider Clinic]	[Enter Policy Name/Number]
Prepared by:	Approved by:
Effective Date:	Revised Date:
Purpose Statement: The purpose of this policy is to provide guidance to CDI and coding professionals when sending queries to providers at this clinic. All queries should be sent following the guidelines outlined in the AHIMA Practice Brief "Guidelines for Achieving a Compliant Query Practice."	
Scope: All queries sent in this facility should follow the procedures listed below. Queries are to be sent to identify high-quality clinical documentation. Queries should never lead a provider to any particular response. All queries should include clinical evidence from the health record used to support the need for the query. All queries should be answered by the provider using his/her professional judgment based on current clinical evidence.	

Procedures:

1. All queries should include a clear statement of issue in the form of a question. Multiple choice queries may be utilized but all options should be supported by the clinical evidence/indicators within the health record that was used to support the need for the query. Multiple choice queries should also include options for "other explanation" and "clinically undetermined." A query should never indicate the impact it may have on reimbursement or quality.
2. Yes or no formatted queries will only be used in the circumstances listed in the AHIMA practice brief "Guidelines for Achieving a Compliant Query Practice."
3. Verbal queries may be utilized, but must follow the same format and guidance as written queries and should be documented and tracked in the same method as written queries.
4. A query will be considered responded to when the provider updates the documentation within the health record encounter note or has informed the CDI professional, either verbally or in writing, that no further clarification can be provided.
5. A query will be considered as agreed to when the provider documents a higher level of specificity within the encounter note as a result of the query being sent. If the provider responds to the query that no further clarification can be provided, then the query will be considered a disagreement.
6. When the query has been responded to, it will be marked complete. If there is no response to the query, the CDI professional is to follow the No Response Policy and Procedure.

Sample Outpatient No Response Policy and Procedure

[Enter Name of Organization]	[Enter Policy Name/Number]
Prepared by:	Approved by:
Effective Date:	Revised Date:
Purpose Statement: The purpose of this policy and procedure is to provide guidance to CDI professionals when a query has not been responded to within the allotted time frame.	
Procedures: 1. The CDI professional will contact the provider when a query has not been responded to within the allotted time frame. 2. If the query remains a "no response" at the end of the business day, the CDI professional will escalate the no response query to the staff nurse (or other designee). 3. The staff nurse will contact the provider on the day he/she received the escalated query. If the query remains a "no response" at the end of the business day that the staff nurse contacted the provider, the staff nurse will escalate the query to the clinic manager. 4. The clinic manager will contact the provider on the day he/she received the escalated query. The clinical manager will continue contacting the provider until the query has been responded to or decides to mark the query as a no response.	
Note: If the provider receives a query or staff contact regarding a query, he/she will have until 10:00 am the following business day to respond to the query.	

APPENDIX C: JOB DESCRIPTION

Sample Job Description for Outpatient CDI Professional

Job Description	
Position Title:	Reports To:
Department:	Review date:
Purpose: The Clinical Documentation Improvement (CDI) professional will provide concurrent and retrospective health record reviews for the seven characteristics of high quality clinical documentation.	
Scope: CDI professionals will send queries to providers when documentation does not meet high-quality clinical documentation standards.	
Experience: Three years healthcare experience in either a coding or clinical area	
Education: Associate's degree required, bachelor's degree preferred	
Duties: 1. Perform concurrent and retrospective health record reviews 2. Demonstrate proficiency in CDI regulatory requirements 3. Identify gaps within the clinical documentation 4. Follow all policies and procedures when sending queries 5. Communicate documentation issues clearly and succinctly 6. Interact in a professional manner with all interdisciplinary team members 7. Remain compliant with all policies and procedures, including continuing education requirements	

APPENDIX D: INTERVIEW QUESTIONS

Sample Outpatient CDI Specialist Interview questions

Knowledge/Skill Questions:

- Explain to me your understanding of outpatient reimbursement methodologies?
- Can you explain what a first-listed diagnosis is?
- What would you consider clinical evidence?
- What would you consider a secondary diagnosis?
- Are you aware of the seven characteristics of high-quality clinical documentation? If so, please provide an example of a scenario of one?
- Have you ever presented information to a large group and if so, what is the largest group you have presented to and on what topic?

Behavior Questions:

- How do you organize yourself each day?
- Can you provide an example of a time you have had to lead a project in work or life and explain how you approached it?
- Can you provide an example of a time you achieved a goal and explain how you reached the goal?
- Can you provide an example of a time you had to teach on a subject and explain how you organized your information and presented the information?
- Can you provide an example of a time you helped influence someone who was initially resistant to a new process?

APPENDIX E: CHECKLIST TO STARTING AN OUTPATIENT CDI PROGRAM

	Step1 Perform a gap analysis to determine the need for an outpatient CDI program. A gap analysis will provide the information needed to gain administrative support of the program. Items to consider: Risk adjustment scores E/M levels Denial rate
	Step 2 Determine the budget of the program to guide the size and realistic expectations of the program. Items to consider: Equipment needs Staff salaries Office space Physician advisor salaries Orientation and ongoing education Consultation fees
	Step 3 Determine the structure of the program, including which department the program will reside in, as well as the staff requirements. Items to consider: Reporting structure In-house vs. remote Staff backgrounds (e.g., HIM professional, nurse, coding professional, educator) Years of experience Level of education
	Step 4 Determine the focus area or patient population that will comprise the health records to be reviewed. Potential areas of focus: Medicare Advantage High-risk diagnoses Area with high claim denials
	Step 5 Determine the number and frequency of reviews. Examples of review processes: CDI to work in scribe role to support concurrent review of all patient health records for assigned provider CDI to review all Medicare advantage cases within 24 hours of patient encounter CDI to review all Medicare cases in the hospital observation unit

	Step 6 Determine the metrics that will be run and the frequency of the reports. Common metrics to track: Review rate Query rate Response rate Denial rate Risk adjustment score
	Step 7 Develop detailed policies and procedures that outline the required and preferred credentials, education, and experience of the CDI professionals. These should also include the mission, vision, and procedures of the program.
	Step 8 Develop a detailed orientation program. Potential items to include: Two weeks in a classroom/CDI Academy Four weeks with a preceptor Hire consulting company
	Step 9 Develop an ongoing educational plan. Potential items to include: Monthly staff meeting with education Webinars Conferences CDI Summit CDI Academies
	Step 10 Implement the program and follow the policies and procedures, while maintaining a level of flexibility for needed changes that will keep the program moving forward. Potential item to develop: Process flow map: updating when changes are made

APPENDIX F: PRE-HIRE ASSESSMENT

Pre-Hire Assessment

1. Which of the following is the communication tool that is utilized between healthcare providers?
   a. Query
   b. Health record
   c. E-mail
   d. In basket

2. Which of the following are potential areas of focus for outpatient CDI programs?
   a. Diagnosis-Related Groups
   b. Severity of illness
   c. Improvement of E/M levels
   d. Patient safety indicators

3. Ambulatory Payment Classifications (APCs), which are a major component of the outpatient payment system (OPPS), are based on which of the following?
   a. CPT® codes
   b. ICD-10-CM codes
   c. ICD-10-PCS codes
   d. HCCs

4. Which of the following is used in the outpatient setting in lieu of the principal diagnosis?
   a. First listed diagnosis
   b. Major diagnosis
   c. Chief diagnosis
   d. Primary diagnosis

5. Which of the following is the health record used for?
   a. Evaluation of the quality of care
   b. Reporting communicable diseases
   c. Billing and reimbursement
   d. All the above

6. Which of the following statements is true in the outpatient setting?
   a. Coding professionals code a diagnosis documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty.
   b. Coding professionals do not code a diagnosis documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty.
   c. Coding professionals do not code radiology findings unless they are confirmed by the attending provider.
   d. None of the above

7. Evaluation and Management codes are part of a subset of which larger code nomenclature?
   a. ICD-10-CM
   b. ICD-10-PCS
   c. CPT
   d. HCPCS

8. Which code set is used to report procedures in the inpatient setting?
   a. CPT
   b. ICD-10-CM
   c. HCPCS
   d. ICD-10-PCS

9. Which of the following code sets is used to report US diagnosis/es in all healthcare settings?
   a. ICD-10-PCS
   b. CPT
   c. HCPCS
   d. ICD-10-CM

10. Which of the following is a true statement regarding healthcare reimbursement?
    a. Healthcare reimbursement is shifting from value-based models to fee-for-service.
    b. Healthcare reimbursement following the same process in all healthcare settings.
    c. Healthcare reimbursement is shifting from fee-for-service to value-based models.
    d. Healthcare reimbursement is not impacted by CDI efforts.

11. Which of the following is the new outpatient quality payment program for providers?
    a. MACRA
    b. SOI
    c. ROM
    d. PSIs

12. _____ is an outpatient service utilized when the patient requires additional monitoring/observation beyond what should be provided in the ER or an office visit.
    a. Inpatient status
    b. Observation status
    c. Skilled nursing facilities
    d. Medical necessity

13. Which of the following is a challenge in obtaining complete quality documentation and coding in the ED?
    a. Extreme variety of patient conditions
    b. Around the clock patient care
    c. Both a and b
    d. Neither a nor b

14. There is an increase in the use of _____ to drive payment models such as hierarchical condition categories.
    a. Diagnosis codes
    b. Prescriptions
    c. Therapy needs
    d. Durable medical equipment

15. Which of the following may result in a payment denial for lack of medical necessity?
    a. History of a compliance infringement
    b. Long wait times
    c. HIPAA violation
    d. Inadequate documentation

16. The CMS-HCC methodology is organized by categorizing specific _____ codes into categories of diseases.
    a. ICD-10-PCS
    b. HCPCS
    c. ICD-10-CM
    d. CPT

17. _____are available for a continuation of healthcare in a patient's home.
    a. Inpatient rehabilitation
    b. Skilled nursing facilities
    c. Inpatient psychiatric care
    d. Home health agencies

18. Which of the following refers to accounting processes and tools used to predict healthcare costs based on relative actuarial risks including demographic and health-related factors?
    a. Severity of Illness
    b. Risk adjustment
    c. Risk of mortality
    d. Complications and comorbidities

19. Which of the following was developed specifically for commercial insurance plans?
    a. CMS-HCCs
    b. HHS-HCCs
    c. RX-HCCs
    d. Ambulatory Payment Classifications

20. Which of the following can be a free-standing facility or hospital based center that performs same-day surgical procedures that do not require an overnight stay?
    a. Skilled nursing facilities
    b. Hospital observation units
    c. Ambulatory surgery centers
    d. All the above

21. Which of the following statements is true regarding high quality clinical documentation?
    a. High-quality documentation will typically result in a reduction in the number of denied claims for missing or inadequate documentation.
    b. High-quality documentation will typically result in an increase in the number of denied claims for inaccurate code assignment.
    c. High-quality documentation will typically result in a decrease in reimbursement.
    d. High-quality documentation will typically result in inaccurate quality scores.

22. When developing benchmarking standards, it is important for organizations and providers to compare themselves to peers that deliver_____.
    a. Lower level of services
    b. Higher level of services
    c. The same level of services
    d. A poor quality of care

23. Which of the following is crucial in the success and sustainability of any CDI program?
    a. Pharmacy engagement
    b. Physician engagement
    c. Physician frustration
    d. Radiology engagement

24. Which of the following is a benchmarking survey?
    a. Hospital Compare
    b. Physician Compare
    c. Healthgrades
    d. All the above

25. Which of the following focuses on the quality of a CDI professional's productivity?
    a. Query rate
    b. Quantitative productivity
    c. Review rate
    d. Qualitative productivity

Pre-Hire Assessment Answer Sheet (Please note that correct answers are marked with an "*")

1. Which of the following is the communication tool that is utilized between healthcare providers?
   a. Query
   *b. Health record
   c. E-mail
   d. In basket

Feedback:

The documentation in a patient's health record is used as a communication tool between healthcare providers

2. Which of the following are potential areas of focus for outpatient CDI programs?
   a. Diagnosis-Related Groups
   b. Severity of illness
   *c. Improvement of E/M levels
   d. Patient safety indicators

Feedback:

Potential areas of outpatient CDI program focus includes the elements of the Outpatient Prospective Payment System (OPPS), diagnosis specificity for risk adjustment and improvement of E/M levels based on documentation enhancements.

3. Ambulatory Payment Classifications (APCs), which are a major component of the outpatient payment system (OPPS), are based on which of the following?
   *a. CPT® codes
   b. ICD-10-CM codes
   c. ICD-10-PCS codes
   d. HCCs

Feedback:

The major component of the outpatient prospective payment system (OPPS) is Ambulatory Payment Classifications (APCs), which are based on CPT (Current Procedural Terminology).

4. Which of the following is used in the outpatient setting in lieu of the principal diagnosis?
   *a. First-listed diagnosis
   b. Major diagnosis
   c. Chief diagnosis
   d. Primary diagnosis

Feedback:

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

5. Which of the following is the health record used for?
   a. Evaluation of the quality of care
   b. Reporting communicable diseases
   c. Billing and reimbursement
   *d. All the above

Feedback:

The health record is also used for billing and reimbursement, evaluation of quality of care, hospital and physician ranking, reporting communicable diseases, registries, and research.

6. Which of the following statements is true in the outpatient setting?
   a. Coding professionals code a diagnosis documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty.
   *b. Coding professionals do not code a diagnosis documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty.
   c. Coding professionals do not code radiology findings unless they are confirmed by the attending provider.
   d. None the above

Feedback:

In the outpatient setting, coding professionals do not code diagnoses documented as 'probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty.

7. Evaluation and Management codes are part of a subset of which larger code nomenclature?
   a. ICD-10-CM
   b. ICD-10-PCS
   *c. CPT
   d. HCPCS

Feedback:

Evaluation and Management codes, a subset of the larger Current Procedural Terminology (CPT) code nomenclature, are used to report the intensity of care provided during a patient encounter.

8. Which code set is used to report procedures in the inpatient setting?
   a. CPT
   b. ICD-10-CM
   c. HCPCS
   *d. ICD-10-PCS

Feedback:

Inpatient setting procedures are reported with ICD-10-PCS codes.

9. Which of the following code sets is used to report US diagnosis/es in all healthcare settings?
   a. ICD-10-PCS
   b. CPT
   c. HCPCS
   *d. ICD-10-CM

Feedback:

ICD-10-CM codes are used in all US healthcare settings to report the diagnosis/es.

10. Which of the following is a true statement regarding healthcare reimbursement?
   a. Healthcare reimbursement is shifting from value-based models to fee-for-service.
   b. Healthcare reimbursement following the same process in all healthcare settings.
   *c. Healthcare reimbursement is shifting from fee-for-service to value-based models.
   d. Healthcare reimbursement is not impacted by CDI efforts.

Feedback:

Healthcare reimbursement is shifting from fee-for-service to value-based models.

11. Which of the following is the new outpatient quality payment program for providers?
*a. MACRA
b. SOI
c. ROM
d. PSIs

Feedback:

CMS has developed a new outpatient quality payment program called Medicare Access and CHIP Re-authorization Act (MACRA) for providers.

12. _____ is an outpatient service utilized when the patient requires additional monitoring/observation beyond what should be provided in the ER or an office visit.
a. Inpatient status
*b. Observation status
c. Skilled nursing facilities
d. Medical necessity

Feedback:

Observation status is an outpatient service utilized when the patient requires additional monitoring/observation beyond what should be provided in the ER or an office visit.

13. Which of the following is a challenge in obtaining complete quality documentation and coding in the ED?
a. Extreme variety of patient conditions
b. Around the clock patient care
*c. Both a and b
d. Neither a nor b

Feedback:

The extreme variety of patient conditions treated in the ED, coupled with supporting staff that must provide care around the clock create numerous opportunities and challenges to obtaining complete quality documentation and coding.

14. There is an increase in the use of _____ to drive payment models such as hierarchical condition categories.
*a. Diagnosis codes
b. Prescriptions
c. Therapy needs
d. Durable medical equipment

Feedback:

There is an increase in the use of diagnosis codes to drive payment models such as hierarchical condition categories.

15. Which of the following may result in a payment denial for lack of medical necessity?
a. History of a compliance infringement
b. Long wait times
c. HIPAA violation
*d. Inadequate documentation

Feedback:

Inadequate documentation may result in a payment denial for lack of medical necessity.

16. The CMS-HCC methodology is organized by categorizing specific _____ codes into categories of diseases.
    a. ICD-10-PCS
    b. HCPCS
    *c. ICD-10-CM
    d. CPT

Feedback:

The CMS-HCC methodology is organized by categorizing specific ICD-10-CM (diagnosis) codes into categories of diseases.

17. _____are available for a continuation of healthcare in a patient's home.
    a. Inpatient rehabilitation
    b. Skilled nursing facilities
    c. Inpatient psychiatric care
    *d. Home health agencies

Feedback:

Home health agencies (HHA) are available for a continuation of healthcare in a patient's home.

18. Which of the following refers to accounting processes and tools used to predict health care costs based on relative actuarial risks including demographic and health-related factors?
    a. Severity of Illness
    *b. Risk adjustment
    c. Risk of mortality
    d. Complications and comorbidities

Feedback:

Risk adjustment refers to accounting processes and tools used to predict healthcare costs based on relative actuarial risks including demographic and health-related factors.

19. Which of the following was developed specifically for commercial insurance plans?
    a. CMS-HCCs
    *b. HHS-HCCs
    c. RX-HCCs
    d. Ambulatory Payment Classifications

Feedback:

The Health and Human Services Hierarchical Condition Categories (HHS-HCC) was developed specifically for the commercial plans.

20. Which of the following can be a free-standing facility or hospital-based center that performs same day surgical procedures that do not require an overnight stay?
    a. Skilled nursing facilities
    b. Hospital observation units
    *c. Ambulatory surgery centers
    d. All the above

Feedback:

Ambulatory surgery centers (ASC) can be free-standing facilities or hospital-based centers that perform same day scheduled surgical procedures not requiring an overnight stay.

21. Which of the following statements is true regarding high-quality clinical documentation?

*a. High-quality documentation will typically result in a reduction in the number of denied claims for missing or inadequate documentation.

b. High-quality documentation will typically result in an increase in the number of denied claims for inaccurate code assignment.

c. High-quality documentation will typically result in a decrease in reimbursement.

d. High-quality documentation will typically result in inaccurate quality scores.

Feedback:

It only stands to reason that when the documentation within the health record is of high quality then the number of denied claims for missing or inadequate documentation would also decrease.

22. When developing benchmarking standards, it is important for organizations and providers to compare themselves to peers that deliver_____.

a. Lower level of services

b. Higher level of services

*c. The same level of services

d. A poor quality of care

Feedback:

When developing benchmarking standards, it is important for organizations and providers to compare themselves to peers that deliver the same level of services.

23. Which of the following is crucial in the success and sustainability of any CDI program?

a. Pharmacy engagement

*b. Physician engagement

c. Physician frustration

d. Radiology engagement

Feedback:

Physician engagement is crucial to the implementation, success and sustainability of any CDI program, whether it be inpatient, outpatient or any other health care setting

24. Which of the following is a benchmarking survey?

a. Hospital Compare

b. Physician Compare

c. Healthgrades

*d. All the above

Feedback:

There are several benchmarking surveys that are publicly available. Some of these include Hospital Compare, Physician Compare, Healthgrades, and the Leapfrog Hospital Survey.

25. Which of the following focuses on the quality of a CDI professional's productivity?

a. Query rate

b. Quantitative productivity

c. Review rate

*d. Qualitative productivity

Feedback:

Qualitative productivity focuses on the quality of a CDI professional's productivity.

APPENDIX G: POST-HIRE ASSESSMENT

Post 90-Day Hire Assessment

1. Which of the following models focuses on the quality of care?
   a. PQRS
   b. DRG
   c. APC
   d. RUG

2. Which of the following statements is true?
   a. For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.
   b. For inpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.
   c. For outpatient encounters for diagnostic tests that have been interpreted by a nurse, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.
   d. All the above

3. When a patient presents for outpatient surgery (same day surgery), code the _____ as the first-listed diagnosis even if the surgery is not performed due to a contraindication.
   a. Reason for contraindication
   b. First diagnosis documented by the provider
   c. Reason for surgery
   d. Complication

4. A provider is exempt from MIPS reporting if they are part of which of the following programs?
   a. PQRS
   b. APM
   c. OASIS
   d. PAI

5. The MIPS program repeals which of the following programs?
   a. Physician Quality Reporting System (PQRS)
   b. Value-based modifier (VM)
   c. Sustainable growth rate (SGR)
   d. Electronic health record (EHR)

6. Which of the following HCC methodologies relies on certain conditions/diagnoses to predict the prescription cost for those conditions/diagnoses?
   a. CMS-HCC
   b. RxHCC
   c. HHS-HCC
   d. HACs

7. The hierarchical condition categories determine reimbursement and consist of families of diseases that are assigned a _____and_____.
   a. Cost based on service, projected use of medication
   b. Cost based on severity, projected use of resources
   c. Cost based on the number of providers, projected wait times
   d. Cost based on staff, projected documentation time

8. Which of the following is the correct calculation of the query rate?
   a. Number of denied claims divided by the number of claims submitted
   b. Number of health records reviewed divided by the number of health records assigned to be reviewed
   c. Number of health records reviewed that resulted in a query divided by the number of health records reviewed.
   d. Number of queries with a response divided by the number of queries sent.

9. Which of the following characteristics of high quality clinical documentation thoroughly describes what is occurring with the patient?
   a. Consistent
   b. Reliable
   c. Timely
   d. Clear

10. _____can help facilitate the documentation bridge between the outpatient observation record and the admitting History & Physical (H&P).
    a. CDI professionals
    b. Quality professionals
    c. Compliance professionals
    d. Care coordinators

11. Which of the following is used nationally to inform healthcare practitioners of appropriate or covered diagnosis codes associated with specific procedures?
    a. Local coverage determination
    b. Denied claims
    c. Recover audit contractors
    d. National coverage determination

12. The _____ methodology requires all Medicare Advantage accepting providers to capture each beneficiary's HCCs at least once every 12 months
    a. HHS-HCC
    b. Rx-HCC
    c. CMS-HCC
    d. None the above

13. Which of the following characteristics of high-quality documentation is detailed and has the maximum content?
    a. Reliable
    b. Complete
    c. Timely
    d. Clear

14. CMS- HCCs contains which of the following two components?
    a. A hierarchy and the condition category
    b. An ICD-10-PCS and CPT® code
    c. An ICD-10-CM and ICD-10-PCS code
    d. A CPT and HCPCS code

15. In general, _____ codes for physician services are assigned as supported by the documentation of key elements of history, examination and medical decision making or, under certain circumstances, codes may be assigned based on the amount of time required for the encounter.
    a. ICD-10-CM
    b. E/M
    c. HCPCS
    d. ICD-10-PCS

16. Which of the following services may be beneficial for OP CDI activities to include in their health record reviews?
    a. Radiology
    b. Laboratory
    c. Cardiovascular
    d. All the above

17. Which of the following can occur when CDI professionals assist providers in capturing the completed clinical picture of their patients?
    a. Meet medical necessity
    b. Shorter office times
    c. Increase in procedure time
    d. Increase in patient satisfaction

18. Which of the following models rely on hierarchies that group related conditions based on the overall severity of the condition?
    a. Diagnosis-related groups
    b. Ambulatory Payment Classifications
    c. Severity of illness
    d. Risk adjustment

19. Which of the following healthcare settings use the OASIS assessment tool to drive their documentation?
    a. Home health agencies
    b. Skilled nursing facilities
    c. Ambulatory surgery centers
    d. Hospital observation

20. Which of the following healthcare settings serves as an initial entry point through to care in other settings?
    a. Inpatient
    b. Home health
    c. Emergency department
    d. All the above

21. Which of the following is the correct calculation for the denial rate?
    a. Number of denied claims divided by the number of claims submitted
    b. Number of health records reviewed divided by the number of health records assigned to be reviewed
    c. Number of health records reviewed that resulted in a query divided by the number of health records reviewed
    d. Number of queries with a response divided by the number of queries sent

22. A qualitative audit tool can be developed that assigns a _____to each element to provide a measurable data score.
    a. Numeric value
    b. Objective
    c. Outcome
    d. Resource

23. Which of the following is a general expected outcome that governs many CDI programs?
    a. Appropriate reimbursement
    b. Accurate quality score
    c. Reduction in denied claims
    d. All the above

24. Which of the following would represent an "Interest" level of physician engagement?
    a. Query rate of 46%
    b. Query rate of 20%
    c. Query rate of 37%
    d. Query rate of 25%

25. It is beneficial to have ongoing metric reporting for a (n) _____of the program's performance.
    a. Annual assessment
    b. Continual assessment
    c. Disciplinary action
    d. All the above

Post 90-Day Hire Assessment Answer Sheet (Please note that correct answers are marked with an "*")

1. Which of the following models focuses on the quality of care?

*a. PQRS

b. DRG

c. APC

d. RUG

Feedback:

As reimbursement for healthcare shifts from fee-for-service to value-based models, it relies heavily on quality measures and data from programs like Physician Quality Reporting System (PQRS) and Hospital Inpatient (and Outpatient) Quality Reporting (IQR/OQR).

2. Which of the following statements is true?

*a. For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.

b. For inpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.

c. For outpatient encounters for diagnostic tests that have been interpreted by a nurse, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation.

d. All the above

Feedback:

2017 Official Guidelines for Coding and Reporting

"For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis (es) documented in the interpretation. This differs from the guidelines in the hospital inpatient setting regarding abnormal findings on test results."

3. When a patient presents for outpatient surgery (same day surgery), code the _____ as the first-listed diagnosis even if the surgery is not performed due to a contraindication.

a. Reason for contraindication

b. First diagnosis documented by the provider

*c. Reason for surgery

d. Complication

Feedback:

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis even if the surgery is not performed due to a contraindication

4. A provider is exempt from MIPS reporting if they are part of which of the following programs?

a. PQRS

*b. APM

c. OASIS

d. PAI

Feedback:

If a provider is part of an APM, they are exempt from MIPS reporting.

5. The MIPS program repeals which of the following programs?
   a. Physician Quality Reporting System (PQRS)
   b. Value-based modifier (VM)
   *c. Sustainable growth rate (SGR)
   d. Electronic health record (EHR)

Feedback:

The MIPS program repeals the sustainable growth rate (SGR) and consolidates aspects of the Physician Quality Reporting System (PQRS), Value-based Modifier (VM), and the Electronic Health Record (EHR) incentive programs.

6. Which of the following HCC methodologies relies on certain conditions/diagnoses to predict the prescription cost for those conditions/diagnoses?
   a. CMS-HCC
   *b. RxHCC
   c. HHS-HCC
   d. HACs

Feedback:

The RxHCC methodology relies on certain conditions/diagnoses to predict the prescription cost for those conditions/diagnoses.

7. The hierarchical condition categories determine reimbursement and consist of families of diseases that are assigned a _____and_____.
   a. Cost based on service, projected use of medication
   *b. Cost based on severity, projected use of resources
   c. Cost based on the number of providers, projected wait times
   d. Cost based on staff, projected documentation time

Feedback:

The hierarchical condition categories determine reimbursement, and consist of families of diseases that are assigned a cost based on severity and projected use of resources.

8. Which of the following is the correct calculation of the query rate?
   a. Number of denied claims divided by the number of claims submitted
   b. Number of health records reviewed divided by the number of health records assigned to be reviewed
   *c. Number of health records reviewed that resulted in a query divided by the number of health records reviewed.
   d. Number of queries with a response divided by the number of queries sent.

Feedback:

The query rate measures the number of health records reviewed that resulted in a query divided by the number of health records that were reviewed.

9. Which of the following characteristics of high quality clinical documentation thoroughly describes what is occurring with the patient?

a. Consistent
b. Reliable
c. Timely
*d. Clear

Feedback:

Clear documentation thoroughly describes what is occurring with the patient.

10. _____can help facilitate the documentation bridge between the outpatient observation record and the admitting History & Physical (H&P).

*a. CDI professionals
b. Quality professionals
c. Compliance professionals
d. Care coordinators

Feedback:

CDI professionals can help facilitate the documentation bridge between the outpatient observation record and the admitting History & Physical (H&P).

11. Which of the following is used nationally to inform healthcare practitioners of appropriate or covered diagnosis codes associated with specific procedures?

a. Local coverage determination
b. Denied claims
c. Recover audit contractors
*d. National coverage determination

Feedback:

National coverage determination policies are used nationally to inform healthcare practitioners of appropriate or covered diagnosis codes associated with specific procedures.

12. The _____ methodology requires all Medicare Advantage accepting providers to capture each beneficiary's HCCs at least once every 12 months

a. HHS-HCC
b. Rx-HCC
*c. CMS-HCC
d. None of the above

Feedback:

The CMS-HCC methodology requires all Medicare Advantage accepting providers to capture each beneficiary's HCCs at least once every 12 months.

13. Which of the following characteristics of high quality documentation is detailed and has the maximum content?
    a. Reliable
    *b. Complete
    c. Timely
    d. Clear

Feedback:

Complete documentation is detailed and has the maximum content. This means that the physician has fully addressed all concerns in the patient record.

14. CMS-HCCs contains which of the following two components?
    *a. A hierarchy and the condition category
    b. An ICD-10-PCS and CPT code
    c. An ICD-10-CM and ICD-10-PCS code
    d. A CPT and HCPCS code

Feedback:

CMS-HCCs contains two components, the hierarchy and the condition category. The hierarchies are the compilation of related condition categories (CCs), which then the CCs become HCCs.

15. In general, _____ codes for physician services are assigned as supported by the documentation of key elements of history, examination and medical decision making or, under certain circumstances, codes may be assigned based on the amount of time required for the encounter.
    a. ICD-10-CM
    *b. E/M
    c. HCPCS
    d. ICD-10-PCS

Feedback:

In general, E/M codes for physician services are assigned as supported by the documentation of key elements of history, examination and medical decision making or, under certain circumstances, codes may be assigned based on the amount of time required for the encounter.

16. Which of the following services may be beneficial for OP CDI activities to include in their health record reviews?
    a. Radiology
    b. Laboratory
    c. Cardiovascular
    *d. All the above

Feedback:

Services such as radiology, laboratory, cardiovascular, and pulmonary diagnostic testing and therapeutic treatments may benefit from the inclusion of OP CDI activities to ensure compliant ordering and intake processes along with accurate documentation to support billing and reimbursement.

17. Which of the following can occur when CDI professionals assist providers in capturing the completed clinical picture of their patients?

*a. Meet medical necessity

b. Shorter office times

c. Increase in procedure time

d. Increase in patient satisfaction

Feedback:

CDI professionals can assist providers in capturing the complete patient's clinical picture to support capturing the diagnostic statements for medical necessity.

18. Which of the following models rely on hierarchies that group related conditions based on the overall severity of the condition?

a. Diagnosis-related groups

b. Ambulatory Payment Classifications

c. Severity of illness

*d. Risk adjustment

Feedback:

Risk adjustment models rely on hierarchies that group related conditions based on the overall severity of the condition.

19. Which of the following healthcare settings use the OASIS assessment tool to drive their documentation?

*a. Home health agencies

b. Skilled nursing facilities

c. Ambulatory surgery centers

d. Hospital observation

Feedback:

Home health agencies use the Outcome and Assessment Information Set (OASIS) assessment, tool which drives their documentation

20. Which of the following healthcare settings serves as an initial entry point through to care in other settings?

a. Inpatient

b. Home health

*c. Emergency department

d. All the above

Feedback:

The emergency department serves as an initial entry point through to care in other settings.

21. Which of the following is the correct calculation for the denial rate?

*a. Number of denied claims divided by the number of claims submitted

b. Number of health records reviewed divided by the number of health records assigned to be reviewed

c. Number of health records reviewed that resulted in a query divided by the number of health records reviewed

d. Number of queries with a response divided by the number of queries sent

Feedback:

The denial rate is measured by dividing the number of denied claims by the number of claims submitted.

22. A qualitative audit tool can be developed that assigns a _____ to each element to provide a measurable data score.

*a. Numeric value

b. Objective

c. Outcome

d. Resource

Feedback:

A qualitative audit tool can be developed that assigns a numeric value to each element to provide a measurable data score.

23. Which of the following is a general expected outcome that governs many CDI programs?

a. Appropriate reimbursement

b. Accurate quality score

c. Reduction in denied claims

*d. All the above

Feedback:

Many CDI programs have three general expected outcomes that govern their programs. These include appropriate reimbursement, accurate quality scores, and a reduction in denied claims

24. Which of the following would represent an "Interest" level of physician engagement?

a. Query rate of 46%

b. Query rate of 20%

*c. Query rate of 37%

d. Query rate of 25%

Feedback:

A query rate ranging between 35-45% reflects an engagement level of Interest.

25. It is beneficial to have ongoing metric reporting for a (n) _____ of the program's performance.

a. Annual assessment

*b. Continual assessment

c. Disciplinary action

d. All the above

Feedback:

It is beneficial to have ongoing metric reporting for a continual assessment of the programs performance. These reports may be presented at staff meetings, quarterly meetings, or a one-on-one meeting.