CODERS OR NURSES FOR CDI TEAMS: Why Hiring Both to Collaborate Works Best
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Navigating Today’s HIM Job Market
From the top skills employers are looking for to how to navigate the market to locate the job that best matches your goals, this article takes a look at how to plot your course.

Listen Up! AHIMA Launches New Podcast
The HI Pitch podcast explores emerging topics in the industry, from CDI to data analytics.

Under the Dome
Check out last month’s posts from this web-exclusive column for highlights from the World Health Assembly and AHIMA’s comments on the ONC and CMS information blocking proposed rules.
HIM is the Link Between CDI and Precision Medicine

By Valerie Watzlaf, PhD, MPH, RHIA, FAHIMA

DR. AMAL ALZU’BI, a graduate of the doctoral program at University of Pittsburgh, just had part of her dissertation published in AHIMA’s online scholarly journal *Perspectives in Health Information Management* under the title “Genetic Variations and Precision Medicine.” It was even highlighted in a recent AHIMA e-Alert—did you read it?

Reading through it again, I started to think about how clinical documentation improvement (CDI) and precision medicine really fit together. Precision medicine can include genetic, environment, and lifestyle information to provide a granular approach to treatment for the patient. So, just how does the genomic information get incorporated into the electronic health record (EHR)? According to Joel Diamond, MD, FAAP, adjunct associate professor of biomedical informatics at the University of Pittsburgh, one of the key steps that can grow a precision medicine program is to “evaluate and assess technologies and solutions that can bring genomics data directly into the EHR workflow, allowing providers to use it in real-time clinical decision-making.” He goes on to explain that “new platforms are emerging that bridge the gap between genomics and useful data at the point of care.”

There are several databases (summarized in Dr. Alzu’bi’s article) with which HIM professionals can help clinicians link with a specific disease for direct care. Some of these databases also provide useful information on outcome studies, clinical trials, and quality assessment studies. All of these genomic databases can be used to support the accuracy and validity of the diagnosis, procedure, ICD-10-CM/PCS code assignment, severity of illness, risk of mortality, and reimbursement. HIM professionals can assist by educating and assisting physicians and other clinicians on the best way to search these databases to see if their patients have a specific genetic variation that can then be used as a test result to support specific treatments and procedures. These databases can be easily searched by HIM professionals who can then work with a team of physicians, nurses, quality improvement specialists, finance, and so forth to incorporate precision medicine into the CDI process.

According to Diamond, patients are further along in the genomic testing process than their healthcare providers. How do we as HIM professionals fix this? One of the principles of the AHIMA Code of Ethics is to “Advocate for appropriate uses of information resources across the healthcare ecosystem.” Are we doing that when very few healthcare systems use genomic databases to support and enhance treatment for patients? HIM professionals are ideally positioned to educate and explain the types of genomic databases that are available to the CDI team. It is another tool that can be used to assist in the support of clinical documentation.

Notes

Valerie Watzlaf (Valerie.watzlaf@ahima.org) is vice chair of education and associate professor at University of Pittsburgh.
AHIMA CONFERENCE ATTENDEES CAN EXPECT BOTH NEW AND TRIED-AND-TRUE EDUCATION AT THIS YEAR’S EVENT.

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  - Continuum of Care
  - Innovation
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- Attendees enjoy the freedom to choose their general session experience on Tuesday where two sessions happen simultaneously:
  - **Theater**
    - Addressing the Opioid Epidemic and Burden of Chronic Diseases
    - Rising to Leadership in Today’s Healthcare System
  - **Exhibit Hall Floor**
    - CMS Interoperability and Patient Access Initiative
    - Patient Advocacy: How to Make Unlikely Things Happen

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- Build knowledge through interactive sessions, roundtables, panels, town halls, and site visits on topics like:
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  - Behavioral Health
  - Coding
  - Hot Topics
  - Physician Practice
  - Privacy and Security
  - Quality
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Healthcare Providers Should Embrace Text Messaging with Patients

Physicians and other healthcare providers should embrace HIPAA-compliant text messaging apps to improve outcomes and better engage with younger, tech-savvy patients, according to a recent editorial.

“A unified and secure communications platform can help providers stay compliant while enabling patients to exchange medical information through text or social media messaging, giving a level of caring and intimacy that other forms of communication can’t touch,” wrote Shannon Hastings, the chief technology officer for Rhinogram, a virtual care technology company, for MedCity News.

Providers have been ambivalent about texting with patients in the past due to concerns around privacy. However, Hastings argues that emerging secure communication platforms can better help patients retain and understand elements of their diagnosis and treatment. He points to a study that found 27 percent of patients fully comply with their treatment regimens and that 40 percent believed they could do better if they received timely reminders in the form of automated push notifications as well as advice from their providers.

To make texting in healthcare more mainstream, providers need to be mindful of several things, Hastings wrote. Providers should avoid using their own personal apps and devices for such communications, opting instead for a unified, secure, and encrypted platform. Ultimately, the information exchanged between users should flow back to the patient’s electronic health record (EHR) portal.

Texting is an acceptable form of communication as long as it’s HIPAA-compliant, which means restricting access to authorized users, “creating a unique identifier for each user, keeping messages in accordance with data retention policies, and using an audit trail to monitor disclosure,” the editorial stated.

Health IT Advisory Committee Votes to Add to USCDI Dataset

The Office of the National Coordinator for Health IT’s (ONC’s) Health IT Advisory Committee (HITAC) voted in May 2019 to add multiple new sets of demographic data to the US Core Data for Interoperability (USCDI) dataset. The new data includes:

- Current and previous addresses
- Mobile and landline phone numbers
- Email addresses
- Last four digits of a patient’s Social Security number

The thought is that the additional data will help to improve patient health record matching, which has been a consistent area of concern for the healthcare industry.

The full recommendations from the USCDI Task Force referenced by HITAC are available online at www.healthit.gov/sites/default/files/facac/USCDI_Phase1_Draft_Requirements_Letter.pdf.

Provider Groups Say MACRA’s Administrative Burdens Continue to Plague Providers

Since its inception, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has faced criticism from physicians about adding to administrative burdens. And now, physician groups remain concerned that the Merit-based Incentive Payment System (MIPS) portion of the law continues to add significant burden without providing appropriate clinical benefits, as evidenced in statements for a recent Senate Committee on Finance hearing.

MACRA, which replaced the sustainable growth rate methodology for reimbursing physicians, and went into effect January 1, 2017, was another lever meant to transition reimbursement from a fee-for-service system to one that rewarded quality. However, officials from physician groups including the American Medical Association, American Academy of Family Physicians (AAFP), American College of Surgeons, and American Medical Group Association, as well as from the Brookings Institution told Congress that two years into MACRA, physician burnout and administrative costs are hindering its effectiveness.

Although none of the officials advocated for MACRA’s repeal, some did call for the elimination of the MIPS program. “While MIPS, at least in its current form, appears unlikely to substantially improve patient care, it is creating substantial compliance costs. For the 2019 performance year, CMS estimates that providers will incur $482 million in reporting costs related to MIPS, with the MIPS quality category accounting for the majority of those costs,” said Matthew Fielder, PhD, a fellow at USC-Brookings Schaeffer Initiative for Health Policy at the Brookings Institution, in written testimony. “Notably, this figure does not include the costs providers incur to develop a strategy for complying with...”
MIPS, including deciding which quality measures it is most advantageous to collect and report. These activities are likely to require providers to invest substantial staff time, hire outside consultants, or both.”

Fielder, however, did express support for the advanced alternative payment models (APM) portion of MACRA to create similar incentives for other categories of providers.

“In the absence of broader changes to MACRA, several narrower reforms are worth considering. These include making the advanced APM bonus permanent, eliminating the ‘cliff’ in the advanced APM bonus eligibility rules, standardizing the measures used in the MIPS quality category, and replacing the MIPS practice improvement and promoting interoperability categories with more targeted incentives,” Fielder’s testimony stated.

AAFP President John Cullen, MD, testified that MIPS has created a burdensome and extremely complex program that has increased practice costs and is contributing to physician burnout.

“Understanding the requirements and scoring for each MIPS performance category and reporting required data to CMS is a complex task and detracts from physicians’ ability to focus on patients,” Cullen stated in written testimony. “Many of my colleagues are frustrated and angry.”

Report: Insider Threats Cause Majority of Healthcare Breaches
When it comes to healthcare data breaches, the majority are caused by insider threats, according to a report from Verizon.

Built upon analysis of 41,686 incidents that included 2,013 confirmed data breaches, the 2019 Verizon Data Breach Investigations Report found that external threats remain the cause of the majority (69 percent) of breaches across all other industries. The healthcare industry stands alone in facing the majority (59 percent) of their attacks perpetrated by insiders. According to the report, there were 466 cybersecurity incidents affecting healthcare last year, and 304 of those incidents resulted in a confirmed breach.

<table>
<thead>
<tr>
<th>Cause of Healthcare Data Breaches in 2018</th>
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<tbody>
<tr>
<td>59% Insider Attacks</td>
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<tr>
<td>42% External Attacks</td>
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AHIMA CEO Wylecia Wiggs Harris was named to Health Data Management’s list of the 50 Most Powerful Women in Healthcare IT for 2019.

The Centers for Medicare and Medicaid Services has launched a social media campaign for people to share their experiences with health information interoperability using the hashtag #ItsMyMedicalRecord.

The Health IT Advisory Committee has recommended the creation of a separate task force to work on requirements for price transparency.

CLICK LIST

EHR BENEFITS: UNLOCKING THE SECRETS OF SUCCESSFUL ORGANIZATIONS

A report from the Chartis Group found that most US hospitals at Stage 4 of the HIMSS Analytics’ EMR Adoption Model do not experience the benefits of electronic health records (EHRs) anticipated prior to implementation. The report authors discuss hurdles organizations face when it comes to realizing the benefits of EHRs and offers examples of best practices employed by successful organizations.

TOOLS

PATIENT INTAKE SURVEY TOOL
www.regenstrief.org/projects/symtrak

A new tool has been developed by researchers at the Regenstrief Institute and Indiana University to help providers track and identify early onset of more complex and serious underlying issues. The tool, called SymTrak, is designed to track symptoms such as pain, fatigue, sleep disturbance, memory problems, anxiety, and depression that can be relevant for multiple chronic conditions.
This year’s institute delivers prominent speakers from diverse backgrounds like privacy, breach notification rules, cyber-security, and access controls.

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- Advance this unique skill set to lead your organization with effective privacy and security management
- Gain practical insights for alternative privacy and security operational methods and solutions
- Network with peers and policy makers

General Session
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Updates from HHS OCR—What’s Your Favorite Regulator Done for You Lately?

Sunday
Healthcare Cybersecurity: Top Threats and Best Practices

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Status Check on CDI Transformation

By Wylecia Wiggs Harris, PhD, CAE, chief executive officer

THE JOURNAL’S CLINICAL documentation improvement (CDI) issue gives me an opportunity to provide an update on some of the important work AHIMA has been doing in 2019.

As you know, we’ve been undertaking what we call AHIMA’s transformation. This is an opportunity for us as an association to reassess approaches and develop new strategies, leveraging our current skills and adapting to the changing future of healthcare.

We’ve been doing just that with CDI. And AHIMA has seen some great results this year, including:

- A licensing agreement with Artifact Health allowing the company to integrate AHIMA’s query templates into its mobile query platform
- Industry education on how AHIMA’s CDIP credential is carefully developed to be the gold standard in CDI certification
- A recent study (published in these pages) on the state of CDI, giving readers a snapshot of this changing field
- The continued success of our CDI Trainer workshops, which recognize CDI professionals who are equipped to train others
- This month, AHIMA will host our CDI Summit in Chicago, IL, once again convening the premier industry event dedicated to advancing the documentation journey
- Coming up, look for more cutting-edge learning on CDI (and many other topics) at the AHIMA Health Data and Information Conference in September in Chicago, IL

In addition, to inform our thinking about what comes next, we have brought together a panel of industry experts to serve as thought leaders and advisors as we plan for the future. One of the interesting discussions has been the concept that the way we talk about CDI may need to change. While the “I” in CDI has traditionally been short for “improvement,” the better word may be “integrity.”

The discipline of CDI is evolving beyond improving certain elements of documentation to encompass protecting the overall integrity of documentation in the record.

In this month’s issue, you’ll find articles that delve into the latest on CDI and beyond. James Fee and co-authors discuss the evolving role of CDI in accountable care organizations. A. Andrews Dean explores the recent emphasis on application program interfaces (APIs) and their increasing role in policy related to interoperability. Lisa Eramo offers a sneak peek at the AHIMA World Congress Healthcare Information Summit in October in Abu Dhabi, UAE, an event that is emerging as the “best in class” professional development platform in the region, thanks to its presentation of best practices from AHIMA.

Finally, Mary Butler tackles an industry hot topic—addressing the long-standing debate in the CDI space as to whether nurses or coding professionals are preferred for CDI specialist positions. This article calls a truce and discusses how a combination of both nurses and coders on a CDI team may be the ideal state. The right balance, it seems, may come down to a combination of skills, communication, and willingness to learn from others. Which, come to think of it, seems appropriate when the end game is better patient care.

Questions? Comments? Let us know what you think. E-mail the Journal team at journal@ahima.org.
CODERS OR NURSES FOR CDI TEAMS: Why Hiring Both to Collaborate Works Best

By Mary Butler
ON THE MOST widely used job search websites, listings for clinical documentation improvement (CDI) specialists typically look something like this:

**Description:** The clinical documentation improvement specialist provides support of clinical documentation improvement activities in an effort to support accuracy and quality in the patient records at Hospital X and to ensure that coded diagnoses are an accurate reflection of the patient's clinical status and care.

**Duties and responsibilities:** Participating in education of members of the patient care team on documentation guidelines; electronically querying physicians/other providers regarding missing, unclear, or conflicting medical record documentation.

**Licensure or certifications:** RHIA, RHIT, BSN, RN, MD, or comparable. The following are preferred: CDIP, CCDS, CCS, and ICD-10 certification or designation.

There are two different types of healthcare professionals that can look at this description and envision it as a stop on their career path—coders and nurses. The answer to the question about just who can do this job the best, however, is at the crux of a professional rivalry that remains just under the surface on teams of CDI specialists working all over the United States.

Some CDI teams were built around the belief that registered nurses, both with and without CDI and coding credentials such as the CCS or CDIP, are the best fit for the job. Other CDI teams were assembled based on an assumption that health information management (HIM) professionals with some combination of coding or CDI credentials best fit the bill. But there's a third option that some providers—and AHIMA—believe works best: the hybrid approach. Ideally, a hybrid CDI team consists of both credentialed HIM professionals and registered nurses.

In practice, a hybrid team builds on the strengths of both HIM and nurse professionals’ skillsets. A hybrid team benefits from the knowledge of coding guidelines and compliance expertise through its HIM professionals, as well as the intrinsic clinical relationships that have been forged between nurses and physicians. Facilities with functioning hybrid teams have already started to see clear financial benefits of working this way, according to several CDI experts interviewed for this article. They also see it as an opportunity to put to rest some of the tensions that exist between nurses and HIM professionals.

As the prominence of CDI has grown in response to reimbursement reforms and expansion into outpatient settings, some HIM professionals remain frustrated by what they see as resistance created by the notion that CDI requires clinical experience that only nurses can bring. Some feel as if they are being pushed out of CDI based on the myth that HIM professionals are insufficiently clinical. To understand why hybrid CDI teams hold the most promise for providers, it’s important to understand the history of CDI and why tensions exist between HIM and nursing professionals in the first place. To overcome this rivalry, both sides need to acknowledge how their backgrounds and skills complement each other, and why cooperation between them can result in the best documentation possible.

CDI’s Past and Present

Over the last 10 years, with the advent of electronic health records (EHRs), clinical documentation has largely become electronic—leading to numerous changes in the way nurses, physicians, and HIM professionals do their jobs. Historically, CDI has been a function of HIM and medical record departments. Approximately 25 years ago, hospitals started practicing “concurrent coding”—CDI’s precursor. Concurrent coding was performed by coding professionals who worked on hospital floors coding charts of patients who were currently in the hospital and querying physicians for additional details. The need for CDI grew when diagnosis related groups (DRGs) came on the scene, but CDI still wasn’t a priority for many providers.

In recent years, however, with the implementation of payment reforms tying reimbursement to quality-based care, CDI’s profile began to rise. This time around, consulting companies and CDI software vendors gained a foothold with providers and started urging hospitals to move nurses working in areas like quality and utilization review—which were also HIM domains—into CDI.

“The purpose of our profession [HIM] is to ensure that quality documentation supports the needs of healthcare and we’ve been doing that all along,” says Pamela Hess, MA, RHIA, CDIP, CCS, CPC, lead faculty, healthcare informatics at Grand Canyon University, and vice president, strategy and operations at MedASTUTE Consulting.

In an effort to better understand HIM’s current reach in CDI and to see how nurses and coders stack up in CDI roles, AHIMA recently conducted a survey that was sent to individuals in AHIMA’s member database who identified themselves as CDI or coding professionals, and to those who had one or more of the following credentials: CDIP, CCDS, CCS, RN, BSN, MSN, FNP, or MD. According to the survey, roughly 59 percent of respondents said their facilities hire HIM professionals for CDI roles, while 41 percent do not. As for which department oversees CDI, 51 percent of respondents said their CDI teams report to the HIM department, and roughly 18 percent of CDI reports to the finance department. The survey also found that the most frequently required credentials for CDI specialists were the RN and CCS, while the most frequently preferred credentials were the CDIP and CCDS.

When respondents were asked why they chose not to hire HIM professionals and coders for CDI, they responded that they were looking for staff with clinical knowledge—a curious response given that clinical documentation has long been considered the defining territory of HIM.

“Nurses and physicians have experience in applying clinical knowledge in direct patient care and HIM/coding professionals have experience in applying clinical knowledge in the accurate representation of diagnosis and procedural codes,” the survey report states. “Both of these areas of clinical knowledge are crucial in the accurate representation of patients through clinical documentation.”

Complementary Skills

Nobody disputes that nurses and HIM professionals are quali-
Coders or Nurses for CDI
Teams: Both Work Best

fied for CDI roles, based on both their professional experiences and educations. HIM professionals with RHIA and RHIT credentials and registered nurses undergo similar—if not identical—coursework, including classes in medical terminology, anatomy, physiology, pharmacology, pathophysiology, biology, chemistry, and clinical pathology, according to Paul Evans, RHIA, CCS, CCS-P, CDI, clinical documentation team staff member at Sutter Health, who currently works on a CDI team made up of HIM professionals and nurses.

As someone who has worked on CDI teams with registered nurses and even physicians, Evans sees nurses and HIM professionals as equally qualified—but pushes back against what he sees as a pervasive assumption that HIM professionals don’t have the clinical chops for CDI.

“When I was trained, one of my last courses in college was from a physician. He’d give us signs and symptoms and we had to stand up and say, ‘I think the patient has pneumonia and diabetes, here are the tests I would order.’ He was training us to think critically and clinically so that we could have a conversation with a physician,” Evans says.

He notes that when working with nurses, some have been surprised by the depth of knowledge coding professionals bring to CDI.

“There’s a different mindset when you’re looking at evidence and thinking critically about that rather than simply following the orders. The RNs were surprised we think that way. But really, it’s just germane to how I was trained,” Evans says.

One reason that nurses, vendors, and consultants might underestimate coders’ clinical expertise and what they bring to the table is the fact that coders are out of sight. Many more providers are outsourcing coders and letting them work remotely. Physicians still receive queries from coders, but that’s the extent of most interactions.

Debra Beisel Denton, RHIA, CCS, CDI, CRCR, CICA, supervisor, HIM system coding educator, revenue cycle and inpatient coding auditor at Maricopa Integrated Health System, agrees that remote coders aren’t as able to demonstrate their clinical knowledge to colleagues. She says technology that allows remote work such as EHRs and coding platforms are great, but they eliminate occasions for HIM professionals to talk shop.

“I see it as a disadvantage to not have a peer next to you to talk to and discuss cases—so they’re missing out on that,” Denton says.

Nurses do have that ability to have clinical discussions with doctors, which helped them edge into HIM’s CDI territory.

“They bring a unique perspective with their clinical experience—and the fact that they have built and understand how to drive relationships with providers,” says Deirdre LeBlanc, RHIA, vice president for HIM, Parkland Health and Hospital System, in Dallas, TX, where CDI specialists are RNs and report to her in the HIM department.

LeBlanc says CDI specialists at Parkland are all nurses currently because when CDI staff transitioned from the case management department to HIM, the department was staffed by nurses. However, it is her interest and intention to hire both coders and nurses depending on their availability and skill. In addition, if CDI specialists don’t come in with a credential, they would be required to earn one during their time at Parkland.

While it can be accurate to say that some physicians have a higher level of comfort working alongside nurses and communicating with them, the mindset that this domain belongs to clinicians alone is one that that HIM professionals can—and should—resist.

In CDI, “the HIM professional brings an in-depth understanding of coding guidelines and an understanding of the content that’s required in the clinical record to support so many things,” Hess says. “Not only an accurate code, but medical necessity guidelines and an understanding of how a payer reads the record and accepts it and pays the claim.”

Hess notes that it’s not easy for someone who has never studied coding or coded themselves to understand how far-reaching
Coders or Nurses for CDI Teams: Both Work Best

Irina Zusman, RHIA, CCS, CCDS, director of HIM, coding, and

The Case for a Hybrid Dream Team

It would take work to transition CDI teams made up of only nurses or only coding or HIM professionals to a hybrid team with a perfect ratio of each perspective. But providers that have been lucky enough to deliberately hire a mix are glad they did.

In her consulting work, Hess encourages providers launching CDI programs to hire a team that’s made up of half clinicians and half individuals with HIM backgrounds. When facilities have the option of including physicians in that group, all the better. In many places, CDI teams comprised of foreign-born MDs have also been successful.

Hess says that if she were to assemble a hybrid CDI “dream team” she would have nurses paired up with HIM professionals and they would be given the same tasks during the workday. Ideally, the pairs would set aside 10- or 15-minute meetings at the beginning and end of each day to discuss their cases.

“That’s a really nice learning tool and it also helps build their relationship together,” Hess says. “In complicated care settings there are always issues that need to be talked through.”

Irina Zusman, RHIA, CCS, CCDS, director of HIM, coding, and CDI initiatives at New York University Langone Health, was encouraged to form a hybrid CDI team by a consultant who had seen good results in other facilities. Zusman says the suggestion was quite a new concept at the time. Once she had a blended CDI team in place, however, they became “famous” at the facility for helping physicians with documentation questions, in part because the HIM professionals on the team understood data analysis and clinical concepts.

“It came to the point where we don’t have to run after the physicians. They’re coming to us because they know we can help and analyze data and explain how they can improve their reimbursement using some other methods. How they document so they can directly capture PSIs, what kind of clarifications they can provide. So yeah, I think that we were lucky in many respects,” Zusman says. “I talk to people who say, ‘We only hire RNs with ICU experience’ or ‘We don’t hire foreign medical graduates,’ and we have foreign medical graduates working in our program. I think that CDI is a multifaceted profession, and every background brings something else and enriches it. We are living in the era of data. In order to analyze data you really have to understand coding.”

Having hybrid teams lets CDI professionals play to their strengths while acknowledging areas where they might have knowledge gaps.

Carolyn Page, CDIP, CCS, coding manager and CDI liaison at Sisters of Charity Leavenworth Health System, oversees clinical documentation specialists who are all nurses that are required to get a CDI credential. Even though her clinical documentation specialists aren’t hybrid by definition, they work in close collaboration with coders. The team has taken an integrated approach to pre-bill reconciliation where clinical documentation specialists and coders work together on every bill.

“With implementation of the CDI program, it was a great opportunity to collaborate and bring the clinical and coding side together,” Page says. “The reason we like it is that you just give everybody the opportunity to do what they do best. Nurses do clinical, coders do coding, then we bring them together before the bill goes out the door and hopefully get a bill that comes back without a denial—and the cooperation has paid off.

“We decreased our rebill percentages dramatically because of pre-bill reconciliation... The other thing was satisfaction among the team. Coders learned so much from CDS [clinical documentation specialists] and CDS learned from coders at the time of coding, even if it was email back and forth. We’ve seen tremendous increases in job satisfaction,” Page says.

One thing on which healthcare professionals on both sides of the CDI qualification spectrum agree, however, is the notion that CDI shouldn’t be considered solely the domain of professionals with one background. CDI professionals should be hired, they say, based on their abilities, skills, training, and competence.

“Part of the conversation around the CDI role is one of the things I find people don’t talk about,” says Sutter Health’s Evans. “I’m being very honest. I have a lot of RN friends that are wonderful in this role. I’ve trained many RNs. I’m not saying only we [HIM] can do this. I’m saying if a person displays the critical skills and abilities to think critically and logically and work in a compliant manner with clinical knowledge, the person should be considered suitable for this role.”

Note


Mary Butler (mary.butler@ahima.org) is associate editor at the Journal of AHIMA.

Journal of AHIMA Continuing Education Quiz

Quiz ID: Q1919007  |  EXPIRATION DATE: JULY 1, 2020
HIM Domain Area: Clinical Data Management
Article—“Coders or Nurses for CDI Teams: Why Hiring Both to Collaborate Works Best”

Review Quiz Questions and Take the Quiz Based on this Article Online at https://my.ahima.org/store

Note: AHIMA CE quizzes have moved to an online-only format.
Focus on Population Health CDI Generates ACO Shared Savings

By James P. Fee, MD, CCS, CCDS; Sonia Trepina, MPA; Jennifer Boles, CPC, CRC; and Joel Sparks, PMP

COST CONTAINMENT. IT’S a concept that accountable care organizations (ACOs) cite frequently as they strive for shared savings. This makes sense because expenditures drive cost thresholds. If an ACO meets all quality benchmarks—and the cost of caring for its attributed population is below that threshold in accordance with its minimum savings rate (MSR)—then the ACO shares a defined percentage of the savings. Taking steps to address cost outliers, reduce hospital admissions and readmissions through preventive care, and prevent system leakage for attributed patients should therefore theoretically put the ACO on a path for financial success. So why do the majority of ACOs fail to realize shared savings payments?

To answer this question, an ACO must examine whether its costs make sense given the severity of its attributed patient population. When costs remain high despite robust reduction strategies, perhaps costs aren’t the problem. The real problem could be the way in which providers document the patient story. Costs typically correlate with chronic disease burden and disease interactions. Does physician documentation portray this risk? Oftentimes not. This is where population health clinical documentation improvement (CDI) can help.

Timing is Important
Unfortunately, many ACOs make the mistake of focusing exclusively on cost containment when their strategy should instead be twofold: Reduce costs and improve documentation, thereby increasing the accuracy of expected population risk. It’s easy to get derailed with costs because they’re a tangible target for improvement. Another reason ACOs forget about documentation is that they’re focused on all of the steps necessary to form the legal entity itself—forming a legal structure to receive and distribute shared savings payments, considering tax status, raising capital for staffing and IT systems, and more. It’s a huge undertaking, and inevitably something will be overlooked. In most cases, that “something” is the documentation—even though it’s the single most important element that helps payers understand the complexity and morbidity of the population the ACO serves.

Best practice is to involve CDI from the beginning, and ideally before an ACO is formed. This is because an ACO’s
benchmark is based on its historical performance—more specifically, its population risk adjustment factor defined by hierarchical condition categories (HCCs). For Medicare Shared Savings Program (MSSP) ACOs, this threshold remains in place for a minimum of five years with a potential risk score growth of three percent during that timeframe. However, per the “Pathways to Success” final rule, there is no defined limit on risk score decreases over the agreement period. Documentation must accurately reflect disease complexity because this information translates to medical codes that convey the financial resources the ACO needs to function properly.

If an ACO isn’t able to communicate the resources it needs to effectively serve its population, it could face years of insufficient reimbursement. Interestingly, a recent survey of 43 Track 1 MSSP ACOs conducted by the National Association of ACOs prior to the release of the Centers for Medicare and Medicaid Services’ (CMS) Pathways to Success final rule found that 71 percent of these entities will likely leave the MSSP as a result of assuming risk in a two-sided model. Could subpar documentation be one reason why? Quite possibly. These ACOs may not be able to sustain the care they provide because their documentation doesn’t justify their costs. Creating a population health CDI program can help solve this issue and others for an ACO.

Justifying the Need for Population Health CDI

Obtaining executive-level buy-in is the first step in creating a population health CDI program because it ensures there will be resources dedicated to the effort. However, demonstrating an immediate return on investment (ROI) can be challenging because ACO reimbursement is based on retrospective data. Even if an ACO improves its risk adjustment factor (RAF) scores in the short-term, it won’t see a potential increase in its benchmark immediately, as is realized in inpatient or fee-for-service models. Even then, the ACO would still need to contain costs and meet quality metrics to drive a shared savings payment. Instead, health information management (HIM) professionals can articulate the following to hospital executives:

1. While adding dollars to the ACO benchmark does not mean we have improved our bottom line, it does make it easier for the organization to meet the MSR.
2. By improving our organization’s outpatient documentation, we’ll also improve our inpatient documentation specificity. This will help with prior authorizations, cost justification, medical necessity, risk adjustment for hospital-centric outcome measures, star ratings, and more.
3. By improving our organization’s outpatient documentation, we can reduce denials in our system-owned physician practices.
4. Having complete, accurate, and detailed provider documentation is key to ensuring patient safety and providing consistent quality care. This documentation also informs payers and system leaders when making strategic business decisions (e.g., whether to participate in a bundled payment model).

Forming a Population Health CDI Team, Strategy

A population health CDI team should exist at the corporate level and include the following individuals:

- Ambulatory coding and/or CDI director
- Executive director of HIM
- Hospital coding and/or CDI director
- Operations directors
- Project manager
- Vice president and/or manager of population health and chief transformation officer

The team should also include at least one physician champion. Depending on the size of the ACO, multiple physician champions may be necessary. However, rather than strive to assign a physician champion for each specialty or region, focus on finding the right individual for the role. A physician champion should be someone who is enthusiastic about CDI, respected by their peers, influential within the medical community, and whose documentation can serve as a model for others.

Together, a population health CDI team can answer the following strategy-related questions:

- What HCCs will we target, and why?
- What HCCs have not yet been captured in the current year? Are we able to capture these HCCs during and before each visit? For example, can nurses and medical assistants obtain and present pre-visit planning information to physicians before they meet with patients so physicians can monitor, evaluate, assess, or treat the conditions during the visit? Can we incorporate point-of-care technology into the provider workflow to assist with this process?
- How will we streamline CDI efforts across disparate providers to prevent physician burnout and improve physician satisfaction and engagement? For example, how can we align messaging from CDI, coders, care coordinators, compliance, legal, and others to reduce the documentation burden as much as possible? Can we leverage our inpatient CDI program in any way? In many cases, targeted diagnoses will overlap.
- How will we provide ongoing education to all physicians, including those working in independent practices? How will we track new providers who are onboarded into the ACO so they don’t fall through the cracks?
- How can we work with IT to develop documentation tools that integrate easily into physician workflows?
- How will we continually measure and communicate the ROI of our program?

Understanding Baseline Documentation

Identifying the quality of baseline documentation enables an ACO to track its progress and identify high-risk areas to target
Six Ways in Which CDI Efforts Support Population Health Initiatives

THE EARLIER AN ACO establishes a population health CDI program, the better. However, ACOs can also benefit from CDI efforts at any point in their journeys. Consider the following six ways in which population health CDI supports ACO success:

1. Understanding costs. Accurate documentation translates to accurate data. Without data, organizations can’t justify costs.
2. Reducing patient leakage. Accurate documentation drives the data that helps organizations identify opportunities for new patient services, new contractual relationships, and other changes necessary to retain patients within the ACO by improving patient access and the care experience.
3. Maximizing pay-for-performance reimbursement. Accurate documentation helps providers close gaps in care, thereby driving better outcomes through preventive medicine and an avoidance of “never events” and hospital-acquired conditions.
4. Reducing utilization. Accurate documentation helps organizations reduce costly hospitalizations, emergency department visits, and 30-day readmissions.
5. Supporting chronic disease management. Accurate documentation enables organizations to target and engage high-risk patients with meaningful interventions.
6. Predicting individual patient health. Accurate documentation supports accurate data analytics—the ability to predict outcomes based on the number and severity of a patient’s comorbid conditions. Organizations can then target these individuals with early interventions.

A vendor can also help articulate the impact of CDI efforts (i.e., how much do we anticipate the RAF score has moved?).

Using Data Analytics to Drive the Program

Where can an ACO have the biggest financial impact across the entire system? Based on the data, it may be better to focus on one high-impact diagnosis (e.g., diabetes without complications) rather than several lower-impact ones. However, an ACO must be cautious when using data. Partnering with practice managers and others in operations (e.g., care coordinators and physician advisors) can help CDI specialists identify whether they should target certain providers as early adopters or for ongoing CDI interventions. For example, if data analytics identifies that an endocrinologist continually forgets to document body habitus to support the body mass index and morbid obesity diagnosis, it might not make sense to engage this provider as an early adopter if the practice manager states that the physician typically resists CDI efforts. When targeting interventions, it’s important to ask these questions:

- How far does the provider’s RAF scores deviate from expected scores?
- How large is the provider’s patient panel?
- Is the effort required to convince the provider to support CDI worth the anticipated benefit?
- Is the provider participating in other initiatives/projects that may limit their ability to focus on CDI?

Providing Ongoing Physician Education

The success of a population health CDI program depends largely on an ACO’s ability to provide ongoing physician education. All physicians, including primary care providers and specialists, should strive to capture HCCs that are pertinent to the current encounter. Be sure to include the ACO’s independent providers in HCC education. Explain to physicians that a RAF score is assigned to a patient—not a provider. As patients move throughout the ACO receiving care in multiple settings, each physician must do his or her part to capture the HCCs that cumulatively affect this patient-specific score. Establish a baseline average RAF score for each physician, provide education regarding HCC capture, remeasure the average RAF score, and then provide additional education as needed.

Linking Documentation with Patient Engagement

Population health CDI programs are unique in that they include an element of patient engagement that’s typically absent from inpatient CDI programs. That’s because population health is all about managing the continuum of care rather than an isolated inpatient admission. To truly enable population health management, patients must be empowered throughout their healthcare journey to make healthy choices, participate in preventive screenings, and stay out of high-cost settings. ACOs that ultimately improve the health of their populations are those that can identify high-risk patients (both from a clinical perspective and based on their social determinants of health) and target them with tailored education.
interventions to improve outcomes. How can ACOs identify these patients? Coded data based on clinical documentation. CDI plays an important role in obtaining this documentation.

**Articulating Benefits of Population Health CDI**

As with any CDI effort, it is important to continually articulate the benefits of the program to ensure continued executive sponsorship and physician buy-in. In addition to revenue accuracy, focus on changes in RAF scores over time, improvements in provider engagement and satisfaction, and improvements in patient safety.

**Five Population Health CDI Best Practices**

1. Create a corporate-level CDI team with executive sponsorship.
2. Identify at least one physician champion who can engage all providers, including those working in independent practices.
3. Launch a CDI program as soon as possible while forming an ACO.
4. Let data analytics combined with operational insights drive the direction of your program.
5. Understand baseline documentation before launching the CDI program.

**Note**


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APIs and the Privacy, Security Challenge for HIM

By A. Andrews Dean, CPHIMS, CHDA, CPHI, CPPM, CPC
THE CENTERS FOR Medicare and Medicaid Services (CMS) turned many healthcare information technology consultants’ heads in March 2018 when they announced the new MyHealthEData initiative—intended to continue CMS’s goal of digitizing the country’s health system and medical records. The initiative came with a hint of emphasis on application program interfaces (APIs) and their transformative role in healthcare to come. While a bold move, many consultants realized this was just the first step toward an API-driven future of healthcare data exchange.

Since then, APIs in healthcare have earned a spot among the many value-based care-related acronyms that have arisen as a result of health IT legislation like the Medicare Access and Children’s Health Insurance Reauthorization Act (MACRA). While APIs are just now gaining steam in healthcare, they are more common outside of healthcare. Many people have APIs on their smartphones, frequently just called “apps.” There are many types of apps (which have technical differences from APIs but are very similar). The focus in health IT is on the APIs that deal with patient data, an especially sensitive area of data management. APIs are like “apps” that focus on connecting technologies for information sharing and are now set to become the centerpiece and lynchpin of health IT and data exchange in the industry.

Because of this, APIs are going to become a major privacy and security issue for health information management (HIM) this year with the overhaul and continuation of the Promoting Interoperability Program, now combined with two new rules from the Office of the National Coordinator for Health IT (ONC) and CMS on information blocking and implementing the 21st Century Cures Act. These programs and rules promote the use of APIs for exchanging protected health information and put patients in charge of their own data by placing them in the information release driver’s seat, requiring payers and health plans to provide access to holder data and claims via APIs. Also driving this is that providers are reacting to the government crackdown on information blocking by making their information available via APIs. Taken together, Promoting Interoperability and the new CMS and ONC rules on information blocking and the 21st Century Cures Act are going to cause a real sea change in the field of release of information and HIM. This article will address the many concerns that are related to implementing Fast Healthcare Interoperability Resources (FHIR) and APIs for Promoting Interoperability Compliance (i.e., sensitive diagnoses and treatments, alcohol/substance use/abuse & mental/behavioral issues) due to the absence of privacy and filtering controls in the initial releases of some APIs.

What’s with the Emphasis on APIs and Why are They Important?

When the MyHealthEData initiative was announced in March 2018, CMS stated the initiative “is designed to empower patients around a common aim—giving every American control of their medical data. The MyHealthEData Initiative will help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice.” CMS also stated they believed that “the MyHealthEData initiative will work to make clear that patients deserve to not only electronically receive a copy of their entire health record, but also be able to share their data with whomever they want, making the patient the center of the healthcare system.”

Then in April 2018, CMS announced the rebranding of “Meaningful Use” to “Promoting Interoperability” effective in 2019 for eligible clinicians and hospitals, which also requires use of the 2015 edition of certified electronic health record (EHR) technology to demonstrate “meaningful use” and qualify for EHR incentive payments, as well as avoid reductions to Medicare payments. The Promoting Interoperability program refocuses EHR use objectives related to healthcare data exchange to encourage care coordination between both patients and providers to promote better patient engagement. The program even includes a measure intended to improve the flow of information via APIs, allowing patients to collect their health data from multiple providers and organize their information in a single program or source. The Promoting Interoperability program requirement to use 2015 certified EHR technology requirements included the ability to provide patients with healthcare data via APIs, which paved the way for APIs to take center stage.

Is Your API a Mobile Medical App? Have You Revised Your Security Risk Assessment Lately?

With more data exchange, the healthcare industry will face even more privacy and security issues. Although the ONC 2015 Certification Rule established a baseline of security controls, risk is always there whenever data is transferred or shared. Although federal rules for data transfer do exist—and the 2015 ONC Certification Criteria Rules require certified health IT to provide access to information using APIs—the burden still exists on health IT vendors, healthcare providers and organizations, covered entities, and business associates to comply with HIPAA.

Under HIPAA, providers must release certain data to patients, and the Office for Civil Rights is tasked with protecting patient data. All healthcare APIs involve healthcare data sharing and must protect data transferred, but not all health IT APIs are technically considered “mobile medical apps,” which are a portion of mobile apps that are subject to additional US Food and Drug Administration regulatory oversight of medical applications.

How can someone know if an API is also considered a “mobile medical app?” Health IT vendors, healthcare providers, plans, and other entities can utilize the Federal Trade Commission’s (FTC) Mobile Health App Interactive Tool, which provides guidance on whether an app or API falls into the special category of “medical device” and determine which federal regulations might apply. Ensuring security and privacy will
be an even greater challenge with the increased quantity of data expected to flow between health systems.

Also consider that many APIs’ default settings allow information to flow freely, and in some cases immediately, to the patient when an update is made to the patient chart. Not all APIs may have customizable “release delays” set into them, have robust administrative dashboards for management, or control and filter what information is released to the patient (including such information as substance abuse treatment, mental/physical abuse, or sexual/behavioral health records). Many patient portals have these types of controls, but the healthcare API market is new and not yet mature. Therefore, any APIs used by a healthcare facility should be tested with adequate due diligence, and HIPAA-compliant security risk assessments should also be updated with API usage considerations.

Enter ONC Information Blocking and CMS Interoperability Rules

In February 2019, CMS and ONC announced that Health Level Seven’s FHIR standard would be the required format for APIs—which essentially cemented it as the industry standard for healthcare’s API data exchange platforms—as part of CMS’s and ONC’s proposed new rules on information blocking and interoperability. These rules were intended to further promote and go beyond the MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the US healthcare system. The CMS Interoperability and Patient Access Proposed Rule outlined opportunities to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats.

As the new ONC Information Blocking and CMS Interoperability Rules come into play, healthcare provider organizations and health IT vendors will need to be working at a rapid pace to adopt, implement, adapt, deploy, and adjust to newer technologies and information-release protocols. This includes consideration of FHIR-based APIs that are intended to give patients more control of their medical information (and therefore medical history) and review how that information can be shared with other individuals or entities, most of which will fall outside of normal operations for historical record exchange and controls in the healthcare community. It will not be enough for HIM professionals to just change incentive program names and measures and continue doing what they have always done.

What HIM Professionals Need to Know About APIs in 2019 and Beyond

The new emphasis on healthcare data exchange via APIs is expected to have far-reaching consequences, and there is even consideration of re-drafting HIPAA legislation to encourage data exchange and reduce risk. Alternative payment models (APMs) will require population health and more provider-provider and provider-patient data sharing efforts to achieve the APM/accountable care organization goals of cost saving and care improvements. This unfiltered data sharing among groups of providers requires more open exchange than HIPAA originally anticipated. The industry is also expected to see a potential shift away, over time, from patient portals as the primary mechanism of data sharing between patients and providers as APIs take the new lead role in this function.

“APIs are the fastest growing business-influencing technology in the IT industry today. The way HIM professionals work and reach consumers/patients is evolving,” according to a May 2019 Journal of AHIMA article on API governance. “The healthcare industry is seeing a fundamental shift from legacy systems and websites as being the information technology access mechanism for most organizations to the rapidly growing ecosystem of interconnected devices that require APIs to improve business functions.”

The use of APIs will not only transform health information exchange and medical records release, but APIs will also contribute in other ways in the research world, such as the Precision Medicine Initiative where programs like “AllOfUs” or “Sync For Science” (S4S) could benefit from pooled data sharing by patients with a health IT API. More information on these programs and how APIs are being used is available at these websites: www.healthit.gov/topic/scientific-initiatives/precision-medicine and www.healthit.gov/buzz-blog/health-innovation/nih-and-onc-launch-the-sync-for-science-pilot.

“API-based approaches to interoperability have the advantage that APIs can be assembled to rapidly create different kinds of aggregate functions,” states HealthIT.gov. “However, API-based interoperability still requires attention to important implementation details, similar to traditional interoperability specifications. In particular, given the flexibility of APIs, an API-based approach will need to address many required and optional constraints that are necessary to support a desired use-case.”

Within the health IT industry, it may be difficult to find something that has a comparable impact like APIs’ on healthcare data exchange practices—how information is shared and transferred will forever be altered in healthcare moving forward.
Also, 2019 Quality Reporting Programs are already underway, and healthcare providers and patients are entering a whole new world of health information exchange. It has taken a long time to get here, but adequate preparation and investment can ensure that everyone achieves interoperability. Organizations that haven’t achieved interoperability should further engage with their EHR/health IT vendor, and their app “library” should have all of their available APIs prepared to support information exchange.

This also provides a good time to review an organization’s security risk assessments, focusing on any 2015 Certified EHR Technology requirements-related technology changes and API adoptions that may impact an organization’s risk profile, technical operations, and performance with government reporting programs. HIM professionals should make sure their organization’s IT departments are aware of these API requirements and the need to support them. This will be a truly transformative year for health IT data exchange.

Notes
Leveraging the Value of Coding Audits

By Ed O’Beirne

EXPERIENCED HEALTH INFORMATION management, revenue cycle, and coding leaders know that coding audits are a good idea. Like your regular visits to your physician for your health, and your mechanic for your car, so too should your coding department undergo periodic audits to ensure quality and accuracy of the performance of your individual coders and the department as a whole.

Setting Auditing Goals
The most reliable way to ensure that your coding audits are done regularly is to set in place a compliance plan that lays out the frequency, size, and scope of the audit project. Plan it well and stick to it.

The Office of Inspector General says: “Although many monitoring techniques are available, one effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in Federal and State health care statutes, regulations and Federal health care program requirements.”

But performing coding audits is not a just way of “ticking the box,” and it would be a tragic misuse of time and effort to simply perform an audit and tuck away the results without leveraging the maximum value for you and your team.

Value Besides the Accuracy Numbers
Let’s look at some of the clear benefits but also some less often appreciated advantages of performing and interpreting a coding audit. If you perform your own internal coding audits, consider designing your audit process and reporting to leverage the most from each of these value-add components. If you partner with a vendor, be sure that they are equipped and willing to address these elements.

Correct Reimbursement
Foremost on the minds of CFOs and revenue cycle leadership is the financial accuracy of the coding as it lands on the claims which are submitted for reimbursement. Naturally they don’t want to leave any money on the table, but it is equally undesirable for a provider to inadvertently or intentionally overbill payers. A comprehensive coding audit should include financial impact, which identifies actionable trends and is reportable in clear, simple terms to finance-oriented leaders.

Coder Development
It should almost go without saying, but the main goal of a coding audit truly should be the enhancement of coders’ competency and comfort at performing their work accurately and efficiently. Coding audits are excellent opportunities to offer education to coders individually and as a team. A seasoned auditor will know which audit findings are simple mistakes and
which present pathways for coder growth. Be sure to allow time and resources for educational feedback between the auditor and coders. Always approach the auditing process as a positive experience for coders. Auditors are not the cops to get anyone in trouble. They are allies and they are there to help!

**Denials Minimization**

Denials are a headache for everyone involved. A clinical denial makes the usually smooth workflow of clinician to coding to billing run in reverse and can suck up hours of resources. Technical denials seem less arduous individually but add up to a great deal of rework. Unfortunately many billing departments just take care of these themselves or even write off such denials without ever engaging the expertise and workflows in the coding department. A coding audit can uncover such situations. Simple examples include diagnosis coding for medical necessity and CPT modifiers. Billers may simply work around these but diagnosis coding and CPT modifiers are at the core of a coder’s expertise. A coding audit should be designed to look for these hidden opportunities for process improvement in order to minimize denials whenever possible.

**Provider Documentation**

Coding and documentation go hand-in-hand and any quality coding audit simply must review the provider documentation along with the coding that work. The coding is only as good as the documentation. A coding audit should have a special focus on documentation quality and deficiencies that can be trended by the provider, and depending on the size of your organization, by the location, department, and specialty.

By reviewing the documentation simultaneously with the coding, there is a higher likelihood of discovering findings that will serve as educational opportunities for the providers. Approach in a positive, collaborative manner, most providers are very amenable to being taught better documentation practices, particularly when presented with the compliance and financial implications that their documentation has. This is well-illustrated by a coding audit.

**Departmental Workflows**

All too often, coders and their managers will be happily working along day to day, blind to subtle problems happening right under their noses! The frequent explanations for these problems are the “that’s the way we’ve always done it” and “someone told me to do it that way.” These types of coding errors may range from the mundane to fraudulent, with examples including:

- Clinic staff is entering codes but not quantities for supplies and substances.
- Never coding structural allograft in spine surgery unless the surgeon says the word “structural.”
- Always (erroneously) coding a central line insertion CPT along with a cardiac catheterization, though only one catheter is inserted.

These errors add up, whether in lost revenue or mounting compliance risk. But they often stay in the shadows until a good coding audit shines the light. You don’t know what you don’t look for!

These are some of the aspects of your organization or team that may benefit from coding audits in unexpected ways. When was your last coding audit? Do you have a plan?

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TELLING AN ACCURATE and complete patient story through clinical documentation is a goal that transcends cultures and geographic boundaries. It’s also the primary theme at the 2019 AHIMA World Congress (AWC) Healthcare Information Summit that will take place October 3 to October 5 in Abu Dhabi, United Arab Emirates (UAE).

This ninth consecutive summit—which draws attendees from the UAE as well as Kuwait, Saudi Arabia, Bahrain, Oman, Qatar, and other areas—is quickly emerging as the “Best in Class” professional development program throughout the region. Last year, a record number of nearly 700 individuals—including physicians, nurses, case managers, medical coders, finance professionals, revenue cycle managers, and others—attended the event, which focuses on medical coding, clinical documentation improvement (CDI), data analytics, informatics, artificial intelligence, and more.

The AWC Summit provides attendees with various opportunities for global networking and professional development, says Alexandre Bouché, global managing director at AWC. The summit includes state-of-the-art lectures by renowned speakers from around the world, case study discussions, hands-on workshops, and more.

Attendees consistently provide positive feedback about the event. “I have learned a lot from my first AWC conference experience,” Chyndy Crisvir Corpuz, clinical coder at Tawam Hospital, wrote in a post-conference survey. “It is nice to see different points of view about the importance of clinical documentation improvement here in UAE.”
“The AHIMA Summit opened a channel for UAE to understand the importance of proper documentation,” Maria Lejazen Rivera, medical coder at Al Ain Hospital, wrote in a post-conference survey. “For as long as coding has existed, coders were viewed as merely a tool for reimbursement and considered at fault for revenue loss. The event opened eyes, beginning with management, to all stakeholders on the importance of training doctors.”

Many attendees participate in the AWC Healthcare Information Summit through an AWC organizational membership as well as summit sponsorships from local, international, and US-based organizations, giving them access to high-quality education that they might not otherwise be able to afford. AWC organizational membership also provides organizations with three years of support based on AHIMA best practices. AHIMA subject matter experts perform an initial assessment of an organization’s current process, prepare a gap analysis, conduct onsite customized training, complete an annual assessment, and provide ongoing monthly support.

The AWC Summit touches on various health information challenges, many of which are felt in both the United States and in countries abroad, Bouché says. For example, the six Emirates in the Gulf Cooperation Council (GCC) implemented ICD-10-CM in early 2018, and many providers continue to struggle with documentation specificity to support code assignment and accurate revenue under International Refined Diagnosis-Related Groups (IR-DRGs). The lack of complete and accurate documentation also makes it difficult for providers and others to rely on coded data for the purposes of analytics and forecasting. In addition, the relatively recent UAE shift from a single government payer system to a multi-payer system introduced a whole host of coding and documentation-related challenges that are similar to ones experienced in the United States.

Another commonality is the desire to exchange health information seamlessly between providers and give patients access to a longitudinal view of their own health information. Abu Dhabi, for example, recently introduced Malaffi (translation: ‘My File’), an Abu Dhabi Department of Health-led initiative to develop a health information exchange platform that providers across the Emirate can access when needed. Eventually, patients will also have access through a patient portal. Malaffi also includes a centralized database of real-time population health information and analytics, enabling better management of chronic illnesses. The goal is to enhance care coordination, reduce duplication, enable precision medicine, and develop effective public health initiatives.

“Malaffi will be highlighted throughout the summit and integrated into the breakout sessions,” Bouché says.

In addition to general sessions, the first two days of the AWC Summit will include three main tracks:

1. Medical coding and revenue cycle management (including topics such as inpatient and outpatient coding best practices, coding productivity, and denials management)
2. CDI and quality (including topics such as establishing and expanding a CDI program as well as CDI best practices)
3. Data analytics, informatics, and artificial intelligence (including topics such as data reporting and visualization, database management, project management, and electronic health record integrity)

The AHIMA-designed and AHIMA-led AWC Summit program welcomes speakers, presenters, sponsors, and participants from the Abu Dhabi Department of Health, UAE Ministry of Health and Prevention, local payers and providers, educators, and vendors. In addition, representatives from the Healthcare Financial Management Association (HFMA), the American Medical Association (AMA), and 3M Health Information Systems (3M HIS) will present best practices at the event. The third day of the summit includes various professional development workshops delivered by AHIMA, HFMA, AMA, and 3M HIS that provide a more concentrated focus on healthcare topics as well as AHIMA certification exam preparation.

“This event is critical in terms of helping organizations abroad improve the quality of their documentation,” Bouché says. “It also helps healthcare professionals abroad achieve their full potential.”

To learn more about the 2019 AWC Summit, visit www.awc.world/summit-2019/.

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How Do You Contribute to the Story of Healthcare?

At the AHIMA19: Health Data and Information Conference (formerly known as the AHIMA Convention and Exhibit), attendees will discuss the evolving healthcare ecosystem, engage in the transformation of how health data and information is viewed throughout the industry, and learn how to contribute to the story of healthcare in their role as health information management (HIM) professionals. At AHIMA’s annual national event, attendees have the chance to meet with established leaders in the industry, foster lasting connections, and discuss strategy around the industry’s newest innovations.

Interactive sessions, roundtables, panels, townhalls, and site visits covering various disciplines and hot topics offer an immersive learning environment for AHIMA19 attendees, with educational tracks such as:

- Career Development
- Clinical Documentation Improvement
- Coding
- Continuum of Care
- Disruption in Healthcare
- HIM Case Studies
- Innovation
- Leadership
- Performance Improvement
- Physician Practice
- Privacy and Security
- Quality Measures
- Revenue Cycle
- Third Party Audits

Visit www.ahima.org/conference for the latest updates to the program and follow #AHIMA19 on social media for special announcements.
New Pitch Competition

The healthcare ecosystem is complex and interconnected, as are its challenges. This year, AHIMA invites conference attendees to apply for the chance to pitch their innovative ideas to disrupt the healthcare industry in front of a panel of expert judges. Visit ahima.org/pitch for more information.

Keynote Speakers

Carey Lohrenz
USN 1st Female F14 Pilot, Aviator, Author, and Speaker

Doug Lindsay
Patient Advocacy: How to Make Unlikely Things Happen

The Opioid Epidemic and the Burden of Chronic Diseases
Patrice A. Harris, MD, MA President-Elect of the American Medical Association (AMA) and David Barbe, MD, MHA Past President of American Medical Association (AMA)

Pre-Conference, Networking, and Site Visit Opportunities

Several pre-conference meetings and events offer attendees the opportunity to further expand their knowledge:

- Clinical Coding Meeting
- Privacy and Security Institute
- VUCA and the Voices of Leadership
- Pre-Conference Workshops

This year’s networking breakfasts include:

- Are You on Autopilot?
- Legacy Systems: To Keep or Not to Keep
- GIS and Its Impact
- HIM Directors/Leaders: What’s the Plan?
- Patient Directed Requests—What’s the Elephant in the Room?

Site visits give attendees a closer look at Chicagoland organizations’ operations, including:

- Rush University Medical Center
- University of Chicago Medicine
- Cermak Health of Cook County (Cook County Jail)
- Ann & Robert H. Lurie Children’s Hospital of Chicago
- Shirley Ryan AbilityLab

The all-inclusive registration option includes one pre-conference meeting and all pre-conference workshops, as well as one site visit, one networking breakfast each day, and full session recordings in addition to standard conference admission and exhibit hall access.

Follow AHIMA19 News Online

To get news by the minute, follow the hashtag #AHIMA19 and AHIMA’s social media accounts on Twitter, Facebook, and LinkedIn and keep an eye out for special announcements as September approaches. For special previews of what to expect at conference this year, and coverage of the event itself, don’t forget to visit the Journal of AHIMA website at https://journal.ahima.org/category/event-coverage/.
AHIMA’S 2019 ELECTION

Vote—It’s Your Right and Responsibility
This issue of the *Journal of AHIMA* includes brief biographies, photographs, and the position statement questions for candidates in each ballot position for the 2019 AHIMA Election.

The Nominating Committee asked candidates for the AHIMA Board of Directors to answer the question: “AHIMA’s long-term vision for transformation is: Lay the foundation for innovation and greater impact within the healthcare ecosystem by 2022. How will you leverage your industry experience, governance expertise, and understanding of organizations’ turnaround to support achievement of AHIMA’s long-term strategic vision?”

Candidates for Commission on Certification for Health Informatics and Information Management (CCHIIM) Commissioner were given the question: “The recognition of CCHIIM-certified professionals’ role in maintaining and enhancing quality health information for the safety of the public and the improvement of healthcare is a core CCHIIM value. How do you see the Commission supporting this value in the rapidly changing healthcare environment?”

The Council for Excellence in Education (CEE) candidates were asked to answer the question: “How do you feel about the current state of education in HIM and where do you see the state of HIM in the future?”

The candidates’ answers to these questions and detailed biographies are available in the AHIMA Ballot at [www.ahima.org/vote](http://www.ahima.org/vote). **Log in to the ballot with your AHIMA ID number and password, then select the AHIMA Election–2019 link to access the ballot.** Voters may also review the candidates’ brief bio, photo, and position statement question answers in the AHIMA Membership and Business Community on Engage. Visit [http://engage.ahima.org](http://engage.ahima.org) and log in to the site with your AHIMA ID number and password. Under the library section, select the AHIMA 2019 Election link.

The AHIMA election begins Monday, July 8 at 8 a.m. CT and runs through Monday, July 22, 2019 at 5 p.m. CT. All AHIMA members are eligible to vote with the exception of student members. If you have any questions, please contact AHIMA’s Customer Relations at 1-800-335-5535 or email volunteer.services@ahima.org. Cast your vote for the next set of HIM leaders.

### President/Chair-elect

Select One

**Katherine G. Lusk, MHSM, RHIA, FAHIMA,** is the chief health information management and exchange officer for Children’s Health System of Texas. As an active AHIMA member, Lusk’s attention is focused on patient identity, health information exchange, standards development, and information governance. Lusk has received the 2012 AHIMA Pioneer Triumph Award, and her organization has received HIMSS Level 7 Analytics and HIMSS Davies Awards as well as the AHIMA Grace Award. She has served as the president of the Texas Health Information Management Association, on AHIMA’s House of Delegates, and in multiple workgroups. Lusk has represented HIM by speaking at the national and local levels on interoperability, clinical documentation improvement, patient identity, and the importance of HIM professionals.

### Speaker-elect of the House of Delegates

Select One

**Aurae Beidler, MHA, RHIA, CHPS, CHC,** is the compliance and privacy officer at Linn County Department of Health Services where she oversees the compliance and privacy program. Prior to working at the county, she served as the Oregon Health Authority’s privacy officer and as an assistant professor and program director for the healthcare compliance graduate certificate program at Pacific University. Her experience includes auditing and monitoring coordination, investigations, education, and HIPAA privacy officer duties. She has published several articles in *Compliance Today* and the *Journal of AHIMA*. She currently serves as the co-chair of the AHIMA House of Delegates Envisioning Collaborative and is past president of the Oregon Health Information Management Association.

The 2019-2020 Delegates will elect the Speaker-elect of the House of Delegates and the 2020 Nominating Committee. Voting will take place from August 5, 2019 at 8 a.m. CT through August 16, 2019 at 5 p.m. CT.
Brenda K. Beckham, RHIA, is executive director of HIM at Baptist Health in Louisville, KY. She began her career as a file clerk in the “medical records” department and has performed every job role within health information management (HIM). The last 10 years have consisted of standardizing the HIM and coding departments in a total of eight facilities and over 300 physician practices, which includes the implementation of a system-wide electronic health record system. With Beckham’s oversight, her team is currently creating an ambulatory clinical documentation improvement (CDI) department. Beckham has served as president and treasurer of the Kentucky Health Information Management Association where she was presented with the Distinguished Member Award. She has presented locally and nationally on topics covering CDI, change management, HIM operations, and IT collaboration.

Theresa A. Eichelmann, MBA, RHIA, has over 30 years of experience as a leader in HIM. She is currently the director of health information management at BJC Healthcare in Saint Louis, MO. Eichelmann is adjunct faculty in the HIM program at Saint Louis University. She sits on the advisory boards for the HIM program at Saint Louis University and HIT program at St. Charles Community College. She currently volunteers on the AHIMA Triumph Awards Committee. She has served as a collaborator on articles, served on the Southern Illinois Health Information Management Association Planning Committee, and has been a speaker at various events.

Elisa R. Gorton, MAHSM, RHIA, CHPS, CHC, is regional compliance/privacy officer for the northeast for Ascension. Prior positions were director of corporate responsibility, assistant director of health information/privacy officer, director of revenue cycle, and chairperson for the health information technology certificate program at St. Vincent’s College. She has served on the board of directors for the Connecticut Health Information Management Association, and is an AHIMA mentor and advisory board member for Stratford Public School for Health Careers. She is a contributing author to Practice Briefs and toolkits, and she serves on the Privacy and Security Practice Council. Gorton has also previously served on the Information Governance Practice Council, Standards Task Force, and Job Analysis Task Force, as well as the task force for the Office of the National Coordinator for Health IT’s Roadmap to the Interoperability of Health Information, and has spoken nationally on privacy.
Julie R. Hatesohl, MBA, RHIA, CPHQ, FAHIMA, FHFMA, is the director of coding appeals management for R1RCM. She has served on the AHIMA House of Delegates for five years from 2011 to 2015. Hatesohl served as president of the Kansas Health Information Management Association (KHIMA) in 2015 as well as other positions at the association. Hatesohl has been a guest speaker at the KHIMA annual meetings and has done webinar presentations for KHIMA as well as the Sunflower Chapter of the Healthcare Financial Management Association. Her passion is revenue cycle management and process improvement.

Marcia F. Matthias, MJ, RHIA, CHPC, is the corporate director of HIM and privacy officer at Southern Illinois Healthcare. Matthias oversees hospital-based and practice management services for HIPAA privacy, coding, transcription, release of information, HIM operations, clinical documentation improvement, and patient portal management. Matthias has served most recently as president of the Illinois Health Information Management Association. She is currently serving on the HIMR Marketing/Messaging Work Group, and has served as a member of the AHIMA Standards Task Force, AHIMA practice councils, and the state of Illinois HIE Patient Choice and Meaningful Disclosure Work Group. Matthias has presented at the AHIMA Annual Conference as well as at state and regional meetings on a variety of topics including electronic health record systems, LMRs, HIPAA privacy, and patient portals.

Jami R. Woebkenberg, MHIM, RHIA, CPHI, FAHIMA, is senior director of HIM operations at Banner Health in Phoenix, AZ, which includes supporting acute care hospitals, urgent care centers, and ambulatory health centers. Woebkenberg has served on the board of directors for the Arizona Health Information Management Association (AzHIMA) in various volunteer capacities, most recently as the AzHIMA president. She is co-chair for AHIMA’s EHR Documentation Integrity Practice Council and a member of the LGBT Workgroup. She previously served as the co-lead for the Informatics Practice Council and was a member of the Information Governance Practice Council. Woebkenberg is currently the chairperson of the advisory council for the HIM program at Phoenix College.
Jeanne M. (Donnelly) Freeman, PhD, RHIA, is the program director for the master’s of science in health informatics and information management program at Davenport University in Grand Rapids, MI. Freeman, who lives in St. Louis, MO, taught for over 25 years in the health information management program at St. Louis University. She served as an administrator for HIM at the Washington University School of Medicine and St. Louis University Hospital. Freeman is a peer reviewer for *Perspectives in Health Information Management* and served as a member of the AHIMA CEE Graduate Resource Alliance Workgroup. She has served in various roles in the Missouri Health Information Management Association, including president, and has served on the board of directors for the local Healthcare Information and Management Systems Society chapter as student liaison. Freeman has given presentations at the state and national level.

Pamela S. Greenstone, MEd, RHIA, is an associate professor, educator within the University of Cincinnati online HIM program. She has served as the program director since 2014 and is also vice chair of the Department of Clinical and Health Information Sciences. Greenstone is a member of the CEE Curriculum Committee (two years) and was a member of the Health Informatics Graduate Curriculum Task Force in 2016. She is an active member in the Ohio Health Information Management Association where she has held the following positions: project lead, delegate, president-elect, president, and past president. Greenstone is president of the Greater Cincinnati Health Information Management Association.

Debra L. Hamada, EdD, MA, RHIA, is an assistant professor and chair at Loma Linda University’s HIIM department. She completed her baccalaureate studies at the College of Saint Scholastica, completed her master’s at the University of Redlands, and received a doctoral degree from the University of Southern California. Hamada began her career in academia in 1992. She has volunteered for national, state, and local component associations and was a CCHIIM commissioner. Currently, she serves on the Health Informatics Curriculum Taskforce, on the CEE Graduate Resource Alliance Workgroup, and as a CAHIIM peer reviewer. At the California Health Information Association she was a director and a local component association president. Hamada has also published articles and offered educational presentations.
Christina Manley, MAEd, RHIT, has three years of experience as a health information technology program director at an educational institution and has been a full-time faculty for five years. Manley believes collaboration with both professionals in academia and the professional field is crucial to success as an educator. She has been involved in AHIMA and the Ohio Health Information Management Association (OHIMA) as a member since 2010 and has been an active volunteer, serving as an AHIMA RHIT certification exam item writer and on the RHIA Certification Exam Development Committee, taking part in advocacy with OHIMA, and serving on the CEE Educational Programming Workgroup. Manley is also on the Ohio Department of Higher Education Health Pathway Committee and is Quality Matters Certified and a Certified Quality Matters Course Reviewer.

Dasantila (Tila) Sherifi, PhD, MBA, RHIA, is a professor at DeVry University online. She also teaches graduate health administration courses at Pennsylvania College of Health Sciences, in Lancaster, PA. Sherifi’s prior experiences include HIT program chair at DeVry Fort Washington, PA, data analyst at Holy Redeemer Hospital, research assistant at Merck & Co, Inc., and business professor and director of the business assistance center at Shkodra University, Albania. As a volunteer, she has served as Pennsylvania Health Information Management Association Education Committee chair and PA eHealth Liaison, and Southeast Pennsylvania Health Information Management Association president, treasurer, finance, and nominating committee chair. During the last two years, Sherifi has been serving as a Curricular Workgroup member under AHIMA’s CEE.

Lynn I. Ward, EdD, MS-HA, RHIA, CPHIMS, CPC, COI, is an associate dean at Southern New Hampshire University. She has been the associate dean of the undergraduate and graduate HIM programs for over three years. She has served on the AHIMA Council on Education’s Curricular Workgroup for two years. Ward has also been a member of the Associate Education Coalition, CEE HIM Reimagined Workgroup, the AHIMA Foundation Research Network (AFRN), the AFRN Privacy and Security Foundation subgroup, and the HIM Education Foundation subgroup. She was recently elected to serve on the New Hampshire Health Information Management Association Nominating Committee. Ward also serves as a peer reviewer for Perspectives in Health Information Management and on the New England HIMSS Student and Mentor workgroups.
Misty Neal, MBA, RHIA, is the HIM program director/assistant professor at Albany State University in Albany, GA. She has been a member of AHIMA's Student Honor Society Taskforce, HIM Reimagined Market Assessment-Technology Subgroup, CEE HIM Reimagined (HIMR) Workgroup, CEE Curricula Workgroup, CEE HIMR Baccalaureate Revision Group, and has served as an AHIMA textbook reviewer. Neal is currently a Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM) peer reviewer for HIM. She has served on the Georgia Health Information Management Association (GHIMA) Board of Directors and Nominating Committee since 2013 and is the incoming First Year Delegate for GHIMA. Neal is also the co-chair of the GHIMA Student Outreach Committee. She has served as the West Georgia Health Information Management Association treasurer since 2009.

Lynette M. Williamson, EdD, MBA, RHIA, CCS, CPC, FAHIMA, is a professor in the HIT/CIM department at Santa Barbara City College. She has been a member of the CAHIIM Board of Directors and currently serves on the HIM Accreditation Council of CAHIIM. In 2017, Williamson received an AHIMA Foundation Merit Scholarship for Leadership.
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AHIMA’S ELECTION RESULTS WILL BE ANNOUNCED VIA E-ALERT IN LATE JULY
ahima.org/vote | #ahimavote19
Exploring Permitted Disclosures of Health Information for Treatment and Care Coordination

By Aurae Beidler, MHA, RHIA, CHC, CHPS

IN DECEMBER 2018, the Office for Civil Rights (OCR), the entity that enforces HIPAA, requested public input on ways to modify HIPAA Rules to “facilitate efficient care coordination and/or case management and to promote the transformation to value-based health care.” The key point for many stakeholders was a provision to remove regulatory obstacles and decrease burdens on healthcare entities and patients.¹

The Centers for Medicare and Medicaid Services (CMS) also introduced the Interoperability and Patient Access Proposed Rule on February 11, 2019, which proposes policies to prevent healthcare providers from inappropriately restricting the flow of information to other healthcare providers and payers and ensure better interoperability to reduce the burden on healthcare providers. Timothy Noonan, OCR’s acting deputy director, also reiterated the issues with sharing records between providers when he spoke at the AHIMA Advocacy Summit on March 25, 2019. In its request, OCR asked for input on whether it should clarify this provision and ways to encourage healthcare entities to share protected health information (PHI) with non-covered entities when it’s needed to coordinate care and support patients. As OCR looks to clarify its current rules, it’s important for health information management (HIM) professionals to understand what is currently permitted under HIPAA in order to best serve patients now and better prepare for regulatory updates.

It has been many years since the HIPAA Privacy Rule was implemented, meaning it is crucial to understand the original regulations as well as the new commentary being produced by OCR and CMS. The comments contained in the request for information (RFI), the proposed rules, and the final rules can give context to many of the more gray areas of regulations such as HIPAA. By reading the recent RFI and CMS proposed rule, HIM professionals gain a better understanding of the current permitted practices of disclosure under HIPAA. They may also provide a preview about where OCR and CMS are headed in the near future with advancing data exchange and care coordination throughout healthcare and beyond. These potential changes to release of information and disclosures to more nontraditional entities could change how HIM professionals conduct business.

Form Happy
Currently, it seems that healthcare entities require a form for any disclosure outside the brick and mortar establishment, and patient stories of release of information denials and delays in receiving records abound. In January 2017, OCR provided guidance that this should not be the case, noting that organizations must not implement barriers to patient-directed access and disclosure of records. Historically, HIPAA-covered entities prefer to withhold information and require an authorization form to be on the safe side. Yet, as the transformation to provide better care for individuals and better health for populations at reduced costs continues, more nontraditional ways to share PHI are needed, with fewer gaps and less reluctance to share. This slow-moving paradigm shift may be accelerated as OCR and CMS provide future guidance or rulemaking.

Non-Covered Entities Providing Value-Based Healthcare
As OCR stated in its RFI, disclosures to social service agencies, including not-for-profit housing, adult foster care homes, homeless shelters, schools, churches, and other community-based support programs, are permitted and may be essential to an individual’s healthcare. Multidisciplinary teams come together to assist in coordinating services and care for individuals who may have chronic conditions and need a variety of assistance, not just traditional
healthcare activities of a covered entity. It may not be widely known that the HIPAA Privacy Rule permits covered entities to disclose information to those types of programs for coordination or management of treatment. OCR even stated an “expressed reluctance to share this information for fear of violating HIPAA” exists.2

Mandatory Disclosures for Coordinated Care
In the state of Oregon, healthcare providers that participate in a coordinated care organization (CCO) must disclose PHI to other healthcare providers participating in the CCO for treatment, payment, and healthcare operations (TPO). These disclosures may be made without the authorization of the patient or patient’s personal representative. CCOs are a network of physical health, addiction, mental health, and dental care providers who work together locally to serve Oregon’s Medicaid population. CCOs may connect Medicaid members with healthcare, housing, transportation, employment, social services, and other resources in order to improve health and outcomes.

Permitted Versus Required
HIPAA and state law do not require an authorization or consent for disclosures to carry out a patient’s treatment, to arrange payment, or for healthcare operations. This includes treatment, assessment, coordination or management of services, referrals, and consultation. Bear in mind that disclosures to entities that are not healthcare providers should be subject to minimum necessary requirements. This means covered entities are permitted to share information with a primary care provider, social service agencies, or community-based support programs for these purposes. Covered entities are “permitted, but not required, to use and disclose protected health information, without an individual’s authorization,” for treatment, payment, and healthcare operations.3

Treatment is defined as “the provision, coordination, or management of healthcare and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care to one health care provider to another,” according to 45 C.F.R. § 164.501. Obtaining a written consent or permission to disclose PHI for treatment, payment, or healthcare operations is optional and “at the discretion of the covered entity electing to seek consent.” Of course, this does not pertain to uses or disclosures that require an authorization.

OCR asked for comments on “whether it should modify or otherwise clarify provisions of the Privacy Rule to encourage covered entities to share PHI [protected health information] with non-covered entities when needed to coordinate care and provide related health care services and support for individuals in these situations.”

Guidelines for Disclosures to Non-Covered Entities
It can be a challenge to find the balance of protecting an individual’s confidential health information while not prohibiting a permitted activity by placing burdens on those involved in the treatment of an individual. A key step that HIM professionals can take is to simply ask several important questions about the request, including:

• Is the request for PHI a necessary component of the individual’s healthcare?
• Would the request to disclose PHI to a social service entity help further the individual’s care?

If those answers are yes, then the minimum necessary PHI may be disclosed without the individual’s authorization. An OCR FAQ from January 2018 provides an example of this, stating that “a provider may disclose PHI about a patient needing mental health care supportive housing to a service agency that arranges such services for individuals.”4 Of course, each entity needs to take state disclosure laws into account for any potential specially protected information such as that relating to mental health, HIV status, or genetic information, as well as federal requirements for substance use disorder information.

As OCR reviews comments and discussions continue at the national and state level surrounding disclosures to promote value-based healthcare, it is a good time for HIM professionals to review policies and practices related to these disclosures. For some entities, this may require something of a culture change to permit disclosures for continuum of care, especially to non-covered entities. Shifting from a culture that tends to err on the conservative side of protecting an individual’s privacy to one that encourages information sharing and care coordination takes understanding, practice, and integrity in following the spirit of the regulations and those forthcoming.

Notes
2. Ibid.

Aurae Beidler (auraeb eidler@gmail.com) is the compliance and privacy officer at Linn County Health Services.
Reference Data Management: Overcoming Challenges, Taking Hold of Opportunities

By Cheryl Mason, MHSI

THE SCOPE OF healthcare’s Big Data imperative is growing by the day. For instance, one study reveals that the doubling time of medical data in 1950 was 50 years; in 1980, seven years; and in 2010, three and a half years. In 2020 it is projected to be 0.2 years—just 73 days. In truth, the industry has made notable progress in its ability to collect and store vital information that can be used to drive improvements in clinical outcomes, costs, and research. But that’s just the first step.

Without harmonization, data aggregation and understanding is difficult at best. Central to overcoming this challenge is the industry’s ability to fully leverage an important asset: reference data. Comprised of industry terminology standards, like ICD-10, and other proprietary content, reference data provide not only the building blocks for analytics efforts and better understanding of our patient population, but the foundation of interoperability needed to support the free flow of information between systems.

Reference data management (RDM) is a strategy that employs people, processes, and technology to organize and understand its data. RDM encompasses oversight of important data assets to ensure that all stakeholders across an enterprise are drawing from a single source of truth for analytics and reporting. A component of an organization’s master data management framework, RDM is increasingly central to any forward-thinking data governance strategy that supports mission-critical activities.

Consider two proposed rules: the Centers for Medicare and Medicaid Services’ Interoperability and Patient Access Proposed Rule and the Office of the National Coordinator for Health IT’s Proposed Rule for Improving the Interoperability of Health Information. Together, these rules aim to advance information exchange to allow patients greater access to their health data and call for the implementation of the US Core Data for Interoperability (USCDI). Among other important changes, they require that electronic health information (EHI) be made available via common Fast Healthcare Interoperability Resources (FHIR) application program interfaces (APIs).

If passed in its current form, this new legislation will impact every sector in healthcare. Health IT vendors will have new requirements to certify their software; providers will be required to share additional types of data found in free text notes such as laboratory and imaging narratives, consultation and discharge summaries, and progress notes; and payers will be expected to make claims, clinical, and cost data readily available to their members. Without a complete RDM strategy, healthcare organizations will struggle to comply.

As the industry continues to up the ante on information exchange, the ability to maintain the integrity of the patient story as it moves through electronic systems is increasingly important. HIM professionals have always been responsible for managing that critical part of care delivery. It’s important that HIM leaders have a seat at the data governance table and a keen understanding of the challenges and opportunities of managing all an organization’s data assets.

Big Data Challenges: A Deeper Look

The industry is sitting on a wealth of information that has potential to transform care delivery. Consider the various forms of data needed to drive performance improvement:

- Structured data such as claims information derived from CPT, ICD-10, MS-DRG, and HCPCS codes
- Semi-structured data such as labs, medications, and social determinants of health found in electronic health record (EHR) drop-down menus
• Unstructured data such as free text found in clinician notes and PDF documents

Healthcare organizations are increasingly trying to draw insights from all this information, but much of it remains locked in silos due to communication barriers between systems. To achieve a foundation of accurate analytics, all this data must be represented by a standard terminology—content that makes up an organization’s reference data—to establish a single source of truth that allows information to flow easily.

While this equation may seem simple on the surface, the reality is that many organizations struggle because they lack an effective RDM strategy. This state of affairs leads to poor data quality and notable downstream consequences including cost duplications, negative impacts to reimbursement, and ineffective approaches to care and disease management.

The RDM Opportunity
RDM plays an important role in an organization’s data governance strategy. When healthcare organizations centralize management of their data assets through RDM, they can simplify complex data governance processes, establish a single source of terminology truth to optimize analytics, and reduce overhead. The key is having systems in place that ensure reference data is current and accurate and used consistently across an enterprise. Otherwise, inconsistencies can diminish the opportunity.

A comprehensive RDM strategy addresses five components: Governance, Acquisition and Promotion, Content Authoring, List or Value Set Management, and Integration and Distribution.

Governance. Healthcare organizations must ensure alignment of a RDM strategy across people, processes, and technology. Some questions to ask include: How will my team govern terminology definition, intended use, versioning, and implementation across data domains? How do I align my enterprise around a single source of terminology truth?

Acquisition and Promotion. Identifying all code sets used across an enterprise and defining what it takes to maintain them in an optimal way is the next step in designing an RDM strategy. For instance, CPT is a commonly used code set throughout healthcare today. It is found in many disparate systems such as EHRs, admission and registration, billing, and financial systems. Each of these systems is frequently managed on the department level, requiring CPT to be acquired departmentally. By adopting a centrally managed data acquisition process, healthcare organizations can reduce cost duplications related to the acquisition, updating, and maintenance of CPT while also ensuring that all systems are operating on the same version of the code set. Some questions organizations can ask include: Are we sourcing the same thing from different vendors? Are we paying duplicate fees? How do we keep up to date with changes in our reference data as new versions are released?

Content Authoring. Once sourcing is addressed, an RDM strategy should consider an organization’s needs around enriching and authoring data. As such, the next step requires defining what that information model looks like and supporting it with toolsets and services. Some questions to consider are: How can custom content be authored in a consistent manner? How do we notify downstream users of any changes to both standards and local data?

List or Value Set Management. Moving beyond sourcing and authoring data, the next step is the management of groups or lists of codes. Code groups or lists are often used as building blocks for business rules that help inform such initiatives as population health and quality measures. For example, how does your organization identify patient cohorts for research, create preference lists for provider workflows, and know which patients need additional intervention for their chronic conditions? It is important to not only curate these lists in a logical and data-driven way, but to ensure that once created, lists are kept up to date as the underlying standards update. A good RDM platform can keep these processes automated, accurate, and available throughout the enterprise.

Integration and Distribution. Finally, RDM must address the distribution of content and how an organization will integrate data into its infrastructure either manually or automatically via APIs. This part of RDM should be supported by processes that handle communication and change management across an organization. Often, this begins with a question: How do I ensure systems are receiving the updates they need?

Implementing the above five steps lays the groundwork for effective RDM. Many resource-strapped healthcare organizations find that the business case for leveraging a framework of automation to do the heavy lifting is an easy one to make. The good news is that technological infrastructures exist that can help healthcare organizations extract the greatest value from reference data.

The best strategies draw on the right data, software, and services to advance RDM. First, healthcare organizations should consider single sourcing reference data to reduce costs and overhead that can result from managing multiple suppliers.

Once content is in place, advanced infrastructures can be deployed to overcome the burden of managing reference data on spreadsheets. Healthcare organizations can consider applications that provide tools for modeling, grouping, and searching data, as well as automating the distribution of updates.

Even with an advanced technological infrastructure in place, many organizations are still challenged to allocate resources to RDM initiatives. In these cases, organizations can lean on third-party informaticists, clinicians, and coders with intimate knowledge of reference data to help augment staff as necessary.

Note

Cheryl Mason (cheryl.mason@wolterskluwer.com) is director of clinical informatics consulting at Wolters Kluwer, Health Language.
Clinical Documentation Improvement and Data Analytics Combine to Improve Patient Safety

By Teresa Evers, RN, RHIA, CDIP, CCS

HEALTHCARE PROFESSIONALS HAVE all been subjected to mountains of information urging them to amplify quality care and patient safety. Everyone who works in healthcare, including health information management (HIM) professionals, must strive to advocate and serve these two areas. Patient safety is an evolving path connecting every member of the healthcare team. The medical record is the chief communication tool used to provide safe and efficient patient care and allow for appropriate reimbursement of services and equipment.

This article will focus specifically on the link between the clinical documentation improvement (CDI) specialist and the data analyst. The data analytics team must rely on the fact that the data they review is an accurate reflection of the patient encounter. Linking accurately coded data to pertinent clinical information is the primary focus of most CDI teams. By working directly with physicians and coders, CDI specialists help interpret, communicate, and educate the healthcare team to produce a clear and precise reflection of the care and progress of each patient encounter.

Precise Documentation Is a Must

The clinical staff within an organization are responsible for direct patient care and must document assessments, decision-making processes, and patient outcomes for translation of the medical record into specified coded diagnoses and procedures. Consistent and precise documentation in the medical record produces favorable results and enhances information gathering processes for analysis and process change. Data integrity is directly related to the input of information in the medical record as well as the interpretation of the consolidated documentation. Direct care providers record the essential foundation of documentation for data analysis. Provider communication with the clinical documentation specialist team through queries and education of coding guidelines and specificity requirements for accurate coding produces favorable patient outcomes and focused data analysis of benchmarked data. More than a keystroke, the information in the medical record tells the story of the patient encounter. Quick access to positive and negative outcomes is essential for healthcare providers when determining the continuity of care and creating safe evaluation and treatment modalities. Federal and state guidelines mandate that physicians, and in some states nurse practitioners and physician assistants, have ultimate responsibility for accurate documentation and control over the content of the medical record.

CDI Team Vet Documentation for Care and Cost

The CDI team performs inpatient and outpatient reviews “to ensure that physicians provide the most complete, clear, reliable, timely, legible, and precise documentation consistent with the clinical findings in the medical record.” CDI strives to combine clinical and coding knowledge to substantiate correct DRG assignment and reporting of a secondary diagnosis. Concurrent reviews help align patient information within the medical record for clarity and consistency, which facilitate coding accuracy. Additionally, the CDI team communicates verbally or electronically with clinical providers to educate them on the need for clear, concise, and specific documentation to facilitate proper coding for patient quality and safety. Clinical validation may occur during the patient stay, or retrospectively. CDI pulls data from a variety of entry points in the medical record to confirm supporting documentation of a diagnosis. Monitoring for clinical validity within the medical record to support the professional judgment of providers allows for further study of patient safety and quality outcomes.
Facilities or departments may determine critical areas of interest for focused CDI reviews based on quality indicators, length of stay, mortality, readmissions, or other benchmarked data. For example, CDI could conduct a targeted study to determine how patient length of stay affects the occurrence of pressure ulcers, ultimately improving the standard of care for this population. Identifying links between activity levels, nutritional status, and the presence of comorbid conditions helps carve new procedures, enhance documentation practices, and improve nurse/provider communication while identifying the need for improvement or confirming best professional practice. In this way, patient safety outcomes are reflected by the efforts of the CDI specialist working with physicians and coders to ensure appropriate capture of primary and secondary diagnoses for every patient at every encounter. CDI specialists work to sort through the complex medical record with concurrent or retrospective reviews to determine the most appropriate code selection.\(^5\)

The CDI team may include previous direct care providers, experienced coders, or a combination of both. This team approach yields quality documentation that will positively reflect on patient safety scores. Record reviews and physician queries resolve questions of causal relationships. For example, did a medication cause an adverse effect in a patient because of dosing, underlying medical conditions, drug interactions, or intolerance to the substance? When examining why patients fall in the hospital, this in-depth study could prevent future falls.

The goal of concurrent or retrospective documentation reviews by the CDI specialist enhances patient safety by ensuring the first line of defense with consistency and accuracy within the patient record.\(^5\) Data analysts can then create descriptive databases and produce statistical information with correct information, thus enhancing patient safety outcomes.

### Data Analytics Team Searches for Significance

Data analysts compile large volumes of information to determine significant outcomes of care that may influence future treatment modalities or avoid potentially dangerous situations by identifying patterns and trends.\(^5\) Precise data entry by clinical staff at the bedside leads to more specified clarification of clinical documentation by CDI professionals, resulting in clean data for statistical analysis. Decision-making processes begin with benchmarking data to determine trends, correlations, or variances within a specific population.

Coded data can be sorted and arranged with ease, allowing the data analyst to apply calculations. Information can be evaluated within an organization with a prescribed timeline or compared with reported data from archived databases with selected significance. In this way, healthcare professionals may not only establish new plans of care but determine the effectiveness of change. Benchmarking is the driving force to assess the effectiveness or need for improvement of performance and quality standards.\(^8\) Since the advent of the electronic health record (EHR) system, a streamlined approach to data management has paved the way to new opportunities to improve patient outcomes. Accurate data entry provides the groundwork for reporting and analyzing vast quantities of information using a systematic approach.

Consolidated data entry provides an efficient manner in which chart reviews are conducted for coding or auditing, and data is extracted for analysis or reporting. Identifying and monitoring patterns within the healthcare delivery system provide guidance for system development, business management, and medical decision-making. Operational system alerts and enhanced order entry procedures can be established as a result of proper reporting of concise data. The Office of the National Coordinator for Health IT (ONC) was created in 2004 to “spur the widespread adoption of the interoperable EHR within 10 years.”\(^9\) Advanced education can be developed to facilitate a deeper understanding of the importance of accurately and precisely capturing appropriate diagnosis and procedure codes from provider documentation.

### Connecting for Improved Patient Safety

The future of healthcare quality and safety can best be determined by the complete and accurate interpretation of the quality information in the patient record to include treatment modalities, patient safety indicators, and response to care including outpatient follow-ups and quality measures.

Patient safety and quality care is the responsibility of all healthcare professionals. The patient record remains the most prominent method of communication between healthcare providers to include direct patient-specific care as well as understanding quality measures and performance outcomes to improve the management of population health initiatives.\(^10\) From facility and provider communication for each patient encounter to the analysis of coded data, clinical documentation specialists provide another link to quality and safety.

### Notes

5. Ibid.
6. Johns, Merida L. *Enterprise Health Information Management and Data Governance*.
8. Ibid.
10. Ibid.

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Employees are requesting more flexibility and organizations are now finding that by offering remote capabilities, they are getting some of the best talent that may not reside in their same town or state. Remote capabilities have also reduced facility costs—which has also allowed organizations to offer attractive perks and benefits to promote employee satisfaction.

According to the 2018 AHIMA CDI Industry Survey, approximately 17 percent of clinical documentation improvement specialists (CDIS) work completely remotely, whereas about 42 percent have a hybrid model of remote and on-site. Of these hybrid models, approximately 37 percent of the respondents work remotely twice a week. With the increased use of technology in the healthcare setting and providers documenting in the electronic health record remotely, remote clinical documentation improvement (CDI) is the next frontier for many organizations.

One Size Doesn’t Fit All with Remote CDI
In recent years, CDI has expanded from the traditional setting of inpatient healthcare to other settings like outpatient and other non-acute care. With this expansion, qualified employees are harder to find and retain because there is so much competition and new opportunities for CDI professionals. This has caused many organizations to consider the possibility of implementing a remote CDI program so they can remain competitive in the industry while providing their employees with some flexibility to help promote work/life balance and increase job satisfaction.

While the concept of remote CDI seems attractive, it is important to know that there is no “one size fits all” approach. Various elements—query process, maturity of the program, level of physician engagement, equipment/internet access, and more—must be considered. A preliminary assessment of the current state is needed to determine the sustainability and amount of investment that will be required to implement a successful remote CDI program. For example, it is beneficial to evaluate all of the pros and cons, along with determining how the current CDI processes and provider engagement will be impacted if a remote program is implemented.

Pros of remote CDI include:
- It can lead to increased productivity
- Allows for flexibility and reduces the number of call outs
- Can lead to a reduction in high turnover, allowing for retention of skilled and experienced staff
- It saves cost by eliminating or reducing overhead costs
- Increases recruitment reach, not limited to a specific geographical location

Cons of remote CDI include:
- Loss of relationship with the providers and colleagues
- Privacy and security concerns
- Reduction in productivity
- Inability to properly track productivity and down time
- Hidden costs involved with creating a home office

Types of Remote Models
Before starting a remote CDI program, HIM professionals should decide which type of program to launch—full-time remote or hybrid.

Many will want to consider a full-time remote (100 percent) program. This type of CDI program has all CDI reviews done remotely. This model works best for mature CDI programs, where the physicians need little or no hand-holding to get queries answered or documentation done accurately. This gives the physicians the ability to focus on patient care and not be saddled with bumping into CDISs on the floor. It is also beneficial for
programs that want to include weekend coverage. There could be quarterly on-site educational meetings for physicians, so that physicians can connect names with faces of CDISs. There also needs to be a designated physician educator/liaison, if possible, who fully engages with physicians on CDI education.

Another approach to consider is the hybrid remote/on-site program. This is a combination of on-site and remote CDISs and it can be structured in various ways. This model provides the ability to have face-to-face interactions with physicians, which some programs want to maintain, and also provides the flexibility to the CDI staff to work from home.

One common model that currently exists is where the CDI team works remotely at a minimum of two days and works onsite the other three days. In this format, not everyone is onsite or remote on the same days. Another common model is where half of the team works remotely for a period of time (example: six months) and then switch over with the other half of the team that was working on-site.

There must be a coordinated effort and plan to educate providers so that there won’t be a lapse in provider education when the CDI team is not on site. Building and sustaining relationships with providers is vital to the success of a CDI program; it is important for the organization to implement a CDI program that allows the CDI team to continue to communicate effectively with the providers, including the ancillary team. Most hybrid CDI models will provide the flexibility that employees are seeking but continue to provide a consistent CDI presence as well.

Transitioning CDI teams to work completely remotely may limit the team’s ability to meet directly with providers. It is vital for the CDI management team to monitor the provider’s active participation and response to the CDI team when everyone is working remotely. Active participation and prompt responses are key to the success of all CDI initiatives.

Things to Consider

While the decision to implement a remote program appears relatively simple, many factors must be considered to build the program in a sustainable fashion. Remote CDI work requires managers to develop structured policies and agreements for the staff to follow. Prior to working remotely, CDI professionals should be expected to meet established productivity standards with the expectation that if metrics decrease the CDI professional may be directed to return to a site-based role. Managers have the responsibility of ensuring an individual has the proper work ethic to work remotely and can work without direct supervision. Therefore, it is important for every organization to perform their due diligence and determine whether their department will benefit from having the team work remotely.

The management team also needs to consider logistical issues that may arise from having remote capabilities. For example, strong internet connectivity will be required to ensure productivity doesn’t decline. Confidentiality is a risk with remote work and remote employees must have a proper working environment and tools to protect the health record. It is crucial to work with the organization’s information technology and human resources departments to ensure the success of remote CDI. Human Resources can help guide the CDI management team through the process of hiring and offer advice on current departments that have remote capabilities so that they do not have to recreate the wheel. IT can provide system requirements (i.e., VPN, virus scans, etc.) and help with other issues such as connectivity and ergonomic configurations.

While working remotely may help reduce overhead costs required to run the department, it is important to note that there may be other costs associated with a remote team, such as attending on-site meetings and education. The organization needs to evaluate who will bear these costs and address this topic in the policies and procedures. Policies and procedures also should address, but are not limited to, the following:

- Confidentiality/HIPAA Compliance
  - Confidentiality employee agreement
  - Telecommuting agreement
- Employee Telecommuting Expectations
  - Productivity standards
  - Schedule
  - Down-time procedure
  - Time off and/or call out procedure
  - Directions and expectations with timesheets
  - On-site requirements (if applicable, include reimbursement of expenses)
  - Reasons for termination of the remote program
- Technology
  - How to access the system remotely
  - Hardware/software requirements

Creating policies and procedures that outline all requirements and expectations prior to implementing remote CDI will help the management team avoid any misunderstandings or abuse of the process.

As healthcare continues to evolve, telecommuting has become more desirable. And, in most cases, the benefits may outweigh the negatives. Remote capabilities have helped increase job satisfaction and employee performance as evidenced by increased productivity—when done right. Furthermore, remote CDI also offers the leadership team an ability to find more talent because they can now offer the desired work-life balance that everyone wants. It is vital for organizations to consider all associated pros and cons surrounding remote capabilities and to create appropriate safeguards to minimize any risks and abuse that may arise with work from home privileges. Remote CDI is truly the next frontier in CDI.

Note


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Definition, History, and Use of the Problem List

THE PROBLEM LIST was first defined and created by Lawrence Weed in the 1960s at a time when care continuity was its primary purpose. Problem lists have become more widely used as a basis for problem-oriented charting, a methodology for clinical documentation embraced by many in the medical establishment. Problem lists were later required as part of the “meaningful use” Electronic Health Record (EHR) Incentive Program (now referred to as “Promoting Interoperability”) and have proliferated greatly in their utilization as a result of the implementation of the EHR.

The Centers for Medicare and Medicaid Services (CMS) has defined a problem list as “a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.” Maintaining the problem list is one of the core measures under the eligible professional meaningful use initiatives. The objective of this core measure is to have providers maintain an up-to-date problem list of current and active diagnoses. “Up-to-date” is also defined under this core measure as having the problem list “populated with the most recent diagnosis known.” An accurate problem list is critical to providing better patient care across the continuum of care/settings. A problem list should be maintained in order to ensure accuracy, completeness, and integrity.

EHR certification for eligible professionals and hospitals required EHR products to store problem list entries using a designated “CORE” problem list subset of Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) codes. The process for adding problem list entries as SNOMED CT codes varies by EHR vendor. The most common method is for clinicians to choose interface terminology terms mapped to SNOMED CT codes from menus that appear during clinical documentation. In other instances, users choose the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code titles during the documentation process that are subsequently mapped to SNOMED CT codes. A few EHR systems use SNOMED CT terms during the documentation process.

Most EHRs “map” SNOMED CT entries in the problem list back to an ICD-10-CM code that is pre-selected based upon the model setup of the EHR. When two or more terminologies are used during the process of generating the problem list, challenges with accurate mappings may occur, although error rate reductions are possible through the use of advanced mapping techniques. Organizations should have a policy governing the review of these mappings on an annual basis to ensure that the most appropriate codes (specificity, pertinence, and accuracy) are available to the provider. In addition, the organization should consider monitoring the use of unspecified codes and those integral to other conditions or excluded by other conditions in the problem list to be certain that providers are aware that more specified codes are available.

Currently, there is no single standard for the structure or content of problem lists. Clinicians vary in how they prioritize and manage problem list entries, creating further challenges to their use as a source of diagnoses for claims data. However, there are existing standards from organizations like the Joint Commission’s Hospital Accreditation Standard and the American Society of Testing and Materials (ASTM) that address content in the problem list which will be discussed later in this document. As a result, healthcare organizations have developed their own policies and procedures, creating a great deal of variability in practice when it relates to the coding and clinical documentation improvement (CDI) domains. This variability, in return, has led to inconsistent practices that affect the accuracy and quality of claims data.

The EHR systems used by some organizations can be set to automatically pull forward all diagnoses from the previous problem list (with or without associated ICD-10-CM codes) that may not be relevant and/or up to date into subsequent encounters. On the other hand, prior to the data being pulled forward some systems may prompt providers to review and/or update the problem list. In either of these instances, a validation process should be included. An accurate problem list should include conditions that were current and active during the encounter. Problems resolved prior to the current encounter should be delegated to the past medical history (e.g., appendicitis that was treated surgically) and be removed from the problem list. In the event that the condition cannot be removed from the problem list, resolved conditions should be identified with a notation like “resolved,” “not active,” “in remission,” or “date condition resolved.”

Per the AHIMA Thought Leadership Series “Problem Lists in Health Records: Ownership, Standardization, and Accountability,” the problem list may be considered a part of the legal health record depending on how it was generated. Information generated by a provider for patient care is considered a part of the
Developing Organizational Policies

THESE LISTS ARE adapted from the AHIMA Thought Leadership Series white paper “Problem Lists in Health Records: Ownership, Standardization, and Accountability.”

ORGANIZATIONAL POLICY should be based on:
- Defining the role of the problem list as a tool to support patient care
- Defining the philosophy about patient involvement in their care
- Workflow efficiency and organizational requirements

ORGANIZATIONAL POLICY must be clear about the following:
- Who may add, modify (update), and delete/demote/retire a problem from the problem list?
- Who has access and retrieval privileges of the problem list?
- Safeguards for authentication, security, and reliability.
- Establish a mechanism for “provenance” of the problem list, such as a process that stores the identity of the individual who made or modified a problem list entry, as well as a date and time stamp.
- Changes to the problem list. No one should be authorized to delete/demote/retire (e.g., resolved date) problems from this list without following the standard process for updating, correcting, or amending the health record.
- When updating takes place (items added, archived, or marked as resolved).
- If applicable, linkage to source documents should be permitted.
- Items affecting patient safety (e.g., fall risk) should always be prominently displayed. Ideally, these items appear at the top of any problem list for emphasis.
- The process for creating and using specific “views” of the list to improve functional utility for problem entry, user access, and maintenance efficiency.
- The process for resolving disagreements between providers concerning problem list content.
- The process for accommodating differing views between patient and provider on the list.
- The role of the clinician in this person’s care.
- Where the list is viewed and stored.
- How and when the list is maintained for accuracy and completeness.
- Tools or vocabulary sources (if any) required to support interoperability and information retrieval.
- Standards (if any) that govern the use or content of problem lists literacy level.
- Policies for reconciling problem lists received from other organizations in electronic or other form.


legal health record, while system-generated information based on the abstraction from other parts of the EHR, which may be used for administrative purposes, may have other legal implications. A problem list that is considered part of the legal health record must be produced upon request by a patient and/or third party during a lawsuit.

The following are some contemporary issues with the problem list that should be considered.

Governance, Authorship, and Ownership
Patients frequently receive care from multiple providers from different specialties that may use disparate EHR software platforms. In this situation, it is common for a patient’s problem list to vary by setting, which undermines the purpose of the problem list—a central repository of active and chronic conditions for the patient as a whole. Ideally, problem lists and updates would be accessible to all providers across the patient’s spectrum of care, but in most settings problem lists are maintained independently in each organization’s EHR.

The problem list should be maintained and updated every time the patient is seen by a provider so that the continuity of care is maintained. A patient might not see the same provider, and therefore it is impossible to have continuity of care when a patient’s appendicitis remains in the problem list two years later because there is no formalized process in place to review and address outdated entries. It is each provider’s responsibility to go through the problem list and validate the status of each condition during each visit/encounter. Best practice would be for all active/current diagnoses to be reviewed with the patient during the encounter. For example, this could be done prior to obtaining and/or reviewing the patient’s history to update the status of conditions that resolved between healthcare encounters.

Organizations should develop a policy that outlines who can make entries into the problem list and that determines if the entries are to be considered as clinical documentation to guide CDI and coding practices. Organizations that allow the problem list to be used as clinical documentation need
policies that establish processes for updating and/or removing diagnoses resulting from a provider’s response to a CDI or coding query. Specifically, they need to address whether editing is permissible by roles other than independent licensed professionals who are able to make medical diagnoses; if so, those roles should be specified in the organization’s privileging policies and their responsibilities in terms of authorship should be clearly stated. See the sidebar on page 45 for more on developing organizational policies.

CDI and coding professionals do not typically modify a provider’s documentation in the health record. Some organizations require the provider to update their documentation in the health record in response to a query, while other organizations include the query as part of the legal health record to update a provider’s documentation. Ideal practice is to have a provider of record update the problem list. Unfortunately, the effectiveness of using a query to amend the provider’s documentation will be limited within the confines of a problem list so organizations may decide to allow CDI and/or coding professionals to update and/or remove problem list diagnoses when supported by provider documentation in response to a query. If an organization grants such permissions to non-practitioners, authorship of such entries should be clearly identified and closely audited for compliant practice. Health information management (HIM) and CDI professionals play an important role in helping to maintain the problem list, but review and oversight by a provider is also required, as inaccurate or outdated problem list entries can impact patient safety. Therefore, it is important for each organization to have medical staff bylaws that clearly address provider responsibilities in regard to reviewing and updating all documentation in the health record, including the problem list.

While each provider rendering patient care should be responsible for updating the problem list during each encounter, the provider’s ability to make accurate revisions to an existing problem list may vary according to their familiarity with the patient and area of practice. Additionally, providers may not have access to all relevant diagnoses due to challenges related to the current state of interoperability. How problem lists are updated may also depend on the capabilities of the specific EHR platform. Managing the problem list can be labor-intensive which means this is often inconsistently performed, which may lead to inaccurate, incomplete, duplicative, and outdated lists.

Hospital and practice scores in the Quality Payment Program’s “Promoting Interoperability” performance category require healthcare organizations to import and reconcile electronic summary of care documents, including the problem list. Organizations need to develop policies, procedures, and work flows that optimize the reconciliation process.

Organizations that classify the problem list as clinical documentation need to create an ongoing standardized reconciliation process to synchronize the problem list among providers and across settings. Such a reconciliation process with the use of reporting capabilities may allow a designated individual (example: HIM/CDI professional) to use the Strengths, Weaknesses, Opportunities, and Threats (SWOT) approach to make recommendations to the primary care provider:

1. Identify patients who were seen by a provider in the healthcare system at least twice during the past 12 months. Organizations should establish the level of frequency for this step (i.e., monthly, quarterly, etc.).
2. Compare each diagnosis included on each problem list to documentation available in the applicable health record to confirm, suggest an update, or suggest removal of an included diagnosis.
3. Create a master problem list that includes the recommendations across all reviewed encounters to identify opportunities to consolidate similar diagnoses and remove conditions integral to other diagnoses.
4. Forward the recommendation to the designated provider of record (i.e., provider, nurse practitioner/physician assistant (NP/PA), etc.) for review.
5. Once the master problem list has been approved by the designated provider of record, update the problem list in the patient’s longitudinal record of care according to organizational guidelines.

Regulatory Requirements and Compliance
The following offers a summary of problem list regulatory requirements and other compliance initiatives.

The Joint Commission
The Joint Commission’s (TJC’s) Hospital Accreditation Standard (RC.02.01.07) requires a summary list for each patient who receives continuing ambulatory care services in the health record. This summary list is required to be initiated by the third visit. Even though a summary list is not the same as the problem list, some organizations view both lists to be the same. The summary list may include medical diagnoses, operative and invasive procedures, and any current medications. These content elements potentially require additional provider consideration or intervention. TJC standard requires providers to update a patient’s summary list whenever there is a change in diagnosis, medications, and/or allergies to medications and whenever a procedure is performed. TJC also requires the patient summary list to be readily available to other providers so that the appropriate treatment and care can be provided.

ASTM International
ASTM International’s Standard Practice for Content and Structure of the Electronic Health Record (E1384-07) indicates that the problem list should contain all past and current diagnoses, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions. The standard also notes that the problem list should be amended as more precise definitions of problems become available.
ICD-10-CM Official Guidelines for Coding and Reporting
The Code Assignment and Clinical Criteria in Section I.A.19 states that the assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

The Reporting Additional Diagnoses guideline in Section III defines “other diagnoses” as additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. The Uniform Hospital Discharge Data Set defines other diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

Coding
Outpatient coding is often the responsibility of the provider in the office setting without prior review of a coder. Providers in both the outpatient and inpatient setting often leverage a drop-down list within the EHR to select their diagnoses. Often, the selected term along with the associated SNOMED CT or ICD-10-CM code does not fully or accurately represent the concept the provider is trying to enter into the record from a decision tree or pick list. Providers may choose the first available diagnosis on a drop-down list or within a decision tree without realizing that there was a more appropriate selection. Furthermore, the problem list does not contain a provider diagnostic statement, which is required for coding and reporting. Organizations should have a policy for clinical validation that provides situational guidance to coding and CDI professionals as to when a query is indicated. See the Practice Brief “Clinical Validation: The Next Level of CDI,” updated in January 2019, for more information on clinical validation. While the problem list should not be solely relied on for coding and query considerations, it should be a point of reference when determining code assignment and physician query opportunities.

Technology Considerations for the Problem List
Where artificial intelligence capabilities such as computer-assisted coding are deployed, organizational practices with regard to the use of the problem list, diagnosis selection drop-down lists, and query language for coding and CDI processes tend to be both complex and variable. Technology that assists with problem list and diagnosis selection may create myriad compliance and regulatory issues that will require manual review and revision by the provider. Organizations should prevent their EHR from automatically pulling diagnoses from the problem list into other documents like the discharge summary or on to claims unless they have a robust process in place that validates the accuracy of the included diagnoses. Key considerations for problem list technology in coding, CDI, and the query process may include but are not limited to the following.

Copy, Paste, and Pull-Forward Functionality
Organizations utilizing copy/paste or “pull-forward” of clinical diagnosis functionality in the problem list should have a policy statement regarding the conditions by which this practice is permitted. For example, are providers allowed to copy/paste or pull forward conditions from previous encounters into the current history and physical and/or other specific documentation? Organizations should also consider performing a quality review of the functionality as part of their ongoing record review to identify opportunities for improvement and providers that may not be reliable users of the functionality per the policy. In 2014, AHIMA published a position paper titled “Appropriate Use of the Copy and Paste Functionality in Electronic Health Records.” This position paper cautions that “users of the copy/paste functionality should weigh the efficiency and time savings benefits it provides against the potential for creating inaccurate, fraudulent, or unwieldy documentation.”

Artificial Intelligence, Data Mining, and Computer-Assisted Coding Applications
Organizations should clearly define the responsibility for authorship of entries into the problem list and declare the entries into the problem list as clinical documentation if they intend to allow applications utilizing artificial intelligence access to the problem list for purposes of data mining. Additional or updated diagnoses that may be identified through machine learning and natural language processing need to be flagged for review by designated professionals prior to being incorporated into the patient’s problem list.

Query Process
Organizations are finding great value in problem list entries in the coding and query process. CDI or coding queries should have traceability of clinical indicators in support of the query and ensure that information used from prior encounters is compliant with coding guidelines and payer regulations. According to the 2019 update of the Practice Brief “Guidelines for Achieving a Compliant Query Practice,” queries using information from prior encounters may be utilized when relevant including, but not limited to, the following situations:

- Diagnostic criteria allowing for the presence and/or further specificity of a currently documented diagnosis (e.g., to ascertain the type of congestive heart failure (CHF) or specific type of arrhythmia)
- Treatment/clinical criteria or diagnosis relevant to the current encounter that may have been documented in a prior encounter
- Determine the prior patient baseline, allowing for comparison to the current presentation
- Establish a cause-and-effect relationship
- Determine the etiology when only signs, symptoms, or
Problem List Success is Important to Quality Patient Care

Problem lists should be standardized and designed to support an interdisciplinary and patient-centered approach for all provider health record entries. An up-to-date and accurate problem list is critical to the success of organizations providing patient care across the continuum of care in all settings. A problem list should be maintained in order to ensure the accuracy and integrity of the data. CMS has defined the problem list as "a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient." The problem list should not be used solely for coding. Every codable diagnosis should contain a provider diagnostic statement with supporting clinical indicators, monitoring, and/or treatment in the record to support such diagnosis. Per the ICD-10-CM Official Guidelines for Coding and Reporting, "the assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists." Industry standardization will help facilitate interoperability within a healthcare organization. By standardizing and having specific policies and procedures in place, the use of the problem list will be more efficient and meaningful for all providers. Ultimately, the attending/primary provider is responsible for reviewing, reconciling, and updating all documentation related to the patient’s care, including the problem list in the health record. It is important for organizations to remember that all entries in the EHR are tracked and this metadata is used to identify who documented and/or updated what within a patient’s health record. Furthermore, when designing EHR workflows, organizations should lean on HIM/CDI professionals for guidance on how to improve documentation processes. Involving qualified experts in documentation requirements is the key to standardizing and improving the use of the problem list in all healthcare settings.

Notes


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THERE ARE MULTIPLE benefits of an effective coding compliance program. An article published in the January 2019 issue of the *Journal of AHIMA* titled “Components of an Effective Outpatient Coding Compliance Policy Program” identified these benefits and outlined 15 important considerations when developing a voluntary compliance program in the outpatient setting. This article presents additional considerations specific to coding compliance in the inpatient setting. Essential components include inpatient coding policies and procedures, inpatient coder continuing education, diagnosis related group (DRG) reconciliation, case-mix index (CMI) tracking, auditing and monitoring, corrective action, and annual updates.

**Inpatient Coding Policies and Procedures**

Inpatient coding policies and procedures should address coding functions, standards, and practices specific to inpatient coding to ensure complete and accurate coding results. Inpatient coding policies should incorporate:

- AHIMA Code of Ethics
- AHIMA Standards of Ethical Coding
- ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting
- Applicable federal and state regulations
- Internal facility-specific policies, including a policy requiring physician documentation to support all reported diagnosis and procedure codes

Procedures related to specific coding functions should include step-by-step descriptions of the process to ensure maximum coding quality and productivity.

In instances where no official coding guidelines exist, facilities should develop internal policies to ensure inpatient coding consistency and accuracy. Internal policies should not conflict with guidance and instructions in the ICD-10-CM and ICD-10-PCS code sets, the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, published advice in the American Hospital Association’s (AHA’s) *Coding Clinic*, or any federal or state regulations. The compliance program policy should specify that ICD-10-CM/PCS coding and sequencing guidance takes precedence over official coding guidelines and official coding guidelines take precedence over facility-specific guidelines.

**Continuing Education is Key**

Regular and consistent education and training for inpatient coders is key to ensuring inpatient coding compliance. Coding compliance issues are often due to inconsistencies or misinterpretation of coding guidance that are a result of a lack of regular education.

Annual education should include information related to complete and accurate documentation and coding and how these components support the overall compliance plan. Ongoing regular education should address both the technical and clinical aspects of a coding topic. This education should include data monitoring, results of ongoing coding audits, and discussion of trends identified in the audit process. Education should also include information related to the Office of Inspector General’s (OIG) current work plan and the impact to inpatient coders at least annually.
Regular inpatient coder education provides an opportunity for staff to discuss difficult coding cases and determine a resolution. These education sessions are often more effective when both inpatient clinical documentation improvement (CDI) specialists and coding specialists are included.

Inpatient coder education should address the following areas at a minimum:

- Annual updates to the Inpatient Prospective Payment System (IPPS)
- Annual changes and updates to the ICD-10-CM/PCS classification systems
- Quarterly review of the AHA’s Coding Clinic for ICD-10-CM/PCS to ensure consistent application of published advice
- Ongoing review and application of the ICD-10-CM/PCS Official Guidelines for Coding and Reporting
- Ongoing review of clinical information related to error-prone diagnosis and procedure codes, such as ICD-10-PCS body systems

With increased payer scrutiny surrounding clinical validation, the inpatient CDI process is a critical part of inpatient coding compliance programs. Documentation education and training should be ongoing with a collaborative effort between coding and CDI staff. Inpatient coders and CDI staff should have an opportunity to share and review areas of concern regarding clinical documentation and identified documentation gaps.

**DRG Reconciliation and CMI Tracking**

DRG reconciliation provides a mechanism to validate final coded DRG cases through a second-level review process. Both CDI and coding staff should provide input in reconciling inpatient cases. Second-level review involves an additional review of the clinical documentation on high-risk inpatient cases to confirm there is appropriate representation of the coded information. These types of reviews identify opportunities for clarification of provider documentation to accurately reflect the patient’s severity of illness and validate the clinical appropriateness of the admission. Complete these reviews before claim submission to avoid improper billing resulting in improper reimbursement.

CMI tracking should also be included in the inpatient coding compliance program. The CMI is calculated by dividing the MS-DRG relative weights of inpatient discharges in a specific time frame by the total number of discharges in that same time frame. There are legitimate reasons for CMI variances, such as:

- The addition or deletion of services representative of high-weighted MS-DRGs
- Shifts in volumes from low- to high-weighted MS-DRG cases, or vice versa
- Addition or loss of a new local or regional competitor
• Addition or loss of a specialty physician(s) to the medical staff
• Changes in coding practices or guidelines

However, significant and unexplained variations in the CMI may be an indicator of coding variances and therefore should be investigated.

DRG reconciliation and CMI tracking should be concomitant compliance processes. Effective DRG reconciliation processes may result in appropriate changes to the CMI while a CMI variance may indicate a need for more robust DRG review.

Auditing and Monitoring Necessary to Maintain Accuracy
An inpatient coding compliance plan must include auditing and monitoring of the inpatient coding staff. Ongoing coding quality reviews are necessary to maintain a high level of accuracy, ultimately resulting in billing accuracy. Considerations in developing coding auditing and monitoring processes include:
• Utilize Medical Provider Analysis and Review (MEDPAR) data or other national data to determine differences between an organization’s billed data and the national average. Identified variations may or may not indicate potential fraudulent or abusive coding and billing practices. However, variations require further analysis to determine if there is a compliance issue.
• Organizations should monitor those areas under investigation by government payers and other external entities. Examples include:
  - CC/MCC capture rates
  - Single CC/MCC cases
  - High-risk DRGs, such as Sepsis, Acute Respiratory Failure, and Encephalopathy
  - Clinical or DRG denials
  - Changes in CMI

Inpatient coding audits can be performed on cases selected at random or more intentionally. Sampling approaches include, for example, random samples of specific record types or identified coders, focused samples of specific codes, or statistically valid random samples with and without stratification. The inpatient coding compliance program should provide guidance to determine the appropriate sampling methodology to accomplish the goals of a specific audit effort.

Have a Corrective Action Plan
A corrective action plan is a necessary part of any inpatient coding compliance program. Design corrective actions to prevent reoccurrence of the same problem in the future. Corrective actions often include updated policies and procedures as well as staff education to ensure a thorough understanding of the appropriate coding practice.

The compliance officer should investigate any potential coding fraud or abuse issue. The investigation should include interviews with coding staff, coding management staff, and any others directly involved. The investigation should also include review of policies, coded data, and any related previous education provided. The purpose of the investigation is to identify the underlying cause of the coding issue, the extent of the impact, and ultimately determine if there is truly a compliance issue versus an error, for example.

Keep Up with Annual Updates
Review and update the inpatient coding compliance program at least annually. As previously noted, inpatient compliance should address areas under investigation, which are constantly changing. For example, in 2017 the OIG transitioned to a web-based work plan that is regularly updated. The annual work plan covers projects performed under the supervision of the OIG by the Office of Audit Services, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Counsel to the Inspector General. Each of these agencies assists in the development of the OIG’s work plan. Their actions, related to the work plan, include audit, inspection, investigation, and litigation.

Update inpatient coding compliance efforts at least annually to align with industry trends in coding compliance, including OIG priorities. For example, since December 2018, the OIG Work Plan has included an explanation of the OIG’s intent to assess inpatient hospital billing for Medicare beneficiaries. The plan describes a two-part study. The first part gathers “landscape information about hospital billing, and how it has changed over time.” The second part will use the information to “target certain hospitals or codes to look for patterns of incorrect coding or billing.”

A robust inpatient coding compliance program should include the essential components described in this article at a minimum and should be regularly updated to ensure all aspects are current and adequate to maintain inpatient coding compliance.

Notes

References


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AS MANY HIM professionals know, there are substantial “red flag” terms related to coding myocardial infarctions (MIs) and non-MI troponin elevation, which can cause considerable challenges for providers, coding professionals, and clinical documentation improvement (CDI) staff. Coding accuracy related to MI diagnosis affects a multitude of areas, including:

- Centers for Medicare and Medicaid Services quality claims-based measures
- Public health data tracking
- Physician comparisons
- Reimbursement
- Patient outcomes

With the release of the fourth universal definition of MIs and the implementation of type-specific MI codes released in October 2017, it has become increasingly important to have Type 1 MI, Type 2 MI, and Non-MI troponin elevation documented appropriately. Vague or conflicting terms in documentation such as demand ischemia, demand mismatch, and troponin leak are common.

These statements cause confusion for CDI and coding professionals. Code accuracy is reliant on the appropriate documentation by providers, but it is also dependent on coding and CDI professionals understanding the clinical differences between Type 1 MI, Type 2 MI, and Non-MI troponin elevations. The article “Translating the Fourth Universal Definition of Myocardial Infarction into Clinical Documentation: Ten Pearls for Frontline Clinicians” gives clinical insight into the distinct differences between diagnoses.

**Type 1 MI (STEMI, NSTEMI)**

A Type 1 MI (acute STEMI and NSTEMI) is defined by infarction due to a coronary thrombus or plaque rupture/erosion. The documentation of STEMI and NSTEMI should be supported by the underlying etiology. Patients having a Type 1 MI should exhibit symptoms of ischemia (chest pain or other angina equivalent) and/or evidence of ischemia on electrocardiography, echocardiography, or stress testing. The diagnosis is usually confirmed by coronary angiography. STEMI (codes I21.01-I21.3) documentation should indicate the underlying etiology of acute coronary thrombus as well as location and artery involved. Equally, a NSTEMI (code I21.4) should include the underlying etiology of plaque rupture/erosion. Documentation that includes the underlying etiology and site serves to support the diagnosis, leading to accurate coding and denial prevention.

**Type 2 MI**

Type 2 MI (code I21.A1) is defined as a myocardial infarction due to ischemic imbalance from a supply demand mismatch. Typically, the patient will have underlying coronary artery disease (CAD). Patients having a Type 2 MI should exhibit the same symptoms of ischemia (chest, jaw, or arm pain), and/or positive ischemic changes on ECG, echocardiography, or stress testing that would be found in a patient having a Type 1 MI. Documentation of a Type 2 MI should include the underlying cause, such as acute blood loss anemia, acute hypoxia, or coronary artery vasospasm. However, the quintessential requirement when determining etiology and type of MI is dependent on ruling in or ruling out cardiac ischemia. Coding and CDI professionals should
Diagnosis is usually confirmed by coronary angiography.

Type 5 MI (MI due to CABG)
Type 3 MI (Sudden Cardiac Death)
AMI Unspecified should be avoided
Type 4 MI (MI due to PCI)
Ischemic electrocardiogram changes

Education and Documentation Challenges
It is the duty of coding and CDI professionals to educate, query, and re-educate providers to achieve the appropriate documentation habits for coding and reporting. Throughout health information management professional’s (HIM’s) endeavors to achieve desired goals, HIM must remember providers are here to take care of patients and sometimes view coding and CDI efforts as intrusive. However, HIM is ultimately responsible for making sure conditions are coded and reported accurately. Provider buy-in is a necessity to make this or any documentation endeavor a success.

Education Leads to Strong Coding, CDI
As demonstrated throughout this article, there are many red flags when dealing with the accurate coding and reporting of MIs and Non-MI troponin elevations. The key element of appropriately coding and reporting these conditions is education. Having a strong education component for coding professionals, CDI professionals, and providers is essential to ensure a good understanding of the coding and clinical differences between these diagnoses. According to ACC, having this knowledge will facilitate the education of providers on documentation specifics. This will ultimately improve patient outcomes, quality reporting, and reimbursement for all involved.

Acknowledgment
A special thank you is extended to Dr. Thad Waites, MD, MACC, for his research and passion for the field.

The Clinical Picture for Correct MI and Non-MI Designation

THE FOLLOWING LISTS key elements needed for identifying the specific type of MI and non-MI Troponin Elevations for appropriate documentation and reporting.

Troponin Elevation
Troponin elevation alone, or even a rise and fall alone, is not diagnostic of acute myocardial infarction.

- Diagnosis of Type 1 or Type 2 MI requires ischemic indicators be present:
  - Signs/symptoms of ischemia (e.g., chest pain)
  - Ischemic electrocardiogram changes
  - Imaging evidence of ischemia (e.g., ischemic perfusion defect, or new wall motion abnormality)
  - Diagnosis is usually confirmed by coronary angiography

Type 1 STEMI
- Cause: Acute Coronary Thrombus
- Treatment: Early Reperfusion Therapy
- Documentation: STEMI of vessel or myocardial segment

Type 1 NSTEMI
- Cause: Plaque rupture/erosion
- Treatment: IV Heparin, early Cath/PCI, etc.
- Documentation: NSTEMI

Type 2 MI
- Cause: Ischemic imbalance due to supply/demand mismatch
- Treatment: Treat underlying cause. IV Heparin, antiplatelet agents, Cath/PCI often not indicated and may even be harmful.
- Documentation: Type 2 MI due to_____

Non-MI Troponin Elevation
- Cause: Non-ischemic mechanism (cardiac stretch, direct injury, or other unclear mechanism as in ESRD)
- Treatment: Underlying cause or no treatment
- Documentation: Non-MI troponin elevation due to_____

Other Cardiac Types
- Type 3 MI (Sudden Cardiac Death)
- Type 4 MI (MI due to PCI)
- Type 5 MI (MI due to CABG)
- AMI Unspecified should be avoided

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A Look Ahead
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Continued from page 55 (“Red Flags for Myocardial Infarctions Coding and CDI”)

based at Hattiesburg Clinic/Forrest General Hospital, for his contributions, insight, and collaboration on this piece.

Notes

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A COUPLE YEARS AGO, SATURDAY Night Live spoofed how senior citizens use automated home assistant products such as Amazon’s Echo by imagining a fictional product called Amazon Echo Silver—a device designed to help forgetful, hard of hearing seniors manage activities like turning up the thermostat. Now Comcast, the parent company of the network that broadcasts SNL, has entered the market for assistive devices intended to help the elderly age in place.

Comcast’s device, which doesn’t have a name yet but which reportedly has a “personality” like Amazon’s Alexa, will enter the pilot stage later this year through partnerships with major hospitals.

“The device will monitor people’s basic health metrics using ambient sensors, with a focus on whether someone is making frequent trips to the bathroom or spending more time than usual in bed. Comcast is also building tools for detecting falls,” sources told CNBC.¹

Additionally, Comcast is looking to provide the device to at-risk populations, including the elderly and individuals with disabilities, with no plans to only offer it to Comcast subscribers. The device will also not function like other devices that control light or television switches or perform internet searches. It will, however, be able to make emergency phone calls.

Comcast is the latest tech company to get into the home monitoring and healthcare device market, and like other home assistance, raises issues about data privacy for vulnerable populations. One market where Comcast could find traction with its device is providers that are financially penalized when Medicare patients return to the hospital within 30 days of discharge. There are several monitoring services for the aging-in-place market, and Comcast’s broadband capabilities could help set it apart.

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