CORE CDI

Evaluation and Management- A Clinical Perspective
The Art of Communicating.

Evaluation and Management (E & M) from a clinician perspective versus a coding and billing perspective is distinctly different. A clinical perspective entails resorting to William Osler's thoughts on what the medical record stands for, that is a means for the physician to observe, record, tabulate and communicate the actual care provided. The advent of the electronic health record, the increasing mandates for reporting supposed measures of quality promulgated by CMS, and the increasing focus on "optimizing" E & M assignment and billing has seriously upended the focus and spirit of documentation other than for communication of patient care. This phenomenon is even more magnified given the movement of physician practices selling out to hospitals and health systems and now being "employed," with the employer setting high expectations for physician relative value units generated with patient encounters.

E & M-Going Beyond Reimbursement

E & M represents the exchange of clinically reasonable and necessary information between the patient, the family, other relevant patient related members, and the physician and the use of the information in the clinical management of the patient. This is the crux of the practice of medicine, utilizing clinical judgment, medical decision-making, thought processes, analytical skills and critical reasoning skills to diagnosis, treat, manage, minimize and prevent disease processes. The biggest challenge is capturing these crucial elements fundamental to the practice of medicine in a succinct, clear and accurate fashion that best facilitates fully informed coordinated care to the mutual benefit of the patient, physicians involved in the patient care and all associated healthcare stakeholders.

Affecting Fully Informed Coordinated Care

Documenting fully informed coordinated care does not require more documentation, just more effective documentation. This article is the first in a series dedicated to sharing guidance on best practices of documentation reflective of the quality focused, outcomes based, cost effective, evidence based care provided and achieved in the practice of medicine. Let's start with the basics of documentation. Documentation must explicitly demonstrate and substantiate the care provided, explicitly address the following elements, remembering that meeting these elements requires attention to clinically solid focused documentation, not more documentation:

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- **R**ight Care
- **R**ight Time
- **R**ight Reason
- **R**ight Venue
- **R**ight Clinical Judgment, Medical Decision-Making and Thought Processes
- **R**ight Documentation
- **R**ight Follow-Up

Assembling a Construct

Adequately representing, reporting and reflecting complete and accurate documentation of care provided is like assembling a series of building blocks. Constructing a strong foundation is vitally important in compiling and assembling a logically flowing clear explanation of your clinical judgment and medical decision making. A concise **Chief Complaint** is the natural starting point for setting the stage for the patient encounter, regardless of setting. A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for a medical encounter. The patient's initial comments to a physician, nurse, or other health care professional help form the differential diagnosis and serves as a reasonable Segway to the **History of Present Illness.** A chief complaint should be stated and recorded in the patient's **own words** versus recording of a diagnosis; Think sign and symptoms when recording the Chief Complaint. Recording of an accurate HPI is the critical first step in determining the etiology of a patient's problem.

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI represents the patient's **"Present Illness"** versus **"Past Illness"** with strong emphasis upon the present illness. Think of a HPI as the nature of the presenting problem, facilitating the projection of the patient's problems and complaints to any outside clinician reviewer, ranging from low complexity to severe complexity. There are eight elements of a HPI, each vitally important in describing and showing the patient's severity of signs/symptoms, clinical problems and the amount of physical, cognitive work and time required to work-up and manage the patient's clinical issues. Even more importantly is the role of the HPI in establishing medical necessity for the patient encounter. The HPI functions as a prism for medical necessity, justifying, substantiating and best explaining the unequivocal need for the patient encounter and subsequent physician work performed. The eight elements of HPI include:

- Location (example: left leg)
- Quality (example: aching, burning, radiating pain)
- Severity (example: 10 on a scale of 1 to 10)

- Duration (example: started 3 days ago)
- Timing (example: constant or comes and goes)
- Context (example: lifted large object at work)
- Modifying factors (example: better when heat is applied)
- Associated signs and symptoms (example: numbness in toes)

A key point to keep in mind in the documentation scheme of things is **Medical Necessity** of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. This concept applies to sound principles in communication of patient care aside from documentation required for CPT E & M assignment. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. Medicare Benefit Policy Manual (Chapter 12, Section 30.6) Remember that the volume of documentation bears no resemblance to medical necessity; instead the quality and completeness of documentation in the communication of patient care serves as a proxy for medical necessity. The adage of more is less applies to documentation for communication of patient care. In short, Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/acuity of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.

Clinical Documentation Improvement Programs-
Process Improvement vs. Data Gathering

The medical record serves as a means for communicating patient care provided by physicians, non-physician providers as well as ancillary care providers. Functions and roles contributing to and furthering the patient's care include case management, utilization review/management, discharge planning, quality and safety to name just a few. Communication of patient care spans well beyond diagnoses reporting translated into ICD-10 codes utilized in the coding, billing and reimbursement process. Diagnosis securement and solidification is imperative to the lifeblood of the revenue cycle; no patient care services are reimbursable without diagnoses. Consider CDI specialists auditing charts for diagnosis as a data gathering task, like a squirrel gathering acorns in the fall for the winter season. Contrast

this with CDI specialists devoting energy and time to actually reviewing the record, being able to hone in on true insufficiencies in documentation negatively impacting the effectiveness and completeness in communication of patient care, being able to not only identify insufficiencies but also possess the skills sets, core competencies and confidence to converse with physicians through use of a physician advisor to address and rectify the documentation insufficiencies and short comings. Of note is that documentation insufficiencies and short comings contribute to unnecessary avoidable self-inflicted medical necessity denials. A quick conversation with your hospital's denials and appeals department will offer testament to the direct correlation between documentation insufficiencies and medical necessity denials, insufficiencies CDI is fully capable of addressing and offering a positive impact.

The first step in transforming CDI from a data gathering task based function to a role based function that affects measurable meaningful change in physician patterns of documentation through real physician engagement is to truly redesign and reengineer current structural frameworks of processes. Contrary to misguided advice being promulgated by CDI consulting companies and perpetuated and reinforced by CFO's, throwing more bodies at chart auditing generating more queries does not produce tangible improvement in the quality of the documentation, just the data that is reported. Let's take a hard look at the current state of our CDI programs, move away from simple data gathering and redirect our efforts at "reviewing" medical records for completeness, accuracy and usability. Let's dispel the common myth and misconception that CDI evolves around queries, reactionarily waiting for the results of lab values, radiology reports and other diagnostic workup in anticipation of drafting a query that facilitates data gathering. Unequivocally, it is far better to be proactive and initiate steps that support real process improvement in documentation.

Closing Remark

I provided some thoughts on the constitution of chart reviews as a reasonable starting point for proactivity versus reactivity. Proactivity necessitates a totally different mindset, digressing from auditing of a record to reviewing of a record. Auditing implies a narrow focus while review not only implies but requires an expanded focused mindset and purpose. Chart reviews for completeness and accuracy require CDI to embrace learning, understanding and putting into play almost entirely new skill set, something that can't be learned per se at a boot camp or taking a crash course. Instead, it is incumbent upon the CDI specialists to supplement structured learning mechanisms with self-paced on-the-job real-time learning supplemented by an insatiable appetite for reading as many resources and articles on documentation. There are a host of learning opportunities available, all that is needed is the self-motivation, dedication and commitment to learn and practically apply one's knowledge of best practice documentation standards to everyday chart review.