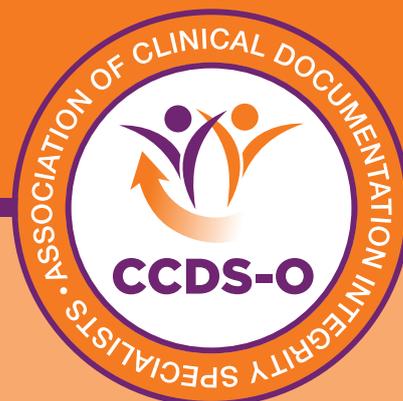


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CCDS-O

EXAM Study Guide





CCDS-O

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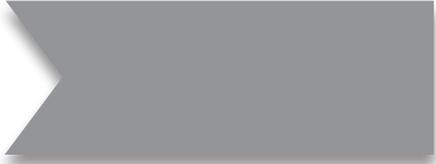
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The Association of Clinical Documentation Integrity Specialists (ACDIS) Certified Clinical Documentation Improvement-Outpatient (CCDS-O) volunteer certification committee spent more than a year working with the ACDIS administrative staff and PSI/AMP, a third-party exam administration firm, to determine the core competencies and exam questions required for those serving in the clinical documentation integrity (CDI) role in the outpatient setting. Once the test was completed, the team turned their attention to creating this *CCDS-O Exam Study Guide*. Contributors to this volume include the following:

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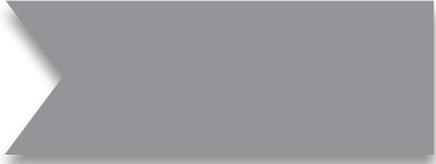
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Introduction

Since 2009, the Association of Clinical Documentation Integrity Specialists (ACDIS) has hosted the Certified Clinical Documentation Specialist (CCDS) certification program, which has grown to 4,500 CCDS-certified clinical documentation integrity (CDI) professionals nationwide. The content domains of the CCDS exam pertain to acute care inpatient medical record review expertise. In 2018, ACDIS and a 12-member volunteer board of trusted industry experts began the development of the CCDS-Outpatient (CCDS-O) credential as a companion certification to provide a trusted baseline of CDI specialist competency in the outpatient setting, including CDI efforts within physician practices, hospital clinics, and the emergency department (ED), among other settings.

Every candidate wishing to obtain the CCDS-O credential should familiarize themselves with *The Exam Candidate's Handbook*, which includes a complete content outline, candidate prerequisites, and information related to the application process. While this book will cover some of the information contained within the handbook, a thorough review of its materials will aid applicants as they proceed to apply, sit for the exam, and begin to consider their recertification efforts. It is available under the certifications tab of the ACDIS website and is included in the online materials of this book.

CDI efforts have been shifting settings as necessary due to changes in the healthcare delivery and reimbursement systems over the past several years, with more recent rapid expansion of outpatient CDI being driven by the growth of accountable care organizations, Medicare Advantage, and care increasingly delivered in outpatient settings. As the federal government represents the largest healthcare insurance provider, it has struggled to rein in costs associated with the care provided. Coupled with reports of medical errors and quality concerns in the inpatient setting, the Centers for Medicare & Medicaid Services has increasingly pushed for care to be provide in alternative settings through a series of carrot-and-stick payment options.

“The CDI profession has evolved tremendously over the last six to eight years to encompass hospital quality measures and now the outpatient setting,” said ACDIS Director Brian Murphy in a release regarding the launch of the CCDS-O. “With the corresponding need to capture an accurate record of patient care in the outpatient setting, the CCDS-O will serve as a foundation for the development of baseline practice standards and a recognizable symbol of excellence for CDI professionals.”

For some time, however, the CDI industry struggled to develop a unified definition for outpatient record reviews. Some identified as working in the field if they conducted part-time ED reviews, while others did so if they worked with hospital-affiliated physician practices. Over time, ACDIS, its advisory board, and industry experts have come to view *outpatient CDI* as an umbrella term covering all such situations.

“[O]utpatient CDI is a very broad concept, encompassing any CDI effort not associated with an inpatient claim,” according to the 2016 ACDIS white paper *Outpatient Clinical Documentation Improvement (CDI): An Introduction*.

It goes on to say that those working in outpatient frequently review records that would be reported under the Outpatient Prospective Payment System (OPPS), paid by the Medicare Part B benefit, and are more heavily dependent upon the Healthcare Common Procedure Coding System (HCPCS) codes.

In its work, the CCDS-O committee developed five core competencies through a series of interviews with representatives of high-performing outpatient CDI programs in hospitals and healthcare organizations throughout the country. Candidates who wish to hold the CCDS-O certification should have an awareness of the following:

1. Healthcare regulations, reimbursement, and documentation requirements related to the *Official Guidelines for Coding and Reporting* (OCG), the OPPS, and provider coding and billing
2. Diseases and disease processes and application to the clinical chart review
3. Risk-adjustment models and impact of documentation and coding
4. CDI program concepts such as department metrics and provider education
5. Quality, regulatory, and health initiatives

Throughout this manual, readers will obtain some insight into common practices related to CDI in a variety of outpatient settings. This book will explain several of the most common coding assignment and risk-adjustment reimbursement methods used across these settings and offer insight into how CDI programs commonly conduct reviews and define metrics to analyze outcome data. It will also offer information related to common query targets and compliant query practices.

The goal of the CCDS-O program is to develop a mark of excellence for CDI professionals operating in outpatient settings as well as provide employers with a baseline of competency for existing staff or potential hires. As such, there are certain prerequisites CDI specialists must have in order to be eligible to sit for the exam, such as a minimum of two years' experience in outpatient CDI record review or one

year of inpatient CDI experience and one year of outpatient experience and clinical or coding license/certifications. (For a complete list of prerequisites, please read *The Exam Candidate's Handbook*.)

The certification program is also expected to further spur the development of core competencies for outpatient CDI professionals and encourage the development and standardization of national best practices for outpatient CDI departments. A number of additional references will be cited throughout this book. Those wishing to excel at their work in outpatient CDI would do well to further their training and studies by reviewing the recommended sources of study outlined in *The Exam Candidate's Handbook* as well as the sources cited within this manual. Candidates taking the CCDS-O exam may want to use one of the following drug reference guides during the exam:

- *Nursing Drug Handbook/Lippincott's*
- *Mosby's Nursing Drug Reference*
- *Physicians' Desk Reference (or PDR Nurse's Drug Handbook)*
- *Pearson Nurse's Drug Guide*
- *Saunders Nursing Drug Handbook*
- *Davis's Drug Guide*

Books will be checked for additional pages or loose notes. Tabs and handwritten notes in these books are allowed, but loose notes are not. Candidates may not write in their books or elsewhere during the exam to maintain the integrity of the procedure. ACDIS contracts with a third party to provide administrative support for the certification process, including examination development, validation, and other administrative tasks. Through this third-party support, ACDIS applies industry standards for development of practice-related, criterion-referenced examinations to assess competency. It provides practice analyses and development of examination specifications and psychometric guidance to the CCDS-O advisory board to assist with examination question writing, development of content, and creation of valid examination instruments, scoring, and reporting of examination results. Once a candidate has been approved to sit for their exam, they will be asked to schedule their test at a convenient time at a testing center near them. Note that although there are many testing centers across the country, some individuals may need to travel to an exam testing site and should plan accordingly.

The examination is an objective, multiple-choice test consisting of 140 questions, 120 of which are used to compute the final score. The exam questions have been designed to test the candidates' multidisciplinary knowledge of clinical, coding, and healthcare regulations as well as the roles and responsibilities of a clinical documentation specialist. Choices of answers to the examination questions will be identified as A, B, C, or D. Each question on the examination is categorized by a cognitive level that a candidate would likely use to respond. These categories are:

- **Recall:** The ability to recall or recognize specific information
- **Application:** The ability to comprehend, relate, or apply knowledge to new or changing situations
- **Analysis:** The ability to analyze and synthesize information, determine solutions, and/or evaluate the usefulness of a solution

The online practice exam included with this manual provides 60 questions and remediation (why an answer is deemed correct or incorrect) and covers each of the content domains and question category types.

According to Zoe Balaconis in an August 2018 blog post for Cambridge Coaching, “7 Essential Tips for ANY Standardized Test,” those preparing to sit for an exam should:

1. “Study well”: Establish a schedule for exam preparation activities such as setting aside two hours per week to read a chapter of this *Study Guide* and practicing their test-taking skills via the online practice exam. Candidates may also wish to set aside additional time to read supportive materials and further their understanding of the core competencies and rationale for expanding outpatient CDI efforts. Candidates should take note of which question types in which content area they need help with and seek out a mentor within their organization to help clarify any areas of concern.
2. “Know the exam format”: As indicated, the CCDS-O exam is made up of 140 multiple-choice questions. Multiple-choice questions allow the test taker to review all possible answers and root out any clearly incorrect responses. Doing so provides the test taker better odds of choosing the most clearly appropriate answer and responding to the exam question correctly.
3. “Keep track of the time”: Although the practice exam is only 60 questions, it should give candidates a feel for how the actual test will go. If there is an area of greater concern, understand that this might take longer to review and respond to questions within that content domain and adapt to that flow in timing for the actual exam. Candidates are allowed three hours to complete the CCDS-O exam.
4. “Adapt a mantra”: She also recommends developing a mantra for use during study sessions and particularly during the exam itself, such as “calm, cool, collected” or “focus the mind, quiet the body.” Such mantras will help candidates stay positive during the exam and help reduce stress.
5. “Be physically prepared”: Once the test is scheduled and the testing date comes, be sure to put the pens and study tools away, have a nice meal, and get a good night’s sleep. Cramming for an exam typically doesn’t lead to positive results, and physical exhaustion leads to muddled thinking and mental exhaustion.
6. “Visualize success”: Balaconis recommends picturing oneself celebrating the passing of the exam with family and colleagues. While many choose to keep their exam date private, it helps to have a study crew or supportive colleagues to assist with training and exam preparations. Consider planning a potluck or cookie break to share with these colleagues as a means to thank them for their support and assistance as well as a way to celebrate the accomplishment of passing the exam.
7. “Focus your eyes to focus your mind”: Keeping a focused mind is sometimes as easy as keeping your eyes literally focused on the task at hand, Balaconis writes. Candidates are not allowed to bring any personal items into the room; only wallets and keys are allowed, and those will be placed in a locker. There is no eating or drinking in the exam centers. While breaks may be taken, they do take away from the exam time. So settle in and focus on one question at a time and doing the best job possible based on your preparations.

The first step in preparing for successful completion of the certification has already occurred—as the work performed every day provides the foundation for exam success. Much of what is included in this study guide should not be new information. If there are content areas where you feel weaker, then think about spending some additional time using the references available to support your knowledge in that area. Make sure you feel confident in all content areas. Do not rely on areas of strength to overcome an area of weakness. Become comfortable with all topics, as this will ensure a more successful outcome.

When you do sit for the exam, understand that the conference committee did not write the questions to trick the examinee. Don't overthink responses. Read the questions at face value. Sometimes all the information you need to choose the correct answer is within the question itself.

Here are a few additional suggestions to help you succeed on exam day:

- Read each question in its entirety. Pay attention to every detail in the question.
- Read each question as if you had to answer it without choosing from a list of alternative answers, or in other words try to answer the question first without looking at the list of choices.
- If you encounter a confusing question, or don't know the answer, flag it and return to it later. Sometimes revisiting the question helps to clear the confusion.
- If you're unsure of the correct answer, use the process of elimination to narrow down choices. Read every answer and eliminate those that are definitely wrong. Unfortunately, there's no "phone-a-friend" option during the certification exams like there was on the "Who Wants to Be a Millionaire?" gameshow.
- Be sure to answer each question before ending the examination. There is no penalty for guessing.
- Use your available resources to check your answers as appropriate.
- Be mindful of the passing time and check your pacing. How many minutes do you have left? How many questions do you have left? When you practice, make note of which sections take you more time and adjust your pacing for the live test.

The CCDS-O certification committee and the ACDIS administration are rooting for you.

Healthcare Regulations, Reimbursement, and Documentation Requirements

Clinical documentation integrity (CDI) specialists working in the outpatient area need to understand a host of various payment and coding methodologies depending on the specific setting type in which they work as well as the patient population their setting serves. For comparison, traditional CDI programs operate within the short-term acute care hospital setting and start out focused on the Medicare population as the largest healthcare payer in the country. The most typical model for outpatient CDI activities has grown from large, successful inpatient programs, which identified documentation improvement opportunities either within hospital departments such as the emergency department (ED) or radiology department or within system-owned practice settings such as primary care provider offices and ambulatory surgical centers.

Care provided for Medicare and Medicaid patients within these settings are reimbursed by the Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS) under Medicare Part A and Part B. Medicare Part A is hospital insurance and generally covers inpatient hospital stays, skilled nursing care, hospice care, and limited home healthcare services. Medicare Part B is medical insurance and generally covers services and items such as doctor office visits, preventive services such as certain tests and screenings, flu and pneumonia shots, physical therapy, diabetes treatments, and durable medical equipment (DME such as wheelchairs), among other items.

Code assignment requires knowledge of the International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) governed by the four Cooperating Parties:

- American Health Information Management Association
- American Hospital Association (AHA)
- Centers for Medicare & Medicaid Services (CMS)
- National Center for Health Statistics (NCHS)

Each of the three RVUs are also adjusted based on the geographic location of the practice because costs can vary from location to location (GPCIs).

The conversion factor is a set dollar amount and is updated annually. The conversion factor enables the RVU to be converted into an actual dollar amount, as illustrated in Figure 1.2.

Figure 1.2 Calculating payment amounts

$$\text{Work RVU } x \text{ + PE RVU } x \text{ + MP RVU } x \times \text{CF} = \text{Payment}$$

The MPFS is effective January 1 each year. The fee schedule includes the associated payment amounts for individual HCPCS codes as well as other important billing related information such as:

- Professional component/technical component: Indicates if a service can be reported for both the professional and technical components (e.g., radiology services)
- Global: Indicates whether the service has a zero-, 10-, or 90-day global surgery period or identifies if this concept is not applicable
- Bilateral: Indicates whether a service can be performed as a bilateral procedure and paid at 150% of the fee schedule amount or if it is not applicable
- Assistant: Indicates whether an assistant surgeon may be paid for the service
- Cosurgeon: Indicates whether a cosurgeon (each of a different specialty) could be paid if determined two surgeons were necessary

Many commercial payers may also use this fee schedule or a derivative. (Additional information regarding the physician fee schedule can be found on the CMS website www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.)

National and Local Coverage Determinations (NCDs and LCDs)

CMS develops NCDs to describe the circumstances for Medicare coverage nationwide for a specific service, procedure, or device. On the other hand, LCDs vary by state or region and are determined by a fiscal intermediaries (FI) called *Medicare administrative contractors* (MAC), which decide whether to cover a particular service, procedure, or device. Coverage determinations generally include:

- A list of CPT/HCPCS codes
- ICD-10-CM diagnosis codes (if applicable) that will support the medical necessity of the procedure/service
- Documentation requirements (if any)

- **Review of systems (ROS):** The patient's inventory of signs and/or symptoms of body systems. ROS documentation may be obtained by ancillary personnel or a form completed by the patient and then dated and initialed by provider. The following list contains the systems recognized for ROS purposes:
 - Constitutional
 - Eyes
 - Ears, nose, mouth, throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Integumentary (skin and/or breast)
 - Neurological
 - Psychiatric
 - Endocrine
 - Hematologic/lymphatic
 - Allergic/immunologic
- Past, family, and/or social history includes three subelements:
 - **Past history:** A review of patient's past experiences with illness, operations, injury, and treatment
 - **Family history:** A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk
 - **Social history:** An age-appropriate review of past and current activities

Physical examination

As mentioned earlier in this chapter, the most significant differences in the 1995 and 1997 versions of the DGs occur in the examination component. For billing Medicare, a provider may use either version of the DGs for a single patient encounter, not a combination of the two. Deciding which DG version to use depends on the degree to which the examination performed is unique to the provider practice, their judgment, and the specific encounter.

The 1997 DGs define the type of examinations as either general multisystem or single organ systems.

For purposes of physical examination according to the 1995 DGs, the following body areas and organ systems are recognized:

- Body areas:
 - Head, including the face

In general, risk-adjustment models use an individual’s demographic data and existing diagnoses to determine a risk score. The score is seen as a relative measure of the probable costs to insure an individual and allows stakeholders to quantitatively compare individual patients or patient populations. (See the box below for a list of commonly considered risk-adjustment elements.)

Risk adjustment: Common elements considered

- Age
- Gender
- Socioeconomic status
- Disability status
- Functional status
- Insurance coverage
 - Medicare
 - Medicaid
 - Dual-eligible
 - Other
- Claims data
 - Diagnosis codes
 - Procedure codes
 - Place of service
 - Prescription drugs
- Patient-specific conditions
 - End-stage renal disease
 - Hospice
 - Other

Let’s look at an example comparing two individuals and identify which individual will likely incur higher healthcare costs over the next year.

Risk adjustment examples	
Patient #1 85-year-old male	Patient #2 87-year-old female
Lives at home	Resides in a skilled nursing facility (SNF)
Active in community and exercises regularly, nonsmoker	Sedentary, minimal interaction with others, long history of nicotine dependence
Osteoporosis	Diabetes with peripheral vascular disease
Hypertension	Diabetic foot ulcer
	Chronic respiratory failure
	Dementia

Quality and Regulatory Concerns for Outpatient Initiatives

Over the past several decades, healthcare innovation has seen a meteoritic increase, enabling improvements in patients' quality of life and life expectancy. The previous care delivery model (encounter-based), however, has been overwhelmed by an increase in retiring Baby Boomers and increases in the chronic conditions from which they suffer. In addition to the increased number of patients needing care, provider shortages and rising costs have led to an annual healthcare spending that continues to outpace the growth of the United States' gross domestic product (GDP; an indicator of the economy's health). Currently, healthcare spending in America is 50% more than any other developed country, and despite technological advances, many reports show that healthcare in the United States is subpar.

As the year 2020 approaches, the population also has greater access to a wealth of data regarding the healthcare industry as well. Healthcare organizations are required to collect and externally report data related to patient safety, quality measurement, and patient satisfaction. These are requirements that will likely increase as the federal government seeks to improve both costs associated with, and efficiency of, its healthcare system.

Government initiatives such as the 2010 implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System, the meaningful use electronic health record (EHR) incentive program, and accountable care organizations (ACO) support the need for obtaining quality healthcare data and making that data publicly available for benchmarking and analysis.

This benchmarking data can greatly influence an organization's success, but such data depend on the original physician documentation and coding of patient encounters. It's those data that drives patient safety reporting and risk-adjustment methodologies. It's those data private payers use to negotiate contracts with organizations and providers.

In short, physician documentation and coding in the outpatient setting affects more than code assignment and reimbursement—it could very well affect the structure of the future healthcare system in the United States and the assessment of the health of its population overall.

Public Reporting

Consumers now shop for the best-quality care when making choices in healthcare delivery. The Centers for Medicare & Medicaid Services' (CMS) *Physician Compare* webpage provides consumer information to help patients make informed decisions about their healthcare as well as to drive incentives for physicians to perform better—improving outcomes for patients while reducing overall costs. The site includes information comparing physician performance on quality and patient experience measures. This site also includes the *Physician Compare* Star Ratings, which ranks performance based on individuals who submitted data as well as patient experience data.

And that's just the federal government's public reporting site. A host of other public facing sites exist and offer consumers insight in a wide range of outcome measures across a variety of setting types—including physician practices—such as *U.S. News and World Report*, *Leapfrog*, and *Consumer Reports*, among others. Know, too, that physicians are also judged by the insurers with which they contract, and most insurers post their own star rankings on their websites.

For each public facing report leveraged, however, the clinical documentation integrity (CDI) staff need to understand how that particular site calculates its ratings by determining:

- The measures being analyzed
- The methodology of measure analysis
- The data source for the measure abstraction (CMS, claims, proprietary)
- The performance period being measured
- The risk-adjustment methodology used (CMS-hierarchical condition categories [CMS-HCC])
- What measure weighting occurred (i.e., are all measures considered equal, or were some considered of greater importance than others?)

One of the benefits, from the consumer's perspective, are the easy-to-see, easy-to-understand visualizations such reports provide. They often feature stars, ranks, or letter grades accompanied by the typical red, yellow, or green coloring or other spotlight shading. They also compare physicians and facilities by others in their region or by similar specialty type, according to Kristen Geissler, MS, PT, CPHQ, MBA, who presented "Managing the Maze of Public Quality Report Cards" at the Association of Clinical Documentation Integrity Specialists 2019 national conference.

CDI professionals working in the outpatient arena can leverage this information to target seemingly underperforming physicians, bringing forward information regarding how documentation improvement may help improve their public-facing image.

Additionally, at least 75% of the practices wishing to participate in the Advanced APM must use an EHR. These thresholds increase over time. Some examples of advanced APMs include but are not limited to:

- Comprehensive Primary Care Plus
- Next-Generation ACO
- Bundled Payments for Care Improvement
- Comprehensive End-Stage Renal Disease Care

Participation in an Advanced APM will not only earn a 5% bonus from 2019 through 2024, but beginning in 2026, those participating in Advanced APMs will also receive an annual update of 0.75% rather than the 0.25%.

Promoting Interoperability (PI)

Formerly known as *Advancing Care Information*, PI replaces the former Certified EHR Technology (CEHRT) incentive program. CMS requires the use of 2015 CEHRT, and eligible clinicians must still report PI for MIPS through annual attestation regarding use. Other changes to the PI performance score include reporting at least six measures across four objectives:

- E-prescribing
- Health information exchange
- Provider-to-patient communication
- Public health clinical data

Clinical Practice Improvement Activities (CPIA)

CPIA include the following areas:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessments
- Participation in an APM
- Health equity (for underserved populations)
- Emergency preparedness and response
- Integrated behavioral and mental health

CMS gives full CPIA credit to all ACOs and will continue to evaluate annually how this credit will be provided to APMs.

Sepsis is a serious illness that occurs when the body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation, which leads to blood clots and leaky blood vessels resulting in poor blood flow, which deprives the body's organs of nutrients and oxygen. In severe cases, this can lead to organ failure. Septic shock occurs when the blood pressure drops due to vasodilation and does not respond appropriate to fluid resuscitation, according to National Institute of General Medical Sciences.

There is no benchmark for the definition of sepsis, and clinicians have attempted to diagnose sepsis by combining nonspecific physiological and laboratory anomalies. Therefore, definitions of sepsis were proposed at international conferences that were held in 1991, 2001, and, finally, in 2016. The appendix of this book includes a table of comparison for these various definitions.

A consensus conference of the American College of Chest Physicians (ACCP) and the Society of Critical Care Medicine (SCCM) convened in August 1991 and developed the initial definitions that the SIRS response to infection would be called *sepsis*. Definitions of sepsis and septic shock were revised in 2001 when several North American and European care associations, sponsored by the SCCM and the ACCP and including the European Society of Intensive Care Medicine (ESICM), the American Thoracic Society, and the Surgical Infection Society, agreed to revisit them. These revisions included the threshold values for organ damage.

In early 2016, a task force with expertise in sepsis pathobiology, clinical trials, and epidemiology was convened by the SCCM and ESICM. The new definitions of sepsis and septic shock established by this task force changed dramatically. According to these organizations, as published in the *Journal of the American Medical Association*, *sepsis* is now defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. The consensus document describes organ dysfunction as an acute increase in total SOFA score by two points consequentially to the infection, as illustrated in Figure 4.1.

A significant change in the new definitions is the elimination of any mention of SIRS. The Sepsis-3 Task Force also introduced the new bedside index, called the *qSOFA*, as explained in the appendix, to identify outside of critical care units patients with suspected infection who are likely to develop sepsis. Sepsis is treated with intravenous (IV) fluids, antibiotics, antifungals, antivirals, and antipyretics. Treatment for severe sepsis includes positive pressure ventilation, oxygen, and vasopressors in addition to the above.

Sepsis and sepsis-related conditions are traditionally treated in the hospital and most commonly seen in the emergency department. For additional information on the progression of sepsis definitions, read the 2017 white paper *Where Are We Now With Sepsis?* published by the Association of Clinical Documentation Integrity Specialists (ACDIS).

Neoplasms

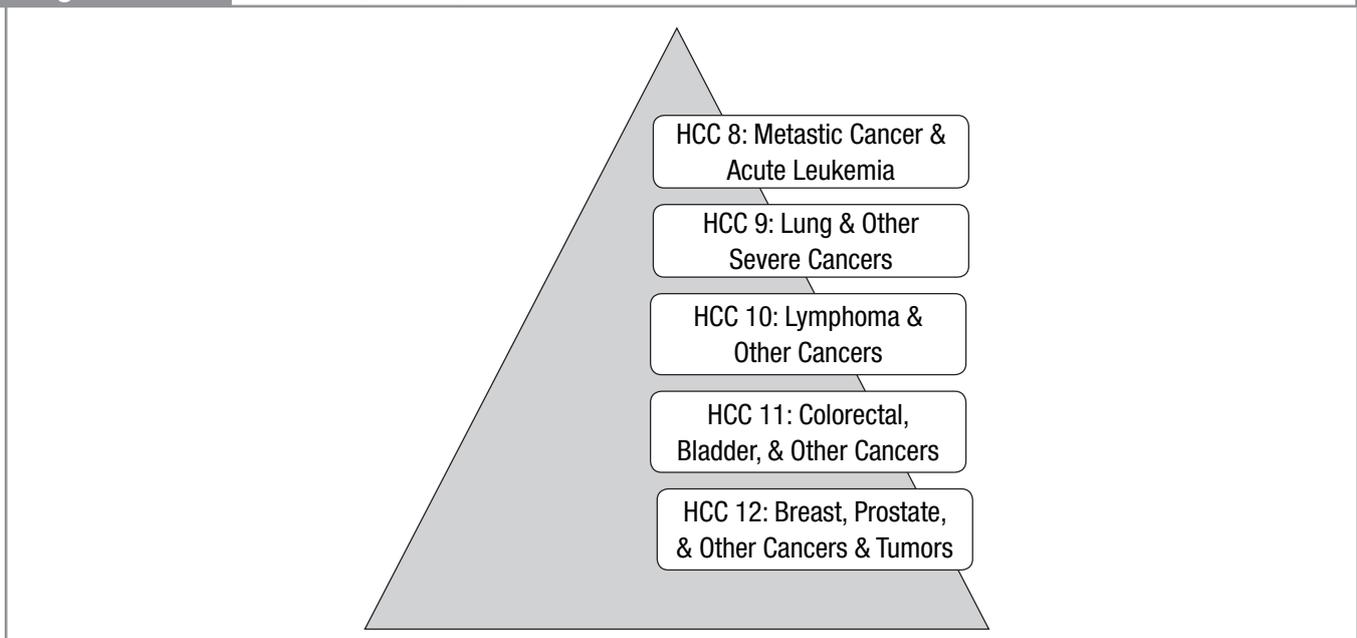
HCCs 8, 9, 10, 11, and 12

The neoplasm hierarchy includes five different HCC groups; however, only one HCC in this group may be assigned—with HCC 8 being the highest and HCC 12 being the lowest in the hierarchy, as shown in Figure 4.2.

A neoplasm is an abnormal growth of cells, usually derived from a single abnormal cell, that have lost normal control mechanisms and are able to multiply continuously, invade nearby tissues, migrate to distant parts of the body, and promote the growth of new blood vessels from which the cells derive nutrients. These cells can develop from any tissue within the body. As the cells grow and multiply, they form a mass of tissue, called a *tumor*, that invades and destroys normal adjacent tissues. The term *tumor* refers to an abnormal growth or mass. Tumors can be malignant or benign. Malignant cells from the primary or initial site can spread throughout the body or metastasize.

Malignancies can be further divided into those of the blood and blood-forming tissues, such as leukemias and lymphomas, and solid tumors, which can be carcinomas or sarcomas. Leukemias and lymphomas are cancers of the blood and blood-forming tissues and cells of the immune system. Leukemias come from blood-forming cells and crowd out the production of normal blood cells in the bone marrow. Cancer cells from lymphomas expand lymph nodes, producing large masses in the armpit, groin, abdomen, or chest. Carcinomas are cancers of cells that line the skin, lungs, digestive tract, and internal organs. Sarcomas are cancers of mesodermal cells that form muscles, blood vessels, bone, and connective tissue (Gale, 2018).

Figure 4.2 Hierarchy of neoplasm HCCs



Treatment for cancer takes into consideration the type of cancer, including its location, stage, and genetic characteristics as well as specific characteristics of the person being treated. When the diagnosis of cancer is first made, the main goal of treatment is to remove the cancer completely if possible, through a single treatment or through a combination of surgery, radiation therapy, chemotherapy, or immunotherapy. Treatment sometimes also aims to eliminate cancer cells elsewhere in the body, even if there is no sign of those cells (Gale, 2018).

Accurate reporting of a diagnosis of cancer requires the determination and documentation of whether the patient's cancer has been eradicated or is currently being treated. Many neoplasm codes require further specificity type, site, and laterality.

If there is no further treatment directed to the site and there is no longer evidence of existing primary malignancy, the correct personal history code should be reported. CDI specialists should look to clarify the sites and the treatment and ensure that documentation includes information about where the cancer has spread.

The physician needs to describe whether the condition is acute (in relapse) or chronic (remission) or whether the patient has not achieved remission, according to *The Outpatient CDI Specialist's Complete Training Guide* (Boldt & Jentzer, p. 94). So CDI specialists need to watch for documentation related to "history of" cancers to determine whether the conditions represent any true remissions or whether the cancer is still being actively treated. Per the official guidelines, for outpatient encounters for diagnostic tests that have been interpreted by a physician and for which the final report is available at the time of coding, coders can assign a code any confirmed or definitive diagnoses documented in the interpretation.

Sample query: Cancer

Dear Provider:

Information in the medical record indicates that your patient has metastatic cancer. Patient has a history of testicular cancer. He underwent an orchiectomy and chemotherapy. He is on surveillance, now in his third year. CT scans showed no evidence of disease, chest x-ray pending. Tumor markers are at normal levels.

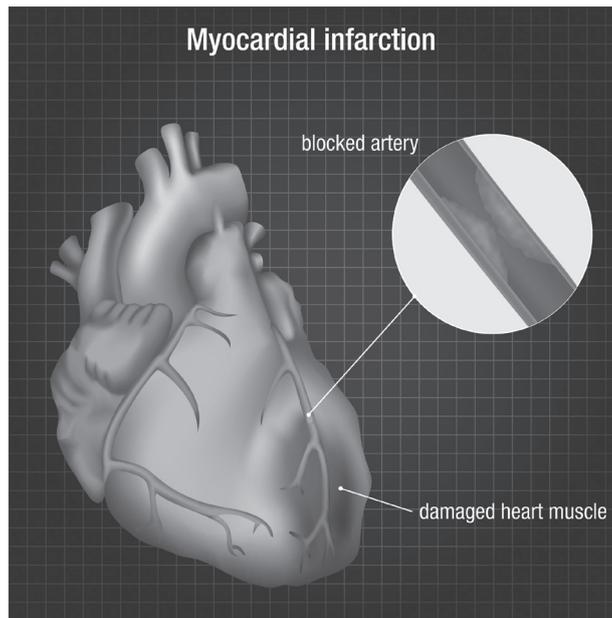
If this is a condition that you are continuing to monitor, evaluate, or treat, please document in your clinic note your patient's metastatic cancer status as a current diagnosis, as a "history of" diagnosis or resolved in your clinic notes.

Sincerely,
Clinical Documentation Specialist

Most cancer patients are treated on an outpatient basis at specialty cancer centers, with more serious cases being treated at cancer-focused hospitals. However, patients may be continuing visits with their primary care physicians, and any discussions or changes in other noncancer-related conditions due to the neoplasm treatments should be captured in the medical record documentation. Similarly, patients may be admitted to the hospital for emergent conditions such as anemia or dehydration due to cancer-related

Figure 4.11

Illustration of AMI



Source: Retrieved October 28, 2019, from www.shutterstock.com/image-vector/myocardial-infarction-heart-attack-blocked-artery-514226467

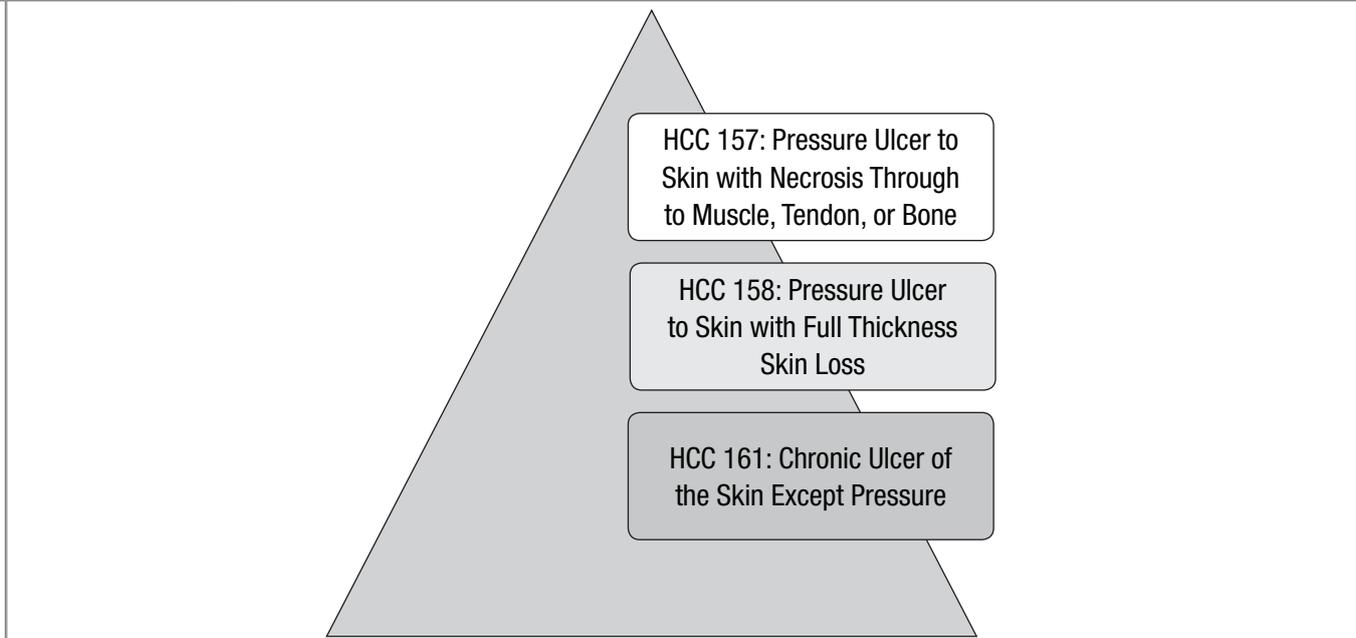
A diagnosis of an old MI is important in risk-adjustment models and carries implications for ongoing treatment of the patient. CDI specialists should be familiar with common wording used to document MI for correct code assignment (AAPC, 2019, p. 154). The terms include the following:

- Transmural vs. non-transmural
- Q wave vs. non-Q wave
- ST elevated MI (STEMI) vs. non-ST elevated MI (NSTEMI)
- Acute MI (AMI)
- Right ventricular or left ventricular MI
- Anterior, posterior, lateral, inferior
- Apical, septal, subendocardial
- Anterolateral
- Anteroseptal
- Extensive anterior

AMI codes to either I21 or I22 sections in ICD-10-CM, depending on when condition occurred. AMI that occurred within the last four weeks codes to I21; AMI that occurs within four weeks of a previous AMI, regardless of site, codes to I22 and must be accompanied by a code in the I21 section.

Figure 4.20

Hierarchy of tissue HCCs



HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone; HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss; and HCC 161: Chronic Ulcer of Skin, Except Pressure Ulcer

Pressure ulcers affect superficial tissue and may progress to affect muscle and bone. Patients at risk of developing pressure ulcers include bedridden, unconscious, or immobile patients, such as patients with paralysis or who have had a stroke and/or the elderly. Pressure ulcers are classified by location, shape, depth, and stage of healing. If a pressure ulcer is suspected, query for any of the above to determine the best ICD-10-CM code to use. If a pressure ulcer was coded on the prior year for the patient and the patient appears to have a decrease in mobility, recommend that a query be placed if clinical indicators point to treatment of an ongoing ulcer.

- Pressure ulcers (site, stage, unspecified) L89
- Stage 1: nonblanchable—reddened area on skin
- Stage 2: partial thickness skin loss abrasion, shallow, open
- Stage 3: full thickness skin loss or necrosis into the subcutaneous tissue
- Stage 4: full thickness skin loss with necrosis of soft tissues through the muscle, tendons, or tissues around underlying bone
- Chronic ulcers (site, unspecified) L97

Chronic skin ulcers affect superficial tissue and may affect muscle and bone. Patients at risk from development of chronic skin ulcers include those with debilitating disease with impairment of sensation or impaired immune systems.

Sample query: Skin ulcer

Clinical scenario: A 41-year-old morbidly obese male with bilateral chronic lymphedema had chronic right posterior lower leg ulcers that ultimately healed after long wound care. However, he presented around 10 days ago in the wound care clinic with recurrence of ulcer and surrounding cellulitis. Cultures were obtained, and the patient was empirically started on oral Bactrim. Today, wound care evaluated the patient and noted significant deterioration of cellulitis in wound.

Query opportunity:

Dear Medical Professional:

Please specify the type of ulcer by documenting in an addendum to your clinic note (please include type and location):

- Venous ulcer
- Decubitus/pressure ulcer (include stage)
- Suspected deep tissue injury
- Other (specify)
- Unable to determine
- Not applicable

Thank you,
CDI Specialist

Figure 4.21 Pressure ulcer types

Stage I

Skin intact but with nonblanchable redness for >1 hour after relief of pressure.

Stage II

Blister or other break in the dermis with partial thickness loss of dermis, with or without infection

Stage III

Full thickness tissue loss. Subcutaneous fat may be visible; destruction extends into muscle with or without infection. Undermining and tunneling may be present.

Stage IV

Full thickness skin loss with involvement of bone, tendon, or joint, with or without infection. Often includes undermining and tunneling.

Unstageable

Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.

Suspected deep tissue injury

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying tissue from pressure and/or shear.

Source: National Pressure Ulcer Advisory Panel.

It is important to note that although the method of communication and format may vary in different situations, a compliant query should be accompanied with appropriate clinical indicators that are patient- and episode-specific and support the condition being clarified. Additionally, queries should allow for the provider to identify the most appropriate clinical condition and not “lead” or direct the provider to a specific condition. The amount of clinical support identified in a query may depend on the purpose or type of query; however, all relevant clinical information should be included when posing a query to a provider.

Leading queries

Perhaps the most important concept, and oftentimes one of the most difficult for a new CDI professional to grasp, is the ability to form nonleading queries. According to AHIMA, a query can be a strong tool for coding professionals when seeking accurate documentation to support code assignments but should never *lead* a provider to one diagnosis by suggesting or advising that a certain diagnosis is present when it has not yet been stated in the healthcare record.

According to ACDIS’ publication “Queries in outpatient CDI: Developing a compliant, effective process,” a leading query directs the provider to specific diagnoses that, while not supported by clinical indicators, are found in the health record. Clinical indicators are those clinical elements one would expect to find monitored, evaluated, assessed/addressed, or treated when a provider has diagnosed a condition or is in the process of determining a diagnosis. Elements that may act as clinical indicators include:

- Clinical symptoms/signs
- Lab tests/results/impressions
- Medications/orders/responses
- Counseling/therapies

For more information about clinical indicators, visit the American Academy of Professional Coders website at www.aapc.com/blog/41212-include-meet-in-your-risk-adjustment-documentation/.

For an example of a leading query, see the box below. CDI professionals should never introduce a diagnosis and should also never state the intent of the query as related to coding, financial, or quality outcomes.

Example of a leading query

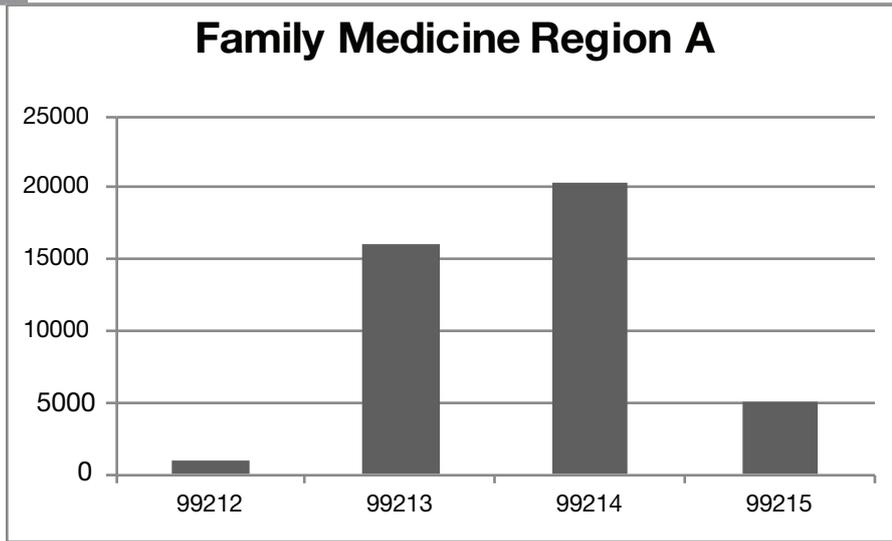
Scenario: A patient is seen for increasing lower-extremity edema. The problem list states the patient has a history of chronic heart failure. An echocardiogram, within the past year, showed left ventricular ejection fraction (EF) of 33%. The patient’s current medication list includes metoprolol and furosemide.

Dear Doctor:

During the next encounter, please document and code that the patient has chronic diastolic heart failure. This will help increase our quality scores and help capture our patient’s risk adjustment.

Figure 6.2

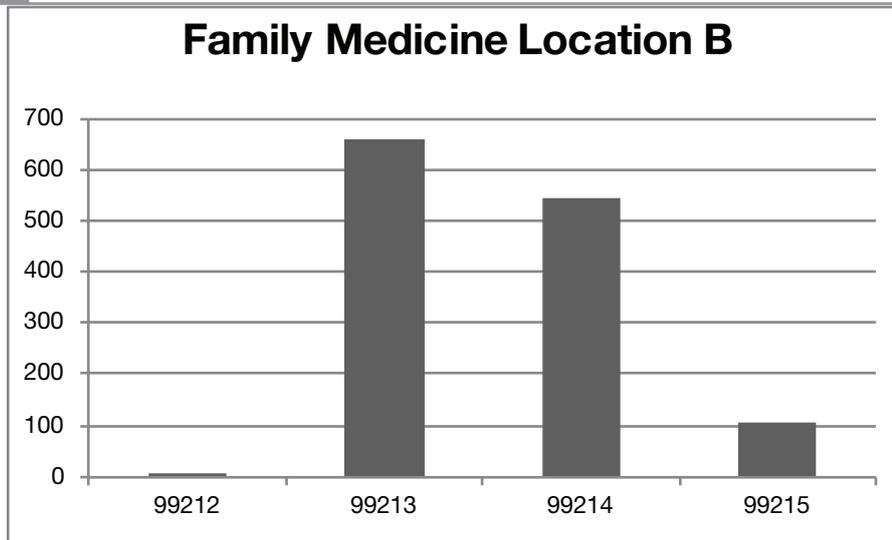
E/M RVU norms



E/M: evaluation and management; RVU: relative value unit.

Figure 6.3

E/M RVU outliers



E/M: evaluation and management; RVU: relative value unit.

Appendix: Tools to Leverage Data to Monitor Performance

Providers at most organizations are the ones who do the majority of ambulatory coding, so it is imperative to distill the work into manageable pieces and achieve success incrementally—in other words, set the stage so that all can believe that the goals are attainable.

Listed below are concepts of how data can be used to monitor performance. It is not meant to be an exhaustive listing, but a starting point of options to consider.

Organizational

1. Overview of clinical documentation integrity and back-end coding work.
 - a. Productivity—volume of work they are doing.
 - b. Impact—it's not just quantity alone; what is the RAF impact?
2. Focus resources to match needs
 - a. What service lines/providers?
 - b. Risk adjustment, evaluation and management, denials
3. Identify common themes:
 - a. Add/remove/modify findings on postencounter reviews—focus education and efforts to improve
 - b. Disease focus opportunities, e.g.:
 - i. Complicated vs. uncomplicated diabetes
 - ii. Obesity vs. morbid obesity
 - iii. Unspecified depression vs. specified major depressive disorder
 - c. Common errors in coding (e.g., acute stroke in the office)
4. Assess provider engagement
5. Establish competencies for providers to achieve
6. Define where you focus next—what specialties and why
7. High-level view of program success directed to key initiatives (such as improved diabetes coding accuracy)
8. Hierarchical condition category (HCC) score current year and 12-month roll-up
9. Gap closure
10. Assessment of third-party commercial and government payer information:
 - a. Performance compared to peers

CCDS-O

EXAM Study Guide

The Association of Clinical Documentation Integrity Specialists (ACDIS) developed the Certified Clinical Documentation Specialist-Outpatient (CCDS-O) credential to provide a trusted baseline of competency for CDI in the outpatient setting, which includes locations such as physician practices, hospital clinics, and the emergency department.

For those planning to sit for the CCDS-O exam, The CCDS-O Exam Study Guide is their resource to help prepare.

The guide aligns the testing content domains chronologically, matching how CDI professionals obtain core skill sets. It provides targeted information regarding test objectives prepared by the CCDS-O Certification Committee, letting candidates focus their time on areas of CDI practice with which they are least familiar.

Spiral bound to make studying with colleagues easier, it also comes with an online practice exam complete with remediation, so candidates can quickly understand why an answer is correct or incorrect.

The CCDS-O Exam Study Guide will:

- ▶ Help candidates determine whether they are ready to take the exam
- ▶ Give qualified candidates the confidence they need to succeed
- ▶ Provide sample questions for self-assessment

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