AAPC

Official Study Guide

Clinical Documentation Improvement Training

CDEO®

Certified Documentation Expert - Outpatient

Certification Preparation

2022

2022

Official Study Guide

Clinical Documentation Improvement Training: CDEO® Certification

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Chapter 1

Purpose of Clinical Documentation Improvement

This study guide prepares experienced coders and auditors for the Certified Documentation Expert Outpatient (CDEO®) certification exam. Individuals who hold a CDEO® credential are clinical documentation improvement (CDI) experts for outpatient services performed by professional healthcare providers. Throughout this training, CDEO® refers to a clinical documentation specialist in the outpatient setting.

Tested competencies on the CDEO® exam include: the benefits of CDI programs; documentation requirements; quality measures; payment methodologies; and clinical conditions including common signs and symptoms, typical treatment, clinical documentation details, and coding concepts.

Clinical documentation improvement is a proactive measure, which requires consistency and attention to detail. Successful CDI programs do not focus narrowly on maximizing reimbursement; but, instead, focus on documenting the clinical conditions, treatment and management of the conditions, and outcomes of treatment. As reimbursement models shift from fee for service to quality of care and patient outcomes, there is a need to efficiently communicate the quality of care provided and patient outcomes associated with that care.

The growing coding, billing, and auditing workload is reshaping the workflow. In smaller practices, coding and auditing staff also may be responsible to perform CDI (this can be a struggle, if the coding/auditing staff must "wear too many hats"). In large practices or facilities, responsibility for CDI and quality assurance typically is assigned to dedicated staff within the coding and billing departments.

The Professional Side of Clinical Documentation

Changes in healthcare and technology require a central focus on CDI, working prospectively. CDEO®s strive to improve clinical documentation to accurately describe patient care, to adhere to regulatory requirements, and to support services reported. CDEO®s work with everyone who has a role in the documentation process, to develop and monitor CDI policies and procedures.

CDI is important for many reasons. Errors in the medical record can erode patient/provider trust (or worse). Widespread use of the electronic health record (EHR) has allowed "over documentation," cloned medical records, and other compliance failures to flourish. Digitized data and modern computing power allow payers to enforce compliance aggressively using audits, recoupments, and payment denials. You should assume that all clinical documentation will be scrutinized at some point.

The Role of the CDEO®

A CDEO® works with facilities, clinicians, and staff to facilitate excellence and compliance in all medical record entries through the use of internal documentation guidelines. Such guidelines may include:

- The medical record is complete and legible
- The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party with appropriate medical training
- CPT® and ICD-10-CM codes used for claims submission are supported by documentation and the medical record
- Appropriate health risk factors are identified
- The patient's progress, response to and change in treatment, and revised diagnoses are documented

Documentation challenges vary based on the provider/facility type. For example:

- **Inpatient hospital**: Monitoring documentation for multiple providers involved in patient care is a challenge, and maintaining consistent, quality documentation is difficult because deficiencies may not be identified until after the provider has left the facility.
- **Outpatient diagnostic centers**: Often, physicians order tests, but the medical necessity isn't clear.
- **Comprehensive outpatient rehabilitation centers:** The patient care plan must be accurate and updated every 90 days, as required for Medicare patients.
- **Nursing home facilities**: The nursing home is responsible to coordinate care for patients and must ensure proper reimbursement for services performed by other providers.
- **Home healthcare entities:** Obtaining a compliant plan of care from the ordering provider is vital: Without it, services are not justified.

EXAMPLE

COVID-19 Increased FMAP State Eligibility Audit

The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentages (FMAPs), which vary depending on the State's per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time. On March 18, 2020, the then President signed into law the Families First Coronavirus Response Act (FFCRA), which provided a temporary 6.2-percentage-point increase to each qualifying State's and territory's FMAP under section 1905(b) of the Act effective January 1, 2020. States must meet the requirements of section 6008(b) and (c) of the FFCRA to qualify to receive the temporary 6.2-percentage-point increase. We plan to perform audit work at selected States to determine whether those States met the requirements to receive the temporary COVID-19 FMAP increase.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
August 2021	Centers for Medicare & Medicaid Services	COVID-19 Increased FMAP State Eligibility Audit	Office of Audit services	W-00-21-31556	2022

Compliance Plans

A compliance plan is a comprehensive document establishing that a provider, practice, facility, or other healthcare entity is taking steps to adhere to the federal and state laws that affect it. The OIG has developed 13 voluntary compliance plan guidance (CPG) documents for a variety of healthcare settings, to indicate the comprehensive framework, standards, and principles by which an effective internal compliance program may be established and maintained. Compliance plans for healthcare providers are mandatory under the Affordable Care Act (§6401), but no implementation date is specified. At this writing, compliance plans are voluntary.

The OIG has identified seven elements that should be present in every compliance plan, based on criteria adopted by the federal government in the federal sentencing guidelines. They are:

1. Implementing written policies, procedures, and standards of conduct;
2. Designating a compliance officer and/or compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Enforcing standards through well-publicized disciplinary guidelines;
6. Conducting internal monitoring and auditing; and
7. Responding promptly to detected offenses and developing corrective action.

Compliance guidance indicates that if non-compliance is identified, corrective action must be taken. Findings of non-compliant conduct must be documented in the compliance files, and should include:

- date of incident;
- name of the reporting party;
- name of the person responsible for taking action; and
- the follow-up action taken (there may be varying degrees of disciplinary action).

Compliance Program Guidance

Of the 13 CPGs created by the OIG, there is one for individual and small group practices, one for hospitals, and one for nursing facilities.

Compliance Program Guidance for Individual and Small Group Physician Practices

The CPG for individual and small group physician practices was issued in the *Federal Register* on October 5, 2000. The OIG acknowledges that not all seven components are necessary for an individual or small group practice: (II.A) states, "The OIG acknowledges that full implementation of all components may not be feasible for all physician practices. Some physician

Chapter 6

Clinical Conditions and Diagnosis Coding Part I: Chapters 1-11

Introduction

Proper ICD-10-CM code selection is accomplished by following ICD-10-CM conventions, general guidelines, and chapter-specific coding guidelines. The Tabular List is organized into 21 chapters by etiology or anatomic site. Section I.C. of the ICD-10-CM Official Guidelines for Coding and Reporting provides instructions for correct code selection and sequencing specific to each chapter. Here, we will discuss the chapter-specific coding guidelines for chapters 1 through 11 of the ICD-10-CM code book, as well as common diagnoses in each chapter.

The information in this chapter is meant as a supplement and is not intended to replace the official coding guidelines found in the ICD-10-CM code book. You should read and understand every guideline and convention found in ICD-10-CM.

CHRONIC CONDITIONS

Risk adjustment has created the need to ensure providers document care of chronic conditions at least once per year. As a result, it is important for a documentation specialist to be able to identify chronic conditions and determine when a provider has documented treatment of any existing chronic conditions. To qualify for risk adjustment, chronic conditions must be documented in a way that is reasonable to determine that a physician is managing the patient and treating the chronic condition within the year.

CMS considers the following conditions as chronic conditions:

Alcohol Abuse	Drug Abuse / Substance Abuse
Alzheimer's Disease and Related Dementia	Heart Failure
Arthritis (Osteoarthritis and Rheumatoid)	Hepatitis (Chronic Viral B & C)
Asthma	HIV/AIDS
Atrial Fibrillation	Hyperlipidemia (High cholesterol)
Autism Spectrum Disorders	Hypertension (High blood pressure)
Cancer (Breast, Colorectal, Lung, and Prostate)	Ischemic Heart Disease
Chronic Kidney Disease	Osteoporosis
Chronic Obstructive Pulmonary Disease	Schizophrenia and Other Psychotic Disorders
Depression	Stroke
Diabetes	

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html

CDEO TIP

To reduce the Comprehensive Error Rate Testing (CERT) error rate, Medicare clarified what documentation should be used if there is conflicting or contradictory information in a hospital record and the attending physician cannot be queried (*MLN Matters*® article SE1121):

"When coding claims, if there is conflicting or contradictory information in the medical record, a coder should query the attending physician to clarify the correct principal and secondary diagnoses. Remember that the "Coding Clinic, First Quarter 2004" states, if there is conflicting physician documentation, and the coder fails to query the attending physician to resolve the conflict, hospitals are encouraged to code the attending physician's version. However, the failure of the attending physician to mention a consultant's diagnosis is not a conflict. So, if the consultant documents a diagnosis and the attending physician doesn't mention it at all, it is acceptable to code it. A conflict occurs when 2 physicians call the same condition 2 different things – for example, the attending physician documents a sprained ankle and the orthopedist refers to the same injury as a fracture."

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1121.pdf

Chapter 1: Certain Infectious and Parasitic Diseases (Codes A00–B99)

Infectious and parasitic diseases include communicable diseases, as well as those of unknown origin but possibly due to infectious organisms. Infective organisms in this chapter include bacteria, chlamydiae, fungi, helminthes, mycoplasmas, protozoans, rickettsiae, and viruses.

Diagnoses from this chapter may be reported as:

- Two codes: one for the organism, and one for the condition;
- A combination code for the organism and condition; or a
- A single code.

EXAMPLE

A 24-week pregnant patient with Type 1 diabetes develops a diabetic foot ulcer on her left heel involving breakdown of the skin.

O24.012 Pre-existing type 1 diabetes mellitus in pregnancy, second trimester E10.621 Type 1 diabetes mellitus with foot ulcer

L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin Z3A.24 24 weeks gestation of pregnancy

Preeclampsia

Preeclampsia is an abnormal condition in pregnancy that involves high blood pressure and a high level of protein in the urine. The condition will usually appear during the third trimester but can appear earlier. Preeclampsia can cause serious complications for the mom and the baby. Codes for preeclampsia are found in category O14. The severity of the preeclampsia must be documented for accurate code selection. Subcategories for preeclampsia include:

O14.0 Mild to moderate preeclampsia

O14.1 Severe preeclampsia

O14.2 HELLP syndrome

O14.9 Unspecified preeclampsia

APPLICATION OF PROVIDER COMMUNICATION

A patient 29 weeks pregnant complains of excessive swelling in her feet. Her blood pressure is high and her urine shows high levels of protein. The patient is diagnosed with preeclampsia.

Potential provider query:

For appropriate reporting of preeclampsia, if known, please amend progress not 3/15/XX to indicate the severity of the pre-eclampsia.

EXAMPLE

A patient 29 weeks pregnant complains of excessive swelling in her feet. Her blood pressure is high and her urine shows high levels of protein. The patient is diagnosed with mild preeclampsia.

O14.03 Mild to moderate pre-eclampsia, third trimester

Z3A.29 29 weeks gestation of pregnancy

Twins

Documentation for multiple gestations must include the number of gestations (single, twins, triplets, quadruplets, sextuplets, other), the number of amniotic sacs, and the number of placentae. Monochorionic means the fetuses share the same placenta. Monoamniotic means the fetus share the same amniotic sac. Dichorionic means each fetus has its own chorionic and amniotic sac.

Codes for multiple gestations are found in category O30. Codes specific to complications of multiple gestations are found in category O31. A 7th character is required for codes in category O31 to identify the fetus for which the code applies. 7th character 0 is reported for a single gestation, or for multiple gestations where the fetus is unspecified.

EXAMPLE

A patient 16 weeks pregnant with triplets comes to the office for her routine OB appointment.

O30.102 Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester

Z3A.16 16 weeks gestation of pregnancy

Placental and Amniotic Differences in Twin Gestations

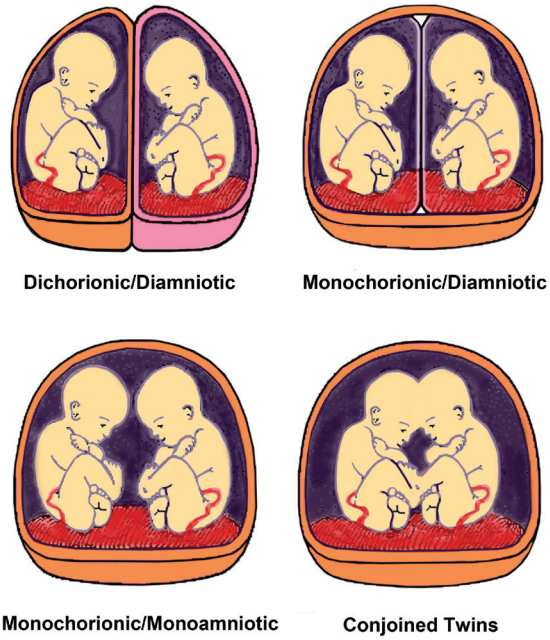

Chart #: _____

E/M Audit Form

Patient Name: _____ Date of service: __/__/___ Provider: _____ MR #: _____

Place of Service: _____ Service Type: _____ Insurance Carrier: _____

Code (s) selected: _____Code(s) audited: _____ ☐ Over ☐ Under ☐ Correct ☐Miscoded

History

History of Present Illness

☐ Location
☐ Quality
☐ Severity
☐ Duration
☐ Timing
☐ Context
☐ Modifying factors
☐ Associated signs and symptoms
☐ No. of chronic diseases

Review of Systems

☐ Constitutional symptoms
☐ Eyes
☐ Ears, nose, mouth, throat
☐ Cardiovascular
☐ Respiratory
☐ Gastrointestinal
☐ Genitourinary
☐ Integumentary
☐ Musculoskeletal
☐ Neurological
☐ Psychiatric
☐ Endocrine
☐ Hematologic/lymphatic
☐ Allergic/immunologic

Past, Family & Social History

PAST MEDICAL

☐ Current medication
☐ Prior illnesses and injuries
☐ Operations and hospitalizations
☐ Age-appropriate immunizations
☐ Allergies ☐ Dietary status

FAMILY

☐ Health status or cause of death of parents, siblings, and children
☐ Hereditary or high risk diseases
☐ Diseases related to CC, HPI, ROS

SOCIAL

☐ Living arrangements
☐ Marital status ☐ Sexual history
☐ Occupational history
☐ Use of drugs, alcohol, or tobacco
☐ Extent of education
☐ Current employment ☐ Other

PF=Brief HPI
EPF=Brief HPI, ROS (Pertinent=1)
Detailed= Extended HPI (4+) + ROS=(2-9) PFSH=1
Comprehensive= Extended HPI + ROS (10 + systems) PFSH=2 Established, 3 New Patient
☐ PFSH Form reviewed, no change ☐ PFSH form reviewed, updated ☐ PFSH form new

**Extended HPI=Status of 3 chronic illnesses with 1997 DG. Some allow for 1995 as well.

History _____

General Multi-System Examination

Constitutional
☐ 3 of 7 (BP, pulse, respir, tmp, hgt, wgt)
☐ General Appearance

Eyes
☐ Conjunctivae, Lids
☐ Eyes: Pupils, Irises
☐ Ophthal exam -Optic discs, Pos Seg

ENT
☐ Ears, Nose
☐ Oto exam -Aud canals,Tymp membr
☐ Hearing
☐ Nasal mucosa, Septum, Turbinates
☐ ENTM: Lips, Teeth, Gums
☐ Oropharynx -oral mucosa,palates

Neck
☐ Neck
☐ Thyroid

Respiratory
☐ Respiratory effort
☐ Percussion of chest
☐ Palpation of chest
☐ Auscultation of lungs

Cardiovascular
☐ Palpation of heart
☐ Auscultation of heart (& sounds)
☐ Carotid arteries
☐ Abdominal aorta
☐ Femoral arteries
☐ Pedal pulses
☐ Extrem for periph edema/varicoscities

Chest
☐ Inspect Breasts
☐ Palpation of Breasts & Axillae

Gastrointestinal
☐ Abd (+/- masses or tenderness)
☐ Liver, Spleen
☐ Hernia (+/-)
☐ Anus, Perineum, Rectum
☐ Stool for occult blood

GU/Female
☐ Female: Genitalia, Vagina
☐ Female Urethra
☐ Bladder
☐ Cervix
☐ Uterus
☐ Adnexa/parametria

GU/Male
☐ Scrotal Contents
☐ Penis
☐ Digital rectal of Prostate

Lymphatic
☐ Lymph: Neck
☐ Lymph: Axillae
☐ Lymph: Groin
☐ Lymph: Other

Musculoskeletal
☐ Gait (...ability to exercise)
☐ Palpation Digits, Nails
☐ Head/Neck: Inspect, Palp
☐ Head/Neck: Motion (+/-pain,crepit)
☐ Head/Neck: Stability (+/- lux,sublux)
☐ Head/Neck: Muscle strength & tone
☐ Spine/Rib/Pelv: Inspect, Palp
☐ Spine/Rib/Pelv: Motion
☐ Spine/Rib/Pelv: Stability
☐ Spine/Rib/Pelv: Strength and tone
☐ R.Up Extrem: Inspect, Palp
☐ R.Up Extrem: Motion (+/- pain, crepit)
☐ R.Up Extrem: Stability (+/- lux, sublux)
☐ R.Up Extrem: Muscle strength & tone
☐ L.Up Extrem: Inspect, Palp
☐ L.Up Extrem: Motion (+/- pain, crepit)
☐ L.Up Extrem: Stability (+/- lux, sublux)
☐ L.Up Extrem: Muscle strength & tone
☐ R.Low Extrem: Inspect, Palp
☐ R.Low Extrem: Motion (+/-pain, crepit)
☐ R.Low Extrem: Stability (+/- lux, laxity)
☐ R.Low Extrem: Muscle strength & tone
☐ L.Low Extrem: Inspect, Palp
☐ L.Low Extrem: Motion (+/-pain, crepit)
☐ L.Low Extrem: Stability (+/- lux, sublux)
☐ L.Low Extrem: Muscle strength & tone

Skin
☐ Skin: Inspect Skin & Subcut tissues
☐ Skin: Palpation Skin & Subcut tissues

Neuro
☐ Neuro: Cranial nerves (+/- deficits)
☐ Neuro: DTRs (+/- pathological reflexes)
☐ Neuro: Sensations

Psychiatry
☐ Psych: Judgement, Insight
☐ Psych: Orientation time, place, person
☐ Psych: Recent, Remote memory
☐ Psych: Mood, Affect (depression, anxiety)

Exam: _____

1995-1=PF, limited 2-7=EPF, extended
2-7=Detailed, 8+ organ systems=Comprehensive
1997-1-5=PF, 6-11=EPF, 2x6 systems=D
2 from 9 systems=Comp.

- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Typical postoperative follow-up care

Anesthesia, other than local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia, is not included.

32. Answer: A

Rationale: In the CPT® Index look for Injection/Bursa. You are referred to 20600-20611. Review the codes to choose appropriate service. 20610 is the correct code because the injection was given in the trochanteric bursa (hip, a major joint) without ultrasound guidance for drug therapy. In the HCPCS Level II code book look in the Table of Drugs and Biologicals for Kenalog and you see Kenalog-10 and Kenalog-40, which both refer you to See Triamcinolone Acetonide. Triamcinolone Acetonide leads to several codes J3300, J3301, and J3302. J3301 10 mg lists Kenalog in the notes below the code. Report 4 units for 40 mg of Kenalog.

33. Answer: D

Rationale: Constitutional, ENMT, Eyes, Lymphatic, Respiratory, Cardiovascular, and Gastrointestinal (7 OS, detailed, for a detailed exam). The following body areas were also documented: Head, including face and neck. The 1995 Guidelines allow only organ systems for a comprehensive exam.

34. Answer: D

Rationale: Code 69209 is reported when the ear wax is impacted. In this case, the ear wax is acute, but not stated as impacted. There is also no mention of how the ear wax was removed. For cerumen removal that is not impacted report with an E/M level.

35. Answer: A

Rationale: The PCP transferred the patient to the cardiologist to manage/treat the congestive heart failure. The cardiologist accepted the transfer of care of the patient and sent a letter to the PCP with findings of the first visit and stress test. This would be coded as a new patient since the cardiologist accepted the patient and is taking over the care of a specific problem.

Clinical Conditions

36. Answer: B

Rationale: We have a confirmed diagnosis of apical lung cancer, a cancer in an upper lobe, which is code C34.10 (no indication of right or left lung). The term apical means the tip of a pyramidal or rounded structure, so apical lung cancer means the tumor/cancer is located at the top or upper lobe of the lung. We find this by looking in the Table of Neoplasms for Neoplasm, neoplastic/lung/upper lobe and select from the Primary Malignant column which directs you to code C34.1-. Verification in the Tabular List indicates the code requires five characters. There is no indication which side of the lung has cancer, report code C34.10 for unspecified lung. There is also an instructional note under category C34 to use additional code for tobacco use. Code F17.210 is reported to indicate the patient is a smoker. Look for Smoker – see Dependence, drug, nicotine. Look for Dependence/drug NEC/nicotine/cigarettes which directs you to code F17.210. Verification in the Tabular List confirms code selection.

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