1) **General Procedure/Guideline Statement:** It is the policy of the Clinical Documentation Excellence Department that clinical documentation reviews be conducted on appropriate accounts in the ambulatory setting.

   a. **Scope:** This procedure/guideline/protocol will be utilized by all Outpatient Clinical Documentation Specialists and Clinical Documentation Compliance Coordinators.

   b. **Responsible Department/Party/Parties:**
      i. **Procedure owner:** Director, Clinical Documentation Excellence Department.
      ii. **Procedure:** Manager, Outpatient Clinical Documentation Excellence Department.
      iii. **Supervision:** Manager, Outpatient Clinical Documentation Excellence Department.
      iv. **Implementation:** Manager, Outpatient Clinical Documentation Excellence Department; Clinical Documentation Compliance Coordinators.

2) **Definitions:**

   a. **Initial Review:** First review of documentation for prospective encounter, with entry of findings into the WakeOne software.

   b. **Concurrent Review:** Subsequent review of documentation, since the initial review, such as consult notes, labs, radiology notes and any other applicable data.

   c. **Retrospective/Reconciliation Review:** Review of documentation for purposes of correlation for final coding and billing. This will include any reconciliation of queries needed to support the clarity of the record.

3) **Procedure/Guidelines:**

   a. Processes and Responsibilities of the Clinical Documentation Specialist (CDS):
i. The CDS will identify and review upcoming patients assigned to their clinics via a WakeOne workbench report, throughout the business day. During times of volume load shift between services, the CDS will assist with other clinics as needed.

ii. The CDS has clinic assignments for which they are responsible for covering. The CDS assignment may be re-evaluated and changed by the Manager or his/her designee as needed to make best use of staff resources and provide most productivity.

iii. The CDS will review and resolve any clinical issues arising in the pre-bill (before billing has occurred) stage of medical coding to ensure the most accurate documentation has been obtained for coding purposes.

iv. The CDS will work collaboratively with clinical staff to identify any missed opportunities related to clinical documentation. Prompt and professional interactions are used to effectively resolve any deficiency. Unresolved questions or issues will be referred to leadership or designee.

v. The CDS will be responsible for interacting with physicians and clinic staff on a regular basis to establish complete and concise documentation. Queries will be communicated to the provider(s) by the CDS to facilitate appropriate clinical documentation to support the severity of illness and complexity of care rendered to all patients.

vi. The CDS will collaborate with nurse navigators, patient care advocates, clinic managers, nursing staff, quality and analytics and other ancillary staff as needed regarding interactions with physicians on documentation so as to resolve physician queries prior to billing.

vii. The CDS will participate in clinical documentation compliance activities including those related to value-based care initiatives by assuring accurate documentation resulting in the most appropriate Hierarchical Condition Category (HCC) assignment and ICD 10-CM specificity.

viii. The Manager will collaborate with the CDS to establish group presentations. The CDS will be responsible for maintaining collegial relationships and providing one-on-one education to providers and ancillary staff regarding the need for accurate, specific and complete clinical documentation in the patient’s medical record.

b. Record Review:

i. Initial, concurrent, retrospective/reconciliation review of medical record will occur with appropriate entry of information into WakeOne Outpatient CDE Platform.

   1. Focus of review to include identification of HCC diagnoses not having been accurately captured, or supported in documentation,
for the calendar year, and any inconsistencies (unspecified, conflicting, etc.) in documentation of ICD 10-CM diagnoses.

2. Appropriate physician queries completed as indicated to support HCC diagnoses and ICD 10-CM specificity, along with accurate, complete and compliant documentation.

   ii. Initial Review: 1 to 3 business days before visit date. The timeframe of review may vary based upon clinic volumes. Clinic/case specific parameters may be implemented by the manager or his/her designee.

   iii. Concurrent Review: Each business day, occurring on the day of the visit and/or up to 4 business days after the visit, the CDS will review records for query follow-up according to departmental protocol (see attached flowchart). The frequency of concurrent review may vary based upon provider feedback and clinic. This includes “closing” of any open queries and placing findings in WakeOne Outpatient CDE platform. Clinic/case specific specific parameters may be implemented by the manager or his/her designee.

       1. Any questions regarding records will be communicated between the CDS and appropriate clinic staff member. If unable to resolve the question, the chart will be referred to the manager or designee.

       2. The manager or designee will complete a second level review of the findings and place notes within the WakeOne Outpatient CDE platform.

   iv. Retrospective/Reconciliation Review: Occurring after 4 business days following the clinic visit, with the review of any documentation since the last concurrent review. Review focus is for the final documentation (when available) and correlation of the record for final coding and billing. This will include reconciliation of any final query RAFs and documentation to support the clarity of the record.

       1. Appropriate Risk Adjusted Factor (RAF) score will be placed in WakeOne “RAF” field once verified.

c. Provider Query Process:

   i. Standardized interactions with Wake Forest Baptist Health and all affiliate clinic providers will occur to ensure accurate, complete and compliant documentation within the medical record.

   ii. Clarifying questions/queries will be based on clinical indicators and diagnoses already in the medical record and will meet current standards for compliance. (See Guidelines for Achieving a Compliant Query Practice, AHIMA Practice Brief, 2013, updated for ICD-10, 2016).
iii. Queries will be crafted in such a fashion to include necessary clinical indicators, non-leading, and free from introducing data (diagnoses, RAF scores, or codes).

iv. Prospective/Concurrent queries will be delivered by way of “Quality BPA” in Wake One. They will also be documented in the “query” field in the Outpatient CDE WakeOne platform for tracking purposes.

v. The CDS will review the documentation after the visit encounter for provider response. Responses to queries will be clearly documented in the Outpatient CDE WakeOne platform to reflect physician response.

vi. Queries that fail to receive a response will be followed up by phone or one-on-one physician interaction by the CDS. If a response is not obtained, the query will be closed and “resolved” and “Quality BPA” removed. The manager or designee will follow-up based upon case specifics.

vii. Cases with needed clarification discovered during coding of the medical record will have a physician query initiated by the medical coder. Cases with needed clarification discovered during audit or second level review will be tracked and have provider education and/or outreach initiated by the manager or designee.

d. Program Metrics:
   i. Performance evaluation will include review of individual metrics, data reports generated by manager or designee, professional conduct, accuracy, and ability to apply advanced clinical nursing knowledge, compliance with industry and program standards.

4) Review/Revision/Implementation:
   a. Review Cycle: This policy shall be reviewed by Clinical Documentation Excellence at least every 3 years from the effective date.
   b. Office of Record: After authorization, the department of Clinical Documentation Excellence shall house this policy in a policy database and shall be the office of record for this policy.

5) Related Governing Policies: None.

6) References, National Professional Organizations, etc.:

7) **Attachments**: Outpatient Review-Query Process (revised August 2017)
   Outpatient Look Back Review Process (revised June 2017)

8) **Revision Dates**: N/A
Outpatient Clinical Documentation Review Process 2017

1. Save new Look Book report to H: Drives (initials_Look Back Report_Date), at the beginning of each month.
2. Email to Alicia no later than two business days before the end of each month by 5pm.
3. DO NOT file report excels.

Begin - Open WakeOne OP CDE Workbench

Choose appropriate clinic accounts having appointment within next 1-3 business days [DO NOT review further than 1 week ahead]

Open monthly Look Back report; use Control F to look up to find MRN

Account on Look Back report

Review chart; Follow Review - Query Process

Are codes Valid

Yes

Place asterisk under “Validated” in Look Back report

No

Yes

Query Needed

Yes

In WD, under the Query Info Section, enter “Yes” into the Look Back data field and place D/W(s) in note beside “Yes” box

No

Follow Review - Query Process

End/Sign/Close Account

Place asterisk under “Non-Valid” in Look Back report
Cross-Functional Flowchart – Outpatient CDE Review/Query Process

1. **Pre-Visit:**
   - Start: Select patients
   - WO Workbench 1-3 business days before patient visit for assigned clinics

2. **Day of Visit:**
   - Click on chosen patient and Open New OP CDE Encounter
   - Review chart for accuracy (beginning with renewal)
   - Look back report; may review 2 years

3. **2nd Business Day (Day After visit):**
   - Cross-Functional Flowchart – Outpatient CDE Review/Query Process
   - Open New Encounter, review chart after visit (stay until review next business day if visit after 3pm)
   - Query answered in Patient Record or "other" appropriate response?

4. **3rd Business Day:**
   - Enter comments in CDE Review Only section, Close and Sign

End

Note: Query Workbench should be utilized daily to find "open" queries for the date of visit.