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AI Scribe Guide: Why Coding-Aware AI Scribes Are Essential

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Executive Summary

In 2024, there has been a notable surge in leveraging AI to alleviate the documentation burden on clinicians. Following the success of tools like ChatGPT and GPT-4, over a dozen tech companies have quickly entered the market with "AI scribe" solutions, each at varying stages of development. Many health systems are piloting these technologies in hopes of reducing the time clinicians spend on EHR documentation.

Despite the growing fascination with technology, the results from AI scribing pilots have largely been mixed. One major area of concern is the unintended impact on revenue cycle performance. Specifically, revenue cycle teams have raised concerns over the quality and integrity of AI-generated documentation. As their footprint across a health system increases, AI scribes have begun to negatively impact CDI query volume and coding performance. In some cases, revenue cycle teams are lamenting that these technologies have reversed years of training and change management around coding and documentation.

Despite these challenges, there's also a promising opportunity. When implemented thoughtfully, **"coding-aware" AI scribes** — those fine-tuned with revenue cycle needs in mind — can play a role in dramatically improving coding and documentation integrity at the point-of-care, while reducing the system's reliance on resource-intensive training initiatives. By ensuring clinicians receive proper credit for the work they're already doing, coding-aware AI scribes could reduce the need for resource-heavy training programs while becoming a valuable, revenue-generating investment for health systems.

How AI scribes impact clinical documentation integrity (CDI)

THE IMPORTANCE OF CDI TO THE HEALTH SYSTEM

Clinical documentation integrity (CDI) refers to the accuracy of electronic health record documentation and coding decisions in reflecting:

1. The disease process and level of clinical risk for the patient
2. The specific care administered to the patient by the rendering clinician
3. The medical decision-making behind all important care decisions

CDI performance is a business-critical metric for healthcare organizations, as documentation and coding quality are intimately tied to reimbursement. While each care setting and contract type may have different payment models with vastly different mechanics (e.g., DRG-based hospital billing vs. global capitation for value-based-care (VBC) primary care clinicians vs. fee-for-service (FFS) reimbursement for orthopedics), the underlying philosophy is still largely shared across the industry:

1. The coding decisions (i.e., the specific CPT®, HCPCS, and ICD-10 CM codes selected) ultimately determine how much the health system should be reimbursed for services rendered.
2. In order to justify reimbursement/coverage, payers will look for specific pieces of evidence within documentation to determine validity and/or medical necessity. If the decisions are not supported by documentation, the payer is likely to deny reimbursement.

The challenge for most health systems is that, while CDI performance is directly correlated with the institution's financial health, it's proven to be a challenging set of metrics to improve. At baseline, guidelines around coding and documentation are complex, may be different based on payer and contract type, and could change over time. For instance, the transition from v24 to v28 effective January 1, 2024, poses serious challenges to organizations with meaningful exposure to Medicare Advantage. Navigating the transition requires major investments in change management, training clinicians on the new rules and the implications for coding and documentation. Unfortunately, these efforts are often met with resistance, as most clinicians are not trained in (nor do they enjoy) the nuances of coding and documentation.

Despite these challenges, health systems have invested significant infrastructure in improving overall CDI performance. After all, denials have been a growing problem for health systems over the past decade. In a 2024 survey conducted by Premier, nearly 15% of all claims submitted to private payers were denied. Of those, over half were ultimately overturned, but not without substantial expense. On average, health systems spent $43.84 per claims denial, amounting to an estimated $19.7 billion a year just to adjudicate with payers.

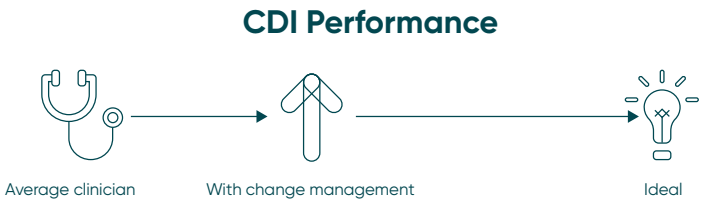
The alternative is no better. Fearing denials, many clinicians who operate in settings without professional coder support (e.g., most ambulatory settings) choose to code more cautiously. While they may experience fewer denials, they also struggle to get full credit for the work they do. In a recent audit case study performed by AAPC Services, results indicate that the average clinician leaves 5-10% of their total reimbursement opportunity on the table due to overly conservative coding decisions.

Historical efforts to improve CDI performance

The average clinician's CDI performance is largely affected by two major classes of mistakes:

1. **Picking the wrong codes:** Clinicians miss a code that can impact reimbursement, include a code that's inappropriate, or select a code that's at the wrong level of specificity.
2. **Incomplete documentation**: Clinicians do not create sufficient documentation (from the payer perspective) to justify the selection of selected codes.

In general, the average clinician's CDI performance is far from the theoretical ideal. To address this gap, health systems commonly invest in initiatives to encourage clinicians to select more accurate codes that result in more compliant documentation. These change management initiatives often involve bringing in external experts to baseline the organization's current CDI performance and identify key gaps. These assessments are invaluable in pinpointing the specific training clinicians need to close knowledge gaps and strengthen the organization's overall coding and documentation practices.

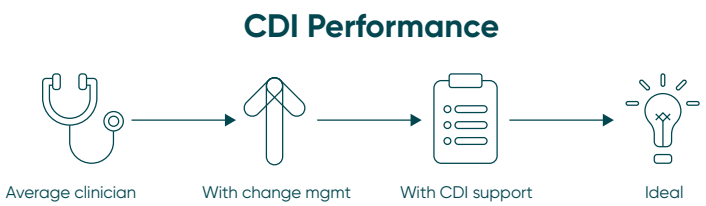


Another effective strategy for change management is equipping clinicians with the right tools to enhance documentation quality. Many revenue cycle leaders collaborate with medical directors to improve the templates and dot phrases used by each specialty and subspecialty. These tools serve as important reminders of the key elements that clinicians should not forget to include. For example, here's a template used in the emergency department to document the MDM portion of a note for critical care encounters, tailored for the 2023 billing changes:

```
MDM

Patient with history as above presented with [chief
complaint]. History obtained from [patient, parent,
caregiver, EMS].

Patient was ill appearing, with unstable vitals. Patient
was placed in resuscitation room, IV was established and
patient was placed on a monitor. Considered intubation,
but patient was protecting airway. [Fluids/medications]
were immediately ordered and administered, with
improvement in vitals.

EKG reviewed.

Labs reviewed.

Independently reviewed imaging.

Reviewed external records.

Differential diagnosis considered.

Overall presentation is consistent with [].

Low suspicion for [].

Patient was treated with [].

Discussed case with [consultant].

Admitted to ICU for [].
```

Templates and dot phrases can often fall short due to the complexity and variety of situations they need to cover. In many cases, it's difficult to standardize guidance. For example, in behavioral health, the add-on code 90833 for psychotherapy must be used with an E/M code for medication management consultation. Clinicians must follow strict rules when documenting 90833, including specifying the nature of therapy, therapeutic interventions, and total time, which must be clearly separate from the E/M service documentation. These nuances are crucial for correctly reporting both codes, but can be challenging to execute consistently.

In settings where the financial impact of CDI performance is significant, and the rules are complex — such as in hospital inpatient care — revenue cycle leaders may invest in dedicated teams to support clinicians by validating coding decisions and documentation. These CDI support teams can play a vital role in improving performance by identifying and correcting suboptimal coding before claims are submitted.



CDI teams also play a role in improving documentation. For example, if a CDI analyst identifies a potential gap that could lead to a claim rejection, they can initiate a query to prompt the clinician to address the issue before the claim is submitted. However, this process is not without challenges due to several potential issues:

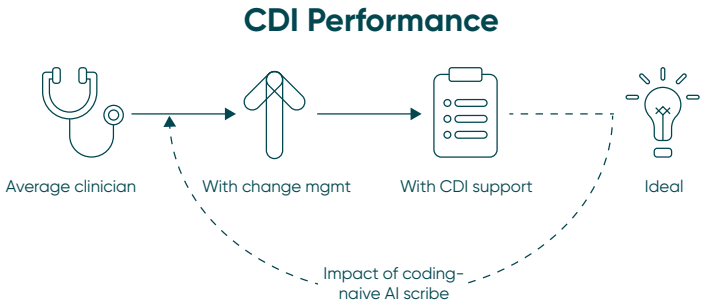
1. **Delays:** It can take days for a CDI query to be initiated and acted upon, by which time the details of the interaction may have faded from memory.
2. **Incomplete Documentation:** CDI teams rely solely on what's documented. If a clinician provided smoking cessation counseling but didn't document it, the CDI team wouldn't know during their review.
3. **Cultural Friction:** CDI teams are often staffed by non-physicians with limited physician advisory support, leading to cultural friction between CDI staff and frontline physicians or advanced practice staff.
4. **Lack of Coverage:** Many care settings lack CDI support due to the significant investment needed to build and maintain a team, along with a shortage of qualified professionals for the role.

While these investments aren't complete solutions, collectively, they can significantly improve CDI performance, bringing it much closer to the ideal than would be possible without them. Given the financial and compliance implications, these investments often become a top priority at the enterprise level.

CODING-NAIVE AI SCRIBES UNDERMINE HEALTH SYSTEM CDI INVESTMENTS

With the considerable time clinicians spend on documentation and impressive demos from off-the-shelf LLM technology, many software companies began promoting AI scribe solutions. Some of these tools have been introduced through health system-approved pilot programs, while others have gained grassroots adoption by clinicians without formal review.

Although widespread adoption is still limited — especially for specialists outside adult primary care — these technologies remain largely unvetted by certified auditors or revenue cycle leaders, who are often excluded from decision-making. However, the documentation generated by AI scribes inevitably affects CDI performance metrics, which revenue cycle teams have worked so hard to optimize over the years.



As revenue cycle teams encounter these AI scribe technologies in the wild, many have begun to raise concerns about the quality of AI-generated documentation. Specifically, most AI scribing technologies on the market (even from some of the most well-recognized brands) are relatively coding-naive. Because these AI scribes are unaware of all the requirements on documentation from a revenue cycle perspective (they're just naively summarizing what's explicitly verbalized), they often undo much of the hard work invested in change management and make it more challenging for CDI teams to deliver on their objectives.

The case for "coding-aware" AI scribes

THE IMPACT OF EMBEDDING CDI KNOWLEDGE INTO AI SCRIBES

While the risks of coding-naive AI scribes are concerning, we also suspect that AI scribes, if executed well, may also present an opportunity to improve upon historical CDI efforts. For example, rather than relying heavily on change management to incrementally coach better clinician behavior, a coding-aware AI scribe could leverage best practices to automatically create compliant documentation at the point of care. In fact, a coding-aware AI scribe could be an indispensable tool for revenue cycle teams looking to achieve better CDI performance at a lower cost.

As an illustration of this thesis, we include several examples of real AI-generated documentation — across various settings of care — that were flagged by revenue cycle teams and AAPC Audit Services. In each, we highlight the deficiencies of coding-naive AI scribes and the potential impact on financial performance and compliance. We subsequently show how a coding-aware AI scribe might not only neutralize these risks, but also improve upon the baseline clinician's CDI performance in each of these situations.

Example 1: MDM documentation in the emergency department

In the emergency department, the ability to assign the best possible level of service code requires the documentation to fully reflect the complexity of the clinician's medical decision making. This MDM is generally reflected in the assessment/plan, which a coding-naive AI scribe attempted to generate below:

> **Assessment/Plan:**
>
> - Two weeks of chest pain, left arm pain, and swelling in left leg.
> - Exam showed no tenderness in chest, normal heart rate, no pitting edema.
> - Elevated troponin and BNP.
> - Chest x-ray showed trace pleural effusion.
> - EKG performed; normal findings.
> - Patient admitted.

Now, this AI-generated MDM poses several issues based on the 2023 billing guidelines:

1. The payer is likely to expect far more detail on the interpretation of the x-ray, and attestation that it was independently interpreted.
2. It omits clear documentation of the consultation with Cardiology.
3. There's insufficient detail in the EKG interpretation, and missing attestation of independent interpretation.

Now, a rushed clinician may also miss many of these elements, but the implication is that the data section only codes as "Moderate" in the complexity calculation.

On the other hand, consider the following MDM for the same visit generated by another (actual) AI scribe that is coding-aware:

> **Impression/Plan:** 45 y.o male with history of diabetes and two prior MIs presenting with two weeks of concomitant chest pain, left arm pain, and swelling in the left LE. Exam did not reveal any tenderness with palpation of the chest, heart with normal rate and rhythm, no pitting edema in bilateral LEs and no significant tenderness with movement of the left arm and shoulder.
>
> Labs show elevated troponin at 843 and BNP 835 as well as mild AKI with a creatinine of 1.5. Chest x-ray showed trace right-sided pleural effusion, but no significant consolidations.
>
> Given patient's history and elevated cardiac markers, a cardiac etiology for the chest pain is highly suspected.
>
> Initiated heparin for unstable angina and will admit patient to cardiac unit for further management under Dr. Smith; Dr. Smith consulted at 13:00 and

he agrees to admit. Patient and his family has been informed of plan to admit and agree with plan.

EKG Report: EKG performed on 02/15 at 11:50 AM. Interpretation: Normal sinus rhythm, 64 beats per minute, no ST elevations, no abnormal T-wave inversions, narrow QRS, normal PR and QT interval.

Independently interpreted by myself, Dr. Andrew James, MD.

Imaging: Chest x-ray shows trace right-sided pleural effusion, but no significant consolidations.

I independently interpreted the chest x-ray.

Consideration of Admission: Patient admitted to Cardiology. Differential Diagnoses: Myocardial Infarction, Chest Pain, Elevated Troponin, DVT, PE, Pneumonia

This much more comprehensively captures the medical decision making of the clinician and hits all the expected elements from the CDI perspective. The data section of this version codes as "Extensive" as opposed to "Moderate."

Example 2: Supporting HCC coding in value based primary care

In a value-based primary care setting, where a health system is receiving capitated payments for taking care of a patient, it's important for the health system to capture the clinical complexity of this patient's care. This is done primarily through the capture of HCC codes (which are mapped from ICD-10 codes) that are correlated with empirically higher costs of care. However, to get credit for risk-adjustment, the clinician must demonstrate through documentation that the patient actually has this condition and that they are actively treating/managing it. This is generally demonstrated in the assessment/plan, which a coding-naive AI scribe attempted to generate here for a patient with congestive heart failure and stage 3 CKD:

Patient presents with worsening edema and fatigue. Current medications reviewed and continued.

Recommended low-salt diet and fluid restriction.

Follow-up in one month to reassess kidney function and heart failure status.

Here, the assessment/plan does not indicate the type of heart failure, stage of CKD, nor the interactions between the two conditions. It also lacks sufficient detail on the monitoring and treatment plan, hence noncompliant with MEAT (Monitoring, Evaluation, Assessment, Treatment) criteria requirements. Contrast with the performance of a coding-aware AI scribe on the same visit:

Exhibits signs of volume overload, exacerbated by underlying chronic systolic heart failure and stage 3 CKD. Medication regimen reviewed and optimized for renal function preservation and cardiac output improvement. Initiated diuretic adjustment to manage edema more effectively.

Dietary consultation arranged to tailor a low-sodium diet and fluid management plan. Scheduled follow-up in four weeks

with renal function tests and echo to closely monitor disease progression and therapeutic response. Emphasized importance of medication adherence and daily weight monitoring to track fluid status.

These differences enable the clinician to get credit for two HCC codes (226 for the CHF, and 329 for the stage 3 CKD in the v28 model). Including the interaction factor, this is a 1.193 incremental RAF score impact which, for a system taking on global risk for this patient, might translate to over $12,000 in additional annual payment for cost sharing with the health plan.

Example 3: Support DRG capture in hospital medicine

Similar to value-based primary care, reimbursement in the inpatient setting is largely dependent on selection of the most appropriate ICD-10 codes and ensuring that documentation supports those codes. Lack of appropriate support for supporting ICD-10 codes may result in failure to qualify for potential CC/MCC that would map to a higher value DRG. Take for instance the following assessment/plan generated by a coding-naive AI scribe for a patient requiring respiratory support because of severe sepsis:

Assessment/Plan:

- Patient presents with fever, hypotension, and confusion; blood cultures positive for sepsis, secondary to a recent respiratory infection. Additionally has a history of COPD.
- Initiated broad-spectrum IV antibiotics. Initiated medications to improve hypotension. Respiratory support initiated due to observed respiratory distress.
- Nursing staff to monitor vital signs every 30 min - 1 hour. Labs ordered.
- Consulted pulmonology who will see the patient in the unit today.

This assessment/plan is likely to prompt several CDI queries because of documentation insufficiencies. The payers will expect far more detail on ventilator settings as well as clear justification for its use. The review of the blood cultures also doesn't include the necessary detail on the infecting organism, and the treatments administered are not documented at the required level of specificity. On the other hand, compare to the documentation produced by a coding-aware AI scribe for the same visit:

Assessment/Plan:

- Patient in septic shock with persistent hypotension; initiated norepinephrine at 0.1 µg/kg/min, titrated to maintain MAP ≥ 65 mmHg. Noted multi-organ dysfunction involving respiratory and renal systems, necessitating multiple high-level interventions. History of COPD and recent pneumonia contributes to sepsis diagnosis.
- Blood cultures positive for Streptococcus pneumoniae; complicated by ARDS and acute renal failure.
- Initiated IV Piperacillin/Tazobactam 4.5 g IV Q6H and Vancomycin 1 g IV Q12H.
- Started mechanical ventilation for ARDS management. Ventilator settings: FiO2 60%, PEEP 12 cm H2O, tidal volume 6 mL/kg of predicted body weight. ABGs to be monitored every 4 hours to adjust ventilator settings and ensure adequate oxygenation and ventilation.
- Began continuous renal replacement therapy (CRRT) for management of acute renal failure; settings include a blood flow rate of 200 mL/min and a dialysate flow rate of 2,000 mL/hour. Fluid removal rate adjusted based on patient's fluid status, aiming for a net ultrafiltration of 500 mL/hour.
- Nursing staff to continue monitoring vital signs, renal function, and respiratory status.
- Consulted with Dr. Jones in pulmonology at 14:30 for evaluation. Dr. Jones to evaluate current ARDS management at 15:00 today.

With the improved clinician documentation, this likely means the difference between coding DRG 872 (FY2024 relative weight ~1.82) vs being able to code DRG 870 (FY2024 relative weight ~5.32). Assuming a national average base payment rate of ~$6,000, the reimbursement difference may be as large as $21,000 in additional reimbursement for this one patient.

Example 4: Demonstrating medical necessity for prior authorization

The final example illustrates the importance of documentation to demonstrate medical necessity for prior authorization. Without clear justification aligned with payer expectations, a coding-naive AI scribe risks increasing rates of prior authorization denials and causing delays in important interventions. This is a snippet of documentation (in the assessment/plan) generated by a coding-naive AI scribe for a patient with back pain who needs a joint injection:

Sacroiliac Joint Dysfunction

- Patient reports ongoing back pain for 8 months, with significant pain levels.
- Previous treatments including NSAIDs, acetaminophen, cyclobenzaprine, and physical therapy have not provided full relief.
- Imaging shows sacroiliac joint dysfunction, but no fractures or tumors.
- Will perform targeted joint injection as next step of management.
- Discussed potential risks and benefits of the injection with the patient, and they agreed to proceed.
- Plan to check on the patient's progress after the injection in 5 weeks.

Unfortunately, this prior authorization for joint injection is likely to be denied because of insufficient documentation support. There's no mention of the location of the back pain, it's missing the NRS pain scale and ODI disability assessments, the full conversation around risks and benefits, and any mention of specific goals for improvement. All of this critical information from the prior authorization discussion, including key details, has been omitted. On the other hand, a coding-aware AI scribe captures all these details from the clinician's conversation with the patient on the same visit:

Sacroiliac Joint Dysfunction

- Patient notes lumbar spine back pain lasting 8 months with a NRS score of 7/10 at baseline, indicating severe pain levels. ODI utilized, with the patient scoring 25, categorizing disability as moderate and impacting daily activities.
- Lack of improvement in pain despite trials of physical therapy, NSAIDs, acetaminophen, and cyclobenzaprine.
- MRI and CT scans performed, ruling out fractures, tumors, infections, or significant deformities as pain sources, but indicated signs consistent with sacroiliac joint dysfunction.
- Based on chronicity of pain, functional impairment, and joint dysfunction signs, patient is a candidate for targeted sacroiliac joint injection therapy.
- Informed patient about joint injection risks including infection, bleeding, allergic reaction, temporary increase in pain, along with benefits, and informed consent was obtained.
- Schedule follow-up reassessment post injection in 5 weeks. Will use NRS and ODI scales post-injection to evaluate pain relief and functional improvement; aiming for reduced NRS score to ⩽ 4/10 and ODI to ⩽ 15.

By capturing all the essential details from the conversation accurately, a coding-aware AI scribe ensures clinicians receive proper credit for the work they put into reaching a treatment decision. More importantly, it reduces the risk of claim denials, increasing the likelihood that patients receive the necessary care in a timely fashion.

In-workflow nudges as CDI 2.0

In addition to enhancing baseline documentation quality, we believe coding-aware AI scribes should take a more proactive role in identifying information gaps and prompting clinicians to address them in real-time, at the point of care. One challenge with traditional CDI teams is that:

1. Delays in CDI queries frequently result in clinicians forgetting key details that might be relevant to CDI performance.
2. CDI teams rely solely on the documentation, which means they must work with an incomplete picture to identify opportunities.

A coding-aware scribe at the point of care, however, might be able to deliver nudges in-workflow when information is still fresh in the clinician's mind. Moreover, a coding-aware scribe has direct access to the source truth by virtue of listening to the entire encounter.

Already, we're beginning to see examples of this paradigm achieve adoption within health systems. In settings where there are no CDI teams, these nudges represent major sources of untapped revenue opportunity. In settings with existing CDI teams, health systems are finding reduced burden on CDI staff, who are now able to operate closer to the top of their license because of point-of-care augmentation. We include several examples here to illustrate opportunities for in-workflow nudges.

Example 1: Identifying missing or more specific CPT® codes

As discussed previously, selecting the right CPT® codes can have meaningful reimbursement consequences in many settings. For example, MMR vaccine administration codes are commonly leveraged in pediatric settings, but when counseling is provided (90460 + 90461 x2), the revenue generated is much higher than when counseling is not provided (90471).

However, this is a commonly missed opportunity for many clinicians (e.g., ~$19.63 in potential missed revenue for the MMR vaccine administration). To address this gap, a coding-aware AI scribe could consider nudging a clinician for the missing CPT® code(s) and billing units for vaccine counseling and, if accepted, generating the documentation to support the provided counseling:

90471 - Encounter for Immunization (MMR Vaccination)

- Patient presents for scheduled MMR vaccination as part of the routine immunization schedule for children.
- No contraindications for vaccination identified during the pre-vaccination assessment.
- Administered MMR vaccine intramuscularly in the left deltoid. No immediate adverse reactions observed post-administration.

90460, 90461 x2 - Encounter for Immunization Safety Counseling

- Explained the significance of the MMR vaccine in preventing multiple diseases including measle, mumps and rubella. Emphasized the role of this vaccine in maintaining public health and individual immunity.
- Discussed common side effects of the MMR vaccine such as soreness at the injection site, low-grade fever, and rare but serious reactions like allergic responses. Advised patient on when to seek medical attention for severe symptoms.
- Advised on managing common side effects with simple home care measures such as applying a cold compress to reduce soreness and taking over-the-counter pain relievers.
- Stressed the importance of keeping an updated vaccination record and how it assists in managing future healthcare decisions.

Example 2: Improving ICD -10- CM documentation for HCC

Similar nudges can also be useful in helping clinicians select a more specific ICD-10 code, when necessary. For example, many groups taking on Medicare Advantage contracts are struggling to transition from HCC v24 to v28. Part of the challenge is certain codes which mapped to HCCs in v24 (e.g., E11.31 Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy) no longer map to an HCC in v28. In a situation like this, the ability to nudge the clinician to provide more information to get to a more specific code (e.g., E11.3212 Type 2 Diabetes Mellitus with Mild Nonproliferative Diabetic Retinopathy with Macular Edema, Left Eye) can have a significant impact on reimbursement (in this case, an incremental RAF score of 0.436 under v28).

Example 3: Improving modifier 25 utilization

In some settings, clinicians may provide multiple services within a visit. However, to get full credit for both services, a clinician would have to document both services and append modifier 25. For instance, in the case that a pulmonologist provided outpatient E/M consultation to a patient and separately provided smoking cessation counseling (an additional of ~$27.30 in reimbursement), the clinician would have to document not only the evaluation, but also details related to the smoking cessation and then append a modifier 25:

CPT Codes: 99214-25, 99407

COPD & Nicotine Dependence, Cigarettes

- 41-year history of cigarette smoking, currently smoking 1.5 PPD, contributing to COPD exacerbations. Experiencing increasing dyspnea, chronic cough, and frequent respiratory infections.
- Currently not taking medications. Initiated treatment with tiotropium to improve lung function and alleviate symptoms. Will evaluate effectiveness and tolerance at next follow-up.
- Enrolled patient in pulmonary rehabilitation to enhance respiratory strength and endurance, which can significantly improve quality of life and physical capacity.
- Smoking cessation was discussed with patient
- Patient is up to date with pneumococcal and annual influenza vaccines, which can help prevent serious respiratory complications.
- Ordered CT scan to assess the extent of lung damage.

Tobacco Cessation Documentation: 13 minutes spent providing tobacco cessation counseling in today's visit.

- Patient expressed a strong desire to quit smoking and has tried multiple methods in the past including Chantix and nicotine patches without long-term success. Patient expresses interest in trying Wellbutrin as a new approach to cessation.
- Discussed side effects and risks of Wellbutrin, including the potential for seizures, particularly when combined with alcohol. Patient does not have a history of seizures.
- Patient educated that Wellbutrin for cessation can take upwards of a month to manifest. We will start with a low dose of 150 mg PO QD. Patient to follow-up in one month to assess progress.

Normally, missing the tobacco cessation service may be a challenging mistake to catch for a CDI team, especially if it was never clearly documented or if the ICD-10 CM code of F17.2xx was never reported. Here, the in-workflow nudge (and AI-generated coding-aware documentation) makes catching this mistake as easy as a single click.

We often see similar missed opportunities during AWVs and well-child visits, where the patient may also present with a sick complaint (therefore, also qualifying for a modifier 25). Here, sometimes up to 50% of the total potential reimbursement opportunity may be left on the table.

Example 4: Increasing complaint critical care code utilization

We're also seeing that coding-aware AI scribes can help prompt more compliant use of critical care codes in the emergency department. Traditionally, emergency department directors or CDI teams audit charts to identify potential critical care opportunities, a labor-intensive and often imperfect process. By listening to the entire encounter, a coding-aware AI scribe can prompt clinicians to consider coding for critical care. For example, here's an actual nudge generated by an AI scribe during a visit:

> We detected that you provided the following services, or the patient had diagnostic results, final diagnoses, or vitals that might apply for critical care time:
>
> - Patient found unconscious and unresponsive, requiring intubation.
> - Administration of IV Versed, ketamine, Valium, and dopamine.
> - Hypotension treated with IV dopamine and norepinephrine.
> - Seizures treated with IV Ativan and Keppra.
> - Suspected STEMI evaluated by cardiology.
> - Central line placement and administration of IV broad-spectrum antibiotics (Vancomycin, and Rocephin) for suspected sepsis.
> - Elevated procalcitonin at 6.49 and a white count of 20, indicating potential sepsis.
> - Rhabdomyolysis with CK in the 6000s.
> - Elevated potassium treated with IV calcium gluconate.
> - Lumbar puncture performed to evaluate for potential meningitis.

Every time a coding-aware AI scribe catches a missed critical care opportunity, the organization recovers between $120-$275 in potential reimbursement for that encounter.

Evaluating AI scribing tools

Choosing the right AI scribing tool requires a strategic approach to enhance clinical operations and protect revenue streams. This 5-step guide offers key insights for evaluating scribing tools to optimize CDI and coding practices, ensuring both compliance and efficiency during implementation.

1. **Support Provider Coding Decisions**: Ensure the tool accurately documents and reflects the coding decisions made by providers in their notes.
2. **Prevent Fraudulent Coding**: The tool should flag inappropriate coding decisions by comparing what was coded to what actually happened during the visit, alerting the provider to inconsistencies.
3. **Go Beyond the SOAP Note**: Verify that the tool captures documentation beyond the standard SOAP (Subjective, Objective, Assessment, Plan) note. Many CPT® codes require additional details to meet payer requirements for medical necessity.
4. **Certified Auditor Review**: Have your auditing team review sample documentation from complex encounters early in the evaluation. Auditors should validate accuracy in both documentation and coding.
5. **Monitor During Rollout**: As you implement the new scribing software, have auditors closely monitor its impact. This ensures it doesn't negatively affect the revenue cycle, such as causing an increase in claim denials before full deployment.

Conclusion

In an era where AI continues to reshape healthcare, AI scribes can have a wide-ranging impact on CDI performance. A coding-naive AI scribe risks undoing years of CDI progress made by revenue cycle teams. However, a coding-aware AI scribe could become a powerful tool to elevate CDI performance beyond traditional limits. It's crucial for revenue cycle leaders to be involved in their organization's AI scribing initiatives and ensure CDI impact is a key consideration when selecting an enterprise-scale AI partner.

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Stephani Scott, RHIT, CPC, Vice President of AAPC Services, has over 25 years of experience in the healthcare industry, working closely with physicians and staff in health information management. She has worked in a variety of settings including hospital, long-term care, large multispecialty physician practice, and electronic health record software design and development. Scott has extensive experience in inpatient and outpatient auditing and coding compliance and is responsible for overall project performance and client satisfaction. Scott was also a part-owner of a consulting company for many years, providing services in best practices for physician practice management services including coding, billing, and revenue cycle management audits.

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