Definition, History, and Use of the Problem List

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The problem list was first defined and created by Lawrence Weed in the 1960s at a time when care continuity was its primary purpose. Problem lists have become more widely used as a basis for problem-oriented charting, a methodology for clinical documentation embraced by many in the medical establishment. Problem lists were later required as part of the "meaningful use" Electronic Health Record (EHR) Incentive Program (now referred to as "Promoting Interoperability") and have proliferated greatly in their utilization as a result of the implementation of the EHR.

The Centers for Medicare and Medicaid Services (CMS) has defined a problem list as "a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient." Maintaining the problem list is one of the core measures under the eligible professional meaningful use initiatives. The objective of this core measure is to have providers maintain an up-to-date problem list of current and active diagnoses. "Up-to-date" is also defined under this core measure as having the problem list "populated with the most recent diagnosis known."[1] An accurate problem list is critical to providing better patient care across the continuum of care/settings. A problem list should be maintained in order to ensure accuracy, completeness, and integrity.

EHR certification for eligible professionals and hospitals required EHR products to store problem list entries using a designated "CORE" problem list[2] subset of Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) codes.[3] The process for adding problem list entries as SNOMED CT codes varies by EHR vendor. The most common method is for clinicians to choose interface terminology terms mapped to SNOMED CT codes from menus that appear during clinical documentation. In other instances, users choose the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code titles during the documentation process that are subsequently mapped to SNOMED CT codes. A few EHR systems use SNOMED CT terms during the documentation process.

Most EHRs "map" SNOMED CT entries in the problem list back to an ICD-10-CM code that is pre-selected based upon the model setup of the EHR. When two or more terminologies are used during the process of generating the problem list, challenges with accurate mappings may occur, although error rate reductions are possible through the use of advanced mapping techniques.[4] Organizations should have a policy governing the review of these mappings on an annual basis to ensure that the most appropriate codes (specificity, pertinence, and accuracy) are available to the provider. In addition, the organization should consider monitoring the use of unspecified codes and those integral to other conditions or excluded by other conditions in the problem list to be certain that providers are aware that more specified codes are available.

Currently, there is no single standard for the structure or content of problem lists. Clinicians vary in how they prioritize and manage problem list entries,[5] creating further challenges to their use as a source of diagnoses for claims data. However, there are existing standards from organizations like the Joint Commission's Hospital Accreditation Standard and the American Society of Testing and Materials (ASTM) that address content in the problem list which will be discussed later in this document. As a result, healthcare organizations have developed their own policies and procedures, creating a great deal of variability in practice when it relates to the coding and clinical documentation improvement (CDI) domains. This variability, in return, has led to inconsistent practices that affect the accuracy and quality of claims data.

The EHR systems used by some organizations can be set to automatically pull forward all diagnoses from the previous problem list (with or without associated ICD-10-CM codes) that may not be relevant and/or up to date into subsequent encounters. On the other hand, prior to the data being pulled forward some systems may prompt providers to review and/or update the problem list. In either of these instances, a validation process should be included. An accurate problem list should include conditions that were current and active during the encounter. Problems resolved prior to the current encounter should be delegated to the past medical history (e.g., appendicitis that was treated surgically) and be removed from the problem list. In the event that the condition cannot be removed from the problem list, resolved conditions should be identified with a notation like "resolved," "not active," "in remission," or "date condition resolved."

Per the AHIMA Thought Leadership Series "Problem Lists in Health Records: Ownership, Standardization, and Accountability," the problem list may be considered a part of the legal health record depending on how it was generated. Information generated by a provider for patient care is considered a part of the legal health record, while system-generated information based on the abstraction from other parts of the EHR, which may be used for administrative purposes, may have other legal implications. A problem list that is considered part of the legal health record must be produced upon request by a patient and/or third party during a lawsuit.

The following are some contemporary issues with the problem list that should be considered.

Governance, Authorship, and Ownership

Patients frequently receive care from multiple providers from different specialties that may use disparate EHR software platforms. In this situation, it is common for a patient's problem list to vary by setting, which undermines the purpose of the problem list—a central repository of active and chronic conditions for the patient as a whole. Ideally, problem lists and updates would be accessible to all providers across the patient's spectrum of care, but in most settings problem lists are maintained independently in each organization's EHR.

The problem list should be maintained and updated every time the patient is seen by a provider so that the continuity of care is maintained. A patient might not see the same provider, and therefore it is impossible to have continuity of care when a patient's appendicitis remains in the problem list two years later because there is no formalized process in place to review and address outdated entries. It is each provider's responsibility to go through the problem list and validate the status of each condition during each visit/encounter. Best practice would be for all active/current diagnoses to be reviewed with the patient during the encounter. For example, this could be done prior to obtaining and/or reviewing the patient's history to update the status of conditions that resolved between healthcare encounters.

Organizations should develop a policy that outlines who can make entries into the problem list and that determines if the entries are to be considered as clinical documentation to guide CDI and coding practices. Organizations that allow the problem list to be used as clinical documentation need policies that establish processes for updating and/or removing diagnoses resulting from a provider's response to a CDI or coding query. Specifically, they need to address whether editing is permissible by roles other than independent licensed professionals who are able to make medical diagnoses; if so, those roles should be specified in the organization's privileging policies and their responsibilities in terms of authorship should be clearly stated. See below for more on developing organizational policies.

Developing Organizational Policies

These lists are adapted from the AHIMA Thought Leadership Series white paper "Problem Lists in Health Records: Ownership, Standardization, and Accountability."

Organizational policy should be based on:

- Defining the role of the problem list as a tool to support patient care
- Defining the philosophy about patient involvement in their care
- Workflow efficiency and organizational requirements

Organizational policy must be clear about the following:

- Who may add, modify (update), and delete/demote/retire a problem from the problem list?
- Who has access and retrieval privileges of the problem list?
- Safeguards for authentication, security, and reliability.
- Establish a mechanism for "provenance" of the problem list, such as a process that stores the identity of the individual who made or modified a problem list entry, as well as a date and time stamp.
- Changes to the problem list. No one should be authorized to delete/demote/retire (e.g., resolved date) problems from this list without following the standard process for updating, correcting, or amending the health record.
- When updating takes place (items added, archived, or marked as resolved).
- If applicable, linkage to source documents should be permitted.
- Items affecting patient safety (e.g., fall risk) should always be prominently displayed. Ideally, these items appear at the top of any problem list for emphasis.
- The process for creating and using specific "views" of the list to improve functional utility for problem entry, user access, and maintenance efficiency.
- The process for resolving disagreements between providers concerning problem list content.
- The process for accommodating differing views between patient and provider on the list.
- The role of the clinician in this person's care.
- Where the list is viewed and stored.
- How and when the list is maintained for accuracy and completeness.
- Tools or vocabulary sources (if any) required to support interoperability and information retrieval.
- Standards (if any) that govern the use or content of problem lists literacy level.
- Policies for reconciling problem lists received from other organizations in electronic or other form.

Source: Bice, Michael O. et al. "Problem Lists in Health Records: Ownership, Standardization, and Accountability." 2012. http://bok.ahima.org/PdfView?oid=106339.

CDI and coding professionals do not typically modify a provider's documentation in the health record. Some organizations require the provider to update their documentation in the health record in response to a query, while other organizations include the query as part of the legal health record to update a provider's documentation. Ideal practice is to have a provider of record update the problem list. Unfortunately, the effectiveness of using a query to amend the provider's documentation will be limited within the confines of a problem list so organizations may decide to allow CDI and/or coding professionals to update and/or remove problem list diagnoses when supported by provider documentation in response to a query. If an organization grants such permissions to non-practitioners, authorship of such entries should be clearly identified and closely audited for compliant practice. Health information management (HIM) and CDI professionals play an important role in helping to maintain the problem list, but review and oversight by a provider is also required, as inaccurate or outdated problem list entries can impact

patient safety. Therefore, it is important for each organization to have medical staff bylaws that clearly address provider responsibilities in regard to reviewing and updating all documentation in the health record, including the problem list.

While each provider rendering patient care should be responsible for updating the problem list during each encounter, the provider's ability to make accurate revisions to an existing problem list may vary according to their familiarity with the patient and area of practice. Additionally, providers may not have access to all relevant diagnoses due to challenges related to the current state of interoperability. How problem lists are updated may also depend on the capabilities of the specific EHR platform.[6] Managing the problem list can be labor-intensive which means this is often inconsistently performed, which may lead to inaccurate, incomplete, duplicative, and outdated lists.[7]

Hospital and practice scores in the Quality Payment Program's "Promoting Interoperability" performance category require healthcare organizations to import and reconcile electronic summary of care documents, including the problem list. Organizations need to develop policies, procedures, and work flows that optimize the reconciliation process.

Organizations that classify the problem list as clinical documentation need to create an ongoing standardized reconciliation process to synchronize the problem list among providers and across settings. Such a reconciliation process with the use of reporting capabilities may allow a designated individual (example: HIM/CDI professional) to use the Strengths, Weaknesses, Opportunities, and Threats (SWOT) approach to make recommendations to the primary care provider:

1. Identify patients who were seen by a provider in the healthcare system at least twice during the past 12 months. Organizations should establish the level of frequency for this step (i.e., monthly, quarterly, etc.).
2. Compare each diagnosis included on each problem list to documentation available in the applicable health record to confirm, suggest an update, or suggest removal of an included diagnosis.
3. Create a master problem list that includes the recommendations across all reviewed encounters to identify opportunities to consolidate similar diagnoses and remove conditions integral to other diagnoses.
4. Forward the recommendation to the designated provider of record (i.e., provider, nurse practitioner/physician assistant (NP/PA), etc.) for review.
5. Once the master problem list has been approved by the designated provider of record, update the problem list in the patient's longitudinal record of care according to organizational guidelines.

Regulatory Requirements and Compliance

The following offers a summary of problem list regulatory requirements and other compliance initiatives.

The Joint Commission

The Joint Commission's (TJC's) Hospital Accreditation Standard (RC.02.01.07) requires a summary list for each patient who receives continuing ambulatory care services in the health record. This summary list is required to be initiated by the third visit. Even though a summary list is not the same as the problem list, some organizations view both lists to be the same. The summary list may include medical diagnoses, operative and invasive procedures, and any current medications. These content elements potentially require additional provider consideration or intervention. TJC standard requires providers to update a patient's summary list whenever there is a change in diagnosis, medications, and/or allergies to medications and whenever a procedure is performed. TJC also requires the patient summary list to be readily available to other providers so that the appropriate treatment and care can be provided.

ASTM International

ASTM International's Standard Practice for Content and Structure of the Electronic Health Record (E1384-07) indicates that the problem list should contain all past and current diagnoses, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions. The standard also notes that the problem list should be amended as more precise definitions of problems become available.

ICD-10-CM Official Guidelines for Coding and Reporting

The Code Assignment and Clinical Criteria in Section I.A.19 states that the assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

The Reporting Additional Diagnoses guideline in Section III defines "other diagnoses" as additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. The Uniform Hospital Discharge Data Set defines other diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."

Coding

Outpatient coding is often the responsibility of the provider in the office setting without prior review of a coder. Providers in both the outpatient and inpatient setting often leverage a drop-down list within the EHR to select their diagnoses. Often, the selected term along with the associated SNOMED CT or ICD-10-CM code does not fully or accurately represent the concept the provider is trying to enter into the record from a decision tree or pick list. Providers may choose the first available diagnosis on a drop-down list or within a decision tree without realizing that there was a more appropriate selection. Furthermore, the problem list does not contain a provider diagnostic statement, which is required for coding and reporting. Organizations should have a policy for clinical validation that provides situational guidance to coding and CDI professionals as to when a query is indicated. See the Practice Brief "Clinical Validation: The Next Level of CDI," updated in January 2019, for more information on clinical validation. While the problem list should not be solely relied on for coding and query considerations, it should be a point of reference when determining code assignment and physician query opportunities.

Technology Considerations for the Problem List

Where artificial intelligence capabilities such as computer-assisted coding are deployed, organizational practices with regard to the use of the problem list, diagnosis selection drop-down lists, and query language for coding and CDI processes tend to be both complex and variable. Technology that assists with problem list and diagnosis selection may create myriad compliance and regulatory issues that will require manual review and revision by the provider. Organizations should prevent their EHR from automatically pulling diagnoses from the problem list into other documents like the discharge summary or on to claims unless they have a robust process in place that validates the accuracy of the included diagnoses. Key considerations for problem list technology in coding, CDI, and the query process may include but are not limited to the following.

Copy, Paste, and Pull-Forward Functionality

Organizations utilizing copy/paste or "pull-forward" of clinical diagnosis functionality in the problem list should have a policy statement regarding the conditions by which this practice is permitted. For example, are providers allowed to copy/paste or pull forward conditions from previous encounters into the current history and physical and/or other specific documentation? Organizations should also consider performing a quality review of the functionality as part of their ongoing record review to identify opportunities for improvement and providers that may not be reliable users of the functionality per the policy. In 2014, AHIMA published a position paper titled "Appropriate Use of the Copy and Paste Functionality in Electronic Health Records." This position paper cautions that "users of the copy/paste functionality should weigh the efficiency and time savings benefits it provides against the potential for creating inaccurate, fraudulent, or unwieldy documentation."

Artificial Intelligence, Data Mining, and Computer-Assisted Coding Applications

Organizations should clearly define the responsibility for authorship of entries into the problem list and declare the entries into the problem list as clinical documentation if they intend to allow applications utilizing artificial intelligence access to the problem list for purposes of data mining. Additional or updated diagnoses that may be identified through machine learning and natural language processing need to be flagged for review by designated professionals prior to being incorporated into the patient's problem list.

Query Process

Organizations are finding great value in problem list entries in the coding and query process. CDI or coding queries should have traceability of clinical indicators in support of the query and ensure that information used from prior encounters is compliant with coding guidelines and payer regulations. According to the 2019 update of the Practice Brief "Guidelines for Achieving a Compliant Query Practice,"[8] queries using information from prior encounters may be utilized when relevant including, but not limited to, the following situations:

- Diagnostic criteria allowing for the presence and/or further specificity of a currently documented diagnosis (e.g., to ascertain the type of congestive heart failure (CHF) or specific type of arrhythmia)
- Treatment/clinical criteria or diagnosis relevant to the current encounter that may have been documented in a prior encounter
- Determine the prior patient baseline, allowing for comparison to the current presentation
- Establish a cause-and-effect relationship
- Determine the etiology when only signs, symptoms, or treatment are documented
- Verify present on admission (POA) indicator status
- Clarify a prior history of a disease that is no longer present (e.g., history of a neoplasm)

Query templates are frequently embedded in the EHR or workflow software, so CDI/coding professionals must ensure that relevant clinical indicator(s) specific to the particular patient as cited within the health record are applied and referenced appropriately. Additionally, the choices provided as part of the query must reflect reasonable conclusions specific to the clinical scenario of the individual patient. Organizations should also have a policy for retention of queries. See Appendix A: Problem List Examples and Best Query Practices, available in the online version of this Practice Brief in AHIMA's Body of Knowledge at http://bok.ahima.org for more on this topic.

Problem List Success is Important to Quality Patient Care

Problem lists should be standardized and designed to support an interdisciplinary and patient-centered approach for all provider health record entries. An up-to-date and accurate problem list is critical to the success of organizations providing patient care across the continuum of care in all settings. A problem list should be maintained in order to ensure the accuracy and integrity of the data. CMS has defined the problem list as "a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient."[9] The problem list should not be used solely for coding. Every codable diagnosis should contain a provider diagnostic statement with supporting clinical indicators, monitoring, and/or treatment in the record to support such diagnosis. Per the ICD-10-CM Official Guidelines for Coding and Reporting, "the assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists."[10]

Industry standardization will help facilitate interoperability within a healthcare organization. By standardizing and having specific policies and procedures in place, the use of the problem list will be more efficient and meaningful for all providers. Ultimately, the attending/primary provider is responsible for reviewing, reconciling, and updating all documentation related to the patient's care, including the problem list in the health record. It is important for organizations to remember that all entries in the EHR are tracked and this metadata is used to identify who documented and/or updated what within a patient's health record.[11] Furthermore, when designing EHR workflows, organizations should lean on HIM/CDI professionals for guidance on how to improve documentation processes. Involving qualified experts in documentation requirements is the key to standardizing and improving the use of the problem list in all healthcare settings.

Notes

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Acknowledgments

Appendix A: Problem List Examples and Best Query Practices

Professionals issuing queries should review the medication list to see if there is evidence of therapeutic treatment continuing for this patient. If present, the provider should be queried to update the problem list to validate the currency of the clinical diagnosis prior to coding.

Case Examples	Scenario	Risks	Best Practices
An inpatient diagnosis in the problem list and pertinence to the outpatient encounter.	During an annual wellness visit, the primary care physician notes chronic kidney disease (CKD) stage 3 appears on the problem list from hospital discharge that occurred 6 months ago. The problem list has not been reconciled, the provider is not aware of	The standard for query in all settings is whether the condition is still being treated or is affecting the patient's condition. Chronic conditions are those conditions most often reviewed for hierarchical condition category (HCC) reporting, and they often are still	Each facility should develop a policy on how far back it will review prior records and follow that policy in a consistent manner and query the provider to determine if ongoing monitoring or

	this diagnosis and does not document an assessment or management/treatment of this condition.	affecting the patient—hence the word "chronic." Clinical documentation improvement (CDI) professionals and coders must therefore review previous encounters in order to determine clinical relevance based on current signs and symptoms, medications, and recent treatments. Note: Most importantly, this CKD diagnosis impacts the provider's ability to care for the patient—but it also has a risk adjustment factor score (i.e., HCC coding) for this patient.	treatment is being done.
An outpatient diagnosis in the problem list and pertinence to the inpatient encounter.	Cachexia appears in the problem list for a patient admitted to the hospital for abdominal pain and acute blood loss anemia (ABLA). Cachexia was added to the problem list three months ago.	Cachexia is a diagnosis ripe for regulatory scrutiny and the standard for query is whether the condition is still being treated or is affecting the patient condition. The CDI professional or Coder should review the acute care health record to determine if there is additional clinical support for the diagnosis such as the patient being underweight (Body Mass Index (BMI) <19), receiving nutritional supplements, or reviewing a nutritional assessment done by a registered dietician.	Each facility should determine the timeframe by which a diagnosis that appears in the problem list will be valid for consideration in clinical validation and a resulting query.
Clinical Indicator Support for Diagnosis	The patient has a BMI of 17.9 during an established patient visit. The problem list was updated 12 months ago with a diagnosis of Underweight.	The BMI cannot be coded as a secondary diagnosis unless the physician documents a diagnosis or condition relevant to the abnormal BMI. For example, weight loss, undernutrition, anorexia must be coded to provide clinical support.	Each facility should have a policy for all providers to update the problem list to verify that existing conditions are diagnoses and still current. If the coder or CDI professional is unsure as to the currency of the diagnosis in the problem list, then the provider should be queried as to the existence of a clinical condition

			relevant to the abnormal BMI.
Hierarchical Condition Categories	A patient has Major Depression; Single Episode in full remission noted in the problem list from two years ago. The patient is admitted to the hospital with acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD).	The coder/CDI specialist should refer to Official Guidelines for Coding and Reporting definition of secondary diagnoses that require documentation of: • Clinical Evaluation, or • Therapeutic treatment, or • Diagnostic procedures, or • Increased nursing care/monitoring, or • Extended length of stay (LOS). Secondary diagnoses that are documented but do not meet one of these requirements should not be coded.	Professionals issuing queries should review the medication list to see if there is evidence of therapeutic treatment continuing for this patient. If present, the provider should be queried to update the problem list to validate the currency of the clinical diagnosis prior to coding.
Prospective Review and Concurrent Query	The CDI professional notes that a provider entered Atrial Fibrillation in the problem list 14 months ago. Upon review of the medication history, which is also 14 months old, the patient appears to be on Coumadin daily.	Secondary diagnoses that are documented in the problem list but do not meet the requirements for secondary diagnoses outlined in the OCG should not be coded. Because the medication list has not been updated in 14 months, there may not be current clinical support (treatment) for the condition. Further, the atrial fibrillation may not be the condition being treated with Coumadin. Lastly, the diagnosis is unspecified.	Professionals issuing queries should query the provider to update the problem list and provide a current status on the atrial fibrillation along with specificity (chronic, persistent, etc.).
Prospective Review and Retrospective Query	A patient presents for his annual cardiology check-up. A day before the patient's visit, the CDI professional notes that a provider entered Congestive Heart Failure (CHF) in the problem list 13 months ago. Upon review of the medication history (logs for refills), the patient is still on Lasix 20mg. It was also noted in the office visit from 13 months ago that an echo	Diagnoses that are documented in the problem list but do not meet the requirements for secondary diagnoses outlined in the OCG should not be coded. It is important for the diagnosis of CHF to be further specified given that the recent echo that was addressed in the current office note mentioned an EF of 40 percent and patient remains on Lasix 20mg.	The CDI professional identifies an opportunity to further clarify CHF during their prospective review of the chart in preparation of the patient's annual cardiology check-up.

was ordered for the patient's next annual visit. The CDI professional reviews the provider's office note after the patient is seen and notes that the recent echo showed an EF= 40 percent and the patient was sent home to continue Lasix 20mg.		Upon the end of the patient's visit, the CDI professional will review the current office visit note and should query the provider to update the problem list with the highest level of specificity for CHF by providing the echo results.

Driving the Power of Knowledge