Outpatient Clinical Documentation Improvement (CDI): An Introduction

WHITE PAPER

Summary: In order to facilitate the growth of outpatient CDI, the ACDIS Advisory Board has written the following white paper. Its goal is to explain what typically constitutes outpatient CDI, and to discuss ways in which CDI specialists can be leveraged to improve documentation associated with outpatient facility and/or provider encounters, ensuring accurate representation of the quality of those services as well as appropriate reimbursement.

FEATURES

According to a February 2016 survey deployed by the Association of Clinical Documentation Improvement Specialists (ACDIS), only a minority (approximately 10%) of hospitals currently possess an outpatient CDI program. However, survey data also shows outpatient CDI is becoming more common; more than 20% of respondents indicated that they plan to cover outpatient and/or physician services in the next 6–12 months. Clearly, this is an area of growth and opportunity.

But what is outpatient CDI? How is it defined? Some in the industry define outpatient CDI as reviewing documentation in the emergency department (ED) to ensure medical necessity and the solidification of patient status (i.e., outpatient or inpatient). Others focus on review of local coverage determinations (LCD) or national coverage determinations (NCD), as failure to meet coverage criteria can mean denial of Part B facility and provider payment for expensive outpatient surgeries or injections/infusions. For those with Medicare Advantage (MA) contracts, their CDI specialists target diagnoses impacting Hierarchical Condition Categories, or HCCs, a payment methodology associated with patients seen in the physician practice setting. This, too, falls under the umbrella of outpatient CDI.

Outpatient CDI is still being defined, and a variety of opportunities exist regarding the review of provider documentation entered during an outpatient or provider encounter. While this diversity translates into numerous possibilities for CDI expansion, it's also muddied the clarity of CDI's mission in the outpatient setting, and created unrealistic expectations that a CDI department can cover all of these areas simultaneously—especially with the same staffing and training associated with inpatient CDI efforts. This lack of consensus makes it difficult to compare and quantify outpatient CDI to create practice standards.

Outpatient CDI: Where to begin?

Many organizations are recognizing the benefits of CDI efforts that cover documentation challenges found in both the inpatient and outpatient settings. The same code set, ICD-10-CM, is used to report diagnoses regardless of setting. However, the diagnosis codes reported on an outpatient or professional services claim have historically been less significant than an inpatient claim. Now, due to recent changes in CMS payment methodologies, including the implementation of

MA paid under Medicare Part C and the impact of quality of care measures, outpatient payment represents a larger piece of overall hospital revenue. From 2004 through 2011, for example, outpatient services per beneficiary grew 34% and inpatient admissions declined by 8% (MedPAC, 2013).

At a minimum, a CDI specialist working in the outpatient setting must understand the differences between OPPS methodology and the inpatient prospective payment system (IPPS).

Typically, facility outpatient encounters are reported under the outpatient prospective payment system (OPPS), which is paid by the Medicare Part B benefit. OPPS claims depend more heavily upon the Healthcare Common Procedure Coding System (HCPCS) code or codes reported on the claim than the diagnosis code, although only as long as the diagnosis code supports medical necessity for the reported service. At a minimum, a CDI specialist working in the outpatient setting must understand the differences between OPPS methodology and the inpatient prospective payment system (IPPS). If a CDI specialist is planning to expand his or her scope of practice into physician services, he or she should also learn the payment methodologies associated with professional encounters, including the Medicare Physician Fee Schedule and evaluation and management (E/M) coding.

A comprehensive approach to reviewing documentation in all settings can help providers and organizations improve the accuracy of risk scores, which are calculated from the diagnoses reported on these claims. Providers are often confused by CDI efforts that limit their reviews to a particular patient population. If CDI reviews all types of encounters, providers are likely to receive consistent feedback on how their documentation translates into coded data. Additionally, this approach to reviews cultivates a more consistent and comprehensive health record that supports better quality of care and patient outcomes.

As mentioned, outpatient CDI is a very broad concept, encompassing any CDI effort not associated with an inpatient claim. Most hospitals have a significant volume of outpatient services, and it can be overwhelming to determine where CDI efforts have the greatest impact. According to Chapter 6 of the *Medicare Benefit Policy Manual,* "hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature and other services that aid the physician in the treatment of the patient." One way to determine how to best leverage CDI in an outpatient setting is through collaboration with other departments impacting the revenue cycle, including health information management or case management. In the inpatient setting, CDI efforts typically measure their impact using the metrics of improved compliance with quality of care measures or improved financial

measures. Likewise, outpatient CDI efforts are typically based upon an underlying target of quality of care or reimbursement. For example, some questions to consider include the following:

- What is your organization's volume of denials for medical necessity of patient status (i.e., inpatient vs. outpatient), which can result in lost revenue through auditor recoupment?
- What is your organization's volume of denials for outpatient surgical cases due to medical necessity as a covered benefit, which can result in lost revenue?
- Is your organization part of an accountable care organization (ACO) with a physician practice that participates in MA paid under HCCs, which can affect inpatient quality of care measures?

When CDI specialists are stationed in the ED, their mission must be clear to all involved to avoid the temptation of using them as "another pair of hands" to assist with patient care.

There are many factors to consider when determining where to focus initial outpatient CDI efforts. This white paper provides a high-level overview of six focus areas in an effort to inform, educate, and offer ideas to organizations considering an expansion of their CDI department's initiatives.

The ED

The ED sees a significantly higher number of encounters than the inpatient setting, and documentation review must occur very quickly due to quick patient turnaround. When CDI specialists are stationed in the ED, their mission must be clear to all involved to avoid the temptation of using them as "another pair of hands" to assist with patient care. The CDI specialist reviewing ED encounters should work collaboratively with case management and utilization review rather than replacing their services. Organizations benefit from providing all of these services in the ED setting, and each typically has a different focus.

Assigning CDI specialists in the ED can help ensure physician documentation reflects the physician's clinical judgment, demonstrates medical decision-making, and captures the acuity of the patient, which will lead to fewer medical necessity denials. The ED is also the gateway to inpatient admissions, so clear documentation regarding the reason for inpatient care can assist with accurate assignment of the principal diagnosis as well as strengthen the medical necessity of the admission. Additionally, admitted patients are typically at their

worst health-wise during their ED treatment, and often the severity of the patient's condition is lost during the admission process. CDI efforts can help preserve and accurately capture the patient's initial presentation.

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Other benefits of providing CDI services in the ED may include:

- Accurate capture of facility ED level charges (i.e., facility E/M)
- Improved documentation of infusions and injections
- Creation of an accurate problem list starting in the ED
- Improved accuracy of present on admission (POA) indicators
- Improved patient safety due to a complete and comprehensive health record
- Addressing and correcting fragmentation or gaps in patient care during the ED encounter
- Improved documentation supporting observation services as well as observation start times
- Proactive capture of data elements associated with quality of care measures that may be specific to the ED setting (i.e., ED transfer communication) or that also impact the inpatient setting

The role of an outpatient CDI specialist reviewing ED encounters may differ based upon objectives. Some organizations may focus on the impact of ED services on the facility while others may focus on the impact on the provider, for example.

Since CDI specialists understand the relationship between provider documentation and coded data, it may be beneficial to use them to educate the ED nursing team. For example, the nursing team may benefit from learning about documentation requirements related to infusions and injections, as well as the importance of clearly documenting when a condition like a pressure ulcer was POA. Triage notes can also provide valuable information from first responders, including the circumstances of injury, that may be otherwise lost. By comparing provider and nursing documentation to charges, organizations can ensure charges for supplies and medications are appropriate for the services documented.

Ambulatory clinics

Ambulatory clinic encounters, including primary care services, infusion services, diagnostics, ambulatory surgery, and wound care clinics, can also benefit from outpatient CDI efforts.

- Primary care clinics: Primary care clinics are frequently staffed by family practice and internal medicine providers. In this setting, CDI specialists

often review medical records to ensure accurate and complete documentation of diagnoses that impact the HCC assignment and the associated risk adjustment factor (RAF) scores on MA patients; this methodology will be discussed in detail later within this white paper. Depending on the size of the clinic, the provider may be "coding" his or her own claims by checking items on a superbill rather than having a coder assign codes based on the associated documentation. CDI specialists can perform their reviews retrospectively as well as prospectively to ensure physician documentation addresses all acute and chronic conditions during the encounter. Reviews can also identify those patients who have low RAF scores to check whether the low scores are due to insufficient documentation. The benefits of dedicated CDI review include improved overall financial stability and billing compliance within the clinic.

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- Infusion clinics: For accurate billing of services, infusion clinics need documentation of an order for services, the type of infusion, the infusion route and site, and stop and start times, as well as nursing and provider documentation that is consistent. Nursing staff often document services following a provider's order. Because CDI specialists are documentation educators, in this setting they can expand their educational efforts to nursing and ancillary staff, instructing them on the requirements for accurately documenting all the elements necessary to support payment of infusions and injections.
- Diagnostic clinics: Diagnostic clinics that perform colonoscopies may benefit from CDI specialists clarifying the documentation requirements for diagnostic versus screening services. According to CPT guidelines, screening colonoscopies are performed on patients who have no presenting signs or symptoms but have reached the appropriate screening age. In contrast, diagnostic colonoscopies are performed on patients who have presenting signs or symptoms or have a personal or family history of cancer or polyps. It is important for providers to understand this difference, and CDI can assist through education. CDI specialists can also encourage providers to document the specifics of their findings (i.e., additional relevant diagnoses, including the cause of the gastrointestinal bleed and any other symptoms the patient is experiencing) to better support the medical necessity of the colonoscopy. Since CDI specialists are the liaisons between the coding and clinical world, their elbow-to-elbow education in this setting can reduce provider confusion.
- Ambulatory surgical clinics: Surgical clinics can also benefit from outpatient CDI services. CDI specialists can review medical records to ensure medical necessity for outpatient procedures is clearly documented and meets relevant NCD and LCD requirements for the procedure performed. CDI specialists can also assist with initiatives related to bundled payment; for example, the Comprehensive Care for Joint Replacement (CJR) Model is meant to address variation in payment by focusing on "

coordinated, patient-centered care" for Medicare beneficiaries (CMS, March 31, 2016). The model consists of a bundled payment and quality measurement for an episode of care associated with hip and knee replacements. The intent of CJR is to encourage hospitals, physicians, and postacute care providers to work together to improve the quality and coordination of care from the initial hospitalization through the recovery period. This can only be accomplished through accurate and complete documentation throughout the continuum of care (i.e., inpatient, outpatient, and postacute). Documentation and coding impacts cohort inclusion/exclusion in the CJR bundle as well as the total hip arthroplasty and/or total knee arthroplasty quality measure (National Quality Measures Clearinghouse, n.d.). From a care coordination standpoint, much of the supporting documentation for joint replacements is created prior to admission. CDI specialists can help capture documentation for risk adjustment during pre-admit testing and primary care referral. They can also assist in proper documentation after discharge to ensure proper postacute transfer.

- Wound care clinics: For accurate coding and reporting, the provider must document the diagnosis of a wound and its location, including laterality, wound type (e.g., pressure ulcer, chronic ulcer, non-healing surgical wound, etc.) and the cause of the wound, when applicable. CDI specialists can intervene and ensure these conditions are accurately captured.

Diagnostic clinics that perform colonoscopies may benefit from CDI specialists clarifying the documentation requirements for diagnostic versus screening services.

Due to the level of specificity required in ICD-10-CM, there will always be opportunities to improve provider documentation across all types of ambulatory clinics. CDI specialists can identify opportunities for documentation specificity and educate providers on how to appropriately and compliantly document the true health status of their patients. CDI specialists can also develop tools to improve documentation up front, including tip sheets and cards or electronic documentation prompts. By ensuring specificity of codes, an outpatient CDI program can maximize payment and support provision of outpatient services.

Observation services

CMS' 2-midnight rule has resulted in Medicare beneficiaries shifting from the inpatient setting to observation, which is an outpatient service. Unlike the IPPS, where reimbursement is determined by an associated MS-DRG based on ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes, reimbursement under the OPPS is primarily paid under ambulatory payment classifications (APC). The APC rate is determined by the services provided to the beneficiary as reported

using HCPCS codes. CDI specialists who review observation cases also need to understand Current Procedural Terminology (CPT) codes, a subset of HCPCS codes, to accurately report provided services and determine reimbursement.

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As with MS-DRG assignment, not all CPT codes impact the associated APC rate. Each HCPCS code has an OPPS payment status indicator that signifies whether it qualifies for separate payment (status indicator V) or is included in a packaged payment (status indicator N). APCs are developed with the notion that certain ancillary and supportive services should be packaged with the primary service because they are integral to that service. For example, routine supplies, diagnostic tests, implantable devices, and operating room/recovery room charges are all supplemental services that are packaged (i.e., status indicator N) within the reimbursement for the APCs associated with the primary service.

CMS expanded the concept of APCs in January 2015 to include comprehensive APCs, which are designated by status indicator J1 and provide an all-inclusive payment for certain outpatient procedures. The change moves OPPS methodology closer to a true prospective payment system (like the IPPS) and away from a fee schedule system. This methodology change also supports expansion of CDI efforts. The American Hospital Association expressed concern regarding comprehensive APCs, citing they may negatively affect hospital revenue, but they can also encourage hospitals to be more efficient in the delivery of outpatient services.

Although observation services aren't outpatient procedures, they are paid under a comprehensive APC. CMS defined observation services in 1986, and that definition has not changed. The purpose of observation is to allow the provider to determine, through treatment and/or monitoring, whether the patient can be safely discharged or requires inpatient admission.

As is the case with an inpatient admission, CMS has many guidelines associated with determining the medical necessity of observation care and when criteria for payment have been met under APC 8009 ("Extended Assessment and Management"). Although this APC does not require any particular reported diagnosis to justify observation services, it does require at least eight hours of observation care, but

those hours cannot be associated with any other service paid under Medicare Part B (i.e., outpatient services). Additionally, CMS typically only covers up to 48 hours of observation services, which aligns with the 2-midnight requirement for inpatient services (CMS, July 1, 2015). Monitoring the requirements for payment under APC 8009 doesn't typically fall within the scope of utilization review because of its relationship to coded data. As such, many organizations are turning to CDI for support, especially as the volume of patients who receive observation services continues to grow.

E/M services

As ACOs continue to grow as an alternative reimbursement model, many healthcare organizations are starting to offer CDI services to support the billing of provider services.

Although this paper has mostly focused on the impact of outpatient CDI on facilities, providers are also paid under Medicare Part B when they treat fee-for-service Medicare beneficiaries, or under Medicare Part C when they treat beneficiaries enrolled in MA. As ACOs continue to grow as an alternative reimbursement model, many healthcare organizations are starting to offer CDI services to support the billing of provider services. Additionally, many larger physician practices are also realizing the value of CDI efforts to support the complexity of their patient population. Improved documentation in the outpatient setting, regardless of its impact on facility or provider reimbursement, often has an impact on inpatient, outpatient, and professional quality measures.

E/M is one of six sections that comprise the HCPCS Level I CPT classification system, which is utilized by physicians and nonphysician practitioners to describe the services and procedures provided to patients. Clear and concise medical record documentation is critical to provide the patient with quality care and is required to receive accurate and timely payment for furnished professional services. Documentation for E/M services must accurately support the reason for service, medical necessity, and appropriateness of service coupled with the relevant provider (CMS, February 11, 2016).

E/M services require the correct selection of a CPT code that establishes patient type, setting of service, and level of E/M service provided. These items are defined as follows:

- Patient type: Patients are identified as either new or established. A new patient is defined as a patient who has not received professional services from a provider of the same specialty within the same group practice in the previous three years. An established patient has received professional services from a provider of the same specialty within the same group practice in the previous three years.

- Setting of service: E/M services are categorized based upon where the service is provided. These settings include office (outpatient), hospital inpatient, emergency department, and nursing facility.
- Level of E/M service provided: There are two to five levels in each category or subcategory of E/M services. The more complex the care provided, the higher the level within the category.

Documentation of E/M levels includes the following seven components:

- History
- Examination
- Medical decision-making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Providers commit a great deal of thought to their medical decision-making, and the shift from thoughts to a written medium is one of several pivotal areas where CDI can create positive change within the practice of professional services.

The first three components (history, examination, and medical decision-making) are identified as key components and are the drivers for the majority of E/M levels. The components of counseling, coordination of care, and nature of presenting problem are contributory factors. The component of time is only used when counseling and coordination of care are provided, when prolonged services are provided, or when providing critical care services and discharge services.

Within the history component are subcomponents of chief complaint, history of present illness (HPI), review of systems (ROS), and past, family, and/or social history (PFSH). The chief complaint is the reason for the encounter, stated in the patient's own words. The HPI contains eight elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. The ROS contains 14 body systems, while the PFSH contains three major factors, each with multiple components.

The examination component covers the body areas and organ systems and describes the type of examination, including the number of areas and/or systems that are inspected.

A common adage in healthcare is "if it wasn't documented, it wasn't done," and this is the underlying premise for medical decision-making. Providers commit a great deal of thought to their medical decision-making, and the shift from thoughts to a written medium is one of several pivotal areas where CDI can create positive change within the practice of professional services.

Just as patients deserve the benefits of precise and complete documentation while inpatients, they are equally deserving of the same precision in the outpatient setting. Thankfully, ensuring this is relatively easy for CDI. Using the elements contained within the three key components, outpatient CDI efforts can positively affect the specificity of the patient's condition(s) using ICD-10-CM verbiage and the documentation of complete and detailed medical decision-making.

CMS HCCs

Outpatient CDI efforts can include reviewing medical records for accurate and complete capture of diagnoses impacting assigned HCCs, which affect RAF scores for MA patients.

As mentioned previously, outpatient CDI efforts can include reviewing medical records for accurate and complete capture of diagnoses impacting assigned HCCs, which affect RAF scores for MA patients. So what are HCCs? Medicare implemented the CMS Hierarchical Condition Categories (CMS-HCC) model in 2004. Its purpose is to adjust Medicare capitation payments to MA healthcare plans for the health expenditure risk of plan enrollees and to pay plans appropriately for their expected relative costs (CMS, January 8, 2016).

Currently in the Version 22 model, there are approximately 8,800 ICD-10-CM codes that map to approximately 79 HCCs. Each HCC has an associated weight, or "risk factor," that changes annually. The risk factor weights are one element used to determine the premiums paid to an MA plan. Since CMS also uses demographics (age, sex, etc.) and chronic conditions to calculate each member's risk score, it is very important for providers to submit all applicable diagnosis codes. This is an area where CDI specialists can make a difference.

Accurate CMS-HCC payment relies on the submission of all of a beneficiary's relevant diagnoses, as specified by the *ICD-10-CM Official Guidelines for Coding and Reporting*, which are used prospectively to adjust capitation payments. For certain disease groups, CMS uses the logic of families (aka hierarchies) to determine the member's overall risk. In other words, as a beneficiary's chronic condition becomes more complex or severe, he or she will require more healthcare services, so the MA plan would be paid a higher rate to cover the associated expenses. For example, a patient with diabetes has a lower associated risk factor when compared to a patient who has diabetes leading to neuropathy, and whose condition is accurately captured through a code for diabetes with a neurological manifestation.

The HCC model is cumulative, meaning that a patient can have more than one assigned HCC category. Each HCC is factored into the member's risk profile depending on the number of current chronic

disease processes and disease interactions. Disease groups are based on clinically related diagnoses that have similar Medicare cost implications. Each group relates to a specific ICD-10-CM diagnosis (e.g., diabetes), and the RAF equates to the member's health status. Low RAF scores may be an indication of a healthier population—or of inaccurate coding due to a lack of specific documentation. It is vital for providers to document all chronic disease processes and their manifestations (e.g., "diabetes with neuropathy") that are either active or chronic to accurately capture the corresponding RAF.

CDI programs that cover both inpatient and outpatient settings will help improve the accuracy of risk scores and reporting of diagnoses while mitigating risks associated with inaccurate coding.

Timing of documentation is the key to success since MA plans require each member's HCCs to be captured at least once every 12 months. As a result, providers need to be educated on the following:

- Diagnoses must be made in a face-to-face encounter with a patient and should follow MEAT (Monitoring, Evaluating, Assessing, Treating)
- Diagnoses must be clearly stated as a current problem on the date of service
- Diagnoses must be documented each year, ongoing, as each year is evaluated without historical context
- Documentation in the health record must meet coding guidelines
- Health records must be signed and have identifiable credentials (i.e., MD, DO)

Many organizations are realizing that the key to success with risk-based/value-based reimbursement is complete and accurate documentation of diagnoses. CDI programs that cover both inpatient and outpatient settings will help improve the accuracy of risk scores and reporting of diagnoses while mitigating risks associated with inaccurate coding.

HCCs for payment vs. quality measure outcomes

Risk-adjusted outcomes are not just used for capitated payments, but are also the basis of Alternative Payment Models (APM) such as the CMS-HCC model for MA, ACOs, and bundled payment models. The adjustment is based on claims data derived from each beneficiary's claims (Part A and Part B) during a designated time period. CDI staff can improve these outcomes by assisting with the capture of high-quality documentation, which is translated into HCCs across all healthcare settings.

In addition to determining payment in the outpatient setting, CMS uses the HCC risk adjustment methodology as part of several value-based programs that impact both inpatient payments and quality

outcomes across the healthcare continuum. These programs reward providers with incentive payments for providing better care in relation to their peers as measured by improving healthcare outcomes and managing cost across the population.

The global use of condition categories for risk adjustment is a catalyst for expansion of CDI efforts into the outpatient setting, where the focus is often the monitoring and treatment of chronic conditions.

The modified versions of the HCC methodology, which are used in Patient Safety Indicator 90, the Hospital Value-Based Purchasing Program (HVBP), the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Condition Reduction Program (HACRP), the Merit-based Incentive Payment System, and Medicare Spending Per Beneficiary, employ use of the condition categories (CC) without applying the hierarchy component of the HCC risk adjustment model. Each program currently uses different versions (see Table 1 for details) of the condition categories to calculate outcomes. Scoring methodologies, risk adjustment coefficients, and performance periods vary by measure.

Table 1

Hierarchy	No hierarchy (CC only)		
CMS-HCC (APMs)	**HRRP** (effective FY 2017)	**HACRP** (effective FY 2015)	**HVBP** (effective FY 2016)
V22	V8.2	V4.5a	V4.4

The complexity of the various methodologies demands an in-depth knowledge of HCCs and CCs. To achieve optimal outcomes in these measures, CDI specialists must possess an understanding of the associated technical specifications, documentation requirements, and institutional vulnerabilities. Documentation and coding have a significant impact on these claims-based measures, and therefore on an organization's financial well-being. The global use of condition categories for risk adjustment is a catalyst for expansion of CDI efforts into the outpatient setting, where the focus is often the monitoring and treatment of chronic conditions.

Summary

In order to be successful in outpatient CDI, organizations must establish their primary focus area and determine how to measure improvement associated with their efforts. Each organization's priority will differ based on current initiatives and obligations, workflow, and staffing. Understanding the organization's data and how its particular setting affects reimbursement and documentation is key to success. It is also important to analyze current denial trends and identify patterns in the outpatient setting that can benefit from CDI intervention, including provider education.

ACDIS does not recommend that hospitals attempt to implement an outpatient CDI program that addresses all of the areas mentioned in this white paper. Each hospital must decide for itself where to best align its limited resources, including review staff and/or assistive technologies, as well as where its greatest vulnerabilities lie.

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WHAT IS AN ACDIS WHITE PAPER?

An ACDIS white paper discusses CDI best practice, advances new ideas, increases knowledge, or offers administrative simplification. It can be written by an ACDIS Advisory Board member or a smaller subset of the board, or written by external sources subject to board approval. It is less formal than a position paper.