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# FIRST STEPS IN OUTPATIENT CDI

Tips and  
Tools for  
Building a  
Program

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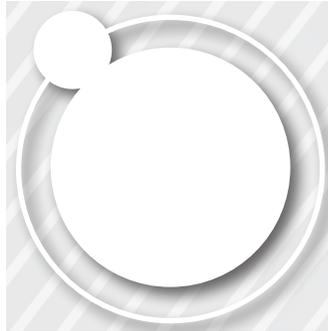
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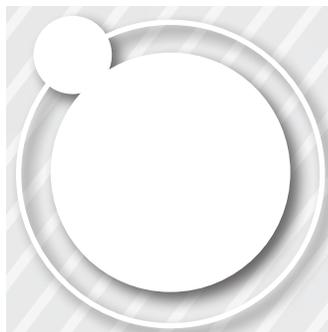


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## About the Authors

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Anny Pang Yuen, RHIA, CCS, CCDS, CDIP, is a clinical documentation improvement (CDI) and health information management (HIM) professional who has extensive experience in healthcare and revenue cycle consulting. She has implemented and re-invigorated many CDI programs nationwide and has also provided onsite CDI support to major health systems.

Yuen serves as the VP of revenue cycle for Intellis. Along with her past inpatient and outpatient CDI consulting experiences, she was previously the corporate director of CDI at a major health system in Philadelphia. In this role, she was responsible for the oversight of four hospitals and was successful in developing a unified and multidisciplinary corporate CDI process focused on improving provider documentation through specialty specific education.

Yuen holds a bachelor's of science degree in HIM from Temple University, where she minored in business, and is an active member of the American Health Information Management Association (AHIMA), the Association of Clinical Documentation Improvement Specialists (ACDIS), and the Philadelphia/Southern New Jersey local ACDIS chapter. Yuen currently serves on the ACDIS Advisory Board as an elected member since 2015. She is a co-author of *The Complete Guide to CDI Management* published by ACDIS/HCPro, has written many articles for the *ACDIS CDI Journal*, and contributed to the May 2016 ACDIS White Paper offering an introduction to outpatient CDI.

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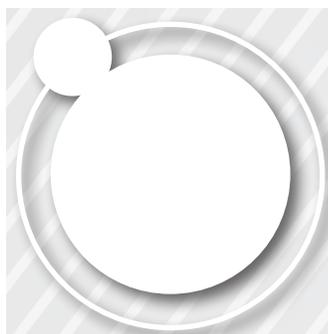
Page Knauss, BSN, RN, LNC, ACM, CPC, CDEO, works as an outpatient CDI specialist. As part of the CDI team, she performs medical record reviews for the Physician Quality Reporting System (now called the Merit-based Incentive Payment System [MIPS]) and educates providers on everything outpatient, including risk adjustment factor, Hierarchical Condition Categories, the Medicare Access and CHIP

## ABOUT THE AUTHORS

Reauthorization Act, and accountable care organizations. She has experience in regulatory, clinical, legal, and administrative areas across multiple healthcare delivery models, including acute care, long-term acute care, long-term care, and the outpatient arena.

After her clinical experience, Knauss moved to Miami where she began working with the Florida Peer Review Organization, then worked at Baptist Hospital in the quality assurance department. She has worked in Atlanta at Vencor Hospital and obtained her legal nurse consultant certificate. While in Washington, D.C., she worked for the U.S. government, at sales and marketing firms, and as a utilization review specialist at Georgetown University Hospital.

Knauss received her bachelor's degree from Skidmore College in Saratoga Springs, New York, and performed her clinical rotations in Manhattan. She was one of the first to achieve the Clinical Documentation Outpatient Expert (CDEO) credential by passing the American Academy of Professional Coders Clinical Documentation Expert Outpatient Beta exam. She is a member of ACDIS, the American Case Management Association, and the AAPC.



# Foreword

## What's in a Name?

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### *Outpatient versus ambulatory clinical documentation improvement*

As a CDI specialist, you may use the words “outpatient” and “ambulatory” interchangeably due to the common use of terms like “ambulatory surgery” and “ambulatory clinics.” However, outpatient care is a broader term that encompasses any healthcare service provided to a patient who is not admitted as an inpatient to a hospital or facility. Outpatient healthcare services may be provided in outpatient clinics, the patient’s home, or hospital outpatient departments.

According to the Centers for Medicare & Medicaid Services (CMS), a patient receives outpatient services if he or she gets treated in the emergency department, observation, or outpatient surgery, or if he or she receives lab tests, X-rays, or any other hospital services and the physician has not written an order to admit that patient into the hospital as an inpatient. Even if the patient spends the night in the hospital, he or she may still be considered as receiving treatment as an outpatient.

Also of note, many national associations—including the Association of Clinical Documentation Improvement Specialists (ACDIS), American Health Information Management Association (AHIMA), and the AAPC—all use the terminology “outpatient CDI.”

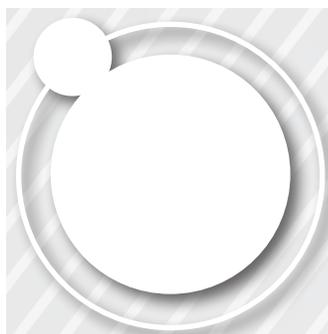
CDI is at a crossroads. As a profession both individually and collectively, we have much work to accomplish in redirecting and refocusing our current CDI processes in achieving documentation improvement. Until we define what CDI truly means, discussion about CDI's success is premature.

As the CDI profession begins to affect the outpatient clinical setting, the words we use matter. As the new world of outpatient CDI evolves, we need clarity to guide our work. Such clarity is essential as we work to provide a framework and to define and demonstrate our impact. Therefore, whether you are involved with an outpatient clinic, observation unit, or ambulatory surgical center (ASC), understand that these clinical settings represent outpatient health services. We need to speak with a confident and

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unified voice within our own organizations, in the consulting arena, or in conversation with other CDI departments. Doing so helps ensure clarity as we develop new outpatient CDI programs and the data analytics to demonstrate our impact on denials prevention, quality metrics, and revenue capture.

As a CDI profession, we need to move forward with clarity and a common vision for the future. We must define our objective and identify our impact and tangible contributions. In addition, it is essential that we continue to interact and collaborate with other professions and departments. Think beyond your boundaries, break the silos, and align your CDI processes and procedures to support compliant coding and billing and improved patient outcomes.



# Introduction

## Exploring Outpatient CDI

---

Over the years, the volume of hospital inpatient services has decreased significantly, with shorter lengths of stay and fewer inpatient admissions as a result. Conversely, the scope and volume of outpatient services is on the rise—and with it comes new opportunity for clinical documentation improvement (CDI) programs.

Yet few hospitals currently review outpatient medical records. According to a white paper by the Association of Clinical Documentation Improvement Specialists (ACDIS) (2016), approximately 10% of respondents indicated their hospital currently possesses some form of outpatient record review. However, survey data also shows that 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 six to 12 months. A follow-up poll (ACDIS, 2017) showed that roughly 9% of respondents currently focus on outpatient CDI.

So what is “outpatient CDI,” and how is it defined?

The truth is, outpatient CDI remains ambiguous. Some define it as reviewing documentation in the emergency department (ED) to ensure medical necessity and the solidification of patient status (i.e., outpatient, observation, 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 affecting Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Categories (HCC), a payment methodology associated with MA patients seen in the physician practice setting.

CDI as a profession continues to progress across the continuum of care. There are various opportunities for reviewing provider documentation, starting with the physician’s office, surgical centers, and EDs, through hospital care, and on to post-discharge settings such as long-term acute care, skilled nursing

## INTRODUCTION

facilities, and even home health. CDI specialists aim to ensure that a given patient's medical record represents that individual's complete healthcare story, beyond the boundaries of a particular setting.

Although this diversity translates into numerous possibilities for CDI expansion, it has also muddied many CDI programs' missions and created unrealistic expectations for CDI departments. Hospital or healthcare system administrators want CDI staff to work their inpatient miracles to cover a wide range of outpatient goals simultaneously—often without additional staffing or training.

To add to the challenge, not only are payment methods different, but patient populations vary as well. The prevalence of certain diagnoses differs from one setting to another, as does the treatment focus for those conditions. Physician workflow and documentation processes also follow very different paths depending on the setting. Such differences make it difficult to identify CDI program structure, workflow, policies and procedures, outcome expectations, and return on investment assessments.

The goal of this book is to serve as an introduction to CDI in the various settings commonly deemed “outpatient.” Specifically, we will discuss reimbursement, regulatory requirements, and quality aspects related to CDI in outpatient services in the emergency department, ambulatory surgery, and physician clinics/practices.

Provider engagement in the outpatient setting presents a host of new challenges relating to the brevity of patient encounters and the unfamiliarity with CDI practices; therefore, we will touch on how to engage providers in these new settings. Next, we will review the process of implementing an outpatient CDI program in your organization, including determining the potential value and ongoing impact of a program. Finally, we will discuss CDI methods in each of the outpatient settings discussed.

Every healthcare organization tries to ensure accuracy and completeness in clinical documentation. In the inpatient setting, we have seen improved reimbursement and quality outcomes due to improved quality documentation. In the outpatient setting, it can be argued that documentation is even more significant: Without appropriate documentation in the outpatient setting, facilities risk not only how much a provider is paid but also whether they are paid at all. There is more at stake in the outpatient world, but there is also more opportunity for CDI.

This book is dedicated to the forward-thinking CDI specialists, coders, providers, and other staff who support CDI programs as they take this crucial step, and as they allow us to improve the quality of clinical documentation and, ultimately, patient care beyond the traditional inpatient settings.

## INTRODUCTION

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Association of Clinical Documentation Improvement Specialists (ACDIS). (2016). Expansion of clinical documentation improvement to outpatient and physician services: A growing trend [White paper]. Retrieved from <https://acdis.org/resources/expansion-clinical-documentation-improvement-outpatient-and-physician-services-growing>

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# The Evolution of CDI

The language that physicians use to describe the care they provide to patients isn't always the same as the language used for medical coding purposes. To address that challenge, clinical documentation improvement (CDI) programs were developed to serve as translators between these two languages and, ultimately, to ensure that a given patient's clinical story is accurately reflected in the codes assigned.

Regardless of care setting, these codes are used in various ways—from reimbursement for physicians and facilities to quality assessments, pay-for-performance measures, and even publicly reported quality data. Most CDI programs, however, started within the walls of short-term acute care hospitals.

In 2007, the Centers for Medicare & Medicaid Services (CMS) created its Medicare Severity Diagnosis-Related Grouping system, which categorized similar patients with theoretically similar treatments and charges together based on each patient's principal diagnosis and up to eight secondary diagnoses. Certain conditions thought to increase the complexity of a hospital stay were classified as complications and comorbid conditions, or as major complications and comorbid conditions (CC/MCC). The more complex care provided, the higher the compensation for it.

In implementing this system, CMS assumed that facilities would aim to improve their documentation and capture those complicated conditions. Then, in the fiscal year 2008 inpatient prospective payment system final rule, CMS clarified that “we do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by the documentation in the medical record ...” (CMS, 2008)

Since then, CDI efforts have grown exponentially. The Association for Clinical Documentation Improvement (ACDIS) has long professed the importance of clinical documentation accuracy as a remedy for healthcare industry challenges. Today, facilities are beginning to understand the return on investment in CDI efforts, which includes both increased financial solvency and improved public perception of the quality of care provided in organizational and professional profiles.

## CHAPTER 1

Today, spurred by the federal government's attempts to rein in healthcare costs and maintain Medicare solvency, the healthcare industry is placing more emphasis on pay-for-performance than on fee-for-service reimbursement. CDI programs are responding by expanding documentation reviews to cover severity of illness/risk of mortality (SOI/ROM), readmission rates, and quality measures.

These concerns, however, are not limited to the care provided within a hospital's walls, so CDI departments are expanding their scope across the continuum of care—to pediatric floors and facilities, to long-term acute care hospitals and skilled nursing facilities, and to emergency departments and physician practices. Of all of these contexts, CDI efforts are growing most quickly in the wide array of outpatient services.

### Why Is Outpatient CDI Necessary?

---

Advancements in medicine and technology shifted a variety of services that were once solely performed in the inpatient setting to the outpatient setting. The Medicare Payment Advisory Committee's (MedPAC) Report to Congress in March 2013 demonstrated that from 2004 to 2011, outpatient services per beneficiary grew 34%, while inpatient admissions declined by 8% (MedPAC, 2013).

The agency's 2016 report revealed a drastic shift to outpatient services since 2006. This analysis reflected a 44.2% increase in outpatient visits per fee-for-service Part B beneficiary compared to a 19.9% decrease in inpatient discharges per fee-for-service Part A beneficiary (MedPAC, 2016).

CMS pays for outpatient encounters under Medicare Part B, according to rules in the outpatient prospective payment system (OPPS). OPPS claims are processed using the Healthcare Common Procedure Coding System (HCPCS), which must support medical necessity for the services provided. CDI departments planning to expand their scope of practice to include physician services need a working knowledge of the payment methodologies associated with professional encounters. Such methodologies include the Medicare Physician Fee Schedule (MPFS) and evaluation and management (E/M) coding, based on which physicians get paid, as well as the International Classification of Diseases, 10<sup>th</sup> Clinical Modification/Procedure Coding System (ICD-10-CM/PCS).

Outpatient CDI is a broad concept and can describe any CDI effort not associated with an inpatient claim. The *Medicare Benefit Policy Manual* states the following:

*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. (CMS, n.d.b).*

## THE EVOLUTION OF CDI

Most hospitals have significant volumes of outpatient services, and it can be difficult to determine where CDI efforts have the greatest potential effect.

Data metrics, such as improved compliance with quality measures or improved financial measures, can help you determine how to best leverage CDI. Reviewing documentation in the various outpatient settings also helps healthcare organizations and providers improve accuracy of risk scores, calculated from the diagnoses coded. Diagnoses—specifically chronic conditions—along with the beneficiary’s demographic information are used to calculate risk scores, which we will discuss later in this chapter.

### QUESTIONS TO CONSIDER

An organization may want to consider the following questions when establishing an outpatient CDI program:

- Is your organization part of an accountable care organization (ACO)?
- Do your providers participate in the Value-Based Payment Modifier Program?
- Do your providers participate in Medicare Advantage?
- Does your organization have access to risk adjustment data (i.e., patient overall risk-adjusted score)?
- Do your providers receive reports from the Physician Quality Reporting System (PQRS)?
- What is your organization’s volume of denials for medical necessity of patient status?
- What is your organization’s volume of denials for outpatient surgical cases for medical necessity as a covered benefit?

### *Shift to quality*

The Patient Protection and Affordable Care Act (PPACA), commonly referred to as the Affordable Care Act (ACA), enacted in March 2010, aimed to improve the cost of and access to quality healthcare. Historically, providers were paid by the volume of services provided. The ACA instead emphasizes the link between provider reimbursement and quality of care, which resulted in the Department of Health and Human Services (HHS) and CMS adopting a quality-focused vision as well.

In January 2015, CMS announced a new quality-driven initiative that paid providers for value, not volume. In partnership with the private sector, the HHS is testing and expanding new healthcare payment models, including the following:

## CHAPTER 1

- Category 1—fee-for-service with no link of payment to quality
- Category 2—fee-for-service with a link of payment to quality
- Category 3—alternative payment models built on fee-for-service architecture
- Category 4—population-based payment

Value-based purchasing includes payments made in categories 2–4. Moving from category 1 to category 4 involves two shifts: increasing accountability for both quality and total cost of care, and a greater focus on population health management as opposed to payment for specific services. Prior to 2011, many Medicare payments to providers were tied only to volume, rewarding providers based on how many tests they ran, how many patients they saw, and how many procedures they did, regardless of whether these services helped the patient. With the reforms under the Affordable Care Act as well as other changes, by 2014, an estimated 20% of Medicare reimbursements had shifted to categories 3 and 4, directly linking provider reimbursement to the health and well-being of their patients. CMS planned for an 85% shift from Medicare fee-for-service to value-based purchasing categories 2–4 by 2016 and 90% by 2018. To help move the healthcare system toward a value-based purchasing model, CMS set a goal of having 30% of Medicare payments in alternative payment models (APM) by the end of 2016 and 50% by the end of 2018.

Reimbursement relies heavily on quality measures and data from programs such as Hospital Inpatient (and Outpatient) Quality Reporting (IQR/OQR) and PQRS. These programs evaluate the quality of patient care and the provider’s ability to manage costs for both the hospital and the provider. All of this, healthcare organizations now acknowledge, depends on accurate documentation of patient diagnoses and treatment plans, regardless of the healthcare setting in which that care was provided.

### Risk adjustment

Risk scores measure an individual beneficiaries’ relative risk, allowing payment adjustments for each beneficiary’s expected expenditures. Risk adjustment is a process in which a third-party payer, such as Medicare, compensates a provider or facility based on the underlying health status of their enrolled beneficiaries or members. The purpose of risk-adjusted payment methodologies is to reward provider efficiency and encourage quality of care for the chronically ill patient population. Risk adjustment is based on claims data derived from each beneficiary’s or member’s claims during a selected time period, usually one calendar year.

## THE EVOLUTION OF CDI

Every patient has his or her own medical complexity, which includes the severity of illness and expected cost to manage their care needs. CDI specialists must ensure that the physician's documentation captures those complexities.

### **RISK ADJUSTMENT CASE EXAMPLE**

A 85-year-old woman who lives at home, participates in aerobic dance and yoga twice a week, is a non-smoker, and has osteoporosis as her only comorbid condition will have a very different rating in risk adjustment than an 87-year-old who lives in a skilled nursing facility, is diabetic, has a history of stage 4 chronic kidney disease, and has chronic obstructive pulmonary disease with a history of smoking. This higher risk adjustment score reflects the higher cost of care expected due to the higher severity of illness.

Many quality measures included in CMS' hospital value-based purchasing program are risk-adjusted, including 30-day mortality and 30-day readmissions. Risk adjustment methodologies and outcomes are not only used for capitated payments but are also the basis of APMs.

#### **CMS-HCCs versus HHS-HCCs**

The most common methodology used in risk-adjustment is CMS' Hierarchical Condition Categories (HCC), which are very similar to the MS-DRG system with which CDI specialists are used to working. Both MS-DRGs and CMS-HCCs are prospective systems, meaning that there are pre-determined payments for different diagnoses, and both use diagnostic information to drive the overall assignment of either the DRG or the HCC.

CMS-HCCs categorize ICD-10-CM codes into disease groups. Each CMS-HCC includes diagnosis codes that are related clinically and have similar cost implications, just as MS-DRGs do. The most recent CMS-HCC version has approximately 8,800 ICD-10-CM codes that map to approximately 79 CMS-HCCs.

CMS-HCCs are solely diagnosis-driven. Procedures do not affect the grouping, which make this approach an ideal fit for CDI specialists who typically focus on diagnoses for documentation improvement on the inpatient side. However, CMS-HCCs are cumulative in nature—even though you only need one heavily weighted diagnosis to boost the DRG for a singular inpatient admission, CMS-HCC diagnoses are extrapolated for many encounters for that beneficiary for a time period (e.g., year) that contribute to the total patient risk score.

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Even though CMS-HCCs reflect hierarchies among related disease categories, unrelated diseases' HCCs accumulate for the enrollee, too, so a patient can have more than one HCC category assigned to him or her.

The patient's risk adjustment factor (RAF) score weighs the patient's demographic information as well as applicable diagnosis codes, particularly those for ongoing chronic conditions that contribute to the complexity of the patient's care. The score is used to predict future healthcare costs for the member—the higher the RAF score, the sicker the patient, and the higher the reimbursement will be. Lower RAF scores may indicate a healthier population, but they can also be a sign of inaccurate documentation and coding.

CMS-HCCs have two components: the hierarchy and the condition category (CC—note this is different from a complication/comorbid condition, which has the same abbreviation). Hierarchies are imposed among related CCs. After imposing hierarchies, CCs become HCCs.

The hierarchy determines reimbursement and consists of families of diseases that are assigned a cost based on severity and anticipated resource use. As a beneficiary's chronic condition becomes more complex or severe, the patient will require more healthcare services. For example, a patient with diabetes that leads to neuropathy will require more services than a patient with diabetes alone, and that patient will therefore have a higher associated risk factor. The Medicare Advantage plan would be paid a rate to cover the associated expenses.

Medicare Advantage (MA) plans require providers to capture each member's HCCs at least once every 12 months, or they could lose the HCCs for that patient. For example, a female with coronary artery disease, diabetes, and cancer has at least three separate HCCs coded, and her predicted cost will reflect increments for all three problems. If that patient only comes to the physician's office once that year, the physician would need to capture all three of these chronic conditions during her visit.

Another type of risk adjustment methodology is the Health and Human Services Hierarchical Condition Categories (HHS-HCC), developed for commercial (non-government) plans. The HHS risk adjustment methodology was finalized in the HHS Notice of Benefit and Payment Parameters for 2014 final rule (78 *FR* 15410), which was published in the *Federal Register* on March 11, 2013. The HHS-HCC risk adjustment methodology calculates a plan average risk score for each covered plan based upon the relative risk of the plan's enrollees. A payment transfer formula is then applied to determine risk adjustment payments and charges between plans within a risk pool, in a given market, within a particular state.

## THE EVOLUTION OF CDI

The HHS-HCC risk adjustment methodology addresses three considerations:

1. The newly insured population
2. Plan metal-level differences and permissible rating variation
3. The need for risk adjustment transfers that net to zero

The risk adjustment methodology establishes concurrent risk adjustment models, one for each age group (i.e., adult, child, infant) and combination of metal level (i.e., platinum, gold, silver, bronze, catastrophic).

Unlike the CMS-HCC methodology, the HHS-HCC uses concurrent diagnoses to calculate the patient risk score. The HHS-HCC uses a similar HCC groupings logic but is refined to reflect the expected risk adjustment population. Unlike the CMS-HCC methodology in which the risk scores represent a member’s overall health status, the HHS-HCC risk scores represent member’s health status and benefit plan selection. All diagnoses/conditions must be documented annually when the plan changes. As a result, the HHS-HCC methodology does not transfer patient data between plans, whereas the CMS-HCC model reports all historical diagnoses/conditions and transfers with the patient between MA plans. (See Figure 1.1 for a chart of a comparison of key elements of these two systems.)

<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; padding: 5px; margin-right: 10px;"> <b>FIGURE 1.1</b> </div> <div> <b>KEY DIFFERENCES BETWEEN CMS-HCCS AND HHS-HCCS</b> </div> </div>	
CMS-HCC	HHS-HCC
<ul style="list-style-type: none"> <li>• Medicare Advantage plans risk adjustment model                             <ul style="list-style-type: none"> <li>– Population includes Medicare Advantage patients</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Commercial risk adjustment model                             <ul style="list-style-type: none"> <li>– Population includes adult, children, and infants</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Funded by CMS</li> </ul>	<ul style="list-style-type: none"> <li>• Funded by members &amp; supplemented by the government</li> </ul>
<ul style="list-style-type: none"> <li>• Prospective data                             <ul style="list-style-type: none"> <li>– Model uses prospective data to predetermine the cost for the next year.</li> <li>– CMS pays a per-member per-month fee to the payer based on the prospective year’s risk scores.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Concurrent data                             <ul style="list-style-type: none"> <li>– Model uses concurrent data to determine patient risk scores (i.e., risk score is calculated based on diagnoses from the same payment year).</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Providers must identify/document all HCC conditions that their patients have in a given year to substantiate a “base year” health profile for each patient that predicts costs in the following year.</li> </ul>	<ul style="list-style-type: none"> <li>• Providers must identify/document all HCC conditions that their patients have in that year. Risk score is calculated for each member but applied in aggregate and will redistribute funds between issuers within state when necessary for that payment year.</li> </ul>
<ul style="list-style-type: none"> <li>• 79 CMS-HCCs                             <ul style="list-style-type: none"> <li>– Range is 1–189</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 127 HHS-HCCs                             <ul style="list-style-type: none"> <li>– Range is 1–254</li> </ul> </li> </ul>

### **CONSIDERATIONS FOR PHYSICIANS**

CDI professionals can help educate providers unfamiliar with HCC documentation concepts and requirements. Both CMS-HCC and HHS-HCC risk adjustment models involve medical diagnoses/conditions that have been treated and/or addressed; therefore, providers should consider the following:

1. Diagnoses must be made in a face-to-face encounter with the patient
2. Documentation of diagnoses should follow MEAT (Monitor, Evaluate, Assess, Treatment) criteria
3. Diagnoses must be clearly stated as a current problem on the date of service
4. Diagnoses must be documented annually, as each calendar year is evaluated without historical context
5. Documentation in the health record must meet coding guidelines
6. Health records must be signed and have identifiable credentials (i.e., MD, DO)

Chronic conditions for risk adjustment have a much bigger role in CMS-HCCs and HHS-HCCs than in DRGs. Take heart failure, for example. In the MS-DRG system, the CDI specialist may find an opportunity to query for added specificity for systolic or diastolic, as well as acuity to optimize the DRG. However, for risk adjustment, the documentation of heart failure in the record yields a CMS-HCC and/or HHS-HCC assignment even without the additional specificity.

The common misconception is that HCCs apply to the outpatient setting only. This is not the case. Documentation to support a condition assigned to an HCC can come from outpatient, inpatient, or professional service documentation. Payers review documentation from every setting for the reporting period for each beneficiary to determine whether a diagnosis should have been reported and is supported in the documentation.

Although conditions count toward a patient's HCCs regardless of treatment setting, documentation and coding specialists need to follow the coding rules applicable to the setting in which the patient was treated and services were provided. Depending on the setting (outpatient or inpatient), documentation requirements for certain diagnoses in the HCC methodology will differ.

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For facilities looking to expand into risk adjustment, first identify which diagnoses will map to which CMS-HCCs and which diagnoses will map to HHS-HCCs. For information about the CMS-HCC methodology, visit the CMS.gov website to find comprehensive CMS-HCC information, including lists of codes and how each diagnosis maps to a CMS-HCC and its associated risk value.

### ADD MEAT TO YOUR DOCUMENTATION

Complete and accurate documentation affects quality, safety, efficacy, and data integrity. Additionally, complete and accurate documentation helps safeguard against audits and denials. However, sometimes it can be a challenge to remember exactly what constitutes a complete and accurate record that establishes the presence of a chronic condition or diagnosis during an encounter.

That's where MEAT comes in. This four-letter acronym can help you remember the factors that must be present in documentation to establish the presence of a diagnosis:

- **Monitor:** Signs, symptoms, disease progression, and disease regression
- **Evaluate:** Tests results, medication effectiveness, and response to treatment
- **Assess/Address:** Ordering tests, discussion, review records, and counseling
- **Treatment:** Medications, therapies, and other modalities

Here are a few documentation examples using the MEAT criteria:

- CHF: "Symptoms well controlled with Lasix and ACE inhibitor. Continue meds."
- Major depression: Patient continues with feelings of hopelessness and anhedonia despite Zoloft 50 mg daily. Will increase dose to 100 mg daily and monitor."

*Source: Rushlau 2016.*

## Value-Based Programs

CMS uses the HCC risk adjustment methodology for a number of its value-based programs. These programs reward providers with incentive payments for the quality of care they provide to Medicare patients. Each value-based program in the outpatient setting uses the HCC model differently—for example, some use condition categories but not the hierarchy. Therefore, scoring methodologies, risk adjustment coefficients, and performance periods vary by measure. The following programs currently use HCCs:

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- Hospital Value-Based Purchasing (HVBP) program
- Hospital Readmission Reduction Program (HRRP)
- Merit-Based Incentive Payment System (MIPS)

### *HVBP*

Under the ACA, Congress authorized the HVBP program. This program uses hospital Inpatient Quality Reporting (IQR) program data to link Medicare's payment system to improved quality of care.

Under the HVBP model, hospitals will be paid based on the quality of care, not based on the volume of services provided. The HVBP looks at historical data to determine payment adjustments, if any, to a hospital's Medicare payment rate for a future fiscal year. There are four performance areas that make up the total performance score used to compare providers:

1. Clinical care
2. Patient-and-caregiver-centered experience of care
3. Efficiency and cost reduction
4. Safety

The total performance score for value-based purchasing is composed of clinical care outcomes and safety outcomes. The clinical care performance area tracks 30-day mortality for conditions such as congestive heart failure, pneumonia, and myocardial infarction. These scores are risk-based and use the HCC model. They are based on an observed-to-expected (O/E) mortality ratio. CDI may affect the expected risk of mortality by obtaining complete documentation and ensuring that it accurately reflects the patient's acuity.

The second area is safety, which primarily focuses on hospital-acquired infections and Patient Safety Indicator (PSI) 90. The key element is to ensure accuracy of the present-on-admission status for all infections and to report all significant conditions. This area is also risk-adjusted.

### *HRRP*

The Hospital Readmissions Reduction Program (HRRP), established under the ACA and implemented in 2012, reduces Medicare payments to hospitals that have excessive readmissions. HRRP tracks the

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frequency of a patient's readmission within 30 days of an initial hospitalization, also known as the "index admission."

HRRP uses the HCC model for risk adjustment. Such risk adjustment is used for Medicare Part C capitation and captures chronic conditions across the continuum of care. The documentation of secondary diagnoses affects risk adjustment because some secondary diagnoses increase the probability of a readmission and may improve the overall O/E outcome ratio. CMS refers to these diagnoses as "risk variables." They can be present in any medical record documentation for up to 12 months, which means that documentation in both the inpatient and outpatient settings are considered when assessing risk scores.

### ***Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)***

On October 14, 2016, the HHS finalized its policy implementing the MIPS and the Advanced Alternative Payment Model (APM) incentive payment provisions in MACRA. The new program, collectively referred to as the Quality Payment Program (QPP), does the following:

- Ends the Sustainable Growth Rate formula for determining Medicare payments for providers' services
- Establishes a new framework for rewarding providers for quality care
- Combines existing quality reporting programs into one system

The program, which began January 1, 2017, requires more than 600,000 clinicians across the country to either participate in an APM, such as an accountable care organization, or join MIPS and regularly submit quality-reporting data to Medicare.

CMS released its proposed rule in the spring of 2016, receiving nearly 4,000 comments—including opposition from the American Hospital Association—with the general concern being that physicians wouldn't have enough time to prepare effectively. In September, CMS announced a "pick your pace" option that allows providers to choose how they will participate in the first QPP performance period. CMS offers physician practices resources and support once they select their reporting plan.

Accompanying the announcement is a new QPP website, which explains the program and helps clinicians identify the measures most meaningful to their practice or specialty.

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### *Band APMs*

The MIPS combines parts of the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier, and the Medicare Electronic Health Record (EHR) incentive program into a single program in which eligible professionals (EP) will be measured on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.

CMS predicts that most providers will select MIPS to link quality and reimbursement in their facility. CMS will factor in performance data reported from each eligible provider and will determine a composite performance score (ranged from zero to 100 points) for each eligible MIPS clinician or group.

In contrast, APMs offer reimbursement alternatives for providers, including lump-sum incentive payments. The program will offer increased transparency of physician-focused payment models and, starting in 2026, offer some participating healthcare providers higher annual payments for meeting quality care standards. According to 42 *CFR* Parts 414 and 495, for performance years 2026 and later, providers may earn a 0.75% fee schedule update for sufficiently participating in an Advanced APM, whereas those clinicians who do not achieve sufficient participation in Advanced APMs will earn a 0.25% fee schedule update and may also be subject to MIPS reporting requirements and payment adjustments.

### **Areas of Potential Focus**

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Regardless of setting, complete and accurate documentation of diagnoses in the medical record is now the single most important factor to ensure success among new payment initiatives. CDI departments have an opportunity to improve the accuracy of patient risk scores and diagnosis coding, which are both vital to the success and financial stability of healthcare organizations.

Seasoned and successful CDI departments are also beginning to explore or consider expanding into the outpatient arena. A complete, legible record has particular significance in the outpatient setting because the documentation is often limited. The provider needs to document properly from the start to ensure a successful and sustainable outpatient CDI program. Many are expanding their existing coverage without additional CDI specialists, so a CDI manager will have to assess where to best leverage initial outpatient CDI efforts and determine the organization's focus. Potential areas of expansion that have been commonly discussed within the CDI industry include the following:

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- Emergency departments and observation services
- Ambulatory surgery and ambulatory surgery centers
- Outpatient clinics/physician practices

### *Emergency department*

Providers in the emergency department see many more patients than do providers in the inpatient setting, and documentation occurs rapidly. Patients in this department may arrive with trauma, so documentation may not occur in real time and may be post-entered once the patient stabilizes. In the emergency department, documentation typically consists of a history and physical, nurse's notes, laboratory reports, and radiology reports. Triage notes can also provide information from first responders, including the circumstances of injury, that may be otherwise lost.

Assigning CDI specialists in the emergency department can help ensure that documentation accurately captures the patient's acuity. The emergency department is also the gateway to potential inpatient admissions. Complete documentation can assist with proper assignment of the principal diagnosis and strengthen the medical necessity of an inpatient admission. Additionally, admitted patients are typically at their "worst" during their treatment in the emergency department, and often the severity of the patient's condition is lost during the admission process if documentation isn't captured appropriately. CDI efforts can help capture and preserve the patient's initial presentation.

For example, a common scenario involves a patient presenting to the emergency room with signs and symptoms of sepsis (e.g., tachycardia, hypotension, fever, etc.), but due to early administration of fluids and/or antibiotics, the patient's condition improves. A CDI specialist can ensure that the patient's sepsis, which was present on admission but has now resolved due to early intervention in the emergency room, is appropriately documented and captured during the inpatient admission.

CMS' 2-midnight rule resulted in Medicare beneficiaries shifting from the inpatient setting to observation, which is considered an outpatient service. CMS defines observation services as follows:

*A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital (CMS, 2006).*

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As is the case with an inpatient admission, CMS has many guidelines associated with determining the medical necessity of observation care. The criteria for payment of observation services can be found under comprehensive-APC 8011 (comprehensive observation services). Any clinic visit, emergency department visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital, in conjunction with observation services of eight or more hours, will qualify for comprehensive payment through C-APC 8011.

The purpose of observation is to allow the provider to gather more information through treatment or monitoring to determine whether the patient can be safely discharged or requires inpatient admission. The CDI team can help ensure that the proper documentation, including diagnoses and treatment plans, is captured to justify the observation status.

### *Ambulatory surgery*

Ambulatory surgery and pre-admission testing include pre-scheduled patient visits. Typically, a patient will have a physician order at the time of pre-admission testing, requesting lab work or X-rays. On the day of surgery, the surgeon should already have documented a history and physical pertaining to the patient's condition as well as the need for surgery. This documentation is typically completed prior to the surgery. On the day of surgery, an anesthesiologist documents an assessment of the patient. The surgeon then completes an operative note following the completion of the surgery. The operative note may (or may not) include a definitive diagnosis if the surgeon is waiting for a pathology report.

CDI specialists in this setting may consider reviewing the surgeon's history and physical to ensure that medical necessity for the outpatient procedures is clearly documented and meets relevant National Coverage Determination (NCD) and Local Coverage Determination (LCD) requirements. NCDs and LCDs will be further discussed in Chapter 3.

CDI specialists can also assist with initiatives related to bundled payments. Medicare has four Bundled Payments for Care Improvement (BPCI) models, each linked to payments for the services provided to a patient during an episode of care. These models aim to ensure that healthcare organizations accept both financial and performance accountability. Bundled payments include some outpatient procedures, such as back and neck, hip and femur, and cardiac procedures. CDI specialists can ensure that all documentation is complete and specific across the continuum of care post-surgery.

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### *Outpatient clinics/physician practices*

CDI efforts may be undertaken in outpatient clinics, which typically include primary care services, infusion services, diagnostics, and wound care clinics. The Veteran Health Administration (VHA) also implemented Community-Based Outpatient Clinics (CBOC) to make access to healthcare easier for veterans so that they don't need to deal with the hassle of visiting a large medical center. Family practice and internal medicine providers frequently staff primary care clinics. In this setting, CDI specialists often review medical records to ensure that documentation captures diagnoses that affect CMS-HCC assignment and associated RAF scores for Medicare Advantage patients. Furthermore, CDI can help capture the preventive care and/or screening quality measures that CMS requires. For example, a CDI specialist can ensure that the documentation of preventive care and/or screening for blood pressure and follow-up is appropriately documented in the outpatient clinic (i.e., at a wellness visit). Other preventive care quality measures also include influenza immunization and body mass index screening/follow-up that can be easily captured in the outpatient clinic.

Depending on the size and type of clinic, the provider may assign their own ICD-10 and HCPCS codes by checking items on a superbill, also known as a "charge slip," to submit a claim for a patient's encounter for reimbursement rather than using the services of a coder to assign codes. A superbill is often used by providers in settings such as outpatient clinics because, depending on the services rendered, such clinics often use a predefined list of commonly used codes and charges. Therefore, there is an opportunity to review the superbill form for documentation specificity and acuity for accurate reporting.

A CDI specialist can perform reviews retrospectively as well as prospectively, to ensure that physician superbill documentation addresses all acute and chronic conditions during the encounter. Reviews can also identify those patients who have low RAF scores to determine whether the scores are accurate and whether documentation is sufficient.

Documentation for infusion clinics includes the order for services, the type of infusion, and the route, site, stop, and start times. Consistent nursing and provider documentation are necessary to bill these services accurately. Services provided in an infusion clinic are often documented by nursing staff following the provider's order. CDI specialists in this setting can expand their educational efforts to nursing and ancillary staff, instructing them on requirements for accurately documenting elements necessary to support payment of injections and infusions.

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CDI specialists in diagnostic clinics, such as gastroenterology, can help clarify documentation for diagnostic versus screening services. According to the CPT Guidelines on Procedure Coding, screening colonoscopies are performed on patients who have no presenting signs or symptoms related to the digestive system 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. CDI specialists can also encourage providers to document the specifics of their findings, including relevant diagnoses and other symptoms, to better support the medical necessity of the colonoscopy.

In wound-care clinics, CDI can help educate providers regarding the required documentation of the diagnosis of a wound and its location, including laterality, type of wound, and its cause, when applicable.

Due to the level of specificity required in ICD-10, there will always be opportunities to improve provider documentation across all types of ambulatory clinics. By ensuring code specificity, an outpatient CDI program can maximize payment and support provision of outpatient services.

### *Physician practices*

Many healthcare organizations are starting to offer CDI services to support billing of provider services. Additionally, many larger physician practices see the value of CDI efforts in supporting the complexity of their patient populations. Most provider documentation currently lacks the specificity to support the treatment and maintenance of chronic conditions and medical necessity. Such incomplete documentation and outdated problem lists are areas of opportunity in physician practices.

## Summary

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Patients typically present to one of these many outpatient settings before arriving at the inpatient hospital setting. Therefore, CDI professionals have an opportunity to affect reimbursement and quality of care across the healthcare continuum. CDI should have specific strategies in place for reviewing documentation in each of these unique settings. We will discuss potential areas of expansion in depth later on in this book.

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**Medical necessity:** CDI can help ensure that the reason for outpatient clinic services is clearly documented and meets relevant national coverage determinations (NCD) and local coverage determinations (LCD) requirements for the procedure performed. CDI specialists can help clarify whether outpatient services, such as a mammogram, are performed for diagnostic reasons or for screening purposes.

### Opportunities for CDI Intervention

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The role of an outpatient CDI specialist reviewing documentation in the outpatient clinics may differ from one organization to another and from clinic to clinic. Infusion clinics may focus on documenting infusion times, wound care clinics may focus on diagnosis specificity, and primary care clinics may focus on accurately capturing the provider's assignment of E/M codes and diagnosis specificity.

Outpatient clinic visits are short but, in some cases, recurrent, so concurrent intervention can be challenging due to lack of physician documentation. Generally, there is opportunity to intervene at the point of care or just after the patient's visit. For CDI interventions to succeed, CDI professionals must understand each clinic's documentation process.

### Staffing Considerations

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When seeking a CDI specialist to focus solely on outpatient clinics, look for someone who has a clinical background and a strong working knowledge of E&M/CPT/HCPCS coding, outpatient coding guidelines and CMS-HCC/HHS-HCC coding. The candidate must have a strong working knowledge of NCDs and LCDs. He or she should also possess critical thinking skills and be able to adapt to a fast-paced environment. This candidate will need to be able to prioritize tasks and effectively and quickly resolve any issues due to the volume of patient visits. A successful CDI specialist will be able to approach any provider to ask for clarification.

Establish a CDI escalation process to incorporate the documentation process flow that is specific to the clinic, and identify a physician advisor who can help in this escalation process in the outpatient clinic.

### *Physician clinics*

#### Documentation processes in physician clinics

Documentation in physician clinics begins when the patient makes an appointment. Patients are pre-registered, and basic demographic information is filled in ahead of time. When the patient arrives for the appointment, he or she may have the option to confirm information or fill out a patient questionnaire, including medical history and any current conditions, symptoms, or medications.

During the appointment, the first piece of documentation is likely to be nursing notes for an initial exam. Depending on the nature of the appointment, vital signs, blood work, or other labs for screening and diagnostic purposes may be performed. The provider then completes a physical exam and should document any significant findings, diagnoses, orders for further tests or specialty appointments, and orders for medications. At the end of the appointment, the physician completes a patient summary before handing the record over to billing for processing.

In some smaller physician clinics, the providers themselves may code and bill their own records.

### *Documentation to consider*

#### Problem list

The problem list summarizes a patient's major medical conditions and surgical history. However, it is not always maintained, and it may contain resolved conditions or a duplication of conditions due to inconsistent specificity by the provider. In most electronic health record (EHR) systems, the date of onset and resolution should automatically update next to each problem, but many are finding that these dates are not always correct. CDI staff have the opportunity to clarify whether conditions are present or resolved.

#### History and physical

The patient's medical history and physical exam may include helpful information to support a diagnosis' medical necessity. However, history and physical information in the physician practice setting is often unclear and incomplete, and it may only include the patient's symptoms. If a definitive diagnosis is not provided at the end of the patient's exam, the provider should document any conditions that are ruled out, probable, or possible, or opt not to establish a diagnosis at the time of the exam.

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### Medication lists

CDI specialists may identify undocumented chronic conditions being managed by a medication. For example, long-term use of insulin could prompt a query to obtain an associated condition of diabetes. Undocumented chronic conditions may affect the overall risk adjustment factor score and CMS-HCC/HHS-HCC assignment.

### Physician orders

Orders are the provider's instructions for treatment, which may include medications, diagnostic tests, and laboratory tests. CDI specialists identify undocumented diagnoses associated with these physician orders. For example, if a provider orders a prescription, the CDI specialist should consider a provider clarification to document the associated diagnosis in the provider progress note.

### *Opportunities for CDI intervention*

There are several opportunities for CDI intervention in the physician clinic. Intervention can occur concurrently, prospectively, or retrospectively. In the concurrent model, a few approaches may be considered. For example, in the physician clinic, there may be different types of concurrent reviews due to the provider's level of comfort with CDI and existing data entry workflows. Some providers may not want a CDI specialist to be in the room during the patient encounter. Therefore, one approach is to have a CDI specialist review a patient's medical history one day before the scheduled visit. A schedule is typically accessible by service dates, so the next day's list of patients should be available to the CDI team. Please keep in mind that this schedule does not include the same-day sick visits that are added at the last minute; therefore, it is important to get a new schedule on the day of the visit to identify any missed reviews.

Some electronic health records do not allow anyone to open an outpatient visit until the patient is being actively seen in the office. As a result, when designing the CDI workflow, it's important to investigate the full capabilities of the CDI tracking tool and the electronic health record. Will the CDI specialist be able to log their initial review in the tracking tool, issue queries to the providers through the electronic health record prior to the day of the patient's visit, and follow up on the day of the encounter? Or should the CDI specialists identify a patient's chronic health conditions and/or abnormal findings prospectively, send the provider a note before the patient's visit to remind them to capture all of the conditions that will be addressed on the day of the patient's visit, and then perform a concurrent review on the day of the encounter to ensure that everything was documented correctly?

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Another concurrent model may involve a CDI specialist being assigned to a provider so that the workflow is synchronous with the patient's visit. The CDI specialist follows the patient schedule and looks for any documentation clarification opportunities. The CDI specialist concurrently takes notes (e.g., history, assessment, treatment plan) and provides any feedback or recommendations on the provider's documentation at the time of the patient encounter. For example, the CDI specialist can quickly evaluate whether the provider documented and selected the most specific diagnosis within the electronic health record (EHR). Because the CDI specialist was in the room, he or she can immediately identify diagnoses that were discussed during the visit but missed in the documentation.

Concurrent CDI reviews in the physician clinic provide opportunities for the CDI specialist to perform immediate verbal queries. These real-time queries help avoid inaccurate documentation and post-date addendums. They also affect the final coding of the E/M level and/or diagnoses.

Another model is a retrospective process, which occurs after the patient's encounter. As mentioned above, some electronic health records do not allow anyone to open the patient's visit until the patient is being actively seen in the office. Therefore, the CDI specialist will perform a complete CDI review after the provider has seen the patient, which means that no real-time interaction with the provider occurs during the patient's visit. As in an inpatient CDI review, the CDI specialist queries the provider for any clarification after the initial documentation is completed.

This process involves some investigation into how the claims are dropped. If the provider closes an encounter upon the completion of the face-to-face visit with the patient, does the claim get dropped immediately, or will a claim edit need to be created to ensure that all patient encounters are reviewed by a CDI specialist prior to billing? Additionally, does this review occur immediately after the patient's visit to ensure that the review is as immediate as possible? For example, if a CDI specialist is paired with one provider, they follow the patient schedule and review immediately what was documented and issue any clarifications on the same day. The goal is to have the provider clarify any documentation gaps before the claim is submitted. Of course, with the retrospective methodology, most providers find it cumbersome to re-enter the patient's record to change their documentation. That is where creativity comes into play when building an outpatient CDI workflow.

### ***Staffing considerations***

When seeking a CDI specialist in the physician clinic, look for someone who has either a clinical background or a strong working knowledge of outpatient coding guidelines and CMS-HCC/HHS-HCC

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stratification methods. The candidate must have a strong working knowledge of NCDs and LCDs. He or she should possess critical thinking skills and be able to adapt to a fast-paced environment. Due to the volume of patient visits, this candidate will need to be able to prioritize tasks and effectively and quickly resolve any issues.

An effective CDI specialist should not be afraid to approach any provider to ask any question—for most CDI departments, success is due to provider interactions and building these relationships. Establish a CDI escalation process to incorporate the documentation process flow specific to the physician practice, and identify a physician advisor within the practice to help ensure the CDI team’s success.

Staffing will depend on the volume of patient encounters, number of providers, and opportunities identified. If a physician practice is part of an organization that has an established CDI department, a CDI specialist in the physician practice setting should ideally report to a CDI manager or director. Such a reporting structure will support career growth and expansion of knowledge into the outpatient setting within a CDI department. If the physician clinic is not part of an organization that has an existing CDI department, a physician clinic CDI specialist may report directly to the practice’s manager or director.

With that in mind, note that the qualifications for a CDI specialists may be reduced due to a private practice’s ability to pay for a seasoned CDI specialist. Some practices have incorporated licensed practical nurses (LPN), medical assistants, and/or scribes into their own CDI process instead of hiring the traditional RN-, BSN-, RHIA-, or RHIT-credentialed CDI specialists.

### *Potential challenges in outpatient clinics*

The key to provider buy-in is to support the provider’s productivity and ensure that their relative value units will not be affected by the CDI workflow. Therefore, it is important to evaluate everything, from who enters the initial patient information to when and how the providers enter their patient information into the health record.

In outpatient CDI, you may need to consider partnering with the “medical scribe” or the LPN who performs the bulk of the clinic’s documentation. Medical scribes are frequently found in such settings because the demands of documentation in the EHR have become overwhelming for some providers, making it difficult to fulfill all of the documentation/clerical responsibilities while also maintaining quality face-to-face patient care. In essence, the medical scribe is a personal assistant who can help gather and perform documentation duties on behalf of the provider. Of course, at the end of the day, the provider is responsible for validating and signing off on the documentation; therefore, it is important

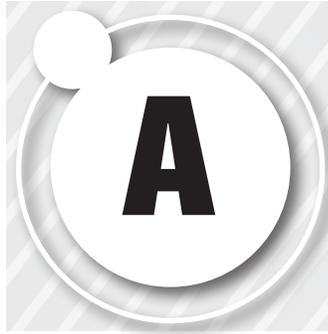
## CDI IN PHYSICIAN PRACTICES

to understand their current workflow and the organization's acceptance of the "scribes" documentation. For example, is there a policy and procedure indicating that the scribe's documentation must be reviewed, validated, and co-signed by the provider?

Another difference in the clinic setting is that most providers assign codes within the EHR, and unless there is a built-in review edit, most of these encounters are billed based on the provider's code selection. Most EHR systems utilize a drop-down list of all diagnoses, and typically the first-listed ones are either non-specific diagnoses or frequently used diagnoses. The intent of these lists was to make the provider's life easier so that they could avoid additional typing and scrolling; however, it failed to recognize the importance of documentation specificity. Therefore, CDI professionals will have the opportunity to educate the provider on documentation requirements related to outpatient specific guidelines and explain why it is different from the inpatient coding guidelines about which they are accustomed to hearing.

Another potential challenge in the clinic is the lack of a CDI tracking tool and reporting capability. This is the case especially if the physician clinic hired its own CDI specialist. As a result, reporting CDI efforts may be a challenge, and it may be very difficult to prove success. Understanding your specific data requirement from start to finish of a clinic review will help build your CDI process flow, improve the build of specific reports related to CDI efforts, and increase their effectiveness.





# Glossary

## A

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**Accountable care organization (ACO):** A model of healthcare delivery and payment. Voluntarily formed network of providers who are jointly held accountable for providing coordinated care and for achieving measured quality of care while reducing spending. These providers receive a share of the savings.

**Accreditation Association for Ambulatory Health Care (AAAHC):** An organization that offers accreditation programs for ambulatory/outpatient organizations.

**Advanced alternative payment model (Advanced APM):** A model that requires significant financial risk on the part of the eligible clinician for providing coordinated, high-quality, efficient care to patients with Medicare Part B.

**Advancing Care Information (ACI) Performance Category:** Category that was previously called meaningful use, or MIPS. Proposed for January 1, 2017.

**Affordable Care Act (ACA):** Officially known as the Patient Protection and Affordable Care Act of 2010.

**Alternative payment model (APM):** APMs are new approaches to paying for medical care through Medicare. They incentivize quality and value.

**Ambulatory payment classification (APC):** A Medicare payment system for the outpatient prospective payment system (OPPS) that classifies outpatient services into a resource-based reimbursement system. The payment unit is the ambulatory payment classification (APC) group.

**Ambulatory payment classification group (APC group):** The payment unit for the ambulatory payment classification system. Within each APC group, the diagnoses and procedures are organized by similar terms, resources used, conditions, and illness complexity.

**Ambulatory surgery:** Outpatient surgery or surgery that does not require an overnight hospital stay.

## APPENDIX

**Ambulatory surgery center (ASC):** A freestanding outpatient facility where outpatient surgeries are performed.

**American Academy of Professional Coders (AAPC):** Professional association for coders.

**American Health Information Management Association (AHIMA):** The professional association of the health information management industry. AHIMA helps set standards and best practices for medical coding, health data management, and information privacy, and it also offers a variety of professional certifications.

**American Hospital Association (AHA):** A professional association that seeks to promote quality health-care provision by hospitals and healthcare networks through public policy and providing information.

**American Hospital Association (AHA) Coding Clinic for HCPCS:** Official coding guidance for Healthcare Common Procedure Coding System (HCPCS) Level II procedures, services, and supplies.

**AHA Coding Clinic for ICD-10-CM and ICD-10-PCS:** A quarterly publication by the American Hospital Association to provide coding guidance for the International Classification of Diseases, 10th Revision, Clinical Modifications/Procedure Coding System (ICD-10-CM/PCS).

**American Medical Association (AMA):** The largest association of physicians and medical students in the United States. It was founded in 1847 and incorporated in 1897.

**American Recovery and Reinvestment Act (ARRA):** Also known as the Recovery Act, signed into law on February 17, 2009. The ARRA was an unprecedented effort to jumpstart our economy, save and create millions of jobs, and put a down payment on addressing long-neglected challenges so that our country can thrive in the 21st century.

**Appeal:** A process in which a provider or organization can submit a request to a health plan to reconsider the denial of a claim (i.e., health plan's decision to deny payment for specific patient care).

## B

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**Beneficiary:** A person or individual who is covered by a health insurance plan.

**Bundling:** A lump-sum payment for a combination of medical visits associated with specific procedures or services.

**C**

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**Category I CPT Code:** A Current Procedural Terminology (CPT) code that represents a procedure or service that's consistent with contemporary medical practice and/or performed by many providers.

**Category II CPT Code:** A Current Procedural Terminology (CPT) code that represents services contributing to quality patient care. These are supplementary tracking codes that can be used for performance measures.

**Category III CPT Code:** A Current Procedural Terminology (CPT) code that represents emerging technology and/or services and procedures. These are temporary codes.

**Centers for Medicare & Medicaid Services (CMS):** Part of the Department of Health and Human Services. Administers Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

**Certified clinical documentation specialist (CCDS):** The CCDS credential provides a mark of distinction for this unique profession.

**Certified Electronic Health Record Technology (CEHRT):** A designation given to electronic health record products that meet specified structured data standards and technical capabilities, functionality, and security; the Office of the National Coordinator (ONC) manages the requirements for certification as spelled out under the Health Information Technology for Economic and Clinical Health Act. Providers who participate in the CMS electronic health record (EHR) Incentive Program (meaningful use) must use Certified Electronic Health Record Technology to qualify for payment.

**Children's Health Insurance Program (CHIP):** A medical coverage source for individuals under age 19 whose parents earn too much income to qualify for Medicaid but not enough to pay for private coverage.

**Claim:** A medical bill/itemized statement of healthcare services that is sent to an insurance company for payment.

**Claim form:** A form that is completed and submitted to the insurance company for payment of specific procedures/services.

**Clinical documentation improvement (CDI):** The process of improving healthcare records to ensure improved patient outcomes, data quality, and accurate reimbursement. The profession was

## APPENDIX

developed in response to the Centers for Medicare and Medicaid Services (CMS) Diagnostic-Related Group (DRG) system.

**Clinical documentation specialist:** Clinical documentation specialists understand a wide range of specialized disciplines, including education in anatomy and physiology, pathophysiology, and pharmacology; knowledge of official medical coding guidelines, CMS, and private payer regulations related to the inpatient prospective payment system; an ability to analyze and interpret medical record documentation and formulate appropriate physician queries; and an ability to benchmark and analyze clinical documentation program performance.

**CMS-1500:** Universal insurance claim form developed and approved by the American Medical Association and CMS. Providers utilize this form to bill Medicare, Medicaid, and private insurers for professional services provided.

**Coding Clinic for ICD-10-CM/PCS:** Official coding guidance for the International Classification of Diseases, 10th Revision, Clinical Modifications and Procedure Coding System (ICD-10-CM/PCS) diagnosis and procedure codes.

**Computerized provider order entry (CPOE):** Health information technology capability through which clinicians enter medication, test, and procedure orders directly into the EHR system. CPOE provides standardized, legible, and complete orders, and it frequently applies clinical decision support to help providers avoid errors or retrieve relevant supporting information.

**Current Procedural Terminology (CPT) codes:** A coding system used to describe/report diagnostic and surgical procedures and services provided. This coding system was created and is maintained by the American Medical Association. This coding system is updated annually and goes into effect every January 1.

## D

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**Department of Health and Human Services (HHS):** A cabinet-level department of the U.S. federal government. Its goal is to protect the health of all Americans and provide essential human services. Provides effective health and human services and fosters advances in medicine, public health, and social services.

**E**

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**Electronic healthcare records (EHR):** A digital version of a patient’s paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. Although an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider’s office and can include a broader view of a patient’s care.

**Electronic medical records (EMR):** A digital, systemized collection of longitudinal patient data records for an organization. Data collected includes demographics, progress notes, medications, vital signs, medical history, and lab and radiology reports. Sometimes used synonymously with EHR. EMR systems have various value-added capabilities such as clinical decision support and computerized provider order entry.

**Eligible providers (EP):** Under the Physician Quality Reporting System (PQRS), covered professional services are those paid under or based on the Medicare Physician Fee Schedule (PFS). To the extent that eligible professionals are providing services that get paid under or based on the PFS, those services are eligible for PQRS incentive payments and/or payment adjustments. EPs include physicians, practitioners, and therapists.

**Emergency department (ED):** Medical treatment facility specializing in emergency medicine—the acute care of patients who present without prior appointment, either by their own means or by ambulance.

**Encounter:** A documented, face-to-face contact between a patient and a provider who exercises independent clinical judgment in providing services to the individual. As part of an encounter, the services rendered must be documented.

**Evaluation and management (E/M) codes:** Current Procedural Terminology (CPT) codes that describe patient encounters with a provider. Providers are required to use E/M coding to be reimbursed for these patient encounters.

**F**

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**Fee-for-service (FFS) reimbursement:** Payment model in which services are unbundled and paid for separately. In healthcare, it creates an incentive for physicians to provide more treatments because payment depends on the quantity of care rather than the quality of care.

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**Fiscal intermediary (FI):** A local payment branch of the Medicare program. These intermediaries are either public or private companies that CMS contracts to act as agents of the federal government in dealing directly with providers of Medicare services.

## H

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**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs. Passed by Congress in 1996.

**Health Information Technology for Economic and Clinical Health (HITECH) Act:** Enacted as part of the American Recovery and Reinvestment Act of 2009, it was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

**Healthcare Common Procedure Coding System (HCPCS):** A coding system created and maintained by CMS that provides codes for services, procedures, and/or supplies not represented by a CPT code.

**Hierarchical Condition Category (HCC):** A payment methodology based on “risk” used by CMS to adjust Medicare Advantage health plan payments at the patient level. This means that two patients within the same community can have a different payment rate based on several factors relating primarily to the amount of risk—or work—it takes to maintain the patient’s health. This model prospectively estimates the future year’s predicted costs for enrollees.

## L

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**Local coverage determination (LCD):** Policies about reimbursements and medical necessity that are established by regional fiscal intermediaries and may vary from state to state. LCDs provide information on what diagnoses justify the medical necessity of a specific service/test.

**M**

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**Managed care:** Payment methodology that third-party payers have implemented to control the costs of healthcare while maintaining quality of care.

**Meaningful use (MU):** Using certified electronic health record (EHR) technology to do the following: Improve quality, safety, efficiency, and reduce health disparities. Engage patients and family. Improve care coordination and population and public health. Maintain privacy and security of patient health information. (Name will be changing to Advancing Care Information-ACI Performance Category, proposed for January 1, 2017.)

**Medical necessity:** Healthcare procedures/services and supplies that are acknowledged/justified as reasonable, necessary, and/or appropriate in the diagnosis and/or treatment of a health condition.

**Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):** Establishes a new way to pay doctors who treat Medicare patients, revising the Balanced Budget Act of 1997. In April 2016, HHS issued a notice of proposed rulemaking to implement MACRA.

**Medicare Administrative Contractor (MAC):** Private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or durable medical equipment (DME) claims for Medicare fee-for-service (FFS) beneficiaries.

**Medicare Advantage (MA) plans:** Optional managed care plan for Medicare beneficiaries who are entitled to Part A and are enrolled in Part B. MA plans (also known as Part C plans) are offered by private companies approved by Medicare.

**Medicare Shared Savings Program (MSSP):** Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an accountable care organization (ACO).

**Merit-based Incentive Payment System (MIPS):** Participation compares the entire pool of MIPS-eligible clinicians against each other for payment adjustments (+ or -) to Medicare Part B dollars.

**Modifier:** Two-digit codes that can be alpha/alphanumeric/numeric that help describe a procedure without changing the definition of CPT and HCPCS codes. It helps a provider or facility indicate service provided to the patient that has been altered by some special circumstance(s).

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### N

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**National Correct Coding Initiative (NCCI):** Coding regulations that help prevent fraud and abuse in outpatient coding. These regulations address unbundling and mutually exclusive procedures.

**National coverage determination (NCD):** National medical necessity and reimbursement regulations.

### O

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**Observation:** A designation used by hospitals to bill Medicare B service in which a patient is monitored to decide whether he or she requires inpatient care or continued outpatient care.

**Office of Civil Rights (OCR):** Part of HHS. Ensures equal access to certain health and human services, and protects health information privacy and security. This organization oversees HIPAA and investigates any reported violations.

**Office of Inspector General (OIG):** Their mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

**Office of the National Coordinator on Health Information Technology (ONC):** The principal federal entity charged with coordinating nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

**Optimization:** IT optimization refers to the addition of new functionality and improvements in technical reliability, efficiency, and accuracy, as well as improvements in system design and workflows to make IT easier for clinicians to use.

**Outpatient (OP):** A service rendered in one day, at a hospital or clinic, without staying overnight.

**Outpatient Service-Mix Index (SMI):** The sum of the weights of APC groups for patients treated during a given period, divided by the total number of patients treated.

**P**

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**Pay-for-performance:** Type of provider payment system that is based on performance and incentives.

**Physician fee schedule (PFS):** A payment model in which services are unbundled and paid for separately. In healthcare, it creates an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.

**Physician Quality Reporting System (PQRS):** A quality reporting program that encourages individual eligible professionals (EP) and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.

**Population health management (PHM):** A care strategy in which providers focus on improving the overall health of a specified patient population by focusing on keeping healthy people healthy and preventing at-risk patients from becoming sicker. High-risk patients with certain conditions are managed closely to prevent escalation.

**Provider:** Under federal regulations, a “healthcare provider” is defined as a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the state and who is performing within the scope of their practice as defined by state law. A healthcare provider is also any provider from whom the university or the employee’s group health plan will accept medical certification to substantiate a claim for benefits.

**Q**

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**Quality Payment Program (QPP):** The Quality Payment Program has two tracks: Advanced Alternative Payment Models (APM) or The Merit-based Incentive Payment System (MIPS).

**R**

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**Recovery audit contractor (RAC):** Designed to protect Medicare by identifying improper payments and referring potential fraud to CMS.

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**Relative value unit (RVU):** Unit of measure used to compare the amount of resources necessary to perform specific provider services by assigning weights to such factors as level of skill, equipment used, and personnel time. RVUs are part of the resource-based relative value scale (RBRVS). RVUs reflect national averages and are the sum of the provider's work, practice expenses, and malpractice.

**Resource-based relative value scale (RBRVS):** In 1992, Medicare changed the way it pays for physicians' services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). Payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying combined costs of a service by a conversion factor (a monetary amount that is determined by the CMS). Payments are also adjusted by geographical differences in resource costs.

**Risk adjustment factor (RAF):** Each patient has a RAF or risk score that includes baseline demographic elements (age/sex and dual eligibility status) as well as incremental increases based on HCC diagnoses submitted on claims from face-to-face encounters with qualified providers during the calendar year.

**Risk adjustment model:** A tool used to predict healthcare costs based on the relative actuarial risk of enrollees in risk adjustment-covered plans.

## S

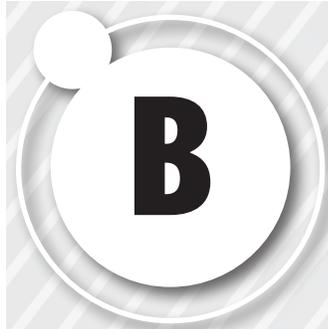
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**Systemized Nomenclature of Medicine Clinical Terms (SNOMED CT):** A standardized, multilingual medical code set focused on clinical documentation that covers diverse subject areas including diagnoses, procedures, medications, physical objects, substances, processes, animals, and numerous other topics that could be considered part of a medical narrative. Primarily used in the capture of clinical documentation, for use by other clinicians and in quality-focused analytics.

## V

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**Value-based purchasing (VBP):** The linking of provider payments to improved performance by healthcare providers. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.



## CDI Activities Related to Physician Clinic Visits

### *Preparation for CDI specialist visit:*

- Identify a principal contact for CDI visits.
- Develop an introduction letter with program overview and purpose for visit.
- Make contact via email and attach the prepared letter.
- Ask for time to schedule training/education for the providers (group or individually).
- Once the date and time are determined, prospectively perform documentation reviews and prepare queries (if delivering Tuesdays, queries should be for Wednesday's patient visits forward).
- Determine process for retrieving queries.
- Place queries and/or CDI tip sheets and tools into information folders. Attach business card.

### *Day of clinic visit:*

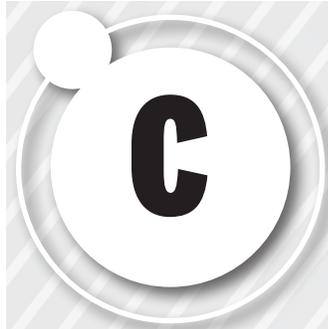
- Explain who you are and why you are there.
- Discuss risk adjustment factor (RAF), Hierarchical Condition Categories (HCCs), medical necessity, and best practices.
- Discuss fee-for-service reimbursement versus pay-for-performance compensation.
- Review tip sheets, other created materials, or pertinent information.

### *Provider one-on-one:*

- Pull up patient charts to discuss how CDI specialists navigate through a medical record looking for query opportunities.
- Discuss lack of documentation to support a more specific diagnosis, lack of documentation to support medical necessity or quality measures, etc.

## APPENDIX

- Discuss missed opportunities due to lack of documentation or diagnosis specificity and HCCs that were not captured.
- Assist with cleaning up the problem list and discuss the importance of it being current.
- Review any metrics with providers that shows how they are doing relative to their RAF score, quality measures, etc.
- Answer questions from the provider.
- This process can be modified to work in an observation unit, emergency, or surgery center. Electronic queries are the preferred delivery method.



## Case Studies and Query Examples

### *Outpatient provider encounter from ophthalmologist: Cataracts*

A 75-year-old woman presents to clinic with complaints of worsening vision over past several months. She reports blurred vision at near and distance and is bothered by oncoming headlights when driving at night. Patient with painless, progressive loss of vision in the right eye that interferes with lifestyle activities. Limitations of vision secondary to cataract development, progressive development with vision getting worse. Patient with no concomitant ocular disease. Patient continues to smoke one pack of cigarettes per day.

Documentation includes the following:

Left eye:

- Corrected visual acuity: 20/60
- Corrected near: 20/30
- Best corrected final visual acuity: 20/70

Vital signs:

- Temperature 98.4°F
- Blood pressure 126/72
- Pulse 76
- Respirations 16
- Oxygen saturation 96% room air
- BMI 45

## APPENDIX

Laboratory studies:

- Hgb 12.2 gm/dL
- PT 11.2 seconds
- INR 0.9
- K+ 3.4 mEq/L

EKG: Sinus rhythm with occasional PVC

Past medical history:

- Benign essential hypertension
- Diabetes Type 2
- Current tobacco use

Surgical history: Laparoscopic hysterectomy

Query opportunities:

- Query for documentation discrepancy related to laterality. Physician documents cataract located in right eye in the narrative and left eye under visual acuity measurements.
- Query for ophthalmic manifestation related diagnosis DM type II. ICD-10 E11.3xx.
- Query for morbid obesity. BMI greater than or equal to 40?
- Query for tobacco dependence.

### ***ED to observation: Chest pain***

68-year-old male presents to ED via ambulance with complaints of sudden onset of SOB, epigastric pain radiating to jaw. Patient transferred to observation services for CP rule out. Also of note, patient with left foot ulcer.

Vital signs:

- Temperature 98.7°F

## APPENDIX

- Pulse 89
- Respiratory 22
- Blood pressure 177/90
- Oxygen sats 97% on room air

### Diagnostics:

- Chest X-ray negative

### Laboratory studies:

- Cardiac enzymes negative
- BNP normal range
- GFR 41

EKG: Normal sinus rhythm

PMH: Diabetes

- CKD stage 2
- Benign essential HTN

Consult: Chronic diabetic stage 2 left foot ulcer

Patient rules out for MI

### Query opportunities:

- Query for diabetes diagnosis clarification
- Query for CKD stage due to GFR of 41
- Query for manifestation of CKD, related to DM or HTN
- Query attending regarding if in agreement with consult diagnosis of chronic diabetic stage 2 foot ulcer
- Query for the etiology of chest pain after study

## APPENDIX

In the above scenario, if the patient is managed exclusively in the ED for chest pain rule out, the same query opportunities for the ED provider would apply.

### *Ambulatory surgery center (ASC) planned outpatient procedure*

Operative report includes the following:

- Pre-operative diagnosis: Right knee medial meniscal tear
- Post-operative diagnosis: Right knee medial meniscal tear
- Procedure: Right knee arthroscopy with medial meniscectomy

Summary of procedures includes the following:

A 26-year-old male taken to surgical suite. After adequate anesthesia was obtained, a tourniquet was applied to the right thigh. Examination of the left knee showed full range of motion. No instability to provocative testing. The left lower extremity was placed in a well-leg holder, then prepped and draped in the usual sterile fashion.

Anteromedial and anterolateral portals were established after distention of soft tissues with 20 cc of 0.5% Marcaine® with epinephrine. The arthroscope was inserted with a blunt trocar and the joint distended with lactated Ringer's solution. Examination of the medial compartment showed a tear in the posterior root of the medial meniscus right at the intersection that was unstable to probing. This area was debrided with punch, motorized shaver, and electrocautery unit until stable. The anterior compartment showed normal articular cartilage and no loose bodies. The joint was copiously irrigated with lactated Ringer's and the instruments were removed. The wounds were closed with 4-0 nylon suture in an interrupted fashion. The joint was injected with additional 10 cc of 0.5% Marcaine with epinephrine and 2 mg of estradiol. Sterile dressings were applied. The patient was awakened and brought to recovery room in stable condition. The tourniquet was applied but not inflated, and blood loss was minimal. The patient tolerated the procedure well.

Query opportunities:

- Query clarification for laterality? Pre-op diagnosis states right and note states left.
- Query for specificity of medial meniscus tear? Further clarification found in note = Posterior root of the medial meniscus.

## APPENDIX

**CDI tip: Medical necessity:** As an outpatient CDI specialist, it is important to understand that clinical documentation improvement and coding specificity support medical necessity. Therefore, it is essential to be familiar with active NCDs or LCDs that provide coverage guidance related to coverage indications, limitations, and medical necessity. Equally important, the coverage guidance includes coding information related to billing, revenue codes, CPT/HCPCS codes, and a list of ICD-10 codes and documentation requirements that support medical necessity. As an outpatient CDI specialist, you must understand this fundamental concept in order to support denials prevention and the future of population health management. Improving the quality of clinical documentation improves coding specificity and supports compliant billing and accuracy of quality reporting.

### ***Provider clinic, hypertension***

Patient is a 65-year-old white male. Comes in for a recheck of Type 2 diabetes, hypertension.

Vital signs include the following:

- BP 125/60
- P 62
- T 98.9°F
- BMI 42.5
- H/H 9.4/28.4

Review of systems includes the following:

- Respiratory: Positive for shortness of breath, negative for chest tightness.
- Cardiovascular: Negative for chest pain. All other systems negative.
- After review of the medical record, the provider did not link any of the diagnoses and no documentation found to further specify anemia.

Problem list includes the following:

- Essential HTN, benign
- Coronary atherosclerosis of native coronary artery
- A. Fib

## APPENDIX

- DM Type 2 controlled
- CKD stage 3
- Anemia

Query opportunities:

- Query for CKD due to DM
- Query for HTN/CKD/HF to see if provider can link
- Query if anemia can be further specified (e.g., anemia of chronic disease vs. iron deficiency, etc.)
- Query for morbid obesity for BMI  $\geq$  40

Remember, the provider can always update the problem list without making an addendum. Can document on the change at later visit.

### *Provider clinic, hypertension*

An 81-year-old black male presents with hyperlipidemia and hypertension.

Subjective documentation includes the following:

- Hyperlipidemia: Tolerating medications well. He is on Pravachol. Denies myopathies, myalgias, hot flashes. Following Mediterranean-style diet. Regular cardiovascular exercise.
- HTN: Denies CP/SOB/DOE. Tolerating Lisinopril well. Lab 3/5/16 serum creatinine 1.83. Diet: Low fat and low sodium. Exercise: Cardio with walking; strength training with light weights.
- Anemia: He is taking a daily MVI and Vitamin D replacement. Good energy levels. No blood or dark tar in stools. Labs 3/5/16: H/H 9.8/11.7, vitamin D 26.

Objective documentation includes the following:

Vitals:

- BP 142/72
- Pulse 68 20
- Ht 5' 7.5"

## APPENDIX

- Wt 151 lbs
- BMI 23.3

General: Patient is well nourished and well developed and in no apparent distress.

- Eyes: Conjunctiva and lids without obvious abnormalities. Pupils and irises grossly normal. No scleral icterus noted.
- HEENT: External ears intact. Hearing is grossly normal. External nose intact. Lips and teeth intact.
- Neck: Supple without lymphadenopathy noted.
- Respiratory: No respiratory distress, normal effort.
- CV: Regular rate, no murmurs appreciated. 1+ peripheral pulses bilaterally, no edema.
- Neurologic: Cranial nerves grossly intact. Sensation grossly intact.
- Psychiatric: A & O x3. Judgment and insight grossly intact. Recent and remote memory intact. Mood and affect grossly normal.
- Musculoskeletal: Gait grossly normal for age. Extremities grossly normal without obvious deformity.
- Past medical history, past surgery history, allergies, social history, and family history were reviewed and updated.
- Review of systems: Positives noted in the HPI, otherwise negative.

Problem list:

- Nontoxic multinodular goiter
- Chronic renal insufficiency, stage 3
- Renal disease due to HTN
- Hypertensive renal disease, stage 1–4 or unspecified chronic kidney disease
- Anemia, unspecified
- Hyperlipidemia

## APPENDIX

Visit list diagnoses:

- Hyperlipidemia
- Hypertension
- Anemia

Query opportunities:

- Chronic renal insufficiency, stage 3 AND renal disease due to HTN AND hypertensive renal disease, stage 1–4 or unspecified chronic kidney disease on problem list. Query for HTN/CKD clarification. Clinical indicators: GFR was 39 on 3/5/16. Patient on Lisinopril. (Can include “Kidney Foundation, Managing Chronic Kidney Disease-Early Detection” when looking at GFRs.)
- Anemia, unspecified on problem list. Query for anemia clarification clinical indicators. Per visit 7/3/16, “Patient with CKD stage 3. Per lab 3/5/16, H/H was 9.2/11.3.”
- No diagnosis on problem list. Query for vitamin D deficiency. Clinical indicator: Per visit 7/3/16, patient taking “vitamin D replacement” was documented. Per lab 3/5/16, vitamin D was 26.
- Ask provider to clean up problem list.

Scenario after query:

E. Smyth is an 81-year-old black male. Presents with hyperlipidemia and hypertensive CKD stage 3.

Hyperlipidemia: Tolerating medications well. He is on Pravachol. Following Mediterranean-style diet. Regular cardiovascular exercise.

Hypertensive CKD stage 3: Denies CP/SOB/DOE. Home blood pressure numbers NA. Not at goal. GFR was 39-3/5/16. Diet: Low fat and low sodium. Exercise: Cardio with walking; strength training with light weights.

Anemia: Due to chronic renal failure. Good energy levels. No blood or dark tar in stools.

Vitamin D deficiency: He is taking a daily MVI and Vitamin D3 replacement (vitamin D 26).

Objective, past medical history, etc., and review of systems no changes

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### Impression:

1. Hypertensive kidney disease with CKD stage 3: Not at goal. Will D/C Lisinopril. Trial Diovan/HCT. DASH. Continue active lifestyle and cardio regularly.
2. Hyperlipidemia: Stable and at goal. Continue current medications. Mediterranean diet. Daily cardiovascular exercise.
3. Anemia of chronic disease: Has been stable. Follow clinically.
4. Vitamin D deficiency: Continue vitamin D3 and MVI. Follow clinically.

### Problem list:

1. Nontoxic multinodular goiter
2. Hypertensive kidney disease with CKD, stage 3
3. Anemia of chronic condition
4. Hyperlipidemia
5. Vitamin D deficiency

### Visit list diagnoses:

1. Hyperlipidemia
2. Hypertensive kidney disease with CKD, stage 3
3. Anemia of chronic condition
4. Vitamin D deficiency

After review of the completed query and medical record, the provider updated the problem list; added new, more specific diagnoses and resolved others; and supported visit diagnoses with comprehensive documentation. Hypertensive CKD is an assumed relationship, so provider does not have to state, “CKD related to HTN.” (Recommended that provider document relation so the provider doesn’t have to remember which diagnoses are assumed or not.)





## Examples of Diagnoses for Query Opportunities

### *Cardiac clarification*

- Angina (stable, unstable, variant)
- Cardiomyopathy (dilated, hypertrophic, ischemic)
- Chest pain (cardiac or non-cardiac)
- Congestive heart failure (systolic, diastolic)
- Coronary artery disease (location and cause)

### *CVA clarification*

- History of TIA, CVA without residual deficits
- Late effects (hemiplegia, cognitive, speech and language deficits)
- Other late effects (muscle weakness, dysphagia, ataxia)

### *Dependence clarification*

- Alcohol (uncomplicated, in remission, continuous, episodic)
- Nicotine (uncomplicated, in remission/cigarette, smokeless, chewing, snuff)
- Opioid (uncomplicated, in remission, continuous, episodic)

### *Diabetes clarification*

- Circulatory manifestation (stasis ulcer, peripheral vascular disease)
- Kidney manifestation (CKD with stage, microalbuminuria, proteinuria)
- Long-term use of insulin
- Neurologic manifestation (neuropathies)
- Ophthalmic manifestation (glaucoma, cataract, retinopathy)

## APPENDIX

### *Hypertensive disease clarification*

- Hypertensive chronic kidney disease (specify stage)
- Hypertensive heart (HF present-type and acuity)
- Hypertensive heart and CKD (CKD stage; HF present-type and acuity)

### *Mental Health clarification*

- Anxiety disorders (GAD, panic disorder)
- Major depressive disorder-MDD (single/recurrent, mild/moderate/severe, partial/full remission)
- Mood disorders (episodic, mild/moderate/severe, partial/full remission)

### *Metabolic clarification*

- Hypercalcemia/hypocalcemia
- Hyperchloremia/hypochloremia
- Hyperkalemia/hypokalemia
- Hyponatremia/hyponatremia

### *Nutritional clarification*

- Cachexia (type-cancer, AIDS)
- Protein-calorie malnutrition (mild/moderate/severe)
- Vitamin deficiencies (type)

### *Nervous system clarification*

- Alzheimer's disease (early or late)
- Cerebral palsy (type)
- Dementia (vascular and/or underlying disease)
- Epilepsy and seizures (type of seizures)
- Multiple sclerosis
- Pain (type-neoplasm, chronic pain syndrome, generalized)
- Parkinson's disease

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### *Respiratory clarification*

- Asthma (mild/mod/severe, intermittent/persistent, exacerbation)
- Bronchitis (chronic/acute, obstructive, decompensated, with emphysema)
- COPD (exacerbation, with chronic bronchitis/emphysema/obstructive asthma)
- Emphysema (unilateral, panlobular)

### *Weight clarification*

- Morbid obesity (BMI  $\geq 40.0$  or  $\geq 35.5$ -39.9 with comorbidities)
- Obesity (BMI 30.0-39.9)
- Overweight (BMI 25.0-29.9)





## Case Study: Outpatient CDI at Ochsner Health System

### Background and Timeline

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The Ochsner Clinic Foundation was founded in 1942 and, over the years, has come to encompass 28 hospitals, over 60 health centers, more than 17,000 employees, and more than 2,500 affiliated physicians. Its far reach makes Ochsner the largest health system in Louisiana. Under the Ochsner Health System, primary care physicians are the main contact for patients. They have the ultimate say over patient care and often have years of experience with the individual patients themselves.

When the Centers for Medicare & Medicaid Services (CMS) implemented the CMS Hierarchical Condition Categories (HCC) model in 2004, Ochsner needed to ensure HCCs were captured annually for all patients. The HCCs affect the risk adjustment factor (RAF), which communicates the severity of the patient's condition. Capturing HCCs accurately ensures both proper reimbursement for the hospital system and quality patient care.

Along with the HCC model, Ochsner began its Ambulatory Clinical Documentation Excellence (CDE) program in 2004. The system referred to the program's specialists as CDE specialists to serve as differentiation from Ochsner's more established inpatient CDI program. At the beginning, however, the physicians were only informed about the HCC model. Most providers assumed the model was just one more requirement from insurers and hospital administrators and didn't see the importance of the effort, according to Diana Ortiz, JD, RN, CDIP, who now serves as director of ambulatory CDE at Ochsner.

In 2012, Ochsner attempted to cement information about HCCs and clinical documentation accuracy by hiring a new physician leader. The physician leader held an educational session, which seemed to overload physicians rather than help propel the program forward.

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In 2013, Ochsner began to identify financial risks associated with the poor capture of HCCs. The physician leader visited all the clinics across the system in 2014. “That involved him in his car, driving across the system, and meeting one-on-one with the providers,” Ortiz says. The leader’s efforts helped with HCCs to a certain extent, but Ochsner’s ambulatory CDE program really took flight in 2015 with the development of its health risk assessment program, under which the CDE program gained full administrative support. In 2016, Ochsner fully implemented the ambulatory CDE program, continuing to develop methodology and tweak processes as it grows.

### Program Scope and Structure

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Ochsner’s ambulatory CDE program was developed to be flexible and to change slightly as the team evolves. Nevertheless, defining its scope early paved the way for CDE professionals to tackle one step at a time, rather than multiple responsibilities all at once.

One of the most effective decisions for the Ochsner ambulatory CDE program was the program’s structural layout. From the beginning, Ochsner knew that a physician-led organizational structure was essential. Providers respond better to peer physicians than nurses, so, at least for educational purposes, the peer-to-peer model was crucial for Ochsner.

After the physician leads, the primary care and internal medicine clinics were divided by region with a CDE specialist assigned to each. This allowed for staff to have more personal relationships with the physicians in their regions and develop more meaningful conversations related to medical record documentation education. It also allowed the CDE specialists to do more “deep dives” into physician charts rather than covering a larger number of physicians from all over the system. Specialists do not report directly to the physician leads, but rather to Ortiz, the ambulatory CDE director. All the CDE specialists are registered nurses, which means they have the same experience and credentials when hired as the inpatient CDI specialists at Ochsner. The nursing background has two main advantages for Ochsner: First, the nurses already have clinical knowledge, and second, they often have standing relationships with the providers.

A CDE regional lead was assigned to oversee each region of the Ochsner Health System. Although the CDE leads are CDE specialists, they function in a quality assurance role and are responsible for assessing the CDE specialists’ chart reviews; they are also heavily involved in the provider and CDE team education.

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In addition to the CDI specialists and the physician leads (who were also assigned to oversee a whole region), there were local leads placed within each facility to serve as the point person for each location. Ochsner found that it was helpful to have someone on hand for real-time questions and problems. The local leads also deliver messages to the providers at the clinics, which frees up the physician leads and CDE specialists for chart reviews and education.

As the ambulatory CDE program grew, Ochsner expanded into other areas of patient care, adding several specialty-focused programs within the hospitals to ensure the capture of HCCs and quality patient care across the whole system. Over the course of the next two years, Ochsner plans on adding six new specialties to the program.

### Training and Education for CDE Specialists

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With the program structure in place, Ochsner needed to develop a training process for its new CDE staff. The first step was an inpatient CDI boot camp, since outpatient/ambulatory CDI programs were scarce. The boot camp also ensured efficient staffing: If a new hire wasn't a good fit for the ambulatory CDE program, Ochsner could shift that staff member to the inpatient side thanks to the training already received. The second step was job shadowing, starting with the inpatient CDI team. This step gave the new CDE specialists a chance to see the rapport between CDI and physicians. Additionally, the CDE specialists shadowed the second-level review and ambulatory coding teams. This gave them a better understanding of the workflow on the ambulatory side. It also showed the new specialists the type of documentation the coders were looking for, what CDE specialists had to query for, and common chart deficiencies.

The CDE specialists also trained on the electronic health record (EHR) system. This training is ongoing, which lets them share the tricks they pick up with the rest of the team, including physicians. The specialists also regularly review the encoder training and decision tree. They received education on the American Health Information Management Association's guidelines for ethical queries.

The most pointed part of the education process was the HCC training course, which came last because it was so specific to their day-to-day duties. While the rest of the education was focused on tools and workflow, the HCC training focused on the CDE specialists' main goal. For this component, Ochsner used a review course from the AAPC.

## CDE Specialists' Workflow

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After education, the CDE specialists needed to establish a workflow pattern. Ochsner first focused on retrospective reviews and provider education.

Each CDE specialist reviewed about 10 charts per day retrospectively only. Later, as the program began to mature, the workflow began to incorporate pre-visit reviews as well. Now, CDE specialists complete between 12 and 15 pre-visit reviews per day in addition to their original 10 retrospective reviews.

Ochsner was careful to introduce new duties slowly so that the CDE specialists wouldn't be overwhelmed by the amount of work. The incremental incorporating of tasks also allowed the CDE specialists to build on their previous experience with each new task.

The CDE specialists are heavily involved with provider education—a natural fit, since the specialists are the ones reviewing the records. These educational sessions take place on a schedule that incorporates both one-on-one education and group lunch sessions. The one-on-one sessions provide a more intimate, directed educational opportunity; the group sessions allow the CDE specialists to address common trouble areas rather than sitting down with five providers individually for the same reason.

### *Tools and forms*

Within the EHR system, Ochsner built in a query program for pre-visit reviews, piloting it with select providers and incorporating their feedback into query template development. The clinical indicators are populated automatically on the query form, and every query is checked to ensure compliance.

Two common problems Ochsner encountered were coding for a high BMI without documentation of morbid obesity, and coding for an ongoing condition that should have been a “history of” code. Though the problem areas will most likely vary from system to system, the standard query forms will help with streamlining the process and bringing perennial problems to light for education, says Malissa Lauren Brettner, RN, CDE specialist for Ochsner.

Ochsner also developed chart review forms that allow CDE specialists to record potentially missed HCC opportunities, unclear documentation, and the like. Not only do these forms provide good educational materials, but they also make it possible for any CDE specialist to cover for any other CDE specialist because everyone's notes are consistent.

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The HCC review tool also helped the ambulatory CDE program unify its classification and documentation protocols. The tool was especially useful with patient demographic questions and let the CDE specialists and providers see what was the most clinically pertinent condition for a given patient. The CDE and physician leads both had to agree on the makeup of the tool prior to its implementation.

### Provider Education

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By the end of 2015, the CDE specialists had conducted approximately 50 provider education sessions and had begun to develop educational plans for each provider. The team created provider education packets through several iterations of feedback.

The first component of the packet was a cover page with the provider's baseline RAF, the provider's projected RAF, and the variance between the two. The next component was a summary of the 10 charts included in the review. Then, the actual 10 chart reviews were included. Providers kept this packet to review on their own, and for the CDE specialist it served as an educational guide to illustrate which lessons required additional follow-up.

When Ochsner began its foray into ambulatory CDE, it focused on retrospective charts post-appointment. Since the documentation had already been completed, such reviews were used for educational purposes only. The CDE specialists would never encourage the physicians to change anything in the completed record, but instead position the providers to recognize the documentation opportunities in the future. These retrospective reviews were also included in provider education packets so the providers could see where they had room to improve.

The retrospective review process also provided a jumping-off point for the ambulatory CDE program to highlight missed HCCs—a concrete way to demonstrate that documentation errors, poor capture of HCCs, and common problems were happening on a large scale. This was instrumental in getting the administration on board with the ambulatory CDE program early in the development process.

The retrospective reviews also serve as a way to mark a provider's progress. Since the providers were given one-on-one education specific to their needs, later reviews could look back on those educational attempts and determine where further educational opportunities lay.

Another big part of the retrospective reviews was to determine whether captured HCCs contained documentation that a condition had been monitored, evaluated, assessed/addressed, and treated (MEAT).

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The MEAT standard ensures the documentation fully supports the reported diagnoses and the captured HCCs. The standard also comes into play with provider education, as it offers a concrete set of guidelines for the providers to keep in mind during future documentation.

### Review Types: Pre-Visit Reviews

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In contrast to retrospective reviews, pre-visit reviews happen before the provider sees the patient in person. The goal of these reviews is for the provider to act on the reviewed information to capture the correct diagnoses and HCCs during the face-to-face appointment with the patient. In conjunction with the retrospective reviews, CDE specialists can see where providers are learning and where they need more education.

After the patient's appointment has taken place, the CDE specialist goes back into the chart and conducts a retrospective review to see whether the provider acted on the pre-visit information. Since the record has not been completed at the time of a pre-visit review, Ochsner has a query process in place. The queries are all compliant and stored directly in the EHR system. When a provider opens the patient's record, any extant queries are automatically visible. Though providers cannot respond to a query directly, they can act on it by adding specificity to their documentation within the record itself.

Whereas inpatient CDI reviews can only take the patient's current visit into consideration, ambulatory CDE can look back at three years of patient history. During the pre-review process, this is an important step since it can bring any chronic conditions to the provider's attention and remind him or her to document them. Even though a chronic condition only needs to be documented in the record once per year for a given patient, Ochsner wants every record to stand on its own. That way, when a specialist sees a patient, the primary care record is always as complete and thorough as it can be.

#### *Query process*

Having query forms directly in the EHR means providers cannot misplace or overlook them. Each query is attached to a specific chart, which means that if there is an outstanding query from the CDE specialist, it will pop up when the provider opens the chart. This ensures the provider at least knows that the query exists, and makes him or her more likely to review it.

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Additionally, storing the queries in the EHR means they are accessible later. Though Ochsner does not maintain the queries as a part of the patient's legal medical record, they are always available on the EHR. This is especially helpful when performing retrospective reviews, because a CDE specialist can look back at the pre-visit queries to determine what the provider missed and caught on the record. Having that reference point allows the CDE specialist to make more informed educational decisions.

One major difference between queries for the ambulatory CDE program and queries for the inpatient CDI program is that CDE queries do not necessarily require a response from the provider. Since CDE queries are performed only with pre-visit reviews, the provider can simply act on the query information during the visit with the patient. At Ochsner, about 50% of the providers routinely add a note to the chart as a query response. Otherwise, they simply conduct the patient visit and complete the required documentation with the query information in mind.

In lieu of a query response, CDE specialists conduct retrospective reviews the day after the patient's visit. This way, the CDE specialist can see if the provider acted on the query and follow up with the provider if necessary. If a provider routinely ignores queries, the physician leads are responsible for meeting with that provider and discussing the issue.

### Moving Into Specialties

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At first, Ochsner focused on general practice and internal medicine providers since those groups see patients with the most regularity. If a patient of one of these providers goes to see a new specialist, the clarity in the primary care physician documentation will help to provide consistency. Soon, however, Ochsner began expanding into the specialties, increasing CDE staff with nurses who had previous experience within a given specialty. Specialty provider leads meet with CDE specialists on a regular basis to discuss concerns, develop educational models, and promote provider interaction.

Although the primary care provider is considered top dog in an individual patient's care, often it's the specialty physician who provides most of the care during the treatment period. This is especially true with specialties such as oncology. Since the patient will receive most care from the oncologist for several months or years, the oncologist's documentation needs to be top notch. That way, when the patient returns to his or her primary care provider or moves to another specialist, all the information regarding previous treatment and conditions is readily available.

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Specialties received initial general information regarding CDE efforts, then CDE specialists and provider leads met with each specialty provider separately and provided documentation tip cards for the providers. The Ochsner ambulatory CDE program did not expand into every specialty at once, partly because of the size of the undertaking and partly to ensure everyone involved had enough knowledge to institute specialty coverage on a large scale.

The first specialty Ochsner tackled was hematology and oncology. The next specialty it moved into was cardiology because it offered a variety of opportunities to improve documentation. Like oncology, the documentation of a patient's cardiac history is important for when the patient returns to his or her primary care physician after receiving care from a cardiologist. During the same year, Ochsner also expanded the CDE program to the neurology department. The system plans to further extend into the surgical, rheumatology, and podiatry departments.

### Summary

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As with many inpatient CDI programs, the ambulatory CDE program at Ochsner began because there was a financial opportunity in capturing HCCs correctly. As with many inpatient programs, however, the ambulatory CDE program has begun to focus on quality measures as well.

Although Ochsner's program began with a strict focus on retrospective reviews, Ochsner suggests that programs start both types of reviews (retrospective and pre-visit) simultaneously. This would take place after the initial educational period, of course, because the providers need a basic understanding of CDE before they can synthesize the review information. Starting retrospective and pre-visit reviews at the same time offers a larger platform for educational opportunities from the get-go. If a provider catches an HCC during a patient's visit because of a pre-visit review and query, then the retrospective reviews become easier. Additionally, it's always good to start with the best information possible; the pre-visit reviews give the providers a leg up in the CDE process.

Going forward, Ochsner is looking to cross-train its inpatient CDI and ambulatory CDE specialists. The idea is that if each group knows the other's job, specialists could provide better coverage across the system and more easily share their knowledge and experience. Though the ambulatory CDE side adapted inpatient CDI queries and workflow and attended an inpatient boot camp, the inpatient CDI specialists have not undergone the same type of exposure to the ambulatory side.

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Cross-training will eventually help to synergize the Ochsner CDI and CDE programs across the entire system.

*Editor's note: This information was compiled based on the 2016 ACDIS Live! webinar "Outpatient CDI at Ochsner: A Case Study Approach." For additional information, visit <http://hcmarketplace.com/acdis-live>.*





## Ambulatory CDI Efforts: Get Thee to the ED

Many programs remain focused on inpatient populations, but branching into the ED provides a good starting point for those venturing into the outpatient arena. Not only does it offer outpatient opportunities, but the documentation from ED encounters directly affects the documentation if (or when) patients move to the inpatient setting.

### The Impetus for ED Expansion

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What drives a CDI department into the crazy world of the ED? Well, like other areas, the reasons are often as varied as facilities themselves—and the transition may be easier for some departments than others.

“The ED program was something that the institution wanted when the [CDI] program was being rebuilt,” says **Bernadette Slovensky, RN, MSN, CCDS**, medical coordinator for CDI at Stony Brook Medicine in Stony Brook, New York. In fact, one of Stony Brook’s ED physicians was a major force behind the process.

Just like starting a CDI program from scratch, the process goes more smoothly when administration is on board—after all, convincing physicians of the need for CDI is difficult enough on its own.

For some programs, though, the CDI specialists themselves may need to be the lifeblood of expansion efforts. Such was the role of **Jessica Stevenson, RN**, CDI specialist at Yampa Valley Medical Center in Steamboat Springs, Colorado, a 32-bed nonprofit facility. Like many professionals at small facilities, Stevenson wears many hats. One hat, labeled “bill reviewer/auditor,” brought ED documentation improvement deficiencies to her attention.

“We were already in those ED charts and realized there might be an opportunity to educate the physicians specifically,” she says.

So, Stevenson ventured into the ED with her one other CDI cohort. Beginning with education, they chipped away at the documentation opportunities found during bill reviews.

### CDI Staffing for the ED

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Though CDI staffing requirements vary significantly between facilities, a couple models work particularly well in the ED:

- Reviewing ED documentation as part of the whole inpatient record
- Reviewing ED records concurrently on the floor

The first option is familiar territory for seasoned CDI specialists. ED documentation can lend valuable clinical indicators to a query during a patient's hospital stay. To ensure the accurate capture of a patient's severity of illness (SOI) and risk of mortality (ROM), CDI specialists should review this documentation whenever possible.

If the CDI staff reviews the ED documentation as part of the whole record, there's likely no need to have a CDI specialist physically present in the ED. This lack of floor presence could, however, lead to missed opportunities—what **Donald Blanton, MD, MS, FACEP**, at CDIMD-Physician Champions in Brentwood, Tennessee, calls “disappearing diagnoses.” The second model of staffing seeks to relocate these diagnoses. At least at the beginning of a CDI program's excursion into the ED, having someone present in the room can be valuable.

“Many ED physicians mentally acknowledge secondary diagnoses, but don't write them down,” Blanton says. If a CDI specialist physically sits in the ED, he or she can be on hand to ask questions and ensure physicians capture the complexity of a given patient's condition prior to discharge, admission, or placement in observation status, he says.

After the initial education, however, it may be best to cut the proverbial apron strings, according to Slovensky. “We didn't really need to be there holding their hands,” she says.

There's a twofold reason for this approach, Slovensky explains. First, it allows the CDI specialists more freedom with their limited time. CDI staff typically work regular business hours, whereas the ED is staffed 24/7. When the CDI staff is in the hospital, as is the case in Stony Brook, they have to divide their time between inpatient and ED records. Having someone in the room with the ED physicians

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would be time-consuming and impractical, says Slovensky. Second, stepping back after the education allows the physicians to focus on patient care instead of having a CDI specialist breathing down their necks.

After the initial educational process, “the ultimate goal is zero queries. You shouldn’t need to ask the question if the physician is educated,” Blanton says. Still, the code set includes so many specific language requirements, definitions, and thresholds between severity levels that physicians often need prompts baked into their workflow to ensure proper and accurate documentation, he says.

### Common ED Query Opportunities

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If you grabbed five CDI specialists throughout their days and asked them for their top queried diagnoses, you’d likely get some significant overlap. Acute respiratory failure, sepsis, malnutrition, and other bemoaned conditions are often a thorn in the side of CDI specialists everywhere.

Acute respiratory failure can be easily overlooked when documenting a patient’s acute systolic heart failure, Blanton says. It’s certainly treated, and often with rapid improvement—so rapid that “by the time the hospitalist comes [onto the case], the patient looks so much better than when they came in that their original acuity will be lost to the hospitalist,” Blanton says.

If the documentation of acute respiratory failure disappears in the fog of the ED, patients could go through their hospital stay and get discharged without anyone knowing how sick they really were upon arrival. “The insurers only know what we tell them,” Blanton says. “To them, every patient looks the same: like a piece of paper with ink on it.”

The ED holds opportunities for many of the same diagnoses commonly requiring clarification on the inpatient side, but it presents unique potential for diligent reviewers as well.

“We do a heavy audit of evaluation and management service (E/M) levels in the ED,” Stevenson says. Often, however, that query for E/M levels results in a reimbursement downgrade. “We’re trying to make sure everything’s accurate,” she says.

Stevenson has also found many query opportunities with hydration levels. If a patient comes into the ED severely dehydrated, is treated for the dehydration, and then is admitted for a more severe condition, the ED physicians may never get the credit deserved for their hydration work. The CDI team looks for

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opportunities for dehydration documentation in the ED, especially when a patient gets transferred to observation status. This allows the facility to receive accurate reimbursement.

Although the CDI staff at Stony Brook review ED notes with every inpatient record, mortality cases pose a particular opportunity, Slovensky says.

“Sometimes, the ED physicians are the only ones who see and treat a patient before they expire. This happens when a patient is admitted, deteriorates, and dies before the admitting physician has a chance to see them,” she says.

A patient dying does not look good for the physicians or the facility if that patient’s SOI/ROM scores were low, Slovensky says, so capturing the complete clinical picture for mortality cases represents an obvious priority.

### Gaining Physician Support

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Even with the maturation of CDI programs over the last decade, physician engagement still rates as the top problem facing CDI specialists—and ED physicians pose a unique challenge, according to Blanton. ED physicians work 24/7, so CDI specialists may find it more challenging to gather them all together as a group for education, and they’re often too busy to drop what they’re doing and discuss CDI for an hour.

“We have no control over patient volume. It’s often controlled chaos in the ED,” Blanton says.

Slovensky—as the CDI contact for her ED physicians—attends monthly ED meetings and comes armed with case studies. “The trauma cases are especially helpful,” she says. Walking through those case studies with the ED physicians reassures them that CDI specialists don’t “ask for anything that won’t make a difference.”

The CDI team at Yampa Valley Medical Center also attends monthly ED staff meetings where they present the inpatient problems they see to the ED physicians, offering the physicians insight on how documentation problems early on continue throughout the patient’s care.

After the first educational push with a CDI specialist in the ED, Blanton advises using an electronic medical record (EHR) to encourage documentation habits through prompts in the system. Incorporate

a user-friendly, multiple-choice system that prompts the physician for complete documentation on the spot, he suggests.

Since CDI has already provided the initial education, the EHR provides a helpful nudge toward appropriate diagnoses. Ideally, this also takes less time in the ED physician's day than answering 10 queries would.

### Proving It's Worth the Work

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From a financial perspective, identifying ED CDI benefits is more complex than tracking MS-DRG changes. Much of the benefit comes from improved quality scores and public perception, according to Blanton.

Slovensky simply showed administration how the ED work helped raise the case-mix index (CMI). Many CDI inpatient programs see a drop in CMI over time, and the ED offers an opportunity to help those numbers remain strong.

Any additional documentation taking place in the ED helps immensely if an ED patient gets admitted, Stevenson adds. "It cues us into things we might need to follow when the patient gets onto the floor," she says.

Quality-based payment programs judge facilities' performances based on comparisons with other facilities—specifically, comparisons between patients who seem to have the same SOI/ROM, Blanton says.

The SOI/ROM scores come directly from the documentation in the patient's medical record. Problems can arise if the documentation suggests a patient is healthier than he or she actually is due to undocumented secondary diagnoses. Should complications arise or the patient expire, it will look like a relatively healthy patient died unnecessarily.

"CDI is about getting it right. We're not presenting a representation of a patient that is sicker and more complex than they are, but as sick and as complex as they truly are," says Blanton. "If you don't put people in the right basket, they'll be compared with healthier people."

*Editor's note: This article originally appeared in the May/June 2017 edition of CDI Journal.*



# FIRST STEPS IN OUTPATIENT CDI

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a Program

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