

Q&A

Outpatient CDI



As part of the 10th annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics.

Doris Mollenkopf, MBA, BA, CPC, CRC, CCDS-O, CDI and risk adjustment specialist at Clinicas del Camino Real in Valencia, California, and a member of the 2020 CDI Week Committee, answered these questions. Contact her at mollenkopfd@gmail.com.

Q How is your outpatient program staffed? How often do inpatient and outpatient teams interact? How often does the outpatient team interact with coding/office management staff?

A Our risk adjustment department consists of five medical coders, four outpatient coders, and one inpatient coder. We're actually an outpatient-only organization, so we've never reviewed inpatient records at my organization. We have daily interaction with our individually assigned clinics.

Q Which services do you review? How did you decide which outpatient services to review?

A We review our primary care and mental health office visits for Medicare Advantage patients on a daily basis. Our medical review focus is on accurate and complete clinical documentation to support Hierarchical Condition Category (HCC) capture and accurate risk adjustment.

Q People often define the terms "outpatient" and "ambulatory" differently. How would you define those terms? Are they interchangeable in your opinion?

A The term outpatient is broad whereas ambulatory is more specific. I would define an ambulatory care setting as treatments, procedures, or surgeries for care provided outside a hospital setting. Patients come for a procedure but are not admitted to the hospital. The term outpatient can be used to describe a wide range of settings, including emergency departments, clinics, ambulatory surgery centers, etc.

Q Most of the 2020 Industry Survey respondents focus their reviews on HCC capture. What's the primary focus of your program's outpatient reviews?

A Our program's primary focus is HCC capture as well, and we work closely with our risk adjustment department since they focus on clinical validation to support the HCC diagnosis.

Q According to the Industry Survey, nearly 40% of respondents review outpatient records prospectively, more than 30% review retrospectively, and under 15% review concurrently. When do your CDI specialists review outpatient records? Why did you choose that timing?

A Our clinics are very fast-paced environments, and providers have only a limited amount of time before seeing another patient, so concurrent reviews wouldn't be feasible. Instead, our team focuses on prospective reviews before the physician ever sees the patient and retrospective reviews after the appointment is over. The prospective reviews help ensure that the HCC diagnoses—which need to be captured on an annual basis—are addressed during the patient's visit; the retrospective reviews help us identify potential education opportunities.

Q **What does the query process look like for your outpatient CDI reviews? Do you have a query policy in place?**

A Our query process is based on the ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice” brief. Because of this, it's largely based on inpatient compliance guidelines. We have our own internal software system whenever we need to query our providers.

Q **In your opinion, why should CDI professionals review outpatient records? What's the danger in not doing so?**

A In my opinion, CDI record reviews are critical because we want to make sure provider documentation supports the diagnoses and accurately reflects the patient's true condition. CDI is key to an organization and plays a big role in the outpatient settings by providing medical record reviews and provider education, just like on the inpatient side.

The danger of not reviewing outpatient records is that you may not capture a patient's true chronic illness. HCC diagnoses need to be captured annually, and there's a real danger of them “dropping off” the patient's chart, which will negatively affect resource allocation and reimbursement for that patient's care.

Q **For those looking to expand to outpatient reviews, what do you recommend as a first step?**

A I think that the first step is to decide what your organization's CDI program mission and focus is. “Outpatient” is a very broad term, and the CDI team's focus needs to evolve to follow the organization's mission.

How COVID-19 moved the adoption of telehealth regulations

by Colleen Deighan, RHIA, CCS, CCDS-O

Telemedicine is not new—it's been around for about 40 years, according to the [American Telemedicine Association](#), founded in 1993.

Telemedicine, in a nutshell, is the use of technology to deliver care. If there is a silver lining to the COVID-19 public health emergency (PHE), it's telemedicine. COVID-19 was the fuel that quickly removed barriers and permitted the expansion of telemedicine to allow access to care and care delivery during the PHE. Let's recap the timeline and barriers removed:

- Prior to the PHE, Medicare only paid for telehealth on a limited basis—specifically, the patient would have to leave their home and travel to an originating site location, either a county outside a metropolitan statistical area (MSA) or a rural health professional shortage area (HPSA) in a rural census tract, to participate in a telehealth visit with a provider at a distant site.
- On March 17, 2020, CMS expanded access to telehealth services under the temporary 1135 waiver authority, the Coronavirus Preparedness and Response Supplemental Appropriations Act, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The waiver:
 - Allowed care delivery in the patient's home or any healthcare facility
 - Recognized telehealth visits as in-person visits

- Reimbursed telehealth visits the same as in-person visits
- Expanded the relationship between patients and providers
- Expanded the types of services that could be provided via telehealth
- Allowed for practicing across state lines
- Reduced or waived cost-sharing
- Allowed any technology platform to be used and relaxed penalties for safeguarding information
- Expanded access to include physical and other therapies along with audio-only services
- Ensured that federally qualified health centers (FQHCs) and rural health centers (RHCs) could provide telehealth services
- Allowed Medicare Advantage organizations and other organizations that submit diagnoses for risk-adjusted payment to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility

Prior to the PHE waivers, reimbursement and access barriers majorly limited the use of telemedicine, but they were not the only barriers. There was also reluctance and resistance from providers and patients to adopt and support the use of technology to deliver care. What

did we learn during the PHE about telemedicine? Telemedicine works! For some providers, their entire practice transitioned to telemedicine.

So, what's next? How do we continue to use technology and redefine how care is delivered?

The intent of the PHE waiver was to contain the spread of COVID-19 and increase access to care. The PHE waiver currently expires on July 25, 2020; it has been extended once already, and it is expected that the Department of Health and Human Services (HHS) will extend it again for 90 days.

Seema Verma, administrator for the Centers for Medicare and Medicaid Services, was quoted recently as saying, "I think the genie's out of the bottle on this one. I think it's fair to say that the advent of telehealth has been just completely accelerated, that it's took this crisis to push us to a new frontier, but there's absolutely no going back."

Jim Parker, senior advisor for health reform for HHS, said, "The cat is out of the bag, so to speak. We look forward to helping policymakers, congressional

leaders, and regulators move the interest in telehealth and healthcare consumerism particularly for rural areas forward in a more permanent way."

Verma also said at a recent telehealth conference that the agency is in the process of rulemaking, and she expected some provisions that had been temporarily extended during the pandemic to become permanent. On June 25, 2020, [CMS issued their proposed rule](#) for calendar year 2021 for home health. The rule proposes to permanently finalize, beginning January 1, 2021, the home health regulations outlined in the PHE interim final rule. This proposal means that home health agencies can continue to use telemedicine to provide care for Medicare beneficiaries. Look for the physician fee schedule proposed rule to address further telemedicine reform.

The use of telemedicine remains essential during the uncertainty of COVID-19. To secure its place in the future and ensure continued adoption by patients and providers, permanent telemedicine reform must include proper payment for services provided.

Colleen Deighan, RHIA, CCS, CCDS-O, has more than 25 years of progressive technical and managerial experience in the field of health information management. She has worked as a hospital coder and professional coder, coding supervisor, director of professional coding, director of clinical documentation integrity, and senior director of coding compliance. As a consultant, Deighan provides advisory services for ambulatory CDI, clinical coding, and revenue cycle management to 3M clients.