Q&A

CDI WEEK

Outpatient CDI

ChartWise Medical Systems

*As part of the eighth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Kim Charles, CPC, CPCO, CPMA, CEMC,** who is the charge integrity manager at UK Healthcare in Lexington, Kentucky, and a member of the 2018 CDI Week Committee, answered these questions. Contact her at kim.charles@uky.edu.*

Q **According to the 2018 CDI Week Industry Survey results, 19% of respondents review outpatient records of some kind. Does your CDI program include an outpatient program? If so, how did you decide which outpatient services to review/not review?**

A Outpatient CDI is a very broad concept, and not something that everyone is even aware exists. When implementing an outpatient CDI program, it's helpful to collaborate with both your inpatient CDI team and health information management department.

Review medical necessity denials for patient status (inpatient versus outpatient), and review the largest outpatient areas (e.g., ED, ambulatory clinics, etc.), then make the decision on which area is best to focus on.

The important thing to remember when developing an outpatient CDI program is that it really must be a joint effort; the lines of communication must always be open.

Q **People define the terms "outpatient" and "ambulatory" differently. How would you define those terms? Are they interchangeable in your opinion? If not, how do they differ?**

A In most circles, "outpatient" and "ambulatory" are considered synonyms of one another, but don't be too quick to agree.

My opinion is that they mean two different things.

The term "outpatient" refers to treatment provided without requiring an overnight stay by the patient (e.g., outpatient observation status in the ED, or a patient who comes in only for a procedure and is discharged home the same day or next day).

The term "ambulatory" refers to treatment provided to a patient who is not stationary (i.e., they are not lying in bed when the treatment is provided). These would typically be your clinic patients.

Q **What's the primary focus of your program's outpatient reviews? How did you decide what to focus on?**

A In making a decision on what your outpatient CDI program's primary focus should be, there are a number of factors to consider. The best method is to pull and analyze data to identify denial trends, and focus on those areas first. Once you verify those trends, your team can more effectively communicate global CDI opportunities that sometimes a random sample audit may or may not detect.

Q **How is the outpatient program staffed? Do the same CDI specialists review both inpatient and outpatient records? If not, how often do inpatient and outpatient teams interact? How often does the outpatient team interact with coding/office management staff?**
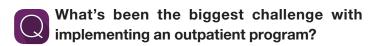
A Typically, the same CDI specialists do not review both inpatient and outpatient records. Inpatient and outpatient CDI differ greatly, so having one designated team for each area is the most effective method. Interaction between the two teams is important, as there is much we can learn from each other.

It is also essential to keep the lines of communication open with coding and management staff in order to have a successful outpatient CDI program.

Q **What type of professional backgrounds do you employ as outpatient CDI specialists and why? What level of experience do they have and why?**

A In order to have a top-notch outpatient CDI team, it is important that each CDI specialist be able to read, interpret, and analyze the information in the medical record at an expert level; possess sound knowledge of medical coding, compliance, healthcare regulations, and payer guidelines; and possess clinical knowledge to include medical terminology, and anatomy and physiology.

It is also essential that they have the ability to communicate documentation deficiencies/audit results in a clear and effective manner.

Q **What's been the biggest challenge with implementing an outpatient program?**

A It is essential when implementing any new program to have both administrative support and physician buy-in. This can be accomplished by promoting awareness, providing evidence that simplifies the process, showing how CDI improves quality of care for patients, and showing how CDI reduces compliance risks.

Q **According to the Industry Survey, roughly 15% of respondents review their outpatient records prospectively, 12% do so concurrently, and 22% do so retrospectively. When do your CDI specialists review outpatient records? Why did you choose that timing?**

A There is an old idiom which states: "Don't put all your eggs in one basket." Basically, this translates to pinning your success on only doing one thing. That is not a good recommendation for any outpatient CDI program.

It is important to have a good mix of records that are reviewed in all three of these ways (prospective, concurrent, retrospective) in order to get clear and consistent results.

Q **Can you tell us a bit about your program's outpatient query process? Is there a set policy governing those queries? What guidance/resources did you use to build that policy or procedure?**

A Provider queries should always be performed for legibility (handwriting that cannot be read by two other individuals), completeness (e.g., an abnormal lab result for which clinical interpretation is not given), clarity (documentation of a patient's symptom for which an underlying cause was not elucidated), consistency (conflicting documentation, e.g., left versus right), and precision (the need for greater specificity of a diagnosis for ICD-10-CM).

At a minimum, CMS states that a physician query should be clear and concise, contain precise language, present the facts, identify why the clarification is needed, and present the scenario.
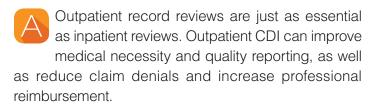
Q How has your outpatient CDI program dealt with physician engagement? What's been the most successful approach?

A Physician engagement is very important to a successful CDI program. It is important that physicians understand that CDI specialists are not the "medical record police," and that the program is there to help them so their documentation is clean, accurate, and reflects the outstanding quality of care that they provide. Keep your communication with your physicians as brief as possible, as pointed as possible, and consistent. Over time, as the relationship is established, the physician will be more than happy to engage.

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

A Outpatient record reviews are just as essential as inpatient reviews. Outpatient CDI can improve medical necessity and quality reporting, as well as reduce claim denials and increase professional reimbursement.

In addition, a proactive approach to CDI can potentially assist in protecting the provider should an outside entity decide to perform a retrospective review.

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

A The first step should be to perform extensive research. Begin gathering information online, in print, and networking with other outpatient CDI teams. There have recently been some very informative books published on the topic. I recommend *First Steps in Outpatient CDI: Tips and Tools for Building a Program*.

Q How do you measure success in outpatient CDI? What's proved the most insightful in terms of metrics and measurements?

A There are four basic metrics that every CDI program can use to measure success: volume, activity, results, and compliance.

To measure volume, simply look at the number of cases reviewed. To review activity, examine query rate percentages. There are a number of ways to do this, and you should evaluate what works best in your individual situation.

When evaluating and reporting results, it is important to align your measures with the declared intent of your outpatient CDI program, since programs and their focus will differ depending on the needs of the organization.

CONSIDER THE SIMILARITIES BETWEEN OUTPATIENT AND INPATIENT CDI

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Outpatient CDI: Everybody's talking about it. This is certainly understandable given the way healthcare in general is focusing on moving care as much as possible from the inpatient to the outpatient setting. And with the continued rise in Alternative Payment Models (APM), there is an increasing awareness of the importance of thoroughly documenting all factors contributing to the calculation of a patient's Risk Adjusted Factor (RAF). Most of the new payment models are based on risk, measuring both how sick the patient is, but also more importantly as a measure of the magnitude of resources needed to care for the patient in a given eligibility year.

It is very common to start discussions about outpatient CDI by describing everything about it that is different than inpatient CDI, including: different coding systems and billing (ICD-10 vs. CPT, HCPCS), the wide variety of outpatient settings, potentially different coders and coding requirements, annual requirements for documentation of chronic conditions, and the timing of reviews and queries.

While it is important to keep these differences in mind, it can leave CDI programs with outpatient aspirations scratching their collective heads trying to figure out where to start. In this situation, it is often helpful to focus on similarities rather than differences.

There are five steps needed for both inpatient and outpatient CDI, namely: (1) find the patients to review; (2) get assistance in chart review and finding opportunities for improvement; (3) query the provider for the clarification(s); (4) measure progress with one or more Key Performance Indicators (KPIs): and (5) have comprehensive and timely reports and metrics to tie it all together.

For inpatient CDI, DRG weight is an effective KPI reflecting the completeness of the documentation of <u>acute conditions</u>. This methodology and workflow was originally developed for reviewing documentation patients covered by Medicare insurance, but it turns out to be equally effective as a KPI for patients with private health insurance. For outpatient CDI, the RAF score is a metric that reflects the completeness of the documentation of <u>chronic conditions</u>. Analogous to the selection of an KPI for inpatient CDI, the use of RAF as a KPI for outpatient CDI works well across all payment plans, not just risk-based plans. The use of RAF as the KPI has the added advantage that CDI staff is already well-versed in the application of ICD-10, and that is the code set used for the RAF calculations.

When considering the move to outpatient CDI, providers should first look to ensure that they have a solid inpatient CDI program. Inpatient CDI is well-defined and focused, and it has known content and workflows. It is a great place for a new CDI specialist to become familiar with chart reviews, the structure and flow of queries, and the use of metrics. It is also a setting that allows all CDI staff to get familiar with Hierarchical Condition Categories (HCC) and their associated RAF scores. Properly designed CDI software tools can be used both in the inpatient and outpatient settings.

Rather than jumping directly to the conclusion, "We *have to do outpatient CDI*," time should first be spent developing strict definitions of exactly what you want to accomplish and what problem(s) you are trying to solve using outpatient CDI. Determine the areas in which outpatient CDI can be helpful for your organization, while shifting the focus from documenting acute conditions to documenting chronic conditions. Remember that some issues may not be directly impacted by CDI.

Determine the specific setting or settings in which to start. Define the metrics to be used to guide the process. Remember that a KPI should be a measurable value that demonstrates how effectively an organization is achieving key business objectives, and that it is only as valuable as the action it inspires. And be prepared to be flexible with staffing considerations, as workflows and hands-on needs for staffing an outpatient CDI program are still evolving.