Outpatient CDI and risk adjustment

As part of the twelfth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Lena Wilson, MHI, RHIA, CCS, CCDS,** the RCS specialized manager of CDI and ICD-10 clinical education at Indiana University Health in Indianapolis, answered these questions. She is a member of the ACDIS Advisory Board and the 2022 CDI Week advisor. For questions about the committee or the Q&A, contact ACDIS Associate Editor Jess Fluegel (*jfluegel@acdis.org*).

Q Can you define what "outpatient CDI" means to you/your organization?

A Outpatient CDI is a broad term used to describe CDI efforts not related to the hospital/inpatient operations. This could range from outpatient procedures (same-day surgery), observation patients, emergency room/department, and professional/physician office. Regardless of what you consider to be outpatient CDI, the CDI reviews are still in their infancy stages at most organizations—when looking at the survey results, not even a quarter of the respondents have an outpatient component. But even if you do not have an outpatient component to your CDI program, there are still some things that your inpatient program can do to support those outpatient efforts as some metrics (Hierarchical Condition Categories [HCC]) will include the inpatient records as part of their diagnosis capture.

Q How do you recommend departments staff their outpatient programs? Should the same CDI specialists review both inpatient and outpatient records? If not, how often should inpatient and outpatient teams interact? How often should the outpatient team interact with coding/office management staff?

A Depending on where your outpatient CDI program is reviewing, your CDI specialists would need to also be well versed in the coding rules related to those patient types. This will not only include ICD-10 coding guidelines but also evaluation and management (E/M) coding criteria/guidelines. Given those factors, it may be appropriate to consider having two teams. This does not mean that you couldn't provide the same diagnosis education to both teams at the same time, but there are nuances that may be confusing. For those topics, it may be best to deliver that content in a separate meeting/session.

As for interacting with office staff/leadership, depending on your organization's structure, you may work with the practice administrator or a lead provider in the office. If there are documentation concepts that need to be addressed that are only impacting a smaller number of providers, there may be an opportunity to reach out to your point of contact and schedule a one-on-one or small-group session to go over the concepts that they may be struggling with. Regular auditing/feedback to the providers is helpful. Everyone wants to do their best at their job, and providing them with this feedback equips them with the tools necessary to do their best on their documentation.

From my experience with a pilot of CDI in the professional/physician office space at my health system, I needed to research HCC diagnosis codes. During

my research, I learned that the capture of HCC diagnoses can occur not only in the professional/physician office space, but that also inpatient encounters would be utilized to capture those HCCs during each calendar year. Even though our system ultimately decided to not continue in the professional/physician office space with CDI at this time, it is still something that my inpatient team can support. Education was then provided to my inpatient team on what HCCs are and the importance of capturing these diagnoses at least once during the calendar year for the patients. At our health system, and I would imagine for most other health systems, many conditions we are querying for in the inpatient space are also HCC diagnoses. So even if you are not able to truly enter into an outpatient CDI space, your inpatient teams can continue to support those efforts.

Q Which services do you recommend reviewing? How should a team decide which outpatient services to review/not review?

A If you are looking to set up an outpatient/professional program, the first step is to determine what patient types that you would like to review—observation, outpatient in a bed, emergency, professional/physician office, etc. As with anything related to documentation, there will always be some opportunity for improvement. You should then review data to determine whether reviewing the accounts and sending queries would address the issue/concern. You may identify that provider education or even a new field on a form may be the solution that is required, rather than additional CDI intervention.

If you determine that your patient population needs a CDI specialist reviewing the records, try implementing a pilot program. Test out your review process and work out the kinks with a smaller group. My personal recommendation is to begin with taking recommendations from provider leadership and looking for volunteers. After that, reach out to a cross-section of providers based on their level of engagement: 1) providers who are great documenters, early adopters, and always "on board" with CDI efforts, 2) providers who are seeing a large volume of patients and may need some education on why CDI is important, and 3) providers whom you struggle with, because if you are able to get them on board with your CDI efforts, they will be your biggest advocates!

You may determine after the pilot that it isn't the right time to implement an outpatient program for your facility—and that's OK. Just remember, again, there are things that you can take back to your inpatient programs and incorporate there.

Q Among those who currently review outpatient records, the most popular focus area was HCC capture (58.52%), and just under half (40.74%) say they review records prospectively. Why do you think this focus and review timing work well for outpatient programs? The prospective process is obviously much different from the traditional concurrent CDI review; do you have any tips for teams expanding to these types of reviews?

A Personally, I think that the prospective review is the best for the HCC diagnosis capture in terms of timing and sending a query to a provider. During our professional CDI pilot, we focused solely on the HCC diagnosis capture. We called them pre-visit reviews. The patients were reviewed ahead of time and provider notifications (the term that we used for the professional space for our queries) were sent to the providers two days prior to the patient's visit. This allowed them time to prep for the patient's visit.

Timing-wise, most of us are aware that there can be additional delays on an inpatient query that is sent after the patient is discharged; therefore, we felt it best to go the pre-visit/prospective route with our reviews. Everything moves much faster in the professional space, and providers have even less time to go back and document on a patient that has already had their visit.

One nuance to reviewing in the professional space is that patients move their appointments around. You may send a query/notification on a patient, only to go back in and realize that they have moved or even cancelled their appointment.

Sending queries/notifications in the professional space felt very different from the traditional inpatient queries. It took some time to ensure that our template was compliant and to come up with a format that wasn't too verbose for the providers due to the sheer volume of patients that are seen in the professional space.

If you are looking to expand into the professional space, the tips mentioned above would be helpful, but look for those clinics with a higher population of

Medicare patients and pilot your CDI efforts with them. Letting them know that they are helping to shape CDI efforts in the professional space may also help motivate the providers, as you really want their feedback to help you along the way.

For our HCC pre-visit review pilot, my health system has clinics called Connected Care. These clinics are structured to manage the care of patients who have two or more chronic comorbid conditions. We began with them and expanded out to other clinics across our state to gain additional feedback. Those may be additional approaches you could take in order to implement an outpatient/professional CDI work effort.

Q In your opinion, why do you think now is the time for outpatient expansion? What might be holding folks back from exploring this setting?

A I will start with what I think might be holding people back first. My own personal thought is what holds us back on everything: FEAR of the unknown! We are all pros at inpatient CDI, or are on the path to becoming pros, and things have become second nature. Outpatient/professional CDI is a scary unknown world that we are trying to dip our toes into. When CDI was looped in at my health system for our professional CDI pilot, I spent many hours doing quite a bit of research so that I had a better understanding of HCCs. I felt like I needed to learn as much as I possibly could before we began our pre-visit reviews and sending notifications (queries). My mind was spinning with all of the new information that I was reading. I asked questions—a lot of questions!—and you shouldn't be afraid to do so.

Reach out to your professional coding leadership and see if they have any information to pass along. You will also need to understand how E/M leveling works in the outpatient/professional space. The rules are different in capturing a diagnosis code in that the diagnoses have to be confirmed; you cannot rely on the verbiage of "possible," "probable," or "likely" in the outpatient/professional space. You also will have to familiarize yourself with the concept of MEAT (Monitoring, Evaluation, Assessment, and Treatment) criteria. You will need to ensure that the documentation includes those components; if the providers do not include them, the diagnosis code may not be captured.

If you do determine that now is the time to implement an outpatient/professional CDI program, start small and expand. Expansion can be as slow or as fast as you would like, but by starting with a small group of providers/clinics, you will be able to ensure a smooth process for your CDI efforts.

Maybe your facility will conduct some evaluations or even attempt to pilot CDI in the outpatient/professional space and ultimately determine that this isn't the right time. I assure you that the information that you learned during this process will not go to waste. Even though we ultimately determined that a professional CDI program wasn't the best fit at this time, I have taken the things that I have learned and worked to incorporate them, where possible, on the inpatient side. As mentioned previously, documentation during the inpatient encounters will also "count" for HCC diagnosis code capture, and many of those top queries are also HCC diagnoses, so you are not necessarily asking for documentation on things that are irrelevant in the inpatient space. When looking at the *ACDIS Pocket Guide*, almost 100% of the diagnoses covered in the guide are also HCC diagnoses, so you are already helping in the outpatient/professional space and may not even realize it!

I think that my last piece of advice is just in general, regardless of where you are at in your career and considering expanding into other areas, is to be easy with yourself. So many of us in the CDI profession are type A and perfectionists! That is a great thing, but we can also easily turn into our own worst enemy. The level of doubt and negative thoughts that we have can begin to hinder us from learning and growing. Think back to when you started in inpatient CDI—we were all newbies at one point just trying to get a handle on things. As you learn more and apply that knowledge, your confidence will increase. Give yourself time for this to happen and use your resources. That is one of the amazing things I really appreciate about our profession—we are not trying to do this all alone! We have peers in our own organizations, people we may have met along the way at our local/state meetings and even at a national level. Maybe you feel stuck and that you have exhausted all of your resources, but remember that you can also reach out to other ACDIS members through the website or even the ACDIS Leadership Council. We are all here to help and want everyone to be successful!

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Outpatient CDI: The impact on Hierarchical Condition Categories

by Keri Hunsaker, marketing manager, 3M HIS

The changing dynamics of risk-based contracts

Medicare Advantage enrollment has more than doubled from 2000 to 2021. This trend is expected to continue, reaching 70% by 2030. Together with other risk-based contracts, Medicare Advantage will continue to challenge the traditional fee-for-service payment methodology and move reimbursement to a more complex value-based model. This also challenges how healthcare organizations and physicians create documentation, as reimbursement relies on risk adjustment factor (RAF) scores to predict care costs and resource utilization, as well as the proper documentation of Hierarchical Condition Categories (HCC). HCCs are a measure used to tell the documented story of a patient's health, and to track the burden of illness among a healthcare organization's population of patients. Documentation must be more robust, accurate, and compliant, ensuring the correct capture of the most appropriate ICD-10-CM diagnosis codes representing the patient and patient care.

Outpatient CDI: Expertise provides focus

As risk-based programs continue to expand, an outpatient CDI program with a focus on HCC documentation can have a significant impact. Because we can expect older Medicare patients to experience new conditions as a result of disease progression, the CMS-HCC methodology requires providers to capture each beneficiary's HCCs at least once annually. An outpatient clinical documentation specialist can provide the expertise needed to understand the documentation and identify gaps required for pinpointing HCCs. These specialists are also skilled at working with physicians to ensure the patient's complexity is documented and follows MEAT (monitor, evaluate, assess, and treat) criteria required for compliance.

The importance of monitoring and capturing HCCs also provides the financial metric needed for investment in an outpatient CDI program. Annual monitoring and documentation of HCCs is a complex process that calls for the skills and training of a clinical documentation specialist. The additional financial metric may be found by identifying "suspected" HCCs, which are defined as conditions "not diagnosed or documented, but suspected based on laboratory results, medications, and procedures." An outpatient clinical specialist will understand and respond as documentation is clinically presented, working with the physician for appropriate and accurate documentation.

A program worth the investment

Healthcare organizations have known the value of inpatient CDI specialists for many years in working with physicians for complete and accurate documentation. Expanding this role to the outpatient setting is a natural progression of the CDI skill set. However, there have been challenges quantifying the return on investment with an outpatient program. As the healthcare environment transitions to outpatient and ambulatory

settings, and as patients move toward Medicare Advantage, investing in an outpatient CDI program will provide the bridge needed to represent patient care and compliant documentation, and ultimately the financial return for the care delivered. An outpatient clinical documentation specialist can provide the proficiency and dedication required to keep up with complicated and changing documentation needs, focusing on HCCs, quality measures, and other documentation that tells the patient's story. Investing in an outpatient CDI program will deliver the financial and quality results needed as healthcare organizations continue to evolve.