Outpatient CDI and risk adjustment

As part of the 13th annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Jennifer A. Boles, BS, CPC, CRC, CCDS-O,** ambulatory CDI manager at Baptist Health Medical Group in Louisville, Kentucky, answered these questions. For questions about the Q&A, contact ACDIS Associate Editor Jess Fluegel (*jfluegel@acdis.org*).

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

A Our outpatient CDI is called ambulatory CDI. This covers the professional (provider) billed documentation in our medical group clinics, outpatient, and hospital places of service.

Q How is your outpatient program staffed? Do the same CDI specialists review both inpatient and outpatient records? If not, how often do the inpatient and outpatient teams interact? How often does the outpatient team interact with coding/office management staff?

A My team is staffed with specialty certified coders. Their titles are ambulatory CDI specialist level I or level II, according to their experience. They review provider documentation in inpatient and outpatient settings. We use different EHR work queues and report to different leadership than the inpatient CDI department. We are located in the ambulatory coding department, which reports to the vice president of finance. I work closely with the inpatient CDI director and hospital coding director. Both teams reach out to each other whenever we need joint provider education or EHR builds to help providers. Hospital CDI and ambulatory CDI communicate monthly and sometimes weekly. The ambulatory CDI staff communicate with ambulatory coding staff daily. Communication with office management occurs whenever we send emails to providers or need assistance with process changes or updates.

Q Which services do you review/not review? How did you decide which outpatient services to review/not review?

A The ambulatory CDI department concentrates on risk adjustment, ICD-10-CM, and template documentation. We have a separate team that concentrates on evaluation and management (E/M) and procedure reviews/education. Leadership decided that there were current resources already focusing on E/M levels and denials, therefore ambulatory CDI should focus on risk adjustment projects and audits. We review face-to-face visits for risk-adjusted CMS-approved providers. The majority of our reviews focus on payer-specific members (Medicare ACO and Medicare Advantage) or annual wellness visits.

Q According to the 2023 CDI Week Industry Survey results, 26.82% of respondents either have a dedicated outpatient program or have inpatient CDI also reviewing some outpatient records, which is just slightly higher than 2022's results. Additionally, 20.35% of respondents noted that while they do not currently have an outpatient CDI program, they plan to

expand into outpatient. What advice do you have for those looking to expand into outpatient CDI?

A I highly recommend starting an outpatient CDI program. We have been able to assist inpatient CDI, hospital coding, and quality departments with care gap closure and mortality measures and projects. We have been able to attribute over 60% of our Medicare Shared Savings Program payout to risk adjustment capture. We have improved our provider relationships and have increased the outpatient query response rate.

Q Among those who currently review outpatient records, the most popular focus area was HCC capture (47.09%), and the majority (40.12%) said 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 those expanding to these types of reviews?

A HCC capture reviews are a good way to show return on investment and financial impact. My team concentrates our reviews after the provider has documented the note but prior to the claim submission to the payer, which allows the CDI specialist to send a query and understand where education is needed. Our prospective review process is built through electronic notifications and practice staff.

I recommend using the tools you have available. If you have staff available to review prospectively or medical assistants within the practice willing to review conditions with the provider prospectively, I would concentrate on those resources. If you do not have resources within the practice, then concentrate on sending queries or building best practice alerts that are built within the EHR.

Q What does the query process look like for your outpatient CDI reviews? Do you have a separate policy for these queries, or is it combined with the inpatient query policy? 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 (i.e., did you reference the "ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice" or "Queries in Outpatient CDI: Developing a Compliant, Effective Process" recommendations into your practices)?

A For us, inpatient CDI is a different department with different policies and processes. The outpatient CDI staff follow the ambulatory coding processes, policies, and escalations. We follow the *ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice* and *Queries In Outpatient CDI: Developing a Compliant, Effective Process*. We also use multiple-choice query templates similar to the ones inpatient CDI staff use so the providers are comfortable with the format. We limit the number of queries we send to the providers. The ambulatory coders send queries to providers but utilize the ambulatory CDI team for education and advisement. If the coders do not receive a response, the ambulatory CDI staff are used to escalate for a response. I recommend only letting those who understand compliant querying send queries. Understanding clinical indicators and writing clear and concise queries is pertinent to having happy providers.

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

A Yes, it is time for outpatient expansion. Metrics are showing that patients are being seen more in the outpatient setting each year. Payers are wanting to lower costs and readmissions. Focusing on outpatient settings will assist in documenting conditions needed to close care gaps and exclusions that can be captured prior to admissions or within 30 days of discharge. I believe folks are still of a mindset that we are in a fee-for-service world and have not made the connection that both inpatient and outpatient need each other to be successful.

My ambulatory CDI team has been able to assist in moving the needle in heart failure mortality measurements as well as getting conditions documented for preop coronary artery bypass graft procedures. We are available for provider education as well as template builds that assist provider documentation. With both inpatient and outpatient CDI staff working together, the providers have a better understanding of what documentation is needed for both inpatient and ambulatory settings. We support each other.

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CDI Week

A team-based approach to outpatient CDI is key to quality care and capturing a broader picture of each patient's chronic conditions

by Robert Budman, MD, MBA, Nuance Communications

As more organizations enter risk-based compensation plans, they face the enormous responsibility of managing care for large patient populations with a range of complex diagnoses. Accurate documentation and capture of Hierarchical Condition Categories (HCC) must occur every calendar year. It's necessary to ensure you receive full payment in the following calendar year. If you miss diagnoses that would have raised Risk Adjustment Factor (RAF), then you won't get adequate payment for patient care and leave money on the table. This challenge is echoed by outpatient leadership across the country.

For busy physicians, the complexity of this diagnosis capture, annually, for the prospective payment system is time-consuming and labor-intensive. Without a coordinated process, you will potentially miss HCC diagnoses and payments on the table.

Organizations should take a comprehensive approach to their outpatient CDI program: an innovative CDI framework that includes outpatient CDI specialists and leveraging artificial intelligence (AI) technology. This is essential to successfully manage high-risk large patient populations. The datasets and EHR documentation needs are just too massive to review and collate evidence without AI. Outpatient CDI teams must innovate and embrace technology.

According to ACDIS, only around 25%* of practices have outpatient CDI processes to tackle the RAF score challenge.

**ACDIS 2022 CDI Survey*

Outpatient CDI improves documentation and RAF scores

The issue with most risk-based payment models is that if you didn't document it, you didn't manage it. Therefore, you can't prove it with coding and billing. HCC diagnoses add up to impact your RAF score that Centers for Medicare and Medicaid Services (CMS) calculates into their payment models.

Knowing your RAF score is critical as it impacts prospective payments for the care of patients in the next calendar year. To elevate RAF score, you need to capture as many of your patients' HCC conditions as possible. Missed diagnoses, especially the higher risk diagnoses, in charts affects the annual calculation and leads to inadequate patient care and lower payment.

RAF improvement is the goal and benefit to implementing an outpatient CDI process. That's because CDI programs can identify the sickest patients who require visits related to their high-risk HCC's and ensure diagnoses are recaptured, new ones added, and most importantly documented on an annual basis.

Weighing the risk vs. the reward

Gaining support for an outpatient CDI program amid staff shortages, competing priorities, and financial challenges requires a close look at the risks and rewards. It is important to weigh the expense of creating a program against the cost of not capturing and documenting all HCCs for each patient. You risk achieving a lower RAF score and even worse not taking care of your sickest patients.

How to determine the real value of outpatient CDI

One way is by calculating the number of risk-adjusted patients and projected diagnoses for each person. Then, weigh the cost of starting a program, hiring outpatient CDI staff, and adding technology against potential payment losses for missed diagnoses and the negative impact that leads to a lower RAF.

Missing just one or two diagnoses per patient directly correlates to a lower RAF based on fewer HCC diagnoses used to determine the RAF and prospective payment for the following year. Understanding the financial impact of missed diagnoses helps highlight the bigger value in outpatient CDI.

Why technology is vital to closing HCC gaps

Manual processes for outpatient CDI are very time-intensive. It requires staff to comb through the EHR to surface HCC opportunities. AI-powered computer-assisted physician documentation (CAPD) technology built in the EHR and existing workflows is critical. Moreover, CAPD technology is fast, efficient, automated, and it can read thousands of notes in a millisecond, easily uncovering HCC opportunities and present them in a busy physician's workflow for reconciliation.

If you're going to take care of a high-risk population, the most important thing you can do is provide them with great care. That great care is contingent on knowing all their medical conditions and documenting all their current diagnoses properly. A team-based approach to outpatient CDI allows you to provide superior patient care and not miss out on HCCs and their support for a higher RAF score.