

Summary: This paper is the third in a series on risk-based clinical documentation integrity (CDI). As the use of risk adjustment in healthcare expands, so too does the reach of CDI professionals in capturing the patient’s story, including level of risk related to demographic factors, comorbidities, and health history. This series will highlight the major risk models, explore the ways in which CDI professionals can impact risk-adjusted methodologies, and describe how these methodologies are transforming the nature of the CDI profession and the day-to-day work of CDI professionals.

FEATURES

- **Getting started in the ambulatory setting: A unified front** 2
- **Appendix: Conclusion and common risk-adjusted conditions** . . . 3
- **Acknowledgements** . . . 5
- **References** 5

Many CDI professionals understand the importance and impact of Hierarchical Condition Categories (HCC). HCCs are assigned from several sources in inpatient and outpatient settings, including both acute and chronic conditions; thus, risk adjustment is integral to documentation and coding integrity in the ambulatory arena. Accurate HCC assignment ensures that a patient’s health status is properly translated into a risk score, which ultimately aids in predicting healthcare cost.

However, many CDI professionals do not fully realize the downstream impact of HCC accuracy in the ambulatory space, on what we know as hospital claims-based quality measures.

As noted in the second paper of this series, CDI efforts commonly focus on risk adjustment in the inpatient space. Inpatient admissions trigger claims-based measures such as PSI 90, where risk adjustment is calculated solely through the diagnoses that appear on one inpatient claim. However, other CMS claims-based quality measures, including 30-day mortality readmissions and complications, have a 12-month lookback period for risk adjustment. Furthermore, CMS uses diagnoses appearing on both inpatient and outpatient claims in their risk adjustment methodology.

For CDI professionals, this means ambulatory documentation and coding integrity not only influences HCC scores, but also serves as the *only* opportunity for risk adjustment related to hospital quality measures. In other words, to be used for risk adjustment, certain diagnoses must appear on a claim prior to the inpatient admission triggering the quality measure. This methodology aims to promote comprehensive disease management, including documentation and coding of those diseases in the ambulatory space to promote quality of care, and appropriate chronic disease management.

The challenge with ambulatory CDI is the promotion and implementation of documentation and coding integrity strategies outside the four walls of the hospital. Without appropriate attention to documentation in both the inpatient and ambulatory spaces, accurate risk adjustment for the CMS 30-day measures will be

difficult. However, this challenge offers a wonderful opportunity for collaboration and knowledge sharing across teams, departments, and locations.

Outpatient CDI is growing quickly. According to the Association of Clinical Documentation Integrity Specialists (ACDIS), survey data in 2016 showed that just 10% of hospitals possessed an outpatient CDI program (ACDIS, 2016). Just five years later, that number has expanded to 24% (ACDIS, 2021).

But this expansion has come with growing pains. Many hospitals compartmentalize CDI into separate inpatient and outpatient teams, but risk adjustment across the patient care continuum requires ongoing collaboration between the two. Inpatient and outpatient teams can exist side by side with a clearly defined focus. To ensure alignment of goals and processes, they should report to the same department and preferably to the same director.

Getting started in the ambulatory setting: A unified front

In any project, a successful outcome starts by identifying the right team members to bring to the table and level-setting based on the current state of affairs. In contrast to inpatient CDI, which has evolved for over a decade, ambulatory CDI in many organizations is nonexistent, in its infancy, or in a limited-resource pilot phase.

Inpatient and outpatient CDI initiatives often seem to run in opposition, with priorities that may not align with risk adjustment strategies for claims-based measures. For example, an organization's ambulatory CDI program may focus on recapture of diabetic manifestations as part of a broader HCC recapture strategy, while the same organization's inpatient efforts may focus on capture of chronic kidney disease with staging as evidenced by lower risk adjustment capture rates in the hospital specific reports. Both goals are appropriate and have merit, but they are misaligned. Alignment can be accomplished through greater awareness and education, showcasing the multitude of ways (direct and indirect) that documentation and coding accuracy impacts risk adjustment and reimbursement.

Some strategies for alignment and removing barriers between inpatient and outpatient efforts include the following:

- 1. Asking other teams about their goals and their barriers to success.** Laying the foundation for collaboration is key to allowing greater collaborative opportunities in the future.
- 2. Sharing data and promoting potential opportunities.** Understanding not only opportunities and gaps, but also their downstream impacts, is vital for any CDI program. Only then can the program truly outline resources and processes that promote the greatest chance of strategy success.
- 3. Jointly reviewing the average number of codes captured on claims.** In the ambulatory setting, claims often do not include the maximum number of codes, which could indicate missed risk adjustment opportunities. The same holds true for inpatient claims, which should aim to capture all clinically supported, relevant, and documented diagnoses. Reviewing

“ In contrast to inpatient CDI, which has evolved for over a decade, ambulatory CDI in many organizations is nonexistent, in its infancy, or in a limited-resource pilot phase.

claims together can create cohesion and areas of overlapping opportunity. Note that an outpatient claim can include a maximum of 12 diagnoses, while Medicare accepts 25 diagnoses (including the admitting diagnosis). When looking at a long or complex case with many codes, teams will need to work together to re-sequence codes, elevating those that have a greater impact on quality outcomes.

4. Educating inpatient and outpatient CDI on the variations between HCC risk adjustment and CMS claims-based measure risk adjustment.

The similarities are numerous, but there are also differences. For one, CMS claims-based measure risk adjustment does not incorporate a hierarchy; even the most nonspecific diagnoses can impact quality risk scores. As an example, unspecified heart failure is a risk adjuster for CMS claims-based measures, regardless of whether congestive heart failure is documented and coded as chronic/acute or systolic/diastolic, and carries the same risk adjustment weight under the CMS risk adjustment methodology.

In summary, a great starting point is bringing the two groups together to feel out pain points, align success strategies, recognize the differences between inpatient and outpatient CDI, and set common goals.

For more information on how you can expand into outpatient/ambulatory settings, review the ACDIS white paper *Outpatient Clinical Documentation Improvement (CDI): An Introduction*, as well as the ACDIS position paper *Queries In Outpatient CDI: Developing A Compliant, Effective Process*.

Appendix: Conclusion and common risk-adjusted conditions

As this series has demonstrated, many factors play into risk-adjusted CDI. We hope that these papers have helped you understand the main types of risk adjustment methodologies and how they impact overall healthcare quality, reimbursement, and documentation, as well as given you strategies for implementing risk-based capture in your organization.

While it's impossible to create one list of diagnoses that impact all risk models across the board, this appendix highlights a few key conditions that may help with your organizational alignment and goals. Most CDI professionals aim for an SOI/ROM of 4/4; however, this is independent of reaching the optimal observed-to-expected ratio of the hospital stay.

A few tips to close out this series:

- Identify your organization's greatest opportunities for improvement by performing a deep dive analysis. Look for trends in denials management, hospital-acquired conditions/Patient Safety Indicators, value-based purchasing, HCCs, and the Hospital Readmissions Reduction Program.
- Consider outliers in your mortality ratings and their possible causes. For example, can they be traced to a DRG that repeatedly falls

“ When looking at a long or complex case with many codes, teams will need to work together to re-sequence codes, elevating those that have a greater impact on quality outcomes.

“ Many inpatient mortalities may qualify as inpatient hospice admissions. Appropriate utilization of inpatient hospice provides many important aspects of holistic care for the patient and family, and prevents the patient from skewing hospital data.

outside the organizational goal, or a documentation issue that requires constant querying?

- Many inpatient mortalities may qualify as inpatient hospice admissions. Appropriate utilization of inpatient hospice provides many important aspects of holistic care for the patient and family, and prevents the patient from skewing hospital data.
- If you perform retrospective reviews, ensure that your admitting team has the correct identifiers for admission status, including transfer from an outside hospital, admission from a skilled nursing facility, elective admission, and trauma/emergency admission. These statuses can impact overall risk. Also sometimes overlooked are dates of procedure codes, capture of mechanical and non-mechanical ventilation, and codes for do-not-resuscitate orders, palliative care, and social determinants of health.

A risk adjustment mindset requires coding and CDI professionals to think outside the box of traditional chart reviews and instead perform them holistically. Many risk adjustment criteria are not only about the current active primary and secondary reportable conditions—chronic conditions are equally important, as are history codes.

The following is a list of common risk adjustment criteria. Use these as a reference for your risk-adjustment efforts.

- Electrolyte abnormalities, laboratory findings
- Oncology: cancer and the presence of metastatic sites
- Nutritional diagnoses: malnutrition, adult failure to thrive, obesity, morbid obesity, cachexia
- Heme diagnoses: anemias, pancytopenia, coagulation defects, hereditary clotting disorders
- Diabetes with manifestations
- Psychiatric conditions: polysubstance and alcohol use, specified depressive disorder, schizophrenia, bipolar disorder
- Neurologic disorders: cerebrovascular accident, Alzheimer’s dementia, epilepsy with/without status epilepticus, severe brain conditions including coma, vasogenic edema, herniation, anoxic brain injury
- Functional status: hemiplegia, monoplegia, quadriplegia, chronic fatigue
- History codes: history of cardiac arrest, history of coronary artery bypass graft, presence of implants/devices such as stents
- Cardiac: ST-elevation/non-ST-elevation myocardial infarction, congestive heart failure, coronary artery disease (native vs. bypass), cardiomyopathy, pulmonary hypertension, arrhythmias and heart block
- Vascular: atherosclerosis, peripheral vascular disease
- Respiratory: acute and chronic respiratory failure, use of invasive and noninvasive mechanical ventilation, asthma, chronic obstructive pulmonary

disease, lung disorders/interstitial lung disease, pneumonia (highest specificity possible)

- GI: esophagitis, ulcers (including type and location), ulcerative colitis, Crohn’s disease, acute and chronic vascular disorders of intestines, intestinal obstructions, complications related to ostomy/colostomy
- Hepatic: hepatitis, acute hepatic failure/shock liver, chronic inflammatory liver diseases
- Integumentary: pressure ulcers, non-pressure chronic ulcers
- Infectious disease: sepsis, severe sepsis, noninfectious systemic inflammatory response syndrome, osteomyelitis, spontaneous bacterial peritonitis, cause-and-effect relationships

Acknowledgments

ACDIS would like to thank the following ACDIS Advisory Board members for their contributions to this series:

- | | | |
|-------------------|-------------------|-------------------|
| ➤ Jennifer Eaton | ➤ Chinedum Mogbo | ➤ Erica Remer |
| ➤ Emily Emmons | ➤ Chris Petrilli | ➤ Aimee Van Balen |
| ➤ Fran Jurcak | ➤ Laurie Prescott | ➤ Irina Zusman |
| ➤ Vaughn Matacale | ➤ Autumn Reiter | |

References

Association of Clinical Documentation Integrity Specialists. (2016). *Outpatient clinical documentation improvement (CDI): An introduction*. <https://acdis.org/resources/outpatient-clinical-documentation-improvement-cdi-introduction>

Association of Clinical Documentation Integrity Specialists. (2021). *2021 industry overview survey*. <https://acdis.org/cdi-week/2021-cdi-week-industry-overview-survey>

Note

ACDIS members have access to an additional pair of associated tip sheets, *Top mortality and length of stay comorbidities*. You can find these in the member-protected [white paper section of the ACDIS website](#).

What is an ACDIS Position Paper?

An ACDIS Position Paper sets a recommended standard for the CDI industry to follow. It advocates on behalf of a certain position or offers concrete solutions for a particular problem. All current members of the ACDIS Advisory Board must review/approve a Position Paper and are encouraged to materially contribute to its creation.