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## Program Notes for CDI Outpatient Workshop Series



- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
    - <https://acdis.org/2017-outpatient-cdi-workshop>
- Continuing education information
  - Please note: In order to receive your continuing education certificate(s) for this workshop series, you must complete the online evaluation, which can be found in the CE instructions file on the download page. The evaluation will open after the last event in the *entire* series on November 17, 2017.

## Disclaimer

- The opinions expressed here are my own
- The model we built is very successful
- Some of this may be feasible at your institution ...
- ... some of it may not
- Trial & error
- Informal, interactive
- Interrupt with questions any time

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## Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Describe the importance of an ambulatory CDI program
  - Describe the structure of the ambulatory team
  - Define metrics to measure impact
  - Take home strategies to implement ambulatory CDI

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## CDI at Cooper

- Launched in 2014
- Hybrid team (remote & on-site)
- Inpatient and ambulatory
- Patient Safety Indicators/hospital-acquired conditions and infections
- *All* aspects of documentation improvement
- National presentations
- Peer-reviewed publications
- 100% physician response rate to queries

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#ilooklikeasurgeon

#ilooklikeamedicaldirector

#ilooklikei'mcrazy



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## Why Ambulatory CDI?

- Healthcare reform focused on improving quality, affordability, and access to care through:
  - Transition to value-based payment
  - Improved care delivery through innovation
  - Expanded information sharing, including increased transparency on cost and quality for better consumer decision-making
  - Increased regulatory oversight and scrutiny
  - **Shift to outpatient services**

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## Why Ambulatory CDI?

- 2014 AHIMA Foundation Clinical Documentation Improvement Job Description Summative Report:
  - 337 randomly selected CDI specialist job descriptions
  - 99% of the job locations were in the acute care setting
- 2016 survey by ACDIS:
  - 10% of hospitals have an outpatient CDI program
  - 20% of respondents plan to cover this area (6–12 months)

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## *Inpatient CDI ≠ Ambulatory CDI*

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### Getting Started

- Do you already have an inpatient CDI program?
  - What are your metrics?
  - How do you measure success?
  - Are your physicians engaged with the program?
  - Are there educational programs in place?
- Do you want to expand to ambulatory?
  - What will be your area(s) of focus?
  - Where do you want to start?
  - What resources do you have?
  - What resources do you need?

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## Getting Started

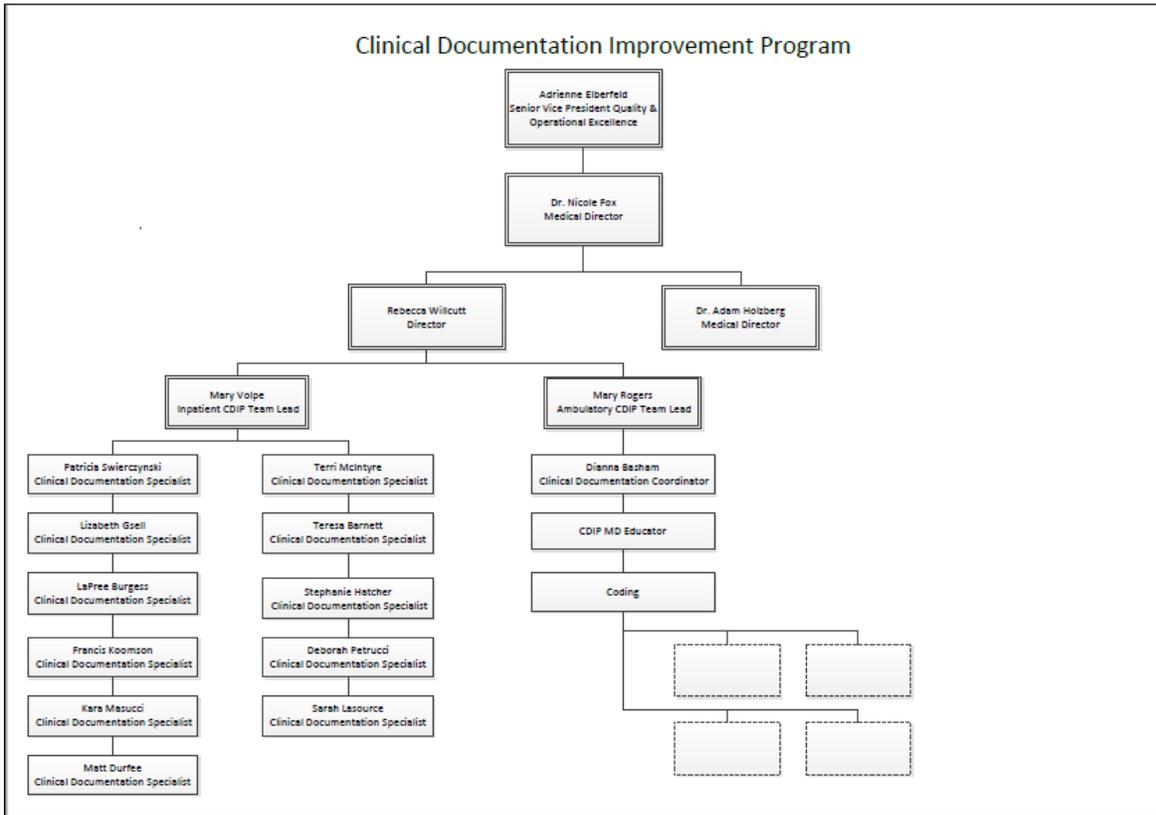
- Hired an additional medical director
  - Primarily outpatient experience
  - Interest in informatics/EHR
- Combined teams
- Partnered with compliance, revenue cycle, and informatics
- Started with template optimization in ambulatory practices

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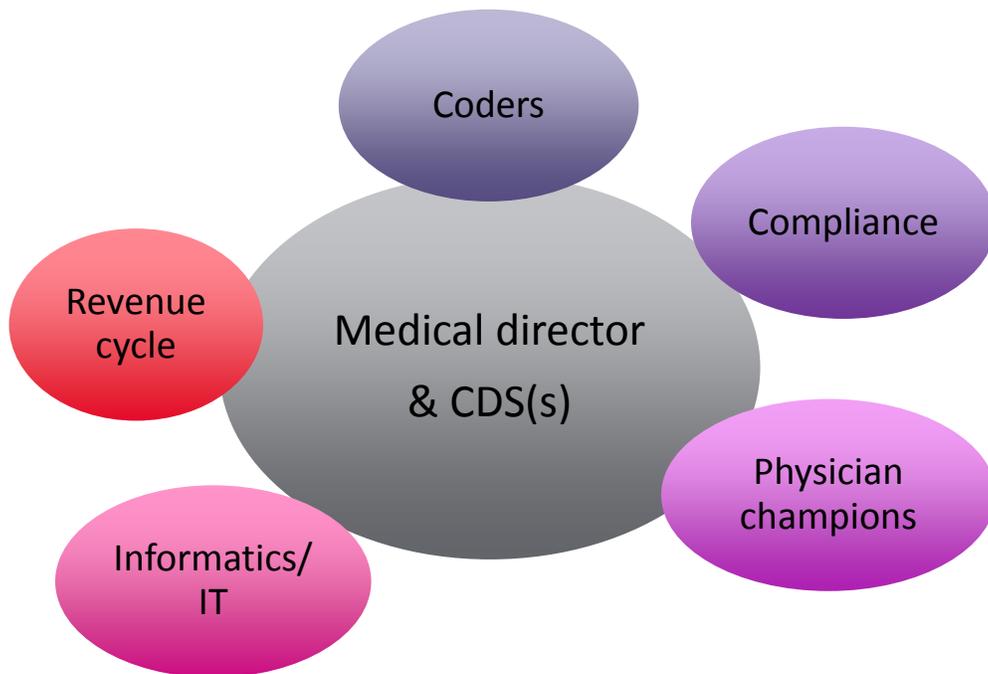
## Medical Director

- Should be hired by senior administration
- Should be:
  - ***A practicing clinician***
  - Well known by the medical staff
  - LIKED by the medical staff
  - A leader and communicator
- Disclaimer: May need ***EDUCATION***

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## Team Members



## ACDIS White Paper

- Outpatient CDI still being defined
- Any CDI effort *NOT* associated with an inpatient claim
- Focus areas:
  - ED
  - Ambulatory clinics
  - Observation services
  - ***E/M services***
  - ***CMS HCCs***

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## Rationale

- **E/M services:**
  - Revenue opportunity
  - System already in place
  - Physicians should be physicians (NOT coders)
  - Affects RVUs (automatic engagement)
- **CMS HCCs:**
  - AllCare Health Alliance
  - Population health
  - Care across the continuum
  - Can quantify impact

\*compliance, revenue cycle, chiefs/chairs

\*compliance, population health, ACO and ACO providers

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## Acquiring New Skills

- Due diligence and auditing of outsourced coding
- Management of deficiencies in E&M documentation
- EHR functionality for HCCs
  - What do we have in place?
  - How can we marry this to physician workflow?
- Risk-adjusted coding (CRC)
  - Now required certification
  - On-site course conducted

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## Physician Education

- E/M services:
  - Choosing their level of service (vs. coder)
  - Deficiency reports
  - Ongoing education (scheduled and by request)
- HCCs:
  - Mandatory educational sessions focused on HCCs and risk adjustment
  - Offered live and recorded to put on Cooper Learning Network
  - Chose Cooper ACO as starting point
  - Drilled down on one practice as a “pilot”

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## The Reality

### What we are taught ...

- Basic sciences
- Clinical medicine
- Procedural skills
- Communication

### ... & what we are not

- DOCUMENTATION
- Compliance
- Appropriate/efficient use of the EHR
- Value-based purchasing
- Coding/billing
- Revenue cycle

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## Challenges

- Distrust
- Overconfidence in coding abilities
- Impact on salary/incentive
- Not “one size fits all”

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## E&M Services

- Tight management of outsourced coding
- Generation of requests for additional information (RAI)
  - 6,000 per year
  - Tied directly to revenue & RVUs
- Deficiency reports
- Coding-level reports

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## RAI Process

- Requests for additional information
- Indicates note in current form not “code-able”
- Mediator between physician and coding company
  - Cooper employed
  - Coding background
  - Physician educator
- Provides opportunity for physician education
- Can identify missed opportunities and errors

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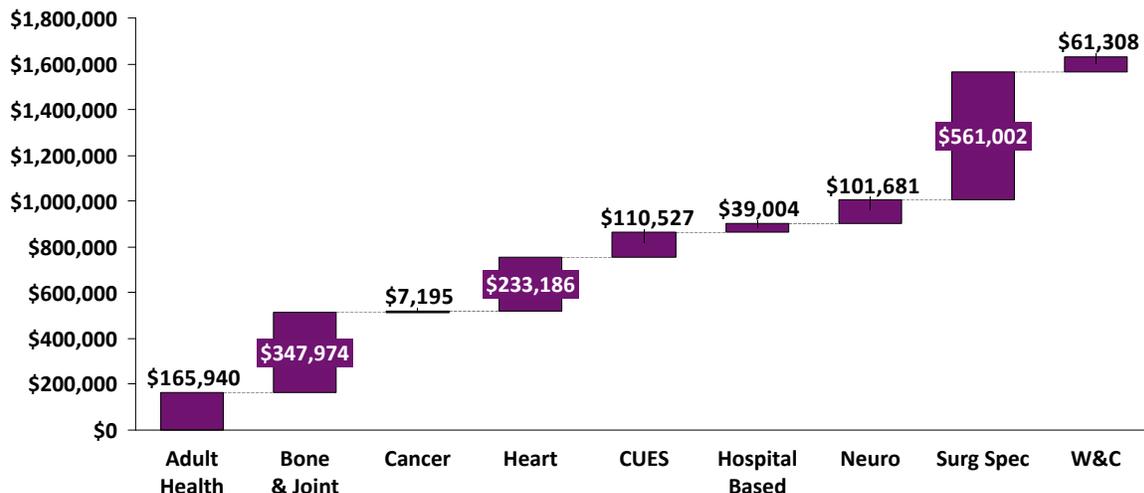
**RAIs with Date of Service Jan 16 thru Oct 16**

**RAIs Normalized for Full Year of Work**

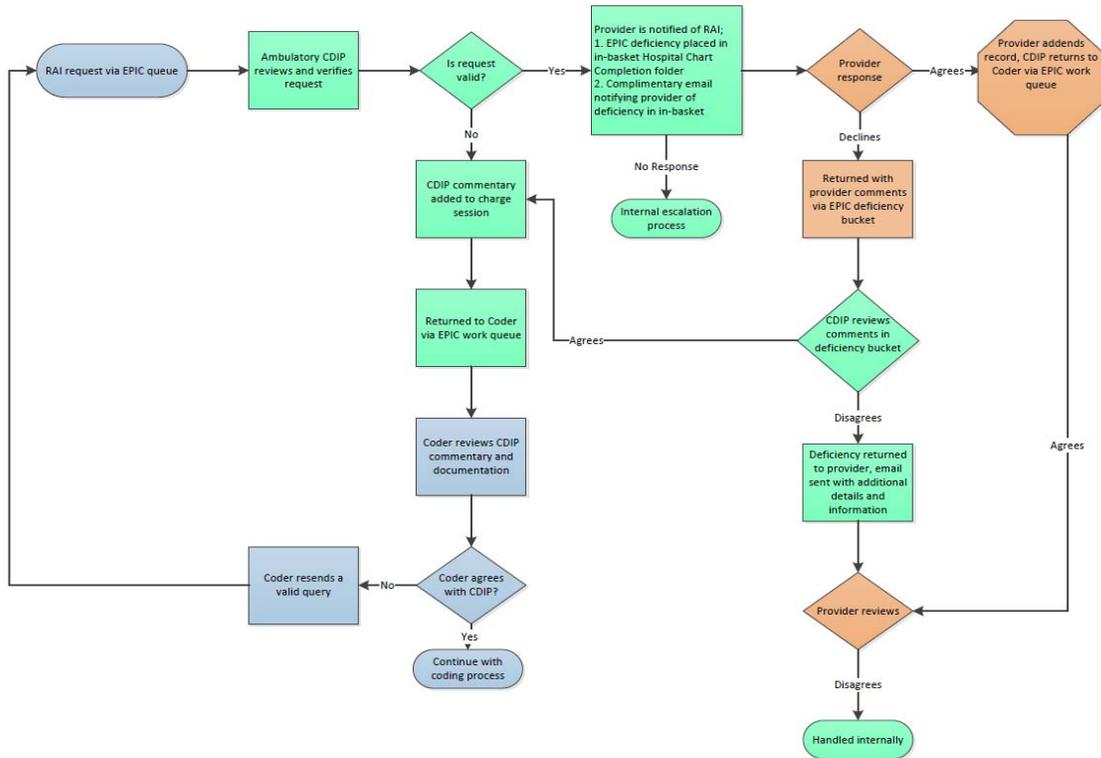
	Estimated			Estimated		
	Total RVUs on RAI CPTs	Revenue RAI Code	Collection per Total RVU	Total RVUs on RAI CPTs	Revenue RAI Code	Collection per Total RVU
Adult Medicine	4,518	\$ 127,646	\$ 28.25	5,873	\$ 165,940	\$ 28.25
Bone and Joint	8,495	\$ 267,672	\$ 31.51	11,044	\$ 347,974	\$ 31.51
Cancer	195	\$ 5,534	\$ 28.36	254	\$ 7,195	\$ 28.36
Cardio - Thoracic	5,574	\$ 179,374	\$ 32.18	7,246	\$ 233,186	\$ 32.18
CUES	2,700	\$ 85,021	\$ 31.49	3,510	\$ 110,527	\$ 31.49
Hospital Based	957	\$ 30,003	\$ 31.36	1,244	\$ 39,004	\$ 31.36
Neurosciences	2,490	\$ 78,216	\$ 31.41	3,237	\$ 101,681	\$ 31.41
Surgical Specialties	14,358	\$ 431,540	\$ 30.06	18,666	\$ 561,002	\$ 30.06
Women & Children	1,492	\$ 47,160	\$ 31.62	1,939	\$ 61,308	\$ 31.62
<b>Total</b>	<b>40,778</b>	<b>\$ 1,252,166</b>	<b>\$ 30.71</b>	<b>53,012</b>	<b>\$ 1,627,816</b>	<b>\$ 30.71</b>

## Valuation

- Methodology:
  - GPCI POS adjusted total RVUs were calculated for these CPT codes and the 2016 collection per total RVUs was applied at the division/location level
  - Based on this analysis, clinical documentation touched claims with a calculated 53,013 total RVUs and an estimated reimbursement of \$1,627,816



### Ambulatory CDIP Request for Additional Information (RAI) PFM



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## Escalation Process

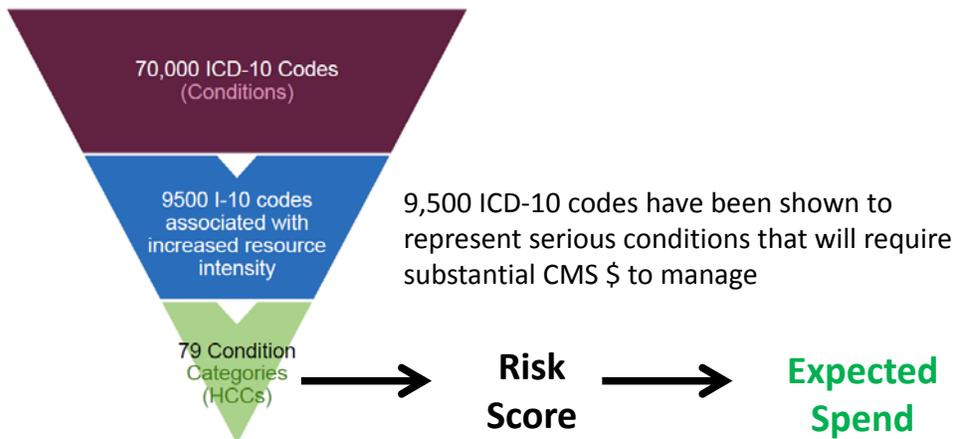


<b>4 business days after RAI sent (held only if WE are aware physician is away)</b>	
Escalation #1	Email physician
<b>4 business days hours after escalation #1</b>	
Escalation #2 (final)	Email physician, copy Dr. Fox and department head
<b>4 business days after escalation #2 Return to coder as not added, code (as is) if possible</b>	
	Notify Dr. Fox, will escalate to CMO if necessary

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## HCCs

### Claim in Measurement Year



Conditions grouped into Condition Categories:

- Similar conditions
  - Similar recourse needs
- = 79 different Condition Categories

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## What Does It Mean?

- Risk adjustment scores higher for sicker patients
- HCC coding is *prospective*; score and funding established for the subsequent year
- Chronic conditions must be reported once per year
- January 1st, the slate is “wiped clean”
- If physicians are coding, they *must* be educated
- Audits demonstrate that HCCs are often underbilled

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## Starting Points

- Past assessment diagnosis not found in current year claims
- Problem list event not assessed or claimed in year
- Historical event indicates undocumented condition
- Medication infers undocumented condition
- Claims/billed events not submitted to CMS

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## Importance of CDI

- A strong CDI program ensures accurate coding that results in **maximum reimbursement, optimal quality scores, and minimal penalties**
- High volume of visits:
  - Inpatient query process doesn't "fit" here
  - Must leverage the EMR
  - Analyze data
- Will be an ongoing, malleable process

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## Gap Analysis

**2015**

COPD  
Diabetes  
CHF  
Vascular disease

**1.2**

Risk Score

**\$11,520**

Expected PMPY

**2016**

COPD  
Diabetes  
CHF  
Vascular disease

**0.8**

Risk Score

**\$7,680**

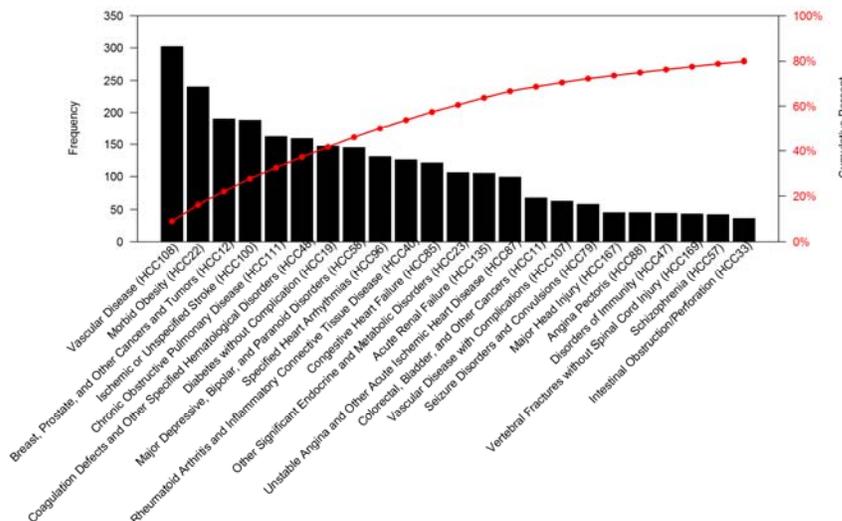
Expected PMPY

**= -\$3,840**

Expected PMPY

Medicare spend – impacts ACO shared savings opportunity  
Need to maximize acuity combined with control spend (care coordination, reducing readmissions)

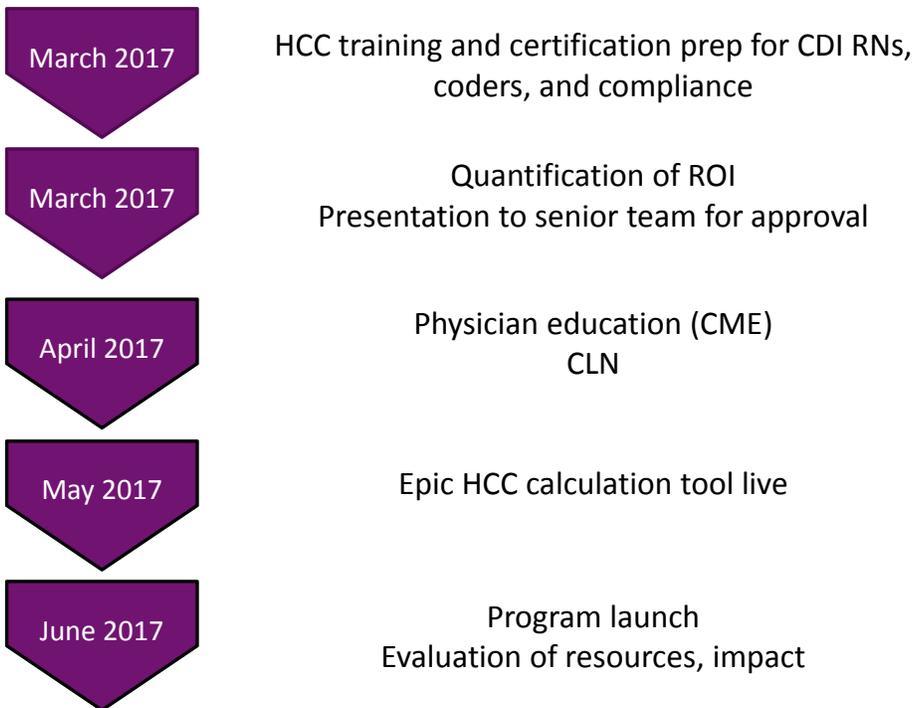
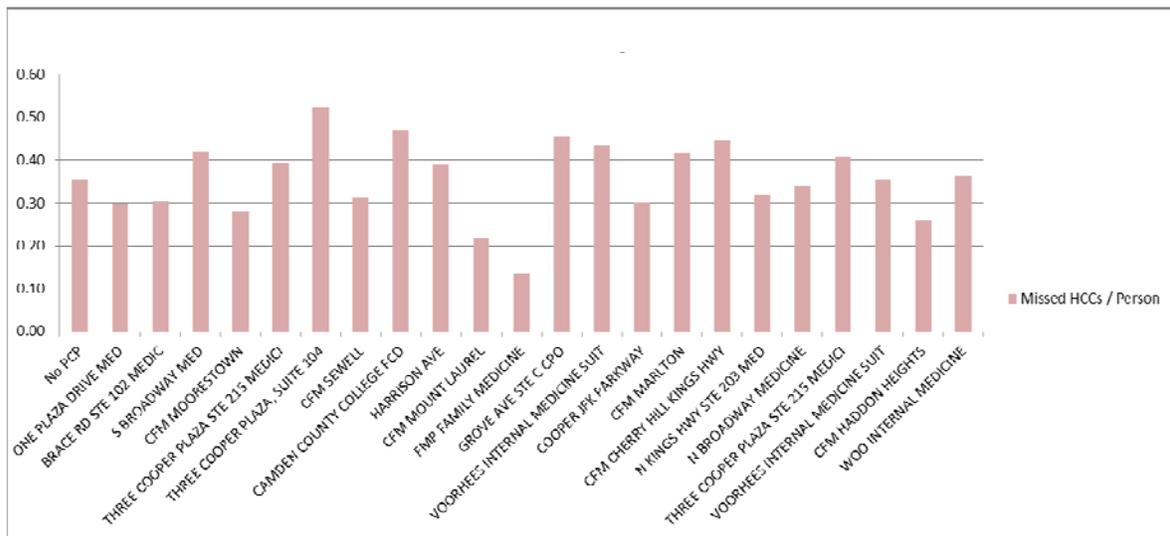
## The Cooper Experience



- Top 10:**
- Vascular disease
  - Morbid obesity
  - Cancer/tumors
  - Ischemic stroke
  - COPD
  - Coagulation defects
  - Diabetes
  - Major depression
  - Heart arrhythmias
  - Rheumatoid arthritis

*Top 23 HCCs account for 80% of all missed diagnoses*

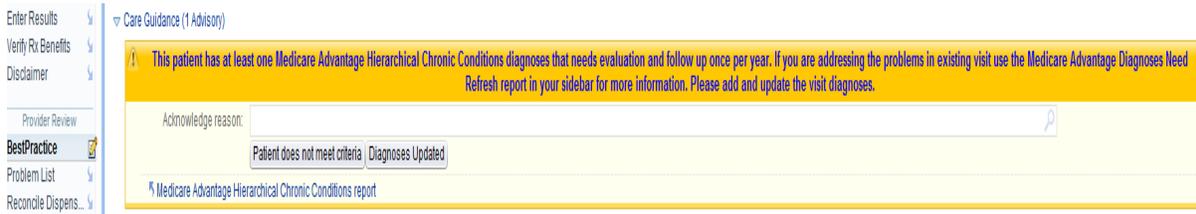
# Missed HCCs by PCP Location



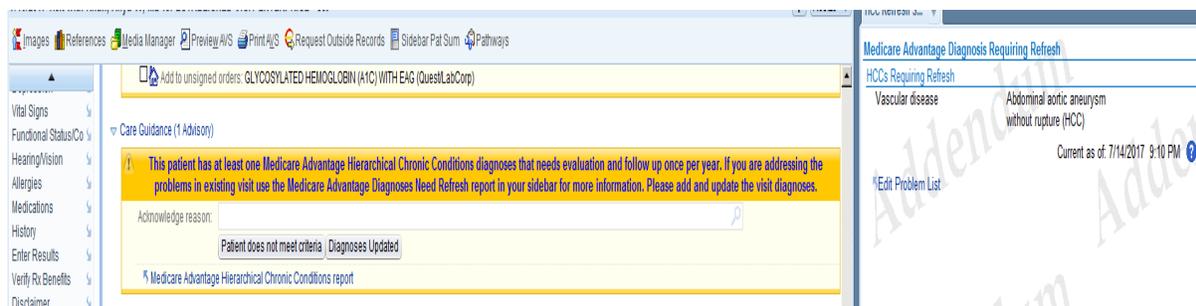
## Pilot Practice

- Internal medicine practice (4 physicians)
- Look for patients with “HCC gaps”
- Chart review and provider education
  - Importance
  - Most common diagnoses
  - EPIC workflow
- Epic BPA for missing HCCs

## Best Practice Alerts



The screenshot shows a Best Practice Alert (BPA) in a yellow box. The alert text reads: "This patient has at least one Medicare Advantage Hierarchical Chronic Conditions diagnoses that needs evaluation and follow up once per year. If you are addressing the problems in existing visit use the Medicare Advantage Diagnoses Need Refresh report in your sidebar for more information. Please add and update the visit diagnoses." Below the text is an "Acknowledge reason:" field with a search icon and a dropdown menu showing "Patient does not meet criteria | Diagnoses Updated". At the bottom of the alert is a link for "Medicare Advantage Hierarchical Chronic Conditions report".



This screenshot shows a patient chart with a Best Practice Alert (BPA) and a Medicare Advantage Diagnosis Requiring Refresh report. The BPA is identical to the one in the previous slide. The report on the right, titled "Medicare Advantage Diagnosis Requiring Refresh", lists "HCCs Requiring Refresh" with a table of diagnoses: "Vascular disease" and "Abdominal aortic aneurysm without rupture (HCC)". The report is dated "Current as of: 7/14/2017 9:10 PM" and includes an "Edit Problem List" link.

PULMONARY
<p><b>Acute Respiratory Failure</b>- Rarely treated in an office setting. Treated in ER or inpatient setting and followed up with PCP. Document "history of" or "chronic" respiratory failure as appropriate.</p> <p><b>COPD</b>- Document current treatment, medication, response to treatment and any related PFT or CT results. Document tobacco exposure. Example:</p> <ul style="list-style-type: none"> <li>Moderate COPD- Compensated on Albuterol, PFT done 05/12/14, shows mod. obstruction. 40+ pack year smoking hx. Pt continues to smoke.</li> </ul>
RENAL DISEASE
<p><b>Chronic Kidney Disease</b>- Document stages of CKD along with evaluation and treatment. Calculated eGFR from labs are recommended to establish CKD stages. Example:</p> <ul style="list-style-type: none"> <li>CKD stage 4, GFR 20, will refer to nephrologist for evaluation.</li> </ul> <p><b>Dialysis Status</b>- Document if patient is on long term dialysis also, frequency, who they are seeing for treatment and any complications. Example:</p> <ul style="list-style-type: none"> <li>CKD stage V, currently on dialysis with Dr. Smith, 3x wk, no problems today.</li> </ul>
SKIN
<p><b>Ulcers</b>- Do not document skin ulcers as "open wound" or "chronic wound" This will not allow coder to assign the correct code for skin ulcer. Examples:</p> <ul style="list-style-type: none"> <li>Diabetes type 1, uncontrolled with rt ankle ulcer, little improvement, will continue dressing changes 3xwk</li> <li>Pressure ulcer lower back, stage 3, improving, continue packing 3xwk. Slp back surgery.</li> </ul>
STATUS AND CO-EXISTING CONDITIONS
<p>Many of these conditions get left off the medical record: Document, at least, annually.</p> <ul style="list-style-type: none"> <li>Ostomies</li> <li>Quadriplegia</li> <li>Paraplegia</li> <li>Amputations</li> <li>Alcoholism in remission</li> <li>Organ transplants</li> <li>Dialysis status</li> <li>Drug dependence</li> <li>AIDS or HIV</li> </ul>

## Documentation Tips

Document explicitly for all conditions being addressed. Documentation must be complete now more than ever with ICD-10 implementation.

Do not list diagnoses in the assessment without some sort of treatment or status documented to show that you have addressed each condition on that visit. **Remember MEAT!**

Make sure all codes reported on encounter forms or superbills match what's charted for that date of service.

Do not write the diagnosis code in place of the narrative diagnosis. This is not acceptable because all coding must be done from a narrative to ensure the correct code is assigned.

Do not use symbols to indicate a disease. Examples: †BP or †lipids. These are not the same as hypertension or hyperlipidemia and are coded differently.

*If it isn't documented, it didn't happen!*

### Medical Record Criteria

- Use only standard medical abbreviations
- Ensure the medical record is legible and complete.
- Patient's name and date of service must be on each page of the record.
- Use SOAP note format when applicable.
- Each record must have clear clinician signature with a credential after the name.
- Stamped signatures are not accepted.
- Electronic signatures must be stated as "Authenticated by" "Signed by" or "Approved by" and include the date, name and credentials of the authoring provider.
- Amendments to records must be made as close to the date of service as possible, generally within 72 hours. It is not acceptable to create an amendment months or years after a service.
- Late entries should be clearly labeled as such with:
  - Date and time of late entry
  - Reason for late entry
  - They should be done relatively close to the time of service.
- Corrections should be done by a single strike through to the error. No portion of the medical record should ever be obliterated.



## HCC Documentation Tip Sheet

### First, let's define MEAT:

- **Monitor**—signs, symptoms, disease progression, disease regression
- **Evaluate**—test results, medication effectiveness, response to treatment
- **Assess/Address**—ordering tests, discussion, review records, counseling
- **Treat**—medications, therapies, other modalities

For more information on HCC documentation please contact Clinical Documentation Improvement:

**Mary M. Rogers, CCS, CPC, COC**  
 856.981.1508  
**Trish Swierczynski BSN, RN, CCDS**  
 856.534.3388  
**Rebecca Willcutt BSN, RN, CCDS, CCS**  
 205.613.0025

## Diabetes and Complications

**When documenting diabetes, it's important to note the following:**

- Type of diabetes, type 1 or type 2 or secondary.
- ICD-10 does not recognize type 1.5 and coding rules say it is to be coded as type 2.
- If secondary DM, document what the cause is or primary condition along with secondary diabetes.
- Is the diabetes CONTROLLED or UNCONTROLLED? "Poor control" must be coded as controlled diabetes as it is not specific.

### Documenting Diabetic Complications

Causal relationships should be stated, not implied. Use phrases such as "due to" "because of" or "related to" to establish a clear relationship.

### Diabetes with Renal Manifestations

Examples of clear documentation:

- "CKD stage 4 due to DM 2, uncontrolled"
- "Type 1 controlled Diabetic CKD stage 5, on long term dialysis 3x wk with Dr. Smith, no problems at this time"

### Diabetes with Ophthalmic Manifestation

Diabetic patients should have diabetic eye exams annually.

Examples of clear documentation:

- Blindness due to DM 1, controlled.
- Type 1 uncontrolled diabetic proliferative retinopathy.

### Diabetes with Neurological Manifestations

Examples of clear documentation:

- Polynuropathy and gastroparesis due to DM 2, uncontrolled
- Type 1 controlled diabetic peripheral autonomic neuropathy
- Type 2 uncontrolled diabetic peripheral neuropathy

### Diabetes with Peripheral Circulatory Disorders

Examples of clear documentation:

- PAD lower exts. due to DM 2, controlled.
- Gangrene lt great toe due to controlled Diabetic PVD.

## CHARTING SPECIFICS AND EXAMPLES

### CARDIOLOGY

Often Old MI and Angina co-exist. Evaluate and document all cardiac conditions, and any treatment patient is receiving.

### CHRONIC CONDITIONS

All chronic conditions must be fully assessed annually. Examples of terms that indicate evaluation and treatment:

- Stable on meds.
- Conditions worsening- medication adjusted (include name of medication and changes made or changes to treatment plan).
- Tests ordered- documentation reviewed and results entered into treatment plan.
- Condition improving.

### CIRCULATORY

**Acute CVA**- Rarely treated in an office setting. Most cases are treated in ER or inpatient setting and followed up with PCP. Documentation that states "history of" CVA for follow up treatment is clearer, as it is no longer an acute event.

**CVA Late Effects**- Document any late effect due to CVA, "Hemiparesis" should not be documented only as "R/L sided weakness". Dominant or non-dominant sides are additional important qualifiers to note. Example:

- Dominant right-sided hemiparesis, due to CVA in 2008, stable with no improvement.

**Vascular Disease of Aorta vs Aortic Valve**- Atherosclerosis of aorta must clearly distinguish vessel from the valve—using "aorta" or location to indicate the vessel. Examples:

- Ascending aortic atherosclerosis
- Atherosclerosis of aortic arch
- Aortic valve stenosis
- Abdominal aortic atherosclerosis

Do not document "Venous insufficiency" if you mean PVD or PAD.

### FRACTURES

Document Pathological Fractures as current, acute or chronic as long as there is active treatment documented as well. Document cause as well.

### HISTORY OF

Do not use "History of" if patient is still receiving treatment and condition is not resolved.

Examples of incorrect usage:

- History of Diabetes- Type II, diet controlled.

### LABS

Do not code a lab test result without connecting it to a diagnosis. Simply referring to an abnormal blood sugar without noting the patient is a diabetic cannot be coded as diabetes.

### MENTAL DISORDERS

**Major Depression**- Clearly document "Major Depression" or "Major Depressive Disorder" (MDD) if that is what is wrong with the patient. Examples:

- Major depression- Stable on Med.(include name) Patient able to do daily tasks, sees Dr. Smith for treatment. You must note severity as well.

### NEOPLASMS

Becomes "History of" if it has been treated by surgery, radiation or chemotherapy and there is no current indication of disease.

- Patients who have not received treatment for their malignancy should continue to be documented as current and not history of.
- Breast and prostate cancer patients receiving long term adjunct therapy can be documented with a current malignancy, as long as treatment is documented and active.

**Metastatic Disease**- Document all metastatic diseases and site along with primary site, and current treatment. Examples:

- Mets to bone, multiple sites, due to prostate CA, patient is on chemotherapy.
- Stage IV lung CA with mets to brain, patient is on chemotherapy.

### NEUROPATHY

Assess and document current treatment for chronic neuropathy conditions:

- Multiple Sclerosis
- Alzheimer's Disease
- Huntington's Disease
- Myasthenia Gravis
- Inflammation and Toxic Neuropathies
- Epilepsy

### NUTRITION

ICD-10 requires a BMI of 40 or above when diagnosing and documenting for Morbid Obesity. This may differ from other standards.

**Malnutrition**- Evaluate and document for BMI less than 20.

## Keys to Success

- Choose your area(s) of focus
- Build your team
- Understand physician workflow
- Leverage success of inpatient CDI if applicable
- Maximize use of the EHR
- Seek as much education as you can
- **Share** information



**Thank you. Questions?**

[fox-nicole@cooperhealth.edu](mailto:fox-nicole@cooperhealth.edu)

To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

## Conclusion

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## Thank You!

The next program in the  
**Outpatient CDI Workshop** series,

***Where's Waldo? Common Diagnoses Often  
Missed in Outpatient Documentation,***

will be broadcast live on  
Wednesday, November 1 at 1 p.m. ET.

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