Outpatient Clinical Documentation Improvement (CDI)

Anny P. Yuen, RHIA, CCS, CCDS, CDIP, AHIMA Approved ICD-10 CM/PCS Trainer

Florida ACDIS Meeting

Objectives

- The Changing Healthcare Landscape
- Evolution of Clinical Documentation Improvement (CDI)
- Why is Outpatient CDI Necessary?
- Where To Begin?
- Understanding Denials
- How To Measure Impact?
- Key Take-Aways

The Changing Healthcare Landscape

The Changing Healthcare Reimbursement Landscape

- According to the March 2016 Medicare Payment Advisory Commission *Report to the Congress: Medicare Payment Policy*: hospital inpatient discharges declined by nearly 20% between 2006 and 2014 while outpatient services increased by nearly 44%
- Early 2015, CMS introduced a new quality-driven initiative that paid providers for value, not volume. Reimbursement relies on quality measures and data from programs like the Inpatient/Outpatient Quality Reporting.

The Changing Healthcare Reimbursement Landscape (continued)

- Healthcare providers are increasingly accepting financial risk associated with patient management.
- The purpose of risk adjusted payment methodologies is to promote fair payments to providers that reward efficiency and encourage quality of care for the chronically ill patient population.

The Changing Healthcare Reimbursement Landscape (continued)

The shift to quality has introduced us to many new terms:

- MACRA: The Medicare Quality Payment Program with two tracks- the Merit-based Incentive Payment system (MIPS) and the advanced Alternative Payment Models (APMs)
- Risk Adjustment: A methodology used to predict healthcare costs based on the relative risk of the enrollees in the covered plans (45 CFR 153.20)
- HCCs: Hierarchical Condition Categories
  - CMS-HCC is used by Medicare Advantage Plans
  - HHS-HCC is used by Commercial Plans

The Changing Healthcare Reimbursement Landscape (continued)

- In today's healthcare reimbursement landscape, hospitals as well as physicians now have reason to be concerned with documentation due to various forms of value-based reimbursement models. The burden is increasing and it is now a shared burden.
- Reimbursement for hospitals and physicians now relies on the accuracy of documentation and the reporting of all patient diagnoses.

Financial Impact on Providers- Payment Framework

	Fee for Service No Link to Quality	Fee for Service Link to Quality	Alternative Payment Models Built on Fee-for-Service Architecture	Population-Based Payment
Description	• Payments are based on volume of services and not linked to quality of efficiency	• At least a portion of payments vary based on the quality of efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of service but opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 yr)
Example	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medical homes • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

Source: CMS Fact sheets: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. 01/26/15

Evolution of Clinical Documentation Improvement (CDI)

Evolution of CDI: Past, Present and Future

Past:

- Clinical documentation improvement began mostly in the inpatient setting
- Most CDI Specialists were trained to review and/or target the following:
  - Focus on Medicare cases only
  - DRG focus specifically those that will impact reimbursement (i.e. CC/MCC capture)

Evolution of CDI: Past, Present and Future (continued)

Current & Future:

- Increase importance of clinical documentation
- Shift in CDI focus & need to expand into outpatient CDI
- Documentation impacts clinical care, accurate reimbursement, and reportable research/quality data
- Payment models are shifting from Fee-For-Service to an alternative payment model

Why is Outpatient CDI Necessary?

What is Outpatient CDI?

- The scope of outpatient CDI is contingent on the objectives of the organization and the resources and time that can be made available for the process.
- Outpatient Clinical Documentation Improvement (CDI) focus areas may include the following:
  - Emergency Department
  - Observation Services
  - Physician Offices
  - Other Outpatient Settings (i.e. Clinics, Surgery Centers, etc.)

Why is Outpatient CDI Necessary?

- Due to the changing focus on outpatient reimbursement and overall quality measurements, physicians and hospitals now share the burden of not only getting paid for services rendered, but also keeping the reimbursement already received and ensuring future reimbursement and possible incentives through reporting positive quality measures

General Outpatient Barriers

- Volume of outpatient encounters
- Time is not on the outpatient side like it is in the inpatient setting.
  - Documentation in the outpatient occurs quickly so the program must be nimble.
- Physicians coding with no understanding of coding guidelines (inpatient versus outpatient)
  - Too many coding selections built into their coding tables for selection
- Incorrect/inaccurate problem lists
- Technology: EMR versus Paper.
  - Some EMR's were implemented first in the OP setting then in the IP setting therefore, some existing processes and/or applications may not work for your CDI objectives and mission.
- Not establishing clear mission and goal with outpatient CDI

Overall Benefits of Having Both Inpatient and Outpatient CDI

- Enhance inpatient and outpatient coding accuracy
- Improve Risk Adjustment Factor (RAF) score, and HCC risk scores.
- Create an accurate problem list starting in the physician office and/or Emergency Department to ensure coding accuracy and the capture of present on admission indicators.
- Improve documentation and assure chronic conditions are continuously captured within the EMR/EHR that impacts both inpatient and outpatient value-based outcomes.
- Reduction of audit risks and/or denials.
- Capture level of specificity to accurately reflect patient complexity in reported data impactful to quality outcomes.
- Produce reliable medical records that can enhance the quality of patient care and patient satisfaction.
- Be proactive in capturing data elements that may be required in the future for quality reporting for care coordination

Where To Begin?

Where to Begin?

- Every organization will have their own opportunities so know your organization's data/vulnerability.
- Organizations must establish their focus area(s) and understand that the OP CDI team cannot do it all.
- Every OP CDI Team must establish a mission to avoid mission creeping.

Where to Begin? (continued)

Perform your due diligence:

- Determine where to begin your data analysis
- Determine what type of internal audit (post-bill versus pre-bill)
- Trend your findings from the data analysis and internal audit
- Identify bottlenecks and/or breakdowns within the revenue cycle process (i.e. is there a lag time in re-submitting claims that are denied due to lack of staffing to process denials, etc.)
- Determine if specific education is needed (i.e. medical necessity for the registration and OP CDI team, etc.)
- If needed, implement process changes

Areas of Outpatient CDI Opportunity: Emergency Department (ED)

- Opportunities in the Emergency Department may include, but not limited to the following:
  - Obtaining proper documentation to support medical necessity of observation care.
  - Time capture for all treatment services rendered (i.e. infusions): This is a common ED denial related to lack of documentation.
  - Charge capture validation: CDI specialists can collaborate w/ the CDM department to help ensure charges for supplies and/or medications rendered in the ED are appropriate for the services documented.
  - Present on Admission

Areas of Outpatient CDI Opportunity: Ambulatory Surgery

- Opportunities in the Ambulatory Surgery may include, but not limited to the following:
  - Ensure history & physical clearly documents a diagnosis that meets medical necessity for the outpatient surgery.
  - Review the operative note to ensure the accuracy of postoperative diagnoses, especially those that are awaiting pathology results.

Areas of Outpatient CDI Opportunity: Physician Practices/Clinics

- Opportunities in the Physician Practices/Clinics may include, but not limited to the following:
  - Diagnosis Specificity: Ensure all diagnoses are documented to the highest level of specificity and is supported by documentation through M.E.A.T. (monitoring, evaluation, assessment, treatment).
  - Medical Necessity: Ensure that the reason for outpatient clinic services is clearly documented and meets relevant national coverage determination (NCD) and local coverage determination (LCD) requirements.

Building an OP CDI Team

- Determine staffing needs and skillset required in outpatient CDI
- Define your Mission/Scope
- Determine KPIs/Metrics to measure success
- Develop policies and procedures
- Develop education materials and tailor it to the audience (i.e. registration staff, physicians, coding, etc.)
- Leverage technology

Understanding Denials

Importance of Collaborating with Others

With the shift of the reimbursement model, it is vital for CDI departments to collaborate with other departments that may impact provider documentation and/or may be impacted by the provider documentation. Departments may include:

- Health Information Management/Coding
- Utilization Review (UR)
- Denials Management (Billing Department)
- Quality

Importance of Understanding Your Organization's Data

Identifying Outpatient CDI opportunities by understanding your organization's data

- Does your organization have a denials management process?
- If so, can your team obtain a report that identifies specific denial versus payer denial reasons?
  - Medical Necessity Denials (i.e. Lack of documentation, IP versus Observation, No authorizations, etc.)
  - Authorization Issues (i.e. No authorization, authorization of incorrect service)
  - Non-covered
  - New Technology Denials (i.e. Experimental & Investigational
- Utilize these report findings and identify those that are related to documentation issues
  - CDI team help educate providers
  - CDI team expand coverage/focus areas

Frequent Causes of Incorrect Reimbursement

- Frequently organization's/providers encounter incorrect reimbursement of claims because of the following reasons:
  - Insufficient provider documentation
  - Lack of medical necessity
  - Incorrect coding of ICD/ CPT/HCPCS codes
- Insufficient provider documentation is often the cause of claims being rejected.
- Providers need to be educated on the importance of documenting chronic conditions and how it may impact the overall treatment plan. This level of detail in documentation may help support medical necessity and the accuracy of the reported codes. CDI efforts can support this effort.

Understanding Denials

- Looking at denial history can be the foundation for starting a successful CDI program
  - It has been said that nearly 90% of all denials are preventable
  - Focus on those denials related to lack of documentation.
- Denial prevention requires dedicated staff to perform root-cause analysis, sufficient data collection tools, timely feedback and continued process improvement efforts in various formats

Examples of a Denial Report

What to Look For?

- **Identify Top Denials**
- **Identify Diagnosis/Documentation Related Denials**
- **Identify specific denial trends by Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs)**

Code	Description	YTD Volume
1	All or part of this benefit applied to your deductible.	4,637
97	Payment included in allowance for another service/procedure.	3,104
18	Duplicate claim/service.	2,131
M15	Services bundled considered components of same procedure.	1,776
96	Non-covered charges.	1,294
31	Claim denied patient cannot be identified as our insured.	999
N702	Denied, previous claim adjudicated for same/similar service.	604
29	The time limit for filing has expired.	575
N216	Patient not enrolled in this portion of benefit package.	541
234	This service cannot be paid separately	507

RARC CD	DESCRIPTION	JAN	FEB
M64	Incomplete/invalid other diagnosis code.	1	0
M76	Incomplete/invalid patient's diagnosis/condition.	62	38
MA63	Incomplete/invalid principal diagnosis code.	0	0

CARC CD	DESCRIPTION	JAN	FEB
167	Diagnosis not covered.	2	0

Common Outpatient Denials

Authorization Denials may be due to the following reasons:

- Lack of documentation to support medical necessity for the procedure(s).
- Not having authorization for the correct CPT code (i.e. different CPT was authorized).
- Lack of diagnosis and/or documentation to support high dollar drugs.

Medical Necessity:

- Lack of documentation supporting services rendered.

Common Outpatient Denials (continued)

Short Stays:

- Payer(s) will deny a short stay when the stay is not justifiable for inpatient services.
- Documentation must support the patient's severity of illness.

Non-Covered Services:

- Non-covered denials may be due to documentation issues and/or contractual issues with the payor(s).

How Outpatient CDI Can Help Reduce Denials

Reduction of Medical Necessity Denials

- Create a process to review short stay patients
- Educate all on the basics of the Medicare 2 Midnight Rule and documentation requirements

Reduction of Authorization Denials

- Ensure that all bedded patients have been evaluated for authorization. This will help reduce retrospective authorization (i.e. increase back end work)
  - If the service scheduled and is not the service provided, identification of this is important so that the authorization can be changed.
  - Stat MRI, Stat CT and high cost drugs requires authorization and often times they are missed: A process should be in place to ensure an authorization has been obtained

Reduce the use of Condition Code 44 and/or Observation write-offs

- Review records when a provider wants to change an IP order to Observation.

How To Measure Impact?

How To Measure Impact?

Outpatient CDI impact should focus on improving compliance and reduction of payor denials, for example:

- Measure denials: Evaluate the daily, weekly, monthly, and year-to-date volume of denials and compare historic denials to the current number and identify trends
- Measure rework: Measure the dollar amount and volume of rework needed to re-submit claims
- Chart reviews: Perform regularly scheduled (i.e. quarterly) chart review to determine the quality of clinical documentation.
- How many denials and/or appeal letters have been generated?
- How many orders require further clarification or rework?
- What is the percentage of cases that contained documentation deficiencies?

How To Measure Impact? (continued)

Improved documentation practices and workflows to assist in proper documentation of acuity and provider productivity will help improve:

- HCC Risk Scores and Risk Adjustment Factor (RAF) Score
- E& M Performance
- Relative Value Units (RVUs)

Key Take-Aways

Key Take-Aways

- In response to the increase volume of care being provided in the outpatient setting, Medicare and other payers are beginning to collect data in aggregate format submitted by healthcare organizations and providers nationwide.
- Analysis of the aggregated data analysis and new quality measures will impact the future of reimbursement
  - The time has come for healthcare facilities and providers to consider adopting some form of outpatient CDI to address these documentation requirements.
- It is important to have consistent provider documentation across the continuum of care to accurately reflect the patient's overall risk.
- Outpatient CDI is a Pandora box with lots of opportunities but there is no cookie-cutter or a one size fits all methodology. Every organization will have their own opportunities, priorities and process flows.
- ***Perform Your Due Diligence and Know YOUR DATA!!!! Time to think outside the box and be creative!!!***

Thank you. Questions?

Contact Information:
Anny P. Yuen, RHIA, CCS, CCDS, CDIP
Email: anny.yuen@apconsultingassociates.com
Phone:(856) 242-1628