Outpatient & Risk Adjustment

As part of the fifteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Amy Campbell, MSHCA, RN, CCDS-O, director of outpatient CDI at Lifepoint Health, answered these questions. For questions about the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to the 2025 CDI Week Industry Survey results, 31.74% of respondents either have a dedicated outpatient program or have inpatient CDI also reviewing some outpatient records, which is a small increase from 2024's results (27.06%). Of those who reported that they do not have an outpatient CDI program, 21.31% of respondents said they plan to expand into outpatient. How long has your outpatient CDI program been running for? What successes/challenges have you seen, and how are they similar or different to the inpatient setting? What advice do you have for those looking to expand into outpatient CDI?

A: Lifepoint has had an outpatient CDI program for a little over two years, supporting eight clinically integrated networks operating under the Advantage Point Health Alliance (APHA) banner in nine states. There are two teams with differing reporting structures working in different aspects of the ambulatory care revenue cycle. My team supports providers at the point of care through prospective or pre-visit reviews and compliant query submission prior to scheduled Medicare annual wellness visits (MAWV).

Scaling expansion was one of our big challenges in the first two years along with coordination of the post-visit CDI coding team's expansion. Capturing metrics for such a large population of providers around the country remains a huge barrier as most of the software available is more focused on coding or capturing productivity over quality of actionable information surfaced to the providers

Q: The majority of respondents who conduct outpatient reviews on average complete more than 25 daily (38.10%). In comparison, 30% are expected to complete more than 25 by their department. How does your CDI program handle chart review expectations with its staff? Do you think a specific goal can be helpful, and/or are there other metrics helpful to track? What advice would you give an outpatient CDI professional to improve their chart review tactics, query writing, etc.?

A: Personally, I am not a fan of review quotas or even query quotas. Our job is to support providers by surfacing accurate information at the point of care. Every CDI specialist on my team has a different trajectory as they grow, and outpatient CDI is an area where there are significantly few people to jump into this role "out of the box." I far prefer bringing people on my team that are open to learning and sharing gifts the whole team needs.

It is infinitely important to understand the goals of the initiative, as well as those of the providers, as these programs start.

What are the abilities of the electronic health record (EHR) the team will be using? What software is the team using and how effective is it in making the team more efficient? What is the clinical experience of the team? Our hybrid team of coders and clinicians with coding experience allows the team to learn from one another to analyze clinical data. Our providers trust us to surface as many clinical indicators as possible because their time with the patient is so limited.

Q: When respondents were asked which outpatient settings their program currently reviewed, physician practices/clinics/Part B services was by far the most common (49.47%), followed by outpatient oncology (20.53%) and emergency department (19.47%). Of the settings they plan to review in the next 12 months, outpatient oncology was most popular (5.26%), while emergency department was the most popular choice for programs with plans that are further out than a year (9.47%). Which settings does your CDI outpatient program review, and what factors went into that decision? What advice do you have for CDI programs needing to choose their focus?

A: Our pre-visit/pre-encounter outpatient CDI specialists review for primary care providers' MAWVs predominantly in the Medicare Shared Savings Program. As we gain provider engagement and negotiate payer contracts, we will expand to more payers, visit types, and specialty providers. We still have large pockets of primary care providers for whom we are waiting to go live in some networks.

We have begun discussing which specialties with whom we will roll out next, so this is still unknown for the APHA. In past roles, cardiology, endocrinology, and oncology were deemed the highest-priority specialties to target. Each organization will have a different mix of employed specialists depending upon the locations they serve. In my experience, primary care providers often defer to these specialists to document about these conditions. I try to gently remind our primary care providers these specialized conditions affect the care of the whole patient, so they need to consider these things in the care of the whole patient.

My advice is that auditing must be done to identify problem areas before any program can be started. Action plans can be built and scoped when the findings are apparent. The system and program leader must be synced on strategic goals and how progress is measured over a finite time frame.

Q: Among those who currently review outpatient records, the most popular focus area was Hierarchical Condition Category (HCC) capture (51.05%). Almost 46% of respondents reported that their outpatient CDI program uses HCC capture rate to monitor their impact, followed by their Risk Adjustment Factor (RAF) score year-over-year (38.42%). What is the primary focus of your outpatient reviews? If you focus on HCC capture, what are the challenges unique to this type of review? How does your program track impact, and what advice would you give others about measuring the success of their efforts?

A: Our pre-visit team tracks provider response rates, which includes agreement and disagreement rates, as well as responses that were "uncapturable" despite provider attempts to document. The latter provides educational targets. We measure the team's potential RAF surfaced to the provider and the "realized" RAF or solidly documented risk-adjustable conditions. There is no way in our EHR to detect if the provider responded at a different time. We have a value-based care (VBC) platform that tracks recapture rate, but it has not yet learned to eliminate the acute codes that could trigger audits. The VBC platform also does not include the clinical indicators upon which our providers have come to rely.

Q: This year, the most common time CDI specialists perform outpatient chart reviews was nearly tied between prospective (37.89%) and retrospective, which saw a notable increase year-over-year (36.85% in 2025 vs. 23.24% in 2024). Why do you think there is an equal divide between the two, and what factors go into this decision? When does your program perform outpatient chart reviews? If prospectively, do you have any tips for those who are new to this type of review?

A: I think it is becoming clear the providers have come to rely upon our support prior to the visit or prospectively. It is not a secret that providers' mission or calling is to care for patients and not to accurately code their notes. As scrutiny increases on the codes submitted and the presence of supportive documentation, I expect this trend will continue.

Lifepoint's post-visit CDI coders review claims against the encounters prior to payer submission—some refer to this as pre-drop or concurrent review. Retrospective reviews are most often performed by payer organizations. As this segment of ACDIS' membership continues to morph, we will likely see more CDI specialists from payer organizations receiving their CCDS-O and responding to the salary surveys.

Q: Of respondents with outpatient CDI programs, 42.63% reported that their CDI team reviews for risk adjustment during their chart reviews in both the inpatient and outpatient settings, while 22.63% do so in just the inpatient setting and 11.05% in just the outpatient setting. In what cases does your CDI team review for risk adjustment, and what has been your experience thus far? What challenges and/or successes have you had?

A: I cannot speak to what role risk adjustment plays on Lifepoint's inpatient side, but I expect it does play a role. Our organizational structure and the age of our outpatient CDI program have not yet allowed for much collaboration between teams.

Q: When asked which risk adjustment methodologies their organization uses, the most popular choice of respondents was CMS-HCCs (77.08%), with Vizient's Risk Adjusted Index in second place (56.25%) and the Elixhauser Comorbidity Index in third place (52.08%). What methodologies does your organization use, and how was that decision made? What advice do you have for a CDI professional wanting to get educated on them?

A: Our outpatient CDI teams focus on CMS-HCCs for our traditional Medicare and Medicare Advantage populations. There are multiple outpatient methodologies in risk adjustment such as HHS-HCCs for commercial plans, RxHCCs for Medicare Part D/pharmacy coverage, and Medicaid's Chronic Illness and Disability Payment System that many other programs utilize. The documentation tips we help our providers implement can be applied to any methodology because all diagnoses are supported in much the same way regardless of methodology in the outpatient setting. Many of the differences between the methodologies center around eligibility periods for payment years. ■