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Clinical documentation improvement

Understanding risk adjustment and compliance for outpatient CDI

There's no doubt about it: Outpatient CDI programs are growing. In the 2017 **HIM Briefings** coding productivity benchmarking survey, 13.6% of respondents said they have CDI staff working on inpatient and outpatient records, and 8.6% said they are planning to expand to outpatient in the next 12 months. According to the Association of Clinical Documentation Improvement Specialists' (ACDIS) 2017 CDI Industry Survey, more than 30% of respondents plan to expand their CDI program to some type of outpatient service in the near future.

One of the main drivers of the expansion is changing reimbursement models. Reimbursement is increasingly tied to quality, patient outcomes, and the particular health risks facing a patient or patient population. Risk-adjusted and value-based reimbursement models, such as the Quality Payment Program (QPP), Medicare Advantage, or the Hospital Value-Based Purchasing Program, are expanding and impacting reimbursement across the industry. Generally, these programs adjust for risk by calculating risk scores based on Hierarchical Condition Categories (HCC). CDI specialists can make a sizable impact by bringing their documentation expertise and clinical knowledge to bear on outpatient records.

However, organizations and CDI specialists must have a thorough understanding of how regulations and guidelines impact risk adjustment in the outpatient setting. A misinterpretation can easily lead to inadvertent upcoding—and that can lead to costly audits, settlements, and accusations of fraud. As payment models shift from volume to value, documentation to support risk scores will come under increasing scrutiny.

A new frontier

Traditional fee-for-service reimbursement models, in which the volume of patients impacts reimbursement, are being supplanted by value-based, risk-adjusted models. These reimbursement models place a greater emphasis on the overall health of patients and how much work actually goes into caring for them. A patient with complications/comorbidities (CC) or major complications/comorbidities (MCC) will likely need more intensive care and monitoring—during inpatient acute care episodes and

during regular, ongoing primary care. Risk scores, based on HCCs, are meant to capture a level of detail that explains the greater amount of resources needed to care for complex patients.

HCCs aren't new to healthcare. However, in programs such as Medicare Advantage, the commercial payer handles risk score calculations based on HCCs. As a result, provider organizations might not have a solid grasp of risk adjustment. For more on HCCs, see the March 2017 and November 2017 issues of **HIMB.**

In addition, CDI specialists who got their start on the inpatient side will be accustomed to reviewing charts for documentation and coding concerns that carry more weight in that setting, such as Diagnosis-Related Group (DRG) assignment. Making the leap to outpatient might entail a steep learning curve.

"CDI grew up in fee-for-service where most of the opportunity was in the inpatient setting," says **James P. Fee, MD, CCS, CCDS,** CEO of Enjoin in Eads, Tennessee, and a hospitalist at Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. "Now we have to extend across the continuum. How do we better define outpatient severity and complexity to justify resource use and truly reflect outcomes?"

It's natural that organizations and CDI specialists would attempt to frame outpatient CDI and risk adjustment in terms they're familiar with. For example, a CDI specialist in the inpatient setting who is reviewing a chart for a patient with pneumonia might ask what specific type of pneumonia the patient was diagnosed with. This focus on acute disease manifestations and severity as defined in the APR-DRG model can be beneficial in the inpatient setting, Fee says. However, CDI specialists must take a broader approach in the outpatient setting.

"Certainly, those acute conditions are impactful, especially in HCCs, but there's a large portion where if we're only focusing on that philosophy of acute disease manifestation, we're going to miss out on risk adjustment across the continuum," Fee says.

Chronic diseases are weighted heavily in risk scores, but ensuring they're documented appropriately and regularly can be a challenge. Providers are generally focused on what they're treating a patient for on that particular visit, Fee says. The patient may receive treatment for influenza but also have a chronic condi-

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tion such as multiple sclerosis (MS). If the MS isn't appropriately documented annually, or at a particular visit if it's discussed, the omission could skew the patient's risk score.

"A lot of people will target those conditions that are MCCs or CCs, which is not going to have an impact in an outpatient setting," Fee says. "On the contrary, if you're looking for chronic disease, that can drive those risk-adjusted performance measures within the inpatient setting."

It might appear simpler—and more comfortable for the organization and CDI staff—to focus outpatient CDI efforts on departments more closely tied to the hospital such as an emergency department or ambulatory surgery center, says **Sonia Trepina, MPA,** director of ambulatory CDI services for Enjoin in Eads, Tennessee. However, depending on the individual organization, the best opportunity for outpatient CDI might lie well outside of that comfort zone.

"We have found that if you're entering into risk, the more risk you're entering into as an organization—whether that's through Medicare Advantage programs, becoming a payer, becoming part of an ACO—there's opportunity in the physician office setting," Trepina says.

A physician office might also represent the biggest challenge to an outpatient CDI program. Physicians were traditionally reimbursed based on evaluation and management (E/M) services. Complete documentation for the ICD-10 code diagnostic component of E/M services requires a maximum of only four diagnoses, Fee says. Entering into risk-adjusted models requires physicians to make a major shift in their documentation. A complex patient will require more than four diagnoses—including past surgeries or conditions such as a myocardial infarction.

To make things even more challenging, many patients are seen only a few times or even just once each year. That drastically reduces the opportunities to capture data, making it even more important that providers document thoroughly for each encounter. However, providers shouldn't view documentation as simply an administrative burden. The more information a provider collects from a patient, the better the care will be, Fee points out. Each piece of data helps the provider create a larger picture of the patient's overall health and allows tracking of health trends for individuals and populations.

Nevertheless, it's no surprise that physicians already feel overwhelmed by documentation requirements. Primary care physicians (PCP) in particular are key to documenting chronic conditions captured in HCCs. A chronic condition only needs to be documented once a year, but organizations should keep in mind that PCPs typically have a heavy workload. Capturing all chronic conditions can turn out to be a taller order than it initially appears.

"The PCPs become really important to risk adjustment," Trepina says. "But just the sheer volume of patient loads and what they need to capture, even though they only need to capture it once a year for HCCs, it can be overwhelming."

Getting up to speed

Misconceptions about risk adjustment are common, Fee says. Some organizations might struggle to get a handle on HCCs, while others may assume that HCCs are the only factor that influences risk and quality calculations and then fail to hold other aspects of documentation to the appropriate standard.

"For ambulatory CDI, the focus on documentation compliance, accuracy, and completeness is important, but reporting is critical and often overlooked," Fee says.

Organizations must keep in mind that risk adjustment also impacts an organization's quality measures. This point is often overlooked, Trepina points out, leaving an organization vulnerable on multiple fronts.

"Not a lot of people realize that when you capture certain diagnoses and certain codes in the ambulatory setting, that impacts your quality measure, for example, in your hospital setting," she says. "The risk adjustment piece is so critical."

Compliance pitfalls

Putting the focus on risk adjustment means organizations need to hold documentation and staff to a higher standard. Even a suggestion of inappropriate coding

and documentation that makes patients appear sicker than they truly are can land organizations, providers, and other staff in hot water.

As organizations move to risk-adjusted models and train staff, they must stress the role of compliance. The organization should also take a look at its EHR system and how users interact with and are influenced by the system's interface. A particular EHR can, even inadvertently, guide the information a provider enters. In turn, that impacts coding.

"The EMR and the provider choosing the diagnosis code becomes the first step in the coding process," Trepina says. "Making sure that providers know that what they're clicking is the right thing is important."

Some EHRs are set up to drive HCC maximization and optimization. Vendors and some other stakeholders might see this as a feature that can help remind busy providers, but it can easily become a fast track to noncompliant documentation. Some EHRs that are set up to identify HCCs may pose what can be construed as leading documentation options to providers.

"A physician might forget that when you choose a diagnosis, it has to be supported in the documentation," Fee says. "Something has to be done for that condition, and if it's not and you're reporting that because it's an HCC, then there's a compliance risk."

CDI specialists can help head off those compliance risks, Trepina says. CDI reviews shouldn't be limited to records that might have an opportunity to capture more HCCs. Instead, CDI specialists should also take a look at records where the risk score is fairly high and ensure that the documentation supports that score, she says. In either case, CDI specialists should have the resources to offer education to providers on appropriate capture and documentation of HCCs.

"The provider doesn't need to write paragraphs," she says. "It's not the length of the note: It's the choice of words to accurately describe the situation."

The challenge is twofold: to capture a risk score that reflects the complexity of a patient and to ensure that the supporting documentation is complete and compliant. In service of this aim, organizations should build infrastructure that continually supports and reinforces providers, Fee says.

"Providers have a lot on their plate managing care for the patient," he says. "So, having an infrastructure built to keep them up-to-date, to reinforce what they're doing and why they're doing it and not lose sight of it, will help maintain a healthy program long term and will avoid having OIG knocking at your door."

Working together

Collaboration is key to a successful outpatient CDI program, Fee says. CDI grew up on the inpatient, acute care end of the spectrum and generally had little contact with or awareness of concerns that impact outpatient documentation. When a CDI program expands, the CDI specialist may not know whom to contact to help the outpatient branch of the program thrive. CDI specialists should reach out to physician offices and other outpatient facilities to establish communication and connections.

"Once you get involved, then you get to understand what's happening on that side of the world and where you can help," Fee says. "Get involved in as many meetings as possible where coding and documentation is impacted."

The patient's health and well-being must be the focus, Trepina points out. Risk adjustment is ultimately about the patient. Organizations should keep that perspective in mind, and CDI specialists should act as the advocate for translating that principle into documentation. Correct, complete documentation leads to correct code assignment, and that in turn helps providers, payers, and organizations understand how to care for patients and allocate resources.

Questions? Comments? Ideas?

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