includes all services, tests, and procedures bundled into one payment of $7,068. This payment includes:

» Diagnostic procedures
» Laboratory and pathology tests
» Other diagnostic tests (i.e., radiology, pulmonary, cardiology)
» Treatments that assist in the delivery of the primary procedure (i.e., preoperative, intraoperative, recovery, post-anesthesia care unit)
» Visits and evaluations associated with the procedure
» Coded and uncoded services and supplies used (i.e., observation)
» Blood and blood products
» Outpatient department services delivered by therapists
» Supplies and devices provided as part of the outpatient service (i.e., implants, tissue expanders)
» Durable medical equipment such as prosthetic and orthotic items and supplies
» Any other components reported by HCPCS codes that are provided during the comprehensive service

Although hospital outpatient departments rely on CPT/HCPCS codes, assigning ICD-10-PCS codes enhances data mining opportunities since each code character describes a specific variable, which can assist with financial predictive modeling. The fourth character indicates right, left, or bilateral; the fifth indicates the approach; the sixth indicates the device; etc.

This data pinpoints financial variables such as resources (i.e., time in operating room, observation, recovery) and implants (type, manufacturer, laterality, cost). Isolating financial outliers, payers, surgeons, type of device/implant, laterality, and other resources will enable hospitals to perform predictive financial modeling for both current and future endeavors. Improved data reporting and analysis by payers and providers will, in turn, improve reporting, mining, and tracking of population health management programs.

Robust procedure data on the outpatient side can be incorporated into hospital quality, safety, and prevention, providing the facility with a better overall performance record as it relates to patient outcomes.

You don’t need to cloud integration of ICD-10-PCS assignments for hospital outpatient encounters with complicated statistics and formulas. The highest outpatient charges, regardless of payer, include same-day surgery, interventional radiology, and cardiology procedures, either electively scheduled or through observation services. With a cohesive approach to a complicated question, it is amazing how simple the answers can be.

“You’re off to great places! Today is your day! Your mountain is waiting, so get on your way!”

EDITOR’S NOTE
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ACDIS Insight: Outpatient CDI on the rise in facilities

In 2008, only 11% of respondents to an ACDIS poll indicated their CDI program either reviewed outpatient records for documentation improvement opportunities or were looking to expand into outpatient areas (8% and 3% respectively).

How has the climate changed?

Of the more than 400 respondents to the question on the ACDIS website (see the poll at www.hcpro.com/acdis/readerpoll_results.cfm), 35% now say they conduct outpatient reviews and 61% do not (1% say they only review emergency department records, and 2% plan to start outpatient reviews within the next year).

Outpatient record reviews are evolving,” says Mel Tully, MSN, CCDS, CDIP, VP of clinical services and education at Nuance Communications, Inc., in Burlington, Mass. “I think it is a loop that hasn’t been closed yet but one that can help bridge the gap between hospitals and providers.”

Outpatient reviews, for example, can help demonstrate to physicians that CDI isn’t only for hospital billing and reimbursement purposes—it can also help with professional reimbursement, reduce claims denials, improve medical necessity and quality reporting, and even assist in capturing information necessary for Hierarchical Condition Category (HCC) coding.
ED difficulties

One obstacle to outpatient CDI is the timing, says Laurie L. Prescott, MSN, RN, CCDS, CDIP, a CDI education specialist with HCPro in Danvers, Mass. If the ED is busy, CDI specialists can be seen as a nuisance. “You can’t interfere with the immediate care that’s needed,” she says.

Conversely, on days when the ED activity is slow, there’s little to review. “You have to have patients and conditions to talk about,” she says.

When Kathy Shumpert, MSN, RN, CCDS, CDI specialist at Community Howard Regional Health in Kokomo, Ind., started outpatient reviews she tried a variety of things, including emergency department (ED) reviews, “but because of the pace the best we can do is get whether the diagnosis isn’t of a symptom,” she says.

Part of the problem of implementing CDI in the ED comes from timing.

When Prescott initially entered the ED, a couple of physicians allowed her to shadow them and responded to her verbal queries, ensuring they added appropriate wording into the charts. “It worked great for those who would let me,” she says.

Bernadette Slovensky, RN, MSN, is a CDI specialist at Stony Brook (N.Y.) University Medical Center, a level-one trauma care center with 100,000 emergency bed cases per year. Her facility made the leap to outpatient CDI simply because physician leadership asked them to, she says. The physician champions realized the importance of capturing present on admission indicators and obtaining documentation to ensure medical necessity, says Slovensky, who discussed her program’s efforts on the February 2014 ACDIS quarterly conference call (http://tinyurl.com/lk28ohx) and will present on the topic during the May ACDIS Conference in Las Vegas.

“It’s a busy place,” she says. “It is so fast-paced patients may be in the ED for 15 minutes before they’re off to the operating room. We were trying to ensure that those patients’ conditions were accurately captured because once they’re gone, they’re gone.”

For example, a septic patient may come into the ED and receive treatment, but by the time the admitting physician sees the patient he or she doesn’t look septic anymore, so that diagnosis and treatment slips through the cracks, says Slovensky.

“CDI professionals need to educate the clinicians about how to appropriately document these types of things,” says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, CCDS an independent consultant in Madison, Wis.

Take, for example, a case where a patient comes to the ED via ambulance after falling and breaking her foot. The physician notes altered mental status, orders an x-ray and mental consult. In an inpatient-only model, CDI professionals typically do not review the record until the second day of the patient’s stay; when they do, they may discover evidence in the laboratory workup of renal failure but have to chase down the ED physicians for any indications that such a condition was present on admission, says Krauss.
An outpatient CDI program would eliminate that problem. Shumpert’s program focuses on medical necessity. If the ED secretary enters all the diagnoses but the patient condition does not seem to warrant an inpatient admission, the record is flagged and turned over to Shumpert to review. From there, she looks to ensure that any local or national coverage determination requirements were met, and queries when necessary.

Some of these codes and payment systems are foreign to CDI specialists, who may only understand the inpatient prospective payment system and MS-DRGs.

“This was pretty successful because we were able to get items covered that may have been otherwise written off as charity or simply not reimbursable, like a CT scan,” she says.

If insurance does not cover a particular treatment or exam for medical necessity or other reasons, the hospital has a limited window of time in which to explain to the patient his or her payment options (known as an advance beneficiary notice, or ABN). If the patient does not receive this notification, the test may not be covered, the patient may not pay, and the cost for the service may go uncollected by the facility, Shumpert explains.

Payment problems

Payment for outpatient services requires Current Procedural Terminology®/Healthcare Common Procedure Coding System codes and follows outpatient prospective payment system rules. Physicians receive payment for their services partly based on evaluation and management (E/M) codes, which take into consideration the amount of time physicians spend reviewing patient symptoms, body systems, diseases, and treatments, as well as the complexity of the medical-decision making required to care for their patients.

Some of these codes and payment systems are foreign to CDI specialists, who may only understand the inpatient prospective payment system and MS-DRGs. “Certainly, one first step to help CDI expansion into the outpatient services is obtaining an understanding of E/M,” says Prescott.

Shumpert obtained a basic level of E/M knowledge and worked with the physicians to improve their impression and planning documentation, she says.

“I don’t know E/M well, but I did work with them to help them pull in that additional information they need to support their own code assignments, and I think that really helped,” says Shumpert.

At University of Tennessee Medical Center at Knoxville (UTMCK), Trey La Charité, MD, the CDI physician advisor there, has begun expanding his educational efforts to the outpatient realm, taking road trips to associated physician practices and spending roughly 45 minutes on documentation improvement lessons. He brings an outpatient coder with him, hired specifically to audit physician practice records and reinforce documentation improvement information.

On the outpatient side, many physician practices do not have dedicated coding staff, La Charité says. Instead, they have secretaries, depend on their electronic health records (EHR), or simply code the records themselves. This leads to new obstacles.

“Understanding the physician documentation processes in the electronic medical record and paper record systems in the outpatient setting is critical to capturing the appropriate diagnoses and procedures for coding compliance,” agrees Bonnie S. Cassidy, MPA, RHIA, FAHIMA, FHIMSS, senior director of HIM innovation for Nuance Communications. “Most of our focus has been on the acute care side of healthcare and we now have a tremendous opportunity to address clinical documentation integrity and coding compliance in the ambulatory care setting.”

In addition, the rise of HCCs provides additional impetus for outpatient CDI. HCCs are a subcategory of codes based on chronicity, Krauss says, used primarily by Medicare Advantage and managed care companies.

James S. Kennedy, MD, CCS, CDIP, president of CDIMD Physician Champions in Smyrna, Tenn., points to a couple new conditions qualifying as HCCs in 2014, plus their relative weights (RW) and definitions, including:

» Morbid obesity (RW 0.365). A BMI of 40 or more, requiring code 278.01, morbid obesity, or V85.4, BMI > 40.0, defines this condition. Note: ICD-9-CM or ICD-10 does not allow the BMI to be coded from nursing or dietitian documentation unless a provider (e.g., medical...
doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant) documents a nutritional diagnosis, such as morbid obesity, obesity, underweight, or malnutrition.

» Consequences of cirrhosis (RW 0.923). Cirrhosis causes portal hypertension resulting in esophageal varices or hepatic encephalopathy often requiring lactulose or rifaximin, which can be coded only if documented. Even if the varices are not bleeding or if the encephalopathy is stable on medication, if these consequences are monitored, documented, and coded, they count as HCCs. Note: Don’t forget to document any monitoring of chronic hepatitis (e.g., due to hepatitis C), even if it hasn’t progressed to cirrhosis.

HCCs link payment to performance and relative risk of a patient population through analysis of the code set, Kennedy explains. If it typically costs a dollar to treat a particular condition, and one physician spends less than a dollar, that physician will be deemed to provide “efficient” care and could see his quality ratings and reimbursement rate improve.

Conversely, the physician who treats the same patient type but at a higher cost could be deemed “inefficient” and suffer the consequences.

“Physicians aren’t used to anyone reviewing their outpatient records for accuracy of diagnoses in the clinical documentation the way they are used to with inpatient CDI initiatives,” says Cassidy. “They need to understand the long term benefits of clinical documentation accuracy in the outpatient setting.”

Eventually, HCCs may become as important to physician payments as DRGs are to hospitals, Kennedy predicts.

Volume concerns and expansion solutions

Since the Institute of Medicine’s November 1999 report To Err Is Human, which showed a shocking number of unexpected deaths related to hospital admissions, a new mantra regarding the structure of healthcare delivery and reimbursement has emerged. There has been renewed focus on keeping patients out of the hospital.

This has had a negative effect on hospitals’ bottom lines, however. According to an article in Modern Healthcare, some of the biggest U.S. hospitals blame weak performance on flagging inpatient volumes. A report in Healthcare Finance News states that analysts at both Moody’s Investors Service (in a November 2013 report) and Standard & Poor’s predict a continuing decline in inpatient volumes due, at least to some extent, to a shift toward outpatient care rather than inpatient services. The theory goes that as inpatient volumes decrease, so will hospital revenues. For CDI specialists, this means capturing accurate data for each and every inpatient admission, but it may also mean expanding horizons for the future to offset the drop in inpatient revenue, Krauss says.

Just as hospitals will need to integrate their businesses to provide care across a continuum, so too will CDI departments will need to explore ways to provide value to those various service lines, too, he says.

When Cassidy first joined the coding world, she worked on both inpatient and ambulatory records. “It was one organization, and you had to be familiar with both sides,” she says.

In the ’80s and ’90s, coders became specialized, but now she believes that the tide is shifting again to learning both inpatient and outpatient, and that it will be important for CDI and coding staff to have a firm grasp of both. A majority of the information related to risk adjustment and population health management will come from the physician office—information that never made it to the inpatient side before, she says.

“It has been an inpatient-focused world,” Cassidy says, “and now the volume of care is shifting to ambulatory and outpatient services.”

In short, outpatient CDI is looking more and more like the wave of the future.

Tip: Look for wound care opportunities

At Community Howard Regional Health in Kokomo, Ind., CDI is now being incorporated into its affiliated wound care center. Kathy Shumpert, MSN, RN, CCDS, CDI specialist there, discovered that documentation was often incomplete. So she networked with the physicians and nursing staff, conducted focused record reviews, provided education, and worked with the IT staff to amend the electronic health record templates and prompt the clinical staff for the documentation needed.

“We quickly saw an improvement,” she says.