OUTPATIENT EFFORTS

Define outpatient CDI nuances

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As healthcare providers increasingly accept financial risk associated with patient management due to the transition from fee-for-service to risk-based/value-based reimbursement, the traditional model of healthcare reimbursement has been flipped upside down.

Many of the value-based incentives and penalties rely on quality measures reported to programs like Physician Quality Reporting System (PQRS), Hospital Inpatient Quality Reporting (IQR), and Hospital Outpatient Quality Reporting (OQR).

The intent is to have the providers show that they meet quality standards and provide quality care to the patient while managing costs. As a result, many organizations realize that success with risk-based/value-based reimbursement actually relies, in large part, on complete and accurate documentation of diagnoses.

Therefore, many organizations also acknowledge that having a CDI program cover both inpatient and outpatient settings improves the accuracy of risk scores and reporting of diagnoses while mitigating risks associated with inaccurate coding (i.e. overcoding or undercoding).

With that said, the million-dollar question remains: How can an organization effectively strategize its existing CDI program and position the program for success while still trying to define what ambulatory (outpatient) CDI is?

Let’s start by examining how outpatient CDI differs from inpatient CDI. First, the volume of outpatient encounters will be significantly higher than in the inpatient setting. Secondly, timing is not on the outpatient reviewer’s side. Documentation in the outpatient setting occurs quickly; therefore, an outpatient CDI program must be nimble.

As a result, it is important to evaluate for any opportunity to improve process flow and to leverage technology so that all necessary documentation can be captured to the highest level of specificity. Some areas for outpatient CDI may include the emergency department (ED) and physician practices/clinics.

Emergency department

The role of a CDI specialist is to ensure physicians’ documentation accurately reflects their clinical judgment and medical decision-making, as well as the acuity of patients; therefore, having a CDI presence in the ED will lead to fewer medical necessity denials. Other benefits of having a CDI team in the ED may include (but are not limited to) the following:

- Creating an accurate problem list starting in the ED
- Addressing and correcting any fragmentation/gaps in patient care from the time of admission into the ED to discharge
- Improving documentation of observation hours
- Improving documentation of infusions and injections
- Improving accuracy of present on admission indicators and reporting of codes
- Reducing audit risks

Outpatient CDI is like Pandora’s box, especially in the ED. So, the tasks of outpatient CDI specialists in the ED may be different from one organization to another. Some programs may have their CDI specialists review provider and nursing documentation for evidence of patient monitoring, along with compliance of physician orders and confirmation of diagnoses. Others may have the CDI team evaluate and monitor documentation of observation hours from a compliance standpoint and/or review and educate physicians regarding the importance of accurate documentation of infusions and injections.

Since CDI specialists are documentation educators, it makes sense for the CDI team to expand its education to

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the nursing team on the requirements for documentation of infusions/injections. By comparing provider and nursing documentation to charges, organizations can ensure that charges for supplies and medications are appropriate for the services documented.

**Physician practices/clinics**

Similar to the ED, outpatient CDI specialists need to assist in obtaining documentation of confirmed diagnoses in the physician practice/clinic.

It is essential for the highest level of specificity to be documented to support outpatient services and to maximize ambulatory payment classification (APC) reimbursement. Some other benefits of having a CDI team in a physician practice/clinic may include (but are not limited to) the following:

- Creating an accurate problem list starting in the physician’s office
- Improving documentation and ensuring that chronic conditions are continuously captured within the EMR/EHR
- Producing reliable medical records that can enhance the quality of patient care
- Reducing of audit risks and/or denials
- Improving accuracy of coding (i.e., outpatient, HCC) and Risk Adjustment Factor (RAF) score

As mentioned above, the scope of outpatient CDI is of course contingent on the objectives and mission of the organization, along with the resources that can be made available for the expansion of CDI into the ambulatory arena.

The key to success is to develop and nurture collaboration between providers, nursing, CDI, health information management/coding, and case management within the outpatient and inpatient setting.

As CDI continues to evolve, the sharing of knowledge will become essential. Since outpatient coding guidelines are different than inpatient coding guidelines, one of the main tasks for outpatient CDI specialists will be working with providers on the confirmation of diagnoses and accurate documentation with appropriate specificity to support these diagnoses.

Furthermore, both outpatient and inpatient documentation principles should be integrated into a CDI education program. Providers should understand the difference in documentation requirements since both outpatient and inpatient require strong foundations of documentation to support medical necessity and intensity of resource utilization.

Providers should have an understanding of how their documentation in both the outpatient and inpatient settings affects their ability to assign and bill evaluation and management levels and reduce claim denials.

A successful ambulatory CDI program will help demonstrate to the providers that CDI efforts will have an impact across the continuum of healthcare (i.e., ambulatory, inpatient, postacute).

**Editor’s note:** Yuen is an ACDIS Advisory Board member. She previously served as a corporate director of CDI at Penn Medicine, where she oversaw four hospitals and developed a unified and multi-disciplinary corporate CDI process focused on improving physician/provider documentation and accurate CDI financial reporting. Contact her at anny.p.yuen@gmail.com.