




**Outpatient Clinical Document Improvement**



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**Learning Objectives**

- At the completion of this program, the learner will be able to:
  - ✓ identify the five basic components common to all CDI programs
  - ✓ describe ways to leverage the similarities between inpatient and outpatient CDI to grow their CDI program
  - ✓ select an appropriate Key Performance Indicator (KPI) for measuring the quality of documentation in both the acute care (inpatient) and chronic care (outpatient) settings
  - ✓ describe the value of the Risk Adjustment Factor (RAF) in inpatient and outpatient CDI
  - ✓ identify metrics and reports valuable to monitor and improve CDI programs

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**Jon Elion MD, FACC**

*Five Things to Know about Jon...*



Jon Elion, M.D., FACC

- Medical Computing:** Since 1969
- Clinical:** Duke-trained cardiologist
- Academic:** Clinical Associate Professor at Brown
- Administration:** Hospital Boards, Foundation and Finance Committees
- Commercial:** Medical software since 1994. Now CEO of ChartWise Medical Systems (Computer-Assisted Clinical Documentation Improvement)

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**It's All About Quality...**

If you pursue reimbursement, you will miss the High Quality Medical Record

... but ...

If you pursue a High Quality Medical Record, the *proper* reimbursement will follow.

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**...Not Just About Reimbursement**

Complete, accurate coded data essential for:

- ✓ Improved quality of patient care
- ✓ Decision-making on healthcare policies
- ✓ Optimizing resource utilization
- ✓ Measuring patient safety issues
- ✓ Identifying and reducing medical errors
- ✓ Clinical research, epidemiological studies

*Clinical Documentation is the cornerstone of accurate coding*

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**Don't fall into this trap!**



**Find an MCC and move on...**

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### Have You Heard This Before?

#### Outpatient CDI ≠ Inpatient CDI

- Different coding systems and billing (ICD-10 vs. CPT, HCPCS)
- Multiple outpatient settings (various clinics types, ED, etc.)
- Potentially different set of coders and coding requirements
- CDI activities are *during* inpatient stay, but *before/after* for outpatient visits
- Annual requirements for outpatient
- Single outpatient episode may include several encounters (e.g., lab tests on Tuesday, physician visit on Thursday)

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### And Look at All These Stakeholders!

<ul style="list-style-type: none"> <li>E&amp;M coding</li> <li>National Coverage Determination</li> <li>Local Coverage Determination</li> <li>CPT, PCPCS coding</li> <li>Emergency Department</li> <li>Physician office</li> <li>Denials management</li> <li>Patient safety</li> <li>Quality</li> <li>Value-Based Purchasing</li> <li>Physician Quality Reporting System (PQRS)</li> <li>Medicare Access &amp; CHIP Reauthorization Act (MACRA)</li> </ul>	<ul style="list-style-type: none"> <li>Imaging centers</li> <li>Merit-based Incentive Payment System (MIPS)</li> <li>Advanced Alternative Payment Models (APMs)</li> <li>Ambulatory Payment Classification (APC)</li> <li>Ambulatory Surgery Centers</li> <li>Rehab (inpatient and outpatient)</li> <li>Home Health</li> <li>Urgent Care</li> <li>Hospital-affiliated clinics</li> <li>Diagnostic laboratory</li> <li>etc...</li> </ul>
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### Goal: Quality Documentation

Criteria	Example/Description
<b>Legibility</b>	Required under all government and regulatory agencies
<b>Reliability</b>	Treatment provided without documentation of condition being treated
<b>Precision</b>	No specific diagnosis documented, more specific diagnosis appears to be supported
<b>Completeness</b>	Abnormal test results without documentation for clinical significance (Joint Commission requirement)
<b>Consistency</b>	Disagreement between two or more treating physicians without obvious resolution of the conflicting documentation upon discharge
<b>Clarity</b>	Vague or ambiguous documentation
<b>Timeliness</b>	Not completed within the guidelines set by the facility, CMS, state, Joint Commission, or other regulatory agencies

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**Outpatient CDI *Extends* Inpatient CDI**

Basic CDI processes and software tools apply for both Inpatient and Outpatient CDI:

1. Find the patients of interest
2. Assist with the review process
3. Have appropriate and conformant queries
4. Track appropriate metrics and KPIs
5. Comprehensive reporting

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**Patients of Interest: Outpatient Census**

- Inpatient census is easily derived from HL7 ADT (Admission-Discharge-Transfer)
- Outpatient census can be derived from:
  - ✓ HL7 ADT (Admission, Discharge, Transfer)
  - ✓ HL7 SIU (Scheduling Information Unsolicited)
  - ✓ Custom interface to Practice Management systems
- Example: Show me a list of patients in Dr. Elion's Tuesday afternoon clinic in the East Greenwich location

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### Artificial Intelligence: Rules Engine



- takes facts and tries to draw new conclusions (“forward-chaining”)
- keeps its knowledge separate from the computer software
- can process vast amounts of knowledge rapidly
- well-established form of Artificial Intelligence
- easily extended with new knowledge

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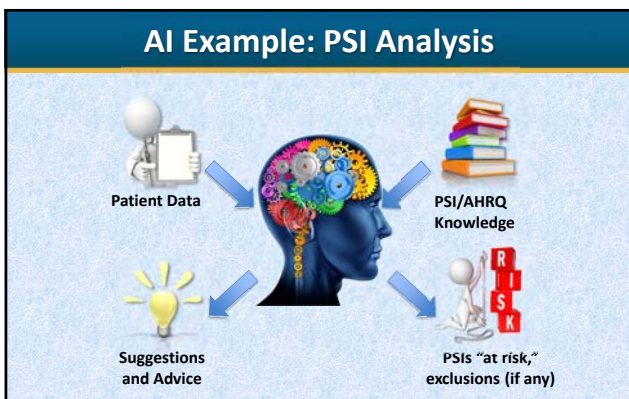
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### PSI Analysis: Sample of Rules

**PSI 02: Death Rate In Low-Mortality Diagnosis Related Groups (DRGs)**

**Description:**  
In-hospital deaths for low mortality (less than 0.5%) Diagnosis Related Groups (DRGs) among patients ages 18 years and older or obstetric patients. Excludes cases with trauma, cases with cancer, cases with an immunocompromised state, and transfers to an acute care facility.

**Include if all are true:**

- Expired
- Age greater than 18 -- OR --
- Pregnancy, Childbirth and the Puerperium diagnosis
- Low-mortality MS-DRG

**Exclude if any are true:**

- Trauma Diagnosis
- Cancer diagnosis
- Immunocompromised state diagnosis
- Immunocompromised state procedure
- Transferred to an acute care facility

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### Outpatient CDI Query Focus

1. An existing condition that in this year has not yet been addressed, documented in the assessment and plan, or submitted with the correct code.

**Example:** Status post prostate cancer with prostatectomy; no assessment of status or plan for monitoring of PSA documented

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### Outpatient CDI Query Focus

2. Two diagnoses that the provider hasn't connected.

**Example:** 66 year old man, Type 1 Diabetes and polyneuropathy:

ICD-10	Description	HCC	Risk
E11.9	Diabetes without complications	19	0.104
G62.9	Polyneuropathy, unspecified		
<b>Total</b>	(includes 0.300 demographics risk)		0.404

Rule: If E11.9 and G62.9 but not E11.40, suggest a query for E11.40

ICD-10	Description	HCC	Risk
E11.40	Diabetes with diabetic neuropathy	18	0.318
<b>Total</b>	(includes 0.300 demographics risk)		0.618

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**Outpatient CDI Query Focus**

3. A condition that is being addressed is not documented  
**Example:** A patient's problem list includes obesity. Height and weight are measured with a calculated BMI of 46 (ICD-10 code Z68.42). Weight loss discussed but is not documented.

4. Findings that suggest a possible diagnosis not yet documented  
**Example:** Incidental finding of calcified hilar node on chest x-ray that needs to be addressed and documented

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**Outpatient CDI Query Focus**

5. Compliance: documentation and coding of a condition or activity that has not been addressed in any way during the visit  
**Example:** Checking off boxes on a clinic note template regarding seat belt usage, sun screen and smoking cessation when the counseling was not done

6. Clinical validation: Make sure the basis for a diagnosis is present  
**Example:** Documentation and coding of coronary artery disease in a patient with Type 1 diabetes whose ECG shows only minimal inferior Q-waves

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**Clinical Validation**

- Challenging "Clinical Validation" has become a common reason for payers to deny payment.
- In addition to validating the condition was addressed during the encounter, the physician must document the basis for the diagnosis (show that the patient actual has the condition)
- Information in the chart must substantiate coded diagnoses
- There is no definitive list of criteria per diagnosis. A reasonable provider would agree based on widely-accepted diagnostic standards, clinical criteria and medical practice.
- The "opposite of CDI"?

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### Key Performance Indicators

A **Key Performance Indicator** (“KPI”) is a measurable value that demonstrates how effectively an organization is achieving key business objectives.



*A KPI is only as valuable as the action it inspires.*

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### Key Performance Indicators

	Specific	<b>S</b>	• What <i>specifically</i> do you want to do?
	Measurable	<b>M</b>	• How will you know when you reached it?
	Attainable	<b>A</b>	• Is it in your power to accomplish it?
	Relevant	<b>R</b>	• How does it fit into the “big picture” goals?
	Time Based	<b>T</b>	• When exactly do you want it done?

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### Choosing the KPI

- Based on Experience with Inpatient CDI:
  - ✓ Based on methodology for Medicare patients:
  - ✓ Focuses on acute conditions
  - ✓ DRG weight reflects documentation completeness (acute)
  - ✓ Also works for patients with private payers
- Suggested approach for Outpatient CDI:
  - ✓ Based on methodology for risk-based plans
  - ✓ Focuses on chronic conditions
  - ✓ RAF score reflects documentation completeness (chronic)
  - ✓ Also works for patients not on risk-based plans

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### Choosing the KPI

- Outpatient CDI based on RAF:
  - ✓ Outpatient visits coded/paid based on CPT and HCPCS codes
  - ✓ However, it is not clear what metric would assess CPT shifts; this may not be helpful of sufficient to measure CDI impact
  - ✓ RAF scores computed from ICD-10 (CDI staff are already trained on ICD-10, but not CPT or HCPCS)

*Why is "Risk Adjustment" such a big deal?*

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### Payment Reform

- Slow and complicated
- Improve quality and reduce costs
- HHS Goals by 2019:
  - ✓ 40-50% of Medicare payments using alternative payment models
  - ✓ 90% of remaining CMS FFS payments tied to value
  - ✓ Private payers follow suit

Year	Fee for Service (FFS)	Alternative Models
2008	85%	15%
2009	78%	22%
2010	72%	28%
2011	68%	32%
2012	62%	38%
2013	58%	42%
2014	55%	45%
2015	50%	50%
2016	45%	55%
2017	40%	60%
2018	35%	65%
2019	30%	70%
2020	20%	80%

Content provided by Cathleen Bigo, President/CEO Cardiovascular Management of Illinois

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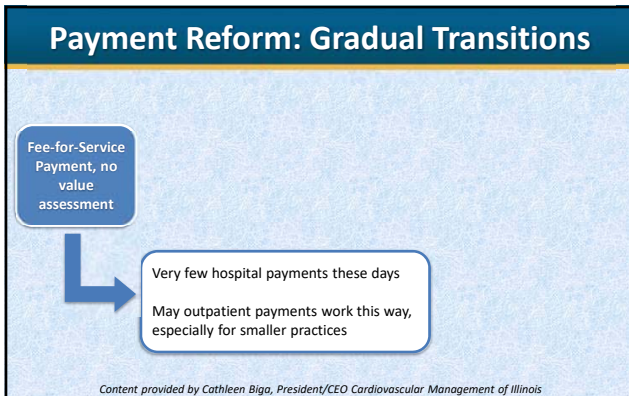
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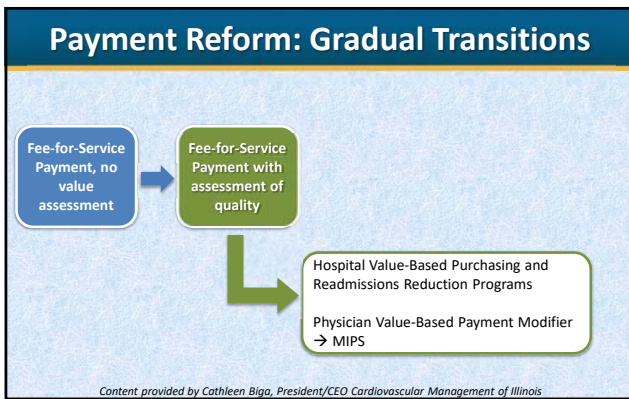
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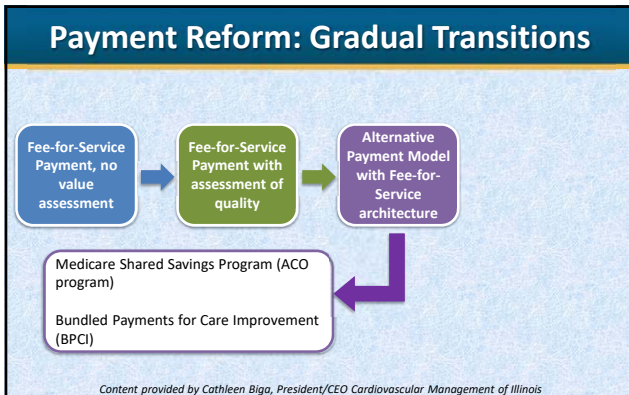
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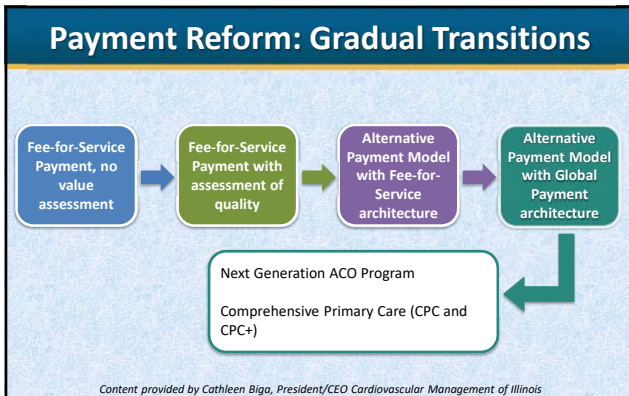
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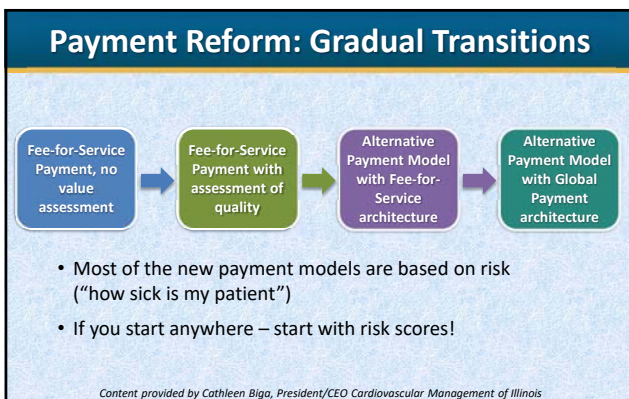
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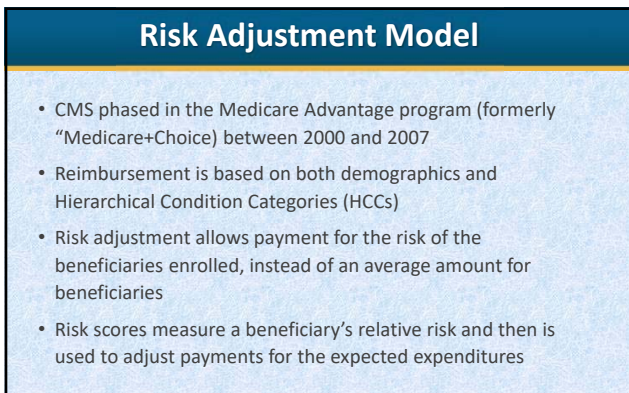
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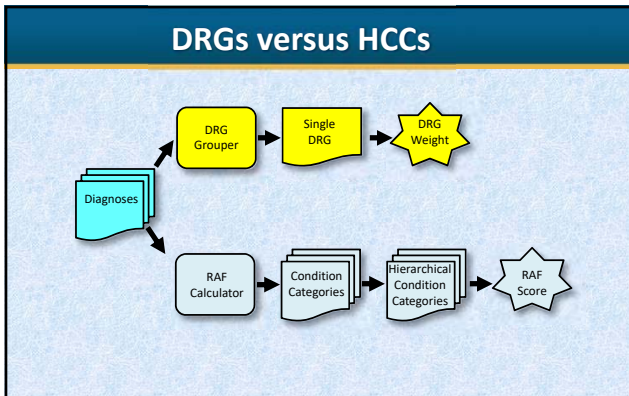
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### HCC Specific Characteristics

Characteristic	Descriptions
Models are Additive	Individual risk scores are calculated by adding the coefficients associated with each beneficiary's demographic and disease factors.
Prospective Model	Diagnostic information from base year predicts Medicare benefit costs for the following year.
Site Neutral	Models do not distinguish payment based on site of care.
Diagnostic Sources	Models recognize diagnoses from inpatient, hospital outpatient, and physician settings.

From Medicare Managed Care Manual, Chapter 7 – Risk Adjustment, Rev 118, 09-09-14

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### HCC Specific Characteristics

Characteristic	Descriptions
Multiple Chronic Diseases Considered	Diagnoses assigned to disease groups, (Condition Categories or CCs). Most influenced by costs associated with chronic disease.
Hierarchies	CCs are placed into hierarchies by severity and cost. Favors the disease with highest severity or that subsumes the costs of other diseases.
Disease and Disabled Interactions	Higher risk scores for certain conditions when disease interactions demographic status (e.g., disabled), indicates higher costs.
Demographic Variables	Five demographic factors: age, sex, disabled status, original reason for entitlement, Medicaid or low income status (total of 9 models)

From Medicare Managed Care Manual, Chapter 7 – Risk Adjustment, Rev 118, 09-09-14

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### Hierarchical Condition Categories

<p><b>CMS HCC (Medicare)</b></p> <ul style="list-style-type: none"> <li>Developed by CMS for risk adjustment of the Medicare Advantage Program</li> <li>CMS has also developed a CMS Rx HCC model for Medicare Part D risk adjustment</li> <li>Based on over 65 population</li> </ul>	<p><b>HHS HCC (Commercial)</b></p> <ul style="list-style-type: none"> <li>Department of Health &amp; Human Services (HHS) developed from commercial payer population</li> <li>HHS-HCCs predict the sum of the combined medical and drug spending</li> <li>Includes all ages</li> </ul>
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*HHS RAF scores tend to be higher than CMS RAF scores, due to the inclusion of drug spending in the models*

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### HCC Documentation Needs

- Based on a documented face-to-face encounter
- Patients need to be seen at least annually.
- For each condition, document **M**onitoring, **E**valuation, **A**ssessment or **T**reatment (M.E.A.T)
- Conditions should be documented to the highest level of certainty and specificity at each encounter
- All confirmed conditions should be integrated into the documentation. Include significance of abnormal findings

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### Provider Documentation for HCCs

HCCs represent chronic conditions, so:

- diagnoses must be identified during a face-to-face encounter
- diagnoses must appear on the Problem List for that patient
- lab, x-rays, procedures and medications should all be appropriate for the diagnoses
- documented History for the condition should be present. For example, current treatment for a patient with breast cancer.
- physical examination should be specific for the diagnoses. For example, heart and lung exam for a patient with CHF.

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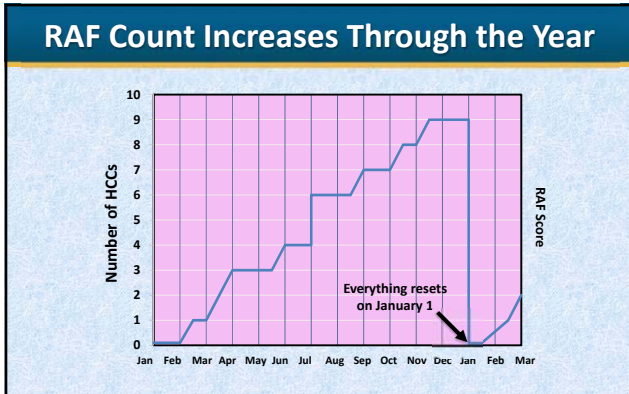
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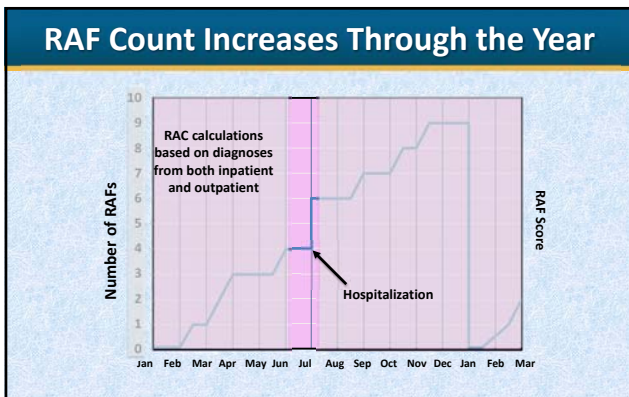
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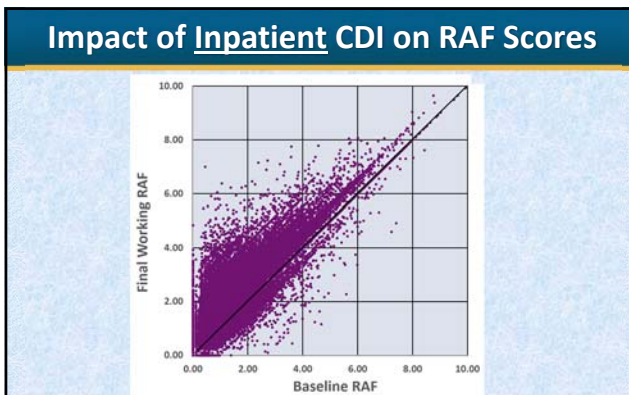
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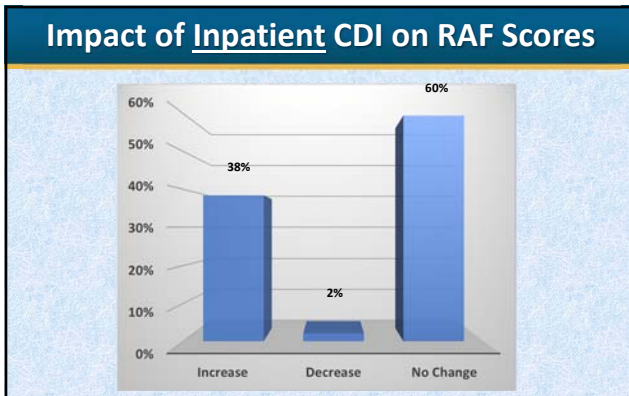
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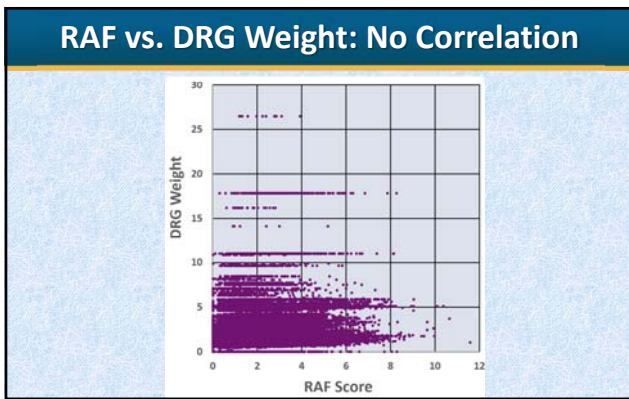
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### Top 20 Inpatient HCCs

HCC	Description	Percent
85	Congestive Heart Failure	10.46%
84	Cardio-Respiratory Failure and Shock	8.58%
111	Chronic Obstructive Pulmonary Disease	8.30%
135	Acute Renal Failure	8.12%
2	Septicemia, Sepsis, SIRS/Shock	7.10%
96	Specified Heart Arrhythmias	6.64%
19	Diabetes without Complication	5.65%
21	Protein-Calorie Malnutrition	5.11%
22	Morbid Obesity	3.40%
18	Diabetes with Chronic Complications	3.00%
114	Aspiration and Specified Bacterial Pneumonias	2.52%
108	Vascular Disease	1.93%
48	Coagulation Defects & Other Specified Hematological Disorders	1.81%
86	Acute Myocardial Infarction	1.57%
33	Intestinal Obstruction/Perforation	1.39%
79	Seizure Disorders and Convulsions	1.12%
8	Metastatic Cancer and Acute Leukemia	0.96%
23	Other Significant Endocrine and Metabolic Disorders	0.95%
170	Hip Fracture/Dislocation	0.95%
47	Disorders of Immunity	0.86%

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### Bottom 20 Inpatient HCCs

HCC	Description	Percent
167	Major Head Injury	0.16%
99	Cerebral Hemorrhage	0.15%
34	Chronic Pancreatitis	0.13%
88	Angina Pectoris	0.12%
75	M. Gravis/Myoneural Disorders, Inflammatory & Toxic Neuropathy	0.11%
74	Cerebral Palsy	0.11%
1	HIV/AIDS	0.11%
72	Spinal Cord Disorders/Injuries	0.11%
173	Traumatic Amputations and Complications	0.09%
29	Chronic Hepatitis	0.08%
186	Major Organ Transplant or Replacement Status	0.05%
83	Respiratory Arrest	0.05%
104	Monoplegia, Other Paralytic Syndromes	0.04%
76	Muscular Dystrophy	0.02%
73	ALS and & Other Motor Neuron Disease	0.02%
162	Severe Skin Burn or Condition	0.01%
110	Cystic Fibrosis	0.01%
166	Severe Head Injury	0.01%
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.00%
124	Exudative Macular Degeneration	0.00%

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### Top 25 Diagnoses Driving Large RAF Shifts

• Secondary malignant neoplasms	• Myelodysplastic syndrome
• Pressure ulcers stage 3-4, unstageable	• Malignant neoplasm of large intestine
• Malignant neoplasm of pancreas	• Schizophrenia
• Immunodeficiency	• Myasthenia gravis and other myopathies
• Gastrostomy status	• Parkinson's disease
• Multiple myeloma	• Anuria and oliguria
• Malignant neoplasm bronchus or lung	• Abdominal aortic aneurysm
• Acquired hemolytic anemia	• Multiple sclerosis
• Gangrene	• Long term (current) use of systemic steroids
• Colostomy status	• Peripheral vascular disease
• Malignant neoplasm of prostate	• Coronary angioplasty status
• Malignant (primary) neoplasm	
• Secondary polycythemia	
• Quadriplegia, paraplegia	

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### Stamp Out Unspecified Codes!

- Current ICD-10-CM code set has 94,127 diagnostic codes
- Of those, 9,057 (9.6%) are "unspecified," such as:
  - ✓ C81.9 Hodgkin lymphoma, unspecified (there are 63 more specific codes)
  - ✓ E10.40 Type 1 diabetes mellitus w/ diabetic neuropathy, unspec'd (there are 5 more specific codes)
  - ✓ I21.9 Acute MI, unspecified (there are 12 more specific codes)

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### Sample Report: RAF Impact

Discharge Month	Patients	Baseline RAF Avg	Current RAF Avg	Impact RAF	RAF % Change
	<b>1118</b>	<b>2.07</b>	<b>2.81</b>	<b>0.74</b>	<b>34.8%</b>
	573	2.07	2.77	0.37	34.4%
January 2017	73	1.81	2.49	0.68	37.9%
February 2017	88	2.01	2.67	0.66	32.8%
March 2017	59	2.12	2.76	0.64	30.4%
April 2017	64	2.06	2.52	0.45	22.0%
May 2017	50	1.94	2.84	0.90	46.4%
June 2017	36	2.08	2.78	0.69	33.3%
July 2017	28	1.71	2.64	0.93	54.2%
August 2017	35	2.26	2.94	0.69	30.4%
September 2017	23	2.09	2.87	0.78	37.5%
October 2017	25	2.08	2.72	0.64	30.8%
November 2017	25	2.28	3.04	0.76	33.3%
December 2017	18	2.33	2.78	0.44	19.0%
January 2018	20	2.05	2.90	0.85	41.5%
February 2018	29	2.17	2.86	0.69	31.7%

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### Sample Report: Visit RAF Scores

Visit Date	Account Number	CDS	Baseline RAF	Working RAF	CDI RAF Impact
11/30/2017	879949	MORRIS, LILLIAN	4.201	6.402	2.201
11/30/2017	1100058	MARTINEZ, IRENE	3.569	4.106	0.537
11/30/2017	6899242	MARTINEZ, IRENE	2.783	3.872	1.089
11/30/2017	5201563	MORRIS, LILLIAN	2.904	3.402	0.498
11/30/2017	9235178	MARTINEZ, IRENE	2.308	2.108	(0.200)
11/30/2017	6312456	MORRIS, LILLIAN	3.104	3.457	0.353
10/24/2017	3578925	TAYLOR, AMANDA	2.907	2.804	(0.103)
10/14/2017	8334589	TAYLOR, AMANDA	1.084	2.456	1.372
10/13/2017	1631564	MORRIS, LILLIAN	2.891	3.206	0.315
10/13/2017	2815371	PEREZ, DORIS	1.905	2.465	0.560
10/12/2017	6780260	THOMPSON, NORMA	2.074	3.527	1.453

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### Outpatient CDI: Start with Inpatient

- First look to achieve a solid *inpatient* CDI program because:
  - ✓ Inpatient CDI is well-defined, focused, and has known content and workflows. This is where a new Clinical Documentation Specialist (CDS) and a new CDI program should begin.
  - ✓ Inpatient CDI is a great place to become familiar with chart reviews, the structure and flow of queries, and the use of metrics.
  - ✓ Get familiar with HCCs and RAF scores in the inpatient setting
  - ✓ If properly designed, the same CDI software tool can be used both in the Inpatient and in the Outpatient setting; inpatient is the best place to get familiar with it.
- Stamp out the “unspecified” codes!

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### Outpatient CDI: Next Steps

- Recognize the areas where Outpatient CDI can help be helpful. Shift the focus from the acute to chronic conditions
- Recognize the limitations of issues that may *not* be directly impacted by CDI (Local Coverage Determination, Physician Evaluation & Management coding, etc.)
- Develop strict definitions of exactly what you want to accomplish and what problem(s) you are trying to solve using Outpatient CDI.
- Start with a narrow focus

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### Outpatient CDI: Next Steps

- Determine in which clinics and setting to start.
- Define the metrics to be used to guide the process. A KPI should be a measurable value that demonstrates how effectively an organization is achieving key business objectives, and is only as valuable as the action it inspires.
- Identify staffing considerations, and be prepared to be flexible with this. Workflows and hands-on needs for staffing an Outpatient CDI program are evolving.

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