Clinical Documentation Improvement in the Outpatient Setting

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Clinical documentation improvement (CDI) programs have proven their worth with over a decade of success and continued role expansion in the inpatient setting. As the healthcare industry prepares for new initiatives such as value-based purchasing, electronic health records (EHRs), and ICD-10-CM/PCS implementation, clinical documentation improvement has become a focus for organizations that do not yet have a well established program in place.

Facility-based outpatient services and physician practices acknowledge there are benefits to a CDI program in the outpatient setting. Outpatient needs for clinical documentation improvement are much different than inpatient needs. As outpatient federal incentive programs grow, so too does the need for accurate, concise, and reliable documentation. A widely-accepted pathway to analyze, develop, implement, and monitor an outpatient-focused CDI program has not been defined. The question becomes, “Where do we begin?”

The physician office setting has a different approach and focus than the facility-based setting. Whether facility-based or physician practice-based, it’s best to begin by determining the scope and focus of the program. If claim denials are an area of focus, drill down into the denials to conduct an analysis of audit findings and medical necessity reviews. Are denials due to misleading, inadequate, and/or poor clinical documentation? Many problem-prone areas have well defined expectations on how to minimize denial risk and avoid intensified reviews, such as National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

Are claims denied repeatedly for similar documentation issues, such as inadequate documentation to support medical necessity or previously treated conditions from the problem list being reported as current conditions? Is nursing documentation falling short on logging infusion times? In addition to identifying areas with recurring issues, CDI professionals should also investigate whether the provider documentation is capturing all the acute and chronic conditions that are being evaluated and treated.

A successful outpatient CDI program begins by developing tools to analyze where clinical documentation in the outpatient arena falls short in providing the necessary documentation to establish medical decision making, justify services rendered, promote continuity of care, and support proper reimbursement. Establishing procedures to address identified issues and monitor outcomes will help ensure the success of an outpatient CDI program.

Start With an Outpatient Data Assessment

Conduct an outpatient assessment to investigate the quality and thoroughness of outpatient claims data. This assessment will identify issues and determine if improved documentation will resolve the issues. Analysis of the needs assessment will help to determine where to begin the process. The facility should clearly state the goals of the program and create policies and procedures for outpatient CDI.

Baseline dashboards for the outpatient setting should be established. The outpatient dashboards could be developed for the quality indicators, rejected claims, appealed claims, and additional documentation requests. The dashboards can also be displayed by clinical specialties and/or departments. The outpatient data should be evaluated for potential lost charges as well as accurate pricing. A chargemaster review may be another method for evaluating charge and pricing information. These tasks will ensure the accuracy of the data before the creation of the outpatient CDI program.

The approach of an outpatient CDI program may differ depending on the focus. If the goal is to accurately capture outpatient quality indicators, then the process would be to review the quality indicators to ensure the documentation is comprehensive and

accurate and easily captures the required data. The emergency department may be an area where opportunities abound for improvement in the capture of the true clinical picture of the patient and use of resources required to treat patients.

Challenges the facilities could face when setting up an outpatient CDI program include:

- Short length of stay for outpatient cases
- Outpatient case volumes
- Lack of focus

The program should have a clear hypothesis in order to move forward and address specific issues. Increased attention occurs by limiting the focus to a specific procedure(s). For example, a focus could be the resolution of claim denials for orthopedic procedures. This approach will also remediate the volume issue.

After determining the focus and completing the data review, the next step is to evaluate a claim sample with clinical documentation and a detailed bill. The clarity, completeness, and reliability of documentation should be considered for the sample. Processes may be evaluated for the data capture. Electronic health record (EHR) templates may be revised to promote data accuracy.

The facility benefits of an outpatient CDI program include:

1. Increased documentation specificity
2. Decreased additional documentation requests
3. Decreased claim denials/rejections
4. Reduced barriers to reimbursement
5. Increased quality of care
6. Increased compliance to billing and coding regulations/principals

CDI in the Physician Practice Setting

An emerging trend in outpatient CDI is the implementation of a physician practice-based model, which focuses on three goals:

1. Ensure the capture of all diagnoses that the provider is currently assessing, treating, or monitoring.
2. Ensure that the Evaluation and Management (E&M) code assigned for the encounter is correct based upon the available documentation in the EHR.
3. Identify opportunities for remediation of the EHR software to improve the provider workflow in support of efficiency and clarity of documentation.

The CDI program can be implemented in a concurrent workflow, which is synchronous to the patient encounter, or in a retrospective workflow, which occurs after the patient encounter. Concurrent CDI programs allow for a CDI specialist to observe the clinical encounter from patient intake to discharge and to observe for opportunities to improve the documentation before final coding—and thus have the greatest potential for immediate impact.

In the concurrent workflow model, a CDI specialist is assigned to “room” with a provider, and follows their patient schedule. While observing the clinical encounter directly, the CDI specialist takes note of the review of the patient history, the patient assessment (review of systems), and any diagnosis and ongoing treatment the provider discusses and makes note of. If the documentation is concurrent to the clinical encounter, the CDI specialist has the opportunity to directly observe the documentation templates used by the provider and make recommendations about how the templates can be improved to strengthen the clinical documentation.

In the case of an EHR that utilizes pick lists, it is important that the list contains selections with all required specificity and that the most frequently selected items appear at the top of the list to avoid scrolling and typing by the provider. A concurrent review also easily creates an opportunity to verbally query the physician for missing diagnoses and other gaps in documentation that may improve the final coding for both the diagnosis and E&M level. The ability to observe the patient encounter is key to discerning documentation gaps such as diagnoses that were discussed during the visit but were not documented by the provider.

The focus on diagnosis coding is very important in the physician practice setting. In some of the first research of its kind, a link has been established between patient outcomes and uncoded diagnoses in the patient record. Patients that have uncoded diagnoses account for higher utilization of inpatient and emergency services, and experience less than optimal patient outcomes for chronic diseases such as congestive heart failure, hypertension, diabetes, and dyslipidemia.[1]

Beyond the impact that diagnosis coding has on patient outcomes, missing diagnoses can also account for medical necessity denials for referred services such as diagnostic testing, poor continuity of care between specialists, and decreased reimbursement in risk-adjusted reimbursement programs such as Hierarchical Condition Categories (HCCs) used in Medicare Advantage programs.

In today's world of quality reporting, audits, and incentive programs, the need for accurate, concise, timely, reliable, and complete documentation is greater than ever. Facilities and physician offices alike should be evaluating their investment in CDI efforts in the outpatient setting. Determining weaknesses and identifying vulnerabilities in current documentation practices will provide a starting point to create workflows, policies, and procedures for outpatient clinical documentation improvement.

Note

[1] Orr, Jeremy and Allen Kamer. "Accurate coding: the foundation of accountable care." Optum white paper. December 1, 2014.

References

Collins, Corliss. "How to Fast Track Your Outpatient Clinical Documentation Program." Hayes Management Consulting Blog. December 17, 2014. http://meetings.hayesmanagement.com/blog/fast-track-your-outpatient-clinical-documentation-program.

Johnson, Laurine. "The Implementation of an Outpatient Clinical Documentation Program." Ingenix white paper. 2008. https://etg.optum.com/~/media/Ingenix/Resources/White%20Papers/Ingenix_OutpatientCDI_WP_1001055.pdf.

Linnander, Robert. "CDI in outpatient settings: Are you ready for the challenge?" The Advisory Board Company's *At the Margins* Blog. October 14, 2014. www.advisory.com/research/financial-leadership-council/at-the-margins/2014/10/how-to-create-outpatient-cdi-program.

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