Expanding CDI to Physician Practices: Five Documentation Vulnerabilities to Address in 2016

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Inpatient clinical documentation improvement (CDI) has thrived since the implementation of MS-DRGs. More recently, it has grown in popularity commensurate with the implementation of ICD-10-CM/PCS. In some cases, organizations took a holistic approach to ICD-10, deliberately embedding CDI specialists within their owned or affiliated physician practices to ensure a smooth transition—thereby expanding CDI efforts into outpatient and ambulatory settings.

With the proliferation of accountable care organizations (ACOs) and the rise in healthcare mergers and acquisitions, many hospitals and health systems are looking for ways to continue the ICD-10 educational momentum and expand CDI efforts into outpatient, ambulatory, and physician practice settings. Beyond these hospital-led initiatives, many independent practices and private physicians are also quickly recognizing the importance of documentation quality—and how coded data translates to reportable outcomes. This article takes a deeper dive into implementing effective CDI programs within physician practices.

Why the Timing is Right

In today's healthcare environment, documentation is paramount, being used for medical coding and reimbursement. It's also increasingly used to gauge the quality of care provided. When physicians accurately and thoroughly capture the true clinical picture of a patient's condition or problem, not only do they justify medical necessity, they may also avoid third-party audit scrutiny and denials. This has a direct positive effect on cash flow and the overall successful operation of the business—for both hospitals and physicians.

Regulatory changes have also forced physicians to take a closer look at clinical documentation. ACOs and bundled payments, for example, incentivize efficient and effective care, requiring physicians to document as specifically and completely as possible. Public outcomes data has also forced physicians to question the efficacy of their coded data, which almost always leads back to a discussion about documentation. In addition, the Physician Quality Reporting System (PQRS) and "meaningful use" Electronic Health Record (EHR) Incentive Program are pushing the need for better physician documentation.

In the years ahead, the Centers for Medicare and Medicaid Services' (CMS') new Merit-Based Incentive Payment System (MIPS) will become a significant regulatory driver behind physician practice CDI. This program, which consolidates the PQRS, value-based payment modifier (VBPM), and meaningful use incentive program, uses data collected during 2017 to determine potential payment adjustments in 2019. Payment adjustments are determined based on a MIPS composite score that is partially driven by the coding of hierarchical condition categories (HCC), making HCC capture vital in the practice setting.

Negative payment adjustments will be distributed as follows, depending on whether a provider's composite score falls below a particular performance threshold: four percent in 2018, five percent in 2019, seven percent in 2020, and nine percent in 2021 through 2023. Above-par performance could earn a physician a bonus as high as 12 percent in 2018 and 27 percent by 2021.

Because of this potential negative impact on finances due to lax clinical documentation, CDI programs in physician practices will certainly become the norm. The question today is: How can HIM professionals help support them?

Logistics of CDI in a Physician Practice

Unlike hospitals that have more operational and personnel resources for CDI, physician practices must often rely on a certified coding professional or office manager to perform the task. In addition to overseeing CDI efforts, these individuals may also be

responsible for checking patients in and out, obtaining insurance authorizations, responding to audits, coding, billing, performing accounts receivable follow-up, contracting, and much more.

Given the plethora of responsibilities, CDI must therefore be extremely targeted and thoughtful in the practice setting. Those charged with CDI must audit documentation frequently so they can pinpoint educational opportunities for each individual provider—physicians, nurses, medical assistants, and scribes.

Another challenge is that CDI in a physician practice is often retrospective. Practices typically receive a denial and then perform physician or staff education based on the reason for the denial. Unfortunately, by the time the education occurs most physicians don't remember making the documentation error or omission, and don't recall the specifics of the case. Retrospective CDI also permits subsequent errors to snowball, causing a cascade of denials before a correction is provided.

To be truly effective, practices need a "front-to-back" approach—proactive education and concurrent CDI on the front end of the process. This may require a more dedicated CDI resource within the practice as well as close collaboration with the practice's EHR vendor to remediate documentation vulnerabilities, tweak templates, and update documentation alerts and prompts.

Physician Documentation Vulnerabilities

To identify documentation vulnerabilities, one needn't look further than the "FY 2016 Office of Inspector General (OIG) Work Plan" in which the OIG identifies trends and patterns of compliance risk and fraud. Some of these include non-covered chiropractic and anesthesia services as well as unreasonable use of prolonged services, high use of outpatient physical therapy services, and non-compliant referrals/orders for certain Medicare services, supplies, and durable medical equipment. But there are many other areas ripe for CDI. Consider the following five areas.

Cloned notes and assessments

This occurs when nurses or other providers copy and paste information from a previous visit into the current visit without verifying the accuracy of that information. In many cases, details are completely inaccurate or omitted entirely. There's also often a mismatch between the chief complaint/history of present illness and the assessment. For example, a patient complains of neck pain but the entire assessment addresses the patient's lower back pain. This incongruence can certainly benefit from a CDI specialist's analytical eye.

Medical necessity

Physicians sometimes don't understand that medical necessity isn't synonymous with medical decision making. The specific ICD-10 diagnosis codes that the physician chooses can either make or break a payer's decision to deem services medically necessary for the patient. Many physicians don't even realize that local coverage determinations (LCDs) exist, requiring certain diagnoses as a prerequisite for payment. As payers continue to update these LCDs in light of ICD-10, someone focused on CDI can monitor changes and ensure that documentation is updated accordingly.

ICD-10 diagnosis specificity

Certain specialties, such as orthopedics, OB/GYN, internal medicine, and cardiology, saw many more code expansions in ICD-10-CM than others. These specialties could benefit from CDI that prompts greater specificity related to laterality, disease manifestation, anatomical location, and more. An individual trained in CDI can help explain ICD-10 terminology to physicians and create ICD-10 favorite lists and shortcuts to alleviate the burden of sifting through diagnosis codes listed in the EHR—ultimately increasing productivity.

Unspecified codes may prove to be particularly problematic in practices. That's because CPT codes—not diagnosis codes—drive reimbursement in the practice setting, leaving little incentive for physicians to pay attention to diagnoses. In addition, the American Medical Association/CMS joint announcement made last July indicates that contractors conducting medical reviews (i.e., Medicare administrative contractors, recovery auditors, zone program integrity contractors, and the supplemental medical review contractor) during the 12-month period following ICD-10's implementation on October 1, 2015 could not deny claims

solely for the specificity of the ICD-10 code. This is as long as the code is in the correct family of codes (i.e., the correct ICD-10 three-character category) and there is no evidence of potential fraud. This flexibility applies to both automated and complex medical reviews.

Many physicians don't understand that this flexibility pertains only to Medicare and only to retrospective audits. Some have misinterpreted the announcement to mean that they have complete flexibility with all payers for ICD-10 reporting on the front end. Someone well-versed in CDI can ensure compliant coding that won't subsequently jeopardize reimbursement once the Medicare flexibility has expired.

E/M levels

Due to fear of denials and audits, physicians frequently down-code their evaluation and management (E/M) levels (i.e., code a lower-level, lesser paying E/M code). In some cases, a higher level might be justified if the individual trained in CDI can identify opportunities where documentation is lacking—and then query for clarification. In other cases, a CDI specialist can identify patterns of over-coding that could trigger an audit or raise a payer's red flag. An example is when a physician provides a follow-up office visit or subsequent hospital visit and then bills using a higher level E/M code as though a comprehensive new patient office visit or an initial hospital visit had been provided.

Bundling and modifier usage

CDI specialists can help physicians identify when it's appropriate to use a modifier and when a particular procedure or service is inherent in a more extensive procedure or service performed at the same time.

How to Get Started with Physician CDI

In this age of documentation scrutiny, physician practices can't afford to wait for an OIG or CMS audit to reveal noncompliance. Doing so could put a practice out of business. It's also in the practice's best interest to improve documentation if it's part of an ACO, shared-savings initiative, or larger health system. Consider these three strategies:

- **Hire a certified coding professional.** Several associations, including AHIMA, can point a practice to certified coding professionals. By ensuring that documentation meets regulatory requirements, a certified coding professional is an invaluable asset for any physician practice. A certified coding professional can also use his or her auditing skills to provide CDI feedback. Allow coding professionals to spend time in the clinical areas of the practice so they become more familiar with clinical diagnoses and procedures and can assist with documentation improvement.
- **Focus on collaboration.** Collaboration among key staff members in the provider practice will help providers document better and more efficiently. Also, quality CDI programs can help a practice streamline processes and procedures that currently create extra work for office staff and providers alike.
- **Seek assistance from hospital-based CDI specialists and HIM directors.** These individuals can share valuable resources (i.e., policies, documentation tools/tips) that can help practices launch their CDI efforts.

Documentation quality begins in the outpatient setting. Physicians who document well in their practices help establish a baseline for patient severity and justify medical necessity for inpatient services. Quality documentation enhances outcomes and ensures accurate revenue. Now is the time to evaluate needs, build partnerships, and begin the important task of improving physician practice documentation.

Reference

Department of Health and Human Services' Office of Inspector General. "Fiscal Year 2016 Work Plan."

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