Outpatient CDI: A Solution for Navigating Risk Adjustment

By Pamela C. Hess, MA, RHIA, CDIP, CCS, CPC, and Karen Frosch, CCS, CCDS, CRC, CPHQ

With payers moving to risk adjusted payment models such as Hierarchical Condition Categories (HCC) for Medicare Advantage, health systems are challenged to improve clinical documentation in physician practices to support ICD-10-CM linked HCC codes.

Christiana Care Health System, one of the nation's largest healthcare providers, ranking 21st in the nation in hospital admissions, responded to this challenge by launching an outpatient clinical documentation improvement (CDI) program. The following case study looks at how Christiana Care enhanced their current CDI program by expanding into the physician space —and results they have seen over the last several months.

"As payers increase the pay for performance methodology and the healthcare industry moves from a fee-for-service environment, the clinical documentation specificity of diagnoses, procedures, and services is integral to ensuring accurate reimbursement from the payers," says Amanda McMullen, PhD, RN, CPHQ, the corporate director of ambulatory and network quality at Christiana Care and architect of the outpatient CDI program. "Our new program helps to ensure that Christiana Care's clinical and claims data accurately represents the severity of the patient population we are pleased to service."

The outpatient CDI program began with a strategy to include one physician practice pilot site as the initial focus on the risk-based payment programs. Now currently underway, Christiana Care's six-month-old outpatient CDI program has already quantified a significant return on investment. The program quickly expanded to all of Christiana Care's primary care practices.

Process Driven by Risk-Based Payer Guidelines

The Medicare Advantage Risk Adjustment Model is administrated by the Centers for Medicare and Medicaid Services (CMS) for services billed under Medicare Parts A (hospital), B (outpatient), and D (prescription drugs). For the Medicare Advantage Risk Adjustment Model, these services are paid under Medicare Part C and Part D. "Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee such as age, sex, Medicaid eligibility, original reason for entitlement (OREC) and disabled status," CMS guidance states. "Risk scores measure individual beneficiaries' relative risk and risk scores are used to adjust payments for each beneficiary's expected expenditures."[1]

The CMS-HCC Risk Adjustment Model is used to adjust payments and bids for subpopulations with distinct cost patterns. HCC codes are cross-walked to ICD-10-CM codes and placed in hierarchies based on severity and cost. For example:

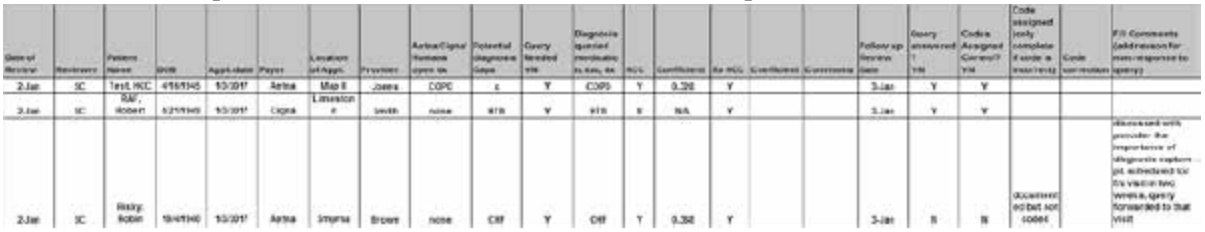
- An 83-year-old man who originally became entitled to Medicare as disabled is diagnosed with diabetes and CHF (ICD-10-CM code E11.9 and I50.9)
- Originally insured due to disability, OREC = 1
- Originally disabled, male = 0.168
- Diabetes without Complication, HCC 19 = 0.118
- Congestive Heart Failure, HCC 85 = 0.368
- Disease Interaction (CHF and Diabetes) = 0.182
- Risk Adjustment Factor (RAF) Score = (demographics) +0.168 + 0.118 + 0.368 +0.182

Integrated health systems or other groups such as hospitals or physician practices may enroll in Medicare Advantage and be reimbursed an annual fee based on a flat per patient per contract rate, which is multiplied by the total annual RAF for the patient. Each HCC may only be reported once per year for each patient regardless of the number of providers. CMS reimburses the Medicare Advantage Plan based on the RAF scores and contract rate calculation. The Medicare Advantage Plan reimburses the health system or group based on a contractual agreement calculated from the RAF scores and contract

rates. The providers are reimbursed based on a distribution model established by each health system or group. It is to the Medicare Advantage plan, health system, and individual provider's advantage to identify as many HCCs as possible during the annual period—payment determination is prospective and is based on the previous year's RAF score. The higher the RAF, the higher the payment.

Table 1: CDS Worksheet Example

Below is an example of the current CDS worksheet, used to capture chart review information and to tabulate KPIs.



Christiana Care's Call to Action

Sharon Anderson, RN, BSN, MS, FACHE, chief population health officer and senior vice president of quality and patient safety at Christiana Care, says a motivating factor for establishing the new outpatient CDI program was the ongoing success of the inpatient CDI program.

"Christiana Care as a regional tertiary care health system has recognized the importance of accurate documentation and coding to reflect the severity of illness of the patients we serve in the hospital setting. Several years ago, an inpatient clinical documentation improvement program was established and has been well received by our providers. Recently, we have begun to recognize that there is the same opportunity in ambulatory care," Anderson says. "An ambulatory clinical documentation improvement program is of critical importance as we move away from fee-for-service payments to value- and risk-based performance contracts. Christiana Care has established a Medicare Shared Savings Program ACO and participates with several Medicare Advantage Plans, which has been the impetus for us to establish an outpatient clinical documentation program to support the education and training of our providers."

Christiana Care included the original CDI program stakeholders when developing the outpatient CDI program strategy. "It was important to gain agreement from key stakeholders such as finance, operations, and the medical staff," McMullen says. "Because of the value proposition that has been proven year after year across the nation through inpatient CDI programs, the concept was one that our colleagues were willing to support. As soon as the stakeholders understood the implications for the outpatient setting, it was easy to ride the wave of the inpatient setting. It is also important to evaluate how HCC payments will impact the provider, either directly or indirectly. Healthcare systems may choose to incentivize providers directly or indirectly by supporting clinical efforts with additional dollars for staff, supplies, and equipment."

After the key stakeholders were identified, the group gathered to perform a set of key tasks required to jump-start the program.

Key outpatient CDI program tasks included:

- Identify the HCC and risk adjustment subject matter expert
- Identify which group of providers to target
- Determine method of educating providers on risk adjustment and HCCs
- Reinforce to the providers that Christiana Care would build a process to help them—this was key to the program's success
- Meet with pilot site providers to observe their workflow for preparing and documenting the patient's visit before, during, and after the visit
    - Challenges included the multiple electronic health record (EHR) systems used by providers in the inpatient and outpatient settings

- Determine the scope of work and create job specifications for the position to recruit outpatient clinical documentation specialists
- Determine Key Performance Indicators (KPI) and methodology for KPI capture
- Design a streamlined chart review and query process/workflow and test before involving the pilot providers
- Create query templates to ensure compliance, consistency, and ease of training
- Hire and train an ambulatory clinical documentation improvement specialist

In addition to the key implementation tasks, consideration was given to how the program would be socialized within the health system. High-level visibility and program sponsorship by the health system executives and primary care medical staff leaders encouraged buy-in by the providers. Other steps that encouraged buy-in at Christiana Care were:

- The inpatient CDI project manager met with each practice for an hour-long presentation to introduce the providers to risk adjustment and HCCs and assure them that a process was being put in place to help them document to support this initiative.
- Humana's free Cadet Program was used to assist with provider and clinical documentation improvement specialist/coder education in risk adjustment and HCCs.
- An HCC physician champion was selected to assist with provider communication about the program and to encourage buy-in from the provider perspective.

Getting Started with the Pilot Site

The idea for the ambulatory CDI program began in August 2016 because HCC capture and risk scores affect the next year payment for Medicare Advantage plans. The program had to be up and running before the end of the year to enable capture of missed HCCs on scheduled patients. The goal was set for an official start date by November 1, 2016.

The selected pilot site was an important consideration. The perfect pilot site was the practice of the HCC physician champion. She assisted in testing the proposed process. Once she was comfortable with the query and feedback process, the program was rolled out to the other providers in the practice.

Implementation of the Program

Once the pilot site testing was complete, it was time to begin program implementation. Careful consideration was given by the key stakeholders to ensure a streamlined implementation. Each step of the process was outlined prior to the program start. The final implementation steps were:

- Identify Medicare Advantage patients scheduled for the next week.
- Review the patient's history, problem list, and medication list for potential HCC capture and record this information on a worksheet.
- Verify diagnoses that have been billed during the previous year. This is done via the internal billing system and via access to the Medicare Advantage provider's database. Each of the major Medicare Advantage plans provided access to the patient's billed diagnoses for identification of any potential diagnosis gaps. This helps prevent the end-of-the-year "closing the gap" process the Medicare Advantage plans struggle with to ensure optimal risk scores before the final reimbursement rates are determined.
- Review the clinical record for documentation or treatment to support any missed diagnosis.
- If documentation or treatments/medications support a diagnosis that has not been addressed by the provider, then a query is attached to the chart. This reminds the provider to review and include the diagnosis in the assessment and plan during the face-to-face encounter with the patient and to add the diagnosis code to the claim. A flagging system has been created to alert the provider that a query is present.
- The ambulatory clinical documentation improvement specialist records all potential and queried diagnoses in a spreadsheet, along with HCCs or Rx HCCs, coefficients, queries, and other pertinent comments. Eventually, an electronic worksheet will be developed when the transition to a new EHR system is completed. (See Table 1 on page 24 for an example.)
- All queried charts are reviewed the day after the patient visit. This verifies that the query has been answered and the appropriate diagnosis code has been added to the claim. The outcome is recorded on the spreadsheet.

- If the provider did not respond to the query, selected an incorrect code, or did not add the code to the claim, feedback is sent via e-mail, a phone call, or an in-person office discussion.
- Steps are taken to correct an incorrect code.
- If the provider did not respond to the query, he/she cannot go back and edit the chart as the diagnosis must be addressed in the face-to-face encounter.
- The query is flagged in the patient's next scheduled visit to be addressed.

This feedback process has been key to the implementation and initial success of the program.

Looking back at the implementation process, the largest challenges for getting started with the program were the time commitment by the stakeholders, the resources required to implement and maintain the program, and the variable workflow processes encountered at each provider site. The query process that worked for one group had to be modified for another group. Also, this was a new concept both to the primary care providers and CDI team, so the amount of education needed by all was tremendous. Just knowing where to begin was challenging as there are few ambulatory CDI models to emulate—it is important to start with a small focus and expand once the providers become comfortable with the process.

Exciting Times for Outpatient Clinical Documentation Improvement Specialists

This is an exciting time in the clinical documentation improvement profession. A whole new category of clinical documentation improvement specialists are needed, which will expand HIM skill set requirements and the number of positions available in the healthcare industry. The skill set requirements for the outpatient clinical documentation improvement specialists are the same in many ways as the inpatient clinical documentation improvement specialists. These requirements include:

- Previous clinical documentation improvement experience (inpatient or outpatient)
- Extensive knowledge of medical terminology, physiology, pharmacology, and disease processes
- Ability to work efficiently and independently
- Ability to effectively communicate and educate providers
- Ability to identify trends and/or opportunities to improve clinical documentation and offer potential solutions
- Extensive critical thinking skills for effective health system communication and program promotion, program redesign, strategy, and program analytics

The outpatient CDI setting also requires a new set of skills because of the variable work flows and reimbursement methodologies found in the outpatient setting. Essential skills include:

- Three to five years CDI and coding experience (this is not an entry-level position)
- Mandatory coding certification (CCS, CRC, or CPC)
- Knowledge of risk adjustment (HCCs), guiding principles, and reimbursement methodology
- For programs that include outpatient facility components, CPC, CPT/HCPCS coding experience, knowledge of OPPS, APCs, RVUs, fee schedules, charge masters, charge capture, and other components of ambulatory reimbursement

Christiana Care was fortunate to be able to rapidly fill this position—transitioning one of their current inpatient clinical documentation improvement specialists to the ambulatory position. The employee's in-depth knowledge of coding and documentation guidelines and ability to interact and educate providers was key to a successful implementation. This employee also had prior physician billing experience, which was an asset.

Determining the number of staff required for an outpatient CDI program is based on the target population and number of visits per year for the population. Christiana Care has experienced the average amount of chart review time per day at around 6.5 hours. During this time about 20 initial reviews and 16 follow-up reviews are completed. These numbers are used to determine the full-time employees needed for the program.

Options for staffing the outpatient CDI program are variable and based in part on the timetable for program implementation. Because outpatient CDI is a relatively new concept, experienced staff is typically not readily available. Consideration should be given to these options:

- Contract-to-permanent employment or outsourced model: Consultants can be contracted to perform the work while the health system recruits permanent staff. The consultants can be used to train the staff after being hired. Contract staff are also available for systems who chose the outsource-managed model.
- Employee-trained: Health systems may choose to train their own employees. Christiana Care used Humana's Cadet Program to teach the basics of HCCs, risk adjustment principles, chart review, and query for HCC capture. HCC boot camps are also offered from various professional organizations.

Key Performance Indicators for Christiana Care's CDI Program			
Month	**Query Response Rate**	**% of HCCs queried and subsequently captured**	**% of codes needing correction**
Nov. 16	34%	25%	7.4%
Dec. 16	44%	49%	21.6%
Jan. 17	59%	53%	9.1%
Feb. 17	69%	79%	12.4%
Nov. 17	56%	48%	6.4%

Calculating CDI's Return on Investment

At the beginning of the program it was difficult to determine the actual or potential financial return on investment (ROI). Christiana Care started out with the premise that if they captured missing HCCs and/or RxHCCs, this would improve the patient's risk score and the increased revenue would follow. In the first two months of the program 76 missed HCCs and 76 RxHCCs were captured with a query response rate of around 39 percent. With the ongoing provider collaboration and one-on-one education sessions, the query response rate rose to 68 percent in the fourth month of the program with a substantial increase in the number of captured HCCs. Knowing an organization's current risk score for each of the Medicare Advantage plans will help calculate the potential ROI as updated risk scores are reported back to the organization, which can be provided quarterly.

Below is an example calculation:

- Medicare Advantage Monthly Contract Rate: $819
- Annual Medicare Advantage Contract Rate: $9,828
- Total point improvement in reported Risk Adjustment Factor (RAF): 125.6
- Annual Program ROI: $1,234,397

The monthly KPI report includes the number of queries submitted, response rate, number of HCCs captured, and number missed due to no response or other reason by practice and by provider. The chart on page 26 offers a snapshot of the success that Christiana Care has had to-date with the program KPIs.

The KPIs are shared monthly with the primary care practice leadership. It is important to share ROI information with the key stakeholders of the outpatient CDI program on an ongoing basis. This reinforces the value and sustainability of the program. Providing practice-specific HCC capture on a frequent basis can encourage participation among providers.

Future of Outpatient CDI at Christiana Care

Challenges to the successful CDI program implementation have been met and the CDI program has been rolled out to all primary care practices within the integrated health system with plans to expand to the specialty offices in the future. An additional full-time employee has been approved to help implement the expansion. Further refinements to the program need to be made, but the foundation has been laid and the providers are on board. Christiana Care, an early responder to the HCC payment model challenge, is on the way to a successful outpatient CDI implementation.

Note

[1] Centers for Medicare and Medicaid Services. "Medicare Managed Care Manual: Chapter 7 – Risk Adjustment; Transmittal for Chapter 7; 20 - Purpose of Risk Adjustment." June 7, 2013.

Pamela C. Hess (phess@himaginesolutions.com) is managing director of CDI at himagine solutions, Inc. Karen Frosch (KFrosch@Christianacare.org) is clinical documentation improvement project manager at Christiana Care Health System.

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