Implementing an Outpatient CDI Program

PRESENTED BY:
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This information is meant to be simply a guide for implementation based on the presenter’s experience. Any persons wishing to implement a CDI program should perform their own individual research.
What is CDI?

- CDI – Clinical Documentation Improvement
- Focus should always be to improve the quality of data
- Collaboration amongst CDI specialists, coders, and providers
- Meant to reduce documentation ambiguities, compliance risks, fraud and abuse practices

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Benefits of CDI

- Identify areas for documentation improvement
- Improve clinical documentation that will better reflect the patient’s severity of illness (SI)
- Positive impact on quality measures – MIPS/MACRA
- Improve physician scoring
- Ultimately promote accurate reimbursement
- End result – Clinical data integrity
Patient seen in office, appears happy today. Complains of mild HA over the past 3 days, throbbing in nature. She is diagnosed with depression, but has no previous history of suicides.
Role of the CDI Specialist

- Perform documentation audits – concurrent and retrospectively
- Query
- Identify patterns
- Team approach
- Educate on documentation guidelines
- Adherence to Code of Ethics

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Every CDI Specialist Should...

- Be able to read, interpret and analyze the information in the medical record at an expert level
- Possess sound knowledge of medical coding, compliance, healthcare regulations and payor guidelines
- Possess clinical knowledge to include medical terminology, A&P, pathophysiology, pharmacology, etc.
- Ability to communicate documentation deficiencies/audit results in a clear and effective manner
Mechanics for the Physician Practice

- Targeted approach for CDI
- Why retrospective only approach will not work
- Certified coder/nurse collaboration
- Speak with inpatient CDI directors/staff
- EHR system ‘fixes’
- Identify a physician champion
- Utilize the HCC Risk Adjustment Model and the OIG Work Plan to hone in on areas for your CDI focus
- Physician Buy-In
CDI Shift - Outpatient Hospital

Where to begin?
- Setting: ED/Physician Practice/Observation/Outpatient Clinic
- Utilize current inpatient CDI program

What to review?
- HCC
- Claim denials
- Charge capture
- Evaluation & Management
- Edits (OCE, MN, Etc.)

Additional questions to ask?
- Where are you in the marketplace?
- What’s important to you?
Both AHIMA and ACDIS – Association for Clinical Documentation Improvement Specialists recommend having policies and procedures in place to govern a CDI program (inpatient).

Recommendation: Mission statement, Orientation, Competency and QA Process; CDI Review Process; Rules for Provider Query; Education Process; Metrics and Reporting.

There are no official outpatient CDI guidelines.
Standards of Ethical Coding

The coding professional shall:

- Participate in the development of query policies that support documentation improvement and meet regulatory, legal, and ethical standards for coding and reporting.
- Query the provider for clarification when the documentation in the health record that affects an externally reportable data element is illegible, incomplete, unclear, inconsistent, or incomplete.
- Use queries as a communication tool to improve the accuracy of code assignment and the quality of health record documentation, not to inappropriately increase reimbursement or misrepresent quality of care.

The coding professional shall not:

- Query the provider when there is no clinical information in the health record prompting the need for a query.

AHIMA
Excerpt from consult note:

**Admitting diagnosis:** OA of right knee

On the second day, the knee was better, and on the third day it disappeared.
Provider queries are appropriate in the following circumstances:

- **Legibility**: Defined as handwriting that cannot be read by two other individuals.
- **Completeness**: Represented by an abnormal lab test result for which a clinical interpretation has not been given or the indication for a prescribed drug was not provided.
- **Clarity**: Represented by a patient with a symptom for which an underlying cause was not elucidated (e.g. fever).
- **Consistency**: Represented by conflicting documentation.
- **Precision**: Represented by the need for greater specificity of a diagnosis when allowed by ICD-10-CM.
How to Query?

- Queries should not be used to question a provider’s clinical judgment. Example, provider may make a clinical determination that a patient has PNA even though the CXR results are negative.
- At minimum, CMS states a physician query should be clear and concise, contain precise language, present the facts and identify why the clarification is needed, and present the scenario.
- A query form should include the patient’s name, date of service, MRN#, provider’s name, name and contact of the individual sending the query, query date, and statement of the issue in the form of a question.
Non-leading vs. Leading Queries

**Leading Query:**

- Dear Dr. X: The pt has a documented diagnosis of PNA that is being treated with Vancomycin IV. Since Vancomycin is used for gram-negative organisms, please document that the pt has gram-negative PNA in your progress note.

**Non-leading Query:**

- Dear Dr. X: The pt has a documented diagnosis of PNA that is being treated with Vancomycin IV. Please clarify and document in the progress note the type of PNA being treated.
Dear Dr Y: Pt discharged from St. Mary’s hospital 3 days ago with a GI bleed. Today seen in GI clinic with HGB of 7.8 and HCT of 20.4 percent. Provider documents anemia as the diagnosis being treated. Since the patient received 2 units of PRBCs with HGB of 7.8 and HCT of 20.4, please document acute blood loss anemia.

Non-leading Query:

- Can the anemia be further specified as:
  - Acute blood loss anemia
  - Chronic blood loss anemia
  - Other: __________________________
  - Undetermined
Non-leading vs. Leading Queries

Which of the following are example(s) of a leading query?

- A. Dear Dr. X: The documentation indicates only lung cancer (unspecified), however a diagnosis code of head & neck cancer was assigned to the chemo order. Please also add the head & neck cancer to the assessment in your progress note.

- B. Dear Dr. Y: The pt’s weight is 385 lbs and has a BMI over 50%. Overweight is documented in the HPI and the assessment states obesity. Due to the recorded weight and BMI, would you agree the patient is morbidly obese?

- C. Dear Dr Z: It is noted in the A/P that the patient has chronic congestive heart failure. The most recent echocardiogram revealed an EF of 25%. Can the CHF be further specified as:
  - Systolic CHF
  - Diastolic CHF
  - Systolic and Diastolic CHF
Additional Query Tips...

- Have a mechanism in place to track your queries in case of an audit
- Never tell the provider what to write no matter how ‘clear’ the clinical picture appears
- Avoid the words “you” and “but” in queries, such language tends to result in a defensive reaction
- Do not query when no clinical indicator supports
- Never indicate the financial impact of the response to the query
Dear: Smith MD, John

Please refer to your progress note dated 09/01/2016. The HPI documents an indwelling foley, and the A/P states UTI. Can the etiology of the UTI be further specified?

Is the UTI due to the Foley?
___ Yes
___ No
___ Undetermined
___ Other: ___________________

Provider Signature: ___________________________ Date: _________
Dear Smith MD, John

Please refer to your progress note dated 09/01/2016. The HPI documents an indwelling Foley, and the A/P states UTI. Can the etiology of the UTI be further specified?

Is the UTI due to the Foley?

X Yes
___ No
___ Undetermined
___ Other: ___________________

Provider Signature: John Smith, MD  
Date: 09/04/2016
Top Physician/Outpatient CDI Areas

- Medical Necessity
  - Chiropractic Manipulation
  - Physical Therapy
  - DMEs
  - LCD/NCD Adherence
  - Diagnostic Lab/Radiology

- Cloned Documentation
  - Copy Forward EHR Abuse
  - Documentation Mismatch/Conflict

- E/M Leveling
  - Patterns of over-coding/under-coding
  - Proper Modifier Usage
  - Consultations

- ICD-10-CM Code Assignment
  - Claim denials for lack of specificity, medical necessity, etc
  - Reimbursement incentive for quality models based on claim data

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Query for the Needs of Your Clinic

Key: Reasons for Query

1. Treatment is documented without a supporting documented diagnosis (e.g., Procrit administered/billed w/o anemia documented).
2. There is clinical evidence for a higher degree of specificity or severity (e.g., unspecified cancer location lung, breast, colon).
3. There is clinical indicators (lab, diagnostic study) of a diagnosis or documentation of a problem in the Hx/PE, but diagnosis is not included in A/P.
4. Cause-and-effect relationship between two conditions or organism (e.g., individual assessments of pain (780.96) and a neoplasm).
5. Diagnosis code assigned w/o supporting documentation.
6. Documentation contradictions (e.g., HPI states chest pain, ROS states no complaints of CP).

Key: Query Response

A - Provider Agree
D - Provider Disagree
N - No Response from Provider
Query Tracking Form

What your tracking form should tell you...

- Most common query reasons
- Providers with high/low query percentage
- Where education is most needed
- Provider response rate (turn-around time)
- Provider agree rate

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HPI – She has no rigors or shaking chills, but her husband states she was very hot in bed last night.

PE – Large brown stool ambulating in the hall.

DS – Alive, but without my permission.
Physician Buy-In

- Get administrative support – CEO/COO
- Promote awareness
- Provide evidence that simplifies the process
- Show how CDI directly affects physician profiling
  - Healthgrades
  - Leapfrog
  - WebMD
  - CMS
- Show how CDI improves quality of care for patients!
- Show how CDI reduces compliance risks

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