

# Guiding outpatient clinical documentation improvement

by Laura Jacquin, RN, MBA

Patient care continues to move from the inpatient setting to outpatient. With this change, the challenge of securing comprehensive documentation that articulates the services rendered and the patient care provided now needs to extend across the care continuum.

Very few hospitals have expanded their clinical documentation improvement (CDI) programs to the outpatient setting. A 2017 survey conducted by The Association of Clinical Documentation Improvement Specialists (ACDIS) indicated that only 9% of respondents currently focus on outpatient CDI.

The first question an organization must ask when deciding whether to implement an outpatient CDI program is: Where do we focus our efforts? For many health systems, outpatient CDI remains ambiguous.

To guide their efforts, organizations should first gather data that will define the focus of their outpatient CDI program. Data metrics such as improved quality indicators, which measure improved compliance with quality measures or improved financial outcomes, can assist in identifying areas of opportunity. A health system may want to consider the following questions when implementing an outpatient CDI program:

- What is your organization's volume of denials for medical necessity of patient status (observation versus inpatient)?
- What is your organization's volume of medical necessity denials for outpatient surgical cases?
- Is your organization part of an accountable care organization (ACO)?
- Do your providers participate in Medicare Advantage programs?
- Do your providers participate in any value-based payment programs?

The Department of Health and Human Services in conjunction with the Centers for Medicare and Medicaid Services (CMS) continue to explore new health-

care payment models, such as:

- Fee-for-service with no link of quality outcomes to payment
- Fee-for-service with a link of quality outcomes to payment
- Quality outcomes-based reimbursement
- Population-based outcomes reimbursement

CMS continues to drive reimbursement strategies that will evaluate the quality of patient care and the ability to manage costs for both the hospital and provider. The only way to capture these efforts will be through accurate documentation of patient diagnoses and treatment plans.

CDI program leaders need to consider the following potential areas when expanding their program to the outpatient setting.

## Emergency department

A CDI specialist covering the emergency department (ED) must be trained to review medical record documentation from both a CDI and case management perspective. Comprehensive documentation in the ED can assist with the proper assignment of the principal diagnosis and support the medical necessity of the inpatient admission. The CDI specialist can garner documentation that demonstrates the patient's acuity and diagnoses that are present on admission. Organizations continue to struggle with determining patient status (i.e., observation versus inpatient). A CDI specialist in the ED can collaborate with the provider to ensure documentation that supports the level of care needed based on the severity of illness and intensity of required services.

## Ambulatory surgery

Most patients who receive ambulatory surgery services have seen a provider prior to preadmission testing (e.g., for lab work, radiology services, etc.). Diagnoses that demonstrate the need for ambulatory surgery as well as any pre-surgical testing must be documented to support medical necessity. A CDI specialist assigned

to this area can review the surgeon's history and physical to ensure the outpatient procedure is clearly documented and meets third-party payer local coverage determination requirements and national coverage determination guidelines.

### Outpatient clinics

Expansion of CDI programs into outpatient clinics can provide support in capturing documentation related to diagnostic testing, injections and infusions, and wound care.

Infusion clinic documentation must include a physician order for the needed services. It must also outline the type of infusion required, the route of the infusion/injection, and the start and stop times. In many infusion clinics, the patient care delivery model supports a more expanded multi-disciplinary team that includes nursing and ancillary providers. A CDI specialist can be valuable in educating the team regarding the documentation needed to support billing accuracy.

Wound care clinics are another area of potential focus. A CDI specialist covering the services rendered here can assist in securing documentation that supports the diagnosis of the wound, its location specificity, the type of wound, and its cause.

Diagnostic clinics such as gastroenterology can be another area of focus for CDI program expansion. The need for diagnostic services versus screening and the documentation needed to support which service is required often present challenges for obtaining correct reimbursement. It is imperative that providers document the specifics of their findings, the diagnoses, and any other supporting information that can demonstrate the medical necessity of the services rendered and the testing performed. A CDI specialist can support these efforts.

### Physician practices and clinics

Over the past several years, there has been an increase in family practice and internal medicine clinics. In these settings, a CDI specialist can play a vital role in securing comprehensive documentation. If the providers participate in Medicare Advantage programs, CDI

specialists can review medical records to ensure provider documentation captures diagnoses that can impact CMS Hierarchical Condition Category coding and the associated Risk Adjustment Factor scores. In addition, a CDI specialist can assist in supporting accurate capture of the documentation needed for preventive care and wellness programs. Many quality care programs emphasize wellness visits, immunizations, and patient education (e.g., for smoking cessation). A CDI specialist can review medical record documentation retrospectively as well as prospectively to ensure documentation in the patient's medical record addresses all acute and chronic conditions during the patient visit. This will support quality patient care documentation and compliant reimbursement.

### In summary

With the shift of services from inpatient to outpatient, CDI leaders can expand their programs across the continuum of care. Knowing that resources must be targeted to provide the greatest quality and financial impact, organizations need to smartly define the focus of their outpatient CDI programs.

We have seen significant improvement in the capture of inpatient documentation that more accurately supports severity of illness and risk of mortality. It is time to expand these efforts to the outpatient setting in support of the shift in care volumes and future payment strategies. 

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### EDITOR'S NOTE

Jacquin is a seasoned healthcare executive with over 25 years of healthcare management expertise in clinical operations and performance improvement. In addition to clinical practice, Jacquin has held senior leadership roles with several national and international consulting firms, providing consulting services involving hospital and continuum-based care coordination, care progression, and clinical optimization. Jacquin was responsible for the implementation of the CDI methodology at WellSpring Partners and successfully integrated the CDI initiative with all other service offerings, including revenue cycle, labor, non-labor, physician services, patient progression, and clinical services.