OPTIMIZING CLINICAL DOCUMENTATION IMPROVEMENT

AT THE INTERFACE OF CLINICAL OPERATIONS AND THE REVENUE CYCLE

For most hospitals, Clinical Documentation Improvement (CDI) has become a top priority. As they move from volume- to value-based care, healthcare organizations recognize that better documentation can improve quality, lessen risk, and raise reimbursements. In fact, most hospital coding and information management professionals (88%) represented in a recent American Hospital Association survey (Wuebker, RACmonitor.com, April 27, 2015) classified their CDI programs as growing or at a mature stage.

Accurate, complete, and specific clinical documentation has become increasingly critical to comply with regulations and for physician and hospital profiles, payment for services delivered, and exposure to liability. The transition to the APR-DRG, MS-DRG, and ICD-10 systems makes precise, comprehensive documentation and coding even more imperative.

OUTPATIENT CLAIM DENIALS GROW, CDI MUST CATCH UP

A comprehensive CDI program should improve coding documentation for:

• Hospital outpatient services
• Physician practices
• Hospital-based physician services
• Multi-specialty physician services

Yet the dynamics of patient flow through the care continuum have created even greater urgency for accurate documentation in the outpatient setting as hospitals experience fewer admissions and shorter lengths of stay. In fact, inpatient utilizations per 1,000 notably declined from 2000 to 2011, and outpatient and ambulatory care rose from 2010 to 2013 (Adamopoulos, Becker’s Hospital Review, 2014). Many inpatient procedures, surgeries, and tests are steadily moving to the outpatient setting.

A typical CDI program occurs in the inpatient setting but, as more physicians become employed by hospitals, this creates a demand for outpatient CDI. An ambulatory/outpatient CDI program is imperative to ensure compliant documentation for optimal reimbursement—so hospitals can recoup the expenses/resources used to provide their services and so that physicians/providers can get paid for their professional services.

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A focused review of each of the following elements helps guarantee accurate charge capture in the ambulatory/outpatient setting:

• Clinical documentation and billing records for correct assignment of all Professional CPT-4 Procedure Coding to include the correct application of modifiers
• Facility process for identifying opportunities to improve the capture of procedures
• Enabling technology and its ability to support efficient processing
The number and complexity of outpatient services, along with inpatient clinical documentation, should provide more reimbursement opportunities. Yet, organizations are still trying to catch up. Some report that the lack of optimal clinical coding resides in the sheer volume of outpatient departments while others state a lack of understanding of the financial risk in these areas (King, Advance Healthcare Network, January 14, 2014).

Only 11% of Association of Clinical Documentation Improvement Specialists (ACDIS) members who responded to a 2008 poll indicated their CDI program either reviewed outpatient records for documentation improvement opportunities or were looking to expand into outpatient areas (8% and 3% respectively). By 2014, the percentage that conduct outpatient reviews rose to only 35%; and only 2% said they planned to start outpatient reviews in 2015 (Varnavas, ACDIS Blog, March 4, 2014).

Complex denials by CMS Recovery Auditors for outpatient coding rose to 28% in the fourth quarter of 2014, up from 7% at the end of 2013, according to data reported from 879 hospitals in the American Hospital Association’s most recent quarterly assessment of the impact of the Medicare Recovery Audit Contractor (RAC). This rise in complex outpatient denials is financially impactful since their average amount was $5,615 compared to the average automated denial amount of $688. While hospitals achieved a 70% success rate recouping payment after appeal, they were still awaiting the results of 59% of appealed claims and regularly face significant time and administrative burdens due to this process (RACTrac, American Hospital Association, March 30, 2015).

Another significant financial issue is how physicians are reimbursed in the outpatient setting. They can incur more expenses by performing certain services in their offices and, to account for this increase, Medicare reimburses them at a higher rate. However, when they perform these services in settings such as an ambulatory surgical center, Medicare reimburses the overhead expenses to the facility and a lower reimbursement rate to the physician. Improper payments happen when physicians bill certain services with the incorrect place of service.

So, as hospitals employ more group practices, they find themselves responsible for the claim denials caused by these improper payments. And, if CMS red flags a coding error that involves a particular physician, scrutiny can follow that physician into a variety of potential care settings. As Medicare reviews both hospital and physician billing, payers want to ensure that physician and facility billing match. This combined review makes hospital and physician reimbursement vulnerable, but represents an opportunity for CDI specialists (Varnavas, ACDIS blog, March 4, 2014).

BIGGEST BARRIER TO CDI SUCCESS: PHYSICIAN ENGAGEMENT

Whether for outpatient or inpatient care, clinical documentation is at the heart of every patient encounter. The internal auditing function and education provided by a CDI program assures that a patient’s medical record is complete and free of conflicting information. When it is not, CDI specialists and coders seek clarification from the medical team.
But, a broad gap exists between the terminology used by clinicians and the terminology of coding and billing systems. The CDI liaison role, then, must expand to reflect the complexity of an industry increasingly focused on regulatory compliance, managed care profiles, revenue and reimbursement, and mitigation of risk. According to ACDIS, all of these factors are increasingly dependent on the integrity of complete and specific clinical documentation in the medical record.

Most CDI programs (98.5%) believe their physicians could help improve documentation practices (RACmonitor.com, April 27, 2015). The reasons why this does not happen often include a hospital leadership vacuum, collaboration issues, and not enough ongoing physician training. Yet 95% of respondents in this same AHA survey said that physician engagement is the biggest issue they face. Two-thirds of respondents said physicians do not engage with CDI because they do not understand the importance of documentation; almost half said it was lack of time; and just over a third blamed a lack of interest. Only 5% had no barriers with physician involvement.

While reviewing physician cases one-on-one is critical to successful CDI, for many hospitals this ideal scenario is labor and time intensive. Physicians do not view CDI as a priority, often have a difficult time with process change, and consider administrative meetings to be time taken away from patients who need care. Managing physician engagement and training can be challenging. Physicians often respond better to peers or third-party educators who can get to the point quickly about the slippery slope from faulty documentation to inaccurate coding and, ultimately, to reimbursement deficit.

Physician advisors/champions would make good resources for encouraging more engagement with clinicians, but more than 89% responding to the emerging trends survey reported that their CDI programs lack such a full-time resource (RACmonitor.com, April 27, 2015). The time and resources needed by CDI and coders to interact with clinicians is compounded by the timeliness of resolving any documentation problems while the patient encounter is still fresh. Usually only a small percentage of queries by CDI specialists are answered within 24 hours.

Patient population, payer, and technology issues are also important. Resource-strapped CDI programs find themselves having to target cases based on payer type, leaving nearly 83% of hospitals unable to ensure that all complex cases get through CDI review. Medicare fee-for-service, Medicare Advantage, and Medicaid cases take priority, with commercial health plan cases significantly underrepresented (only 25%). The electronic medical record (EMR) has helped organize and stratify clinical information. Yet the use of copy-forward, copy and paste, and other documentation shortcuts make it easier for clinicians to respond to a query before proceeding within the health record. And, many details crucial to accurately representing a case’s complexity do not fit neatly into the EMR template (RACmonitor.com, April 27, 2015).
BEST PRACTICES TAKE A TEAM EFFORT

Starting a CDI program, or challenging the status quo to optimize an existing program and transform it into a sustainable one, requires executive, clinical, and staff agreement on what is best for your hospital and its revenue cycle management. ACDIS offers an advisory board-approved Clinical Documentation Improvement Roadmap, which provides an industry standard and best practice for the establishment and ongoing maintenance of a CDI program in a short-term acute care hospital. The Roadmap currently includes guidance on both pre-CDI program implementation and implementation phases and a series of informational white papers, supporting documents, and sample policies, procedures, and forms.

Pre-implementation often begins with assessing your team and its responsibilities, program objectives, communications process, training objectives, timeline to completion and more. At this point, you should determine if you will need outside consulting support. Your baseline data is also important. Questions to ask include:

- What types of metrics do you use?
- What is your current and past claims denial rate?
- Have you had any governmental audit issues?
- What other CDI reports do you have?
- What are your financial targets?
- What are your quality metrics?
- Are you meeting your length of stay targets?
- What is your clearing process?

Beginning with an evaluation, a best-in-class redesign process typically moves strategically through three detailed phases—assessment, hands-on implementation, and postimplementation monitoring. Documentation and knowledge transfer experts ensure that all areas of hospital staff understand the importance of accurate documentation and have the skills to chart, code, and bill every case properly.

In today’s economy, it is vital to ensure your CDI program is operating successfully throughout your organization. Maximizing reimbursement under value-based payment models requires a highly precise and accurate documentation effort. Emphasizing CDI certainly helps contribute to an organization’s bottom line. When done right, CDI also accurately represents the quality of the care you deliver.

“We implemented a Provider Documentation Program (PDP) to bridge the gap between partnered providers and the health system through coding education, improved communication, and assistance with the transition and maintenance of ICD-10 implementation, culminating in complete provider documentation. We were very fortunate to partner with Huron, which helped shape our program by providing baseline data from onsite reviews, personal interviews, training physician leadership and the PDP staff, and ongoing support. Huron tailored their education to the needs of our organization and vision for the program. We couldn’t ask for a better partner launching this new endeavor.”

SHANNON WELCHLI, RHIA, DIRECTOR, CODING AND CLINICAL DOCUMENTATION IMPROVEMENT, ALLEGIANCE HEALTH
CONTACTS
To find out more about achieving compliant documentation and optimal reimbursement in the ambulatory/outpatient setting from a team with more than 60 years of combined experience in the inpatient and outpatient arenas, please contact:

Gerri Birg, MSN, RN, CCDS
Managing Director – Clinical Documentation Improvement

Gerri Birg is the National Lead for Huron’s CDI solution practice. Over the last 12 years, she has led large-scale CDI implementation efforts working with a variety of clients, including children’s hospitals, large academic medical centers, and multi-hospital systems. Her extensive background in healthcare operations management encompasses utilizing outcome data to coach, guide, and train staff in providing strategic direction, benchmarking opportunities, and appropriate outcome management techniques as it integrates into continuous quality improvement.

Heather Dunn, MSPM, RHIA, CCDS, CCS-P
AHIMA Approved ICD-10-CM/PCS Trainer
Manager – Clinical Documentation Improvement

Heather Dunn has more than 23 years’ experience, specifically in outpatient/inpatient coding, regulatory compliance, reporting, medical billing software, audit reviews and corrective action, quality improvement initiatives, billing, and project management. She has a talent for defining and resolving discrepancies to avoid unnecessary cost expenditures, and is proficient in ICD-10 CM/PCS, ICD-9-CM, CPT-4, CDI, and HCPCS coding. Her credentials complement her comprehensive background in teaching, auditing, compliance, and physician education.

Rafael Gonzalez, CPC, CPC-H, PCS, FCS
Managing Director – Clinical Documentation Improvement

Rafael Gonzalez has more than 16 years’ experience assisting dozens of hospitals and hundreds of physicians across multiple specialties improve documentation and coding for medical services by providing intensive auditing and focused education. He has extensive experience in project management, auditing, coding for physician and office staff, training and compliance education with emphasis on Medicare guidelines, and the development of multiple tools and databases to improve management control.

Jim Tamburini, BS, RHIT, CCS
AHIMA Approved ICD-10-CM/PCS Trainer
Manager – Clinical Documentation Improvement

Jim Tamburini is a health information management (HIM) professional whose more than 13 years’ experience includes an extensive background in acute-care inpatient and outpatient coding, HIM department management, and CDI. He conducts regular ICD-9-CM and CPT-4 coding audits of outpatient and inpatient cases aimed at identifying compliant documentation opportunities that optimize billing and coding, improve severity of illness and risk of mortality scores, and facilitate a smoother transition to ICD-10-CM/PCS. He has also trained many physicians and coders on compliant documentation and coding.
ABOUT HURON

Huron is committed to achieving sustainable results in partnership with its clients across the institutions, industries and communities it serves. The company brings depth of expertise in strategy, technology, operations, advisory and analytics to drive lasting and measurable outcomes for leaders in the healthcare, higher education, life sciences and commercial sectors. Through focus, passion and commitment, Huron works closely with its clients to solve their most pressing problems, providing strategic guidance in the face of the rapid change transforming their industries. Learn more at www.huronconsultinggroup.com.

REFERENCES


