Road Map
How to Optimize Reimbursements by Improving Your Outpatient Clinical Documentation
The Evolving Role of Clinical Documentation

Healthcare organizations are facing significant scrutiny of their coding and billing transactions and it’s affecting their bottom line. In the 2014 American Hospital Association Report, U.S. hospitals provided $45.9 billion in uncompensated care in 2012, representing 6.1 percent of annual hospital expenses.1

Evaluation of medical coding and billing compliance is causing increased challenges and can create substantial implications as it relates to a hospital’s continuous revenue streams. Establishing and supporting a revenue cycle management program that includes clinical documentation assessments, coding audits and monitoring for outpatient service settings is vital to an organization’s financial security.

The focus of clinical documentation improvement (CDI) has traditionally been on inpatient documentation quality initiatives. However, the role of clinical documentation is now evolving to include the outpatient settings.

As a provider, your ability to ensure data integrity for clinical decisions needs to be documented for each patient care encounter. Medical code assignments are determined by the provider documentation which establishes what can ultimately be billed and reimbursed. Accurate documentation of patient encounters has a significant financial impact on revenue cycle outcomes.
In a recent series of surveys of 125 healthcare facilities, it was evident that CDI initiatives topped the list of concerns; especially as it relates to ICD-10. Outpatient clinical documentation setting deficiencies are found 25 to 35% of the time in audits.

Reimbursements are impacted significantly as a direct result of these gaps.

The value of clinical documentation programs to the financial health of an organization is sometimes underestimated. Identifying clinical coding errors and the source of the deficiencies is vital and a key component of improving the quality of patient care, meeting medical necessity guidelines, increasing reimbursements and supporting your organizations’ overall bottom line.

Implementing a formal CDI program for outpatient services ensures that the evaluation of five key data quality elements are being met:

- Accuracy
- Consistency
- Reliability
- Timeliness
- Completeness
Every organization is different as far as their clinical documentation audit process and methodology needs. However, there are nine essential steps to consider when planning your CDI audit and compliance program, including:

1. **Verification**: It is important to define and verify your organization’s objectives for audit and compliance initiatives.

2. **Process and methodology**: Outline the clinical documentation process and methodology that you will be using.

3. **Define baseline**: Identify the extent of medical record deficiencies that you would like to address and leverage your policy and procedures. Make sure that your clinical coding department and teams receives a copy.

4. **Create a timeline**: Discuss and agree on a timeline for the completion of your CDI audits.

5. **Assess document sources**: Review available document sourcing options, data abstraction requirements and identify records flagged for CDI audits.

6. **Identify opportunities**: Confirm CDI, coding, charge capture or billing audit opportunities.

7. **Confirm standards**: Confirm the documentation review and audit measurement process.

8. **Determine documentation source**: Establish a documentation sourcing instrument for CDI data abstraction efforts to be performed; will you be using paper or electronic patient records?

9. **Conduct analysis**: Perform data quality review, data abstraction, data capture and CDI assessments.
Implementing an effective CDI program for outpatient settings requires peer-to-peer engagement. The primary stakeholders are physicians, physician assistants, nurse practitioners, certified nurse midwives, registered and clinical nurses. Subject matter experts, medical coders and CDI specialist are charged with showing providers where missing documentation deficiencies are located in the patient’s medical record. Providers buy-in and resources are essential to the launch of a successful CDI program.

CDI program advocates must demonstrate a vested interest to win providers’ buy-in, including the following:

- CDI checks and balances enhances the quality of patient care
- Documentation improvement efforts can capture in real time how patients are responding to treatment, or not
- Allergy, allergic reactions and lethal contraindications can be spotlighted for provider awareness
- Identify, track and trend regulatory and compliance issues quickly
The healthcare industry is constantly changing, and yet regulatory and compliance issues continue to be a core function of improving revenue cycle performance. An effective outpatient CDI program corrects deficiencies, optimizes reimbursements and encourages CDI, medical coding, charge capture and billing compliance.

Building an effective CDI program requires commitment, stakeholder engagement and an understanding of your organization’s unique challenges. Hayes compliance experts can help you manage risk, improve clinical documentation accuracy, coding integrity, data quality, solve charge capture issues and minimize billing errors that improves reimbursements and your organizations’ bottom line.
Sources

1. American Hospital Association, 2014 Uncompensated Hospital Care Cost Fact Sheet. http://www.aha.org/content/14/14uncompensatedcare.pdf


Resources


AHIMA. Testimony of Michelle Dougherty, MA, RHIA, CHP, on Behalf of AHIMA to the HIT Policy Committee Hearing on Clinical Documentation. http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=xPublishSite+%3csubstring%3e+%60BoK%60+%3cAND%3e+%28xDomain+%3csubstring%3e+%60HIM%60+Processes%60%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok1_050231&HighlightType=HtmlHighlight&dWebExtension=hcsp
Once you’ve established a baseline, the next step is to make improvements by initiating a corrective action program that addresses your people, process, and technology.

**People**
Focus on training and education so everyone in the organization understands the depth and impact of the problem and what their role in solving it should be. Specific actions to take include:

- Establish accountability and self-reporting by root cause owner and process owner
- Set a zero to low tolerance for finger pointing and excuses
- Recognize improvement and determine consequences for unacceptable outcomes

**Workflow**
A thorough process review will help highlight redundancies and time-wasting tasks and will quantify the outcome or performance expectation for each task. The most effective way to improve the workflow process is to eliminate errors that could result in a denial.

Key points to include:
- Develop robust pre-visit/visit management process

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