CDI Across the Continuum – Moving to a Patient Centered Solution

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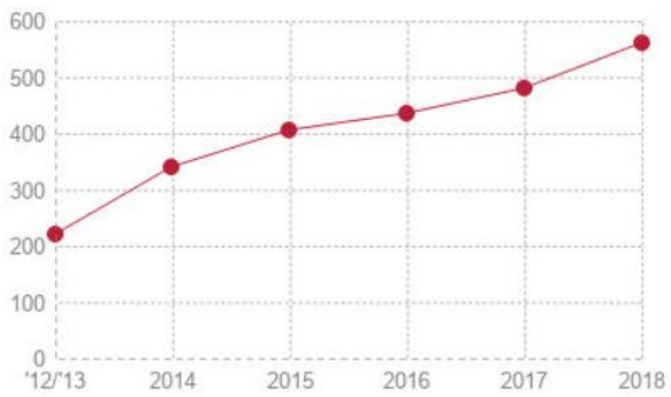
Today’s Agenda

- Volume to value – how did we get here
- Documentation challenges
- Trends – CDI in different settings
- Outpatient/Ambulatory CDI and HCCs
- Concurrent coding
- Quality CDI
- Proactive and downstream CDI

Value Based Care and Accountable Care Organizations



- ACO is a group of providers with collective responsibility for patient care that helps coordinate services and deliver high quality care while holding down costs.
- Medicare ACO's increased by 18% in 2018 (HFMA, January 2018)
- About 34 million or 1/3rd of eligible Medicare beneficiaries are enrolled
- Must achieve long-term sustainability to reduce healthcare costs and improve quality in the Medicare Program

Challenges with data

Data in an Electronic Health Record comes from multiple sources and in a variety of standards and terminologies. The vocabularies, codes and terms used in one system may mean something different—or nothing at all—in another.

When a cold is not really a cold…

Common words in the English language present their own challenges

COLD

Sensory perception

"I'm feeling cold"

COLD

A pulmonary diagnosis

Chronic Obstructive Lung Disease

COLD

An upper respiratory viral infection

"I have a cold"

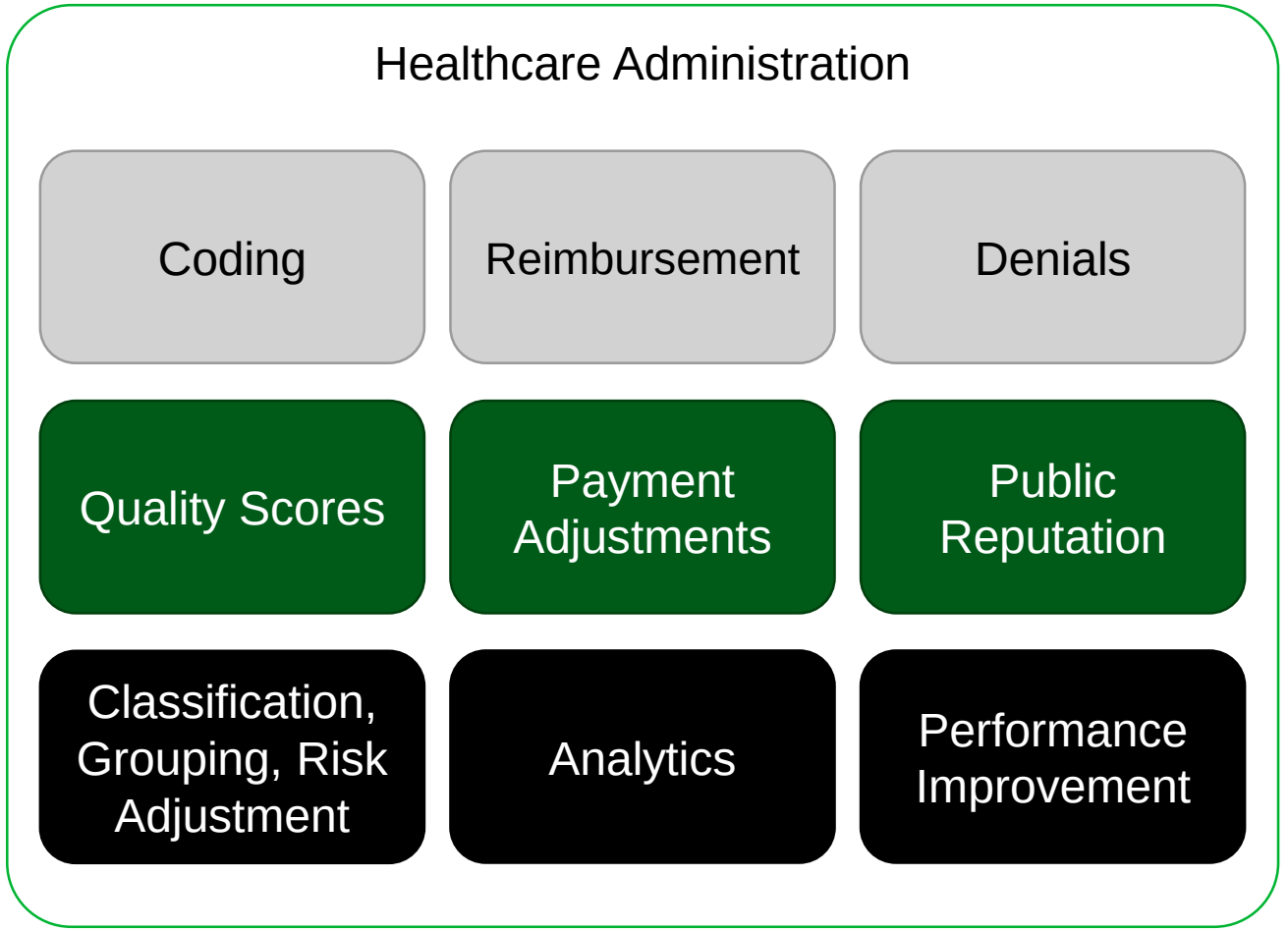
- **Their**
- **There**
- **They're**

Documentation is the source of truth

Care Provided

Care Documented

When these don’t match, everything else is at risk



Medical Record Content

- Contains sufficient documentation to identify the patient, supports the diagnosis and justifies the treatment
- Documents the course (and results) of treatment and facilitates the continuity of care
- Sufficiently detailed enough to enable the practitioner to provide continuing care, determine later what the patients condition was at the specified time and review diagnostic/therapeutic procedures performed and the patients response to treatment

Clinical Documentation Improvement

- (**CDI**) is the recognized process of improving healthcare records to ensure improved patient outcomes, data quality and accurate reimbursement.

- CDI helps by accurately telling the story of the clinical care that was provided.

A comprehensive approach to clinical documentation

- Closer proximity to the physician
- Greater collaboration and transparency among roles through concurrent workflows
- Meaningful, real-time interactions and validations through work flow efficiency
- Drives current and future reimbursement and quality models

The role of a Clinical Documentation Specialist

- Intermediaries between inpatient coders and healthcare providers and nurses
- Many clinical coders may not have patient care backgrounds
- Core Responsibilities/Key Metrics
  - #Records Reviewed
  - CC/MCC Capture
  - DRG Match/Mismatch
  - CMI Fluctuations
  - Monitoring Indicators
  - Educating Physicians

Traditional CDI has been driven by revenue cycle needs

Physician

CDI Coder PFS Admin

Patient Care

Revenue Cycle

Review cases concurrently to identify documentation opportunities
Send queries to physicians to clarify documentation
Calculate value based on accepted queries, DRG shifts
Provide additional physician education when possible

Great ROI (inpatient Medicare)
Heavy personnel requirement
Perpetual demand for this service

- Diminishing returns
- Increased query rates don’t necessarily mean improvement
- Challenges with coverage, more payers, always need to do more

Pressures on CDI

Internal pressures to continually perform and improve traditional CDI operations

- Need to educate physicians on latest issues and regulations
- Need to re-evaluate and optimize performance
- Need to demonstrate ROI
- Acquisitions keep resetting the baseline and the goalposts

CDI

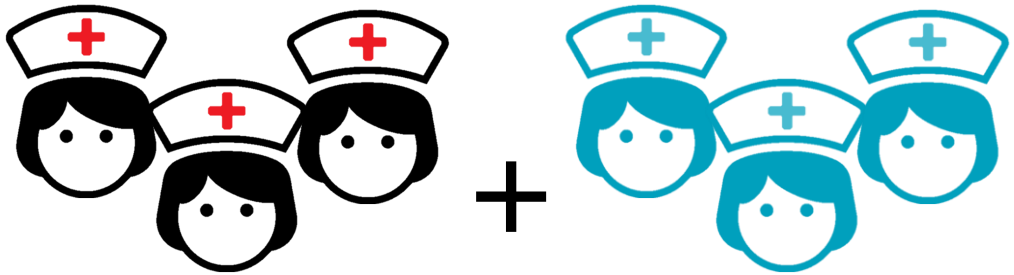
External market forces on the provider to cut costs, improve quality

- Government and other payer reimbursement model changes
  - Additional payers using prospective payment
  - Quality payment adjustments
  - Payer denials
  - Population-based payment
- Public reputation (quality scorecards)
- Shifting of volume and revenue from inpatient to other care settings

Other Issues around CDI

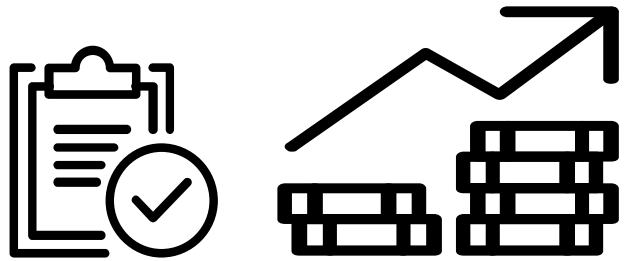
- **Cost Avoidance**
  - Inefficiencies and waste
  - Leverage existing investment with HER
  - Justifying CDI FTEs/ROI
- **Physician burn-out**
  - EHR burden / alert fatigue
  - Competing incentives
  - Inadequate CDI sustainability
- **Quality**
  - Penalties and scorecards (PSI, HACs)
  - MIPS and MACRA physician metrics
  - Limited qualified talent pool

Moving to the ambulatory setting – how can CDI expand to meet these outpatient needs.



X They can't hire another full CDI team

- Volume of outpatient = more than inpatient
- Budgets are shrinking
- Not enough qualified people



X They can't review every clinical document

√ They must redesign the model

Ambulatory CDI

A *patient-centric solution* that supports all Clinical Documentation Improvement activities *beyond the traditional acute care setting*; using AI where possible, including *prioritized workflows* for document review, *query delivery and response*, *clinical validation* and *performance tracking* to *ensure quality documentation and compliant coding practices*. (3M HIS Defintion)

Ambulatory or Outpatient CDI

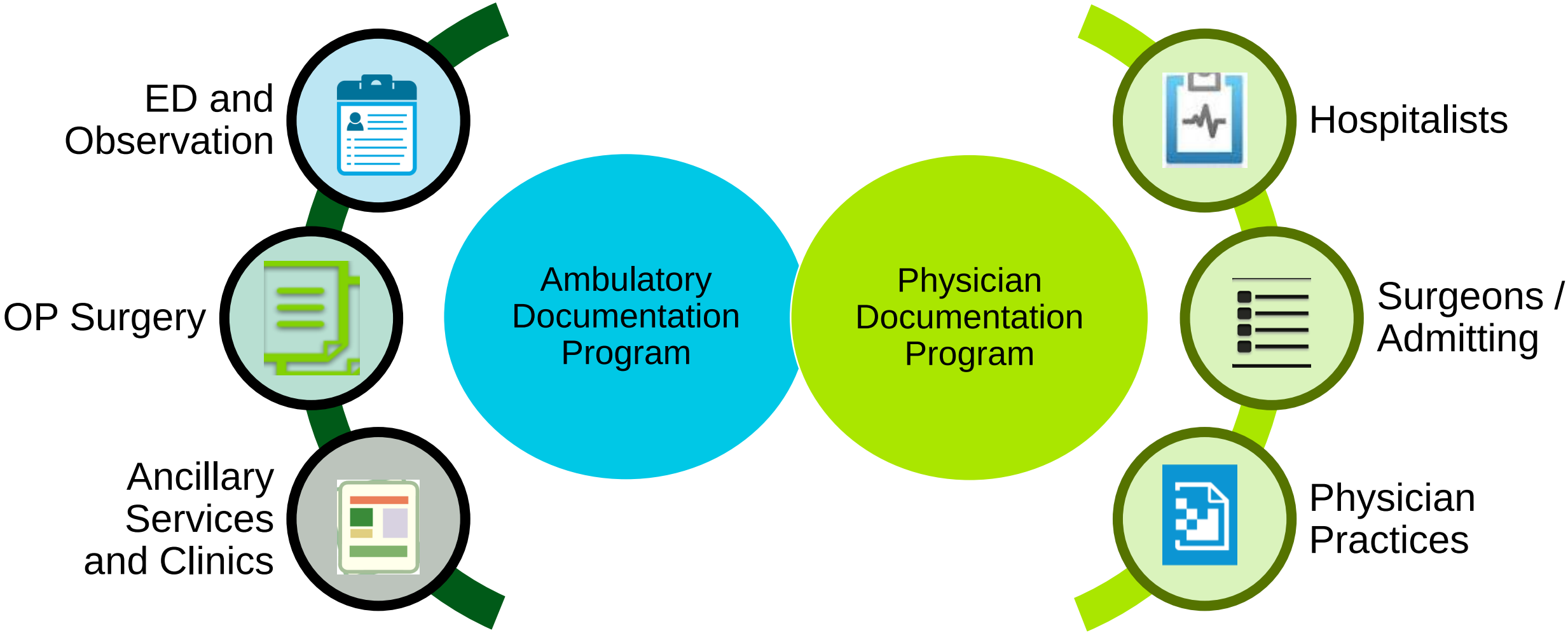
- Reviewing documentation in the emergency department (ED) to ensure medical necessity and the solidification of patient status (are they an outpatient or inpatient)
- Review of local or national coverage determinations (LCDs or NCDs)
- CDI specialists target diagnoses impacting Hierarchical Condition Categories, or HCCs, a payment methodology associated with patients seen in the physician practice setting
- Population health and impact

Ambulatory CDI comparison to inpatient

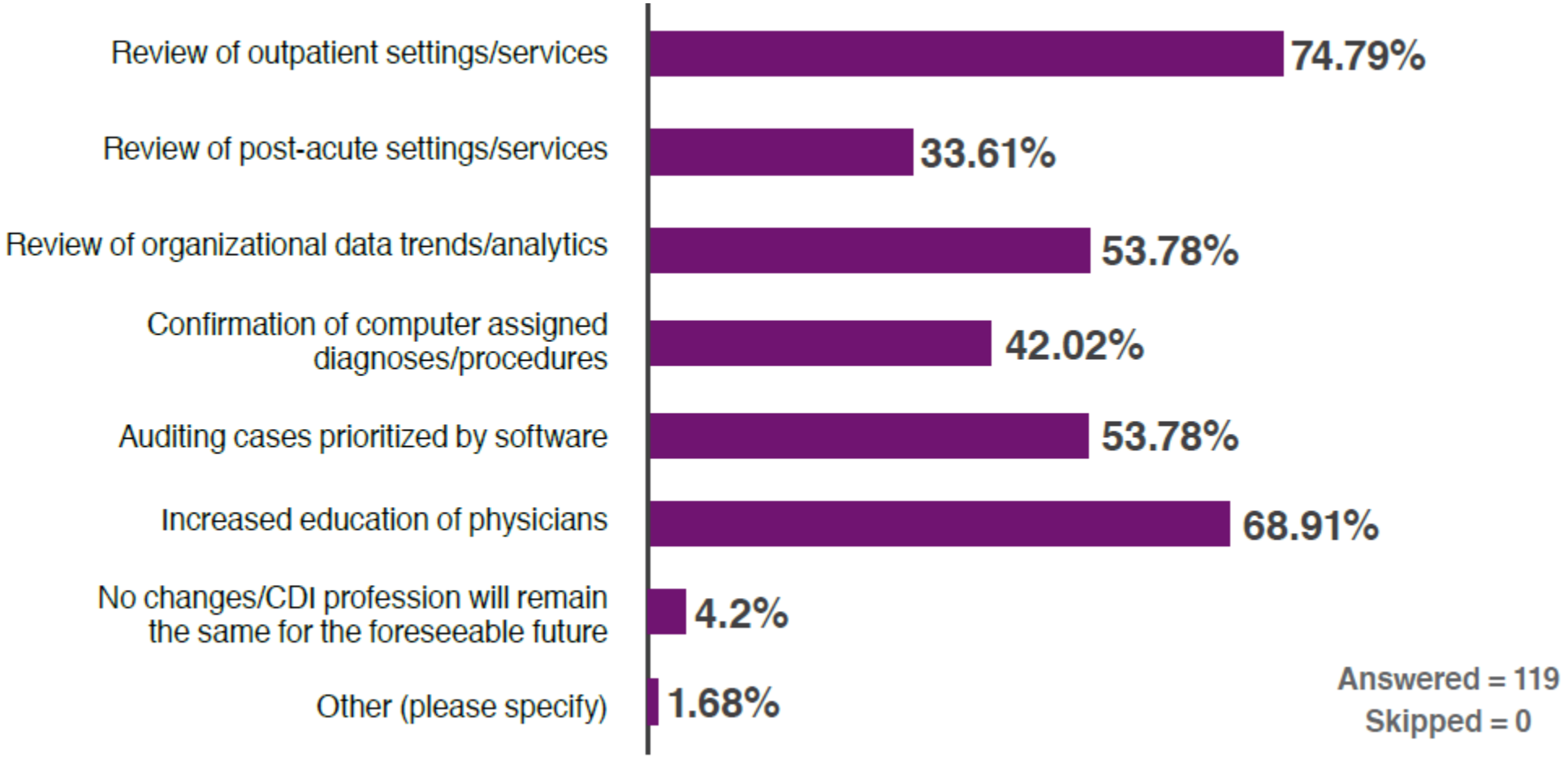
Four ways the setting changes CDI activities

	Outpatient and Professional	Inpatient
Timing	Fast pace in minutes and hours before discharge	Encounter spans days, allowing for concurrent CDI
Objective	Priority on charge capture and reducing rework and denials	Focus on comorbid conditions, SOI, and case mix
Code sets for payment	Payment is usually based on procedures (CPT and APC). . .	Payment varies based on diagnosis coding (ICD-10-CM)
Payment reform	. . . Although HCC-based physician pay puts attention on chronic conditions	Attention to POA, PSIs, other quality measures

Where there’s a need.

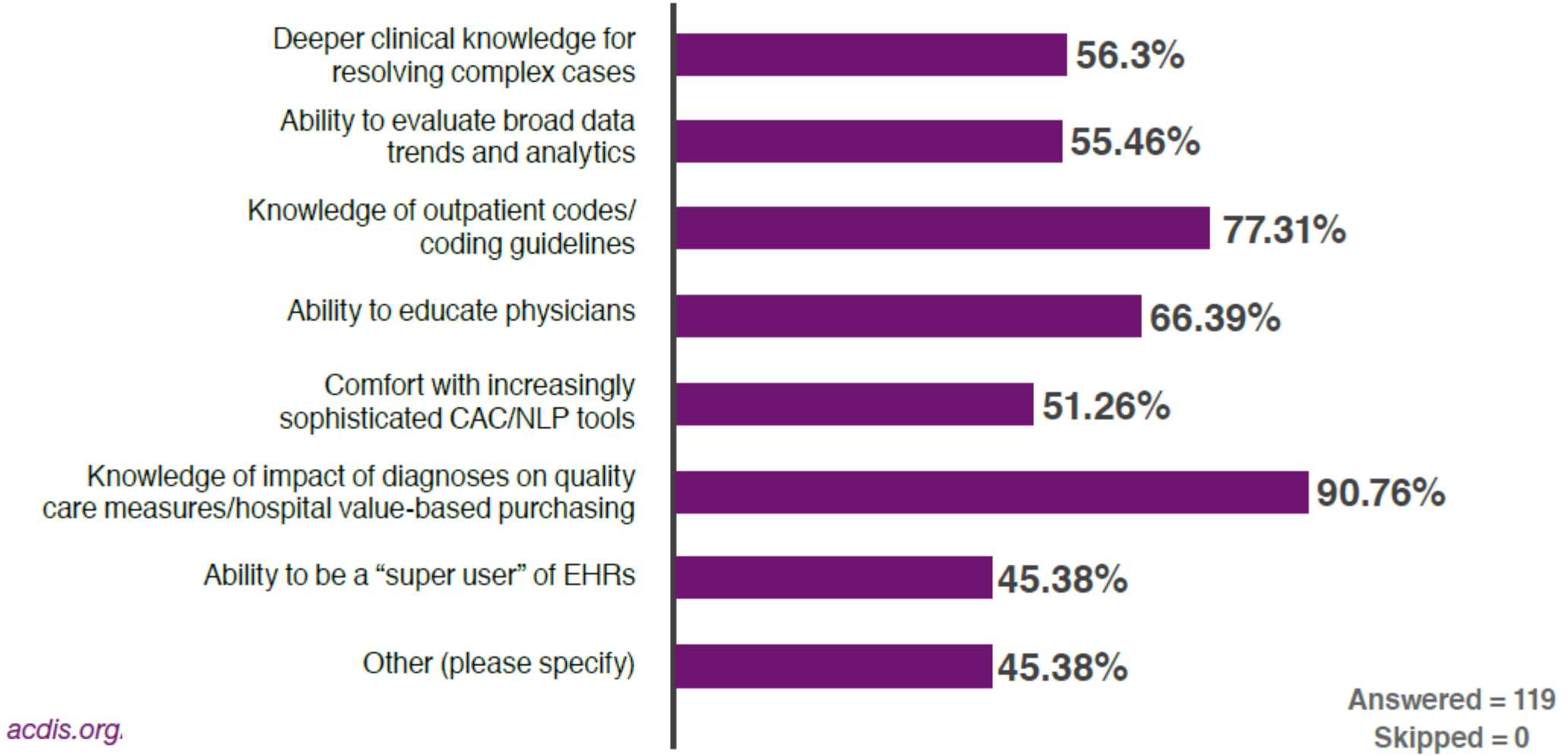


Which of the following initiatives do you anticipate CDI specialists being used in the future?

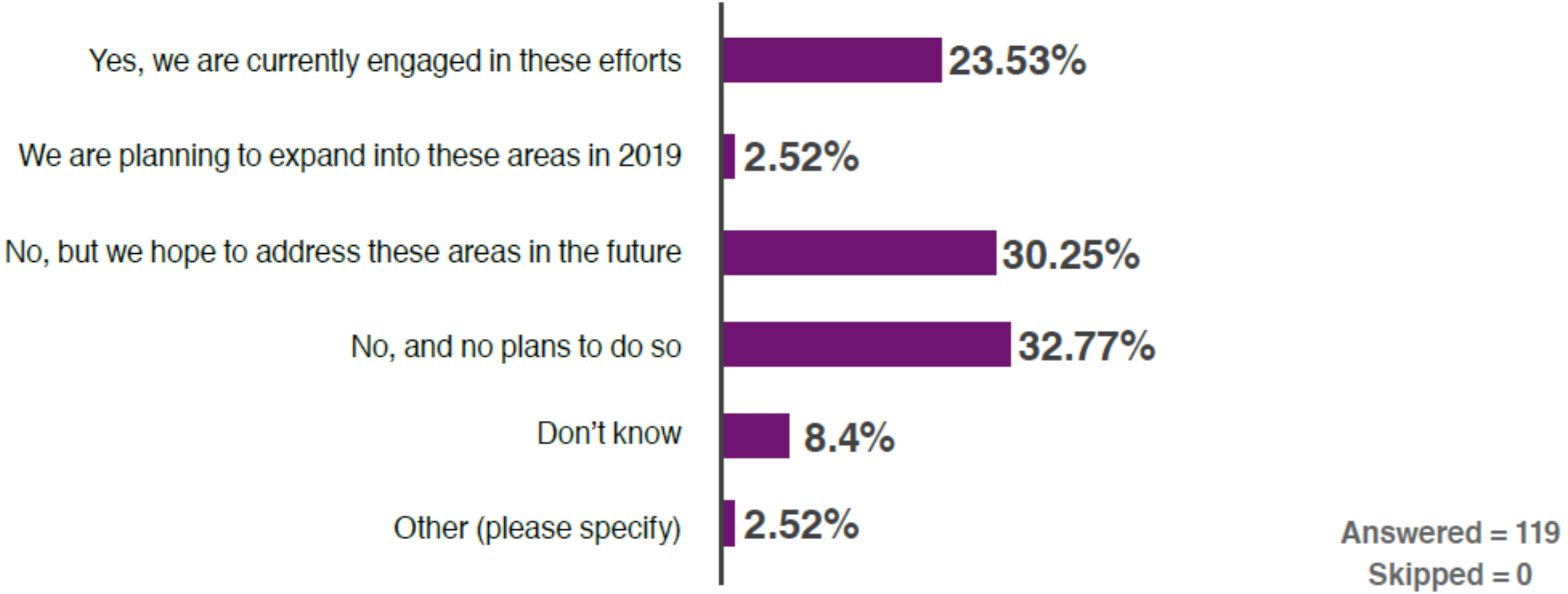


acdis.org

What changing skill sets or knowledge bases do you think CDI specialists of the future will require



Is your CDI department involved in educational efforts to improve population health/social determinants of health

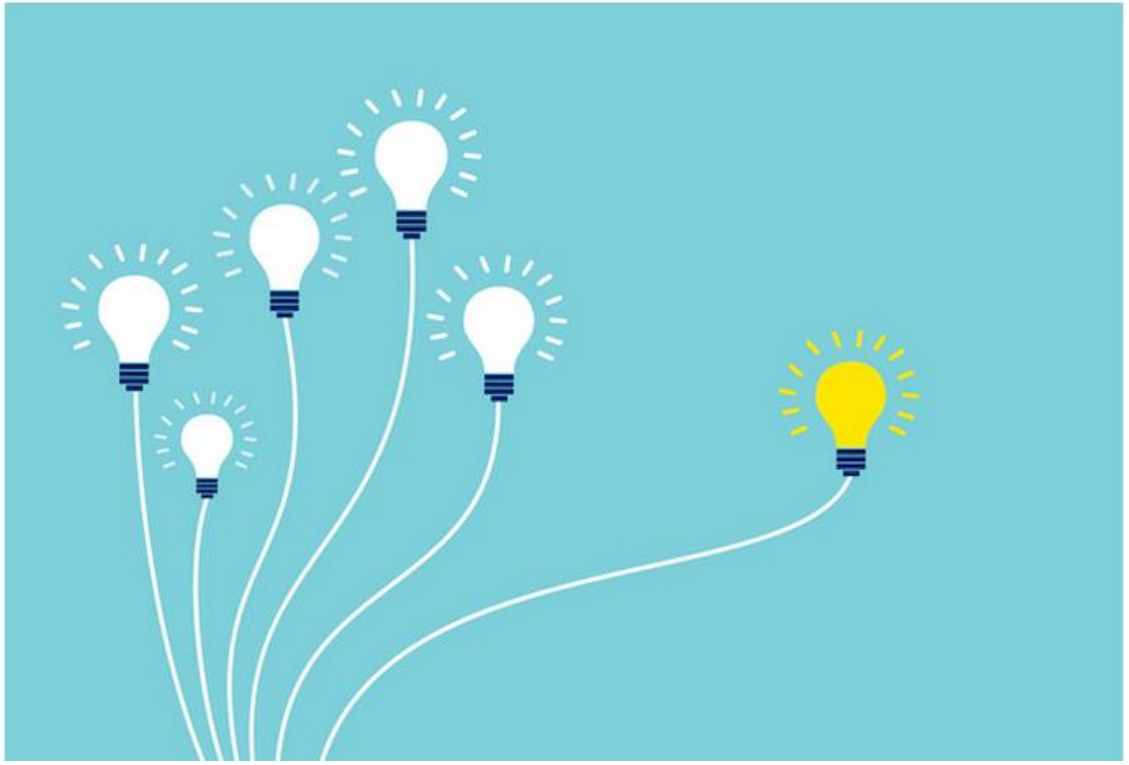


What ways has your CDI department been able to assist with population health improvement efforts?

Why the buzz

How Medicare Advantage is Leading Payers to Adopt Value-Based Care

The transition to value-based care has stalled, but the unique structure of Medicare Advantage can help payers advance to lower costs and better outcomes.



Beneficiaries in Medicare Advantage Receive Better Value and Spend 40% Less than Beneficiaries in Medicare FFS

Beneficiaries in Medicare Fee-For-Service (FFS) receive coverage for hospital and physician office services and can purchase a prescription drug plan (PDP) for drug coverage. Medicare Advantage (MA) plans cover the same services as Medicare FFS and typically offer additional protections and services, not covered by Medicare FFS, that support beneficiaries in staying healthy, improving care outcomes, and avoiding unforeseen medical costs. Compared to Medicare FFS, MA beneficiaries with chronic conditions receive more preventative care[1] and experience fewer emergency department visits and lower rates of avoidable hospitalizations.[2]

Differences in Benefits Covered By Medicare FFS and Medicare Advantage

Medicare FFS

Covers 83% of costs for:
Part A Hospital services
Part B Physician office services

vs.

Medicare Advantage

Medicare FFS

Covers 83% of costs for:
Part A Hospital services
Part B Physician office services

6% additional costs covered for:
Parts A & B services

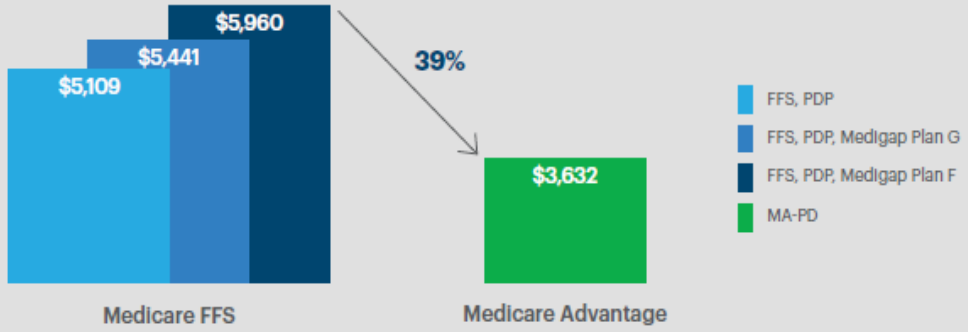
+

Financial Protections and Enhanced Services May Include

- Part D prescription drug coverage
- Caps on annual out-of-pocket costs
- Dental, vision, and hearing coverage
- Care management programs

The estimated health care costs for a beneficiary represent a key factor in the choice between MA and FFS coverage, especially since half of Medicare beneficiaries live on fixed annual incomes below $27,000.[3] The annual health care costs[a] for a 72 year-old beneficiary of average health in MA ($3,632) are as much as 39% less than for a comparable beneficiary in FFS.[b,4]

Annual Health Care Costs for Comparable Beneficiaries, 2019



What are Hierarchical Condition Categories (HCCs)?

Chronic conditions and a limited number of major acute complications, identified by an ICD-10 code, that are associated with a “risk score”

Risk score is determined based on the most specified diagnosis captured throughout the year (i.e. type 2 diabetes vs. type 2 diabetes with diabetic nephropathy)

Fully specified HCC diagnoses may carry higher risk weights than less specified diagnoses.

Patient risk scores are determined based on **billed diagnoses**, that must be **supported by comprehensive documentation**, **at least once annually**

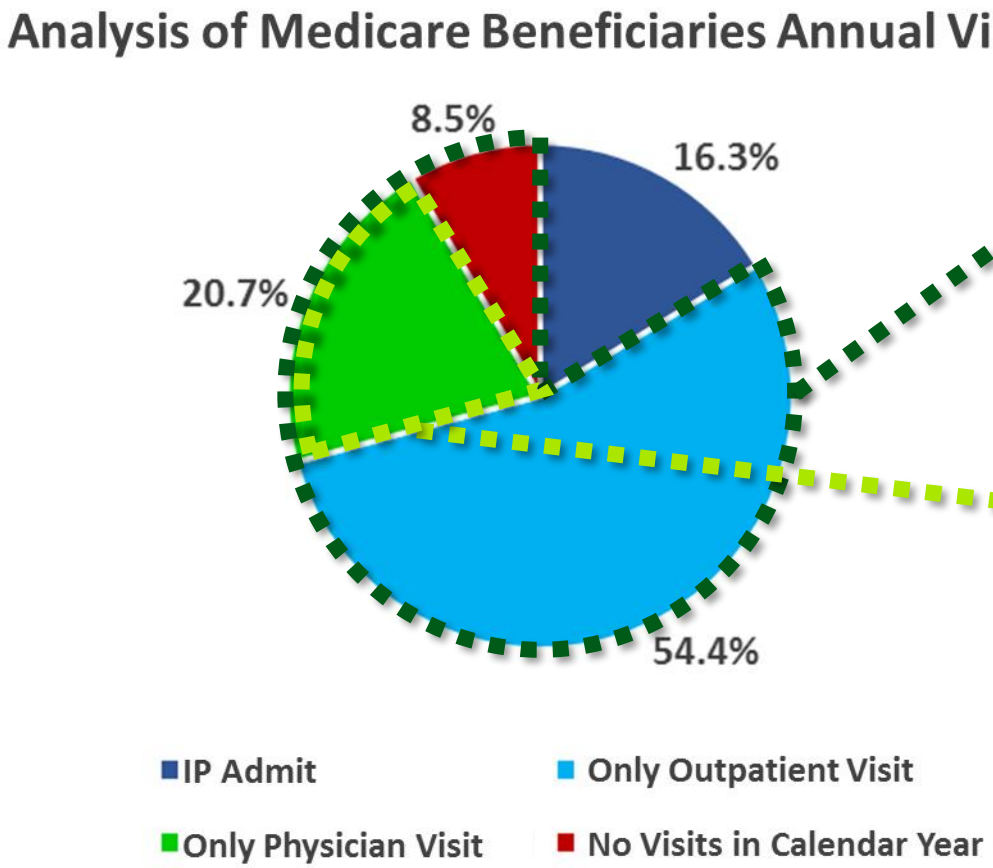
This score can impact payment to healthcare organizations and shared savings incentives, **meaning providers carry greater financial risk** than under fee for service reimbursement.

Risk Adjustment: CMS and Commercial HHS HCCs

- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population
- Based on aged population (over 65)

- Developed by the Department of Health and Human Services (HHS)
- Designed for the commercial payer population
- HHS-HCCs predict the sum of medical and drug spending
- Includes all ages

HCC gaps across a population



*IP admission patients may have also had a physician office or outpatient visit as well in the calendar year
**Patient receiving outpatient care or physician visits had no other visit types in the calendar year

Outside the Hospital

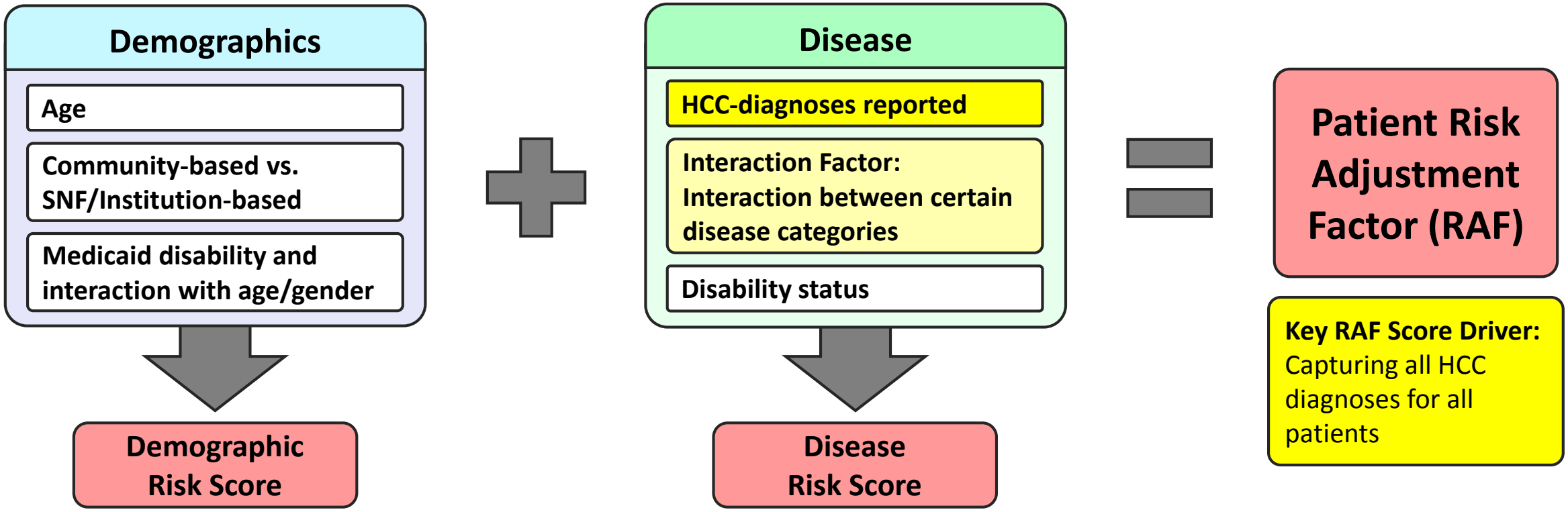
- CDI programs today focus on IP acute admissions
- Little to no documentation review and physician guidance in OP or office settings
- Automated tools can guide physicians to capture HCC diagnoses

Physician Office

- 80-90% of office visits are coded by providers with no coder review
- Physicians focus on CPT not complete diagnosis billing
- Computer-assisted coding can aid complete HCC diagnosis coding

HCC and RAF (Risk Adjustment Factor) Calculations

Total score of all relative factors related to one patient for a total year derived from a combination of the two scores



Ideal state: HCC diagnoses drive RAF scores

Paul Smith, 78-year-old male, community based, managing chronic conditions

2018 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2018	
Demographic score: 2018	0.442
HCC 18: Diabetes w/retinopathy	0.368
HCC 22: Morbid Obesity	0.365
HCC 40: Rheumatoid arthritis	0.374
HCC 85: Dilated cardiomyopathy	0.368
HCC 111: COPD	0.346
HCC Interaction Score: CHF—COPD	0.259
HCC Interaction Score: Diabetes—CHF	0.182
Total RAF Score	2.704

2019 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2019	
Demographic score: 2019	0.466
HCC 18: Diabetes w/retinopathy	0.318
HCC 22: Morbid Obesity	0.273
Total RAF Score	1.057
2019 Missing RAF Score	1.647

Capitated Pay Per Member Per Month (PMPM):

- $800 PMPM x 2.704 RAF = $2,163
- $800 PMPM x 1.057 RAF = $846

-$15,804 Annual

**Example of payment made to Medicare Advantage payer based on $800 PMPM base rate*

RAF Scores → Drive Value-Based Reimbursement

2018

$800 Baseline PMPM	X	**2.704** Individual RAF Score	=	**$2,163** Individual PMPM

2019

$800 Baseline PMPM	X	**1.057** Individual RAF Score	=	**$846** Individual PMPM

$15,804

Missed Annual Payment 2019

*Assumes capitated program is based on negotiated $800 per member per month agreement

How specificity impacts CMS HCCs and RAF scores

Specificity Impact	Diagnoses		Examples
DOES NOT impact the HCC/RAF	1. Secondary cancers 2. Malnutrition 3. Hepatic failure 4. Cirrhosis 5. Chronic hepatitis 6. Osteomyelitis 7. Osteonecrosis 8. Rheumatoid arthritis	9. Schizophrenia 10. Epilepsy 11. Resp. failure 12. Atrial fib/flutter 13. COPD 14. Emphysema 15. Heart failure	• Severe / Moderate / Mild / Unspecified Malnutrition all under HCC 21 • Twenty-seven ICD-10 codes related to respiratory failure HCC 84 ○ Acute / Chronic / Acute and Chronic / Unspecified Respiratory Failure

DOES impact the HCC/RAF	1. Diabetes
	2. Angina
	3. Pneumonia
	4. Renal failure unspecified
	5. Chronic kidney disease unspecified
	6. Pressure ulcer unspecified
			• Chronic kidney disease:
			  ○ Stages 1, 2 and 3 are not HCCs
			  ○ Stage 4 and Stage 5 are HCCs
			• Different HCCs for diabetes with:
			  ○ Acute complications (HCC 17)
			  ○ Chronic complications (HCC 18)
			  ○ Without complications (HCC 19)

The most critical factors is ensuring providers are aware of the full historical HCC diagnosis list

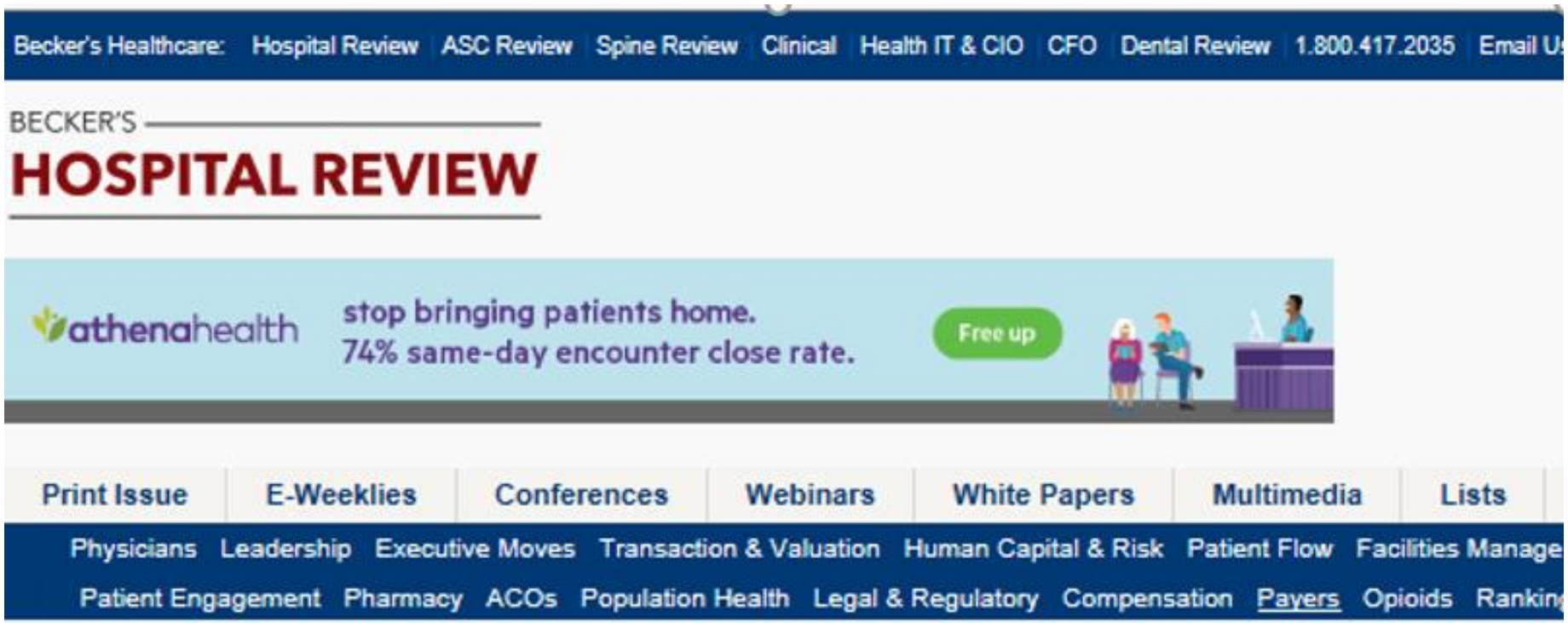
Under-documented and Resolved HCCs

- Amputations
- Artificial Openings
- Asthma and pulmonary disease
- Chronic skin ulcer
- Congestive heart failure
- Drug dependence
- Metastatic cancers
- Morbid obesity
- Rheumatoid Arthritis
- Specific type of major depressive order

Source: 3M aggregated claims data

Resolved HCCs – Cancers, Aneurisms

- Risk Adjustment Data Validation Audits – RADV – New Acronym
- These audits confirm that MA organizations self-reported risk adjustment data, or diagnosis codes used to depict how sick beneficiaries are, match medical documentation,
- Estimated to recoup 1$ billion dollars I in improper payments by 2020

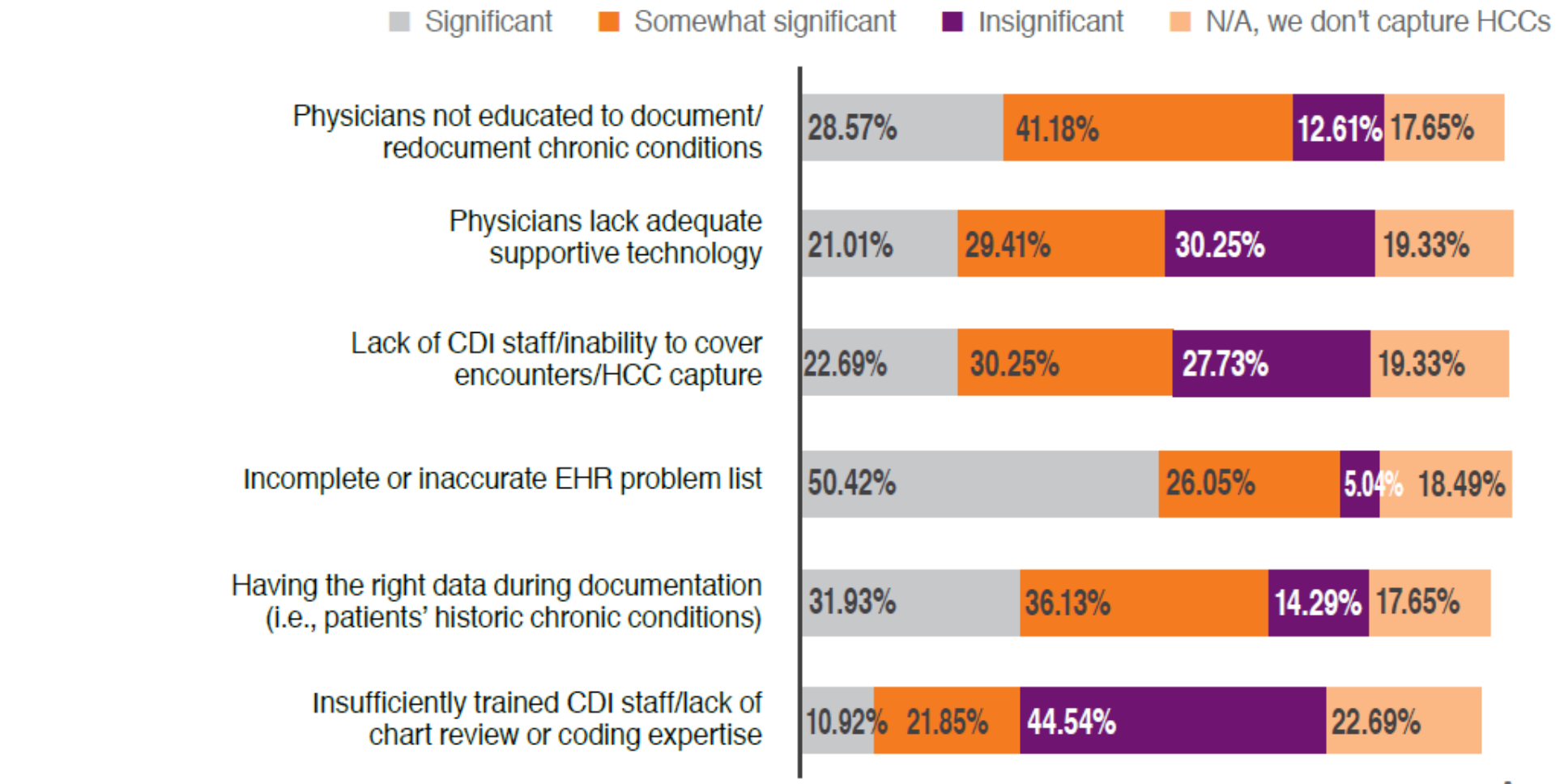


CMS says it will recoup $1B in improper Medicare payments by 2020

Written by Morgan Haefner | October 31, 2018 | Print | Email

CMS said it is poised to claw back $1 billion from Medicare Advantage organizations by 2020 through widespread audits, according to a proposed rule.

Obstacles related to accurate capture of Hierarchical Condition Categories (HCCs)



Trends - Concurrent Coding

- Better coding
- Fewer post-discharge queries
- Earlier resolution of quality indicators

Collaborative Concurrent Coding

23% of provider organizations perform concurrent coding enterprise-wide

30% perform some concurrent coding

Source: ACDIS survey, December 2018

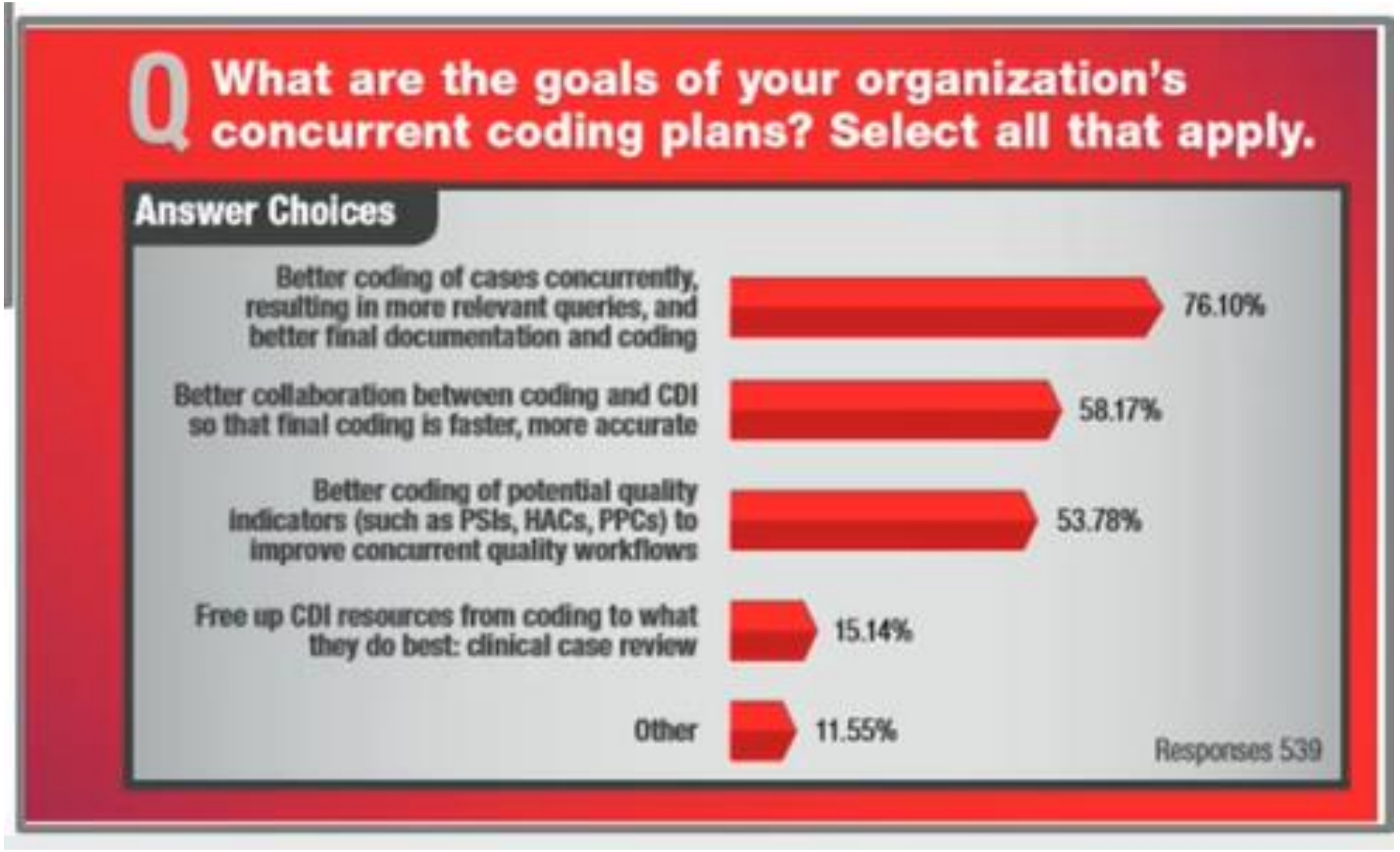
Why?

+ Better coding
+ Fewer post-discharge queries
+ Earlier resolution of quality indicators
= Greater return on your CDI Program

Success:

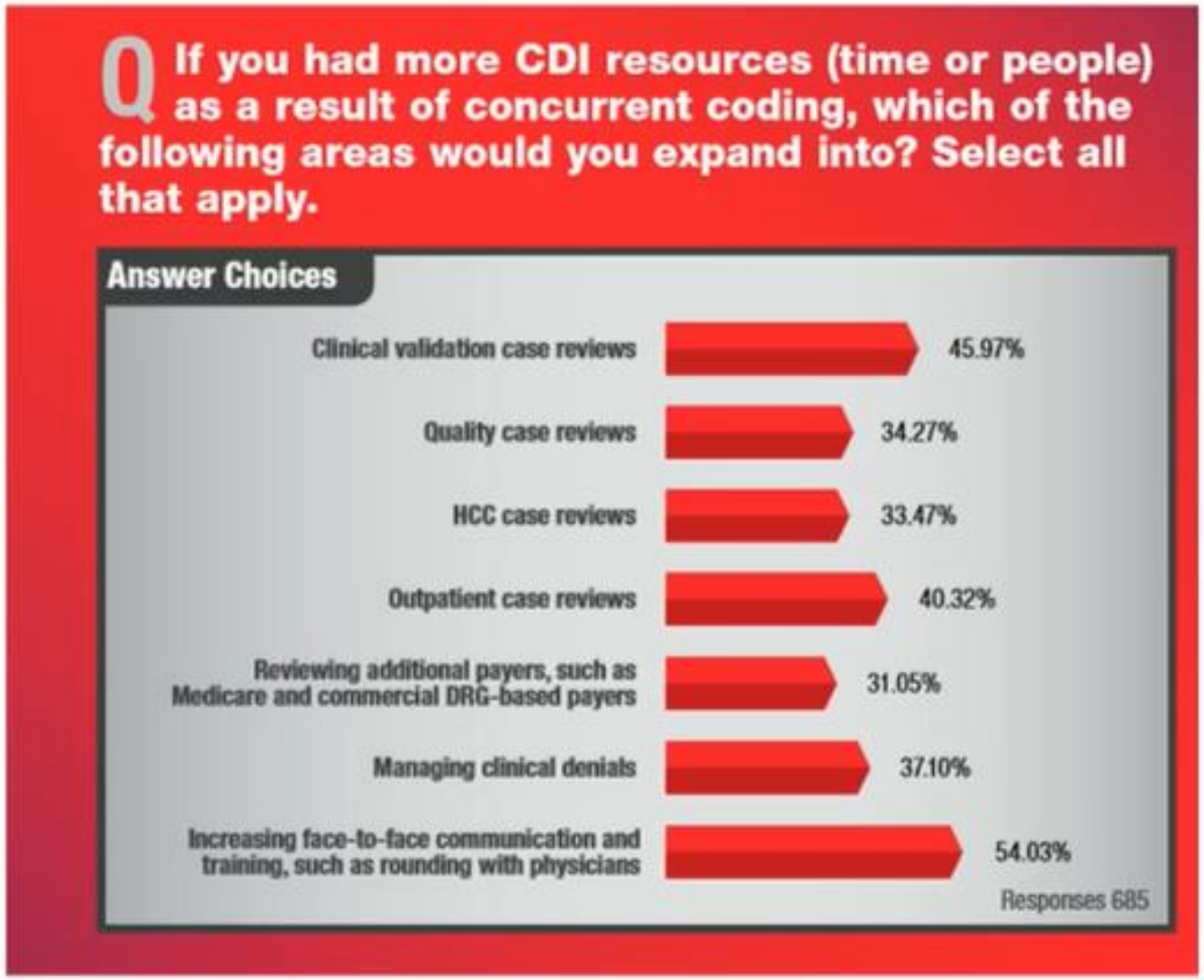
- Improve DNFB
- Accurate CC/MCC capture (CMI)
- Reduce rebills/DRG mismatches
- Accurate reporting of quality metrics
- Improve CDI, coding and quality collaboration

Collaborative Concurrent Coding - Goals



Source: ACDIS report/survey: "Concurrent Coding Efforts Offer New Opportunities for CDI Program Innovations" (December 2018)

Collaborative Concurrent Coding – Priority Areas



Source: ACDIS report/survey: "Concurrent Coding Efforts Offer New Opportunities for CDI Program Innovations" (December 2018)

Key features and benefits of a concurrent coding program

Documentation

Improve documentation quality

- Improve documentation quality & code assignment
- Identify & resolve pre-discharge documentation issues

Billing

Reduce rebills and days discharged not final billed

- Reduce rebills and DRG mismatches
- Reduce post-discharge queries
- Reduce days discharged not final billed

Communication

Improve CDI-coding communication

- Improve CDI-coding communication
- Effective resolution of quality indicators based on coding.

Coding

CDI and coders add codes to the working DRG

- On discharge coders can complete discharge coding within the concurrent coding workflow
- Concurrent coder can code the case concurrenty, allowing CDI to focus on clinical aspects

Working Collaboratively

Working collaboratively is a best practice of the concurrent coding workflow. Concurrent coders and CDI specialists work collaboratively to add and edit findings, and respond to action items, and follow-ups.

- Concurrent Coder
- CDI Specialist
- Using Worklists

Case Selection Criteria for Concurrent Coding

GENERAL CRITERIA:

FUTURE CRITERIA:

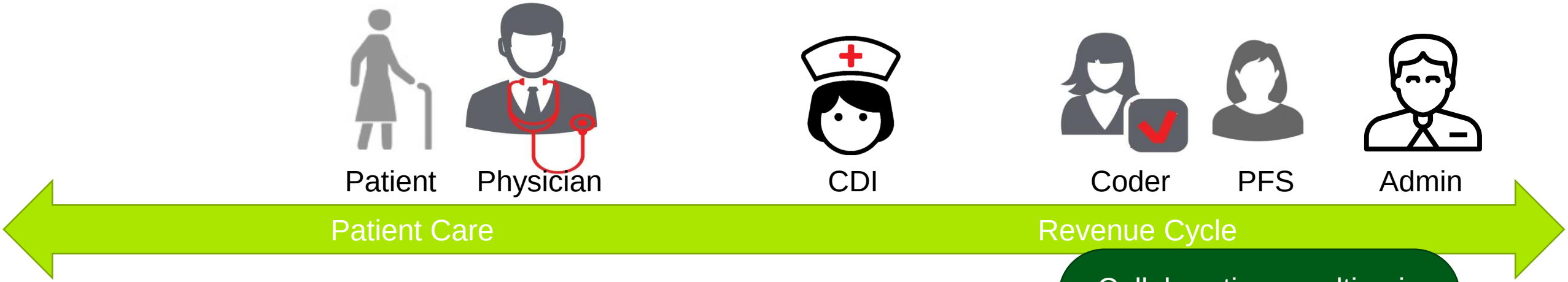
Ideal work flow

- Typically, a software platform that facilitates concurrent review is required, that allows two or more users to review the case concurrently, with visibility into each others work and without overwriting each others work. The software should be able to track financial and quality impact from collaborative efforts.

- Cases are assigned through automation to align with organizations objectives/clinical priorities. Ideally, when a clinical priority is triggered, the patient is assigned to the concurrent coding team including CDI, coding, quality and where needed, case management.

- A team effort is required so the team can work collaboratively, be able to quickly pick up where each other left off, explore query opportunities, track changes and prioritize activities.

Trends – Concurrent Coding and Quality CDI



Collaboration resulting in accurate coding, quality, reimbursement, and analytics, and resulting in fewer denials

How concurrent coding applies to quality

Concurrent coding session

Coding/CDI

Clinicians

Quality

Quality analytics engine

PSIs
HACs
PPCs
PPRs
ACRs
PDIs
NQIs

PSIs: AHRQ's Patient Safety Indicators
ACRs: All-Cause Readmissions
HACs: Hospital Acquired Conditions
NQIs: AHRQ's Neonatal Quality Indicators
PPCs: 3M Potentially Preventable Complications
PDIs: AHRQ's Pediatric Quality Indicators
PPRs: 3M Potentially Preventable Readmissions

Concurrent quality reviewer workflow

Show evidence
of Quality Indicator in electronic documentation

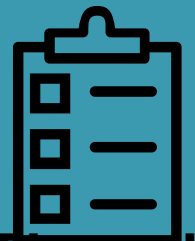
Analyze
inclusion/exclusion criteria, methodology, and reason for inclusion

Take action
immediately to correct documentation or care planning in real time

Root cause analysis and prevention

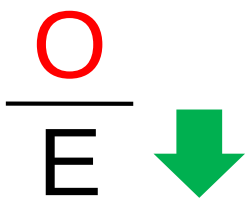
Removed
false positives from documentation or coding issues

Identified
most common quality indicators, causes, and opportunities



Plan and execute
Create and execute action plans to improve quality of care

Benefits of surfacing early warning quality indicators



Reduce number of reported quality indicators

Reduce quality-based payment adjustments

Improve results of value-based care and reimbursement

Improve public reputation

Example – In-hospital Hip Fracture – Falls and Trauma

AHRQ – Patient Safety Indicator 08 (PSI 08) In Hospital Fall with Hip Fracture Rate

HAC - Hospital Acquired Condition – PSI 90

PCC 28 – In-hospital Trauma and Fractures

Falls are a leading cause of hospital-acquired injury and frequently prolong or complicate hospital stays. Falls are the most common adverse event reported in hospitals. In-hospital injuries are highly preventable and serious.

Added expertise of the Quality Specialist

Patient Safety Indicator 08 (PSI 08) In Hospital Fall with Hip Fracture Rate

Inclusions

- In hospital fall with hip fracture (secondary diagnosis) per 1,000 discharges for patients ages 18 years and older.

Exclusions

- Excludes discharges with principal diagnosis of a condition with high susceptibility to falls (seizure disorder, syncope, stroke, occlusion of arteries, coma, cardiac arrest, poisoning, trauma, delirium or other psychoses, anoxic brain injury), diagnoses associated with fragile bone (metastatic cancer, lymphoid malignancy, bone malignancy), a principal diagnosis of hip fracture…. and obstetric cases

Present on Admission

- a principal diagnosis of hip fracture, a secondary diagnosis of hip fracture present on admission.

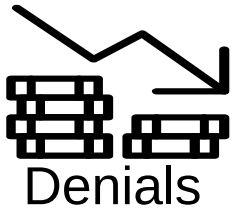
Quality Validator Workflow - Example

Goal: Focus on PSI 90

- Complication identified
- Notification between concurrent coding team (including CDI, Coding, Quality, and Physician Quality Champions)
  - Notification acknowledged
  - Complication validated
  - If not, communication sent back to validators and conversation begins
  - Complication assigned to concurrent coding team
  - Record is reviewed and code triggers researched
  - Complication is confirmed or avoided – secondary diagnosis, POA, documentation queried
  - Education and training is completed

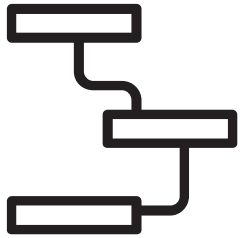
Downstream CDI Redesigned

CDI across the continuum supports all current and future reimbursement models and supports accurate reporting of quality in a value based model.



Denials Prevention, Management

- Prioritized clinical validation opportunities
- Automated appeals workflow
- Prioritized based on performance and payers
- Peer education for physicians on regulations

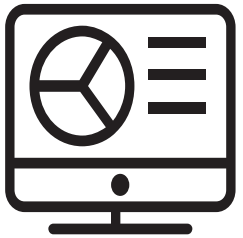


Collaborative Workflow

- Concurrent coding and CDI tool
- Working data shared with Case Management
- Quality indicators collaboration
- Process and education based on best practices
- Downstream Insights

Documentation Compliance

- Documentation supports accurate coding
- Revenue cycle and quality issues addressed
- Process and education based on best practices



Actionable Reporting

- Operational reporting metrics
- Easily accessible for all stakeholders
- Benchmarks and best practices coaching

Thank you

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