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CDI Across the Continuum – Moving to a Patient Centered Solution

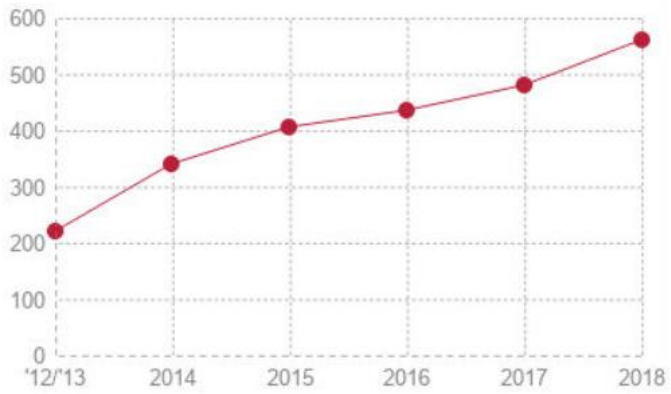
LIHIMA Presentation
Phil Goyeau – Revenue Cycle SSE
3M Health Information Systems

May 2019

Today's Agenda

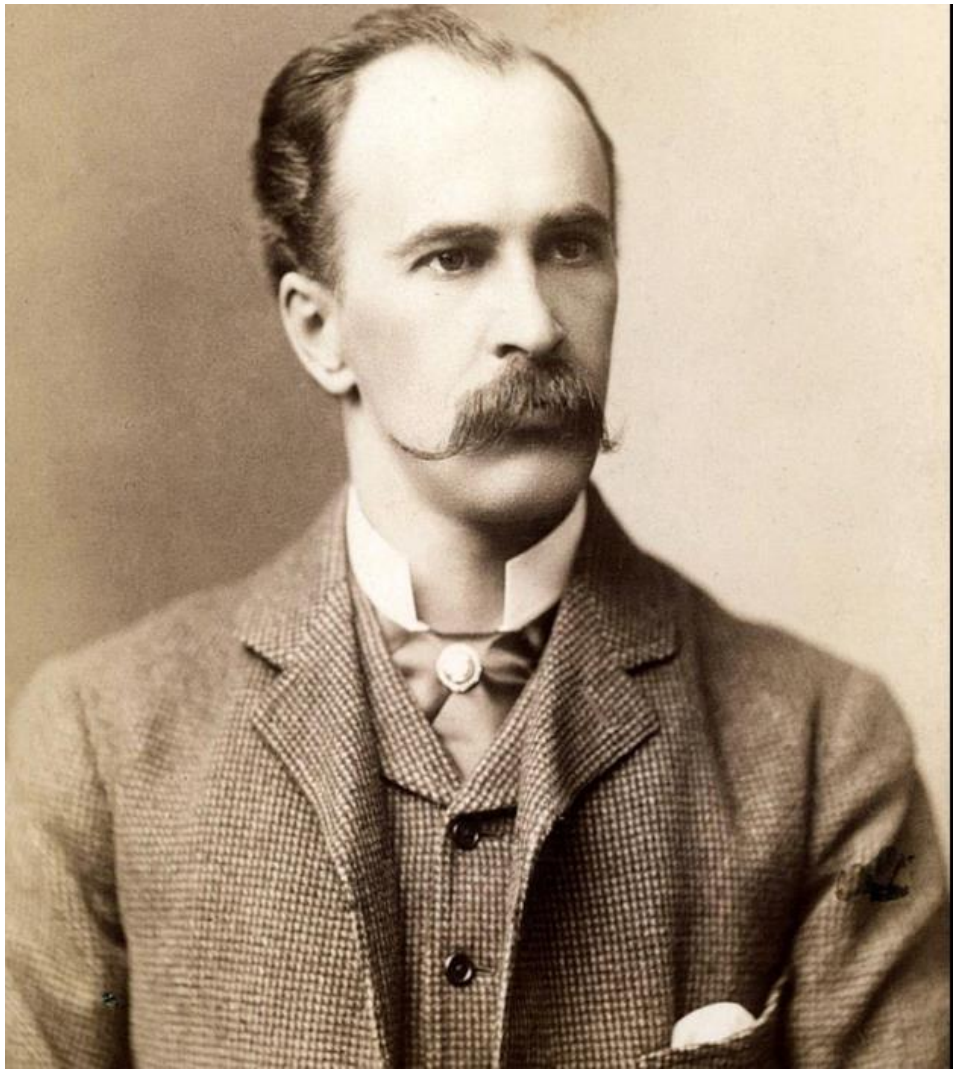
- Volume to value – how did we get here
- Documentation – Importance of being complete
- Trends and challenges – CDI in Different Settings
  - Inpatient CDI
  - Outpatient/Ambulatory CDI
  - Quality CDI
  - Concurrent coding
  - Risk Adjustment through HCCs
- Proactive and Downstream CDI

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

Sir William Osler - The father of medical documentation



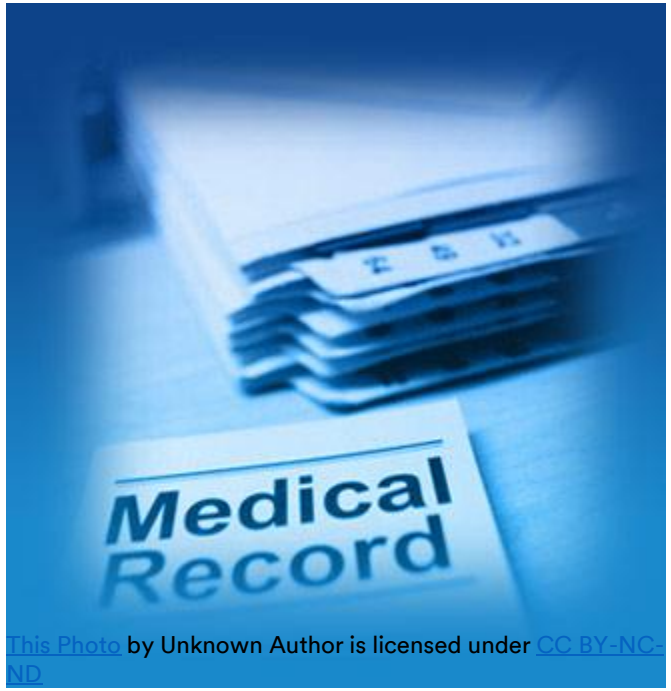
Sir William Osler (1849 – 1919) was a Canadian physician and one of the four founding professors of Johns Hopkins Hospital. He was frequently described as the Father of Modern Medicine.

Created the first residency program and felt that the best training of a physician was on the floor.

His best-known saying was "Listen to your patient, he is telling you the diagnosis," which emphasizes the importance of taking a good history.

Osler quote: “Observe, record, tabulate, communicate. Use your five senses. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone you can become expert.”

The importance of healthcare documentation



- Serves as a legal document
- Validates the patient care provided
- Facilitates claims processing, coding, billing and reimbursement
- Facilitates quality reviews

Medical Record Content

- Contains sufficient documentation to identify the patient
- Supports the diagnosis and justification of 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

Complete Documentation – Through-put

- As coders, we look at the revenue side of documentation.
- Other physicians should be able to review physician author note and assume care where physician left off
- Past and current diagnosis, current patient problems as well as treatment and plan of care.
- Planned work-up, clinical rationale, judgment, medical decision making, thought processes and problem solving/analytical skills
- Follow-up care and justification for diagnostic work-up & therapeutic treatments

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

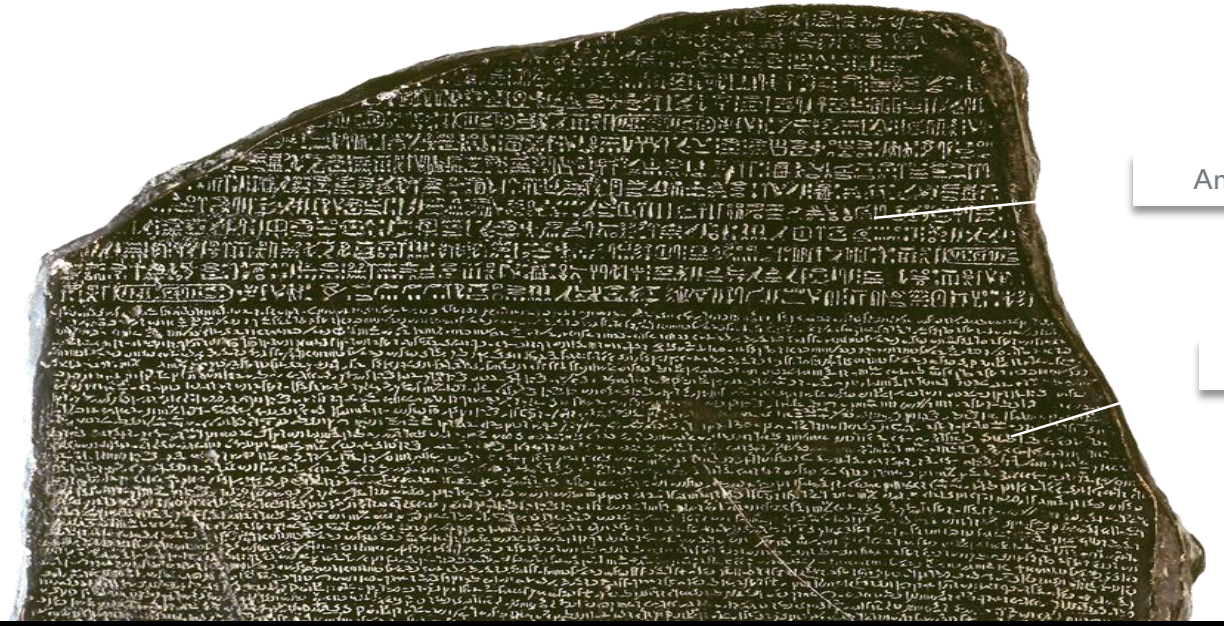
An upper respiratory viral infection

"I have a cold"

Challenges with data – The Rosetta Stone

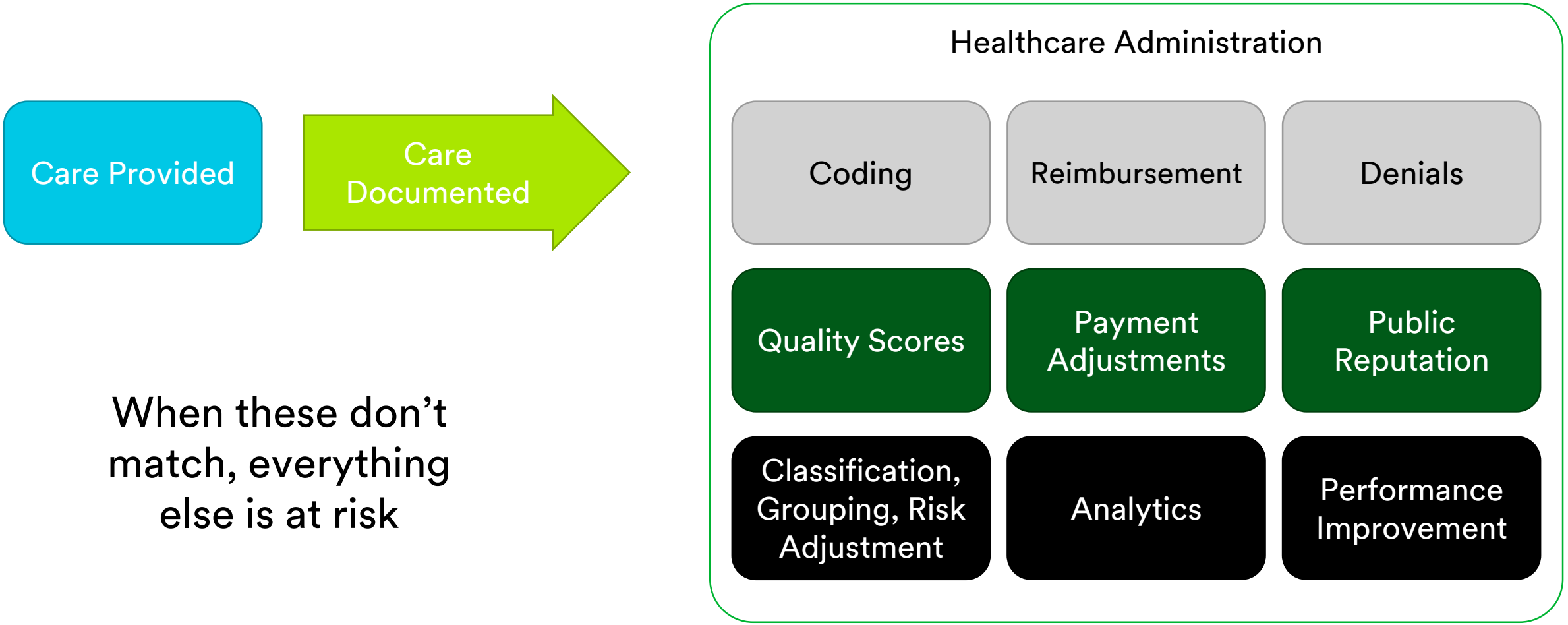
The Rosetta Stone

One set of instructions in three languages.



The term Rosetta Stone has been used to idiomatically to represent a crucial key in the process of decryption of encoded information, especially when a small but representative sample is recognized as the clue to understanding a larger whole….sort of like CDI….

Documentation is the source of truth



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

Clinical Documentation Improvement

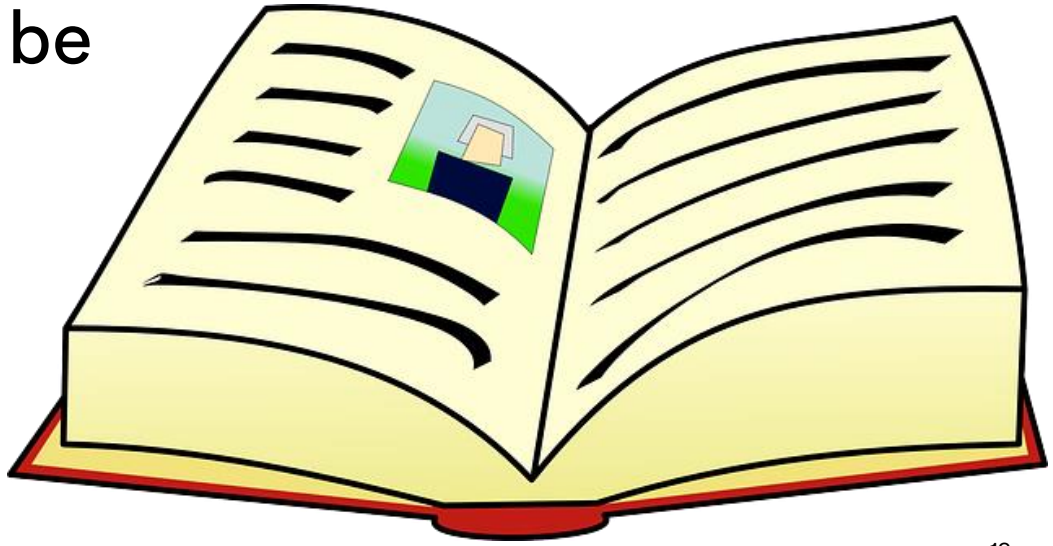
- (**CDI**) is the recognized process of improving healthcare records to ensure improved patient outcomes, data quality and accurate reimbursement.

- The profession was developed in response to the Centers for Medicare and Medicaid Services (CMS) Diagnostic-Related Group (DRG) system, and gained greater notice around 2007.

From Wikipedia, the free encyclopedia

CDI - Observe, record, tabulate, communicate

CDI helps by accurately telling the story of the clinical care you're providing. This vision has to flow through not only the CDI team, but the care management team, the physicians, and all the way on up through the senior leadership. As we transition to an accountable care and a risk based structure, this common vision is going to be incredibly important.



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

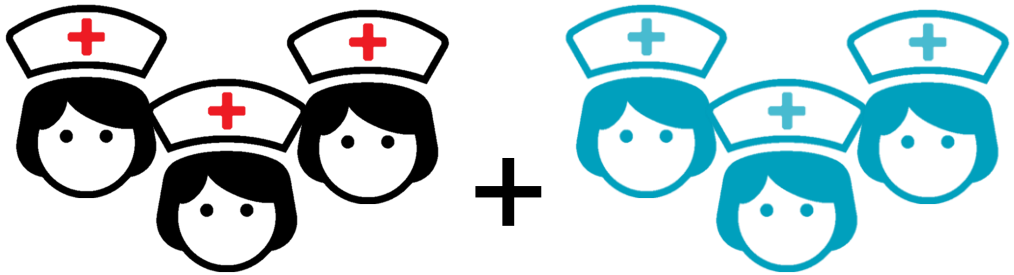
External market forces on the provider to cut costs, improve quality

- 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

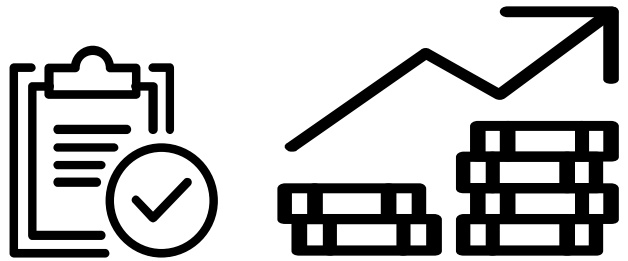
- **Cost Avoidance**
  - Inefficiencies and waste
  - Leverage existing investment with HER
  - Justifying CDI FTEs/ROI
- **Physician burn-out**
  - EHR burden / alert fatigue
  - Competing incentives
  - Inadequate CDI sustainability
- **Quality**
  - Penalties and scorecards (PSI, HACs)
  - MIPS and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

How can CDI expand to outpatient to meet those 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

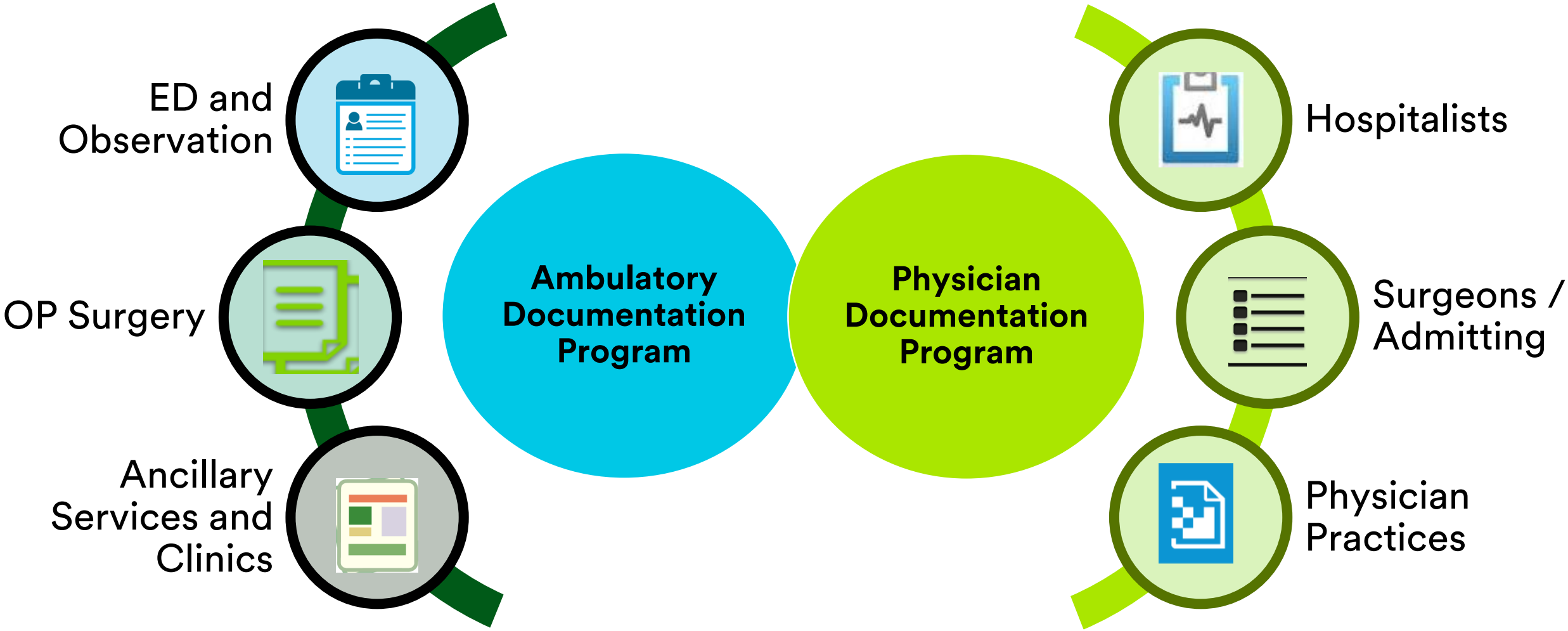
A *patient-centric solution* that supports all Clinical Documentation Improvement activities *beyond the traditional acute care setting*; using AI where possible, including *prioritized workflows* for document review, *query delivery and response*, *clinical validation* and *performance tracking* to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

Ambulatory CDI comparison to inpatient

Four ways the setting changes CDI activities

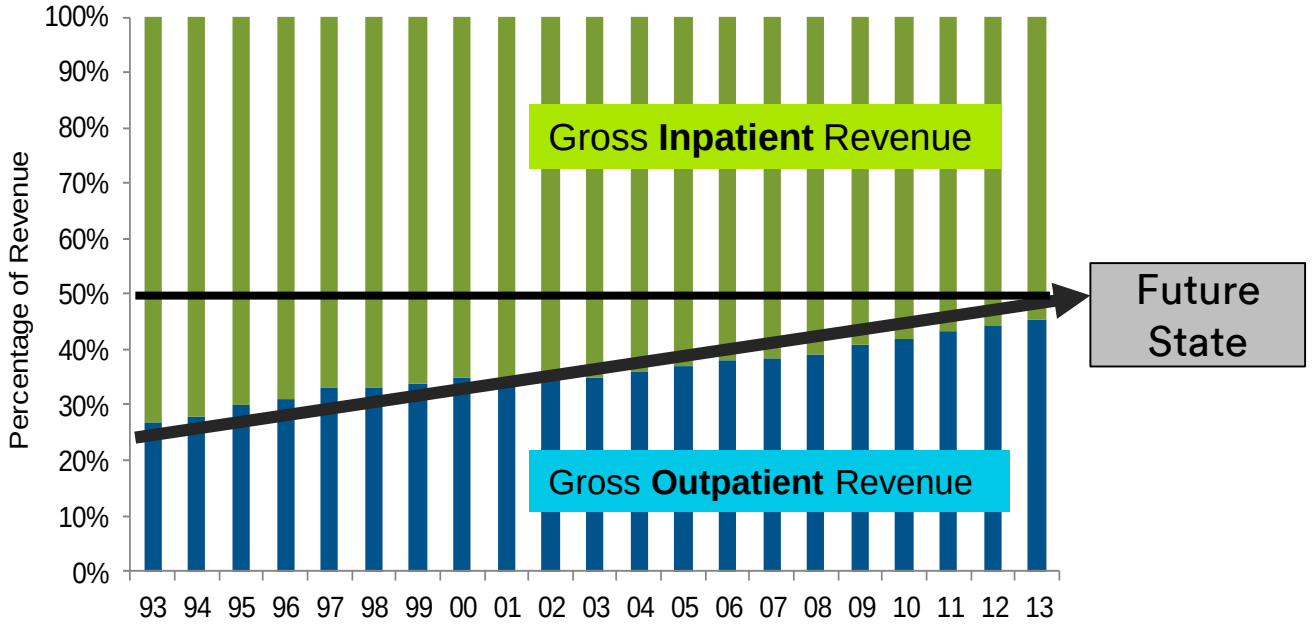
	Outpatient and Professional	Inpatient
Timing	Fast pace in minutes and hours before discharge	Encounter spans days, allowing for concurrent CDI
Objective	Priority on charge capture and reducing rework and denials	Focus on comorbid conditions, SOI, and case mix
Code sets for payment	Payment is usually 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.



What Customers Have Told Us About Outpatient CDI

- A significant portion of existing revenue comes from outpatient services and is expected to increase by at least 25% over the next 3 years
- Only 5% have an existing OP CDI program
- 56% participants will invest in an OP CDI program in the next few years
- Most participants need help starting a program



What we know…there's a revenue management challenge.

Revenue Management challenges are affecting the bottom line.

- Hospitals are losing an estimated 3-5% of net revenue from inadequate revenue management; $4.5 - $9 million for an average 300 bed facility
- Gross charge denials have grown to 15% - 20% of the nominal value of all claims submitted
- Every rejection or denial introduces the risk of not getting paid.

3% - 5% potential lost revenue

15% - 20% claims denied

Increased denials = decreased revenue

OP/Professional Business Challenges

Outpatient facility claims

- Inpatient-only procedures not identified in time to get the order prior to surgery
- Medical Necessity edits remaining after scrubbing (both ED and non-ED)
- Significant scrubbing performed to get the claims out the door
- Emergency Department E/M level skewed to highest level on 50% of visits
- Admission to hospital inaccurately noted as discharge from ED or observation
- Inaccurate time stamps for transfer from observation to inpatient
- Incomplete Documentation
- Denials

Professional claims

- Based on documentation, E/M levels are coded either too high or too low
- Critical care charged when patient stable or improving
- Missing charges for procedures and screening services rendered during visit
- Missing supporting documentation for surgical procedures
- Inappropriate modifier placement
- HCC diagnoses not noted (amputation) or “softened” (morbid obesity, alcohol abuse)
- Incomplete Documentation
- Coding related denials

The most frequent coding/documentation errors

- Unbundling codes
- Upcoding
- Not checking NCCI edits with multiple codes
- Missing or inappropriate modifiers
- Overusing modifier 22
- Time-based infusions and hydration
- Improper reporting of injection codes
- Reporting unlisted codes without documentation
- Lack of documentation of active HCC diagnoses
- Use of unspecified codes

How do you stay compliant?

https://www.beckershospitalreview.com/finance/8-most-common-coding-errors.html

Health System A

Profile

Publicly funded health system with multiple hospitals

Broad outpatient services including same-day surgery, emergency department, cancer care, and rehabilitation services

Objectives

- Improve the accuracy of outpatient reimbursement
- Maintain compliance with CMS rules and regulations
- Build staff efficiency and productivity to reduce rework
- Reduce delays in A/R and unbilled claims (which exceed $6 million)
- Maintain the charge description master and fix deficiencies in processes and communication to capture complete charges

Estimate of opportunity for Health System A

Claims data analysis and chart reviews for two hospitals

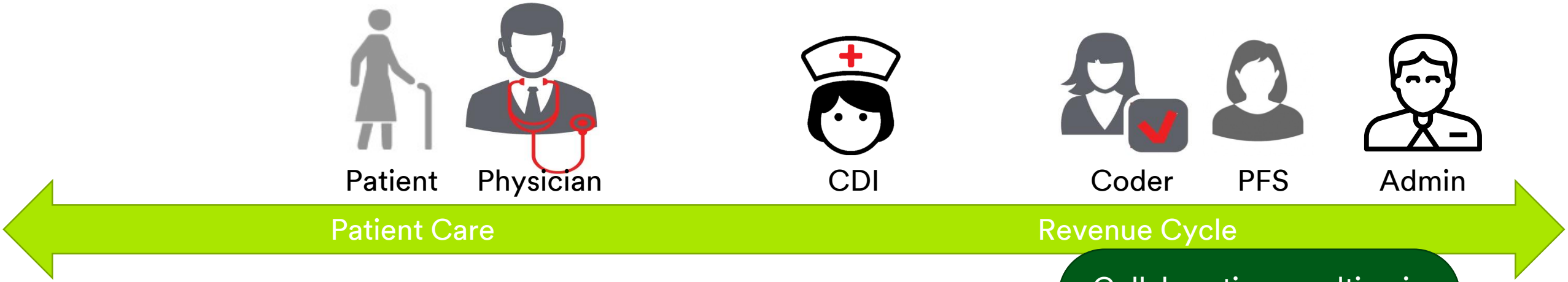
Of 35,000 outpatient claims. . .

15%	of pre-scrubbed claims result in an edit	About 5,200 claims get reworked @ $24 per claim	Cost of rework is $125K
7%	of post-scrubbed claims still have edits	About 2,300 claims have line item edits or won't be paid	Denials for OCE, MN and other edits are $750K
63%	have charge errors, omitted charges or missing modifiers	Average impact per "dirty" claim ranges from $42 – 102	Charge errors and omissions cost up to $1.7 million annually

How did Health System A fix the problem?

Phased rollout of process improvement and education	• First, correct the root causes, as determined by claims analysis and chart reviews • Then address consistent issues • As performance stabilizes, monitor daily edits and other measures
Performance measurement against objectives	• Ongoing data reporting to monitor claim integrity and edits • Feedback to users and key stakeholders • Monthly executive status reports
Organizational support	• Executive support from CFO • Involvement of clinical department chairs • Collaboration among health information management, patient financial services, and clinical departments

Trends - Quality CDI



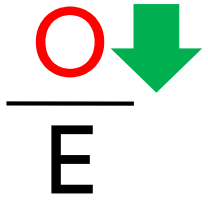
Collaboration resulting in accurate coding, **quality**, reimbursement, and analytics, and resulting in fewer denials

Early Warning Quality Indicators

Quality Analytics

Early identification of cases with quality indicators

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



Reduce number of reported quality indicators

Reduce quality-based payment adjustments

Improve results of value-based care and reimbursement

Improve public reputation

Trends - Concurrent Coding

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

Concurrent CDI / Coding collaboration

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 and coding collaboration

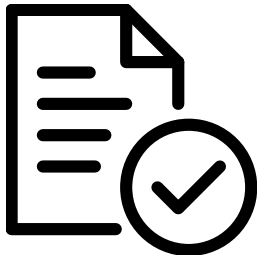
Concurrent Coding

- Concurrent coding is the process of real time patient data record review
- Quicker turnaround of final coded records
- Capturing the correct DRG (diagnosis-related group) assignment
- Enhanced case management
- Length of Stay concerns related to DRG
- Clinical indicators review
- Medical Necessity management

Concurrent Coding Features

Concurrent Coding:

- Uses technology to manage workflow
- Complete final coding much sooner



Ability to add findings and create action items to help facilitate an easy back and forth workflow for Coding and CDI.

Concurrent Coding Worklists

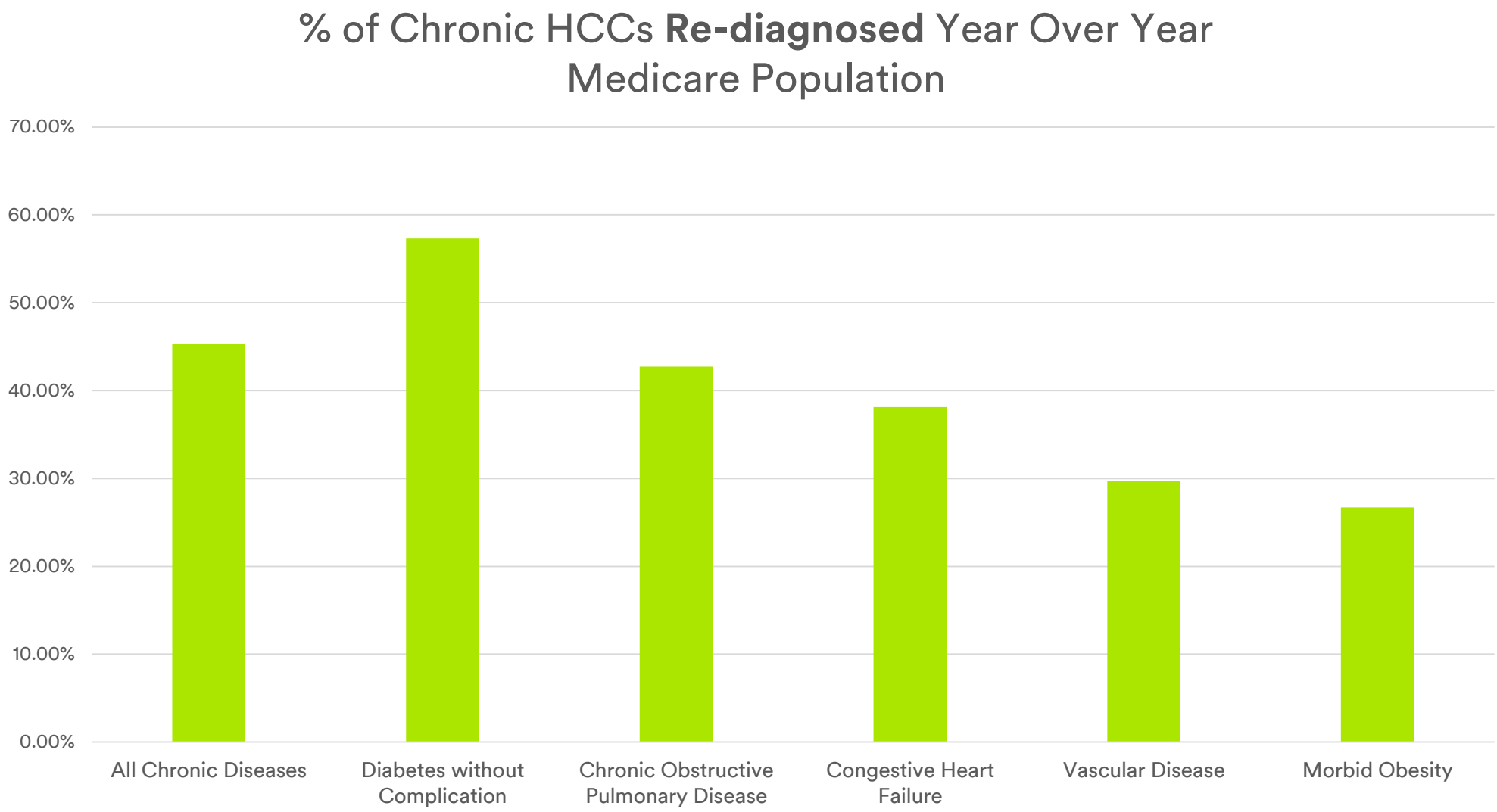
- Can be defined like CDI worklists
- Priority factors that support concurrent coding workflow
  - Addl display: case status, priority score, last coder, last reviewer

Care management, discharge planning

Risk Adjustment and Value Based Care

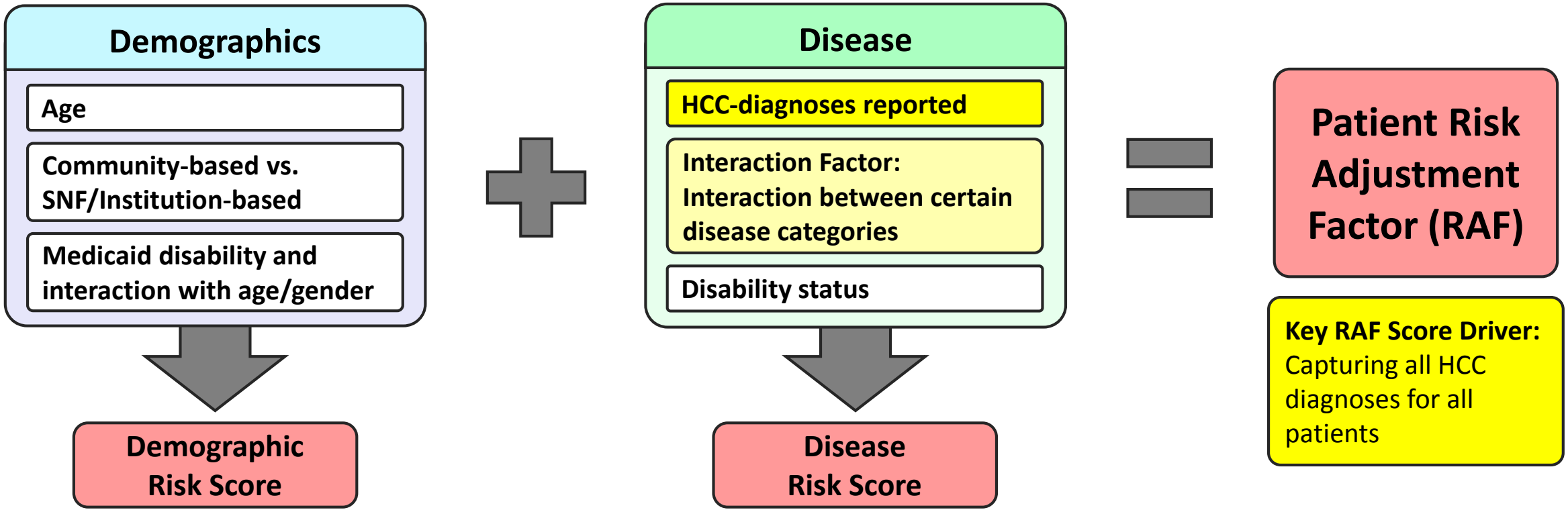
- Medicare Advantage Plans
- Capitated payments
- Different models
  - HCCs
  - DxCGs

Chronic disease is re-diagnosed only 45% of the time



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



HCC Risk Adjustment Factor Methodology Example

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

2017 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2017	
Demographic score: 2017	0.466
HCC 18: Diabetes w/retinopathy	0.318
HCC 22: Morbid Obesity	0.273
HCC 40: Rheumatoid arthritis	0.423
HCC 85: Dilated cardiomyopathy	0.368
HCC 111: COPD	0.328
HCC Interaction Score: CHF—COPD	0.190
HCC Interaction Score: Diabetes—CHF	0.154
Total RAF Score	2.520

2018 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2018	
Demographic score: 2018	0.466
HCC 18: Diabetes w/retinopathy	0.318
HCC 22: Morbid Obesity	0.273
Total RAF Score	1.057
2017 Missing RAF Score	1.463

Capitated Pay Per Member Per Month (PMPM):

- $800 PMPM x 2.520 RAF = $2,016
- $800 PMPM x 1.057 RAF = $846

$14,045 Annual

RAF Scores → Drive Value-Based Reimbursement

2015

$800	X	2.520	=	$2,016
Baseline PMPM		Individual RAF Score		Individual PMPM

2016

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

$14,045

Missed Annual Payment 2018

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

Common HCC Clarification Opportunities

Top 10 Most Under-Documented 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 disorder

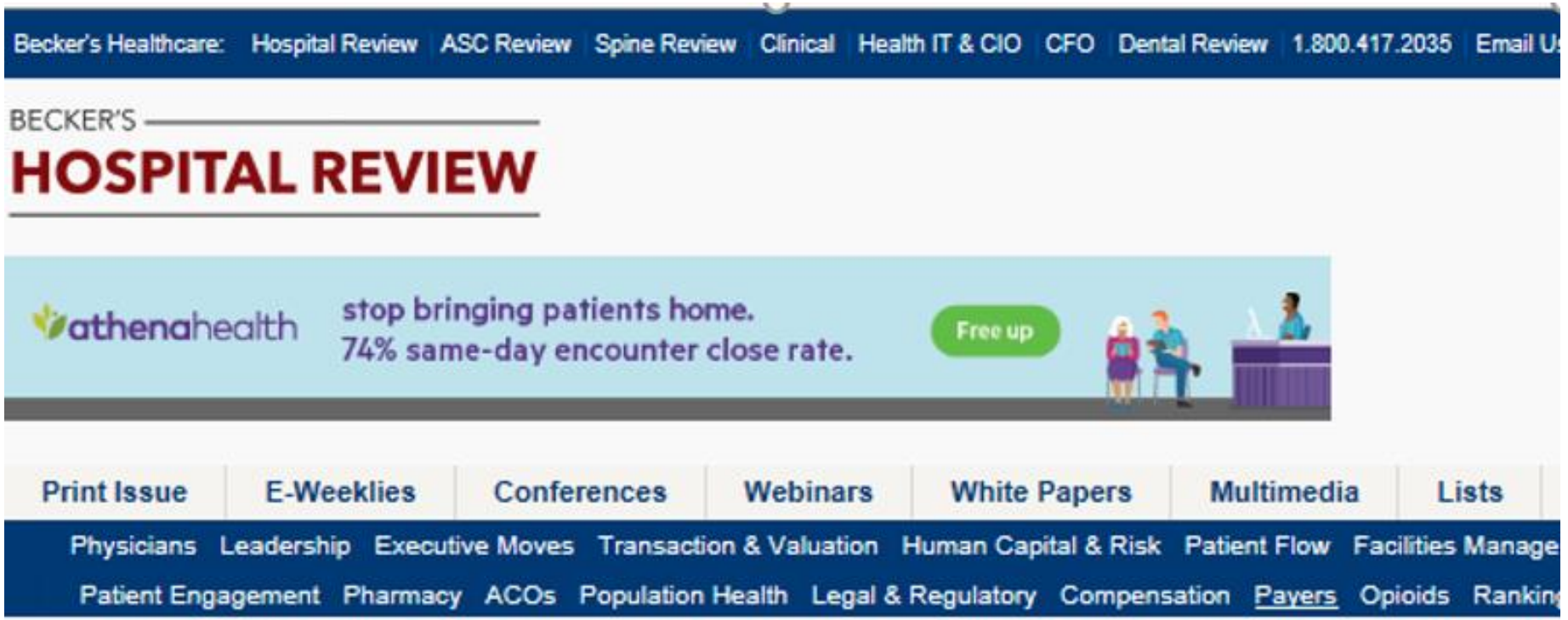
Source: 3M aggregated claims data

Top 10 Most Over-Documented HCCs

- Conditions that have been surgically corrected (e.g., abdominal aortic aneurism)
- Diabetes with complications
- Malnutrition
- Nephritis
- Pathological fractures (e.g., old pathological fractures reported as current)
- Pneumococcal pneumonia (e.g., unspecified pneumonia reported as pneumococcal)
- Polyneuropathy (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
- Primary site cancers (e.g., indicating historical conditions as current)
- Strokes (e.g., indicating acute stroke instead of late effect of stroke)
- Vascular disease (e.g., reported as current when no treatment, evaluation or monitoring is documented)

Source: 3M aggregated claims data

In the News



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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.

In the news

- The audits target Medicare Advantage health plans
- 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 in improper payments by 2020.

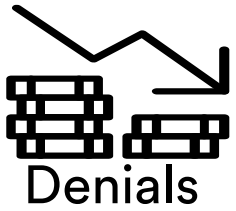
Becker's Hospital Review, October 31, 2018

Outpatient CDI Program

- An Outpatient CDI Program focuses on producing documentation and coding for compliant, optimal billing, which require attention beyond traditional inpatient documentation improvement:
  - ✓ Clinical documentation improvement
  - ✓ Complete charge capture
  - ✓ Chart reviews and coding audits
  - ✓ Medical necessity checking
  - ✓ Accurate claims submissions, billing, and denials management
  - ✓ Site of service determination (outpatient and observation versus inpatient) and the “Two Midnight Rule”
  - ✓ Attention to HCC diagnoses in documentation, coding, and billing

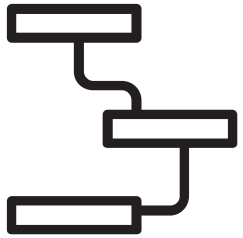
Downstream CDI Redesigned

CDI across the continuum supports all current and future reimbursement models, serves population health, social determinants 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

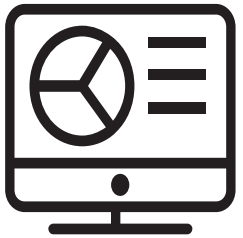


Collaborative Workflow

- 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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