BENEFITS REALIZATION FROM COLLABORATION: EMBRACING AND INTEGRATING THE FOCUS ON CLINICAL DATA INTEGRITY

Bonnie S. Cassidy, MPA, RHIA, FAHIMA, FHIMSS

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AGENDA

• The Clinical Documentation Integrity Value Chain
• ICD-10 lessons learned
  - The need for *collaboration*
• Regulatory Impact
  - MACRA Data Needs
• Collaboration
• Action Items
• Summary
Core Clinical documentation integrity has never been more vital since performance based payments are now directly linked to quality measures that require data and information.

Health information governance, Quality Monitoring, Performance Indicators, Risk of Mortality and Severity of Illness, Evidence based Medicine, Coding and CDI programs provide significant benefit to the new payment models since they allow a deep dive into information collection processes, sources and uses.

Providers, Nursing, Clinical Care Specialists, Health information management (HIM), Professional Coding and CDI professionals are at the center of assuring Clinical Documentation Integrity.
Clinical Documentation Value Chain
Clinal Documentation Integrity Value Chain

• The time is now to examine skills sets, timing, and performance among each of the disciplines that require accurate clinical documentation to provide value to their organization.

• Continuous quality improvement in the clinical documentation value chain is critical; such a value chain is a group of activities that are performed in order to deliver a valuable product or service for the organization.
The clinical documentation value chain consists of your physician documentation, CDI, and coding and compliance processes. Your goal should be to develop a future-state documentation, CDI, and coding and compliance value chain that is focused on the integrity of the clinical documentation.

The ideal structure will cut across the entire continuum of care and utilize complete and electronic physician documentation and substantiated/validated ICD-10 code selection.
As you create the future-state design, follow the critical path of your clinical documentation integrity value chain from pre-admission through the close of the encounter and final billing.

You are looking for an end-to-end value chain running from patient care to payment.
Clinical Documentation Integrity Value Chain

• This will enable you to find new opportunities and creative approaches to streamlining workflows and crafting new ways to leverage your technology investments.

• We must insist on integrity in the value chain’s processes and technology solutions that are connected intimately into the EHR workflow, where they will influence clinical documentation as it is created.
Keep in mind

As provider reimbursement and compliance become increasingly dependent upon the timeliness, completeness, accuracy and measured quality of documented care, collaboration with clinicians, Quality, Case Management, CDI and Coding teams remains one of the keys to survival.
CLINICAL DOCUMENTATION INTEGRITY VALUE CHAIN

IP OP ED patient encounter

Clinical Documentation

CDI & Case management

ICD-10 & CPT coding

Informatics & Analytics

Quality Collection Reporting

Compliance Monitoring
• **Medical necessity** — can we defend the patient’s care setting?

• Establishing **Severity of Illness (SOI)** and **Risk of Mortality (ROM)** to ensure appropriate risk-adjusted outcome profiles and payments for hospitals and physicians.

• **Preventing Hospital Readmissions** means we need to identify risks, implement a comprehensive discharge plan, and communicate effectively with community care providers.

• Improving the **Quality of Care** means we need to identify patients at risk for potential complications and implement preventive measures.

• Identifying conditions that may have been **Present on Admission (POA)** rather than hospital acquired will prevent payment penalties.

• **Withstanding audit activity** is dependent on the accuracy and consistency of the clinical documentation.
Clinical Documentation enabled Quality Measures Performance

Quality Measures Performance is very real and evolving to tie to optimal reimbursement
ICD-10 Lessons Learned
Lessons Learned from ICD-10

• ICD-10 implementation success to date is a result of Collaboration and leveraging technology and Education.

• Just as we experienced with the planning for the successful implementation of ICD-10, we have learned that it takes a team of health care colleagues working together and sharing expertise across the continuum of patient care to sustain ICD-10 quality and accuracy.
What ICD-10 Has Shown Us

Connection of clinical documentation integrity to accurate facility and physician coding, profiling, appropriate severity of illness and risk of mortality scores, improved patient safety indicator ratings, proper reimbursement, and decreased denials.
How ICD-10 has changed things

• The impact of the value-based payment system is being felt in earnest, addressing the clean-up on the clinical documentation “after the fact” is no longer a viable option.

• Neither is relying on traditional EHR point-and-click documentation methods that produce less complete, less accurate and often less compliant clinical documentation.
• What better way to accomplish all this than to implement a clinically integrated, intelligent solution that enables physicians to rapidly document the complete patient story in their own words while also guiding them on the specific clinical documentation elements needed to describe the patient’s condition while documenting in the EHR?
ENSURING CLINICAL DOCUMENTATION INTEGRITY

Accurate Clinical Documentation

- Patient safety and coding
- Compliance
- CMI
- Severity of illness
- POA/HAC
- Core measures
- Medical necessity
- Coding
- Audits
- Outcome measures
HIM OVERSIGHT ROLE IN INFORMATION GOVERNANCE

MANAGING CLINICAL DOCUMENTATION & INFORMATION

- Compliance
- CMI
- Severity of Illness
- POA/HAC
- Core Measures
- Patient Safety
- Point of Entry
- Care Summary
- Discharge Summary
- Outcome Measures
Regulatory Impact
THE MEDICARE CHALLENGE

INCREASING MEDICARE REVENUES REQUIRES CONGRESS TO INCREASE TAXES – OR – TAKING BUDGETED GOV’T FUNDS FROM OTHER PROGRAMS

FOR NOW, “COST CUTTING” IS THE FOCUS!

• Increased fraud enforcement (“Medically Unnecessary” procedures)
• Increased recovery of overpayments (Retrospective AND prospective denials)
• Linking payment to “Quality” (Payment for “Severity-Adjusted Patient Outcomes”)
WHAT IS RISK ADJUSTMENT

• Risk adjustment is an actuarial tool used to predict health care costs and set capitation payments to health plans to reflect the expected costs of providing care to their members.

• Adjustments consider demographic information (age, sex, eligibility) and health status (diagnoses).
WHY IS RISK ADJUSTMENT NECESSARY

• To account for changes in severity & case mix over time
• Accurately set performance targets
• Reduces competition among plans for favorable risks (aka “cherry picking”)
• Helps mitigate adverse selection
• Provides incentives to enroll high-cost individuals
• Helps ensure that plans/ACOs that enroll high-cost patients have the resources needed to provide efficient and effective treatment
RISK ADJUSTMENT PAYMENT METHODOLOGIES ARE USED ACROSS A VARIETY OF GOVERNMENT (FEDERAL & STATE) PRIVATE & COMMERCIAL INSURANCE PROGRAMS

THE FOUR PROMINENT SYSTEMS

- Ambulatory Care Groups (ACGs)
- Chronic Illness and Disability Payment System (CDPS)
- Diagnostic Cost Groups (DxCGs)
- Hierarchical Condition Categories (HCCs)
What is MACRA?

President Obama signed into law the Medicare Access and CHIP Reauthorization Act (MACRA) on April 16, 2015.

This legislation repealed the sustainable growth rate (SGR) but also introduced a number of provisions designed to compensate physicians and other healthcare professionals based on the **quality of care they provide** and **utilization of services**.

In order to judge performance fairly and accurately, a much higher premium will be placed on the **integrity of clinical data** generated during patient care due to MACRA.
MACRA Background

Under MACRA the majority of Medicare eligible providers will participate in one of two programs that focus on shifting away from fee-for-service reimbursement and towards reimbursement based on quality and utilization.

They are referred to as the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs).
MIPS started **January 1, 2019** and consolidates existing quality and utilization-based programs, including the Physician Quality Reporting System (PQRS), the Value-Based Modifier Program (VBM), and the “meaningful use” Electronic Health Record (EHR) Incentive Program Certified EHR Technology (CEHRT).

The central value of accurate and complete data has never been greater given the implications of MIPS and APMs.

Health information management (HIM) and CDI professionals will likely find themselves at the center of these efforts.
MIPS rolls together and sunsets three legacy CMS programs: Meaningful Use, the Physician Quality Reporting System and the Value-Based Payment Modifier.

Payment adjustments in the first year will be neutral, positive or negative up to 4 percent. This will grow to 9 percent by 2022.

CMS is allowing physicians to pick their pace between the following four options in 2017.

1. **No participation** and an **automatic 4 percent negative payment adjustment**.
2. Submission of a **minimum amount of data**—i.e. one quality measure—and a neutral payment adjustment.
3. Submission of **90 days of data** for a potential **small** positive payment adjustment or a neutral adjustment.
4. Submission of a **full year of data** for the potential to earn a **moderate** positive payment adjustment.
Clinical data integrity in this setting can be viewed as having four areas of potential compromise. These include:

- **Accuracy**: This refers to whether or not the code represents information correctly.

- **Completeness**: This refers to whether or not the codified representation of the clinical concept represents the concept in its fullest capacity.

- **Preserved context**: This refers to the tendency of codified clinical information to be separated from context that is provided in the clinical record.

- **Currency**: Clinical information in the patient’s longitudinal record of care requires continuous updating.
Collaboration Opportunities
What is in it for me?

Our Common Goals
KNOCKING DOWN THE SILOS
COLLABORATION ALONG THE ENTIRE CLINICAL DOCUMENTATION CHAIN

- To improve patient care, revenue and compliance, a clinical documentation chain requires collaboration throughout the organization.
- Weak links anywhere along the chain will contribute to poor data quality.
COLLABORATION IS NEEDED TO RESULT IN CLINICAL DOCUMENTATION INTEGRITY
Successfully automating the entire clinical documentation and coding workflow requires integrating People, Process and Technology.
CODING MANAGERS AND CDI DIRECTORS ARE WORKING TOGETHER TO IMPLEMENT THE FOLLOWING PROCESSES

• **Ongoing ICD-10 education** is available for coders and CDS staff

• DRG discrepancies are reviewed with the coder/CDS on an individual basis and common DRF discrepancies are reviewed with the two teams

• Coder/CDI queries are modified to meet ICD-10 compliance – **about 15-20%** of the ICD-10-CM guidelines affecting when and how a code is assigned were revised and PCS requires much more specificity (approach, device, body part, etc.)
CODING MANAGERS AND CDI DIRECTORS ARE WORKING TOGETHER TO IMPLEMENT THE FOLLOWING PROCESSES

- **All HACs** are reviewed pre-bill collaboratively by the Coding Manager/CDI Director to ensure the appropriateness of HAC reporting
- **All DRG denials** accepted by the facility are reviewed with the individual coder/CDS who coded the account are reviewed with the coder/CDS team
CODING MANAGERS AND CDI DIRECTORS ARE WORKING TOGETHER TO IMPLEMENT THE FOLLOWING PROCESSES

• Review any trend in DRG or APR-DRG discrepancy between the coding team and CDS staff

• Discuss clinical indicators of commonly targeted CCs/MCCs by RACs (ex. encephalopathy, postoperative respiratory failure, acute cor pulmonale, etc.)

• Review any recently reported HACs with the coding team, CDS staff, and quality leadership so the facility is in agreement with when a HAC is to be reported
THE KEY TO IMPROVED DOCUMENTATION IS A SUCCESSFUL RELATIONSHIP AMONG CODERS AND CDS STAFF BASED ON COLLABORATION
THE KEY TO IMPROVED DOCUMENTATION IS A SUCCESSFUL RELATIONSHIP BASED ON COLLABORATION

• Work together (Coding, CDI, and Quality) to educate providers on quality documentation to meet ICD-10-CM and ICD-10-PCS coding guidelines. Explain to providers how SOI and ROM will impact their bottom line.

• Review reported HACs and PSIs on a regular basis as a team.

• Educate coding and CDI teams on all DRG denials accepted by the facility.
Action Items
Just like with coding, the same workflow and technology can be extended to a traditional CDI program to improve efficiency and allow an all-payer coverage model that has previously been dependent on adding expensive FTEs.

The CDI team can now back up the physician activity described earlier so nothing gets overlooked – SOI, POA conditions, Patient Safety Indicators (PSIs), hospital IQR measures, and ICD-10 specificity.

Appropriate CMI can be maintained. Where necessary, inpatient status can be properly justified.
UPDATE YOUR CDI PROGRAM

ADDRESS AMBULATORY CARE

• Strengthen documentation of diagnoses under ICD-10 to support OP services and address changes in ambulatory reimbursement.

• This is another reason why CDIs need to train physicians in ICD-10 documentation requirements. CDIs should be part of developing electronic health record templates that guide physicians toward documentation of diagnoses, rather than symptoms.
ADDRESS AMBULATORY CARE

• Assist in documentation of confirmed diagnoses. Just as with inpatients, CDIs teach physicians to link s/s to diagnoses and confirm diagnoses for emergency department and observation patients.

Because unconfirmed diagnoses are not coded, CDIs connect confirmed diagnoses to documentation that supports medical necessity.
UPDATE YOUR CDI PROGRAM

ADDRESS AMBULATORY CARE

• Ensure that documentation meets medical necessity standards for the appropriate level of care assigned.

• CDIs work collaboratively with case management to educate physicians in documentation standards that validate medical necessity of observation/outpatient services, including retrospective record audits.
ON GOING PERFORMANCE MONITORING

• Be proactive
• Monitor volumes of cases in comparison to other quarters and years
• Monitor performance on accountability measures and composite scores
• Drill down into reports to determine what is causing outliers, if applicable
• Augment and customize standard reports by adding additional fields that are specific to your organization and needs
• Benchmark against like facilities and your own previous performance
FORMALIZE YOUR DENIAL PROCESS

BEST PRACTICES

- Ensure you have the right people at the table
- Track results
- Meet monthly to review progress
- Address 60 day Rule
CREATE A SPIRIT OF DENIAL AVOIDANCE
SO YOU ARE NOT CONFRONTED WITH OVERPAYMENT CONCERNS

OVERPAYMENT EXAMPLES INCLUDE:

- Payments for non-covered services
- Payments in excess of allowed amount of a covered service
- Errors and non-reimbursable expenditures in cost reports
- Duplicate payments
- Receipt of Medicare payment when another payor is primary
SUMMARY
As provider reimbursement and compliance become increasingly dependent upon the timeliness, completeness, accuracy and measured quality of documented care, collaboration with clinicians, Quality, Case Management, CDI and Coding teams remains one of the keys to survival.
In Summary

• The future-state clinical documentation integrity value chain is a cross-functional approach that leverages your EHR’s investment and utilizes technology across the continuum of care.

• Your strategy for continued success with clinical documentation that supports your ICD-10 coding is multi-pronged and should include a) physician-generated clinical documentation; b) a clinical documentation improvement program; and c) coding compliance processes and solutions, including a defined core clinical documentation record set for coding compliance.
• The future-state clinical documentation integrity value chain is a cross-functional approach that leverages your EHR’s investment and utilizes technology across the continuum of care.
In Summary

• Success requires focusing on the beginning of the process and ensuring that your physicians are engaged and empowered with the tools necessary to help them capture high-quality documentation from the beginning, in their preferred workflows, and keeping the process tightly integrated with the EHRs.
In Summary

• A clinically focused CDI approach engages your physicians with evidence-based strategies, education, and technology support, giving them the tools to help ensure that documentation is clear and accurate from the moment the patient enters the hospital – thus enabling better communication between caregivers, especially at critical transitions of care, and that documentation better reflects the true severity of illness and risk of mortality of each patient.
From this point forward…
we must accept one another as equal shareholders of a partnership called “The Future State of Clinical Documentation Integrity”
CEU Code  3959
QUESTIONS?