RISK IN A VALUE BASED PURCHASING ENVIRONMENT

The role of accurate, complete documentation and coding

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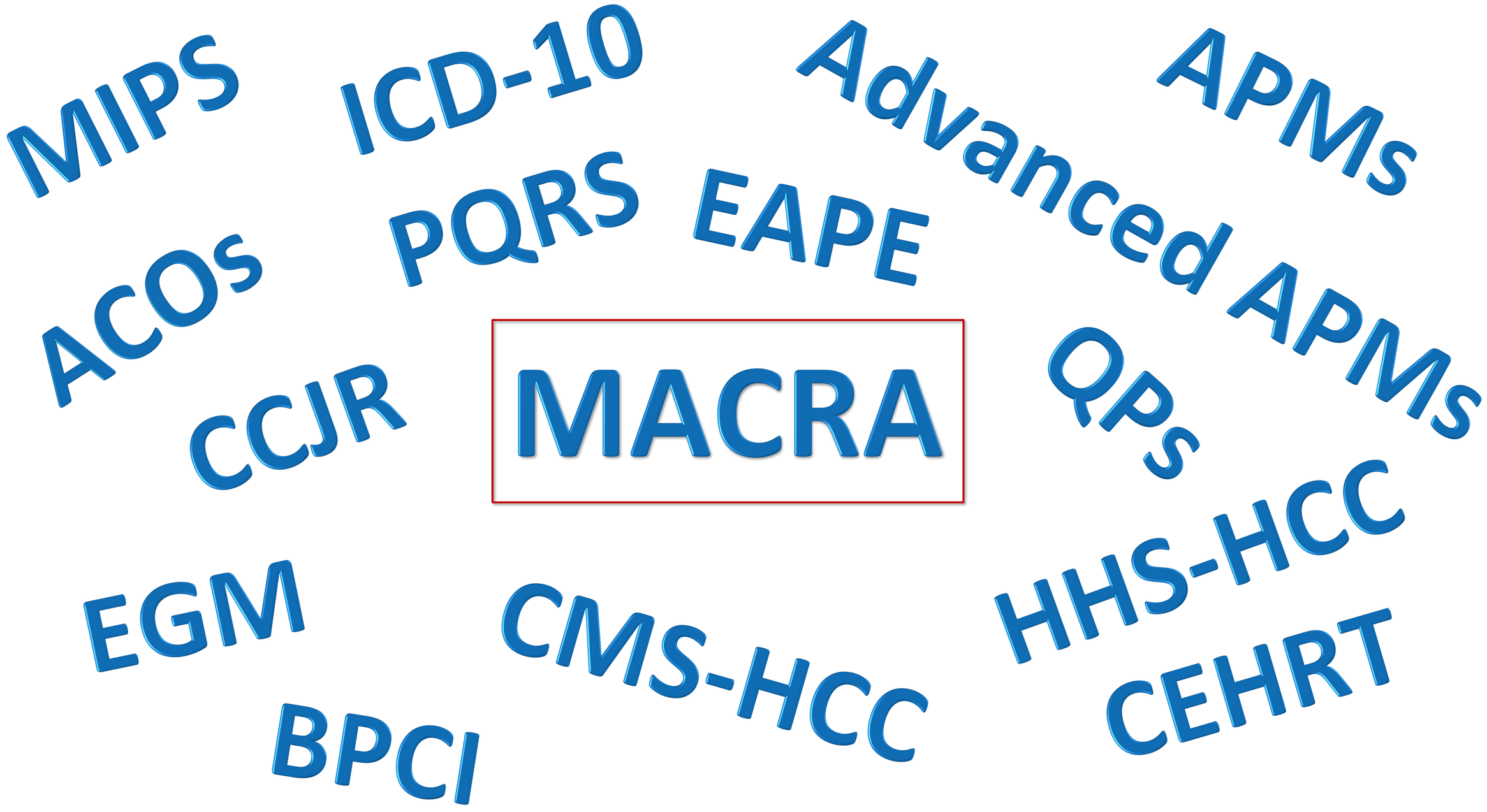
Agenda

- What does risk mean in a value-based purchasing environment?
- What are current measures of risk and how do they factor into payment?
- How is risk used to adjust quality and payment?
- What are the strategies for improving the quality of data needed to succeed?


MIPS
ICD-10
Advanced APMs
APMs
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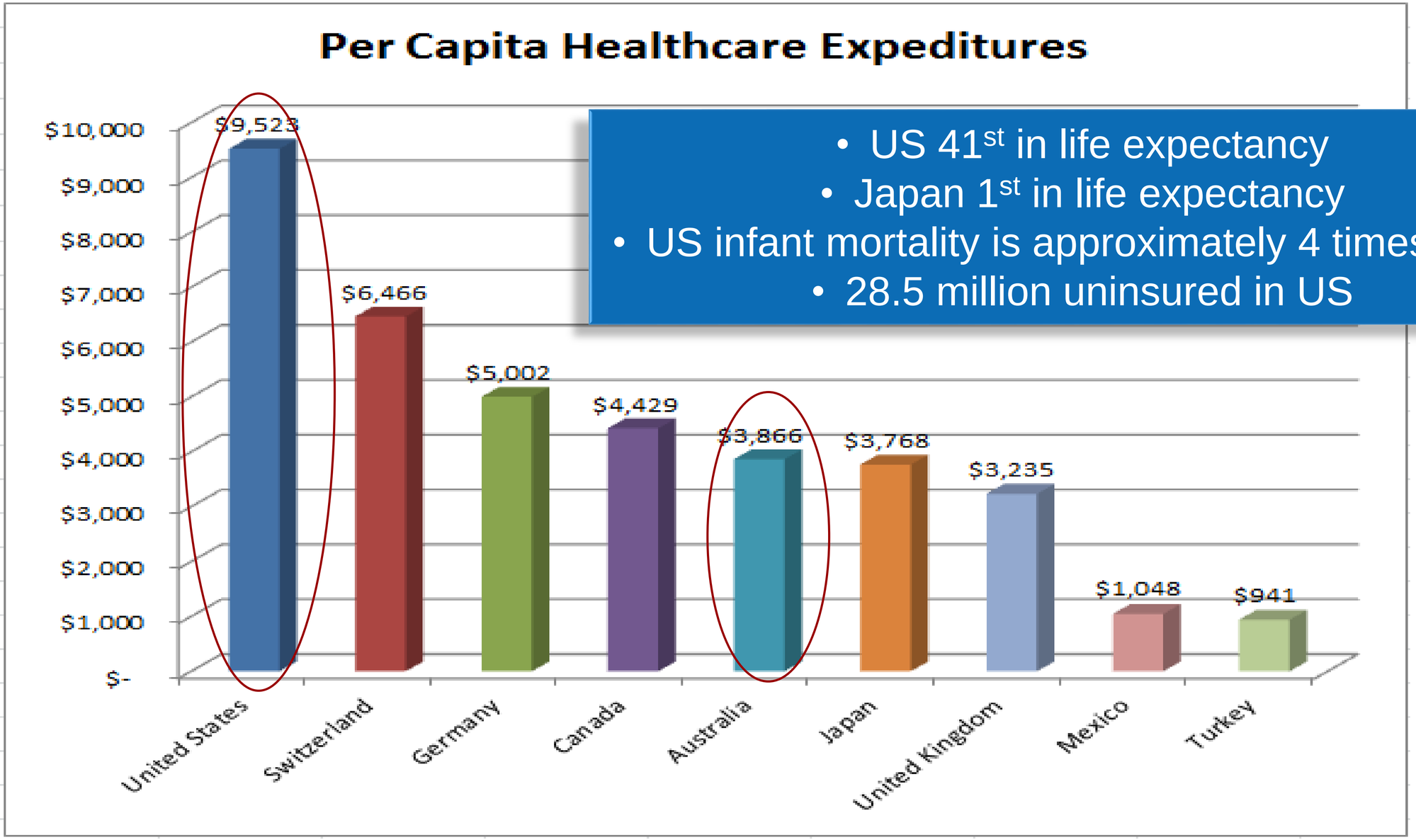


- US 41st in life expectancy
- Japan 1st in life expectancy
- US infant mortality is approximately 4 times Japan
- 28.5 million uninsured in US

*Source: OECD (Organization for Economic Co-operation and Development) 2015

The Public View of Value

CNN Health » Diet + Fitness | Living Well | Parenting + Family Live TV

Hospital suspends elective heart surgeries on children after CNN investigation

Atlanta (CNN)—St. Mary's Medical Center in West Palm Beach, Florida, has suspended elective pediatric heart surgeries after a CNN investigation calculated that the program had a mortality rate for open heart surgeries three times higher than the national average.

A press release issued by the hospital late Sunday night said they were launching a "comprehensive review" of the program involving external experts.

CNN report on high mortality rate for babies at Florida hospital leads to inquiry

Increasing Measures of Value

Standardizing Patient Outcomes Measurement

Michael E. Porter, Ph.D., M.B.A., Stefan Larsson, M.D., Ph.D., and Thomas H. Lee, M.D.

The arc of history is increasingly clear: health care is shifting focus from the volume of services delivered to the value created for patients, with "value" defined as the outcomes achieved relative to the costs.[1] But progress has

*Source:

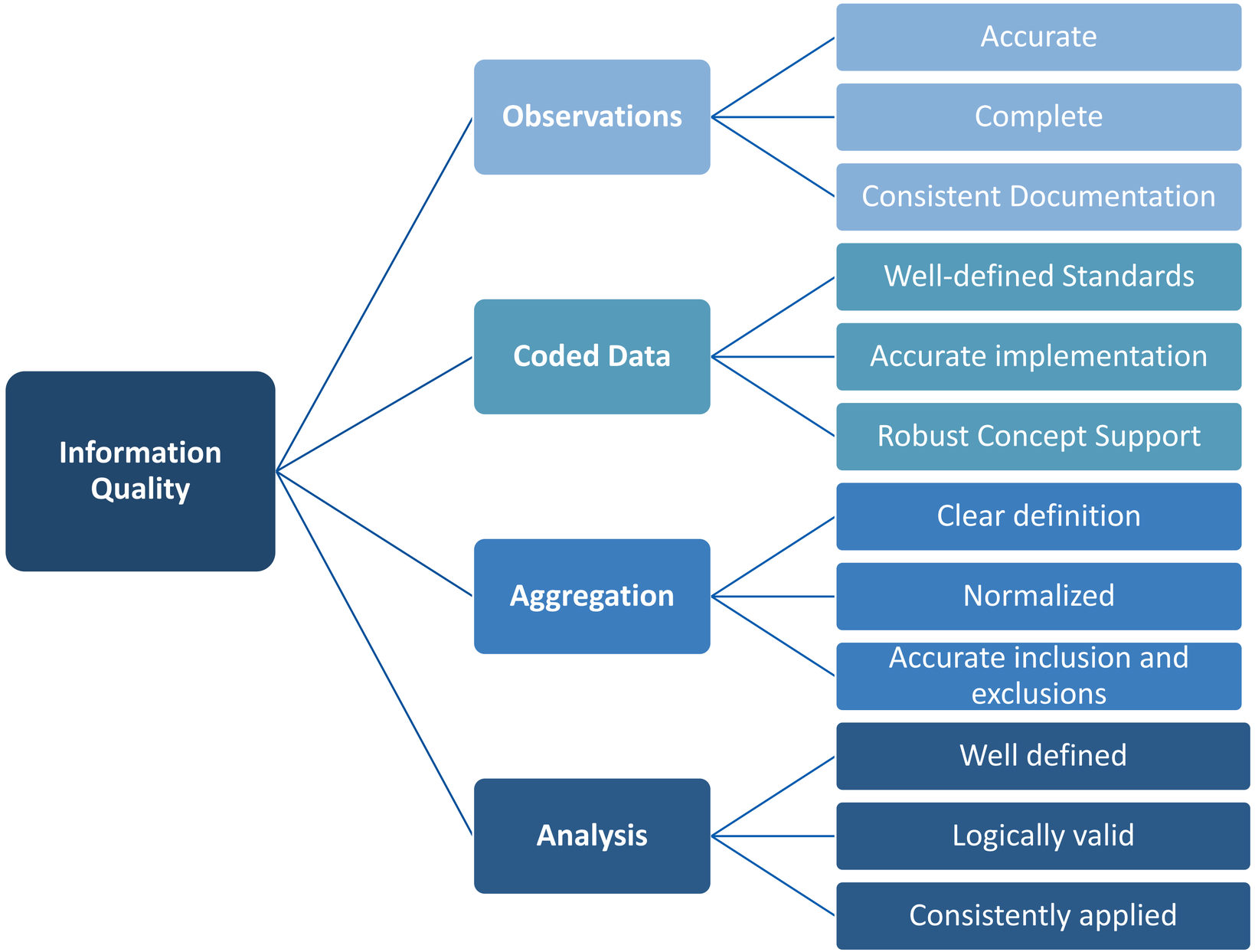
N ENGL J MED 374;6 NEJM.ORG FEBRUARY 11, 2016

Good Patient Data

1. *Observation* of all objective and subjective facts relevant to the patient condition

2. *Documentation* of all of the key medical concepts relevant to patient care

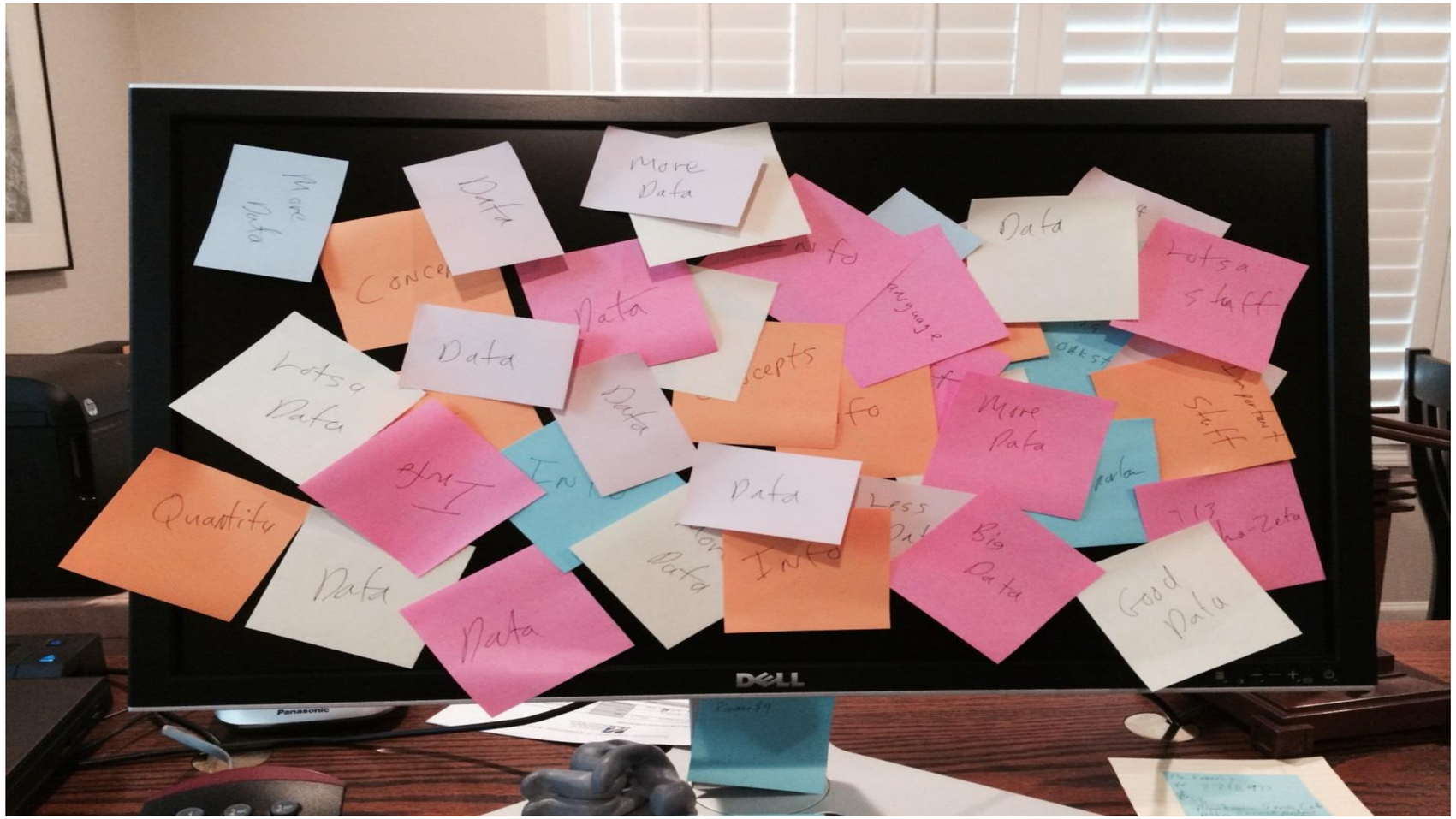
3. *Coding* that includes all of the key medical concepts supported by the coding standard and guidelines



Source: Health Data Consulting Inc.

Big Data

Unstructured Data



"It appears that my bad documentation was offset by the coder's bad coding, so statistically your health has never been better!

The Focus is Changing

The Focus is Changing

Diagnosis

Services

Medical Concepts

Medical documentation scenario:

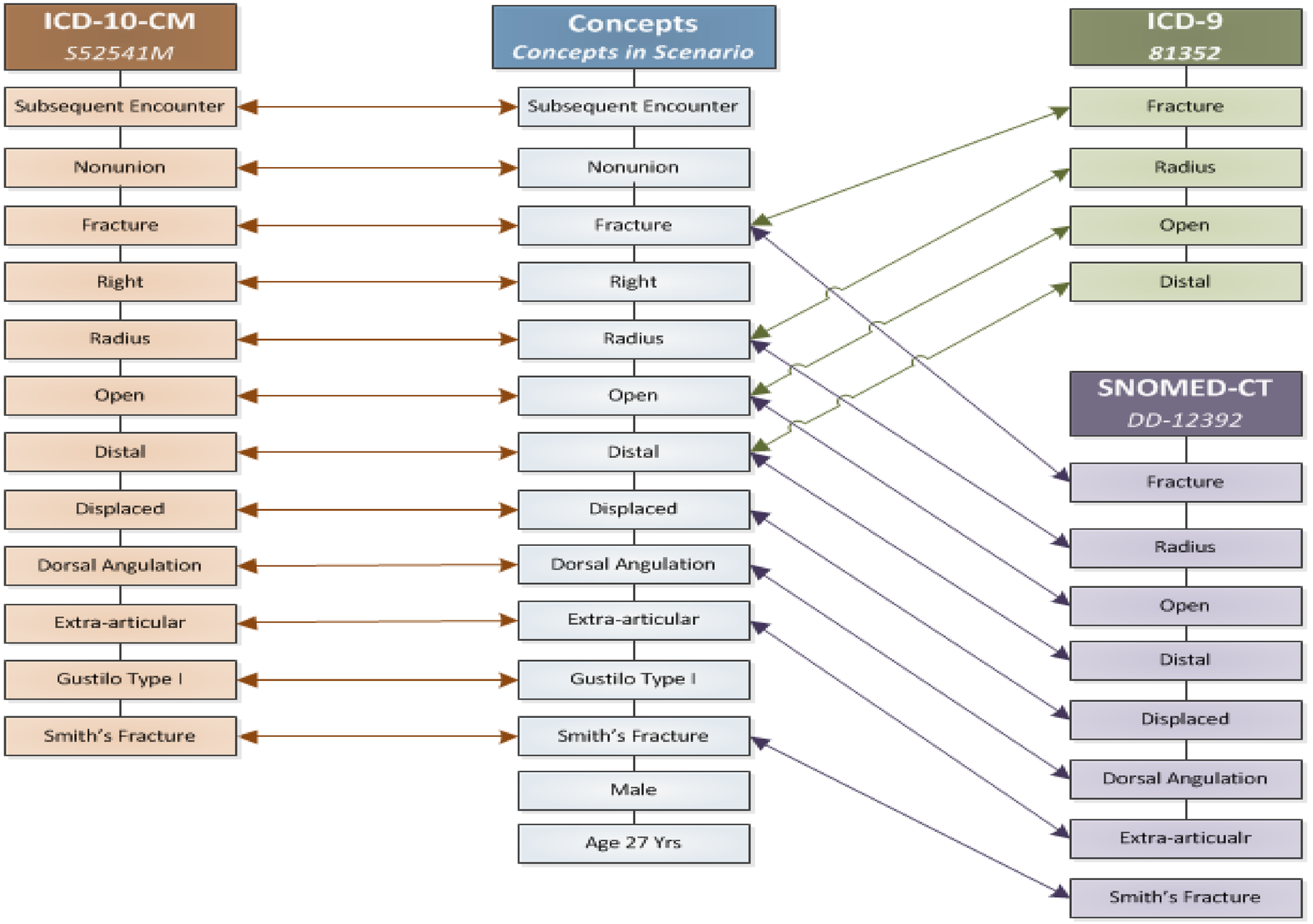
A [27 year old] [male] patient is seen in [follow-up] for a [Smith's fracture] on the [right] that was exposed through an [open wound] with [minimal opening and minimal tissue damage]. The fracture has [not healed after 6 months].

Though not explicitly stated in this scenario certain expressions imply other concepts:

"Smith's fracture" >> [fracture], [radius], [distal], [dorsal angulation], [extra-articular], [displaced]

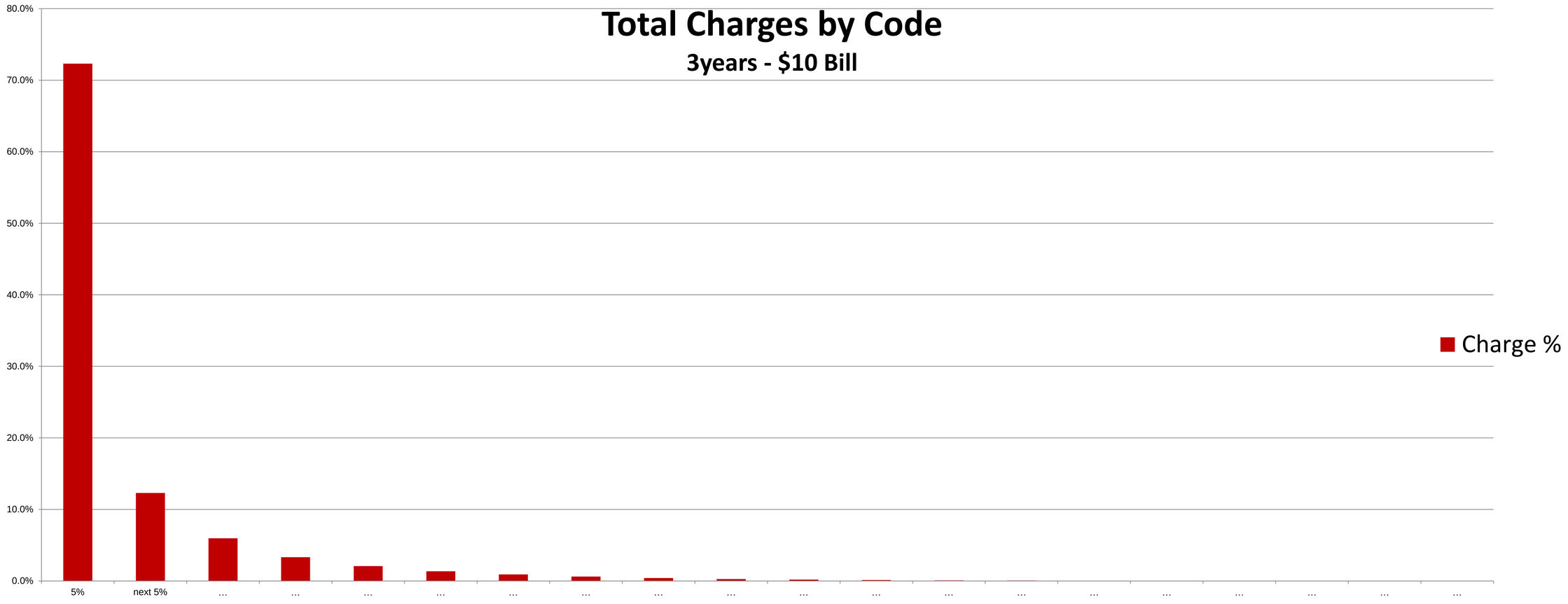
"minimal opening and minimal tissue damage" >> [Gustilo classification I]

"not healed after 6 months" >> [nonunion]



Source: Health Data Consulting Inc.

Historical Distribution of ICD-9 Diagnosis Codes



Source: Health Data Consulting Inc.

Coding Specificity

Code Type	Claims	Total Charges	%Claims	%Charges
All Professional Claims	*15,352,056*	*$ 4,030,052,634*	*100%*	*100%*
‘Unspecified’ (and not ‘Other’ or ‘Symptom or Finding’)	2,902,691	$ 709,765,341	19%	18%
‘Other’	1,917,163	$ 509,694,935	12%	13%
‘Symptom or Finding’	3,530,464	$ 675,662,073	23%	17%
Total 'Unspecified', 'Other' and 'Symptom or Finding'	8,350,318	$ 1,895,122,349	54%	47%

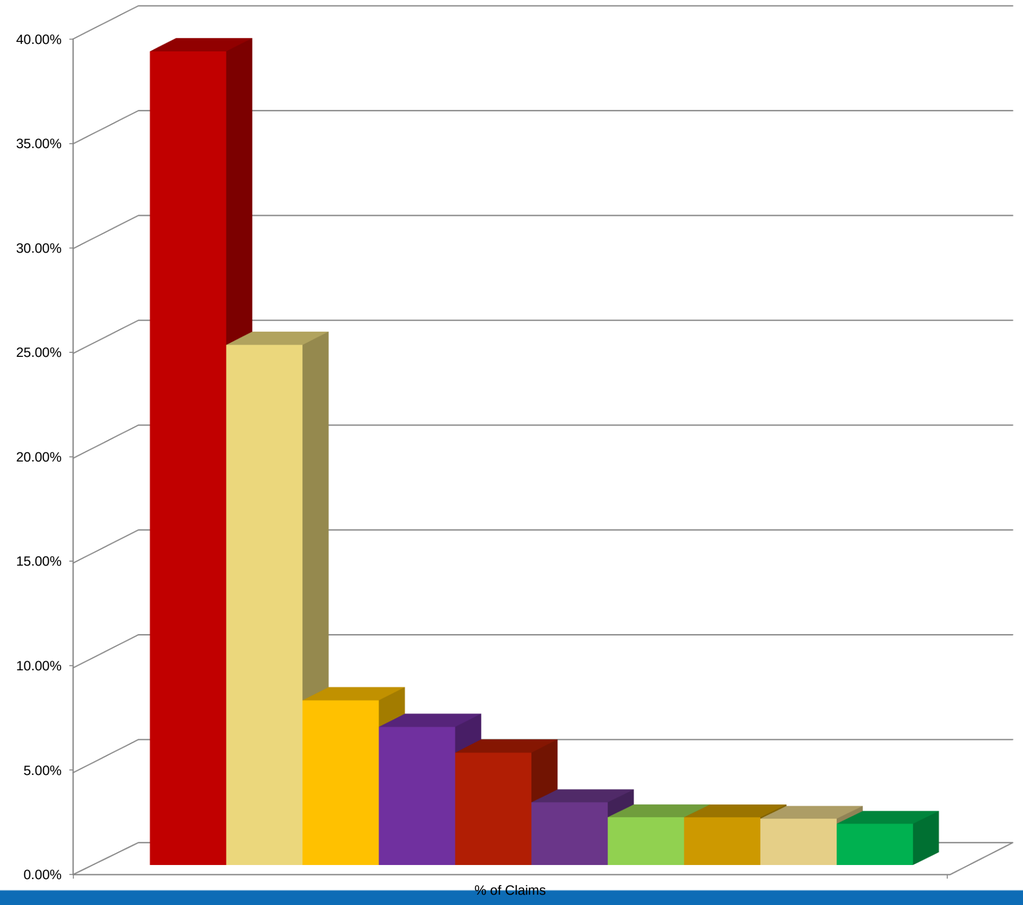
Source: Health Data Consulting Inc.

Coding Specificity

Code	Description	Total Charges	Claims
78900	Abdominal pain, unspecified site	$ 29,331,412	123,737
71946	Pain in joint, lower leg	$ 22,973,230	96,786
7295	Pain in limb	$ 13,668,722	78,505
78605	Shortness of breath	$ 12,533,909	43,463
9597	Knee, leg, ankle, and foot injury	$ 9,979,457	41,707
7862	Cough	$ 9,250,724	77,430
7851	Palpitations	$ 8,181,439	28,228
7820	Disturbance of skin sensation	$ 6,531,675	18,238
78060	Fever, unspecified	$ 5,269,369	32,603
7823	Edema	$ 2,772,549	16,450

Source: Health Data Consulting Inc.

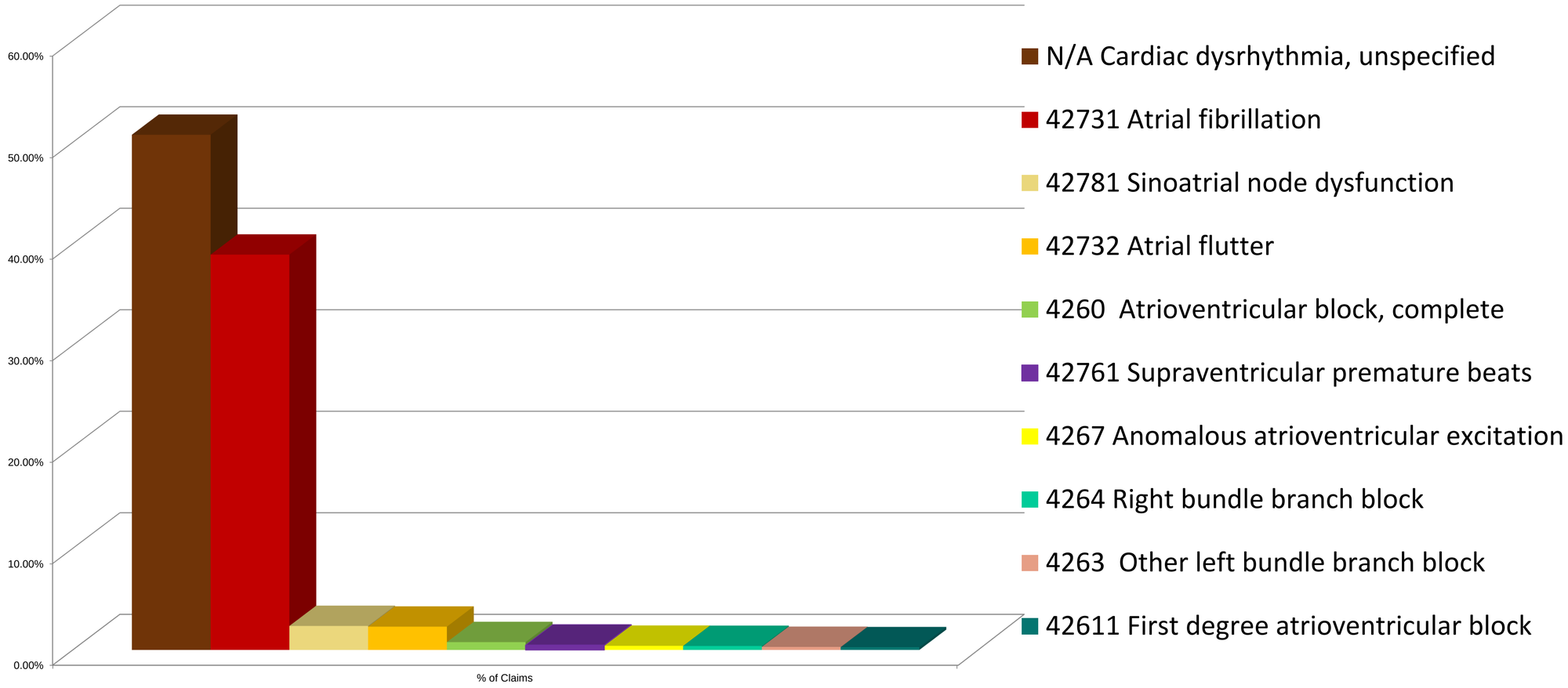
Coding Patterns



- 42731 Atrial fibrillation
- 7851 Palpitations
- 42789 Other specified cardiac dysrhythmias
- 7850 Tachycardia, unspecified
- 4279 Cardiac dysrhythmia, unspecified
- 4270 Paroxysmal supraventricular tachycardia
- 42769 Other premature beats
- 42781 Sinoatrial node dysfunction
- 42732 Atrial flutter
- 4271 Paroxysmal ventricular tachycardia

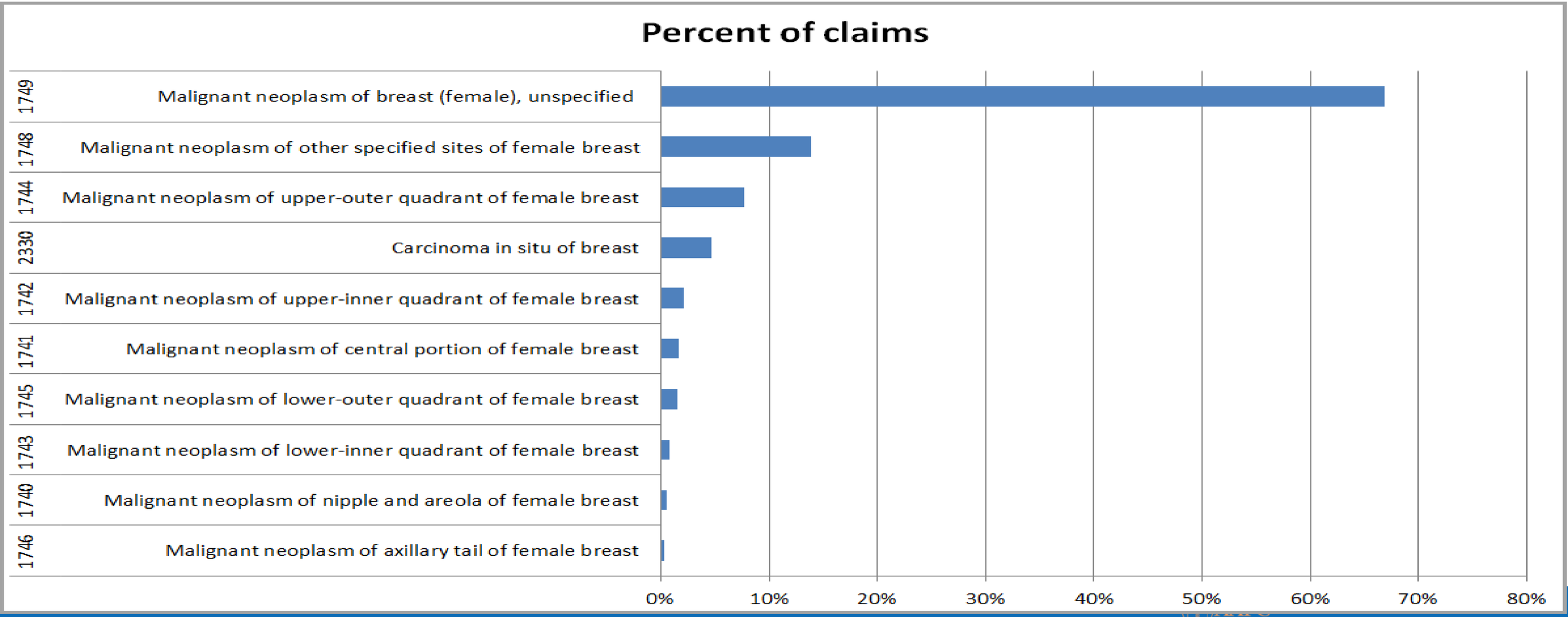
Source: Health Data Consulting Inc.

Coding Patterns



Source: Health Data Consulting

Coding Patterns



Source: Health Data Consulting Inc.


RISK

Healthcare Risk

What does it mean?

- Financial Risk

  The risk that payment for the care of a population will not meet the financial requirements to deliver that care

- Clinical Risk

  The risk of an undesired outcome for the patient relative to the baseline status of the patient's health condition

Financial Risk

Requirements

- Identify the types of conditions within the population
- Stratify the population based on historical cost experience
  - Assigning patients to a category based on historical data
  - Reconciling multiple assignments to the greatest risk
- Adjusting for risk, severity and complexity based on historical experience

Clinical Risk

Requirements

- Patient focused
- Understanding individual risk requires:
  - The specific definition of the patient condition or diagnosis
  - The level of severity of the condition
  - Co-morbid condition(s) that may impact outcomes
  - The availability of proven and effective treatment modalities for that condition
  - The ability of the patient to comply with recommended care
  - Resources available for care

Healthcare Risk

It’s all about the data

Without detailed, accurate and complete data about the patient’s condition, management of both clinical and financial risk will fail.

Risk Adjustment

Data Requirements

- Accurate
- Complete
- Specific
- Properly attributed
- Properly categorized
- Adequate sample size
- Hierarchal assignment
- Standardization

Attributing Risk

- What are the parameters that define the patient health state?
- To what degree did the patient health state influence the likelihood of a desirable outcome?
- To what degree did the patient health state impact the cost of care?
- How is risk attributed to the patient?
- How is risk attributed to the provider?

Hierarchal Condition Categories

HCCs

- CMS-HCCs
  - Focused on premium adjustment for Medicare Advantage
  - Introduced in 2004
  - 79 clinical code categories based on Medicare claims
- HHS-HCCs
  - Categories defined to support Medicaid exchange risk adjustment
  - Introduced in 2014
  - Proposed for risk adjustment and provider resource metrics under MACRA
  - 126 clinical code categories based on commercial claims

Hierarchal Condition Categories

Stated Principles

1. Clinically meaningful
2. Predict medical expenditures
3. Adequate sample size
4. Hierarchal classification
5. Encourage specific coding

Hierarchal Condition Categories

Stated Principles

6. Discourage coding proliferation
7. No punishment for additional diagnosis
8. Internal consistency
9. Classification of all ICD-9 and ICD-10 codes
10. Exclude discretionary codes

Risk Adjustment Challenges

- Poor historical data quality
- ICD-9 to ICD-10 transition
- Insufficient granularity
- Incomplete definitions
- Lack of clinical relevance
- Lack of homogeneity
- Focused on premiums

Hierarchal Condition Categories

Exclusions

HCC	Exclude	HCC Description
8	9 ,10 ,11 ,12 ,13	Metastatic Cancer
9	10 ,11 ,12 ,13	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
10	11 ,12 ,13	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
11	12 ,13	Colorectal, Breast (Age < 50), Kidney, and Other Cancers
12	13	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
13		Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors

Business Impacts

Diagnosis impacts?

- Quality measures
- Resource use (cost) measures
- Adjustments for risk, severity and complexity
  - Quality measures
  - Outcomes, complication, potentially preventable re-admissions
  - Efficiency / utilization measures
- Current and evolving payment models dependent on conditions and outcomes of care

Source: Health Data Consulting

Hospital Payment Impacts

Scenario		
56 year old male is admitted for treatment of a ruptured abdominal aortic aneurysm. The patient demonstrated a drop in blood pressure of 40 mm of mercury shortly after admission and was noted to have minimal urinary output. The patient was also noted to have tachypnea, tachycardia and signs of decreased peripheral perfusion. He had a dramatice drop of his hematocrit to 22.		
Variation 1	**Documentation and Coding**	**Payment**
Primary Dx	I713 -Abdominal aortic aneurysm, ruptured	
Secondary Dx	D62 - Acute posthemorrhagic anemia	
Secondary Dx	I959 - Hypotension, unspecified	
Primary Proc	04R00JZ - Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach	$ 19,121
Variation 2	**Documentation and Coding**	**Payment**
Primary Dx	I713 -Abdominal aortic aneurysm, ruptured	
Secondary Dx	D62 - Acute posthemorrhagic anemia	
Secondary Dx	R571 - Hypovolemic shock	
Primary Proc	04R00JZ - Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach	$ 28,391
Variation 3	**Documentation and Coding**	**Payment**
Primary Dx	I713 -Abdominal aortic aneurysm, ruptured	
Secondary Dx	D62 - Acute posthemorrhagic anemia	
Secondary Dx	T8110XA - Postprocedural shock unspecified, initial encounter	
Primary Proc	04R00JZ - Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach	$ 19,121

Source: Health Data Consulting Inc.

Current Distribution of ICD-9 diagnosis codes

Code	Long Description	Claim count	% of claims
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	412,178	54.19%
25001	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled	83,961	11.04%
25002	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled	76,814	10.10%
25003	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled	36,021	4.74%
	Total	608,974	80.07%

Source: Health Data Consulting Inc.

Hospital Payment Impacts

Scenario		
23 year old female is admitted for control of her Type II diabetes. She is noted at the time of admission to have findings of hyperosmolarity and hyperglycemia. The patient does not have significant alteration in mental status.		
Variation 1	**Documentation and Coding**	**Payment**
Primary Dx (9)	25000 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	$ 3,388
Variation 2	**Documentation and Coding**	**Payment**
Primary Dx(10)	E1165 - Type 2 diabetes mellitus with hyperglycemia	$ 7,786
Secondary Dx(10)	E1100 - Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	

Concept Based Analysis

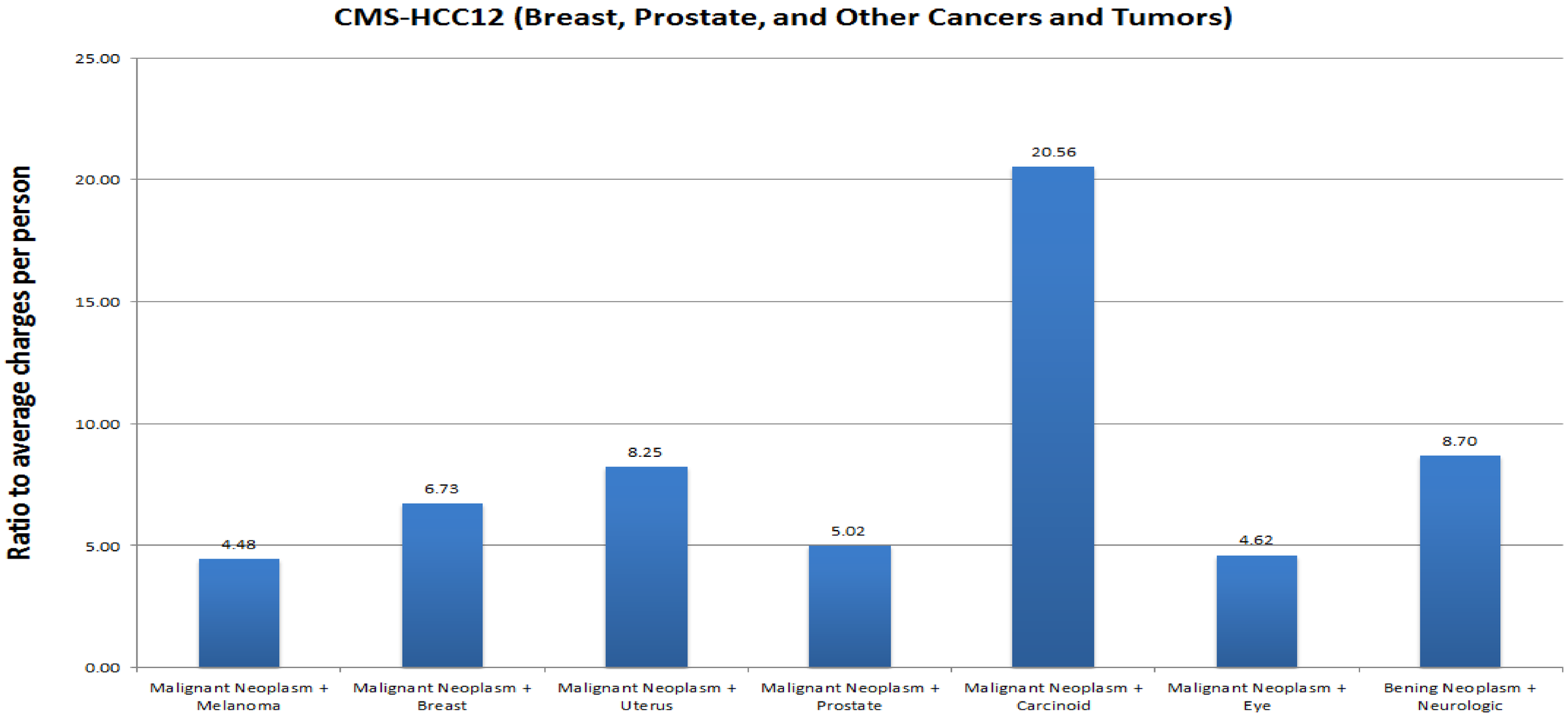
Condition Parameter	Per person charges*	Ratio to Average**
Diabetes	$35,341	2.90
Diabetes + Retinopathy	$69,424	5.69
Diabetes + Retinopathy + Proliferative	$118,654	9.73

** Average total of all claim charges for a person with any claim in this diagnostic category*

*** Ratio of the average total of all claim charges for a person with any claim in this diagnostic category compared to the average for all persons for all claim charges ($12,200)*

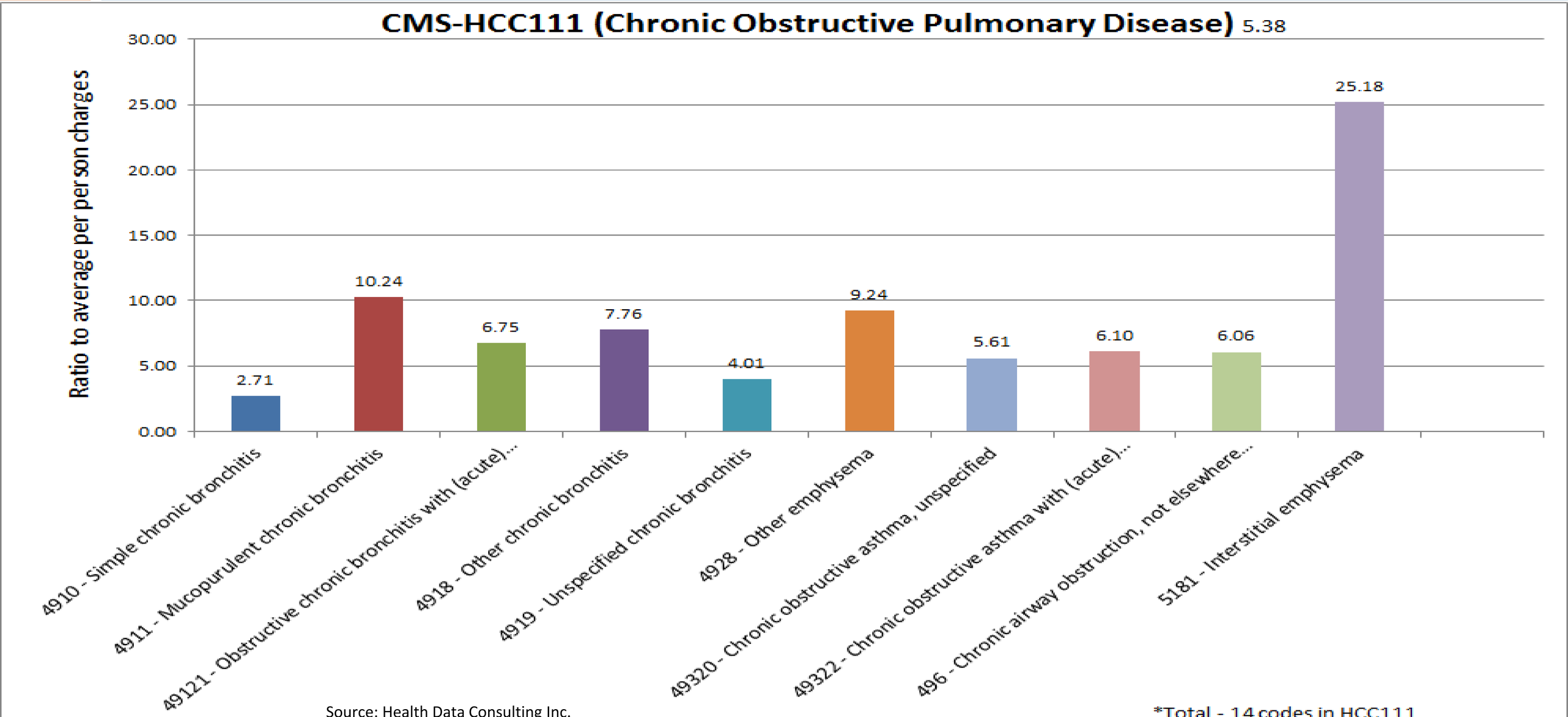
Source: Health Data Consulting Inc.

Concept Based Analysis



Source: Health Data Consulting Inc.

Concept Based Analysis



Source: Health Data Consulting Inc.

*Total - 14 codes in HCC111

Creating a data environment for success

Preparing for success and good patient care

- Establish the value of good documentation and good coding for your organization
- Focus on good patient care
  - Good patient care always require good patient data
- Create more efficient ways to collect data
- Know more about your data than anyone else

Preparing for success and good patient care

Reducing the burden of documentation

- There are a limited number of clinical concepts
  - For each clinical condition there are a finite set of clinical parameters that need to be captured from the perspective of ICD-1
  - Most of these condition factors recur in many different codes
- The physician does not need to capture everything
  - He/she must review and agree with data captured in other ways in the office

Preparing for success and good patient care

Reducing the burden of documentation

- Use other resources to capture data
  - Patient intake forms
  - Trained nursing assistance and medical assistant interviews
- Prompting for the right stuff
  - Documentation requirements are condition specific
  - Forms and templates can help remind physicians about key concepts

Preparing for success and good patient care

- Always focus on your value proposition
- Understand the risk severity and complexity of what you do
- Don’t get caught up in the negatives
- Participate in advocacy for what you do
- If you want a better solution, be part of it

Avoid Common Pitfalls

- Just making life easier for the clinician (while a good thing) is not what this is all about
- Don’t believe in magic
  - Technology is great, but no substitute for the human brain
  - Don’t believe anything without good evidence
- Don’t push the envelope on fraud, waste and abuse
- Templated text and “copy and paste” can be a trap

The Pitfall of copy and past

Does it accurately reflect what you observed?

Palmetto Medical Cloning Policy (CMS MAC Payer)

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

*Source: http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-B~8MKQK88358

Summary

- The concept of “Value” is changing healthcare policy, payment and measures
- The focus is shifting from services to health conditions
- Accurate, complete, standardized and reliable data about the patient’s health condition is critical to success
- Organizations should focus on improving the quality of transactional data at its source

Sometimes the choice is clear…

Questions?

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Health Data Consulting

Thank you !

* Please remember to complete your online session evaluations.