Thinking Outside the Inpatient Box: Preparing for the Future with Clinical Documentation Improvement in the Ambulatory Care Setting
Presenters Today

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Agenda

– What are the Drivers of Ambulatory CDI?
– Inpatient vs. Ambulatory CDI
  – Similarities and Differences
– Developing an Ambulatory CDI Strategy
  – Risks and Opportunities
  – Best Practices and Critical Success Factors
– Ambulatory CDI Models
  – Model Considerations and Options
– Value to Patient and Provider
– Summary
Why is Advancing CDI Beyond the Inpatient Walls a Strategic Imperative?

– Healthcare reform driven by the Affordable Care Act (ACA) is geared to improve quality, affordability and access to care through the key focus areas below.
  – Transition to value-based payment
  – Improve care delivery through innovation
  – Expand information sharing including increased transparency on cost and quality for better consumer decision making
– Increased regulatory oversight and scrutiny
– Shift to outpatient services
Accelerated Transition To Value-Based Payment

## Impact on Providers

### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Category 2:</th>
<th>Category 3:</th>
<th>Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service—No Link to Quality</td>
<td>Fee for Service—Link to Quality</td>
<td>Alternative Payment Models: Built on Fee-For-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td><strong>Limited in Medicare fee-for-service</strong></td>
</tr>
<tr>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td><strong>Majority of Medicare payments now are linked to quality</strong></td>
</tr>
<tr>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td><strong>Hospital value-based purchasing</strong></td>
</tr>
<tr>
<td>Payment is not directly triggered by service delivery or volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)</td>
<td><strong>Physician Value-Based Modifier</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Readmissions Hospital Acquired Condition Reduction Program</strong></td>
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<td><strong>Accountable care organizations</strong></td>
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<td><strong>Medical homes</strong></td>
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<td><strong>Bundled payments</strong></td>
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<td><strong>Comprehensive primary care initiative</strong></td>
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<td><strong>Comprehensive ESRD</strong></td>
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<td></td>
<td><strong>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Eligible Pioneer accountable care organizations in years 3-5</strong></td>
</tr>
</tbody>
</table>

Center for Medicare & Medicaid Innovation
Physician Payment: Value Modifier and PQRS

For CY 2017 payment adjustment, physician solo practitioners and physician groups with 2+ EPs

PQRS Reporters – 3 types
1a. Group reporters – Register for GPRO Web Interface, Registry, or EHR AND meet the criteria to avoid the 2017 PQRS payment adjustment OR
1b. Individual reporters in the group – at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.
2. Physician Solo practitioners - Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.

Non-PQRS Reporters
Do not register for GPRO Web Interface, registry, or EHR or 50% EP threshold OR do not avoid the 2017 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

-2.0% (for groups with 2-9 EPs and solo practitioners)
-4.0% (for groups with 10+ EPs) (Automatic VM downward adjustment)

Groups with 2-9 EPs and solo practitioners
Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

Groups with 10+ EPs
Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

Note: The VM payment adjustments are separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Source: 2015 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS/MLN National Provider Call, 12/02/14
Timeline for Phasing in the VM

Source: How to Register for the PQRS Group Practice Reporting Option in 2015, CMS/MLN National Provider Call, 04/16/15
Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: New Mandates

MACRA amends section 1848(a)(8)(A) of the Social Security Act affecting the quality reporting programs

- PQRS ends in 2018, certain aspects of the program may be incorporated under the new incentive program
- EHR Meaningful Use Incentive payments will be made under MIPS as below
- Value-based payment modifier adjustments will be combined under MIPS as below
- Payment Modifier will not be applied for items and services furnished on or after January 1, 2019

MACRA created the Merit-Based Incentive Payment System (MIPS) and incentive payments for participation in eligible alternative payment models beginning in 2019

MIPS replaces the sustainable growth rate

Components of the MIPS include:

- MIPS Adjustment Factor/Scoring
  - Composite Performance Score
  - Performance Threshold

Source: CMS Quality Reporting Programs under the 2016 Medicare Physician Fee Schedule Proposed Rule, CMS/MLN National Provider Call, July 16, 2015
Merit-Based Incentive Payment System (MIPS)

- MIPS adjustment factor is for each MIPS EP/year in the form of a percentage
- Determined by comparing the composite performance score to the performance threshold
- Scoring is either positive, negative, or zero
- Aggregate Application of MIPS Adjustment for additional performance threshold for exceptional performance
  - Scaling Factor will apply to ensure budget neutrality requirement is met
- In addition to the MIPS Adjustment Factor, EPs can earn an additional positive percent (EPs composite performance score has to be ≥ to the performance threshold)
  - 2019 - 4%
  - 2020 - 5%
  - 2021 - 7%
  - 2022 and beyond 9%

Source: CMS Quality Reporting Programs under the 2016 Medicare Physician Fee Schedule Proposed Rule, CMS/MLN National Provider Call, July 16, 2015
MACRA: Promotes Alternative Payment Models (APMs)

Provisions include:

- Increasing transparency of physician-focused payment models
- Criteria and process for submission and review of physician-focused payment models
- Incentive payments for participation in eligible APMs
- Encouraging development and testing of certain models
- Integrating Medicare Advantage alternative payment models
- Study and report on fraud related to APMs under the Medicare program

Incentive payments for participation in eligible alternative payment models:

- Types of APMs include: medical homes under 1115A, shared savings program under section 1899, a demonstration under section 1866C and a demonstration required by Federal law.
- Some demonstrations and models are excluded (health care innovation award)
- “Eligible APM entities” participate in eligible APMs that:
  - Require the use of certified EHR technology
  - Provide for payment for covered professional services based on quality measures comparable to measures under the MIPS performance category, and
  - Bear financial risk for monetary losses under the APM that are in excess of a nominal amount or are medical homes expanded under 1115A(c)
So Who’s Watching?

<table>
<thead>
<tr>
<th>Federal Government Audit Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT</td>
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<tr>
<td>DOJ</td>
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<tr>
<td>HEAT</td>
</tr>
<tr>
<td>MAC</td>
</tr>
<tr>
<td>Medicaid RAC</td>
</tr>
<tr>
<td>MFCU</td>
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<tr>
<td>MIC</td>
</tr>
<tr>
<td>MIP</td>
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<tr>
<td>OIG</td>
</tr>
<tr>
<td>OMISS</td>
</tr>
<tr>
<td>PERM</td>
</tr>
<tr>
<td>RAC</td>
</tr>
<tr>
<td>ZPIC</td>
</tr>
</tbody>
</table>
### Top 15 Part B Service Types with Highest Improper Payments

<table>
<thead>
<tr>
<th>Part B Services (BETOS Codes)</th>
<th>Projected Improper Payments</th>
<th>Improper Payment Rate</th>
<th>95% Confidence Interval</th>
<th>No Doc</th>
<th>Insufficient Doc</th>
<th>Type of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Codes</td>
<td>$2,092,821,992</td>
<td>6.60%</td>
<td>5.5% - 7.8%</td>
<td>2.50%</td>
<td>87.50%</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>$1,174,125,211</td>
<td>20.70%</td>
<td>18.9% - 22.5%</td>
<td>4.40%</td>
<td>53.90%</td>
<td>Incorrect Coding</td>
</tr>
<tr>
<td>Lab tests - other (non-Medicare fee schedule)</td>
<td>$1,069,657,944</td>
<td>36.10%</td>
<td>30.6% - 41.6%</td>
<td>0.50%</td>
<td>93.60%</td>
<td>Other</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>$1,042,121,031</td>
<td>7.20%</td>
<td>6.2% - 8.2%</td>
<td>3.00%</td>
<td>30.30%</td>
<td>Other</td>
</tr>
<tr>
<td>Hospital visit - initial</td>
<td>$912,148,529</td>
<td>31.30%</td>
<td>29.1% - 33.5%</td>
<td>1.60%</td>
<td>31.50%</td>
<td>Other</td>
</tr>
<tr>
<td>Minor procedures - other (Medicare fee schedule)</td>
<td>$815,527,799</td>
<td>25.50%</td>
<td>21.8% - 29.2%</td>
<td>0.10%</td>
<td>93.30%</td>
<td>Other</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$716,920,640</td>
<td>12.40%</td>
<td>9.4% - 15.5%</td>
<td>0.00%</td>
<td>81.30%</td>
<td>Other</td>
</tr>
<tr>
<td>Office visits - new</td>
<td>$459,363,024</td>
<td>17.10%</td>
<td>14.4% - 19.9%</td>
<td>0.00%</td>
<td>15.90%</td>
<td>Other</td>
</tr>
<tr>
<td>Specialist - psychiatry</td>
<td>$316,246,868</td>
<td>28.70%</td>
<td>21.7% - 35.6%</td>
<td>0.30%</td>
<td>97.20%</td>
<td>Other</td>
</tr>
<tr>
<td>Emergency room visit</td>
<td>$311,925,707</td>
<td>14.30%</td>
<td>11.7% - 16.9%</td>
<td>0.00%</td>
<td>29.10%</td>
<td>Other</td>
</tr>
<tr>
<td>Nursing home visit</td>
<td>$305,949,346</td>
<td>15.80%</td>
<td>13.0% - 18.6%</td>
<td>1.70%</td>
<td>35.80%</td>
<td>Other</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$303,816,558</td>
<td>54.10%</td>
<td>48.9% - 59.4%</td>
<td>2.10%</td>
<td>92.20%</td>
<td>Other</td>
</tr>
<tr>
<td>Hospital visit - critical care</td>
<td>$294,609,764</td>
<td>29.20%</td>
<td>23.6% - 34.9%</td>
<td>0.00%</td>
<td>46.90%</td>
<td>Other</td>
</tr>
<tr>
<td>Other drugs</td>
<td>$217,579,139</td>
<td>3.70%</td>
<td>2.4% - 5.0%</td>
<td>0.00%</td>
<td>97.30%</td>
<td>Other</td>
</tr>
<tr>
<td>Other tests - other</td>
<td>$181,609,537</td>
<td>12.60%</td>
<td>8.6% - 16.5%</td>
<td>0.00%</td>
<td>69.80%</td>
<td>Other</td>
</tr>
</tbody>
</table>

### Medicare FFS 2014 Improper Payments Report
Top 15 Part B Service Types with Highest Improper Payments: Evaluation & Management Services Subset

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<tr>
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<td>53.90%</td>
<td>0.10%</td>
<td>41.30%</td>
<td>0.30%</td>
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<td>0.00%</td>
<td>46.90%</td>
<td>0.00%</td>
<td>47.00%</td>
<td>6.10%</td>
</tr>
</tbody>
</table>

# Improper Payment Rate and Projected Improper Payments

<table>
<thead>
<tr>
<th>Service</th>
<th>Improper Payment Rate</th>
<th>Projected Improper Payments</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>46.30%</td>
<td>$8,457,512,641</td>
<td>42.3% - 50.2%</td>
</tr>
<tr>
<td><strong>Hospital Outpatient</strong></td>
<td>7.30%</td>
<td>$3,305,285,183</td>
<td>4.2% - 10.5%</td>
</tr>
<tr>
<td>SNF Inpatient</td>
<td>5.20%</td>
<td>$1,844,226,232</td>
<td>3.6% - 6.8%</td>
</tr>
<tr>
<td>Clinic ESRD</td>
<td>10.40%</td>
<td>$1,138,589,072</td>
<td>7.7% - 13.1%</td>
</tr>
<tr>
<td>Lab tests - other (non-Medicare fee schedule)</td>
<td>33.80%</td>
<td>$1,001,069,244</td>
<td>28.6% - 38.9%</td>
</tr>
<tr>
<td>Oxygen Supplies/Equipment</td>
<td>58.50%</td>
<td>$897,402,654</td>
<td>55.3% - 61.7%</td>
</tr>
<tr>
<td>Minor procedures - other (Medicare fee schedule)</td>
<td>23.80%</td>
<td>$761,170,506</td>
<td>20.3% - 27.3%</td>
</tr>
<tr>
<td><strong>Hospital Inpatient (Part A)</strong></td>
<td>6.60%</td>
<td>$638,414,585</td>
<td>4.2% - 8.9%</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>11.20%</td>
<td>$633,004,222</td>
<td>9.6% - 12.7%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>10.10%</td>
<td>$582,984,004</td>
<td>7.2% - 13.0%</td>
</tr>
<tr>
<td>Glucose Monitor</td>
<td>48.30%</td>
<td>$573,785,692</td>
<td>44.6% - 52.1%</td>
</tr>
<tr>
<td>CPAP</td>
<td>44.50%</td>
<td>$344,090,083</td>
<td>37.4% - 51.7%</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>2.20%</td>
<td>$315,389,642</td>
<td>1.5% - 2.9%</td>
</tr>
<tr>
<td>Specialist - psychiatry</td>
<td>27.90%</td>
<td>$307,493,947</td>
<td>20.8% - 34.9%</td>
</tr>
<tr>
<td>Hospital visit - initial</td>
<td>9.80%</td>
<td>$286,878,096</td>
<td>7.9% - 11.8%</td>
</tr>
</tbody>
</table>

## Shift To Outpatient Services

### Table 3-1: Growth in Medicare inpatient and outpatient spending

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Inpatient services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FFS payments (in billions)</td>
<td>$110</td>
<td>$119</td>
<td>$118</td>
<td>1.3%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Payments per FFS beneficiary</td>
<td>3,084</td>
<td>3,232</td>
<td>3,192</td>
<td>0.8</td>
<td>-1.3</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FFS payments (in billions)</td>
<td>29</td>
<td>46</td>
<td>49</td>
<td>7.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Payments per FFS beneficiary</td>
<td>884</td>
<td>1,395</td>
<td>1,471</td>
<td>7.9</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Inpatient and outpatient services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FFS payments (in billions)</td>
<td>139</td>
<td>165</td>
<td>167</td>
<td>2.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Payments per FFS beneficiary</td>
<td>3,968</td>
<td>4,627</td>
<td>4,663</td>
<td>2.6</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Note: FFS (fee-for-service). Reported hospital spending includes all hospitals covered by Medicare’s inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Fiscal year 2013 payments include partial imputation to account for hospitals that typically do not submit their cost reports to CMS before CMS makes the most recent year available to the public. The combined inpatient and outpatient services per capita are based on a weighted average of Part A and Part B beneficiaries.


Shift To Outpatient Services

**Figure 3-1**
Medicare inpatient discharges per beneficiary declined as outpatient visits per beneficiary increased

**Table 3-2**
E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

<table>
<thead>
<tr>
<th>Service</th>
<th>HOPD</th>
<th>Freestanding office</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M office visits</td>
<td>10.7%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Echocardiography</td>
<td>34.6</td>
<td>7.4</td>
</tr>
<tr>
<td>Nuclear cardiology</td>
<td>39.0</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Note: E&M (evaluation and management), HOPD (hospital outpatient department). E&M office visits include Current Procedural Terminology codes 99201-99215. Echocardiography includes services in ambulatory payment classification (APC) 0269, APC 0270, and APC 0697. Nuclear cardiology includes services in APC 0377 and APC 0398.


CDI in the Ambulatory Setting
Ambulatory CDI (AKA Outpatient CDI)

– Goals and Objectives:
  – To ensure complete, accurate, and compliant clinical documentation, coding and billing resulting in an accurate reflection of patient severity, the level of services provided, quality of care delivered, and reimbursement.
Inpatient CDI ≠ Ambulatory CDI

– Key differences in the ambulatory setting:
  – Volumes are significantly higher.
  – Timeframes for episodes of care are significantly shorter.
  – Multiple and different code sets, guidelines, claim forms, and payment methodologies depending on ambulatory setting.
  – Role of non-physician documentation.
Inpatient CDI ≠ Ambulatory CDI

– Key differences in the ambulatory setting (cont.):
  – Setting specific workflows, roles, and operational differences.
  – Deeper involvement and more complexity in the revenue cycle.
    – Clinical documentation
    – Coding
    – Billing
    – Payment
Ambulatory CDI Strategy: Where to Begin?

– Three broad areas of opportunity:
  – OPPS/ASC
    – Hospital-based outpatient departments, clinics, or centers
    – Community-based ambulatory care, surgery and diagnostic procedure centers
  – Physician Fee Schedule
    – Hospital/Health System (HS) Employed Physician Group Practices
    – Private Independent Physician Group Practices
  – Risk Adjustment (RA) Payment Methodologies
    – Hospital/HS that:
      – Own a Medicare Advantage (MA) health plan
      – Employ physicians with MA contracts that include RA score incentives
      – Participate in an ACO.
Ambulatory CDI Strategy: Where to Begin?

- Key general discovery questions about these three areas:
  - How is clinical documentation captured?
  - What is the coding process?
  - What is the billing process?
  - Who oversees the revenue cycle?
  - Are the physicians employed or private practice?
  - What are the driving concerns for the areas:
    - Claim denials
    - Adverse external audits/compliance concern
    - Revenue generation/underperformance
    - AR Days
    - New service line
    - Regulatory changes
- Additional questions applicable to RA
  - MA health plan ownership or ACO participation?
  - Employed physician incentives?
Ambulatory CDI Strategy: Where to Begin?

– Analyze your claims denials for patterns and trends to narrow down your focus.
– If under Risk Adjustment, what does your aggregate Risk Adjustment Factor score tell you?
– Prioritize the area that will bring most value to the organization and then stay focused.
Best Practices and Critical Success Factors

– Auditing
  – Best practice includes regular, periodic external audit by credentialed specialty coder/auditor
  – Include high risk compliance target areas in addition to areas exposed by denial analysis
  – Assess clinical documentation, coding, billing, and remittance advice for end-to-end evaluation
    – Uncovers risks as well as missed opportunities due to undercoding/underbilling
    – Answers the “why”? Is deficiency due to insufficient clinical documentation, coding error, or billing error
  – Identifies systems issues, educational needs, etc.
Best Practices and Critical Success Factors

– Education/Training
  – Based on audit findings/assessed needs
  – Routine education on general and specialty specific Fed/State regulations and guidelines, as well as private payer policies
  – Organizational policies/procedures including compliance program and ethics
  – Peer-to-peer and/or interdisciplinary education targeted to audience
Best Practices and Critical Success Factors

- Engagement and collaboration
  - Leadership: Executive, physician, department/practice, CDI, HIM, revenue cycle, quality, IT
  - Physicians/Non-physician providers
  - Staff: Department/Practice, coding, billing, CDI specialist

- Leverage technology & tools: Current and future
  - Ensure EHR and/or paper templates, forms and flow sheets meet current documentation guidelines; routinely review
  - Speech recognition technology to improve capture of individualized narrative documentation at the point of care
  - Smart text/Documentation prompts and tip sheets
  - CAC
  - CAPD
Best Practices and Critical Success Factors

– Assess and redesign workflows specific to the setting to maximize complete, accurate, efficient and compliant processes with seamless handoffs and minimal rework
  – Pre-visit data collection and preparation
  – Physician vs. coder assignment of codes from documentation
  – Chart completion
– Ongoing data analytics, auditing and monitoring to sustain improvement and proactively identify new issues due to changes in guidelines, rules and regulations
– Formalize your denial management process
Ambulatory CDI Model Considerations

– CDI is an ongoing interdisciplinary process – it is not a single person or role
  – While there may be a specialized role in place or one instituted, it still requires a team approach to be effective
– Approach must be customized to the setting
  – Size/Number of locations
  – Patient volume and pace of work area
  – Length of encounter time
  – Workflow
  – Financial and talent bandwidth
  – Available technology
Ambulatory CDI Model Options

- **Pre-visit Model:**
  - Clinical records from prior visits reviewed prior to patient encounter and physician clarifications sought by CDI specialist before patient is seen
  - Sites to consider: Physician Office with RA payment/incentive, high dollar imaging or surgery/procedures areas
  - Advantages: Proactive real time capture of previously under documented chronic conditions, ensure pre-procedure medical necessity documentation per NCD/LCD is documented

- **Concurrent or Pre-Bill Model:**
  - Clinical records reviewed during or immediately following patient encounter
  - Sites to consider: Those with longer encounter times such as Emergency Department, Observation Unit, Infusion Centers
  - Advantage: Identify issues and resolve during or shortly after encounter but prior to billing to prevent denials/re-work
Ambulatory CDI Model Options

– Retrospective Model:
  – Post bill audit/review with strong focus education, tracking and trending
  – Sites to consider: High volume/short encounter times such as physician offices, labs, or routine radiology; smaller sites with limited resources
  – Advantage: Focused strategy for education, prevention, and mitigation.
CDI Specialist Role

– To date, there been little penetration of the CDI Specialist role into the ambulatory setting.
  – According to a 2014 AHIMA Foundation Clinical Documentation Improvement Job Description Summative Report, which reviewed 337 randomly selected CDI Specialist job descriptions, 99% of the job locations were in the acute care setting.

Source: Clinical Documentation Improvement Job Description Summative Report. 2014. ahimafoundation.org
CDI Specialist Role

– There is no ONE single discipline that will meet the unique needs and challenges across the multiple types of ambulatory settings.
– You must match the skill set to the needs of the setting.
– Creating a cross functional and interdisciplinary team with complimentary skill sets is ideal. For example:
  – Nursing is well suited in RA settings where reviewing complex patient records to uncover missed diagnoses
  – Certified specialty coders are especially well suited in specialty procedure areas due to their CPT coding knowledge
Clinical Documentation Improvement is no longer relegated to the Inpatient setting. Future success will require CDI across the care continuum

- Mitigate the financial risks associated with deficient clinical documentation, over or under-coding and billing and medical record deficiencies.
- Ensure readiness for the increased regulatory environment
- Risk Adjustment Factor alignment with patient acuity and severity
- Identification of patients for inclusion in population health initiatives
- Ultimately—improved….
  - Communication between providers
  - Patient care and outcomes
  - Patient satisfaction
What is Risk Adjustment?

– Risk Adjustment is a form of case mix index used for predictive modeling.

– A corrective tool used by actuaries to level the playing field regarding the reporting of patient outcomes, adjusting for the differences in risk among specific patients.

An actuary is a business professional who analyzes the financial consequences of risk. Actuaries use mathematics, statistics, and financial theory to study uncertain future events, especially those of concern to insurance to manage financial risk.
Why is Risk Adjustment Important?

– It’s a necessary tool for Managed Care Programs
  – Account for changes in severity & case mix over time
  – Accurately set performance targets (quality & efficiency)
  – Provide incentives to enroll high-cost individuals into managed care programs by ensuring health plans/ACOs have the resources needed to provide efficient and effective treatment

– It’s prominent
  – Risk adjustment payment methodologies are used across a variety of government (Federal & state) private & commercial insurance programs

– It’s relevant
  – Risk adjustment is an important element in VBP

– It’s here to stay!
How Prominent is Risk Adjustment?

– 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) (John Hopkins)
  – Chronic Illness and Disability Payment System (CDPS) (Managed Medicaid)
  – Diagnostic Cost Groups (DxCGs)
  – Hierarchical Condition Categories (HCCs)
    – CMS HCCs (Managed Medicare)
    – HHS HCCs (Managed Commercial in Health Insurance Exchange)
What are HCCs?

- HCCs are diagnostic categories assigned based on age, gender, eligibility status (age, disabled, end stage renal disease, PACE) and the ICD-9-CM diagnosis codes from encounter claims to assign patients to different "categories."

- The categories are designed to "bucket" patients that are not only clinically similar but follow similar cost patterns to predict future healthcare costs.
Where should you begin?

Determine scope & depth of opportunity
– Varies based on patient population/insurance type & contracts

**Medicare**
– Does your organization offer their own Medicare Advantage Plan? (aka “Medicare HMO”) *(Full risk contract!!)*
– Do your employed physicians receive incentives from Health Plans with a Medicare Advantage Plan if they improve risk scores?
– Is your facility part of a Accountable Care Organization (ACO)?

**Commercial Health Insurance Exchange Members**
– Does your organization receive incentives from Health Plans within the Commercial HIE if they improve risk scores?

**Medicaid**
– Does your state utilize a risk adjustment methodology for Medicaid patients?
Start with your Inpatient Admissions….

- What insurance types are the CDS’ actively reviewing?
  - Traditional Medicare only?
  - Your own Medicare Advantage members?
  - Medicare Advantage members from other health plans treated by employed providers?
  - Your own ACO members?
  - Commercial Health Insurance Exchange members?
  - Managed Medicaid?
- You will need to take of your “DRG” hat
- Learn and apply the correct methodology
- Educate the key stakeholders; providers, CDS’, coders & HIM
- Consider how you will improve risk score across the care continuum
- Stay up to date with risk adjustment changes
  - Methodology & rates, code sets, coding guidelines
….then capitalize on the opportunities in the ambulatory setting

- Assessment
  - Documentation, Coding, Billing, Medical Record Deficiencies
- Education
  - Based on methodology(ies) in your organization
  - CMS-HCCs, HHS-HCCs, CDPS, etc.
  - Acceptable settings & nuances
    - Acceptable provider types
  - Based on the opportunities identified
    - Diagnosis, member or provider level
    - In general or result of assessment
- CDI Program Implementation
  - Tailored to the setting & prioritized by opportunity
  - Deploy technology & tools to handle the volume
- Data Analytics
  - Create, utilize, validate or enhance
VALUE
Ambulatory CDI Value

– Supports the delivery of quality of patient care by ensuring a complete and accurate medical record.
– Ensures complete, accurate, and compliant clinical documentation that supports the medical necessity and appropriateness of services provided.
– Promote complete, accurate, and compliant assignment of codes based on clinical documentation evidenced in the medical record.
Ambulatory CDI Value

– Promotes complete, accurate, and compliant billing practices.
– Improve documentation to proactively defend against claim denials and adverse audit outcomes.
– Improve documentation to reflect accurate quality and utilization reporting.
Ambulatory CDI Value

– Improve documentation for Value-Based and Risk Adjusted Payment methodologies.
– Improve policies, procedures, and workflows that promote compliant practices and operational excellence.
Implications for CDI/HIM Leaders

– As patient care shifts to the ambulatory/outpatient setting, CDI/HIM leadership responsibilities may expand as well.
– Due to historical inpatient focus of CDI/HIM, ambulatory settings are in desperate need of CDI/HIM expertise.
  – Physician offices are especially in need of information governance assistance by HIM leadership.
– This is an opportunity to expand your skill set and extend your knowledge in an area you may not be unfamiliar with.
Summary

– To position our organizations for future success, CDI efforts cannot stop at the walls of the acute care setting.
– Ambulatory CDI cannot be simply mirrored after inpatient CDI.
– Analyze your data to identify risks and opportunities.
– Be strategic in where you start, customize your approach to fit the setting and achieve objectives, and stay focused.
– Optimize the use of all available technology to effectively capture complete and compliant documentation at the point of care, and efficiently manage the volume of encounters in the ambulatory setting.
– Perform ongoing data analysis and monitoring to maintain success and proactively address new issues as they arise.
Thank you