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hfma washington-alaska chapter
healthcare financial management association

Physician Professional Fee -

Launching a Successful
Clinical Documentation Improvement (CDI) Initiative

February 22, 2017

Agenda

- Clinical Documentation Improvement (CDI)
  - Evolution of CDI
  - Perspective
  - Benefits of CDI Across the Care Continuum
- Assessing Areas of Most Significant Opportunity for Physician Evaluation & Management Leveling
- Physician Professional Fee CDI Initiative Strategies
  - Provider Education
  - Monitor, Measure and Report
  - Hierarchical Condition Categories (HCCs) Review

Evolution of CDI

Primarily focused on DRG assignment and capturing CC/MCC

- Focus primarily on inpatient Medicare cases

Increase focus to include APR SOI/ROM scores

- Focus especially on obtaining a 4/4 score in mortality cases

Increase focus on impact of documentation on quality initiatives

- Healthgrades, VBP, Readmissions, O/E ratios, Vizient, etc.

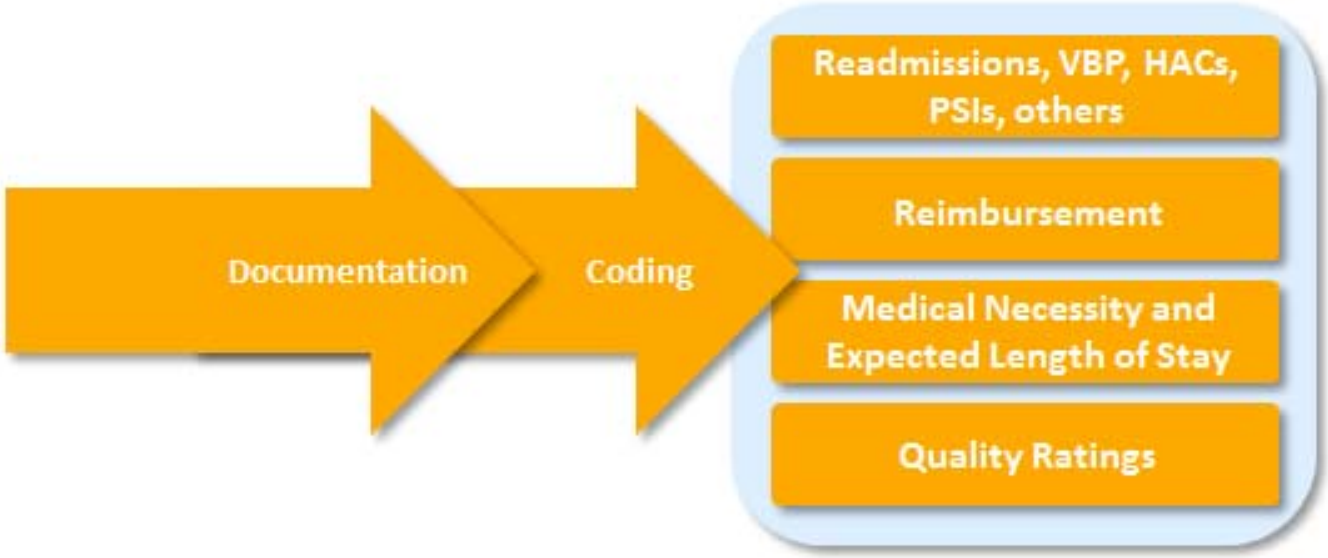
Focus on documentation across the entire care continuum with increased focus on quality

- HCCs, ACOs, Bundled Payments

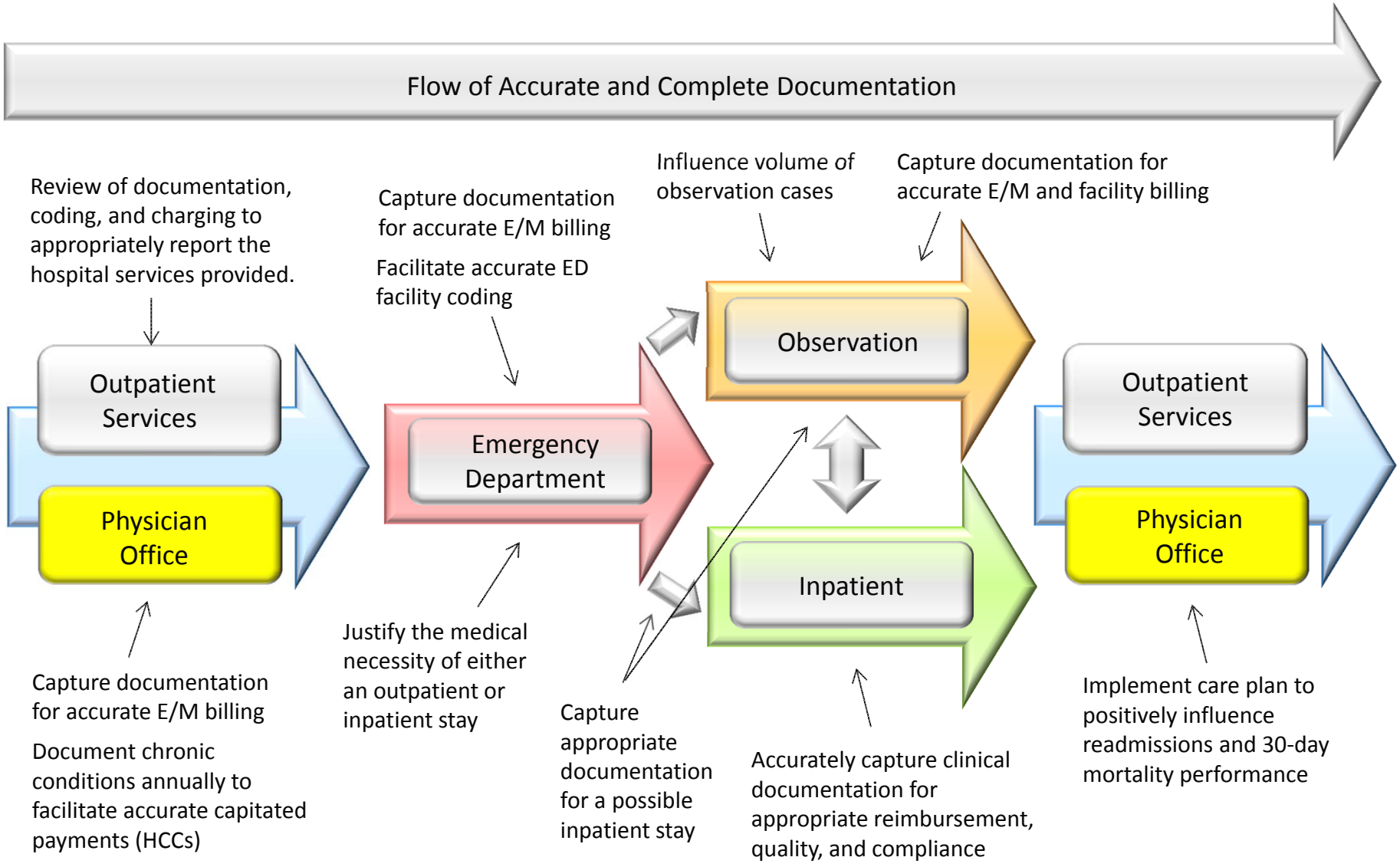
The focus must be on getting EVERY record right EVERY Time

Documentation is Critical to Physician and Hospital Quality Ratings

- Documentation is critical for physicians and hospitals:
- Quality ratings are primarily driven by:
  - Actual quality of care
  - Medical record documentation



Comprehensive CDI – Benefits Across the Care Continuum



Comprehensive CDI – Documentation Perspective

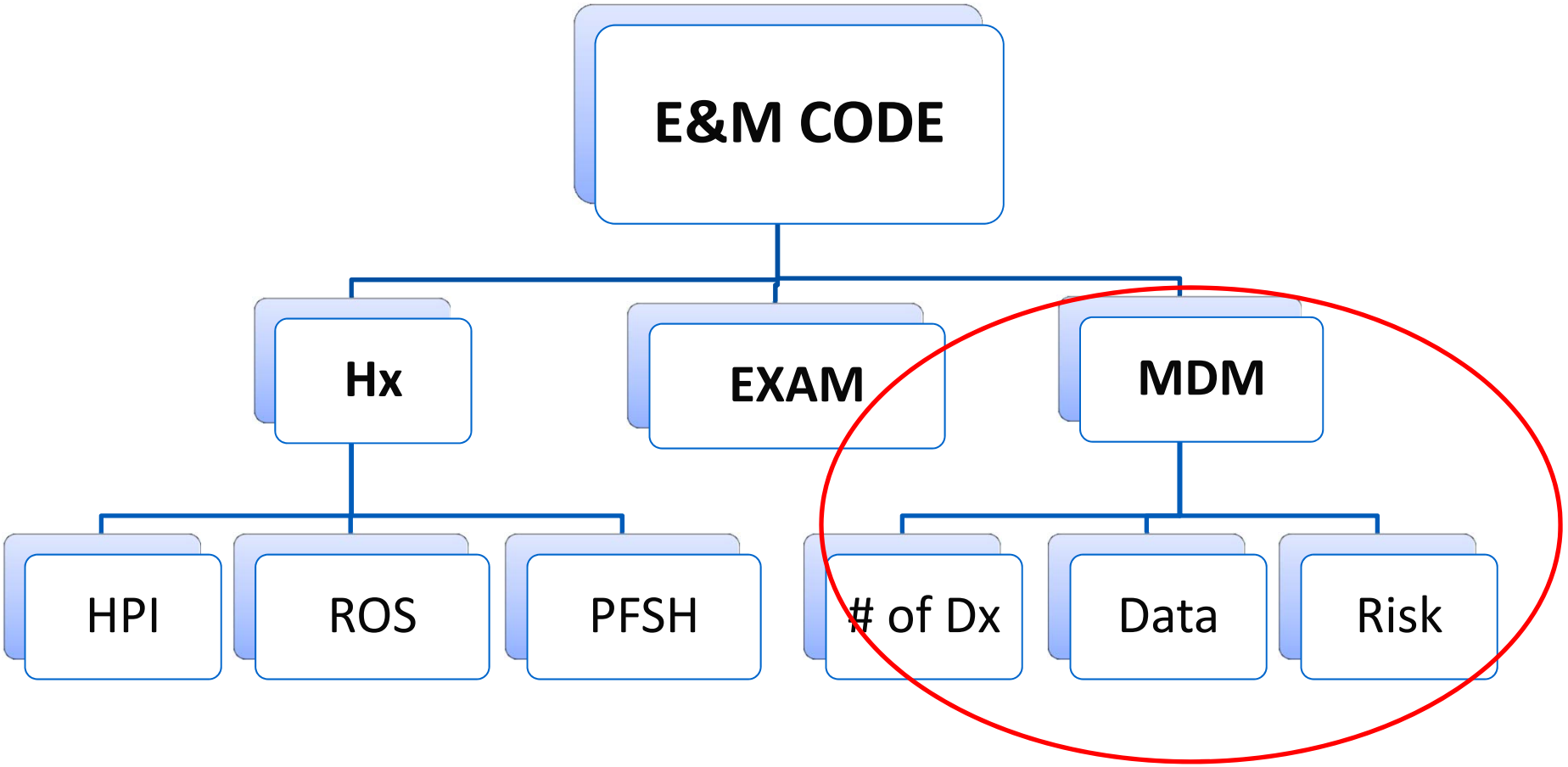
- Documentation guidelines and the clinical purpose are similar irrespective of the place of service
  - While coding/billing guidelines differ between the hospital and physician office; the focus should not be on billing
- **The purpose of physician/nurse documentation is to describe the care being provided to the patient whether in the hospital or office**
  - What is the most accurate diagnosis that describes the patients condition? What is being evaluated, monitored or treated?
  - What diagnostic tests and meds are ordered and what is the interpretation of such?
  - What is important for other care givers to know?
- Overall, the emphasis should be placed on communicating sound clinical information to the care team which meets administrative criteria concurrently

Professional Fee CDI – Documentation Perspective

- Improve the accuracy and completeness of patient records by extending the CDI process to the professional setting to better reflect:
  - Severity or complexity of patients
  - Medical decision making (MDM) or treatment planning
  - Diagnoses captured via delivery of care to patients
  - E/M leveling and RVUs
  - Accurate capture of HCCs for Medicare Advantage plans and other commercial plans
- Consider an initial focus on E/M levels and RVUs to include:
  - Validating the charging/coding for what is currently being billed
  - Identifying opportunities for improved documentation that can impact the E&M billing (what is missing)
- Expand scope to focus on a complete and accurate medical record which would impact risk variables such as HCCs.
  - HCCs utilized in risk adjustment methodology for capitation payments within Medicare Advantage populations
  - Depending on a hospital's contract with the plans (shared savings plan), there can be material revenue opportunity that is passed on to the provider
  - ACOs and other quality organizations are beginning to consider or are already utilizing HCC methodology

Level of Service Selected

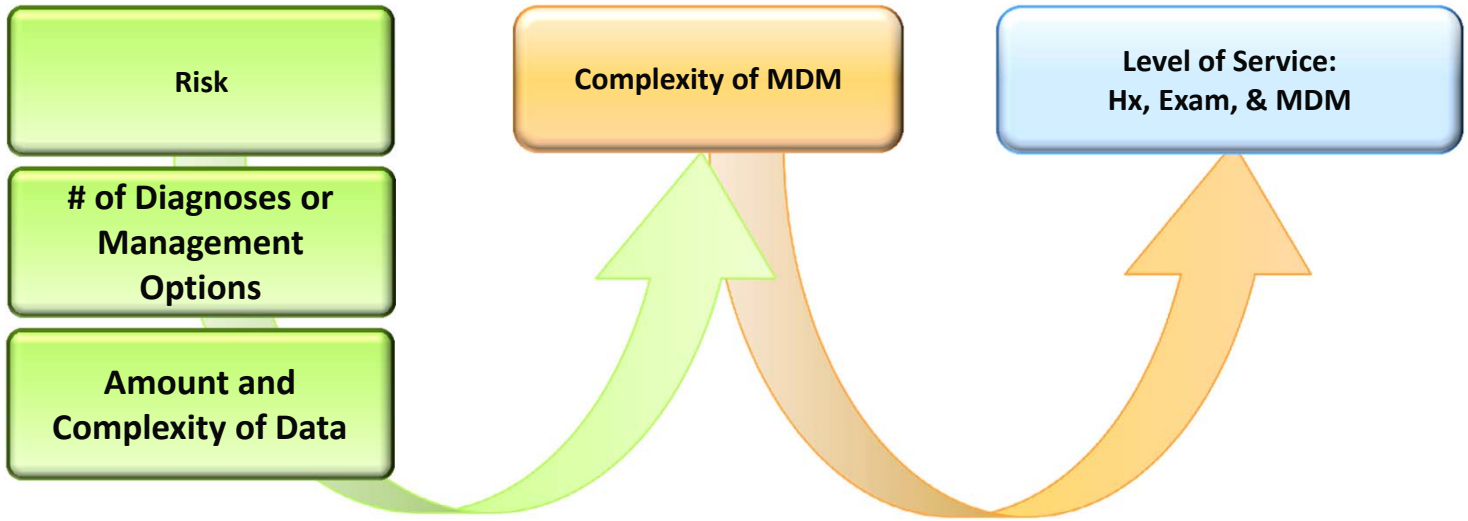
- The level of service selected is a function of History, Exam and Medical Decision Making. For the purposes of this session we will focus on MDM but for all level codes the appropriate history and exam must be documented.



MDM Is Your Guide

- MDM should support the history and exam, and vice versa
- This may seem backwards, but all components are connected by the reason for visit (Chief Complaint) and the complexity of MDM
- *"What is the focus of today's visit?"*

1. Evaluate MDM
2. Check code that supports level of complexity
3. Perform and document appropriate history and exam



Professional Fee CDI – Overview of Opportunity Assessment

- Determine the professional fee settings of care that should be assessed – e.g., office visit, hospital visit, emergency department visit, observation visit
- Perform analysis of physician claims data for a certain period of review
  - Use Medical Practice Benchmarks – MGMA, AMA, MDtools
  - Specialty opportunity analysis based on local and national comparisons
  - Individual providers within specialty groups ranked by weighted average and compared to local and national comparisons
- Perform a targeted chart review across providers for opportunities and accuracy
  - Selected charts across specialties and for E&M levels for all settings of care to be assessed
- Understand provider education team perspectives on current processes and physician billing practices, past reviews and perceived opportunities for improvement
- Understand coding processes and involvement with provider education

Benchmarking Analysis

Professional E & M Comparison
All Specialties; All Payers

- Over 95% of new patient visits are level 3 or below compared to 74% for the local benchmark (21 percentage points lower)

CPT - New Patient Visit						
Specialty	**99201**	**99202**	**99203**	**99204**	**99205**	**Total**
Primary Care	15	693	635	70	7	1,420
ENT	0	0	781	4	0	785
OB	0	0	24	7	0	31
Orthopedic Surgery	0	122	621	0	0	743
Pain Management	0	0	76	1	0	77
Peds	0	18	34	9	0	61
Total	15	833	2,171	91	7	3,117
Distribution	**0.5%**	**26.7%**	**69.7%**	**2.9%**	**0.2%**	**100%**
Local Benchmark Comparison	0.9%	20.8%	52.4%	22.3%	3.6%	100%

- Over 63% of established patient visits are level 3 or below compared to 50% for the local benchmark (13 percentage points lower)

CPT - Established Patient Visit						
Specialty	**99211**	**99212**	**99213**	**99214**	**99215**	**Total**
Primary Care	0	3,475	19,716	15,630	64	38,885
ENT	0	21	347	746	0	1,114
OB	0	13	52	23	4	92
Orthopedic Surgery	0	412	645	174	0	1,231
Pain Management	0	2	203	285	0	490
Peds	0	19	4,273	72	2	4,366
Total	0	3,942	25,236	16,930	70	46,178
Distribution	**0.0%**	**8.5%**	**54.6%**	**36.7%**	**0.2%**	**100%**
Local Benchmark Comparison	2.4%	2.6%	44.6%	46.6%	3.8%	100%

Data includes all payers
Distribution timeframe is January 1, 2016 to December 31, 2016
Local Distribution used is for Primary Care

Professional E & M Opportunity
All Payer

- The following table shows the opportunity for New and Established Office visits vs. local benchmark distribution

E/M Distribution Analysis (1/16 - 12/16)								
Code	Local Benchmark Distribution	Client Visits	Client Distribution	Client Visits at Local Benchmark Distribution	Net Medicare Fee	Revenue at Client	Revenue at Local Benchmark Distribution	Opportunity
New Patient Office Visits								
99201	0.9%	15	0.5%	29	$ 44	$ 660	$ 1,289	$ 629
99202	20.8%	833	26.7%	648	$ 75	$ 62,546	$ 48,680	$ (13,865)
99203	52.4%	2,171	69.7%	1,633	$ 109	$ 236,752	$ 178,081	$ (58,670)
99204	22.3%	91	2.9%	694	$ 166	$ 15,097	$ 115,058	$ 99,961
99205	3.6%	7	0.2%	113	$ 208	$ 1,459	$ 23,521	$ 22,061
Total	100%	3,117	100%			$ 316,513	$ 366,629	$ 50,116
Established Patient Office Visits								
99211	2.4%	-	0.0%	1,113	$ 20	$ -	$ 22,283	$ 22,283
99212	2.6%	3,942	8.5%	1,187	$ 44	$ 173,362	$ 52,192	$ (121,170)
99213	44.6%	25,236	54.6%	20,582	$ 73	$ 1,840,703	$ 1,501,209	$ (339,495)
99214	46.6%	16,930	36.7%	21,519	$ 108	$ 1,834,141	$ 2,331,293	$ 497,152
99215	3.8%	70	0.2%	1,773	$ 146	$ 10,237	$ 259,312	$ 249,076
Total	100%	46,178	100%			$ 3,858,443	$ 4,166,289	$ 307,845
							Total Revenue Impact	$ 357,961

* Projections based on achieving 65%, 75%, 100% and 110% of the local benchmark. Benchmark represents the 50th percentile

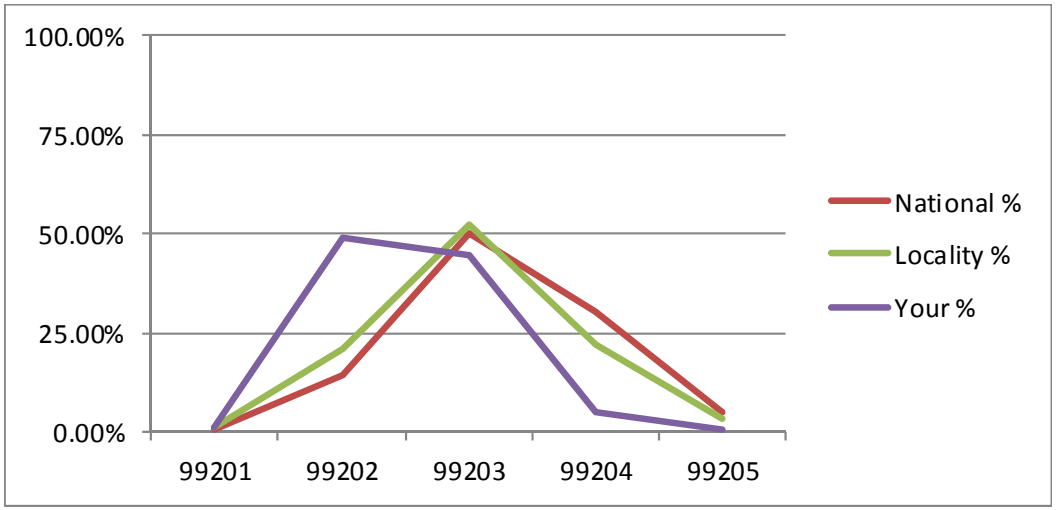
Revenue Projection			
65%	75%	100%	110%
$ 232,675	$ 268,471	$ 357,961	$ 393,757

Note: Net Medicare Fee calculated using the Medicare 2016 RVU calculations.
Local Distribution used is for Primary Care

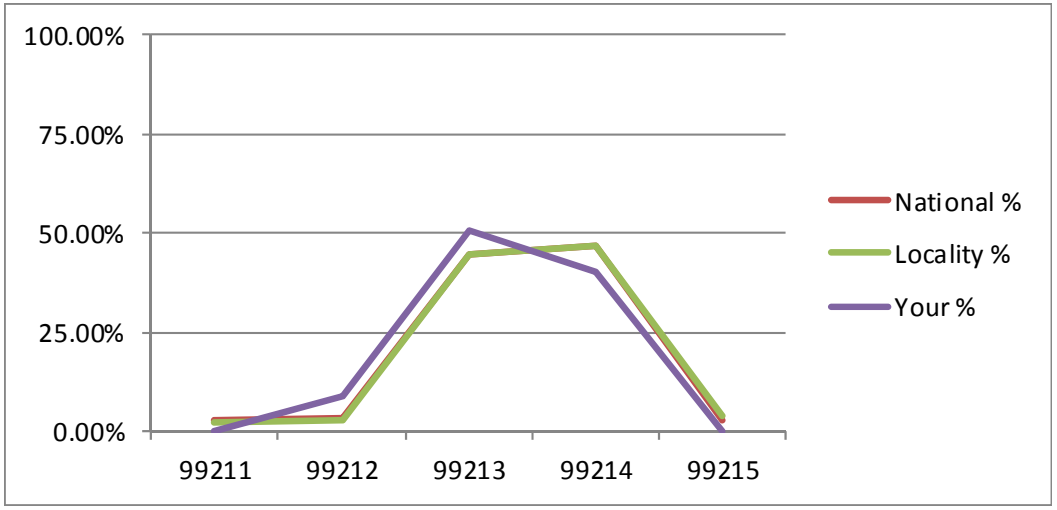
E & M Benchmark Analysis for Primary Care

New & Established Patient Office Visits

New Patients



Established Patients

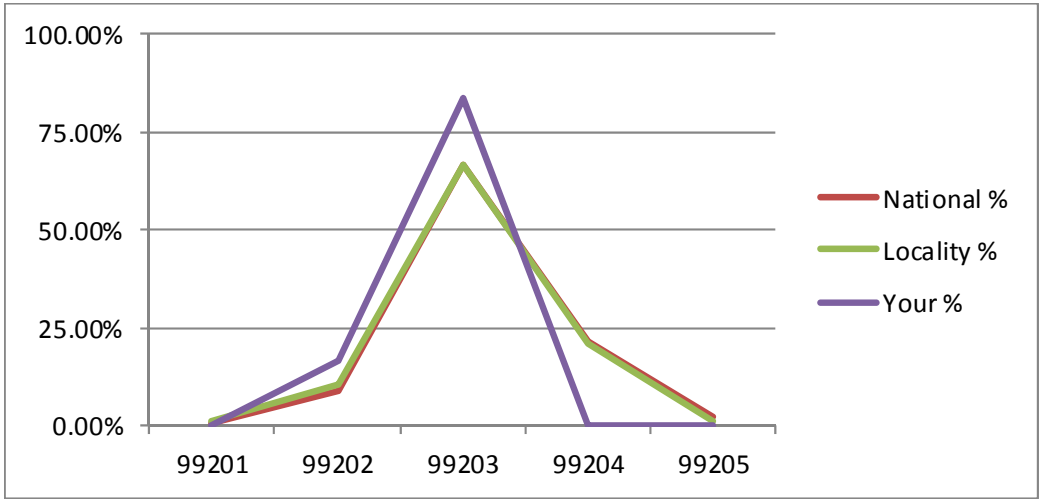


Note: All Payer data 1/1/2016 – 12/31/2016.

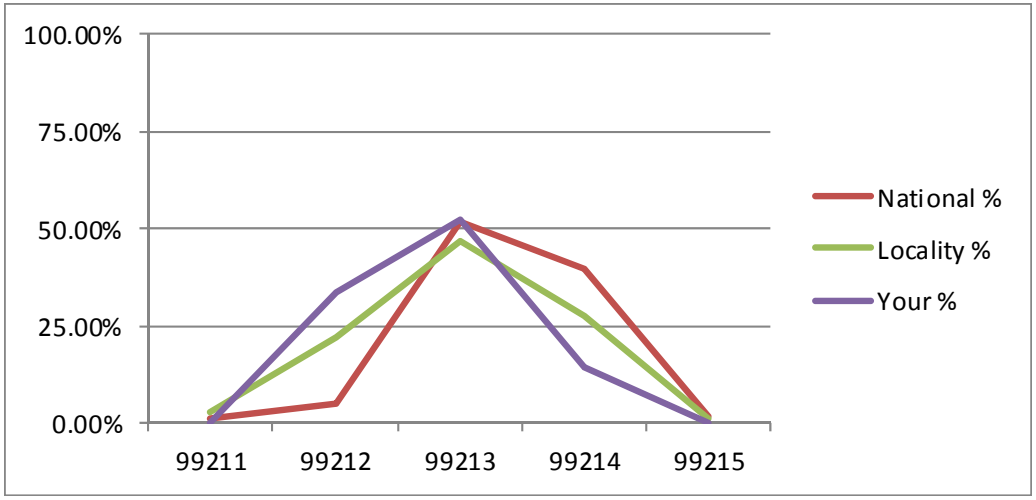
E & M Benchmark Analysis for Orthopedic Surgery

New & Established Patient Office Visits

New Patients



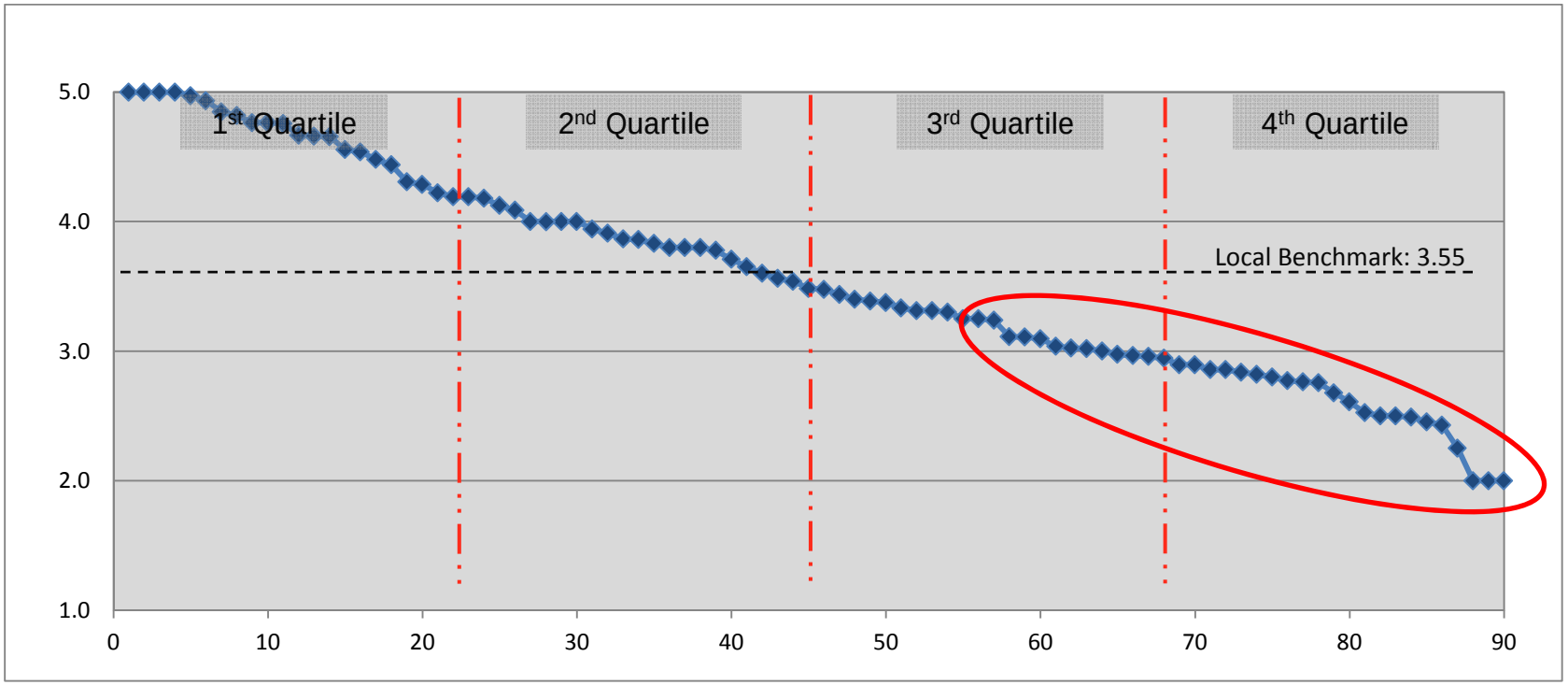
Established Patients



Note: All Payer data 1/1/2016 – 12/31/2016.

Primary Care – Initial Office Visit Codes (99201 – 99205)

- Below is a graph representing physicians and their weighted average for initial office visit codes compared to the local benchmark.
- The weighted average of the group is 3.51 which is lower than the local benchmark of 3.55.



Orthopedic Surgery – Established Office Visit Codes (99211 – 99215)

- Below is a graph representing physicians and their weighted average for established office visit codes compared to the local benchmark.
- The weighted average of the group is 2.64 which is lower than the local benchmark of 3.24.

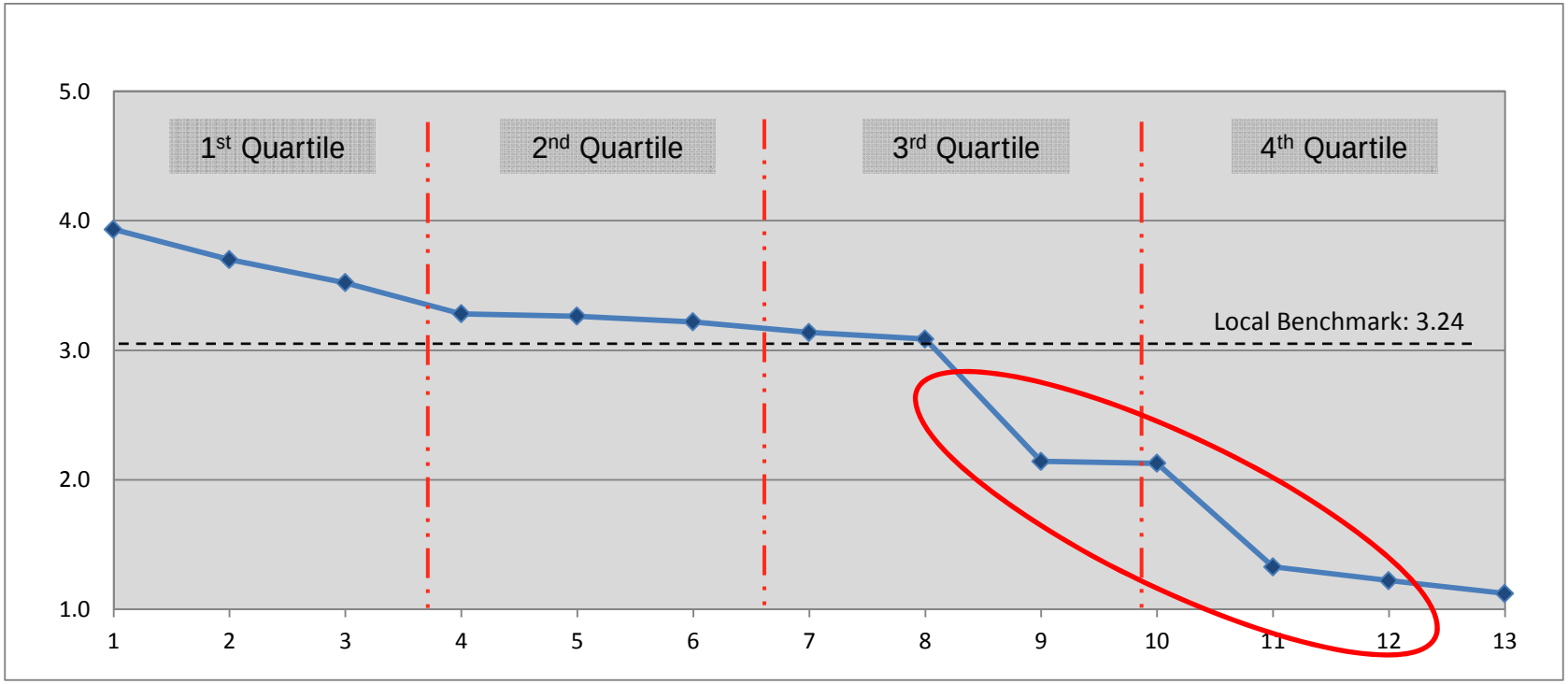


Chart Review Findings and Observations

Chart Review Findings and Observations

Chart Review Results

- The chart review was a targeted review of 300 charts. There were 109 charts with possible E&M code changes identified.

Chart Review Finding Description	Number of Findings	% Findings of Charts Reviewed
Higher E&M code based on current documentation	22	7%
Education - Potential opportunity for higher E&M code based on MDM	20	7%
E&M code category change	5	2%
Education -Incorrect ICD-10 CM diagnosis code(s)	1	0%
Insufficient Documentation to support E&M code (Lower E&M code)	61	20%
Total - Possible Changes	**109**	**36%**
No note found	38	13%
Other - Incident to	15	5%
No Change	138	46%
Number of Charts Reviewed	**300**	

Note: Findings should not be extrapolated over the population, due to the targeted approach in selecting the charts for review. The sample was not selected on a random basis and was not representative of the population.

Higher E/M Current Documentation

The following cases illustrate the opportunity to select a higher E/M code based on existing documentation or using Medical Decision Making as the driver

Sample #	Billed As	Should be	Key Elements
#12 ***New Outpatient***	99203	99204	Chief complaint (CC): Multiple chronic illnesses & new onset vaginitis Assessment: Anxiety Disorder, Hep C, Acute vaginitis, ADHD (All new problems) MDM: Moderate (Rx drug management)
#171 ***Established Outpatient***	99214	99215	Chief complaint (CC): R-sided facial paralysis Assessment: DMII, Hep C, Skin sensation disturbance, non-compliance MDM: High (Peripheral Neuropathy)
#235 ***Inpatient Follow-up Cardiology***	99232	99233	CC: Systolic Heart Failure; Severe Aortic Stenosis Assessment: ARF on CKD stage 4, Cardiomyopathy, Acute Systolic HF; Severe AS MDM: High (Plan TAVR (major PDx) with risks)

Missing Element Examples

The following cases identify cases with a missing element. Additional documentation would help support the billed level.

Sample #	Billed As	Should be	Key Elements
#3 ***New Outpatient***	99204	99203	Chief complaint (CC): Anemia Assessment: Testing, Hep B Titer MDM: Moderate (Rx drug management) Documentation: Physical Exam is detailed vs. comprehensive
#180 ***Established Outpatient***	99214	99213	CC: Shortness of Breath on exertion Assessment: Worsening CHF; L knee arthritis MDM: Moderate (Rx Drug Management) Documentation: ROS: none; PE: 4 systems only
#280 ***Heme/Onc Outpatient Consult***	99244	99242	CC: Antiplatelet therapy Assessment: Pre-op management MDM: Moderate (Rx Drug Management) Documentation: HPI – missing elements

Education, Monitoring and Support

Professional Fee CDI Initiative – Action Plan Overview

Provider Education

- Annual coding/charge capture education for providers
- Supplement existing provider training material; coordination with existing revenue integrity team
  - Clinical education for physicians, residents, NPs, PAs and office staff
  - Practice Management, compliance
  - E&M level assignment – use documentation guidelines and case examples
  - Medical Decision Making approach, use findings from record review
  - Feedback from record reviews
  - ICD-10 and HCC capture
  - Prioritization of specialties
- Coordinate message with broader CDI initiative
- Develop strategy to engage department chairs
- New providers (resident education is also provided)
  - Face to face meeting during orientation
  - Orientation audit of 10 notes

Electronic Medical Record Customization

- Review and customize EMR to support appropriate level of specificity and diagnosis

Professional Fee CDI Initiative – Action Plan Overview

Monitor, Measure and Report:

- Quarterly encounter and procedure reviews for providers
  - Providers and Revenue Integrity team will be advised of the review findings and offered instructional education, up to and including development and implementation of a corrective action plan
  - Evaluation sent to compliance and leadership
- E & M, Procedures, ICD-10 and HCC reporting
  - Monthly and quarterly reporting to monitor progress and identify focused areas for improvement, including financial impact and E&M Leveling trending
    - Physician benchmark analysis
- Development of additional data analytics to identify opportunity areas to support E&M assignment

Hierarchical Condition Categories (HCCs)

Why Review for HCCs?

- Hierarchical Condition Categories are selected as a risk adjustment model for accountable care organizations (ACOs). Physician practices invested in ACOs as well as those hospitals that have purchased these practices are affected in regards to reimbursement.
- HCCs are also the risk adjustment model for readmissions, VBP mortality , and HACRP which makes them increasingly important for hospitals.
- Medicare Advantage (MA) plans are reimbursed by risk adjustment of the HCC model. MA plan purchase has been increasing every year among the Medicare population. As more and more physicians practices are being purchased by hospital systems, not only is physician revenue increased but hospital revenue as well.
- HCC documentation can affect publicly reported quality scores, managed care contracting, and reimbursement from other insurers as well.

Hierarchical Condition Categories (HCCs)
Why Review for HCCs?

- Risk-based contracts adjust capitation payments for the health care expenditures of patients enrolled using a 1 year lag, e.g., the unit record created in 2017 will impact the risk factors assigned in 2018
- Proper HCC capture is essential for physician networks and hospitals to accurately demonstrate high quality of care at a lower cost.
- HCCs help predict resource use, thus properly documenting and capturing HCCs predicts the cost of forthcoming care for your patient population and adjusts the patients' risk scores and next year's capitation payment
- Documentation driving HCC capture is typically from the physician office visit and not an inpatient stay, that said HCCs can be captured in several settings of care including,
  - Hospital
  - ED
  - Home health
  - Specialist office visit
- On January 1 of each year patients are assumed healthy with no chronic conditions unless any such conditions are documented.
- Providers typically lack visibility into HCC documentation needs (what documentation is important) and how it impacts risk scoring

Hierarchical Condition Categories (HCCs)

Professional Billing– Clinical Scenario – HCC Capture

76 year old female seen in the office for routine f/u.

- Meds include Metformin, Coreg and Lisinopril.
- Patient reports numbness and tingling of feet and occasional sharp shooting pain.

76 year old female **= 0.448 RAF score for demographic**

Scenario 1: Documentation:

- Documentation includes only symptoms and treatment plan
- **Total RAF score: 0.448**
- **Reimbursement: $4,032**

Scenario 2: Documentation:

- Diabetes documented w/o associated complications or manifestation
  - **RAF score 0.104**
- CHF not documented
- **Total RAF score: 0.552**
- **Reimbursement: $4,968**

Scenario 3: Documentation:

- Diabetes with peripheral neuropathy
  - **RAF score 0.318**
- Chronic diastolic CHF
  - **RAF score 0.323**
- Additional score for CHF + DM
  - **RAF score 0.154**
- **Total RAF score: 1.347**
- **Reimbursement: $12,123**

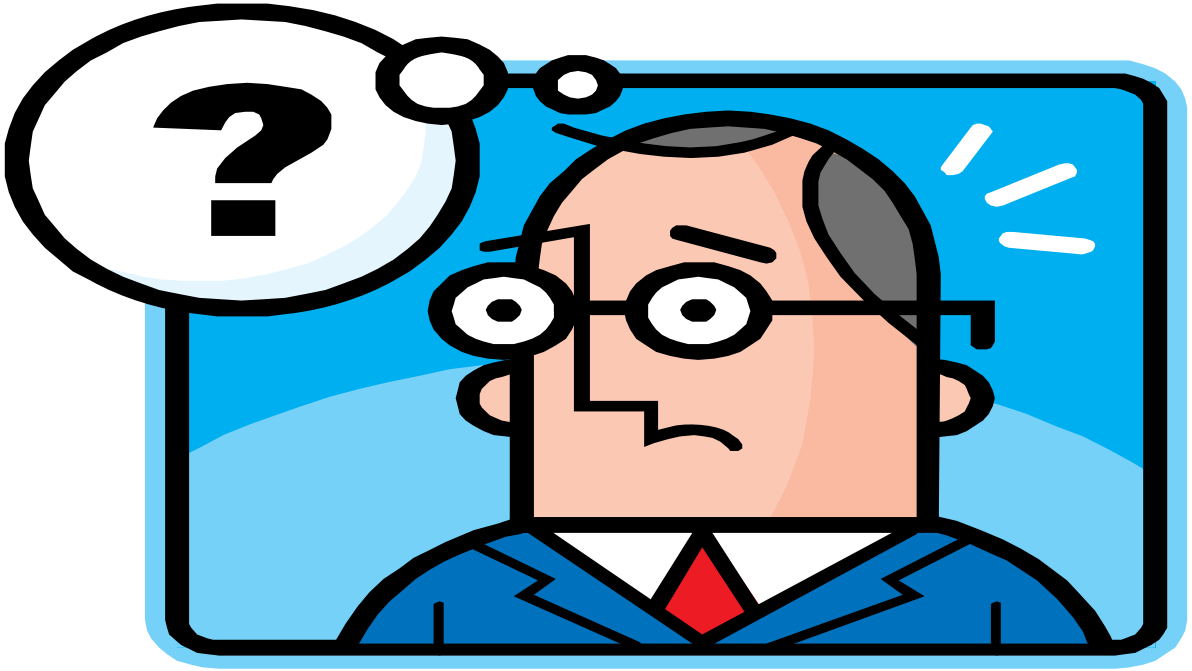
Hierarchical Condition Categories (HCCs)
CDI HCC Considerations

- Conditions must be reiterated every calendar year in the documentation.
  - Chronic conditions – CHF, diabetes, COPD
  - Acute conditions – Protein calorie malnutrition
  - Active status conditions – Amputations, dialysis, ostomies
  - Pertinent past conditions – Old MI
- Perform a quarterly review of patients with RAFs of greater than 1, below 1 and those with jumps in RAF scores.
- Provide physician education regarding the specificity of documentation required, the need to reiterate diagnoses each calendar year, patient identifiers, and legibility requirements.
- Ensure that the documentation is coded accurately as supported by the specificity of the documentation.
- Provide coder education regarding the importance of accurate coding.

Keys to Success for CDI

- Focus on quality and accuracy of the medical record
- Extensive use of data
- Highly engaged executive team
- Engaged physician leadership
- Auditing and monitoring of CDI Program performance, quality ratings and financial impact with feedback and ongoing education

Questions and Contact Information



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