Transforming Clinical Documentation Integrity Services (CDS) to Meet the Demands of CMS Reimbursement Models
How to Participate Today

*Click here* to expand or collapse the control panel.

*Click here* to type and send questions for us to address.
**Today’s Presenters**

**Wayne Little**  
Partner, DHG Healthcare  
- Wayne is a part of the DHG Healthcare’s CDS team with over 23 years of experience in healthcare finance assisting clients in such areas as revenue cycle financial and operational performance improvement.  
- Wayne is a guest speaker/presenter for numerous healthcare industry forums and webcasts covering topics including ICD-10 preparedness, Revenue Cycle performance improvement, Bundled Payment initiatives, fraud and abuse and other compliance topics.

**Michelle Wieczorek**  
Senior Manager, DHG Healthcare  
- Michelle is a part of DHG Healthcare’s CDS team and focuses on clinical documentation and revenue integrity initiatives.  
- She is a Registered Nurse, Registered Health Information Technician and Certified Professional in Healthcare Quality with over 30 years of experience in healthcare.  
- She recently won the Pennsylvania Health Information Management Association’s (PHIMA) Distinguished Member Award for 2016.

**Cheryl Ericson**  
Manager, DHG Healthcare  
- Cheryl is the newest member of DHG Healthcare’s CDS team.  
- She is a Registered Nurse and Certified as a Clinical Documentation Improvement Specialists and Clinical Documentation Improvement Practitioner with over 25 years of experience in healthcare.  
- She is a member of the Association of Clinical Documentation Improvement Advisory Board.
Objectives

• At the conclusion of this session participants will be able to
  – Explain the evolving impact of CMS’s shift from volume based reimbursement to value based reimbursement on the role of CDI within healthcare organizations
  – Describe CMS alternative payment methodology of Episode-based payments and the implications for CDI efforts
  – Analyze the impact of changing healthcare reimbursement strategies on the role of CDI within healthcare organizations
  – Discuss the importance of understanding the impact of risk adjustment on the new reimbursement methodologies and how legacy CDI efforts fall short
CDI Programs

• The goal of CDI is to facilitate clear, concise, clinically accurate information in the medical record through the identification of incomplete, vague and/or missing diagnoses allowing “capture” of all applicable diagnoses by codes to reflect:
  – Accurate reimbursement
  – Quality of care/services provided
  – Coding reflective of the provider’s intent
  – Appropriate hospital and physician profiles
  – Patient severity of illness (SOI) and risk of mortality (ROM)

• As of 2015, more than 80% of hospitals report staffing a CDI program according to recent industry surveys
The Legacy Approach to CDI

• Legacy CDI efforts typically target diagnoses affecting Medicare Severity (MS)-DRG assignment
  – MS-DRG methodology was designed to account for severity of illness (SOI) and resource consumption i.e., volume of services, within the Medicare population
  – As most already know, there are up to three levels of severity in the MS-DRG system
    o MCC–Major Complication/Comorbidity, which reflect the highest level of severity and resources use
    o CC–Complication/Comorbidity, which is the next level of severity and resource use
    o Non-CC–Non-Complication/Comorbidity, which do not significantly affect severity of illness and resource use

Why CDI Must Continue to Evolve . . .

• Traditionally, CDI focused on the inpatient, adult Medicare fee-for-service population with success typically measured by Case Mix Index (CMI) growth

• MS-DRG accuracy does not precisely reflect patient acuity, which is necessary for the risk adjustment of outcome measures to avoid reduced payments so this approach may not support long-term success
CMI Reflects Fee-For-Service Methodology

- CMS reports inpatient CMI increased 4.7% between 2011 and 2016
- CMI is derived from the relative weight associated with the billed MS-DRG
  - Fewer cases are being paid under the Inpatient Perspective Payment System (IPPS) methodology resulting in lower revenue
Polling Question #1

1) Does your organization have resources, tools and processes in place for a good clinical documentation program?
   a. Completely competent
   b. Somewhat competent
   c. Not at all competent
   d. Unsure
CMS’s Two-Tiered Payment Reform Strategy

• Value-based purchasing (VBP) framework - incorporates National Quality Strategies (NQS) into 90% of inpatient reimbursement mechanisms by the end of 2018

• Alternative payment models (APMs) - promotes collaboration across settings and providers so they comprise 50% of Medicare payments by the end of 2018

Impact of Value-Based Reimbursement

• Poor performance under new reimbursement mechanisms can lower IPPS payments within a particular fiscal year by up to 6%
  – HVBP – up to 2% reduction or increase in the base rate
  – HRRP – up to 3% reduction in the base rate
  – HACRP – 1% of MS-DRG payment

• Value-based payment adjustments aren’t reflected in the CMI
  – May obscure clinical documentation improvement opportunities
  – May misrepresent the financial health of the organization
## Value-Based Reimbursement Examples

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HVBP</strong></td>
<td>Base rate increased by 0.0016253990&lt;br&gt;$5,000 x factor = $5,008</td>
<td>Base rate increased by 0.0049538750&lt;br&gt;$5,000 x factor = $5,025</td>
</tr>
<tr>
<td><strong>HRRP</strong></td>
<td>Base rate decreased by 0.9968&lt;br&gt;$5,000 x factor = $4,984 (-$16)</td>
<td>No adjustment</td>
</tr>
<tr>
<td><strong>Revised Base Rate</strong></td>
<td>$4,992</td>
<td>$5,025</td>
</tr>
<tr>
<td><strong>DRG 292 w/RW of 0.9707</strong></td>
<td>$4,846 after adjustments</td>
<td>DRG 292 w/RW of 0.9707&lt;br&gt;$4,878 after adjustments</td>
</tr>
<tr>
<td><strong>HACRP</strong></td>
<td>HACRP penalty of 1% = adjusted payment of $4,798&lt;br&gt;Total penalties = loss of $56</td>
<td>No HACRP penalty&lt;br&gt;Total incentive = gain of $24</td>
</tr>
</tbody>
</table>

- **HVBP**: Base rate increased by 0.0016253990<br>$5,000 x factor = $5,008
- **HRRP**: Base rate decreased by 0.9968<br>$5,000 x factor = $4,984 (-$16)
- **Revised Base Rate**: $4,992
- **DRG 292 w/RW of 0.9707**: $4,846 after adjustments
- **HACRP**: HACRP penalty of 1% = adjusted payment of $4,798<br>Total penalties = loss of $56

If 20,000 discharges, loss = $1.12M

If 20,000 discharges, gain = $480K
Polling Question #2

2) Which of the following describes the relationship between penalties associated with CMS quality programs i.e., HVBP, HRRP, HACRP, and Case Mix Index (CMI)?

a. It has no impact on CMI
b. It has minimal impact on CMI
c. It greatly reduces CMI
d. It increases CMI
Alternative Payment Models

• An example of an alternative payment model (APM) impacted by CDI efforts is mandatory bundled payments
  – The Comprehensive Care Joint Replacement Model (CJR) holds participant hospitals financially accountable for both the quality and cost of a CJR episode to incentivize increased coordination of care among hospitals, physicians, post-acute care providers
    o First performance period began April 1, 2016
    o Participation is required for 67 Metropolitan Statistical Areas (MSAs) ~800 hospitals

https://innovation.cms.gov/initiatives/cjr
CJR Quality Component

- The **quality component** is risk standardized so provider documentation will impact hospital performance
  - The composite quality score is a hospital-level summary reflecting performance and improvement on two quality measures
    - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
    - HCAHPS patient experience Survey measure (NQF #0166)
  - And the successful reporting of THA/TKA patient-reported outcomes and limited risk variable data

https://innovation.cms.gov/Files/x/cjr-faq.pdf
Alternative Payment Model Expansion

• CMS proposes expansion of mandatory “bundled payments” through episode payment models (EPMs) beginning July 1, 2017
  – Surgical Hip/Femur Fracture Treatment (SHFFT) will include the same 67 MSAs as CJR
  – AMI will include 98 randomly selected MSAs
  – CABG will include 98 randomly selected MSAs

https://innovation.cms.gov/initiatives/cjr
Polling Question #3

3) Under new payment models, clinical documentation services only impact revenue cycle integrity?
   a) True
   b) False
Risk Adjustment

• CMS uses risk adjustment to account for differences in beneficiary-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided.

• The goal of risk adjustment is to enable more accurate comparisons across providers that treat beneficiaries of varying clinical complexity, by removing differences in health and other risk factors that impact measured outcomes but are not under the provider’s control.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Risk-Adjustment-Fact-Sheet.pdf
CMS and Risk Adjustment

- Risk adjustment for most outcome measures is based on diagnoses reported **prior to** the indexed admission i.e., episode of care.
- These risk adjustment models seek to diminish case differences based on the clinical status of the patient **at the time of the index admission**
  - Comorbidities that convey information about the patient at that time or in the 12 months prior, and **NOT** complications that arise **during the course of the index hospitalization**, are included in the risk adjustment.
    - Consequently, legacy CDI efforts focusing on capturing CCs/MCCs are likely to have limited impact on risk adjustment.
Case Study: Risk Adjustment

- Patient presents with dysuria, fever and altered mental status:
  - “Urosepsis” documented in progress notes. Dry, low urinary output.
  - Lab reports showed serum creatinine and BUN levels of 4.5 & 50, respectively.
  - Physician ordered 1L of IV NS wide open with maintenance IVF of 150 cc/hr to follow.
  - Serial creatinine and BUN levels declined over the next 3 days to 1.2 & 2.4, respectively.
  - Patient maintained on Symbicort and Lipitor at home.
The CDI Specialist queried based upon lab values and presence of clinical indicators to verify an alternate principal diagnosis of **sepsis** to achieve an improved MS-DRG with higher reimbursement.
The CDI Specialist sought clarity in the presence of COPD – a secondary diagnosis not impacting the MS-DRG through reviewing of the medication list and noting Symbicort.

The CDI Specialist also noted the presence of clinical indicators indicative of ATN; and queried the physician to clarify the diagnosis.

The combination of the additional secondary diagnoses moved the SOI, ROM and Expected Mortality.
Understated Patient Acuity

• In our experience, 20-30% of cases grouped under APR-DRG understate the acuity of SOI/ROM due to the failure to code a diagnosis whose clinical indicators appear in the medical record
  – This directly impacts the expected Readmission and Mortality rates of your organization AND
  – The comparative cohort an organization is seated in for the Hospital Value Based Purchasing Program
# Importance of Diagnosis Coding Depth

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amputation Status, Lower Limb</strong></td>
<td>Status amputation, toes, foot, ankle below/above knee</td>
<td>Z89.411-619</td>
</tr>
<tr>
<td><strong>Congestive Heart Failure</strong></td>
<td>CHF</td>
<td>I50.9</td>
</tr>
<tr>
<td></td>
<td>Pulmonary Heart Disease</td>
<td>I27.9</td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td>COPD</td>
<td>J44.9</td>
</tr>
<tr>
<td></td>
<td>Emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td></td>
<td>Chronic Bronchitis</td>
<td>J42</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Diabetes, uncontrolled</td>
<td>E11.65</td>
</tr>
<tr>
<td><strong>Major Depressive Disorders</strong></td>
<td>Major Depression</td>
<td>F32.9</td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
<td>Schizophrenia</td>
<td>F20.9</td>
</tr>
<tr>
<td><strong>Vascular Diseases</strong></td>
<td>Peripheral Vascular Disease</td>
<td>I73.9</td>
</tr>
<tr>
<td></td>
<td>Aortic Atherosclerosis</td>
<td>I70.0</td>
</tr>
<tr>
<td></td>
<td>Aortic Aneurysm</td>
<td>I71.9</td>
</tr>
<tr>
<td></td>
<td>Abdominal Aortic Aneurysm</td>
<td>I73.9</td>
</tr>
<tr>
<td><strong>History of CABG</strong></td>
<td>Presence of coronary bypass graft</td>
<td>Z95.1</td>
</tr>
</tbody>
</table>

Diagnosis codes having the Greatest Impact on Risk Adjusted Reimbursement (Readmissions and Mortality) that are **NOT** classified as a CC or MCC under MS-DRG Methodology
Risk Adjustment Beyond the CC/MCC

- CMS uses the condition categories associated with their hierarchical condition category (HCC) methodology to risk adjust the patient’s clinical status at the time of the indexed admission for most outcome measures.
- Patient Safety Indicators (PSI’s) use a different, but similar methodology for risk adjustment.
- All of these methodologies are impacted by the totality of reported diagnoses and their specificity, requiring a more comprehensive CDI review process.
- Because those diagnoses classified as CCs and MCCs don’t typically capture the impact of multiple chronic conditions and MS-DRG doesn’t reflect the interaction among diagnoses, organizations should leverage APR-DRG methodology.
There are many health status codes that risk adjust, but would likely be overlooked during a traditional CDI review and may also be missed by coding because they do not impact the MS-DRG assignment.

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>CMS-HCC PACE/ESRD Model Category V21</th>
<th>CMS-HCC Model Category V22</th>
<th>CMS-HCC PACE/ESRD Model for 2016 Payment Year</th>
<th>CMS-HCC Model for 2016 Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z794</td>
<td>Long term (current) use of insulin</td>
<td>19</td>
<td>19</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z89411</td>
<td>Acquired absence of right great toe</td>
<td>189</td>
<td>189</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z89412</td>
<td>Acquired absence of left great toe</td>
<td>189</td>
<td>189</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z89419</td>
<td>Acquired absence of unspecified great toe</td>
<td>189</td>
<td>189</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z9115</td>
<td>Patient's noncompliance with renal dialysis</td>
<td>134</td>
<td>134</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z930</td>
<td>Tracheostomy status</td>
<td>82</td>
<td>82</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z931</td>
<td>Gastrostomy status</td>
<td>188</td>
<td>188</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z932</td>
<td>Ileostomy status</td>
<td>188</td>
<td>188</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z933</td>
<td>Colostomy status</td>
<td>188</td>
<td>188</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z934</td>
<td>Other artificial openings of gastrointestinal tract status</td>
<td>188</td>
<td>188</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z95811</td>
<td>Presence of heart assist device</td>
<td>186</td>
<td>186</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z95812</td>
<td>Presence of fully implantable artificial heart</td>
<td>186</td>
<td>186</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z9911</td>
<td>Dependence on respirator [ventilator] status</td>
<td>82</td>
<td>82</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Z992</td>
<td>Dependence on renal dialysis</td>
<td>134</td>
<td>134</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Condition Categories Impact CJR

- Morbid obesity
- COPD (CC 108)
- Stroke (CC 95, 96)
- Skeletal deformities
- Dementia and senility (CC 49, 50)
- Chronic atherosclerosis (CC 83-84)
- Protein-calorie malnutrition (CC 21)
- Major psychiatric disorders (CC 54-56)
- Osteoarthritis of hip and knee (CC 40)

- Vascular or circulatory disease (CC 104-106)
- Cardio-respiratory failure and shock (CC 79)
- Diabetes and DM complications (CC 15-20, 119, 120)
- Respiratory/Heart/Digestive/Urinary/Other Neoplasms (CC 11-13)
- Osteoporosis and Other Bone/Cartilage Disorders (CC 41)
- Rheumatoid Arthritis and Inflammatory Connective Tissue Disease (CC 38)
Polling Question #4

4) Which of the following are ways that CMS risk adjusts data?
   a. APR-DRG’s
   b. Health Status Codes
   c. Hierarchical Condition Categories
   d. All of the above
Implications for CDI Departments

1. Legacy CDI programs focused on MS-DRG’s rather than portraying an accurate clinical picture are insufficient for success under value-based or risk-adjusted payment models because:
   - They lack the fundamental approach to risk-adjustment more often associated with an APR-DRG Based Program
   - They lack clinical insight into the diagnosis drivers for quality-based and alternative payment mechanisms
   - They lack an attention to the concept of diagnosis depth; and capture of secondary diagnosis beyond the level of a CC or MCC
Implications for CDI Departments

2. Clients are unsuccessful in value-based or risk-adjusted payment models due to root causes beyond clinical variability:
   - Clinical Documentation Integrity
   - Coding Quality

3. A core competency for any organization that wishes to expand their Risk Capability is Clinical Documentation Integrity
   - Patient acuity is adequately depicted in claims and clinical data used for risk adjustment
   - Clinicians understand that reducing clinical variability AND improving clinical documentation are required to improve financial performance in risk-based contracts
DHG healthcare

Audience Questions
Upcoming Webinars

**Clinical Documentation Services (CDS)**

*Aligning CDI Performance Metrics: When CMI and Quality Metrics Are Misaligned*
January 24, 2017 at 12:00PM EST

**Enterprise Strategic Planning**

*Session 1: CEO Advisors Panel Discussion-Lessons Learned From a Career in Strategy Planning*
November 4, 2016 at 12:00PM EST

*Session 2: Key Strategic Questions in a Risk Capable Environment*
November 17, 2016 at 12:00PM EST

*Session 3: Client Case Study Utilizing Dynamic Strategic Planning Methodology*
December 1, 2016 at 12:00PM EST
Wayne Little, Partner  
DHG Healthcare, Atlanta, GA  
P: (404) 681-8297  
Wayne.Little@dhglp.com  

Michelle Wieczorek, Senior Manager  
DHG Healthcare, Virtual PA  
P: (814) 440-0471  
Michelle.Wieczorek@dhglp.com  

Cheryl Ericson, Manager  
DHG Healthcare, Virtual SC  
P: (843) 696-6877  
Cheryl.Ericson@dhglp.com