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CDI Evolution 2017...The Road to Risk Adjustment & Quality Measurement

Presenter:
Pam Hess, MA, RHIA, CDIP, CCS, CPC
Managing Director, CDI

Terry Buske
Director, Strategic Accounts

June 30, 2017

James Bryant Conant

President of Harvard University in the 1930's

"Each honest calling, each walk of life has its own elite, its own aristocracy based on excellence of performance."

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Learning Objectives

- What factors in the healthcare landscape are changing the requirements of a best in class CDI program
- How to redesign CDI programs to include all patient care settings
- How risk based payer models affect CDI program design
- How to develop a collaborative team of inter-departmental stakeholders
- How to utilize the latest technology and data analytics to enhance CDI program ROI and facility revenues

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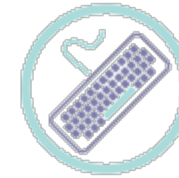
Stakeholders for The CDI Continuum of Care



Coding	Quality, UR, Compliance	IT	Medical Staff Leaders	Revenue Integrity/ Denials
ICD-10-CM specificity driving quality scores, risk based scoring, denial reduction	Improve quality scores and accurate payment through complete and timely clinical documentation	Data Driven Technology Solutions & interoperability spanning all sites of service	Essential to program success, physician champions drive the program with the medical staff	Clinical documentation driven charge capture root cause analysis & decreased denials

CDI Pre-encounter, Concurrent and Post-encounter Case Review

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New Addition
Outpatient & Profee CDI

- Emerging CDI opportunities beyond reviewing for MS-DRG based major complications and comorbidities (MCCs) and complications and comorbidities (CCs).
- CDI programs are expanding the scope of work to include support of risk based payer methodologies and quality reporting metrics.
- CDS skills sets are expanding to include not only clinical, coding, and communication skills, but also the ability to manage work flow redesign, quality, compliance, and regulatory initiatives.
- CDI programs are moving outside the walls of the traditional inpatient acute-care setting into other settings, such as hospital outpatient, physician offices, long-term care, and home health.

Written by: Melanie Endicott, MBA/HCM, RHIA, CDIP, CCS, CCS-P, FAHIMA
Senior Director of HIM Practice Excellence, AHIMA

http://www.icd10monitor.com/enews/item/1593-cdi-beyond-acute-care-and-reimbursement

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Selling the Concept

Gaining interest in Ambulatory CDI

- Identify key stakeholder and medical staff leaders
- Meet to discuss the need for ambulatory CDI
- Present audit results (HCC, quality measures, coding, medical necessity gaps)
- Propose pilot site to validate ROI
- Discuss best way to communicate the program to the medical staff

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Example ROI Calculation: HCCs

- Identify RAF Scores (before and after audit) *OR*
- Identify weights for added HCCs

HCC	Weight
Diabetes with complications	0.318
Vascular disease	0.4
CHF	0.323
Disease interaction (DM + CHF)	0.182
Total	**1.223**

- Identify Medicare advantage Per Patient Per Month contract rate

The following data pertain to the Year 2017 Medicare Advantage Risk Rates for All Plans except PACE plans

Code	State	County	2016 FFS Rate	2016 IME Phase-out Dollar Amount	2016 Pre-ACA Rate (excludes phased-out IME)	2016 Pre-ACA Rate (includes phased-out IME)	2016 Rate Category	2017 Minimum Update Rate	Risk Score Model Adjustment Factors	2017 GME Factor	2017 DOD Adjustment Factor	2017 VA Adjustment Factor	2017 AGA factor
01000	AL	AUTAUGA	739.08	6.07	865.00	871.07	M	897.90	1.000000	0.002522	1.0000	1.0028	0.91466
01010	AL	BALDWIN	727.65	3.10	867.97	871.07	M	897.90	1.000000	0.001555	1.0000	0.9997	0.90618

- Example Calculation: Add weights together (1.223), multiply X PPPM rate X 12
- Annual HCC payment increase *to the Medicare Advantage Plan* = 1.217 X $897.90 X 12 = $13,178. Next Step – review payer contracts

Citation: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2017Rates.html

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Identify the Best Pilot Sites

- Select pilot site(s)
  - Formal / informal physician leaders
  - Primary care practices
  - Sites with MIPS and quality measure gaps
- Identify targets for focused case review
  - MIPS and quality measure gaps
  - HCC coding for Medicare Advantage
  - Example charge capture issue: Echocardiograms charge capture and coding process
  - Denials (NCD/LCD)
    - Observation vs. inpatient documentation
    - Myocardial Perfusion
    - Hyperbaric oxygen therapy

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Ambulatory CDI Program Components

<u>Overarching</u> or <u>independent</u> based on governance model:

- Outpatient Facility & Professional Practice
  - Data analytics for focus areas
  - Determine Focus Areas: HCC capture, quality metrics, charge capture, coding specificity
  - Conduct case review
  - Redesign workflow (pre, concurrent and post encounter case review)
  - Educate providers and coders
  - Track and Trend
- Repeat the process!

Medical Center CDI Work Plan/Time Line 12/23/16

Pending | Complete

Task #	Topic	Tasks	Status Notes	Disp	Responsible party	Client responsible party	Start Date	Due Date	Dec	Jan
	PHASE I: CDI PROGRAM ASSESSMENT		Poss. Lift Change							
1	Data Analytics	Submit Data Requests for 835/837 files and DRG volume list		Complete	Project Manager		12/5/16	12/5/16		
		Upon receipt of DRG volume list, upload and review DRG grouping MedPAR comparisons for focused chart selection.	Due to volume of available records, Cindy reviewed all records available during the time period 12/5 - 12/16. Future reviews will be conducted based on focused DRGs per Shelly's agreement. This will extend the Inpatient assessment process but may produce	Complete	Project Manager		12/5/16	12/5/16		
		Upon receipt of 835/837 files, submit to IT for the denials and ambulatory claims manager access.	835/837 files received. Analytics review Is underway.	Pending	Project Manager		12/5/16	12/5/16		
		Gather additional information as needed from client for project assessment.	Files gathered during on-site review: HIM.Gen001 Discharge_Listing, Charge master, DNFB Worksheet, DRG Query log, and Payor Contract Matrix.	Complete	Project Manager		12/12/16	12/15/16		

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Redesign Workflow

Task List

- Establish and obtain agreement on CDS integration process (clinic manager and physicians)
  - Patient identification focused cases (HCC, denials, MIPS)
  - Case review location: Remote vs. on-site
  - Case review type:
    - Pre-encounter (inpatient, outpatient, professional fee)
    - Concurrent
    - Post-encounter
  - Query communication: alert, tasks, notes, in-line communication technology
  - Create process for timely case bill drop

- Establish CDS case tracking mechanism
- Establish monitoring and trend reporting

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Example Outpatient CDI Focus Area

CDI/Coding case reviews are a critical component of an effective Outpatient Clinical Documentation Program.

OPPS Final Rule 11/1/16 presents 25 new Comprehensive APCs for 2017 (also called C-APC) :

- 1,877 CPT codes are now grouped into the new C-APCs increasing the number from 66 to 312
- When a primary procedure associated with a C-APC is reported with a second C-APC procedure or packaged add on code the CMS payment will be equal to the next higher APC in the group.

Citation: https://acdis.org/articles/news-outpatient-payment-system-final-rule-includes-measures-watch

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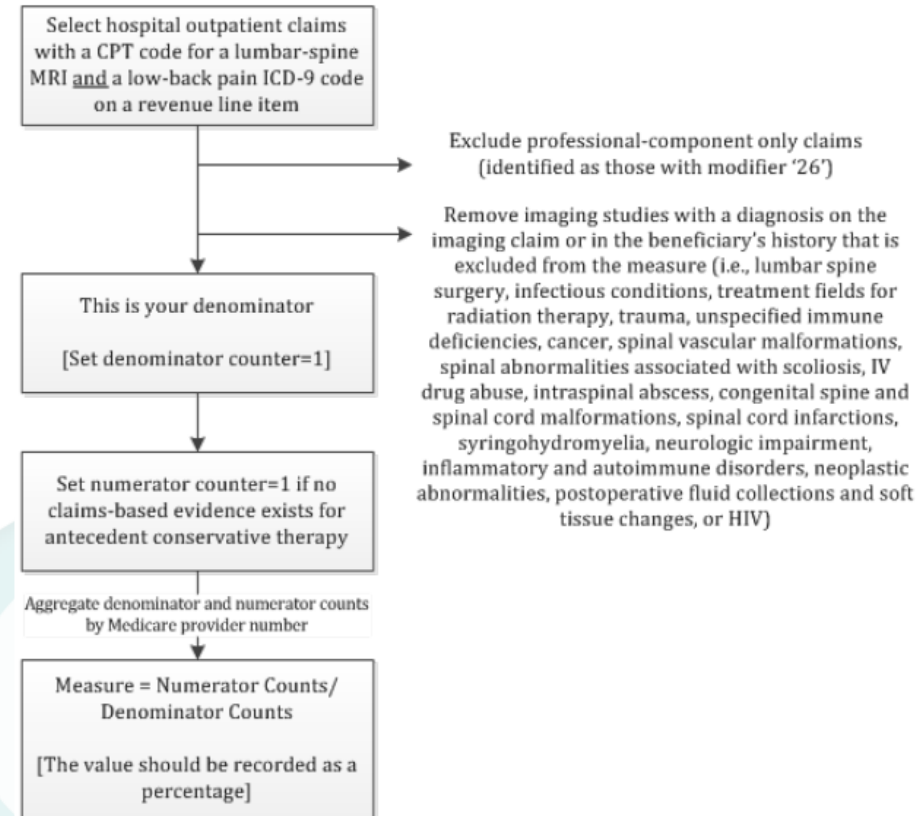
Example Outpatient CDI Focus Area

CMS Outpatient Quality OP-8 MRI Lumbar Spine for Low Back Pain

- Low numerators are the goal
- Remove cases with modifier -26
- Remove cases with coded diagnosis or history: lumbar spine surgery, infectious condition, treatment fields for radiation therapy, trauma, unspecified immune deficiencies, cancer, etc.)



Citationhttp://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120

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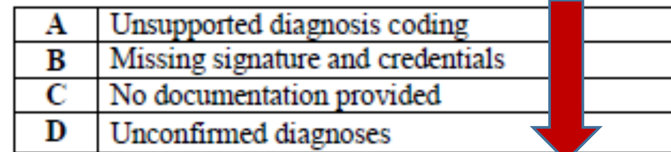
OIG Risk Adjustment Data Validation Audit

- OIG monitors HCC documentation
- Most frequent documentation error type:
  - A. Unsupported diagnosis coding

APPENDIX C: DOCUMENTATION ERRORS IN SAMPLE



A	Unsupported diagnosis coding
B	Missing signature and credentials
C	No documentation provided
D	Unconfirmed diagnoses

	Hierarchical Condition Category	A	B	C	D	Total Errors
1	Specified heart arrhythmias	X				1
2	Ischemic or unspecified stroke	X				1
3	Diabetes with neurologic or other specified manifestation			X		1
4	Ischemic or unspecified stroke	X				1
5	Vascular disease	X	X			2
6	Cardiorespiratory failure and shock	X				1
7	Angina pectoris/old myocardial infarction	X			X	2
8	Vascular disease	X				1
9	Breast, prostate, colorectal, and other cancers and tumors	X				1
10	End-stage liver disease	X				1
11	Specified heart arrhythmias	X	X			2
12	Chronic obstructive pulmonary disease	X	X			2
13	Vascular disease	X				1
14	Unstable angina and other acute ischemic heart disease	X				1
15	Chronic obstructive pulmonary disease	X				1
16	Unstable angina and other acute ischemic heart disease	X				1
17	Chronic obstructive pulmonary disease	X	X			2

Citation: Department of Health and Human Services, Office of Inspector General Report September 2012, Paramount Care, Inc.

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Coded Data and Analytics Tools

Physician Practice CDI

EHR Documentation for MIPS and Advanced APMs

EHR Considerations:

- EHR systems may allow for data capture that is not supported by documentation
- Large amounts of revenue are tied to reporting under the QPP programs, and lack of sufficient documentation could result in denials and penalties
- Develop method to avoid interrupting provider workflows to enter quality data
- High success rates have been achieved with documentation and data capture by using **in-line measure documentation in EHR templates**
  - In-line documentation refers to the process of allowing the provider to document measure related information within the body of a progress note template.
  - Improves efficiency, provider effectiveness, measure data documentation and measure performance

Citations: http://journal.ahima.org/2016/06/02/macra-mips-and-advanced-apms-time-to-prepare/
Marron-Stearns, Michael. "How MACRA Changes HIM" Journal of AHIMA 88, no.3 (March 2017): 22-25.

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In-line Documentation for Quality (MIPS) Measures

Example: Diabetic Patient

- The provider is prompted to document information about the patient's most recent diabetic eye examination.
- The provider is given a series of menu choices that will be mapped to the requirements for this measure.
- The provider may also be prompted to:
  - Generate an ophthalmology referral
  - Document that the patient has declined the dilated eye examination, because the most recent examination took place within the specified timeframe and was normal
  - Other findings that meet the measure requirement, including exclusions.

Citations: http://journal.ahima.org/2016/06/02/macra-mips-and-advanced-apms-time-to-prepare/
Marron-Stearns, Michael. "How MACRA Changes HIM" Journal of AHIMA 88, no.3 (March 2017): 22-25.

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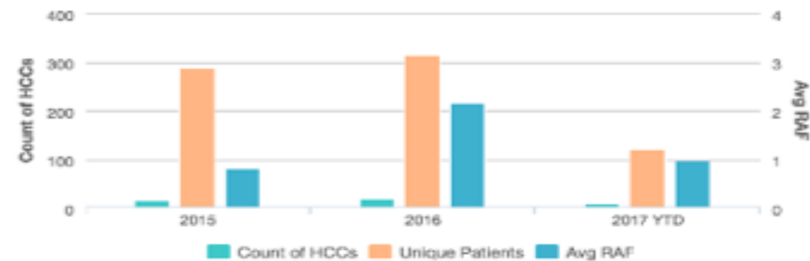
HCC Analytics

				2015 -2016		YTD 2017 - 20
Attributed Physician	**Claims CY**	**RAF 2015**	**RAC 2016**	**RAF Var**	**RAF YTD**	**RAF VA**
Love, Sheryl, O	120	0.803	2.173	-1.37	0.967	1.2
Roberts, Ryan, O	57	0.118	1.472	-1.354	1.472	
Tuttle, Norman, U	103	0.298	0.289	0.009	0.434	-0.1
Frazier, Eddie, R	82	0.3	0.446	-0.146	0.727	-0.2
Mangum, Max, A	68	0.341	0.455	-0.114	0.322	0.1
Sullivan, Nancy, U	101	0.337	0.501	-0.164	0.534	-0.0
Davidson, Jan, A	201	0.352	0.384	-0.032	0.484	-0
Bland, Michelle, L	147	0.317	0.344	-0.027	0.481	-0.1
Wise, Matthew, I	74	0.192	0.192	0	0.812	-0.
Patel, Geoffrey, A	93	0.479	0.638	-0.159	0.441	0.1
Houston, Martin, O	35	0.286	0.405	-0.119	0.182	0.2
Wrenn, Gordon, R	10	0.462	0.493	-0.031	0.452	0.0
Cross, Norma, R	85	0.283	0.386	-0.103	0.469	-0.0
Conner, Regina, O	160	0.315	0.511	-0.196	0.338	0.1
Rich, Marian, I	43	0.315	0.448	-0.133	0.523	-0.0
Bryant, Priscilla, R	57	0.355	0.517	-0.162	0.471	0.0
Nixon, Melvin, I	153	0.098	0.283	-0.185	0.92	-0.6
Nelson, Mike	82	0.177	0.227	-0.05	0.283	-0.0
Callahan, Nathan, A	52	0.864	1.01	-0.146	0.425	0.5
Sawyer, Gloria, A	168	0.787	0.854	-0.067	0.214	0.

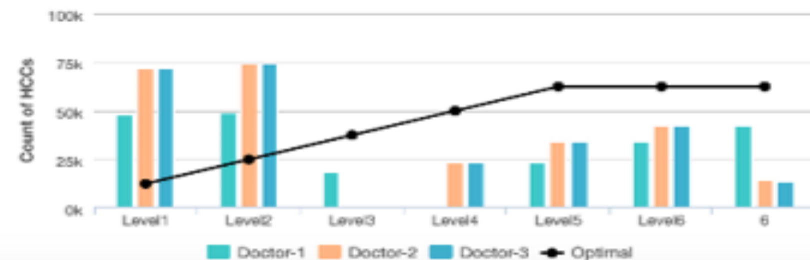
Trended HCCs



Top Impact HCCs

HCC	2015	2016	2017
hcc1	45	32	16
hcc2			
hcc3			
hcc4			
hcc5			
hcc6			
hcc7			
hcc8			
hcc9			
hcc10			

E&M Distribution



Example Report:

Per provider analysis

- *Total claims*
- *RAF score (3 year trend)*
- *Top Impact HCC,*
- *E&M Distribution*

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MedeAnalytics

Revenue Risks – Missing Charges

Risk Category	Volume	% of Total	Average Charges	Avg Commercial/Other Pmts	Avg Medicaid Pmts	Avg Medicare Pmts	Average Pmts
Missing Charges							
Review for missing flu vaccine or admin charge (187)	3,902	33.79%	$363	$71	$0	$10	$81
Review for Missing Radiology Payment in Fracture Care (224)	3,786	32.78%	$2,636	$972	$0	$52	$1,024
Review for missing pneumococcal vaccine or admin charge (186)	2,770	23.98%	$335	$62	$0	$21	$83
Review for Observation Services billed for 7 hours (225)	442	3.83%	$5,216	$1,674	$0	$173	$1,847
Review for missing blood or admin charge (185)	250	2.16%	$4,555	$1,012	$0	$310	$1,322
Review for missing implantable (189)	129	1.12%	$10,141	$4,283	$0	$486	$4,770
Review for Missing tissue acquisition charges on OP corneal transplant (194)	98	0.85%	$13,245	$5,436	$0	$0	$5,436
Review for Missing ultrasounds with multi-gestation diagnosis (201)	69	0.60%	$1,321	$341	$17	$7	$365
Review for Missing ablation in conjunction with cardiac electrophysiology studies (199)	60	0.52%	$16,901	$4,984	$0	$941	$5,925
Review for Missing Mesh implantation when mesh supply present - Pelvic Floor Defect (198)	28	0.24%	$32,850	$7,282	$0	$484	$7,766
Review for Missing Mesh implantation when mesh supply present - Hernia or Necrotizing Infection (197)	11	0.10%	$13,139	$2,310	$0	$710	$3,020
Review Modifier Usage Modifier 51 (233)	4	0.03%	$671	$0	$0	$352	$352
Total : Missing Charges	**11,549**	**40.13%**	**$1,779**	**$585**	**$0**	**$51**	**$636**

Example Report: shows potential charge capture gaps requiring further validation by outpatient CDS

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MedeAnalytics

Revenue Risks – Procedure Related

Risk Category	Volume	% of Total	Average Charges	Avg Commercial/Other Pmts	Avg Medicaid Pmts	Avg Medicare Pmts	Average Pmts
Missing Charges	11,549	40.13%	$1,779	$585	$0	$51	$636
Proc Related							
Review for Mutally Exclusive Edits (192)	8,958	90.30%	$2,889	$738	$1	$16	$755
Review Age of patient is inconsistent with code description (167)	300	3.02%	$5,657	$1,617	$0	$6	$1,623
Review for Pulmonary Diagnostic Procedure w/ E&M (234)	250	2.52%	$593	$1	$0	$209	$209
Review Procedure Code for New vs. Established Patients (193)	149	1.50%	$450	$110	$36	$2	$148
Review coding for Add On codes used without Primary code (260)	109	1.10%	$6,676	$0	$0	$1,353	$1,353
Review Principal Procedure for Medical Necessity Modified Barium Swallow (168)	68	0.69%	$909	$6	$0	$165	$171
Review Procedure code on Medicare IP-only list conducted as OP (188)	42	0.42%	$25,607	$329	$0	$378	$708
Review for Billing for Partial Hospitalization Services (221)	25	0.25%	$1,211	$0	$0	$1,353	$1,353
Review for Billing with Incorrect Drug Revenue Code (215)	15	0.15%	$10,162	$645	$0	$73	$718
Review for Medical Necessity Blepharoplasty (268)	4	0.04%	$14,970	$0	$0	$1,964	$1,964
Total : Proc Related	**9,920**	**34.47%**	**$3,014**	**$719**	**$2**	**$42**	**$762**

Example Report: shows potential procedure code gaps requiring further validation by outpatient CDS

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Compliance Risks

Risk Category	Line Items	% of Total	Total Amt at Risk	Total Pmts	Avg Pmts	Medicare Pmts
CPT Guideline						
Review Age of patient is inconsistent with code description (16)	4,822	81.40%	860,342	188,082	39	3,683
Review coding for Add On codes used without Primary code (23)	23	0.39%	5,721	655	28	100
Review coding for New vs. Established Patients (18)	1,079	18.21%	254,908	32,284	30	3,202
Total : CPT Guideline	**5,924**	**45.75%**	**1,117,602**	**221,021**	**37**	**6,985**
Global Package						
Review for potential duplicate billing Antepartum code billed once per patient per pregnancy (36)	1	0.02%	1,945	0	0	0
Review for potential duplicate billing for Global Days Post Op (21)	5,217	97.01%	2,499,874	856,299	164	44,985
Review for potential duplicate billing for Global Days Pre Op (22)	150	2.79%	65,398	5,757	38	0
Review for potential duplicate billing Ultrasound or diagnostic procedures should not be billed separately from antepartum care (35)	10	0.19%	8,748	1,427	143	0
Total : Global Package	**5,378**	**41.54%**	**2,566,473**	**863,482**	**161**	**44,985**
Modifier Usage	25	0.19%	45,466	1,410	56	0
Non Covered Service	3	0.02%	5,673	1,547	516	0
Proc Related	214	1.65%	39,039	5,503	26	129
Service Count	1,404	10.84%	455,921	22,421	16	174
Total : Selected Filter(s)	**12,948**	**100.00%**	**4,230,174**	**1,115,385**	**86**	**52,273**

*Example Report: shows potential **CPT code** and **global package compliance gaps** requiring further validation by outpatient CDS*

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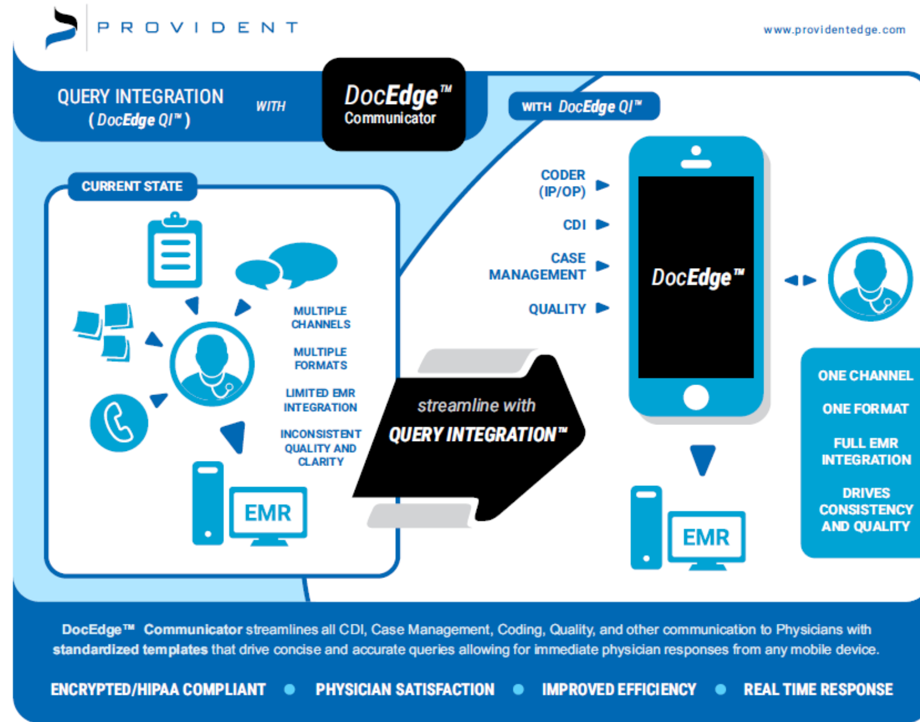
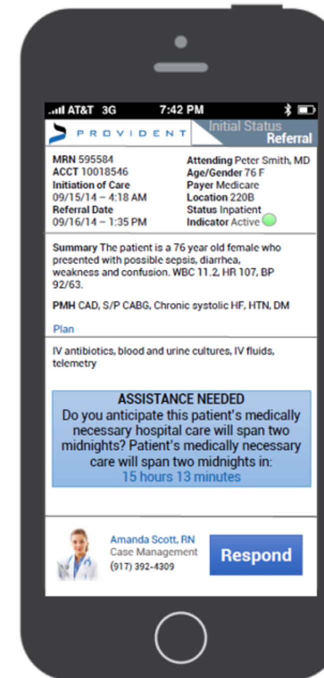
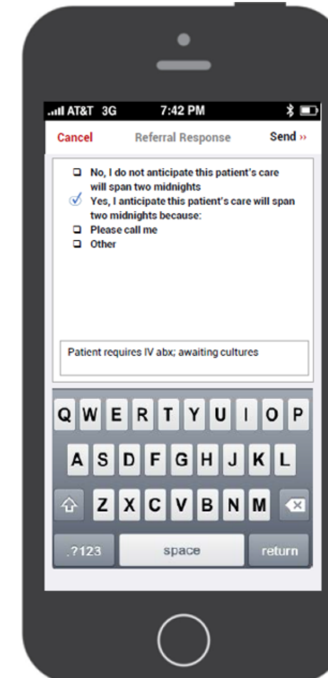
Steamlined Query Process







Personal Mobile Device: Provider response and clinical record update in one click

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Questions & Answers

Upcoming Events:

Alamo Area HIMA in August
HA HIMA in Sept
AHIMA Annual Meeting in LA - Oct
ACHE 2017 Healthcare Leadership Conference in Houston – Oct

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Thank you friends!

Pamela Hess – Managing Director, CDI

- Pamela C. Hess is the Managing Director, CDI at **him**agine Solutions Inc. She is a nationally recognized expert in Health Information Management with extensive healthcare experience in revenue cycle operations, clinical documentation improvement, electronic health record applications, reimbursement, coding, billing, compliance, quality control, and coding training. She is known in the industry as a trusted advisor and subject matter expert, and has authored the original edition of the *Hospital Charge Description Master Guide*, by OptumCoding, *Cardiology Procedural Coding Select*, by Decision Health and most recently *Clinical Documentation Improvement- Principles and Practice* by AHIMA Press. Her experience in the healthcare industry has focused on CDI program implementation at large academic medical centers and medium to small regional facilities. She has extensive experience managing HIM operations as a consultant and as a health system HIM director. Prior to joining himagine, she led the CDI service line for Deloitte & Touche, LLC and Navigant Consulting, Inc. She is currently the President of the Arizona Health Information Management Association.

phess@himaginesolutions.com
Office: 813-331-0711

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Terry Buske – Director, Strategic Business Development

- 25 years' experience in driving economic improvements in healthcare. He began his career in billing & insurance resolution. Towards the end of the Clinton administration, he was appointed by the Deputy Director of the Veteran Health Administration to serve on a National Revenue Taskforce; subsequently consulting with Department of Defense Hospitals, DHHS and the Indian Health Services. From there, he progressed to continuous process improvement and helped drive expansion of the 1115 Medicaid Waiver in Texas and California. Prior to joining himagine, Terry was the Sr. Vice President for a private equity group helping incubate healthcare start-ups. He has been involved with the American College of Healthcare Executives since 2009 and has been mentored by some of the best CEO's in the Texas Medical Center. As a member of the Healthcare Financial Managers Association and AHIMA; he is passionate about contributing to TxHIMA and supporting regional HIM chapters across Texas.

tbuske@himaginesolutions.com
Office: (813)331-0734
Mobile: (218)703-6133

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