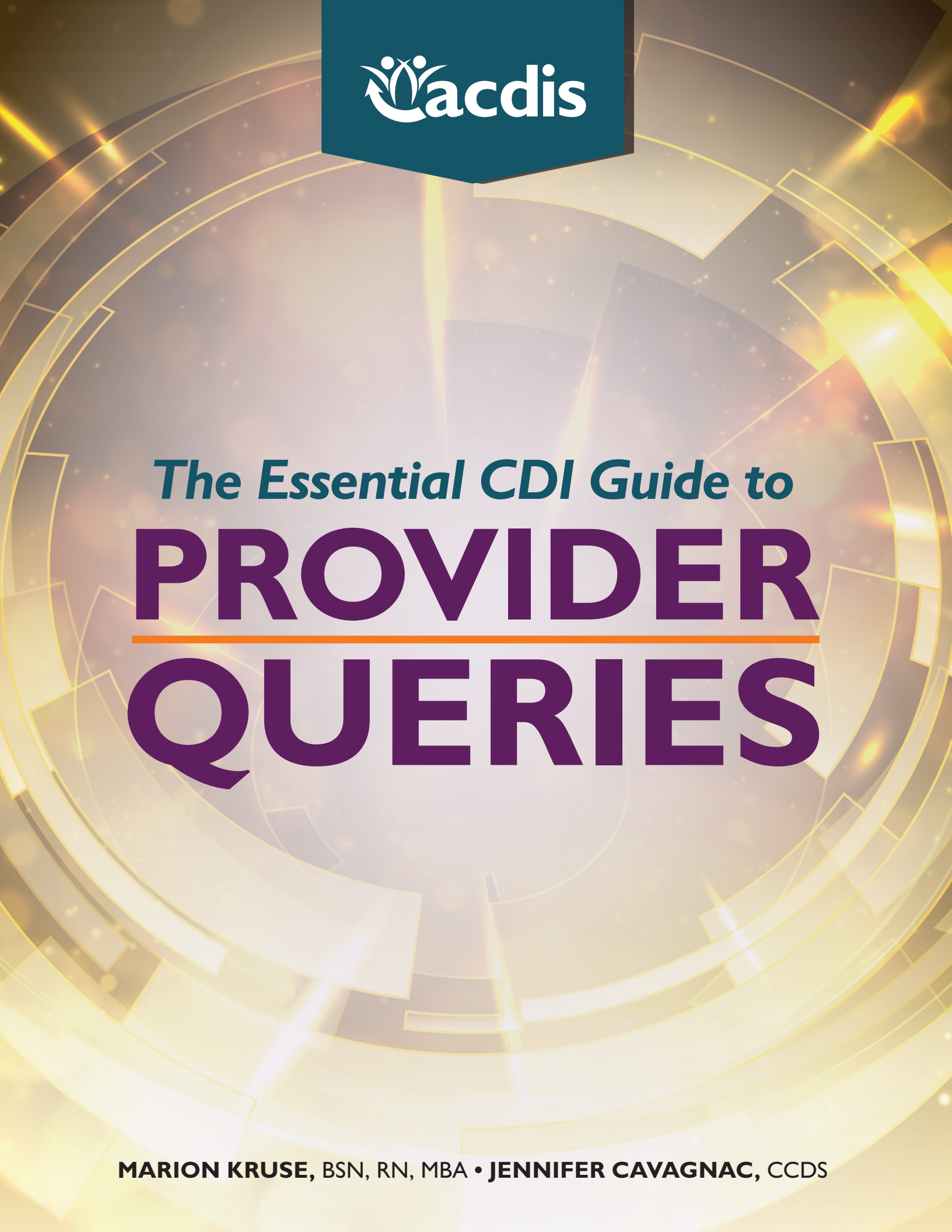
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The Essential CDI Guide to
PROVIDER QUERIES
MARION KRUSE, BSN, RN, MBA • JENNIFER CAVAGNAC, CCDS

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The Essential CDI Guide to Provider Queries is published by HCPro, a division of BLR.

ISBN: 978-1-68308-084-8

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- Physician Query Benchmarking Survey
- ACDIS Position Paper: Electronic Health Records and the Role of the CDI Specialist
- Additional Sample Queries

About the Authors

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Marion Kruse, BSN, RN, MBA, is an independent healthcare consultant. She has extensive expertise in clinical documentation improvement and consulting. She is a highly accomplished professional in the areas of CDI, ICD-10, revenue cycle, value-based purchasing, and other Medicare initiatives. She excels at strategic healthcare solution development, translation, and execution.

Earlier in her career, Kruse was employed by Precyse and FTI Consulting where she was a director in the healthcare practice. She was responsible for creating a CDI curriculum, technology, and ICD-10 readiness assessments to assist hospitals of varying sizes in implementing CDI programs. She also served on various revenue cycle projects.

Kruse also served as a managing consultant at Navigant Consulting Inc. Prior to this, she had a seven-year career at OhioHealth Corporation, where she served as a director of its clinical documentation program.

She holds a Bachelor of Science degree in Nursing from The Ohio State University and a Master of Business Administration from Franklin University. She co-authored the *Physician Queries Handbook* (August 2009) and wrote a revision of it in 2013. She also co-authored T*he Clinical Documentation Improvement Specialist's Handbook* (February 2011). All books were published by HCPro.

Jennifer Cavagnac, CCDS

Jennifer Cavagnac, CCDS, is the assistant director for clinical documentation improvement at Baystate Health System in Springfield, Massachusetts. She currently leads a team of clinical documentation specialists, coding compliance post-discharge reviewers, and outpatient coders across three campuses at Baystate Health.

Cavagnac developed the CDI program from the ground up. She aggressively searches for the latest technology and best practices to maintain a top-performing program that is consistently measured against national benchmarks. Her efforts managing an entirely remote CDI team resulted in an average 90% plus query response rate.

For the past 14 years, Cavagnac has worked in documentation and coding, specializing in interventional cardiac and radiological procedures for both inpatient and outpatient settings. She has been responsible for pre- and post-discharge coding quality reviews and analytics, and electronic documentation design projects. In preparation for ICD-10, Jennifer developed and continues to oversee service line-specific provider education.

Jennifer actively participates in both the Connecticut and Massachusetts ACDIS local chapter meetings, and has been a facilitator at a regional New England ACDIS/AHIMA symposium held in Holyoke, Massachusetts. This collaborative event encourages attendees to meet, share, discuss, and learn about current documentation and coding challenges. Cavagnac has been a speaker for a number of educational webinars provided to ACDIS local chapters over the years.

Introduction

Provider Query Practices Progress

As a result of the shift to ICD-10-CM/PCS, employment of electronic health records, and boost in quality and performance-based efforts, the clinical documentation improvement (CDI) industry is changing rapidly. It is no longer limited to the inpatient acute care world, and many CDI programs have expanded query efforts to include other types of mid-level providers. Thus, the term "physician queries" is not an accurate descriptor for today's query practices, and we opted to recognize the important role that all providers play in the CDI process in this new book, *The Essential CDI Guide to Provider Queries*. This book offers expanded guidance to CDI specialists as they navigate new roles with regard to query practices.

Initially, American Health Information Management Association's (AHIMA) *Code of Ethics* offered a single set of rules, and its 2001 brief "Developing a Physician Query Process" provided additional direction. In 2008, AHIMA offered further clarification with briefs entitled "Standards of Ethical Coding" and "Managing an Effective Query Process." These directives aimed to simplify querying practices and to expand AHIMA's governance to include anyone involved in the process, regardless of their professional background.

Following these directives, AHIMA convened a comprehensive committee to draft "Guidance for Clinical Documentation Improvement Programs," which was published in the 2010 *Journal of AHIMA*. It also published a 41-page *Clinical Documentation Improvement Toolkit* and, in the fall of the same year, the "Ethical Standards for Clinical Documentation Improvement Professionals."

In 2007, the Association of Clinical Documentation Improvement Specialists (ACDIS) was born. Over the next few years, ACDIS created its own *Code of Ethics*, with its most recent update published in November 2015. It began to publish reports analyzing the latest query practices through benchmarking and surveys of its membership. Discussion of query practices has become one of the most important aspects of establishing an effective CDI program. Its members helped draft the 2010 query publications, and in 2013, ACDIS and AHIMA worked together to create the practice brief, "Guidelines for

Achieving a Compliant Query Practice." Because it was officially a joint publication, this brief cemented the applicability of its guidance to CDI and coding/HIM staff members. The brief was updated with ICD-10 references in 2016.

But what is a query, and why is such a device needed? How has such a simple thing—asking a physician for clarification of the documentation within the medical record—spurred the creation of a whole new profession? "Guidelines for Achieving a Compliant Query Practice" answers this question as follows:

> *A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.*

The trouble is that physicians rarely learn about the intricacies of healthcare coding or the documentation requirements that coders must follow in order to assign a code. They know little, if anything, about how their documentation translates into various code sets for billing, research, and quality control and reporting efforts. That common language is the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/PCS).

The ICD-10-CM *Official Guidelines for Coding and Reporting* continues to call for a joint effort between the healthcare provider and the coder to obtain complete and accurate descriptions of the care provided. It states the following:

> *A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.*

Such hand-in-hand relationships are essential to code assignment and reporting of diagnoses and procedures. In addition, the importance of consistent, complete documentation in the medical record cannot be overemphasized—such sentiments are echoed in ACDIS' query guidance and publications, by ACDIS Advisory Board members, and in nearly every government statement regarding query practices. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

That unique set of skills—the ability to interrogate the medical record clinically while understanding the rules of compliant code assignment—spurred the creation of the CDI profession.

INTRODUCTION

Any discussion of CDI should pay particular attention to the concept of "compliance." Since the first publication of this book, a variety of healthcare organizations have come under investigation for inappropriate query practices, including submitting leading queries, upcoding, and other concerns. Recovery Auditors (formerly called Recovery Audit Contractors) target high-volume diagnosis areas and deny claims for which the medical record lacks supportive clinical evidence. Many auditors have even started to request query forms during their medical record reviews.

The question of what, exactly, constitutes a "leading" query has been subject to much debate throughout the various query guidelines over the years. The most recent ACDIS/AHIMA joint query practice guidance defines a leading query as follows:

> *One that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.*

Throughout *The Essential CDI Guide to Provider Queries,* we will address the various government, coding, and industry developments that have shaped CDI and query practices, offer examples of various query forms, and discuss how to craft effective and compliant query policies and procedures in an electronic world. If nothing else, those who purchase this edition should gain an awareness of the importance of creating specific policies and procedures governing facility query efforts. Such policies should be consistent across departments and should address processes for query retention, reconciliation, and escalation, among other items.

For healthcare providers (e.g., physicians, nurse practitioners, physician assistants, nurses, respiratory therapists, and their extenders) and data quality specialists—as well as HIM and CDI specialists who compliantly interpret, abstract, and code documented clinical information into administrative coded data sets—success is about relationships. A few years back, the relationship between CDI professionals, coders, and physicians was still relatively new. Many argued for different query rules depending on the professional submitting the query and the timing—either concurrent or retrospective—of the query. Discussions regarding the best type of query form to use for which diagnosis type also raised questions. Some professionals indicated that open-ended, formless queries were best, while others opined that only multiple-choice query forms should be used, and still others indicated that verbal encounters presented the best option. These concerns only grew as facilities introduced electronic health records, which brought additional challenges and questions regarding the eQuery.

Despite the volumes of query advice now available, definitive solutions remain elusive. As the adage goes, the solution is not black or white but is rather a shade of gray. Each query submitted must be used to best reflect the conditions and response sought. For example, the latest query guidance permits "yes/no" queries, which will be helpful as CDI specialists and coders work to clarify cause-and-effect relationships needed for accurate present on admission modifier and ICD-10-CM/PCS code assignment.

The heart and soul of successful query processes depends on crafting useful policies and effective relationships across departmental lines. It depends on the ability of the provider and the CDI and HIM professionals to be conscientiously and consistently aware of each other's backgrounds, biases, wants, and needs.

Failure to adequately foster these relationships frequently proves detrimental, not only to personal and professional relationships, but also to the care of the patients themselves. In healthcare, lives really are at stake—even when it comes to appropriate documentation and application of transactional code sets.

There are consequences for failing to understand this critical link between patient treatment and the documentation and coding for that treatment. ICD-10-CM/PCS coding based on nonspecific physician documentation has led insurers to issue clinical denials and even raise patient copayments for certain "inefficient" providers, particularly those in tiered networks currently advocated by insurers and increasingly affecting Medicare payments via the hospital value-based purchasing program.

In the same light, coding from nonspecific physician documentation has led to negative publicity for hospitals and their physicians, conveyed via publicly reported mortality data posted on the Centers for Medicare & Medicaid Services' Hospital Compare website and other public websites. Here, some providers have high risk-adjusted readmission and death rates for community-acquired pneumonia, heart failure, myocardial infarction, or other conditions and procedures based on ICD-10-CM/PCS coded data. Communities have witnessed their local hospitals close, in part as a result of providers' and coders' inability to negotiate the code-based reimbursement systems that are integral to establishing medical necessity, which is required for accurately assigning diagnosis-related groups for inpatient reimbursement, and for assigning Hierarchical Condition Categories for outpatient services that are paid by accountable care organizations. Moving forward, physicians will be paid under a value-based purchasing system that depends on coded data for risk adjustment. As the government and the public continue to demand improved quality of care, cost control, and transparency of data, the physician documentation and coder translation of the medical record becomes almost as vital as the care that the patient receives.

INTRODUCTION

Although various stakeholders may not share the same interests or incentives, everyone involved—from physicians to administrators, from program directors to coders and CDI staff—must have familiarity with and empathy for the interplay of each professional's contributions to the healthcare system. This will help bridge the communication gaps that exist and improve the quality of healthcare. Although reading literature and going to school helps, the best (and sometimes the only) way to learn about another person's world is to ask and listen. Every question deserves a respectful answer.

This book is dedicated to the coders, clinicians, mid-level providers, and physicians who work diligently every day to develop and support the professional relationships and processes that are essential to ensure coded data quality.

Special recognition must be extended to ACDIS, which sponsored the publication of this edition and donated numerous materials and tools.

As ever, we are grateful to the many colleagues, clients, and peers who continue to challenge us to achieve excellence.

Sincerely,
Marion Kruse, BSN, RN, MBA
Jennifer Cavagnac, CCDS

1 Healthcare Reimbursement Evolution

In the past 30 years, as the government has attempted to reign in the unsustainable healthcare costs of an aging population, rules governing healthcare reimbursement in the United States have evolved dramatically. The question of the solvency of the government's healthcare programs has fallen victim to political ideology within the past decade. Total Medicare spending has been projected to increase from $703 billion in 2016 to $1.167 trillion by 2024. Enrollment in the time period is projected to increase from 56.1 million to 70.3 million.[1]

Over the years, the government has developed a number of initiatives to handle the dilemma, shifting the focus of payment away from episodic reimbursement to funding based on clinical outcomes and the quality of care provided across the healthcare continuum. In this chapter, we discuss two such payment shifts as representatives of this initiative—the implementation of diagnosis-related groups (DRG) and pay-for-performance strategies—to highlight the important roles of physician documentation and clinical documentation queries in this landscape.

In the course of changing the way it pays for services, the government has kept its eye trained on inappropriate healthcare billing and outright fraud with the implementation of recovery auditors, Medicare Administrative Contractors, and other efforts (discussed in greater depth in Chapter 2). In this environment, clinical documentation improvement (CDI) program growth has flourished. However, the reasons for such growth are not limited to the aforementioned trends. Some are more complex—from implementation of electronic health record systems and computer-assisted coding to the transition to the International Classification of Diseases, 10th Revision (ICD-10)—all of which require the capture of specific documentation to be effective.

Add to this the knowledge that data extrapolated from clinical documentation is used in a variety of ways by a variety of organizations—everything from Medicare and Medicaid reimbursement, federal and private quality reporting systems, and even national publications that rank the quality of hospitals and physicians—and the need for accuracy becomes even more important. Yet the clinical language

written by physicians frequently does not match the nuanced language required by coders. Ongoing shifts in healthcare regulatory and reimbursement requirements only increase the challenges that coders face in translating physician documentation into applicable codes.

The goal of a compliant CDI program is to address these complex issues by working across departments as translators in order to obtain complete and accurate documentation of the severity of illness and care provided. The primary tool used to accomplish this task is the physician query.

The goal of this book is to review the regulatory infrastructure governing the query process and to outline an approach to help facilities successfully negotiate the communication barriers between providers and facilities in a compliant manner.

Although many tie the exponential growth of CDI programs to the implementation of Medicare Severity (MS)-DRGs, coders and other professionals have used retrospective queries for many years to facilitate accurate coding. In Chapter 4, we review the evolution of the concurrent query process and CDI. For now, let's review how the historical changes in healthcare reimbursement led to the vital need for concurrent queries, and how current changes in that arena are shifting the focus of CDI efforts.

Advancement of Payment Methods

To understand how clinical documentation influences hospital reimbursement, CDI specialists must first understand how the federal government, through the Centers for Medicare & Medicaid Services (CMS), pays for those services.

In 1965, Medicare reimbursed healthcare based on actual charges. The federal government introduced the inpatient prospective payment system (IPPS) in October 1983 as a way to influence hospital behavior through financial incentives and, in effect, encourage more cost-efficient management of medical care. Three years later, in 1986, CMS implemented the DRG system. This system summarizes the care provided during each patient's stay, grouping up to 24 secondary diagnoses that indicate comorbidities and complications (CC) and up to 25 procedures completed during the patient's stay into a DRG based on the principal diagnosis. The idea was to group diseases together based on comparative costs.[2]

In this system, instead of receiving a payment for each charge submitted, hospitals would receive one pre-dictated sum of money regardless of the number of tests performed or length of the hospital stay. By changing the reimbursement system, CMS felt that hospitals would be incentivized to control costs and length of stay so that they could remain profitable.

Almost 20 years later, in August 2007, CMS finalized its plans to implement the new MS-DRG system as detailed in the fiscal year (FY) 2008 IPPS Final Rule. More than 700 new MS-DRGs replaced the previous 538 DRGs. Additionally, the CC classification expanded to include major complications and comorbidities (MCC), conditions that require more resources than simple CCs.[3]

GETTING MORE SPECIFIC: A CMS-DRG/MS-DRG EXAMPLE

Under the previous DRG system, congestive heart failure (CHF), unspecified—ICD-9-CM code 428.0—was a CC, and if a physician documented it in the record and a coder assigned it, there was a change in the DRG.

Under the MS-DRG system and ICD-10-CM, CHF, unspecified is not a CC. However, if the physician further clarifies whether the CHF is chronic diastolic (I50.32) or chronic systolic (I50.22), it becomes a CC. Further, if a physician specifies CHF as acute diastolic (I50.31) or acute systolic (I50.21), it qualifies as a major complications and comorbidities (MCC).

The catch, as always, is that physicians must be precise with their documentation. For example, even documentation of "acute left heart failure" will not result in an MCC. The words "acute" along with the type, as well as "diastolic and systolic" or "combined systolic and diastolic" congestive heart failure, must be documented to code the MCC. This level of specificity makes an enormous difference in the MS-DRG assigned.

In a press release, CMS Acting Deputy Administrator Herb Kuhn stated that Medicare payments for inpatient services "will be more accurate and [will] better reflect the severity of the patient's condition."[4] CMS also said that the new system would support facilities caring for sicker patients and would help to prevent abuses:

> *Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to cherry pick—the practice of treating only the healthiest and most profitable patients.*[5]

One of the more controversial components of MS-DRG implementation was the assessment of a documentation and coding payment adjustment (DCA). The DCA decreased reimbursement based on the

assumption that facilities would see an increase in their case-mix index not due to an actual increase in cases or care provided, but simply due to the more explicit documentation and coding that the new system required.

Although some labeled this "DRG creep," many pointed to the improvements as the natural outcome of increased cooperation between the coder and provider to accurately define, document, and code patient conditions using appropriate terminology. In fact, given that hospitals faced a new DRG methodology and across-the-board reimbursement cuts by way of the DCA, many believed that hospitals were being incentivized (and were encouraged by the American Health Information Management Association [AHIMA] and other professional organizations) to partner with physicians to improve the definition and documentation of treated conditions.

In fact, the 2008 IPPS Final Rule included the following instruction:

> *We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.*[6]

Facilities began to find better ways to structure their query processes; to clarify imprecise, illegible, inconsistent, or otherwise incongruent physician documentation; and to refine or implement new concurrent record review and query processes to support the retrospective efforts already in place.

The good news with the new MS-DRG system was that coders would still follow the same principal/secondary diagnosis and procedure coding conventions as before. Furthermore, the MS-DRGs were expected to positively impact profiling and reimbursement for hospitals with a higher case-mix index (i.e., more severely ill patients) while requiring more complete and specific information regarding the patient's diagnoses and the care that physicians provided. The related Figure 1.1 illustrates the potential opportunity as well as the potential financial risk.

Although assigning a DRG based on the principal diagnosis and procedure remained essentially the same under the new MS-DRG system, considerable reorientation was needed to understand how the newly added and deleted CCs and MCCs affected secondary-diagnosis assignment and sequencing practices. (Guidance governing such sequencing practices is discussed further in Chapter 3.) Additionally, although the shift to MS-DRGs did not change the coding structure and process, it made various stakeholders along the healthcare chain of command more aware of the documentation specificity required to

appropriately capture the CC/MCC. Just like in the old system, it still takes only one CC or one MCC to change the MS-DRG. In other words, a single element could dramatically alter the clinical picture and the payment related to a given case.

FIGURE 1.1 EXAMPLE OF A DRG CHART REVIEW

Deficiency	Volume	Revenue implication
None	34	0
DRG documentation opportunity	10	$65,867
SOI/ROM* documentation opportunity	7	n/a
Coding DRG opportunity	4	$23,452
Coding SOI/ROM* opportunity	4	n/a
Potential coding risk	2	$-10,422
Total		$78,897

*Additional documentation or coding would not change the DRG; however, it would change the APR-DRG severity of illness and/or risk of mortality for the case.

Obtaining that level of documentation may require CDI specialists to ask multiple physicians a number of questions to capture the terminology that best reflects a patient's severity. Asking such a volume of questions retrospectively (i.e., after the patient has been discharged from the hospital) can prove time consuming, lead to inaccuracies (e.g., the physician does not want to revisit the data and disagrees with the query to make it go away), and delay final coding and billing. Conversely, performing such inquiries on a concurrent basis, while the patient is still in the hospital under a physician's care, not only hastens the process but also improves the accuracy of the information obtained.

Pay for performance

In 1999, the Institute of Medicine reported that medical errors caused more than 50,000 preventable deaths each year, with an associated cost of $20 billion.[7] The 2006 Institute of Medicine report "Preventing Medication Errors" recommended the following:

> *… incentives … so that the profitability of hospitals, clinics, pharmacies, insurance companies, and manufacturers (are) aligned with patient safety goals; … (to) strengthen the business case for quality and safety.*[8]

When healthcare providers receive incentives for performing better—that is, providing better care in a more cost-efficient manner and meeting pre-established targets for the delivery of healthcare—along with disincentives, such as eliminating payments for negative consequences of care (medical errors) or increased costs, the quality of care for Medicare beneficiaries will improve. This is a fundamental change from the traditional fee-for-service and DRG payment methods. The various approaches used to achieve this goal are discussed below.

Signed on February 8, 2006, the Deficit Reduction Act (DRA) required CMS to identify hospital-acquired conditions (HAC) that:

- Are high cost, high volume, or both
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- Could reasonably have been prevented through the application of evidence-based guidelines and are a CC or MCC for the MS-DRG system[9]

In addition, as of October 2007, CMS began requiring assignment of present-on-admission (POA) indicators. The goal of the POA indicator is to better define clinical conditions or consequences that arise during an inpatient admission. Reporting options include the following:

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission
- U = documentation is insufficient to determine whether condition is POA
- W = provider is unable to clinically determine whether condition was POA
- Unreported/not used (or "1" for electronic billing) = exempt from POA reporting

Figure 1.2 illustrates one possible query template that CDI professionals may use to clarify whether a particular diagnosis was POA. It also allows CMS to identify whether an HAC is POA. If it was not (or documentation is insufficient to determine), then the diagnosis does not qualify as a CC or MCC for the MS-DRG assigned. Moreover, if it is the only CC or MCC, the case is assigned to the lower-paying MS-DRG and, hence, penalizes hospitals with poor quality.

FIGURE 1.2

SAMPLE POA QUERY FORM

Clarification is needed for one (or more) of the following conditions in order to assign the "present on admission" indicator accurately. Please check the box that indicates whether the associated condition was present at the time of the order for inpatient admission.

Y	N	U	W	
Yes	No	Unknown	Clinically unable to determine	
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____

Please sign and date below:

_____ _____

Physician signature Date

Source: Physician Queries Handbook, First Edition.

In addition, on October 1, 2014, CMS launched the Hospital Acquired Condition Reduction Program (HACRP)—see Chapter 2 for more information— to incentivize hospitals to reduce HACs. This is part of the Hospital Value-Based Purchasing program.

Value-based purchasing

In 2010, the Affordable Care Act (ACA) required the U.S. Department of Health and Human Services to establish a value-based purchasing (VPB) program for inpatient hospitals and, on May 6, 2011, CMS

published the VBP Final Rule. Whereas the CMS Hospital Inpatient Quality Reporting (IQR) program is a pay-to-report structure (i.e., hospitals receive payments for reporting data), the VBP program provides financial incentives based on adherence to processes and outcomes. It acts in tandem to the IQR.

Starting in FY 2013, CMS began withholding 1% of the base operating MS-DRG payments for each discharge, with plans to gradually increase the amount withheld to 2% by FY 2017. This allows CMS to create a pool of money that is used to reward higher-quality hospitals.[10]

RECENT PERFORMANCE SCORING PLANS

For the final score, each domain score is weighted as follows:

2015

1. Outcome domain = 30%
2. Clinical process of care domain = 20%
3. Patient experience of care domain = 30%
4. Efficiency domain = 20%

2016

1. Outcome domain = 40%
2. Clinical process of care domain = 10%
3. Patient experience of care domain = 25%
4. Efficiency domain = 25%

2017

1. Clinical Care = 30%
   a. Process of Care = 5%
   b. Outcomes = 25%
2. Efficiency domain = 25%
3. Safety domain = 20%
4. Patient experience of care domain = 25%

Sources:

1. *Medicare, Hospital Compare. "The Total Performance Score Information." www.medicare.gov/hospitalcompare/data/total-performance-scores.html*
2. *Stratis Health. "FY 2017 Value-Based Purchasing Domain Weighting." http://www.stratishealth.org/DOCUMENTS/VBP-FY2017.PDF*

FIGURE 1.3

VBP TOTAL PERFORMANCE SCORE (TPS) 2016

VBP total performance score (TPS)		
Domain	**Dist.**	**Measures**
Clinical process of care	10%	• Acute myocardial infarction (AMI): – AMI-7a: Given fibrinolytic medication within 30 minutes of arrival • Pneumonia (PN): – PN-6: Appropriate initial antibiotic(s) • Surgical care improvement project (SCIP): SCIP-Card-2: Patients kept on the beta blockers prior to and after surgery – SCIP-VTE-2: Treatment within 24 hours prior or after their surgery to prevent blood clots after certain types of surgery • Healthcare-associated infections (HAI): SCIP–Inf–2: Surgery patients given correct antibiotic – SCIP–Inf–3: Prophylactic antibiotics are stopped within 24 hours after surgery – SCIP–Inf–9: Surgery patient urinary catheter removed first or second day after surgery • Preventive care: – IMM-2: Patients assessed and given influenza vaccination
Patient experience of care	20%	• Communication with nurses • Communication with doctors • Responsiveness of hospital staff • Pain management • Cleanliness and quietness of hospital environment • Communication about medicines • Discharge information • Overall rating of hospital
Outcome	40%	• Acute myocardial infarction (AMI) 30-day mortality rate • Heart failure (HF) 30-day mortality rate • Pneumonia (PN) 30-day mortality rate • AHRQ (PSI-90) patient safety for selected indicators (composite) • Central line-associated bloodstream infection (CLABSI) • Catheter-associated urinary tract infection (CAUTI) • Surgical site infection (SSI)
Efficiency	25%	• Medicare spending per beneficiary (MSPB-1) measure • Episode spans 3 days prior to and 30 days after the index admission

Source: Centers for Medicare & Medicaid Services, Hospital Compare, www.medicare.gov/hospitalcompare/data/efficiency-domain.html.

The initial 2013 VBP program adopted performance measures under the following two "domains":

1. Clinical process, composed of 12 measures
2. Patient experience, composed of the Hospital Consumer Assessment of Healthcare Providers and Systems survey[11]

Hospitals are evaluated based on whether they met the performance standards for the measures by comparing their performance during the performance period to their performance during a three-quarter baseline period. Each hospital is scored based on achievement and improvement ranges for each measure. Then, a total performance score is calculated by combining the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain.[12]

CMS then converts each hospital's total performance score into a value-based incentive payment.

In 2014, CMS added two more domains to the hospital VBP scoring methodology. The first of these outcome domains encompasses 30-day mortality rates for acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PNA). It also includes Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Indicator (PSI) 90, which is a composite of patient safety measures using coded data. Second, an efficiency domain was added that measures Medicare spending per beneficiary. This measure includes all Medicare Part A and B payments from three days prior to admission through 30 days post-discharge. Both domains are risk-adjusted to account for the severity of the patient's illness.[13]

The VBP performance measures are noted in Figure 1.3. Keep in mind that the resulting scores calculated use hospital data from two years, and that any improvements made this year may not be immediately reflected in VBP data.

Hospital Readmissions Reduction Program

Beginning in 2013, Section 302 of the ACA established the Hospital Readmissions Reduction Program. The program requires CMS to monitor hospitals with excessive readmissions for AMI, HF, and PNA, which are measured by dividing a hospital's number of predicted 30-day readmissions by the number that would be expected based on an average hospital with similar patients. A ratio greater than one indicates excess readmissions and is subject to a payment penalty.

In 2015, CMS expanded the measures to include monitoring of readmissions for chronic obstructive pulmonary disease (COPD) and elective primary total hip and/or total knee arthroplasty (THA/TKA).

Then, in 2016, CMS updated the pneumonia readmission measure by expanding the measure cohort to include the following additional pneumonia diagnoses:

- Patients with aspiration pneumonia
- Sepsis patients coded with pneumonia present on admission (but not including severe sepsis)[14]

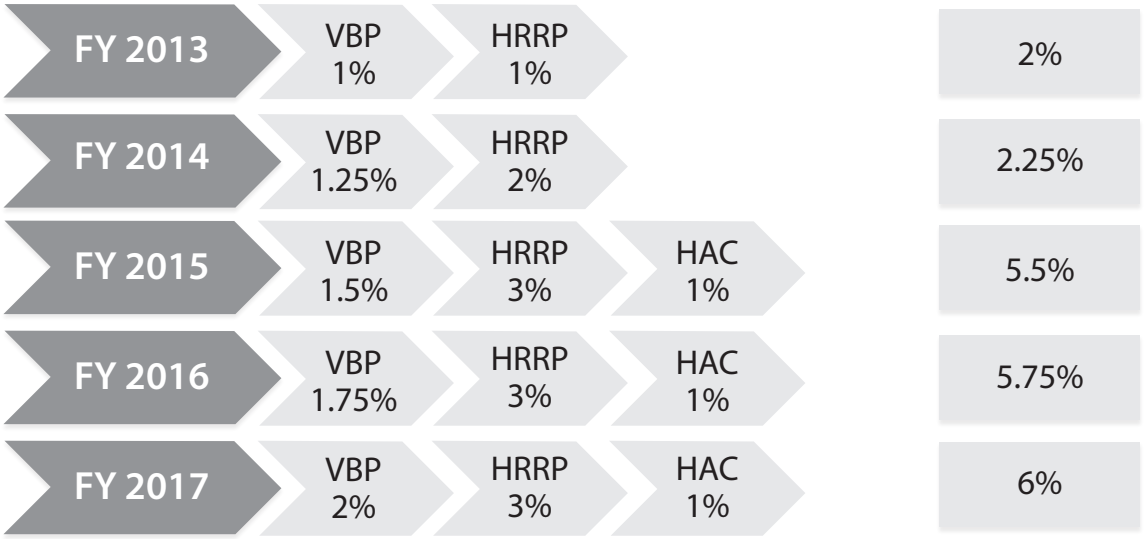
Although the program only monitors certain DRGs, a hospital's base rate for *all* DRGs during that fiscal year will be adjusted based on readmission rates. Figure 1.4 illustrates how these payment reductions have played out, and will continue to play out, over time.

Under such financial constraints, facilities must have a mechanism that both ensures accurate physician documentation and information collection and promotes collaborative effort among medical staff, coders, CDI, case management, and quality team members.

FIGURE 1.4

VBP REDUCTIONS

Value-based purchasing, hospital readmissions reduction program, and hospital-associated conditions reimbursment incentives



Source: Kristen Geissler, MS, PT, CPHQ, MBA, Director, Clinical Economics Berkeley Research Group, LLC, in Cockeysville, MD, presented during the 2012 ACDIS National Conference in San Diego.

Additional pay-for-performance initiatives made headlines in early 2013 when New York City's Health and Hospitals Corporation, the nation's largest public health system, entered into negotiations with its physician unions to tie bonuses of nearly $60 million through 2016 to their quality measures.[15]

Although the onset of MS-DRGs may have increased the need for CDI efforts, the implementation of VBP is changing the focus of those programs dramatically. They are shifting away from CC/MCC capture rates ("one and done") and case-mix index ratios and toward capturing the complete specificity of the entire medical record and facilitating documentation improvement conversations across departmental lines.

To make such a shift requires programmatic changes for CDI professionals. It may require additional staffing or changes to productivity requirements. It may require additional education for CDI specialists and physicians or changes to institutional query forms to incorporate elements of the VBP initiative.[16]

Regardless, facilities with CDI programs and query efforts in place will undoubtedly fare better than those without any concurrent review and query program. Programs that continue to focus solely on CC/MCC capture will need to expand and recalibrate their query efforts to include documentation that supports POA, quality, and risk adjustment.

Meaningful use

Beginning in 2011, CMS and the Office of the National Coordinator for Health Information Technology (ONC) developed Electronic Health Records (EHR) Incentive Programs The program, commonly referred to as "meaningful use," established incentive payments to encourage eligible professionals and eligible hospitals, critical access hospitals (CAH), and Medicare Advantage Organizations to adopt and demonstrate meaningful use of certified health information technology (HIT) and qualified EHR technology. The goals of the meaningful use program include the following:

1. Improving quality, safety, and efficiency
2. Reducing health disparities
3. Engaging patients and families in their health
4. Improving care coordination

5. Improving population and public health

6. Ensuring adequate privacy and security protection for personal health information

To meet these goals, the program has been organized into three stages, which CMS updates each year:

Stage 1: Data capture and sharing

Stage 2: Advance clinical processes

Stage 3: Improved outcomes

Failure to meet the criteria for each designated phase within a pre-defined period of time will result in a penalty. Although participation is voluntary, facilities and providers who failed to join by the 2015 deadline will receive negative adjustments to their Medicare fees, starting from 1% and increasing to a total of 3% by 2017.

The penalties collected are then given to those facilities who have successfully implemented EHR technology and demonstrated meaningful use as set by the criteria at each stage. As of January 2016, more than 484,000 health care providers received payments for participating in the Medicare and Medicaid EHR Incentive Programs, equating to more than $21 billion in payments between May 2011 and December 2015.[17]

CDI can have a significant role in each stage of the EHR implementation process, but it can also reap the benefits in the physician query process. Electronic patient records contribute to much clearer and more legible information, and the EHR is a central repository of information that allows caregivers timely access and input of all patient information. In that context, it is the CDI professional's role to ensure that the record's quality and accuracy meets the needs of all who use the information. This role has never been more critical.

All these changes speak to the importance of CDI programs, including a need for a structured concurrent and retrospective physician query processes. In fact, one of the greatest challenges comes from helping physicians understand the reporting language of the clinical care they provide. The rest of this book explores how to accomplish concurrent and retrospective queries in a manner that is compliant and that promotes accurate DRG, quality, and VBP reimbursement.[18]

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The Essential CDI Guide to PROVIDER QUERIES

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ISBN-13: 978-1-68308-084-8
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