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Your Compass For Navigating Turbulent Financial Waters for Revenue Cycle 2015

Clinical Documentation: The Foundation for Revenue Cycle Excellence

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Project Manager for Lahey Hospital and Medical Center

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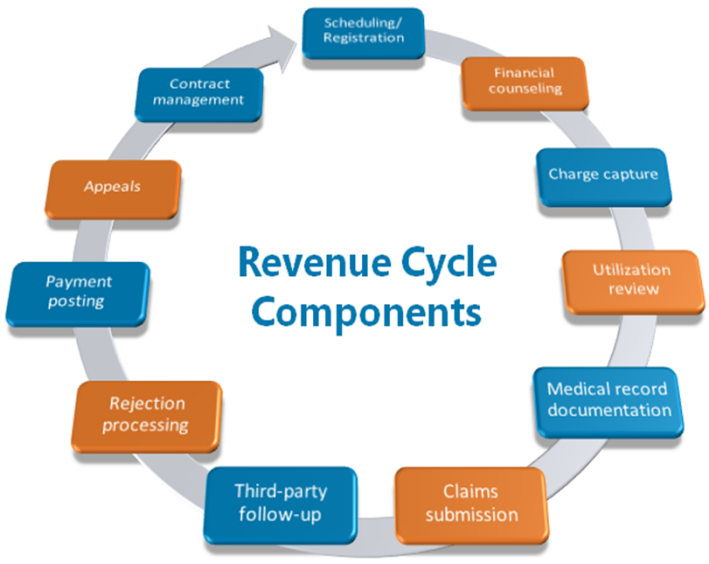

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Your Compass For Navigating Turbulent Financial Waters for Revenue Cycle 2015

Financial Drivers of Clinical Documentation Improvement (CDI)

- DRGs
- Professional Coding and Billing
- OPPS
- HCC

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Financial Drivers of Clinical Documentation Improvement

- Pay for Performance
  - Value Based Purchasing
  - HACRP
  - HRRP
  - PSIs
  - IQIs
  - HACs

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Financial Impact of CDI on Inpatient Revenue

Increase CMI from 1.3 to 1.4 at mid-size hospital with blended rate of $6000 and 4000 discharges/year:

0.10 X $6000/discharge X 4000 discharges/yr =

$2,400,000 per year

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Financial Impact of Clinical Documentation on Medicare Advantage

- Increase average RAF (risk adjustment factor) per patient from 1.0 to 1.1 based on documentation. The effect on Health Plan with $600 pmpm payment and 10,000 covered lives:

0.10 X $600 pmpm X 10,000 members =
$600,000/month increase

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Financial Impact of Documentation on Professional Billing

- Increase E&M levels from average of 3.5 to 4.1 in Emergency Department with 30,000 visits per year
- Equivalent to an increase in 0.81 RVUs per encounter.

0.81 rvu/pt X $35/rvu X 30,000 pts/yr = $850,000/yr

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Financial Impact of Documentation on Pay for Performance Measures

- Inadequate documentation result in falsely elevated numbers of Patient Safety Indicators (PSIs) and poor risk adjustment of severity of inpatient cases can result in loss of Medicare revenue:
  - 1% in HACRP
  - 1.5% in VBP
  - 3.0% in HRPP

  For Hospital with $35,000,000 in annual Medicare Revenue, 5.5% of $35M = $1,925,000 is at risk

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Clinical Documentation Impact on Coding

- Documentation determines coding
- Coding determines:
  - Payment
  - Quality metrics
  - Resource utilization metrics
  - Risk adjustment of cases
  - Pay for Performance
  - Medical necessity

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Coding: Healthcare's Clinical Accounting System

- Every encounter/claim
  - ICD-9 diagnosis code
    - Reason for service
    - Justification for Medical Necessity
    - Risk adjust encounter/pt
    - Determines payment
  - 'Service Code'
    - E&M code
    - CPT procedure code
    - ICD-9 procedure Code
    - Determines Payment

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Lahey CDI Program

- History
  - 2011 - 0.75 FTE
  - 2012 - 1.5 FTE
  - 2013 - 2.0 FTE
  - 2014 - 3 FTE
  - 2015 - 5 FTE

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Targeting of Cases

- Small vs. Large CDI staff
- Medicine vs. Surgery
- Information sources for targeting
  - Coding/DRG validation
  - Physician Advisor
  - Quality
  - Case management

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Technology

- CDI tracking
  - Manual
  - CDIS 3M 360

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Communication

- Interaction between Departments
  - CDI
  - Coding
  - Quality
  - Case Management
  - ACO

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Physician Engagement

- Education and involvement by Physician Advisor
- Repetition
- Building close relationships

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Data Collected

- Volume
- Percentage of Queries
- Physician response rate
- SOI/ROM
- UHC data
- CMI

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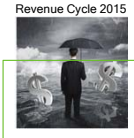

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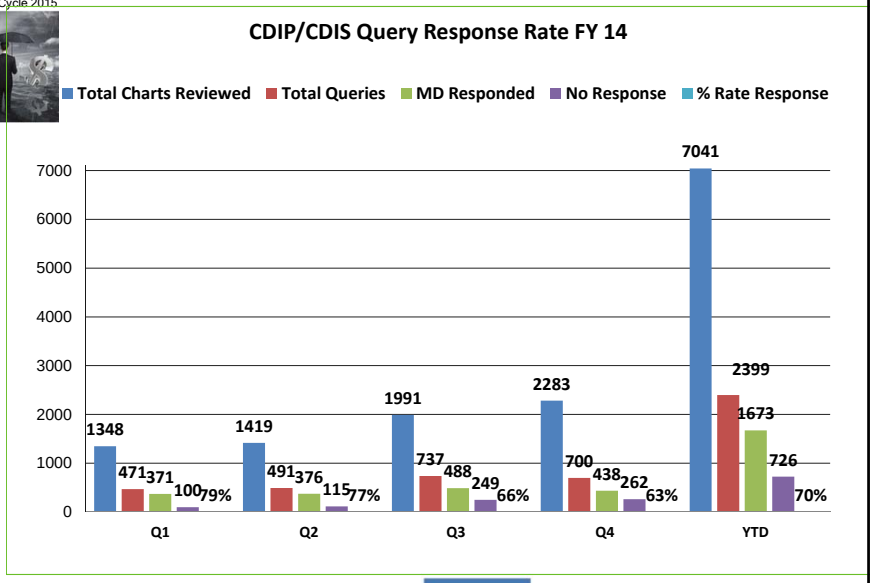

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No Response, MD Queries, September 2014

Attending Physician Service:	Query Type:	Pre-Query Financial Impact	Post-Query Financial Impact	
CARDIOLOGY	003 Clinical Findings	$74,058.73	$109,851.39	$35,792.66
COLON RECTAL SURGERY				
GENERAL INTERNAL MEDICINE				
HEPATOBILIARY SERVICES				
HOSPITALISTS				
NEUROSURGERY				
HOSPITALISTS	041 Pneumonia Specificity	$7,813.35	$7,813.35	$0.00

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No Response, MD Queries, September 2014

Attending Physician Service:	Query Type:	Pre-Query Financial Impact	Post-Query Financial Impact	Difference
GENERAL INTERNAL MEDICINE	210 Documentation Clarification	$60,172.99	$77,055.21	$16,882.22
HOSPITALISTS				
ORTHOPAEDIC SURGERY				
PERIPHERAL/VASCULAR SURGERY				
VASCULAR MEDICINE				
HOSPITALISTS	227 Rule Out Sepsis	$8,071.65	$8,071.65	$0.00

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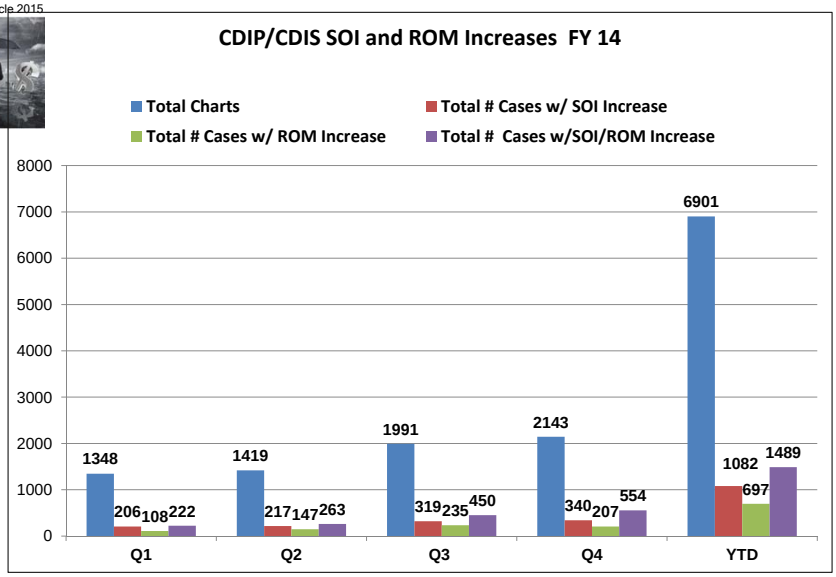

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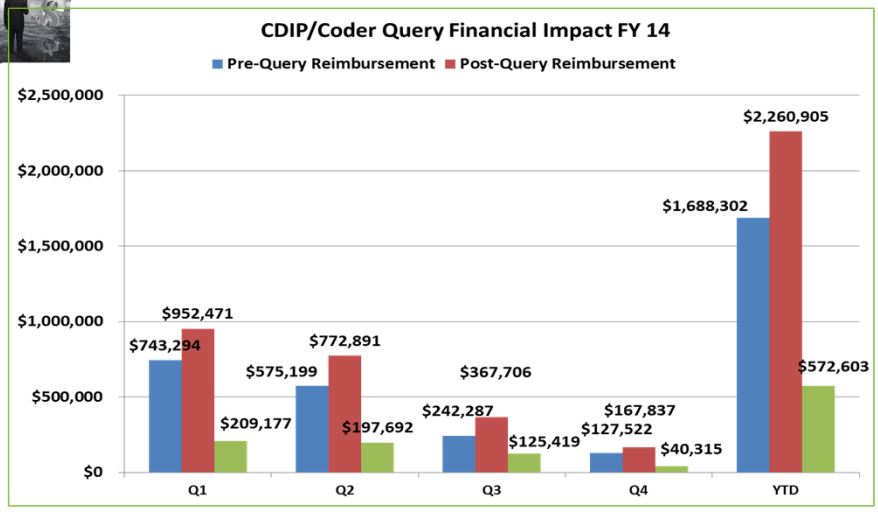

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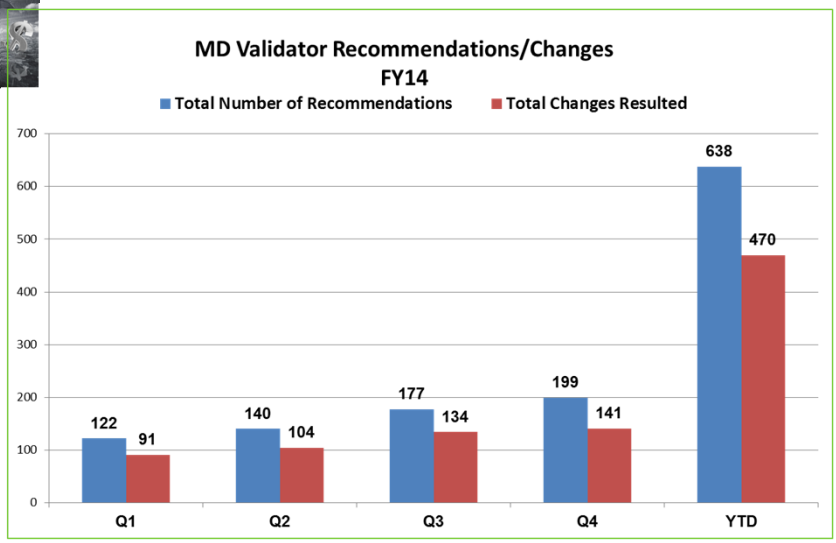

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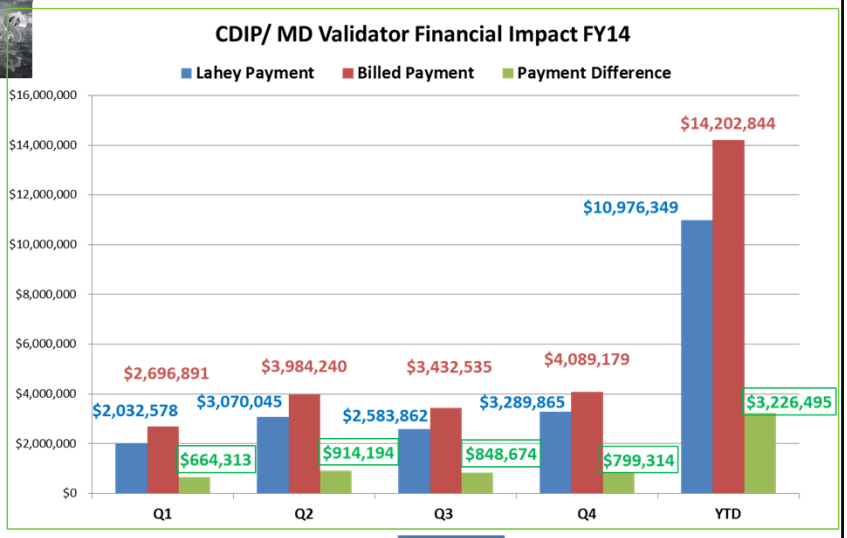

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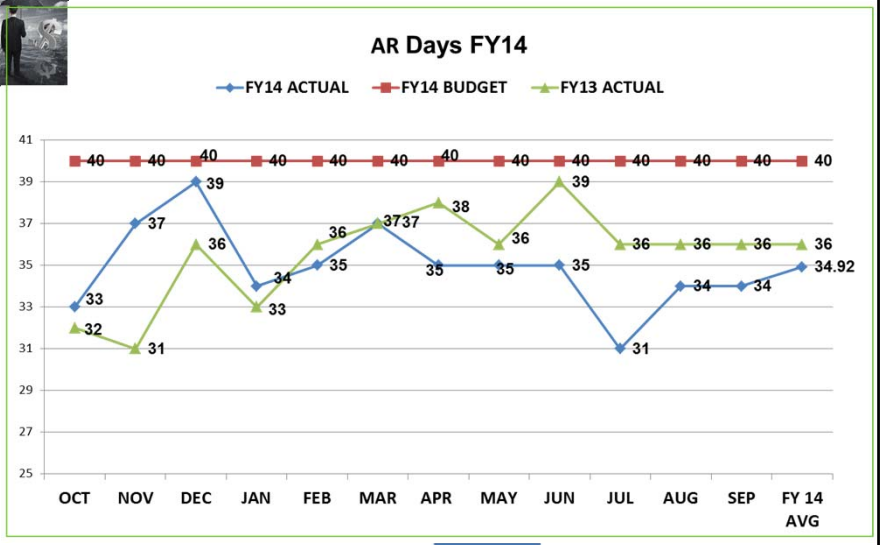

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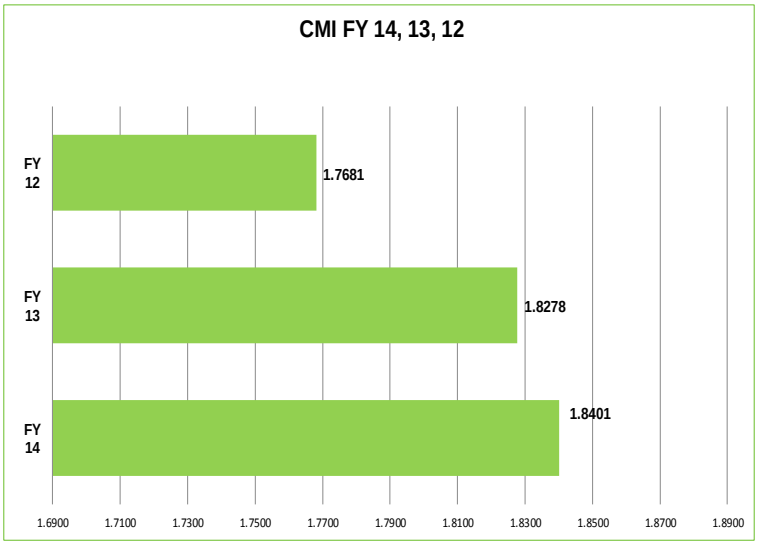

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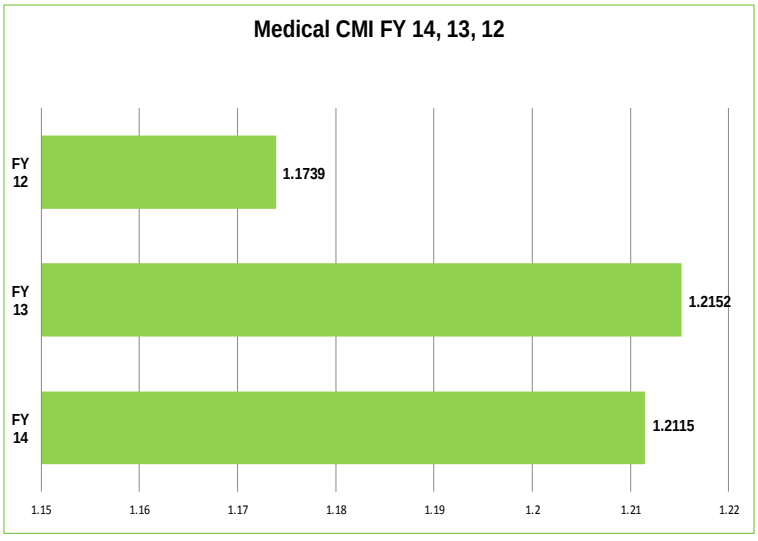

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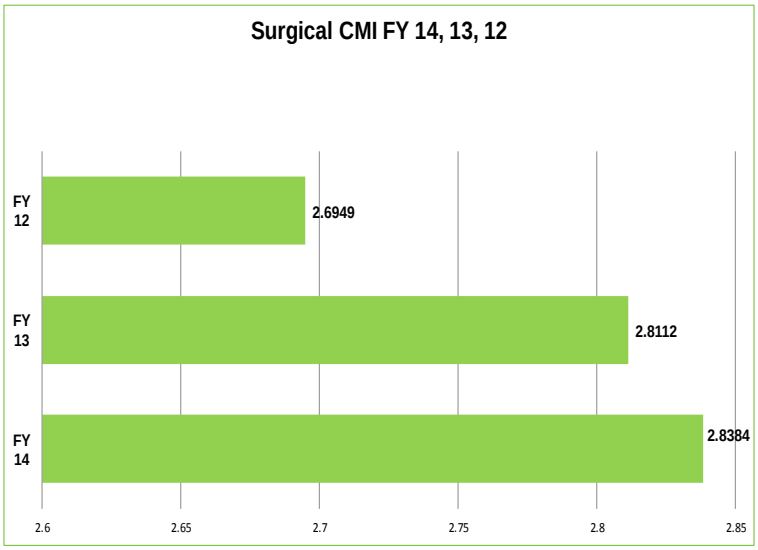

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CDI PRESENTATION SCHEDULE, FY14

Department	Department	Department
Hospital Medicine first group	Surgical Critical Care	Vascular Surgery and MIDLEVELS
Gastroenterology	Neurology	Surgical Residents
Residents	Radiology/IR	Neurosurgery Mid-levels
GIM~BUR	Cardiothoracic Surgery	Neuro Mid-levels
Hematology/ Oncology	Colorectal	Transplant
Hospital Medicine second group	General Surgery	Emergency Medicine
Cardiology	Gynecology	Urology
Infectious Disease	Neurosurgery	Case Management
Nephrology	Orthopedic Surgery	Quality
Pulmonary and Midlevel's	Orthopedic Mid-Levels	Coding
	Plastic Surgery	Admitting

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CDIS FOCUS for FY15

- For all services increasing verbal queries, being more aggressive with the surgical specialties, utilizing other services to improve information sharing to optimize inpatient cases, trying to maximize capture of POA electrolyte imbalances and PMH for SOI/ROM, trying to get diagnoses specified instead of symptoms (i.e. AMS, chest pain, fall etc.)
- For all services trying to educate re: all HAC's but a strong focus on appropriate documentation of CAUTI's and CLABSI's not POA but when appropriate to document clinically unable to determine, if not proven source.
- For all PSI's, emphasis is on clarifying when conditions are intrinsic to procedure and not of clinical significance, so complication codes are only assigned where appropriate.
- For all HAC's clear documentation when can find evidence was POA (pressure ulcers, PNA's, DVT's, CAUTI's and CLABSI's).

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CDIS FOCUS for FY15

Intensivists: really stepped up education with Physicians via several meetings and ongoing 1:1. Focus on POPI when appropriate, early sepsis (v. post op), shock instead of 'hemodynamic instability' or hypotension. Trying to coordinate efforts with Intensivist documentation/education with that of main services that admit to SICU to minimize conflict.

Cardiology: More recent focus with cardiology attendings to document hypertensive heart Disease w/ CKD to capture MCC when admission for CHF exacerbation only. Using 'small' NSTEMI over demand ischemia when appropriate. Generally they are doing very well specifying heart failure.

- Ongoing focus on maximizing SOI/ROM by querying for CKD stage, DM complications, and complete PMH's.
- PSI/HAC focus: Accidental puncture/Lac, Metabolic derangement, AKI

Neuro: Continue to maximize capture of high impact Neurology Diagnoses including Cerebral Edema and Compression of Brain, Obstructive Hydrocephalus and Hemiparesis, Accelerated HTN, TIA's going for underlying cause.

- Reinforcement in Education session promises greater attending by-in, spoke directly to need for attending oversight of mid-levels to assure highest rate of capture possible
- PSI/HAC focus: Dural tear (separate coding from Accidental puncture/Lac), AKI (toxic nephropathy)

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CDIS FOCUS for FY15

Vascular: DM complications and underlying causes for ulcers, ischemia. CKD staging. Sepsis w/ post op wound infections
PSI/HAC focus: POPI (w/ Intensivist), DVT's (make sure clear documentation when POA)

Heme – Onc: Malnutrition and pancytopenia, including r/t to chemo. Clarification re: active CA's v. Hx. CKD/AKI. Cerebral edema/compression of brain w/ brain lesions/masses/CA
PSI focus: CLABSI's, CAUTI's, pressure ulcers

Ortho: Maximize POA Diagnoses, post op capturing expected ABLA when fractures present, acute drop in Hematocrit when expected post op no fracture, DVT's POA
*Cases with complication issues usually get transferred to hospitalists, so have worked with them re: specific documentation needed when intrinsic or expected.
PSI focus: postoperative anemia (see above), DVT's, complications of prosthetics, POPI with Intensivists

Urology: CKD staging, DM complications, Cancer documentation (active Dx v. Hx) to maximize SOI/ROM, Sepsis/SIRS (Urosepsis)
PSI focus: post op AKI (need to clarify guidelines during education session as we have w/ Cardiothoracic), postop anemia, Accid., Punct./Lac, POPI (w/ Intensivists)

Hospitalists/GIM (All CDI's): Diagnoses for symptoms. Maximizing PMH (CKD stage, DM complications, active conditions). Documentation of Acute Resp Fx, Encephalopathy, Malnutrition w/ severity, Sepsis/SIRS, CHF specificity, AKI. Still need to improve documentation of likely complex PNA's
PSI/HAC focus: general guidance/education to document when intrinsic to procedure v. a complication, when possibly POA (pressure ulcers, DVT's, PNA's, CAUTI's).

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CDIS FOCUS for FY15

Hepato-Biliary: Queries to clarify when hepatic encephalopathy active Dx v. PMH, AKI/CKD, complications of transplanted organs, post-op complications (typically infection/abscesses, retroperitoneal hemorrhage), Acute Liver Injury (when doesn't meet criteria for shock liver)
PSI/HAC focus: Accid. Punct./Lac., Anemia, POPI (with Intensivists)

ColoRectal: Clarifying abscess to capture MCC when intra-abdominal, sepsis/SIRS queries, Malnutrition, early sepsis v. post op sepsis
PSI/HAC focus: Accid. Punct./Lac., POPI (with Intensivists), post op sepsis, ileus

Gen. Surg.: Sepsis/SIRS, CKD staging/AKI, abscesses,
PSI/HAC focus: Accid. Punct./Lac, POPI (trauma, with Intensivists), post op ileus

Cardiothoracic: New understanding/goals following meeting w/ MD Validator, emphasis on capturing SOI/ROM via PMH (CKD stage, DM comp., chronic CHF specificity. Seems to be some consensus agreement w/ documenting 'acute drop in hematocrit' as more accurate than 'expected acute blood loss anemia', will use this for queries going forward. Clarified CTS guidelines for querying for AKI (typically post op). Also broached topic of POPI.
PSI/HAC focus: Pneumothorax excluded as PSI, Accid., Punct/Lac, AKI (only PSI if dialysis)

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FY 2015 Medical Staff EDUCATION Objectives for CDIS

1. Verbal Engagement/physicians and midlevels
   A. DRG and APR-DRG assignment
   B. SOI/ROM
   C. Value Based Purchasing
      i. PSIs/HACS
2. ICD-10 Specialty Specific Education
3. Education of Medical Staff leadership regarding documentation and coding impact on VBP

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How does CDI translate documentation into RESULTS?

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CDI target: DRGs

78 y/o admitted thru ER with fever, confusion and UTI. T-102.2, BP86/60, WBC-15,000, lactate 4.8. Pt is admitted to ICU with UTI and hemodynamic instability. Will tx with ABX, fluids and pressors as needed.

Principal dx: UTI **DRG: 690 UTI w/o cc**

Payment: $5200 **ROM/SOI: 1 / 1**

78 y/o admitted thru ER with fever, confusion and UTI. T-102.2, BP86/60, WBC-15,000, lactate 4.8 Pt is admitted to ICU with Sepsis due to UTI. Meets SIRS criteria. Suspect early septic shock evidenced by hemodynamic instability and acidosis. Likely metabolic encephalopathy. Tx with ABX, fluids and pressors .

Principal dx: Sepsis **DRG: 871 Sepsis w mcc**

sec dxes: septic shock, UTI, **Payment: $13,000**

acidosis, encephalopathy **ROM/SOI: 3 / 3**

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CDI target: DRGs

78 y/o admitted thru ER with abd pain x 6 hours, Tender abdomen with rebound. T-99.2, WBC-15,000, Cr 1.8 CT with free air in abdomen. Pt taken to OR. Perforated diverticulitis dxed. Turbid peritoneal fluid present. Hemicolectomy with peritoneal irrigation.

Principal dx: diverticulitis **DRG: Major colon surgery w/o cc**

Payment: $13,000 **ROM/SOI: 2 / 1**

78 y/o admitted thru ER with abd pain x 6 hours, Tender abdomen with rebound. PMH-CKD T-99.2, WBC-15,000, CT with free air in abdomen. Pt taken to OR. Perforated diverticulitis dxed. Turbid peritoneal fluid present. Hemicolectomy, peritoneal irrigation. Peritonitis documented

Principal dx: diverticulitis **DRG: Major colon surgery w mcc**

sec dxes: peritonitis, ckd

Payment: $41,000 **ROM/SOI: 3 / 3**

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Medicare Advantage

- Medicare HMOs
- 25% of all Medicare patients
- Payment is per member per month to HMO
- HMO contracts with hospital and MDs
- Risk adjusted by HCC

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HCC Hierarchical Condition Category

- Risk Adjustment System
- Based on demographic factors and on ICD-9 diagnosis codes
- Patient is assigned to one or more of approximately 70 HCCs
- HCCs are designed to predict utilization of all Healthcare

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HCC Example

Risk Factors	RAF
76 y/o female	0.468
Medicaid Eligible	0.177
Total RAF	0.645
PMPM payment	$485
Annual Payment	$5805

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Risk Factors	RAF
76 y/o female	0.468
Medicaid Eligible	0.177
Diabetes (HCC 19)	0.181
Vascular Dis. w/o chronic condition(HCC 105)	0.324
Total RAF	1.15
PMPM payment	$863
Annual Payment	$10,350

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Risk Factor	RAF
76 y/o female	0.468
Medicaid Eligible	0.177
DM vasculopathy(HCC15)	0.608
Vascular Dis. w chronic condition(HCC 104)	0.645
CHF 80	0.395
Disease Interaction	0.204
Total RAF	2.497
PMPM payment	$1873
Annual Payment	$22,473

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Pay for Performance (P4P)

- CMS is transitioning from being a payer for services rendered to a purchaser of care based on quality of services provided. Three key programs provide the framework for this transition:
  - Hospital Acquired Condition Reduction Program HACRP
  - Hospital Value Based Purchasing HVBP
  - Hospital Readmission Reduction Progeram HRRP
- Each program measures hospital performance using defined risk adjusted outcomes and assigns rewards and penalties based on performance.

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P4P

- P4P outcomes can impact up to 5.5% of hospital Medicare payments.
- These outcomes are derived from or modified by ICD-9 codes on claims.
- Clinical Documentation determines these code assignments.
- For 2015
  - HACRP 1.0%
  - HVBP 1.5%
  - HRRP 3.0%

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HACRP

(Hospital Acquired Condition Reduction Program)

- 1% reduction in annual Medicare revenue if hospital is in worse performing quartile
- Determinates:
  - PSI Composite 90 (Patient Safety Index)
  - Incidence of
    - Catheter Associated UTI (CAUTI)
    - Central Line Associated BloodStream Infection (CLABSI)

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PSI-90 composite

- Defined by assigned codes on claims
  - Accidental puncture/laceration during a procedure (998.2)
  - Peri Operative DVT or pulmonary embolus
  - Post Op Sepsis
  - Post Op Respiratory Failure
  - Post Op Hip Fracture
  - Central venous catheter infection
  - Iatrogenic pneumothorax
  - Pressure Ulcer
  - SCORES ARE GREATLY AFFECTED BY DOCUMENTATION AND CODING

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HVBP

(Hospital Value Based Purchasing)

- Payments for all hospital are reduced to fund an "incentive pool" which is paid to hospitals who perform well on metrics which are based on:
  - Outcome measures: PSIs, 30 day mortality rates, CLABSI, all of which are risk adjusted
  - Patient experience of care
  - Process of Care (core measures)
  - Efficiency
    - Includes proposal for how much episode of care cost as opposed to hospital care cost

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HRRP

(Hospital Readmission Reduction Program)

- Hospital with excess readmission for heart failure, pneumonia, MI, COPD, Hip and Knee replacement are financially pnealized up to 3% of Medicare reimbursement.
  - Excludes planned readmission
  - Risk adjusted

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Risk Adjustment

- All P4P measures are risk adjusted
- DRG and HCC payments are based on risk adjustment concept
- Risk adjustment is the rationale on which changes in Healthcare purchasing are based

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Risk Adjustment

- Adjusting the outcome measurement (readmission rates, quality measures, resource utilization measures) based on the difference in risk in specific patients that make up the sample.
  - Allows for comparison of physicians, hospitals, healthcare systems
  - Allows for increase payment for better care
  - Allows for direction of patients to preferred providers based on quality and utilization measures
  - Depends on accurate risk adjustment which in large part depends on accurate documentation and coding.

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Risk Adjustment

- Risk adjust cases by coding diagnoses that are documented
- Identify diagnoses that are not (adequately) documented and obtain further documentation
- Obtain institution wide definitions and education on diagnoses that are often present but frequently underdiagnosed.

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Public Reporting

- Hospital Compare
- Physician Compare
- Insurance Plan reports
- Health Grades

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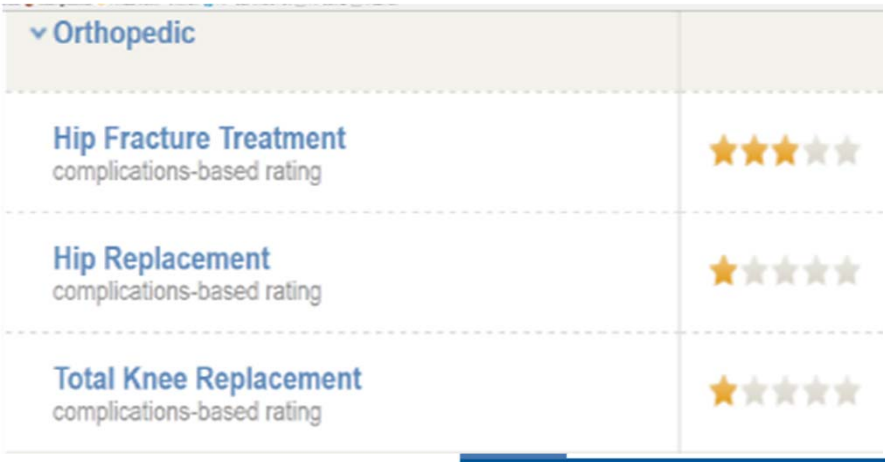
Health Grades



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Value Based Purchasing for Physicians

- "value based payment modifier"
- Will be used to adjust Medicare FFS payments
- Based on quality and cost measurements
- To be phased in over 2015 to 2017
- Based on performance beginning in 2013

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Quality and Resource Use Reports

- Provides report for individual physicians on performance on 28 quality indicators
- Resource use
  - Per capita costs
  - Pt care directed by M.D. -35% or more care
  - Risk adjusted by HCC

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• Medical Necessity

- CMS
  - 2 Midnight Rule
- Insurance:
  - InterQual
  - Milliman

  - Role of CDI in Medical Necessity

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Your Compass For Navigating Turbulent Financial Waters for Revenue Cycle 2015

Conclusions:

- Shifting of the payment system

- Highly integrated program
  - Staffing
  - Physician Advisor
  - Effective operational management

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Conclusion

- Direct CDI program to multiple targets
  - CMI
  - HCC
  - Professional services
  - P4P

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Conclusion

- CDI must engage physicians.
- CDI must integrate with coding.
- CDI must integrate with quality .
- CDI must integrate with case management.
- CDI must have physician advisor
- CDI must have effective ongoing operational management

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