Achieving Optimal CDI ROI—Proper Alignment & Integration with Revenue Cycle

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Objectives

- Understand the fundamental framework and key provisions of CDI initiatives which in turn serve as the basis for success and measureable, meaningful return on investment (ROI).

- Outline pitfalls of traditional CDI programs and identify opportunities to engage physicians in true CDI efforts that support the overall revenue-cycle process.

Objectives

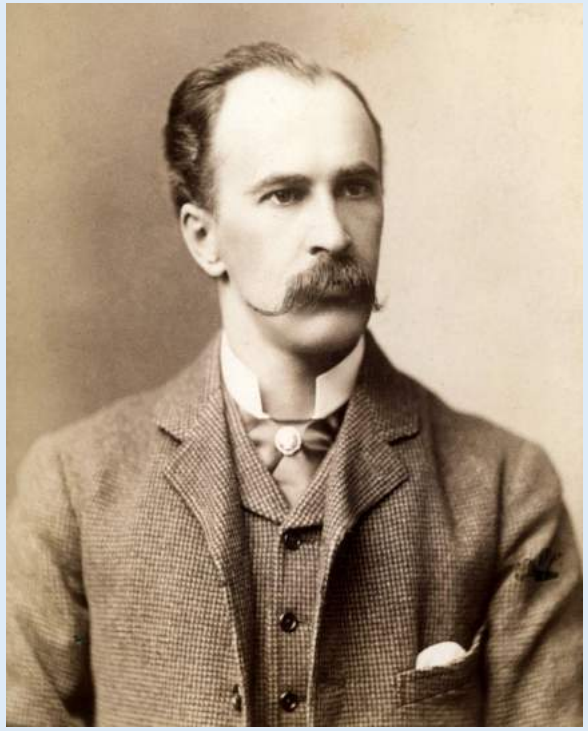
- Learn what measures to utilize when measuring and demonstrating reliable ROI from your CDI program.
- Outline how best to incorporate CDI into a proactive approach to denials avoidance vs. a reactive approach to denials and appeals management.
- Learn how to realign and more closely integrate CDI with the revenue cycle, fostering a culture of denials avoidance

Clinical Documentation – the Purpose

- **Communication of Care Rendered to Patient**
  - Continuity of patient care
  - Measures of Outcome and Quality
  - Fee-for-Value
  - Measures of Efficiency
  - Reimbursement & Revenue Cycle Processes
  - Case Management & Utilization Review
  - Joint Commission Requirements
  - Conditions of Participation

Know Thy Purpose

- The medical record was first used by physicians to record their findings and actions and as a vehicle to communicate with other physicians who might care for the patient in the future.



Getting Started—Transforming CDI

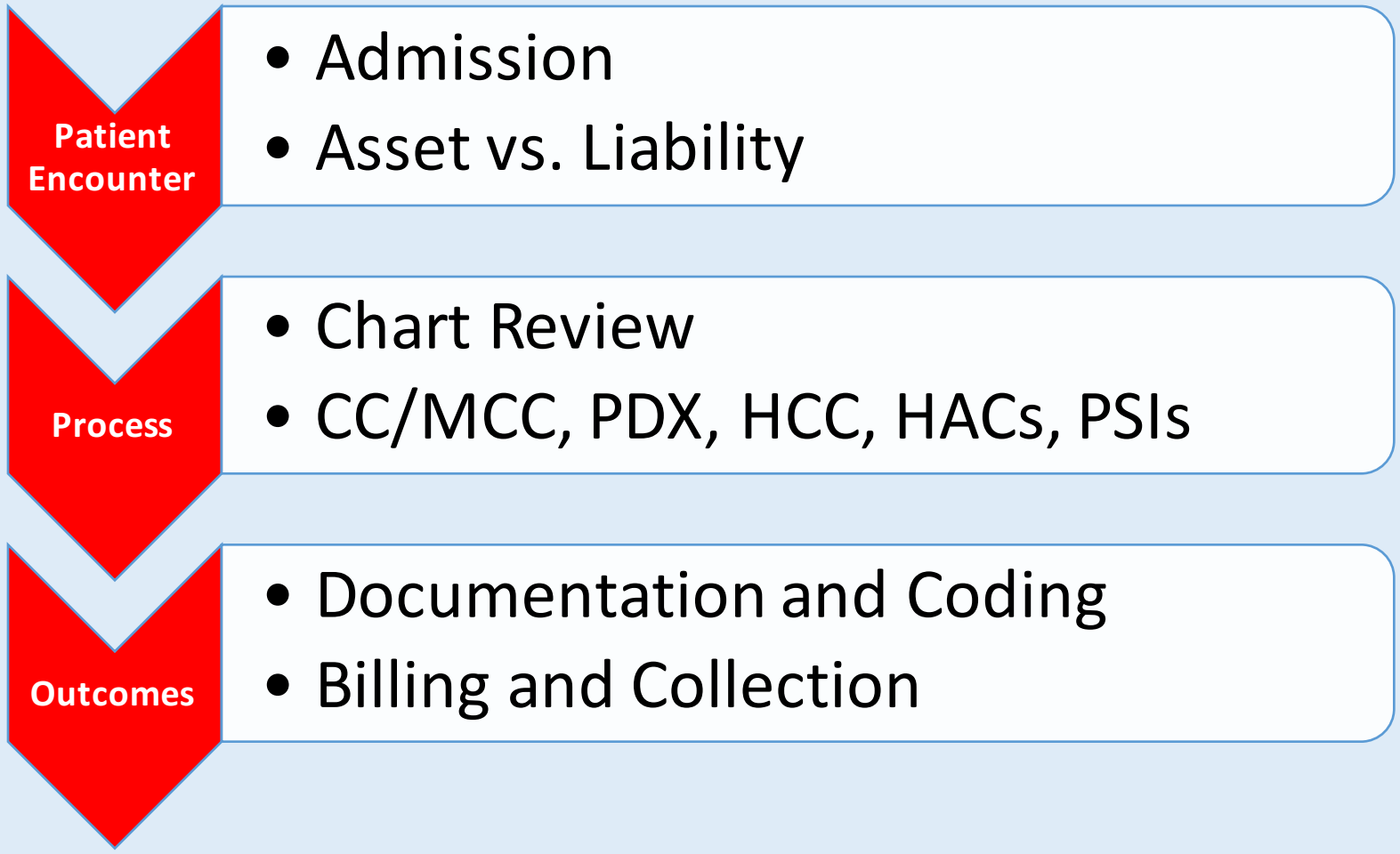
PDI (aka CDI) – What It Is and Isn't

- **"PDI"** vs. **"CRI"**
- **"Physician Documentation Improvement"** vs. **"Clinical Reimbursement Improvement"**
- **"Outcomes"** vs. **"Process Improvement"**

Current Framework

- CDI Staff Review Charts
- Clinical Queries
- Query Response
- Coding & MS-DRG Enhancement
- Positive* Case-Mix & Reimbursement Effect

Current Framework




DON'T ASK WHAT'S WRONG,
ASK WHAT'S MISSING.
— MICHAEL HYATT —
MICHAELHYATT.COM

Missing Elements

- Process Improvement
- Driving Change in Physician Documentation Behaviors
- Encompassing Birds-Eye View
- Alignment & Integration with Revenue Cycle

Current Process Limitations

- Episodic
- Repetitive; Only Low-Hanging Fruit
- Narrow Scope
- Documentation Insufficiencies and Inconsistencies
- Process vs. Outcomes – Approach and Mindset
- KPI – Reimbursement-Focused

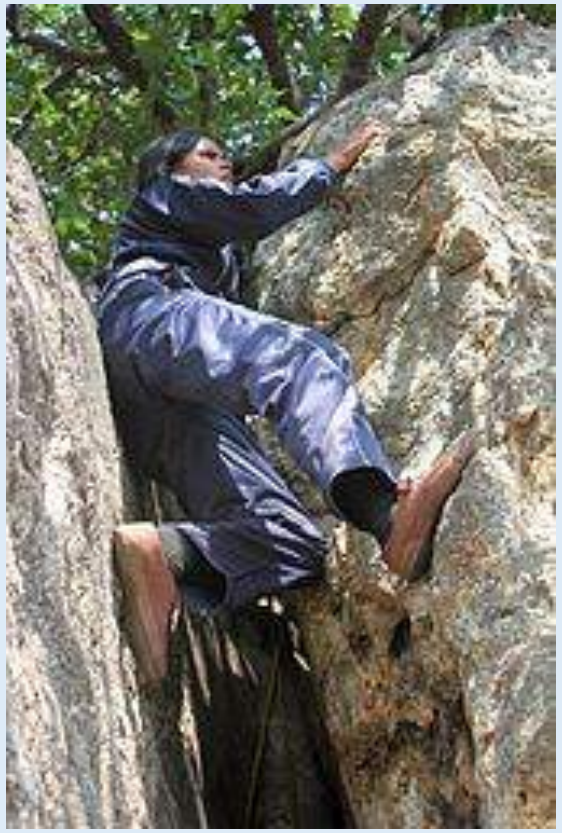
Current Process Limitations

- Clinical Validation
- Clinical Content and Context vs. “Buzz Words”
- Progress Notes that Neither Describe Nor Show Progress
- Discharge Summaries that Fail to Capture Discharge Information
- Insufficient Data Analysis, Data-Mining, and Computer Matching
- Potential for Increased Medical-Necessity Denials
- Potential Incongruence with Quality Department

Limiting Factors

- **Status quo**
  - Consulting Companies
  - **C**linical **R**eimbursement **I**mprovement
  - Training
  - Ingrained Standardized Process
  - Skillsets, Core Competencies, and Knowledgebase
  - Lack of Forces to Drive Change

Other Limitations

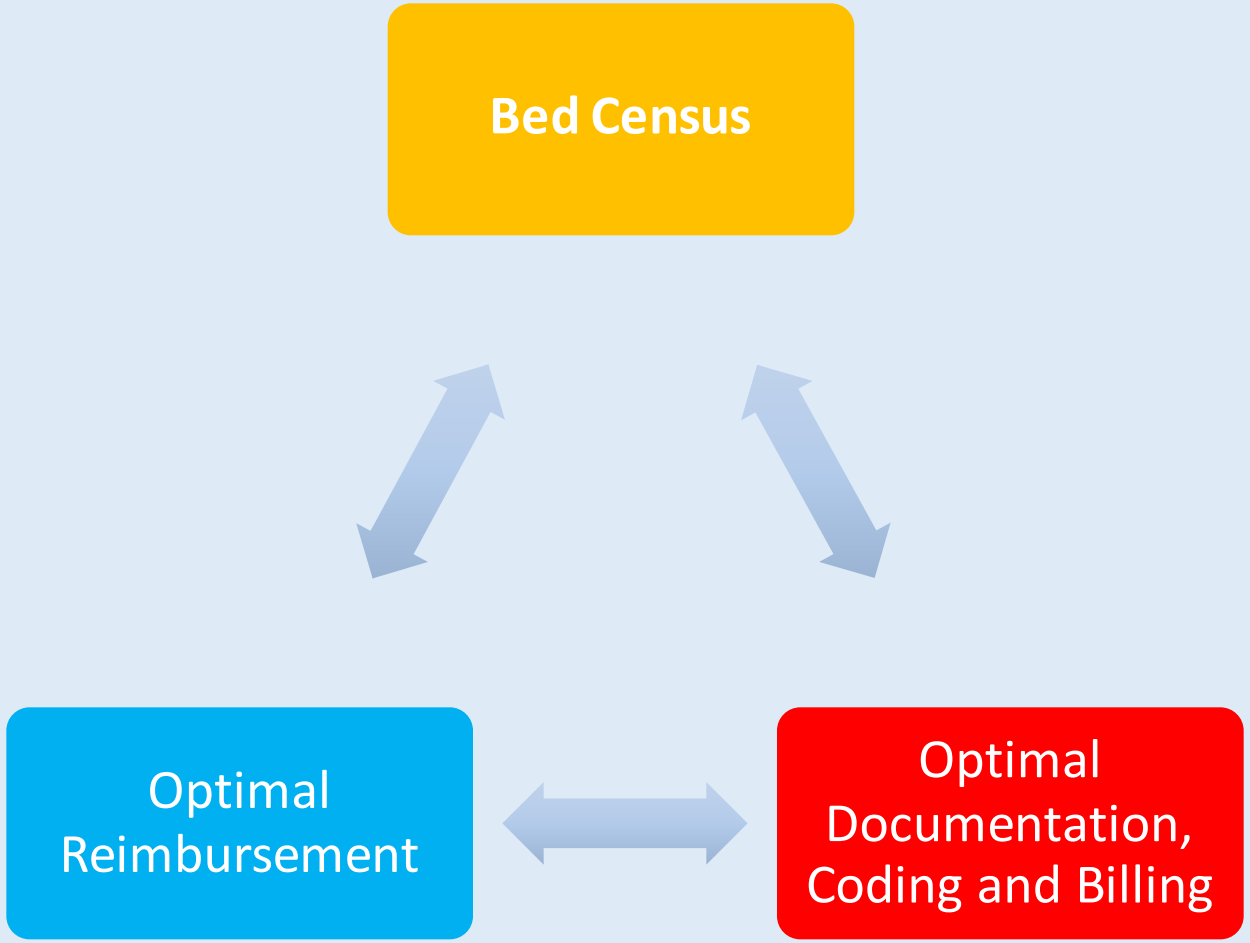


Blind Obedience

- Preoccupation with Outcomes
- Aftereffect Deficient
- Cognitive Bias
- Revenue Cycle Impediment

Case in Point

- **Highest-Cost MS-DRGs Consistently (2013). Total Costs:**
  - Major Joint replacement or Reattachment of Lower Extremity: $6.6 B
  - Septicemia or Severe Sepsis: $5.56 B
  - Infectious & Parasitic Diseases: $2.18B
  - Heart Failure & Shock: $2.11B
  - Spinal Fusion Except Cervical: $2.10 B


Bed Census
Optimal Reimbursement
Optimal Documentation, Coding and Billing

Current Key Performance Indicators (KPIs)

- # Cases reviewed
- # Cases queried (sent request for clarification to a provider)
- % Cases queried
- $ Impact
- % Increase in CMI
- % Queries with DRG changes
- Query response rate

Current KPIs

- Secondary diagnosis addition—revenue versus non-revenue impact
- SOI & ROM increase
- Number of charts touched
- Follow-up percentage
- Days taken to open case

Current KPIs

- Query agreement rate
- Provider groups queried
- Compliant Query template usage
- Individual providers queried

Potential KPIs

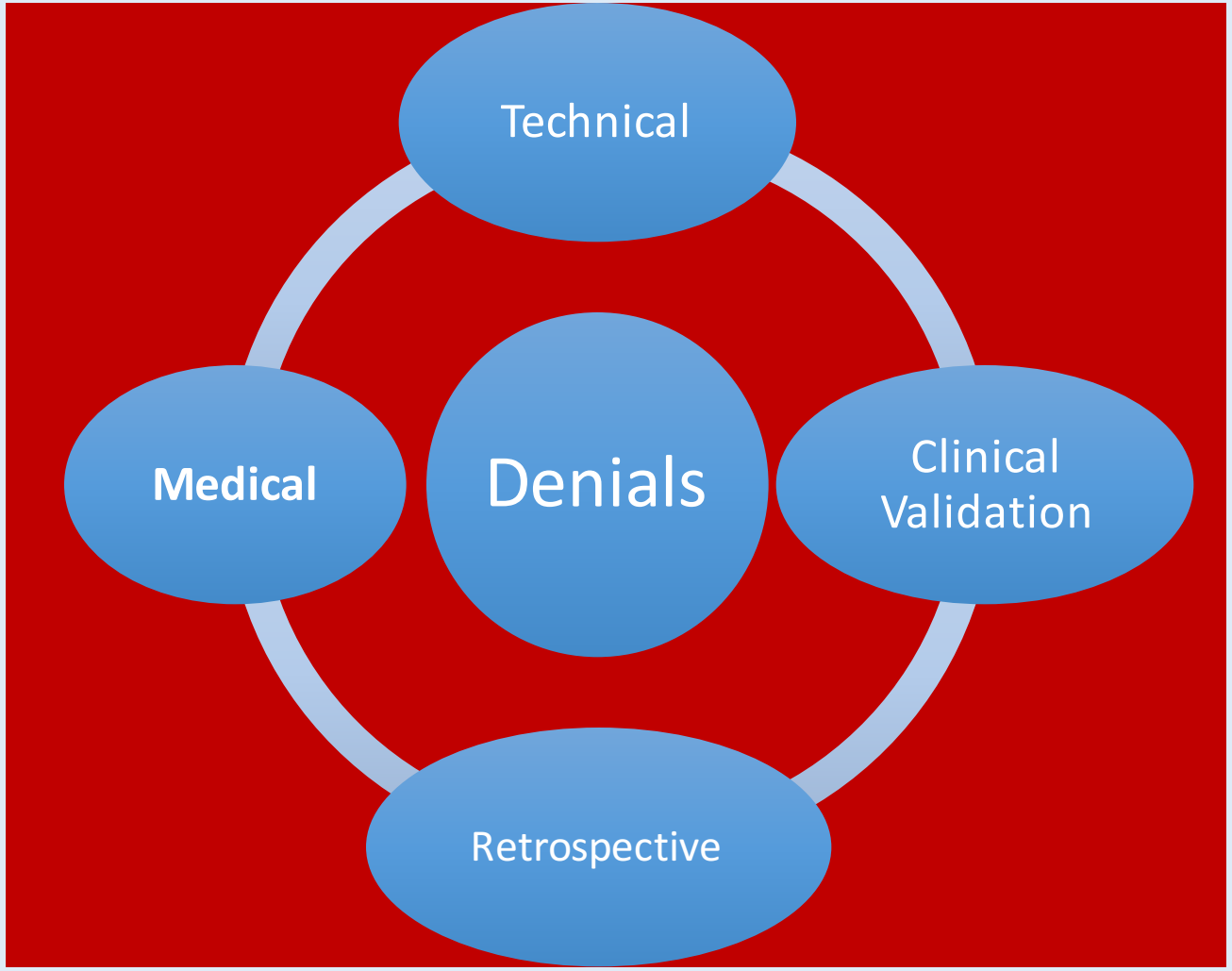
Potential KPIs

- Net monthly case-mix trends (Case-mix achieved minus medical necessity denial case-mix)
- **Adjusted net patient revenue**
  - Monthly net patient revenue—medical-necessity denial net patient revenue
- Medical necessity denials
  - Monthly denials $ & % GPR
  - 2 Midnight Rule, Number and $ amount
- Clinical validation denials
  - Monthly denials $ and % GPR

Potential KPIs

- Number of queries post-coding awaiting response to retrospective query
- DNFB $ post-coding awaiting response to retrospective query
- Monthly total and $ amount of clinical validation denials
- Monthly total and $ amount of medical necessity denials
- Number of rebills for HWDR BFCC-QIO

Net Patient Revenue Leakage



Promoting Efficiency through Documentation

- **R**ight Care
- **R**ight Time
- **R**ight Reason
- **R**ight Documentation
- **R**ight Venue
- **R**ight Clinical Judgment & Medical Decision-Making

Evaluation and Management

- **E & M** – Exchange of **clinically reasonable and necessary** information and the use of the information in the management of the patient

- **Gather**

- **Process**

- **Transfer**

Effective & Complete Documentation

- **Effective & Complete Documentation**
  - Concise—No “fluff”
  - **Accurate reporting of acuity**
    - Nature of presenting problem
    - Chief Complaint
    - History of **“Present Illness”** vs. **“Past Illness”**
    - Physical exam reflective of nature of presenting problem & clinical judgment
    - Assessment
      - Clinical specificity
      - Diagnosis relevant to the patient encounter
      - Trace back of diagnosis
    - Plan of care—congruent with assessment

Medical Record Content

- Medical Record Documentation and Content: The medical record *is considered complete if it contains* ***sufficient*** documentation to identify the patient, **support the diagnosis**, **justify the treatment, and document the course and results of treatment and facilitate continuity of care.** The medical record is **sufficiently detailed** and organized to enable:
  - The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.

CDI Objective, Goals, and Value Statement

- **Value Statement**
  - *By securing a thorough, complete, and accurate patient health record, we will achieve the correct reimbursement for resource utilization, the highest quality measures and outcomes, superior communication between providers, and ultimately high patient satisfaction.*
- **Goals and Objectives**
  - Promote and achieve complete, accurate and effective clinical documentation that best serves to communicate the nature, value, quality, and outcomes of care provided that supports and reflects the complexity of care, clinician medical judgment, medical decision making, thought processes and medical necessity.
  - CDI will closely align and integrate with the goals and objectives of the revenue cycle by promoting and advocating for documentation describing and showing the clinical context, content and facts of the case supportive of net patient revenue that stands the test of time.

CDI—Moving the Needle

- **Changing the Framework—a New Paradigm**
  - Clinical Documentation Improvement is defined by **the completeness, consistency, organization and accuracy of the medical record,** reflecting the physician's clinical judgment and medical decision making.
  - CDI **supports positive outcomes** in patient care, quality, cost, resource consumption, fee for value, **patient reimbursement and revenue cycle processes.**

8W Principles of Documentation

Physicians' focus on capturing:

1. **Where has the patient been?**
2. **Where is the patient now?**
3. **What are you thinking?**
4. **Why you are thinking that?**
5. **Where are you going and why?**
6. **What did you find when you got there?**
7. **What actions did you take, what actions are still needed, and how long is it going to take?**
8. **What actions remain for post-acute care?**

Eight W's Principles of Documentation

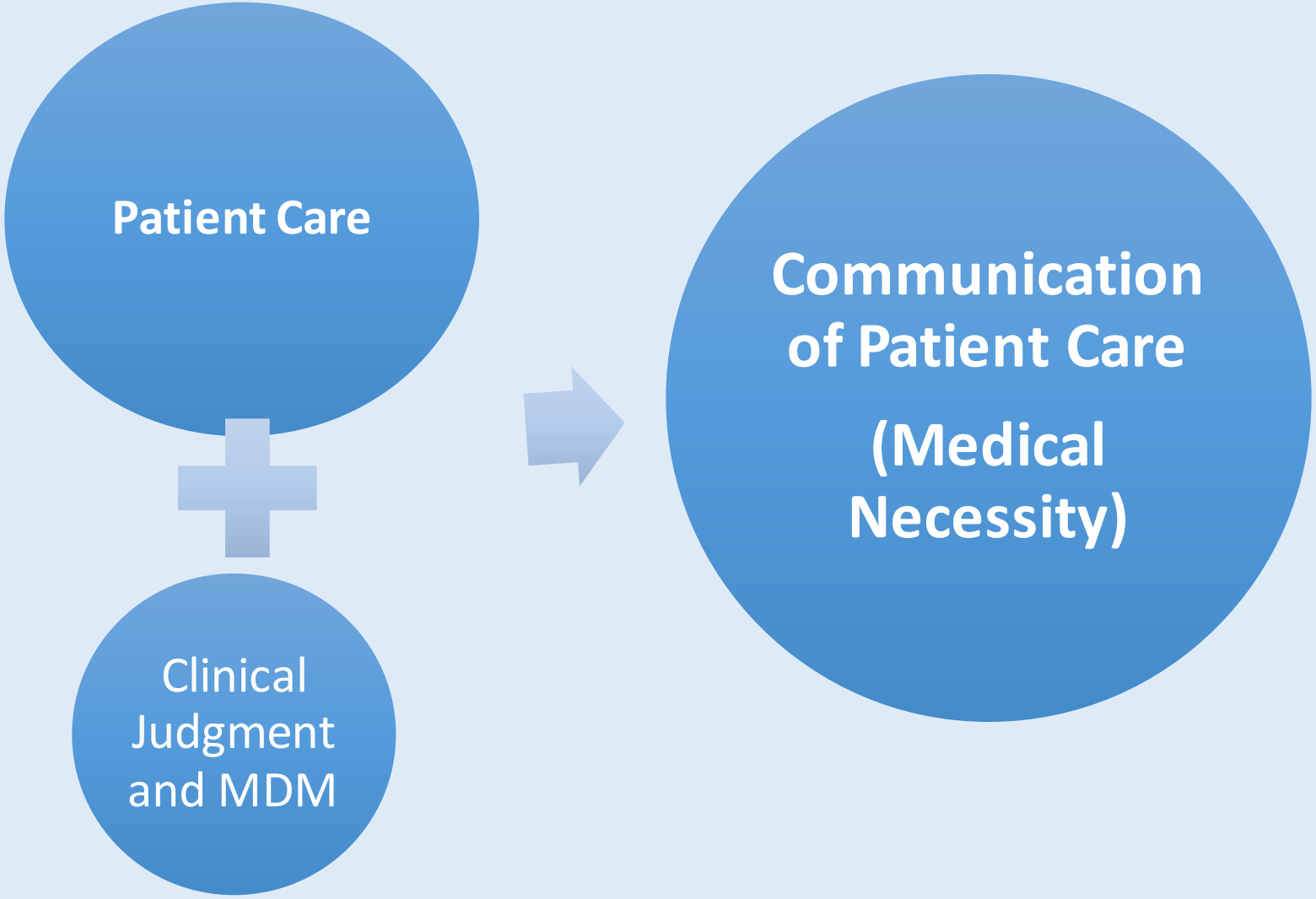
- Incorporating the achievement of 8 W's Principles of Documentation into CDI
- **Focus upon capturing:**

Where has the patient been?	**HPI**
Where is the patient now?	**HPI & PE**
What are you thinking?	**Assessment**
Why are you thinking that?	**Assessment**
Where are you going and why?	**Assessment**
What did you find when you got there?	**Progress Notes, Assessment**
What actions did you take?	**Plan of Care**
• What actions are still needed and how long is it going to take?	
What actions remain for post-acute care?	**Plan of Care**

“Complete and Accurate”

- *All entries in the medical record must be complete. A medical record is considered complete if it contains **sufficient** information to identify the patient; **support the diagnosis/condition**; **justify the care, treatment, and services; document the course and results of care, treatment and services;** and promote continuity of care among providers. With this criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard.*

Communication of Patient Care



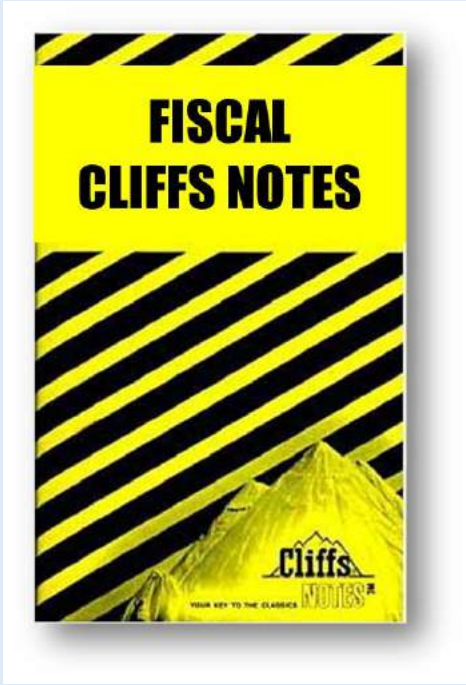
The Undisputable Goal

- Achievement of Documentation Excellence!

- Res Ipsa Loquitur

Content & Context!

- **Effective communication of patient care**
  - Right care
  - Right time
  - Right reason
  - Right venue
  - Right documentation
  - Right clinical judgment and medical decision-making



Whiff Test

- Previous admissions and accurate and complete H & P
- Congruent picture—does it tell the story?
- Show and Describe—no cliff notes!
- Progress notes that demonstrate progress!
- How about the discharge summary?

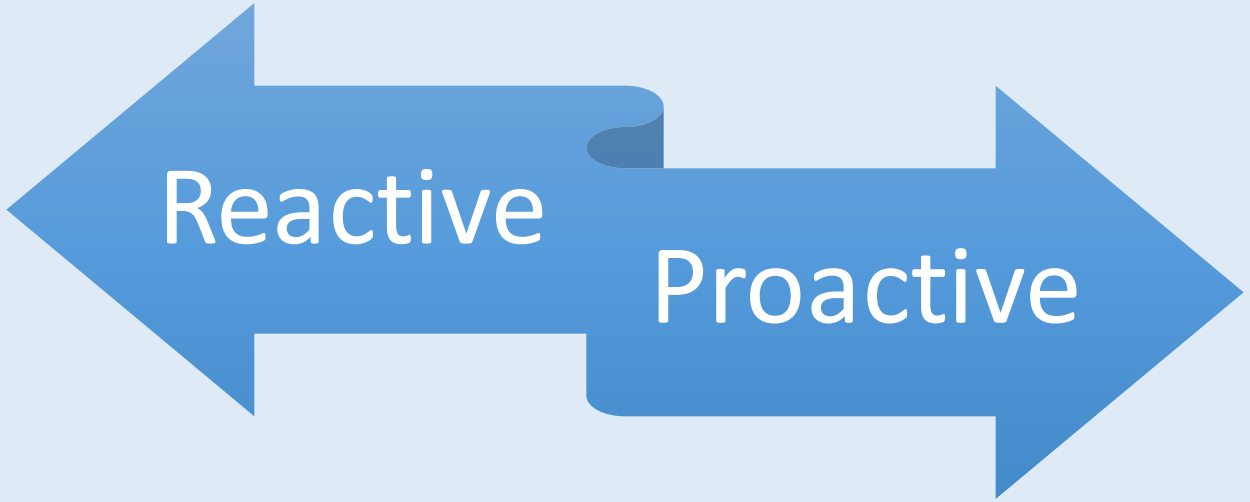
Getting Started

- What are the goals and objectives of the program?
- The 5 R's of CDI
  - **R**evisit
  - **R**evise
  - **R**eformulate
  - **R**ebrand
  - **R**eengineer

Operationalizing

- Focus
- Structure
- Process
- Track and Trend
- Standardize

Future Investment



Medical Necessity

- **Establishment of Medical Necessity**
  - Number, acuity, severity, and duration of problems and/or diagnoses the physician must address.
  - Number, type, and acuity of co-morbidities that impact physician clinical management of acute conditions and reason for admission/encounter.
  - Context and previous management of clinical conditions.
  - Amount of physician work performed in relationship to physical systems affected by patient problems.

Gaining a Proper Perspective

- Take a stance – **“Getting Ahead of the Curve”**
- “Active” vs. “Reactive” approach to documentation improvement
- **Content and Context**
  - ER
  - H & P
  - Progress notes
  - Discharge summary

2 Midnight Rule

QIOs will, when conducting patient status reviews, consider factors that support a **reasonable expectation** relative to the 2-midnight benchmark.

- The decision to keep the beneficiary at the hospital and the expected duration of the stay are based on complex medical factors such as:
  - **beneficiary medical history and comorbidities.**
  - **the severity of signs and symptoms.**
  - **current medical needs.**
  - **risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.**

- Physicians need not include a **separate attestation** of the expected length of stay; rather, this information may be **inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.**
  - Patient dynamically stable with no complaints
    - Disposition – admit inpatient for further workup
  - PE: Patient alert and oriented X 3, resting comfortably with no evident respiratory distress
  - Assessment: R/O MI – patient chest-pain free now

What is Known?

- QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician **at the time of admission**.
- The expectation for sufficient documentation is well rooted in good medical practice **"supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities."**

Don’t Get Caught…

- Physicians need not include a **separate attestation** of the expected length of stay; rather, this information may be **inferred from the physician’s standard medical documentation, such as his or her plan of care, treatment orders, and physician’s notes.**
  - Patient dynamically stable with no complaints
    - Disposition – admit inpatient for further workup and
  - PE: Patient alert and oriented X 3, resting comfortably with no evident respiratory distress
  - Assessment: R/O MI – patient chest-pain free now

You Be the Judge

- **Assessment:**
  - Abdominal pain, acute-on-chronic
- **Plan of Care:**
  - Admit to hospital as inpatient for further workup and management
  - Start IV medications
  - Order radiology
  - Order consults
  - See orders for further information

Current State of Affairs

Crossroads

Current CDI

- Retroactive
- Reactionary
- Narrow focus
- Limited scope
- Cliffs Notes style of synopsis

Future CDI

- Proactive
- Anticipatory
- Clinical facts –what is known
- Expanded scope
- Action-packed “drama”
  - “Meat of the story”
  - Conclusion

Integrating & Realigning CDI with Revenue Cycle

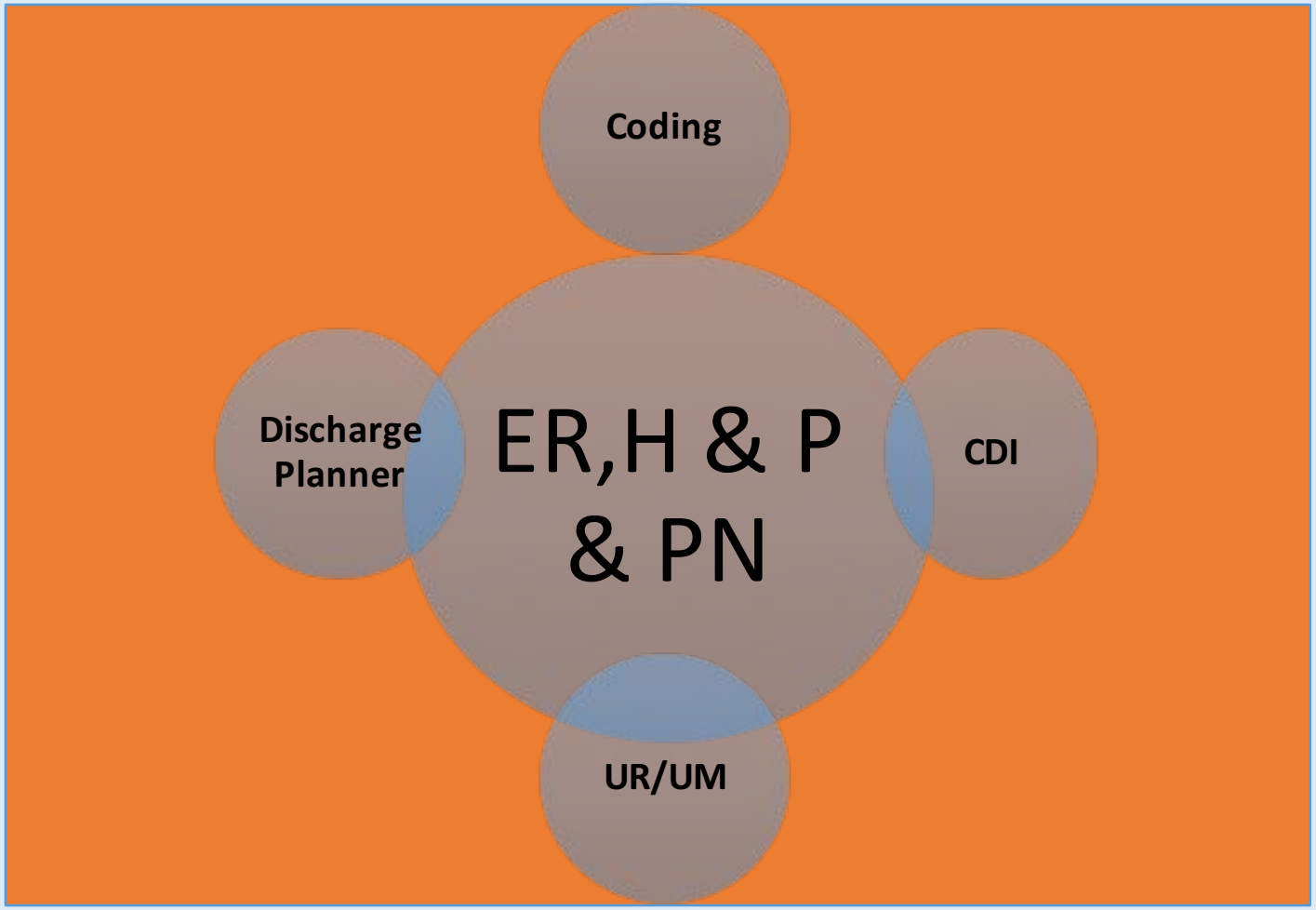
- **“The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated”**
- **Integration…**
  - Accurate capture & reflection of clinical content and context
  - Supportive foundation for documented diagnoses
  - Natural progression with consistency & completeness
  - Reasonable conclusion

True Revenue-Cycle Integration

- Clinical validation is a separate process, which involves a **clinical review** of the case to see whether or not the patient truly possesses the conditions that were documented.

- DRG Validation is the process **of reviewing physician documentation** and determining whether the correct codes and sequencing were applied to the billing of the claim. For DRG Validations, certified coders shall ensure they are not looking beyond what **is documented by the physician,** and are not making determinations that are not consistent with the guidance in Coding Clinic.

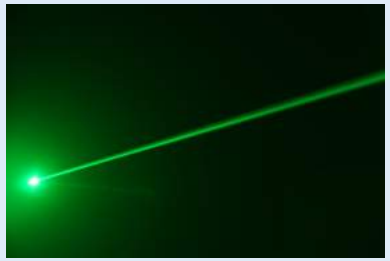
Center of Attention



Gaining a Proper Perspective

- Effective documentation
  - Clinically relevant diagnoses for the encounter
  - Appropriate clinical specificity
  - PFSH—**"Cognizant"** of past
  - Physical exam relevant to CC and Nature of Presenting Problem
  - Assessment—Avoid "Rabbit out of the Hat"
    - Clinical reasoning and rationale
    - Clinical criteria utilized
    - Linking diagnostic tests/treatments to definitive/provisional diagnoses
  - Plan of care congruent with assessment
    - Can a physician assuming care be informed about where you are and where are you going?

HPI—Laser Focus



Indirect

- Mrs. Jones, a 75 year old woman well known to me with a history of heart attack, stroke, colon cancer s/p toe amputation, hyperlipidemia, hypertension and diabetes presents to the office with abdominal pain.

Direct

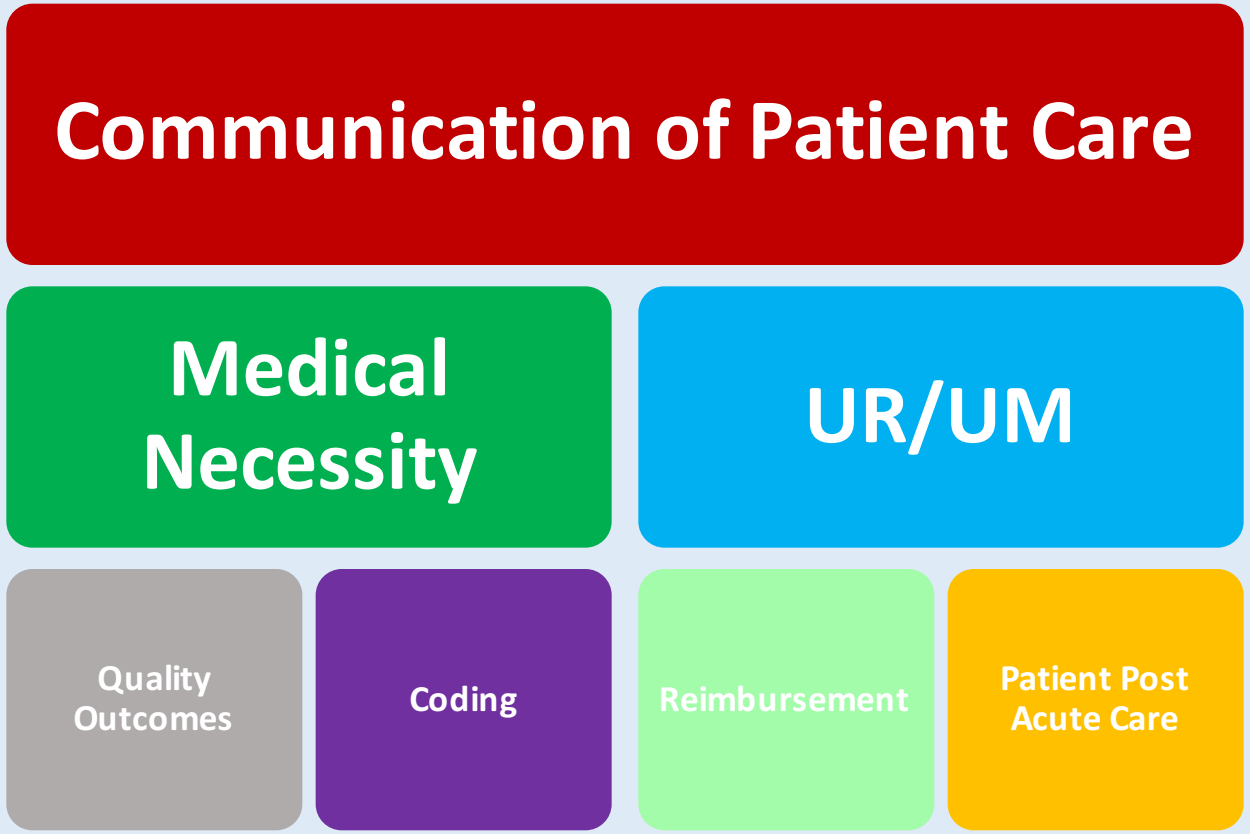
- Mrs. Jones, a 75 year old woman well known to me presents to the office today with abdominal pain of 3 days duration, been worsening over the last 24 hours, described as stabbing at times, waxed and waned over the last three days, now constant in nature, took OTC remedy to no avail, also complains of patient radiating to back, thought it may be related to some left over egg salad she ate for dinner last night, may have been “ripe.”

Sniff Test

Homework Assignment

- Denial volumes and rate
  - Medical-necessity denials
  - Clinical-validation denials
  - DRG downcodes
- Overturn rate
  - Medical-necessity denials
  - Clinical-validation denials
  - DRG downcodes
- Estimate costs to appeal/record (cost to collect)

Sufficient Documentation



Ultimate Standards of Documentation

- **Other Physicians** should be able to review physician author note and assume care where physician left off.
  - Past and current diagnoses
  - Current patient problem(s)
  - Current treatments and plan of care
  - Planned workup
  - Clinical rationale, judgment, medical decision making , thought processes, and problem solving/analytical skills
  - Follow-up care
  - Justification for diagnostic work-up & therapeutic treatments

Final Notes

- Caring for Medicare patients is a **Partnership**
  - **Understanding** the applicable Medicare coverage criteria (for example, medical necessity) and documentation guidelines for those services is extremely important for the accurate and timely processing and payment of both your claims and the claims of other entities.
  - Audits conducted by the Comprehensive Error Rate Testing (CERT) program, Recovery Auditors (RA), and Medicare Administrative Contractors (MAC) have frequently shown that available documentation lacks information to establish medical necessity. Audits also have consistently shown that the medical records provided by physician lack sufficient documentation to justify an item or service ordered by them.
  - **This lack of documentation on the physician part is causing a lack of payment for the services and the potential to cause your patient not to have access to care they need.**

Epidemic Proportions

- Average wait time for ALJ hearing 544 days
- ALJ backlog approximately 770,000 cases
  - Capable handing 220,000/year
- $5,000 appeal costs (at last count)
- Medicare audits have ticked up 936 percent in the last five years as RACs deploy big data analytics tools to trawl through claims and target providers' vulnerabilities.

Making the Transition

- **“Denials Avoidance”** vs. “**Denials Management”**
- Capitalizing on “**True**” CDI – Opportunities to Drive Change
- **Realigning and Reintegrating**

Questions?-I Have Answers!

- Glenn.Krauss@ZirMed.com
- (603) 303-3337
- Thanks for attending!

Appendix

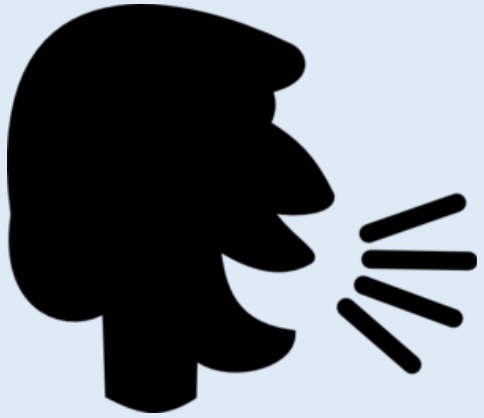
Documenting Medical Necessity

- **Documentation Supporting Medical Necessity** must be complete, legible, and include, at a minimum:
- Identity of person providing the service(s)
- Date of service
- Patient's signs and symptoms
- Detail of the services rendered and items furnished
- Indication of where the services were provided
- Signed orders for services and the clinical rationale for the orders
- Rationale for the level of care provided
- Intensity, frequency, duration and scope of services
- Legible signature of the person rendering the service and the physician ordering and approving treatment plans. (If signature not legible - include a signature log showing name in print and signature)

Do Your Part

- Medical necessity cannot be quantified using a points system. Determining the medically necessary LOS involves many factors and is not the same from patient to patient and day to day**. Medical necessity is determined through a culmination of vital factors, including, but not limited to:**
  - Clinical judgment
  - Standards of practice
  - Why the patient needs to be seen (chief complaint),
  - Any acute exacerbations/onsets of medical conditions or injuries,
  - The stability/acuity of the patient,
  - Multiple medical co-morbidities,
  - And the management of the patient for that specific DOS.

Speaking of Relevant!



- **Medical necessity is not just a "hospital concern."**
  - Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
  - It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
  - The volume of documentation should not be the primary influence upon which a specific level of service is billed.
  - Documentation should support the level of service reported.
  - The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

Practically Speaking

- **Documentation of Medical Necessity**
  - Number, acuity, severity and duration of problems addressed by physician
  - **Extent to which comorbidities impact complexity in management of acute clinical conditions**
  - Context of previous management of same conditions
  - Number of body areas and organ systems the physician must contend within clinical management
  - Challenges and complexity of arriving at a diagnosis (es) and development of a reasonable management action plan

A Word on Progress Notes

- **Conceptual characteristic progress notes**
- Factually correct
- Temporally relevant (no future tense references to procedures already done)
- Concise (no fluff; just a concise statement of the facts)
- Devoid of plagiarism
- Analytic – (reflects thoughtful analysis of patient's diagnosis, status, and treatment options)
- Reflective of collaboration (acknowledges collaboration with house staff, nursing, and other consultants)

Physician Storytelling

- Does your progress note accurately tell the patient story and report the clinical picture
  - "Usually the patient is stable, recovering or improving."
  - "Usually the patient is responding inadequately to therapy or has developed a minor complication."
  - "Usually the patient is unstable or has developed a significant complication or a significant new problem."