Doctors & Diligent Patient Care Communication- A Strategy for Mitigating & Alleviating Costly Downgrades & Denials

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Objectives

- Understand and operationalize conducting of root cause analysis of medical necessity denials, clinical validation denials and DRG down-grades at your facility
- Redesign and reposition current CDI initiatives to achieve real performance with purpose sustainable over time, enhancing the true value and completeness of communication of patient care

2

Objectives

- Discuss the role of the Physician Advisor in propelling current CDI initiatives from a transactional repetitive reactive model to one embracing proactivity with meaningful physician supported administrative burden reduction interventions
- Create a mission and vision of CDI that inspires physicians to becoming willing active participants in improving their documentation and communication of patient care as a regular part of their practice of medicine

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Objectives

- Establish valid and reliable Key Performance Indicator Measures that drive continuous quality improvement efforts in documentation improvement
- Develop a strong feedback loop mechanism in denials, transforming the function of Denials and Appeals to a more efficient effective role of Denials Avoidance

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Truth Or Consequences

https://www.youtube.com/watch?v=0UvewI5ALHY

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Clinical Documentation Improvement Programs

- **CDI Programs improve documentation supportive of enhanced reimbursement**
  - True
  - False
- **CDI Programs alleviate medical necessity & clinical validation denials while optimizing reimbursement**
  - True
  - False

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CERT Program

Comprehensive **E**rror **R**ate **T**esting

Intent of the CERT program is to protect the Medicare Trust Fund by identifying errors and assessing error rates, at both the national and regional levels.

Findings from the CERT program are used to identify trends that are driving the errors, such as errors by a specific provider type or service, and assist with allocation of future program integrity resources.

CERT error rate is also used by CMS to evaluate the performance of Medicare contractors, like CGS.

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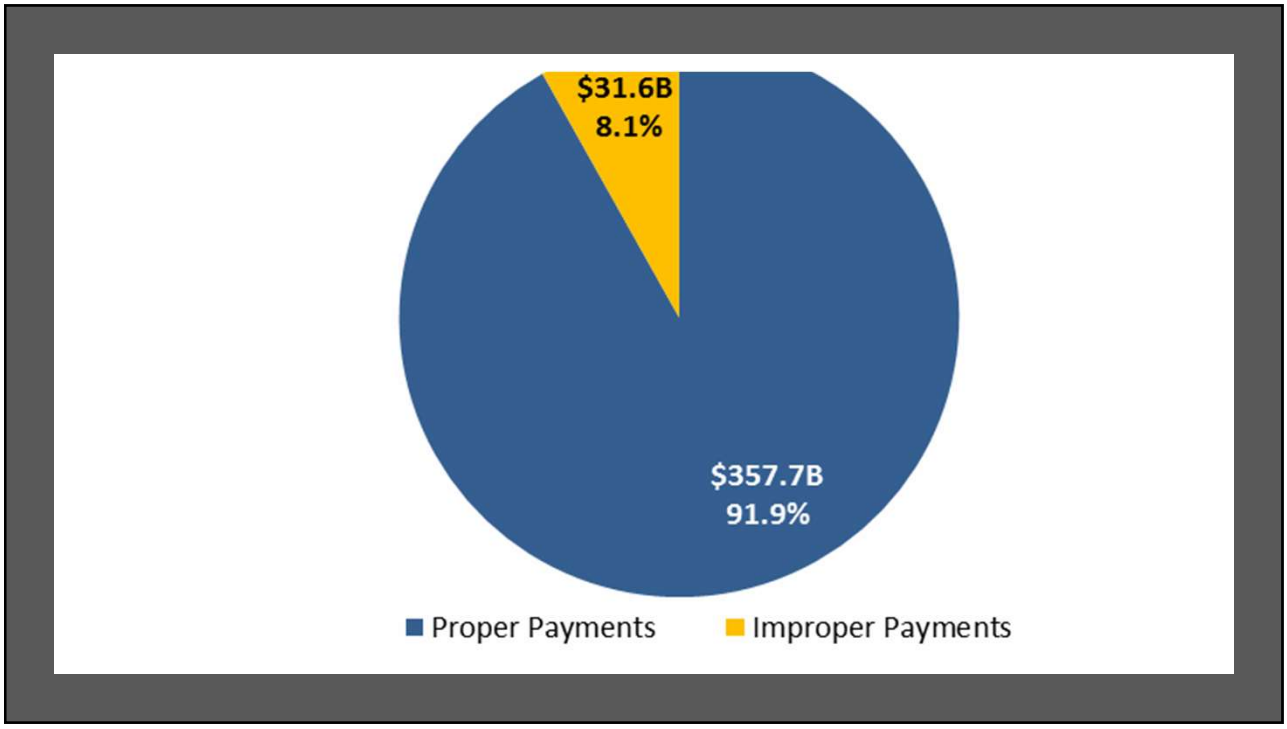

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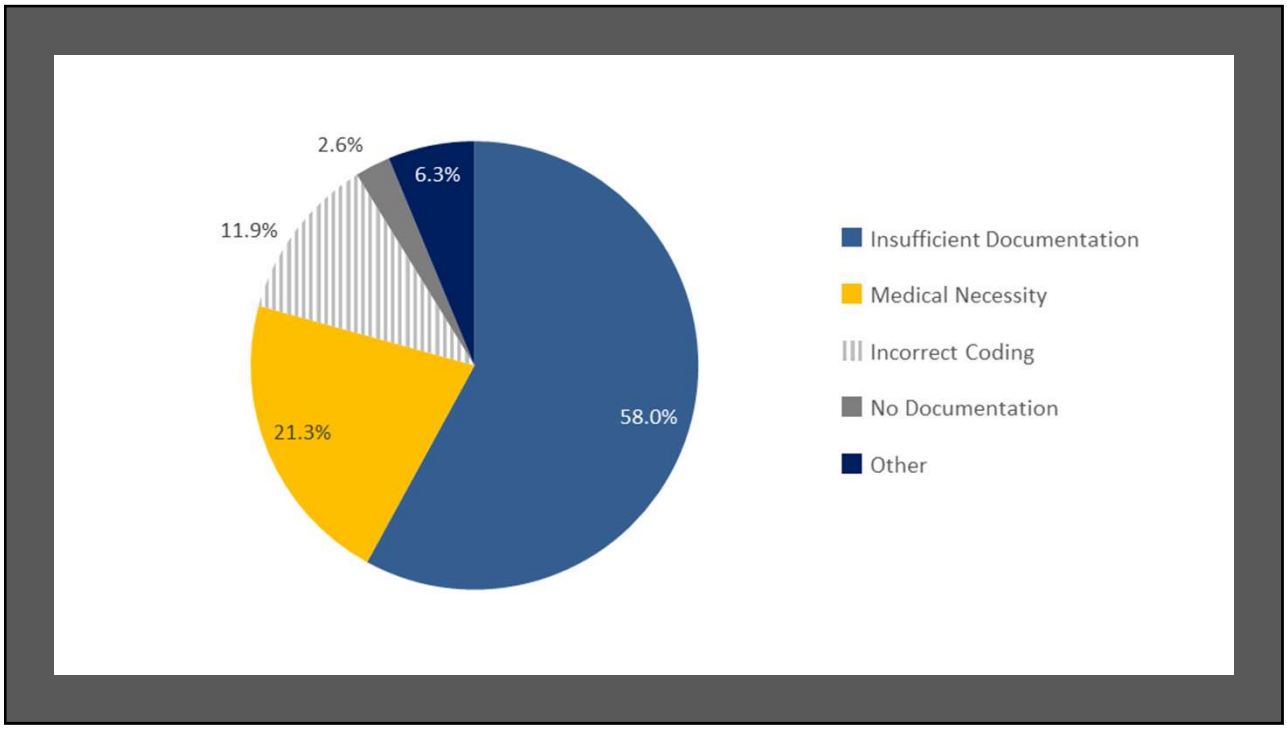
2.6%
6.3%
11.9%
21.3%
58.0%
Insufficient Documentation
Medical Necessity
Incorrect Coding
No Documentation
Other

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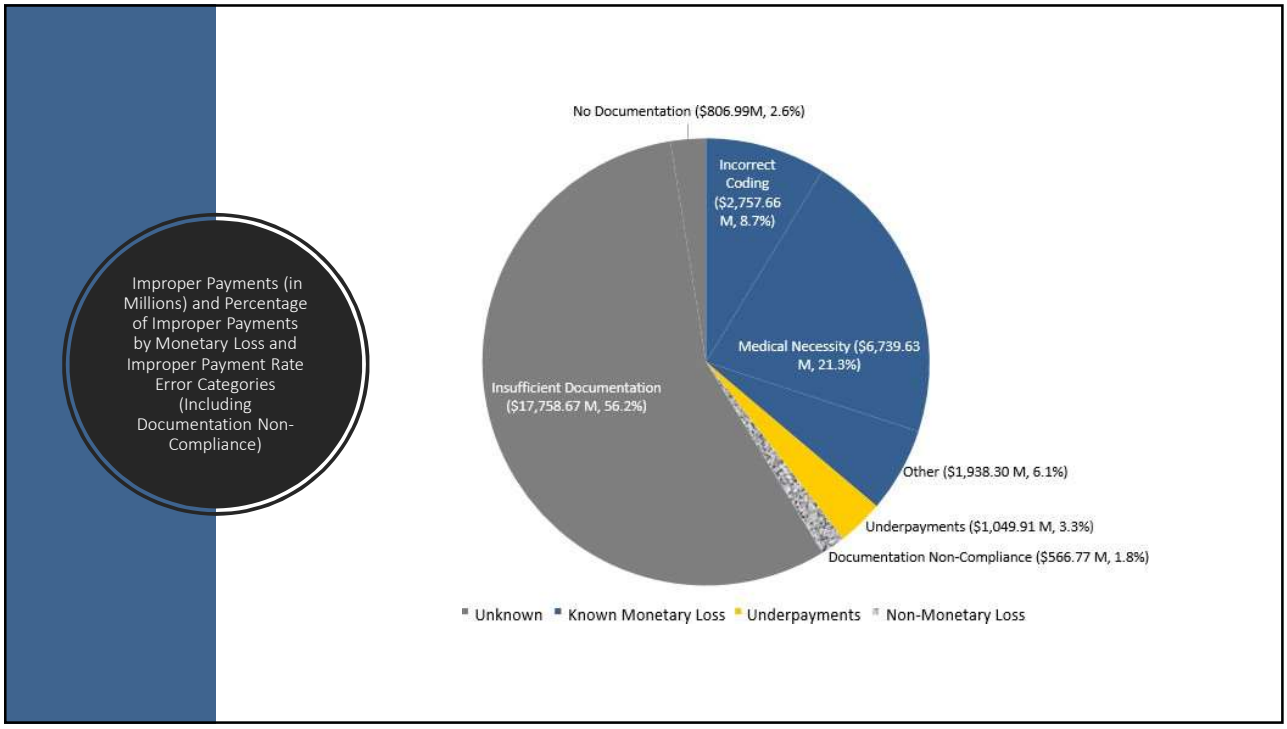
Improper Payments (in Millions) and Percentage of Improper Payments by Monetary Loss and Improper Payment Rate Error Categories (Including Documentation Non-Compliance)
No Documentation ($806.99M, 2.6%)
Incorrect Coding ($2,757.66 M, 8.7%)
Medical Necessity ($6,739.63 M, 21.3%)
Insufficient Documentation ($17,758.67 M, 56.2%)
Other ($1,938.30 M, 6.1%)
Underpayments ($1,049.91 M, 3.3%)
Documentation Non-Compliance ($566.77 M, 1.8%)
Unknown
Known Monetary Loss
Underpayments
Non-Monetary Loss

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Part A Hospital IPPS Services (MS-DRGs)	Projected Improper Payments		Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error				Percent of Overall Improper Payments
					No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Psychoses (885)	$461,746,775	13.2%	9.9% - 16.5%	0.0%	60.0%	30.9%	0.2%	8.9%	1.4%
Major Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$348,336,657	5.2%	3.1% - 7.3%	0.0%	91.8%	4.0%	4.3%	0.0%	1.1%
Endovascular Cardiac Valve Replacement (266,267)	$264,908,175	16.2%	9.9% - 22.4%	0.0%	84.6%	11.2%	4.2%	0.0%	0.8%
Septicemia Or Severe Sepsis WO MV >96 Hours (871, 872)	$147,126,944	1.9%	(0.0%) - 3.8%	24.2%	0.0%	11.2%	64.6%	0.0%	0.5%
Degenerative Nervous System Disorders (056, 057)	$142,872,343	16.4%	11.4% - 21.3%	0.0%	48.0%	47.4%	4.7%	0.0%	0.4%
Renal Failure (682, 683, 684)	$105,377,332	4.9%	2.6% - 7.1%	0.0%	0.0%	80.1%	19.9%	0.0%	0.3%
Simple Pneumonia & Pleurisy (193, 194, 195)	$104,208,684	5.4%	0.1% - 10.8%	0.0%	0.0%	64.6%	35.4%	0.0%	0.3%
Spinal Fusion Except Cervical (459, 460)	$91,167,248	4.5%	2.3% - 6.6%	0.0%	27.8%	61.0%	5.7%	5.5%	0.3%

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Other Musculoskelet Sys & Conn Tiss O.R. Proc (515, 516, 517)	$89,315,292	22.4%	10.1% - 34.7%	0.0%	0.0%	98.9%	1.1%	0.0%	0.3%
Organic Disturbances & Mental Retardation (884)	$85,827,492	16.9%	9.9% - 23.9%	0.0%	45.8%	51.1%	0.6%	2.4%	0.3%
Signs & Symptoms (947, 948)	$84,887,297	32.0%	20.3% - 43.8%	0.0%	0.0%	92.5%	7.5%	0.0%	0.3%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$84,856,223	7.0%	3.7% - 10.3%	0.0%	0.0%	77.9%	22.1%	0.0%	0.3%
Respiratory Infections & Inflammations (177, 178, 179)	$80,132,038	6.9%	0.7% - 13.1%	0.0%	0.0%	72.1%	27.9%	0.0%	0.2%
Extensive O.R. Procedure Unrelated To Principal Diagnosis (981, 982, 983)	$80,062,488	7.8%	1.6% - 14.0%	0.0%	3.2%	61.2%	35.6%	0.0%	0.2%

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Misc Disorders Of Nutrition,metabolismfluids/Electrolytes (640, 641)	$79,535,230	6.8%	2.4% - 11.2%	14.4%	4.0%	70.8%	10.7%	0.0%	0.2%
Syncope & Collapse (312)	$74,952,089	17.8%	12.1% - 23.5%	0.0%	2.9%	96.9%	0.2%	0.0%	0.2%
Chest Pain (313)	$72,065,446	28.3%	19.5% - 37.1%	0.0%	0.0%	98.8%	1.2%	0.0%	0.2%
Other Vascular Procedures (252, 253, 254)	$71,206,333	4.2%	1.0% - 7.4%	20.2%	9.4%	67.6%	2.7%	0.0%	0.2%
Diabetes (637, 638, 639)	$68,564,186	10.6%	3.8% - 17.4%	0.0%	0.0%	79.8%	20.2%	0.0%	0.2%
Seizures (100, 101)	$66,414,503	12.9%	5.9% - 20.0%	0.0%	0.0%	90.5%	9.5%	0.0%	0.2%
All Type of Services (Incl. Codes Not Listed)	$5,548,362,053	4.8%	4.4% - 5.2%	1.6%	22.4%	57.9%	15.9%	2.2%	17.2

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CDI Can Play a Major Role

Error Category	Percent of Overall Improper Payments
No Documentation	2.5%
Insufficient Documentation	56.9%
Medical Necessity	22.8%
Incorrect Coding	11.7%
Other	6.1%
Total	100.0%

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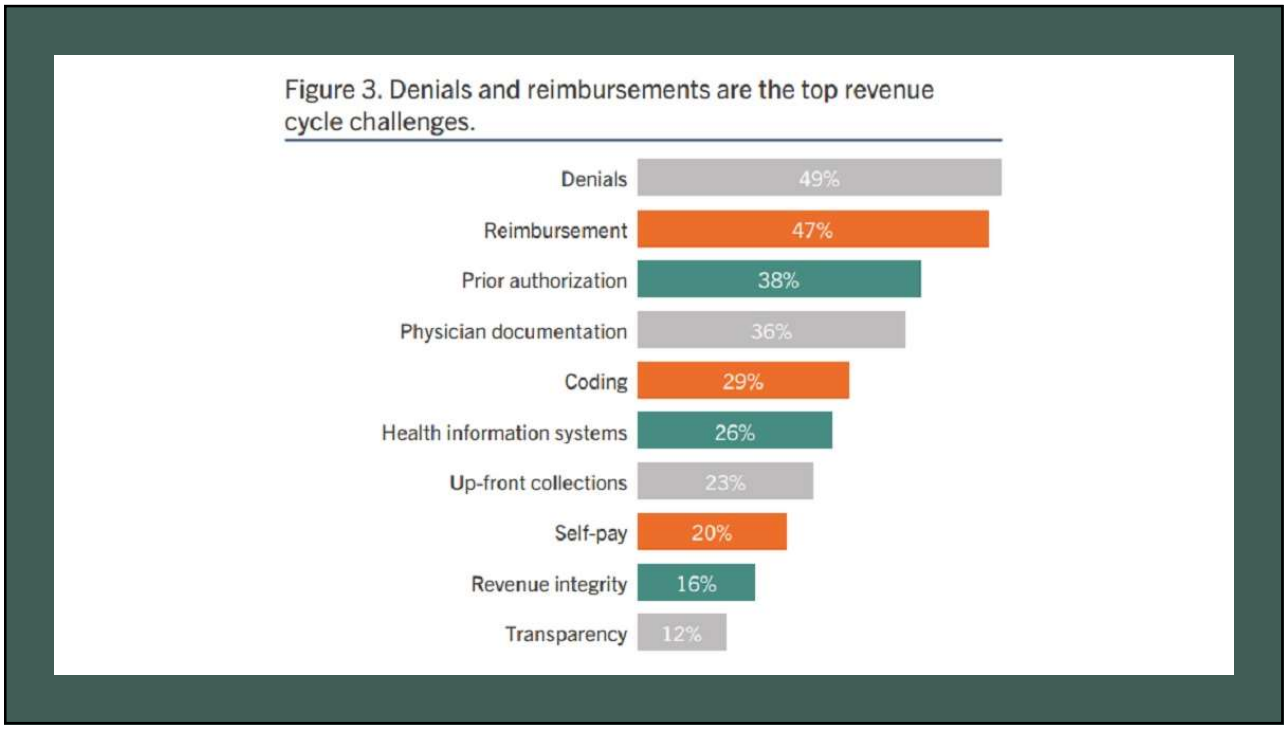

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Other Tidbits

- HIMMS Media-Bessler survey 84 percent of respondents believe clinical documentation and coding are high or medium revenue cycle risk.
- Almost one-half of finance leaders chose clinical documentation and coding as their greatest revenue cycle vulnerability.
- Clinical documentation and coding are creating revenue cycle vulnerabilities because solutions are not optimized for the diagnosis-related group (DRG) payment system, respondents shared. Only about one-third of hospital leaders said DRG optimization is a solved problem. In other words, the majority of hospital leaders (68 percent) do not think their solutions are equipped to manage DRG coding.

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CDI-The Real Facts *

- Recent KLAS survey (KLAS Survey)
  - Healthcare executives, medical records directors and managers, and other decisionmakers surveyed by the research firm in the new performance report, "Clinical Documentation Improvement 2018: Workflows and Prioritization Drive Quality and Financial Outcomes."
  - Revenue improved for 53% of respondents surveyed
  - Approximately 38 percent of respondents also reported improved workflow efficiency and 19 percent said reporting accuracy and metric tracking improved

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CDI-The Real Truth

- Fewer healthcare leaders and decisionmakers, however, are realizing financial gains in the form of increased acuity (18 percent), improved documentation quality (16 percent), fewer full-time equivalents (3 percent), and reduction in payer denials (1 percent)
- Potential to increase **compliance exposure & denials** → **cost to collect**
- OIG Workplan Addition- **Assessing Inpatient Hospital Billing for Medicare Beneficiaries**
  - Concern with upcoding in hospital billing: the practice of mis- or over-coding to increase payment
    - **OIG Work Plan**

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Get This….

- Black Book Survey-New Generation CDI Enhances Patient Care and Reduces Financial Risk
- 89% of hospital financial officers claim that the biggest motivator for adopting additional CDI situations is to provide improvements in case mix index, resulting in increased revenues and the best possible utilization of high-value specialists
- An impressive 88% of hospitals confirm documented quality improvements and increases in case mix index within six months of CDI implementation

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Citing severe financial difficulties, Hahnemann University Hospital in Philadelphia will close its doors in early September of this year with inpatient admissions ceasing in July.

According to CEO Joe Freedman, there were four major factors that caused the financial hemorrhage:

The hospital was not successful in getting commercial insurers to negotiate new contracts

Volume dropped from an average of 300 patients per day to between 200 and 250

The academic training program Hahnemann operates through its affiliation with the Drexel University School of Medicine is on pace to lose $30 million this year

The lack of clinical documentation training for physicians has resulted in downgrades and denials from insurers

Where Documentation Quality Matters

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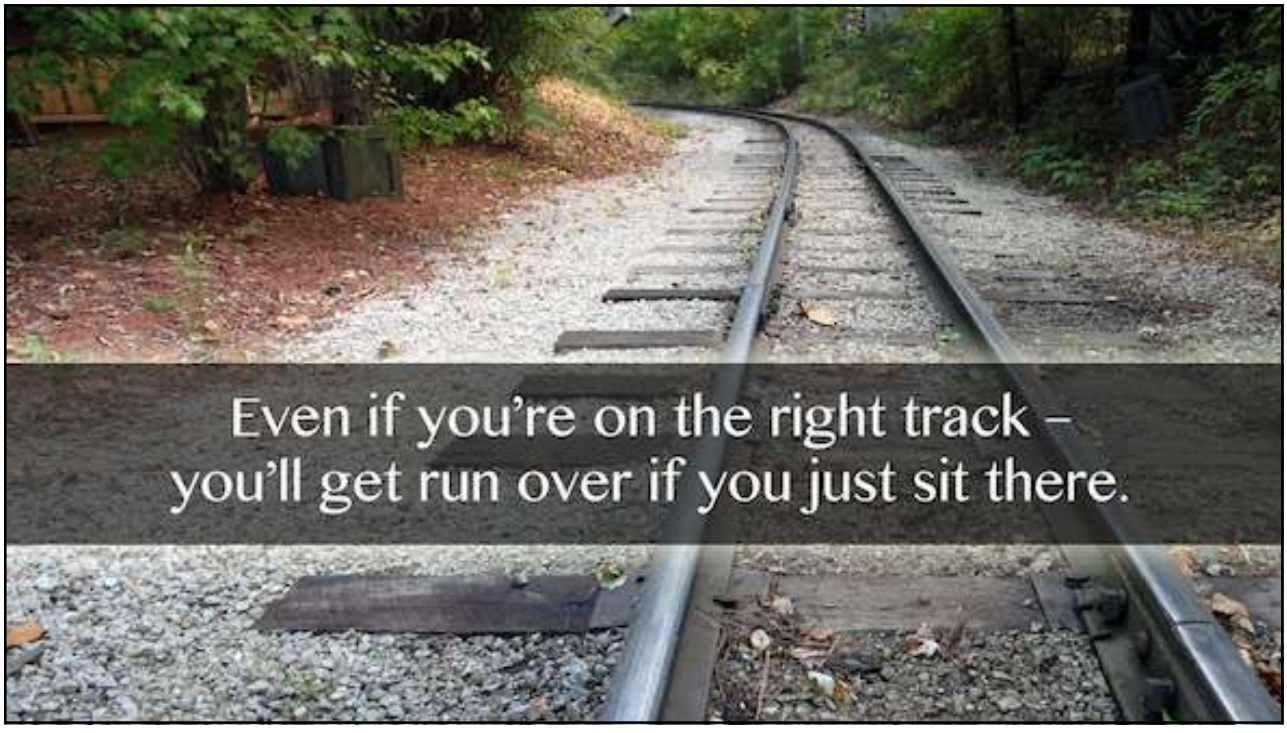

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Poll Question

- Do you have a CDI informed Physician Advisor ?
  - Somewhat helpful
  - Helpful only during denials
  - Helpful with queries
  - Strong Supporter

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Physician Advisor and CDI

- Physician Advisor
  - Inspires
  - Collaborates
  - Champions
  - Educates
  - Informs
  - Measures Outcomes

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Create a mission and vision of CDI that inspires physicians

- Collaborate with CMO ,
- a mission and vision of CDI.
- Inspires physicians to becoming willing active participants
- What's in it for them?
- improving their documentation and communication of patient care as a regular part of their practice of medicine

Check out the drg tools

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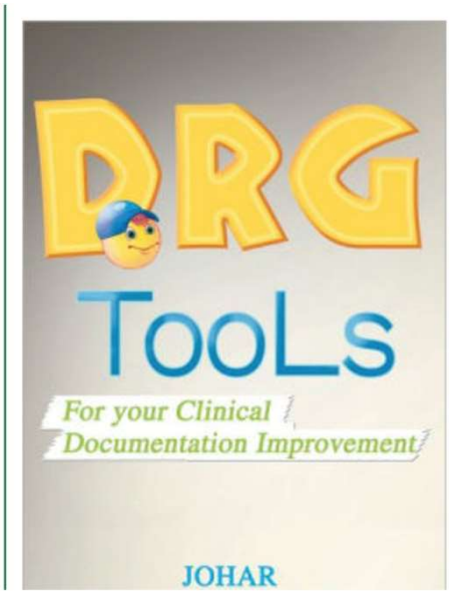

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Changing of Landscape

- **IPPS CMS Proposed Rule**
  - 1,492 MCC/CC changes total
  - 1,148 CCs to non-CCs
  - 17 MCCs to non-CCs
  - 136 MCCs to CCs
  - 8 CC to MCC
  - 183 Non-CC to CC

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Top 10 MCC Codes by Volume for Alabama

ICD-10-CM Diagnosis Code	Code Description	Volume of Claims	Current Severity Designation	Proposed Severity Designation
N18.6	End stage renal disease	9,191	MCC	CC
E43	Unspecified severe protein-calorie malnutrition	3,661	MCC	CC
L89*	All Stage 3 & 4 Pressure Ulcer Codes Combined (Note: This volume is for all 50 proposed codes)	955	MCC	CC
I46.9	Cardiac arrest, cause unspecified	408	MCC	Non-CC
D61.810	Antineoplastic chemotherapy induced pancytopenia	338	MCC	CC
G93.5	Compression of brain	306	MCC	CC
J95.821	Acute postprocedural respiratory failure	207	MCC	CC
	All Fracture Codes Combined *(Note: This volume is for 38 proposed codes)*	137	MCC	CC
K63.1	Perforation of intestine (nontraumatic)	130	MCC	CC
K57.31	Dvrtclos of lg int w/o perforation or abscess w bleeding	108	MCC	CC
I49.01	Ventricular fibrillation	106	MCC	CC

MCC Major Changes

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Potential CC/MCC Changes

Severity Level Increase

- **Non-CC To CC:**
- Heparin-induced thrombocytopenia (HIT)
- Stage 1 and 2, unstageable and unspecified pressure ulcers
- Foreign bodies in respiratory tract with asphyxiation
- Acute bronchospasm
- Homelessness
- Neutropenia and agranulocytosis
- Epistaxis and throat hemorrhage

Severity Level Increase

- **CC To MCC:**
- Bacteremia
- Candidal esophagitis and enteritis
- Moderate protein calorie malnutrition
- Severe persistent asthma with exacerbation

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Potential CC/MCC Changes

Severity Level Decrease

- MCC To Non-CC/MCC:
  - Sickle Cell disease with crisis/complication
  - Cardiac arrest
  - Complicated acute appendicitis

Severity Level Decrease

- MCC to CC:
  - STEMIs – initial and subsequent
  - Unspecified severe protein-calorie malnutrition
  - Ventricular fibrillation/flutter
  - Stage 3 and 4 pressure ulcers
  - Femur fractures
  - Postoperative acute respiratory failure

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Potential CC/MCC Changes

Severity Level Decrease

- **CC to Non-CC**
  - GI, respiratory, pancreatic central and peripheral nervous system, GU, connective and skeletal system primary and secondary neoplasms
  - Kaposi's sarcoma
  - Leukemia and lymphomas
  - Acute blood loss anemia
  - Chronic heart failure
  - Ulcerative colitis and Crohn's disease

Severity Level Decrease

- **CC to Non-CC**
  - Cutaneous abscess
  - Reiter's disease
  - Stage 4 and 5 CKD
  - BMI 19.9 or less
  - BMIs 40.0 – 44.9 and 45.0 – 49.9
  - Transplant status

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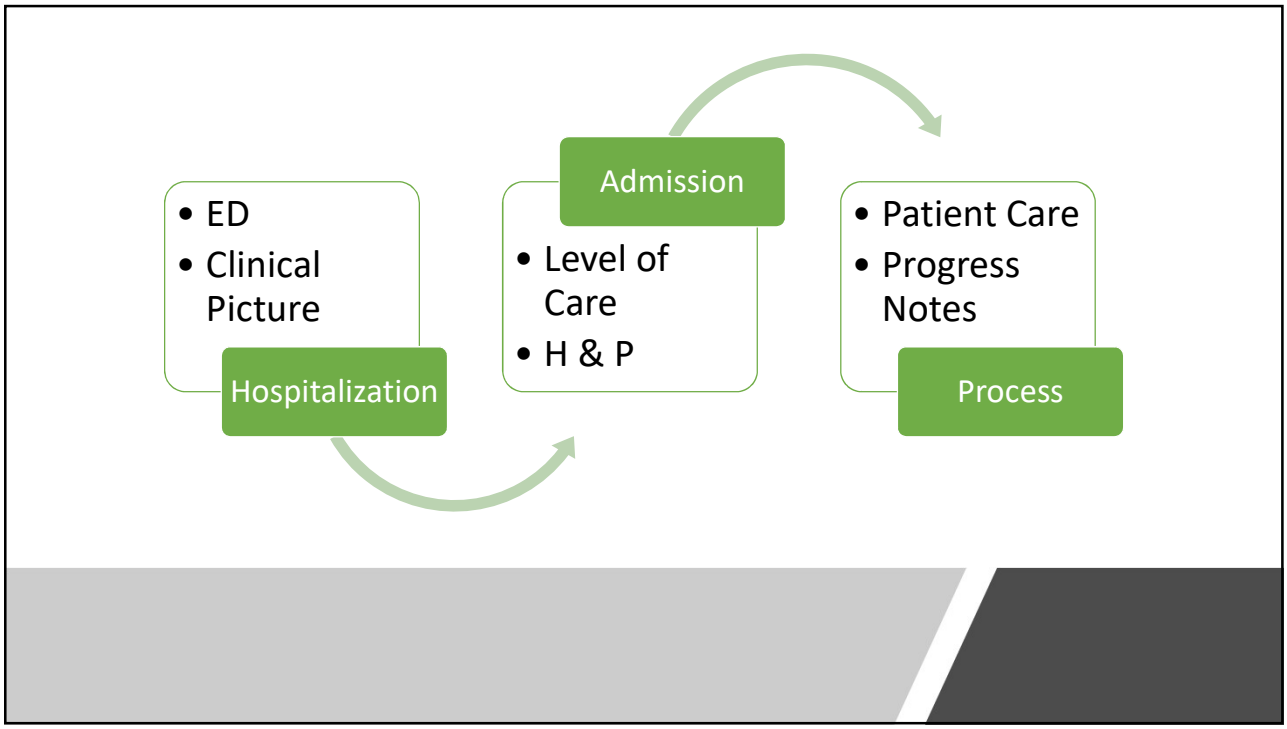
• ED
• Clinical Picture
Hospitalization
Admission
• Level of Care
• H & P
• Patient Care
• Progress Notes
Process

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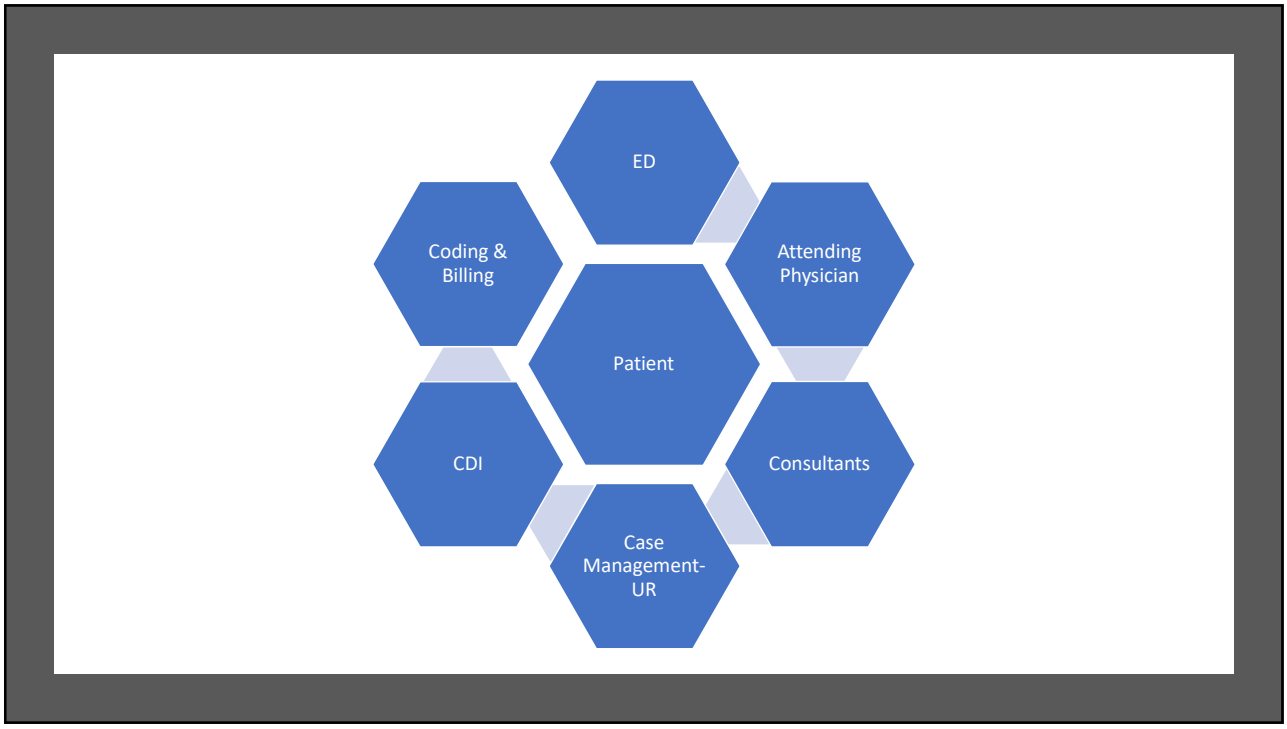
ED
Coding & Billing
Attending Physician
Patient
CDI
Consultants
Case Management- UR

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WHAT
WHERE
WHEN
WHY
HOW
QUESTIONS
ANSWERS

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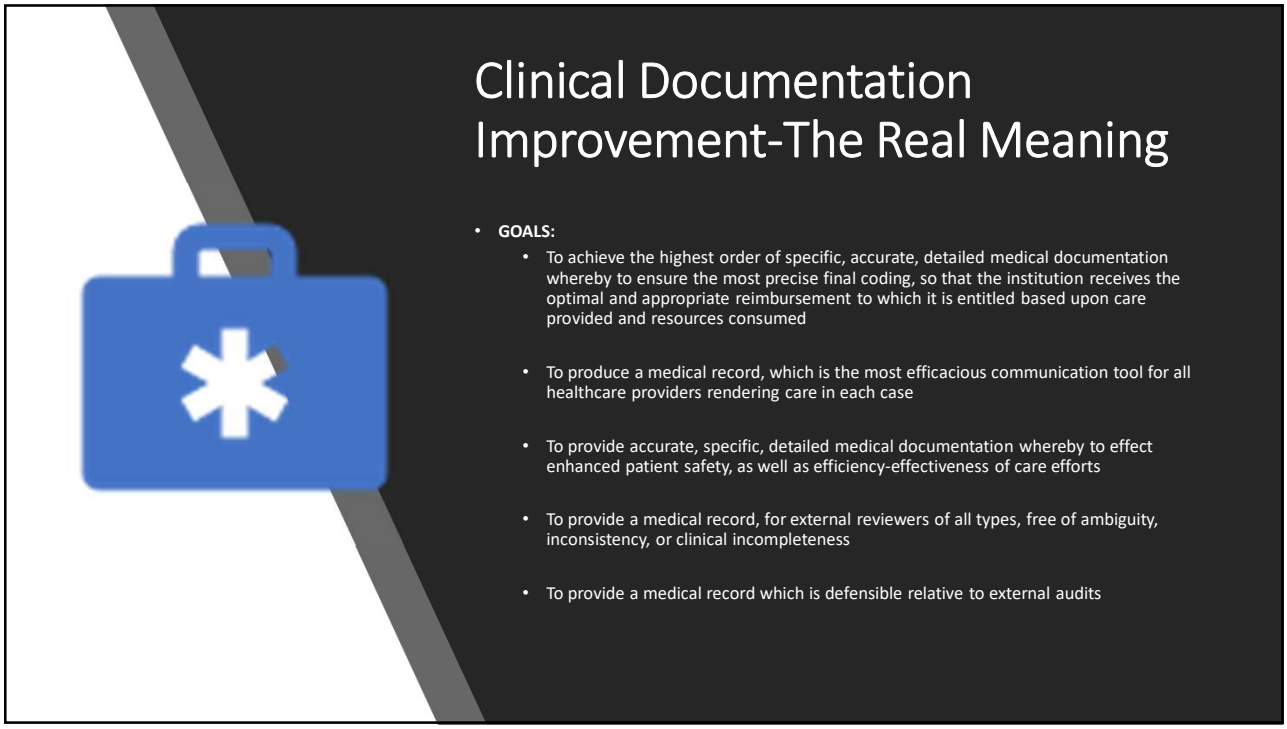
Clinical Documentation Improvement-The Real Meaning
GOALS:
To achieve the highest order of specific, accurate, detailed medical documentation whereby to ensure the most precise final coding, so that the institution receives the optimal and appropriate reimbursement to which it is entitled based upon care provided and resources consumed
To produce a medical record, which is the most efficacious communication tool for all healthcare providers rendering care in each case
To provide accurate, specific, detailed medical documentation whereby to effect enhanced patient safety, as well as efficiency-effectiveness of care efforts
To provide a medical record, for external reviewers of all types, free of ambiguity, inconsistency, or clinical incompleteness
To provide a medical record which is defensible relative to external audits

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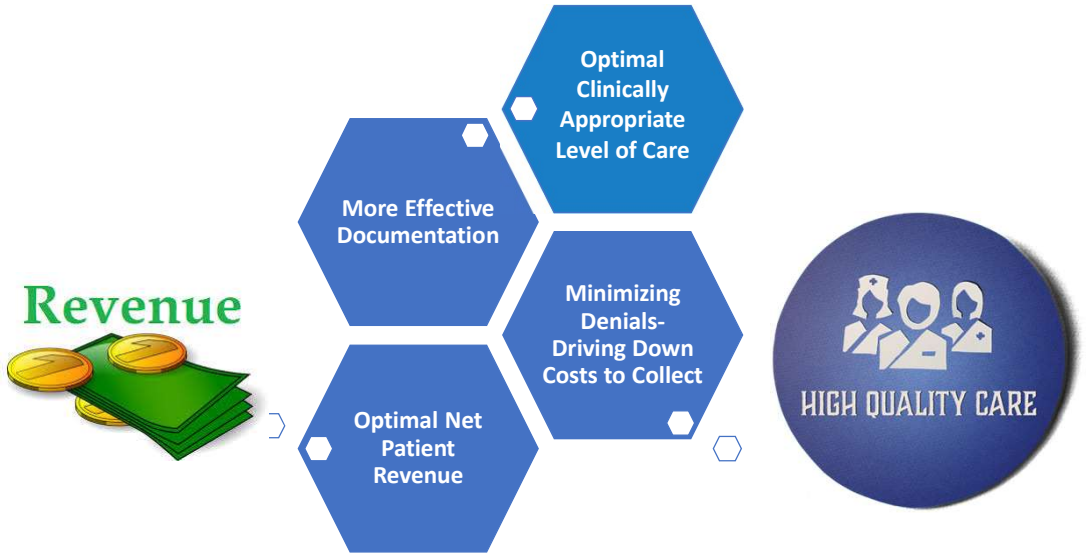

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Closing Remarks

- An average **350-bed hospital may be leaving $22M on the table** by focusing upon cutting costs over optimizing revenue cycle processing (The Advisory Board)
- **67%** of denials are recoverable and **90%** of denials are preventable (The Advisory Board)
- An average hospital can **RECOVER $5M** to **$10M** with upfront denial and underpayment processes

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  - Maria@TopGunAuditSchool.com
  - Thanks for Attending

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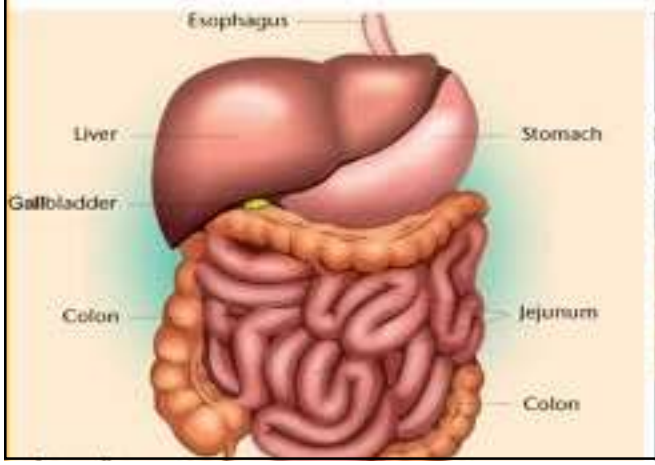
WHAT IS APPENDIX?



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Top Five KPIs-Valid & Reliable

Medical necessity denials-volume and dollar amount by payer and by physician (provide score card to all physicians with all physicians listed)

Clinical validation denials-(track and trend diagnoses by payer by #cases & volume)

DRG down codes-(track & trend by payer by #cases & volume, discharging physician)

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Top 5 KPIs-Valid and Reliable

- Number of cases reviewed by CDI/Number of medical necessity, clinical validation denials and DRG down-codes
- Number of cases reviewed by CDI and Query Generated/Number of medical necessity, clinical validation denials and DRG down-codes
- Net Monthly Case-Mix= Gross Case Mix Index-CMI of all medical necessity & clinical validation denials

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