CDI across the continuum of care

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Agenda

• Market forces driving traditional CDI
• Redesigning Outpatient CDI
  — CDI workflows
  — Physician documentation
  — Downstream CDI
• Prioritizing Inpatient CDI
  — Concurrent coding
  — Coding and CDI collaboration
• Ambulatory CDI
• HCCs and RAFs
• Conclusion and Questions
Market Forces
Why change a good thing by expanding CDI to the OP side of the world?

- Hospital outpatient revenues will soon surpass inpatient revenues
- Only 5% have an existing OP CDI program
- 56% participants will invest in an OP CDI program in the next few years
- Most participants need help starting a program
Risk adjustment and Value Based Care

- **Annual Capitated Payment** (Medicare Advantage, HIX)
- **Bundled Payment** (CMS CJR)
- **Pay-for-Performance** (MACRA, commercial contracts)
- **ACO Shared Savings/Risk** (MSSP, commercial ACOs)
- **Primary Care First** (CMS)
Risk adjustment gaps

Analysis of Medicare Beneficiaries Annual Visits

Outside the Hospital
- CDI programs today focus on IP acute admissions
- Little to no documentation review and physician guidance in OP or office settings

Physician Office
- 80-90% of office visits are coded by providers with no coder review
- Physicians focus on CPT, not complete diagnosis billing

*IP admission patients may have also had a physician office or outpatient visit as well in the calendar year.
**Patient receiving outpatient care or physician visits had no other visit types in the calendar year.
Documentation is the source of truth

When these don’t match, everything else is at risk.
Traditional CDI has been driven by revenue cycle needs

- Review cases concurrently to identify documentation opportunities
- Send queries to physicians to clarify documentation
- Calculate value based on accepted queries, DRG shifts
- Provide additional physician education when possible

- Great ROI (inpatient Medicare)
- Heavy personnel requirement
- Perpetual demand for this service
Pressures

Internal pressures to continually perform and improve traditional CDI operations
- Need to educate physicians on latest issues and regulations
- Need to re-evaluate and optimize performance
- Need to demonstrate ROI
- Acquisitions keep resetting the baseline and the goalposts

External market forces on the provider to cut costs, improve quality
- Government and other payer reimbursement model changes
  - Additional payers using prospective payment
  - Quality payment adjustments
  - Payer denials
  - Population-based payment
- Public reputation (quality scorecards)
- Shifting of volume and revenue from inpatient to other care settings
How can CDI expand to meet those needs?

- They can’t hire another full CDI team
  - Volume of outpatient = more than inpatient
  - Budgets are shrinking
  - Not enough qualified people

- They can’t review every clinical document

✅ They must redesign the model
Traditional CDI workflows redesigned

Effortless workflows
- Case reviews
- All care settings
- All payment/ and grouping models
- Educated on process and impact

Prioritization
- Prioritized Case Review
- Priorities based on performance and peers
- Users see priorities in workflow

Reference Materials
- Trends, best practices, regulations
- Continuing education materials
- Context relevant within the software

CA-CDI Prompts
- Focus on key opportunities within workflow
- Prompts based on performance and peers
Traditional CDI workflows redesigned

Effortless, collaborative workflows:
optimized, prioritized, CACDI prompts and reference materials
Physician Documentation Redesigned

**CAPD**
- Documentation prompts help physician documentation in real-time.
- Prompts based performance and comparison to peers.
- Intuitive workflow, feedback mechanism, easy help from CDI.

**CDI Queries**
- Peer-to-peer education on documentation standards.
- Intuitive query workflow on device they choose.
- Evidence and context-specific reference materials.
Physician Documentation Redesigned

- Improve documentation at the point of care with CAPD prompts
- Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials

Roles:
- Patient
- Physician
- CDI
- Coder
- PFS
- Admin

Patient Care to Revenue Cycle
Downstream CDI Redesigned

Denials Prevention, Management

- Prioritized clinical validation opportunities
- Automated appeals workflow
- Prioritized based on performance and payers
- Peer education for physicians on regulations

Collaborative Workflow

- Concurrent coding and CDI tool
- Working data shared with Case Management
- Quality indicators collaboration
- Process and education based on best practices

Documentation Compliance

- Documentation supports accurate coding
- Revenue cycle and quality issues addressed
- Process and education based on best practices

Actionable Reporting

- Operational reporting metrics
- Easily accessible for all stakeholders
- Benchmarks and best practices coaching
Downstream CDI Redesigned

Patient Care

- Improve documentation at the point of care with CAPD prompts

Revenue Cycle

- Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials
- Collaboration resulting in accurate coding, quality, reimbursement, and analytics, resulting in fewer denials
Proactive CDI

Personalized Tools for Proactive CDI Education

- Provider specific data and case examples at the click of a button
- Prioritized case audit recommendations
- Education reference materials per provider specialty
- Ability to track and manage educational efforts
- Report up to management

CDI Rounding

- Workflows for CDI to identify outstanding query opportunities
- Prioritized rounding recommendations
- Continuing education materials
- Process and education based on best practices
Proactive CDI

Care Setting Agnostic

Patient
Physician
CDI
Coder
PFS
Admin

More proactive and personalized tools for CDI auditing, rounding, real-time education, and resources

Improve documentation at the point of care with CAPD prompts

Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials

Collaboration resulting in accurate coding, quality, reimbursement, and analytics, as well as fewer denials

Patient Care
Revenue Cycle
The future of CDI across the continuum

CDI across the continuum supports all current and future reimbursement models, serves population health, social determinants models and supports accurate reporting of quality in a value based model.

**Patient care**
- High impact tools.
- Personalized tools and information to support proactive education.
- Quality documentation at the point of care with CAPD prompts.

**Revenue cycle**
- Collaborative workflows.
- Optimized, prioritized, CACDI prompts and reference materials.
- Downstream insights.
- Better documentation and coding support downstream (denial and underpayment).

**Combined technology and talent strategy to support a more proactive and complete CDI model.**
Worklist prioritization

Effortless, collaborative workflows:
optimized, prioritized, CACDI prompts and reference materials
Adaptable, rules-based case prioritization

Continuous, real-time prioritization based on new information and user activity

**DRG opportunities**
- e.g. Medical or surgical cases w/o CC or MCC

**Focus DRGs**
- e.g. Medicare bundle payments, questionable admits

**Clarification queries**
- e.g. Potential sepsis, malnutrition, CHF, ARF, COPD

**Specificity queries**
- e.g. Diabetes specificity

**Quality indicators**
- e.g. Unreviewed potential PSI 90?

**LOS, SOI, ROM**
- e.g. New LOS categories & APR model

**Case status**
- e.g. Discharged/pending query, escalated

**Documentation**
- e.g. New documentation factors - OP report

**Dismiss Factors**
- e.g. New ability to dismiss resolved factor – DRG category

**Financial opportunity**

**Quality opportunity**

**Low Priority Cases**

Medications – in beta

Labs – coming soon

Ancillary Notes – coming soon
Concurrent coding

Effortless, collaborative workflows:
optimized, prioritized, CACDI prompts and reference materials
Concurrent CDI/Coding collaboration

23% of provider organizations perform concurrent coding enterprise-wide

Why?
+ Better coding
+ Fewer post-discharge queries
+ Earlier resolution of quality indicators

= Greater return on your CDI Program

30% perform some concurrent coding

Success:
✓ Improve DNFB
✓ Accurate CC/MCC capture (CMI)
✓ Reduce rebills/DRG mismatches
✓ Accurate reporting of quality metrics
✓ Improve CDI and coding collaboration

Source: ACDIS survey, December 2018
Coding and CDI Collaboration

• The goal is a “clean” record with patient acuity and care accurately documented and coding captured
• Players have different roles and skillsets to contribute
• Team needs to react in real-time to unexpected events, complications
• Communication and efficiency are keys to success

What play are we running?
Who has the ball?
Who gets it next?
What needs to happen?
Concurrent coding features

Concurrent Coding Dashboard is the launch pad for concurrent coders:
• Manage workflow
• Complete final coding

Concurrent Coding Worklists
• Can be defined like CDI worklists
• Priority factors that support concurrent coding workflow
  o case status, priority score, last coder, last reviewer

Ability to add findings and create action items to help facilitate an easy back and forth workflow for Coding and CDI.

Activity Summary displays all review activities for 360 Encompass users with delineation by role.
Quality CDI

Collaboration resulting in accurate coding, quality, reimbursement, and analytics, and resulting in fewer denials.
Computer-assisted content

Improve documentation at the point of care with CAPD prompts

Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials
Computer-assisted content

- Improve documentation at the point of care with CAPD prompts
- Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials
- Collaboration resulting in accurate coding, quality, reimbursement, and analytics, and resulting in fewer denials

Patient Care

Revenue Cycle
Effortless, collaborative workflows: optimized, prioritized, CACDI prompts and reference materials

Collaboration resulting in accurate coding, quality, reimbursement, and analytics, and resulting in fewer denials
Ambulatory CDI
Ambulatory CDI defined

A *patient-centric solution* that supports all Clinical Documentation Improvement activities *beyond the traditional acute care setting*; using AI where possible, including *prioritized workflows* for document review, *query delivery and response*, *clinical validation* and *performance tracking* to ensure quality documentation and compliant coding practices.

*Source: 3M Health Information Systems*
## Ambulatory CDI: The problem

### Revenue Concerns
(under-Payment, Denials, Write-offs, Payment Adjustments)
- Hospital Inpatient Payment / Pre-admit Review (MS DRG / APR DRG Accuracy)
- Hospital Outpatient Payment (APC / EAPG Accuracy)
- Professional Fee Payment (E/M Accuracy)*
- Population-based Payment (HCC / Risk Adjustment Accuracy)

### Administrative Burdens
- Payer Denials Management
- Pre-Payer Denials / Edits (“Rework”)
- Medical Necessity
- Physician Frustration (Documentation Time and Dissatisfaction)
- No Workflow / Too Many Clicks / Lack of Automation

### Compliance Concerns
- Clinical Documentation Quality
- Coding Quality
- Risk-Adjusted Data Validation
HCCs and RAFs
HCC and RAF calculation

Total score of all relative factors related to one patient for a total year.

Demographic Risk Score
- Age
- Residence (in community versus SNF or institution)
- Medicaid disability and interaction with age/gender

Disease Risk Score
- Reported HCC diagnoses
- Interaction factors (for interactions between disease categories)
- Disability status

Patient Risk Adjustment Factor (RAF)
- Key factor is capturing all HCC diagnoses
RAF is used to calculate monthly payments for patients

The RAF is a multiplier used to calculate the monthly reimbursement for individual patients in a capitated payment arrangement.

Key RAF Score Driver:
Capturing all HCC diagnoses for all patients

PMPM Base Rate:
Monthly capitated reimbursement paid to a payor for an at-risk contract.

Monthly Reimbursement:
Monthly payment for a patient in a capitated arrangement.
HCC Risk Adjustment Factor methodology example

Paul Smith, 78-year-old male, community based, managing chronic conditions.

<table>
<thead>
<tr>
<th>2017 Risk Adjustment Factor (RAF) Score</th>
<th>2018 Risk Adjustment Factor (RAF) Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses documented/billed during visits in 2017</strong></td>
<td><strong>Diagnoses documented/billed during visits in 2018</strong></td>
</tr>
<tr>
<td>Demographic score: 2017</td>
<td>0.466</td>
</tr>
<tr>
<td>HCC 18: Diabetes w/retinopathy</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC 22: Morbid Obesity</td>
<td>0.273</td>
</tr>
<tr>
<td>HCC 40: Rheumatoid arthritis</td>
<td>0.423</td>
</tr>
<tr>
<td>HCC 85: Dilated cardiomyopathy</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 111: COPD</td>
<td>0.328</td>
</tr>
<tr>
<td>HCC Interaction Score: CHF—COPD</td>
<td>0.190</td>
</tr>
<tr>
<td>HCC Interaction Score: Diabetes—CHF</td>
<td>0.154</td>
</tr>
<tr>
<td>Total RAF Score</td>
<td>2.520</td>
</tr>
</tbody>
</table>

Capitated Pay Per Member Per Month (PMPM):
- $800 PMPM x 2.520 RAF = $2,016
- $800 PMPM x 1.057 RAF = $846

$14,045 Annual
Simple HCC Reimbursement Formula

Medicare Advantage Plans

$800 PM x 12 Months  \times 2,500  \times 1.00 = $24,000,000

PMPY  $9,600

Members  2,500

RAF  1.00

Annual Reimbursement for Medicare Advantage Plan
Risk adjustment gaps

Analysis of Medicare Beneficiaries Annual Visits

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Physician documentation and coding

Annual physical for Paul Smith, a 78-year-old male, living at home

The physician documents:

“Mr. Smith is here for his annual physical. He is a 78 y/o male with continued morbid obesity and diabetes with retinopathy. Current meds are still being taken as directed...”

And codes:

<table>
<thead>
<tr>
<th>E&amp;M level</th>
<th>99213</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/retinopathy</td>
<td>E11.319</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>E66.01</td>
</tr>
</tbody>
</table>
HCCs require more detailed documentation and coding

Ideal documentation:

“Mr. Smith is here for his annual physical. He is a 78 y/o male with continued morbid obesity and diabetes with retinopathy. Current meds are still being taken as directed... ...rheumatoid arthritis... .dilated cardiomyopathy... ... and COPD...”

Optimal coding:

<table>
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<tr>
<td>Morbid obesity</td>
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</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>M06.9</td>
</tr>
<tr>
<td>Dilated cardiomyopathy</td>
<td>I42.0</td>
</tr>
<tr>
<td>COPD</td>
<td>J44.9</td>
</tr>
</tbody>
</table>

About 90% of office visits are coded by providers with no coder review. Will providers document and code complex diagnoses correctly?
Chronic disease is re-diagnosed only 45% of the time
Common HCC Clarification Opportunities

Top 10 Most Under-documented HCCs
- Amputations
- Artificial openings
- Asthma and pulmonary disease
- Chronic skin ulcer
- Congestive heart failure
- Drug dependence
- Metastatic cancers
- Morbid obesity
- Rheumatoid arthritis
- Specific type of major depressive disorder

Top 10 Most Over-documented HCCs
- Conditions that have been surgically corrected (e.g., abdominal aortic aneurism)
- Diabetes with complications
- Malnutrition
- Nephritis
- Pathological fractures (e.g., old pathological fractures reported as pneumococcal)
- Polyneuropathy (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
- Primary site cancers (e.g., indicating historical conditions as current)
- Strokes (e.g., indicating acute stroke instead of late effect of stroke)
- Vascular disease (e.g., reported as current when no treatment, evaluation or monitoring is documented)

Source: 3M aggregated claims data
Questions
Contact Information

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