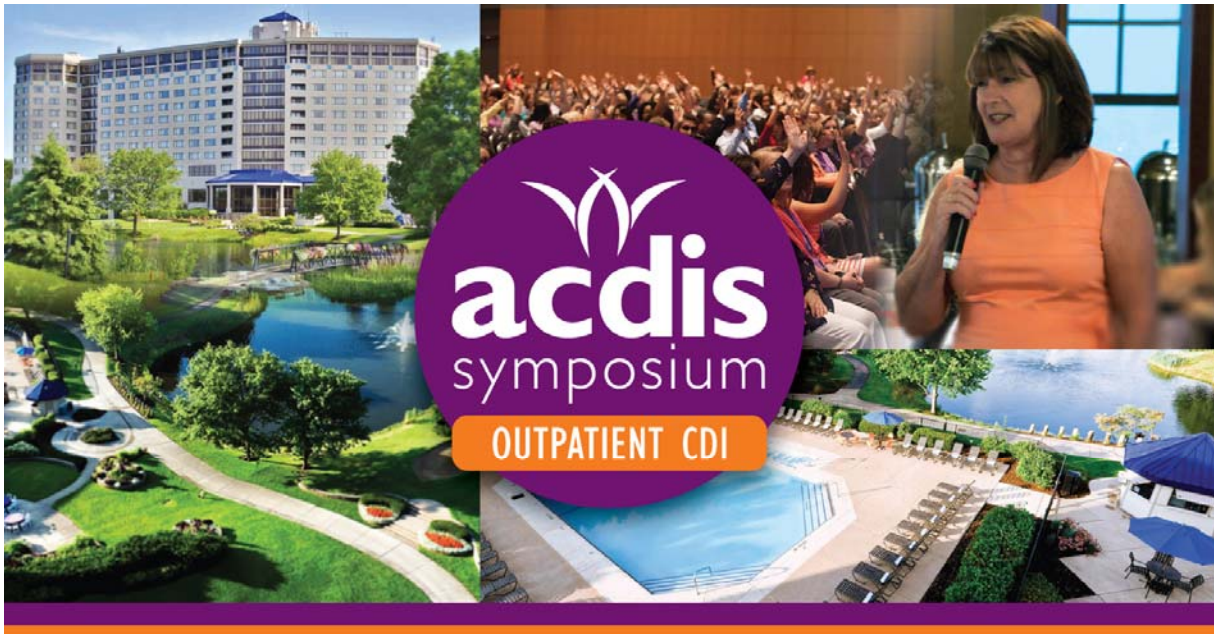

Novant Health Ambulatory CDI—How We've Grown!

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Program Notes for CDI Outpatient Workshop Series

- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2017-outpatient-cdi-workshop
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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Define Risk Adjustment Model
  - Describe RAF, HCCs, and the impact on reimbursement
  - Identify successes and challenges in implementation of an ambulatory CDI program
  - List some potential tools that might be used by an ambulatory CDI team

Novant Health
Making healthcare remarkable

- Not-for-profit, integrated health system that spans communities in the Carolinas, Virginia, and Georgia
- Over 24,000 employees and physician partners
- 463 physician locations and 15 medical centers
- Nationally recognized for quality and safety measures
- HIMSS Stage 7 Ambulatory Award—first in the country to renew
- Epic Professional Billing MVP Award
- Over 675,000 patient portal users

Risk Adjustment Model

Model used by CMS and other payers taking known variables to predict healthcare dollars required to care for a patient population.

What does this mean?

This can impact your reimbursement as most value programs from payers risk-adjust your cost scoring (high-cost or low-cost provider)

Some examples are in the new Medicare payment programs (MIPS, MSSP, bundles, and more)

Risk Adjustment Model

Risk Adjustment Factor (RAF)

- Demographics—patient age/gender/insurance status (i.e., aged-dual eligible)
- HCC (Hierarchical Condition Category) diagnoses from all claims submitted for a patient in a calendar year
- Diagnosis codes must be addressed during a face-to-face encounter with an eligible provider (i.e., MD, PA, NP)
- Must address each patient HCC diagnosis once per calendar year

Higher RAF score = higher complexity of care required for the patient = *higher predicted costs for care of the patient*

HCC (Hierarchical Condition Category)

- Diagnoses filtered by groups, then into condition categories
- Usually chronic, permanent condition that is considered costly
- Trumping
- Disease interactions
- Can be cumulative

Impact of RAF on Financials

- Moving from a payment model of fee-for-service to pay-for-performance (quality at lower cost)
- Current-year claims with diagnoses affect reimbursement allocations 2 years later (for Medicare)
- Impacts MIPS (Merit-based Incentive Payment System) and/or MSSP (Medicare Shared Savings Program) through incentives or penalties to your fee schedule and shared savings
- Chronic conditions require increasing costs; unspecified diagnoses lead to underpayment and limited resources
- All diagnoses should be included that affect medical decision-making

Impact of Diagnosis Specificity on RAF and Reimbursement

Example 1*	HCC Value	Example 2*	HCC Value	Example 3*	HCC Value
76-year-old female	.448	76-year-old female	.448	76-year-old female	.448
Major depressive disorder (unspecified)	0	Major depressive disorder (unspecified)	0	Major depressive disorder recurrent, severe	.330
		DM w/out complications	.118	DM with renal complications	.368
		Morbid obesity	.365	Morbid obesity	.365
				Chronic diastolic CHF	.368
				Disease interaction (CHF + DM)	.187
Total RAF	**.448**		**.931**		**2.066**
PMPM	$336.00		$698.25		$1,549.50
Yearly reserve	**$4,032**		**$8,379**		**$18,594**

Ambulatory CDI—in the Beginning

- Created 3 RN positions—clinical documentation specialists (CDS)
- Developed paper query form
- CDSs covered 603 PCPs
- Met face-to-face with each provider to teach the "why"
- 25–30 queries per provider
- Depending on number of providers, CDSs would be available on-site every day (sometimes up to a month)

Ambulatory CDI Today

- Team of 11 RN CDSs educating PCPs, cardiology, vascular, hematology/oncology, neurology, behavioral health, and wound care
- 2 RN CDS analysts focused on analysis of payer reports
- Created formal policy and procedures
- Productivity metrics for team member accountability, efficiency, and provider data
- All CDSs have obtained CPC; in process of completing CRC and CDEO certification

Ambulatory CDI Today

- Provider is queried for specificity about every 8–10 weeks with special focus on those needing additional education
- 3 types of scenarios:
  1. Documentation present to support additional diagnoses
  2. Many diagnoses listed without “MEAT”
  3. Frequent use of unspecified diagnoses
- Developing streamlined electronic query and reporting tools

Ambulatory CDI Today

- Extract data from thousands of charts for Quality Measure reporting for Medicare
- Built relationships and now collaborate with multiple diverse teams:
  - Coding and coding education
  - Clinical services
  - Acute CDI
  - Corporate compliance
  - Dimensions (EPIC)
  - Payers
- Contributed to increased RAF score, potentially opening the door for increased shared savings
- Through payer data analysis, identified coding edit issues with claims and partnered with coding to identify solutions

CDI Tools

- Scripting for CDSs regarding the "why" for increased specificity with diagnoses and documentation; keeping the education consistent
- Queries to providers (usually prospective)
- Reference guides for providers on tips regarding specific diagnoses
- CDS productivity and provider tracking spreadsheet
- Assist with building their favorites diagnosis list within EPIC
- HCC refresh needed and ICD-10 calculator—EPIC tool

CDI Tools: Sample Query

NOVANT HEALTH

Clinical Documentation Improvement Query

Action Required:

- Assign diagnosis to the highest degree of specificity
- Include supporting documentation in the encounter

A cause and effect relationship between diagnoses may not be assumed and must be explicitly documented.

- Update Problem List

Clinician: Dr. No Name
Patient Name / DOB: Doe, John A 1/1/50

MRN: XXXXXXX
Next Visit Date: XX/XX/XXX

Behavioral Health Clarification

1. Current Diagnosis: Anxiety

Clinical Indicators: 4/12/17 PHQ-9 score 19; currently taking Prozac, Xanax

Agree	Disagree	
☐	☐	MDD (single/recurrent, mild, mod, severe, partial or full remission)
☐	☐	Bipolar (I, II, single/recurrent, manic/depressed/mixed/unspecified episode)
☐	☐	Anxiety (GAD, panic attack, unspecified)
☐	☐	Other diagnosis (please specify)
☐		Unable to Determine

For accurate documentation specificity this query is created for you. When responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected.

Clinician Initial and Date: _____

CDS Reviewer and Contact Info: _____

CDI Tools: Quick Reference Guide

NOVANT HEALTH Clinical Documentation Improvement

Cardiology Quick Reference Guide

Update problem list
Document chronic conditions and diagnoses at least yearly
Document association with all manifestations, i.e. **due to, related to, assoc with** etc

Cardiac Arrhythmias

I44.2 Complete AV block *(third degree)*
I44.X Conduction disorders *(includes 1st or 2nd, left and right BBB and other unspecified and specified blocks)*
I47.1 Supraventricular tach: *includes PAT, AVNRT, AVRT, junc (parox) tach, nodal (parox) tach*
I48.X A-fib: *must specify and document 'chronic', 'paroxysmal', 'persistent'*
I48.X A-flutter: *must specify and document typical (Type I) or atypical (Type II)*
*(Also assign **Z79.01** long term (current) use of anticoag, if appropriate)*
I49.5 Sick sinus syndrome *tachy-brady syndrome, persistent bradycardia*
R00.1 Sinus bradycardia
I49.9 Cardiac dysrhythmia unspecified

CHF

I50.XX CHF: *specify and document acute/chronic/acute on chronic and systolic/diastolic/combined*
I42.X Cardiomyopathy: *specify and document type ischemic, obstructive hypertrophic, restrictive, alcoholic, etc*

Must document CKD and/or heart disease 'due to' HTN

I11.X Hypertensive heart disease *(with or without HF: if with HF must include **I50.X**)*
I12.X Hypertensive chronic kidney disease *(must also include CKD stage **N18.X**)*
I13.X Hypertensive heart and chronic kidney disease *(with or without HF, must include CKD stage **N18.X** and if with HF **I50.X**)*

I20.X Angina: *specify and document unstable, stable, with documented spasm*
I25.2 Old MI (for MI greater than *28 days*)
I25.XX Atherosclerosis: *specify and document native or bypass grafts*
Z86.73 CVA/TIA without residual deficits: *to be considered day after hospital discharge* **OR.....**
I69.3X Late effects of CVA: *specify and document hemiplegia, hemiparesis, aphasia, dysphagia, cognitive deficits, etc*

CDI Tools: Productivity/Tracking

Total Queries Dropped Off	Date Given	Total Queries Picked Up	Date Collected	Agreed	Disagreed	Unable to Determine	Other	Problem List Updated	Visit Diagnosis Updated	MEAT	# of Charts Audited	Feedback Comments
4	6/12/17	4	6/16/17	3	1	0	0	3	3	3	14	
3	6/12/17	2	6/16/17	3	0	0	0	0	0	0	6	
3	6/12/17	3	6/16/17	3	0	0	0	3	3	3	20	
1	6/12/17	1	6/16/17	1	0	0	0	0	1	0	4	
4	6/12/17	0	6/16/17	0	0	0	0	0	0	0	11	Misplaced per provider
3	6/13/17	2	6/13/17	2	0	0	0	1	1	1	8	
5	6/13/17	5	6/13/17	3	2	1	0	1	1	1	8	
3	6/13/17	3	6/13/17	3	0	0	0	3	3	0	13	
2	6/13/17	2	6/13/17	2	0	0	1	0	1	1	17	
4	6/13/17	4	6/13/17	4	0	0	0	4	4	4	20	

CDI Tools: Favorites Diagnosis List

Some Common Diagnoses When Making Your Favorites List

For some listed below, calculator will open with specificity choices—please choose as appropriate, avoiding "unspecified" whenever possible. Highlighted letters = quick look up in EPIC search list. Asterisk* = HCC value.
Documentation must support all diagnoses and include casual relationships if appropriate.

Diabetes mellitus

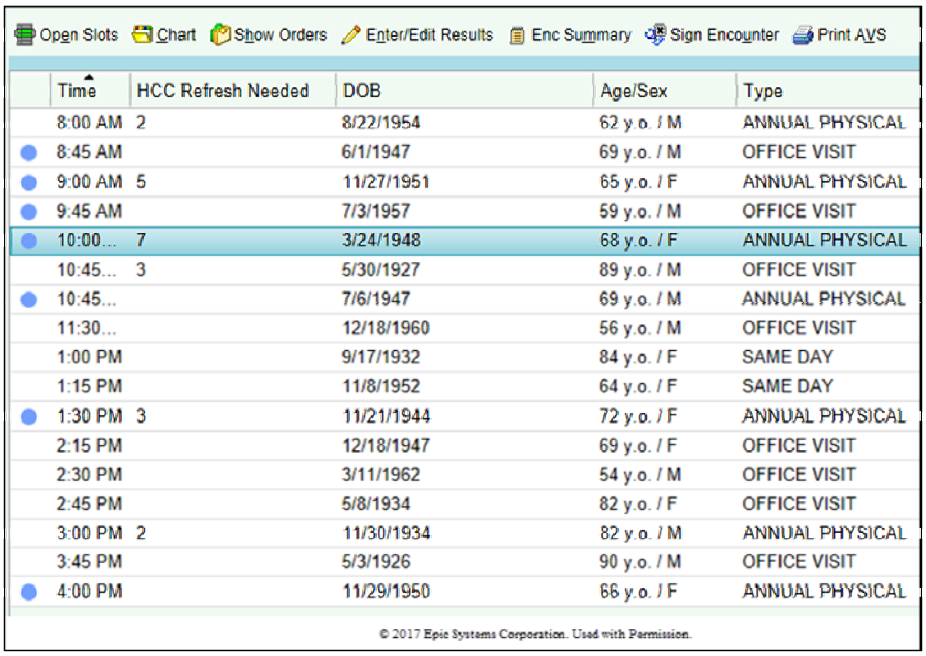
Diabetes without complications
DM Type 2*** = E11.9** *'dia'*
DM Type 1***** = **E10.9** *'dia 1'*
Long-term use insulin***** = **Z79.4** *'ins use'*

Uncontrolled DM
DM Type 2 with hyperglycemia* = ***E11.65*** *'unc dia'*
DM Type 1 with hyperglycemia*** = *E10.65*** *'unc dia 1'*
Hyperglycemia code to be used *in addition to* manifestation codes below if appropriate
Example: **Uncontrolled DM with PVD = DM Type 2 w/periph circ manifestation, w/hyperglycemia* = E11.51, E11.65**

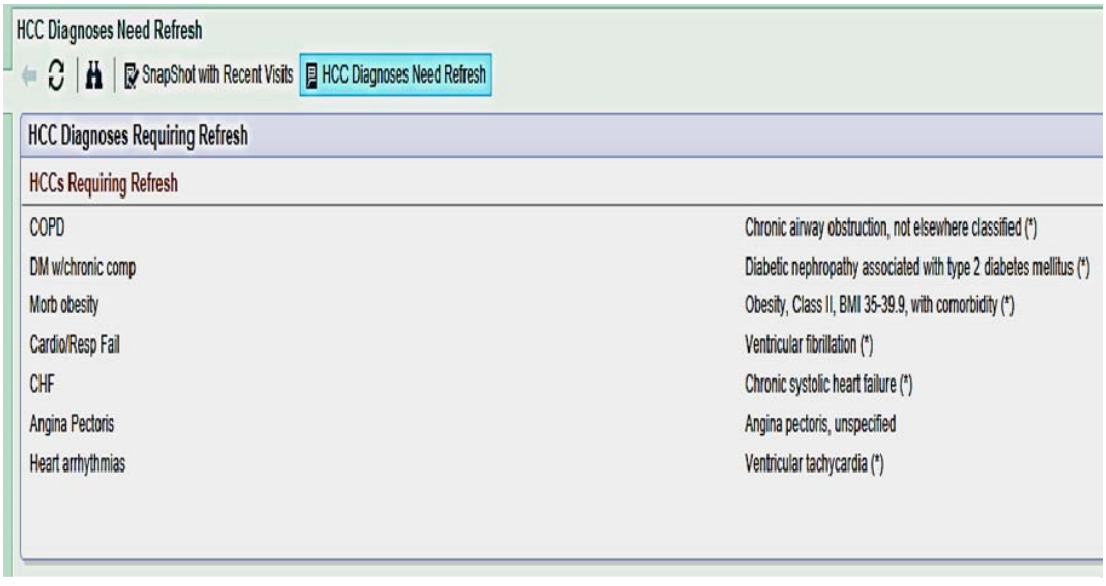
Renal *'dia nep'*
DM 2 controlled with renal manifestations***** = **E11.2X**
DM 2 w/hyperglycemia with renal***** = **E11.2X, E11.65**
DM 1 controlled with renal***** = **E10.2X**
DM 1 w/hyperglycemia with renal***** = **E10.2X, E10.65**

Requires additional code if due to CKD: *'dia kid'*
Examples: DM 2 controlled with CKD stage 1* = E11.22, N18.1
DM 2 controlled with CKD stage 2* = E11.22, N18.2
DM 2 controlled with CKD stage 5* (with ESRD not on dialysis) = E11.22, N18.5
DM 2 controlled with CKD stage 6* (with ESRD requiring dialysis) = E11.22, N18.6

CDI Tools: HCC Refresh Needed



CDI Tools: HCC Refresh Needed



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What We've Learned for Provider Engagement

- Face-to-face meetings
- Reinforce the why—MACRA/MIPS/RAF impact on reimbursement
- Educate clinical staff, including practice managers
- Senior leadership support
- Persistence, flexibility, and a sense of humor
- Feedback from providers
- Brainstorming for fresh ideas to engage providers
- Building respectful relationships

Thank you. Questions?

yrwhitley@novanthealth.org

To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the

Outpatient CDI Workshop series,

The Ins and Outs:

Inpatient and Outpatient Coding,

will be broadcast live on

Wednesday, November 8 at 1 p.m. ET.