The CACDIS Connection

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OK – I Have Years of Experiences as a Hospital CDI – What Else Can I Do?

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2020 has been a year with deep financial impact on health care organizations. Many experienced Clinical Documentation Specialists have found themselves being transferred to other duties, placed on partial or complete furlough, or separated from their organization.

There are other opportunities where you can use your skills, both in the hospital and in other health care organizations. Using your skills in the Managed Care/Medicare/MediCaid Advantage arena can open opportunities in consulting; both on site and remote, finance, contracting, and working with physician organizations.
Let's start with some background.

Managed Care

"Managed Care" is a phrase used to describe a variety of techniques meant to reduce the cost of providing health benefits and improve the quality of medical care for organizations that use those techniques or provide them as services to other organizations. It is also used to describe systems of financing and delivering health care to enrollees organized around managed care techniques and concepts.

Over the past 20 years, managed care has become the predominant form of healthcare in most parts of the United States. More than 75 million Americans have been enrolled in HMO's and more than 90 million have been part of PPO's. A Managed Care Organization is a health care provider or group or organization of medical service providers who offers managed care health plans. It is a health organization that contracts with insurers or self-insured employers and finances and delivers health care using a specific provider network and specific services and products.

Managed care organizations provide a wide variety of quality and managed health care services to enrolled workers or Medicare or Medicaid (MediCal) beneficiaries to keep medical costs down through preventive medicine, patient education, and in other ways.

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Managed care organizations vary in their makeup as some organizations are made of physicians, while others are combinations of physicians, hospitals, and other providers. Examples include a group practice without walls, an independent practice association, management services organization, and a physician practice management company.

Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of the patient's care the plan will pay depends on the network's rules.

- Health Maintenance Organizations (HMO) usually only pay for care within the network. The patient chooses a primary care physician who coordinates most of the patient's care.
- Preferred Provider Organizations (PPO) usually pay more if the patient gets care within the network. They will pay part of the cost if the patient goes outside the network.
- Point of Service (POS) plans allow the patient to choose between an HMO and a PPO each time the patient needs care.

Medicare Managed Care Plans are also known as Medicare Advantage plans, available through the Medicare Part C program. These programs are another way for Medicare recipients to receive their Medicare Part A (hospital) and Part B (Physician) coverage. Hospice care is covered under Medicare Part A. Some plans offer additional benefits such as routine vision care, drug coverage, and dental coverage. Types of Medicare Managed Care Plans include HMOs, PPOs, and POS plans. There are also Medicaid (MediCal) Managed Care Plans.

Diagnosis-Based Risk Adjustment

Simply put, diagnosis based RA (Risk Adjustment) is a methodology with a two-pronged goal: to ensure that patients' conditions are sufficiently diagnosed, documented, and coded in an effort to measure and monitor outcomes, and to accurately track the care needed through current and potential resources and reimburse accordingly. RA widens the marketplace for health care insurers by rewarding those insurers who enroll patients they would otherwise consider too risky to insure, i.e., to stop the practice of "cherry picking. In other words, insurers are discouraged from enrolling only the healthiest patients and discontinuing coverage for those with resource intensive comorbidities.

RA's effect goes far beyond the payer organizations and the patients who participate. Risk is determined from the diagnoses in each patient's medical record, which are translated into ICD-10-CM codes. The diagnoses entered into the medical record by the physician must be specific, accurate, clinically valid and translatable into ICD-10-CM language if risk is to be captured accurately. Likewise, a lot rides on the correct abstraction of the ICD-10-CM codes in the inpatient and outpatient setting based on this documentation. RA affects, hospitals, physicians, coders, other health care professionals who document in the medical record, and payers.

Diagnoses from physicians and other qualified health care providers are the source of most codes submitted for RA. The RA rules for medical record documentation and abstraction are about the same as for rules for physician and facility coding, but it is important to remember that those rules for physician coding are different. Enforcement of diagnostic coding guidelines in the outpatient and physician office arena has been lax for decades, but this is changing, and this is where you, as the CDI specialist, come in.

Physician payment is based primarily on Current Procedural Terminology (CPT) codes, so CPT code accuracy is the focus for outpatient coding. It's important to document and code procedures and services accurately to ensure full payment and prevent fraud and abuse. Coders in many physician offices ensure that ICD-10-CM codes abstracted from the medical record are valid only to the extent they support the medical necessity of the service provided. There is little to no oversight to

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ensure that the diagnosis codes are complete or precise and if they conform to current ICD-10-CM conventions, guidelines and advice. These are situations that could negatively affect RA. For example, a malignant neoplasm of the breast risk adjusts, where a documented "history of breast cancer" does not, as the first is documented with the actual breast neoplasm code and the second is coded with a personal history code. The official *ICD-10-CM Guidelines* stipulate that any malignancy undergoing active treatment should be coded with the actual malignant neoplasm code where the personal history code is applied only if the malignancy is not present or is being actively treated. Either visit may justify a Level 4 CPT Evaluation and Management oncologist office visit, but the reported diagnosis may wrongly risk-adjust or not risk adjust when it should.

What exactly ARE HCC Codes?

Hierarchical Condition Category (HCC) is hard to pronounce; understanding HCCs is even more challenging. Developed in 2000, HCCs are part of a risk-adjustment model allowing Medicare to project the expected future annual cost of care. They're used for calculating payments to Medicare Advantage plans, accountable care organizations (ACOs), and certain Affordable Care Act (ACA) plans. Generally, chronic conditions are responsible for more Medicare costs than acute ones, so many chronic conditions are included among the HCCs.

Risk adjustment allows Medicare to "level the playing field" so plans that cover patients with more severe, complex, and costly conditions receive a larger capitated payment than plans with less costly patients. A plan must cover all the costs for its patients' care during the year with the funds received. If costs exceed the payment, the plan loses money. If costs are less than the payment, the plan keeps the residual.

HCCs group together ICD-10 codes for related diagnoses with similar clinical complexity and expected annual costs of care. Each HCC is assigned a relative weight proportional to the relative costs associated with its constituent diagnoses. Higher-cost HCCs have higher relative weights. HCC relative weights are therefore similar to diagnosis-related group weights and to relative value units for CPT codes.

CMS has created two separate sets of HCCs. The CMS-HCC set is used for Medicare Advantage plans and quality measure adjustment. The Department of Health and Human Services (HHS) HCC set is for ACOs and ACA plans. A total of 189 HCCs have been developed, but not all of them are used by Medicare. The CMS-HCC set includes 89 HCCs with more than 9,500 codes; the HHS-HCCs total 117 HCCs and more than 7,700 codes.

While there are some differences between these HCC sets, they are not substantial and the principles are the same. HCCs do not directly impact traditional Medicare fee-for-service payments to physicians, but for physicians participating in ACOs or other ACA shared-risk plans, compensation could be affected.

Impact of HCC Coding

Example: Under documentation

Note: Not all diagnoses carry an HCC value. Always use the most specific diagnosis code to accurately describe the patient's condition.

See Table 1 next page for examples of HCC with and without a value.

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Table 1

ICD-10-CM	Has CMS-HCC Value	ICD10-CM	No CMS-HCC Value
I20.9	Angina Pectoris	R07.9	Chest Pain
G20	Parkinson's	R25.1	Tremor
J42	Chronic Bronchitis	R05	Chronic Cough
F32.0	Major Depression, single, mild	F32.9	Depressed
I48.91	Atrial fibrillation	I49.9	Arrhythmia
D61.9	Aplastic Anemia	D64.9	Anemia
J69.0	Aspiration Pneumonia	J18.9	Pneumonia
I50.21	Acute Systolic Heart Failure	E87.70	Volume Overload
N18.4	CKD 4	N28.9	Renal Insufficiency

Table 2 IMPACT OF APPROPRIATE HCC CODING ON PAYMENT

Female, Age 76. Not: originally disabled, Medicaid, ESRD, or institutionalized.

Option 1	HCC Risk Score		Option 2	HCC Risk Score
Obesity	0		Morbid Obesity, BMI 42	.250
Type 2 diabetes, exudative retinopathy	.105		Type 2 Diabetes w/diabetic retinopathy	.302
Major depression disorder, single episode, unspecified	0		Major depressive disorder, single episode, mild	.309
CHF	.331		CHF, class 3	.331
Asthma	0		COPD	.335
Pressure ulcer of right heel, unspecified	1.069		Pressure ulcer of right heel, stage 3	1.069

The next issue will have a following article that will continue the opportunities for CDI professionals in the outpatient arena.

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ACDIS Diversity and Inclusion Task Force: An Interview With ACDIS Director Brian Murphy

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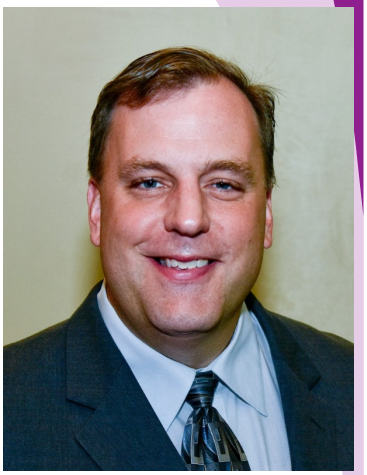

We live in very stressful times these days. We are over 6 months into a deadly COVID-19 pandemic with no end in sight, but to add to that, we have an even more deadly pandemic to deal with: Racism. The American Public Health Association has declared racism a public health crisis (APHA.org). There is empirical evidence that people of color are more likely to die from diseases and violence, and the recent incidences of video after video of African American men dying at the hands of police has only amplified this crisis. Recently ACDIS Director Brian Murphy started a new committee aptly called the ACDIS Diversity and Inclusion Task Force to tackle the issue of race and inclusion within the CDI field. A committee of diverse CDI professionals was started with Brian leading the helm. (August 13, 2020 – CDI Strategies – Volume 14, Issue 33**).**

We have had meetings discussing our own experiences as CDIs who are of different races and ethnicities and how our own field, while mostly diverse, still also has a long ways to go to be more inclusive and welcoming. I interviewed Brian about what led to the creation of this much needed committee. Here is our interview:

RJ: First of all I would like to commend you on this wonderful, much needed initiative. Can you please tell our readers about how and why this Task Force was started?

BM: The staff at ACDIS is certainly not immune to the events of the day, be it political, social, or otherwise. We were very troubled by the recent social unrest beginning with the protests over the gross excesses taken in the arrest of George Floyd, actions that led to his tragic, unnecessary death. As we now know this event was a lightning rod, sparking not only widespread protest but also a greater social conversation about race relations and the persistence of both surface-level and systemic racism in our society. We wondered what we could do in our small-ish corner of healthcare, and decided that the formation of a task force was a great first step.

RJ: How can ACDIS promote more diversity and inclusion in the CDI profession?

BM: I think we can do that in a few different but related ways. One (and perhaps the most important) is to give a voice to people of color, whether they be a leader in their organization or someone at the ground floor of CDI, whether they have encountered no obstacles in their career or whether they have been unfairly treated or marginalized due to their race, ethnicity, or gender. ACDIS has many platforms and avenues to broaden this conversation, including but not limited to the CDI Journal, the ACDIS Podcast, and the podium at our local and national conferences. A second is to use our position as an association with broad representation including thousands of members across the nation to get an accurate picture of the true state of diversity in CDI. A third is to recognize and honor those organizations that promote diverse practices, and thereby encourage CDI departments to take a look at the candidates they interview for jobs or consider for promotion.

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RJ: Can ACDIS leadership get involved with CDI hiring managers to encourage hiring more diverse candidates?
BM: Yes, I think we can. While we certainly cannot mandate behavior or set organizational policy, we can broaden hiring managers' decision-making processes by getting them to think about the candidate regardless of race or ethnicity as a person, and the greater value that diversity can bring to their organization. CDI professionals with diverse backgrounds bring new and different perspectives that can strengthen a CDI department, and add credibility with people of color within their organization including physicians and other healthcare providers, as well as HIM and case management professionals. If you think about it, if you have a diverse physician base (as many hospitals do), why shouldn't the professionals charged with improving the integrity of his or her documentation belong to a diverse team, too?

RJ: In my own professional experience working as a CDI, I have noticed that programs that hire CDI professionals with various backgrounds such as physicians, especially foreign medical graduates, seasoned HIM, Coding professionals and licensed RNs tend to be more diverse than those that only hire licensed RNs for instance. Do you think that can be adding to the lack of diversity?
BM: I think that practice can contribute to the problem. RNs make FANTASTIC CDI professionals, and there is no question about that. They bring clinical knowledge as well as a level of comfort and familiarity in physician relationships that are undeniable, due to their years of working at the elbow of physicians in stressful patient care situations. But I'm also well aware through first-hand experience that many great CDI professionals are foreign medical graduates. Often hailing from the likes of Africa or India, and the Middle East or the Philippines, these folks also possess extensive clinical knowledge and training, built-in physician mindsets, and therefore make excellent CDI professionals. Overlooking or excluding them from consideration, and likewise HIM professionals with diverse backgrounds, is a mistake in my opinion. But we don't have a good picture right now of the true state of diversity in CDI—whether CDI is truly welcoming and diverse or has more work to do—and that is part of the goal of this new Task Force.

RJ: Most organizations have diversity and cultural sensitivity trainings as well as anti-bias trainings but do you think CDI programs need to develop their own trainings as well?
BM: I think today more than ever this is a necessary and positive step to insure that we're being ethical and fair, and sensitive in our relationships with people that may look and sound different than we do, or dress differently or wear their hair differently. The good news is, as you've mentioned, many organizations are already doing this training, and so CDI managers can consider adopting them and putting the necessary CDI "spin" on them to create department-specific training. And there is an opportunity (and obligation) for ACDIS to assist with this effort**.**

RJ: Do you think physician advisors should be brought on board to encourage medical staff to also be accepting of CDI staff, especially those who are people of color? I ask this because I know of stories where physicians have shown bias towards CDI staff, one even asking 3 (they were of 3 different races, non-white) of them if they spoke English.
BM: First of all, I'm sorry to hear about these examples of bias. I do think physician advisors are an integral part of a high-functioning CDI team regardless of issues of diversity, as they bring a level of credibility and authority that can help defuse difficult situations and provide a peer-to-peer approach to scenarios like you've just described. I know that budget is often an issue since physician advisors command higher salaries, but part time physician advisors, or "physician champions" that still practice full time clinically but serve as CDI spokespeople, can also be effective in

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Highlights and Coming Attractions - - - IPPS Final Rule FY2021

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The Inpatient Prospective Payment System ("IPPS") controls and regulates almost all forms of payment for acute care hospital inpatient stays paid under Medicare Part A. One of those types of payment is the Medicare-Severity Diagnosis Related Groups ("MS-DRGs") which is a grouping system for ICD-10 charges. Individual ICD-10-CM Diagnosis Codes are assigned different weights as Complications and Comorbidities (CCs) or Major Complications and Comorbidities (MCCs) or, as Principal Diagnoses are assigned to different MS-DRGs. ICD-10-PCS codes are also assigned different weights allowing some procedural codes to control the MS-DRG and prohibiting other procedural codes from having any impact on the MS-DRG. The weights and assignments carried by different ICD-10 codes determine under which MS-DRG a case will be paid.

Each year the IPPS evaluates the need for change, and proposes changes in May. After a period of commentary, the IPPS finalizes the proposed rules, adopting some of the proposed changes and altering or deleting others. When the IPPS determines the changes for that fiscal, the finalized regulations are released as "The Final Rule" for that Fiscal Year. For FY2021, the IPPS released the "Final Rule" In September 2020. Most ICD-10 and MS-DRG changes will go into effect on October 1, 2020.

The number of changes that were made are too comprehensive to list in this article, but we thought we would provide some highlights.

In 2021, there will be some MS-DRG Changes:

- New MS-DRG (018) for Chimeric Antigen Receptor (CAR) T-cell Therapy which is a type of Immunotherapy used for Cancer patients. This MS-DRG has a much higher relative weight than MS-DRG 016 where most immunotherapy for Cancer Codes were previously grouped.
- MS-DRG changes for hip and knee replacements.
- MS-DRGs 14, 16 and 17 for 8 Bone Marrow procedures were incorrectly assigned last year as Operating Procedures and will now be assigned as Non-Operating Room Procedures.
- Open Carotid Artery Procedures will be reassigned to new MS-DRG categories.
- And procedures involving supplemental tissue will be subjected to change in MS-DRG assignment as well.

There will also be over 450 new, over 40 revised, and 58 deleted ICD-10-CM diagnostic codes. For example:

- There will be a new code for Intracranial hypotension,
- New codes and higher weighted codes for Sickle Cell Anemia (D57) which will also offer greater specificity in coding.
- Other Anemia codes, especially including hemolytic Anemia codes (D59), will also be given a greater deal of specificity.
- COVID codes will be formally included and a code for Cytokine Release Syndrome (D89) will also be added.
- The greatest number of additional codes will be added in the area of drug and alcohol use, dependence and withdrawal which are predominantly Chapter 5 (F) codes.
- S and T codes for poisoning and adverse effects of drugs will likewise be an area of coding change, addition and deletion.
- It seems scooters are more popular and more dangerous than we had thought because V000-V006 will also be revised.
- To celebrate the October Release of ICD-10 (FY2021), Arthritis Codes in Chapter 13 will also be given greater specificity with some coding additions.
- Corneal Dystrophy (H16) and several headache codes will be deleted to make room for additional, more specific codes.
- Some BMI codes are slated to be revised as well.
- Some Sickle -Cell Anemias codes will also receive greater weight as an MCC.
- Drug and alcohol abuse codes will also be higher weighted.

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- Osteoporosis with pathological fracture will also be given weight as a CC.

For ICD-10-PCS there will be several code changes in:

- Cardiac "fragmentation" procedures in codes starting with 02F, 03F and 04F. Fragmentation did not used to be a root operation that was available in heart and great vessel procedures.
- Low dose Brachytherapy codes will be added in Section D.
- Several drainage codes including 0W9J70Z, Drainage of Pelvic Cavity with Drainage Device with artificial or natural opening will be added.
- Two new Coding Guidelines will also be added to the Official Coding Guidelines for ICD-10-PCS. B3.18 will state that when excision or resection of body part is followed by a Replacement Procedure, both procedures may be separately coded unless the excision or recision is considered "integral to" the replacement. B5.2b will provide that procedures performed via a percutaneous endoscopic approach with an incision or extension of incision to assist in removal of a portion of a body part or a body part are to be coded as percutaneous endoscopic. B5.2n will prevail despite the increased incision size which may otherwise make it appear to have been converted to Open.

Every year The Final Rule makes many changes that ripple across the Healthcare waters impacting care and reimbursement. However, ICD-10 and MS-DRG changes are but one impact of the Final Rule. This year the Final Rule is also implementing the initiation of rules that will require hospitals to ***publicly*** report inpatient payer-specific median negotiated rates with Medicare Advantage organizations and third-party payers on the hospital cost report. These rates until have historically been held very confidential so that patients could not make decisions for receiving care based on the least expensive care. Also, each facility was permitted to feel the negotiated rate they received was the best rate. This initiative by the IPPS is referred to as "Price Transparency".

Also, this year the IPPS will begin in small ways to move healthcare payments even further away from report the information, the proposal will not create additional burden for hospitals. The agency also fee-for-service reimbursement arrangements to "market-based payment systems".

Wow – just when you thought Covid was complicated! Stay tuned.

References:

Cite for final rule:
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MS-DRG changes
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these roles.

RJ: Finally, is there any advice you would like to offer to the CDI community in terms of diversity and inclusion?
BM: I would say, be open minded. Recognize that not everyone is going to look like you, or think like you. But at the core we are all human beings, we all inhabit the same planet, and we all deserve the same opportunities of making a good life for ourselves and our families and children. Don't deny diverse candidates these opportunities. Practice being self-reflective rather than engaging in reflexive behavior. Analyze your own conscious or unconscious biases. Take the time to listen rather than express your own predetermined opinion when it comes to matters of diversity, as it's very hard to put yourself in the shoes of another human being. And stay tuned for more great things coming from the Task Force!
RJ: Thank you so much for starting this wonderful initiative and making the CDI profession more inclusive and welcoming!
BM: Thank you for the opportunity to be interviewed Rabia!

September is the month of the much awaited CDI Week. Please join Brian Murphy, Laurie Prescott and the ACDIS Diversity and Inclusion Task Force members during the ACDIS Virtual Education Curtain Call: Behind The Scenes Of Start-Studded CDI Programs (September 22-25, 2020). We will be speaking during the Opening Remarks on Day 3, Thursday September 24, 2020 from 10:30-11:00 AM (EST).
https://events.simplifycompliance.com/event/virtual-education-curtain-call/

References:

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