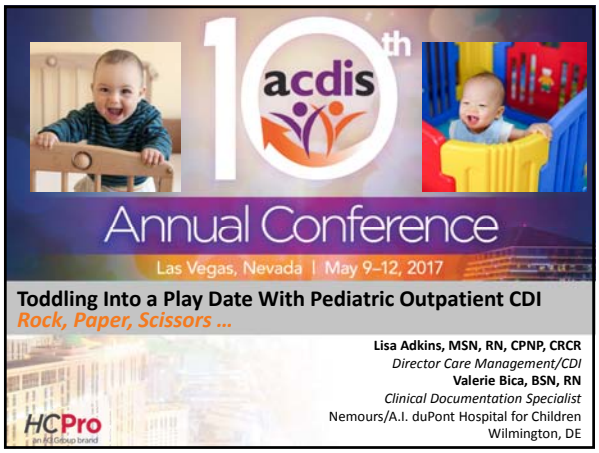

Toddling Into a Play Date With Pediatric Outpatient CDI

Rock, Paper, Scissors …

Lisa Adkins, MSN, RN, CPNP, CRCR
Director Care Management/CDI
Valerie Bica, BSN, RN
Clinical Documentation Specialist
Nemours/A.I. duPont Hospital for Children
Wilmington, DE

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Presented By

- **Lisa Adkins, MSN, RN, CPNP, CRCR, CPHM,** director of patient authorization, care management/CDI and family financial services
- Lisa Adkins is the director of clinical documentation integrity at Nemours/A.I. DuPont Hospital for Children in Wilmington, Delaware. She has 30 years experience in pediatric nursing, including inpatient and outpatient acute care, surgical, pediatric ICU, otolaryngology, care management, and CDI. She is certified as a pediatric registered nurse and a pediatric advanced practice nurse. She developed and implemented the pediatric CDI program at Nemours with a team of exceptional nurses and physicians.

2

Presented By

- **Valerie Bica, BSN, RN**
  CDI Specialist for Clinical Documentation Integrity
  Nemours/A.I. duPont Hospital for Children
- Valerie Bica is the lead CDI specialist for clinical documentation integrity at Nemours/A.I. duPont Hospital for Children in Wilmington, Delaware. She has 40 years of pediatric/NICU nursing experience, including case management, care management, managed Medicaid, acute care pediatrics, pediatric ICU, neonatal ICU, and high-tech pediatric homecare. Bica helped establish the clinical documentation integrity program for the A.I. duPont Hospital for Children, a 200-bed, freestanding pediatric facility. She is a co-leader of APDIS, the Association of Pediatric Documentation Improvement Specialists, an ACDIS networking group, and served on the 2015–2016 ACDIS Pediatric Respiratory Failure Work Group.

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Nemours/A.I. duPont Hospital for Children
DOB: 1941 to 1984 to 2014

Nemours. Alfred I. duPont Hospital for Children

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Nemours/A.I. duPont Hospital for Children
DOB: 1941 to 1984 to 2014

Nemours. Alfred I. duPont Hospital for Children

- Freestanding pediatric hospital
- 200+ beds
- PICU, NICU, CICU, telemetry, heme/onc, and BBMT
- 3 full-time CDI nurses
- Review all payers, focus on APR DRG/CMI/SOI and ROM

5

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Understand the goals of attempting outpatient CDI
  - Understand the possible gains from outpatient CDI
  - Identify barriers to outpatient CDI
  - Understand the concepts of pay-for-performance in non-DRG payer system

6

Nemours/A.I. duPont Hospital for Children CDI

- Our story began 6 years ago in the planning stages of getting ready for ICD-10
- We interviewed consultants to help us implement a CDI program for pediatric-only hospital
- Didn't bill by DRG, so the Medicare model didn't work
- Right from the start, focus was on chart integrity, diagnosis specificity, and accuracy
- Focus: CMI, SOI/ROM
- Now looking at requirements for partnering with payers, shared risk and moving toward ACO, quality measures, and education
- Common clarifications: Global dev delay, acute pyelo/cystitis, pancytopenia secondary to chemo

Nemours. Alfred I. duPont Hospital for Children

7

Current State—Inpatient CDI Program

- We divide to conquer …
- Each of the 3 nurses has 1 of the ICUs: PICU, NICU, CICU
- We each have multiple other teams that we support
- We each round daily with a separate team
- Verbal clarifications are key!
- Daily education of attending, resident, and med students in rounds
- Little bites … they go down easier with a spoonful of sugar provided by CDI
- Feedback from outside residents: "We were the only ones to teach them anything about ICD-10"
- "Makes more sense when in second year and have been through PICU"

8

Why Outpatient CDI?

- Possible gains from outpatient review of charts
- Where to begin?
- Challenges to outpatient CDI
- What is a risk-adjusted reimbursement structure for pediatric hospitals?
- Lessons learned as we begin in the outpatient world

9

Where to Begin?

- Considerations: Problem lists are a chronic problem—lots in, little out, and very low specificity.
- On admission we are *reinventing the wheel*, again and again, for comorbid conditions.
- Approach of the end of the grace period of ICD-10 "dreaded unspecified diagnoses."
- Enrollment in ACO-type reimbursement structures with a pay-for-performance/risk-adjusted reimbursement structure.
- AAAHHHH! *What would ACO/risk-adjusted reimbursement mean to us*? HCCs? Probably not …

10

Who First?

- Which lucky service line would be the first to benefit from our extraordinary knowledge of ICD-10 and unspecified diagnoses?
- Let us in!
- Well, what do YOU want?
- Let's look at the ED … no diagnoses there, maybe them?
- How about gen peds? Nope, no diagnoses there either …
- Hmmm … sub-specialties?
- Return on investment—have to start small and show a gain before we can increase the staffing numbers for this progression of CDI

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Letters From Major Managed Medicaid in DE … About That Diagnosis?

13

So the Payers Have Started "Communicating"

Dear UDAYAN K. SHAH:

Health Options is offering your practice a $150 reimbursement to review and confirm any diagnosis codes not previously sent to the health plan for dates of service between 7/1/2015 and 6/30/2016. Enclosed please find a list of patient specific conditions previously reported on a claim for which we are requesting confirmation.

- Upon your review of the patient's record we are requesting reprocessing of all claims with the additional diagnosis codes found not previously sent to the health plan in the reporting period. All new diagnosis codes require the submission of a paper corrected claim along with the enclosed patient specific Risk Gap Closure form signed by the provider to be eligible for reimbursement.
  NOTE: Corrected Claim must be submitted on paper to qualify.
- If no new conditions are found, submission of a corrected claim is not required or advised. Please make note of that on the form and return to the address below.
  NOTE: This list does not replace any documentation in the patient's medical record, and you should not code from this list.
- All diagnosis codes submitted on a claim must follow the ICD-9/10 coding and documentation guidelines as applicable.
- Always submit diagnosis codes to the greatest specificity to precisely describe your patient's medical conditions. Accurate coding and documentation assists in validating and establishing the appropriate disease burden of the member with the State and Federal entities.
- For easy identification we ask that you stamp "CORRECTED CLAIM" on each paper claim form and

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Unspecifieds Report, Surgery Division, 4th Quarter 2016

• Acute recurrent tonsillitis, unspecified	J03.91	78
• Allergic rhinitis, unspecified	J30.9	95
• Dental caries, unspecified	K02.9	83
• Diarrhea, unspecified	R19.7	50
• Disorder immune mechanism, unspec	D89.9	54
• Down syndrome, unspecified	Q90.9	129
• Enc exam/obs for unspec cause	Z04.9	59
• Hydrocele, unspecified	N43.3	78
• Injury, unspecified	T14.90	61
• Otitis media, unspecified, bilateral	H66.93	682

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ICD-10 Outpatient Denial Examples

Code/Description	Diagnosis Documented	Problem
94620/Pulmonary stress test	E66.9 Obesity, unspecified	Diagnosis unspecified and does not support medical necessity for procedure
93010/EKG	Z98.8 Other behavioral & emotional disorders	Diagnosis does not support medical necessity
99222/Initial H&P	R10.9 Unspecified abdominal pain	Diagnosis unspecified
85018/Hemoglobin assay	Z23 Encounter for immunization	Diagnosis does not support medical necessity for lab procedure

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Even the Physician Level of Billing

code 99215. The medical record submitted supports the paid E&M code 99213, as the Medical Decision Making was of low complexity, as evidenced by the following: Limited number of diagnoses or management options: FAP (familial adenomatous polyposis), Constipation. Limited amount and/or complexity of data to be reviewed: none noted. Low risk of significant complications, morbidity and/or mortality: ordered colonoscopy w/biopsy, changed 1 medication dosage. The original decision is upheld. Keystone First will not adjust this claim nor make any incremental payment..

- The clinic note really and truly only supports the diagnosis of FAP and constipation. Having CDI in the clinic could explore more specificity about these diagnoses and/or other risk factors that are being ignored by the GI physician billing at an intensive level of care. Could avoid simple denials—EDUCATION!

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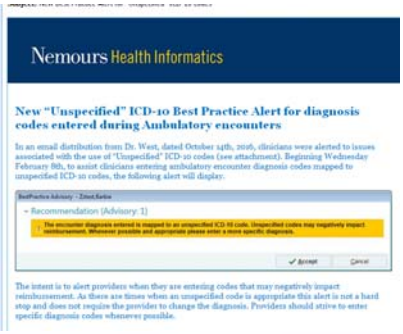
So What Was Gained?

18

So What Is New for the Outpatient World?


Nemours Health Informatics

New "Unspecified" ICD-10 Best Practice Alert for diagnosis codes entered during Ambulatory encounters

In an email distribution from Dr. West, dated October 14th, 2016, clinicians were alerted to issues associated with the use of "Unspecified" ICD-10 codes (see attachment). Beginning Wednesday February 8th, to assist clinicians entering ambulatory encounter diagnosis codes mapped to unspecified ICD-10 codes, the following alert will display.

- Recommendation (Advisory: 1)

The intent is to alert providers when they are entering codes that may negatively impact reimbursement. As there are times when an unspecified code is appropriate this alert is not a hard stop and does not require the provider to change the diagnosis. Providers should strive to enter specific diagnosis codes whenever possible.

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Coding Compliance Outpatient ED

- Reciprocity—picking the data bank of coding compliance for denied outpatient claims, including ED
- In turn they asked for help with denied claims, esp. ED
- Send CDI a list of denials with request for review of chart to identify if the denial for level of care is appropriate
- CDI to review for diagnoses coded and whether there are other or more accurate diagnoses that would help overturn denial
- CDI gave feedback to providers for better documentation and other diagnosis codes that could be captured
- Also accuracy of level of billing improved

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Documentation: ED to Inpatient

- ED resistant to support at the time of progress note
- Open to intermittent education—taking place quarterly during business meeting
- Examples of lost diagnoses, comparing what ED wrote with what was documented on admission
- Confusion of providers between E&M coding diagnoses and instruction from abstractors and CDI education for diagnoses
- Co-presenting with abstractor and coding compliance rep to send the same message

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The "BEFORE" of the Problem Diagnoses

22

Voila! New, Improved Problem List

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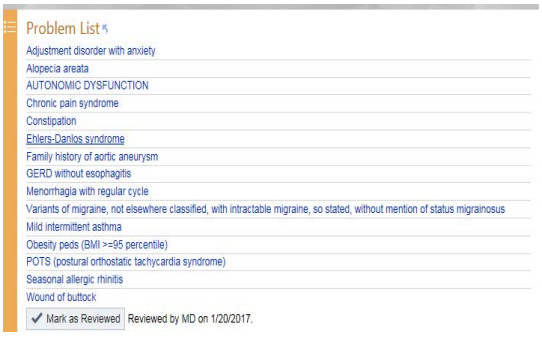
The "AFTER" of the Problem Diagnoses



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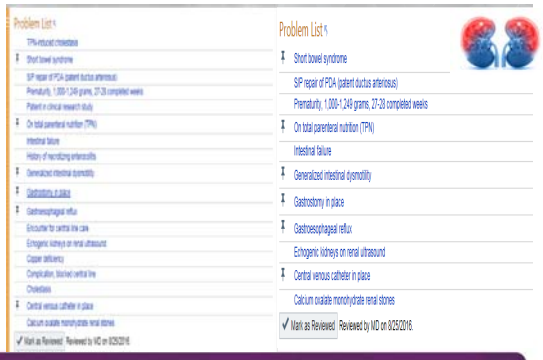
As We Begin in Nephrology Clinic



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So About Those HCCs …

- Few Medicare (none to speak of), especially no Advantage, so not currently using CMS/HHS HCCs
- Only have DRG billing with 2 payers
- Medicaid not asking for them yet
- CMS HCCs developed using data from those > 65 years
- CMS concedes that separate models would be optimum
  - 0–1 yr
  - 2–20 yrs
  - > 20 yrs
- SO NOT US! No payer requests for HCCs …

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Commercial Payer Risk Adjustment

- National dataset of performance measures used for National Pay for Performance Incentive Program
  - 30-day readmission rate
  - Average length of stay
  - Adverse event as defined by this payer
  - CMS HCAHPS measures
  - Case-mix index
  - Consider age group, commercial payer, risk level
  - Exclusions: Transplant, maternity care, children age < 1 yr, where the length of stay is outlier

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Moving Toward Value-Based Care—Vocab 101

- **FFS = Fee-for-service**—a payment scheme that compensates healthcare providers for each separate medical service they deliver, rather than paying them salaries or capped amounts for bundled services per patient or patient group
- **VBC = Value-based care or value-based contracting**

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Moving Toward Value-Based Care—Vocab 101

- **CIN = Clinical integrated network**—a collection of healthcare providers, such as physicians, hospitals, and post-acute care treatment providers, that come together to improve patient care and reduce overall healthcare cost. CINs can negotiate as one contracting entity with payers.
- **ACO = Accountable care organization**—a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated healthcare providers forms an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, upside/downside shared savings, etc.)

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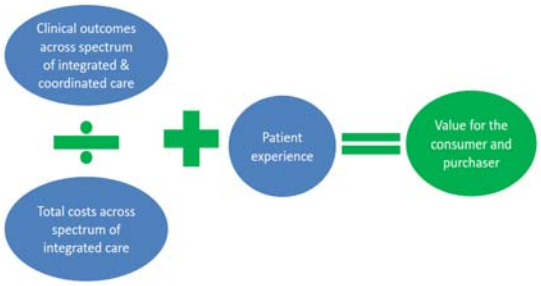
Why Move to Value-Based Care?

30

What Is Healthcare Value?



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The Market Is Shifting From Volume to Value

Volume Focused

- Reimbursed per admission and/or units of work
- Physicians seeking employment models for income security and lifestyle reasons
- Limited incentives to prevent admissions or coordinate care
- Continuum lacks integration
- Declining reimbursement for hospitals and physicians
- Significant uninsured and underinsured
- "Pay-for-compliance" rather than true outcomes-based reimbursement
- Regulatory issues that restrict integration (e.g., Stark, anti-kickback, private inurement, etc.)

Health Reform

Value Focused

- Future is based on managing value-based care competing on quality, patient safety, cost effectiveness, and coordination of care
- Shift of large groups of uninsured to capitated Medicaid population
- HITECH dollars technology use and integration
- Improved documentation of care and information sharing through HIEs
- Models for consideration: P4P; accountable care solutions/medical homes; episodic/bundled payments mechanisms; shared savings/risk; capitation models; provider-owned plans
- New focus on prevention and population health

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Risk-Based Models for Consideration

Common Models for Providing Value Based Care

P4P | Bundled Payment | Shared Savings/ Shared Risk | Partial/Full (Global) Capitation | Provider-Sponsored Plans

Degree of Risk and Clinical Integration

Low — High

Description of Models

- Low downside option
- Largely fee-for-service model with a layer of P4P
- Shared savings/bonuses for clinical process–driven improvements and defined measures of clinical metrics

- Fixed payment amount per patient for defined services rendered over a set period
- Model bases provider payment amounts on the costs of adhering to clinical standards of care, risk stratification, and compliance allowances
- Downside is having to cover costs of services for procedures and conditions exceeding agreed-upon reimbursement amount

- Shared savings arrangements represent a potentially higher level of reward for practitioners
- Payer spends less than it otherwise would have spent, and provider gets more revenue than it otherwise would have expected
- Shared risk models receive performance-based incentives to share cost savings combined with disincentives

- Provider receives set PMPM for specified medical services as well as takes on 100% of the insurance risk for the covered patient and services
- There are two models:
- Partial: single monthly feed that is paid to the provider; only covers a defined set of healthcare services
- Global: provider organization or organizations come together to receive a single fixed payment for the entirety of the patient services (e.g., primary care, hospitalizations, specialist care and ancillary services)

- Most comprehensive of risk-based models
- Provider assumes 100% of the financial risk for insuring the patient population
- Provider is in the driver's seat with respect to how care is delivered to patients and how much is spent on delivering the care

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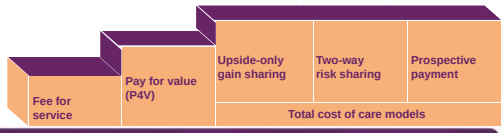
Value-Based Care Continuum

The value-based care continuum allows providers to build upon internal infrastructure, knowledge, and culture to move toward greater levels of financial risk and care coordination

- In a P4V model, metrics would be measured against some set scorecard of metrics
- Most models require meeting quality/experience measures to qualify for gains
- For total cost of care models, would measure total cost for payment (reporting utilization for information)
- Also recommended that payers fund two additional types of support in addition to outcomes-based payments
  - Care coordination fees
  - Practice transformation support



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Pay-for-Performance Measures

Measure	Measure Description
30-day readmission	This measure calculates the percentage of acute care inpatient hospitalizations followed by a subsequent acute care inpatient hospitalization within 30 days of the discharge date of the first hospitalization. This measure excludes counting readmissions that would have been expected based on the clinical nature of the case.
Asthma: Use of appropriate medications	This measure calculates the percentage of members age 5 to 64 who were identified as having persistent asthma and receiving appropriately prescribed medication.
Diabetes: Hemoglobin A1c testing	This measure calculates the percentage of members age 18 to 75 with diabetes receiving annual HbA1c testing.
Diabetes: Hemoglobin A1c poor control (> 9.0%)	This measure calculates the percentage of members age 18 to 75 with diabetes that demonstrate poor glycemic control, based on an HbA1c level greater than 9%.
Diabetes: Hemoglobin A1c control (< 8.0%)	This measure calculates the percentage of members age 18 to 75 with diabetes that demonstrate glycemic control, based on an HbA1c level less than 8%.
Diabetes: Medical attention for nephropathy	This measure calculates the percentage of members age 18 to 75 with diabetes receiving medical attention for nephropathy.
Diabetes: Retinal eye exam	This measure calculates the percentage of members age 18 to 75 with diabetes receiving an annual retinal eye exam.
Diabetes (pediatric): Hemoglobin A1c testing	This measure calculates the percentage of members age 6 to 18 with diabetes receiving HbA1c testing.
Persistent medication use with lab monitoring: Digoxin, ACE-I/ARB or diuretic	This composite measure calculates the percentage of members age 18 and older who received at least a 180-day supply of digoxin, ACE-I/ARB or diuretic and therapeutic monitoring testing: • Digoxin—a digoxin level, metabolic panel or a serum potassium and a serum creatinine • ACE-I/ARB or diuretic—a metabolic panel or serum potassium and a serum creatinine

35

Potential Challenges With Value-Based Care

- Transparency, provider, payer, and patient engagement are keys to success
- Meaningful measures can be difficult to identify, develop, administer
- Purchasers and consumers of healthcare must be convinced value-based contracting has value
- Population health improvement is longitudinal and not a "quick hit"
- ROI can be difficult to define and may vary by model
- IT infrastructure is limited but necessary for success
- Physician alignment and incentives
- Cultural challenges
- Network
- HCCs are NOT kid-friendly!

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What Happened "Out There"

- Of course, more education!
- And of course, more pushback
- Slowly improved diagnoses and comorbid conditions in the outpatient notes
- Big-time cleanup of the problems—*problem list*
- Avoid unspecified diagnoses after coding
- Much listening and sympathy about "what do 'they' expect from us?"

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Resident Identified Diagnoses—Like None …

- Chronic lung disease,
- trach and vent,
- GT,
- has been vomiting frequently.
- Concern for aspiration event,
- failure to thrive,
- CP.
- Here for exam because after vomiting yesterday she has more secretions, is breathing faster and desats overnight.
- She is nonverbal and nonambulatory.
- Mom increased her oxygen thru the vent and wants to increase the vent rate.

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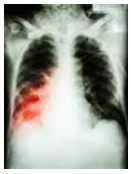
Clinic With Dr. C—What About These?



- BPD related to prematurity
- Gastro-esophageal reflux
- Spastic quadriplegic cerebral palsy
- Moderate intellectual disability
- Expressive language delay
- Moderate malnutrition due to inadequate feeding tolerance
- *Acute on chronic respiratory failure w/hypoxia*
- *Aspiration pneumonitis*
- ADMIT TO PICU!

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The Final Outcome

- The big unknown—time will tell.
- Limited time running, limited results.
- Pushback from providers/CDI nurses.
- Time, time, and more time! And education!
- Slow and steady—we are the tortoise!
- Some improvement in diagnosis specificity on admission after clinic visits.
- Better use of problem list.
- Increased awareness of unspecified diagnoses.
- Decreased denials based on unspecifieds or inappropriate E&M billing level.
- Improved relationships between CDI and providers.
- Unknown—influence of political climate on this reimbursement methodology.

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Lessons Learned

- Having good relationships is key.
- Slowly introduce the subject in a discussion.
- Start with education—understanding *why* helps.
- Begin with short bursts of time in clinic.
- BRING CANDY! Everything goes down easier with sugar!
- Report on unspecifieds before and hopefully after.
- Timing—know what you want to ask and do it quickly!
- What's in it for me?

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Still to Come …

- Hopefully, increase in staffing to allow more robust outpatient CDI effort
- Involvement of primary care satellite sites
- More active role in ED documentation
- Possible opportunity for further collaboration with abstractors and coding compliance
- Reports that show:
  - Decreased unspecified diagnoses
  - Decreased denials (inpatient and outpatient)
  - Improved quality of problem lists for better functionality
  - Hope for using problem lists for coding diagnoses

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