It's All in the Claims Data! Observed to Expected Ratio & Risk-Adjusted Rates Explained

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*Dr. Hussain’s contributions to this presentation do not include any CHSPSC, LLC data, processes or other information.
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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Demonstrate the CDI clinician’s suitability to conduct 2nd-level reviews to optimize SOI/ROM and impact the O/E ratio before the bill is dropped
  – Utilize the query process and collaborate with coding teams to influence the O/E ratio and obtain risk adjustment data that impacts the administrative claims data (coding summary) before the bill is dropped
  – Demonstrate how SOI/ROM and risk adjustment diagnoses impact the O/E ratio and the administrative claims data
  – Substantiate the rationale for using a CDI clinician to improve the administrative claims data for public reporting and hospital quality metrics
  – Use knowledge gained in the session to obtain executive leadership buy-in for expanding CDI team scope of practice
Steps for Attendees to Answer/View POLLING QUESTIONS

1. Navigate to the event **Agenda** in the main menu
2. Tap the **name of the current session** to view the session details page
3. Tap **Polls**
4. Tap the **name of the poll**
5. Tap your **answer choice** and then tap **Submit**
Polling Question #1

- **Do you have CDI staff doing ANY retrospective reviews in your organization?**
  - No! CDI should ONLY be involved in concurrent processes
  - No, due to concerns about adverse effect on DNFB
  - No, but we plan to have some of them do retro reviews
  - Yes, but it is limited to productivity reconciliation
  - Yes, CDI staff do pre-bill mortality and/or quality reviews
Domains of Healthcare Quality – Institute of Medicine (IOM)

• Safe, Effective, Patient-Centered, Timely, Efficient, & Equitable

• Promote dissemination about the quality & value of healthcare services
  – Consumer understanding & choice

(The Six Domains of Healthcare Quality, 2016)
Measuring Quality and Safety (Hospital Value-Based Purchasing)

• IOM (1999; 2001)

• National Quality Forum (1999)
  – NQF develops and implements a national strategy for quality measurement and reporting

• CMS (2003) institutes a pay-for-performance pilot program (voluntary reporting)
  – System of rewards and penalties

• AHRQ reports to Congress on the state of the nation’s healthcare quality
  – Measures safety, effectiveness, timeliness, and patient-centeredness
  – Using AHRQ’s research tools, the U.S. healthcare system prevented 1.3 million errors, saved 50,000 lives, and avoided $12 billion in wasteful spending from 2010–2013.

• ACA 2010 (took effect 1/1/14)

(Forthman, Gold, Dove, & Henderson, 2010)
Abstracting

• National initiative to voluntarily collect & report data (AHA, Federation of American Hospitals, AAMC)
• Quality abstracting teams
• CMS, JC, and AHRQ supports this initiative to collect and disseminate hospital performance data
  ➔ Accessible to consumers, payers, and providers of care (Leapfrog Group, Healthgrades, WebMD, U.S. News & World Report)

(Forthman, Gold, Dove, & Henderson, 2010)
Outcomes Reporting Is Shifting

• Decrease in data abstracted by quality teams for reporting
  – October 2017—CMS administrator Seema Verma announced the agency is streamlining quality measures across ALL programs
  – Reduce regulatory burden
  – AHA purports non-clinical regulatory requirements cost providers $39 billion a year

• Risk adjustment diagnoses *coded* in the administrative claims data is comparable to record abstraction reporting

(American Hospital Association, 2017)
(Ericson, Evans, Fee, & Yuen, 2017)
(Forthman, Gold, Dove, & Henderson, 2010)
Administrative Claims Data (Coding Summary)

• Increased use of claims data decreases the amount of data that must be abstracted and reported
• Profiling hospitals and physicians on clinical quality measures
• Compares complications, readmissions, patient safety events, and the actual and expected rates of mortality (HVBP)
• Quality and performance metrics drive payer reimbursement and consumer choice
• Mortality
• Reimbursement

(Forthman, Gold, Dove, & Henderson, 2010)
Traditional Focus of CDI Teams

- Financial reimbursement
  - Optimize MS-DRG with CC/MCC capture rates, sequencing, and procedures
  - Optimize APR-DRG (SOI/ROM) for Medicaid payers
Expanding Focus of CDI Teams

• Quality teams
  – Augment the mission of abstracting teams
    • CAUTI, CLABSI, core measures, PSIs, HACs, and readmissions

• Coding
  – POA indicators
  – Clinical explanation & interpretation
  – Comfort care
Expanding Focus of CDI Teams

• UR/UM
  – Opportunities to convert patients through documentation (observation to inpatient)

• Denials/appeals

• HCC risk adjustment methodology
  – Medicare Advantage plans
  – Commercial payers
  – Additional focus on the patient’s chronic disease burden

• Outpatient
Missed Opportunities

• Traditional focus of CDI & coding teams has been CC/MCC capture, optimized DRG, & CMI watching
  – Financial focus is often the starting point for new CDI teams
  – Must master basic concepts before teams can expand to include quality focus

• Coding, CDI, & quality teams working in isolation
  – All share & work toward the same goal, but teams work in isolation/silos

• Failure to include a clinical validation process with code assignment
Missed Opportunities Lead to ...

- Disconnect between clinical record and administrative claims data (coding summary)
- Incorrectly reported administrative claims data
  - Inaccurate public reporting (HACs, PSIs, & complications)
  - Denials for medical necessity & DRG downgrades
  - Penalties & loss of incentive payment
Many CDI Teams Already Utilize All-Patients Refined (APR) DRG Methodology

- APR-DRG methodology is sensitive to patient acuity
- Positive correlation with mortality index
- Determine query focus, GMLOS, & SOI/ROM
- Caveat—CC/MCC capture without context leads to negative performance reporting in the administrative claims data (coding summary)

(Ericson, Evans, Fee, & Yuen, 2017)
Inpatient Reimbursement Methodology Is Changing

• Value-based payment methodology (pay-for-performance)
  – Inpatient reimbursement driven by quality measures (HVBP, HRRP, HACRP)
  – Improve quality, efficiency & value of healthcare
  – Triple Aim: Better healthcare, improved patient experience, & reduced costs

Hospital Value-Based Purchasing, Hospital Readmissions Reduction Program, Hospital-Acquired Condition (HAC) Reduction Program, & Patient Safety & Adverse Events Composite (PSI 90)

(Ericson, Evans, Fee, & Yuen, 2017)
CMS – Management of Chronic Disease Burden & Reducing Healthcare Costs

• Risk adjustment extends beyond acute disease manifestations (CCs/MCCs)
• Diagnoses that *change* a risk profile & *increase* the likelihood of mortality (sicker patient populations)
• HCCs: Only 3% of HCCs used for risk adjustment qualify as CCs/MCCs in the MS-DRG system
• The coding journal, *For the Record*, purports approximately 50% of diagnoses in the medical record are not prioritized for review
• Multiple risk adjustment methodologies

(Chavis, 2017)
(Ericson, Evans, Fee, & Yuen, 2017)
Value-Based Payment Methodology (Pay-for-Performance)

- CC/MCC capture rates, optimized DRGs & CMI **AND**
- Opportunity to expand CDI team focus
  - Quality and value of care
  - Medical necessity (appropriate utilization of services & setting)
  - Readmissions
  - Patient safety
  - Complications
  - MORTALITY
  - REIMBURSEMENT

(Chavis, 2017)
Public Visibility of Coded Data – Big Brother

Medicare.gov: Hospital Compare

Hospital profile

Any Hospital
123 Main St
Any City, US 00000
(555) 555-5555

Overall rating: ★★★★★

Learn more about the overall rating

View rating details

Distance: 3.1 miles

General information

- Hospital type: Acute Care Hospitals
- Provides emergency services: Yes
- Able to receive lab results electronically: Yes
- Able to track patients' lab results, tests, and referrals electronically between visits: Yes
- Uses outpatient safe surgery checklist: Yes
- Uses inpatient safe surgery checklist: Yes

Add to My Favorites
Map and directions for
Public Visibility of Coded Data – Healthgrades®

Any Hospital
123 Main St, Any City, US 00000
(555) 555-5555

65% of patients would definitely recommend this hospital.
Public Visibility of Coded Data – Healthgrades®

Clinical Quality: Critical Care

Research Hospital Ratings: Talk to Your Doctor

All hospitals strive to offer great medical care—but some do a better job than others. Use Healthgrades to research hospital performance and talk to your doctor about what’s right for you.

* Number of cases may not represent total volume.

Mortality Based Ratings

<table>
<thead>
<tr>
<th></th>
<th>Mortality In Hospital</th>
<th>Mortality Within 30 Days</th>
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<tbody>
<tr>
<td><strong>Sepsis</strong></td>
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<tr>
<td>Mortality Based Rating on 96 cases. Less ▲</td>
<td>★★★★☆☆</td>
<td>★★★★★</td>
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<tr>
<td>Actual Mortality</td>
<td>10.42%</td>
<td>22.92%</td>
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<tr>
<td>Predicted Mortality</td>
<td>8.1%</td>
<td>13.82%</td>
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What Is Sepsis?

Sepsis is caused by any serious infection that spreads through the bloodstream and results in potentially life-threatening inflammation throughout the body.

Research Hospital Ratings: Talk to Your Doctor

All hospitals strive to offer great medical care—but some do a better job than others. Use Healthgrades to research hospital performance in treating patients with sepsis and talk to your doctor about what’s right for you.

★★★★★ Worse than Expected ★★★★★ As Expected ★★★★☆☆ Better than Expected

NOTICE: Use of this website and any information contained herein is governed by the Healthgrades User Agreement.
Public Visibility of Coded Data – CareChex®

Hospital Quality Ratings 2018
Medical Excellence: Red

Overall Hospital Care

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Quality Rating Legend:
- ✓++ = Highest
- ✓+ = High
- ✓ = Average
- ✓- = Low
- ✓-- = Lowest

Data Time Period: January 2014 - June 2019
Based on National Percentile Scores
Public Visibility of Coded Data – LeapFrog®

Any Hospital - Any City
123 Main St
Any City, US 00000
Map and Direction

Learn how to use the Leapfrog Hospital Safety Grade

Infections
Problems with Surgery
Practices to Prevent Errors
Safety Problems
Doctors, Nurses & Hospital Staff

Click Each Measure to Learn More

Hospital Performs Below Average
Above Average
Polling Question #2

- Is Risk Adjustment Mortality Index (O/E ratio) a main focus of the CDI program at your facility?
  - No, this is a responsibility of the quality team
  - No, but we want to move in that direction and need more education
  - No, but we plan to move in that direction soon
  - Yes, CDI does CONCURRENT reviews to optimize SOI/ROM
  - Yes, CDI does pre-bill RETRO reviews to optimize SOI/ROM
Your crazy is showing you might want to tuck that back in.
Hey, Your Integrity Is Showing — You Better Not Tuck It Back In!
Past, Present, & Future of CDI

Purveyors for clinical truth in documentation

• Robert S. Gold, MD & Cesar Limjoco, MD
What Is Your Definition of a Mature CDI Program?

• **Immaturity**
  – $$$$$—query financial impact
  – CDI team metrics—CC/MCC capture & DRG optimization

• **Advancing program**
  – Collaborate with coding, UR/UM, case management, denials/appeals teams, quality teams & conduct reviews for Medicare Advantage plans & outpatients
  – Still primarily reimbursement focus

• **Mature program**
  – Leaders—quality documentation focus—building bridges and relationships
  – Ownership of a robust, comprehensive concurrent query & record review processes
  – Ownership of post-coding/pre-bill audits of the medical record
    • Retrospective process
  – Clinical validation
  – Education, education, education
CDI Team Maturity

• Active collaboration with coding & quality teams, UR/UM, case management, mortality committees & revenue cycle teams to ensure the administrative claims data (coding summary) accurately reflects:
  – Quality and value of care
  – Medical necessity (appropriate utilization of services & setting)
  – Readmissions
  – Patient safety
  – Complications
  – MORTALITY
  – REIMBURSEMENT

• BEFORE THE BILL IS DROPPED
CDI Team Maturity

• Public visibility of coded data
  – Is your integrity showing?

• Post-DC & pre-bill clinically focused audit of the coding summary & the medical record
Accurate & Complete Documentation

• Once the basics are mastered ...

• CDI teams have a responsibility to ensure the medical record is *accurate* and *complete*
  – CDI teams can ID documentation and coding opportunities as new measures are introduced *before* the measures impact value-based performance

• CDI teams should take *ownership* of the *integrity* of the *documentation* in the *medical record*
What Do You See When You Look at a Coding Summary?

• Is there clinical truth?
  – Does the coded data reflect an accurate clinical picture?

  Coding summary incongruence with the medical record can occur when coding guidelines/Coding Clinics are correctly applied.

  • Documentation issues
    – Unspecified codes/unclear POA status
    – Ambiguous link between a diagnosis & a complication
    – Diagnosis without link to clinical evidence, treatment, and response

  • Coding issues
    – Codes assignment w/o clinical validation

  • Discharge disposition

  • Clinical performance issues
    – Rates of hospital-acquired infections & readmissions
    – PSIs & HACs

(Ericson, Evans, Fee, & Yuen, 2017)
Program Immaturity to Maturity

• Holistic review
  – Coined by Glenn Krauss
  – CDI record review
    • Total picture
    • Documentation that informs
      – Coordination of care & response to treatment
      – Authentic documentation (no copy/paste progress notes)
    • Clinical truth

• Ultimate goal for CDI teams: Maturity
  – Ownership of the integrity of the medical record
  – Increase depth & breadth of clinical knowledge
  – Excellence

(Krauss, 2017)
Value-Based Payment Methodology (Pay-for-Performance)

- Penalties, incentives
  - Adjustments to MS-DRG payments
- Observed/expected ratio
- Risk Adjustment Mortality Index

Incomplete provider documentation adversely affects YOUR hospital’s mortality index.

(The Joint Commission, 2013)
Observed Mortality / Expected Mortality = Risk Adjustment Mortality Index

• Observed mortality = patients that expired in a patient population (numerator)
• Expected mortality = patients that survived in a patient population (denominator)
• Risk Adjustment Mortality Index = risk of dying or surviving hospitalization \((O/E\) ratio)

  - Mortality index > 1 implies mortality is ↑ than expected (HVBP penalties)
  - Mortality index = 1 implies mortality = expected # Deaths (no penalties or incentive payments)
  - Mortality index < 1 implies mortality is ↓ than expected (HVBP incentive payments)

Incomplete provider documentation adversely affects YOUR hospital’s mortality index.
O/E Ratio Trending

![Mortality Index Graph]
Risk Adjustment Mortality Index (RAMI)

• RAMI is a method for comparing hospital death rates using existing abstract or billing data

• Adjusts for individual patient risk factors & comorbidities, which increases or decreases the risk of dying in the hospital

• Dependent on quality of coded data (clinical truth in the administrative claims data)

• CDI opportunity to influence the expected risk of death (denominator)
  – 2nd-level clinical reviews—How sick is the patient?
  – Exclusions
  – Query process
  – Code modification requests

(Elion, 2015)
(Rees, Richardson, & Woodward, 2005)
(Wroblewski, McMahon, Chesney, McMahon, & Fleming, 1988)
Observed Mortality / Expected Mortality = Risk Adjustment Mortality Index

• Evaluate performance
  – Reducing preventable mortality
  – Measurable improvement initiatives that include documentation accuracy
  – Reduce mortality and improve patient care

• Accuracy
  – Completeness of provider documentation
  – Chart abstractors & coders cannot interpret or extrapolate
  – Education, education, education

Incomplete provider documentation adversely affects YOUR hospital’s mortality index.

(Forthman, Gold, Dove, & Henderson, 2010)
(The Joint Commission, 2013)
Observed Mortality / Expected Mortality = Risk Adjustment Mortality Index

“The primary determinant of the expected component of the mortality index is derived from administrative data collected from the medical record following hospital discharge.”

Incomplete provider documentation adversely affects YOUR hospital’s mortality index.

(The Joint Commission, 2013)
Expanding Role of CDI Teams

• Affect the *expected* component of the mortality index
• Fully documenting comorbidities
  – *Accurate* quality scores
  – *Documentation that increases the expected death rate in the surviving population*
• Complete & accurate documentation that supports code assignment
• CDS query & code modification focus
  – Documentation that reflects patient complexity (SOI/ROM)
  – Focus on chronic conditions
  – Diagnosis specificity
  – POA status (complications)

*Incomplete provider documentation adversely affects YOUR hospital’s mortality index.*

(Elion, 2015)
Expanding Role of CDI Teams: 2nd-Level Audits

• Post coding pre-bill holistic chart review
  – Last opportunity to ensure administrative claims data is accurate
  – Clinical truth & clinical validation
  – Integrity
  – Excellence in outcomes
  – Include all mortalities

• Clinically skilled CDS

• Reconciliation
  – Code modification requests

• Clinical validation to support code assignment
  – Query process

Incomplete provider documentation adversely affects YOUR hospital’s mortality index.
Pre-Review: SOI/ROM/DRG 4/4; 338 (2.7639)

- Code modification request:
  - Sepsis POA (core measures & PPC)
  - Removal of post-procedural infection
### Post-Review Results: 4/4; DRG 853 (5.1279)

- **Query answer:** Sepsis POA
- **Positive impacts:**
  1. HACs removed—sepsis (POA) & no post-procedural infection;
  2. Financial

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#### Diagnoses:

- **Admit:**
  - K35.2: Acute Appendicitis with Generalized Peritonitis
  - A41.9: Sepsis, Unspecified Organism
- **Princ:**
  - K35.2: Acute Appendicitis with Generalized Peritonitis
  - I21.4: Non-ST Elevation (NSTEMI) Myocardial Infarction
  - G93.40: Encephalopathy, Unspecified
  - I50.21: Acute Systolic (Congestive) Heart Failure
  - E46: Unspecified Protein-Calorie Malnutrition
  - N17.9: Acute Kidney Failure, Unspecified
  - K56.7: Ileus, Unspecified
  - I11.0: Hypertensive Heart Disease with Heart Failure
  - D62: Acute Posthemorrhagic Anemia
  - K92.2: Gastrointestinal Hemorrhage, Unspecified
  - K91.870: Postproc Hematoma of a DGSTV Sys Org Fol a DGSTV Sys Proc
  - R65.20: Severe Sepsis without Septic Shock
  - E11.40: Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unsp

#### Operations:

- **Proc Code & Name:**
  - 0DTJ4ZZ: Resection of Appendix, Percutaneous
Pre-Review: SOI/ROM/DRG 2/2; 872 (1.0283)

- 86M expired with 1-day admission
- Queried provider for:
  - Acute hypoxic respiratory failure
  - Acute liver failure
Post-Review Results: 4/4; DRG 871 (1.7660)

- Positive impacts: (1) financial; (2) increased risk of mortality (SOI/ROM)

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<td>K72.00 ACUTE AND SUBACUTE HEPATIC FAILURE WITHOUT COMA</td>
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<td>J96.01 ACUTE RESPIRATORY FAILURE WITH HYPOXIA</td>
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<td>D61.818 OTHER PANCYTOPENIA</td>
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<td>F03.90 UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE</td>
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<td>I10 ESSENTIAL (PRIMARY) HYPERTENSION</td>
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<td>K21.9 GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS</td>
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<td>D63.8 ANEMIA IN OTHER CHRONIC DISEASES CLASSIFIED ELSEWHERE</td>
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<td>G40.909 EPILEPSY, UNSP, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS</td>
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<tr>
<td>Z51.5 ENCOUNTER FOR PALLIATIVE CARE</td>
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<td>E78.5 HYPERLIPIDEMIA, UNSPECIFIED</td>
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<tr>
<td>E03.9 HYPOTHYROIDISM, UNSPECIFIED</td>
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<td>N40.0 BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMP</td>
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<td>R65.20 SEVERE SEPSIS WITHOUT SEPTIC SHOCK</td>
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Present & Future for CDI Teams

• If the CDI team has mastered the basics, it’s time to grow and expand!
  – Multiple quality initiatives
  – Prep for move to value-based payment methodologies
• Responsibility to ensure the medical record is accurate and complete
  – ID documentation and coding opportunities as new measures are introduced before the measures impact value-based performance
• Move toward maturity
  – Education, education, education
  – Clinical validation
• Ownership of the integrity of the documentation in the medical record
  – Empower & equip your CDI teams!
The Time Is Now for CDI Teams to Lead & Embrace Change

• Improve capture of all secondary diagnoses that impact SOI/ROM BEFORE administrative claims data is billed!
• It is critical to *focus on inpatient risk adjustment diagnoses* in the administrative claims data to move from volume-based to value-based payment methodologies
• Utilize the seasoned, clinically skilled CDS to perform 2nd-level audits (post coding & pre-bill)
  – *Advanced* application of clinical pathophysiology
  – Coder education—advanced clinical concepts
The Time Is Now for CDI Teams to Lead & Embrace Change

- Workflow adjustments & process reengineering to accommodate risk-adjustment focus
  - C-suite buy-in—it starts at the top!
    - Education—risk-adjusted payment methodologies
    - CFOs—expanding focus & move to value-based payment methodologies
    - Revenue cycle teams—expectations, changes in billing procedures
    - CDI, coding, & quality should not work in isolation!
    - Collaborate with UR/UM, case management, denials/appeals, & revenue cycle teams
    - Coding teams—education & expanding horizons—coding is a team sport!
      - Guideline 19 & Fourth Quarter 2016 Coding Clinic
      - Coders may assign a diagnosis based on provider’s statement alone, but clinical validation is necessary to prevent fraudulent billing practices!
The Time Is Now for CDI Teams to Lead & Embrace Change

• Clinicians performing clinical validation concurrent with code assignment
• Concurrent CDI team processes
  — Education, selection of auditors, & structure
• 2nd-level post-coding/pre-bill audits
  — Education & training to perform reviews
  — FTEs—requirements & skills assessment of current CDI staff
  — Nurses & RHIA—application of advanced clinical pathophysiology
• Provider education
  — Pre-bill review process & post-DC queries
• Software—data collection, metrics & AI—prioritize reviews
It’s All in the Claims Data!

• **Clinical truth**
  - Capture ALL *clinically significant* comorbid conditions during every encounter
  - Clinical congruence with the medical record & coding summary

• **Integrity** of the documentation in the medical record

• **Excellence** in outcomes

• **Decrease** in number of *denials* and *reduction* in *costs* associated with *appeals*!
Vince Lombardi

“Perfection is not attainable, but if we *chase perfection*, we can *catch excellence*."

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Polling Question #3

• In your opinion, is there a place for CDI to do ANY retrospective reviews to achieve greater ownership of the Integrity of the documentation in the medical record, and to ensure the chart’s clinical validity, accuracy, and completeness BEFORE the bill is dropped?
  – No! CDI should ONLY be involved in concurrent processes
  – No, due to concerns about adverse effect on DNFB
  – Yes, but need buy-in from C-suite & other key stakeholders
  – Yes, we plan to start it soon with our CDI program
  – Yes, and we are already doing it at our facility
References


Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.