Maximizing Reimbursement through Clinical Documentation Improvement

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HFMA Fall Institute 2013

Goals for Today

• Learn the purpose of an audit based education program.

• Outline the framework for a successful audit and education program.

• Understand which coding issues to target.

• Distinguish between the types of education provided and the target audience for each educational session.

• Understand the importance of reproducibility and consistency of the plan while maintaining flexibility and humor.

• A successful audit program is indirectly tied to reimbursement and can help with expediting revenue realization.
Our Mantra

Document what is done, and report based upon documentation

Chart documentation = Codes submitted for reimbursement

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<tbody>
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Why Documentation Matters

- Shift from volume-based to value-based purchasing
- Medicare Advantage
  - Documentation of high acuity patient populations to support shared savings programs-payment multipliers
- Audit liability
  - False claims
  - Recoupment
  - Underpayment
- Audit Benefits
  - Visibility of physician coding practices
  - Promoting a culture of compliance
  - Developing effective communication
  - Illuminating practice liabilities
  - Dispelling myths that can improve performance
## Physician Groups Today

### The Urge to Merge
- Better contracting
- Less administrative hassle
- Incentive program participation
- EMR cost relief
- Refuge from financial, legal, or other difficulties

### Challenges of a Medical Group
- Clinical integration
- Implementing an EMR versus maintain the status quo
- Patient Centered Medical Home
- Medicare Advantage
- ACO participation

## Communication

- **Communication is key!**
  - With team members...
  - With other departments...
  - With participants...

- "I don't have time to change..."
- "I'm too old to change..."
- "Someone was just out here last week and told me something else!"
- "I've been audited for years and no one has told me this..."
- "The rules have changed..."
  
  They're right!
- "I shouldn't have to change for auditors..."
- "I can't change..."
**What is the situation?**

*Non-existent audit program*

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**Designing an Audit Program**

The intent of the audit process is to reduce the variability of standard of integrity. The organization needs a process that is reproducible and sustainable over time.

Key considerations:

- Who is audited?
- What is the audit frequency?
- What are the parameters of the audit?
- Who will perform the audits?
- What is the desired outcome of the audit?
- What are the plans for audit results?
- How are results communicated?
- How is education delivered?
A baseline audit revealed an overall accuracy rate of 65%. The organization needed a process to educate targeted physicians on their results and re-audit them again in a timely manner. This would require a long-term cadence of activity to be successful:

- Obtain Records
- Audit
- Communicate Audit Results
- Provide Education to Physicians
- Repeat

### Obtain records
- Obtain billing reports
- Follow up on records requests
- Training of staff
  - EMR training
  - Complete document package
**Audit the Records**

- In-house or out-source?

<table>
<thead>
<tr>
<th>In House</th>
<th>Outsource</th>
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<tbody>
<tr>
<td>Own the process</td>
<td>Objectivity</td>
</tr>
<tr>
<td>Staff readily available</td>
<td>Don’t have to employ, train, or maintain staff</td>
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</tbody>
</table>

- Quality checks
- What are the coding issues?
- Audit report specifications
- Timely and personal communication
- Process knowledge

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**Define the Scope of the CPT Audit**

Work with your vendor or internal audit team to develop a clear scope, objective, and scoring methodology for the audit prior to kickoff.

- Target score of 90%
- Score based upon level of service or professional services
- Reduce the variability within audits

**Scoring:** Over-coding by 2 or more levels and use of the wrong code category pose considerable risk for the organization. Therefore these errors received full weight in the audit scoring methodology. Under-coding at all, or over-coding by 1 level, received half weight.
### Diagnosis Coding Audits

- Diagnosis codes paint a picture of the patient and drive risk scores in Medicare Advantage programs
- Each .01% increase in Risk Adjusted Factor results in 1% increase in reimbursement
- Documentation in the medical record supports high acuity codes and drives reimbursement

### Why Documentation Matters

- “c/o visual disturbance. PMH + Retinopathy and DM2”
  - 250.00 and 362.10 (retinopathy w/o mention of diabetes)
  - Risk Score: .162 (.162 + 0)
- “Proliferated retinopathy due to DM2”
  - 250.50 and 362.02
  - Risk Score: .511 (.259 + .252)
### Why Documentation Matters

<table>
<thead>
<tr>
<th>ICD 9</th>
<th>Description</th>
<th>HCC</th>
<th>Rx HCC</th>
<th>Risk Score</th>
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<tbody>
<tr>
<td>250.02</td>
<td>DM, Type II, Uncontrolled</td>
<td>19</td>
<td>18</td>
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<tr>
<td>355.9</td>
<td>Neuropathy, NOS</td>
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<td>707.15</td>
<td>Foot Ulcers, NOS</td>
<td>149</td>
<td>157</td>
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<tr>
<td>443.9</td>
<td>Peripheral Vascular Disease</td>
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<td>106</td>
<td>0.316</td>
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<tr>
<td>424.1</td>
<td>Aortic Stenosis</td>
<td>None</td>
<td>None</td>
<td>0</td>
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<tr>
<td>413.9</td>
<td>Angina, NOS</td>
<td>83</td>
<td>92</td>
<td>0.244</td>
</tr>
</tbody>
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**Demographic Factor:**

80 yrs old/Female/Assumed Aged in: 0.544

**Total Risk Score = 1.715**

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</thead>
<tbody>
<tr>
<td>250.02</td>
<td>DM, Type II, poorly controlled with Peripheral Neuropathy:</td>
<td>16</td>
<td>17</td>
<td>0.408</td>
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<tr>
<td>357.1</td>
<td>Peripheral Neuropathy in Diabetes</td>
<td>71</td>
<td>78</td>
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<tr>
<td>250.02</td>
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<td>17</td>
<td>0.408</td>
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<tr>
<td>707.15</td>
<td>Diabetic Foot Ulcers</td>
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<tr>
<td>041.84</td>
<td>Anesthetic Infection</td>
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<td>None</td>
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<tr>
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<td>DM, Type II, w/ Peri Cir, Uncontrolled</td>
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<td>17</td>
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<tr>
<td>443.21</td>
<td>Peripheral Vascular Disease</td>
<td>105</td>
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**Demographic Factor:**

80 yrs old/Female/Assumed Aged in: 0.544

**Total Risk Score = 2.391**
One thing we know is that physicians are competitive. They want to score well on tests, and are used to being good students. Part of their frustration is that they’ve never heard the rules of engagement. Once they know the rules, they will excel, and will work to improve their scores.

**Delivery of Education**

- **Onboarding Education**
  - Occurs during the first month of employment.
  - Tailored to specialty
  - Food, fun, and specified information to their specialty

- **Monthly Sessions**
  - Evening session in various locations across our 16-county coverage area
  - 1 hour of CME
  - Occasionally video taped available online

- **One on One Education**
  - Required of physicians who score less than 80% on their audit
  - Personalized to the audited behavior
  - Shadowing during clinic

**Consistent Message**

At the same time that we are discussing a physician’s opportunities for improvement in the medical record, we must ensure that our message is consistent:

- We are not coaching documentation to a higher level of service or to a diagnosis that doesn’t exist.
- We acknowledge the commitment of each provider to do their very best every day to provide high quality care to each patient, and want them to document their services accurately in the medical record.
- More often than not, providers are not over-coding, but under-documenting their services. The importance of reconciling these two items is critical.
- We understand that there are competing demands on clinicians within an organization: ACO, EMR implementation/optimization, PCMH, etc.
- The health care industry is a changing milieu and physicians can be resistant to the audit process for any number of reasons. Things have changed, and we must change with it.
Understand the Coding Issues

* * *

Documentation = Coding

Audit Findings

Correct Codes
Supports E&M code Reported

Wrong Code Category
Incorrect CPT code reported

Diagnosis Coding errors
Documentation supports a different code

Under Coding
Documentation supports higher level of service

Over Coding
Insufficient Documentation
Communicate the Results

- **Utilize peer to peer communication:**
  Key leaders commit to communicating priorities to their constituents

- **A physician’s perspective:**
  Not all of the physicians read their work email on a daily basis. Their first priority is seeing patients, and your message (via work email) can quickly fall to the bottom of their to do list.

- **Include practice managers/directors:**
  Leverage the staff you have at the practice site and make sure they are included on all audit communication. These team members are the physician’s right hand man on a day to day basis. Alert staff to the time-sensitive nature of the results, and the need for scheduling education in the case of scores less than 80%.

- **Provide a high-level summary cover letter:**
  Include a succinct, audit summary report that identifies the key metrics the physician is being measured on, past performance to date, and what the ultimate desired outcome should be.

Educate

- **Scoring methodology for level of service audits**
  - >90% No education required; repeat in 1 year - 2 year
  - 80-89% - Education recommended; repeat in 1 year
  - <80% - Education required, one on one is strongly recommended

- **Challenges**
  - **Physician Resistance:** Not all physicians are eager to hear their scores and take time away from patient care to meet with the compliance education team. There is often a feeling of hopelessness and frustration mixed with righteous indignation. Calculation of risk scores occurs the following year-delayed gratification
  - **Number of Physicians:** The sheer number of physicians of a large provider group makes it difficult to reach everyone in a timely manner.
  - **Geographic Distribution:** It is not always possible for physicians to leave their practice area to come to the corporate office. Meeting the physician on their own turf is a gesture of good will that does not go unnoticed... in most cases.
**Results**

- Physicians are asking more questions and disputing audit results with increasing frequency.
- Our physicians understand the rules, they appreciate the consistency, and they know the consequences of noncompliance.
- Our organization is at less risk for payment recoupment, and more likely to withstand outside audit.

<table>
<thead>
<tr>
<th></th>
<th>Initial Audit</th>
<th>Follow Up Audit</th>
<th>Third Audit</th>
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<tbody>
<tr>
<td>Audits Completed</td>
<td>96</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>Accuracy:</td>
<td>63% (Red)</td>
<td>88% (Green)</td>
<td>96% (Green)</td>
</tr>
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</table>

**Results**

- Increase in RAF scores: 13%
- Annual percentage of providers UNDER coding: 6%
- Improvement in audit scores: 19%
Final Thoughts

• Clinical documentation improvement helps identify coding opportunities, ultimately leads to cleaner claim generation, and expedites revenue realization.

• Accurate description of patient diagnosis and acuity allows for accurate payments in Medicare Advantage and Shared Savings programs.

• With the upcoming ICD-10 conversion scheduled for October 1, 2014, increased documentation will be required to support the new coding specificity mandate under ICD-10. Implementing this process now will only prepare organizations for the upcoming changes under healthcare reform.

Questions?

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