Integrating Performance Excellence and Business Strategy –

Managing Coding, Audit and CDI has been challenging the industry for several years, and the increasing financial pressures on healthcare providers, it has never been more vital to have consistent and reliable clinical documentation, coding and audit services.

Some health systems have fully outsourced the function, some have maintained a portion of the services in-house, while others have benefitted from a blend of U.S. based inpatient-trained coders and offshore coders to maintain quality and outcomes.
THE LANDSCAPE HAS CHANGED

After this presentation, participants will:

Learn the options available, the importance of making the right choice for your organization, and the key success factors that other hospitals, health systems, and physician organizations are implementing.

DISCUSSION TOPICS

1. Coding: It’s About Predicting Your Business!
2. Quality Audit: Managing Future Business Strategy
3. CDI: Key CDI Success Factors
   - CDI Inpatient
   - CDI Outpatient
ICD-10 CODING

Since the Implementation of ICD-10 CM/PCS in October 2015, the periodic coding updates have included many changes for FY 2019, the diagnosis update includes 279 new codes, 143 revised codes, and 51 deleted codes. For our guidelines, there were 3 new guidelines with 18 changes. “Updates are getting back to normal”

Immediate needs are for the decision makers to think strategically about the forces of disruption and innovation shaping our future.
ICD-10 BUSINESS CROSSROADS

Coding goes beyond selecting the right code… it is about predicting your business!

Investing in your business is more than getting the word out, it’s about being prepared for future changes and how to outperform the competition.

- **Poor coding** activities = **bad quality** = < **dollars**
- Forecast of hospital payments, where are they heading?
- Feeling the impacts of readmit penalties
- Profiling physician data efficiently?
- Improve clinical outcomes in documentation, quality and coding?
- Seize opportunities for improvement and desired outcomes

CODING – CULTIVATING HEALTHCARE

Groom  
Motivate  
Engage
CODING – WHAT ARE THE CHOICES?

**Focus first on internal customers:**
- Focus on coders resulting in more satisfied external clients
- Focus on external clients
- Choose technology path
- Provide tools and growth capabilities
- Technology is not an exogenous force over which we have no control

**A provider in a changing healthcare landscape, we must cultivate:**
- The ability to recognize good talent
- Keep existing talent happy
- Search for new talent
- Rule with technology
- We are not constrained by a binary choice between “accept and live with it” and “reject and live without it”

Coding – Volume to Value

Moving from Volume to Value
- By 2018, expect CMS to move at least half of all Medicare payments from FFS to alternative-based systems.

In December, CMS published Quality
- Measure Development Plan (MDP)
- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

Passed by Congress
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Plan focuses on CMS
- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare Electronic Health Record (EHR)
- Eligible Professionals (EPs) = Meaningful Use
CODING QUALITY

Landscape Changes Impact Coding Quality:
- Demand for quality/productivity increases as healthcare entities struggle to meet financial goals and bottom line margins

- Increasing coding complexity and demand
  - Navigating systems, cloning, hidden tabs, hard to find documentation, collaboration with other departments (quality, CDI etc)
  - Pressure to perform: quality and productivity
  - Protecting and preserve payment (denial prevention)

- Reimbursement/payment model changes – dynamic shift towards pay for performance based on quality/safety measure accuracy (code assignment affects quality and profiling scores)
CODING QUALITY

- Increase in external audits (insurance payors, RAC, etc) and resulting denials
  (Every denial worked requires an average 1.6-2 hours to research/write appeal)

- Denial Trends
  • Medical Necessity
  • Clinical Validation Denials – at all-time high
    ◦ Diagnosis documented without clinical evidence / clinical indicators to support diagnosis validity
    ◦ Targets: Sepsis, Encephalopathy, Malnutrition, Renal Failure

TEAM COLLABORATION

Coding, Coding Audits and CDI functions intersect:
- All teams perform a complete review of record documentation and have the opportunity to communicate and impact the following (utilize the collective wisdom of your teams!!)
  ◦ Severity of illness (how sick are our patients)
  ◦ Risk of mortality
  ◦ Accurate and specific code assignment (reduce non-specific codes, ensure accurate and deserved reimbursement)
  ◦ Facility and physician profiling
  ◦ Quality and patient safety measures
  ◦ Reduce denials
TEAM COLLABORATION

Integration and collaboration of the coding, quality and CDI solutions:

- Analyze the data – identify your opportunities for improvement and risk
- Determine what information should be communicated for meaningful action and results
- Collaborate (how can we share the collective wisdom of the team!)
  - Coder, quality reviewers, educators, CDI
  - Identify and discuss cases with opportunities
  - Provide education across teams
- Share meaningful data (the demand for data to make decisions has increased dramatically)
  - Education trend opportunities:
The industry focus has moved from the review of government only payers to all payers. With the evolution of pay for performance, value-based purchasing and bundled payments the industry has acknowledged the benefits of reviewing all payers. Documentation accuracy needs to be a priority for every record, every provider, every specialty and every department. The reviews may occur on the patient care units or conducted remotely via electronic health record.

Resulting benefits of a robust, all payer CDI review include the following:

- Accurate and specific code assignment (reduction in unspecified codes)
- Ensure accurate reimbursement
- Accurate reflection of severity of illness and risk of mortality (paint the picture of how sick your patient population is)
- **Accurate capture of quality/safety measures**
- Reduce payer denials (clinical validation denials are at an all-time high)
- Improve delivery of care and physician communication
- Increased audit defensibility and minimize risk
- Cornerstone of medical necessity to validate level of patient care

**OBJECTIVE OF A CLINICAL DOCUMENTATION SOLUTION**

- Review all payers
- Concurrent review within 24 hours of admission
- Evaluate weekend coverage/hybrid onsite/remote model
- Automate CDI workflow
  - Work queue assignment
  - Review prioritization/follow-up
  - Seamless integration with EMR and encoder
  - AI/NLP efficiency
- Establish clear expectations / hold team accountable
  - Review scope
  - Productivity standards
  - Key performance indicators (KPI’s)
### BEST PRACTICE CDI METRICS

<table>
<thead>
<tr>
<th>Reporting Metrics</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI review rate</td>
<td>90% of admits</td>
</tr>
<tr>
<td>Percentage of queries to total admissions</td>
<td>25-30%</td>
</tr>
<tr>
<td>Physician query response rate (by physician, service line, overall)</td>
<td>90%</td>
</tr>
<tr>
<td>Average physician query response time</td>
<td>&lt;48 hours</td>
</tr>
<tr>
<td>Physician agreement rate (by physician, service line, overall)</td>
<td>85%</td>
</tr>
<tr>
<td>CDI productivity (initial and follow up reviews, queries initiated)**</td>
<td>20 - 25 reviews/day</td>
</tr>
<tr>
<td>CDI/Coder reconciliation rate</td>
<td>90%</td>
</tr>
<tr>
<td>Total number of queries initiated by physician, service line, CDI</td>
<td></td>
</tr>
<tr>
<td>Total number of queries by query type (sepsis, POA, malnutrition etc..) and physician</td>
<td></td>
</tr>
<tr>
<td>Query tracking by type (sepsis, renal failure, malnutrition, urinary related complications, etc.) and reason (PDX clarification, clinical validation, POA etc.) – support physician education</td>
<td></td>
</tr>
</tbody>
</table>

### BEST PRACTICE CDI METRICS

<table>
<thead>
<tr>
<th>Reporting Metrics</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMI Shift (direct result of CDI)</td>
<td>Facility/Corporate Goal</td>
</tr>
<tr>
<td>CMI Financial Impact (CDI, facility)</td>
<td>Facility/Corporate Goal</td>
</tr>
<tr>
<td>Quality Measure Reporting</td>
<td>QM Measure/Report</td>
</tr>
<tr>
<td>• Hospital Acquired Conditions (HAC’s)</td>
<td>QM Measure/Report</td>
</tr>
<tr>
<td>• Core Measures Scores</td>
<td>QM Measure/Report</td>
</tr>
<tr>
<td>• Safety Measure Scores</td>
<td>QM Measure/Report</td>
</tr>
</tbody>
</table>
BEST PRACTICE CDI SOLUTION COMPONENTS

Automate physician query management
- Electronic Query Forms
- Automated query assignment with EHR integration (query and query answer part of legal record)
- Automated physician notification
- Provider response, tracking and accountability
- Query response rate and benchmarking

BEST PRACTICE CDI SOLUTION COMPONENTS

- Robust Reporting
  - Data is power!!!
  - Data drives change and results

- Physician Champion
  - Identify a physician champion
  - Provide clear expectations for physician champion role
  - Leverage the physician champion to for provider education and validation of clinical indications and treatment

- Educate, Educate, Educate
  - Analyze the data
  - Implement a review strategy and communicate consistently with the CDI team
  - Identify meaningful ways to share education with physicians to change root behavior
BEST PRACTICE CDI SOLUTION BENEFITS

- CDI program should align with areas of focus that the hospital has greatest need to address.
- A concurrent review, query process of health records reduces the need for retrospective reviews, which allows HIM coders to expedite coding the record and getting the claim to the insurance company, resulting in faster payment.
- If payer or other external audits are initiated, the documentation supports the coding, reducing refunds and targeted audits.

*** GOAL: FASTER, CLEANER, MORE ACCURATE ***

Healthcare executives are more interested in healthcare data than ever before. That's because their primary concerns are all related to:
- Demographics
- Financial strategies
- Reimbursement
- Population health
Are outpatient CDI programs an area of growth and opportunity?

- According to a February 2016 survey deployed by the Association of Clinical Documentation Improvement Specialists (ACDIS), only a minority (approximately 10 percent) of hospitals currently possess an outpatient CDI program.

- From 2007 – 2017 outpatient visits have increased 44% while inpatient visits have decreased by 20%. The healthcare trend has been to move more and more care to the outpatient setting.

- Survey data also shows outpatient CDI is becoming more common; more than 20% of respondents indicated that they plan to implement outpatient and/or physician services in the next 6–12 months.

Facilities and physician clinics are determining what an outpatient CDI solution looks like for them.

- Determine areas of improvement specific to your facility
  - Review denial trends
  - Review documentation weaknesses
  - Review accounts that are held in the OP editor
  - Review Medicare Advantage Contracts
    - Each enrollee is assigned a RAF score
    - Risk Adjustment Factor (RAF)
    - Patient’s considered more complex to treat and manage will require more resources
    - Target diagnoses impacting HCC’s – chronic conditions
    - Ensure physician documents corresponding manifestations
    - MA plans utilize this score to predict patient care cost for the next year
OUTPATIENT CDI FOCUS IN THE ED

Example of CDI Solution Review Focus in an ED:

• Accurate capture of facility ED level charges
• Documentation of infusions / injections – start / stop times
• Creation of an accurate problem list
• Improved accuracy of POA indicators for admits
• Improved patient safety, complete health record
• Addressing / correcting fragmentation or gaps in patient care
• Improved documentation supporting observation services / start times
• Proactive capture of data elements associated w/ quality of care measures

NAVIGANT HEALTHCARE – WHO WE ARE

WHO WE ARE: 600+ CONSULTING PROFESSIONALS

2,500 BUSINESS PROCESS MANAGEMENT PROFESSIONALS

MUTIDISCIPLINARY

Physician Enterprise Solutions  Strategy Solutions
Specialized Solutions  Centralized Analytics  Revenue Cycle Solutions
Performance Excellence Solutions  Government Healthcare Solutions

WHAT WE DO: • STRATEGY
• OPERATIONAL IMPROVEMENT
• BUSINESS PROCESS MANAGEMENT

DELIVERED TO:

HOSPITALS  MEDICAL GROUPS  PAYERS  AMCS

#5 ON MODERN HEALTHCARE’S LARGEST HEALTHCARE MANAGEMENT CONSULTING FIRMS

FORBES – AMERICA’S BEST MANAGEMENT CONSULTING FIRMS: HEALTHCARE 1 STARS
RESULTS

- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Factsheets/
- 2015-Fact-sheets-items/2015-07-01-2.html
- http://journal.ahima.org/

THANK YOU FOR YOUR TIME TODAY

MAY WE ANSWER ANY QUESTIONS?
QUESTIONS

Shela Schemel  
Vice President, Operations  
shela.schemel@navigant.com  
479.770.0199  
navigant.com

Twillia Phillips  
Vice President, Operations  
twillia.phillips@navigant.com  
479.770.0199  
navigant.com