

Impact of Documentation and Coding on the Provider Organization

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Discussion Points

1. What can be done to improve documentation capture without negatively impacting provider productivity?
2. Which data elements will be the drivers for at-risk reimbursement arrangements?
3. How best can one assess documentation deficiencies that are negatively impacting reimbursement?
4. What to anticipate after the CMS “ICD-10 grace period.”

Copy & Paste / Forward Situation

Summary of the Thought Readings

Copy and Paste (AMDIS)

- Since the primary goal of our profession is to spend as much time as possible listening to, understanding and helping patients, clinicians need information technology to make electronic documentation easier, not harder.
- At the same time, need to avoid “Note Bloat.”
 - New generation of tech savvy clinicians
 - EHR functionality
 - Plagiarism risks
 - Deciphering what is new

Summary of the Thought Readings

Copy and Paste (AHIMA)

- Industry stakeholder collaboration needed – Best Practices
- EHR Vendors – Audit trails
- Public Entities – Focus on documentation capture processes such as copy/paste that may present potential risks for quality of care, patient safety, and fraud
- Gelzer's challenges

Summary of the Thought Readings

Copy and Paste (AHIMA)

- Gelzer's Challenges:
 - Inaccurate or outdated information
 - Redundant information, which makes it difficult to identify the current information
 - Inability to identify the author or intent of documentation
 - Inability to identify when the documentation was first created
 - Propagation of false information
 - Internally inconsistent progress notes
 - Unnecessarily lengthy progress notes
- How do these impact patient care? Provider efficiency? Reimbursement?

Summary of the Thought Readings

In Defense of Copy-Forward (Berkowitz)

- Supports efficiency and quality
- Progress notes will look the same, regardless
 - Focus should be on figuring out the diagnosis
- Helps avoid missing diagnoses
- Good for Past Histories
- “The Note is the Chart”
 - “The chart should no longer be a collection of distinct and incomplete notes, but rather the last note can really be the complete chart which contains everything a provider needs.”
 - What do you think?

General Comments - EHRs

- EHR design features:
 - Templates vs. unique patient documentation: Pros/Cons?
 - Cloning (See UF College of Medicine)
 - OIG Radar since 2013
 - Ease in finding what you need?
 - Color or font differentiation
 - Apparent when disclosing to others?
- Computer interpretations: Friend/Foe?

EHRs: Friend or Foe?

Summary of the Thought Readings

Volume to Value Transformation (Wallace)

- HIMSS Brief on Meaningful Use: Mandatory (at Stage 3 level of participation) by 1/1/2018
 - 8 Objectives:
 1. Protect Patient Health Information
 2. Electronic Prescribing
 3. Clinical Decision Support
 4. Computerized Provider Order Entry
 5. Patient Electronic Access to Health Information
 6. Coordination of Care through Patient Engagement*
 7. Health Information Exchange*
 8. Public Health and Clinical Data Registry Reporting*

Summary of the Thought Readings

Volume to Value Transformation (Wallace)

- Shifting from volume based reimbursement to value based reimbursement
 - Will our EHRs support this transition?
 - Do our EHRs support patient-provider communication?
 - Will our EHRs demonstrate quality of care (value-added)?
- “To support the volume-to-value transformation, the primary focus of the next-generation EHRs has to be making it easier for individual caregivers to improve patients’ health.”

Summary of the Thought Readings

Opinions (Wike)

- Productivity Impact
 - Scribes?
- Primary Care happier than Specialists with their EHRs
 - Why is this?

Summary of the Thought Readings

Clinical Documentation (Kuhn et al)

- Productivity Impact
- E&M: Instead of clinical needs determining the level of detail of the physical examination, documentation of the examination is driven by the required number of “bullets.”
 - Help achieve the “right” code
- Structured data from data entry
- Do drop downs contribute to the quality of the assessment or cloning?

Summary of the Thought Readings

Clinical Documentation (Kuhn et al)

- The clinical record should include the patient's story in as much detail as is required to retell the story. (Paint a picture.)
- When used appropriately, macros and templates may be valuable in improving the completeness and efficiency of documentation... (Explain a plan)

Summary of the Thought Readings

Clinical Documentation (Kuhn et al)

- The EHR should facilitate thoughtful review of previously documented clinical information. (Understand a trend.)
- As value-based care and accountable care models grow, the primary purpose of the EHR should remain the facilitation of seamless patient care to improve outcomes while contributing to data collection that supports necessary analyses.



Summary of the Thought Readings

Clinical Documentation (Kuhn et al)

- EHRs should be leverage for what they can do to improve care and documentation...not optimized based on coding requirements.
- Purpose of coding:¹
 - Aggregation
 - Decomposition
 - Data and machine centered

1-David Civic 5/16/14

General Comments – Documentation

Clinical Documentation¹

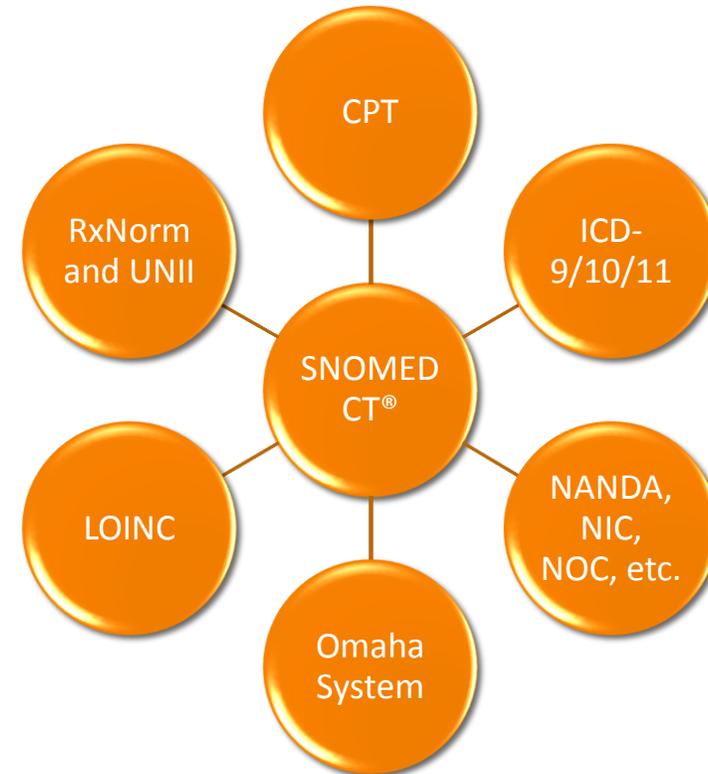
- Inclusive: Not too little
- Uncluttered: Not too much
- Ordered: A place for everything
- Prioritized: Important jumps out
- Expedient: No time spent on non-value work

1-Dave Civic 5/16/14

Why not using foundational tools?

SNOMED: Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)

- Comprehensive
- Multi-language
- Computer enabled
- Accommodates or links with many standard terminologies
- Reduces ambiguity

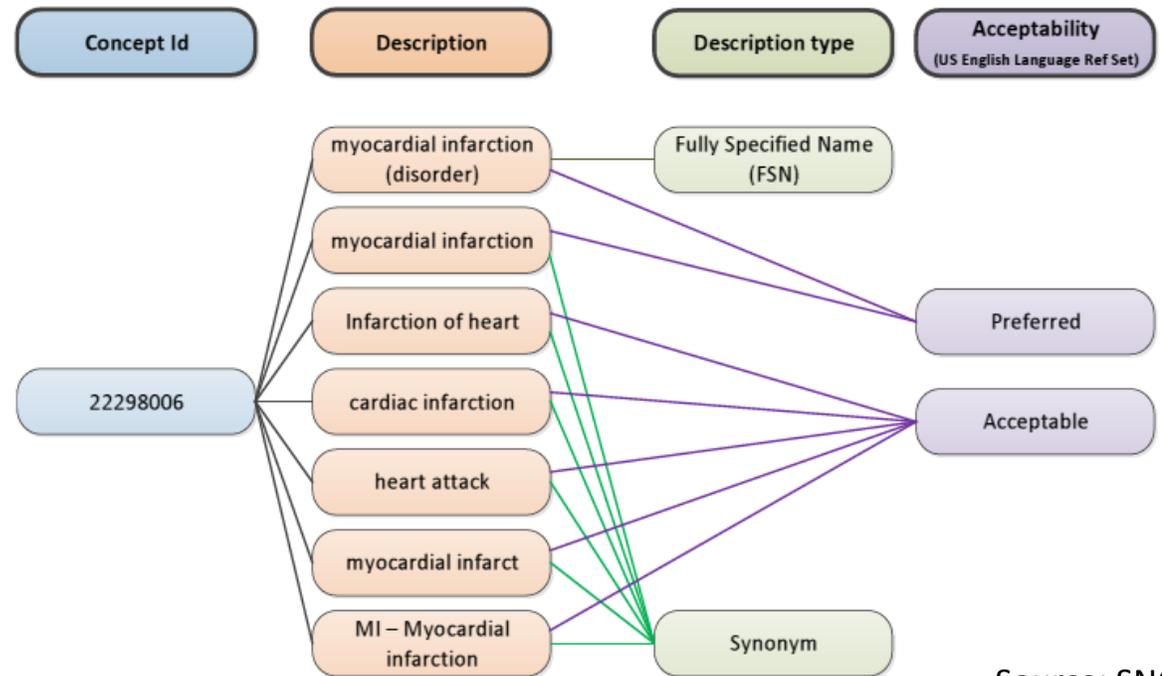


Why not using foundational tools?

International Health Terminology Standards Development Organization (IHTSDO) (Denmark) (Originally CAP)

Utilizes Concept Approach

- Reduces many synonymous descriptions into a single unit of meaning



Source: SNOMED CT

Why not using foundational tools?

International Health Terminology Standards Development Organization (IHTSDO) (Denmark) (Originally CAP)

Levels of Detail

- Pneumonia, bacterial pneumonia, pneumococcal pneumonia

Links Concepts

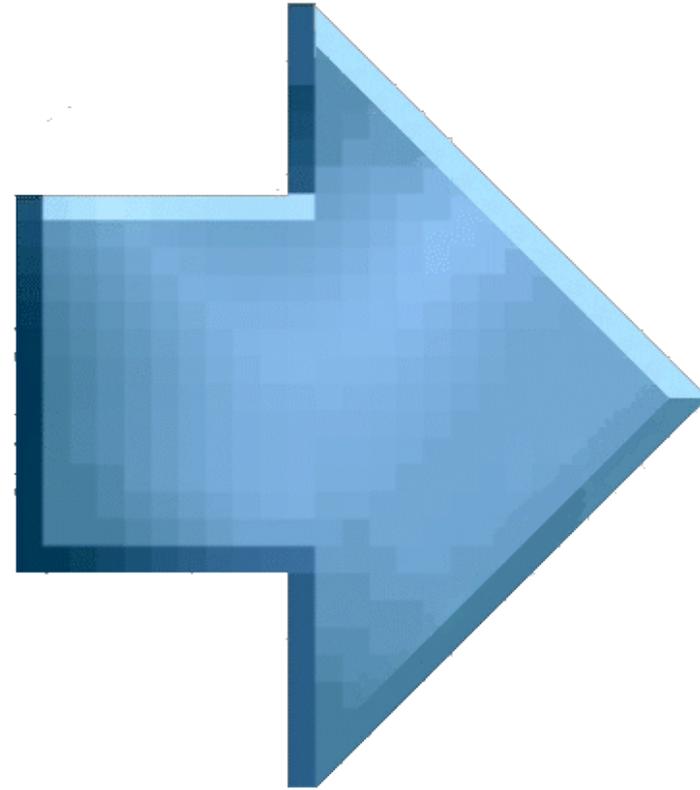
- Pneumococcal pneumonia (with a finding or site) of right upper lobe of lung

Greater specificity than ICD-10

Feeds from many data sources.

Reimbursement Impact

Next



General Comments - HCCs



Hierarchical Condition Categories (HCCs) utilized in Medicare Advantage and Medicaid Managed Care arrangements and by Commercial Payers, too!

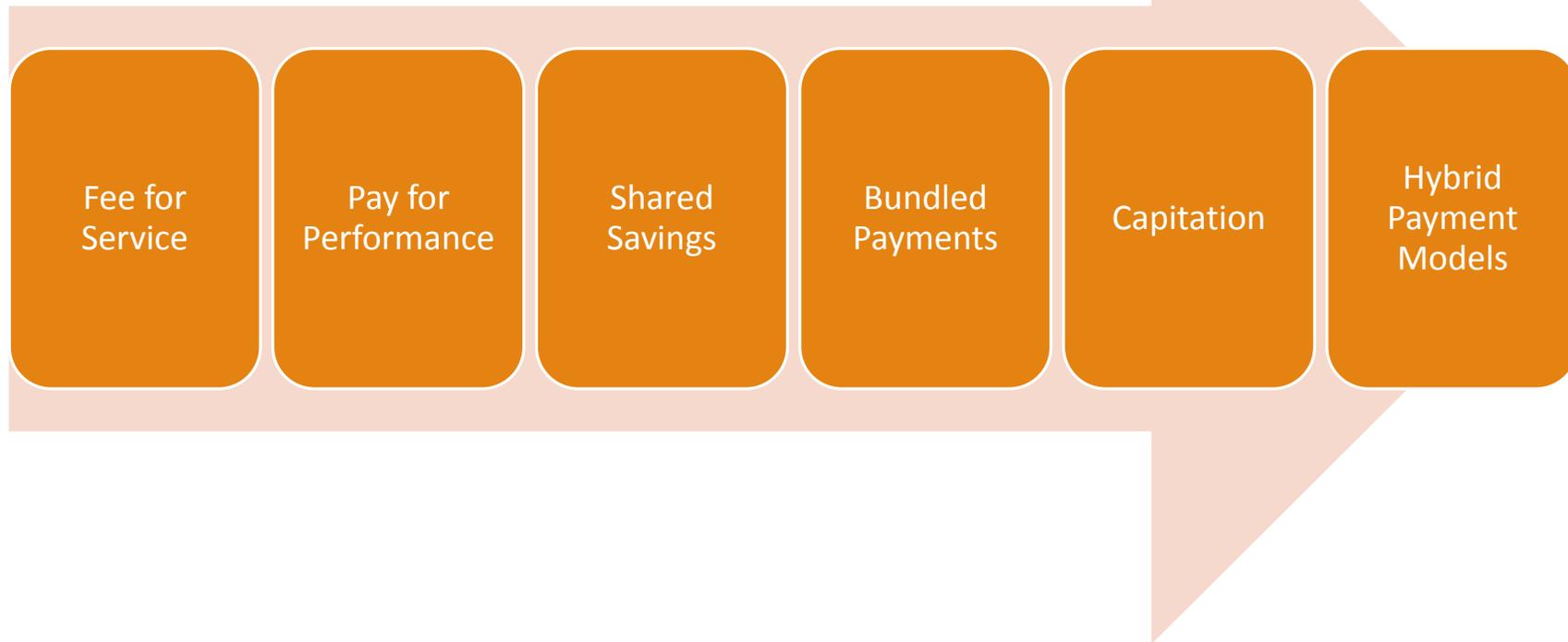
- Been the basis of reimbursing Medicare Advantage Plans since 2004

Patient Protection and Affordable Care Act/Healthcare Reform:
Created Value Based Purchasing, Bundled Payments, ACOs

- Being used to determine, in part, reimbursement for ACOs and VPB program
- Creates risk for the provider based on the patient's conditions
- 3,000 codes in ICD-9 → 11,000 codes in ICD-10

Summary of the Thought Readings

Shifting Reimbursement (Ritchie)



Summary of the Thought Readings

Shifting Reimbursement (Ritchie)

- Pay for Performance
 - Compensate physicians on clinical and cost-saving outcomes rather than being reimbursed for services and procedures (ala Fee for Service)
 - Pay for performance models reward physicians who can keep track of how they keep patient care cost-effective (e.g. PQRS measures)
 - Value modifier (payment differential): Based primarily on PQRS
- Shared Savings
 - Accountable care organizations (health systems and large multispecialty practices)
 - Results have been variable: Need to know composition (all players) and who within the ACO can affect patient outcomes
 - 25% of the MSSP ACOs received shared savings

Summary of the Thought Readings

Shifting Reimbursement (Ritchie)

- Bundled payments
 - A version of EPGs (kickback from the 1980s)
 - Typically condition specific
 - Who gets what piece of the payment
- Capitation
 - Prepayments to physicians/groups for pre-defined services
 - Allegedly creates an incentive to spend less money on each patient
 - MGMA Data: Practices with capitation contracts received 36% more revenue than those that rely only on FFS reimbursement

General Comments – HCC payments

HCCs reimburse the physician or health plan based on chronic conditions that must be managed for the patient

- The more conditions managed...the more challenging the patient's care is to manage (more time)...higher risk...higher cost → higher reimbursement for the provider
 - Many **non-specific ICD-10 codes** are not included in an HCC
- Need an infrastructure (Pennic)
- Reimbursement rate is “by patient” ...not an average of the entire population
- Patient conditions are based on documentation that is audited
 - Typically based on outpatient services
 - Auditing entity is a RADV (Risk Adjustment Data Validation) Contractor

Summary of the Thought Readings

12 Steps (Pennic)

- Need an infrastructure to handle risk and manage your population's health
 - Data aggravation: Integrated clinical and financial Data analytics and predictive modeling
 - Patient “registries”: Lists patients' diagnoses and lab results, what was done for each patient and when, and when they are due for particular kinds of care, other data points
 - Care management structure including sufficient primary care physicians

Summary of the Thought Readings (Kautter et al)

CMS-HCC (MEDICARE ADVANTAGE)

- Population: ≥ 65 and disabled ≤ 65 in Medicare population
- Base year diagnoses and demographics predict next year's spending (exc. Drug)
- Provider payments
- Less than 100 HCCs
- ~2004

HHS-HCC (ACA POPULATION)

- Population: Adult, child, and infants in "commercial" population
- Base year diagnoses and demographics predict current spending (inc. Drug)
- Health plan payments
- Less than 200 HCCs
- 2014

Summary of the Thought Readings

Adverse Selection in ACA Market (Siegel and Petroske)

- “Traditionally, health plans have been motivated to attract and retain healthy individuals.”
- Can providers, especially those that are serving as “payviders” mine the data in their repositories to assess the impact of ACA Insureds?
- Which HCCs will be most profitable for your plan (and providers)?
- Do we expect payers to share their profits with providers?
- Given the Post-3Rs data, should providers skew their acceptance of certain aged/gender patients?

3Rs: Transitional Risk, Risk Corridor, Permanent Risk Adjustment

**Figure 1: Pretax Profit Margin by Demographic Grouping
Assuming a 3% Pricing Margin Built into Rates**

Age Group	MALE		FEMALE	
	Pre-3Rs	Post-3Rs	Pre-3Rs	Post-3Rs
0	-317.60%	18.00%	-339.40%	14.20%
1	-33.10%	-4.30%	-18.40%	-6.30%
2-4	5.60%	-3.00%	11.20%	-5.00%
5-9	13.80%	-3.70%	22.50%	-4.30%
10-14	5.30%	-3.20%	10.80%	-3.00%
15-20	-6.60%	2.20%	-24.50%	2.10%
21-24	34.80%	-3.00%	-5.80%	-0.30%
25-29	34.30%	-3.20%	-31.50%	1.00%
30-34	32.00%	-2.90%	-32.30%	2.50%
35-39	25.20%	-1.10%	-25.10%	5.40%
40-44	13.00%	-0.40%	-23.10%	6.20%
45-49	7.60%	2.50%	-16.30%	6.90%
50-54	4.10%	4.90%	-9.90%	6.80%
55-59	2.40%	7.10%	-3.80%	6.60%
60+	-8.80%	7.30%	-4.90%	6.70%
Composite	6.70%	2.20%	-14.70%	4.50%

Source: When adverse selection isn't. Milliman. J. Siegel, J. Petroske 12/13

Which population to pursue?

HCCs in both CMS and HHS HCC Models

- HIV/AIDS
- Malignant Neoplasms
- ESRD/Chronic Renal Failure
- Acute or Chronic Pancreatitis
- Diabetes
- MI, Unstable Angina, Arrhythmias, CHF
- CVA and Intracranial Hemorrhage, Hemiplegia, Monoplegia
- COPD/Cystic Fibrosis
- Cardio-respiratory Failure
- Inflammatory Bowel Disease
- Severe and persistent mental illness: psychosis, personality disorders, major depression, drug dependence
- Seizure disorders
- Traumatic spinal cord lesions, quadriplegia, and paraplegia
- Multiple sclerosis
- Bone, joint, and muscle infections/necrosis, necrotizing
- Chronic skin ulcers
- Opportunistic infections
- Protein-calorie malnutrition

General Comments - HCCs

Built on DIAGNOSES (not CPTs)

- Of the ~70,000 ICD-10 diagnosis (CM) codes → 7,700 map to HCCs
 - HCC are high-cost medical conditions and current conditions that impact the encounter in terms of requiring MEAT
 - **M**onitored
 - **E**valuated
 - **A**ssess/**A**ddressed)
 - **T**reated
 - Typically exclude SYMPTOMS and conditions that are past or resolved
 - Typically exclude “Unspecifieds” (e.g. lacking laterality, episode of care, severity, etc.)

Many HCCs may be profitable; few will be losers

General Comments - HCCs

Individual patients may have multiple HCCs and these result in a Risk Adjustment Factor (RAF)

- Each condition must be addressed in a Face-to-Face encounter ANNUALLY

Provider documentation from several settings is considered: Hospital inpatient, hospital outpatient, and provider outpatient

- Medical record deficiencies could make the Face-to-Face encounter invalid
 - Unsigned
 - Undated
 - Provider credentials noted (e.g. MD, DO, PA, NP, OT, CRNA, LCSW)
 - No patient identification (2 required on each page)
 - Legibility
 - Coding “Rule out” and “History of” diagnoses

General Comments - HCCs

Important to understand limitations of your ACA/Medicare Advantage Health Plans in terms of number of diagnoses they capture from your claim

- 5010 Transaction Set allows 12 diagnoses and still 4 limitation to link to a service

For Medicare Advantage (CMS-HCC) there are RxHCC for drugs

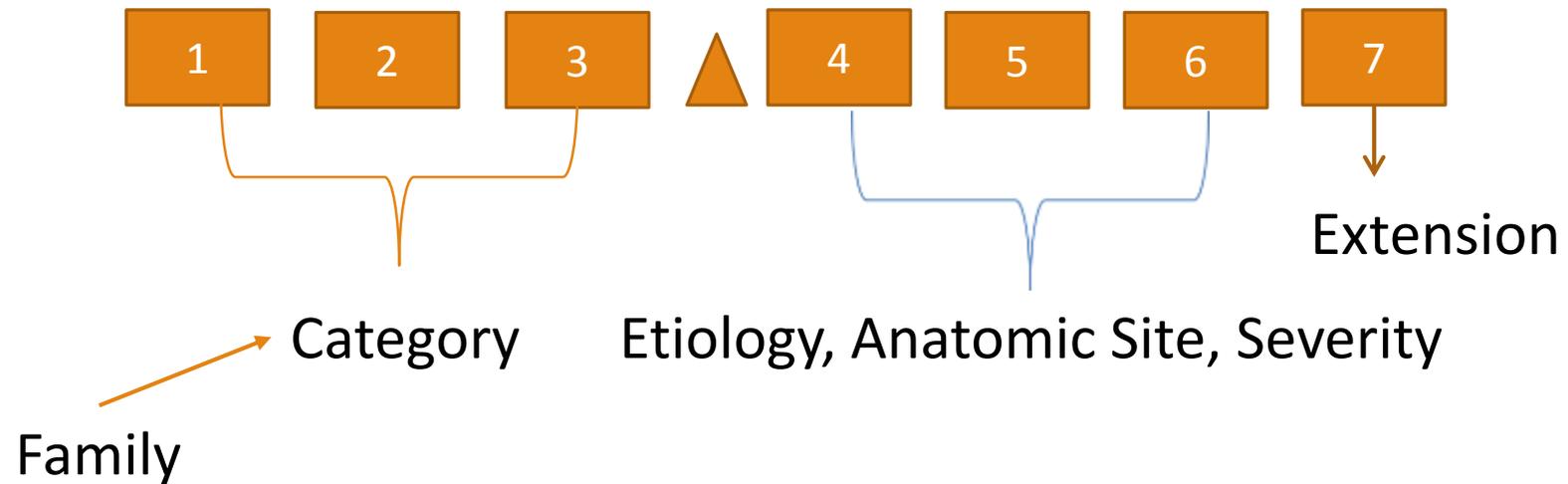
RADV and ZPIC audits – 100 members and extrapolate from those findings

Summary of The Thought Readings

CMS Grace Period:

- 1 year (ends 9/30/16)
- **Medicare** only
- Valid code that lacks specificity but is in the correct “**Family**” and meets medical necessity will not be denied or negatively impact quality incentives
 - Valid code: Up to 7 characters
 - Correct family = Correct category
 - Medical necessity (check the LCDs/NCDs)
 - But doesn't exclude reviews for other reasons and other entities: MACs, RACs, ZPICs, SMRCs

ICD-10 Code Structure



Extension Character

Initial Encounter for this injury (A)

Subsequent Encounter for this injury (D)

Encounter for a sequel related to this injury (S)

More for fractures

- Related to:
 - Healing statuses
 - Malunion issues
 - Closed or Open

Injuries and Poisonings

- Documentation needs to capture:

1. **What** was the injury (Specifics):
 - Specific Site
 - Laterality
 - Depth/Degree/Severity of injury.
2. **When** did it occur
3. **Where** did it occur
4. **What** was the patient doing at the time of the injury
5. **What** is the patient's occupation/status
 - For income/pay; Military; Volunteer; Other: Includes babysitting a family member, hobby, leisure, off-duty, student, recreation
6. **Which** encounter is this

Structure

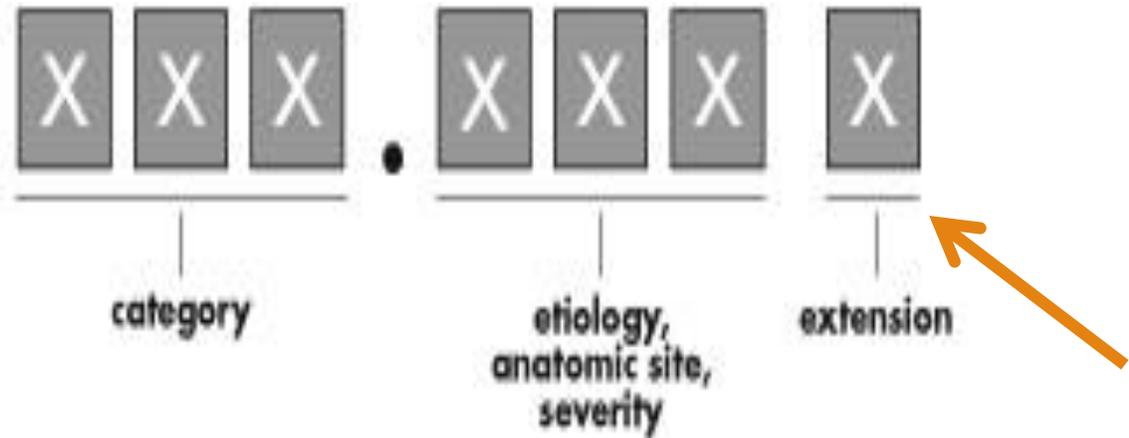
Unrelated to “New” or
“Established”

This is a feature of the ICD-10
CM/Diagnosis code; not the CPT
E&M code

ICD-10 CM

- Category (3)
- Etiology
- Anatomic Site
- Severity
- Extension

ICD-10



Understanding The Rules

Initial vs. Subsequent Encounters

- When to use: Only for injuries, poisonings, and burns

A-Initial episode of care: When the patient is **receiving active** treatment for a condition

- **Includes ER encounter**, surgical treatment, **evaluation and treatment by a new physician**
- Includes patients that have delayed treatment for a fracture or non-union.

D-Subsequent episode of care: Completed active treatment and is in the healing phase

S-Sequela episode of care: All treatment and healing has been completed, however, a condition exists due to the original condition

7th character is required for all injuries and poisonings

Other use of Extension Characters

Also used to define:

- Conditions that may affect the fetus (which fetus when more than one)

0 not applicable or
unspecified

1 fetus 1

2 fetus 2

3 fetus 3

4 fetus 4

5 fetus 5

9 other fetus

Where does this leave us?

- ❖ Providers must use electronic tools to improve their efficiency but also assist them in effectively selecting treatment modalities
 - ❖ Cumbersome documentation practices can lead to overlooking important signs, symptoms, conditions and result in safety issues
- ❖ Cost effective treatment that meets benchmarks for quality *may* result in fiscal rewards

Where does this leave us?

- ❖ Understanding the patient population being served will require data analytics
 - ❖ Does your organization have what it takes to massage the data
- ❖ Documenting all the conditions that requires attention while caring for a patient may enhance outcomes and reimbursement.
- ❖ ICD-10 creates a new dimension of data specificity that can benefit health care providers that use the data to drive protocols, identify effectiveness of treatment plans, and describe the severity of the conditions being treated.



About the Speaker

Ms. Dunn is a Past AHIMA President and recipient of AHIMA's 1997 Distinguished Member and 2008 Legacy Awards. She is Chief Operating Officer of St. Louis-based, First Class Solutions, Inc., a national health information management consulting firm providing coding compliance and coding support services for health systems and provider practices, as well as, and HIM operational consulting services for hospitals, physician practices, and SNFs. Rose is active in ACHE, AICPA, HFMA, and AHIMA. Ms. Dunn is the author of several texts and numerous articles.

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