CDI in the Outpatient World: Not Your Typical Day at the Office

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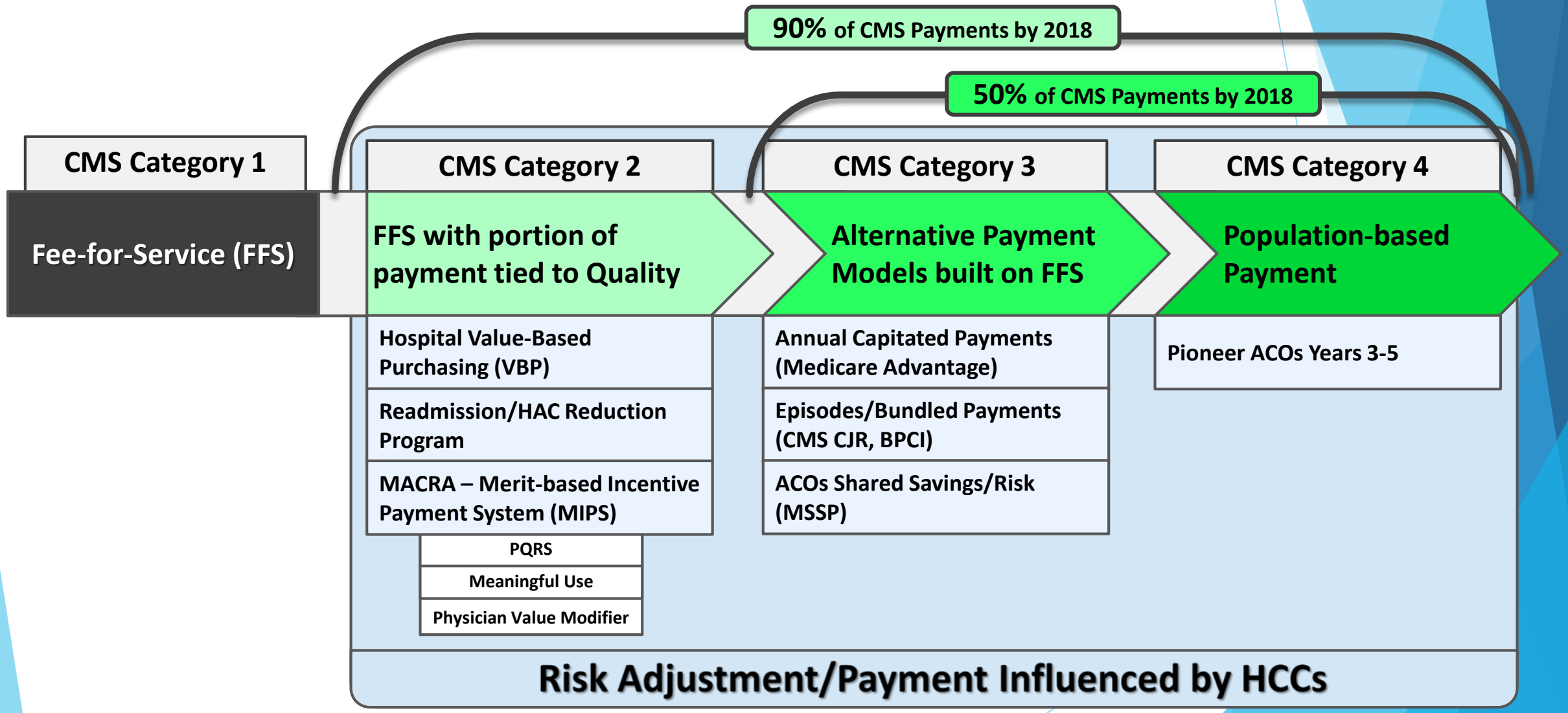
Agenda

- Industry shift to value based care
- CDI Expansion – Inpatient to Outpatient
- Differences between Inpatient and Outpatient
- Documentation challenges in Outpatient Setting
- Outpatient CDI – Program focus
- Questions

Industry Shift to Value Based Care

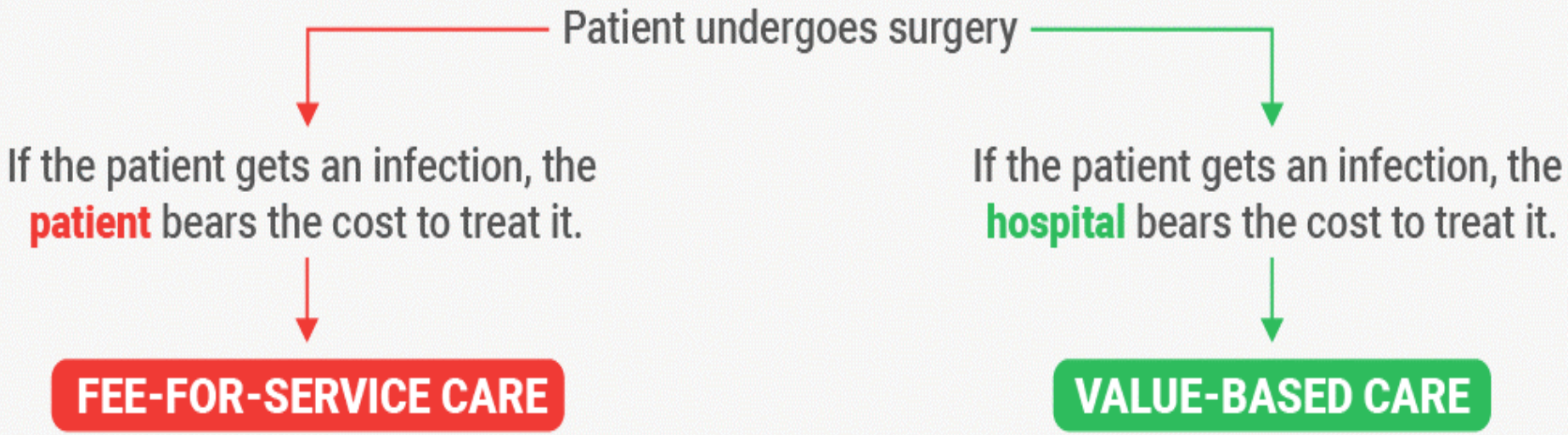
CMS Payment Model Categories: Value-Based Reimbursement



HOW VALUE-BASED CARE WORKS

Value-based care ties reimbursement to quality, not quantity, of care.
The goal is to incentivize better care and lower costs.

This example shows its use in a hospital, but it can apply to any healthcare provider:



How Does Value Based Care Reduce Cost?

- Avoiding unnecessary emergency visits
- Preventing diseases from causing deteriorations in a patient's health by discussing proper management strategies
- Standardizing processes for cost-effectiveness
- Reducing costs by reducing readmissions, or excessive medical tests
- Eliminating unnecessary administrative procedures or tests by using data to analyze and create best practices and "care paths". Using technology for modern healthcare can be a big help in this area.
- Creating stronger alliances, communication, and evaluation of the regulations for drug companies so that costs associated with drugs are directly related to outcomes or how effective the drug is.
- Better coordination of medical teams and access to services

Value Based Care Impact on Providers

- A 2016 study published in *Health Affairs* estimated that an average-size medical practice spends 785.2 hours ($40,069 per physician, $15.4 billion per year in the aggregate) reporting on quality measures that do little to help improve care or assist patients with treatment decisions.
- The aggregate cost of dealing with billing complexities, including the denial of claims, is as much as $54 billion a year, just for outpatient visits.
- Medicaid denies initial claims at a rate that is substantially higher (17.8 percent) than any other payers, citing providers' failure to comply with various complex billing requirements.
- 2015 – MACRA Came into Law
- Repeal of SGR and stimulate transition to VBC through QPP
  - Two payment approaches: MIPS and APMs

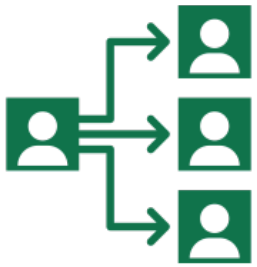
https://www.healthaffairs.org/do/10.1377/hblog20180927.405697/full/

The Burdon of MIPS

- Links payment to an individual provider's performance on measures in four categories:
  - Quality
  - Advancing Care Information
  - Clinical Practice Improvement Activities
  - Resource Use
- provider will receive a positive, negative, or neutral update to their fee schedule payments two years following the year they were evaluated.
- A physician who performs in the bottom quartile could see their reimbursement cut by as much as 9 percent (the maximum cut for 2022).

Shift to Outpatient CDI

Provider trends 2018 -2022


Payment

- Managed care
- E/M payment changes
- Outcomes-based reimbursement models
  - Hospital Outpatient Quality Reporting
  - MACRA/MIPS
  - Risk adjustment (HCCs)
- Payer audits; clinical validation
- Medical necessity

Staffing

- Outsourcing of administrative functions
- Nursing shortages (CDS)
- Coder shortages
- Expertise by setting and specialty; facility versus profee

Care Delivery

- Move away from inpatient to ambulatory care delivery models

Competition

- Continued hospital consolidation and health system expansion
- Entry of other care providers and partners—employers, retail clinics, virtual health

Technology

- Disjointed technologies in ambulatory revenue cycle; limited interoperability
- Physician coding and documentation
  - EMR burden
  - Alert and query fatigue

Ambulatory CDI comparison to inpatient

Five ways the setting changes CDI activities

	Outpatient and Professional	Inpatient
Timing	Brief encounters, hours if not minutes before discharge; limited documentation	Encounter spans days, allowing for concurrent CDI; multiple documents
Objective	Priority on charge capture, reducing rework, denials, and appeals	Focus on PDX, MCC and CC, SOI, and case mix
Staffing	Professional services may be coded real-time by the physician and sent directly to PMS	Bench of coding, clinical documentation specialists, and auditors
Code sets for payment	Payment is usually based on procedures (CPT, E/M levels, and APC), although diagnoses determine medical necessity	Payment varies based on diagnosis coding (ICD-10-CM)
Payment reform	HCC-based physician pay puts attention on chronic conditions	Attention to POA, PSIs, other quality measures

Market forces that drive ambulatory CDI

- Medical necessity
- Hierarchical Condition Categories (HCCs)
- Diagnostic and procedural specificity
- HEDIS measures
- Value-based Payment Modifier (VPM)
- MACRA physician payment
- Outpatient Prospective Payment (OPPS)
- Ambulatory Payment Classification (APC)
- Benchmarks and quality measures
- Inclusion and rates with private payers

CDI drivers by setting

Hospital Outpatient	Emergency Department	Ambulatory Surgery	Physician Offices
• Revenue shift IP to OP • Growth in OP visits • Acquisition of physician practices • HCC risk pay	• Medical necessity • Time capture (e.g., infusions) • Charge capture validation • Present on admission	• Medical necessity • Screening versus diagnostic Px • Conservative therapy (alternatives exhausted) • Operative note to have post-op Dx	• Documentation missing or incomplete • Dates and times • Medical necessity • Conflicting problem lists • Clones; copy/paste • Denials

Overall goals:

Shift focus from fee for service to pay for performance/quality

Retain current reimbursement (confirm ROI) and ensure future reimbursement

Achieve complex documentation required for coding and billing

Prevent denials

Support accurate quality measures

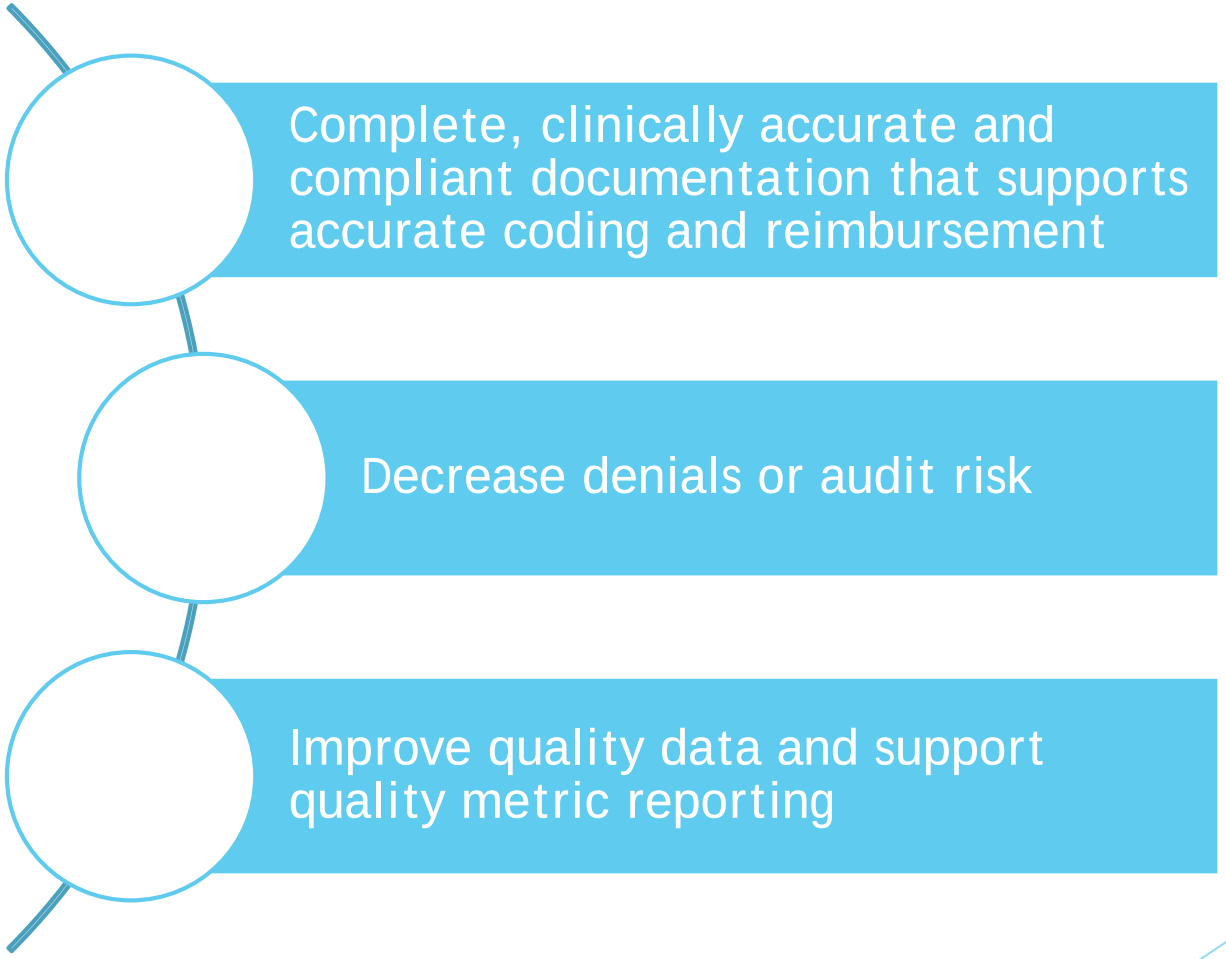
Support continuity of care

Drivers for Outpatient CDI

- Healthcare reform driven by the Affordable Care Act (ACA) is geared to improve quality, affordability and access to care through these key focus areas:
  - Transition to value-based payment
  - Improving care delivery through innovation
  - Expand information sharing including increased transparency on cost and quality for better consumer decision making
- Increased regulatory oversight and scrutiny
  - RAC, ZPIC, Commercial payer reviews
- Shift to outpatient services
  - Technical and medical advances

OP CDI Program Initiative

The initiative of an OP CDI review is to help an organization achieve the following:



The risk of denials

- The national average for claim denials is 4%*.
- Outpatient services represent 15% of overall denials**.
- The average outpatient denial claim is $882 (automated denials) but as high as $5,659 (complex denials).
- The average cost for rework is $25 per claim***.
- Administrative costs to manage RAC appeals range from $10,000 - $50,000.
- 48% of denials are appealed with a 70% success rate.
- 59% of denials are appealed, but pending.

What is your risk?

*http://revcycleintelligence.com/news/quantify-denial-rates-for-smooth-revenue-cycle-management
**RACTRAC AHA RACTRac Survey, May 2014
***http://www.healthfusion.com/blog/2014/practice-management/denial-management-can-afford-throw-away-25-denial/

The most frequent coding errors

- Unbundling codes
- Upcoding
- Not checking NCCI edits with multiple codes
- Missing or inappropriate modifiers
- Overusing modifier 22
- Time-based infusions and hydration
- Improper reporting of injection codes
- Reporting unlisted codes without documentation

How do you stay compliant?

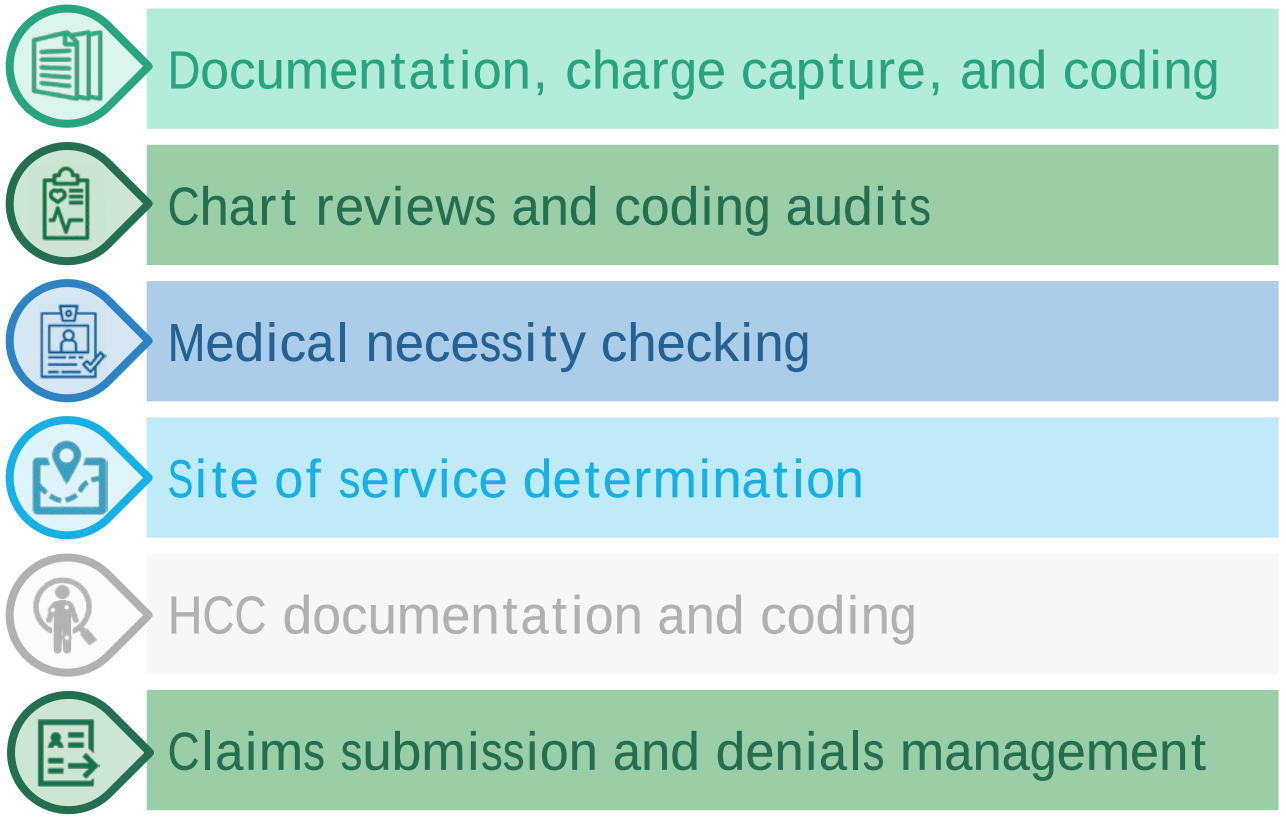
https://www.beckershospitalreview.com/finance/8-most-common-coding-errors.html

What indicates a potential CDI problem?

Inaccuracies in billing	
Coding errors and indefensible charges	
Missing charges	
Unresolved edits	
Medical necessity denials and write-offs	
Inaccurate patient placement for level of care	
Incorrect coding of observation and admits to hospital	

End goal: compliant, optimal billing

Requires more than just CDI



Common customer challenges

- Outpatient facility claims
  - Inpatient-only procedures not identified in time to get the order prior to surgery
  - Medical Necessity edits remaining after scrubbing (both ED and non-ED)
  - Significant scrubbing performed to get the claims out the door
  - Emergency Department E/M level skewed to highest level on 50% of visits
  - Admission to hospital inaccurately noted as discharge from ED or observation
  - Inaccurate time stamps for transfer from observation to inpatient
- Professional claims
  - Based on documentation, E/M levels are coded either too high or too low
  - Critical care charged when patient stable or improving
  - Missing charges for procedures and screening services rendered during visit
  - Missing supporting documentation for surgical procedures
  - Inappropriate modifier placement
  - HCC diagnoses not noted (amputation) or “softened” (morbid obesity, alcohol abuse)

Delivery of Care in Outpatient Settings

- According to a 2016 report from BC/BS, *The Health of America Report,* analysis of claims data for approximately 4 million members from 2010 to 2014 support the shift to outpatient services as driven by:
  - Consumer expectations for greater convenience when receiving elective surgeries
  - Commercial payer and clinical pressures for minimizing inpatient hospital stays
  - Clinical advancements that have been proven to achieve similar quality with lower intensity medical services
- "Complex procedures and surgeries now are possible in outpatient facilities due to new medical technologies, such as minimally invasive surgical techniques, new anesthesia and pain control techniques, that prevent complications and allow patients to return home more quickly."

https://www.bcbs.com/about-us/capabilities-initiatives/health-america/health-of-america-report/how-consumers-are-saving

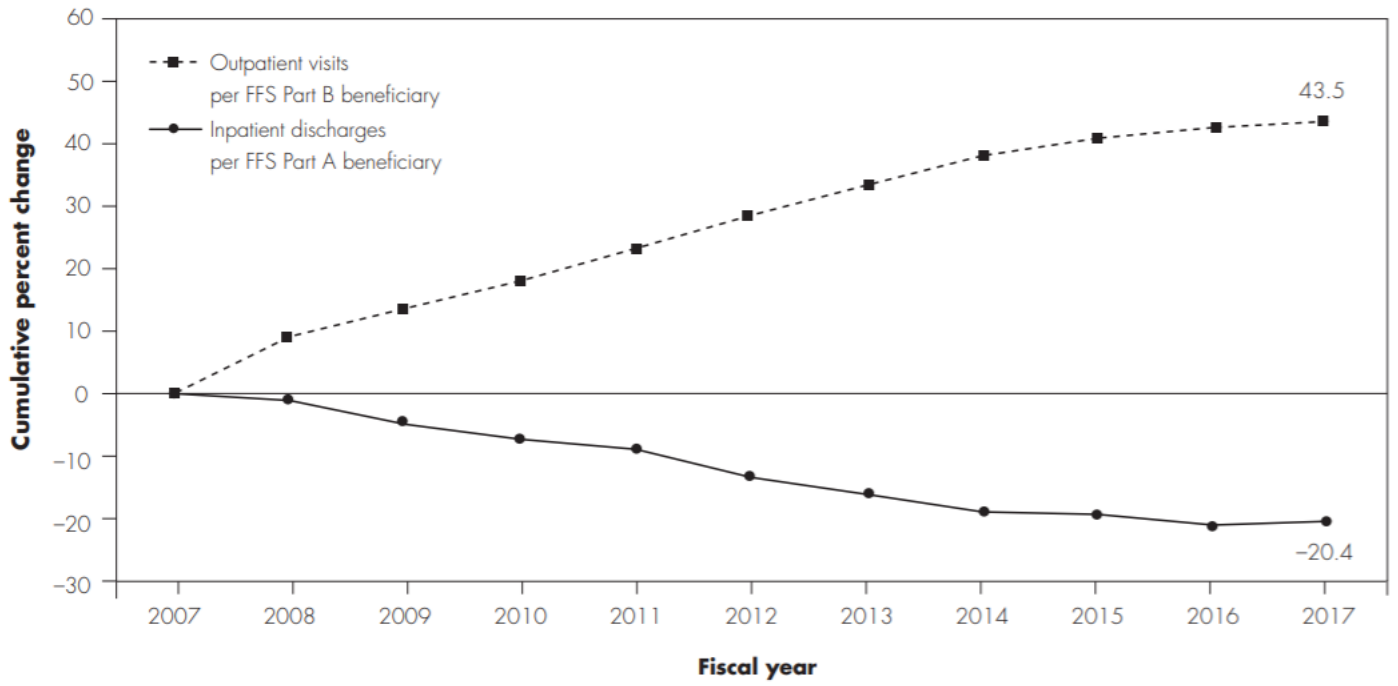
Many Eyes on Payments & Reimbursement

Federal Government Audit Entities	
CERT	Comprehensive Error Rate Testing Program
DOJ	Department of Justice
HEAT	Health Care Fraud Prevention and Enforcement Action Team
MAC	Medicare Administrative Contractor
Medicaid RAC	State Medicaid Recovery Audit Contractor
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MIP	Medicaid Integrity Program
OIG	Office of Inspector General
OMIG	State Office of Medicaid Inspector General
PERM	Payment Error Rate Measurement Program
RAC	Medicare Recovery Audit Contractor
ZPIC	Zone Program Integrity Contractor

Some Perspective on the Swing to OP Services

FIGURE 3–2

Medicare inpatient discharges per beneficiary and outpatient visits per beneficiary increased from 2016 to 2017



Note: FFS (fee-for-service). Data include general and surgical, critical access, and children's hospitals.

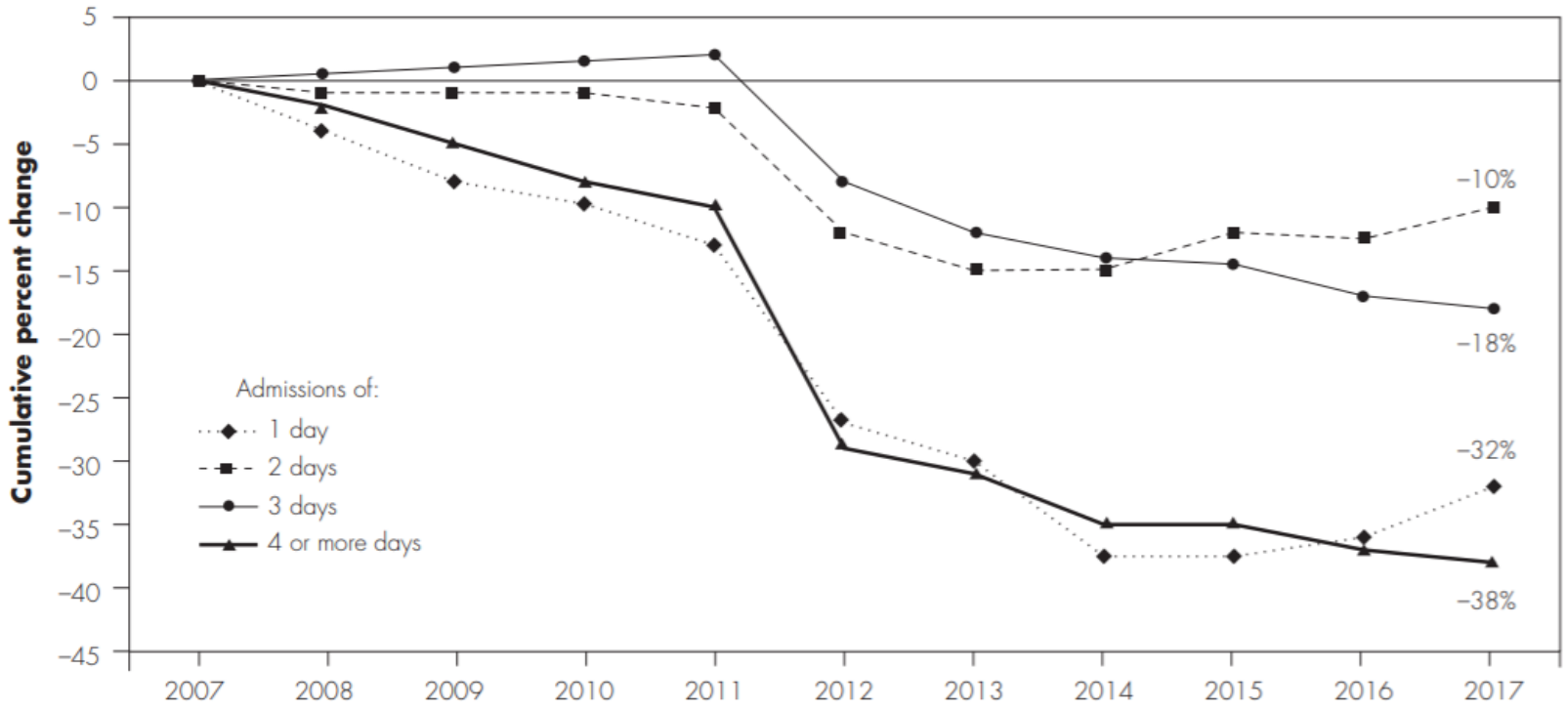
Source: MedPAC analysis of CMS's inpatient and outpatient claims and enrollment data.

Source: Medicare Payment Advisory Commission (MedPAC) March 2019 *Report to the Congress: Medicare Payment Policy*. March 15, 2019

Short Stays are on the Rise

FIGURE 3–3

The number of short (one- and two-day-stay) Medicare inpatient discharges per beneficiary increased from 2016 to 2017



Source: Medicare Payment Advisory Commission (MedPAC) March 2019 *Report to the Congress: Medicare Payment Policy*. March 15, 2019

Drivers for OP CDI

Background

Medicare spending on hospitals

In 2017, the Medicare fee-for-service (FFS) program paid acute care hospitals almost $119 billion for inpatient care, about $66 billion for outpatient care, and $6 billion in payments for uncompensated care (Table 3-1). From 2016 to 2017, inpatient payments increased by 2.2 percent, or $2.6 billion. This growth in inpatient payments resulted from an increase in payment rates of 1 percent, a 0.7 percent increase in the number of inpatient admissions, and a 0.6 percent increase in inpatient case mix.[1] In the same period, outpatient payments per FFS beneficiary grew by 8.1 percent, or approximately $5 billion. The

TABLE 3-1 Growth in Medicare inpatient and outpatient spending

Hospital services	2007	2016	2017	Average annual percent change 2007–2016	Percent change 2016–2017
Inpatient services					
Total FFS payments (in billions)	$111.3	$116.0	$118.6	0.5%	2.2%
Payments per FFS beneficiary	3,148	3,026	3,102	–0.4	2.5
Outpatient services					
Total FFS payments (in billions)	30.9	60.6	65.5	7.8	8.1
Payments per FFS beneficiary	953	1,799	1,950	7.3	8.4

Increase due to volume, price and shift from physician offices to higher cost hospital outpatient settings

Source: Medicare Payment Advisory Commission (MedPAC) March 2019 Report to the Congress: Medicare Payment Policy. March 15, 2019

Outpatient Spending Growth

TABLE 3–2

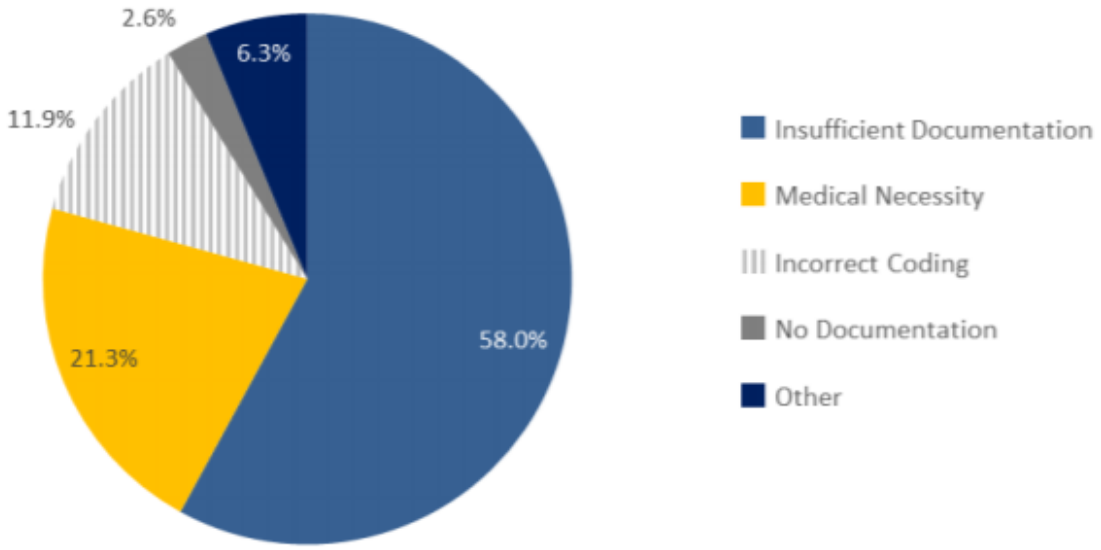
Hospital outpatient departments had strong spending growth for separately payable drugs, observation care, ED visits, clinic visits, and chemotherapy administration, 2012–2017

Service or item	Spending (in billions) 2012	Spending (in billions) 2017	Percent change 2012–2017	Driver of growth
Drugs	$6.0	$12.0	99%	High-cost drugs, increased volume, shift from physician offices
Observation care	0.9	3.1	263	Larger payment bundle
ED visits	2.4	4.1	72	Larger payment bundle, coding to higher levels
Clinic visits	1.9	3.4	81	Shift from physician offices
Chemotherapy administration	0.4	0.7	84	Shift from physician offices
Total	43.2	65.5	52	

Source: Medicare Payment Advisory Commission (MedPAC) March 2019 Report to the Congress: Medicare Payment Policy. March 15, 2019

Improper Payments 2018

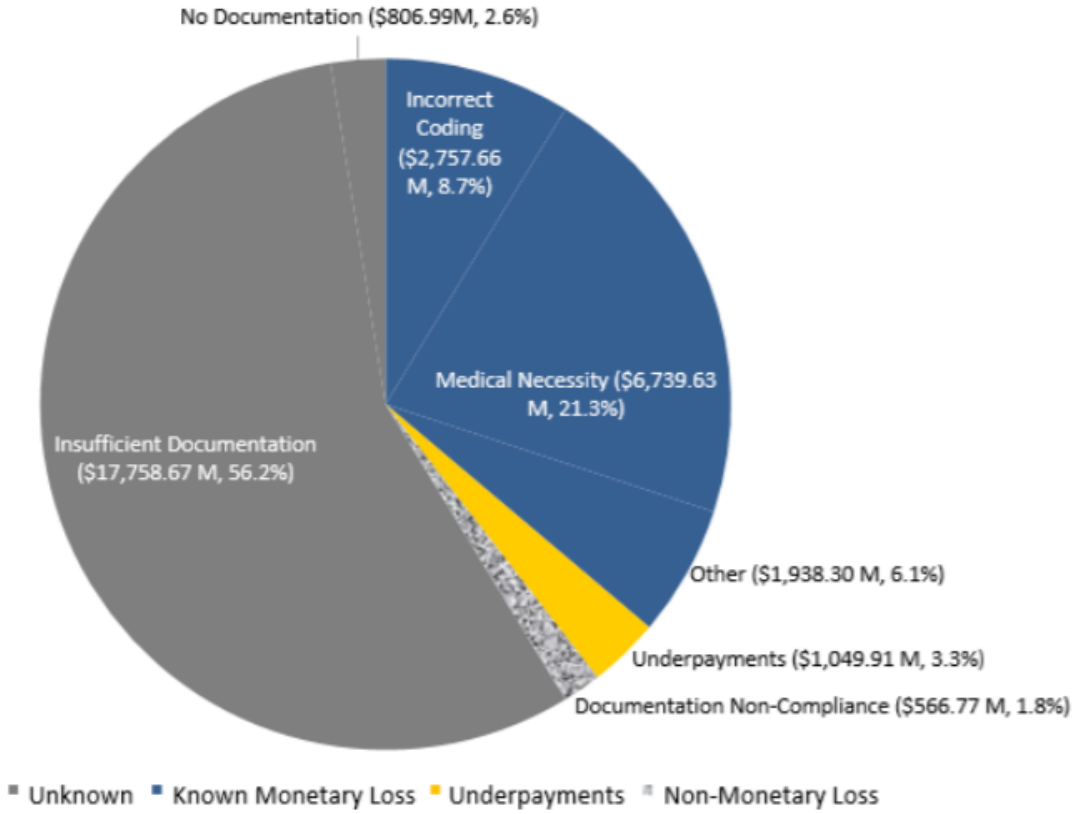
Figure 2: Improper Payment Rate Error Categories by Percentage of 2018 National Improper Payments



https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf

Financial Loss Due to Improper Payments

Figure 5: Improper Payments (in Millions) and Percentage of Improper Payments by Monetary Loss and Improper Payment Rate Error Categories (Including Documentation Non-Compliance)[6]



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Improper Payment by Service Line: Part A: IPPS 2018

Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Psychoses (885)	$461,746,775	13.2%	9.9% - 16.5%	0.0%	60.0%	30.9%	0.2%	8.9%	1.4%
Major Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$348,336,657	5.2%	3.1% - 7.3%	0.0%	91.8%	4.0%	4.3%	0.0%	1.1%
Endovascular Cardiac Valve Replacement (266,267)	$264,908,175	16.2%	9.9% - 22.4%	0.0%	84.6%	11.2%	4.2%	0.0%	0.8%
Septicemia Or Severe Sepsis WO MV >96 Hours (871, 872)	$147,126,944	1.9%	(0.0%) - 3.8%	24.2%	0.0%	11.2%	64.6%	0.0%	0.5%
Degenerative Nervous System Disorders (056, 057)	$142,872,343	16.4%	11.4% - 21.3%	0.0%	48.0%	47.4%	4.7%	0.0%	0.4%
Renal Failure (682, 683, 684)	$105,377,332	4.9%	2.6% - 7.1%	0.0%	0.0%	80.1%	19.9%	0.0%	0.3%
Simple Pneumonia & Pleurisy (193, 194, 195)	$104,208,684	5.4%	0.1% - 10.8%	0.0%	0.0%	64.6%	35.4%	0.0%	0.3%
Spinal Fusion Except Cervical (459, 460)	$91,167,248	4.5%	2.3% - 6.6%	0.0%	27.8%	61.0%	5.7%	5.5%	0.3%
Other Musculoskelet Sys & Conn Tiss O.R. Proc (515, 516, 517)	$89,315,292	22.4%	10.1% - 34.7%	0.0%	0.0%	98.9%	1.1%	0.0%	0.3%
Organic Disturbances & Mental Retardation (884)	$85,827,492	16.9%	9.9% - 23.9%	0.0%	45.8%	51.1%	0.6%	2.4%	0.3%
Signs & Symptoms (947, 948)	$84,887,297	32.0%	20.3% - 43.8%	0.0%	0.0%	92.5%	7.5%	0.0%	0.3%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$84,856,223	7.0%	3.7% - 10.3%	0.0%	0.0%	77.9%	22.1%	0.0%	0.3%
Respiratory Infections & Inflammations (177, 178, 179)	$80,132,038	6.9%	0.7% - 13.1%	0.0%	0.0%	72.1%	27.9%	0.0%	0.2%
Extensive O.R. Procedure Unrelated To Principal Diagnosis (981, 982, 983)	$80,062,488	7.8%	1.6% - 14.0%	0.0%	3.2%	61.2%	35.6%	0.0%	0.2%
Misc Disorders Of Nutrition,metabolism fluids/Electrolytes (640, 641)	$79,535,230	6.8%	2.4% - 11.2%	14.4%	4.0%	70.8%	10.7%	0.0%	0.2%
Syncope & Collapse (312)	$74,952,089	17.8%	12.1% - 23.5%	0.0%	2.9%	96.9%	0.2%	0.0%	0.2%
Chest Pain (313)	$72,065,446	28.3%	19.5% - 37.1%	0.0%	0.0%	98.8%	1.2%	0.0%	0.2%
Other Vascular Procedures (252, 253, 254)	$71,206,333	4.2%	1.0% - 7.4%	20.2%	9.4%	67.6%	2.7%	0.0%	0.2%
Diabetes (637, 638, 639)	$68,564,186	10.6%	3.8% - 17.4%	0.0%	0.0%	79.8%	20.2%	0.0%	0.2%

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf

Improper Payment: Documentation Error 2018

Table F1: Top 20 Types of Services with No Documentation Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Nonhospital based hospice	$92,352,308	0.6%	0.0% - 1.1%	0.3%
Hospital visit - subsequent	$79,444,399	1.5%	0.6% - 2.4%	0.2%
Home Health	$62,754,416	0.3%	0.0% - 0.7%	0.2%
Office visits - established	$59,365,702	0.4%	(0.0%) - 0.8%	0.2%
SNF Inpatient	$51,578,264	0.2%	(0.0%) - 0.4%	0.2%
Hospital Outpatient	$44,072,372	0.1%	(0.0%) - 0.2%	0.1%
Nursing home visit	$40,824,072	2.1%	0.4% - 3.8%	0.1%
Septicemia Or Severe Sepsis WO MV >96 Hours (871, 872)	$35,595,553	0.5%	(0.4%) - 1.4%	0.1%
Hospital visit - initial	$22,953,047	0.8%	0.3% - 1.4%	0.1%

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf

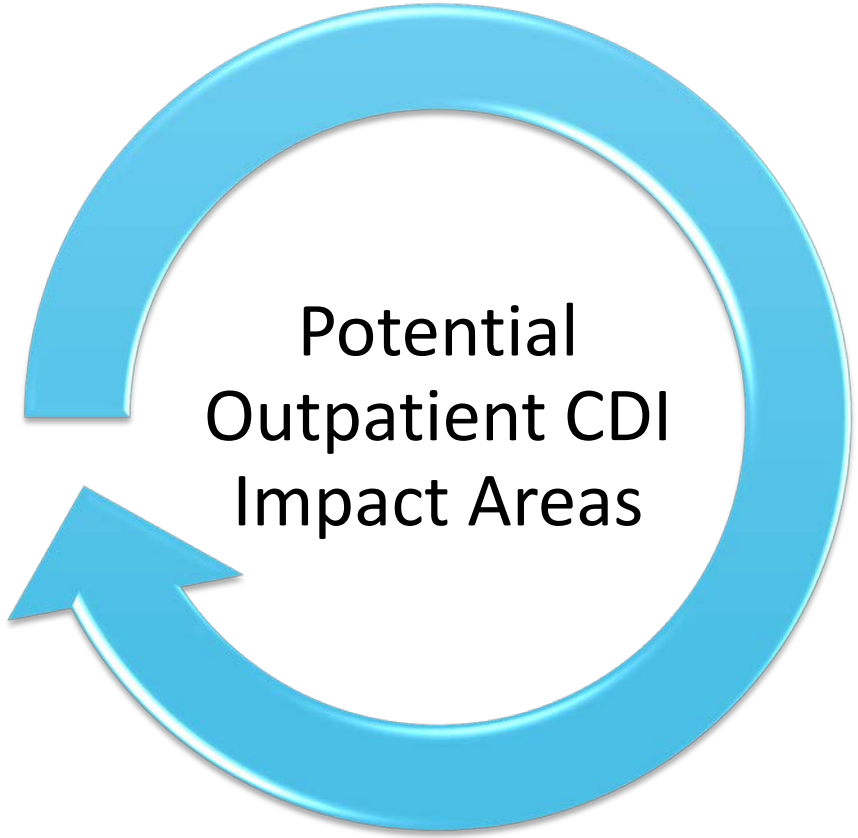
Medical Necessity: Primary Driver in OP Care

- Patient Impact
  - Documentation to support appropriate delivery of care
  - Charges to patient can vary based on assigned status
  - CMS specifically states “medical necessity is the overarching criteria for appropriate reporting and reimbursement of professional services”
- Financial
  - Appropriate reimbursement for resources utilized
  - Prevention of payment denials and claim delays
  - Prevention of unnecessary payback to payers
- Regulatory Compliance
  - Prevention of penalties for over/under payment
  - Protection against accusation of improper or inappropriate services
  - Mitigation of risk

Detailed recommendations

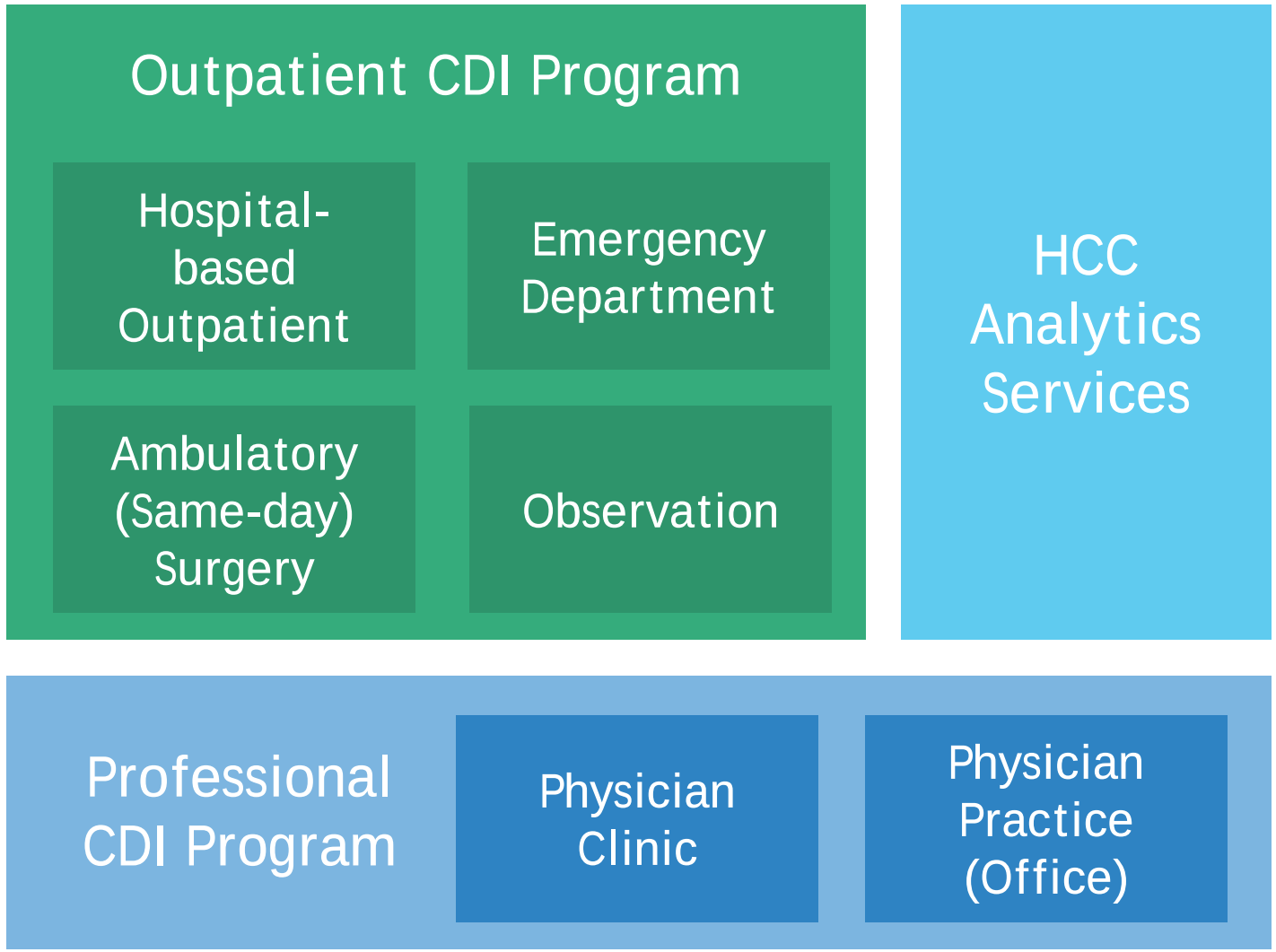
Elements of a consulting engagement

Where to Begin



- Emergency services
- Ambulatory services
- Diagnostics
- Clinics
  - - Wound Care
  - - Infusion
  - - Cardiac Lab
- Rehab
- Observation
- Physician practices

Three flexible, modular ambulatory CDI programs



How to Kick Off Your OP CDI Program

- Key general discovery questions:
  - How does the organization and providers capture documentation?
  - How are the records coded?
  - What is the billing process?
  - Are the physicians employed by the Hospital/Health Systems (HS) or private practice?
  - What are the driving concerns for these areas:
    - Claim denials
    - Compliance
    - External Auditors
    - Revenue generation/underperformance
    - DNFB/Service performed, not billed
    - New service lines
    - Regulatory changes

Outpatient and Professional CDI Programs

Three phases

Assess

Identify process gaps, policy change requirements, ineffective practices, and inefficient workflow

- Data analysis
- Record review
- Onsite interviews and shadowing
- Recommendations

Implement

Work with key stakeholders to integrate new policies, processes, education and tools

- Onsite visit
- Implement best practices and process improvements
- Training and customized education for CDI staff and physicians (peer to peer)
- Quality measures and HCCs
- Reporting and oversight

Sustain

Measure and monitor progress; review with key stakeholders to ensure goals are achieved and to validate and sustain success

- Onsite follow-up visits
- Post-implementation audits
- Performance monitoring
- Retraining as needed

Assessment

Data Analysis

Physician Reports

Record Reviews

Department Interviews

Evaluation of CDI Tools

Refine Revenue Opportunity

Comprehensive Outpatient CDI discovery questions

- What does it cost to get paid for outpatient services?
- What are the claim denial volumes?
- How much rework (number of claims) are being re-processed each day?
- How long does it take to be reimbursed from:
  - Original claim to payment or denial
  - Resubmitted claim to payment
- How much staff is involved in this process?
- How much time is invested in making sure charge information gets to the bill correctly?
- How often is information reprocessed because the root cause of the problem is not identified and corrected?

Professional Practice and Clinic CDI discovery questions

- How are the E/M levels and procedure codes assigned? By the physician? Coder? Superbill?
- What criteria do you use for billing (AHIMA, point structure, self-developed, or vendor proprietary criteria)?
- Are you outsourcing your coding and/or billing? Clearinghouse for billing?
- When was your last external coding and billing audit?
- What technology tools are you using within the physician office and/or clinic?
- Is the documentation routinely reviewed to support coding? Do you have a CDI program in these settings?
- Are E/M levels graphed to trend utilization by physician or physician group?
- What denials are occurring from your physician and/or clinic services?
- How much money are you writing off on denials? How much does it delay A/R?

HCC services discovery questions

- Do you manage a Medicare ACO? Do you share in any losses or suffer penalties for missing cost targets?
- Do you score in the bottom quartile in the Medical Value-Based Purchasing Program for clinical outcomes and/or efficiency?
- Does more than half of your revenue come from Medicare patients?
- Do you employ specialists and/or primary care providers, either directly or through a subsidiary? Or, do you have a joint venture with physician partners?
- Do you manage a Medicare Advantage health plan or offer a commercial plan on the state insurance marketplace?
- Do you have contracts with commercial insurers that mirror Medicare payment programs or use HCCs for risk adjustment?

Areas of Opportunity

- Key Financial Entry Points:
  - Risk Adjustment (RA) Payment Methodologies
    - Heath Systems and Healthcare Organizations:
      - Management/Ownership of a Medicare Advantage (MA) health plan
      - Engage/Employ physicians with MA contracts including RA score incentives
      - Operate or participate in an ACO.
  - Physician Fee Schedule Based Services
    - Hospital/Health System Employed Physician Group Practices
    - Outpatient professional services provided under the direction of the healthcare organization
  - OPPS (APC, C-APC) Service Lines
    - Hospital-based outpatient departments, clinics, or centers
    - Community-based ambulatory care, surgery and diagnostic procedure centers

Analytics as a Starting Point

- Operational assessment to determine most significant “pain points”
  - Claim denial analysis for obvious trends
  - Value assessment – relative revenue vs. volume of service
  - Adaptability to change management
- Consider comprehensive improvement strategies
  - Baseline analysis to identify opportunities
  - Qualification of deficiencies
  - Workflow redesign
  - Education and strategy sessions

Making the Move

OUTPATIENT CDI:

OP CDI Program Development

- Education should be focused on high denial, error-prone or compliance risk areas
    - Focused, relevant and directed to clinical integrity of the record
- Starting point for greater expansion
- Consider how to improve documentation across the care continuum
    - Primary care vs. Specialty services
    - Diagnostic services

OP CDI Program Development (cont.)

- Stay up to date with coding and payment methodology changes
  - Payer contracts, code sets, coding guidelines
- Assess your operations
  - Documentation Chain
- CDI Program Implementation
  - Based on Assessment & prioritized by opportunity
- Data Analytics
  - Create, utilize, validate or enhance

Outpatient Solutions

Outpatient CDI Solutions

- Support medical necessity and appropriateness of services provided to patients.
- Ensure complete, accurate, and compliant coding and billing practices, based on clinical documentation evidenced in the medical record.
- Identify deficiencies in Charge Description Master (CDM) and coding process.

Outpatient CDI Solutions

- Pinpoints educational needs to achieve quality and compliance.
- Proactively defend against claim denials/adverse audit outcomes; reflect accurate quality and utilization reporting.
- Advance policies, procedures, and workflows to promote compliant practices and operational excellence.
- Prepare for Value-Based and Risk Adjusted Payment methodologies.

Questions

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