The Middle Revenue Cycle: How CM, HIM and CDI Provide the Vital Link Between Patient Engagement and Revenue Capture

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OBJECTIVES:
- Attendees will learn how the middle space of the revenue cycle (Case Management, CDI, and HIM) is essential for documentation clarity and capture of correct revenue for the health care entity.
- Attendees will participate in a review of best practices for different size (large facilities, community hospitals and critical access hospitals) and types of facilities (both ambulatory and inpatient facilities) with regard to revenue cycle middle space integrated processing.
- Attendees will learn how this is imperative not only for efficient throughput of the revenue cycle but also for the increased scrutiny of all types of audit initiatives that are currently being enacted.
Health Care Reimbursement-A
Short History

- **1900**- Shift in cause of death from infectious to chronic illness. Public health played significant role in curtailing the spread of infectious disease.

- **Post WW I**- Government providing hospital services to veterans with service related disabilities or if non service related and unable to pay for care.

- **1914**- First broad coverage health insurance emerged in the form of worker’s compensation programs. Originally concerned with cash payments to workers for lost wages. Served as trial balloon for the idea of government sponsored insurance against illness.

- **1850**- Private insurance limited to bodily injuries has been available. Early policies in the early 1900’s were to protect against loss of income during illness.

- **Health Insurance Movement in early 20th century**- Technology advancements, medical care became more socially desirable thus an increase in demand.

- **Economics**- Inability to predict need for medical care made it more desirable but less affordable.
Health Care Reimbursement-A
Short History

- **1929-1941**—Great Depression—hospital reimbursement shifted from philanthropic donations to patient fees for support. Patients needed protection from the economic consequences of sickness and hospitalization.

- **1929**—Blueprint for modern health insurance was established when J.F. Kimball began a single hospital insurance plan for teachers at Baylor Hospital.

- **1930's**—It became model for Blue Cross plans around the country and then the model shifted from single hospital plans to community wide plans to provide more consumer choice.

- **1933**—Blue Cross plans started to grow. Non profit and covered only hospitalization. AMA lobbied for no physician coverage so as not to infringe on that revenue stream.

- **1939**—Blue Shield plans started for physician fee coverage and by 1974, most Blue Cross and Blue Shield plans had merged.

- **1965**—Social Security Act, creating Medicare and Medicaid. No means testing for Medicare but it is there for Medicaid. 1965-1980—Cost based reimbursement shift to PPS. DRG’s, shorter length of stays.

- **1980-present**—Growth of HMO’s, PPO’s, capitation, technology advances, new illnesses, patient right’s, ACA, Medicaid expansion, ACO’s, Clinically integrated networks.
Market Forces in Today’s Environment

What market forces at work in the health care world today?

• Federal Payment Reform

• State Payment Reform-Medicaid State or No

• Health Insurance Exchanges-High Deductible and Out of Pocket Expense

• Employer Provided Insurance Shrinking

Market Forces in Today’s Environment

Market Forces, cont.

• ICD 10

• Economic Compression-pressure to reduce cost of care.

• Physicians working harder for less.

• Value Based Purchasing

• ACO’s and Clinically Integrated Networks
Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Market Forces in Today’s Environment

Payers will control health care spending by:

- Cut the Fee for Service Reimbursement rate. **This is volume based contracting**
- Contract with providers who can control the total cost of care. **This is value based contracting**
HFMA Value Project Report

Transition Risk

“Putting both feet in the “new system” boat too early can have serious financial consequences if, for example, reduced utilization from better coordinated care reduces revenue under the current payment system. But staying on the “old system” dock too long risks missing the boat altogether if other providers have developed the capabilities they need to take advantage of value-based opportunities as they arise. Transition risk refers to the potential costs inherent in either of these scenarios.”

The Advisory Board reported that:

- Increasingly, Health Systems are in some form of risk contract, from high risk to low.

- Top Two Investments to Prepare for Risk Based Contracts.

  Investing in Care Management Programs and Reducing Inpatient Costs
Whose Accountable?

- Safety Net Clinics-partnership for expedited access.
- Transportation Assistance, counseling, motivational interviewing.
- Patient Centered Medical Home? To what extent? What are patient populations?
- Post Discharge Appointment access, Outpatient care managers?
- Palliative Care Team, Ethics Consults, POSLT
- Shared chronic disease management protocols. SBAR for nurse with physician, preferred provider status for facilities with low readmission rates.
Shift in Care Delivery

**FROM**
- Silo Care Mgmt
- Episodes of Care
- Hospital Centric
- Discharges
- Utilization Mgmt
- Caring for the Sick
- Production (volume)

**TO**
- Enterprise Care Mgmt
- Coordination of Care
- Patient Centric
- Transitions
- Proactive care at the right place, right time
- Prevention and Wellness
- Performance (Value)

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**How To Start? Without Falling in the Water?**

- Analysis of existing resources to uncover potential overlaps in order to optimize deployment of existing staff. Identify interrelated steps and failure points.

- The functional needs of the patient should be addressed by the lowest-cost applicable staff.

- Identify a patient population to focus on. Starting small is still a start. Leverage existing clinical protocols and infrastructure. Ex. CHF, COPD.

- If there is access to a disease registry, that can provide analytics on claims data, biometric information, pharmacy data, ED usage to begin honing in on a population, use this to help identify population.
How To Start? Without Falling in the Water?

- Utilize a psychosocial assessment tool to identify non-clinical factors impacting patients' health paired with the clinical assessment.
- Assess financial case for centralized pharmacy support for targeted population.
- Develop triage and handoff protocols.
- **Develop scoring tool to identify those patients who will be assigned a care manager.**
- Clarify who are the key stakeholders to be involved in the project.
- Obtain administrative support.
- Set goals and a timeline and outcome measurements.

High Risk Screening Options

**CMS Readmission Penalty DRGs**

- CHF-Congestive Heart Failure
- AMI-Acute Myocardial Infarction
  - PN-Pneumonia
- COPD-Chronic Obstructive Pulmonary Disease
- THA-Total Hip Arthroplasty
- TKA-Total Knee Arthroplasty
High Risk Screening Options

• **LACE** Index, a validated risk assessment tool, to prospectively identify patients who might benefit from more intense post-discharge care.

• **LACE** Index scores for every patient on admission and discharge on the following parameters:
  - Length of stay
  - Acuity of the admission
  - Co-morbidities
  - Emergency Department visits in the previous 6 months

• **LACE** scores range from 1-19 and predict the rate of readmission or death within 30 days

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High Risk for Readmission Screening

**BOOST TOOL**

- **Problem Medications**: anticoag, insulin, aspirin, digoxin
- **Depression**: screen positive or diagnosis
- **PRINCIPLE DIAGNOSIS**: COPD, cancer, stroke, DM, heart failure
- **Polypharmacy**: >5 or more routine meds
- **Poor Health Literacy**: inability to do teach back
- **Patient Support**: support for d/c and home care
- **Prior Hospitization**: non-elective in last 6 months
- **Palliative Care**: pt has an advanced or progressive serious illness
Comprehensive Care for Joint Replacements-Total knee/Total hip
• Mandatory participation for identified facilities.

• Starts Q2 2016 through Q4 2020.

• Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2014, there were more than 400,000 procedures, costing more than $7 billion for the hospitalizations alone.

Comprehensive Care for Joint Replacements-Total knee/Total hip
• The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.
Comprehensive Care for Joint Replacements-Total knee/Total hip

• The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities).

Comprehensive Care for Joint Replacements-Total knee/Total hip

• It ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries.

• The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions.
Comprehensive Care for Joint Replacements - Total knee/Total hip

Discussion:

- Is your hospital in the CJR program?

- What are key actions needed to succeed financially and maintain quality?

- What are some strategies to incentivize post-acute facilities to work more collaboratively?

- Is anyone using Scorecards for tracking post-acute length of stay, readmissions and quality?

- What else?

THE CHALLENGES ARE HUGE AND MULTI-TIERED!
MIDDLE SPACE OF THE REVENUE CYCLE

- As hospitals and other healthcare providers struggle to adapt to new reimbursement models, the “mid-revenue cycle” is becoming increasingly important for driving financial stability and improvements in quality performance.
- In general terms, the mid-revenue cycle is defined as the phase in the process between patient access and the care provider's business office.
- More specifically, it’s “the moment the physician puts pen to paper or literally finger to key to document the care that’s been delivered and the disease state of the patient, all the way to the completion of coding and the handoff of a case to the billing team in the business office.”

Reference: Healthcare IT News; April 8, 2015

DEPARTMENTS INVOLVED (ACUTE CARE)

- CASE MANAGEMENT
- CLINICAL DOCUMENTATION IMPROVEMENT
- HEALTH INFORMATION MANAGEMENT/MEDICAL CODING
ICD-10 IMPLEMENTATION PREDICTION

ICD-10 IMPLEMENTATION REALITY
ARE THE ICD-10 WATERS REALLY THAT CALM? (HOW DO YOUR KEY PERFORMANCE INDICATORS LOOK TODAY?)

- ANY 10% CHANGE IN THESE KPIs...SHOULD TRIGGER DEEP DIVE ANALYSIS:
  - DRG SHIFTS AND + - FINANCIAL IMPACT
  - CODING PRODUCTIVITY AT 80% OF ICD-9 LEVELS
  - INTERNAL AUDITING OF DOCUMENTATION SPECIFICITY
  - DNFB/DNFC COMPARED TO PRE-ICD-10 LEVEL
  - CURRENT DENIAL RATE BY PAYOR COMPARED TO PRE-ICD-10 LEVEL
  - LEVEL OF CASH ON HAND AT PRE-ICD-10 LEVEL

NATIONAL EXPERIENCE TO DATE OF DRG SHIFTS

- CMS STATED THAT CMI WOULD NOT SHIFT MORE THAN 1%

- INFORMAL SURVEY RECENTLY FOUND:
  - 22% OF RESPONDENTS FEEL THAT THE SHIFT IS GREATER THAN 1%.
  - .....BUT MORE CONCERNING IS THAT AN ASTOUNDING 50% OF RESPONDENTS DID NOT KNOW IF THERE HAD BEEN A CMI SHIFT IN THEIR FACILITY SINCE THE IMPLEMENTATION OF ICD-10!!
CMI IS THE GLOBAL METRIC THAT MEASURES THE SEVERITY OF YOUR PATIENTS....DO YOU KNOW YOUR MEDICARE CMI?

• POSSIBLE CAUSES OF MC CMI SHIFT:
  
  ➢ NON-SPECIFIC DX BEING A MCC/CC IN ICD-9 BUT NOT IN ICD-10
  ➢ COMBINATION CODES
  ➢ CHANGE IN DRG FOR DIFFERENT PROCEDURE CODES

• HAVE YOU ANALYZED YOUR MC CMI TO IDENTIFY SHIFTS SINCE IMPLEMENTATION OF ICD-10? ANY 0.1 CHANGE OF THE CMI MUST TRIGGERED AN IN-DEPTH ANALYSIS!

IS THE EARTH SHIFTING WHERE YOU LIVE?

➢ ONE DRG SHIFT EXAMPLE SHOWS WHY ANALYSIS IS CRITICAL!

➢ PT ADMITTED WITH DIVERTICULITIS WITH PERFORATION AND PERITONITIS...OPEN RESECTION: IN ICD-10 THERE IS NOT MCC FOR THE PERITONITIS...THERE IS A LOSS OF > $21K PER CASE! HOW CAN THIS BE??

➢ THIS CHANGE IS BECAUSE OF A COMBINATION CODE:

➢ ICD-9 329: RELATIVE WEIGHT 5.0709...ICD-10 348

RELATIVE WEIGHT 1.4486

➢ LOSS OF MCC AND CHANGE OF PROCEDURE CODE = LOSS OF >$21K PER CASE

➢ THIS SHOWS THE IMPERATIVE THAT DRG SHIFTS MUST BE ANALYZED WITH AN ACTION PLAN IF THE SHIFT IS OVER WHAT WAS EXPECTED

➢ LIST ON CMS WEBSITE
ANALYSIS SHOULD INCLUDE!!

- ACTION NEEDED IF ANY OF THE TOP 25 DRGS SHIFTING +/- 0.1!

- MOST AT RISK DRGS NEED TO BE AUDITED AND MONITORED BY CDI

- CODERS MAY NEED MORE EDUCATION ON DRGS

CURRENT DRG/CMI SHIFT ANALYSIS IMPERATIVE

- IMPERATIVE TO IMMEDIATELY COMPLETE ANALYSIS OF DRG/CMI SHIFTS

- NEW CODES 2016....
  - 3,651 new procedure codes...Comments were due to CMS 4.8.16
  - 1,928 new diagnosis codes...Comments due to CMS 5.6.16

- Analysis of DRG Shifts need to be done before 5,579 new codes are implemented: after that it will be impossible to tell what is causing the DRG Shift.
MIDDLE REVENUE CYCLE SPACE CHALLENGES ON THE HORIZON

• ALTERNATIVE PAYMENT ARRANGEMENTS
• REGULATORY CHANGES IN ALL CLINICAL AREAS
• INCREASED AUDITING ACROSS ALL PAYERS

➢ Recent study showed that some hospitals reporting a doubling of denials

CORRECT CODING LEADS TO PATIENT ENGAGEMENT

- Benefit to the Patient, the Medical Staff, and the Facility
- Optimal Reimbursement & Solid Data
- Correct DRG
- Accurate Coding
NEED FOR SPECIFICITY LEADS TO FOCUS ON CLINICAL DOCUMENTATION IMPROVEMENT

• SPECIFICITY IS THE ‘NAME OF THE GAME:
  DOCUMENTATION IMPROVEMENT HAS MANY ATTRIBUTES:

  ➢ QUALITY AND SAFETY (SOI AND ROM)
  ➢ NEED FOR CDI IN PHYSICIAN OFFICES WITH MOVE TO NEW PAYMENT STRUCTURES
  ➢ PATIENT SATISFACTION DUE TO IMPROVED QUALITY
  ➢ PROVIDER SATISFACTION DUE TO CORRECT SEVERITY SCORES
  ➢ STABILIZATION OF CASE MIX INDEX

CDI GOLD STANDARD OF QUALITY CLINICAL DOCUMENTATION

• LEGIBILITY
• RELIABILITY
• PRECISION
• COMPLETENESS
• CONSISTENCY
• CLARITY
• TIMELINESS
CDI....WHERE SHOULD IT REPORT IN THE ORGANIZATION?

- Pamela Hess in her book, Clinical Documentation Improvement; Principles and Practice, states a CDI service should report to a Department:

  ➢ That is efficient and effective.....the best choice is a department that has met or exceeded key metrics consistently for at least three years
  ➢ One with a visionary department director....CDI is a dynamic concept....the manager must be capable of creative, out-of-the-box thinking for the program to be successful

CDI....CODING INTERFACE

![CDI Function Diagram]

Figure 7.4 Sample clinical documentation improvement organization chart
IS YOUR CDI PROGRAM EFFECTIVE?

Figure 11.1 Collection of operational core CDI key metrics

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Concurrent review</th>
<th>Physician response</th>
<th>Retrospective review</th>
<th>Physician response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician documentation</td>
<td>Concurrent physician query rate</td>
<td>Concurrent physician response rate</td>
<td>Retro physician query rate</td>
<td>Retro physician response rate</td>
</tr>
</tbody>
</table>

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SAMPLE CDI KEY MEASURES

Table 11.1 Sample clinical documentation key measures

<table>
<thead>
<tr>
<th>Key Metric</th>
<th>Quarter 1</th>
<th>Target*</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent: Record review rate</td>
<td>75%</td>
<td>90%</td>
<td>83%</td>
</tr>
<tr>
<td>Concurrent: Physician query rate</td>
<td>40%</td>
<td>40%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician response rate</td>
<td>50%</td>
<td>75%</td>
<td>67%</td>
</tr>
<tr>
<td>Physician validation rate</td>
<td>70%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Retrospective: Physician query rate</td>
<td>5%</td>
<td>15%</td>
<td>33%</td>
</tr>
<tr>
<td>Physician response rate</td>
<td>100%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Physician validation rate</td>
<td>65%</td>
<td>85%</td>
<td>76%</td>
</tr>
</tbody>
</table>

*Note: The targets noted were created specifically by the healthcare organization using its own assessment data. All targets should be organization-specific and be validated on at least an annual basis.

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HOW’S YOUR CDI DASHBOARD?

The challenges are huge and multi-tiered!

Table 11.7 - Sample CDI dashboard with strategic and operational metrics

<table>
<thead>
<tr>
<th>Concurrent Queries</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>YTD 06</th>
</tr>
</thead>
<tbody>
<tr>
<td># Queries placed</td>
<td>414</td>
<td>440</td>
<td>475</td>
<td>510</td>
<td>4,461</td>
</tr>
<tr>
<td>Response rate (Target: 90%)</td>
<td>31%</td>
<td>32%</td>
<td>28%</td>
<td>40%</td>
<td>36%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concurrent Reviews</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Patient reviews completed</td>
<td>794</td>
<td>826</td>
<td>893</td>
<td>864</td>
<td>7,940</td>
</tr>
<tr>
<td># Patients eligible for CDI review</td>
<td>1,407</td>
<td>1,405</td>
<td>1,476</td>
<td>1,336</td>
<td>14,024</td>
</tr>
<tr>
<td>% of eligible patients reviewed (Target: 85%)</td>
<td>56%</td>
<td>59%</td>
<td>61%</td>
<td>64%</td>
<td>57%</td>
</tr>
<tr>
<td># Patient reviews in progress</td>
<td>844</td>
<td>737</td>
<td>712</td>
<td>772</td>
<td>7,670</td>
</tr>
<tr>
<td>% Patient reviews with answers completed</td>
<td>52%</td>
<td>53%</td>
<td>59%</td>
<td>66%</td>
<td>56%</td>
</tr>
<tr>
<td>% CDI reviews with severity assigned</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
<td>93%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Retrospective Queries by 2024
- # LAb tests placed
  - January: 17
  - February: 18
  - March: 20
  - April: 20
  - YTD 06: 112
- Response rate: 22%

Process Flow
- # CDI reviews accessed in CDI system by HIM
  - January: 594
  - February: 583
  - March: 595
  - April: 693
  - YTD 06: 4,462

Documentation Compliance
- # charts reviewed documenting at time of coding
  - January: 661
  - February: 572
  - March: 649
  - April: 864
  - YTD 06: 3,462

Quarterly Change in Severity Level
- Level 1
  - January: 10%
  - February: 15%
  - March: 14%
- Level 2
  - January: 42%
  - February: 42%
  - March: 40%
- Level 3
  - January: 28%
  - February: 29%
  - March: 31%
- Level 4
  - January: 11%
  - February: 11%
  - March: 11%

THE CHALLENGES ARE HUGE AND MULTI-TIERED!
CMS’s BHAG for payment reform
Shift to accountability

CMS 2015 announcements
Episodic cost
Total cost
Alternative payment models
2016 30%
2018 50%
2016 85%
2018 90%
Medicare quality measures
Full-risk
Partial risk
Shared Savings
Episodic bundling
Pay-for-performance
Fee-for-service

Patient centered medical home
Accountable care organization
Provider accountability

Source: Centers for Medicare and Medicaid

HOW CAN WE BEGIN TO COLLABORATE?

Collaboration Techniques
- Staff Meetings
- Share Metrics
- Policy Development
- Escalation Process
WITH THIS TYPE OF STORM LOOMING...COLLABORATION WITHIN THE REVENUE CYCLE IS A MUST!

- POINTS TO PONDER:

- What is the Structure of our CDI/CODING INTERFACE...do we have objective data to indicate that it is effective and efficient?
- Do we need Team Building for the staff of these functions?
- Would it make sense to specialize CDSs and Coders around Product Lines making them ‘partners’ and thus improving throughput?
- Do we have Executive Support/Mandate to strengthen CDI/CODER alliance?
- Should we add CDI review on the Ambulatory side?

6 YEAR OLD SHOWS US THE BENEFITS OF WORKING TOGETHER AS A TEAM!
https://www.youtube.com/watch?v=vm0UNn7J59
In closing.....

Progress is impossible without change, and those who cannot change their minds cannot change anything.
George Bernard Shaw

QUESTIONS?
References


4. Hogan, Christopher, Lunney, June, Gabel, Jon and Lynn, Joanne. “Medicare Beneficiaries Cost of Care in the Last Year of Life.”

http://content.healthaffairs.org/content/20/4/188.full.Pdf

5. BOOST-Better Outcomes for Older Adults Through Safe Transitions. Mark Williams, MD.


ADDENDUM

• Excerpts from:

   The Revolving Door: A Report on U.S. Hospital Readmissions
   An Analysis of Medicare Data by the Dartmouth Atlas Project: Stories From Patients and Health Care Providers by Perry Undem Research and Communication.
Common Themes

Health Care Providers

• The issue is on their radar.

• Readmissions are complicated.

• There are financial pressures to discharge as soon as possible.

• The quality and training of the providers can make a difference.

• Some hospitals are improving their discharge process and in-hospital experience to reduce readmissions.

• Some hospitals try to avoid readmissions by referring patients to their own outpatient clinics for follow up care.