Exploring an Integrated Clinical Documentation Improvement & Education Program

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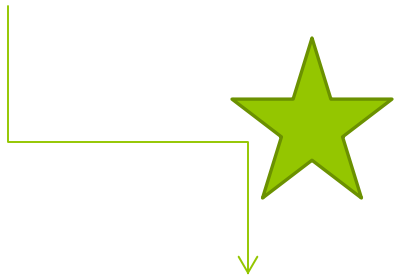
Why have Clinical Documentation Improvement?



- A consistent ‘set of eyes’ on the record
- Concurrent review, with direct feedback
- Concurrence –
  - Handoffs between ED and the hospitalist – pt status
  - Consistency with the ‘reason for admit’ throughout the pt’s stay/story
  - Continuous feedback loop to the provider, nursing and others documenting in the record
  - Detailed, diagnosis to avoid queries
  - A VISION FOR CHANGE…

What efforts are being done to ensure the record can support the pt status and is coded correctly?

- CDI specialist
- Focus: concurrent interaction with providers to ensure co-morbidities and other complications are well documented.
- AND ICD 10 is coming

- UR/Case mgt
- Focus: work to ensure the patient status is correct and supported by the physician's order (and run reports & insurance work & criteria)

Do we have enough resources to do it all well and add charge capture ownership? Any? Or some?

With new challenges and demands on documentation – time to think new, creative (even scary thoughts) = AN INTEGRATED CDI PROGRAM/TEAM APPROACH

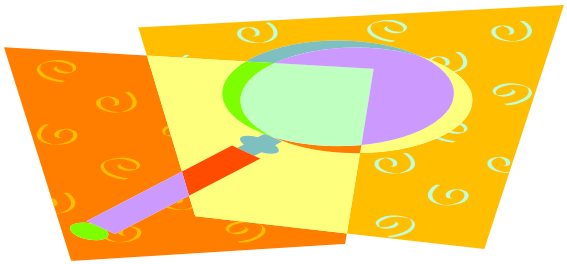
An Integrated CDI Program

LOOKS AT……

Three distinct documentation challenges (Coding/ICD 10, Pt Status and Charge Capture) , incorporate them all into 1 integrated CDI program with focused education for all 'at risk' patterns thru coordinated CDI specialist/trainer(s)

WIN WIN WIN- 1 voice of education with the providers/clinical team

Correct coding	Pt status	Charge Capture
• Coders back end clean up • CDI specialist – front end, more interactive • Tracking and trending patterns?	• UR/Case Mgr – both front end and back end • Auditors – denial /appeals • Tracking and trending patterns?	• Dedicated staff • Internal auditor – only upon request • Few individual depts doing • Tracking and trending patterns?



Let's look at how and why to implement an integrated approach

1) Limited resources and still need to do it 'all'
2) Providers confused, push back, lack of buy in, inconsistent message from multiple staff
3) No effective change in documentation –difficult to sustain – fragmented efforts.
4) Too darn many denials with no change in patterns

Step One: Pt Status

First and Foremost…

- **The 2 MN rule is alive and well**! In effect since Oct 2013. No 'grace period' for compliance. MACs are continuing to audit.
- HR 4302 "Protecting Access to Medicare Act of 2014" signed into law, effective 4-1-14.
- (b) Limitations- the Sec of HHS shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contactors/RAC under section 1893 (h) of the Social Security Act for inpt claims with dates of admission Oct 1, 2013 – March 31, 2015, unless there is evidence of gaming, fraud, abuse of delays in the provision of care by a provider of services.

Complex Denials/Setting

By Dollar 64% of denials =wrong setting

% of Complex Denials for Lack of Medical Necessity for Admission – thru 3rd Q 2013/4th Q 2011- by $$ Impacted	
Syncope and collapse (MS-DRG 312)	15/14/18/14/17/25/21%
Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)	19/17%/19/21/23/24/14%
T.I.A. (MS-DRG 69)	4/0/0/0/0/6/8%
Chest pain (MS-DRG 313)	10/10/10/13/10/9/8%
Esophagitis, gastroent & misc digest disorders w/o MSS (392)	11/13/16/13/10/3/0%
Back & Neck Proc exc spinal fusion w/o CC/MCC (DRG 491)	0/5/5/5/5%//

RAC 2014

AHA RACTrac

RAC Appeals:

3rd Q/2nd Q/1st Q 2013/4th Q /3rd Q/ 1st Q 2012
Value of appealed claims: $1.5B reported thru 3rd . Ave 247 appeals per hospital up to 309 per hospital/3rd Q. Major backlog /3rd Q, 70% of all appeals still pending

	% of denials appealed	% of denials overturned on appeal ¾ still pending…
Region A	41/31/51/ 50/51/41	67/71/79/81/82/ 70
Region B	48/43/45/ 38/39/40	63/77/79/74/82/ 84
Region C	45/39/39/ 39/37/27	67/74/76/75/77/ 79
Region D	47/48/48/ 48/48/43	42/61/60/62/61/ 55
National	47/40/44/ 42/42/34%	63/70/72/72/74/ 75%

RAC 2014

AHA RACTrac

Expanded education on 2 MN & Probe update

- Jan 30, 2014
- CMS updates: “Hospital inpatient Admission Order and Certification”
- Lots of clarity on signatures, verbal, etc.
- www.cms.gov/MEdicare/Medicare-fee-for-service-payment/acuteinpatientPPS/downloads/IP-Certification-and-order-01-30-14.pdf

Jan 31, 2014

- “Extension of the probe and educate period.”
- All elements of no RAC auditing remains/MAC only
- MACS will continue to select claims for review with admission dates between March 31 and Sept 30, 2014 (PROPOSED: Thru 3-15)
- They will continue to deny if found not in compliance.
- Hold educational sessions thru Sept 30,2014 w/hospitals

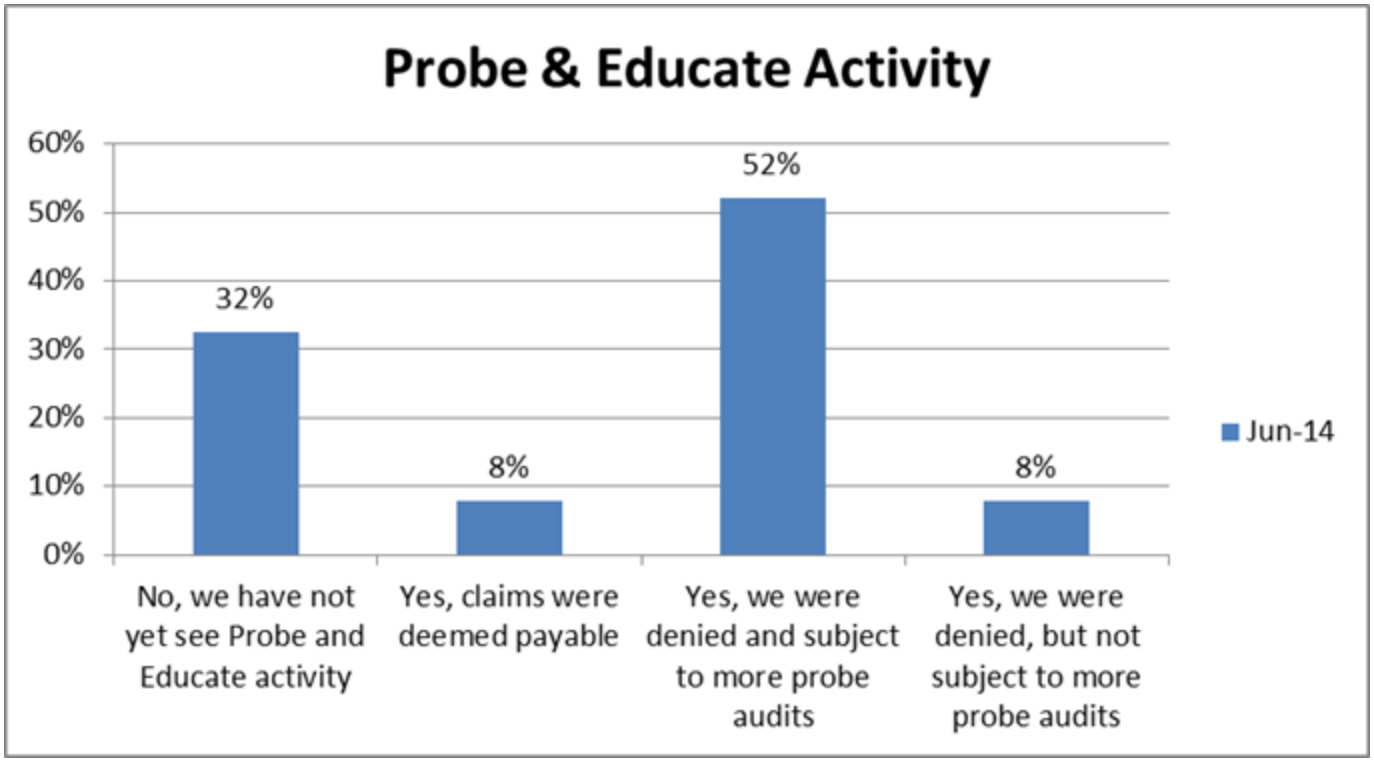
More audit guidance – Probe and Educate expanded thru 10-14

- "CMS will not permit RAC to conduct pt status reviews on inpt claims with dates of admission between Oct 1, 2013-March 31, 2014.(Now Oct1) These reviews will be disallowed PERMANENTLY, that is, the RAC will never be allowed to conduct pt status reviews for claims with DOS during that time period. "
- "In addition, CMS will not permit RAC to review inpt admissions of LESS than 2 MNs after formal inpt admission that occur between Oct 1-March 31, 2014. (update: March 2015)"
- *www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medical-review/inpatienthospitalreviews.html*

MAC Actions Following Patient Status Probe Reviews

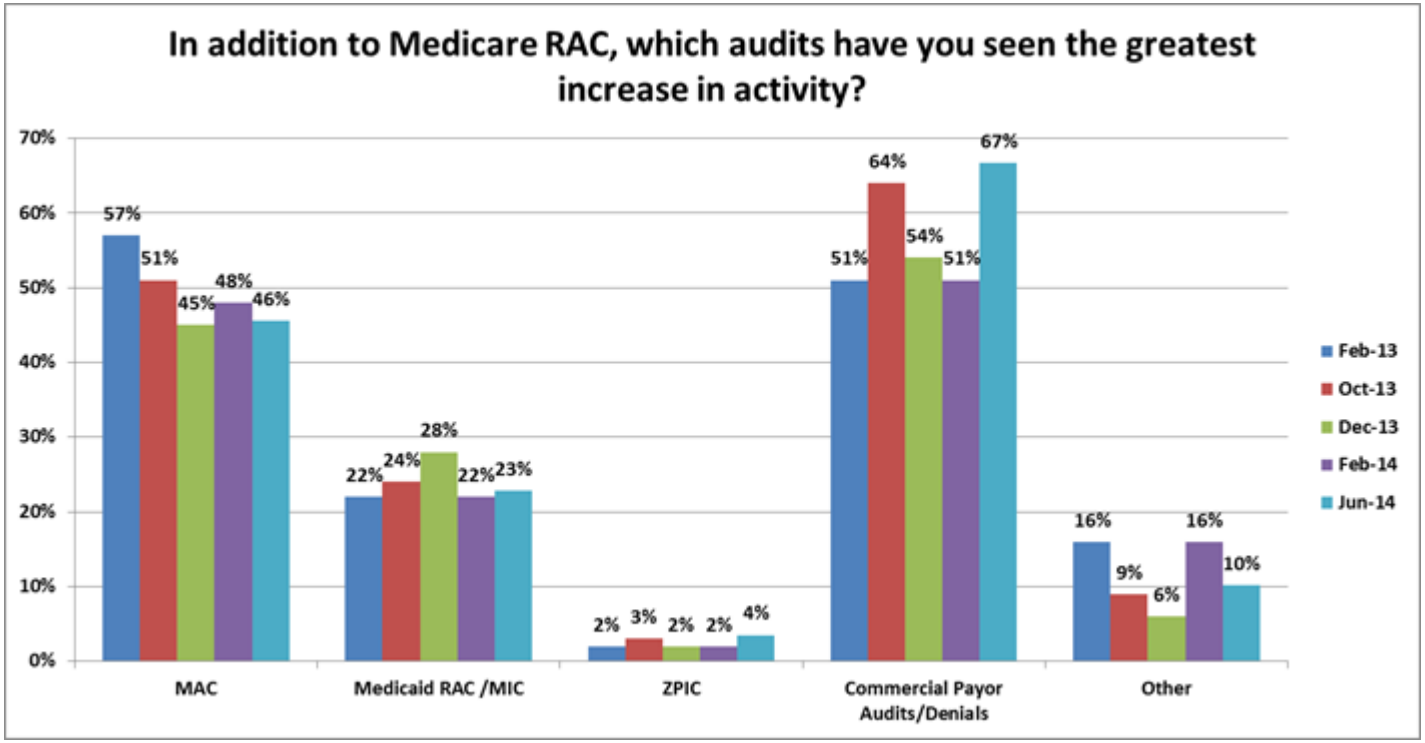
	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concerns	**Moderate to Significant Concerns**	**Major Concerns**
10 claim sample	0-1*	2-6*	7 or more*
25 claim sample	0-2*	3-13*	14 or more*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: 1. Deny non-compliant claims 2. Send summary letter to providers indicating: • What claims were denied and the reason for the denials • That no more reviews will be conducted under the Probe & Educate process. • That the provider will be subjected to the normal data analysis and review process 3. **Await further instruction from CMS**	For each provider with moderate to significant concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014**	For each provider with major concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014** 5. **If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims**

Feedback from attendees at Compliance 360 Webinar



RAC 2013

Results from Feb 14 Compliance 360 Free Webinar – Attacking the 2 MN rule ALL PAYERS ARE AUDITING



RAC 2014

More Updates – OIG work plan 2014

- OIG 2014 work plan
- "New inpt admission criteria"
- "We will determine the impact of new inpt admission criteria on hospital billing, Medicare payments, and beneficiary payments. …determine how varied among hospitals in FY 2014.
- "Context: Previous OIG work found overpayments for short inpt stays, inconsistent billing practices among hospitals and financial incentives for billing Medicare inappropriately. …expected 2 MN = inpt, less than 2 MN= outpt, The criteria represent a substantial change in the way hospitals bill for inpt and outpt stays.:

Key elements of new inpt regulations – 2 methods

- **2midnight presumption**
- "Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

Pg 50959

- **Benchmark of 2 midnights**
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

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- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.

- Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.

Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

Effective 12-1-13: new use of occurrence span code 72

- National UB committee – Occurrence code 72
  First /last visit dates
- *The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) ..... AND*
- *On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11-20-13)*
- *Per George Argus, AHA, a redefining of the existing code will allow it to be used Dec 1, 2013. CMS info should be forthcoming.*
- *MM8586 ML Matters, Jan 24, 2014 CR 8586*

Key areas to support documentation for pt status

- Admitting physician 'starts the pt story' thru use of the certification process – including REASON FOR ADMIT.
- Internal Physician Advisor- trainer/champion, works closely with UR and all providers to ensure understanding/compliance.
- Nursing continues with the care/assessments/interventions relative to the reason for admit.
- UR works with the treating/admitting physician to expand/clarify the documentation at the beginning and conclusion of the patient's stay. Additionally UR closely monitors completion of the certification for ALL payers.
- Integrated CDI continually interacts with providers/nursing to ensure all elements are clear /complete . 1 voice of ongoing education...

Use for both OBS and Inpt – clarification of order and intent. Consistency. SAMPLE

Date/Time	Patient Status	INPATIENT ADMISSION CERTIFICATION
	Date of Service:	Must be completed by provider for Inpatient Admissions
	Check appropriate box for patient status:	**Box A** This patient is admitted for inpatient services. The patient is medically appropriate and meets medical necessity for inpatient admission in accordance with CMS section 42 C.F.R §412.3. I reasonably expect the patient will require inpatient services that span a period of time over two midnights. My rationale for determining that inpatient admission is necessary is noted in the section below. Additional documentation will be found in progress notes and admission history and physical. **Primary Diagnosis**: **Expected Length of Stay: (MEDICARE ONLY)** **Select One:** 2 Midnights (MN) Inpatient 1 MN Outpatient (ER or Obs) and 1MN Inpatient **For Initial Certification (CAH only)** I Expect the Length of Stay to Not Exceed 96 hrs **For Re-Certification** The Length of Stay is Exceeding 96 hrs
	Place in Outpatient Observation Diagnosis:_____ **Reason** for Placement: _____	
	Admit to Inpatient Services (Medical) *PROVIDER MUST COMPLETE CERTIFICATION*	**Plans for Post-Hospital Care:** See Discharge Summary **Supportive Findings to Primary Diagnosis:** [examples: co-morbidities, abnormal findings, diagnostic abnormalities, exacerbations, new onset of disease with_____(co-morbidities)] _____ _____ _____ _____
	Level of Care Acute Care Telemetry **Reason** for Admission: _____	
	Attending Provider (Print Name) (Note: if the ER provider does not have 'admitting privileges, only transitional privileges", important that this include a statement: Spoke with the admitting/attending_____, and we concur with the admission status." ER provider signs.	
	PCP (Print Name)	
	PCP (Print Name) **Provider Signature**	
	Provider Signature **Date/Time**	**Certifying Provider Signature (this 2nd signature required for inpatient admissions as the provider who is directing care.)**
		Date/Time

RAC 2014

Identify ‘place and chase’ with UR

- What are the daily hrs of coverage for UR?
- Is there UR in the ER and if so, hrs?
- Have patterns of poor admission orders and action plan to support both OBS and inpt status been tracked and trended? Discharge challenges included.
- What changes have been made to attack the new 2 midnight Medicare rule? Same for all payers?
- FIND YOUR LOST INPATIENTS!

Step Two: Coding Focus

2) Correct Coding – the 1st time

- CDI concurrently reviews
- Receives ‘problem/concern’ from coders
- Interacts with the providers daily
- Has established relationship
- Eyes of the back end coders
- Reduces queries thru interactive dialogue
- Ongoing education with providers

And then there was ICD -10

- “Easy” ways to show new way of documenting
- Better documentation = ques, auditing to ‘see’ at risk, ongoing support
- Track and trend queries to incorporate into training
- Specialty specific training . EX) Ortho/Jan, ER/Feb, OB/Mar.
- Teach with audited examples, made easy.
- Doctors take lead from hospital = positive message

ICD -10 Continues the Documentation Enhancement Story

- Along with focusing on enhanced documentation to support inpt level of care, the expanded narrative to support ICD 10 conversion continues the story.
- Support team to make this happen:
  Integrated CDI with feedback from coders
  PFS /denial 'busters' with feedback to CDI
  Payer new edits –PFS monitors and advises
  IT with ability to test, submit, and maintain both ICD 9 and ICD 10 post go live.
  Eyes in the record – nursing/24-7.

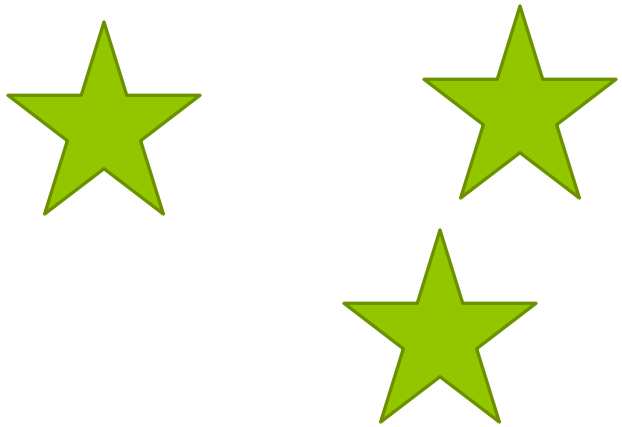
Departments who are impacted by ICD -10 changes

- 1st point of contact =provider offices/dx to get pre-certifications with payers.
- Pre-auth with payers = internal staff, UR
- Medically necessary edit = diagnosis to screen diagnosis against CPT tests to determine if Medicare or other payers will allow. ABN completed with Medicare pts prior to the test.
- Internal IT, scrubber company, payer's IT systems = prior to go live and post go live.
- Concern: Worker's Comp and Liability not covered entities/HIPAA Standard Transaction. Maintain both ICD 9 & ICD10??

More areas impacted by ICD 10

- Lab, Chemo, Imaging, Cardiology, Specialty services = all usually require "medically necessary payer screening" prior to the procedure. Cheat sheets = gone!
- Doctor offices = new encounter forms.
- Rehab = Work comp pre certs. (? ICD 9 & 10)
- PFS = new rejections, new return to provider edits, potential new denials
- HIM/the clean up crew = all payer rejections due to coding, internal issues, more?
- IT decision support = historical to current codes
- Others? = any area tracking by Dx code…more!

Step Three: Charge Capture



Golden rule = Billable service

- Does the order match…
- What was done/documented…
- That matches what was billed?
- Hot spots: protocols, changes from ordering physician by ‘other providers’, lost charges due to lack of ownership.

3) Charge ownership

- Who owns completeness of the charges? Manual and/or electronic?
- Is a daily charge reconciliation process done – aligning orders with charges?
- Is there a dedicated charge capture analyst for certain 'nursing difficulty with accuracy' items – like drug adm in an outpt setting?
- Any known hot spots? (Surgery/Drugs, supplies, pharmacy)

Case Study – how a Midwest health system made it work!

Yeahhooo!!

Mercy HEALTH NETWORK

Sponsored by Catholic Health Initiatives—Englewood, CO and Trinity Health—Livonia, MI

MHN Central Iowa Division Results

15 hospitals in MHN's Central Iowa region participated in Clinical Documentation Improvement Request for Proposal.

15 hospitals very satisfied with results and well on their way to improve documentation and tell the story leading to patient safety, quality, and ultimately appropriate reimbursement

Mercy Health Network

Identified Top Priority among CEO's, CFO's, HIM and Revenue Leaders

Request for Proposal – Team Established to drive proposal

- **We had to get real about our CAH realities and craft a proposal that works for our needs**
- **CDI, HIM, Physicians, Leadership on board for sustainability of program**

Education & teaming –

- **Clinical Leadership – Top success measure**
- **Success Measure - identification of CDI specialist**
- **HIM coders are not the lead CDI specialists**

Program Implementations - Audits – November 2013

- **CDI Specialist Education November 2014**
- **Site visits Leadership, CDI, Nursing, HIM and Physician Education – Dec/Jan 2014**
- **Coding Education - April 2014**

Mercy Health Network

Clinical Leadership in place across network

- **CDI specialists named and working with physicians**

HIM leadership teaming with CDI and providers monthly

- **Review of documentation and practicing transition to ICD10**

Regardless of delay of ICD10, CDI critical to quality and patient safety – continue education path as a network.

- **Sustainability critical to moving to the next level so we practice and make this part of our monthly network meetings for practice**

Feedback from hospitals

- **Excellent program design focused on improving CDI, coding, physician understanding and adoption. Well positioned for future transition.**

Audit current inpt and obs:

1) Patient Status – Inpatient vs. Observation.

- Audit of existing documentation to determine current understanding of documentation requirements – for the physician as well as nursing. With the new definition of an inpt, this type of auditing and education is timely and critical.

2) Audit for at risk ICD -10 coding

- Audit up to 5 records for all providers
- Identify audit sample from a) high volume, b) known weak documenting providers, c) coder feedback d) ICD -10 major change areas.
- ICD -9 validate while performing ICD -10 readiness , provider/patient specific.

Audit order to documentation to UB 04/billing document:

3) Charge capture

- Audit of existing 'hot spot' departments – surgery, ER, observation – with a focus on identifying under charges as well as over charges that includes 'challenges of orders matching what was done and billed.
  - Line item audit to match order to documentation to UB

Next – Share results from Audits, UR and Coder Feedback – Sr leaders buy in

- Time to do education with impacted areas
- Physician, nursing, dept heads = all owners of an integrated CDI program
- No final decision yet on how to integrate – just learning the current processes

Finally – brainstorm how to move to 1 consistent message of education

- Leadership facilitates the brainstorming session –sharing the goal:
  - To create a single, integrated system of CDI specialists within the organization.
  - To create a consistent message of how to fix what was broken from the audits- coding/ICD 10, pt status, charge audits.
  - To create a single, training message to providers with the 'pearls' from all the audits (as providers are the key in most audits)
  - To ensure no silos exist within the organization

EXCITING Kick Off Education with audit results – who of the UR , CDI, case mgt or others are the best trainers for the integrated team?

- Within a very short time frame, create a timeline for a 1 day kick off. (All CDI team = 1 trainer/mgs)
- Incorporate:
  - Kick off Physician education:
    - "What are documentation standards and why do I care" –with EASY to implement documentation tools
    - "Attacking the challenges of inpt vs obs- why is it so hard?" -with the tools for enhancing the patient story.
    - Determine if 'ensuring the order matches what was done' requires a formal class or individual physician education but share the 'big message' of the facility's commitment to CDI…

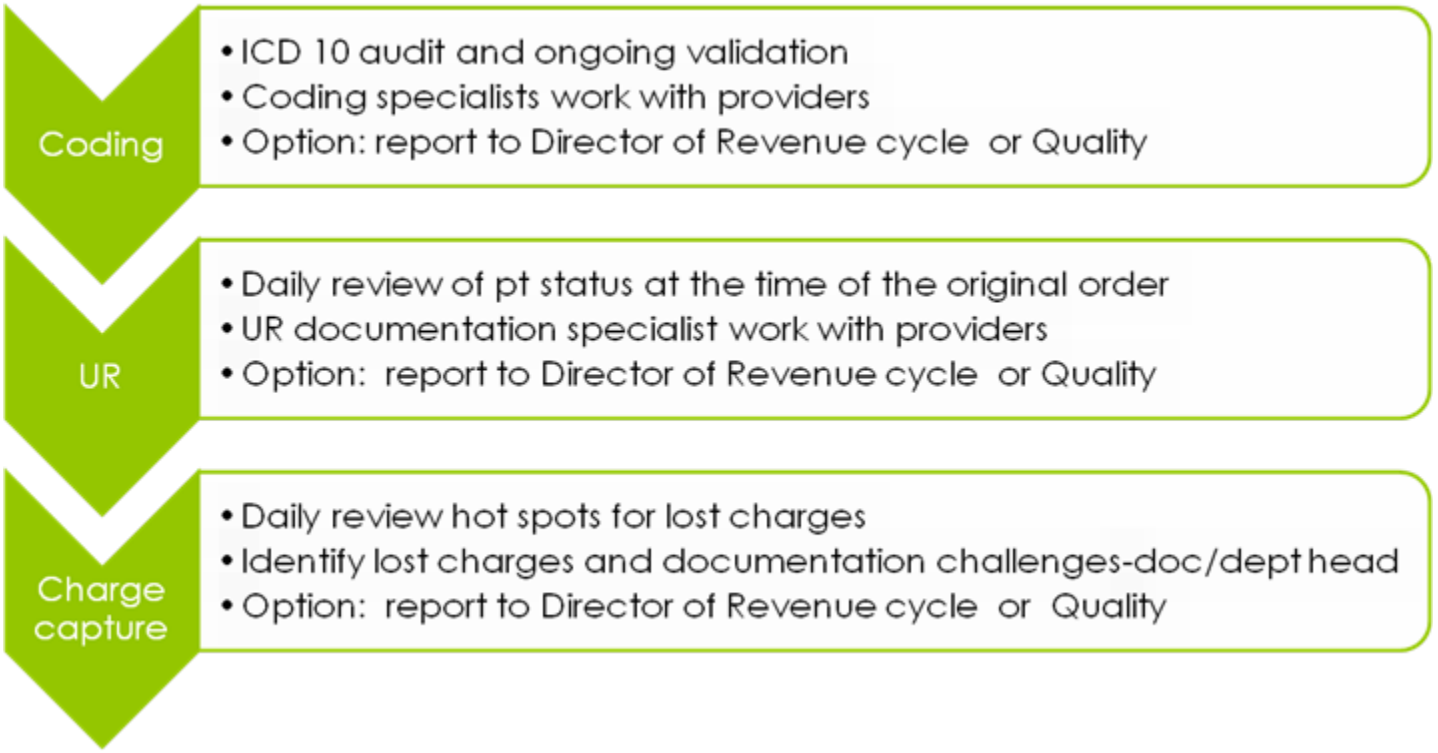
And additional clinical education

- **Nursing, nursing, nursing…. Has been left out of significant documentation training.**
- Ensure the audits include nursing's role in enhancing the pt story. (Obs, inpt)
- Ensure nursing understands how they can compliment the work of a dedicated CDI specialists – they are the eyes of the record 24/7 with immediate alerts.
- Other hot departments? Ensure they meet with the CDI team to determine –next steps.

Ongoing physician education looks like….

- Integrated CDI team (UR and Coders) and/or (UR, coders, charge capture) meet frequently to discuss – what is broken?
- Develop training outlines to address 'roll out' of pearls of training .
- EX) **ICD 10**- March/focus on ER; April/focus on Cardio; May/focus on Ortho with follow up by ALL the team on a daily basis
- EX) **Inpt status** – Dec/focus on Inpt certification form
- EX) **Chrg capture-** Jan/focus on protocols ordered specific to the pt.

Last step: Explore changing reporting relationships while consolidating into 1 **clinical-focused** educational voice



Doing nothing …is not an option. Be creative in attacking the challenges of documentation to support billable services.

It is darn fun! Move forward with a new, dynamic approach to a challenging environment.

PS Don't' forget those pesty EMR's too…they can help with creating 'coaching/ques/queries/forms" – all tools.

GO TEAM! THANKS A TON

Thanks for a fun training time!

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Hey join us for the RAC Summit Nov. 13-14, 2014
RACSummit.com

New web:http://arsystemsdayegusquiza.com

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