CDI SUMMIT: Leading the Documentation Journey

VBP, HAC, PSI....Oh My! The Pre-Bill Review Gives Focus to CDI

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AHIMA Approved ICD-10-CM/PCS Trainer
Vice President, Huff DRG Review
Objectives

• Understand the importance of the pre-bill review as the foundation for impacting change with a CDI program.
• Demonstrate the impact of the pre-bill review on the CDI program, physician education, and quality metrics reinforced by a physician advisor program.
• Take away a methodical approach for a customized infrastructure.
TODAY’S HEALTHCARE

Ambulatory

Inpatient (Acute)

Post Acute

CURRENT CDI FOCUS
• **Inpatient**
  
  – MSDRG
  – CC/MCC Capture
  – Medicare Predominance
  – Limited Focused Quality Reviews (Mortality, PSIs, HACs)
  – Education (Physician Advisor)
  – ICD -10 ?
Tomorrow’s Continuum

- Patient
- Cost Reduction
- Healthcare Spending

Quality of Care (Life Expectancy)

Quality Improvement
CDI is a “team sport”

Successful programs are dependent upon engagement and participation by all team members
CDI: Preparing for Tomorrow

Ambulatory  Inpatient  Post Acute

Patient Centered Around Episodes of Care
Value Based Purchasing Performance Shift

1.75% Reduction in Total Medical $$

Source: cms.gov
Physician Value Based Purchasing

Merit-based Incentive Payment System (MIPS)

• Replaces SGR (performance 2017)
• Composite performance score that determines provider’s reimbursement rates
• Four performance categories:
  1. Quality (PQRS, VBM)
  2. Resource Use (VBM)
  3. Meaningful Use (EHR)
  4. Clinical practice improvement activities

At RISK: up to 9% of Total Medicare $$
Incentive: 27%
The Impact

Care Continuum  Physicians

Medical Necessity
Case Management
CDI
Case Mix
Revenue
Profiling
Quality
Quality of Care & Risk Adjustment (HCCs)
Recovery Audits

Mortality & Re-admissions
HACs
PSI
Core Measures
HCCs

P
A
T
I
E
N
T

VBP
MIPS
ACO
The Pre-Bill Review
Pre-Bill: CDI Life Cycle

Establish Focus (Screens)

CDS Concurrent Review

CDS, Coder, Physician Advisor & Medical Staff Education

PRE-BILL

Analysis

Reconciliation

Coder, Quality Team, & Physician Advisor

CDS, Coder, Physician Advisor & Medical Staff Education

PRE-BILL
A Methodical Approach

- Focused Review of Documentation (Continuum)
- Involve Physicians /CDI
- Specialty Specific

- Peer Education
- Physician Advisors
- Competitive Data
- Mobile Technology

- Analysis (Clinical)
  - Financial Accuracy
  - Quality / Risk
  - Length of Stay

- Align with Specialty
  - “What’s missing”
  - Trend Analysis to Refine

A Methodical Approach

13
Where to Start ----> Plan

• Strategize and Set Objectives Based on Existing Data
  – CC/ MCC Capture rates for all MS-DRGs
  – MSDRG Frequency and Impact by Facility
  – Risk Adjustment (Conditions Categories)
  – APR-DRG Severity Assessment
  – Quality Focus: Mortality, Patient Safety Indicators, Healthcare Acquired Conditions, Readmissions
  – Compliance Risk
  – ICD-10 Documentation Gaps (including changes in impact of diagnoses)
  – Explore the Ambulatory setting with Hierarchical Condition Categories (HCCs)
• Assemble team (Coders, CDI, Physician Advisors)
DO: 30-Day Analysis

- Initial review of Medicare sample with future goal of all charts and payers (Sample size depends on maturity of program).

- Pre-bill post discharge with 24-hr. turnaround minimizes impact on DNFB, but attainment of wealth of information.
Initial Analysis Defines Future Focus

- Ambulatory and Post Acute Care
- Healthcare Acquired Conditions
- Patient Safety Indicators
- Specificity for Severity and Risk
- MSDRG Validation

American Health Information Management Association®
Study: Initial Pre-Bill Discoveries

• Coding and Documentation Data
  – Incorrect diagnosis and procedure code assignment
  – Overlooked opportunities regarding application of coding guidelines
  – Opportunities for specification of physician documentation for conditions suggested by clinical indicators
  – Compliance risks including code assignment but also conditions documented that lack clinical validity
  – Errors in coding complications of medical or surgical care
  – Lack of specific documentation that impact inclusions and exclusions from quality metrics
  – Missed opportunities for maximizing risk and severity
  – Need for ambulatory review to establish admission source, long term risk and care
## Opportunities for Refinement

<table>
<thead>
<tr>
<th>Account#</th>
<th>Change</th>
<th>Coding Issue</th>
<th>Issue</th>
<th>Query</th>
<th>Facility Coder</th>
<th>Physician ID</th>
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<tr>
<td>12345678</td>
<td>FYI</td>
<td>ac renal failure, KDIGO</td>
<td>CC</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
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<tr>
<td>12345678</td>
<td>Increase</td>
<td>functional quad, cdI query- severe maln</td>
<td>MCC</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
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<td>severe maln</td>
<td>MCC</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
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<tr>
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<td>dec ulcer, stage 3</td>
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<td>DOCTOR</td>
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<td>MCC</td>
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<td>DOCTOR</td>
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<tr>
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<td>DOCTOR</td>
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<tr>
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<td>Increase</td>
<td>met enceph</td>
<td>MCC</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
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<tr>
<td>12345678</td>
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<td>esrd, bacterial endocarditis, ac resp failure</td>
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<td>CODER</td>
<td>DOCTOR</td>
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<tr>
<td>12345678</td>
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<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
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<tr>
<td>12345678</td>
<td>Decrease</td>
<td>iatrogenic hypotension</td>
<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
<tr>
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<td>Increase</td>
<td>late effect of cva</td>
<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
<tr>
<td>12345678</td>
<td>Increase</td>
<td>severe maln, ileus</td>
<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
<tr>
<td>12345678</td>
<td>FYI</td>
<td>aki, kdigo</td>
<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
<tr>
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<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
<tr>
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<td>FYI</td>
<td>sepsis poa</td>
<td>PDX</td>
<td>Y</td>
<td>CODER</td>
<td>DOCTOR</td>
</tr>
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</table>
# Study: Initial Pre-Bill Discoveries

## 30-Day Assessment Financial Impact

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total # of charts</strong></td>
<td>205</td>
<td>238</td>
<td>465</td>
<td>1006</td>
<td>284</td>
<td>100</td>
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<tr>
<td><strong>Increase Reimbursement</strong></td>
<td>$165,351</td>
<td>$115,315</td>
<td>$181,512</td>
<td>$826,892</td>
<td>$152,569</td>
<td>$66,727</td>
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<tr>
<td><strong>Compliance Adjustment</strong></td>
<td>$41,120</td>
<td>$49,315</td>
<td>$53,593</td>
<td>$278,178</td>
<td>$89,609</td>
<td>$17,051</td>
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<tr>
<td><strong>ROI</strong></td>
<td>934%</td>
<td>572%</td>
<td>400%</td>
<td>954%</td>
<td>646%</td>
<td>853%</td>
</tr>
</tbody>
</table>

*Source: American Health Information Management Association®*
ACT: Pre-Bill Drives Education

• Coding education yields quality data.

• Clinical coding seminars integrate coding and CDI to improve compliance as well as recognition of opportunities for specificity.

• Physicians play integral role to bridge gap of care delivery with the coding database.

• Pre-bill allows for formalization of an educational process which fosters the development of standard clinical topic references for continued reinforcement through newsletters and query references.

• Fortifying the CDI team with evidence based clinical knowledge escalates the level of communication with the medical staff, which in turn supports a long-term successful relationship.
Act: Targeting Physician Education

- Physician documentation central to 4 P’s
- Peer-to-peer specialty directed education
- Clinical trend analysis from pre-bill directs concise education
- Organize by service line with unique approach for hospitalists for a comprehensive framework as opposed to “nuts and bolts” for medical and surgical specialties
- Extend into ICD -10 CM/PCS documentation issues with specialized task force
### Specialty Specific Focused Education

#### Dr Bone Documentation Analysis

<table>
<thead>
<tr>
<th>DRG</th>
<th>Procedure Issue</th>
<th>Diagnosis Issue</th>
<th>Documentation Element Omitted</th>
<th>DRG Impact</th>
<th>Possible Delay of Billing</th>
<th>Coding Impact Only</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>*</td>
<td></td>
<td>Amputation procedure location</td>
<td>None</td>
<td></td>
<td>*</td>
<td>give location of amputation as (high, mid, low)</td>
</tr>
<tr>
<td>240</td>
<td>*</td>
<td></td>
<td>Amputation procedure location</td>
<td>Impact: DRG 240 = if osteomyelitis is due to diabetes (circulatory) with BKA DRG 617 = if osteomyelitis is due to diabetes (metabolic) with BKA DRG 475 = if osteomyelitis not linked to diabetes with BKA * it is no longer assumed to be linked if patient has both conditions, so must state relationship</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>link between CM and osteomyelitis</td>
<td></td>
<td></td>
<td></td>
<td>give location of amputation (high, mid, low) possible connection between DM and osteomyelitis</td>
</tr>
<tr>
<td>240</td>
<td>*</td>
<td></td>
<td>Skin ulcer depth</td>
<td>Potential: DRG 617 = Diabetic (metabolic) PDX with amputation of foot or toe DRG 256 = Diabetic (circulatory) PDX with amputation of toe DRG</td>
<td>*</td>
<td></td>
<td>Please indicate the severity of ulcers. E.g. necrosis muscle, fat layer, bone or limited to skin breakdown. For &quot;transmetatarsal&quot; amputations, specific &quot;rays&quot; should be documented, e.g 1st ray - 5th ray. The exact location of the amputation along the foot should be noted because locations proximal to the metatarsal-phalangeal joint are &quot;foot&quot; and distal to the metatarsal-phalangeal joint are &quot;toe&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Foot and toe amputation site</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
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</tbody>
</table>
Targeted Approach Yields Demonstrable Benefits

Concurrent Query Impact
Pre-Bill Impact (Final)
Total CDI Program Impact

Q1 Q2 Q3 Q4 YTD
Targeted Approach Yields Demonstrable Benefits

**Physician Response**

- **Response Rate**
- **Agree Rate**

- Q1
- Q2
- Q3
- Q4
- YTD

- 100%
- 95%
- 90%
- 85%
- 80%
Expand Education: Train a Physician Advisor

• A physician advisor program is pivotal in solidifying the outcomes of a successful relationship between the CDI team and the medical staff.
• A physician advisor will enhance other physicians’ clinical understanding, while at the same time, provide expert opinion regarding clinical validity assessments and query development for the CDI team.
• Specialty-specific “line of service” leaders will impact the area of quality outcomes and ICD 10-CM/PCS unique to their specialty.
Who is the Best Physician Advisor?

- Broad clinical knowledge base
- Respect from medical staff or “clout”
- Ability to effectively communicate with physicians and non-physicians
- Availability
Success Hinges on Role of Advisor

• Liaison between CDI team and medical staff
• Attain specificity while educating other physicians on key issues as well as CDI team
• Query validation and development consistent with best clinical practice and evidence based
• Peer-to-peer mediation with explanation of global and individual impact of documentation
• Facilitate ongoing education with medical staff
Success Hinges on Role of Advisor

• With comprehensive training, long term influence on:
  – MS-DRG validation
  – Risk adjusters for 30-day mortality, 30-day readmission, Patient Safety Indicators, etc.
  – APR-DRG risk of mortality and severity of illness
  – DRG adjustments by outside reviewers
  – ICD-10 clinical validation and medical staff education
  – Extend into ambulatory setting with HCCs and CPT
Hard Work Pays Off: Physician Advisor Training

• Amass the fundamentals through comprehensive study:
  – Inpatient Prospective Payment System
  – Quality including risk adjustment
  – Ambulatory
  – Post Acute Care
  – Fundamentals of Physician Advisor Role

• Ongoing maturation with integration into pre-bill review
Integrating the Physician Advisor into Pre-Bill Review

• Benefits:
  – Ground level chart review solidifies the understanding of the disconnect with documentation for patient care and accurate coding
  – Direct individualized education for colleagues peer to peer reinforcing the CDI team’s credibility
  – Fosters regular reconciliation of the CDI initiative achieving complete and accurate documentation
  – Integration of the pre-bill process within the CDI team and the physician advisor training has reinforced the realized benefits regarding improvement in case mix index, quality metrics, and severity of illness justified by a continued return on investment.
Full Integration of Pre-Bill: Case Mix Impact

500 Acute beds
11,575 Medicare Discharges

Chart Review
Physician Advisor Training
Medical Staff Education

Concurrent Documentation Program

Added Reimbursement $18.1 Million Annually
Experience Benefits of Physician Advisor and CDI

APR-DRG Risk of Mortality: Mortality Index Increase Over 2 year period (Medicare Only)
Experience Benefits of Physician Advisor and CDI

APR_DRG Severity of Illness: Severity of Illness Increase Over 2 Year Period

Severity Index

Severity 1
Severity 2
Severity 3
Severity 4

Yr.1 A
Yr.1 B
Yr.2 A

23% 21% 19%
45% 43% 40%
27% 29% 31%
5% 7% 10%
Physicians Enhance Benefits of Pre-Bill

- Specialized Audits Utilizing Similar Methodology and Educational Approach
  - Patient Safety Indicators (PSIs)
  - Hospital Acquired Conditions (HACs)
  - Risk Adjustment for 30-day Readmissions and 30-day Mortality
  - Risk Adjustment for Physician Value Based Payment
  - Incorporate ICD -10 into Physician Workflow
Outcome Measures: Value Based Purchasing

Outcome Measures for FY 2015

1. AHRQ (PSI-90) Patient Safety for Selected Indicators (composite)
2. CLABSI Central Line-Associated Bloodstream infection
3. MORT-30-AMI Acute Myocardial Infarction (AMI)
4. MORT-30-HF Heart Failure (HF)
5. MORT-30-PN Pneumonia (PN)
### Patient Safety for Selected Indicators (PSI-90)

<table>
<thead>
<tr>
<th>PSI 03 – Pressure Ulcer Rate</th>
<th>excludes: hemiplegia, monoplegia, neurogenic bladder, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 06 – Iatrogenic Pneumothorax Rate</td>
<td>excludes: pleural effusion</td>
</tr>
<tr>
<td>PSI 07 – Central Venous Catheter-Related Bloodstream Infection Rate</td>
<td>excludes: immunocompromised state (cancer [present or past history]), neutropenia, severe malnutrition, etc.</td>
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<tr>
<td>PSI 08 – Postoperative Hip Fracture Rate</td>
<td>excludes: PDx of syncope, CVA, dementia, etc., or any diagnosis of MS system, e.g. osteoporosis</td>
</tr>
<tr>
<td>PSI 12 – Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate</td>
<td>excludes: PDx of PE or DVT</td>
</tr>
<tr>
<td>PSI 13 – Postoperative Sepsis Rate</td>
<td>excludes: PDx of infection or immunocompromised state (cancer [present or past history]), neutropenia, severe malnutrition, etc.</td>
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<tr>
<td>PSI 14 – Postoperative Wound Dehiscence Rate</td>
<td>excludes: immunocompromised state (cancer [present or past history]), neutropenia, severe malnutrition, etc.</td>
</tr>
<tr>
<td>PSI 15 – Accidental Puncture or Laceration Rate</td>
<td>excludes: spinal surgery</td>
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</table>
## Patient Safety Indicators Audit

<table>
<thead>
<tr>
<th>PSI</th>
<th>Rate</th>
<th>Cases</th>
<th>Exclusion (potential)</th>
<th>Adjusted Rate</th>
<th>Median</th>
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<tbody>
<tr>
<td>-02</td>
<td>0.83</td>
<td>2</td>
<td>1</td>
<td>0.41</td>
<td>0.00</td>
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<tr>
<td>Death in low MR DRGs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-03</td>
<td>0.97</td>
<td>4</td>
<td>2</td>
<td>0.48</td>
<td>0.00</td>
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<tr>
<td>Pressure ulcers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-04</td>
<td>142.01</td>
<td>24</td>
<td>3</td>
<td>124.26</td>
<td>117.65</td>
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<tr>
<td>Surgical Deaths w treatable compls.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-09</td>
<td>2.59</td>
<td>11</td>
<td>3</td>
<td>1.89</td>
<td>1.71</td>
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<tr>
<td>Postop hem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-11</td>
<td>13.03</td>
<td>26</td>
<td>11</td>
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<td>22</td>
<td>2</td>
<td>4.71</td>
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<td>Postop PE/DVT</td>
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<td>-15</td>
<td>2.49</td>
<td>32</td>
<td>5</td>
<td>2.10</td>
<td>1.80</td>
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<tr>
<td>Acc. Puncture</td>
<td></td>
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Pre-Bill: Your ICD-10 Success

• Reinforce and Monitor Recent Training
• Identify Documentation Gaps
• Incorporate Findings into Education plan ASAP
• Specialty Specific Peer-to-Peer Utilizing Service Line Leaders and Advisors
• Allows for Preparation and Alignment for ICD-10 integrated into Pre-Bill and CDI focus
Longevity: Prioritize Physician Queries

• Accuracy of payment
• Validate POA status for Hospital Acquired Conditions
• Severity of illness / Risk of Mortality
• Risk adjustment for outcome analyses
  1. 30-day mortality
  2. 30-day readmission
  3. Patient safety indicators
  4. Cost per beneficiary analyses

Querying merely for coding specificity that has no significant impact can be problematic
The Future is Upon Us

• Fiscal Responsibility
• Transparency with Accountability
• Quality Driven Care
• Physician Centric with Documentation as Source
• The Pre-bill drives local reform......
Pre-Bill: Wheels of Change
QUESTIONS?

THANK YOU!

JAMES.FEE@DRGREVIEW.COM