



Clinical Documentation for Value-based Reimbursement

Why It Takes a Village to Ensure Success

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LIKE IT OR not, the transition to value-based healthcare is well underway. In January 2015, the Department of Health and Human Services (HHS) announced its Better, Smarter, Healthier campaign with clear goals and a timeline for shifting Medicare reimbursement from volume to value. Through a variety of programs, HHS set a goal of tying 85 percent of all traditional Medicare reimbursement to quality or value by 2016, and 90 percent by 2018.

Providers, payers, and patients alike are working towards the same three-fold vision as stated by the campaign's October 2015 update: incentivize quality of care over quantity of services, promote coordination and integration, and share health information.¹

So far, the industry is ahead of schedule as verified by HHS's March 2016 announcement.² But what is the impact of value-based reimbursement on health information management (HIM) and clinical documentation professionals? This article outlines immediate impacts for health information workflow and physician relationships within the era of pay for performance. It also lays out three practical steps for hospitals and health systems to move closer to value-based care.

From Jog to Sprint

In the years to come, the gradual jog toward value-based payments will likely become more of a sprint. Physician documentation will play an even bigger role in four areas: capturing patient severity, identifying risk, justifying resources, and demonstrating outcomes. Organizations must ensure their clinical documentation accurately reflects the care provided across the continuum—or run the risk of jeopardizing their reimbursement.

This monumental change in reimbursement methodologies has direct implications for HIM workflow. Organizations that weather the storm successfully will be those that make a concerted effort to integrate coding, quality, and clinical documentation improvement (CDI) with the goal of complete and accurate clinical documentation for every patient, every encounter, every claim.

It will take an entire team of professionals to drive the changes necessary to be successful under value-based reimbursement models. Collaboration is the key, with these initial priorities:

- CDI spearheads documentation improvement across all care settings.
- Coding professionals apply consistent coding guidelines and establish stronger communication with non-acute care peers.
- Quality teams ensure best clinical practices are met during encounters and monitor patient outcomes post-discharge.
- Revenue cycle tracks costs across the entire care episode (i.e., pre-admission to post-discharge).
- Executive leadership seeks out important care affiliations and partnerships to integrate and share patient information.

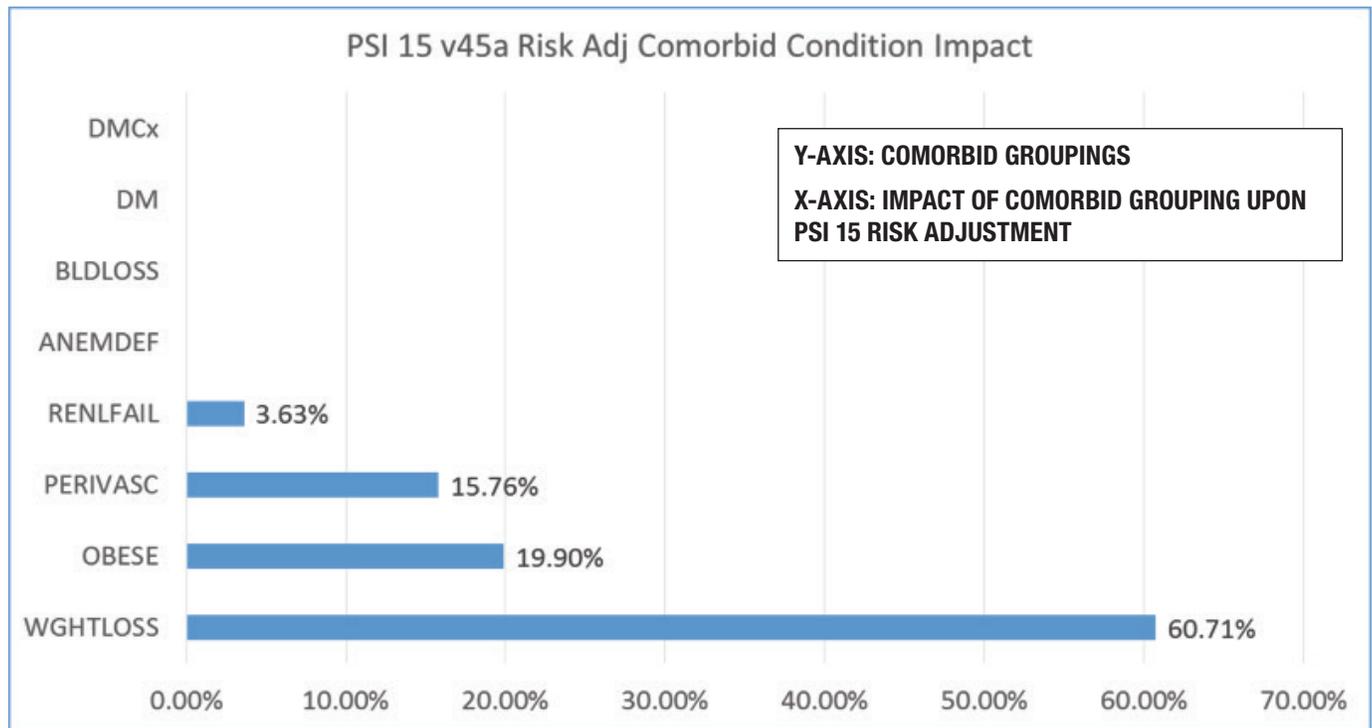
Consider taking the following three steps now to run smarter and more efficiently in the race toward value-based care.

CDI Looks Beyond CCs and MCCs

In value-based reimbursement models, complications and comorbidities (CCs) and major complications and comorbidities (MCCs) aren't the only determining factors for reimbursement.

Example of Risk Adjustment Variables that Impact PSI 15 (Accidental Puncture or Laceration Rate)

Top 90 percent variables with highest weight that risk adjust PSI 15



Value-based outcome measures play a role as well. As CDI programs continue to mature, they must expand beyond CC/MCC capture to include diagnoses that affect patient risk and cohort definitions. Even if certain diagnoses don't affect MS-DRGs directly, chances are likely that these diagnoses do affect risk adjustment for quality measures that impact payment.

Tip for collaboration: gather coding, CDI, and quality teams together to review Centers for Medicare and Medicaid Services (CMS) methodology for value-based outcomes. Note that this methodology differs from APR-DRG methodology used regularly by many CDI and quality professionals to calculate severity of illness and risk of mortality. For example, although obesity has a minimal impact in the APR-DRG system, it has a significant impact on PSI 90, making it critical to capture, document, and code this condition correctly.

PSI 90 is included in both the Hospital Acquired Condition (HAC) Reduction Program and the Hospital Value-Based Purchasing Program. Initially developed by the Agency for Healthcare Research and Quality (AHRQ) and subsequently modified by CMS, PSI 90 is a weighted composite of eight patient safety indicators and provides information on potential in-hospital complications and adverse events during surgeries and procedures. It reflects quality of care delivery with an emphasis on potentially avoidable complications and iatro-

genic events.

To prioritize time and resources, take a targeted approach to quality-driven CDI. Focus on diagnoses that feed the MS-DRG but also have a positive effect on quality reporting (i.e., define cohorts and patient risk). Then gradually expand beyond this list to ensure the most accurate and complete record possible.

Coded Data Accurately Reflects Clinical Processes

Consider claims-based PSI 7 (central venous catheter-related bloodstream infection rate). The denominator for this measure includes all medical and surgical patients. The numerator includes patients with a central venous catheter-related bloodstream infection. To ensure the ratio reflects the population measured, CDI specialists must strive to risk-adjust all patients—not only those who have a central venous catheter-related bloodstream infection.

However, it's equally important to ensure the cohort is defined correctly for the measure. Exclusions take the patient out of the denominator for the measure. To do so, CDI and quality teams must work together to specify the following information so coding professionals can report the most accurate codes:

- Central-line vs. mid-line insertion—the codes differ for these procedures, and only a central-line bloodstream in-



fection is included in the numerator of PSI 7.

- Bloodstream infection vs. another type of infection—exit or insertion site, tunnel, or localized. For example, the presence of cellulitis (a localized infection) without an associated bloodstream infection would not trigger PSI 7. Is the cellulitis due to the catheter? Is code assignment reflective of the documentation? Is the cellulitis documented and coded appropriately?
- Type of encounter—initial, subsequent, or sequela. Note that subsequent and sequela encounters for the bloodstream infection aren't currently included in the numerator for PSI 7.
- Presence of any exclusions—does the patient have neutropenia, pancytopenia, or representative of an immunocompromised state? If so, the case is excluded from PSI 7. When appropriate, CDI specialists must clarify the clinical significance of any abnormal lab values.

Tip for collaboration: coded data determines whether a case is included or excluded in a particular quality measure. This requires coders and CDI specialists to work closely with the quality team to ensure documentation is aligned with clinical proto-

cols and provider processes.

For example, consider a concurrent review process for all central-line bloodstream infections to establish severity and risk. Also perform a second-level review prior to billing (post-discharge) to ensure accurate cohort inclusion/exclusion. The second-level review should include quality, coding, CDI, and a physician advisor. Did the encounter meet the inclusion or exclusion criteria correctly? Is the case risk-adjusted to the fullest extent possible?

Also, the team must remember that as the CDI program matures, the goal is to target risk adjustment for all patients in the measure—not just those that have a central-line associated bloodstream infection.

Redesign Workflows with Value in Mind

As organizations strive to improve documentation for quality measures, they'll also reap the rewards of more accurate coding and reimbursement. Opportunities for clinical process improvement will arise.

Consider malnutrition, a CC. In addition to driving the MS-DRG, malnutrition also affects risk adjustment. To ensure accurate reimbursement and outcomes reporting, CDI, quality,

and coding teams can work together to implement process- and documentation-related triggers.

For example, nursing assessments that reveal a 10 percent weight loss should immediately trigger a physician review. Physicians can then validate this information and order a dietary assessment. Not only does this help improve the care of the patient, it also improves the likelihood of accurate coding.

Tip for collaboration: bring coding, quality, information technology, and the care team (nutrition, wound care, physical therapy, etc.) to the table to identify ways in which the organization can use technology to enhance efficiencies and redesign workflows. What diagnoses could benefit from clinical process improvement while also impacting value-based payments? Malnutrition, central-line insertions, and wound care are just a few examples.

Data is the Driver

When it comes to integration, the time to act is now. Today's data drives tomorrow's reimbursement. Inaction will undoubtedly yield significant financial penalties for organizations whose data indicates poor outcomes. In fact, it's not unrealistic for some facilities to project a five-year loss of \$6 million to \$8 million.

If these facilities don't act now to drive greater integration this projected loss will only increase. Ask this question: What story does your data tell? And how can coding, quality, and CDI work together to improve it? Your bottom line—and perhaps even your patients—will thank you for it in the future. ●

Notes

1. Assistant Secretary for Public Affairs. "Moving Toward a Better, Smarter Health Care System With an Engaged and Empowered Consumer at the Center." HHS.gov. October 23, 2015. www.hhs.gov/healthcare/facts-and-features/fact-sheets/moving-toward-better-smarter-health-care-system.html.
2. Department of Health and Human Services. "HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule." Press release. March 3, 2016. www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html.

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