Ambulatory Clinical Documentation Improvement: A Peer-to-Peer Discussion
July 17, 2018
Noon – 1:00 PM

Welcome! The webinar will begin shortly.
For audio: Use your computer speakers or call (213) 929-4221 and enter code 466-143-008.

WHILE WE WAIT... PLEASE TYPE IN THE CHAT BOX:

1. Questions for your peers around aCDI
2. What are some success stories you can share?
Stay in Touch

Subscribe to our monthly e-newsletter to get info about upcoming webinars and events

text MHACO to 22828
Today’s Webinar: Please Ask Questions!

Type your question in the chat box

Raise your hand and we’ll unmute you

Click the icon to raise your hand.
After the Webinar

• Please take our quick survey.

• Before the end of this week, all attendees and registrants will receive an email with slides attached and a link to the webinar recording.
Objectives

➢ Provide background and rationale for ACDI

➢ Discuss scenarios and examples

➢ Connect around questions, challenges, successes

➢ Open forum
Why is Documentation Important?

For Patients

• Unlocks health plan benefits based on severity of condition:
  o No-cost preventive services and care management
  o Lower or waived co-pays for some medical services

For Providers

• Better communication with care team
• Better performance on quality measures
• Incentive revenue available to fund practice resources
• Impacts data used for public reporting
Why is Risk Important?

**PROVIDER VIEW**
RAF SCORE 3.41

**CMS VIEW**
RAF SCORE 0.59

Completely documenting and accurately coding allows the payers to see the full picture of your patients health status.
Why is Risk Important? Example...

**SITUATION:**
76 year old male who is both Medicare and Medicaid eligible with Diabetes, Vascular Conditions and CHF.

Assume patient has $19,000 dollars in medical expenses for services that you and your facilities (hospitals, labs, specialist) receive for providing care to this individual.

How does coding accuracy impact diagnosis and quality and potential shared savings?
Let’s Look at Notes…

64 Year old disabled female patient with Type II diabetes and Diabetic Chronic Kidney Disease. Patient has congestive heart failure and Stage IV Chronic Kidney Disease (GFR 64 ml/min Filtration). Patient is obese, with a BMI of 56.0, is on insulin and is paraplegic. Patient is on Medicaid.

CODING IS OFTEN GENERIC AND UNSPECIFIED...THIS DOES NOT ACCURATELY REFLECT THE COMPLEXITY OF THE PATIENT
Getting Better…

64 Year old disabled female patient with Type II diabetes and Diabetic Chronic Kidney Disease. Patient has congestive heart failure and Stage IV Chronic Kidney Disease (GFR 64 ml/min Filtration). Patient is obese, with a BMI of 56.0, is on insulin and is paraplegic. Patient is on Medicaid.

1.08

ADDING IN THE CODING FOR THE SPECIFIC DIABETES TYPE, AND THE CKD STAGE ALMOST DOUBLES THE RAF SCORE
Best...

64 Year old disabled female patient with Type II diabetes and Diabetic Chronic Kidney Disease. Patient has congestive heart failure and Stage IV Chronic Kidney Disease (GFR 64 ml/min Filtration). Patient is obese, with a BMI of 56.0, is on insulin and is paraplegic. Patient is on Medicaid.

Reflects optimal and specific coding for the complexity of this patient.
## Comparing Notes…

<table>
<thead>
<tr>
<th>1. No Conditions Coded (Example Patient seen for only acute visits)</th>
<th>2. Some Conditions Coded with Poor Specificity (most common)</th>
<th>3. All Conditions Coded Appropriately (Ideal State)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year female</td>
<td>76 year female</td>
<td>76 year female</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
</tr>
<tr>
<td>Diabetic not Coded</td>
<td>DM w/o CC, 0.181 (HCC 19)</td>
<td>DM w/ vascular CC, 0.608 (HCC 15)</td>
</tr>
<tr>
<td>Vascular disease not Coded</td>
<td>Vascular Disease w/o CC, 0.324 (HCC 105)</td>
<td>Vascular Disease w/ CC, 0.645 (HCC 104)</td>
</tr>
<tr>
<td>CHF not Coded</td>
<td>CHF not Coded</td>
<td>CHF (HCC80), 0.395</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>No Disease Interaction</td>
<td>Disease Interaction, 0.204</td>
</tr>
<tr>
<td>Total RAF</td>
<td>Total RAF, 1.15</td>
<td>Total RAF, 2.497</td>
</tr>
<tr>
<td>PMPM Payment</td>
<td>PMPM Payment, $863</td>
<td>PMPM Payment, $1,873</td>
</tr>
<tr>
<td>Annual CMS Payment to Plan</td>
<td>Annual CMS Payment to Plan, $10,350</td>
<td>Annual CMS Payment to Plan, $22,473</td>
</tr>
</tbody>
</table>
The Big Picture

$32,726

Payer

MHACO
Your Organization
Patient

$5,741

Payer

MHACO
Your Organization
Patient

OPTIMAL CODING

GENERIC CODING

MaineHealth
Accountable Care Organization
Pieces of the Puzzle

An example of reports that can be provided:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Payer Source</th>
<th>PCP</th>
<th>DOB</th>
<th>Total RAF</th>
<th>Coded RAF</th>
<th>Risk Opportunity</th>
<th>Category Count</th>
<th>Last PCP Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>66</td>
<td>66</td>
<td>61</td>
<td>86</td>
<td>68</td>
<td>86</td>
<td>2.98</td>
<td>2.98</td>
<td>1/15/2017</td>
</tr>
<tr>
<td>61</td>
<td>86</td>
<td>68</td>
<td>97</td>
<td>86</td>
<td>68</td>
<td>86</td>
<td>2.98</td>
<td>2.98</td>
<td>1/15/2017</td>
</tr>
<tr>
<td>86</td>
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<td>68</td>
<td>86</td>
<td>68</td>
<td>86</td>
<td>2.98</td>
<td>2.98</td>
<td>1/15/2017</td>
</tr>
</tbody>
</table>

- What does this tell you?
  - How would you use it?
  - Is it helpful?
A Provider’s Perspective

Patient List for one payer; 34 patients total

At this point, a list can seem overwhelming. But…

Same Patient list; removed the closed opportunities and any visit from 2018; 11 patients remain

Reviewed schedule found Patient in red was coming in for an Office Visit
Pre-visit Planning – A Suggestion

*Look ahead* (Monthly/Quarterly)

*Do these patients have an upcoming appointment?*

**Yes**

Document the GAP in the upcoming appointment notes, and/or on a “sticky note” in the patient chart.

**No**

Plan your next steps (OUTREACH):
- call for appointment?
- send a letter?

Who will do this?
By when?
Let's Talk About aCDI

- What has your experience been?
- What are your challenges?
- Is your organization working on any implementation/improvement currently?
- What would you like to see from the ACO / your peers / other?
Contact Info/Questions

MaineHealth Accountable Care Organization:

- www.mainehealthaco.org

Jennifer Tardif, CPC, Provider Relations Manager – jtardif@mmc.org

Regina Quattrucci, Improvement Advisor – rquattru@mmc.org
aCDI Survey

MaineHealth ACO is asking for your assistance. We are fully invested in helping ambulatory practices and providers succeed in their Clinical Documentation Improvement efforts by developing educational materials and trainings. To ensure those materials and trainings are useful and appropriate as possible, we’d like your help in understanding what your practice’s current level of familiarity is with certain aspects of aCDI.

Please take the aCDI survey that will be sent to your practice the week of July 23rd. We are looking for a physician, manager and another staff member to complete the survey. The survey only takes 5 minutes to complete.

Please complete the survey by 08/03/2018

Thank you for taking the time to complete the survey.
The Big Picture

REIMBURSEMENT

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

+/- Maximum Adjustments

-4% -5% -7% -9%

+4% +5% +7% +9%

Adjusted Medicare Part B payment to clinician

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)

The potential maximum adjustment % will increase each year from 2019 to 2022.

REPUTATION

Performance Categories

- Quality
- Improvement Activities
- Cost
- Advancing Care Information

- Your coding will impact the claims data used by CMS to produce your publicly reported performance.
- CMS uses risk scores to adjust several reimbursement programs.
Provider Resource

**M.E.A.T. - criteria to substantiate coding:**

- **Monitor** — signs, symptoms, progression or regression
- **Evaluate** — review results, medication, and response to treatment
- **Assess/Address** — order tests, discussion, review records, counseling
- **Treat** — refer, prescribe, modalities, therapies, plan surgery

(1 element required per DX code; more is better)

These four factors help providers to establish the presence of a diagnosis due to ensure proper documentation. For medico-legal purposes, complete documentation of a diagnosis that is, "if it was not documented, it does not exist".

Review problem list, document as ‘current’ or ‘active’

Do not use ‘history of’ for chronic conditions unless issue is fully resolved or asystole

Avoid use of acute diagnoses after initial onset/diagnosis

For success with documentation, clinicians should make sure it adheres to M.E.A. M.E.A.T. is not documented to validate the diagnosis, the diagnosis will be rejected lack of evidence by provider. The following is an example of supported documentation: Congestive Heart Failure (CHF) – 150.3, symptoms well controlled with Lasix and continue current medications

**L.O.S.T. — commonly overlooked diagnoses to consider**

- **Limbs** — hemiplegia, amputation, paralysis status
- **Organs** — dialysis status, transplant status, respiratory failure
- **Secondary DX** — diabetic nephropathy + chronic kidney disease stage IV, use language that ties conditions together (because of, related to, secondary to)
- **Tubes and Tummy** — any ‘...ostomy’, morbid obesity
- **Other conditions** commonly lost: alcohol/substance abuse, AIDS or HIV, mental health severity and status

**Document anything that impacts your medical decision making** to reflect the complexity and level of care provided. Documentation improves care, coverage, costs, and compliance.
Provider/ Staff Resources

- Education

- Utilize patient Gap Lists provided by ACO in order to identify future opportunities
  - Coordinate with Leadership, Quality, and Care Teams to determine how the information will be most useful

- Use of AWV Smart Set in Primary Care Practices using EPIC