MaineHealth
Accountable Care Organization

Three Simple Ways to Improve Clinical Documentation

A Clinical Documentation Improvement Training for MaineHealth ACO Participating Providers

2018/2019

Welcome!

- Today's speakers have no financial relationships or affiliations to disclose.
- Review of this presentation fulfills the MaineHealth ACO's requirement that all participating providers attend a training on ambulatory clinical documentation improvement.
- To record your attendance, complete the evaluation after the presentation.
- NOTE: To receive CME, completion of post-test is also required.

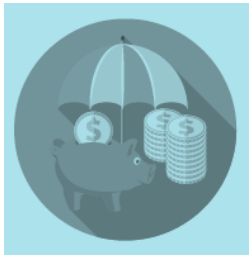
What is the MaineHealth ACO?

A network of providers who:

- Coordinate the care of individuals

- Manage the health of populations

- Are compensated for value



- Ultimately, keep patients and communities healthy

MaineHealth ACO Priorities

Achieve the Quality Top 10

Focus on the 10 highest-impact quality measures

Manage Utilization & Costs

Reduce ED visits and avoidable admissions/readmissions

Accurately Represent the Health of Patients

Improve clinical documentation in the ambulatory setting

Supporting the success of practices and providers

1. Achieve the Quality Top 10

Provide improvement support through

- On-site training
- In-person, online and peer-to-peer learning opportunities
- Develop reports on gaps in care that identify specific improvement opportunities

2. Manage Utilization & Costs

- Increased and improved care management of high-risk patients
- Spread of care coordination best practices (post-acute care, etc.)
- Introducing effective protocols (HF, EOL, etc.)
- Data reports that identify specific improvement opportunities

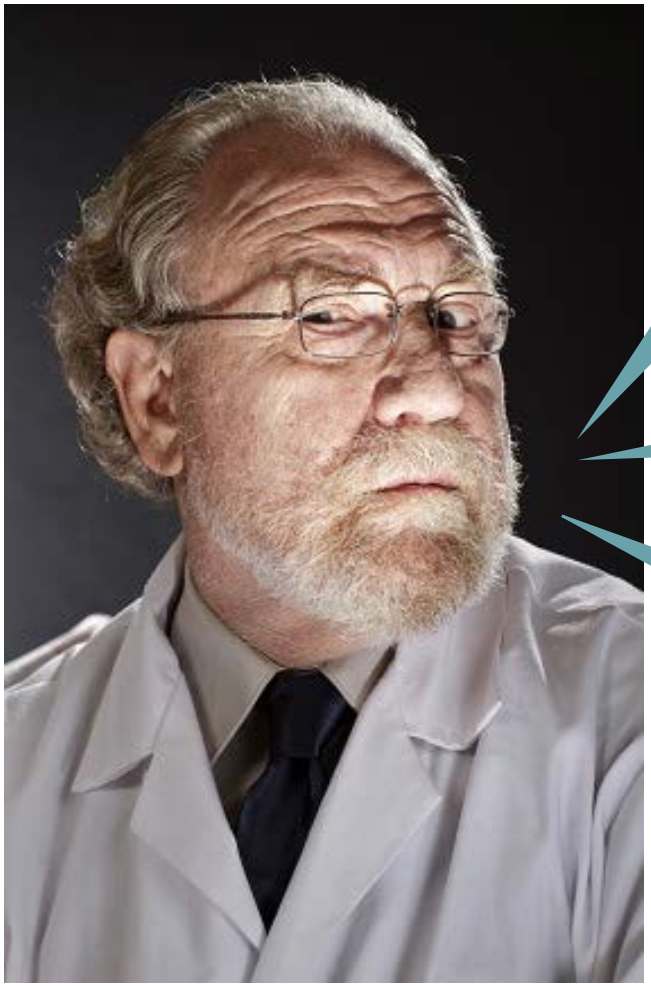
3. Accurately Represent the Health of Patients

- Clinical documentation improvement training
- Medicare Annual Wellness Visit workflows and training
- Provision of reports to highlight opportunities for clinical documentation

Take note!

- What we're discussing today **IS NOT** about CPT codes.
- It **IS** about recording the true nature and acuity of patients' conditions using the most specific ICD-10 diagnosis code.

The Inner Skeptic



I am paid to be a doctor- not a coder

This is busy work that only benefits the insurance company

I just want to care for my patients

Why do we care about clinical documentation?

Recording the true nature and acuity of a patient's condition leads to many positive outcomes.

The **patient** gains access to resources and preventive care services that are based upon his or her disease acuity.

The **care team** becomes better informed, making more confident care decisions and improving coordination.

The cost benchmarks that **providers** must meet become more realistic and attainable.

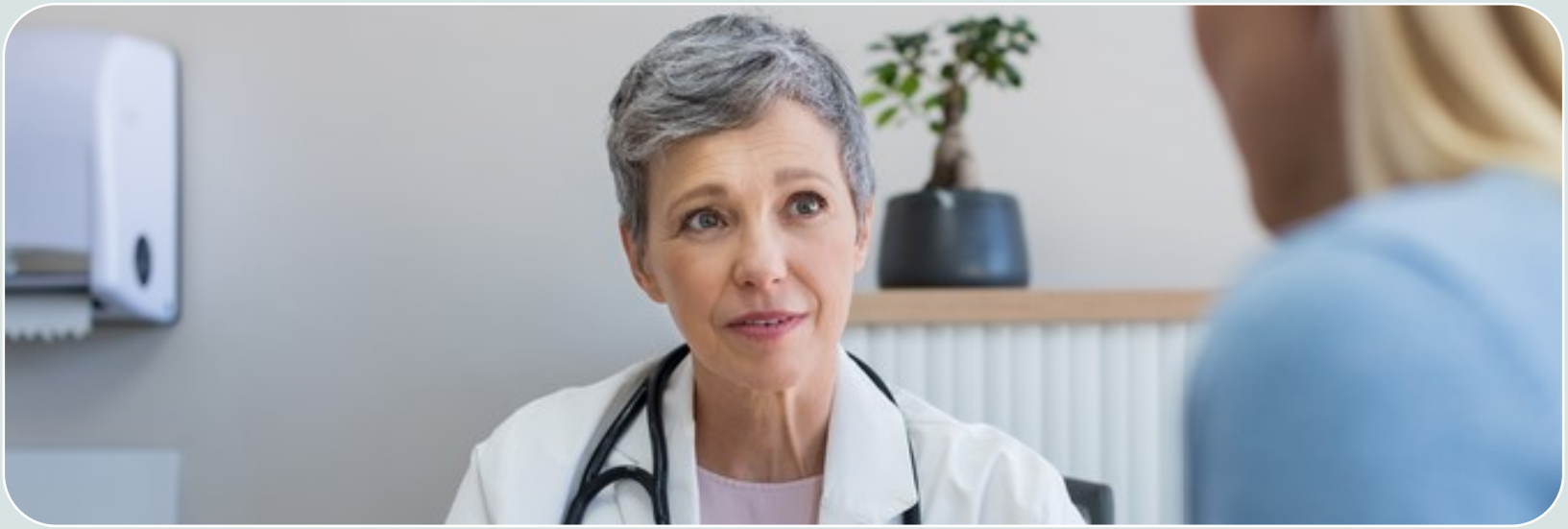
Why do we care about clinical documentation?

The **patient** gains access to resources and preventive care services that are based upon his or her disease acuity.

Why do we care about clinical documentation?

The **care team** becomes better informed, making more confident care decisions and improving coordination.

Why do we care about clinical documentation?



The cost benchmarks that **providers** must meet become more realistic and attainable.

The Impact of Clinical Documentation: A tale of two Risk Adjustment Factor (RAF) scores

NON-SPECIFIC CODING		SPECIFIC CODING	
ICD 10 Code	**RAF***	**ICD 10 Code**	**RAF***
Demographic RAF	**0.395**	Demographic RAF	**0.395**
E11.9: Type 2 diabetes mellitus without complications	0.104	E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease	0.318
N18.9 Chronic kidney disease, unspecified	0.000	N18.4: Chronic kidney disease, stage 4	0.237
E66.9: Obesity unspecified	0.000	E66.01: Morbid Obesity	0.273
F32.8: Other depressive epsiodes	0.000	F32.1: Major depressive illness, single episode, moderately severe	0.395
I25.9 Chronic ischemic heart disease, unspecified	0.000	I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	0.140
Total	0.499	**Total**	1.758
***Payment Year 2017, Average Total RAF FFS Medicare is 1.000*			

Source: *Keeping it Real – Success through Documentation*, Haydar & Hemphill, MMP, presented 4.11.17

Same patient, different scores, dire consequences

Three simple ways to improve clinical documentation

1. Start with chronic conditions

2. Record the most specific diagnosis and update problem list accordingly

3. Review diagnoses annually

1. Chronic conditions

High impact conditions	
1. DM with Comp	6. Rheumatoid Arthritis
2. Specified Heart Arrhythmias	7. Major Depression
3. COPD	8. Metastatic Cancers
4. Vascular Disease	9. Morbid Obesity
5. CHF	10. Amputations

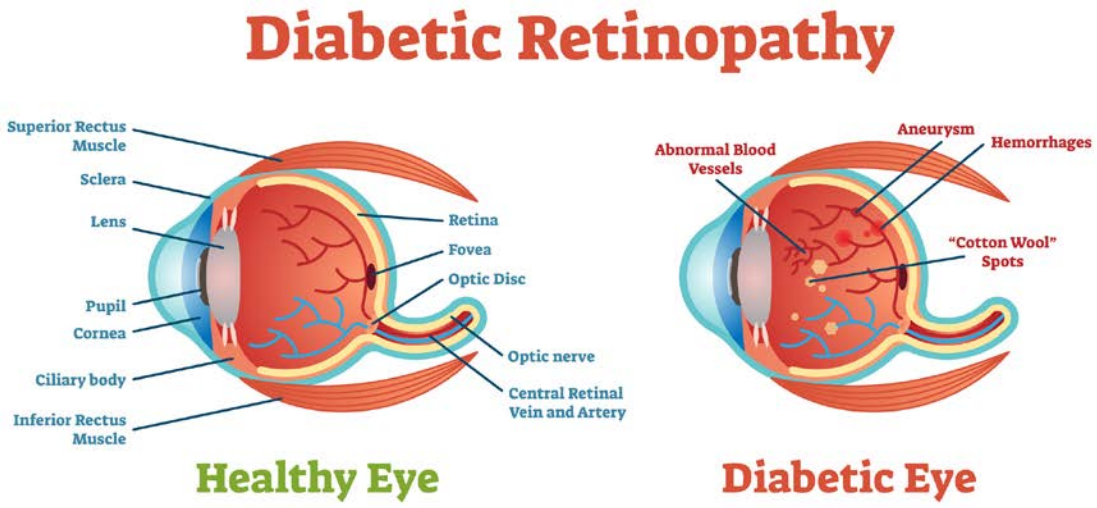
Source: NAACOS recommended prevalent HCC

2. Specific diagnosis

Diabetic Patient with retinopathy.

E10.9- Diabetes w/o complication

E11.359- DM type 2 with Prolif Retinopathy



3. Update documentation annually

photo credit James St. John

Action you can take tomorrow . . .

- Focus on chronic conditions.
- Use the most specific diagnoses to document the true nature and acuity of conditions.
- Review your problem list and update diagnoses.

. . . and in the near future

- Use Annual Wellness Visits (AWVs) as an opportunity to update problem list to the most specific chronic diagnoses.
- Urge your practice manager to complete and submit an action plan to the ACO Network team.

Recap

High impact conditions	
1. DM with Comp	6. Rheumatoid Arthritis
2. Specified Heart Arrhythmias	7. Major Depression
3. COPD	8. Metastatic Cancers
4. Vascular Disease	9. Morbid Obesity
5. CHF	10. Amputations

Contact info

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APPENDIX

Example Action Plan

Ambulatory Clinical Documentation Action Plan Form

Organization/Practice Information						
Organization/Practice Name:						
Tax ID:						
Organization Type (select all that apply):	Primary Care	Specialty	Multi-Specialty			
Address:						
City:		State:		Zip Code:		
Primary Contact Information (for questions, follow up, general communications)						
Name:						
Title/Role:						
Phone:		Email:				
Action Plan Details related to how your practice will be improving clinical documentation						
Action Plan Start Date:		Action Plan End Date:				
Describe Goal / Desired Outcome:						
If focused on a segment of your patient population, describe:						
Describe the activities that took place to execute this plan:						

Ambulatory Clinical Documentation Action Plan Form (cont.)

How did you measure progress?
What resources were required? Did you have adequate resources to manage this project? If no, explain what was needed and not available:
What were your final outcomes?
Do you feel your plan was successful? Please explain.
What did you learn from your action plan? These learnings may be shared with other ACO participants.

Please attach any additional descriptions or supporting information that you feel will aid in the review process.

Case Study 1

BEFORE

DOS: 02/24/17

Name: Patient One **DOB:** 01/04/1951

Chief Complaint & HPI

- 66 year old male here for routine follow-up visit with known history of diabetes and major depression

Past Medical History

- DM, Neuropathy, MDD, Congestive Heart Failure, Traumatic toe amputation (2011)

ROS

- No current complaints

Vitals

- Ht. 64 in, Wt. 240 lbs, BMI: 42.5 kg/m2

Exam

- General Appearance: Patient is obese
- ENMT: Normal
- Abdomen: Soft, no abdominal tenderness Heart: RRR,
- Lower Extremities: Reveals decreased sensation, great toe amputation

Assessment/Plan

1. DM II - Stable, continue current treatment plan
2. Major Depression - Stable, continue treatment plan

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Case Study 1

AFTER

DOS: 02/24/17

Name: Patient One **DOB:** 01/04/1951

Chief Complaint & HPI

- 66 year old male here for routine follow-up visit presents with ~~known history of~~ diabetic neuropathy, ~~and~~ major depression and CHF

Past Medical History

- DM, Neuropathy, MDD, Congestive Heart Failure, Traumatic toe amputation (2011)

ROS

- No current complaints

Vitals

- Ht. 64 in, Wt. 240 lbs, BMI: 42.5 kg/m2

Exam

- **General Appearance:** Patient is morbidly obese
- **ENMT:** Normal
- **Abdomen:** Soft, no abdominal tenderness Heart: RRR,
- **Lower Extremities:** Reveals decreased sensation, left great toe amputation

Assessment/Plan

1. Diabetic Neuropathy - Stable, continue current treatment plan
2. Major Depression, Mild Severity - Stable, continue treatment plan
3. Morbidly Obese with BMI 42.5 - Counseled on diet and exercise
4. Congestive Heart Failure - Stable, continue treatment plan

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Case Study 1

RAF Impact - For Illustrative Purposes Only

Code assignments based on conditions documented in first case study			
Condition	**I-10**	**HCC**	**Factor***
66 year old, male	--	--	0.300
DM Uncomplicated	E11.9	19	0.104
Major Depression	F32.9	n/a	--
Obesity	E66.9	n/a	--
BMI 42.5	Z68.41	22	0.273
Great Toe Amputation	Z89.419	189	0.588
		Total RAF	1.265

Code assignments based on more specific documentation in first case study			
Condition	**I-10**	**HCC**	**Factor***
66 year old, male	--	--	0.300
Diabetic Neuropathy	E11.40	18	0.318
Major Depression, Mild	F32.0	58	0.395
Morbid Obesity	E66.01	22	0.273
BMI 42.5	Z68.41	22	above
Left Great Toe Amputation	Z89.412	189	0.588
Congestive Heart Failure	I50.9	85	0.323
+ Disease interaction factor with DM & CHF			0.154
		Total RAF	2.351

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Case Study 2

BEFORE

DOS: 05/9/17

Name: Patient Two **DOB:** 05/29/1949

Chief Complaint & HPI

- 67 year old male with a history of Crohn's disease present for follow-up. Pt notes recent, persistent diarrhea, and weight loss.

Past Medical History

- Prostate cancer, migraines

ROS

- **GU:** admits urinary frequency, no hematuria
- All other systems negative

Vitals

- Ht. 72 in, Wt. 129 lbs.

Exam

- **General Appearance:** Patient with abnormal weight loss of 28 lbs. since office visit in January
- **GI:** Abdominal tenderness and pain noted, pain assessed at 4/10

Assessment/Plan

1. Crohn's – Current therapy is not providing sufficient control, adding to current medication regimen
2. Suspect Malnutrition – Nutritional supplements/Ensure recommended
3. Requesting follow-up in two weeks

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Case Study 2

AFTER

DOS: 05/9/17

Name: Patient Two **DOB:** 05/29/1949

Chief Complaint & HPI

- 67 year old male with ~~a history of~~ Crohn's disease present for follow-up. Pt notes recent, persistent diarrhea, and weight loss.

Past Medical History

- ~~Prostate cancer,~~ migraines

ROS

- **GU:** admits urinary frequency, no hematuria
- All other systems negative

Vitals

- Ht. 72 in, Wt. 129 lbs, BMI 17.5

Exam

- **General Appearance:** Patient is underweight with abnormal weight loss of 28 lbs. since office visit in January
- **GI:** Abdominal tenderness and pain noted, pain assessed at 4/10

Assessment/Plan

1. Crohn's – Current therapy is not providing sufficient control, adding to current medication regimen
2. ~~Suspect~~ Mild Malnutrition – Nutritional supplements/Ensure recommended
3. Prostate Cancer – continue injections, followed by oncology
4. Requesting follow-up in two weeks

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Case Study 2

RAF Impact - For Illustrative Purposes Only

Code assignments based on conditions documented in first case study			
Condition	**I-10**	**HCC**	**Factor***
67 year old, male	--	--	0.300
Crohn's disease	K50.90	35	0.294
Abnormal Weight Loss	R63.4	--	--
Note: Cannot code suspected conditions			
		Total RAF	0.594

Code assignments based on more specific documentation in first case study			
Condition	**I-10**	**HCC**	**Factor***
67 year old, male	--	--	0.300
Crohn's disease	K50.90	35	0.294
Mild malnutrition	E44.1	21	0.545
BMI 17.5	Z68.1	---	---
Prostate cancer	C61	12	0.148
		Total RAF	1.287

Source: Medicare Risk Adjustment and Documentation Guidance presentation, Anthem, fictitious patient

Cardiac HCC

I00-I60	Circulatory System - Cardiac		
I11.0	Hypertensive Heart Disease w failure	HCC85	.351
I21-	STEMI and non-STEMI MI	HCC87	.246
I20.0	Unstable Angina	HCC87	.246
I20.9	Angina Pectoris, unspec	HCC88	.134
I27.81	Cor Pulmonale, chronic	HCC85	.351

ICD-10	DiagDescr	HCC	Coef
I42.9	Cardiomyopathy, unspecified	HCC85	.351
I47.1	Supraventricular Tachycardia	HCC96	.281
I48.91	Atrial Fibrillation, unspecified	HCC96	.281
I49.5	Sick Sinus Syndrome	HCC96	.281
I50.9	CHF, unspecified	HCC85	.351
I50.30	Diastolic Heart Failure, unspecified	HCC85	.351

Diabetic HCC

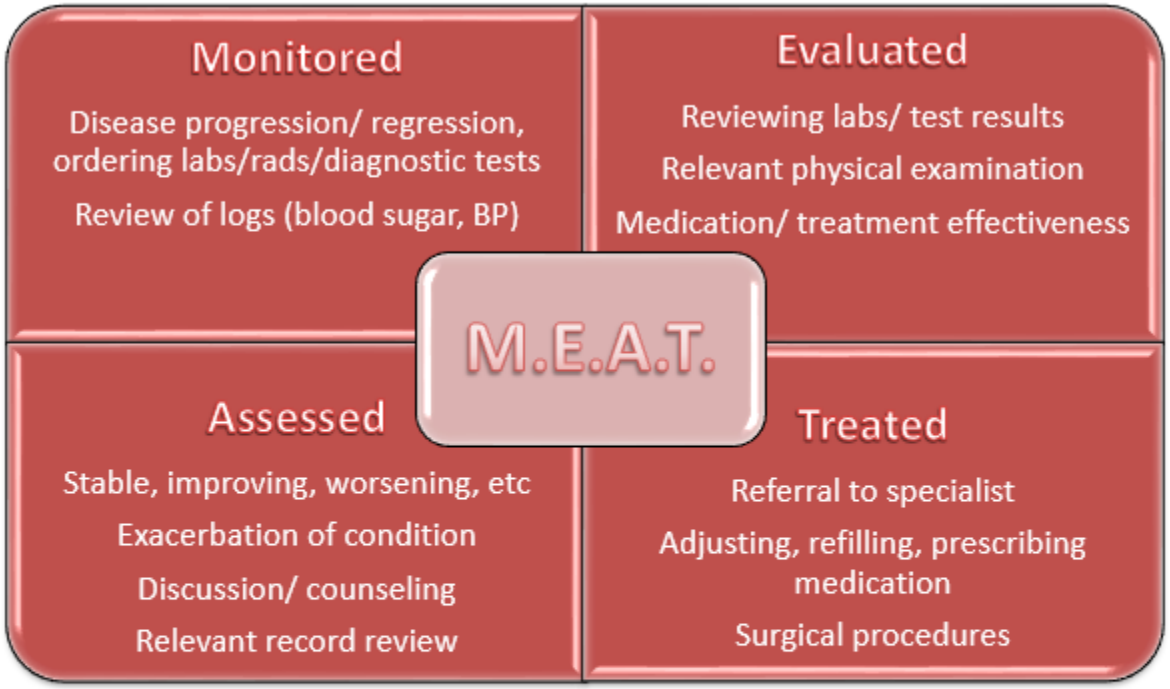
E00-E89	Endocrine		
E10.9 / E11.9	DM w/o Complication (Type 1/Type 2)	HCC19	.113
E11.22	DM Type 2 w diabetic CKD	HCC18	.351
+N18.4	CKD Stage 4	HCC137	.214
+N18.5	CKD Stage 5	HCC136	.214
+N18.6	End-Stage Renal Disease	HCC136	.214
+N18.9	CKD Unspecified	HCC136	.214
E11.42	DM Type 2 w Polyneuropathy	HCC18	.351

ICD-10	DiagDescr	HCC	Coef
E11.40	DM Type 2 w Unspecified Neuropathy	HCC18	.351
E11.43	DM Type 2 w Gastroparesis	HCC18	.351
E11.329	DM Type 2 w Mild non Prolif Retinopathy	HCC18	.351
E11.359	DM Type 2 w Prolif Retinopathy	HCC18	.351
E11.51	DM Type 2 w Periph Angiopathy w/o gangrene	HCC18	.351
E11.59	DM Type 2 w other Circulatory Complication	HCC18	.351
+I73.9	Periph Vasc Disease	HCC108	.285
E11.621	DM Type 2 w Foot Ulcer	HCC18	.351
+L97.4-	also code site of ulcer	HCC161	.511
+L97.5-		HCC161	.511

ICD-10	DiagDescr	HCC	Coef
E21.0	Primary Hyper-Parathyroid	HCC23	.234
E20.9	Hypo-Parathyroid	HCC23	.234
E21.5	Parathyroid Disorder NOS	HCC23	.234
E24.9	Cushing's Syndrome, unspecified	HCC23	.234
E27.1	Addison's Disease	HCC23	.234

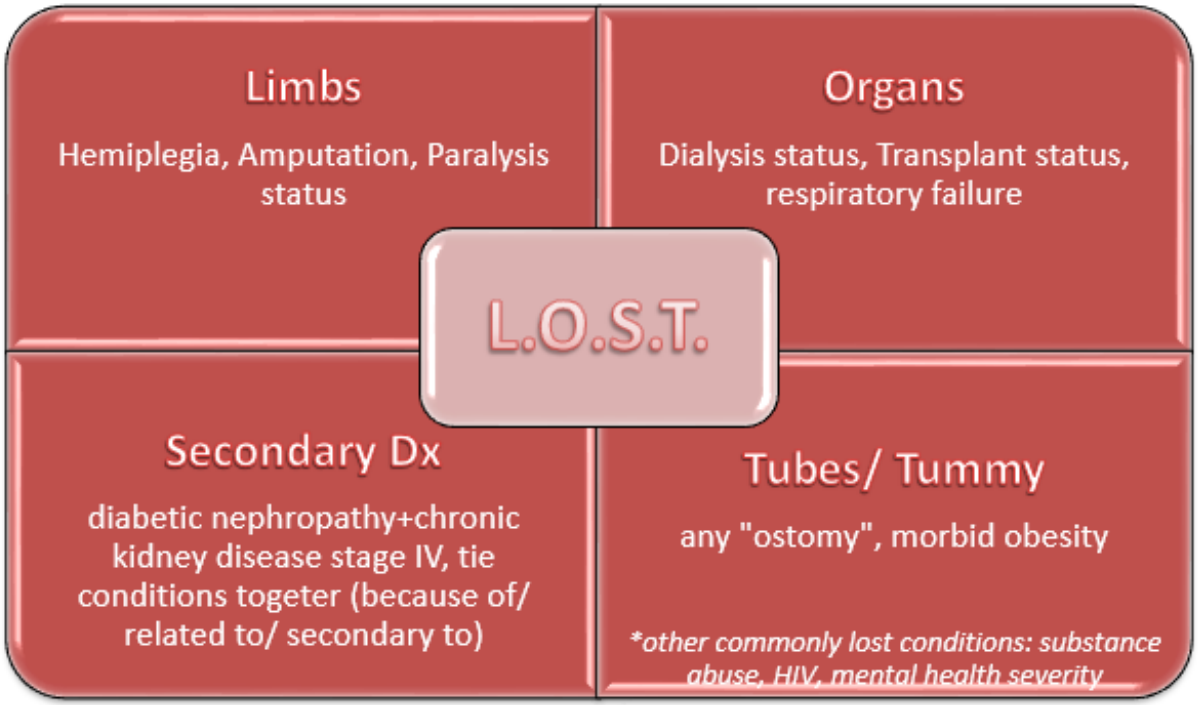
KEY: "-" indicates incomplete code | "Code also" and "Add-on" codes

As A Provider, What Is My Part?



- 1 element required per Dx code; more is better
- These factors help providers to establish the presence of a diagnosis during an encounter ("if it wasn't documented, it doesn't exist")
- Review problem list, document as 'current' or 'active'
- Do not use 'history of' for chronic conditions unless is fully resolved. Instead use 'stable

As A Provider, What Is My Part?



- **Document anything that impacts your medical decision making** to reflect the complexity and level of care provided.
- Documentation improves care, coverage, costs and compliance.
- other commonly lost conditions: substance/alcohol abuse, AIDS or HIV, mental health severity and status

LIST OF HCC CATEGORIES

HCC number and brief description of disease/condition	
HCC1 = HIV/AIDS	HCC82 = Respirator Dependence/Tracheostomy Status
HCC2 = Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	HCC83 = Respiratory Arrest
HCC6 = Opportunistic Infections	HCC84 = Cardio-Respiratory Failure and Shock
HCC8 = Metastatic Cancer and Acute Leukemia	HCC85 = Congestive Heart Failure
HCC9 = Lung and Other Severe Cancers	HCC86 = Acute Myocardial Infarction
HCC10 = Lymphoma and Other Cancers	HCC87 = Unstable Angina and Other Acute Ischemic Heart Disease
HCC11 = Colorectal, Bladder, and Other Cancers	HCC88 = Angina Pectoris
HCC12 = Breast, Prostate, and Other Cancers and Tumors	HCC96 = Specified Heart Arrhythmias
HCC17 = Diabetes with Acute Complications	HCC99 = Cerebral Hemorrhage
HCC18 = Diabetes with Chronic Complications	HCC100 = Ischemic or Unspecified Stroke
HCC19 = Diabetes without Complication	HCC103 = Hemiplegia/Hemiparesis
HCC21 = Protein-Calorie Malnutrition	HCC104 = Monoplegia, Other Paralytic Syndromes
HCC22 = Morbid Obesity	HCC106 = Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC23 = Other Significant Endocrine and Metabolic Disorders	HCC107 = Vascular Disease with Complications
HCC27 = End-Stage Liver Disease	HCC108 = Vascular Disease
HCC28 = Cirrhosis of Liver	HCC110 = Cystic Fibrosis
HCC29 = Chronic Hepatitis	HCC111 = Chronic Obstructive Pulmonary Disease
HCC33 = Intestinal Obstruction/Perforation	HCC112 = Fibrosis of Lung and Other Chronic Lung Disorders
HCC34 = Chronic Pancreatitis	HCC114 = Aspiration and Specified Bacterial Pneumonias
HCC35 = Inflammatory Bowel Disease	HCC115 = Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC39 = Bone/Joint/Muscle Infections/Necrosis	HCC122 = Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC40 = Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	HCC124 = Exudative Macular Degeneration
HCC46 = Severe Hematological Disorders	HCC134 = Dialysis Status
HCC47 = Disorders of Immunity	HCC135 = Acute Renal Failure
HCC48 = Coagulation Defects and Other Specified Hematological Disorders	HCC136 = Chronic Kidney Disease, Stage 5
HCC54 = Drug/Alcohol Psychosis	HCC137 = Chronic Kidney Disease, Severe (Stage 4)
HCC55 = Drug/Alcohol Dependence	HCC157 = Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC57 = Schizophrenia	HCC158 = Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC58 = Major Depressive, Bipolar, and Paranoid Disorders	HCC161 = Chronic Ulcer of Skin, Except Pressure
HCC70 = Quadriplegia	HCC162 = Severe Skin Burn or Condition
HCC71 = Paraplegia	HCC166 = Severe Head Injury
HCC72 = Spinal Cord Disorders/Injuries	HCC167 = Major Head Injury
HCC73 = Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	HCC169 = Vertebral Fractures without Spinal Cord Injury
HCC74 = Cerebral Palsy	HCC170 = Hip Fracture/Dislocation
HCC75 = Myasthenia Gravis/Myoneural Disorders, Inflammatory and Toxic Neuropathy	HCC173 = Traumatic Amputations and Complications
HCC76 = Muscular Dystrophy	HCC176 = Complications of Specified Implanted Device or Graft
HCC77 = Multiple Sclerosis	HCC186 = Major Organ Transplant or Replacement Status
HCC78 = Parkinson's and Huntington's Diseases	HCC188 = Artificial Openings for Feeding or Elimination
HCC79 = Seizure Disorders and Convulsions	HCC189 = Amputation Status, Lower Limb/Amputation Complications
HCC80 = Coma, Brain Compression/Anoxic Damage	

Source: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/downloads/2016-riskadj-factsheet.pdf