Moving clinical documentation improvement

Outside inpatient walls

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Healthcare reform, driven by the Affordable Care Act (ACA), has reduced patient volumes in the hospital setting, while moving traditional inpatient services to the ambulatory or outpatient setting. This has led hospital, health system, and physician leaders to bolster current, or create new, clinical documentation improvement (CDI) programs to manage increasingly complex clinical and payment scenarios in the outpatient setting.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) were signed into law in March 2010. Together they contain more than 500 provisions. But the ACA has three simple – but laudable – goals: to improve quality, affordability and access to care. Implementation of these goals is the responsibility of The Department of Health and Human Services (HHS) and its Centers for Medicare and Medicaid Services (CMS). These agencies have pledged to concentrate on these primary requirements to make healthcare available to more Americans.

The first objective is to transition from the current Fee-For-Service (FFS) payment structure, to a value-based payment (VBP) system. There are alternative payment models through which this can be accomplished, including Accountable Care Organizations (ACOs), Bundled Payments for single episodes of care across care settings and providers, and performance measures tied to traditional Medicare Fee-For-Service payment.

Second, CMS promises to improve care delivery through innovation in the areas of prevention, wellness, and care coordination and integration across the care continuum.

As its third strategy, CMS will expand information sharing, to increase transparency on cost and quality data. This will help consumers make better care decisions, and improve evidence-based, clinical decision making by making more information and clinical evidence available at the point of care.

Shifting to value-based payment: Errors matter

In January 2015, HHS announced an aggressive goal of tying 85% of all Medicare FFS payments to quality or value by 2016 and 90% by 2018. HHS and CMS are not venturing into this alone. They are partnering with private payers, employers, consumers, providers, state agencies and others to accelerate.
“The goals of CDI in the inpatient and ambulatory setting are the same: to ensure complete, accurate, and compliant clinical documentation, coding and billing resulting in an accurate reflection of patient severity, the level of services provided, quality of care delivered, and appropriate reimbursement.”

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and align the transition to alternate payment models by a broad payer base. Value-based payment for physician providers was further strengthened with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 which became law on April 16, 2015.

These changes, coupled with increased regulatory oversight and scrutiny by CMS, Recovery Auditors (RAs), Office of the Inspector General (OIG), the Department of Justice (DOJ) and commercial payers pose significant documentation and operational challenges for providers. In HHS’s Supplementary Appendices for the Medicare Fee-For-Service 2014 Improper Payments Report, Hospital Outpatient Services ranked second with the highest error rate due to insufficient documentation, with an improper payment rate of 7.3% and projected improper payments of $3.3B.

In comparison, Hospital Inpatient (Part A) ranked eighth in errors due to insufficient documentation, with a 6.6% improper payment rate and projected improper payments of $638M.

Three Part B Professional Services types also hit the top 20 list for Insufficient Documentation Errors: Physician services for Subsequent Hospital Visits (9th) had an improper payment rate of 11.2% and projected improper payments of $633M; Established Office Visits (13th) had a rate of 2.2% with $315M projected improper payments, and Initial Hospital Visits (15th) had a 9.8% improper error rate with projected improper payments of $287M.

In the same report, when only looking at Part B services for five different types of payment errors (no documentation, insufficient documentation, medical necessity, incorrect coding, and other), insufficient documentation was the most common type of error for 14 out of the top 20 Part B services. Incorrect coding was the most common for 5 out of the top 20 Part B services, and insufficient documentation and incorrect coding tied as the most common type of error for one of the top 20 services.

This report suggests there is significant risk to organizations—and tremendous opportunity for improvement—in clinical documentation for services billed under CMS’s Hospital Outpatient Prospective Payment System (OPPS) and Physician Fee Schedule (PFS).

Results of the American Hospital Association’s 2014 Q3 RACTRAC (Recovery Auditor Contractor Trac) Survey released last December revealed a significant increase in RA complex denials for outpatient coding errors reported, compared with prior quarters. The 2014 Q4 RACTRAC Survey, released in March, showed that rate decreased, but was still slightly above prior quarters. Whether this develops into an ongoing trend remains to be seen.

Providers are reporting denials for RA, Medicare Administrative Contractor (MAC), and other payer denials for hospital outpatient and professional services resulting from insufficient documentation and/or perceived cloning of physician documentation in the medical record. They must be keenly aware of the clinical documentation requirements to substantiate the medical necessity and appropriateness of services provided, which is often driven by CMS National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). They must also ensure the documentation is individualized for each patient for each encounter.

While templates may be used, they should be reviewed regularly to ensure they meet documentation requirements and providers are supplementing the template documentation with narrative text for individual patients.

Ambulatory CDI is not just CDI in the outpatient setting
The goals of CDI in the inpatient and ambulatory settings are the same: to ensure complete, accurate, and compliant clinical documentation,
coding and billing resulting in an accurate reflection of patient severity, the level of services provided, quality of care delivered, and appropriate reimbursement. There are universal documentation requirements—such as medical necessity and appropriateness, signatures, dates, and legibility—regardless of setting.

However, there are also significant differences and requirements in the various settings; therefore, CDI cannot simply be mirrored or replicated from the inpatient to ambulatory/outpatient arena. The most notable differences are the substantially higher patient volumes, shorter timeframe for episodes of care, code sets used, coding guidelines, billing guidelines and requirements, claim forms used, and payment methodologies. Not only are there differences between inpatient and ambulatory requirements, there are also different requirements and payment methodologies between the various ambulatory settings.

There are three major areas where CDI can have a meaningful impact for your organization beyond the traditional Part A inpatient focus. The first is in outpatient facilities, including hospital outpatient departments and free-standing Ambulatory Surgery Centers, each having its own CMS guidelines and payment policies and methodologies.

The second area is for Part B professional services for physicians and other eligible providers delivered in the office or facility setting.

The third area of opportunity is in Risk Adjustment payment methodologies, including CMS HCCs (Hierarchical Condition Categories), which can be impacted in the physician office setting, hospital inpatient and hospital outpatient settings such as the emergency department or observation units. Risk Adjustment has been a topic in prior Solutions editions and while it has been around for quite a long time, many inpatient CDI professionals are not familiar with it and unsure if it is an area they should be concerned with. If your organization is part of an Accountable Care Organization, has its own Medicare Advantage health plan, or has owned physician practices whose physicians are incentivized to improve patients’ risk factor scores, this is an area you want to explore further.

CDI in the ambulatory space is complex and may feel overwhelming, but the rewards of advancing your program will be worth the effort.

Nuance provides expert consulting services in each of these areas, led by professionals fluent in the J.A. Thomas and Associates (JATA) clinical methodology. They will partner with your organization and help you gain and sustain success over time to:

– Ensure complete, accurate, and compliant clinical documentation that supports medical necessity.
– Promote complete, accurate, and compliant assignment of codes based on clinical documentation evidenced in the medical record.
– Improve documentation to proactively defend against claim denials and adverse audit outcomes, and to reflect accurate quality and utilization reporting.
– Advance policies, procedures, and workflows that promote compliant practices and operational excellence.
– Prepare you for value-based and risk adjustment payment methodologies that ensure financial integrity.
To learn more about Nuance Cl Integrity™ CDI Ambulatory Services please contact us at 877-805-5902 or visit www.nuance.com/healthcare.