

Unified Reimbursement Strategy: Implementing Common Ground Among Next Generation Reimbursement and Quality Systems

By John Glatthorn

Date: September, 2016

We may look back on the 25 year span following the change of the millennium as one of the most densely populated periods of healthcare regulation ever seen in the history of the United States. Every year, individual clinicians, private practices, and health systems are bombarded with new coding, compliance, quality, and reimbursement models, making staying ahead of curve in terms of overall strategy nearly impossible. Executives, physicians, and healthcare experts would probably agree that it is impossible to maintain a status quo level of performance if your strategy is one of pure reaction to each new deadline that rears its head from The Department of Health and Human Services.

Although we all agree that this is not an ideal way to approach the onslaught of rules and penalties that will inevitably change our healthcare business forever, this siloed and reactive thought process is by far the most commonly implemented strategy (or lack of one) in the marketplace today. For many institutions, ICD-10 was the first significant foray into a highly structured, project management oriented transition plan that encompassed almost all the healthcare provider and administrative disciplines into one unified approach. Enterprise EHR implementations have done this for the information technology and clinical worlds but one might argue that these projects rarely included HIM, revenue/reimbursement, and CDI professionals as equals or even key players.

ICD-10 presented three large and diverse challenges:

1. It was so big that its change had an impact on almost every function of a health system
2. The specificity offered called into question the sacredness of physician discretion over depth of diagnosis
3. It made clinical documentation completeness and coding accuracy the cornerstone for all future healthcare reimbursement and quality strategies

Some of the earliest lectures and briefings on the subject back in 2010-2011 made a point of stating that “this is not just an IT problem or a coding problem.”¹ This is because when we as healthcare professionals are confronted with problems that shake our very foundation, we must look to more innovative and structured methods of problem solving that transcend departments and business units. We must create a more unified approach to managing our changing clinical, regulatory, and revenue cycle environment. Creating a strategy begins and ends with understanding the problem you wish to solve and creating goals you wish to achieve.

The problem with government mandates and blindly issued regulations is that they create a sea of acronyms fostering confusion, contradiction, and most importantly to our success, poor communication resulting in poor planning. Applying those same problem solving principles to next generation healthcare is certainly daunting, but not impossible. The first step in this journey is to ask the correct questions about these new regulations. To use a cooking analogy, we must determine if they are all made from the same ingredients, and do they share a common cooking philosophy? On the surface, initiatives like ICD-10, IPPS/DRGs, HACs, RACs, HCCs, MIPS, and ACOs seem distinct, but we will soon find that they share a common language. Each was instituted by the government with a common set of problems and goals.

¹John P. Glatthorn, Preparing for 5010 – A Provider Perspective, GetReady5010 – An Industry Collaborative, January 13, 2011, Presentation Content

FUNDAMENTAL PROBLEM: UNSUSTAINABILITY

Regardless of your party affiliation or personal views on healthcare reform, it is a fact that the United States government must address the current and impending problem of healthcare costs relative to revenue.² In other words, healthcare reimbursement in the past has heavily rewarded volume and paid little attention to population health by placing no reimbursement incentive on outcomes. This has resulted in a system that contains multiple levels of intentional and unintentional waste, fraud, and abuse coupled with a lack of incentive to create healthier populations in turn curtailing cost. By purely looking at the regulatory trend, regulators have deemed this unsustainable and it must be eliminated. Its overarching mantra is to make populations healthier and make treatment better, while curtailing spending on those practices with motivations driven by volume only.

NEXT GENERATION REIMBURSEMENT PHILOSOPHY: THE 5 PILLARS

The 5 pillars is an arbitrary collection of healthcare concepts derived from the collective regulation of the past 10 years. It may not be collectively exhaustive but it does form a concrete basis for a unified reimbursement strategy. They are not in order of importance.

Pillar 1: Generate economies of scale from patient populations

Looking at healthcare services from a supply chain perspective helps us understand that we can decrease costs, make the patient experience better, and pay less by looking at the overall volume and similarities of patient conditions coupled with what standard treatment paths are offered relative to the norm. Doing this for large segments of diseases, age groups and geographic regions can decrease the variability of both treatments and error rates for that population.

Pillar 2: Incentivize better outcomes / Penalize poor outcomes

When anyone is incentivized, motivation to meet the goal, provided it is ethical, is usually assured in the short term. This point is fairly straight forward and often touted as the main point in next generation strategy. By itself, however, it does not address the problem completely. Codifying penalties for those not incentivized by better outcomes acts as a deterrent for those looking to cling to volume based methodologies.

Pillar 3: Penalize “waste”

The term “waste” is abundant in healthcare regulatory discussions but for the purposes of this paper we would like to define this as inefficient or redundant processes or services and expressly disassociate them from fraud and abuse. Waste increases cost unnecessarily with no benefit to the patient.

Pillar 4: Punish fraud and abuse

Civil and criminal penalties have always loomed heavily on providers given their fiduciary duties of compliance, but in recent years prosecutions are up and the term “fraud” is being used more frequently where others might have considered “mistake” at the turn of the millennium.

Pillar 5: Make providers share measured reimbursement risk for the four previous pillars

This is the philosophical pin that holds next generation reimbursement strategy together. At-risk provider compliance and performance replace volume as the key indicator for business success. The concept of measurement itself also takes a more objective form.

²Department of the Treasury, Financial Report of the United States Government – Fiscal 2015, (Department of the Treasury, February 25, 2016), [https://www.fiscal.treasury.gov/fsreports/rpt/finrep/fr/15frusg/02242016_FR\(Final\).pdf](https://www.fiscal.treasury.gov/fsreports/rpt/finrep/fr/15frusg/02242016_FR(Final).pdf), Page 6

IMPLEMENTING THE 5 PILLARS: THE RULES GOVERNING THE REIMBURSEMENT OF HEALTHCARE SERVICES

These implementation axioms, or rules if you will, represent the do's and don'ts of what governmental healthcare organizations (with private payers following suit) will pay for in the coming years. Consider them a fundamental precept of how the healthcare business will function after the first quarter of the 21st century. They answer the key question: *How and for what will we get paid?*

We don't pay for volume; we pay for single occurrence acuity. The Inpatient Prospective Payment System for Medicare providers and the APR-DRG reimbursement model moving west to east across the United States as of this writing was designed with this concept in mind. Your acuity and complexity demonstrate justification for higher payment because there is an implied (and usually factual) usage of more resources/higher cost for increased complexity. Variance from the norm play a crucial part as the concept of inpatient days is eliminated in favor of diagnosis and procedure presence on a case demonstrating its level of complications.³

We don't pay for volume; we pay for long term disease burden. Hierarchical Condition Categories (HCC) in the payment of Medicare Advantage plans personify this implementation point. Calculating the raw risk score takes into account the conditions influencing the treatment at the time of visit, but for some it also poses inherent contradictions in the way physicians were taught to code single encounters. In any case, this represents an acknowledgement not only of sicker instances requiring more care, but chronically ill patients needing more care over the long term, therefore taking up more resources.⁴

We don't pay for provider "mistakes" or poor service. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Hospital Acquired Conditions (HAC) were created to measure overall satisfaction from the patient's perspective and deduct conditions from reimbursement that are preventable from payments respectively. It is HCAHPS that represents the one deviation from pure coding and claim data as the trigger for hospital performance measures.⁵

We'll pay you based on your efficacy within a patient population. Accountable Care Organizations (ACO) and private Value Based Purchasing (VBP) agreements structure all contracts to compare the providers' reimbursed amount against the ACO population on a cost per patient basis. The variance from that norm is either added or deducted from your organizations at risk percentage. It also measures providers' consistent use of well accepted medical practices and disease control protocols against the chronically ill patient and those with conditions easily treated by modern medicinal measures like antibiotics. The Medicare Access and CHIP Reauthorization Act (MACRA) with its Merit-Based Incentive Payment System (MIPS) is yet another movement toward efficacy based reimbursement on the professional side coupling it with meaningful use and PQRS type characteristics.⁶

³The Department of Health and Human Services – Center for Medicare and Medicaid Services, IPPS Annual Proposed and Final Rules, and Relevant Correction Notices: Fiscal Year 2017, (Department of the Health and Human Services – Federal Registry, April 27, 2016), CMS-1655, 42 CFR Parts 405, 412, 413, et al., Vol. 81, No. 81, <https://www.gpo.gov/fdsys/pkg/FR-2016-04-27/pdf/2016-09120.pdf>, Entire Document.

⁴World Economic Forum/Harvard School of Public Health, The Global Economic Burden of Non-communicable Diseases, (World Economic Forum, September 2016), http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf, Pgs. 23-35.

⁵Center for Medicare and Medicaid Services, HHS-Operated Risk Adjustment Methodology Meeting, (CMS Discussion Paper, March, 24, 2016), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>, Pgs. 12-26.

⁶Center for Medicare and Medicaid Services, ICD-10 HAC List, (Center for Medicare and Medicaid Services, 08/04/2016), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html, Downloads.

⁷Center for Medicare and Medicaid Services, HCAHPS Fact Sheet, (Center for Medicare and Medicaid Services, 9/25/2014), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalHCAHPSFactSheet201007.pdf>, Pgs. 1-6.

⁸Center for Medicare and Medicaid Services, The Merit Based Incentive Payments System [MIPS], <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf>

⁹Centers for Medicare and Medicaid Services. The Medicare Access and CHIP Reauthorization Act: Path to Value, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

We measure performance largely based on administrative data. This concept is worth clarifying. Almost all of the measures stated above use administrative/coding data as the basis for payments, denials or triggers to investigate. Two conclusions can be drawn from this fact: (1) The accuracy and completeness rate of your coding data will either represent or misrepresent your risk level to third parties and (2) Hyper-accurate coding data can predict your reimbursement risk in the new era making problem areas quantitatively provable and solutions apparent. Examining this further will mean that HIM managers and executives need to question the written in stone “95%” accuracy touted by coding auditors and take a granular look at coders’ understanding of clinical phraseology and indicator presence in a given chart.

NEXT GENERATION HEALTHCARE VARIABLES: WHAT IS BEING MEASURED?

1. Healthcare coding data – As stated previously, the accuracy and completeness of coding data forms the foundation of administrative data. Its reliability and completeness should be fundamental to organizational reimbursement strategy.
2. Diagnostic specificity – Unspecified code usage will become harder to justify. Calculations and medical policies will expand their penalization when more specific information is clearly known.
3. Non-present on admission conditions – HACs and serious safety events exemplify these ingredients.
4. Complicating and concurrent conditions – Code capture rates in the inpatient and outpatient class will become critically important especially as we move toward efficacy base models of reimbursement.
5. Chronic conditions – Demonstrating long term disease burden is impossible without the consistent documentation of those conditions influencing patient care at the encounter level.
6. Patient experience – Independent verification of patient experience can be invaluable in predicting government measured statistics as well as continuously improving the efficiency of the delivery and billing.
7. Documented justification for treatment path and procedures (notice we did not say medical necessity) – Medical necessity is an affectation of the payer wanting to justify the denial of services. What we are truly discussing is the documented justification for treatment path and procedures with a specific focus on what has been tried already and why the current treatment is the next stage in appropriate problem solving. This encompasses justifying length of stay for the inpatient financial class.

STEP 1: MAKING ADMINISTRATIVE DATA A STRATEGIC PRIORITY

Administrative/coding data has long been the stepchild of the care continuum. It is not exactly clinical documentation and not exactly claims data. Professionals in this space are not considered clinical but not entirely revenue cycle. Next generation reimbursement changes this for the foreseeable future.

All healthcare billing and reimbursement actions start because the application of codes from source documentation triggers a response from the payer. The rules and medical policies themselves are written and being drafted with express lists of acceptable and non-acceptable codes. A further examination of source clinical documentation may settle disputes or justify care but some health systems record first time claim payment rates as high as 65%. This means that nothing other than the codes and computed information on that claim were used to adjudicate the case. As stated earlier, almost all the newly implemented initiatives in the alphabet soup use billing/administrative data (or the correlation of it to source data) to determine performance and penalties. If you or your clinicians believe the patient’s disposition or the completeness of the note is the sole arbiter in these initiatives, this belief is false.

We are nearing a tipping point in modern healthcare where clinical documentation may be referenced more times for reimbursement than for coordination and patient care. This necessitates for the survival of the revenue cycle that practices and health systems make the accuracy and completeness of administrative/coding data a STRATEGIC priority on par with patient safety. Providers must concentrate their efforts in three areas of enhancement; (1) the accurate reflection of complexity/acuity and long-term disease burden, (2) assuring the source documentation has the clinical phraseology and connecting language necessary for coding, and (3) coders and CDI professionals must learn to understand highly complex clinical terminology and indicators beyond book learning and nursing school. This includes studying actual disease and treatment patterns by specialty along with viewing various surgical and procedural techniques. The treatment of this data's accuracy as a tactical or departmental goal centralized only in HIM or CDI is now obsolete.

STEP 2: BUILDING A UNIFIED REIMBURSEMENT STRATEGY, NOT SILOED INITIATIVES

If we are to begin managing this sheer volume of rules and regulations in a unified manner we must first stop trying to manage the amount of silos and instead change the conversation. Clinicians and their administrative counterparts are now forced into a relationship of inseparability. This is not all about money; this is about survival and paradigm shift. Conversations solely about money, reputation, quality of patient care, safety, or sustainability are incomplete. They are being mandated together – address them together as one.

Start by demonstrating the sustainability risk of fee for service/volume based models and dispel rumors created by incomplete and often anomalous information. Demonstrating sustainability risk at a strategic level is not difficult given that no regulation passed in the last 10 years references volume as the primary driver for at risk monies. Help leaders understand upfront that code-able clinical documentation forms the foundation for all next generation reimbursement models. During the ICD-10 education phase, many of my customers were surprised by how many surgeons had no idea that their procedures were being recoded without their consultation in a code set other than CPT (recoded in ICD-9-CM Volume III and later ICD-10-PCS). Some high level physicians are still under the impression that the more codes they put on a chart, the better the reimbursement! This same type of revelation must occur for the importance of administrative data in areas like the computation of DRGs.

Presenting new ideas or activities as must do regulatory actions is a recipe for disaster. Present the problem as just that, a common problem we must all solve. No administrative body can affect strategic change without its clinical counterparts and no clinical body can do the same on administration without a common set of goals and a baseline for communication. It has been my experience that people in general are scared of the “shoot the messenger” principal. This is NOT something to fear, it is beyond a doubt your friend. Shooting the messenger means an airing of grievances and disgust that you yourself also feel – only you have accepted them as inevitable, your audience has not. Once you all agree this will be hard and will likely result in a great deal of push-back you can begin asking for help and expertise to solve the common problem.

Despite your feelings of being alone in this transition, you are not. There are many teams in your organization that have accepted this future long ago. You know them well. Teams like HIM, CDI, Quality and Patient Safety, Revenue Integrity, and Specialty Clinical Champions are forced to see these changes every day in articles, conferences and peer discussions. They do not lack the intestinal fortitude to be an agent of change or unifier of that which is siloed. What they lack is the formal structure and referential authority to do something about it in a measurable way.

Once you have convinced your core group of influencers, form a strategic workgroup to understand your strengths and weaknesses better. The next step is to create a basic research agenda to demonstrate the institution's risk in a quantitative manner (both physicians and finance will love quantitative proof).

STEP 3: CREATING A UNIFIED RISK SCORECARD

1. Question and measure true coding/administrative data completeness and accuracy for inpatient and outpatient accounts – Do not depend solely on coding professionals (either internal or external) to audit coders or CDI professionals. The 95% coding accuracy that we so proudly espouse at operating committee and QA meetings will likely go down drastically when a physician also audits the chart. Coders are trained from books. Few have ever seen what appears through an endoscope or could identify a given technique by sight. They cannot be expected to read a chart with the comfort of a physician without significant training and exercises. Expect 10-20% downside variances from the norm during this assessment process.⁷
2. Measure diagnostic specificity – Measure the volume and source of unspecified code usage along with its appropriateness for your highest volume areas. Publicly ban any diagnosis codes that can plainly be more specific with no effort from the clinician. Good results would be 2-5% appropriate unspecified usage in specialties and .5% or below overall occurrence of prohibited unspecified codes.⁸
3. Review non-present on admission conditions – Gather statistics from your quality teams on the occurrence, source departments and frequency along with work queue volume if these are caught in a billing system as a pre-bill audit. Serious safety events should already have internal quantitative goals in your organization.
4. Measure complicating and concurrent condition capture – Work with your CDI team and physician advisors to identify your highest rates of undocumented complicating and concurrent conditions. This should include both an inpatient and outpatient study. Outpatient CDI is new or nonexistent at most organization since its ROI has yet to be determined. At this stage you are not practicing actual changes toward completeness but collecting information to form a baseline for risk.
5. Gauge procedure/surgical note criteria for complete coding and its ability to stand alone – Understand the coding applied to your highest volume and highest reimbursement procedures vs. the detail provided in the operative report. Identify shortcomings or ambiguities and take specific note of medical justification for the procedure in the note itself. This will help with medical necessity claims.
6. Analyze chronic condition presence – Start this analysis by measuring the consistent presence of chronic conditions in the primary and secondary positions across multiple professional visits within a predefined time period. Clinicians must agree up front which conditions will automatically influence the patient's health status and should appear on the encounter to avoid simple inclusion without proof of factors influencing health. Compare these with their presence on the problem list.
7. Institute independent patient surveys that mirror HCAHPS criteria.

For each of the above measurements be sure to isolate (1) the coder coding (if applicable), (2) the clinicians documenting, (3) the department treating the condition in question, and (4) the tools utilized in any decision making. These four characteristics will help you isolate patterns and focus areas for education. Also, a personal meeting showing stand-out issues can be far more motivating than a group discussion where the sharing of results may conflict with egos in the room. Save the group presentation of de-identified problem areas for groups that don't respond.

STEP 4: UNDERSTANDING YOUR PATIENT POPULATION

Your practice or health system cannot hope to serve a given population if you do not know its characteristics at a granular level.

⁷John P. Glatthorn, Based on Optera Healthcare Strategies client experience using physician reviewed Vs. coder reviewed charts.

⁸John P. Glatthorn, Based on Optera Healthcare Strategies client experience in comparison against the Unicode Health Prohibited List of Unspecific Diagnoses Version 2015-2016.

Begin stratifying patients by diagnostic conditions with and without comorbidities to determine the breakdown of your geographic region's patient population. The outcome should be a workable model for average length of stay with accompanying services rendered for simple, medium and advanced cases. Using severity of illness can assist in this process if you wish to use DRG as a grouping tool.

Compare your clinical pathways for the conditions above to actual care provided and determine if the pathway and the actuals were reimbursed properly by governmental and third party payers. Clinical pathways often represent good practice based on peer reviewed information but are rarely compared directly to payers' medical policy reimbursement standards. This leads to one of the harder decisions in the process: Decide upfront what the facility and its clinicians are willing to do for free.

Lastly, perform an age/sex/diagnosis correlation analysis and match that data to the independent patient satisfaction surveys helping you define "excellent" care for each demographic group. Target new customer relationship, patient access, and coordination of care/monitoring projects around that reality. These projects can be cheaper following the analysis because it may only be a select demographic that finds a particular enhancement useful. This can limit the number of resource intensive enterprise rollouts redirecting focus to the centers and specialties with the most utility.

STEP 5: ENHANCING AND OPTIMIZING TOOLS

Billions have been spent on EHR implementations nationwide. Use their considerable capabilities to make accurate and complete clinical documentation the easy thing to do.

Much has been made about the dangers of templates and copy and paste capabilities within an EHR. That being said, templates can be a strong asset in the fight against incomplete or arbitrarily different levels of capture and specificity. While using templates, place your fundamental focus on uniqueness per chart and set penalties for multiple copy and paste violations. Teaching institutions with codified methods of procedure techniques can benefit even further since your procedures are supposed to be similar – but with enough wiggle room to accommodate patient case uniqueness. Medical necessity denials for procedure or venue of procedure can also be combated by including the treatment history and justification in both the Assessment/Plan and the Operative Note itself. This helps payers and auditors isolate medical necessity claims without reviewing the full chart. It also provides a defense if the only document requested is the operative note.

For physician coded encounters, especially on the professional side, make sure clinical term-to-ICD diagnostic mapping tools display the diagnoses that are most used and most specific. Avoid searching large databases where unknown correlations to possible unspecified codes can exist with impunity. Upload prohibited lists to billing and revenue cycle work queue systems that automatically screen for the specificity required and hold claims if not corrected.

STEP 6: TRAINING RESIDENTS, CLINICIANS, CODERS, CDI SPECIALISTS, AND REVENUE INTEGRITY PROFESSIONALS

Residents. These individuals may rotate and renew each fiscal year, but ignoring their clinical documentation education means you do so at your peril. New research suggests that residents spend roughly 5 hours per day doing clinical documentation.⁹ While it is true that their first priority is safety followed by learning and treatment, don't underestimate their role in the documentation integrity process. When educating residents, you must boil down concepts to fundamentals and make your references easy to use and rotation specific.

⁹Lu Chen, Uta Guo, Lijo C. Illiparambil, Matt D. Netherton, Bhairavi Sheshadri, Eric Karu, Stephen J. Peterson, and Parag H. Mehta (2016) Racing Against the Clock: Internal Medicine Residents' Time Spent On Electronic Health Records, Journal of Graduate Medical Education: February 2016, Vol. 8, No. 1, pp. 39-44.

Attending Clinicians. Start by dispelling billing rumors that proliferate in the medical community. More is not necessarily better, more diagnoses does not mean more money and longer notes do not equal better notes. Help clinicians understand the criteria/depth needed for a condition's highest level of specificity. Focus your efforts on those your institution deems most problematic and educate by specialty. Never create a one size fits all. Do not limit yourself to inpatient physicians. Outpatient procedures may pale in charge value to inpatient days but to a surgeon, a case is a case. Documenting completely on a habitual basis typically means ignoring financial class. With increased interest in HCC criteria, differentiating conditions that influence current health status can eliminate the "code everything" mindset that can create legal and compliance difficulties.

Coders, CDI Specialists and Revenue Integrity Professionals. The CDI specialist and coder are natural allies. Unfortunately with recent conflicts between the ICD-10-CM 2017 Coding Guidelines and the practice of Recovery Audit Contractors/third party payer auditors, anyone practicing code debate or assignment will need to increase their clinical knowledge to include clinical indicators supporting express diagnoses to compete with medical necessity and other claims that threaten reimbursement.¹⁰ This combined with the revised PCS root operations means that both groups will require more training and exercises combined with the video witnessing of procedures to obtain a level of competency necessary for a physician audited 95% accuracy plateau.

CONCLUSION

Governmental regulation has and will continue to use administrative data as its primary source to determine compliance, penalty, investigation and incentives to both private practices and health systems alike. The integrity of the source documentation combined with the competence of the coder assigning create the backbone of reimbursement success or failure in a regulatory environment where aggregated datasets are the first source of truth. Providers of all sizes should begin building their analysis and education toolkit in a unified fashion to avoid isolated, fear driven work streams that may ultimately yield confusion rather than results.

About Elsevier Revenue Cycle Solutions

Elsevier offers a full suite of education solutions designed to help healthcare organizations optimize staff performance and data quality for value-based programs and financial health. Through education and training, staff can be confident in their coding and data abstraction skills, and be empowered to help obtain appropriate reimbursement, reduce risk, and improve performance.

¹⁰Centers for Medicare and Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, http://www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf, Pg. 13.

¹⁰Sandra L. Brewton, ICD10Monitor, Coding Conundrum: Clinical Indicators for Code Assignment, August 22, 2016, <http://www.icd10monitor.com/enews/item/1687-coding-conundrum-clinical-indicators-for-code-assignment>