DC VIRTUAL LEARNING COLLABORATIVE WORKSHOP: CLINICAL DOCUMENTATION AND CODING FOR VALUE-BASED PAYMENTS

HMA

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Presented By:
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Department of Health Care Finance

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POLL

1. **Provider type**
   - Mental Health
   - SUD
   - FQHC
   - Other Primary Care
   - Care Management

2. **We have contracts with MCOs:** yes/no

3. **We have contracts with MCOs with quality incentives:** yes/no

4. **We bill entirely FFS:** yes/no

5. **What is your biggest fear for the transition to VBP?** Type this in the chat box!

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AGENDA

I. Overview of clinical documentation
II. How to align clinical documentation with coding practices
III. Risk Adjustment, Documentation & Coding
IV. Medical documentation and coding to optimize Value Based reimbursement and enhance patient care
V. Quality
    - Quality clinical documentation
    - Quality measures

Learning Objectives

1. Describe the importance of accurate clinical documentation and its link to coding
2. Discuss coding for Value-Based Metrics
3. Explain auditing and compliance monitoring

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WHAT DOES A GOOD DOCUMENTATION PROGRAM LOOK LIKE IN PRACTICE?

- Develop a quality program
- Develop documentation and data systems
- Provide ongoing staff education
- Execute program & monitor (audits with queries to clinicians)

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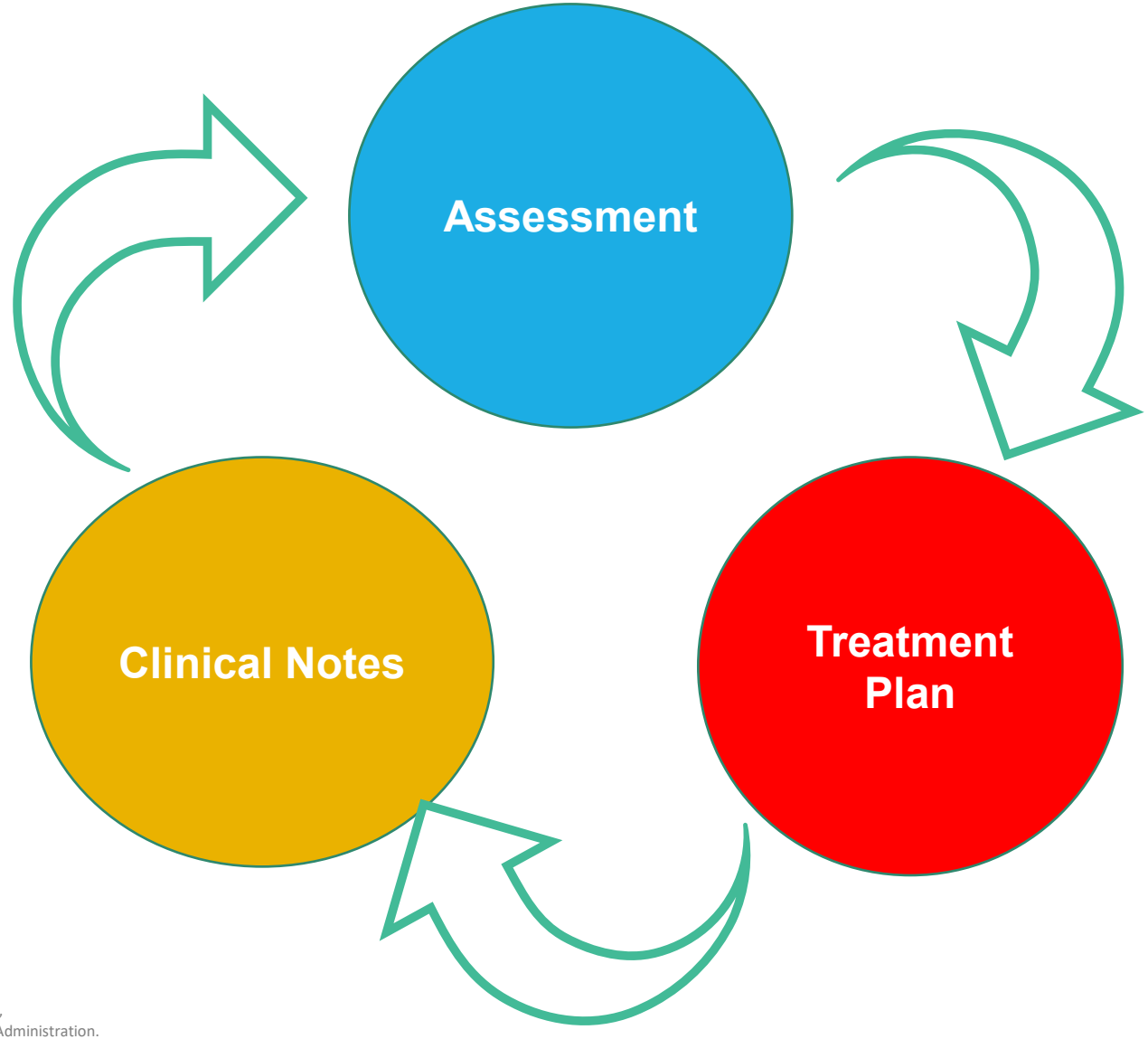
DOCUMENTATION SYSTEMS



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DESIGNING YOUR DOCUMENTATION PRACTICES

Typical Stakeholders	Regulators, Accreditors, Payers, Clinicians
What do they want to see	Crosswalk their standards/regulations/contract terms to develop documentation practices

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DOCUMENTATION

Treatment Plan

- Based on assessment and diagnosis
- Person-centered
- Supports the level and frequency of services
- Updated in real time as information changes

Clinical Notes

- Reflects the goals, objectives and interventions of the treatment plan
- Reflects the level of care and frequency of services recommended
- Reflects delivery of evidence-based practices that are normed for the person's condition and population
- Reflects that EBPs are delivered with fidelity to the model

Assessment

- Should clearly support and document rationale for diagnoses
- Diagnosis should be updated as new information arises

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DOCUMENTATION- TREATMENT PLANNING

Goals	Objectives	Interventions
• Reflects the global needs and desires of the client • Pulled from the areas identified as needs in the assessment	• Specific outcomes to reach each goal	• What you as the provider will do to help the person reach each objective

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DOCUMENTATION- MEET STAN

- Stan is a 51-year-old male residing in DC. Stan has a 13-year history of heroin use and 3-year history of crack-cocaine use. He uses daily, both smoking and injection; about 3 bundles of heroin and crack cocaine when he feels he needs to wake up. Stan reports 5 prior treatment episodes. He last used just before coming to meet with you.
- Stan reports:
  - No professional trade or skill and worked sporadically “under the table” and supplement his income often with illicit activities he does not want to disclose at this time.
  - His primary source of income is disability for pain and mobility challenges related to his gunshot wound.
  - Limited relationship with his family as they do not approve of his lifestyle. He does not have a current significant other. He has two children, aged 35 and 33 and he has had no contact with them in 5 years.
  - Being unhoused and spends much of his time sleeping on people’s couches, most of whom are using substances with him.
  - Significant pain in his leg as a result of a gunshot wound 10 years prior. Many days it is painful to walk.

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DOCUMENTATION- TREATMENT PLANNING

Today's Date: 11/12/2022
Need/ desire: I need to stop using. I know I will die if I stay out there, and I don't want to die without seeing my kids again

Goal: I want to stop using all drugs so I can be there for my kids
Projected: 5/1/2023

Objective: Stan will be stabilized on a maintenance dose as evidenced by reduced cravings for opioids
Projected: 12/1/2022
Interventions: The doctor will meet with Stan daily for the first two weeks to adjust his dose until it is effective at suppressing abstinence symptoms

Objective: Stan will increase his understanding of his substance use as evidenced by identifying three triggers that could result in use of substances
Projected: 12/1/2022
Interventions: Counselor will meet with Stan weekly and utilize motivational interviewing and cognitive-behavioral therapy to identify situations that could prompt Stan to use substances

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DBH TREATMENT NOTE FORMAT

- **Focus of the session**

This session focused on Stan's recent loss of housing and his frustration with the process of securing housing through the shelter system.

- **Presenting problem**

Stan currently has no permanent housing. Stan's identified housing resources are actively using and are triggers to his progress in recovery. Stan feels frustrated by the process of locating housing through the shelter system and residing in a communal environment with many other people.

- **Interventions used**

Counselor utilized Motivational Interviewing to explore with Stan how leaving the shelter to return to friends who are using could impact his recovery process and his longer-term goal of reuniting with his children.

- **Clients' response to the intervention**

Stan was initially determined to leave the shelter however he was able to engage with counselor to develop a plan to manage his frustration and remain focused on how this is an
important step in securing permanent housing and maintaining recovery

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DBH TREATMENT NOTE FORMAT (CONTINUED)

- **Client progress towards identified goals in treatment**

Stan has submitted toxicology tests consistent with the expected results for 2 consecutive tests. Stan has taken steps to change his living environment to reduce his relapse triggers. Stan expressed he is not yet ready to reach out to his children as he would like to feel more confident in his recovery before he reaches out to them.

As Stan's housing situation has changed; counselor and Stan discussed his treatment plan and agreed to add a goal related to housing. Stan stated he would like to focus on "getting out of the shelter and into his own place" and building recovery skills that help him to manage the challenging situations he faces in the shelter system.

- **Plan for future session:**

Stan and counselor will meet Friday. Stan's homework is to provide an update on the use of the skills and tools outlined in his relapse prevention plan specific to managing the challenges of the shelter system. *Stan and counselor will reassess Stan's weekly counseling schedule the following week and increase sessions if needed.*

Don't forget to consider!

- ✓ Significant events or changes in the life of the client (*italicized in the note)*
- ✓ Changes in frequency of services or levels of care *(italicized in note)*

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DOCUMENTATION QUICK TIPS

- A condition only exists when it is documented
  - Diagnoses do not carry over year to year. They can carry over visit to visit.
- A condition can be coded and reported as many times as patient receives care and treatment for the condition.
  - Do not code for conditions that were treated in a previous year but no longer are treated.
- Conditions can be coded when documentation states condition is being monitored and treated by a specialist
  - Do not code diagnoses with less than 95% certainty of the diagnoses.
- Co-existing conditions can be coded when documentation states that the condition affects the care, treatment, or management of the patient.
- Document and code status conditions at least once a year.
  - Examples: transplant status, amputation status, chemotherapy
- Do not code unconfirmed diagnoses
  - Examples: probable, possible, suspected
  - Do not use arrows or symbols to indicate diagnosis
    - Cholesterol, >hypertensive
- Be sure diagnosis codes are consistent with medical record documentation
  - Example assessment and plan documentation
  - Cannot list ICD-10 Diagnosis code alone

Medical history is the information about the patient's health before the presenting complaint

- Some conditions are chronic; however, coding from past medical history without current support for the condition is not acceptable
- Beware that some EMR software "auto populates" all conditions previously coded for that patient
- Do not "copy and paste" without updating/ editing the conditions
  - Why is this condition a problem?
  - Was it coded correctly?
  - Is the condition still active?
  - When did the condition last occur/ symptoms present?
  - Who is treating the condition?

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RISK ADJUSTMENT, DOCUMENTATION & CODING

MEDICAID CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (CDPS)

CDPS is the risk adjustment payment methodology the District of Columbia uses for Medicaid beneficiaries who enroll in a Managed Care Organization (MCO).

Medicaid risk adjustment identifies the demographics of an enrollee and uses different values of risk score calculation for disabled individuals, adults, and children. The Medicaid risk adjustment model is concurrent in that the ***current*** year's diagnoses affect the ***current*** year's risk score.

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MEDICAID CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (CDPS)

CDPS uses a crosswalk that assigns certain diagnosis codes to an HCC, which then is computed into a risk score. In the Medicaid risk adjustment payment model, conditions are weighted hierarchically within major condition category groups.

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What is “Risk Adjusted” payment?

- Risk Adjustment (RA) is a Value Based Reimbursement (VBR) methodology. Documentation requirements differ from Fee For Service (FFS)
- ICD-10 coding translates to Hierarchical Condition Categories (HCC’s) Diagnoses in categories that have more or less impact. Hierarchies.
- HCC codes are weighted and result in Risk Scores (risk adjustment factors – RAF)
- Those weights/RAF translate into the revenue
- All revenue is pooled for the patients in a plan
- All expenses come out of that pool

MEDICAID CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (CDPS)

The providers are in control and risk score accuracy improves when they:

- Identify *all* the patients' disease states each year (and document per guidelines and code them specifically).
- Capture all defensible revenue

And focus on patient care

- Address their conditions whenever needed... take good care of patients
- Reduce hospital admissions and re-admissions
- Quality is a natural byproduct and the focus creates revenue surplus

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The Challenge is to Improve Risk Score Accuracy

- Most fundamentally, the challenge is related to physician documentation
- A Trap - focusing on finding things to code
- Do not: Target codes and diseases
- Do: Emphasize Risk Score Accuracy (two sided)
- Transition PCP's mindset away from the Volume Based (FFS) model to Value Based Reimbursements (HCC)
- Find ALL of the diseases and conditions
- Be as specific as possible

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MEDICAL DOCUMENTATION & CODING TO OPTIMIZE REIMBURSEMENT IN A VALUE BASED MODEL

WHY DOCUMENTATION IS IMPORTANT

Conditions in the CDPS model are categorized by example:

- **Psychiatric – low (PYSL), medium (PSYM), high (PSYH), Substance, very low (SUVBL), low (SUBL)**

Example: Only Depression is documented
(If only documented this way this condition is not on the CDPS model.)

- Be specific – Is it Major Depressive Disorder (PSYL)?
  If so, specify:
- Episode (single/recurrent)
- Severity (mild moderate or severe)
- Status (partial remission, full remission)

- **Schizophrenia vs Eating disorders vs Bipolar and Major Depressive Disorder**

Be specific:

- Schizophrenia is in the psychiatric high (PSYH)
- Eating disorders are in the psychiatric medium (PSYM)
- Bipolar and major depressive disorder are in category psychiatric low (PSYL)

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MEAT & BEST PRACTICE IN DOCUMENTING SUBSTANCE USE DISORDER

Providers must accurately document the patient's diagnoses for each visit (encounter). Utilizing the MEAT acronym is a tool to use when documenting current and chronic conditions.

- Any condition that is supported by monitoring, evaluating, assessing or treating can be coded.

Medical record documentation must have MEAT documented for each diagnosis
• A simple list of diagnoses is not acceptable

M

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A

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Managed or Monitored – Document how and who is monitoring and managing the condition(s).

Evaluation – DSM-5, Exam

Assessment – What is the assessment that day? Improving, worsening, progressing, current, partial remission or full remission, withdrawal symptoms

Treatment and/or Plan –

- Medication review with patient and link to condition(s)
- When is the patient returning?
- Referring for other therapy, counseling, psychotherapy, inpatient/outpatient treatment facilities
- Lifestyle changes

Include MEAT in Your Risk Adjustment Documentation - AAPC Knowledge Center

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COMMON CONDITIONS IN THE PSYCHIATRIC CATEGORIES

Psychiatric High – only 2:

- Schizophrenia (F20.0 - F20.9)
- Schizoaffective disorder (F25.0 - F25.9)

Psychiatric Medium:

- Psychosis, NOS (F29)
- Eating disorders (F50.0 - F50.9)
- Personality disorders (F60.0 - F60.9)

Psychiatric Low:

- Major DD, single, mild, mod, severe, on remission, in partial remission (F32.x - F33.9)
- Psychiatric and Mood disorders (F06.0 - F06.4)
- ADHD (F90.0 - F90.9)

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SUBSTANCE USE CATEGORIES

For CDPS there are two categories under Substance Use:

- Substance Abuse, Very Low (SUBVL)
- Substance Abuse, Low (SUBL)

Common conditions that fall within these categories:

- Substance Abuse Low – All Substance disorders except Nicotine Dependence
- Examples: Disorders Use, Abuse, Dependence (Opioid, Cannabis, Cocaine, Sedative hypnotic anxiolytic, Inhalant, Hallucinogen)
- Substance Abuse Very Low

Only Alcohol Disorders (Use, Abuse, Dependence)

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OTHER SAMPLE CDPS CATEGORIES

Gastrointestinal Conditions	Eye Conditions	Hematological Conditions
Central Nervous System Condition	Metabolic Conditions	Renal Conditions
Skeletal Conditions	Skin Condition	Pulmonary Conditions
Developmental Disabilities	Cerebrovascular Conditions	Pregnancy and Newborn Conditions

**Not an exhaustive list*

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CHRONIC HEALTH FAILURE & CASE EXAMPLE

Example 1:

21-Year-Old female with HTN and Schizophrenia

ICD-10 CM	Description	RAF
I10.0	HTN	0.062
F31.10	Schizophrenia	0.271
Age/Gender Age 15 to 24, Female		0.036
Total		0.369

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CHRONIC HEALTH FAILURE & CASE EXAMPLE

Example 2:

50-Year-Old female with HTN and CHF, Schizophrenia

ICD-10 CM	Description	RAF
I11.0	Hypertensive Heart Dx with CHF	0.735
F31.10	Schizophrenia	0.271
Age/Gender		
Age 45 to 64/Female		0.068
Total		1.074

Example 3:

50-Year-Old female with HTN, CHF, CKD, and Schizophrenia

ICD-10 CM	Description	RAF
I13.0	Hypertensive Heart Dx with CHF and CKD	0.735
N18.9	CKD, unspecified	0.928
F31.10	Schizophrenia	0.271
Age/Gender		
Age 45 to 64/Female		0.068
Total		2.00

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BEST PRACTICE IN DOCUMENTING DIABETES

- Make sure the diabetes and complication(s) are well documented and the complication is linked by using “with”, “due to”, or “secondary to”, showing a cause-and-effect relationship.
- Pulling the diabetes with complication code is not enough. Both the DM and the Complication need individual documentation as they fall into 2 CDPS categories and both conditions need documentation.

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CARDIOVASCULAR & DIABETES CATEGORIES

Four Cardiovascular categories:
Cardiovascular, extra low (CAREL)
Cardiovascular, low (CARL)
Cardiovascular, medium (CARM)
Cardiovascular, very high (CARVH)
It is important to capture all conditions.

Example:
HTN is in category Cardiovascular, extra low (CAREL).
HTN with CHF (I11.0) is in Cardiovascular, medium (CARM).
(Higher payment)
HTN with CHF and CKD (I13.0) pays for Cardiovascular, medium (CARM)
but also Renal Medium (RENM).

Diabetes has two categories:
Type 1 DM (DIA1) and Type 2 DM (DIA2).
The complications do not change anything in CDPS.

However, if a patient has DM2 with CKD (all levels CKD – Unspecified through End Stage) this would fall into 2 categories DIA2 plus Renal Medium (RENM).

Examples:
DM2 with Neuropathy – 2 categories: DIA2 and Central Nervous System, low (CNSL)
DM2 with PVD – 2 categories: DIA2 and Cardiovascular, low (CARL)
DM2 with Cataracts – 2 categories: DIA2 and Eye, very low (EYEVL)

The specificity in documentation is very important! Code all conditions and provide individual documentation for each.

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DOCUMENTATION SPECIFICITY

- Documentation should be as specific as possible.
- Specific documentation and coding guidelines are mandated by HIPAA.

If you mean.....	Don't say.....
Chronic obstructive asthma with acute exacerbation	COPD
Hypertensive heart disease with heart failure	Heart failure/Hypertension
Lung cancer with metastasis to liver	Lung cancer Liver cancer
Alcohol Dependence	Alcohol abuse
Dominant side hemiplegia due to CVA	History of CVA/ Hemiplegia

Frequent coding errors

- Coding a past condition as active
- Coding a history of when condition is still active.

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QUALITY & CODING

QUALITY MEASUREMENT SYSTEMS

Compliance

- Meeting requirements of all payors, state/county/federal regulations, contracts, and accreditation entities

Reimbursement Accuracy

- Ensuring that we are billing for the appropriate service at the highest appropriate reimbursable rate

Quality

- Providing documented care that is evidence-supported results in strong, equitable, measured outcomes for people served

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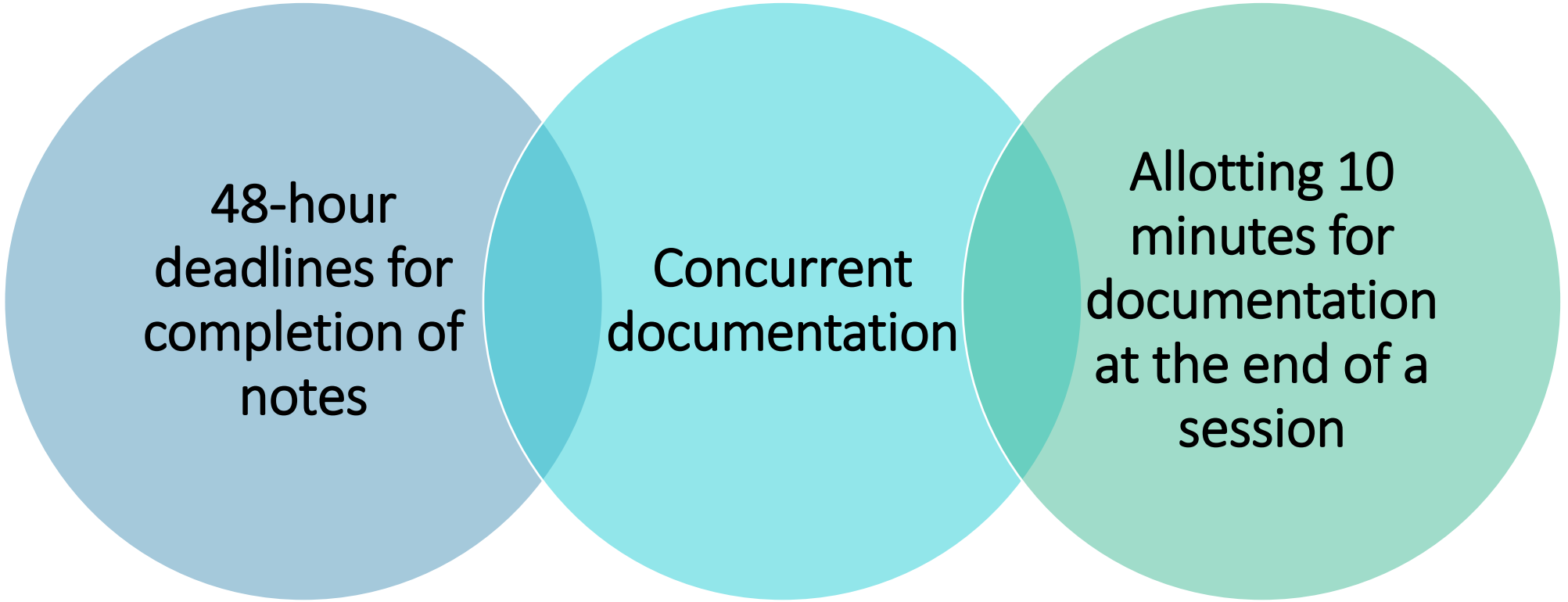
QUALITY MEASUREMENT SYSTEMS

Techniques for maintaining timeliness of documentation:



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QUALITY MEASUREMENT SYSTEMS

Example:
Clinic director maintains a dashboard with key measures:

Outcomes:
- Improved mental health symptomology
- Number of toxicology screens showing reduced use
- Number of people living with HIV who are virally suppressed
- Number of people with diabetes who improved their HbA1c

Process:
- Number of no-shows
- Percentage of people retained in care at 30, 60, 90 days

Business Operations:
- Revenue collected
- % of time spent in direct service

QA/QI plan and schedule:

- *What* do we want to measure?
- *Why* do we want to measure it?
- *How* do we want to measure it?
- About *whom* do we want to measure it?
- *Where* can we track that information?

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CLINICAL DOCUMENTATION IMPROVEMENT (CDI) PROCESSES

Convene a multi-disciplinary team of leaderships and clinical to develop a CDI process. Can be done proactively, retrospectively or a combination.

Conduct a gap analysis to identify documentation issues in the following areas:

- Patient population
- Severity of illness and/or risk of mortality
- Patient safety indicators
- Hospital-acquired conditions
- Key quality measures
- Claim denial rates
- Hierarchical Condition Categories

CASE STUDY: *Heritage Valley Health System in Pennsylvania implemented a clinical documentation improvement program and saw a 27% mortality rate reduction.*

In a provider's office, the CDI staffer will review the medical record and identify issues such as:

- Medication is prescribed but the condition for which it is prescribed is not listed.
- The cause-and-effect relationship between two conditions was not documented.
- There is clinical evidence for a higher level of severity of a diagnosis than was reported.

Clinical Documentation Improvement Vital for Patient Care (ehrintelligence.com)

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SUMMARY

- Provider and facility compensation is tied to **high quality documentation,** coding and quality metrics.
- Healthcare providers need **to prove** through clinical documentation and tracking outcomes/quality that you are delivering high quality care.
- Data tools are critical- especially those that allow real-time reporting to drill down to ICD-10 codes, complications and other specialized details to see how your organization is performing.
- Training & continuous quality improvement are essential to advance from FFS to value based models
- It is important that all chronic conditions are documented thoroughly and to their greatest specificity for quality patient care, defensible documentation and for greatest reimbursement potential.
- Then they are coded and either risk adjust or not.
- The accuracy of physician documentation and effective revenue cycle management allows organizations to adopt proactive initiatives such as clinical documentation improvement and training that maximize resources and achieve optimal outcomes.

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APPENDIX

DEFINITIONS

CDPS: A risk adjustment model used by many Medicaid entities

Risk Adjusted reimbursement: Revenue that is based on the diagnoses that create risk for the patient and financial risk for the payor.

RAF – Risk Adjustment Factor: A numeric weight assigned to each condition determined to have financial impact.

Risk Score: The total of all RAFs for a patient or the average RAF for a group of patients.

Risk Adjustment Coding: The assignment of the most specific ICD-10 diagnosis codes.

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WRAP-UP/NEXT STEPS

BRIEF EVALUATION

- Please Complete the Online Evaluation:

https://healthmanagement.qualtrics.com/jfe/form/SV_9zEbuA1AyGmE6IC

ADDITIONAL INFORMATION

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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