Optum

Winning on Value and Fee-for-Service with Outpatient CDI

HFMA Greater Heartland Chapter Summer Conference

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Agenda

Caroline Mei, RN, CPC, CRC
Manager, Ambulatory CDI
Optum Advisory,
Provider Finance & Operations

David Enevoldsen
Senior Director,
Optum Advisory,
Provider Finance & Operations

1. **Welcome & Introductions**
2. **Understand how the current environment is driving the need for ambulatory clinical documentation integrity (CDI)**
3. **Summarize key considerations unique to ambulatory CDI**
4. **Explain program components inherent in a successful ambulatory CDI program**
5. **Q&A**

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Underscoring the Importance and Complexity of Documentation

Addressing these challenges requires collaboration among healthcare providers, coders, administrators, and technology vendors to implement effective documentation and coding processes, ensuring compliance and optimizing reimbursement.

Middle Revenue Cycle

Clinical Story

Challenges

Accuracy

Compliance

Coding Complexity

Documentation Integrity

Electronic Health Records

Reimbursement

Physician Education & Training

Accurate Quality & Reimbursement

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According to CMS, Medicare Fee for Service ACO's are Thriving

Current ACO Coverage:
Nearly half of fee-for-service Medicare beneficiaries, or 13.7 million people, are covered under ACOs this year, a 3% increase, the agency said in a news release.

ACO Growth:
CMS' goal is that all fee-for-service Medicare enrollees will be under accountable care organizations or other valued-based care arrangements by 2030, and the agency is relying on potential cost savings to shore up the Medicare trust fund, which is projected to run dry by 2031.

Since 2021, CMS has undertaken steps to attract more providers and encourage more ACOs to form. For instance, the agency **reworked the Shared Savings Program** to promote risk sharing, offer upfront funding, and focus on rural and underserved enrollees. CMS also scrapped the Geographic Direct Contracting Model and replaced the Global and Professional Direct Contracting Model with ACO REACH.

The Shared Savings Program has 480 ACOs on board this **year**, including 71 renewals, 50 additional preexisting ACOs and 19 newly formed ACOs, CMS announced. These organizations comprise nearly **635,000 providers** that treat more than **10.8 million beneficiaries**, the agency said. Those providers include more than 9,000 community health centers, rural health clinics and critical access hospitals, which is 27% more than last year, according to CMS.

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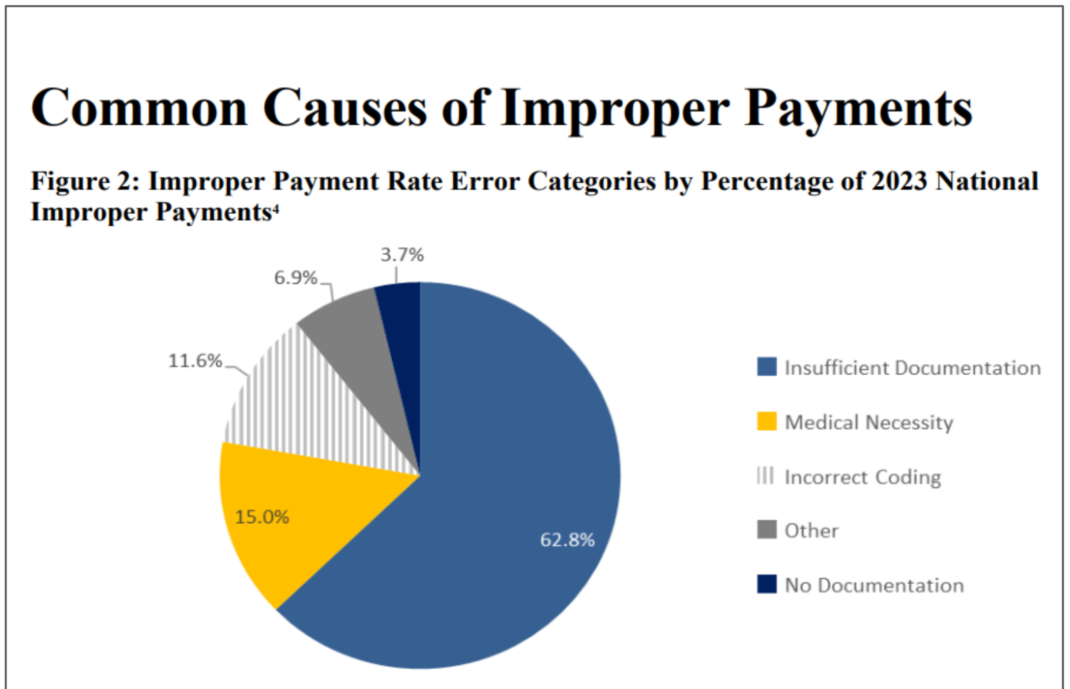
CMS: More ACOs participating in 2024 | Modern Healthcare

2023 Improper Payment Report from CMS Demonstrates Impetus for ACDI

The projected improper payment amount for Hospital Outpatient services during the 2023 report period was $4.0 billion, resulting in an improper payment rate of 5.2 percent. The following shows the top root causes of improper payments overall.



Top Root Causes for Office Visits - Established	
Root Cause Description	**Error Category**
Documentation supports lower level of E/M service than what was billed*	Incorrect Coding
Documentation supports higher level of E/M service than what was billed*	Incorrect Coding
Documentation for the billed date of service – Inadequate	Insufficient Documentation
Attestation for unsigned documentation – Missing	Insufficient Documentation
Documentation for the billed date of service – Missing	Insufficient Documentation
Note: Root causes frequently associated with partial improper payments are identified with an asterisk (*).	

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[Medicare Fee-for-Service 2023 Improper Payments Report (cms.gov)]

Settlement Over Improper Medicare Billing Claims

- "Penn State Health voluntarily disclosed in October 2023 the improper billings related to Medicare annual wellness visit services not supported by medical records.
- The allegations spanned December 2015 through November 2022.
- Worked with OIG on a settlement and repayment of any reimbursements that did not fully meeting Medicare documentation requirements.
- Penn State Health will pay more than $11.7 million to resolve allegations the health care system improperly submitted Medicare claims during the span of eight years."

$11.7M

Settlement Over Improper Medicare Billing Claims

"Penn State Health's Compliance Office discovered a discrepancy with regard to documentation requirements for Medicare Annual Wellness Visits. After discovering these documentation errors, Penn State Health voluntarily disclosed them to the United States Attorney's Office."

February 2024

Source: Centre Daily Times, February 7, 2024

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Medicare Advantage Compliance Audit of Specific Diagnosis Codes

Audit Focus

- The OIG "reviewed one MA organization, MediGold, and focused on seven groups of high-risk diagnosis codes.

- The audit objective was to determine whether selected diagnosis codes that MediGold submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

- OIG included a stratified random sample of 210 unique enrollee-years with the high-risk diagnosis codes."

High-Risk Diagnoses

- Acute stroke
- Acute myocardial infarction
- Embolism
- Lung cancer
- Breast cancer
- Colon cancer
- Prostate cancer

$2.2M

Estimated
Net Overpayments

We are recommending a refund of $2.2 million in net overpayments ($224,001 for the sampled enrollee-years from 2017 and an estimated $2 million for 2018).

U.S. Department of Health & Human Services | Office of Inspector General, February 2024

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Source: OIG, Feb 2024; Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MediGold (Contract H3668) Submitted to CMS (hhs.gov)

How and Why Providers Should Scale their HCC Risk Capture

Providers are embracing and experimenting with value-based risk-adjustment payment models.

Accurately defining, documenting and managing population complexity is more critical than ever. Hierarchical condition categories (HCC) codes are used to determine care funding under value-based payment programs within CMS, HHS and Medicaid risk-adjustment models and must be document and captured each year. But without the right support, risk-adjusted conditions can be difficult for providers to document.

Most providers have invested some infrastructure to facilitate complete and accurate documentation that supports HCCs. Yet to realize care and financial goals, they must consistently improve performance year over year.

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Six Pillars of CDI Program Success

Use Optum's framework to develop a holistic clinical documentation integrity program to support accurate and complete documentation in the outpatient and ambulatory care settings.

Defined Mission, Vision, Goals and Department Structure

Define the vision for ambulatory/outpatient clinical documentation integrity to incorporate both financial and quality goals necessary to both optimize and protect revenue, considering the shift to value-based care and increased quality risk arrangements.

Staffing, Productivity and CDI Roles

Prioritize task allocation across departments and within daily staff responsibilities to align with new mission and goals. Define FTE staffing requirements, skill sets and competencies. Develop and execute a detailed onboarding and ongoing training plan.

Efficient and Consistent Process Flow

Develop process and workflows to incorporate a clear mission and strategy for CDI and Coding. Revise current query process flows to adjust for utilization by all individuals, regardless of title, following AHIMA guidelines. Implement and/or optimize utilization of technology including natural language processing (NLP).

Strong Relationship and Rapport

Enhance integration and collaboration between CDI, Coding Education, Quality, Compliance, and Physicians through improved communication, education, and mutual goals.

Continuous Performance Accountability

Define performance metrics and tracking mechanisms to measure the outpatient CDI program impact on documentation integrity. Instill the ability and accountability for proactive processes through real-time monitoring and identification.

Consistency Across Care Settings

Integrate ambulatory/outpatient CDI efforts with key stakeholders and related departments to meet organizational goals for value-based care performance.

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CDI Program Considerations by Setting

Ambulatory CDI (ACDI) is challenging in that it cannot simply replicate inpatient-oriented CDI processes. The differences between inpatient and physician practices need to be considered in establishing an ambulatory clinical documentation integrity and education program.

	Type of Encounter	Timing	Technology Platform	Coding Framework	Oversight Responsibilities	Provider Clarification
Inpatient	Lower volume, higher payment per case	Multi-day stay	Unified	ICD-10 CM/PCS, DRGs	Hospital and system management	Reactive
Ambulatory Network	Higher volume, lower payment per case	~20-minute encounter	Disparate	ICD-10 CM, HCCs, CPT, HCPCS	Physician enterprise	Proactive
Key Differences Preventing Scale	Need to prioritize subset of cases	Need to get information during shorter visit	Must capture data from multiple sources	Need unique coding knowledge	Greater physician involvement required	Inpatient and ambulatory documentation and coding guidelines

While inpatient care allows time for concurrent CDI, outpatient care is better suited to CDI activities completed before (prospective) and after (retrospective) the patient visit.

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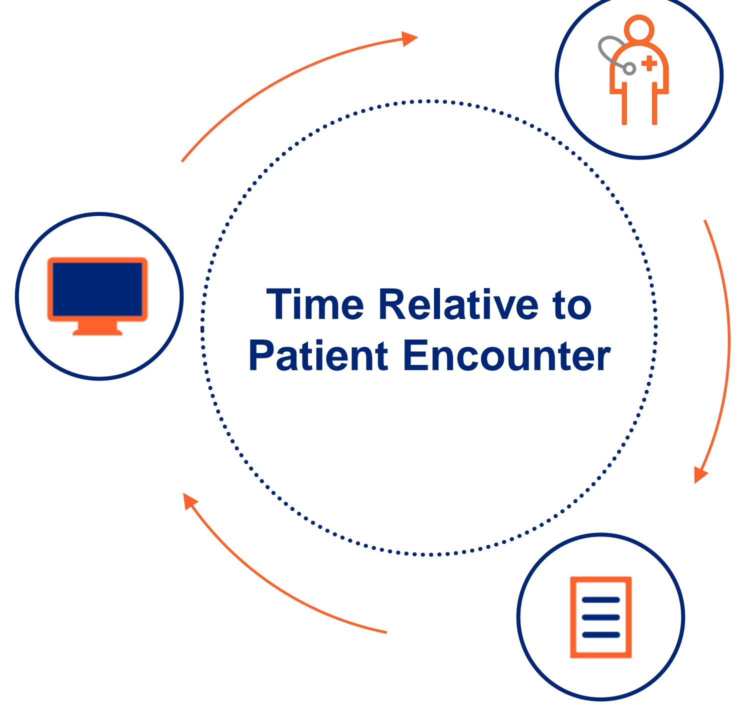
Key CDI Activities Relative to Patient Encounter

Through our research and experience to-date, we have found that identifying and designing consistent, hardwired effective processes and protocols both before, during, and after the patient visit is imperative to success.



Pre-Visit

- Chart Prep/Problem List Clean up
- Suspect Condition Review
- Annual Wellness Visit Prep
- Health Maintenance Review and Prep
- Pre-Visit Questionnaires
- Patient Scheduling & Activation

Point-of-Care

- Annual Wellness Visit completion
- Documentation workflow, methods, templates and efficiency
- Working at top of license
- Comprehensive ICD/HCC capture
- Health maintenance
- Accurate E&M selection
- Medication list reconciliation
- Enroll in Chronic Care Management Services

Post-Visit

- E&M Distribution and Profile Review
- Revenue and reimbursement accountability
- NLP targeted encounter review
- Denials management
- Claims Scrubbing / editing
- Work queue management
- Provider education

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Complete Documentation of Patient Complexity

Pre-Visit, Point of Care, and Pre-Bill teams working in tandem to fully capture complexity of care.

Pre-Visit

Establish a sustainable *pre-visit* process to support the identification of highly probable care gaps.

Point-of-Care

Pre-Bill

Close coding gaps *prior* to submitting the claim leveraging NLP powered review of 100% of encounters before claim submission.

1. Identify the **PATIENT** accounts with upcoming scheduled visits to be reviewed
2. Identify the **GAPS** that need to be addressed
3. Have the **CLINICIAN** see the patient to address the gaps
4. Ensure that **CONDITIONS** are properly documented according to MEAT criteria
5. Put the documented conditions on the **CLAIM** and bill for it

Add team to Ambulatory CDI **WORKFLOW** for simple, integrated access

Display clinical **EVIDENCE** to reveal why a suspect condition was identified using additional data sources (claims, unstructured data, etc.)

Allow team to easily **DOCUMENT** their care gap assessment and notify clinicians

Integrate highly probable suspect condition into provider **WORKFLOW** and ensure sufficient **RECONCILIATION** processes.

ADD documented diagnosis codes to the bill and/or **REMOVE** codes that are unsubstantiated

Leverage NLP to **INCREASE** review productivity, accuracy and efficiency

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Approach to Provider Documentation and Coding Education

1

Leverage Data

- Analyze data
- Benchmark performance
- Interview stakeholders
- Identify providers with documentation opportunities

2

Review Charts

- Use Client's own data and feedback from CDI team to identify specific charts with documentation opportunity
- Perform forensic documentation review
- Develop customized educational materials

3

Provide Education

- Equip providers with integral documentation concepts through one-on-one education sessions

4

Monitor and Report

- Provide post-education quality and financial metrics

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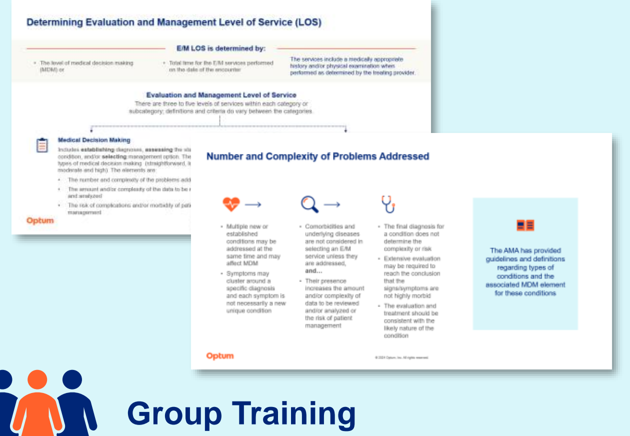
Various Modes and Topic Offerings for Education

Focus on Documentation Fundamentals

A range of potential topics for orientation/ annual competency:

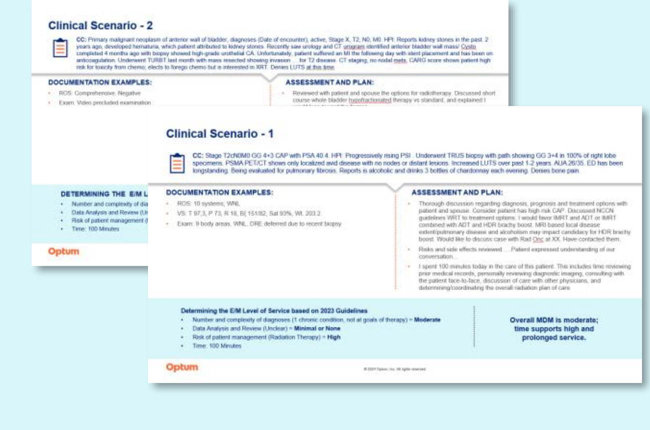
- CMS Regulatory Changes
- Coding Updates
- E/M Documentation Standards
- Diagnosis Specificity
- Preventive Visits and AWV
- Clinical-Risk Adjustment, HCC, RAF

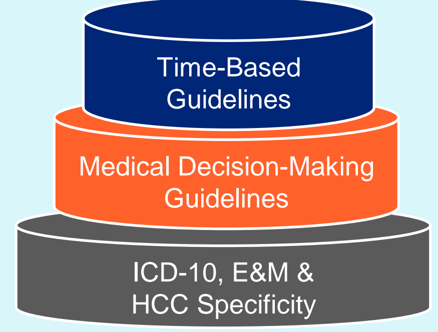


Group Training
(In-person, Live Remote, or Self-Directed)

Specialty Specific Topics & Scenarios

Tailored content for a range of specialties

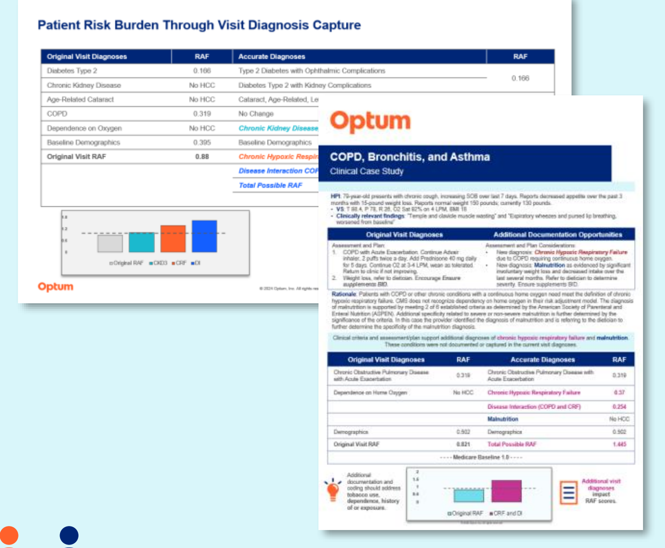


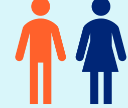


The Core of Ambulatory Education

Personalized Training for Practice & Provider Relevance

- Physician specific chart reviews and findings
- Focus on real case examples
- Disease state focused discussions and tips for documentation improvement and diagnosis specificity





1:1 Training
(In-person, Live Remote, or Self-Directed)

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Clinical Example: Urology Documentation Education

CC: Patient presents with Urinary Tract Infection

HPI: 87-year-old with hx of bladder CA presents today as a new patient for recent episode of asymptomatic gross hematuria x 3 days in urostomy bag and negative urine culture at ER [last week]. Pt denies any abdominal pain, flank pain, weakness, fatigue, fevers or chills.

Documentation Examples

- ROS, Vitals, and Exam: (well-documented)
- GENITOURINARY: RLQ red/pink stoma; urostomy light urine in urostomy bag

Data Reviewed:

- Urine culture was negative
- Per chart review, pt had a CTAP (7 years ago) that revealed right atrophic kidney and multiple abdominal wall hernias without obstruction

Assessment and Plan

1. *Gross hematuria*

   Hematuria could be trauma induced given hernia and being on blood thinner, otherwise unclear cause at this time. Family expressed concerns for cancer recurrence. Given CKD III history, I recommend CTAP without contrast for further eval to address concerns. Not candidate for CTU.

2. *Stage 3b chronic kidney disease*
3. *Atrophy of right kidney*

DETERMINING THE APPROPRIATE E/M LEVEL BASED ON MDM

- Number and complexity of problems addressed (1 undiagnosed new problem with uncertainty) = ***Moderate***
- Amount and/or data reviewed (1 lab reviewed, 2 tests reviewed/ordered) = ***Moderate***
- Risk of complications and/or morbidity of patient management (CTAP without contrast/“Not candidate for CTU.”) = ***Low***

Reported as 99203 (Low), however documentation supports 99204 (Moderate) based on MDM.

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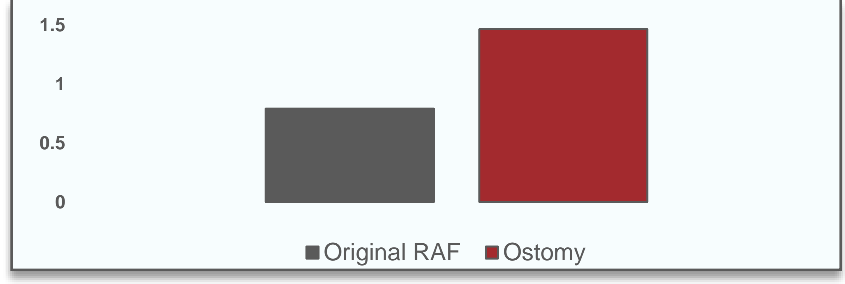
Patient Risk Burden Through Visit Diagnosis Capture

Original Visit Diagnoses	RAF	Accurate Diagnoses	RAF
Gross hematuria	No HCC	Gross hematuria	No HCC
Chronic kidney disease, stage 3b	0.127	Chronic kidney disease, stage 3b	0.127
Atrophy of kidney	No HCC	Atrophy of kidney	No HCC
		Ileostomy status	***0.673***
		Personal history of malignant neoplasm of bladder	No HCC
Baseline Demographics	0.664	Baseline Demographics	0.664
Original Visit RAF	**0.791**	***Total Possible RAF***	***1.464***



Additional visit diagnosis impact RAF scores

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Status Conditions | Artificial Openings

Status conditions need to be documented at least one time per year and are appropriate to capture every time they are addressed.

	Amputations	Status	Artificial Openings
Considerations	• After an amputation, subsequent documentation should indicate “amputation status” or “acquired absence” • What is the amputation etiology? Traumatic, or due to diabetes, infection, PVD or cancer	• Includes transplants of (any organ); clarify if there is failure or rejection • ESRD with **renal dialysis status (requires two visit codes)** • Add associated conditions such as immunodeficiency secondary to medications	• Include any ostomy, suprapubic catheters or stomas • Presence of an ostomy is captured with a status code • “Encounter for” is used when any care is directed at the ostomy • “History of” is used when an ostomy has been reversed • Add any associated conditions e.g., malnutrition or complications
Examples of “MEAT” • **Monitor** • **Evaluate** • **Assess** • **Treat**	• Assessment of amputation stump • Wound care, labs or cultures • Prosthetics/assistive devices • Lifestyle modifications • Pain medications	• Medication management and monitoring • Labs • Referrals	• Assessment of stoma • Dressing changes or wound care • Medications or enteral supplies • Consults with wound and ostomy • Other referrals

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Where to begin? Start by Assessing Current State

Organizations often are reactionary to underwhelming performance results and immediately want to jump into improvement mode. Before doing so, it is imperative that organizations assess their current state.

Organizational Commitment to Value-Based Care

Pre-Encounter	Pre-encounter suspect condition identification	Provider education and partnerships	NLP advanced analytics to identify suspect diagnosis	Robust patient activation and outreach strategy	Comprehensive performance analytics
Point-of-Care	EHR embedded workflow for gap closure	EHR-agnostic gap closure workflow	In-home assessments	Concurrent quality/HEDIS documentation and capture	
Post-Encounter	Post-encounter coding	Prioritized work queues for coding staff	Integration with disease management programs	Retrospective reviews/chart audits	

People
Organize and leverage talent effectively across network

Processes
Bring technology and people together to achieve outcomes

Technology
Use existing systems and robust analytics to drive ROI

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Ambulatory CDI Program Assessment

Optum Advisory recommends defining your focus areas and quantify the potential financial impact that can be gained from developing an outpatient and ambulatory CDI program. As part of the assessment phase, you should focus on the following activities.

Performance Data Analysis

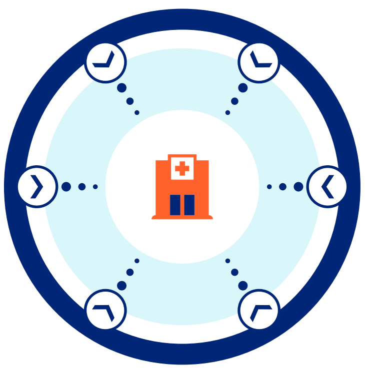
- Collect data elements to benchmark performance (denials, RAF capture rate, E/M distribution, etc.)
- Analyze KPIs to identify gaps in current state compared to industry best practices at clinic, specialty, and physician level
- Quantify financial opportunity and program return-on-investment potential

Workflow Evaluation

- Conduct a gap analysis to compare current ambulatory operations to best practice
- Observe a representative sample of sites to understand execution of day-to-day responsibilities and shadow physician workflows
- Understand existing physician education strategy
- Conduct stakeholder interviews and process mapping as appropriate

Multidisciplinary Staffing & Org Structure Review

- Assess management authority, hierarchies, clinical skill mix, job functions and duties, span of control, productivity, and staff efficacy to determine future players and stakeholders in ambulatory CDI
- Conduct stakeholder interviews to understand current perspectives on ambulatory CDI to navigate any barriers



Applications & IT Review

- Evaluate current EMR and supporting applications based on current workflows and utilization
- Complete data tracing exercises to identify inaccurate information capture and matriculation
- Catalog automation capabilities available, and estimate possible complexities for future adoption and associated impact
- Evaluate currently used reporting tools

Implementation Blueprint Design

- Develop implementation plan to guide and govern optimization efforts
- Recommend ambulatory CDI program KPIs ensure accountability
- Identify team leaders and launch workstreams to kick off initiative

Chart Analysis & Review

- Conduct targeted, deep-dive chart reviews for a sub-set of encounters to identify reimbursement opportunities
- Reviews will assess accuracy and capture of several chart elements necessary for optimized reimbursement including CPT/HCPCSs, E&M levels, HCCs, etc.

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Ambulatory CDI Program Optimization

There is no one size fits all approach to building the right program for your organization. Optum Advisory can help you identify and prioritize your opportunity, implement a comprehensive program, and optimize performance across provider and specialties.

Blueprint for a Scalable Program

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