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Ambulatory Clinical Documentation Integrity

Unlock the Potential of your Clinical Mid-Revenue Cycle

HFMA Hawaii Chapter 2024
Revenue Cycle Seminar

November 8, 2024
1:30PM – 2:30PM HST

Agenda

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Purpose

While every organization's journey towards risk-based reimbursement is variable, all medical groups must balance fee for service and value-based documentation needs for the foreseeable future. This discussion highlights a framework for ambulatory CDI, as well as avoid potential pitfalls across the outpatient continuum.

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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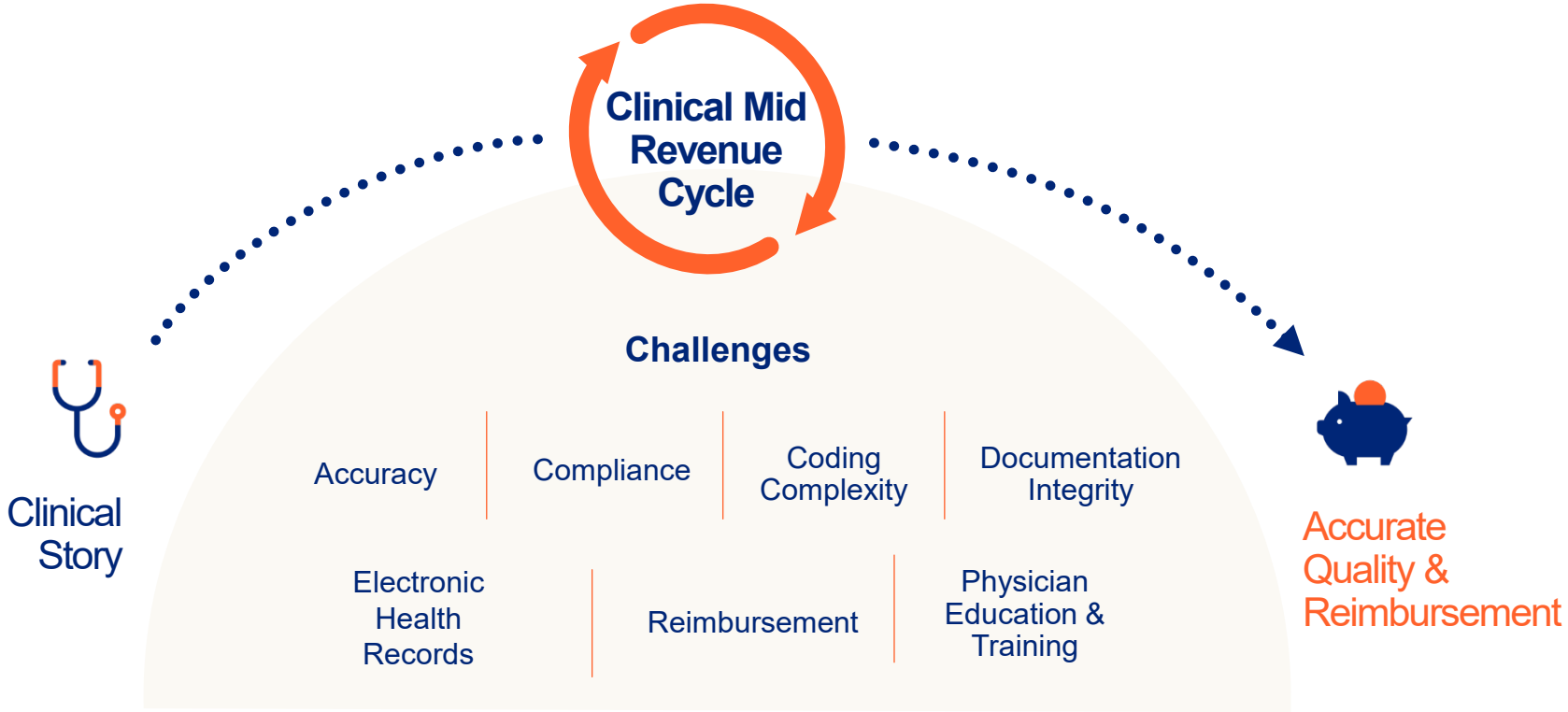
Underscoring the Importance and Complexity of Documentation

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.

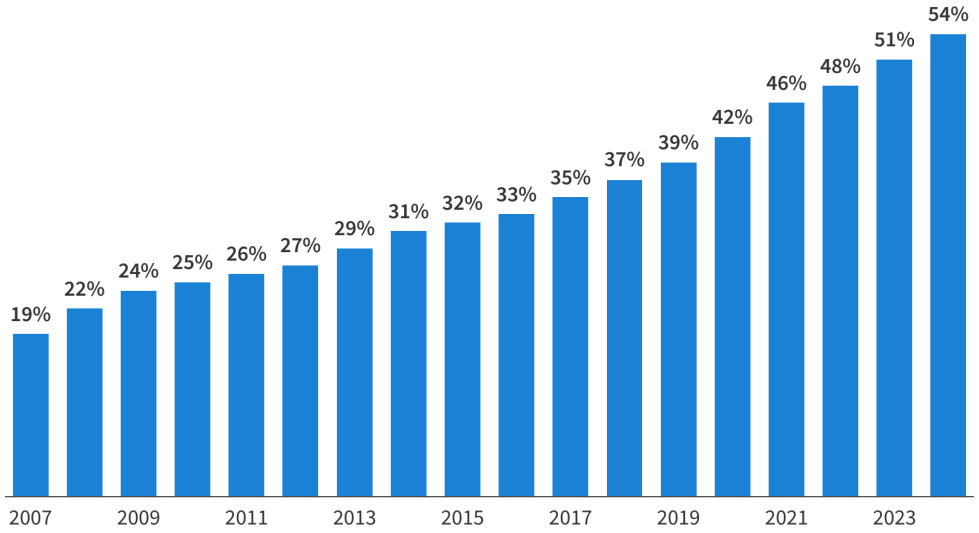


Medicare Advantage Has Almost Tripled Since 2007

CMS risk-adjusts the capitated payments to Medicare Advantage (MA) plans based on an enrollee's "risk score" – a measure of the expected costs associated with a person's care. Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called "risk adjustment" to adjust payments based on the health status of enrollees.

Figure 1

Total Medicare Advantage Enrollment, 2007-2024



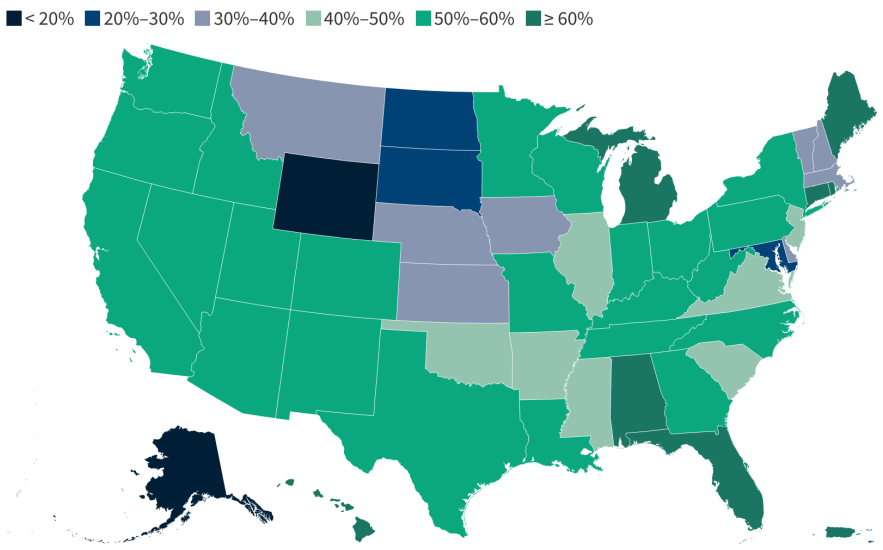
Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.6 million people are enrolled in Medicare Parts A and B in 2024.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024.

KFF

Share of Beneficiaries Enrolled in Medicare Advantage in 2024, by State

Click on the buttons below to see enrollment data for 2024 and 2014:



Note: Includes only Medicare beneficiaries with Part A and B coverage.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2014 and 2024.

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Source: Kaiser Family Foundation
https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

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)

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

Medicare HCC Model V28 Better Reflects the Costs of Care

Conditions captured in 2023 will drive final 2024 (financial reconciliation) which is released in August 2025 using the HCC transition model: 33% V28 and 67% V24.

Alignments Across the Health Care System

The updated risk adjustment model is developed **using ICD-10 codes**, rather than ICD-9 codes, to align with the rest of the health care system, which has been using ICD-10 since 2015.

Updated Data

It also incorporates newer data – the existing V24 risk adjustment model is calibrated with 2014 diagnosis data and 2015 FFS expenditure data and the new model (V28) uses 2018 diagnosis data and 2019 expenditure data.

Clinically-Based Adjustments

Importantly, the revised model includes **clinically-based** adjustments to ensure that conditions included in the model are **stable predictors of costs**. These adjustments help ensure payments accurately reflect what it costs to care for beneficiaries and make the model less susceptible to discretionary coding, which can lead to excess payments to MA plans.

The CY 2024 Rate Announcement finalized an important transition to an updated risk adjustment model that implements a set of common sense, clinically-based technical updates needed to keep MA payments up-to-date and to improve payment accuracy to MA plans.

Date of Service Year 2023

- 2023 Claims Data
- 2025 Final Payment
- 33% V28
- 67% V24

Date of Service Year 2024

- 2024 Claims Data
- 2026 Final Payment
- 67% V28
- 33% V24

Date of Service Year 2025

- 2025 Claims Data
- 2027 Final Payment
- 100% V28

"Diagnoses captured during the year prior to the performance year impact the ACO's benchmark during the performance year; financial reconciliation is provided in August of the following year". – Value-Based Care Executive

Source: *Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (cms.gov)

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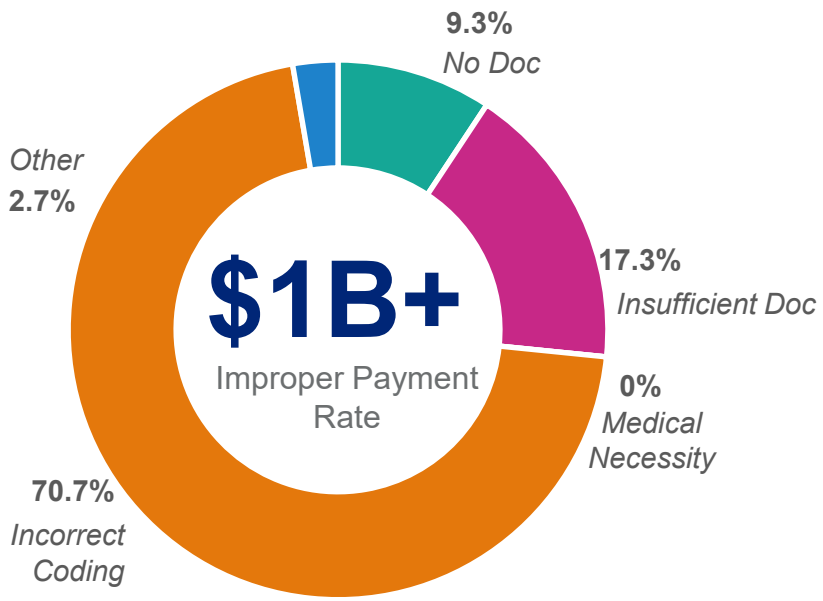
2023 Improper Payment Report from CMS Demonstrates Impetus for ACDI

This tables below is sorted in descending order by projected improper payments with Office Visits – Established projecting improper payments greater than $1B or a 6.4% improper payment rate.

Percent of Service Type Improper Payments by Type of Error

Part B Services: Office Visits - Established



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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Source: Medicare Fee-for-Service 2023 Improper Payments Report (cms.gov)

2024 CPT E/M HCPCS Updates

A summary of key changes related to Evaluation and Management – the focus of our Profee provider documentation education – is found below.

Significant Changes Made to:

- Introduced new complexity code (G2211)
- Split or shared visits
- Multiple E/M services on the same date
- Proper use of hospital inpatient or observation services (including admission and discharge services) – 99234, 99235, 99236

CMS' goal is to move towards administrative simplification and greater knowledge of certain rules.

Split or Shared Services

- If using time, whoever spends the majority of total time on the date of the encounter reports the service
- If using MDM, whoever approves the care plan for the problems addressed reports the service

Multiple E/M Services

- Adopts long-standing, generally accepted rules and CMS policy
- Exception: CPT codes allow reporting two services by the same practitioner on the date of another E/M service, whereas CMS does not

Admission or Discharge Services

- Revisions provide direction on the appropriate use/label of certain types of services for coding and create consistency with CMS
- Address short stays (<8 hours) on same or different date as date of admission or start of observation

Office / Outpatient Visit Complexity

- Goal is to pay to treat single, serious conditions or a complex condition with a consistency and continuity over long periods of time
- Not all E/Ms are eligible
- Not reimbursable when used with modifier 25, on the date of a minor procedure

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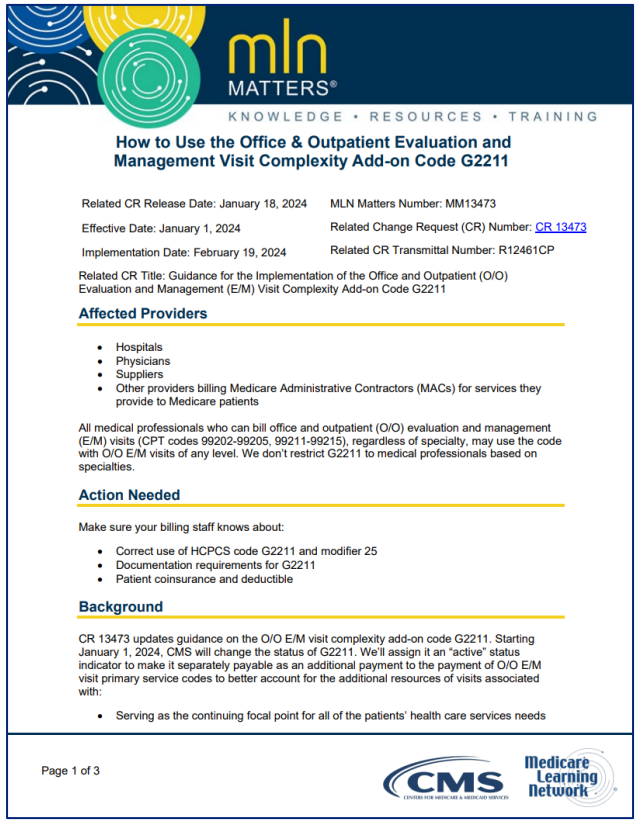
1. American Medical Association
2. Optum360

Office/Outpatient Visit Complexity: G2211

Medicare's HCPCS code to describe intensity and complexity inherent to Office/Outpatient E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. The 2024 national Medicare allowable for G2211 is $16.05. CMS assumes 38% of all E/M services in 2024 will be billed with G2211.



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How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

Related CR Release Date: January 18, 2024 — MLN Matters Number: MM13473

Effective Date: January 1, 2024 — Related Change Request (CR) Number: CR 13473

Implementation Date: February 19, 2024 — Related CR Transmittal Number: R12461CP

Related CR Title: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211

Affected Providers

- Hospitals
- Physicians
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

All medical professionals who can bill office and outpatient (O/O) evaluation and management (E/M) visits (CPT codes 99202-99205, 99211-99215), regardless of specialty, may use the code with O/O E/M visits of any level. We don't restrict G2211 to medical professionals based on specialties.

Action Needed

Make sure your billing staff knows about:

- Correct use of HCPCS code G2211 and modifier 25
- Documentation requirements for G2211
- Patient coinsurance and deductible

Background

CR 13473 updates guidance on the O/O E/M visit complexity add-on code G2211. Starting January 1, 2024, CMS will change the status of G2211. We'll assign it an "active" status indicator to make it separately payable as an additional payment to the payment of O/O E/M visit primary service codes to better account for the additional resources of visits associated with:

- Serving as the continuing focal point for all of the patients' health care services needs

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CMS Medicare Learning Network

E/M Code	Code Description
+G2211	• Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.
Additional Details	• Add-on code, list separately **in addition to** office/outpatient E/M visit, new or established. • Includes services that enable practitioners to **build longitudinal relationships** with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. • Reporting is **not restricted based on specialty**, but certain specialties will likely furnish these types of visits more than other specialties. • CMS does not expect reporting of HCPCS code G2211 when the office/outpatient E/M visit is reported with payment modifiers such as a **modifier 24 or 25.** • HCPCS code G2211 may be reported with **any visit level.**

MM13473 - How to Use the Office and Outpatient Evaluation and Management Visit Complexity Add-on Code G2211 (cms.gov)

Our Point of View on Ambulatory Documentation

Ambulatory environment requires a **different-in-kind approach** than traditional Inpatient CDI

The **motivations and goals behind each ambulatory CDI program vary** based on their organizational make-up, payer mix, current state performance, etc.

Ambulatory CDI is still in its early stages across the industry, with just 27%[1] of ACDIS respondents either having a dedicated outpatient CDI program or inpatient CDI reviewing some outpatient records.

Hallmarks for success in ambulatory environment closely align with inpatient: defined purpose, well-defined team and roles, efficient process flows, strong relationships, and a continuum-wide strategy

Professional Fees

With the 2021 & 2023 changes to E&M reimbursement methodology, capturing accurate documentation for high-cost surgical procedures is critical to ensure medical necessity and associated reimbursement.

Downstream Denials

Use retrospective denials data to target route causes and implement prevention strategies up-front to decrease denials, reduce cost to collect, and accelerate cash.

New Revenue Streams

Take a proactive approach to capture a new revenue stream such as Annual Wellness Visits; identify Medicare population eligible for this reimbursable service with specific documentation requirements.

Risk-Based Reimbursement

Accurate risk-adjusted payment relies on comprehensive documentation and diagnosis coding; educate and support providers in capturing hierarchical condition categories (HCCs) to capture additional reimbursement.

Optum believes speaking a common language with our clients is important, and thus we offer the following possible delineations/definitions for outpatient versus ambulatory documentation and coding integrity:

Acute Care Outpatient

- Focus on key areas within the hospital facility that deliver outpatient services (e.g., Emergency Department, observations, etc.)
- Not inclusive of the professional office setting

Outpatient

- Inclusive of both acute care outpatient and ambulatory settings
- Addresses both fee-for-service and risk-based populations and opportunities

Ambulatory Care

- Focus on professional setting (office visits, in office procedures, ambulatory surgical centers, etc.)
- HCC, Risk Adjusted Factor (RAF), Risk, etc.
- Not inclusive of the acute care outpatient setting

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Source: ACDIS

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, ambulatory care is better suited to CDI activities completed before (prospective) and after (retrospective) the patient visit.

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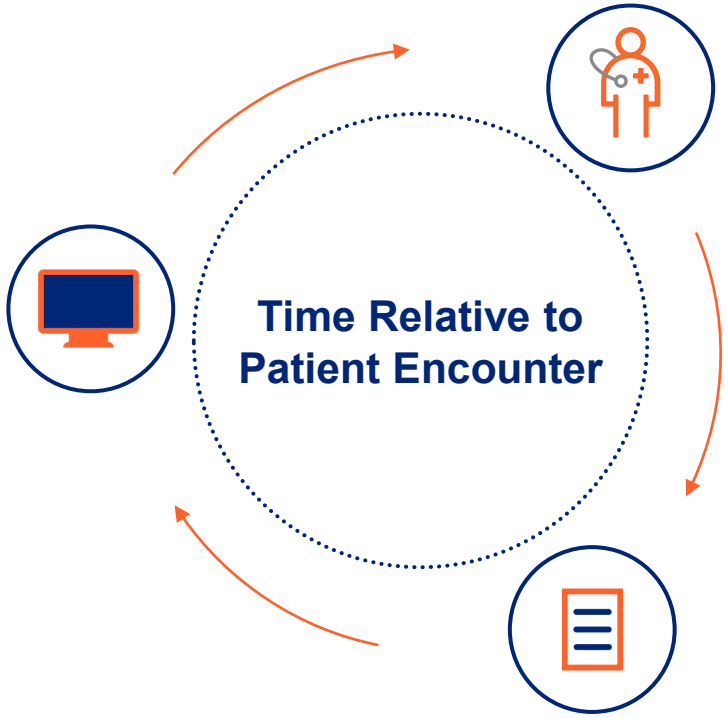
Key Activities Relative to Patient Encounter

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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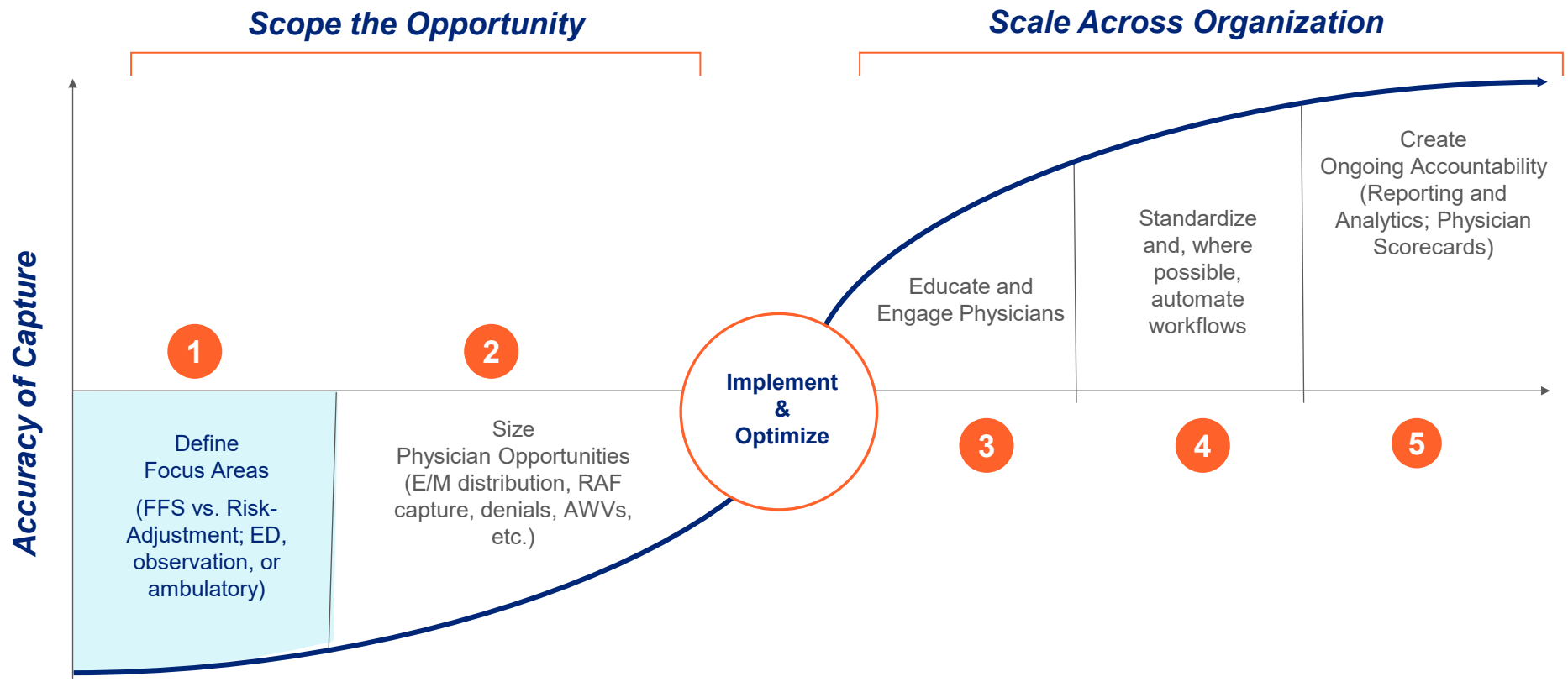
Where to Begin?

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



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 ambulatory/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.

Essential Questions

Strategy

What are the primary objectives of your Ambulatory CDI program?

Balance

How do you balance the need for accurate documentation with the administrative burden it places on clinicians?

Alignment

What strategies have you implemented to ensure that CDI efforts align with both fee-for-service and value-based care models?

Enhancement

What role does technology play in your CDI processes, and how do you ensure it enhances rather than hinders clinical workflows?

Success

How do you measure the success of your ambulatory CDI program, and what key performance indicators (KPIs) do you track?

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Ambulatory Clinical Documentation Integrity (ACDI) Program Evolution

Timeline for scaling an ACDI program and HCC capture interventions across Primary Care.

Year Diagnoses are Captured	Integration 2018	Assessment & Planning 2019	Disruption 2020	Strategic Expansion 2021	Significant Growth 2022	Optimization 2023
# of ACDI Covered Clinics/Practices	5	5	12	23	74	76
# of ACDI Team Members	2	2	12	12	22	22
# CDI Chart Reviews	-	-	17,434	30,490	65,448	74,900
HCC Capture on All-Payer Claims	-	-	NA	95,483	106,624	138,976
MSSP Risk Adjustment Factor (RAF)	-	-	0.941	0.942	TBD – reported in CY24	TBD – reported in CY25

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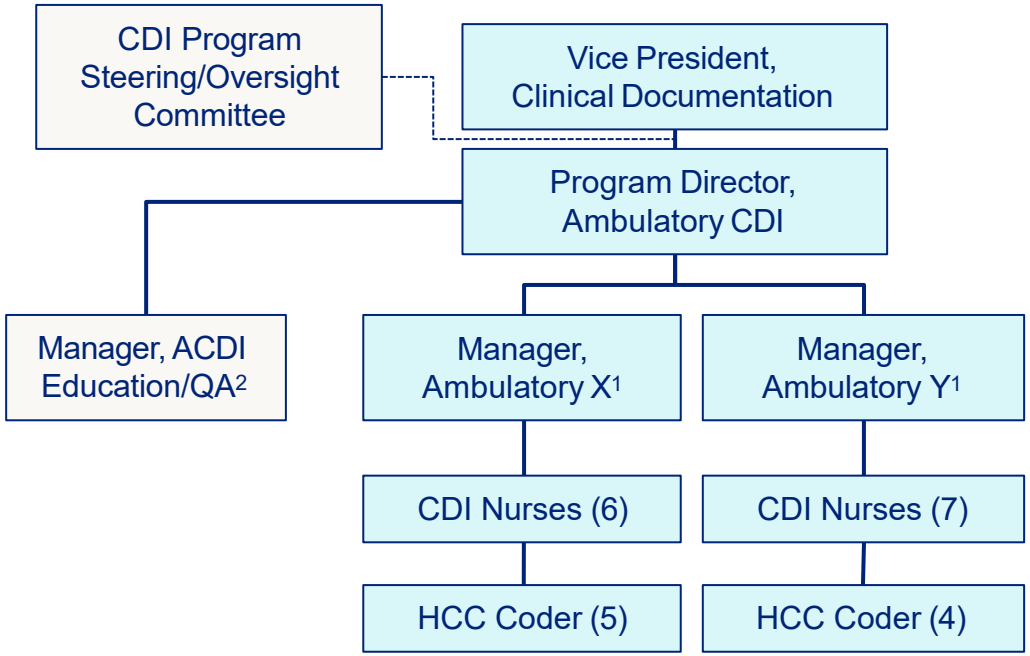
ACDI Program Mission Statement

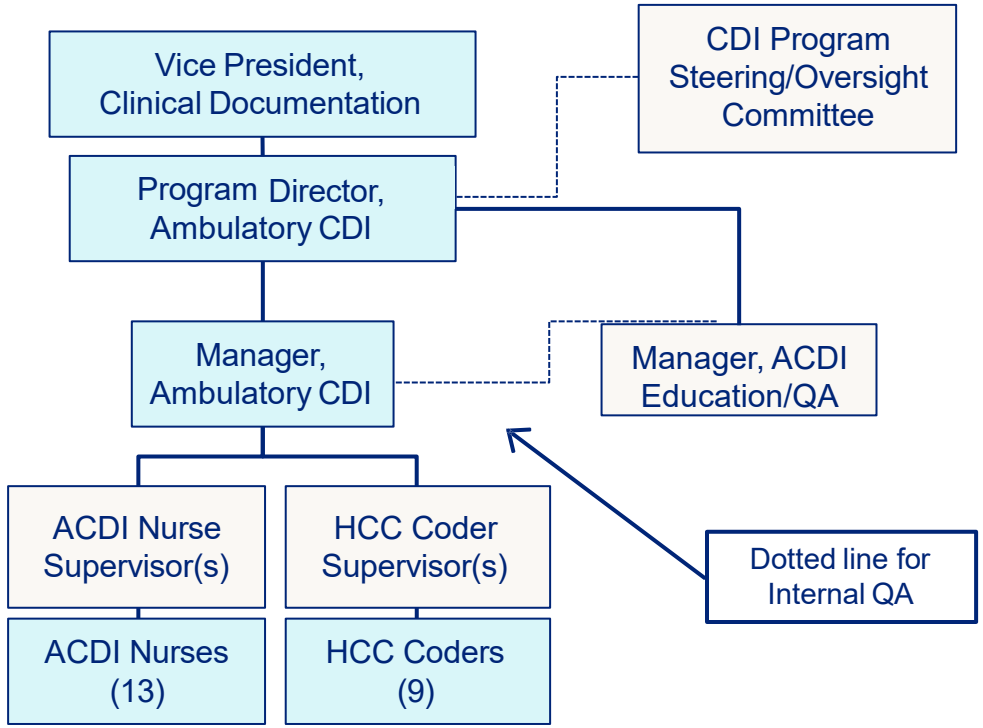
“The Ambulatory Clinical Documentation Integrity (ACDI) team supports the program and physician practice operations through pre and post encounter clinical documentation review to ensure that all conditions that have been documented are captured and accurately billed to the appropriate payer.”

ACDI Program Org Structure

Education and Quality Assurance Focus



Role-Based Management



1. Education/QA Manager must be a Registered Nurse and appropriately credentialed in risk adjustment and clinical documentation.

Assessing ACDI Staffing Needs

The model below outlines initial staffing and expansion options, both with and without technology enablement, based on 2023 volumes. Optum recommends initially staffing 10.8 RN FTEs and 4.7 RA Coder FTEs, along with 3 Managers and a shared Analyst.

		Medicare Advantage		Medicare Shared Savings Program		All Risk Plans	
	Staffing Model Criteria (*CY23*)	AWV Only	AWV + Follow-up Visits	AWV Only	AWV + Follow-up Visits	AWV Only	AWV + Follow-up Visits
	Total Annual Covered Lives	50,000		25,000		75,000	
	% of Members with AWV[5]	67%		64%		66%	
	Avg. PCP Visits per Member[6]	3.32		3.32		3.32	
With NLP (or like functionality)[1]	ACDI Nurse FTEs	2.9	12.0	1.4	16.0	4.3	18.0
	RA Coder FTEs	1.5	7.6	0.7	3.8	2.3	11.4
Without NLP[2]	ACDI Nurse FTEs	7.3	30.0	3.5	15.0	10.8	45.0
	RA Coder FTEs	3.2	15.8	1.5	7.9	4.7	23.6

Staffing Model Inputs

- Use of technology enablers
- Number of visits per member per year
- Total attributed lives
- Percent of members with AWV
- Avg. follow-up visits per member
- Expected ACDI RN and RA Coder productivity

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1. "With NLP" model assumes 6.5 productive hours per day for RNs, with a productivity of 6-8 charts/hour, and 7.5 productive hours per day for coders, with a productivity of 10 charts/hour. Productivity may vary by technology enablement solution.
2. "Without NLP" model assumes 6.5 productive hours per day for RNs, with a productivity of 3-4 charts/hour, and 7.5 productive hours per day for coders, with a productivity of 6 charts/hour.
3. Model assumes a coverage rate of 100% of eligible visits without NLP and 80% coverage rate with NLP (or like functionality)
4. Model accounts for a 5-day work week and 26 days of holiday, PTO, and sick time.

Establishing an Ambulatory Clinical Documentation Integrity (ACDI) Governance Structure

A well-defined governance structure is essential to achieve and maintain ACDI program results, having overarching authority to promote and hold accountable cross functional workflows.

Governance Group

Maintain and support ACDI program goals

- Support achievement of best practice clinical risk adjustment processes
- Define Key Performance Indicators and review performance monthly
- Communicate program successes
- Review root cause analysis of obstacles and barriers to program success, take ownership, and create action plans for resolution
- Coordinate, collaborate, and communicate with related disciplines to address and integrate opportunities for documentation improvement

Commissioned Work Teams

Manage operational challenges and risks and provide recommended program changes, including technology solutions

- Engage, facilitate, and foster provider engagement and leadership
- Review reporting and identify root cause analysis of obstacles and barriers to program success
- Provide support to practice leadership
- Identify needs of executive team to remove barriers
- Ex. Pre-Visit Planning Work Team, Post-Visit Work Team, etc.

Example ACDI Governance Structure

Purpose: Define, guide, govern, and enforce the ACDI program goals, strategic mandates, financial incentives, policies, procedures and return on investment to support long-term program success.

Short Term Goal

Swift decision-making from clinical and operational leadership on initiatives and performance that impacts ACDI program goals and development

Long Term Goal

Development and continued optimization of best-in-class ACDI program to drive optimal risk reimbursement, RAF capture and chronic disease management

ACDI Core Team

Governing body for ACDI strategic imperatives supported by three (3) work teams

1 Pre-Visit Planning Work Team

- Chart auditing
- Problem list cleanup
- Suspecting

2 Post-Visit Work Team

- Post encounter documentation review

3 Provider Engagement Work Team

- Education
- Coaching
- Performance Improvement

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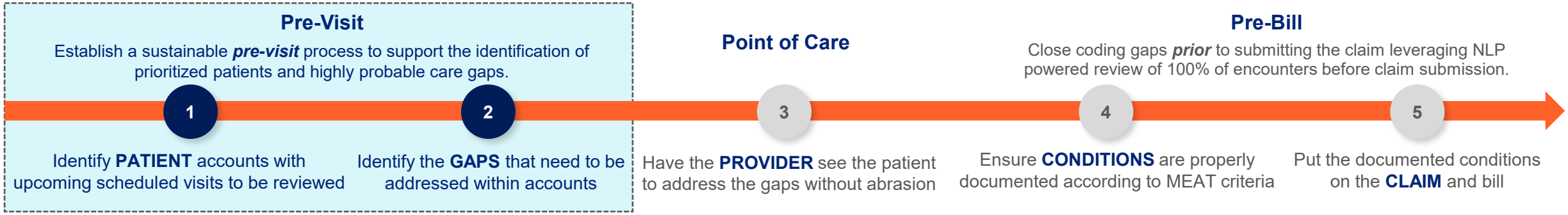
Exploring a Pre-Visit Planning Team Development

Blueprint Development: Achieving Complete Documentation of Patient Complexity

Best practice workflow ensures Pre-Visit, Point of Care, and Pre-Bill teams work in tandem to fully capture complexity of care. OA and Agora focused entirely on pre-visit team development for this engagement.



Problem List Management

A role-based future state model allows pre-visit ACDI staff to operate at top of license when aiding in Problem List maintenance, therefore allowing providers more time to focus on quality patient care.

Role	Tier One: ACDI Pre-Visit Clinical Staff	Tier Two: Provider
Responsibilities	Ability to update (add/resolve) the Problem List for limited diagnoses inside clearly defined documentation criteria including the following 15 Suspect Conditions on current EPIC BPA algorithm.* • Morbid Obesity • CKD Stage 3-5, ESRF (ESRD) and / or Dialysis status • Angina • Amputation Status • Chronic Respiratory Failure • CHF • PAD, PVD, and Atherosclerosis • Diabetes, Poor Control, any associated related manifestations / complications Reconciliation of external Medical Record documentation with Epic Problem List Review of Problem List for acute diagnoses no longer present * Suspect conditions outside of the Clinical CRA approved chronic conditions guidelines require providers review and addition to the problem list, if appropriate.	The ultimate responsibility for maintaining and ensuring accuracy of Problem List. • Review Problem List during patient visits to ensure Problem List reflects current and active problems

Supercharge ACDI Impact with Technology Enablement

Technology enablers will increase ACDI chart coverage, productivity, and overall RAF score through identification of suspect conditions, review prioritization, and other means.

1. Patient Activation
Scheduler makes outbound call to patient

2. ACDI Pre-Visit Review
ACDI RN conducts a comprehensive review to identify suspect conditions and chronic conditions in need of refresh

3. ACDI Pre-Visit Query
ACDI RN pushes BPA(s) to the provider

4. Visit Documentation
Provider addresses relevant BPAs and documents all addressed conditions and activities performed

5. Problem List Maintenance
Provider and care team update the Problem List to accurately reflect active and past conditions

6. ACDI Post-Visit Review
ACDI RA Coder reviews encounter documentation and code set for clarity and accuracy

7. ACDI Post-Visit Query
RA Coder sends query to provider to ensure documentation supports assigned codes

8. Provider Query Response
Provider responds timely to post-visit query, allowing RA Coders to adjust code set and release encounter for billing

9. Reporting and Analytics
On an ongoing basis, pre-set KPI dashboards and reports are refreshed and distributed to all stakeholders

Technology Enablement Prioritization

Integrations with Epic:

1. Pre-visit NLP or similar
2. Encoder
3. Post-visit NLP
4. Business Intelligence (BI)

Native Epic functionality:

1. Best practice advisories (BPAs)
2. RAF gap calculation
3. Epic work queues & routing rules
4. Standardized documentation templates
5. Standardized SmartPhrase library
6. Risk Adjustment dashboards
7. Specialty-specific diagnosis favorite lists

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Indicates opportunity for technology enablement

ROI is Variable Based on Technology Enablement Decisions

Optum Advisory's return on investment (ROI) calculations assume a July 2024 ACDI launch, with staffing costs held constant across all three years.

Year 1 (2025)

ACDI only, using native Epic

Shared Savings Increase
- MSSP: $2.6M
- MA: $12.9M

Investment
- Staffing: $2M {19 FTEs}

Estimated Net Income: $13.4M

ACDI with technology enablement

Shared Savings Increase
- MSSP: $4.8M
- MA: $13.9M

Investment
- Staffing: $995K {9.1 FTEs}
- Tech. Enablement: $2.2M

Estimated Net Income: $15.5M

Year 2 (2026)

ACDI only, using native Epic

Shared Savings Increase
- MSSP: $2.7M
- MA: $17.3M

Investment
- Staffing: $2M {19 FTEs}

Estimated Net Income: $18M

ACDI with technology enablement

Shared Savings Increase
- MSSP: $5M
- MA: $22.2M

Investment
- Staffing: $995K {9.1 FTEs}
- Tech. Enablement: $610K

Estimated Net Income: $25.6M

Year 3 (2027)

ACDI only, using native Epic

Shared Savings Increase
- MSSP: $2.9M
- MA: $20.3M

Investment
- Staffing: $2M {19 FTEs}

Estimated Net Income: $21.2M

ACDI with technology enablement

Shared Savings Increase
- MSSP: $5.2M
- MA: $31.7M

Investment
- Staffing: $995K {9.1 FTEs}
- Tech. Enablement: $760K

Estimated Net Income: $35.1M

9:1

Projected 3-Year Return on Investment

Est. Net Income: $59M

Est. Net Income: $83M

12:1

Projected 3-Year Return on Investment

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1. Technology enablement ROI based on use of Optum's RIC solution and does not include post-visit NLP. ROI projections may vary based on solution(s) used.

Dashboard and KPIs to Drive Program Accountability

Reporting should be transparent, timely, actionable, and clearly defined.

Metric	Best Practice (by EOY)	Executive-Level	Practice-Level	ACDI-Level
Provider Metrics				
Overall RAF Capture	90%	X	X	X
Total Patients with RAF Gaps	*Monitor and trend*	X	X	
Patients with Known RAF Seen by PCP This Year	95%	X	X	
RAF Capture for Patients Seen by PCP	90%	X	X	
RAF Capture by Practice	90%	X	X	X
RAF Capture by Physician	90%		X	X
ACDI Metrics				
Number of Charts Reviewed by ACDI, Pre- and Post-Visit	Pre-Visit: 3-4/hour Post-Visit: 6-7/hour		X	X
Number of HCCs to Consider Identified	*Monitor and trend*		X	X
Number of HCCs to Consider Addressed	*Monitor and trend*		X	X
Query Rate, Pre- and Post-Visit	*Monitor and trend*	X	X	X
BPA Acceptance Rate	*Monitor and trend*			X
Physician Response Rate	> 90%	X	X	X
Physician Agreement Rate	> 90%	X	X	X
Proficiency Score	80%			X
Quality Assurance Score	95%			X
Query Accuracy Score	95%			X

- Distribute to all practices and review the **ACDI dashboard monthly**
- Identify **targeted performance opportunities**
- Ensure that ACDI staff are **held accountable for their performance** by enforcing explicit performance expectations and tracking of productivity, accuracy, and financial impact
- At each Steering Committee meeting, review the ACDI dashboard to **reflect on program goals and targets to track ongoing performance and return on investment, and modify targets as needed**
- Monitor **BPA Acceptance Rate** to track efficacy of ACDI query delivery and identify provider educational needs

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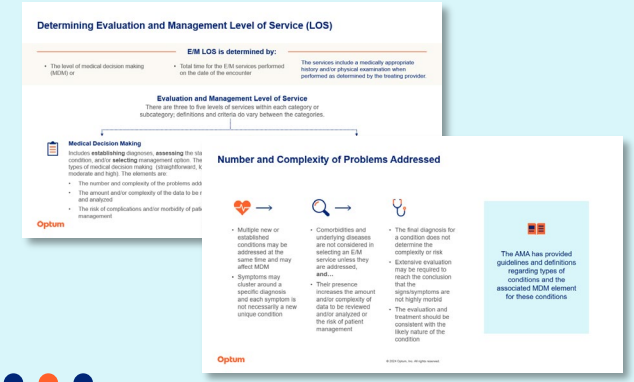
Various Modes and Topic Offerings for Education

Focus on Documentation Fundamentals

A range of potential topics for orientation/ annual competency:

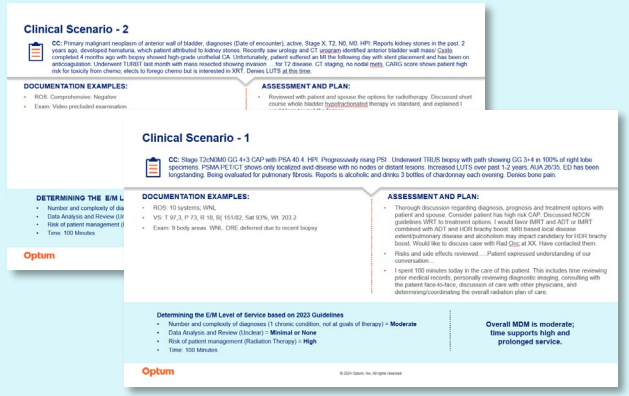
- CMS Regulatory Changes
- Coding Updates
- E/M Documentation Standards
- Diagnosis Specificity
- Preventive Visits and AWV
- Clinical-Risk Adjustment, HCC, RAF

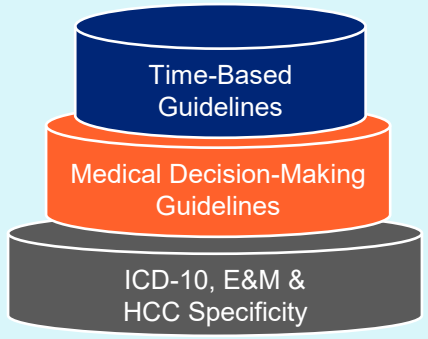


Group Training
(In-person, Live Remote, or Self-Directed)

Specialty Specific Topics & Scenarios

Tailored content for a range of specialties

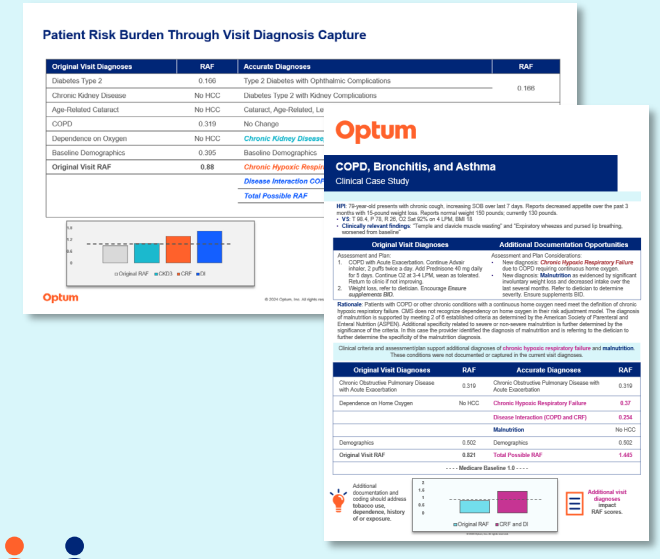




The Core of Ambulatory Education

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)

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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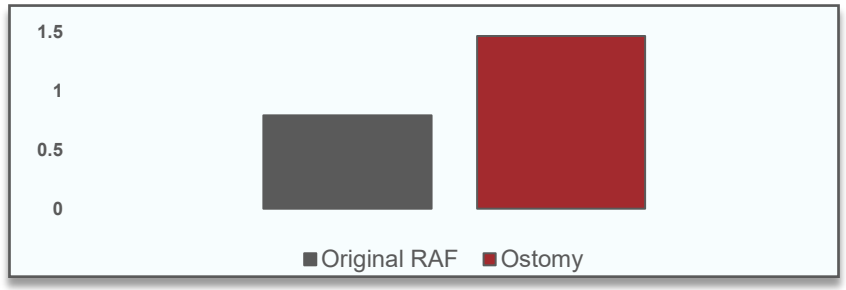
Patient Risk Burden Through Visit Diagnosis Capture

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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