Making the Connection: Strategic Documentation, Compliance, and the Revenue Cycle
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Agenda

- Learn how quality-based payment models will affect revenue cycle operations and compliance efforts
- Learn how to self-audit their revenue cycle and identify top compliance risk areas.
- Learn how to recover revenue and prevent losses while achieving compliance goals.
Overview

- FFS plans are ill suited for initiating investments and sustaining population health management innovations such as:
  - Information technology
  - Clinical decision support tools
  - Patient engagement and care coordination functions

Evidence-Based Medicine

- Systematic Reviews
- Critically Appraised Topics
- Randomized Controlled Trials
- Cohort Studies
- Case-Controlled Studies Case Series/Reports
- Background Information/Expert Opinion
Evidence-Based Medicine
Level Ia: Good evidence-base. Guideline recommendations are based on comprehensive, systematic literature search and review and either a description of the quality assessment of the studies or the overall body of literature or best evidence approach.
Level Ib: Fair evidence base. Guideline recommendations are based on non-systemic literature review, or literature review using unspecified methods and either a review of the quality of the studies or the overall body of literature or description of a best evidence approach.
Level II: Poor evidence base or not well characterized. Evidence is not cited, but guideline authors do not describe quality or strength of evidence.
Level III: No evidence base.

Guidelines Utilized
- National Guideline Clearinghouse
- Federal Register
- CDC
- Medscape
- US Department of Veteran Affairs

Advance Payment Models
Understanding the why...

An estimated 25.9 percent of adults have two or more treated chronic conditions and they account for 57 percent of all health care expenditures.

Adults ages 18-44, 94.4 percent have no treated chronic conditions or only one treated chronic condition. Among adults age 65 and older, only 34.4 percent have no treated chronic conditions or only one treated chronic condition. Of adults age 65 and older, 42.3 percent have 2-3 treated chronic conditions and 23.2 percent have 4 or more treated chronic conditions.

Average total health care expenditures were higher for adults with 2-3 versus 0-1 treated chronic conditions within each of the age groups for all three race/ethnicity groups.

Seven Principles for APM Framework

Changing providers financial incentives is not sufficient enough to achieve person centered care must empower patients to be healthcare partners.

The goal for payment reform is to shift U.S. health care spending significantly towards populations based payments (more focused)

Value based incentives should ideally reach the providers that deliver care

Payment models that do not take quality into account are not considered APMs in the APM framework, do not count as progress toward payment reform

Value based incentives should be intense enough to motivate providers to invest and adopt new approaches to care delivery

APMs will be classified according to the dominant form of payment when more than one type of payment is used.

Centers of excellence, ACOs, and patient centered medical homes are examples, other than categories in the APM framework because they are delivery systems that can apply to many payment models

APM Framework

**Category 1**

Fee for Service - No Link to Quality & Value

**Category 2**

Fee for Service-Link to Quality and Value

- Foundational payments for infrastructure and operations
- Pay for reporting
- Rewards for performance
- Rewards and penalties for performance

**Category 3**

APMs Built on Fee-for-Service Architecture

- APMs with Upside Gainsharing
- APMs with Upside Gainsharing/Downside Risk

**Category 4**

Population-Based Payment

- Condition-specific/
- Population-Based Payment
- Comprehensive Population-Based Payment
Understanding the Case for Reforming Health Care Payment System

**Person (patient) Centered Care:**
High quality care that is both evidence based and delivered in an efficient manner, and where patients and caregivers individual preferences, needs, and values are paramount

Quality

Patients receive appropriate and timely care
Consistent with evidence based guidelines and patient goals
Also results in optimal patient outcomes and patient experience
Should be evaluated using a set of appropriately adjusted process, outcome, patient reported outcome and patient experience measures that provide an accurate and comprehensive assessment of clinical and behavioral health
Report results can be meaningfully accessed, understood, and used by patients and consumers

Cost Effectiveness

Indicates a level of severity adjusted total costs
Reflects benchmarked best achievable results
Consistent with robust and competitive health insurance marketplaces
Costly could be considered if there are dramatic improvements on patient outcomes
What is not counted:
Less expensive but results in poor clinical outcomes
**Patient Engagement**

- Encompasses the important aspects of care
- Improves patient experience
- Enhances shared decision making
- Ensures that patients and consumers achieve health goals
- Should occur at all levels of care with patients and caregivers serving as partners

**Chronic Conditions**

- **Diabetes**: 245 billion annually
- **Heart Disease**: 90.9 billion
Patients with MCCs

A day in the life
About 1/3 of patients have multiple chronic conditions
What does that mean for the patient?
What does that mean for healthcare costs?
How can we better help the patient and improve healthcare delivery and costs?

Patients with MCCs

1% of Americans with the highest health care expenses accounted for nearly 22% of the nation’s total health care expenditures
The top 5% of the population accounted for 48.7% of total expenditures

Patients with MCCs

Just like Mike
HTN, Type 2 DM requiring insulin – monthly visits with PCP
ESRD (Hemodialysis 3 x week) Polycystic kidney disease – Nephrologist manages and sees monthly
CAD – Stent proximal left anterior descending (widow maker) – Cardiologist
Chronic pain – Pain management or PCP
COPD, asthma, sleep apnea – Pulmonologist
Osteoarthritis with left total knee - Orthopedist
Solutions- We All Make A Difference

Talking the Same Language

The Physician Burden/Solution

- Better documentation
- Patient engagement
- Streamlining administrative functions
- Participate- not procrastinate
Documentation Strategies

- Many hoops- We JUMP!
- Streamlining process is necessary

Documentation Concepts CPT

- Type
- Anatomical site
- Site
- Number
- Time
- Complexity
- With or without
- Depth
- Space
- Modifying factors
- Time
- Some codes include the concept of time documented to perform the service or procedure
- Age
- Site of service

Clinical Concepts ICD-10-CM

- Type
- Temporal factors
- Cause by/Contributing factors
- Symptoms/Findings/
- Manifestations
- Localization/Laterality
- Anatomy
- Associated with
- Severity
- Episode
- Remission status
- History of
- Morphology
- Complicated by
- External Cause
- Activity
- Place of Occurrence
- Loss of Consciousness
- Substance
- Number of Gestations
- Outcome of Delivery
- SWE
Overlapping Criteria – Engaging Physicians and Stakeholders

Concepts listed for both are clinical related
Captures information needed for correct coding/data capture
Captures more informative information for patient encounter
Simplifies the documentation process

Current Challenges

- EMR dependency
- Administrative frustrations
- Staff skill levels
- Trust

Revenue Reports – 1st Line Defense

- Meaningful reports
  - Validations
  - Acknowledgment reports
  - Payer requirements
  - No-shows
  - Patient re-engagement
Supporting the Cause
- Techs/Scribes
- Comorbid conditions
- Frequency reporting (Registry can help)
- Cause and effect

Questions?
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