

Physician Advisors & Mid-Revenue Cycle The Clinical Financial Partnership

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August 29, 2022

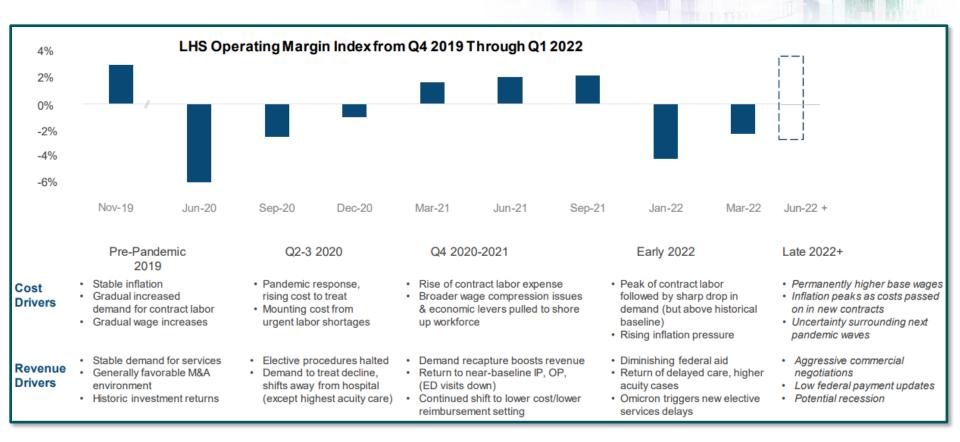
Learning Objectives

At the completion of this education session, attendees will be able to:

- Define the value of investing in physician leadership and the clinical financial partnership
- Identify KPIs that align with revenue cycle goals and organizational strategy
- Understand the impact of establishing a physician advisor program through case studies at Franciscan Missionaries of Our Lady Health System



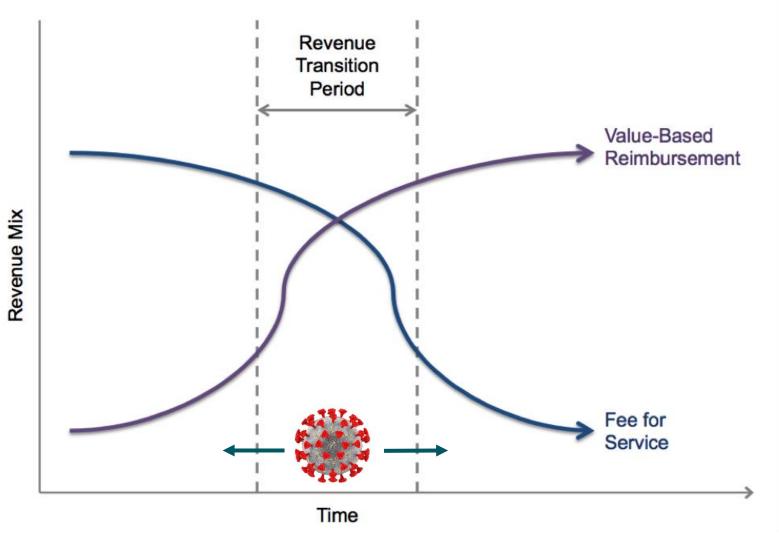
Current State: Margin Swings / Economic Shock Waves



Source: Kaufman Hall Flash Reports / Academy IQ research



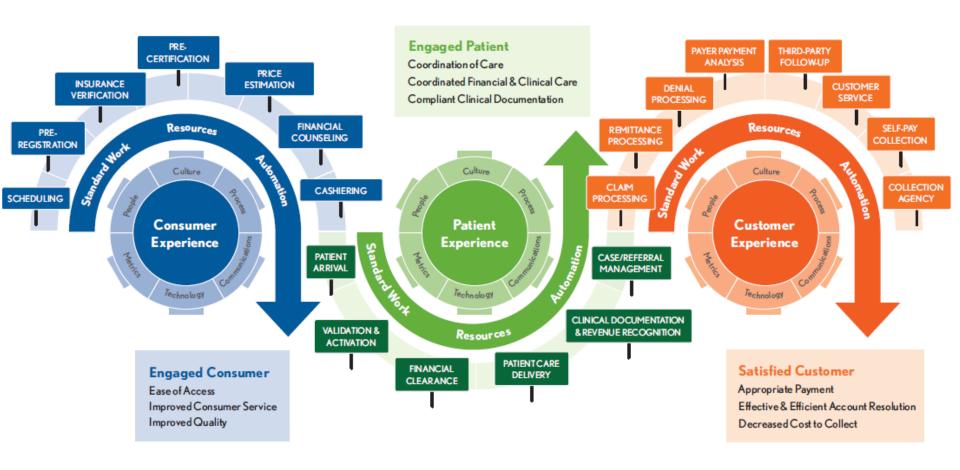
Future of Healthcare: Quadruple Aim



Source: https://downloads.healthcatalyst.com/wp-content/uploads/2013/12/revenue-vs-time.png (modified)



Clinically Integrated Patient Centric Revenue Cycle



Source: HFMA

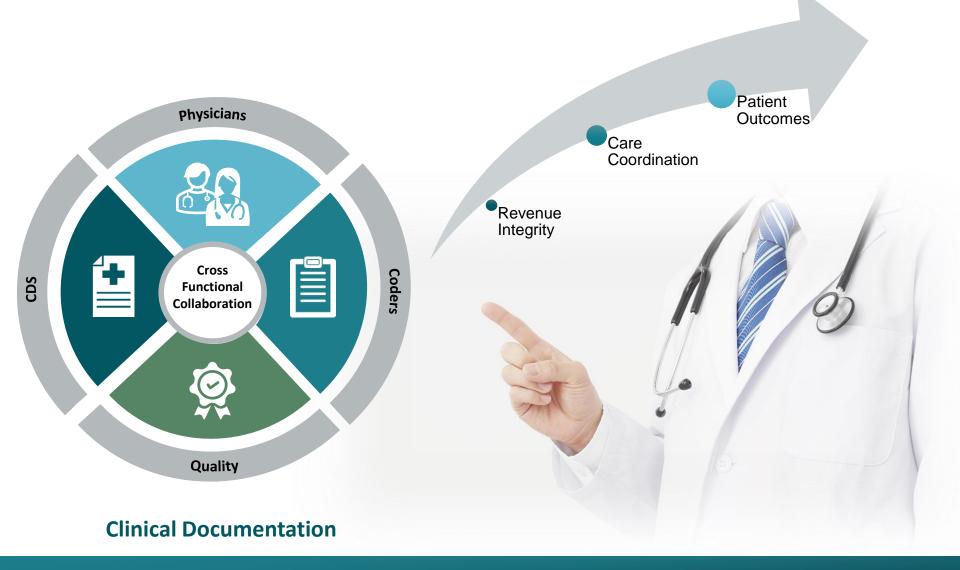


Revenue Cycle Challenges





Physician Leadership in Revenue Cycle





Clinical Financial Partnership Drives Revenue Cycle Performance



- Financial accuracy (MSDRG, APR-DRG, Per Diem, Contractual, Capitated)
- Denial prevention and management
- Alternative payment models
- Utilization
- Medical necessity (LCD, NCD, Statusing)

- Quality (care plans, sentinel events, avoidable events, reporting)
- Customer satisfaction / leakage / reputation
- Leadership understanding
 - Provider engagement
 - CDI/Coding
 - Quality



Aligning Physician Advisor and Revenue Cycle KPIs

Revenue integrity

- Revenue recovery
- Compliance
- DNFB (query response / query agree rate)
- CMI; CC/MCC
- Cost to collect (functional-HIM)
- Denial rate / denial write-off at percentage of NPR

Care coordination

- Avoidable days (ALOS); LOS/CMI
- Authorizations
- Observation: inpatient ratios
- Medical necessity denials

Patient outcomes

- Clinical variation
- Quality O:E (mortality, readmissions, PSIs)
- Performance penalties
- Hospital-Acquired Condition rates
- Third party reporting (US News and World Report)

Care team collaboration

 Team engagement (reduce provider burnout, retention)



Franciscan Missionaries of Our Lady Health System

- 1,747 Licensed Beds
- 65,322 Discharges
- 44,592 OR Procedures
- 10,827 Full Time Employees
- 331,360 Inpatient Days
- 1,915 Active Medical Staff
- 229,296 Emergency Visits
- Net Patient Revenue: \$2.8B
- Inpatient Medicare Denial Rate: 2.8%

Physician Advisor Program

- System PA (0.75 FTE)
- Part-time MD with internal education for large hospitalist group





"There is a great joy in being useful" Maurice Hilleman, Ph.D.





FMOLHS Physician Advisor Program

Charter

• Implementation of a well integrated Clinical Documentation Improvement Program is key to ensure optimal reimbursement and accurate hospital and provider profiling scores

Timeline

- 2013 Physician Advisor Training
 - -Physicians educating physicians
 - -First ever look at DRGs, codebook, CMI, CC/MCC, etc.
- 2019 System Physician Advisor position created (0.75 FTE)

Priorities

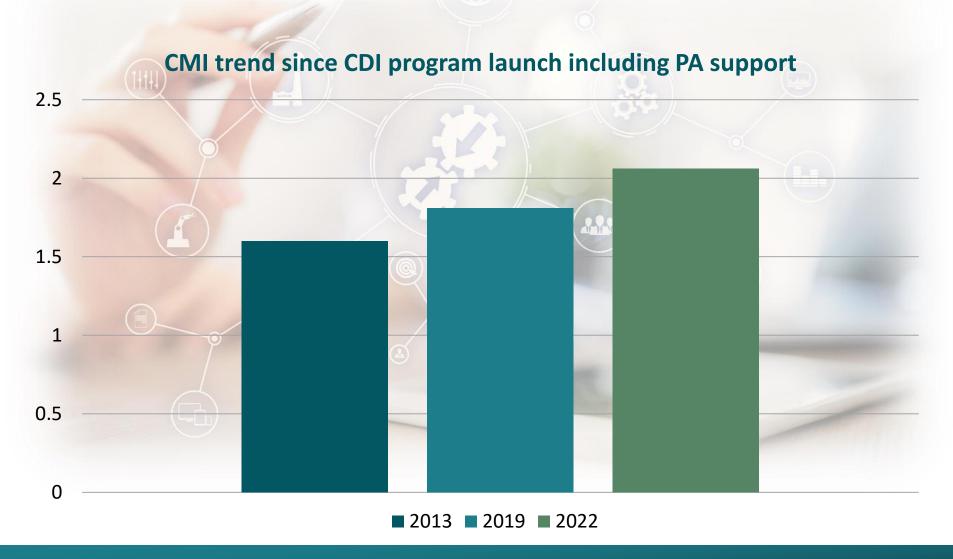
- Physician education: What is the clinical truth?
- MS-DRG optimization
- CC/MCC Capture
- Quality metrics influenced by documentation/coding, e.g., PSI

Goals

- Maintain successes
- Accurate and comprehensive risk adjustment
- Incorporate Vizient Clinical Data Base into CDI processes
- Denials and Medical Necessity



Revenue Integrity: CMI Trend





News: Poor documentation training cited as one reason for possible hospital closure

July 11, 2019 - CDI Strategies - Volume 13, Issue 29

Citing severe financial difficulties, Hahnemann University Hospital in Philadelphia will close its doors in early September of this year with inpatient admissions ceasing in July, according to a FAQ on the hospital's website.

Since its purchase by the California-based American Academic Health System in January 2018, Hahnemann has routinely lost between \$3 million and \$5 million per month, Joel Freedman, the president and CEO of American Academic Health System, told the *Philadelphia Business Journal*.

According to Freedman, there were four major factors that caused the financial hemorrhage:

- The hospital was not successful in getting commercial insurers to negotiate new contracts
- Volume dropped from an average of 300 patients per day to between 200 and 250
- The academic training program Hahnemann operates through its affiliation with the Drexel University School of Medicine is on pace to lose \$30 million this year
- The lack of clinical documentation training for physicians has resulted in downgrades and denials from insurers

The denials situation has gotten so dire, Freedman estimated that the hospital is only being paid for 50% of the services it provides. Additionally, the hospital has a high rate of observation stays, which are reimbursed at a lower rate than an inpatient admission would be, according to the *Philadelphia Inquirer*.

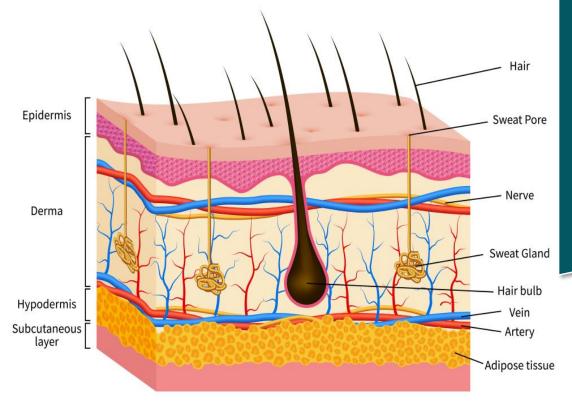
The closure will leave thousands of healthcare professionals out of work, hundreds of medical residents without placement for the year, and an untold number of patients without a hospital close-by. Though the plans to close are final according to the hospital, the employees of the hospital and members of the Drexel administration, among others, are seeking a legal recourse to save the organization.





Why should Physicians/APPs care about documentation?

SKIN ANATOMY

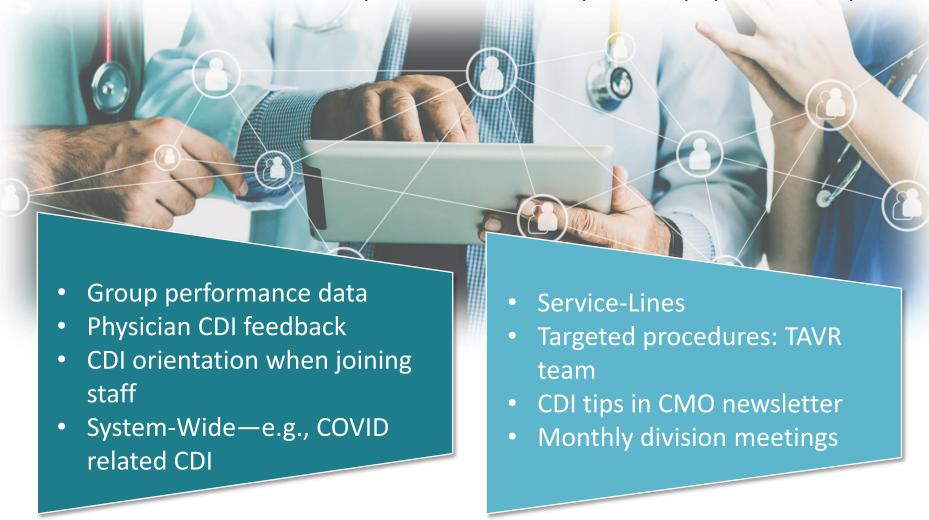


- If not documented, it wasn't done
- Get credit for your hard work
- Quality of your documentation
 - Quality of care
- Required for professional billing
- Payers are tiering physicians
- Payers are excluding physicians from networks
- Medical Tourism



Physician/APP CDI Education Strategies

Under-documentation can prove hazardous to patients, physicians, hospitals





It's just vocabulary words



Non-Specific	Specific-translates well to ICD-10 Codes
Altered Mental Status (AMS), Acute Confusion	Acute Metabolic or Toxic Encephalopathy
Acute Renal Insufficiency, Chronic Kidney Insufficiency, Azotemia, Uremia, Renal Failure Unspecified	AKI, Acute Renal Failure, ATN, CKD (stage I-V), on dialysis or ESRD
Dyspnea, Tachypnea, SOB, resp insufficiency	Acute resp failure, Acute pulm edema, acute asthma exacerbation, acute pulm insufficiency
Anorexia, weight loss, underweight	Cachexia, Severe malnutrition
Sepsis Syndrome, Urosepsis	Sepsis, Septic shock, Sepsis due to UTI, etc.
CHF	Acute HFpEF (or diastolic) heart failure, chronic HFrEF (or systolic) heart failure, Acute combined HF, etc.
Chronic hypoxemia; COPD on home 02	Chronic resp failure
Elevated Troponin	Acute or Chronic Myocardial Injury, Type 2 MI, NSTEMI, STEMI
Anemia	Acute blood loss anemia, Hemolytic anemia, other specified anemias



MD Group and Service-Line Query Data

								1
Physician	# MD Queries	# MD Responses	% MD Response Rate	# MD Response Agreed	# MD Responses Disagree	# MD Responses Unable To Determine	% Agree Rate	# MD No Response
	21	21	100%	21	0	0	100%	0
	66	66	100%	66	0	0	100%	0
	32	30	94%	26	2	0	87%	2
	24	24	100%	23	1	0	96%	0
	11	11	100%	11	0	0	100%	0
	34	30	88%	28	2	0	93%	4
	47	47	100%	47	0	0	100%	0
	18	12	67%	7	3	2	58%	6
	26	23	88%	23	0	0	100%	3
	30	30	100%	29	1	0	97%	0
	31	30	97%	28	2	0	93%	1
	26	25	96%	22	3	0	88%	1
	4	4	100%	4	0	0	100%	0
	30	27	90%	23	3	0	85%	3
	38	36	95%	34	2	0	94%	2
	41	41	100%	41	0	0	100%	0
	45	44	98%	39	5	0	89%	1
	23	23	100%	23	0	0	100%	0
	40	39	98%	39	0	0	100%	1
	8	8	100%	6	2	0	75%	0
	31	29	94%	28	0	0	97%	2
	14	13	93%	12	1	0	92%	1
	8	8	100%	8	0	0	100%	0
	0	0	N/A	0	0	0	N/A	0
	16	16	100%	14	0	1	88%	0
	20	20	100%	18	1	0	90%	0
	19	19	100%	19	0	0	100%	0
	7	7	100%	7	0	0	100%	0



Bridging the Gap: Clinical and Coding Terminology

76yo male smoker, HTN, HLD with HA, difficulty speaking, and right sided weakness onset 24h ago. Head CT neg. Given ASA. MRI revealed acute left MCA ischemic stroke. Associated dysphagia resulted in an aspiration event with acute resp distress and sats 82% on RA. Required nebs and up to 6L NC for few days. Discharged to SNF on Day 6

What is optimal discharge diagnoses documentation?





Example of Stroke Documentation

	Partial Truth	Full Truth
Identical diagnoses in discharge summary	CVA with infarct due to suspected left MCA thrombosis Right hemiparesis Htn-essential HLD	CVA with infarct due to suspected left MCA thrombosis Right hemiparesis Htn-essential HLD
Additional diagnosis in discharge summary	Hypoxemia	Acute hypoxic resp. failure
DRG Relative Weight and reimbursement	1.0277 (\$5744)	1.8748 (\$10409)
Expected Length of Stay	3 days	4.3 days
Risk of Mortality	1 (minor)	3 (major)
Severity of Illness	2 (moderate)	3 (major)







Clinical Consensus to Battle Sepsis Denials



(Sepsis-2) of the Clinical Indicator Committee. The Clinical Indicator Committee is a multi-specialty team of medical staff members at Franciscan Missionaries of Our Lady Health System Hospitals (FMOLHS). It is the goal of FMOLHS to provide the most specific diagnosis that describes the patient's condition by incorporating evidence-based medicine and coding guidelines through inter-departmental collaboration.

Our committee shares CMS' concern that "a change from the existing definition (Sepsis-2) could disrupt the 15-year trend toward further reduction in sepsis mortality." Also, "...the use of SIRS criteria have



Care Coordination / Utilization: Medical Necessity

Certain procedures require strict adherence to qualifying criteria

- Defibrillators
- Vertebroplasty/Kyphoplasty
- Watchman devices
- TAVR/Mitral valve repair

Procedure may not meet medical necessity requirements

Why is this a problem?

- Denials
- Audits
- Non-compliance

Medical Necessity Forms created

- Based on LCD/NCD
- Checklist with good terminology
- To be completed by attending or ordering provider



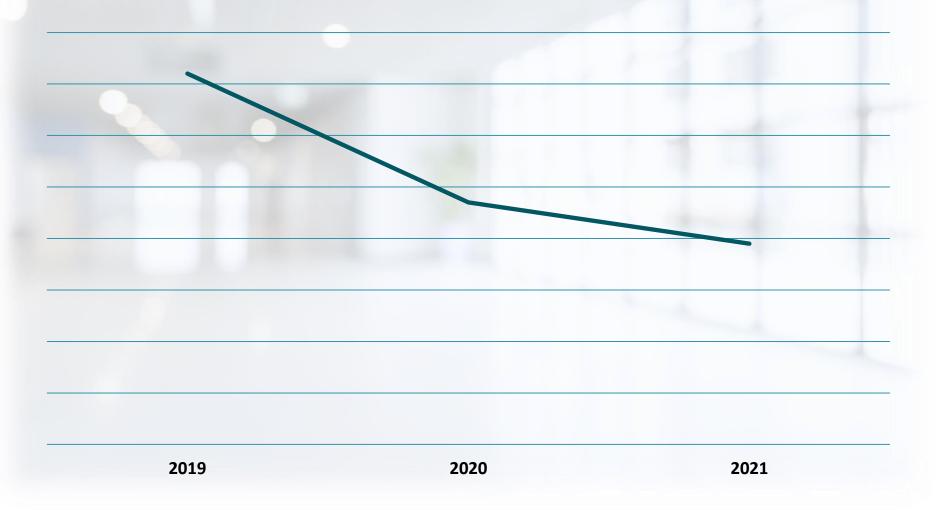


Medical Necessity and Compliance Form

PERCUTANEOUS VERTEBR	OPLASTY/KYPH	OPLASTY (PVA) Complian	ce Form		
Patient Name	D	OB: Ordering F	Physician:		
Primary Payor [Check one]	Medicare	Medicare Advantage	Medicaid _	Commercial	Military Health Care
THORACIC OR LUMBAR OSTEOPOROSIS	R SPINE DUE TO: teolytic vertebr	al metastasis or myelor			



Reduction in Procedure Denials





What is the 2 Midnight Rule?

- CMS rule: appropriate inpatient admissions
- Inpatient (Medicare Part A payment) vs. Observation (Medicare Part B payment)
- "Emphasis on the importance of a physician's medical judgment"
- Recovery Audit Contractor (RAC) target-"high rates for hospital error"



Centers for Medicare & Medicaid Services

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Fact sheet

Fact Sheet: Two-Midnight Rule

Oct 30, 2015 | Hospitals, Quality, Billing & payments

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Fact Sheet: Two-Midnight Rule

On October 30, 2015, CMS released updates to the Two-Midnight rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. These changes continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries. These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule.

Hospital Inpatient vs. Outpatient

Because of the way the Medicare statute is structured, the Medicare payment rates for inpatient and outpatient hospital services differ.

CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A program. CMS sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness.

In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure.

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether to admit the beneficiary as an inpatient or treat him or her as an outpatient. These decisions have significant implications for hospital payment and beneficiary cost sharing. Not all care provided in a hospital setting is appropriate for inpatient, Part A payment.

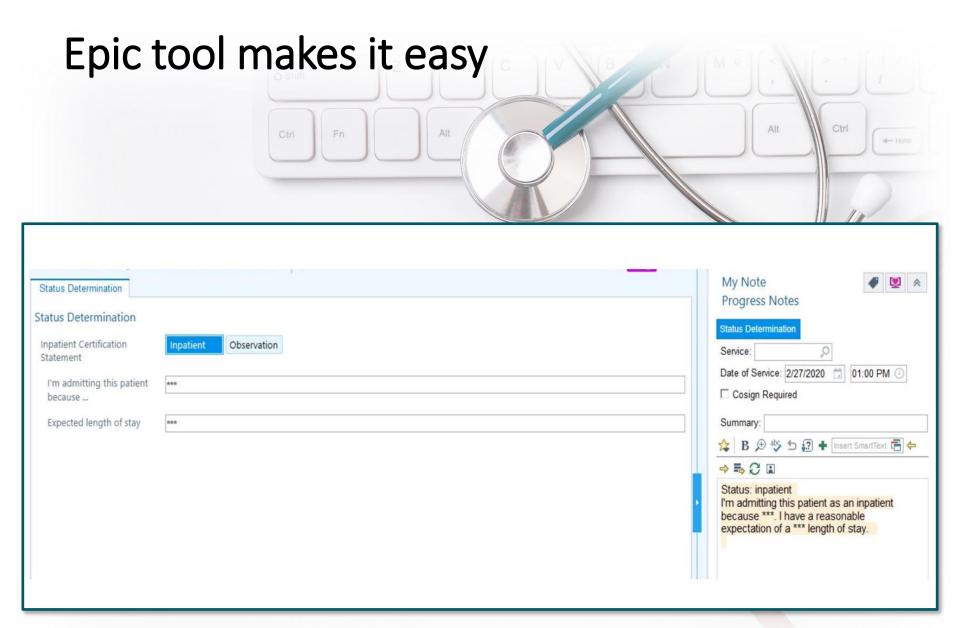
The Two-Midnight Rule

Background



	Inpatient	Observation
 How long will they need in hospital? (time starts in ED when care begins) 	You expect > 2 midnights	You expect < 2 midnights (or if unsure)
Why do you think they need to be admitted as an inpatient?	You must make the case: Risk of adverse outcome, risk of rapid deterioration, severity of illness, intensity of service, etc.	Clinical need to continue to evaluate signs/symptoms with intervention as indicated

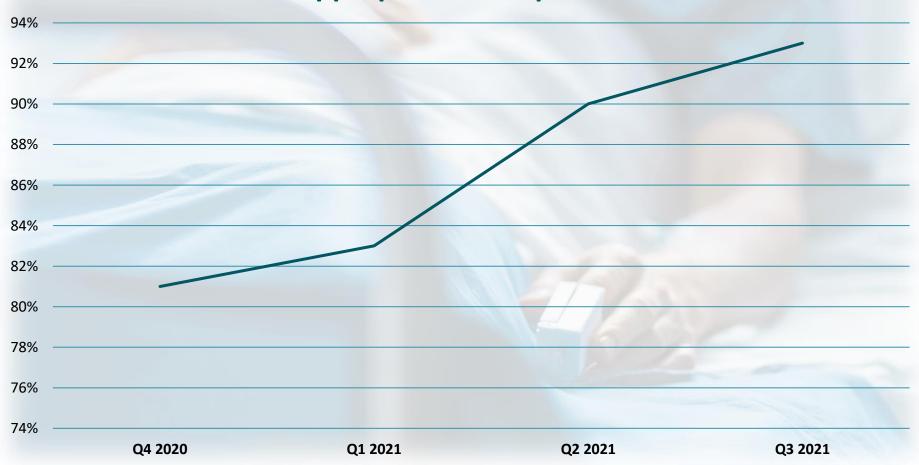






Medicare Two Midnight Rule Education Impact

Appropriate for Inpatient





Patient Outcomes: Quality Metrics

Readmissions

3% of Medicare reimbursement at risk

Hospital Value
Based Purchasing
(includes Mortality)

2% of Medicare reimbursement at risk

Hospital Acquired
Conditions
Reduction Program
(includes PSI)

1% of Medicare reimbursement at risk

Hospital Compare

Reputational Penalty, e.g., "Worse than national rate"



PSI 12 Review for Perioperative DVT/PE

Key points:

- **Often is a true PSI... ensure DVT/PE was not Present on Admission (POA)**
- Subacute or acute (<3months from diagnosis) DVT/PE which are POA are not PSIs
- Specify location of DVT. Calf and superficial vein phlebitis/thrombophlebitis/clots are not PSIs. (Query if clinician documented a calf vein clot as an unspecified DVT)
- Septic and Fat emboli are not considered PE and are not PSIs

Inclusion criteria:

- Age >18
- Surgical discharge
 - Only cases which have an ICD-10 PCS code for an OR procedure are included
- Acute PE or DVT

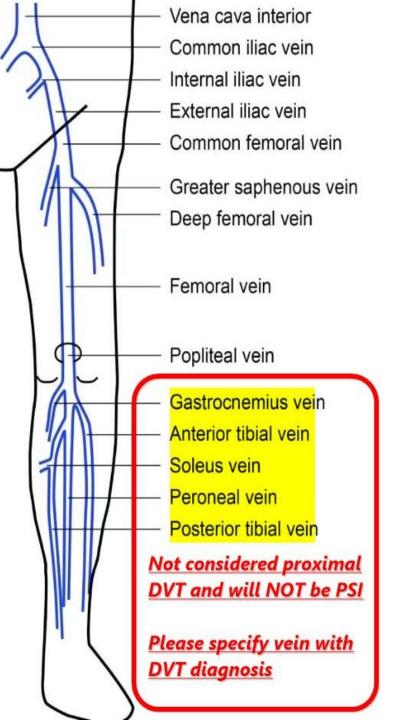
Exclusion Criteria:

- PE or DVT POA
- Interruption of IVC (e.g., IVC filter placement) before or on same day as the first OR procedure
- Only OR procedure was pulmonary artery thrombectomy or interruption of IVC
- Obstetric cases
- ECMO used
- Acute brain or spinal injury POA (e.g., SAH, SDH, unspecified injury at C7, etc.)
 - Acute=initial...while the condition is being actively treated
- MDC 14 (pregnancy, childbirth, and puerperium)

https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2021/TechSpecs/PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate.pdf

updated 3.7.2022 MDT





Specificity Matters

Calf vein DVT is not a PSI

Hospital Mortality Performance

Risk Adjusted Mortality Index



Observed Deaths

Expected Deaths



Interpreting O/E index

O/E Index < 1

- Observed less than expected
- Lower costs than expected
- Fewer deaths than expected
- Shorter LOS than expected

O/E Index = 1

 Observed equals expected

O/E Index > 1

- Observed greater than expected
- Higher costs than expected
- More deaths than expected
- Longer LOS than expected



Mortality Review

Coding Work queue pre-bill hold: coder assigns focus condition as principal diagnosis: >65yo, enrolled in Medicare, with Death or Hospice at discharge

Clinical and CDI review by Physician Advisor/CDI educator:

what condition was chiefly responsible for hospital admission, primary clinical focus of care, and most appropriate as principal diagnosis; risk stratification; query process

FMOLHS coding audit coordinator: Reviews preliminary coding, PA/CDI recommendations, reviews queries, assigns final codes



Inpatient Heart Failure Mortality CY 2018 **CY 2019 CY 2020**

Physician Advisor Programs Drive the Clinical Financial Partnership



Physician advisors drive the accuracy of clinical data supporting revenue integrity, care coordination and patient outcomes.



Return on investment is measurable when aligned with organizational strategy and priorities.



The greatest value of a physician advisor program is provider collaboration and change management.





Thank you!



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