Put a Ring On It:
The Secret to Effective Provider Engagement

Presented By:

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Webinar Participant Tips

- All participant lines are muted. To protect your privacy, you will only see your name and the presenters names in the participant box.
  - To submit a question to the presenters any time during the event;
  - In the Event window, in the Panels drop-down list, select Q & A.
  - Type your question in the Q & A box.
  - Click “Send”.

Learning Objectives

- Learn how to develop and implement effective non-clinical documentation improvement strategies to complement CDI strategies
- Discover how to overcome barriers to effective provider engagement and enablement
- Understand the resources and tools needed to inform enablement strategies as the foundation of a robust clinical and non-clinical documentation improvement program for risk adjustment

Image: Kevin Mazur, 2013

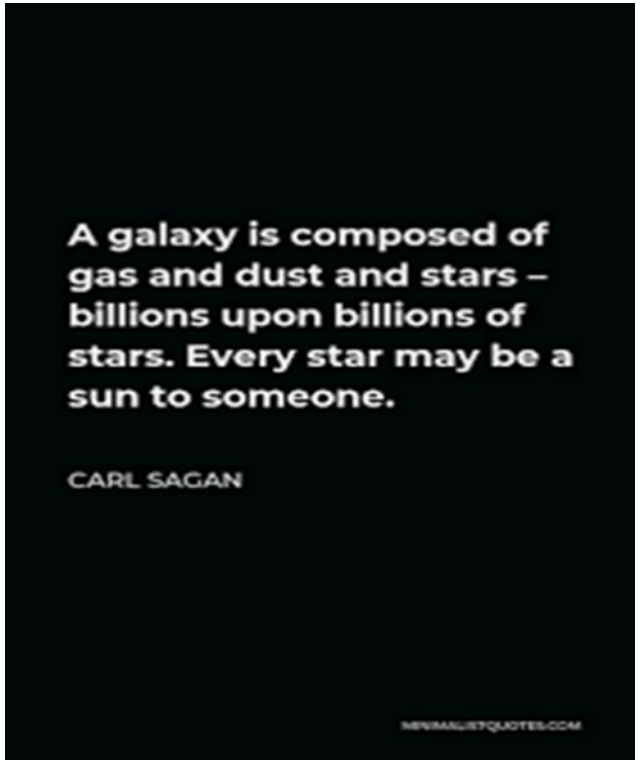
Polling Question!

Are provider engagement and provider enablement the same thing?

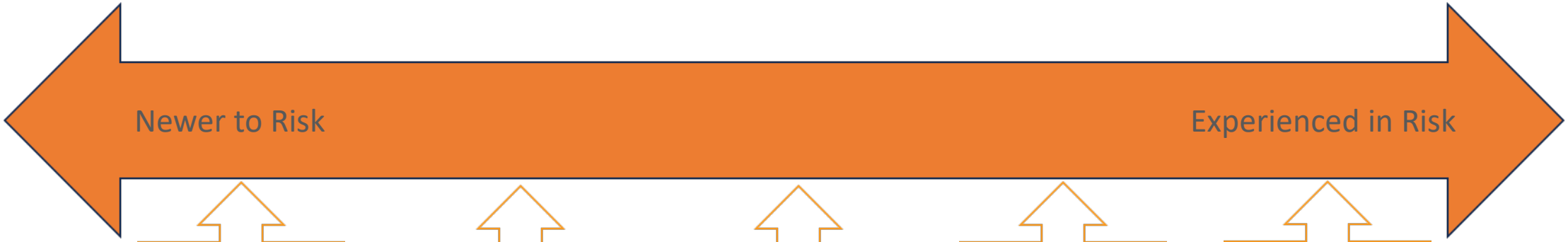
a) Yes
b) No
c) Are we talking about marrying the providers here?
d) What’s love got to do with it?

Billions upon billions…

- **V24 to V28 Transition: Estimated Cost to MAOs = $7.62 Billion**
  - V24: 9,797 ICD10 diagnoses map to 86 HCCs
  - V28: 7,770 ICD10 diagnoses map to 115 HCCs
  - Total ICD10 Codes Added: 209
  - Total ICD10 Codes Removed: 2236
- **Targeted RADV: Extrapolated Net Overpayment = $463 Million and Counting**
  - OIG has audited 32 MAOs so far, and these audits will continue
- **Capture of SDOH Data**
  - Risk models will eventually include this data for the purposes of risk adjustment
- **Denials Management/Prior Authorization**



Enablement Maturity Model



Risk Adjustment Education

- ❑ Inservices
- ❑ Provider-Focused Coding Bootcamp
- ❑ RISE/AHIP/CMS/ACDIS
- ❑ AAPC/AHIMA/HFMA
- ❑ LinkedIn
- ❑ Newsletter
- ❑ Queries
- ❑ Physician Champion

EMR Integration

- ❑ Maximum diagnosis capture
- ❑ Intuitive gap identification
- ❑ Queries

Pre and Post Visit CDI Workflow

- ❑ Upskill staff
- ❑ Patient Profiling
- ❑ Opportunities
- ❑ SDOH
- ❑ Queries

Operational Dashboard and Reports

- ❑ Specificity
- ❑ High risk
- ❑ Number per claim
- ❑ Denials
- ❑ Suspected vs. Captured
- ❑ Queries
- ❑ Provider satisfaction

Financial Dashboard and Reports

- ❑ RAF scores
- ❑ RAF trends by group/geography
- ❑ Recapture vs. new
- ❑ HCC prevalence by group/geography
- ❑ ED visits/hospitalizations
- ❑ Audit results by group/geography

Definitions

Engagement: the act of being involved with something, or the process of encouraging people to be interested in something

Enablement: the act of giving the authority or means to do something

Bonus Definition:

Engagement + Enablement = Empowerment: the process of becoming stronger and more confident

*Definitions courtesy of Merriam-Webster

2 Good 2 Be 4 Gotten…the “2 Goods”

Good Documentation…

- Improves communication
- Increases recognition of comorbid conditions that are responsive to treatment
- Validates that care was provided for audit-proofing and denial management
- Shows compliance with quality and safety guidelines

2 Good 2 Be 4 Gotten…the “2 Goods”

Good Program:

- Must demonstrate to providers the effects of documentation quality in terms of clinical and non-clinical (operational and financial) value.

- Risk and quality outcomes must not be the sole indicator of engagement but should be used as a starting point into how providers are being engaged and enabled.

    - **Example:** Morbidly obese patients often require extra care as a comorbid condition, and hospital reimbursement as well as risk adjusted reimbursement for these additional costs depends upon provider documentation.
    - **Example:** A provider will often document an unspecified code such as “CHF NOS”, because it makes no difference to them from a claim payment perspective. However, a hospital and an MAO need “Acute Systolic CHF” to accurately capture the costs of caring for this patient.
    - In either case, is it fair for providers not to do their part and the hospital or MAO suffer financially, and then the quality of patient care is affected?

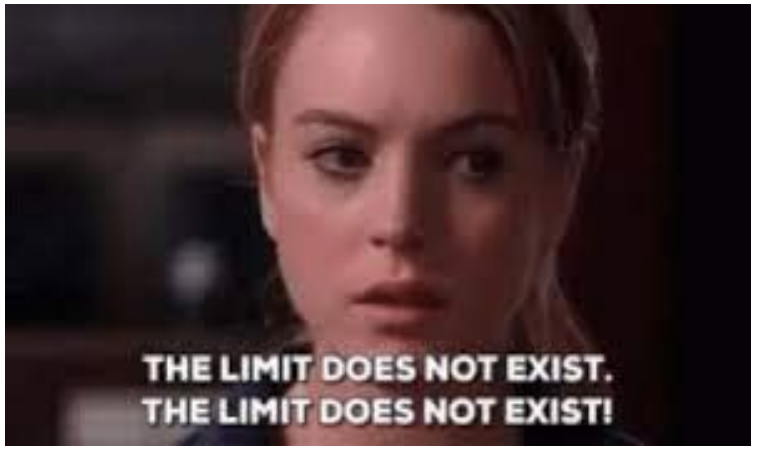
EMR Integration and Pre-and Post-Visit CDI Workflow

- **Pre- Visit: Medical assistants/certified coders**
  - Evaluate gaps, medication lists, hospitalization records, ED visits
  - Update problem lists
  - Screen and document for SDOH
  - Specific EMR template for AWV vs. physical
- **During visit: Providers/other clinical staff**
  - Review and update problem lists, especially if copy/pasting
  - Ensure all gaps and chronic conditions reviewed and documented (MEAT review)
  - Ensure labs and other test results are reviewed and documented
- **Post-visit: Coding staff**
  - Review codes suspected vs. codes captured and dropped to claims
  - Provide coding and documentation feedback
  - Query the provider

Polling Question!

How many diagnosis codes are allowed on an electronic claim (EDI)?

a) There is no limit
b) 12 Professional/12 Institutional
c) 25 Professional/25 Institutional
d) None of the above
e) What is EDI?

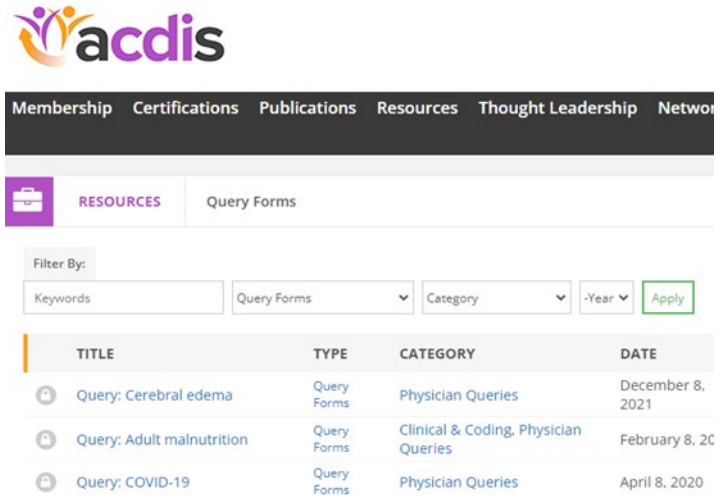


Operational Reporting

- Not coding to highest specificity/excessive use of unspecified codes
  - Codeset (system/process) issue vs. knowledge issue (people)
- Truncation of diagnosis codes/average number of diagnosis codes on claims
  - Max diagnosis capture: electronic claims can accommodate 12/25, so ensure your EMR allows for the capture of at least that many, and that all that are captured are dropped to claims.
  - Goes hand in hand with average HCCs per member (for gaps) and per provider (for undercoding), and recapture rates
  - Paper claims, superbills, # allowed in EMR: Paper claims allow far fewer diagnoses and prone to errors.
- High risk diagnosis codes: OIG Toolkit: https://oig.hhs.gov/oas/reports/region7/72301213.pdf
  - Acute MI and CVA in office with no corresponding inpatient claim, cancers with no evidence of active treatment, vascular claudication with no medication therapy, etc.
  - Active vs. historical conditions
  - Suspected vs. confirmed conditions
  - Rules can be written to catch these
- Claim denial analysis
  - Pay special attention to prior auth denials
- Conditions Suspected (Pre-CDI) vs. Conditions Captured on Claims (Post-CDI)
- Query rate/timeliness

Speaking of queries…

- Queries should be clinically meaningful and cite evidence-based guidelines, because clinical relevance promotes higher trust and engagement
- Narrow the gap between “doctor-speak” and “coder-speak” by using tools they are familiar with such as medical textbooks, journals and online resources – not Coding Clinic
- The **ACDIS** website has a list of query templates available in the Resources area (membership required)



Financial Reporting

- Month over month and year over year trending
- Comparison to peers in same specialty in the region or across the health system
- Show the value from a clinical (quality) and financial (quantity) perspective

Education

- ✓ Inservices and provider coding bootcamps
- ✓ Industry Organizations: RISE/AHIP
- ✓ CMS/HHS/Medicaid
- ✓ Professional Organizations: AAPC/AHIMA/HFMA/ACDIS
- ✓ LinkedIn
- ✓ Physician Champion

- ✓ Your Provider Services and/or CDI department should facilitate the collaboration needed to develop meaningful education as part of the organization's CDI and non-CDI program, to monitor its efficacy against established metrics and adjust as needed based on outcomes.

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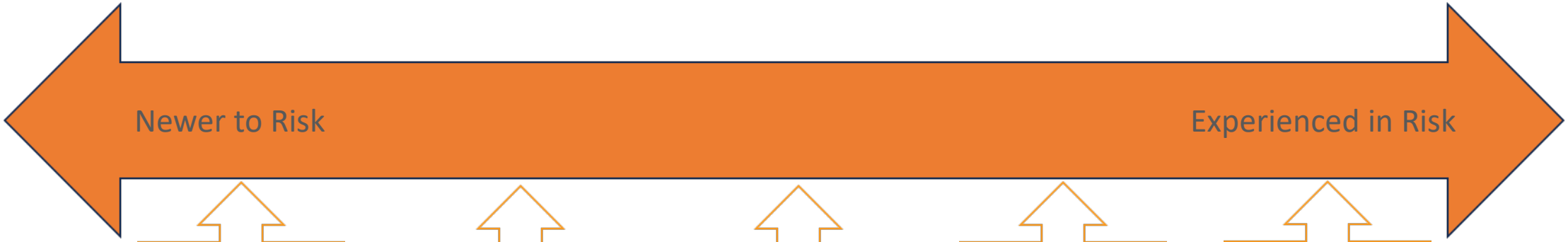

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THANK YOU