



3M Health Information Systems

Executive briefing:

Are your claims ready for value-based reimbursement?

It's time to fully invest in clinical documentation improvement (CDI) initiatives across all care settings.

Why?

The trends are clear: Today, clinical documentation and physician professional coding are used for more than just fee-for-service billing and payments. An ever-increasing amount of care is provided under **value-based reimbursement (VBR) models** that use claims data from all care settings to risk-adjust payments.

The challenge? Many healthcare systems lack the processes, workflow tools and training for clinical providers in both office and outpatient settings—all factors that are critical if the data in each claim is going to deliver the level of patient detail needed to succeed under VBR models.

Healthcare systems have invested heavily in CDI programs for their inpatient, acute-care hospitals, focusing on accurate reimbursement for higher-priced inpatient care. But most patient encounters and a larger percentage of overall revenue now come from patient visits to physician offices, clinics and ambulatory centers. While the claims for these visits drive fee-for-service revenue, they increasingly drive VBR-model revenue, too.

For example, consider the annual payment amount a healthcare system receives from Medicare Advantage if the system is a shared savings plan. This payment is based on a risk-adjustment model that projects health expenditures for each patient in the coming year and uses **hierarchical condition categories (HCCs)**, which are driven by the ICD-10 diagnoses that are documented and billed for each patient over the course of a year. HCC-linked diagnoses are collected from all care settings.

What do HCCs have to do with your reimbursement?

HCCs have been around since 2004 to adjust annual capitated payments for Medicare Advantage plans. The HCC model is also being applied to determine reimbursement for accountable care organizations (ACOs), the Medicare Shared Savings Program (MSSP), and the Medicare Hospital Value-Based Purchasing (HVBP) program.¹

Under these models, healthcare providers assume more revenue accountability and risk, but this situation is a two-sided coin: On one side, there's an opportunity for heads-up success for providers who can accurately and completely document each patient during an encounter. But on the flip-side, providers who fail to provide complete and accurate documentation are likely to lose revenue and increase risk.

Can your current CDI program be “transplanted” to physician offices and clinics?

From a CDI perspective, fundamental differences exist between a successful inpatient hospital CDI program and a successful outpatient/office setting CDI program.

Inpatient CDI programs deal with limited locations, patients who typically receive care over multiple days, and physicians who deliver and document care at several touch points. In this scenario, a relatively small staff of CDI professionals can review patient records and query physicians for more diagnosis detail. Physicians can typically respond to such queries in subsequent documents created

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¹ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Risk-Adjustors.html>

during the patient's inpatient stay, which again allows the coding and CDI staff to have a more hands-on, positive impact on the quality and completeness of patient documentation.

In physician office/outpatient settings, caregivers are spread across many locations and see vastly more patients in any given year than in the inpatient setting. Patients are typically only seen for a short time during a visit, with physicians doing their documentation and visit coding once before moving on to their next task. It would take an expensive army of documentation reviewers to cover all patient encounters, and the same documentation query process that works in the inpatient setting would only increase the workload, stress level and annoyance for time-strapped physicians.

What does success look like in the new VBR world?

To succeed under VBR models, organizations must focus and invest in CDI for outpatient and office settings on a par with the CDI effort given to the inpatient, acute-care setting. Whereas diagnosis documentation and specificity traditionally drove inpatient DRG-based reimbursement, E&M and CPT® coding coding. As part of a shared savings program, revenue from services provided can be adjusted based on the risk adjustment scoring. Documenting, coding and billing for complete diagnosis detail for each patient is now crucial across all care settings—otherwise, a healthcare system risks inaccurate risk adjustment of their revenue.

If office and outpatient CDI efforts are to successfully capture complete patient diagnosis information, the focus must be on reviewing patient records *before* the visit occurs and providing physicians with *prospective guidance* on what to review during the patient encounter and while they document the visit. With the information they need available upfront, physicians can document and code for key HCC-linked diagnoses and avoid disruptive, time-consuming, retrospective queries and rework.

Through improved office/outpatient HCC monitoring and diagnosis capture, an organization can also benefit from:

- Improved data capture of chronic conditions
- Ability to compare risk-adjusted physician performance to focus CDI efforts on needed areas
- Optimized clinical and case management as a result of having more detailed information about each patient

Call today

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at www.3m.com/his.



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HCC software and services from 3M

3M understands what a healthcare system needs to set up a successful office/outpatient CDI program. 3M has HCC solutions for CDI and coding that deliver training, process design and end-to-end workflow tools and technology to cover all patient encounter claims. We help our clients generate claims containing complete patient diagnosis information and accurate HCC capture, while also maintaining coding integrity and managing fee-for-service-based visits. Our solutions include:

HCC Assessment and Education Programs from 3M Consulting Services

- Perform chart and claims data audit to identify gaps in capturing HCCs
- Identify coding and documentation process improvement opportunities
- Provide role-specific HCC training and education to reviewers, coders and clinicians

3M™ 360 Encompass™ System – Patient Insights

- Patient HCC and RAF gap analysis for entire population
- HCC reviewer/care coordinator web portal for custom work lists, pre-visit patient reviews and in-depth HCC reporting
- Offers EHR-integrated physician diagnosis guidance to improve HCC diagnosis documentation and billing

3M computer-assisted coding (CAC) systems and technologies

- Identify uncoded diagnoses in clinical notes for inclusion in the visit claim
- Help improve billing accuracy and revenue integrity for professional coding

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Published 02/17
70-2011-6668-6