

**HEALTH CARE REFORM: IMPROVING
HEALTHCARE THROUGH SUPERIOR
MEDICAL DOCUMENTATION AND
PRACTICING IN A HEIGHTENED
ENFORCEMENT CLIMATE**

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OBJECTIVES

- Understand current healthcare transformation trends
- Learn how clinical documentation directly impacts the “business of medicine” from a present and future perspective
- Understand and practically apply best practice strategies of clinical documentation to effectively represent and report practicing efficiencies of medicine
- Appreciate limitations of present provider reimbursement methodologies leading to healthcare transformation trends

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CURRENT STATE OF HEALTHCARE

- Share of Gross Domestic Product devoted to healthcare spending grew from 9% of GDP in 1980 to 16% of GDP in 2008
- Health & Human Services Department expects health share of GDP to reach 19.5% of GDP by 2017
- In 2007, U.S. spent \$2.26 trillion on healthcare, or \$7,439 per person, up from \$2.1 trillion, or \$7,026 per capita the previous year
- In 2009, the U.S. collectively spent \$2.5 trillion or \$8,047 per person on health care
 - Represented 17.3% of GDP, up from 16.2% in 2008

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RACS FOCUS IMPROPER PAYMENT

- AHA RACTrac
 - 84% of participating hospitals with complex denials cited medically unnecessary as reason for denial
 - Majority of medical necessity denials reported for 1 day stay, not because care medically unnecessary

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RACS FOCUS IMPROPER PAYMENT

- \$167 million denials through 1st quarter 2011, nearly double amount reported through 4th quarter 2010.
- 95% of denied dollars were complex denials totaling over \$158 million dollars.

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RACS FOCUS IMPROPER PAYMENT

- Average dollar value complex denials was \$5,649
- Medical necessity **the** top reason for complex denials
- Medical necessity denials have largest financial impact of all denials

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ONE DAY STAYS...

- Majority denials consists of one-day stays:
 - One day Stay (1st Quarter 2011)
 - \$37.9 (78%) million inappropriate setting
 - \$10.7(22%) million medically unnecessary
 - > One day Stay (1st Quarter 2011)
 - \$3.4 (37%) million inappropriate setting
 - \$5.9 63%) million medically unnecessary

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CURRENT STATE OF HEALTHCARE

- Of each dollar spent on health care in the United States,
 - 31% goes to hospital care,
 - 21% goes to physician/clinical services,
 - 10% to pharmaceuticals,
 - 4% to dental,
 - 6% to nursing homes, and 3% to home health care,
 - 3% for other retail products,
 - 3% for government public health activities,
 - 7% to administrative costs,
 - 7% to investment, and
 - 6% to other professional services (physical therapists, optometrists, etc).
 - Source Wikipedia.org

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INCREASED EXPENDITURES ≠ INCREASED QUALITY

- Dartmouth Atlas of Healthcare in 2008 found that providing Medicare beneficiaries with severe chronic illnesses with more intense health care in the last two years of life—increased spending, more tests, more procedures and longer hospital stays—is not associated with better patient outcomes.
- Underuse of effective care is widespread and occurs even at some hospitals considered among the best in the country.
 - Source: <http://www.dartmouthatlas.org>

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WHAT IS DRIVING U.S. HEALTHCARE DOLLAR SPENDING?

- Technology and Prescription drugs
- Chronic diseases
- Aging of the population
- Administrative costs

- U.S. healthcare costs does not correlate with superior quality

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LANDMARK STUDY

- According to the Commonwealth Study, in a 2010 comparison with six other countries (Australia, Canada, Germany, Netherlands, New Zealand, and the U.K.), the U.S. had the second lowest rank in quality of care and ranked the lowest in all other aspects of health care: efficiency, equity, access, and length/health/productivity of citizens' lives.
- This gave the U.S. the overall lowest ranking. Efficiency was brought down by administrative costs among other things.

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“WASTEFUL SPENDING” IN HEALTH CARE

- Wasteful spending in the health system has been calculated at up to \$1.2 trillion of the \$2.2 trillion spent nationally, more than half of all spending
 - Classified into three waste “baskets:”
 - Behavioral
 - Clinical
 - Operational
 - Top three areas of wasted spending are:
 - Defensive medicine (\$210 billion annually)
 - Inefficient claims processing (up to \$210 billion annually)
 - Care spent on preventable conditions related to obesity and overweight (\$200 billion annually)
 - Source: The price of excess- Identifying waste in healthcare spending; PricewaterhouseCoopers’ Health Research Institute <http://www.pwc.com/cz/en/verejna-sprava-zdravotnictvi/prices-of-excess-healthcare-spending.pdf>

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AFFORDABLE CARE ACT

- March 23, 2010 President Obama signed Affordable Care Act
 - Comprehensive healthcare insurance reform
 - Measures to expand access to healthcare while improving/promoting quality, efficiency and effectiveness of healthcare delivery while driving down costs
- Focus upon **“Physician Efficiency”**
 - Providing and ordering a level of service that is sufficient to meet a patient’s healthcare needs but not excessive, given the patient’s health status
 - GAO Report 07-307, Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency
<http://www.gao.gov/new.items/d07307.pdf>

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AFFORDABLE CARE ACT

- ACA Provisions
 - Increased effort at fighting fraud and abuse in Medicare program
 - Current efforts fighting fraud returned \$2.5 billion to the Medicare Trust Fund 2009
 - Focus on Preventing Fraud Before it Happens
 - Rigorous screening process for providers and suppliers
 - Temporarily stop enrollment of new providers and suppliers
 - Temporarily stop payments to providers and suppliers in cases of suspected fraud
 - New resources to Fight Fraud
 - Provides an additional \$350 million to ramp up anti-fraud efforts

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AFFORDABLE CARE ACT

- Sharing Data to Fight Fraud
 - Initiatives to improve coordination across agencies working to stop fraud, requiring from Medicare, Medicaid, CHIP, VA, Department of Health, and Indian Health Service to be centralized, thereby making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.
- Enhanced Penalties to Deter Fraud and Abuse:
 - The Affordable Care Act provides the OIG with the authority to impose stronger civil and monetary penalties on those found to have committed fraud.
 - Providers who identify an overpayment from Medicare or Medicaid but do not return it within 60 days may be subject to new fines and penalties

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MEDICARE PAYMENT TRANSFORMATION

- General Principles
 - Transformation from a passive payer of services into an active purchaser of higher quality, affordable care.
 - Efforts to link payment to the quality and efficiency of care provided.
 - Creation of appropriate incentives encouraging all providers to deliver higher quality at lower total costs.
 - Public reporting of healthcare outcomes.
 - <http://www.hospitalcompare.hhs.gov/>
 - <http://www.healthcare.gov/news/videos/tour.html>
 - Value Based Purchasing Initiative
 - Value Based Payment final rule published May 6, 2011

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TEMPLATE FOR VALUE BASED PURCHASING

- Template
 - Identification and promotion of the use of quality measures through pay for reporting,
 - Payment for quality performance,
 - Measures of physician and provider resource use,
 - Payment for value-- promote efficiency in resource use while providing high quality care,
 - Alignment of financial incentives among providers, and
 - Transparency and public reporting.

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THE WORD OF “EFFICIENCY”

- “In the U.S., the sources of inefficiency that are leading to rising healthcare costs include payment systems that reward medical inputs rather than outcomes.
- Medicare is transforming from a system that rewards volumes of service to one that rewards efficient, effective care and reduces delivery system fragmentation”.
 - Federal Register/Vol. 76, No. 160/Thursday, August 18, 2011/Rules and Regulations

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EFFECTIVE CLINICAL DOCUMENTATION IMPROVEMENT & INTEGRITY

- Effective CDI captures:
 - Severity of Illness & Intensity of Service
 - Risk of morbidity and mortality
 - Risk of readmission
 - Physician's clinical judgment, medical decision-making and clinical rationale
 - Medical diagnoses congruent with clinical information and facts of the case
 - Adherence to clinical best practices of medicine

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PRINCIPLES OF MEDICAL DOCUMENTATION

- **Principles of Medical Record Documentation**
 - “Reasonable and Necessary” and “Supporting Documentation of the Same” are key elements
 - The interdisciplinary team documentation of assessment, intervention and outcomes provides a picture of the patient's clinical condition and response to treatment
 - Each component is useful in determining “reasonable and medically necessary” services are provided and billed to the contractor for reimbursement”

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ROLE OF CLINICAL DOCUMENTATION

- Accurate representation:
 - “Clinical Effectiveness, Efficiency” in support of strong clinical outcomes
 - Medical Necessity
 - Care coordination
 - Sound discharge plan
 - Resource consumption supportive of coding and reimbursement (Medicare spending per beneficiary)
 - Risk of readmission and third party payer expenditure

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EXPANDED ROLE OF CLINICAL DOCUMENTATION INTEGRITY



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ENCOMPASSING ROLE CLINICAL DOCUMENTATION

- Medicare's words:
 - “We believe that hospitals which provide quality inpatient care and appropriate discharge planning and work with providers and suppliers on appropriate follow-up care will realize efficiencies and perform well on measures, because the Medicare beneficiaries they serve will have reduced need for excessive post-discharge services”
 - Federal Register August 18, 2011, page 146
- “Quality” patient care and “Appropriate” discharge planning” predicated upon effective clinical documentation and coordination of care including discharge summary and history and physical.

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ANOTHER POINT

- In Medicare's words:
 - “We believe that as hospitals focus on working to redesign care systems and to coordinate with other providers of care they can have a significant impact on the quality and efficiency of services provided to the Medicare beneficiaries they serve.
 - We believe that hospitals have a significant influence on Medicare spending during the episode surrounding a hospitalization, through the provisions of appropriate, high quality care before and during inpatient hospitalization and through proper hospital discharge planning, care coordination, and care transitions.”
 - Federal Register , August 18, 2011, page 149

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\$64,000 QUESTION



- What is the status of the clinical documentation in your facility?
 - Focus upon reimbursement
 - Focus upon quality and effectiveness/outcomes of care
 - Focus upon holistic reporting of patient encounter, regardless of setting (inpatient versus outpatient)
- Inventory assessment of clinical documentation:
 - Define
 - Measure
 - Analyze
 - Improve
 - Control

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SPEAKING OF QUESTIONS

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