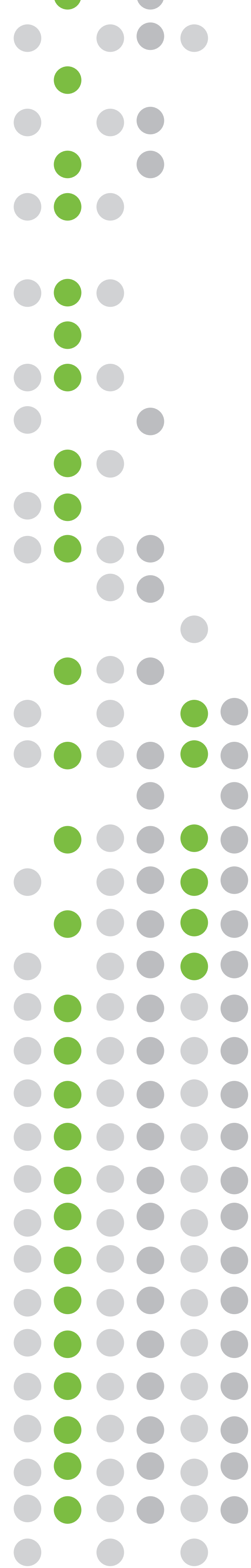
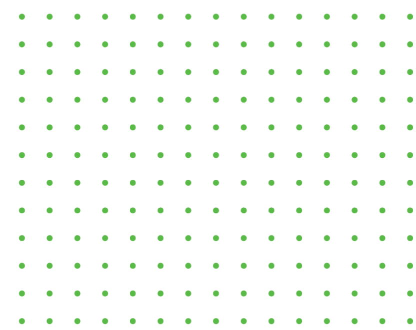


Proper Documentation Ensures Organizations Remain Compliant and Optimize Revenue in Value-Based Care



Executive Summary

Healthcare financing is undergoing a significant transformation. Historically, payments made by both private and public health plans have been primarily based on the number and type of services provided, ranging from surgical interventions to evaluation and management encounters. Rarely was the effectiveness of an intervention questioned, and reimbursement was the same regardless of outcomes.

Today, value-based payment models are tied to the quality of care provided. These models are largely focused on improving patients' health, and organizations assume financial risk for the cost of providing care to their patients.

Value-based models are formulated on the assumption that providers' coordinated care and interventions will produce better outcomes and keep patients healthier, thus reducing the cost of care while increasing quality and patient satisfaction. Some of these payments are based on risk-adjusted capitation models, such as Medicare Advantage and PACE (Program of All-Inclusive Care for the Elderly). Other payment models, including the Center for Medicare & Medicaid Innovation's (CMMI's) Accountable Care Organizations, Independence at Home, and Direct Contracting models, are structured to provide quality care at lower costs in a payment year as compared to historical data. In all payment-model scenarios, participating entities have an opportunity to realize outcomes based on financial incentives.

To discourage risk-based entities from avoiding illness-burdened populations, individual patient's conditions are risk adjusted, meaning each patient's costs of care are compared to an "average" Medicare patient's costs of care. Diseases, and the severity of those diseases, are inferred by ICD-10 codes submitted, and accuracy of documentation specific to ICD-10 codes drives payments to risk-based entities.

The Importance of Understanding Clinical Documentation in Value-Based Care

Because clinical documentation is not closely tied to the traditional fee-for-service reimbursement model, providers may have a learning curve associated with documentation in value-based care settings. Without proper clinical documentation, organizations run the risk of incomplete and unspecified diagnoses, leading to lower risk scores, lost revenue, and inadvertent upcoding, a violation of the False Claims Act.

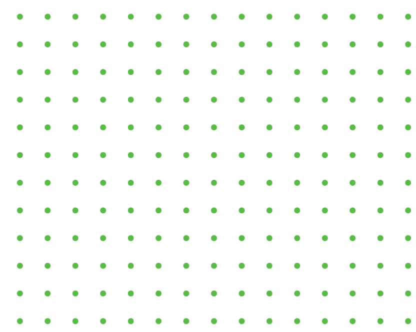
While most electronic health record (EHR) systems offer functionality, which can recommend codes based on clinical documentation, many providers may not realize that in value-based care, these systems do not solve the need for complete and specific diagnostic statements from the assigned ICD-10 outset.

Clinical documentation in value-based care can be validated by an annual retrospective chart review, which captures diagnoses supported from a previous year's encounters and includes missed diagnoses submitted to those codes. Some organizations may not realize these same chart reviews must also include redacting incorrect or unsupported codes discovered during the review. While retrospective reviews are effective, organizations may not understand the timing and the significant effect on cash flow. Additionally, retrospective reviews rarely impact provider documentation behavior.

Effective Solutions

Value-based care involves a unique approach to clinical documentation, diagnoses-specific coding, and supporting statements. Capstone has found organizations are more likely to remain compliant and optimize revenue when they implement solutions including auditing, coding, and provider-to-provider education.

Audits are essential for organizations that rely on accurate documentation and coding as part of their payment model. Certified nurse coders are a critical component of the audit process as they find incorrect and unsupported codes for redaction, which improves compliance. They also review lab results, diagnostic imaging reports and specialty consultations for diagnoses not captured, which increases revenue. Though auditing is critical to maintaining a strong compliance program, audits alone have limited impact on provider documentation habits. Physician-led instruction can–and typically does–impact behavior because of provider-to-provider relatability. Consistent training leads to accountability and presents the opportunity to reinforce risk adjustment methodology and audit trends.



Summary

In the emerging world of value-based healthcare where clinical documentation is key to compliance and revenue, Capstone offers high-impact solutions including auditing, coding, and provider-to-provider education. Certified nurse auditors lead teams who review documentation and offer detailed reports with suggested actions for providers and leadership. Capstone's expert physician-consultants offer provider education in value-based care, including risk adjustment principles and Clinical Documentation Excellence™ education through presentations, as well as on-demand training modules that were developed, written, and presented by seasoned physicians with decades of clinical practice and value-based care experience.

Since 2005, Capstone's clients have typically experienced substantial increases in hierarchical condition category (HCC) risk scores and revenue, along with the peace of mind that comes with knowing their organizations' documentation is compliant.

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