2a. Clinical Documentation Improvement (CDI) – Implementation for Home Health and Hospice

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OBJECTIVE 1

Define Clinical Documentation Improvement in the outpatient setting and its importance in today’s home health and hospice programs.
IS CDI ON YOUR AGENDA FOR 2023?

You are probably doing some form of Clinical Documentation Improvement under different names, but it likely is not the formal program we will talk about in this session.

You may call it Quality Assurance Performance Improvement (QAPI) clinical record audits, or

Continuous Quality Measurement (CQM) quality audits, or

OASIS Reviews, or

Pre-Billing Audits, or

“Fix It – Wing It” when an ADR is received!!

Clinical Documentation Improvement encompasses several of the above (except Fix It-Wing It)

In fact, the concept of CDI assures that you avoid the “Fix It-Wing It” altogether!!

DEFINING CDI

Clinical Documentation Improvement is a new name, not a new process.
It is a structured approach to clinical documentation that focuses on improvement to better support:
• Skilled Need
• Coding
• Outcomes
• Quality initiatives
• Reimbursement

CDI is:
• The process of reviewing medical record documentation for completeness and accuracy and for what is “missing.”
• A formal program or initiative across health care with certifications available in various settings, including acute care hospitals and physician practices.

It’s importance to home health and hospice has only been recognized in the past two years!
ORIGINS OF CDI - INPATIENT

2007 Hospital Implementation - after MS-DRG payment program under the Medicare Inpatient Prospective Pay (IPPS) was implemented

• accurate and thorough diagnosis reporting increased reimbursement and reduced compliance risk

• concurrent review – *before* claim was submitted

• preventing expensive consequences from review by authorities

ORIGINS OF CDI – OUTPATIENT PHYSICIAN PRACTICES

2015 Physician Implementation – Merit-Based Incentive Payment System (MIPS)

• CDI can be instrumental in guaranteeing that clinical documentation includes the necessary information to meet the criteria of MIPS measures.

• 2021 E&M CPT changes physician documentation guidelines from typically requiring key elements such as history, exam, and medical decision making (MDM) to basing the level of the visit on MDM or time.
ORIGINS OF CDI – OUTPATIENT HOME HEALTH (CONT)

Home health CDI can be instrumental in assisting agencies with compliance to quality standards that impact or will impact reimbursement standards in the future.

2020 – Home Health – Patient-Drive Grouping Models (PDGM)

• Payment relies more heavily on clinical characteristics to place home health periods of care into meaningful payment categories (OASIS D-1)

2022 – IMPACT Act of 2022 (PAC Providers)

• Plans for payment unification across PAC payment based on patient characteristics rather than PAC setting (SNFs, LTACS, HHAs, Nursing Facilities)

• Standardized Patient Assessment Data Elements (SPADES)

• OASIS-E continues the standardization of assessment items for home health to match those in the assessment tools for other PAC providers

2023 – Home Health Value-Based Purchasing (HHVBP)

• HH Final Rule 2022 announced the nationwide expansion of the HHVBP model designed to be implemented this year.

• Purpose is to improve the quality and delivery of health care services by providing incentives for better quality care with greater efficiency.
ORIGINS OF CDI – OUTPATIENT HOSPICE

CDI programs for hospice quality initiatives impacting reimbursement is still in development, but accuracy and completeness of the HOPE document will become a focal point for compliance, including reimbursement compliance in the future.

2014 – Hospice Consumer Assessment of Healthcare Providers and Systems (HQRP)
• HIS assessment items uploaded at assessment and discharge
• Currently “pay for reporting” meaning it is the timely submission and acceptance of complete data that determine compliance with HQRP requirements.

2020 – Hospice Outcomes and Patient Assessment and Evaluation (HOPE)
• Finalized in FY 2020 Hospice Final Rule
• HOPE will provide quality data for HQRP through standardized data collection
• HOPE will provide additional data that could inform future payment refinements

WHY CDI AND WHY NOW?

The most significant impact a CDI program can offer in real time for both home health and hospice is the increased scrutiny and oversite experienced by both programs in retrospective audits by the Contractors!

Who is Looking?
• Office of Inspector General (Office of Audit and Investigations)
• Medicare Administrative Contractors (Targeted Probe and Educate)
• Unified Program Integrity Contractors (UPIC) – Qlarant Integrity Solutions
• Supplemental Medical Review Contractors (SMRC) – Noridian Integrity Solutions Comprehensive Error Rate Testing

Why Are They Looking?
• Fraud, abuse, and waste objections
• Qui tam
• Claim data research
• Prior history of providers
• Government chase objectives to recover overpayments at any level!
CDI FOCUS IN 2023

The CDI focus for 2023 for home health and hospice is to focus on prevention of denial!

What are the big areas of concern?

Home Health:
- Improper referrals
- Inadequate Face-to-Face
- Incomplete or inadequate OASIS
- No plan of care or certification
- Incomplete or unsigned and dated physician orders
- Lack of support for medical necessity
- Lack of skill for interventions performed

Hospice:
- Not hospice appropriate (failure to qualify patient under LCD)
- Stable and chronic vs terminal – no medical necessity
- Invalid Notice of Election
- Hospice GIP or CHC services not reasonable or necessary
- Initial/subsequent certification not timely
- Physician narrative on certificate of terminal illness not present or not valid
- Inadequate Plan of Care (not signed or dated)
- Untimely update to POC
- No plan of care or certification
- Face-to-Face encounter requirements not met
OBJECTIVE 2

Describe the conceptual differences between QAPI and CDI and how these two concepts can demonstrate overall compliance to regulation and reimbursement.

QAPI VS CDI? WHAT’S THE DIF?

QAPI is required by both state licensing requirements AND Conditions of Participation. Rule 558.

How Does CDI Differ?

Clinical Documentation Improvement program differs from QAPI in the following ways:

- Focus is reimbursement driven primarily
- Assesses adequacy of processes to improve compliance to coverage requirements and timeliness of claim submission
- Works to prevent denials of payment
WHAT DOES QAPI REQUIRE?

TAC Rule §558.287 “Quality Assessment and Performance Improvement” (applies to both home health and hospice providers)

- An agency must maintain a QAPI Program that is implemented by a QAPI Committee. The QAPI Program must be ongoing, focused on client outcomes that are measurable, and have a written plan of implementation. The QAPI Committee must review and update or revise the plan of implementation at least once within a calendar year, or more often if needed.
- The QAPI Program must include:
  - A system that measures significant outcomes for optimal care. The QAPI Committee must use the measures in the care planning and coordination of services and events. The measure must include the following as appropriate for the scope of services provided by the agency:
    - An analysis of a representative sample of services furnished to clients contained in both active and closed records;
    - A review of:
      - Negative client care outcomes
      - Complaints and incidents of unprofessional conduct by licensed staff and misconduct by unlicensed staff
      - Infection control activities
      - Medication administration and errors
      - Effectiveness and safety of all services provided, including:
        - Competency of the agency’s clinical staff
        - Promptness of service delivery
        - The appropriateness of agency’s response to client complaints and incidents
WHAT DOES QAPI REQUIRE? (CONTINUED)

The QAPI Program must include:

- A determination that services have been performed as outlined in the ISP, care plan or plan of care
- An analysis of client complaint and satisfaction survey data
- An annual evaluation of the total operation, including services provided under contract or arrangement.
  - The agency must use the evaluation to correct identified problems and revise policies if necessary
  - Document the correction action to ensure that improvements are sustained over time

The QAPI Committee membership includes at a minimum – the administrator, the supervising nurse or therapist, an individual representing the scope of services provided by the agency.

WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH?

§484.65 Condition of participation: (CONDITION) – Home Health

Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA’s governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and readmissions; and takes actions that address the HHA’s performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.
WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH? (CONT)

§484.65(a) Standard: Program scope. (Home Health)
484.65(a)(1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.
484.65(a)(2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.

WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH? (CONT)

§484.65(b) Standard: Program data.
484.65(b)(1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program.
484.65(b)(2) The HHA must use the data collected to-
484.65(b)(2)(i) Monitor the effectiveness and safety of services and quality of care; and
484.65(b)(2)(ii) Identify opportunities for improvement.
484.65(b)(3) The frequency and detail of the data collection must be approved by the HHA's governing body.
WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH? (CONT)

§484.65(c) Standard: Program activities.

§484.65(c)(1) The HHA’s performance improvement activities must
(i) Focus on high risk, high volume, or problem-prone areas
(ii) Consider incidence, prevalence, and severity of problems in those areas; and
(iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

§484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions.

§484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained.

WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH? (CONT)

§484.65(d) Standard: Performance improvement projects.

§484.65(d)(1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA’s services and operations.

§484.65(d)(2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.
WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOME HEALTH? (CONT)

§484.65(e) Standard: Executive responsibilities
The HHA's governing body is responsible for ensuring the following:
§484.65(e)(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained;
§484.65(e)(2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness;
§484.65(e)(3) That clear expectations for patient safety are established, implemented, and maintained; and
§484.65(e)(4) That any findings of fraud or waste are appropriately addressed

WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOSPICE?

§418.58 Condition of Participation: Quality Assessment and Performance Improvement
§418.58 - The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice’s governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
WHAT DOES THE CONDITION OF PARTICIPATION REQUIRE FOR HOSPICE? (CONT)

§418.58(a) - (b)(3) Standard: Program scope
§418.58(c) – (c)(3) Standard: Program activities
§418.58(d) – (d)(2) Standard: Performance improvement projects
§418.58(e) – (e)(3) Standard: Executive responsibilities

ARE THERE OVERLAPS BETWEEN QAPI AND CDI?

Yes!

Example 1
CDI audit may have the following elements:
- OASIS is completed timely by the qualified clinician and is signed and dated.
- OASIS is transmitted timely and is validated prior to the submission of the final claim
- OASIS summarizes care needs that supports medical necessity for the episode.

Example 2
- Certificate of terminal illness is signed and dated not more than 2 days following the start of the benefit period.
- Certificate of terminal illness contains a narrative statement by the physician that clearly supports the terminal status of the patient according to the LCD requirements.
OBJECTIVE 3

Identify 5 benefits of a CDI program for home health and hospice.

BENEFITS OF CDI FOR THE HOME HEALTH AND HOSPICE PROGRAM

CDI will assist in compliance with the home health and hospice agency in the following ways:

Home Health:

- Prevention of Denials
- Face to Face
- Skilled Need
- Homebound Status
- OASIS
- STAR Ratings
- Goal Directed Care (objective, measurable)
- Value Based Purchasing
- HIPPS/Case Mix – appropriate reimbursement (PDGM)
BENEFITS OF CDI FOR THE HOME HEALTH AND HOSPICE PROGRAM (CONT)

- Combines clinical expertise, documentation integrity and coding processes to ensure accurate reimbursement, accurate reporting and quality metrics are being achieved
- Protects the agency in liability lawsuits, overpayment decisions, and errors in claims
- Assures that the clinical characteristics and diagnosis selections place the home health episode into the appropriate payment categories impacting reimbursements.
- Justifies the need for home health or hospice services.
- Ensures that ordered, skilled interventions are completely documented on the clinical notes.
- Improves the consistency and congruency in documentation among all service providers

OBJECTIVE 4

Identify four (4) essential elements of approach in the development of a successful CDI program.
ESSENTIAL ELEMENTS IN DEVELOPING A SUCCESSFUL CDI PROGRAM

- **Assessment Phase**
  
  This is the initial phase of the CDI program development and is a key critical success factor to assess the accuracy, specificity and completeness of the clinical documentation as well as to ensure that the documentation clearly identifies the conditions assessed and the treatment rendered.

- **Design Phase**
  
  This phase centers around defining a plan after completion of the Assessment Phase. In this phase, the CD Task Force will define the elements needed for a successful CDI program.

ESSENTIAL ELEMENTS IN DEVELOPING A SUCCESSFUL CDI PROGRAM (CONT)

- **Education & Implementation Phase**
  
  This phase focuses on educating clinical staff based upon the audit findings and defined organizational metrics defined during the design Phase.

- **Monitoring Phase**
  
  This phase is the ongoing auditing and maintenance of the CDI program. It requires some level of project oversight at least monthly by the appropriately assigned staff. The key goal is to monitor and manage the program to ensure it meets the objectives set up by the agency during the Design Phase.
OBJECTIVE 5

Identify the five (5) key steps in implementing a CDI program in your agency.

STEPS IN IMPLEMENTING A CDI PROGRAM

- Create CDI Task Force
  - Determine composition of the CDI Task Force (e.g. Agency Leadership, Coding, QAPI Manager, Clinical Manager, Billing Manager, etc)
  - Limit membership to “need to know” basis for findings
- Develop clear strategies, priorities and goals for the agency’s CDI program
- Perform a comprehensive assessment of clinical documentation
  - Identify areas of risk within the agency for documentation inaccuracy, reimbursement, and non-compliance with coverage requirements and COPs.
    - Past deficiencies and denials
    - Areas found in Agency Assessment
**STEPS IN IMPLEMENTING A CDI PROGRAM (CONT)**

- Examine agency’s processes that lead to non-compliance
  - Referral Intake
  - Eligibility
  - Assessments
  - Order Development
  - Clinical Documentation
  - Pre-Billing Activities
  - Recertifications
  - Transfer/Discharge
- Establish audit tools for concurrent or retrospective audits
- Develop education and training programs
- Re-assess program for effectiveness

**PROTECTING CDI ACTIVITIES**

CDI findings are agency driven activities, but in some situations, the agency may find that refunds are necessary when there is a process breakdown and claims are submitted with insufficient documentation. Follow-up action is important to prevent the agency from allegations of “cover-up or intent to keep funds that were not earned.”

MJS recommends the following best practice:

- Engage your agency’s attorney to provide external oversight over the CDI program on a quarterly basis;
- Use reputable consultants as needed under the engagement with Counsel
- Protect the findings under Work Product and Attorney Client Protections (labeled on the report)
- Inform the Task Force of any actual refunds to close the loop.
REFERENCES

1. The CDI Guide for Home Health and Hospice, HCPro and DecisionHealth Post- Acute, Tricia A.

2. HCPro “Cornerstone of CDI Success: Build a Strong Foundation” https://www.hcpro.com/content/316244.pdf, 2017


THANK YOU

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