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IF IT'S HEALTHCARE; WE'LL BE THERE.

Why Are We Doing All This Work?

by Jerry B. Willis, MBA

UPA members have certainly seen an increase in the communications from the UPA's Division of Clinical Integration in the last year. If you are a PCP, you probably have already had the pleasure of meeting with our team to discuss healthcare reform, HEDIS measures, HCCs, etc. As we move forward in our clinical integration journey, we are often asked a simple question: "Why are we doing all this work?" We hope the following list alleviates your associated angst:

- To improve our patient outcomes by increasing our provider compliance rates with HEDIS and PQRS measures.
- To improve the quality of life our patients' experience through improved compliance with evidenced-based medicine practices and better coordination amongst different providers.
- To reduce the overall costs of providing healthcare to our patients allowing the UPA to take advantage of shared savings contracts.
- To ensure our providers receive appropriate credit from the carriers for taking care of sick and clinically complex patients.
- To improve our providers' performance data which is publically reported for our patients, peers, and carriers to review.
- To prepare us for a whole new world of Federal and State driven payment reforms as our reimbursement system migrates away from fee-for-service.
- To allow the UPA to continue contracting for our members as a single entity by maintaining FTC compliance.

Thus far, the UPA has already invested significant funds into clinical integration on behalf of our members. Fortunately, we are seeing small returns on this investment including improved patient care, improved provider performance data, and some incentive reward payments. Rest assured that the UPA is currently developing a provider distribution plan to begin sharing those incentive rewards. While these rewards are small at present, we anticipate entering into additional and similar pay-for-performance contracts in the future which will hopefully replace some of the declining fee-for-service reimbursements we all face. In an uncertain healthcare environment, clinical integration has become a must for provider survival.

Health Care Delivery Teams

by Blaine L. Enderson, MD

Medical school taught us that we were responsible for our patients' healthcare. Many of us practice in small "cottage industry" style practices. Yet the healthcare delivery system and our patients have become more and more complex. Our patients have multiple complex medical problems and many alternatives for the care of these problems; thus the rules and paperwork to provide this care have become more complex. To say nothing about the electronic medical records and new coding systems that are being required of us.

The practice of medicine is changing rapidly and has become too complex to depend upon individual performance to be correct all of the time. That is where team-based care becomes necessary -- both in the hospital and in the office. UT Medical Center has embarked on a journey to use TeamSTEPPS training to help it move from a "team of experts" to an "expert team". This training is not meant to take authority away from physicians. Instead it is designed to empower -- in fact, **require** -- every member of the healthcare team to speak up when they have knowledge of a situation that may be unsafe which may not have been seen by others.

In an uncertain healthcare environment, clinical integration has become a must for provider survival.

Teamwork in the office can also be designed, using LEAN principles, to provide all of the complex care that our patients require. Each member of the team can have their roles and responsibilities clearly designed to deliver timely and efficient care to the patients and support the physicians so that they can work at the top of their license. Too often, our response to healthcare pressures is to try to decrease our costs and place more responsibility on our physicians. Sometimes by increasing the support for our physicians, we can provide overall care more effectively, meet all requirements, and provide improved satisfaction for our patients and ourselves. The UPA is exploring new ways of delivering quality healthcare for our patients and help our providers get back to practicing quality healthcare. ***We look forward to partnering with you on this journey!***

But They *ALWAYS* Approved That!

by Trey La Charité, MD

If you haven't heard, CMS has mandated that all healthcare providers transition to the ICD-10 coding system effective October 1, 2014. To believe that the AMA or some other entity will (once again) be able to block or delay its implementation at this point is naive. Failure to adequately prepare your practice for its arrival might be construed by some as outright negligence. Unfortunately, simply replacing every ICD-9 code currently used on your office forms or in your EMR may not be enough to survive. If you are a surgeon or a proceduralist, there is another consideration that should be reviewed in detail.

As if getting the requisite prior-authorization for a procedure your patient needs or squeezing out the expected reimbursement for a procedure already performed isn't challenging enough, these things may get harder. Every surgeon and proceduralist must remember that the LCDs (Local Coverage Determinations) and NCDs (National Coverage Determinations) for the procedures they commonly perform must be made ICD-10 compliant by October 1, 2014 as well. Therefore, the new ICD-10-PCS code(s) for the procedure(s) a surgeon or proceduralist performs or wishes to perform must match the new ICD-10-PCS codes found in the updated LCDs and NCDs. Failure to take this preventative step could lead to significant cash-flow problems due to prior-authorization denials or refusals to reimburse for care already delivered. Please remember that the LCDs are created by our MAC (Medicare Administrative Contractor), Cahaba GBA, Inc., but the NCDs are created and maintained by CMS. While Cahaba has created very few LCDs for our region in the first place, CMS has told Cahaba those that have been written are supposed to be fully updated and ICD-10 compliant by April, 2014. Per CMS, all of the NCDs in existence are supposedly already ICD-10 compliant. While the procedures you perform will not change, the submitted codes for those procedures certainly will. Make sure the new codes match those found on the updated LCDs and NCDs.

For more information about LCDs:

- https://www.cahabagba.com/part-a/medical-review/local-coverage-determination-lcds-articles/

For more information about NCDs:

- http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc-BAAAAAAAAAAA

Clinical Documentation Improvement: Transitioning to ICD-10

by Lynn Lowery, CPC, CFPC

Even though I-10 codes can be applied to today's medical record documentation without changing your documentation practices, improved clinical documentation will result in higher coding specificity and possible higher reimbursement. If your practice is fully prepared for I-10 in every aspect, but clinical documentation has not improved, accurate coding and proper payment will not be possible. Also, insufficient documentation represents a larger percentage of at-risk-revenue.

Start reviewing your current clinical documentation for your top diagnoses to determine if your documentation is detailed enough to select the appropriate I-10 code. Coding must accurately reflect the physician documentation. Documentation must include the significance of lab, path and radiology findings. Complications of care need to be documented. More accurate data can lead to better patient care which will allow primary care specialists to accurately depict the chronic conditions. Listed below are major areas where documentation changes will most likely be needed:

- Asthma will require documentation of mild, medium or severe asthma; then: intermittent or persistent, and finally; is it uncomplicated, (acute) exacerbation and status asthmaticus?
- Is this the first visit or subsequent visit?
- Laterality?
- Arthritis-what kind? Area affected?
- Headache-what type?
- DM-controlled (or not controlled) manifestations? Type of diabetes. Body system affected. Complications or manifestations. Using insulin? Secondary code required for long term use.
- Anemia-what kind; due to?
- Pneumonia due to.
- Chest pain-pleuritic, musculoskeletal, non-cardiac.
- COPD-nonspecific term-what kind? W or W/O exacerbation.
- Obesity-morbid, BMI.
- Atrial fib-paroxysmal, persistent, permanent, ischemic, stress induced.
- Cardiomyopathy-dilated, restrictive, hypertrophic.
- Neoplasms-malignant, primary, secondary.

Reviewing your current documentation will allow you note areas where your documentation does not meet the I-10 requirements. Improving your documentation **now** will improve your cash flow in October.

30-Day Readmission Rate for COPD

by Jill Martinez

We are continuing our 30-Day Readmission Series by looking at the readmission rate for COPD. I have narrowed the data to include only the COPD DRGs (190, 191, and 192), and I have compared the data to the UHS system and the top decile Crimson cohorts. The data is from January 2013 through November 2013, and it is blinded for privacy.

	System			Top Decile		
	Readmission	Comparison	Std Dev	Readmission	Comparison	Std Dev
Overall	15.18%	17.11%	-0.08	15.18%	16.65%	-0.06
Group A	14.41%	17.24%	-0.11	14.41%	16.77%	-0.10
Group B	12.50%	17.05%	-0.19	12.50%	16.50%	-0.17
Group C	21.05%	17.33%	0.14	21.05%	16.77%	0.17
Group D	22.50%	16.20%	0.25	22.50%	16.06%	0.25

According to the table, all of the groups that see COPD DRGs showed an average or better performance than the comparison group (everything under 0.50 standard deviations is green). However, it highlights that there are some differences in the way the groups practice. There is a large difference in the readmission rates of Group B and Group D. It also shows that both Group C and Group D have readmission rates above the overall hospital rate. The next step in this evaluation would be to dig further into the readmissions of the four groups and see the similarities and the differences in the cases. It would also be beneficial to compare the length of stay for each group.

Curious about where you fall in this table?

Login to Crimson and review your data!