Welcome to UASI's Lunch and Learn: CDI Management Series
We will be beginning shortly.

UASI CDI/UR Services

CDI Staffing
Expert consultants available to meet any staffing need. Onsite, remote, interim management, full outsource; inpatient and outpatient.

CDI Audits
Client focused results delivered with education and recommendations based on CDI best practices, national benchmarking, and official regulatory sources.

CDI Education and Training
Programs tailored to client needs for CDI staff, coders, physician CDI advisors, physicians; basic, advanced or topic-specific.

CDI Preceptors
Experienced CDI Preceptors partner with client's staff for new CDI professionals and ongoing support.

CDI Consulting
Full program evaluation and assessments of current state to advance CDI program and increase ROI; inpatient and outpatient.

Inpatient Utilization Review Staffing
Experienced UR consultants to meet any staffing need; onsite or remote.

Inpatient Clinical Validation Services
Evidence based approach to capture clinical indicators and minimize clinical denials.

Outpatient HCC Services
Customized OP CDI for specific OP venues. UASI experts are leading development of best practices through progressive innovation.

UASI CDI/UR Service Line Stats

- 4 out of 5 UASI clients request ongoing or return services following an initial CDI engagement

- UASI works for top hospitals utilizing our experienced team of consultants to deliver value tailored to our client's specific needs

- CONSULTANTS average 8 years in CDI and/or UR, and 22 years in clinical nursing

- MANAGERS average 11 years in CDI and/or UR and 24 years in clinical nursing

Inpatient to Outpatient CDI: Understanding the Similarities and Differences

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Director, CDI/UR Services, United Audit Systems, Inc.

January 20, 2021

Desired Outcomes

At the end of this presentation, attendees will be able to:

- Understand the basics of Risk Adjusted Methodology

- Explain the value and role of outpatient CDI

- Identify the similarities and differences between inpatient and outpatient CDI

Polling Question

Does your organization currently have an Outpatient CDI Program?

1. Yes, it's going great
2. Yes, in the pilot phase
3. Yes, but we need help
4. Not now, but planning in near future
5. No, we don't have any plans for an OP CDI Program

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What are Risk-adjustment and HCCs?

Risk-adjustment

- The process the Centers for Medicare & Medicaid Services (CMS) uses to estimate future spending or potential for adverse outcomes, allowing providers to understand the health characteristics of their managed population or a patient cohort
- Predictive model in which CMS is applying the use of an actuarial tool to predict the cost of health care for those covered in the plan
- Risk-adjustment Factor (RAF) score is used to evaluate the prediction of factors (chronic conditions) which apply to the beneficiary
- Applies to the patient for the calendar year across both inpatient, outpatient, and physician office settings
- Determine prospective payments in some reimbursement models
- Normalize the patient population across Medicare Advantage providers to determine performance on quality measures

Hierarchical Condition Category (HCC)

- HCC Diagnosis Conditions must be
  - Captured in a face to face visit (*COVID exception- telehealth)
  - Appropriately documented and supported in the medical record by a provider every year
  - Additive- each HCC adds up to show total health status for patient
  - The more chronic conditions the patient has, the higher the RAF score (average Medicare beneficiary RAF score is 1.0)

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Risk Adjustment Model Basics

Demographic Risk Score:

- Age and either community-based or institution-based
- Medicaid disability and interaction with age and gender

+

Disease Risk Score:

Reported diagnoses determine HCC category

Interaction between certain disease categories

Interaction between certain disease categories and disability status

=

Patient

Risk-adjustment Factor (RAF):

- Reflects underlying health status and expected costs

Risk Adjustment Model Basics

Accounts for known health conditions across all settings

Allows for comparison of health and wellness across patient populations

Uses diagnosis codes (ICD-10-CM) to determine potential risk

Used to predict both cost and quality of care by using an actuarial tool to calculate

Prevents providers from only enrolling patients with better than average health

Provides higher payment for enrollees at risk for being sicker; lower payments for enrollees predicted to be healthier

Allows CMS to pay plans based on the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries

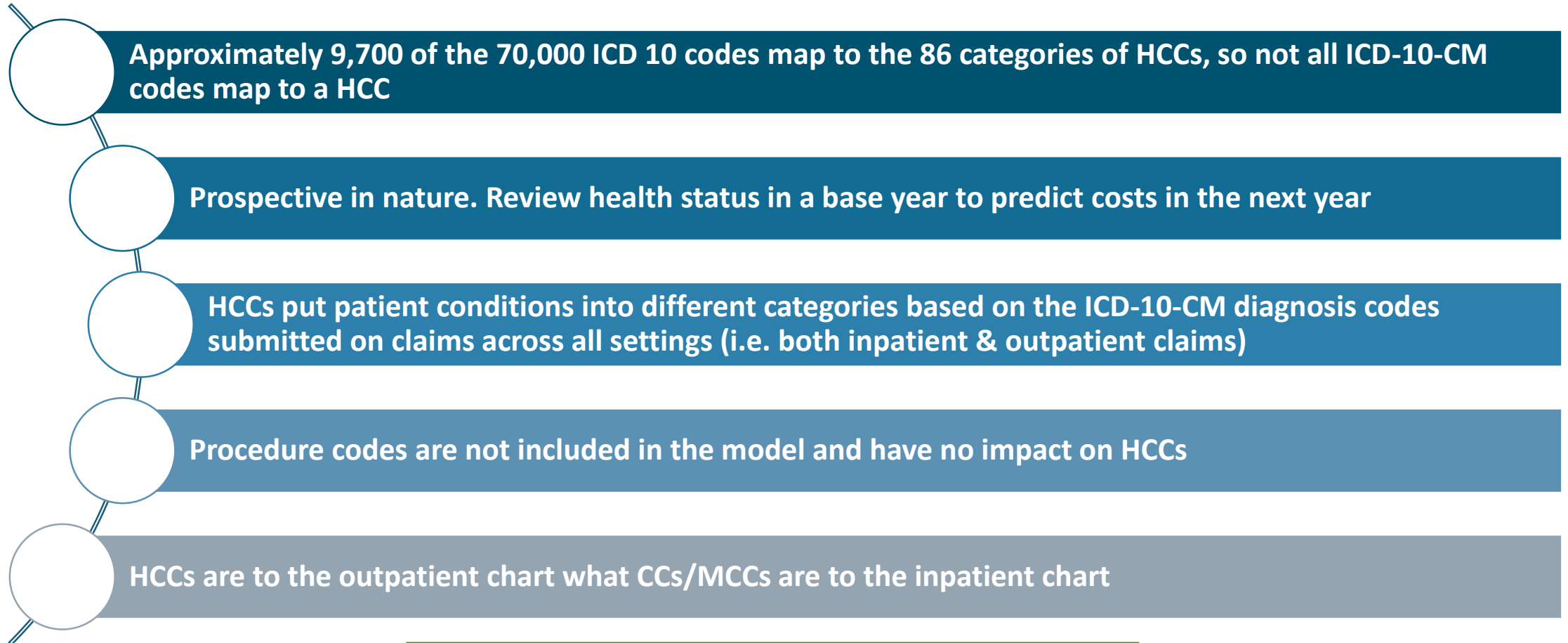Organizations must submit the qualifying diagnoses, which are subject to verification

Each calendar year the RAF score for a patient starts over

Each chronic, non resolving, risk adjusting diagnosis needs to be reported at least once a year on a claim during a face to face visit

Currently, only certain medical plans reimburse based on RAF (Medicare Advantage Plans are an example)

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HCCs (Hierarchical Condition Categories) Basics

Approximately 9,700 of the 70,000 ICD 10 codes map to the 86 categories of HCCs, so not all ICD-10-CM codes map to a HCC

Prospective in nature. Review health status in a base year to predict costs in the next year

HCCs put patient conditions into different categories based on the ICD-10-CM diagnosis codes submitted on claims across all settings (i.e. both inpatient & outpatient claims)

Procedure codes are not included in the model and have no impact on HCCs

HCCs are to the outpatient chart what CCs/MCCs are to the inpatient chart

- 9,702 ICD-10-CM codes included in the CMSHCC version 24 risk adjustment model
- About 13% of all possible codes

HCCs (Hierarchical Condition Categories) Basics

Mainly chronic diseases that statistically support increased costs related to care

Recognize resources are being consumed, similar to DRGs

Each HCC is assigned a Risk Adjustment Factor (RAF) numeric value

Multiple HCCs can be assigned per encounter and can be cumulative

HCCs reflect hierarchies among related disease categories
Hierarchy is involved, however sequencing is not
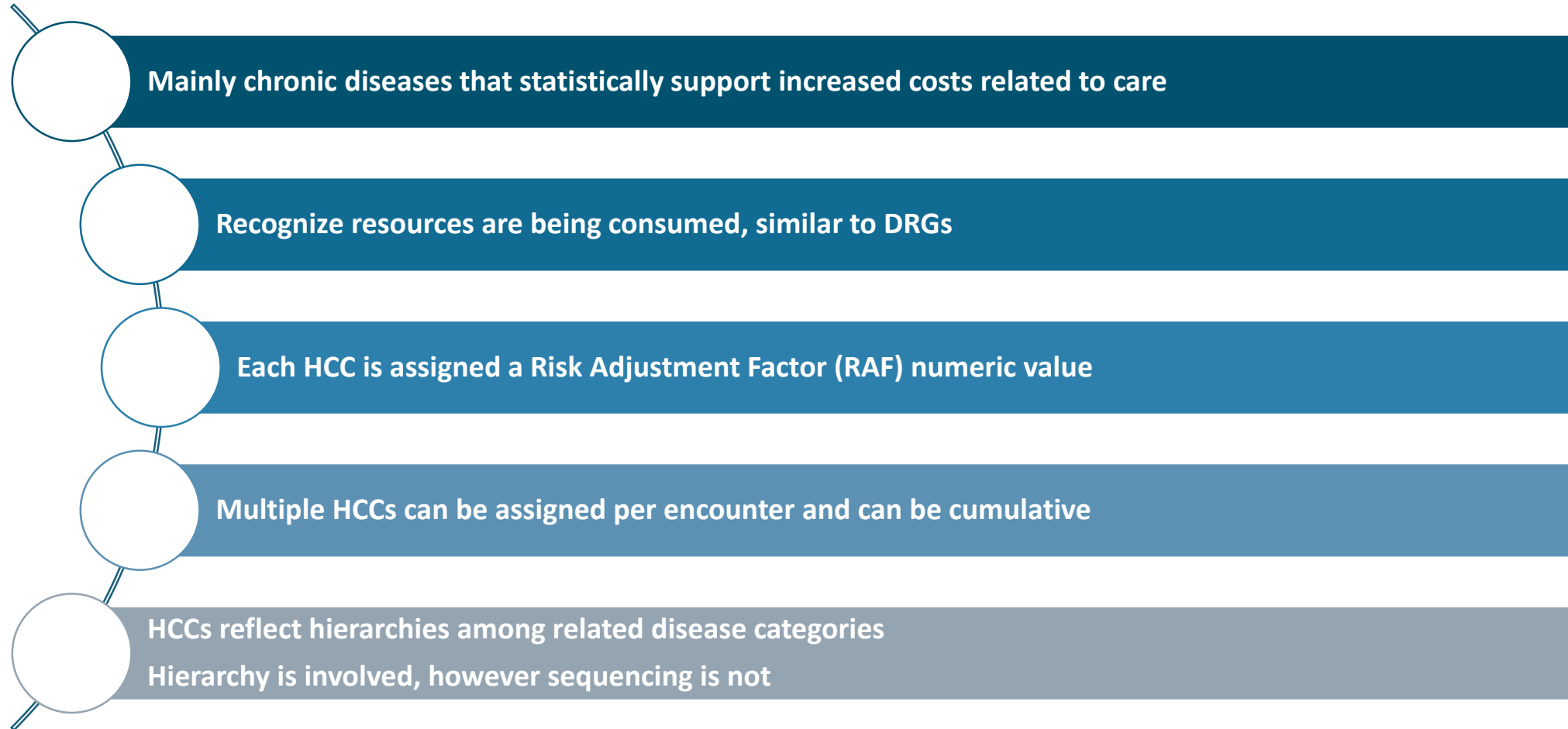
Risk Adjustment Factor (RAF) Scores

Each member (patient) has a Risk Adjustment Factor (RAF) Score

Organization average RAF score (similar to case mix for a hospital)

Patient average RAF Scores

- = 1: Patient is expected to use average resources
- < 1: Patient is expected to use fewer than average resources
- > 1: Patient is expected to use more than average resources

High Risk Adjusted Factor Score (RAF) reflects:

- Most complicated patients
- High consumption of resources
- **Higher complexity of care needed for the patient = Higher predicted costs for care of the patient**

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Risk Adjusted Model Summary

The Risk Adjustment Model

- Is to intended to be predictive
- Goal is to improve predictability of costs, quality of care, and readmission risk
- Codes reported <u>this</u> year, determine resource needs for the <u>next</u> year and predetermines <u>each</u> year (for CMS Medicare Advantage)

HCC Model Comparison

Different HCC Models- Two Main Models

CMS-HCC (Medicare Advantage)

- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS has also developed a CMS Rx HCC model for Medicare Part D risk adjustment
- Population: $\geq$ 65 or disabled in Medicare population
- Base year diagnoses and demographics predict NEXT years spending (excluding drugs)
- Predictive Modeling
- Provider on Health plan payments
- 86 HCCs

HHS-HCC (ACO Population)

- Developed by Department of Health and Human Services (HHS)
- Designed from commercial payer population
- Population: Adult, child, and infants in commercial population
- Base year diagnosis and demographics predict current spending (including drugs)
- Concurrent Payment Model
- Health plan payments
- 200+ HCCs

Other Different types of HCCs and HCC Models exist as well
Medicaid can opt to use various models including CDPS, ACG, and Medicaid RX
Sub Models: Long term institutional, community, ESRD

Accountable Care Organizations (ACOs) fall under the APM (Alternate Payment Models) for quality reporting. Provider members of the ACO bill for the care of all participants under the ACOs single tax ID. The ACO is rewarded by sharing the savings it achieves for Medicare over what Medicare would have spent if the patients weren't within the ACO

Categories

Disease Coefficients	Description Label	
HCC1	HIV/AIDS	0.335
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.352
HCC6	Opportunistic Infections	0.424
HCC8	Metastatic Cancer and Acute Leukemia	2.659
HCC9	Lung and Other Severe Cancers	1.024
HCC10	Lymphoma and Other Cancers	0.675
HCC11	Colorectal, Bladder, and Other Cancers	0.307
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.150
HCC17	Diabetes with Acute Complications	0.302
HCC18	Diabetes with Chronic Complications	0.302
HCC19	Diabetes without Complication	0.105
HCC21	Protein-Calorie Malnutrition	0.455
HCC22	Morbid Obesity	0.250
HCC23	Other Significant Endocrine and Metabolic Disorders	0.194
HCC27	End-Stage Liver Disease	0.882
HCC28	Cirrhosis of Liver	0.363
HCC29	Chronic Hepatitis	0.147
HCC33	Intestinal Obstruction/Perforation	0.219
HCC34	Chronic Pancreatitis	0.287

Variable	Description Label	Community, NonDual, Aged
HCC35	Inflammatory Bowel Disease	0.308
HCC39	Bone/Joint/Muscle Infections/Necrosis	0.401
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.421
HCC46	Severe Hematological Disorders	1.372
HCC47	Disorders of Immunity	0.665
HCC48	Coagulation Defects and Other Specified Hematological Disorders	0.192
HCC51	Dementia With Complications	0.346
HCC52	Dementia Without Complication	0.346
HCC54	Substance Use with Psychotic Complications	0.329
HCC55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	0.329
HCC56	Substance Use Disorder, Mild, Except Alcohol and Cannabis	0.329
HCC57	Schizophrenia	0.524
HCC58	Reactive and Unspecified Psychosis	0.393
HCC59	Major Depressive, Bipolar, and Paranoid Disorders	0.309
HCC60	Personality Disorders	0.309
HCC70	Quadriplegia	1.242
HCC71	Paraplegia	1.068
HCC72	Spinal Cord Disorders/Injuries	0.481
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.999
HCC74	Cerebral Palsy	0.339

Variable	Description Label	Community, NonDual, Aged
HCC75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	0.472
HCC76	Muscular Dystrophy	0.518
HCC77	Multiple Sclerosis	0.423
HCC78	Parkinson's and Huntington's Diseases	0.606
HCC79	Seizure Disorders and Convulsions	0.220
HCC80	Coma, Brain Compression/Anoxic Damage	0.486
HCC82	Respirator Dependence/Tracheostomy Status	1.000
HCC83	Respiratory Arrest	0.354
HCC84	Cardio-Respiratory Failure and Shock	0.282
HCC85	Congestive Heart Failure	0.331
HCC86	Acute Myocardial Infarction	0.195
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease	0.195
HCC88	Angina Pectoris	0.135
HCC96	Specified Heart Arrhythmias	0.268
HCC99	Intracranial Hemorrhage	0.230
HCC100	Ischemic or Unspecified Stroke	0.230
HCC103	Hemiplegia/Hemiparesis	0.437
HCC104	Monoplegia, Other Paralytic Syndromes	0.331
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene	1.488
HCC107	Vascular Disease with Complications	0.383

Categories

Variable	Description Label	Community, NonDual, Aged
HCC108	Vascular Disease	0.288
HCC110	Cystic Fibrosis	0.510
HCC111	Chronic Obstructive Pulmonary Disease	0.335
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	0.219
HCC114	Aspiration and Specified Bacterial Pneumonias	0.517
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.130
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.222
HCC124	Exudative Macular Degeneration	0.521
HCC134	Dialysis Status	0.435
HCC135	Acute Renal Failure	0.435
HCC136	Chronic Kidney Disease, Stage 5	0.289
HCC137	Chronic Kidney Disease, Severe (Stage 4)	0.289
HCC138	Chronic Kidney Disease, Moderate (Stage 3)	0.069
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	2.028
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.069
HCC159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.656
HCC161	Chronic Ulcer of Skin, Except Pressure	0.515
HCC162	Severe Skin Burn or Condition	0.224
HCC166	Severe Head Injury	0.486
HCC167	Major Head Injury	0.077

Variable	Description Label	Community, NonDual, Aged
HCC169	Vertebral Fractures without Spinal Cord Injury	0.476
HCC170	Hip Fracture/Dislocation	0.350
HCC173	Traumatic Amputations and Complications	0.208
HCC176	Complications of Specified Implanted Device or Graft	0.582
HCC186	Major Organ Transplant or Replacement Status	0.832
HCC188	Artificial Openings for Feeding or Elimination	0.534
HCC189	Amputation Status, Lower Limb/Amputation Complications	0.519
Disease Interactions		
HCC47_gCancer	Immune Disorders*Cancer	0.838
Diabetes_CHF	Congestive Heart Failure*Diabetes	0.121
CHF_gCopdCF	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease	0.155
HCC85_gRenal_v24	Congestive Heart Failure*Renal	0.156
gCopdCF_CARD_RESP_FAIL	Cardiorespiratory Failure*Chronic Obstructive Pulmonary Disease	0.363
HCC85_HCC96	Congestive Heart Failure*Specified Heart Arrhythmias	0.085

Approximately 9,700 ICD-10-CM Codes map to the 86 CMS HCC Categories

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Category Example

Diagnosis Code	Description	CMS-HCC Model Category V24	HCC RAF Score	MCC (Y or N)	CC (Y or N)
N18.1	Chronic kidney disease, stage 1			N	N
N18.2	Chronic kidney disease, stage 2 (mild)			N	N
N18.3	Chronic kidney disease, stage 3 (moderate)	138	0.069	N	N
N18.4	Chronic kidney disease, stage 4 (severe)	137	0.289	N	Y
N18.5	Chronic kidney disease, stage 5	136	0.289	N	Y
N18.6	End stage renal disease	136	0.289	Y	N
N18.9	Chronic kidney disease, unspecified			N	N

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Polling Question

If you have an Outpatient CDI Program or in the process of starting an Outpatient CDI Program, who does/will the team report to?

1. HIM/Revenue Cycle
2. Same as the Inpatient CDI Program
3. Through the Physician Practice Clinics
4. Other

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Differences between Inpatient & Outpatient CDI

Approximately 42% of CMS HCCs are NOT CCs/MCCs	**Increased patient volumes in clinics and outpatient settings**	**Timeframes for visits of care are shorter in the outpatient setting**	**Multiple different payment methodologies and workflows in the outpatient setting**

ROI (Return on Investment) not instantly seen in Outpatient CDI

- For Inpatient CDI a query makes a positive DRG difference- can figure out the potential dollars gained instantly
- Outpatient CDI will not see ROI until the following year

Inpatient CDI- Optimize the MS-DRG, by capturing CC/MCCs and Dx impacting SOI/ROM

Outpatient CDI- Optimize the RAF Score by capturing HCCs

Approximately 42% of CMS HCC diagnoses are CCs in MSDRG

- Approximately 16% of CMS diagnoses are MCCs in MS DRGs
- Approximately 42% of CMS HCCs are NOT CCs/MCCs

<u>Same Goal</u>

ALL CDI: to have the most accurate documentation that reflects the care given to the patient

The Reason for Expansion to Outpatient CDI

- **US healthcare is evolving**
  - **CMS assigns plan payments for patients based on risk (not as reimbursement of services provided)**
  - **Higher specificity of diagnosis code(s) better define financial risk**
  - **CMS will only pay for health conditions being currently managed**

- **From a QUANTITY driven system- Fee for Service**
  - **Bill services based on CPT procedure codes.**
  - **Diagnosis codes minimally used only to match procedures; no comprehensive or highest level of accuracy**

- **To a QUALITY driven system**
  - **Pay for Performance**
  - **Value Based Purchasing**
  - **Bundled Payments**
  - **Incentives**
  - **Penalties for hospital acquired conditions**

Challenges in Outpatient CDI

Industry standards not formed yet

- No ratios for provider education and CDS
- How long allowed for pre reviews/post reviews

Defining role of outpatient CDS

- What credentials?
- What skill set?
- What experience?

Determining best process

- Pre reviews
- Post reviews
- Queries

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Challenges in Outpatient CDI

Three types of typical scenarios for documentation improvement in the outpatient clinical record

- Documentation present to support more diagnoses, but very few diagnoses listed and placed on claim
- Multiple diagnoses listed with documentation not supporting all the diagnoses
- Use of unspecified diagnoses

Five things to consider when setting up an Outpatient CDI Physician Clinic Program

- Will it be pre reviews or post reviews of the patient encounter?
- Who does the reviews- what qualifications do you want your outpatient CDS to have?
- What will your query or recommendation process look like?
- What types of patients and records will you want reviewed?
- What will success look like? (increased provider knowledge, more accurate RAF score, etc)?

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Opportunities in Outpatient CDI Audit Results Example

Potential HCC Change Rate for the Patient Sample

Evaluation of each patient's health record to identify any documentation and/or diagnosis code changes impacting HCCs and ultimately the patient's raw RAF score are reflected in the potential HCC Changes.

Potential HCC Changes (N=200 patients)	Results
Number of patients **with** potential HCC changes	145
Number of patients **without** potential HCC changes	55
Percent of 200 sampled patients **with** potential HCC changes	73%

Potential RAF Score Change for the Patient Sample

- To calculate the raw RAF scores, UASI applied the CMS-HCC model, version 24, and payment year 2020. Demographic details were normalized for all the patients, which resulted in a baseline demographic risk factor of 0.323 (female) and 0.308 (male) applied uniformly to all patients.

- The demographic HCC calculation for all patients was based on:
    - Age of the patient set at 65
    - Not Institutional or Medicaid
    - Medicare eligibility set as "Aged"
    - Medicare eligibility due to disability set as "No"

2020 Average Raw RAF Score for the 200 Patient Sample	2020 Potential Average Raw RAF Score with UASI changes	Potential Average Raw RAF Score Variance
1.08	1.40	+ 0.32

TARGETED Audit Potential Risk-adjusted Revenue Impact Calculation:

145 (pts with opportunity) X 0.32 (average increase in RAF score) X $9,366 (CMS relative factor)=$434,582

Understanding Risk Score Calculations

Diagnosis Code	Description	CMS-HCC Model Category V24	HCC Category Description	HCC RAF Score
N18.9	Chronic kidney disease, unspecified			None
N18.1	Chronic kidney disease, stage 1			None
N18.2	Chronic kidney disease, stage 2 (mild)			None
N18.3	Chronic kidney disease, stage 3 (moderate)	138	Chronic Kidney Disease, Moderate (Stage 3)	0.069
N18.4	Chronic kidney disease, stage 4 (severe)	137	Chronic Kidney Disease, Severe (Stage 4)	0.289
N18.5	Chronic kidney disease, stage 5	136	Chronic Kidney Disease, Stage 5	0.289
N18.6	End stage renal disease	136	Chronic Kidney Disease, Stage 5	0.289

- If provider documents only CKD, that is code N18.9, which does not have a HCC associated value.
- However, if the patient is being treated or monitored for CKD 3, there is an associated HCC and value of **0.069**
- As the CKD advances, the hierarchy increases with increased RAF score

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CKD Stage Documentation Example

72 year old female seen in office with bronchitis, DM Type 2 uncomplicated, CKD 4, fluids restricted and creatinine elevated

Example 1: Bronchitis and DM 2 (provider did not document the CKD 4)		
DX Code	**Description-Example 1**	**Score**
	2020 Demographic Risk Factor	0.386
J40	Bronchitis, unspecified	None
E11.9	Type 2 Diabetes Mellitus without complications	0.105
	Total	**0.491**

Example 2: Bronchitis , DM 2, and CKD 4		
DX Code	**Description-Example 2**	**Score**
	2020 Demographic Risk Factor	0.386
J40	Bronchitis, unspecified	None
E11.22	DM2 with CKD	0.302
N18.4	Chronic Kidney Disease, Stage 4 (severe)	0.289
	Total	**0.977**

Example of Calculating Risk Scores

Although HCCs reflect hierarchies among **related** disease categories, for **unrelated** diseases, HCCs accumulate

Description	HCC	HCC Weight	Cumulative Score
80 year old male, aged, community	Demographic	+ 0.556	0.556
Unstable angina	87	+ 0.195	0.751
COPD	111	+ 0.335	1.086
Primary malignant neo prostate	12	+ 0.150	1.236

Predicted cost for this patient is reflected in increments for all three diagnoses. So unlike DRGs, *there may be several HCCs* assigned to an individual, culminating in a single risk score

Example of Calculating Risk Scores

Hierarchies are based only on the most severe manifestation of the disease

Description	HCC	Weight		Cumulative Score
80 year old male, aged, community	Demographic	+	0.556	0.556
Unstable angina	87	+	0.195	0.751
~~DM 2 Uncomplicated~~	~~19~~		~~0.105~~	~~0.856~~
DM 2 with diabetic nephropathy	18	+	0.302	1.053

This patient would not get a risk score for both DM 2 uncomplicated and a more specific diagnosis like DM 2 with diabetic nephropathy. This is where the hierarchy comes into play.

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Determining Payment

The CMS-HCC risk adjustment model is used to calculate risk scores, which predict individual Medicare beneficiaries' healthcare expenditures relative to the average beneficiary.
Risk scores are used to adjust payments based on the health status (diagnostic data) and demographic characteristics (such as age and gender) of a Medicare enrollee

Value of Risk Score $

- In payment year 2020, the denominator used to create relative factors for the CMS-HCC model is $9,365.50

- Example: A patient with a total risk score of 1.000 would lead to a CMS payment to the Medicare Advantage plan of $9,365.50 (approx. $780/month) to cover the care delivered to this patient in payment year 2020

MA Plans Paying Providers Per Member Per Month (PMPM)

- Describes the average dollar amount paid to a provider (hospital or healthcare worker) each month for each person the provider is responsible for seeing

- PMPM forms the basis upon which managed care organizations contract payment to providers under capitation revenue stream or cost for each enrolled member each month

- Capitation describes a system of medical reimbursement where the provider is paid an annual fee per covered patient by an insurer; the aggregate fees are intended to reimburse all provided services

Outpatient CDI Impact Example

Provider query results in the addition of morbid obesity (HCC 22) to a patient's risk score:

- Relative factor increase of 0.250
- Increase payment calculation for following year
  - 0.250 (relative factor) x $780 (PMPM) = $195
  - $195 x 12 months = **$2,340**

Outpatient CDI Impact Example

No Diagnoses	RAF Score	Incomplete Documentation	RAF Score	Complete Documentation	RAF Score
76-year-old female, Community, Aged		76-year-old female, Community, Aged		76-year-old female, Community, Aged	
Dual Full Benefits	0.593	Dual Full Benefits	0.593	Dual Full Benefits	0.593
		CKD Stage 4 (HCC 137)	0.260	CKD Stage 4 (HCC 137)	0.260
		Heart failure (HCC 85)	0.371	Heart failure (HCC 85)	0.371
		Diabetes (HCC 19)	0.107	Diabetes w/renal complications (HCC 18)	0.340
				Hemiplegia (HCC 103)	0.487
				BKA status (HCC 189)	0.795
		DM + HF + CKD	0.379	DM + HF + CKD	0.379
RAF	0.593	RAF	1.710	RAF	3.225
Estimated annual payment	$5,550	Estimated annual payment	$16,006	Estimated annual payment	$30,203

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Depression Documentation Example

76 y.o. female seen in office with UTI, Type 2 DM with no complications. Pt. states that she has been feeling more down lately and wonders about increasing her dose of Prozac.

	Example 1: UTI, DM Type 2 w/o complication and depression	
DX Code	**Description-Example 1**	**Score**
	2020 Demographic Risk Factor	0.451
N39.0	Urinary Tract Infection, site not specified	None
E11.9	Type 2 Diabetes Mellitus without complications	0.105
F32.9	Major Depressive Disorder, unspecified	None
	Total	**0.556**

	Example 2: UTI, DM Type 2 w/o complication and mild recurrent depression	
DX Code	**Description-Example 2**	**Score**
	2020 Demographic Risk Factor	0.451
N39.0	Urinary Tract Infection, site not specified	None
E11.9	Type 2 Diabetes Mellitus without complications	0.105
F33.0	Major Depressive Disorder, recurrent, mild	0.309
	Total	**0.865**

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ROI Example for an HCC Audit:
Focus Area: Major Depressive Disorder (HCC 59)

Depression Population for Extrapolation	
Number of 2020 patients in identified focus area (Depression reported with unspecified diagnosis code)	1500
% of audited patients (out of the identified population) found to have an opportunity for more specific depression (based on UASI audit findings)	50%
Number of patients in identified population who have potential HCC opportunity 1500 (2020 volume) x 50% (based on audit findings)	750
Raw RAF score for HCC 59 (major depressive disorder)	0.309
CMS-HCC model CY 2020, relative factor annual base rate for all segments	$9,366
Potential Annual Increase in Risk-adjusted Reimbursement	750 x 0.309 x $9366= **$2,170,571**

Questions ?

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Join us for the next
UASI Lunch and Learn Topic:
"Introduction to ICD-11 Codes"
February 10, 2021

UASI CDI Management Series :
"10 Key Steps to Successfully Implement Outpatient CDI in a Physician Practice"
February 24, 2021

email: info@uasisolutions.com for invite
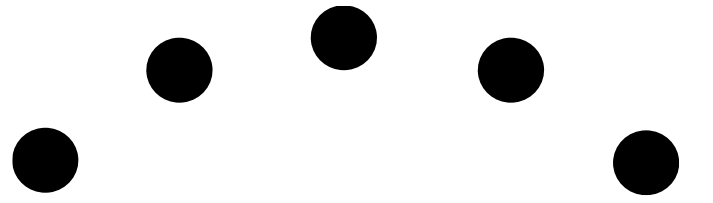
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UASI at a Glance

Headquarters: Cincinnati, Ohio

Founded: 1984

Clients: 200+ hospitals/health systems nationwide

Team: 450+ employees, including AHIMA/AAPC-certified coders, HIM and clinical documentation specialists

Charts handled annually: 3.75 million coded; 200,000 audited

Solutions: Coding Services, Coding Reviews, Clinical Documentation Improvement, Revenue Integrity, HIM Solutions, Strategic Consulting

Experience

- Management: 22 years of HIM experience; 11 in CDI
- Coding staff: 8+ years

Quality

- 97% accuracy in coding
- 100% target for accuracy, certification and meeting industry standards

Reliability

- 32+ years in business
- 40 clients in US News & World Report best regional and honor roll hospitals

Culture

- People-centric, team-driven culture
- High employee satisfaction
- 20% new hires referred from current employee
- Industry-leading average employee tenure