



 IMO Health

Specificity in clinical documentation:

5 considerations for revenue optimization

Ask most anyone who works on the financial side of healthcare and they'll likely tell you it can be a struggle to get paid – whether you're in the billing department of a hospital or working in health tech providing data analysis solutions for an entire health system. While the money of medicine is multifaceted, a lack of specificity within medical records can cause problems across the board.

That's mainly because it's easy to lose or omit specificity during an initial patient encounter – and the issue is compounded when translating a clinician's notes into standardized code sets and transferring that information across systems. What's more, when the precise details, granular insights, and unique nuances of *this* patient's problems and procedures are lost, there's a ripple effect throughout an institution and among its partners. As the losses compound, healthcare stakeholders have to manage the loss of not only important data, but also appropriate financial return and increased patient risk.

With information documentation and transfer being so vital to the success of any health system, understanding how it can go awry – as well as ways to minimize the fallout – are skills that will continue to pay dividends. Read on to learn more about how data specificity gets diminished in a healthcare setting and how to help mitigate its negative effect on the bottom line.

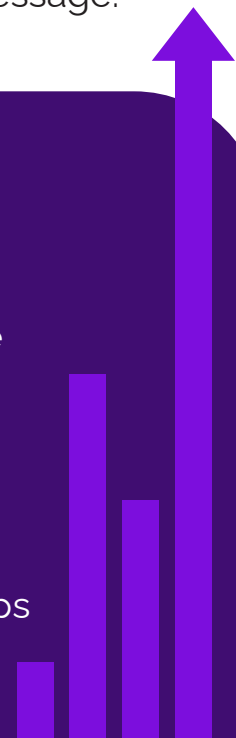
CHAPTER ONE

More data isn't necessarily better

If data doesn't *accurately* reflect clinical meaning, increasing the amount of it ultimately does more harm than good. Why? In the quest for increased specificity, using an approximate code can seem like an easy fix. However, when this *mostly correct* data moves throughout the healthcare ecosystem, small losses or alterations add up and ultimately create a situation where the incorrect parts of the code are maintained while the critical clinical information is lost, changing the intended message.

Impact on the bottom line

The simple act of moving data around often causes specificity – which bears important clinical data – to be lost or altered. As a result, it's important to emphasize to clinicians that, while the most detailed and precise documentation is the gold standard, imprecise information can hurt more than it helps. Prioritizing getting the most accurate data into the chart can minimize denied or delayed claims, and ultimately helps bring in the reimbursements clinicians have earned.



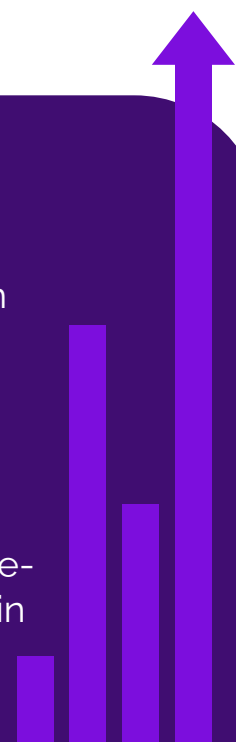
CHAPTER TWO

Losing specificity impacts both the patient and population levels

On the surface, it's fairly easy to see how losing specificity at the point of care can impact a patient's overall health. Typing in *diabetes* when a patient really has *diabetes mellitus due to underlying condition, with stage 4 chronic kidney disease, with long-term current use of insulin* isn't incorrect per se, but it's clearly not as helpful as it could be for the next clinician involved in the patient's care. At the population level, lack of granularity also has major implications. In this situation, the data doesn't hold the level of detail that many health tech solutions need in order to properly process data and provide meaningful insights. Without the details of *this* patient's diabetes – and the relevant details of *every* patient's diabetes – it's also impossible to create accurate value sets in order to generate population health data that can improve patient health and well-being.

Impact on the bottom line

In an outcomes-based care world, accurate population health metrics have financial ripple effects throughout the healthcare system – from hospitals to health tech organizations. Whether a lack of specificity causes Hierarchical Condition Category (HCC) claims to be denied, or contributes to a pool of vague, generalized data that doesn't provide meaningful insights after large-scale analysis, many organizations feel the financial pain long after the patient encounter is documented.



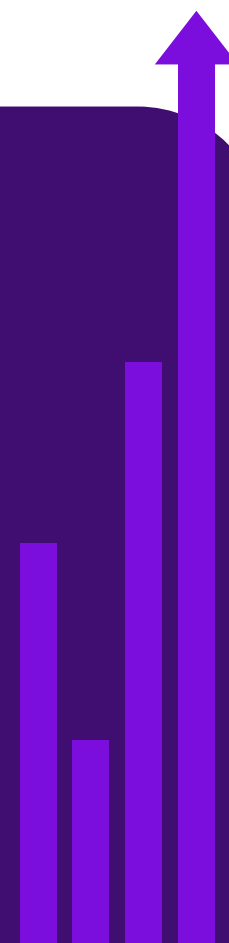
CHAPTER THREE

Standardized codes are specifically specific

Reading the full description attached to any standardized code can be perplexing. With so much detail for each code and so many different code systems, how can specificity be lost? The key here is that each system is *specifically* specific. CPT® terms hold the nuances of countless procedures. SNOMED CT® codes capture the granularity needed for research. ICD-O-3.2 deals with oncology care. And ICD-10-CM codes provide billing specificity, which plays a large role in HCC documentation and reimbursement. However, no standardized system is designed primarily to capture the specifics of the patient's overall health and well-being.

Impact on the bottom line

It is a Herculean task to keep all of these codes straight – especially if you're a busy clinician who needs to focus on providing patient care, not documenting it. For example, a patient can have a diagnosis that fits into multiple HCC categories, but the specificity captured determines which category it is assigned to and that has ramifications for payments, not to mention reporting and population health initiatives. Investing in tools like robust clinical terminologies which work behind the scenes to link a clinician's words to their corresponding codes, helps paint the whole picture of a patient's story – including the specifics needed for reimbursement.



CHAPTER FOUR

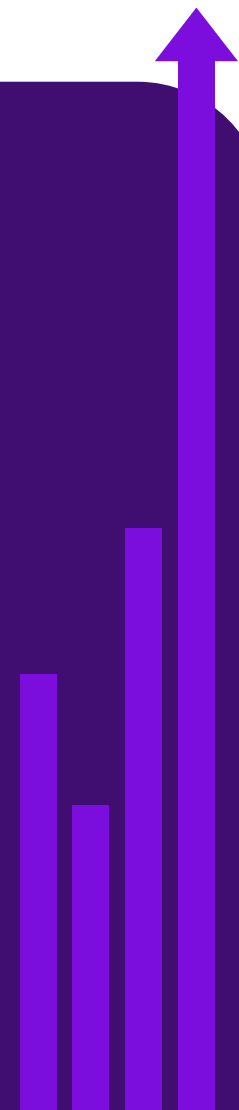
The HCC sands are shifting

In early 2023, the Centers for Medicare & Medicaid Services (CMS) announced significant changes to the HCC model which are being phased in over three years – changes that include revised HCC numbers and names along with variations in risk adjustment factor (RAF) scores. For example, version 28 (V28) has 29 more HCCs than V24 as a result of both newly-created HCCs and the splitting of several existing HCCs which now contain greater coding specificity.

Impact on the bottom line

While the upgrade to V28 will be beneficial in the long run, the transition phase, and the corresponding blended payment model can pose problems for clinical documentation and billing.

Specifically, in Calendar Year (CY) 2024, 67% of risk scores will be calculated with the current V24 model, and 33% will be calculated with the updated V28 model. In CY 2025, CMS anticipates 33% of risk scores will be calculated with V24 and 67% with the V28 model. And finally, in CY 2026, CMS expects 100% of the risk scores to be calculated with V28. Managing the details and nuances of two HCC systems over multiple years is a challenge for many provider organizations as even the smallest modifications or misses can impact payments for specific patient populations.



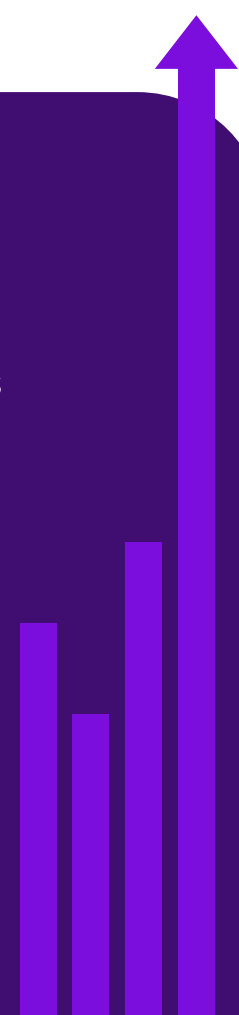
CHAPTER FIVE

Timeliness is key

Even with the best communication and technological assistance, it's inevitable that sometimes, a patient chart arrives at the billing department without the desired level of specificity. Even so, all is not lost. Implementing a system with the billing and revenue team that prioritizes finding documentation issues in the chart as close to the point of care as possible can still make a significant difference. (And so can normalization tools designed to add specificity back into patient data after the fact). Timing, however, is everything.

Impact on the bottom line

Establishing a feedback loop between the revenue team and care providers can be mutually beneficial. By leveraging solutions that quickly catch and address problems with documentation – for example, tools that identify missing secondary codes or HCCs – the cognitive burden associated with such issues can be lightened. In addition, finding incorrect information fast means that clinicians can be asked for important details while the patient visit is still fresh in their minds. And sophisticated data standardization solutions can be used to enhance these efforts with speed and informed automation. No matter the tactic, the quicker the chart can be updated with the missing specificity, the sooner it can be sent to the appropriate payer, which minimizes delays in processing and payments.



Working to improve healthcare outcomes, as a clinician, hospital, or health tech organization, can be complicated. As a result, the industry's pursuit of better documentation and data exchange is critical. It means hospitals can get paid what they're owed, clinicians aren't burdened with unnecessary administrative work, large-scale analysis can provide meaningful and actionable insights, and patients receive the best care possible. At every step, the ability to gather and transmit data – while maintaining meaningful granularity – is invaluable. And while this observation may not be news, the growing complexity of our healthcare ecosystem makes specificity more essential than ever.

To learn how IMO Health can help your organization document and exchange healthcare data with greater specificity, visit imohealth.com/imo-core or imohealth.com/imo-precision-normalize.

IMO Health

About IMO Health

IMO Health is a clinical data intelligence business at the heart of a digital revolution in healthcare. Combining rich, highly nuanced medical terminology, extensive domain knowledge, and artificial intelligence (AI), we expertly structure and operationalize clinical data to generate sharper insights and inform more intelligent decision-making.

Deeply embedded in the provider world, we developed a comprehensive intelligence layer that captures and encodes patient encounters with unmatched completeness and precision. Now, by weaving ethical and accountable AI into this robust content, we are improving how data is used across the healthcare landscape with powerful new applications in health tech, drug discovery, population health, and payer processes.

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