Coding and Clinical Documentation Improvement

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Today’s Topics...

• Review ICD-10 and its impact on documentation

• Discover the hows and whys of clinical documentation improvement programs

• Talk about ways to engage providers in CDI

• Preview the 2018 OPPS updates
Our Ever-Changing Healthcare Environment

Pick Your Poison:

• Declining reimbursement
• Federal/state payment reforms and quality initiatives that impact documentation and coding
• Increasing demands for greater documentation specificity
• Coder shortages
• RAC audits – ZPICs, CERT, etc. etc.
• Fraud and abuse investigations
Centers for Medicare and Medicaid Services

- Add and/or change ICD-10 codes every year on 10/1.

- Revise official coding guidelines every year on 10/1.

- These changes require adjustments in how providers document in the medical record.

- It can make you CRAZY!
So What Can We Control?

- **Coding Accuracy**
  - Provide targeted coder training
  - Correct claims and billing as needed
  - Increase audits of high risk DRGs
  - Ongoing coder feedback

- **Clinical Documentation Specificity**
  - CDI Program
  - Documentation auditing
  - Ongoing provider education
  - Documentation tools
The CMS Word Game

- Specificity is **#1**
- Certain Diagnoses should be linked by the provider
- Diagnostic medical/coding language is required
- Lab, path and imaging reports cannot be used for coding unless their results/significance is documented by a physician who is providing direct care to the patient
- Coders cannot interpret abbreviations or symbols within the record such as:
  - ↑  ↓
Wording must be SPECIFIC

**Nonspecific**
- Anemia
- Hypoalbuminemia
- Abnormal U/A
- Bacteremia
- Urosepsis
- Altered mental status
- CHF
- COPD
- Pneumonia

**Specific**
- Acute blood loss anemia
- Moderate malnutrition
- Urinary tract infection
- Sepsis
- Sepsis or UTI
- Encephalopathy
- Chronic systolic heart failure
- COPD exacerbation
- Strep pneumonia
Specific terms are needed to document severity of illness

- Acute
- Chronic
- Acute on chronic
- Unstable
- Exacerbation
- Postoperative
- Secondary to ___
- Due to ___
- Mild, Moderate, Severe
Specificity is essential to capture ROM and SOI

- Hypotension
  - Low mortality score

- Simple pneumonia
  - 2.5% mortality rate

- Respiratory insufficiency
  - Low mortality score

- UTI

- 1.5% mortality rate

- Shock
  - 50-70% mortality rate

- Complex pneumonia
  - 20% mortality rate

- Acute respiratory failure
  - 30% mortality rate

- Sepsis

- 20% mortality rate
Documentation Improvement is KEY to Coding Accuracy
Reasons For a CDI Program

1. First and foremost, CDI promotes the documentation of medical necessity that supports:
   a. Admission (inpatient vs. observation or outpatient treatment)
   b. Readmission or continued stay
   c. Therapies, treatments, procedures

2. CDI ensures that documentation is comprehensive enough to support coding and reimbursement:
   a. Accurate Case Mix Index (CMI)
   b. Correct payment and reduction of compliance risk
   c. Correct identification of the principal diagnosis and all secondary diagnoses, MCCs and CCs
Reasons For a CDI Program

3. Promotes compliance with The Joint Commission and CMS Conditions of Participation standards and requirements

4. Supports evidence-based care allowing for accurate quality measure reporting
CDI Specialists

Background – HIM coders or nurses

May be credentialed as
- Clinical Documentation Improvement Practitioner (CDIP) through AHIMA or
- Certified Clinical Documentation Specialist (CCDS) through ACDIS

Ideally, the CDI Program has a Physician Champion
- Motivated to drive change facility wide
- Has a strong rapport with physicians
- Resource for CDI staff
What CDI Specialists Do

• Analyze physician documentation in health record while patient is still in hospital
• Identify and correct documentation that is:
  • Insufficient to support the patient’s severity of illness or risk of mortality,
  • Unclear, confusing, or fails to identify principal diagnosis, complications and comorbidities
  • Lacks specificity to accurately capture all treatments and procedures
What CDI Specialists Do

- Query providers to clarify documentation:
  - Queries may be written or verbal (face-to-face discussion with provider)

- Provider’s response to query is documented in the health record progress notes and discharge summary.

- Track and report CDI program and its impact on
  - CMI
  - Reimbursement
  - Quality reporting
Why CDI Matters

• Better documentation to support multiple data-driven objectives
• Decreased reporting of “unspecified” codes
• Preserve current case mix index and reimbursement levels
• Increased coder productivity – all documentation is in chart at time of coding
• Fewer retrospective physician queries (initiated by coders after discharge – hold up claims and increase DNFB)
• Fewer claims denials/rejections
Clinical Documentation Improvement Strategies

- Identify CDI opportunities that affect various initiatives, including Meaningful Use, value-based purchasing, present on admission and hospital-acquired condition reporting
- Once you identify documentation gaps, think about the best solution for addressing each one— one size doesn’t fit all…

  - Change EHR form or template?
  - Add system prompts?
  - Educate...who, when, how often?
  - Change workflow/process

- **Prioritize** – To get the biggest bang for your buck, start with “low hanging fruit” or issues with greatest impact for your facility
How to Find Those Documentation Gaps

Evaluate medical records to determine whether documentation supports the level of detail found in ICD-10-CM/PCS

Sampling techniques could include:

• Samples from the CMS At Risk DRG List
• Sampling by clinical specialty
• Top diagnoses/procedures at your facility
• Top service lines
• Your high volume or high dollar diagnoses/procedures
• Diagnoses or procedures that you already know are problems
Build Solutions That Work for You

Identify and implement process changes (such as use of EHR documentation templates and prompts) that would make documentation capture as complete and as easy as possible.

- **Template**: EHR tool to collect, present, and organize clinical data elements
- **Prompt**: Triggers the provider to enter required or missing documentation
Educating physicians can be quite a challenge. They may be:

- Busy
- Bored
- Resistant
- Confused
- Angry
- Tired
- All of the above!
Providers are bombarded with information on a daily basis. If you want them to remember, make it memorable

- State the facts
- Keep it Simple
- Make it Relevant
- Use provider-speak
- Explain how it helps THEM
Share Provider-Specific Data

- Documentation Examples
- Case Studies
- Mortality Rates
- Missed opportunities for individual practices
- E/M billing documentation
Lack of complete documentation can skew mortality and morbidity data, case-mix index, and possibly reimbursement.

Low CMI and high mortality scores influence provider profiles.

Poor profiles mean lower patient volumes and possible higher malpractice rates.
Describe how wording affects coded data

Patient with respiratory insufficiency = low mortality score
Patient with acute respiratory failure = 30% mortality score
Patient with pneumonia due to pseudomonas = 40%–70% mortality rate
Show what’s in it for them

Show how documentation affects billing.
Give real life examples.
When Presenting to a Provider Group

- If speaking during a service meeting, be first on the agenda
- Make it short and sweet: 1 or 2 documentation points are plenty
- Quote other physicians/cite professional journals
- Show documentation examples from your own medical staff, the good, the bad and the ugly
- Share the bottom line impact of good vs incomplete documentation
- Use humor
- Involve your audience
- Provide CMEs whenever possible – work with your in house education department
Give your providers tools to succeed

Brochures
Newsletters
Pocket cards
Query forms
EHR prompts
Signs
CDI STAFF
Consider EHR Documentation Prompts and Templates

• Provides ongoing learning loop for physicians regarding needed documentation elements at the time care is recorded

• Reduces compliance risks

• Provides consistent complete documentation for coders and eliminates need for costly post-discharge queries

• Quicker claims payment, fewer audits
Suggested Details to be Added to EHR Prompts and/or Templates

• Laterality
• Glasgow coma scale
• Causal organism ("bugs" like staph, strep, pseudomonas)
• Devices
• Anatomic details/diagrams
• Severity- (acute, chronic, mild, moderate, severe, etc.)
• Disease relationships
• Cause/effect
• Underlying disease and manifestation or complication
More...

- Relationship of condition to procedure (intraop, postop complication?)

- Fracture type (transverse, comminuted, spiral, segmental, etc; displaced vs. non-displaced; open vs. closed; Gustilo classification of open fracture; nonunion or malunion)

- Type and severity level of asthma

- Age of acute myocardial infarction
And Yet More...

• Weeks of gestation
• Identification of fetus in multiple gestations
• Acuity of respiratory failure and presence of hypoxia or hypercapnia
• Dominant/Nondominant side (hemiplegia, monoplegia)
• Traumatic vs. pathologic fracture
• Specific body part procedure was performed on (e.g., muscle, tendon, ligament, artery, vein)
• Amputation qualifier – complete, partial, high, mid, low

All these EHR changes give providers needed tools to construct a solid documentation foundation
And Furthermore

Effective 10/1/16, the Official ICD-10 Coding Guidelines added the following statement:

“The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

SO, there may be times when a provider documents a diagnosis like SEPSIS, despite lack of clinical indicators for the diagnosis anywhere else in the chart. No fever, no elevated white count, no positive cultures, no increase in lactic acid levels, etc.
What do you do now?

• The coder MUST code this diagnosis even if there is no supporting documentation in the medical record. That could lead to an audit and ultimate loss of revenue.

• CDI to the rescue! In this situation, the CDI specialist uses her/his clinical knowledge to speak with the provider about the diagnosis, learn what clinical indicators led to the diagnosis, and obtain appropriate documentation.

• Such clinical validation queries can avoid payment denials and audit headaches by validating diagnoses and documenting clinical indicators that support them before the coder gets the medical record.
The Bottom Line

- If it isn’t documented, it didn’t happen!
- Accurate, complete provider documentation paints the fullest picture possible of the patient, care and services provided.
- Specific and complete documentation enables coded data to tell the true story of patient care.
- CDI efforts are key to capturing the specificity and details of the patient encounter and protecting your bottom line.
2018 OPPS Highlights

- **POPI**

Patients Over Paperwork Initiative

CMS is making efforts “to remove regulatory obstacles that get in the way of providers spending time with patients.”

Those efforts in the OPPS Final Rule appear minimal, but include:

- Non-enforcement of the direct supervision requirements for outpatient therapeutic services for CAHs and small rural hospitals with 100 or less beds.

- Removal of 3 ASC quality reporting measures for CY 2019

- Removal of 6 Hospital outpatient quality measures for CY 2020.
OPPS Highlights

• An estimated 1.4% payment increase to providers

• Changes to the “inpatient only” surgical procedures list
  • The following procedures have been removed from the IPO list;
  • 27447 - Total knee arthroplasty
  • 43282- Laparoscopic hiatal hernia repair with mesh
  • 43772- Laparoscopy with removal of restrictive gastric band
  • 43773- Laparoscopy with removal and replacement of restrictive gastric band
  • 43774- Laparoscopy w/removal of gastric band and subcu port
  • 55866- Laparoscopic radical prostatectomy including robotic assistance when performed
Packaging low cost drug admin services

In 2015 CMS conditionally packaged payment of ancillary services assigned to an APC with a geometric mean cost of $100 or less. In 2018 this bundling process continues with the addition of packaging payment for low cost drug administration services.
Payment Reduction for 340B Drugs and Biologicals

If you participate in the reduced-price drug purchasing program of HRSA (Health Resources & Services Administration), your revenue could suffer significantly under the 2018 OPPS rule.

Eligible providers include FQHCs, CAHs, Disproportionate Share Hospitals, Sole Community Hospitals, Children’s Hospitals, STD and TB clinics, free standing cancer centers, and others.

Current reimbursement for drugs purchased under this program is average sale price (ASP) plus 6%. As of 1/1/18, that reimbursement will drop to ASP MINUS 6%. OUCH! CMS estimates a cost savings of $900 million!
Skin Substitute Products

• All skin substitutes used for wound healing are now classified as ‘high cost’ while CMS ponders whether it will refine its payment structure for these products.

• In 2017 CMS used a 2-tier system for skin substitutes with only specific items considered high cost outliers.
No New Device Pass-throughs

• CMS evaluated 5 devices for eligibility to receive pass-through payments and did not approve any of them for CY18.

• Denied devices include skin substitutes: Architect Px, Dermavest and Plurivest Connective tissue matrix, Kerecis Omega3 wound, and X-Wrap and Flograft, an injectable amniotic fluid for tissue regeneration.
Public Reporting

CMS has decided it will publicly report on results for OP-18C hospital outpatient quality indicator:

Median time from ED arrival to ED departure for patients discharged from the ED.

Do you have problems with your ED patient turn-around??
Status Quo

- CMS will continue, among other things, the following for 2018:
  1. Application of the statutory 2% payment reduction to hospitals failing to meet the hospital outpatient quality reporting requirements
  2. The 7.1% payment adjustment to OPPS payments made to Essential Access Community Hospitals (EACHs)
  3. Providing additional payments to Cancer Hospitals
  4. The single payment rate for each provider type for days with 3 or more services per day for Partial Hospitalization Programs.
Questions or Comments?
Contact Today’s Speaker

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