Eyeing
Coding Compliance and CDI Compliance Programs

What Compliance Officers Need to Know or Should Know
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Compliance Objectives

* Discovering who are the healthcare industry watchdogs for coding and CDI programs
* Understand the history of Clinical Documentation Improvement (CDI) programs
* Getting involved with the CDI and coding teams from the compliance standpoint
* Ensuring the coding and CDI reflect an accurate picture of clinical care being given

In 2011-the past history of ICD9

CMS recently released its July edition of the Medicare Quarterly Provider Compliance Newsletter but ACDIS Advisory Board members warn the document includes advice which appears to conflict with other industry guidance such as Coding Clinic for ICD-9-CM and the Official ICD-9-CM Guidelines for Coding and Reporting.

Under advice regarding Recovery Audit Contractors (RAC) findings related to Acute Respiratory Failure (ARF), on p. 2, the auditor finding states that:

"It was determined that the clinical evidence in the medical record did not support respiratory failure, despite physician documentation of the condition."

ICD10 in the Present

* Focus on documentation specificity- should eliminate coding conflicts? Denials?
* Organizations should ensure that their claim submission data accurately reflects the "quality of care" being rendered
* **CMS Hospital Compare website allows the consumer to "shop" and finally select healthcare providers online.**
    * **Quality measures-Jan 2016 Sepsis will be added to this list of "core measures".**

Conflicting Views-Acute Respiratory Failure –with I9

* **The coder:** Typically the physician gets the last say, per a coding Advisory Board member and independent consultant –AND
* "Neither CDI specialists nor coders get to second guess the physician, and CDI staff would rarely (if ever) go back to the physician to query for ARF if the physician documented it several times"

* However, an ACDIS Advisory Board member- a physician- says that some CDI teams are trained to ask that physicians document ARF "in virtually every patient's chart" if the chart included acute exacerbation of chronic obstructive pulmonary disease (COPD) or pneumonia and either a low partial oxygen pressure (pO2) or high carbon dioxide partial pressure (pCO2).
* Where signs of **over documentation** for ARF exist, "it behooves the hospital… to train their staff in matters of **ethical documentation based on nationally recognized definitions by the medical authorities.** If the patient doesn't have it [ARF], it shouldn't be coded as though it does exist," per this physician board member.

Now in I10

* **Respiratory failure, not elsewhere classified J96- >**
* Type 1 Excludes
* acute respiratory distress syndrome (J80)
* cardiorespiratory failure (R09.2)
* newborn respiratory distress syndrome (P22.0)
* postprocedural respiratory failure (J95.82-)
* respiratory arrest (R09.2)
* respiratory arrest of newborn (P28.81)
* respiratory failure of newborn (P28.5)

* **CDI Reviews:**
* Physical Exam/Clinical Evaluation + diagnostic procedures/Therapeutic procedures (vent management)
* Query for conflict between the diagnosis documented and the absence of clinical criteria to support diagnosis
  * Query for acute or chronic/ acute on chronic the Underlying cause

Performance Watchdogs- just a few and they are still looking at healthcare

* HealthGrades
  * Healthgrades.com
* Leapfrog Group- uses 28 national performance measures-PSIs (patient safety indicators)
* Recovery Audit Contractors (RAC)—on limited hold
* Office of Inspector General (OIG)—Federal and State Levels
* U.S. Department of Justice (DOJ)
* Joint Commission - QualityCheck.org
* CMS.gov
  * CERT guidelines(Part B for physician evaluation and management levels of service was how it began, now looks at Part A facility)
  * Medical necessity issues-outpatient review to justify inpatient admissions
  * Hospital Compare website
  * EMR tracking=meaningful use

Watchdog Objective

* To uncover signs of poor patient care (quality and documentation) AND fraudulent billing.
* What is their main or base source for their investigations? Audits?
  * Coded claim data equates to data mining databases
  * Databases equates to setting of practice standards of care
  * Databases are used in Quality Care; CMS chronic care management project

Be Aware and Be Involved

* The CMS and its contractors have integrated data mining in their enforcement strategy to prevent waste, fraud, and abuse.
* The Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program (MIP) will also be using data mining as part of their plan to prevent Medicaid fraud, waste, and abuse.
   * This will include the institution of a "national claims registry" that will provide increased access to beneficiary, provider, and claims data.

Monitoring

* "It is imperative that providers keep up to date on the latest published government investigations. Government techniques will be constantly evolving to increase effectiveness, so for a compliance program to truly use internal data mining effectively, they must do what they can to stay one step ahead of published reports.
* If a new technique, focus area, or formula is part of a government agency investigation involving data mining, a provider might theoretically be on the receiving end of a similar government query."
   * June 2012 Claims Data Analysis by SMS, LLC

The Future of Data

* As our coded data and data capture are utilized in reporting, such as Physician Quality Reporting System (PQRS), the potential VBP modifier, the forthcoming Merit-based Incentive Payment System, and long-standing Medicare Advantage payments, to name a few, it is important to increase attention to this data.
  * Key metrics for the above quality areas are risk adjustment and awareness of patients with multiple chronic conditions and their relationships to other disease processes to benchmark level of quality measures and cost measures.

CDI History

Clinical Documentation Improvement Programs

Organizational Coping

* Organizations implemented coding compliance along with clinical documentation improvement (CDI) programs.
* The objectives:
    * Ensuring revenue integrity
    * Reduce external investigations and risk
* What was missed in I9:
    * Data quality that appropriately reflects the picture of healthcare in this country. Did we coded just the "words"?

CDI Historical Objectives

* A clinical documentation improvement (CDI) program promotes clear, concise, complete, accurate and compliant documentation.
* This is accomplished through analysis and interpretation of health record documentation to identify and rectify situations where documentation is insufficient to accurately support the patient's severity of illness (SOI) and care, including specificity of principal diagnosis, associated comorbidities or complications, treatments and procedures.

Compliance Departments Should Understand the following---

* Review coding quality by checking the reports from HIM:
  * Quarterly for established coders and every 30 days for the first quarter for new coders
  * Monthly review of external coders/contract coders
  * *Does your system's compliance plan routinely conduct self-evaluation of risk areas, including internal audits and as appropriate external audits?*
  * *Does your organization do any type of claim "prebill" auditing*

* Be aware of the CDI functions:
  * CDI staff will analyze data, formulate physician queries, track CDI program performance, and successfully communicate with physicians, administration, HIM staff and others as necessary.
  * How does the internal CDI program promotes compliance with The Joint Commission and Conditions of Participation standards or requirements
  * *Does your system look at these tracking reports for possible risk issues?*

Understand what CDI and Coders Know (or Should know)

* Comprehend the effects of Present on Admission (POA) and Hospital Acquired Conditions (HACs) initiatives
  * POA indicators are tied to patient safety indicator rate (PSI)
  * Coders should code these correctly/CDI should only focus on POA for infectious diseases, HACs and patient transfers
* Understand quality reporting measures to help promote documentation of compliance with standards
* Possess working knowledge of federal, state, and payer-specific requirements for coding, documentation and reporting

SOI and ROM- *Why these abbreviations need to be understood*

* These calculations are based on the interaction of multiple co-morbidities and disease processes.
* APR DRG system is not the MS DRG system for reimbursement
* Conditions and demographics affect the APR DRG system regardless of their status as CC or MCC.
    * <u>CDI should focus on accurate documentation for ALL diagnoses affecting a patient's stay NOT just the CC or MCC categories.</u>

Be Aware of New CDI Guidelines- AHIMA 2014(ICD10)

Malnutrition

• Severity:
  - Mild (first degree)
  - Moderate (second degree)
  - Severe (third degree)
• Avoid documenting a range of severity, such as "moderate to severe"
• Form:
  - Kwashiorkor *(rarely seen in the U.S.)*
  - Marasmus
  - Marasmic kwashiorkor
  - Other
• Document any associated diagnoses/conditions

A potential facility issue

* Pediatric Facility
    * CDI program advised physicians to document "anorexia" instead of "failure to thrive" or "feeding issues"—WHY?
        * This affects the SOI (anorexia) under payment for services rendered in the APR DRG program of reimbursement
    * External audit found a compliance documentation issue
    * **ICD-10 Clarification**
    * Applicable To
        * Malnutrition NOS
        * Protein-calorie imbalance NOS
        * Type 1 Excludes • nutritional deficiency NOS (E63.9)

Another New CDI Guideline
AHIMA 2014 (ICD10)

Systemic Infection/Inflammation

• Bacteremia (positive blood cultures only)
• Urosepsis—MUST specify sepsis with UTI, versus UTI only
• Sepsis—specify causative organism if known
• Sepsis due to:
  - Device
  - Implant
  - Graft
  - Infusion
  - Abortion
• Severe sepsis—sepsis with organ dysfunction
  - Specify organ dysfunction
    ◦ Respiratory failure
    ◦ Encephalopathy
    ◦ Acute kidney failure
    ◦ Other (specify)
• SIRS (Systemic Inflammatory Response Syndrome
  - With or without organ dysfunction

Current Example

* Acute Care Facilities
  * Overcoding of sepsis due to ………………
  * ICD10 Core Measure on Sepsis-
    * Simplified Guidance for Documentation of Sepsis in ICD-10
      * If your patient has sepsis, document it, not "SIRS 2/2 to ____."
      * Document POA status.
      * When documenting severe sepsis, make a relationship statement between it and the end-organ dysfunction. "Severe sepsis with acute respiratory failure."
      * If your patient is in septic shock, document it. "Hypotension" is not equivalent to shock.
  * Is there an alternate PDx?
    * Where is sepsis in the nation's top 10 reasons for death?
    * Is this truly capturing data correctly or aiming for an increase in the overall Case Mix Index (CMI)?

Current Example-I10

Symptoms and signs specifically associated with systemic inflammation and infection R65- >

R65 Symptoms and signs specifically associated with systemic inflammation and infection

* R65.1 Systemic inflammatory response syndrome (SIRS) of non-infectious origin
  * R65.10 …… without acute organ dysfunction
  * R65.11 …… with acute organ dysfunction
* R65.2 Severe sepsis
  * R65.20 …… without septic shock
  * R65.21 …… with septic shock

* Remember specifity now rests with organism defined AND organ dysfunction

ICD10 Coding Issues
Looking at the documentation

Perils of unspecified codes

* Vague, incomplete or non specific documentation is one of the most common challenges for coders. The results:
  * Unspecified codes draw down the case mix index
  * Negatively impact severity of illness and risk of mortality scores (per HealthGrades)
  * What do to now: (discussion)
    * Encephalopathy: G93.40 (unspecified) but record also had coded F05 (Delirium due to known physiological conditions)

High Cost-High Volume

* Identify the top 20 conditions for volume and cost
  * There should be an in-depth analysis by the CDI, coding (and add compliance)- team to assure documentation will support the new codes.
    * Example: Asthma
    * Why be concerned now: Does affect one's severity of illness
    * Have HIM give a short summary of the PEPPER (Program for Evaluating Payment Patterns Electronic Report) to compliance
    * These reports should be done monthly-internally

Example-AHIMA ICD10 Coding

Pancytopenia

• Specify if:
  - Antineoplastic chemotherapy induced pancytopenia
  - Other drug-induced pancytopenia
    ∘ Specify drug
  - Other pancytopenia
• Specify the etiology of pancytopenia (if known), such as:
  - Myelodysplastic Syndrome
  - Leukemia
  - HIV
  - Other (specify)

Pancytopenia in I10

D61 Other aplastic anemias and other bone marrow failure syndromes
* D61.0 Constitutional aplastic anemia
    * D61.01 Constitutional (pure) red blood cell aplasia
    * D61.09 Other constitutional aplastic anemia
* D61.1 Drug-induced aplastic anemia
* D61.2 Aplastic anemia due to other external agents
* D61.3 Idiopathic aplastic anemia
* D61.8 Other specified aplastic anemias and other bone marrow failure syndromes
    * D61.81 Pancytopenia
        * D61.810 Antineoplastic chemotherapy induced pancytopenia
        * D61.811 Other drug-induced pancytopenia
        * D61.818 Other pancytopenia
* D61.82 Myelophthisis
* D61.89 Other specified aplastic anemias and other bone marrow failure syndromes
* D61.9 Aplastic anemia, unspecified

What Should a Compliance Department Do?

Monitoring per Compliance-Define it within the organization

* Monitoring has become a basic expectation of ethics and compliance management. The U.S. Sentencing Guidelines include 'monitoring and auditing' among the principal components of a recommended compliance and ethics program.
* The U.S. Department of Health and Human Services' model compliance programs for healthcare-related companies also include monitoring.
    * This framework encourages "the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area."
    * Monitoring allows for early identification and correction before a problem festers and causes the company to be in non-compliance.

Ongoing

* Monitoring
    * To ensure policy and procedures are in place and being appropriately followed. Looked at continually?
    * Does the organization have a QA program for claims review? Remember that monitoring measures compliance and accuracy but also can improve cash flow (decreased overhead from working denials) and limited exposure of audits

* Auditing
    * Performed by parties that are independent of the department that is being audited.
    * Perform this function more than "annually"
    * Validate that the program managers are meeting the obligations of compliance – affecting physicians, nursing (CDI), IT, patient accounting and HIM-medical records/coding

Know the future trends

* Outpatient CDI programs
  * Starts at the ED level
* CDI is now called: clinical documentation integrity
* Quality departments are now the "in"

* Build a team approach to data quality
  * Should be a quality driven focus –appropriately documented
* Know what the data is saying –whether you are physician clinic or hospital entity

Coding & Documentation Risk EMR Areas

- Problem lists not updated with conditions resolved; conditions that are no longer acute illnesses should be resolved or listed as chronic as applicable or listed as chronic versus acute
- Past medical history with treatment addressed; when a condition is chronic/ongoing any maintenance therapy or treatment should be stated/documented
- Stating current state of disease (acuity, chronicity, establishing a relationship between disease processes); specifying the current state of a disease process is important for treatment and data collection
- Incomplete documentation; awareness in coding rules and guidelines for diagnoses is limited

  - Documentation of neoplasm as active, secondary, and as history
  - Documentation for type of depression

- Coders are not involved in some settings for appropriate code assignment –the EMR is!!!

Overall Improvement

* Should be expected and seen in the following areas:
    * Communication between departments
    * Tracking of rules and regulations; and do the policies and procedures reflect these updates
    * Define and have appropriate follow-up for corrective action plans
    * Data Quality!-Understand the content of your data!
    * Understand your payment structure and how your data is being analyzed and reviewed by those who pay for services rendered to patients.

Compliance Words to Remember

* If we want to capture the clinical truth, we have to start having clinical conversations initiated by clinical thought processes unhindered by semantics and coding language that everyone misinterprets as the gospel truth.
* Computer Assisted Coding programs are not designed to identify what is not written – they bank on words being present within the medical record to build on, not analysis of a clinical course. Computer Assisted Coding is in the same fix. Hear me out. I'm not suggesting that coding clinic is useless or AHIMA practice guidelines are not helpful because they are. **But too often I work with people who do not understand the intent of the guidance being issued. Their entire process gets skewed due to a lack of understanding of how to look at the patient and not just words and laboratory values.**

    * Dr Robert S. Gold-2015