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Meet the Presenter...



Pam Joslin
MM, CMC, CMIS, CMOM
Faculty
Practice Management Institute

On the topic:

Coders & Clinicians: Communication and Documentation Improvement

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Improving the business of medicine through education

Coders & Clinicians: Communication and Documentation Improvement

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Introduction

We all know the motto of coders and auditors alike – “If it wasn’t documented and documented accurately, it never happened.”

Accurate and quality documentation is a reflection of great patient care.

What is Clinical Documentation Improvement?

This is a fairly new area of specialty focusing on sound clinical knowledge and experience, clinical documentation expertise, and quality. This field requires a cooperative in communication between the provider and the clinical documentation improvement specialist.



What You Need To Know

- It is important to know the roles between the providers and the clinical documentation specialist.
- A thorough understanding of MS-DRGs, severity of illness and co-morbid conditions.
- Focus on accurate, complete and specific documentation.
- Sound clinical knowledge working in acute care.

What You Need To Know

This position usually consists of registered nurses, foreign MDs, RN case managers, experienced coders with strong clinical background in acute care setting, strong analytical skills, ability to work independently with little supervision, ability to work collaboratively with multi-disciplinary team (not limited to physicians, coders, health information management, case managers, quality personnel, nurses, dieticians), knowledge of CMS guidelines, MS-DRG, ability to provide one on one or group presentations.

Responsibilities

- Ensure accurate, complete and specific documentation of the patients' illnesses, co-morbid conditions, treatment, and procedures.
- Provide concurrent review of patients' records during their stay in the hospital to ensure accurate MS-DRG assignment and length of stay for admitted patients.
- Provide education to physicians and other medical staff on the need for accurate and specific documentation in order to reflect the severity of illness and risk of mortality.
- Identify and clarify conflicting and non-specific documentation by the physicians.

Responsibilities

- Ensure the accuracy of the reported data to reflect the quality of care provided.
- Serve as a conduit between the clinical and coding personnel.
- Work closely with case managers, coding personnel, quality improvement staff and others to improve the quality of care, reduce the length of stay and improve the revenue of the hospital.
- Ensure proper reimbursement through accurate documentation.



What Are You Looking For?

- Incomplete, imprecise, conflicting, illegible, ambiguous or inconsistent documentation.
- Actual treatment without accompanying diagnosis
- Diagnosis without underlying clinical indicators or validation (gone are the days when you can code diagnosis simply because it was written by the provider)
- Documented clinical indicators without a definitive relationship to an underlying diagnosis.
- Documented clinical indicators, diagnostic procedure and/or treatment not related to a specific condition or procedure.
- Is unclear for present on admission (POA) indicator assignment.

What Are You Looking For?

If there is a gap in the documentation meeting any of the above bullets, a query or queries for the treating provider/providers should be performed. If there is conflicting documentation between two or more treating providers, then query the Attending provider.

Communication – “The Query”

According to the 2013 AHIMA/ACDIS query practice brief:
“Guidelines for Achieving a Compliant Query Practice.”

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050018.hcsp?dDocName=bok1_050018

The queries must be in compliance and should not be leading.

- Each query must be supported by clinical indicators
- Do not direct the provider to a specific diagnosis or procedure

Three Main Utility for Queries

- Accurate DRG assignment
- Outcome measure
- Quality of Care provided

The queries help to clarify the severity of the patient's illness (SOI) and the risk of mortality (ROM). These two factors help to provide medical necessity for the actual length of stay versus the suggested length of stay.

Principle Diagnosis (PDX) and Secondary Diagnosis (SDX) for Inpatients

According to the ICD-10-CM guidelines and Uniform Hospital Discharge Data Set (UHDDS), Principle Diagnosis is defined as:
“that condition established after study to be chiefly responsible for occasioning the admission of the patient to hospital for care.”

Principle Diagnosis (PDX) and Secondary Diagnosis (SDX) for Inpatients

According to UHDDS, secondary diagnosis is defined as:

“all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.”

Principle Diagnosis (PDX) for Inpatients

- The PDX must be present on admission.
- It could take a few days for the provider to make the diagnosis, so as long as the signs and/or symptoms are present at the time of admission.
- The admission starts the moment the admitting provider writes the order for admission.
- Always ask the WHY question. WHY is this patient in the hospital and could not go home? Or why can't this patient be treated in the outpatient setting?

Secondary Diagnosis(SDX) for Inpatients

According to the ICD-10-CM Official Coding Guidelines for Coding and Reporting (OCG), in order to assign a code for additional condition(s) or secondary diagnosis(es), that/those condition(s) must meet any of the following:

- *Clinical evaluation;*
- *Therapeutic treatment;*
- *Diagnostic procedures;*
- *Extended length of hospital stay; or*
- *Increased nursing care and/or monitoring*

Secondary Diagnosis(SDX) for Inpatients

The conditions must be properly documented by the provider in order to be captured and coded.

Must REMEMBER – just because it is documented, doesn't mean it can be coded!!!

What Can I Code?

UNABLE TO CODE	ABLE TO CODE
<ul style="list-style-type: none">× Nursing Notes (except for the stage of pressure ulcer and BMI result)× Pathology report× Laboratory Report× Radiology Report× Physical Therapy× Wound Care (except for the stage of pressure ulcer)× Transfer Documents	<ul style="list-style-type: none">✓ ED provider's Notes✓ History and Physical✓ Progress Notes✓ Consult's Notes✓ Providers' Orders✓ Discharge Summary✓ Operative/Procedure Notes

Know Your Guidelines

Understanding the key points in the official coding guidelines for ICD-10 is important while performing the role of a clinical documentation improvement specialist. These key points are:

- Excludes note
- NOS
- NEC
- *“Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Where such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”*

Know Your Guidelines

These key points are (continued):

- “In diseases classified elsewhere”
- Signs and Symptoms
- Conditions that are an integral part of a disease process
- Combination code
- Sequela (late effect)

Pay for Performance

Pay for Performance is a CMS financial incentive program mandated by the Affordable Care Act to reward hospitals and physicians based on the cost and quality of care provided. In the past payment system, it was based on volume. Now there are three pay for performance programs for hospitals and one for physicians.

Pay for Performance

The ACA established the hospital readmissions reduction program (HRRP) which requires CMS to reduce payments of inpatient prospective payment system (IPPS) to hospitals with excess readmissions for certain diagnoses effective for discharges beginning on October 1, 2012.

The original three conditions include myocardial infarction (AMI), heart failure (HF) and pneumonia (PN). The list has since been expanded to include COPD, patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA).

2016, CMS expanded the pneumonia measure cohort to include aspiration pneumonia and sepsis patients with pneumonia present on admission (with exception of severe sepsis).

Pay for Performance

2017, CMS will include patients admitted with CABG.

The list continues to get bigger. CMS uses the policy of the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures to calculate the excess readmission ratios. The methodology includes adjustment for factors that are clinically relevant like patient demographic characteristics, co-morbidities and patient frailty.

This is why it is important that all the patient's risk factors be accurately documented regardless if they impact the DRG or not.

Readmission

Defined as any patient admitted to the hospital for any reason within 30 days of discharge. Exemptions to this rule is patient admitted for scheduled chemotherapy and patients admitted for rehabilitation.

Hospital Value Based Purchasing (HVBP)

CMS adjusts hospitals' payments based on their performance on four domains that reflect hospital quality:

1. The clinical process of care domain (12 measures). The clinical process is weighted as 20% of the Total Performance Score (TPS) for the four domains
2. The patient experience of care domain (obtained from the patients through survey after discharge) (8 measures). It is weighted as 30% of the TPS.

Hospital Value Based Purchasing (HVBP)

CMS adjusts hospitals' payments based on their performance on four domains that reflect hospital quality (continued):

3. The outcome domain (measures 30 day mortality rates for 3 conditions: acute myocardial infarction, heart failure, and pneumonia, along with Composite Patient Safety Indicator (PSI-90) by Agency for HealthCare Research and Quality (AHRQ). It is weighted at 30% of the TPS
4. The efficiency domain measures Medicare spending per beneficiary. This is weighted at 20% of the TPS.

Hospital-Acquired Condition (HAC) Reduction Program

CMS' goal is to use financial penalty to encourage hospitals to reduce HACs. The ACA authorized Medicare to reduce payments to hospitals that rank in the worst performing quarter with respect to hospital-acquired conditions (HACs). The worst performing quarter is identified by calculating a Total HAC score which is based on the hospital's performance on risk adjusted quality measures. Hospitals with a Total HAC score above the 75th percentile may be subject to 1% payment reduction beginning October 1, 2015.

Domains for HAC Scoring

The CMS uses scoring methodology to calculate total HAC score for each hospital using two domains.

Domains for HAC Scoring

- **Domain 1:** Comprises the Patient Safety Indicator (PSI) 90 measure, an administrative claims based measure developed by the Agency for Healthcare Research and Quality (AHRQ). PSI-90 is a composite of 8 measures:
 - PSI-03 Pressure Ulcer – Stage 3 and 4 and unstageable
 - PSI-06 Iatrogenic Pneumothorax
 - PSI-07 Central Venous Catheter-related Bloodstream Infections
 - PSI-08 Post operative Hip Fracture
 - PSI-12 Post operative Pulmonary Embolism or Deep Venous Thrombosis
 - PSI-13 Post operative Sepsis
 - PSI-14 Post operative Wound Dehiscence
 - PSI-15 Accidental Puncture or Laceration

Domains for HAC Scoring

- **Domain 2:** The measures include two healthcare associated infection (HAI) measures developed by the Centers for Disease Control and Prevention's (CDC), National Health Safety Network (CDC NHSN):
 - Central Line-Associated Blood Stream Infection (CLABSI)
 - Catheter-Associated Urinary Tract Infection (CAUTI)

Physician Value-Based Payment Modifier Program (VBM)

Mandated by the ACA, this program provides for differential payment to a physician or a group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care provided compared to cost.

In 2015, the VBM affected Medicare payments to physicians in groups of 100 or more eligible professionals (EP). 2016, the modifier applies to physicians in groups of 10 or more EPs. 2017, the modifier will apply to all physicians.

Physician Value-Based Payment Modifier Program (VBM)

Physicians performing below the national average will be penalized with payment reduction while the high performing physicians will be rewarded with the reimbursement generated from penalizing the worst performing physicians.

Physician Value-Based Payment Modifier Program (VBM)

Measures include the following **acute care conditions**:

- ✓Bacterial pneumonia
- ✓UTI
- ✓Dehydration

Chronic conditions:

- ✓COPD
- ✓Heart Failure
- ✓Diabetes

The outcome measures are risk-adjusted. The penalty for poor performance could reach as high as 4% reduction in payment in 2017.

Effective and Efficient Documentation Improvement

- Every outcome measure or rate in the P4P is “risk-adjusted.”
- You should pay close attention to co-morbid conditions that have a high impact on P4P even if those conditions do not impact the DRG.
- You should work collaboratively with the quality department to design a facility-wide strategy on educating the providers and staff on the P4P measures including creating a core measure template.

Effective and Efficient Documentation Improvement

- Patients that leave AMA prior to discharge are excluded.
- You should make sure that every co-morbid condition documented in the medical records has a clear present on admission (POA) indicator, if not, query the provider.
- You should be involved in the monthly interdisciplinary team meeting to review and discuss how the facility is doing with the measures.

Tips and Communication Tools

- Identify methods for creating physician education forms and tools.
- Demonstrate the ability to produce basic educational presentations specific for.
- Departments/services, including physicians, nurse practitioners and administration.
- Develop ways to communicate with physicians in an effective, non-confrontational manner.

Tips and Communication Tools

- Understand your role and responsibilities as a documentation specialist.
- Understand your role and responsibilities as a coder working in conjunction with a CDI Department.
- Be able to reconcile discrepancies between working DRG assignments assigned by the CDI staff and final coded DRGs.
- Identify situations in which verbal, personal communications with physicians are more favorable than written communication.

Questions?

- Get your questions answered on PMI's Discussion Forum:
<http://www.pmimd.com/pmiForums/rules.asp>

*Presentation originally created by
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