CODING COMPLIANCE RISKS – TIPS & HINTS FOR THE COMPLIANCE PROFESSIONAL

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& Dana Brown, MBA, RHIA, CHC

HCCA Compliance Institute
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Las Vegas, Nevada

SPEAKERS

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS

AHIMA Approved ICD-10-CM/PCS Trainer

Gloryanne is the Past-President of CHIA and a volunteer of local, state and national associations.

Gloryanne is a sought-after advisor, mentor, national educator, speaker and author for 35+ years.

She writes, speaks and provides education on healthcare compliance, reimbursement, clinical documentation improvement, physician querying, coding regulations (ICD-10-CM/PCS and CPT), coding compliance and ethics. She serves as a catalyst for quality coded data, integrity, compliance and improvement in Clinical Coding across all of healthcare.

Dana Brown, MBA, RHIA, CHC

Dana has over 30 years experience in coding, compliance, and CDI, and is the President and Founder of RMC.

Dana is ultimately responsible for the quality of services provided to RMC clients. Daily involvement with coding review, education and training, as well as business and staff development are areas of focus in Dana's position.

Dana's expertise in Compliance, Inpatient Coding, DRG's/MSDRG's, OIG & RAC Targets, Clinical Documentation Improvement, as well as an interest in HCC auditing and Critical Access Hospitals round out her areas of focus.

DISCLAIMER

Every reasonable effort has been taken to ensure that the educational information provided in this presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation. A thorough individual review of the information is recommended and to establish individual facility guidelines.

The speakers make no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. The speakers have no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this presentation material, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this presentation. The speakers makes no guarantee that the use of this presentation material will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

GOALS/OBJECTIVES

Review of coding compliance risk concerns for the hospital inpatient and outpatient setting.

Review of coding compliance risk concerns in the outpatient clinic based setting

Review of coding and clinical documentation (CDI) concerns

Provide information on charge and Chargemaster topics

Provide best practice solutions and hints to improve compliance outcomes

BACKGROUND: KEY MESSAGE FROM OIG

"It's Incumbent upon a health system's corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct."

- *Office of Inspector General*

NOTE: It says "ethical" and "Legal", keep in mind that unethical behavior or acts are not always illegal.

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OIG COMPLIANCE PROGRAM GUIDANCE

Seven Elements of a Compliance Program:

1.Standards of Conduct

2.Compliance Officer and Board/Committee

3.Education

4.Auditing and Monitoring

5.Reporting and Investigations

6.Enforcement and Discipline

7.Response and Prevention

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WHAT A COMPLIANCE PROGRAM SHOULD DO . . .

Provide oversight to **Detect, Prevent and <u>Correct</u>** "Fraud, Waste and Abuse".

Define expectations

Create and foster a culture of compliance
- Do the right thing

Encourage reporting
- Open lines of communication

Monitoring and Auditing

Education

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OIG WORK PLAN FOR 2018

Review and discuss more than once a year!

The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections.

BEING ETHICAL

A key component to **workplace ethics** and behavior is integrity, or **being** honest and doing the right thing at all times.

- For example, health care employees who work with mentally or physically challenged patients must possess a high degree of integrity, same as those who manage and work primarily with money.

Ethical behavior tends to be good for business and involves demonstrating respect for key moral principles that include honesty, fairness, equality, dignity, diversity and individual rights.

> "An ethical culture is created by the organization's leaders who manifest their ethics in their attitudes and behavior." McMillan, Michael. "Codes of Ethics: If You Adopt One, Will They Behave?".

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CLINICAL CODING

- Review patients' records , translate and assign numeric codes for each diagnosis and procedure following Official Coding & Reporting Guidelines
- Possess expertise in the ICD-10-CM and CPT coding systems
- Knowledgeable about medical terminology, disease processes, and pharmacology.
- Documentation, Billing, Reimbursement systems and methodologies, revenue cycle and compliance.

CODING PROFESSIONAL

Health Information Management (HIM), health records or medical records oversight via credential individual(s).

Clinical Coding is a core function of HIM; also needs to have credentialed individual(s).

These coding practitioners:

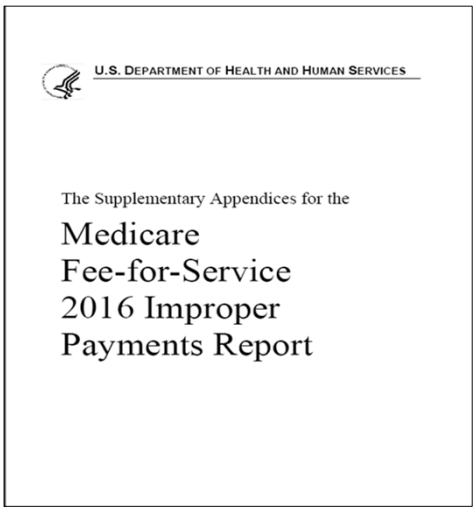
- Applies to all healthcare settings!
- Ethical, professional and compliant!

REMEMBER: Clinical Coding is used to translate medical documentation (the language of medicine) into medical data (the language of coding) for statistical, research, and reimbursement purposes.

KNOWING THE RISK, VULNERABILITIES AND GAPS!

Maintain compliance and ethics at all times!

HHS REPORT: MEDICARE FFS IMPROPER PAYMENTS



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Supplementary Appendices for the

Medicare
Fee-for-Service
2016 Improper
Payments Report

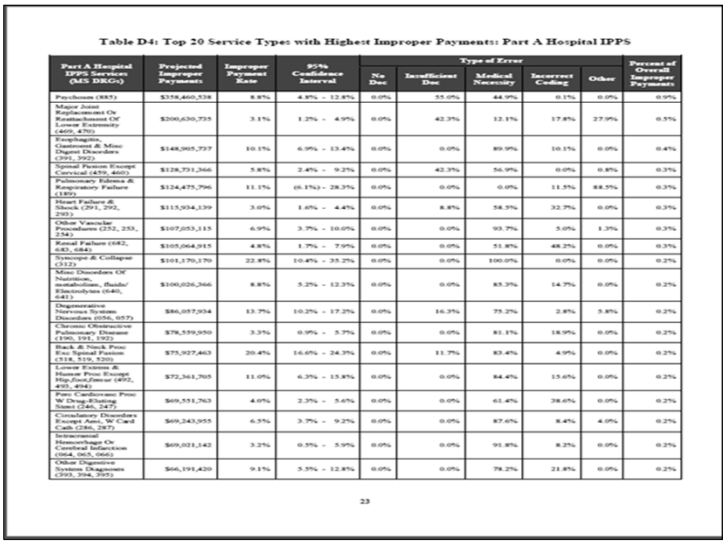


Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Psychoses (885)	$358,460,538	8.8%	4.8% - 12.8%	0.0%	55.0%	44.9%	0.1%	0.0%	0.9%
Major Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$200,630,735	3.1%	1.2% - 4.9%	0.0%	42.3%	12.1%	17.8%	27.9%	0.5%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$148,905,737	10.1%	6.9% - 13.4%	0.0%	0.0%	89.9%	10.1%	0.0%	0.4%
Spinal Fusion Except Cervical (459, 460)	$128,731,366	5.8%	2.4% - 9.2%	0.0%	42.3%	56.9%	0.0%	0.8%	0.3%
Pulmonary Edema & Respiratory Failure (189)	$124,475,796	11.1%	(6.1%) - 28.3%	0.0%	0.0%	0.0%	11.5%	88.5%	0.3%
Heart Failure & Shock (291, 292, 293)	$115,934,139	3.0%	1.6% - 4.4%	0.0%	8.8%	58.5%	32.7%	0.0%	0.3%
Other Vascular Procedures (252, 253, 254)	$107,053,115	6.9%	3.7% - 10.0%	0.0%	0.0%	93.7%	5.0%	1.3%	0.3%
Renal Failure (682, 683, 684)	$105,064,915	4.8%	1.7% - 7.9%	0.0%	0.0%	51.8%	48.2%	0.0%	0.3%
Syncope & Collapse (312)	$101,170,170	22.8%	10.4% - 35.2%	0.0%	0.0%	100.0%	0.0%	0.0%	0.2%
Misc Disorders Of Nutrition, metabolism, fluids/ Electrolytes (640, 641)	$100,026,366	8.8%	5.2% - 12.3%	0.0%	0.0%	85.3%	14.7%	0.0%	0.2%
Degenerative Nervous System Disorders (056, 057)	$86,057,934	13.7%	10.2% - 17.2%	0.0%	16.3%	75.2%	2.8%	5.8%	0.2%
Chronic Obstructive Pulmonary Disease (190, 191, 192)	$78,559,950	3.3%	0.9% - 5.7%	0.0%	0.0%	81.1%	18.9%	0.0%	0.2%
Back & Neck Proc Exc Spinal Fusion (518, 519, 520)	$75,927,463	20.4%	14.6% - 24.3%	0.0%	11.7%	83.4%	4.9%	0.0%	0.2%
Lower Extrem & Humer Proc Except Hip,foot,femur (492, 493, 494)	$72,361,705	11.0%	6.3% - 15.8%	0.0%	0.0%	84.4%	15.6%	0.0%	0.2%
Perc Cardiovasc Proc W Drug-Eluting Stent (246, 247)	$69,551,763	4.0%	2.3% - 5.6%	0.0%	0.0%	61.4%	38.6%	0.0%	0.2%
Circulatory Disorders Except Ami, W Card Cath (286, 287)	$69,243,955	6.5%	3.7% - 9.2%	0.0%	0.0%	87.6%	8.4%	4.0%	0.2%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$69,021,142	3.2%	0.5% - 5.9%	0.0%	0.0%	91.8%	8.2%	0.0%	0.2%
Other Digestive System Diagnoses (393, 394, 395)	$66,191,420	9.1%	5.5% - 12.8%	0.0%	0.0%	78.2%	21.8%	0.0%	0.2%

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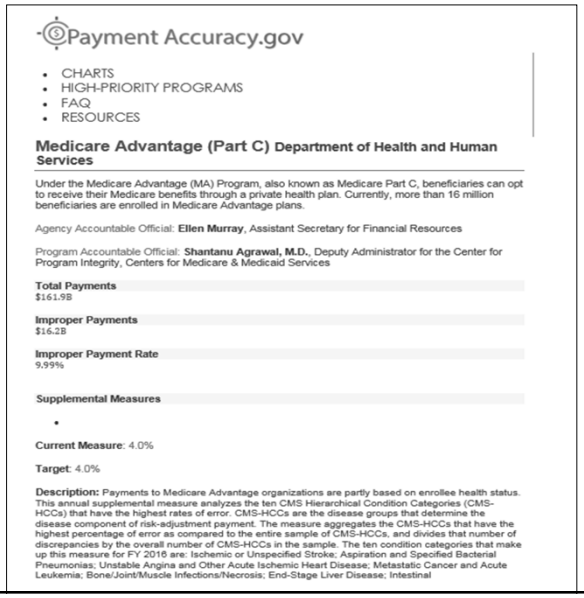
PAYMENTACCURACY.GOV

This site provides insight into all federally funded program, not just healthcare, in which payment errors have occurred.

- Medicare
- Medicaid
- Medicare Advantage (see to the right)

Note the dollars!!



Payment Accuracy.gov

- CHARTS
- HIGH-PRIORITY PROGRAMS
- FAQ
- RESOURCES

Medicare Advantage (Part C) Department of Health and Human Services

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, beneficiaries can opt to receive their Medicare benefits through a private health plan. Currently, more than 16 million beneficiaries are enrolled in Medicare Advantage plans.

Agency Accountable Official: **Ellen Murray**, Assistant Secretary for Financial Resources

Program Accountable Official: **Shantanu Agrawal, M.D.**, Deputy Administrator for the Center for Program Integrity, Centers for Medicare & Medicaid Services

Total Payments
$161.9B

Improper Payments
$16.2B

Improper Payment Rate
9.99%

Supplemental Measures

Current Measure: 4.0%

Target: 4.0%

Description: Payments to Medicare Advantage organizations are partly based on enrollee health status. This annual supplemental measure analyzes the ten CMS Hierarchical Condition Categories (CMS-HCCs) that have the highest rates of error. CMS-HCCs are the disease groups that determine the disease component of risk-adjustment payment. The measure aggregates the CMS-HCCs that have the highest percentage of error as compared to the entire sample of CMS-HCCs, and divides that number of discrepancies by the overall number of CMS-HCCs in the sample. The ten condition categories that make up this measure for FY 2016 are: Ischemic or Unspecified Stroke; Aspiration and Specified Bacterial Pneumonias; Unstable Angina and Other Acute Ischemic Heart Disease; Metastatic Cancer and Acute Leukemia; Bone/Joint/Muscle Infections/Necrosis; End-Stage Liver Disease; Intestinal

PAYMENTACCURACY.GOV

Improper payments occur when either:

- Federal funds go to the wrong recipient,
- The recipient receives the incorrect amount of funds (either an underpayment or overpayment)
- Documentation is not available to support a payment, or
- The recipient uses Federal funds in an improper manner

Under Medicare Advantage (MA) Program (AKA: Part C) there are more than **19 million beneficiaries.**

Total Payments	Improper Payments	Improper Payment Rate
$172.8B	$14.4B	8.31%

Supplemental Measures		
High-Risk Hierarchical Condition Categories	**Current Measure**: 3.3% **Target**: 3.3%	**Update Frequency**: Annually **Data Current as of**: November 2017

E&M CODING: COMPLIANCE RISK

Professional E&M (Evaluation and Management) CPT coding should convey the professional effort attributed to evaluation and management based on documentation and medical decision making

ER setting

Physician Office setting

Clinic/ Urgent Care

Inpatient Hospital visits/encounters

Most important to **be consistent!!**

- Monitor accuracy regularly, ensure tool is being used the same way by everyone

NOTE: one-level E&M change represents an error!

TRACK E&M ACUITY DISTRIBUTION

Bell Curves:

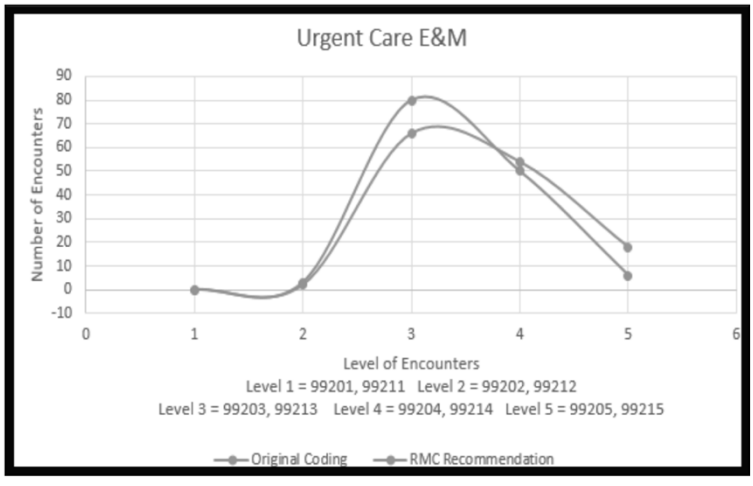
Expected use of the Emergency E&M code range should be a bell-shaped curve

- indicating the highest occurrence of level assignment should be moderate levels with a taper down effect on occurrence for the highest and lowest level assignments
- Clinic/Hospital Administration may request from CMS a "provider bell curve". This bell curve will show an individual providers acuity compared to their peers in their area.

Irregularity of Bell Curve can indicate:

- Poor documentation
- Documentation issue
- Handwritten can pose issues
- Dictation of poor quality
- EHR/EMR issues

E&M BELL CURVE SAMPLE



INJECTION/INFUSION CPT CODING: COMPLIANCE RISK

- Complex rules for coding
- Documentation from non-physician providers (nursing) often lacking needed information and details
- Start and stop times needed
- EHR/EMR can help: Medication Administration Record (MAR)
- Need ongoing auditing and education
- ER/ED setting
- Chemotherapy setting
- Other OP clinic settings

HOSPITAL OUTPATIENT CLINIC: COMPLIANCE RISK

- Modifiers are a huge risk!
- Modifier 25 attached to an E&M (this Modifier is for significantly separately billable procedure). However the E&M code is not justified – no exam was done, no documentation etc..... to support the E&M. Therefore they will kick out the E&M
- Modifier *57* – "Decision for Surgery" – seeing this modifier attached automatically to E&M for when patients are brought in for pre-op apt (H&P). (Intent of Mod *57* is for when the original decision for surgery is made)

HOSPITAL OUTPATIENT CLINIC: COMPLIANCE RISK (CONT.)

Modifier 59 – "Distinct Separate Procedure" – this will go on procedure codes (not E&M)

- Assure that it is used appropriately and not automatically attached to surgery CPT codes.
- Do not use this modifier to override edit if documentation is not supportive

E&M used in the OP clinic setting

- Monitor and track levels
- High levels for service line

HOSPITAL OP CLINIC: COMMON SOLUTIONS

Track/Trend statistics of modifiers

- Modifier 25 should not be attached 100% to an E&M – auto attaching
- Modifier 59 should not be attached 100% to CPT code – auto attaching

Develop policy on COPY/PASTING

- Monitor internally

Engage CDI on all levels of care!

HOSPITAL INPATIENT CODING

- Principal and secondary diagnosis code assignment
  - Entire medical record is reviewed
- Uses ICD-10-PCS for procedure coding
- CMS reimbursement is based on IPPS which is determined by MS-DRGs

MS-DRG: COMPLIANCE RISK

- MS-DRG = Medicare Severity Diagnosis Related Group
- Hospital receives just one payment based on this DRG.
- Payment must cover all expenses for hospitalization.
- Affects studies, patient care, and healthcare trends. Affects the BOTTOMLINE!

MS-DRG 469 Major Joint Procedures

MS-DRG 207 Respiratory System with Vent Support 96+ Hours

MS-DRG 871 Sepsis w/o Vent with MCC

MS-DRG 853 Infectious and Parasitic Diseases with O.R. Procedure

MS-DRG 247 PTCA w/Drug Eluting Stent

MS-DRG 460 Spinal Fusion except Cervical

MS-DRG 313 Chest Pain

*The above DRGs are either external audit targets or costly Medicare DRGs that are susceptible for a facility audit.

CC/MCC RISK

Single CC/MCC is a red flag – audit

- Malnutrition – protein calorie
- Respiratory Failure – acute and chronic
- Sepsis and Severe Sepsis
  - With Organ Dysfunction
- Encephalopathy

Low LOS in MS-DRG

MONITORING CMI AND CC/MCC

- Facilities need to monitor their CMI for trends in coding accuracy (upward/downward)
- Monitoring CC, MCC, and No-CC charts is critically important.
- Monthly trending is recommended
- Can be an indicator of either low intensity of coding, coding errors, or omissions.
- Conversely OVER coding too!

DC DISPOSITION: COMPLIANCE RISK

"Discharge Disposition" = The code assigned to represent where the patient went at discharge from an acute care hospital.

- Inpatient MS-DRGs

•Can affect $$ amounts under the "transfer DRG's" rule (Post-Acute Care Transfer)

•If level of care changes within 3 days after discharge – must correlate on bill (or facility intends to make correction/adjustment). CMS will not make adjustments in facility favor.

Inaccurate Discharge Disposition

- Social Work note documents home; Discharge Summary documents discharge with home health

Physician Order

- No "admit to inpatient" order on hospital stays 2 days or less
- On RAC's radar

•Attention is needed!

TIP: SEE OFFICIAL MLN Matters Number: SE0801

HCC RISK: COMPLIANCE RISK (PAYMENTACCURACY.GOV)

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1. Ischemic or Unspecified Stroke
2. Cerebral Hemorrhage
3. Aspiration and Specified Bacterial Pneumonias
4. Unstable Angina and Other Acute Ischemic Heart Disease
5. End-Stage Liver Disease
6. Diabetes with Opthalmologic or Unspecified Manifestation
7. Drug/Alcohol Psychosis
8. Lung, Upper Digestive Tract, Other Severe Cancers
9. Vascular Disease with Complications
10. Major Complications of Medicare ad Trauma

HCC: COMPLIANCE RISK

- Diagnosis documentation and coding
- Querying: leading
- Retrospective medical record "diving" and then querying
- Data Mining
- Using EHR/EMR to highlight Dx to select
- Only asking physician about Dx that pays
- Encounter: face to face documentation

PHYSICIAN QUERYING: COMPLIANCE RISK

Written physician Queries

When and How to Query…if documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Verbal Querying

Every verbal exchange related to a specific record, must be recorded and stored per hospital policy.

Summarize every verbal query in writing for compliance purposes.

Follow the same guidance for written AND verbal querying (queries).

NOTE: Federal Investigators were onsite at a hospital, they observed interactions between CDI staff and providers and identified noncompliant, leading exchanges, this raised questions and vulnerabilities.

CDI: RISK COMPLIANCE

CDI = Clinical documentation improvement

- Healthcare Professional with a background and education of clinical processes (RN, RHIT, CCS, CDIS, CDIP etc) that would review for clinical documentation and provide feedback to physicians.
- Very common in the inpatient setting; growing in outpatient.
- Need formal CDI program or plan to include Query Policy

Caution – No leading MDs to write certain words

CDI: COMPLIANCE RISK (CONT.)

Concerns:

Having financial goals as the center of CDI program.

Only focusing on Medicare – all payers

Not having a formal QA process in place or auditing CDI for compliance

- Appropriate querying
- Non-Leading
- Missed query
- Over querying

CDM: COMPLIANCE RISK

CDM Maintenance

- Update the CDM at least annually and potentially quarterly to coincide with CMS OPPS updates and other transmittals.
- Limit access to the CDM to the CDM Coordinator position and perhaps the PFS or Revenue Integrity director to prevent unauthorized or unintentional changes.
- Consider a team approach for structural and pricing decision-making and policy and procedure development related to the CDM and charge capture.
- Develop a 'data dictionary' for CDM terms and abbreviations to ensure consistency amongst departments. This can easily be maintained in spreadsheet format. In addition, for supplies, consider 'noun' first terminology, e.g., CATH or STENT, and for procedures, 'verb' first, e.g., INJ or BX. *Remember patient-friendly billing is key!*

CDM COMPLIANCE HOT TOPICS (CONT.)

CDM Hard-coding vs. HIM Soft-coding

- If procedures are hard-coded in the chargemaster that also may be coded by HIM staff, precautions should be taken to prevent:
  - ❑Duplication of codes on the UB-04
  - ❑The compliance risks associated with overriding a code for a charge code with pricing tied to the hard-coded HCPCS
  - ❑Missing codes because the flags are set to pull the HCPCS from the CDM.

Statistical Codes in the CDM

- If you really need to account for a service that is not separately billable, consider the selective use of tracking codes. However, ensure that the system does not append any pricing and that the department(s) utilizing them have policies and procedures in place for their use.

CDM COMPLIANCE HOT TOPICS (CONT.)

Duplication of Procedures Across CDM Departments

- Procedures such as CPR, EKGs, and venipunctures, as well as minor surgical repair, should be billed separately in addition to E/M level of service in the Emergency Department or Clinic setting;
- however, care should be taken to avoid potential duplicate billing when multiple departments respond to, assist with, provide over-reads for, or attach such services to ancillary system order sets.

Modifiers in the CDM

- Ensure the CDM does not contain subjective modifiers such as Modifier 59 or the more recent X{EPSU} modifiers unless there is no other option
  - XE (separate encounter—service that is distinct because it occurred during a separate encounter)
  - XP (separate practitioner—a service that is distinct because it was performed by a different practitioner)
  - XS (separate structure—a service that is distinct because it was performed on a separate organ/structure)
  - XU (unusual non-overlapping service—the use of a service that is distinct because it does not overlap usual components of the main service)

OUTPATIENT CLINIC: COMPLIANCE RISK

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OUTPATIENT CLINIC: COMPLIANCE RISK (CONT.)

Modifier 59 – "Distinct Separate Procedure" – this will go on procedure codes (not E&M)

- Assure that it is used appropriately and not automatically attached to surgery CPT codes.
- Do not use this modifier to override edit if documentation is not supportive

EHR: COMPLIANCE RISK

CLONING!!!

COPY/PASTE is a major problem!

- Must have a policy in place to assist coding professionals

OTHER RISKS: TECHNOLOGY

Charge Capture: non-coding professionals keying charges that are linked to CPT codes

CAC (computer assisted coding): suggestion of codes (ICD-10-CM/PCS and CPT) not validated by coding professional

CDI software: used by CDI staff, and generates query form and electronically sends to the physician, needs oversight of the wording process

Querying software: used by coding staff, and generates query form and electronically sends to the physician, needs oversight of the wording process

OTHER HOT TOPICS FROM 2017 OIG WORK PLAN

- Hyperbaric Oxygen Therapy
- Two-Midnight Rule
- Provider Based vs. Freestanding Clinics
- Hospice Medicare documentation reviews
- Inpatient Rehab Hospital
- Positive Airway Pressure Devices

TIPS FOR CODING COMPLIANCE BEST PRACTICES

Regular coding reviews (audits) -Develop an internal audit team and utilize external auditors

- MS-DRG focused Audits
- Random Quality Audits
- Coder Quality 95% or higher
- All settings
- All payers

Track/Trend MS-DRGs: produce reports, compare to PEPPER

Education and Audit and repeat

Educate CDI professionals on appropriate querying

TIPS FOR CODING COMPLIANCE BEST PRACTICES (CONT.)

Work with physician's on documentation

- Importance cannot be stressed enough
- Collaboration – ongoing
- Physician Champion – documentation liaison

Utilization Review

- Ensure the level of service (IP vs. OBS) is correct - validation

Designate a specific place in the EHR/EMR to document the discharge disposition and validate.

TIPS FOR CODING COMPLIANCE BEST PRACTICES (CONT.)

New Business line

- Ensure a new business line has brought into the planning an HIM Coding leader
- Discuss the documentation process and determine if education is needed
- Review documentation and coding within first week of operations
- Plan to make revisions and changes
- Incorporate into regular auditing plan and process

New technology

- Ensure a new technology being implemented touches, creates, using or reports on ICD-10-CM/PCS or CPT codes
  - Including documentation used for coding
- If yes, bring in an HIM Coding leader to assess the technology functionality and output
- Determine if there are issues (risks) or changes needed
  - Turning off viewing or selection of "all" codes possible
  - Querying that could be leading
- Monitor and report on technology portion that relates to "coding" or documentation that would be used for coding.

WHO'S THE GATEKEEPER?

SHOULD BE Coding Compliance and the HIM Coding professional

- Ethical
- Good communicator
- Viewed as a Leader

Knowledgeable of coding, compliance and CMS regulations

Work closely with Compliance Officer (Dept), Legal and Internal Audit

Open and transparent

A CODING COMPLIANCE PLAN/PROGRAM

Follow these seven elements:

- Mission/Vision Statement
- Oversight and Leadership
- Communication and Policies/Procedures (written)
- Auditing and Monitoring
- Education and Training
- Investigation and Corrective Action (including Rebilling)
- Prevention and Discipline (this can be tired directly to the organizations policy and practice)

ESTABLISH CODING POLICIES AND PROCEDURES

Coding Policies and Procedures (written) – for all healthcare settings:
Cover a variety of topics/functions

Must be current, accurate, relevant to the setting and used daily by staff as a resource

Official "Coding Resources" used for the process of coding and for auditing.

- "Official Guidelines"

Put into writing the acceptable resources:

- Current year "Official Coding & Reporting Guidelines"
  - Your department's commitment and adherence to official coding guidelines should be explicitly stated.
- AHA Coding Clinic (subscription)
  - ICD-10-CM/PCS
  - HCPCS
- AMA CPT Code book (current book)
- AMA CPT Assistant (subscription)
- Merck Manual? (useful but not an "official source")
- Coders Desk Reference? (useful but not an "official source")

ESTABLISH CODING POLICIES AND PROCEDURES (CONT.)

Budget for Required "Coding Resources"

- Budget for these . . . At a minimum
  - AHA Coding Clinic
    - ICD-10-CM/PCS
    - HCPCS
  - AMA CPT Assistant
  - **AND Add CMS Transmittals and Memorandums to this list**
    - **Program Manual does provide additional insight often too.**
    - The Medicare Administrative Contractors MACs

Physician Querying P&P

Follow the AHIMA Practice Briefs
- Gold Standard across the industry
- Educate on querying

Wording and format – nonleading

Retention of queries
- Monitor

Escalation and Physician Champion

QA of physician queries: review and report

- While we may not always agree with published advice the Official Coding and Reporting Guidelines and AHA Coding Clinic guidance are the rules that we must follow when reporting ICD-10-CM/PCS codes.

PHYSICIAN QUERYING: INDUSTRY GOLD STANDARD

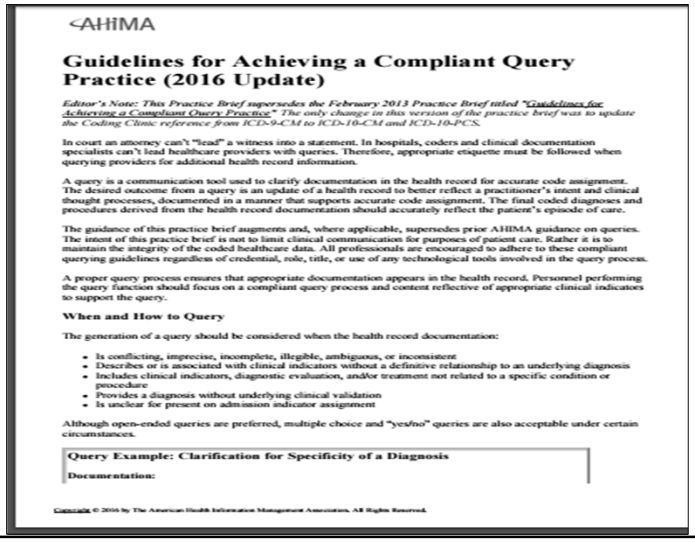
"AHIMA Guidelines for Achieving a Compliant Query"

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

PHYSICIAN QUERYING: INDUSTRY GOLD STANDARD



AHIMA

Guidelines for Achieving a Compliant Query Practice (2016 Update)

Editor's Note: This Practice Brief supersedes the February 2013 Practice Brief titled "Guidelines for Achieving a Compliant Query Practice" The only change in this version of the practice brief was to update the Coding Clinic reference from ICD-9-CM to ICD-10-CM and ICD-10-PCS.

In court an attorney can't "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists can't lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

The guidance of this practice brief augments and, where applicable, supersedes prior AHIMA guidance on queries. The intent of this practice brief is not to limit clinical communication for purposes of patient care. Rather it is to maintain the integrity of the coded healthcare data. All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances.

Query Example: Clarification for Specificity of a Diagnosis

Documentation:

ESTABLISH CODING POLICIES AND PROCEDURES (CONT.)

Coding Education and Maintenance of Credentials

- Annual coding educational hours
  - Require a minimum
- Review the continuing education unit requirement for the different coding credentials
  - RHIA/RHIT
  - CCS/CCS-P
  - CPC, etc.
- Require annual proof of credentials
  - Maintain copies
- EXTERNAL staff…. Should also show evidence of credentials and maintenance
  - Required as part of the contract with external vendor

ESTABLISH CODING POLICIES AND PROCEDURES (CONT.)

Coding Education Program:

- Quarterly, or more often is ideal
- Even changes in regulations can result in more education
- Staff exposure to news, information, and other entity approaches

Hours per year provided or obtained

- Live-Webinars
- Face to Face
- Online – independent

Support credentials

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CODING AUDITS… A MUST!

Policy and Procedure in place and annual plan

Random and Focused

All Payers

All Settings

Sample size – meaningful (not too small)

Reporting the findings

Recommendations and Corrective action plan (with timeline)

Rebilling (timely)

UTILIZE THE AHIMA "CODE OF ETHICS" (CONT.)

The AHIMA Code of Ethics serves seven purposes:

1. Promotes high standards of HIM practice.

2. Identifies core values on which the HIM mission is based.

3. Summarizes broad ethical principles that reflect the profession's core values.

4. Establishes a set of ethical principles to be used to guide decision-making and actions.

5. Establishes a framework for professional behavior and responsibilities when professional obligations conflict or ethical uncertainties arise.

6. Provides ethical principles by which the general public can hold the HIM professional accountable.

7. Mentors practitioners new to the field to HIM's mission, values, and ethical principles.

UTILIZE THE AHIMA STANDARDS OF ETHICAL CODING

12/2016 AHIMA *Standards of Ethical Coding*

- Introduction: applies to all who code, involved in coding or utilize coded data.
- Applies to all AHIMA Members & Non-Members – in all settings!
- Definitions
- 11 Principles
- How to Interpret the Standards of Ethical Coding: Standards and Guidelines

This is available for AHIMA Members, so check with your HIM Coding leadership and obtain this document and resource.

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UTILIZE THE AHIMA STANDARDS OF ETHICAL CODING

AHIMA
American Health Information Management Association

American Health Information Management Association Standards of Ethical Coding

Introduction

Coding is recognized as one of the core health information management (HIM) functions within healthcare. Due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical coding and coding-related challenges. The Standards of Ethical Coding are important established guidelines for any coding professional and are based on the American Health Information Management Association's (AHIMA's) Code of Ethics. Both reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding, data abstraction and related coding and/or data activities.

A Code of Ethics sets forth professional values and ethical principles. In addition, a code of ethics offers ethical guidelines to which professionals aspire and by which their actions can be expected and be judged. HIM and coding professionals are expected to demonstrate professional values by their actions to patients, employers, members of the healthcare team, the public, and the many stakeholders they serve. A Code of Ethics is important in helping guide the decision-making process and can be referenced by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies, and other professional groups). The Code of Ethics[1] is relevant to all AHIMA members, students, and CCHIIM credentialed HIM and coding professionals, regardless of their professional functions, the settings in which they work, or the populations they serve. All core health information coding activities are performed in compliance with state and federal regulations, and employer policies and procedures.[2]

The AHIMA Standards of Ethical Coding are intended to assist and guide coding professionals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students. The standards outline expectations for making ethical decisions in the workplace and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported. They are relevant to all coding professionals, regardless of the healthcare setting (e.g., inpatient, outpatient, post-acute care, alternative care, etc.) in which they work or function.

These Standards of Ethical Coding have been revised in order to reflect the current healthcare environment and modern coding practices. This document is in two parts; part one includes the standards and part two contains the standards, guidelines, and examples. Additionally, definitions have been added for some key words and terms used throughout the document. The following definitions relate to and are used within the context of these Standards for consistency and continuity.

DEFINITIONS

The purpose of this definition section is to achieve clarity without needless repetition. These definitions are intended to reflect everyday meaning. It is not within the scope of this document to establish new definitions for the words.

Coding Professional: Individuals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students.

Coding-related activities: The activities includes selection, research, and completion of code assignment, querying, other health record data abstraction, data analytics and reporting with codes, coding audits, remote coding, and coding educational activities and functions.

Data: All healthcare data elements including clinical, demographic, and financial.

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STANDARDS OF ETHICAL CODING: **PRINCIPLES**

1. Apply accurate, complete, and consistent coding practices that yield quality data

2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions

3. Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements

4. Query and/or consult, as needed, with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.

5. Refuse to participate in, support, or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.

STANDARDS OF ETHICAL CODING: (CONT.)

6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.

7. Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.

8. Maintain the confidentiality of protected health information in accordance with the Code of Ethics.

9. Refuse to participate in the development of coding and coding-related technology that is not designed in accordance with requirements.

10. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

11. Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding-related practices.

UTILIZE THE AHIMA PRACTICE BRIEF ON QUERYING 2016

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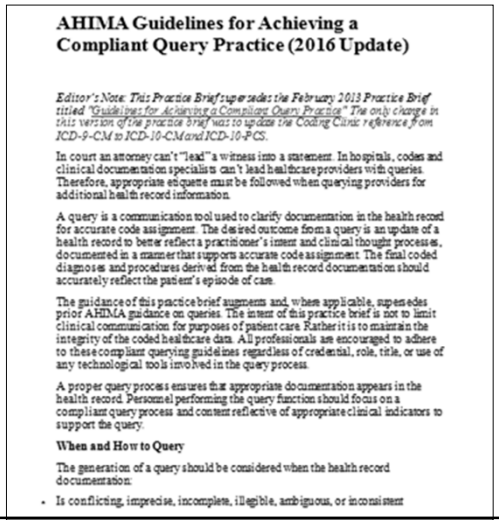

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USE AND FOLLOW THIS RESOURCE!: **OFFICIAL 2018 ICD-10-CM/PCS CODING & REPORTING GUIDELINES**

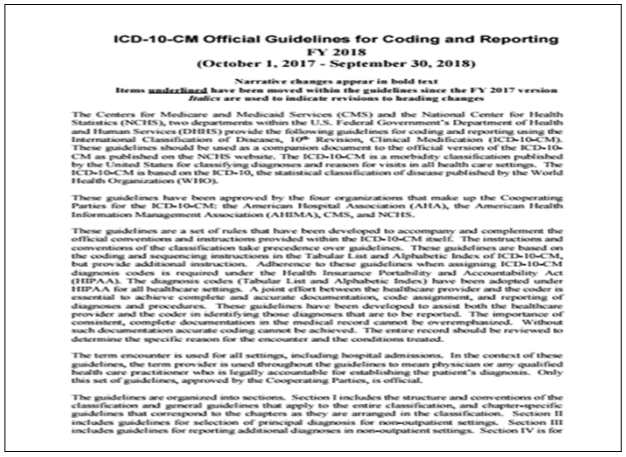
Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.

These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

USE AND FOLLOW THIS RESOURCE!: **OFFICIAL 2018 ICD-10-CM/PCS CODING & REPORTING GUIDELINES (FREE)**



ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2017 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for

I've heard many times , even within the past year that "physician coding staff" don't use this resource because they believe it is only for hospitals, which is not accurate.

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USE AND FOLLOW THIS RESOURCE!: **AHA CODING CLINIC** FOR ICD-10-CM/PCS:

Official Coding Professional Required Resource and Guidance (subscription)

The AHA Central Office is the publisher of the *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* and the *AHA Coding Clinic for HCPCS*. *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* represents a formal cooperative effort between the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS).

This resource is a MUST for any coding professional and even CDI staff no matter what setting they work in.

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USE AND FOLLOW THIS RESOURCE!: CPT ® ASSISTANT

Monthly guidance (subscription $199.)

AMA's CPT Assistant Newsletter has been instrumental to many in their appeal of insurance denials, validating coding to auditors, training their staff and simply making answering day-to-day coding questions second nature. Each monthly issue offers vital and timely information, including:

Keeping abreast of the latest codes and trends in the coding industry

Clinical scenarios that demystify confusing codes

Answers to your most frequently asked questions

Quick reference to anatomical illustrations, charts and graphs

MISTAKES HAPPEN… BE SURE TO REBILL

Follow the 60-day Rebilling Rule

Ensure HIM and Billing Department know the rule and the process within your organization/facility or practice

Log and track the rebilling to completion

- Tip: check and use the RA (Remittance Advice)

NEXT STEPS . . .

Ask questions

Discuss with HIM Coding leadership

Determine risks, gaps and vulnerabilities

Promote "Official Coding & Reporting Guidelines" at all times

Follow and support the AHIMA Code of Ethics and Standards of Ethical Coding

Have a Coding Compliance Program
- Policies/procedures
- Auditing and encourage outside education

COMPLIANCE AND ETHICS GO HAND IN HAND!

SUMMARY

Review regulatory reports

Documentation and Coding Risks are across healthcare

Different healthcare settings have different issues
- All have documentation, coding and reimbursement risks

Establish and/or include "Coding Compliance Program"

Utilize Official Coding Resources

Develop and implement Coding Policies and Procedures

Continue Auditing and Education

CONCLUDING THOUGHTS

- Compliance risks are vast!
- Get ahead of the curve
- Open dialog helps
- **Do The Right Thing!**

QUESTIONS . . .

THANK YOU!

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT US:

GLORYANNE BRYANT, RHIA, CDIP, CCS, CCDS
GLORYANNEB@SBCGLOBAL.NET

DANA BROWN, MBA, RHIA, CHC
DANA@RMCINC.ORG

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Recommendation for Standardized Hospital Evaluation and Management Coding for Emergency Departments

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