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
* Understand the history of Clinical Documentation Improvement (CDI) programs
* Getting involved with the CDI and coding teams from the compliance standpoint
In 2011

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."

Conflicting Views

* The coder: Typically the physician gets the last say, per a coding Advisory Board member and independent consultant
* "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, fellow 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.
Performance Watchdogs- just a few

* HealthGrades
  * Healthgrades.com
* Recovery Audit Contractors (RAC)
* Office of Inspector General (OIG)
* U.S. Department of Justice
* Joint Commission - QualityCheck.org
* CMS.gov
  * CERT guidelines(Part B for physician evaluation and management levels of service)
  * Medical necessity issues

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?
  * Coded claim data and data mining
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
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 has been missed:
  * Data quality that appropriately reflects the picture of healthcare in this country.
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.

**CDI Historical Objectives**

- 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
* 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

Be Involved-Top 5 hospital diagnoses and procedures*

<table>
<thead>
<tr>
<th>Most expensive diagnoses</th>
<th>Most expensive procedures</th>
<th>Most common diagnoses</th>
<th>Most common procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal cord injury</td>
<td>Heart, lung, pancreas and liver transplantation</td>
<td>Liveborn infant</td>
<td>Other procedures to assist delivery</td>
</tr>
<tr>
<td>Infant respiratory distress syndrome</td>
<td>Tracheotomy</td>
<td>Coronary atherosclerosis and other heart disease</td>
<td>Circumcision</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>Bone marrow transplantation</td>
<td>Pneumonia</td>
<td>Cesarean section</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Kidney transplantation</td>
<td>Congestive heart failure</td>
<td>Episiotomy</td>
</tr>
<tr>
<td>Heart valve disorders</td>
<td>Heart valve procedures</td>
<td>Acute myocardial infarction</td>
<td>Diagnostic cardiac catheterization</td>
</tr>
</tbody>
</table>

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

**Current Example**

- Pediatric Facility
  - CDI program advised physicians to document “anorexia” instead of “failure to thrive” or “feeding issues”
  - This affects the SOI (anorexia) under payment for services rendered in the APR DRG program of reimbursement
  - External audit found a compliance documentation issue
Another New CDI Guideline
AHIMA 2014 (ICD10)

**Systemic Infection/Inflammation**
- Bacteremia (positive blood cultures only)
- Urinoplasma—MUST specify sepsis with UTI versus UFI 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 ..................
- 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)?
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)
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

Current 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)
What Should a Compliance Department Do?

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
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!