



# Coding Compliance and CDI Compliance Programs

What Compliance Officers Need to Know or Should Know under  
Auditing and Monitoring Guideline-Avoiding Headaches

By  
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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 under compliance-audit and monitor

## Coding is Key to Data Quality

- Coding depends on physician/non-physician documentation
- 2011: ICD9 and the RACs—Findings in Medicare Quarterly Provider Compliance Newsletters
- 2015: CMS-Hierarchical Condition Category (HCC) risk adjustment model for predicting costs of dual eligible beneficiaries
  - The CMS-HCC risk adjustment model is used to calculate risk scores to adjust capitated payments made for aged and disabled beneficiaries enrolled in Medicare Advantage (MA) plans and certain demonstrations.
- State Medicaid Programs: Utilize All Patient Refined-Diagnostic Related Groups (APR-DRGs) for reimbursement-calculating severity of illness and risk of mortality (SOI and ROM)

## ICD10 Coding 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—move to a prebill review
- **CMS Hospital Compare website allows the consumer to “shop” and finally select healthcare providers online.**
  - **Quality measures–Jan 2016 Sepsis was added to this list of “core measures”. Core measures are the PSI’s – Patient Safety Indicators**

## A Conflicting View between Coding and CDI -Acute Respiratory Failure (ARF)-

- 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 physician board member.
- Coder: Typically the physician gets the last say; and the code is entered into the patient's data base
- CDI specialist: Some are trained to ask the physician to document ARF "in virtually every patient's medical record/EMR" when the documentation may state: *"acute exacerbation of chronic obstructive pulmonary disease OR pneumonia and the lab value shows either a low partial oxygen pressure (pO2) or a high carbon dioxide partial pressure (pCO2)"*

## With-- ICD10-CM Evaluated, Monitored, Treated

- **Respiratory failure, not elsewhere classified J96-** >
- Type 1 Excludes
  - acute respiratory distress syndrome (I80)
  - cardiorespiratory failure (R09.2)
  - newborn respiratory distress syndrome (P22.0)
  - postprocedural respiratory failure (I95.82-)
  - 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
  - Queries should be answered before coding/billing

# Data Profiling Watchdogs

They have been here for a long time

## Performance Watchdogs- just a few of those who have been looking

- HealthGrades----Healthgrades.com
- Leapfrog Group- uses 28 national performance measures-PSIs (patient safety indicators)
- Recovery Audit Contractors (RAC)—on limited hold—CMS reported in 2016 a 91% decrease in their recoveries since being placed on 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
- QIO—Quality Improvement Organizations (TMF)

## What is a QIO?

- Since 1984, Medicare Quality Improvement Organizations (QIOs) have been a driving force for quality improvement throughout the country. The Centers for Medicare & Medicaid Services (CMS) has transformed the QIO program to more effectively support the National Quality Strategy, and has again looked to the QIO program to work side-by-side with providers and patients in all settings of care. CMS has charged the Quality Innovation Network (QIN) QIOs with implementing strategies facilitating quality improvement throughout the health care system.

## Watchdog Overall Objectives

- 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; for example–CMS chronic care management project (involves coding)

## 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.

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PEPPERresources.org is the official site for information, training and support related to the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments.

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## Monitoring Basic Defined

- “Effective auditing and monitoring plans will help hospitals avoid the submission of incorrect claims to Federal health care program payors. Hospitals should develop detailed annual audit plans designed to minimize the risks associated with improper claims and billing practices.”
  - Federal Register /Vol. 70, No. 19 /Monday, January 31, 2005 /Notices
- Monitoring–
  - Risk foundation
  - Focus on internal controls
  - Can be continuous within the process
  - Goal is to have internal control– preventive or detective
  - Per previous slide–know your databases for compliant monitoring

## 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 (value based payment) 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.

## Clinical Documentation Improvement Programs

# CDI History

## 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 missing in I9 coding:
  - 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.

## What is MedPar?

- Researchers who are interested in studying inpatient utilization (e.g. hospital stays) have two options:
  - the Inpatient claims file or the Medicare Provider Analysis and Review (MedPAR) file.
- It is important to note that the differences between the two files will vary depending on whether a researcher is interested in the Research Identifiable File (RIF) or Limited Data Set (LDS) versions of the two files.
- *Data review and analysis can and is often complicated*
  - *<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/MEDPAR.html>*

## An Example-Data Comparison to CMS MedPar-(Green is sign of opportunity)

DRG Group	DRG Group Description	Cases	Hosp CC Rate	Bench CC Rate	Hosp MCC Rate	Bench MCC Rate	Hosp CMI	Bench CMI	Potential Opportunity (1)	Potential RAC Risk (2)
193/194/195	SIMPLE PNEUMONIA & PLEURISY	99	88%	74%	36%	22%	1.15	1.04		X
190/191/192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	93	81%	65%	54%	33%	1.04	0.96		X
291/292/293	HEART FAILURE & SHOCK	77	86%	75%	30%	30%	1.12	1.08		X
469/470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	66	6.1%	4.0%	6.1%	4.0%	2.19	2.16		
391/392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS	64	4.7%	12%	4.7%	12%	0.74	0.77	X	
308/309/310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	53	49%	55%	15%	20%	0.76	0.80	X	
871/872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS	48	63%	65%	63%	65%	1.63	1.65	X	
896/897	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY	47	8.5%	11%	8.5%	11%	0.72	0.74	X	
064/065/066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	34	88%	68%	26%	20%	1.31	1.19		X
377/378/379	G.I. HEMORRHAGE	34	76%	76%	15%	17%	1.06	1.07	X	
689/690	KIDNEY & URINARY TRACT INFECTIONS	28	39%	20%	39%	20%	0.96	0.87		X
480/481/482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT	27	85%	74%	26%	15%	2.15	1.98		X
640/641	NUTRITIONAL & MISC METABOLIC DISORDERS	26	15%	17%	15%	17%	0.76	0.77	X	
602/603	CELLULITIS	25	20%	12%	20%	12%	0.97	0.91		X
329/330/331	MAJOR SMALL & LARGE BOWEL PROCEDURES	22	95%	78%	32%	32%	3.40	3.23		X
438/439/440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	21	62%	62%	24%	16%	1.08	1.02		X
177/178/179	RESPIRATORY INFECTIONS & INFLAMMATIONS	20	90%	85%	50%	36%	1.73	1.62		X
388/389/390	G.I. OBSTRUCTION	18	72%	61%	28%	14%	1.05	0.92		X

## 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?*

## CDI programs do affect coding and quality

- The negative impacts of poor quality documentation are many. This is particularly true for multi-location healthcare organizations and those sharing data within a health information exchange or accountable care organization.
- Clinical coding is based solely on the medical record (clinical) documentation by the physician.
  - Coders are only permitted to code what is documented by physicians and other providers such as NPs and PAs. Therefore coding, reimbursement and case mix are directly impacted when documentation is missing, unclear or insufficient.
  - Coders are forced to use non-specific codes, resulting in lower-paying DRGs and faulty case mix index.
- Quality scores and HealthGrades reporting are also based on coded data — again stemming from the clinical documentation in the medical record. Quality scores could be falsely reported due to improper documentation, placing organizations in a one-down position in local and regional care markets.
- Ongoing patient care is impacted when the next physician in line is unclear or misinformed.
- Additional costs may be incurred as physicians are forced to repeat tests and exams when the original, treating clinician failed to fully document what was performed, ruled out or treated.

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

- These calculations are based on the interaction of multiple co-morbidities and disease processes; and often reflect Quality of care elements
- 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.
  - CDI should focus on accurate documentation for ALL diagnoses affecting a patient's stay NOT just the CC or MCC categories.
- SOI (Severity of Illness)
- ROM (Risk of Mortality)

## A potential facility issue under APR DRG

- **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—internal coding guidelines
    - Applicable To
      - Malnutrition NOS
      - Protein-calorie imbalance NOS
      - Type 1 Excludes • nutritional deficiency NOS (E63.9)

## QIO Sepsis Watchdog: Current Coding/CDI Discussion

- 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)?
    - In 2016 CDI vs. Coding dilemma with sepsis per new guidelines—oops! CMS tried to settle it.

## 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 specificity now rests with organism defined AND organ dysfunction

## 2018 Update to Sepsis

- e.g. Sepsis Coding Guideline

".....If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider" . .

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## An Overzealous CDI Person

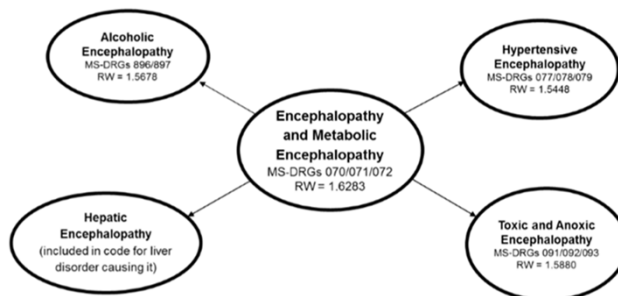
- “AMS” – broad term that does not communicate patients’ severity of illness or complexity of care during coding. “Encephalopathy” does, and it should be used when applicable or reasonable to suspect.
- Side note: Conditions that contribute substantially to the severity of illness and complexity of care are designated by CMS and are called:
  - Major Complications & Comorbidities (MCCs)
  - and
  - Complications & Comorbidities (CCs) (impact less than MCCs)

## Leading #1

MCCs:

- Unconsciousness
- Coma
- Encephalopathy – broad term describing any disorder of cerebral function.
  - Alcoholic encephalopathy (G31.2) – damage to brain tissue caused by thiamine deficiency
  - Anoxic encephalopathy (G93.1)
  - Encephalopathy, unspecified (G93.40)
  - Hepatic encephalopathy (K72 – hepatic failure, not elsewhere classified)
  - Metabolic encephalopathy (G93.41) - due to such things as fever, dehydration, electrolyte imbalance, acidosis, hypoxia, infection, and organ failure.
  - Other encephalopathy (G93.49)
  - Toxic encephalopathy (G92) – refers to effects of drugs, toxins, poisons, and medications.
  - Septic encephalopathy (G93.41) – represents manifestation of severe sepsis

## Leading #2



## Leading #3

### CCs:

- Alcohol dependence with alcohol-induced persisting dementia (F10.27)
- Alcohol abuse/dependence/use with intoxication delirium (F10.121; F10.221; F10.921)
- Alcohol/drug withdrawal
- Anoxic brain damage, NEC (G93.1)
- [Specific drug] abuse/dependence/use with intoxication delirium (or withdrawal)
- Delirium due to known physiological condition [specified cause] (F05)
- Dementia with behavioral disturbance (F03.91)
- Hypertensive encephalopathy (I67.4)
- Persistent vegetative state (R40.3)
- Sedative, hypnotic or anxiolytic abuse/dependence/use with intoxication delirium (or withdrawal)
- Stimulant abuse/dependence/use with intoxication delirium (or withdrawal)

## The True Picture for the Physician per Coding & CDI

- Altered Mental Status is a sign/symptom that can point towards one of the following dependent on physician documentation:
  - Alzheimer's
  - CVA
  - TIA
  - Encephalopathy
  - Hypertensive Encephalopathy
  - Coma
  - Drug induced delirium
  - Dementia
  - UTI
  - Diabetic Ketoacidosis
  - Hepatic Encephalopathy
  - Seizures

## Looking at the documentation

### ICD10 Coding Issues



## 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)

## CMS says August 2016

- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined).
- In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.
  - Reference: [www.cms.gov/medicare/coding/icd10/downloads/icd-10mythsandfacts.pdf](http://www.cms.gov/medicare/coding/icd10/downloads/icd-10mythsandfacts.pdf)

## High Cost-High Volume-Compliance Review

- 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 or COPD (on CMS chronic care management list)
    - 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

## MACRA Law (2015) Data is reviewed.....Resulting in

- Consolidates three existing quality reporting programs, plus adds a new program, into a single system through MIPS:
  - Physician Quality Reporting System (PQRS)
  - Value Based Payment Modifier (VBPM)
  - Meaningful Use (MU)
  - Clinical practice improvement activities (CPIA)
- **And who is watching all of this? Quality Improvement Organizations (QIOs).**

## What Should a Compliance Department Do?

Monitoring allows for early identification and correction before a problem festers and causes the company to be in non-compliance.



## 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.
  - OIG Workplan Annual Review for Monitoring Categories
- 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."

## Ongoing-Compliance Overview

### 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? Review of MCC DRG List?
- 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 (internal or external) 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

## Coding & CDI Documentation Risk EMR Areas

- EMR 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
  - CMS Chronic Care Management Programs are evaluating databases now (HCC letters)
- 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.
- **Coders are not involved in some settings for appropriate code assignment –the EMR is!!!**

## Overall Compliance Improvement

- Should be expected and seen in the following areas:
  - Communication between departments–sit in on the coding and CDI team meetings
  - 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 for Coding/CDI

- 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 for clinical truth. 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