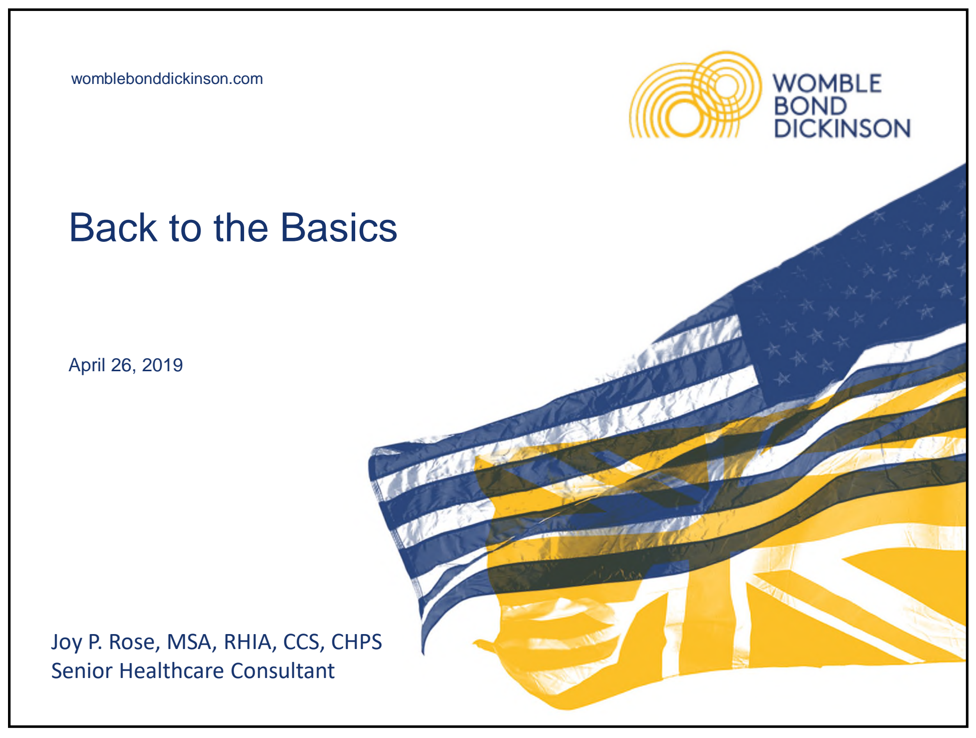



# Back to the Basics

- This presentation will focus on basic coding conventions and guidelines, and specifically why this knowledge is essential within your organization. As healthcare continues to evolve, accuracy in ICD-10 assignment continues to be crucial for compliant coding in any setting. By getting "back to the basics", we can be confident in the accuracy of our code selections.

# • GOALS/OBJECTIVES

## Coding Compliance

- Snapshot review of ICD-10-CM coding guidelines
- Review of coding compliance risk concerns in the outpatient clinic based setting
- Review of coding and clinical documentation (CDI) concerns
- Provide hints to improve compliance outcomes

## What is Clinical Coding

- The review of patients' records to translate and assign numeric codes for each diagnosis and procedure following Official Coding & Reporting Guidelines
- A coder should possess expertise in the ICD-10-CM and CPT coding systems and be;
- Knowledgeable about medical terminology, disease processes, and pharmacology and;
- Well-informed on documentation, billing, reimbursement systems and methodologies and compliance

## Back to the Basics

- Clear and accurate diagnosis and procedure code reporting provides valuable information about patient care.
- It also provides important information for accurate reimbursement and medical necessity determination.

## Back to the Basics

- Inaccuracy in clinical coding creates distorted or misinterpreted information about patient care and on a higher or administrative level, also can result in faulty investment decisions to improve health care delivery.
- Reimbursement and fiscal well-being relies on complete and readily available health record documentation to accurately assign the codes for the billing.
- Basically, without quality documentation, quality coding will not occur which can lead to clinical and administrative decisions that affect the fiscal health of an organization.

## OFFICIAL CODING GUIDELINES
## Format and Structure

2019 GUIDELINES

- Section I. Conventions, general coding guidelines and chapter specific guidelines
- Section II. Selection of Principal Diagnosis
- Section III. Reporting Additional Diagnoses
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

## OFFICIAL CODING GUIDELINES

- **Section I. Conventions for ICD-10-CM**
- Placeholder character “X”. This is used to allow for expansion, where a place holder exists the “X must be used for the code to be valid
- Compliance with specificity
  - Codes may 3, 4, 5, 6 or 7 characters long
  - Simply put – codes are only permissible, not categories or subcategories,
  - so assign a code to the highest character in the code,

1. i.e., if there is an applicable $7^{th}$ character then assign the $7^{th}$ character.

# Abbreviations in Tabular and Alphabetic Indices

- **Unspecified or not ?**
- NOS
  - **NOT OTHERWISE SPECIFIED** = represents "not otherwise specified" or the equivalent of unspecified.
- NEC
  - **NOT ELSEWHERE CLASSIFIABLE** = when a specific code is not available for a condition

# When to use NEC or NOS?

- When would you use NOS or NEC?
- When the information in the record is insufficient to assign a more specific code. Answer: Use NOS code.
- When the record provides detail and a specific code does not yet exist. Answer: Use NEC code.
  - Examples:
    I69.39 Other sequelae of cerebral infarction?

Is this NOS or NEC? Answer: this represents NOS

  - "Cognitive deficits following cerebral infarction"

Is this NOS or NEC? Answer: neither, this is a specific code and would be I69.31

## Punctuation / Inclusion Terms

- Inclusion terms are not necessarily exhaustive. These terms are the conditions for which that code is to be used.
- **EXCLUDES 1 AND EXCLUDES 2**
  - What do they mean?
  - Excludes 1 “NOT CODED HERE”
  - Excludes 2 “Not included here”

## Punctuation / Inclusion Terms

- Parenthesis ( )
- Brackets [ ]
- Colons :

- () Enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. They are referred to as nonessential modifiers.
- [] identify manifestation codes
- - : used after an incomplete term which needs more to make it assignable.

# OUTPATIENT

- **Section IV Outpatient Coding Guidelines**

# Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

- “These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.”

## Section IV. Outpatient

- Section I. Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits
- C. Accurate reporting of ICD-10-CM diagnosis codes For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter

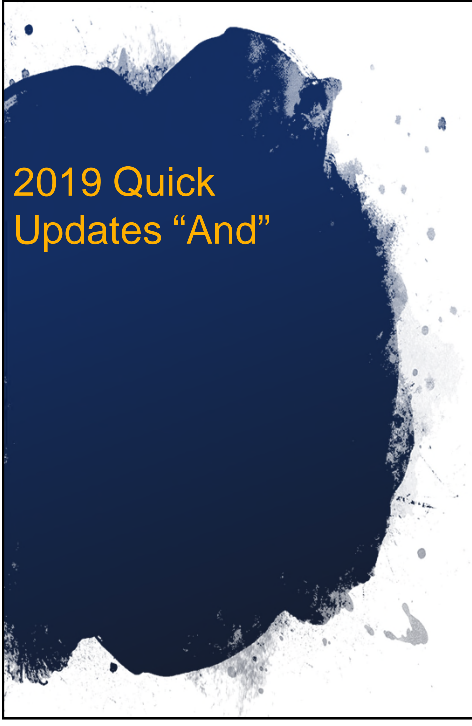
## Section IV. Outpatient

- I. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

## Section IV. Outpatient

- J. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80- Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment

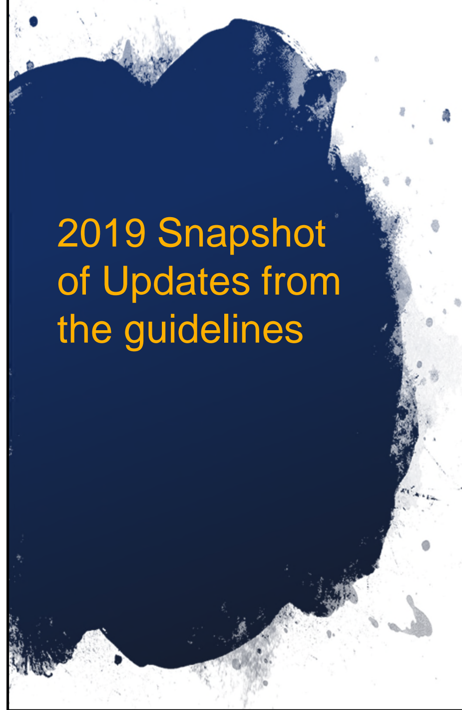
17



## 2019 Quick Updates "And"

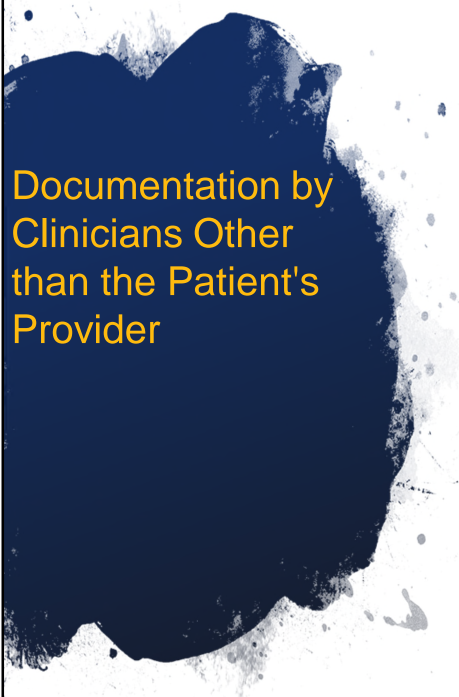
- The word "and" should be interpreted to mean either "and" or "or" when it appears in a title. For example, cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints. The "with" guidelines at times has conflicted with coding clinic, pay careful attention to the conventions and coding clinic.

- "With" The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or sub term), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").




- Additional updates to the 2019 *Guidelines* include, but are not limited to, the following topics and conditions:
- Body mass index
- Burns of the same anatomic site
- Documentation by clinicians other than the patient's provider
- Drug use during pregnancy, childbirth, and the puerperium
- Factitious disorders
- Healthcare encounters in hurricane aftermath
- Underdosing

- Assign Z01.89, Encounter for other specified special examinations.
- If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

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## Documentation by Clinicians Other than the Patient's Provider

- Assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale).

## Documentation by Clinicians Other than the Patient's Provider

- However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.
- EXCEPTIONS: BMI, Depth of non-pressure chronic ulcers, pressure ulcer stage, NIH stroke code

## Documentation by Clinicians Other than the Patient's Provider

- For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses.
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 Page 18 of 120. The BMI, coma scale, NIHSS codes and categories Z55-Z65 should only be reported as secondary diagnoses.

## "Borderline" Diagnosis

- Borderline Diagnosis If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

## Use of Sign/Symptom/Unspecified Codes Sign/symptom and unspecified

- Use of these codes have acceptable, even necessary, uses.
- Each healthcare encounter should be coded to the level of certainty known for that encounter.

## Code for what?

- Medical Necessity
- Denials
- Nursing/ancillary documentation
- Start/stop
- Scan paper test results
- Acute and chronic conditions
- Problem lists not updated
- MDM not justified?
- , justify services rendered
- promote continuity of care
- support proper reimbursement.

28

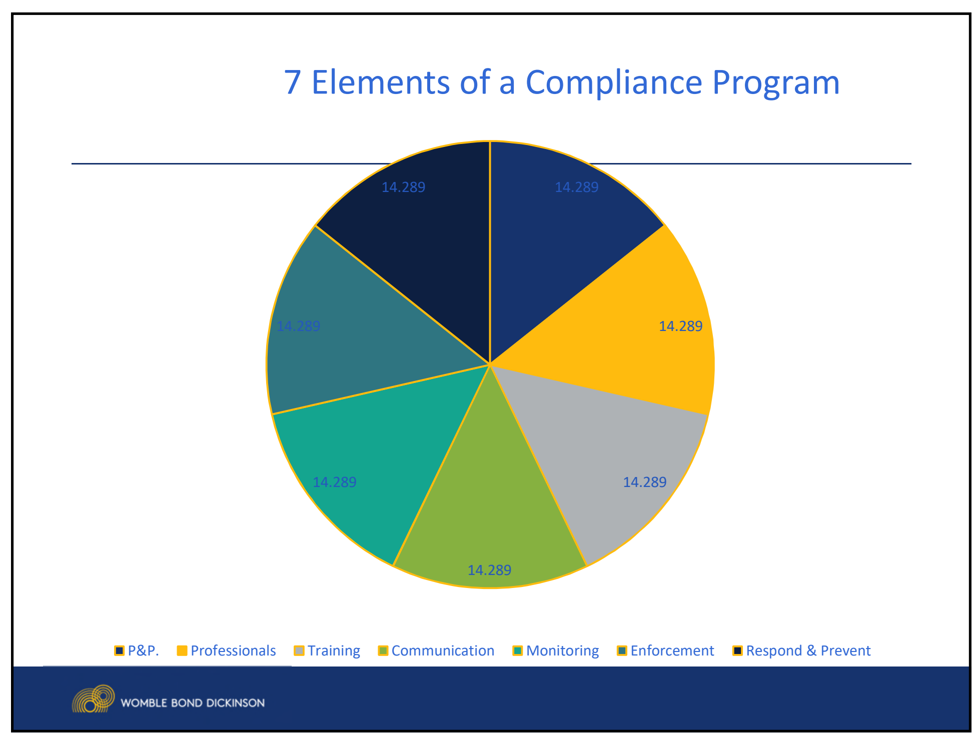
# FY 2018 Improper Payment Rates

- https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf

# CMS CERT Medicare Report FY 2018

- 91.9 Percent Accuracy Rate and
  - $357.7 billion dollars
- 8.1 Percent Improper Payment Rate 1, 2, 3
  - $31.6 billion dollars

  - What percentage is from incorrect coding?
    11.9%




# *Seven Elements of a Compliance Program:

1. Written policies and procedures (Standards of Conduct)
2. Compliance Professionals
3. Effective training
4. Effective communication
5. Internal Monitoring (Reporting & Investigation)
6. Enforcement of Standards
7. Response and Prevention

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https://oig.hhs.gov/compliance/provider-compliance-training/index.asp#materials

OUR CULTURE IS GREAT
WORLD'S
BEST
BOSS
WE DON'T EVEN NEED TO ASSESS IT

Open lines of communication are necessary for a culture of compliance
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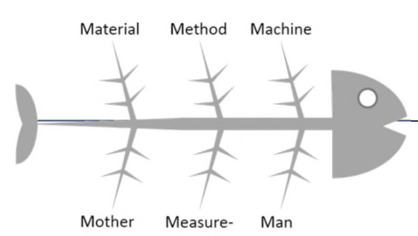
34

## Risk Assessment




- Conduct a Risk Assessment or conduct a snapshot. Ask yourself:
- Are payors requesting refunds?
- Is my AR down, where is this decrease coming from?
- Fish Bone Diagram – invaluable.
- If claim denials are an area of focus, drill down into the denials to conduct an analysis of audit findings and medical necessity reviews.

## One Prominent Risk- Denials

- Are denials due to misleading, inadequate, and/or poor clinical documentation?
- Many problem-prone areas have well defined expectations on how to minimize denial risk and avoid intensified reviews, such as National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

# Education -A Core Component to Compliance

Where do I start to educate?

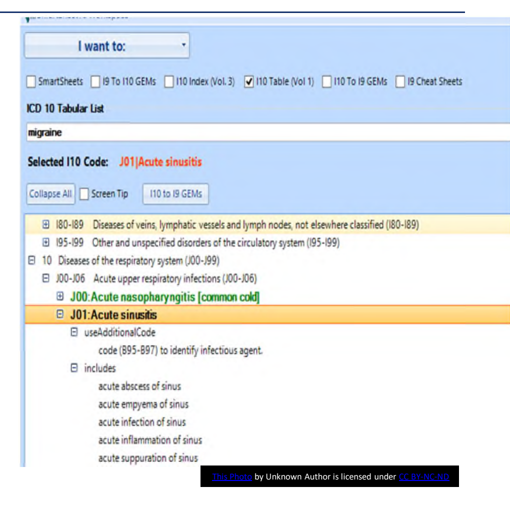
First identify the root cause of the identified problem (fish bone diagram or flow charts)

Second start with the basics.

Some suggestions follow

# CODE LOOK UP - Educate

- Locating a code in the ICD-10-CM to correspond to what is documented in the medical record
- Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.
- How do you assist your provider or coding staff find the most accurate codes
  - Know your system
  - Practice look up with top 20 most common codes in your practice
  - Educate



## CMS-HCC

- Prospective model
  - Collects data in the year to determine expected costs for the following year
- Examines how demographic characteristics and health diagnoses relate to expenditures for population
- Diagnostic groups are organized into condition categories ranking conditions with similar cost patterns
- Focus on long term conditions, e.g. CHF, diabetes

## CMS - HCC

- An individuals HCCs are valid for one year, January 1 becomes blank
- Importance of updating problem lists
- Assigning codes for chronic conditions
- Training all staff on the importance of documentation

## 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

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# TIPS FOR CODING COMPLIANCE BEST PRACTICES

- Regular coding reviews (audits) -Develop an internal audit team and utilize external auditors
- Random Quality Audits
- Coder Quality 95% or higher
- All payers
- Track/Trend Denials: produce reports, compare monthly or quarterly
- Conduct follow up for all claims – policies and procedures
- Education and Audit and always repeat
- Educate CDI professionals on appropriate querying

# SUGGESTIONS FOR CODING COMPLIANCE BEST PRACTICES

- Work with physician's on documentation
- Importance of documentation cannot be stressed enough
- Collaboration – ongoing between provider, ancillary and coding staff
- Champion / Liaison / Gatekeeper between physician and staff
  - Ethical
  - Good communicator
  - Viewed as a Leader
- Always open and transparent

## REFERENCES


- ICD-10-CM Official Guidelines for Coding and Reporting FY 2019, https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf
- CMS Medicare FFFS Compliance Program CERT 2018 Improper Payment Report: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf
- The Office of Inspector General –U.S. Department of Health and Human Services. https://oig.hhs.gov/compliance/provider-compliance-training/index.asp#materials
- Clack, Crystal; Freeman, Rae; Lewis, Laquette. "Provider's Condensed Resource for Revenue Cycle, Coding Tools, and More" *Journal of AHIMA* 88, no.1 (January 2017): 44-47. http://bok.ahima.org/doc?oid=302019#.XMIDeqqWzVg

## OUTPATIENT CLINIC: COMPLIANCE RISK

- Modifiers continue to be a 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
- 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

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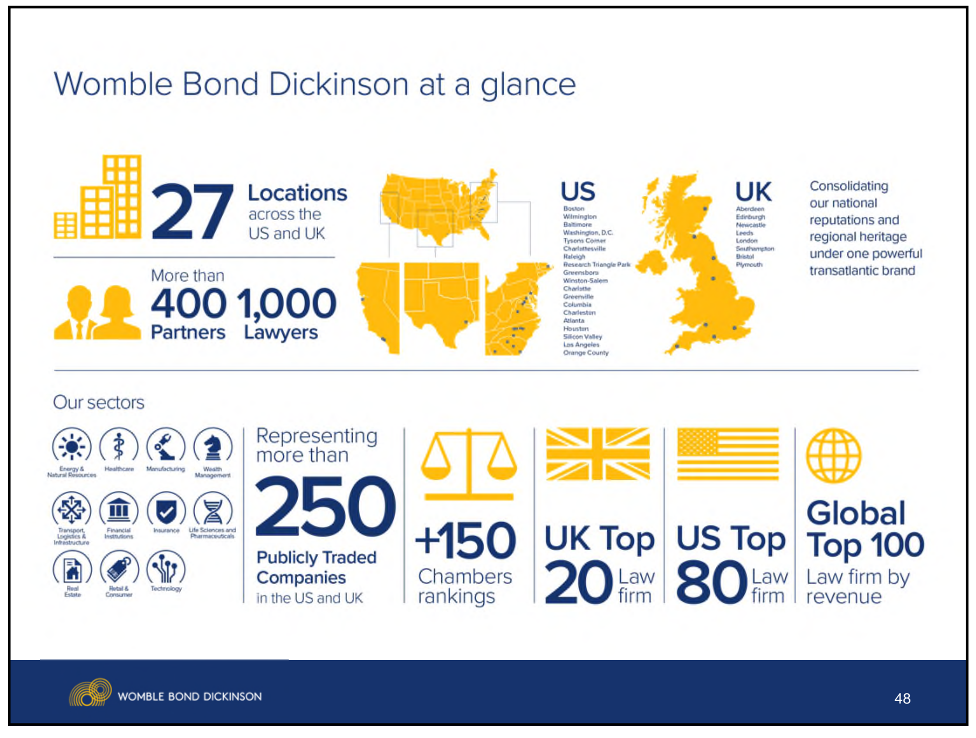
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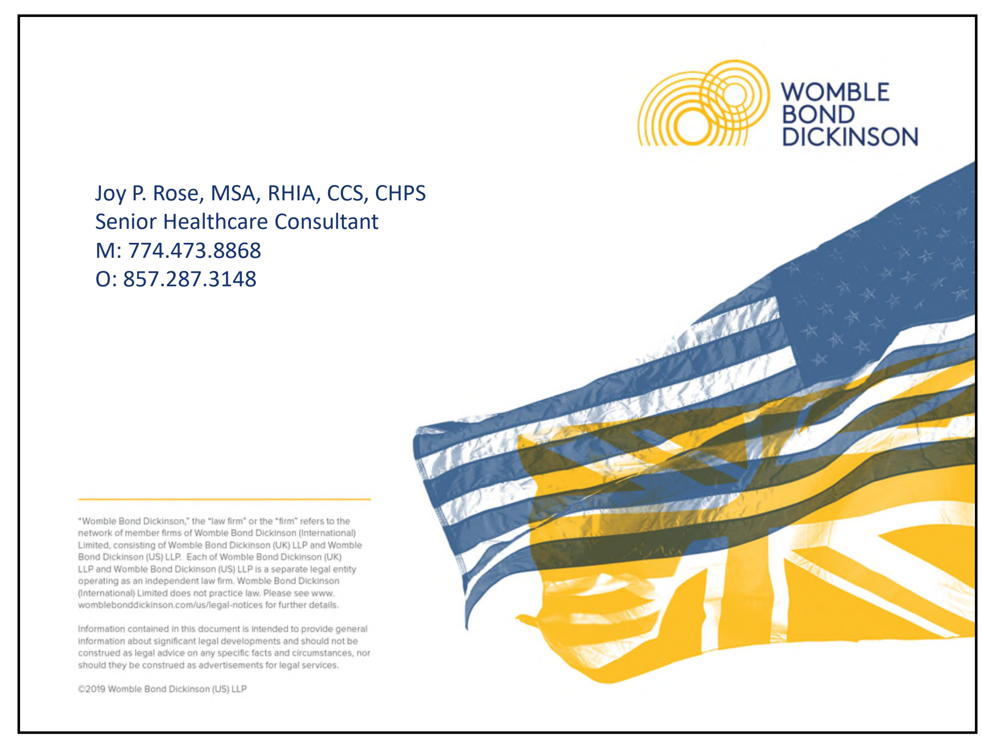
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