From Patient-to-Payment,℠ nThrive empowers health care for every one in every community.®

How Provider Documentation Impacts Coding and Reimbursement

Jason Siedman, VP Business Development

Jennifer Stager, Director Business Development

LEARNING OBJECTIVES

- ✓ Common opportunities for poor documentation
- ✓ Coding struggles based on poor documentation
- ✓ Benefits of routine audits

Agenda

- What a Health Information Management Coder is
- How coding impacts reimbursement
- How Coders determine what codes to assign
- Opportunities for poor documentation
- Common coding struggles based on poor documentation
- How to monitor documentation and coding

What is a Health Information Management (HIM) Coder?

HIM Coders

Are trained in	• Coding of ICD-10-CM/PCS, CPT, HCPCS, and Modifiers as well as the guidelines and official references that govern the coding of these code sets • Correct application of NCCI (National Correct Coding Initiative) edits • Reimbursement methodologies
Work in	• Hospitals • Clinics • Physician Offices
Educated by	• Thorough on-the-job training with possession of a medical field degree • Certification program in Health Information • College degree in Health Information

HIM Coders
Credentials

American Health Information Association (AHIMA) include

- **CCA** (Certified Coding Associate)
- **CCS** (Certified Coding Specialist)
- **CCS-P** (Certified Coding Specialist – Physician based)
- **RHIT** (Registered Health Information Technician) – associate's degree
- **RHIA** (Registered Health Information Administrator) – bachelor's degree

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American Academy of Professional Coders (AAPC)

- **CPC** (Certified Professional Coder)
- **COC** (Certified Outpatient Coder)
- **CIC** (Certified Inpatient Coder)
- **CRC** (Certified Risk Adjustment Coder)
- Additional certifications based on specialty disciplines

HIM Coders
Education

At the minimum have completed courses in

- Medical Terminology
- Anatomy & Physiology
- ICD-10-CM/PCS
- CPT/HCPCS

With college degrees have completed courses in

- Pharmacology
- Psychology
- Human Pathology
- Healthcare Reimbursement Methodologies
- Health Information Law
- Health Care Statistics

HIM Coders
Annual Updates

Annually required to learn updates to

- ICD-10-CM/PCS codes, conventions, and guidelines
- For FY 2019 ICD-10-CM, there were 279 new codes, 143 revised codes, 51 deleted codes
- AHA Coding Handbook
- CPT-4 codes and guidelines
- For 2019, there were 335 code changes (additions, deletions, revisions)
- HCPCS codes and guidelines
- Modifiers and definitions
- NCCI policies
- Reimbursement methodologies

HIM Coders
Quarterly and Monthly Updates

Quarterly required to learn the updates to	• AHA Coding Clinic for ICD-10-CM/PCS • AHA Coding Clinic for HCPCS
Monthly required to learn updates to	• AMA CPT Assistant
Must stay abreast of	• Developing medical technologies • New diseases • New and updated medical terminology • New prescription and street drugs • State reporting requirements for certain sets of codes

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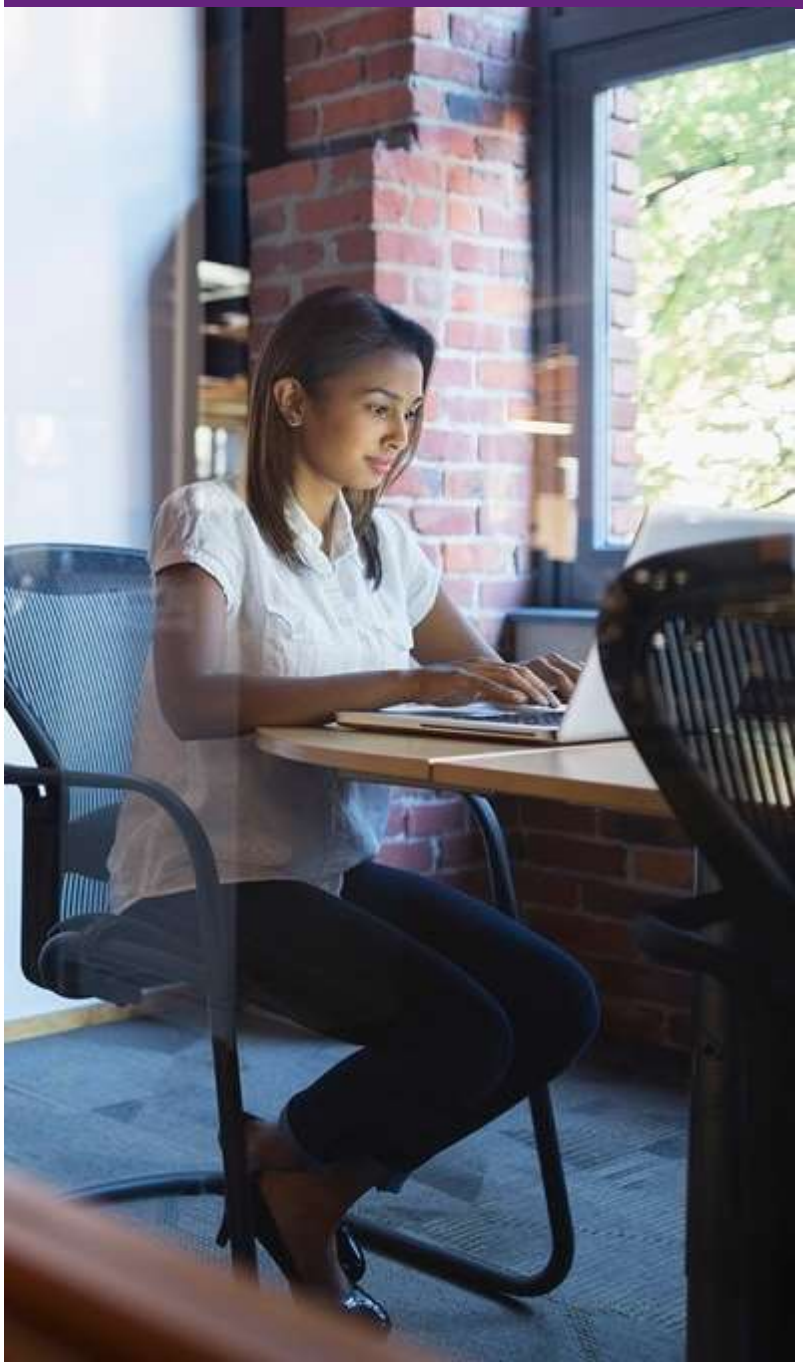
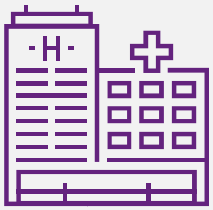


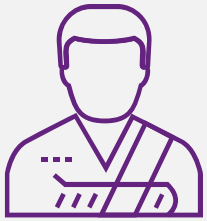
How Does Coding Impact Reimbursement?

Coding and Reimbursement
Inpatient



- **Acute care claims** are primarily paid based on MS-DRG
- **Most of the remaining acute care** claims are paid by APR-DRG
- **The grouping methodology** in both MS- and APR-DRG is dependent on ICD-10 code assignments
  - A few groups are based solely on the principal diagnosis
  - Most are dependent on the principal diagnosis and secondary diagnosis
  - Many operating room procedures can impact the grouping

Coding and Reimbursement
Outpatient and Other



- **CMS outpatient claims** are usually paid by the CMS APC methodology which is based primarily on CPT / HCPCS coding
- **Some insurers pay based on the CMS methodology** while others pay based on their own fee schedule which are also usually based on CPT / HCPCS coding
- **Other patient types** have varying payment methodologies, most of which are dependent on coding
- **Not all codes that impact reimbursement** are coder-driven, particularly in the outpatient setting, as many are entered via charge entry

How do Coders determine which codes to assign?

Available Codes from a Financial Perspective

68,000 ICD-10-CM (diagnosis) codes used for all patient types	• Have the greatest financial impact in the inpatient setting • Support medical necessity for other patient types
87,000 ICD-10-PCS (procedure) codes used primarily for inpatient	• Many have financial impact
71,932 CPT (Current Procedural Terminology) codes used for outpatient and professional fee patient types	• Usually drive financial impact
71,932 CPT (Healthcare Common Procedural Coding System) codes used for outpatient and profession fee patient types	• Usually drive financial impact

ICD-10-CM/PCS Official Guidelines for Coding and Reporting

Preamble to the guidelines

- 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.
- 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.

ICD-10-CM/PCS Official Guidelines for Coding and Reporting

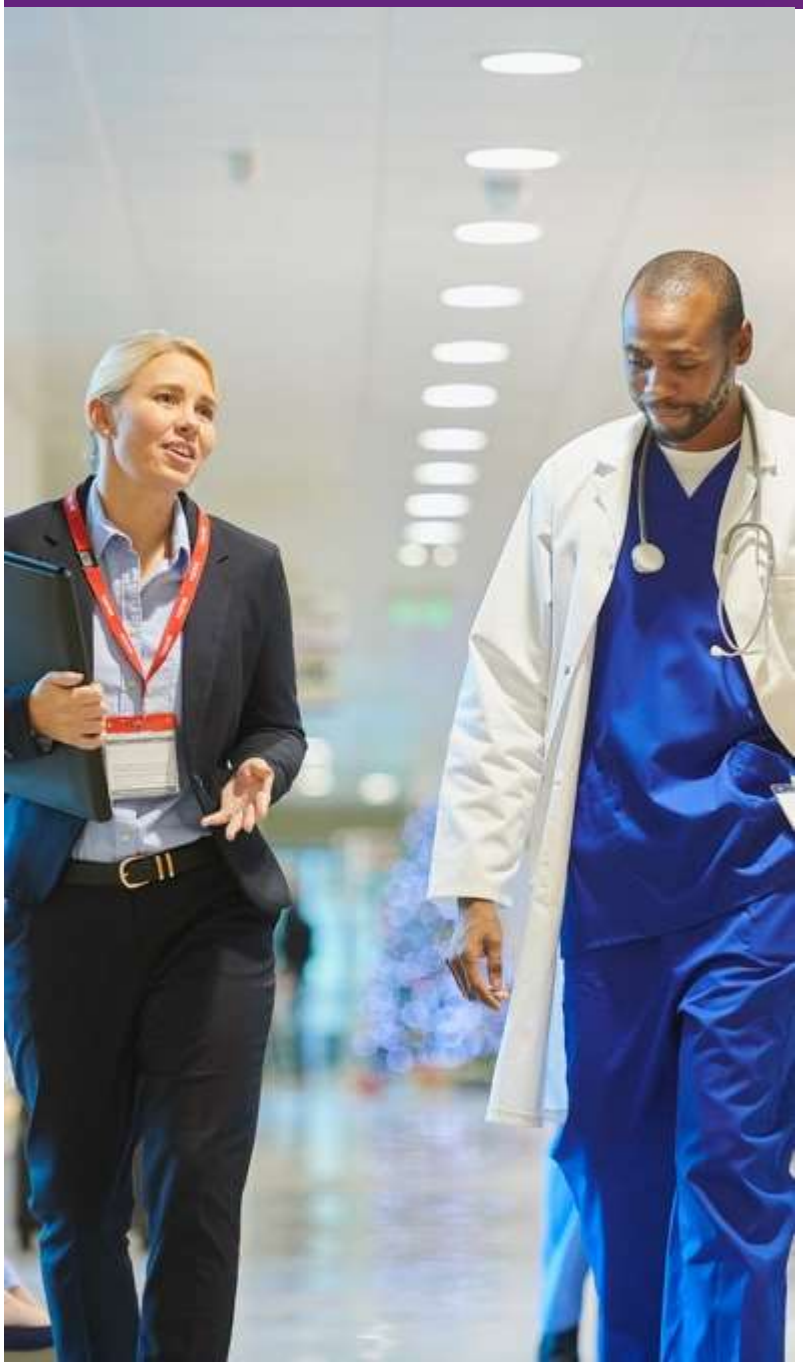
- Of the 68,000 ICD-10-CM codes, **there are only 5 sets of codes that can be assigned** based on non-provider documentation but only when the provider documents the related condition
  - BMI (60 codes)
  - Non-pressure ulcer depth (24 codes)
  - Pressure ulcer stage (150 codes)
  - Coma scale (19 codes)
  - Stroke scale (43 codes)
- There are separate rules for outpatient
  - Signs and symptoms can be coded
  - Uncertain diagnoses cannot be coded

CPT Guidelines

- Select the name of the procedure or services that accurately identifies the service performed.
- Do not select a CPT code that merely approximates the service provided.
- If no such specific code exists, then report the service using the appropriate unlisted procedure or service code…
- Any service or procedure should be adequately documented in the medical record.

Steps to Code Assignment

- ✓ Review of entire medical record
- ✓ Apply guidelines to determine what diagnosis and procedure codes can be assigned based on the documentation in the medical record
- ✓ Check official references when guidelines are not clear
- ✓ Enter the codes into the abstracting system
- ✓ Check the edit messages
  - This code cannot be used with that code
  - Use of these codes may be subject to review
  - Use of these codes may require a modifier for justification
- ✓ Review record again if necessary
- ✓ Make required changes
- ✓ Check edits again
- ✓ Finalize coding



How does documentation impact coding?

Level of Specificity
Heart Failure

- Arteriosclerotic
- Biventricular
- Biventricular due to left heart failure
- Combined left-right sided
- Combined left-right sided due to left heart failure
- Compensated
- Congestive
- Congestive with active rheumatic fever
- Congestive with inactive or quiescent rheumatic fever
- Congestive, rheumatic chronic
- Congestive, rheumatic, active or acute
- Congestive, rheumatic, active or acute, with chorea
- Decompensated
- Degenerative – see Degeneration, myocardial
- Diastolic, unspecified - CC
- Diastolic, acute – MCC
- Diastolic, acute and chronic – MCC
- Diastolic, chronic – CC
- Diastolic, combined with systolic, unspecified – CC
- Diastolic, combined with systolic, acute – MCC
- Diastolic, combined with systolic, acute and chronic – MCC
- Diastolic, combined with systolic, chronic – CC
- Due to presence of cardiac prosthesis – CC
- End Stage
- Following cardiac surgery – CC
- High output
- Hypertensive
- Left – see Failure, ventricular – CC
- Left, combined diastolic and systolic – see Failure, heart, diastolic, combined with systolic
- Left, diastolic- see Failure, heart, diastolic
- Left, systolic – see Failure, heart systolic
- Low output
- Rheumatic
- Right
- Right, acute
- Right, acute and chronic
- Right, chronic
- Right, secondary to left heart failure
- Specified, not elsewhere classified
- Stage A
- Stage B
- Stage C
- Stage D
- Systolic
- Systolic, acute
- Systolic, acute and chronic
- Systolic, combined with diastolic
- Systolic, combined with systolic, acute
- Systolic, combined with diastolic, acute and chronic
- Systolic, combined with diastolic, chronic
- Thyrotoxic

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Common Level of Specificity Issues
Diagnosis

Skin ulcers

- With gangrene – CC
- With bone involvement without necrosis – CC
- With bone involvement with necrosis
- With muscle involvement without necrosis – CC
- With muscle involvement with necrosis
- With fat layer exposed
- With other specified severity – CC
- Decubitus / pressure – stages 3 and 4 are MCC
- Varicose

Type 2 diabetes mellitus

- With hyperosmolality – MCC
- With ketoacidosis – MCC
- With kidney complications
- With diabetic retinopathy
- With neurological complications
- With circulatory complications without gangrene
- With circulatory complications with gangrene – MCC
- With hypoglycemia
- With hypoglycemia with coma – MCC

Common Level of Specificity Issues
Procedures

Skin ulcers
- Excisional – can have DRG impact
- Non-excisional
- Skin grafting – can have DRG impact

Respiratory system
- <96 hour v >96 hours of mechanical ventilation

Musculoskeletal
- Biopsy v excision
- Partial prosthesis removal v removal and replacement

Graft material
- Allograft v Autograft

Lesion size and Laceration length
- If size is not documented, the CPT code for the least size is assigned

Lesion type
- Malignant v benign

Prosthetic devices
- Cemented v Uncemented

Infusions (nursing documentation)
- Start and stop times

Financial Impact
Examples by Encounter

APR-DRG Excisional debridement v Non-excisional debridement for post operative infection

- Excisional debridement: RW 1.4152 or national average of $10,614
- Non-excisional debridement: RW 0.7820 or national average of $5,865
- Difference: RW (0.6332) or ($4,749)

MS-DRG Extraction v Excision Aortic Lymph Node

- Extraction: RW 1.7275 or national average of $12,956.25
- Excision: RW 3.5242 or national average of $26,431.50
- Difference: 1.7967 or $13,475.25

Financial Impact
Examples by Encounter

MS-DRG Respiratory Infection/Inflammation with MCC v with CC

- With MCC: RW 1.8408 or national average of $16,806
- With CC: RW 1.2744 or national average of $9,558
- Difference: RW (0.5664) or ($7,248)

MS-DRG COPD v Asthma with Exacerbation

- With CC: RW 2.3584 or national average of $17,688
- With MCC: RW 3.9282 or national average of $29,461.50
- Difference: RW 1.5698 or $11,773.50

Financial Impact
Examples by Encounter

MS-DRG Principal Diagnosis Acute bronchitis v Aspiration pneumonia

- Acute bronchitis: RW 0.9401 or national average of $7,050.75
- Aspiration pneumonia: RW 1.8408 or national average of $13,806
- Difference: RW 0.9007 or $6,755.25

Full Term Neonate with Major Problems v with Significant Problems

- With major problems: RW 3.7969 or national average of $28,476.75
- With significant problems: RW 1.3439 or national average of $10,079.25
- Difference: RW (2.4530) or ($18,397.50)

Financial Impact
Examples by Encounter

MS-DRG Gastrointestinal Obstruction without CC/MCC v other Digestive System Diagnosis with CC

- GI Obstruction w/o CC/MCC: RW 0.5966 or national average of $4,474.50
- Aspiration pneumonia: RW 0.9431 or national average of $7,073.25
- Difference: RW 0.3465 or $2,598.75

MS-DRG COPD v Asthma with Exacerbation

- COPD: RW 0.7265 or national average of $5,448.75
- Asthma with exacerbation: RW 1.493 or national average of $11,197.50
- Difference: RW 0.7665 or $5,748.75

Financial Impact
Examples by Inpatient Audit

Audit 1
Large Annual Audit

- Over coding ($71,954.25)
- Under coding $39,722.25
- Net impact ($32,232.00)

Audit 2
Large bi-annual audit

- Over coding ($1,423.50)
- Under coding $8,658.00
- Net impact $7,234.50

Audit 3
Small quarterly audit

- Over coding ($37,609.50)
- Under coding $9,601.50
- Net impact ($28,008.00)

Financial Impact
Examples by Outpatient Audit

Audit 1
Large annual audit

- Over coding ($36,071.55)
- Under coding $18,317.26
- Net impact ($17,754.29)

Audit 2
Large bi-annual audit

- Over coding ($559.08)
- Under coding $4,102.06
- Net impact $3,542.98

Audit 3
Small quarterly audit

- Over coding ($0.00)
- Under coding $7,773.37
- Net impact $7,773.37

How does monitoring documentation and coding improve your outlook?

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Purpose of Audits

- **Monitor coding and documentation quality** as part of the coding and documentation compliance program
- **Provide education and support** to coding colleagues, CDI specialists and providers
- **Ensure the optimal** reimbursement is identified
- **Ensure accurate data** is available for analysis, benchmarking, scorecards, reporting, etc.
- **Ensure patients receive** accurate insurance/payer information about their care
- **Maintain compliance with all coding** and compliance guidance published by the American Hospital Association, the American Medical Association, and The Centers for Medicare and Medicaid Services (CMS)

Impact of Auditing

Improved coder accuracy

- Better understanding of coding guidelines, anatomy for procedure codes, and disease processes/progression
- Help with identifying incomplete, contradictory, ambiguous or unclear documentation

Improved documentation

- Supports coding accuracy
- Improves legal validity of the record

Realization of problem areas that may bring scrutiny from

- CMS
- Commercial Payers
- OIG

Improved Coder Accuracy

116 pages of ICD-10-CM (diagnosis) Guidelines

- **Conventions of ICD-10-CM** – 6 pages
- **General Guidelines** – 9 pages
- **Chapter Specific Guidelines** –86 pages
- **Selection of Principal Diagnosis** – 3 pages
- **Additional Diagnoses** – 2 pages
- **Outpatient Services** – 5 pages
- **Present on Admission** – 5 pages

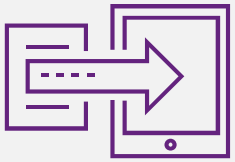
13 pages of ICD-10-PCS (procedure) Guidelines

- **Conventions of ICD-10-PCS** – 2 pages
- **Medical and Surgical Guidelines** – 6 pages
- **Body Parts** – 3 pages
- **Approach** – ½ page
- **Device** – ½ page
- **Obstetrics** – ½ page
- **New Technology** – ½ page
- **Principal Procedure** – ½ page
- **Plus** 12 tables of definitions

28+ pages of CPT (procedure) Guidelines

- Many guidelines are within a section rather than on a separate page

Improved Documentation



Most physicians are more concerned about providing quality care to their patients

- And we prefer that they are

Most physician's education on documentation to support coding is via

- A seminar
- One-on-one training from a mentor whose training was from a seminar
- Interaction with an office manager whose primary role is not coding
- Individual documentation issue review with CDI or Coding Specialist
- Interaction with auditors on audit findings

Documentation that supports code assignments provide a complete legal representation of the patient's visit

Prevent Scrutiny Resulting In

CMS

- Waste, Fraud and Abuse reviews
  - Fines
  - Sanctions
  - Participation exclusion
- Payment denials

Commercial Payers

- Payment denials
- Partnership revocation

OIG

- Fraud and Misconduct reviews
  - Fines
  - Program exclusions

In Summary

Many things impact proper payment for services rendered

- Documentation
- Charges
- Coding
- Timely billing

Use all available tools to ensure appropriate reimbursement is received

- Trending and projection reports
- Coding, Charge Capture, and CDI audits
- Up-to-date coding, abstracting and billing systems

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Questions

Contact Information

Jason Siedman
VP Business Development
jason.siedman@nthrive.com
703-819-7435

Jennifer Stager
Director Business Development
jstager@nthrive.com
678-248-8230

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Kelley Haddox, RHIT, CCS, NPB
khaddox@nthrive.com