Educational Breakout Session

Improving Revenue Capture: Best Practices in Coding, Documentation and Charge Capture

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PRESENTERS

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30 plus years in Health Information Management
Coding and Compliance education and training
AHIMA Certified ICD-10-CM/PCS Trainer

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BREAKOUT SESSION OVERVIEW

In this Session you will learn about:

1. Compliance and Internal Policies & Procedures
2. Coding Changes on the Horizon
3. Documentation & Charge Capture

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INTERNAL POLICIES AND PROCEDURES

- **Compliance**

  Should be at the heart of any organization's policies and procedures. The OIG has identified 7 fundamental elements to an effective compliance program.
  (Federal Register, Vol. 63, No. 243, December 1998)

  1. Implementing written policies, procedures and standard conduct
  2. Designating a compliance officer and compliance committee
  3. Conducting effective training and education

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INTERNAL POLICIES AND PROCEDURES

OIG 7 Fundamental Elements to Effective Compliance Program (cont'd):

4. Developing effective lines of communication
5. Enforcing standards through well-publicized disciplinary guidelines
6. Conducting internal monitoring and auditing
7. Responding promptly to detected offenses and developing corrective action

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INTERNAL POLICIES AND PROCEDURES

- Focus on first element:
  Implementing written policies, procedures and standards of conduct.

  Policies and procedures are important for many reasons:
  - ✓ Required by regulatory/accreditation agencies
  - ✓ Standardization of processes and consistency of outcomes
  - ✓ Lays out direction for co-workers' responsibilities
  - ✓ Tools for performance evaluations

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INTERNAL POLICIES AND PROCEDURES

- Standard Procedures for:
  - ✓ Scheduling/Registration
  - ✓ Verification of Benefits
  - ✓ Patient Contact – Financial Expectations Time of Service
  - ✓ Coding
  - ✓ Submitting Insurance Claims

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INTERNAL POLICIES AND PROCEDURES

- Scheduling/Patient Registration

  ACCURACY is key to timely reimbursement
  - ✓ Patient Demographics
  - ✓ CPT and Diagnosis Codes; preferable to receive codes rather than descriptions (e.g. 29881 rather than knee arthroscopy w/meniscectomy)
  - ✓ Insurance Information – Make sure you know if the case is the result of an accident or some other third-party liability
  - ✓ Financial Responsible Party/Guarantor

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INTERNAL POLICIES AND PROCEDURES

- Verification of Benefits

  Make sure comprehensive verification takes place
  - ✓ Thorough knowledge of managed care contracts
  - ✓ Educate staff on asking the right questions
  - ✓ When can they use automated systems or websites versus speaking to a representative?
  - ✓ Documentation of benefits is vital

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INTERNAL POLICIES AND PROCEDURES

- Patient Contact – Financial Expectations Time of Service
  - ✓ Set expectations that copays, unmet deductible, and co insurance will be paid at time of service
  - ✓ Give adequate advance notification
  - ✓ What if the patient/guarantor does not bring payment at time of service? Have clear protocol for staff to follow – they should be confident and sure.

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INTERNAL POLICIES AND PROCEDURES

- Coding
  More thorough discussion with Ms. Richmond
- Submitting Insurance Claims
  - ✓ Establish billing rules for payers so special instructions are easily available to billing staff

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CHANGE – CHANGE - CHANGE

- The entire revenue cycle process begins "at the beginning" with scheduling and progresses through coding and claim submission.
- Healthcare is ever changing, and coding is on the brink of the most significant change in more than 30 years

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CODING CHANGES & DOCUMENTATION
Preparation for ICD-10-CM

- **OBJECTIVE:**
- ✓ To provide a review of documentation requirements for orthopedic diagnosis coding
- ✓ Emphasize the importance of clinical documentation as related to ICD-10-CM
- ✓ Overview documentation challenges for accurate ICD code assignment for "injury" vs. "chronic" diagnosis code reporting
- ✓ Provide ICD-9-CM and ICD-10-CM nomenclature that substantiates documentation requirements
- ✓ Learn documentation pitfalls and the implications

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PHYSICIAN DOCUMENTATION ISSUES

- Distinguishing applicable time lines "injury-acute" vs. "chronic"
- No supporting documentation
- Conflicting documentation from different providers
- Documentation and medical necessity

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CHALLENGES

- The greatest challenge to achieving complete documentation in the medical record is getting "buy-in" by all providing patient data
- Tailoring training and staff education to specific services and specialties
- Bridging the gap of communication between hospital staff, medical providers, and physicians with coding staff

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IMPLICATIONS – DEFICIENT DOCUMENTATION

- Vulnerability to regulatory scrutiny
- Risk of unlawful and improper diagnosis code reporting
- Claims denial postponing reimbursement
- Difficulty substantiating Medical Necessity for services performed
- Lack of patient data integrity
- Deficient conveyance of medical care provided to the patient

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STANDARD DOCUMENTATION
Diagnosis Code Reporting

- Diagnosis codes that support Medical Necessity
- The primary reason a procedure or service is performed
- Distinguishing the nature of the condition and occurrence
- Provide complete documentation of the patient's present complaint

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PRINCIPLE DIAGNOSIS CODING AND REPORTING
Three Vital Pieces of Documentation

- Three vital pieces of information that effect correct principle diagnosis coding should be documented:
  - ✓ When?
  - ✓ How?
  - ✓ What happened after?

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PRINCIPLE DIAGNOSIS CODING AND REPORTING
Vital Documentation – WHEN?

When?

This question allows the coding staff to distinguish between two patterns

1. Complaints with an identifiable starting point, a known accident (traumatic or post-traumatic disorder
2. Complaints that appear to have come on more insidiously, which would be more suggestive of inflammatory or degenerative disease

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PRINCIPLE DIAGNOSIS CODING AND REPORTING
Vital Documentation – HOW?

How?

The correct diagnostic code requires the exact circumstances of:

1. How the disorder occurred; or a description of how the accident happened
2. How the problem developed over time
3. In a trauma case; the nature of the external cause of injury should be documented

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PRINCIPLE DIAGNOSIS CODING AND REPORTING
Vital Documentation – WHAT HAPPENED AFTER?

What happened after?

In order to determine and substantiate the condition as an:

- old injury
- late effect of an injury
- chronic condition

Documentation of any diagnostic, medical or surgical treatments performed is necessary for correct clinical coding of the diagnosis for the encounter

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DOCUMENTATION MAKES THE DIFFERENCE

- **When?**
- **How?**
- **What happened after?**

Documentation of complete "patient history data" makes the difference between assigning an "acute traumatic injury" code versus a "chronic" or "recurrent" musculoskeletal diagnosis code assignment

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MEDICAL NECESSITY

- Diagnostic codes identify the medical necessity of services provided with a description of the patient's condition
- Without complete and concise documentation, the most accurate code will not be assigned
- To properly demonstrate Medical Necessity, documentation must substantiate the correct diagnosis code assignment as it relates to the procedure performed

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MUSCULOSKELETAL CONDITIONS
Common Documentation Pitfalls

Documentation pitfalls often occur for accurate assignment of diagnoses codes for:

Knee ACL Tears (Old vs. New)
Shoulder Rotator Cuff Tear (New vs. Recurrent)

PITFALLS

- ✓ Incomplete "History Data" documentation
- ✓ Physician nomenclature differs from ICD-9-CM nomenclature
- ✓ Ambiguous terminology

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WHAT IS THE DIFFERENCE?

- The following slides walk through an example of the change in diagnosis coding for ACL Tear of the Knee

  Acute versus Chronic

- This example demonstrates the need for more specific documentation

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ACCURATE CODING AND PROPER DOCUMENTATION

- **Accurate coding begins with proper documentation, and the outcome is:**
  - ✓ Continuity of patient care
  - ✓ Timely claims submission
  - ✓ Quality data repository
- **An equally excruciating result of incomplete documentation is:**
  - ✓ Denial of claims
  - ✓ Postponement of payment due to mis-coding
  - ✓ Shuffling documentation back and forth to support claims reimbursements
  - ✓ Red flags to payers
  - ✓ Increased risk of unlawful or improper coding

A review of the Coding Nomenclatures for ICD-9-CM and ICD-10-CM Diagnoses Codes will help with documentation, protect the integrity of the quality of data and reporting, but most importantly, improve patient care.

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ICD-9-CM NOMENCLATURE FOR KNEE CODING

ICD-9- CM Nomenclature "KNEE (ACL)-Acute"
"Include" and "Excludes" Coding Instructions
(Excerpt from the ICD-9-CM Coding Manual - Tabular Section)

836 Dislocation of knee
EXCLUDES dislocation of knee:
old or pathological fracture (718.2)
recurrent (718.3)
internal derangement of knee joint (717.0 – 717.5, 717.8-717.9)
old tear of cartilage or meniscus of knee (717.0 – 717.5, 717.8 -717.9)

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ICD CODES – 836 DISLOCATION OF KNEE, CURRENT

836.0 Tear of medial cartilage or meniscus of knee, current
Bucket handle:
NOS } current injury
Medial meniscus

836.1 Tear of lateral cartilage or meniscus of knee, current

836.2 Other tear of medial cartilage or meniscus of knee, current
Tear of:
Cartilage (semilunar) } current injury
Meniscus not specified medial or lateral

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ICD NOMENCLATURE - INTERNAL DERANGEMENT OF KNEE

ICD- 9 - CM Nomenclature "Chronic Knee" Conditions
"Includes" and "Excludes" Coding Instructions
(Excerpt from the ICD-9-CM Coding Manual - Tabular Section)

717 Internal derangement of knee

INCLUDES
Degeneration } of articular cartilage or meniscus of knee
Rupture, old tear, old

EXCLUDES
acute derangement of knee (836.0 – 836.6)
ankylosis (718.5)
contracture (718.4)
current injury (836.0 – 836.6)
deformity (736.4 – 736.6)
recurrent dislocation (718.3)

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ICD CODES – 717 INTERNAL DERANGEMENT OF KNEE

- **717.0** Old bucket handle tear of medial meniscus
- **717.1** Derangement of the anterior horn of medial meniscus
- **717.2** Derangement of the posterior horn of medial meniscus
- **717.3** Other and unspecified derangement of medial meniscus
- **717.4** Derangement of lateral meniscus *(expanded codes includes "Bucket Handle" tear)*
- **717.5** Derangement of meniscus, not elsewhere classified
- **717.8** Other internal derangement of knee *(expanded codes includes "old disruption")*
- **717.9** Unspecified derangement of knee

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ICD-10-CM NOMENCLATURE FOR KNEE DIAGNOSIS CODING

- Providers should exercise independent clinical judgment when selecting codes and submitting claims to reflect accurately of the coding reported.
- With ICD-10 swiftly approaching (October 1, 2013), it is important to take primary step toward documentation improvement.
  - ✓ Review documentation requirements with specificity regarding the extra clinical data required to assign the new coding classification system.
  - ✓ Gauge documentation adequacy by reviewing ICD-9-CM nomenclature to the ICD-10-CM

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ICD-9-CM NOMENCLATURE TO THE ICD-10 CM EQUIVALENT

ICD-9-CM	836.0	Tear medial cartilage of knee, current
ICD-10-CM	S83.21	Bucket-handle tear of medial meniscus, current injury

ICD-10 code S83.21 requires a seventh character extension - A, D, or S

The appropriate 7th character is required for codes from category S83

A initial encounter
D subsequent encounter
S sequela

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ICD-10-CM S83.2 TEAR OF MENISCUS, CURRENT INJURY > 836.0

S83.2 **Tear of meniscus, current**
EXCLUDES 1 old bucket- handle tear (M23.2)

S83.21 **Bucket-handle tear of medial meniscus, current injury**
- S83.211 Bucket-handle tear of medial meniscus, current injury, right knee
- S83.212 Bucket-handle tear of medial meniscus, current injury, left knee
- S83.219 Bucket-handle tear of medial meniscus, current injury, unspecified knee

S83.22 **Peripheral tear of medial meniscus, current injury**
- S83.221 Peripheral tear of medial meniscus, current injury, right knee
- S83.222 Peripheral tear of medial meniscus, current injury, left knee
- S83.229 Peripheral tear of medial meniscus, current injury, unspecified knee

S83.23 **Complex tear of medial meniscus, current injury**
- S83.231 Complex tear of medial meniscus, current injury, right knee
- S83.232 Complex tear of medial meniscus, current injury, left knee
- S83.239 Complex tear of medial meniscus, current injury, unspecified knee

S83.24 **Other tear of medial meniscus, current injury**
- S83.231 Other tear of medial meniscus, current injury, right knee
- S83.232 Other tear of medial meniscus, current injury, left knee
- S83.239 Other tear of medial meniscus, current injury, unspecified knee

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ICD-9-CM VS. ICD-10-CM CONCEPTUAL DIFFERENCE

- The ICD-10 clinical concepts are updated to include "due to old tear or injury" clarifying the type of condition
- More granularity by noting derangement due to old injury
- ICD-9 only makes the distinction," Old Bucket-handle and "Old disruption".

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CONCLUSION

- Patient care and reimbursement relies on documentation and coding; both correlate to establishing and thoroughly documenting medical necessity.
- Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions.
- Reimbursement issues along with clinical data capture issues are improved by documentation reviews and education.
- An understanding of the complexity of ICD-9-CM with an advanced knowledge and overview of ICD-10-CM can make the difference in improving clinical documentation.
- ICD-10-CM will require much more clinical information for coding and reporting.
- There are exponentially more codes in ICD-10, with the granularity of the terminology, complete and concise documentation will be required to avoid data pitfalls, and reimbursement delays.

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ONLINE REFERENCES AND RESOURCES

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/nchs/icd/icd10cm.htm

Centers for Medicare and Medicaid Services (CMS)
http://www.cms.hhs.gov/ICD10

National Center for Health Statistics (NCHS)
http://www.cdc.gov/nchs/

AHIMA - American Health information Management - Clinical Documentation Improvement
http://www.ahima.org

AHA Coding Clinic - American Hospital Association
http://www.ahacentraloffice.org

ICD-9-CM Guidelines for Coding and Reporting
http://www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf

ICD-10-CM Guidelines for coding and Reporting
http://www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf

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QUESTIONS?

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