10 WAYS TO IMPROVE AN ASC'S CODING – DOCUMENT DEFICIENCIES, FINANCIAL IMPACTS AND HOW TO WORK WITH PHYSICIANS

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10 Keys To Improving Coding Efficiency

- Knowledge of Multi-specialty procedures and coding guidelines
- Continuing Education
- Utilization of Credible and Current Resources
- Knowledge of AMA vs CMS
- Knowledge of Commercial vs Medicare reimbursement and reporting guidelines
- Understanding of Medicare Edits (NCCI)
- Workload
- Work Environment (Logistics)
- Detailed Documentation
- Compliance Audits

Knowledge of Multi-specialty Procedures and Coding Guidelines

- Simply because an ASC employs a ***certified*** coder, does not denote the coder automatically has a good working knowledge of the facility's various specialties.
- The coder should have experience in *ASC* coding.
- The coder should have experience in coding the varying specialties performed in the facility.

Think About It . . .

- Would you expect that your orthopaedic surgeon knows how to perform all GYN procedures simply because he is an "MD"?
- Don't expect ***your*** coder to automatically know everything either!
- *Bring in the new specialties but ensure your coder **has the knowledge to code** these new specialties!!!*

Coding Compliance Plan – Continuing Education

TRAINING PROGRAM AND AUDITS

- Coding Staff needs to be educated annually regarding the compliance plan
- Coding staff has potential of putting facility at risk.....additional education should be provided regularly.
- Education programs should include coding conventions, guidelines, documentations etc.
- Keep records of staff education programs and attendees.
- Formal Coding audit protocol should define purpose of audit, frequency of review, sample size. *Medicare Desk Reference 2008*

Coding Compliance Plan: Monitoring Coding Performance (Audits)

STANDARDS OF CONDUCT

- Standards must include measurable performance standards to include code assignment accuracy.
- Measure code accuracy to establish baseline indicator of coding accuracy.
- By monitoring actual performance against the established baselines, variations in coding practices can be determined. *Medicare Desk Reference 2009*

Benchmarking Coding Quality

- **Identify root causes for coding errors to decrease variance and increase reliability**
- **Identify strengths and weaknesses of coders to establish education component**
- **To ensure all codes reported represents quality data**

Standards for Coding Quality

- **Facilities should adopt a standardized method to:**
- **Measure coding quality performance**
- **Standardize definitions for "how" to count coding variance.**
- **Standardize a method for classifying and reporting variances.**

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CMS vs AMA vs SPECIALTY

- CMS GUIDELINES
- AMA GUIDELINES
- SPECIALTY GUIDELINES (AAOS, NASS, AGA etc)

Medicare Edits (NCCI)

- In addition to understanding Medicare guidelines, the coder should be quite knowledgeable in regards to modifier usage when reviewing Medicare Edits.
- Coders tend to err on the side of caution when reviewing the edits or they don't understand "when" modifiers should be appended to the CPT code to indicate a "separate" and "distinct" procedure that would otherwise be considered bundled.
- Medicare edits may allow a modifier to be utilized when a normally integral procedure is separate and distinct: however, this doesn't imply to automatic utilization of a modifier for all scenarios! (Don't take it and run!!!)
- In this instance, the coder's knowledge of the procedure(s) will assist in determining whether a modifier is applicable.

NCCI Edits – If MCR Edits Allows use of a Modifier

- NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances.
- If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters.
- Carrier processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier -59 and other NCCI associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf

Key Points

- Why Deficient Documentation?
- Why Detailed Documentation?
- Physician education
- Statistical Reporting
- Rewards

Physician Perspective?

- Physicians don't deliberately withhold information from the medical record . . .
- They may forget to include or omit necessary information or . . .
- They don't feel the detail is necessary for accurate coding. . . After all, they know what they did.

Coding Documentation Challenges

- Contradictory information
- Errors dictated in the operative report
- Op notes that result in more questions than answers
- Missing or incomplete information in operative report

Deficient Documentation

Deficient operative report "description" may require a written addendum.

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Establish a Query Process

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Track Trends

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Educate

Query Process

"A joint effort between the health care provider and the coding professional 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 coding professional in identifying those diagnoses and procedures 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."

Centers for Medicare and Medicaid Services and the National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.

Query Process

Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator). American Health Information Management Association. "Standards of Ethical Coding." 2008. Available online at www.ahima.org/infocenter/guidelines.

Query Process

- Communication tools between coding personnel and physicians, such as physician query forms), should never be used as a substitute for **appropriate physician documentation.**
- Physician education is needed.

Query Process – Expectation of the Provider

According to the Centers for Medicare and Medicaid Services and the Joint Commission, providers are expected to provide legible, complete, clear, consistent, precise, and reliable documentation of the patient's health history, present illness, and course of treatment.

This includes observations, evidence of medical decision-making in determining a diagnosis, and treatment plan, as well as the outcomes of all tests, procedures, and treatments. This documentation should be as complete and specific as possible, including information such as the level of severity, specificity of anatomical sites involved, and etiologies of symptoms.

Query Process – Expectation of the Provider

Providers are expected to follow medical staff bylaws and assist in developing documentation and query policies and procedures.

The query policy may include a statement regarding timely response and consequences for noncompliance or lack of response to queries.

Query Process – Retention of Query

- Permanence and retention of the completed query form should be addressed in the healthcare entity's policy, taking into account applicable state and quality improvement organization guidelines.
- The policy should specify whether the completed query will be a permanent part of the patient's health record.
- If it will not be considered a permanent part of the patient's health record (e.g., it might be considered a separate business record for the purpose of auditing, monitoring, and compliance), it is not subject to health record retention guidelines. (Verify with state guidelines)

The Query Format

It is recommended that the healthcare entity's policy address the query format. A query generally includes the following information:

- Patient name
- Admission date and/or date of service
- Health record number/Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question

Query Process – Verbal Queries

- Verbal queries have become more common as a component of the concurrent query process.
- Entities should develop specific policies to clearly address this practice and ***avoid potential compliance risks.***
- Queries should be ***written*** with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case.

Query Process

- The physician query process should only be triggered when there is a problem with documentation quality. Some guidelines for the physician query process include the following:
  - Ask only questions that are drawn from the clinical documentation that the physician has provided in the patient's record.
  - Ask only open-ended questions if possible or provide reasonable choices for the physician, so it does not appear that you are showing preference for a particular response.
  - Never make any clinical assumptions - clinical documentation is solely the job of the physician.
  - Remember your role in the coding/billing function is to translate the physician's documentation into billable "coding" language.

Query Process – Don't LEAD a physician!

- Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding.
- The query format should ***not*** sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.

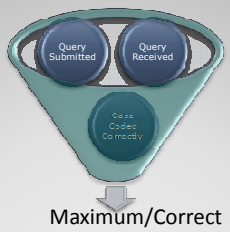
Query Process

- Examples of leading queries include:
- Dr. Smith—Based on your documentation, this patient has anemia and was transfused 2 units of blood. Also, there was a 10 point drop in hematocrit following surgery. Please document "Acute Blood Loss Anemia," as this patient clearly meets the clinical criteria for this diagnosis.

Query Process – Multiple Choice Formats

- Multiple choice formats that employ checkboxes may be used as long as all clinically reasonable choices are listed, regardless of the impact on reimbursement or quality reporting.
- The choices should also include an "other" option, with a line that allows the provider to add free text. Providers should also be given the choice of "unable to determine." This format is designed to make multiple choice questions as open ended as possible.

Query Process



Maximum/Correct Reimbursement Received

EDUCATE PHYSICIANS –SHOW THEM THE MONEY!

- Show physicians how they can improve record-keeping using specific examples from their own practices.
- Physicians are more likely to support and respond to documentation and coding improvement initiatives if financial managers present the information in the context of real-life situations from the physicians' individual documentation practices.

Financial Impact of Incorrect Coding

- Provide physicians with specific examples of their documentation (BOTH *deficient* AND *detailed*).
- Provide a comparison (financial impact).

Documentation Deficiency Reimbursement Impact

- CPT Code 11403- exc benign lesion
  . . . 2.1 to 3.0 cm = 74.99 (2010 MCR)
- CPT Code 11404 – exc benign lesion
  . . . 3.1 to 4.0 CM = 605.36 (2010 MCR)

Documentation Deficiency Reimbursement Impact: Acute vs. Chronic

- CPT Code 23410 – Repair of ruptured musculotendinous cuff open; acute = 1570.94 MCR (approx. 2010)
- CPT Code 23412 – Repair of ruptured musculotendinous cuff open; chronic = 1637.43 MCR (approx. 2010)

Reimbursement Impact (MCR)

- 29877 Knee arthroscopy/surgery, chondroplasty ($1049.62 MCR 2010)
- 29879 Knee arthroscopy/surgery, abrasion arthroplasty ($1020.91 MCR 2010)

Reimbursement Impact (MCR)

- **GO1O5** Screening colonoscopy –high risk patient ($320.67 MCR 2010)
- **45378** Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedue) ($348.60 MCR 2010)
- Reimbursement Impact if incorrect code is selected due to vague or deficient documentation.

ICD-10
NEED FOR DOCUMENTATION SPECIFICITY

535.10

CODE	DESCRIPTOR
K29.4Ø	Chronic atrophic gastritis without bleeding
K29.5Ø	Unspecified chronic gastritis without bleeding

ICD-10
NEED FOR DOCUMENTATION SPECIFICITY

211.3

CODE	DESCRIPTOR
D12.1	Benign neoplasm of appendix
D12.6	Benign neoplasm of colon, unspecified
D12.Ø	Benign neoplasm of cecum

Resources for Query Process

- Centers for Medicare and Medicaid Services and the National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.
- American Health Information Management Association. "Standards of Ethical Coding." 2008. Available online at www.ahima.org/infocenter/guidelines.
- Prophet, Sue. *Health Information Management Compliance: A Model Program for Healthcare Organizations.* 2d edition. Chicago, IL: AHIMA.

Thank You!

For Further Assistance:

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