Do EHRs enable fraud and abuse by encouraging upcoding? What other factors could have led to higher levels of E/M coding over the past decade? Who or what organizations are responsible for ensuring compliance?

These are just a few of the questions addressed during a listening session held in May by CMS and the Office of the National Coordinator for Health Information Technology (ONC). More than 5,000 people participated via phone, webcast, and in person at CMS’ central office in Woodlawn, Md., during the five-hour event.

The purpose of the session was to seek feedback and input regarding strategies to encourage health information technology (HIT) adoption while also lowering costs and ensuring accurate payments, said Jonathan Blum, deputy administrator and director for the Center of Medicare at CMS.

Upcoding is certainly a concern that requires further investigation, he said. “We don’t see evidence of [upcoding]. It’s too early in our data, but we are mindful of the concern,” he added.

**Physicians speak out**

Various physicians spoke during the session about the promise as well as the limitations of EHRs.
July audio conference to review sepsis coding

On Thursday, July 25, from 1–2:30 p.m., ACDIS founding board member Gloryanne Bryant, BS, RHIA, CCS, CDIP, CCDS, joins Robert S. Gold, MD, CEO of DCBA, Inc., for a special audio conference to review the clinical criteria and clinical documentation changes, and coding guidelines. They will also provide sample queries and discuss how documentation needs will change after ICD-10-CM implementation.

http://tinyurl.com/ppklgba

ICD-10-PCS adds new codes for 2014

The ICD-10-PCS codes for 2014 are now available on the CMS website. CMS also posted the 2014 ICD-10-PCS guidelines and an ICD-10-PCS reference manual. You will find four new codes under new technology application, valid October 1, 2013. The update also includes three new codes added and three codes deleted, to correct body part value for temporary occlusion of abdominal aorta.

http://blogs.hcpro.com/icd-10

Follow Us
Follow and chat with us about all things healthcare compliance, management, and reimbursement.

@HCPro_Inc

Questions? Comments? Ideas?
Contact Senior Managing Editor Jay Kumar at jkumar@hcpro.com or 781-639-1872, Ext. 3144.
Enabling actionable data is one of the most beneficial aspects of EHRs, said Benjamin K. Chu, MD, 2013 chairman of the AHA and regional president of Southern California, Kaiser Foundation Health Plan and Hospitals. “You can’t audit on a real-time basis 600,000 charts day in and day out, but you can if you have an electronic health record where the information is extractable and you can organize it,” he said.

Chu said Kaiser has used the EHR to identify and improve outcomes for sepsis as well as protein-calorie malnutrition.

By identifying protein-calorie malnutrition, a predictor to pressure ulcers, Kaiser reduced its hospital-acquired pressure ulcer rate to less than 1% across all hospitals, said Chu.

“You could say that this could lead to higher numbers of people being diagnosed with malnutrition, but if the conditions are there, and they are factors that influence the course of therapy, well you want to identify that so you can begin to utilize that information to get a better outcome,” he said.

Standardization is also a benefit of EHRs, said Chu. “Some people think that standardization is cookbook medicine. Standardization is not necessarily bad,” he said. “We’d never take the clinical decision out of the hands of a clinician ... But the ability to reduce unwarranted variation through standardization is a very important part of an electronic health record.”

However, the EHR has drawbacks, most notably its effect on physician productivity, said Steven J. Stack, MD, board chair for the AMA. “Even after many months of use, physicians are unable to return to their pre-EHR level of productivity,” he said.

Usability is crucial, Stack said. “Attempting to transform the entire healthcare system in such a rapid and prescriptive manner has compelled providers to purchase tools not yet optimized to the end user’s needs and that often impede rather than enable efficient clinical care,” he said. AMA advocates for the ONC to add usability criteria into its certification process, he added.

Shortcuts to improve efficiency (e.g., templates, macros, and cut-and-paste functionality) must be more closely examined. Although these shortcuts can enable errors and upcoding, their usage doesn’t necessarily denote fraud, said Stack. “None of these are inherently bad, but each of them can be misapplied accidentally or intentionally,” he added.

Even though the technology may make it easier to create voluminous documentation, physicians must fundamentally understand that quality always takes priority over quantity, said Jacob Reider, MD, family physician. “My goal as the physician is to capture the shared decisions that I’ve made with my patient,” he said. “It’s to capture the communication that we’ve had about the topics. It’s to capture my examination of both the patient’s data and the patient’s physical status so that I can accurately reflect what we thought about, what we saw, and what we planned to do both for myself … and for my colleagues who are going to participate in the care of this patient in the future.”

Patient complexity is clearly an important part of the discussion related to EHRs and billing, said Chu. He cited data recently collected by The Moran Company (at www.aha.org/content/13/13moranreport-ed.pdf) to indicate that complexity of care provided in the ER has changed dramatically over the past 10 years.

“People are living longer, and they have a larger disease burden,” Chu said. Chronic disease rates are rising in the Medicare population. These beneficiaries are also receiving a greater volume and intensity of ED services, according to the data, he added.

Bruce Siegel, MD, MPH, president and CEO of the National Association of Public Hospitals and Health Systems, agreed that patients are more clinically complex than in the past.

“The ER is often the first point of contact for people in the community who are most vulnerable,” he said. Many of these patients have never accessed care before. Others present with a host of behavioral health diagnoses that complicate their conditions. Emergency psychiatric care has been challenging. In the last seven years, Siegel said the number of psychiatric beds in state hospitals has dropped by 8,000. Many of these patients are seen instead in the ER. “This drives huge resource utilization and huge complexity,” he added.

Coding, billing, HIM

Documentation in the EHR can have a significant
impact both from data reporting and reimbursement standpoints, said Sue Bowman, MJ, RHIA, CCS, FAHIMA, senior director of coding policy and compliance at AHIMA. One benefit of an EHR is that it can enable more complete documentation. This in turn enables more complete coding. More complete coding can lead to increased reimbursement. “So it’s no surprise that these are all related,” she said.

However, Bowman admits that there are several features of the EHR that can potentially enable fraud. These include cut-and-paste functionality, auto-creation of documentation, single-click template notes, templates with limited options, E/M code optimization alerts, and “make me an author” functionality. “Make me an author” allows clinicians to assume authorship for a previous clinician’s note without showing attribution for the original author.

“Ultimately, the move to value-based purchasing, where reimbursement is based on patient outcomes and quality of care rather than volume of documentation produced, will be fundamental to preventing fraud in the long term,” said Bowman.

Fostering a culture of compliance is a crucial part of the solution, said Steven A. Wartman, MD, PhD, MACP, president and CEO of the Association of Academic Health Centers.

In addition, coding and billing regulations must reflect a more dynamic healthcare environment in which multiple providers contribute simultaneously to a patient’s record.

“In professional fee billing, a single note is required for each billing provider. Those single notes must include the same items collected and already stored by other providers,” said Wartman.

“I believe that this example highlights the disparity between the regulations and the way that care actually needs to be delivered,” he added.

Training and policies are also important, said Bowman. She identified the following goals to ensure compliance:

• Develop organizational policies/procedures for proper use of EHR documentation
• Provide comprehensive training/education to users on proper EHR use
• Monitor use of EHR documentation features
• Adopt a national set of coding guidelines for hospital

reporting of ED and clinic visits

Lisa Gallagher, vice president of technology solutions at HIMSS, agreed that CMS should simplify E/M codes or provide more granular and specific guidance. Medical school residency programs should also incorporate E/M documentation training and oversight, she added.

Ivy Baer, senior director and regulatory counsel of healthcare affairs at the Association of American Medical Colleges, cited three EHR compliance advisories devoted to appropriate documentation in the EHR that the association has published on its website.

To download the advisories, visit www.aamc.org/members/cof, scroll to the bottom of the page, and click on the PDFs under “COF EHR Compliance Advisories.”

The role of EHR vendors

EHR vendors also play a role in compliance, said Bowman.

Vendors should employ EHR system design and usability standards and implementation specifications that promote accurate and compliant documentation, she said.

“For example, instead of copying and pasting content from a previous note, embed links to take the user back to the original note for reference purposes,” she advised.

Usability and usefulness of the technology will continue to be a crucial element of adoption, said Mickey McGlynn of Siemens Medical Solutions and chair of EHR Association. “[Vendors] have not yet landed on the right approach that benefits the providers and meets regulatory requirements,” she said.

Providers, EHR vendors, and CMS should collaborate to determine an appropriate solution, not necessarily rush to implement certification criteria immediately, said McGlynn. “We want to be a partner in helping to solve this issue. We just want to understand that we’re solving the right issue,” she said. “There could be unintended consequences of solving the wrong problem.”

EDITOR’S NOTE
To access the slide presentation that accompanied the listening session, visit www.cms.gov/ehealth/codingsession_may3.html.
Inpatient charging: Consistency is paramount

Charging for inpatient ancillary procedures and supplies has always been confusing. “CMS provides very little guidance ... Its theory is that it’s up to the provider to figure it out,” says Kimberly Anderwood Hoy, JC, CPC, director of Medicare and compliance at HCPro, Inc., in Danvers, Mass.

The Provider Reimbursement Manual, sections 2203 and 2202.4 states that facilities must have an established charge structure; apply that structure uniformly across all settings for each patient and payer; and use charges that reasonably and consistently relate to the cost of services.

The rest is simply up to the provider, says Hoy. Why do inpatient charges matter so much?

CMS uses charges as a proxy for cost. The agency then uses these costs to determine DRG payment rates in the PPS system. Essentially, accurate charges equal more accurate DRG payments.

Ancillary vs. routine services

Though it’s certainly no easy task, distinguishing between ancillary and routine services is crucial when it comes to complaint charging.

In its Provider Reimbursement Manual, section 2202.6, CMS defines “routine” services as a facility’s room and board charge. This charge includes regular room, dietary, and nursing services; minor medical and surgical supplies; medical social services; psychiatric social services; and the use of certain equipment and facilities for which a separate charge is not customarily made.

Many charge description masters (CDM) include a charge for room and board only, says William L. Malm, ND, RN, CMAS, senior data products manager at Craneware in Atlanta. This is a stark contrast to the “a la carte” format of most outpatient CDMS in which each individual service and/or supply is listed separately.

This inconsistency across settings doesn’t comply with Medicare regulations, says Malm. “In my mind, if you have a charge on the outpatient side, you should have a requisite charge that is identical on the inpatient side,” he says. “To be compliant with charge rules and regulations—and to not put your facility at risk of over- or undercharging—all bedside supplies and procedures need proper documentation. This is also an important part of determining the actual cost of care.”

Section 2202.8 of the manual defines “ancillary” services as laboratory, radiology, drugs, delivery room (including maternity labor room), OR (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational). These services may also include special items or services for which charges are customarily made in addition to a routine service charge.

The FY 2009 IPPS final rule states that providers in the same state should follow similar charging practices. “If there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same state, a provider’s customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program,” the rule states.

The problem is that hospitals sometimes include a multitude of services in their room rates (i.e., as routine charges), says Hoy. This happens because it’s either easier to do so operationally or because many hospitals incorrectly believe that they aren’t allowed to charge separately for certain items or services.

“What I find is that payers will sometimes say with quite a bit of authority that you can’t bill for that or that can’t be billed separately,” says Hoy. “They’ll deny services ... what they’re really doing is denying those costs that were really incurred by the facility.”

This in turn leads to incorrect DRG payment rates, says Hoy. “It’s no secret that some of our DRGs are really, really ‘off’ in terms of what they pay us,” she adds. In some cases, reimbursement for a device-dependent procedure is actually less than the cost of the device itself. Implantation of a cardiac resynchronization therapy defibrillator is one example.

Consistency is key. “Many of our nursing ancillary and bedside procedures are all charged separately to outpatients,” says Hoy. “Then when it comes to
an inpatient, we bundle them into our room rate. We really are being a little inconsistent about how we’re billing and charging between inpatients and outpatients.”

For example, hospitals may want to consider separate inpatient charges for blood transfusions and certain nursing services (e.g., debridements, cardioversions, PICC line insertion, Foley inserts, thoracentesis, paracentesis, incision and drainage, lumbar puncture, central line insertion, or bone marrow aspiration).

Special qualifications aren’t a prerequisite of separately charged procedures. In other words, hospitals can separately charge a PICC line insertion, for example, even when a nurse without special qualifications performs it, says Hoy. If a procedure is within a practitioner’s scope of practice under state law, then a payer can’t dictate whether a hospital can separately charge for the procedure, she adds.

**Charging inpatient supplies**

Charging inpatient supplies also poses a dilemma. In section 2203.2 of its *Provider Reimbursement Manual*, CMS provides the following criteria for routine supplies:

- Not identifiable to a patient
- Not generally provided to most patients
- Not reusable
- Represents a cost for each preparation
- It’s complex medical equipment

However, these criteria pertain to skilled nursing facilities (SNF) only, says Hoy. Section 2203.1 provides additional stipulations, but again, they technically only pertain to SNFs, not acute care facilities. These stipulations state that routine supplies include patient gowns, paper tissues, water pitchers, basins, bedpans, deodorants, and mouthwash. They also include items stocked at nursing stations or on the floor in gross supply and that are distributed or used individually in small quantities (e.g., alcohol, cotton balls, aspirin, or Band-Aids).

Even though the criteria apply only to SNFs, “there are things that we can take from these criteria that are very instructive,” says Hoy. For example, supplies that are identifiable to a patient are easier for auditors to audit because they can confirm based on documentation that it was used separately. If a supply is generally provided to most patients, it’s easier to include it in the room and board rate. “Our charge should really relate to a cost of care,” she says. “If it’s not really a cost of care because it’s reusable, then it’s going to be difficult to assign some sort of charge to that.”

The SNF criteria do provide a commonsense approach to charging and accounting for resources, says Malm. Maintaining individual charges in the CDM for all chargeable inpatient supply items could require significant time and resources, he adds.

However, there are exceptions for which hospitals may want to make case-by-case decisions, says Hoy. For example, even though bandages may be generally considered routine, a bandage used for wound VAC is expensive and patient-specific. Therefore, hospitals may want to assign a separate charge for it.

Other hospitals may use a low-dollar threshold for charging inpatient supplies, says Malm. For example, a hospital may choose to bundle all items under $5 into the procedure charge. For a laceration repair, this might include gauze ($0.10), a Band-Aid ($0.10), and an Ace wrap ($3.00). Bundling these items into the procedure charge for the laceration would increase the charge by $3.20.

Striking a balance is essential, says Malm. “The more charge items you have in the CDM, the greater the risk for charge capture loss,” he says. “Is the nurse in the OR looking to charge the Band-Aid and forgets to charge the $100 specialty item?”

**Maintaining compliance**

So what can hospitals do?

First and foremost, focus on documentation. “Once a charge goes in, it’s automatically forgotten,” says Malm. “On audit, if the documentation is not present, then it’s a false charge.” Detailed nursing documentation must justify separate charges for services and supplies. Nursing buy-in is essential. EMR templates and order sets may mitigate documentation insufficiencies, he adds.

Developing a policy is the most important aspect of maintaining compliant charging practices, says Hoy. A team approach works most effectively. This team should include revenue integrity, the chargemaster...
Those who perform the task of charging must fully understand and be able to implement the policy correctly. Auditing is crucial, says Malm. “The obligation to internally audit your claims is paramount. You have to always audit whatever you do,” he says.

**ICD-10-PCS: Put your heart into coding pacemakers**

Upon quick glance, codes for insertion, removal, and revision of pacemakers look quite different in ICD-10-PCS. The good news is that much of the logic that coders use to assign these codes in ICD-9-CM won’t change. The silver lining? The procedure itself doesn’t change, nor does anatomy.

A pacemaker is a small device that treats heart arrhythmias. Physicians place the device in the chest or abdomen where it uses electrical pulses to prompt the heart to beat at a normal rate. A pacemaker device includes two basic parts: a pulse generator (battery) and leads (wires that attach to the generator and connect to the atrium, ventricle, or both).

**Find comfort in what’s familiar**

Consider the following similarities between ICD-9-CM and ICD-10-PCS coding for pacemakers:

- **Insertion requires two codes.** In both ICD-9-CM and ICD-10-PCS, coders must report two codes for the insertion of a pacemaker. One of the two codes denotes the insertion of the generator itself, and the other code denotes the insertion of any leads.

  In ICD-9-CM, procedure codes 37.82–37.83 denote insertion of a single-chamber or dual-chamber device respectively. ICD-9-CM procedure code 37.71 denotes insertion of a transvenous lead (to be used with single-chamber devices) into the atrium. Codes 37.72–37.73 denote insertion of transvenous leads (to be used with dual-chamber devices) into either the atrium and ventricle or simply the ventricle alone. Code 37.74 denotes insertion of an epicardial lead into the epicardium (the outer layer of the heart tissue).

  In ICD-10-PCS, table 0JH denotes the insertion of a pacemaker. Table 02H denotes the insertion of the leads. Note that for codes in table 02H, body part characters 6 and 7 specify the atrium. Characters K and L specify the ventricle. Character N specifies the pericardium. Coders should report N when the physician places an epicardial lead.

- **A singular code captures the revision of a lead, pocket, or device.** In ICD-9-CM, coders report one code for a revision of either a lead, pocket, or the pulse generator itself.

  In ICD-9-CM, code 37.79 denotes revision or relocation of a cardiac device pocket. This code is necessary when a device pocket becomes infected, for example. The code includes debridement of that pocket. Code 37.75 denotes revision or repositioning of a lead (e.g., when a lead becomes disconnected). Code 37.89 denotes revision of a pacemaker device (e.g., when a device malfunctions).

  In ICD-10-PCS, coders have similar options. The relevant root operation is revision (i.e., correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device). Therefore, table 0JW denotes revision of a pacemaker device. Note that the root operation in this code doesn’t include debridement.

“*If you look at the definition of revision, it says you...*
must do something with the device—move it over or put it in a better position,” says Melanie Endicott, MBA/HCM, RHIA, CDIP, CCS, CCS-P, FAHIMA, director of HIM Practice Excellence at AHIMA in Chicago. “If the physician is just cleaning out the pocket—and not touching the device at all—then excision might be an option. This would be less common, though, because if there’s an infection, the physician is going to get that pacemaker out and move it.”

Table 02W denotes revision of a cardiac lead. The fourth character (body part) will always be A (heart). The sixth character (device) will always be M (cardiac lead).

Hone in on differences

There are some differences between ICD-9-CM and ICD-10-PCS. Consider the following:

- **ICD-10-PCS removes unspecified options.** In ICD-9-CM, coders can report code 37.70 for insertion of a lead, not otherwise specified. In ICD-10-PCS, they must specify in the fourth character (body part) whether the lead is inserted into the coronary vein, atrium, or ventricle. Likewise, in ICD-9-CM, coders can report code 37.80 for insertion of a pacemaker, type of device not specified. In ICD-10-PCS, they must specify in the sixth character (device) whether the device that’s inserted is single chamber, single chamber rate responsive, or dual chamber. For example, code 0JH636Z denotes insertion of a dual-chamber pacemaker into the chest via a percutaneous approach.

- **ICD-10-PCS adds laterality.** When a physician inserts a lead into either the atrium or ventricle, coders must specify laterality using the fourth character (body part). For example, code 02H73JZ denotes insertion of a pacemaker lead into the left atrium via a percutaneous approach.

- **ICD-10-PCS codes for insertion of a pacemaker device are included in the subcutaneous tissue and fascia body system.** ICD-10-PCS codes for insertion of a lead are included in the heart and great vessels body system. In ICD-9-CM, these codes are both included in the cardiovascular system.

“If you think about it, the body system into which the device goes isn’t the heart or the cardiovascular system,” says Kimberly J. Carr, RHIT, CCS, CDIP, manager of clinical documentation at HRS in Baltimore. “The physician creates a little pocket in the subcutaneous tissue of the chest or abdominal wall.”

- **Replacement of a pacemaker or lead requires two codes in ICD-10-PCS—one for the removal and one for a reinsertion.** That’s because the PCS root operation replacement (i.e., putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part) isn’t applicable.

“Replacement in PCS is a replacement of a body part like a hip joint replacement or knee replacement. It’s not a replacement of a device,” Endicott explains.

For removal of a pacemaker, report ICD-10-PCS table 0JP. The fourth character (body part) is T (subcutaneous tissue and fascia, trunk) if the physician removes a pacemaker in the chest. The sixth character will always be P (cardiac rhythm related device). Note that this category of codes doesn’t specify whether the device is a single-chamber vs. dual-chamber pacemaker, says Endicott. For the removal of a lead, report ICD-10-PCS table 02P. The fourth character (body part) will always be A (heart). The sixth character (device) will always be M (cardiac lead).

Tips for compliance

Consider the following tips:

- **Always check the DRG after code assignment to ensure that it accurately and completely reflects the patient’s story.** “Don’t depend on your encoder,” says Carr. “Use your book and look at those definitions of each of the root operations ... Make sure you get all components of the surgery captured with your codes.”

- **Review the PCS tables.** Familiarize yourself with the code tables in the ICD-10-PCS manual, says Endicott. Most of the documentation that coders will need is already in the record, but it doesn’t hurt to double-check and start to prepare physicians now for any additional documentation needs, she adds.
Create a coding roundtable to ensure data integrity

When coding guidelines are murky and open for interpretation, coders can sometimes feel as though they’re pinned between a rock and a hard place. Discussing the gray areas of coding during a coding roundtable not only helps relieve this tension, but it also helps to establish policies that ensure consistency and continuity.

“Especially with ICD-10 coming, you need to establish a forum to address questions and then give the guidance so that individuals are coding consistently,” says Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, HIM professional in Fremont, Calif.

Creating a roundtable can also help establish a culture of learning and connectedness, particularly for facilities that employ remote coders, says Laura Legg, RHIT, CCS, HIM and coding consultant in Renton, Wash.

Getting started

Consider drafting a formal charter to explain how the roundtable will be conducted, says Bryant. The charter should address goals of the roundtable, the development of the agenda, and how attendees will disseminate information following the roundtable. (See the template below for a sample charter.)

---

**HIM coding roundtable charter**

**Purpose**

[Insert name of organization] is committed to a national program of coding integrity and high ethical standards. The mission of the coding roundtable is to assist with interpretation of relevant laws, guidelines, coding technical questions, and ethical standards that pertain to coding. To this end, the coding roundtable will meet quarterly [insert your own frequency], share information pertinent to crucial coding issues, and provide subject matter expertise in establishing standards and oversight for coding quality with consistency and continuity. The coding roundtable will make recommendations and assist with promoting coding best practices based on guidelines to ensure compliant and ethical coding outcomes.

**Accountability**

The activities and reports of the coding roundtable fall under the review of [insert individual’s name].

**Group Key Linkages:**

- HIM coding staff from across regional/corporate or area hospitals
- Regional HIM leadership and staff
- HIM directors and local and/or regional HIM coding managers

**Goals/objectives**

- Support clinical care and support operations through establishment of policies and practices that support coding completeness and integrity
- Comply with the organization’s revenue cycle expectations maintaining compliant and ethical coding practices
- Identify and implement HIM best practices in all hospital settings
- Identify and define education and training needs and assist in development of associated support materials for coding and HIM professionals to educate them regarding compliance with federal and state regulations relating to coding
- Define measures and develop reporting mechanisms related to the management of the coding and documentation querying and clarification issues
- Support ICD-10 preparations to assist and support the national implementation efforts when coding and HIM professionals are necessary to the process
- Develop parameters for the coding roundtable

**Structure/logistics**

Coding questions will be vetted first with the department coding manager and/or HIM director before submission to
It’s important to codify any decisions made during the roundtable. For example, consider sending a formal memo or email to all coders and CDI specialists that includes a brief background about the question, a summary of the discussion, any action steps, and an effective date for any changes. The effective date is important because it can affect data trending. “You may see patterns or trends in the data that could have been related to a decision made in the roundtable,” says Bryant.

Inviting attendees
At a minimum, roundtable attendees should include coding managers, auditing specialists, and coders. For providers with multiple facilities, ensure that there is a representative from each location, says Bryant.

Conducting the meeting
During the meeting, attendees should have access to coding manuals as well as AHA Coding Clinic, says Bryant.

Focus on coding questions that are truly challenging.

HIM coding roundtable charter (cont.)

the roundtable facilitator. This represents the coding question hierarchy. The coding roundtable will meet [insert frequency]. Roundtables will be conducted in person and via WebEx. Length of time for these roundtables will be [insert allotted time] or longer if needed to cover the issues and topics on the agenda. Meeting frequency may be altered by roundtable participants if need be.

Membership
Roundtable members have been identified by management and staff from across the region/area and corporation who are representative experts in coding. Additional members from local and regional HIM management will be included in the roundtable.

Guests shall be invited as appropriate to provide background on related subjects (e.g., physicians).

Roles/responsibilities
• Facilitator:
  – Acts as timekeeper during the quarterly meeting
  – Facilitates and documents the decision-making process (i.e., minutes)
  – Takes attendance at each meeting or designates an attendee/member to do so
  – Gathers, summarizes, and disseminates minutes from the roundtable
  – Is a HIM managing director or director of hospital coding or associate director of hospital coding
• Roundtable members:
  – Represent the organization’s commitment to ethical and legal behavior in all of its coding and coding-related activities
  – Regularly attend scheduled roundtable meetings or delegate attendance, if necessary or appropriate
  – Review materials presented and provide advice and recommendations on the topic or materials presented
  – Review minutes and approve them for dissemination
  – Participate in subcommittees formed for the purpose of carrying out the prioritized tasks on the coding roundtable portion of the meeting

Group duties
The duties of the roundtable shall include as appropriate:
1. Provide coding expertise and oversight for the development, implementation, and evaluation of the coding interpretations, guidelines, and guidance memos. This will include suggestions for:
   a. Developing high-level policies and/or procedures to support compliant coding practices
   b. Education and training of coding personnel
   c. Physician query changes, revisions, etc.
2. Review recommendations and new federal and state coding regulations from AHA’s Coding Clinic on ICD-9-CM and/or HCPCS or AMA’s CPT Assistant as appropriate.
3. Participate in subcommittee work related to identified coding areas.
4. Assist in the regional implementation (i.e., communication) of approved standards of practice, policies, workflows, and other related activities.
Value-based purchasing: What to expect in FY 2014 and beyond

by Robert S. Gold, MD

Hospital value-based purchasing (HVBP). It’s the latest buzz phrase in the healthcare industry, and it’s something in which all insurers are interested. Data drives the HVBP program. Data can indicate physicians with poor mortality statistics as well as hospitals with poor outcomes. Providers could ultimately lose market share based on this crucial data.

HVBP, patient safety, and HACs

The data derived for the HVBP program is closely tied with properly identifying patient safety indicators and HACs. It’s also closely tied with 30-day Medicare readmissions. Acute myocardial infarction, heart failure, and pneumonia will be the focus of readmission prevention for now. In its FY 2014 IPPS proposed rule, the CMS also proposes to add exacerbation of COPD and patients admitted for elective total hip or total knee arthroplasty to the readmissions reduction calculations for FY 2015. Over time, there will be an increased focus on minimizing readmissions. Medicare as well as all other payers will be interested in these initiatives.

Capturing the entire clinical picture

Physician documentation of the patient’s primary disease as well as all comorbidities can greatly help with these initiatives by assisting those in discharge planning and care management. Case managers must consider all aspects of patient care and be able to anticipate as well as mitigate any potential problems before patients are discharged. This will require input from staff members caring for the patient on the unit, social services, pharmacy, and dietary.

Although no one can predict the future, providers must be prepared to do what they can to prevent readmissions. This involves taking a holistic approach that includes helping patients manage their acute and chronic conditions, obtain access to medications, and engage in follow-up care. If providers can accomplish these tasks, they’ll likely lower their rates of preventable readmissions. Current statistics show that 17% of Medicare patients are readmitted within 30 days of any hospital stay. Providers may be able to reduce this number if they can identify all of a patient’s needs and ensure that case management meets those needs when preparing for the patient’s discharge.

“Clinical integration” is another buzz phrase that refers to the cooperative approach between the hospital personnel, private practitioners, and everyone else involved in a patient’s care. The goals are to achieve the best results of a hospital stay, maximize the stability of the venue to which the patient is discharged, and avoid a readmission.

What coders can do

Coders must be careful when reporting complication codes in the 900 series. In particular, coders shouldn’t...
default to a complication code simply because a physician documents that a condition is “postoperative.” ICD-9-CM guidelines specifically state that the physician must confirm the condition as a complication before coders can report it as such. However, coders shouldn’t purposely underreport complications either. The data is the data, and coders must apply the guidelines correctly.

Consider ICD-9-CM code 998.4, foreign body accidentally left behind. AHA’s Coding Clinic hasn’t been updated to reflect the National Quality Forum’s (NQF) new definition of “end of surgery.” Current Coding Clinic advice is based on inappropriate criteria from NQF for the time that surgery ends, formerly stating this time is when the wound is closed or the anesthesia is reversed or the patient leaves the operating suite.

The normal standard of care with every open procedure is to perform a sponge, needle, and instrument count when closure starts and to reopen the wound when a second count indicates that something is missing. An x-ray must also indicate where that item is located. The surgery technically ends when the object is removed, the closure resumes, and the anesthesia is reversed and the patient leaves the suite.

Some physicians purposely leave patients paralyzed and on a ventilator when they leave the OR so they can spend extra time reversing those patients from anesthesia on the ICU. In other instances, physicians will maintain patients on a ventilator for one or more days due to extensive trauma, the need to perform additional observation, or the potential need to return the patient to the OR quickly. Thus, the end of surgery isn’t strictly defined by all of these criteria all of the time.

Coders should also be careful not to overreport iatrogenic pneumothorax after insertion of a central venous catheter. An x-ray immediately after a subclavian or jugular line is inserted may demonstrate an apical cap. However, if the physician doesn’t address it by specific treatment or prolonged observation, it’s not codable. A single repeat x-ray is normal after insertion of a line, so coders can’t use this evidence to identify increased utilization of resources. An apical cap (i.e., a tiny pneumothorax at the top of the lung field in an upright film) is usually clinically insignificant and probably won’t even be seen if the film had been taken with the patient in the supine position. However, if the lung continues to drop and a third film is necessary—or the patient must undergo aspiration of a pneumothorax or receive a chest tube to resolve it—that’s a sure sign that coders can report the iatrogenic pneumothorax.

Remember that catheter-related urinary tract infection extends beyond the presence of a Foley catheter. Suprapubic tubes, nephrostomy tubes, and ureteral stents are all indwelling urinary catheters. Coders must work with their CDI team and physicians to be able to differentiate between colonization and an actual urinary tract infection. Documentation should also distinguish between acute (or chronic) cystitis and pyelonephritis.

Bundled payments

Although the FY 2014 IPPS proposed rule doesn’t address bundled payments directly, this is certainly another topic of interest. Regardless of whether bundled payments pertain to cardiac and orthopedic procedures, medical diagnostic hospitalizations, or any other types of services, this payment structure will work more effectively for hospitals and physicians. Bundled payments will also encourage more cost-effective care and better outcomes. This will lead to greater profits for hospitals and physicians as well. In addition to Medicare, several commercial payers are interested in bundled payments. The concept of bundled payments will continue to permeate more procedures, and more payers will jump on board.

In summary

Physicians must document a real and comprehensive list of relevant diagnoses so that the care management team knows what it must address to ensure patient safety and care throughout discharge to the most appropriate venue for additional care. The computer-generated patient problem list isn’t always reliable. How can the industry ensure meaningful use of a medical record if nobody knows what’s wrong with the patient?

To learn more about the HVBP program, visit the CMS website at http://tinyurl.com/dxqea2u.
Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Review all documentation specific to your scenario before determining appropriate code assignment.

Q Is it true that a CDI physician advisor/champion cannot be a direct patient care provider?

A CDI departments are not required to have a physician advisor; however, it is beneficial to have a physician champion. I make a distinction between the two. I define a physician advisor as someone who holds a formal position for which he or she has interviewed and receives compensation. On the other hand, a physician champion can be a provider who understands and supports the mission of CDI, serves as an informal resource for the CDI staff, and promotes the efforts of the CDI staff among his or her colleagues.

Either the physician advisor and/or physician champion can be a direct provider of patient care. Hospitalists often make great advisors/champions.

The distinction is that as the CDI advisor, the provider cannot document in the record of patients for whom he or she is not providing direct care.

It is unacceptable for the advisor/champion to add documentation or order services for the purpose of reimbursement/metrics for those under the care of another provider. Just because a physician advisor/champion is an independent licensed practitioner does not mean that he or she can render a medical opinion on all patients and change the documentation within the health record.

Additionally, physicians’ opinions do not supersede that of the attending provider when they are consulting, as their documentation would be treated the same as that of any other consultant. If their documentation conflicts with that of the attending, a query for clarification may be warranted. When acting in the role of advisor/champion, they must abide by industry standards (AHIMA guidelines) for communication with the medical team (e.g., querying) just like coding and nursing/CDI staff.

Q A surgeon’s dictated report for a right hip hemiarthroplasty states the following:

Of note, while drilling one of our transosseous suture holes with a 2.0 mm drill bit, the end of the drill bit broke off inside of the trochanter. It seemed to be quite deep into the bone and was not retrievable. As such, it was left in place.

Should we report 998.4 (foreign body accidentally left during a procedure) for this case?

A Three separate Coding Clinic references address code 998.4, and each of them supports assigning the code for the scenario you describe above.

Coding Clinic, First Quarter 2012, p. 12 states that the occurrence of unintended retention of objects at any point after the surgery ends should be captured regardless of the setting or whether the object is removed.

Coding Clinic, First Quarter 2011, p. 5 clarifies that although the provider makes a decision to leave the drill bit (i.e., foreign body) behind because it is too difficult to retrieve, the provider’s intent/intent of the procedure isn’t to leave a drill bit in the bone. Therefore, it’s still considered an accidental occurrence.

Unlike other complication codes, I didn’t find any
In some cases, a new diagnosis may be the only option listed in the multiple-choice format along with “other” and “clinically undetermined.”

William E. Haik, MD, FCCP, CDIP, director of DRG Review, Inc., in Fort Walton Beach, Fla., answered the previous question that originally appeared on JustCoding.com.

Q  A 2-day-old newborn is observed for suspected tobacco exposure in utero. What ICD-10-CM code(s) should we assign for this scenario?

A  Report P04.2 (newborn [suspected to be] affected by maternal use of tobacco). Locate this code by looking for the terms “newborn” and “twin” in the Alphabetic Index. Next, find the subterm “born in the hospital,” which maps to Z38.30. Look for this code in the Tabular List to verify it.

Q  How will we report a robotic-assisted right total knee arthroplasty in ICD-10-PCS?

A  Report 8E0YOCZ. Look up “robotic-assisted procedure, extremity, lower.” The Other Procedures section appears to have been created to capture procedures that are new and emerging, providing better statistical data capabilities. Although these codes don’t provide the specificity that coding this procedure from the Medical and Surgical section would, they provide information about this unique procedure.

The previous two questions are excerpted from The Coder’s Guide to ICD-10, published by HCPro, Inc. To learn more, visit www.hcmarketplace.com/prod-9661.

Counseling Q&A is a monthly service to Briefings on Coding Compliance Strategies subscribers. Reproduction in any form outside the subscriber’s institution is forbidden without prior written permission from HCPro, Inc. Copyright © 2013 HCPro, Inc., Danvers, MA. Telephone: 781-639-1872; fax: 781-639-7857. CPT codes, descriptions, and material only are Copyright © 2013 American Medical Association. CPT is a trademark of the American Medical Association. All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The American Medical Association assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.