While it can be challenging to define your organization’s legal health record (LHR), one health system in Denver is proving that collaboration and perseverance can lead to an effective LHR and EHR.

Sisters of Charity of Leavenworth (SCL) Health System operates eight hospitals, four safety net clinics, one children’s mental health center, and more than 190 ambulatory service centers in Colorado, Kansas, and Montana. SCL Health originally used various EHRs and applications to capture patient information but sought to select one EHR for use across the entire organization. This would allow the system to effectively manage patient-related data and documents and establish a consistent definition of an LHR so everyone would know what information should be retained and released, says Barbara Manor, MA, RHIA, vice president of HIM at SCL Health.

“Defining the LHR is difficult for organizations who may be in an electronic hybrid state, where all of the output from their EHR is not being housed completely in an electronic document management system, and still may have fragmented discrete data elements and templates that are in an active clinician-based EHR system,” says Darice Grzybowski, MA, RHIA, FAHIMA, president of HIMentors, LLC, in Westchester, Illinois.

Indeed, as records continue to shift from paper to electronic format, many organizations struggle with defining their LHR, especially those that are merging or that use multiple EHRs, says Mary Beth Haugen, MS, RHIA, founder and CEO of Haugen Consulting Group in Denver, who helped SCL Health as it sought to better manage its patient data.

Streamlining EHRs and establishing an LHR

Consider the following when making an effort to move to one EHR or define an LHR at your organization:

• **Work together.** SCL Health brought together a multidisciplinary team to help define the LHR so
it would have all of the information necessary for determining what data and documents are essential, Haugen says. “It can’t be just HIM working in a silo, and it can’t be just IT working in a silo,” she says. “Identify the right players.”

HIM should collaborate with IT, compliance, and the end users—including the clinical staff. At SCL Health, the HIM department reports to the chief information officer, which links HIM to IT. “I think that one of the things that SCL Health has really done well is partnering with IT,” Haugen says. This type of partnership is not something that she sees every day, although she notes that it can be beneficial because it brings HIM to the table when IT develops programs that affect patient data, such as patient portals.

- Locate the data and documentation.

Unfortunately, many organizations—especially larger health systems—are unsure of where all their patient information lives or are unaware of legacy systems that were not converted into the EHR, Haugen says. SCL Health had this issue as well.

It was difficult for SCL Health to determine the location of its data, Manor says. However, she advises organizations to begin inventorying their data as soon as possible to get the process of creating an LHR and merging EHRs off the ground. “Start inventorying where all that data resides and figure out who are those stakeholders that have the data,” she says. “Just start writing down where all the data is.” The health system was able to manage this task with the help of consultants that interviewed key stakeholders and workforce members to better understand where data was stored and how it was used.

Once you know where the data lives and where documents that are necessary for output, printing, and archive purposes are, you can determine what needs to be done with this information and whether it should be included in your LHR, says Grzybowski.

The trick is determining what works best for your organization. “There are some pieces and parts that are standard, but there are other pieces and parts that aren’t necessarily going to be consistent across
organizations,” Manor says.

While some components of the EHR should obviously be included in the LHR, such as patients’ histories and physicals or discharge summaries, organizations should determine whether to include other data or documents. Some may opt to include coding queries, email communication between providers and patients, records from other hospitals or clinics, problem lists, and elements of patients’ personal health records, Haugen says.

Ensure that the LHR is accessible and can be managed from a single point of access. If the EHR vendor system is replaced in the future, the record should be able to stand on its own with stored document output, and not in discrete data fragments, Grzybowski says.

Consider retention times when determining what should be included in the LHR. Some record types, such as pediatric records, are retained for a long period of time. Since storing unnecessary information in the LHR can be costly, it is advisable that organizations consider all record types before setting standards for their LHR, Haugen says.

The LHR should provide the necessary and pertinent patient information, but be careful not to commit to including more information than you can realistically provide. LHRs must be produced when requested by patients, caregivers, or attorneys; therefore, they must be relatively easy to share, Haugen says.

- **Communicate with workforce members.**

  While defining the LHR is important, so too is communicating with workforce members to ensure they understand what should be included, Haugen says.

  Educate workforce members on how information in the medical record can be used concurrently and retrospectively. Ensure that they are aware of the role that patient data plays not only in defining the LHR but in other areas such as auditing, Haugen says.

  “Bring it down to a basic level,” she says. “Put yourself in the patients’ shoes.” Ask workforce members to consider how patients would feel if they were unable to get the requested data from their medical record. This may help your workforce better understand the importance of a complete and accurate LHR.

  Haugen set up 30- to 60-minute group meetings with SCL Health workforce members to educate them about the plans for patient data and to learn how they used and stored information. This was done through questionnaires, which she gave to staff members prior to the meetings to allow them the opportunity to think about their responses and fill out the questionnaires ahead of time if possible. (See pp. 4–5 for a sample questionnaire.)

  Manor says this worked well because it allowed people to reveal their work habits to an outside source in a nonthreatening environment while freeing up some of her own time to focus on the overall project.

**Lessons learned at SCL Health**

As part of its effort to better organize and define medical record data, SCL Health developed a systemwide policy that documents all of its systems and links data sets to the systems in which they reside, including information about when systems were launched or retired. The policy and its appendices are designed to help workforce members look up the type of data they have questions about, find its location, and determine whether the data should be included in the LHR or designated record set, Manor says. The policy itself does not need to be revised when systems are retired; all that is required is a quick update of the appendices.

“We are trying to keep it all in one simple matrix table,” she says. “It’s been very helpful to all of our staff when they’re going to release data or they need to figure out where data is.”

The health system is currently using one vendor for its EHR in its hospitals, compared to the four it originally used. Like most organizations, there are still some paper records at SCL Health, so the health system moved to one scanning system from seven, Manor says. It took SCL Health approximately two years to get to where it is today.

“It’s still a work in progress,” Manor says. “We own about 200 clinics, and some of them are on our EHR, and we are slowly but surely getting them all on it, but some of them still have other EHRs.”

Currently, the health system is focused on moving all of its legacy system data to one system so it is easily accessible and can be included in the overall LHR. The trick is determining whether the legacy system data and reports should be included in the health system’s new EHR or in an archival system, Manor says.
## Legal health record questionnaire: Current state

Use the following sample questionnaire to determine how your workforce members use and store data. This process may be helpful when identifying which data and documents should be included in your organization’s legal health record (LHR).

<table>
<thead>
<tr>
<th>Assessment criteria</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a current LHR policy at your facility?</td>
<td></td>
</tr>
<tr>
<td>• If so, please provide an electronic copy.</td>
<td></td>
</tr>
<tr>
<td>2. Do you have any additional policies you feel will be impacted by the LHR policy?</td>
<td></td>
</tr>
<tr>
<td>• If so, please provide electronic copies.</td>
<td></td>
</tr>
<tr>
<td>3. Do you have a designated record set policy?</td>
<td></td>
</tr>
<tr>
<td>• If so, please provide an electronic copy.</td>
<td></td>
</tr>
<tr>
<td>4. Is your LHR record currently residing in (identify current EMR or document manage-</td>
<td></td>
</tr>
<tr>
<td>• For what time frame (go-live date)?</td>
<td></td>
</tr>
<tr>
<td>5. If the LHR is not in the EMR, what other systems?</td>
<td></td>
</tr>
<tr>
<td>• Please list each system and the time frame.</td>
<td></td>
</tr>
<tr>
<td>6. Any paper medical records not stored in your current electronic system?</td>
<td></td>
</tr>
<tr>
<td>• If yes, what time frame?</td>
<td></td>
</tr>
<tr>
<td>7. Do you have a forms inventory?</td>
<td></td>
</tr>
<tr>
<td>• If yes, please provide an electronic copy.</td>
<td></td>
</tr>
<tr>
<td>• If yes, how and who maintains the inventory?</td>
<td></td>
</tr>
<tr>
<td>• Please provide contact information.</td>
<td></td>
</tr>
<tr>
<td>8. Is all medical record documentation either dictated or completed electronically?</td>
<td></td>
</tr>
<tr>
<td>• If not, what is the documentation and how is it being managed?</td>
<td></td>
</tr>
<tr>
<td>9. Are you aware of medical records being stored outside your department?</td>
<td></td>
</tr>
<tr>
<td>• If so, what documents?</td>
<td></td>
</tr>
<tr>
<td>• What time frame?</td>
<td></td>
</tr>
<tr>
<td>• Please provide a contact name and number.</td>
<td></td>
</tr>
<tr>
<td>10. Please provide a list of applications that impact the LHR. For example, mom/baby,</td>
<td></td>
</tr>
<tr>
<td>• cardiology, radiology, etc.</td>
<td></td>
</tr>
<tr>
<td>• How are these systems made part of the LHR?</td>
<td></td>
</tr>
</tbody>
</table>
Haugen urges organizations not to forget about data in legacy systems, because you never know when you may need to retrieve it. The systems cannot be turned off, but they can be challenging and costly to support. Develop a strategy for rolling data off legacy systems as part of your overall strategy to streamline EHRs and define the LHR, she says. Haugen and Manor offer the following advice based on their experience with merging EHRs and defining the LHR at SCL Health:

• **Map out a plan.** Because forming a single EHR and a precisely defined LHR can often take years, key players at SCL Health had to sit down and develop a plan before embarking on their journey. “I think you have to have a strategic vision,” Manor says. Think about where the data and documentation live, who will access it, and how it will be accessed. Determine whether all of the necessary data can be incorporated in one EHR and, if not, what will be done with all of the records, she says.

• **Keep it clean.** Patients may not understand the complexities of EHRs; they may assume that all of their records throughout a health system can be easily shared and accessed. Ideally, a patient’s records at a hospital would carry over to a health system’s clinic records, but this is not always the case. For this reason, organizations must ensure that records are cleaned up and reviewed so the data is as concise and accessible as possible if EHRs are merged, Haugen says.

• **Don’t be afraid to ask for help.** Manor says that bringing in consultants was key in helping SCL Health focus its EHR and LHR efforts. “Organizations have so many competing priorities, and it’s difficult to really wrap your arms around a topic that’s as important as this,” Manor says. Consultants helped SCL Health work with stakeholders, educate workforce members on the importance of the project, and determine what questions to ask to help define the LHR, she says. "
ICD-10 countdown

Respiratory coding updates and guidance

Coding and documentation should tell a patient’s complete story. With the greater specificity in ICD-10, organizations should be better able to capture these stories, and the respiratory codes, listed in Chapter 10: Diseases of the Respiratory System (J00–J99), are no exception.

As the industry moves toward ICD-10 implementation, organizations should focus on updating their query forms to meet ICD-10 documentation requirements. For respiratory coding, the forms should ask providers whether the condition is acute, chronic, or recurrent, since this information is needed for coding in ICD-10-CM, said Tara L. Bell, RN, MSN, CCM, AHIMA-approved ICD-10-CM/PCS trainer and assistant manager of clinical documentation improvement services at UASI in Cincinnati. Bell spoke about changes to respiratory coding and documentation during HCPro’s webcast “Transition to ICD-10-CM Respiratory Coding: Anatomy, Documentation, and Guidelines.”

“The major hitters are the new indications for asthma and pneumonia,” Bell said. One way to help coders on the back end is to ensure query forms address the key points needed for thorough documentation so that information can be included in the medical record, she said.

ICD-10-CM coding guidelines for respiratory conditions

When coding a respiratory condition that is documented as occurring in more than one site and not specifically indexed, classify it to the lower
anatomic site. For example, trachea bronchitis would be coded as bronchitis since the trachea is in a higher site, Bell said.

ICD-10-CM offers great detail for coding upper respiratory infections. According to Bell, the documentation and coding must reflect:

- The specific anatomical site
- Whether the infection is acute, chronic, or recurrent
- Whether there is obstruction
- The specific infectious agent (e.g., strep throat, methicillin-resistant *Staphylococcus aureus*) if applicable

Additional characters are not required for acute nasopharyngitis (J00), but coders should add them to the diagnosis based on the documentation.

Much like upper respiratory infections, when coding for lower respiratory infections or disorders, the documentation must specify whether the condition is acute, chronic, or recurrent, and whether there is an applicable infectious or external agent. Documentation of bronchiectasis should include information about whether the condition is associated with lower respiratory infection or exacerbation, Bell said.

Examples of specifically documented and coded lower respiratory conditions include:

- J20.3: Acute bronchitis due to coxsackievirus
- J21.1: Acute bronchiolitis due to human metapneumovirus
- J38.5: Laryngeal spasm
- J45.30: Mild persistent asthma, uncomplicated
- J62.0: Pneumoconiosis due to talc dust

**Tobacco use, exposure, and dependence**

The requirement to document and code tobacco use, exposure, or dependence was not part of ICD-9-CM but should be reported with nearly every respiratory condition coded in ICD-10-CM, said Shelley C. Safian, PhD, MAOM/HSM, CCS-P, CPC-H, CPC-I, CHA, AHIMA-approved ICD-10-CM/PCS trainer and a senior assistant professor at Herzing University Online.

“Tobacco use or exposure may not be the reason for a patient’s respiratory condition, but this information must still be documented and coded. Providers should document exposure to smoke during the perinatal period so this can be coded as well,” Safian said. “The point here is to track those who do have the condition as a result of smoking,” she said.

**Asthma coding in ICD-10-CM**

Coders must add an additional character to some of the tobacco codes to identify whether the dependence is uncomplicated, in remission, in withdrawal, or with other nicotine-induced disorders. Communicate with providers so they are aware that this information must be documented for coders to add the appropriate character, Safian said. Some of the tobacco codes have an Excludes1 note, which identifies certain codes as being mutually exclusive of others in ICD-10, she said. The Excludes2 notes in ICD-10-CM, which are listed with some tobacco dependence codes, are similar to the excludes notes in ICD-9-CM.

Coding for asthma changes significantly from ICD-9-CM to ICD-10-CM, and providers will need to change their documentation standards for this...
condition to effectively transition to ICD-10, Safian said. The descriptors used for coding asthma in ICD-9-CM involved documenting whether the condition was intrinsic or extrinsic, but ICD-10-CM offers enhanced specificity for this condition.

Coding and documentation for asthma must specify whether the asthma is mild, moderate, or severe, and whether it is intermittent or persistent, Bell said. If the patient’s asthma is associated with exacerbation or status asthmaticus, that should be documented and will be represented in the fifth character of the ICD-10-CM code.

“An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection,” Safian said. “This is giving you a specific direction that when the infection is in there and the doctor has said, ‘Well, the infection exacerbated the condition,’ that now ICD-10 is telling you directly that doesn’t mean that you’re reporting this as an exacerbation.”

Safian advises organizations to encourage physicians to document the severity and frequency of asthma symptoms—which are denoted by a fourth character in ICD-10-CM—using the following definitions:

- Intermittent: Symptomatic less than or equal to two times per week
- Mild persistent: Symptomatic more than two times per week
- Moderate persistent: Daily symptoms that may restrict physical activity
- Severe persistent: Symptoms occur throughout the day and frequent, severe attacks limit the ability to breathe

One includes note and two excludes notes are listed for asthma in ICD-10-CM compared to just one excludes note and no includes notes in ICD-9-CM. “Asthma is now all included in this one code category; that’s no longer a differentiation that you or your physicians need to make,” Safian said.

The second excludes note for asthma in ICD-10-CM is the same as the excludes note in ICD-9-CM and lists three diagnosis codes that are not part of the J45 code set. The new excludes note added to ICD-10-CM identifies codes that are mutually exclusive and cannot be used on the same claim as a code in the J45 set, Safian said.

**Influenza coding in ICD-10-CM**

Coding for influenza in ICD-10-CM will be similar to ICD-9-CM. The documentation must capture any respiratory manifestations, including pneumonia, pleural effusion, or laryngitis, Safian said. The ICD-10-CM combination codes in this category will capture the causal organism (i.e., H1N1), which must be documented by the provider.

“This saves us some work because we do in ICD-10 have more combination codes,” Safian said. “There are more instances where one code is going to tell the whole story and we don’t have to go searching for a second code.”

Common influenza combination codes include:

- J09.X (using X as a placeholder): Influenza due to identified novel influenza A virus
- J10: Influenza due to other identified influenza virus
- J11: Influenza due to unidentified influenza virus

Coders should only report J09 or J10 in the outpatient setting if influenza is confirmed; otherwise, the signs and symptoms should be coded instead, Safian said. The codes must be based on physician documentation of the condition. “There is no assumption allowed here,” she said. “If the provider documents suspected avian flu or novel flu, or other, then you can’t report those. You have to report the influenza due to unidentified influenza virus or wait for the pathology report to come back.” However, coders may report that influenza was unconfirmed, probable, or possible for those patients in the inpatient setting, she added.

**Pneumonia coding in ICD-10-CM**

Coding for pneumonia in ICD-10-CM will be similar to ICD-9-CM, Safian said. Coders will need to document in the record the type of pneumonia (e.g., viral, fungal, bacterial, aspiration) and underlying disease.

“It’s emphasized, of course, that the provider has to identify that causal relationship between the
organism and the pneumonia,” she said. “The documentation must state this specifically. We are not permitted to connect the dots by ourselves.” Start talking to your providers about this documentation now so they are ready for October 1, 2015, she added.

For ventilator-associated pneumonia, the documentation must specify that the patient’s pneumonia was in fact caused by being on a ventilator. If the patient is admitted for pneumonia and develops ventilator-associated pneumonia after admission, coders should report the primary cause of the pneumonia as the principal diagnosis. Ventilator-associated pneumonia will be the secondary diagnosis, Safian said. “You still need the physician to connect those dots,” she said. “You are not allowed to assume a connection.”

The ICD-10-CM contains combination codes for pneumonia much like it does for influenza, which should help coders arrive at the appropriate code quickly and easily as long as the documentation is thorough, Safian said. The combination codes include:

- J12: Viral pneumonia
- J13: Pneumonia due to Streptococcus pneumoniae
- J14: Pneumonia due to Hemophilus influenzae
- J15: Bacterial pneumonia
- J16: Pneumonia due to other infectious organisms
- J17: Pneumonia in diseases classified elsewhere
- J18: Pneumonia, unspecified organism

ICD-10-CM contains an Excludes1 note for diagnoses that are mutually exclusive of pneumonia.

**Bronchitis coding in ICD-10-CM**

ICD-10-CM offers greater specificity than ICD-9-CM when documenting and coding for bronchitis. Physicians should still document the acuity of the condition (e.g., acute, chronic, acute on chronic), but if the documentation for this does not exist, coders can default to chronic. However, organizations should work with physicians now to ensure they document acuity of bronchitis so that coders do not have to default to chronic every time, Safian said. “We don’t want to have to label a patient with chronic bronchitis when it may really just be acute bronchitis. [We don’t want] to make that patient live with the repercussions of a chronic illness that they don’t have,” she said.

Bronchospasm is included in the diagnosis for acute bronchitis, whereas chronic bronchitis with obstruction is coded as chronic obstructive pulmonary disease (COPD) in ICD-10-CM. Bronchitis can be specified as due to fumes, a specific organism, radiation, or viral organism. Approach physicians and ensure they are aware of this increased specificity so they can begin documenting accordingly, Safian said.

**COPD coding in ICD-10-CM**

Like many other respiratory conditions, COPD can also be coded with greater specificity in ICD-10-CM with the requirement to add codes that identify tobacco use, exposure, or dependence, Safian said. The level of exacerbation and type of COPD (e.g., chronic obstructive bronchitis, chronic bronchitis with emphysema) should also be documented and coded. The code category for COPD (J44) allows coders to identify whether the condition is associated with acute lower respiratory infection or exacerbation unless it is unspecified. ICD-10-CM features an Includes note for COPD.

“These inclusions make it very easy for you to be able to connect physician documentation to this code category, which we always love,” Safian said.

Like other respiratory conditions, this category also features an Excludes1 note because it is mutually exclusive, she added.

**Respiratory failure coding in ICD-10-CM**

ICD-10-CM allows for specific coding of whether respiratory failure should be coded as acute, chronic, or acute on chronic. Just like with COPD, an additional code for identifying tobacco use or exposure must be included.

A principal diagnosis of respiratory failure is based on the circumstances of the admission. “If the cause for admission or the primary cause for the encounter has been documented as acute respiratory failure, you are permitted to use J96.0 or J96.2 as the principal diagnosis, and of
course, if it’s developed after admission, or if it’s present on admission but not the main reason for the admission, it can be reported as a secondary diagnosis,” Safian said.

Providers should document whether respiratory failure is with hypoxia or hypercapnia and should specify the etiology of the respiratory failure to allow for more specific coding, Safian said. An Excludes1 note lists conditions from which respiratory failure is mutually exclusive.

**Emphysema coding in ICD-10-CM**

Emphysema must be documented for and coded more specifically in ICD-10-CM than in ICD-9. ICD-10 offers codes for the type of emphysema and whether it is unilateral, panlobular, or centrilobar. Check your current patient records to determine whether physicians are documenting this information. The information may already be present in the record, but it may have been overlooked because ICD-9-CM did not allow coders to incorporate it, Safian said.

Physicians should document external causes of emphysema so coders can report them. This includes code T79.7 (Traumatic subcutaneous emphysema) and T81.82 (Surgical emphysema (subcutaneous)).

**Coding malignant neoplasm of the lung in ICD-10-CM**

Coding for malignant neoplasm of the lung in ICD-10-CM will be similar to ICD-9-CM in that the documentation and codes must reflect the site of the neoplasm (e.g., carina, upper lobe, main bronchus). Just as in ICD-9-CM, there are different codes for primary, secondary, in situ, and benign malignant neoplasms of the lung. ICD-10-CM focuses on documentation and coding for laterality, and malignant neoplasms of the lung are no exception, Safian said.

“The biggest thing that has changed with malignant neoplasms of the lung is you are now going to need to identify laterality,” she said. “This is most likely going to be something that is already in the documentation—we’ve just never had to pay attention to it before.”

**Pulmonary embolism coding in ICD-10-CM**

Providers should document whether pulmonary embolisms are acute, chronic, or healed in ICD-10-CM. If the condition is chronic, documentation and coding should reflect whether the patient is a long-term user of anticoagulants. Physicians should also note the type of embolism (e.g., saddle, septic) along with whether it is associated with acute cor pulmonale. This is not much different than what is currently done in ICD-9-CM, Safian said.

Pulmonary embolism is listed in ICD-10-CM with an Includes note that associates the code for this condition with:
- Pulmonary (acute)(artery)(vein) infarction
- Pulmonary (acute)(artery)(vein) thromboembolism
- Pulmonary (acute)(artery)(vein) thrombosis

An Excludes2 note is listed in the pulmonary embolism category in ICD-10-CM and is similar to that of ICD-9-CM. “It just means this is not included in this code,” Safian said. “So maybe you’re in the wrong place or maybe you need an additional code.”

**Pneumothorax and air leak coding in ICD-10-CM**

Providers must document the cause of pneumothorax or air leak (e.g., postprocedural, traumatic, congenital, tubercular) for the condition to be coded accurately in ICD-10-CM. The ICD-10-CM codes for this condition are similar to those in ICD-9-CM in terms of the level of detail that must be documented and coded, Safian said. “This is not going to cause too much of an adjustment to what you’re doing now,” she said.

The Excludes1 note for this category in ICD-10-CM lets coders know that the codes are mutually exclusive from several conditions.

Overall, the key to mastering documentation and coding for respiratory conditions in ICD-10-CM is understanding anatomy and physiology and having a firm grasp on the codes commonly reported at your facility, Bell said. “Coding and the queries are going to be much easier if you actually understand the process and understand why the codes are so specific,” she added.
Transformational HIM strategies

The role of HIM in risk adjustment and HCC coding

by Adriana van der Graaf, MBA, RHIA, CHP, CCS

More than ever before, HIM is being recognized as an enterprise profession important to ambulatory, acute, and postacute settings. A good example of the transformation is HIM’s involvement in CMS’ risk adjustment and Hierarchical Condition Category (HCC) coding system. CMS mandated HCCs as a payment model in 1997. This model was implemented in 2003 and identifies patients with severe or chronic illness. It has been the reimbursement basis for Medicare Advantage plans since 2004 and is used to predict the cost of care for individuals enrolled in the plan for the following year. With increased focus on containing healthcare costs, HCC coding has continued to gain ground as the payment model under the Affordable Care Act. It is the risk adjustment model mandated by CMS for accountable care organizations (ACO).

The HCC structure identifies a risk factor score for the patient based on a blend of his or her health conditions and demographic details. CMS’ HCC model dictates that risk adjustments must meet the following standards:

- Prospective in nature
- Derived from diagnostic sources (i.e., inpatient and outpatient hospital and physician data)
- Base payment for each patient based on HCCs and influenced by Medicare costs for chronic diseases
- Additional factors applied when hierarchy of more severe and less severe conditions coexist
- Final adjustment due to age, sex, original Medicare entitlement, disability, and Medicaid status

The patient’s health conditions are currently identified using ICD-9-CM diagnosis codes that are submitted by providers on incoming claims. There are approximately 3,300 ICD-9-CM codes that map to 87 HCC codes in the current risk adjustment model. Providers can expect this to change significantly with the advent of ICD-10-CM.

While CMS has not yet released the ICD-10-CM relevant HCC codes that will go into effect October 1, 2015, code translations using General Equivalency Mappings indicate that the number of HCC codes will quadruple. Coders will not be able to assign ICD-10 codes without the presence of accurate and comprehensive supporting documentation by the qualified provider.

Chronic conditions such as diabetes and hypertension play a significant role in HCC coding as they are predictors of future healthcare resource needs. These types of conditions will require more specificity in ICD-10-CM. One tenet of HCC codes is that they must be based on face-to-face encounters with the provider.

CMS requires documentation in the patient’s medical record by a qualified healthcare provider to substantiate the submitted diagnosis. The documentation must support the presence of the condition as well as the provider’s assessment and plan for managing the condition. A provider must see a patient at least once each calendar year for CMS to acknowledge that the individual continues to have the condition. The physician must document the condition to the highest level of specificity.

Many nonspecific diagnoses are not designated HCC codes, and therefore do not carry a risk-adjusted weight that enhances revenue for the covered member. For example, bronchitis, not otherwise specified (ICD-9-CM code 490) is not an HCC and carries no weight. Simple chronic bronchitis (ICD-9-CM code 491.0) has a weight of 0.34 and falls under HCC category 108, chronic obstructive pulmonary disease. In ICD-9-CM, lobar pneumonia (which includes streptococcus pneumonia) falls into HCC 112, Pneumococcal pneumonia, empyema, and lung abscess, with a weight of 206. Lobar pneumonia likely will not be an HCC code under ICD-10-CM because streptococcal pneumonia is not included as a nonessential modifier.
for lobar pneumonia in the new code set. Physicians should review their documentation patterns carefully to see how the terminology they use will translate into ICD-10 language.

Providers working with risk-adjusted HCCs should bear in mind that most documentation comes from outpatient office visits, while relatively little comes from inpatient encounters. Some physician groups request a data dump of their patients’ inpatient diagnosis codes from local hospitals. Because inpatient encounters contain ICD-9 codes assigned by certified coders based on documentation from a face-to-face physician encounter, physician groups often look to this data for improved specificity. Integrated delivery systems with enterprise data warehouses should evaluate differences between chronic conditions coded on inpatient accounts versus outpatient accounts for the same patients.

Historically, outpatient documentation has not been subject to the oversight common to inpatient documentation. In fact, many providers directly assign codes for each encounter without the benefit of specific ICD-9-CM or ICD-10-CM coding education, and rarely do trained coders review and code from documentation or audit accounts. Providers are often unfamiliar with valuable coding resources, official coding guidelines, or encoder software programs. Some may select codes from superbills or EHR drop-down menus, which often limit the available options to nonspecific codes. If trained coders are involved in the process, they typically work remotely and may be contract employees. These coders have little if any opportunity to question diagnoses and codes with the provider. Traditionally, experienced and credentialed coders are placed in the inpatient environment rather than in the outpatient environment, but HCCs may be a good reason to reverse this trend.

Some organizations are in the process of expanding their clinical documentation improvement (CDI) efforts to include HCCs because of their growing use and the intersecting demand for increased specificity under ICD-10-CM. Now is the time to consider adding an HCC specialist to the current team of CDI specialists and expanding CDI into the outpatient arena. Other measures should include assessing all EHR templates for ICD-10 readiness, reducing or eliminating coding cheat sheets, and providing ongoing assessment and education to providers, CDI specialists, and coders. Strong consideration should also be given to eliminating or at least strongly limiting cut-and-paste capability in EHRs.

Any healthcare organization moving into the risk-adjusted market of ACOs, hospital value-based purchasing, or Medicare Advantage ownership should closely inspect their HCC documentation, coding, and process oversight. This will be critical for maintaining compliance, accurate quality measures, and financial stability following the transition to ICD-10-CM. To manage these hazards, organizations should begin to assess methods to educate, monitor, and evaluate the quality of outpatient documentation and coding as they pertain to HCCs.

Technology can assist in many facets of the process, allowing for improved capture of documentation with computer-assisted physician documentation, automated code capture with computer-assisted coding, and simplified clarification and follow-up with computer-assisted CDI. This type of technology will not replace the need for providers to accurately and completely document patient conditions that support the greatest possible code specificity. However, many organizations are adding coders and CDI specialists to collaborate with providers on the best means to improve documentation and leverage technology.

As integrated delivery systems grow with more primary and specialty ambulatory services, HIM leaders are often in the best position to guide their organizations in understanding the importance of different code sets and reimbursement models. HCCs are another model for HIM professionals to gain understanding and advise their respective leadership in investments with the greatest return in both the integrity and accuracy of health information.

EDITOR’S NOTE
Van der Graaf is the associate director for Navigant Consulting, Inc., in Washington, D.C., where she is responsible for CDI programs, ICD-10 education and training, and HIM assessment and redesign. She has more than 35 years of HIM and revenue cycle experience and is an HIM educator and AHIMA mentor.
Dear colleagues:

As most of you know, the current diagnosis coding system (ICD-9-CM) is slated to transition to ICD-10-CM on October 1, 2015, after having been delayed three times.

As you have also likely heard, ICD-10-CM will have 69,823 codes instead of the 14,035 codes in ICD-9-CM, will expand to as many as seven characters as opposed to ICD-9-CM’s five, and will use more letters than ICD-9-CM. Please read the Centers for Disease Control and Prevention (CDC)’s perspectives on this change, available at [http://tinyurl.com/CDCicd10intro](http://tinyurl.com/CDCicd10intro).

The ICD-10 Coalition ([http://coalitionforicd10.org](http://coalitionforicd10.org)) is gearing up a political campaign with Congress to squash any further ICD-10 delay, even though the AMA, which is not a member of the coalition, considers ICD-10 to be a costly yet unfunded mandate that should be scuttled. Read the AMA’s perspective at [http://tinyurl.com/3gahnm](http://tinyurl.com/3gahnm) and AHIMA’s perspective at [http://tinyurl.com/ltgw7hw](http://tinyurl.com/ltgw7hw). As Joan Rivers would have said, “Let’s talk.” Let’s talk about ICD-10 and how physicians can approach it with HIM professionals in a win-win fashion. There must be a way that the AMA or other physician groups can vet the issues at hand and promote the goals of ICD-10 without unduly burdening the providers obligated by HIPAA to use it.

**Who’s in charge of ICD-10?**

What you may not know is that ICD-10 is controlled by four Cooperating Parties, none of whom directly represent practicing physicians. These Cooperating Parties include:

- **CMS**, which represents payers and has final authority for ICD-10 inpatient procedures
- **American Hospital Association**, which represents hospitals (not physicians)
- **AHIMA**, which represents coders and HIM professionals

Physicians, you’ll note, are not directly represented; although the Cooperating Parties claim that they “reach out” and listen to us, they are not obligated to follow our advice. Meetings finalizing and interpreting the ICD-10 code sets are held behind closed doors with no published agenda or minutes. In my opinion, having an ICD-10 code introduced or changed is like passing a bill in Congress; one pretty much needs a full-time lobbyist and physicians who will travel to Baltimore to convince four nonphysicians as to why the code change is necessary.

**So what’s the deal with ICD-10?**

The ICD-10 Coalition will tell you there’s a lot to like about ICD-10. I agree. While there’s a 400% increase in the number of codes, much of the expansion is for conditions we document anyway (i.e., laterality). Diabetes, obstetrics, trauma, and orthopedics have greater specificity than in ICD-9. As healthcare reform and resource allocation demand rich, complete, and specific data, ICD-10 has the capacity to accommodate this need.

Unfortunately, even with the benefits ICD-10 offers, the Cooperating Parties also tell us that:

- ICD-10 coding is based *only* on the provider’s documentation and the terminology he or she uses, not upon the patient’s apparent clinical indicators. Physicians must completely, consistently, and sometimes repetitively document using ICD-10 language that
does not necessarily sync with what we read in our literature, meaning we often get queried for clarification on issues that appear obvious. On the other hand, CMS-sanctioned Recovery Auditors may remove a code using their own clinical interpretations—even if the diagnosis is consistently documented by the provider—thus lowering our reimbursements. Is that fair?

- Weaknesses in ICD-9-CM will carry forward to ICD-10-CM, such as heart failure with reduced ejection fraction not being coded as systolic heart failure, reactive airway disease being coded as asthma, and nonischemic cardiac necrosis being coded as a myocardial infarction. Call me if you want to hear more.
- Coders cannot tell us what to write. Even if the suggestion is accurate, doing so would be considered “leading” by CMS and subject to government scrutiny.
- Our EHRs don’t tell us what language to use either, which means remembering the increased specificity offered by ICD-10 and how to appropriately document it, a near-impossible task.
- Payers will not publish their ICD-9-CM to ICD-10-CM crosswalks, which will increase our denials. One payer told me recently that it plans to deny claims with unspecified laterality (e.g., right, left, bilateral) or that lack a coded trimester. Given that each denial costs $50–75 to refile, that’s a heavy burden. We need to receive this information up front.
- ICD-10 is not approved for EHR problem-list management under meaningful use, whereas SNOMED-CT is, meaning we have two clinical languages to contend with. ICD-11 is more compatible with SNOMED-CT, yet it is not likely to be available in the U.S. until 2025, if then.

The political challenge

The ICD-10 Coalition is pushing Congress hard to implement the Cooperating Parties’ masterpiece in 2015. Given that ICD-10 could be a bargaining chip as we fight the Medicare sustainable growth rate issue, the code set could be delayed again. To avoid this, we must ask our specialty societies and the AMA to negotiate in good faith so that ICD-10 is a win-win for both sides when (not if) it comes to fruition.

Allow me to suggest the following negotiating points:

- Ask your specialty society to advocate with Congress that there be a fifth Cooperating Party for ICD-10 to represent physician interests so that we can have a direct say in the maintenance of ICD-10. This will also promote the physician-coder partnership in the ICD-10 Official Guidelines, ensuring a level playing field.
- Call your congressional representatives to ask that the ICD-10 documentation requirements be loosened such that a competent coder can clinically interpret the record within reasonable parameters and assign a defendable code, preventing a payer or Recovery Auditor from denying reimbursement when the circumstances are obvious.
- Partner with your hospitals to ask the Cooperating Parties to let coders and clinical documentation improvement specialists be more direct with what they need from us in real time, instead of playing “20 questions” to get the exact ICD-10-based documentation supporting the correct code.
- Advocate with your EHR companies to develop clinical documentation templates and tools promoting problem-oriented charting (especially in the problem list), emphasizing the ability to link conditions to each other (e.g., fractures with osteoporosis, congestive heart failure with cardiomyopathies) and to express uncertainty or working diagnoses (e.g., pneumonia likely due to methicillin-resistant *Staphylococcus aureus*) where appropriate.
- Tell the ICD-10 Coalition (which includes Blue Cross) that it must publish its ICD-9-CM to ICD-10-CM crosswalks as a condition of our acceptance of ICD-10 so that our claims are not denied just because we unwittingly documented or used an unspecified code.

Thank you so much for your attention to this matter. Godspeed in what you do.

With warm regards,

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