Explore pre-bill audits to help reduce instances of rebilling and recoding

Conducting pre-billing audits can be challenging, but when done correctly, it can save organizations from spending time recoding and rebilling claims that payers deny. These audits can be conducted on the front end, in both inpatient and outpatient settings, once records have been coded.

“You’re coding and auditing the entire account before it goes out the door,” says Christi Roberts, RHIA, CCA, director of operations at Woodham HIM Solutions in Tequesta, Florida. “You’re decreasing the chance that it’s going to kick back.”

Healthcare organizations are conducting increasing numbers of pre-bill audits, both internally and externally, says Monica Pappas, RHIA, president of MPA Consulting, Inc., in Long Beach, California. These audits offer the opportunity to increase the percentage of clean claims submitted by an organization, which can help reduce erroneous claims that raise red flags with payers, says Pappas, an MRB editorial advisory board member.

In the inpatient setting, the primary focus of pre-bill audits is often limited to ensuring claims have the correct MS-DRG code assignment and appropriate complication codes, says Robert S. Gold, MD, founder of DCBA, Inc., in Atlanta. Outpatient pre-bill reviews tend to focus on medical necessity. “Not enough pre-bill audits are directed to the patient, and in today’s environment, this is the most important focus,” he says.

Gold recommends that organizations focus on auditing all charts, not just those for Medicare or Medicaid patients. If an organization is going to invest time and resources in conducting pre-bill audits, it must do so as thoroughly as possible.

“Pre-bill audits that are limited in scope in the current era of value-based purchasing are doing half the job,” he says. “Look way beyond the DRG, way beyond Medicare patients. Look at what’s wrong with all patients that are treated at your hospital so you can validate quality of care for all patients, payers, and doctors.”
Auditing coded records

Ideally, someone with knowledge of coding and billing should conduct the pre-bill audits. For this reason, coding compliance officers are often well suited for the task. Both billing and auditing experience is required, so coders are not always the ideal candidates to handle these audits, Roberts says.

“Additionally, a reviewer needs expertise in revenue codes, charge description master, and payer requirements,” says Rose Dunn, RHIA, CPA, FHFMA, chief operating officer of First Class Solutions in St. Louis, Missouri. “This may be an individual with coding and billing experience, and the person may be housed in the patient financial services [PFS] or compliance departments.”

In most cases, it is not sufficient to have a person with knowledge of ICD codes and coding rules perform these audits, because there is a chance that records can be coded incorrectly based on documentation in the medical record, Gold says. Auditors should be able to review records from a clinical perspective while still applying coding expertise to ensure diagnoses coded accurately reflect the patient’s condition.

The workforce members responsible for the reviews must be attentive to detail and should be capable of educating coders so they understand why records are returned after coding and auditing. “They need to be able to present and support their findings to the coder and explain and justify why there is a need for a change,” Roberts says.

This person should also be able to justify any change to the claim made after the pre-bill audit and should be adept in updating the chargemaster, says Dunn, an MRB editorial advisory board member.

Pre-bill auditing can often be difficult for organizations that are understaffed or are exceptionally busy; in such a case, outsourcing the task may be appropriate. In addition to completing reviews and finalizing bills, vendors can often report back to coding managers once errors are identified and may be able to provide coder education based on the common errors, Roberts says.
However, Dunn advises organizations to avoid compensating pre-bill audit vendors on a contingency basis as this is often frowned upon by CMS and the OIG.

Coding compliance software can often help organizations identify duplicate claims or those with erroneous or missing codes, Pappas says. Software can also help flag claims that may otherwise be targeted by payers or the OIG. “Even though we see coders really progressing in their knowledge of charging and billing, without technology no one can remember all of these details,” she says.

Note that pre-bill audits may not always eliminate the need for post-bill audits, especially if reimbursement ends up being different than what was expected, says Darice M. Grzybowski, MA, RHIA, FAHIMA, president of HIMentors, LLC, in Westchester, Illinois. Unfortunately, some facilities neglect to monitor instances when expected reimbursement does not equal actual reimbursement. This can lead to unnecessary write-offs when there are rejections or denials.

“This revenue leakage can be due to erroneous stripping or manipulation of codes on a bill due to an outdated claims scrubber software,” says Grzybowski, an MRB editorial advisory board member. “Many times, when digging deeper, the cause of those write-offs is a bill scrubber that stripped a valid code or charge from a claim simply because it was not in synch or updated with latest coding changes, CCI edits, HCPCS updates, or other information.”

Pay attention to all steps in the pre-bill process, and ensure any technology used contains edits that do not conflict with the other software, and are updated with the same frequency.

**What to look for during an audit**

Before beginning pre-bill audits, an organization should determine what it plans to accomplish through this process, Gold says. This should help pave the way for comprehensive auditing and should help an organization determine who will be responsible for conducting the audits.

The workforce member responsible for pre-bill audits should pay close attention to medical record documentation to ensure the assigned codes accurately represent treatment and diagnoses. Review the record to ensure that treatment and patient status are medically necessary. The auditor must also ensure DRG assignment is accurate for DRG payers, and that evaluation and management (E/M) coding assignment is correct on the outpatient side, Roberts says.

“You want to make sure you have that clean bill that is completely validated and compliant,” Roberts says. Organizations should consider conducting focused reviews of billing and coding problem areas.

Do not limit reviews to coding errors. Review for incorrect, misplaced, and missed charges as well as incorrect revenue codes, Dunn says.

Also consider reviewing hospital-acquired conditions, potentially preventable complications, mortality, and readmissions when conducting these reviews. “These areas that define a facility’s quality are becoming more critical with value-based purchasing, therefore categories that must have a secondary review prior to release of the claim,” says Pappas.

**Timing of audits**

Develop a timeline for coding and reviewing records to prevent the audits from having a negative impact on your discharge not final billed (DNFB) and the overall goals of the organization. Adhering to a timeline can be challenging because after initial coding and auditing, some cases may need to be recoded and re-reviewed.

“That can be the biggest challenge, so you have to really establish that turnaround time that makes the pre-bill audits doable,” Roberts says. In addition, organizations must invest time in educating coders as to why a claim came back for recoding after the audit.

Organizations typically allot 8–24 hours post-discharge for reviews and recoding, Roberts says. However, each facility has different expectations for initial coding times, which must be taken into consideration when building a timeline for pre-bill reviews. Facilities with hybrid medical records must also consider how much time is allocated for scanning paper records into the electronic record prior to coding.

Meeting turnaround times may be more difficult for coders and auditors on days with higher discharge rates. Although HIM departments are structured differently, the coding manager should oversee the auditing process if possible. This will help ensure coders and auditors work efficiently to adhere to turnaround times whenever they can, Roberts says.
Justification for pre-bill audits

When done correctly, pre-bill audits should reduce coding and billing error rates, Roberts says. Since these audits should be conducted frequently, the errors should be caught before the bill is out the door.

“Monitoring claim rejections and denials prior to implementation of a pre-bill review process and comparing results after its implementation is a metric that should be put in place to demonstrate the program’s success or failure,” Dunn says.

Some organizations opt for quarterly audits, which are retrospective and often include auditing a sample of records (e.g., 20 records per coder for the designated time frame). This can be problematic because errors are not identified until the facility has already submitted the claim to the payer, Roberts says.

If a claim must be resubmitted due to coding errors, the PFS department will need to refund the initial payment and then resubmit the claim, which often must be accompanied by a copy of the record, Dunn says.

Pre-bill audits can also serve as an educational opportunity for coders. If a coder commonly miscodes a treatment or diagnosis, the facility can bring that error to the coder’s attention before it is repeated on other claims.

Similarly, pre-bill audits allow organizations to educate physicians early on about documentation issues that end up leading to inaccurate coding. “This helps with your clinical documentation improvement process and also helps with your coding process,” Roberts says. “As we move into ICD-10, you may see opportunities where physicians need to be documenting differently.”

The auditing process requires investing significant resources up front; HIM professionals and others should weigh the pros and cons of this process and present them to the organization’s chief financial officer. When done correctly, pre-bill audits should decrease recoding and rebilling. It should also decrease the likelihood that an organization receives inaccurate reimbursement from a payer.

“The last thing the hospital wants to see is that they have to reimburse Medicare or another payer for payment it shouldn’t have received,” Roberts says.

HIPAA Q&A

Sharing patient information within the minimum necessary requirements

by Chris Simons, MS, RHIA

Q You are reviewing a computer-generated insurance claim before it is sent to the insurance carrier, and you happen to notice the patient’s name on the claim—it’s an old friend of yours. You quickly read the code for the diagnosis. Is this a breach of confidentiality?

A Yes, it is, unless you need to know that information to do your job. HIPAA requires us to access only the minimum we need to know to do our jobs. If you don’t need to know your friend’s diagnosis, you shouldn’t look at it.

If you do see it, remember that you may never share with anyone, including your friend, what you have seen. This knowledge can be a heavy burden, but it is our ethical and legal obligation not to share any information we obtain in the course of doing our work in healthcare.

Q If a psychiatric nurse is looking at an emergency department (ED) patient’s information as part of his or her job, and notices that a friend’s child is in the ED, can the nurse go visit this patient?

A No. The nurse must not use the information he or she obtains during the course of doing his or her job for anything other than work. In this case, the nurse discovered the information incidentally and should not use it to visit the child since doing so would not be related to the nurse’s work. On the other
hand, if the friend notifies the nurse of the child’s ED stay, or if the nurse finds out the child is there in some other way that is unrelated to work, it would be acceptable to visit.

**Q** Is it a HIPAA violation to post family satisfaction survey comments or family thank-you letters in all-employee work areas? What if the comments reference patient and caregiver names?

**A** There are several things to consider in this question. What is the nature of your practice? (Thank-you notes to a psychiatrist or infectious disease specialist could require a higher level of protection.) Where will the notes be posted? Will members of the public see them, or are they in restricted areas? What is the content of the notes—are they just to say thank you, or is more detailed PHI included? Can the identity of the note writer be redacted before the note is posted? If yes, that would be a strong mitigator.

Once you have assessed these issues (preferably in writing, perhaps in the context of HIPAA-related meeting minutes) you will have your answer. My advice would be to post the notes in employee areas only and redact the names.

**Q** A patient recently informed me that she was surprised to learn from a physician at our facility that her adult child had been prescribed blood pressure medication. Is it a HIPAA violation for providers to discuss the care of adult children with parents? Would it be considered a violation if the child was a minor?

**A** Yes, it is a violation for a practitioner to share information about one patient with another without permission, even if the patients are related. The only exception would be if the mother is providing care to the adult child. In that case, it would be acceptable for the provider to share only the information necessary for the mother to provide care.

In most cases, it is acceptable and even required that practitioners share information with the parent(s) of minors. Exceptions to this might be information on mental health information, substance abuse treatment, sexually transmitted disease treatment, etc. Check your state statutes for specifics.

**Q** Are HIPAA requirements different for college campus health centers than for larger facilities or private practices? For instance, would a college campus health center be permitted to disclose information about students who are patients to faculty members if the health center believed a student’s condition may affect his or her ability to come to class or complete assignments? What if the health center believed the student may be a danger to himself or herself, or to others?

**A** Campus health centers are covered entities and must follow HIPAA. Information should not be shared with faculty without the patient’s written permission (this would not be a release for treatment, payment, or operations), although a note excusing a student from class or supporting an extension to a deadline (similar to a work note) would be appropriate (without details).

If there is an immediate concern that the patient is a danger to himself or herself, or to others, then there is a “duty to warn” exception that allows you to share information (again, minimum necessary). However, this would not include notifying the faculty unless the threat was against a faculty member. Even then, if your providers believe the threat is significant enough that faculty need to be notified, it would be appropriate to involve the police and to take whatever steps are indicated in your state to initiate a psychiatric hospitalization, either voluntary or involuntary.

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**EDITOR’S NOTE**
Simons is the director of health information and privacy officer at Cheshire Medical Center/Dartmouth-Hitchcock in Keene, New Hampshire. She is also an MRB advisory board member. This information does not constitute legal advice. Consult legal counsel for answers to specific privacy and security questions. Send your questions related to HIPAA compliance to Editor Jaclyn Fitzgerald at jfitzgerald@hcpro.com.

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**Questions? Comments? Ideas?**

We at MRB value and welcome your feedback and opinions. Do you have a response to any of this month’s articles, an idea for a best practice or success story you’d like to share, or a recent survey experience you would like to recount? We would love to hear from you.

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CDI specialists play vital role in capturing pay for performance measures

Editor’s note: This is the first in a series of articles covering Medicare’s pay-for-performance measures. These articles will cover some of the basics of the different measures and highlight how they relate to the work of coders and clinical documentation improvement (CDI) specialists.

Since the implementation of the Hospital Value-Based Purchasing (HVBP) Program in 2013, CMS has adjusted the MS-DRG payment for each traditional Medicare discharge. The type and amount of the adjustment, which could be a financial penalty and/or an incentive payment, is determined by the hospital’s performance for defined quality measures, such as risk-adjusted mortality. Since that time, the number of pay for performance (P4P) programs and quality measures has expanded. By 2017, P4P payment adjustments will impact up to 6% of traditional Medicare revenue.

Why is this relevant to the coding and CDI team? Because many of the P4P measures are claims based, the performance for claims-based measures is derived from diagnosis codes submitted on claims.

CDI role

The CDI team are the subject matter experts on accurate and complete assignment of diagnoses, and provider documentation requirements to support code assignment. The CDI team must understand CMS P4P measures in order to improve data quality.

The types of diagnoses that can impact these measures are typically chronic conditions, many of which have been off the radar in the inpatient acute care setting, such as restless leg syndrome or loss of weight.

In this article series, we will take a closer look at one of the CMS claims-based P4P measures—Patient Safety Indicator (PSI) 90. We’ll do so from a CDI team perspective. We’ll learn about the measure, common coding and documentation vulnerabilities, and approaches the team might consider to strengthen the reporting of impactful diagnoses and procedures with ICD codes on submitted claims.

Introduction to PSI 90

PSI 90 evaluates hospital performance for defined in-hospital complications and adverse events. The measure was developed by the Agency for Healthcare Research & Quality (AHRQ) and adopted by CMS for inclusion as a measure in two P4P programs:

• HVBP
• Hospital-Acquired Condition Reduction Program (HACRP)

PSI 90 is referred to as a composite measure because eight different PSIs are rolled up to provide an overview of hospital performance. The eight PSIs included in the CMS PSI 90 composite measure include:

• PSI 03, pressure ulcer
• PSI 06, iatrogenic pneumothorax
• PSI 07, central venous catheter-related bloodstream infections (CLABSI)
• PSI 08, postoperative hip fracture
• PSI 12, postoperative pulmonary embolism or deep venous thrombosis
• PSI 13, postoperative sepsis
• PSI 14, postoperative wound dehiscence
• PSI 15, accidental puncture or laceration

CMS provides each hospital with an annual report, referred to as a Hospital Specific Report, which provides feedback on PSI 90 performance for the HVBP Program and HACRP. Feedback provided by the HACRP Hospital Specific Report is more meaningful for the CDI team than that provided for the HVBP.

Unlike the HVBP Program, the HACRP uses the most recent version of the measures. Different measure versions affect how the PSIs are weighted in PSI 90. For example, PSI 15 is weighted at 49% in the HACRP vs. 42% in the HVBP Program. In addition, the HACRP uses 25 diagnosis and procedure codes, while the HVBP Program uses only nine diagnoses and six procedure codes.

The time period of data included in the performance evaluation differs as well. For FY 2015, the HACRP time period is two years (from July 1, 2011, to June 30,
Get engaged in PSI 90 data quality improvement

The following key steps can position the CDI team for successful engagement:

- Meet with the quality department to learn about PSI 90 improvement priorities
  - Heighten the quality department’s awareness of CDI team contributions to measure performance with improved data quality
  - Get a seat at the table for existing organizational improvement initiatives
- Identify coding and documentation vulnerabilities for each PSI
- Develop an action plan to strengthen documentation capture and code assignment for conditions pertinent to the PSI measure(s), including:
  - Coding and documentation query processes
  - Provider educational initiatives
  - Documentation infrastructure refinements
  - Additional performance metrics

Identify PSI coding and documentation vulnerabilities

The CDI team (and inpatient coders) must understand PSI measure structure in order to identify data quality vulnerabilities. Three key concepts are associated with the structure of PSIs.

The first is inclusions. These variables trigger a discharge to be counted in one of the measures. Inclusions consist of ICD-9-CM codes for diagnoses and/or procedures.

The second is exclusions. These variables cause a discharge triggered for inclusion in the measure to be excluded from the measure; they will not count. Exclusions consist of ICD-9-CM diagnosis and procedure codes, admission source codes, and discharge disposition codes. They exist to improve capture of the intended population and enhance validity of the measures with clinicians. As an example, a patient with a stage III, stage IV, or unstageable pressure ulcer would be included in the PSI 3 measure unless:

- The diagnosis was not present on admission
- The patient had a length of stay less than five days (it is unlikely that a patient would develop such a serious pressure ulcer during the course of a five-day stay)

The third concept is risk adjustment. Twenty-five different comorbid categories impact PSI risk adjustment, some positively and others negatively.

ICD-9-CM codes are mapped to each comorbid category. The number of ICD-9-CM codes mapped to each category ranges from a low of 1 to a high of approximately 800. The capture of one ICD-9-CM code for each comorbid category with a positive impact on risk adjustment would optimize risk adjustment for the PSI.

The impact that a comorbid category has on the risk adjustment is PSI specific. As an example, the capture of restless leg syndrome has a positive risk adjustment impact of 10% on PSI 3 (pressure ulcers). A review of the measure specifications (www.qualitynet.org) can be conducted to identify inclusions, exclusions, and risk adjustment variables for each PSI. To support identification of data quality vulnerabilities, this analysis is best performed by someone on the CDI team who understands the coding classification system, coding guidelines, documentation requirements, and associated documentation improvement strategies. Consider the following examples:

- For PSI 8, which measures in-house hip fractures, patients are excluded from this measure if the fracture is pathologic.
- Patients are excluded from PSI 13 if secondary diagnoses reported are considered an immunocompromised state. Chronic kidney disease (CKD) stage 5 and malnutrition are examples.
• Patients have a strengthened risk adjustment for PSI 15 if secondary diagnosis are reported for defined risk adjustment variables. The capture of obesity, CKD, and peripheral vascular disease would optimize risk adjustment for this PSI.

**Leverage your EHR to improve documentation capture**

A broad range of ICD codes impact each PSI as part of an inclusion, exclusion, or risk adjustment comorbid category. Leveraging the EHR to automate capture of critical diagnoses is an essential component of best practice CDI programs under CMS P4P measures.

As an example, PSI 3 measures the frequency of pressure ulcers (stage III, stage IV, or unstageable) which are not present on admission:

- The presence of any pressure ulcer (regardless of stage) on admission will exclude a discharge from counting in the measure.
- Medicare data shows a pressure ulcer rate of only 0.20%, but surveillance data suggests that the actual rate is 10 times higher. This discrepancy indicates that coders are missing provider documentation related to pressure ulcers, or that providers are under-documenting this condition.
- The capture of pressure ulcers (regardless of stage) is also important to the risk adjustment methodology for other CMS P4P measures such as readmissions, mortality, and complications.

Let’s look at ways to customize the EHR to efficiently and consistently support the capture of pressure ulcer documentation in provider notes.

Partnership with subject matter experts to design how and what documentation must be captured is critical to effective leverage of the EHR. For pressure ulcers, this partnership would consist of EHR design and build staff, a representative from the CDI team, and the clinical subject matter expert(s).

- **Identify the clinical subject matter experts:** Wound care nurses are considered the subject matter experts when it comes to pressure ulcer assessment, staging, and treatment recommendations.
- **Embed informational text in your wound care documentation tools:** The IT team would embed pressure ulcer documentation requirements wherever nurses can document pressure ulcer assessments in the EHR (e.g., flow sheets). Requirements would include site, laterality, stage, present on admission status, and the presence of (any) gangrene.
- **Provide wound care nurses with the ability to manually update the problem list:** The wound care nurses would be provided with EHR access to add a pre-defined set of pressure ulcer problems to the problem list. Nurses would add the appropriate problem to the problem list after completing their pressure ulcer documentation. It is important to understand that the addition of the condition to the problem list does not mean that the wound care nurse is diagnosing the patient. As a subject matter expert, the wound care nurse is using the problem list to communicate the condition to the provider.

In addition to wound care nurses, provide floor nurses with access to update the problem list if they assess the majority of pressure ulcers. If floor nurses assess but do not always stage pressure ulcers, consider configuring your EHR so that the capture of pressure ulcer documentation by a floor nurse triggers the addition of the patient to a custom work list. Wound care nurses monitoring this work list can then assess the patient, document an ulcer stage, and update the problem list after finishing their assessment.

- **Link the problem list to the provider note:** The IT team would embed a link to the problem list in all provider note templates. The pressure ulcer diagnosis and associated information would then be automatically integrated into the provider progress note. The provider could then sign off on this documentation by filing the note to the patient’s chart.

  Links are tools available in many EHR systems. They allow providers to pull information into their notes from elsewhere in the patient’s chart.

  Other tools available in many EHR systems are note templates. These templates can include links to important patient clinical information such as recent vitals, lab results, and current home medications.

  Coders typically are restricted from assigning codes to diagnoses on problem lists. However, they can code diagnoses included in physician’s notes.
Coming up

Next month, we’ll review the measure specification variables pertinent to PSI 15, which has the biggest impact on the PSI 90 composite weight. We’ll discuss coding and documentation vulnerabilities, and provide additional examples to leverage the EHR to systemize documentation capture. We’ll also discuss ways to customize the EHR so that it encourages better adoption and maintenance of the problem list, leading to cleaner, more accurate, and better-updated problem lists across your patient population.

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Leverage your EHR to capture pressure ulcer information

A pressure ulcer is predominantly a hospital-acquired condition that commonly affects the elderly. Medicare data shows a pressure ulcer rate of only 0.20%, but surveillance data suggests an actual rate 10 times higher than that. This discrepancy indicates either that coders are missing provider documentation related to pressure ulcers, or that providers are not documenting (or are under-documenting) this condition.

Clinical documentation improvement (CDI) specialists or coders generally limit querying to cases where some documentation exists related to the pressure ulcer. Also, at many organizations, midlevel providers, such as wound care nurses, physician assistants, and nurse practitioners, help deliver better clarity in documentation, but the hiring of midlevel providers adds significant costs.

Instead of relying solely on queries or additional staff, organizations can improve both the capture and specificity of documentation by properly leveraging their EHR. The methods discussed here will empower your experts to identify and describe the pressure ulcer and allow your providers to sign off on the documentation and incorporate it into their notes.

Who are your experts?

Who are your subject-matter experts? Wound care nurses assess and document pressure ulcers every day, but how can we take advantage of their knowledge in a way that improves provider capture of pressure ulcer diagnoses? The answer: by empowering them with the ability to update the EHR-based problem list manually.

If a provider never mentions the pressure ulcer in a note, then coders are unable to code it, and the condition can’t be reported for quality and financial purposes. By allowing wound care nurses to add, change, or remove a predefined set of pressure ulcer problems, and by promoting a partnership between nurses and providers, your organization can achieve better capture of pressure ulcer diagnoses not only on the problem list, but also in provider documentation.

Defining the problem

If wound care nurses can add a pressure ulcer diagnosis to the problem list, they must understand the language and/or wording that will yield the greatest detail and specificity for the diagnosis, particularly with the upcoming transition to ICD-10. For pressure ulcers, this detail should include:

• Site
• Laterality
• Pressure ulcer stage
• Whether gangrene is present
• Whether the ulcer was present on admission
To encourage nurses to include this specificity in their problem list entries, your IT team should embed informational text regarding these details wherever nurses can document pressure ulcer assessments in your EHR (e.g., flowsheets). When updating your wound care documentation tools with this embedded text, include the latest relevant classification standards, such as the definitions of the pressure ulcer stages developed by the National Pressure Ulcer Advisory Panel (NPUAP).

Using this embedded information as a guide, your wound care nurses will be able to document with greater specificity during the pressure ulcer assessment. After completing the assessment, nurses should then add the appropriate pressure ulcer diagnosis to the problem list. The problem selected should contain as much detail as possible and reflect the documentation captured during the assessment.

“Pressure ulcer of foot” and “pressure ulcer of foot, stage III,” for example, have the same ICD-9-CM code, but different ICD-10-CM codes. While nurses are not diagnosing the patient, they are communicating the condition to the provider, so they need to choose a problem that includes the relevant clinical details to assign an ICD-9-CM or ICD-10-CM code.

If, at your organization, floor nurses normally assess the majority of pressure ulcers, provide floor nurses with access to update the problem list as well. If floor nurses assess but do not always stage pressure ulcers, consider configuring your EHR so that the capture of pressure ulcer documentation by a floor nurse triggers the addition of the patient to a custom worklist. Wound care nurses monitoring this work list can then assess the patient, document an ulcer stage, and update the problem list after finishing their assessment.

The missing “link”

Once a pressure ulcer diagnosis is on the problem list, it can be incorporated into the provider’s note seamlessly. Many EHR systems support tools, commonly referred to as links, that allow providers to pull information into their notes from elsewhere in the patient’s chart. Additionally, most EHR systems support the use of note templates, which may include links to important patient clinical information, such as recent vitals, lab results, and current home medications.

While coders cannot code based on the problem list, they can code from the list if it’s included in the physician’s note, so we suggest including a link to the patient’s problem list as well. Your wound care nurses have already completed the difficult task of identifying, classifying, and adding the pressure ulcer diagnosis to the problem list. If your IT team embeds a link to the problem list in all provider note templates, the provider won’t need to remember to document the condition, for it will be linked into his or her note automatically.

At this point in the workflow, your clinical documentation specialists are happy. The pressure ulcer problem, as added by the nurse and now seamlessly displayed in the provider’s note, includes detail related to site, laterality, etc. Certain key information, however, such as gangrene presence, may have been missed. Coders also like to see documentation regarding any additional associated conditions (if applicable). Therefore, in the next and final step of this workflow, the provider can add, remove, or modify the pressure ulcer documentation as necessary. The provider then signs off on this documentation by filing the note to the patient’s chart.

Source

Steve Weichhand and Sean Johnson lead the provider documentation improvement service line at Falcon Consulting Group, an EHR consultancy specializing in EHR planning, implementation, optimization, and support. Weichhand and Johnson are both former Epic employees with years of technical experience, and their service line has been proven to improve physician efficiency, enhance documentation specificity, and create a structured process for future optimization. Contact Falcon at 312-751-8900 and ask for Steve or Sean or email Steve Weichhand at steve.weichhand@falconconsulting.com or Sean Johnson at sean.johnson@falconconsulting.com.
Evaluating privacy and information security governance processes

As required by The Joint Commission, a board of directors should regularly assess its performance, appropriateness of board and committee processes and charter fulfillment, adequacy of meeting structures and goals, communication with management, and other governance structures and activities. Generally, boards and their committees complete this assessment through self-surveys, internal audits, or collection of results as performed by legal services. Assessment results can lead to changes in board processes, with the goal of adapting to changing risks and environmental requirements, and improvements in governance.

Boards rarely use survey questions for privacy and information security program risk assessment. The audit committee self-assessment process might include one or two questions that address this topic, but these surveys generally do not consider the board’s role in enterprisewide risk assessment processes. As privacy and information security programs become more embedded in an organization’s culture, this will change.

Some boards are becoming more involved in information security risk analysis and risk management processes at a high level. This includes discussing and advocating for resources for specific programs and strategies aimed at improving security (e.g., implementation of data loss prevention technical tools and enhanced network and infrastructure controls).

Board members need ongoing education that addresses significant issues facing their organizations, including emerging risk areas in healthcare privacy and security. This information can be presented regularly as well as during board meetings and annual retreats. A mix of training methods may be the most effective way of providing board members the information they need to meet their responsibilities in this area.

Selecting a privacy model

Selecting a privacy model is a challenging endeavor. The HIPAA Privacy Rule is more complex than the Security Rule and includes more prescribed standards. Most healthcare organizations have focused on the HIPAA Privacy Rule and have not considered how other models might be used to develop and enhance their privacy programs.

Further, implementing the HIPAA Privacy Rule includes addressing each of the privacy standards and developing and implementing policies and procedures to effect the standards.

Privacy by Design (PbD) offers an alternative approach. PbD is a framework developed by Ann Cavoukian, PhD, information and privacy commissioner of Ontario, Canada. It appears to have originated when Cavoukian and the Dutch Data Protection Authority released a joint report on privacy-enhancing technologies. The concept of privacy-enhancing technologies and PbD have been accepted in Canada and Europe, where privacy laws and methodologies are more highly developed than in the United States. The philosophy of privacy-enhancing technologies is that individuals retain control of information about themselves at all times and that the amount of data about individuals held by others should be minimized.

“Privacy by Design advances the view that the future of privacy cannot be assured solely by compliance with legislation and regulatory frameworks; rather, privacy assurance must become an organization’s default mode of operation.” “The objectives of Privacy by Design—ensuring privacy and gaining personal control over one’s information and, for organizations, gaining a sustainable competitive advantage—may be accomplished by practicing the Foundational Principles.”

This model can be applied to healthcare organizations that desire a proactive, transparent approach to privacy program development and evolution rather than the reactive, regulatory approach that so many have adopted. The manner in which many healthcare providers have implemented the HIPAA rules has, in fact, delayed development of a PbD approach because emphasis has been primarily on compliance and avoidance strategies.
Selecting an information security model

Most healthcare organizations are only beginning to understand, develop, and implement effective privacy and information security programs that will meet patients’ needs while providing clinicians the information they need to manage and coordinate care. Participation in HIEs, ACOs, and other integrated delivery models will require healthcare providers to reexamine their approach to privacy and information security. The increase in cybercrime, as well as new initiatives such as the President’s Commission on Cybersecurity and recommendations developed by the Health Policy Committee and subcommittees of the Office of the National Coordinator, have led to increased emphasis on security of information of all types, including the nation’s infrastructure.

HIPAA compliance represents only a portion of an effective privacy and information security program. State laws are often more stringent, as evidenced by the breach reporting laws that now affect providers and residents in 47 states. Other federal laws (e.g., U.S. Federal Trade Commission regulations, Clinical Laboratory Improvement Amendments) and the privacy regulations of the U.S. Food and Drug Administration apply to healthcare organizations.

Healthcare organizations that are serious about privacy and information security go beyond HIPAA requirements. They select models or frameworks to enhance their programs, considering factors such as program governance, privacy standards, breach notification requirements, technical and physical safeguards, risk management, quality assurance, and environmental controls.

Each organization must decide which model represents the best approach for a long-term view of information security and can be implemented with the privacy program in mind as well. This decision also depends on which model can be most effectively implemented considering staff experience and expertise, resources, and management support. Even if resources are limited, healthcare organizations should begin this process. Many resources available on the Internet can help organizations assess, analyze, and select models.

The National Institute of Standards and Technology (NIST), a non-regulatory federal agency within the U.S. Department of Commerce, says its “mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.” NIST offers resources for information security professionals, such as NIST Special Publication 800-66 Revision 1, An Introductory Resource Guide for Implementing the Health Insurance and Portability and Accountability Act (HIPAA) Security Rule; Special Publication 800-30 Revision 1, Guide for Conducting Risk Assessments; and Special Publication 800-50, Building an Information Security Awareness and Training Program. Refer to the online Appendix for a list of additional NIST references.

ISACA®, previously known as the Information Systems Audit and Control Association, provides resources for organizations that use information systems, including Control Objectives for Information and Related Technology (COBIT). ISACA describes COBIT as “an IT governance framework and supporting toolset that bridges the gap between control requirements, technical issues and business risks.”

The International Organization for Standardization (ISO) develops and publishes international standards. The ISO/IEC 27000 series includes information to assist organizations in managing the security of assets such as financial information, intellectual property, and third-party information.

The Health Information Trust Alliance is a collaboration of healthcare, business, technology, and information security leaders. It has developed a Common Security Framework (CSF), which “provides organizations with the needed structure, detail and clarity relating to information security tailored to the healthcare industry.” Organizations use CSF to create, access, store, or exchange personal health and financial information.
Most physicians have learned about the concept of medical decision-making (MDM) and its complexities. This is one of the essential elements of personal, professional billing that determines the monetary value of a patient encounter. The AMA developed these classifications and categories for professional services billing. Many physicians have learned about this through trial and error, through study, or through letting someone else do their billing for them so they can totally avoid the concept. We’ve all heard of initial and subsequent office visits; hospital visits with initial, subsequent, and discharge visits; levels of critical care; and emergency department consultation visits. Most have heard about number of elements of history of present illness; past medical and family history; social history; review of systems; and physical examination going into the determination of the billing level.

Practically, physicians are used to assigning a single diagnosis code to justify each office visit because that’s how they’ve always been paid. The code may represent a disease (e.g., cold, pneumonia, urinary tract infection, benign prostatic hypertrophy), or it may be a symptom (e.g., shortness of breath, syncope, persistent cough).

In some states, an MDM point system is used, which may take into account whether the patient has a new condition on the current visit or chronic conditions that are being managed (as well as the number of such conditions). Some payers consider not only the number of diagnoses on the individual visit, but also the severity of those conditions. Others use problem points to determine risk (e.g., whether a new disease is self-limited and minor, whether additional workup is required, and what management options are planned).

Some states use a methodology called Hierarchical Condition Classifications in which a particular disease can have various levels of complexity or organ involvement. For example, hypertension may have renal, heart, or central nervous system involvement, or it may be caused by a disease of other organ systems. The base ICD-9 code 250.00, describing diabetes, fails to even scratch the surface of a patient who truly has controlled Type 2 diabetes on long-term insulin (V58.67), diabetic chronic kidney disease (250.40) at stage 3 (585.3), moderate diabetic nonproliferative retinopathy (250.50 plus 362.05), and diabetic foot pain due to peripheral autonomic neuropathy (260.60 plus 337.1). This is a complex patient with a complex single disease covering a lot of manifestations, and the case should be coded accordingly. Some HMOs are set up such that if a physician sees more complex patients (as demonstrated by identification of patient complexity through ICD codes), they will be given a higher number of dollars per member per month to manage their patient load.

The future of managing patients should focus on promoting optimal control in the patient’s existing environment, reducing emergency situations when possible, and reducing avoidable readmissions. Some new care management codes for billing in Medicare can be used to increase reimbursement even if the physician sees the patient fewer times in a year—so long as the system they are running or participating in leads to better long-term outcomes. Insurance companies are looking for these quality indicators as well. Some diseases have inherently low complexity and are associated with low utilization of resources. If a provider consistently bills high levels of evaluation and management (E/M) for diagnosis codes that should cost little, someone will check into the practice. Some diseases are associated
with extremes in risk and utilization, such as acute myelogenous leukemia or amyotrophic lateral sclerosis. Here, one ICD code may justify the highest level of billing; however, if certain disease manifestations or information about resistance or response to treatment are missing, physicians are underserving themselves. Some diseases have a multiplicity of manifestations. In these instances, the more complex the manifestations, the more complex the coding should be. Vanilla documentation leads to vanilla coding. Using not otherwise specified or not clinically established codes will ensure the lowest payment for every disease category. Documenting “Doing well -RTC 1 mo” will ensure no payment for services provided. Oh yes, and documenting office notes illegibly will lead to payment problems too.

What should physicians do? Learn to do the following:
1. Name every disease that is actively managed/treated
2. Document symptoms in those instances where a definitive diagnosis has not been established
3. Document the pathophysiology of every disease that can have multiple etiologies
4. Make entries on every patient encounter including the date, diagnosis, relevant findings, plans, and follow-up, along with the physician’s signature
5. Instruct the physician office to identify every page on the record with the patient’s name and medical record number, or other tracking method
6. Address every chronic, stable condition at least once a year and document the evaluation and status of that condition, whether the condition is stable, whether the condition requires adjustment of treatment regimen, and whether the condition requires ongoing testing to validate its stability

Under this system, there is no requirement to document every disease each time a patient is seen. Instead, the expectation is to appropriately address and document every disease that requires attention and medical management at the time of the visit. Standards of medical practice dictate that any chronic illness be evaluated at least annually when stable, and more often when unstable or when following regimens of treatment as promulgated by entities such as the Agency for Healthcare Quality and Research.

Let’s take a moment to expand upon the concept of vanilla. In the absence of any other qualification by the physician in his or her documentation, a patient with anemia simply has anemia. A patient with “anemia of chronic renal failure” has a low blood count based on failure of the kidneys and inability to produce erythropoietin. A patient with “anemia of chronic GI blood loss” has a low blood count based on long-term loss of sub-clinical amounts of blood from some gastrointestinal source (be sure to identify that source when possible). A patient with “Mediterranean anemia” has a chromosomal abnormality. A patient with any low blood count based on “identifiable” problems has a quantifiable and qualifiable degree of disease complexity, as opposed to vanilla anemia.

Or take a patient with chronic obstructive pulmonary disease (COPD). What type of COPD is it? What severity? Is it restrictive disease due to kyphoscoliosis? Is it chronic bronchitis with emphysema or bronchiectasis? Perhaps the patient has chronic respiratory failure that requires home oxygen and continuous positive airway pressure because without it the patient’s pO2 on room air would be 40%, which would likely equate to death. Perhaps the patient has a pH of 7.4 today (no guarantee what it will be tomorrow) with a chronic pCO2 of 84 because of inability to exchange carbon dioxide. A patient with COPD can be much more complex than that single acronym suggests.

The issue is that most descriptors of pathogenesis have more specific codes available to represent higher complexity, possibly contributing to a higher severity. In addition, many diseases have descriptors that portray higher severity depending on the terminology employed. Virtually all physician billing will soon be based on ICD codes that validate E/M professional billing. Where there are mismatches, investigation will take place. If you overdo it for dollars, you will be identified and embarrassed. If you do it right for the patient, you will be rewarded in many ways.

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