Defend code assignments to help improve coding quality and reduce take-backs

While some HIM professionals may feel a sense of relief knowing RAC audits are on hold for the remainder of 2015, that should not deter workforce members from keeping track of denials and appeals and defending code assignments.

Other auditors are still on track and may be looking for the same errors that RACs once pinpointed, says Cathie Wilde, RHIA, CCS, an AHIMA-approved ICD-10-CM/PCS trainer and the director of coding services for MRA Health Information Services in Quincy, Massachusetts.

Most major health plans are tracking claims and flagging denials, making it all the more important for organizations to ensure their coding and documentation is up to par, agrees Kim Carr, RHIT, CCS, CDIP, CCDS, an AHIMA-approved ICD-10-CM/PCS trainer and ambassador as well as the director of clinical documentation at HRS. “Everybody is jumping on board now with the denials,” she says.

In essence, with RAC audits on hold, hospitals may have experienced a decrease in the number of audits that must be addressed. This lull in audit activity means now is a good time to examine query processes and physician documentation to ensure your organization is prepared for any audits that come your way. “Ideally, it’s good to look at that process when you have a bit more time and are not in the thick of things,” Wilde says.

With ICD-10 coming down the pipeline, auditors may not have a handle on how certain diagnoses and procedures should be coded, which is why hospitals will need to carefully review any future ICD-10 audits rather than assuming auditors are correct. “It’s all new to everybody, so [auditors] are getting a feel for it as well,” Wilde says.

Defend codes, improve quality

The process of defending code assignments or improving coding quality can often help organizations prevent take-backs from RACs and other auditors. The HIM director or manager should support coders in the effort to correctly assign codes to help ensure accurate
reimbursement and avoid take-backs, Wilde says.

This begins with an organization’s ability to justify the codes assigned to its patients’ records, she says. If the code assignment cannot be justified by Coding Clinic guidelines or backed up by solid physician documentation, it is advisable to select a more appropriate code. “If you can’t justify it, it’s likely not the most valid code that you should be using,” she says.

Some hospitals are not as aggressive about reviewing denials and pursuing appeals; however, it can be advantageous to review the record associated with each denial and draft an appeal letter.

“It’s definitely worth the effort,” Wilde says. “If you put the time in to code that record and you know you can justify what you’ve coded, then you certainly should be able to justify the appeal and get reimbursement for that.”

Confusion over principal diagnosis

Wilde notes there are several things organizations can do to make it easier to defend code assignments and avoid denials. Tracking trends coupled with adherence to coding guidelines can help avoid some challenges when claims are submitted.

For starters, when reporting additional diagnoses, ensure that diagnosis codes submitted on a claim are supported by the criteria outlined in Section III of the ICD-9-CM Official Guidelines for Coding and Reporting. Other diagnoses are interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring, Wilde says.

Failure to ensure that the diagnosis meets criteria may affect coverage, she says.

In some instances, there may be more than one diagnosis that could potentially meet the definition of a principal diagnosis, Wilde says. When considering sequencing one diagnosis over another, start by ensuring that it meets the definition of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set as “that condi-
tion established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

For example, a patient may come into the hospital for one condition but lab work completed at the hospital indicates the patient has another condition, such as cancer. In this instance, the cancer was present on admission, but it wasn’t what prompted the patient to visit the hospital or be admitted. Situations like this require some critical thinking so the appropriate principal diagnosis can be assigned based on the condition that is the root cause of the patient’s admission, Wilde says.

“Make sure you’re really paying attention to why the patient came into the hospital and what resources were invested in treating that patient during the course of hospitalization,” she says. “If one condition weighs more than another in terms of treatment and workup, then you would defer more to that one.”

Documentation and queries

Conflicting documentation from multiple providers is not only a headache for coding and HIM, but can often lead to denials.

For example, a resident may document metabolic encephalopathy in the progress notes while a patient is admitted to the hospital. Later, the attending physician completes the patient’s discharge summary and notes acute confusional state. The documentation of the patient’s mental status is conflicting. However, Coding Clinic states coders must defer to the attending physician for the final word on the patient’s diagnosis. Did the attending physician intend to indicate the patient was treated for acute confusional state, or was the actual condition metabolic encephalopathy?

“That’s a documentation issue that the coder should pick up on and query with the physician,” Wilde says. “If you really mean metabolic encephalopathy, don’t just document acute confusional state.”

HIM can use principal diagnosis queries for situations like this as teachable moments for clinical documentation improvement (CDI) specialists and for physician education, she says. In addition to querying scenarios with conflicting documentation, coders should also query physicians if the documentation is muddled and the principal diagnosis is unclear. Querying in either instance can help defend code assignments in the event of a denial. “If it does get a denial, that query supports your code further and in fact may negate the denial because you have that additional piece of documentation,” Wilde says.

However, says Carr, documenting conditions is not enough. A physician can document the name of a patient’s medical condition on every page of the medical records, but if it’s not supported by clinical indicators it may be at risk for a denial, she says.

This also ties into the issue of conflicting documentation from multiple providers. For example, a physician may document metabolic encephalopathy, but a consultant’s review of systems in the history and physical note the patient is alert and oriented. These clinical indicators do not match up with the definition of encephalopathy, which is acute delirium or acute confusional state.

“How can you defend your diagnosis of encephalopathy when the physician is documenting that the patient is alert and oriented?” Carr says. “We have to defend that now and we will have to defend it in ICD-10.”

A good rule of thumb is to remember the keywords coders may look for in the record to assign a code are often the same ones that auditors are looking for, she says. If these terms are not in the record, the codes may not be supported, and the claim will likely be denied. Clinical indicators are not only critical to selecting the right code the first time, but are also necessary when coders reach a point where they must query to assign the correct code, Carr says.

“In order to be compliant with our coding guidelines, the clinical indicators must be present,” she says. “You’ve got to have clinical indicators to have a compliant query. If you don’t have clinical indicators, it could be considered a leading query and result in compliance issues for the organization.”
CDI specialists are well suited to ensure clinical indicators and necessary documentation are included in the record, Carr says. If someone in your organization doesn’t question inadequate documentation to support coding, auditors likely will. Pre-bill auditing can often help avoid denials and thus minimize the appeal process (see the May 2015 issue of MRB for a story about the ins and outs of pre-bill auditing).

Carr notes she frequently sees organizations receive denials for accelerated hypertension, acute renal failure, acute respiratory failure, sepsis, and encephalopathy.

Consider devising a reference sheet that lets coders and others within the organization know what to look for to support the assignment of certain codes for these conditions, she says. If other conditions are the cause of denials at your organization, develop reference sheets specific to those problem areas.

The denial and appeal process
Consider the following processes when working through denials and appeals:

- **Track each denial and appeal.** Organize documentation so it is easy to find each denial and appeal. Lay out a process that allows workforce members to quickly and easily access this information and follow up on pending denials and appeals. This is also useful when appealing claims a second time for reconsideration, Wilde says.

  Each hospital will operate differently in terms of its process and whom the denials and appeals will be directed to, but HIM is typically tasked with this responsibility.

  The denials and subsequent appeals are likely funneled to the coding manager, who may then direct it to the coder to obtain rationale for the coding that was originally submitted. The conversation between the coding manager and the coder is often the first step in determining whether a denial may be able to be appealed, Wilde says.

- **Pay attention to medical record documentation.** Ensure that you submit the complete medical record when appealing a denial. Seek physician involvement, if necessary, to support your appeal. The physician cannot add any clinical documentation that is not already present in the medical record, but he or she can clarify and summarize the facts already documented in order to support the coding, Wilde says.

  “Outline the details in your appeal letter to substantiate your codes,” she says. “If you can support your appeal by listing pertinent clinical findings, official guidelines, and references and notations in the medical record, such as where you found information on the progress note, I think that helps.”

  The appeal letter should not be long-winded, but should contain enough data to support coding and should specifically address the issues identified by auditors. The appeal letter should be succinct and to the point, outlining supportive documentation, Wilde says.

  Unfortunately, not all appealed denials will be successful. However, if the organization feels strongly about the validity of its coding, there is often an opportunity for second-level reconsideration. “If you get denied, it’s well worth the effort to pursue further the appeal to next level if you really believe that you have coded it correctly based on the documentation and official coding guidelines,” Wilde says.

- **Keep coders in the loop.** HIM should work with coding managers—if they are not already the ones overseeing coders—to ensure coders are aware of each denial and appeal.

  “Most hospitals do have a coding manager or coding supervisor, and those are the people who really do the appeals,” Wilde says. While HIM should be involved in this process, the coding manager and coders have the coding expertise and can use that knowledge to help outline letters for successful appeal.

  Coders should be aware of the areas auditors are focusing on so they can work on improving documentation and queries when necessary. Coupled with official coding guidance, denials and appeals can serve as a great learning tool for coders, Wilde says. “You want to make sure the denial doesn’t happen again, because you don’t want to have to go through this whole process again if it’s unnecessary,” she says.

  In some instances, when presented with a denial for justification of coding, the coder (and coding manager) may agree with the auditor’s rationale. This is also a learning experience for the coder and underscores the need for hospitals to engage coders in the denial and appeal process, Wilde says.
Why HIM input is critical for ICD-10 end-to-end testing: Eight ways to remain involved

by Kelly Whittle, MS

As the industry approaches ICD-10 implementation, end-to-end testing becomes more critical. Testing allows organizations to determine the efficacy of their preparations. It also answers critical questions for ICD-10 stakeholders: Can applications accommodate ICD-10 codes correctly? Does data flow seamlessly between internal and external interfaces? Are payers able to receive, adjudicate, and pay claims correctly?

Although information technology (IT) professionals handle the bulk of the technical upgrades and remediation necessary for ICD-10, comprehensive testing also requires significant HIM expertise and input. HIM not only identifies the cases that are most appropriate for testing purposes, but makes testing possible by providing cases that include ICD-10-coded data.

This article provides eight ways in which HIM professionals can—and should—remain involved in ICD-10 testing within their organizations.

Identify and manually code cases for testing

HIM professionals possess the business logic and coding knowledge to identify optimal medical records for testing. Best practice is to include cases with diagnosis code expansions or ones that require significantly enhanced procedural documentation.

And since General Equivalence Mappings (GEM) and other crosswalks can skew testing results, it is suggested that HIM manually assign ICD-10 codes for their test cases. Include cases that have high-volume, high-revenue diagnoses and procedures. DRGs commonly audited by RACs and other auditors should also be included in your collection of claims for testing. Cases that make your organization most vulnerable today in ICD-9 are the same ones that should be used for end-to-end testing exercises.

Select trading partners for testing

When selecting trading partners for ICD-10 testing, include payers, vendors, and clearinghouses. Don’t assume all trading partners will be ready for ICD-10. If a particular trading partner gives pushback on testing, how will your organization respond? HIM professionals play a key role in initiating closer auditing and monitoring with these partners to ensure readiness. HIM knows where data is stored and how it can be accessed. This information is vital to IT professionals serving on the front lines of testing exercises. HIM know-how helps IT build a comprehensive testing plan that takes all systems and applications into account.

Collaborate with IT to develop comprehensive test scripts

Test scripts must address all aspects of a patient encounter or admission, including registration, treatment, coding, billing, discharge, claim submission, adjudication, and payment. Encourage IT professionals to shadow HIM so they accurately capture workflow processes, and incorporate those processes into actual test scripts. Pay particular attention to variations in workflow and ancillary systems used by HIM.

Review test results carefully and thoroughly

Demand as much detail from trading partners as possible. What percentage of claims was accepted or rejected? What specific cases were denied and why? How did revenue expectations and projections compare with actual outcomes? How did coder productivity fare during each test? Share these results with coders, clinical documentation improvement specialists, billers, and others on the HIM team to ensure that everyone is on the same page.

Be prepared to provide additional coder education

According to the HIMSS/WEDI National Testing Pilot, which took place April 16 through July 31, 2013, coders often confused the number zero with the letter O (www.himss.org/ResourceLibrary/genResourceDetailPDF.aspx?ItemNumber=23944). They also often confused the number one with the letter L. Occasionally, coders coded the diagnosis but
forgot the procedures. Coders also relied too much on the GEMs/encoders and reported nonspecific codes even when documentation indicated otherwise, as mentioned above. Your organization’s own testing may reveal similar results, requiring additional coder education to combat these common errors.

Keep others within the organization abreast of testing developments

HIM can help track testing results and convey this information to key stakeholders, including executive leadership, finance, IT, information governance, quality, compliance, and those in charge of the master patient index.

Also keep these stakeholders abreast of CMS testing strategies and results. Ideally, your ICD-10 project manager is relaying ICD-10 updates, but if not, HIM can serve in this role. Recent testing results are provided later in this article.

Advocate for physician practice involvement

According to an AHIMA/eHealth Initiative 2014 ICD-10 readiness survey, organizations with no plan to conduct end-to-end testing often cited a lack of knowledge as a reason to forego testing. Nearly half of these organizations (45%) are clinics and physician practices.

Hospital-based HIM teams can encourage practices to engage in testing by accepting and providing payer feedback regarding ICD-10 diagnoses on referrals and orders before October 1. Share dual coding strategies and timelines with physician practices to help prepare them for testing. Remember that without dual-coded claims there is no testing, including physician claims.

Network with peers

Ask your peers whether they have conducted end-to-end testing, and if so, with which payers. Share lessons learned regarding denials and errors. Also be on the lookout for information about testing initiatives and results on payer and clearinghouse websites. HIM can then convey this information to IT to make testing more effective and comprehensive.

The latest results of ICD-10 testing

There are two types of ICD-10 testing: acknowledgment testing and end-to-end testing. The first week of
CMS’ formal ICD-10 acknowledgment testing, which verifies whether CMS can accept a claim, took place November 17–24, 2014. During this week, providers submitted nearly 13,700 claims. Nationally, CMS accepted 76% of the total test claims. During the second week of testing, held March 2–6, 2015, testers submitted more than 127,000 claims. Nationally, CMS accepted 89%. CMS scheduled a third week of acknowledgment testing for June 1–5, 2015.

With regard to end-to-end testing, results have also been favorable. The most recent round of end-to-end testing took place April 27–May 1, 2015. More than 88% of the 23,138 ICD-10 claims filed during this latest round passed, according to CMS, with only 2% of rejections coming as a result of ICD-10 coding errors in the claims (for more information, see www.cms.gov/Medicare/Coding/ICD10/Downloads/2015-April-Testing-Results.pdf).

Several errors not related to ICD-10 were noted during CMS’ end-to-end testing, including incorrect National Provider Identifier, Health Insurance Claim Number, or Submitter ID; dates of service outside the range valid for testing; invalid HCPCS codes; and invalid place of service. Testing identified one issue related to certain inpatient hospital test claims that were inappropriately processed due to a systems issue with codes that are exempt from present on admission reporting. CMS plans to resolve this issue prior to the round of testing slated for July 20–24, 2015; additional information was not available at presstime.

Note that a proposed bill would require CMS to make comprehensive end-to-end testing available to all providers. This bill, the Increasing Clarity for Doctors by Transitioning Effectively Now Act, would also require an 18-month transition period during which HHS would be required to submit a report to Congress certifying whether the ICD-10 standard is fully functional and not hindering the fulfillment of provider claims.

Take your seat at the testing table

HIM professionals must have a seat at the ICD-10 testing table—even if they aren’t formally invited. ICD-10 testing requires HIM expertise. Without HIM input, testing will be ineffective and could result in a catastrophic number of ICD-10 claim denials post-go-live. Unfortunately, these denials could be blamed on HIM. Now is the time to get involved, do your part, and share your knowledge. Don’t miss out on this valuable opportunity to ensure readiness and once again prove the value of HIM.

Drill down into PSI 7

Editor’s note: This is the third in a series of four articles on Patient Safety Indicator (PSI) 90.

In the first article in this series, we provided an introduction and overview of the PSI 90 measure, which is included in two CMS pay-for-performance programs. Because PSI 90 is a claims-based measure, performance is largely determined by ICD-9-CM codes on the claims.

In the second article in this series, we focused on one of the eight PSIs in the CMS PSI 90 composite, PSI 15. PSI 15 assesses risk-adjusted performance for accidental punctures and lacerations due to a medical or surgical procedure. We discussed measure specifications and risk adjustment variables, identified common data quality issues, and provided examples of use of the EHR to promote documentation capture.

We now continue our exploration of PSI 90 with a review of another one of the eight PSIs: PSI 7.

Introduction to PSI 7

PSI 7 evaluates the hospital’s risk-adjusted rate of central venous catheter–related bloodstream
infections. Organizational performance for PSI 7 contributes 6.5% of the PSI 90 composite score under the Hospital-Acquired Condition Reduction Program. Data quality issues associated with measure inclusions, exclusions, and risk adjustment variables can contribute to suboptimal organizational performance. You can find the PSI 7 technical specifications and information on the risk adjustment methodology at www.qualitynet.org.

**PSI 7 exclusions**

CMS scrubs all submitted acute inpatient claims to identify discharges that qualify for the PSI 7 measure.

The discharges that may count in the measure denominator essentially include all medical and surgical discharges for patients 18 years or older. Exclusions narrow the pool of identified discharges into the eligible discharges that will count.

Two key PSI 7 exclusions include the capture of diagnoses for cancer and immunocompromised states:

- **Cancer diagnoses**: A list of the cancer diagnosis codes that serve as exclusions is provided in the Agency for Healthcare Research and Quality (AHRQ) PSI 90 Technical Specifications (Appendix H). The list is voluminous (seven pages); however, on review of the codes, the coder and CDI specialist can narrow the focus to the following key concepts, which are important to consistently capture:
  - Primary and secondary malignancies of most sites
  - Hodgkin’s disease
  - Leukemia
  - Personal history of any malignant neoplasm
- **Immunocompromised state diagnoses**: Appendix I in the AHRQ PSI 90 Technical Specifications provides a list of these diagnosis codes. Examples of these diagnoses include:
  - AIDS
  - Chronic kidney disease stage V or end-stage renal disease
  - Malnutrition
  - “penia” (e.g., leukocytopenia, neutropenia, pancytopenia)
  - Renal dialysis status
  - Renal transplant status

To qualify as exclusions, the physician must document these diagnoses using terminology to support accurate code assignment, the coder must assign the correct codes, and the codes must be listed on the claim as a secondary diagnosis present on admission (POA).

**Coding and documentation vulnerabilities for exclusions**

Several common documentation and coding vulnerabilities can impede the capture of a diagnosis that will exclude a discharge from PSI 7. Examples of common vulnerabilities include:

- **Capture of the code for AIDS (042)**. The root cause of this issue is typically a combination of provider documentation and a breakdown of continuity of diagnoses across encounters.
  - Provider terminology: Coding guidelines require specific provider documentation to support assignment of the ICD-9-CM code. Providers often document “HIV” or “HIV+” for patients who meet the CDC diagnostic criteria for AIDS. This documentation results in the assignment of ICD-9-CM code V08 (asymptomatic HIV infection status), instead of code 042.
  - Continuity of diagnoses across encounters: Coding guidelines stipulate that “once a patient has developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08” (ICD-9-CM Official Guidelines for Coding and Reporting, Section I.C.1). However, PSI record review audits often identify ICD-9-CM code 042 assigned on one encounter followed by the assignment of V08 on a subsequent encounter. This is inconsistent with coding guidelines.

- **Capture of the personal history of malignant neoplasms.** Common root causes for this omission include:
  - Omission of the ICD-9-CM code due to the coder’s lack of awareness of the impact that the personal history code has on quality profiles.
  - A breakdown in provider documentation across encounters.
**PSI 7 inclusions**

Once PSI 7-eligible discharges are identified, the subset of these discharges that have an outcome of interest is identified.

For PSI 7, the outcome of interest is central venous catheter–related bloodstream infections. The PSI 7 Technical Specifications show that two ICD-9-CM codes trigger a discharge as having an outcome of interest:

- 999.31, other and unspecified infection due to central venous catheter
- 999.32, bloodstream infection due to central venous catheter

To identify data quality vulnerabilities for these two codes, coders must review coding guidelines. Key guidance for accurate and complete code assignment includes:

- These codes are to be assigned when an infection is due to an associated central venous catheter or line.
- Local infections due to central venous catheters or lines are assigned a different code. Local infections might include exit or insertion sites, port or reservoir infections, and tunnel infections.
- Infections due to an implanted device, implant, or graft are assigned a different code.
- Infections due to or resulting from injection, inoculation, infusion, transfusion, or vaccination (prophylactic or therapeutic) are assigned different codes.
- Sepsis or bacteremia due to a central venous catheter or line requires that the codes be sequenced first followed by the codes for sepsis or bacteremia.

**Coding and documentation vulnerabilities for inclusions**

Common data quality vulnerabilities that inappropriately trigger a discharge as having an outcome of interest for PSI 7 include:

- Incorrect assignment of these codes in patients with an infection due to a peripheral line instead of a central line.
- Incorrect assignment of these codes in patients with local infections.
- Unclear and/or inaccurate physician documentation to establish that the infection is due to the central line/catheter.
- Inaccurate POA assignment. If this diagnosis was POA, it does not count as an outcome of interest.

**PSI 7 risk adjustment**

Hospital performance for PSI 90 is not determined by the actual (or observed) number of discharges with an outcome of interest, but on risk-adjusted performance. AHRQ comorbidity software identifies the presence or absence of defined risk adjustment variables, each of which has a coefficient weight. These risk adjustment variables are critical inputs in the calculation of the hospital’s predicted events, and thus the risk adjustment calculation.

Fourteen comorbid categories impact PSI 7 risk adjustment. Twelve of these categories have a positive risk adjustment impact.

Note that only three of the comorbid categories were also applicable to PSI 15. This illustrates how critical it is that coders and CDI specialists understand and focus on what drives each specific PSI.

**Documentation and coding vulnerabilities for risk adjustment**

To optimize risk adjustment, one ICD-9-CM code needs to be captured for each comorbid category. By reviewing the ICD-9-CM codes that map to each comorbid category, you will uncover a voluminous number of codes.

The purpose of the review should be to identify the most likely conditions that may be present in most discharges, as well as those conditions that require the lowest documentation specificity for impactful code assignment.

The resulting list of codes can serve as a checklist for use in the concurrent, retrospective, pre-bill, and/or post-bill validation process.

Examples of coding and documentation vulnerabilities pertinent to risk adjustment for this PSI include:

- Assignment of the accurate POA status for comorbid conditions.
- Underdocumentation of “-plegia,” such as hemiplegia (342.90) or functional quadriplegia (780.72). Physicians often use the term “weakness” instead of hemiplegia, and the clinical definition of functional
quadriplegia is often not well understood.

- Underdocumentation and/or underreporting of restless leg syndrome (333.94). A patient may be continued on a home medication for this condition (e.g., Requip®, Mirapex®) without the physician documenting the condition for which the medication was prescribed.
- Underdocumentation of chronic blood loss anemia (280.0).
- Underdocumentation of anemia (285.9).

**Next month: A look at PSI 12, perioperative deep vein thrombosis or pulmonary embolus**

In the final article in this series, we will study PSI 12. We’ll review measure specifications (inclusions and exclusions) as well as risk adjustment variables. We’ll provide examples of coding and documentation vulnerabilities, and illustrate opportunities to leverage the EHR to systemize documentation capture.

**Physician engagement and documentation excellence**

*by Terrance Govender, MD, CHBC, C-CDI*

Finding themselves at the center of a tumultuous, dynamic healthcare environment, physicians are becoming increasingly frustrated and anxious, frequently questioning their career choice. Preparation to be a lifelong healthcare provider inadequately prepares clinicians for the emerging value-based healthcare world to which they are being subjected. Physicians believe that they have little control over or input into the metrics that are rapidly determining their fates with healthcare organizations, third-party payers, and inevitably patients themselves.

Optimizing the delivery of healthcare in the United States, though, is fundamentally about healthcare organizations and physicians working toward interrelated goals and collaborating to improve outcomes and efficiency. Physician engagement in the transformation of healthcare will be the catalyst to better outcomes, improved patient satisfaction, better quality of care, and preservation of physicians’ good reputations. HIM professionals, more than many others involved in healthcare finance, have experience working closely with physicians. As HIM and clinical documentation improvement (CDI) professionals continue to evolve their clinical documentation programs, outcomes dependent on physicians can benefit from new insights gained from understanding skills and strategies for effective physician engagement.

**The physician and clinical documentation**

As we continue to evolve from a volume fee-for-service model to a value-based model, clinical documentation begins to take on a new meaning. Physicians have been taught that the sole purpose of clinical documentation in the patient’s record is to communicate among providers and satisfy medico-legal requirements. As we evolve from a volume- to value-based landscape, physicians’ communication tool has morphed to an accountability tool. This is a paradigm shift for clinicians.

The concept of risk adjusting payments and quality metrics, which is based on codes generated from clinical documentation, is not new. However, it triggers anxiety and frustration among physicians who have dedicated their lives to achieving excellence in a profession that not many can stomach. So we are left with a
gap between the language that physicians speak, which serves clinical purposes, versus the language that can be captured and risk adjusted by ICD-9 and soon to be ICD-10 codes. Bridging the gap and achieving buy-in from physicians is not easy because many physicians view documentation excellence initiatives as a challenge to their clinical judgment and medical-decision making; essentially, when compared to the clinical care they provide, physicians see documentation excellence as a triviality.

The role of clinical documentation in healthcare reform, however, is far more significant than most clinicians appreciate. The physician perspective is that documentation, when viewed in unison with the patient’s clinical presentation, should be of value to physicians and their colleagues, but it should not form the basis of that physician’s reputation, or that of the physician’s organization. Physician engagement is no easy initiative, but focusing first on the goals of the program helps immensely with buy-in and collaboration.

**Starting with why**

When many organizations communicate their goals and objectives, they usually start with the *what* and then get to the *how*, but very rarely include the *why*. This is what author Simon Sinek refers to as the Golden Circle in his 2009 book *Start With Why*. Sinek states that organizations who are able to successfully communicate the *why* to constituents end up with greater buy-in and engagement with the goals and vision of that organization. He explains that when people understand and believe in the *why*, the *how* and the *what* become rational decisions they make to support their belief in the *why*.

The *why* is a belief. *Hows* are the actions you take to realize that belief. *Whats* are the results of those actions, according to Sinek.

Consider applying this concept to the documentation excellence program. HIM professionals may say, “Physicians, please provide more specificity in your documentation by answering queries in a timely manner.” The *what* and the *how* are clearly expressed, but the *why* is not articulated at all.

Now consider starting with *why*, which is a belief, and then articulating the *how* and *what*. Try something along the lines of: “We believe that our physicians are some of the most clinically astute in the country. We believe that they practice a standard of care that is of the highest quality. We believe that every patient that walks through our doors receives the highest quality and standard of care and will always be at the center of our healthcare delivery model. This will be reflected in our quality and patient satisfaction scores, which are determined by the data generated based on documentation best practices and standards. Can we help you with those best practices and standards so we are accurately represented in the marketplace?”

Starting with *why* presents a far more compelling case for physician buy-in. This approach, coupled with tried and tested physician engagement strategies, predicts a more successful outcome with documentation excellence initiatives.

In his 2009 book *Engaging Physicians: A Manual to Physician Partnership*, Stephen Beeson describes the following nine highly effective stages that lead to successful physician partnership:

- Creating and communicating organizational vision and goals
- Leadership development and accountability for performance
- Establishing physician confidence and trust
- Building physician leadership
- Training physicians
- Physician measurement and balanced scorecards
- Implementing physician behavioral standards
- Managing the disruptive physician
- Recognizing physicians

Additionally, an adaptation of Max Weber’s typology of social action describes four motivational tools that leaders can leverage to engage physicians in healthcare:

- Engage in a shared purpose
- Satisfy self-interest
- Earn respect
- Embrace tradition

We know that if wholly committed to, these strategies work, either on their own or together. (See the *Harvard Business Review* at https://hbr.org/2013/10/the-strategy-that-will-fix-health-care and https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution.)
Creating and communicating organizational goals and engaging in a shared purpose

Goals of the documentation improvement program must not only align themselves favorably with that of the organization as a whole, but also with that of the physicians we wish to engage. Too frequently, CDI programs take flight without ample time spent on crafting goals that speak to a shared purpose with physicians. Organizations need to identify what matters to physicians, and then craft organizational and documentation initiative goals that are appropriately aligned. These goals, once established, must be effectively communicated to physicians in a manner that resonates with them.

This communication must start in the early stages of the development and/or reinvigoration of a documentation improvement program. Repetitive, deliberate communication with physicians concerning the why and the program’s goals and objectives is necessary to affirm the shared purpose and common organizational goals.

Those leading the effort must be well respected by their peers. Physician leaders/advisors must have credibility in the eyes of the physicians, and must accurately represent their best interests, which should align with the program goals. These leaders must also be provided with the skills to perform appropriately, and just like the physicians involved in the program (stage 6 of the highly effective stages), physician advisors should be held accountable for not meeting the program goals. This stage can be the linchpin to moving forward with an organizational initiative, and its importance should not be underestimated.

Adequate training for physicians that consistently iterates the why will be necessary for documentation improvement program buy-in and engagement. Physicians are scientists, and being trained to ask why is second nature to them; this tendency can be leveraged to ensure that we are not only providing training with regard to documentation skills, but also simultaneously answering the why with pertinent content.

Physicians appreciate feedback, and are frequently concerned with losing the respect of their colleagues (again, see the Harvard Business Review at https://hbr.org/2013/10/the-strategy-that-will-fix-healthcare and https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution). High-performing organizations are seeing positive results with publishing physician performance cards, which appeal to the competitive nature of doctors. When physicians are doing well, displaying engagement and helping the program realize its desired outcomes, this cooperation should be noted and mentioned. Positive feedback is a means to sustain engagement and results that have already been achieved. It also presents an opportunity for organizations to appeal to the self-interest of physicians, which may include both financial and non-financial incentives.

A sense of belonging to an organization allows leaders to set certain behavioral standards with physicians when it comes to various initiatives. Physicians are willing to comply because they are motivated to adhere with the standards and traditions of an organization of which they are proud to be an integral part.

The cost of ignoring the unengaged physician in our new framework of healthcare is too high, so every effort must be made to ensure that physician engagement begins at the conception of a new idea, initiative, or program, especially those concerning documentation excellence.

Always start by communicating the shared purpose or the why, and engagement and positive actions will be the result of physicians’ belief in the common organizational goals.

References


EDITOR’S NOTE
Govender is a director for Navigant Consulting, Inc., in Seattle. He brings with him a unique background of clinical and healthcare business experience. He has extensive experience in the development and implementation of clinical documentation improvement programs, as well as physician-to-physician education and attaining physician buy-in. Govender has been able to leverage his clinical experience to identify with clinicians and create awareness and education with regard to the business side of healthcare. He has extensive experience as an executive clinical liaison as well as serving as a trusted advisor to executive clinical staff.
Dear colleagues (particularly obstetrics):

On October 1, 2015, we all will transition to ICD-10-CM when reporting our patients’ diagnoses. Based only on our documentation supported by appropriate clinical circumstances, these codes factor into our success with CMS’ proposed alternative payment models, such as bundled or episode payments and the new Merit-based Incentive Payment System (MIPS).

Obstetrics (OB) is in CMS’ crosshairs as ripe for payment reform, especially as states grapple with the increasing costs of their Medicaid programs.

In ICD-10 and risk adjustment, garbage in is garbage out. Unless high-risk pregnancies and their consequences are completely documented and coded using ICD-10 language and codes, providers are likely to be unduly penalized, even if their outcomes are stellar.

**Obstetric codes double in ICD-10-CM**

In ICD-10-CM, the number of OB codes increases from 1,107 to 2,155.

All completely normal pregnancies are reported under category Z34 (Encounter for Supervision of Normal Pregnancy), which differentiates the first pregnancy from other pregnancies.

If any other diagnosis exists during pregnancy, ICD-10-CM requires the use of a code from Chapter 15, Pregnancy, Childbirth, and the Puerperium (letter O codes) instead of a Z34 code unless the provider explicitly documents that the diagnosis is not related to the pregnancy.

Unlike ICD-9-CM, ICD-10-CM classifies antenatal conditions in trimesters, defined as:

- First: Less than 14 weeks, 0 days
- Second: 14 weeks 0 days to less than 28 weeks, 0 days
- Third: 28 weeks 0 days until delivery

ICD-10-CM also has codes to indicate the weeks of pregnancy under category Z3A. If the gestational age (weeks and days) is documented, the trimester can be calculated by the coder; obviously, if only the trimester is documented, a coder cannot accurately code the number of weeks.

While ICD-10-CM has codes for unspecified trimesters, CMS and other insurers promise denials or reductions in illness severity for claims using these unspecified codes. Therefore, the gestational age or the trimester must be specified on any test ordered or referral made so that the appropriate trimester is reported by others.

ICD-10-CM changes the ICD-9-CM definition of early pregnancy from 22 weeks to 20 weeks, which is applicable to the onset of severe vomiting (e.g., hyperemesis gravidarum), abortions, fetal deaths, and OB hemorrhage. Pre-term conditions (e.g., false or true labor, delivery, or membrane rupture) occur before 37 weeks, while post-term pregnancy occurs after 40 weeks and prolonged pregnancy occurs after 42 weeks. Gestational age documentation facilitates appropriate capture of these conditions.

**Increased documentation of high risk required**

ICD-10-CM OB documentation must include the following information:

- **High-risk conditions.** Note any grand multiparity, age of delivery before 16 or after 35, morbid obesity (BMI over 40), bariatric surgery status, or
insufficient prenatal care. Also note any past history of infertility, ectopic or molar pregnancy, pre-term labor, stillbirths, or recurrent pregnancy loss. Differentiate between maternal drug, alcohol, or tobacco use (legal or prescribed), abuse (illegal or misuse), and dependency (drug-seeking behavior, withdrawal, or continued use), especially in light of the increasing incidence of neonatal abstinence syndrome.

• **Multiple gestations.** Note the number of placentas and amniotic sacs. In the event of OB complications affecting a fetus (e.g., breech presentation, maternal disproportion due to an abnormal fetus, oligo- or polyhydraminos), specify which fetus (e.g., A, B, C, or 1, 2, 3) was involved.

• **Diabetes mellitus.** Specify whether the diabetes is gestational or preexisting Type 1, Type 2, or due to a drug (e.g., steroids) or a specific disease (e.g., Cushing’s disease). Also note whether it is out of control and document any specific diabetic complications (e.g., neuropathy, vasculopathy, retinopathy)

• **Other.** Note any known mild, moderate, or severe depression, schizophrenia, or bipolar disorder and whether it is currently present or in remission. Also note any sickle-cell trait or disease, HIV disease (previously known AIDS, CD4 count less than 200, or acute HIV syndrome), group B streptococcus infection, asymptomatic bacteriuria, or Tdap vaccination.

**Obstetrics complications are complicated**

Having a baby is not for the timid. Please document the following when and if it occurs:

• **Hypertension.** Any documented high blood pressure will be reported as hypertension unless explicitly documented not to be hypertension. Specify whether hypertension is non-severe or severe and whether gestational or preexisting. Specify any hypertensive consequences, such as chronic kidney disease, cardiomyopathies, and/or systolic or diastolic heart failure.

• **Edema and proteinuria.** ICD-10-CM allows the separate reporting of gestational edema and/or proteinuria if defined, diagnosed, and documented.

• **Preeclampsia.** ICD-10-CM differentiates mild/moderate from severe preeclampsia; however, the provider must document what qualifies the preeclampsia to be severe, such as severe hypertension; acute kidney injury; thrombocytopenia; elevated liver enzymes; cerebral edema; vasospasm or vasoconstriction; metabolic encephalopathy resulting in delirium, psychosis, or hallucinations; and/or cardiogenic or non-cardiogenic pulmonary edema. HELLP syndrome has its own designation in ICD-10-CM. Eclampsia will be reported if any seizure occurs in the setting of preeclampsia, hypertension, edema, or proteinuria unless the provider explicitly documents that the seizure is not eclampsia.

• **OB hemorrhage.** Note any underlying causes of OB hemorrhage, such as placenta previa, sexual trauma, or cervical neoplasia.

• **Perineal lacerations.** Be certain that the torn anatomy correlates with the documented degree, such as second (perineal muscle), third (external or internal anal sphincter), or fourth (anal or rectal mucosa) degree. Document exactly what anatomy is repaired, such as the muscle, sphincter, and/or anus, in your operative note.

• **Postpartum hemorrhage.** ICD-10-CM recognizes postpartum hemorrhage (defined as blood loss over 500 cc after vaginal delivery or 1,000 cc after cesarean section) and its underlying cause (i.e., retained placenta, uterine atony, any coagulopathy).

• **Anemia.** Do not rely on your lab’s normal values for healthy females in making a diagnosis of peripartum anemia. If there is a significant drop in the hematocrit qualifying as anemia during or after delivery, note its underlying mechanism (e.g., acute blood loss, hemolysis) and cause (coagulopathies, postpartum hemorrhage).

Your coding department, as well as the American Congress of Obstetricians and Gynecologists, has resources that can help you document and code in ICD-10-CM; be sure to reach out and ask for their help. Thank you for your time and attention to this matter.

Respectfully,

James S. Kennedy, MD, CCS, CDIP
President, CDIMD – Physician Champions