Assuring that your Physicians are Ready for ICD-10 Clinical Documentation & Medical Necessity Compliance? The Countdown has Begun

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Objectives

• Discuss significant changes in clinical documentation requirements for ICD-10, and how they will impact Physician hospital and office practices.
• Provide strategies for Compliance Officers to use in engaging clinicians to implement appropriate clinical documentation & medical necessity requirements.
• Raise awareness of Compliance Officers’ role in overseeing Medicare/Medicaid ICD-10 compliance
SEVEN ELEMENTS: THE COMPLIANCE APPROACH

- Standards and Procedures
- Compliance Oversight
- Education/Training
- Communication & Processes
- Enforcement and Discipline
- Auditing and Monitoring
- Investigation, Response and Prevention

https://oig.hhs.gov/authorities/docs/cpghosp.pdf

#1: STANDARDS AND PROCEDURES

✓ Address applicable laws and regulations.
✓ Establish controls, policies and procedures to comply.

- What clinical documentation policies do you have?
  - Timely documentation
  - Clinical documentation standards
  - Discipline policies
  - Non-retaliation/non-retribution
  - Seeking guidance from a third-party

- Are policies, procedures and standards available in written form and/or on a website?
- Can you demonstrate that policies are consistently followed?
- How do you document compliance with the policies, procedures and standards?
#2: COMPLIANCE OVERSIGHT

- Does your organization have a Compliance Program?
- Who is the Compliance Officer?
- How is the Compliance Officer involved with clinical documentation issues?
- Is there buy-in for the Compliance Program?
- Is a clinical documentation specialist (i.e. coder, case manager) on the Compliance Oversight Committee?

#3: EDUCATION AND TRAINING

- Is education and training provided to all persons involved with clinical documentation?
- Are laws, regulations and standards presented in a clear manner that is easily understood?
- Are all areas of medicine represented at the hospital covered?
- Do coders receive on-going training?
- Does formal education and training occur at least on an annual basis?
#4: COMMUNICATION

- The organization will be held responsible to effectively communicate and train any employee or others in the supply chain regarding the company's compliance controls, policies and procedures respective of their roles and responsibilities.

- Is there appropriate communication between providers, case managers, and coders?
- Do the coders and case managers feel free to discuss questions and concerns with the providers?
- Is there commitment from the top of the organization?
- Does your organization have a reporting system in place? (i.e. hotline)
- Is the reporting system advertised?

#5: ENFORCEMENT AND DISCIPLINE

- Is there discipline for those that do not follow the rules?
- Do employees understand the discipline policy?
- Is discipline consistent?
- Is the organization monitoring the Office of Inspector General’s exclusion list and the GSA list, now known as the Excluded Parties Listing System (EPLS)?
#6: AUDITING AND MONITORING

- Is there a clinical documentation improvement program in your facility?
- Is there an annual process for auditing clinical documentation?
- Is the audit plan defined and updated at least annually?
- Is there on-going monitoring of clinical documentation?
- Is a risk assessment completed annually and prioritized directly related to clinical documentation?
- What do you do with the results of the audits and monitors conducted?

#7: INVESTIGATIONS, RESPONSE AND PREVENTION

- When issues arise are they investigated?
- Who is responsible for their investigation?
- Who receives the response from the investigations?
- Are findings used to prevent issues from reoccurring?
- Do you find the same issues over and over again?
ICD-10 Clinical Modification

• Why?
  – Not enough detail for analyzing diseases
  – Not enough detail for payment
  – Insufficient attention to
    • Medical encounters for reasons other than death
    • Non-lethal manifestations
    • ICD-9-CM 16,000 codes; ICD-10-CM 70,000 codes
    • The detail is demanded not by government nor by payers but by specialty societies

Clinical Documentation Integrity
Clinical Documentation Integrity

Clinical Documentation Improvement

What is CDI?

- **Purpose of Clinical Documentation Improvement & Integrity**
  
  - To enhance concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation of medical necessity and compliance.

- **Goal of reviews is to identify clinical indicators to ensure that the diagnoses and procedures are supported.**
Key Stakeholders of CDI

- Medical staff and physician leadership
- Executive leadership
- CDI Nurses & HIMs
- Case management and utilization review
- Health Information Management and coding departments
- Finance and revenue cycle
- Quality management
- Denials management and appeals
- Nursing staff
- Compliance officers

CDI GOALS

- Identify and clarify missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures
- Support accurate diagnostic and procedural coding, DRG assignment, severity of illness, risk of mortality
- Demonstrate and establish medical necessity for hospital admission and continued stay
- Promote health record completeness during the patient encounter
Impact Upon Physicians

- Current Environment
  - Practicing medicine without much feedback (Medicare beneficiaries)
  - Physician profiling - Comparative Business Reports
  - Aberrant coding and billing patterns
- Evaluation and Management
- Transforming Environment
  - Physician control their own financial destiny
  - Financial risk and financial benefit transfer
  - Medical Necessity outlook and impact
  - The “Business of Medicine”

Physician Vested Interest

- **Hospital Business Success** = **Physician Business Success** with advent of Accountable Care Organizations
- Business of Medicine → Physician & Hospital working together towards interrelated business goal objectives.
  - Practice survival dependent upon providing and delivering quality, cost effective efficient medicine
  - “Darwinism”
Business Side of Medicine

- Promote complete, concise and clear documentation, consistent throughout the record
- Physician Buy-In for specificity and consistency
  - Control of their own destiny
  - Financial economic impact
- Healthcare delivery and reimbursement reform methodologies

Claim Denials & Rejections

- Common denials/rejection issues
  - Medically unnecessary services
  - Insufficient clinical documentation
  - Service incorrectly coded
  - Conclusory statement lacking clinical confirmation and clinical rationale
  - Conflicting clinical documentation between physician and ancillary staff
  - No signature, date of service
  - Illegible hand writing
CRIMINAL PENALTIES

- Felony for failure to disclose a known overpayment **even if initially obtained innocently**
- Continuing offense = pattern
- Failure to disclose = **intent at time of decision**
- Concealment after the fact = **scheme**
- Prison, fines and restitution
- Exclusion
- CMPs
- CIAs

ICD-10-CM vs. ICD-9-CM

- **Why?**
  - Out of room
  - Obsolete family groups
  - 30 years of medical knowledge of etiology
  - Not enough detail for computerized analysis
  - Inadequate attention to
    - Continuum of disease
    - Clinically relevant subsets ICD-10 is necessary
Coding and Documentation

• Nonspecific codes are still available when necessary. The goal is always to work toward better documentation for the following reasons:
  - Avoid misinterpretation by third parties (such as auditors, payers, attorneys, etc.)
  - Justify medical necessity
  - Provide a more accurate clinical picture of the quality of care provided
  - Support current and future initiatives aimed at improving quality and reducing costs, such as value-based purchasing

• **Issues related to inconsistent, missing, conflicting, or unclear documentation must still be resolved by the provider—both today under ICD-9-CM, as well as in the future with ICD-10-CM/PCS**

The Risk in Using Unspecified Codes

• **Unspecified codes are used:**
  - Lack of unspecified documentation
  - Easy and everyone is getting paid

• **Potential results in revenue cycle**
  - Heightened need or cause for more audits
  - Draw down the Case Mix Index (CMI)
  - Negative impact to severity and risk scores (part of many/most reimbursement models)
  - Falls into lower DRG group
Status of Disease

• **Status of disease**
  – Acute or subacute
  – Chronic, Intermittent, Recurrent,
  – Transient
  – Mild, Moderate, Severe
  – Primary Versus Secondary
  – Major

What are the Benefits?

– **Measure the quality, safety, and efficacy of care**
– Reduce the need for attachments to explain the patient’s condition
– Design payment systems and process claims for reimbursement
– Conduct research, epidemiological studies, and clinical trials
– Set health policy
– Support operational and strategic planning
– Design health care delivery systems
– **Monitor resource utilization**
– Improve clinical, financial, and administrative performance
– Prevent and detect health care fraud and abuse
– Track public health and risks
Thinking Beyond

Ggg
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New Way of Thinking

• Clinical medicine application
  – Going beyond rote
  – Proactivity
  – Construction zone
    • Disease relationships
    • Atypical manifestations

A Word on Clinical Specificity

ICD-9
• 707.1X Ulcer of lower limbs, except pressure ulcer
• 707.11 Ulcer of thigh
  – Code if applicable, any causal condition first:
    • Atherosclerosis of the extremities with ulceration (440.23)
    • Chronic venous hypertension with ulcer (459.31)
    • Chronic venous hypertension with ulcer and inflammation (459.33)
    • Post phlebitic syndrome with ulcer (459.11)
    • Post phlebitic syndrome with ulcer and inflammation (459.13)

ICD-10
• L97.1X Non-pressure ulcer of thigh
• L97.111 Non-pressure chronic ulcer of right thigh limited to breakdown of skin
• L97.112 Non-pressure chronic ulcer of right thigh with fat layer exposed
• L97.113 Non-pressure chronic ulcer of right thigh with necrosis of muscle
• L97.114 Non-pressure chronic ulcer of right thigh with necrosis of bone
• L97.119 Non-pressure chronic ulcer with unspecified severity
Clinical Specificity

- **ICD-10 provides enhanced specificity**
  - Change in specificity versus change in clinical medicine
  - Approximating clinical thought processes
    - Recording versus thinking
    - Role in Evaluation and Management Assignment
    - Establishing medical necessity
    - Recognizing the business of medicine

Clinical Thought Processes
Capturing Thought Processes

Fracture of the Femur

- 821.11 Fracture of shaft of femur
- S72.30-Unspecified fracture of shaft of femur
  - S72.301 Unspecified fracture of shaft of right femur
  - S72.302 Unspecified fracture of shaft of left femur
  - US72.309 Unspecified fracture of shaft of unspecified femur
Increasing Specificity

- **S72.32 Transverse fracture of shaft of femur**
  - S72.321 Displaced transverse fracture of shaft of right femur
  - S72.322 Displaced transverse fracture of shaft of left femur
  - S72.323 Displaced transverse fracture of shaft of unspecified femur
  - S72.324 Nondisplaced transverse fracture of shaft of right femur
  - S72.325 Nondisplaced transverse fracture of shaft of left femur
  - S72.326 Nondisplaced transverse fracture of shaft of unspecified femur

- **S72.33- Oblique fracture of shaft of femur**

Seventh Character

- The appropriate 7th character is to be added to each code from category S72
- A - initial encounter for closed fracture
- B - initial encounter for open fracture type I or II
- C - initial encounter for open fracture type IIIA, IIIB, or IIIC
- D - subsequent encounter for closed fracture with routine healing
- E - subsequent encounter for open fracture type I or II with routine healing
- F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
- G - subsequent encounter for closed fracture with delayed healing
- H - subsequent encounter for open fracture type I or II with delayed healing
- J - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
- K - subsequent encounter for closed fracture with nonunion
- M - subsequent encounter for open fracture type I or II with nonunion
- N - subsequent encounter for open fracture type IIIA, IIIB, or
### Other Points

- Combination codes for certain conditions and common associated symptoms and manifestations
- **For example:**
  - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
  - E11.341 – Type 2 diabetes mellitus with severe non-proliferative diabetic retinopathy with macular edema
  - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

### Physician Mindset

- ICD-10 does not impact me
- I code in CPT
- It is just a hospital thing
- Something more for me to worry about
- What else does hospital administration want from me?
- I am going to retire by next year (hopefully)
- I will deal with ICD-10 when the time arrives
Reality

- ICD-10 – October 1, 2014
- Collaborative approach to ICD-10 readiness
- Physician support and engagement
- Prepare for tomorrow today
  - Immediate benefit to physician
  - Lesson in efficiency
  - Value Modifier Program
  - Pay-for-Performance

ICD-10 - Medical Necessity

- Congruous terms
  - ICD-10 and Medical Necessity
- Medical Necessity
  - Synergies of Clinical Documentation
  - Traveling the same path
  - Material benefit
  - New added meaning with transition away from Fee-for-Service
Medical Necessity

• 1862 (a)(1)(a)
  – Section 1862(a)(1)(a) SSA Title XVIII- No payment may be made under part A or part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis of illness or injury or to improve the functioning of a malformed body member

Medical Necessity

• Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
• It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
• The volume of documentation should not be the primary influence upon which a specific level of service is billed.
• Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.
Context of Medical Necessity

- Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician's documented work:
  - Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
  - The context of the encounter among all other services previously rendered for the same problem.
  - Complexity of documented comorbidities that clearly influenced physician work.
  - Physical scope encompassed by the problems (number of physical systems affected by the problems).

The Specifics

- Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
- HPI- Mrs. Jones, a pleasant 75 year old female patient presented to the Emergency Room with acute onset of shortness of breath in the middle of the night, she described a feeling of impending doom, complains of some chest pain, waxing and waning associated with the shortness of breath, worse when she exerts herself. Took some Motrin and feels a bit better
More Information

• **Assessment:**
  – Acute onset chest pain and shortness of breath, concern for ST elevated MI given her current risk factors for MI of female patient over 65 with strong family history of MI, diabetes, past smoking history, mildly and relatively sedentary lifestyle. EKG shows abnormalities in the anterior wall
  – Concern also for acute pulmonary embolism with acute cor pulmonale given her swelling of the ankles and feet with frank pedal edema and jugular venous distension. She has the risk factor for pulmonary embolism of a previous pulmonary embolism, may have sub therapeutic coagulation profile. Check INR

The Specifics

• Complexity of documented comorbidities that clearly influenced physician work.
  
• Acute on chronic diastolic congestive heart failure- I50.33
• Chronic renal failure stage III- N18.3
• Long standing diabetes moderately controlled culminating in chronic renal failure unfortunately- E08.22
Solidifying Physician Buy-In

- **Medical Decision Making**: the thought processes of the physician. Refers to the complexity of establishing a diagnosis and selecting a management and treatment option as measured by the following:
  - The number of possible **diagnoses** and/or the number of management options that must be considered.
  - The amount and/or complexity of **data** - medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.
  - The **risk** of significant complications, morbidity and/or mortality, as well as comorbidities, associated with that patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Presenting Problem

**Minimal Level of Risk**
- One self-limited or minor problem,
  - e.g., cold, insect bite, tinea corporis

**Low Level of Risk**
- Two or more self-limited or minor problems
- One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH
- Acute uncomplicated illness or injury, e.g., cystitis, allergic
- rhinitis, simple sprain
### Presenting Problem

<table>
<thead>
<tr>
<th><strong>Moderate Level of Risk</strong></th>
<th><strong>High Level of Risk</strong></th>
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<tbody>
<tr>
<td>• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td>• Two or more stable chronic illnesses</td>
<td>• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
</tr>
<tr>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
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<td>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
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<tr>
<td>• <strong>Acute complicated injury, e.g., head injury with brief loss of consciousness</strong></td>
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### Capturing Medical Necessity

- **Drivers of Lack of Medical Necessity**
  - Insufficient documentation
    - Signs and symptoms versus specific diagnoses
    - No diagnoses
    - Cut and paste and carry forwards
    - Cloning of documentation-widespread and prevalent
## Traumatic Subdural Hemorrhage

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
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</thead>
<tbody>
<tr>
<td>852.20- Subdural hemorrhage following injury without mention of open intracranial wound unspecified state of consciousness</td>
<td>S06.5X0- Traumatic subdural hemorrhage without loss of consciousness</td>
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<tr>
<td>852.21- with no loss of consciousness</td>
<td>SO6.5X1- Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less</td>
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<tr>
<td>852.22- with brief (less than one hour) loss of consciousness</td>
<td>SO6.5X2- Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes</td>
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## Traumatic Subdural Hemorrhage

- S06.5X4- Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours
- S06.5X5- Traumatic subdural hemorrhage with loss of consciousness of greater than 24 hours with return to pre-existing conscious level
- S06.5X6- Traumatic subdural hemorrhage with loss of consciousness of greater than 24 hours without return to pre-existing conscious level
- S06.5X9- Traumatic subdural hemorrhage with loss of consciousness of unspecified duration
Cloned Documentation

• Medical Record Cloning
  – When documentation is worded exactly like previous entries, the documentation is referred to as cloned documentation.

  Whether the cloned documentation is handwritten, the result of pre-printed template, or use or Electronic Health Records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Five Step Process for Documentation

• Treatment and billing-compliant practice
  – 1) Decide that a service is medically necessary for this patient
  – 2) Provide the best service to met, but not exceed, the patient’s needs
  – 3. Document the service provided in the medical record.
  – 4. Select the most appropriate CPT/HCPCS code for the service
  – 5. Submit your bill to third party payer
Tips to Avoid Physician Service Denials

- Order and perform clinically appropriate services required to care for the patient in light of patient chief complaint(s) and presenting signs and symptoms
- Describe each service ordered or performed in the medical record in enough detail to adequately and sufficiently portray the patient’s condition and the work performed or requested
- “Enough detail” → Clinical specificity versus generic clinical diagnoses & symptoms

Cardinal Rule of Documentation

- “Describe” versus “Generalize”
- Tell” versus “Show”
- Common theme → Clinical specificity in documentation
- ICD-10 offers clinical specificity
Thank you

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