Difficult Coding Issues - Lessons from the Trail
Lynn Myers MD, CPC, CHC & Jeep enthusiast

Goals for Today
- Prepare for the ride.
  - Learn five keys for communicating with providers
- Choose a line that gets you down the trail
  - Design the audit process
  - Just because you didn’t break an axel today doesn’t mean you won’t the next time
- Navigate the steep hills and big rocks
  - Training on specific codes
- Enjoy the journey!

Prepare for the Ride

Five Keys to a Successful Conversation
It seems steeper when you’re in the driver’s seat...

The Challenge

“The rules have changed…”

“I don’t have time to change…”

“I should’ve changed for auditors…”

“I’m too old to change…”

“Operations says my volume is low—it is why…”

“I’ve been audited for years and no one has told me this…”

“The rules have changed…”

They’re right!

1. Deliver a Consistent Message

At the same time that we are discussing a physician’s opportunities for improvement in the medical record, we must ensure that our message is consistent:

- We are not coaching documentation to a higher level of service or to a diagnosis that doesn’t exist.
- Acknowledge the need for documentation that supports the care that is given, which supports the codes that are submitted for reimbursement.
- More often than not, providers are not over-coding, but under-documenting their services. The importance of reconciling these two items is critical.
- We understand that there are competing demands on clinicians within an organization: ACO, EMR implementation/optimization, PCMH, etc.
- Be aware of other parts of the organization that may have contacted the provider
2. Begin with Acknowledgement

Always start with acknowledging the commitment to great patient care.

The mantra: Document the excellent care, and report codes based upon documentation.

Chart documentation = Codes submitted for reimbursement

<table>
<thead>
<tr>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
</table>

3. Know your rules!

- Physicians are the experts in their field, and we are experts in ours
- Physicians respond to evidence
  - Show them the documentation guidelines
  - Identify opportunities using their own documentation
- Physicians are competitive
- Queries cannot lead!
  - Enumerate clinical indicators
  - Labs
  - Medications
  - Give choices for diagnosis, including other or unable to determine

4. Show examples

Right Code, Right Reimbursement
5. Anticipate obstacles to communication

- Interact with other departments
  - Are there competing influences in play (personal, financial, professional)

- Challenges
  - Physician Resistance: Not all physicians are eager to know their documentation falls short. There is often a feeling of hopelessness and frustration mixed with righteous indignation.
  - Number of Physicians: The sheer number of physicians in a large provider group makes it difficult to reach everyone in a timely manner.
  - Geographic Distribution: It is not always possible for physicians to leave their practice area to come to the corporate office. Meeting the physician on their own turf is a gesture of good will that does not go unnoticed... in most cases.
  - Time: It's a premium for everyone!

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Choosing a line

Designing an Audit Process

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Choose a line that gets you down the trail
Designing an Audit Program

The intent of the ambulatory audit process is to reduce the variability of standard of integrity. The organization needs a process that is reproducible and sustainable over time.

Key considerations:
- Who is audited?
- What is the audit frequency?
- What are the parameters of the audit?
- Who will perform the audits?
- What is the desired outcome of the audit?
- What are the plans for audit results?
- How are results communicated?
- How is education delivered?

Audit Cadence

Obtain Records

Audit

Communicate Audit Results

Provide Education to Physicians

Repeat

Obtain billing reports
- Follow up on records requests
- Training of staff
  - EMR training
  - Complete document package
Audit the Records

- In-house or out-source?
  - In-House
    - Own the process
    - Staff readily available
  - Outsource
    - Objectivity
    - Don’t have to employ, train, or maintain staff

- Quality checks
- What are the coding issues?
- Audit report specifications
- Timely and personal communication
- Process knowledge

Define the Scope of the CPT Audit

Work with your vendor or internal audit team to develop a clear scope, objective, and scoring methodology for the audit prior to kickoff.

- Target score of 90%
- Score based upon level of service or professional services
- Reduce the variability within audits

Scoring: Over-coding by 2 or more levels and use of the wrong code category pose considerable risk for the organization. Therefore these errors received full weight in the audit scoring methodology. Under-coding at all, or over-coding by 1 level, received half weight.

Communicate the Results

- **Utilize peer to peer communication:**
  - Key leaders commit to communicating priorities to their constituents
- **A physician’s perspective:**
  - Not all of the physicians read their work email on a daily basis. Their first priority is seeing patients, and your message (via work email) can quickly fall to the bottom of their to do list.
- **Include practice managers/directors:**
  - Leverage the staff you have at the practice site and make sure they are included on all audit communication. These team members are the physician’s right hand man on a day to day basis. Alert staff to the time-sensitive nature of the results, and the need for scheduling education in the case of scores less than 80%.
- **Provide a high-level summary cover letter:**
  - Include a succinct, audit summary report that identifies the key metrics the physician is being measured on, past performance to date, and what the ultimate desired outcome should be.
Deliver of Education

One thing we know is that physicians are competitive. They want to score well on tests, and are used to being good students. Part of their frustration is that they’ve never heard the rules of engagement. Once they know the rules, they will excel, and will work to improve their scores.

Onboarding Education
- Occurs during the first month of employment.
- Tailored to specialty
- Food, fun, and specified information to their specialty

Monthly Sessions
- Evening session in various locations across our 16-county coverage area
- 1 hour of CME
- Occasionally video taped available online

One on One Education
- Required of physicians who score less than 80% on their audit
- Personalized to the audited behavior
- Shadowing during clinic

Results in year 1
- Physicians are asking more questions and disputing audit results with increasing frequency
- Our physicians understand the rules, they appreciate the consistency, and they know the consequences of noncompliance.
- Our organization is at less risk for payment recoupment, and more likely to withstand outside audit.

<table>
<thead>
<tr>
<th>Initial Audit</th>
<th>Follow Up Audit</th>
<th>Third Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>96 Audits Completed</td>
<td>96 Audits Completed</td>
<td>4 Audits Completed</td>
</tr>
<tr>
<td>Accuracy: 63%</td>
<td>Accuracy: 88%</td>
<td>Accuracy: 96%</td>
</tr>
</tbody>
</table>

YTD 2014 Results
- Physicians are asking more questions and disputing audit results with increasing frequency
- Our physicians understand the rules, they appreciate the consistency, and they know the consequences of noncompliance.
- Our organization is at less risk for payment recoupment, and more likely to withstand outside audit.

<table>
<thead>
<tr>
<th>TOTAL AUDITS SUBMITTED</th>
<th>#RESULTS RECEIVED</th>
<th>OVERALL ACCURACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>596</td>
<td>91%</td>
</tr>
</tbody>
</table>
It takes teamwork!

Navigating the Steep hills and the Big Rocks

Educating the providers

Why Documentation Matters

- Shift from volume-based to value-based models
- Medicare Advantage
  - Documentation of high acuity patient populations to support shared savings programs-payment multipliers
- Audit liability
  - False claims
  - Recoupment
  - Underpayment
- Audit Benefits
  - Visibility of physician coding practices
  - Promoting a culture of compliance
  - Developing effective communication
  - Illuminating practice liabilities
  - Dispelling myths that can improve performance
Why Documentation Matters

<table>
<thead>
<tr>
<th>Accurate medical record</th>
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<tbody>
<tr>
<td>Patient care, communication with other providers, medico-legal, billing</td>
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<tr>
<td>Billing</td>
</tr>
<tr>
<td>Professional services, DRG, Case Mix Index, SOI/RAM assessment</td>
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<tr>
<td>Continuity of Care</td>
</tr>
<tr>
<td>Patient’s rights, Transitions of care</td>
</tr>
</tbody>
</table>

Think twice before taking the really steep hills...

Functional Quadriplegia

- The inpatient medical record reflects the following clinical findings, risk factors and treatment.

An 89 yo female has been admitted with pneumonia. She is described by the nurses as a “total care patient” due to severe contracture and end stage dementia. The patient requires maximum assistance with all activities of daily living.

Query: Please clarify and document your clinical opinion in the progress notes and discharge summary the definitive and/or presumptive diagnosis, (suspected or probable), related to the above clinical findings. Please include clinical findings supporting your diagnosis.

- Functional Quadriplegia in the setting of severe contracture and end stage dementia requiring total care
- Other, with explanation for clinical findings
- Unable to determine (no explanation for clinical findings)
Cerebral Edema

- The inpatient medical record reflects the following clinical findings, risk factors and treatment:
  A 54 year old has been admitted with syncope. She is described in the progress note as confused, complaining of headache and nausea. The patient has a history of meningioma. The patient is being treated with mannitol, and CT shows vasogenic edema.

Query: Please clarify and document your clinical opinion in the progress notes and discharge summary the definitive and/or presumptive diagnosis (suspected or probable) related to the above clinical findings. Please include clinical findings supporting your diagnosis.
- Cerebral (vasogenic) edema
- Other: with explanation for clinical findings
- Unable to determine (no explanation for clinical findings)

Chest Pain - Inpatient

- Differential Diagnosis of pts admitted to a hospital with acute chest pain and not MI:
  - GERD/esophageal motility disorder/peptic ulcer/gallstones 42%
  - Ischemic Heart Disease 31%
  - Costochondritis/chest wall syndromes 28%
  - Pericarditis 4%

- Link the chest pain to the underlying condition. You can use probable/possible/likely/suspected.
- Example: possible chest pain d/t GERD
- Patient being treated with IV Proton Pump Inhibitor points to probable GERD

Chest Pain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>DRG</th>
<th>RW</th>
</tr>
</thead>
<tbody>
<tr>
<td>786.50</td>
<td>Chest pain, unspecified</td>
<td>313</td>
<td>0.5992</td>
</tr>
<tr>
<td>786.52</td>
<td>Painful respiration</td>
<td>204</td>
<td>0.6780</td>
</tr>
<tr>
<td>511.0</td>
<td>Pleurisy</td>
<td>195</td>
<td>0.6997</td>
</tr>
<tr>
<td>530.81</td>
<td>Esophageal reflux</td>
<td>392</td>
<td>0.7395</td>
</tr>
<tr>
<td>733.6</td>
<td>Costochondritis (Tietze's disease)</td>
<td>206</td>
<td>0.7911</td>
</tr>
</tbody>
</table>
**Chest Pain-Ambulatory**

- **Etiologies**
  - Cardiac
  - Gastroesophageal
  - Pulmonary
  - Musculoskeletal
  - Dermatologic
  - Psychiatric
- **Code signs/symptoms when provider has not established diagnosis**
  - Essential Documentation Modifiers
    - 786.50 Musculoskeletal
    - 786.51 Precordial
    - 786.51 Midsternal
    - 786.51 Substernal
    - 786.52 Painful respiration (includes anterior chest wall pain, pleuritic, pleurodynia)
    - 786.52 Chest wall
    - 786.59 Chest pain (unspecified) (central) includes chest discomfort, pressure, tightness
    - 786.59 Atypical-sudden, sharp, short-lived, may be due to overexertion, spasms, indigestion, anxiety

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**Chest Pain Coding**

- Chest pain due to angina is considered to be integral to the cardiac condition: **Only the angina would be coded.**
- A 63-year-old women presents with non-cardiac chest pain that and severe anxiety: Code non-cardiac chest pain (786.59) and anxiety (300.00).
- A driver involved in a collision presents with chest pain. The patient’s chest is tender on palpation where he hit the steering wheel; however the physician did not document injury. **Code for chest pain, not the injury. Do not assume an injury if it is not indicated specifically.**
- A patient is seen in urgent care for chest pain. The EKG is normal. The final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The primary diagnosis code for the EKG should be chest pain, unspecified (786.50). Although the EKG was normal, a definitive cause for the chest pain was not determined.

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**Sepsis**

Commonly caused by bacterial infections. Link the organism or the underlying cause.
- Other causes i.e., appendicitis, pneumonia, meningitis or UTI
- Examples:
  - Sepsis d/t specific organism (positive blood culture)
  - Sepsis d/t pneumonia/UTI/indwelling catheter/dialysis access
  - Sepsis d/t central line associated blood stream infection (CLABSI)
- Bacteremia is a lab finding **only** without evidence of a systemic inflammatory response.
- Severe sepsis = sepsis with organ dysfunction, poor perfusion, lactic acidosis, low urine output, AMS (Encephalopathy).
- Septic shock = Hypotension from sepsis despite adequate volume resuscitation with perfusion problems, lactic acidosis, low urine output, AMS, may require pressors.
CHF

- Acuity – Acute, Chronic, acute on Chronic
- Specificity – Systolic, Diastolic, Combined
  - States that depress systolic ventricular function and ejection fraction (e.g., coronary artery disease, hypertension, dilated cardiomyopathy, valvular disease, congenital heart disease).
  - States of heart failure with preserved ejection fraction (e.g., restrictive cardiomyopathies, hypertrophic cardiomyopathy, fibrosis, endomyocardial disorders), also termed diastolic failure.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>DRG</th>
<th>RW</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDx</td>
<td>486.0</td>
<td>195</td>
<td>0.6491</td>
</tr>
<tr>
<td>Sec.Dx</td>
<td>428.0</td>
<td>Pneumonia, organism unspecified</td>
<td>194</td>
</tr>
<tr>
<td>PDx</td>
<td>486.3</td>
<td>195</td>
<td>1.4550</td>
</tr>
<tr>
<td>Sec.Dx</td>
<td>428.22</td>
<td>Chronic systolic heart failure (SC)</td>
<td>194</td>
</tr>
<tr>
<td>PDx</td>
<td>486.3</td>
<td>195</td>
<td>1.4550</td>
</tr>
<tr>
<td>Sec.Dx</td>
<td>428.23</td>
<td>Acute on chronic systolic heart failure (MCC)</td>
<td>194</td>
</tr>
</tbody>
</table>

Sycope - Is it always High Risk?

- "Pt presents with complaint of fainting several times in the last 3 weeks. Has felt well otherwise, and presents today for evaluation."
  - New problem, uncertain etiology/prognosis—Moderate risk

- "Pt presents with complaint of fainting this am. Is brought in today by his wife, who relates that the patient was unresponsive for about 4 minutes, and has been shaky since the event, with poor concentration."
  - Abrupt change in neurologic status—High risk

The Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Measurable Problem(s)</th>
<th>Treatment Plan (Ideal, Expected, Minimum)</th>
<th>Management Systems Introduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Low</td>
<td>Treatment with &amp; Discharge (Disc)</td>
<td>1. Controls the symptoms.</td>
</tr>
</tbody>
</table>
**Syncope**

- Syncope is a transient, self-limited loss of consciousness and postural tone due to reduced cerebral blood flow.
- The cause may be apparent only at the time of the event, leaving few, if any, clues when the pt is seen by the physician. First consider serious underlying etiologies; among these are massive internal hemorrhage, myocardial infarction (can be painless), and cardiac arrhythmias.
- In elderly pts, a sudden faint without obvious cause should raise the question of complete heart block or tachyarrhythmia.
- The position of the pt at the time of syncopal episode is important; syncope in the supine position is unlikely to be vasovagal and suggests arrhythmia or seizure.
- Etiology: Syncope is usually due to a neutrally mediated disorder, orthostatic hypotension, or an underlying cardiac condition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>DRG</th>
<th>RW</th>
</tr>
</thead>
<tbody>
<tr>
<td>780.2</td>
<td>Syncope and collapse</td>
<td>512</td>
<td>0.7028</td>
</tr>
<tr>
<td>337.01</td>
<td>Carotid sinus syncope</td>
<td>74</td>
<td>0.8786</td>
</tr>
</tbody>
</table>

**Home Health Certification**

- Face to Face Requirement for certification
  - 90 days prior to certification or within 30 days after certification
- Two required elements for brief narrative supporting home health services
  - Explanation of why patient confined to home
    - Need for supportive devices OR medically contraindicated
    - Must be unable to leave home and leaving requires considerable & taxing effort
  - Explanation of why patient needs skilled services
    - Medically necessary skilled nursing
    - Medically necessary PT, OT, SLP

  "skilled nursing required to assess and manage new COPD regimen."

**Medical Necessity**

“It cannot be stressed enough that the volume of documentation is not the sole indication of the level of service. Documentation that is aimed to meet the guidelines for payment but is excessive for the treatment of the patient on the visit in question will not increase the level assigned to that visit.”

NHIC Corp., Provider Education – Medicare Part B 2/28/08
Medical Necessity

- Not the same as Medical Decision Making
- May be evaluated by same-specialty provider

But, some guidance for auditors may be considered:
- Nature of Presenting Problems
  - Pt presents with new problem that is minor or straightforward (sinus infection, URI, allergies, rash) with Rx medication and no other affected comorbid condition-Low Complexity
  - New problem that is minor or straightforward, which is affecting a comorbid condition with Rx management-Moderate Complexity
  - Pt presents with acute problem and no workup-Low Complexity
  - Head injury with change in neuro status-High Risk
- Chronic Conditions
  - 3 or more stable problems and no work-Low Complexity
  - 3 or more problems with documentation of work done-Moderate Complexity
  - Problem with severe exacerbation-High Risk

Medical Necessity

- Chronic problem treated by other provider
  - Must document how the chronic problem affects what the specialist is actively treating

- High Risk Medications

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Warfarin, heparin, enoxaparin, fondaparinux, rivaroxaban, apixaban, edoxaban</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Aminoglycosides (gentamicin, tobramycin, amikacin), vancomycin, clindamycin, imipenem, piperacillin-tazobactam</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Carbamazepine, phenytoin, phenobarbital, lamotrigine, ethosuximide, topiramate, oxcarbazepine</td>
</tr>
<tr>
<td>Antineoplastic</td>
<td>Vinca alkaloids, paclitaxel, docetaxel, doxorubicin, mitomycin, topotecan, irinotecan, cisplatin, 5-fluorouracil, hydroxyurea</td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>Angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, diuretics, beta-blockers, calcium channel blockers</td>
</tr>
<tr>
<td>Anticholinergics</td>
<td>Pyridostigmine, neostigmine</td>
</tr>
<tr>
<td>Antimicrobials</td>
<td>Antiretroviral agents, protease inhibitors, non-nucleoside reverse transcriptase inhibitors</td>
</tr>
<tr>
<td>Other</td>
<td>Opioids, methadone, transdermal fentanyl, gabapentin, pregabalin</td>
</tr>
</tbody>
</table>

Stroke

- Use of 434 series code only appropriate in first 24 hours
  - Otherwise code the sequelae (late effects), if present
  - Or use the V code, if there are no late effects
Cancer Diagnoses

- Code the active cancer diagnosis
  - As long as there is treatment for the disease
  - Even when there is no treatment for active cancer

- Use the V code for history of cancer
  - When documentation states "h/o"
  - When there is no evidence of disease and no current treatment

Time-based Services

- E&M Service
  - Outpatient-based upon face to face time with patient
  - Inpatient-based upon face to face time and floor/unit time
  - Required documentation:
    "More than 50% of this XX minute encounter was spent counseling regarding the following..."

- Prolonged service
  - Must exceed typical time of the E&M Service by at least 30 minutes
  - May only count face to face time in Outpatient POS
  - Count face to face and floor unit time in Inpatient POS
  - Documentation:
    "A total of XX minutes (XX minutes + typical time for E&M) was spent discussing the following..."

  Risk in this method of documentation around number of hours spent in patient care.

Critical Care

CPT Codes 99291 – 99292

- 99291 = Critical Care Services for first 30-74 minutes.
- 99292 = Critical Care Services for each additional 30 minutes. Example – Total Critical care time = 110 minutes
  Use code 99291 + 99292

Determining Criteria

- Medical Condition
- Time

This type of care REQUIRES PHYSICIAN ATTENDANCE! The patient must be of critical status, not just in the critical care unit.
Definition of Critical Care

A critical illness or injury acutely impairs one or more vital organ systems such that a patient's survival is jeopardized.

CMS NOTES: The term “unstable” is no longer used.

Include but are not limited to the treatment, prevention or further deterioration of:
- CNS Failure
- Circulatory Failure
- Shock Like conditions
- Renal, Hepatic, metabolic or respiratory failure
- Post-op complications
- Overwhelming infection

Critical Care-Time

Requirement for “Constant attention” eliminated.
- Time is cumulative:
- Report total duration spent by physician – Even if not continuous.
- Time must have been spent directly engaged in work directly related to the individual patient's care, whether at the bedside or elsewhere on the floor or unit.
- Time spent must be documented in the record!

Summary

Be Prepared
- Do your homework
Choose the line
- Process-oriented approach
Navigate the rocks and hills
- Educate/train
Enjoy the ride!
<table>
<thead>
<tr>
<th><strong>Thank you!</strong></th>
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<tbody>
<tr>
<td>Lynn M. Myers MD, CPC, CHC</td>
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<tr>
<td>AHIMA Certified ICD-10 Trainer</td>
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<td>Medical Director – Quality, Coding &amp; Education</td>
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<td><a href="mailto:LynnMyers@texashealth.org">LynnMyers@texashealth.org</a></td>
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