Preparing for ICD-10 Compliance While Living in ICD-9

A Challenge to Overcome

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Objectives

• Demonstrate how Compliance Officers can champion physician documentation and coding
• Identify methods to improve ICD-9 documentation that will reduce transition chaos into ICD-10
• Increase awareness of the ICD-10 compliance impact
Focus of Compliance

• Model Hospital Compliance Program
  – Regular (annual or quarterly) coding audit

• Coding accuracy
  – 95% benchmark standard
  – Ongoing coding education

• Development and Implementation of daily coding review
  – Insure accurate assignment of principal diagnosis
  – Insure capture of all clinically relevant CCs/MCCs
Changing Landscape

Document- tation

Coding

Medical Necessity
Form vs. Function

• Coding
  – “Gold sheet coding” vs. “Clinical Coding”

• Going beyond strict coding accuracy

• Increased skills sets and core competencies of coding professionals
  – Clinical knowledge
  – Awareness and familiarity of medical necessity
Speaking of Medical Necessity

• Title XVIII Social Security Act 1862 (a)(1)(a), 42 CFR
  – No payment can be made for services under Part A or Part B that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.
Medical Necessity

• Health care services that a physician, who is exercising prudent clinical judgment, performs for the purposes of evaluating, diagnosing, treating, and/or preventing an illness, injury, or symptoms.

• These services should be clinically appropriate, provided in accordance with generally accepted healthcare standards, and not primarily for the convenience of the physician or the patient.
Physician Perspective

- **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.
Establishment of Medical Necessity

• For a service to be considered medically necessary, it must be all of the following:
  – Appropriate in duration and frequency
  – Suitable for the patient’s medical needs
  – Provided in accordance with accepted standards of medical practices
  – Neither experimental or investigational
  – Performed by qualified personnel in appropriate settings
New Age of Coding

Medical Necessity
Reality

- Code assignment
- Supporting elements of the case
  - Patient presentation
  - Signs and Symptoms
  - Provisional diagnoses
  - Progress notes
  - Consultant’s notes
  - Nurse’s and other ancillary documentation
  - Discharge summary
Code Assignment

• ICD-9 code assignment
  – Does clinicals of the case lend **creditability**
  – Signs and Symptoms
  – Diagnosis Rabbit out of Hat
  – Diagnoses documentation continuity
  – “Realistic Conclusion” vs. Conclusory Statement”
Scope of Work-
Recovery Auditors

• Unless prohibited by Section 2B, the Recovery Auditor may attempt to identify improper payments that result from any of the following:
  – Incorrect payment amounts
  – (Exception: in cases where CMS issues instructions directing contractors to not pursue certain incorrect payments made)
  – Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act),
  – Incorrectly coded services (including DRG miscoding)
DRG Validation

• DRG Validation is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim.

• This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in Coding Clinic.
Clinical Validation

• Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented.

• Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.
Case Study

• An 81-year-old female was admitted with complaints of dry cough for a couple of weeks. The patient was admitted through the emergency department and was assessed for wheezing and coughing.

• H&P impression is acute respiratory failure secondary to exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Progress notes through the stay also document the diagnosis of acute respiratory failure secondary to exacerbation of COPD.

• Final diagnosis on the discharge summary is acute respiratory failure secondary to COPD exacerbation
Case Study

• **Auditor finding:** After physician and auditor review, it was determined that the clinical evidence in the medical record did not support respiratory failure, despite physician documentation of the condition.
Case Study

• **Action:** The auditor deleted acute respiratory failure and changed the principal diagnosis to COPD Exacerbation. The auditor deleted respiratory failure code 518.81 and changed the principal diagnosis to hypoxemia code 799.02. This resulted in a MS-DRG change from 189 to 192–Chronic Obstructive Pulmonary Disease without CC/MCC. This change resulted in an overpayment.
DRG Code Assignment

• DRG 189-Pulmonary Edema & Respiratory Failure
  • Relative weight=1.2461
  • GMLOS=4.1 days
  • Average reimbursement- $7,175.01

• DRG 192- Chronic Obstructive Pulmonary Disease w/o CC/MCC
  • Relative weight= .7072
  • GMLOS=2.9 days
  • Average Reimbursement- $4,072.04
## Respiratory Failure

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>518.81- Acute respiratory failure</td>
<td>J96.00- Acute respiratory failure, unspecified whether with hypoxia or hypercapnia</td>
</tr>
<tr>
<td>518.82- Other pulmonary insufficiency, NEC</td>
<td>J96.01- Acute respiratory failure with hypoxia</td>
</tr>
<tr>
<td>518.83- Chronic respiratory failure</td>
<td>J96.02- Acute respiratory failure with hypercapnia</td>
</tr>
<tr>
<td>518.84- Acute -on -chronic respiratory failure</td>
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ICD-10 Respiratory Failure

- J96.10- Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- J96.11- Chronic respiratory failure with hypoxia
- J96.12- Chronic respiratory failure with hypercapnia
- J96.20- Acute-on-chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- J96.21- Acute-on-chronic respiratory failure with hypoxia
- J96.22- Acute-on-chronic respiratory failure with hypercapnia
ICD-10 Respiratory Failure

• J96.90- Respiratory failure, unspecified whether with hypoxia or hypercapnia
• J96.91- Respiratory failure unspecified with hypoxia
• J96.92- Chronic respiratory failure unspecified with hypercapnia
Clinical Accuracy

• Coder clinical knowledge of respiratory failure
  – Acute vs. chronic
  – Hypercapnea vs. hypoxic

• Case Management and Utilization Review/Utilization Management
  – Insure the physician conclusory statements are corroborated by Severity of Illness/Intensity of Service and supported by nursing interventions and explicit documentation
Complement & Supplement

• **Question**: Regarding medical necessity, is nursing documentation that isn't reflected in the physician's documentation sufficient to satisfy criteria that establishes inpatient status, or is physician documentation along with diagnostics the only elements taken into account?

• **Answer**: The entire medical record is reviewed and taken into account. The medical review analyst considers any pre-existing medical problems or extenuating circumstances that would make the admission/treatment medically necessary or reasonable.
Multi-Disciplinary Approach

• Multi-Disciplinary approach to documentation
  – “Effective documentation consists of Ancillary service providers include objective documentation of patient outcomes, assessments, and interventions in support of accurate reporting of patient acuity, physician clinical judgment, orders and medical decision-making complementing physician diagnostic conclusory statements”
Compliance

• Clinical documentation Inclusive of:
  – Patient presentation-Chief Complaint, Signs and Symptoms
  – Clinical Context
  – Physician clinical judgment, thought processes, analytical and problem solving skills, and medical decision-making
Content Generation

• “Good Practice Documentation”- Defined as exemplary documentation that clearly identifies the treatment rendered throughout the hospital stay, allowing for an accurate account of the patient health status
Content Generation

• “Good Practice” habits – Proper documentation ensuring that each medical record shows that a beneficiary is receiving reasonable and necessary services covered by Medicare by providing detailed documentation including:
  – Severity of signs and symptoms
  – Predictability of something adverse happening
Good Practice

• Need for and availability of diagnostic studies to assist in assessing whether the patient should be admitted
• Utilization of Milliman and InterQual guidelines
• Concern for possible complications documented clearly
Collaborative Approach

• Working collaboratively to demonstrate the following “good practice”:
  – A clearly documented Plan of Care and treatment prior to and throughout admission/observation
  – Documentation that includes patient awareness of treatment/plan of care
  – Intensities of services needed clearly documented
  – Continuity of care between all services/providers
Collaboration Matters

• Documented decisions made throughout the inpatient admission or observation stay including:
  – **Who** was involved in the decision making
  – **What** the plan was during admission
  – **Where** the patient was admitted
  – **When** the patient may be discharged
  – **Why** the patient is being admitted as inpatient or observation
The Main Question

• **Why** is the patient being admitted as inpatient or observation?
  • Fundamental basis for medical necessity
  • Screening criteria vs. clinical judgment, thought process and medical decision-making
  • What is the physician really thinking?
  • Explicit documentation of thought processes

– If documentation does not support registered patient status, accuracy of ICD-10 code and DRG assignment is immaterial
Clinical Scenario

• Patient presents to Emergency Room after experiencing unwitnessed episode of syncope. Previous history of deep vein thrombosis with known history of atrial fibrillation managed with Coumadin. Patient recently diagnosed with lung cancer with 100 pack year history of smoking culminating in carrying diagnosis of chronic obstructive pulmonary disease.
Provisional Diagnosis

• Embolism
  – A clot or other plug brought by the blood from another vessel and forced into a smaller one, thus obstructing the circulation
  – Sudden blocking of an artery by a clot or foreign material which has been brought to its site of lodgment by the blood current

• Pulmonary embolism- the closure of the pulmonary artery or one of its branches by an embolus, sometimes associated with infarction of the lung
Essentials of Diagnosis

• Predisposition to venous thrombosis, usually of the lower extremities
• Abrupt onset of dyspnea, chest pain, apprehension, hemoptysis, or syncope
• Acute respiratory alkalosis and hypoxemia in most patients
• Characteristic defects on ventilation/perfusion lung scan
• Diagnostic findings on pulmonary angiogram
Clinical Characteristics

**Symptoms**
- **Chest pain**
  - Pleuritic/Nonpleuritic
  - Dyspnea
  - Apprehension
  - Cough
  - Hemothysis
  - Sweats
  - Syncope

**Signs**
- Respiratory rate >16/minute
- Crackles
- Accentuated S2P
- Pulse >100/min
- Temperature >37.8 C
- Phlebitis
- Gallop
- Diaphoresis
- Edema
- Murmur
- Cyanosis
Code Assignment
Pulmonary Embolism

ICD-9

• 415.12- Septic pulmonary embolism
  – Code first underlying condition such as sepsis
• 415.13- Saddle embolus of pulmonary artery
• 415.19- Pulmonary embolism
• 416.2- Chronic pulmonary embolism

ICD-10

• I26.01- Septic pulmonary embolism with acute cor pulmonale
  – Code first underlying condition
• I26.02- Saddle embolus of pulmonary artery with acute cor pulmonale
• I26.99- Other pulmonary embolism with acute cor pulmonale
ICD-10 Pulmonary Embolism

- I26.90- Septic pulmonary embolism without acute cor pulmonale
  - Code first underlying condition
- I26.92- Saddle embolus of pulmonary artery without acute cor pulmonale
- I26.99- Other pulmonary embolism without acute cor pulmonale
- I27.82- Chronic pulmonary embolism
Engaging Physicians

- Engaging physicians in documentation specificity
  - Medical Necessity for E & M assignment
  - Number of diagnoses and management options
  - Impact upon physician medical decision-making
    - Complexity of the case
    - Physician work performed, cognitive/analytical/problem solving skills
Medical Necessity

• All Medicare services including E & M services must meet 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.
Medical Necessity- "The Reality"

• Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).

• Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.

• Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.

• At audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient’s documented needs.
Medical Necessity-Physician Responsibility

• 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).
Medical Complexity

Diagnoses Specificity

Complexity

Medical Decision Making
Medical Decision Making

• Medical decision making (MDM) is considered the thought process of the physician.

• **MDM 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.
ICD-10 Specificity

• Intended to promote specificity in diagnoses reporting
• Motivating physicians to improve documentation today for the future
• Increased specificity ↔ Increased complexity
• Complexity directly impacts E & M assignment
Getting Started
Roadmap Development

• Identify top 10 MS-DRGs by service line
  – Drill down within each DRG
  – Determine code specificity
  – Develop clinical documentation education and training based upon code specificity

• Engage and collaborate with Clinical Documentation Improvement Specialists
Other Considerations

• ICD-10
  – CDIS “Train the Trainer”
  – Content expert
  – De Facto Leader
• Incorporate clinical specificity into daily chart review
• Include case management & utilization review in training process
  – Two pronged approach
• Clinical documentation trails evolution of clinical medicine
  – Bridging the gap
Timeline

• Evolution of timeline
  – Non-traditional
  – “Catch-Up”
• Development
• Implementation
• Adherence and enforcement
Timeline

- Start today
- Engage physician section chiefs/medical directors
- Highlight current benefits to physician’s business of the practice of medicine
- ICD-10 inevitable

Compliance Planning today = Viability & Success today, tomorrow and beyond
Questions?
Contact Information

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