OUTPATIENT DOCUMENTATION IMPROVEMENT

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Disclaimer

This presentation is for general education purposes only.

The information contained in these materials is not intended to be, and is not legal or business advice.

The regulations and guidance for claims submission and plan coverage vary by payer and state, and the methodology described may or may not be pertinent in all circumstances.
What is (Clinical) Documentation Improvement?

The Process of facilitating an accurate representation of a patient’s clinical status that is able to be translated into coded data.

Why is this important?

To provide information necessary for quality reporting, physician report cards, reimbursement, public health data, and disease tracking and trending.

By permission, Baker, Newman, Noyes; Portland, ME
How do we use OP Documentation Improvement?

• Better data
• Concurrent care review
• Denial reduction
Better Data

• Population Health
• Strategic Planning
• Supports use of resources
• Risk Adjustment
Risk Adjustment

• Who are our patients and where should we focus our resources?
• Getting the data to people who need to know?
• OIG work plan
Concurrent Care

- Review prior to discharge/coding
- Medical necessity?
- Medical Records completion
- Fewer queries
Other benefits of OP Documentation Improvement Analysis

• Improved processes
• OP departments have a better understanding of the financial implications
• May Impact APCs (OP surgery, OP clinics, ED services and OP testing)
• Better patient satisfaction
Wait….we don’t have a problem….

- Significant write-offs
- Denials
- Patient complaints
- OP departments not meeting financial goals
- Increased pre-payment probes
The Process:

1. Identify Trends
2. Identify the root cause
3. Research guidance
4. Evaluate possible solutions
5. Create and communicate plan
Identifying Denial Trends

• Tracking the denial type
  • “this payment is adjusted based on the diagnosis”
  • “Coverage/program guidelines were not met or were exceeded”
  • “Procedure or treatment has not been deemed ‘proven to be effective’ by the payer”
  • “Precertification/authorization/notification absent”
  • “This service/equipment/drug is not covered under the patient’s current benefit plan”
• These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”
Identifying Denial Trends

• # of denials as a percentage of # of charges

CPT 93306 (Transthoracic Echo)
Billed 193 cases. 102 were denied (~53% denial rate) based on volume.
Identifying Denial Trends

• Dollar amount of denials as a percentage of dollar amount of charges

$157,000 in denials; $235,000 in charges (for same CPT). 67% denial rate.
Identifying (Denial) Trends

• “Big Ticket” Items
  • Chemotherapy drugs
  • Imaging
  • Surgical services
  • Recurrent services (wound, pain)
Identifying Denial Trends

• Specific Trends:
  • CPT Codes
  • Payers
  • Diagnosis Codes
  • Rendering providers
The Process:

1. **Identify Trends**
2. **Identify the root cause**
3. **Research guidance**
4. **Evaluate possible solutions**
5. **Create and communicate plan**
Identifying the Root Cause

• CPT Codes
  • Wrong code?
  • Wrong code authorized?
  • LCD or NCD not met?

Be wary of scope creep!
Identifying the Root Cause

• Chargemaster issues
• Wrong code selected
• Codes sets are bundled
Identifying the Root Cause: Coding Errors

• HIM-assigned codes only
• Know your resources
  • CPT Assistant
  • AHA Coding Clinic
  • Professional Associations
  • AAPC (specialty certifications)
Identifying the Root Cause: Payer Guidelines

- Categorically denied vs. Medical necessity
Payer Guidelines vs. AHA Coding Clinic

AHA Coding Clinic 1Q2014
What happens when payers don’t follow Coding Clinic advice or the Official Guidelines for Coding and Reporting?

Traditionally Coding Clinic does not address coding for reimbursement. Coding Clinic’s goal is to provide advice according to the most accurate and correct coding consistent with ICD-10-CM and ICD-10-PCS principles. The official guidelines are part of the HIPAA code set standards. There are a variety of payment policies that may impact coding. Some payment policies may contradict each other or may be inconsistent with coding rules/conventions. Therefore, it is not possible to write coding guidelines that are consistent with all existing payer guidelines.

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Identifying the Root Cause: Medical Necessity -- How do you show that?

- Documentation
  - EHR Templates
  - Dictation
- Orders
Identifying the Root Cause: Templates

- System Defaults
- System limitations
- Software change
Identifying the Root Cause: Dictation

- Provider education
- Templates
- Pull-forward (CAUTION!!)
Ankylosing Spondylitis - Documentation

Routine Follow up Visit:
HPI
- Specify reduction in signs and symptoms by describing improvement in physical function from last visit.
- If no improvement/reductions specify contributing factors. (*Assessment should convey thought process to support rationale for continued treatment or change in treatment).

Physical Exam:
- Support severity by describing joint function/limitations and physical appearance.

Assessment:
- Specify status such as severity as well as improving/stable, worsening, need for continuation of Remicade, dosage/changes. *see HPI
Orders

• Many OP diagnostics are coded from the order only—and sometimes with CAC
• Orders provided by physicians with little motivation to code for payment
• Consider disease-specific orders for high-denial conditions
## Granix Order

Start Date________________
End Date____________________

**Indication:**

- [ ] NEUTROPENIA, UNSPECIFIED
- [ ] DRUG INDUCED NEUTROPENIA
- [ ] NEUTROPENIA DUE TO INFECTION
- [ ] OTHER NEUTROPENIA
- [ ] OTHER SPECIFIED PROPHYLACTIC OR TREATMENT MEASURE
- [ ] UNSPECIFIED PERSONAL HISTORY PRESENTING HAZARDS TO HEALTH
- [ ] ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
- [ ] CONVALESCENCE FOLLOWING CHEMOTHERAPY
- [ ] Other__________________________________________
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Resources

- Depends on the issue
  - AHA Coding Clinic
  - AHIMA/AAPC
  - CPT Assistant
  - NCD
  - LCD
  - Commercial Payer Guidelines
  - Published Clinical Studies
RN Denials Review

Clinical review of entire patient chart/episodes of care
Review of payer policy
Collaboration with coders to understand code assignment
Determination of medical necessity
Can query the provider for clarification
Peer-to-peer discussion of patient care
The Process:

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The Process:

Identify Trends

Identify the root cause

Research guidance

Evaluate possible solutions

Create and communicate plan
Aranesp®

• Trend: noted an increase in medical necessity denials for HCPCS J0881 darbepoetin alfa (Aranesp®)

• Root Causes:
  • Diagnosis D50.9 (Iron deficiency anemia, unspecified) being reported as an additional diagnosis
  • Incorrect modifier on claim
  • Lack of medical necessity.
Aranesp®

Research

• LCD indicates that Iron deficiency anemia must be corrected prior to administration.
• EA, EB or EC modifiers are required.
• Correct Coding indicates that conditions reported as ‘history of’ with current treatment indicate current condition

Solution

• Provide clinician education regarding clinical documentation requirements for Aranesp administration by condition.
• Provide instruction to coding staff for reporting current conditions and for issuing queries for clarification
• Set up claim edit on J1885 to assign correct modifier.
• Communicate Plan:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Documentation Required to support medical necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia related to AVM (arteriovenous malformation)</td>
<td>Location – ex; Brain, Cerebral, GI Specify Acquired vs. Congenital</td>
</tr>
<tr>
<td>Anemia due to chronic condition resulting/concerning for chronic blood loss</td>
<td>Specify chronic condition if known ex: ulcerative colitis</td>
</tr>
<tr>
<td>Multi-factorial Anemia</td>
<td>Specify all conditions contributing known.</td>
</tr>
<tr>
<td>Anemia related to chronic GI bleed</td>
<td>Specify hemorrhage, hematemesis, Melena, or other specified type</td>
</tr>
<tr>
<td>History of iron deficiency anemia</td>
<td>Specify if corrected.</td>
</tr>
<tr>
<td>Anemia due to CKD</td>
<td>Specify stage 3, 4, 5 or end stage on dialysis</td>
</tr>
</tbody>
</table>
Wait….we don’t have a problem…. 

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• Denials
• Patient complaints
• OP departments not meeting financial goals
• Increased pre-payment probes
• Population health data
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Top 10 Chronic Conditions

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Vascular disease
- Cancer
- Ischemic heart disease
- Specified heart arrhythmia
- Diabetes
- Ischemic or unspecified stroke
- Angina
- Rheumatoid arthritis
- Inflammatory connective tissue disease
<table>
<thead>
<tr>
<th>Patient #</th>
<th>DOB</th>
<th>Age</th>
<th># Visits</th>
<th>Primary Provider</th>
<th>Secondary Provider</th>
<th>Reported v22 model category</th>
<th>Audited v22 model category</th>
<th>Age Relative Factor</th>
<th>Relative Factor Reported</th>
<th>Relative Factor Audited</th>
<th>Raw Risk Score Audited</th>
<th>Raw Risk Score Reported</th>
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<td>1</td>
<td>06/15/1951</td>
<td>65</td>
<td>4</td>
<td>Affleck</td>
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<td>111</td>
<td>23</td>
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<td>8</td>
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<td>Hilton</td>
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<td>48</td>
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<td>0.323</td>
<td>1.017</td>
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</tr>
</tbody>
</table>
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Remicade® Infusions

• Trend
  • Increase in pre-payment probes for HCPCS J1745 (infliximab) with the administration code 96415, totaling $157,169.40.

• Root Cause
  • Claims were part of a targeted review by CMS, resulting in a later denial due to lack of supporting medically necessary documentation.
Remicade® Infusions

• Research
  • Per LCD, patient chart must document ‘inadequate response to conventional treatment’, or ‘severity of condition’.

• Solution
  • Need to provide clinician education to improve documentation and workflow to secure medical necessity.
Remicade® Infusions

• Communicate Plan
  • New order (to include instructions)
  • Infusion data sheet
• Shared documents to support LCD requirements (office H&P and diagnostic reports that confirm covered diagnosis) that can be coded for the facility encounter
Metrics (how are we doing?)

Reduction in % of denials ($\text{denials}/\text{charges}$)
Elimination of denials by CPT
Elimination of payer-specific issues
Decrease in CPT-specific appeals

Increase in HCC raw score

Better data for population health

Reduction of payment probes (in a fantasy world!)
Lessons Learned

• This is a BIG job
• Communicate issues/solutions only to those who can effect change
• Know where your responsibility ends
• Consider your organization's values
The ideal OP Documentation Improvement Specialist:

- Experience with revenue cycle
- Certified Coder, with OP CPT knowledge and solid ICD-10-CM skills
- Knowledge of data analytics
- Excellent research skills
- Understanding of clinical concepts
- Written and verbal communication skills
- Ability to present to clinicians
Resources

• American Hospital Association, Chicago, IL.
  To submit a question to the American Hospital Association’s Coding Clinic, or to obtain Coding Clinic subscriptions, please go to:  http://www.codingclinicadvisor.com

• Baker, Newman, Noyes. Portland, ME

• Center for Medicare and Medicaid Services  www.cms.org

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• National Government Services.  www.ngs.com

• Wendy Rowe, COC, CPMA, CPC