ALABAMA HIMA: Outpatient Clinical Documentation Integrity

April 14, 2016
Disclaimer

• This material is designed and provided to communicate information about inpatient coding, clinical documentation, and/or compliance in an educational format and manner

• The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding

• Every reasonable effort has been taken to ensure the educational information provided is useful and accurate

• Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation
Topics for Discussion

• Objectives of Clinical Documentation Program
• Differences - Inpatient (IP) vs. Outpatient (OP)
• Benefits of OP Clinical Documentation Program
• Medical Necessity
• National and Local Coverage Determination (NCD and LCD)
• Supplemental Medical Review Contractors (SMRCs)
• Charge Description Master (CDM)
• Examples of Services for Outpatient CDP
• Getting Started
Objectives of a OP Clinical Documentation Program (CDP)

• Integrity of clinical documentation
  – Clearly and accurately reflect the condition of the patient and services rendered
  – Support medical necessity
  – Comply with audits and regulatory requirements
    • RAC
    • TJC
    • OIG
    • Quality Initiatives
  – Tell the full story for continuity of care
  – Accurate reimbursement
# Differences - Inpatient vs. Outpatient

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume decreasing</td>
<td>Volume increasing</td>
</tr>
<tr>
<td>Physician’s/Provider’s documentation</td>
<td>Non-physicians documentation</td>
</tr>
<tr>
<td>ICD-10-CM/PCS</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>Differential diagnoses</td>
<td>Confirmed diagnoses</td>
</tr>
<tr>
<td>Principal diagnosis</td>
<td>First listed diagnosis</td>
</tr>
<tr>
<td>CMS 5010 / UB04</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Less change</td>
<td>Constant change</td>
</tr>
<tr>
<td>Focus on clinical</td>
<td>Focus on business and clinical</td>
</tr>
</tbody>
</table>
Benefits of OP CDP

• Supports high-quality care
• Captures accurate documentation for IDC-10-CM diagnoses
• Ensures medical necessity is met
• Reduces denials/rejections
• Safeguards appropriate reimbursement
Medical Necessity

Title XVIII of the Social Security Act §1862 (a) (1) (A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Considerations for Medical Necessity

• The patient
• The setting
National Coverage Determination

**National Coverage Determination (NCD):** Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). The NCDs are developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision.
Local Coverage Determination

- **Local Coverage Determinations (LCD):** In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare Contractors based on a local coverage determination (LCD).
- Section 522 of the Benefits Improvement and Protection Act (BIPA) defines an LCD as a decision by a FI or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (e.g., a determination as to whether the service or item is reasonable and necessary).
SMRCs

• Supplemental Medical Review Contractors
  – Determines if Medicare claims were billed in compliance with coverage, coding, payment, and billing practices
  – Topics determined at the direction of CMS
  – Begins with ADR (Additional documentation request) for post payment medical review
  – ADR details the basis for the audit and have gone back four years
SMRCs

• Supplemental Medical Review Contractors
  – Providers must provide the SMRC with requested records within 45 days
    • Providers are not reimbursed for any costs associated with these records
    • If Providers cannot locate or does not send documentation, the SMRC may collect the funds
  – SMRC ≠ RACs
    • Paid at a flat fee – not contingency fee basis
SMRCs

• Supplemental Medical Review Contractors
  – Area of focus
    • Power mobility devices
    • Skilled Nursing Facilities
    • Diabetic testing strips
    • Polysomnography
SMRC Case Study

• Polysomnography
  – Medicare inappropriately paid $16.8 million

<table>
<thead>
<tr>
<th>Reason Claim Did Not Meet Medicare Requirements</th>
<th>Number of Claims</th>
<th>Percentage of All Claims</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate diagnosis code</td>
<td>20,110</td>
<td>3.21%</td>
<td>$16,050,155</td>
</tr>
<tr>
<td>Same-day duplicate claim</td>
<td>1,178</td>
<td>0.19%</td>
<td>$669,540</td>
</tr>
<tr>
<td>Invalid NPI</td>
<td>109</td>
<td>0.02%</td>
<td>$86,594</td>
</tr>
<tr>
<td>Overlap</td>
<td>(49)</td>
<td>(0.01%)</td>
<td>($28,846)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>21,348</strong></td>
<td><strong>3.41%</strong></td>
<td><strong>$16,777,443</strong></td>
</tr>
</tbody>
</table>
Charge Description Master (CDM)

- Per an article in the *Journal of AHIMA* (2010), “…the CDM usually drives more than 70% of an organization’s revenue cycle dollars”
- An inaccurate CDM file can impact the organization in the following ways
  - Revenue management
    - Over payment/over charging
    - Under payment/under charging
    - Claim rejections
      - Out of date CPT and HCPCs codes
    - Fines and Penalties
      - Noncompliance with NCCI and Outpatient Code Editor (OCE) edits
Emergency Department

- Inaccurate problem list
- Documentation gaps between ED and admission
- Lack of appropriate documentation in ED for
  - Observation hours
  - Infusion/injections
- POA inaccuracy beginning in ED
- Lack of medical necessity – clinical validation
- Lack of understanding of facility leveling:
  - Poor encounter form design
  - Professional leveling – CPT based
  - Technical leveling – Resource based
  - Poor documentation of nurse specific procedures
Rehabilitation Therapy

- Medical Necessity
- Physician Signatures
- Functional Progress
- Time based code vs. service based code
- NCCI noncompliance
- LCD excluded therapy codes
- Recertification
- Using the wrong ICD-10 code
- Exceeding the OP therapy cap limits
  - 2016 = $1,960 for PT and SLP combined
  - 2016 = $1,960 for OT
Infusions/Injections

• Reporting the following services separately when facilitating the infusion/injection
  – Local anesthesia
    • IV starts (e.g., access to subcutaneous indwelling port/catheter, tubing, syringes)
    • Flush at conclusion of infusion

• Reporting more than one “initial” service (not first in time)

• Reporting incorrect medications and inaccurate of J code but even more important the units

• Lack of understanding of hierarchy (e.g., chemotherapeutic, therapeutic, and hydration)
Infusions/Injections

- Lack of understanding of sequential and concurrent
- Lack of understanding of route of administration (e.g., IV, IVP, and SQ/IM)
- Lack of understanding of documentation
  - Access (e.g., anatomic site, including laterality)
  - Duration of administration - time
    - Start time
    - Stop time
  - Episode of services
    - Initial
    - Additional
    - Subsequent
    - Concurrent
Getting Started

• Identify the Outpatient Service Lines
• Analyze the Data
• Identify Goals and Objectives
• Develop and Implement a Strategic Plan
• Review and Assess
Outpatient Service Lines

• Diagnostics
  – Laboratory
  – Radiology
  – Cardiology
• Hospital Owned Practices
• Clinics
  – Wound Care
  – Pain Management
• Ambulatory Surgery
• Observation
Analyze the Data

• Track denials
  – Pre authorization
  – Lack of adequate provider documentation
  – Medical Necessity
  – Duplicate claims
  – Non compliance with – LCDs and NCDs
  – Coding errors

• Trend findings
  – High dollar
  – High volume
  – Specific provider or practice
  – Specific coder

• Review outcomes from quality initiatives
Identify Goals and Objectives

• Example
  – Reduce denials
  – Accurate reimbursement
  – Accurate quality reporting
  – Improve patient satisfaction
  – Improve provider satisfaction
Develop a Strategic Plan

• Example
  – Evaluate processes
  – Provide training to patient access staff
  – Provide training to coders
  – Provide documentation training to providers
  – Monitor RAC Website
  – Review HHS OIG Workplan
Implement Changes And Reassess
THANK YOU...QUESTIONS?

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