COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Provider Education Webinars

Course 8:
Optimizing Documentation for
Quality of Care and Reimbursement
(the Microcosm and Macrocosm)

Housekeeping Items

Technical Difficulties

If you experience technical difficulties, please

- utilize the “Chat” feature of the GoToWebinar application to let us know what kind of problem you’re having
- exit the application and try re-establishing your internet and phone connections
- call 1-888-206-2266 and enter Conferee pin number that came with your invitation/registration (if you cannot establish a webinar connection, this number will allow you to follow along with the conference using your handout). If you have to fall back on this method, please email us at the below email address and let us know what kind of problem you’re having.

Webinar Questions

For questions concerning the content of this webinar, CHP has a dedicated email address: Providereducation@chpw.org.

Questions about Specific Coding Scenarios

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at Providereducation@chpw.org.

Questions about Claims

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

Continuing Education Credit

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: Providereducation@chpw.org.

Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 8: Optimizing Documentation for Quality of Care and Reimbursement (the Micro- and Macrocosm)

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

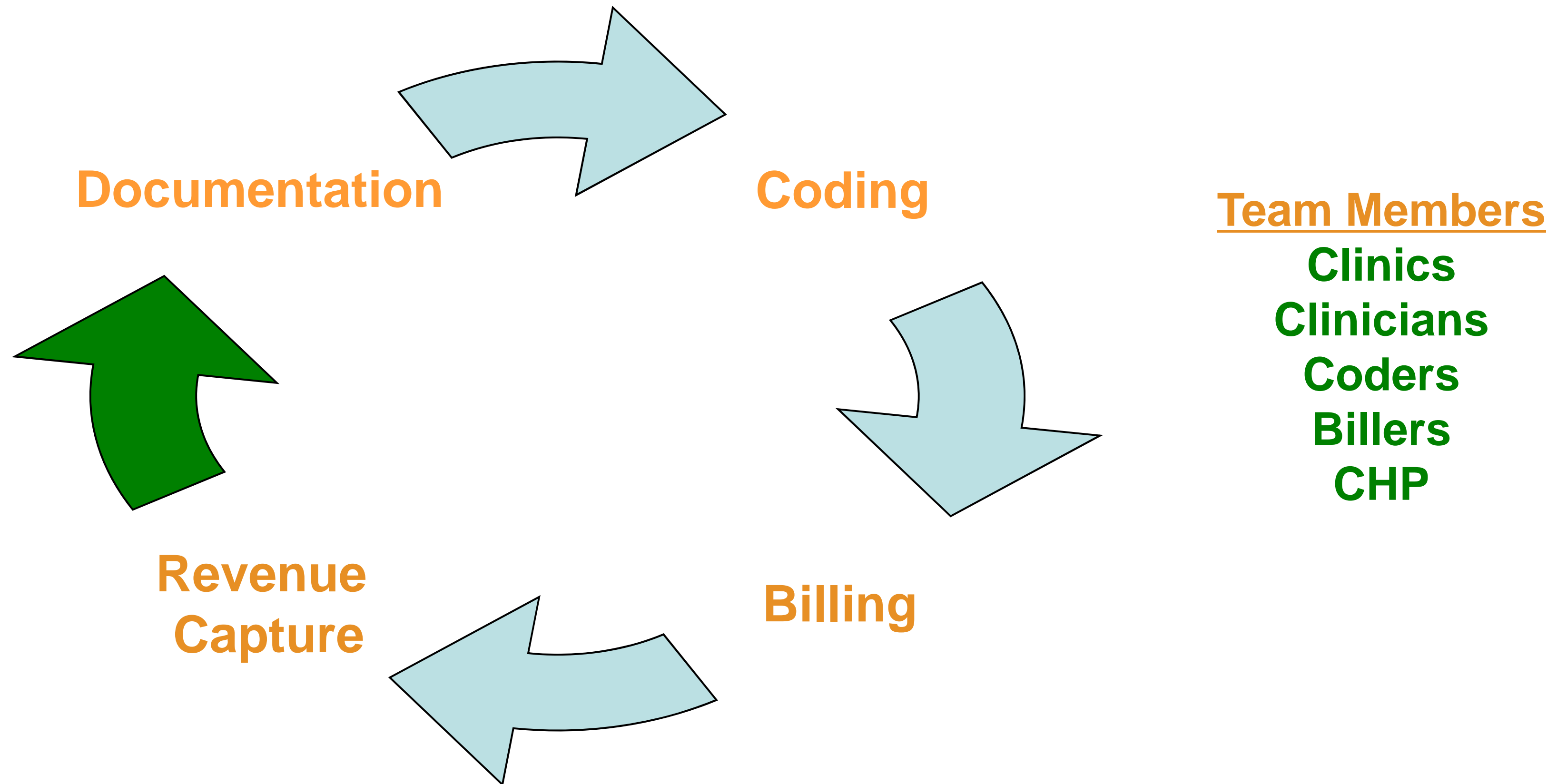
Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians
** American Academy of Professional Coders
*** American Health Information Management Association

A Comprehensive Approach to Optimizing Documentation & Coding



Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

Community Health Plan - Medicare Advantage

Member HCC Report

HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
Address: 1234 Main Street, Anytown, US 98765
Phone: (555) 555-5555

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning _______________ (mm/yyyy).

Printed Name & Credentials | *Signature* | *Date*

Confidential patient information. Not to be filed in chart.

Community Health Plan of Washington Provider Education Webinar

Course 8:
Optimizing Documentation for Quality of Care and Reimbursement (the Microcosm and Macrocosm)

Marvel Gray, CPC, CCS-P, MCS-P, PCS, CCP, CCO, CMPM
Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P
Cost Recovery Analyst

Learning Objectives

Webinar Learning Objective:

The goal of Community Health Plan is that our Providers will apply this career training and best practices information across their care spectrum, regardless of their Patients' ability to pay or insurance type.

Course 8:

Optimizing Documentation for Quality of Care and Reimbursement, AKA the Micro- and Macrocosm of Coding

Learning Objective:

To focus on proper documentation to optimize the quality of care and optimize use of ICD-9, CPT, & HCPCS codes.

Participants' learning objectives for Course 8:

- Understand the purpose of coding in reimbursement and beyond reimbursement
- Learn how proper documentation leads to better patient care and to better reimbursement for that care, benefitting the Patient and Provider
- Recognizing how documentation quality translates to accurate coding and beyond, into integrity of claims data, and how claims data accuracy benefits everyone.

Claims Data Integrity - Some Perspective

How to Assure that the Integrity of Data Derived from Documentation and Coding of Medical Records is Accurate, and Why

Step 1: Document and Code Correctly

Medical record documentation must justify the coding submitted on health insurance claims.

Step 2: Codes on Claims travel an Information Superhighway (the Intranets of the Industry)

Claims data is collected by numerous research and other entities for many purposes.

Step 3: Claims Data is Gathered for Analysis

Many of those entities are responsible for the allocation of billions of disease research dollars,

Step 4: Analysis of Data Leads to Efforts to Cure Disease

Monies are allocated to medical research which works to (and does) cure, prevent, and treat disease.

Therefore,

The accuracy of medical record documentation and claims coding impacts everyone's health, by supplying information to numerous entities, many of which are serving the greater good for humanity.

We all benefit only when the data is accurate.

Common Documentation Inadequacies

The following elements need to be present on the medical record. This prevents compromising continuity and reimbursement problems.

- Illegibility – the record needs to be legible to someone other than the writer
- Missing authentication by the person responsible for the medical record entry (please see below for references).
- Missing Chief Complaint/Reason For Visit
- Omitted date of service
- Patient's name and identifying information not present
- Rule-out, versus, probable, possible, differential, suspected, working, etc. terms relating to the diagnosis (undeveloped as yet diagnosis: awaiting further study): in these instances, code the most specific signs/symptoms, exposure to, personal or family history of diagnosis that applies.

Quality or quantity of actual medical care delivered is not what Coders are looking for or able to capture from medical record documentation. Only the services and diagnoses documented can be reported for reimbursement.

*National Committee for Quality Assurance Guidelines for Medical Record Documentation, WAC 388-502-0020, CMS 2006 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide, and American Medical Association 1995 and 1997 Documentation Guidelines.

A Day In the Life of a Code: Where Does All That Information Go? (In Addition To Insurers)

An Example:

Mrs. Jones presents with a fractured ulna to her Primary Provider. The Provider stabilizes the fracture and refers the Patient to an orthopedic Provider for treatment of the fracture.

Inaccurate coding of the note creates an error: the fracture care CPT code is coded and billed instead of the proper coding for the service done by a Provider who is not assuming all future care of the fracture. The orthopedic Provider charges the fracture care CPT code.

Error on the claim: the incorrect coding on the claim (claims data) goes to the insurer and beyond, to other entities. The insurer may or may not deny the charges for the work the Provider did, but the claims data is inaccurate.

Inaccurate claims data moves beyond the insurer to information clearinghouses and databases that are huge. Public Health and Research policy makers gather that data along with other data to analyze.

Leadership decisions are based on the aggregate of claims data. At least one part of that data (Mrs. Jones' claim data for that visit) is inaccurate.

Whether or not a corrected claim is submitted, information that has gone out into the superhighway to so many entities is not easy to retrieve for correction, and usually isn't corrected at every level that the original information traveled to.

Example - Mr. Jones Has A Skin Lesion

Mr. Jones is seen by his Primary Care Manager (PCM) for excision of a skin lesion on his R arm, which is performed and sent to the path lab. Results will be back in a few days.

The PCM's office needs to get the claim for the services sent in to the payer. Instead of waiting for the results to come in from the lab to use a precise diagnosis code, the excision is coded as a biopsy: 11100 (Biopsy, skin, single) with an unspecified diagnosis: 239.8 (Neoplasm, skin, arm, unspecified). The claim is sent to the payer.

The claim can deny for lack of specificity. If it's denied, that creates reimbursement delays for the Provider's office. Even if it isn't denied, the entities down the line from the PCM's office that are tracking and researching skin lesions will get no information about the nature of the lesion (since is coded as unspecified).

Waiting for diagnostic information to be received, and for the PCM to develop a more specific diagnosis with it pays off by decreasing denials due to lack of specificity, and by supplying specific information down the line to numerous entities that are able to utilize it for medical reasons.

The National Claims Data Warehouse

Required Reporting of Claims Data

For two decades, a national health data warehouse of Medicare fee-for-service claims has been maintained and mined by health services researchers and analysts for national policy development and, more recently, to monitor quality of care. Many other entities now require reporting of claims data, and more reporting is being required as the industry continues to develop health information management strategies.*

* https://www.himss.org/content/files/jhim/18-1/contribution_national.pdf

Example: Very simple, yet accurate E/M Documentation & Coding

Example of a simple visit with simple documentation

CC: DM F/U
No complaints, “I feel good”, getting regular exercise
BP 128/85, P 80, O2 98%, Glucometer reviewed: 74 – 110, at goal
Stable DM2 stable, controlled
Continue Metformin at current dose, RTC 3 months/sooner if needed

Documentation doesn’t need to be time-intensive and grueling. It does need to be accurate.

Some examples of notes which are brief yet concise can be found at: http://emuniversity.com/case042809.html. Dr. Jensen is an MD and a certified coder, and his website provides documentation examples and insight from a Provider’s view.

What is the Medical Information Bureau (MIB) and Why is it important to Providers and Coders?

From the MIB website:

MIB is a corporation owned by member insurers in the U.S. and Canada which maintains a database to exchange confidential information (among member insurers) of underwriting significance when an individual applies for life, health, disability income, long-term care or critical illness insurance.

Requesting Your MIB Record

MIB website: http://www.mib.com/html/request_your_record.html

Example: Mrs. Smith Gets An Immunization

Mrs. Smith's Hep B immunization gets documented poorly and coded by her Provider's office as though she has the actual condition of Hep B instead of getting coded as the immunization against Hep B.

Her claim is submitted to the payer, who is a member insurer of the MIB.

Later that year, Mrs. Smith applies for disability and long-term care insurance, and consents to have the insurer access MIB.

The MIB's record indicates that she has received services from a health care Provider for the actual condition of Hepatitis B.

Mrs. Smith has not indicated on her application for insurance that she has Hep B.

Accuracy in Documentation and Coding is Crucial to Everyone's Health

Medical record accuracy can be a key issue in:

Disability Claims
Custody Issues
National Security Issues
Criminal Cases
Worker Injury Claims
Insurability
Employment
Legal Issues
Credit Issues
Public Health Initiatives
Patient Trust

and many more.

The value of pursuing the highest possible accuracy in medical record documentation and coding can't be overemphasized.

Documentation, Coding, and Reimbursement when Reporting CPT Code 69210

- Cerumen Removal –"How can we be reimbursed for this service?"
- Make sure the cerumen is truly impacted,
- Visual Considerations - Cerumen impairs exams of clinically significant portions of external auditory canal, TM, or ME
- Qualitative Considerations – Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss
- Inflammatory Considerations – Associated with foul odor, infection, or dermatitis
- Quantitative Considerations – Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills
- Ensure a physician or non physician (nurse practitioner or physicians assistant) performed the service, and
- Confirm that your physician used an otoscope and instruments like wax curettes in order to accomplish the procedure.
- Do not bill code 69210 when all you did was lavage
- Report Medicare Code G0268
- Report ICD-9 Code 380.4 for impacted cerumen.

Documentation and Coding Integrity = Health Care Industry Data Integrity

<u>The Microcosm of Our Desks</u>

The Documentation and Coding that we perform every day for our Patients and Providers is a microcosm for the data we create and process.

<u>The Macrocosm of Claims Data</u>

The Coding on claims that we submit to the payers launches that data into the Macrocosm of the Health Information Databases of the USA and beyond.

<u>How The Two Serve Each Other</u>

This Microcosm and Macrocosm ultimately serve each other by ensuring the accurate flow of important health information.

Signs That Your Clinic May Have A Problem:

- Claims denials due to non-specific ICD-9 code
- Claims denials due to medical necessity
- Delay in posting services
- Report from billing staff of diagnosis code errors
- Deleted diagnosis codes still on encounter forms/superbill
- Multiple requests for record copies from payers
- “Coders” ICD-9-CM knowledge does not extend beyond the cheat sheet you gave them 3 years ago
- Computer’s coding software or database not updated yearly
- Using out dated coding books

Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: Providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar
- are counted as present
- complete a brief Self-Assessment and Quality Survey at the end of the webinar
- request the continuing, education credit in the manner described in the steps in the next slide.

Obtaining Continuing Education Credits

1. Send an email to providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.

2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and

3. Include your contact information in the body of the email.

4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and

5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.

6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).

7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education
   credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit
   certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: http://www.cms.hhs.gov/MLNGenInfo/ and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series.

Send an email to providereducation@chpw.org with "Continuing Education Credit Request" in the subject line.

We cannot address specific, individual claims processing queries. There are other resources available for specific claim reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.