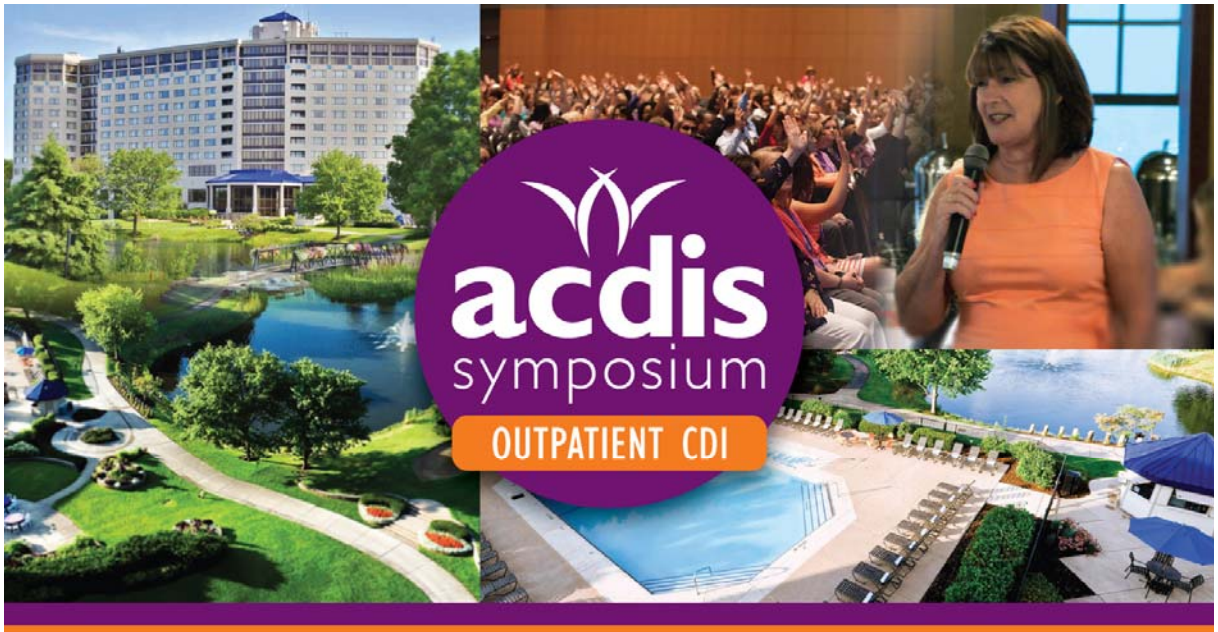

The Ins and Outs: Inpatient vs. Outpatient Coding

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Program Notes for CDI Outpatient Workshop Series

acdis
Association of Clinical Documentation Improvement Specialists

- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2017-outpatient-cdi-workshop
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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Identify source authorities associated with coding for outpatient services
  - Define key terms and differences in Section IV: *Official Guidelines for Coding and Reporting*
  - Identify key differences in reimbursement methodologies for outpatient versus inpatient services

Source Authority for Outpatient Coding

- Diagnosis coding
  - Section I: Conventions, general coding guidelines, and chapter-specific guidelines

    visits. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.

  - Section IV: *Official Guidelines for Coding and Reporting*
    - Applies to hospital-based outpatient services and provider-based office visits
    - https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf
  - AHA *Coding Clinic for ICD-10-CM/PCS*

Source Authority for Outpatient Coding

- Procedure coding
  - CPT® Manual (AMA version)
  - AMA's *CPT Assistant*
  - AHA's *Coding Clinic for HCPCS*
  - Specialty coding guides
    - E.g., Society of Interventional Radiology

Section IV: General Terms

- For outpatient visits, the term "encounter" or "visit" (as opposed to "admission") is used
- The term "first-listed" diagnosis is used in lieu of principal diagnosis

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits.

Section IV: First-Listed Diagnosis

- Selecting the first-listed diagnosis
  - The first-listed diagnosis should be the condition chiefly responsible for the services rendered (primary reason for the encounter/visit)
    - The first-listed diagnosis may be a sign or symptom if a confirmed diagnosis is not established
      - It may take a couple of encounters before a diagnosis is confirmed

Signs/Symptoms

- Assigning codes for signs/symptoms for an encounter
  - A sign/symptom may be reported if a physician has not confirmed a definitive diagnosis
  - Do not code related signs/symptoms as additional diagnoses if the signs/symptoms are integral to the first listed code
  - Additional signs/symptoms that are not integral to a disease process should be reported separately

Uncertain Diagnoses – OP and Professional Services

- Do **not** code diagnoses documented as:
  - Probable
  - Suspected
  - Questionable
  - Rule out
  - Consistent with
  - Compatible with
- Rather, code to the highest degree of certainty possible based on documented signs and symptoms

Section IV: Additional Diagnoses

- Additional codes may be reported for any coexisting conditions
  - Coexisting conditions should be reported if they affect the management or the treatment of the patient
    - Do not code conditions that no longer exist
      - History codes (Z80–Z87) for personal or family history should be reported if they are relevant
    - Chronic conditions may be treated on an ongoing basis and may be reported as many times as the patient receives treatment or care for the conditions
      - Chronic conditions may be reported as the first-listed diagnosis or as a secondary diagnosis depending on the clinical circumstances

Chronic Conditions

- Chronic conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay may be coded as many times as the patient receives treatment and care for the conditions

Reportable Diagnoses

M - Monitored
E - Evaluated
A - Assessed
T - Treated

T - Treatment
A - Assessment
M - Monitor/Medicate
P - Plan
E - Evaluate
R - Refer

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Documentation Sources

- History of present illness
  - Development of current issue or reason for encounter/visit
- Past medical history
  - Relevant past medical/surgical history
    - Some diagnoses may be listed in H & P under PMH that are ongoing chronic problems – they should be coded as current and not "history of" if treated/evaluated/relevant during current encounter/visit
- Physical exam
- Plan of care

The Value of Chronic Conditions

- Providers should document any and all diagnoses related to a condition. They should discuss the relationships between the conditions and the considerations made in planning the care and treatment.
- Often chronic diseases are overlooked in documentation as the providers don't necessarily consider them directly relevant.
  - If they are mentioned, they are not always reported because the coders may not clearly see the relevance to the encounter/visit

Medical Decision-Making Is Often Invisible

- Documentation of medical decision-making
  - Identify all problems managed or addressed during each encounter;
  - Identify problems as stable or progressing, when appropriate;
  - Indicate differential diagnoses when the problem remains undefined;
  - Indicate the management/treatment option(s) for each problem; and
    - Note management options to be continued somewhere in the progress note for that encounter (e.g., medication list) when documentation indicates a continuation of current management options (e.g., "continue meds")

Coding From Diagnostic Tests

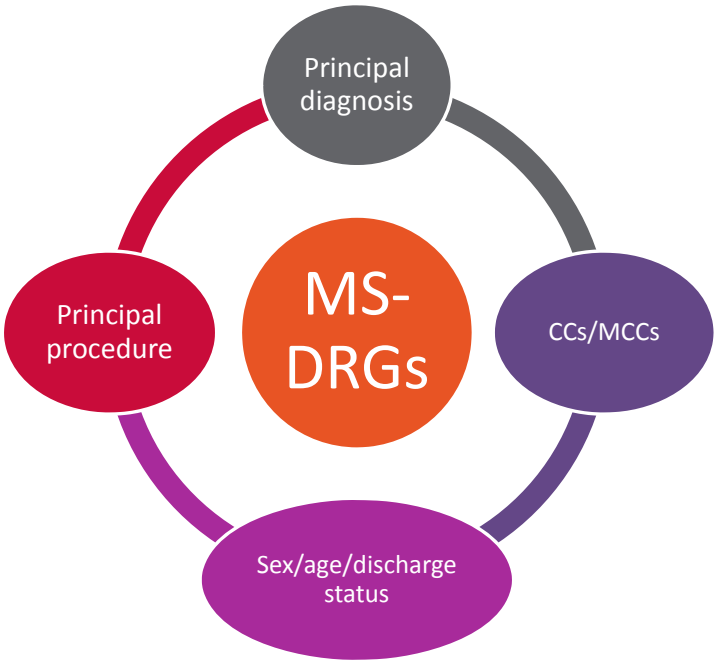
- Interpreted tests such as radiology and pathology tests CAN be used to support code assignment

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Other Challenges

- Outpatient services
  - Volume of encounters/timelines shorter
  - Medical necessity denials (LCDs, NCDs)
- Physician services
  - Providers select their own diagnosis codes based off "pull down" lists in the EHR
    - Can lead to less-than-specific diagnoses being reported (unspecified codes)
    - Chronic conditions may not be coded separately

Reimbursement for Inpatient Services



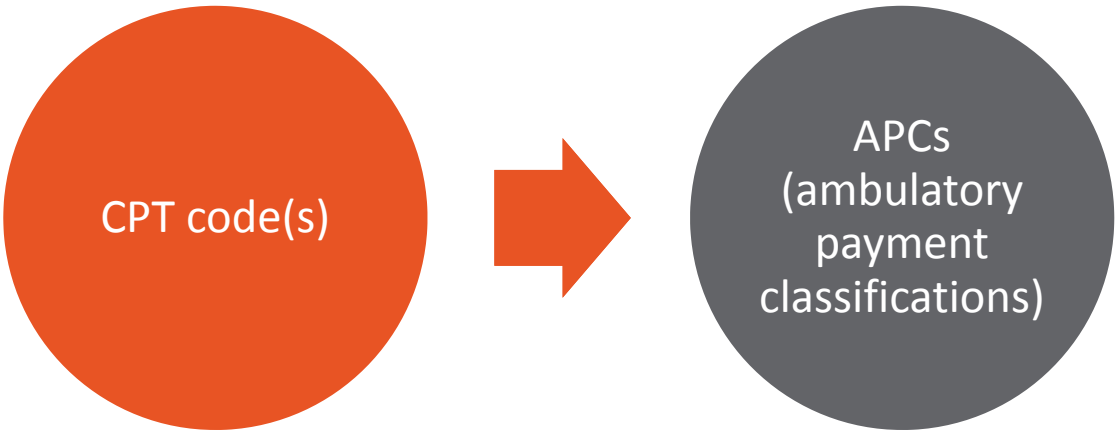
CDI and Quality – Inpatient

- Hospital Inpatient Quality Reporting Program
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- 30-day mortality measures
- Hospital-Acquired Condition Reduction Program
  - Mainly ICD-10-CM diagnosis based

Reimbursement for OP and Professional Services

- Traditional payment classifications are CPT based
  - Outpatient prospective payment system
  - Physician fee schedules

Reimbursement for OP Services Under OPPS

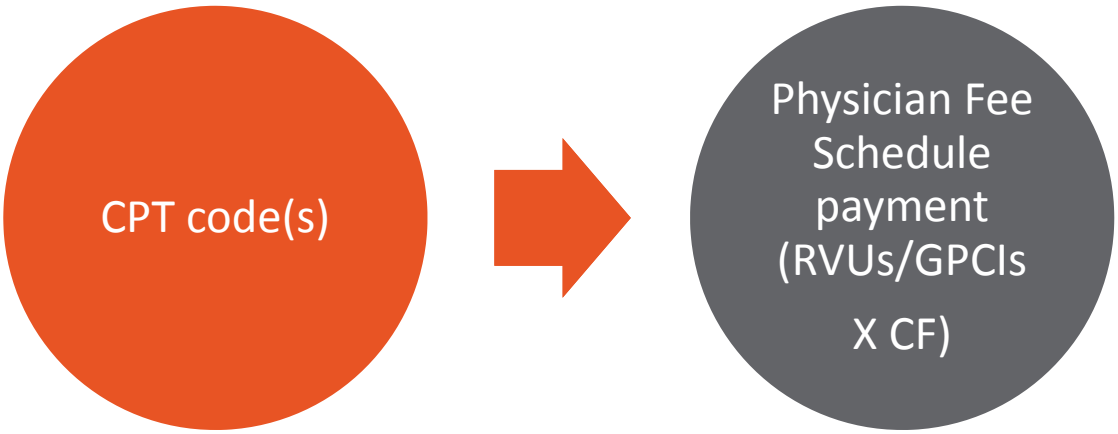


CDI and Quality – Hospital Outpatient

- Hospital Outpatient Quality Reporting
  - Measures for conditions like acute MI, chest pain, stroke
  - ED encounters "left before being seen"
  - Pain management for long bone fractures
  - Follow-up colonoscopy for "Hx of adenomatous polyps"

http://www.qualityreportingcenter.com/hospitaloqr/information/

Reimbursement for Professional Services



CDI and Quality – Physician Services

- Physician Quality Reporting System – Quality
  - Measuring and rewarding quality versus quantity of services provided
  - Documentation to support quality measures for conditions such as hypertension, CKD, diabetes (denominator)
    - https://qpp.cms.gov/mips/quality-measures

Risk-Adjusted Methodologies

- Risk adjustment payment methodologies are ICD-10-CM diagnosis code driven
  - Diagnostic information can be obtained from hospital inpatient, hospital outpatient, and provider services claims
  - Applicable diagnoses are assigned to HCCs (Hierarchical Condition Categories)
  - Unspecified codes can have a negative reimbursement impact
    - For example:
      - C77.9 (secondary CA to lymph nodes, **unspecified site**) is assigned to a much LOWER HCC than C77. 2 (secondary CA to lymph nodes, **intra-abdominal**)

Outpatient Setting – Documentation Opportunities: CMS-HCCs

67-year-old male, lives @ home. Appointment for AWV with his GP.

Active problem list

- Diabetes with peripheral neuropathy (HCC 18)
- COPD (HCC 111)
- Hypertension
- Obesity — **MORBID obesity?**
- Osteoporosis

Medication list

- Insulin
- Fluticasone (Flovent)
- Levalbuterol (Xopenex)
- Metoprolol (Lopressor)
- Citalopram (Celexa) — **Missing diagnosis?**
- Alendronate (Fosamax)
- Gabapentin (Neurontin)

Present Risk Score = .946
(Demographics: .300 + .318 (HCC 18) + .328 (HCC 111)

Outpatient Setting – Documentation Opportunities: CMS-HCCs

Active problem list

- Diabetes with peripheral neuropathy (HCC 18)
- COPD (HCC 111)
- Hypertension
- Obesity
- Osteoporosis

Mr. Bean
Queries answered:
Morbid obesity: HCC 22
Major depression, recurrent, mild: HCC 58

Present risk score: 1.614
Demographics: .300
HCC 18: .318
HCC 111: .328
HCC 22: .273
HCC 58: .395

Risk score by .668

Summary

- CDI specialists can:
  - Start accurate problem lists in the outpatient departments
  - Capture inconsistencies in documentation across departments and practices
  - Provide prospective education on documentation across the spectrum of services
  - Ensure accuracy of identification of observation care services versus transition to an inpatient encounter
  - Review risk-adjusted encounters for accurate capture of chronic conditions (especially annual wellness visits)

Thank you. Questions?

smccall@hcpro.com

To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the
Outpatient CDI Workshop series,

A New Documentation Frontier: Expanding CDI to the Outpatient Observation Setting,

will be broadcast live on
Friday, November 10 at 1 p.m. ET.