ICD-10 Implementation on the Horizon
The Best Just Got Better.

Introducing...

CREATE A CUSTOMIZED ICD-10 PCS QUERY—LIKE MAGIC!

The new ChartWise Query Wizard is the only tool on the market capable of assisting in the clarification of ICD-10 PCS procedure codes. It’s designed to take the complexity out of querying your physicians for the additional information—resulting in a more efficient CDI process, improved coding accuracy, and proper reimbursement.

ONLY CHARTWISE 2.0 OFFERS THE TOTAL PACKAGE:
Better documentation tools, greater efficiency, improved outcomes and a fast ROI.

Advanced User Interface
Give documentation specialists the tools to do their job efficiently and accurately.

ICD-10 Made Easy
Work in ICD-9 and simultaneously see the results in ICD-10—and vice versa.

Unmatched DataScan Reporting
Unrivaled reporting and management dashboards let you dig deeper into your data.

Go Beyond CDI
Improve outcomes with alerts to your Case Management and Quality teams.

Believe in Better
Clinical Documentation Improvement

Visit www.ChartWiseMed.com to request a demonstration. Contact us at (888) 493-4502 to learn more.
FEATURES

7 Picking last-minute ICD-10-CM/PCS priorities
We've rounded up our CDI and coding Boot Camp instructors and asked them to share their top three tasks to help you get your priorities straight and your facility set for ICD-10.

10 Last-minute ICD-10 training tips for documentation
By now, facilities should be past basic ICD-10 overview education. Now is the time to reinforce ICD-10 knowledge through refresher courses and training methods, says Robin Keeney, CCS, CCDS, director of revenue cycle services at VHC, Inc., in Oakbrook Terrace, Illinois.

23 Outpatient endeavors: HCC expansion tips
WellStar Health System pulled from its successful inpatient program and built its outpatient clinical documentation efforts from there.

DEPARTMENTS

4 Associate director’s note
ICD-10-CM/PCS implementation has the potential to improve patient care. It’s a story that CDI specialists need to help spread.

5 Note from the Advisory Board
Anny Pang Yuen, RHIA, CCS, CCDS, outlines why ICD-10-CM/PCS implementation matters so much and offers insight into the lingering challenges CDI programs face.

13 Ask ACDIS
Members of the ACDIS Advisory Board offer their insight into whether non-treating physicians can offer their responses to queries.

14 In the news
There are a lot of changes coming with ICD-10—including an update to the exam for the Certified Clinical Documentation Specialist (CCDS) credential. Beginning in mid-January 2016, the exam will include ICD-10-related questions.

15 Meet a member
Romerl “Cris” Gumayagay, CCDS, CCS, CDIP, knows a thing or two about passion for CDI. The foreign medical graduate has been involved in CDI for more than five years and holds a CDI position at the University of Southern California, Keck Medicine, in Los Angeles; he also volunteers with the California ACDIS chapter.

17 Ask ACDIS
If the clinical indicators do not seem to support the diagnosis, it is the responsibility of the CDI/coding team to submit a query to the physician, says Cheryl Ericson, MS, RN, CCDS, CDI-P, CDI education director at ezDI.

19 Clinically speaking
Linda Renee Brown, RN, MA, CCDS, CCS, CDIP, discusses documentation opportunities associated with an initial venous thromboembolism event, pulmonary embolus, or deep vein thrombosis.

21 Coding Clinic for CDI
Sharme Brodie, RN, CCDS, reviews the latest guidance on root operation definitions.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978-750-8400.

CDI Journal (ISSN: 1098-0571) is published bimonthly by HCPro, 75 Sylvan St., Suite A-101, Danvers, MA 01923. Subscription rate: $165/year for membership to the Association of Clinical Documentation Improvement Specialists. • Copyright © 2015 HCPro, a division of BLR. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center at 978-750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781-639-1872 or fax 781-639-7857. For renewal or subscription information, call customer service at 800-650-6787, fax 800-639-8511, or email customerservice@hcpro.com. • Visit our website at www.acdis.org. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of CDI Journal. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.
ASSOCIATE DIRECTOR’S NOTE

It’s hard not to use some form of cliché to describe the advent of ICD-10-CM/PCS on October 1, 2015. “Implementation is on the horizon.” “It’s time for a wake-up call.” “Alarm bells are ringing.” The images throughout this edition of the Journal mimic many of them.

While clichés can be helpful, we would do well to toss away their negative associations. The truth of the matter is that October 1—and the ICD-10-CM/PCS implementation that comes with it—marks a long-awaited milestone for the healthcare industry. With hard work and perseverance, it might actually bring true changes, not only from an industry perspective but from a population health standpoint as well.

My 96-year-old grandmother recently took a spill. She hit her head on the corner of the kitchen counter, which earned her seven stitches over her left eye plus a compression fracture in her neck. Of course, as those with an inpatient nursing background might have suspected, within 24 hours of her stay she obtained an infection—pneumonia. And then, either due to infection or the medication, she became delirious. She came around fairly quickly, thank goodness, and was back to her cheery self by the next day.

Now, I am not a nurse. I’m not a coder either. After 10 years at HCPro, eight of them as the senior managing editor of ACDIS, I know enough to be dangerous, enough to ask the nurses to make sure her medical record clearly documented the type of pneumonia and that it was not present on admission. I knew enough to ask them to be specific when describing the type of altered mental status she had, too.

As ICD-10-CM/PCS implementation takes place, CDI teams will need to work to obtain ever more specificity to capture the clinical picture of the patient’s treatment. If they do their jobs well (and I know they will), coders will then be able to assign more specific codes. Scientists and researchers will study trends associated with those codes. They will make discoveries about treatments and uncover patterns that shine a light on healthy or unhealthy actions—actions which may affect the way I’m treated when I get to be my grandmother’s age.

For CDI specialists, although the code set may be new, the concept of querying for greater specificity is not. All CDI specialists need to worry about is to keep doing the amazing work you do. If you need additional go-live advice, we’ve got it for you throughout this edition of CDI Journal. And we want to hear your go-live journey stories. Email them to me at mvarnavas@acdis.org.

One final cliché: It’s a brave new world, and you are experienced explorers. See you on the next horizon.

—Melissa Varnavas
NOTE FROM THE ADVISORY BOARD

ICD-10 is around the corner—are you ready?

by Anny Pang Yuen, RHIA, CCS, CCDS

Did you know the United States is the last country in the world to adopt ICD-10? Many organizations held off on preparations, waiting in case another delay came. Now, however, the clock continues to tick, louder and louder. Now, the reality of ICD-10 looms—for many, it looms large. Implementation is less than 30 days away.

According to CMS, we must transition to ICD-10 because:

- “ICD-9 has outdated terms, and is inconsistent with current medical practice.”
- “ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures.”
- “The structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.”

Systems check

If you’re not on top of your ICD-10 implementation initiatives, you may be scrambling to make sure your systems are in place to accept the code changes, along with making sure everyone in your organization is properly trained.

Many working in the healthcare industry witnessed the holdup in billing, specifically the Discharged Not Final Billed, known as the DNFB report, during the transition to MS-DRGs back in 2007.

So those with foresight may be anticipating that the ICD-10 transition could be an even bigger issue for the revenue cycle. If payers and/or hospital billing systems are not able to submit and/or accept the claims using ICD-10 codes on October 1, 2015, those claims won’t be reimbursed.

Hopefully, however, with the many delays of ICD-10, organizations have taken advantage of the time and done their due diligence, assessed their current workflows, and successfully performed a remediation of systems and templates.

Additionally, facilities should have already provided the necessary training to all the different types of professionals who need to understand the importance of the transition.
Workflow adjustment

As an industry, we recognize that documentation specificity will be significantly increased in ICD-10, but how can an organization work smarter instead of harder during this transition?

Many organizations have either implemented CDI programs or employed their CDI teams to assist with the transition. The goal is to have the CDI team clarify any documentation gaps and/or ambiguities before the medical record gets to the coding team. The collaboration of CDI and coding can really help minimize retrospective ICD-10 coding queries and improve overall coding productivity in a time when most industry experts expect productivity lags of 20%–30%.

Additionally, it is really important for organizations to determine who will be involved in provider education and to address potential workflow issues prior to October 1 to ensure the transition from ICD-9 to ICD-10 is as smooth as possible.

Luckily, the mechanics of ICD-10-CM (diagnosis coding) are actually very similar to ICD-9. Therefore, the biggest learning curve for most will be in procedure (PCS) coding. ICD-10-PCS is a completely new coding system with its own guidelines, so documentation requirements will be different. Traditionally, CDI specialists have not queried physicians regarding the assignment of procedure codes unless it was related to type of debridement since such codes typically did not add a CC/MCC. Yet the additional specificity coupled with concerns regarding coder productivity may make it feasible for CDI specialists to own both the CM and PCS query processes.

This means that, if your organization has not examined this area, it will need to determine who will query providers regarding the assignment of PCS codes, review the specificity requirements for non–operating room procedures, and examine current templates for “simple” procedures to include the level of specificity needed in ICD-10.

For example, transfusions and venipuncture will require further specificity in ICD-10, but this level of specificity may be captured within a template procedure note rather than having a query placed for each occurrence.

Refocused CDI efforts

We can all hope for the best outcomes after October 1, but for now, during this transition period, CDI specialists should consider the following items during their current reviews and begin incorporating them into their provider queries:

- **Laterality:** Much of the increase in ICD-10 codes is due to the capture of laterality; therefore, CDI specialists can begin educating providers on the importance of documenting laterality.

- **Acuity and chronicity:** This documentation was important in ICD-9, and it remains so in ICD-10. Providers should always document the acuity or chronicity of all diagnoses. Physicians need to explain whether a condition is a new onset (acute) or whether the patient has been experiencing the condition for a period of time and/or for more than three months (chronic). The documentation of acuity helps support the level of care given to the patient.

- **Linkage of conditions:** In ICD-10, documentation must often support a relationship between two conditions in order for a combination code to be assigned. Therefore, it is important for providers to document a cause-and-effect relationship between related conditions. For example, the provider must document a cause-and-effect relationship between hypertension and heart failure/heart disease.

- **Procedure coding:** One must know the body system and/or body part, objective of procedure, approach and/or technique, and device to properly assign a PCS code. If that information isn’t in the chart, then someone—either the coding or CDI staff—will need to query for it.

Editor’s note: Yuen is an ACDIS Advisory Board member. She previously served as a corporate director of CDI at Penn Medicine, where she oversaw four hospitals and was successful in developing a unified and multidisciplinary corporate CDI process focused on improving physician/provider documentation and accurate CDI financial reporting. Contact her at anny.p.yuen@gmail.com.
IMPLEMENTATION ADVICE

Picking last-minute ICD-10-CM/PCS priorities

Dual coding. Reformatting queries. Educating physicians. Let’s face it—the to-do list for ICD-10 preparation is pretty long and can be a bit daunting. With only a few short weeks left before the transition, there’s one thing your facility should do: prioritize.

We’ve rounded up our CDI and coding Boot Camp instructors and asked them to share their top three tasksto help you get your priorities straight and your facility set for ICD-10.

Laurie Prescott, MSN, RN, CCDS, CDIP, CDI education director for ACDIS/HCPro

1. Get your house in order.
We anticipate an increase in query rates resulting from the increased specificity, and we’ll likely be asking more procedure-related queries than [CDI staff] have in the past. Therefore, organizations would benefit from reviewing and updating their query policies and practices. Ask yourself, and your staff, the following questions:

■ How will you prioritize queries if you have several identified for a record?
■ Should you ask the queries related to CC/MCC capture first (a financial focus), or do you prioritize queries related to quality indicators?
■ How will the query process be shared between CDI specialists and coders?

Each organization may have a different focus or mission, and this would influence prioritization decisions.

2. Make sure your physicians know the basics.
Make sure they know how they will receive queries and how to answer them. This is also a good time to let them know the purpose of your CDI department. Surgeons especially may not be used to the queries; they should understand the expectations and how to support CDI efforts. It is also important to review existing operative notes now to identify any education needs. Target your high-frequency surgeries for your high-frequency surgeons. Take the time now to teach them about the required documentation. There is a lot of information required to complete a PCS code that many of us may have never noticed within the record because we didn’t previously need it. However, only teach physicians when you find something is missing. Education should be targeted to their specialty and reflect
their specific documentation habits. You may find in your review that their operative notes are better than you thought.

3. Update query templates. Every query template should be reviewed and updated as needed, at least on an annual basis. Now, however, it’s time to double-check all those forms to make sure they reflect ICD-10 specificity. The answers provided in multiple-choice queries should reflect the needed specificity of the new code set and follow the latest, 2013 physician query practice guidance from ACDIS/AHIMA.

Documentation templates or EHR choices or prompts should also be updated to reflect the ICD-10 code set specificity. Updated EHR prompts could help the CDI team obtain the necessary medical record documentation without additional physician queries.

If you do not have electronic records, look at any hard copy dictation templates or forms that include identification of diagnoses. These should all reflect the appropriate wording of diagnoses as needed in ICD-10.

For example, “UTI due to a Foley catheter” tells us much more about the relationship than just “UTI with a Foley catheter.”

In ICD-10-CM, the use of combination codes will increase significantly, and the number of anticipated queries will increase as well.

Talk to physicians now and get them in the habit of identifying conditions that could possibly be linked. Encourage CDI staff to review history and physicals, progress notes, and discharge summaries for these conditions.

Educate physicians on common documentation issues, such as identifying the relationship between two or more conditions, in order to avoid queries later on. The best way to teach our physicians is to choose linking language that works in every situation, such as “due to,” and have them use it. It not only links conditions to complications or manifestations, but it also demonstrates a cause-and-effect relationship.

Similarly, connect organisms and infections. Come ICD-10, specific codes will be chosen based on the possible organism causing the infection. Any time you have an infection, regardless of the location of the infection, have the physician identify the causal organism and, with the use of linking language, have him or her link the organism to the infection.

1. Use linking language. In ICD-10-CM/PCS, some conditions require linking language, while others require a cause-and-effect relationship to be demonstrated by the use of verbiage such as “due to.”

2. Practice laterality. Even though ICD-9 does not require laterality, many CDI programs started capturing it ahead of time to get physicians in the habit. It never hurts to have greater specificity earlier than required by the code set! Remember, even the abdominal muscles have laterality.

3. Start documenting time frame in days. The time frame for acute myocardial infarction codes has changed from eight weeks or less in ICD-9-CM to four weeks or less in ICD-10-CM. Even though this change from eight weeks to four weeks will not begin until October 1, you can adopt it now by documenting the number of weeks in days. You’ll have one less issue to deal with come implementation.

1. Work on procedure codes. Ensure that physicians’ operative reports contain adequate documentation in order to support all seven characters required for correct ICD-10-PCS assignment.

2. Plan for productivity decreases. CDI and coding should expect productivity decreases at first with ICD-10 implementation and plan accordingly so that revenue is not affected more than necessary.

3. Meet with your staff. Organize meetings to identify and communicate documentation issues encountered on a weekly or biweekly basis after the go-live date to ensure energy is focused on the biggest areas of concern from all departments. Good communication
and a team effort is the best way to tackle the upcoming challenges. It’s a new system for everyone, so use the strength of your numbers and experience to capture those problems and uncover solutions.

1. **Continue dual coding.** Facilities who do well after ICD-10-CM/PCS implementation will be those who have practiced dual coding cases. It is reasonable to assume those facilities who’ve done so will cross the learning curve with fewer errors than those who waited until the end to begin practicing ICD-10 code assignment.

2. **Engage leadership.** Leadership—including chief medical officers, physician advisors, and CDI department managers—will play a vital role in whether a facility moves seamlessly into ICD-10. CDI specialists should try to be as involved with these important decision-makers as possible.

   Work with leadership to schedule department meetings and set goals or standards for CDI and coding practices. Help them with educational activities and bring forward any opportunities for education.

   Those who are able to look at the big picture and recognize the importance of the changes related to ICD-10 can help the entire facility understand the importance of ICD-10 and help the organization be better prepared to handle the challenges.

3. **Have a post-implementation plan.** Understand how decreases or delays in productivity will be addressed, and work with CDI staff members to address the anticipated learning curve beyond implementation. CDI managers should create a plan to track and target any improvement opportunities with continued training and education efforts, addressing ICD-10’s challenges as well as its proposed ability to drive quality initiatives and more.

   **Cindy Basham,** *MHA, MSCS, BSN, CCS, CPC, CCDS, regulatory specialist and instructor for the Certified Coder Boot Camp® for HCPro*

**1. Look at facility statistics.** One of the biggest things facilities need to consider is whether they want to capture ICD-10-PCS on their outpatient facility cases. There is a lot of difference between ICD-10-PCS and CPT codes, so it could cause a lot of confusion for outpatient coders.

   Many facilities have coders specialized by either inpatient or outpatient cases. Outpatient will still be financially reimbursed by CPT/HCPCS II codes, and so there may be no financial rationale for capturing the ICD-10-PCS codes on outpatient claims.

   That said, however, some facilities have captured Volume 3 ICD-9 codes for ease of statistical data reporting for facilities. This could cause coders additional confusion and slow down productivity significantly. Therefore, in my opinion, it is important to look for other ways to run statistical reports in order to capture this same information.

2. **Train coders beyond the basics.** Ensure coder training goes beyond an ICD-10-CM/PCS overview and really delves into the specifics. Facilities should verify with the vendors—such as their encoder systems—to ensure that their pathways or decision trees do not rely on the General Equivalency Mappings. Coders need to learn to rely on documentation, the ICD-10 code books, and ICD-10 guidance to help them find the appropriate answers to their coding dilemmas.

3. **Educate your nurses and physicians.** Ensure appropriate documentation of clinical terms that will help coders capture the specificity and/or cause and effect required to capture good statistical data. ICD-10-CM/PCS is only as good as the people who use and understand it.

   The data we collect can help a facility not only financially, but also help us capture data to help shape our healthcare in the future. Although physicians may not have a stake in the facility financially, both facilities and physicians have one goal in mind: patient care. Many people are concerned that the decision to give a “grace period” for reporting will have a negative impact on hospital data. It is our responsibility as coders, CDI specialists, and physicians to strive for the appropriate reporting regardless.

   **Jennifer Avery,** *CCS, COC, CPC, CPC-I, regulatory specialist and lead instructor for the Certified Coder Boot Camp*

© 2015 HCPro, a division of BLR®
Last-minute ICD-10 training tips for documentation

It’s the final weeks before healthcare entities across the United States officially start employing the International Classification of Diseases, 10th Revision Clinical Modification and Procedural Coding System (ICD-10-CM/PCS).

While most understand the ICD-10-CM/PCS acronym easily enough, it’s worth spelling out from time to time to remind ourselves of the code sets’ origins and intent—a unifying numeric data set allowing healthcare workers across the world to compare trends in healthcare.

Experienced CDI professionals now well understand that the new code system contains exponentially more codes than its ninth revision counterpart and that these additional codes allow for more details and greater specificity regarding the acuity of a particular patient’s medical condition.

However, this simple fact requires a sea change of thought and actions throughout our healthcare system—one which advanced facilities and CDI programs have been preparing for, in some cases, for more than a decade.

Nevertheless, even the best prepared have a lot of last-minute to-dos to consider:

- Update forms and policies
- Test the systems
- Make sure staff are educated and prepared

The list goes on and on. As you work to put the final touches on your pre-implementation plan, here are a few things to consider.

Refresh education

By now, facilities should be way past the basic ICD-10 overview education. Now is the time to reinforce ICD-10 knowledge through refresher courses and training methods, says Robin Keeney, CCS, CCDS, director of Revenue Cycle Services at VHC, Inc., in Oakbrook Terrace, Illinois.

Look at the differences in documentation from ICD-9 to ICD-10, and determine any knowledge gaps for both physicians and coders.

“The best use of an organization’s time right now is to take a close look at the data [from dual coding] and identify coding weaknesses and opportunities for higher physician documentation specificity,” says Keeney.
CDI specialists can incorporate a variety of methods to maintain and further ICD-10 knowledge, says Keeney. Webinars, workbooks, and abbreviated ICD-10 courses can be very helpful for facilities that feel they need more formal training. Education at this point, however, should be targeted to address identified weaknesses. Similarly, training for coders and physicians needs to move beyond the basics.

“ICD-10 has so much more detail, in particular in the PCS. Coders need to understand the definitions of root operations, and CDI must work with physicians on achieving the highest level of specificity possible in procedure documentation,” Keeney says.

Networking with and asking questions of CDI colleagues will undoubtedly help facilities as they work through the “nitty gritty” of the implementation process, she says. Regularly schedule calls with local member hospitals to discuss specific cases that presented coding or documentation challenges, Keeney recommends, and hold meetings where cross-discipline groups can bounce ideas off of one another and ask questions specific to their facility and departmental needs.

“People need to start using networking and group discussions so they get the benefit of everyone’s findings” as the country moves through the implementation stages into active use of the ICD-10 codes, she says.

Dual coding
One of the most obvious tips for training has been reiterated time and time again: Practice makes perfect.

By now, facilities should be dual coding not only to learn the ins and outs of the system, but also to identify opportunities for education, says Tina Brooks, RN, CCDS, CRCR, CDI specialist at NCN Revenue Integrity.

“Training can only hit so much,” says Brooks. “What I’ve found is when we are dual coding, that’s when we learn the most because you get into the meat and potatoes of finding the correct code, using Coding Clinic, dual coding summaries, and addressing the physicians’ needs.”

Brooks’ facility focuses its dual coding efforts on identifying diagnoses and surgeries that can’t be coded in ICD-10 based on the documentation, so CDI staff can go back and provide additional information and education to the physician teams. Coders focus on mastering the ins and outs of surgery cases, Brooks says, to avoid a holdup in the overall coding process.

As far as practice goes, Brooks says there’s no such thing as being over-prepared. She suggests going to the CMS website, downloading the Official Guidelines for Coding and Reporting for both the CM and PCS portions, and reading through them extensively. She keeps copies of them on her computer desktop and, whenever she or one of her colleagues has a question, uses the word search feature to find the answer—a much quicker method than flipping through multiple books, Brooks says.

“It’s on every [CDI professional] to do that, whether you read the rules in a book or off of the CMS website,” she adds. “You learn a lot more by going directly to the source.”

Portable references
Most facilities anticipate a delay in productivity post-implementation, says Deanne Wilk, BSN, RN, CCDS, CCS, CDI and inpatient coding manager at Good Samaritan Health System in Lebanon, Pennsylvania. The last thing a hospital needs are delays caused by simple questions.

By creating tools to answer commonly asked questions or address identified “problem zones,” CDI specialists can help reinforce coder and physician knowledge and prevent unnecessary delays, Wilk says.

Now that her facility is past initial training and practicing the ICD-10 codes, Wilk started targeting education based on physician specialty and query/educational preferences. Facilities should experiment with what works best for them and their own physicians.

For example, Wilk developed PowerPoint presentations and 8-by-11 code sheets for coders that cater to their specialty. Coders also have access to an online portal where they can complete training and go back for additional clarifications.

“We don’t want coders to mark everything as ‘unspecified,’ ” says
Wilk. “The physician’s diagnosis needs to match with the final codes assigned to a given medical record.”

Pocket cards and posters are another easy method for quick references and tips. These tips can be translated into weekly emails or newsletters and distributed throughout the hospital, she says. Keep pocket cards succinct and focused. Any quick reference should be easy for a physician to navigate, and should not be a burden for them to use.

“While we want to prevent delays if at all possible, make sure your physicians know they can use CDI staff as a resource. If a physician really needs help, even if it is for a simple question, one-on-one discussions can be a huge help for the physician, and can also help CDI identify educational methods or tools on that topic,” Wilk says.

Create a task force

As CDI specialists, it can be difficult to effectively engage and educate coders and physicians without the support of the rest of the facility administration. By having a team of directors and hospital leaders behind you, it will be that much easier to navigate the ICD-10 battle, says Kerry Seekircher, RN, BS, CCDS, CDIP, CDI manager at Northern Westchester Hospital (NWH) in Mount Kisco, New York. NWH put together a task force that meets weekly and includes:

- HIM director
- ICD-10 project director
- CDI managers
- Coding manager
- IT department

The task force works on a variety of projects, Seekircher says. It plans, coordinates, and implements all of the necessary training, ensuring the coding staff, CDI staff, providers, and ancillary staff receive the right combination of boot camps, anatomy and physiology training, and e-learning. After ICD-10 implementation was confirmed, the group worked to bring back refresher boot camps and training for staff.

The task force also reviews forms, templates, and policies for opportunities for increased specificity and works as a team to make the necessary changes. The group members combine their different perspectives to identify the biggest documentation opportunities and top service lines, and to plan additional education or resources as needed. The group is also in charge of testing the software systems.

“We try to bring in the different disciplines as needed to make sure we’re covering all of our bases,” says Seekircher.

Even if you don’t have a designated task force, CDI can work with other departments to identify educational needs and opportunities. “If you can’t make a formal task force, try to set up weekly meetings where representatives from various departments can check in,” she says.

Efforts and analysis need to continue after implementation as well, Seekircher says.

“Begin to consider an additional budget for post-implementation if there are unexpected hiccups. Have a plan in place if you need outside support, contracted coders, more physician training, and the like. We don’t know if we’ve done enough education or if we have the right resources in place,” says Seekircher.

“Make sure your organization is prepared, have a planned budget, and be ready to act. We all need to know what we would do in the event of barriers, issues coding records, or bill delays.”

Additional staff

Lastly, as a facility goes through its last-minute training and preparation, a wise thing to do is bring in backup, says George Redd-Hachey, CCS, CCDS, CHDA, former coding and CDI manager at the University of Florida Health Shands Hospital in Gainesville. Having an extra helping hand available in light of the mountain of tasks that ICD-10 has brought (and will continue to bring) could make the difference between a successful or stressful transition.

Shands hired new graduate coders to start in July, August, and September to work exclusively in ICD-10, while existing staff amp up their dual coding efforts more and more as October approaches.

CDI staff can work with leadership to get approval for additional staff if they feel it’s necessary. Since no one can say for sure exactly where coder productivity will be, Keeney says there’s a strong case to beef up your coding and CDI staff with backups. ☛
Non-treating physician responses to queries

Q: May a physician/provider, who does not attend the patient during an episode of care but does act in an advisory capacity for the CDI and/or coding departments, answer a formal query? Could that documented response be used as a basis for compliant code assignment?

A: No. Official Guidelines for Coding and Reporting clearly indicate that provider documentation should come from a provider who is legally accountable for establishing the patient’s diagnosis. Therefore, documentation from a physician/provider who did not attend to the patient during the episode of care is not appropriate for code assignment.

According to the Guidelines, the term provider is defined as a “physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.” On p. 97, the Guidelines add that “medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not” (emphasis ours). Additionally, p. 97 of the Guidelines adds that “issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.”

Furthermore, according to the CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, §482.24(c)(1):

All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures (again, emphasis ours).

Coding Clinic provides a couple of additional references pertinent to this question. Coding Clinic, First Quarter 2014, pp. 11–13, includes similar references as above and is worth researching. In addition, Coding Clinic, First Quarter 2004, pp. 18–19, adds the following advice regarding appropriateness of code assignments based on the documentation in the medical record by a physician other than the attending physician:

Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician. Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. A physician query is not necessary if a physician involved in the care and treatment of the patient, including consulting physicians, has documented a diagnosis and there is no conflicting documentation from another physician. If documentation from different physicians conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis.

In summary, ACDIS does not condone the practice of a provider, be that person a nurse, physician assistant, physician, or other—including a physician advisor to CDI—answering a query when serving in a nonclinical capacity without direct responsibilities for the patient in question. Queries must be directed to physicians directly involved in the care or treatment of the patient. In the rare instance of a physician who unexpectedly leaves a facility and has unanswered outstanding queries that must be addressed, hospital-specific HIM rules and regulations pertaining to chart completion/close-out would apply.

Editor’s note: This question was posed to the ACDIS Advisory Board, which reviewed and researched the question and drafted the response. It should not be construed as legal advice, just the advisory board’s consensus opinion on this issue.
CCDS certification set to receive an ICD-10 update

There are a lot of changes coming with ICD-10—including an update to the exam for the Certified Clinical Documentation Specialist (CCDS) credential. Beginning in mid-January 2016, the exam will include ICD-10-related questions. Approved candidates have 120 days from the date their name is submitted to the testing firm, Applied Measurement Professionals, to schedule and take their exam. Those who have already applied and been approved to take the exam should schedule an appointment to sit for it by early September. That way, those who do not pass still have time to schedule a make-up test prior to the implementation of the revised exam in January. Note that there is a mandatory 90-day waiting period between exam attempts.

Another significant change in terms of exam content will be the addition of a new section covering the impact of reportable diagnoses on quality of care. This content change reflects changes in the healthcare industry associated with healthcare reform as well as the shift in reimbursement models toward pay-for-performance methods, such as value-based purchasing, over traditional fee-for-service models. As these advancements take hold, CDI programs will play an important role in capturing the additional documentation specificity required.

The CCDS Exam Study Guide will be updated to reflect these changes, and will be available for purchase early next year.

Some exam basics

To apply, submit the exam application from the ACDIS website. Every exam candidate should read the Exam Candidate’s Handbook before applying. You must meet certain eligibility requirements, which include a minimum of two years’ CDI experience. The exam fee is $255 for ACDIS members and $355 for non-members. You will not be charged if your application is denied. Submit your application by fax, email, or mail.

ACDIS membership is not required to take the CCDS exam, and CCDS holders are not required to become ACDIS members.

Recertification

CCDS credentialed individuals must recertify every two years. To recertify, submit the CCDS Recertification Application along with evidence of having earned 30 continuing education units relevant to the field of CDI.

A free CCDS Frequently Asked Questions webinar was held in August, and an on-demand recording is available on the Certification page on the ACDIS website. The certification page also provides a number of resources with information necessary to apply, certify, and recertify, including:

- A detailed list of CCDS prerequisites.
- Requirements for recertification.
- How to apply for the exam and how to recertify.
- Exam and testing information, including where you can take the exam, resources that can be used during the exam, pass/fail statistics, and examination content.
- Links to our exam application and the Exam Candidate’s Handbook. We strongly urge anyone considering the CCDS certification to take the time to carefully read this handbook. It covers all of the basics and has a number of helpful tips for taking the exam.

For additional information, contact customer service at 800-650-6787 or email customerservice@hcpro.com.
MEET A MEMBER

Foreign Medical Grad finds CDI home in California

Romerl “Cris” Gumayagay, CCDS, CCS, CDIP, knows a thing or two about having passion for CDI. The foreign medical graduate (FMG) has been involved in CDI for more than five years and holds a CDI position at the University of Southern California, Keck Medicine, in Los Angeles. An active member of the California ACDIS chapter leadership team, Gumayagay has organized an annual CDI Week meet-and-greet in Los Angeles for the past four years. He is currently working on earning his master’s degree in business administration for healthcare management.

When he’s not busy with CDI, Gumayagay spends time at home in Arcadia with his family. He has two sons—Nix, 17, who is a college freshman, and Geo, 13, who is in eighth grade—and a 14-year-old daughter, JC, who is a high school sophomore. He also enjoys taking road trips and traveling.

CDI Journal: What did you do before entering CDI?
Gumayagay: Shortly after working with my physician friend’s private practice in Los Angeles, I moved to the hospital setting as an acute care hospital case manager, and eventually became a CDI specialist and CDI manager. However, my goal was to work in an academic medical center, so I took a position in healthcare compliance at the University of Southern California, overseeing healthcare compliance activities within the university, and stayed there for almost three years. I shifted back into CDI because it’s what I’m really passionate about.

CDI Journal: What has been your biggest challenge?
Gumayagay: It’s a fact that the biggest challenge of our profession is to deal with difficult physicians. Getting physician support is critical for the program’s success. Establishing good rapport is important, and constantly educating the physicians and/or any midlevel medical provider is the key to obtaining that rapport.

CDI Journal: What has been your biggest reward?
Gumayagay: I’ve grown so much, professionally speaking, in this field, and that has been my biggest achievement and reward so far. Learning new things each day from my colleagues and working with a great team is also quite rewarding.

CDI Journal: How has the field changed since you began working in CDI?
Gumayagay: When I started in the fall of 2007, CDI programs were just focused on Medicare cases. That was the time MS-DRGs were rolled out. After that, programs evolved robustly to include reviews of all payers. CDI professionals today are now more involved in quality initiatives, and some facilities are also doing pediatric and outpatient case reviews.

CDI Journal: Where do you see CDI in the future?
Gumayagay: Putting my compliance hat back on, I foresee that someday, CDI specialists will be involved in research initiatives, especially in academic medical centers. Research documentation is quite complex, and bridging documentation gaps in that field might make a difference.

CDI Journal: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on “CDI Talk” or through ACDIS?
Gumayagay: There’s a ton—I couldn’t elaborate well enough how ACDIS has helped me become an efficient CDI professional since day one. The organization itself is amazing, not to mention the robust networking opportunities. The ACDIS website is a treasure. It’s a good resource to learn almost anything about CDI. Every CDI
specialist should have the link in their browser favorites bar—there’s just a lot of good stuff. Attending ACDIS conferences is a highlight, and highly recommended for all CDI professionals.

**CDI Journal:** What piece of advice would you offer to a new CDI specialist?

**Gumayagay:** Take one day at a time. There’s so much to learn when you’re new, and the best way to learn is to learn from experience. If you come to the field with a medical background, then you may have the clinical knowledge needed to perform well in the role, but having a good understanding of coding guidelines helps as well. I recommend that new CDI professionals read published practice briefs on managing physician queries, and use the [ACDIS Code of Ethics](#) as a guide.

Reach out to other experienced CDI specialists and pick their brains. CDI specialists love to share good and effective ideas. New CDI staff should consider joining and becoming active in their local chapter. If you can, attend the next annual ACDIS Conference, which will motivate you more for sure. Lastly, when you qualify, aim to get certified as a CCDS professional.

**CDI Journal:** If you could have any other job, what would it be?

**Gumayagay:** I may fit in medical research. Or manage a small business franchise—just a thought.

**CDI Journal:** What was your first job?

**Gumayagay:** In the Philippines, students didn’t work until they finished college or their degree. My first job wasn’t until I graduated from medical school. I remember moonlighting, as a starting physician, and being paid very little—much less than my allowance from my parents. I did that with various HMO-affiliated companies in urban Metro Manila. I also did a short stint as a vessel physician on board inter-island cruise ships. That was quite an experience.

**CDI Journal:** Tell us about a few of your favorite things.

- **Vacation spots:** San Diego for short road trips. Yosemite in the spring. Boston and New York City have been my frequent getaways in the past, and I want to go back soon.
- **Hobby:** I have a thing for collections. I started collecting coins and stamps as a kid, and had several completed albums. At present, I collect Starbucks collectible “city mugs.” I now have about 400 Starbucks city mugs to date, consisting of four different series from various cities/countries.
- **Non-alcoholic beverage:** Regular Coke, passion iced tea lemonade, or green tea Frapps.
- **Foods:** Thai food is my current favorite.
- **Activity:** Just being with my family when I’m not working. 🌸
Escalation policies and clinical validation queries

Q: There seems to be an abundance of articles on posing clinical validation queries and escalating such situations to the CDI physician advisor; however, there is not a wealth of information on what to do when the query is answered and the answer still does not support the diagnosis.

For example, if, after query response, the physician advisor doesn’t feel the documentation supports a diagnosis such as acute respiratory failure, could an internal policy allow us to not drop the bill with that code on the chart? Even after peer review, the physician may verbally agree but never amend the chart. What are other facilities doing to avoid denials on the back end and code the chart accurately the first time with a clinically supported diagnosis?

A: You bring up an excellent point. If the clinical indicators do not seem to support the diagnosis, it is the responsibility of the CDI/coding team to submit a query to the physician.

There are a few things you and your organization need to consider, however. First, the Official Guidelines for Coding and Reporting gives the responsibility for assigning diagnoses to the attending provider. As such, if the attending states there is acute respiratory failure and stands by the diagnosis even if the physician advisor disagrees, the Guidelines would support the coding of the diagnosis. Unfortunately, CDI does not have a process similar to the utilization review (UR) department. With the UR committee, members can “override” the admitting provider in regard to patient status. The Guidelines do not allow an override process when it comes to the attending provider and the patient diagnosis.

Best practice would be to make your queries a permanent part of the medical record to demonstrate CDI/coding efforts in obtaining clarification regardless of the outcome. CDI/coding can’t be held accountable for the actions of the attending provider. I think many organizations fail to realize the importance of keeping the queries as part of the medical record. Even queries which aren’t answered by the provider or instances where there is disagreement with a query should be saved because they show transparency of the efforts to accurately assign codes to the record. Furthermore, maintaining a transparent process allows the CDI team and/or the denials management team to review the record and reinforce the importance of CDI efforts to the physician should that record’s claim later receive a denial.

I think a major issue is how to construct the clinical validation query. A multiple-choice query is often best in these situations. For example, I would write a query as follows:

Please clarify the status of the diagnosis “acute respiratory failure” as documented [where/when] in this patient who received a maximum of three liters of oxygen [whatever clinical indicators make you doubt the clinical validity of the diagnosis]. The acute respiratory failure was:

- Confirmed/validated
- Ruled out
- Without clinical significance
- Unable to determine
- Other: _____________

This approach allows providers an “out” if they were mistaken when they wrote the diagnosis, as they can always clarify the condition was without clinical significance and therefore shouldn’t be reported. However, if
an attending provider confirms the diagnosis even with what CDI/coding feels is a lack of clinical support, the diagnosis must be reported. This claim may receive a denial, but CDI/coding clarified the diagnosis with the provider, which is what they are required to do.

Unfortunately, many coders and CDI overstep their roles when they decide not to code a condition documented by the provider. There is no guideline or guidance that says the coder can choose not to report a diagnosis if it meets the definition of a reportable diagnosis according to UHDDS definitions. This issue was addressed in the 2008 AHIMA practice brief, “Managing an Effective Query Process,” with the following guidance:

Codes assigned to clinical data should be clearly and consistently supported by provider documentation. Providers often make clinical diagnoses that may not appear to be consistent with test results. For example, the provider may make a clinical determination that the patient has pneumonia when the results of the chest x-ray may be negative. Queries should not be used to question a provider’s clinical judgment, but rather to clarify documentation when it fails to meet any of the five criteria listed above—legibility, completeness, clarity, consistency, or precision … In situations where the provider’s documented diagnosis does not appear to be supported by clinical findings, a healthcare entity’s policies can provide guidance on a process for addressing the issue without querying the attending physician.

However, the 2013 ACDIS/AHIMA guidance titled “Guidelines for Achieving a Compliant Query Practice” states “generation of a query should be considered when health record documentation ... provides a diagnosis without underlying clinical validation.” In addition, the brief states:

Best practice would be to make your queries a permanent part of the medical record to demonstrate CDI/coding efforts in obtaining clarification regardless of the outcome.

The focus of external audits has expanded in recent years to include clinical validation review. … When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility’s escalation policy.

Again, the brief doesn’t say the code should be omitted, only that it should be addressed. I would suggest that best practice is to have an organizational definition (including coders, providers, CDI specialists, compliance, and quality) for high-risk diagnoses like acute respiratory failure, severe malnutrition, etc., that include treatment parameters because the treatment is often the most powerful clinical indicator differentiating a minor condition from a more severe one.

Once definitions are established, I would query when a diagnosis is documented but doesn’t meet the established criteria. If the provider confirms the diagnosis after a clarifying query, I would report the diagnosis, keeping the query as part of the health record to demonstrate clarification was sought by the provider. If the provider habitually fails (i.e., determine how many is too many times—three, five, seven?) to use organizational definitions for diagnoses, that should trigger an escalation process (physician advisor, peer review, etc.)

Physician education may be a useful tactic as you may want to educate providers to document why the patient has acute respiratory failure when the “standard” clinical indicators aren’t met. Maybe the patient has underlying lung disease, etc., so the provider might document “unable to administer more than 40% oxygen as treatment of acute respiratory failure due to underlying COPD” or whatever the concern may be. Medicine doesn’t follow a recipe book, so the provider’s best course of action is to always document why he or she has deviated from the “expected” protocol/standard. If this documentation exists and it is reasonable, it will often support an appeal as CMS recognizes the provider’s clinical judgment.

Editor’s note: Cheryl Ericson, MS, RN, CCDS, CDI-P, CDI education director at ezDI, answered this question. Contact her at cherylericson@comcast.net.

Editor’s note: Cheryl Ericson, MS, RN, CCDS, CDI-P, CDI education director at ezDI, answered this question. Contact her at cherylericson@comcast.net.
Adding venous thromboembolism to the CDI checklist

by Linda Renee Brown, RN, MA, CCDS, CCS, CDIP

The annual incidence of an initial venous thromboembolism (VTE) event, either a pulmonary embolus (PE) or a deep vein thrombosis (DVT), is approximately 0.1% in the United States, with the highest incidence among the elderly and a recurrence rate of about 7% at six months. At the same time, thrombotic stroke is the third leading cause of death in the United States. Virchow’s triad theory suggests that VTE occurs due to three factors:

1. Altered blood flow
2. Vascular endothelial injury
3. Alterations in the blood constituents, or hypercoagulable state

A patient with an abnormally increased tendency toward coagulation may be said to experience a hypercoagulable state. Hypercoagulable states can be further specified as primary or secondary. Primary hypercoagulable states are inherited thrombophilia conditions caused by deficiencies or defects of the physiologic anticoagulants or increased coagulation factors, according to the journal *Cardiovascular Medicine* (2007). The major causes of inherited thrombophilia include factor V Leiden mutation, antithrombin deficiency, protein S and protein C deficiency, and prothrombin gene mutation.

Secondary, or acquired, hypercoagulable states are a varied group of disorders with an associated elevated risk for developing thromboses. Many conditions can effect changes in the coagulation system, resulting in a hypercoagulable state. Secondary hypercoagulable state, when documented in the medical record, is a comorbidity that can increase reimbursement, impact length of stay, and reflect a higher severity of illness and risk of mortality, but it is often underdocumented and underreported.

Many clinicians easily recognize that patients may present a higher risk of thrombosis with evidence of a previous thrombus, recent major surgery, new trauma, malignancy, pregnancy, the use of oral contraception, antiphospholipid syndrome, or the use of a central venous catheter.

Patients undergoing surgery who have not received VTE prophylaxis experience a rate of DVT from 15–30%, and fatal PEs from 0.2%–0.9%, according to a 2007 article in the journal *Circulation*. Trauma patients run almost a 60% risk of VTE. Among cancer patients, at least 50% are found to have a VTE at autopsy.

Increases in blood viscosity, fibrinogen, and factor VIII during pregnancy increase the risk of VTE in pregnant women six times higher than that of nonpregnant women. The prevalence of VTE in pregnancy is 1:600, and PE causes 9% of all deaths during pregnancy. In one study, currently available oral contraceptives increased the risk of VTE to five times that of a non-user.

The risk increases within four months of the start of therapy and remains unchanged, regardless of duration of use, until three months after the end of therapy.

However, additional conditions seen among the inpatient population also may increase the risk of developing VTE. Diabetic patients are at higher risk of thrombosis; 80% of Type 2 diabetic deaths may be attributed to thrombi. The risk of stroke and myocardial infarction is significantly higher in the diabetic population.

Researchers have found modifications in the coagulation pathway in diabetic patients, including abnormal coagulation screening tests and altered clotting factor levels. Enhanced platelet aggregation and activation, along with an inhibited fibrinolytic system associated with insulin resistance, can suggest a hypercoagulable prothrombotic state that increases risk of a cardiovascular event.

In metabolic syndrome, in which we find obesity, chronic inflammation, and insulin resistance, we also find a hypercoagulable state associated with increased clotting factors and an inhibited fibrinolytic pathway. Elevated cholesterol levels can impact platelet aggregation and
clot formation. Smoking causes damage to the endothelium, adhesion of platelets, release of growth factor, and reduced tPA production that can result in a prothrombotic state. Immobility associated with travel can triple the risk of thrombosis, particularly in obese patients. Heart failure, chronic renal failure, thyroid disease, and sepsis can also result in a prothrombotic state.

Documentation of secondary hypercoagulable state must, as with all secondary diagnoses, meet the definition of a secondary diagnosis, to include at least one of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of stay
- Increased nursing care and/or monitoring

In all physician documentation, the diagnosis to the correct degree of specificity, the supporting clinical indicators, and the treatment plan must always be in alignment.

While encouraging physicians to capture this comorbidity when clinically warranted, we must also emphasize that documentation of secondary hypercoagulable state is incomplete without referencing the indicators that support the diagnosis, as well as how it is being evaluated, treated, or diagnosed.

Documentation of anticoagulant therapy in patients at risk for VTE should not only be associated with meeting core measures requirements, but should also be linked to the secondary hypercoagulable state and the underlying conditions that put the patient at risk.

The goal of any clinical documentation program is to paint the full clinical picture, so consider adding secondary hypercoagulable state to the paintbox.

**Editor’s note:** Brown is the director of CDI for Tanner Health System in Carrollton, Georgia. She has experience in critical care, nursing education, case management, long-term care, and, of course, CDI. She thinks the only thing better than writing for ACDIS is snuggling with her cat Thomas. Contact Brown at catladyrn@gmail.com.

---

### ADDITIONAL READING

Use these resources for additional information related to venous thromboembolism.

CODING CLINIC

Guidance offers further insight into root operation definitions for procedure coding and sequencing

by Sharme Brodie, RN, CCDS

Many of the questions and answers supplied in AHA Coding Clinic for ICD-10-CM/PCS, Second Quarter 2015, surrounded the use of the correct root operation. Per ICD-10-PCS Official Guideline for Coding and Reporting, “[i]t is the coder’s responsibility to determine what the documentation in the medical record documentation equates to in the PCS definitions.”

It could very well be the CDI’s responsibility, however, to make sure the medical record contains all the documentation necessary for the coding team to assign the correct “root operation.”

There are 31 root operations with distinct definitions, divided into nine different categories based on the intent of the procedures. Both coding and CDI teams need to have an understanding of all 31 root operations.

CDI professionals should also become familiar with the types of approaches and devices used in ICD-10-PCS. There are seven different approaches and four general types of devices.

On p. 22, Coding Clinic explains that although the alphabetic index entry “Laminectomy” instructs the coders to see “excision,” the objective of a decompressive laminectomy is to release pressure and free up the spinal nerve root—therefore, the appropriate root operation would be “release.” This would be an example of how the coding staff will have the responsibility of reading the postoperative note and, based on the surgeon’s documentation, independently deciding on the correct root operation to be used.

Similarly, shoulder decompression procedures typically include minor shaving or debridement of the articular surfaces of the joint, performed in order to free up the joint. This is considered integral to the release procedure and is not coded separately.

Coding Clinic discussed the use of Gelform device for embolization of the uterine artery on p. 27. Gelform is coded as an intraluminal device when used in this way, according to Coding Clinic. Determining whether something is considered a device can at times be tricky. The coding guidelines regarding devices must be followed.

Coding Clinic clears up some confusion regarding what constitutes a coronary artery intervention “site.” As stated in the ICD-10-PCS Official Guidelines for Coding and Reporting, B3.6b, “Coronary arteries are classified by the number of distinct sites treated, rather than the number of coronary arteries or anatomic name of a coronary artery.”

A coronary intervention “site” refers to each distinct lesion treated, unless a single lesion extends into more than one artery.

One of the Official Guidelines for Coding and Reporting discussed in this volume of Coding Clinic is B3.2b, which states:

“During the same operative episode, multiple procedures are coded if: The same root operation is repeated at different body sites that are included in the same body part value.”

The Guideline uses the example of two separate and distinct muscles in the upper leg. In ICD-10-PCS, when more than one distinct anatomical structure is named in a single ICD-10-PCS body part description, the procedure being coded does not need to include all of the body parts listed in the description. ICD-10-PCS Guideline A10 states, that the word “and” when used in a code description, means “and/or.”

This is not a change from ICD-9.

P. 22 of this Coding Clinic states that because the cervical spinal cord is classified as one body part, having a patient that has a surgical procedure involving different levels of the cervical spine does not qualify for the multiple procedure guideline.
In both ICD-9 and ICD-10, the clinical significance of adhesions is determined by the physician documentation. When the adhesiolysis is integral to a procedure, the lysis of the adhesions will not be coded separately, but if the physician’s documentation uses verbiage such as “dense” or “extensive,” the lysis of the adhesions may be coded separately. So be sure to read the entire postop note for clues that the lysis of adhesions may have been more extensive.

Although ICD-10-CM/PCS allows us to capture much more specificity regarding diagnoses and procedures, there are areas that are lacking the added specificity. A few examples are discussed on pp. 31 and 32.

In the first example, the patient presents for right talc pleurodesis via video-assisted thoracoscopic surgery. A right-sided thoracoscopy was performed, followed by placement of an additional port with injection of talc within the right chest. In this case, the talc is being injected, and “introduction” is the correct root operation. In the table 3EO (Introduction), there is no approach for “percutaneous endoscopic” for the pleural cavity body part, so you have to use the percutaneous approach.

Since the endoscopic component of the procedure is not captured by the approach value in this case, a code for inspection of the pleura for the thoracoscopy must be added.

Another example is a patient who presents for insertion of a leadless pacemaker. In ICD-10-PCS, there is no value for a leadless pacemaker. Intraluminal device is the closest available equivalent.

Another item reviewed was ICD-10’s use of the 7th character extension. Most codes that require a 7th character have three standard choices: “A” for active treatment, “D” for subsequent care, and “S” for sequela. Aftercare “Z” codes are not used for aftercare for conditions such as injuries or poisoning, where 7th characters are provided to describe subsequent care. The use and definitions of the 7th character extensions was discussed at length in the First Quarter edition of Coding Clinic.

On p. 15, another concept reviewed involves “use, abuse, and dependence” of substances. Only when a physician documents dependence can withdrawal be coded. If the physician documents abuse along with withdrawal, a query must be issued to clarify level of dependence. There is a combination code in ICD-10-CM, but the physician must link the substance dependence and withdrawal to use it.

Also on p. 15, Coding Clinic reiterated that it is acceptable to report pleural effusion in patients with congestive heart failure (CHF) if the condition requires either therapeutic intervention or diagnostic testing. The advice is similar to previous guidance, which advised that pleural effusions are usually minimal and not specifically addressed other than through more aggressive treatment of the CHF, so they are not coded separately.

Coding Clinic also answered questions regarding coding for the Glasgow Coma Scale in ICD-10-CM. One code will be needed for each of the three subcategories of the scale (i.e., eyes open [R40.21-], best verbal response [R40.22-], and best motor response [R40.23-]).

These codes are only used when the individual score(s) or numeric values are documented in the health record. If only the total score is documented within the health record, then code R20.24 is used.

The total score does not equate to a MCC or CC, but the highest severity level of each subcategory will allow the facility to capture MCCs in ICD-10 as long as the complete score is also documented and not just the total score. The seventh character will indicate when the scale was recorded, and all three of the seventh characters need to match.

Editor’s note: Brodie is a CDI education specialist for HCPro in Danvers, Massachusetts. Contact her at sbrodie@hcpro.com.
OUTPATIENT EFFORTS

One system’s efforts to address physician practice documentation improvement needs

20 million. That’s what WellStar Health System reportedly showed to Medicare in one year of savings due to its transition to a value-based care, shared savings model. Of that, Medicare returned $10 million to the WellStar system, Jennifer Bratz, MA, BSHAS, RHIA, executive director of healthcare data integrity and clinical documentation excellence for WellStar Health System, told ACDIS Radio in April.

WellStar’s inpatient CDI program began in 2009. Hospital administrators and physicians were hesitant in the beginning, Bratz says. As the system incorporated an accountable care organization, leadership began to ask how it could leverage its existing inpatient CDI efforts to the totality of its healthcare system—and just like that, Bratz was charged with starting an outpatient CDI program.

“They basically told us to go forth and design something,” says Bratz, who also presented a poster session on the topic at the 2015 ACDIS Conference in San Antonio.

So she started researching “the thousands of stimulating pages of CMS regulations” for physician payments, she says. She learned WellStar’s new reimbursement model relied on a risk adjustment factor, which CMS calculated by ICD-9-CM coding bundled into hierarchical condition categories (HCC), similar to diagnosis-related groups on the inpatient side.

WellStar’s score, however, showed it had a population of average, healthy Medicare patients—not exactly an accurate depiction of the patient population it serves.

“So we had to look to see what was driving that score,” Bratz says. They quickly realized physician documentation sat behind the wheel.

**Physician payment nuances**

Way back when, Medicare reimbursed on actual charges—hospitals and physicians received what they billed for. This changed when CMS implemented the Medicare inpatient prospective payment system (IPPS). Traditional inpatient CDI specialists learn about the IPPS, the intricacies of the ICD system, and the coding conventions that govern code assignment, but there are a number of additional coding systems too, such as common procedural terminology (CPT) and the Healthcare
Common Procedure Coding System (HCPCS), among others.

HCCs came about as a new method to adjust Medicare+Choice (now Medicare Advantage) payments to account for cost variations due to health status and demographic factors such as age, sex, and disabilities. HCCs include roughly 70 disease groups derived from approximately 3,600 (mostly chronic) diagnosis codes.

Basically, HCCs predict an individual beneficiary’s healthcare expenditures relative to the average beneficiary. CMS uses the scores to adjust payments based on the health status and demographic characteristics of a beneficiary. (Read the article in the July edition of CDI Journal, “Physician advisor’s corner: What your primary care physicians need to know about CDI,” and for additional information, read “HCC codes offer new area of CDI focus.” a 2014 ACDIS featured article.)

Outpatient implementation

Bratz pulled from the successful inpatient program and built out from there, hiring contract CDI staff to fill in as needed. The group identified the top documentation improvement opportunities and dug into the coding and documentation nuances, keeping in mind the differences governing inpatient and outpatient reimbursement.

Before engaging with physician practices, the CDI staff audited an 18- to 24-month period worth of medical records looking for information the physicians knew about their patients but maybe did not include in the medical record, says Letitia Rushin, RN, CCDS, CCM, WellStar Health System’s team lead for outpatient clinical documentation excellence.

“We’re looking at laboratory results, x-ray findings, etc., just like you would on the inpatient side, and try to help the physicians comprehensively document all existing conditions,” Rushin explains.

The example Bratz uses most often to illustrate the bizarre nature of the HCC system is a lower limb extremity amputation. “If the physician doesn’t document the fact that the patient has had a lower limb amputation in the record at least once during a 12-month period, CMS considers it a magically reattached limb for that year.”

As another example, Rushin says if the patient comes to the doctor’s office for bronchitis but also suffers from chronic asthma that wasn’t documented in the past year, it doesn’t get calculated in the HCC score. “They write beautiful narrat-ives,” she says, “but ultimately they did not effectively illustrate the burden of the collective conditions they were treating.”

In the early days of their CDI efforts on the inpatient side, physicians were a bit resistant, but now, “we’re getting to hold hands with the physicians a lot more,” Bratz says, adding that initial efforts required every engagement tool at her disposal, including cookies.

“We’re in a very exciting career right now,” she says. The most important thing is to “just stay fresh and watch where healthcare is moving. We need to stop thinking about patients in terms of a single episode of care but look at it instead as a continuum and how can we support that patient. If we do, as CDI professionals, the sky is the limit in terms of how our efforts can affect healthcare.” 🌈