READY. SET. GO.
We’ll get you to ICD-10 in record time.

Take the Risk Out of Risk Adjustment
Lynne Padilla and Sheri Poe Bernard
Publisher Notice

Although we have tried to include accurate and comprehensive information in this presentation, please remember it is not intended as legal or other professional advice.
Today’s Agenda

• Discussions limited to Medicare Advantage and risk adjustment coding:
  – NOT an introduction to risk adjustment

• Understand coding guidelines and federal regulations that impact RA coding and auditing

• Expand the limited resources available to you for RA guidance

• Share ideas for improving accuracy of coding and clinical documentation
Who are we?

• Sheri Poe Bernard, CPC, CPC-H, CPC-I
  – Consultant with this work history:
    • VP of Quality and Training, Outcomes Health Information Solutions
    • 15 years leading product development at Medicode/Ingenix/OptumHealth
    • 3 years VP of clinical content at AAPC

• Lynne Padilla, CPC, AHIMA-Approved ICD-10-CM/PCS Trainer
  – Coding professional with more than 25 years of work history:
    • VP of Coding Operations and Quality, Peak Health Solutions
    • Director of Quality and Training (Coding and HEDIS), Outcomes Health Information Solutions
    • Director of Medical Course Development, Allied Medical Schools
Who are you?

- Raise your hand if:
  - You are a coder/manager in a provider office
  - You are a hospital coder/manager
  - You are an RA auditor/manager working for a consulting company
  - You are an RA auditor/manager working for a health plan
  - You are with the government
  - Who else is out there?

- Welcome!
Top 10 Errors in Risk Adjustment Coding

• The countdown begins …
For **clinicians**, ask yourself these questions:

- Is the physician a certified coder?
- What sort of coding training has the clinician had?
- Does the clinician understand the conventions of ICD-9-CM? Know about the *Official Guidelines for Coding and Reporting*?
- How often is the clinician’s training updated? Where is information on each year’s code changes reaching the clinician?
- Is the clinician aware that selecting a code is not “documentation” of a condition?
- Who audits the clinician’s coding?
- How is feedback given to the clinician based on audit?
• For **software**, ask yourself these questions:
  – Was the software developed by a team that included certified coders in the design and decision-making?
  – Is a certified coder from the software company available to answer your questions?
  – Are full descriptions with inclusion and exclusion information included in any code-selection lists?
  – Are the codes mapped properly to HCC RA tables?
  – What is the update schedule for the codes?
  – Does the software excessively default to .9 and .0 codes?
  – Are the guidelines available as a resource within the software?
  – Does the software include *Coding Clinic* and other resources?
Ignoring ICD-10-CM as a Resource for ICD-9-CM Coding

• ICD-10-CM implementation October 1, 2014, but …
  – When you are defending your coding and there is no written rule to support your coding, you can use ICD-10-CM to support your coding decisions in ICD-9 today

• How?
Ignoring ICD-10-CM as a Resource for ICD-9-CM Coding

How?

• Using ICD-10-CM guidelines not included in ICD-9-CM

• Blood work reveals that the patient has borderline neutropenia, which the physician attributes to long-term use of phenytoin used to treat the patient’s epilepsy

• No index entry for neutropenia under “Borderline”
• No index entry for borderline under “Neutropenia”
• No mention of “borderline” in ICD-9-CM guidelines
• Coding Clinic now supports ICD-10-CM guideline for ICD-9-CM

• Code neutropenia (HCC 45)
• If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

• You can infer from this guideline that coding the borderline neutropenia is acceptable.

• Report 288.03 Drug-induced neutropenia (HCC 45)

• Note: This rule also appears in Coding Clinic in 2012 in an entry regarding borderline pulmonary hypertension
Ignoring ICD-10-CM as a Resource for ICD-9-CM Coding

How?

• Using ICD-10-CM *excludes notes* to clarify ICD-9-CM excludes notes

2013 ICD-9-CM Guidelines  I.A.4

• ICD-9-CM has one excludes note with several possible interpretations:
  – Terms are excluded from the code and are to be coded elsewhere
  – Two codes may be coded together if both conditions exist
  – Congenital and acquired should not be reported together
Ignoring ICD-10-CM as a Resource for ICD-9-CM Coding

How?

• Using ICD-10-CM **excludes notes** to clarify ICD-9-CM excludes notes


• ICD-10-CM has two types of excludes notes. Each type of note has a different definition:
  – **Excludes1** is a pure excludes note meaning **NOT CODED HERE**! The code excluded should never be reported at the same time as the code listed above the Excludes1. For example, two conditions that can never be reported together such as congenital versus acquired for the same condition
  – **Excludes2** means “**NOT INCLUDED HERE**.” The condition excluded is NOT part of the condition represented. Excludes2 codes are acceptable to report together if appropriate.
• **Documentation states that the patient has a history of smoking, PVD, and atherosclerosis of the extremities. Patient is on Plavix.**
  – In ICD-9: PVD (443.9) **Excludes** atherosclerosis of the extremities (440.20)
  – Do I code both conditions?

  – In ICD-10: PVD (I73.9) **Excludes1** atherosclerosis of the extremities (I70.299)
  – Using ICD-10 as a resource for ICD-9, clearly we could not report PVD and atherosclerosis of the extremities together. In this case, atherosclerosis of the extremities is more specific than the general term “PVD,” which is what was coded.
Diabetes “with”

- Does your organization accept diabetes “with” for all associated manifestations as acceptable linkage?
  - What is the risk?
- Diabetes “with” cataracts
  - Is it safe to assume that ALL cataracts are caused by or are a manifestation of diabetes?

- *Coding Clinic*, second quarter 2009, page 15 states:
  - “In the ICD-9-CM Alphabetic Index, the subterm “with” means associated with or due to.” Therefore, if provider documentation indicates “diabetes with” another condition, it is appropriate to assign the appropriate diabetes etiology/manifestation combination codes.”
How can ICD-10 help you refine your diabetes “with” policy?

ICD-10-CM Guidelines  2.4.a

• The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08–E13 as needed to identify all of the associated conditions that the patient has.

• In ICD-10-CM, diabetes codes and manifestations have been combined as combination codes.
Tamoxifen refill

Patient is seen today for follow-up. Patient is 18 months post-mastectomy and has completed her chemo and radiation therapies but continues to be prescribed tamoxifen. She is here today for evaluation of her tolerance of tamoxifen and as a follow-up to her breast cancer.

For the outpatient coder, what is essential to capture for appropriate reimbursement?

How does this differ for a risk adjustment coder?
Tamoxifen

Coordination and Maintenance Committee Meeting agenda Sept 27-28, 2007:

The ICD-9-CM distinguishes between current cases of cancer and personal history of cancer. The use of long-term prophylactic agents to prevent recurrence of disease raises questions as to when treatment is actually complete. This issue was raised with Gyn-oncologists at ACOG. These agents are used to prevent recurrence and metastasis, so classifying their use as prophylactic is valid, regardless of whether a cancer code or a V code for history of cancer is used.
Expecting non-RA Coders to Code Accurately for RA

Prophylaxis OR active cancer:

- Anastrozole (Arimidex)
- Exemestane (Aromasin)
- Fulvestrant (Faslodex)
- Gonadotropin-releasing hormone (GnRH) agonist
  - Goserelin acetate (Zoladex)
- Letrozole (Femara)
- Leuprolide acetate (leupreolelin) (Lupron)
- Megestrol acetate (Megace)
- Raloxifene (Evista)
- Tamoxifen (Nolvadex)
- Toremifene (Fareston)

Reported with V07.5x
### Tamoxifen

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>174.9</td>
<td>Malignant neoplasm of the breast, unspecified</td>
<td>10</td>
</tr>
<tr>
<td>V10.3</td>
<td>Personal history of malignant neoplasm of breast</td>
<td>NO</td>
</tr>
<tr>
<td>V07.51</td>
<td>Use of selective estrogen receptor modulators (SERMs)</td>
<td>NO</td>
</tr>
</tbody>
</table>
A 73-year-old man presented with a firm node on his right upper arm. The node was biopsied and found to be a Merkel cell carcinoma. A surgical excision with wide margins followed.

Common coder error is to report malignant neoplasm of skin from the Neoplasm Table:
- Meets medical necessity requirements
- Doesn’t map to HCCs

Merkel cell carcinoma is more deadly than melanoma, and both conditions map to HCC 10
Expecting non-RA Coders to Code Accurately for RA

• Status codes often overlooked by regular coders, who focus on the presenting problem of the current encounter

  – HIV positive status       HCC 1
  – Amputation status        HCC 177
  – Renal dialysis status    HCC 130
  – Colostomy status         HCC 176
  – Transplant status        HCC 174
How does delaying the implementation of a CDI program impact patients, providers, and health plans?

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality of care</td>
<td>• Supports accountability</td>
<td>• Supporting documentation</td>
</tr>
<tr>
<td>• Continuity of or access to care</td>
<td>• Performance management</td>
<td>• Coding and billing</td>
</tr>
<tr>
<td>• Non-reimbursement for eligible conditions</td>
<td>• Reduced or denied payments</td>
<td>• Loss of revenue versus risk</td>
</tr>
</tbody>
</table>
What are the benefits of implementing a CDI team?

- Bridges gaps in communication between clinical and coders:
  - Improved specificity
  - Leads to quality coding
  - Improved reimbursement/HCC capture
  - Reflects the severity of the patient’s clinical condition and complexity of care
- Records are reviewed from both perspectives (clinical and coding):
  - Identifies gaps to close the loop in missed opportunities
  - Feedback to providers results in improved documentation NOW
  - Decreases RADV risk exposure
  - Identifies areas where providers can improve documentation leading to a clearer picture of the patient’s health status
- Supports other programs such as HEDIS and STARS
Delaying the Implementation of a CDI Program

- Complete
- Patient centered
- Timely
- Legible
- Clear and concise
- Accurate

Clinical documentation in the MR requirements
Delaying the Implementation of a CDI Program

Good clinical documentation improves care and closes gaps:

• Clinical documentation in the medical record must be:
  – Complete
  – Legible
  – Accurate
  – Clear and concise
  – Patient centered
  – Timely

• Documentation should include past and present conditions/diagnoses:
  – Complete history and ROS (includes medications, supplies etc.)
  – Reason for the encounter (face-to-face visit)
  – All relevant health risk factors such as PMH of smoking should be identified
  – All DXs supported by describing the patient’s treatment, assessment, and plan
Delaying the Implementation of a CDI Program

Who are the key players on your CDI team?

- Provider Advisor
- CDI Staff
- Coders
- Compliance
- QA Auditors
Delaying the Implementation of a CDI Program

Monitoring your CDI initiatives

• Reporting metrics tied to performance:
  – Provider report card (prospective feedback)
  – Identifies percentage of coding errors
  – Reduced ROI due to provider documentation deficiencies
  – Ability to analyze trends based on queries and feedback
  – Provider and coder education based on trends:
    • One-on-one
    • Group
    • Specialty
    • Team approach (clinical and coding)
  – Promote/incentivize the best documenters
  – Prepare for ICD-10
• Guidelines I.C.2.d.

• When a primary malignancy has been previously excised or eradicated from its site and there is **no further treatment directed to that site** and there is **no evidence of any existing primary malignancy**, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.
  – At odds with clinical perceptions regarding malignancies
  – At odds with documentation
  – Top RADV error
• Guidelines I.A.6.

• Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation.

• Report the manifestation, even when it isn’t risk adjusted
  – Most manifestations of 250.5x, 250.6x, 280.8x don’t map
  – Common RADV error
• Guidelines I.C.1.b.1).(b)(ii)

• Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. **If the causal organism is not documented, assign code 038.9, Unspecified septicemia**

• Sepsis and severe sepsis do NOT map
• The underlying infection (septicemia) DOES map

• Guidelines tell us to code the infection *even when it is not documented* if the documentation states sepsis or severe sepsis.
Underestimating the Importance of *Official Guidelines*

**Recommendations:**

- Once a year, read the *Guidelines* in their entirety
- Highlight guidelines pertinent to risk adjustment
- Make notes next to codes, referring back to the guidelines
- Managers can send out email reminder excerpts from the *Official Guidelines* regularly to keep concepts fresh in the minds of coders/auditors
- Remember, however:
  - “The instructions and conventions of the classification take precedence over guidelines.” -- from Introduction to *Guidelines*
Overlooking the Need to Audit Coders Regularly

• How can a good QA policy close the gaps in quality?

• Is a 5% to 10% audit of a coder’s work enough?
  – Does this give an accurate picture of a coder’s true quality?
  – If 50% of coding errors are “diabetes related,” what happens if none of these charts drop into the QA queue?

• For each new project, initiate a soft launch to determine whether coding methodologies are aligned:
  – Create coding specifications for each new project
  – QA 100% of the first 20 charts for each coder
  – Identify coding discrepancies by a coder and retrain areas when necessary
Target trends and HCCs/ICD-9 code ranges with high error stats

Use data mining with suspect member charts with a high probability of errors:
- Patient age
- HCCs
- Chart size
- No HCC found
- ICD-9 codes
- Variance reports from auditors

Is a 95% IRR score achievable?

Missed HCCs versus extra HCCs—What is your “real” risk?
Overlooking the Need to Audit Coders Regularly

- Is a “traditional” 95% IRR score achievable on an HCC project?
  - Roundtable discussion on the “elephant in the room”

- Missed HCCs versus extra HCCs

- What is your “real” risk?
4 Coding Diseases and Conditions Without Support

- CMS conducted a study that identified risk adjustment diagnoses likely to be associated with payment error and examined the reasons these diagnoses are problematic. Use of this guidance may help MA organizations select a medical record that best documents these error-prone diagnoses.

- The checklist and guidance is available on CMS’s web site at:
  - [https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/PaymentValidation.html](https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/PaymentValidation.html)

- The most common payment errors include:
  - Neoplasms stated as a history
  - Diabetes with “linked” manifestations requiring support for both components
  - Signature and credential deficiencies without proper attestation
What are the most common conditions submitted by MA plans for payment lacking adequate support?

- **Neoplasms** (such as prostate and breast) stated as a history (HCC 10) without evidence of current treatment:
  - Chase the oncology records to support these conditions per RADV checklist

- **Diabetes** with renal manifestations or peripheral circulatory manifestations that are not clearly linked by acceptable language showing a cause and effect (HCC 15)

- **Major depressive disorder** (296.xx) (HCC 55) overcoded due to assumptions from the work-up. Physicians must document the characteristics of the mood disorder (such as major, mania, single, recurrent). Conditions must be coded exactly according to the narrative provided by the physician
  - Reference: CMS Risk Training 2008, 6-8 Example 7
• What did RADV-style confirmation audit pilot 1 find?
  – 30% codes not confirmed due to lack of support in medical documentation
  – 30% codes date of service not present:
    • Which conditions accounted for the highest percentage of DOS not present? Why?
      – AIDS and mental disorders
• What were the top 10 codes (categories) unsupported? Is this consistent with national trends?
  – *Diabetes and diabetes with manifestations* accounted for 6 of the top 10 errors
  – AIDS/HIV disease (042) (HCC 1)
  – Cerebrovascular disease such as stroke (436) (HCC 96)
  – *Peripheral vascular disease* (443.9) (HCC 105)
  – Chronic hepatitis C (079.54) (HCC 27)
What did RADV-style confirmation audit pilot 2 find?
- % codes not confirmed due to lack of support in medical documentation

What were the top 10 codes (categories) unsupported? Is this consistent with national trends?
- **Diabetes** and diabetes with manifestations accounted for **4 of the top 10 errors**
  - Breast, prostate, colorectal, and other cancers stated as a history and coded as active (HCC 10)
- **Vascular disease** (HCC 105)
- Renal failure (HCC 131)
- Major depressive disorder (HCC 55)
- COPD (HCC108)
- Heart arrhythmias (HCC 92)
• Recommendations:
  – Target HCCs and ICD-9 codes with a high error percentage
  – Conduct a confirmation audit by provider, POS, HCC, and ICD-9 code level
  – Identify your risk for RADV
  – Determine loss of ROI including possible fines and paybacks
  – Analyze clinical data and compare with HCCs reported to RAPS
  – Tie your findings into your CDI initiatives
Keeping References and Resources Current

- Pharmacology—a critical key to substantiate support
- Anatomy & pathophysiology
- Update your guidelines
- Tips of the day
- FAQs
- Internet
Pharmacology—a critical key to substantiate support

• Support in the medical record is often substantiated by medications:
  – Prescribed
  – Should be linked to the condition/disease
  – Don’t forget about OTC medications (aspirin, ibuprofen, Zantac, Tums etc.)

• Optum ICD-9 code book:
  – Refer to pharmacological listings in the resources found in the back of your code book
  – Alphabetized list of drugs/agents by code category and disease
Keeping References and Resources Current

- Free drug reference is the #1 mobile drug reference for U.S. physicians
- Search brand, generic, and OTC medicines
- 50% of U.S. physicians use Epocrates
- Coders should too!

Source: Epocrates
http://www.epocrates.com/mobile/iphone/rx
Anatomy & pathophysiology

• Knowledge is critical for transition to ICD-10
• Identify deficiencies in body systems
• Beef up your skills now prior to ICD-10 training

Update your guidelines
• Staying current can mean the difference between making the QA grade or not
Tips of the day (TODs) and FAQs

• Send coding TODs and FAQs via email blasts
• Discuss challenging coding scenarios:
  – *Aortic stenosis* How do I code this?
    – According to the *Coding Clinic*, fourth quarter, 1988: Do not code valve stenosis automatically. Review documentation or query the physician to determine if the aorta or the aortic valve is affected.
    – Aortic stenosis 747.22 No HCC
    – Aortic arch stenosis 747.10 No HCC
    – Aortic valve stenosis 424.1 No HCC
    – *Arteriosclerotic stenosis of aorta* 440.0 HCC 105
Keeping References and Resources Current

ICD10 App for your iPhone

*iTunes has come out with a new app that allows coders to download the latest ICD-10-CM and ICD-10-PCS on your iPhone, iPod, or iPad. The 2012 ICD10-CM diagnosis codes can be searched and browsed by their traditional categories. Coders can search by code or diagnosis through all of ICD-10-CM or through just a category or selected nonspecific code. Images within the list indicate whether a code is specific or nonspecific. Simply tap to view the diagnosis and the full text of its standard ICD-10 long description and to add it to your Favorites list for access later.*

Assuming Coding Clinic Guidance Is Only for Inpatient

**Coding Clinic for ICD-9-CM**

- Published by American Hospital Association
- Official publication of advice as designated by AHIMA, AHA, CMS, and NCHS
- Published quarterly, but back issues necessary too
- $1,250 a year for comprehensive CD of past issues
  – Vendors offer it embedded into coding software at reduced rates
Assuming *Coding Clinic* Guidance Is Only for Inpatient

2008 Risk Adjustment Data technical Assistance for Medicare Advantage Organizations Participant Guide

6.4.1 Co-Existing and Related Conditions
The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM published at www.cdc.gov/nchs/icd9.htm and in the *Coding Clinic*
Assuming Coding Clinic Guidance Is Only for Inpatient

Aftercare Following Heart Transplantation Q3 2011

• Q: The patient had a heart transplant several years ago and now presents for an annual heart evaluation. There are no acute issues on presentation. How should this be coded?

• A: Assign code V58.44, Aftercare following organ transplant, as the reason for the encounter. ... Code V58.44 is intended for patients who receive an organ transplant and are seen on a routine basis to assess the functioning of the new organ ... Please note than an additional transplant status code (V42.0-V42.9, in this case V42.1) may be used with code V58.44 to provide additional information regarding the specific organ transplanted.

• V58.44 Aftercare following organ transplant NO HCC
• V42.1 Status heart transplant HCC 174
Ulcer, diabetic vs. decubitus, with osteomyelitis Q1

Q: A patient was admitted with complaints of continuous bleeding from a chronic ulcer of the left heel. The patient has type 2 diabetes, PVD due to the diabetes, ESRD, HTN, and status post right above-the-knee amputation. Because of gangrene and acute osteomyelitis from the heel ulcer, the patient underwent a left below-the-knee amputation. If the physician documents that the ulcer is a decubitus ulcer, the ulcer should not be reported as a diabetic ulcer. However ICD-9-CM assumes a cause-and-effect relationship between osteomyelitis and the diabetes so that a diabetic complication code needs to be assigned for the same ulcer. Does the decubitus ulcer have to be reported as a diabetic ulcer simply because of the osteomyelitis? What are the diagnosis code assignments for this case?
Assuming *Coding Clinic* Guidance Is Only for Inpatient

**Ulcer, diabetic vs. decubitus, with osteomyelitis Q1**

**Q:** ICD-9-CM assumes a cause-and-effect relationship between osteomyelitis and the diabetes so that a diabetic complication code needs to be assigned for the same ulcer. Does the decubitus ulcer have to be reported as a diabetic ulcer simply because of the osteomyelitis?

**A:** If the physician indicates diabetic osteomyelitis or the patient has both diabetes and acute osteomyelitis and no other cause of the osteomyelitis is documented, it would be appropriate to assign codes 250.80 Diabetes, 731.8 Other bone involvement in diseases classified elsewhere, and 730.0X Acute osteomyelitis. ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes. **In this case, the physician has indicated that the osteomyelitis is due to the decubitus ulcer, so the osteomyelitis would not be coded as a diabetic complication.**
## Ulcer, diabetic vs. decubitus, with osteomyelitis Q1

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>707.0</td>
<td>Decubitus ulcer</td>
<td>148</td>
</tr>
<tr>
<td>730.07</td>
<td>Osteomyelitis</td>
<td>37</td>
</tr>
<tr>
<td>785.4</td>
<td>Gangrene</td>
<td>104</td>
</tr>
<tr>
<td>250.70</td>
<td>Diabetes mellitus with circulatory complications</td>
<td>15</td>
</tr>
<tr>
<td>443.81</td>
<td>Peripheral angiopathy</td>
<td>105</td>
</tr>
<tr>
<td>V49.76</td>
<td>Status knee amputation</td>
<td>177</td>
</tr>
</tbody>
</table>

### With support:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>585.6</td>
<td>End stage renal disease</td>
<td>131</td>
</tr>
<tr>
<td>403.91</td>
<td>Hypertensive renal disease</td>
<td>131</td>
</tr>
</tbody>
</table>
1. Believing Your Education Is Complete

- Brush up on anatomy & physiology
- Conduct weekly team meetings to discuss trends
- Take an ICD-10 readiness assessment
- Create a professional development plan for every team member
- Attend conferences and local coding meetings
- Cross-train your HCC coders in non-HCC projects (HEDIS, HRAs, CDI)
1

Believing Your Education Is Complete

Brush up on your anatomy & physiology

- A&P is the cornerstone for accurate code assignment
- With transition to ICD-10 on the horizon, now is the time to take an advanced A&P course
- In a training program conducted for 200 RNs with no coding experience—A&P was the prerequisite:
  - Nurses had to achieve a minimum score of 80% to be invited to training
  - Nurses who scored above 90% performed better on HCC coding than those who scored <90%
  - Of 200 RNs with A&P training, only 14 (or 7%) were not invited to code on the HCC project
  - Quality scores for HCC coders with recent A&P education performed better than those with no A&P coursework

*Copy and paste this text box to enter notations/source information. 7pt type. Aligned to bottom. No need to move or resize this box.
Conduct weekly team meetings to discuss trends

• Get to know EVERY person on your team. Builds confidence, morale, and trust in managers and the organization as a whole
• Many RA coders work remotely, which presents managers with challenges on how to effectively keep coders engaged and informed
• Managers who conduct weekly meetings via phone or WebEx have an opportunity to close gaps in quality and performance:
  – Discuss coding trends identified during QA
  – Review charts as a team to collaborate and identify best coding practices
  – Poll the team (Would you code this? Why?)
• Share health care news in a variety of forums (health, wellness, new drugs and procedures used to treat and diagnose conditions, Coding Clinic advice, etc.)
Take an ICD-10 readiness assessment

- Get ready for ICD-10-CM. Part of your gap analysis and ICD-10 roadmap should include administration of an ICD-10 readiness assessment:
  - Identify weaknesses in anatomy & physiology
  - Identify body systems (code categories/blocks) where individual coders struggle
  - Invest in your coders’ education to close the quality gaps
  - Use the information to tackle coding deficiencies in ICD-9 now
  - Identify the best coders in your organization to assist with transition to ICD-10

Believing Your Education Is Complete
Believing Your Education Is Complete

Create a professional development plan for every team member

- Based on ICD-10 readiness assessment results, develop individual coder ICD-10 professional development plans
- Use this tool to achieve improved quality
- Incentivize coders based on quality and education
- Invest resources in your budget to reimburse coders for A&P and ICD-10 education:
  - Develop a reimbursement policy that is a “win-win” for the coder and your organization
  - Coders must agree to work with the organization for a period of time in order to achieve 100% reimbursement for education/training
Believing Your Education Is Complete

Attend conferences and local coding meetings

• In addition to attending national coding conventions such as AAPC and AHIMA, send coders to HCC-specific conferences
• Alternate who goes to which meetings. Often, staff come back with different priorities and lessons learned that can be shared with your team
• Get out of your comfort zone!
  – Ask coders on your team to prepare a 15-minute presentation on a specific coding topic. Share via WebEx. Builds collaboration and promotes a team effort
Cross-train your HCC coders in non-HCC projects (HEDIS, HRAs)

• Provides year-round employment opportunities
• Did you know that quality-driven coders make great HEDIS chart reviewers?
  – Coder trained in HEDIS measures abstraction
  – Quality was consistent with RN/LPN clinical abstractors
  – Digging for HCCs is very similar to digging for clinical documentation
• Mining supported diagnoses from an chart is a transferrable skill for coding and auditing health risk assessments:
  – HCCs have high value for ROI
  – Code all diagnoses (even those that do not map) utilizing HCC coders to ensure high quality
Sources of Government Guidance for RA Coding

• RADV reports
• 2008 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide
• *ICD-9-CM Official Guidelines for Coding and Reporting*
• *ICD-10-CM Official Guidelines for Coding and Reporting*
• *Coding Clinic for ICD-9-CM*
• YOUR OWN INTERNAL REPORTS

*Copy and paste this text box to enter notations/source information. 7pt type. Aligned to bottom. No need to move or resize this box.*
Thank You!
lpadilla@peakhs.com
sheri.p.bernard@gmail.com

Lynne Padilla, VP Coding Quality
Peak Health Solutions
505.228.1857
lpadilla@peakhealth.com

Sheri Poe Bernard, CPC, CPC-H, CPC-I
Poe Bernard Consulting
801.582.7000
sheri.p.bernard@gmail.com
Top 10 Errors in Risk Adjustment Coding

- 10 Trusting clinicians (or software) to code correctly
- 9 Ignoring ICD-10-CM as a resource for ICD-9-CM coding
- 8 Expecting non-RA coders to code accurately for RA
- 7 Delaying the implementation of a CDI program
- 6 Underestimating the importance of the *Official Guidelines to Coding and Reporting*
- 5 Overlooking the need to audit coders regularly
- 4 Coding diseases and conditions without support
- 3 Keeping references and resources current
- 2 Assuming *Coding Clinic* guidance is only for inpatient coders
- 1 Believing your education is complete