THE PATH FORWARD
Coding & PDPM

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Disclaimer

- This workshop was developed as a general educational offering and reference for long-term care professionals and is not intended as legal advice nor should it be a substitute for professional advice in any specific situation.
- To the best of our knowledge, it reflects current state and federal regulations and practices. The examples used do not represent the employer of the presenter or any preferred electronic health record system or health information technology.
- Information contained in this workshop must be considered in light of the individual organization.

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Objectives – Participants Will Review:

1. 1st Quarter results under PDPM/reconciliation with National Standards
2. **Redirected focus re: System Changes for Diagnosis Selection/ Sequencing/Coding Processes** and impact on quality of care and reimbursement
3. Roles/Responsibilities – Coding Accuracy
4. Evaluate tools used to facilitate and monitor compliance: Coding, Clinical Documentation, Performance Measures, QAPI

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PDPM First Quarter Results

- PDPM budget-neutrality is already over
- Independent studies have shown an overall increase in the daily payment rate:
  - CORE Analytics found Medicare reimbursements of $614.96 per patient day in October for the average SNF, compared with $562.89 under RUG-IV.
- Interim Payment Assessments done in October may slightly skew data, but the overall conclusion is payment increased with PDPM over RUG-IV

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PDPM – Early days

- Continued increase in payments under PDPM?
- CMS could impose parameters around the system to restore budget-neutrality
- Change in focus for therapy driven to acuity-based payment system has caused shifts in services rendered – reduction in utilization of therapy
- What does this mean for the SNF?
- **Facilities should prepare for the inevitable correction**[-1]
  - Watch for Proposed Rule FFY 2021 expected release April 2020

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Will your health record support your case?[-2]

- **Clear procedure needed** when the record is closed or if **same record is reopened** after resident is transferred to the acute and returns within the **Interrupted Stay Window** (3 Midnight Rule)
  - Has your policy and procedure been updated for chart closure?
    - Coordinated with Business Office / Billing for Medicare Skilled Days
    - Face Sheets updated upon return / Diagnoses updated
  - Utilize Interrupted Stay / Readmission Checklist used to ensure documentation is complete and consistent

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Interrupted Stay / Readmission Checklist

Check for the following:

- Nursing Admission Summary/Readmission Assessment with body diagram completed
- Skin Scale (Norton/Braden, Skin Trauma), Fall, Pain Assessments, if applicable
- Nurse's readmission Note
- Date/time of admission
- From where the resident was admitted, how admitted, accompanied by whom?
- Condition upon readmit, body description
- MD informed of admission, and orders verified
- Readmission orders or order to continue all previous orders

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Interrupted Stay / Readmission Checklist-2

- Bowel/Bladder re-evaluation if the resident's status has changed
- Update of H & P or Progress Notes, including consideration of capacity (Epple)
- Update of diagnosis/diagnoses obtained from MD if not present on Readmission
- Consents and T.B. screening as applicable
- Update care plan
- Medicare A Certification Interrupted Stay
  - Continue use of prior Certification if the resident returns within the 3-day window
  - Start a new Medicare A Certification when the resident returns outside the 3-day window

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Interrupted Stay / Readmission Checklist-3

Resident Assessment/MDS

- MDS Discharge Tracking form if out of the facility for 24 hours (or more, unless on therapeutic leave)
- Completed Entry Tracking form if Discharge Tracking Form indicated return anticipated or discharged prior to initial assessment completed
- Entry Tracking form will not be completed if the Discharge Tracking Form indicated discharge, return not anticipated
- Last 15 months MDS filed in the electronic record or manual record

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Interrupted Stay / Readmission Checklist_4

- If 3 months elapsed since last Comprehensive Assessment/MDS completed, a quarterly update done even though 15 months of the Comprehensive Resident Assessment/MDS forms copied/brought forward
- If return stay (not expected to return after discharge and does), a new Comprehensive Resident Assessment/MDS and a Care Area Assessment and Summary completed
- If readmitted (discharge return anticipated), a new Resident Assessment/MDS does not have to be completed
- If readmit and Discharge Assessment form indicates return anticipated, the previously completed MDS items A0500-A1600 copied/filed in the new record
- Discharge Assessment indicates return not anticipated, new MDS Identification Information (A0500-A1600) is completed with the date of new entry in item A1600

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Metrics Matter

- Key Indicators
  - Whether the quality measures (QMs) improve or worsen after any PDPM-related reductions
  - Goal: If rehab minutes go down
    - Pressure ulcers QMs don't decline
    - Readmission QMs are stable or improve
    - Functional scores improve

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Metrics Matter_2

- Measuring accurate diagnosis selection and ICD-10 coding performance
  - E HR system generated tools can detect incomplete or inaccurate codes
  - Using MDS scrubbers cue staff to inconsistencies in documentation
  - Consistent review of coding performance measures by an HIM professional
  - Review of billing errors/rejected billing

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Problems Encountered *Nationally*

- Per the American Health Information Management Association: **Facility coding guidelines are usually undocumented**
- Resulting problems
  - Diagnosis List – Diagnoses incomplete/not specific
  - Not everyone agrees on the facility coding guidelines

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Guidance for Coders

- Coding must reflect care to support billing
- **Collect consistent data/track changes of data collection from month to month, year to year (QAPI & Compliance)**
- **Specific coding guidelines necessary** for training clinical staff and coders

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Guidance for Coders$_{-2}$

- **Best practice for facility-specific coding guidelines:**
  - Put them in writing – HIM Consultant can assist you
  - Use Performance Measures to identify areas needing clarification or other guidance
    - Code descriptions in classifications do not necessarily reflect terms used between care providers, leading to errors in code selection
  - Review on an annual basis and update for changes to each code set as applicable to the SNF

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Official Guidance

- The ICD-10-CM Code book published by the Centers for Disease Control and Prevention (CDC) are the Official Guidelines for Coding and Reporting
  - Published annually and include revised, added, & deleted codes
  - These references can be used to respond to coding audits and claim denials
- American Hospital Association's (AHA's) *Coding Clinic for ICD-9-CM and ICD-10-CM*
  - *Published Quarterly by subscription*

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Official Guidance_2

- **National Center for Health Statistics ICD-10-CM Browser tool is available for use** https://icd10cmtool.cdc.gov/ Updates ICD-10-CM annually.
- User-friendly web-based query allows users to search for ICD-10-CM codes and **provides instructional info needed to understand the usage of ICD-codes. (i.e., includes, excludes, code first, code also)**.
- In addition to the new browser tool, ICD-10-CM and all approved updates to the classification are still available on this webpage for public use.
  - https://www.cdc.gov/nchs/icd/icd10cm.htm
- **Coding books published annually for Skilled/Rehab coding provide additional, specific care level guidance to coders not included in the search tool.**

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Tools

- **Use a Current** ICD-10 coding book
  - Using last year's coding book can result in incomplete, inaccurate codes
  - **Googling codes** and use of drop-down menus in the E HR system for code selection can result in incomplete, inaccurate codes due to lack of additional guidance that is provided in the code book directing the coder to the most accurate code selection
  - **National Center for Health Statistics Code Lookup Tool** – Although much more completed and accurate than Googling – if used alone without the code book may not get you to the most accurate code for SNF

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Tools-2

- Coding Performance Measures
  - Regular reviews
  - Analysis of findings
  - QAPI as needed
  - Share results with the team/train/retrain – competency-based
- MD Query Tools

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Acute Care Documentation – Where Do We Start?

DON or Administrator meet with Hospitals to establish electronic exchange of Health Information for admissions

CMS EHR Coding Interoperability Initiative – Share info with facility to use when approaching hospitals about data sharing

Handout → HO1a_EHR MedicarePromotingInteroperabilityProgram

HO1b 2020 PI Fact Sheet 2019 10 08.pdf

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Obtain Acute Hospital Documentation-2

Acute hospitals with exchange capability **motivated to do** so because:

- Points awarded for sharing data electronically will be considered a meaningful **EHR user under the initiative and avoid a negative Medicare 2+% payment adjustment (VBP)**

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Obtain Acute Hospital Documentation-3

Timely and complete transfer of information contributes to decreased rehospitalization rates

Win-Win – the acute care hospital and SNF are both subject to reimbursement penalties related to preventable readmissions within 30 days

Acute documentation diagnoses alert SNF upon admission of conditions defining potentially preventable readmissions

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Acute Hospital Documentation-4

- Acute care documentation used to determine admission diagnoses
  - Accessible for review by clinical staff **timely,** as needed
  - If scanned into the record
    - Can be systematically retrieved
    - Scanned and named consistent with facility policy
  - Acute Discharge Summary usually not available upon transfer – Is Medical Records following up to obtain a copy or is it available via the Acute Care Portal?

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Diagnosis Selection, Sequencing Coding – Systems in Place

1. Admission Diagnosis worksheet/NTA checklist used to assist with diagnosis selection/sequencing

2. MD **Query Tool** in use to obtain most specific, complete diagnosis to support reimbursement?

- Medical Records **monitoring Physician Orders complete with diagnosis**, documented in the record by MD
- Diagnosis added to the Diagnosis List and correctly coded = **$$**

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Diagnosis Selection, Sequencing Coding – Systems in Place-2

3. Morning clinical meeting or daily PPS meeting to discuss new admissions/diagnoses/changes in condition

- Set the stage for coverage:
  - New admissions/Readmission
  - Or continued coverage if there is a question regarding the diagnosis and services needed
  - Or consideration for Interrupted Payment Assessment

4. **Coding Performance Measures** in place

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Diagnosis Selection, Sequencing Coding – Systems in Place-3

Admission Diagnosis Worksheet**

Cue staff to abstract Diagnoses from Hospital and SNF Medical Records for:

- **Principal Diagnosis** – must map
- Speech Language Pathology Comorbidities/Non-Therapy Ancillary Comorbidities and related diagnoses = $$ – must map
- Nursing Case Mix Comorbidities = $$

Use Admission Diagnosis Worksheet along with NTA checklist** and surgical categories checklist

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Admission Diagnosis Worksheet-2

	Diagnoses – be specific	ICD-10 Code
1.	ACUTE POSTHEMORRHAGIC ANEMIA	D62
2.	SEVERE PROTEIN CALORIE MALNUTRITION	E43
3.	PRESSURE ULCER OF SACRAL REGION, STAGE 4	L89. 154
4.	CHRONIC RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA	J96.10
5.	GASTROINTESTINAL HEMORRHAGE, UNSPECIFIED	K92.2
6.	UNSTEADINESS ON FEET	R26.81
7.	MUSCLE WEAKNESS (GENERALIZED)	M62.81
8.	MALIGNANT NEOPLASM OF UNSPECIFIED OVARY	C56.9
9.	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED	F32.9
10.	ANXIETY DISORDER, UNSPECIFIED	F41.9

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Admission Diagnosis Worksheet-3

	Medical Diagnoses		
	Amputation – specify site and laterality ☐ Prosthesis care [5]		Asthma ♦
	Cardio-Respiratory failure & Shock ♦*		Cerebral Palsy [3]
	Chronic Lung Disease ♦		Chronic Myeloid Leukemia ♦*
	Cirrhosis of the Liver ♦*	✓	COPD [2] ♦ ✓☐ Shortness of breath while lying flat
	Intractable Epilepsy ♦	✓	**Malnutrition (or at risk for) ♦**

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Admission Diagnosis Worksheet-4

✓	**Pressure Injury upon admission Stage 4 ♦ [✓]*Review Skin Treatment Sheet Site: Coccyx Laterality: Stage 4**		**Chronic Ulcer upon admission/ ♦ ☐ *Review Skin Treatment Sheet ☐ Diabetic ☐ vascular ☐ Foot Ulcer/infection/open lesion Site: Laterality: Severity**

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Admission Diagnosis Worksheet-5

	Traumatic Brain Injury I5500 (SLP) S06.xxx Sequela:	✓	**Physical Therapy Treatment Diagnosis: Unsteady on Feet PT R26.81**
✓	Occupational Therapy Treatment Diagnosis: Muscle Weakness OT M62.81		Speech Therapy Treatment Diagnosis:

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NTA Checklist

	Condition/Extensive Service	Source	Points
☐	Lung Transplant Status	MDS Item I8000	3
☐	Major Organ Transplant Status – Except Lung	MDS Item I8000	2
✓	Malnutrition	MDS Item I5600	1
☐	Morbid Obesity, BMI Index >40	MDS Item I8000	1

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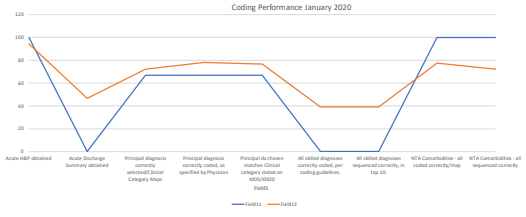
Measuring Performance



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Coding Performance Measures-1
Acute Care Documentation

1. Acute H&P obtained
2. Acute Discharge Summary obtained

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Coding Performance Measures
Principal Diagnosis

3.	Principal diagnosis correctly selected/Clinical Category Maps if N0 = return to provider* Medicare $$$
4.	Principal diagnosis correctly coded, as specified by Physician (Query??)
5.	Principal diagnosis chosen matches Clinical category coded on MDS/I0020 (MDS accuracy)

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Coding Performance Measures
Principal Diagnosis$_{-2}$

- **UHDDS Definition of Principal Diagnosis:** Condition established after study, chiefly responsible for the admission to the hospital or a condition that was treated at the hospital that affects the treatment being received and/or the length of stay
- Must
  - **Be an active diagnosis**
  - Support the need for skilled services – cannot be a chronic diagnosis that does NOT justify skilled services

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Coding Performance Measures
Principal Diagnosis$_{-3}$

- **Resolved Conditions:** Do not include conditions that:
  - Have been resolved
  - Do not affect the resident's current status, or
  - Do not drive the residents plan of care during the 7-day look-back period
  - **These would be considered inactive diagnoses**
- **CMS still expects correct coding practice** (not going by highest paying category – unless 2 equally qualifying Principal diagnoses)

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Coding Performance Measures
Principal Diagnosis – Problems encountered-4

- Bottlenecks
  - Acute care documentation not available timely
  - Clinical Team not abstracting/compiling diagnosis list for coding timely
  - Diagnosis conflict/unclear – NO MD query or MD not responding to Query
  - Diagnosis not coded / entered into system timely by coder

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Coding Performance Measures
Principal Diagnosis – Problems encountered-5

- Disagreement over Principal Diagnosis Selection – Who makes the final decision?
- Change in principal diagnosis may result in conflicting information in the record
- i.e., Therapy diagnoses selected medical diagnosis as entered into the system
  - Principal diagnosis changed by clinical team without communication to therapy = Therapy eval medical diagnosis no longer matches newly assigned Principal Diagnosis

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Performance Measures
Secondary Diagnoses/Comorbidities

6.	Skilled secondary diagnoses correctly coded, per coding guidelines Medicare/Case Mix $
7.	Skilled secondary diagnoses sequenced correctly, in top 10 Medicare/Case Mix $
8.	NTA Comorbidities - all coded correctly/map - PDPM Case Mix $$$
9.	NTA Comorbidities - all sequenced correctly - ↑ In top 10 UB-04
10.	SLP Comorbidities - all coded correctly/map - PDPM Case Mix $
11.	SLP Comorbidities - all sequenced correctly - ↑ In top 10 UB-04

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Performance Measures

Secondary Diagnoses/Comorbidities_2

- **Non-Therapy Ancillary (NTA) and Speech Language Pathology (SLP) Comorbidities**
  - **List after Principal reason(s) for admission to make sure they appear on MDS/I8000, if needed = $$$**
  - If E HR system does NOT include comorbidity mapping staff should be checking NTA and SLP mapping to ensure that those must be on MDS/I8000 have the correct code and sequencing
- Nursing Case Mix diagnoses and therapy diagnoses are part of skilled coverage
  - Sequenced after the NTA and SLP Codes

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Performance Measures

Secondary Diagnoses/Comorbidities – Problems Encountered_3

- Secondary diagnoses coded on the MDS not supported by MD documentation of the corresponding diagnosis
- **Example** – Can facility code for at risk for malnutrition (not actual malnutrition) without an MD diagnosis – just on symptoms/situation alone?
- NO: All diagnoses coded in section I need the same documentation following the RAI rules, including what makes a diagnosis active
- If screening indicates 'At risk for malnutrition' – query the physician or extender. Their documentation is required before you can code the diagnosis

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MD Query – Malnutrition

To Primary MD: _____ **Query Date:** _____

Issue: 92 y/o resident: BMI <18, poor appetite, eats <50% of most meals refuses supplement

Malnutrition – Please clarify diagnosis

☐ At risk for malnutrition
☐ Mild protein calorie malnutrition
☐ Severe protein calorie malnutrition
☐ Undetermined
☐ Malnutrition
☐ Moderate protein calorie malnutrition
☐ Other _____

_____ MD Signature

_____ Date

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Anther Common NTA Question

- Can the morbid obesity codes be assigned if the BMI is less than 40 when physician documents a morbid obesity diagnosis?
- You can assign the E66 morbid obesity code if it is:
  - Specifically documented by the provider, even if the BMI is <40
  - Per ICD-10 Convention I.A.19. Code Assignment and Clinical Criteria, "diagnosis code is based on provider's diagnostic statement that the condition exists and statement that the patient has a particular condition is sufficient"
  - Code assignment not based on clinical criteria used **by the provider** to establish the diagnosis
- Nursing documentation should support health-related conditions related to morbid obesity

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To Primary MD: Query Date:
Issue

Obesity

[ ] They have a BMI of =/>35 and is experiencing obesity related health conditions such as:
[ ] High blood pressure [ ] Heart disease [ ] Diabetes mellitus type 2
[ ] Sleep apnea [ ] Depression [ ] Urinary incontinence
[ ] 100 pounds above IWR
[ ] Obesity
[ ] Obesity with alveolar hypoventilation/hypoventilation syndrome
[ ] Morbid obesity
[ ] Adrenal obesity
[ ] Drug-induced obesity
[ ] Familial obesity
[ ] Severe obesity
[ ] Specified type _____

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Performance Measures

Secondary Diagnoses/Comorbidities
Problems Encountered_4

- Conflicting documentation of a diagnosis in acute care documentation, i.e., active vs inactive – confirmed diagnosis vs rule out diagnosis
  - MD query needed to obtain the accurate diagnosis for coding
- Using Laboratory Results to obtain a diagnosis is not acceptable – for example using GFR lab results to stage Chronic Kidney Disease
  - Must query the MD for the diagnosis
- Does staff have
  - Guidance **as to when they should query physicians for clarification of their documentation?**
  - **MD query tools to solicit valid diagnosis documentation for the medical record?**

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Performance Measures
Secondary Diagnoses/Comorbidities
Problems Encountered-5

- **Updating diagnoses**
- **Must review the SNF H&P after MD initial visit** and add or revise the diagnoses as needed
  - Done at morning clinical meeting or daily PPS meeting
  - Conflicting or incomplete diagnoses may result in inaccurate charting and denial of claim

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Performance Measures
Secondary Diagnoses/Comorbidities
Problems Encountered-6

- **Changes in diagnoses communicated to the coder**
- Timely coding and inclusion in the diagnosis list
- **Face sheets reprinted** that include new diagnoses
- Medicare Certification reflects conditions being covered
- Daily Skilled charting reflects care and treatment based on medical necessity, skilled coverage

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Performance Measures
Secondary Diagnoses/Comorbidities-7
Problems Encountered

- Nursing staff assigning an ICD-10 code when writing a new order may result in inaccurate code assignment
- New diagnoses should be identified as part of the Change of Condition Monitor and coded by the assigned coder
- Not utilizing system checks available to
  - Alert for incomplete or incorrect codes
  - Identify inconsistencies between codes on the MDS and lacking/conflicting codes on the Medical Diagnosis List

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Performance Measures
Therapy Diagnoses

12.	Therapy treatment diagnoses coded and in computer timely (7 days) – Part of PDPM Case Mix $
13.	Therapy treatment diagnoses - all sequenced correctly – Sequence after Nursing Case Mix – still in top 10
14.	Therapy evaluations reflect correct medical condition diagnoses – Matches I0020b

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Performance Measures
Therapy Diagnoses-2

- Therapy evals assigned medical diagnosis must match facility assigned principal medical diagnosis
- If not, why? Common issues:
  - Therapy starting on the weekend prior to assignment of the Principal Diagnosis by Clinical Staff
  - Principal Diagnosis not entered in the system timely
    - Diagnosis List not completed by clinical team
    - Codes not entered in the system timely by coder
  - Lack of communication between therapy and clinical staff

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Performance Measures
Therapy Diagnoses-3

- Therapy clarification orders should have diagnosis to support therapy
- Treatment diagnosis specific for each therapy discipline
- Analyze Rehab code assignments across the board – What patterns are emerging?
- Using the same few codes for all residents may result in CMS review
  - Discuss with Director of Rehab
  - CMS expects resident specific treatment conditions listed – Therapy treatment diagnosis should differ based on the resident
- Diagnoses must be resident specific, patient-centered, individualized

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Coding Performance Measures Other Diagnoses-1

15. Aftercare codes assigned correctly, based on coding guidelines. Aftercare codes are not used in conjunction with codes with a seventh character extension for the episode of care (Fractures, Injuries) Updated codes for fractures in 2020

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Coding Performance Measures Other Diagnoses-2

16. Injuries correctly coded, with correct 7th character, based on coding guidelines and chart specificity. Caution Codes with Acute "A" suffix map – Must use appropriate SNF "D" or "S"
17. Non-traumatic head injuries (CVD) correctly coded with I69 code. Common error using I60-63 Acute care only – these map but are not the correct code for SNF
19. All DM complications correctly coded, per coding guidelines and chart specificity – NTA $$$

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Coding Metrics show the trends

Key areas of non-compliance – **Focus your Efforts**	Oct	Nov	Dec	Jan
2. Acute Discharge Summary obtained	0%	0%	25%	
3. Principal diagnosis correctly selected. $$	90%	70%	95%	
4. Principal diagnosis correctly coded, as specified.	90%	80%	95%	
6. Top 10 secondary diagnoses correctly coded, included all skilled diagnoses. $$	70%	90%	100%	
8. NTA Comorbidities - all coded correctly/map. $$	33%	100%	90%	
10. SLP Comorbidities - all coded correctly/map. $$	67%	75%	85%	
14. Non-traumatic head injuries (CVD) correctly coded with I69 code) $$	67%	80%	100%	
15. Aftercare codes assigned correctly, based on coding guidelines/not used in conjunction w/ codes with 7th character extension for the episode of care (Fractures, Injuries) $$	67%	75%	85%	
19. DM correctly coded, per coding guidelines and chart specificity. NTA $$	50%	40%	50%	

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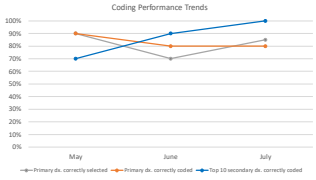
Metrics Provide Actionable Intelligence

- How will the information collected inform your next steps in the development of a performance improvement plan?



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Step Back and Analyze

- Coding Performance measure trends versus
  - Changes in Quality Measures
  - Rejected billing
  - Medical Records Consultant/Clinical/MDS Consultant Reports
- QAPI areas not meeting established benchmarks – root cause analysis
  - Identify bottlenecks that affect accurate, timely coding
    - Analyze processes starting with admission
    - See HO7_Coding Flow chart – where are your issues arising? Solutions?
  - Revisit tools used for efficacy, process issues, consistent use
  - Consider need for additional training
  - Clarify guidance to staff

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Facility Specific IPA Policy

- Should an Interim Payment Assessment be considered with the addition of new diagnoses?
  - Who decides?
  - When?
  - Process?
  - Using the CMS Grouper Analyze each component – estimate what the new score would be based on current condition
- Staff aware of and follows facility Interim Payment Assessment Policy Guidance

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Coding Staff/Systems

- Coding training completed for PDPM for:
  - Coders, backup coders ✓
  - Clinical staff who assign and sequence diagnoses ✓
- Are backup coders given opportunity to code with evaluation of performance?

TIME TO EVAULATE PERFORMANCE

Post-training competency evaluations for ALL coders

Targeted re-training based on results of objective performance measure data evaluations and coding reviews

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Coding Evaluation Tools

ICD-10 Coding Quality Performance Measures – Performed by Health Information Consultant at prescribed intervals

- Reports to Administrator
- Focus training/re-training on most common errors that affect
  - Reimbursement
  - Accuracy of the record – incorrect, incomplete conflicting documentation of the diagnosis
- Explores reasons for performance measure errors
  - Wrong code versus incorrect diagnosis provided to the coder

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ALERT

- Issue on PCC where NTA codes being picked up under two codes and showing points twice on Medical Diagnosis List… In any area where you are scoring under an NTA comorbidity category you will only be awarded the allowable points once in that category
- i.e., Specified Hereditary Metabolic/Immune Disorders MDS Item I8000 1 point
- If resident has two disorders you still only get one point even though the two codes will appear on the Medical Diagnosis list twice – once for each diagnosis

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Problem – Analysis – Improvement Plan

- Conflict between instructions for coding in the RAI Manual v17.0 and the official ICD-10 Coding Guidelines
  - MAY BE A CHALLENGE FOR FACILITY – PLAN AND UPDATE
- Code may map on the mapping tool and in your computer system but are not correct codes for use in the SNF
- Computer system changes and tools designed to assist with selection of codes still need the human touch to review for correct application based on coding and reimbursement rules

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Analysis of Coding Trends

HIM Consultant can assist you to identify causes of errors:

Acute care documentation not available timely or data received not incorporated into the record

- Operative reports not utilized for coding section J Surgery codes **($$)** and possible Section I Diagnosis/Codes
- Labs not available/reviewed for underlying cause of infections = **Incomplete or incorrect code used**
- Discharge Summary from Acute (MD has 14 days to complete) included additional diagnoses not yet coded = incomplete codes/possible conflicting diagnostic information in the record (**legal and billing risk**)

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Analysis of Coding Trends-2

HIM Consultant can assist you by:

- Providing, analyzing, and summarizing coding trends/issues
- Set coding accuracy performance goals/thresholds
- Draft QAPI

Facility Reports significant trends at QAA

QAPI errors based on frequency, prevalence, or risk

Plan changes… then change!

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Recent Developments

- Health & Safety Code § 1418.8 – Epple Bill
- The Court of Appeal Ruling in *CANHR v. Chapman/Smith* (Additions to the Statute) – New documentation requirements
- Next Steps:
  - Identify current residents who, as determined by MD, lack capacity to make healthcare decisions and have no resident representative
  - Notification of determination and rights for current and all new residents who fall under Epple

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Recent Developments_2

- Modify existing Ethics Policy/IDT substitute Decision-making to reflect new requirements for:
  - IDT committee members and documentation of determinations made in meetings
  - Notification of Current and New Residents
  - ID Appointment of Resident Representative

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