Optimizing ICD-10 Coding for PDPM

A Management Perspective

PRESENTED BY

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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.

Objectives – Participants will identify:

PDPM and Coding Management plans to:

1. **Change System Processes** and $$$ impact
2. Key on the
   - Administrative Roles/Responsibilities on the Coding Accuracy
   - Staff roles related to coding – MDS, DON/Direct Care Nursing Staff, Coders & Physician's , IDT, & Therapies
3. Develop and or utilize tools to facilitate coding, clinical documentation, Performance Measures, QAPI

Get Systems in Place Today!

Communication – *hospitals, ID Team, Physicians, Administration*

ICD-10 Training – education, communication, practice, evaluate – QAPI as needed; use your HIM Consultant resource

MDS Accuracy – education, timely completion, ongoing monitoring, system improvement

Quality of Documentation – support skilled medical necessity, MDS coding; nurse leadership involvement; education; system improvement – Documentation Review early

Plan Change – then CHANGE!!

Admissions Process/System

- DON or Admin **meet with Hospitals** to establish electronic exchange of health information for admissions
- HIM Consultant /Admin – Set up **tracking for completeness of transfer documentation** from hospital paper and electronic*

Plan Change – then CHANGE!!-2

Physician's/Documentation requirements

- *Admin* –
  - **Meet with Medical Director** re: Clinical Documentation Improvement Program (CDI)
  - Schedule **Physician Orientation** to PDPM and CDI
- *HIM Consultant* –
  - **Develop/Adopt Tools for CDI including MD query**
  - Set up **MD query tracking** tools/reporting system
  - Support Admin; meet w/ Medical Director

Plan Change – then CHANGE!-3

Medical Records Coding Staff/Systems

- ***Admin***/DON
  - Schedule **coding training for PDPM** for coders, backup coders, MDS and clinical staff who assign and sequence diagnoses
  - Work with HIM Consultant to develop or adopt **coding accuracy performance measures/metrics/reporting** system tools
  - Set up **coding accuracy evaluation** schedule
  - Set up **follow-up training** based on results of coding performance evaluations

Plan Change – then CHANGE!!-4

Medical Records Coding Staff/Systems (continued)

- ***Admin***/DON
  - Install/**test updates to ICD-10 coding entry into computerized diagnosis list**
  - **Start coding for PDPM by third week in June***
- ***Admin***/Medical Records – **Purchase ICD-10 Coding book** for 2020 (Ready for use on October 1, 2019; place order early)

Plan Change – then CHANGE!!-5

Billing System

- ***Admin***
  - Set up **monthly reporting of rejected billing** due to coding inaccuracy to Admin/Medical Records/HIM Consultant
- ***Admin***/HIM Consultant –
  - **Trend data**
  - Schedule **follow-up training/system modifications** as indicated by error type

Plan Change – then CHANGE!!-6

Clinical Systems

- DON/MDS/Medical Records
  - Adapt **Admission Diagnosis Coding Worksheet/related tool**
  - Set up/analyze **coding process work flow HO #1**
    - Identify *bottlenecks* in system
    - Revise as needed

Plan Change – then CHANGE!!-7

Clinical Systems

- DON/MDS
  - Review and revised Medicare Documentation tools
  - Medicare Certification form/process – Include specific reason for coverage that matches billing/Clinical Documentation
  - Medicare Charting Guidelines to support PDPM – Assigned Nursing/NTA comorbidity category

Plan Change – then CHANGE!!-8

Clinical Systems

- DON/Admin consider adopting Care Management Software to assist nursing staff in writing skilled documentation

Plan Change – then CHANGE!!-9

IDT Coordination

- **Therapies Medical Records/DON**
  - **Review system** for use selected principal diagnosis and communicate therapy diagnoses for coding
- **MDS Coordinator**
  - Regularly makes **IDT aware of the ARD** for timing completion of portions of the MDS (i.e., BIMS, PHQ-9, Behavioral, Discharge Planning)

Plan Change – then CHANGE!!-10

Diagnosis Review System

- ***Admin*** consider automation – E HR system add-on alerts for MDS/Diagnosis List matching
- ***Admin***/DON/MDS – Process in place for maintaining an accurate diagnosis list including when an Interim Payment Assessment **(IPA) is done**
- MDS review ICD-10-CM codes prior to completion of MDS for missed/inaccurate diagnoses – **automated check vs manual review**

Plan Change – then CHANGE!!-11

Policy Changes – IPA

- *Admin*/DON
  - Draft/finalize IPA Policy
  - In-service staff/consider coding workflow
  - Assess need for additional staff required to complete the MDS/IPA during transition (1st week in October)

Plan Change – then CHANGE!!-12

QAPI Coding/Billing rejections/Clinical Documentation to support medical necessity/PDPM

- Admin/DON/Billing/HIM Staff and Consultant
  - Trend performance measures
  - Establish compliance thresholds
  - Analyze bottlenecks in the coding process work flow
- QAPI Team
  - Initiate QAPI based on performance
  - Report results/corrections to QAPI Team and QAA Committee

Other Impacts – NO SNF CONTROL

Physicians are not employed by the facility and may not respond timely or at all to inquiries

Hospital documentation

- Not completed timely
- Not provided to the facility at transfer or upon request

Managed Care Providers not adopting PDPM – No more RUGS-IV levels

- May cause some issues during transition

What do I need to know? Getting into the weeds…

Process Changes – Preadmission

- **Receipt of acute documentation** – **TIMELY RECEIPT = $$$**
  - Establish methods for obtaining acute documentation
    - Via electronic portal from the hospital
    - MRD keeps track of what % is timely via Admission Monitoring
      - H&P's, Labs, X-rays and other studies, Operative Reports, Progress notes, Consults
      - Discharge summaries – *Note: MD has 14 days to complete at the acute hospital*
    - **Trend with hospitals**

Getting the Right Diagnoses

Starts prior to admission – what are you getting at the inquiry?

Clinical Documentation Improvement (CDI) process (Physician specificity of Diagnosis to code/bill correctly)

Same as in the acute hospital;

Supporting clinical documentation for each of the diagnoses for accurate coding

Physician Orientation

Involve the Medical Director in the process of engaging the physicians

ORIENT physicians

- Complete and timely diagnoses
- Response for additional diagnostic information to support coding and billing – Use MD Query Process (as done in Acute Hospitals)
- Set a goal date to roll out MD awareness and education Program
- See HO #1 Physician Role/PDPM Implementation

Physician Orientation-2

- **Review**
  - Diagnosis list (on skilled residents) for all current diagnoses
    - specificity of the active diagnoses – i.e. fractures – traumatic vs. pathologic, laterality, complications, type of diabetes, asthma, pressure ulcer sites, acute vs chronic conditions, etc.
- Facility staff will be asking MD to clarify if any diagnoses are conflicting or lacking documentation
- *MD office billing diagnoses must MATCH the resident chart*

Administrator	Do you have the following processes/systems in place?

MD Query Process

Different methods:
- Via telephone orders* – must be specific
- Via progress notes
- Use of "query" form
- Printing diagnosis list for MD signature

must have supporting MD documentation in chart signed and dated!

System to Track response to queries and trend

See HO #2 MD Query Log

Documentation Based on Selected Codes

SYSTEMS:

1. Staff using **Query Tool** to obtain most specific, complete diagnosis to support reimbursement?

2. Medical Records **monitoring Physician Orders**
- Complete with diagnosis, documented in the record by MD

3. Coding performance Measures in place
- Diagnosis correctly coded and added to the Diagnosis List **= $$**

Medicare Review and Coding Accuracy

THESE ARE THE RULES

ICD-10 coding edits – Medicare Beneficiary Claims Manual pg. 31

MACs, CERT, Recovery Auditors, and ZPICs shall
- **apply coding guidelines** to services selected for review
- **determine that an item/service is correctly coded when it meets all the coding guidelines listed International Classification of Diseases Guidelines (ICD-10) For Skilled Nursing**

How will I know I'm in compliance?

Administrative Information System

What **you** were paid = what was billed?

No ADRs
- MACS $$ paid as billed

NO ZPICS

THE RULES ARE MET BY REGULAR REPORTING/QUALITY MONITORING RESULTS

Diagnosis Selection/Coding Compliance – Admin Informed

Rule #1 Resident's principal diagnosis maps into one of Ten PDPM clinical categories – ICD-10 codes assigned for Principal Dx. listed as "Return to Provider" may result in denied claims

Rule #2 Additional ICD-10 codes capture documented secondary diagnoses and comorbidities = $$
- i.e., HIV/AIDS will result in an 18 percent add-on to the nursing payment component

Rule #3 Correctly coded diagnoses drive the 5-day assessment/sets the payment rate for the entire stay
- No longer driven by therapy minutes

Diagnosis Selection/Coding Compliance – Admin Informed-2

Rule #4 Staff familiar with/use mapping tools **and** ICD-10 Coding sequencing rules

How will you check compliance?
- **Rule #5** Ongoing performance evaluation and quality monitoring
  - Computer system alerts used or CMS PDPM Mapping Tool – Clinical Category for Primary Diagnosis
  - Coding performance measures eval for correct assignment/sequencing of diagnoses/codes
- Rule #6 Identify issues now and come up with a plan

Coding for PDPM should have begun by 3rd week of June

Coding Skill Competencies – Admin Informed

Training for **ICD-10 coders** – staff who code regularly and backup coders
- MDS
- Medical Records

Establish Performance Measures/competencies to evaluate coding skills, accurate billing practices

Begin **regular review** using coding performance measures by HIM Consultant – **Trend results** – Report to Admin – **Performance Metrics**

Ongoing education based on identified areas of need/risk – coding updates

Establish QAPI for areas of non compliance

Unresolved Issues… Admin Informed

Are you staff aware of the 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!**

Skilled Documentation Evaluation – Admin Informed

Nursing staff
- Medicare Certifications specify which services are being covered **based on qualifying diagnoses**
  - No more just checking off PT, OT and Speech on the Medicare Cert
  - Skilled documentation = documented diagnoses = billing
- All billed diagnoses are linked back to assigned ICD-10 codes

Best Practices

Clinical Documentation Improvement – CDI – Best Practices

ADMINISTRATOR/Medical Director have adopted CDI PROCESSES

Focus on **documentation for PDPM** diagnosis related payment methodology
- Must **reflect patient acuity** which drives reimbursement

Defined SNF specific CDI program

Foster collaboration between coders and those serving in the role of CDI specialist and MDS coordinator

Provide the right tools to assist staff and physicians

Why do I need CDI?

More complete diagnostic information may = more $$$

CDI includes obtaining:
- Complete hospital record – Hospital Discharge Summary, Operative reports, Interfacility Transfer Report Acute MD Progress Notes/Consults which may be omitted during the transfer/admission process
  - *Unit clerk or medical records can assist in obtaining these*
- Complete SNF documentation of diagnoses by MD/Consultants upon admission H&P/Progress Notes (Updated as new conditions arise)

Tools for the Job

MD query templates, query tracking tools, CDI tip sheets, and physician education materials needed to:

- Clarify specificity of diagnosis
- Select principal diagnosis and comorbidities – why is the resident receiving skilled services?

Admission Diagnosis Worksheets, Medicare Charting Guidelines, computer software to ensure:

- All current/relevant diagnosis captured
- Nursing documentation supports medical necessity as well as information reported on the MDS

CDI tools

Query templates for your most common diagnoses to obtain specificity

See HO #3 MD Query CHF

Query tracking tools

- Are coders querying MD when lacking a diagnosis or diagnosis is non-specific?
- Are physicians responding to queries?

CDI tip sheets and physician education materials

See HO #4 Physician Role/PDPM Implementation

Nursing Staff Tools Updated for PDPM

Admission Diagnosis Worksheets

- Cue staff to abstract Hospital and SNF Medical Records for
  - Principal Diagnosis – must map
  - SLP Comorbidities /NTA Comorbidities and related diagnoses = $$$
  - Nursing Case Mix Comorbidities = $$$
  - SEE HO #5 Admission Diagnosis Worksheet Sample / use with NTA checklist and surgical categories checklist

Nursing Staff tools updated for PDPM-2	**Review and Revise Skilled Documentation Charting Guidelines** **Technology** – Consider Care Management Software to assist nursing staff in writing skilled documentation to support care and reimbursement that aligns with the MDS

Coding Skill Competency Tools	▪ICD-10 Coding Quality Performance Measures – Performed by Health Information Consultant at prescribed intervals ▪ Reports to Administrator ▪ Follow-up training provided as needed ▪ Focus training/re-training on most common errors and ▪ Errors that affect reimbursement ▪QAPI ▪HO #6 ICD-10 Coding Skills Quality Performance Measures ▪HO #7 Coding Metrics ▪HO #8 Coding QAPI

Looking ahead

ICD-10 Coding Changes

Changes are coming…

- **ICD-10 Coding** for 2020 (Ready for use on October 1, 2019)
- Updates to the 2020 coding were released by CMS **June 21, 2019**
  - **71932** codes in icd10cm_order_**2019**.txt – **72184** codes in icd10cm_order_**2020**.txt
  - **273 additions – 21 deletions**
  - www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html
- Includes revised codes for E. coli, added codes for fractures and much more

CMS answers to unresolved mapping issues

- Incorrect mapping of acute care codes as acceptable principal diagnoses

But what about Managed Care?

Have relied on the facility to provide RUGS-IV levels for their billing –

- What will you do when your software is set up for PDPM – will Managed Care provide their RUGS own codes after October 1st? Do they have plans to convert to PDPM system?

CMS will support RUGS-IV for managed care into 2020 but have not specified for how long.

The Government Accountability Office (GAO) in a letter to HHS Secretary Azar (March 28, 2019) has addressed CMS failures related to diagnostic coding differences between Medicare Advantage and Medicare Fee for Service, including better accounting for beneficiary characteristics and more refined data for determining Medicare Advantage Payments.

Spades

*** FY 2022 proposed Transfer of Health Information to the Provider–PAC**

*** FY 2022 proposed Transfer of Health Information to the Patient–PAC QM**

The calculation of the proposed QM "would be based on the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the resident, family, or caregiver at the time of discharge".

*** FY 2020 Discharge to Community–PAC SNF QRP revision**

Spades

SNF QRP: Proposed FY 2022 SNF QRP QMs require SPADEs

Providers would begin reporting MDS data for the two new QMs proposed for the FY 2022 SNF QRP (Transfer of Health Information to Provider–PAC and Transfer of Health Information to Patient–PAC) for residents beginning with October 1, 2020 discharges. Measures specified under the Transfer of Health Information domain are required to use SPADEs, says CMS.

The agency does not discuss these SPADEs further in the FY 2020 SNF PPS Proposed Rule. However, the information is in the *Proposed Specifications for SNF QRP Quality Measures and Standardized Patient Assessment Data Elements* and the Change Table for Proposed SNF QRP New and Modified Items – Effective Date: October 1, 2020.

For the proposed Transfer of Health Information to Provider–PAC, three SPADE MDS items would play a central role:

Cures 21

In short – documentation and billing across the spectrum of care will be monitoring for

Continuity of diagnoses, billing, payment

Interoperability is a large component of having consistent clinical information to support the ICD Code, Current Procedural Terminology Codes (CPT) = equals the diagnosis, applied also to the type of visit, complexity of the visit and documentation by the physicians/PA/NP

New: Medicare Promoting Interoperability Program

Why hospitals will be motivated to exchange data with the SNF:

Health Information Exchange:

- The scores for each of the individual measures are added together to calculate the total Promoting Interoperability **Program score of up to 100 possible points for each eligible hospital**
- **Support Electronic Referral Loops by Sending Health Information = 20 points**
- **Support Electronic Referral Loops by Receiving and Incorporating Health Information = 20 points**

Conclusions

Management Plan Checklist *(See HO #9 Optimizing Coding Admin Checklist)*
- Staff trained
- Systems in place
- Tools ready/in use

Evaluation of
- Staff skills/competency
- $$ impact – billing rejections, denied claims due to incorrect/incomplete coding

QAPI Process in place w/ metrics = measurement and progress

Thank you for attending