Coding and Quality Reporting: Resolving the Discrepancies, Finding Opportunities

by Nelly Leon-Chisen, RHIA

National quality-of-care and public reporting initiatives are creating new challenges and new opportunities for coding professionals.

Quality medical coding has always been important. Coded data are used for many essential functions including reimbursement, benchmarking, clinical and financial decision making, healthcare policy, public health tracking, and research. Recently, medical coding has taken on increased importance as it relates to issues of quality of care and publicly reported data.

There are many challenges associated with this increased importance, including new collection and reporting responsibilities and discrepancies between established coding guidelines and the requirements of varying quality measurement specifications. The expectations for coding professionals are likely to increase in years to come. Coding professionals will need to engage physicians and other healthcare professionals to work together to improve the accuracy of coded data to meet these new demands.

Discrepancies between Coding Guidelines and Quality Measures

Most quality or safety reporting is based on data originally collected for clinical and administrative needs. There is no formal process or system, and to date it has been a matter of adapting existing processes created for other purposes.

Using existing coding structures is easiest and less burdensome, but there are challenges associated with using coded data to address quality. There are also opportunities.

Retrospective chart abstraction is burdensome, time-consuming, and for the most part a manual process. However, a review of the entire medical record allows the opportunity to collect more specific clinical measures, especially for information that is not readily coded with the existing coding systems (e.g., if an aspirin was given within two hours of admission). The development of data content standards will allow digital abstraction of these clinical data when the quality measure requires more granular clinical data than provided by administrative code sets.

Administrative claims data are more efficient and involve a single review of the record and assignment of codes as part of the administrative process. In this manner, quality reporting becomes a by-product of the administrative process and does not require additional reviews. However, the challenge is that ICD-9-CM and HCPCS codes do not always provide the necessary level of detail. There are also some concerns about the accuracy or consistency of claims data.

The "system" is far from perfect. Case selection is not entirely sensitive to coding guidelines, and in some situations it may not be appropriate. The clinical classification system was not specifically designed for the purpose of collecting quality or patient safety outcomes, so it may not capture all the nuances of each individual case. Either the coding guidelines or the quality measures may require revision.

Promoting Communication, Looking for Guidance

Communication between the HIM and quality management departments may not be sufficient to resolve these types of issues, but it will go a long way in determining where the potential flaws in the system exist and point to where remediation may be found.

Consider the problem of a facility admitting a heart failure patient for a heart transplant. The quality measure regarding heart failure requires that the patient be discharged on an angiotensin receptor blocker or angiotensin converting enzyme (ACE) inhibitor. However, a successful heart transplant patient would not require these medications. After discussions with the organization responsible for establishing the quality standard, the measure specification was modified to exclude patients with heart transplant from the denominator.

Coding professionals rely on the *ICD-9-CM Official Guidelines for Coding and Reporting* and *AHA Coding Clinic for ICD-9-CM*. Both of these publications are developed and approved by the ICD-9-CM Cooperating Parties (the Centers for Medicare and Medicaid Services, the American Hospital Association, the American Health Information Management Association, and the National Center for Health Statistics). This collaborative group has a tradition of dealing with difficult coding questions and providing advice that standardizes coded data and ensures as much consistency as possible. In recent years, emerging issues have been addressed with more focus on quality and patient safety issues, as well as the need for further refinement or specificity for severity reporting. This helps address the issues surrounding the discrepancies between coding guidelines and quality measures.

Guidelines for the new present on admission indicator were introduced last year to provide a national standard for the reporting of this important new piece of data. For quite some time now, researchers and others have complained about the inability to distinguish chronic comorbid conditions from conditions that develop during a patient's admission to the hospital. The guidelines were developed in anticipation of the need for additional specificity, especially with the potential implications of the Deficit Reducation Act requirement regarding hospital-acquired conditions.

In addition, specific guidance has been published in *Coding Clinic* on topics submitted by readers on questions related to patient safety, severity of illness, and quality of care. These examples include fluid overload due to noncompliance with dialysis versus congestive heart failure, ventilator-associated pneumonia, complication of medical care versus surgical misadventure, and hypoxemia with pneumonia or respiratory failure.

National Initiatives Affecting Coding

Major national initiatives related to quality of care and public reporting are already having an impact on the strategic importance of coding. Meeting the data needs of these programs brings new challenges, expectations, and opportunities for coding professionals.

Public Reporting

Public reporting is a driving force. Many initiatives are emerging to evaluate and report quality of care and patient safety. Some of these initiatives rely directly on administrative claims data, while others use data derived from detailed clinical documentation in which case-coded data may still play a role in appropriate case sampling and selection.

Reported data serve four common interconnected purposes: quality improvement, public health reporting, pay-for-performance (also called value-based purchasing), and research. The pressure for publicly reported data originates from diverse sources such as employers, health plans, and consumers. All of these groups are interested in reducing costs and improving clinical quality. However, their interest in publicly available data, or in making their own data available to the public, may vary.

Pay-for-Performance

Pay-for-performance programs are rapidly expanding. These programs generally consist of a differential payment to hospitals and other providers based on the performance of a set of specified measures. These measures may relate to quality of patient care, clinical outcomes, efficiency, patient satisfaction, or structural reforms (such as implementation of information technology).

These pay-for-performance programs align financial incentives with the delivery of high-quality care. Most include process and structure measures. Some include condition-specific clinical outcome measures, but process measures are easiest to identify because processes actually get coded. The Centers for Medicare and Medicaid Services (CMS) considers pay-for-

performance a priority. CMS has launched various initiatives to encourage improved quality of patient care in different healthcare settings such as hospitals, physician offices, nursing homes, home healthcare agencies, and dialysis facilities.

CMS is using quality reporting programs to dramatically affect hospital and ambulatory care. For example, the Hospital Quality Alliance (HQA) is a public-private collaboration to improve the quality of hospital care by measuring and publicly reporting on that care. The HQA measure set currently consists of 21 measures. CMS links voluntary reporting of these measures to payment.

Currently, 98 percent of eligible hospitals participate in the program. Beginning this year CMS's Physician Quality Reporting Initiative focuses on physician services. Data will be collected and reported via claims using CPT category II codes and HCPCS level II G codes, where CPT codes were not yet available.

The Deficit Reduction Act of 2005

The Deficit Reduction Act (DRA) requires CMS to reduce payment in cases where patients experience a hospital-acquired infection or condition that would move them from a lower-paying to a higher-paying diagnosis related group (DRG). In the recently published fiscal year 2008 proposed rule for inpatient prospective payment system changes, CMS outlines the requirement for hospitals to start reporting the present on admission indicator. It also outlines the proposed conditions CMS is considering as the first set of hospital-acquired conditions to meet the DRA requirement.

The proposed conditions range from catheter-associated urinary tract infections, ventilator-associated pneumonia, and decubitus ulcers to serious preventable events such as objects left in surgery and air emboli. All of the proposed conditions had to be evaluated in terms of specific criteria such as:

- Coding: only conditions that have (or could have) a unique ICD-9-CM code that clearly describes the condition
- Burden: cases that are high in cost, high in volume, or both
- Prevention guidelines: conditions that could reasonably have been prevented through the application of evidence-based guidelines
- Complication/comorbidity: codes that result in assignment of the case to a DRG that has a higher payment when the code is present as a secondary diagnosis

Strategies to Engage Other Healthcare Professionals

The increased interest in and the higher importance placed on coded data require HIM professionals to engage other healthcare professionals such as physicians and quality management professionals in meeting these new challenges.

The disconnect between responsibility and authority is problematic. Physicians have authority to document the care provided; hospitals (and other professionals) are held responsible for documentation that supports code assignment. New initiatives to improve performance metrics are attempting to bridge the gap and align physician and hospital performance improvement metrics.

The big challenge for HIM professionals involves how to engage physicians. Coding professionals have always relied on physician documentation for code assignment. Nurses and other clinical personnel involved in quality management activities may not have the same constraints when assessing data for quality measurement, and they may not understand that official coding guidelines preclude the assignment of codes to complications that are inferred and not explicitly stated in the medical record.

There has been growing tension between coding professionals and quality management professionals in the inpatient setting. In some institutions, HIM professionals work in the quality management department and can bridge the gap to provide the support needed in coding and documentation issues. Other facilities are not organized in this manner and require close communication between these two departments to relieve the perceived tension.

Non-HIM professionals, such as quality management staff, nurses, or physicians, may not be aware of coding requirements that have a negative impact on quality measurement results. For example, a patient admitted for treatment of pulmonary

congestion due to fluid overload from noncompliance with dialysis regimen must be assigned a principal diagnosis of congestive heart failure. In return, this case is flagged as failing the congestive heart failure Core Measures for the National Patient Safety Goal because the patient was not treated with ACE inhibitors. The treatment for fluid overload in patients in end-stage renal disease is dialysis, not ACE inhibitors. This discrepancy between coding guidelines and quality measures causes potential tension between the two departments.

By the same token, coding professionals may not be aware of the quality measures that the hospital reports. The situation requires a team approach with the ultimate goal of providing the best possible patient care. Dialogues between coding professionals and quality management professionals should occur regularly to understand the constraints and needs of both systems. Physicians should be engaged in the process.

Identifying Physician Champions

These dialogues benefit from first identifying physician champions within the facility. HIM professionals can ask for their assistance and request that they provide education to the HIM department. Once the dialogue is initiated, coding professionals can share information regarding documentation gaps and the challenges they face when trying to clarify documentation with physicians.

An honest exchange of information is likely to benefit both coding professionals and physicians. Physicians are more likely to be motivated when the encouragement for improved documentation originates from a peer rather than a coding professional. Physician champions may be of assistance in this regard.

Voluntary reporting on quality measures is being implemented for physician offices as well. As physicians become more involved in reporting quality measures for their own services, they are likely to take a more active interest in the documentation and quality reporting requirements for hospitals.

The Future Will Rely Heavily on HIM Professionals

Healthcare is increasingly data-driven. Data and information specialists are taking center stage.

Electronic records, clinical decision support, and quality monitoring all equate to job security for strong HIM professionals because they are positioned right in the middle, between physicians and other patient care professionals and the systems collecting and processing clinical data.

The future will create new, increased expectations for HIM professionals because they are strategically positioned to understand how information is created and used. HIM professionals already know the rules and guidelines governing administrative code sets, while the rest of the care team may need additional training and guidance on information architecture. HIM will be at the center of every major delivery change in the coming decades.

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