Concurrent Process to Enhance Coding Compliance

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by Judith A. Scott, RN, Karen J. Clary, RN, and Marlene J.E. Smith, BA, BS, RRA

Medicare fraud. These two words can strike fear in the hearts of healthcare professionals. In the wake of recent federal investigations alleging fraudulent billing practices at hospitals across the nation,[1] this fear may be justified. In recent years, there have been an unprecedented number of successful prosecutions.[2]
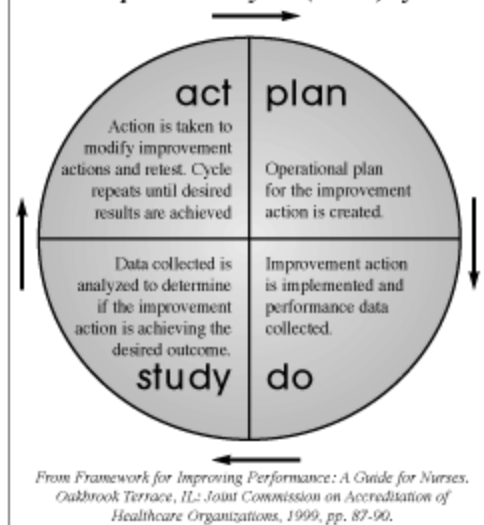
But how can physicians and administrators ensure accurate coding and billing practices while safeguarding against claims of Medicare fraud? One answer lies in physician documentation in the medical record. In addition to a principal diagnosis, every record must include documentation of all procedures and complications and co-morbid conditions (CCs) treated during the patient's stay. When physician documentation is thorough, coders can accurately assign ICD-9 codes, and the resultant bills will be closely aligned with federal standards. Improved physician documentation will lead to more accurate coding and billing and benefit the hospital and physicians through various measures, including:

- appropriate reimbursement from all payers, not just Medicare
- accurate case mix index (CMI)
- improved severity-adjusted quality outcomes
- documented support for length of stay (LOS) and resource use
- improved performance profiles for hospitals and physicians
- inclusion in payer contracts and panels
- a reliable database for quality improvement, outcomes management, clinical program and pathway evaluation, benchmarking, and research

The Role of Accreditation

Organizations accredited by the Joint Commission are required to adhere to its documentation standards. One such standard, IM 3.2.1, describes minimal standards for documentation review and requires that "action is taken to improve the quality and timeliness of documentation that impacts patient care."[3] Methodist Hospital, a 760-bed tertiary-care facility in Indianapolis, IN, implemented a documentation management program in accordance with the Joint Commission's requirements. Methodist Hospital, Indiana University Hospital, and Riley Hospital for Children make up Clarian Health Partners, Inc., the second largest integrated health system in the country.

When administrators and physician leaders of Methodist recognized the impact medical documentation could have on the institution's future, they contracted a consulting firm to launch a program to achieve quality physician documentation in the medical record. What follows is Methodist's story of program implementation, initial barriers encountered, and how utilization of the continuous quality improvement cycle of plan-do-study-act[4] eventually achieved successful outcomes (see Exhibit 1 below).

exhibit 1—plan-do-study-act (PDSA) cycle

act

Action is taken to modify improvement actions and retest. Cycle repeats until desired results are achieved.

plan

Operational plan for the improvement action is created.

Data collected is analyzed to determine if the improvement action is achieving the desired outcome.

Improvement action is implemented and performance data collected.

study   **do**

From *Framework for Improving Performance: A Guide for Nurses.*
Oakbrook Terrace, IL: Joint Commission on Accreditation of
Healthcare Organizations, 1999, pp. 87-90.

Step 1: Plan = Assessment

The consulting firm completed a retrospective review of randomly selected inpatient Medicare records. The Medicare population was chosen because it generally has a higher acuity level, greater opportunities for documentation improvement, and a convenient way to measure outcomes (through CMI). Usually, the more CCs documented and treated in this population, the higher the overall CMI. Opportunities to improve documentation in 23 percent of the cases were found by looking for conditions that were treated by the physician but not actually documented in the progress notes or dictated reports. Using Medicare guidelines, the consultants evaluated the accuracy of assigned ICD-9 codes and estimated that Methodist could increase its Medicare CMI by 6 to 8 percent by improving coding practices and physician documentation in the medical record. This would also lead to improved regulatory compliance and more accurate reimbursement to the institution. A concurrent method of improving medical documentation was introduced by the firm and implemented as the documentation management program.

Step 2: Do = Program Structure and Implementation

Thirty-two patient care coordinators (PCCs) and nine coders began working with physicians to improve documentation. At Methodist, the PCCs for the adult patient populations are unit-based RNs responsible for discharge planning, patient education, quality improvement activities, and coordinating the care of up to 40 patients.

Shortly after the initial assessment was completed, the consultants conducted a five-week training session to familiarize PCCs and coders with appropriate ICD-9 codes, DRG assignment, and clinical clues to diagnoses. Several days were spent practicing chart reviews.

Then the documentation management program was introduced to the medical staff committee, which served as the leverage point to reinforce the program's importance. All physicians received personal invitations to a kick-off dinner where consultants, hospital administrators, and physician leaders (including the medical staff president) made presentations. They stressed that the program was grounded in better documentation, not hospital revenue. Many physicians took advantage of free in-office consultations provided by the consulting firm. They were offered as an incentive for physician involvement in the program.

The PCCs began reviewing all inpatient Medicare charts on their respective units to assess accuracy and completeness of physician documentation. The initial review was done within 24 hours of admission and secondary reviews took place every three days during the entire hospitalization. A collaborative care worksheet (see Exhibit 2) was completed by the PCC and placed in the physician progress notes section of the chart. The worksheet contained clinical findings, treatments, diagnostic tests, and procedures that could support a condition that may have been present but not documented by the physician. Questions concerning additional documentation and/or clarification by the physicians were also addressed on the worksheet. On subsequent review, if the requested documentation was not present, a reminder was written or the physician was directly approached. Many physicians took note and responded accordingly—either in the progress notes or dictation. Response to

questions improved when the color of the worksheets was changed from white to pink, which made them stand out from other documents. The worksheet helped obtain documentation that included all the patient's CCs and supported the assignment of the most resource-intensive DRG under Medicare guidelines. It also served as a means of educating physicians about documentation and coding guidelines.

exhibit 2—collaborative care worksheet

COLLABORATIVE CARE WORKSHEET

This worksheet outlines your options for the principal diagnosis under current DRG guidelines.

| Dates of Review | Patient: |
| MR #: |
| Physician: |
| Room #: |
| Admission Date: |

LOS	DRG	PRINCIPAL DIAGNOSIS	PROCEDURES
	WEIGHT	SECONDARY DIAGNOSIS	
LOS	DRG	PRINCIPAL DIAGNOSIS	PROCEDURES
	WEIGHT	SECONDARY DIAGNOSIS	
LOS	DRG	PRINCIPAL DIAGNOSIS	PROCEDURES
	WEIGHT	SECONDARY DIAGNOSIS	

Physician Input: *Please clarify the following in the Progress Notes (Section H).*

| Dates | CLINICAL FINDINGS AND CONSULTATIONS | Dates | TREATMENTS, IVs, MEDICATIONS, BLOOD |

DIAGNOSTIC TEST RESULTS

PROCEDURES

DO NOT REMOVE FROM CHART UNTIL AFTER FINAL CODING

NOT A PERMANENT CHART DOCUMENT

After discharge, the coders reviewed the medical records and assigned appropriate ICD-9 codes for each account. They reviewed the collaborative care worksheet to determine whether documentation had been obtained to support a DRG change. To track program progress, they entered information into a database about each Medicare account: the DRG assigned by the PCC, the final DRG assigned by the coder, and reasons for disagreement. This information was printed weekly for the PCCs' review and education. Unfortunately, questions concerning DRG disagreements were often discussed several days or weeks after the account was finalized. These disagreements stemmed from the PCCs' clinical point of view that the medical documentation present was sufficient to support a diagnosis. However, the coders, adhering to coding guidelines, required more precise documentation.

A coder attended the weekly PCC meeting to distribute printouts and answer coding questions. This was also a time to resolve DRG disagreements and solving problems identified with the work process. However, few questions were raised, few DRG disagreements were resolved, and education was sketchy.

Two additional committees were formed to assist PCCs and coders in their efforts: the administrative steering committee to direct and supervise the program's implementation, function, and progress, and the transition council, created to facilitate:

- implementation of the documentation management program
- promotion of the program among the medical staff
- communication with the steering committee regarding the status of program implementation and progress

Step 3: Study = Barriers to Success

It became evident in the first few months that the program would not be as successful as anticipated. Several barriers were identified:

- *too many staff members involved in the program*—56 administrators and staff members were involved at various levels. A large steering committee relaying information through the transition council to 41 staff members made for a cumbersome and ineffective system
- *multiple managers with varying expectations*—PCCs reported to the special projects director while coders reported to the coding and data quality director. Information and direction was confusing and often conflicting
- *unrealistic workload*—PCCs maintained their usual responsibilities in addition to the chart reviews. Lack of time resulted in incomplete worksheets and infrequent followup reviews. In addition, key information was frequently not identified on the worksheets. Coders were expected to maintain their same productivity rate despite the additional duties of database maintenance, PCC education, and meeting attendance. Furthermore, coders were responsible for all of the records from their respective units, not just the Medicare accounts
- *vague priorities*—PCCs, with their various roles, did not know whether documentation management or discharge planning had priority. Leadership was not clear regarding this issue
- *opposing views*—based on their backgrounds and differing interpretations of the material taught by the consulting firm, PCCs and coders often disagreed about whether there was sufficient documentation to support coding a particular diagnosis
- *lack of commitment*—poor commitment and time constraints hampered efforts to educate physicians on documentation improvement and the proper use of the collaborative care worksheets. Lack of continued education and incomplete worksheets lead to physicians misunderstanding the program. This led to decreased compliance, physician support, and trust
- *incomplete database*—the only data used to track program progress were the Medicare CMI and trends in certain DRGs, which were inconsistently shared with PCCs and coders. Other data, which may have helped track performance, were not monitored
- *decentralized staff and lack of communication*—there was little contact between the coding department and the PCCs. Physical distance and lack of familiarity contributed to communication difficulties and mistrust between the two groups

The original goals of the program—to improve medical documentation and produce a 6 to 8 percent increase in the Medicare—were not achieved due to lack of time and resources. Morale plummeted. It was impossible for the PCCs to consistently review documentation while still performing their other duties, and coders' productivity lagged behind department standards. The end result: a meager 1 percent increase in the Medicare CMI during the first five months of the program.

Step 4: Act = Strategies for Success

We learned that a small group working exclusively on the documentation management program could be more successful than a large group of people who did not have the time or commitment. With administrative support, four new FTEs were hired as documentation management coordinators (RNs) and four existing FTEs were designated as documentation management coders. The positions were filled with former PCCs and senior coders whose initial focus was solely to improve medical documentation.

The RNs had autonomy to choose the units they would cover based on their areas of clinical expertise and were responsible for reviewing all the inpatient Medicare records in these units. The chart review process did not change. Each RN was partnered with a coder with expertise in coding similar patient populations. The coder was required to code only the Medicare records from the partner's specific units.

It was evident that the new group was going to be more successful at documentation improvement. However, conflict can arise within a group when members become ingrained in their individual positions.[5] This group was no different. There were trust issues between the coders and RNs. Disagreements on final DRGs were frequent and resolution was often unsuccessful without management's assistance. There was conflicting communication because two leaders remained: the special projects director and the coding and data quality director. The group still lacked clear goals and objectives. There were still no measurable goals or standards to track efforts—except for the CMI and DRG trends. The group felt fragmented, frustrated, and ineffective, so it returned to the plan-do-study-act cycle to reassess the process and identify more opportunities for improvement.

Three days were spent with the consultants to work on team-building activities that have paid tremendous dividends over the past year. The group of eight RNs and coders began to think and function like a team. They developed mission and vision

statements outlining their objectives and goals, individual and team performance standards were designed, and an action plan with short-term target dates was used to track progress. A computerized database was created by the team to monitor the program's success. The data collected reflects 100 percent of the hospital's Medicare population. Some of this data includes the percent of charts reviewed by the RNs, the number of reviews done per patient LOS, the percent of CCs captured, and the Medicare CMI. The collected data allows for measurements of the team's performance and identifies areas in need of improvement.

The coding and data quality director was designated to manage the team and reports directly to the hospital's chief financial officer. The single director provides guidance and support without dictating how the team should achieve its goals. The team meets weekly (or as needed) to provide continuing education, solve problems, track performance, and complete tasks necessary to achieve goals. Team members rotate as facilitator for meetings and presentations.

The RNs were moved to an open office within the coding and data quality department, encouraging daily contact among team members. In addition, the RNs received personal computers and systems support to maintain the database, allowing coders to focus more on coding. The transition council was eliminated and the steering committee's composition changed. The team prepares data presented at the quarterly meetings, and with guidance and support from the rest of the steering committee, makes most program decisions. Because their focus is primarily documentation management, RNs and coders are able to spend more time educating physicians on documentation and coding guidelines. The worksheet was streamlined to provide the physicians with better information, and documentation pocket guides were developed and given to the medical staff. These, along with one-on-one teaching, section meetings, and intern orientations, are used as a means of reaching the physicians. Their increased trust and understanding of the program, better compliance, and improved medical documentation resulted from these changes.

The ongoing education and exchange of ideas has created a better understanding between the coders and RNs regarding DRG resolution, required documentation, and coding guidelines. Getting to know one another on a more personal level has helped improve trust. The RNs are able to examine more Medicare charts and consistently perform subsequent reviews, while the coders' productivity has increased since they code just those charts included in the program. The team developed a resolution process for DRG disagreements that takes place before the chart is finalized. The time spent on educating physicians has resulted in better program compliance and an increase in the Medicare CMI. The PCCs no longer have the responsibility of documentation review. However, with their knowledge of the DRG system, they have a greater appreciation of average LOS and estimated reimbursement to the hospital, which promotes timely discharge planning. Team coders are held to the same productivity standards as the other coders within the department. Occasionally, due to patient volume, coders outside of the team code charts that have been reviewed by the RNs. After the coding is complete, the worksheets are given back to the RNs for data entry. If a final DRG does not match the nurse's, the RN and coder work together to determine the appropriate final DRG based on documentation. The team coders have become knowledgeable resources in their areas of expertise for other coders in the department.

New goals are set as current ones are achieved. Performance is tracked by monitoring collected data and developing ways to improve processes and outcomes. The RNs can re-review the worksheets—and the coded charts if necessary—to screen for incorrect diagnoses while entering data into the team's database.

Although short of the original target of 6 to 8 percent, the team's success is reflected in the hospital's 5 percent increase in the Medicare CMI, which has been maintained to date. The team's focus has expanded to include concurrent record review on all inpatients who are 50 years of age or older, and APR-DRG data tracking, in addition to the CMI. Documentation for all other patient groups is retrospectively reviewed through quarterly random sampling. The physicians are updated on changes in documentation requirements and coding guidelines through the team's quarterly newsletter and annual presentations at section meetings. This helps ensure continued compliance with Joint Commission and Medicare regulations.

Steps to expand the documentation program to the Indiana University and Riley Hospital campuses have been initiated. Besides expansion of the program, the team is looking to the future in other areas, developing ideas to adapt a successful documentation program to an electronic medical record in preparation of the new millennium.

Notes

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Judith A. Scott, Karen J. Clary, and Marlene J.E. Smith *are members of the documentation management program team at Clarian Health Partners, Inc. The authors may be reached at j1scott@clarian.com.*

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