Holistic Coding Requires Amped Up Clinical Documentation

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Accurately coded data does more than just provide the mechanism for appropriate reimbursement. It also tells the story of the patient, the complexity of the patient's case, and reflects the care provided to the patient. This growing trend of "holistic coding" seems to be gaining attention in the healthcare industry. Holistic coding in the inpatient setting goes far beyond the basic capture of the MS-DRG. To apply classification codes with a holistic approach means identifying not only the MS-DRG and principal and secondary diagnoses and procedures, but the additional elements that come from a full clinical documentation improvement review as well. Other elements sought out by coders and clinical documentation integrity specialists contribute to achieving the goal of holistic, accurately coded data. This includes coding for:

- Hospital-acquired conditions (HACs)
- Quality indicators-specifically, patient safety indictors (PSI) and inpatient quality indicators (IQI)
- Risk adjustment factors, such as severity of illness and risk of mortality
- Core measure reporting
- Other hospital-specific internal initiatives

More than Just Data

When coding holistically, healthcare professionals must consider how the story of coding and CDI completely ties together from an outcomes perspective on each chart. For example, respiratory failure following trauma and surgery (518.84) is a current major complication or comorbidity (MCC). However, it is also a PSI (PSI 11) according to the Agency for Healthcare Research and Quality. Another example is the instance of Other/Unspecified Infection Central Venous Catheter (999.31), a current CC that is also a PSI (PSI 07) and a HAC.

Both of the ICD-9-CM code examples above can impact MS-DRG assignment and reimbursement when assigned as a secondary diagnosis. However, this coded data also populates publicly reported quality data available through entities such as Medicare's Hospital Compare website. The data generated through physician documentation, CDI efforts, and accurate coding reflects a given hospital or physician's profile on quality of care and outcomes.

The Joint Commission has established four core measurement areas for hospitals, which are acute myocardial infarction (AMI) or heart attack, heart failure (HF), pneumonia (PN), and the Surgical Care Improvement Project. Coded data drives cases that are ultimately abstracted by the quality management department for Joint Commission core measures reporting, such as congestive heart failure (CHF), AMI, and PN.

In some work environments, the clinical documentation and coding team members are responsible for reviewing new admissions and assigning working diagnoses and MS-DRGs each day. Primarily this is done to capture and alert clinicians and physicians of potential core measure cases on a concurrent basis and to help resolve coding or documentation challenges that may exist prior to the patient's discharge and before final coding and quality reporting submission. Some clinical documentation and coding staff may also work on a team responsible for the identification of-and alert to-the CHF bundling group members in preparation for bundling payment initiatives. The early identification of these cases assists the physicians and other caregivers to initiate the specified care plans and follow-up with associated CHF cases.

Install Final Coding Review and Flag Mechanisms

Building a mechanism that reviews overall coding prior to final coding and billing is critical. It can further ensure compliance, ensure thorough and accurate quality reporting, and enhance a hospital's clinical and financial leadership teams' confidence

and support of coding and CDI efforts. To support "holistic coding accuracy," some coding teams have designated quality staff to perform a second level review of flagged codes and MS-DRGs. With many striving each day to improve efficiency and speed, the addition of this second-level review can be burdensome. However, it can also have a positive impact.

By stopping these cases for pre-bill review, it allows the opportunity to address documentation challenges on a concurrent basis-or shortly after discharge, depending on how the coding and CDI teams function within a given hospital. Coding and CDI teams can better track and trend how they are assigning codes. For example, staff could monitor consistency in code assignment for palliative care (V66.7) based on documentation provided for all mortality cases. They could track if all team members assign this code based on the same source documentation, the consults and attending documentation available, the order for palliative care, etc. This particular V code can impact observed and expected mortality ratios from a quality reporting perspective-making it a high priority to capture and track.

Additionally, having a pre-bill review in place allows for more immediate identification of cases requiring physician education and clarification. Specific flags were built within some compliance software systems. These flags were built to stop the case prior to final coding and billing and alert for a second-level review. Comment flags include all PSIs, IQIs, HACs, and mortality cases as well as other focus areas and regulatory initiatives.

The implementation of these flags for a second-level review can be burdensome. For example, the University of Arkansas for Medical Sciences (UAMS) currently has about 43 percent of inpatient charts stop for a second-level review. This equates to about 800 inpatient charts per month on average. Taking compliance reviews to this next level has increased complexity and the time it takes to complete the reviews at UAMS.

However, it has also afforded an opportunity to further drill down and take a look at overall coding quality and how the coding impacts various outcomes past the correct MS-DRG and basic code assignment. For example, UAMS's coding and quality management team recently completed a study of cases coded and assigned to PSI 07, PSI 09, and PSI 11-pre- and post-compliance module implementation. The results indicated the facility had some opportunities for coding and CDI education. However, most of the opportunity rests within the need to work with the physicians on documentation clarification in conjunction with understanding coding guidelines, especially pertaining to post-operative respiratory failure (PSI 11).

Need for Speed and Proper Documentation

To be a coding or a clinical documentation improvement professional takes a tremendous amount of critical thinking and technical skills and a commitment to stay abreast of the ever-changing regulatory environment. As health information migrates and becomes more data-driven, the industry will rely on people with the skills to not only understand and apply coding and other regulatory guidelines but to also interpret for others. They must explain how documentation should change to better reflect the rules and regulations, and keep documentation accurate and compliant so that it translates to usable and understandable data for outcomes reporting and management.

Hospitals recognize the challenge to meet the need for efficiency and speed from a revenue cycle perspective while also ensuring their coding is correct and holistic. The need for speed and efficiency is going to continue. The ability to balance that with the critical need to ensure compliant, accurate, and thorough coding and CDI efforts will be critical as healthcare continues to move to a pay-for-performance environment. Soon outcomes reporting will be the ultimate goal for coding and data analysis, especially as the industry transitions to ICD-10-CM/PCS.

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