Peeking Over the Fence: a Look at Canadian Coding and CDI Processes, and How They Differ From the US Due to Varied Financial Structures

By Lisa A. Eramo

The grass is always greener on the other side—or is it?

Canada's universal, federal healthcare system may seem like a utopia to some as scrutiny continues to surround the Affordable Care Act in the United States. Not only has Canada fully transitioned to ICD-10-CA, but it has also developed a healthcare model that effectively eliminates payer-driven care.

But how does each country's payment model affect HIM professionals? Experts say there is no straightforward answer, and in fact this question just leads to a litany of others: Does payment structure actually affect the codes that coders assign? Coders shouldn't be influenced by the payment system, but are they? Does the payment model affect clinical documentation improvement (CDI) efforts or the transition to ICD-10? Is one country's data quality better than the other simply because of its unique healthcare funding strategy?

A peek over the fence at our neighbors to the north shows that even though the payment system is different, both countries are moving their systems toward more quality-based payment and measurement tracking.

'Fund'amental Differences and Similarities

In the US, independent for-profit insurers pay for healthcare services after those services are rendered alongside government programs like Medicare and Medicaid. In Canada, each province funds its own healthcare, allotting a certain amount of money up front for each hospital annually. It's up to the hospitals themselves to spend that money wisely.

Although insurance companies are not evident in the Canadian healthcare landscape, "you don't have to scratch too far below the surface to know that there is, in fact, a reimbursement model," says Gillian Price, BA, PMP, Canadian national director of projects at QuadraMed in Ottawa, Ontario, Canada. Price explains that resource intensity weights (RIW), which are driven by coded data, have historically been the most important factor in determining how hospitals are funded. RIWs reflect patient acuity—the higher the RIW, the more global funding the hospital is eligible to receive.

It has always been crucial for hospitals to spend the money that the government has allotted to them, says Doris Gemmell, BSc, MBA, CHIM, director of coding services at Nuance in Ottawa, Ontario. "All managers want to spend the amount of money that they've been given because if they don't spend it, then the next year, [the budget is smaller]," she says. "So there's no great incentive in that kind of system to save money in the short term."

In some ways, the healthcare system in Canada is simpler from a coding and HIM standpoint, Gemmell says. "We don't have payers competing, and we don't have to adhere to different rules for different payers. We don't have that negotiation between payers and hospitals on an individual basis," she says. "That's a double-edged sword, though, because sometimes you don't get the drive for innovation that you might get in a for-profit system."

Currently, Canadian healthcare is undergoing significant changes. During the last few years, Canada has begun a major shift toward accountability and efficiency that ironically parallels a similar movement in the US.

"The United States always looks at the healthcare system as a business. We've been slow to do that because we've been focused on the quality of care at any cost," says Price, who previously worked as a hospital CIO and consultant in Canada.

"Now we've shifted to say 'Yes, we're still responsible for the quality of care, but we've also got to be fiscally responsible as well as accountable.'"

The Ministries of Health in two Canadian provinces—Ontario and British Columbia—have begun to implement a pay-for-performance model in which hospitals are reimbursed based on what the government considers to be reasonable costs for a particular procedure or diagnosis. Experts say that other provinces will likely adopt these practices as well. Outcomes are also being incorporated into funding models. For example, if a hospital reduces nursing-sensitive adverse events (i.e., pneumonia or urinary tract infections), that facility will receive more funding.

"There's an incentive for all of the documentation to be much more specific to justify why the province is spending more money," says Gemmell, who previously worked as a HIM director at a large hospital in Ottawa.

Documentation and Coding Challenges Persist in Canada, US

If coders in Canada don't need to worry about individual payer rules and regulations, does that mean they have more time to focus on coding and CDI? Not necessarily, Gemmell says. CDI hasn't been a priority in Canada until recently when pay-for-performance started to take center stage, she says. "It's been a more passive system up until now. I think Canadians are starting to see that everything starts with clinical documentation, but it has been a slow movement and less focused [than in the United States]," she adds.

This lack of urgency definitely affected Canada's transition to ICD-10, Gemmell says. "In Canada, the transition to ICD-10 was not terribly well done," she says. "As a result of that, the documentation didn't catch up to what was needed for coding for quite a few years. Even now, Canadians struggle with clinical documentation."

There definitely hasn't been an urgency to improve documentation, agrees Gerald Yu, MHA, CHIM, director of coding at Lower Mainland Health Information Management Coding Services in Vancouver, British Columbia, Canada. Yu is responsible for centralized coding services at Fraser Health, Providence Health Care, Provincial Health Services Authority, and Vancouver Coast Health.

Yu launched a CDI initiative at each of the four hospitals he oversees three years ago when pay-for-performance was first implemented in British Columbia. He says hospital executives and the medical advisory committees largely drove and continue to support implementation of the initiative focused on combating incomplete records, standardizing the discharge summary, and improving the timeliness of dictation.

"When you start using coded data for funding, all of the executives want to make sure that the hospital is getting the funding it deserves and that treatments aren't missed," he says. "Nobody wants anything that was provided to not get documented by the physicians. If it's not documented, then coders can't code it."

As in the US, convincing physicians to document more completely and specifically has been challenging in Canada. Focusing on continuity of care seems to be the most effective solution. "We always go back to patient care and continuity of care. If I tell physicians to be more complete and specific for coding or reimbursement, there isn't that acceptance," Yu says.

Physicians are beginning to realize that documentation affects the funding for programs in which they participate, he adds. For example, cardiac surgeons want to make sure that documentation is accurate because they realize that all of the funding for a cardiac surgery program at the hospital depends on coded data. "They're more vested in the data since they are using the data themselves. Physicians are doing a better job at documenting the discharge summary or just making sure that the documentation is there for the coders," he says.

What's ironic is that although both Canada and the United States have tried to focus CDI primarily on clinical continuity of care rather than reimbursement, the initiative in both countries grew primarily after reimbursement changes took effect. Pay-for-performance drove CDI in Canada while MS-DRGs originally launched formal CDI programs across the United States.

Experts say that as CDI programs have sprung up, both countries have also struggled with coding and documentation optimization. The implementation of MS-DRGs tempted hospitals to inflate documentation in the US. Similarly, the shifting reimbursement model in Canada initially caused hospitals to inflate their RIWs by reporting complications for which there was

minimal or no clinical evidence in the medical record, Price says. However, he notes that "the majority of Canadian hospitals are committed to accurate coding and reporting practices."

Since implementing a formal CDI initiative, Yu says his own program has focused on incorporating more comorbid conditions simply because these diagnoses affect reimbursement. However, the Ministry of Health is trying to strike a balance between reimbursement and outcomes—both of which are important in terms of patient care as well as financial stability.

Canadian Coding Profession Structure Differs

Aside from funding, one of the noticeable differences between Canada and the United States are the ICD-10 codes themselves. The World Health Organization publishes ICD codes, but each country licenses and modifies those codes to fit its specific needs. The US modification is ICD-10-CM. Canada's modification is ICD-10-CA.

"In general, one of the differences I have seen with the US modification is the level of specificity in ICD-10-CM codes, such as laterality and different seventh character extensions related to fracture diagnoses," says June Bronnert, RHIA, CCS, CCS-P, director of terminology coding at Intelligent Medical Objects, based in Chicago, IL. "I have seen this detail to be part of the code set and descriptions more so than in ICD-10-CA."

Intelligent Medical Objects, whose clients include both US-based hospitals as well as those in Canada, specializes in mapping clinician-friendly terms in electronic health record (EHR) systems to other terminologies, such as SNOMED and ICD. Bronnert says the differences between ICD-10-CM and ICD-10-CA could be due to specific reporting needs in the United States, including reimbursement.

Another difference pertains to coding guidelines. The Canadian Coding Standards, published by the Canadian Institute for Health Information (CIHI), require coders to report a main problem rather than a principal diagnosis.

The main problem is defined by the coding standards guide as:

The main problem is deemed to be the clinically significant reason for the client's visit, and which requires evaluation and/or treatment or management. This can be a diagnosis, condition, problem or circumstance. The main problem is assigned by the health care provider at the end of the visit. This may be the physician or another health care professional responsible for the client's care (e.g. allied health professional). When multiple problems are considered as the main reason for the provision of ambulatory care services, the main problem is that which is responsible for the greatest use of resources.

Determining the main problem can be just as challenging as identifying the principal diagnosis, Yu says. This ambiguity can jeopardize data quality if physicians don't clarify the circumstances surrounding the admission.

However, coders in Canada have an advantage. The Canadian Coding Standards allow them to code from documentation provided by any allied healthcare professional responsible for the patient's care. Coders in the US don't have this ability and usually end up using the information to formulate a physician query, Bronnert says.

There are other differences, too. The coding profession in Canada is structured quite differently than in the US, Gemmell says. In Canada, coders wear many hats, so to speak. "Having worked with both coders in the US and in Canada, what I can say is that the scope of practice for Canadian coders tends to be broader," she says. "What I see in the US is that a coder is a coder and that's their main task. In Canada, a coder might be asked to do different things—perform quality reviews, review clinical documentation, perform ROI."

In Canada, coders frequently serve as data or business analysts. "Data analytics is huge here," Gemmell says. "Most hospitals have dedicated analytics staff members who specifically look at the codes and produce reports for physicians, researchers, and administration," Gemmell says. "Coders are expected to understand how to gather data."

In the United States, these positions are only starting to grow as hospitals implement EHRs and grapple with the enormity of Big Data. Yu says that HIM professionals at Lower Mainland are the ones performing CDI tasks. Coders often work side-by-side with a physician documentation educator (similar to a physician advisor) in addition to performing all of the daily coding responsibilities.

Coding Accuracy Checked by Ethics

Do payment structure and coding guidelines affect data quality? Experts say there is no easy answer to this question and that both countries struggle with coding specificity.

One advantage for Canada is that all hospitals are mandated to report coded data to the CIHI. Not only does CIHI publish the country's coding guidelines, but it also analyzes national coding data to provide healthcare statistics for the entire country.

"It's a good cross-section of the country. You can slice and dice the information in a variety of ways. At the end of the day, the agency that makes the rules also collects the information so it can apply it for the good of all," Gemmell says.

In the US, the Centers for Medicare and Medicaid Services (CMS) collects similar data but only for Medicare and Medicaid patients. There is no central repository for other coded data. The American Hospital Association publishes the *Coding Clinic*. The official coding guidelines for ICD-9-CM and ICD-10-CM/PCS are a joint effort of the American Hospital Association, AHIMA, CMS, and the National Center for Health Statistics.

"It stands to reason that because we have one national reporting body, there is a greater potential for increased data quality and standard reporting," Price says. "However, my firsthand knowledge of the United States' data quality is limited. Therefore, I cannot comment on the beneficial differences between the Canadian data reporting environment compared to the United States."

CIHI also audits hospitals, but unlike the US' Recovery Audit Contractor program, there are no financial recoupments. "You might get a stern speaking to if you're over-coding. People do take this very seriously, though. I think for the most part, it comes down to ethics," Gemmell says. "If you're over-coding, it's a reputation thing."

In Canada, coders have always been associated with outcomes rather than reimbursement. "Since we're not billing, the codes are useful outside of just reimbursement. It can really drive how your hospital services patients, how physicians treat patients, how nurses treat patients, so you can build up data-driven evidence about the efficiency and efficacy of treatment," Gemmell says. However, experts agree that it remains unclear as to whether data quality is better in Canada for this reason.

Effects of the Affordable Care Act Fully Unknown

Will the Affordable Care Act force hospitals in the United States to better emphasize data quality and outcomes as Canada has done in the past?

The future is largely unknown, Bronnert says, adding that data integrity—whether it's for reimbursement or outcomes purposes—is crucial. "I believe regardless of the payment system you need solid foundational information," she says. "To me, that's based on terminology standards and classification systems. The need for quality data remains regardless of how healthcare is financed."

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