Positioning Your Facility for Severity Adjusted Coding

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by Paul Whitaker, RHIA, CCS

With the recent talk of implementing a severity adjusted payment methodology, facilities must begin considering how they will prepare for this transition. Some healthcare organizations are concerned that the process is resource intensive, time consuming, and tedious.

Organizations that begin to lay the groundwork before a mandate will be able to dedicate the appropriate time, resources, and funds to make this transition as painless as possible. This article outlines a number of initiatives that facilities can take to prepare for a severity adjusted methodology and make the implementation process streamlined and successful.

Productivity Impact

The implementation of a severity adjusted methodology will bring a new set of challenges that will require significant adjustments. One major challenge will be coding productivity. Severity adjusted methodologies require a comprehensive coding approach for successful implementation. A comprehensive coding approach requires additional time for accurate coding. Therefore, coding productivity will decrease while the length of revenue cycles will increase.

Maryland served as the litmus test for all other states in preparing for such a conversion, implementing the APR-DRG methodology. Mary Lou Bond, RHIA, CCS, of Sinai Hospital in Baltimore, found that coding productivity dropped approximately 20 percent during the transition to APR-DRGs. In order to compensate for this decrease Sinai Hospital hired new coders, used contract coders during the hiring process, and adjusted its productivity standards.

Opinions vary regarding the projected decline in coder productivity, but popular estimates are in the 20 to 25 percent range. As a result of the expected decline, facilities will need more staff in a field already experiencing a shortage. As exemplified by Sinai Hospital, many facilities will be forced to hire new coders, employ contract coders, or outsource the coding responsibilities altogether. Ensuring adequate staffing will be one of the most significant obstacles in successfully implementing a severity adjusted payment methodology.

HIM Department Operations

Even though the coding process is just one component of an HIM department, its activities are vital to the livelihood of a facility. Any changes made in the coding process must be carefully considered-not only to the coding functions themselves, but to all HIM departmental functions.

With any decline in coder productivity, other processes should be evaluated in order to identify and implement any compensatory activities. A coding-focused operational review will evaluate the content, quality, and availability of medical records to better prepare for severity adjusted coding and DRG assignment.

Healthcare organizations must also assess their policies and procedures to identify workflow barriers and optimize coding accuracy. The physician query process, whether concurrent or retrospective, and any associated query patterns should be studied in order to resolve disruptions in the communication chain. The query process will be heavily tested in severity adjusted coding, and refining it in advance will prove to be beneficial for the organization.

Documentation improvement activities should be evaluated to ensure conformity to severity adjusted coding practices. Ongoing educational and monitoring procedures should be tailored for a comprehensive approach to the entire code assignment process. An operational review may be as inclusive as a facility desires, but it should serve to recognize and eliminate barriers to preparing for a severity adjusted coding methodology.

Auditing Activities

To prepare for severity adjusted coding and DRG use, consistent auditing will be the single most important investment that a facility can make. A baseline audit provides a comprehensive picture of the coding staff's skills, identifies documentation deficiencies, and paves the way for planning educational initiatives with coding and clinical staff. This audit also identifies the amount of training the coding staff will need and ensures the recovery of missed revenue if the audit is conducted within appropriate rebilling time frames.

A statistically significant baseline audit of 150 to 200 inpatient records expedites a facility's preparation for severity adjusted coding. The success of the preparation is contingent not only on the audit process, but also on the subsequent follow-up that addresses identified deficiencies to enable corrective action.

It is imperative that organizations continually monitor Centers for Medicare and Medicaid Services' DRGs as inadequate coding could result in missed revenue and a decline in case-mix index. Follow-up audits should be conducted to evaluate the success of coder and clinician educational initiatives and ensure compliance across all payment methodologies.

Coder Education

The educational process related to severity of illness capture must focus on a comprehensive coding approach. Coders must not only understand and apply official coding guidelines as published in *Coding Clinic*, they must know ICD-9-CM codes in depth. Unfamiliarity with V codes and traditionally insignificant diagnosis codes can sabotage a facility's ability to receive proper reimbursement.

Understanding clinical information takes on new importance in severity adjusted coding as coders will need to differentiate between manifestations of disease processes and other symptoms. Understanding disease etiologies enables coders to identify deficient documentation and initiate queries to capture missed opportunities for reimbursement. Facilities that are truly invested in the severity adjusted coding methodology should prepare coders to think like clinicians while operating within the full scope of official coding guidelines.

Activities such as group discussions, periodic assessments, internal ongoing monitoring, and quarterly external coding audits can all provide ongoing educational opportunities. Coders will need to refine their coding skills for severity adjusted coding for their future and the future of their facility. As the bar is raised to improve quality of care, so it should be for those in the coding profession to improve the quality of coded data.

Documentation Improvement

Ambiguous, conflicting, illegible, nonprovider, and missing documentation are all contributing factors in validating and capturing severity of illness through ICD-9-CM coding. As facilities rely more on coding professionals to understand clinical concepts the way a physician does, a similar focus should be placed on the clinicians to comply with documentation requirements essential for code accuracy and completeness.

Documentation improvement programs are an essential step in preparing for a severity adjusted DRG environment. Programs vary among facilities based on specific needs and staff availability. Facilities may offer a direct point of contact with the physicians, while others may use current staff including case managers, care coordinators, and physician liaisons to contribute to the program and provide support for better data capture.

Providers do not have to understand the technical aspects of code assignment, but they must recognize deficiencies in documentation identified in the coding or auditing process and know how to rectify them. An effective program will provide education to physicians, the designated liaisons, or both that highlights a team effort toward data quality and compliance with official coding and reporting guidelines.

Each individual involved in a documentation improvement program should understand the purpose and methodology of the severity adjusted DRG system, his or her role in the process, and how his or her actions can positively or adversely affect the organization. HIM staff should receive an overview of severity adjusted DRGs with an emphasis on severity of illness and risk of mortality. Providers and coders should collaborate in their roles in the use of queries. Communication is essential to the

program's success. Examples from the baseline audit are useful in highlighting the significance of proper documentation to the clinical staff.

Regardless of the approach to a documentation improvement program, physician buy-in is vital. Physicians must understand that any improvement in documentation practices is likely to have a positive impact on both the facility and on them personally. Physician report cards have been useful in some organizations for improving documentation practices.

Thorough documentation allows for accurate coding that translates into improved hospital ratings, thus favorably affecting individual physician ratings. In addition, providers who develop quality documentation habits will likely see improvements in the evaluation and management levels billed in their own practices.

Concurrent Review and Feedback

Concurrent review and feedback of the coding process (reviewing coded records prior to bill drop with educational feedback to the coding staff) serves as reinforcement to compliance with policy, procedures, and guidelines and provides immediate feedback on coding issues before the codes are reported outside the organization. Concurrent review can capture coding scenarios that a retrospective audit might not capture, particularly if the audit selection is limited to the traditional DRGs that are most likely to change.

Dolores Stephens, MS, RHIT, HIM director at St. Agnes Hospital in Baltimore, used this type of program to prepare coding staff for APR-DRG coding. "The most significant contribution to our preparation for APR-DRG coding was a concurrent review and feedback program performed in conjunction with our discharge coding," she notes. "This program provided our coders with the ability to learn in a one-on-one atmosphere and allowed them to focus their efforts on direct coding improvements at the point of contact with educators. This initiative allowed us to address quality assurance and coder education simultaneously and streamlined our preparation for severity adjusted coding."

The review of records and subsequent feedback also allows coding errors to be identified and corrected prior to external reporting. Documentation issues that are recognized may be addressed in the form of physician queries and future clinical staff education sessions.

Concurrent review of coding and feedback is critical in the educational process as it provides real-time responses to actual code assignment challenges. In essence, it is a rudimentary version of on-the-job training for coders. This quality assurance and educational activity can be implemented as an ongoing or periodic (e.g., monthly or quarterly) supplement to the quality reviews called for under a facility's coding compliance plan.

Success under any payment methodology requires comprehensive and accurate coding. A change in payment methods requires considerable time and resources for successful implementation. Due diligence calls for early, well-planned preparation by hospital leadership and coding professionals.

Paul Whitaker *(pwhitaker@lexicode.com) is the contract division manager at LexiCode Corporation.*

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