Role of Coding and Documentation in the Quality Payment Program

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In the current era of healthcare transformation, the continuing importance of documentation and coding cannot be overstated. With the multitude of acronyms being added to the healthcare vocabulary, one may wonder where documentation and coding fits in. It's important to remember that accurate documentation and complete and compliant coding impacts almost all areas of quality reporting and, ultimately, provider reimbursement.

There has been much discussion about the Medicare Access and CHIP Reauthorization Act (MACRA) program which began in 2015 and will continue beyond 2021. MACRA replaces the current Sustainable Growth Rate (SGR) methodology, streamlining multiple quality reporting programs and creating a Quality Payment Program (QPP). This new framework will reward healthcare providers for giving better—not just more—care, and combines existing quality reporting programs into one new system. The MACRA QPP includes the Merit-based Incentive Payment System (MIPS), which combines the Physician Quality Reporting System (PQRS), the Value-based Modifier (VM), and the Medicare "meaningful use" Electronic Health Record (EHR) Incentive Program into four new performance categories on which provider quality will be measured. Data collection for the four MIPS categories will start in 2017 and this data will begin to impact provider reimbursement in 2019.

Not only does MACRA introduce MIPS, it also includes Advanced Alternate Payment Models (APMs), which:

- Requires participants to use certified EHR technology
- Provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS
- Can be either a Medical Home Model expanded under section 1115A of the act or bear more than a nominal amount of risk for monetary loses

Clinicians who meet MACRA's standards for sufficient participation in Advanced APMs would be exempt from MIPS payment adjustments and would qualify for a five percent Medicare Part B incentive payment. APMs include:

- Comprehensive primary care plus
- Oncology care model—one- and two-sided risk
- Next generation ACO
- Medicare shared savings 1, 2, 3
- Comprehensive ESRD care models—LDO, non-LDO, one- and two-sided risk
- Medical home

MIPS-eligible clinicians participating in medical home models automatically receive the full score for the MIPS improvement activities performance category.

Identifying and understanding the types of payment models is important for coding and clinical documentation improvement (CDI) professionals to ensure they are playing a role in program success. These types of professionals will also ensure physician profiles and patient severity can be accurately reflected.

Key areas of these programs include documentation and coding related to relationship categories, the Episode Grouper for Medicare (EGM), and hierarchical condition categories (HCCs). Episode grouping applies algorithms specially designed for constructing episodes of care in the Medicare population. An episode of care ("episode") is defined as the set of services provided to treat a clinical condition or procedure. A patient's diagnoses (acute and chronic conditions) are a critical component of the EGM. Specific diagnosis codes equate to HCCs and impact the Risk Adjustment Factor (RAF) for

Medicare Advantage (MA) beneficiaries as well as some commercial payer beneficiaries. HCCs are also found within Advanced APMs and are important in capturing the acuity, severity, and chronicity of patient conditions. Reimbursement is linked to how sick the member is and adjusts "risk" based on specific documented diagnoses. When there are multiple codes from the same HCC category, the one with the highest risk value supersedes the rest.

These select diagnoses ensure the patient's severity can be properly delineated to make sure they are managed appropriately throughout the payment year. There are also disease interactions in conditions such as sepsis and pressure ulcers. The interactions within certain disease categories may impact the scoring, much like with MCCs and CCs in MS-DRGs in the Inpatient Prospective Payment System (IPPS). Assignment of HCC-related diagnosis codes require specific documentation, as addressed by the provider, in most healthcare settings.

MACRA Increases Need for CDI

The implementation of MACRA has increased the need for organizations to consider CDI in different outpatient settings. Until recently, little attention has been paid to CDI in the physician practice setting. Physicians who provide inpatient care will likely have had some interaction with CDI professionals in the hospital, but they may not have applied any of that knowledge to the office setting.

There may be different issues in physician practice diagnosis coding. For example, very little sepsis is treated in the office setting and oftentimes long-term chronic conditions are not documented and coded. In many cases, the only diagnosis coding training physicians and staff have received has been from Medicare Advantage (MA) plans. MA plans have been responsible for correctly and completely identifying the conditions a patient has, and have spent considerable time and effort reviewing documentation and educating providers. There may be limits, however, as the MA plans may have focused only on those diagnoses that trigger an HCC. If the diagnosis specificity does not impact the RAF, it may be ignored. Providers may also have only focused on this level of specificity in coding for the patients covered by MA plans and not extended it to all patients.

Much of healthcare is still provided in small office settings where there may not be a nurse or coding professional on staff. An office "nurse" may be a medical assistant with little training other than that provided by their predecessor. Billing staff may not be coding professionals or not have received any formal coding training other than that provided by a predecessor. Until the last few years while preparing for ICD-10-CM, coding professionals focused on CPT codes as they directly impact physician reimbursement. Many coding professionals received minimal diagnosis coding education prior to studying for an ICD-10-CM proficiency assessment. Professional organizations have created CDI or risk adjustment coding certifications, but even in offices with a certified coding professional on staff few have pursued these designations.

As MIPS is implemented, the need for accurate, specific, and complete diagnosis documentation will be necessary in the physician practice setting. Physicians will need to be willing to institute a CDI process in their practice and work with documentation and coding experts in improving overall documentation. In the physician practice setting, staff working on documentation improvement will require clinical knowledge and an understanding of outpatient coding guidelines. A physician practice may consider investing in a current staff member with good understanding of disease processes who then receives coding education. If a practice currently employs a certified coding professional, encouragement and opportunities can be provided for that person to improve their clinical knowledge and participate in clinical documentation activities.

A suggested application can be hospital-owned practices sharing CDI resources amongst several practices. Hospitals can also encourage such alliances with community physicians, which may improve hospital and physician practice documentation. Independent practices may consider pooling resources for CDI through affiliations such as Medical Group Management Association (MGMA) chapters. Physician practices may actively seek opportunities to review and improve documentation and willingly accept offers of education from the MA plan. Practices can then apply the knowledge to all patient documentation, and provide opportunities for staff development related to clinical documentation initiatives. Expanding CDI to the physician practice setting will require action, planning, and focus from all members of the team.

During 2017 there is an increased importance placed on complete and accurate documentation as it relates to MACRA and upcoming quality and reimbursement impacts to providers. The focus on quality documentation in the outpatient setting, including physician practices, will continue to increase in importance. Now is the time to review the initiatives associated with MACRA and consider the necessity of education and training for both providers and staff. It will be important to review

current documentation and coding practices and identify the potential benefits of CDI programs in the physician practice setting.

Some helpful HCC hints include:

- Ensure diagnoses submitted by the provider are being captured for claims data reporting—especially CMS-1500, which captures 12 diagnoses per claim
- Review processes for code assignment in the ambulatory/clinic setting; within the EHR, in most cases, diagnosis, procedure, and evaluation and management (E&M) codes are being assigned by the physician
- Document/report all active chronic conditions annually as identified by plan
- Diagnosis capture for HCCs should be performed during a face-to-face encounter, including the patient's annual physical exam
- Show current state of disease process for accurate reporting:
    - Acute, chronic, compensated, decompensated, exacerbated
    - If ruled out/resolved, state it
    - Cause of condition should be reported, if known
- Signs and symptoms are acceptable if there is no definitive diagnosis
- Show relationship in diagnoses to other disease process through linking conditions' Alphabetic and Tabular indices of ICD-10-CM, providing linking terms between diagnoses, such as:
    - With
    - Due to
    - Caused by
    - Secondary to
- Know the coding rules for diagnosis coding in the outpatient setting; potential problem areas are:
    - History of (Coding conditions as active that are removed or resolved and no longer under active treatment should be documented and coded as "history of")

The MACRA Final Rule was published on October 14, 2016 with all details available on the CMS website at https://qpp.cms.gov/education.

References

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