Understanding HIM's Impact on Quality at the National Level

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The future of healthcare continues to evolve with the introduction of alternative reimbursement models. The industry is moving from traditional fee-for-service models to those focused on quality of care and documented outcome improvements. The Patient Protection and Affordable Care Act of 2010 created both accountable care organizations (ACOs) and the National Quality Strategy (NQS). The goal of these national programs, overseen by the Department of Health and Human Services (HHS), is to improve patient safety and quality while reducing healthcare costs and striving for affordable care.

An ACO consists of a group of healthcare providers who receive bundled payments for coordinating and managing a patient's care. There are many caveats to this approach that require communication and coordination among caregivers at all touch points of the care continuum. The NQS addresses payment incentives as a way to increase both provider and consumer compliance. As the NQS continues to expand and broaden its reach, the need for data integrity and data governance will also increase. With quality measures that are valid and reliable, ACOs and other providers will begin to view the health status and outcomes of their patient through the lens of quality vs. quantity. The role of HIM will continue to expand and become more prominent as the need for reliable and valid data escalates. Coding proficiency and clinical documentation improvement (CDI) go hand in hand in supporting this critical initiative.

Data and Documentation Supports Quality Initiatives

Knowing what is appropriate for documentation and how to generate a query when a physician has documented a condition that is not clinically supported is paramount to ensuring that the information extracted from the claims data, for quality programs such as the Physician Quality Reporting System (PQRS), is accurate and complete. CDI specialists play a critical role in the capture and integrity of the documentation contained within the patient's medical record by working with physicians to ensure their understanding of the data needed. Coding professionals complement the CDI role through their own clinical knowledge and application of coding rules and conventions when encoding patient conditions and procedures associated with each patient encounter.

Because the fee-for-service environment is rapidly changing to a quality-based reimbursement model, non-specific codes can dramatically impact reimbursement. Having clear, specific codes supported by objective diagnostic data and patient symptomology can not only improve reimbursement, but meet legal health record requirements and quality expectations as well. This is true no matter what your role is in the patient care process.

The need for concise documentation is further illustrated in legislation such as the IMPACT Act of 2014. This act requires the standardization of interoperable Medicare post-acute care patient assessments. Data from the assessment will provide longitudinal patient information to facilitate coordinated care and to improve beneficiary outcomes. In the ACO environment, where patient populations are managed and longitudinal information is needed to manage across levels of care, complete and measurable data will be critical to the success of an ACO in providing patient care and demonstrating its commitment to quality.

As the electronic health record (EHR) has become more ingrained within healthcare, organizations are recognizing the need for this clinical enabler to be more than a clinical support tool for documentation. Information governance is taking root so that organizations can ensure that their electronic record functions as the "official" legal business record of the organization by addressing attributes such as accuracy, completeness, data integrity, and other important factors that benefit patient care and the organization as a whole.

Applying Critical Thinking Skills to Quality Measures

The Agency for Healthcare Research and Quality (AHRQ) offers a Quality Indicators Toolkit with instructions on documentation and coding for patient safety indicators (PSIs).[1] This toolkit assists coders in defining appropriate PSIs for consideration in their daily coding process. Use of this toolkit will assist the coder in ensuring accurate PSI rates for their respective facilities.

As part of this process, a coder needs to perform a critical assessment of the documented condition, evaluate if the condition is supported with documentation, and determine if it meets the definition for reporting. An example of this is the reporting of a post-operative condition. When identifying a reportable condition, a coder needs to identify whether the condition is related to the procedure or to something that happened during the postoperative period. Historically, coders were quick to report a post-operative complication as due to a procedure because of its impact on the DRG. As payment systems have progressed, the reporting of post-operative conditions is more far-reaching than the DRG, and can have significant quality and reimbursement repercussions in the future. The term "post-operative" does not necessarily constitute "due to" a procedure, and may only indicate a condition that has occurred in the post-operative period.

Coding professionals can assist quality teams in understanding what triggers a case to be included or excluded from a quality metric, and can serve as experts in the area of reportable conditions. A coder can also assist in identifying how a complication or comorbid condition will impact expected mortality and complication rates.

Risks and Opportunities of Changing Codes and Using Data to Advance Quality

Changing codes or rebilling claims creates additional facility rework and a potential data manipulation flag to external agencies. Revision has to occur within the Centers for Medicare and Medicaid Services' (CMS') timeframe for those measures. A facility's quality team identifies documentation and generates a retrospective query. The concern is the physician nullifying a condition previously documented. The quality team and the physician need to acknowledge the risk in changing codes on submitted claims. Concurrent coding was created in an effort to improve days from patient discharge to billing. With an EHR, coding can be performed concurrently so any quality/documentation concerns can be addressed prior to discharge, ensuring the account is coded and reported correctly the first time.

Quality Best Practices for HIM

In any healthcare organization, physician office, or ACO, HIM professionals have an expanding leadership role and add value to the care team. Some of the ways HIM and CDI can ensure efficient processes could include:

- Scheduling regular meetings or communication with quality professionals, opening up dialogue, and addressing any concerns. Daily huddles that are service-line specific can be useful in addressing issues as they arise.
- Avoiding claim submissions with inaccurate or incomplete information.
- Participating in proactive education/training for clinicians, offering guidance on coding rules and guidelines.
- Conducting weekly meetings with physicians, CDI specialists, coders, and quality staff to review all cases discharged during the previous week with complication codes that were not present on admission.
- Instituting a process for a second level of coding review to ensure accuracy and reduce the number of complications.

Indra Osi, RHIA, CHP, director of hospital coding at Ochsner Health System, based in New Orleans, LA, described how Ochsner's HIM hospital coding and CDI departments work collaboratively to review and confirm the accuracy of coding and DRG assignment as it relates to quality.

"In the past the surrogate for quality was embodied in the APR-DRG classification system. We would carefully scrutinize the risk of mortality (ROM) and severity of illness (SOI) levels to ensure that our patients demonstrated the highest acuity and thereby justified the care that was provided to the patient," Osi says. Osi also noted that all parties should be aware of external rating agencies that use specific methodologies to expand what is considered high or low acuity. These entities, such as Healthgrades, Leapfrog, and Truven, have determined that certain conditions when present on admission constitute being named a complication, and may or may not be considered contributory to the risk of mortality on any given case.

There are data analytics vendors that track hospitals' risk of mortality and complication rates and compare this data with national, state, and local rates. HIM professionals can use this information when discussing coding accuracy and application of the complication coding guidelines.

For More Information

To learn more about CDI and AHIMA's CDIP credential, visit www.ahima.org/topics/cdi. For additional information on health data analytics, AHIMA's Health Data Analysis Toolkit is available online in AHIMA's HIM Body of Knowledge.

The Office of the National Coordinator for Health IT also offers a health IT-enabled clinical quality improvement tool for providers that explains how clinical decision support plays a vital role in healthcare delivery improvement and practice transformation, and how to begin planning and implementing improved care processes. Access this tool at www.healthit.gov/providers-professionals/ecqi-what-it-and-how-it-can-help-you.

Note

1. Agency for Healthcare Research and Quality. "Quality Indicators Toolkit." www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html.

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