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Coding Concerns Uncovered and Four Organizational Risks: Don't Let ICD-10 Efforts Overshadow ICD-9 Coding Accuracy

By Barbara Hinkle-Azzara and Kimberly J. Carr

The journey to ICD-10 can easily be characterized as an emotional and financial rollercoaster. However, efforts towards ICD-10 readiness have not been in vain. In particular, the dual coding of medical records in preparation for ICD-10 sheds light on coding quality issues in ICD-9.

Dual coding is one component of ICD-10 preparation that most organizations will continue with, albeit at a slower pace now that the latest ICD-10 implementation deadline has been set for October 1, 2015. Organizations should continue their efforts and use this additional time to their benefit.

HRS's recent experience dual coding a sample of approximately 1,000 medical records for a large community health-care system revealed four key areas for current coding concern. This article summarizes these four areas and describes how executives can help.

Why Is ICD-9 Still so Relevant?

During the highs and lows of what has become a very tumultuous transition, some organizations have lost sight of the here and now; that is, how ICD-9 codes continue to drive reimbursement, power case mix index, and accurately measure IDC-10's expected financial impact.

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Drive Reimbursement

Accurate ICD-9 codes drive accurate reimbursement. This is true today, and it will remain true until the new proposed deadline of October 1, 2015—at which point ICD-10 will go into effect. If organizations want to receive every dollar they are entitled between now and then, current coding must be accurate and complete. Accurate ICD-9 coding also reduces denials, increases clean claim rates and mitigates RAC risk.

Power Case Mix Index

Another reason why health-care executives need to keep ICD-9 on the front burner is because this data continues to drive the current-day case-mix index (CMI). Many organizations use CMI to project budgets for the upcoming fiscal year. If coding and MS-DRGs are inaccurate, the CMI will be skewed as well, making it difficult to make informed decisions regarding capital expenditures, new service lines, staffing budgets and more.

Measure Financial Impact

Perhaps most important, organizations must rely on ICD-9 data as their baseline to predict shifts in MS-DRGs as well as the overall financial impact of ICD-10. If current baseline data are inaccurate, all predictions will be inaccurate, as well. Executives must understand ultimately that inaccurate ICD-9 can cause a whole series of revenue, planning and operational headaches.

Time to Break the Pattern

Unfortunately, problems with ICD-9 coding accuracy have plagued the health-care industry for a long time. Many of these problems continue to haunt organizations and feed RAC and other auditor pursuits. With the

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ICD-10 delay and new insights gleaned through dual coding efforts, now is the time to fix ICD-9 coding problems once and for all.

Calling Executives! 5 Ways Coding Needs You

- Continue to reiterate that importance of correcting coding errors today, in ICD-9, as a path to improving reimbursement and CMI.
- Emphasize the need for accurate principal diagnosis identification and documentation with medical staff.
- Compel physicians to completely document underling cause of signs and symptoms; as well as document all complications during each care episode. Support the importance of your organization's physician query process.
- Raise awareness among all clinicians about documenting correct patient status upon discharge.
- Fund ongoing dual coding efforts (was originally part of ICD-10 preparedness, but increasingly important for executive decision making).

Many of the ICD-9 challenges throughout the industry are universal. HRS's recent experience in dual coding cases for ICD-10 readiness revealed many of those challenges. During its analysis, HRS determined that ICD-9 codes had been assigned inaccurately over 7 percent of the time. Once HRS staff assigned the correct ICD-9 codes (and changed the DRG, if necessary), they were able to dual code those same records in ICD-10 to determine whether any true MS-DRG shifts would occur.

After a detailed analysis, staff determined that there would be a 2.5 percent shift in MS-DRGs between ICD-9 and ICD-10. What happened next is something that every health-care executive fears: This MS-DRG shift resulted in a significant negative net variance in the CMI.

Accurate Baseline is Critical for Executive Decision Making

There are two important elements of this project that hospital executives must understand. First, the shift from inaccurate to accurate coding in ICD-9 (i.e., 7 percent) may be far greater than the feared shift in MS-DRGs between ICD-9 and ICD-10 (i.e., 2.5 percent). Hopefully, that should calm some of the anxiety associated with ICD-10.

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Some MS-DRG shifts in ICD-10 will be positive while others will be negative. The negative shifts will occur largely because ICD-10 eliminates many of the complications and comorbidities (CCs) that previously existed in ICD-9. Positive shifts will occur in instances where procedures (e.g., excisional debridement) shift from medical to surgical. Although many of those shifts—both positive and negative—are unavoidable, it's incredibly important to be able to predict them accurately.

These predictions not only signal how ICD-10 may affect an organization's bottom line, but they also help hospital executives determine just how much money may be necessary for cash reserves. Executives can incorporate this important financial information in considering revisions to service lines or specialties to positively affect the CMI.

The second point for hospital executives to understand is that our prediction of the 2.5 percent MS-DRG shift for this particular population was only accurate because we had first validated and corrected the ICD-9 data. The baseline for any organization must be accurate to truly predict the variances that will result. This is why hospitals executives must continue to reiterate the importance of correcting any errors that exist today in ICD-9 coding.

Four Areas for Coding Concern and Executive Support

Based on HRS's experience, we've identified the following four ICD-9 culprits that every hospital executive's should consider:

1. *Principal diagnosis code assignment.* The principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient's admission to the hospital. This condition must be present on admission. Assignment of the principal diagnosis is crucial because this condition along with any procedures and CCs or major CCs ultimately determine the MS-DRG.

   How executives can help: Support the importance of your organization's physician query process. Ensure that clinical documentation specialists and coders query physicians when the principal diagnosis is unclear. Physicians must understand the rationale for these queries and be willing and able to provide a sufficient response.

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■ When two or more conditions equally meet the definition for principal diagnosis, coders are able to choose the condition that will result in the higher-weighted MS-DRG. However, ensure that physician documentation clearly supports the coding choice.

2. *Signs and symptoms vs. the underlying condition.* If the physician know the underlying cause of a sign or symptom (even if it is a possible, probable or unable to rule-out underlying cause), they should document this information. Codes that describe signs or symptoms are reportable as a principal diagnosis only when a definitive diagnosis has not been confirmed or established. In addition to ensuring coding compliance and accuratelyreflecting required resource consumption , it is also financially advantageous to capture the underlying diagnosis, when known and documented

   How executives can help: Reiterate that physician documentation must be as thorough and clear as possible. Ensure that physicians clearly document the underlying cause, if known, of these problematic signs and symptoms:

   -Chest pain

   -Syncope

   -Seizure

3. *Lack of documentation for complications/comorbidities (CCs) and major complications/comorbidities (MCCs)*. Coders cannot code conditions that lack documentation regarding monitoring, treatment or evaluation. HRS' analyses indicate that coders may assign CCs and MCCs without evidence of proper clinical indicators or treatment. Upon retrospective audits, these coded conditions are removed from the case, which then negatively impacts the final MS-DRG's relative weight.

   How executives can help: Again, this goes back to physician documentation. Ensure that your facility has a strong documentation improvement program in place. Consider appointing a physician champion who can reiterate the importance of documentation pertaining to medical decision-making and evaluation for all diagnoses and particularly those that qualify as a CC or MCC.

4. *Discharge status for patients with certain conditions*. Correct assignment of a patient's status upon discharge is also critical for both the data collection and potential financial impact, as the relative weights for some MS-DRGs vary greatly. Some of these conditions include patients with acute myocardial infarction, premature infants, alcohol/drug abuse or dependence

   How executives can help: Help all clinicians understand how their documentation (or lack thereof) of patient status upon discharge impacts MS-DRG assignments.

Make the Most of the Delay

The ICD-10 delay affords organizations the opportunity to really dive more deeply into the issues that continue to plague them in ICD-9. Dual coding helps to identify these issues, and correcting them now not only improves today's revenue, it also results in more accurate ICD-10 impact comparisons and even ICD-10 coding in the future.

Executives should focus on the following goals to make the most of the time between now and October 1, 2015 while also leveraging the current ICD-9 work for the transition to ICD-10.

- **Ensure that coders capture all reportable conditions.** An incomplete record is an inaccurate one. The omission of even one CC or MCC can shift an entire MS-DRG. This will still be the case when we move to ICD-10. Omission of other conditions greatly affects severity of illness or risk of mortality. Coders must strive to capture all reportable conditions, complications, and manifestations in order to ensure accurate reimbursement and data quality. This must be a mantra within the organization and something that executives support wholeheartedly. Clinical Documentation Improvement programs are an important component of this effort.

- **Educate physicians about documentation quality.** Coders can't code all relevant conditions unless physicians document those conditions. Ensure that physicians detail all treatment and medical-decision making so coders can validate whether a condition is reportable in coding terms. This, too, must be an initiative that receives executive support and priority.

- **Look for the root-cause of ICD-9 problems.** Incorrect coding can occur for a variety of reasons. In order to truly remedy the problem, organizations must be able to identify its underlying cause. For example, do coders require additional education about a particular guideline? Do physicians require documentation education? Is a lack of policy regarding encoder and computer-assisted coding validation causing the issue? Could it be a combination of all of the above?

- **Fix and monitor.** Once organizations identify and address the root cause of ICD-9 problems, they must continue to monitor those problems to look for improvement. In some cases, other problems may be revealed that require attention. For example, once coders receive education about a coding guideline, this may prompt a revamp of the query system or templates (which, in turn, requires physician education) to obtain the necessary information. Continued monitoring in ICD-9 can help with the transition to ICD1-10 monitoring as well. Organizations can begin to incorporate language into queries to promote necessary documentation outcomes.

Final Word on Coding: Computer-Assisted

Although computer-assisted coding (CAC) technology has the potential to increase coder productivity, organizations must be careful when using it. CAC uses natural language processing software to examine documentation, identifying key words and phrases for coding.

However, CAC systems can't always apply complicated coding rules and guidelines, some of which may be facility-specific. If coders don't validate the information provided by the CAC software, coding accuracy can be compromised. Human intervention is still required and must not be overlooked.

For example, documentation indicates that a patient underwent hip surgery three weeks ago and is presenting today for a follow-up visit. CAC may find this information and suggest the coder report the procedure.

Without proper validation, this surgery would be coded with absolutely no documentation to support it. Organizations must have a good handle on the data that the CAC presents and insist that coders validate this information before finalizing the bill. Otherwise, significant errors and potential for claims of coding in accuracies may result.

Insights for Tomorrow. Accuracy for Today

Revenue cycle improvement in health-care relies on accurate coding in both ICD-9 and ICD-10. And beyond immediate revenue impact, coding data serves as the basis for case mix index and executive decision making. During the ICD-10 delay, executives should encourage the dual coding of medical records as the process delivers insights, sheds light on current problems, and guides future opportunities.

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