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THE LANDSCAPE IS CHANGING FOR CODING, AUDIT AND CDI

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil. Today, we are joined by Shela Schemel, vice president of operations at Navigant. As a registered health information administrator, Shela has more than three decades of healthcare experience across hospital and physician practice management. In her role at Navigant, Shela supports comprehensive revenue cycle and modular solutions for hospitals and physician practices all across the United States. Annually, Shela and her team code more than two million charts for hospitals and health systems. Welcome, Shela.

Shela Schemel: Thank you, Alven.

Host: So, today we are discussing coding of medical services at hospitals, outpatient facilities, and physicians. More than 6,000 new codes were added in 2017 to Medicare's ICD-10. This growth in the number of codes also comes with increased coding specificity that requires more detail and documentation. All of this at a time where anywhere between 30 to 80 percent of provider medical bills are estimated to have errors. Shela, how can providers ensure documentation leads to the correct ICD-10 codes?

Shela: Well, Alven, in short, what they need to do is be documenting specificity. As we know with the voluminous code expansion that happened this past year, and more to come, we now have the ability to get down to the additional details of a patient's condition that we've never had in the past.

Actually, this added specificity requires all the known details about each specific diagnosis that's documented for that encounter, whether it be an inpatient or outpatient setting. The known specificity, details of the specificity, are things like cause and effect, laterality, right/left, timing, associated conditions, contributing factors, remission status, severity, episode of care, trimester of pregnancy, complications in manifestations, agent and/or organisms, anatomical locations, comorbidity, death in stage for wounds and ulcers, as well as late effects.

SPEAKER

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About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage, and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

All of these known conditions play a very important factor in the specificity of coding and getting the documentation to its most complete status. It is acceptable, especially in the outpatient setting, if we do not have sufficient clinical information about a particular condition to code it to a non-specific code. For the most part, the more specific the code is, the more the doctor is going to be successful in getting his reimbursement, as well as getting the acuity level to where it needs to be.

On the flip side of that, we all have to appreciate our healthcare providers and that they are faced with — not only challenging the balance of managing the care of their patients — but also, they have this enormous responsibility now for the continuity and specificity of their documentation to support all this coding.

It has to be, in their eyes and in all eyes that are working with a physician, looked at as a pathway that the physician has to master in order to provide proof that providers did their diligence and each physician did due diligence for the care of their patients, as reflected in the patient outcomes.

Host: Now, ICD-10 arrival coincided with the electronic health record movement, whereas coding now depends on physicians, and not trained coders, to document patient encounters. I think it's easy to see a scenario in which physicians, and they're already over-burdened with IT requirements through the EHRs, where they incorrectly code accounts.

This can lead to over-charging or under-charging and it also presents compliance and revenue risks. How can providers ensure proper documentation is being captured, all the while taking some of that coding burden off of clinicians and physicians?

Shela: Sure. One of the things that I'm an advocate of is that physicians have to take advantage of every existing resource they have, in order to meet the measures and mandates of accurate complete documentation, quality coding, and in the end, accurate billing and reimbursement.

A key integral, in my mind and what I've seen all over the country that is working for physicians, is CDI programs. These are clinical documentation programs. They're integral to assist the providers in the acute care, and now we're going to see, over the next five years, a huge growth in the outpatient setting, as the industry pushes more and more services and procedures to the outpatient realm.

The documentation in these areas are going to increasingly see more scrutiny. Physicians don't always have a plethora of staff to help them with documentation and interpretation of guidelines, thus, they need to depend upon CDI specialists to be able to ask the questions for clarity to get to that specificity level that they need in order to obtain the reimbursement and the documentation to support that reimbursement that's supported in the coding.

As providers, of course, the primary concern is taking care of their patients and documenting, of course, well enough to get credit for the care that they've delivered, as well as sustain the continuity of care for that patient. The extra burden and the additional work involved in this requires strategy.

Part of that strategy is the CDI professionals. I think that the success we see is that many times physicians just don't know. They don't know the coding guidelines. They know their diagnosis, they just don't know the specificity that's out there for them to choose from, and it becomes very complicated for them to try to stop and learn all this and keep up with the ever-changing, yearly updates that come out.

They just really need to rely on the CDI team to help them understand and bridge that gap, if they will... again, in the acute care setting, and then have an open mind for the outpatient setting, as well. That's something that we're again going to see. In the next five years, we're going to see this grow tremendously.

I also think, over time, we're going to see the acute care and the outpatient care episode combined, so that those diagnosis codes really need to match. If they see them in the hospital, they need to be billing the same diagnosis codes that the hospital billed for that episode of care.

Vendors are going to play a big role in the outpatient CDI. Specifically, when it comes to the integration of the physicians throughout the hospital system and their documentation. I'm already talking with some of our large,

hospital acute care settings that they're in the business right now of seeking outpatient CDI vendors. It's not something that has really caught on in the vendor realm, but it will catch on within the next six months, and over a five-year span, it's going to be almost in every physician clinic, hospital setting throughout the country.

Also, we see natural language processing programs, CAC, computer-assisted coding, electronic health records that are literally setup to capture certain measures, and then outpatient CDI, of course, is the tip of the spear in documenting the hierarchal condition categories. As we see huge growth in this department as well, CDI is going to be critical to ensuring that documentation is there.

The values gained from these software updates, and as I mentioned natural language processing solutions, is costly. Consultant retainment is costly, but well worth the spend in the long run to improve documentation and coding specificity. Providers in today's healthcare landscape are often the center of numerous requests.

The balance that they have to create to prevent CDI specialists to perform his or her role without impending upon the physician's day-to-day caregiving is very vital to the success of keeping a physician, seeing his patients, documenting accurately in the hospital and/or clinic, capturing the acuity levels that they need to be capturing based off of that documentation.

Host: In addition to the complexity of new codes and the need to bridge that clinical back office gap, we're also seeing a shortage of coders. To address this, and to staff appropriately, some health systems have fully outsourced the functions, some have maintained a portion in-house, and then some are blending U.S.-based and patient trained coders and offshore coders. Shela, if I'm a provider executive, how can I determine which scenario is best for my organization?

Shela: Well, Alven, as a result of all the scenarios you mentioned above in your scenario that you just gave us, there are various expenses, there are various scalability issues. We see CFOs looking for a way to save costs. We look at accuracy, scalability, all of the things that I just mentioned play into where they make their decisions.

I think that providers are involved in this too, and we have to understand there are options when it comes to where they are most burdened. Helping them to understand that they need to give us, as a vendor, or help them, as a consultant, to see where that burden is really causing them the most pain.

With knowing that, if it's cost, many times we'll suggest, and they should look at, perhaps, a model that might be offshore, or perhaps a hybrid scenario so that outsourcing everything from cradle-to-grave related to coding may not make sense to them, so they want to keep their inpatient acute care close to home within the brick and mortar of their hospital. That doesn't mean they can't send their lower lying fruit like EDs, ancillaries, those types of things, offshore.

Definitely there are options. As a vendor and as a consulting entity, we always want to be able to give them a solution that fits their need and be that partner that provides a service that fits their need. Even if it's 100 percent outsourced, we may make a suggestion, "This might work keeping this within the U.S. This might work sending this offshore," but then providing a model that they can understand the workflow, how we're going to deliver that, and what is going to be the cost of that. Ultimately, that's what they're looking at.

I'd encourage providers and organizations to make a list of the qualities that they want in a partner. What they want them to possess as far as the proven footprint in the industry. Do they want to see that? Where they've been? What they've done for other clients?

Also, it has to be a similar type of organization for what they're dealing with. We always try to pair them up with someone that has a similar need and has had success with another vendor, or an offshore company, or something that we can provide them.

The other thing is ensuring that they know that, whoever they go with, it's a compliant company, and that they're going to provide them with certified coders, or individuals that can do the work and are well-qualified to deliver results.

I think positioning yourself for a quick recovery from any unnecessary strain in the areas that were mentioned like you just can't find enough coders or you're running out of money, this expense is overwhelming, or your accuracy is not

sustainable. All of those things go into establishing the right vendor and the right partnership that can deliver years and years of savings as well as sustainable growth.

Host: Before we wrap up, if you could, please share with us some of the dynamics of coding audits.

Shela: Sure. When you have coders you need to know the answer: "Is your coding good? Bad? Great? Where do you fall?" Many of our providers, especially, they really don't know the answer to that. There may be audits going on, but they may or may not be aware of where these audit results are, as far as, like I just stated: good, bad, or great.

They need to know. It creates stress for them, it creates risk for them. The hospitals are a little better about this, but for the most part, the providers — that has been an issue, because many of them are paid by RVUs. If the coding is not sufficient, if the documentation is not sufficient, based off of what was coded, there's a problem.

Audits offer visibility into operational coding processes. Consequently, the term audit obviously creates a little bit of a fear and dread, sometimes with individuals that are performing those procedure processes like coding and this especially is true when you have coders that are onsite that have worked somewhere for many, many years and have never been audited.

It's a valuable, valuable process to have in place for at least yearly. An annual audit is something that you need to put in your objectives. You need to make sure that the value of this is known, that it helps strengthen the future for payments, for alleviating the fears and unknowns. Physicians, I think the morale is better when they know that they have got a solid team supporting them and they also know that they're receiving feedback.

If you have an audit, and the docs aren't aware of it, or the proper individuals at hospital administration are not aware of this, this is a serious issue and it should be taken to those individuals because it accomplishes very little if we have an audit returned and we don't show the good news, or even — more importantly — we don't show the bad news.

When there is bad news, a bad audit, that means that we need to take action, and there needs to be some education, there needs to be some change process put into place. The burden is on the provider, the burden is on the hospital administration to know your accuracy. It doesn't matter if it's outsourced, it doesn't matter if it's in-sourced, it doesn't matter if the provider is providing the coding, there has to be a level of understanding of the accuracy that's going to that payer.

The loss is real. It's financial. It sometimes can be punitive in a way that financially, the organization or the provider cannot afford to have happen because they can go back and extrapolate from many, many months of incorrect coding if they find a pattern, whether it's intentional or not. Many times it's not, but you should have known that it was coded incorrectly because there are guidelines out there that are accessible to everyone that is providing care to patients and billing third-party payers.

Audits are vital to the long-term sustainability of an organization and a provider. I just feel that in the long run they pay for themselves, over and over.

Host: Great information, Shela. Thank you so much.

Shela: Absolutely. Thank you, Alven.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.