April Lewis:

Good afternoon everyone. Thank you so much for joining. This is April Lewis. I'm Director of Health Center Operations and HR Training here at NACHC. We're so pleased that you took the time out of your schedule to join us for part one of our Coding and Documentation series. This particular series is focused on the recommendation for outlining the patient conditions for risk.

April Lewis:

I see we have several people on the webinar, so if you're having any issues with hearing me, if I'm not loud enough, please just comment in the chat box, and I will do what I can to make sure your experience here is solid.

April Lewis:

To the person... There is no access number, so you should all be able to be in and see my screen just fine, and if, for whatever reason, you don't see the slide number one, do let me know, and I will make sure that I troubleshoot it for you from this end.

April Lewis:

Well, I want to roll right into our webinar because we have lots of good information that we want to put out, and our presenter for the day is Shellie Sulzberger, who is a trusted, trusted partner with NACHC.

April Lewis:

Shellie is faculty for not only the practice operations management portfolio, but also or finance track with, some of you may know, my colleague, Gervean Williams.

April Lewis:

Shellie is not new to coding. You saw her brief synopsis of her bio on the registration page, and also, when we get to the end of the slide sheets, I have included her bio as well as she's going to do her introduction, but I just want to let you know, she knows coding inside and out, so we are pleased to have her on the line.

April Lewis:

Shellie, she's a Licensed Practical Nurse, so very much in her position in healthcare. She's a certified professional coder in ICD-10 training.

April Lewis:

Now, she has six years coding and billing experience with the national accounting and consulting firms to include BKD and Grant Thornton. Now, Shellie currently is the President of Coding and Compliance Initiative Incorporated. Again, we have a powerhouse who's coming in today to bring forth this information.

April Lewis:

I'm going to pass it over to Shellie, and she will take it from there. I do hope you all are online comfortably to where you can engage in some polling questions. We have three questions throughout

this presentation to get some feedback for you, and with NACHC we always welcome your response from the field, so we can take it to all of our trainings accordingly.

April Lewis:

Shellie, I'm going to pass the baton to you.

Shellie S.:

Thank you April. Good afternoon everyone. Welcome to today's seminar on coding and documentation, really just kind of outlining the patients' condition for risk as we move forward into this value-based healthcare world.

Shellie S.:

One of the things I did want to mention as well is that we do have on Friday... and I know April will kind of close and give you more information. On Friday, we're doing kind of an office hours. We'll go through some questions and answers that have kind of been trickling in over the last week, plus the ones that we talk about today.

Shellie S.:

As you hang out between today and Friday, if you have other questions, get those to April as soon as possible so she can get them to me, and we can include those in the webinar on Friday.

Shellie S.:

So, first of all, just, again, thank you for NACHC and April. There is some information about the upcoming FOM/IT conference in October in Las Vegas, so I'll let you guys have that, and you can look at that on your own.

Shellie S.:

So, a little bit about my background is my connection to coding and documentation is I am a Certified Professional Coder. I work all over the country with FQHCs and non-FQHCs helping providers and coders with coding and documentation for credible, concise, clear documentation and really how to support the risk of the patient and the work that's being done by the providers.

Shellie S.:

My connection to the clinical process is I am a nurse by background. I did work in Internal Medicine, so I really have a good understanding of the clinical side as well as the coding and documentation and how do we marry that together to get our providers onboard and make it easy for them.

Shellie S.:

My connection to ICD-10 is I'm an ICD-10 Certified Trainer, so, again, just helping practices and health centers get up on ICD-10 and really understanding how to report the appropriate ICD-10 codes to outline the risk of your patient and the work that you guys are doing as a health center.

Shellie S.:

Then, of course, my connection to you is I am a national speaker for NACHC as well as I do lots of practice assessments from operations and coding and documentation reviews and education with FQHCs just like yours.

Shellie S.:

Just a quick disclaimer, there's nothing in my presentation that's legal. I don't give you legal advice. Most of the opinions and commentary are totally from me as a speaker or information that I've researched on the most common regulatory guidelines, such as Medicare, some of the Medicaids, etc.

Shellie S.:

Let's get started. Today, we're really going to talk about making sure we have a complete, accurate, and credible documentation, so, at the end of your two-hour session, we're really hoping that you'll understand what our current model has been in healthcare, and then what our future model's going to look like as we start outlining the patients' risk and the work that our providers are doing.

Shellie S.:

Hopefully, by the end, you'll understand why clinical documentation is critical from not only a compliance standpoint, but also reimbursement and patient care.

Shellie S.:

Then we'll talk about the most common clinical documentation issues and how to really get started on what we would call like a CDI program, Clinical Documentation Improvement.

Shellie S.:

Throughout the presentation, as I mention the word CDI, it's clinical documentation improvement, and that's how we're moving in this healthcare world.

Shellie S.:

I first just want to get a quick polling question, and I'll let April take over from here on how to sign up in the polling question just so we can figure out who's in the audience. So, April, if you want to go ahead and unmute and teach them how to do the polling, that would be great.

April Lewis:

Of course. I'm talking, but my phone's still muted.

Shellie S.:

I thought so.

April Lewis:

Of course, so, I'm going to open up a poll, and you all can just click on and answer... Hold on one second. All right, for poll question number one, it's just one minute. You click on it to let us know who's in the audience, and you should see it to the right of your screen.

April Lewis:

Oh, you all are fast.

Shellie S.:

As you guys are doing your polling, just remember, if you have questions today, please make sure to do them through the chat box so that April can tally those questions.

Shellie S.:

We'll definitely answer some today at the end of the call, but a lot of these we'll like to hold till Friday so that we can really use our hour on Friday to do the questions and answers.

April Lewis:

All right. You have about 20 seconds left. Thank you for your responses. No surprise that we mostly have billing staff.

Shellie S.:

Perfect.

April Lewis:

Mm-hmm (affirmative).

April Lewis:

All right. Thank you all so much. Shellie, I'll pass it back to you.

Shellie S.:

Great. Can you give me just kind of a quick breakdown. I can't see it.

April Lewis:

Oh, I'm sorry. I guess you -

Shellie S.:

Yeah.

April Lewis:

Oh yes. Oh, I'm looking right at them. We have 34% are billing staff, 5% provider... Welcome our providers! 2% clinical staff, 2% quality, 2% compliance, 17% administrative, 18% coding staff, and then we had 21% not answer.

Shellie S.:

Okay, perfect.

April Lewis:

So, the vast majority are our billing teams.

Shellie S.:

Perfect. Okay, so let's really get started and kind of dig in. Kind of just an overview on what is risk adjustment? Risk adjustment's really not a new concept. This process has been used by CMS centers for Medicare and Medicaid for quite some time to really predict healthcare costs based upon the relative risk of our enrolled patient.

Shellie S.:

Medicare really began using this risk model back in 1996, and then the Medicare Advantage Plans started using it somewhere around 2004, so it's definitely not a new model.

Shellie S.:

Right now, providers haven't always been paid based upon risk. Medicare is really starting to look at patient engagement, how sick our patients are, the work that providers are doing, so the risk factor is really determined based upon your diagnosis coding.

Shellie S.:

It is so important that our providers understand the importance of documentation and documenting the diagnosis that that patient has that are being addressed today or impact that patient's care or the provider's thought process related to the work.

Shellie S.:

With EMRs, it's a little tricky because we're used to pulling in several diagnoses that may not be addressed today and may not even be relative to today's visit. It's really working with our providers on how to put in the diagnosis that they're either treating, so that encounter, or that impact the risk or the work. How to tie that together so it doesn't lead anyone hanging to wonder why is that diagnosis pulled in the assessment and plan when there's nothing in the history or exam related to that?

Shellie S.:

Our current model really, again, is just based upon the intensity of the service. We support our fees and our charges with a CPT or HCPCS code. We submit that. Of course, with FQHCs, for Medicare, you guys are using your G code in addition to your other E and M codes, and there really hasn't been as much emphasis in the past on diagnosis coding. However, as we move, again, to the value-based healthcare world, our ICD-10 and diagnosis specificity is going to be so important.

Shellie S.:

The future model, kind of what we were just talking about, how important it is going to be with diagnosis codes, and really thinking about how sick our patients are.

Shellie S.:

For example, this morning, I was doing a chart review, and the provider documented the diabetes as E11.9 in the assessment. The claim form went out with E11.9, which is diabetes, type two, unspecified, which a lot of times that is what we have. However, when I was looking at the note, the provider had indicated that over the last like six months this patient's hemoglobin A1c has been running between 11 and 13, which tells us from a clinical perspective that patient is an uncontrolled diabetic.

Shellie S.:

However, the coding and billing staff cannot diagnose patients, so even though they may be able to figure out that patient's uncontrolled, we depend on our providers to indicate that the patient's diabetic with hyperglycemia or uncontrolled, so we can report the most specific diagnosis.

Shellie S.:

This is an area where we're really going to have to work with our coding and billing staff to kind of think outside the box and not just look at the words just because our providers say, "diabetes." I want them to really think outside the box and start working with our providers on how to document and things to think about because our healthcare, as we know, is rapidly changing.

Shellie S.:

As we start looking at this risk-sharing model, it's going to be important that our providers understand what has to be documented in the ways of diagnosis to the highest level specificity.

Shellie S.:

When you start thinking about ICD-10 codes, you have to ask yourself a question. Does ICD-10 and risk-based coding really go together, and how does it impact our documentation? So, all of you should be thinking about that every single day.

Shellie S.:

Diagnosis coding does impact the risk and the documentation because our diagnosis codes are what are used to calculate that patient's complexity.

Shellie S.:

Our diagnosis codes, the ICD-10 codes we submit on a claim form, generate what we call a risk adjustment factor or also known as a RAF, which numerically reflects the severity of the patient's illness based upon the information we've provided, so the medical severity of that illness is derived only from the diagnosis.

Shellie S.:

So, using my example from this morning when I looked at that chart, if I have a diabetic patient, and I report E11.9, but I have an uncontrolled diabetic patient, then I report with E11.65, a payer doesn't even have to look at the documentation to start thinking about the patient that's an uncontrolled diabetic with the appropriate ICD-10 code is more complex and more risky than the patient who is not an uncontrolled diabetic based upon the code that we submitted.

Shellie S.:

It's really important we work with our providers because that is how our payers are going to understand the severity of the illness, based upon the diagnosis codes we submit on our claim forms.

Shellie S.:

Clinical documentation improvement, again, CDI, it's really just an initiative that's focusing on improving our documentation at the point of service that we see the patient. CDI really has a great impact and a

direct impact on patient care, so we have to really start thinking about how to work as a team in our organization because the CDI program is really going to take a team of people... your scheduling people, your front desk, your medical assistants, your providers, your coding and billing.

Shellie S.:

We all have to learn how to work together and kind of put the... It's like a puzzle, and really putting the pieces together because organizations have to have well-rounded individuals who can articulate all of these pieces. You can see, one person can't do everything, so we have to have somebody that understands the documentation requirements. We have to have people that understand the right questions to ask when I schedule my appointment. We have to have the providers who understand the clinical side, so it takes all of us to make this work.

Shellie S.:

Clinical documentation really is going to affect a lot of different areas. Identifying a condition by the thought permits others to kind of follow that thought process through the documentation based upon what our providers are documenting. It's really painting a clear clinical picture of your patient.

Shellie S.:

What are they there for? What did we do today? What's been done so far? What are the results of what we've done so far? Again, the better the documentation, the better we can understand the complexity and the risk, the easier it is to explain the morbidity and mortality of those patients.

Shellie S.:

Also, it helps us support that the service was provided and performed. As we've heard in the old days, if it's not documented, it wasn't done. Obviously, in today's world, we ask if it's documented, was it really done based upon the EMR, but we're looking now at really reading the words of what's written in that note.

Shellie S.:

In the past, most auditors, most coding people, are not really looking at the clinical perspective of that patient. They're reading words on a piece of paper to see if you met the criteria for the code. As we move into this clinical documentation improvement, which is really going to affect quality of care, liability, acuity, all of that's going to go together.

Shellie S.:

Now, we're asking our auditors and our coding and billing staff really to look at the whole note and the documentation, and does it reflect the complexity and the risk? Again, providers have seen this in hospitals, but we haven't really done a CDI program on the clinic side.

Shellie S.:

The other reason this is so important for our providers really to get a jump start on this, even though it's not in FQHCs right now as a whole... We have to start educating our providers because payers and patients are starting to look at what we call health grades, so if I google one of your providers, it will pull up the health grades, and it's going to include currently what other patients have said about your providers.

Shellie S.:

Remember, it's the perception that's reality for that patient, so if a patient's had a bad experience, they're going to put that in their health grades, but as we start moving towards quality indicators, those quality indicators are also going to be part of our health grades.

Shellie S.:

This can be a little bit detrimental because if our providers are not doing a great job documenting and putting the information to the highest level specificity, then, obviously, the health grades go down.

Shellie S.:

As a layperson, looking at those numbers, they are looking at the percentage and the grades for that provider, and what happens is it starts to give people the perception that, golly gee, that provider's not a great provider. We could have the best provider in the world, but if we don't have the appropriate health grades because we didn't document and code appropriately, it could cause some information to be skewed on the backend.

Shellie S.:

What is documentation? Well, document is a timeline. Really, it's a snapshot in time of the health events that we're contributing to that patient's care.

Shellie S.:

It is also used as a communication tool, so communication between your provider and other providers, between your provider and patients. We're really using this for coordination and continuity of care, and, of course, as a legal document. It's proof that the care was provided, and it outlines the type of care that was provided to that patient.

Shellie S.:

I'm going to ask another polling question just part way through. My question is: Documentation is not that important in an FQHC since we're paid at the same PPS rate for each patient we see. True or False?

Shellie S.:

I'll have April go ahead and open the polling question.

April Lewis:

All right everybody. It is open, and I forgot to change the time from one minute, so I'm going to stop it at the one-minute mark. I don't think it'll take you five minutes to do true or false. All right, about 20 more seconds. Thank you all for your responses. All right, we're going to close this. We have 1% say true, three out of the total attendees, and we have 79% to say false, and 20% did not answer.

Shellie S.:

Okay. The question again was documentation is not that important in an FQHC, and that is false. Documentation is really important, and it doesn't matter whether we're in an FQHC and paid the same PPS rate or we're in a freestanding clinic and paid fee for service.

Shellie S.:

Why is it so important? Well, first and foremost, documentation is critical for patient care. We have to know what's been going on, and what are we currently doing, and what's the game plan for going forward.

Shellie S.:

Also, documentation is important for quality reviews. I already work with a lot of FQHCs that are risk sharing with other managed Medicaid organizations, so quality reviews. Obviously, it validates the care was provided to that patient. It reduces the risk of denials or rejections, which reduces the rework of the claims processing side.

Shellie S.:

Every time we touch that claim in your organization, it costs you around $12, so, when you're thinking about that, if we submit a claim, and it's denied or rejected because the diagnosis code wasn't appropriate or it wasn't to the highest level of specificity, and it comes back... Every time that claim is worked, it costs your organization money.

Shellie S.:

Again, documentation is key for the reworking of claims processing. Also, documentation's important if we have to support it to a payer if they don't think that the service has been provided or was medically necessary. Again, documentation is critical for that.

Shellie S.:

Of course, compliance, as you know, with CMS as well as other payers, a legal document, and, as I said earlier, it totally impacts our coding, billing, and reimbursement, as well as supporting medical necessity, claims rejections, or denials of claims.

Shellie S.:

Again, current versus historical diagnosis or conditions... We have to really teach our providers to be clear on what diagnosis or conditions are current that they are treating today versus ones that are historical and no longer present. This is a little bit challenging in some of our electronic health records. Many of the electronic health records, as we build that problem list or what some of them would call and active list, if those diagnoses or problems are not removed, or we don't put a date for them to expire, those diagnoses or conditions continue to fall on the documentation of each note.

Shellie S.:

So, a couple of things we run into... Number one, those may not be treated that day. Number two, they could pose some liability, so, if a patient had chest pain two years ago, and it continues to show up on every single note, but, today, they're there for a rash that has nothing to do with chest pain, and between today and when they come back, something happens regarding their cardiovascular health, it could be a liability risk to that provider because it's on our documentation of that either problem list that fell into the note today, or an active problem list, which falls into the note today.

Shellie S.:

It's really looking at your documentation to see... Is the documentation reflective of the work that you provided during that encounter?

Shellie S.:

Also, documentation is key for monitoring that patient. All monitoring efforts should be included in our medical documentation. A lot of times, when I shadow providers, I go in the room, listen to what happens, providers are monitoring the patient's chronic health conditions.

Shellie S.:

Sometimes they're really good about indicating that in their history and assessment/plan, "Patient also has diabetes and hypertension. They're taking their medications as prescribed, etc.," in their diagnosis, "Number two, diabetes. Continue metformin. Number three, hypertension, continue lisinopril."

Shellie S.:

Other times, providers are not great about putting the information that they're monitoring. Then, of course, we want to take into consideration our diagnosis for the medical decision making.

Shellie S.:

With the electronic medical record, as auditors and coders, we have to look at that note. Why is the patient being seen? What is that patient's story? Then we have to correlate the diagnosis. Sometimes what we find is providers put in diagnoses that are not addressed anywhere in the history and exam. However, during that encounter, the patient said, "Oh, by the way, Doctor, can you refill my lisinopril?" The provider will list that diagnosis and the medication.

Shellie S.:

We've got to start working with our providers to either in the assessment and plan indicate patient's taking medications as prescribed, needs a refill on lisinopril, or they need to mention something in the history. Otherwise, payers are wondering if we're just pulling in diagnosis that that patient has to get extra credit on our medical decision making even though they're not documented as being addressed.

Shellie S.:

Again, looking at our diagnosis and conditions, what's current, what's historical, and what's being treated during today's encounter.

Shellie S.:

Also, the condition has to be documented in the medical records. That's kind of what I was just talking about. If you see it in the assessment and plan, does it correlate with why you're seeing that patient, or have I mentioned it somewhere else, or have I said that it's just going to be a refill today?

Shellie S.:

Coders cannot diagnose patients. We can't take test results and say, "Wow, they've got elevated blood sugar, so I'm going to give them prediabetes." We can't do that. We need our providers to diagnose the patient. Coders can go back and talk to the provider when they see maybe something was missed, but, again, we can't diagnose patients.

Shellie S.:

We really have to start teaching our providers to kind of what I call give us the meat. I want to make sure that every condition that is documented in the assessment and plan was monitored, evaluated, assessed, and/or treated. We're looking for that document indication to correlate, so one of the things I do when I teach providers is I teach them your documentation is like a storybook.

Shellie S.:

If at the very beginning of my book or my novel, I have three characters, but, when I read through, the middle of the book is still about all three of those characters... I get to the end of the book, if I have five or six or seven or eight characters, I am now lost because I'm like where did these other characters come from if there's no information? That is the way our notes in our medical records appear sometimes. We look at the history, and we have two or three conditions we're managing or treating today that correlates to the exam, and we get to the assessment and plan, and, holy cow, there's 12 diagnoses.

Shellie S.:

We have no idea where those came from. It doesn't correlate anywhere together. Our providers haven't given us the meat, monitoring, evaluating, assessing, and treating of those diagnoses. So, again, documentation for each visit has to stand alone.

Shellie S.:

Medicare doesn't want you to send in this year's notes. They say each visit must stand on its own, so when you're looking at the documentation, is there a reason for visit? Do they have other coexisting or underlying conditions that impact or affect that care that's provided today?

Shellie S.:

For example, if you have a patient that comes in with a cough and upper respiratory infection, and they're a smoker and they have COPD, those are coexisting conditions that are going to impact the care provided today, so, again, looking at all of that together.

Shellie S.:

The other thing I want to talk about on this slide with relation to documentation is the second to the last bullet, cloning. Cloning is a big deal right now. Cloning is where we either take and pull forward a previous note, or we copy and paste, or we have our templates built identical and we don't change them.

Shellie S.:

Medicare is starting to really watch for cloning. They want to know, did you see a patient today and bill for a service and then in a month or two months or three months see the patient for those chronic conditions again and copy and bring forward that entire note and not change anything or change very little? That is on the OIG Work Plan every year right now. It's been on there for the last two or three on cloning of documentation.

Shellie S.:

So, for my coding, billing, compliance, quality staff, one thing you can do internally is just pull maybe five patients that have chronic conditions by provider, and pull two or three or four visits. Put the notes side

by side starting with the oldest date of service, and on the second date start highlighting things that are different. Do you have enough information to support the level you're billing for those additional dates?

Shellie S.:

Now, with the exam, most providers document the same type of exam, so I don't get super excited about that, but when my history and medical decision making are identical, that does give me a little heartburn. Sometimes, I can take the notes and put them up to the light and even just looking at the letters all the way down, I can tell nothing has changed. Those are little things you can start doing in your own practice related to documentation.

Shellie S.:

What are some of the documentation issues that we see when we do chart reviews? A lot of times I see chronic or coexisting conditions that are not documented. I can tell they go together. Providers are doing joint injections, but they don't tell that diabetic patient or they don't document that they told the diabetic patient, "Hey, watch your blood sugars because they may spike due to being on the steroids." Things like that or patients that come in with ENT and respiratory, I see that there's a history of a smoker or a current smoker or exposure to smoke, but those conditions are not included in the assessment and plan, which means they're not included on the claim form.

Shellie S.:

Sometimes it's hard for providers because time is money, and I do understand if you go look and hunt and peck for every single diagnosis, then you might not ever see enough patients to make it through the day.

Shellie S.:

You have to come up with a way that works. One thing you can do, if you have somebody in your office, like I've been working with an IT guy that's helping me with some of my clients write what they call "rules" so that when your medical assistant or the provider evaluates that the patient is a current smoker, for example, and under the social history it indicates the patient is a current smoker of cigarettes, we can write rules with IT people that say if the provider addresses this, they can click a button, and that will automatically drop in the assessment and plan, or, if the patient's morbidly obese, and the provider lists that in the assessment and plan, we can write a rule to pull down the BMI, called the Z code, to correlate with that morbid obesity or vice versa.

Shellie S.:

So, work with your IT people to help write rules where you can pull some of the documentation issues into the assessment and plan to really give that story of that patient.

Shellie S.:

Again, discrepancies is a big deal that I see with documentation. In some spots, it's say the patient's a current smoker. In other spots, it'll say the patient doesn't smoke, they've never smoked, or a former smoker, so, again, working with our medical assistants and our providers on how important it is with the documentation. I see this a lot as well in the review of systems. The review of systems will be prepopulated, so providers will say, "Shellie's here today for x, y, and z. She also has nausea, vomiting,

diarrhea." You'll get down to the review of systems, and it'll say, "Denies nausea, vomiting, diarrhea." Payers are starting to ask the question, "Did we do the work today, or did we click a button?"

Shellie S.:

The documentation doesn't always indicate if the patient is getting better, if they are worsening, so, again, working with our providers to really tell that story. How is the patient doing today from the previous visit? Are they stable? Are they getting better? Are they getting worse? Do we have a change, and just making sure that the documentation is clear, and that we signed the note, and we used standard abbreviations.

Shellie S.:

Let's look at a few examples of what might be considered not so great versus better documentation. So, if you look at the example of COPD, continue meds. This is typically what we see, but COPD, stable, controlled with Advair is much better documentation.

Shellie S.:

History of angina, continue meds. For coding purposes, history of angina, if they're on medications, would not be a "history of." They have that currently, so, angina, they have that diagnosis, stable on nitro.

Shellie S.:

Diabetes, increase insulin. How about diabetes, type two, with hyperglycemia, increase insulin. Neuropathy, diabetes, type two, with polyneuropathy, long-term insulin. So, again, just best practice, we want to make sure that we document to the highest level of specificity. Include any of those underlying conditions. Tie things together for the coding and billing staff.

Shellie S.:

Depression. Is it major? Is it mild? Is it a single episode? Is it recurrent? Things like that are the most specific. Sometimes, we don't have the most specific code, and that's okay. However, when we continue to use an unspecified code for multiple years, payers start to ask why we don't have a more specific code.

Shellie S.:

Diabetes and chronic kidney disease, so, again, how about diabetes and CKD with type two uncontrolled diabetic, stage three chronic kidney disease?

Shellie S.:

One of the things with an electronic medical record, which are a little bit challenging for our providers is if we have a controlled diabetic today with stage two kidney disease, we build our problem list. Well, maybe in six months that patient gets a divorce, loses their job, a lot of other factors go on. Maybe they're not compliant. Now, they have an uncontrolled diabetes, and their kidney disease has changed based upon the GFR, and now they're a stage three or four.

Shellie S.:

Well, when we built our problem list, it takes our providers a long time to update that problem list. Typically, what will happen is, in the verbiage of the history and exam or assessment, they might document to the highest level specificity, but when they pull the diagnosis codes over, we get a discrepancy because maybe in my history it says the patient's an uncontrolled diabetic. Their hemoglobin A1c has been 14. They're stage three chronic kidney disease. However, you get to the assessment and plan, and it says, "Diabetes, stage two chronic kidney disease," so, again, working with our providers to use that problem list and take the additional time to update it.

Shellie S.:

Asthma. How about asthma, mild, persistent, stable with a personal history of smoking? You can see the specificity changes how you think about a patient. If you see a patient with asthma, you're like, "Oh, not a big deal," but when you start to see more specificity and, "Oh, gosh, they used to smoke." That increases the risk, which we start thinking about from this risk-based coding, value-based healthcare.

Shellie S.:

Behavioral health. Most of our behavioral health providers are really good at documenting their diagnosis to the highest level of specificity. Where we see behavioral health providers struggle a little bit more is thinking about the medical disorders that impact the mental disorder being treated.

Shellie S.:

That patient goes to see my psychiatrist, and they have a lot of underlying medical conditions that are impacting the mental disorder. We need to learn how to tie that together. It doesn't mean that our psychiatrists have to take care of those medical disorders, but kind of document and tell me how those correlate. With Shellie's underlying x, y, z, it increases her anxiety, or medications that impact the thought process of the psychiatrist... maybe they're thinking about, "Gosh, with her uncontrolled diabetes and her COPD, I've got to be really careful on which medications I prescribe." So, again, tying that together to talk about the complexity of that patient and the work that's performed.

Shellie S.:

Let's look at an example. So, the patient's been seen for deposition and general anxiety. No symptoms of psychosis, but severely depressed. The patient's recently been abusing alcohol subsequent to the onset of depressive symptoms. The patient's had two anxiety attacks in the last month, having marital problems, lost her job due to poor performance and absence. Her past medical history reveals treatment for hypothyroid and hypertension.

Shellie S.:

When we're looking at diagnosis, we have several. Major depressive disorder, recurrent, severe, and she doesn't have psychotic features. The patient also has generalized anxiety disorder, alcohol abuse that's uncomplicated, hypothyroid, hypertension, problems with relationship of a spouse or partner, and then unemployment. So, when you're looking at just the ICD-10 codes, it gives you a pretty good idea that this patient is not a stable, well-controlled patient that's going to be okay between today's visit and the next one. This patient is more complex. It gives us a lot of information about the severity, the risk, and the work that's being done, so, again, clearly documenting and coding really helps us reflect the severity of the patient's overall illness and the work that our providers are doing.

Shellie S.:

With the history, exam, and decision making, that's kind of a process for diagnosis and treatment. So, teaching our providers, I want to know what did the author think about each of the issues that they're dealing with? What did the author do with each of those issues? What do the other people need to know about those issues, and then what do the other people, i.e., providers, need to do about those issues?

Shellie S.:

What are we thinking about, what are we doing, what do the other providers taking care of that patient need to know, and what do the other providers need to do about those issues? So, again, teaching our providers how to document a note that helps them clinically and also tells the story of that patient.

Shellie S.:

So, when you're looking at clinical documentation, we have several pieces, but the three main pieces, patient, physician or provider, and then the health center.

Shellie S.:

The patient... We have to show that the quality of care was provided. We have to be able to document so that we have continuity of care between the provider and the patient, and the provider and other providers treating that patient. Then, of course, if the insurance denies the payment for the patient because of medical necessity or diagnosis, that impacts our patient because our patient may be due the money because we didn't document very well.

Shellie S.:

For the physician or provider, again, it demonstrates accountability when we document well. It helps with performance management, and, again, helps with reduced denied payments or rejected payments.

Shellie S.:

Then, of course, with a health center, our documentation is key for revenue, right, so, coding and billing the treatments and services that we provided and making sure that we were paid appropriately. It's really hard for our CFOs to go back and try to get a higher PPS payment rate when we don't have any good data to give to a payer to say, "Wow, look at how sick our patients are," because in an FQHC, most providers are billing 99213s, and we are very lax on our diagnosis codes.

Shellie S.:

We have to really step it up and give better diagnosis and really start coding for the work that the providers are doing so that our CFOs can go back to the Medicaid contractors and say, "Wait a minute. This 130 bucks isn't going to work." I've got to have a little bit more because look at all the work we're doing."

Shellie S.:

So, again, kind of working together between our providers and our coding staff to help each other code to the highest level and document to the highest level.

Shellie S.:

Templates can help or hurt you. Sometimes, templates have missing information, or sometimes it's very convenient to click a button, as I said earlier, maybe for review of systems, and it shows everything's normal, so then we have discrepancies.

Shellie S.:

Of course, it can be easily abused by practices because they check off all exam items, or maybe they draw lines through them. It doesn't always reflect what we did.

Shellie S.:

There are times when I've done reviews where I can tell a template has been abused because the exam does not correlate with the reason the patient came in or vice versa... patient came in for something, also complained about maybe low-back pain. Maybe low back was not an exam component, so now I don't have an exam of a condition that the patient complained about that we treated.

Shellie S.:

So, again, then we start looking at credible. How credible is the note when it doesn't correlate? One of the things I would tell you is just really go through and look at your templates to make sure that they have the correct information and we're not abusing them, and we're using them correctly.

Shellie S.:

Why does the diagnosis coding really matter? Again, documentation for your history, exam, as well as the diagnosis codes are so important, number one, it describes the chronic conditions that are being managed on a daily basis for those patients. Again, it helps with reporting the appropriate ICD-10 code to the payer so that we can go back and trend. It helps with medical necessity. Definitely, it reduces and minimizes administrative burden of additional paperwork later. Again, our diagnosis coding in today's world is so important.

Shellie S.:

Our next polling question is how many of our providers and staff huddle each morning before seeing the patients and really kind of talking about those patients?

April Lewis:

All right everybody. The poll is open. You have one minute to answer.

April Lewis:

I got you, Belinda. Some of the polls... If you aren't able to use the poll, feel free to just stick it in a chat box. 40 seconds left.

April Lewis:

All right, Judy, thank you for that. If you don't know, please let us know that you don't know. We're using all of the feedback.

April Lewis:

All right, just a couple more trickling in. Down to the last 10 seconds. Thank you for those responding saying that you do not know. All of this will be captured. Okay, perfect, we have 40% of the responders say true, 25% say false, and 29% did not provide an answer, and even after the fact, team, if you want to still include some information, just stick it in a chat box, and we'll get it.

Shellie S.:

Okay, the reason I want to know if you huddle is I think in today's world, if the providers and staff can take five or 10 minutes in the morning to talk about our patients, it helps our providers know who's coming in and things to think about, so, again, documentation of the condition.

Shellie S.:

If we huddle, we can tell the provider, "Hey, I've got three diabetics coming in. I've got two depressed patients coming in," to help remind them we need to document to the highest level specificity. "Oh, by the way, don't forget, Shellie's a type two diabetic on insulin," so that our providers include all that information.

Shellie S.:

Just Medicare wants us to report all diagnoses that are evaluated and treated during that encounter, so, again, reminding our providers how important it is, so huddling helps.

Shellie S.:

Again, documentation needs to reflect the specificity, so it should clearly indicate if the patient has an acute or chronic condition. Did they have a chronic condition that exacerbated? Our coders can't assume chronic versus acute, so we can't just add diagnosis. We really need our providers to start giving us the highest level.

Shellie S.:

We've talked about this a little bit, so I won't bang on it, but just make sure that providers truly identify the conditions, the clinical indicators, and what's the plan of care, and when the patient comes back, how did they respond to that treatment plan?

Shellie S.:

When we start looking at some diagnoses, you hear providers say, "Gosh, Shellie, I have the sickest patients, but I'm not getting paid. I'm working really hard, but I'm not getting paid what I probably should."

Shellie S.:

When you start looking at the diagnosis, the patient was billed with a 99214 on sinusitis, and a coder may say, "Gosh, doc, you can't do that. Doesn't support a four."

Shellie S.:

Well, come to find out, the patient has diabetes, COPD, congestive heart failure, history of smoking, but the provider did not include any of that information. The provider knows about it because they have the chart in front of them, but when they documented the note, it doesn't reflect that those were even thought about.

Shellie S.:

They might be in the past medical history, but they're not tied to the note to give us those additional diagnoses and what the provider's thinking about, so, again, we need that clinical evaluation.

Shellie S.:

Let's look at some diagnoses that need more specificity. Diabetes. I'm going to go to the next slide just to give you the key things that you need for diabetes. We want to know is it type one or type two? Do they have any underlying complications or comorbidities? Are they a type two on insulin? If so, we want to know that. Do they have any other conditions that affect their hyper or hypoglycemia? Do they go up and down when they're taking other medications? Are they on an insulin pump? Do they have foot ulcers or polyneuropathy, chronic kidney disease? Those are things that we want our providers to start documenting and our coders to start teaching the providers what we need, so, internally, create expectations of documentation based upon the disease process.

Shellie S.:

Have your coders start building some of these and giving them to our providers to start maybe just one or two diagnoses at a time.

Shellie S.:

Depression. We want to know is it single or recurrent? We want to know how severe. Is it mild, moderate, severe? Is it with or without psychotic features? Then, other underlying diagnoses or conditions, so, again, just more specificity.

Shellie S.:

Chronic kidney disease. Again, with chronic kidney disease, we want to know, number one, what stage is it, and are there other underlying conditions? Chronic kidney disease and diabetes, chronic kidney disease and hypertension, so we need just the most specificity. If the patient's in kidney failure, it's important to specify the type of kidney failure, so, again, we need our providers to give us as much information as possible.

Shellie S.:

These next few slides on under dosing is really important for an FQHC. When we're looking at patients that under dose their medication or they're not compliant, we have a couple of different ways for coding purposes. We have codes for noncompliance, but we also have codes for intentional or unintentional under dosing. Is it intentional because they can't afford it? Is it unintentional because maybe they have age-related dementia?

Shellie S.:

Let's look at some codes. So, here, you can see under dosing for antihypertensive. The first time we know about it versus subsequent times we know about it. Intentional hardship, so there's all different ones where we can start really outlining how our patients are with their medications. This is great from a grant perspective. Payers... You can start writing grants to see if people will give us money to help teach patients about their medications, when to take it, or help them with the financial perspective. Again, it talks about how sick your patients are.

Shellie S.:

Annual wellness visits. This is a great time to capture all those chronic conditions, so when your patient's coming in for an annual wellness visit, start including all the chronic conditions. This is when we're going through that planning schedule, updating our problem list. This is a great time to talk about how sick your patients are and the work that you're doing. Again, you're reviewing preventative schedules. Work with your staff on what they can help with. They can start looking at some of these screenings. Has the patient had their mammogram, their blood work, things like that?

Shellie S.:

What does the medical record actually facilitate? Well, it facilitates patient care, so the ability for your physician to evaluate the patient's care. Again, we've talked about communication between you and other providers, reimbursement, profiling, data collection, so all of this is used. All of our documentation, our diagnoses, is all used in a multitude of areas, patient care, reimbursement, communication, again, quality, education, profiling.

Shellie S.:

Providers have to start painting a picture. What's the patient's clinical picture during today's visit? What have you already done? What were the results? How is the patient responding? Again, just identifying the condition and taking that all the way through helps provide better patient care, better documentation.

Shellie S.:

We talked about reviewing chronic conditions, teaching our staff to help get a really good reason for visit... not followup for med refills or meet and greet. Again, why is the patient walking in the door, and really work with your medical assistants to start training. I said this was going to be a team process.

Shellie S.:

So, clinical documentation... complete, concise, clear, patient centered, accurate, timely. All of this takes the entire team to work together.

Shellie S.:

Our first part of our team is our providers. What is our providers' view on all of the documentation? Our providers' view is, "I'm here to take care of patients. I'm not a coder. Not my job. This is busywork," but we have to start engaging our providers. Shadow them, start some lunch and learns. Try to figure out how you can help your providers. "What can I do to make it easier for you, doctor?"

Shellie S.:

Anything we can do to kind of get on their side and get buy-in, it makes it a lot easier to change the view of our providers. We have to make sure our provider's aware of the billing codes, and we have to make sure they understand what the specificities are for each ICD-10 code. What are our most common ones? Run your top list, start with two or three. Teach our providers how important the diagnosis codes are compared to the medical decision making. That helps show the complexity of the patient care and the work being provided.

Shellie S.:

We have to educate our providers on things that we see, so if we're seeing that there's not accurate coding, we need to educate them. We have to talk to our providers about barriers, so, again, "What can I do to help you?"

Shellie S.:

We have to start promoting communication between coders and providers. There's been this barrier, so, again, we have to monitor progress, provide feedback, and really ask our providers, "What can our coders do to help you more?"

Shellie S.:

Due to time, we're going to go ahead and skip this polling question. Just make sure that your coders are meeting with your providers and providing education on an ongoing basis, not just when we have time or once a year. Providers are like all of us. We need ongoing education.

Shellie S.:

Ah... There we go. Sorry! I lost... couldn't get the... Coding and billing: Coding and billing really need to be an adjunct to our providers. Verify we're getting the highest level of specificity. Some coding and billing staff are truly assigning the codes, so, again, you have to look and see what works best in your practice, but, again, how can they help the providers?

Shellie S.:

This is definitely a team effort, so providers, clinical team, coding and billing, administrative... It takes the entire team to make this work as we're moving into this new value-based healthcare world.

Shellie S.:

Looking at our team, identify problems. Start thinking about strategies for prevention of problem. How do we coordinate care? Even looking at the drug interactions that pop up in our computer where providers are clicking them off, and then just communication. Again, it takes the whole team, as I said earlier, so how do we incorporate clinical documentation improvement into your organization? You have to incorporate into the physician work flow, so, when you're thinking about the providers, we have to think about their process and how to make it easier. How can we take clinical documentation and really put it through their work flow without significant challenges?

Shellie S.:

Again, it might be looking at our templates. It might be changing the work flow we currently have. So, again, accurate coding and quality measures, a robust CDI program can produce dynamic regulatory and coding environment that requires our physicians to have ongoing education.

Shellie S.:

Then, reinforcement. We have to reinforce it with our providers. It does help with our query responses. At first, you might have an increase, but, eventually, when you get a good CDI program, the queries should go down, and definitely helps with any kind of audit defensibility. If a payer is looking at any kind of documentation from an abuse or medical necessity, better CDI documentation definitely helps with that defensibility to a payer or anyone questioning our documentation.

Shellie S.:

Then, obvious, CDI is taking an identified, targeted patient population, so, again, start small. Diabetes and COPD, just pick your top two or three. Start looking for weaknesses, and work with our providers on our documentation weaknesses to get better. Look at your current coding practices. Is everything a 99213, and all our specificity is diabetes, COPD with depression, without the highest level, and then start educating with the provider's own notes. Re-audit, reeducate, so it should be this ongoing circle. It should go 360 all the way around.

Shellie S.:

Understanding what the hierarchical condition categories are, so our HCC coding. These are diagnostic categories based upon age, gender, eligibility status, so they kind of have what we call buckets.

Shellie S.:

So, major depressive bipolar, asthma and pulmonary, these are different HCC categories. This is how you can pick your top two or three to start looking at to build your own clinical documentation improvement program.

Shellie S.:

How do you build that, right? Number one, we have to start with better communication because our clinical documentation improvement program will lead to all of these things: Better patient care, better communication, decreased queries, minimize accounts that are being denied or rejected, but, most of all, we have better documentation.

Shellie S.:

So, to get here, you have to be able to set up a clinical documentation improvement program. Run your top 15 diagnoses codes. Pick the top three to five to start reviewing. Once you get to the top three to five, work with your providers. Let them help, so that they buy in on what we're going to do. Then, review three dates of each service. Pick one patient, pull three... If we're picking diabetes, hypertension, and COPD, pull patients with those diagnoses. Take three dates of service for each of those patients to see are we really telling that story?

Shellie S.:

Then, you have to do the fourth bullet. This is where people get lost. We have to provide feedback to our providers. If we're still having issues, or we're not really sure we're getting it all, start shadowing providers. Stand in the room, observe. Help the providers understand what they're doing and how to document that.

Shellie S.:

Then, of course, what we're going to do is work with IT to see if they can help reduce some of the burden on a documentation that takes so long. So, again, we just have to start education, running our top diagnoses, and providing feedback in a constructive manner to our providers because we need clear, concise, credible documentation really outlining the meat, the monitoring, evaluating, assessing, and treating, of those patients and those conditions to tell the story on how risky that patient is and the work we've done.

Shellie S.:

So, I know we're right at three o'clock, so I'll open it up to questions. Again, Friday, we are having the question and answer session... is where we'll go through most of those questions, but I do have time if we want to do one or two, April.

April Lewis:

Okay, yes, we did receive five questions, so you all please put your questions in Q and A log, and we will get to them on Friday. In the email that I sent out, you have the link to register, if you have not, for part two. It'll register you all live for the webinar. Then, we also have an anonymous survey if you want to submit your questions there. So, just for the sake of time, if you have to hop out because it is three o'clock, thank you so much for joining, and we will look to hear from you on Friday, but if you did submit a question, I'm definitely going to get to it on Friday, but, just for the sake of time, we'll respond to the first one that came in.

April Lewis:

For documentation of diagnosis being taking into consideration towards MDM, should we add a question? For example, the patient is in for a UTI, but has CKD treated by a nephrologist. Would we code it as a UTI and CKD to reflect the MDMs when prescribing the correct medication and a risk of assessment?

Shellie S.:

So, that's a great question, and, yes, you should document and report the CKD to the highest level specificity as a secondary diagnosis to your UTI because your providers have done more work and had to think about that process. However, we need our providers to give us the stage of that chronic kidney disease, if they know it.

Shellie S.:

Do you have other questions, April?

April Lewis:

Okay, can you hear me now?

Shellie S.:

I can.

April Lewis:

Well, thanks everybody for joining. We will have all the questions included in Friday's presentation. Feel free to... Excuse me? Can you hear me, Shellie?

April Lewis:

Okay, feel free to email me, and we will be back on this same line Friday, 2:00 p.m. Eastern Standard Time. Thank you all so much for joining.

Shellie S.:

Thank you.