IMPORTANCE OF DOCUMENTATION INTEGRITY

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CLINICAL DOCUMENTATION INTEGRITY TEAM AND TOOLS

- Policies & Procedures / Current Reference Materials
- Standards
- Dedicated CDI Staffer / Physician Advisor (yeah, right!)
- Providers
- Health Information Staff / Electronic Health Records
- Billers / Coders & the Accountability Table
- Compliance Officer
- Quality Improvement Committee
- Risk Management Tracking

POLICIES & PROCEDURES

- Providers are not taught or trained as coding professionals
- Standardization is beneficial and requires P & P as Providers will not arrive prepared for *your* standards
- P & P create an atmosphere of good 'documentation hygiene' and define team
- Should answer the
  - Who? Licensed, Credentialed and 'other' service providers
  - What? All types of documentation should be addressed
  - When? This answer can set you up for failure or success
  - Where? Is there more than one EHR? Any other approved tracking methods?
  - Why? Under what authorities and for what purposes?
  - How? Which coding language is expected?

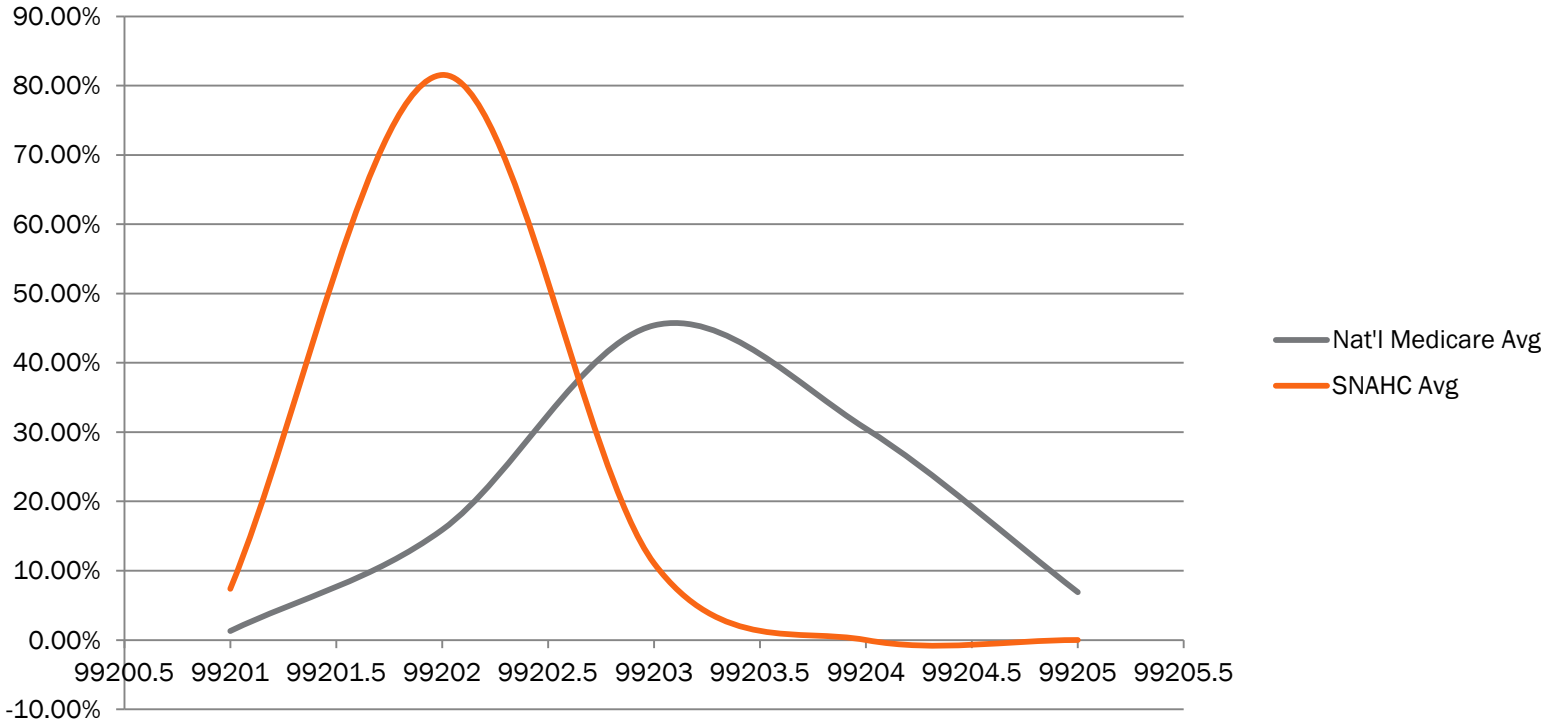
STANDARDS

- ICD-9, SNOMED, ICD-10, HCPCS Level II
- Ensure that diagnoses and procedures correlate
- Contract Work vs. Reimbursable (Is there any expectation of a documentation standard difference?)
- Accreditation Body requirements
- Patient Safety
- Reporting Outcomes (GPRA / HEDIS)
- Know your ~~Audience~~ Auditors (CMS, OIG, DOJ, CERT, RAC, ZPICS, OCR, DEA, Payers, IHS, etc.)
- Solid implementation of health/wellness assessments = Incentive Payments

PROVIDERS

- The best defense is a good offense – Understand where others can complicate or confuse your documentation
  - Medical Assistants / Specialty Providers / Labs / Intake Staff / Nurses
    - While your work may be fine, it gets tagged if not supported by the rest
- Continuous Documentation Improvement is a good use of CEU commitment
- EHR should facilitate streamlined work, NOT including cloning documentation
- Provider is not always the only arbiter of 'Medically Reasonable and Necessary'
- Technophobes will try to work twice, on paper and in EHR, this will likely create several issues – re: timeliness, privacy, veracity of documentation
- Struggle to go paperless
- Should see Evaluation & Management work in context of 'Big Picture'

E & M BENCHMARKING



HEALTH INFORMATION STAFF / BILLERS & CODERS

- Need a well-implemented EHR with ready access and support for template improvement and upgrades
- Not usurping clinical role – confirming linkages between diagnostic and procedural with a different expertise
- Query process needs guidelines and training
  - Query language is critical
    - Avoid leading questions
    - Keep providers in the drivers' seat
    - These are not 'corrections'
  - Track Query process for accountability and liability management
    - Email not safe enough for potential PHI
    - Intranet solutions such as SharePoint may offer increased security options

COMPLIANCE OFFICER

- Periodic audits (frequency determined per internal Compliance Program Policy) of provider work
- Recommended that C.O. obtain Compliance Officer *and* Medical Auditor certification (if not a certified coder)
- This review becomes a review of both the provider work and the work of any other pre–C.O. reviewers, such as HIT Staff or Coders/Billers, facilitating any need to train or re-train in order to avoid re-capture of funds
- C.O. responsibility ranges over a broad spectrum of risk management including Internal Policy, Quality of Care, RX Requirements, etc.
- Found lots of need for improvement in the various transitions around documentation of chronic pain RX

QUALITY IMPROVEMENT COMMITTEE

- Often includes Board representation, which is a quick way to get results
- Data / Reporting is easily shared out with peers
- Study Idea – Conduct a Mock Visit to learn what the templates are pulling forward
- Study Idea – Gather assortment of provider de-identified documentation samples and see if the committee members can deduce who is responsible for which visits. How can they tell? Is there any risk involved in those 'tells'?
- Study Idea – If you suspect that a provider is just pulling previous visits forward and making minor modifications, print the documentation out. Then you can even hold them up to a light source and determine whether the bulk of the data is 'cloned.' That would lead you to a deeper study of the visits looking for carryover data that doesn't make sense.

RISK MANAGEMENT / TRACKING

- How well do your providers understand CPT coding?
- Are you on-target with internal audit commitments?
- How are you sharing the responsibility among the entire team?
- What solutions have you devised for training in our busy industry?
- Are relationships with your payers convivial or adversarial?
- Are you analyzing denial trends?
- Finally, is there a product or service that can actually help you with your identified set of risks / needs?

QUESTIONS?

Thanks!

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