How Lack of Proper Coding and Documentation Can Derail Compliance Efforts
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When completing the clinical documentation for a leg fracture under ICD-9, there were sixteen codes from which to choose. With the introduction of ICD-10 in October of 2015, that same event requires sifting through 1,530 possible codes. This increased complexity is mirrored throughout ICD-10 as the number of codes has increased from 14,000 to 69,000. Other changes include shifting from limited to extensive severity parameters, from limited to extensive combination codes, moving from one to two types of exclude codes, and increasing the number of code digits from three, four, or five, to seven.1

While it is generally agreed that the shift to ICD-10 adds clarity and definition to clinical documentation and will lead to improved quality and efficiency of patient care delivery, the added complexity clearly increases the difficulty of proper coding and documentation for healthcare professionals. Failure to code and document properly not only impacts your organization’s revenue cycle, it can increase the risk for compliance violations.

There’s no question that healthcare providers are under intense oversight scrutiny from multiple entities including CMS, OIG, Recovery Audit Contractors (RAC’s), Medicaid Integrity Contractors (MIC’s), and Zone Program Integrity Contractors (ZPIC). Keeping up with the requirements of ICD-10, Meaningful Use, and the Affordable Care Act are daunting enough, but as the industry shifts to value-based payment methodologies, compliance demands will continue to increase. To meet these challenges, organizations need to be vigilant when it comes to their coding and clinical documentation processes.

This paper will look at the obstacles to proper coding and documentation, the financial and regulatory risks of failing to properly address the issue, the causes of the problem, and some proven solutions.

The Problem of Inappropriate Coding and Documentation
As providers transition to ICD-10, a common issue has surfaced. Coders are working hard to incorporate the new codes, but there appears to be a widespread failure to then follow up with proper documentation.

While it is difficult to change things overnight, organizations still need to be diligent in documenting the changes they are making. The shift to ICD-10 is bringing the issue to the forefront, but lack of proper coding and documentation has long been an issue for providers and continues to be a major compliance risk issue.
Providers have now been given a grace period until October 1, 2016 where they are allowed to use unspecified codes that do not include the degree of specificity or granularity of the ICD-10 standard. However, it’s optimal to begin to implement the new standard as quickly as possible since the change is inevitable. The conversion process also provides an ideal time for organizations to review and enhance their coding and documentation procedures.

Financial and Operational Consequences

Failing to properly code and document billing can result in serious consequences for healthcare organizations.

From a financial standpoint, breakdowns in this critical area can lead to revenue loss from denied, returned or suspended claims, or to significant payouts in non-compliance penalties or repayments. A broken coding or documentation process can drive increased operational costs since resources must be devoted to chasing and resolving problems that could have been prevented from the outset. These can all have a severe negative impact on the bottom line.

Finally, improper coding and documentation can lead to incorrect or incomplete billing that ultimately requires patient intervention. With the healthcare industry moving more toward a consumer mindset, documentation errors that involve patients can lead to dissatisfied customers.

Common Problem Areas

Clinician resistance

One of the more consistent roadblocks to effective coding and documentation is resistance by physicians. A 2015 survey by the American Hospital Association and Executive Health Resources revealed that 98.5% of Clinical Documentation Improvement (CDI) programs are dealing with physicians who could improve their documentation practices. Two thirds of respondents said the primary barrier to physician engagement in CDI programs is a lack of understanding of the importance of strong documentation. If services aren’t coded properly at the time of service, there’s little chance for coders and documentation specialists to solve the problem down the line.
ICD-10 complexity
The massive increase in code choices from ICD-9 to ICD-10 is necessary to incorporate new specificity and granularity. The new standard also encompasses laterality – whether the treatment is on the right or left side of the body. This expanded complexity has slowed down coders and increased chances of errors. Some physicians don’t have the codes for their specialties in their systems yet which compounds the problem further. When this occurs, they fall back on the use of the familiar, unspecified codes.

Lack of timely training
Most organizations have invested significant resources for education in anticipation of ICD-10 go-live. Focus areas include general awareness, intense training for specific diagnostic codes, and extensive training for anyone involved in ordering tests, reimbursement, or quality initiative. While this training is important, it also needs to be timely, and the gap between the actual training and implementation can reduce effectiveness.

Lack of organizational resources
Because of tightened budgets, many organizations are operating with reduced coding and documentation staff. The impact of ICD-10 is straining many of these departments to the point where they simply don’t have enough resources to meet the growing demand. Overtaxed coding staff struggle to handle the demand for facility coding, outpatient setting coding, and other documentation requirements. The errors and incomplete coding issues that result can be costly for the organization.

Insufficient senior management support
An effective coding and documentation program requires everyone in the organization to be in alignment, and instilling that commitment starts at the top. In many cases, senior managers aren’t vocal and visible enough in sending the message of how important the program is to the financial well-being of the organization. This lack of support can provide a convenient excuse for physicians and other staff members to slack off when in comes to adhering to coding and documentation standards and processes.
Ensuring Accurate Coding and Documentation

Increased/better staff education

According to the AHA report, organizations have implemented many types of training including lectures/seminars, webinars, and emails but most have been deemed ineffective. The most successful training method, according to more than 85 percent of survey respondents, is real-time, patient specific, case-by-case instruction. While this may take more time and resources, the increase in retention and effectiveness is worth it.

Physician education and training is key but this is an area that has commonly been lacking in many organizations. It is not the result of a lack of effort on the part of compliance departments, but more often because of physician resistance. When they are focusing on treating patients but get confused over coding or documentation, they tend to fall back on procedures they’ve followed for years.

The arrival of ICD-10, makes reinforcing training even more crucial. Initial training may have taken place months before go-live, but now that everyone must actually apply the new standard, refreshing the training may be in order. The instruction may make more sense since coders and documentation specialists can immediately apply what they have learned in their daily activity.

It’s also well known that people respond better to their peers when it comes to training. To take advantage of that, organizations should consider designating individuals as coding or documentation or billing champions. Outside experts coming in to work with these champions in a “train the trainer” program is an effective way to build a strong team of internal influencers. This is a powerful way to engage physicians and executive staff who have the power to drive the program.

Focused change management

Any significant change like the shift to ICD-10 can be jarring to an organization. The best way to address the discomfort everyone experiences is by instituting a structured change management initiative. An effective program starts by identifying and engaging key stakeholders, defining roles and expectations, and establishing goals and objectives. By formally setting expectations, employing tools to improve communication, and proactively seeking ways to
reduce misinformation, stakeholders are more likely to accept and embrace the change. This is a crucial step to establishing an effective coding and documentation program.

**Enhanced management support**
The consequences of non-compliance fall most heavily on senior leadership so it is critical for them to stress the importance of proper coding and documentation. The communication should start with the Board of Directors and the C-suite who should regularly stress the importance of compliance for the entire organization. This presents a “we’re all in this together” message crucial to success.

**Increased/more effective auditing**
Ensuring effective coding and documentation starts with a comprehensive audit of the process. If there are issues, organizations need to determine if they are caused by errors in documentation or in the diagnoses. After conducting root cause analysis, a corrective action program can be mapped out. That should be followed by a re-audit to ensure that corrective actions are in place, have taken hold, and are effective.

**Engage outside resources**
There are a number of outside consulting and staffing organization that can help relieve the burden of overworked staff. This can be an effective way to cut through the backlog of the coding workload and can also provide the resources necessary to focus on training. Engage organizations with a wide range of coding and documentation expertise. An experienced consultant will not only help with the workload, but can also provide input as to possible improvements to help streamline your processes going forward.
Summary
A common refrain in the healthcare industry says, “If it hasn’t been documented, it hasn’t been done.” That’s never been more true than in today’s rapidly evolving environment which is increasingly focused on accuracy and accountability. The lack of proper coding and documentation leads to non-compliance issues that can have a negative effect on your organization from both a financial and patient care perspective.

Organizations are recognizing this reality and working to improve their coding and documentation process. Resolving the issue requires a focus that is driven from the top and is embraced at all levels of the organization including management, clinicians, compliance staff, and administrators. Once you achieve organizational buy-in, achieving successful, in-depth, and effective training will ensure that a well-documented, effective process is followed every time. In the end, both providers and patients will benefit, which is the ultimate goal.

About Hayes
Hayes Management Consulting is a leading, national healthcare consulting firm and software developer that partners with healthcare organizations to streamline operations, improve revenue and enhance technology to drive success in an evolving healthcare landscape. To learn how Hayes can help you with your compliance needs, call 617-559-0404 or requestconsultant@hayesmanagement.com.

Sources
1. What is different with ICD-10?, Road to 10: The Small Physician Practice Route to ICD-10, CMS Roadto10.org.