



What You Need in Electronic Health Records for Risk Adjustment

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Why is this an important topic?

▶ Audience Poll (True or False)

- Implementing an EHR will ensure correct coding of procedures and diagnoses
- Implementing an EHR will eliminate all legibility issues
- Implementing an EHR will improve clinician documentation.



The EHR Self-Scoring Tool

- ▶ What is it?
 - A self-service tool to evaluate how well your EMR supports appropriate clinical documentation and coding for Risk Adjustment Data Validation
- ▶ Current draft version contains
 - 8 domains
 - ~50 items to review with rationale for why important

The EHR Self-Scoring Tool



- ▶ Does your EHR help or hurt?
- ▶ Workgroup's current draft version – 8 domains
 - 1) Printing Capabilities and Technical Components of a Visit Note
 - 2) Signature and Amendment Capabilities
 - 3) Voice Recognition, Transcription, and Scanning
 - 4) Disease Templates and Note Structure

The EHR Self-Scoring Tool (cont)



- ▶ Workgroup's current draft version – 8 domains
 - 5) Diagnosis and CPT Selection Support and Insertion into Visit Notes
 - 6) Transfer of Codes to Practice Management Module or Claims/Encounters
 - 7) Concurrent Coding Review, Visit Note Audits, and EMR Audit
 - 8) Training for EMR users

Example 1



- ▶ **Domain 1: Printing Capabilities and Technical Components of a Visit Note**
- ▶ Item 5: Printed visit note contains member name and a second identifier (ie date of birth or medical record number) on each page
- ▶ **Problems**
 - Needed to differentiate members with same name.
 - Needed to identify each page of record to the member.

Example 2



› Domain 5: Diagnosis and CPT Selection

- Item 1: Diagnosis picklists are kept up to date for ICD-9 codes (or ICD-10 codes upon implementation) and CPT/HCPCS codes through date imposed validation for the date of service

› Problems

- Outdated codes can be chosen, as when 585 switched to 585.1-585.9; new codes may not be available for look up.
- CMS-HCC model requires valid ICD-9 codes.
- Critical-Full encounter data submission beginning in 2012

Where can I find this tool



- › Draft 3 located on ICE website under EHR Team August meeting documents:
- › <http://iceforhealth.org/library.asp?sf=&scid=2502#scid2502>
- › Look in library under team folder: ICE RADAR – Electronic Health Records (EHR) Team for final document upon approval from ICE RADAR Main Team

Ideas on How to Use




- › Medical Coder can take sample of notes printed from EHR and evaluate each note vs tool to identify deficiencies
- › EHR Manager can use tool to evaluate the efficacy of the EHR in general based on knowledge of the system setup and functionality
- › Organization can utilize a checklist when choosing EHR to utilize or during implementation process
- › Organization can prioritize enhancements to address identified issues

Questions?




ICD-10



**ICE Collaboration:
Providers working together**


**Mechelle Reed, Brand New Day Health Maintenance Organization, Director, Provider Data Management
ICE, ICD-10 Co Chair**

Timelines




What	Change	When	Driver
<p>HIPAA 5010</p>	<p>Upgrade of the formats used to send transactions between payers and providers (837, 278, etc.)</p>	<p>January 1, 2012 Compliance date for 5010 implementation</p>	<p>Federal Mandate Department of Health and Human Services Final Rule CMS-0013-F Published January 2009</p>
<p>ICD-10</p>	<p>Upgrade of the codes used to describe diagnosis and procedures on clinical transactions (claims, etc.)</p>	<p>October 1, 2013 Compliance date for ICD-10 implementation</p>	


The Impact




Internal Functions		
Operational	Finance	Technology
<ul style="list-style-type: none"> Revenue Cycle Clinical Documentation Coding Clinical Operations Human Resources Administration Marketing Credentialing Compliance 	<ul style="list-style-type: none"> Budgeting Reimbursement Managed Care Contracting Act Management and Cash Flow DRG Management Reporting and Planning Research and Intellectual Property 	<ul style="list-style-type: none"> EMR Desktop Support Report Generation Auxiliary Systems Revenue Cycle Tools Interfaces Interprete Analytics and Business Intelligence
External Constraints		
<ul style="list-style-type: none"> Patients Physicians Payors Outsourced Solutions Trading Partners 	<ul style="list-style-type: none"> Outsourced Operations Coders Clinical Support Solution Vendors 	

Implementation Phases 


- **Planning**
- **Communication and Awareness**
- **Assessment**
- **operational Implementation**
- **Testing**
- **Transition**

Develop a relations with the plan 

Look Beyond the coding – It is an entire new system
 Changes Include:
 Your Coding
 Your Billing System
 Your Electronic Health Record (EMR) system
 Your Superbill
 And more!


ICE Team 

- ICE team shares information presented by CMS, and works as group to develop tools and ideas to assist with the transition of data submission.
- Did you know section...
 ICE has produced timelines as a suggestion to the provider to ensure that each area of the organization is address during the transition
 ICE keeps the group informed regarding Billing hurdles of claims: Dual claims processing: submitting ICD-9 codes and ICD-10 codes to payers for those payers that are not ready.

ICE Team 


GEMS: General Equivancy Mapping
 Team discusses how to use the crosswalk, and are reminded that the GEMS do not always have a direct match

http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp

ICE Team - Tips 

Communicate with you healthplans and vendors


1. Pull your contracts and evaluate how each system and vendor will impact ICD-10 implementation in your practice.
2. Check to see that your contracts includes statements which indicates government mandates are covered.
3. Contact plans and vendors and assess their ICD-10 readiness.
4. What are the cost involved with implementing

ICE Team 

The Goal of the ICE – ICD10 team is create a place where plans, groups, and providers can have a place which they are able to express concerns, and have questions implementation questions answered. The deadline is fast approaching, and we are reiterating to the team that the following need to happen to be successful with the transition.


- **Be educated.** Start reviewing ICD-10 code set changes now to plan for upcoming changes.

Handbooks



- CMS Handbooks – Step by Step templates
- **Small/Medium Provider Practices**
- **Large Provider Practices**
- **Small Hospitals**
- **Payers**

Questions ?



References:
ICE : <http://iceforhealth.com>

Centers for Medicare and Medicaid Services (CMS):
<http://www.cms.gov>

Visit the [ICD-10 website](#) for the latest news and resources to help you prepare!

Provider Education Strategies

Presented by:
Cathy Prado, CPC and
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Provider Education Strategies

- ▶ Establish trust
 - Get to know your providers
 - Find the communication style that works for the individual

Patient care remains the priority



Provider Education Strategies

- ▶ Make it practical
 - Recommendations for improvement must make sense to the provider

Patient care remains the priority



Provider Education Strategies



- ▶ Recognize improvement
 - Measurable progress
 - Compare “apples to apples”

Patient care remains the priority



Provider Education Strategies



- ▶ Encourage friendly competition
 - Break up long education sessions with raffles or contests
 - Make it fun
 - Online trivia templates

Patient care remains the priority




Jeopardy Game




- ▶ jeopardylabs.com/play/2011-ice-conference-radar-breakout-jeopardy




RADAR's..... 

- ▶ Physician Education Work Group
 - ▶ PRESENTS
 - ▶ New Tools for 2011


Provider Education 

▶ 2011 handouts include:

- 2011 Documentation and Coding Handout
- Diabetes Coding Chart
- Handwriting Letter and Resource List
- Documentation quiz

2011 Documentation and Coding Handout 

- ▶ Documentation subjects
 - CVA
 - Breast and other cancers
 - Rule-out diagnosis
 - Malnutrition
 - Depression
- ▶ Documentation quiz
- ▶ Check list for medical records
- ▶ Reminders



Do You Have Any IDEAS?



- ▶ If you have any ideas for future handouts please email Kathi Wylie
- ▶ kwylie@synermed.com

We thank you
for you time



2011 Documentation and Coding Handout for the Primary Care Physician

Some Documentation Rules You May Not Know

Never code CVA

A stroke is an acute event. Never code a CVA unless the patient is having one in your office. Document and code a history of stroke (V12.54- if no lasting problems) or lasting effects from a stroke (438.x). If you do need to use the CVA code, make sure you have a note about calling the paramedics or ambulance. You might consider documenting and coding signs and symptoms and send the patient to the hospital for testing.

Breast cancer and other cancers

Document and code breast cancer for the entire time that the patient is going through treatment, including radiation therapy and chemotherapy. If Tamoxifen is given for 4-5 years afterwards, continue to use the breast cancer (current cancer) code. It then will become history of breast cancer after the medication is stopped. If the Tamoxifen is given prophylactically, then you should not use a cancer code.

These rules apply to prostate cancer and Lupron also. All other cancers become history of cancer once all treatment is complete and the cancer is eradicated.

Don't give a diagnosis until you are sure

There are no such things as rule-out codes. Until you make a final diagnosis, all you can document and code are signs and symptoms. Be cautious about giving your patient a diagnosis you are not sure of. It can stick with them for years when in fact they never had the condition.

Malnutrition

This is a common condition among the elderly and is very under-reported. One guideline is a weight loss of over 10% over a short period (e.g., in the last few months). Remember that some of these seniors only weigh 100 pounds to begin with, so a 10 pound weight loss is significant. Review these guidelines to make the diagnosis. They do not have to have all of them to qualify for this diagnosis.

Involuntary weight loss over 10% in previous months

Food intake severely curtailed*

Muscle wasting and fat loss (Edema or ascites)

Daily gastrointestinal symptoms for 2 or more weeks

Reduction in physical capacity

Serum albumin > 3.5

**Find out why the food intake is curtailed. Is it a transportation problem to buy groceries; is it fear of the stove or setting a fire? Do they need Meals-on-Wheels? Is it a symptom of depression?*

Depression

Depression is common in this population. They often have many life-changing events and it may be hard to cope for some of them. Their friends and family die, they may lose their driving privileges, or they may become isolated as they retire. Here is a list of some of the criteria used for major depression. Please document it as MAJOR depression. Note that this is not normal grief.

Depressed most of day or loss of interest in activities

Not eating or eating all of the time

- Malnutrition?

Not sleeping or sleeping all of the time

- If they complain of insomnia make sure they are not napping throughout the day

Feeling worthless or inappropriate guilt

Diminished concentration

Documentation examples

Can you tell what is wrong with this list of diagnosis?

Diabetes	MI
CHF	CAD
CVA	↑BP
History of COPD	Leg wound

See the next page for the answers

Check list for medical records

- Each progress note dated, has patient name and DOB on every page, signed by provider with first and last name and credentials
- Problem and medication lists up to date with beginning and ending dates
- All notes legible without unusual abbreviations and symbols
- Chart neat and organized
- Documentation supports all diagnosis codes used for each visit

Reminders

Are you calculating the BMI at each yearly comprehensive exam?

Are you checking the GFR's for early stages of chronic kidney disease? (2 GFRs at least 3 months apart)

Are you using status codes such as organ transplant, artificial openings, amputations, alcoholism in remission?

Are you documenting a cause and effect of medical conditions? (Diabetic neuropathy)

Is your office staff using HIPAA regulations?

Documentation Examples Answers:

Diabetes	There are no descriptive words to show that the condition was evaluated. Also what type of diabetes is this, I or II? Is it controlled? Are there any manifestations from the diabetes? Use a statement such as "Controlled type II diabetic"
CHF	What about the CHF. Is it compensated? Is there an exacerbation? Is there follow up needed? You need to show an evaluation statement.
CVA	You will NEVER code CVA unless it is a rare instance when there is one taking place in your office. It is a hospital code. You will use history of stroke and any lasting conditions from the stroke.
History of COPD	It may be true that in the patient's history he had COPD but it is also a current problem. "History of COPD" is an incorrect statement. "Stable COPD" would be correct.
MI	This is correct if it is within 8 weeks of the initial heart attack. After that it is history of MI using code 412.
CAD	CAD is a very vague term. Are you meaning to say history of heart attack, atherosclerosis, angina, carotid artery disease or?
↑BP	Signs are not allowed and will not pass an audit. Also BP means different things in different offices. Are you meaning to say high blood pressure (not hypertension) or increased back pain?
Leg wound	What are you trying to say about the wound? Is it cellulitis, ulcer, lesion or infection? Is it healing or getting worse?

How did you do? If you have 6 or more correct you did pretty well!

Diabetes Code Chart

To help get the right code pick one from each group

- The **root** code

250.

- The **4th digit**-manifestation

0 no complications
1 ketoacidosis
2 hyperosmolarity
3 other coma
4 renal

5 ophthalmic
6 neurologic
7 circulatory
8 other specific manifestation
9 unspecified manifestation

- The **5th digit**-type I or II and controlled or uncontrolled

0 type II controlled
1 type I controlled
2 type II uncontrolled
3 type I uncontrolled

Note: all diabetes codes have 5 digits





Compliance Training

Handwriting

Legible penmanship has come to the forefront lately in the medical field. It has become the subject of jokes and blogs. But the issue can be fixed! There are several issues regarding handwriting readability that we will discuss here.

- Quality of care-
 - Offices-in many of our offices there are several providers and shared medical records. It is imperative that each provider knows exactly what was written by the other providers for continuity of care for each patient.
 - Pharmacy-each year it is estimated that there are 7000 deaths a year due to pharmacy errors. 1.5 million more are harmed. It is a frequent complaint of pharmacists that they cannot read what medication is ordered. This leads to the wrong medication being given to the patients.
 - Time is spent by nurses and other providers trying to decipher orders. Time is wasted calling the physician to clarify what is written
- Legality
 - Your medical records are legal documents
 - Courts can subpoena them
 - Federal auditors and health plans can review them
 - If you coded for medical conditions but the documentation cannot be read you may be charged with fraud and abuse
 - Patients have the right to receive copies
- Consequences
 - If we cannot read your HRA documentation it will be rejected = no pay
 - If we cannot read your authorization request approval will be delayed
 - If your chart gets selected for a RADV (HCC audit) and does not pass because of illegible writing, money may be recalled by Medicare
- Solutions
 - Use a transcription service
 - Consider installing EMR in your office
 - Take your time and write clearly.
 - Take a handwriting course or read a book about this subject
 - See resource list

Remember it is not if your records will be reviewed, but WHEN!

References

Anyone Can Improve Their Handwriting available at Amazon.com

Teach Yourself Better Handwriting by Rosemary Sassoon

Improve Your Handwriting by Tom Gourdie

Improving Handwriting by Julia Sinclair

<http://www.calligraphylearn.com/handwriting-improvement.html>

<http://handwritingimprovement.com/>

http://www.ehow.com/how_4419883_improve-handwriting-skills.html

<http://myhandwriting.org/>

<http://www.wonderhowto.com/topic/improve-handwriting/>

<http://ireport.cnn.com/docs/DOC-535847?ref=feeds%2Flatest>

There are many more references on the internet



Which Phrases Show Good Documentation?

Why or why not

CKD due to DM **What stage CKD? What type DM?**

Diabetes
Proteinuria **Is there a cause and effect between the two conditions?**

CKD + DM **+ does not show cause and effect. Signs are not allowed.**

Diabetic nephropathy
CKD stage 4 **Good documentation**

End stage renal failure **Dialysis is not documented**
What is the cause of the renal failure if known (Diabetes, hypertension)

Dialysis **CKD stage 6 or end stage renal failure is not documented**

Diabetes with renal manifestations **What is the renal condition?**

BEST PRACTICE WINNER

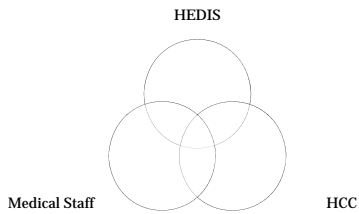


Connecting the Quality Dots and Stars

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Brand New Day Health Maintenance Organization
Manager, Quality Improvement
ICE-RADAR – Team Participant;
Physician Education Co-Lead;
HRA Workgroup – Team Participant

1

Working Together



2


Team Players



- ▶ Patient / Member
- ▶ Health Plan
 - Encounter Data Unit
 - Medical Coders
 - Field Intervention Nurse (FIN)
- ▶ Health Plan Provider
 - Registered Nurse (RN)
 - Licensed Vocational Nurse (LVN)
 - Medical Assistant (MA)
 - Front and Back office staff



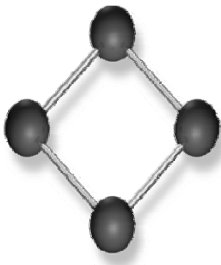
3




Identifying and Connecting the Dots

Tools Used

1. Individual Care Plan
2. HEDIS Intervention Report
3. Bi-Annual Review of HEDIS Domains
4. CMS Star Measure Review
5. Wellness Fairs



4




Sample HEDIS Intervention Report


Member Demographics are located at the top of this report

<ul style="list-style-type: none"> ▶ Access/Availability of Care ▶ Measure ▶ AAP Adults' Access to Preventive/Ambulatory Health Services 	<p>Compliant Yes</p>
<ul style="list-style-type: none"> ▶ Cardiovascular Conditions ▶ Measure ▶ CBP Controlling High Blood Pressure 	<p>Compliant</p> <p><small>The member needs a documented visit prior to 6/30 with a confirmed diagnosis of HTN, and his BP controlled (<140/90) after that this year.</small></p>
<ul style="list-style-type: none"> ▶ Prevention and Screening ▶ Measure ▶ ABA Adult BMI Assessment 	<p>Compliant Yes</p>
<ul style="list-style-type: none"> ▶ Annual Monitoring for Patients on Persistent Medications (MPM) ▶ Measure ▶ ACE Inhibitors/ARBs ▶ Miscellaneous Anticonvulsants 	<p>Compliant Yes</p> <p><small>No – The member needs a drug serum concentration level monitoring test for valproic acid or divalproex this year</small></p>

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Purpose



- ▶ **Purpose of Individual Care Plan**
Identifies missing HCC's over 3 year period for chart pursuit or the need for provider education by reviewing labs, medications currently taking, also identifies gaps in care.
This report is provided quarterly to every provider.
- ▶ **Purpose of HEDIS Intervention Report**
Identifies each HEDIS Domain and element required for compliance for the measurement year
This report is provided bi-annually to every provider.



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Purpose Cont'd

- ▶ Purpose of BI Annual Review HEDIS– CMS Star Measures
Identifies where we stand as a health plan at the time the report is generated. This report allows us to develop interventions which could ultimately influence better rates for both HEDIS and HCC reporting.
- ▶ Wellness Fairs and Flu Shot Clinics
Under physician standing orders the yearly required assessments are conducted at these events which includes stations for:
 - Blood draws (Lab panel includes screening WBC, RBC, thyroid panel, lipid panel, Hgb A1c, Liver panel, Urine Micro albumin, PSA where applicable, and therapeutic monitoring for anticonvulsants)
 - Spirometry Testing (includes height and weight measurement for yearly Body Mass Index (BMI)),
 - Advanced Care Planning (which includes an LCSW completing and SF-36 and an advanced directive)


BRINGING IT ALL TOGETHER

- ▶ Identify prevalent populations
 - Diabetics
 - SPMI's
 - Respiratory Conditions
- ▶ Become Pro-active with interventions
 - Once populations have been identified interventions can be developed based specific to member needs.
 - Example: Wellness Fairs bring members out in large numbers. At these events we are able to not only gain member compliance for HEDIS measures but also capture HCC's.
 - How do we do this?
 - Through provider review of data received from Wellness Fairs a physician can contact the member for an appointment, do an assessment and then institute a treatment plan where needed.
- ▶ Identify Barriers
 - Review reports and identify barriers based on demographics.

Example:

Bringing It All Together



Example: Upon analysis of data from our Bakersfield region our SPMI's showed decreasing compliance with Spirometry testing. The analysis proved that the reason for non-compliance with Spirometry testing was that the provider offices had no spirometer's to test the members with.

The purpose of Spirometry testing is 2-fold:

- (1) Re-evaluation of COPD for HCC purposes
- (2) Identifying new COPD diagnosis and medication management for HEDIS.

Intervention:

Due to member's not completing their spirometry tests the plan provided spirometers to the Field Intervention Nurses to complete. Once completed the FIN forwards to the member's PCP for interpreting and institution of a treatment plan where appropriate.

Additional Avenues



- ▶ Conduct provider trainings for both HCC and HEDIS simultaneously.
- ▶ Audit provider office medical records with re-evaluation in 6 months.




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Questions?



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Health Risk Assessment

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Health Risk Assessment

- ▶ **What is the purpose of the ICE Health Risk Assessment (HRA) Team?**
 - Develop a standard HRA form

- ▶ **How is HRA related to the Annual Wellness Visit (AWV)?**
 - HRA is part of an AWV

2




Health Risk Assessment

HRA is an evaluation tool that meets the following requirements:

- Collects self-reported information about the beneficiary
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter
- Is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs,
- Takes no more than 20 minutes to complete

3




Health Risk Assessment

Addresses, at a minimum, the following topics:

- Demographic data
- Self assessment of health status, frailty, and physical functioning.
- Psychosocial risks
- Behavioral risk
- Activities of daily living
- Instrumental activities of daily living

4




Health Risk Assessment

CMS Proposed HRA Requirements for 2012

➤ As proposed, the law specifies that the HRA is to be completed before, or as part of, an annual wellness visit with a health professional who may be a physician, medical practitioner, medical professional or a team of medical professionals. The law specifies that the HRA:

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Health Risk Assessment

- Must identify chronic disease, modifiable risk factors, and urgent health risks (Element 1) This includes assessment of ADLs and IADLs.
- May be furnished through a web based or interactive telephonic means (Element 2)
- May be offered through the encounter with the health care professional or through a community based prevention program (Element 3)
- May be provided by any other means appropriate, ensuring ease of use/privacy of beneficiaries (Element 4)

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Health Risk Assessment

Questions?

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