

Medical Records Briefing

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P4 Clinical document architecture

Tips for HIM in an interoperable healthcare environment.

P6 Outpatient CDI

Consider adding clinical document improvement specialists in outpatient departments to help ease the ICD-10 transition while improving ICD-9-CM coding accuracy.

P8 Who is the average coder?

The 2014 JustCoding.com Coder Salary Survey offers insight about coder salaries, credentials, and more.

P11 HIPAA Q&A

You've got questions. We've got answers!

HIM leadership and interdepartmental collaboration needed to finalize charts post-discharge

Organizations often struggle to finalize charts after discharge so they can be coded in a timely manner, but this process can be completed efficiently with direction from HIM professionals and coordination between departments.

While it may seem like a straightforward task to work on medical record documentation while a patient is still in the hospital and push the record out to HIM at the time of discharge, obstacles can stand in the way and cause delays in coding and billing.

"Many facilities are still experiencing delays in getting their documentation together in a timely manner so that coding can be completed in a timely manner," says **Andrea Romero, RHIA**, client development executive for Coding Services Group in Naples, Florida.

Many hospitals still rely on paper documentation that must be scanned into the EHR. While this process is nothing new, it can often hold up records and increase a hospital's discharge not final billed (DNFB). "You have to be able to secure that paper documentation right at

the point of discharge," Romero says.

HIM can steer a hospital in the direction of expediently completing records through the use of hospital-wide policies and EHR reports. Establishing a process for completing and scanning documentation to ensure a smooth chart flow can often ease the burdens associated with a high DNFB, Romero says.

Medical record life cycles

The life cycle of a patient chart depends upon the nature of a facility and its EHR. However, migrating paper documentation to the EHR as quickly as possible after discharge is the key to beginning the clean coding process, Romero says. HIM may experience pushback from hospital departments when making an effort to streamline chart flow, but strong HIM leadership and open communication between departments can help, she says.

HIM needs to take ownership of the paper portion of a record at the time of discharge. Ideally, CDI will have

reviewed the chart and completed any physician queries by then, Romero says. Physicians and case managers should also complete their documentation while the patient is in-house so that there are few loose ends in the medical record. This should allow for the HIM department to retrieve the record within one hour of discharge, she says.

Failure to retrieve the paper record shortly after discharge can open the doors for physicians and case managers to add documentation to the record once the patient is out the door, which calls the legal medical record into question, Romero says.

"Where is your legal medical record?" she says. "Is it the one that's already been scanned or is it another paper copy sitting on a shelf that has had something added?"

Create policies that prohibit records from being held on a unit after discharge to avoid an increase in DNFB, Romero says.

Simple processes that change behaviors may help expedite record retrieval and coding process, says **Kellye Reers, RHIT**, director of operations at Coding

Services Groups. In addition to establishing timelines for when charts must be retrieved and scanned, organizations should establish a chart reconciliation process that occurs prior to scanning, she says. Comparing paper documentation to the discharge list is key to ensuring that all of the discharges for that day are retrieved for scanning. Failure to perform reconciliation will likely result in delays in coding. These problems are no different from those that existed prior to the introduction of EHRs, but now organizations must add time for scanning, Reers says. Physicians and nurses often retain all or part of a chart to complete documentation after discharge, which can lead to creating an incomplete picture of the patient in the EHR or a missing chart altogether, she says.

"That chart reconciliation process is really important prior to the scanning process so that you can ensure that 100% of your charts are ready and available for you in the electronic record for coding," Reers says.

Romero agrees and notes that unfortunately without reconciliation, organizations may not realize that documentation was missing until the point of timely filing.

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Scan daily

From a best practice standpoint, Romero recommends that after timely retrieval of a record, the organization scans the paper documentation so it can be made available electronically so all involved in a patient's care can access it as soon as possible. Failure to communicate documentation and scanning needs and processes to an EHR vendor—and in some instances a vendor responsible for scanning records—can create a roadblock that may prevent the timely entry of paper records into the electronic record, Romero says. Manage these vendor partnerships to ensure scanning occurs 365 days a year, she says.

Daily scanning is not the norm at all hospitals, but should be the goal, Reers says. Failure to keep up with scanning can result in a backlog of records, which impedes several departments, she says. In some instances, organizations may have week-old documentation waiting to be scanned. However, HIM professionals should strive to ensure that documentation for each day's discharges is scanned within 24 hours so it can be made available to coders and caregivers, Reers says.

Scanning delays are problematic for many reasons outside of timely coding and billing. Allowing paper documentation to sit around for a week or more before scanning it increases the likelihood that the documentation goes missing, Romero says. In addition, many departments rely on the documentation to perform their jobs and deliver the best possible quality of care.

"So many people want to get their hands on the chart after discharge," Romero says.

HIM should take the lead in managing the life cycle of the documentation so as not to create delays for other departments that rely on the medical record to perform their duties. For example, case managers will need to access a patient's completed medical record shortly after discharge to follow up with the patient, Romero says. Similarly, workforce members in the operating room may need to call a patient the day after discharge to ensure his or her stay was satisfactory and to answer any outstanding questions. The physician will also need to sign off on the chart and ensure the discharge summary is accurate, she says.

Whether its scanning is performed in-house or with an external vendor, HIM must ensure records are scanned promptly to lessen the likelihood that workforce members from other departments need to refer back to the

paper chart because documentation is not yet available electronically, Romero says.

Encourage collaboration between departments

Strong HIM leadership is needed to bring departments together to ensure records are retrieved, scanned, and coded in a timely manner, Romero says.

Some coding queries may come in post-discharge, so HIM should communicate with coders to ensure they generate queries in an efficient manner and provide the appropriate documentation to expedite queries, she says.

Buy-in from senior leadership is critical when creating policies and procedures for expediting the record retrieval and scanning process. Ensure that senior leaders understand the financial implications of failing to quickly gather documentation for scanning so that it is available for coding, Romero says. Be specific. Let the chief executive officer (CEO), chief financial officer (CFO), and chief nursing officer (CNO) know how much money is held up in billing for records that are waiting on physician queries or charts that have not come down from the floor yet, she says.

"That's going to get the CEO, CFO, and CNO's attention because it's striking the bottom line there," Romero says. In addition, HIM should communicate the need for timely record retrieval with the medical executive committee to encourage workforce members to comply with policies and procedures that prohibit holding a file on the floor for too long, she says.

HIM should update the medical executive committee on a daily basis as to whether physicians have outstanding queries or requests, Romero says. HIM can also help engage physicians in the clinical documentation improvement (CDI) process and ensure that CDI reaches as many physicians as necessary and that CDI is communicating with physicians in a mutually beneficial way. Often, there are ways in which HIM can help physicians with these tasks to expedite the process of completing a record that may have been held up.

"Sometimes you have to reach out to them, offer them help with what they need in their office setting," Romero says. "Build that trust and physicians will become partners in the documentation process."

HIM should also reach out to nursing leaders and unit clerks. These workforce members are the gatekeepers of the records on the unit floors and can help HIM keep

track of records before they are entered into the EHR, Romero says.

HIM should make an effort to meet with unit clerks on all shifts at least once a month to review common issues with the breakdown of charts, Reers says. This practice should be applied to HIM communication with the medical staff as well. When possible, HIM should attend medical staff meetings with each department to discuss documentation challenges, she says.

Leverage your EHR

EHRs are packed with tools and reports that can often simplify the process of tracking the medical record as it moves throughout an organization. Although EHRs have different functionalities, there are commonalities among them that organizations can leverage to make the process of converting paper charts and readying records for coding easier, Romero says.

After scanning a record, it should be routed through queues in the EHR so the abstracting and coding processes can begin, Romero says. These tasks can be completed at the same time once the record is electronic.

Incorporate admission, discharge, and transfer feeds from the point of registration into the EHR to generate reports that help HIM determine which records have been entered in the EHR and which have not yet been retrieved. Queues should be established in the EHR to let HIM professionals quickly and easily determine which records are waiting on queries, need to be abstracted, and need to be coded, Romero says. Communicate with the EHR vendor to determine which reports are available and whether to create new reports to make the process easier, she says.

Be careful. If an EHR is not well managed, reporting can often be detrimental, Reers says.

"A lot of HIM directors don't familiarize themselves well enough with their EHR," she says. "They rely on IT to do that, but IT doesn't understand the HIM workflow." A missing trigger document may prevent an account from flowing into the correct queue for coding. If the EHR queues are not managed daily, the facility DNFB can skyrocket, Reers says. HIM must be familiar with EHR functionality so records do not get hung up and delay coding and billing, she says. ❏

Clinical document architecture: Implications for HIM in an interoperable healthcare environment

HIM professionals are at the center of a shift from a paper-based to an electronic healthcare environment. As healthcare organizations work toward Meaningful Use attestation, there are standards that can help HIM professionals ensure that their electronic records are interoperable.

Health Level Seven® (HL7) is accredited by the American National Standards Institute to develop standards for electronically sharing health information.

The goal of HL7 is to enable greater interoperability for healthcare organizations, says **Steve Bonney**, executive vice president of RecordsOne in Naples, Florida. Bonney discussed HIM involvement in HL7 and consolidated clinical document architecture (C-CDA) at the 2014 AHIMA Convention and Exhibit September 27, 2014, through October 2, 2014, in San Diego, and believes EHRs are a stepping stone to a more

interoperable healthcare industry.

The push toward health information exchanges (HIE) meant that the HL7 Version 2.x messaging standard, which helped providers communicate, was no longer up to par. "It would be improbable for every healthcare provider to connect to every other healthcare provider the way we used to connect to people with traditional HL7 Version 2.x messaging," Bonney says. "You'd have millions of interfaces running around the country."

While HL7 can help organizations communicate, people must understand that it is designed to connect a limited number of systems to each other within an organization or to other organizations with whom we communicate very often (i.e., an external lab), says **Margret Amatayakul, MBA, RHIA, CHPS, CPHIT, CPEHR, CPHIE, CPORA, FHIMSS**, president of Margret\A Consulting, LLC, in Schaumburg, Illinois.

According to the HL7 website, 95% of healthcare organizations in the United States are using Version 2.x. HL7 Version 3 offers greater flexibility in part due to the introduction of the C-CDA, which is a standard for the structure of clinical documents stored in medical records (e.g., discharge summaries, imaging reports).

"We really don't 'connect' with C-CDA, we share documents more readily with C-CDA," Amatayakul says. "The sharing is enabled with other tools, including privacy permissions, technical transport mechanisms."

C-CDA helps store and move clinical documentation across healthcare organizations in a streamlined manner. For example, if a patient is travelling and is treated by an out-of-state provider, HL7 Version 3 C-CDA should allow that provider to access the patient's medical records at his or her primary care provider in a standard format, Bonney says. (For more information about HL7 C-CDA, visit www.hl7.org/implement/standards/product_brief.cfm?product_id=186.)

"The consolidated CDA is a good thing," Bonney says. "It's a benefit to all the folks that are providing care, not just in a certain area but ultimately nationally."

Vendors often have a lot on their plates. It can take time for them to modify point-to-point interfaces, which consume valuable IT resources, Bonney says. However, C-CDA gives healthcare organizations the flexibility to share information without the need for constant point-to-point interfacing, he says.

"My hope is that if people start to understand what is feasible with consolidated CDA, they'll start to look at it as the new way of sharing information," Bonney says.

Sharing patient information through a secure protocol such as C-CDA is often safer and more secure than transmitting it via mail or fax, he says.

However, Amatayakul notes that often the most secure means of sending structured data is through a virtual private network.

Regardless of the approach, HIM professionals should be closely involved in the protocol for transmitting data, says **Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA**, chief operating officer and founder of First Class Solutions, Inc., in Maryland Heights, Missouri. This will help ensure the approach is HIPAA-compliant and the organization is capturing the disclosure occurrence for accounting of disclosure reporting, says Dunn, an **MRB** editorial advisory board member.

The connection to meaningful use

Meaningful Use Stage 2 objectives and 2014 EHR certification criteria emphasize the importance of care coordination and patient engagement. Organizations can use C-CDA to help comply with some meaningful use objectives and move toward a more interoperable HIE. (An overview of Stage 2 is available on the CMS website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2Overview_Tipsheet.pdf.)

"In a nutshell, if you have a Stage 2–certified EHR, you have the capacity to be able to send and receive C-CDA," Bonney says.

Meaningful Use attestation can be valuable for organizations because meeting some of the interoperability objectives can facilitate the transmission of data that help improve care. HL7 and C-CDA can enable organizations to provide transfer of care summaries in an expedient manner, Bonney says. This technology can also speed up the process of delivering information to patients via their personal health records. It also makes it easier for providers in the hospitals to share test results and patient information with primary care providers so they can understand why a patient was admitted and discharged, he says.

HIM professionals should assess whether the CDA is capturing amendments to the documentation that is transferred to the primary care provider as well as data that may be accessed by an out-of-state provider, Dunn says. Amendments (i.e., lab result corrections and misplaced documentation) may be important for these providers but they may not have access to the entire patient's record, she says.

"It's not just about attestation and getting your money," Bonney says. "It's about facilitating better quality of care throughout the ecosystem and the only way you're going to do that is if everybody is sharing data."

Bonney predicts that certification for EHRs may eventually require organizations to adopt systems that are capable of supporting new standards for health information that physicians can use for clinical decision support. C-CDA would allow organizations to quickly and easily transmit health information so it is available for other organizations to access shortly after the documentation is created, he says.

"All that interoperability really starts now, and it starts with C-CDA," Bonney says.

Although it may prove valuable, organizations should perform testing prior to implementing the current version of C-CDA as it is largely untested, Amatayakul says.

"To get to the most granular level of the C-CDA—which would yield the specific data elements needed to support clinical decision-making—we need people like HIMs to identify what data within a document should be 'tagged,'" Amatayakul says. HIM should work with physicians and nurses to identify key data elements needed for sharing information prior to implementing C-CDA, she says.

Opportunities for HIM

HIM professionals are often viewed as the custodians of the medical record. HIM involvement in HL7 and C-CDA is critical because the knowledge HIM professionals have about patient data can help structure C-CDA programming or manual intervention, Amatayakul says.

Bonney recommends that HIM professionals focus on the ways to integrate C-CDA at their organizations. HIM should be the center of the data revolution. As the custodians of the medical record, HIM is well suited to be at the center of the documentation revolution, with HL7 and C-CDA playing a major role in making health data interoperable. "I don't think it's any mystery that the HIM department is the center of the clinical document universe," Bonney says.

Understand the implications of the interoperable document. Although considering interoperability with outside entities should be a focus for HIM, also consider how data flows within an organization between HIM, case management, clinical documentation improvement, and quality, Bonney says. Work toward creating an environment that is data-driven, and facilitate connections between departments to maximize patient

care and receive accurate reimbursement for care provided, he says.

"Understanding the implications of the interoperable document doesn't have to happen just outside your facility with your trading partners and with your patients," Bonney says. "Understand the value that this interoperable document can bring within the hospital and then use that to enable these different departments that traditionally are relying on HIM."

Other implications of C-CDA

The benefits of C-CDA in the healthcare industry go beyond helping providers communicate for treatment purposes. This standard can also be useful for researchers who obtain clinical information from healthcare organizations for the purpose of selecting patients to participate in clinical trials or studies, Bonney says. Providing comprehensive patient information early on in a study can help researchers select the appropriate candidates for study from the start. Often, information that could disqualify a research candidate is revealed once a study is underway, which can drive up the cost of research. However, C-CDA can make it easier for researchers to receive patient data from facilities so they can select appropriate candidates during the trial screening, he says.

C-CDA can also help lower release of information costs because information can be entered into the personal health record in a standard format that organizations can make available to patients, Bonney says. Rather than investing time and money in having internal or external workforce members copy paper records, organizations can push the necessary data out to patients electronically, thereby reducing costs, he says. ■

Consider expanding CDI to outpatient departments

Even before ICD-10-CM was delayed until October 1, 2015, the quality of physician documentation to accommodate the new code set was a top concern for the healthcare industry.

According to a survey before the delay by the Medical Group Management Association, changes to clinical documentation to accommodate ICD-10 rated as the top concern (68%) of the 570 physician

group practices polled—in which more than 21,416 physicians practice.

As a result of the delay, however, providers have been able to spend more time fine-tuning their ICD-10-CM training, both for coders and physicians. The unanticipated delay also added time for providers to consider adding clinical documentation improvement (CDI) specialists in outpatient departments to help ease the transition while also improving ICD-9-CM coding accuracy.

CDI specialists typically review inpatient records to obtain specificity related to principal and secondary diagnoses. As a profession, such staff combine clinical knowledge with coding, billing, and documentation experience. Although not as prevalent as inpatient efforts, outpatient CDI is a growing trend.

With the increased need for specificity associated with ICD-10-CM and other regulatory changes, more facilities are considering implementing outpatient CDI programs, according to **Elaine King, MHS, RHIA, CHP, CHDA, CDIP, FAHIMA**, AHIMA-approved ICD-10 CM/PCS trainer, a senior consultant for Nuance Communications in Dunwoody, Georgia.

Benefits of outpatient CDI

An outpatient CDI program should be aligned with a facility's ICD-10-CM initiatives, according to King, since both require a focus on coding and documentation. Payers may also be changing their policies regarding ICD-10-CM, which could require reporting much more accurate diagnoses. "In ICD-9, [payers] covered a lot of unspecific diagnoses, [but] they are saying no in ICD-10," King says. "Their reasoning is that with the availability of more specificity, an unspecific code could be reflective of either fraud or poor patient care."

For example, while current documentation for reporting asthma in ICD-9-CM may be sufficient, ICD-10-CM requires physicians to document terms such as "mild intermittent," "exacerbation," or "with status asthmaticus" in order for coders to report the most specific code. An outpatient CDI specialist will be able to look for those terms and query physicians when they are not included.

Outpatient CDIs will also be able to target areas of incomplete and insufficient documentation, such as infusion start and stop times or date of service errors.

A key driver for outpatient CDI efforts is denials, according to King. The top reasons claims are denied on the outpatient side include:

- Incomplete or insufficient documentation
- Medically unnecessary treatment
- Incorrect coding

CDIs will be able to reduce denials from each of those categories by correcting documentation errors before the claim drops. CDI specialists can also assist in ensuring claims include medically necessary diagnoses required by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

For example, CPT® code 77080 (dual-energy X-ray absorptiometry [DXA], bone density study, one or more sites; axial skeleton [e.g., hips, pelvis, spine]) requires the documentation to support specific ICD-9-CM codes in order to avoid denials.

According to NCD 150.3, claims submitted with 77080 must include one of the following diagnosis codes:

- 255.0, Cushing's syndrome
- 722.90, other and unspecified disc disorder, unspecified region
- 733.00 through 733.03, unspecified, senile, idiopathic, and disuse osteoporosis, respectively
- 733.09, drug-induced osteoporosis

"[Payers] have very straightforward rules," King says. "It's just challenging at times to keep up with what those are and making sure that you comply."

Outpatient CDI challenges

CDI staff often come from the inpatient setting, which can make expanding to the outpatient world challenging. For example, inpatient stays are reimbursed on the DRG system, while outpatient facilities use more of a fee-for-service system, with charges for each service. Outpatient billing also includes both the professional side for physicians—using CPT codes—and the facility side—using ICD-9-CM or ICD-10-CM codes.

Outpatient facilities include ambulatory surgical centers, clinics, physician practices, and EDs. Health-care systems may own any number of these pieces of outpatient endeavors—each of which may have its own payment systems.

"With these different facilities, often managed separately with different reimbursement methodologies, it really does create a very complex environment for managing the documentation," King says. "That's one of the things that makes outpatient CDI so challenging."

The growth of accountable care organizations (ACOs) and risk-adjusted reimbursement models are another reason to implement a CDI program, King says.

Hierarchical condition category (HCC) coding, a methodology for stratifying the growing number of Medicare Advantage patients, includes different documentation requirements that physicians and coders need to understand. Timing can also be a challenge for CDI specialists, according to **Laurie L. Prescott, MSN, RN, CCDS, CDIP**, a CDI education specialist with HCPro, a division of BLR, in Danvers, Massachusetts. This is particularly true in EDs.

"You can't interfere with the immediate care that's needed," she says.

However, if an ED is slow, the CDI staff may struggle to find improvement opportunities. "You have to have patients and conditions to talk about," she says.

The outpatient CDI process

Outpatient CDI has four major phases, according to King:

- Assess
- Educate
- Remediate
- Monitor

The first phase requires a look at the coding department's top denials, either by dollar amount or by weekly, monthly, or annual volume. "Try to find patterns by either service, provider, [or] high-cost medicines, and just look to see what your big problem areas are," says King. "Those high-dollar denials are going to lead you right to where you need to begin your work."

The next step is to make sure that providers are aware of what needs to be included in documentation in order to ensure diagnoses and procedures get coded as accurately as possible. Most providers never learn proper documentation methods or what their documentation means for reimbursement and other purposes. So they need tips to help them, King says.

"They may not understand, especially on the outpatient side of things that their thought process [and clinical decision-making] has to be recorded."

Giving immediate feedback to a provider can be another way to facilitate his or her understanding of necessary documentation.

Prescott shadowed several providers when she initially started CDI services in the ED. She was able to verbally query them throughout the day to ensure appropriate documentation was entered.

"It worked great for those who would let me," Prescott says. Physicians can also be receptive to improving documentation when they understand the impact it can have on quality scores, she adds.

"Some of them may not care anything about the dollars and cents, but they want to make sure they stack up well against their peers," King says.

During the remediation phase, King recommends that timelines, goals, and objectives are set so that CDI efforts can be quantified. Outpatient CDI programs should follow existing query best practices. If query policies do not exist, develop them for your program following recommendations from AHIMA and the Association of Clinical Documentation Improvement Specialists. Initially CDI reviews should target procedures and diagnoses that are either high-dollar, high-volume, or both, and engage physician and coding staff to ensure everyone understands the documentation elements needed for accurate coding. If coders use cheat sheets or templates to quickly apply codes, these may need to be eliminated or updated.

"I think you really should look at eliminating those coding cheat sheets," King says. "Especially as we move to [ICD-10-CM], we're going to see too many unspecified codes. Update or implement, if you don't already have them, EHR templates so your documentation supports the new specificity."

The final phase is to monitor progress of the CDI program. King recommends at least quarterly chart reviews, looking for:

- Indications for procedures
- Number of denials and appeal letters
- Denial rates and financial impact
- Numbers of questions or volume of communication from physicians
- Percentage of cases with documentation deficiencies

CDI specialists will also be able to help by continuing coder and physician education as guidelines change, according to King.

"[Outpatient CDI programs] is where things are moving," she says. "The volumes are moving from inpatient to outpatient, and the methodologies for reimbursement in the outpatient are moving away from a straight fee-for-service. To remain solvent going forward, you

absolutely have to have quality documentation and coding in every environment, including outpatient."

*To learn more about outpatient CDI, order an on-demand version of the webinar "Outpatient CDI: Implement an Effective Program," from www.hcmarketplace.com. This article originally appeared in HCPRO's **Briefings on APCs** (www.hcpro.com/publication-newsletter-116-2015-department-corporate-compliance.html). *

How do your coders compare to the average coder?

Do your coders ever feel as if they work more hours than most coders? Or perhaps they think their compensation is lower than other coders across the country? Have you ever wondered how your coders compare to the average coder?

According to the 535 HIM professionals who answered the *2014 JustCoding.com Coder Salary Survey*, the average coder:

- Is paid \$40,000-\$49,999 per year
- Aged 50-59
- Has 6-10 years of experience
- Works 32-40 hours per week
- Received a 2% raise in the last 12 months

Overall, 21% of coders reported receiving a salary in the \$40,000-\$49,999 range, with a salary of \$50,000-\$59,999 a close second at 20%. Respondents earning less than \$39,999 per year dropped substantially over the past year. In 2014, only 19% of coders reporting earning less than that, with 32% reporting a salary of \$39,999 or less in 2013.

"Salaries are going up and will continue to rise," says **Monica Lenahan, CCS**, AHIMA-approved ICD-10-CM/PCS trainer, director of coding compliance and education for Centura Health in Englewood, Colorado, citing added responsibilities as the job evolves and potential coder shortages in the future.

The increase in average salary could be due, in part, to the increase in education level amongst respondents. The most common degree among respondents remained an associate's degree, with 34% holding one in 2014. The

number of respondents with a bachelor's degree climbed from 16% in 2013 to 23% in 2014.

Another 31% reported their highest level of education as high school or "some college" in 2014, down from 38% reporting those levels of education in 2013.

The most common credentials among respondents are:

- AHIMA-approved ICD-10 trainer, 10%
- CCS, 31%
- CPC, 34%
- RHIT, 27%

The increase in salary could also be due to coders working more hours in 2014. Last year, 63% reported working between 32-40 hours a week, but that fell to 53% in 2014. Coders working more than 41 hours per week jumped 10 percentage points to 44% in 2014.

Despite the increase in salary, the majority of respondents (57%) do not believe that the combination of coder salary, benefits, and bonuses have kept up with the cost of living, though this is down from the 76% who felt that way in 2013.

"Employer-sponsored medical insurance premiums have gone up exponentially and benefits have degraded substantially in the last year," says one respondent. "This is resulting in much more out-of-pocket costs for medical care, thereby creating a huge deficit in overall compensation that is not keeping up with the cost of living."

Changing compensation for coders to match systems used by hospitals to set salaries for clinical staff could be a solution, according to another.

Pay scales for coders should be similar to those

for other ancillary services (e.g., diagnostic imaging, nursing, respiratory therapist) as far as certified and non-certified or the specific level of education, according to one respondent.

"A two-year degree should have more validity and compensation over a certificate or diploma. Coding is patient care on the back end. If we don't do our job well, patients, providers, and insurance companies cannot manage care and finances in an accurate manner. Coders have regulations to abide by just like any other patient care area. Why is our profession not recognized in the same context, yet employers want us credentialed and educated in our specialty?" the respondent added.

The majority of respondents (55%) still believe that they are fairly compensated for the work they do, even though only 41% believe coders in general receive sufficient compensation. This is still a marked increase from 2013, when only 34% felt fairly compensated and 26% thought coders overall were compensated sufficiently.

Additional responsibilities

Coding is just one facet of the job that coders have to actually perform, according to the survey.

"Coders have to be more revenue cycle-minded than ever now," said one respondent. "It's not just the coding rules, but the reimbursement rules, as well."

In the last year:

- 87% engaged in some level of ICD-10 training
- 55% performed more tasks related to data-tracking (e.g., entering data into a spreadsheet)
- 55% participated in auditing activities (e.g., review records related to Recovery Auditor validation areas)
- 57% participated in training related to new coding software or electronic health record system
- 48% trained coders or clinical documentation improvement specialists
- 28% contributed to Recovery Auditor-related efforts (e.g., preparing charts for review, gathering information for appeals, etc.)

"I think coders should be happy that responsibilities have grown, which means facilities do have a level of dependency on coders and we should embrace that,"

says **Susan E. Garrison, CHCA, CHCAS, CHC, CCS-P, CPC, CPC-H**, executive vice president with Med Law Advisors in Dawsonville, Georgia. "At the same time, we should continue to look proactively for ways to improve ourselves and our facilities and how we can grow those responsibilities and hopefully impact our salaries more positively."

Will age cause a shortage?

It's an undeniable fact that the coder population continues to age without an influx of new, young coders.

"This is a rapidly approaching big problem," says Lenahan. "There was a fair amount of coder recruitment and training in the 1980s due to DRGs, and it's obvious from my experience and your survey that these folks have stayed in the coding profession."

Nearly half (46%) of the respondents in 2014 are 50–59 years old, with 15% aged 60–69. Last year, those numbers were at 38% and 13%, respectively.

What is your current annual salary?

Salary	Percentage of respondents
\$19,999 or less	1.60%
\$20,000-\$29,999	3.80%
\$30,000-\$39,999	13.20%
\$40,000-\$49,999	20.60%
\$50,000-\$59,999	19.80%
\$60,000-\$69,999	16.40%
\$70,000-\$79,999	9.80%
\$80,000-\$89,999	7.00%
\$90,000-\$99,999	3.80%
\$100,000-\$109,999	2.00%
\$110,000-\$119,999	1.00%
\$120,000-\$129,999	0.40%
\$130,000-\$139,999	0.20%
\$140,000-\$149,999	0.20%
\$150,000-\$159,999	0.00%
\$160,000 or more	0.40%

Source: JustCoding.com's 2014 salary survey.

Only 14% of 2014 respondents are between 20–39 years old, while that number was at 20% in 2013.

ICD-10 could serve as the catalyst to encourage hospitals to begin hiring drives for coders again.

"As an industry we haven't done the best job obtaining new recruits into the profession recently, but I think that will change shortly with the coder shortage due to ICD-10," Lenahan says. ☒

HIPAA Q&A

Handling electronic copies of records, minimizing incidental disclosures

by Chris Simons, MS, RHIA

Q I work in long-term care and I am familiar with the language in HIPAA regulations regarding requests for electronic copies of medical records for a reasonable fee according to community standards. However, my company does not maintain its medical records in electronic form, nor do we presently have the capability of converting our paper records into electronic format. Our state legislature addressed the issue of "reasonable charges and community standards" by state statute in 2006 by providing a formula for every medical provider to follow state-wide for copy charges regarding paper copies.

When someone requests copies of our medical records in electronic form, we first have to make a paper copy of the records, then pay an outside service to scan the records and convert them into electronic form. When we billed the person using the state statute for making paper copies, the person objected to paying for the paper copies because he didn't believe that we didn't create the electronic record ourselves. He then threatened to file a complaint with HIPAA.

Are we correct in charging for paper copies according to state statute that provides the same formula for all communities in this state if we cannot produce electronic copies?

A Not surprisingly, state and federal statutes have been slow to comment about charges for electronic copies of PHI. It sounds like the law in your state pertains to paper copies only.

HIPAA allows a covered entity to impose a "reasonable, cost-based fee" for a copy of PHI. However, the fee permitted under HIPAA (45 CFR 164.524(c)(4)) can only include the cost of:

- Labor for copying the PHI, whether in paper or electronic form
- Supplies for creating the paper copy or electronic media (if electronic media is requested)
- Postage

As long as the fee you are charging actually represents the cost of creating the copy (including labor and postage) and does not exceed the costs permitted by your state statute, your charging practices sound acceptable.

I suggest you network with your state AHIMA group or hospital association to develop a charging policy for electronic copies.

Q Should we permit workforce members to use their personal cell phones to communicate with patients? If yes, is there a HIPAA-compliant means of doing so for calls, email, and text messages?

A It is hard to see why this would be necessary when there are so many land lines available in a hospital or physician office setting. Personal cell phone communication, including text, aren't usually encrypted, so this practice would be risky. (Some patient portals have encrypted messaging capability, which would serve as a secure means of messaging patients.)

If, after conducting a risk analysis on this practice, you determine that the risk is an appropriate one to take (for instance, I can imagine a home health provider calling to verify the convenience of a visit), keep the communication brief and administrative. For example, say "I will be there at 2 p.m." rather than "I will be there at 2 p.m. to help you with your dressing change." I would recommend creating a policy that outlines acceptable and unacceptable cell phone communication with

patients. If this practice is permitted, it is also advisable to conduct documented workforce training.

Q My facility is considering working with a software company based in Canada. What can we do to ensure that our facility and the vendor are HIPAA-compliant? Should we have a business associate agreement (BAA) with the vendor?

A A Canadian company would not be required to comply with the privacy and security rules. A BAA would still be a good idea, as it outlines actions to take in the event of a breach, but it wouldn't provide you any protection from liability (nor would one signed with an American company, actually). I would also vet the product and the company to ensure it is as secure as possible and document reference checks as well. In the event of an incident, such activities will show you exercised due diligence.

Q I was recently treated at an urgent care clinic. Upon checking in, I noticed that a television screen in the waiting room displays the first name, last initial, and approximate wait time for each patient. The administrative staff members do not ask whether they can display this information. Is this a violation of HIPAA since anyone in the clinic can look at the television screen and read the names of the patients waiting for treatment?

A This is an incidental disclosure. The clinic has obviously determined that the small risk to privacy inherent in revealing the first name, last initial, and waiting time is worth the benefit of having the information readily accessible. I recently had a similar experience during my loved one's surgery and found it very helpful to know where he was in the process (e.g., operating room, postanesthesia care unit).

I would suggest that if this practice disturbs you, you ask them not to post your information. The practice should be able to accommodate your request (analogous to a facility directory in a hospital setting).

Q Can healthcare providers answer questions from other providers or patients when someone may possibly overhear the conversation? For example, I am an administrator at a provider-based clinic and notice that

patients often ask the providers last-minute questions as they are walked back to the front desk after an appointment. This is an area where most staff members and patients can overhear conversations between the provider and patient, yet our providers often respond to a patient's inquiry in this space rather than taking the patient into an office. Is this a violation of HIPAA?

A Providers should not assume that the patient is okay with discussing the topic in the open area, even if the question was asked there. This is another example of an incidental disclosure, which HIPAA requires us to minimize. It would be better to bring the patient back into the office to discuss these last-minute questions when possible. Err on the side of caution and encourage your providers to ensure all conversations with patients are as private as possible.

Q I recently went to see my primary care provider for an appointment. He was running more than 30 minutes late and felt the need to offer me an explanation for his tardiness when he finally came into the exam room. He said, "Without violating HIPAA, I want you to know the reason I am late is because my last patient was very emotional because she was recently in a bad accident and is also mourning the loss of a close family member." As a HIM professional, it struck me as odd that someone would offer this information. Is it a violation of HIPAA for a provider to share details about one patient with another?

A I am guessing the provider was trying to engage with you because he knows you are a HIM professional, but the disclosure was awkward and unprofessional, if not a HIPAA violation. Even without names or specifics, he should not share this sort of information; putting the pieces of the puzzle together to determine the previous patient's identity might not be very difficult. While I am sure the provider meant no harm, sharing even vague patient stories is not a best practice. 📧

EDITOR'S NOTE:

Simons, the director of health information and privacy officer at Cheshire Medical Center/Dartmouth-Hitchcock in Keene, N.H., answered these questions. Simons is also an MRB advisory board member. This information does not constitute legal advice. Consult legal counsel for answers to specific privacy and security questions. Send your questions related to HIPAA compliance to Editor Jaclyn Fitzgerald at jfitzgerald@hcpro.com.

A Minute for the Medical Staff

The dangers of copy-paste: Why it seems patients never get better, why you won't get paid



Physician and patient risk is associated with use of the copy-paste feature in EHRs. I'd like to discuss the appropriate and inappropriate use of this feature—how some physicians have taken shortcuts to try to get through the day—and results from the premature adoption of a federally mandated digital process that was given a drop-dead date and was inadequately field-tested. The government designed the process with good intentions, with the vendors of the programs given specific guidance on what was to be accomplished, though with no guidance whatsoever on its usefulness in the practice of medicine. It came out as a tool for record-keeping of various elements that systems can track without consideration of the physician or patient. And that's what we have. Physician and patient risk is associated with use of the copy-paste feature in EHRs. I'd like to discuss the appropriate and inappropriate use of this feature—how some physicians have taken shortcuts... Oops, I already said that! Get it?

This is what we see in reviews of records at university, children's, and community hospitals—over and over, repeat of the same verbiage, and without noticeable progress. The use of copy-paste functionality creates redundancies in the medical record and subjects the organization to the pitfalls of the technology.

First, a physician's ability to see and record a patient's work died when paper went away. We see an emergency department (ED) nurse practitioner (NP) completing a history and physical (H&P) exam and an ED resident copying and pasting those notes into the resident's H&P. Then the attending comes along, copies and pastes the resident's copied information into the attending's H&P and bills for seeing the patient when no evidence

exists that the attending did anything at all. Copying and pasting an NP's note and billing as a physician is purely unethical. Next, the internal medicine resident copies and pastes the outpatient H&P and it becomes the inpatient H&P. The attending internist copies and pastes it, then bills for the visit, which was originally completed by the ED NP. Again, this is unethical.

Consultants often create their own records in the EHR, but day after day after day, the history, past medical history, and review of systems completed by residents and attending physicians don't change. Lab results and medication lists get longer and as this information accumulates, it becomes difficult to find the most recent data in the EHR. The patient who was admitted with "septic shock with acute respiratory failure, acute renal failure, and elevation in troponin" has the same diagnoses day after day and is discharged home on oral medication with the same medical record notes that were entered into the EHR upon admission. The physician discharging the patient copies and pastes the NP's H&P, all labs and medications ordered during the prior two weeks, then bills for that discharge note. This is obviously a problem.

The Secretary of HHS said in a note to physicians more than a year ago, "If we have no evidence that you did the work, we're under no obligation to pay you." Physicians are getting caught and they're paying back hundreds of dollars in fines for what HHS calls fraudulent practice. Here are some thoughts regarding copy-paste functionality:

- The copy-and-paste and other functions in EHRs can make it easier to commit fraud when used inappropriately, but they're not fraudulent by default, according to a viewpoint article in JAMA Internal Medicine (<http://archinte.jamanetwork.com/article.aspx?articleid=1878672>).

- The OIG reported earlier this year that CMS has provided its contractors with limited guidance on EHR fraud and raised concerns that the contractors could not identify copied and over-documented information in an EHR. The agency also found that only a quarter of hospitals studied had policies on the use of the EHR copy-paste functionality to reduce the risk of billing fraud, and it recommended that CMS develop guidance on the use of the copy-paste feature in EHR technology (www.fierceemr.com/story/clinicians-copy-and-paste-emr-not-definition-fraudulent/2014-06-04).
- While copy-paste may be a convenient tool for busy clinicians using an EHR, the practice can lead to inaccurate and misleading information in the medical record. Another pitfall of using copy-paste functionality is the ease with which it can support fraudulent billing (<http://tinyurl.com/qecxpxp>).
- Healthcare fraud can be as easy as hitting Control-C, Control-V on your keyboard.
- Federal officials say the cut-and-paste features common to EHRs invite fraudulent use of duplicated clinical notes and that there is a need to clamp down on the emerging threat. That concern is enhanced by the fact that turning off features of EHR systems that track sloppy or fraudulent records is too easy.
- In an audit report released in December 2014, HHS agencies confirmed that they are developing comprehensive plans to deter fraud and abuse involving EHRs, including guidelines for copy-paste features. The issue arises at a time when critics say federally subsidized digital patient record systems allow providers to sometimes use them inappropriately to drive up reimbursement.
- “Certain EHR documentation features, if poorly designed or used inappropriately, can result in poor data quality or fraud,” according to a report from the OIG (www.modernhealthcare.com/assets/pdf/CH92135129.PDF).
- Cloning is so pervasive and troubling, it drew the attention of Kathleen Sebelius, secretary of HHS, and Attorney General Eric Holder. They jointly wrote a stern letter to industry medical groups warning

physicians to stop copying and pasting information in EHRs. They reported “troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled.”

- The OIG also named EHR copy-paste practices as one of its top challenges last year. It noted that cloning could lead to improper payments or inaccurate information in patient records. It’s no small problem (www.healthbizdecoded.com/2013/11/cut-out-the-copying-and-pasting-in-ehrs/).

The pitfalls of copy-paste functionality become so openly fraudulent when a mistake is made in one note and is perpetuated throughout the entire medical record. I’ve seen cases when pneumonia was ruled out within six hours of admission and antibiotics were discontinued, yet the diagnosis of pneumonia was present in every note thereafter for five days. I’ve seen instances when the hospital ruled out acute kidney injury (AKI) when it truly represented advancement of chronic kidney disease, yet AKI was present in every note and it was billed through the hospital. I’ve seen the emergency medical services crew identify “intubated for airway protection” patient who is drunk and not very responsive, but the ED practitioner called it acute respiratory failure and the patient was extubated on arrival in the ED and went home with acute respiratory failure.

Once upon a time, physicians actually wrote out notes. When we did, we did a pretty creditable job. Now, we copy and paste someone else’s work. Mistakes are perpetuated because we don’t always read the notes that we copy-paste, so nobody knows what was ruled in and what was ruled out. There is no evidence that a patient got better or worse. Copy and paste: when physicians use it right, it’s a valuable adjunct. When they don’t think about it, it’s potentially dangerous. We have met the enemy, and he is us. ☒



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