



Clinical Safety & Effectiveness Cohort # 12

**Team 11 Improve Front End Coding Accuracy in a VA
GEM CLINIC.**



Educating for Quality Improvement & Patient Safety

Financial Disclosure

- Dheeraj Anand, MD has no relevant financial relationships with commercial interests to disclose.
- Laura E. Garcia, MD has no relevant financial relationships with commercial interests to disclose.

The Team

- Division
 - CS&E Participant - Dheeraj Anand, MD
 - CS&E Participant - Laura E. Garcia, MD
 - Team Member Elizabeth Packer
 - Team Member Reggie Lebousseire, MD
 - Team Member Jennifer McElroy, CPC HIMS Coding Supervisor
 - Facilitator - Sandra Lilliana Oakes, MD, Nora Hope
- Sponsor Department
 - Araceli Revote M.D. – SOT/Chair/Professor

Aim Statement

Improve the accuracy of coding by providers at the VA Geriatric Clinic from 20% to 50% by JUNE 10, 2013.

Project Milestones

- Team Created Jan 2013
- AIM statement created Feb 2013
- Weekly Team Meetings Jan 31 13-Date
- Background Data, Brainstorm Sessions, Feb 1- Feb 28
Workflow and Fishbone Analyses
- Interventions Implemented April 22 - Date
- Data Analysis Jan 1 – June10
- CS&E Presentation June 14th 2013
- Graduation Date

Background

- Existing system prior to intervention:
 - The VA system did not emphasis billing and coding among providers training consisted of module at the time of the hire.
- This project was started secondary to low reimbursements and low complexity calculations for visits generated by the GEM Geriatric clinic.
- Given the high complexity, age, and interdisciplinary team needs of GEM patients, this feedback revealed a coding gap between documentation and level of service coded by service providers.

Background

- Accurate coding is very important not only to justify resources for patients and for the future practice of the residents and trainees, but for accurate calculation of budget requirements for the services provided.
- Long term goal is to increase the accuracy of the various providers of documentation/front end coding and increase understanding of the importance to patient and provider.

Measures and Targets

- With the tools introduced by the CS&E course, the ALM Geriatric VA Outpatient clinic was evaluated for effective documentation and accurate front-end coding by its health care providers.
- Providers evaluated included Residents, Nurse Practitioners, Fellows, and Faculty.

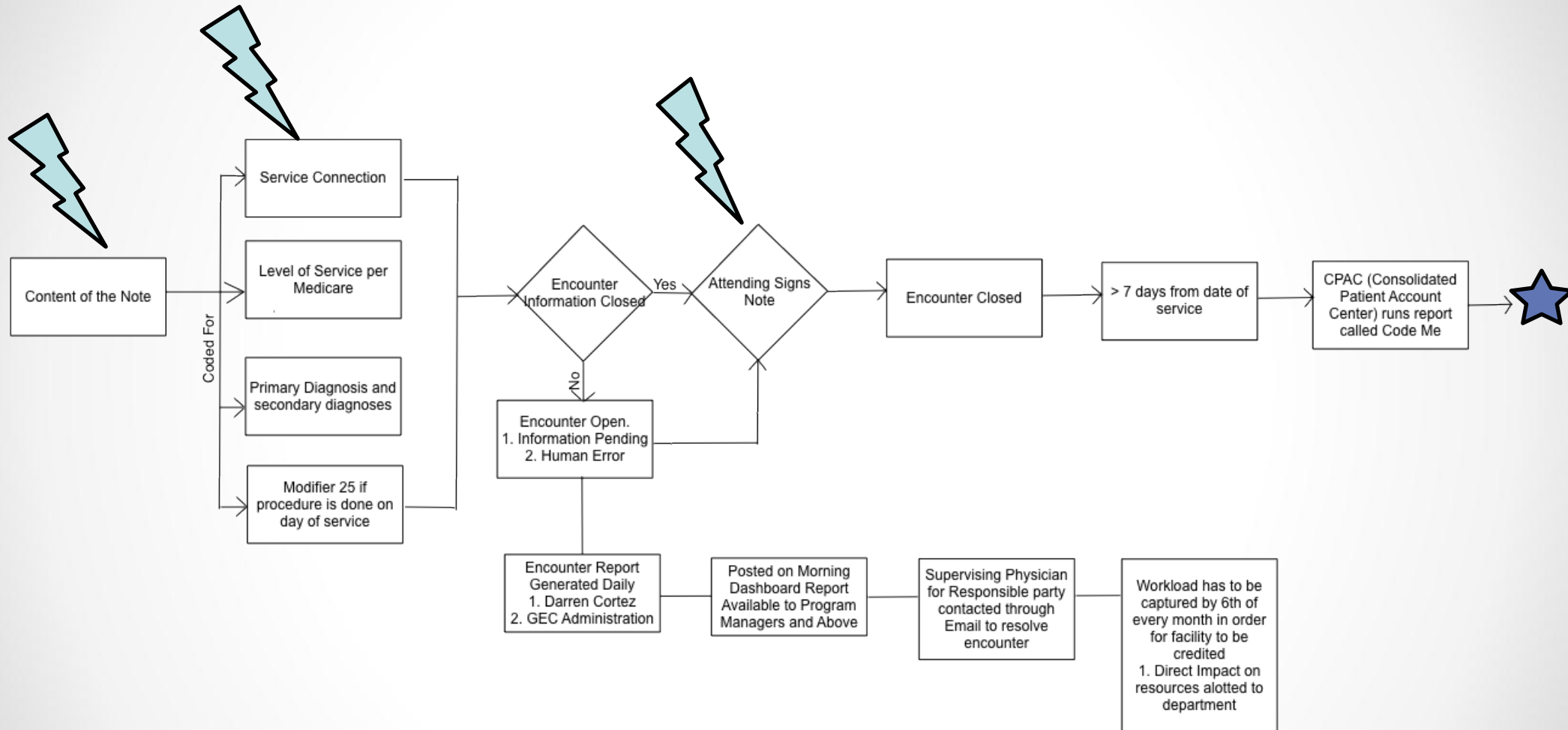
Measures and Targets

- Random selection of GEM Clinic Records were audited utilizing the 95 Medicare guidelines for appropriateness of level of service coded by provider, service connection, modifier 25, primary diagnosis and number of secondary diagnoses.
- Baseline data was established Jan 1 - 31st through 20 chart audits.
- Audit indicated a 20% accuracy rate.

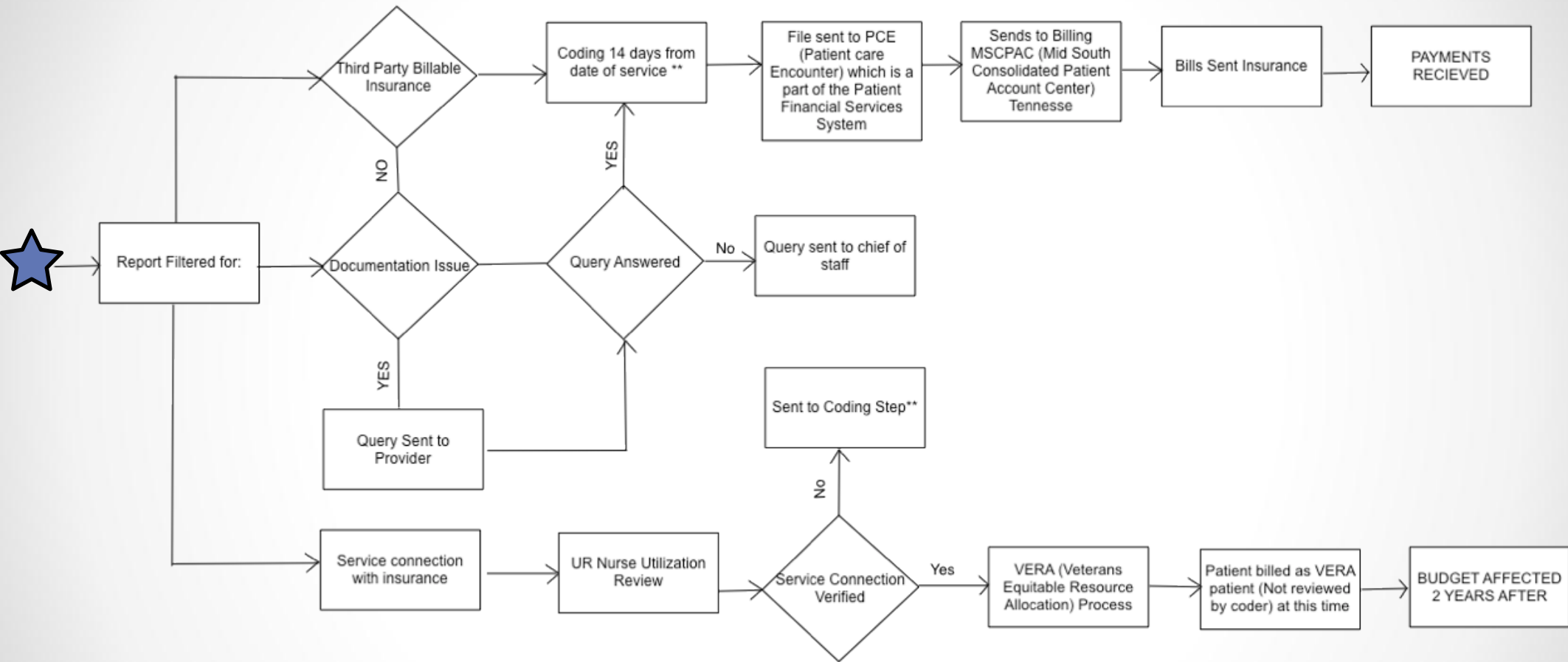
Selected Process Analysis Tools

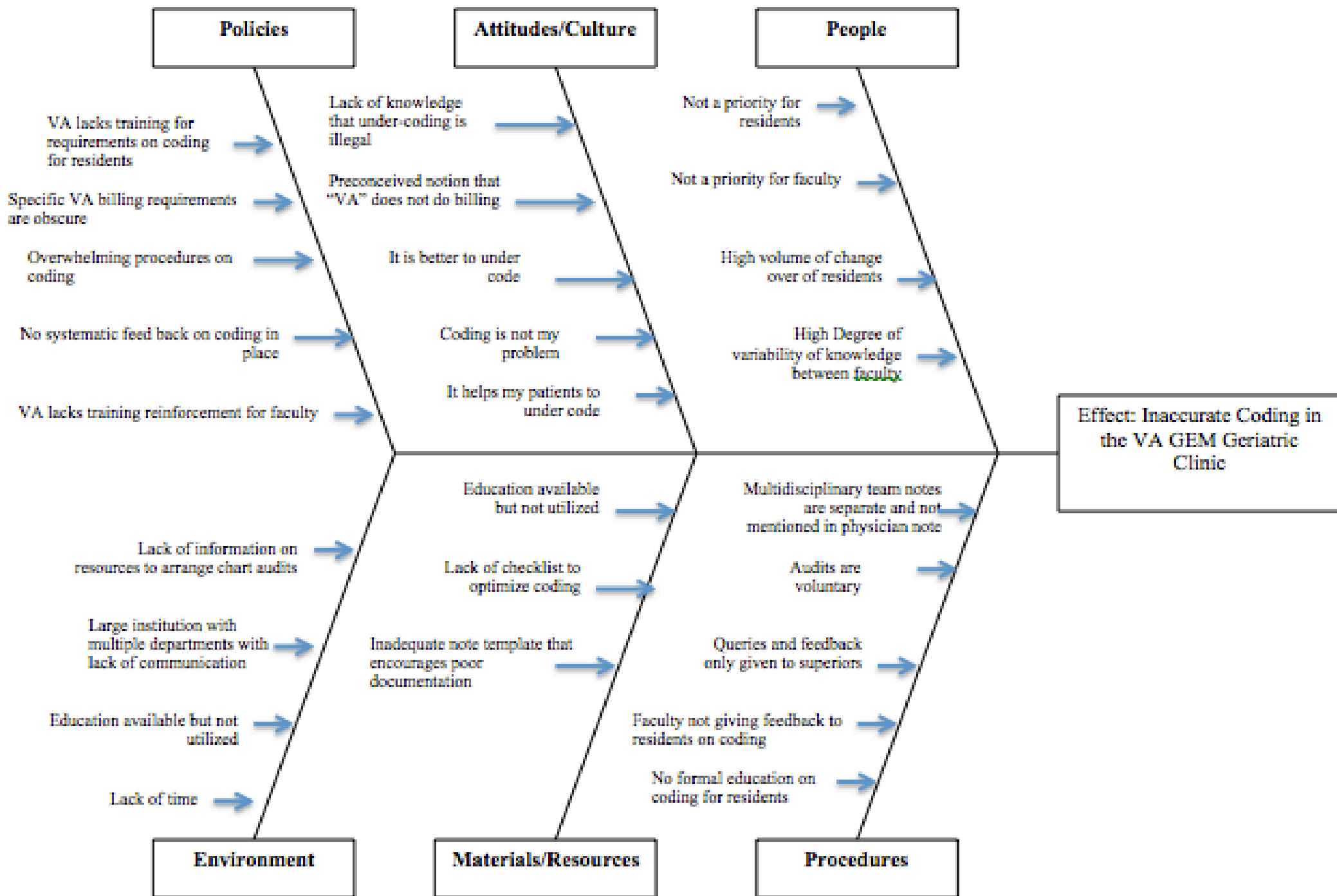
- Brainstorming
- Flowchart
- Fishbone
- Survey

PROCESS FLOW CHART



PROCESS FLOW CHART





Plan

- Educate the faculty
 - Improve supervisory role
 - Increase faculty awareness of the importance of correct coding at the VA
- Resident Turnover is high and training interventions are weak
 - Change orientation policy to include completing a brief training PowerPoint that includes:
 - How to use the Laminated LOS Tool
 - Example video using actual VA EMR environment
- Reference card, short-teaching modules, and timely feedback from attending to residents/learners will be introduced

Training PowerPoint

South Texas
Veterans
Health Care
System



E&M Documentation & Coding

STVHCS
Coding Education
May 2011

Objectives

- ▶ New vs Established Pt
- ▶ Three Key Elements of E&M Leveling
 - History of Present Illness (HPI)
 - Review of Systems (ROS)
 - Medical Decision making (MDM)



New Patient

New patient codes E/M can only be used if any physician within the same specialty in the clinic has not seen the patient within three years.

Established Patient

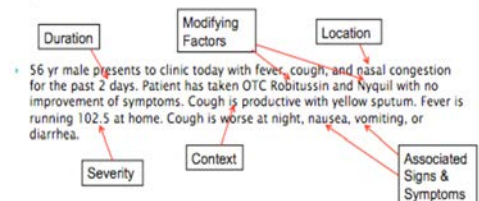
Established patient codes E/M can be used if any physician within the same specialty in the clinic has seen the patient within three years

The Three Key Elements of E&M

- ▶ 1. History: HPI+ ROS+PFSH
- ▶ 2. Physical exam
- ▶ 3. Medical decision Making: is the assessment and plan

History of Preset Illness

- A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem.



Problem focused: 1-3, Expanded problem focused: 1-3,
Detailed : 24, Comprehensive:24

Review of Symptoms (ROS)

Problem focused: N/A

Expanded Problem focused: 1

Detailed : 2-9

Comprehensive: 10+ (complete)

Coding Reference Card

Level of History	HPI	ROS	PFSH
PF	Brief (1-3)	N/A	N/A
EPF	Brief (1-3)	Problem Pertinent (1)	N/A
D	Extended (4+)	Extended (2-9)	Pertinent (1)
C	Extended (4+)	Complete (10+)	Complete (ED=2)
Physical Exam			
PF	1 Body area and/or system		
EPF	Limited 2 to 4 body areas and/or system		
D	Extended 5 to 7 body areas and/or system		
C	8 or more systems		
MDM	#DX	Data Reviewed	Risk
SF	Minimal (1)	Minimal/none (1)	Minimal
L	Limited (2)	Limited (2)	Low
M	Multiple (3)	Multiple (3)	Moderate
H	Extensive (4)	Extensive (4)	High
** Dx effected by documentation of condition			
PF = Problem Focused		M = Moderate	
EPF = Expanded Problem Focused		C = Comprehensive	
SF = Straight Forward		L = Low	
D = Detailed		H = High	

Level of Service Breakdown Tool – Medicare 1995 Guidelines. *
 Anand, D., Garcia, L. 2013. *VA utilizes Medicare 95 guidelines at this time.

New Patient					
History	PF	EPF	D	C	C
Physical Exam	PF	EPF	D	C	C
MDM	SF	SF	L	M	H
Code	99201	99202	99203	99204	99205
Established Patient					
History	Minimal Problem	PF	EPF	D	C
Physical Exam	That may not	PF	EPF	D	C
MDM	require the LIP	SF	L	M	H
Code	99211	99212	99213	99214	99215

* If a procedure (injection, wax cleaning, vaccination) is done on the same day of the visit add the modifier 25 listed in the first tab of the coding portion of your note

Training Video



Training Video

ZZDUCK, DONALD TEST PATIENT (OUTPATIENT) GEMAC Apr 05,13 14:27 Primary Care Team Unassigned
000-00-9994 Sep 18,1930 (82) Provider: ANAND,DHEERAJ Flag ViewWeb Remote Data Postings CWAD

GEM RESIDENT NOTE Apr 05,2013@14:44 Anand,Dheera Expected Co-signer: Oakes,Sandra Liliana Change...

INTERIM HISTORY: 82 y/o M with pmh of DM type 2, CHF, CAD, angina pectoris, B12 deficiency, depression and Vascular dementia presents for a f/u visit. Patient has been taking aricept for his dementia and his behaviors have been controlled. He is independent on his BADLs but needs assistance with his IADLs including managing finances and driving. His cognition is better per family and he is getting less angry compared to before. He has not been having any falls or dizzy spells. Patient denies any hallucinations. He also denies depression. He enjoys working in the lawn, watching t.v and spending time with his family. He c/o lower back pain 5/10, dull, non radiating, worse with standing, relieved by sitting and tylenol. He has been taking metformin for his diabetes and his fasting sugars at home are ranging in 100-130. He denies any spells of hypoglycemia.

REVIEW OF SYSTEMS: All other systems negative.

PHYSICAL EXAMINATION:
General: Alert and oriented, MAB.
Neck: No LAD, no TM.
Chest: Clear to auscultation.
Cardiovascular: Regular rate and rhythm without murmur, rub or gallop.
Abdomen: Soft, non-tender, non-distended, no organomegaly.
Extremities: No clubbing, cyanosis, or edema.

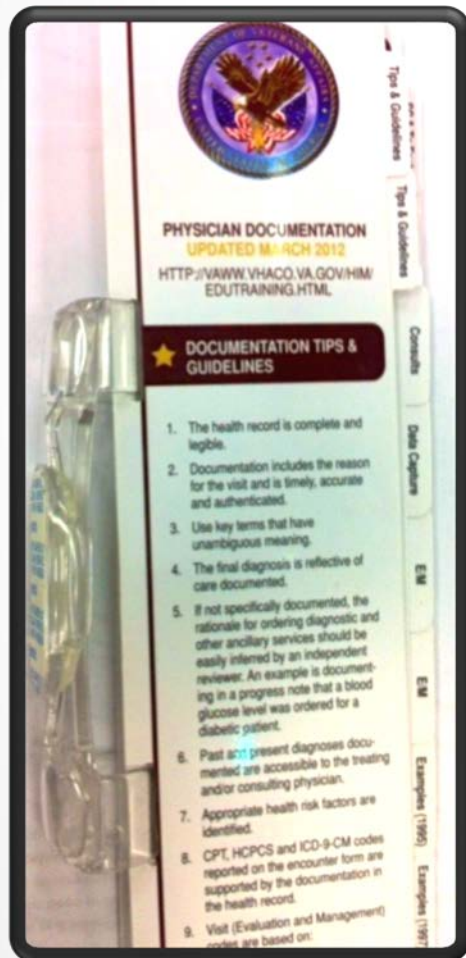
LAB:Cr: 0.7, Hb: 13.4, HbA1c: 6.5
NMSE: 22/30 GDS: 2/15

ASSESSMENT:
1. Vascular dementia: Continue Aricept 10 mg PO daily, cognition is better, behaviors controlled.
2. Back pain: Tylenol 650 mg PO q 6 hrs prn back pain. Not to exceed 2 gms/ day

(No encounter information entered)

Cover Sheet Problems Meds Orders Notes Consults Surgery D/C Summ Labs Reports

Flipcards



- Post Documentation Tips and Guidelines Flipcards in the Faculty staffing room.

Attending Survey

Team 11 Quality Improvement Project Provider Checklist

1. Does the attending educate a new resident about billing and coding?
 - a. Yes
 - b. No
2. Does the attending review the level of service coded by the resident?
 - a. Yes
 - b. No
3. Does the attending provide feedback to the resident on encounter information entered?
 - a. Yes
 - b. No
4. Does the attending check service connection?
 - a. Yes
 - b. No
5. Does the attending modify encounter (coding) information?
 - a. Yes
 - b. No
6. Does the attending discuss what the resident will code during the checkout of the patient?
 - a. Yes
 - b. No

Do: Implement the Change

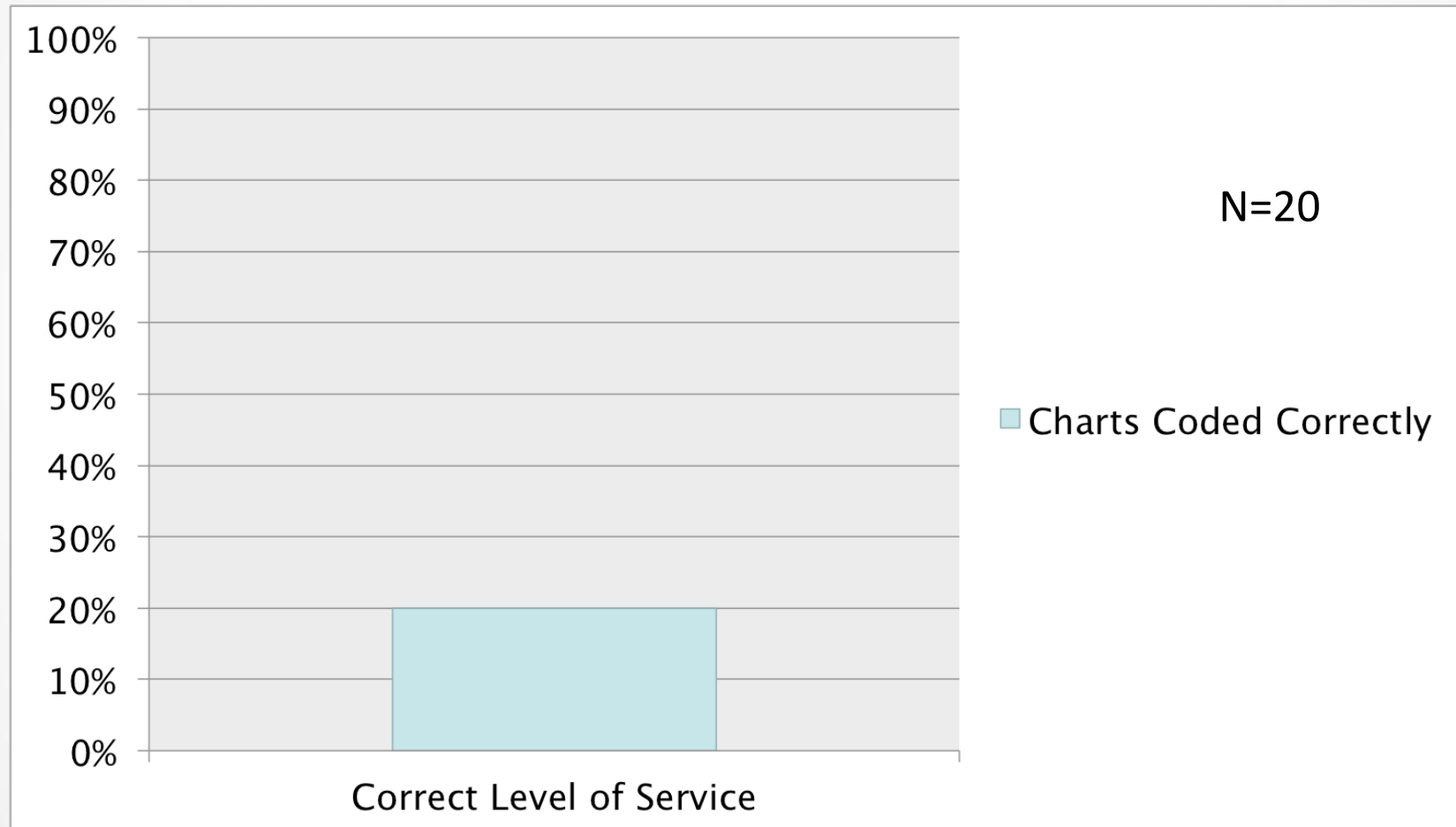
- Schedule Faculty Training April 19th and April 26th
- Upload training PowerPoint and video to YouTube for re-training as needed
- Flipcards placed in room April 19th
- Laminated Cards distributed April 19th

Results/Impact

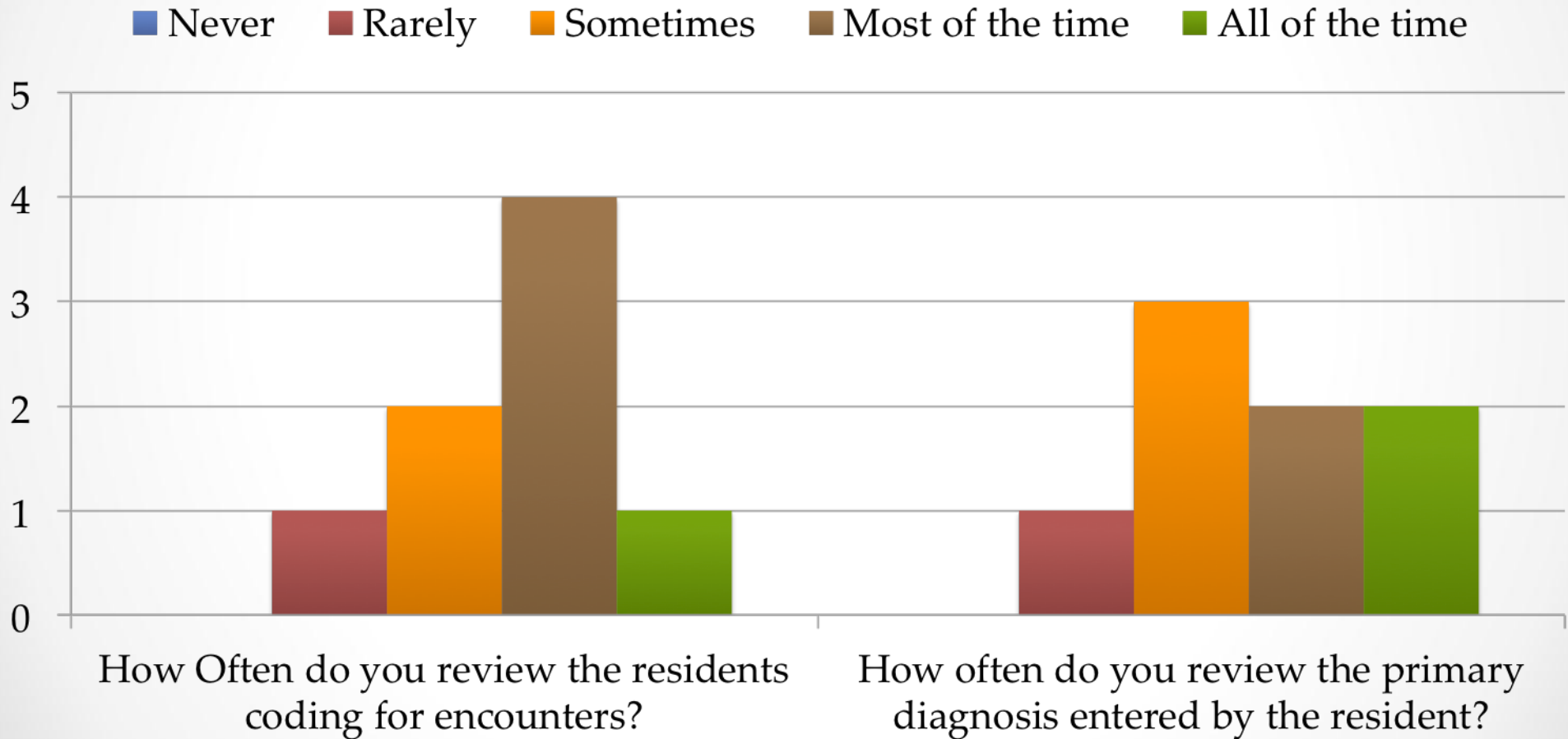
Check:

- Baseline Data
- Survey Data
- Three follow-up data samples

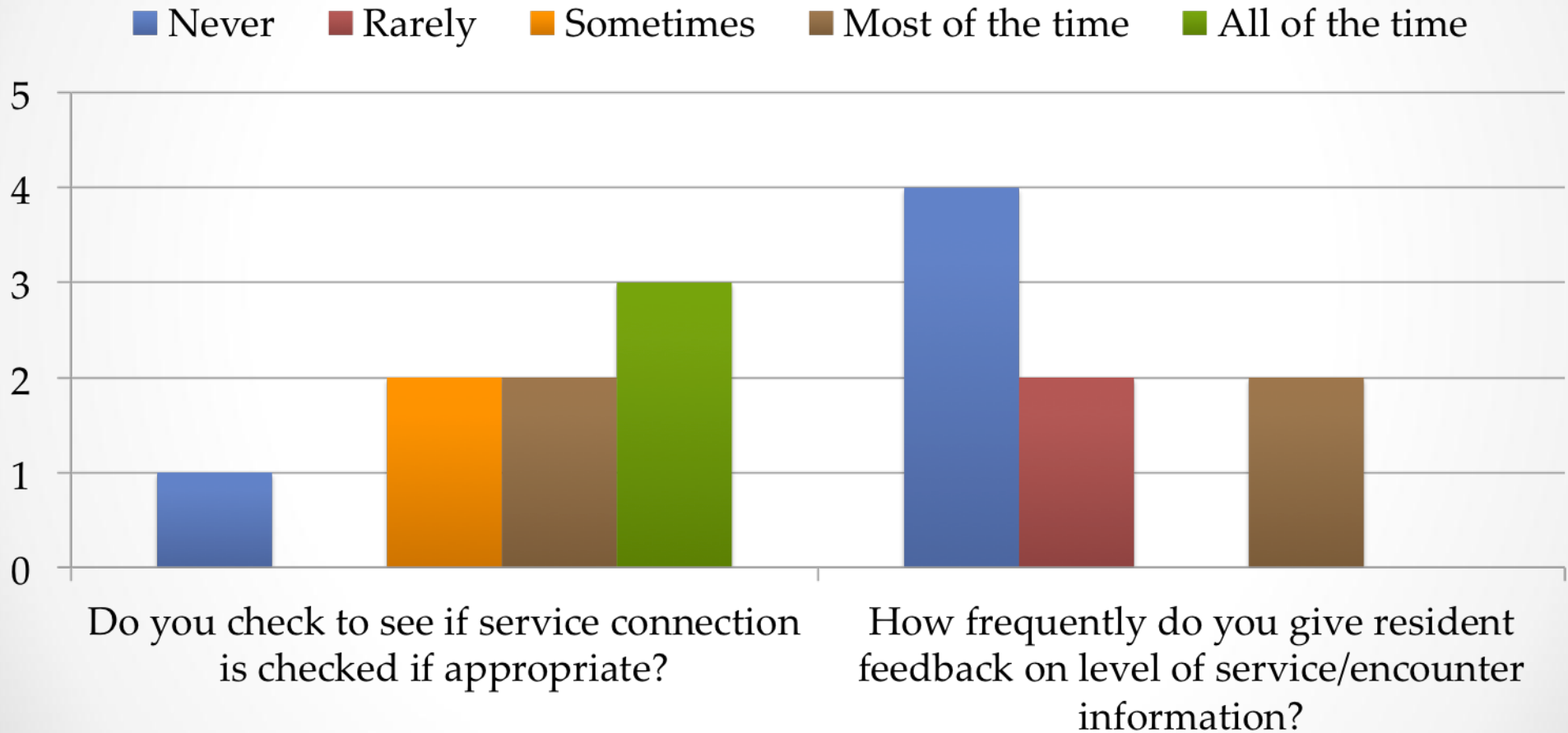
Baseline Data January 2013



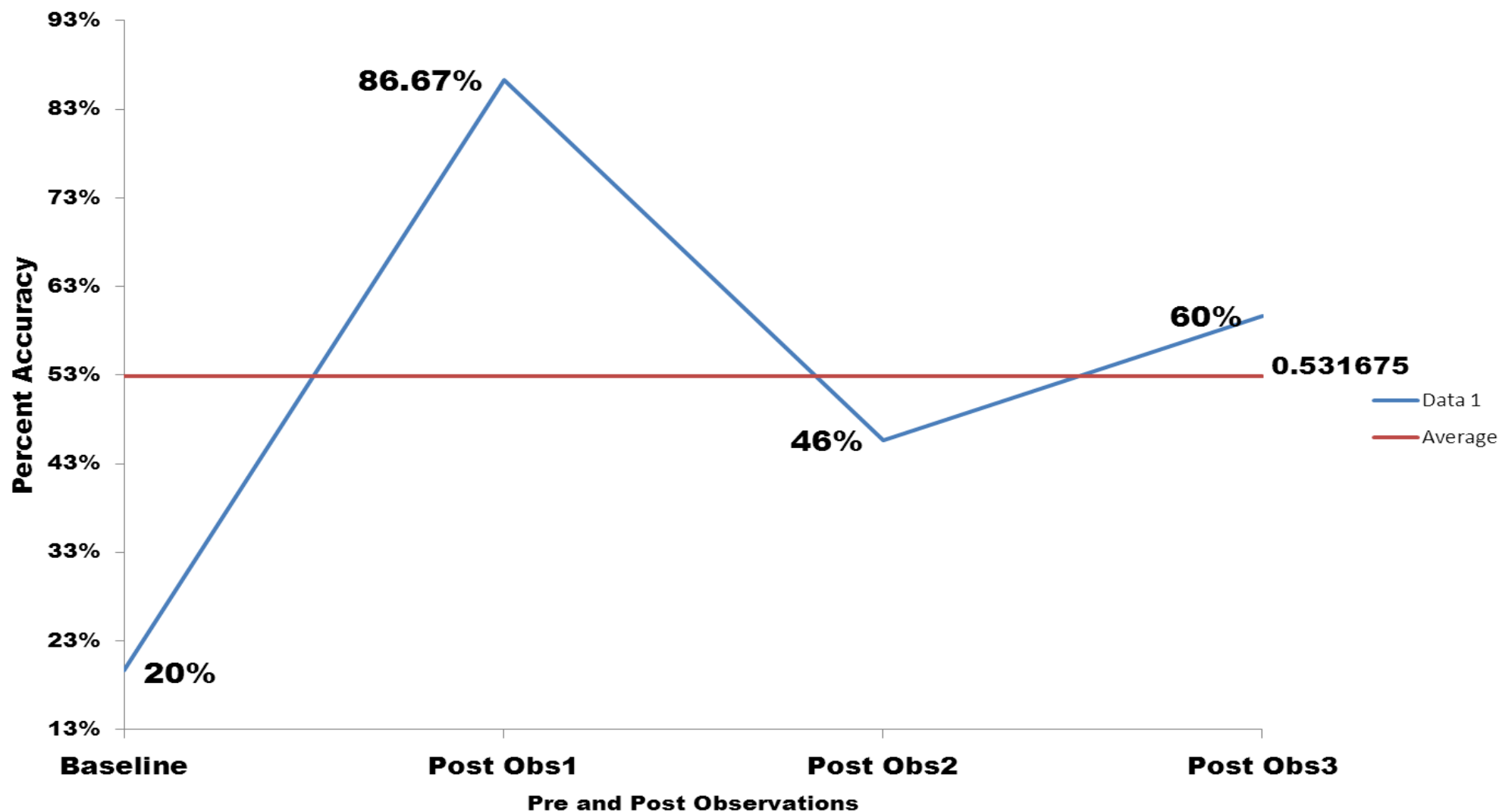
Survey Data



Survey Data



VA GEM Clinic Pre and Post Intervention Coding Accuracy



Return of Investment

- Our clinic was losing approx 46,000 dollars a year as there were only 20% charts coded correctly. Now that there are 60% charts coded correctly we hope to save majority of this money as well as the potential money that we can lose due to penalties from incorrect coding.
- By providing more education to the providers in the future and implementing these interventions to other clinics at the VA Hospital we can potentially increase our revenue by a significant amount.
- With proper documentation we can show the higher acuity of care which will lead to an increase in the annual budget for the hospital.
- Money spent = \$ 5 for flip cards + \$ 60 for laminated reference cards + \$ 3000 for the CSE course = 3065 \$

Expansion of Our Implementation

ACT:

- Project Dr. Oakes, our advisor, plans to continue to utilize these tools with future residents.
- Plan for next class of residents:
 - All residents in the clinic will undergo orientation by the attendings and will be given a copy of the reference cards
 - Flip-cards are attached to monitors in the attending checkout room and will remain there for future reference. Plans include to obtain more flip-cards for the work area.
 - Clinic administration will take responsibility for keeping materials current and accurate.

Future Plans

- This approach can be implemented at other clinics
- Anticipated future interventions will include modifying template to improve documentation.
- Expanding education to include correct ICD9 codes.

Thank you!

