2018 Annual Clinical Coding Meeting, Day One, September 22, 2018

7:30–8:30 a.m.	**Registration and Coffee Service**		
8:30–10:00 a.m.	**National ICD-10 Policy Update** • Learn about key updates to the ICD-10-CM/PCS Official Guidelines for Coding and Reporting. • Hear an overview of the FY2019 ICD-10-CM/PCS code changes • Get the highlights from the FY2019 MS-DRG changes **Nelly Leon-Chisen, RHIA,** American Hospital Association, Chicago, IL & **Sue Bowman, MJ, RHIA, CCS, FAHIMA**, American Health Information Management Association (AHIMA), Chicago, IL		
10:00-10:30 a.m.	**RACE Awards (10-10:15) & BREAK (10:15-10:30)**		
10:30-11:30 a.m.	**CPT Code Set Update** In this session, the most notable changes to the CPT code set for 2018 will be presented. Participants will learn about: • changes to existing CPT codes and guidelines • new codes and guidelines to report new procedures • changes to CPT coding conventions **Lianne Stancik, BA, RHIT**, American Medical Association, Chicago, IL		
11:30-12:30 p.m.	**LUNCH**		
	Compliance/Auditing	**Physician/OP Coding**	**CDI**
12:30-1:30 p.m.	**Facility Evaluation & Management Coding: Are You at Risk?** This presentation will: provide the historical OPPS rules and guidelines on facility E&M codes from CMS since 2000 when they were first implemented and share other industry trended facility E&M data; review the different types of facility E&M criterion that hospitals use and provide examples; cover how to audit your criteria to ensure compliance based on your guidelines and provide information on how to defend yourself in the event of a payer or other agency audit. It will wrap up with best practices and how to move forward.	**Commonly Misused Modifiers** Modifiers are necessary in order to indicate that a service or procedure performed has been altered, but has not changed the definition of the code. Some modifiers effect reimbursement and some are informational. There are a few modifiers that continue to cause confusion among coders. In this session, these commonly misused modifiers will be discussed: modifiers 24, 25, 51, 59, and 76. Each modifier will be broken down with examples and discussed to ensure understanding. **Deborah Grider, CDIP, CCS-P, CPC, CPMS, CEMC, CPC-I, COC**, Karen Zupko & Associates, Indianapolis, IN & **Betty Hovey, CCS-P, CDIP, CPC, CPMA,**	**Inpatient to Outpatient CDS: Making the Move** Attendees will hear practical explanation and discussion of the challenges facing new and experienced inpatient Clinical Documentation Specialists as they transition into the outpatient clinical workspace. Both the IP CDS and HIM/coder views will be presented in how to work effectively while learning new guidelines, structures and perspectives in documentation improvement programs. **Betty Stump, MHA, RHIT, CPC, CCS-P, CPMA, CDIP, CCDS**, OptumInsight, Glendale, AZ & **Stephanie Cantin-Smith, RN, MSN, CCDS**, Optum 360, Eden Prairie, MN

	Kim Charland, BA, RHIT, CCS, MRO, Valley Forge, PA	**COC, CPB, CPCD, CPC-I,** Karen Zupko & Associates, Chicago, IL	
1:30-2:30 p.m.	**The New Coder's Roadmap to Compliance: Fraud and Abuse in 2018** Attendees will: Receive an update on fraud and abuse regulatory changes impacting medical record coding in the physician practice setting; Evaluate the five most common laws regarding compliance in physician practices with real-world Medicare examples and case studies; Recognize how coder relationships are changing under MACRA, MIPS and other quality programs including new physician-coder conversations and important communication requirements for payers, vendors and investors; Build a solid compliance program for physician practices based on seven fundamental elements; and assess the most common compliance concerns in physician practices and take home proven strategies to address each. **Catrena Smith, CCS, CCS-P, CHTS-PW, CPC, CIC, CPCO, CRC, CPC-I**, Kiwi-Tek, Indianapolis, IN	**CDI in E/M coding** This presentation will outline the basics of E&M Coding; emphasize the golden rule of coding and stress why medical record documentation in Evaluation & Management coding is so critical. The need for CDI in E&M settings will be demonstrated and help every entity to understand the benefits of CDI. Attendees will also be guided in how to implement a CDI program in E&M settings. **Brian Benny Michael, CCS, COC, BCHH-C,** Omega Healthcare, Channai, India & **Manoj Achuthan,** Omega Healthcare, Orlando, FL	**The Case for Elevating the CDS' Role to Advanced Practice** HIM professionals will learn the ways in which the role of the clinical documentation specialist has evolved from the early 2000s to today. There will be a focus on the skillset, tools and technologies needed to move beyond the baseline of a conventional program to advanced practice CDI. Audience members will take away a professional development curriculum tailored to acquiring the senior level clinical expertise along with management and leadership skills to collaborate across disciplines and up to senior c-level leaders. Proficiency in leveraging technology, especially data analysis will be a core part of the training. **Mario A. Perez III, RHIA, CDIp, CCS, CCS-P** & **Melinda Tully, MSN, CCDS, CDIP, PS-CDI**, Nuance Communications, Inc., Atlanta, GA
2:30-3:00 p.m.	**BREAK – sponsored by National Health Resources (NHR)**		
3:00-4:00 p.m.	**Compliance Risks Associated with DRG Mismatches** This engaging session will provide an analysis of DRG mismatches and strategies for monitoring and management surrounding this process. Along with the ICD-10 transition has come an increase in DRG mismatches due to circumstances which include	**Covering Your Assets: Best Practices for Diagnostic Radiology Documentation** Attendees will understand the Medicare requirements for diagnostic test orders and how to achieve compliance in the event of an audit. Participants will be able to explain how the rules differ from setting to setting (i.e.,	**Advancing CDI: The Quality Story** The impact of clinical documentation and coding has expanded as CMS and other payers shift from fee for service to value-based payments linked to quality and cost outcomes. CDI must expand and evolve as well to fully safeguard documentation and

	documentation issues, grouper logic issues and use of both ICD-10-CM and ICD-10-PCS. This presentation will discuss each of these issues and how collaboration between CDI and coding can positively impact overall DRG mismatches. Each of the factors in the accuracy of DRG assignment is crucial piece of a compliant revenue cycle process. **Kathryn DeVault, MSL, RHIA, CCS, CCS-P, FAHIMA** & **Mary Stanfill, MBI, RHIA, CCS, CCS-P, FAHIMA**, UASI, Cincinnati, OH	hospital outpatient, physician practice, IDTF). Participants will also learn best practices to ensure compliant ICD-10-CM coding to support medical necessity by reviewing and deciphering all relevant source documents. Additionally, participants will understand the importance of reviewing Local Coverage Determination requirements beyond ICD-10-CM codes listed in the covered indications section to ensure all documentation requirements are met. High risk areas for diagnostic radiology will also be discussed. **Stacie Buck, RHIA, CCS-P, RCC, CIRCC, AAPC Fellow**, RadRx, Palm City, FL	coding accuracy in relation to CMS claims-based measures. Attendees will learn how clinical documentation and reported ICD-10 codes – *across the continuum* - impact quality outcome performance; Identify specific clinical documentation and coding drivers impactful to cohort selection and risk adjustment; be able to describe the benefits of implementing quality focused pre-bill audits as well as understand infrastructure needs for a successful and effective workflow; Identify common motivating factors that will result in an effectively engaged CDI team and successful organization improvement initiatives for claims based quality outcome measures; Define measures of success and efficient/effective metric tracking strategies; and Apply learned concepts to case studies. **James Fee, MD, CCS, CCDS, AHIMA-Approved ICD-10 Trainer** & **Jennifer Eaton, RN, MSN, CCDS**, Enjoin, Knoxville, TN
4:00-5:00 p.m.	**Key Strategies to Reduce your Compliance Risk for Shared Visits & Incident-to Services** Incident-to is one of the most commonly misunderstood and misinterpreted concepts. Many of the recent overpayment, audit and civil false claims act cases instituted by the federal and state agencies overseeing the Medicare and Medicaid programs involve allegations of improper billing for "incident-to" services. This session will review Medicare's rules for incident-to and split/shared services. Attendees will benefit from actual examples of incident-to and shared visits services performed	**So you think you know ProFee Coding?** This presentation will describe the acquisition of a large medical group by a large hospital system and discuss the lessons learned surrounding profee coding/billing practices vs. hospital outpatient coding/billing practices. Many HIM professionals may assume that if they know the facility outpatient coding/billing processes that they will transition to profee coding/billing processes very easily. But there are many lessons to be learned in that transition. Attendees will be presented with the contrast	**Bringing Outpatient Documentation under the HIM Umbrella** Attendees will learn to: Recognize the important shift in procedures, treatment, and care from inpatient (IP) to outpatient (OP), and the impact on clinical documentation and coding. Assess three specific areas of OP documentation and coding concern: emergency medicine, wound care and total knee replacements.Outline specific challenges associated with these three OP problem areas and hear practical advice on improving established workflows, processes, and procedures associated with

	in the physician practice and hospital setting, take home audit tools such as incident-to and split/shared visit checklists and answer questions such as: • Where can the services be rendered? • Who is eligible to bill for these services? • When can they be billed, and how do we bill? • How to audit these services to make sure your practice is compliant. **Elin Baklid-Kunz, MBA, CPC, CPMA, CCS, CHC**, Ayfie, New York, NY	between the facility CPT coding vs. profee CPT coding as well as the provider wRVUs, modifier differences, and provider/coder needed interactions. **Vanessa Youmans, MA, CCS, CPC** & **Karen G. Youmans, MPA, RHIA, CCS**, YES HIM Consulting, Largo, FL	documentation and coding in these specialties. Build a seven-step plan to onboard new OP service lines and bring them under the HIM fold. Share best practices and lessons learned in 2018 OP clinical documentation and coding. Identify new ways to engage physicians, clinics, revenue cycle, and other providers in transitioning documentation and coding from IP to OP care settings. **Nena Scott, MSEd, RHIA, CCS, CCS-P, CCDS,** TrustHCS, Guntown, MS & **Deborah Robb, BSHA, CPC,** TrustHCS, Springfield, MO
			DAY 1 CEUs: 6.5

2018 Annual Clinical Coding Meeting, Day Two, September 23, 2018

Time	**Inpatient Coding**	**Revenue Cycle**	**Hot Topics**
8:30-9:30 a.m.	**Surgical Complication, or not, that is the question** Identifying whether a condition, which occurred in the operative suite or in the post-operative period, is a surgical or post-operative complication can be challenging, even for the most seasoned professionals. The speaker will cover common intra-operative complications and post-operative conditions. This presentation will provide the participant with a clear understanding of these events/conditions, as well as advanced case studies for discussion.	**Revenue Integrity: The Impact of the IPPS Final Rule Coding Changes & Clinical Validation Denials** This presentation will discuss how clinical documentation, coding, and query activities impact the revenue cycle in hospitals and physician offices. The speaker will discuss classification of general medical conditions, while incorporating various medical or technical terminology related to data analytics, Value-Based Purchasing, Bundled Payments and Prospective Payment Systems. Case studies will incorporate key points and	**Welcome to the Alphabet Soup of OIG, MACs, UPICs & RACs** Attendees will receive an overview of the Government's hold on healthcare today by getting to know the various agencies involved. Also learn how to use your claims data to prepare for a benefit integrity program; hot topics in the OIG workplan; the appeals process; discuss the 'rules' - Official Coding Guidelines, Medicare & Medicaid manuals and take away strategies to apply best practice solutions and achieve positive results for your facility. **Arlene Baril, NHA, RHIA, CHC**, Altegra Health/Change Healthcare, McKinney, TX

	Adriane Martin, DO, FACOS, CCDS, Enjoin, Eads, TN	engage participants in order to strengthen their comprehension. **Lynette Thom, RHIT, CCS, CDIP**, Blue & Co, LLC, Indianapolis, IN	
9:30-10:00 a.m.	**BREAK**		
10:00-11:00 a.m.	**ICD-10-PCS Accuracy: Back to the Basics** If you feel you have not yet mastered the ICD-10-PCS coding system, this session is for you! Attendees will benefit from this presentation that uses a common-sense approach to increasing accuracy of ICD-10-PCS coding. Utilizing the nationwide ICD-10 Coder Performance Data, we will identify the root causes of low PCS coding accuracy and use the basic PCS coding conventions and guidelines to combat them! Attendees will use case studies to identify trouble areas in the Operative report, learn how to differentiate correct body part assignment and operative approach. Leave this session with an individual plan to be a ICD-10 PCS expert. **Laura Legg, RHIT, CCS, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer**, Healthcare Resource Group, Spokane, WA	**Cracking the Code: Reducing Denials Through On-the-Spot Education and Corrective Action** In this working session, audience members will hear how to use on-the-spot education and remediation to fix problems and manage denials workflow. Some of the challenges to be discussed in this session include: a real-time assessment of common coder mistakes with corrective actions, time-saving improvements such as custom coding and compliance edits activated in coding workflow, conducting a focused chart audit to pinpoint problem areas, and ways to work with CDIs to improve clinical documentation and obtain appropriate credit for the care provided. Additionally, audience members will take away a coding workflow map with answer keys and sample cases to implement within their practice. **Kenneth Kolenik**, Nuance Communication, Inc, Pittsburgh, PA	**Hierarchical Condition Categories (HCC): Quality, Revenue, Compliance** Participants will be able to implement education and processes to effectively and compliantly capture HCC codes. This session will facilitate discussions with and education of providers to communicate the importance of complete and thorough documentation for correct compliant code assignment that fully describes a patient's clinical picture following the familiar E/M key component format. Expected benefits are improved quality metrics, better pay-for-performance outcomes, and enhanced revenue in a manner already familiar to providers that is consistent with CMS regulations and compliant coding and billing. **Richard Pinson, MD, FACP, CCS**, Pinson and Tang, LLC, Chattanooga, TN
11:00 -12:00p.m.	**Pneumonia Coding – Let's Breath Some Life Into it** Coding for pneumonia is complex. Understanding the disease, the associated coding guidelines and the effects of complete and accurate coding in relation to pneumonia are essential to the vitality of a	**Risk Adjustment: Moving Beyond a MS-DRG Assignment Focus** Most CDI and coding professionals are very adept at translating provider documentation into coded data to impact MS-DRG assignments and provider reimbursement, but	**Measure Twice, Code Once** ***Operationalizing Coding, CDI & quality Collaboration for Value Based Gains*** Ensuring you aren't subjecting your organization to inaccurate financial penalties for HACs, PSIs, and other VBP measures means more than ensuring POA

	hospital's financial well-being. Participants will gain practical knowledge that can be used on a daily basis to assign appropriate codes. They will be able to apply sequencing and POA guidelines to appropriately arrive at the correct code assignments and ultimately the correct DRG. This presentation will inspire the coders to continue their coding education and will influence them to assign accurate and complete codes on all their pneumonia cases. **Sandy Frey, RHIT, CCS**, Ovation Revenue Cycle Services, Pittsburgh, PA & **Karen Bucci, RHIA**, UPMC, Pittsburgh, PA	few have received adequate training regarding how coded data affects performance under value-based reimbursement methodologies or Bundled Payments for Care Improvements (BPCI). Understanding the impact of CMS' mandatory value-based programs and participation in voluntary APMs like BPCI is how healthcare entities will differentiate themselves from each other. CDI and coding professionals should understand the importance of risk adjustment. This session will demonstrate through the use of a case study how legacy CDI efforts contribute to a reimbursement and clinical performance "blind spot." This blind spot can result in lost revenue with a rising CMI. It can also erroneously suggest shortcomings in the delivery of evidence-based medicine as monitored through CMS quality measures, which can negatively impact organizational and/or provider performance in publicly reported data. **Cheryl Ericson, RN, MS, CCDS, CDIP, AHIMA Approved ICD-10-CM/PCS Trainer**, DHG Healthcare, Atlanta, GA & **Michelle Wieczorek, RHIT, RN, CPHQ**, DHG Healthcare, Atlanta, GA	indicators are correct. CDI Specialists, Coders, Clinical Quality staff, and the patient care team must work together to ensure that all stakeholders understand the inclusions and exclusions of each measure and applicable variances between coding rules and clinical language. Learn to avoid common pitfalls that may lead to inaccuracies, as well as proven strategies to ensure accurate documentation is translated to accurate coding and reporting. The presentation will be interwoven with lessons learned from operationalizing the integration of VBP Quality reviews into the revenue cycle within several large healthcare systems. **Amy Czahor, RHIT, CCS, CDIP**, RecordsOne, Conroe, TX & **Tom Scholomiti, RHIT**, RecordsOne, Naples, FL
12:00-1:00 p.m.	**LUNCH**		
1:00-2:00 p.m.	**The FY2018 CC/MCC List: Tools to Identify Clinical Indicators** Are you struggling to identify clinical indicators needed to qualify a diagnosis as a reportable CC or MCC? New and experienced coders often	**Denial Management 101** This presentation will walk the attendee through the best practices for denial analysis and management. Attendees will learn how to analyze their denials and implement key performance indicators. Then, in working the denials, they will learn options	**You need how Many Coders?! Okay let's do it! How to Implement an ICD-10 Productivity Standard that shows not only your Productivity but also your FTE need.** During this session, attendees will learn you how to set up

	do! Add to this the numerous changes associated with the Official Guidelines for Coding and Reporting, AHA's Coding Clinic® for ICD-10-CM/PCS and the changes to the codes and CC/MCC list, the coding staff may feel overwhelmed. This program will provide a detailed look at targeted CC/MCC areas and highlight opportunities for improvement. **William E. Haik, MD, CDIP, FCCP**, DRG Review, Inc, Fort Walton Beach, FL	for managing and organizing the information to provide key information that can be used to impact and effect operational improvements to reduce avoidable denials -- for example, with claims coding, documentation and demographics/registration issues. Finally, the presentation will provide information on how to identify whether the claim should be paid and how to pursue that payment when appropriate, including building a strong appeals case. **Emmy Clancy, MHA, CMPE, CPC, CDEO, CCS, AHIMA Approved ICD-10-CM/PCS Trainer**, Emmy Award Healthcare Consulting, LLC, Englewood, CO	productivity for discharge and concurrent coding and a FTE model for your coding departments that will be realistic for your coders. Using this model can help you support the need for more FTEs while showing the work that is getting done as well as the work that is not getting done. **Rachel Pratt, RHIT, CDIP, CCS**, University of Utah Health, Attica, MI
2:00-2:30 p.m.	**BREAK – sponsored by Health Information Associates (HIA)**		
2:30-3:30 p.m.	**Coding Productivity: Through the Years** How many times have you been asked, "What is an acceptable coding productivity standard for coders? How many records can you code in one day? How important is productivity?" No matter who you ask, the answer is always different. Does bed size really matter? How important is length of stay? This presentation is going to answer those questions….and more. AHIMA has researched coding productivity through the years and found some interesting items to share. Attendees will learn the impact of ICD-10, technology, CAC and other variables on productivity. You don't want to miss this presentation to find out how your organization compares to others. **Lou Ann Wiedemann, MS, RHIA, FAHIMA, CDIP, CHDA, CPEHR**, AHIMA, Chicago, IL		
3:30-5:00 p.m.	**Keynote – "Science of Sanity" for Today's Challenging Healthcare Environment** How to organize your day for better brain performance. Today we need more than time management we need Mind Management. Learn how to steer around cognitive biases that hinder objective thinking. We all have cognitive biases. Amy will give you tips on how to control them. Learn how to positively deal with daily challenges and challenging people while getting tools that will help you manage your mind and make the most out of your day and your relationships. Bring a positive attitude to work just like your bag lunch and laugh while learning how! **Amy Dee, RN, NSA, Motivational speaker**		
			DAY 2 CEUs: 6.5 **TOTAL CEUS for the MEETING : 13**

*invited speaker