

Challenge, Opportunity, Victory

"Don't expect to meet the challenges of today with yesterday's tools and expect to be in business tomorrow"

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Objectives

- | | |
|---|---|
| <input type="checkbox"/> Background: | <input type="checkbox"/> A winning Strategy: |
| <input type="checkbox"/> The problem: | <input type="checkbox"/> Monitoring progress: |
| <input type="checkbox"/> Define CDI: | <input type="checkbox"/> ICD 10 Preparedness: |
| <input type="checkbox"/> CDI's objective: | <input type="checkbox"/> Pearls to embrace: |
| <input type="checkbox"/> The Caveat: | <input type="checkbox"/> Pitfalls to evade: |
| <input type="checkbox"/> The Challenge: | |

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A Snapshot of Healthcare in the United States

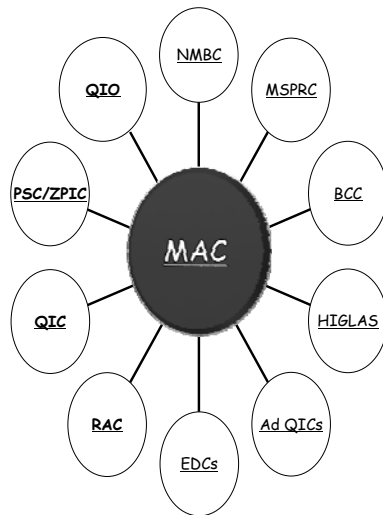
- ❑ **National State of Affairs: CMS is going broke!**
 - **CBO's projections in the absence of federal law changes:**
 1. USA has a Non-sustainable Growth Rate!
 2. CMS's business model needs to change!
 - ❑ **CMS implemented a robust business model**
 - Their Solution: Our Challenge
 - ❑ **The business model has 3 ambitious expectations**
 1. Opportunity
 2. Meet the challenge well
 3. Thrive
- <http://www.cbo.gov/ftpdocs/87xx/doc8758/maintext.3.1.shtml>

CMS New Business Model

- Medicare Prescription Drug, Improvement, and Modernization Act (MMA) 2003
- Deficit Reduction Act 2005 (DRA)

CMS New Business Model (cont.)

Medicare
Administrative
Contractors



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CMS New Business Model (cont.)

- ❑ **MAC Focus:**
 - Centralize Control
 - Data Mining
- ❑ **Improve Quality of Care**
 - Core Measures
 - PSI
 - POA/HAC
 - HCAHPS / VBP
- ❑ **Reduce Billing Inaccuracy**
 - Coding Guidelines (AHIMA)
 - CDI (ACDIS/AHIMA)
- ❑ **Reduce Waste, Fraud, Abuse**
 - Medical Necessity (SOI/IOS)
 - UM: IP/OP (GLOS)
 - RAC

CMS New Business Model (cont.)



Compliance = PMD crafts a precise clinical picture using CMS approved language

MAC Clinical Design

- **QIO**
Quality Improvement Organization
- **PSC/*ZPIC**
Program Safeguard Contractor
Zone Program Integrity Contractors
- **QIC**
Qualified Independent Contractor
- **RAC**
Recovery Audit Contractor

Elements Affecting Profile and Reimbursement

- ☐ **Never Events/Serious Reportable Events (SRE)**
- ☐ **Wrong operation**
- ☐ **Wrong patient**
- ☐ **Wrong side or body part**
 - *Considered complications of care*
 - *No payment for procedure or related care*
- ☐ **PSI / HCAPHS / VBP**

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HAC vs. POA

- | | |
|--|--|
| 1. Foreign body post surgery | 1. Manifestations of poor glycemic control |
| 2. Air embolism | 2. Surgical site Infections |
| 3. ABO Incompatibility | 3. CABG/mediastinitis |
| 4. Decubitus ulcer | 4. Orthopedic surgeries |
| 5. Iatrogenic Pneumothorax post venous catheterization | 5. Implantable electronic devices |
| 6. Falls | 6. Bariatric surgery |
| 7. Catheter associated UTI | 7. DVT/PE post certain ortho procedures |
| 8. Vascular catheter associated infections | |

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CMS made its largest and most significant change to its inpatient prospective payment system (IPPS)-10/2007

- **CMS** Introduced Medicare Severity Diagnostic Related Groups or MS- DRG's: (538 to 751)
- **CMS Created New Classifications**
 - **MCC**– Major Co-morbidity / Complication
 - **CC**– Co-morbidity / Complication
- **DRG Change:**
 - Before: DRG with CC or without CC
 - After: **DRG with CC - or with MCC or without CC**

Secondary Diagnosis: Comorbid Conditions

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Increased nursing care/monitoring
- Extended length of stay

DRG Assignment: Coded Data Integrity

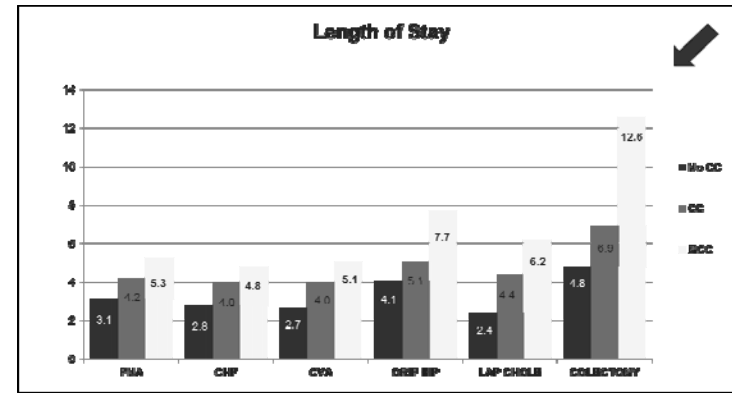
DRG: Assigned based on documentation

IPPS: Inpatient Prospective Payment System (1983)

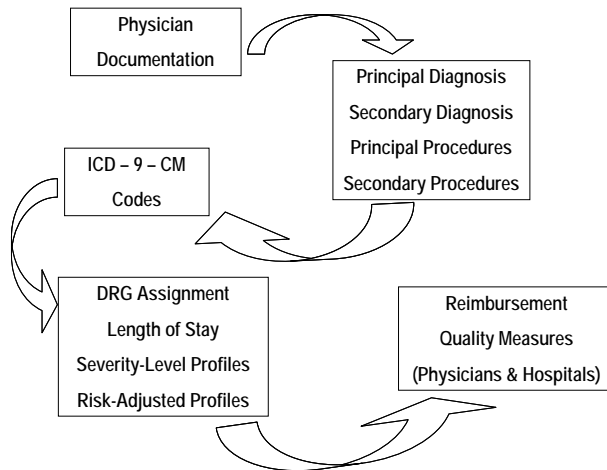
- Fixes payment to DRGs-Relative Weight (RW)
- Resource consumption associated with each DRG
- RW is constant for every hospital X Blended Rate
- 5 DRG Groups
- Length of stay (GMLOS) is assigned to each DRG
- LOS exemplifies effective Physician utilization of resources
- CMI: Patient Severity Index

CHF with MCC	RW: 1.5174	GMLOS: 4.7
CHF with CC	RW: 1.0034	GMLOS: 3.8
CHF without CC	RW: 0.6751	GMLOS: 2.7

The Difference Documentation Can Make!



Documentation Impact:



Basic Coding Guidelines

1. Code assignment can be done from:

- The H&P
- Any physician's progress note, or orders
- Discharge summary

(If NO conflicting information exists)

2. Incomplete, vague, or contradictory information must be clarified. (Queries)

3. The PMD is captain of the ship: She/he is ultimately responsible for the final diagnosis! (Clinical Validity)

ERMD Documentation / Diagnoses needs to be reviewed by PMD and clarified

Basic Coding Guidelines (cont.)

1. **Abnormal findings** are coded only their clinical significance is indicated by the provider i.e.;
**Labs, x-rays, pathology, EEG and Echo's and other diagnostic results*
2. **Diagnosis documented and qualified as shown below** are coded as if the condition was established:
**Probable, suspected, likely, questionable, possible or still to be ruled out.*
3. If **"Rule Out"** is used, the provider must **clarify if it was indeed ruled out or ruled in!**

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Basic Coding Guidelines (cont.)

- ☐ Acute vs. Severe vs. Chronic
- ☐ Decompensated vs. Exacerbation vs. Status
- ☐ Quo
- ☐ Rule of "3"
- ☐ Post op
- ☐ History of
- ☐ DC summary:
 - *Narrate the visit*
 - *How you deduce a never stated diagnosis*
 - *Note all diagnosis*

Typical Conflicting Documentation

<ul style="list-style-type: none"> ❑ Attending MD: TIA ➤ <i>Neurologist:</i> CVA 	<ul style="list-style-type: none"> ❑ ERMD: R/O Sepsis Syndrome UTI ➤ Attending: Urosepsis
<ul style="list-style-type: none"> ❑ Attending MD: Elevated Trop ➤ <i>Cardiologist:</i> NSTEMI 	<ul style="list-style-type: none"> ❑ ERMD: Exac CHF Respiratory Fail/BIPAP ➤ Attending: CHF Resp Distress
<ul style="list-style-type: none"> ❑ Attending MD: Renal Insufficiency ➤ <i>Nephrologists:</i> AKI /CKD with Stage 	
<ul style="list-style-type: none"> ❑ Attending MD: Pneumonia ➤ <i>Pulmonologist:</i> Bronchitis/Exac Asthma 	

Physicians
Document in
Clinical Terms



**Coding, profiling
and compliance
must contain
Specific Diagnostic
terms**

**Improved documentation bridges the gap.
Linking diagnostic terms increases specificity.**

Why Learn About CDI?

- ❑ **Decreased Daily Interruptions**
 - HIM, CDI and Case Management – GLOS and (SOI/IOS)
- ❑ **Accurate Physician Profiling**
 - Health Grades, Physician Compare (QA/UM)
 - Severity of Illness & Risk of Mortality (SOI & ROM)
- ❑ **Decreased Risk: Increase Medical Necessity CDI**
 - Audits (ADR/RAC), Denials, Litigation
- ❑ **Added Value of Proper CDI**
 - Improved contract opportunities
 - Perform better in Global Payment Model
 - Improved practice ROI/Efficiency
 - Better understanding of upcoming changes (ICD10)

YOUR PERCEIVED PERFORMANCE IS AT STAKE!

CMS's Position on Clinical Documentation Integrity

"We do not believe there is anything **inappropriate**, **unethical** or **otherwise wrong** with hospitals taking full advantage of **coding opportunities** to maximize Medicare payment that is supported by documentation in the medical record"

- Direct Quote, CMS 2008 IPPS Final Rule

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>, page 208

Case Example:

85 YO Female – Admitted with AMS

Data:

Bun/Creat: 42/1.7
WBC: 12.7, bands 18, left shift
Urine: + Ecoli
BNP: 95

Documented Diagnoses:

AMS secondary to Urosepsis
Renal Insuff - dehydration
Hx CHF

Events:

- After hydrating the 1st night – pt gets SOB requires IV Lasix, transfer to ICU for BIPAP
- Improves after 24 hours and returns to tele floor on day 3 in the morning.
- Continues to receive IV ABX for next 36 hours.
- Renal function returns to baseline (creat 1.3)

Documented Diagnoses:

Urosepsis
Renal Insuff – improving
Resp distress – BIPAP
CHF

Coded:

Urosepsis - UTI PDX
Rena Insuff – Dehydration No CC/MCC
Resp Distress – CHF No CC/MCC

DRG INFO:

690
Kidney & Urinary Tract Infections w/o MCC

GMLOS 3.4 SOI 2 / ROM 2
Pts actual length of stay was 5 days
RW – 0.7864

85 YO Female – Admitted with AMS

Data:

Bun/Creat: 42/1.7
WBC: 12.7, bands 18, left shift
Urine: + Ecoli
BNP: 95

Documented Diagnoses:

Sepsis secondary to UTI
AKI on CKD III
Chronic systolic CHF

Events:

- After hydrating the 1st night – pt gets SOB requires IV Lasix, transfer to ICU for BIPAP
- Improves after 24 hours and returns to tele floor on day 3 in the morning.
- Continues to receive IV ABX for next 36 hours.
- Renal function returns to baseline (creat 1.3)

Documented Diagnoses:

Sepsis secondary to UTI
AKI on CKD IV
Acute Resp Failure – improved
Acute on Chronic Systolic CHF

Coded:

Sepsis PDX
AKI on CKD III MCC
Acute Resp Failure MCC
Acute on Chronic Sys CHF MCC

DRG INFO:

871
Sepsis or Severe Sepsis with MCC

GMLOS 5.4 SOI 4 / ROM 4
Pts actual length of stay was 5 days
RW – 1.9074

SEPSIS

Bacteremia: presence of bacteria in blood

Septicemia: Presence of any pathogenic microorganism or its toxins in blood

Systemic inflammatory response syndrome (SIRS) is defined by the presence of at least 2 of the following:

- Fever (oral temp >38.3° C) or hypothermia (< 36° C)
- Tachypnea (>20 breaths/min)
- Tachycardia (>90 beats/min)
- Leukocytosis(>12,000/μL), Leukopenia (<4,000/μL), or 10% bands

Sepsis: SIRS plus Clinical condition of proven or suspected infection

Severe Sepsis: SIRS due to Sepsis plus ≥ 1 sign of organ dysfunction

Septic Shock:

- Sepsis with hypotension
- arterial BP< 90mmHg or 40mmHG less than pts normal BP for at least 1 hour despite adequate fluid resuscitation - **OR**
- Need for vasopressors to maintain SBP ≥ 90mmHg -**OR**- MAP ≥ 70

The Reagent: Constant Training

□ Physician advisor and supportive staff: A catalyst for success!

- PA
- CDI
- CM

□ Physician Documentation Goals:

- Clear, Concise, and Complete.
- Accurate and Specific.

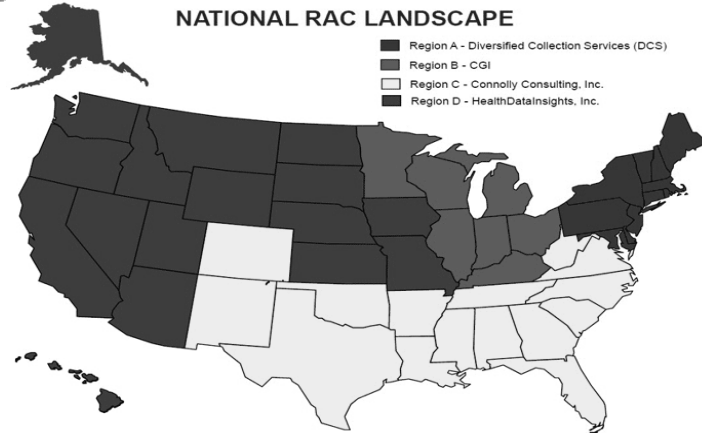
Success is based on physician documentation!

CDI From A RAC Perspective



RAC Regions

NATIONAL RAC LANDSCAPE



Audit and Fraud Entities and Initiatives

1. Office of Inspector General	OIG
2. Department of Justice	DOJ
3. Medicare Recovery Auditors	MCR RA
4. Medicare Administrative Cont.	MAC
5. Health Care Fraud Prevention and Enforcement Action Team	HEAT
6. Comprehensive Error Rate Testing	CERT
7. Medicaid Integrity Plan	MIP
8. Medicaid Integrity Group	MIG
9. Medicaid Integrity Contractors	MIC
10. Medicaid Inspector General	MIG
11. Medicaid Recovery Audit Contractors	MCG
12. Payment Error Rate Measurement	RAC
13. Program Safeguard Contractors	PERM
14. Zone Program Integrity Contractors	PSC
	ZPIC

The RAC Attack on Healthcare

ADR:	Additional Documentation Requests from both the RA and MAC
RAC:	Recovery Audit Contractor Requests
CMS/Palmetto:	Audits the chart for: Appropriateness of physician documentation, codes and charges
PERM Audits:	Payment Error Rate Measurement
Two outcomes:	
1. <u>Appropriate</u>	
2. <u>Inappropriate</u>	

RAC/ADR TARGETED DRG

<u>PIH Top 5 RAC DRG Request</u>	<u>Prepayment Review Demo (ADR)</u>
<ul style="list-style-type: none">•TIA•Syncope•Esophagitis, Gastroenteritis and Misc. Digestive Disorders W/O MCC•Chest Pain•Nutritional & Misc. Metabolic Disorders W/O MCC	<ul style="list-style-type: none">•Syncope & Collapse•Transient Ischemia•G.I. Hemorrhage•Diabetes•Other Vascular Procedures http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html

Top RAC Issue Per Region

Regions A, B & C issues:

Cardiovascular Procedures: (*Med Necessity*) Medicare pays for In patient services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.

Region D issues:

Minor Surgery and other treatment billed as Inpatient: (*Medical Necessity*) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY-2013-2nd-Qtr.pdf>

*March 31, 2013 Data

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Medical Necessity Denials

❑ CMS denials are primarily based on lack of

1. Severity of Illness documentation (SOI)
2. Failure to justify Intensity of Service. (IOS)

❑ Specific Criteria can show:

1. SOI Justifies IOS
2. Inpatient Vs. Observation Status

❑ Down Coding DRGs

1. Clinical Validity Scrutiny

****A patient's share of cost for observation status care is greater than for inpatient Status***

Medical Necessity Documentation

Example # 1:

Based on the available clinical evidence, this patient's medical condition, safety and health is at significant risk of deterioration. The patient's welfare is directly threatened by signs and symptoms of acute and severe...XXX...If further care and work up is provided in a less intensive environment than an inpatient setting.

Example # 2:

Due to the intensity and frequency of the planned treatment...XXX... for this patient, it is imperative it be performed on an inpatient basis for the patients safety and to assure effectiveness of treatment and to avoid an adverse outcome.

XXX= Consistent with Milliman Criteria

Physician Documentation

Physician progress notes should reflect why patient can not return home or be transferred to a lower level of care.

Examples:

- *Primary diagnoses has not improved and requires further inpatient treatment.*
- *New condition developed (describe in detail).*
- *Chronic condition exacerbation/requires treatment.*
- *What is the risk to patient's medical condition, safety or health if discharged.*

The Challenges with ICD-10



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Recognize the Complexity

- **ICD-10:** Will expand from **17,000** codes to **140,000** codes.
- **Clinical Validity:** Evidence in the medical record must support the DRG.
- **Down Coding:** Opportunities for RAC and other auditing agencies to alter service codes to those of a lesser complexity, resulting in less reimbursement.
- **Increased Scrutiny:** Physicians must provide clear, concise, specific and accurate documentation that supports the higher level of specificity of ICD-10 codes.
- **Specificity:** ICD-10 code sets are very specific, providing data that can be analyzed to monitor and measure quality of care for physicians and providers.
 - **Laterality:** ICD-10-Incorporates laterality of conditions or injuries (i.e., left , right).
 - **Site Specific:** ICD-Groups injuries by body area or site of injury and then type.

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ICD-10 Readiness

- Provide continual education to minimize confusion and loss of productivity.
- Educate physicians and staff about documentation requirements for ICD-10 coding system and provide examples:
 - 1) Clinical validity 2) Laterality 3) Site specificity 4) CC/MCC
- Review and revise query templates to ICD-10 specifications.
- Support medical record coding to their greatest level of specificity with appropriate CDI language.
- Clarify and correct documentation of diagnoses, CC and/or MCC's as evidenced by clinical indicators, as it affects the MS-DRG or APR DRG, relative weight's and length of stay.

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CDI Examples:

Specific Documentation

- Urinary Retention
- Epogen for Anemia of Chronic Disease
- Cachexia
- DQ Ulcer and stage
- UTI Probable 2' to Foley
- Sepsis probably 2' to Central line
- HD secondary to ESRD

Vague Documentation

- Unable to void
- Epogen Order
- Waiting, muscle Loss
- Decubitus Ulcer
- UTI
- Bacteremia
- HD Order

CDI Examples: (cont.)

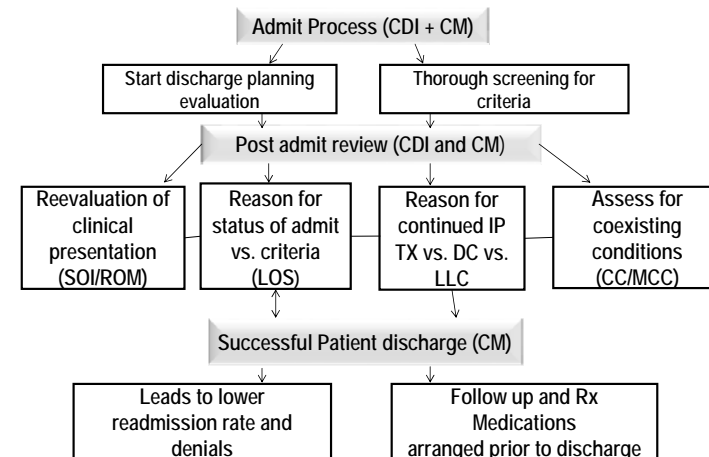
Specific Documentation

- Head Injury
- Pregnant; Pelvic Pain, Vaginal Bleeding
- OB/Pelvic UTZ; for R/O retained Products
- EKG for Chest Pain

Vague Documentation

- Head Trauma
- Blighted ovum **vs.** threatened AB **vs.** complete AB **vs.** Incomplete AB
- Non OB UTZ for R/O retained Products
- EKG done without chest Pain documentation

Anatomy of a Successful Strategy



DRG 313 Chest Pain

- **CMS Goal LOS: ambulatory -1 day**
- **Patient will meet Inpatient criteria if experiencing:**
 1. Hemodynamic Instability
 2. Pulmonary Edema
 3. Respiratory Distress
 4. Angina with ACS/AMI
 5. Aortic Dissection
 6. Pulmonary Embolus
 7. Tension Pneumothorax
 8. Requires Treatment/Monitoring
 9. Decompensated CC/MCC conditions

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DRG 313 Chest Pain (cont.)

- **Chest Pain secondary to:**

Neuromuscular	556
Precordial	313
Musculoskeletal	313
Mid-sternal Chest Pain	313
Other Non-Cardiac	313
Angina Pectoris	311
Pleurisy	204
Chest Wall Pain	204
Smoke inhalation	206
Pleurodynia	195

General Criteria Affecting SI/IS

❑ Hemodynamic Instability

- Hypotension/Tachycardia
- Inadequate Hydration
- Pressor use/ poor perfusion
- Postural VS

❑ HTN (>220/120) or (140/100) + 1

- Encephalopathy
- AKI/ARF
- Aortic Dissection
- ACS
- LVHF
- Retinal Hemorrhage

❑ Acute Ischemia

- Cardiac
- Peripheral

❑ Cardiac Arrhythmias

- Post Arrest
- Ventricular Escape Rhythm
- Sustained V-tach
- (>30 min; HR>100)
- Not sustained V-tach
- Suspected Cardiac Ischemia
- Or Myocarditis

❑ Unstable Conduction Defects

- Type II 2nd Degree AVB
- 3rd Degree AVB
- New Onset LBBB + Suspected Ischemia

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General Criteria Affecting SI/IS (cont.)

❑ Concerning Rhythms +1

- Hypotension
- Respiratory Distress
- Bradycardia
- Syncope
- Dizziness
- SVT with Chest Pain

❑ Monitoring

- Arrhythmogenic drug
- Implantable Defib Adjustment

❑ Respiratory Abnormalities

- RR > 30
- Sat < 90%
- PaCO₂ > 44
- pH < 7.35
- Frequent HHN TX (4)
- New Onset Cyanosis

❑ COPD Patients

- SaO₂ < 5% of Base Line (BL)
- Needs > O₂ to Maintain BL
- PCO₂ increase >5% of BL
- PFR <60% of their prior best
- PFR < 300 L/Minute
- Requires >4 TX
- Decrease Mobility 2' to DOE
- Inability to Eat/Drink 2' SOB
- Mental Status Changes
- Rapid Exacerbation
- Impending Respiratory Arrest

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General Criteria Affecting SI/IS (cont.)

❑ Acute Blood Loss (Active Bleeding)

- ✓ Hg < 10 g/dL or Hct 30% (Not Baseline)
- ✓ Repeat Hematocrit drops \geq 2%

❑ Severe Anemia +1 "Symptomatic Anemia"

- ✓ ALOC/Chest Pain/DOE/Syncope
- ✓ Other Findings suggestive of inadequate perfusion

❑ Post Transfusion or Volume replacement doesn't resolve:

- Tachycardia
- Orthostatic Changes (SBP drops >20; DBP drops >10)

❑ High Risk Low Platelets

- Any # < than normal + Severe Bleeding or Hemolytic
- Anemia
- < 20K + any active bleeding
- < 10K + minor purpura
- < 5k

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Synopsis 1

❑ Outline the problem:

- Increased scrutiny of medical record documentation
- Clinical vs. diagnostic terms
- Medical necessity
- Clinical validity

❑ Define CDI:

- The process and effort promoting appropriate documentation prior to coding and billing

❑ What is CDI's objective:

- Clear, concise, complete, accurate and specific documentation
- Optimum profile; financial solvency

❑ The Caveat:

- Success depends on physician documentation

❑ The Challenge:

- Physician buy in

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Synopsis 2

☐ Devise a winning Strategy:

- WIIFM
- Constant training
- Staff support & cross training
- Physician Advisor
- ED: CSM/CDI
- Track, trend and target education
- Documentation gap analysis
- Basics of coding rules

☐ How do you monitor progress?

- Decreased queries
- CMI
- GMLOS
- Audits (QA/UM/HIM): Less Denials

☐ ICD 10 Preparedness

- General Education
- Gap study: target education

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References:

- Centers for Medicare and Medicaid Services: www.cms.gov
- DRG Expert 2012
- Milliman Guidelines
- ACDIS (Association of Clinical Documentation Improvement Specialist)
- CHIA (California Hospital Information Association)
- AHIMA (American Health Information Management Association).
- <https://www.cms.gov/QualityImprovementOrgs/>
- <http://www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf>

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