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EXCELLENCE IN REVENUE CYCLE

Documentation Impact and the Physician Advisor

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Who Governs Our Coding Language?

- There are four designated entities who control our coding language

- These entities are the gate keeper for how words documented in the medical record translate to medical codes and which diagnoses are recognized in the coded record.

4 Cooperating Parties

- CDC – responsible for diagnoses (the government)
- CMS – responsible for inpatient procedures (the government)
- American Hospital Association – responsible for interpreting ICD-10
  - Through Coding Clinic
- American Health Information Management Association (AHIMA) –
  - Provides input from the coding community

- Who is missing?

Coding Clinic

- Quarterly newsletter published by the **American Hospital Association**

- *Coding Clinic*
  - American Hospital Association (AHA)
  - American Health Information Management Association (AHIMA)
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare and Medicaid Services (CMS)

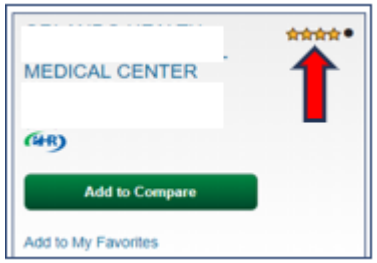
- The Editorial Advisory Board consists of an **expert panel of physicians** representing the American Medical Association, the American College of Surgeons, the American Academy of Pediatrics and the American College of Physicians, as well as coding professionals representing healthcare facilities.

http://www.ahacentraloffice.org/aboutus/what-is-icd-10.shtml

A Few Concepts

Support Hospital Quality Reporting through Clinical Documentation Integrity

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare



healthgrades Find a doctor Find a hospital

Awards
Healthgrades awards tell you which hospitals deliver superior quality care. Healthgrades evaluates hospital performance using objective **quality measures including clinical outcomes and patient safety**, as well as patient experience.

THELEAPFROGGROUP

U.S.News & WORLD REPORT — U.S. News Announces 2018-19 Best Hospitals

CMS.gov
Centers for Medicare & Medicaid Services

Hospital Acquired Conditions	Hosp. Readmission Reduction	Hospital Value-Based Purchasing

Pay For Performance

Value-Based Programs

The left column—HAC Deficit Reduction Act—puts your CC or MCC at risk if the diagnosis is not POA = YES or W.

The center column—HAC Reduction Program—uses PSIs and HAIs to put your hospital at risk of a 1% CMS penalty if your hospital is in the lowest 25%.

The right column—Value Based Purchasing—uses mortality metrics O/E combined with HAIs to put your hospital at risk for up to a 2% penalty (or bonus!).

Penalties and bonuses are based on your documentation! Get credit for the high-quality care you provide!

Hospital Acquired Conditions (HAC) Deficit Reduction Act (DRA)
HAC-1 Foreign Object Retained After Surgery
HAC-2 Air Embolism
HAC-3 Blood Incompatibility
HAC-4 Stage III and IV Pressure Ulcers
HAC-5 Falls and Trauma
HAC-6 Catheter-Associated Urinary Tract Infection (CAUTI)
HAC-7 Vascular Catheter-Associated Infection
HAC-8 Surgical Site Infection, Mediastinitis, Following CABG
HAC-9 Manifestations of Poor Glycemic Control
HAC-10 DVT/PE Following Certain Orthopedic Procedures
HAC-11 Surgical Site Infection Following Bariatric Surgery for Obesity
HAC-12 Surgical Site Infection Following Certain Ortho Procedures
HAC-13 SSI Following Cardiac Implantable Electronic Device (CIED)
HAC-14 Iatrogenic Pneumothorax with Venous Catheterization

Hospital Acquired Condition (HACs) Reduction Program (HACRP)		
DOMAIN 1:	CMS Recalibrated PSI-90 (Composite of below measures) 15%	
PSI 03	Pressure Ulcer	
PSI 06	Iatrogenic Pneumothorax	
PSI 08	In Hospital Fall with Hip Fracture	
PSI 09	Perioperative Hemorrhage or Hematoma	
PSI 10	Postoperative Acute Kidney Injury Requiring Dialysis	
PSI 11	Postoperative Respiratory Failure	
PSI 12	Perioperative Pulmonary Embolism or Deep Vein Thrombosis	
PSI 13	Postoperative Sepsis	
PSI 14	Postoperative Wound Dehiscence	
PSI 15	Unrecognized Abdominopelvic Accidental Puncture/Laceration	
	Charts abstracted and reported to NHSN	
DOMAIN 2:	CDC National Healthcare Safety Network (NHSN) HEALTHCARE ASSOCIATED INFECTIONS 85%	
HAI-1	Central Line-Associated Bloodstream Infection (CLABSI)	
HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)	
HAI-3	SSI Colon Surgery	
HAI-4	SSI Abdominal Hysterectomy	
HAI-5	Methicillin-resistant Staphylococcus aureus bacteremia (MRSA)	
HAI-6	Clostridium difficile Infection (C.diff)	

Hospital Value-Based Purchasing (HVBP)				
DOMAIN:	MORTALITY 25%			
MEASURE ID	Measure Description			
		2019	2020	2021
MORT - 30-AMI	Acute AMI 30-day mortality rate	yes	yes	yes
MORT-30-HF	Heart Failure (HF) 30-day mortality rate	yes	yes	yes
MORT-30-PN	Pneumonia 30-day mortality rate (Incl. sepsis)	yes	yes	no
Complications				
THA/TKA	Total Hip/Knee Arthroplasty Complication	yes	yes	yes
DOMAIN:	PATIENT SAFETY 25%			
MEASURE ID	Measure Description	2019	2020	2021
HAI-1	CLABSI	yes	yes	yes
HAI-2	CAUTI	yes	yes	yes
HAI-3	SSI Colon Surgery	yes	yes	yes
HAI-4	SSI Abdominal Hysterectomy	yes	yes	yes
HAI-5	MRSA	yes	yes	yes
HAI-6	CDI (C.diff)	yes	yes	yes

FINANCIAL IMPACT

Under the DRA HAC payment provision, hospitals no longer receive additional payment for cases in which one of the selected conditions occurred but was not present on admission (POA). That is, the case is paid as though the condition(s) were not present. The DRA HAC-POA payment provision is applicable for secondary diagnosis code reporting only, as the selected conditions are designated as a complication or comorbidity (CC) or a major complication or comorbidity (MCC) when reported as a secondary diagnosis. For the DRA HAC-POA payment provision, a payment adjustment is only applicable if there are no other CC/MCC conditions reported on the claim.

Reduces hospital payments by 1% for hospitals that rank among the lowest-performing 25% (started in 2015 - part of Affordable Care Act)

HVBP
(1) off ALL hospital's base FY18 operating MS-DRG payment
(2) incentives distributed to top performers based on Total Performance Score (TPS)
(3) net result of (1) and (2) above applied to base operating MS-DRG payment (claim by claim)
THEN
Penalty to lowest performing 25% of hospitals (after VBP and Readm Reduction applied)

The Hospital VBP Program is funded by reducing participating hospitals' base operating Medicare severity MS-DRG payments by

DRG	DRG Description	Relative Weight	Base Wt.	Reimbursement
280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6577	$6,000.00	$9,946.20
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9848	$6,000.00	$5,908.80
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7586	$6,000.00	$4,551.60

Present On Admission (POA)

- Present on admission is defined as present at the time the ***order*** for ***inpatient*** admission occurs
  - Conditions that develop during an outpatient encounter are considered as present on admission
    - Emergency department
    - Observation
    - Outpatient surgery

Present On Admission (POA)

- Principal Diagnosis
  - Must be present on admission – POA
- CMS and Premier (Care Science – QualityAdvisor) codes must be POA to risk adjust mortality calculation

Indicator	POA	
Y	Yes	
N	No	
U	Unspecified	Designated NO
W	Clinically cannot determine	Designated YES

Uncertain Diagnoses

- If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established.

2 Midnight Rule

- On July 1, 2015, CMS released the updates to the “Two Midnight” rule.
- CMS emphasis on physician’s medical judgment
- Physician or other practitioner must decide whether to admit as inpatient or treat as outpatient
- CMS observed a higher frequency of extended observation services
- Inpatient admissions will **generally** be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation
- All treatment decisions for beneficiaries were based on the medical judgment of physicians
- CMS sought to respect the judgment of physicians

IPPS Ruling – 2 Midnights Rule

- Inpatient Status

1. Inpatient Order**
2. Expectation of hospitalization crossing “2 Midnights” of time
3. Medical Necessity (what is that?)

Medical Necessity

- "…in order for payment to be provided under Medicare Part A, the care must be reasonable and necessary."

- "The factors that lead a physician to admit a particular beneficiary based on the physician's clinical expectation…must be clearly and completely documented in the medical record."

Medical Necessity

Medical Necessity Buzz Words

Support Inpatient Status

- Acute
- Acute on chronic
- Decompensated
- Exacerbation
- Worsening
- Failed outpatient treatment

- Patient is immunocompromised
- The CURB-65 Score is…
- The Pneumonia Severity Index is. . .
- The TIMI or HEART Score is . . .
- The SOFA Score is . . .

Myocardial Infarction

First Question:
What's the Correct Status?

Medical Necessity – Should the patient be INPATIENT?

- Inpatient admissions will **generally** be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation

- All treatment decisions for beneficiaries were based on the medical judgment of physicians

- CMS sought to respect the judgment of physicians

Medical Necessity

- The care must be ***reasonable and necessary***
- Must be ***clearly and completely documented*** in the medical record

Chest Pain isn't simply Chest Pain

Documentation	MS-DRG	Title	RW	Example Reimbursement
Angina pectoris due to ASCAD	303	Atherosclerosis w/o MCC	0.6656	$4568
Pleurisy	195	Simple Pneumonia w/o CC	0.6868	$4714
Angina pectoris NOS	311	Angina Pectoris	0.6872	$4716
Non-cardiac/musculoskeletal pain	313	Chest Pain	0.7073	$4854
Pericarditis	316	Other Circ System Dx w/o CC	0.7513	$5156
Heartburn / GERD	392	Esophagitis, Gastroenteritis and Misc GI d/o w/o MCC	0.7554	$5184
Pleuritic (not chest wall) pain	204	Respiratory Signs and Symptoms	0.7676	$5268
Biliary colic	446	Disorder of Biliary Tract w/o CC/MCC	0.7950	$5456
Costochondritis or rib fracture	206	Other Resp Dx w/o CC/MCC	0.8635	$5927
Thoracic radiculopathy	552	Medical Back d/o w/o MCC	0.9010	$6184

Fourth Universal Definition of Acute Myocardial Infarction 2018

- Myocardial infarction (MI) is **acute** myocardial injury detected by abnormal cardiac biomarkers in the setting of evidence of **acute** myocardial ischemia
  - Detection of a rise and/or fall of troponin with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following:
    - Symptoms of acute ischemia
    - New ischemic EKG changes
    - Development of pathological Q waves
    - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality consistent with ischemia
    - Identification of an intracoronary thrombus by angiography or autopsy

Fourth Universal Definition of Acute Myocardial Infarction 2018

- **Acute** myocardial injury
  - 20% rise or fall of cardiac troponin over time

- **Chronic** myocardial injury
  - <20% rise or fall of cardiac troponin over time
    - CKD
    - Structural Heart Disease

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Clinical Myocardial Ischemia

Symptoms

- Angina (chest pain, jaw pain, left shoulder/arm pain)
- Angina equivalents (SOB, fatigue)
- Syncope (often due to arrhythmia)
- Flash pulmonary edema (not gradual decompensation of chronic hear t failure)
- Palpitations / Cardiac arrest
- "**OR EVEN WITHOUT SYMPTOMS**"

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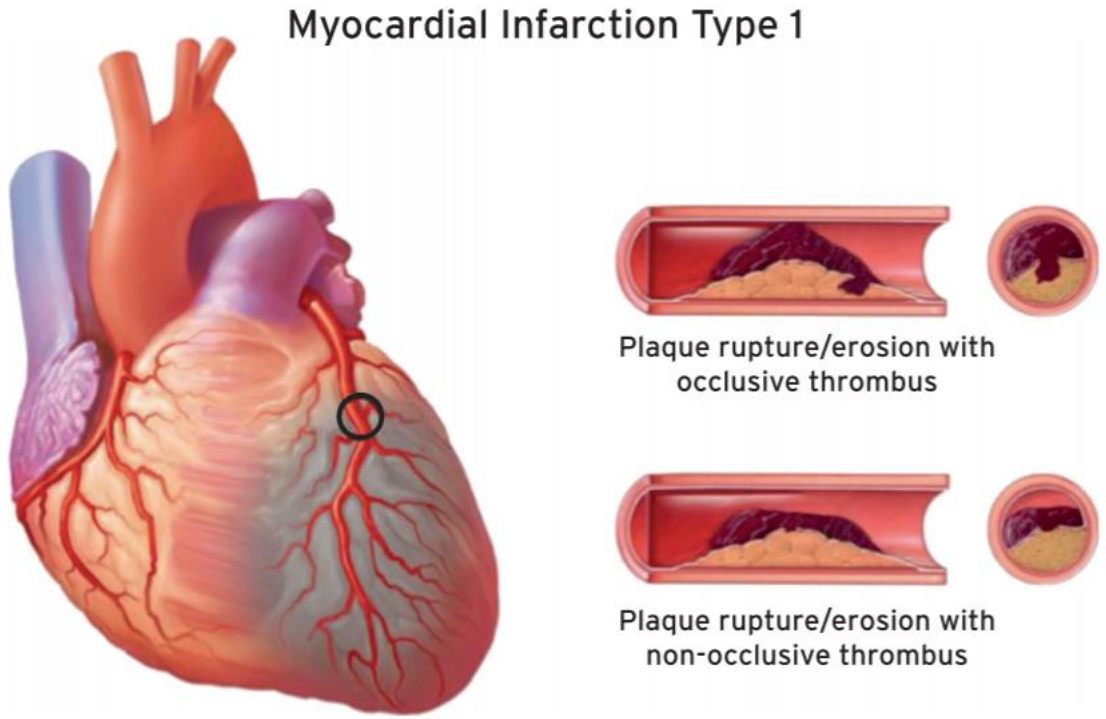
https://www.acc.org/latest-in-cardiology/articles/2018/11/16/09/06/fourth-universal-definition-of-mi

Type 1 MI

- Atherothrombotic coronary artery disease (CAD) and usually precipitated by atherosclerotic plaque disruption (rupture or erosion) is designated as a type 1 MI



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https://www.acc.org/latest-in-cardiology/articles/2018/11/16/09/06/fourth-universal-definition-of-mi

NSTEMI is a Type 1?

Let the controversy begin!

Taken directly from the 4th Universal Definition

- New ST-segment elevations in two contiguous leads or new bundle branch blocks with ischaemic repolarization as an ***ST-elevation MI (STEMI)***

- In contrast, patients with**out ST segment elevation** at presentation are usually designated ***non-ST-elevation MI (NSTEMI)***

https://www.acc.org/latest-in-cardiology/articles/2018/11/16/09/06/fourth-universal-definition-of-mi

MI type 2

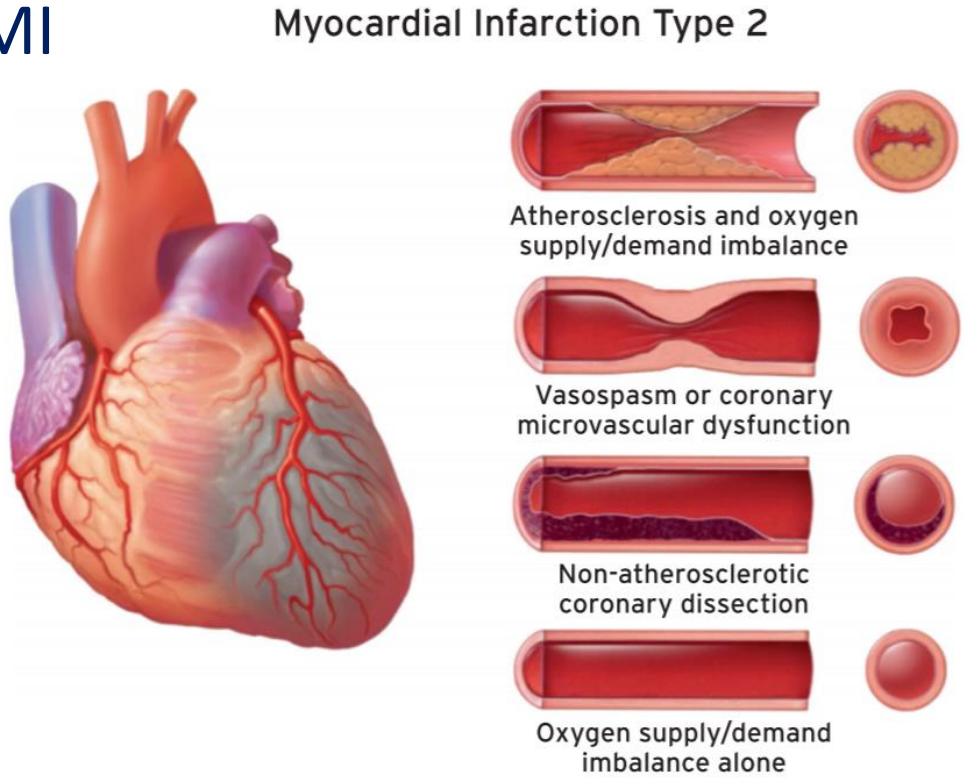
Detection of a rise and/or fall of troponin with at least one value above the 99th percentile upper reference limit (URL) and evidence of an **imbalance** between myocardial oxygen supply and demand unrelated to CAD requiring at least one of the following:

- Symptoms of acute ischemia
- New ischemic EKG changes
- Development of pathological Q waves
- Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality consistent with ischemia
- Identification of an intracoronary thrombus by angiography or autopsy

- MI type 2 has a new code as of October 2017
  - MI due to Demand Ischemia
  - MI due to Ischemic Imbalance

MI type 2

- The pathophysiological mechanism leading to ischaemic myocardial injury in the context of a mismatch between oxygen supply and demand has been classified as type 2 MI
- By definition, acute atherothrombotic plaque disruption is **not** a feature of type 2 MI



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MI type 2

Causes

- Fixed coronary atherosclerosis
- Coronary spasm
- Coronary embolism
- Coronary artery dissection
- Sustained tachyarrhythmia
- Severe hypertension / LV hypertrophy
- Severe Bradyarrhythmia
- Respiratory failure
- Severe anemia
- Hypotension / Shock

Ok, what is “NSTEMI Type 2”?

Depends on who you ask

- Kennedy/Goyal (ACC)
  - NSTEMI type 2 is conflicting documentation because all NSTEMI are type 1
  - Remember the ACC is physician opinion which carries limited weight with the 4 cooperating parties
- Huff/Huff
  - NSTEMI encompasses all MI that do not raise the ST segments
- Coding NSTEMI type 2 codes to MI type 2 (I21.A1) -- Phew!

https://www.acc.org/latest-in-cardiology/articles/2018/11/16/09/06/fourth-universal-definition-of-mi

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- American Health Information Management Association (AHIMA) –
  - Provides input from the coding community

Do you see the American College of Cardiology on that list?

"NSTEMI Type 2"

Coding Clinic, Q4 2017, page 12 "Types of Acute Myocardial Infarction":

Question: **How should a type 2 NSTEMI due to demand ischemia be coded?**

Answer: Assign code I21.A1, Myocardial infarction type 2. Do not assign code I24.8, Other forms of acute ischemic heart disease for the demand ischemia. Code also the underlying cause, if known. According to the *ICD-10-CM Official Guidelines for Coding and Reporting,* "When a type 2 AMI code is described as NSTEMI or STEMI, only assign code I21.A1. Codes I21.01-I21.4 should only be assigned for type 1 AMIs."

https://www.acc.org/latest-in-cardiology/articles/2018/11/16/09/06/fourth-universal-definition-of-mi

Physician Advisors

- Time to change HATS!

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AMI Mortality Cohort

Measure:	30-Day Risk-Standardized Mortality Rate Following AMI
Dx Inclusion:	• **Principal diagnosis of AMI (Excluding Type 2 MI)** • Not transferred from another acute care facility • Age 65 or over • Enrolled in Medicare FFS 12 months prior to index admission or VA beneficiary
Exclusions:	• Discharged alive same day/next day, not transferred to another acute care facility • Enrolled in Medicare hospice program or used VA hospice services any time in the 12 months prior to the index admission (including first day of the index admission) • Discharged AMA
Risk Variables:	• Anterior myocardial infarction (index admission only) • Other (non-anterior) location of myocardial infarction (index admission only) • History of CABG surgery • History of PTCA • 25 condition categories

Acute Myocardial Infarction Metrics

ICD-10 code	Description	CC/MCC	HCC	CMS 30d Mortality
R79.89	Other specified abnormal findings of blood chemistry (troponin elevation)	--	--	NO
I21.4	NSTEMI (Type 1 MI)	MCC	86	YES
I21.3	STEMI of unspecified site	MCC	86	YES
I21.9	AMI, unspecified	MCC	86	YES
I21.A1	MI type 2 (due to demand ischemia)	MCC	86	NO
I21.A9	Other MI type (3,4,5)	MCC	86	NO
I24.8	Demand ischemia	CC	87	NO
I24.9	Acute ischemic heart disease (ACS)	CC	87	NO
I20.0	Angina, unstable	CC	87	NO
I51.81	Takotsubo Syndrome	CC	--	NO
No code	Non-traumatic Acute Myocardial Injury	--	--	--

Pneumonia

First Question:
What's the Correct Status?

Medical Necessity – Should the patient be INPATIENT?

- Inpatient admissions will **generally** be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation

- All treatment decisions for beneficiaries were based on the medical judgment of physicians

- CMS sought to respect the judgment of physicians

Medical Necessity

- The care must be ***reasonable and necessary***
- Must be ***clearly and completely documented*** in the medical record

Pneumonia

Should this patient be inpatient?

- Clinical indicators such as SOB, Fever, Cough
- Infiltrate on CXR
- Abnormalities on Physical Examination
  - Did anyone do a physical examination? Did anyone document it?
    - Crackles
    - Egophony
    - Tactile fremitus
    - Bronchial breath sounds
- Failed outpatient antibiotics
  - Which antibiotics?

Pneumonia

CURB 65

- Confusion
- Uremia (BUN >19)
- Respiratory Rate > 30
- Blood Pressure SBP < 90 or DBP < 50
- Age > 65

Pneumonia Severity Index

Demographic: Age/Sex/Nursing

Home Resident

Neoplastic disease/Liver

disease/Heart Failure/CVA

hx/Renal disease

- AMS
- Respiratory Rate > 30
- SBP < 90
- Temp < 95^o or > 103.8^o
- Pulse > 125
- pH < 7.35
- BUN > 30
- Sodium < 130
- Glucose > 250
- Hematocrit < 30
- PaO2 < 60
- Pleural Effusion

Do you have the right diagnosis?

Pneumonia as Principal Diagnosis

- Will bucket into DRG 195 Simple Pneumonia or DRG 177 Respiratory Diseases

	Clinical to Coding					
	Simple Pneumonia Simple Pneumonia and Pleurisy			Complex Pneumonia Respiratory Infections and Inflammations		
MS DRG	**195**	**194**	**193**	**179**	**178**	**177**
Comorbid	**No CC/MCC**	**w CC**	**w MCC**	**No CC/MCC**	**w CC**	**w MCC**
RW	**0.6868**	**0.9002**	**1.3167**	**0.9215**	**1.2744**	**1.8408**
GLOS	**2.6**	**3.3**	**4.2**	**3.2**	**4.3**	**5.5**
	Influenza PNA Viral PNA like adenoviral, unspecified Strep, H. flu; Mycoplasma, Chlamydial BronchoPNA; Lobar PNA J18.9 Pneumonia, unspecified HCAP!			Influenza PNA w/specified secondary PNA Tuberculous Fungal Virulent organisms like CMV; RSV; K. pneumo; Staph; E. coli; Legionnaires';Gram negative Aspiration Pulmonary Abscess		

Uncertain Diagnoses

- If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established.

Pneumonia

- Probable gram-negative pneumonia, Rx Zosyn
- Probable MRSA pneumonia, Rx Vancomycin

- Suspected Aspiration pneumonia
  - Clindamycin or Flagyl Rx

- All below Map to the DRG for **Simple** Pneumonia
  - Community Acquired Pneumonia
  - Healthcare Associated Pneumonia (**HCAP**)
  - Nosocomial Pneumonia

Pneumonia for ICD-10

ICD-10 code	Description	CC or MCC
J15.9	Unspecified bacterial pneumonia	MCC
J18.9	Pneumonia, unspecified organism (includes CAP & HCAP & Nosocomial)	MCC
J69.0	Aspiration Pneumonia	MCC
J15.6	Pneumonia due to gram negative bacteria	MCC
J15.212	Pneumonia due to MRSA	MCC
J15.8	Pneumonia due to specified bacteria (anaerobic)	MCC

- Simple pneumonia maps to DRG 195 Pneumonia
- Specified codes map to DRG 177 Resp Diseases

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Do you have the right diagnosis?

How many criteria for Sepsis are there?

How many criteria for Sepsis are there?

ONE

Sepsis: If “Some” are due to infection

- SIRS criteria
- Altered Mental Status
- Significant edema or positive fluid balance
- Hyperglycemia in the absence of diabetes
- CRP more than two SD above the normal value
- Procalcitonin more than 2 SD above the normal value
- Hypotension (SBP < 90 mmHg or SBP decrease > 40 mmHg)
- Hypoxemia (PaO2/FiO2 < 300)
- Acute oliguria (urine output < 0.5mL/kg/hr for 2 hours)
- Creatinine increase >0.5mg/dL
- INR >1.5
- Ileus
- Thromobocytopenia (PLT < 100,000)
- Hyperbilirubinemia (> 4 mg/dL)
- Hyperlactatemia (> 1 mmol/L
- Decreased capillary refill or mottling

Other criteria are for Severe Sepsis

Severe Sepsis

Table 2. Terminology and *International Classification of Diseases* Coding

Current Guidelines and Terminology	Sepsis	Septic Shock
1991 and 2001 consensus terminology[9,10]	Severe sepsis Sepsis-induced hypoperfusion	Septic shock[13]
2015 Definition	Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection	Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality
2015 Clinical criteria	Suspected or documented infection and an acute increase of ≥2 SOFA points (a proxy for organ dysfunction)	Sepsis[a] and vasopressor therapy needed to elevate MAP ≥65 mm Hg and lactate >2 mmol/L (18 mg/dL) despite adequate fluid resuscitation[13]
Recommended primary *ICD* codes[a]		
ICD-9	995.92	785.52
ICD-10[a]	R65.20	R65.21
Framework for implementation for coding and research	Identify suspected infection by using concomitant orders for blood cultures and antibiotics (oral or parenteral) in a specified period[b] Within specified period around suspected infection[c]: 1. Identify sepsis by using a clinical criterion for life-threatening organ dysfunction 2. Assess for shock criteria, using administration of vasopressors, MAP <65 mm Hg, and lactate >2 mmol/L (18 mg/dL)[d]	

https://jamanetwork.com/journals/jama/fullarticle/2492881

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Do you see the Society of Critical Care Medicine on that list?

Severe Sepsis-3

- **New Terms and Definitions**
- (Severe) Sepsis is defined as life-threatening organ dysfunction (not failure) caused by a dysregulated host response to infection.
- Organ dysfunction can be identified as an acute change in total SOFA score ≥2 points consequent to the infection.
  - A SOFA score ≥2 reflects an overall mortality risk of approximately 10% in a general hospital population with suspected infection.

http://jama.jamanetwork.com/article.aspx?articleid=2492875

Severe Sepsis Organ Failure Assessment

	System	Score – *Acute change of 2 points due to the infectious process supports sepsis*				
		0	1	2	3	4
Exam	**Neurologic** GCS	15	13-14	10-12	6-9	< 6
Exam	**Respiratory** PaO_2/FiO_2 RA PaO_2, O_2 sat	≥ 400 84, 95%	< 400 84, 95%	< 300 63, 91%	< 200 with respiratory support 42, 80%	< 100 with respiratory support 21, < 80%
Exam	**Cardiovascular**	MAP ≥ 70 mmHg	MAP < 70 mmHg	Dopamine < 5 or Dobutamine (any)	Dopamine 5.1-15 or Epinephrine ≤ 0.1 or Norepi ≤ 0.1	Dopamine > 15 or epinephrine > 0.1 or norepi > 0.1
Labs	**Hepatic** Bilirubin, mg/dL	< 1.2	1.2-1.9	2.0-5.9	6.0-11.9	> 12.0
Labs	**Coagulation** Platelets, x 1,000	≥ 150	< 150	< 100	< 50	< 20
Labs	**Renal** Creatinine, mg/dL	< 1.2	1.2-1.9	2.0-3.4	3.5-4.9	> 5.0
Labs	UOP, ml/d				< 500	< 200

Abbreviations:
PaO_2: partial pressure of oxygen; FiO_2: fraction if inspired oxygen;
MAP: Mean arterial pressure

Catecholamine doses are in mcg/kg/min for at least 1 hour.

Physician Advisors

- Time to change HATS!

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Back to Pneumonia
Do you have the right diagnosis?

Pneumonia Cohort

Measure:	30-Day Risk-Standardized Mortality Rate Following Pneumonia
Dx Inclusions:	• **Principal discharge dx of pneumonia or** • **Principal discharge dx of sepsis (Excluding severe sepsis)** • **with a secondary dx of pneumonia POA (and NO secondary diagnosis of severe sepsis POA)** • Not transferred from another acute care facility • Age 65 or over • Enrolled in Medicare FFS 12 months prior to index admission or VA beneficiary
Exclusions:	• Discharged alive same day/next day, not transferred to another acute care facility • Enrolled in Medicare hospice program or used VA hospice services any time in the 12 months prior to the index admission (including first day of the index admission) • Discharged AMA
Risk Variables:	• History of CABG surgery • History of PTCA • 30 condition categories

If the patient is actually sick enough to meet medical necessity, then you meet “probably” Sepsis

Timing of the Diagnosis

- H&P: “Probable Sepsis”
  - Diagnosis made POA
    - ER
    - Hospitalist, especially Nocturnist
    - Resident
  - Will likely be the Principal Dx and drive the DRG
  - Will risk adjust to Sepsis
  - Will risk adjust to Severe Sepsis
    - IF YOU WANT TO AVOID A DENIAL

Severe Sepsis – SEP 1 Core Measure

The timing of the diagnosis is critical

SEP-1

- Severe Sepsis documented or ABSTRACTED
- Severe Sepsis ABSTRACTED – all three within six hours of one another

a) Documentation of **any** (bacterial) infection

b) 2 or more SIRS Criteria

c) Organ Dysfunction

Severe Sepsis

Sepsis-3 Publication	Severe Sepsis 2012
Sepsis = Severe Sepsis	Sepsis induced hypotension
All SOFA = Severe Sepsis	Lactic Acid > 2
	Urine Output < 0.5 mg/kg/hr for 2 hours w/ fluids
	ALI w PaO2/FiO2 < 250 w/o PNA
	ALI w PaO2/FiO2 < 200 w PNA
	Creatinine > 2
	Bilirubin > 2
	Platelets < 100k
	Coagulopathy INR > 1.5

Sepsis Clinical to Coding

Clinical to Coding	
Sepsis-3 Publication	Sepsis ICD 10 Coding
Sepsis = Severe Sepsis	Sepsis
	Severe Sepsis
	Septic Shock

Summary: Sepsis Clinical to Quality

Mortality Measures

Sepsis POA and Pneumonia POA bucket into Pneumonia Mortality

Severe Sepsis POA and Pneumonia POA bucket into Severe Sepsis

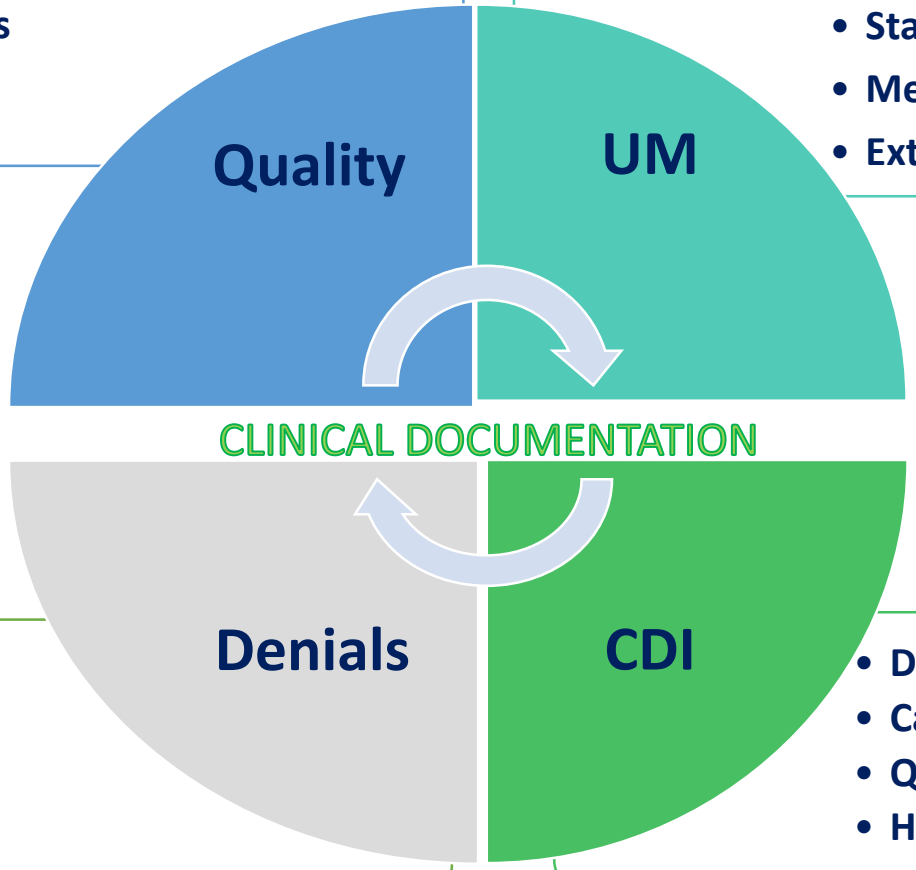
Mortality

Physician Advisor Knowledge

Physician Advisor Skill Set

- Patient Safety Indicators
- Hospital Acquired Conditions
- Mortality Risk Adjustment Optimization

- Physician Advisor Program
- Status Assignment
- Medical Necessity
- Extended Stay Reviews



- Peer to Peer Support
- Appeals Support
- Contract Review

- Documentation Education
- Case Reviews
- Query Support
- HCC Education

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Thank you. Questions?

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