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RAC Coding Issues and CDI

Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS
Independent Health Information Management Consultant

Discussion Points

1. Inventory on current denials
2. Coding and/or clinical
3. Clinical aspect – what's missing?
4. Different viewpoints from the coder, CDI, and the physician
5. Denial topics and successful appeal examples
6. Prevention

Objectives

- After this session, the participation should be able to:
 - Initiate a baseline for all denials and categorize the patterns/trends
 - Differentiate the types of denials for timely assignment to as to “who does what”
 - Substantiate the missing pieces of denials involving coding and/or medical necessity
 - Understand the different focus points from the different perspectives
 - Hone in on (*some*) core content for those “hot topic” denials
 - Define next steps moving forward in the process

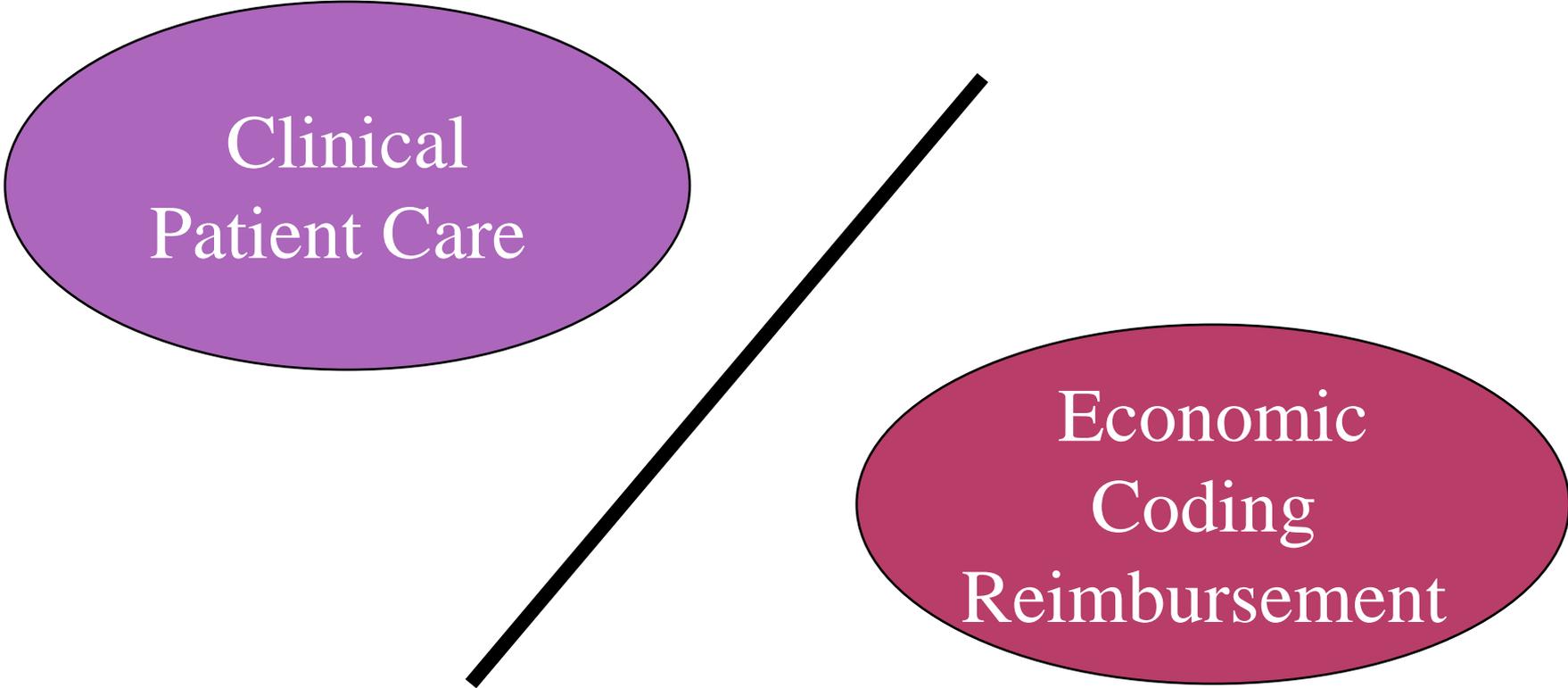
Inventory the Denials

Not just RAC denials...

Categorize all

- Volume? Trends? Patterns?
- Status: Inpatient, outpatient, physician – all of the above?
- What bucket? Coding? Process? Medical necessity? Admission status – case management? Quality? All of the above?
- Medical vs. surgical?
- Is it documentation or a “clinical closeness” question?
- Is this a high risk or high change topic?
- How does it fit with the clinical picture of the patient?

Communication Disconnect



Clinical
Patient Care

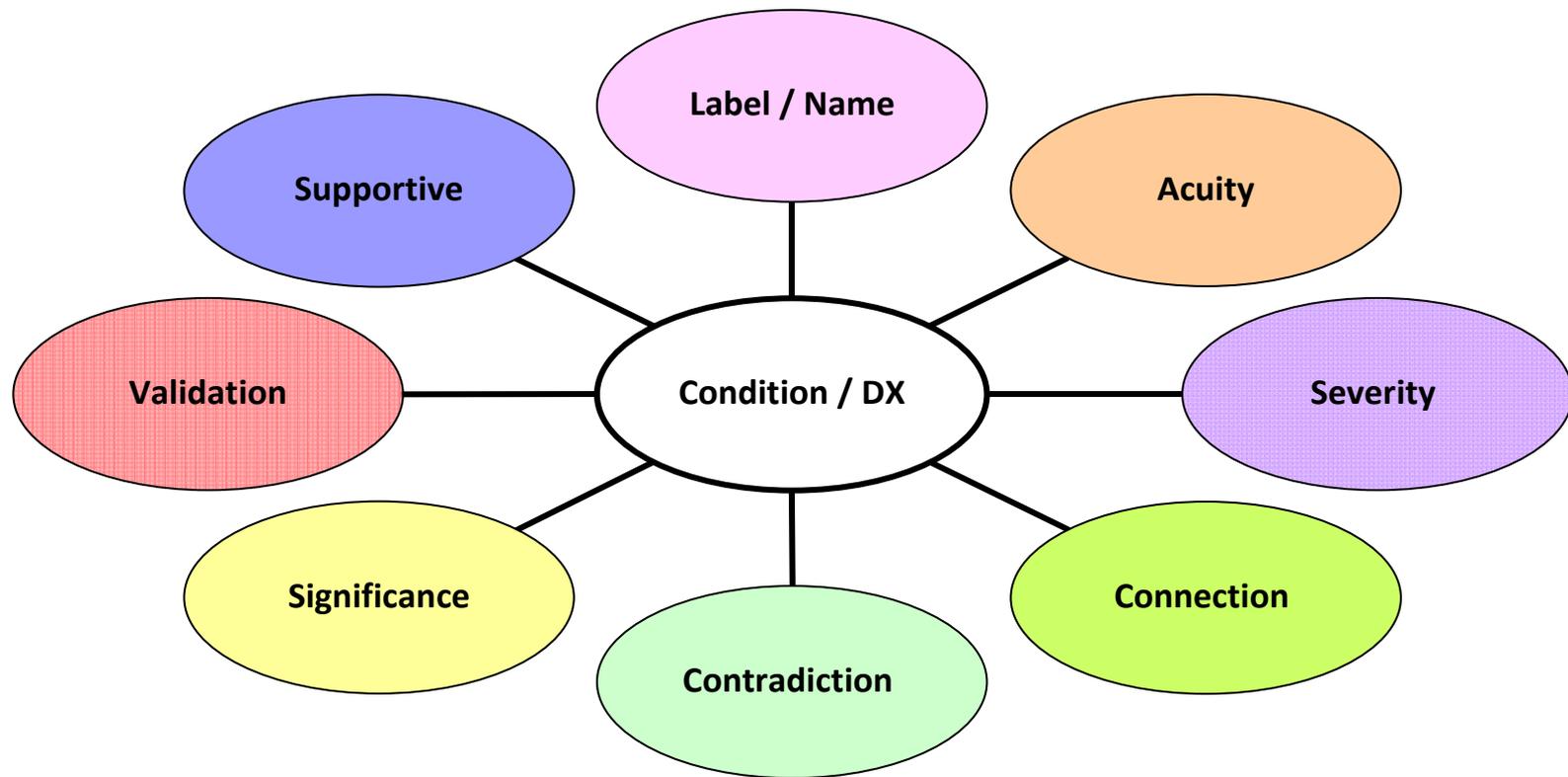
The diagram consists of two ovals. The left oval is purple and contains the text 'Clinical Patient Care'. The right oval is maroon and contains the text 'Economic Coding Reimbursement'. A thick black diagonal line runs from the bottom-left of the purple oval to the top-right of the maroon oval, creating a visual barrier between the two concepts.

Economic
Coding
Reimbursement

Bottom Line

- Hospitals as well as each physician need the most accurate and specific documentation that translates into correct and compliant coding to reflect the true *complexity of care and severity of illness* of their patients.
- **Documentation = Code(s)**

Documentation and "Meanings"



Assign Rank as the #1 Driver

- The principal diagnosis (PDx) is the initial “driver” to the (one) MDC.....
- Then driving on to the most specific DRG/MS-DRG
- *With of course several factors involved and according to the guidelines (several)*
 - Source: ICD-9-CM Official Guidelines for Coding and Reporting, Section II

Selection of the inpatient admission PDx:

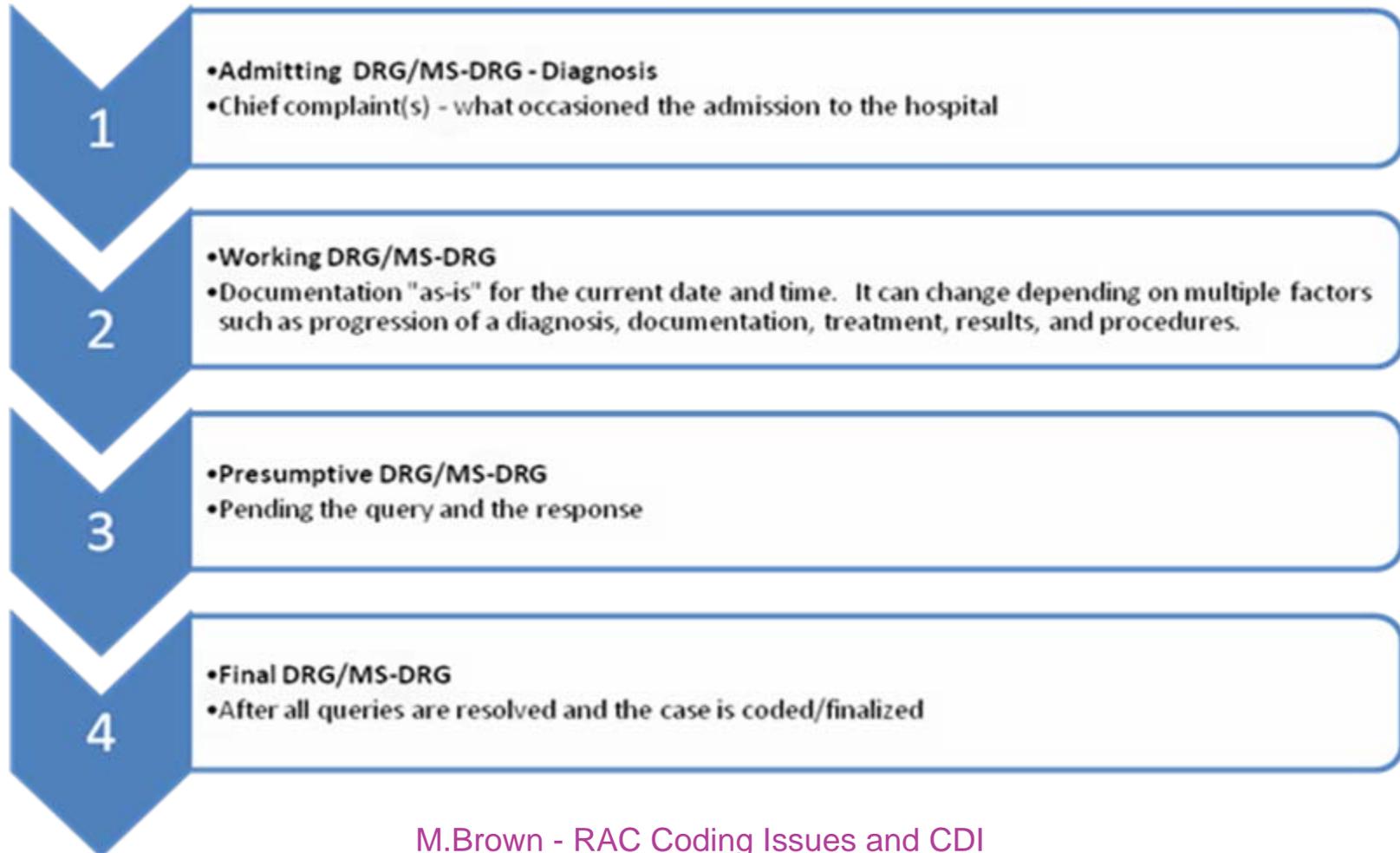
Defined: in the UHDDS as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

“Circumstances of admission always govern the selection of the PDx”.

Meet the definition of the PDx.

Also, “diagnostic work up and/or therapy provided” weighs in....

Inpatient MS-DRG Flow

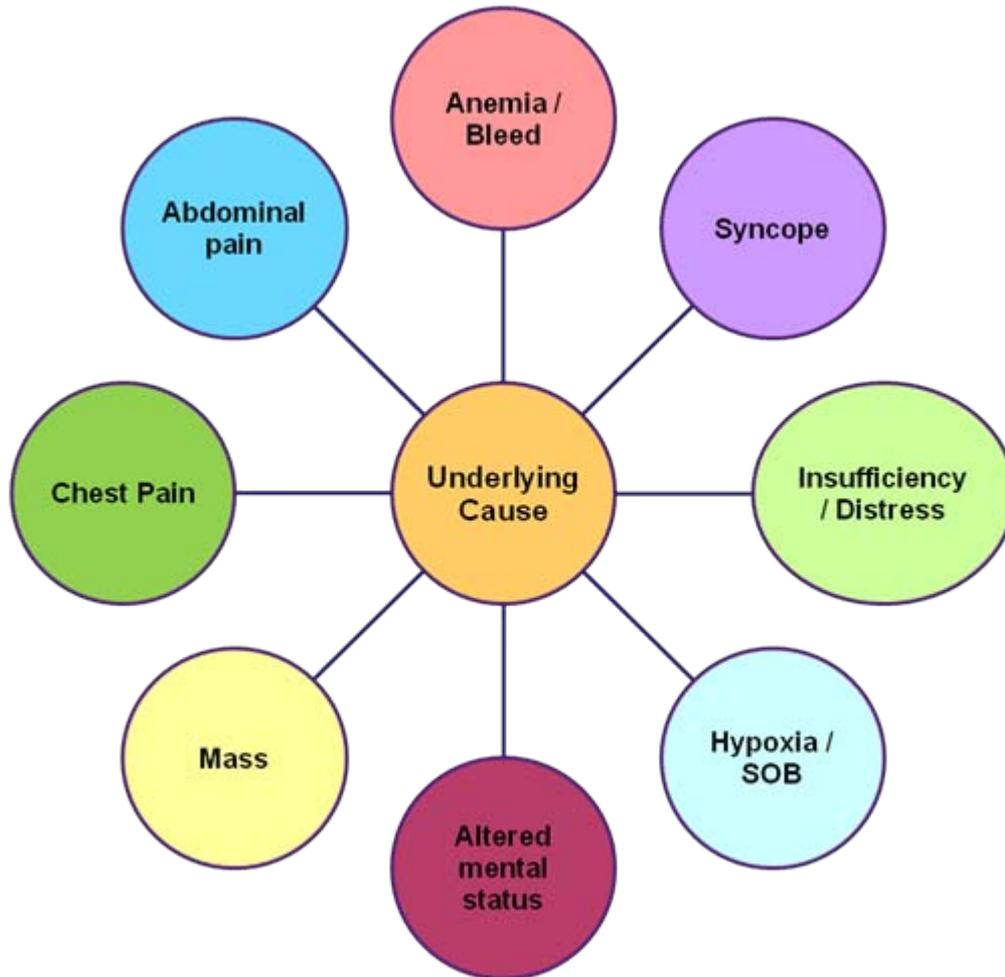


Qualifying the Diagnoses

Diagnosis Status

- Differential diagnosis
- Ruled-out vs. ruled-in
- Rule-out, possible, probable
 - When documented?
(Discharge documentation)
- Resolved
- Natural progression – acute, chronic, acute on chronic, acute vs. chronic, etc.
- “Carried through” the chart
 - Documented *consistently*
- Does it make sense?
 - Was it treated?
 - Was it only mentioned “once”?
 - Were the lab values supportive?
 - Minimal values
 - Did the physician “validate”?
 - Clinical significance
 - Re-confirm the pathology
 - Findings from consultant(s)
 - “insufficiency” vs. “failure”
 - Did it meet the “severity” level?
 - Example: malnutrition – mild, moderate, severe, unspecified

The "Due To", LINK, *and* "Name it"



Admission Status & medical necessity

Back to Basics



How many people are already in the chart?

For what purposes?

Steamline

Communication process - flow

Coordination of billing

Documentation Basics

Just a few:

- The medical record can be compared to a story book of this patient.
- Does the documentation paint the complete picture of the patient?
- Any documentation - the good, the bad and the ugly does affect ALL: the hospital, the provider, the payor - and specifically – the patient. This is the driver of the trickle down effect.
- The basics of just understanding the documentation requirements are critical.

Coder's Role

As a “basic awareness”:

- Coders are required to code to the highest degree of specificity, but the quality physician documentation HAS to be there in the first place.
- Coders are bound by many rules/guidelines for application of the translation process of narratives to numerical codes, which generates the bill.
- Coders are not licensed to make the diagnoses, so if it is not stated, it cannot be coded!

Joint Effort

- Joint effort of documentation and coding
 - “Finally, you should keep in mind that achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures requires a joint effort between the healthcare provider and the coder”.

Source: MLN Matters Number: MM5499 Related
Change Request Number: 5499, 091107
update and Transmittal #289 071707 update

Disease Management and Coding

- New diagnosis
- Acute phase in a chronic, long term disease
- “History of”
 - Cancer
- Another condition related to “that” condition
 - Circumstances of admission
- Disease process with lots of manifestations and coding rules
 - Code first - sequencing
 - Diabetes
- Called something, but coded something else
 - Coagulopathy
 - Coagulopathy in a patient on Coumadin

Medical Targets

Just a few ...

- Procedures unrelated to the principal diagnosis
- High-weighted and/or high-dollar (charges) with short length of stays
- Sepsis
- Renal failure
- Multiple principal diagnosis assignment possibilities
- Add the double check safety net
 - CDI
 - Current denial areas
 - Coding issues
 - Internal & external review
 - National hot spots

Procedures / Surgeries

- It is what it is, but
- Where are those focal points that may need some additional help while the patient is still in house?
 - and why??

Just a few suggestions ...

- “Excisional” debridement
- Adhesiolysis
- Pleurodesis
- Transbronchial “lung” biopsy - TBLB
- Mechanical vent
 - 96 hours

“Excisional” Debridement

- Excisional Debridements
 - Description of the wound(s)
 - Depth and definitions
 - Procedure explained
 - Instruments, methods, etc.
- Location of the procedure
 - OR
 - Bedside
 - Wound Care
- Patient’s clinical picture
 - Current
 - Past and relevant
- Inpatient vs. outpatient / physician
 - ICD-9-CM vs. CPT

Non-excisional
Skin
Skin & sub-Q
Muscle/tendon
Bone
Other

Adhesions

When are adhesions significant enough to code additionally – both the diagnosis and the procedure?

- When obstruction is present or adhesions are cause of pain or dysfunction and lysis is a major procedure
- Obstruction not present
- Strong band of adhesions prevents surgeon from access to the organ being removed
- Requires lysis before operation can proceed
- Significance must be documented by surgeon

Source: Coding Clinic 4th Q 1990

Procedures: Surgical vs. Medical

Pleurodesis

SURGICAL MS-DRGS

- Major chest procedures
 - 163 (w MCC) rw = 5.0828 to
 - 165 rw = 1.7758
- Mechanical = Code: 34.6

MEDICAL MS-DRGs

- “Chemical” = Code 34.92
 - With cancer chemotherapy substance (add 99.25)
 - Tetracycline (add 99.21)
 - Ex: pleural effusion as pdx - 186 – 188
 - Rw = 0.7678 – 1.5637

Coding Clinic References

- 4Q2007, 1Q2007, 1Q1992, 2Q1989, May-June 1985

(Relative weight difference of 1.008 – 3.5191)

Procedures: Surgical vs. Medical

Lung Biopsy

SURGICAL MS-DRGs

- Major chest procedures
 - 163 - 165
 - Open – 33.28
- Other resp system OR procedures 166 (w MCC) – 168
 - Rw = 1.3008 – 3.7383
 - Thoracoscopic 33.20
 - Closed (NEC), endoscopic, Transbronchial lung biopsy, transbronchial needle aspiration of lung (TBNA) – 33.27

MEDICAL MS-DRGs

- Brush 33.24
- Closed / Percutaneous / needle 33.26
- Fine needle aspiration (FNA) of lung
- Transthoracic needle biopsy of lung (TTNB) 33.26

Transbronchial Lung Biopsy

- Documentation must specify the scope passed thru the bronchus and into the lung and actual lung tissue was obtained.
- AHA Coding Clinics
 - 2Q2009
 - 3Q2004
 - 3Q1991
- The *transbronchial* biopsy procedure is performed using a tiny forceps passed through a channel of the bronchoscope *into the lung*.
- The forceps puncture the terminal bronchus, and samples of the peribronchial alveoli (lung tissue) are taken (4Q1992, pages 27-28).

Transbronchial Lung Biopsy

Denial Issue: TBLB

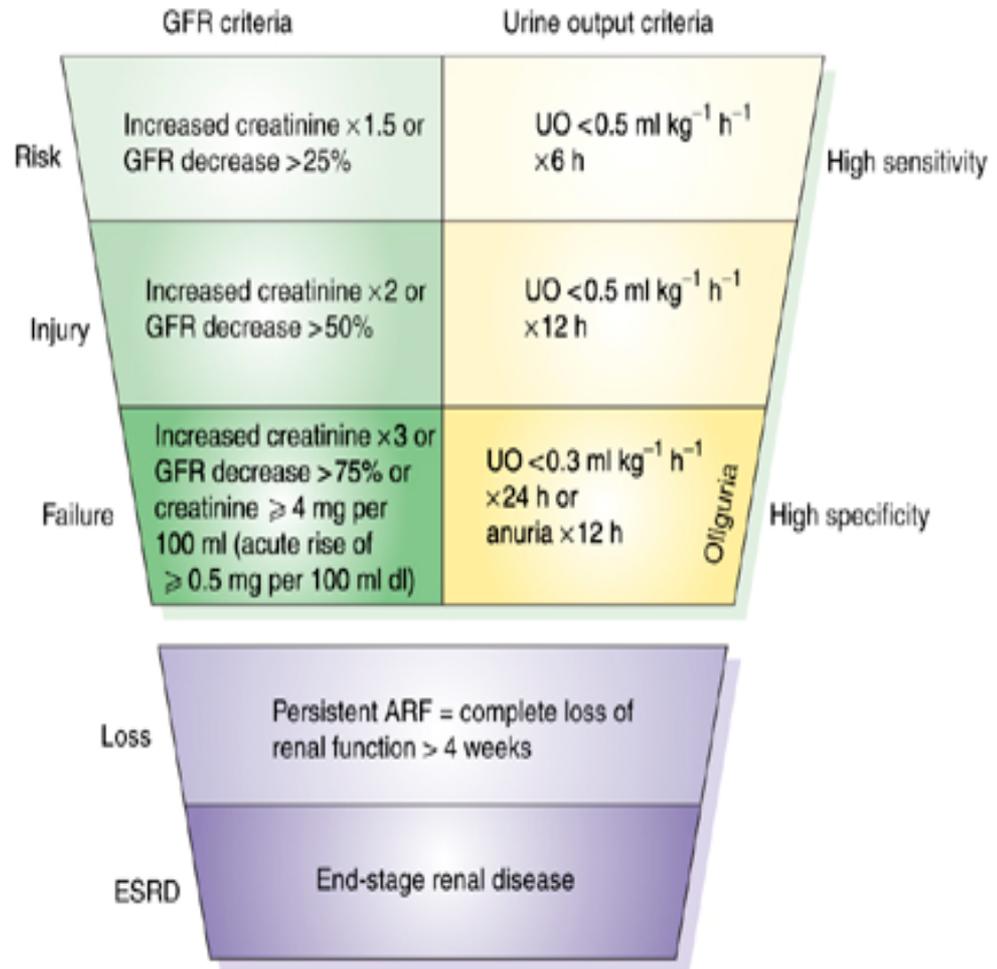
- Both the bronchoscopy with biopsy codes 33.24 (bronchus) and 33.27 - transbronchial (lung) biopsy were coded and assigned to the surgical MS-DRG 166
- The TBLB code 33.27 was deleted with the reasoning that the “path does not show any lung tissue” and this code was not supported in the documentation.
- The MS-DRG was changed from
 - 166 (other resp sys OR w MCC – RW = 3.7383, GMLOS = 9.5 days**to**
 - 186 (Pleural effusion w MCC - RW = 1.5637, GMLOS = 5.3 days)
(Difference rw – 2.1746)
- The OR report states "... endobronchial brushings were obtained from the right lower lobe, followed by transbronchial biopsies and bronchoalveolar lavage."
 - Must define “lobe”
 - Bronchus vs. lung
 - Pathology
 - Radiographic guidance
 - Resources
 - Form revision
 - Impact
 - Volume, dollars, risk factor

Time Based Services

- Vent: Time of 96 hour threshold
 - 96.72 = > 96 hours
 - 96.71 = < 96 hours
- Infusion(s)
 - Start AND stop time
- Evaluation and Management
 - Leveling 3 key components versus time
 - Critical care
 - Only time based codes
 - Default – minimum?
- Status
 - Observation
 - 72 – hour rule
- Billing coordination
- Resource: OIG work plan

Renal Failure

- Insufficiency, Failure or AKI?
- Standard definitions
 - RIFLE criteria
 - Others
- Severity Driver (CC or MCC)
- Various clinical presentations
 - Acute, chronic or acute on chronic
 - Asymptomatic
 - Several etiologies
 - Coding Guidelines



What is “Acute Kidney Injury”?

- Acute Kidney Injury
 - a common clinical syndrome **defined as a sudden onset of reduced kidney function** manifested by increased serum creatinine or a reduction in urine output.
 - It is **NOT** the underlying renal pathology
 - Currently a preferred term and synonym for acute renal failure or acute kidney failure.
 - Some physicians may not agree
- Acute Kidney Insufficiency
 - The same definition as acute kidney injury, yet the rise of creatinine or fall of urine output fails to meet the acute kidney injury criteria
- Azotemia
 - a medical condition characterized by abnormally high levels of nitrogen-containing compounds, such as urea (BUN) , creatinine, various body waste compounds, and other nitrogen-rich compounds in the blood.
- Uremia
 - A term used to loosely describe the illness accompanying kidney failure, in particular the nitrogenous waste products associated with the failure of this organ

Resource: Srisawat N., Hoste, E., Kellum, JA.
Modern Classification of Acute Kidney Injury.
Blood Purification 2010;29:300–307.

Available for free at:
<http://tinyurl.com/AKI-2010-Review>

Acute Kidney Injury

Diagnostic criteria for acute kidney injury

An abrupt (within 48 hours) reduction in kidney function currently defined as an absolute increase in serum creatinine of more than or equal to 0.3 mg/dl ($\geq 26.4 \mu\text{mol/l}$), a percentage increase in serum creatinine of more than or equal to 50% (1.5-fold from baseline), or a reduction in urine output (documented oliguria of less than 0.5 ml/kg per hour for more than six hours).

The above criteria include both an absolute and a percentage change in creatinine to accommodate variations related to age, gender, and body mass index and to reduce the need for a baseline creatinine but do require at least two creatinine values within 48 hours. The urine output criterion was included based on the predictive importance of this measure but with the awareness that urine outputs may not be measured routinely in non-intensive care unit settings. It is assumed that the diagnosis based on the urine output criterion alone will require exclusion of urinary tract obstructions that reduce urine output or of other easily reversible causes of reduced urine output.

The above criteria should be used in the context of the clinical presentation and following adequate fluid resuscitation when applicable. Note: Many acute kidney diseases exist, and some (but not all) of them may result in acute kidney injury (AKI). Because diagnostic criteria are not documented, some cases of AKI may not be diagnosed. Furthermore, AKI may be superimposed on or lead to chronic kidney disease.

*Source: Mehta *et al. Critical Care* 2007 **11**:R31 doi:10.1186/cc5713

Acute Renal Failure

- Example #1: The progress note on discharge documents an improvement with the BUN - 36 and creatinine of 1.2; however the discharge summary (DS) does NOT mention acute renal failure.
- Example #2: This patient had no documentation of their "baseline", so the reviewer's impression of an increase of 50% of this baseline was assumed upon the creatinine level on admission.
- Example #3: Contradictions of terms for the coder: ARF, "AKI", insufficiency, failure, And by which physician – attending vs. consultant
 - Based on different thresholds by the individual physician(s), group(s), etc.
 - Standard definitions?
- NOTE: Acute renal failure code – 584.9 downgraded status from MCC to CC as of 10-1-2010

Terms of Malnutrition

Malnutrition (calorie) 263.9

- Degree
 - First 263.1
 - Second 263.0
 - Third 262
 - Mild (protein) 263.1
 - Moderate (protein) 263.0
 - Severe 261
 - Protein-calorie 262
- **Malignant 260**
- Mild (protein) 263.1
- Moderate (protein) 263.0
- **Protein 260**
- Protein-calorie 263.9
 - *Mild* 263.1
 - *Moderate* 263.0
 - Severe 262
 - Specified type NEC 263.8
- Severe 261
- Protein-calorie NEC 262

- **Weights:**

- MCC: 260, 261, 262
- CC: 263.2, 263.8, 263.9

- **Terms:**

- CC 3Q9009, page 6: ...
- “Code 260, Kwashiorkor, is not appropriate since the provider did not specifically document this condition. Kwashiorkor syndrome is a condition that is caused by severe protein deficiency that is usually seen in some underdeveloped areas in Africa and Central America; however it is extremely rare in the US.”
- The National Center for Health Statistics (NCHS) is considering a proposal to revise the index entries under mild and moderate protein malnutrition in order to provide a “clearer direction to the coder”.

Malnutrition

Values Commonly Used to Grade the Severity of Protein-Energy Malnutrition

Measurement	Normal	Mild Malnutrition	Moderate Malnutrition	Severe Malnutrition
Normal weight (%)	90–110	85–90	75–85	< 75
Body mass index	19–24*	18–18.9	16–17.9	< 16
Serum albumin (g/dL)	3.5–5.0	3.1–3.4	2.4–3.0	< 2.4
Serum transferrin (mg/dL)	220–400	201–219	150–200	< 150
Total lymphocyte count (per mm ³)	2000–3500	1501–1999	800–1500	< 800
Delayed hypersensitivity index†	2	2	1	0

*In the elderly, BMI < 21 may increase mortality risk.

†Delayed hypersensitivity index quantitates the amount of induration elicited by skin testing using a common antigen, such as those derived from *Candida* sp or *Trichophyton* sp. Induration grade 0 = < 0.5 cm, 1 = 0.5–0.9 cm, 2 = ≥ 1.0 cm.

Source: <http://www.merck.com/mmpe/sec01/ch002/ch002b.html>

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Risk vs. Opportunity

Check points

- SOLID
- Supportive coding & documentation
- NO gaps
- Consistent description of the patient, the care, the services provided, including the decision-making
- Evidence-based
- Tie up all loose ends
- Stand the test of time

Discharge Documentation Note Should:

1. Conclude what occasioned the admission and then what is the “principal diagnosis” -- “after study”
2. Discuss the complexity of the patient’s illness (secondary diagnoses)
3. Summarize the things that went wrong and the things that improved
4. Be as specific as possible regarding pathogenesis of disease, the medical decision making, and other “intangible” thought processes
5. Summarize the outcome

Discharge Documentation Note Should:

6. List the post-hospital care to follow
7. Tell the story of the hospital stay.
8. Have no contradictions (Insufficiency, failure, distress, etc....) – and specifically at the time of discharge – what/which is it?
9. Be consistent with the rest of the record, also not introduce new information unless as the result of recent test findings or more recent information.
10. Be clear and concise - the discharge summary should not regurgitate the H&P – it should be what it is called - a “summary on discharge”

Many Query Protocols

- Lack of accurate and complete documentation can result in the use of nonspecific and general codes, which can impact data integrity and reimbursement and present potential compliance risks.
- *The strong purpose* of a query is to assist in providing “solid” documentation of those unique clinical situations and the assurance that the documentation in the record supports the codes assigned.
- It is critical that the *design* of the queries and the query process be created and maintained with legal, regulatory, and ethical issues in mind.
- Infrastructure and policies for concurrent, retrospective, or post-bill queries.
- A *multidisciplinary team* should be involved in creation and evolution of the forms and process. *Involve the physicians* up front and by using their specific examples, pertinent to their specialty.
- Discuss and agree on the basic requirements – permanent part of the chart, format, core content, language of the question, etc.

Query Language and Protocols

- “It is recommended that queries be written with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case”.

Article citation:

AHIMA. "Managing an Effective Query Process" *Journal of AHIMA* 79, no.10 (October 2008): 83-88.

Query Subject “Headers”

- Clarify
- Validate
- Verify
- Conflicting diagnoses
- Significant finding
- Specify
- Complete
- Legible
- Cause and effect
- Due to
- Link
- Manifestation
- Underlying cause

Appeal - Include ALL Details

5 point appeal format

- REVIEW rationale behind the determination
- FIND the “meat and potatoes” of your argument that supports your position that the denial is incorrect and should be reversed.
- CITE official sources to support your position in addition to coding guidelines (CMS regulations, articles from Coding Clinic or CPT Assistant, textbooks, etc.)
- POINT OUT specific documentation to support codes and/or medical necessity. Paint the picture of the patient.
- SUMMARIZE your rationale, in a positive manner and stay focused.

Chronic multiple ulcerations in a debridement case where 86.22 (excisional debridement) was changed to 86.28 (non-excisional).

- “The patient was taken to the OR and ‘using a #10 blade, necrotic tissue was EXCISED from the left and right ulcerations, partial thickness level’ ”.
- “...Very large ulceration to the left medial ankle area, measuring approx 11.4 cm x 6.5 cm, depth of 0.4 cm, mostly granulated tissue, foul odor, with one maggot found.... the right is pale looking, with minimal granulation, measuring approx 3.6 cm x 3.5 cm, with a depth of 0.3. “

Respiratory Failure Denial Example

- Issue: Re-sequence the PDx from acute respiratory failure 518.81 to AECOPD [acute exacerbation of COPD] 491.21 based on the fact that the patient is a smoker and the ABGs and the pulse-ox do not reflect this diagnosis.
- Rebuttal: The physician clearly documents respiratory failure through the chart and as the reason for admission. The discharge summary (DS) provides the final diagnosis of "respiratory failure due to AECB". Hypercapnic respiratory failure was documented by the physician on 09/28 in the progress notes. He was significantly dyspneic and with a frequent cough that substantially interferes with his ability to even communicate ... with an assessment of "respiratory failure due to acute exacerbation of COPD".
- The ABGs were taken while the patient was receiving O₂ via nasal cannula.
- The Interdisciplinary progress note on 09/27 at 5-6 am documents the patient's respirations as "rapid and shallow, R=38 labored, SPO₂ - 84-86%, 2 L O₂".
- He was admitted to the ICU, given IV antibiotics, corticosteroids, aerosol bronchodilators, and oxygen.
- Labs: CO₂ serum on 09/27 at 1330 was elevated at 29.5 with a normal range of 23-29. See the ABGs, day of admission at 1331 as listed: FiO₂ - 27.00, pH - 7.392, elevated PCO₂ 50.8, PO₂ - 91.4, O₂ sat - 97.2, BEvt elevated at 4.3 and HCO₃ elevated at 30.2. The interpretation was "compensated respiratory acidemia".

CDI Frame Work Program

- Set your key goals involving:
 - Complete clinical documentation
 - Coding quality
 - Medical necessity
 - RAC and denial vulnerabilities
- Set the parameters
 - Executive support
 - “Teeth” – enforcement that works in “your” facility
- Set your table
 - Who is involved
 - Who is the “key” point person
 - Determine the level of involvement
 - Responsibility and authority
 - Map the process
 - Agree on the roadmap
- Monitor for tone
 - Too aggressive?
 - Too passive?

Measure and Analyze

**Hospital Staff
with Medical
Leadership,
and ALL:**

**Share reports,
findings, patterns,
trends & seek root
cause(s).**

**Measure rates:
Denial, appeal, &
success**

**Initial
Analysis**

**Further Analysis
& Quantification**

**Individual by
physicians,
group, specialty,
coder, DRG,
diagnosis,
procedure, etc...**

**Develop
improvement
plans,
implement,
monitor,
feedback, etc.**

Prevention

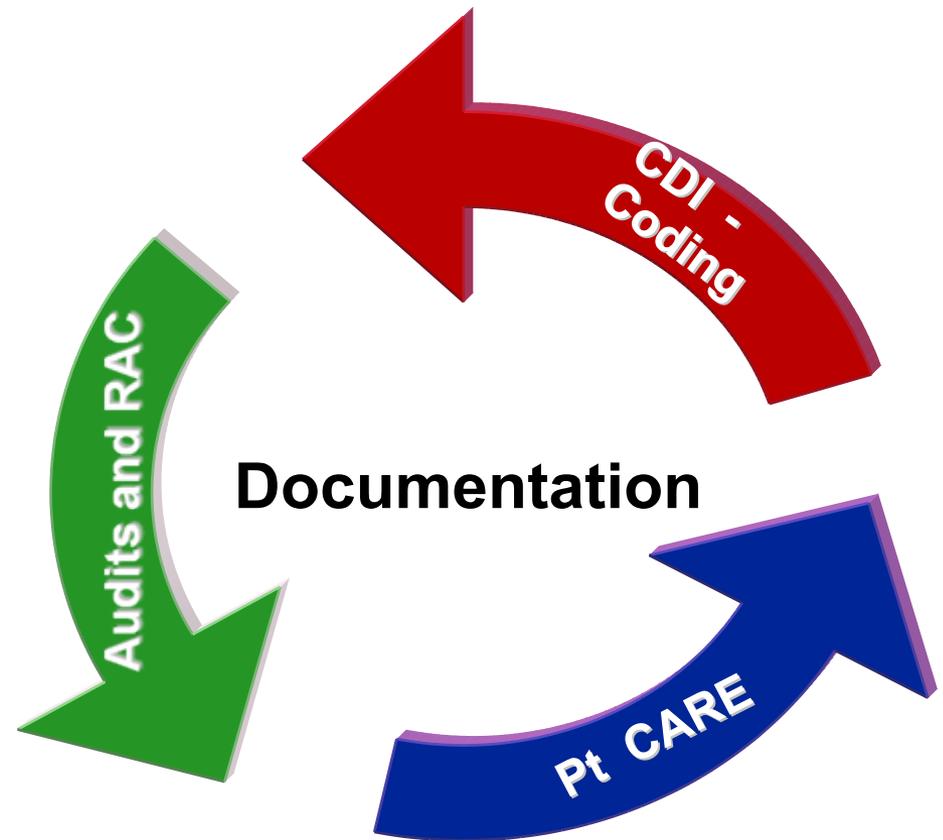
Define the issue(s) and
then the fit(s)

- Maximization – **NO!**
- Optimization – **NO!**

- Solid - YES
- Consistent – YES
- Supported - YES

It Is a Full Circle Process

- Use a “comprehensive” communication process from front to back and visa versa
- Include all other “key” areas
- “Wrap” any retrospective activities including audit results into the CDI program for a “full circle” approach



In Closing

Audience Questions



Thank you for attending

Margi Brown, RHIA,
CCS, CCS-P, CPC, CCDS

codebrown@bellsouth.net