



# RAC Targets, Bullseyes and Near Misses: What Your CDI Program Should Know

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# TARGETS



Approved Inpatient Issue Region C	Date Approved
Medical Necessity - <b>Surgical Cardiovascular Procedures</b> 224-227, 242-244, 245, 246-249, 250-251, 252-254, 258-259, 260-262, 263, 264, 265. (Collaborative)	8/29/11
Medical Necessity-Diseases and Disorders of the <b>Digestive System</b> , MS-DRG 347-349, 350-358, 368-369, 370-379, 380-389, 390-395. (Collaborative)	8/29/11
Medical Necessity- <b>Conditions of the Circulatory System</b> MS-DRG, 286, 287, 288,289,290,291,292,293, 299, 300, 301, 302, 303, 304, 304, 305, 308,309,310, 311, 312, 313, 314, 315 & 316. (Collaborative)	8/29/11

# Bulls-Eyes



RAC	Overpayment Issues
Region A: Diversified Collection Services	Ventilator Support of 96+ hours – Ventilation hours begin with the intubation of the patient (or time of admittance if the patient is admitted while on mechanical ventilation) and continue until the endotracheal tube is removed, the patient is discharged/transferred, or the ventilation is discontinued after a weaning period. Providers are improperly adding the number of ventilator hours resulting in higher reimbursement. (Incorrect Coding)
Region B: CGI, Inc.	Extensive Operating Room Procedure Unrelated to Principal Diagnosis– The principal diagnosis and principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis-Related Group assignment. (Incorrect Coding)

# Bulls-Eyes



RAC	Overpayment Issues
Region C: Connolly, Inc.	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. (Billing for Bundled Services Separately)
Region D: HealthDataInsights	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. (Billing for Bundled Services Separately)

# Short Inpatient Stay

- **312** SYNCOPE & COLLAPSE (medically unnecessary)
- **313** CHEST PAIN (medically unnecessary)
- **69** TRANSIENT ISCHEMIA (medically unnecessary)
- **249** PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC (medically unnecessary)
- **192** CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC (medically unnecessary)

*\*No requirement for a discharge summary on stays less than 3 days.*

*\*Insufficient documentation in the medical record to support the level of care (inpatient acute care)*

*\*Patient may be admitted and discharged before UR admission review*

*\*Documentation not reviewed by CDI*

# MS-DRG Validation Requirements

- When a patient is admitted to the hospital, MS-DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record.
- ❖ *Medical Learning Network, Medicare Quarterly Provider Compliance Newsletter, Guidance to Address Billing Errors, Volume 2, Issue 1 - October 2011, page 8*

# Top Coding Denials

- 312 - Syncope and Collapse
- 166 – Other Resp System O.R. Procedure w/MCC
- 981 – Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/MCC
- 189 – Pulmonary Edema & Respiratory Failure
- 813 – Coagulation Disorders



# Near Misses

- Transbronchial Lung Biopsy
- Excisional Debridement
- Respiratory Failure
- Sepsis
- Discharge status
- Admission order – vague terminology

# RAC Findings – Improper Coding

- Coagulation Disorders–MS-DRG 813
  - 286.9, Coagulopathy in patients on circulating anticoagulants
    - ❖ “A code from category 286, Coagulation defects, is not appropriate for patients on anticoagulant therapy.” Refer to *Coding Clinic, Third Quarter 2004, page 7, Fifth Issue 1993, page 16, and Third Quarter 1992, page 15, for additional discussion.*
- Human Immunodeficiency Virus (HIV) Disease
  - Wrong Diagnosis Code or Wrong Principal Diagnosis Code Billed

# Coding Guidelines for HIV

## a. Human Immunodeficiency Virus (HIV) Infections

### 1) Code only confirmed cases

- Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

### 2) Selection and sequencing of HIV codes

#### (a) Patient admitted for HIV-related condition

- If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

#### (b) Patient with HIV disease admitted for unrelated condition

- If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

# Gastroenteritis with Hemorrhage with CC or MCC

- ✓ **MS-DRG 377–G.I. hemorrhage with MCC**
  - ✓ **MS-DRG 378–G.I. hemorrhage with CC**
  - ✓ **MS-DRG 379–G.I. hemorrhage without CC/MCC**
- ❖ *“The coder should not assume a causal relationship between gastrointestinal bleeding and a single finding such as a gastric ulcer, gastritis, diverticulitis, etc. The physician must identify the source of the bleeding and link the clinical findings....., since these findings may be unrelated to the bleeding.” Coding Clinic 2Q2007*

# Cerebral Infarction

## MS-DRG 064, 065, and 066

Office of Inspector General (OIG) Report OA1-09-86-00052 (January 1998) found an overwhelming majority of errors and assignment for DRG 14, now MS-DRG 064, 065, and 066

✓ **064 Intracranial Hemorrhage or Cerebral Infarction With MCC**

✓ **065 Intracranial Hemorrhage or Cerebral Infarction with CC**

✓ **066 Intracranial Hemorrhage or Cerebral Infarction Without CC/MCC**

- The auditors have noted that the coding for CC and MCC of hemiparesis is often miscoded in both directions

# TIA vs CVA

- Many records lack concise documentation to support either the diagnosis of Transient Ischemic Attack (TIA) or Cerebrovascular Accident

# Postoperative Anemia as a CC in MS-DRGs 467, 481, 486 and 488

- Post-operative anemia, which was not documented as acute blood loss or due to blood loss was incorrectly coded as acute post-hemorrhagic anemia (285.1)(CC)
- Per Coding Clinic guidelines, post-operative anemia codes to 285.9 when not specified as due to acute blood loss.

# RAC Findings

- **Extensive OR procedure unrelated to Principal Diagnosis MS-DRGs 981, 982, 983**
  - **Incorrect selection of the principal diagnosis code**

# Ventilator Time

- **The ventilator weaning time period (process of shifting the breathing function from the machine to the patient to allow the patient to breath on their own) should be included in the hours calculated for mechanical ventilation.**
- **Coders may have been looking at the number of days a patient was actually in the facility rather than the number of hours they were actually intubated.**

❖ MS DRGs 003, 004, 207, 870, 927, and 933

# Respiratory Failure

- (MS-DRG) 189 – Respiratory Failure as the Principal Diagnosis
  - Diagnosis must be specific to “failure”
  - Must be the reason after study for admission
  - Must be present on admission

# Respiratory Failure as PDX

- **Example 2: An 81-year-old female was admitted with complaints of dry cough for a couple of weeks. The patient was admitted through the emergency department and was assessed for wheezing and coughing. H&P impression is acute respiratory failure secondary to exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Progress notes through the stay also document the diagnosis of acute respiratory failure secondary to exacerbation of COPD. Final diagnosis on the discharge summary is acute respiratory failure secondary to COPD exacerbation.**
- ❖ *Medical Learning Network, Medicare Quarterly Provider Compliance Newsletter, Guidance to Address Billing Errors, Volume 1, Issue 4 – July 2011, page 2*

# Respiratory Failure - RAC Action

- **Auditor finding:** After physician and auditor review, it was determined that the clinical evidence in the medical record did not support respiratory failure, despite physician documentation of the condition.
- **Action:** The auditor deleted acute respiratory failure and changed the principal diagnosis to COPD Exacerbation. The auditor deleted respiratory failure code 518.81 and changed the principal diagnosis to hypoxemia code 799.02. This resulted in a MS-DRG change from 189 to 192–Chronic Obstructive Pulmonary Disease without CC/MCC. This change resulted in an overpayment.

# Appeal?

## 3) Sequencing of acute respiratory failure and another acute condition

- When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident), the principal diagnosis will not be the same in every situation. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (*Section II, C.*) may be applied in these situations.

❖ *Coding Clinic for ICD-9-CM, 4Q2007*

# Appeal?

## 6. Signs and symptoms

– Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

❖ *ICD-9-CM Official Guidelines for Coding and Reporting, Coding Clinic, Fourth Quarter 2008 Page: 195*

# Respiratory Failure as an MCC

- The RACs are looking very carefully at Respiratory Failure as a secondary diagnosis
  - Confirmed by attending physician?
  - Possible/probables documented on discharge by the attending physician?
  - Clinical findings and treatment support the diagnosis

# Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC: MS-DRG 040

- ✓ Excisional debridement of wound, infection, or burn (86.22) was coded as the principal procedure; however, the debridement was carried down to the fascia.
- ✓ The RAC auditor found that excisional debridement (86.22) was not appropriate, but did have debridement down to fascia (83.39).
- ✓ *Fascia* - A sheet or band of fibrous connective tissue enveloping, separating, or binding together muscles, organs, and other soft structures of the body.

# Conditions that Resolve Before Admission

- Should not be coded

**Example:** An 82 year old male was seen at the cardiologist's office, and had an echocardiogram with an ejection fraction of 55%. When his carotids were examined, the patient went into asystole. He was given one ampule of atropine with resolution of the asystole (427.5). He was transferred to the hospital.

At the hospital, the patient presented with syncope. The patient has a past medical history, which includes Parkinson's disease, Alzheimer's disease, hypertension, and benign prostatic hypertrophy.

## 3-Day Window (2011)

- Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the **diagnoses**, procedures, and charges for **all outpatient diagnostic services** and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day (or 1 day) payment window.

## 3-Day Window (2012)

- The final 3-Day Payment Window now includes not only outpatient services provided at the hospital or any of its provider-based locations, but also hospital-owned physician practices, regardless of whether these practices are provider-based
- This rule expands the reach of the 3-Day Payment Window and bundles physician payment into the hospital DRG payment

# OP Nondiagnostic/Therapeutic

OP **nondiagnostic** services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, *unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission).*

# Hospital-Owned Physician Practices

**Example:** An 82 year old male was seen at a **hospital-owned** cardiologist's office, and had an echocardiogram with an ejection fraction of 55%. When his carotids were examined, the patient went into asystole. He was given one ampule of atropine with resolution of the asystole (427.5). He was transferred to the hospital.

At the hospital, the patient presented with syncope. The patient has a past medical history, which includes Parkinson's disease, Alzheimer's disease, hypertension, and benign prostatic hypertrophy.

- All diagnoses from the outpatient encounter should be included on the inpatient claim (3-Day Rule) as well as the charge for the office visit which cannot be billed separately.

# Attending Physician's Responsibility

## Tip #1

- Be sure that Attending Physician acknowledges the findings of Consulting Physicians

## Tip #2

- Be sure that the Attending Physician confirms possible/probables on discharge if they were not ruled out

# Observation Time

*Transmittal 2234 (Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)*

- Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour.
- General standing orders for observation services following all outpatient surgery are not recognized.

# Observation Time

- Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services.
- When patients undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

# Observation Time

- Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure
- Hospitals *may determine the most appropriate way to account for this time*
- *Hospital may deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services*
- Observation time ends when all medically necessary services related to observation care are completed

# Hospital IPPS DRG Changes

## Excisional Debridement



- 3 new MS-DRGs for *Excisional Debridement* of skin and subcutaneous tissue
- Revision of existing MS-DRGs 573–578 to include **skin grafts only** to account for the difference in cost

# New MS-DRGs for Excisional Debridement

- MS-DRG 570 (skin debridement with MCC), **2.5158** relative weight (RW)
- Proposed MS-DRG 571 (skin debridement with CC), **1.5427** RW
- MS-DRG 572 (skin debridement without CC/MCC), **0.9872** RW

# MS-DRGs for Skin Grafts

- MS-DRG 573 (skin graft for skin ulcer or cellulitis with MCC), **3.4259** RW
- MS-DRG 574 (skin graft for skin ulcer or cellulitis with CC), **2.6984** RW
- MS-DRG 575 (skin graft for skin ulcer or cellulitis without CC/MCC), **1.2271** RW
- MS-DRG 576 (skin graft except for skin ulcer or cellulitis with MCC), **3.4259** RW
- MS-DRG 577 (skin graft except for skin ulcer or cellulitis with CC), **2.6984** RW
- MS-DRG 578 (skin graft except for skin ulcer or cellulitis without CC/MCC), **1.2271** RW



**STOP**

# 2012 HACs



**POA Alert**

- Foreign object retained after surgery
- Blood incompatibility
- Pressure ulcer stages III & IV
- Falls and Trauma with injury
- **Catheter-associated urinary tract infection** (requires 2 codes)
- **Vascular catheter-associated infection**
- Manifestations of poor glycemic control
- Surgical site infection, mediastinitis, following coronary artery bypass grafts (CABG)
- Surgical site infection following some orthopedic procedures
- Surgical site infection following bariatric surgery for obesity.
- **Deep vein thrombosis and pulmonary embolism** following certain orthopedic procedures

# Questions?

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