What You Don’t Know Might Kill You!

The Impact of Documentation and Coding on Patient Safety Outcomes

February 22, 2018
Alice Fitts, RHIA

Reporting Accuracy for Quality Initiatives

Key documentation / coding actions to assure PSI reporting accuracy:
- ID all reportable secondary diagnoses, as they may impact risk-adjustment or exclude the patient from being counted (i.e. immunocompromised) – don’t just focus on COIs
- Pay attention to all POA indicators – not just the HACs
- Was the surgery done while the patient was an outpatient?
- Verify appropriate application of the Medicare 3-day pay
- Be diligent in validating admit / discharge dates (LOS) and
- Query physician for clarification if the clinical significance
- Follow internal escalation policy when clinical validation is
- Assure someone in PFS evaluates the accuracy of data
What You Don’t Know Might Kill You!

Value Based Purchasing Targets Poor Performing Hospitals

Complete and Accurate Data are Important for:

- Research
- Epidemiology
- Outcomes
- Statistical Analysis
- Financial and Strategic Planning
- Evaluation of Quality of Care
- Communication to Support Patient’s Treatment
- Reimbursement!!

Coding Clinic Qtr 4, 1989
### MS-DRG Example

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>DRG Payment</th>
<th>GMLOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>291</td>
<td>CHF w/ MCC</td>
<td>$9,319</td>
<td>4.5</td>
</tr>
<tr>
<td>292</td>
<td>CHF w/ CC</td>
<td>$6,380</td>
<td>3.5</td>
</tr>
<tr>
<td>293</td>
<td>CHF w/o CC/MCC</td>
<td>$4,759</td>
<td>2.5</td>
</tr>
</tbody>
</table>

### Get Credit for Severity of Illness

Documentation specificity is important for accurate reporting to establish the severity of illness of your patient.

<table>
<thead>
<tr>
<th>Non-Specific</th>
<th>Greater Specificity if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina</td>
<td>Unstable Angina</td>
</tr>
<tr>
<td>CHF</td>
<td>Acute / Chronic; Systolic / Diastolic Heart Failure</td>
</tr>
<tr>
<td>Pneumonia, HCAP, CAP</td>
<td>Pneumonia due to Pseudomonas, Probable Aspiration Pneumonia, etc</td>
</tr>
<tr>
<td>Renal Insufficiency</td>
<td>Acute Renal Failure or Chronic Kidney Disease Stage _____</td>
</tr>
<tr>
<td>Respiratory Insufficiency or Distress</td>
<td>Acute Respiratory Failure or Acute on Chronic Respiratory Failure</td>
</tr>
</tbody>
</table>
Physician Response ----- What’s in it for me?

Medicine Under the Microscope

Cost
LOS
Morbidity
Mortality
Outcomes
Value-based purchasing is an important step to revamping how care and services are paid for, moving increasingly toward rewarding:

- better value,
- outcomes, and
- innovations

instead of merely volume.”

CMS
Unplanned Readmission – CHF
https://www.medicare.gov/hospitalcompare

Hospital A
Hospital B

Number of included patients:
656
636

National rate of readmission for heart failure patients = 21.6%

*State and national averages do not include VHA hospital data.*
CMS Star Ratings

December 2017

Strategy #1 – Risk Adjustment
**VBP Measures**

**FY18 IPPS Final Rule**

- **Person & Community Engagement**
  - HCAHPS Survey

- **Efficiency & Cost Reduction**
  - Medicare Spending per Beneficiary
  - Episode Pymt AMI / HF (21); PN (22)

- **Safety**
  - NHSN – CAUTI, CLABSI, MRSA Bacteremia, CDI
  - ACS-CDC Colon / Abd Hyst SSI
  - Elective Delivery
  - Pt Safety (23)

- **Clinical Care**
  - Mortality – AMI, HF, PN
  - COPD (21); CABG (22)
  - Complications – THA / TKA

**Domains affected by diagnosis / procedure coding**

---

**HCC’s - What They Are?**

- **Select ICD-10-CM codes (Conditions)**
  - 7,768 (11%) of ICD-10-CM codes used

- **Arranged in groups (Categories)**
  - Reviewed / revised annually

- **Assign weights to recognize that some groups are more significant to risk-adjustment than others (Hierarchical)**
How HCC’s Are Used

Hierarchical Condition Categories

- CMS risk adjustment for quality initiatives such as:
  - VBP mortality
  - Readmission reduction program
  - VBP efficiency: Medicare spending per beneficiary

www.hospitalcompare.hhs.gov

- “The statistical process of accounting for differences in patients’ sickness before they were admitted to the hospital is called risk-adjustment. This statistical process aims to ‘level the playing field’ by accounting for health risks that patients have before they enter the hospital.”
How They Are Used

- CMS risk adjustment for Medicare Part C plans
  - Determines relative health risk of populations so that CMS knows how to pay Medicare Advantage plan for coverage of Medicare patients
  - Original purpose for HCC development

- Required per ACA to calculate relative risk of population for commercial plan on behalf of a state
  - CMS and HHS methodologies vary due to expected variations in populations

Medicare Spending / Beneficiary

- Includes Hospital Stay and 30 day Post-Discharge Window
  - Transfer to another subsection (d) hospital for IP care
  - Transfer to post-acute care setting, such as a SNF, LTCH, IRF, or home
  - Readmitted to the same hospital;
  - Admitted to a different subsection (d) hospital.

- Part A and Part B Payments

  to assess payments Medicare makes surrounding an inpatient stay compared to a national benchmark
Risk Adjustment

- Data for risk adjustment of Medicare Spending / Beneficiary
  - Diagnoses submitted via claims
  - 90 days preceding episode and during the episode surrounding the stay.
    - Age
    - Severity of Illness
      - Hierarchical condition categories (HCC)

Case Study: PDX – CHF

MS-DRG 293 CHF w/o CC

- Secondary diagnoses impact risk adjustment
  - Z89.xx Amputation status
  - Z79.84 Long-term use of insulin
  - Diabetes
  - Atrial fibrillation
  - COPD (without exacerbation)

- NONE of these are CCs, still MS-DRG 293
Hospital Value-Based Purchasing

Domain Weights

<table>
<thead>
<tr>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>Efficiency</td>
<td>Outcomes</td>
<td>Process</td>
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<tr>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>20%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>10%</td>
<td>40%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Coded Claims Data / Risk Adjustment Affects All Domains Except Experience

Domain Weights FY19 & Subsequent Years

FY18 IPPS Final Rule

- Person & Community Engagement: 25%
- Safety: 25%
- Efficiency Cost Reduction: 25%
- Clinical Care: 25%
Readmission Reduction Program

- All-cause, risk-adjusted 30-day readmissions following:
  - Acute myocardial infarction (AMI)
  - Heart failure (HF)
  - Pneumonia (PN)
  - Total hip arthroplasty/total knee arthroplasty (THA/TKA)
  - Chronic obstructive pulmonary disease (COPD)
  - Coronary Artery Bypass Graft (CABG) Surgery

Up to 3% reduction

Getting Paid For Value Starts and Ends With Clinical Documentation

*Philip Betbeze, for HealthLeaders Media*, October 16, 2015

- I would be petrified to go into a risk contract where I wasn't sure I was doing everything possible to capture the severity.

- "There's money on the table today, but it's not overwhelming. But by 2020, where 50% of reimbursement is value-based, that's a game changer," says Olivia. "You should be doing clinical documentation improvement right now, because it will help you win in fee-for-service too, but the added benefit is that it's setting you up for that new environment."
  - Excerpts from Anthony Olivia, MD Borgess Health (Ascension)
Nearly 60% of Medicare revenues will be from risk-based contracts by 2019

**AMGA Survey**

- “...expect federal Medicare Advantage revenue to be essentially equal to Medicare fee-for-service payments by 2019.”

- “...expect nearly 60 percent of Medicare revenues will be from risk-based contracts — such as bundled payment, Medicare Advantage, Medicaid managed care organizations and Medicare ACOs — by 2019.”

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Re-evaluate your CDI-Coding Process?

*Still a valid response?*

- “But we don’t query if it doesn’t change the DRG.”
Risk Adjustment

CMS

- “We believed that risk-adjustment for patient case-mix is important when assessing hospital performance based on patient outcomes and experience and understanding how a given hospital’s performance compares to the performance of other hospitals with similar case-mix.”

Your Plan of Action

- Seek documentation and coding of all reportable comorbid conditions,
- *Regardless of their impact to the MS-DRG!*

Strategy #1 – Risk Adjustment

What it Takes?

- Understanding of risk adjusted models and their importance
- Education for coders and CDI specialists
- Emphasis on concurrent documentation
- Effective coding policies directing coders to the expectations for reporting “optional” codes that impact risk
Strategy #2 – Claims Accuracy

ACS Newsletter Emphasizes Risk Adjustment

- [www.ACSTeam.net](http://www.ACSTeam.net)
  - Resources >> Newsletters

![Image of a dart hitting the bullseye]
PSI-90: Far Reaching Impact!

HAC Reduction

Hospital Report Cards

Value-Based Purchasing

PSI-90

HAC Reduction Program

- NOT same as other Hospital Acquired Conditions list.
- WHY? Requirement and program name set per ACA.
- WHAT? 1% payment reduction for hospitals in worst 25th percentile
- HOW MUCH? Estimates reduce payments by $373 million
PSI-90 Composite

*Risk-adjusted, coded data*

- PSI-3 Pressure ulcer;
- PSI-6 Iatrogenic pneumothorax;
- PSI-7 CLABSI;
- PSI-8 Postop hip fx;
- PSI-12 Postop PE/DVT;
- PSI-13 Postop sepsis;
- PSI-14 Wound dehiscence;
- PSI-15 Accidental puncture & laceration

Patient Safety and Adverse Events

*FY18 IPPS Final Rule*

- PSI 03 Pressure Ulcer Rate;
- PSI 06 Iatrogenic Pneumothorax Rate;
- PSI 08 In-Hospital Fall with Hip Fracture Rate;
- PSI 09 Perioperative Hemorrhage or Hematoma Rate;*
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate;*
- PSI 11 Postoperative Respiratory Failure Rate;*
- PSI 12 Perioperative Pulmonary Embolism (PE) or DVT Rate;
- PSI 13 Postoperative Sepsis Rate;
- PSI 14 Postoperative Wound Dehiscence Rate;
- PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate.
Patient-Safety Indicators

- Agency for Healthcare Research & Quality
- [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

**Patient Safety Indicators**

**www.healthgrades.com**

<table>
<thead>
<tr>
<th>Hospital ABC</th>
<th>Worse</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure sores or bed sores acquired in the hospital</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Death following a serious complication after surgery</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Collapsed lung due to a procedure or surgery in or around the chest</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Electrolyte and fluid imbalance following surgery</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Respiratory failure following surgery</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Bloodstream infection following surgery</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during medical care</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

*Other PSI measures were reported as average.*
Hospital Safety Grade.org

Hospital Results

PSI Variables

Why It Matters To Non-Coders

- ICD-10 Codes
- Present on Admission (POA) Indicators
- Admission Date
- Discharge Date
- Priority of Admission (elective, urgent, etc)
- Point of Origin (home, other facilities...)

Dangerous Bed Sores
A bed sore is a cut or wound on the skin that forms when a patient lays or sits in one position for too long without being moved. Advanced bedsores (also known as stage 3 or 4 pressure sores) can become large and very deep. They can reach a muscle or bone and cause severe pain and serious infection. This can lead to longer hospital stays, amputation, or even death.

What safer hospitals do:
When working with a patient who cannot move much on their own, hospital staff always move the patient regularly and checks for bed sores. They also use cushioning to protect bony areas and immediately take steps to treat existing sores.

This number represents the number of times patients experienced dangerous bed sores for every 1,000 patients.
PSI-3 Pressure Ulcer Rate

- Stage III Pressure Ulcer
- Stage IV Pressure Ulcer
- Unstageable Pressure Ulcers
  
  \textit{Where pressure ulcer is not POA}

- Adults 18+

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PSI-3 Pressure Ulcer Rate

- Pressure ulcer as PDX or POA (Y or W)
- Skin disorders POA
- LOS < 3 days
- Transfer from another hospital, SNF, ICF or other healthcare facility
- Hemiparesis, monoplegia, quadriplegia, spina bifida, anoxic brain damage, cerebral palsy
- MDC 14 (OB)
- Debridement (excision or extraction) or pedicle graft before or on day of major surgery or as only major OR procedure
PSI-3 Pressure Ulcer Rate
Assure Reporting Accuracy by Verifying:

- Applicability depends on accuracy of:
  - Principal and secondary diagnosis codes
  - Procedure codes
  - POA indicators
  - Admit / discharge dates for LOS
  - Admit source

Case Illustration

- Patient admitted with pneumonia
- Pressure ulcer unstageable, not POA
- Presents to ED on 2/15
- Admitted to IP status 2/16
- Discharged 2/18

1. Claim shows admit date of 2/15
   - LOS considered 3 days
   - Case hits PSI-3

2. Claim shows admit date of 2/16
   - LOS correctly reported as 2 days
   - Case does NOT hit PSI-3
Strategy #2 – Claims Accuracy

- Audit Accuracy of:
  - Admission Date
  - Priority of Admission
  - Point of Origin

Strategy #3 – Combine Claims Correctly
Three-Day Payment Window

NEW!!! ACS Newsletter for 3 Day Window

- [www.ACSTeam.net](http://www.ACSTeam.net)
- Resources >> Newsletters

![Image](image-url)
Medicare Three-Day Payment Window

Outpatient (Diagnostic or Therapeutic)  ➔  Inpatient Admission

Are You One Of These????

We Always Combine OP Claims Occurring Within 3 Days of IP Admission

We Combine IP Claims Occurring Within 3 Days of Inpatient Discharge
Source Data:

- Medicare Claims Processing Manual
- Chapter 3 Inpatient Hospital Billing
- 40.3 Outpatient Services Treated as Inpatient Services
- The “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010”
- Effective for services furnished on or after the date of enactment
  - June 25, 2010

Three-Day Window with Diagnostic Services

Patient is admitted as an inpatient on a Thursday. Diagnostic services that were provided by the hospital on Monday, Tuesday, Wednesday or Thursday are included in the inpatient Part A payment, and should be reported on the inpatient claim regardless of whether clinically associated with the reason for inpatient admission. *This provision does not apply to ambulance services and maintenance renal dialysis services.*

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab</td>
<td>X-ray</td>
<td>Inpatient Admission</td>
<td>For Stroke</td>
</tr>
<tr>
<td>Diagnostic service – Routine lab work.</td>
<td>Diagnostic service - patient falls; possible head injury. X-ray is negative</td>
<td>MS-DRG 66 Stroke</td>
<td></td>
</tr>
</tbody>
</table>
For Example:

**JULY**

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>Admit as IP</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

OP diagnostic services provided Sunday – Wednesday would be included with inpatient claim.

**Diagnostic Services**

*Determined By Revenue Code*

- 0254 Drugs incident to other diagnostic services
- 0255 Drugs incident to radiology
- 030X Laboratory
- 031X Laboratory pathological
- 032X Radiology diagnostic
- 0341, 0343 Nuclear medicine, dx radiopharmaceuticals
- 035X Computerized Axial Tomography (CT) scan
- 0371 Anesthesia incident to radiology
- 0372 Anesthesia incident to other diagnostic services
- 040X Other imaging services
- 046X Pulmonary function
- 0471 Audiology diagnostic
- 0481, 0489 Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, G0278
- 0482 Cardiology stress test
- 0483 Cardiology, echocardiology
- 053X Osteopathic services
- 061X Magnetic Resonance Imaging (MRI)
- 062X Medical/surgical supplies, incident to radiology or other diagnostic services
- 073X Electrocardiogram (ECG/EKG)
- 074X Electroencephalography (EEG)
- 0918 Testing, behavioral health
- 092X Other diagnostic services
Three-Day Window with Non-Diagnostic (Therapeutic) Services

- When outpatient non-diagnostic (therapeutic) services, provided within the 3 days prior to admission are not clinically associated with the admission, they should be billed separately.

- When outpatient non-diagnostic (therapeutic) services, provided within the 3 days prior to admission are clinically associated with the reason for admission, the services should be reported on the inpatient claim.

Medicare Three-Day Payment Window

Medicare Three-Day Payment Window

1. OP services combined with IP claim
   - OP services provided on day of admission
   - Diagnostic OP services provided within 3 days of IP admission
   - Therapeutic OP services provided within 3 days of IP admission that are clinically related to the reason for admission

2. OP services filed separately
   - Therapeutic OP services provided within 3 days of IP admission that are NOT clinically related to the reason for admission
   - Remember all diagnostic services (per revenue codes) are always combined with IP claim if within 3 day window!
Separate Filing of Unrelated OP Therapeutic Services

- MLN Matters MM7142
- Condition Code 51 on OP Claim
  - Preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary’s admission

Applicable Facilities

- IPPS Hospitals
- Non-IPPS Hospitals:
  - One (1) day rather than three (3)
- Critical Access Hospitals:
  - Does not apply
One-Day Payment Window

- Hospitals and hospital units excluded from the IPPS are:
  - Psychiatric hospitals and units
  - Inpatient rehabilitation hospitals and units
  - Long-term care hospitals (LTCHs)
  - Children’s hospitals
  - Cancer hospitals

Things to Watch

- Procedure IP vs OP
- Timing of inpatient admission order
- Reason for inpatient admission
- Diagnostic vs therapeutic procedure
Medicare Same-Day Readmissions

- Readmission on the **same day** for symptoms:
  - Related to OR
  - For evaluation and management of
- the prior stay’s medical condition...

- COMBINE on single claim.

- CMS Transmittal 266; Claims Processing Manual 40.2.5

Strategy #3 – When To Combine Claims

- Who is responsible for determining whether OP therapeutic service is clinically associated with IP admission?

- Who determines whether the same day readmissions should be combined?
Medicare Same Day Transfers

Novitas Solutions Jan 24, 2017

- A same day transfer occurs if the beneficiary is admitted to your facility and is expected to stay overnight, transfers to a different facility.

- Transferring Hospital
  - Condition Code 40
  - Same “From” and “Through” dates
  - Admit date is same as “From” and “Through” dates

- For AMA discharges (pt status code 07)
  - Readmitted to another facility same day?
  - Original discharging hospital must code pt status 02
  - Submit adjustment if claim already submitted
  - Transfer payment policy applies
    - ACS Note – original DRG payment for d/c status 07 is not transfer-adjusted, but when the d/c status is changed to 02, it will result in payment adjustment.
Medicare Same Day Transfers

*Novitas Solutions Jan 24, 2017*

- For AMA discharges (pt status code 07)
  - Readmitted to another facility same day?
  - Original discharging hospital must code pt status 02
  - Submit adjustment if claim already submitted
  - Transfer payment policy applies
    - ACS Note – original DRG payment for d/c status 07 is not transfer-adjusted, but when the d/c status is changed to 02, it will result in payment adjustment.
Requirements for Staying Alive

- Adequate documentation to support accurate coding
- Recognize importance of risk adjustment – beyond the MS-DRG
- Collaboration with coding and quality and business office
- Processes and policies to assure:
  - Timely and thorough documentation
  - Concurrent review / CDI with timely physician response to queries
  - Auditing of claims elements integral to quality reporting and reimbursement

Requirements for Staying Alive

- Accurate priority of admission and point of origin
- Accurate admit and discharge dates

- Appropriate adherence to payer policies for combining inpatient and outpatient claims
  - Diagnostic vs Therapeutic services
  - Determination of whether OP related to IP admission
Thank You!

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