CDI: A Roadmap to Quality Initiatives

June 8, 2022
Webinar FAQ Document

1. **Question** – How does CMS determine that a patient with mortality measures has died within 30 days?

   Answer – According to the CMS website, "The data sources for these analyses are Medicare administrative claims and enrollment information for patients having hospitalizations with discharge dates between July 1, 2018 and June 30, 2021, excluding December 2, 2019 through June 30, 2020. The datasets also contain associated inpatient, outpatient, and physician Medicare administrative claims from up to 12 months prior to the index admission."[1]

   If a patient expired in a healthcare facility, CMS could find this claim by pulling claims with a discharge status code of 20 (Expired) on the claim.

2. **Question** – Can you elaborate on coding diagnoses from a provider note verses coding from the problem list?

   Answer – Both diagnoses on a provider note and on a problem list can be coded; however, diagnoses documented only in the provider note can be easily missed when coding since the diagnoses are sometimes not documented on additional notes and the discharge summary. Therefore, it is recommended that all diagnoses documented be added to a problem list. This way all diagnoses are brought forward throughout the entire stay until the discharge summary where the provider can then reconcile the list. Some documentation systems prompt physicians to add a diagnosis to the problem list when a diagnosis is documented on a provider note to ensure that the diagnosis does not get missed when coding. For health systems that use a problem list, it is very important to add all diagnoses to this list because the list follows the patient from encounter to encounter so that the physician has a full understanding of the patient's history when treating the patient.

3. **Question** – Can you clarify the fact that Hierarchical Condition Categories (HCCs) only derive from ICD-10 codes or can they derive from CPT/ HCPCS codes too? Do HCCs take into consideration outpatient and inpatient encounters?

   Answer – HCCs are derived from ICD-10 CM (diagnosis) codes only. This risk methodology does take into consideration both outpatient and inpatient encounters.

4. **Question** – Can you please explain more about "Was it treated?" and explain how it doesn't necessarily mean that a procedure was performed or medication was given?

[1] 2022 Procedure-Specific Mortality Measure Updates and Specifications Report. https://www.cms.gov/files/document/2022-measure-updates-procedure-specific-mortality-measure-updates-and-specifications-report.pdf

Answer – Section IV of the ICD-10-CM Official Coding Guidelines states the following in regard to secondary diagnosis code assignment: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."[2] According to this statement, a patient does not need to receive medication or have a procedure in order to pick up the diagnosis code. If the diagnosis required management or affected patient care in some way, it is appropriate to code. A good rule of thumb is that if the diagnosis resulted in additional time or resources from the staff or facility, it can be coded (example: if lab tests are run daily to monitor a condition, that condition can be coded even if the patient is not receiving medication for that condition).

[2] ICD-10-CM Official Guidelines for Coding and Reporting FY 2022. https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf