

# 2019 IP Auditing Results & Moving into 2020

Lessons Learned

Today's Presenter



Lisa Ball, BS, RHIT, CCS, CDIP  
Coding Integrity and Educational  
Coordinator

# Disclaimer Statement

This webinar/presentation was current at the time it was published or provided via the web and is designed to provide accurate and authoritative information in regard to the subject matter covered. The information provided is only intended to be a general overview with the understanding that neither the presenter nor the event sponsor is engaged in rendering specific coding advice. It is not intended to take the place of either the written policies or regulations. We encourage participants to review the specific regulations and other interpretive materials as necessary.

## Agenda

- Gauge how a facility's audits compare with Vitalware results.
- Determine future review areas of interest.
- How to prioritize areas of interest by DRGs, procedures, services, and/or diagnoses.
- Identify industry trends related to DRG audits.
- Identify possible areas of concern.

# Sections

**Section One** – The What, How, and Why of Inpatient Auditing?

**Section Two** – Challenges for Coders.

**Section Three** – Challenges for Clinicians and Clinical Documentation Improvement Team.

**Section Four** – Wrapping up with Q&A.

# **The What, How, and Why of Inpatient Auditing**

# Section One: The What, How, and Why of Inpatient Auditing

## What is an Inpatient audit (internal or external)

- Reimbursement
  - Look at the principal diagnosis, MCCs and/or CCs reported, procedures that affect DRG for appropriate payment
- Quality
  - Review documentation for continuity of care
  - Validate clinical criteria is met
  - Review length of stay and discharge disposition
- Coding Accuracy
  - Review all secondary codes for accuracy in code assignment and reporting



# Section One: The What, How, and Why of Inpatient Auditing

## How is an Inpatient audit performed?

- Deciding on the focus or need
- How to choose your cases (focused/random)
- Who will perform the audit (internal/external)
- How often should the audit be performed (concurrent/retrospective)
- How to present findings





# Section One: The What, How, and Why of Inpatient Auditing

## Retrospective Review

- Facility-specific
- Vitalware Proprietary DRG selection
- Discharge Disposition
- Severity of Illness/Risk of Mortality (SOI/ROM)
- Readmissions for (CHF, Pneumonia, MI etc..)
- Not Otherwise Specified (NOS) Diagnoses
- Clinical Criteria
- Queries and Query opportunities
- Present on Admission (POA)
- Principal diagnosis (PDX) selection
- Secondary diagnosis validation (complication or comorbidity (CC) or a major complication or comorbidity (MCC))

# Section One: The What, How, and Why of Inpatient Auditing

## Concurrent Review

- Similar to a retrospective review except this is more proactive and provides CDI and Coding staff opportunity to interact one-on-one with clinicians to clarify ambiguous documentation prior to discharge and bill submission
  - Principal diagnosis
  - Clinical picture review (treatment and diagnosis match)
  - Ambiguous documentation (concise, consistent)
  - Finalize DRG

# Section One: The What, How, and Why of Inpatient Auditing

## Common MS-DRG Denials Due to CC/MCC

- 166 – Other Respiratory System O.R. Procedures w MCC
- 177 – Respiratory Infections and Inflammations w CC
- 243 – Permanent Cardiac Pacemaker Implant w CC
- 286 – Circulatory Disorders Except AMI, w Cardiac Catheterization w MCC
- 309 – Cardiac Arrhythmia & Conduction Disorders w CC
- 326 – Stomach, Esophageal & Duodenal Procedure w MCC
- 329 – Major Small & Large Bowel Procedures w MCC
- 374 – Digestive Malignancy w MCC
- 380 – Complicated Peptic Ulcer w MCC
- 442 – Disorders of Liver Except Malignancy, Cirrhosis, Alcoholic Hepatitis w CC
- 480 – Hip & Femur Procedures Except Major Joint w MCC
- 823 – Lymphoma & Non-Acute Leukemia w Other Procedure w MCC

# Section One: The What, How, and Why of Inpatient Auditing

## Additional MS-DRGs:

- 813 – Coagulation Disorders
- 871 – Septicemia or Severe Sepsis w/o Mechanical Ventilation & 96 hours w MCC
- 981 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w MCC
- 982 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w CC
- 983 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w/o CC/MCC
- 987 – Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis w MCC
- 988 – Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis w CC

# Section One: The What, How, and Why of Inpatient Auditing

## One CC reported on claim

- Pleural effusion with CHF

## One MCC with and without CCs

- Clinical significance acute respiratory failure
- Clinical significance of pneumonia

## Diagnostic versus therapeutic procedure codes

- Bronchoscopies

# Section One: The What, How, and Why of Inpatient Auditing

Payers pull claims with bronchoscopies procedure codes with the hope of finding an error. Bronchoscopies can be complicated to code. If not coded correctly, can make a major impact on payment.

## **Typically targeted is MS-DRG 163 – 168**

Payer denials with decrease are common with a focus on bronchoscopies that have been assigned to the wrong DRG due to inappropriate usage of the seventh character "Z" for therapeutic which carries more weight as a major procedure instead of the more appropriate seventh character of "X" for diagnostic.

Scenario – Patient with previous visit right upper lobe brushing and BAL suspicious for malignancy. Admitted for diagnostic biopsy by bronchoscopy.

Operative report documentation: "Right VATS with diagnostic biopsies of the right upper lobe, right middle lobe, and left lower lobe by bronchoscopy". Recommend changing procedure codes seventh character from "Z" for therapeutic to "X" for diagnostic. By updating the procedure codes the MS-DRG would move to 168 other respiratory system O.R. procedures without CC/MCC for a decrease in reimbursement of around \$4,000.

By adding changing the procedure codes from therapeutic to diagnostic the MS-DRG shifts from 165 for major chest procedure without CC/MCC to 168 for other respiratory O.R. procedures without CC/MCC for an overall decrease of around \$4,000.

# Section One: The What, How, and Why of Inpatient Auditing

## Sequencing of principal/secondary diagnoses code

- Pulmonary embolism
- Hemorrhagic disorder versus bleed versus blood loss anemia

## POA discrepancy. (principal dx with a POA of “N”)

### Sepsis

- As secondary diagnosis with POA of “Y”
- Clinical significance sepsis

# Section One: The What, How, and Why of Inpatient Auditing

## MS-DRG

- **673** OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC
- **981** EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC
- **940** O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC





# Section One: The What, How, and Why of Inpatient Auditing

## Why Inpatient auditing:

- Ensure quality care
- Aid in quality reporting
- Solidify reimbursement with appropriate payments
- Prevent backend denials and proactively work towards solid rebuttals
- Ensure highest reimbursement is recouped to invest towards advancements within the medical facility and community
- Base performance evaluation on outcomes
- Continuous improvement process identification
- Overall health of the facility

*"For the typical health system, as much as 3.3% of net patient revenue, an average of \$4.9 million per hospital, was put at risk due to denials."*

– Change Healthcare

# Section One: The What, How, and Why of Inpatient Auditing

## 50.6.1 – Routine Monitoring and Auditing

- Sponsors must undertake monitoring and auditing to test and confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements, and all applicable Federal and State laws, as well as internal policies and procedures to protect against Medicare program noncompliance and potential FWA.
- Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

**Source: Chapter IV. CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES Subchapter B. MEDICARE PROGRAM Part 422. MEDICARE ADVANTAGE PROGRAM Subpart K. Application Procedures and Contracts for Medicare Advantage Organizations Section 422.503. General provisions.**

# Section One: The What, How, and Why of Inpatient Auditing

## WHAT IS MEDICARE ABUSE?

- **Abuse** describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards.
- Examples of Medicare abuse include:
  - Billing for unnecessary medical services
  - Charging excessively for services or supplies
  - Misusing codes on a claim, such as upcoding or unbundling codes
- Medicare abuse can also expose providers to criminal and civil liability

# Section One: The What, How, and Why of Inpatient Auditing

## Auditing affects **EVERYONE**

- Patient
- Facility
- Accounts Receivable
- Clinical Documentation Improvement (CDI)
- Coders
- Clinicians
- Compliance (HAC, Patient Safety Indicators)
- Chief Financial Officer (CFO)
- Recovery Audit Contractor (RAC)
- Office of Inspector General (OIG)



# Section One: The What, How, and Why of Inpatient Auditing



# Challenges for Coders

# Section Two: Challenges for Coders

## External Struggles that Lead to Issues

- Time Management
- Productivity
- Accuracy
- Documentation
- Queries
- Physician Education/Response/Interaction
- Gaining further insight into clinical knowledge
- C-suite support

## Coder Struggles with Code Selection

- Procedure coding
  - Body system character selection
  - Diagnostic versus therapeutic
  - Missing procedures
  - Intent/root operation issues
- Diagnosis coding
  - Principal diagnosis selection
  - Clinical validation
  - Sequencing

## Section Two: Challenges for Coders

### Procedure Code Selection – Body System

| <b>MS-DRG 988:</b> NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC<br>ALOS: 5.9    Estimated Reimbursement: \$13,754.56<br>GMLOS: 4.4    DRG Relative Weight: 1.6931  |          | <b>MS-DRG 815:</b> RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC<br>ALOS: 3.9    Estimated Reimbursement: \$7,942.73<br>GMLOS: 3.1    DRG Relative Weight: 0.9777 |                                      |                                     |             |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |
|---|----------|---|--------------------------------------|-------------------------------------|-------------|---|----------|---------|--------------------------------------|---|--|---|---|---|-----------|-------------|----------|---|----------|--|---------|-------------------------------------|--|
| <b>Billing DX</b> Admit DX: S21.232A  |          | <b>Audit DX</b> → Pull Codes    Admit DX: S21.232A  |                                      |                                     |             |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |
| <b>Billing PX</b> <table border="1"> <thead> <tr> <th>P</th> <th>F</th> <th>Procedure</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>1</td> <td><b>P</b></td> <td>0WQLXZZ</td> <td>Repair Lower Back, External Approach</td> </tr> </tbody> </table> |          | P   | F                                    | Procedure                           | Description | 1 | <b>P</b> | 0WQLXZZ | Repair Lower Back, External Approach | <b>Audit PX</b> <table border="1"> <thead> <tr> <th>P</th> <th>F</th> <th>S</th> <th>Procedure</th> <th>Description</th> <th>Provider</th> </tr> </thead> <tbody> <tr> <td>1</td> <td><b>P</b></td> <td></td> <td>0HQ6XZZ</td> <td>Repair Back Skin, External Approach</td> <td></td> </tr> </tbody> </table> |  | P | F | S | Procedure | Description | Provider | 1 | <b>P</b> |  | 0HQ6XZZ | Repair Back Skin, External Approach |  |
| P   | F        | Procedure   | Description                          |                                     |             |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |
| 1   | <b>P</b> | 0WQLXZZ   | Repair Lower Back, External Approach |                                     |             |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |
| P   | F        | S   | Procedure                            | Description                         | Provider    |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |
| 1   | <b>P</b> |   | 0HQ6XZZ                              | Repair Back Skin, External Approach |             |   |          |         |                                      |   |  |   |   |   |           |             |          |   |          |  |         |                                     |  |

Patient admitted due to bicycle accident with splenic laceration, fractures of left ribs, and puncture wound left lower back.

0WQLXZZ Repair Lower Back, External Approach is coded as the principal procedure. By changing 0WQLXZZ to 0HQ6XZZ Repair Back Skin, External Approach.

By changing the principal procedure to 0HQ6XZZ, the MS-DRG shifts from 988 Non-extensive O.R. proc unrelated to principal diagnosis w CC to 815 Reticuloendothelial & immunity disorders w CC for a decrease of \$5,811.83.

In this scenario the body system should have been skin/back and not lower back. This shows how in some instances the body system character can have an impact on the DRG/reimbursement.



# Section Two: Challenges for Coders

## Procedure Code Selection – Diagnostic/Therapeutic Qualifier

|   |          |  |   |
|---|----------|--|---|
| <b>MS-DRG 981:</b> EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC<br><b>ALOS:</b> 11.4 <b>Estimated Reimbursement:</b> \$31,593.25<br><b>GMLOS:</b> 8.4 <b>DRG Relative Weight:</b> 4.3705 |          | <b>MS-DRG 228:</b> OTHER CARDIOTHORACIC PROCEDURES W MCC<br><b>ALOS:</b> 9.7 <b>Estimated Reimbursement:</b> \$47,537.67<br><b>GMLOS:</b> 6.7 <b>DRG Relative Weight:</b> 6.5762 |   |
| <b>Billing DX</b> Admit DX: D15.1   |          | <b>Audit DX</b> → Pull Codes    Admit DX: D15.1  |   |
| <b>Billing PX</b>   |          | <b>Audit PX</b>  |   |
| P   | F        | Procedure  | Description                                 |
| 1   | <b>P</b> | <a href="#">02B70ZX</a>  | Excision of Left Atrium, Open Approach,...  |
| 2   |          | <a href="#">0WCQ8ZZ</a>  | Extirpation of Matter from Respiratory T... |
| 3   |          | <a href="#">5A1221Z</a>  | Performance of Cardiac Output, Contin...    |
| 4   |          | <a href="#">8E0W0CZ</a>  | Robotic Assisted Procedure of Trunk Re...   |

Patient found to have an atrial myxoma with admission for resection of left atrial myxoma.

02B70ZX Excision of Left Atrium, Open Approach, Diagnostic is coded as the principal procedure.

Documentation on the procedure report notes, "The robotic left atrial lift retractor facilitated exposure. It was sharply dissected out. Once the mass was excised was sent for pathological examination. We made sure there was no residual mass left or no stalk or even sessile portion of it. We were able to confirm no residual mass and the left atriotomy was then closed with 3-0 Prolene." Procedure performed was more than a biopsy.

Revision of 02B70ZX to 02BF0ZZ Excision of Left Atrium, Open Approach.

By revising principal procedure to 02BF0ZZ, the MS-DRG shifts from 981 Extensive O.R. procedure unrelated to principal diagnosis w MCC to 228 Other cardiothoracic procedures w MCC for a potential increase of \$15,944.42.

# Section Two: Challenges for Coders

## Procedure Code Selection – Missing Procedure

**MS-DRG 177:** RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC  
 ALOS: 6.9      Estimated Reimbursement: \$13,756.26  
 GMLOS: 5.5      DRG Relative Weight: 1.8912

**MS-DRG 208:** RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS  
 ALOS: 6.8      Estimated Reimbursement: \$18,159.27  
 GMLOS: 4.9      DRG Relative Weight: 2.4841

**Billing DX**      Admit DX: R41.82
 

| P | F  | H   | Diag(s) | Description              | POA |
|---|----|-----|---------|--------------------------|-----|
| 1 | P  | HCC | J15.1   | Pneumonia due to P...    | Y   |
| 2 | MC |     | G93.41  | Metabolic encephal...    | Y   |
| 3 | CC | HCC | Z68.43  | Body mass index (B...    |     |
| 4 | CC | HCC | J96.10  | Chronic respiratory f... | Y   |
| 5 | CC | HCC | Z99.11  | Dependence on res...     |     |
| 6 | CC |     |         |                          |     |

**Audit DX**      Pull Codes      Admit DX: R41.82
 

| P | S | F  | H   | Diag(s) | Description                                   | POA |   |
|---|---|----|-----|---------|---|-----|---|
| 1 | 1 | P  | HCC | J15.1   | Pneumonia due to Pseudomonas                  | Y   | ✗ |
| 2 | 2 | MC |     | G93.41  | Metabolic encephalopathy                      | Y   | ✗ |
| 3 | 3 | CC | HCC | Z68.43  | Body mass index (BMI) 50.0-59.9, adult        |     | ✗ |
| 4 | 4 | CC | HCC | J96.10  | Chronic respiratory failure, unspecified w... | Y   | ✗ |
| 5 | 5 | CC | HCC | Z99.11  | Dependence on respirator [ventilator] st...   |     | ✗ |

**Billing PX**

| P | F | Procedure | Description                            |
|---|---|-----------|--|
| 1 | P | 0B21XFZ   | Change Tracheostomy Device in Trach... |

**Audit PX**

| P | F | S | Procedure | Description  |
|---|---|---|-----------|--|
| 1 | P | 1 | 0B21XFZ   | Change Tracheostomy Device in Trachea, External Approach |
| 2 |   |   | 5A1935Z   | Respiratory Ventilation, Less than 24 Consecutive Hours  |

Validation

Patient with history of chronic respiratory failure with ventilator dependence on tracheostomy, admitted due to pneumonia. In this scenario the patient is using their own equipment.

Add procedure code 5A1935Z Respiratory Ventilation, Less than 24 Consecutive Hours to reflect flowsheet.

Initial claim missed ventilation code reporting. By adding secondary procedure 5A1935Z Respiratory Ventilation, Less than 24 Consecutive Hours, the MS-DRG shifts from 177 Respiratory infections & inflammations w MCC to 208 Respiratory system diagnosis w ventilator support <=96 hours for an increase of \$4,403.01 and change in Severity of Illness from 3 to 4.

# Section Two: Challenges for Coders

## *Missing Procedure Continued...*

### ***Coding Clinic, 2018, Q1 – Mechanical Ventilation Using Patient’s Equipment***

**Question:** A patient with progressive muscular dystrophy, who is “vent dependent” at night and uses mechanical ventilation as needed during the day, is admitted to the hospital with acute on chronic respiratory failure. While in the hospital, the patient was connected to his own ventilator equipment via his tracheostomy tube. The respiratory therapist evaluated and monitored the patient throughout the hospitalization. Would it be appropriate to assign an ICD-10-PCS code for the use of the patient’s ventilator?

**Answer:** It is appropriate to report mechanical ventilation, for patients who are admitted to the hospital on a home ventilator, since the patient is still being evaluated and monitored as well as receiving ventilator assistance. The patient is utilizing hospital resources, and ownership of the equipment has no bearing on code assignment in this case.

Count the hours of ventilation according to established guidelines. Begin counting the duration of mechanical ventilation when ventilation starts. For example, if the patient receives mechanical ventilation for 18 hours, assign the following code:

***5A1935Z Respiratory ventilation, less than 24 consecutive hours***

Additionally, assign ICD-10-CM codes for the progressive muscular dystrophy, acute on chronic respiratory failure as well as Z99.11, Dependence on respirator [ventilator] status, to indicate the patient’s dependence on mechanical ventilation.

# Section Two: Challenges for Coders

## Procedure Code Selection – Intent/Definition

|   |   |   |   |            |   |   |         |   |
|---|---|---|---|------------|---|---|---------|---|
| <b>MS-DRG 981:</b> Extensive O.R. procedure unrelated to principal diagnosis w MCC<br><b>ALOS:</b> 11.5 <b>Estimated Reimbursement:</b> \$31,028.60<br><b>GMLOS:</b> 8.4 <b>DRG Relative Weight:</b> 4.4907 |   | <b>MS-DRG 004:</b> Trach w MV >96 hrs or PDX exc face, mouth & neck w/o maj O.R.<br><b>ALOS:</b> 23.8 <b>Estimated Reimbursement:</b> \$78,109.38<br><b>GMLOS:</b> 19.6 <b>DRG Relative Weight:</b> 11.5438 |   | Validation |   |   |         |   |
| <b>Billing DX</b> Admit DX: T78.3XXA  |   | <b>Audit DX</b> Pull Codes    Admit DX: T78.3XXA  |   |            |   |   |         |   |
| <b>Billing PX</b>   |   | <b>Audit PX</b>   |   |            |   |   |         |   |
| P   | F | Procedure   | Description                                 |            | P | F | S       | Procedure   |
| 1   | P | 0BB10ZZ   | Excision of Trachea, Open Approach          | 1          | P |   | 0B110F4 | Bypass Trachea to Cutaneous with Tracheostomy Device, Open Approach         |
| 2   |   | 02HV33Z   | Insertion of Infusion Device into Superi... | 2          |   | 2 | 02HV33Z | Insertion of Infusion Device into Superior Vena Cava, Percutaneous Appr     |
| 3   |   | 0BH18EZ   | Insertion of Endotracheal Airway into T...  | 3          |   | 3 | 0BH18EZ | Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Op |
| 4   |   | 5A1945Z   | Respiratory Ventilation, 24-96 Consecu...   | 4          |   | 4 | 5A1945Z | Respiratory Ventilation, 24-96 Consecutive Hours                            |

Patient with angioedema in acute respiratory failure with emergency need to ventilate.

Cricothyroidotomy was performed at bedside percutaneously with insertion of endotracheal tube.

Initial claim reported 0BB10ZZ for excision of trachea, open approach. PCS root operations definition of "Excision = the cutting out or off, without replacement, a portion of a body part". In this scenario an incision is made with no tissue of the trachea being removed.

The root operation of "excision would not be appropriate for cricothyroidotomy".

0B113F4 for bypass trachea to cutaneous with tracheostomy device. By changing the PCS code the MS-DRG shifts from MS-DRG 981 Extensive O.R. procedure unrelated to principal diagnosis w MCC to MS-DRG 004 Tracheostomy with Mechanical Vent > 96 hours or procedure excluding face, mouth and neck without major O.R. for an **increase** of \$46,780.53.

# Section Two: Challenges for Coders

## Procedure Code Selection – Intent/Definition

### ***Procedure Report:***

|                                  |                   |
|----------------------------------|-------------------|
| <b>Preprocedural Diagnosis:</b>  | Emergent airway   |
| <b>Postprocedural Diagnosis:</b> | Emergent airway   |
| <b>Procedure Performed:</b>      | Cricothyroidotomy |

**Indication:** I was called stat to the emergency department to establish an airway on a patient undergoing cardiopulmonary resuscitation. The patient had morbid obesity.

**Description of the Procedure:** The patient's neck was prepped with Betadine. I made a longitudinal incision overlying what was felt to be the thyroid cartilage. After multiple attempts, I was able to access the trachea just below the thyroid cartilage with a needle. A wire passed through the needle and a cricothyroidotomy tube was passed over the wire in a Seldinger technique.

The patient had adequate breath sounds after placement of the airway. CPR was ongoing. The tube was secured.

# Section Two: Challenges for Coders

## Procedure Code Selection – Intent/Definition

### AHA Coding Clinic Response:

*“Based on the operative note, assign code 0B110F4, Bypass trachea to cutaneous with tracheostomy device, open approach, for the cricothyroidotomy. This procedure meets the definition of Bypass; altering the route of passage through a tubular body part. The tube was inserted through the trachea to establish a patent airway; bypass the normal route of respiration”.*

*~AHA Coding Clinic, (Internal Response)*



# Section Two: Challenges for Coders

## Procedure Code Selection – Intent/Definition

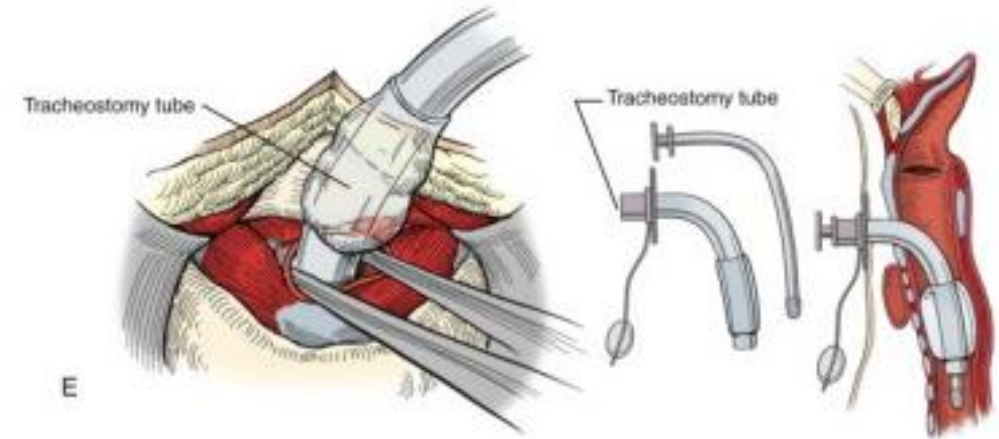
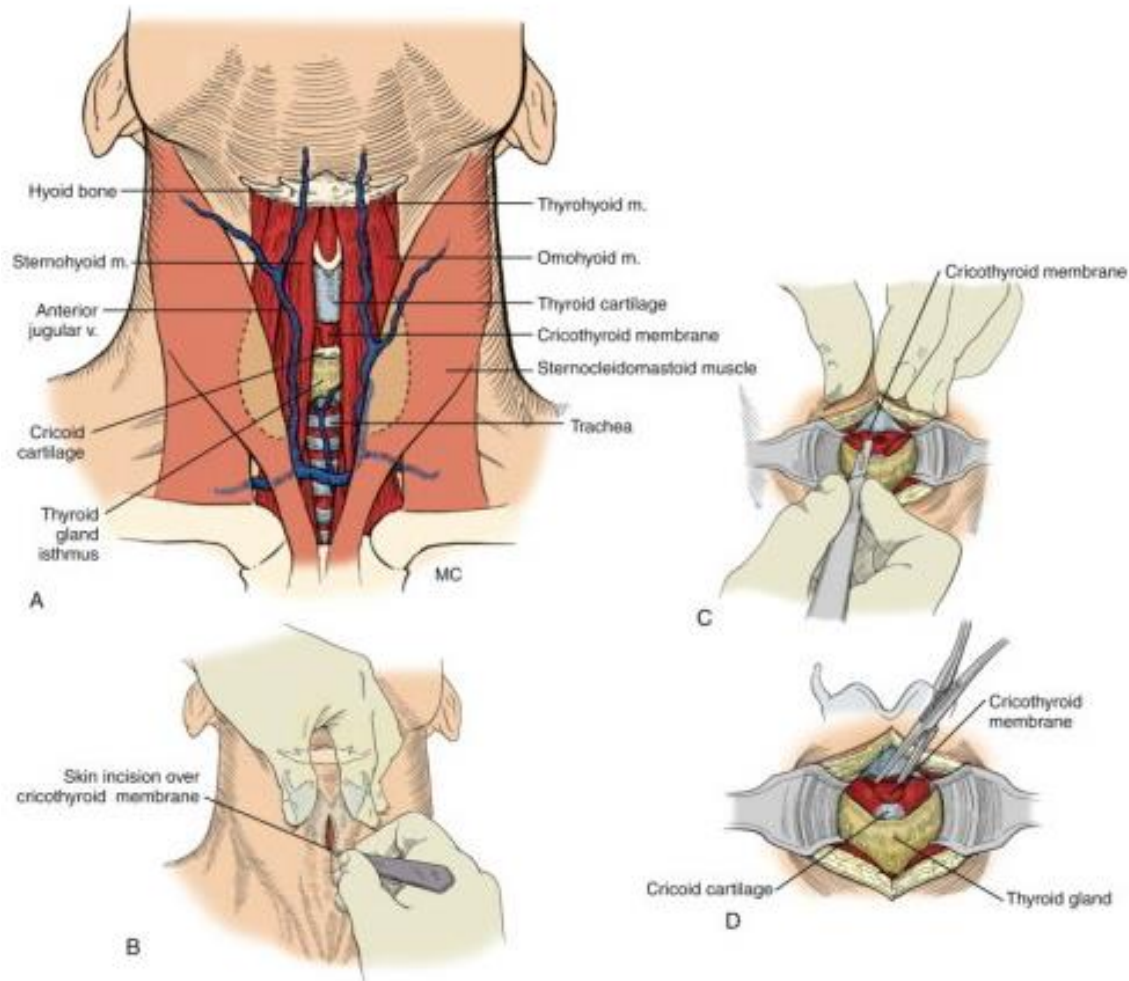


Image Source: Gog.net. (n.d.). *Cricothyroidotomy* [Image]. Retrieved from <https://www.gog.net.nz/SkillCricothyroidotomy.html>

# Section Two: Challenges for Coders

## Sequencing and Principal Diagnosis Selection, POA of “No” on Principal Diagnosis and Principal Procedure Revisions

Validation

|   |  |      |   |  |  |   |  |     |   |  |  |
|---|--|------|---|--|--|---|--|-----|---|--|--|
| <b>MS-DRG 987:</b> NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC |  |      |   |  |  | <b>MS-DRG 871:</b> SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC |  |     |   |  |  |
| <b>ALOS:</b>  |  | 10.8 | <b>Estimated Reimbursement:</b> \$24,090.52 |  |  | <b>ALOS:</b>  |  | 6.3 | <b>Estimated Reimbursement:</b> \$13,419.44 |  |  |
| <b>GMLOS:</b>   |  | 8.1  | <b>DRG Relative Weight:</b> 3.3326          |  |  | <b>GMLOS:</b>   |  | 4.8 | <b>DRG Relative Weight:</b> 1.8564          |  |  |

| Billing DX |    |     |         |                          |     | Admit DX: A41.9 |  |
|------------|----|-----|---------|--------------------------|-----|-----------------|--|
| P          | F  | H   | Diag(s) | Description              | POA |                 |  |
| 1          | P  |     | R19.7   | Diarrhea, unspecified    | N   |                 |  |
| 2          | MC | HCC | A41.9   | Sepsis, unspecified ...  | Y   |                 |  |
| 3          | MC | HAC | N15.1   | Renal and perinephr...   | Y   |                 |  |
| 4          | CC |     | A04.72  | Enterocolitis due to ... | N   |                 |  |
| 5          | CC | HAC | N10     | Acute pyelonephritis     | Y   |                 |  |
| 6          |    |     | N20.0   | Calculus of kidney       | Y   |                 |  |
| 7          |    |     | K80.20  | Calculus of gallbladd... | Y   |                 |  |

| Audit DX |   |    |     |         |  | Pull Codes |   | Admit DX: A41.9 |  |
|----------|---|----|-----|---------|--|------------|---|-----------------|--|
| P        | S | F  | H   | Diag(s) | Description  | POA        |   |                 |  |
| 1        | 2 | P  | HCC | A41.9   | Sepsis, unspecified organism                         | Y          | ✗ |                 |  |
| 2        | 3 | MC | HAC | N15.1   | Renal and perinephric abscess                        | Y          | ✗ |                 |  |
| 3        | 4 | CC |     | A04.72  | Enterocolitis due to Clostridium difficile, not s... | N          | ✗ |                 |  |
| 4        | 5 | CC | HAC | N10     | Acute pyelonephritis                                 | Y          | ✗ |                 |  |
| 5        | 6 |    |     | N20.0   | Calculus of kidney                                   | Y          | ✗ |                 |  |
| 6        | 7 |    |     | K80.20  | Calculus of gallbladder without cholecystitis ...    | Y          | ✗ |                 |  |
| 7        | 8 |    |     | K21.9   | Gastro-esophageal reflux disease without es...       | Y          | ✗ |                 |  |

Patient admitted for sepsis, left sided pyelonephritis with nonobstructive nephrolithiasis, and left renal abscess.

R19.7 Diarrhea, unspecified is coded as the principal diagnosis with a POA of “N” for NO. A symptom as principal diagnosis, a principal diagnosis with a POA of “No”, and the MS-DRG of 987 would all be considered a red flag for an auditor to review. This claim should have been checked prior to being sent out for payment.



## Section Two: Challenges for Coders

### Sequencing and Principal Diagnosis Selection, POA of “No” on Principal Diagnosis and Principal Procedure Revisions

| Billing PX |   |                         |   | Audit PX |   |   |                         |   |
|------------|---|-------------------------|---|----------|---|---|-------------------------|---|
| P          | F   | Procedure               | Description                             | P        | F   | S | Procedure               | Description   |
| 1          |  | <a href="#">0T9470Z</a> | Drainage of Left Kidney Pelvis with ... | 1        |  |   | <a href="#">0T9130Z</a> | Drainage of Left Kidney with Drainage Device, Percutaneous Approach             |
| 2          |   | <a href="#">0DJ08ZZ</a> | Inspection of Upper Intestinal Tract... | 2        |   | 2 | <a href="#">0DJ08ZZ</a> | Inspection of Upper Intestinal Tract, Via Natural or Artificial Opening Endo... |

Additionally on this case... the principal procedure code was revised with impact on the MS-DRG selection.

0T9470Z Drainage of Left Kidney Pelvis with Drainage Device, **Via Natural or Artificial Opening** is coded as the principal procedure.

Principal procedure revision warranted from 0T9470Z Drainage of Left Kidney Pelvis with Drainage Device, Via Natural or Artificial Opening to 0T9130Z Drainage of Left Kidney with Drainage Device, **Percutaneous Approach** to reflect documentation on CT guided placement of left renal abscess drainage catheter procedure note "A suitable skin site was prepped and draped in sterile fashion following CT localization. An 18 gauge Yueh needle was advanced under CT guidance into the fluid collection and a 0.035 guidewire was used to place a 8 French abscess drainage catheter after the fashion tract was dilated."

# Section Two: Challenges for Coders

## Sequencing and Principal Diagnosis Selection, POA of “No” on Principal Diagnosis and Principal Procedure Revisions

| MS-DRG 987: NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC |      |                          |             | MS-DRG 871: SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC |     |                          |             |
|--|------|--------------------------|-------------|--|-----|--------------------------|-------------|
| ALOS:  | 10.8 | Estimated Reimbursement: | \$24,090.52 | ALOS:  | 6.3 | Estimated Reimbursement: | \$13,419.44 |
| GMLOS:   | 8.1  | DRG Relative Weight:     | 3.3326      | GMLOS:   | 4.8 | DRG Relative Weight:     | 1.8564      |

| Billing DX |    |     |         |                          |     | Audit DX |   |    |     |         |  |     |
|------------|----|-----|---------|--------------------------|-----|----------|---|----|-----|---------|--|-----|
| P          | F  | H   | Diag(s) | Description              | POA | P        | S | F  | H   | Diag(s) | Description  | POA |
| 1          | P  |     | R19.7   | Diarrhea, unspecified    | N   | 1        | 2 | P  | HCC | A41.9   | Sepsis, unspecified organism                         | Y   |
| 2          | MC | HCC | A41.9   | Sepsis, unspecified ...  | Y   | 2        | 3 | MC | HAC | N15.1   | Renal and perinephric abscess                        | Y   |
| 3          | MC | HAC | N15.1   | Renal and perinephr...   | Y   | 3        | 4 | CC |     | A04.72  | Enterocolitis due to Clostridium difficile, not s... | N   |
| 4          | CC |     | A04.72  | Enterocolitis due to ... | N   | 4        | 5 | CC | HAC | N10     | Acute pyelonephritis                                 | Y   |
| 5          | CC | HAC | N10     | Acute pyelonephritis     | Y   |          |   |    |     |         |  |     |
| 6          |    |     | N20.0   | Calculus of bladder      |     |          |   |    |     |         |  |     |
| 7          |    |     | K80.20  | Calculus of gallbladder  |     |          |   |    |     |         |  |     |

| Billing PX |   |           |   | Audit PX |   |   |           |   |
|------------|---|-----------|---|----------|---|---|-----------|---|
| P          | F | Procedure | Description                             | P        | F | S | Procedure | Description   |
| 1          | P | 0T9470Z   | Drainage of Left Kidney Pelvis with ... | 1        | P |   | 0T9130Z   | Drainage of Left Kidney with Drainage Device, Percutaneous Approach             |
| 2          |   | 0D08ZZ    | Inspection of Upper Intestinal Tract... | 2        |   | 2 | 0D08ZZ    | Inspection of Upper Intestinal Tract, Via Natural or Artificial Opening Endo... |

By sequencing principal diagnosis to A41.9 and revising principal procedure to 0T9130Z, the MS-DRG shifts from 987 Non-extensive O.R. proc unrelated to principal diagnosis w MCC to 871 Septicemia or severe sepsis w/o MV >96 hours w MCC for a decrease of \$10,671.08.

# Section Two: Challenges for Coders

## Sequencing and Principal Diagnosis Selection

Validation

|   |    |      |                          |                             |             |   |    |      |                          |         |  |   |
|---|----|------|--------------------------|-----------------------------|-------------|---|----|------|--------------------------|---------|--|---|
| MS-DRG 166: Other resp system O.R. procedures w MCC |    |      |                          |                             |             | MS-DRG 981: Extensive O.R. procedure unrelated to principal diagnosis w MCC |    |      |                          |         |  |   |
| ALOS:   |    | 10.2 | Estimated Reimbursement: |                             | \$23,119.00 | ALOS:   |    | 11.5 | Estimated Reimbursement: |         | \$26,031.57  |   |
| GMLOS:  |    | 7.9  | DRG Relative Weight:     |                             | 3.7307      | GMLOS:  |    | 8.4  | DRG Relative Weight:     |         | 4.4907   |   |
| 1   | P  | HCC  | C78.2                    | Secondary malignant ...     | Y           | 1   | 10 | P    | HCC                      | C50.911 | Malignant neoplasm of unspecified site of right femal... | Y |
| 2   | MC | HCC  | N17.0                    | Acute kidney failure wi...  | N           | 2   | 2  | MC   | HCC                      | N17.0   | Acute kidney failure with tubular necrosis               | N |
| 3   |    |      | J91.0                    | Malignant pleural effu...   | Y           | 3   | 3  | CC   |                          | J91.0   | Malignant pleural effusion                               | Y |
| 4   |    |      | Z66                      | Do not resuscitate          | N           | 4   | 4  |      |                          | Z66     | Do not resuscitate                                       | N |
| 5   |    |      | Z51.5                    | Encounter for palliativ...  | N           | 5   | 5  |      |                          | Z51.5   | Encounter for palliative care                            | N |
| 6   |    |      | I95.81                   | Postprocedural hypot...     | N           | 6   | 6  |      |                          | I95.81  | Postprocedural hypotension                               | N |
| 7   |    | HCC  | I11.0                    | Hypertensive heart dis...   | Y           | 7   | 7  |      | HCC                      | I11.0   | Hypertensive heart disease with heart failure            | Y |
| 8   |    | HCC  | I50.9                    | Heart failure, unspecifi... | Y           | 8   | 8  |      | HCC                      | I50.9   | Heart failure, unspecified                               | Y |
| 9   |    | HCC  | J44.9                    | Chronic obstructive p...    | Y           | 9   | 9  |      | HCC                      | J44.9   | Chronic obstructive pulmonary disease, unspecified       | Y |
| 10  |    | HCC  | C50.911                  | Malignant neoplasm o...     | Y           |   |    |      |                          |         |  |   |

Patient with metastatic breast cancer and recurring right malignant pleural effusion, admitted for right thoracoscopic drainage of effusion w/ catheter placement and chemical pleurodesis.

C78.2 Secondary malignant neoplasm of pleura is coded as the principal diagnosis with J91.0 Malignant pleural effusion and C50.911 Malignant neoplasm of unspecified site of right female breast coded as secondary diagnoses.

Documentation throughout chart of malignant pleural effusion, suspect breast CA as primary.

By sequencing C50.911 as principal diagnosis, the MS-DRG shifts from 166 Other resp system O.R. procedures w MCC to 981 Extensive O.R. procedure unrelated to principal diagnosis w MCC for an increase of \$2,912.57.

# Challenges for Clinicians & Clinical Documentation Improvement Team

**Basically, Everyone!**

# Section Three: Challenges for Clinicians & CDI

## Clinician:

- Too many queries
- Denials
- Conflicting education
- Lawsuits
- Documentation requirements
- Patient Satisfaction Surveys
- HACs
- Moral Injury

## CDI:

- Time Management
- Productivity
- Accuracy
- Documentation
- Queries
- Physician Education/Response Rates/Interaction
- Application of Clinical knowledge to Coding Guidelines
- C-suite support

# Section Three: Challenges for Everyone

## Clinical Validation – Acute Respiratory Failure & Only MCC

MS-DRG 177: Respiratory infections & inflammations w MCC

ALOS: 6.9

Estimated Reimbursement: \$13,896.81

GMLOS: 5.5

DRG Relative Weight: 1.8912

MS-DRG 178: Respiratory infections & inflammations w CC

ALOS: 5.1

Estimated Reimbursement: \$9,249.19

GMLOS: 4.2

DRG Relative Weight: 1.2433

Billing DX

Admit DX: J18.9

| P | F  | H   | Diag(s) | Description              | POA |
|---|----|-----|---------|--------------------------|-----|
| 1 | P  | HCC | J15.1   | Pneumonia due to P...    | Y   |
| 2 | MC | HCC | J96.21  | Acute and chronic r...   | Y   |
| 3 | CC | HCC | J44.0   | Chronic obstructive ...  | Y   |
| 4 | CC | HCC | J44.1   | Chronic obstructive ...  | Y   |
| 5 | CC | HCC | R64     | Cachexia                 | Y   |
| 6 | CC |     | Z68.1   | Body mass index (B...    |     |
| 7 |    | HCC | I48.0   | Paroxysmal atrial fib... | Y   |

Audit DX

Pull Codes

Admit DX: J18.9

| P | S | F  | H   | Diag(s) | Description   | POA |
|---|---|----|-----|---------|---|-----|
| 1 | 1 | P  | HCC | J15.1   | Pneumonia due to Pseudomonas                            | Y   |
| 2 | 3 | CC | HCC | J44.0   | Chronic obstructive pulmonary disease with (acute) l... | Y   |
| 3 | 4 | CC | HCC | J44.1   | Chronic obstructive pulmonary disease with (acute) ...  | Y   |
| 4 | 5 | CC | HCC | R64     | Cachexia  | Y   |
| 5 | 6 | CC |     | Z68.1   | Body mass index (BMI) 19.9 or less, adult               |     |
| 6 | 7 |    | HCC | I48.0   | Paroxysmal atrial fibrillation                          | Y   |
| 7 | 8 |    |     | I10     | Essential (primary) hypertension                        | Y   |

Validation

Chart pulled for review of respiratory failure as one MCC.

Patient with severe COPD on supplemental oxygen, presents to the emergency department with c/o right sided chest pain and cough.



# **Section Three: Challenges for Everyone**

## **Clinical Validation – Acute Respiratory Failure & Only MCC**

### **Clinical Indicators:**

On H&P, documentation of "Admits to chronic SOB req 2 L NC throughout day and 4 L NC at night. Physical Exam: Respiration 16 Oxygen Saturation 95% Respiratory: B/L expiratory crackles/wheezing to right lung, stable on 2 L NC.

ABG noted as normal on H&P. Emergency Room Record: Pulmonary: Effort: Pulmonary effort is normal. No respiratory distress. SpO2 of 87%, not on supplemental O2." ED nurse note of "oxygen placed at 2 lpm via nc."

### **Documentation:**

"Acute on chronic hypoxemic respiratory failure: On 2 L NC during day and 4 L NC at night. Continue supportive measures" is documented on the H&P. Agree with coding of J96.21 as indicated in Coding Clinic, Fourth Quarter ICD-10 2016 Pages: 147-149 Clinical criteria and code assignment; if a diagnosis is documented, regardless of how the diagnosis was arrived at, the code for the diagnosis can be assigned.

## Section Three: Challenges for Everyone

### Coding Clinic, Fourth Quarter ICD-10 2016 Pages: 147-149 Clinical criteria and code assignment:

**Question:** Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." Some people are interpreting this to mean that clinical documentation improvement (CDI) specialists should no longer question diagnostic statements that don't meet clinical criteria. Is this true?



## Section Three: Challenges for Everyone

**Answer:** Coding must be based on provider documentation. This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. Coding Clinic and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in Coding Clinic over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient. As also stated in Coding Clinic in the past, clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition...

While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria. In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned...

A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.

# Section Three: Challenges for Everyone

## Clinical Validation – Sepsis

MS-DRG 872: Septicemia or severe sepsis w/o MV >96 hours w/o MCC

ALOS: 4.3    Estimated Reimbursement: \$7,989.87

GMLOS: 3.6    DRG Relative Weight: 1.0393

MS-DRG 603: Cellulitis w/o MCC

ALOS: 3.8    Estimated Reimbursement: \$6,682.86

GMLOS: 3.2    DRG Relative Weight: 0.8435

Billing DX

Admit DX: A41.9

| P | F  | H   | Diag(s) | Description                | POA |
|---|----|-----|---------|----------------------------|-----|
| 1 | P  | HCC | A41.9   | Sepsis, unspecified ...    | Y   |
| 2 | CC |     | L03.114 | Cellulitis of left uppe... | Y   |
| 3 |    |     | Z87.891 | Personal history of n...   |     |
| 4 |    |     | Z79.51  | Long term (current) ...    |     |
| 5 |    |     | Z79.899 | Other long term (cur...    |     |
| 6 |    |     | F10.10  | Alcohol abuse, unco...     | Y   |
| 7 |    |     | K29.20  | Alcoholic gastritis wi...  | Y   |
| 8 |    | HCC | J43.9   | Emphysema, unsp...         | Y   |

Audit DX

Pull Codes

Admit DX: A41.9

| P | S | F | H   | Diag(s) | Description                                 | POA |   |
|---|---|---|-----|---------|---|-----|---|
| 1 | 2 | P |     | L03.114 | Cellulitis of left upper limb               | Y   | ✗ |
| 2 | 3 |   |     | Z87.891 | Personal history of nicotine dependence     |     | ✗ |
| 3 | 4 |   |     | Z79.51  | Long term (current) use of inhaled steroids |     | ✗ |
| 4 | 5 |   |     | Z79.899 | Other long term (current) drug therapy      |     | ✗ |
| 5 | 6 |   |     | F10.10  | Alcohol abuse, uncomplicated                | Y   | ✗ |
| 6 | 7 |   |     | K29.20  | Alcoholic gastritis without bleeding        | Y   | ✗ |
| 7 | 8 |   | HCC | J43.9   | Emphysema, unspecified                      | Y   | ✗ |

Validation

Chart pulled for review of sepsis as principal diagnosis, length of stay one day, and discharge to home.

Patient with presentation of left arm elbow redness and swelling, abdominal pain, and chest pain. One to two day stays with sepsis diagnosis are heavily audited and returned by payers for denial.

# Section Three: Challenges for Everyone

## Clinical Validation – Sepsis as Principal (Possible “Ruled-out”)

### Clinical Picture:

- Normal WBC count
- No fever
- Lactic acid elevated
- Elevated total bilirubin
- Elevated albumin
- Elevated ALT
- Elevated immature granulocyte

ED, H&P, and progress note documentation of "cellulitis/sepsis" and "gastritis" with antibiotics given, blood cultures (no growth), EKG ordered, chest x-ray, troponin lab work, chem profile, CBC, CIWA alcohol abuse protocol started with thiamine, folic acid and MVT given. However, discharge summary does not note sepsis. It should be noted that the coder was limited on code selection with sepsis being documented for such a short stay. However, sepsis was not documented on the discharge summary and could be interpreted by an external reviewer to be "ruled out."

# Section Three: Challenges for Everyone

## Clinical Validation – Sepsis with One CC

MS-DRG 854: Infectious & parasitic diseases w O.R. procedure w CC

ALOS: 7.1

Estimated Reimbursement: \$14,364.15

GMLOS: 5.7

DRG Relative Weight: 2.2028

MS-DRG 661: Kidney & ureter procedures for non-neoplasm w/o CC/MCC

ALOS: 2.3

Estimated Reimbursement: \$6,995.58

GMLOS: 2

DRG Relative Weight: 1.0728

Billing DX

Admit DX: R11.10

| P | F  | H   | Diag(s) | Description              | POA |
|---|----|-----|---------|--------------------------|-----|
| 1 | P  | HCC | A41.9   | Sepsis, unspecified ...  | Y   |
| 2 | CC | HAC | N13.6   | Pyonephrosis             | Y   |
| 3 |    |     | B96.20  | Unspecified Escheric...  | Y   |
| 4 |    |     | E78.5   | Hyperlipidemia, uns...   | Y   |
| 5 |    |     | K21.9   | Gastro-esophageal r...   | Y   |
| 6 |    |     | E03.9   | Hypothyroidism, uns...   | Y   |
| 7 |    |     | I10     | Essential (primary) h... | Y   |
| 8 |    |     | E86.0   | Dehydration              | Y   |

Audit DX

Pull Codes

Admit DX: R11.10

| P | S | F | H   | Diag(s) | Description   | POA |
|---|---|---|-----|---------|---|-----|
| 1 | 2 | P | HAC | N13.6   | Pyonephrosis  | Y   |
| 2 | 3 |   |     | B96.20  | Unspecified Escherichia coli [E. coli] as the cause of d... | Y   |
| 3 | 4 |   |     | E78.5   | Hyperlipidemia, unspecified                                 | Y   |
| 4 | 5 |   |     | K21.9   | Gastro-esophageal reflux disease without esophagitis        | Y   |
| 5 | 6 |   |     | E03.9   | Hypothyroidism, unspecified                                 | Y   |
| 6 | 7 |   |     | I10     | Essential (primary) hypertension                            | Y   |
| 7 | 8 |   |     | E86.0   | Dehydration   | Y   |
| 8 | 9 |   |     | M19.90  | Unspecified osteoarthritis, unspecified site                | Y   |

Validation

**Chart pulled for review of sepsis with one CC.**

### Documentation:

Patient having sepsis noted throughout the chart with patient having ureteral stone and hydronephrosis.

### Clinical Indicators:

Sepsis criteria maybe questioned as patient has only a low grade fever, lactic acid is not elevated.

# Section Three: Challenges for Everyone

## Clinical Validation – Acute Respiratory Failure as only MCC

MS-DRG 742: UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/ CC/MCC

ALOS: 3.9

Estimated Reimbursement: \$12,390.08

GMLOS: 3

DRG Relative Weight: 1.714

MS-DRG 743: UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC

ALOS: 2

Estimated Reimbursement: \$8,064.39

GMLOS: 1.8

DRG Relative Weight: 1.1156

Billing DX

Admit DX: D25.9

| P | F  | H   | Diag(s) | Description  | POA |
|---|----|-----|---------|--|-----|
| 1 | P  |     | D25.9   | Leiomyoma of uterus, unspecified                       | Y   |
| 2 | MC | HCC | J96.21  | Acute and chronic renal tubular necrosis               | N   |
| 3 |    |     | N95.0   | Postmenopausal bleeding                                | Y   |
| 4 |    |     | R93.89  | Abnormal findings on diagnostic imaging of other sites | Y   |
| 5 |    | HCC | J44.9   | Chronic obstructive pulmonary disease, unspecified     | Y   |
| 6 |    |     | I10     | Essential (primary) hypertension                       | Y   |
| 7 |    |     | F17.210 | Nicotine dependence, cigarettes, uncomplicated         | Y   |
| 8 |    |     | E66.9   | Obesity, unspecified                                   | Y   |

Audit DX

Pull Codes

Admit DX: D25.9

| P | S | F | H   | Diag(s) | Description  | POA |
|---|---|---|-----|---------|--|-----|
| 1 | 1 | P |     | D25.9   | Leiomyoma of uterus, unspecified                       | Y   |
| 2 | 3 |   |     | N95.0   | Postmenopausal bleeding                                | Y   |
| 3 | 4 |   |     | R93.89  | Abnormal findings on diagnostic imaging of other sites | Y   |
| 4 | 5 |   | HCC | J44.9   | Chronic obstructive pulmonary disease, unspecified     | Y   |
| 5 | 6 |   |     | I10     | Essential (primary) hypertension                       | Y   |
| 6 | 7 |   |     | F17.210 | Nicotine dependence, cigarettes, uncomplicated         | Y   |
| 7 | 8 |   |     | E66.9   | Obesity, unspecified                                   | Y   |
| 8 | 9 |   |     | E78.5   | Hyperlipidemia, unspecified                            | Y   |

Validation

Chart pulled for review of respiratory failure as one MCC. Patient is admitted status post total abdominal hysterectomy.

By removing J96.21 for acute on chronic respiratory failure with hypoxia the MS-DRG moves from 742 to 743 with an overall decrease in reimbursement of \$4,325.69. SOI/ROM decrease from 3/3 to 1/2.

# Section Three: Challenges for Everyone

## Clinical Validation – Acute Respiratory Failure as only MCC

### Documentation:

Progress note on by nurse practitioner notes, "**Acute on chronic respiratory failure.**" Order for Hospitalist consult was for COPD/home O2 use. Hospitalist medical consultation reason for consult: "SOB in setting of COPD stage 3 with hypoxemia and treatment with bronchodilator scheduled q 4 hr while awake; O2 to maintain SpO2 >92%; encourage incentive spirometry. Solucortef is given earlier for wheezing? Possible AI? Patient not on chronic steroids. Will give brief course of Solumedrol then reassess need to continue said therapy as patient currently in no distress and speaking in full sentences. h/o severe COPD (prescribed 2L O2 continuous). Underwent open hysterectomy earlier today; EBL 1700 otherwise procedure uneventful. Noted w bilateral expiratory wheezing. Patient stated wheezing is chronic and breathing "doing ok". On discharge summary: COPD was managed with help of inpatient medicine team."

# Section Four: Wrapping Up

## Clinical Validation Issues:

- Acute Respiratory Failure
- Encephalopathy (toxic or metabolic)
- Sepsis

## Clinical Validation Resolutions:

- Acute Renal Failure
- Malnutrition



# Section Four: Wrapping Up

## Sepsis Issues For CDI That Can Lead To A Denial:

- Sepsis notation in the ED and not carried forward (Was it ruled out?)
  - If so, would not be assigned a code
- Sepsis Syndrome (Not an acceptable diagnosis)
  - This is an outdated term and does not code to sepsis
- Sepsis only noted on discharge summary (POA issues)
  - For coders this is a very difficult area.
- Sepsis throughout chart with clinical picture not supporting diagnosis  
(Suspicious)
  - If the clinical picture does not support sepsis, this can appear to auditors as if the facility is prompting the providers to note for higher payment. Another good reason for auditors to be able to see clarifications and to have an understanding of the education and verbal interaction happening from CDI and Coders to the physicians.



## Section Three: Challenges for Everyone

***Preventive audits as a pre-bill for areas of concern can greatly help with denials prevention. However, clinicians and CDI staff really need to ensure documentation supports the diagnosis reporting for final code selection!***



***However, this will take a team effort to work...***

# Wrapping Up!

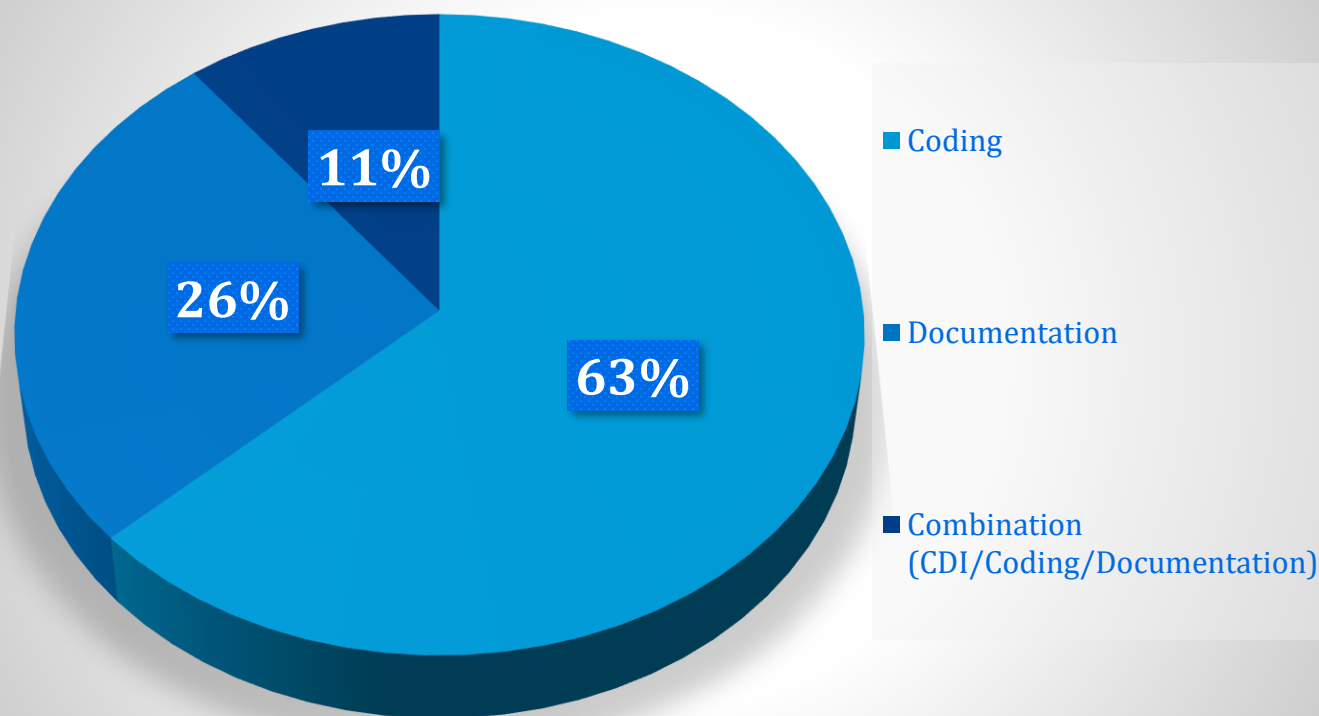
## Section Four: Wrapping Up

**Moving Forward: What can we take away from 2019?**



## Section Four: Wrapping Up

DRG Shift Rates by Type of Error



### DRG Shift Rates by Type of Error – Examples

- **Coding**
  - Principal Diagnosis
  - Missed query opportunities
  - Inappropriate POA selection
  - Procedural coding
  - Diagnoses code assignment
  - CC/MCC – missed or inappropriately reported
- **Documentation**
  - Inconsistent
  - Clinical picture is questionable
  - Unanswered clarifications
- **Combination**
  - Clinical Documentation Improvement
  - Coder
  - Physician

## Section Four: Wrapping Up

MS-DRGs with Highest % Shift Based on Total Number of Claims



## Section Four: Wrapping Up

### MS-DRGs with Highest Opportunity of Shift:

- 981-982 Extensive O.R. Procedure Unrelated to Principal Diagnosis
- 871-872 Sepsis or Severe Sepsis with/without Mechanical Ventilation > 96 Hours
- 689-690 Kidney and Urinary Tract Infections
- 166-168 Other Respiratory System O.R. Procedures
- 189-195 Pulmonary Edema, COPD, and Simple Pneumonia and Pleurisy
- 177-179 Respiratory Infections and Inflammations
- 065-066 Intracranial Hemorrhage or Cerebral Infarction

# Resources

**AHIMA** <http://www.ahima.org/>

**Centers for Medicare and Medicaid Services.** (2020, January). Medicare Parts A & B Appeals Process. Retrieved from <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf>

Gog.net. (n.d.). *Cricothyroidotomy* [Image]. Retrieved from <https://www.gog.net.nz/SkillCricothyroidotomy.html>

**HBMA** [https://www.hbma.org/meeting\\_calendar/details.php?event=1894](https://www.hbma.org/meeting_calendar/details.php?event=1894)

**HFMA** [https://www.hfma.org/home-b.html?adobe\\_mc\\_sdid=SDOD%3D33943C3EE7F859E6-3F8A67E2EE5D678%7CMCORGID%3DC6CD364C5AF2F3CF0A495C66%40AdobeOrg%7CTS%D1589910634&adobe\\_mc\\_ref=https%3A%2F%2Fwww.google.com%2F](https://www.hfma.org/home-b.html?adobe_mc_sdid=SDOD%3D33943C3EE7F859E6-3F8A67E2EE5D678%7CMCORGID%3DC6CD364C5AF2F3CF0A495C66%40AdobeOrg%7CTS%D1589910634&adobe_mc_ref=https%3A%2F%2Fwww.google.com%2F)



# Resources

Recovery Audit Contractor (RAC)

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program>

Office of Inspector General (OIG)

<https://oig.hhs.gov/reports-and-publications/workplan/index.asp>

Inpatient Prospective Payment System (IPPS Final Rule)

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html>

# Questions?

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