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Hindsight's 2020:

A Look Back at Inpatient Auditing Outcomes from 2020

Lisa Ball

RHIA, CCS, CDIP

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Disclaimer Statement

This 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.

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Agenda

- Determine how your facility's current audits compare with Vitalware audit outcomes.
- Gauge what future review areas may be of interest for your facility.
- Prioritize areas of interest by DRG, services and/or diagnoses.
- Identify industry trends related to DRG audits.
- Identify possible areas for concern in 2021 and proactively work to prevent poor audit outcomes.

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Sections

Section One – Understanding IP Audits

Section Two – Coding Challenges

Section Three – Clinical Documentation and Physician Challenges

Section Four – Wrapping up with Q&A.

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Understanding Inpatient Audits

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Understanding Inpatient Audits

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

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Understanding Inpatient Audits

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

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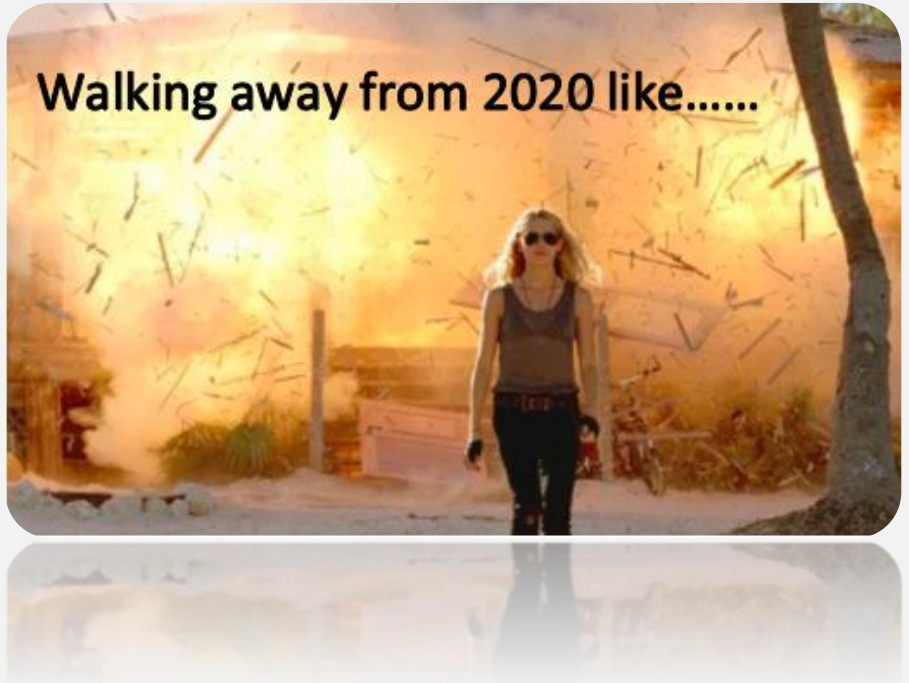
Understanding Inpatient Audits

Retrospective Review

- Facility-specific
- Vitalware Proprietary DRG selection
- Discharge Disposition
- Severity of Illness/Risk of Mortality (SOI/ROM)
- Readmissions for (CHF, COPD, 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)



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Understanding Inpatient Audits

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

Understanding Inpatient Audits

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 Arrythmia & 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

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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

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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

Procedures with appropriate principal diagnosis

Procedures with appropriate body part character

Procedures as open versus perc/endo character

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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

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Understanding Inpatient Audits

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

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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

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Understanding Inpatient Audits

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.

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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

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Understanding Audits

D. Medicare Inpatient Prospective Payment System (IPPS) New COVID-19 Treatments Add-On Payment (NCTAP) for the Remainder of the Public Health Emergency (PHE)

1. SECTION 3710 OF THE CARES ACT IPPS ADD-ON PAYMENT FOR COVID-19 PATIENTS DURING THE PHE

Section 3710 of the CARES Act amended section 1886(d)(4)(C) of the Act to provide for an increase in the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the period of the PHE for COVID-19. To implement this temporary adjustment, Medicare's claims processing systems apply an adjustment factor to increase the Medicare Severity-DRG (MS-DRG) relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments. For additional information regarding this add-on payment, including which claims are eligible for the 20 percent increase in the MS-DRG weighting factor, please see the Medicare Learning Network (MLN) Matters article "New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act" available on the CMS website at https://www.cms.gov/files/document/se20015.pdf.

Source - https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency

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To address potential Medicare program integrity risks, ***effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record.*** Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. ***The test may be performed either during the hospital admission or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement.*** For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government run testing center can be added to the patient's medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.

Source - https://www.cms.gov/files/document/se20015.pdf

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Understanding Inpatient Audits

The pricer will continue to apply an adjustment factor to increase the MS-DRG relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges that report the ICD-10-CM diagnosis code U07.1 (COVID-19***). CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.*** A hospital that diagnoses a patient with COVID-19 consistent with the ICD-10-CM Official Coding and Reporting Guidelines but does not have evidence of a positive test result can decline, at the time of claim submission, the additional payment resulting from the application at the time of claim payment of the 20 percent increase in the MS-DRG relative weight to avoid the repayment. To do so, the hospital will inform its MAC and the MAC will notate the claim with MAC internal claim processing coding for processing. The pricer software will not apply the 20 percent increase to the claim when that MAC internal claim processing coding is present on a claim with the ICD-10-CM diagnosis code U07.1 (COVID-19). The updated pricer software package reflecting this change will be released in October 2020.

To notify your MAC when there is no evidence of a positive laboratory test documented in the patient's medical record, enter a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim

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Understanding Inpatient Audits

CMS issued an Interim Final Rule with Comment Period (IFC) that established the New COVID-19 Treatments Add-on Payment (NCTAP) under the Medicare Inpatient Prospective Payment System (IPPS), effective from November 2, 2020, until the end of the public health emergency (PHE) for COVID-19. To mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments during the COVID-19 PHE, the Medicare program will provide an enhanced payment for eligible inpatient cases that involve use of certain new products with current Food and Drug Administration (FDA) approval or emergency use authorization (EUA) to treat COVID-19.

The NCTAP is equal to the lesser of:

65 percent of the operating outlier threshold for the claim

or

65 percent of the amount by which the costs of the case exceed the standard diagnosis-related group (DRG) payment (including the adjustment to the relative weight under section 3710 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) for eligible cases.

Source - https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap

CMS is offering additional payments above the 20% add-on with the New COVID-19 Treatments add-on Payment called NCTAP for IPPS…there is various guidelines for each type of drug used and with different other medication combinations that apply… however, the most commonly seen scenario for us is the use of Remdesivir with PCS code XW033E5 for introduction of Remdesivir anti-infective into peripheral vein, percutaneous approach, new technology group 5.

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Understanding Inpatient Audits

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)

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Coding Challenges

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Coding Challenges

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

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Coding Challenges

Body Part Character and MS-DRG 981 Example

Clinical Picture:

Patient presents with complaint of ongoing nose bleed and failed nasal packing in the Emergency Department.

Patient was admitted due to continued bleeding. Embosphere particle embolization was performed with successful occlusion of the maxillary artery.

Code Selections:

Principal DX - R04.0 for the epistaxis

Principal PX - 03L03DZ for occlusion of right internal mammary artery with intraluminal device, percutaneous approach

Leading to MS-DRG of 981 for Extensive O.R. Procedures unrelated to Principal Diagnosis with MCC.

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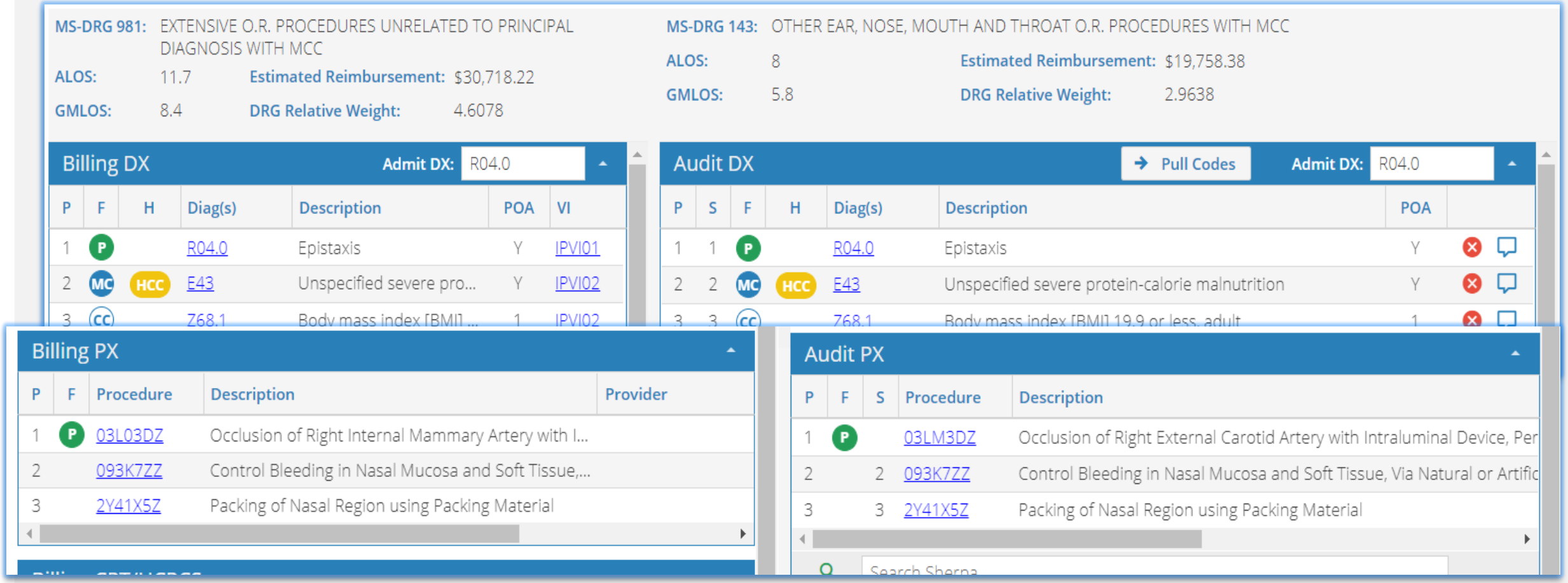
Coding Challenges



Issue with use of body part character “mammary” in place of maxillary… however, PCS doesn’t have “maxillary” and includes this in “external carotid”. Mammary would be used in thoracic procedures.

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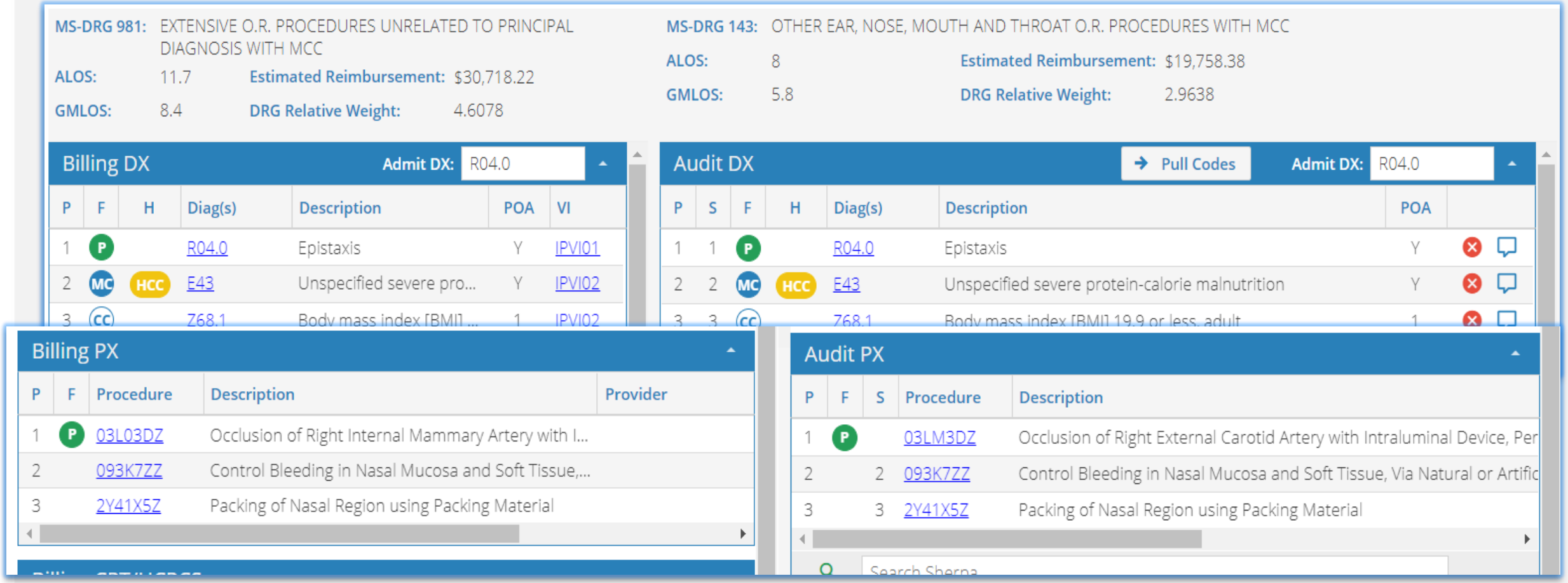
Coding Challenges



Resulting in shift from MS-DRG 981 to 143 and a decrease of close to $11,000 dollars

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Coding Challenges

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.

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Coding Challenges

Body Part Character, Principal Diagnosis, Re-sequencing, and MS-DRG 981 Example

Clinical Picture:

Patient presents for osteomyelitis of the 5th metatarsal, gangrene, ulceration, peripheral neuropathy, and type 2 diabetes.

Procedure performed notes, “removal of 5th metatarsal base” and “specimens: remaining fifth metatarsal base.”

Code Selections:

Principal DX –E11.52 Type 2 Diabetes mellitus with peripheral angiopathy with gangrene.
Principal PX- 0QBR0ZZ Excision of left toe phalanx, open approach

Leading to MS-DRG of 981 for Extensive O.R. Procedures unrelated to Principal Diagnosis with MCC.

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Coding Challenges

MS-DRG 981: EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC

ALOS: 11.5 **Estimated Reimbursement:** $32,758.97

GMLOS: 8.4 **DRG Relative Weight:** 4.4907

MS-DRG 628: OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC

ALOS: 10.1 **Estimated Reimbursement:** $27,046.68

GMLOS: 7.3 **DRG Relative Weight:** 3.6893

Billing DX — Admit DX: M86.9

P	F	H	Diag(s)	Description	POA	VI
1	P	HCC	E11.52	Type 2 diabetes mellitu...	Y	IPVI01
2	MC	HCC	A48.0	Gas gangrene	Y	IPVI02
3	CC	HCC	M86.9	Osteomyelitis, unspecifi...	Y	IPVI10
4	CC	HCC	J44.1	Chronic obstructive pul...	Y	IPVI02

Audit DX — Pull Codes — Admit DX: M86.9

P	S	F	H	Diag(s)	Description	POA
1		P	HCC	E11.69	Type 2 diabetes mellitus with other specified complication	Y
2	1	CC	HCC	E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopat...	Y
3	2	MC	HCC	A48.0	Gas gangrene	Y
4	4	CC	HCC	J44.1	Chronic obstructive pulmonary disease with (acute) exacer...	Y

Billing PX

P	F	Procedure	Description	Provider
1	P	0QBR0ZZ	Excision of Left Toe Phalanx, Open Approach	

Audit PX

P	F	S	Procedure	Description	Provider
1	P		0QBP0ZZ	Excision of Left Metatarsal, Open Approach	

Initial issue with this case, left phalanx was reported for the body part character instead of “left metatarsal.” A simple mistake in body part character here resulted in a decrease of around $8,000.

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Coding Challenges

MS-DRG 981:	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC		
ALOS:	11.5	**Estimated Reimbursement:**	$32,758.97
GMLOS:	8.4	**DRG Relative Weight:**	4.4907

MS-DRG 628:	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC		
ALOS:	10.1	**Estimated Reimbursement:**	$27,046.68
GMLOS:	7.3	**DRG Relative Weight:**	3.6893

Billing DX — Admit DX: M86.9

P	F	H	Diag(s)	Description	POA	VI
1	P	HCC	E11.52	Type 2 diabetes mellitus with diabetic ...	Y	IPVI01
2	MC	HCC	A48.0	Gas gangrene	Y	IPVI02
3	CC	HCC	M86.9	Osteomyelitis, unspecified	Y	IPVI10
4	CC	HCC	J44.1	Chronic obstructive pulmonary diseas...	Y	IPVI02

Audit DX — Pull Codes — Admit DX: M86.9

P	S	F	H	Diag(s)	Description	POA
1		P	HCC	E11.69	Type 2 diabetes mellitus with other specifie...	Y
2	2	MC	HCC	A48.0	Gas gangrene	Y
3	1	CC	HCC	E11.52	Type 2 diabetes mellitus with diabetic peri...	Y
4	5	CC	HCC	M86.272	Subacute osteomyelitis, left ankle and foot	Y

Billing PX

P	F	Procedure	Description	Provider
1	P	0QBR0ZZ	Excision of Left Toe Phalanx, Open Approach	

Audit PX

P	F	S	Procedure	Description	Provider
1	P		0QBP0ZZ	Excision of Left Metatarsal, Open Approach	

Additional, issue with this case, coder did not use “with” guideline for including osteomyelitis with DM II and auditor recommended re-sequencing E11.52 to secondary, adding and making principal E11.69 for type 2 DM with other specified complications for ICD-10-CM index of “with” for DM…osteomyelitis. By missing the “with” link and making E11.69 principal in the end the overall impact financially on this case was a decrease of almost $6000.

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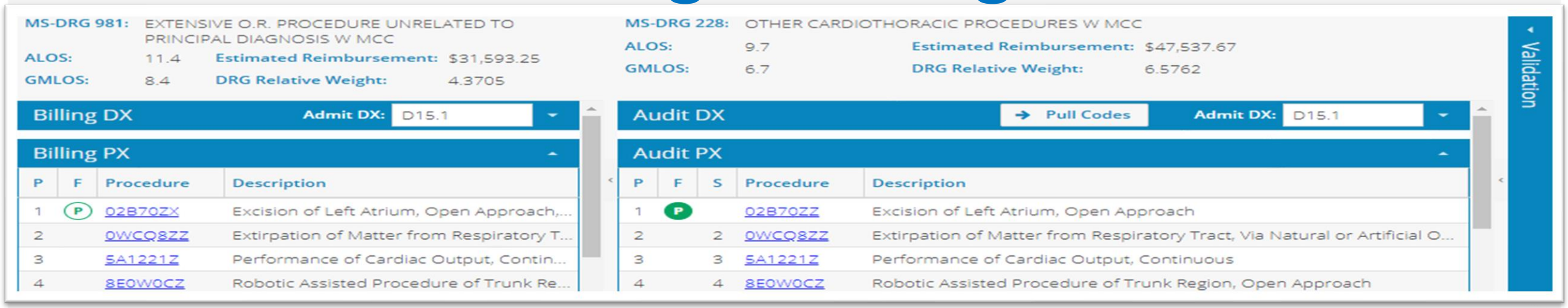
Coding Challenges



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.

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Coding Challenges

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.

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Coding Challenges

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?

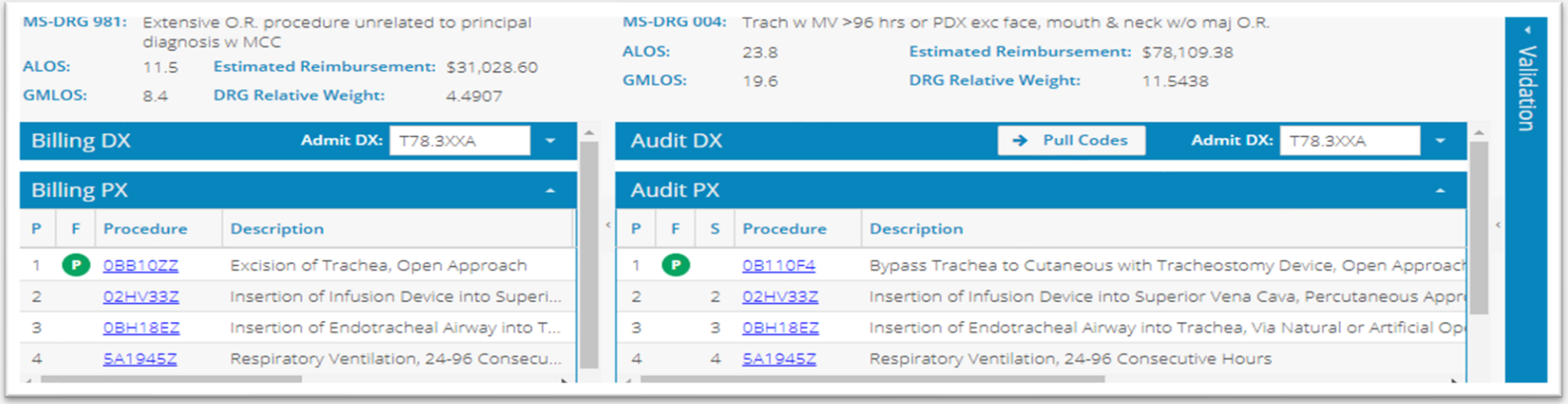
Answer: It is appropriate to report mechanical ventilation, for patients who are admitted to the hospital on a home ventilator, since the patient is still being evaluated and monitored as well as receiving ventilator assistance. The patient is utilizing hospital resources, and ownership of the equipment 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.

Coding Challenges



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.

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Coding Challenges

Procedure Report:

Preprocedural Diagnosis:	Emergent airway
Postprocedural Diagnosis:	Emergent airway
Procedure Performed:	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.

Coding Challenges

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)

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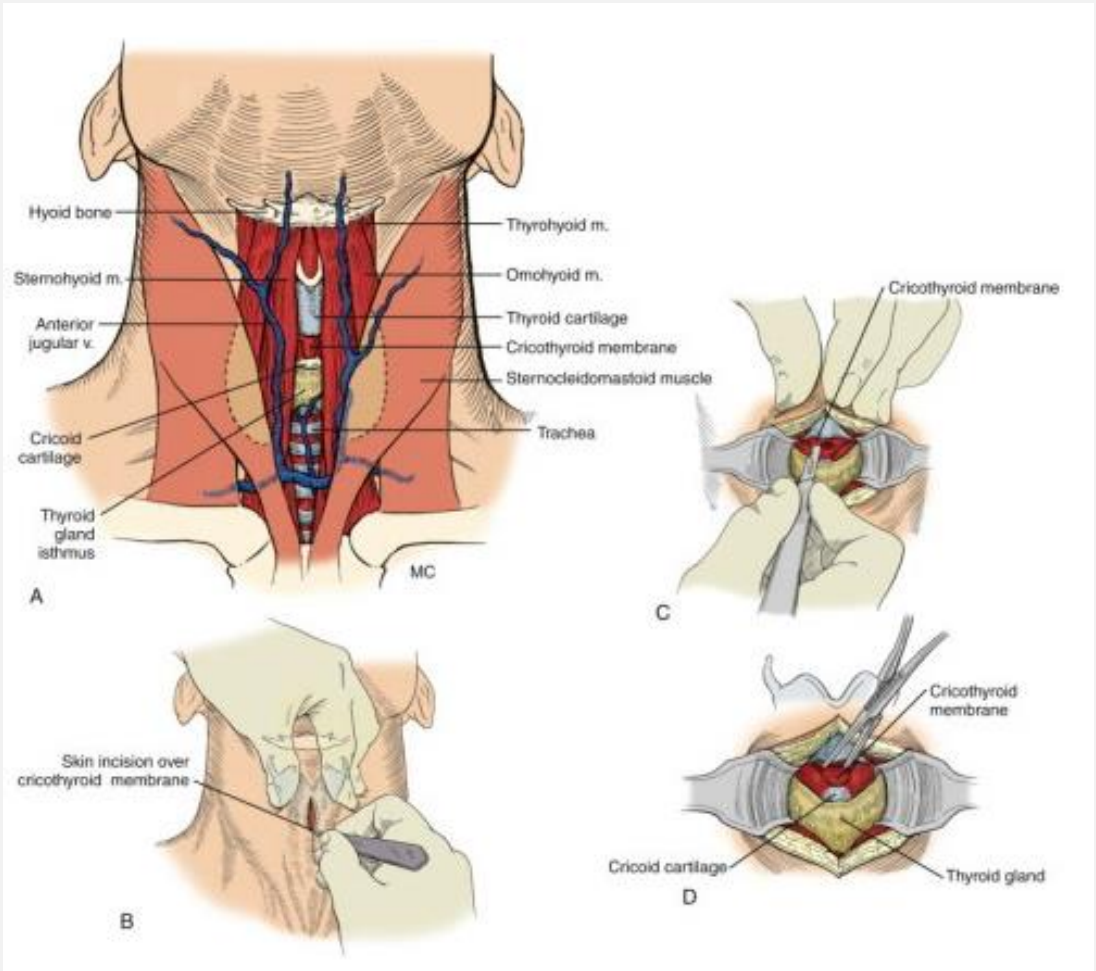
Coding Challenges



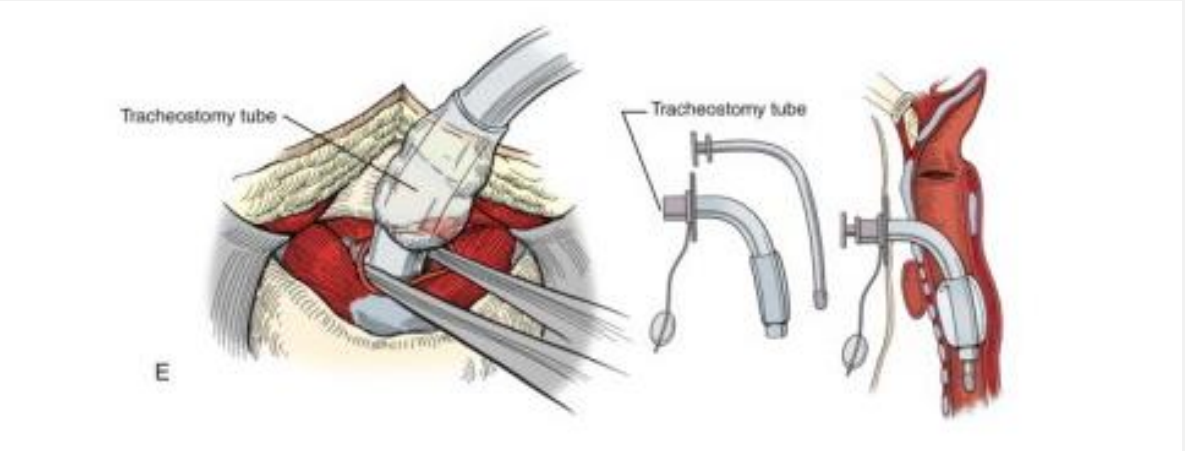


Image Source: Gog.net. (n.d.). Cricothyroidotomy [Image]. Retrieved from https://www.gog.net.nz/SkillCricothyroidotomy.html

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Clinical Documentation and Physician Challenges

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Clinical Documentation and Physician Challenges

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

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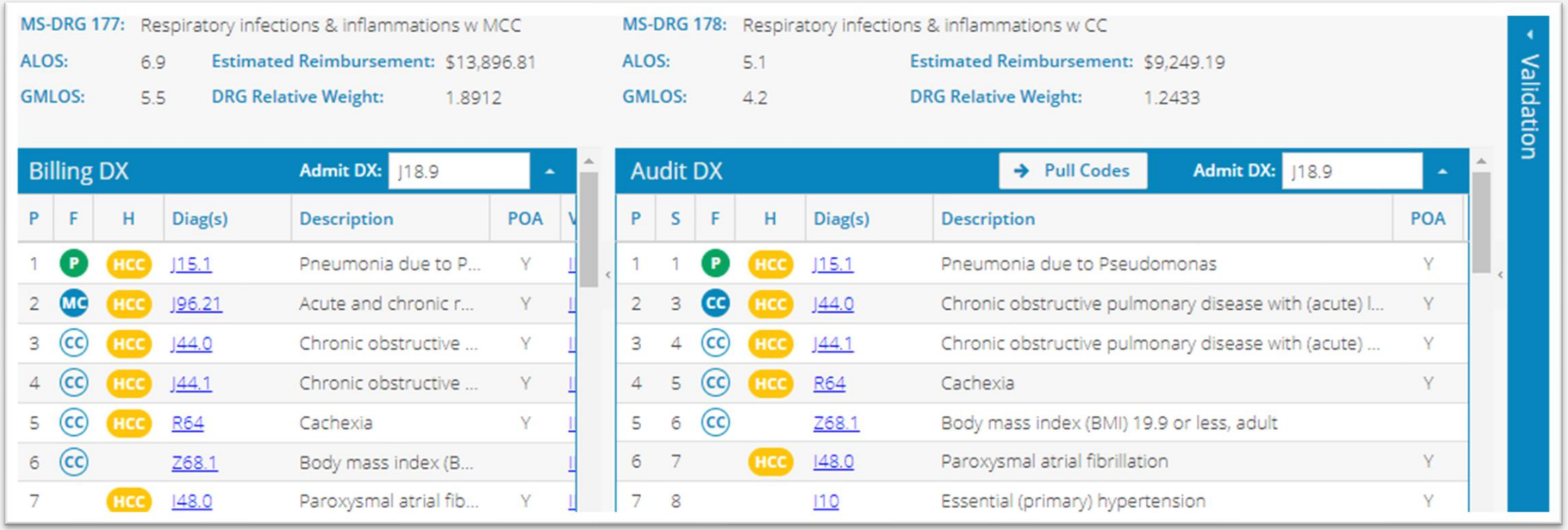
Clinical Documentation and Physician Challenges



MS-DRG 177:	Respiratory infections & inflammations w MCC	**MS-DRG 178:**	Respiratory infections & inflammations w CC
ALOS:	6.9	**ALOS:**	5.1
Estimated Reimbursement:	$13,896.81	**Estimated Reimbursement:**	$9,249.19
GMLOS:	5.5	**GMLOS:**	4.2
DRG Relative Weight:	1.8912	**DRG Relative Weight:**	1.2433

Validation

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

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.

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Clinical Documentation and Physician Challenges

Clinical Indicators:

On H&P, documentation of "Admits to chronic SOB rq 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.

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Clinical Documentation and Physician Challenges

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?

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Clinical Documentation and Physician Challenges

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.

Clinical Documentation and Physician Challenges

Section III Reporting Additional Diagnoses

General Rules for Other (Additional) Diagnoses

For reporting purposes, the definition of “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The Uniform Hospital Discharge Data Set (UHDDS) item #11-b defines “other diagnoses” as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.”

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Clinical Documentation and Physician Challenges

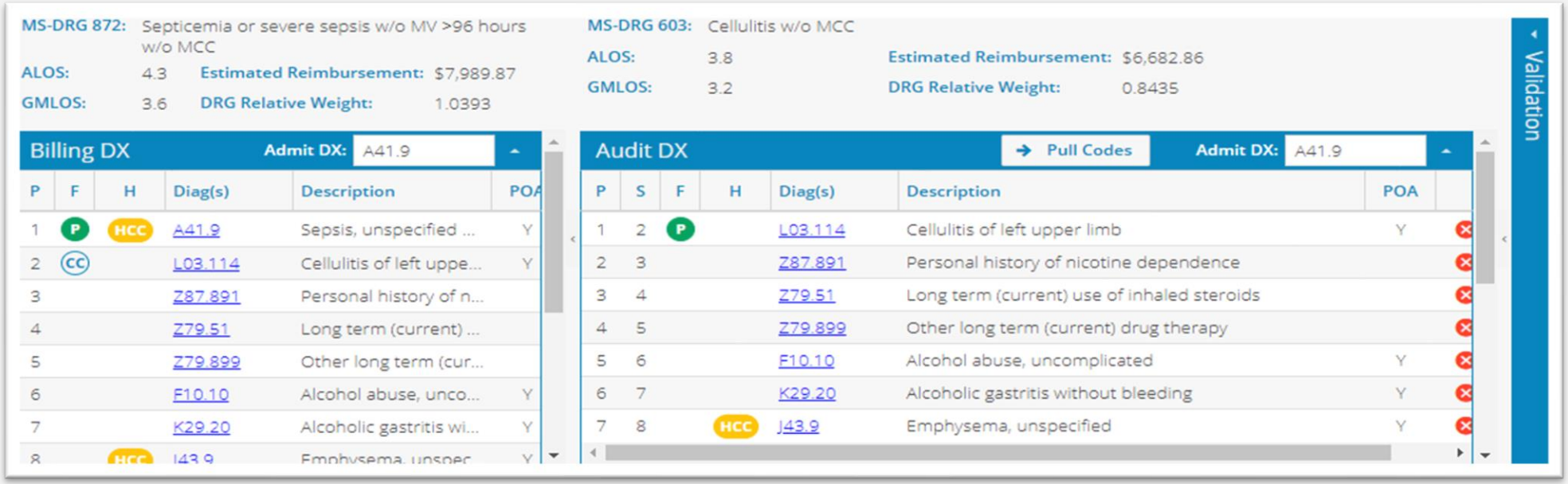

Chart pulled for review of sepsis as principal diagnosis, length of stay one day, and discharge to home.

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.

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Clinical Documentation and Physician Challenges

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."

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Clinical Documentation and Physician Challenges

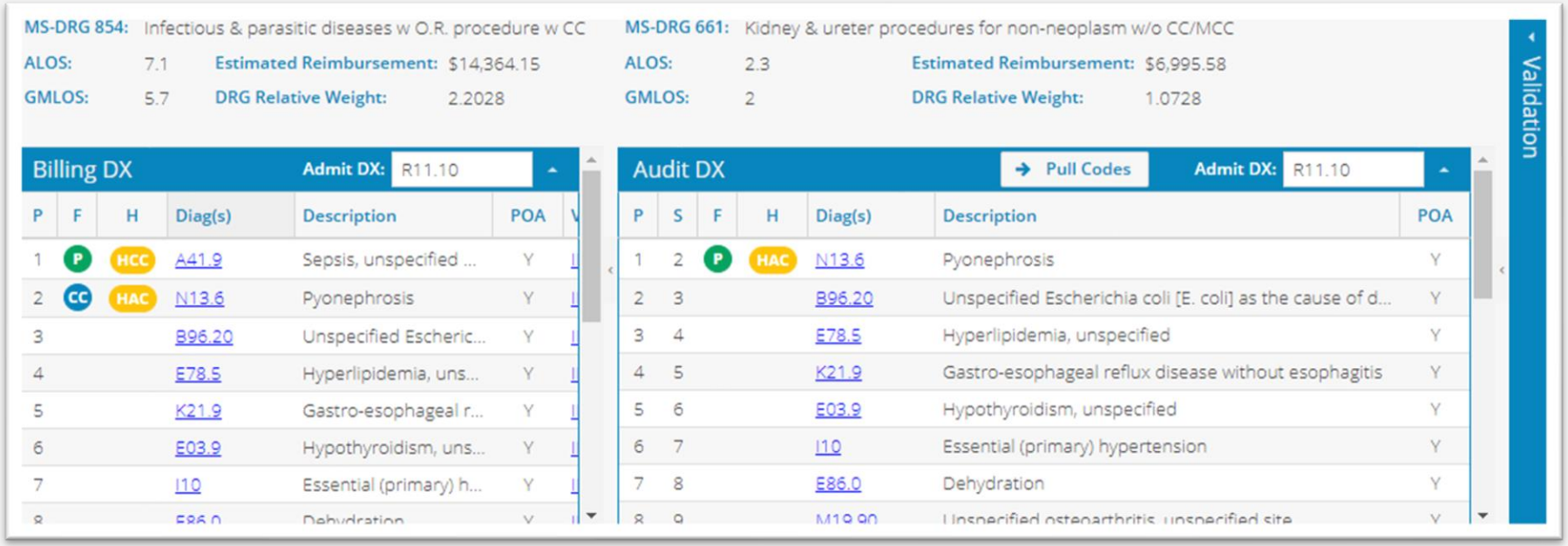

Chart pulled for review of sepsis with one CC.

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, WBC 18,000, lactic acid is not elevated.

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Clinical Documentation and Physician Challenges

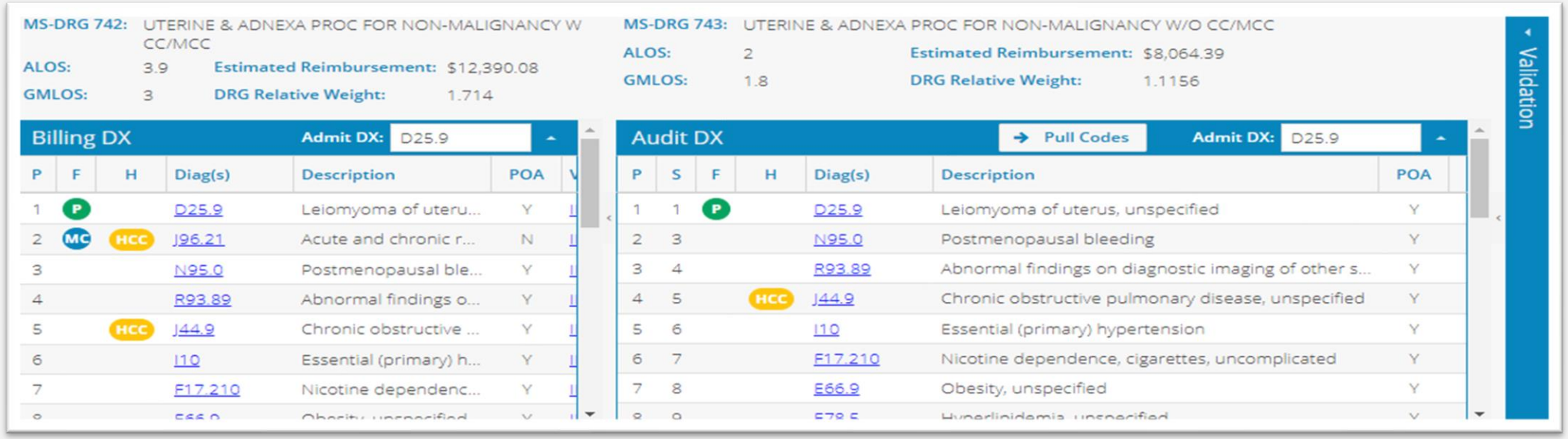

Chart pulled for review of respiratory failure as one MCC. Patient is admitted status post total abdominal hysterectomy.

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.

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Clinical Documentation and Physician Challenges

Documentation:

Progress note on by nurse practitioner notes, "Acute on chronic respiratory failure." Order for Hospitalist consult was for COPD/home 02 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."

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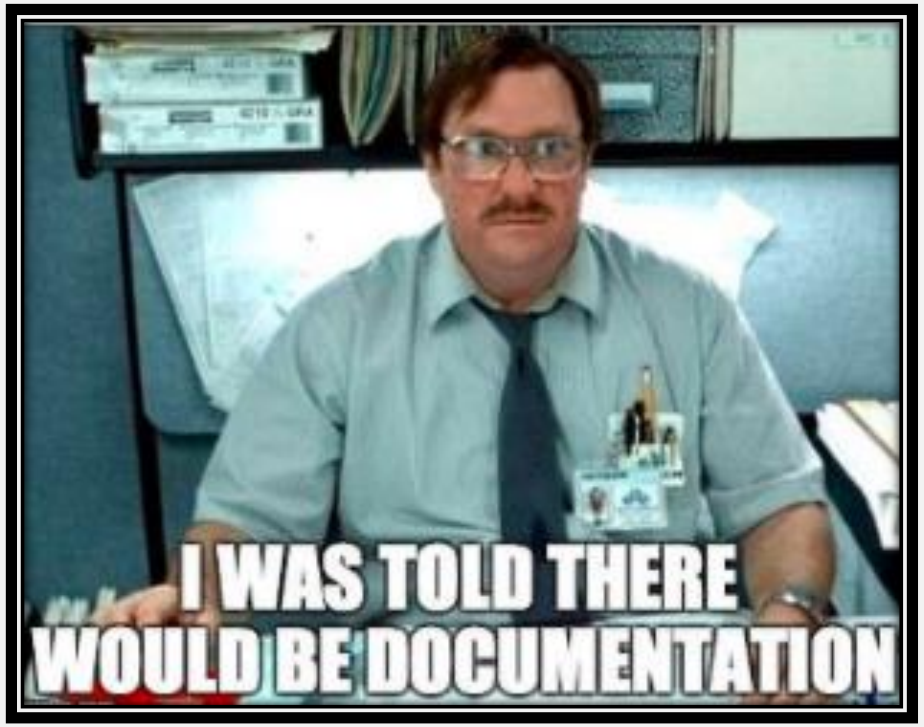
Clinical Documentation and Physician Challenges

Clinical Validation Issues:

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

Clinical Validation Resolutions:

- Acute Renal Failure
- Malnutrition



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Clinical Documentation and Physician Challenges

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.

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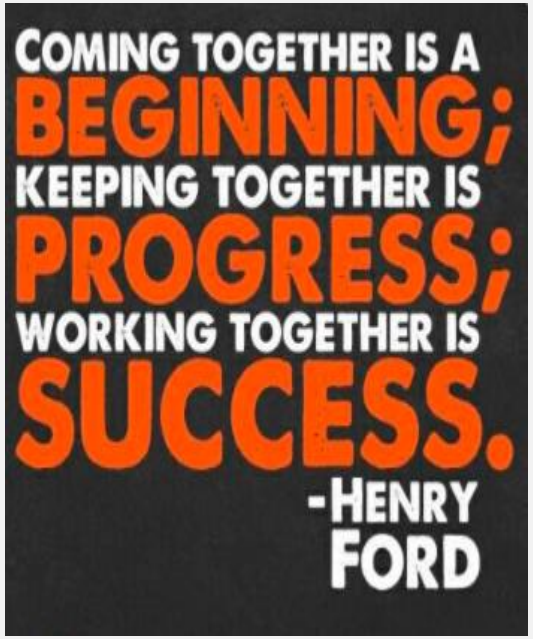
Clinical Documentation and Physician Challenges

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 TEAMWORK…

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Wrapping Up with Q&A

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Wrapping Up

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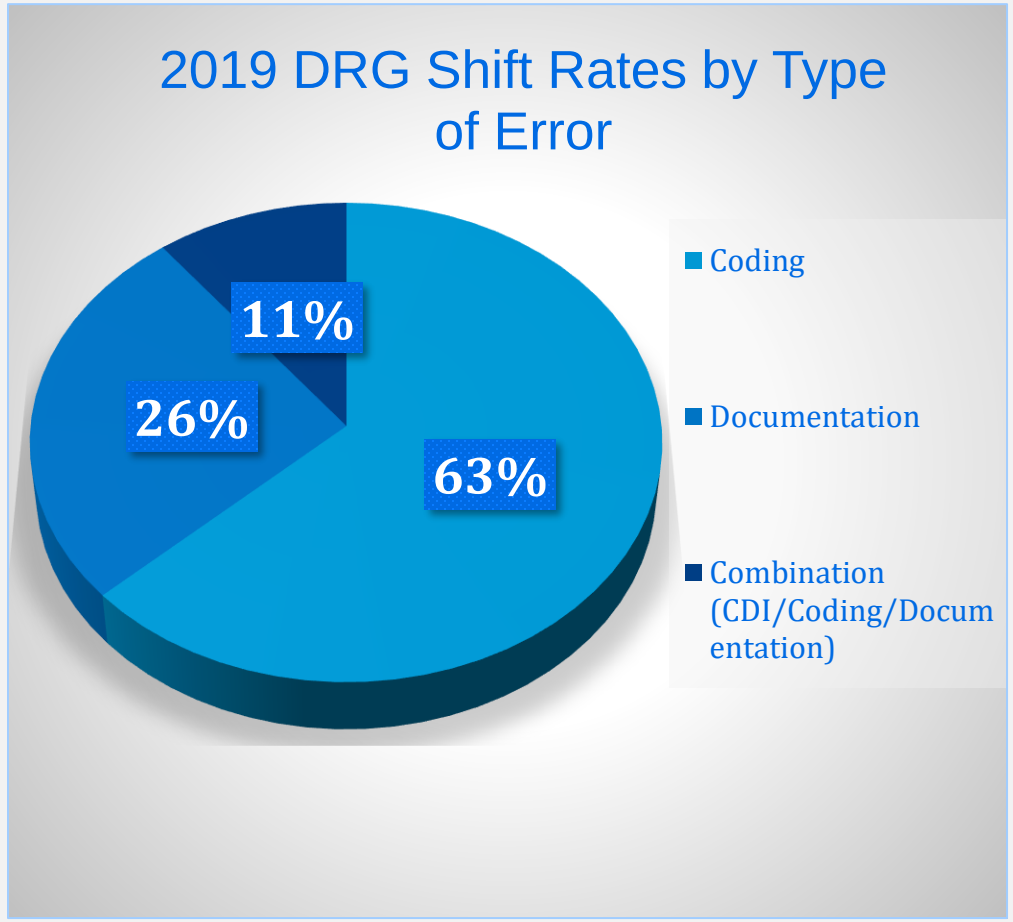
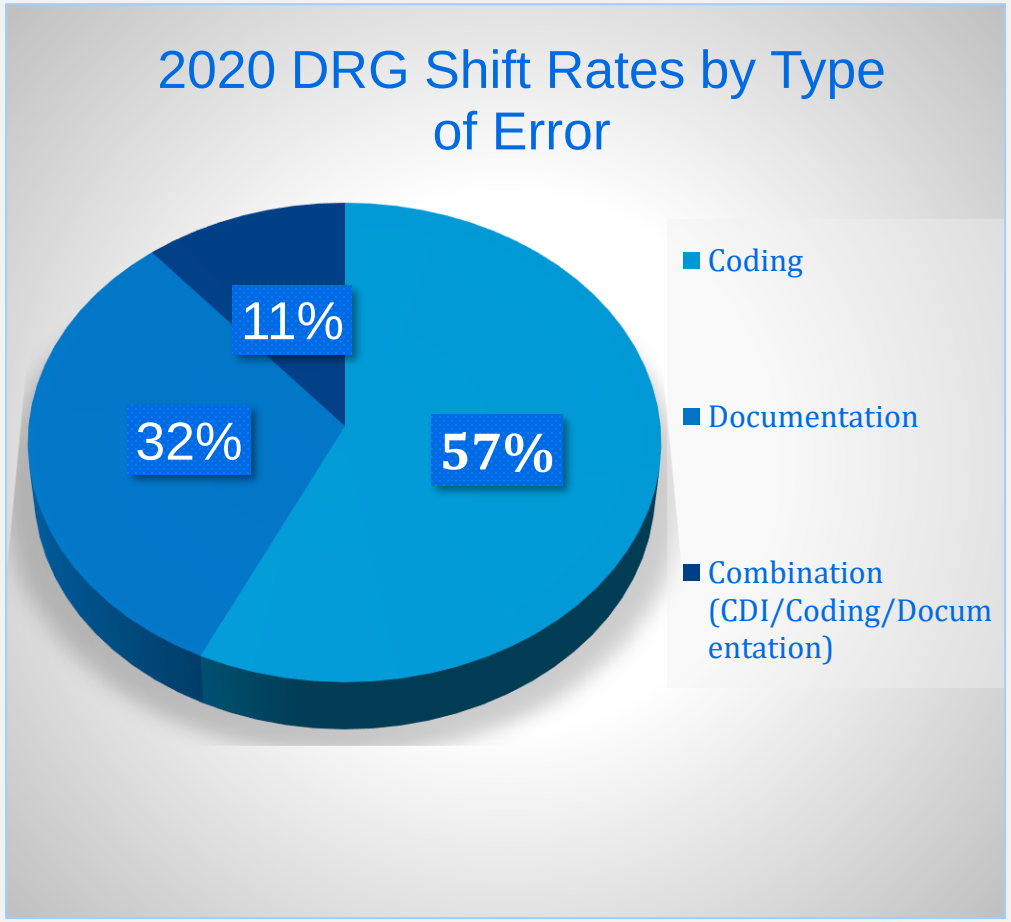
Wrapping Up

2019-2020 DRG Shift Rates by Type of Error - Examples





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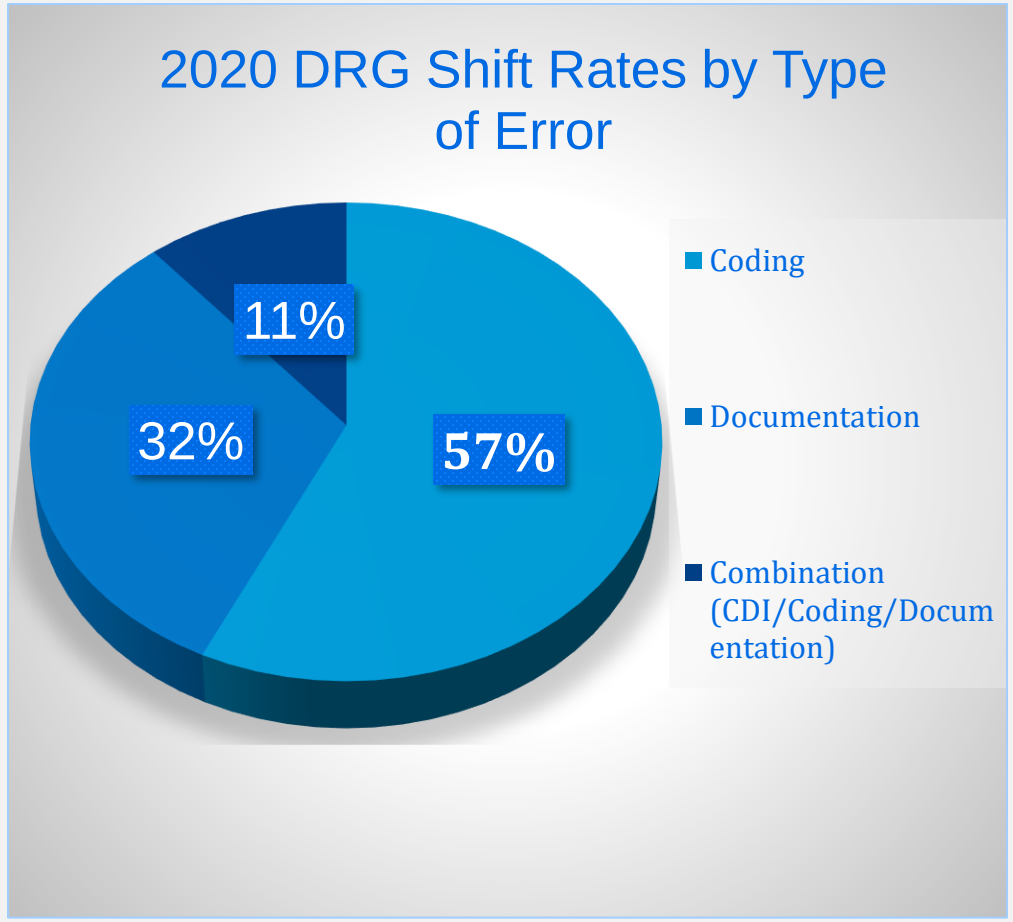
Wrapping Up



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

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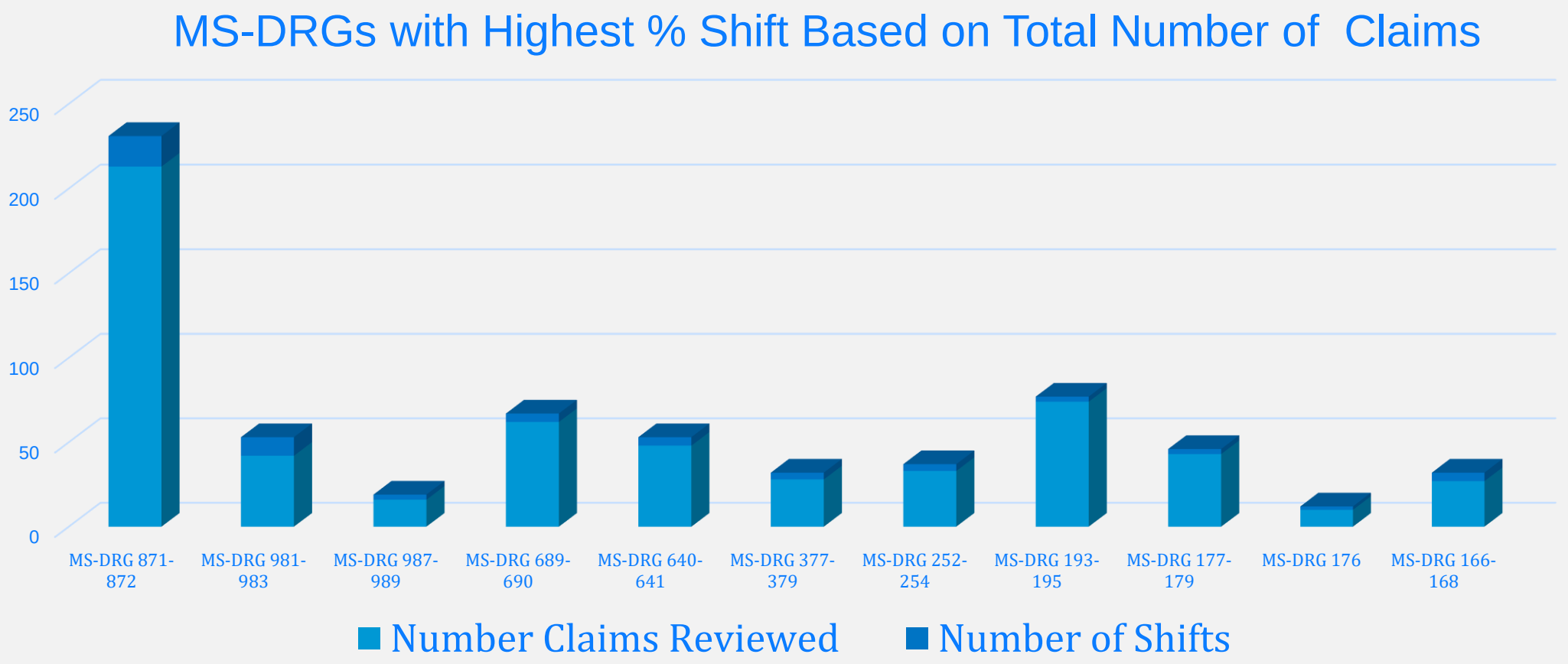
Wrapping Up



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Wrapping Up

MS-DRGs with Highest Opportunity of Shift:

- 988-989 Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis
- 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
- 640-641 Miscellaneous Disorders of Nutrition, Metabolism, Fluids and Electrolytes
- 377-379 G.I. Hemorrhage
- 252-254 Other Vascular Procedures
- 193-195 Simple Pneumonia and Pleurisy
- 177-179 Respiratory Infections and Inflammations
- 176 Pulmonary embolism without MCC
- 166-168 Other Respiratory System O.R. Procedures
- 163-165 Major Chest Procedures

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Resources

AHIMA http://www.ahima.org/

Centers for Medicare and Medicaid Services. (2021, January). Medicare Parts A & B Appeals Process. Retrieved from https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf

Centers for Medicare and Medicaid Services. (2021, February). Section 3710 Cares Act. Retrieved fromSource - https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency

Centers for Medicare and Medicaid Services. (2021, February). Medicare Learning Network. New waivers for inpatient prospective payment systems (IPPS) hospitals. Retrieved from https://www.cms.gov/files/document/se20015.pdf

Centers for Medicare and Medicaid Services. (2021, February). New covid-19t treatments add-on payment (NCTAP). https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap

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Resources

HBMA https://www.hbma.org/meeting_calendar/details.phph?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

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

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Questions?

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Thank you!

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