THE FUTURE OF CODING: CLINICAL VALIDATION OF REPORTED DIAGNOSES

PRESENTED BY:
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**ICD-10: How and Why We Use the Classification System**

How ICD-10 is used:

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The system provides greater detail for data mining for population health management.</td>
<td>• The U.S. is the only nation in the world that uses the ICD system for healthcare reimbursement.</td>
</tr>
<tr>
<td>• Epidemiology</td>
<td></td>
</tr>
<tr>
<td>• Vital health statistics</td>
<td></td>
</tr>
<tr>
<td>• Study of disease processes</td>
<td></td>
</tr>
<tr>
<td>• Study of treatment efficacy</td>
<td></td>
</tr>
<tr>
<td>• Development of new treatments</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 AND DRGs

Some CC/MCC diagnoses have shifted

- **Malignant hypertension**
  - Was a CC, now non-CC
  - Higher → Lower weight DRG

- **Major Depressive Disorder**
  - depending on documentation, this can now be a CC, while it was not a CC in ICD-9
  - Lower → Higher weight DRG

ICD-10 AND DRGs

Principal diagnosis codes as their own CC/MCC

- The MS-DRG structure changed with ICD-10 implementation because of combination codes.

- Some diagnoses are their own CC or MCC
  - M90.51X, osteonecrosis in diseases classified elsewhere (own CC)
  - L89.323, pressure ulcer of left buttock, stage 3 (own MCC)
APR-DRGs and Case Mix Complexity

This refers to an interrelated but distinct set of patient attributes that includes:

- Severity of illness
- Risk of mortality
- Prognosis
- Treatment difficulty
- Need for intervention
- Resource intensity

ALL Patient Refined DRGs (APR DRGs)

- The system is comprised of a clinical model and four severity of illness and risk of mortality subclasses for each base APR DRG.

- The systems are differentiated by trajectory of development, clinical logic, severity classification structure, and level of complexity.
APR-DRG MODEL

Severity of Illness (SOI)

Describes the extent of the physiologic decompensation or organ system loss of function.

- 1 = minor
- 2 = moderate
- 3 = major
- 4 = extreme

Risk of Mortality (ROM)

The risk of mortality indicates the patient’s likelihood of dying.

- 1 = minor
- 2 = moderate
- 3 = major
- 4 = extreme

APR-DRGs: CONDITIONS

Following are examples of conditions and their respective SOI or ROM value:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SOI</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile (C.diff) colitis</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Escherichia coli (E.coli) colitis</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Urinary tract infection (UTI)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Acute on chronic diastolic CHF</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Chronic diastolic CHF</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Chronic respiratory failure</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes, type 2, uncomplicated</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes, type 2, with neuropathy</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
E V O L U T I O N  O F  C O D I N G  A N D  R E I M B U R S E M E N T

Clinical coding and reimbursement plays a significant role in healthcare and has gained more attention with the introduction of:

- Present on Admission (POA) indicators
- Ambulatory Payment Classifications (APCs)
- ICD-10-CM/PCS
- Hierarchical Condition Categories (HCCs)

T O D A Y ’ S  I N D U S T R Y  L A N D S C A P E
Where We Are
THE NEW WAVE OF SYSTEMS DESIGNED TO TARGET “VALUE” OF SERVICES PROVIDED

APR-DRGs

Clinical Validation

HCCs

Unspecified Principal Diagnosis

PEPPER Targets

RAC TARGETS

<table>
<thead>
<tr>
<th>Diagnosis Targets</th>
<th>MS-DRGs</th>
<th>APR-DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified diagnosis</td>
<td>Pneumonia</td>
<td>Acute renal failure</td>
</tr>
<tr>
<td>Sepsis</td>
<td>MIs</td>
<td>Pancreatitis</td>
</tr>
<tr>
<td>MIs</td>
<td>Pancreatitis</td>
<td>Acute blood loss anemia</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>Acute respiratory failure</td>
<td></td>
</tr>
<tr>
<td>Appendicitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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# Hierarchical Condition Categories (HCCs)

## What are they?
- System of assigning risk adjustment factor (RAFs) for an entire year of encounters across the continuum of care
- RAF is based on:
  - categories of diseases (chronic diseases)
  - demographics

## Why do they exist?
- CMS developed HCCs to adjust Medicare capitation payments for Medicare Advantage plans
- Used to determine expenses related to caring for a patient across time.
- Population Health!

## Where are they used?
- Medicare Advantage Plans
- Medicare Shared Savings ACO (expected cost)
- Value Based Purchasing (expected cost/efficiency)
- Some Commercial ACOs/Shared Risk arrangements
- Health Insurance Exchange Plans
- States where Medicare/Medicaid Dual Eligible are Managed Care
- Population Health/Risk Stratification/Cost Prediction
## HCCs

<table>
<thead>
<tr>
<th>Current YTD Acuity</th>
<th>Variable</th>
<th>RAF*</th>
<th>Revised RAF*</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-78 – community based</td>
<td>Age</td>
<td>0.454</td>
<td>0.454</td>
</tr>
<tr>
<td>Diabetes without complications</td>
<td>HCC 19</td>
<td>0.121</td>
<td>0.378 if physician adds diabetic nephropathy</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>HCC 79</td>
<td>0.291</td>
<td>0.291</td>
</tr>
<tr>
<td>Hypertension</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chronic Kidney Disease - 4</td>
<td>HCC 137</td>
<td>0.230</td>
<td>0.230</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>HCC 57</td>
<td>0.503</td>
<td>0.503</td>
</tr>
<tr>
<td>Total Risk Adjustment</td>
<td></td>
<td>1.599</td>
<td>1.856 (0.257 increase)</td>
</tr>
</tbody>
</table>

*Risk Assessment Factor (RAF)
CLINICAL VALIDATION

The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) Scope of Work 2013 includes the following statements:

Clinical validation is an additional process that may be performed along with DRG validation.

Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record.

Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination.

Most identified improper payments due to the coding/DRG assignments were in cases where only one complication/comorbidity (CC) or major complication/comorbidity (MCC) were coded without clinical validation.

“Consensus criteria” are being used to assess the clinical validity of documented diagnoses.
TOP DIAGNOSIS TARGETS

CMS, Managed Medicare/Medicaid plans, and other third party payors are targeting these diagnoses:

- Pneumonia
- Acute respiratory failure
- Acute renal failure
- Acute blood loss anemia
- UTIs
- Sepsis
- Malnutrition

CLINICAL INDICATORS

- RAC and other third party payors utilize Social Security Act (§1861 - §1870) and 42 CFR 405.980 as the basis for identifying improper payments for:
  - Incorrect coding
  - Lack of sufficient documentation/no documentation
  - Use of outdated fee schedule
  - Lack of medical necessity criteria
  - Services/conditions not reasonable and necessary
- In order to substantiate that a condition is reasonable and necessary, payors apply clinical criteria to the medical record documentation
CLINICAL INDICATORS

- In order to substantiate that a condition is reasonable and necessary, payors apply clinical criteria to the medical record documentation.

- Clinical criteria used, sometimes referred to as “consensus criteria,” can come from various sources and can vary by payor.

- Examples:
  - Kidney Disease: Improving Global Outcomes (KDIGO)
  - Acute Kidney Injury Network (AKIN)
  - American Society for Parenteral and Enteral Nutrition (ASPEN)
  - Textbooks (e.g., *Harrison’s Principles of Internal Medicine*)

CLINICAL INDICATORS: PNEUMONIA

1. Documentation of pneumonia, pneumonic infiltrate, infiltrate consistent with pneumonia on chest x-ray and/or CT scan (unless viral or bronchial lavage is consistent with infection), AND

2. Clinical presentation consistent with pneumonia, AND

3. Documentation of at least one of the following clinical features/signs:
   1) O2 sat <90% on room air
   2) WBC count >10K;
   3) + sputum culture;
   4) Clinically significant temperature;
   5) + gram stain;
   6) + urine antigen;
   7) + blood culture indicative of a recognized pulmonary pathogen (e.g., Pneumococcus)
CLINICAL INDICATORS: ACUTE RESPIRATORY FAILURE

- Specific documentation of the condition by the treating physician,
- Examination findings of respiratory distress/increased work of breathing,
- \( \text{O}_2 \text{ Sat} < 90\% \) or \( \text{PaO}_2 < 60 \), or \( \text{PCO}_2 \geq 50 \) with a low pH, **AND**
  - In a patient with chronic disease, the patient must have a 10-15 point drop in saturations from baseline or a \( \text{PCO}_2 > 50 \) with a pH < 7.30.

Treatment directed at the underlying pulmonary condition.

CLINICAL INDICATORS: ACUTE RENAL FAILURE

- Clinically significant rise of creatinine of 0.3 within 48 hours, or
- A rise of creatinine of 50% above baseline, or
- A reduction in GFR of 25% or more below baseline, or
- A fall of urine output below 0.5 mL/kg/hr for a minimum of 6 hours (~200 ml in 6 hours).
**CLINICAL INDICATORS: ACUTE BLOOD LOSS ANEMIA**

- Documentation by the physician of anemia due to hemorrhage or acute blood loss.
- Drop in Hgb of 1.0-2.0 gm/dl and/or Hct of 3-6%.
- Transfusion given.
- Development of symptoms of anemia not previously present.

**CLINICAL INDICATORS: UTI**

**Documentation**
- Documentation of UTI must be in the medical record.

**+ Urine Culture**
- With a colony count >100K (if a clean catch/chronic indwelling catheter specimen), or
- With a colony count of >10K if a straight catheter specimen.

**Urinalysis**
- In the absence of a + urine culture, urinalysis
  - + nitrites
  - + leukocyte esterase, or
  - >WBC/HPF
CLINICAL INDICATORS: SEPSIS

- Documentation of a confirmed infection, AND
- 2 or more positive SIRS findings:
  - Body temperature <36°C or >38°C,
  - Heart rate >90 beats per minute,
  - Respiratory rate >20 breaths per minute,
  - White blood cell count <4,000 cells/ml or >12,000 cells/ml or greater than 10% band forms

CLINICAL INDICATORS: MALNUTRITION

- Documentation of malnutrition, AND
- Presence of 2 or more of the following:
  - Insufficient energy intake;
  - Weight loss;
  - Loss of muscle mass;
  - Loss of subcutaneous fat;
  - Localized or generalized fluid accumulation; and
  - Diminished functional status as measured by hand grip strength.
SAFE HARBOR FOR UNSPECIFIED CODES

- The “safe harbor” practice will end

- This practice has allowed hospitals and other healthcare providers report unspecified principal diagnosis without fear of claim denial

- We expect the 2016 Final Rule to include language aimed at ending the practice

QUESTIONS

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REFERENCES


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“Hierarchical Condition Categories;” 3M Health Information Systems.

“ICD-10 Coordination and Maintenance Committee Meeting Discusses Impending Code Updates;” 3/15/16; Ward and Roper; Journal of AHIMA.


2016 CDI Pocket Guide; Pinson, MD, FACP, CCS and Tang, RHIA, CCS; HCPro; Association of Clinical Documentation Improvement Specialists (ACDIS).

LYNETTE THOM, RHIT, CCS, CDIP
AHIMA APPROVED ICD-10-CM/PCS TRAINER
SENIOR CONSULTANT, BLUE & CO., LLC

Lynette Thom is a Senior Consultant with Blue & Co., LLC on the Indianapolis Revenue Cycle team. She joined the firm in June 2012. She holds a Bachelor of Science in Health Care Administration and is a Registered Health Information Technician (RHIT). In addition, Lynette is an AHIMA Approved ICD-10 Trainer, as well as Certified Coding Specialist (CCS) and a Clinical Documentation Improvement Practitioner (CDIP), certified through AHIMA.

Lynette brings more than 15 years of experience in the field of healthcare. Her experience in clinics and hospitals, as well as academia, bridges a variety of services in the revenue cycle. She is a subject matter expert in hospital coding for all patient types – inpatient, outpatient surgery, observation, emergency department, psychiatric and geropsychiatric health as well as chemical dependency. Lynette also has experience performing coding analyses for ambulatory surgery centers (ASCs) and dental coding analyses.

Her work has included performing ICD-10-CM/PCS and CPT coding analyses, Recovery Audit Contractors (RAC) review management, denials management, and developing coding policies and procedures. Ms. Thom works with coders and physicians in hospitals around the country to improve clinical documentation to increase revenue and decrease risk of recoupment. She has developed and presented CDI training programs for physicians and surgeons as well as clinical and coding professionals in hospitals.

Lynette’s work in academia includes four years as an instructor at community college in health information technology, medical assisting, transcription, radiology and other clinical programs. Her curriculum included ICD-9-CM and CPT coding, health information privacy and release of information (HIPAA compliance), medical legal theory, pathophysiology, medical terminology, transcription, front office reception and many others.

Lynette has also served in different capacities in state component associations of the American Health Information Management Association (AHIMA). During her tenure as the Chair of the Legislative Committee for OrHIMA, she worked with the Oregon Hospital Association, trial attorneys, and other parties to write a Senate Bill which was the state’s precursor to today’s federal version of HIPAA. During her tenure, Lynette also authored the Position Statement for the OrHIMA regarding the Senate Bill, and authored an article about the experience of working on the bill for the publication “For the Record”, which is printed by AHIMA. Mrs. Thom is currently serving on the IHIMA Board as a chairperson for the Professional Development Committee.

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