The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 7th issue of the CA ACDIS journal!

Holy Mole Crisis Averted: FY 2020 IPPS Final Rules, CC/MCC downgrades postponed!

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In April of 2019, The Centers for Medicare and Medicaid Services (CMS) had proposed some shocking proposed changes to the CC/MCC under new rules of the Inpatient Prospective Payment System (IPPS). The changes sent shockwaves in the CDI and medical community. CMS justified these downgrades as "value-based healthcare". However, with the advocacy and persistence of several organizations including ACDIS, AHIMA, AHA, FHMA, and Dietitians. CMS has now postponed most of the almost 1500 proposed changes that would have caused close to 87% CC/MCC downgrades. The final rules do have changes and downgrades, but most are easier to swallow than what was initially proposed. Here are some of the major proposals and the final changes on page 2.

I was fortunate enough to interview an ACDIS celebrity and nationally known CDI Expert Dr. James Kennedy, MD, founder CDIMD, a physician and CDI consulting firm based in Nashville, TN. He has talked about the FY2020 IPPS Proposed and Final Rules extensively at conferences including ACDIS, presented a webinar, and written to CMS as a CDI advocate. Here is his take on the new changes, what they mean for CDI and hospitals, and his valuable tips for CDI professionals:

RJ: You are a practicing internal medicine physician, so how did you end up doing CDI?

JK: I suffered a major illness in 1988. Using my knowledge and skills, I have been involved with hospitals since 2000, including those based in California.

RJ: What is your take on the Final IPPS rules?

JK: We dodged a bullet, or a ricochet, a boomerang.

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RJ: Do you have any advice for CDI professionals going forward with these changes?

JK: Remember these tips. (Some of these tips can be found in Dr. Kennedy's lecture in the link attached at the end of this article.

- Eliminate unspecified Atrial Fibrillation (Hint: Chronic Afib is a CC).
- Documentation of Antibiotic resistance including penicillin needs to be explored by CDI professionals (Antibiotic Stewardship).
- Acute Cor Pulmonale in the setting of pulmonary embolus is an MCC.
- Coding Rule: If Type 2 Myocardial Infarction is documented, query the etiology and make that etiology the principal diagnosis, not the MI.
- We must be aware of new technologies and have a diagnosis code associated with that technology in order to avoid medical necessity denials.
- Work with your hospital CFOs and show them what the proposed and final rules mean for hospital reimbursement and financial impact.
- Work with local organizations such as CA ACDIS, CHIA, and CHIMA.

Proposal	Final ruling
Unspecified severe protein-calorie malnutrition downgraded from an MCC to	Both unchanged
Many ST-elevation myocardial infarction (STEMI) codes of all types down-	All remain MCCs.
Chronic systolic (congestive) heart failure, chronic diastolic (congestive)	All remain CCs.
Cardiac arrest due to underlying cardiac condition, other underlying condi-	All remain MCCs.
Hemoglobin SS (Hb-SS) disease with acute chest syndrome; Hb-SS disease with splenic sequestration; Sickle-cell/Hb-C disease with acute chest syndrome; Sickle-cell/Hb-C disease with crisis, unspecified; Sickle-cell thalassemia with acute chest syndrome; Sickle-cell thalassemia with crisis, unspecified; Other sickle-cell disorders (with acute chest syndrome, with splenic sequestration, with crisis, unspecified) all downgraded from MCCs to non-CCs.	All remain MCCs.
Most cancers downgraded from CC to non-CCs.	All remain CCs.
Stage 3 and Stage 4 pressure ulcers downgraded from MCCs to CCs.	All remain MCCs.
Compression of brain downgraded from MCC to CC.	Remains an MCC.
Antineoplastic chemotherapy induced pancytopenia and Other drug-induced	All remain MCCs.
End stage renal disease downgraded from MCC to a CC.	Remains an MCC.
Chronic kidney disease stages 4 and 5 downgraded from CCs to non-CCs.	Both remain CCs.
Bacteremia upgraded from a CC to an MCC.	Remains a CC.
Severe persistent asthma with (acute) exacerbation upgraded from a CC to	Remains a CC.
Several Z series organ transplant status codes downgraded from a CC to a	Remain CCs.

Reference: https://acdis.org/articles/news-fy-2020-ipps-final-rule-published-ccmcc-downgrades-postponed

Useful resources:

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Be sure to **SAVE THE DATE** for this year's conference:

Friday October 25th, 8AM—4PM at UC Davis
located in Davis, CA

Registration fee: $35; Premium Seating: $45

Evening Social/Networking Event (included in registration fee)

Thursday, October 24, 2019 (6-9 pm)

Venue: Three Mile Brewery, with Food Truck (TBA)

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https://www.cdimd.com/
https://acdis.org/articles/news-fy-2020-ipps-final-rule-published-ccmcc-downgrades-postponed
https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/SODFIPPS082019.pdf
https://acdis.org/resources/webinar-2020-ipps-proposed-rule%E2%80%94update-and-action-plan

Correctly Documenting Encephalopathy

Margaret DeFilippis JD, RN, CDIP, CCS, CPC, CCDS

There are a wide range of psychiatric and neurological mental status and brain disorder diagnoses that are not clearly clinically delineated or defined. These diagnoses often coexist and frequently require legitimate medical care, treatment, and assessment. Length of stay for inpatient care is often increased either by waiting for resolution of symptoms or by finding placement. Documentation of the clinical indicators supporting the diagnoses and documentation of the diagnoses themselves is often sparse. Coding mental status diagnoses and compliant querying for accurate documentation of these diagnoses is fraught with difficulties. Denials of payment are common, making reimbursement for care provided difficult to attain.

How can we create some order out of the Confusion?

Whenever coding, querying, or appealing mental status diagnoses, ask yourself these questions.

- Does the documentation refer to *symptoms* of diagnoses or actual medical *diagnoses* or both?
- Is there documentation of the patient's baseline mental status against which to compare?
- If both, are the symptoms integral to the diagnoses also documented?
- If both, which of the symptoms or diagnoses exclude each other within ICD-10?
- Is the symptom and/or diagnosis a medical or psychiatric diagnosis?
- If it is a diagnosis, are they acute or chronic conditions?
- If it is an unspecified diagnosis, can the documentation be compliantly specified?

If the documentation does not answer these questions, or is conflicting, a query may be indicated.

What clinical indicators of mental status conditions can be found?

- Comparisons to "baseline" mental status and improvement with treatment
- Lethargy, severe fatigue, muscle twitching weakness or shaking, ataxia
- Need for sitter and or constant presence of caregiver or order for restraints
- EEG results and Radiology results may or may not be supporting
- Laboratory test results (ex. electrolyte, medication levels, drug and alcohol levels)
- Mental Status exams documenting altered cognition, impaired judgment, or memory.
- Consultation with neurology +/or psychiatry
- History of sports or trauma injuries

Look for these symptoms throughout the record including in EMS, ED/triage and nursing, nutrition and therapy documentation.

What associated treatments or monitoring can be found in the documentation?

- Treatment of underlying condition (i.e. antibiotics, lactulose, insulin, dialysis, chelation, fluids, oxygen, psychiatric medication, etc.)
- Supportive care to prevent injury while mental status is disrupted
- Regular mental status +/or neuro checks
- In chronic diagnoses, prevent of progression of diagnoses.

Look for these treatments throughout the record including in EMS, ED/triage and nursing, nutrition and therapy documentation

When Encephalopathy is the Principal Diagnosis or is sequenced secondary but is unspecified, the claim is at high risk for claim denial. When psychiatric diagnoses and/or types of Dementia are documented concurrently with mental status diagnoses you are at equally high risk for claim denial. Further, when no treatment or increased monitoring is documented, claim denial may be inevitable. These are times when compliant queries for accurate improved documentation are likely to be essential.

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Note that there are cc and mcc opportunities among both symptom and diagnosis codes. If it is difficult to find documentation supporting Acute Encephalopathy diagnosis and treatment, look for:

- Glasgow Coma Score codes which may provide mcc's.R40.2_
- "Unconsciousness" or "Coma" which may provide mcc R40.20
- "Persistent Vegetative State" which may provide cc R40.3

Following is a summary *some* of the most common mental status codes.

Diagnoses	Summary Definitions	Code	MCC/CC Status
Acute Encephalopathy (Encephalopathy, Unspec.)	Disorder or disease of brain; "global cerebral dysfunction" **Reversible**, temporary (Delirium and AMS are symptoms.)	G93.40	**CC**
Toxic (May include Toxic Encephalitis)	**Due to** medications or toxins	G92	**MCC**
	If "adverse drug rxn ***also*** use	T36.8X5A	
	If poisoning, **also** use **(May code 1st toxic agent)**	T43.592A T51-T65	
Metabolic	**Due to** water, electrolytes, vitamins other internal chemi-cals (incl. due to **Sepsis/Hypoglycemia**)	G93.41	**MCC**
Hepatic	**Due to** Liver's inability to remove toxins – Codes to Liver Failure		
	with "coma"	K72.91	**MCC**
	without coma	K72.90	
Hypertensive	**Due to** (must say) "extreme bp"	I67.4	**CC**
CVA related ("Other Encephalopathy")	**Due to** (must say)	G93.49	**CC**
	CVA		
Neonatal	**Due to** Hypoxic Encephalopathy **-HIE**		
	mild to moderate	P91.60-P91.62	**CC**
	severe	P91.63	**MCC**
(Post-ictal is integral to seizure code and ***not separately coded***)			
Chronic Encephalopathy	Disorder of brain, "slow and progressive+/or **irreversible, "static"**		
Anoxic	Brain damage due to lack O2	G93.1	**CC**
CTE	Post-concussional syndrome	F07.81	
Korsakoff (alcohol related)	Related to Thiamine deficiency	G31.2	
Wernicke's	**Must be specifically dx** (Due to nutritional deficits)	E51.2	**CC**

Hometown CDI Hero spotlight: Interview with Tami Gomez, UC Davis

By Analyn Dolopo-Simon

Tami Gomez, CCS, CCS-P, CDIP, CCDS
AHIMA-Approved ICD-10-CM/PCS Trainer
Manager, Coding & CDI Services
Health Information Management (HIM) Division| Patient Financial Services

University of California Davis Medical Center

What are your favorite things to do in Davis?

Downton Davis is very much a college town like Berkley. In Davis, there are wineries that are owned by UC Davis graduates e.g., Jeff Runquist Winery (try the red blend!). There is also the Mondavi Center at UC Davis for wine (a degree in wine!). The temperature in Davis will probably be in the 70's and nice. But, beware the wild turkey epidemic. Wild turkeys are usually harmless, but they are everywhere! Stand your ground.

Favorite restaurants to recommend in Davis?

There are so many Farm to Fork restaurants with great fresh foods to try.

Interesting facts about UC Davis you would like to share?

UC Davis is located in Davis, but UC Davis Hospital is in Sacramento 40 minutes away. UC Davis is nationally known for the Veterinary Medical School and houses a very large primate research facility that is guarded with armed guards.

What you do you love about your CDI program?

The UC Davis CDI program is very mature program. UC Davis has established a rapport with the Executive level team CEO and CMO and with their Leadership and support have 15 inpatient and 11 outpatient CDSs who are nurses and Foreign Medical Degree Graduates with 2 analysts to support the CDI program, and are able get 100% response and 80% agree on queries. UC Davis CDI program also has the support of Dr. Romero (a UC Davis Physician) who is on the AHRQ and PSI-90 Committee.

Editorial note: UC Davis is at the forefront of PSIs!

DRG reconciliation and challenges come with it: Poster presentation

Muhammad Taha Farooq, M.B.B.S., ECFMG certified, CDIP, CCS, CCDS
Lead Clinical Documentation Improvement Specialist Optum360, Oxnard

My name is Muhammad Taha Farooq. I am a Foreign Medical Graduate. I graduated from one of the top medical schools of Karachi Pakistan in 2012. After graduating, I started my fellowship in psychiatry. I moved to USA in 2014, where I finished my licensing exams USMLE. In beginning years, I did couple of externships and in 2015 I started working as research assistant in Howard University Hospital in Behavioral Health Department. Then, I found the interesting and growing field of Clinical documentation specialist. I started my career as inpatient CDS in Prime Health care, and later in 2016, I joined Optum 360 where I was promoted to Lead CDS. Currently, I am covering central coast Oxnard facilities. I presented 2 posters in ACDIS annual conference and 1 in CA ACDIS conference. In the meantime, I completed my CCS, CCDS, and CDIP certifications.

Below is brief description about the poster:

- Definition of DRG reconciliation and its importance in building a successful CDI program.
- How DRG reconciliation helps strengthen relationships between other teams such as CDI, coding, billing & physicians.
- Various reasons of mismatches & the importance of selecting an appropriate reason for a mismatches.

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Thank you for your support!

MUHAMMAD TAHA FAROOQ | MBBS, CCS, CCDS
LEAD CLINICAL DOCUMENTATION SPECIALIST | OPTUM360 OXNARD, CA

DRG RECONCILIATION

AND THE CHALLENGES THAT COME WITH IT

DEFINITION

DRG reconciliation is the process by which the final coded DRG is validated through a second level, pre-bill review process.

PURPOSE

The purpose of DRG reconciliation is to adjust DRGs when those assigned by CDI specialists do not match those that are assigned by the coders. (HCPro ACDIS)

NECESSITY

The importance of DRG reconciliation:

- Fewer denials/DRG reassignments
- Education opportunities for coders and CDI
- Builds relationships between coders and CDI
- Collaboration between coders, CDI, physicians and billing

DRG RECONCILIATION PROCESS BEST PRACTICE

MISMATCH

Coders must contact CDI if there is a DRG mismatch.

EXPLANATION

The reason for mismatch must be explained.

(Add/Removal of code, coding guideline, change of PDX, subsequent documentation)

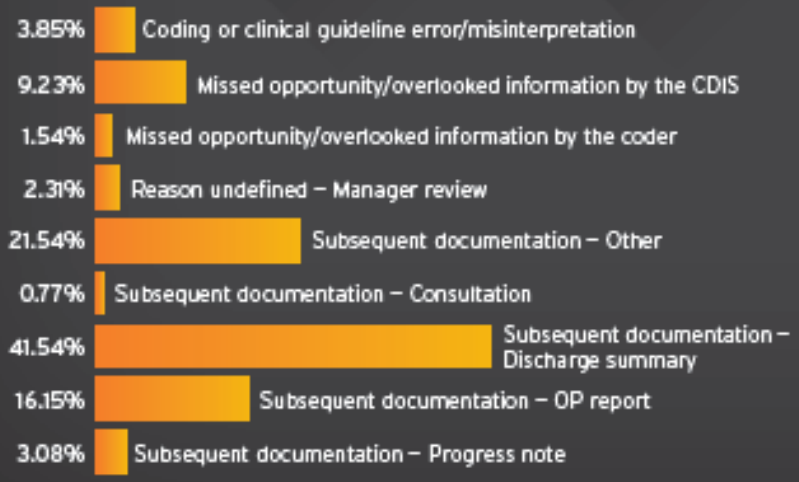
REVIEW

If CDI disagrees with coder, account is reviewed by a manager.

RESOLUTION

Accounts are dropped only after both CDI and coding agree on mismatch.

DRG MISMATCH REASONS



RECONCILIATION CHALLENGES

Disagreements between coding and CDI on mismatches.
Solution: Escalate for a manager review.
Inter-department meeting for learning opportunities.

Selection of correct reason for mismatches.
Solution: Education to coding/CDI.

Cases fall from worklist without DRG reconciliation.
Solution: Educate coding/CDI, importance of the process. Pull DRG reconciliation report at the end of the month and do DRG audits monthly. Send report to CDI and coding leadership to put comments on DRG reconciliation report.