The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 9th issue of the CA ACDIS journal!

The Virus that Shook the World:

Novel Corona Virus

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The end of 2019 saw a major shakeup in the medical community as a new virus known as Novel Corona Virus or COVID-19 caused several deaths in the Wuhan province of China, and within a matter of days spread to several countries all over the world. As of now, the United States has over 80,000 confirmed cases and counting, and more than 1,200 deaths (statistics are at the time of publication). The common flu is more prevalent than COVID-19; however, COVID-19 has a higher mortality risk which is why is it has caused so much fear and panic globally. Basic supplies such as hand sanitizers, toilet paper, bottled water and food are flying off the shelves, as if we are in war time conditions. Cities are quarantined, cruise ships are petri dishes floating in the water, schools are shut down and major events such as concerts and conferences are being cancelled.

So why is the virus causing so much fear and panic? It is due to the fear of the unknown. There are currently no vaccines or medicines that are available, since the virus was a recent discovery. This has led to physicians, public health workers, and governments scrambling to contain the virus and prevent further illness and death. COVID-19 is caused by the SARS-CoV-2 virus and causes respiratory illness which mimics the flu. Symptoms include: cough, fever, shortness of breath and in severe cases can result in pneumonia, sepsis, septic shock and even death (MedlinePlus 2020).

The CDI community has begun to deal with this disease which is now declared a pandemic and with over a thousand cases right here in the US. CDI programs have to deal with proper clinical documentation of the disease.

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I truly hope that what is known as Farr's law will apply to this disease before more CDI professionals have to confront this dilemma. For those who are not familiar with Farr's law, it is an epidemiological concept, named for epidemiologist William Farr, and states that as "the curve of cases of an epidemic rises rapidly at first, then climbs slowly to a peak from which a fall is steeper than the previous rise" (Farlex 2012). So hold on to your seats!

BREAKING News!! The CDC announced on March 18th that the ICD-10-CM code for COVID-19 will be implemented for use in the United States on April 1, instead of October 1, as originally planned. This is due to the urgency to "capture and report the condition in the nation's claims and surveillance data", per the CDC's announcement. This code is NOT retroactive on cases discharged before April 1st.

For more information on COVID-19 https://www.who.int/westernpacific/emergencies/covid-19.
The new COVID-19 code – U07.1 is for all discharges April 1st and onwards. Per AHIMA and AHA guidance, the new code is meant to be used as the Principal Diagnosis, followed by the codes for the manifestations. (https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/)
As more information emerges on the disease, further documentation and coding guidance should be expected from CMS and CDC.

For all discharges before April 1st, the following Coding guidelines are to be used:

Coding Guidelines for COVID-19 (CDC 2020)

Please note that a "suspected" or "possible/probable" case documented by a provider will not be coded. It must be a confirmed case to be coded.

COVID-19 with Pneumonia:
Assign codes J12.89 Other viral pneumonia and
B97.29 Other coronavirus as the cause of diseases classified elsewhere

COVID-19 with Acute Bronchitis
Assign codes J20.8 Acute bronchitis due to other specified organisms and
B97.29 Other coronavirus as the cause of diseases classified elsewhere
Assign codes J40 for Bronchitis NOS Bronchitis, not specified as acute or chronic; and B97.2 Other coronavirus as the cause of diseases classified elsewhere

COVID-19 with Lower Respiratory Infection
Assign codes J22 Unspecified acute lower respiratory infection and B97.2 Other corona virus as the cause of diseases classified elsewhere
For a respiratory infection NOS, assign codes J98.8 Other respiratory disorders and B97.2 Other coronavirus as the cause of diseases classified elsewhere

COVID-19 with ARDS
Assign coded J80 Acute respiratory distress syndrome and B97.2 Other coronavirus as the cause of diseases classified elsewhere

Exposure to COVID-19

If a patient is evaluated for COVID-19 exposure, but it is ruled out, assign code Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

Signs and Symptoms

R05 Cough

R06.02 Shortness of breath

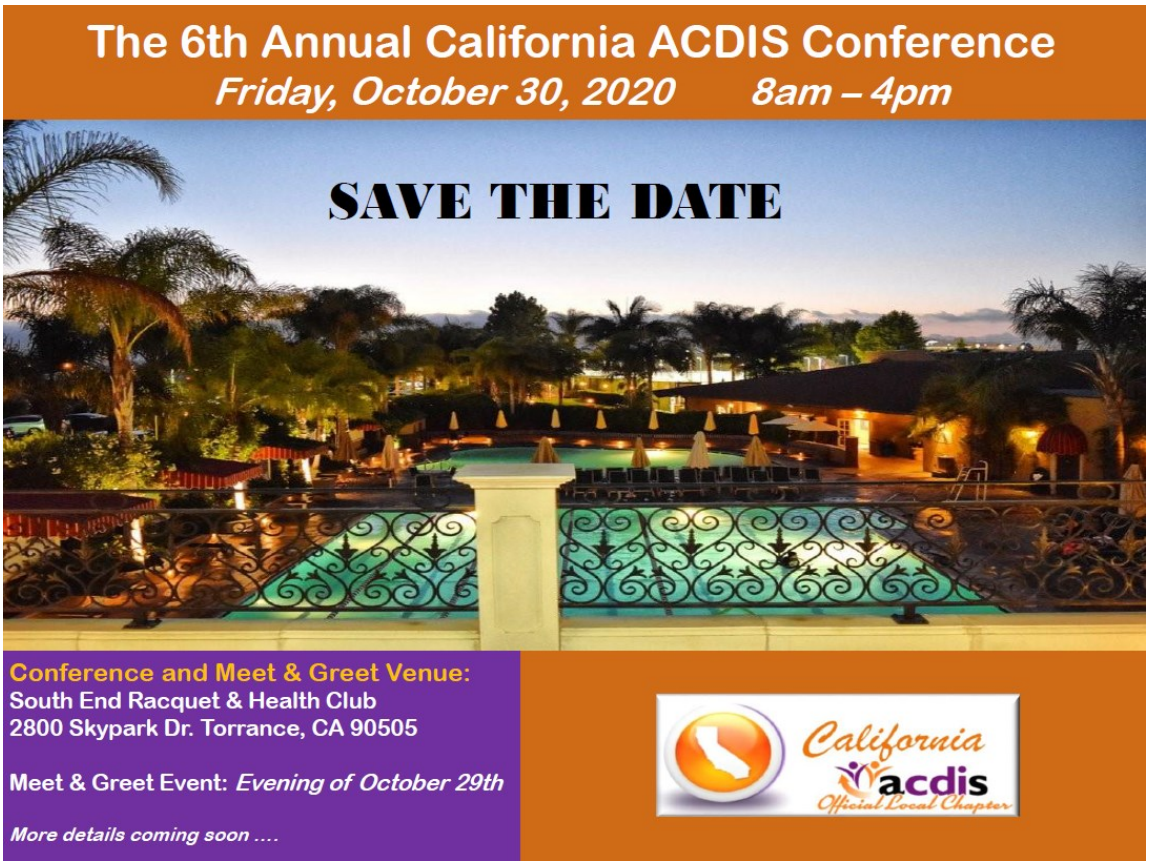
R50.9 Fever, unspecified

References:

"Coronavirus Infections". MedlinePlus (National Library of Medicine of the United States). Retrieved on March 10, 2020.

Medical Eponyms. Farlex 2012. Farr, William. Retrieved on March 10, 2020.

ICD-10-CM Official Coding Guidelines - Supplement Coding encounters related to COVID-19 Coronavirus Outbreak Effective: February 20, 2020. https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf, Retrieved on March 10, 2020.



The Impact of Accurate and Poor Documentation of Transcatheter aortic valve replacement (TAVR) on Physician and Hospital Profiling

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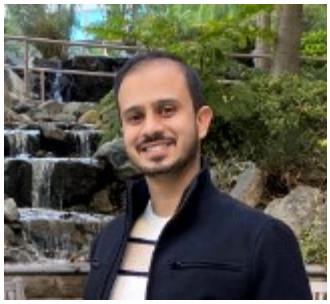


Definition: TAVR is a percutaneous surgical procedure in which the surgeon inserts a catheter in the patient's leg or chest and guided to heart to replace stenotic (narrowed) aortic valve in order to keep the proper blood flow to the body.

Clinical manifestations of TAVR patient:

Chest pain, worsening heart failure and syncope
Other manifestations are: fatigue, dizziness, exertional chest pain etc.

Common MCC[1] Opportunities and its impact on MS DRG:

Acute on Chronic Systolic/Diastolic/Combined Heart Failure
Acute/Acute on Chronic Respiratory Failure with Hypoxia or Hypercapnia
End Stage Renal Disease
Acute Renal Failure with Tubular Necrosis.
Congenital Heart Defects: e.g. Tetralogy of Fallot, Transposition of Great Vessels, Pulmonary Atresia etc.
Cardiogenic Shock
Metabolic/Hypotensive Encephalopathy
Severe Protein-Calorie Malnutrition

Case scenario:

75 y.o. female with a known history of CHF came to ER with the complaint of chest discomfort on exertion, dizziness and SOB. Per patient, she is compliant with her medications and denied peripheral edema, syncope, or orthopnea.

Labs and radiography

BNP- 550 pg/ml

CXR findings – Bilateral mild pulmonary edema.

Echocardiography findings- LV dysfunction with EF 30-35% with underlying aortic insufficiency and LVH.

Cardiologist was consulted and patient underwent TAVR surgery.

After CDI review, the patient documentation met criteria for CHF acuity and type and a CDI query was submitted. The MD responded to CDI query with documentation of "Acute on Chronic Systolic CHF". The impact of the CDS query and additional clinical documentation (MCC) on the MS DRG is displayed below.

MSDRG	DRG description	Relative weight (RW)	GMLOS	SOI	ROM
267	Endovascular cardiac valve replacement & procedure w/o MCC	5.67	1.9	3	1
266	Endovascular cardiac valve replacement & procedure w/ MCC	7.12	3.5	4	3

Possible Physician Education:

Documentation of post-op respiratory failure is coded as a complication and can impact hospital quality scores. Not all conditions that occur following surgery are classified as complications and there must be a documented cause-and-effect relationship[2]. Potential CDS query opportunity maybe available, if the patient is weaned from ventilator in less than 48 hours and clinical documentation does not support post-op respiratory failure.

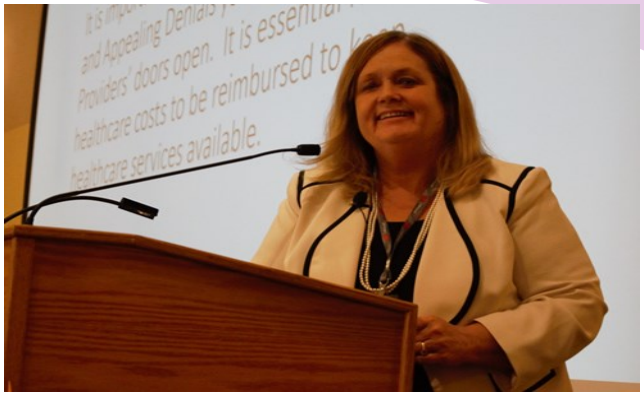
Documentation of acuity of heart failure – acute, chronic, acute on chronic.

Documentation of the type of heart failure – systolic, diastolic, and combined systolic and diastolic.

References:

FY 2015 MedPAR Note: MCC is abbreviated for Major complications and comorbidities

ICD-10-CM Official Guidelines for Coding and Reporting FY 2020 (October 1, 2019 - September 30, 2020) pg 18



Maggie DeFilippis, RN, CCDS, CCS, CPC, JD

HOSPITAL READMISSIONS: THE EXPENSE OF THE REVOLVING DOOR

The majority of healthcare facilities in the United States face significant reductions in payment when patients are readmitted to a healthcare facility within a certain period of time (usually 30 days) after their date of their discharge from a hospital. The reductions in payment include denials of coverage by payers, including Medicare and Medicaid; reductions in base operating DRG payments for the upcoming fiscal year under Hospital Readmissions Reduction Program ("HRRP"); ***and*** as a factor in determining Value Based Adjustment Reductions in base operating DRG payments. To be clear, the HRRP reduction and Value Based adjustments are *cumulative* and each impact the value of *every* MS-DRG assigned by the hospital in the upcoming year. Also, Readmission statistics for each provider are publicly available on the CMS COMPARE website, which impacts patients' choice of provider. In addition to these penalties CMS and commercial payers have been denying payment of individual claims as Readmissions in an increasing number of claims. The financial impact of classification of an admission as a *Re*admission is considerable.

CDI can have a real impact on reducing all types of Readmission reductions of payment. Quality reporting and medical codes are the basis for Inclusion in each of these Readmission categories. When a second admission within thirty days has the same Principal Diagnosis or a Principal Diagnosis *indicating it is a* complication or continuation of the first admission, the second admission is likely to be designated a Readmission. If documentation shows the second admission was planned and/or unavoidable and/or independent of the first admission, penalties for Readmission and Readmission Denials may be avoided. At minimum, with proper documentation, Readmission Denials may be successfully appealed. Payers rely on clinical documentation, accurate coding and compliant quality reporting to determine whether an admission qualifies as a Readmission. By ensuring accurate documentation CDI can help the facility decrease readmission costs and penalties.

In 2019, 84% of teaching hospitals (over 2,400 hospitals) received HRRP reductions in payment. This means that all of these hospitals had a *greater than expected number of admissions* classified by CMS as Readmissions. In 2020 the only conditions upon which CMS bases HRRP and Value Based penalties are: Acute Myocardial infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, Pneumonia, Coronary Artery Bypass Graft surgery and elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty. To determine whether a HRRP penalty should be issued and whether Value Based adjustment should be impacted, CMS calculates the *expected* rate of Readmissions against the actual rate of Readmissions. The expected rate of readmissions is "risk-adjusted." This is a complicated calculation, but the essential result is this. The more chronic conditions that qualify as Hierarchical Condition Category Codes ("HCCs") that are coded, the

higher the complex case mix of the hospital, and the greater the expected rate of Readmissions will be. A greater expected rate of Readmissions lessens the chance of payment reductions. This is another reason for coders to capture all codes that may or may not bear an MCC or CC but show that the patient has many comorbidities that make the possibility of their Readmission greater. CDI education should include the importance of documenting chronic conditions in the medical record. Code as many HCC eligible conditions as the documentation and the Official Coding Guidelines support!

Unlike in the area of CMS penalties, payers may deny payment based upon Readmission in a broad spectrum of cases. Readmission denials essentially state, "*We paid you for the previous hospital stay, and since this new stay is related to that one, we won't pay you anymore.*" The payer feels that *If the patient's conditions had been properly treated as part of the initial admission, the second admission would not be necessary. CMS states,* "*When a patient is discharged/transferred from an acute care hospital, and is readmitted to an acute care hospital on the same day or within 30 days for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.*" *Many payers have similar policies. Aetna's policy states, "Hospital readmissions following* a discharge to home and occurring within 30 days for the same condition should be billed and paid as one charge. The first inpatient stay that was approved and paid by Aetna will be reversed in our system so we can pay the corrected, *combined* claim for both inpatient stays." Whenever two admissions within 30 days bear the same or related Principal Diagnosis and/or MS-DRG, there is a red flag for payers to designate the claim a Readmission.

Clinical Documentation Integrity Specialists (CDIS) have a vital role in making sure documentation accurately reflects whether an admission which occurs soon after discharge from a healthcare facility was avoidable, planned and/or independent of the first admission. If the documentation shows that the patient was noncompliant with the regimen of care despite discharge instructions being given and plans for outpatient care being made, the second admission may *not* be a counted as a Readmission as it was "*unavoidable*." Coding ICD-10 codes for noncompliance helps to accurately portray the unavoidable nature of the second admission. If the patient leaves the hospital to prepare for surgery, the second admission for surgery is "*planned*" and therefore not a Readmission. If the documentation evinces that the patient was doing well after Knee Replacement, but is readmitted for dislocation of synthetic knee joint which occurred during a motor vehicle accident, the second admission may be *independent* of the first, escaping Readmission status. In cases at high risk for Readmission CDI should scrutinize the Principal Diagnosis for accuracy.

The central aim of Readmission payment reductions is to make sure that patients are given the best chance for full recovery on each hospitalization. If CDIs see that patients are often being readmitted for the same diagnosis or a diagnosis primarily linked with the first admission diagnosis, documentation integrity demands that the coding accurately reflect the problem and that quality indicators be sent. The efforts of the CDI are then focused on working with medical providers to prevent such readmissions clinically. Closer outpatient follow-up often prevents readmissions. Admitting patients to Observation or other outpatient alternatives when they are qualified for inpatient admission in an effort to diminish Readmissions is *not* a viable option. Changing the focus of documentation is also *not* a viable option. These practices compromise the integrity of the care and documentation and expose the provider to the possibility of additional penalties.

Knowledge of Conventions, general and chapter specific coding guidelines to reduce the unnecessary Queries for Clinical Documentation Specialist (CDS)

Sandeep Randhawa, MBBS, ECFMG Certified, CCDS, CCS, UCSD Health

Coding is not a primary responsibility of the CDS, but strong knowledge of the coding conventions, general and chapter specific coding guidelines can definitely help to reduce unnecessary queries. This will increase the productivity and efficacy of the CDI program and can save the valuable time of the health care providers to answer queries. The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes. Adherence to convention rule, of with and chapter 9 guidelines for hypertension (included below), the CDS should not query the health care provider to link the hypertension with the heart failure or chronic kidney disease.

"With" The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related, even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions. For example, in Chapter 9: Diseases of the Circulatory System (I00-I99) a. Hypertension: the classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

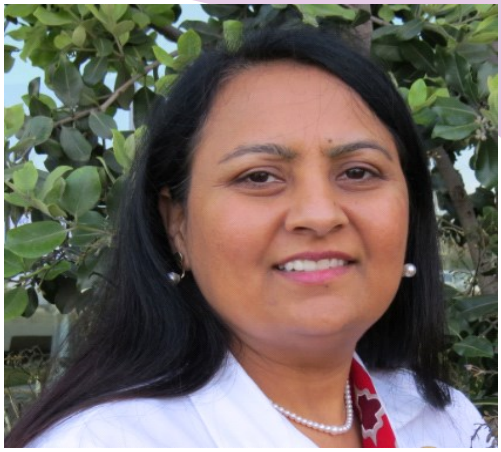
The **"With"** convention rule also applies for anemia in chronic kidney disease (CKD) and anemia in malignancy as well as code assignment of the diabetes with related complication. CDS should not query for the linkage of anemia to CKD or malignancy.

No query is needed to link the diabetes to chronic kidney, osteomyelitis, nephropathy, neuropathy and retinopathy.

CDS can assign a code for anemia of chronic kidney disease of D63.1 and anemia of malignancy D63.0 when anemia is documented in the patient with CKD and malignancy without provider documentation explicitly linking them.

The word "**with** "does not need to be documented by the healthcare providers in the medical records but can be looked under the main tern in the Alphabetic index of the ICD CM code book. By looking at the main term Hypertension in the alphabetic index of the code book, linked to the sub-term heart failure, a combination code I11.0 can be assigned without provider documentation explicitly linking them. Similarly a combination code of E11.69 can be assigned for diabetes and osteomyelitis linked by the word with in the code book.

References: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf



CDS Spotlight Interview

Sandeep Randhawa, MBBS, ECFMG Certified, CCDS, CCS

Brief bio: I am an ECFMG certified foreign trained physician and have completed medical education and training from the prestigious institute of India. I grew up in the Northern part of India and developed interest in healthcare at very early age. After completing medical school I worked as family physician in my home town. I moved to the United States for better opportunities and have successfully completed all 3 parts of US licensing board examinations. I developed an interest in Clinical Documentation Improvement (CDI) Program about 10 years ago. I have a wide range of experiences as a Clinical Documentation Specialist (CDS), as well as a senior coder. Apart from working as a CDS, I enjoy gardening, cooking and going for hikes.

How did a Physician end up in CDI? Getting matched to the residency program is a challenging process for foreign trained physicians. Matching to the residency program is little easier on the East Coast, but relocation to the East Coast was difficult for me with two small children. To get exposure to the US Health System, I started working as a CDS. I found the CDS role very rewarding and challenging. Working as a CDS, I still feel connected to patient care. It is a constant learning experience for me where I can utilize my medical knowledge and can make a difference in the care we provider to our patients. On daily basis, I am growing and updating my medical knowledge.

Favorite things to do in San Diego? Torrey Pines hike, Dixson and Miramar Lake Hike, Horn blower cruise.

Favorite restaurant: Veranda Fireside Lounge and Restaurant, Island Prime Restaurant.

Interesting facts about UC San Diego Medical Center? UC San Diego Health is a tertiary care, teaching hospital with a diverse patient population. It is a research institute, has great technology and treats patients with rare medical conditions as well as international patients. In the current global health situation, UCSD Hillcrest Medical Center has been chosen as the treatment center for affected Corona Virus patients.

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Contact: Analyn Dolopo at adolopo@ucsd.edu

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