The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 6th issue of the CA ACDIS journal!

# Holy Mole!

## 1,500 CC/MCC changes proposed for 2020 with 87% downgrades?????

## WHY, and what's a CDI to do?

**Maggie DeFilippis, RN, JD, CCDS, CDIP, CCS, CPC,**
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In April 2019, The Centers for Medicare & Medicaid Services (CMS) proposed a broad-reaching rule with a singular objective. That stated objective was "to transform the healthcare delivery system through competition and innovation to provide patients with ***better value and results***." Annually, CMS proposes updates to Medicare payment policies for the approximately 3,300 American Acute Care Hospitals paid under the rules of the Inpatient Prospective Payment System (IPPS.) This year, the proposal for 2020 and beyond was *unprecedented* with 1,500 proposed changes in complication and comorbidity (cc) value and major complication and comorbidity (mcc) value. Even more shocking, 87% of these changes lower the re-imbursement amount for taking care of patients with chronic or acute comorbidities. CMS' statement that the changes in cc and mcc were a part of the objective to provide better value and results was also new.

In the next issue of this newsletter, the proposed and accepted changes will be outlined in greater detail – stay tuned! Until then***, just a few*** of the proposed changes as delineated by ACDIS include:

1. Unspecified severe protein-calorie malnutrition (E43) downgraded from an MCC to CC, while Moderate protein-calorie mal-nutrition (E44.0) is being upgraded from a CC to an MCC.
2. ST-elevation myocardial infarction (STEMI) codes of all types downgraded from an MCC to a CC, while Non-STEMI and Type 2, 4, and 5 MIs remain as MCCs.
3. Chronic systolic (congestive) heart failure, chronic diastolic (congestive) heart failure, and chronic combined systolic and diastolic heart failure, all downgraded from CCs to non-CCs.
4. Cardiac arrest due to underlying cardiac condition, other underlying condition, and cause unspecified, all downgraded from MCCs to non-CCs. Ventricular fibrillation and ventricular flutter are proposed to be downgraded from MCCs to CCs.
5. Most cancers downgraded from CC to non-CCs (approximately 766 codes in the C15.3 through C96.Z code range).
6. Stage 3 and Stage 4 pressure ulcers downgraded from MCCs to CCs.
7. Compression of brain (G93.5) downgraded from MCC to CC.

(continued on page 2)

acdis Official Local Chapter

Issue 06 July 2019

(cont'd from page 1)

8. Bacteremia (R78.81) is upgraded from a CC to an MCC.
9. Severe persistent asthma with (acute) exacerbation has (J45.51) been upgraded from a CC to an MCC.

Several Z series organ transplant status codes (kidney, heart, lung, liver, bone marrow, stem cells, etc.) downgraded from a CC to a non-CC.

"WHAT? How does *decreasing* the amount of reimbursement for caring for patients with major or chronic comorbidities "provide patients with better value and results?" Are they talking about providing patients with more valuable healthcare with better healthcare results? The simple answer is no. The reference to "better value and results" is consistently a reference to government and commercial payers' determination to move reimbursement away from all current payment modalities to "Value Based" modalities.

It is interesting to note that CMS also stated it was their principal objective "to transform the healthcare delivery system through competition and innovation to provide patients with better value and results" when they released the following programs in the past year: CMS plan to flatten CPT E&M rates of reimbursement; April 2019 roll-out of *Primary Care First* (a New Initiative for Value Based Transformation of Primary Care;) and the acceleration of the Comprehensive Care for Joint Replacement Model.

The same phrase was used by Health & Human Services (HHS) Secretary Sylvia Burwell when she announced her Department's plan to incentivize and "focus on all efforts on increasing participation in Hospital Readmissions Reductions Programs and Hospital Value Based Purchasing programs with the aim of providing patients *with better value and results*." Similar phrasing has been used by commercial payers such as Aetna when they announced they were "on track to reach their goal of having 75% of total spending in value-based contracts by 2020" stating, "we are on track for reaching our goals of providing our insured clients with improved *value and results* in healthcare." So when we hear these words, we know that government and commercial payers are determined to continue to limit reimbursement based on fee-for-service models (i.e., Case Mix Index, CCs, MCCs, etc.) and incentivize reimbursement based on Value Based models.

This does NOT mean an end to the need for Medical Coding and Clinical Documentation Integrity (CDI) programs. Rather it means medical coders must be more aware of the many uses of claims codes by payers. CDI must be more aware of the accurate documentation that needs to be clear in the medical record to optimize Value Based forms of reimbursement and to protect from retractions of reimbursement by Value Based efforts. Quality Assurance and CDI will need to work closely together to ensure that Quality and Claims data are consistent. Health Information Management and Financial Management will have to find new metrics to measure the valuable efforts of Coders and CDI rather than merely using metrics related to increasing Case mix Index.

**Fear not** my friends; there will still be plenty of work to be done by Medical Coders and CDI to insure accuracy in Medical Record Documentation so that Quality and Claims data can accurately capture Value Based incentives rather than penalties. There will be cases that appear to be readmissions that are not. There will be diagnoses that appear to be HACs that are not. There will be cases where it is warranted and necessary for the patient to have had joint surgery in the hospital which will need to be clarified. CDI will need to understand how medical record documentation, claim and quality data are translated into statistics publicly describing the facility. Coding and CDI will have to understand the use of coded documentation when translated into HCC/Risk Adjustment codes. Coding and CDI will remain essential to the fiscal solvency of healthcare organizations despite governmental efforts to diminish the value of complications and comorbidities.

CMS is accepting comments on the proposed changes through June 24, 2019. Please go to https://www.regulations.gov/document?D=CMS-2019-0073-0001 and click on the Comment Now! button on the right-hand side to note your opinion of these proposed changes. There is no minimum or maximum length for an effective comment.

**This article was prepared by Margaret DeFilippis, RN, JD, CCDS, CDIP, CCS, CPC in her personal capacity. The opinions expressed in the article are the author's own and do not necessarily reflect the views of the NIHH or CMS.*

# Myocardial infarction: Follow the Plaque!

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**Myocardial Injury vs. Infarction**

The 4th Universal Definition of Myocardial Injury is the presence of abnormal cardiac biomarkers evidenced by a rise in the cardiac troponin values (cTn) with at least one value above the 99th percentile upper reference limit (URL).[1]

The cTn values are elevated in both in myocardial injury and myocardial infarction.

If the cTn levels are stable, then it is chronic myocardial injury which can occur with e.g., chronic kidney disease and structural heart disease.[1]

**There are 5 types of Myocardial Infarction**

Type 1 MI: Acute myocardial infarction is the term that is used when there is acute myocardial injury as evidenced with rise and/or fall of cTn and the **presence of at least one** of the following: symptoms (e.g. chest pain, SOB), new ischemic ECG changes, pathological Q waves, imaging evidence (generally echocardiogram) showing new wall motion abnormality, and identification of a coronary thrombus by angiography or autopsy[1]. Acute coronary atherothrombotic myocardial injury is triggered by either plaque rupture or erosion and includes ST-segment elevation MI (STEMI) and Non-ST-segment elevation MI (NSTEMI).[1]

Type 2 MI: Similar to Type 1 MI with the rise and/or fall of cTn and Acute Myocardial Injury as evidenced by the presence of at least one of the following: symptoms (e.g. chest pain, SOB), new ischemic ECG changes, pathological Q waves, imaging evidence (generally echocardiogram) showing new wall motion abnormality; however, the myocardial ischemia is from oxygen supply-demand imbalance that is unrelated to coronary thrombosis. Despite distinct causes, Type 1 NSTEMI and Type 2 MI are difficult to distinguish at presentation, with the diagnosis becoming clear only after further testing is done.[2] Type 2 MI occurs most often due to the presence of one of the following: fixed coronary artery disease without plaque rupture, severe anemia, significant arrhythmias, coronary dissection, intramural hematomas, respiratory failure with severe hypoxemia, or shock.

Type 3 MI: includes patients who had a sudden cardiac death, with presumed new ischemic ECG changes or ventricular fibrillation, but who died before blood samples for biomarkers can be obtained, or before increases in cardiac biomarkers can be identified prior to death, or MI is diagnosed post mortem and detected by autopsy examination.[1]

Type 4 thru 5 MI are procedure/device related: Type 4a is an MI w/in 48 hours of a coronary angioplasty, Type 4b is an MI due to stent/scaffold thrombosis, Type 4c is an MI associated with in-stent restenosis or restenosis following balloon angioplasty in the infarct territory and Type 5 is MI w/in 48 hours of CABG[1]

Accurate documentation of acute myocardial infarction (in particular, Type 1 MI) is important as it impacts accuracy of coded data and data on MI performance measures for Quality CMS Acute MI Core Measures), MI readmission penalty programs (e.g., CMS Hospital Readmissions Reduction Program), and bundled payment programs. The previously mentioned programs only enrolled Type 1 MI patients for analysis[3].

Myocardial Infarction and CDS tips to keep in mind

ICD-10-CM Index classifies all heart injury as traumatic.[3] It is really important to capture the etiology of the condition and cause of elevated troponin.

If Type 1 MI is diagnosed, then location and/or vessel is important to capture.[3] Follow the plaque!
If there is no CAD or significant CAD found on cardiac cath, there can be a potential opportunity for query for clarification and to rule out a Type 1 MI.

If Type 2 MI is diagnosed, for principal diagnosis selection, the underlying cause of the Type 2 MI should be documented as the primary diagnosis (e.g., anemia, acute heart failure, paroxysmal tachycardia, hypertensive crisis, shock); Type 2 MI should only be coded as a secondary diagnosis[2]

(continued on page 4)

(cont'd from page 3)


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A special Thank you! Dr. Lori Daniels, Dr. Mitul Patel and Dr. Lawrence Ang for feedback

Analyn Dolopo-Simon RN, MPH, ACM, CCDS UCSD CDI Program Director. I have an MPH in Health Services Administration. I am a Certified CDS and Case Manager. I have been a nurse for 30 years with experience in: Orthopedics, Telemetry, Trauma/Neuro/Surgical/Burn ICU, Dialysis, Homecare and AIDS Case Management. I was a UCSD Medi-Cal Managed Care Program Manager, Inpatient Case Management and Utilization Review Nurse, California of Department of Health Services (DHS) Nurse Evaluator and UCSD Burn and Wound Research Nurse under Trauma Surgery Department. The UCSD CDI program has been in place since 2003 and I joined the CDI program in 2006. UCSD Medical Center has 4 hospitals in 2 campuses (La Jolla and Hillcrest) with a combined bed capacity of 799 beds and is a major tertiary and quaternary center that serves San Diego, Riverside, and Imperial Counties. We started with 2 hospitals with 3 CDSs in 2006, now we have 4 hospitals and 10.5 CDS (2018) providing concurrent review of targeted service lines/Payors. Clinical Documentation Improvement allows me to use all the experience and lessons learned during my long and varied career.

**Be sure to SAVE THE DATE for next 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)**

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# The 12th Annual ACDIS Conference: Charting the Course!

Rabia Jalal, MBBS, CCS, CDIP, CCDS, RHIA
CDIS/Senior Clinical Analyst at Optum360
Marian Regional Medical Center, Santa Maria, CA

The 12th Annual ACDIS Conference took place this year from May 20 to 23, 2019 at the beautiful Gaylord Palms Resort & Convention Center in Kissimmee, Florida. Like every year, the convention brought together hundreds of Clinical Documentation Specialists, Coders, Physicians and some wonderful keynote speakers. One such speaker was Dr. Natalie Stavas, who was running the Boston Marathon on April 15, 2013, and was just blocks away from the finish line, when the bombs went off in what is now the infamous Boston Marathon Bombing. Her inspirational speech touched on how she went from a runner to first responder within minutes. She captivated the audience with her beautiful presentation and her sense of humor had everyone roaring. Speaking of sense of humor, another inspirational keynote session was one by Joe Tye, a motivational speaker who could double as a comedian. The friendly OIG also made an appearance and assured us all that we were not in any trouble.

There were some amazing sessions both ACDIS regulars and some first-time speakers with a range of topics from Sepsis, Pediatrics, Malnutrition to Coding Clinics, Burns, How to Speak CFO etc. On May 22, 2019, attendees were also able to view a Poster session which also covered a range of topics. Two of the CA ACDIS Newsletter Committee members, Rabia Jalal (BABY BABY: Clinical Documentation in the OB-GYN World) and Muhammad Taha Farooq (DRG Reconciliation and The Challenges That Come with It) also presented posters (see photos on next two pages).

The ACDIS spirit was alive every day with attendees sporting their finest purple and orange outfits and representing their state chapters. This year was also bittersweet as the "ACDIS Chick" Penny Richards is retiring. So many of us have exchanged emails with her for our CCDS certifications and conference attendance over the years. She will be missed!

The vendors are perhaps one of the most popular and sought-after attendees as they brought some of the coolest activities and giveaways, while promoting their services and products. Attendees were able to get into a superhero themed photo booth, have themselves turned into a cartoon, or have their pictures put on a pancake. The raffles had everyone vying for free designer purses, gift baskets, memberships, books and admission to next year's conference. This year Brad Pitt and George Clooney cutouts also made an appearance and were a real crowd pleaser!

We hope to see you at future conferences. Some upcoming conference dates to remember:
5th Annual CA Chapter ACDIS Conference in October 25, 2019 at UC Davis, California and 13th Annual National ACDIS Conference in May 2020 in Las Vegas, NV.

(continued on page 6)

(cont'd from page 5)



From left to right: Rabia Jalal (Dignity Health), Chinedum Mogbo (Tenet Health), Cris Gumayagay (Providence), Dr. Joel Lipin (UCLA) - Co-Chair CA ACDIS, Ami Vyas (Optum360), Madhu Subherwal (Torrance Memorial), Co-Chair CA ACDIS

(continued on page 7)

(cont'd from page 6)


Rabia Jalal (BABY BABY: Clinical Documentation in the OBGYN World), ACDIS Newsletter Committee Member


Muhammad Taha Farooq (DRG Reconciliation and The Challenges That Come with It) ACDIS Newsletter Committee Member

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Contact: Analyn Dolopo at adolopo@ucsd.edu

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