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Trey La Charité, MD, says the days of merely complying with published coding guidelines are gone; now, CDI professionals must grapple with payers who, through denials, sometimes seem to claim medical clairvoyance and immunity to accepted diagnostic criteria.
About a week after the ACDIS staff returned home from Atlanta following this year’s national conference, we packed up yet again, this time for a new corporate home a few towns away, roughly 10 minutes from our previous location. As with any big move, many of us had concerns. What would the new space look like? How much space would we have as individuals and as a company as a whole? What would our new commute turn out like?

We needn’t have worried. Our new location is in a peaceful office park, set back from two major highways, overlooking rolling hills of conservation land. We have spiffy new desks, meeting rooms, and shared gathering spaces where we can interact with our fellow ACDIS, HCPro, and HealthLeaders colleagues. In fact, ACDIS Editor Katherine Rushlau kidded me about the nature images I chose as I pulled together this edition of CDI Journal.

“Why didn’t you just take a picture of the view out the window?” she poked.

“Because I couldn’t bribe the geese to fly in an arrow pattern,” I answered back.

All joking aside, I couldn’t imagine a more appropriate graphic to adorn the cover of this issue—nearly every article in its pages points to how CDI programs can expand their existing efforts and take flight.

Last year, during CDI Week, ACDIS focused on the growth of CDI programs’ efforts; since that time, conversation has centered around the numerous opportunities to meet the needs of our changing healthcare landscape. Those needs include:

- Outpatient CDI
- Risk adjustment
- Multi-facility programs
- Pediatric, rehabilitation, long-term care, and critical access efforts
- Quality
- Value-based purchasing

ACDIS has endeavored to bring its members the latest trends and information on these new horizons, pulling from the experience and knowledge of those working in the field and creating a path for CDI professionals to follow.

And ACDIS continues to grow. Now 5,000 members strong, we have an amazing new website and have just enjoyed our most successful conference to date. Yet we are still right here with you, our thoughts on those new horizons, ready to take flight together. 🎯
ACDIS submits comments on IPPS proposal

Editor’s note: The ACDIS Advisory Board submitted the following comments to CMS on June 16 regarding the 2017 IPPS proposed rule.

The Association of Clinical Documentation Improvement Specialists (ACDIS) is pleased to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed changes to the Medicare hospital inpatient prospective payment system (IPPS) and proposed fiscal year 2017 rates, as published in the April 27, 2016, Federal Register (CMS-1655-P).

ACDIS is a professional association representing more than 5,000 CDI professionals nationwide. Its members include RNs, health information management professionals, quality improvement personnel, and physicians.

CDI professionals work to ensure complete and accurate documentation in the medical record, which is integral to accurate assignment of ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes and the Medicare severity diagnosis related groups (MS-DRG) discussed in this proposed rule.

Their work also helps to ensure the accurate reporting of quality measures; medical necessity of inpatient admissions and procedures; hospital and physician profiles; and other publicly available data.

Our detailed comments and rationale on the FY 2017 IPPS proposed rule are below.

2-midnight rule and documentation and coding adjustment

IPPS FY17 reversed its 0.2% payment reduction for inpatient services that was implemented as part of the original 2-midnight rule. This was an appropriate action to take as ACDIS has heard from its members that implementation of the 2-midnight rule did not result in changes to inpatient volumes that would have justified the payment cuts.

ACDIS is deeply disappointed that the rule includes a large documentation and coding adjustment (DCA)/IPPS reduction to hospitals and health systems at an unexpected rate of 1.5%—nearly double the amount indicated by CMS in the 2016 IPPS rule (0.8%). This steep cut will surely affect patient care.

While we support scientifically justifiable adjustments to payments for coding changes that were
implemented in 2008, we have a concern that the data is not transparent enough to support the adjustments and remains somewhat arbitrary. The very concept of a DCA punishes hospitals that ensure the codes submitted on the claim form are as accurate and specific as possible based on the directives given in the ICD-9-CM Official Guidelines for Coding and Reporting.

CMS itself stated in the 2008 IPPS final rule that: “We do not believe there is anything inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment as long as the coding is fully and properly supported by documentation in the medical record.” This statement is incongruent with the concept of the DCA.

ACDIS believes that the DCA requires further analysis and/or greater transparency. For example, it does not appear to account for hospitals that may have added an expensive new surgical service line that increased its case-mix index (CMI). It also does not seem to recognize the fact that the increased trend toward treating patients on an outpatient basis, and more rigorous standards for inpatient admissions, has resulted in patients that are more severely ill on admission.

CMS noted in its supplementary “Estimate of Medicare Documentation and Coding Adjustments” document that it needed to increase the DCA from 0.8% to 1.5% this year in part due to a decrease in the total number of hospital discharges, which is partially the result of CMS’ Hospital Readmissions Reduction Program (HRRP). The bar has been raised for hospital admission, and these sicker patients have resulted in real changes to the CMI for hospital discharges; they are not artificial changes to the CMI as a result of better documentation and coding.

We believe that the changes in coding noted are related to better reflection of patient-accurate severity of illness and should be considered consistent with the required resources needed for evaluation and management of patients admitted to the hospital, and as such the DCA is not warranted.

**Quality measures additions**

The proposed rule requires Electronic Clinical Quality Measures and adds new quality measures. ACDIS is concerned about the related documentation burden, which creates challenges for physicians in accurately reflecting patients’ severity of illness. Last year’s severe sepsis and septic shock measure (SEP-1) introduced requirements for documentation that have not been easily implemented. The value of very specific documentation has to be weighed against the value for patient care that it brings.

**Total ankle replacement (TAR) procedures**

Accurate representation of patients within each MS-DRG is an important step for fair reimbursement and analysis. Splitting fractures and ankle procedures out of MS-DRGs 469 and 470 would help that purpose, particularly with the Comprehensive Joint Replacement program. We respectfully disagree with CMS’ proposal not to create a new MS-DRG for total ankle replacement procedures.

**Inclusion of social economic status**

Although previously addressed by many stakeholders, absence of adjustment for social economic status (SES) in risk adjustment methodologies for the Value-Based Purchasing (VBP) Program and HRRP remains a concern.

There are compelling reasons to include SES factors in hospital risk adjustment models. Our members are involved firsthand in data quality and integrity efforts and see the impact of the lack of SES adjustments on performance measurements in their institutions.

SES has been a contributing factor in readmission rates and quality scores. Most of the SES factors are beyond facilities’ control, and risk adjustment methodologies are
vital in order not be unfairly penalized. We ask CMS to please consider SES in future rulemaking.

**ICD-10 code additions/hypertension**

The expansion of the hypertension codes (hypertensive urgency, emergency, and crisis) will accurately reflect the complexity of hypertensive disease in the United States. However, individuals with conditions reflected in the new codes require increased monitoring, typically performed in the ICU, and an escalation of care requiring more resources. Certainly these patients carry higher risk of morbidity and mortality.

From a clinical perspective as well as resource data from accelerated and malignant hypertension in ICD-9, ACDIS asks that CMS consider adding hypertensive urgency, emergency, and crisis to the CC list. These codes correlate with ICD-9-CM codes 401.0, 402.00, 402.01, 403.0x, and 404.0x (malignant hypertension), which were previously CCs. Adding these codes as CCs maintains MS-DRG revenue neutrality with the transition from ICD-9-CM to ICD-10-CM.

ACDIS notes that these conditions and codes were discussed during the March 2016 ICD-10 Coordination and Maintenance Committee meeting, although they are not included in Table 6A of the 2017 IPPS proposed rule (“FY 2017 New Diagnosis Codes”). We are not sure if this is an oversight; however, if CMS is instead proposing these codes for FY 2018 adoption, our comment stands.

**VBP, Hospital-Acquired Condition Reduction Program, and use of Patient Safety Indicators**

Regarding the use of modified Patient Safety Indicator (PSI) 90 in the Hospital-Acquired Condition Reduction Program (HACRP) in FY 2018 and the HVBP in FY 2019: In order to promote consistency within pay-for-performance, exceptions should be made to statutory requirements to ensure measures such as PSI 90 are consistent regarding versions and revisions to promote accuracy in assessing quality of patient care.

ACDIS notes that use of the “modified PSI 90” in the HACRP in FY 2018 with no change to the version used in VBP in FY 2018 will ultimately distort data and corrupt hospital performance ratings. ACDIS strongly recommends using “modified PSI 90” in both programs in FY 2018.

Regarding PSI 12 re-specifications: It is important within these specifications to identify the exact ICD-10-CM codes that represent “isolated deep venous thrombosis of calf veins.” In ICD-10 there are codes for deep venous thrombosis of distal lower extremity, calf veins, and tibial vein, all of which are considered “calf veins.” ACDIS urges CMS to consider these codes in PSI 12.

Finally, ACDIS would like to include a general comment regarding PSI specifications and risk adjustment: Given the fact that ICD-10 has been in effect since October 1, 2015, please consider finalizing and updating the cohort ICD-10-CM/PCS definitions as well as the risk adjustment codes to reflect the data periods under study. In other words, ACDIS respectfully asks CMS to transition quality measures to full ICD-10 and not rely upon ICD-9 codes in the new performance periods.

**Medicare Outpatient Observation Notice**

ACDIS supports the development of the standardized Medicare Outpatient Observation Notice (MOON) form to satisfy the requirements of the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. CMS proposes adding 42 CFR 405.926(u), clarifying that the MOON is not considered an initial determination. However, this is not obvious on the MOON form.

Because of the rules governing medical necessity and the elements that influence a physician’s decision to elect observation services for a patient, we request that more information be included in order to reduce the misconceptions that the decision for observation was made to
somehow maximize hospital reimbursement or increase the patient’s copayments.

According to the NOTICE Act, hospitals need to notify, with the MOON, all patients who have received 24 hours of observation services prior to 36 hours after initiation of observation services, or upon release if sooner.

However, the rule needs to clarify situations in which a patient’s status is changed to observation but has not crossed 24 hours, or when the observation services have approached but did not cross 24 hours, or, in rarer situations, where a dismissal is planned but does not actually occur—due to logistical reasons—until after 24 hours, even if the decision to dismiss the patient occurred before the 24 hours had elapsed.

**ICD-10-PCS and CMS grouping logic**

ACDIS has learned that several minor diagnostic and/or therapeutic procedures, when captured with ICD-10-PCS codes, group to surgical DRGs.

This has led to significantly higher rates of reimbursement for these procedures and considerable consternation amongst CDI and coding professionals, who fear that these payments will eventually result in eventual recoupment from CMS and/or private payers.

As a result, some hospitals are opting not to code these procedures. Others are coding them as usual, citing that it is their obligation to do so under HIPAA and per the ICD-10-CM/PCS Official Guidelines for Coding and Reporting.

Some of the problematic procedures ACDIS has identified include the following:

- **Paracentesis.** Coding this procedure as diagnostic versus therapeutic results in a surgical DRG.

- **Esophageal banding of bleeding varices.** This procedure now codes to a surgical DRG.

- **Fine needle aspiration (FNA) of a lymph node.** FNA does not code to a surgical DRG, but when performed on a lymph node it codes to a surgical DRG.

- **Insertion of an arterial line.** Coding this procedure results in a surgical DRG.

- **Pregnancy with a forceps vaginal delivery with a 3rd- or 4th-degree tear repair.** Since the vaginal delivery is not a surgical procedure, but the repair of the anus is surgical, these cases are being assigned to a DRG for an unrelated operating room procedure to the principal diagnosis instead of a pregnancy DRG.

ACDIS brought this issue to the attention of CMS and other industry representatives in February of this year and was encouraged by CMS to comment during the IPPS rulemaking period. While some of these procedures are not discussed in the 2017 IPPS rule, ACDIS considers this issue of extreme importance and urges CMS to examine these concerns due to the amount of reimbursement this apparent grouping logic error has put at risk.

ACDIS considers this issue of extreme importance and urges CMS to examine these concerns due to the amount of reimbursement this apparent grouping logic error has put at risk.

At this time, CMS appears to have addressed and fixed the issue of esophageal banding of bleeding varices and pregnancy with a forceps vaginal delivery with a 3rd- or 4th-degree tear repair in the 2017 IPPS rule, but the other procedures remain unaddressed.

Thank you for the opportunity to comment.

Respectfully,

The ACDIS Advisory Board

ACDIS Director Brian Murphy
Recap of AHA comments on IPPS proposal

by Katherine Rushlau

The American Hospital Association (AHA) expressed concerns about the 2017 inpatient prospective payment system (IPPS) proposed rule, including the documentation and coding adjustment (DCA), changes to disproportionate share hospital (DSH) payments, and the implementation of various quality programs, it stated in a response published in June.

The AHA called the DCA “inconsistent with Congress’ intent” regarding the American Taxpayer Relief Act of 2012, as well as the Medicare Access and CHIP Reauthorization Act of 2015, and urged CMS to return to the standardized amount in FY 2018.

In general, the AHA says the existing Hospital Inpatient Quality Reporting (IQR) Program falls short when it comes to improving quality in the most important areas. The IPPS includes a number of changes to the IQR, including removing two registry participation measures, 13 electronic clinical quality measures (eCQM), and two chart-abstracted measures.

AHA suggested CMS streamline and focus the IQR program by identifying concrete and actionable goals for quality improvement.

Additionally, the AHA didn’t support any of CMS’ four proposed new quality measures for FY 2019. For the three clinical episode-based payment measures, the AHA suggested CMS consider provider data and information about the episodes of care within hospitals using a mechanism other than the IQR program.

On the fourth measure, excess acute care days after pneumonia hospitalization, the AHA says there isn’t clear or consistent evidence to suggest hospitals are substituting observation stays and ED visits in place of readmissions.

The AHA also recommended changes to the hospital-acquired conditions, readmissions programs, and eCQMs.

**IPPS proposal includes changes to PSI 90**

The IPPS proposed rule included changes to Patient Safety Indicator (PSI) 90, one of which is a new name: The Patient Safety and Adverse Events Composite.

The underlying objective of this measure remains the same, however—to provide an overview of hospital-level quality as it relates to a set of potentially preventable hospital-related events associated with harmful outcomes for patients.

The measure will also continue to be included in pay-for-performance programs such as the Hospital-Acquired Condition Reduction Program (HACRP) (to be adopted in FY 2018) and the Hospital Value-Based Purchasing Program (to be adopted in FY 2019).

PSI performance will still be assessed using an observed over expected ratio, and the risk adjustment methodology will remain the same, although comorbidity variables and coefficient weights will likely be refined. PSIs in the CMS composite will change, however, to remove PSI 7, central line-associated bloodstream infection; in addition, three other PSIs (8, 12, and 15) will be re-specified, which means that the types of patients included in the PSIs will be revised.

Although the HACRP will adopt this modified measure in FY 2018, performance will be based on today’s discharges. Therefore, CDI programs should begin to review the revised measure specifications and risk adjustment variables.

Editor’s note: Rushlau is the ACDIS editor. Portions of this article originated in the weekly e-newsletter CDI Strategies. Contact her at krushlau@acdis.org.
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Remember that old adage, “You can’t see the forest for the trees?” It typically refers to one’s inability to pull back from the minutiae and view the totality of a given situation.

For CDI specialists, however, the daunting landscape of changing healthcare initiatives may seem like a broad expanse of impenetrable woods. For many, it may be easier to avoid the rolling mountainside of American healthcare and focus instead on counting trees—adding up CCs/MCCs.

In reality, this ecosystem includes quality-based initiatives related to readmission reductions, 30-day mortality, Patient Safety Indicators, complications, present on admission indicators, and hospital-acquired conditions. And as the CDI landscape stretches to include long-term, critical access, rehabilitation, outpatient, and physician practice settings, CDI professionals need to identify the appropriate path to focus on.

So what “one thing” should CDI staff do to expand their CDI efforts? The ACDIS Advisory Board members offer a few of their thoughts.

**CDI in all settings**

“Simply put, there is an opportunity to institute CDI programs into all healthcare settings where patient care occurs,” says Advisory Board member Wendy Clesi, RN, CCDS, CDIP.

Any condition that is either monitored, evaluated, and/or treated should have a diagnosis documented to the highest level of specificity regardless of impact. The focus of CDI should be geared towards the accuracy of the medical record and not necessarily focusing on one thing.

*Wendy Clesi, RN, CCDS, CDIP*
CCDS, CDIP, executive director of CDI services with Enjoin in Eads, Tennessee.

Anecdotally, pediatric, long-term, and rehab facilities have shown an increased interest in rolling out documentation improvement efforts in the past few years. There’s been a pediatric CDI work group focused on identifying documentation improvement concerns related to respiratory failure; there have been sessions at the annual ACDIS Conference on rehabilitation-focused CDI; and long-term acute care hospitals (also known as transitional care hospitals) across the country have been incorporating CDI programs into their processes for a number of years.

Yet more needs to be done on this matter, says Advisory Board member Wendy De Vreugd, RN, BSN, CCDS, CCS, CCM, CDIP, executive director of CDI services with Enjoin in Eads, Tennessee.

“In an inpatient setting, the healthcare setting illustrates the fundamental fact that no individual requires the same care as another. A 70-year-old morbidly obese woman with a history of smoking, chronic obstructive pulmonary disease, and diabetes requires more services than a 70-year-old vegetarian mountain climber.”

Capturing these factors and including them in data reporting calculations helps ensure accurate reporting. This is not just for reimbursement purposes: As Advisory Board member James P. Fee, MD, CCS, CCDS, vice president of Enjoin, points out, “it’s about population health and how we can make patient data useful to truly improve care.”

The most widely known risk adjustment methodology comes in the outpatient and physician practice setting with Hierarchical Condition Categories, typically employed by CMS’ Medicare Advantage plans.

“I believe the one thing CDI specialists should be thinking about to expand is outpatient CDI,” says Advisory Board member Tamara A. Hicks, RN, BSN, MHA, CCS, CCDS, ACM, director of clinical documentation excellence at Wake Forest Baptist Health. “It’s a huge area of opportunity.”

“I see many CDI programs working to expand into the outpatient arena, and there appears to be a struggle to find their identity or focus for their record reviews. Knowledge of principles of risk adjustment can provide that focus,” Laurie Prescott, RN, CCDS, CDIP, director of CDI education for HCPro in Middleton, Massachusetts, said in a June 30 CDI Strategies “Note from the Director.”
But risk adjustment also applies to quality monitors such as mortality measures, 30-day readmissions, and Medicare spending per beneficiary, added ACDIS Director Brian D. Murphy, CPC, in the article.

“Risk adjustment is an energizing way to view a patient—to consider what are the current conditions that are affecting their state of health today and/or has the potential to affect their state of health tomorrow,” Newhouser says. “That is the future of healthcare, and a CDI specialist can do well to position themselves as an expert in this area.”

**Teamwork**

Still others say that before CDI programs can effectively expand beyond traditional CC/MCC reviews, the team needs to reach out to other disciplines and departments within its own facilities. An open mind and an open door can often lead to new paths.

“I would expand to see how CDI becomes part of the interdisciplinary team that is taking care of patients,” says Sam Antonios, MD, FACP, FHM, CCDS, CDI and ICD-10 physician advisor at Via Christi Health in Wichita, Kansas.

Start the relationship building with the rest of the team, Antonios suggests. Once the value of CDI becomes evident, then integrate documentation improvement efforts into the workflow.

“In the future, just like a physician would be lost without a pharmacist to help with meds and would be lost without a case manager helping with discharge planning, he/she would be lost without CDI helping in accurately capturing his/her quality data,” he says.

CDI programs can and should consider approaching ancillary department heads and assessing their needs, adds Antonios.

“One way to do this is to incorporate CDI staff as active participants in committee activities, education, and development of new programs,” says Judy Schade, RN, MSN, CCM, CCDS, clinical documentation specialist at Mayo Clinic Hospital in Phoenix.

“Personally, I think the most important thing to remember is to understand the global aspect of the patient experience and understand the continuum of care. We all need to work together and partner for the best outcomes for our patients. Yes, at times this is a monumental task. However, our expertise, experience, and knowledge is paramount to better outcomes and patient satisfaction,” Schade says.

**Mission CDI**

The most sage advice may be a phrase you’ve heard before: Return to your roots. Specifically, reexamine the original intent of your facility’s CDI program.

For most, that intent is simply to help physicians capture the best documentation to ensure the most accurate clinical picture for their patients. That clinically accurate picture can then be shown to the whole world and used for any number of initiatives, Clesi says.

“It seems that CDI professionals are on a never-ending chase to keep up with the regulatory changes and demands associated with clinical documentation,” she adds.

The medical record is intended to provide a clear picture of each patient’s unique encounter, Clesi says. “Any condition that is either monitored, evaluated, and/or treated should have a diagnosis documented to the highest level of specificity regardless of impact. The focus of CDI should be geared towards the accuracy of the medical record and not necessarily focusing on one thing.”

Ultimately, expanding your CDI programs’ efforts may mean you need to see both the forest and the trees.

**Editor’s note:** Varnavas is the associate editorial director of ACDIS. Contact her at mvarnavas@acdis.org.
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Hierarchical CDI: Risk adjustment focus helps influence patient care

by Katherine Rushlau

Although most CDI programs say outpatient record reviews aren’t a priority right now, “as we move to value-based purchasing, [risk-adjusted reimbursement models] are going to have a big impact on the outpatient setting,” says Angela Carmichael, MBA, RHIA, CDIP, CCS, CCS-P, CRC, director of HIM at Nuance. So, “in reality, it’s a great time to be transitioning your CDI program to the outpatient space.”

Risk adjustment primer

One element that all new health-care payment models seem to have in common is that providers and facilities will be taking on more financial risk—hence “risk adjustment,” says Carmichael. Risk adjustment works to “level the playing field” among insurers, she says. It’s structured so any insurer that welcomes all new enrollees, including those sicker than average, will receive compensation to help pay for the anticipated extra costs of caring for those patients.

“In essence, the risk adjustment payment methods are built to identify a limited number of discrete ongoing costly conditions and pay insurers extra,” says Carmichael. “These additional risk adjustment funds may also be cascaded down to groups based on how sick or healthy their patients are.”

Risk adjustment can be used in two primary ways. First, it can be used as a payment methodology, whereby it can directly or indirectly impact reimbursement.

For example, the CMS Hierarchical Condition Categories (HCC) set per-member, per-month capitation payments to Medicare managed care plans. These are used in combination with fee-for-service payments to provide Medicare accountable care organizations bonus opportunities.

Second, risk adjustment can be used in conjunction with other payment models or quality measures. CMS HCCs can mathematically reconcile the observed rate from the expected, so that the quality of the care can be isolated and understood.

About 40% of the Medicare alternative payment plans are risk
adjusted, including severity of illness and the Hospital Readmissions Reduction Program.

**HCC methodology**

An HCC is a category of clinically similar medical conditions grouped together with similar cost patterns. This helps predict future healthcare costs and allows for quality of care comparisons, says Carmichael.

There are approximately 8,800 ICD-10-CM codes that map to one of 79 HCCs. Mapping conditions are generated from ICD-10-CM diagnoses submitted on claims from specific settings and provider types where a face-to-face encounter has occurred. They are similar to MS-DRGs; however, only 58% of HCCs are also classified as CCs/MCCs in the DRG payment methodology.

An HCC represents a patient’s disease burden for an entire calendar year across inpatient and outpatient settings, says Carmichael. A diagnosis only needs to be submitted once during the year to impact the patient’s risk score for that year.

There is a caveat, though—each January 1 starts a “clean slate,” meaning diagnoses don’t carry over from year to year. This means chronic, non-resolving diagnoses that map to an HCC have to be reported at least once during the calendar year on a claim, denoting a face-to-face visit with an acceptable type of provider in an acceptable setting.

The HCCs captured are added together to determine the cumulative risk score for that patient for the calendar year. The risk score may be adjusted for factors like hierarchical conditions and disease interactions, says Carmichael.

Each risk score is comprised of two elements:

1. A demographic score based on the patient’s age, gender, and eligibility status
2. A disease burden score based on ICD-10-CM diagnosis codes submitted on a claim during the calendar year

Each HCC category has its own risk adjustment factor (RAF), which range from 0.118 to 2.4888. Each patient has an RAF score, which is the culmination of all RAF values for that patient’s HCC reported for that patient. A patient with a score of 1 is considered to use average resources; someone with a score less than or greater than 1 is expected to use fewer or more resources, respectively, Carmichael says.

CDI experts have an opportunity to impact the disease burden score, says Carmichael. If a diagnosis is not captured in a given year, it essentially “falls off” and does not affect the patient’s risk score for that year. In such situations, says Carmichael, “the costs associated with caring for that patient has not declined, but your reimbursement has.”

What types of conditions group to HCCs? More than just “chronic conditions,” according to Carmichael. These conditions include:

- High-cost medical conditions, such as cancer and heart disease.
- Acute, chronic, status codes, etiology, and manifestation, such as COPD and hip fracture.
- Common conditions, rare conditions, conditions that can be cured, non-curable, congenital, and acquired. These must be current, affect the encounter, and must be predictive of future healthcare expenditures.

Medicare’s most frequently reported HCCs include breast cancer, diabetes without complications, CHF, angina, ischemic heart disease, and chronic obstructive pulmonary disease.

“The more specific the documentation and the coding, the greater the chance you have of capturing an HCC,” says Carmichael.

**Case study**

Providence St. Peter Hospital in Olympia, Washington, has had a successful inpatient CDI program for seven years. In spring 2014, the facility, which encompasses 32 clinics and two acute care hospitals, began discussing CDI in the ambulatory setting, says Lena Lizberg, BSN, CDI program manager.

The team started by doing a comprehensive record review and audit, which showed that providers focused more on E/M coding than diagnosis coding, thus doing little to illustrate their patients’ disease burden, Lizberg says.
“We felt that CDI specialists could be effective support for our ambulatory providers in capturing all reportable diagnoses,” she says.

As Providence began documenting HCCs, they noticed a few specific opportunities for CDI staff to capture greater specificity:

- Diabetes complication versus Type 2 diabetes mellitus with complication or manifestation
- Obesity versus morbid obesity
- Depression versus major depression
- History of versus current condition

“We are continuing to monitor and evaluate topics that providers are struggling with, so we can adjust education as needed,” Lizberg says. “We wanted to improve accuracy and better reflect patients’ disease burden.”

When Providence began its outpatient CDI program in 2014, it looked at four key metrics: provider response rate, provider agreement rate, cumulative projected RAF improvement, and associated reimbursement.

By the end of 2015, Providence noticed significant results, says Lizberg, including an improvement in RAF scores, a decrease in denials, and overall revenue preservation.

“Comprehensive documentation supports all providers in making clinical decisions based on accurate and complete information, potentially improving patient safety,” she says. “Providers have reported improved maintenance of the program list and overall improvement of diagnosis coding accuracy since implementation.”

**Team effort**

Providence St. Peter met with providers, coders, and IT to develop shared goals. As a team, it began a two-part assessment to identify record review opportunities based on members and documentation improvement potential. At the end of the assessment, the team estimated $178,360 in revenue improvement, which helped it obtain leadership buy-in.

Next, Lizberg and her team began educating CDI, coders, and providers. The education was clear, brief, and to the point, allowing more time for group discussions and feedback.

CDI specialists needed to learn what risk adjustment meant and how to conduct on-site record reviews to target those areas. They also needed to learn the fundamentals of HCCs and evaluation and management (E/M) coding.

Providers needed to learn the about the goals of the CDI program and how the process would benefit them. They also needed to better understand how HCCs affected their financial and quality data. Lizberg’s team had to recognize that, up until then, providers had been documenting to support their E/M coding or level of service. The team had to engage providers in diagnosis coding and help them understand why accurate coding was so important.

The CDI team then began developing a daily workflow for record reviews, incorporating HCC capture goals. In this process, the CDI staff review the record the day before an appointment based on the clinic’s census.

The patient’s case is built into the CDI application for inpatient review. HCCs are identified in the diagnosis list. When appropriate, the CDI specialist queries the provider for possible HCCs.

Queries are sent electronically through the EHR. Query responses are tracked from provider progress notes after the appointment and reconciled, and the staff validate HCC capture and final claims date. The CDI team follows up on queries with no response and regularly rounds in clinics for provider feedback and support.

The ultimate goal behind the process is to keep communication open between CDI specialists and providers, to make diagnosis coding easier in the outpatient setting, says Lizberg.

“We improved their understanding for risk adjustment and, as a result, HCCs have become a more prevalent part of the provider’s documentation in a regular daily fashion,” she says. 💫

**Editor’s note:** This article was based on the June 8 webcast “How CDI Professionals Can Influence Patient Care with CMS HCCs.” Contact Rushlau at krushlau@acdis.org.
CODING CLINIC FOR CDI

Deciphering diabetes documentation advice

by Sharme Brodie, RN, CCDS

Call me unorthodox, but let’s start at the back of the latest edition of the American Hospital Association (AHA)’s Coding Clinic for ICD-10-CM/PCS for this review. Here, on pp. 36–37, we have the clarifications, including some potentially confusing—and possibly conflicting—information regarding diabetes documentation requirements.

The AHA says it received many inquiries requesting clarification to advice provided in its First Quarter 2016 edition regarding the appropriate way to code diabetes and its associated manifestations. In that issue, it indicated that to further clarify when a relationship between diabetes and certain manifestations exist, additional queries to the physician may be warranted.

The latest Coding Clinic refers to the Official Guidelines for Coding and Reporting Section I.A.15, which says:

The word ‘with’ should be interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the Alphabetic Index, 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.

The following example from the Alphabetic Index for the main term “Diabetes” and the subterm “with” demonstrates this linkage:

- Diabetes, diabetic (mellitus) (sugar) E11.9 with
  - Amyotrophy E11.44
  - Arthropathy not elsewhere classified (NEC) E11.618
  - Autonomic (poly) neuropathy E11.43
  - Cataract E11.36
  - Charcot’s joints E11.610
  - Chronic kidney disease E11.22

The subterm “with” in the Alphabetic Index should be interpreted as a link between diabetes and any of the conditions indented under the word “with.” Based on this information, physician documentation need not link the diabetes to chronic kidney disease to use the code E11.22; a link can be assumed. However, physician documentation will need to indicate a link when the physician suspects a condition is related to diabetes but the condition is are not found under the verbiage “with” in the Alphabetic Index.

We suggest you review the terms listed under “diabetes-with” in the index—the list above is not all-inclusive. This Coding Clinic advice tells us if the term is listed, then the relationship is assumed. This change, allowing these relationships to be assumed, is huge; it should decrease our queries related to diabetic manifestations. But remember, if another etiology is possible or the documentation is not clear, you still have to query for clarification.

Another matter addressed in the latest edition of Coding Clinic is what ICD-10-CM code should be assigned for diabetic ketoacidosis (DKA) if the type of diabetes isn’t documented or specified by the physician. The Official Guidelines for Coding and Reporting state that if the type of diabetes mellitus is not documented in the medical record, the default is a code from subcategory E11.-, Type 2 Diabetes mellitus.

The Alphabetic Index advises coders to code “diabetes, by type, with ketoacidosis” when referencing ketoacidosis. Therefore, CDI specialists should query the physician for clarification regarding the type of diabetes when diabetic ketoacidosis is documented without further specification. DKA is an acute, life-threatening complication of diabetes that mainly occurs in patients with Type 1 diabetes, but can also occur in patients with Type 2. As stated in Coding Clinic, First Quarter 2013, pp. 26–27, code E13.10, other specified diabetes mellitus with ketoacidosis without coma, is assigned for Type 2 DKA since the condition does not currently have a specific code in ICD-10-CM.

Editor’s note: Brodie is a CDI education specialist for HCPro in Danvers, Massachusetts. Contact her at sbrodie@hcpro.com.
Seeking clarification on diabetes advice

Q: I am looking for additional clarification regarding the recent AHA Coding Clinic for ICD-10-CM/PCS advice related to the assumed link concerning diabetes and the use of the word “with.” While the examples often used in Coding Clinic are specific, the actual advice applies in other instances as appropriate, correct?

My concern is actually of an inquisitive nature. What has changed in the interpretation of the words “with,” “associated with,” and “due to” from ICD-9 to ICD-10?

A: “The coding convention referred to now is the same convention that existed in ICD-9, so I’m scratching my head as I attempt to understand the breadth of these Coding Clinics,” says ACDIS Advisory Board member Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP, director of education for MedPartners in Tampa, Florida.

An excerpt from Coding Clinic, First Quarter 2016, has Newhouser a bit concerned due to the use of the word “these.”

The word ‘with’ should be interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the Alphabetic Index, 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.

Language from Coding Clinic, Second Quarter 2016, also includes the phrase.

For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

Coding Clinic, First Quarter 2016, also reminds readers of previous advice from 2012, which indicates that “hypertension with chronic kidney involvement” can be an assumed link. It stated:

In addition, the following advice published in Coding Clinic, Third Quarter 2012, p. 3, also applies to ICD-10-CM: ‘It is not required that two conditions be listed together in the health record. However, the provider needs to document the linkage, except for situations where the classification assumes an association (e.g., hypertension with chronic kidney involvement).’

Still more advice from Coding Clinic, First Quarter 2016, pp. 12–13, supports an assumed link when the word “with” is seen in the classification, this time related to diabetic foot ulcer. There are many conditions listed under “diabetes, with” in the code book, such as chronic kidney disease, foot ulcer, gastroparesis, nephropathy, autonomic neuropathy, polyneuropathy, retinopathy, skin ulcer, gangrene, cataract, etc.

“Unless I am missing something,” says Newhouser, “every single one of these conditions, plus many more under diabetes, as well as other conditions in the code book that are connected with these words ‘with’ (at the least), ‘associated with,’ and ‘due to’ automatically have a ‘get out of jail free’ card and don’t have to be queried.”

Coding Clinic is “confirming that this is the new era of associated relationships for diabetes,” wrote Allen R. Frady, RN, BSN, CCS, CCDS, senior consultant with Optum360 in Eden Prairie, Minnesota, in a LinkedIn article on the subject.

The concept and use of “with” in this fashion isn’t necessarily new, says ACDIS Advisory Board member Paul Evans, RHIA, CCDS, CCS, CCS-P, clinical documentation
integrity leader at Sutter West Bay Area in San Francisco.

In fact, all manifestations/complications related to diabetes are listed under the word “with” in the Alphabetic Index, not just circulatory, nervous, and kidney-related issues, says past Advisory Board member Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CPC-I, CCDS, director of HIM and coding for HCPro in Middleton, Massachusetts.

One additional area of confusion related to sepsis remains, Newhouser says. “From these Coding Clinics, my interpretation is that, just as with diabetes, sepsis with organ failure could be a presumed causal relationship and the physician does not need to document the link between sepsis and an acute organ dysfunction,” she says.

However, Newhouser points out that in some instances, this interpretation may appear to contradict Official Guidelines for Coding and Reporting I.C.1.d.1.a.iv for acute organ dysfunction not clearly associated with sepsis, which instructs:

An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

“On one hand, we have five instances in three different editions of Coding Clinic which clearly states that the use of the word ‘with’ in the classification—hypertension with chronic kidney involvement, diabetes with foot ulcers, diabetes with polyneuropathy, diabetes with chronic kidney disease, plus other diabetes with—is seen as an assumed relational term and the provider does not need to be queried (unless the documentation states the condition is due to another condition),” says Newhouser. “Then, on the other hand, we have sepsis, and the classification clearly states ‘with,’ yet the Official Guidelines for Coding and Reporting appears to state that we need the documented link.”

For Evans, this means the physician must state that the patient has condition A with condition B (sepsis and acute tubal necrosis). It also means that the Alphabetic Index or Tabular List must cite the word “with” for accurate code assignment. Regarding sepsis, Evans says, the Alphabetic Index lists “Sepsis, with, organ dysfunction (acute)(multiple) R65.20,” and the Tabular List at R65.2 shows “Sepsis with acute organ dysfunction” as an inclusive term (among three other inclusive terms).

While circulatory complications were not specifically addressed in either Coding Clinic, the new advice seems to indicate all possible diagnoses that can be listed as “with” in the code title should be viewed in this manner, Frady wrote.

“I checked, and the wording for vascular manifestations is worded in exactly the same format as the above mentioned chronic kidney disease (CKD), as is neuropathy not specified as autonomic. Coding Clinic goes on to say that a causal relationship is presumed between two conditions linked by these terms. They even go the extra mile and confirm that yes, this now includes diabetes and CKD. The one exception to this new assumed relationship if the documentation clearly states the conditions are unrelated and due to some other underlying cause.”

Value-Based Purchasing and CDI: Advancing Documentation Improvement Efforts to Address Quality Concerns

CDI programs can no longer afford to remain focused on simple CC/MCC capture; they need to understand how the Hospital Value-Based Purchasing (HVBP) Program works and what documentation risks hospitals face under this increasingly important payment method. Join expert speakers Laurie L. Prescott, MSN, RN, CCDS, CDIP, and Sharme Brodie, RN, CCDS, on July 22 for a 90-minute program that will help you understand HVBP to ensure your CDI program is focusing on the right measures.

http://hcmarketplace.com/value-based-purchasing-and-cdi
Risk adjustment and CDI: A natural evolution

by Laurie L. Prescott, MSN, RN, CCDS, CDIP

When I think about risk adjustment, I think about my mother. She is 86 years old with osteoarthritis and a recent total knee arthroplasty. She is active in aerobics and volunteers at the hospital and her church. The only medications she takes on a daily basis are her multivitamin and calcium pill. Now that she has a new knee, she has no complaints and says her health is due to her clean living—no alcohol use and never smoked a cigarette.

Let’s compare my mother to her neighbor, a 75-year-old woman who perhaps has not lived as clean a life. A smoker for more than 50 years, she’s now oxygen dependent with chronic respiratory failure. Her history also includes two myocardial infarctions and two stent placements. She’s diabetic and morbidly obese.

One might think that the younger of the two women would demonstrate a lower risk score, meaning it would likely cost less to maintain her health, but it’s not so in this case. My mother, at 86 years old, is the one with the lower risk score.

CDI specialists have worked with providers for years to better capture patient acuity in the inpatient setting, but it is just as important to ensure the health statuses of both my mother and her neighbor are well documented in the outpatient setting, too.

Healthcare reimbursement is changing; both CMS and private payers are working toward payment methodologies that reflect quality of care versus quantity of care. In most cases, quality is measured based on patient outcomes. The concept of risk adjustment is now being applied to healthcare reimbursement and used for quality monitors such as 30-day mortality measures, 30-day readmissions, and Medicare spending per beneficiary. Healthcare organizations must be aware of how documentation supports risk adjustment and take efforts to educate providers on the importance of complete and thorough capture of their patients’ health status to support accurate code assignment representing the potential risk their patients possess.

I see many CDI programs working to expand into the outpatient arena, and there appears to be a struggle to find an identity, a focus, for record reviews. Understanding the principles of risk adjustment provides that focus. Documentation for outpatient services and primary care is a slightly different beast than the more familiar territory of acute inpatient care for most CDI professionals. This different focus requires a melding of two skill sets, that of CDI specialists and coding professionals, to succeed.

Risk adjustment documentation can be based on records from hospital inpatient, hospital outpatient, and provider services. Although CDI is firmly rooted in inpatient services, now it can extend to outpatient and even professional services. As more hospital systems purchase physician practices, there is increasing interest in areas outside inpatient documentation. The arms reach wider to ensure documentation on the whole is optimized, not just for inpatients, but for patients in all hospital-related settings so accurate reimbursement can be obtained. The CDI team is already clarifying diagnoses like specific manifestations of diabetes mellitus and possibly the significance of pathology reports for metastatic cancer, so why not extend the focus to conditions that may affect risk adjustment scores?

As the world of healthcare reimbursement evolves, the importance of documentation and accurate code assignment will become even more relevant. We as professionals working in documentation improvement and code assignment must continue to grow and evolve as well. This is both an exciting and frightening time for us, and we must expand our horizons to support providers in navigating these changes.

Editor’s note: Prescott is the CDI education director with HCPro. She serves as a full-time instructor for the CDI Boot Camp as well as a subject matter expert for ACDIS. She will be presenting on the topic of risk adjustment at the 2016 Revenue Integrity Symposium, September 26–27 in San Antonio, Texas. This article was originally published in the sister newsletter Medicare Compliance Watch.
Manage denials for BMI morbid obesity

by Katherine Rushlau

When Dee Banet, RN, MSN, CCDS, CDIP, and her CDI team sent out a claim for a surgical patient with body mass index (BMI) greater than 40 with morbid obesity as a secondary diagnosis, they did not expect the claim to be denied; after all they had provider documentation along with the associated diagnosis. However, the payer denied the claim, stating it did not meet the criteria to be coded as a secondary diagnosis—including proper documentation to support increased care and monitoring treatment.

“We have appealed endlessly with Coding Clinic for guidance for this diagnosis,” says Banet, who is the CDI director at Norton Healthcare in Louisville, Kentucky. “All [of our claims] have been denied [again] and the monies recouped.”

In a recent discussion on the ACDIS Forum, Banet asked ACDIS colleagues if they experienced similar audits, and sought advice on how to handle them.

“We want to address this on the front end and educate providers to capture information like we would any other diagnosis,” said Banet. “My fear is that failure to capture this important statistical information on our patient population will affect our data in many ways aside from reimbursement.”

A number of Forum users were surprised. One user says they are never questioned about this diagnosis. Another suggested sending the payer clinically supported documentation (i.e., an article from a medical journal) on morbid obesity and numerous associated health effects.

Another user cited Coding Clinic, Third Quarter 2011, p. 3–4, which states:

**My fear is that failure to capture this important statistical information on our patient population will affect our data in many ways aside from reimbursement.**

*Dee Banet, RN, MSN, CCDS, CDIP*

Individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the body mass index (BMI) code meets the requirement for clinical significance when obesity is documented.

The diagnosis of obesity is one of the more difficult documentation matters that CDI specialists likely face, said Lori-Lynne A. Webb, CPC, CCS-P, CCP, CHDA, COBGC, CDIP, an E/M and procedure-based coding, compliance, data charge entry, and HIPAA privacy specialist, in a recent article published in JustCoding.

According to the National Institutes of Health (NIH), morbid obesity is defined as:

- Being 100 pounds or more above your ideal body weight
- Having a body mass index (BMI) of 40 or greater
- Having a BMI of 35 or greater and one or more comorbid conditions

The NIH breaks down obesity into classes:

- Class I is BMI 30–34.9 kg/m²
- Class II is BMI 35–39.9 kg/m²
- Class III is BMI greater than 40 kg/m²
By using the information documented in the record, coders can report the BMI from a dietitian’s note or from the physician’s documentation, says Webb. However, if the numeric BMI falls into the “class” status, the facility can report and code this as a Class I, II, or III obesity state. The obesity documentation still has to be clearly defined within the medical record. With that, there should be a correlation from the physician to support the obesity code assignment and how it is currently impacting the patient’s current care and ongoing plan, according to Webb.

Additionally, the Uniform Hospital Discharge Data Set (UHDDS) definition of “other diagnoses,” or secondary diagnoses, describes those conditions that coexist at the time of admission, or develop subsequently, and that affect the patient care for the current care episode.

To be considered a secondary diagnosis the condition must require any of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic studies
- An extended length of stay
- Increased nursing care and/or monitoring

The many ramifications of increased nursing care—the propensity to develop an ulcer of the skin, difficulty for the nurse or physician in performing a full exam, modification of dosing by the provider, and difficulty obtaining clear views of internal sites while undergoing various radiological studies—represent just a few reasons obesity is always reportable, says Paul Evans, RHIA, CCS, CCS-P, CCDS, regional clinical documentation manager for Sutter West Bay in San Francisco.

When dealing with denials that cite Coding Clinic, Evans suggests CDI teams know the rules well themselves and make sure the payer complies with the Official Guidelines for Coding and Reporting, which states:

Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act.

Rules governing code assignment follow a strict structure: first the rules in the Tabular List of the code set, then the Official Guidelines for Coding and Reporting, then the AHA’s Coding Clinic for ICD-10-CM/PCS (previously Coding Clinic for ICD-9-CM).

“IT is very obvious that [morbid obesity] is reportable,” Evans responded on the ACDIS Forum. “I continue to be concerned that folks appear to ignore or ‘selectively’ use advice issued in Coding Clinic, which is our ‘Bible’ and applies to everyone, including insurance companies. I can tell you anecdotally that when I have called such third parties and discussed basic concepts of coding and compliance, they were ill-informed.”

When faced with a denial for obesity, CDI teams need to not only ensure that the documentation is complete and accurate, but also back up their appeal with items like scholarly articles and official guidance that show why the condition influences patient care—which, according to Coding Clinic, is always the case.

“Obesity is always reportable,” says Evans. “Period.” 🌟

Editor’s note: Get involved in the CDI conversation and post your questions, conundrums, tips, and training tricks in the new ACDIS Forum at forum.acdis.org. Katherine Rushlau is the ACDIS editor. Contact her at krushlau@acdis.org.
PHYSICIAN ADVISOR’S CORNER
The ‘new’ DRG denial strategy

by Trey La Charité, MD

I have previously addressed the issue of auditor denials. However, given the industry changes I have witnessed in the last 12–18 months, it is time to revisit this problem. And, per communications with colleagues in the CDI world, I suspect the same alarming trends are evident in many facilities. The days of merely maintaining compliance with published coding guidelines are gone. We are in a new era of blatant attempts to purport medical clairvoyance and supplant decades of accepted diagnostic criteria.

The auditors performing DRG reviews are not our friends. They are not poring over our charts simply to suggest how we might code more accurately. The vast majority of auditors are private companies that have one goal: to make money. If they do not turn a profit, they cease to exist. Therefore, they are not concerned about the care-centered missions of our facilities.

I am astounded at the tactics these companies employ to ensure a positive profit margin. While they repeatedly profess that their work protects the financial integrity of the payers with whom they have contracted, their profits are obtained at the expense of our ability to ensure our patients receive the services they need and deserve.

The fundamental principle auditors exploit is that they are allowed to question a provider’s clinical judgment, while coders are not. If a provider states in the medical record that a patient had pneumonia, the hospital coder is expected to code “pneumonia,” regardless of whether the patient actually had it. The auditor, however, is allowed to review the medical record to determine if pneumonia actually existed. If the auditor determines that the patient did not have pneumonia during the hospitalization, the auditor removes the code from the chart.

As we all know, providers and coders are not perfect—providers occasionally document incorrect diagnoses, and coders make data entry mistakes. Either of these unintentional errors results in an invalid diagnosis. Auditors, however, seem to set ridiculously high standards for diagnosis verification and validation.

For example, pneumonia

Continuing with the pneumonia example, a patient is generally considered to have pneumonia if he or she has a “constellation of suggestive clinical features, a demonstrable infiltrate by chest radiograph or other imaging, with or without supporting microbiological data,” according to “Infectious Disease Society of America/American Thoracic Society Consensus Guidelines on the Management of Community Acquired Pneumonia in Adults” published in Clinical Infectious Diseases.

However, one auditor I have dealt with repeatedly states that it only accepts a diagnosis of pneumonia if the patient has:

- A clinical presentation consistent with pneumonia AND
- Radiological imaging consistent with pneumonia AND
- Abnormalities on physical exam consistent with pneumonia AND
- At least one of the following clinical features/symptoms:
  - Oxygen saturation less than 90%
  - White blood cell count greater than 10,000
  - Positive sputum cultures
  - Elevated temperature
  - Positive gram stain
  - Positive urine antigen

This represents the significant chasm between two well-respected professional medical societies and an insurance carrier as to what actually constitutes the definition of pneumonia.

There is a similar attempt by auditors to rewrite the definition of sepsis. Ignoring the recent proposed definition changes published in the Journal of the American...
Medical Association, sepsis has traditionally been defined as “SIRS plus a source,” where patients were considered to have SIRS if they had any two of the following five findings:

- Heart rate greater than 90 beats per minute
- Respiratory rate greater than 20 breaths per minute
- Temperature greater than 100.9°F or less than 96.8°F
- White blood cell count greater than 12,000 or less than 4,000
- White blood cell count differential with greater than 10% band forms

While this definition was expanded to include additional variables by the Surviving Sepsis Campaign, some auditors insist on various combinations of “mandatory” additional criteria before they accept that sepsis was present. These have included:

- Length of hospital stay
- Intensity of treatment provided
- Severity of illness
- Positive blood cultures
- Hemodynamic instability
- The use of vasopressor medications
- Confirmed fever
- An elevated lactic acid level

In my opinion, auditors intentionally rewrite the accepted diagnostic definitions of common disease processes in order to satisfy their financial appetites. We have seen similar attempted diagnosis revisions with acute encephalopathy, urinary tract infection, acute myocardial infarction, and acute kidney failure.

**Lack of response**

In addition to changes in the causation of the DRG validation denials, there has also been a significant change in the tone and transparency of the appeals process. We have noticed a reluctance to give reconsideration to—or perhaps even read—the initial appeals we send. Follow-up letters to our denials appear to be copied and pasted from the initial denial letter—they contain no new information or rebuttal as to why our appeal was incorrect. In the past, appeal rationales were addressed directly.

This recent lack of response seems as though auditors consider their reasoning incontrovertible and unquestionable. I suspect that this represents a concerted effort to prevent appeals beyond the first level. In addition, auditors and payers seemingly insinuate that the appellant only has one opportunity to appeal. Initial denial letters freely list where we should send our appeal, but do not list additional options should our first appeal be denied. Doing so intimates that if the appeal is denied after one attempt, the case is closed.

**Additional appeals**

Do not forget that further appeal options exist. It is up to the appellant to discover what the additional appeals process requires. Sadly, since no two carriers have the same appeals process, it falls to the appellant to discern the subsequent appeal steps for every carrier—as you might expect, this is laborious. As a starting point, I suggest reviewing each payer’s provider manuals. Next, review the situation with your contracting department and leverage any existing payer–medical director relationships to learn the full extent of your appeal options.

Auditors and payers seem to hope that you will not appeal any denials. However, you cannot afford to fall into this trap. Doing nothing puts your facility at risk for further victimization by these unscrupulous predators. When the auditor is wrong, exhaust every level of appeal available. Just as auditors and payers portray themselves as all-knowing and infallible, a CDI professional must send a message that the facility will not roll over and allow repeated attacks on its exposed underbelly. There is value in being perceived as a hard target. Do predators prefer fluffy, defenseless bunnies or spiky, tenacious porcupines? Making things as difficult for them as they do for you will encourage them to search for easier prey elsewhere.

**Editor’s note:** La Charité serves as the physician advisor for the University of Tennessee Medical Center at Knoxville Clachari@UTMCK.EDU.
MEET A MEMBER
Triathlon athlete loves continued learning

Melinda Scharf, RN, BSN, CCDS, CCS, regional clinical documentation integrity educator at St. Joseph Hospital in Irvine, California, has worked in CDI since 2008 after serving as a pediatric nurse for 10 years and an ER nurse for 11.

CDI Journal: Why did you get into this line of work?
Scharf: A friend who was a case manager told me about the job. The hospital was starting a new program, and it sounded interesting. I really didn’t understand exactly what it was at the time!

CDI Journal: What has been your biggest challenge?
Scharf: The lack of physician engagement. There has been more support over the years, but it is still a big problem.

CDI Journal: What has been your biggest reward?
Scharf: The learning continues on a day-to-day basis and will never end. The opportunity to work with a great team and the opportunity to impact the new clinical documentation specialists that are entering the field.

CDI Journal: How has the field changed since you began working in CDI?
Scharf: It is apparent that the CDI profession is growing and the number of experts in the field has grown tremendously. The annual ACDIS Conference agenda gets better every year with more content. The implementation of the EMR has changed the process a lot.
CDI Journal: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on “CDI Talk” or through ACDIS?

Scharf: As an educator, I frequently refer to articles on the ACDIS website as a resource. I have referred to Dr. Richard Pinson’s article on respiratory failure many times. We use the CDI Pocket Guide as a resource for our staff. I used the ACDIS position paper on Sepsis-3 to help guide our staff on handling the new sepsis definition. Dr. Robert S. Gold was very helpful when I was having trouble advising our team on whether to assign a Glasgow Coma Scale score in a patient with hepatic encephalopathy.

CDI Journal: What are some of the high points from the 2016 ACDIS Conference?

Scharf: Vicki Hess was great as the keynote speaker. I think I will always remember “replace your pow with a wow!” Because we are a multi-facility health system, the conference gives us a chance to all spend time together. It is fun meeting other people in the industry and hearing their views. There are some people that I only see at the conference.

CDI Journal: What piece of advice would you offer to a new CDI specialist?

Scharf: Research and understand every diagnosis you are asking for. If you earn the doctor’s respect, this will be half your battle. And don’t get discouraged!

CDI Journal: If you could have any other job, what would it be?

Scharf: I’d be a horse trainer.

CDI Journal: What was your first job (what you did while in high school)?

Scharf: “Busgirl” at a restaurant. I think I made $2.65 per hour!

Here are a few of Melinda’s favorite things:

■ Vacation spots: I like to go to different places. Nashville was one of my favorite spots. I also loved Ireland and New Zealand!
■ Hobbies: Triathlons have been taking up most of my free time recently. Los Angeles Angels baseball, and I enjoy reading a lot. Horses have been a lifelong hobby when I can afford it.
■ Non-alcoholic beverage: Bulletproof coffee
■ Foods: Anything sweet, but I am always trying to change that
■ Activity: Swimming, biking, and running
■ Family: I have three great (of course) adult children. I am impatiently waiting for grandkids! 💫

Editor’s note: If you know a CDI specialist who’d love a moment in the ACDIS spotlight, please nominate him or her by sending ACDIS Editor Katherine Rushlau an email at krushlau@acdis.org.

The Clinical Documentation Improvement Specialist’s Complete Training Guide
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