2019 IPPS PROPOSED RULE CODING HIGHLIGHTS AND THE IMPACT OF CLINICAL VALIDATION DENIALS

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OBJECTIVES

1. Review key issues in the 2019 IPPS Proposed Rule
2. Discuss the difference between DRG Validation and Clinical Validation

2019 PROPOSED IPPS RULE

IPPS

A system of payment for the operating cost of acute care hospital inpatient stays under Medicare A (Hospital Insurance) based on prospectively set rates.

MS-DRG

Medicare's Inpatient Prospective Payment on acute care inpatient stays

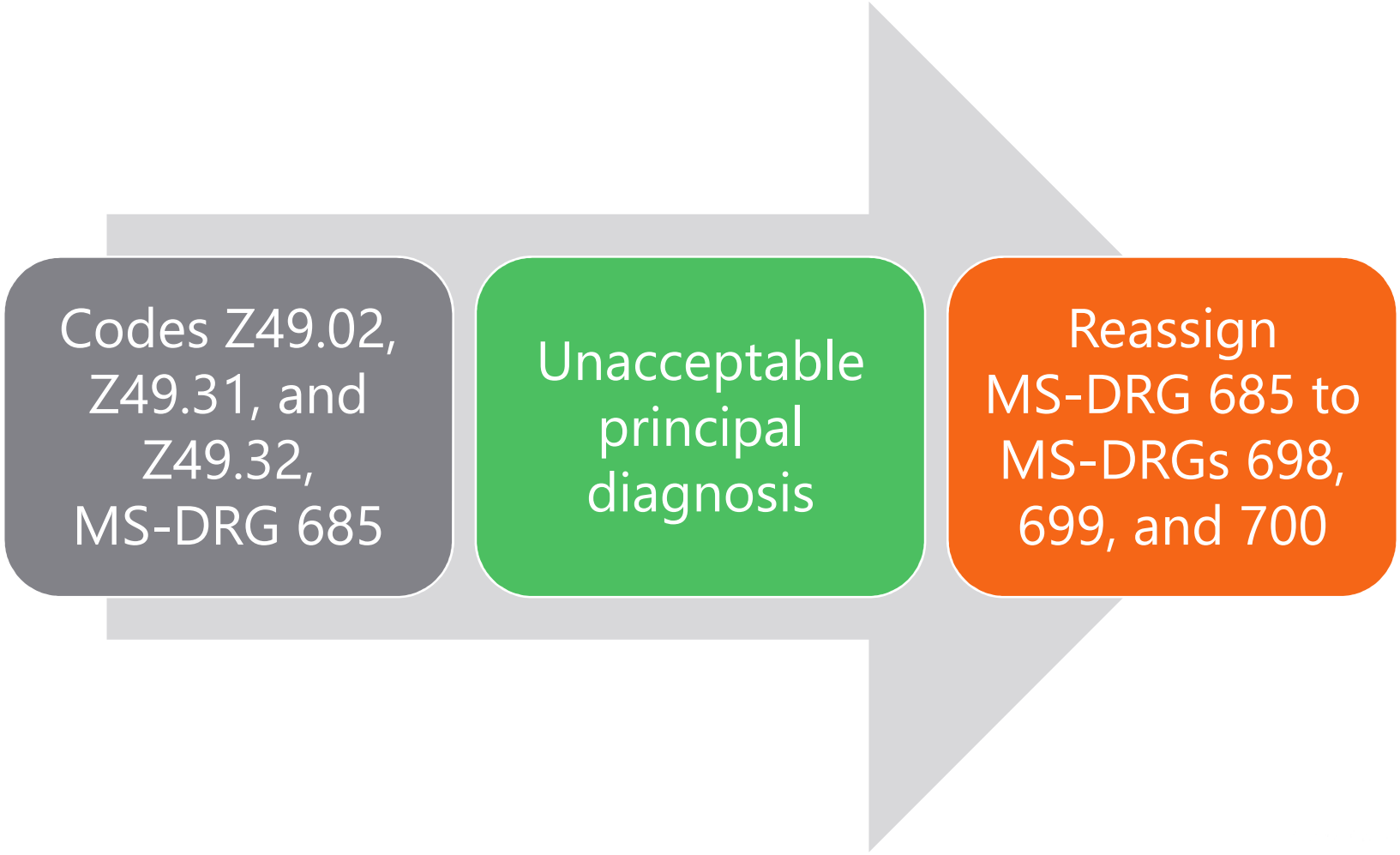
Medicare Severity Diagnosis Related Groups (MS-DRG)

MCC/CC

-Major complications/comorbidities

-Complication/comorbidities

ADMIT FOR RENAL DIALYSIS



SIRS

Reassign ICD-10 CM diagnosis codes R65.10 and R65.11 to MS-DRG 864

AND

Revise the title of MS-DRG 864 "Fever and Inflammatory Conditions"

PROPOSED CHANGES IN OB MS-DRG

Deleted	Proposed New
C-Section w/ CC/MCC	C-Section w/ Sterilization with MCC C-Section w/ Sterilization with CC C-Section w/ Sterilization w/o CC/MCC
C-Section w/o CC/MCC	C-Section w/o Sterilization w/ MCC C-Section w/o Sterilization w/ CC C-Section w/o Sterilization w/o CC/MCC
Vaginal Delivery w/ Sterilization and/or D&C Vaginal Delivery w/ Complicating Diagnosis Vaginal Delivery w/o Complicating Delivery	Vaginal Delivery w/ Sterilization/D&C w/ MCC Vaginal Delivery w/ Sterilization/D&C w/ CC Vaginal Delivery w/ Sterilization/D&C w/o CC/MCC Vaginal Delivery w/o Sterilization/D&C w/ MCC Vaginal Delivery w/o Sterilization/D&C w/ CC Vaginal Delivery w/o Sterilization/D&C w/o CC/MCC

PROPOSED CHANGES IN OB MS-DRG (CONT.)

Deleted	Proposed New
Ectopic Delivery	Other Antepartum Diagnoses w/ O.R. Procedure w/ MCC
Threatened Abortion	Other Antepartum Diagnoses w/ O.R. Procedure w/ CC
False Labor	Other Antepartum Diagnoses w/ O.R. Procedure w/o CC/MCC
Other Antepartum Diagnoses w/ Medical Complications	Other Antepartum Diagnoses w/o O.R. Procedure w/ MCC
	Other Antepartum Diagnoses w/o O.R. Procedure w/ CC
	Other Antepartum Diagnoses w/o O.R. Procedure w/o CC/MCC

PROPOSED ADDITIONS TO MCC LIST

Code	Description
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery
I63.89	Other cerebral infarction
J80	Acute respiratory distress syndrome
K35.21	Acute appendicitis with generalized peritonitis, with abscess
K35.32	Acute appendicitis with perforation and localized peritonitis, without abscess
K35.33	Acute appendicitis with perforation and localized peritonitis, with abscess
O86.04	Sepsis following an obstetrical procedure
P35.4	Congenital Zika virus disease

PROPOSED DELETIONS TO THE MCC LIST

Code	Description
B20	Human immunodeficiency virus {HIV} disease
I63.8	Other cerebral infarction
K35.2	Acute appendicitis with generalized peritonitis
K35.3	Acute appendicitis with localized peritonitis

PROPOSED ADDITIONS TO THE CC LIST

Code	Description
B20	**Human immunodeficiency virus {HIV} disease**
K35.20	**Acute appendicitis with generalized peritonitis, without abscess**
K35.30	**Acute appendicitis with localized peritonitis, without perforation or gangrene**
K35.31	**Acute appendicitis with localized peritonitis and gangrene, without perforation**
K35.890	Other acute appendicitis without perforation or gangrene
K35.891	Other acute appendicitis without perforation, with gangrene
K82.A2	Perforation of gallbladder in cholecystitis
O30.13X	Triplet pregnancy, trichorionic/triamniotic, _____ trimester
O30.23X	Quadruplet pregnancy, quadrachorionic/quadra-amniotic ____trimester
P74.41	Alkalosis of newborn
T81.4XXA	Infection following a procedure_____, initial encounter

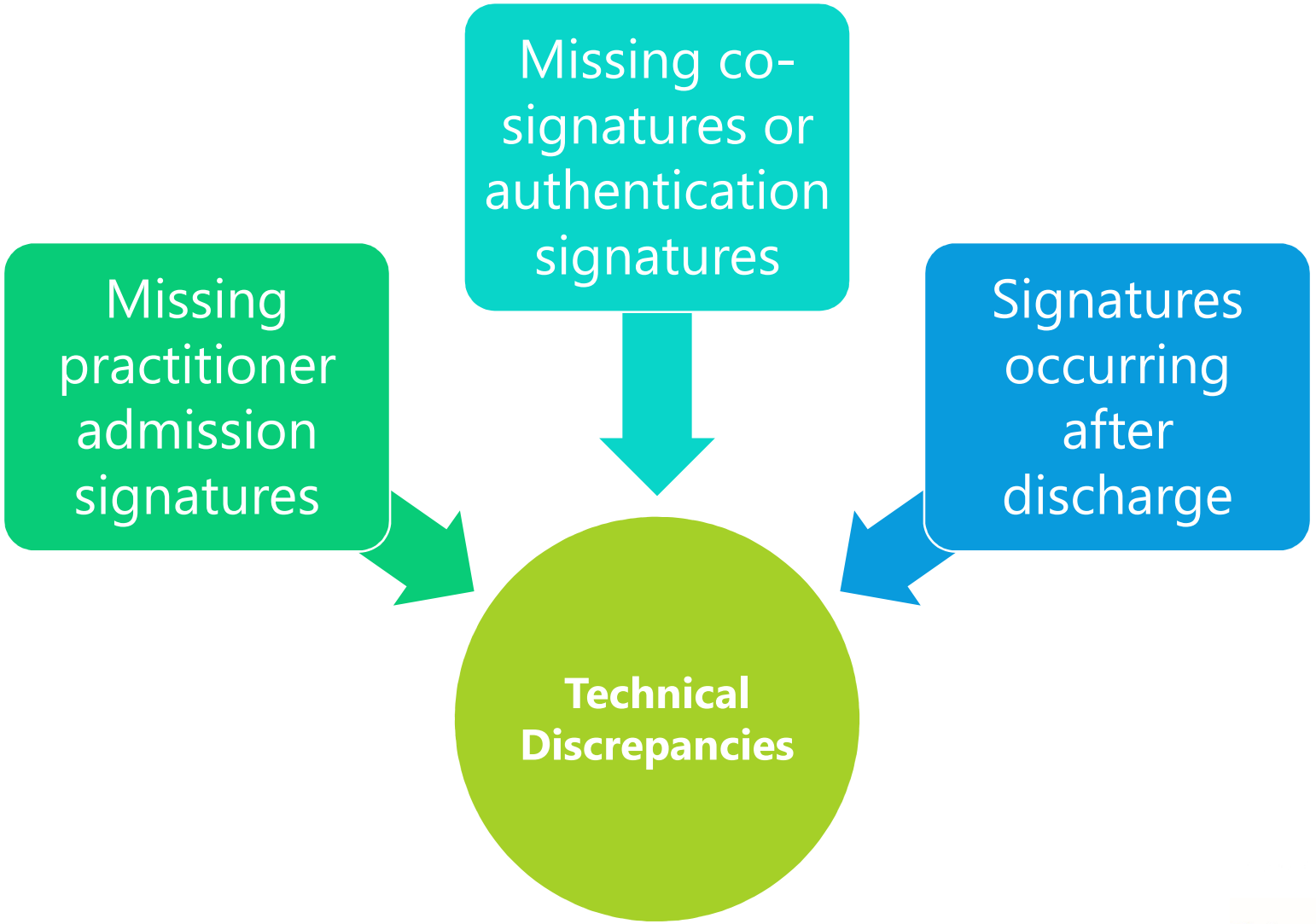
PROPOSED DELETIONS TO THE CC LIST

Code	Description
E72.8	Other specified disorders of amino-acid metabolism
G71.0	Muscular dystrophy
J80	Acute respiratory distress syndrome
K35.89	Other acute appendicitis
K61.3	Ischiorectal abscess
Q93.5	Other deletions of part of a chromosome
T81.4XXA	Infection following a procedure, initial encounter

PROPOSED REVISIONS REGARDING ADMISSION ORDER

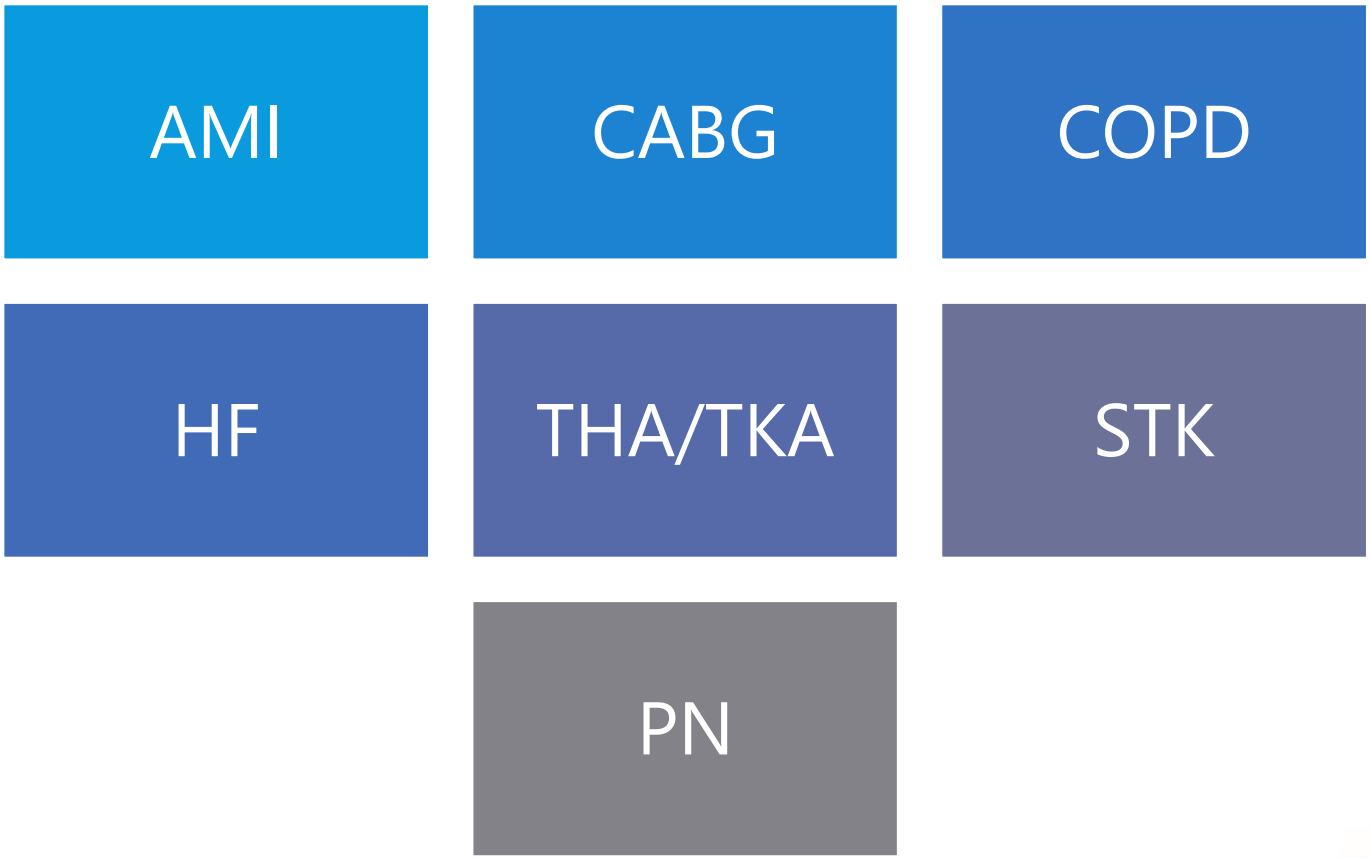
- Proposing that it is no longer necessary to require inpatient admission orders as a condition of Medicare Part A payment. CMS indicates that "This proposal does not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission."
- This is to address technical discrepancies of inpatient admission orders that have led to the denial of otherwise medically necessary inpatient admissions.

TECHNICAL DISCREPANCIES



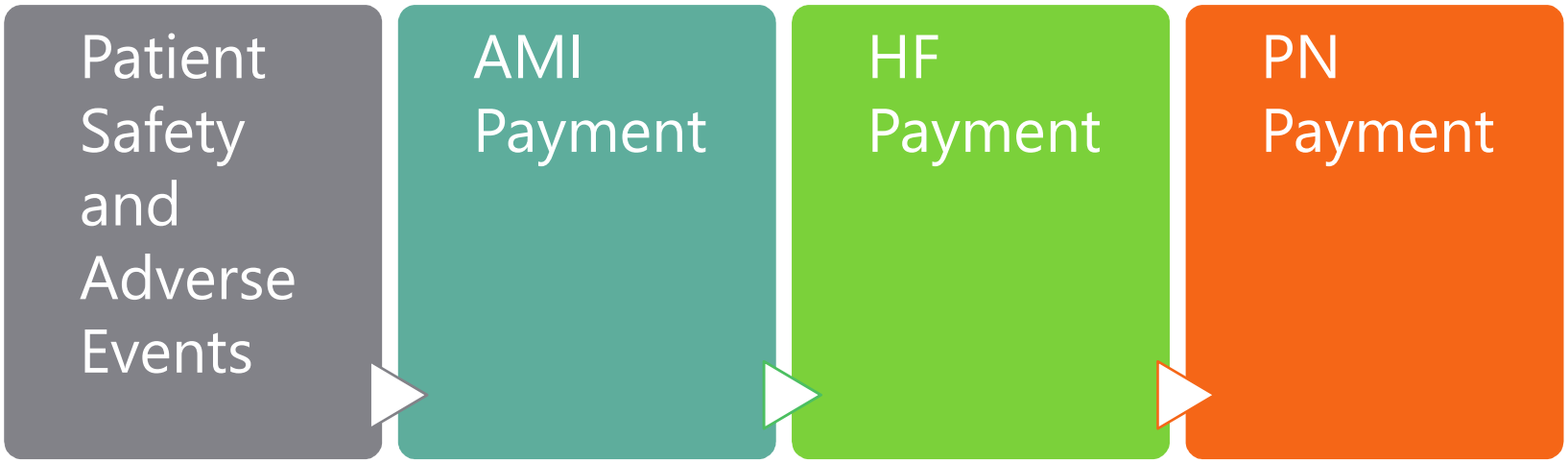
REDUCTION OF HOSPITAL PAYMENTS FOR EXCESS READMISSIONS

Proposing to remove seven claims-based readmission measures

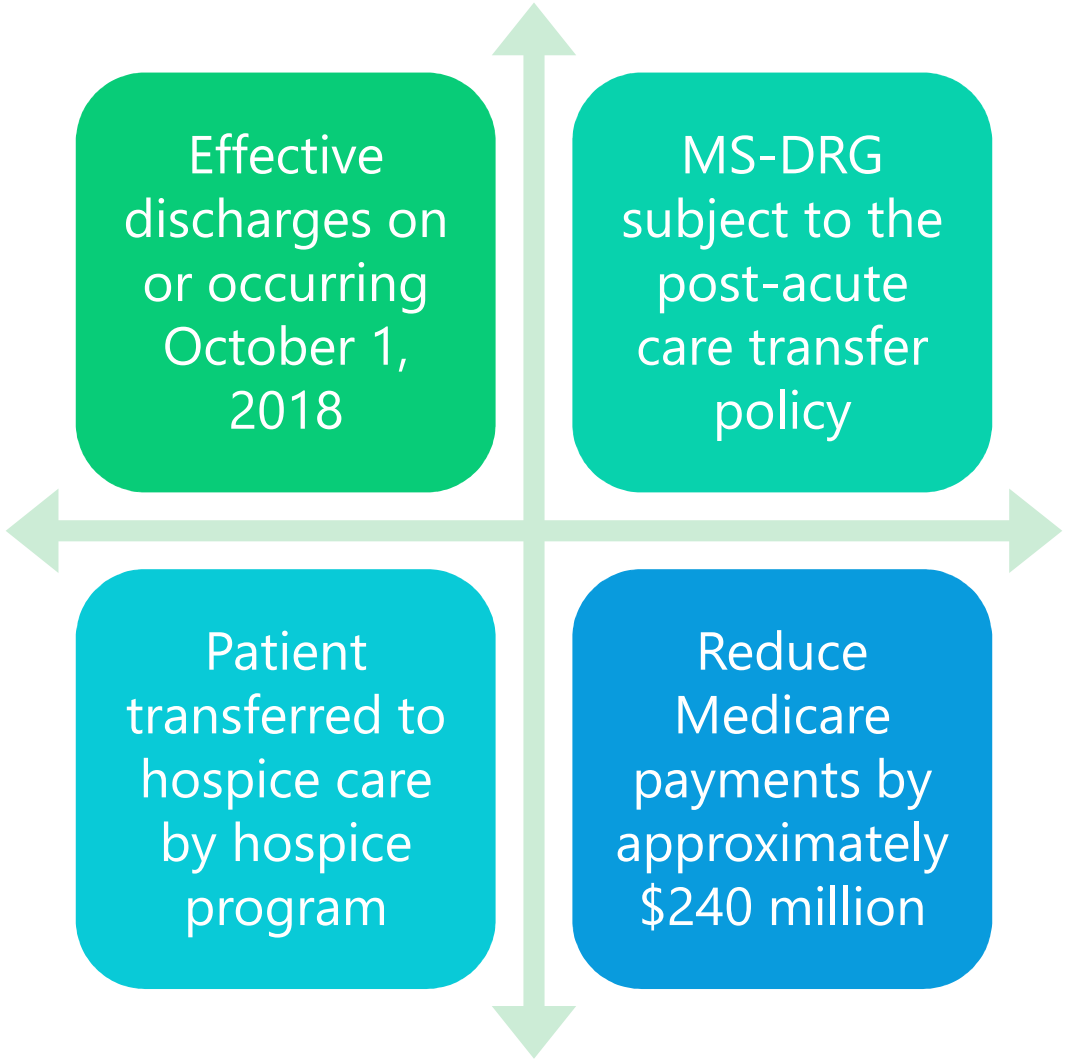


HOSPITAL VALUE BASE PURCHASING

Proposed to remove four measures from the Hospital Value Base Purchasing program



EXPANSION OF THE POST-ACUTE CARE TRANSFER POLICY



TWO MANDATORY PREREQUISITES A HOSPITAL MAY BE CLASSIFIED AS A RRC, IF…

Hospital's case mix index (CMI) for urban hospitals in its census region

Hospital's number of discharges is at least 5,000 per year or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located

RRC PROPOSAL

- RRC proposal
  - Rural hospitals with fewer than 275 beds
  - CMI value for FY 2017 at least
    - 1.66185 (national-all urban)
    - Median CMI value (not transfer-adjusted)

TARGETING CRITERIA FOR THE HAC REDUCTION PROGRAM

- Failed validation the previous year
- Submits data to NHSN after deadline has passed
- Not randomly selected for validation in the past 3 years
- Passed validation previous year but had a two-tailed confidence interval
- Failed to report to NHSN at least half of actual HAI events detected

QUESTIONS

YOLANDA WESLEY, RHIA, CCS

Yolanda Wesley is a Senior Consultant with Blue & Co., LLC on the Indianapolis Revenue Cycle team. She holds a Bachelor of Science in Health Information Administration from Indiana University and is a Registered Health Information Administrator (RHIA). She is also a Certified Coding Specialist (CCS).

Yolanda brings more than 24 years of experience in the field of healthcare. Her HIM management work includes release of information management and inpatient and outpatient coding management. Additionally, Yolanda has extensive knowledge of HIM inpatient and outpatient coding, new hire coding training, EPIC training and physician education. Ms. Wesley also has experience performing internal and external audits (e.g., RAC audits, third party payer audits, quarterly inpatient coding audits, and focus audits).

Yolanda's professional affiliations include American Health Information Management Association (AHIMA) and Indiana Health Management Association (IHIMA).

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IMPACT OF CLINICAL VALIDATION DENIALS

AGENDA

1. DRG coding validation
2. Clinical validation
3. Common clinical validation criteria

MEDICARE PROGRAM INTEGRITY MANUAL

6.5.3.

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

DRG CODING VALIDATION

GOAL
Reduce payment errors by identifying and addressing coding errors.

PERFORMED BY*	
CERT	Comprehensive Error Rate Testing Contractors
RA/RAC	Recovery Auditors/Recovery Audit Contractors
ZPIC	Zone Program Integrity Contractors
MRAC	Medicaid Recovery Audit Contractor
Third Party Payers	Anthem, United Healthcare, etc.

*List is not all-inclusive.

DRG CODING VALIDATION

PROCESS – CONTRACTOR DETERMINES WHETHER…
• The primary diagnosis listed on the claim meets the definition of principal diagnosis; OR
• The additional diagnoses reported (usually CCs or MCCs) were supported in the clinical documentation; OR
• The principal procedure was supported in the clinical documentation.

- **Must follow accepted principles of coding practice, including the *Official Guidelines for Coding and Reporting*, and**
- **Be performed using certified coders.**

CODING VS CLINICAL VALIDATION

ICD-9 Coding Clinic, 3q, 2008, pg 15

"Any clinical information published in *Coding Clinic*, is provided as background material to aid the coder's understanding of disease processes. The information is intended to provide the coder with 'clues' to identify possible gaps in documentation where additional physician query may be necessary. It is not intended to replace the need for specific physician documentation to substantiate code assignment."

CODER'S ROLE IN CLINICAL VALIDATION

ICD-10-CM Coding Clinic: 4Q, 2016, pg 147

- Code assignment is based on physician documentation, not on a particular clinical definition or criteria.
  - Regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned.
- Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.
  - Physician documents sepsis, coder assigns the code for sepsis, but a facility's clinical validation reviewer disagrees. That is a clinical issue, but it is not a coding error.
  - Coders shouldn't code sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria.
  - A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.

CODER'S ROLE IN CLINICAL VALIDATION

Clinical Validation is a separate function from the coding process.

The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief ("Clinical Validation: The Next Level of CDI") published in the August issue of JAHIMA:

> "Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."

DRG CLINICAL VALIDATION

DRG Clinical Validation

CMS RAC Scope of Work 2013 includes the following statements:

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

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

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

DRG CLINICAL VALIDATION

PROCESS – CONTRACTOR DETERMINES WHETHER…

- The patient truly possessed the conditions documented in the medical record.

- **Reviewers do not follow accepted principles of coding practice.**
- ***Performed using clinical staff (MD, RN, etc.)***
- **Currently a lawsuit to force CMS/MACs to make public the "consensus criteria" used for these denials.**
- **3rd Party payers do not have to make public their criteria, or when their criteria changes.**

RAC AND 3RD PARTY TARGETS

	MS-DRGs			APR-DRGs	
	PDX	**MCC**	**CC**	**SOI**	**ROM**
Diagnosis Targets	Unspecified diagnosis	Pneumonia	Acute renal failure	Diagnoses with 3-4	Diagnoses with 3-4
	Sepsis	MIs	Pancreatitis		
	MIs	Pancreatitis	Acute blood loss anemia		
	Pancreatitis	Acute respiratory failure			
	Appendicitis				

DRG CLINICAL VALIDATION

Roadblocks for Providers

- Contractors do not always follow accepted principals of coding practice, but instead follow various "consensus criteria."
- Criteria varies by contractor.
- Contractors are not obligated to publish or provider providers with criteria.

DISCLAIMER

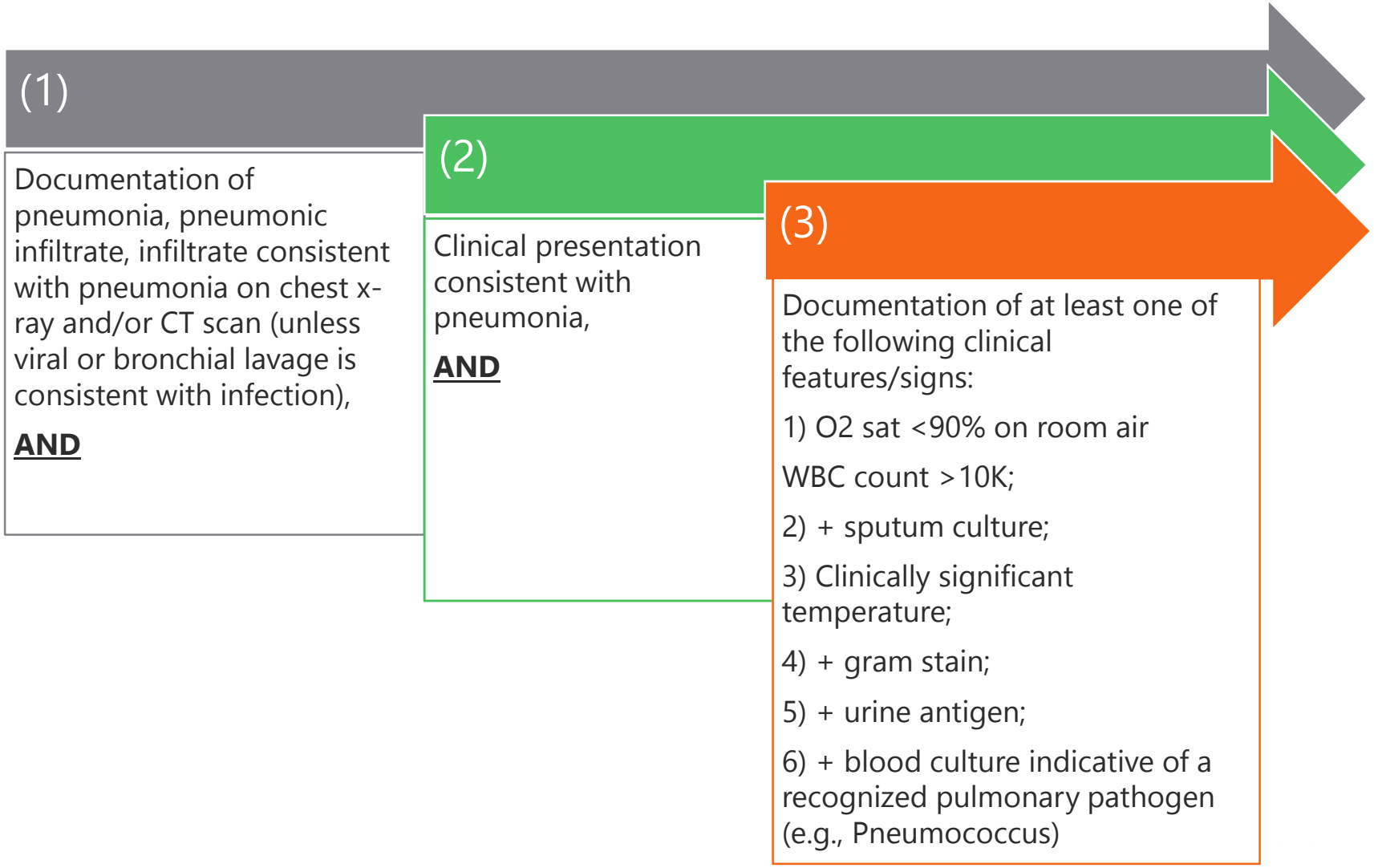
*The following slides contain information regarding clinical indicators that are commonly reviewed based on our experience.

Please note, individual payers and contractors may have unique criteria besides the example criteria included within this presentation.

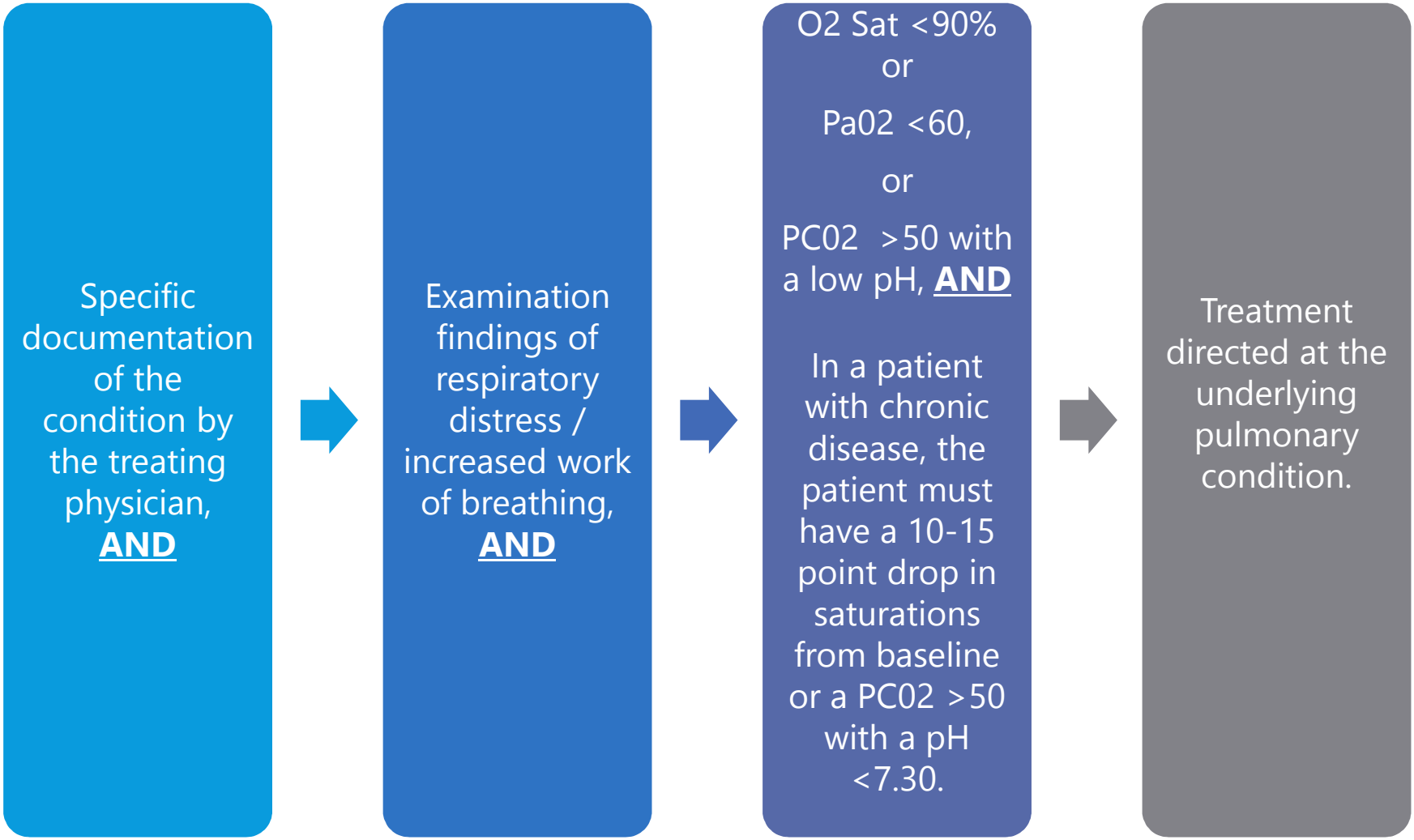
EXAMPLES OF CLINICAL INDICATOR SOURCES*

- Nutritional Diagnoses:
  - ASPEN
- Nephrology:
  - KDIGO
    - http://kdigo.org/home/guidelines/
- Cardiology:
  - American College of Cardiologist Foundation/ American Heart Association
- Sepsis:
  - Surviving Sepsis Campaign
    - http://www.survivingsepsis.org/Guidelines/Pages/default.asp
  - SOFA
    - https://jamanetwork.com/journals/jama/fullarticle/2492881

CLINICAL INDICATORS: PNEUMONIA*



CLINICAL INDICATORS: ACUTE RESPIRATORY FAILURE*



CLINICAL INDICATORS: ACUTE RENAL FAILURE*

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

CLINICAL INDICATORS: ACUTE BLOOD LOSS ANEMIA*

Development of symptoms of anemia not previously present.

Documentation by the physician of anemia due to hemorrhage or acute blood loss,

Drop in Hgb of 1.0-2.0 gm/dl and/or Hct of 3-6%,

Transfusion given,

CLINICAL INDICATORS: UTI*

Documentation	+ Urine Culture	Urinalysis

• Documentation of UTI must be in the medical record.	• With a colony count >100K (if a clean catch/chronic indwelling catheter specimen), or
	• With a colony count of >10K if a straight catheter specimen.
		• In the absence of a + urine culture, urinalysis
		  • + nitrites
		  • + leukocyte esterase, or
		  • >WBC/HPF

CLINICAL INDICATORS: SEPSIS*

Documentation of a confirmed infection, AND

2 or more positive SIRS findings:

- Body temperature <36C or >38C,
- Heart rate >90 beats per minute,
- Respiratory rate >20 breaths per minute,
- White blood cell count <4,000 cells/ml or >12,000 cells/ml or greater than 10% band forms

CLINICAL INDICATORS: MALNUTRITION*

Documentation of malnutrition, AND

Presence of 2 or more of the following:

Insufficient energy intake;	**Weight loss;**	**Loss of muscle mass;**
Loss of subcutaneous fat;	**Localized or generalized fluid accumulation; and**	**Diminished functional status as measured by hand grip strength.**

QUESTIONS

NICOLE CAMERON, RHIA, CDIP, CCS

Nicole Cameron is a Senior Consultant with Blue & Co., LLC on the Indianapolis Revenue Cycle team. Nicole has over 15 years of experience in the healthcare industry in various settings and specialties. Her knowledge spans several areas including medical coding, billing, auditing, and management. She holds a Bachelor of Science in Health Information Administration from Indiana University. Nicole's accreditations include Registered Health Information Administrator (RHIA), Certified Documentation Improvement Practitioner (CDIP), and Certified Coding Specialist (CCS).

Prior to joining Blue & Co., Nicole worked at an acute care hospital and physician practices. Her work included supervising the Medical Records Department and implementing a Clinical Documentation Improvement program. She has expertise in coding for all patient types – inpatient, observation, outpatient surgery, emergency department, and physician office. Additionally, Nicole has experience with creating Health Information Management policies and procedures and appeal review/denial management.

Nicole's professional affiliations include Leadership Hancock County, Indiana Health Information Management Association (IHIMA), and American Health Information Management Association (AHIMA). She is an active volunteer with AHIMA and is currently on an Exam Development Committee. In 2017, Nicole began serving on the Project Development Committee with IHIMA.

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