The Connection Between Coding, Quality Reporting, Reimbursement, LOS and Pay for Performance

The Challenges and Opportunities

March 2011
Coding is in the middle

CODING

- Data Comparisons
- External Audits (OIG, RACs)
- Quality Reporting (SOI/ROM O/E Ratio)
- Reimbursement (MS-DRGs)
- Case Mix Index (CMI)
- Pay for Performance (POA)
- Physician profiling
The Need

Physician Documentation is received in CLINICAL terms

Breakdown between the two
Two separate languages

Documentation for coding, profiling & compliance requires specificity in DIAGNOSIS terms

The 3M™ DRG Assurance™ Program creates a bridge between the gap.
Physician Documentation

- Coders CANNOT assign codes based on “findings and treatment provided”

- Coders CANNOT interpret laboratory, radiological, or other diagnostic findings.

- Coders require physician documentation of diagnoses and procedures, not conditions, symptoms or findings.
<table>
<thead>
<tr>
<th>Unable to Code</th>
<th>Able to Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-system organ failure</td>
<td>Liver failure, renal failure</td>
</tr>
<tr>
<td>Severe respiratory distress</td>
<td>Respiratory failure</td>
</tr>
<tr>
<td>Hemodynamically unstable</td>
<td>Hypotension, CHF, cardiogenic shock</td>
</tr>
<tr>
<td>Will rehydrate patient</td>
<td>Dehydration, hypovolemia</td>
</tr>
<tr>
<td>Rhythm stable today</td>
<td>Ventricular tachycardia</td>
</tr>
<tr>
<td>Unable to void</td>
<td>Urinary retention</td>
</tr>
<tr>
<td>K + 2.0, will give KCL</td>
<td>Hypokalemia</td>
</tr>
<tr>
<td>LLL opacification, will give IV</td>
<td>LLL pneumonia</td>
</tr>
</tbody>
</table>

*Most physician documentation is typically not “poor” or “bad”
....it’s just not “code-able!”*
Probable, Possible, Suspected, Clinical, or Unable to Rule Out

- **Inpatient application:**
  - Code these conditions as though they exist
  - If condition is ruled out, it may not be coded

- **Outpatient application:**
  - Must code signs/symptoms, not the suspected condition

**Note:** When ordering ancillary tests (EKG, radiology, anatomical pathology, etc.) use signs and symptoms to indicate medical necessity
MS-DRG (Medicare Severity Diagnosis Related Group)

- All inpatient cases are assigned a payment grouping (MS-DRG) based on the cumulative diagnosis and procedure codes assigned to each case.
  - **Principal diagnosis** (the condition after study, to be chiefly responsible for the patient’s admission)
  - **Secondary diagnoses** (Defined by UHDSS guidelines)
    - Must affect patient care
    - Require clinical evaluation
    - Therapeutic treatment
    - Diagnostic procedures
    - Extend length of stay
    - Increase nursing care/monitoring
  - **Procedures** performed
MS-DRG - continued

- Three levels of severity
  - MCC (Major complication/comorbid condition)
  - CC (Complication/comorbid condition)
  - Non-CC

- MCCs and CCs are:
  - Significant acute disease
  - Acute exacerbations of significant chronic diseases
  - Advanced stage or end stage chronic diseases
  - Chronic diseases associated with extensive debility

- Reimbursement is calculated based on predetermined dollar amounts for a MS-DRG.
  \[ \text{DRG Weight} \times \text{Hospital Rate} = \text{Payment} \]
Severity of Illness/Risk of Mortality (SOI/ROM)

- If clinical documentation and coding do not accurately reflect the work that physicians do, or the “severity level” of patients’ illness:
  - Length of stay will be impacted
  - Reimbursement will be affected
  - Physician profiles will not be accurate
  - Quality reporting will be affected (Severity of Illness/Risk of Mortality)
Pay for Performance (P4P) and Present on Admission (POA) Indicator

- P4P also called value based purchasing
- Differential payment to hospitals and physicians based on performance on a set of specified measures
  - Quality
  - Efficiency
  - Patient experiences
  - Structural reforms (e.g., information technology)
- Aligns financial incentives with delivery of high quality care
- Rapidly expanding programs

*Effective 10/01/2008 - potential payment reductions apply regarding certain HAC (Hospital Acquired Conditions) and Never Events*
POA Usage

- For inpatient admissions
  - All diagnoses: Principal and all secondary impacted
  - **Currently includes the following HAC events:**
    - Catheter-associated UTI;
    - Pressure ulcers;
    - Retained foreign body after surgery;
    - Air Embolism;
    - Blood incompatibility;
    - Staph Infection/Septicemia;
    - Vent Assisted Pneumonia/Other Pneumonia;
    - Vascular Catheter-associated infections;
    - Surgical site infections;
    - Mediastinitis after CABG;
    - DVT/PE following total joint procedures;
    - Manifestations of poor glycemic control
Service specific examples – Case #1—General Surgery

- This is a case in which the patient came in with a pancreatic pseudocyst and had a partial pancreatectomy and cholecystectomy with a 10 day LOS. It was noted that the x-ray findings indicated atelectasis and/or pneumonia. Antibiotics and incentive spirometry were administered.

- The question posed to the physician was to clarify if there was a specific diagnosis attributable to these findings and treatment as the documentation of any diagnosis being treated was not clearly documented by the physician.
Physician query response

- *Patient had atelectasis due to pain and abdominal splinting. He did not have and was not treated for pneumonia.*

- Having this query response enabled us to assign a code for the atelectasis.
### Case #1 – Before and After query and response

<table>
<thead>
<tr>
<th></th>
<th>407</th>
<th>406</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG</td>
<td>407</td>
<td>406</td>
</tr>
<tr>
<td>MS-DRG weight</td>
<td>1.8068</td>
<td>2.6729</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$14,454.40</td>
<td>$21,383.20</td>
</tr>
<tr>
<td>Length of Stay (LOS)</td>
<td>4.1 days</td>
<td>6.7 days</td>
</tr>
<tr>
<td>Severity of Illness/Risk of Mortality (SOI/ROM)</td>
<td>1- Minor SOI 1- Minor ROM</td>
<td>1- Minor SOI 1- Minor ROM</td>
</tr>
</tbody>
</table>
General Surgery Specific

Example #2

- This was a patient with a large recurrent incisional hernia. Laparoscopic repair was converted to open ventral incisional hernia repair. Complications as noted included an enterotomy x2 requiring repair and one small bowel resection. No other diagnoses were documented in the chart. However, a BMI of 44.4 was documented in the nutritional consult. Patient was discharged after a 6 day LOS.

- No associated diagnosis for the BMI was documented by the physician. To ensure the appropriate severity of illness was reflected, we queried the physician for an associated diagnosis relating to the nutritional consult and stated BMI.
Physician query response

- Per the physician’s response, “the BMI had no significance”.

- What we were actually looking for was a diagnosis of Obesity. The query response didn’t allow us to capture an additional diagnosis.
Case #2 – Result if we had been able to code Obesity

<table>
<thead>
<tr>
<th></th>
<th>330</th>
<th>330</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG weight</td>
<td>2.4981</td>
<td>2.4981</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$19,984.80</td>
<td>$19,984.80</td>
</tr>
<tr>
<td>Length of Stay (LOS)</td>
<td>7.9 days</td>
<td>7.9 days</td>
</tr>
<tr>
<td>Severity of Illness/Risk of Mortality (SOI/ROM)</td>
<td>1- Minor SOI 1 Minor ROM</td>
<td>2- Moderate SOI 1 - Minor ROM</td>
</tr>
</tbody>
</table>
This is a patient who was initially admitted for a renal transplant due to Hypertensive CKD. During the pre-operative work-up, the patient was noted to have an elevated PSA. It was decided the patient should have a needle biopsy on an outpatient basis prior to proceeding with the renal transplant. The patient was discharged with an LOS of 1.

To ensure the appropriate severity of illness was reflected, we asked the physician for clarification of the CKD Stage.
Physician query response

- Per physician response, "Stage IV CKD".

- Having this response allowed us to assigned the Stage IV CKD rather than an unspecified stage.
Case #3 – Before and After physician response

<table>
<thead>
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<th>MS-DRG</th>
<th>684</th>
<th>683</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG weight</td>
<td>.6746</td>
<td></td>
<td>1.0523</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$3,942.36</td>
<td>$8,418.40</td>
<td></td>
</tr>
<tr>
<td>Length of Stay (LOS)</td>
<td>2.9 days</td>
<td>4.2 days</td>
<td></td>
</tr>
<tr>
<td>Severity of Illness/Risk of Mortality (SOI/ROM)</td>
<td>2- Moderate SOI 1 Minor ROM</td>
<td>2- Moderate SOI 2 - Moderate ROM</td>
<td></td>
</tr>
</tbody>
</table>
Case Example #4

- This patient was admitted for elevated LFTs in a patient with history of Liver transplant 8 months prior to admission. The patient was treated with gancyclovir and solumedrol and was discharged after a 2 day length of stay.

- To ensure the appropriate principle diagnosis assignment severity of illness, we queried the physician for clarification of the elevated LFTs.
Physician query response

- Per physician response, “Diagnosis is acute cellular rejection confirmed by liver biopsy but he also has CMV infection, but no CMV disease at this time.”.

- Having this response allowed us to assign the appropriate principal diagnosis of transplant complication (rejection) as well as the CMV infection.
Case #4 – Before and After physician response

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>948</th>
<th>442</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG weight</td>
<td>.6689</td>
<td>.9407</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$5,351.20</td>
<td>$7,525.60</td>
</tr>
<tr>
<td>Length of Stay (LOS)</td>
<td>2.8 days</td>
<td>3.7 days</td>
</tr>
<tr>
<td>Severity of Illness/Risk of Mortality (SOI/ROM)</td>
<td>2- Moderate SOI 1- Minor ROM</td>
<td>2- Moderate SOI 1- Minor ROM</td>
</tr>
</tbody>
</table>
Before and After Case Mix Index (CMI) – all 4 examples.

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL MS-DRG Weights – 4 cases</td>
<td>5.6484</td>
<td>7.164</td>
</tr>
<tr>
<td>TOTAL CMI – 4 Cases</td>
<td>1.4121</td>
<td>1.791</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$43,732.76</td>
<td>$57,312.00</td>
</tr>
<tr>
<td>Difference</td>
<td>$13,579.24</td>
<td></td>
</tr>
</tbody>
</table>
The Future Provides Us With Opportunities

- Getting all healthcare professionals aligned with the same goals
- Engaging our physician colleagues
  - How can we work with better with you to ensure documentation is clear, concise and reflective of the appropriate severity level
    - Flash Rounds concept?
    - Brief call after rounds?
    - Other
- Working together will enable us to provide better data for assessing quality and safety
- Education - Clinical Documentation Improvement I
The DRG ASSURANCE™ Program: A Partnership

Clinical Documentation Review Specialists

Inpatient Coders

Physicians

Patient

A concurrent review by an interdisciplinary team to assess whether all conditions and treatments are reflected in the medical record for proper severity assignment based on CMS’s rules and regulations.
Questions/Comments?