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Clinical Documentation Conundrums in the Face of CMS 1599 E and ICD 10

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Disclosures:

Speaker disclosures that he is an employee/owner of Aerolib Healthcare Solutions LLC and there are no conflicts of interest that exist in relation to his presentation.

The speaker has attested that their presentation will be free of all commercial bias toward a specific company and its products.

The speaker indicated that the content of the presentation will not include discussion of unapproved or investigational uses of products or devices.

AEROLIB HEALTHCARE SOLUTIONS LLC

CLINICAL DOCUMENTATION CONUNDRUMS IN THE FACE OF CMS 1599 F AND ICD 10

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- Dr. Pahuja discloses that he is an employee/owner of Aerolib Healthcare Solutions LLC. No conflict of interest exists in relation to his presentation today.

OBJECTIVES

- Case analysis
- Understand Auditor constraints
- Importance of Documentation
- Hospital reimbursement

IT'S ABOUT SEMANTICS!

67 yr. old with rectal bleed and Hgb of 7 and BP 89/67

Diagnosis: Anemia, hypotension and LGIB

WILL THIS BE DENIED?

WILL THIS BE DENIED?

Acute blood loss anemia with likely source of bleed from rectum with hemodynamic instability requiring 2 unites of blood transfusion for stabilization with a history of polyps and atrial fibrillation.

IT'S ABOUT SEMANTICS!

se-man-tics

S mantiks/

noun

noun: semantics; noun: logical semantics; noun: lexical semantics

The branch of linguistics and logical concerned with meaning. There are a number of branches and sub branches of semantics, including formal semantics, which studies the **logical aspects of meaning**, such as sense, reference, implication, and logical form, lexical semantics, which studies word meanings and word relations, and conceptual semantics, which studies the cognitive structure of meaning.

INSIDE THE MIND OF AN AUDITOR

200 page document
15-25 minute per case
MD, PA, NP, RN

INPATIENT OR OBSERVATION

"SERVICES THAT ARE REASONABLE AND NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF ILLNESS OR INJURY OR TO IMPROVE THE FUNCTIONING OF A MALFORMED BODY MEMBER"

Medical Necessity
Section 1862 of SSA

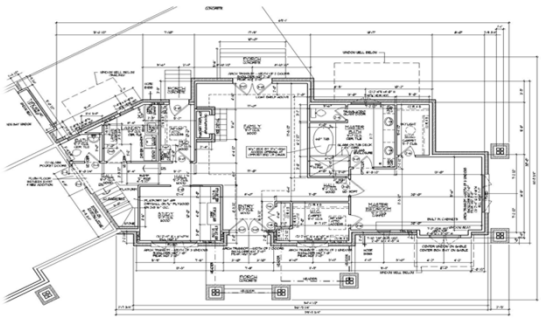
- Assume differences until similarity is proven
- Emphasize on description rather than interpretation
- Put yourself in the auditor's frame of references

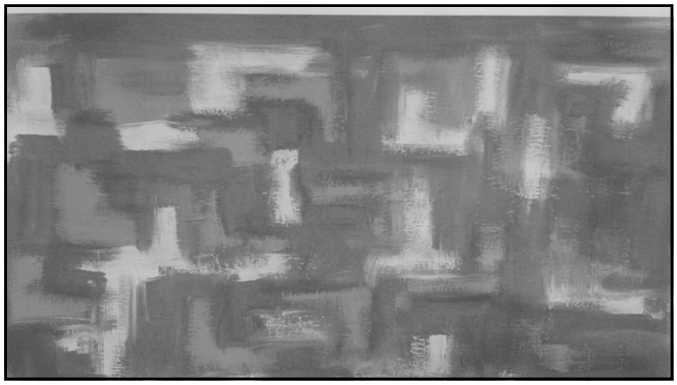
RED FLAGS WITHIN DOCUMENTATION FOR HOSPITALISTS

The Hospitalist, July 2011

Make a defensible medical record!

Pain a picture of clarity of the patient condition





DOCUMENTATION SMARTLY!

- Acidosis/Alkalosis
- Atelectasis
- BMI > 40 or <14
- Cachexia
- Dementia senile/vascular
- Gastrostomy tube repositioning/ cleaning/replacement
- Dementia with acute change
- Encephalopathy
- COPD/Asthma exacerbation
- Hemiparesis
- Malnutrition and stage
- Pressure ulcers

HOW WILL ICD-10 AFFECT CLINICAL DOCUMENTATION?

- Initial Encounter, Subsequent Encounter, or Sequelae
- Acute or Chronic
- Right or Left
- Normal Healing, Delayed Healing, Nonunion, or Malnunion

COMPLICATIONS/COMORBID CONDITIONS (CC)

MAJOR COMPLICATIONS/COMORBID CONDITIONS (MCC)

Significantly increase severity of illness, morbidity, mortality, length-of-stay, and/or utilization of resources.

HOSPITAL REIMBURSEMENT FOR GI HEMORRHAGE

GI Hemorrhage
Secondary Dx: CHF
MS-DRG 379 w/o CC/MCC
$7,377

GI Hemorrhage
Secondary Dx: Systolic heart failure
MS-DRG 379 with CC
$8,293

GI Hemorrhage
Secondary Dx: Acute on Chronic Systolic heart failure
MS-DRG 377 with MCC
$9,086

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MS-DRG 377 with MCC

$9,086

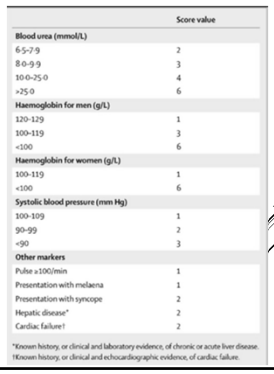
DOCUMENTATION TO SUPPORT A GI HEMORRHAGE DIAGNOSIS

- Blood Urea
- Hemoglobin (g/L)
- Systolic blood pressure (mm Hg)
- Pulse 100 (per min)
- Presentation with melena
- Presentation with syncope
- Hepatic disease
- Cardiac failure

- Hemoglobin level >12.9 g/dL (men) or >11.9 g/dL (women)
- Systolic blood pressure >109 mm Hg
- Pulse <100/minute
- Blood urea nitrogen level <18.2 mg/dL
- No melena or syncope
- No past or present liver disease or heart failure

USE PREDICTION TOOLS!

Glasgow-Blatchford Score



	Score value
Blood urea (mmol/L)	
6·5–7·9	2
8·0–9·9	3
10·0–25·0	4
>25·0	6
Haemoglobin for men (g/L)	
120–129	1
100–119	3
<100	6
Haemoglobin for women (g/L)	
100–119	1
<100	6
Systolic blood pressure (mm Hg)	
100–109	1
90–99	2
<90	3
Other markers	
Pulse ≥100/min	1
Presentation with melaena	1
Presentation with syncope	2
Hepatic disease*	2
Cardiac failure†	2

*Known history, or clinical and laboratory evidence, of chronic or acute liver disease.
†Known history, or clinical and echocardiographic evidence, of cardiac failure.

ICD-10-CM officially replaces ICD-9-CM on October 1, 214 therefore, J17 and all ICD-10-CM diagnosis codes should only be used for training or planning purposes until then

PART OF DIAGNOSTIC RELATED GROUP(S) (MS-DRG V 28.0):

- 377 G.i. hemorrhage with mcc
- 378 G.i. hemorrhage with cc
- 379 G.i. hemorrhage without cc/mcc

- Bleeding gastrointestinal K92.2
- Enterorrhagia K92.2
- Gastrorrhagia K92.2
- Hemorrhage, hemorrhagic (concealed) R58
  - Bowel K92.2
  - Cecum K92.2
  - Colon K92.2
  - Duodenum, duodenal K92.2
  - Gastroenteric K92.9
  - Gastrointestinal (tract) K92.2
  - Intestine K92.2
  - Stomach K92.2
- Rupture, ruptured
  - Gastric – see also Rupture, stomach vessel K92.2

CODING TIPS

- Asthma Exacerbation
- Atelectasis
- COPD w/Acute Exacerbation
- Emphysema w/ Exacerbation of Chronic Bronchitis
- Hemoptysis
- Pulmonary Edema
- Respiratory Alkalosis / Acidosis
- Respiratory Distress, Acute: ARDS
- Respiratory Failure, Chronic
- Respirator Weaning or Dependence

SEMANTIC!

- Azotemia: Obstructive Uropathy, Acute Renal Failure, Chronic Kidney Disease (specify stage)
- Diabetes Mellitus: Diabetic Gastroparesis, Diabetic Nephrosis, DKA, etc.
- Hypertension: Hypertensive Encephalopathy, Accelerate Hypertension, Hypertension with Chronic Kidney Disease (specify stage)
- Hypoalbuminemia: Malnutrition (specify mild, moderate, severe)
- Hypercapnea: Acute Respiratory Failure or Acute Exacerbation of COPD
- Anemia: Acute Blood Loss Anemia, Aplastic Anemia or Sideroblastic Anemia, Pancytopenia (specify if due to drug effects such as chemo)
- GI Bleed: GI Bleed due to Gastritis or other GI condition
- Cardiac Arrhythmia: Atrial Flutter, Paroxysmal Ventricular Tachycardia, etc.
- Cardiomegaly: Acute or Chronic, Systolic or Diastolic Heart Failure
- Schizophrenia: Chronic Schizophrenia or other more specific type

Common confusions regarding status decisions

Day 1

81 year old male presenting from home to Emergency Department at 9 pm with 1 day history of resolved slurring of speech and left sided lower extremity weakness that lasted 5 minutes and occurred at 3 pm. Past medical history is significant for hypertension, COPD and atrial fibrillation. Initial CT scan of the brain is negative for acute bleed. Neurological examination shows expressive aphasia but no motor or sensory deficits.

Day 1: Patient is hospitalized under **Observation** for acute transient ischemic attack and sent to the neurological floor with orders for IV fluids, aspirin, echocardiogram, carotid ultrasound, MRI of the brain, and neurology consultation.

Day 2

On day 2, his blood pressure falls to 80/45 and he is tachycardic with heart rate of 124. MRI of the brain is put on hold due to atrial fibrillation with rapid ventricular rhythm and is transferred to the intensive care unit.

Remains in Obs (Friday 5 pm)

Hospitalist transition

CM/UR Team to weekend coverage

Day 3 and Day 4

Sat-Sun: Patient improves and transferred back to the floor on Sunday by weekender hospitalist

Rec: SNF recommendation

No recommendations by CM/UR team

Day 5

Original hospitalist writes order for SNF

Pt still in Obs status

Discussion between patient, family, hospitalist, CM, UR and SW

SNF staff and patient family discussions regarding payment

Blame game starts

Should this patient have been Obs to begin with?

Day 2: Why was the status was not changed to IP?

Day 3 and 4: Who is accountable for weekend status decisions?

Day 5: SNF discharge: Could this have been avoided by SNF presumption at time of adm?

Early PT-OT-SW consultations

Who are the losers?

Patient: SNF payment coverage at risk since no 3 day IP admission

Hospital: Loss of appropriate Part A pmt

Hospitalist: 2% loss of income due to incorrect status decisions put as a quality metric

CM-UR Team: Black mark on loss of charge capture/ additional resources to identify root cause analysis/ admin burden

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