Devil in the Details:
Compliance Auditing in Quality Indicators

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Corporate Compliance
Sharp HealthCare

Overall Objective:

- Implement an auditing and monitoring program utilizing software solutions to support clinical documentation improvement.
- Access ICD-9 (and ICD-10) hot spots for documentation gaps and opportunities.
- Discuss specific Patient Safety Indicators (PSI’s) and Hospital Acquired Conditions (HAC’s) allowing organizations to monitor, improve and ensure appropriate revenue.
About Sharp HealthCare

• Not-for-profit serving 3 million residents of San Diego County
• Sharp has grown from one hospital in 1955 to an integrated care delivery system
  – Affiliated, aligned, and integrated medical groups
  – Fully integrated information technology systems and infrastructure
  – Centralized system support services (human resources, information technology, clinical effectiveness, billing, accounting, payroll, marketing, etc.)
  – Senior management has an excellent track record of marked financial and operational improvement, with an average of 15 years of service at Sharp
• Largest health care system in San Diego with highest market share
  – 4 acute care hospitals, 3 specialty hospitals, 2 affiliated med groups and health plan,
  – Market share leader and only health system that increased market share each of the past nine years
• Largest private employer in San Diego
  – 17,000 employees, 2,600 affiliated physicians, 2,106 volunteers

Organizational Structure

Sharp HealthCare*

Hospitals

Other Affiliated Entities

Sharp Memorial Hospital*
Including the Sharp Memorial Hospital, Sharp Mary Birch Hospital for Women & Newborns, Sharp Mesa Vista Hospital, Sharp Vista Pacifica Hospital, and the Sharp Memorial Outpatient Pavilion

Grossmont Hospital Corporation*

Sharp Rees-Stealy Medical Centers*
Sharp Community Medical Group
Sharp Health Plan
Continuous Quality Insurance Company, Ltd.

Sharp HealthCare Foundation
Grossmont Hospital Foundation

Sharp Chula Vista Medical Center*

Sharp Coronado Hospital and Healthcare Center

San Diego’s Health Care Leader
What Were the Catalysts for Change?

- **Change the Culture of Compliance**
  - The “No” Department
  - Ho Hum...traditional auditing
  - Becoming the Bridge
  - Move from Quantity to Quality Based Reimbursement
    - CMS’ introduction of Value-based Purchasing (VBP)

What Were the Catalysts for Change?

- A major paradigm shift.....
- CMS introduced VBP with the following statement..
  - “This type of initiative pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services.”
  - Result: A merging of finance with quality in order to improve patient care and outcomes.
What Were the Catalysts for Change?

• Concern about accurate revenue and penalties from PSI and HACs
  – System Goals
    • Readmission Goals
      – Achieve Top Decile 30-Day (Readmission Rates)
    • HAC Goals
      – Eliminate Hospital-Acquired Infections (% Reduction)
• Concern that: physician documentation practices and/or CDI, and/or internal coding practices could lead to a decrease in entitled revenue
• An understanding that improvement in clinical documentation was needed to improve revenue and compliance while maintaining a learning culture

From Quantity to Quality Based Reimbursement

Issues

Move from Quantity to Quality Based Reimbursement

• The Affordable Care Act introduced an array of programs aimed at shifting the paradigm for health care reimbursement in America from a system that reimburses based purely on **quantity to quality** of services.
• Medicare fee-for-service reimbursement system is clearly expanding (trend) towards quality-based reimbursement
• CMS has implemented a blitzkrieg of programs and policies focusing on such quality-of-care issues:
  • Unnecessary readmissions
  • Hospital-acquired-conditions
  • “Never” events
  • Expanding VBP program
  • Mortality rates
What is the impact?

- Quality scores from peer review organizations published with increased consumer availability
  - US News & World Report on Best Hospitals to double weight of patient safety indicators in determining the best hospitals; reported January 2014
- Pay for Performance Initiatives
  - VBP started FY 2013
  - 5 Agency for Healthcare Research (AHRQ) PSI originally introduced into VBP program for FY 2014 and not finalized; AHRQ PSI composite source to be included in FY 2015
- Managed Care and third party payor contract implications
  - Negotiated rates including performance outcomes
- Financial losses due to HACs
  - Central line associated blood stream infection (CLABSI) included in FY 2015
  - VBP and catheter associated urinary tract infection (CAUTI) to be included along with CLABSI in FY 2016

What Were the Catalysts for Change?

- The measures are designed to reflect the quality of care being delivered, but...
  - This information is abstracted from the health record based on coding, with certain inclusions and exclusions, and adjustments for severity.
  - Key: Completeness, accuracy, and timeliness of clinical documentation and coding play a significant role in the integrity of the reported clinical data.
Where is the potential (Compliance) Gap?

• Conflicting and contradictory messages from the various reviewers to providers on required documentation or clarification needed
  – Differences between coding, quality and clinical definitions
• Lack of coordinated system for flagging, reviewing and “correcting” quality concerns
• Lack of knowledge by all team members as to coding and quality definitions
• Frequently identified retrospectively, thereby increasing compliance risk and decreased provider participation

Creating a New Philosophy:
Compliance is an Asset which is beneficial

• History has taught us that the more compliant a health care system is, the greater its revenue
• To be compliant, health care systems need to ensure that they capture entitled revenue. We have seen systems lose entitled dollars because of:
  ✓ Vague clinical documentation
  ✓ Weak internal communication (feedback loops)
  ✓ Incomplete medical records
  ✓ Overly conservative or inconsistent coding
  ✓ Lack of education to physicians
• As systems adopt more stringent compliance procedures, these problems can intensify without better documentation and follow-up processes
Sharp HealthCare Compliance
Strategic Audit Plan

• Increase entitled reimbursement
  – Collaboration with CDI Program/Quality/HIM
• Reduce the number of potential PSI’s and HACs
  – Through data mining, and specific target auditing
• Install a robust education program to improve compliance, coding and physician documentation

Compliance Strategic Audit Plan
Improve Quality Outcomes

• Intensive review of all reporting and audit mechanisms to assess for conflicting messages
• Focused review of cases with various quality review metrics and extensive knowledge of coding, quality and clinical concepts
• Identification and prioritization of most problematic quality concerns
• Development of multidisciplinary task force
How Sharp Reduced Known HAC Risks – Data Analysis and Data Mining

• Data analysis and data mining was the key to reducing Sharp’s known HAC risks
• Data mining provided:
  – A rational basis for its proactive approach
  – An ability to actively prevent the continuance of problematic practices
  – Critical extra time to evaluate problematic cases

How Sharp Uses Data Mining

• Crimson - Clinical Practice Intelligence Continuum of Care Tool
• Focus on Trended Performance by Indicator(s)
• Identify case specific information
• Inpatient Coding Analysis
ICD-9-CM & ICD-10-CM Hot Spots for Documentation Improvement

• Focus on Top Diagnoses
  – Risk Dx Code Prioritization by Specialty and MD
• Secondary Diagnosis Codes
  – Sequencing
• Unspecified Code Usage
  – CHF (11x)
  – Acute bronchitis (10x)
  – Asthma (18x)
• Top Documentation Concepts for ICD-10
• MS-DRG’s CC’s and MCC’s


Uncertain Diagnosis
• If the diagnosis documented at the time of discharge is qualified as “probable”, suspected”, likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established.
  • The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis
• Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.
ICD-9 Hot Spots for Documentation

• The Big Five
  – Pneumonia (PNA)
  – Heart Failure (HF)
  – Acute Respiratory Failure (ARF)
  – Septicemia
  – Acute Renal Failure

ICD-9 Hot Spots for Documentation

• Pneumonia—(An Incredible History)
  – Risk and Reward
  – Is the physician’s diagnosis Pneumonia, organism unspecified (486)
  – If physician doesn’t link documentation to a specific organism, coder cannot make assumptions; MD must link organism to cause of PNA
  – Unspecified
ICD-9 Hot Spots for Documentation

• Pneumonia
  – Considerations when auditing:
    • Is the pneumonia diagnosis clearly substantiated through physician documentation, clinical indicators, etc
    • Was a physician query required to substantiate a principal diagnosis
    • Did physician document in the medical record the cause of pneumonia
    • If the cause was not documented by the physician, is there any documentation present in the medical record that could substantiate a more specific principal diagnosis

PNEUMONIA:
Is the physician’s diagnosis Pneumonia, organism unspecified, (486)

<table>
<thead>
<tr>
<th>195 – Simple Pneumonia and Pleurisy w/o CC/MM</th>
<th>179 – Respiratory Infections and Inflammations w/o CC/MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Weight: .7044</td>
<td>Relative Weight: 1.6869</td>
</tr>
<tr>
<td>Physician documentation supports:</td>
<td>Physician documentation supports:</td>
</tr>
<tr>
<td>Pneumonia due to one of the following:</td>
<td>Pneumonia due to one of the following:</td>
</tr>
<tr>
<td>✓ Pneumococcal</td>
<td>✓ Salmonella</td>
</tr>
<tr>
<td>✓ Viral</td>
<td>✓ Histoplasma capsulatum</td>
</tr>
<tr>
<td>✓ Hemophilus influenza</td>
<td>✓ Histoplasma duboisi</td>
</tr>
<tr>
<td>✓ Streptococcus</td>
<td>✓ Taxoplasmosis</td>
</tr>
<tr>
<td>✓ Unspecified bacterial pneumonia</td>
<td>✓ Pneumocytosis</td>
</tr>
<tr>
<td>✓ Bronchopneumonia</td>
<td>✓ Kiebsiella pneumonia</td>
</tr>
<tr>
<td>✓ Pneumonia, organism unspecified</td>
<td>✓ Pseudomonas</td>
</tr>
<tr>
<td>✓ Influenza with pneumonia</td>
<td>✓ Staphlococcus</td>
</tr>
<tr>
<td>✓ Influenza due to identified avian influenza</td>
<td></td>
</tr>
<tr>
<td>virus w/ pneumonia</td>
<td></td>
</tr>
</tbody>
</table>

Note: Not an inclusive list.
ICD-9 Hot Spots for Documentation

• Heart Failure 428.0 CHF NOS
  – Mostly Reward-Physician query due to documentation of Congestive Heart Failure (CHF), Not otherwise specified
  – #1 Medicare diagnosis
  – Physicians still not documenting “acute”
    • Specify acuity (Acute, Acute on Chronic, Chronic
    • Specify type (Systolic, Diastolic, Systolic and Diastolic)

Impact of Precision
Heart Failure as a Secondary DX

<table>
<thead>
<tr>
<th>Pneumonia without a specified organism</th>
<th>Simple pneumonia &amp; Pleurisy w MCC</th>
<th>Simple pneumonia &amp; Pleurisy w CC</th>
<th>Simple pneumonia &amp; Pleurisy w/o CC/MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>193</td>
<td>1.4491 $10,144 4.9</td>
<td>194 Simple pneumonia &amp; Pleurisy w CC</td>
<td>0.9688 $6,782 3.8</td>
</tr>
<tr>
<td>195</td>
<td>1.7044 $4,931 2.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not a CC</th>
<th>CC</th>
<th>MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF or “history of CHF”</td>
<td>Systolic HF</td>
<td>Decompensated Systolic HF</td>
</tr>
<tr>
<td>Systolic or diastolic Dysfunction</td>
<td>Diastolic HF</td>
<td>Systolic/HF</td>
</tr>
<tr>
<td>Heart failure with normal or reduced ejection fraction</td>
<td>Systolic/diastolic HF</td>
<td>Systolic/diastolic HF</td>
</tr>
<tr>
<td>Decompensated CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoxemia</td>
<td>Chronic respiratory failure</td>
<td>Acute (on chronic respiratory failure)</td>
</tr>
<tr>
<td>Hypercapnia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged hypotension</td>
<td>Shock</td>
<td>Cardiogenic or hypovolemic shock</td>
</tr>
</tbody>
</table>
ICD-9 Hot Spots for Documentation

• Acute Respiratory Failure
  – Patients are expected to be intubated following surgery (as such MD's often document ARF), reality is this is expected and normal, not a complication
  – Needs to be a collaboration with CDI, quality, to understand precise meaning of ARF

ICD-9 Hot Spots for Documentation

• Sepsis/Septicemia
  – Risk and reward
    • A diagnosis of sepsis may be documented without clinical indicators or there may be clinical indicators to support a diagnosis of sepsis; however, the physician didn’t document
    • Audit Issues
      – Although sepsis was documented, it was not clinically validated based on evidence based medicine.
      – Sepsis was incorrectly sequenced as an additional diagnosis as coding guidelines direct the reporting of sepsis as the principle diagnosis and the underlying infection as an additional diagnosis
Sepsis Coding, Sequencing and Clinical Validity Rules

• Sepsis must be consistently documented to be reliably coded
  – Optimally documented on the history and physical, another time to say it is better or worse, and again in the discharge summary
• There must be at least 2 or 3 “SIRS criteria” present that are not due to another disease process
  – If the WBC is elevated due to leukemia, it doesn’t count
  – If the heart rate is elevated due to hypovolemia, it doesn’t count
  – Optimally, the patient should be described as “sick appearing” or “septic/toxic appearing”
• Sepsis must be present on admission to qualify as the principal diagnosis grouping the admission to a sepsis DRG

ICD-9 Hot Spots for Documentation

Neonatal Septicemia
Physician’s document sepsis on a newborn record and start treatment pending completion blood cultures. Physician discontinues treatment following receipt of a negative blood culture; however, physician may not write sepsis ruled out. Physician may write sepsis rule out, leaving off the “d” on the word ruled.

Implications: Incorrect code assignment will impact statistics that are captured and reported to The National Quality Forum.

Definition and Guideline: “Neonatal sepsis is invasive infection, usually bacterial, occurring during the neonatal period. Signs are multiple and include diminished spontaneous activity, less vigorous sucking, apnea, bradycardia, temperature instability, respiratory distress, vomiting, diarrhea, abdominal distention, jitteriness, seizures, and jaundice. Diagnosis is clinical and based on culture results. Treatment is initially with ampicillin plus either gentamicin or cefotaxime, narrowed to organism-specific drugs as soon as possible.”

The 771.81, Septicemia [sepsis] of newborn code should be assigned when the healthcare provider documents “clinical sepsis” or “culture negative clinical sepsis” and treats with antibiotics for 7-10 days.

Coders should assign a code from category, V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

Potential Outcomes of an Audit
(In descending order of correctness)

- Documented and clinically validated
- Borderline documented and clinically validated
- Documented and borderline clinically validated
- Borderline documented and borderline clinically validated
- Not documented, but clinically validated
- Documented, but not clinically validated
- Borderline documented, but not clinically validated
- Not documented and not clinically validated
- Incorrect sequencing of documented and clinically validated diagnosis/procedure
- Incorrect code assignment of documented and clinically validated diagnosis/procedure
- Based on coding guidelines, the documented condition/procedure would not be reported

Compliance Strategy to PSIs/HACs

- First, develop an aggressive strategy for reducing the potential penalties for PSIs that includes:
  - Reducing Known HAC Risks
  - Identifying Hidden Risks
  - Correcting Root Causes
  - Educating Medical Staff, CDS and Coding Staff
Compliance Strategy to PSIs/HACs:

- Second, find the hidden potential risks and develop a strategy to aggressively reduce potential PSIs/HACs:
  - Review high risk PSIs/HACs that have potential coding inconsistencies
  - Analyze pattern of documentation

Compliance Strategy for HACs:

- Third, develop a process to minimize HACs:
  - Educate physicians (surgeons), CDI specialists and coders
  - Create templates and “macros of terminology”
  - Modify behaviors
  - Coding Policy
Key PSI Risks to Audit

The AHRQ and PSIs reflect quality of care for adults inside hospitals and focus on potentially avoidable complications and iatrogenic events.

Key PSI’s to audit...
- Iatrogenic pneumothorax
- Postoperative respiratory failure
- Postoperative pulmonary embolism or DVT
- Postoperative wound dehiscence
- Accidental puncture or laceration

PSI Monitoring

AHRQ Patient Safety Indicators - Trended Performance by Indicator
Concerns for Complications

- A complication basically refers to an unexpected result, outcome, or event.
- Coding complications in ICD-10-CM, coders should focus on the unexpected part.
  - Official Guidelines for Coding: code assignments are based on the relationship between the care provided and the condition the patient has. (that includes any procedure performed)
  - Guidelines further state that not all conditions that occur during or following a procedure are considered complications

- Relationship Matter
  - Physicians must clearly document the cause-and-effect relationship between the care provided and the condition, and also indicate that it is a complication. (Query if in doubt)
ICD-9 Hot Spots for Documentation

Accidental Laceration

Consider this Case:
- A surgeon takes a patient to the OR to remove a mass in the patient’s colon. During the procedure, the surgeon nicks a portion of the small bowel while lysing adhesions to mobilize the portion of colon that the physician is resecting.
- The surgeon discovers the problem, quickly sutures it, completes the procedure without further incident and the patient makes a routine recovery. While the surgeon dutifully notes the dictated OP report that an accidental laceration occurred he or she never states whether it is a complication.
- Did it significantly impact the patient’s care?
- Was it a complication?
- What if instead of nicking the small intestine, the surgeon accidentally puts a two inch laceration in the hepatic artery, halts the procedure has to page the vascular surgeon on call for assistance?
- Surgeon notes in the dictated OP report what happens but fails to label the injury to the hepatic artery as a complication.
- **RULE OF THUMB:** In order to be considered a complication, the condition must be more than a routinely expected condition or occurrence.

Accidental Puncture or Laceration During a Procedure (ICD-9: Code 998.2)

- **998.2 is not assigned when physician documents:**
  - Incidental occurrence inherent in the surgical procedure
  - Clinically insignificant
  - Routinely expected

- **998.2 is assigned when physician documents:**
  - Clinically significant and
  - Complication of procedure
### Accidental Puncture or Laceration during Procedure

<table>
<thead>
<tr>
<th>Excerpt of Documentation in Body of Operative Report</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In the course of doing this, a small hole was made into the diaphragm, and this was closed with a running, interlocking 0 Prolene suture.&quot; Next, 1-1/2 hours were spent using sharp dissection, taking nodules off the colonic wall as well as the serosal surface of the small bowel and mesentery of the small bowel as well as large bowel. The defects in the serosa of the small and large bowel were closed with several seromuscular sutures of 3-0 silk.&quot;</td>
<td>Based upon the existing documentation, recommend not coding 998.2 as documentation is not specific to determine clinical significance, complication or whether the hole/defect is considered an inherent component of procedure. Physician needs to specify whether the occurrence is inherent in the surgical procedure or whether the hole / defect is considered to be a clinically significant complication. Recommend querying physician. Must link to a complication and say unexpected or not inherent</td>
</tr>
<tr>
<td>&quot;Incidental seromuscular cystotomy.&quot; There appeared to be some area incidental seromuscular injury secondary to the dissection of the bladder from the large fibroid uterus. This was not a true complication but incidental to the procedure.&quot;</td>
<td>Based upon physician specifically stating in the body of operative report that &quot;this was not a true complication but incidental to the procedure,&quot; I would recommend not coding 998.2.</td>
</tr>
<tr>
<td>&quot;In the course of freeing up the small bowel, multiple small 2-3 mm nodules of mucous were noted on the serosal surface of the small bowel as well as the mesentery. These were taken down sharply. Multiple enterotomies were performed, closing them with seromuscular sutures 3-0 silk.&quot;</td>
<td>Multiple enterotomies were performed while sharply excising nodules of mucous on the serosal surface of the small bowel. I recommend deleting 998.2 in this case as there is no documentation to support complication of procedure. Additional physician documentation would be needed to support coding 998.2. Recommend querying physician</td>
</tr>
<tr>
<td>&quot;Upon examination of the perineum, a small first-degree laceration inferior to the urethra on the right labia minora was noted, and inferior to the urethra on the right labia minora was noted, and this was oversewn using a 3-0 Vicryl in interrupted fashion.&quot;</td>
<td>Physician documented &quot;COMPLICATION: None.&quot; Recommend deleting 998.2</td>
</tr>
<tr>
<td>&quot;COMPLICATION: Posterior vaginal wall laceration secondary to removal of a large uterus through the nulliparous vagina.&quot;</td>
<td>Based upon physician’s documentation, agree that 998.2 should be coded in this case.</td>
</tr>
<tr>
<td>COMPLICATIONS: During this procedure were none. &quot; In the course of resecting the endometriosis, it was recognized that the right ureter was inadvertently resected.&quot;</td>
<td>Physician documented that there were no complications; however the ureter was inadvertently resected. &quot; Urology, Dr. Knife, was consulted and a right ureteral reimplant with psoas hitch was performed. Recommend coding 998.2 in this case.</td>
</tr>
<tr>
<td>&quot;Repair of seromuscular injury to the rectosigmoid colon. Repair of incidental venotomy of inferior vena cava.&quot;</td>
<td>Agree to code 998.2, based upon physician's documentation of seromuscular injury.</td>
</tr>
</tbody>
</table>

- Physicians are sometimes reluctant to document an unexpected outcome as a complication
  - Some baseline complication rate is expected
  - Complication rates are risk adjusted
- A sicker patient with additional documented comorbidities has an increased likelihood of a complication occurring
- Complication codes can affect DRG assignments, and may be in some instances the principal diagnosis, so it’s going to drive the DRG
Key Take-Aways
PSI#15 Accidental Puncture or Laceration Rate

<table>
<thead>
<tr>
<th>Accidental puncture or laceration</th>
<th>Non-accidental puncture of laceration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terms that are indicative or an accidental puncture or laceration:</td>
<td>Terms that suggest non-accidental puncture or laceration:</td>
</tr>
<tr>
<td>• Inadvertent, inadvertently</td>
<td>• To facilitate</td>
</tr>
<tr>
<td>• Complication, complicated by</td>
<td>• Necessary</td>
</tr>
<tr>
<td>• Accidental, accidently</td>
<td>• Required</td>
</tr>
<tr>
<td>• Unintended, unintentionally</td>
<td>• Intentional</td>
</tr>
<tr>
<td>• Iatrogenic</td>
<td>• Intended</td>
</tr>
</tbody>
</table>

Concerns:
• Coding of ARF, not present on admission, was flagged as an outlier at (X) entities due to a higher volume than peer hospitals.
• Respiratory failure is a relatively common postoperative complication that often requires mechanical ventilation for more than 48 hours after surgery or reintubation with mechanical ventilation after postoperative extubation.
• Many physicians document “acute respiratory failure” in the post operative period, even though it is usual and customary for the procedure
  − Consequently, coders have to query the physician to determine if the code should be added or not
  − OK to add if:
    • Ventilator lasts over two days – ICD-9-CM advice
    • Physician documents it as not routinely expected or as a complication of the procedure
    • Physician documents as due to another cause or due to medication s or anesthesia
• Case
  − An anesthesiologist documented that a patient had respiratory failure after CABG
    • However, the patient was on the ventilator for only 2 hours
    • The DS stated that there was no postoperative complications
AHRQ Patient Safety Indicator
PSI 11 – Postop Respiratory Failure

Results

• (Recommend) Deleting various codes
  – 518.81 Acute respiratory failure, NOS
  – 518.51 Acute respiratory failure following trauma and surgery
  – 518.84 Acute and chronic respiratory failure

• Recommended DRG changes resulted from ARF being solely documented in the immediate postoperative period. (i.e. physician is documenting ARF within 24 hours of surgery while patient is still sedated).
  – Patients were being successfully extubated following surgery and within immediate post-operative timeframe.
  – These patients were intubated for surgery and extubated without delay or complication following surgery.

• Watch for ARF code as the only MCC

• Would not recommend coding ARF when “medically induced” when patient is successfully extubated during the immediate post-op period and would encourage coders to query if there is doubt whether ARF is a codeable condition.

• Develop criteria for appropriate documentation (Pulmonology) and coding of Acute Respiratory during the immediate postoperative course.

Key Take-Aways

Postoperative Respiratory Failure

To validate the diagnosis, the patient must have acute pulmonary dysfunction requiring non-routine aggressive measures. A patient who requires a short period of ventilator support during surgical recovery does not have acute respiratory failure, and a code for it should not be assigned on the claim.⁵

• Examples of when to code postoperative respiratory failure include:
  • An unexpected or prolonged period of mechanical ventilation
  • Inability to extubate the patient as planned in the immediate postoperative period
  • Difficult or prolonged efforts to wean patient from the ventilator
  • Reintubation following postoperative extubation
  • Physician documentation of respiratory failure complicating the clinical course
  • BiPAP or CPAP, or oxygen administration post-extubation, with an O₂ requirement of > 40% (>5 L/minute)

If the documentation is unclear as to whether postoperative respiratory failure was routine in nature, or a complication of the surgery, the provider should be queried.
Additional Opportunities AHRQ PSIs

- The patient Safety Indicators (PSI’s) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth.
- The PSI’s were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment and empirical analyses.

<table>
<thead>
<tr>
<th>AHRQ PSI Composite Measure</th>
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</tr>
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<tbody>
<tr>
<td>Patient Safety for Selected Indicators (PSI #0)</td>
<td></td>
</tr>
<tr>
<td>PSI #03 Pressure Ulcer PSI #06 Iatrogenic Pneumothorax</td>
<td>PSI #11 Postop Respiratory Failure PSI #12 Postop PE or DVT</td>
</tr>
<tr>
<td>PSI #07 Central Venous Catheter-related Bloodstream infections PSI #08 Postop Hip Fracture</td>
<td>PSI #13 Postop Sepsis PSI #14 Postop Wound Dehiscence</td>
</tr>
<tr>
<td>PSI #09 Postop Hemorrhage or Hematoma PSI #10 Postop Physiologic and Metabolic Derangements</td>
<td>PSI #15 Accidental Puncture or Laceration</td>
</tr>
</tbody>
</table>

Summary

- Healthcare organizations need to seek out clinical data integrity solutions that stem from the basic concept that:
  - Physicians
  - Providers
  - Quality Team
  - Coding Staff
- All speaking the same language.
- Only with collaboration will this process fully support clinical data integrity outcomes.
Summary

- Accurate coding of diagnoses and PSI’s can have a significant impact on reimbursement.
- Critical for Providers to be aware of what conditions CMS has designated as PSIs and how HACs can affect reimbursement.
- With the transition to ICD-10, increased emphasis toward data driven outcomes, and the associated financial implications, clinical data integrity is monumental.

Questions