Why U(r) and CDI Matter?

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Disclosures

• No significant financial relationships to disclose
“You must unlearn what you have learned”

Master Yoda
Is Anyone Getting Rich?
Starting Off With Patient Status

Observation vs. Inpatient
How Is OBS Determined?

• Depending on the clinical situation and patient’s insurance status

• Payers rely on commercial criteria as a screening method to determine status except for traditional Medicare

• Traditional Medicare goes with clinical judgment and time spent in the hospital
THE 2 MIDNIGHT RULE…
An Attempt To Solve A Problem…

BUT for Traditional Medicare Patients Only
2 Midnight Rule:
What is this?

• Does not depend on “criteria”

• Requires Physician Attestation to Inpatient status based on *medical necessity and the expectation that care should surpass 2 midnights*

• Requires an Attending Physician admit attestation order that must be signed before discharge
  – Failure to sign this before discharge will result in *non payment of entire hospitalization*
What Does Medical Necessity Mean?

• Physicians are expected to document a reasonable rationale for the patient’s need to be hospitalized > 2 midnights

• Why are services required in the hospital?
  – Complex medical factors like history and comorbidities
  – Severity of signs and symptoms
  – Risk of an adverse event

• Social holds, PT/OT issues, or testing delays do NOT qualify for IP stay
Simply Put

• Does your patient need to remain hospitalized for any medical reason (even if it is for oral medications)?

• Your **Dispo** section of the note:
  – *Needs to remain hospitalized because ...*
  – Avoid putting “Dispo- Gen Med XXX”
Timing of the 2 Midnights

• The clock starts when “care starts”
  – EKG or labs drawn so a patient’s care can start at 2330

• The time in outpatient status (OBS, ED, Recovery Room) is counted when assessing 2 midnights

• If the patient starts as OBS but surpasses the 2\textsuperscript{nd} MN for medical necessity then the whole stay is IP

• \textit{However the 3MN needed for a SNF starts AFTER the conversion to IP status}
2 Midnight Rule –
Are There Exceptions to Less Than 2MN?

• Transfers out of the hospital

• Death

• Patient leaving AMA

• *Unusual recovery or requiring “high intensity of services”* (like a DKA admission overnight)
  – You may be asked if a patient recovered quicker than expected

• Starting a patient on a ventilator

• Admission to Hospice
Case Discussions

• COPD

• UTI

• Weakness
Issues with Observation

• Observation status does not allow for Medicare Part A benefits and thus considered an Outpatient visit (Part B) and hence significant financial responsibilities to patients.

• SNF benefits do not apply under OBS status unless a patient is part of our ACO.

• Reimbursement differences to the hospital
  • Several thousands of dollars per case.
What is Covered In Observation?

• Patient responsibility of 20% co-pay for the hospital bill since it is an “outpatient visit”

• 100% patient responsibility for medications that are given in the hospital

• Possible out of pocket and deductible expenses
What Is A Code 44?

• When a patient needs to be converted from Inpatient to Observation

• This conversion can not take place without a UR nurse serving a paper to the patient stating such a change

• A physician advisor review must be done before a code 44 is determined

• *If you notice a potentially inappropriate Inpatient order, please notify UM*
Failed Code 44

• *When status is changed without UR involvement OR Code 44 is served AFTER a discharge patient order is written*

• Observation will not be paid because the patient was not informed of the change in status

• So *please do not* do this on your own
Moving to CDI
Documentation Affects

• Quality reporting specifically related to mortality and complication rates

• Expected Length of Stay and costs reporting

• Receiving appropriate reimbursement
Your Secondary Diagnoses Matter!

• Secondary diagnoses maximize quality scores such as expected mortality rates and reimbursement

• Captures “CC” or co-morbid conditions

• Captures “MCC” or major co-morbid conditions

• Captures diagnoses that affect quality
Your Discharge Summary Matters!

• Payers and regulatory agencies are looking at the discharge summary first

• All diagnoses MUST be carried through the discharge summary even if that condition is resolved

• *Problem based plan that is written in every day progress notes needs to be in the discharge summary even if it is resolved*

• *PLEASE DO NOT WRITE PARAGRAPH STYLE SUMMARIES*
Quality: SOI & ROM

• Severity of illness (SOI) and Risk of mortality (ROM) are rated on a scale of 1 (being minor) to 4 (being extreme)

• This risk stratification score is dependent on your principle diagnosis, secondary diagnoses and their associated interactions

• When a sick patient gets discharged alive, the hospital’s and physician's profile improves
Hospital-Acquired Condition (HAC) Make sure to Document POA

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III & IV pressure ulcers
- Falls & trauma causing fracture or brain injury
- Manifestations of poor glycemic control
- Catheter-associated UTI
- Vascular catheter-associated infection
- Surgical site infection after CABG, bariatric, or orthopedic surgery or AICD
- DVT or PE with total knee or hip replacement
- Iatrogenic PTX with venous catheterization
2014 Top 10 Diagnoses driving UHC Mortality Projection Models

- Mechanical ventilation and respiratory failure
- Shock
- Coagulopathy
- Fluid and electrolyte disorders
- Acute liver disease
- Metastatic Cancer
- Malnutrition
- Severe brain injuries
- Renal failure
55 yo F with Afib on warfarin presents with headache, right sided weakness and dysarthria. She was found to have an acute ICH. Her mental status deteriorated rapidly and she developed aspiration pneumonia and progressed to Coma.
## Impact of SOI and ROM

### 55 yo Female

**Disposition: Died**  
**LOS: 11 Days**

**Principal Diagnosis:** I61.9 - Nontraumatic Intracerebral Hemorrhage

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secondary Diagnoses</strong></td>
<td><strong>Secondary Diagnoses</strong></td>
<td><strong>Secondary Diagnoses</strong></td>
</tr>
</tbody>
</table>
| • Dysphagia  
• Atrial fibrillation | • Dysphagia  
• Atrial fibrillation | • Dysphagia  
• Atrial fibrillation |
| • Acquired Coagulation Factor Deficiency (CC) | • Acquired Coagulation Factor Deficiency (CC) | • Acquired Coagulation Factor Deficiency (CC) |
| • Pneumonitis d/t Inhalation of Food or Vomitus (MCC) | • Pneumonitis d/t Inhalation of Food or Vomitus (MCC) | • Coma (MCC) |

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>ICH w/CC</th>
<th>ICH w/CC and MCC</th>
<th>ICH w/CC and MCC's</th>
</tr>
</thead>
</table>

| Reimbursement | $5,805 | $7,546 | $7,546 |
| APR SOI | 2 | 3 | 4 |
| APR ROM | 2 | 3 | 4 |
| Expected Mortality Rate | 14% | 39% | 76% |

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Slide courtesy of Christine Stallkamp, MD, FAAFP
Relative Weight (RW), Blended rate, GMLOS

- CMI (Case Mix Index) measures how sick on average your patient population is and is an average of the relative weights

- RW is a numeric representation of resources used
  - Each DRG is assigned a RW
  - The RW is increased by the presence of secondary diagnoses (CC and MCC’s) thus increasing the CMI
Relative Weight (RW), Blended rate, GMLOS

- Then the RW is multiplied by a fixed rate called the blended rate (around $9000 for our facility for a 1.0 RW) to get a payment

- GMLOS is also related to your DRG and associated secondary diagnoses
2020 IPPS Ruling

• Significant changes coming soon to Major co-morbid and co-morbid conditions

• This will have a dramatic reduction in reimbursement

• We need to even more vigilant
### Specific and Accurate Documentation vs. Non-specific/vague documentation

<table>
<thead>
<tr>
<th>Specific and Accurate Documentation</th>
<th>Non-specific/vague documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Acute diastolic CHF <strong>d/t hypertension</strong>, with CKD stage IV</td>
<td>“exacerbated CHF, hypertension, chronic renal insufficiency”</td>
</tr>
<tr>
<td><strong>Diagnosis</strong>: Hypertensive heart/kidney disease with CHF, CKD stage IV</td>
<td><strong>Diagnosis</strong>: CHF, unspecified</td>
</tr>
<tr>
<td>Secondary dx’s: <strong>MCC</strong>-Acute diastolic heart failure; <strong>CC</strong>-CKD Stage IV</td>
<td>Secondary dx’s: hypertension, chronic renal insufficiency. <strong>NO MCC or CC, no severity added</strong></td>
</tr>
<tr>
<td>CMI: 1.5097  GLOS 4.7 days</td>
<td>CMI: 0.6762  GLOS 2.6 days</td>
</tr>
<tr>
<td>SOI/ROM: 2/2</td>
<td>SOI/ROM: 1/1</td>
</tr>
<tr>
<td>Expected payment: $13,184</td>
<td>Expected payment: $5,905</td>
</tr>
</tbody>
</table>

**Example showing outcomes**
I Am Not Sure Of The Diagnosis

IT IS OK TO DOCUMENT:

POSSIBLE
PROBABLE
LIKELY
SUSPECTED
“History Of”

• AVOID SAYING “HISTORY OF” as in the coding it implies that the condition is resolved

• Chronic conditions require treatment plans to maintain the condition
Why did it happen?

NEED TO DOCUMENT:

DUE TO

OR

SECONDARY TO
The Patient Died... I Am Afraid of Going into the Record

- Clarifying clinical diagnoses is completely legitimate

- Example is a patient transferred to the ICU and died from acute respiratory failure but “increased $O_2$ needs” was documented

- So the patient died from “increased $O_2$ needs” which has significant quality and reimbursement ramifications
“DDX”

• List all differentials and then clearly identify whether it was ruled in or ruled out
“Long standing”

• Indicate Acuity even if it is obvious

• Acute on Chronic
Not Just the Inpatient World
Hierarchical Categorical Conditions (HCC’s):

Your Inpatient Documentation Impact on Outpatient

CMS HCC model • 25 condition categories • 79 HCCs • 8,830 ICD-10 diagnosis codes
Risk Adjustment Impact

- *Capitated payment* as a means to control cost and shift risk to providers

- Encourages better care coordination by paying one risk-adjusted sum to a health system to provide all the care and services that a patient requires for the year

- This CMS-HCC risk adjustment model is prospective and it uses health status in a base year to predict costs in the following year

- Hence all chronic conditions need to be reported and documented at least once a year
  - *Inpatient or Outpatient setting count for documentation*
Pt Example of HCC Risk Scoring

Year 2015:
• Six diagnoses were documented that fell under the HCC categories shown
• Several conditions also resulted in an additional RAF score for an interaction factor based on increased complexity when these conditions are present together.

2015 Risk Adjustment Factor (RAF) score
Diagnoses documented/billed during visits in 2015

<table>
<thead>
<tr>
<th>Demographic score: 2015</th>
<th>0.442</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 18: Diabetes w/retinopathy</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 22: Morbid obesity</td>
<td>0.365</td>
</tr>
<tr>
<td>HCC 40: Rheumatoid arthritis</td>
<td>0.374</td>
</tr>
<tr>
<td>HCC 85: Dilated cardiomyopathy</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 107: Abdominal aortic aneurysm w/o rupture</td>
<td>0.299</td>
</tr>
<tr>
<td>HCC 111: COPD</td>
<td>0.346</td>
</tr>
<tr>
<td>HCC interaction score: CHF – COPD</td>
<td>0.259</td>
</tr>
<tr>
<td>HCC interaction score: Diabetes – CHF</td>
<td>0.182</td>
</tr>
<tr>
<td>Total RAF score</td>
<td>3.003</td>
</tr>
</tbody>
</table>

Figure 6. How Sample Patient Walter’s RAF score was calculated for the year 2015
Pt Example of HCC Risk Scoring

Year 2016:

• The only diagnoses documented during the visit were his diabetes, obesity and COPD. The obesity, however, was *not* specified as “morbid obesity” as so the HCC RAF was lost.
• Same patient but lower RAF score

![2016 Risk Adjustment Factor (RAF) score](image)

*Figure 7. How Sample Patient Walter's RAF score was calculated for the year 2016*
## Impact on HCC Capture

<table>
<thead>
<tr>
<th>Year</th>
<th>Monthly Baseline Payment per Patient</th>
<th>Individual Risk Adjustment Factor (RAF) Score</th>
<th>Monthly Individual Patient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$800</td>
<td>3.003</td>
<td>$2,402</td>
</tr>
<tr>
<td>2016</td>
<td>$800</td>
<td>0.906</td>
<td>$724</td>
</tr>
</tbody>
</table>

Figure 8. Example of a common formula used to calculate annual capitated payment under programs such as Medicare Advantage.
Most Common Queries

- Respiratory failure specificity
- Sepsis/Shock specificity
- Malnutrition specificity
- AMS specificity
- Heart failure specificity
- AKI or CKD staging
- Acuity or chronicity of a condition
- Chronic Respiratory failure
- Pneumonia specificity
- Pancytopenia specificity
- Pneumonia specificity
- Is it really there??
Example #1

- **HCAP and SIRS**
  - Continue Pipercillin/Tazobactam and Vanco

- **Pleural effusion**
  - Possible tap

- **CHF and Afib with RVR**
  - Hold diuretics due to low BP

- **Hypotension**
  - Likely due to heart failure

- **Elevated creatinine**
  - Likely from low BP

- **Sepsis secondary to Healthcare associated PNA with possible Staph and/or gram-negative etiology**
  - aggressive but careful fluid management with 500 mL bolus and 125 mL/hr
  - can not give too much fluids because of acute heart failure (see below)
  - Continue Pipercillin/Tazobactam and vancomycin to treat possible MRSA and pseduomonas

- **Right-sided pleural effusion with possible parapneumonic effusion**
  - US done at bedside to evaluate R sided pleural effusion but on US not enough fluid to tap but looks complex and related to infection
  - risks outweigh benefits of tap

- **Acute diastolic heart failure with Afib and RVR**
  - at this point, clinical situation very complicated as she could have signs of cardiogenic shock (RVR with diastolic HF) with cold extremities however at this point we will treat the sepsis first and hopefully the HR will go down and improve cardiac output

- **AKI secondary to intravascular volume depletion**
  - though fluid overloaded has intravascular volume depletion due to sepsis
Example #1

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- **AKI secondary to intravascular volume depletion**
  - though fluid overloaded has intravascular volume depletion due to sepsis
  - accurate I's/O's
Example #2

- **Acute Hypoxemic Respiratory Failure**: improving; 2/2 flu and HCAP; weaning o2 requirement and neg BCX reassuring. HDS on IVF

- Bedridden

- AMS and Staph UTI

- NSTEMI type II, no interventions desired per family for any progressive changes

- Dementia

- **Acute Hypoxemic Respiratory Failure**: improving; 2/2 flu A and possible aspiration pneumonia (likely Gram positives and possible anaerobes)

- Functional quadraplegia

- Sepsis (POA) due to pneumonia and flu A and metabolic encephalopathy

- Coag Neg Staph UTI, catheter related (POA)

- Demand Ischemia: due to sepsis on admission (no EKG changes or symptoms)

- Moderate Alzheimer's Dementia
Example #3

- **Neuro/Psych**
  - Altered Mental Status - Resolved
  - DDx include: infection (leukocytosis) vs. Hepatic encephalopathy in the setting of liver failure vs. Hypoglycemia vs. intracranial process vs. substance abuse

- **CV**
  - CAD w/ ICM EF 15%
  - BNP was elevated to 28,967
  - Patient was given 40 mg IV lasix at HVA

- **GI**
  - Hepatic Failure
  - - Potentially, secondary to fluid congestion secondary to low EF

- **Acute hepatic encephalopathy secondary to acute liver failure or metabolic encephalopathy secondary to hypoglycemia on admission**
  - resolved

- **Acute liver failure secondary to likely passive congestion from advanced heart failure**
  - resolved
  - abd US no evidence of cirrhosis

- **Chronic systolic heart failure secondary to ischemic cardiomyopathy with HTN and HL**
  - euovolemic at the moment and apparently was not fluid overloaded

- **Coagulopathy secondary to liver failure**
  - resolved

- **AKI secondary to intravascular volume depletion from acute liver failure**
  - resolved

- **Chronic COPD**
  - stable
Example #4

- Likely UGI bleed
  - Acute UGI bleed possibly secondary to bleeding duodenal ulcer
  - Coagulopathy secondary to Coumadin use
- AKI on CKD
  - Acute kidney injury on Chronic kidney failure (stage III) secondary to acute blood loss
- NICMP
- Afib
  - Chronic systolic heart failure secondary to uncontrolled HTN (ef 40%)
Questions?

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