
HCCA 2018 Compliance Institute
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AGENDA

• The Issue
  • Coding v. Quality
  • Clinical Integrity and Clinical Validation Denials

• Compliance Dilemmas

• Strategies for Addressing Issues
  - Legal Issues
  - Contracting Issues
The Challenge

Doc, you meant?

Background

• DRG system initiated in 1983….
• Until recently, **DRG** accuracy was based on **coding** accuracy.
  – Coders did not question the clinical validity of diagnoses documented by the physician
  – Providers were reimbursed if physician documentation supported codes and if codes were correctly assigned in keeping with Official Coding Guidelines
Background

- **DRG** accuracy now involves additional components including:
  - Patient Status - Medical Necessity
  - Clinical Validation – Clinical Integrity
- Birth of Physician Documentation (PDI)
- Evolution of PDI to CDI…and CV/I

But in the end….a code, is a code, is a code
- Assigned by coding professionals based on **physician** documentation in accordance with Official Coding Guidelines
- And so, the plot thickens
Uses for Coded Data

- Direct payment - *(Coding)*
  - DRG, APC, HCC, RVU
    - HAC
    - MACRA-MIPS
- Indirect payment - *(Quality Measures)*
  - PSI
  - VB/P4P
  - HEDIS
  - Star Metrics
  - Total performance Score
  - Patient Satisfaction
  - Process of Care & Outcomes Efficiency

Quality Measures

- As defined on its CMS.gov webpage, Quality Measures are:
  - “...tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.
  - *CMS uses quality measures in its quality improvement, public reporting, and pay-for-reporting programs for specific healthcare providers.*”
Quality Measures

• Examples
  – Acute Care Hospitalization During the First 60 Days of Home Health
    • Home Health Value Based Purchasing
  – Adult BMI Assessment
    • Medicare Part C Star Rating
  – Statin Therapy at Discharge after Lower Extremity Bypass (LEB)
    • Merit-Based Incentive Payment System (MIPS) Program
  – Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
    • Hospital Value-Based Purchasing
  – CAHPS Hospice Survey: Getting Emotional and Spiritual Support
    • Hospice Quality Reporting
  – Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
    • Physician Value-Based Payment Modifier

Putting the Pieces Together
Government and Other Payer Audits

• Beneficiary and Family Centered Care QIOs (BFCC-QIO) 11th SOW Annual Medical Services Report

• KEPRO, Area 2, Time Frame: August 1, 2016 – July 31, 2017
  – Florida, Georgia, South and North Carolina, Virginia, West Virginia, Maryland, the District of Columbia, and Delaware
### KEPRO - Government Audit

**Total number of medical record reviews completed for entire Area 2 with type of review performed**

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Number of Reviews</th>
<th>Percent of Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding Validation (120 - HWDRG) Higher Weighted Diagnosis-Related Group</td>
<td>11,028</td>
<td>18.24%</td>
</tr>
<tr>
<td>Coding Validation (All Other Selection Reasons)</td>
<td>8</td>
<td>0.01%</td>
</tr>
<tr>
<td>Quality of Care Review (101 through 104 - Beneficiary Complaint)</td>
<td>1,019</td>
<td>1.60%</td>
</tr>
<tr>
<td>Quality of Care Review (All Other Selection Reasons)</td>
<td>319</td>
<td>0.50%</td>
</tr>
<tr>
<td>Utilization (158 - FUMAC Referral for Readmission Review)</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Utilization (All Other Selection Reasons)</td>
<td>22,861</td>
<td>35.85%</td>
</tr>
<tr>
<td>Notice of Non-coverage (105 through 108 - Admission and Preadmission)</td>
<td>170</td>
<td>0.27%</td>
</tr>
<tr>
<td>Notice of Non-coverage (118 - BIPA)</td>
<td>6,087</td>
<td>9.53%</td>
</tr>
<tr>
<td>Notice of Non-coverage (117 - Grjicalva)</td>
<td>12,533</td>
<td>19.69%</td>
</tr>
<tr>
<td>Notice of Non-coverage (121 through 124 - Weichardt)</td>
<td>8,772</td>
<td>13.76%</td>
</tr>
<tr>
<td>Notice of Non-coverage (111 - Request for QIO Concurrency)</td>
<td>32</td>
<td>0.05%</td>
</tr>
<tr>
<td>Emergency Medical Treatment &amp; Labor Act (EMTALA) 5 Day</td>
<td>162</td>
<td>0.25%</td>
</tr>
<tr>
<td>EMTALA 60 Day</td>
<td>152</td>
<td>0.24%</td>
</tr>
<tr>
<td>Total</td>
<td>63,763</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

### Government Audits

The below data reflect the top 10 diagnoses associated with Medicare claims for Area 2.

<table>
<thead>
<tr>
<th>Top 10 Medical Diagnoses</th>
<th>Number of Beneficiaries</th>
<th>Percent of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A419 - SEPSIS, UNSPECIFIED ORGANISM</td>
<td>131,349</td>
<td>26.72%</td>
</tr>
<tr>
<td>2. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED</td>
<td>53,242</td>
<td>10.83%</td>
</tr>
<tr>
<td>3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM</td>
<td>48,815</td>
<td>9.93%</td>
</tr>
<tr>
<td>4. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE EXACERBATION)</td>
<td>46,688</td>
<td>9.50%</td>
</tr>
<tr>
<td>5. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED</td>
<td>44,065</td>
<td>8.97%</td>
</tr>
<tr>
<td>6. I214 - NON-ST ELEVATION (STEMI) MYOCARDIAL INFARCTION</td>
<td>42,598</td>
<td>8.67%</td>
</tr>
<tr>
<td>7. I130 - HYP HRT &amp; CHR KDNY DIS W HRT FAIL AND STG 1-4 UNSP CHR KDNY</td>
<td>35,279</td>
<td>7.18%</td>
</tr>
<tr>
<td>8. M171 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE</td>
<td>30,765</td>
<td>6.26%</td>
</tr>
<tr>
<td>9. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE</td>
<td>30,110</td>
<td>6.13%</td>
</tr>
<tr>
<td>10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE</td>
<td>28,586</td>
<td>5.82%</td>
</tr>
<tr>
<td>Total</td>
<td>491,497</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
CODING V. QUALITY

DRG Validation

• As defined by Medicare in its Program Integrity Manual, Chapter 6.5.3, and in CMS Quality Improvement Organization Manual, Chapter 4, Section 4130, DRG validation is:
  – “A review process that ensures 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.”
### DRG Validation - Reasons for DRG Change

<table>
<thead>
<tr>
<th>Reasons for DRG Change</th>
<th>Examples</th>
<th>Reward</th>
<th>Risk Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-sequenced Principal Diagnosis code</td>
<td>Osteomyelitis versus Diabetes</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Incorrect code(s)</td>
<td>Thrombosis due to vascular prosthetic devices, implants and grafts, subsequent encounter versus initial encounter</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Omitted code(s)</td>
<td>Anterior or posterior spinal fusion</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Unsupported code(s)</td>
<td>Respiratory Failure, Severe Malnutrition, Encephalopathy, ATN, AKI, Sepsis, UTI, Excisional Debridement</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Validation**

- Clinical Validation is defined in the 2011 Recovery Audit Contractor (RAC) Statement of Work as:
  - “…a process separate from 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. 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 maybe performed by a clinician with approved coding credentials.”
Clinical Validation

• “Clinical validation means that diagnoses documented in a patient's record must be substantiated by clinical criteria generally accepted by the medical community. Generally accepted clinical criteria typically come from authoritative professional guidelines, consensus, or evidence-based sources.”
  – ACP Hospitalist.org By Richard D. Pinson, MD, FACP December 2016

Clinical Indicators

• Clinical indicators consist of:
  – Objective data: e.g., vital signs, height/weight
  – Symptoms
  – Laboratory or diagnostic test results
  – Radiology results
  – Treatments including medications, interventions & procedures
  – Patient’s response to treatment
Clinical Indicators

- Suggested references and resources but nothing “official” from CMS
  - AHA Coding Clinics
  - AHRQ - Agency of Healthcare Research and Quality
  - American Society of Parenteral and Enteral Nutrition - Nutritional Diagnoses
  - KDIGO - is global nonprofit organization developing and implementing evidence-based clinical practice guidelines in kidney disease.
  - American College of Cardiologist Foundation/American Heart Association
  - Surviving Sepsis Guidelines

Clinical Indicators – Acute Respiratory Failure

- Clinical Indicators for acute respiratory failure:
  - Hypoxemia: room air PO$_2$ <60 mm Hg, or PO$_2$/FIO$_2$ ratio <300, or a decrease in PO$_2$ of 10 to 15 mm Hg from the baseline value
  - Hypercapnia: PCO$_2$ >50 mm Hg with any degree of acidosis (generally pH <7.35) or an increase in PCO$_2$ of at least 10 to 15 mm Hg from the baseline value

- One (1) or more of these criteria in the medical record is necessary to **clinically validate a diagnosis of acute respiratory failure**
Clinical Validation
Clinical versus Physician Documentation

• Source Physician Documents
  – History & Physical
  – Progress Notes
  – Orders
  – Procedure Reports
  – Consultation Reports
  – Discharge Summary

• Source Clinical Documents
  – Laboratory Test Results/Ancillary Data
  – Nursing Notes
  – Pharmacy/Medication Reports
  – Nutrition Assessments
  – Wound Care Assessments
And So, The Challenge

- 2017 edition of the ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.19 states:
  - “The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis”

- AHIMA’s compliant query recommendations, which state:
  - “When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility’s escalation policy.”

Choices for Revenue Integrity

CASE STUDY

- Medicare patient with a history diastolic CHF admitted with shortness of breath, cyanosis, pedal edema, and jugular vein distention. Patient treated with IV Lasix, Oxygen and BiPAP. All symptoms resolved. Final diagnosis documented as:
  - PDX: Acute on chronic diastolic CHF – I50.33
  - SDX: Acute respiratory failure with hypercapnia- J96.02 (MCC)

- DRG 291, CHF w/MCC R.W. = 1.4809
  - Adm: 2/5/2018  Disch: 2/8/2018
  - Discharge status:  Home
Lab and radiology results indicated:
- Cardiomegaly
- Pulmonary venous hypertension with peribronchial cuffing and interlobular septal thickening
- $\text{PCO}_2$: 50 mm Hg
  - Historical/Baseline value reported at 45 mm Hg
- pH 7.45

- Physician source documentation:
  - ED, PNs & DS: “Acute CHF, acute respiratory failure”
  - Pulmonary consultation: “Acute respiratory failure with hypercapnia. Documented patient’s baseline $\text{PCO}_2$ at 45 mm Hg but current value of 50 mm Hg in this patient is significant”

- Is diagnosis of acute respiratory failure with hypercapnia validated?
COMPLIANCE DILEMMAS

Compliance Dilemma

• Properly coded claim is denied
  – Medicare Advantage
  • Appeal
  • Arbitration clauses (typically)
    – Contracting Issue?
    – What about Peer Review?
      » Physician "Engagement" ?
Compliance Dilemma

- Properly coded claim is denied
  - Medicare
    - Appeal
      - Use of Coding Clinic FAQs – specific as possible

Compliance Dilemma

- Medicare Appeal
  - If Post-Payment, review is focused on identified basis for denial (MLN Matters No. SE1521)
    - Caveat: ALJs have no such "limitation"
Compliance Dilemma

- Medicare Appeal
  - **Guidance from** MAC website
    - May need to keep written copies/preserve with screen shots
  - What was guidance in place at time claims were filed?

**Caring Hearts Personal Home Services, Inc. v. Burwell (10th Cir.) (May 31, 2016)**

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**Original Medicare (Parts A & B - Fee-for Service)**

<table>
<thead>
<tr>
<th>Initial Determination/Appeals Process</th>
<th>EXPEDITED PROCESS (Some Part A only) Notice of Discharge or Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Determination</td>
<td>Noon the next calendar day</td>
</tr>
<tr>
<td>Standard Process</td>
<td>MAC Redetermination 60 day time limit</td>
</tr>
<tr>
<td>Expedited Process</td>
<td>Noon the next calendar day</td>
</tr>
<tr>
<td>QUALIFIED INDEPENDENT CONTRACTOR</td>
<td>Qualified Independent Contractor Reconsideration 60 day time limit</td>
</tr>
<tr>
<td>80 days to file</td>
<td>qualified Independent Contractor Reconsideration 72 hour time limit</td>
</tr>
<tr>
<td>60 days to file</td>
<td>Office of Medicare Hearings and Appeals ALJ Hearing AIC ≥ $150*</td>
</tr>
<tr>
<td></td>
<td>Medicare Appeals Council 90 day time limit</td>
</tr>
<tr>
<td></td>
<td>Federal District Court AIC ≥ $1,460*</td>
</tr>
</tbody>
</table>

AIC = Amount In Controversy, ALJ = Administrative Law Judge
MAC = Medicare Administrative Contractor

*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2015.
Potential Overpayment Analysis

The 60 Day Rule

Medicare Parts A and B Health Care providers and suppliers are to report and return overpayments within 60 days after the date the overpayment was identified

- Legal DUTY to investigate CREDIBLE allegations of potential overpayments
- Six-year lookback period
- Failure to comply could result in improper retention of an overpayment and violation of the False Claims Act

Potential Overpayment Analysis

The Potential "Problem"

- Government Audit Findings
  - 60 Day Rule: Credible Allegation of an Overpayment is a Government Audit Finding
  - Legally, DUTY TO INVESTIGATE
Compliance Dilemma

• Medicare Appeal
  – Effect of taking a settlement
    • E.g., Low Volume, etc.
    • Good faith basis that claim coded correctly, that there was no overpayment

Compliance Dilemma

• Medicare Appeal
  – What if ALJ issues unfavorable decision?
    • Good faith basis that claim coded correctly, that there was no overpayment
      – ALJs are not "perfect"!
Questions

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