Ready CDI teams for CMS’ proposed expansion of mandatory ortho episode payment models

by Shannon Newell, RHIA, CCS, AHIMA-approved ICD-10-CM/PCS trainer

If your hospital resides in one of the 67 metropolitan statistical areas (MSA) required to participate in the Comprehensive Joint Replacement Model (CJR), you will also be required to participate in a new orthopedic payment model called SHFFT (surgical hip and femur fracture treatment) if an August 2 proposed rule is finalized. The impact? The following assigned MS-DRGs will no longer define hospital reimbursement:

- Major Joint Replacement or Reattachment of Lower Extremity (MS-DRGs 469, 470)
- Hip and Femur Procedures Except Major Joint (MS-DRGs 480, 481, 482)

MS-DRGs 469 and 470 are included in the CJR, which we have discussed in prior articles. Let’s take a look at the proposed SHFFT episode payment model (EPM), which involves the other three MS-DRGs, and see what role the CDI program can play as reimbursement shifts to episode-based payments.

Model overview

The episode of care defined for the SHFFT EPM begins with an admission to a participating hospital of a fee-for-service Medicare patient assigned MS-DRGs 480–482. This admission is referred to as the anchor hospitalization. The episode continues 90 days post-discharge from the hospital, and payments for all related Part A and Part B services are included in the episode payment bundle. CMS holds the hospital accountable for defined cost and quality outcomes during the episode and links reimbursement—which may consist of payment penalties and/or financial incentives—to outcome performance.

This is a mandatory EPM for hospitals already impacted by the CJR; the SHFFT model will apply to the same 67 geographic MSAs. The EPM is proposed to begin July 1, 2017, and will last for five years, ending in December 2021.
Cost outcomes

CMS will initially pay the hospital and all providers who bill for services during the episode using the usual fee-for-service models. Thus, the SHFFT EPM will not impact the revenue cycle at first. However, at the end of each performance period, which typically represents 12 months (January through December), CMS will compare or reconcile the actual costs with a preestablished “target price.”

CMS will set target prices using an approach that will phase in a blended rate of hospital to regional costs. In recognition of the higher costs associated with discharges in MS-DRGs with an MCC or CC, CMS has developed an algorithm to adjust the target price for this subset of the patient population.

If the reconciliation process indicates that the costs to deliver services for the episode were higher than the target price, CMS will require repayment from the hospital. If, however, the costs to deliver care for the episode were lower than the target price, CMS will provide additional payments to the hospital for the provided services. To receive additional payments, however, performance for defined quality outcomes must meet or exceed established standards.

Quality-adjusted target price

To receive any earned financial incentives, the hospital must meet or exceed performance standards for established quality outcomes. CMS therefore adjusts the target price based on quality performance, referred to as the quality-adjusted target price.

The SHFFT EPM uses the exact same quality outcomes as those defined for the CJR:

- **Patient experience.** This is the HCAHPS measure also used in the Hospital Value-Based Purchasing Program (HVBP). The source of information for this measure is the HCAHPS survey.
- **Patient-reported outcome data.** As with the CJR, the hospital can collect and submit patient-reported data elements and at present will earn quality composite points for submitting the data. These data elements are collected both before and after the procedure and will be used by CMS to create a functional status measurement tool.
• **THA/TKA complication rates.** This is the Hospital-Level Risk Standardized Complication Rate (RSCR) following the THA/TKA measure. This measure already impacts financial performance under the HVBP. Like the CJR, performance for this measure is weighted the heaviest in the quality composite comprising 50% of the composite score.

**Hospital (accountable party), collaborators, and Advanced Payment Models**

The hospital is held accountable for episode cost and quality outcomes and all associated financial risks/rewards, even though a variety of providers deliver services and impact performance. As with the CJR, the hospital has been designated as the accountable party because CMS believes the hospital is best positioned to influence coordinated, efficient delivery of services from the patient’s initial hospitalization through recovery.

CMS permits the hospital to enter into collaborative arrangements with physicians and other providers to support and redesign care delivery across the episode and to share financial gains and/or losses. The proposed rule expands the list of collaborators defined in the previous CJR final rule to include other hospitals and Medicare Shared Savings Program accountable care organizations.

The proposed rule also provides an Advanced Payment Model (APM) track for the EPMs, an important step that will further incentivize collaborator participation.

**CDI program opportunities**

There are five key ways that clinical documentation and reported codes across the continuum impact SHFFT performance:

- **Identification of patients included in the EPM.** The assigned MS-DRG impacts which discharges are included in the cohort. As one example, consider a patient who would fall into the EPM (MS-DRGs 480–482) unless he or she has a bone biopsy. If reported, the bone biopsy would result in assignment of different MS-DRGs (477–479) and the discharge would not be included in the EPM.

- **Establishment of target costs.** The capture of the MCC and/or CC impacts establishment of the episode target price.

- **Determination of related costs.** The costs for hospital readmissions within the episode are included in episode costs if the readmissions are related. The assigned MS-DRG for the readmission determines whether the readmission is related.

  The costs associated with Part B claims are included in episode costs if the services are related. The primary diagnosis for each visit determines whether the visit is related.

- **Reported complications.** Assignment of ICD codes for the following conditions are counted as complications when those conditions result in inpatient readmission:

  - **Complication risk adjustment.** As with other hospital-centric measures such as risk-adjusted readmission and mortality rates, comorbidities reported for the 12 months prior to the anchor hospitalization are used to assess case-mix complexity. The CMS risk adjustment module uses defined comorbidity categories to identify conditions that impacted predicted rates of complications for the THA/TKA cohort.

<table>
<thead>
<tr>
<th>Complication</th>
<th>Time frame for occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
<td>Within seven days of index admission admit date</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Same as above</td>
</tr>
<tr>
<td>Sepsis/septicemia/shock</td>
<td>Same as above</td>
</tr>
<tr>
<td>Surgical site bleeding</td>
<td>During the index admission or within 30 days of admit date</td>
</tr>
<tr>
<td>PE</td>
<td>Same as above</td>
</tr>
<tr>
<td>Death</td>
<td>Same as above</td>
</tr>
<tr>
<td>Mechanical complications</td>
<td>During index admission or within 90 days of admission date</td>
</tr>
<tr>
<td>Peri-prosthetic joint/wound infection</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

Source: Shannon Newell, RHIA, CCS, AHIMA-approved ICD-10-CM/PCS trainer, director of CDI quality initiatives for Enjoin.
The capture of at least one condition for each of the 28 comorbid categories over the 12-month period will strengthen risk adjustment and RSCR performance. RSCR performance contributes to 50% of the quality composite score, which, in turn, impacts the quality-adjusted target price.

Summary
Together the CJR and SHFFT models cover all surgical treatment options (hip arthroplasty and fixation) for Medicare beneficiaries with hip fractures. These MS-DRGs typically represent one of the largest inpatient surgical volumes for most short-term acute care hospitals.

Computer-assisted coding: Where are we today?

by Lori-Lynne A. Webb, CPC, CCS-P, CCP, CHDA, COBGC, CDIP

In our computer-savvy tech world, the medical field has been notoriously slow to respond to newer technologies and applications of computer-assisted enhancements. However, in the HIM market, computer-assisted coding (CAC) has been touted to boost coding accuracy and productivity, in addition to being an important tool for the remote inpatient coder.

Background
The term CAC denotes technology that automatically assigns codes from clinical documentation for a human to review, analyze, and use, according to the Journal of AHIMA.

Currently, there are a variety of methodologies, software, and integration interface applications that enable a CAC application to read text and assign codes. This type of software reads the information in a similar way to how a spell-check application works on a traditional computer. According to some users, data-driven documentation (e.g., documentation that is dictated or typed) is more accurately processed by the CAC software than documents that are scanned into the system for the software to use.

CAC software works through recognition; it learns words and phrases, as well as learning the areas within a specific document where standardized words and phrases appear.

As hospitals and collaborators assess and refine the management of patients to achieve or exceed the quality-adjusted target price, the data we submit on claims will be used to assess our performance. The CDI program in the inpatient and ambulatory setting must be positioned to promote and support the capture and reporting of impactful documentation.

Additional information on the proposed rule can be located at https://innovation.cms.gov/initiatives/epm.

EDITOR’S NOTE
Newell is the director of CDI quality initiatives for Enjoin. Her team provides CDI programs with education, infrastructure design, and audits to successfully and sustainably address the transition to value-based payments. She has extensive operational and consulting expertise in coding and clinical documentation improvement, case management, and health information management. You can reach Newell at 704-931-8537 or shannon.newell@enjoincdi.com.
the latest CAC software technology employs a type of natural language and syntax processing to compare, contrast, and extract specific medical terms from electronic data or typed text—so CAC stand-alone technology does exist. In studies conducted by AHIMA, though, the combination of a CAC with a coder/auditor has been proven to be just as good, or better than, a coder or CAC alone.

The biggest challenge CAC poses might be getting buy-in from the hospital coding and HIM staff. The HIM, coding, and clinical staff must all be a part of the changes and be on board with learning how to use this technology enhancement. In the past, there has been some uncertainty and fear related to CAC eliminating coders’ jobs. However, a good CAC solution in conjunction with HIM management allows coders to apply their critical thinking and analytical skills to create well-coded documentation of patients’ care. This, in turn, results in more accurate DRG assignment and reimbursement for the facility.

HIM and coding staff’s responsibility and role in the fiscal revenue stream will change as a result of CAC and similar technology. With this change must comes the acceptance that it takes both a human and a computer to successfully transform a CAC product into good financial outcomes and even better documentation.

As coders will surely agree, the final code selection for inpatient records should be based upon coders’ knowledge of coding guidelines, clinical concepts, and compliance regulations. When working with CAC, the coder has the ability to agree with or to override codes that the software determines.

CAC, clinical documentation, EHR, and providers
Integration of clinical documentation from providers and physicians has always been a challenge, and combined with the implementation of ICD-10, it has presented a huge impetus for the adoption of CAC technology in hospital- and facility-based organizations.

Unfortunately, physicians still don’t provide thorough documentation, instead relying on CDI and coding staff to guide them. There has always been a disconnect in the language spoken by providers and the language spoken by coders. Physicians document in their comfort zone and fall back on terms such as

- Increased coder productivity
- More revenue from more detailed bills
- Return on investment—the CAC system quickly pays for itself

As we’ve said, it hasn’t been shown that CAC actually increases coders’ productivity. In reality, their productivity will probably stay the same, as a coder will still have to audit the information to determine whether the code generated by the software is correct. But in regard to the other CAC benefits on the above list, coder satisfaction should not be overlooked.

During AHIMA’s pilot testing of CAC software, the organization weighed in on some of the potential issues with using CAC software alone (with no human intervention). AHIMA noted that within specific areas of the pilot CAC testing in ICD-10, the coders did not accept 75% of the diagnosis codes presented, and they did not accept 90% of the procedure codes presented within the code sets. However, the information that the CAC software presented did give the coders a good starting reference to drill down to a more comprehensive diagnosis or procedure code.

Coders and CDI personnel will still need to be in charge of the following:
- Ensuring clinical documentation is complete and querying when appropriate
- Ensuring complete coding (e.g., for specificity)
- Ensuring correct sequencing of diagnosis and procedures
- Reviewing CCs/MCCs and DRG assignments with case complexity and severity

Many CAC vendors will try and sell their product based on the following list of features and benefits:
- Better medical coding accuracy
- Faster medical billing
- Greater coder satisfaction
- Identification of clinical documentation gaps
“pneumonia,” whereas a coder is looking for much more specificity. The integration of an EHR-based program and CAC for providers can lead to a good team relationship for both parties. Many CAC programs integrate well with hospital-based CDI programs and EHRs. These combination interfaces allow more real-time processing of possible code selection prior to the coder’s audit and review of the final code selection.

When the CAC software identifies these possibilities, there is an opportunity to identify and improve the DRGs with MCCs and CCs, as well as more quickly address areas for query and missed procedures or diagnoses.

**Wrapping it all up**

It is evident that coders and HIM professionals need to make a commitment to embrace change, which includes new technologies and integration of learning processes and opportunities. A hospital’s success depends on the coder acting as part of a team that will strive for successful outcomes for both the patient and the hospital.

**EDITOR’S NOTE**

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**Key attributes for coders moving forward amidst the 2017 coding guideline changes**

*by Laura Legg, RHIT, CCS, CDIP, AHIMA-approved ICD-10-CM/PCS trainer*

Resiliency is the ability to spring back or rebound. In sports, it’s one of the mental attributes a player must have. Coders are resilient: bouncing back from one change after another, deciding to code smarter and faster, and having the patience to do whatever is expected—even amid closing grace periods and guideline controversies.

The change to ICD-10 in October 2015, was a solid transition, and no one in healthcare was affected by it more than coders. The changes didn’t stop there. The coming months will again prove to be challenging for coders because of the new ICD-10 codes for both CM and PCS beginning October 1, 2016. Along with that, we’ll see the end of the CMS grace period on code specificity for Part B, and updated ICD-10-CM Official Coding Guidelines. Coders have a lot to learn this fall.

The Centers for Disease Control and Prevention published guidelines for discharges effective October 1, 2016, that have been approved by the four organizations that make up the Cooperating Parties for ICD-10-CM: the American Hospital Association, the American Health Information Management Association, CMS, and the National Center for Health Statistics.

The guidelines are available at www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf. In the linked document, the changes are indicated in bold type for easy identification. Below are some of the highlighted changes.

**Excludes1**

This guideline supports the interim advice published last fall. Here, the Cooperating Parties have given instructions that two conditions unrelated to each other represents an exception to the Excludes1 definition. If it is not clear whether the two conditions are related, coders must query the provider.

**With**

Under Section I.B.7 of the guidelines, “multiple coding for a single condition” clarification has been added for interpretation of the word “with.”

The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms.

These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by this term in the classification, provider docu-
mentation must link the conditions in order to code them as related.

**Code assignment and clinical criteria**

Also under Section I, the *Official Guidelines for Coding and Reporting* tell us that 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.

Coders are instructed to assign a diagnosis or procedure code according to physician documentation. Coders have been told in the past not to question the physician’s clinical judgment. This appears to be pretty simple until audits from outside the organization place more emphasis on the use of clinical criteria. This use of clinical criteria to assign reported codes is known as “clinical validation.” When coders follow the official coding guideline instructing them that a code assignment is not based on clinical criteria used by the provider to establish the diagnosis, they will be caught between following the guideline as instructed and being presented with a claim denial based on the absence of clinical validation.

In today’s healthcare environment, it is essential that organizations face this issue head on and provide coders with guidance on how to solve the dilemma of a record that contains physician documentation but does not contain clinical validation. Clinical documentation improvement efforts to improve upon complex clinical condition documentation must continue to bring the coding and medical records together to allow coders to code correctly and avoid payer denials.

CMS must clarify the reason the Recovery Auditors are allowed to deny claims, whether auditors will bypass this official coding guideline, and how organizations can reconcile the discrepancy.

**Laterality coding**

This update clarifies that when a patient with a bilateral condition has surgical correction on both sides, the first side corrected is coded with the bilateral code. The second site is not coded using the bilateral code because the condition no longer exists on the corrected side. If the treatment on the first side did not completely resolve the condition, then the bilateral code is used.

**Documentation for BMI, non-pressure ulcers, and pressure ulcer stages**

Section I.B.14 says for body mass index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH Stroke Scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider. Dietitians often document the BMI, nurses often document pressure ulcer stages, and an emergency medical technician often documents the coma scale. Keep in mind the associated diagnosis must be documented by the patient’s provider. A query should be used to clarify any conflicting medical record documentation.

This guideline shows the addition of the coma scale and NIHSS to conditions where code assignment can be determined from clinicians who are not the patient’s provider. Many coders may not be familiar with the NIHSS—it is a 15-item neurologic examination used to evaluate the effect of acute cerebral infarction. The NIHSS evaluates:

- Levels of consciousness
- Language
- Neglect
- Visual field loss
- Extraocular movement
- Motor strength
- Ataxia
- Dysarthria
- Sensory loss

The NIHSS evaluation is often done by nursing staff and can help physicians quantify the severity of a stroke in the acute setting.

**Zika virus infection**

The official guidelines instruct coders to code only confirmed cases of the Zika virus with code A92.5 as documented by the provider. Note that this is an exception to the hospital inpatient guidelines. “Confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. Documentation of “suspected,” “possible,” or “probable” Zika is not assigned to code A92.5.

**Hypertensive crisis**

A coding guideline has been added to instruct coders to assign a code from category I16 for hypertensive urgency,
hypertensive emergency, or unspecified hypertensive crisis. This may call for some physician documentation education to make physicians aware that these more specific codes are available and can be used instead of documentation of hypertension without any further description.

Coma scale
In addition to using the coma scale codes (R40.2-) for traumatic brain injury codes, acute cerebrovascular disease codes, or sequelae of cerebrovascular disease codes, the coma scale may be used to assess the status of the central nervous system for other non-trauma conditions. Examples include monitoring patients in the ICU regardless of their medical condition.

Observation
One observation Z code category has been added for use when a newborn patient is being observed for a suspected condition that is ruled out. The new code category is Z05: encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out.

Newly added ICD-10 codes
CMS will implement an unprecedented number of new code changes October 1. A partial code freeze prevented regular updates for the last five years, resulting in the release of over 5,000 ICD-10 revisions on that date. The newest coding updates can be found at https://www.cms.gov/Medicare/Coding/ICD10/Latest_News.html.

The new ICD-10 codes come as we thaw out from the code freeze that has been in effect since October 1, 2011. Since that time, we have received only limited code updates to both the ICD-9 and ICD-10-CM/PCS code sets. Now, the long delay is over. ICD-10-CM changes include 1,928 diagnosis code changes with expanded code choices for atrial fibrillation, heart failure, diabetes mellitus Type 2, disorders of the breast, and pulmonary hypertension.

Extensive PCS updates are also being implemented. There are 3,651 new PCS codes, revised code titles, and a grand total of 75,625 valid codes with this update. It is important to note that 87% of the PCS code updates are in the cardiovascular system.

Following adoption of the new codes, review of coding accuracy will be needed. Any misconceptions or incorrect rationale should be recognized and communicated early to prevent ongoing or costly patterns from developing. Remember to ensure software updates are also in place and scheduled on time.

The new cardiovascular PCS codes include:
- Unique codes for unicompartmental knee replacement
- Codes involving placement of an intravascular neurostimulator
- Expanded body part detail for the root operations Removal and Revision
- New codes in lower joint body system
- New codes for intracranial administration of substances such as Gliadel chemotherapy wafer using an open approach
- Addition of bifurcation qualifier to multiple root operation tables for all artery body part values
- Specific body part values for the thoracic aorta
- Specific table values to capture congenital cardiac procedures
- Unique device values for multiple intraluminal devices

Other PCS changes include:
- Donor organ perfusion
- Face transplant
- Hand transplant

The impact of the new codes will depend on what you do, so it’s important for hospitals to assess how the changes will affect them specifically. If you don’t deal with the areas where the codes have changed, the updates will be much easier than if your facility uses all the affected codes. Make sure the applicable codes are integrated into your internal applications and processes, while verifying that vendor products support the new codes. You don’t want to have claims rejected because not all of the new codes were incorporated.

Overall, there are moderate changes to the Official Guidelines for Coding and Reporting. The 2017 coding updates, however, are extensive and may seem overwhelming to some coders. The addition of over 10,000 codes after only one year of using ICD-10 will require coder resiliency to learn them all and understand how to apply them.

EDITOR’S NOTE
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This is part one of a two-part series on the definition changes for sepsis. Look for part two in the next issue of BCCS.

This October will celebrate the eight-month anniversary of the intellectually stimulating, yet controversial, third international consensus definitions for sepsis and septic shock (Sepsis-3), which are available at www.jamasepsis.com. This new definition has generated significant discussions among those invested in ICD-10-CM-based documentation and coding integrity and compliance.

As we negotiate the fiscal year (FY) 2017 ICD-10-CM official guidelines and revisions to the CMS severe sepsis/septic shock core measure (SEP-1), we in coding compliance must develop strategies that preserve the clinical integrity of the definition and diagnosis of sepsis in clinical care, support the proper cohort selection for SEP-1, and compliantly assign defendable ICD-10-CM codes based on provider documentation and coding conventions.

Authored by 19 critical care physicians and endorsed by many critical care societies, including the United States–based Society for Critical Care Medicine and the American Association of Critical Care Nurses, Sepsis-3’s goals were to better differentiate sepsis from uncomplicated infections, and to update definitions of sepsis and septic shock to be consistent with improved understanding of their pathobiology. In recognizing that sepsis is a clinical syndrome without a validated diagnostic test, the committee sought to promulgate clinical criteria that could be standardized as to meet their objectives.

In so doing, the Sepsis-3 committee redefined sepsis as a “life-threatening organ dysfunction caused by a dysregulated host response to infection,” eliminating the concept of sepsis as a systemic inflammatory response syndrome due to infection, which was established with SEP-1 in 1991.

SEP-1 was built into ICD-9 in 2001 (though systemic inflammatory response syndrome due to infection cannot be coded as sepsis in ICD-10-CM), required only two out of four simple criteria (temperature above 101°F, WBC count over 12,000, tachycardia, and tachypnea), and did not require organ dysfunction to be present. The new Sepsis-3 definition also removed the SEP-1 term “severe sepsis,” which is sepsis with acute organ dysfunction.

In identifying a “life-threatening organ dysfunction” for the purpose of diagnosing sepsis, Sepsis-3 changed the Sepsis-related Organ Failure Assessment (SOFA) score to two or more. On the other hand, the CMS SEP-1 core measure, severe sepsis, and septic shock bundle uses different criteria than SOFA in defining severe sepsis (criteria are available at tinyurl.com/2017SEP1) and relies on the documentation and coding of the words “severe sepsis,” no matter how those words are defined.

Organizations respond to sepsis changes

While agreeing with Sepsis-3 in concept, the Surviving Sepsis Campaign (SSC) rebutted that other clinical indicators of organ dysfunction besides SOFA, such as a lactate level over 2, ileus, or sepsis-induced hypotension, should also meet the new criteria for sepsis. View the SOFA criteria at tinyurl.com/Sepsis3SOFA and the SSC clarification at tinyurl.com/SSCrebuttalSepsis3.

One would think this thoughtful conclusion would be welcomed by clinicians, clinical documentation improvement (CDI) specialists, and coders alike, much like the acceptance of the 2012 Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition’s criteria for adult malnutrition (tinyurl.com/2012malnutrition), or the 2013 Kidney Disease: Improving Global Outcomes’ criteria for acute kidney injury (tinyurl.com/2013AKIKDIGO).

Not so. Almost immediately upon the publication of Sepsis-3, Steven Simpson, MD, of the Division of Critical Care Medicine at the University of Kansas in Lawrence, wrote a strong rebuttal and advocated that clinicians not adopt the new definition. Read his reply at tinyurl.com/h4as3b2.
The comment and response section for the July 26, 2016, issue of the Journal of the American Medical Association contained similar rebuttals, including a statement by Lemeneh Tefera, MD, of CMS in Windsor Mill, Maryland, that states, “Although the task force’s definition structure may identify patients with the highest likelihood of poor outcomes, it does not clearly identify patients in the early stages of sepsis when rapid resuscitation provides the greatest patient benefit and improves survival.” Read his comment at tinyurl.com/JAMA20160726.

I’m not aware of any forthcoming changes to ICD-10-CM as a result of Sepsis-3; if there are, we won’t see them until at least October 1, 2017. Therefore, at time of press, unless Coding Clinic publishes advice that changes the landscape, we now have a Sepsis-3 definition in a Sepsis-1, Sepsis-2, SSC, or ICD-10-CM definition, documentation, or coding environment.

**Documentation and coding challenges abound**

There are a number of coding compliance challenges with Sepsis-3 and with sepsis or severe sepsis in general. These are as follows:

- Sepsis-3 states that patients with an infection meeting their sepsis criteria should be coded as R65.20, severe sepsis. This is impossible in the United States, given that ICD-10-CM code R65.20 can only be assigned if the physician documents “severe sepsis,” not sepsis alone, or if the physician documents that an acute organ dysfunction is associated with sepsis, though many coders fail to assign R65.20 when these links are made. It’s apparent that the Sepsis-3 authors are not familiar with Coding Clinic for ICD-10-CM/PCS, the Department of Justice, or our friendly neighborhood Recovery Audit Contractors (RAC).

- ICD-10-CM still has a multitude of codes for sepsis without organ dysfunction (e.g., A40–A41). The FY 2017 ICD-10-CM Official Guidelines state that “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.” Recent nonpublished advice from Coding Clinic supports the concept that if an individual physician documents sepsis using his or her own criteria (that may differ from Sepsis-3 or that of a RAC), coders are obligated to code it. Therefore, if a physician documents sepsis, can we still defend the coding of an A40–A41 code if there is no documented organ dysfunction? I believe that this guideline and Coding Clinic say we can, even if the RAC doesn’t like it.

- The ICD-10-CM table instructions for code R65.20, severe sepsis, state to use an “additional code to identify specific acute organ dysfunction.” If a physician documents severe sepsis based on the SSC’s criteria of a lactate over 2 milliequivalent per liter (mEq/L), or Sepsis-3’s changes in the Glasgow Coma Scale, what is the organ dysfunction that should also be coded or queried for? Without an organ dysfunction documented and coded, a RAC may claim that the severe sepsis code is invalid.

- In my own personal review of the CMS 2015 MedPAR, approximately 45%–55% of MS-DRGs 871 or 872 (septicemia or severe sepsis) do not have a code for severe sepsis, yet a number of patients have acute organ dysfunctions that are present on admission that I believe should have been linked to the patient’s sepsis to render the severe sepsis code. I believe that RACs are looking at sepsis DRGs without R65.20, severe sepsis, or R65.21, septic shock, as opportunities to take money away from us who coded sepsis (e.g., A40–A41) as present on admission and sequenced it as a principal diagnosis without an additional R65.20 or R65.21 code. To take these records out of the RAC data mining pool, coders must make every effort to query providers if the clinically valid indicators of organ dysfunction due to sepsis are present but the record does not have the documentation interpreting these indicators as to report R65.20 and R65.21 and their associated organ dysfunctions. This effort, however, must be coordinated with the SEP-1 or quality manager, given that any coding of R65.20 or R65.21 subjects the record to the SEP-1.

**EDITOR’S NOTE**

Read part two of this series in next month’s November issue. Dr. Kennedy is a general internist and certified coder, specializing in clinical effectiveness, medical informatics, and clinical documentation and coding improvement strategies. Contact him at 615-479-7021 or at jkennedy@cdimd.com. Advice given is general. Readers should consult professional counsel for specific legal, ethical, clinical, or coding questions. For any other questions, contact Associate Editor Amanda Tyler at atyler@hcpro.com. Opinions expressed are those of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.
We want your coding and compliance questions!
The mission of “Coding Q&A” is to help you find answers to your urgent coding/compliance questions.
To submit your questions, contact Briefings on Coding Compliance Strategies Associate Editor Amanda Tyler at atyler@hcpro.com.

Q Our facility has noticed a lot of new additions to tables in the ICD-10-PCS code updates. One of our biggest questions is, once a new technology is assigned to group one or two, will it ever change?

A No! This is a great question that is asked a lot. Just to help you understand, group one identifies the first year that the new technology section existed, which was 2016. Group two, you will notice, is all of the new technologies added for 2017. Next year, if CMS adds anything to new technology, it will be called group three. Once a technology is assigned to a group, that group assignment will never change.

Editor’s note: Shelley C. Safian, PhD, RHIA, CCS-P, COC, CPC-I, AHIMA-approved ICD-10-CM/PCS trainer, of Safian Communications Services in Orlando, Florida, answered this question in JustCoding’s recent “2017 ICD-10-PCS Code Updates” webcast. She is a senior assistant professor who teaches medical billing and insurance coding at Herzing University Online in Milwaukee. Email her at ssafian@embarqmail.com.

Q During an ICD-10-PCS Fusion, when a physician documents the use of a “structural allograft spacer” in the medical record, what sixth character would we use when coding this? Some colleagues say to use A (interbody fusion) and some say to use K (nonautologous tissue substitute). What would be the correct way to code this?

A There are many different structural allograft spacers on the market, but the most common spacers available are sold through Synthesis Spine. These spacers are placed in the interbody space, much like a cage, which will then increase the height between the two vertebral bodies. All spacers have a hollow space to allow for implantation/packing of grafting material, which will facilitate the fusion as well as around the cage.

The only device character that would be reported is an interbody fusion device (device character A).

Per ICD-10-PCS guidelines B3.10c: “If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value interbody fusion device.”

Nonautologous tissue substitutes (allografts) are rarely used alone since they do not have the ability to generate bone (as they have no living cells). Because of this, they can be used as scaffolding. Allografts are usually mixed with autologous bone grafting material if the goal is regenerating bone to create a fusion. Therefore, this material is perfect for inside an interbody fusion device because it can serve as support and doesn’t require a separate incision (like the iliac crest) to obtain it.

Editor’s note: Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, and director of HIM/Coding at HCPro, a division of BLR, in Middleton, Massachusetts, answered this question for JustCoding.

Q In my facility, we are supposed to send an email to our physician advisor (PA) and to administration if a query is not answered within a week. However, this policy doesn’t work well because administration does not do anything with that information, and the PA doesn’t have time to review unanswered queries. Do you have any suggestions concerning when to let a query go unanswered?

A We do suggest every clinical documentation improvement (CDI) program have well-developed query policies. These should be consistent with those policies followed by the coding department. Look at how unanswered queries are addressed on the retrospective side.

Your query policies should include clear guidance on:
• What instances queries are to be asked
• Where queries are placed within the record
• Who is responsible for following through
• How queries are to be prioritized

Query policies should also include an escalation policy that describes how to handle situations in which an answer is not received, an inappropriate answer or comment is provided, etc. The escalation policy should address when the issue is brought to the PA, your department director, or administration with defined actions regarding the responsibilities at each level. The policies should reflect a method of response that can realistically occur at your organization.

In my experience, if a query was unanswered, the CDI specialist and inpatient coder would discuss the need to follow up. If it was determined that the answer would provide little impact, we would close the query, leaving it unanswered. But if we concluded an answer was required, the CDI specialist would address the query with the provider. There was a process of escalation in those instances when no response was received.

Ultimately, your policies should indicate what instances represent a situation when a query can go unanswered, and when it should be followed through. There may be instances when a query does not impact the reimbursement or quality measures and can be left unanswered. These are topics that must be discussed within your organization.

Few organizations can boast a query response rate of 100%, but there are some things you can do to boost response rates. Take a look at your query templates or perform a query audit. There should always be choices that allow the physician to offer his or her own interpretation, or to state that there is no significance or that the answer is unknown. Often, physicians do not answer queries because they either do not like the choices offered or they are unsure exactly what is being asked.

“Recognize those physicians who are working with you and are demonstrating a high [query] response rate.”

It might be helpful to monitor physician query response rate based on the CDI specialist responsible for the account. You may find a specific CDI specialist is having difficulty writing effective queries or lacks assertiveness in following up on unanswered queries. Most programs have a time limit or goal for queries to be answered that is tied to individual CDI productivity or effectiveness in the role. An example is an expectation that 80% of queries asked will be answered within 48 hours.

Administrative support is invaluable in encouraging physician involvement in your program. Many organizations track physician response rates to queries in their physician profiling or “quality report card” efforts. Instead of forwarding administration every unanswered query, set an acceptable response rate. When a physician falls below the suggested benchmark, the matter should be addressed by a department director, a PA, or senior administration.

I also like to give positive reinforcement where it is due. Recognize those physicians who are working with you and are demonstrating a high response rate. It creates a sense of competition, and often, we catch more flies with honey.

EDITOR’S NOTE
Laurie L. Prescott, RN, MSN, CCDS, CDIP, AHIMA-approved ICD-10-CM/PCS trainer and CDI education specialist at HCPro, a division of BLR, in Middleton, Massachusetts, answered this question on the ACDIS website.