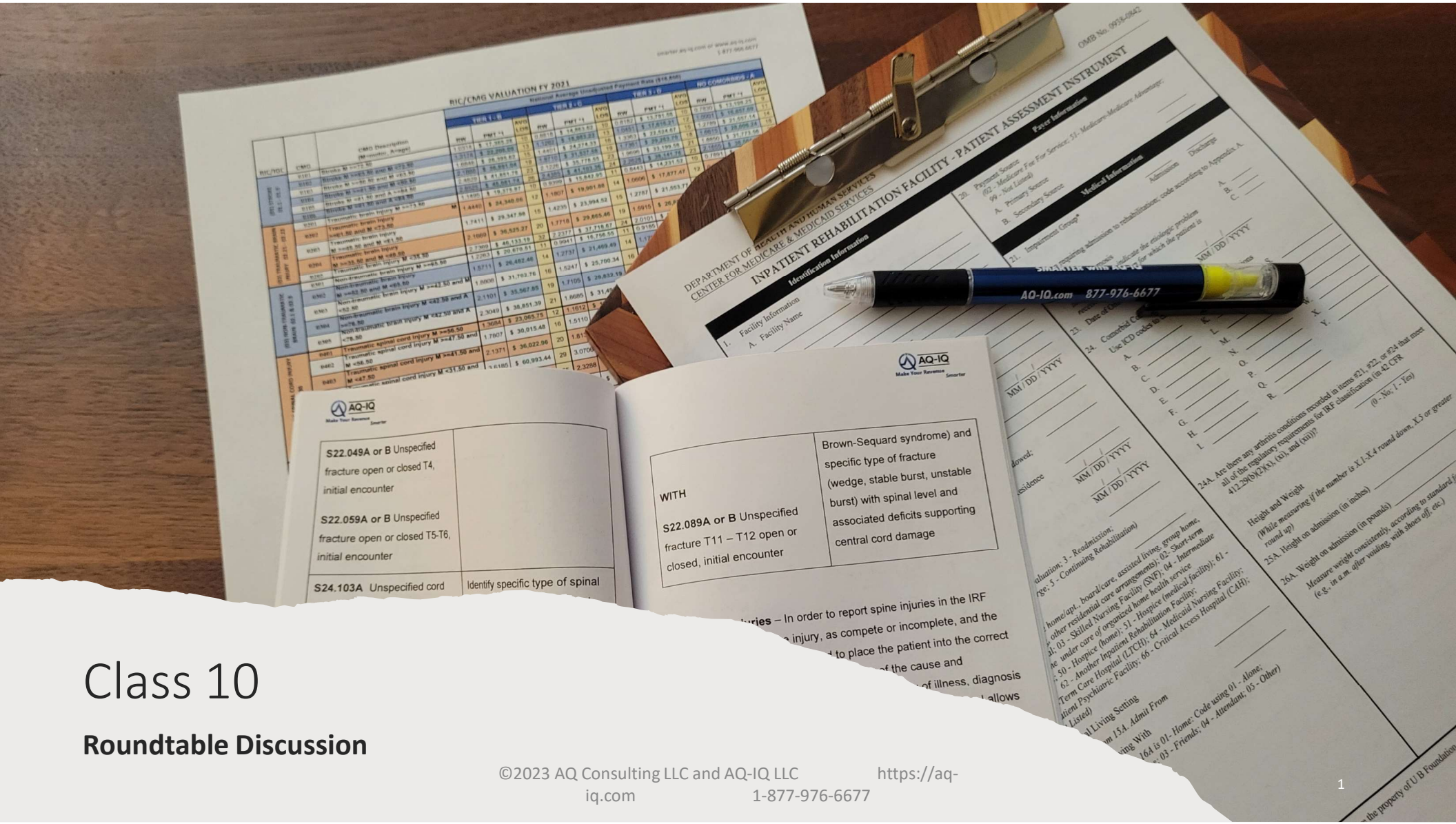


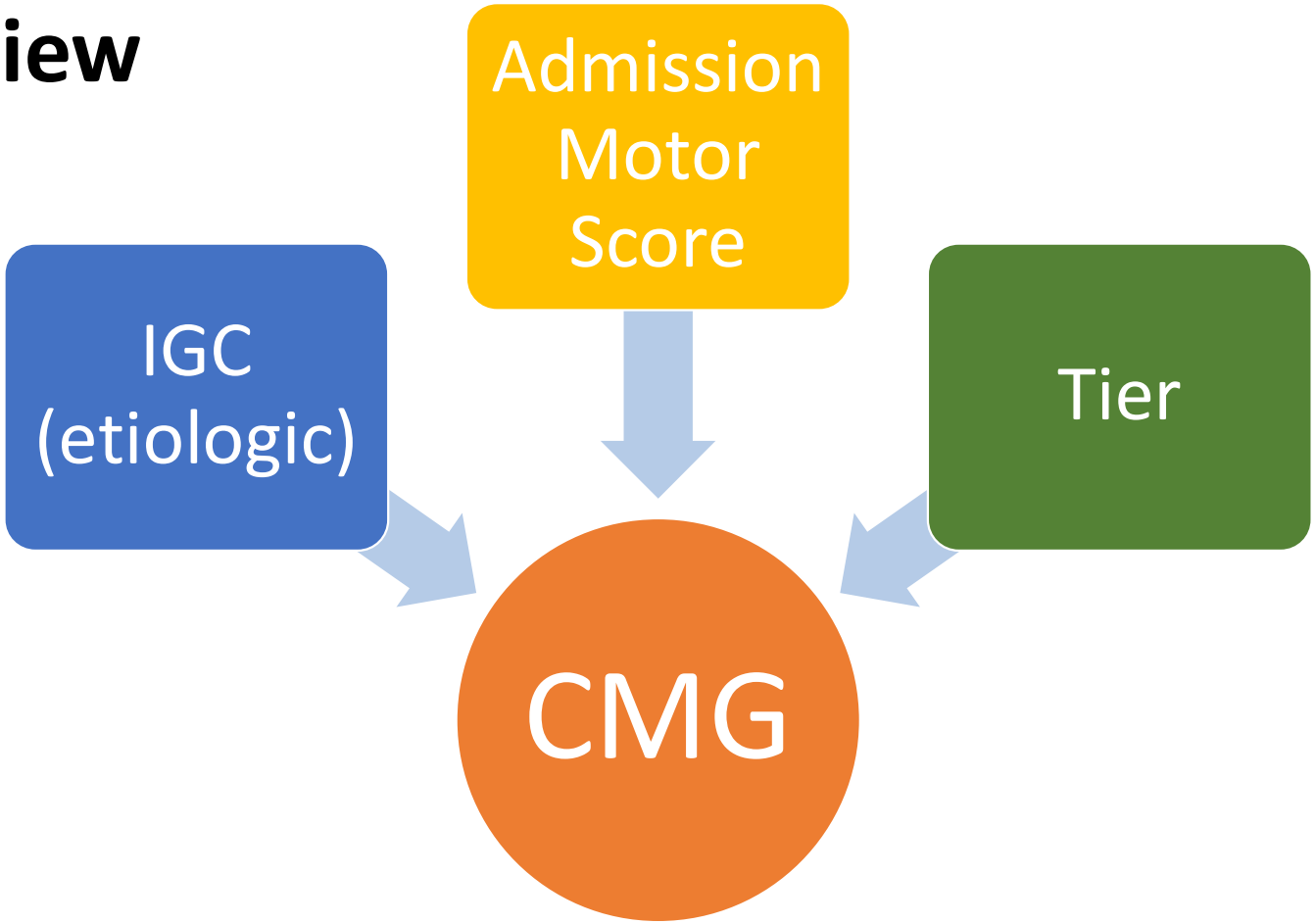
Class 10

Roundtable Discussion

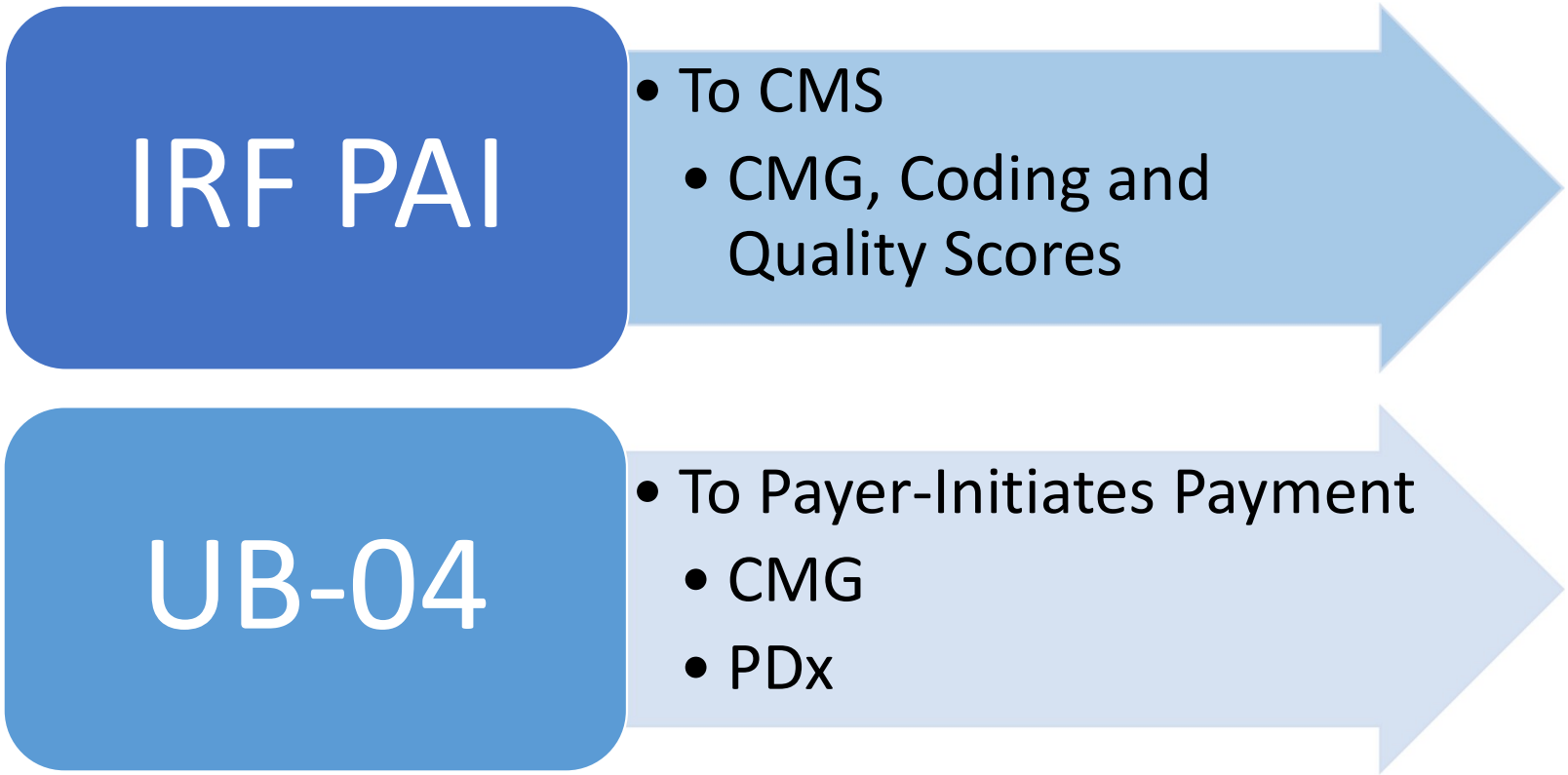
Agenda - Bonus

- Review of Payment Logic and 60%
- Auditing
  - Audit Focus
  - Selection of Sample
  - Auditing Process- Creating Tools based on Focus
  - What to do with the information
    - Associate to processes
    - Relay to relevant team(s)/managers
    - Create Action Plan
    - Educate and Re-evaluate

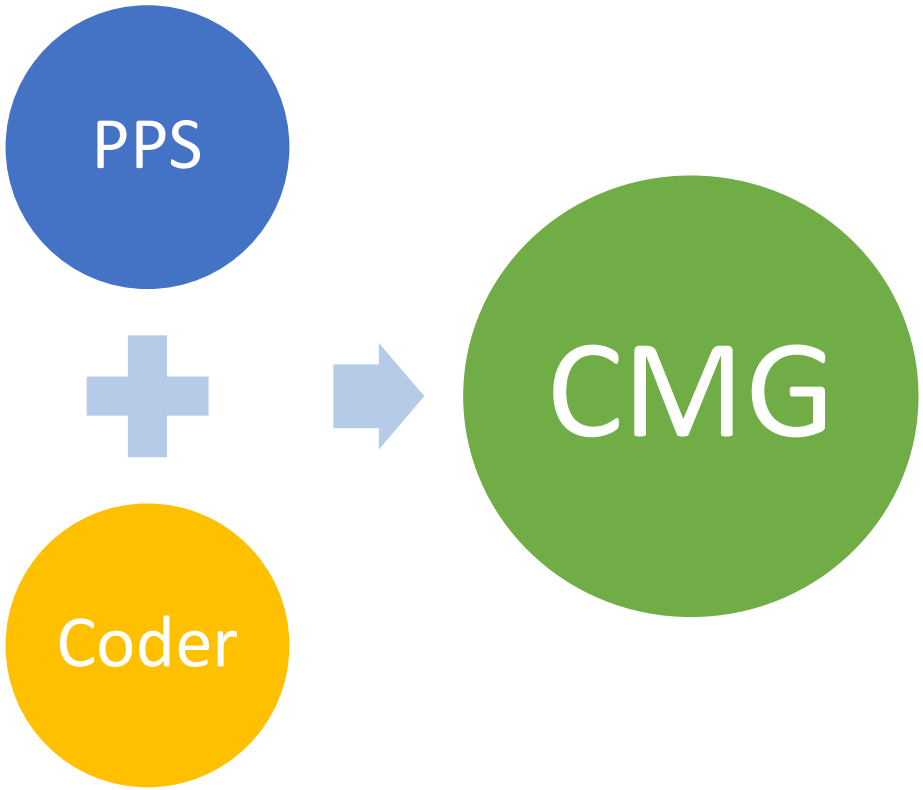
Quick Review



Quick Review



Quick Review



IRF Reimbursement - Different by Payer - Review

- Non-Medicare Payments
- Medicare Payments based on an assigned Case Mix Group (CMG)
- CMG assigned using IRF-PAI
- Payment initiated using UB-04

Quick Review – IRF (CMS)

- **Paid on CMG** (non-Medicare = contract rate)
- **IRF-PAI determines CMG** – submitted to CMS
  - Admission IGC + Admission Motor Score + Tier = CMG
- **UB-04 initiates payment** – submitted to state Medicare contractor
  - CMG translated to claim with Revenue Code 0024 (Required)
- **Must meet 60%** during qualifying period to maintain payment under IRF PPS (CMG's) or risk payment under DRG's
- **Certain documentation requirements** different than other settings
  - Technical components, medical necessity and support for coding/IGC selection

Questions about what we've talked about?

IRF (Physician) Requirements - Review

- **IRF Criteria - MUST prove interdisciplinary approach; need for inpatient services; ability to participate as required**
  - Pre-Admission Screen (PAS)
  - History & Physical (H&P)
  - Individual Overall Plan of Care (IOPOC)
  - 3 Face to Face visits per week (minimum requirement) and progress notes for additional visits
    - Functional and Medical Addressed
  - Team Conference – 1 every 7 days
  - Orders

IRF Physicians Must Document-Review

- Underlying Reason for Impairment/Admission
- Accuracy and Details **(INCLUDING DEFICITS AND CLINICAL INDICATORS)** to support coding of each existing comorbidity
  - Treated/Utilizing a Resource
  - Impacting Treatment
  - Extending the Length of Stay
- Association of ALL treated diagnoses to medications/treatment

IRF Physicians Must Document-Review

- Status of conditions (History/Current/Resolved/Active)
- Relevance of lab tests
- ICD-10-CM Diagnosis statements (Specificity is Key to Success)
- Functional and Medical and the interrelationship between them
- Clarify any reasons for interruption in expected therapy
- Overall Note – History; Exam; Medical Decision Making

CMS Other IRF Documentation Requirements

Three hours of therapy 5 of 7 days

- Fifteen hours over 7 days - medical reason for this
- Reason for missed minutes MUST BE documented
- Make up minutes if reason not acceptable

Team conference every 7 days

- Day 8 first team conference if admitted on day of conference
- RN, PT, OT, CM and Rehab Physician must attend
- Speech if on the team

The Challenges

- Documenting the interdisciplinary team discussion
- Documentation supports the medical necessity criteria/continued stay criteria
- Documentation justifies the decisions made
- Documentation tends to be discipline specific
  - Current status
  - Barriers
  - Goals
  - Interventions
- Nursing report typically limited to bowel, bladder, skin

Continued Stay

- To justify the patient's continued stay, MUST document:
  - Medical status/changes
  - Progress toward interdisciplinary (team) goals
  - Interdisciplinary goals/revised interdisciplinary goals
  - Barriers with actions
  - Discharge plan
  - Discharge planning needs
    - Family training/conference
    - Transitional living apartment
    - Community re-entry activities

Auditing

Top Audit Risk Areas

- Medical Reasonableness and Necessity
- Incorrect IGC;
- Etiologic/IGC miss-match;
- Missed Tier Comorbids/Complication;
- Incorrect Specificity of Diagnoses Reported on IRF-PAI;
- Reporting Unnecessary Diagnoses on the IRF-PAI;
- Reporting Conditions documented too late;
- Reporting codes inconsistent with coding rules

Internal or External Audit/Investigation

Audit Tools - Example

REVIEWER ITEM #	PROVIDER	MEDICAL RECORD			IRF-PAI/ UB-04						UB-04 FINDINGS													
											DRG ACCURACY			COMORBIDITY ACCURACY				UB-04 DIAGNOSIS FINDIN						
		PATIENT ID (Fin#)	INIT	D/C DOS	BILLED PDX UB-04	BILLED DRG UB-04	BILLED IGC IRF-PAI	BILLED ETIO DX IRF-PAI	BILLED CMG IRF-PAI	BILLED CMG UB-04	INACCURATE DRG (4)	AUDITOR PDX	AUDITOR DRG	SECONDARY DIAGNOSIS ERROR	RECOMMEND: ADD CODE(S) (DOCUMENTED NOT CODED COMORBIDITY	RECOMMEND: DELETE CODE(S) (CODED NOT DOCUMENTED OR SUPPORTED)	RECOMMEND: MODIFY CODE(S) (I.E. INCORRECT SPECIFICITY)	DIAGNOSIS SPECIFICITY ERROR	DIAGNOSIS DOCUMENTED NOT CODED ON UB-04	DIAGNOSIS CODED NOT DOCUMENTED	SYMPTOMS OF DEFINITIVE DIAGNOSES REPORTED UNNECESSARILY	MCC/CC DOCUMENTED NOT CODED	POA ERROR (CODES WITH INCORRECT POA)	ICD-10-PCS CODING ERROR	
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								

Digging into the Record- Where to Look

- Former Acute Notes
- H&P *
- Progress Notes/Team/Plan of Care *
- Consultations *
- Labs/Radiology/Pathology
- Nursing/Therapies
- Notes from other ancillary staff
    - Nutrition, Therapy, Wound Care etc.
- Orders *
- Discharge Summary *

Whose Documentation Can Be Used?

Only physician or QHP documentation should be used for coding purposes with some exceptions including:

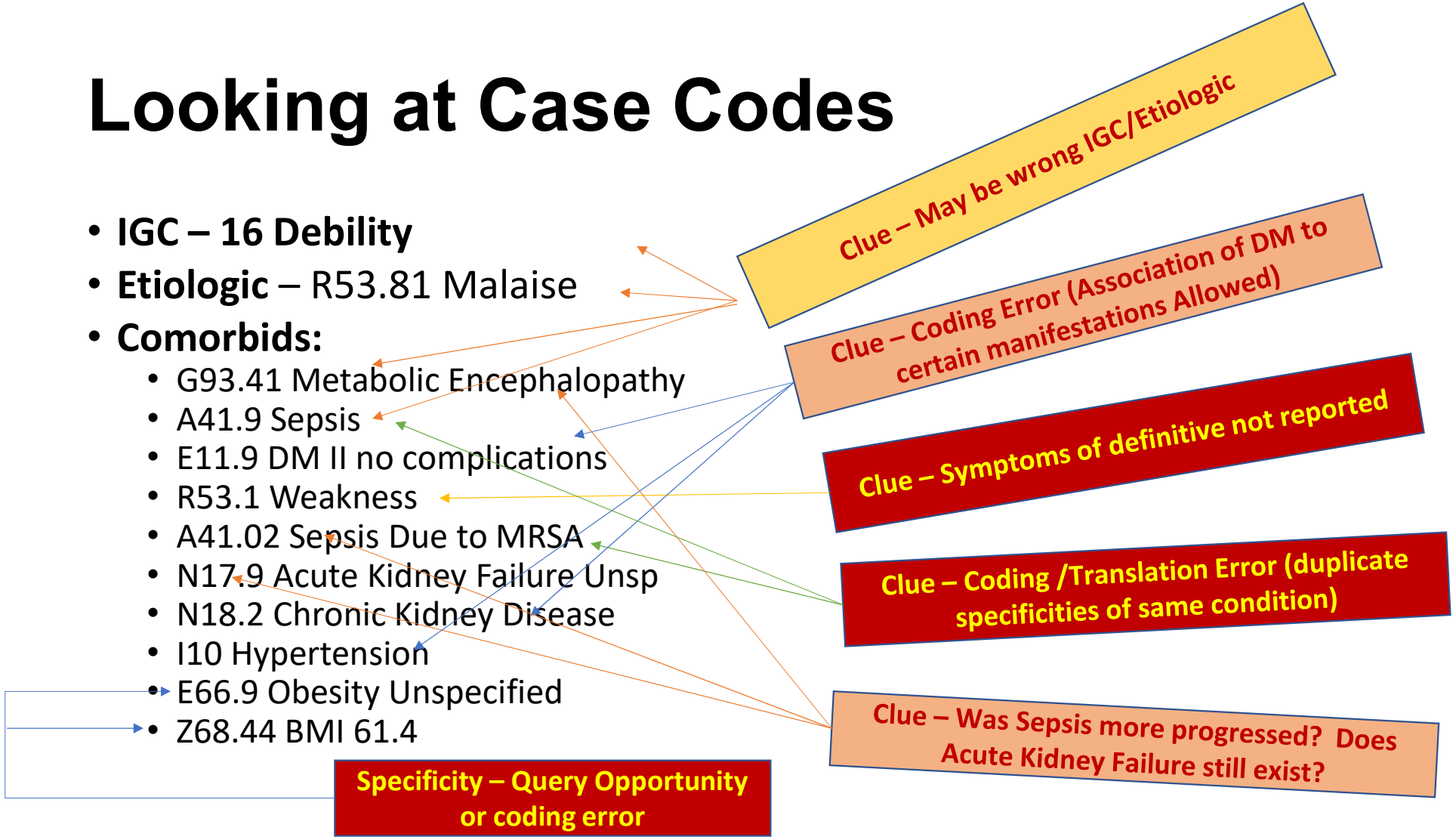
- BMI
- Depth of non-pressure chronic ulcers
- Pressure ulcer stage
- Coma scale
- NIHSS
- SDOH
- Laterality
- Blood alcohol level
- Underimmunization status

Begin Your Investigation: Start with the Claim and IRFPAI

- **Take in claim and IRFPAI from top to bottom**
  - Note important information:
    - *Dates of Service*
    - *D/C Status*
    - *Diagnosis Codes and POA Indicators*
    - *CMG*
    - *PPS Code*
- **Note Finding that Stick Out**
  - Codes that Look Incorrect or Incomplete
  - Potential Query Opportunities etc.

Looking at Case Codes

- **IGC – 16 Debility**
- **Etiologic** – R53.81 Malaise
- **Comorbids:**
  - G93.41 Metabolic Encephalopathy
  - A41.9 Sepsis
  - E11.9 DM II no complications
  - R53.1 Weakness
  - A41.02 Sepsis Due to MRSA
  - N17.9 Acute Kidney Failure Unsp
  - N18.2 Chronic Kidney Disease
  - I10 Hypertension
  - E66.9 Obesity Unspecified
  - Z68.44 BMI 61.4



Get into the Chart – Dig In

Putting It All Together

- Gather Your Resources
- Know the Guidelines and Payer Requirements
- Understand the Claim Form
- Understand how to Dissect Documentation
- Determine Claim Accuracy

Breakout

Create an Action Plan for Actionable Items

IRF Education Workplan

Department/Staff	Goals	Topics	Method Recommended
Executive Team	Create high level buy-in and support for education and training of staff and needed revisions to current practices, policies and procedures as necessary.	• IRF Reimbursement Overview and High level Who, What, When, Where, Why	• 1 Hour In Person/Online

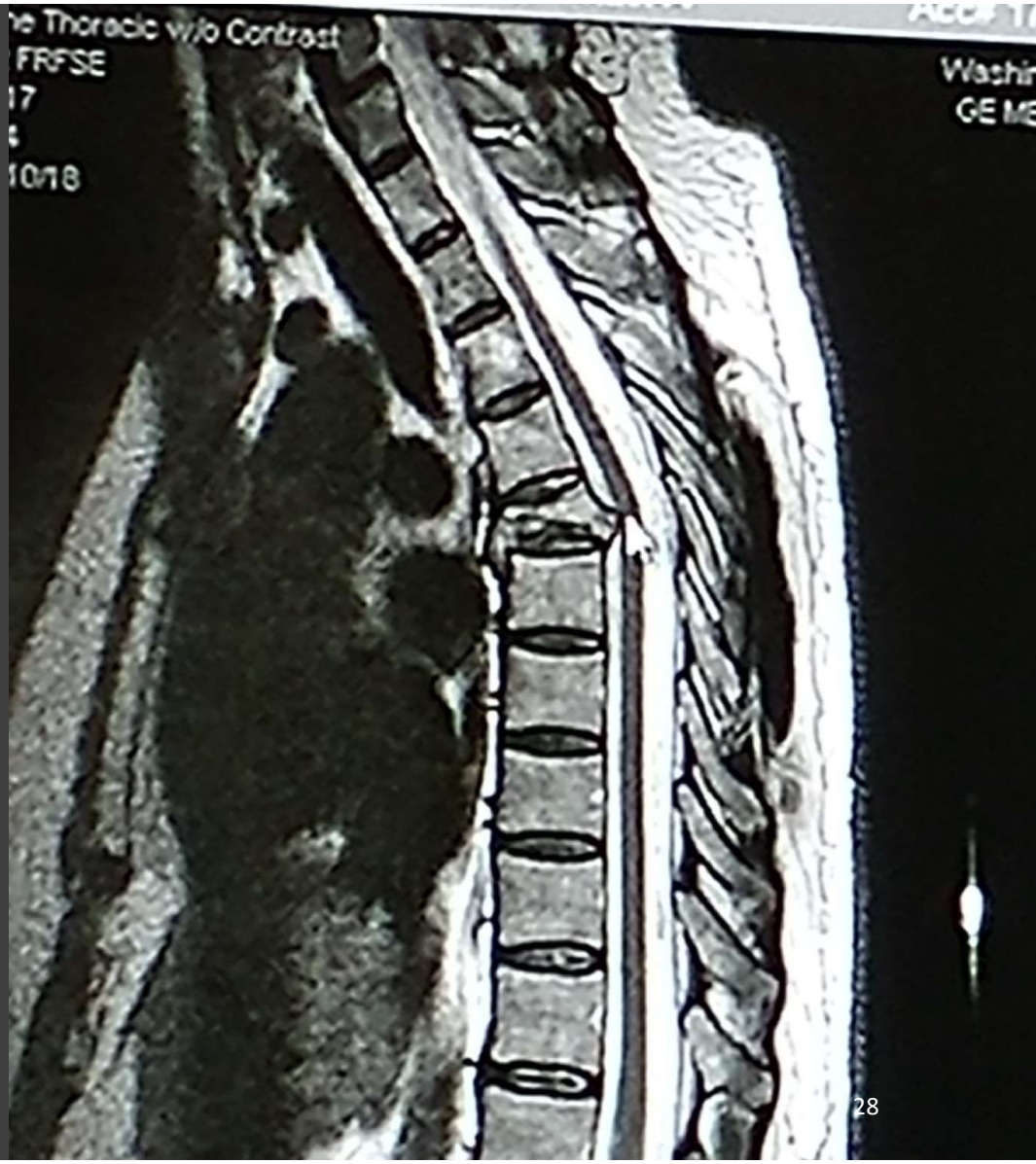
Admission Liaisons	Identify basics of coding and impact on payment for their role in the revenue cycle for IRF Services	• IRF Reimbursement Overview
		• The Perfect PAS
		  ○ IGC Selection
		  ○ Etiologic Selection
		  ○ 60% identification
		• Basics of ICD-10-CM Coding, how it works, why specificity, association of conditions and acquiring relevant
			• In Person or Web Based Interactive 4 hours with case practice & Q&A (can be 4-1 hour sessions if online)
			• Follow up/additional sessions as needed.
			• Mandatory Annual Training and ongoing new hire training (through web-based course) as needed.
			• Additional Action Steps could include:
			  ○ Track errors by individual.

Breakout

Let me tell you a story…..

Once upon a time…….

- Struck on head by tree limb (8ft long 6in diameter)
- Loss of Consciousness
- C7 Spinous Process Fracture
- T6 Burst Fracture
- Bilateral Orbit Fractures



Medical Record from Hospital 1 - ER

- **Nursing assessment** – patient was struck in the head with a falling limb with **loss of consciousness and AMS** immediately following. Patient fell to the left side landing on large rocks. Respiratory effort is regular, unlabored. Patient reports **shortness of breath and pain with respiration**. Patient complains of **pain in back and neck, shoulder and chest**. **Rash on clavicle and left arm and ecchymosis around orbits**. GCS equal 15. Trauma Score: 12, history of essential tremor gestational diabetes 29 years prior.
- **Tests** – CMP results slightly high C02 and BUN. CBC with high white count, low red count, high % neutrophils, low lymph%, high neutrophils. CT Chest, Abdomen and Pelvis, with contrast: results dependent atelectatic changes bilaterally and shallow inspiration. **T6 unstable burst fracture** 50-60% loss of height with retropulsion. **Left clavicle fracture without displacement**. CT C-Spine no fractures. ADDENDUM – **Fracture at C7 spinous process with 2mm separation** just distal to lamina. CT facial bones: **bilateral superior orbital wall fractures** and **right nasal fracture**. CT Brain – No hemorrhage, mass effect or fracture.
- **Physician note** - to ED via ground EMS with back and neck pain. **Tree limb 8 feet long by 6 inches in diameter fell on patient** knocked her to the ground **associated LOC**. Patient sustained **injury to head**, neck cervical collar in place, **upper back, chest, eyes**. Patient had a **fracture at C7** C collar left in place. Orientation is normal mentation is normal, moderately short of breath. Disposition: **laceration on head**, **fatigue fracture of vertebra**, **thoracic burst fracture at T6, fracture of orbital floor, supraorbital bilateral**, **C7 spinous process fracture, and acute pain due to trauma**. Patient will be transferred to larger hospital for higher level of care. Med Flight contacted. – Sunday June 11, 2017, 20:20

Medical Record Hospital 2 – ER - Inconsistencies

- **Physician note** - transfer from smaller hospital. Patient had very large tree branch fall on head **positive for LOC**. Trauma scan at previous hospital showing **bilateral supraorbital fractures, left clavicular fracture, C7 spinous process fracture and T6 burst fracture**. (other fractures/injuries?) Patient was **flown** from previous hospital for further evaluation. Hemodynamically stable complaining of **severe mid back pain**, shoulder and neck pain. **Symptoms are improving**. **History of gestational diabetes** and **central tremor**.

- Patient appears non-toxic, **pain-free**, **patient rates pain at 3**, oriented person place and time. Head exam normal **atraumatic** normocephalic. **Orbital edema and ecchymosis noted bilaterally**. Neck exam limited by cervical collar. **No maxillofacial trauma**, Back exam included **findings of normal inspection and range of motion**, tenderness in the mid back. **Upper and lower extremities normal** all other system normal. Case discussed with neurosurgeon recommended **keeping patient flat** and NPO admitted to trauma surgery service. **Unsteady gait**, GCS 15, no paresthesia's, weakness, or incontinence. **Respiratory effort shallow**. Patient on cardiac monitor. **Unstable burst fracture at T6, C7 spinous process fracture, clavicle fracture, supraorbital fractures bilateral**. Patient on backboard with the collar and Foley. **Active Diabetes**.

Sunday June 11, 2017, 22:17

Medical Record Hospital 2 – H&P

- H&P - **Unstable burst fracture (three column injury) at T6** with 50-60% loss of vertebral height, **C7 spinous process fracture, left clavicle fracture, supraorbital fractures bilateral**. Patient on backboard with the collar and Foley. She is able to move her feet and arms. Patient has history of **central tremor, cervical torticollis and gestational diabetes** twenty eight years ago. **Gait and station in normal limits**. Intact neuro exam. **Skin normal no evidence if lesions or rashes**. Admit for observation consult neurosurgery.
- NEUROSURGEON CONSULT – Cervical collar at all times. Tree branch fell on patient with **LOC < 30 min**. AAO x3, Patient moves all extremities denies paresthesia, full strength all extremities. **flat in the bed.** Left upper extremity in sling. Fusion scheduled for Tuesday.

Monday June 12, 2017, 15:10

Medical Record Hospital 2 - Notes

- ENT CONSULT – **zygomatic fractures bilaterally comprising the superior suture line. Fractures are non-displaced. Also bilateral orbital roof fractures worse on the left and somewhat displaced.** Give the absence of changes in vision, round pupils and absence of subconjunctival hemorrhage or swelling, there appears to be no actionable injury. Avoid direct pressure on the eyes for positioning for surgery.
- RADIOLOGY: **Nasal fracture; T6 3 column Burst fracture with retropulsion and ventral epidural hemorrhage, Bilateral T6 facet fractures, T4-T5 compression fractures, left clavicle fracture, bilateral orbital fractures zygomatic and orbital roof.** Patient fell out of tree.
- POST OP – **T4-T8 fusion. Posterior/Posteriorlateral**, Order CTLSO, back spasms, no numbness or weakness, JP drain in place, transfer patient to IRF.
- CHART REVIEW: **No signs and symptoms of dysphagia**. Consult ST if needed.

IRF H&P and PAS

- IMPRESSION:
  - **Traumatic Brain Injury with loss of consciousness for 130 minutes**
  - Spinal Cord Injury approx. T6 level
  - Diabetes Type 2
  - Dysphagia (oropharyngeal and pharyngeal)
  - Central Tumor
- IRF TEAM
  - For all 3 team conferences goals for ambulation and transfer state Mod Independent, however, patient did not use an assistive device throughout the entire stay.
  - Discharge home with home health, patient was discharged home with outpatient therapy services.

IRF Team

- 3 team conferences treatment focused on:
  - CTLSO donning and doffing
  - Wear sling , gait training
  - Mild Cognition
  - Modified Independent ambulation
  - Improve vocal intensity
  - Noted goals in some areas already met
- Cut/Paste notes – no story

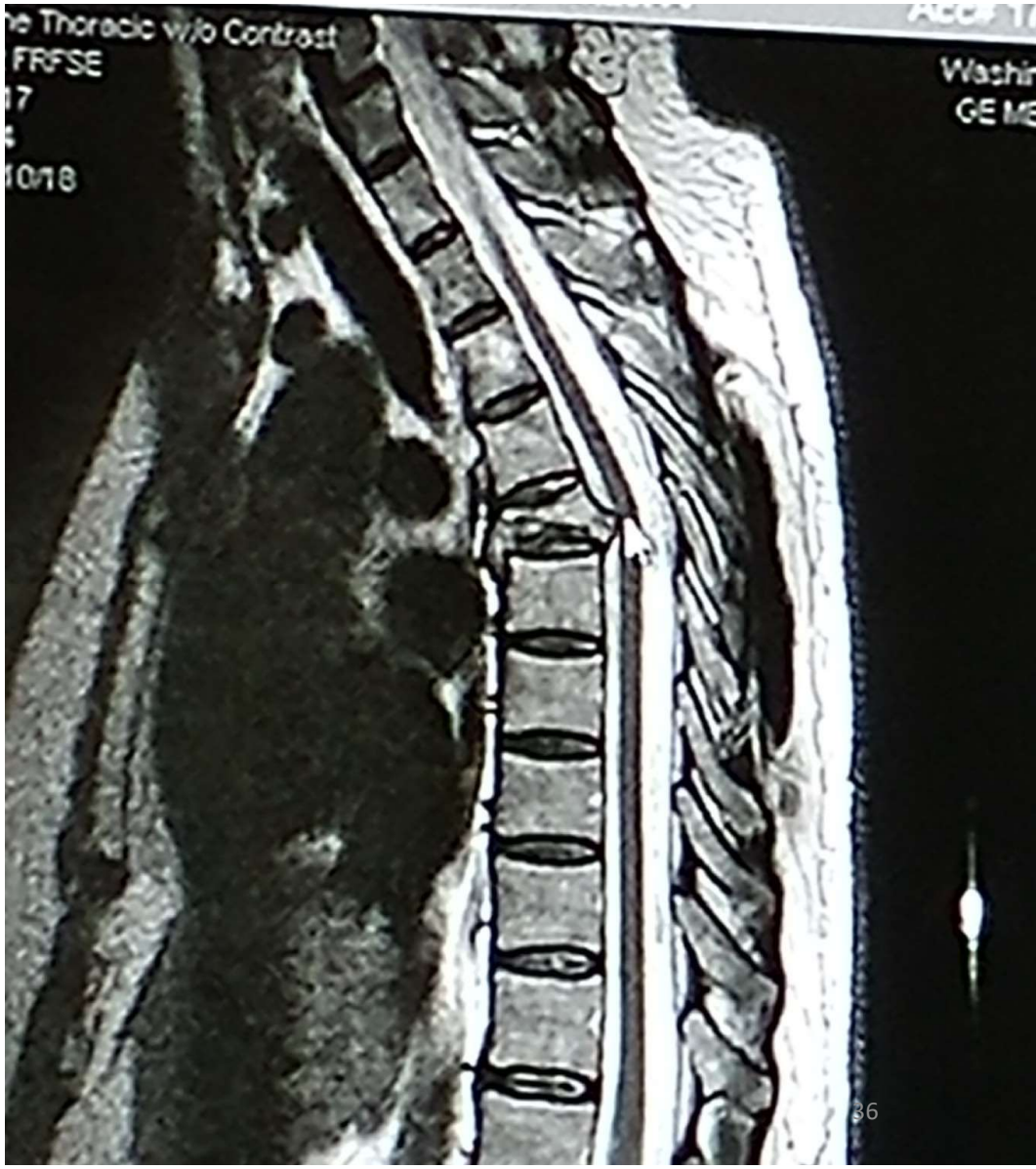
IRF Billing

- Admission IGC: 02.22 Traumatic Brain Injury
- Etiologic: Unspecified brain injury with LOC
- Changed to Traumatic Spine 04.230
- Etiologic: T6 Burst Fracture
- Comorbidities: Dysphagia; Diabetes with hyperglycemia; unspecified tumor; cervical torticollis; clavicle fracture, LOC (All fractures not reported and not documented by physician)

The REAL Story…

Once upon a time…….

- T6 3 column unstable Burst Fracture
- Concussion with Loss of Consciousness
- Head Laceration
- Bilateral Orbit Fractures zygomatic and orbital roof
- Nasal Fracture
- C7 Spinous Process and Laminar Fracture
- T4 and T5 Compression Fractures
- Left clavicle fracture
- Paravertebral Epidural Anterior Hemorrhage (MCC in initial encounter)
- Potential aspiration or atelectasis



Coding and CMG (IRF-PAI)

IGC 2.22 Closed Brain Injury

- Etiologic: Unsp TBI w/ LOC 6-24 hours (S06.9X4A)
- Fracture of skull and/or other facial bones, right (S02.81XA)
- (…, left (S02.82XA)

A0207 - $26,784

C0207 - $32,080

IGC 04.130 Traumatic Spine (Cord) Injury

- Etiologic 1: Unsp Cord Injury T2-T6 (S24.102A)
- Stable Burst Fx T5-T6 (S22.051A)

A0403 - $25,165

C0403 - $31,174

IGC 08.9 Other Orthopedic

- Etiologic: Unstable, T6 Burst Fx (S22.052A)

A0904 - $21,563

C0904 - $25,859

14.1 Brain + Cord or other 14.2, 14.3 w/Multiple Fractures

- Etiologic 1, 2: TBI Loss of Consciousness/Unstable T6 Burst Fx
- 14.9 other mult trauma

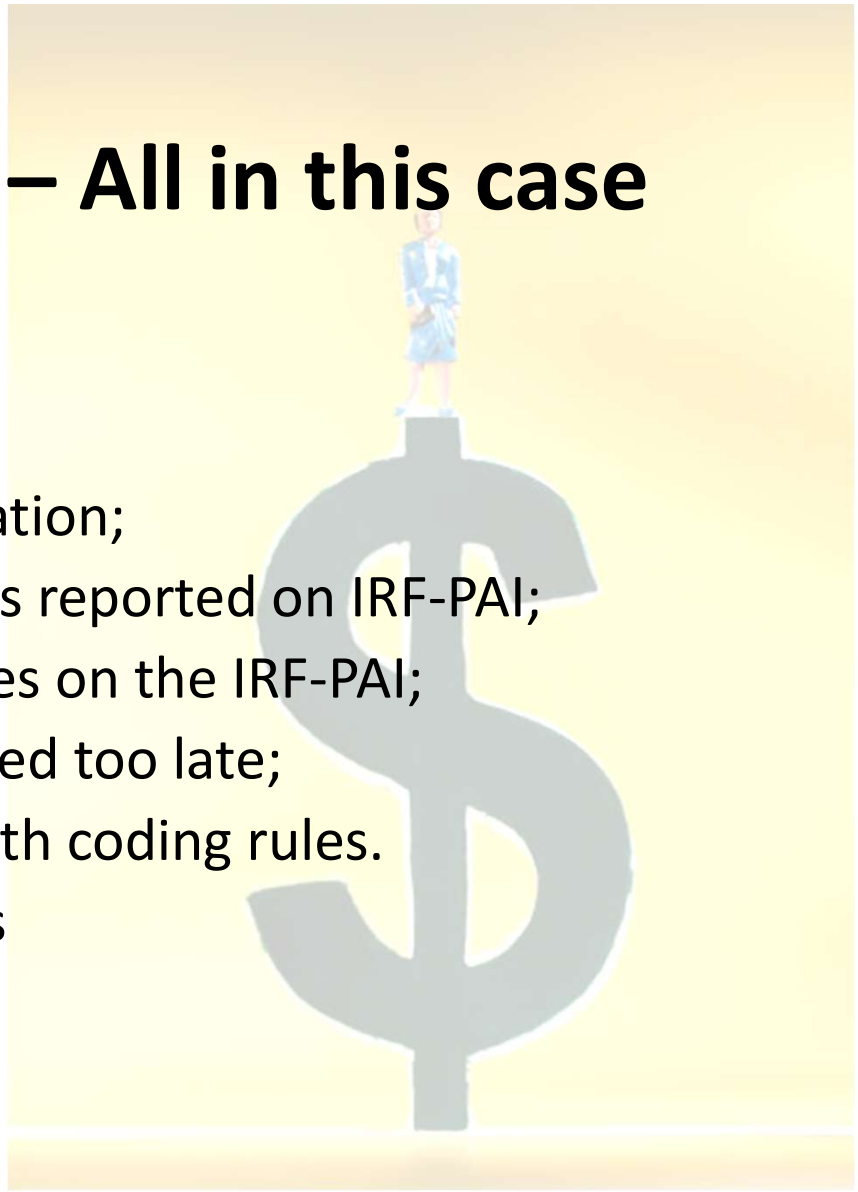
14.1,2,3 = A1803 - $29,085
14.9 = A1704 - $23,318

C1803 - $35,776
C1704 - $28,234

OVER VALUE $9,611

Top Audit Risk Areas – All in this case

- Incorrect IGC;
- Etiologic/IGC miss-match;
- Missed tier comorbids/complication;
- Incorrect specificity of diagnoses reported on IRF-PAI;
- Reporting unnecessary diagnoses on the IRF-PAI;
- Reporting conditions documented too late;
- Reporting codes inconsistent with coding rules.
- Ineffective processes, likely silos
- Education opportunities



Action Steps to Connect the Silos

- Evaluate processes to elicit open communication between staff/departments
- Clinical Documentation improvement
- Educate physicians on best practice documentation
- Educate coders/PPS Coordinators on
  - IGC Selection and Diagnosis capture

Have you used what you learned to assist or educate another?

Who in your organization have you identified you need to connect with and how do you expect it to impact the org?

What changes have you made or plan to make as a result of what you've learned?

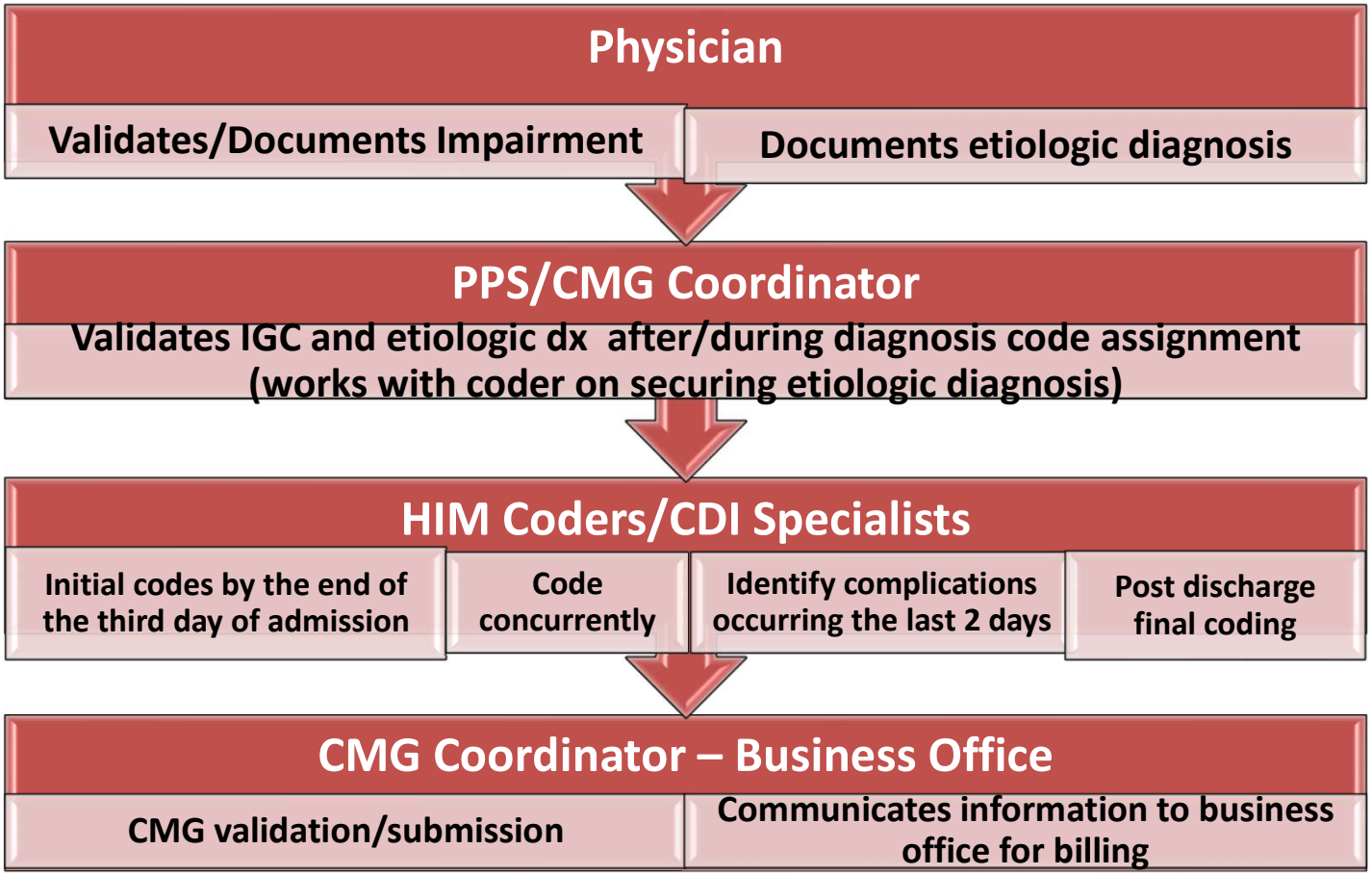
Best Practice: Steps to Take for Coding Accuracy

- Initial codes secured no later than day 3/beginning of day 4 of the admission
  - PPS/CMG Coordinator checks etiologic diagnosis without delay; if inaccurate, discussion ensues with coder
- **Continual** communication between the coder, the PPS/CMG Coordinator/Program Director, and rehab physician is optimal
- Utilize a Clinical Documentation Improvement Specialist (CDI Specialist)

Best Practice Processes

- Open Communication
  - Coders/CDI and IRFPAI/PPS Coordinator
  - Coders/CDI and Physician(s)
- Includes CDI and Concurrent Coding
- ALL should Understand the Rules
- Process for Identifying Conditions that do not belong in the IRF-PAI but DO go on the UB-04
- Process for coding appropriate specificity on each document.
- Process of validating Calculated vs billed CMG and Discharge Status.
- When Questions – Get Help – External Review/Education

Best Practice Processes



- **Institute CDI/Involve Coders – QUERY!**
- **Achieve Physician and HIM Buy-In**
  - Describe the process;
  - Involve them;
  - Tell them why it's important (SOI);
  - Share the tier list;
  - Associate to their reimbursement logic (i.e. what's needed for E/M);
  - Share documentation best practice examples;
  - Develop cues and prompts AND queries;
  - ***Tell them WHAT TO SAY – COMPLIANTLY!***
- **Enlist External Assistance when Necessary.**

- Code Concurrently;
- Start Team reviewing the list of captured diagnoses.
- Validate Your Process for code capture and translation to IRF-PAI.
- Stay on top of changes.
- Educate Staff CONTINUALLY!

Creating a Winning Strategy

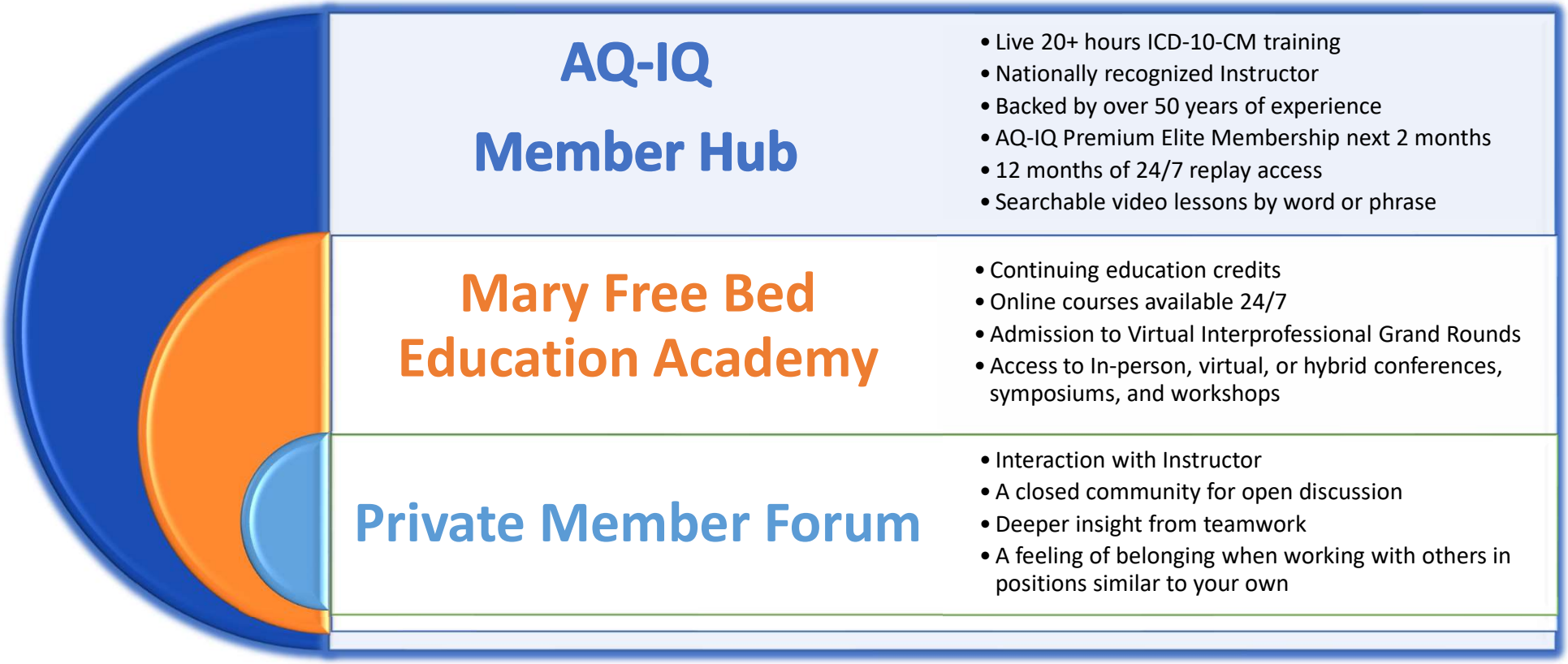
Teach	Teach your team ICD-10 in a nutshell
Understand	Understand the most risky IGCs and ensure your documentation supports their use
Analyze	Analyze processes and documentation to uncover appropriate tier opportunities
Determine	Determine the expected variances between the IRFPAI and the UB (uniform billing)

Have Questions?

Stay in the Group and Connected!

Who else needs to know this information first hand?

3 Resources Partnering for Your Success!



Session 10 Assignments

Go take your quiz for CE Credit at Mary Free Bed Academy

Post in the group ….Stay Connected

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Todays Speaker

Paula Digby, CCS, CDIP, CPC, AAPC Approved Instructor, AHIMA Approved ICD-10-CM/PCS Trainer

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