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Hospital offers incentives for identifying incorrect patient status

It's no secret that hospitals struggle with assigning the most appropriate status for patients, and this challenge is compounded by CMS' frequent changes to its regulations and guidance. To combat incorrect patient status assignments, one hospital has developed a system that rewards employees for speaking up when they suspect a patient's status is incorrect.

After an assessment of its HIM department, Montrose (Colorado) Memorial Hospital began an informal program focused on providing patient status education for physicians and engaging various departments throughout the revenue cycle in identifying whether a patient's status is correct.

The hospital had a long-standing problem with helping physicians understand how to correctly determine patient status throughout the patient's stay. For example, some providers would change a patient's status from inpatient to outpatient at the last minute if a patient seen for an inpatient-only procedure recovered quickly and could return home after one night, incorrectly assuming that a stay of one midnight—regardless of the procedure type—could not be an inpatient stay. This left other hospital staff members scrambling to change the patient's status back to inpatient or face a potential denial, says **Bev Roth, BSN,** case management director at Montrose Memorial Hospital.

"I tried education. I tried to pull in other departments to help," Roth says. "Case management was the lone outfielder trying to catch the fly ball before the patient went out the door."

As more and more providers began throwing up their hands, the hospital decided to take action by bringing HIM, case management, and other departments together to address the issue head on. Some departments felt that tracking patient status was not their responsibility, but Roth sought to ensure each department involved in the patient's care could help protect the correct status, thus ensuring the patient's insurance would be billed correctly and the hospital's claim filed appropriately. "How do you get over the hurdle of people feeling like that type of activity is not their job?" she says.

Roth began developing cheat sheets for physicians to help them differentiate between inpatient, inpatient-only, and outpatient stays. She also worked on educating the hospital's clinical counsel, which includes all of the directors who are directly or indirectly involved with patient care, on patient status. But because getting physicians to adhere to patient status regulations was an ongoing challenge, simple education would not be enough. For this reason, Roth focused on bringing together each department that worked with the medical record and training them to act as watchdogs, keeping an eye out for incorrect patient status assignments and changes.

The workgroup

The hospital established a workgroup that brings several departments (e.g., patient access, case management, HIM, utilization review [UR], coding, patient financial services, clinical documentation improvement) to the table and maps out how each one impacts patient status, says **Jane Bonewell, RHIT, CHDA,** senior consultant for the Haugen Consulting Group in Denver. For example, patient access would discuss the importance of patient status at pre-authorization, pre-registration, registration, and scheduling. This department is important because it follows the patient's journey from beginning to end, but so are departments like case management and UR, which follow the patient through the middle part of his or her journey, as well as HIM, which tracks the medical record, Bonewell says. If the patient's status isn't right from the beginning—often the point when patient access is involved—problems may arise down the line.

"As we all know, we can get all the way from patient access to patient financial services with the incorrect patient status," Bonewell says. "In order to circumvent that from happening and fixing things on the back end or before we drop the bill, we're trying to work through those middle pieces so that we can get it right by the time the patient is discharged."

As the workgroup walks through the patient journey together, each department often experiences "aha moments." Opening the lines of communication between the departments and allowing each to fully understand its

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role, as well as the role of others, can help people understand why their tasks are important not only for their own job, but also for others involved with the patient. "It's been a really good educational process," Bonewell says.

The reward system

Through the case management department, Montrose Memorial Hospital developed a strategy to reward staff members for bringing a possible incorrect status assignment to the attention of the UR staff.

"We created awareness. We did the education," Roth says. But what next? To incentivize the staff to bring incorrect patient status to light, the hospital opted to use gift cards to an on-site coffee shop.

"I really wasn't expecting a whole lot out of that. I didn't think necessarily a free coffee was going to be the big answer to the problem," Roth says. Although some departments were resistant, she decided to roll out the incentive for case managers. Other departments soon followed suit as she began making the rounds and striving to better understand how each department works with and understands patient status. After spotting an incorrect status, staff members can call a hotline that connects them with a UR staff member who is on call for that day. UR will then review the record for medical necessity to determine whether the status is correct.

Employees can also alert the UR staff when a patient should be transitioning to a different status, Bonewell says. For example, if a patient has transitioned from outpatient to inpatient but his or her medical record still reflects outpatient status, an employee can alert others to this discrepancy and be rewarded for his or her efforts.

Often, the UR director will speak with the provider after completing the record review and view the discussion as a clinical documentation improvement opportunity as well as a way to validate patient status. "It gives them the opportunity to have those face-to-face, difficult conversations with the provider," says Bonewell. "They're talking about options and what we can do to protect the patient and the facility." This face time with the provider is preferred over a phone call because it supplies more opportunities for education and communication. For example, if the patient's condition is not severe enough to warrant hospital-level care, this meeting time can allow UR and the physician to discuss options for transfers or homecare, or to reach out to the patient's family for exploration of other options.

Providers are encouraged to contact UR or case management for a status determination on their own cases, although the majority of cases are reported by the nursing staff. "It's turned into this competition among the staff, and some providers are encouraging their peers to take advantage of the program," Bonewell says.

Regardless of whether the person alerting UR to look into a case was right about a patient's status needing to be changed, he or she is still rewarded with a gift card, Bonewell says. If a provider is sitting on a unit or in a hospital lounge, the UR staff will often deliver the provider the coffee of his or her choice rather than presenting a gift card. This helps spur competition because the providers notice when their peers are rewarded. "They compete with each other for who is going to get their coffee delivered that morning," says Bonewell.

"It's an informal program, but everybody gets a big chuckle out of it when you bring the [gift] card by," Roth says.

While the competitive nature of the program has helped it gain awareness and encouraged providers and others to bring attention to incorrect patient status assignments, the real measure of success is that the program has led to changes in status that could have been problematic if not identified prior to discharge, Bonewell says. In addition, it heightens awareness of problems associated with incorrect patient status, educates hospital staff members on what each status means, and gives UR or other hospital staff members the opportunity to have conversations with providers.

Most importantly, it has aided the hospital in catching incorrect patient status early in a patient's stay. Getting the hospital's physician champion involved in the incentive program also helped with physician buy-in. "He really backed me up," Roth says.

With 75 inpatient beds, Montrose Memorial Hospital is smaller than some inpatient facilities, so it has been relatively easy to raise awareness about the workgroup and rewards program. However, Bonewell notes that Montrose's strategy could also take flight at larger facilities.

Analyzing trends

Roth says she is currently tracking the metrics for self-denials, although since Montrose Memorial Hospital is still focusing on education and communication, it's not yet at the point where it can use data from the program to analyze the effort's impact on patient status and denials.

A program such as this could be used to measure a hospital's denials and potentially avoid a high volume of denials further down the line. It could also help hospitals progress toward assigning the correct status or pinpoint the most common mistakes when assigning or changing patient status. When the program is more mature, the UR staff may be able to report statistics from the workgroup at section meetings. At the very least, the workgroup should be prepared to share statistics about the number of hotline calls and potential patient status errors at each of its meetings, Bonewell says.

Bonewell notes that Roth's initial goals were not just focused on getting patient status right at Montrose Memorial Hospital, but also offering staff and providers the education and tools to consider patients' needs after they leave the hospital. She admires Roth's commitment to better connect the hospital with the community to help patients tap into post-discharge resources.

"Where I see her going with this is something pretty unique that I haven't heard happen—and part of it is because it's a smaller community, but that's not to say you can't do that in a big city," Bonewell says. "There are so many resources out there that we never tap into that we can start to educate our providers on."

Roth agrees that connecting with staff and providers individually has made a difference. "This program really developed out of desperation. We had been unsuccessful previously to get buy-in on the importance of correct patient status. Taking the time to deliver a personal thank-you which rewarded them for being a patient advocate was the key," she says. "We now like to say we're changing the world, one cup of coffee at a time."

30th anniversary celebration

A legacy of HIM grows stronger

by Barbara Allen

So many people struggle early in their careers with finding a perfect fit for their talents and passion. My story is exactly the opposite. My entire family is in healthcare, so I chose my career quite naturally. Though I had a bit of a circuitous route into my final landing place, I cannot say I'm surprised to have landed here.

My parents had careers in healthcare, so I was exposed at a young age to patient care and the interworking of healthcare operations. You might say I was "raised up" in the industry. Although I received my bachelor's degree in business communications, my career quickly shifted back to my healthcare roots. I landed in HIM due to my stepmother's influence and passion for the industry. She exposed me to HIM departments, where I began working a variety of jobs throughout my high school and college years. It's interesting how life circles around since I am only now finding the time to attend my stepmother's alma mater, St. Scholastica, to get my master's degree in health information and informatics after spending an entire career in the industry.

Family introduction was the start

Just out of college, I was introduced to a national release of information (ROI) company through my family connections. The company was looking for someone to turn around its day-to-day operations in a challenging geography. This opportunity blended my business degree with my family background and exposure to the HIM industry. The rest is history.

After several years with the company, I was assigned to manage the Midwest region, which I consider home. Even during these early days in HIM, I was being groomed to manage a larger territory and national HIM service organization. I spent 15 years in this position until the company was sold to HealthPort, now CIOX Health, in 2008.

Regulatory and coding challenges test fortitude

I fondly think back over my journey and some of the challenges I faced early on. I've consistently used my experiences to motivate and educate young professionals

in our industry. Some of my most difficult challenges resulted in my greatest professional growth opportunities.

One challenge involved the changing regulatory climate. Early in the 1990s, industry regulation changed the healthcare landscape of ROI. At a young age, I lobbied senators and representatives in an effort to influence a regulatory climate that would be favorable to HIM. Though this was challenging work, the impact we made charted a course for the financial landscape of ROI. I had the opportunity to create a win-win situation in an adverse legislative climate.

In all the years since, little has changed in terms of industry stability—it's just different now. However, one thing I know is that in this space, you have to be flexible at all times. Now we are rightsizing in the face of ICD-10 and looking at adding value around analytics. The impact of technology, businesses processes, and legislation has not lessened in significance over the years.

The business of HIM

My advice to young professionals in our field would be to take business classes and concentrate on data trends in the healthcare industry. Work with physicians and finance departments, and master analytics around documentation, coding, denials, and reimbursements. Of course, your results will only be as good as your communication skills with people. Use these skills to bridge the gap in a data-driven healthcare ecosystem.

Our most successful professionals understand it's necessary to partner with all kinds of departments within the healthcare system. Prepare to work with as many different departments as possible and leverage a multitude of skill sets. This gives you a broad base of expertise and education on which to build solutions. Additionally, doing so sets the stage for moving up through the executive ranks.

Mentors for miles

Throughout my career, I have been fortunate to rely on a strong network of mentors. Now it is time to give back. I have mentored many people through my career who have grown to become leaders of HIM organizations. Mentoring is also excellent management experience. Growing my team, in the end, brings me the ultimate job satisfaction. I have worked through mergers and acquisitions and still grew teams by 150% because I was able to pull people together and unify them around a common goal.

The public, private, and nonprofit landscapes are all different. If I had gained a better understanding of these differences early on, it would have helped me in my career. So in seeking mentors, look for different people from different backgrounds—it will help prepare you for growth.

What HIM offers professionals

For me, the value of HIM peers is camaraderie. I saw this growing up with family members in HIM. Many of the people I met early in my career are still available to me for advice and perspective.

Because the HIM profession isn't huge, we glean information and move forward as a group. There is a unique passion for the industry that involves collaboration and support. HIM isn't competitive—it's about the industry successfully moving forward and embracing change.

I would love to see HIM professionals expand their footprint even more—moving beyond the walls of traditional HIM functions to serve areas like IT, finance, or quality. In doing so, we can widen the scope of our profession and make it more comprehensive.

As I look at my own family, I see a strong legacy of contributions to HIM. I hope my own contributions can help to push boundaries for those who follow me. My life in HIM is one I have cherished, and I wouldn't trade it for the world.

EDITOR'S NOTE
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Leadership lesson

My favorite leadership lesson involves teamwork. Back in 2004, we put together a group of executives who worked together as a team and challenged each other to solve problems. So often, these teams end up in territory battles and struggle to protect their own interests. But in this situation, competition was not the case. This team was totally unified. We rolled up our sleeves together and made things better. Working together with other people who have different points of view is how you learn and grow. This executive team impacted me so much that I'm highlighting it as my most important leadership lesson.

PSI 90's transformation into the Patient Safety and Adverse Events Composite

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

The fiscal year (FY) 2017 IPPS proposed rule alerted us to some major changes to Patient Safety Indicator (PSI) 90, including a new name: the Patient Safety and Adverse Events Composite. A fact sheet from the measure's owner, the Agency for Healthcare Research and Quality (AHRQ), looks at what may lie ahead if the rule is finalized.

Nothing new here

The underlying objective of this modified claims-based quality measure remains the same. The Patient Safety and Adverse Events Composite provides an overview of hospital-level quality as it relates to a set of potentially preventable hospital-related events associated with harmful outcomes for patients.

The measure will also continue to be included in CMS hospital pay-for-performance programs:

- The Hospital-Acquired Condition Reduction Program (HACRP) will adopt the measure in FY 2018
- The Hospital Value-Based Purchasing Program will adopt the measure in FY 2019 after the statutorily required one-year public posting of performance on CMS Hospital Compare under the Inpatient Quality Reporting Program
- PSI performance will still be assessed using an observed over expected ratio, and the risk adjustment methodology will remain the same, although comorbidity variables and coefficient weights will likely be refined

PSIs in the CMS composite will change

CMS has included eight PSIs in the composite used in hospital pay-for-performance programs:

- 3, pressure ulcer
- 6, iatrogenic pneumothorax
- 7, central line–associated bloodstream infection
- 8, postop hip fracture
- 12, preop pulmonary embolism or deep vein thrombosis
- 13, postop sepsis
- 14, postop wound dehiscence
- 15, accidental puncture/laceration

The modified measure will delete PSI 7 from the composite, citing duplication with other similar measures.

Three of the PSIs (8, 12, and 15) will be re-specified, which means that the types of patients included in the PSIs will be revised (see "Revised PSIs" on p. 6).

Revised PSIs

PSI	Current name	New name	Key change
8	Post-Operative Hip Fracture Rate	In-Hospital Fall with Hip Fracture	Targets all hip fractures from inpatient falls, not just postop hip fractures.
12	Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	Same	Removes "isolated calf vein DVT" from the numerator as these are more likely identified in clinical screening and typically clinically insignificant.
15	Accidental Puncture or Laceration Rate	Unrecognized Abdominopelvic Accidental/Puncture Laceration	Revises eligible discharges for inclusion in measure from medical and surgical discharges to surgical discharges with abdominopelvic procedures only. In addition, only counts these reported events as an outcome of interest if the patient was returned to the OR one or more days after the index procedure.

Source: Shannon Newell, RHIA, CCS.

Composite weights are revised

A new algorithm that considers both the volume of events and their probability of harm will be used. The graph below illustrates the proposed impact of each PSI's performance on the overall composite weight. PSI 15, which at present comprises half of the composite weight, is reduced to 0.82%!

Preparation challenges

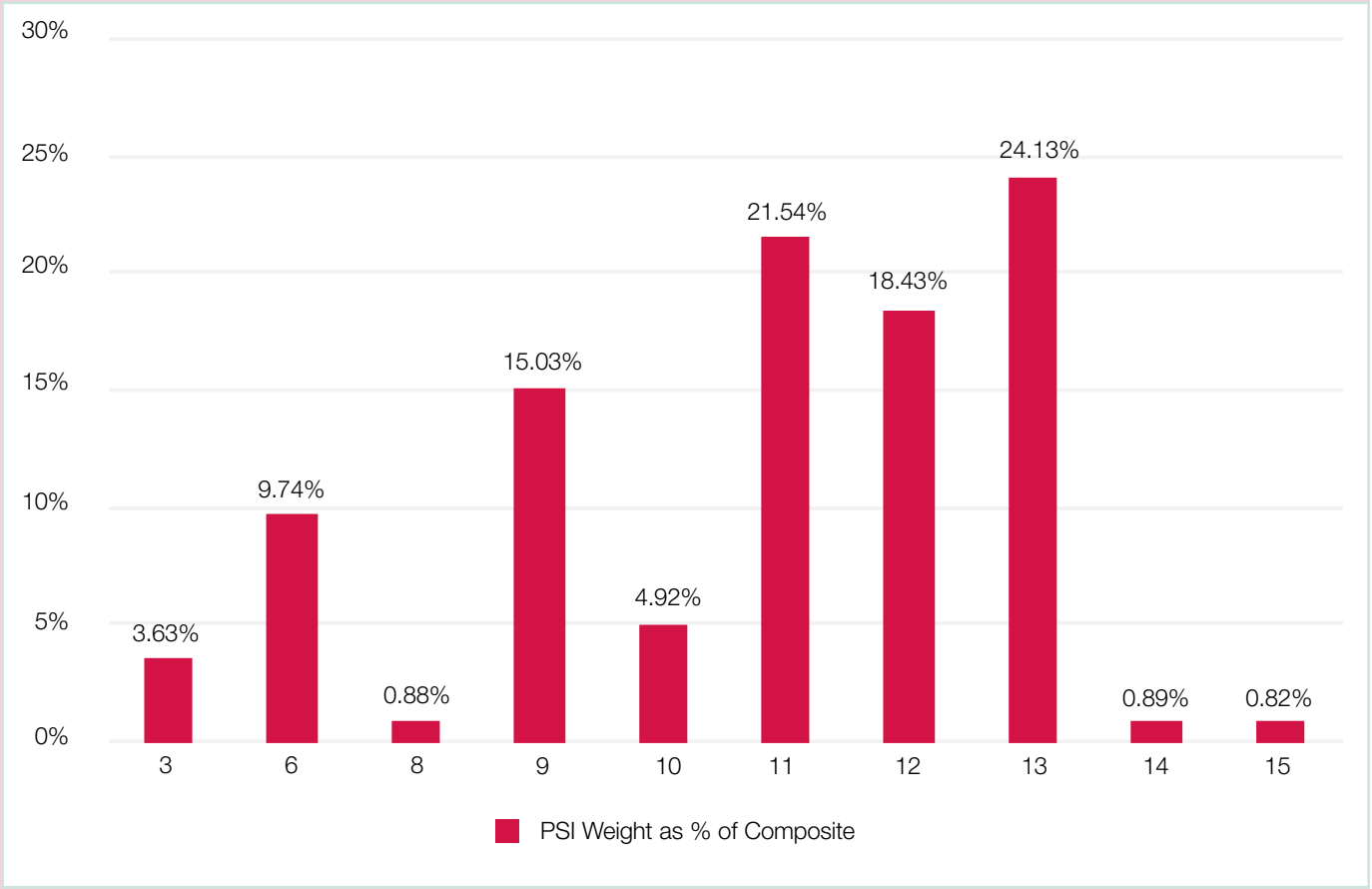
Although the HACRP will adopt this modified measure in FY 2018, performance will be based on today's discharges. Therefore, a review of the revised measure specifications and risk adjustment variables is encouraged. The challenge: The ICD-10-ready specifications for this modified version will not be ready until sometime this summer, and the risk adjustment variables are not anticipated to be ready until next year. AHRQ is evaluating ICD-10 data in its databases to finalize this information.

What to do in the interim?

In the meantime, we recommend the following:

- Continue to use the most recent measure specifications and risk adjustment variables used by CMS for the current PSI 90 cohorts
  - A close review of the ICD-10 drafts by your CDI program experts will likely identify ICD-9 to ICD-10 mappings that do not appear to support the intention of the measure
  - The current ICD-10-ready drafts are just that—drafts—and AHRQ acknowledges that they will likely be refined
- Review the most recent measure specifications for the proposed new cohorts (PSI 9, 10, and 11) to identify CDI risk areas

Modified PSI 90 composite weighting



Source: Shannon Newell, RHIA, CCS.

  - PSI 11, postoperative respiratory failure, has traditionally been a known CDI vulnerability
- Study the proposed re-specified measures to identify CDI opportunities
- Meet with the quality team and determine what version of measures they currently use to assess organizational performance and to get in sync on the versions impactful to CMS value-based outcomes
- Educate your CDI team and providers on PSI documentation needs, and tighten up operational processes to flag discharges that trigger the PSIs
- Don't forget that PSI 90 is a risk-adjusted measure; the capture of comorbidities for all discharges in the measure denominators is essential to reflect accurate performance

Summary

Strong performance in patient safety events has broad implications. Patient safety events have downstream cost and quality ramifications ranging from the cost to treat the safety event to readmissions and mortality. Data quality is an essential component to appropriate focus and measurement of patient care improvement efforts.

CDI programs that have already established the infrastructure to monitor and effectively impact claims-based quality measures are likely positioned well to navigate these changing waters. Additional information can be located at *www.qualityindicators.ahrq.gov/News/PSI90_Factsheet_FAQ.pdf* as well as *www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx*.

EDITOR'S NOTE
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Understanding clinical documentation reconciliation

by Jeannette Fox, MBA

Reconciliation is a noun meaning "the process of finding a way to make two different ideas, facts, etc. exist or be true at the same time." In the world of clinical documentation improvement (CDI), "reconciliation" typically refers to diagnosis-related group (DRG) reconciliation, which is the process of adjusting DRGs when those assigned by the CDI specialist do not match those assigned by the coder.

To understand why the reconciliation process occurs, you must understand the timing and assignment of DRGs by CDI and coders. CDI specialists (who are often clinicians rather than coders) may assign one or more DRGs during concurrent case review. After initially reviewing physician notes, tests, lab results, and other pertinent clinical documentation, the CDI specialist will assign an initial or working DRG. During the course of the patient stay, the CDI specialist may assign subsequent DRGs based on changes to the clinical documentation. These subsequent DRGs are often referred to as CDI DRGs, target DRGs, viable working DRGs, or query DRGs. When properly implemented, the concurrent review process results in a CDI DRG assignment that most accurately reflects the patient stay. The assignment of CDI DRGs is completed before discharge, while documentation is still subject to change. The last DRG recorded by the CDI specialist is typically used to calculate the financial impact of the CDI program for that case.

The assignment of the coder DRG is more straightforward. After discharge, and when all documentation has been completed, coders review the case and assign a final DRG.

Most CDI programs track the financial impact (both positive and negative) of their query efforts by quantifying the difference in relative weights between the working DRG and the CDI DRG. In order to calculate a financial impact, there must be at least one query, and

the CDI DRG assignment must agree with the final DRG.

For example, a patient is admitted with a peritoneal abscess and pneumonia. The CDI specialist identifies an opportunity to clarify whether the clinical indicators on admission indicate a potential diagnosis of sepsis and generates a concurrent query. The CDI specialist would assign:

- Initial/working DRG: 371—major gastrointestinal disorders and peritoneal infections with major complication or comorbidity (MCC) (relative weight = 1.7854)
- CDI Medicare-severity DRG (MS-DRG) 871—septicemia without Mechanical Vent 96+ hours with MCC (weight = 1.7926)

During the coding process, the inpatient coder identifies that the physician documented the diagnosis of "sepsis present on admission" as a result of the query. The coder would assign:

- Final MS-DRG: 871—septicemia without MV 96+ hours with MCC (relative weight = 1.7926)

Since the CDI DRG matches the final DRG, and the physician answered the query by documenting in the progress notes, this case would result in a financial impact. However, the final DRG does not always match the CDI DRG. There are many possible reasons for this:

- Documentation may be added that could affect the DRG assignment, but the CDI specialist is unable to conduct a follow-up review and update the DRG before discharge
- Appropriate coding guidelines are not taken into consideration when assigning the DRG
- Secondary diagnoses or procedures are overlooked
- Queries are pending or unanswered
- The principal diagnosis is assigned

Most CDI programs use an audit or review process to ensure the accuracy of DRG assignments. High DRG accuracy supports the validity of the CDI program and is key to the effectiveness of the query effort. However, it is equally important to accept that there can and will sometimes be discordance between the CDI DRG and the final DRG. As previously stated, often the two are mismatched because of the timing of the DRG assignments. CDI specialists are assigning DRGs during the course of the stay, when the documentation is still subject to change.

Given that DRG mismatches frequently occur, is there value in using a reconciliation process to resolve them? Absolutely! The reconciliation process involves a detailed review of the case by a CDI specialist and coder, or a CDI manager and coding manager, to determine if the documentation supports the assigned DRG. After the review, the CDI or the final DRG is adjusted to reflect agreed-upon coding conventions and code assignment. Reconciliation processes are ideal for identifying educational topics and documentation improvement opportunities that can be shared with CDI and coders. Reconciliation data can also help identify staff who may need extra oversight or education.

However, there are drawbacks to using a reconciliation process to rectify every DRG mismatch. Reconciliation is time-intensive, involving multiple staff members (CDI, coders, managers, and possibly CDI physician advisors). Time spent by CDI on reconciling cases reduces time that could be used to review concurrent cases. Since reconciliation is best completed before billing, cases identified for reconciliation are placed into a hold status, which could impact discharged not final billed. If the reconciliation process is not effectively managed, it could result in a breakdown in communication and trust between CDI and coders.

Keys to the success of a reconciliation process are:

- Determining when reconciliation should occur
  - Should reconciliation be completed when the case is coded, or bundled cases for review?
- Creating an effective workflow
  - How complicated is the workflow?
  - How often will the workflow be assessed to ensure its effectiveness?
  - Is the workflow standardized across the health system?
- Selecting appropriate cases for reconciliation
  - Should every case with a mismatched DRG be reconciled? Or should reconciliation be limited to cases with query responses or high dollar value?
- Identifying a qualified resource to manage and facilitate the process

  - Will the process be conducted using a collaborative/team approach? Or will one department have sole oversight of the process? Who will be responsible for the final decision if there is no agreement on DRG assignment?
- Using the outcome of the process for educational purposes to improve the accuracy of DRG assignment
  - Where will the results/outcomes of the process be stored? Will the information resulting from the process be shared timely with key staff and program stakeholders?

Implementing a clinical documentation reconciliation process can be an effective way to address DRG mismatches. Implemented correctly, the process can promote DRG accuracy and support accurate reporting of CDI financial impact. While there are many benefits to implementing a reconciliation process, CDI programs must also consider the time and oversight required to create and maintain it. Facilities and health systems should evaluate all the benefits and drawbacks to determine whether implementing a reconciliation process (or continuing to conduct an existing process) helps them meet their CDI program goals.

EDITOR'S NOTE
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HIPAA Q&A

Scheduling and confirming appointments

by Chris Simons, MS, RHIA

Q Can I leave a patient a voicemail about an MRI procedure, including the time and date? What should I do if someone else at the patient's home answers the phone? How much info can I leave with the other person, and how can I verify that person's identity and relation to the patient?

A This is a gray area for many reasons, not the least of which is that by leaving a specific message, you are telling whoever listens to that message where a patient will be and at what time. Many organizations will get written patient permission to leave information on voicemail. Failing that approach, I suggest a conservative one: Leave a message to remind the patient of the appointment and state the date and time, but don't say with whom or where. State that if there are any questions, the patient may call you at a call-back number.

With so many organizations adopting patient portals, this vexing problem may be solved. Portals will send reminders (some even through text messages) about upcoming appointments, and patients can restrict or allow access to others as they wish.

Q I went to a medical specialist office with a referral document from my primary care physician to schedule an appointment and was told I couldn't schedule it in person because HIPAA regulations didn't allow it—I had to make the appointment by telephone. Is this true? Which HIPAA regulation addresses this? What are the pros and cons for scheduling in person versus over the phone, and why might a facility elect not to schedule appointments in person?

A HIPAA is blamed for everything! I have no idea why any practice would prefer to make an appointment by phone rather than in person, unless perhaps the practice is using a reverse phone number lookup to identify you. If the practice's goal is to verify your identity, that can be done during an in-person visit by asking for a picture ID or a copy of your insurance card.

Q One of the physicians in our practice frequently speaks about patients in the hallway and even at the front desk, although she doesn't use patients' names. Should I be concerned?

A This is not a good idea. Others who do not need to know may recognize a story, if not the name, and piece together who the physician is talking about. Conversations about patients should not be held where they can be overheard, even if names are not used.

Q Is it a HIPAA violation to write patient information on whiteboards? Are there guidelines on what can and cannot be written on a whiteboard? Is there a difference in what can be written on a whiteboard in a patient's room versus an office or unit floor?

A Documenting on a whiteboard can be very helpful in providing care for a patient. However, you must be careful to adhere to the three basic HIPAA principles: minimum necessary, need to know, and minimal incidental disclosures. So a whiteboard in a patient room with certain needed information might be acceptable, whereas posting that same information at the nursing station where passersby might see it could be a violation. Perform a documented risk/benefit assessment of your practice and consider how you can minimize risk. For instance, can you use patients' initials or medical record numbers instead of names? Can you use a code for fall risk versus writing out the words "fall risk"? Is all that information on your whiteboard really necessary, or is some other alternative just as good? These are the questions you must answer when determining what may be written on a whiteboard.

EDITOR'S NOTE
Simons is the director of health information and privacy officer Maine General Medical Center in Augusta, Maine. Simons is also an **HIMB** advisory board member. This information does not constitute legal advice. Consult legal counsel for answers to specific privacy and security questions. Send your questions related to HIPAA compliance to Editor Jaclyn Fitzgerald at *jfitzgerald@hcpro.com.* Opinions expressed are that of the author and do not represent HCPro or ACDIS.

Q&A

Compliance with the NOTICE Act and MOON

Observation services are an ongoing point of confusion for hospitals and patients, many of whom have become fearful of out-of-pocket costs and SNF coverage eligibility associated with outpatient observation services. Developing a workflow to comply with the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act and the Medicare Outpatient Observation Notice (MOON) is essential and is intended to help hospitals ease patients' concerns by clearing up the implications of observation. As part of an overall strategy, hospitals must arm themselves with knowledge of the appropriate use and financial impact of the new observation C-APC and work to reduce observation costs.

Deborah K. Hale, CCS, CCDS, president and CEO of Administrative Consultant Service, LLC, in Shawnee, Oklahoma, answered the following questions about observation during HCPro's webcast "Observation Services: Focus on the NOTICE Act" *(http://hcmarketplace.com/observation-services-comply-with-the-notice-act)*.

Q Can we give the MOON form up front at the start of placement in observation and not wait until the 24-hour mark?

A I don't know that there is anything that says we can't do that, but in the instruction it says it is only given to patients who require more than 24 hours of observation care. So somewhere between that 24-hour and 36-hour window, it has to be given to the patient. It would seem to me that giving it at the point of admission would be the easiest thing to do, but the CMS instruction does not seem to apply that instruction.

Q Is the MOON notice required for patients in outpatient and a bed status, such as extended recovery?

A No. This is only for patients receiving observation services. It would seem to me that it would be the same, but remember the politics of this issue are primarily circulating around observation services.

Q How do you suggest we manage the need to give the MOON notice after 24 hours of care?

A That's going to be a challenge, and certainly you're going to have to be watching the clock, because you're counting for the 2-midnight rule based upon the time the patient began to receive outpatient services to determine when the patient needs to be admitted—you're also counting based on when the patient first began to receive observation services to determine

the number of hours to be billed. But when you're counting for the time frame to issue the MOON, you're counting from the date and time the physician gave the order to provide observation services. The 2-midnight rule is talking about midnights and the MOON is talking about hours, so we really have some conflicting time frames here that could be incredibly confusing. Don't get those three issues confused. You still want to count, not from the beginning of the order, but from the beginning of the service for your inpatient determinations. For the determination that a patient needs to receive a MOON, you start counting toward or at the time of the order.

First of all, you have to decide who is going to be responsible for issuing the notice and counting the various time requirements. Your electronic record may be able to alert you at 24 hours from the time of the observation order that the MOON must be given, and then perhaps it could also warn you when the 36-hour time period is about to expire and the MOON must be given if it has not already been. I think you're going to need some electronic notices, and if you're going to rely on the nursing, case management, or utilization review staff to issue these MOONs, then I recommend doing some role-play to ensure that they understand how and when to deliver the notice.

Q Is it mandated to use the CMS MOON notice, or can we construct our own notice?

A The MOON notice is the one that is mandated, although we are still waiting on the final version (as of presstime in June 2016). When we read the NOTICE law, it made it clear at that point that it would be CMS' responsibility to develop the format. I think that probably many of you could improve on it significantly, but this is what they're asking us to use.

Q Does CMS give examples or prescriptive language to use when giving the expected verbal explanation with the MOON to a patient?

A No, but as I read through the instructions for completing the MOON notice and the MOON notice itself, you could actually just give a verbal overview of what it says. I don't think you need to go into a lot of detail with a patient or the patient's family unless they raise issues.

Q If the MOON is not given before discharge, do we bill for a denial and indicate it was not given, or do we not bill it at all?

A We don't have an instruction. That's a good question, and I would have to say that I don't know what CMS is going to want us to do. It's just like the Important Message from Medicare (IMM). If we failed to give the IMM, we still would bill for an inpatient admission if the physician had written an inpatient order, so I think that the same would apply—but again, I don't know of anything that CMS has published that would say that we're not entitled to bill if we don't give the MOON within the required time frame.

Q Who is handing out the MOON notice in most hospitals? Would it be case managers, financial counselors, or nurses?

A I think that depends on the individual hospital, but due to the nature of the verbal explanation, I think that this might be a role for case management and utilization review. But if you don't have those staff members available every day, you need to determine who can issue the notice on weekends. I think every hospital has to make the decision for itself, but you've got to think about who is the most available and who is the most capable of delivering a patient-friendly, verbal notification and can explain the situation well.

Q When issuing a MOON in a critical access hospital (CAH), how do we explain the patient financial responsibility since we are not paid the observation set amount?

A CMS requires a 20% percent coinsurance amount due from the patient (or supplemental insurance) plus self-administered drugs when receiving observation services from a CAH. Also, remember that critical access is capped at 48 hours of observation; you cannot go beyond that. You might just want to give the patient an estimate based upon 24 hours, 36 hours, and 48 hours of what his or her copay would be at 20%.

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A supplement to **HIM Briefings**

AUGUST 2016

A Minute for the Medical Staff

Outpatient and inpatient diagnoses crucial to MACRA/MIPS success

Dear colleagues:

I'm sure that you're aware that CMS is transitioning physician reimbursement from a fee-for-service to a value-based (quality and cost-efficiency) payment system as it implements the Patient Protection and Affordable Care Act. While most of us still receive fee-for-service reimbursement today, CMS is implementing accountable care organizations, medical homes, bundled payments, and other challenges that will put our income at risk unless we meet the organization's stated and defined goals.

On April 27, CMS issued a notice of proposed rulemaking regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that will affect our traditional Medicare populations. This proposed rule implements financial incentives and penalties of +9% to -9% beginning in 2018 based on CMS' perception of our quality and cost-efficiency. Learn more at *http://tinyurl.com/MACRA-MIPS*. In this rule, CMS declared Hierarchical Condition Categories (HCC) as its risk-adjustment methodology measuring cost-efficiency.

Under the HCC model, some (but not all) ICD-10-CM codes submitted during a calendar year by qualified entities are assigned to 70 high-cost clinical conditions (each with similar disease characteristics and costs) to capture medical condition risk. From this, CMS determines the predicted cost of the patient population attributed to you and benchmarks it according to actual costs. If your costs are less than expected, then you're deemed cost-efficient; if they are higher than expected, then you're not.

Managing the expected costs, therefore, is crucial given that the government doesn't know that your patients have HCC-sensitive conditions unless you indicate this in your inpatient and outpatient diagnosis code submission. HCC capture is different than inpatient DRGs in that ICD-10-CM codes affecting HCCs span an entire calendar year and are attached to the patient, not to the encounter.

On January 1 of each year, no matter how sick your patients were last year, they have no HCC-related diseases unless you, other providers, or your hospitals submit HCC-sensitive ICD-10-CM codes in their billing. Nursing home, rehab center, home health, laboratory, or outpatient diagnostic center facility diagnosis codes do not count, which means that providers in these entities must report HCC-sensitive ICD-10-CM codes on their billings, not the facility (see *http://tinyurl.com/zprmxep*).

Coordination among all the specialties seeing the patient is crucial. Many accountable care organizations or independent practice associations monitor patient HCC scores to determine if documentation or coding improvement is needed. Many practices are making house calls to ensure that appropriate diagnoses are submitted, given that up to 12 diagnoses may be submitted during one encounter, such as a health maintenance exam.

A CMS list of HCC-pertinent ICD-10-CM codes is available at *http://tinyurl.com/hsuhdec*. SCAN Health Plan of California provides free online HCC training, available at *http://www.hccuniversity.com*. A HCC calculator using ICD-9-CM codes is available at *http://tinyurl.com/ScanHCCcalculator*.

When reporting HCC-pertinent ICD-10-CM codes, let's remember that outpatient and inpatient code reporting rules are different.

For outpatients, not only must the patient have the condition being reported, it must be explicitly documented in the medical record (not just on the encounter form) in the language that ICD-10-CM requires, and it must be shown to have required **M**onitoring, **E**valuation, **A**ssessment, or **T**reatment (MEAT). For example, while the ICD-10-CM code for acquired absence of the little toe is HCC-sensitive, I must list this diagnosis in the assessment of my SOAP note and indicate its stability or its need for assessment or treatment in order to submit its code.

For inpatients, coded conditions must be established as the reason for admission or one impacting length of stay, nursing time, evaluation, or treatment. If the condition is acute, it should optimally be documented three times: once when established, another to indicate its stability, and finally in the discharge summary.

Unlike outpatient diagnoses, inpatient facilities (not physicians) may code uncertain diagnoses (e.g., community-acquired pneumonia likely due to pneumococcus requiring ceftriaxone, troponin leak with ST segment changes suspected due to a NSTEMI) if documented at the time of discharge and reasonably supported by the clinical circumstances. Consequently, for coding purposes, the inpatient discharge summary is more important than the H&P in capturing HCC-sensitive conditions and severity.

Given that ICD-10-CM codes affect both the inpatient DRG and the physician's HCC scores, we must ensure our final diagnoses are properly defined and reported.

Inpatient conditions affecting HCCs include the following:

- **History versus presence of conditions.** In ICD-10-CM, the term "history of" means that the condition has resolved or it is not being treated. A patient documented to have a "history of diabetes" cannot be coded as diabetes, even if the diabetes is being treated. I must say that the patient has diabetes, what type it is (e.g., Type 2), and any related complications. In a similar vein, if an HCC-sensitive condition is controlled due to medications (e.g., amiodarone for atrial fibrillation, tamoxifen for breast cancer), stating that the patient has the condition (not a history of the condition) and that it is controlled allows for that condition to be reported even if the condition is not manifested.
- **Pneumonia.** In HCCs, pneumonia without a designated bacterial organism (e.g., community- or healthcare-associated pneumonia) accrues no HCC weight, whereas pneumonia documented on discharge as suspected to be due to a bacterial organism (e.g., pneumococcus requiring levofloxacin or ceftriaxone, MRSA requiring vancomycin, a multi-resistant Gram-negative rod requiring a carbepenam) does.
- **Stroke versus TIA.** Strokes impact HCCs, whereas transient ischemic attacks (which are not strokes) do not. Consequences of acute or old strokes, such as monoplegia, weakness of one side (hemiparesis), or weakness of all four extremities (quadriparesis) add weight if present and documented at least three times (e.g., present, improved, and/or resolved).
- **Bedridden status.** While coding bedridden status does not affect the HCC score, documentation of functional quadriplegia resulting in a bedridden state does. Functional quadriplegia is defined by the ICD-10-CM Table and *Official Guidelines* as lack of ability to use one's limbs *or* (not and) to ambulate due to extreme debility or severe physical disability, or its neurological causes (e.g., paraparesis, hemiparesis, quadriparesis).
- **Acute organ dysfunctions.** You will likely receive queries from your coding or clinical documentation improvement (CDI) staff regarding abnormal clinical indicators, such as elevated lactate (shock), creatinine (acute kidney injury) values, HCO3 levels reflecting metabolic acidosis, or abnormal sepsis-related organ failure assessment metrics associated with severe sepsis. Answering these affects the inpatient DRG as well as your HCC score.

With kind regards,

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EDITOR'S NOTE
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