E-BRIEF SERIES

AAPC

OIG Cracks Down on HCC Coding for Acute Stroke. Is Your Coding Accurate?

Jennifer Hill

CPC, CPMA, CRC Regional Director Audit Services

Laura Brink

RHIT, CRC Risk Auditors

Acute Life-threatening Conditions in Risk Adjustment

In the Risk Adjustment industry, experienced auditors and coders hear terms such as *Acute life-threatening conditions* and are instantly on high alert, looking for additional documentation to correctly capture these diagnoses. Stroke, embolism, heart attack (MI) and cancer all categorically have both higher risk and reimbursement throughout all HCC models for managing the care of enrollees. *Have you ever wondered what the impact would be if we coded them incorrectly?*

OIG Audit Impacts on Risk Adjustment

Recently, the Office of Inspector General (OIG) performed an audit on submitted acute stroke codes for the Ischemic and Unspecified Stroke category (HCC 100) for 582 enrollee transfers who transitioned from traditional Medicare to a Medicare Advantage plan in the 2014-2015 service year. Of these, 580 enrollees' submitted codes were incorrect and resulted in an overpayment of $14.4 million to Medicare Advantage Organizations (MAO) in the 2015-2016 payment year. Using submission data from the service year, CMS' current process is to analyze submitted HCCs, and issue payments to MAOs for the next payment year. Several flaws can be identified in this audit process:

- The Medicare Administrative Contractors (MACs) review submitted claims based on a fee-for-service model between providers and CMS. Therefore, diagnosis coding is not fully reviewed for accuracy.

- If MAOs request the transfer enrollee documentation from CMS or providers, it is often difficult to receive the entire record. Subsequently, organizations cannot fully validate the HCCs being paid for the enrollee.

Go on the Offense!

Now that the OIG has identified where the errors occur in physician coding and CMS policies and procedures, where does this leave coders and auditors? Often, the best line of defense is a good offense, or in the world of Risk Adjustment: prospective auditing.

The best way to educate providers on proper documentation is to know your guidelines. Acute life-threatening conditions should be approached differently and are dependent on the place of service. The two guidelines (below) break down handling unconfirmed diagnoses in both inpatient and outpatient settings.

In the inpatient setting, the main priority and focus for the provider is to treat the emergent symptoms of the patient and review all differential diagnoses and treatment options available — to stabilize the patient. Within the inpatient setting, the discharge summary is the best documentation to review for risk adjustment. It specifies all conditions that were ruled out where the provider still applied work effort. Additionally, the discharge summary outlines next steps for the provider to treat the patient in the outpatient setting.

From an outpatient perspective, the patient is returning to the office for a hospital follow-up where they previously had a stroke. In this scenario, we should approach with caution and dig deep within the note to find proof the stroke is still active. According to the OIG audit, they found within 99% of the cases, the active strokes were proven not to be current. Per the ICD 10-CM guideline:

- **Section 2.H** states: If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis. Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

- **Section 4.H** states Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," "compatible with," "consistent with," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. Please note: This differs from the coding practices used by short-term, acute care, long-term care, and psychiatric hospitals.

Looking deeper into the acute stroke codes, we find options for late effects, residual damage done by the stroke. Sometimes these sequelas are temporary, including foot drops and unilateral paralysis. However, in many cases the damage is permanent. Frequently, orders for speech or physical therapy, durable medical equipment, such as wheelchairs or walkers, to aid the patient with activities of daily living can be found in the medical record documentation. It is important to read the documentation thoroughly for an overall idea of the patient's condition and their status.

- ICD 10-CM guideline **Section I.C.9.d.1** states: Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits, that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

Find Your Gaps and Tailor Your Provider Education

As risk adjustment coders and auditors, we have the skills and knowledge to identify these areas of risk and correct trends in provider coding and documentation. When looking at focused areas of your physician's coding, look for:

- Uncertain diagnoses coded as confirmed
- Patient presents with life-threatening signs and systems and rushed emergently to the hospital
- Post discharge coding of resolved diagnoses as current in the office setting
- "History of" or sequela

These tips should not only be considered when looking at acute strokes but should also include all acute diagnoses coinciding with a high Risk Adjustment Factor or RAF score, impacting revenue and the long-term integrity of Medicare funds. The guidelines and audit processes surrounding acute strokes can be observed with other acute life-threatening conditions. To identify documentation pitfalls, proactive broad-range audits that include other high-risk conditions should be conducted regularly by knowledgeable risk auditors. For example, discover which acute rheumatoid arthritis codes have the greatest area of opportunity for your facility and focus provider education in this area. Additionally, it is important to develop policies and procedures to continue focused audits — and maintain compliance for these high-risk areas.

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As risk adjustment coders and auditors, we must put our detective hats on and dive into the documentation, allowing us to capture the most accurate picture of risk for the patient pre- and post-discharge from the hospital. Additional areas of risk that could be featured within the scope of an audit include:

Embolism

Providers and coders often capture embolism codes as current when patients are being monitored for long-term medications or having routine ultrasounds. Unless the provider has confirmed the diagnosis within the visit as actively having an embolism and is not referring the patient for diagnostic testing or to a specialist, a coder should code to the signs and symptoms of the condition. As another example, when a patient presents for a hospital follow-up, there is proof the embolism was evacuated during the hospital stay, and the patient is now on maintenance drug therapy, it would be appropriate to code the historical code instead.

Myocardial Infarction

Our ICD-10-CM guidelines give specific instructions on when it is appropriate to code active MI codes. To summarize **Section I.C.9.e.1** – Acute Myocardial Infarction:

- There is a 4-week time frame where it is still appropriate to capture an active MI code. We must look to the date the patient first had the MI and to the current encounter for code distinction.
- If the patient recently had an MI but is outside the 4-week time frame, then the default code would be I25.2 for an Old (healed) MI.

Cancer

There are several ICD-10-CM guidelines that address the correct coding concepts for cancer:

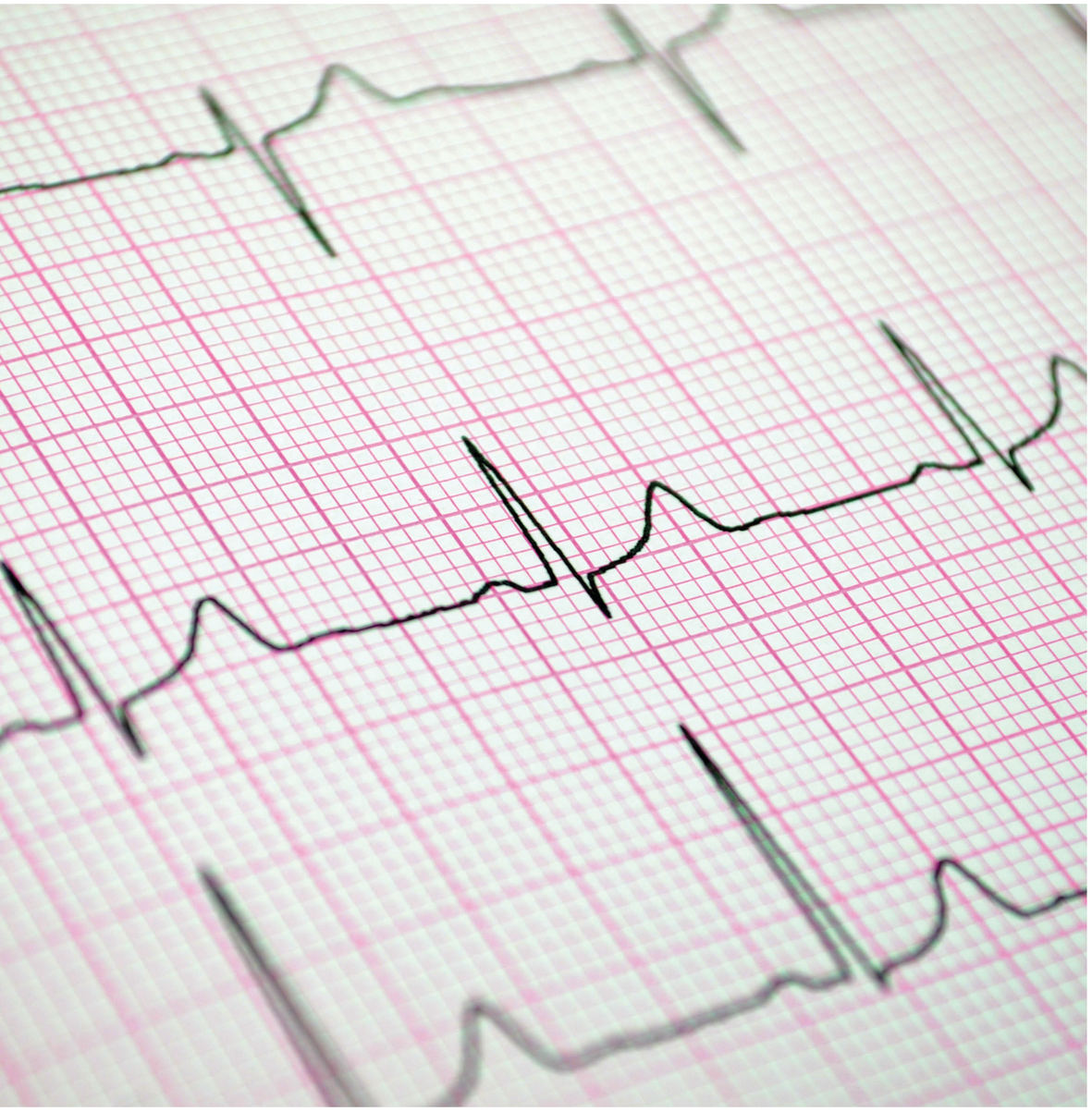
- **Section I.C.2.d** – Primary malignancy previously excised – specifies when we have full removal of the cancer, and there is no further treatment directed towards the site then we should capture a Z85. – historical code.
- **Section I.C.2.m** – Current malignancy versus personal history of malignancy – further specifies that once the malignancy has been excised but the patient is still receiving treatment, which includes medication, chemotherapy, radiation, or future surgery, it is appropriate to continue to capture the active code.

Concept Scenarios:

- A patient having a routine PSA but has been treated with radiation and is not currently on any medication, is not enough documentation to capture the cancer as current.
- A female patient having a routine mammogram to monitor for recurrence would not be captured as a current cancer.

As a risk auditor, I ask myself several questions when coding cancer:

- Has the cancer been removed?
- Was there any chemotherapy or radiation?
- When was the chemotherapy or radiation completed?
- Is the patient still on anti-neoplastic medication such as Lupron or Tamoxifen?
- Is the provider developing a treatment plan?



Is it Current?

When deciding whether to code conditions as current or historical, we must ask ourselves the following questions: Is the patient showing active signs and symptoms of these conditions? What is the place of service? Is the diagnosis definitive or unconfirmed?

Don’t fall into the documentation gaps and caverns that frequently accompany these acute, life-threatening conditions. Get in front of your facility’s documentation and provider education. If you are uncertain where to start, look to third-party vendors for support with proven audit processes to ensure an accurate picture of risk for compliance and reimbursement. The time to start is not when you’re neck deep in a RADV or MAO audit; at that point, it will be too late.

Resources:

www.cms.gov

https://oig.hhs.gov/oas/reports/region7/71701176.pdf

Codify by AAPC https://www.aapc.com/codes/all_coding_tools/home

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