2 and 10

Newman.James@mayo.edu
Admissions
Forsoth yea/we do all suche folke in take
That do aske lodgyng for our lordes sake
And in dede it is our custome and vse
Somtyme to take in/and some to refuse.
Accepted

- Old people
- Poore women in childbed
- Men sore wounded by great Vyoience
- Eaten with pokes and pestylence
- Honest fouls in great poverty
- Maimed soudyours

Denied

- Mylchers
- Hedge Creepers
- Vagabonds
The Pennsylvania Hospital  1752

Rules and Regulations- Credentialing, admission guidelines and of course, fund raising
# Utilization Data

**ABSTRACT of Cases admitted into the Pennsylvania Hospital, from the Eleventh of the Second Month, 1752, to the Twenty-seventh of the Fourth Month, 1754.**

<table>
<thead>
<tr>
<th>Illness</th>
<th>Admitted</th>
<th>Cured</th>
<th>Relieved</th>
<th>Irreg. Behaviour</th>
<th>Incurable</th>
<th>Taken away by their Friend</th>
<th>Dead</th>
<th>Remaining</th>
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<tbody>
<tr>
<td>Cancer</td>
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**Total:** 117  60  11  5  7  10  10  16

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<th>Cured</th>
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<th>Irreg. Behaviour</th>
<th>Incurable</th>
<th>Taken away by their Friend</th>
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<th>Remaining</th>
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</tbody>
</table>

- Admitted
- Cured
- Relieved
- Irreg. Behaviour
- Incurable
- Taken away by family
- Dead
The Pennsylvania Hospital- Admit Criteria

• Patient must be deemed “curable” (except Lunatiks)
• Must require the particular conveniences of the hospital (severity of illness)
• No infectious distempers (ie smallpox or itch) unless proper apartments available (isolation beds)
• Women may not bring their children
• Must be resident of the city
• Out of town patients- pre-approval by managers
• Security deposit to cover discharge costs or burial
Washington D.C. 1965
Types of “admissions”

• Bedded outpatient
• Bedded outpatient overnight
• Observation
• Inpatient
Why do patients dislike OBS?

- Paid under Part B, so patient responsible for a percentage of bill
- Routine medications paid for by patient (at hospital rates)
- No qualifying days towards post-acute care
- “My doctor says I’m admitted”
RISE IN OBSERVATION SERVICES

By Zhanlian Feng, Brad Wright, and Vincent Mor

Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences

ABSTRACT When it is not clear that an ill patient needs to be hospitalized, he or she may be placed “under observation” in a hospital for further evaluation and short-term treatment. These hospital observation services, often a kind of halfway point between emergency department treatment and full inpatient admission, have become a hotly debated policy issue and subject of lawsuits. Using Medicare enrollment and claims data nationwide, we documented a rising trend in the prevalence and duration of hospital observation services in the fee-for-service Medicare population during 2007–09, accompanied by a downward shift in inpatient admissions. As a result, the ratio of observation stays to inpatient admissions increased 34 percent, from an average of 86.9 observation stay events per 1,000 inpatient admissions per month in 2007 to 116.6 in 2009. Medicare beneficiaries were increasingly subjected to hospital observation care and treated as outpatients instead of inpatients, which can expose them to greater out-of-pocket expenses if they are eventually admitted to skilled nursing facilities. Additionally, the nearly one million beneficiaries receiving observation services each year were, on average, being held in observation for a longer period of time per episode—some for longer than seventy-two hours. The prevalence of observation services varied greatly across geographic regions and hospitals. This may be an unintended consequence of Medicare payment policies designed to constrain hospital admissions. Additional research is needed to pinpoint the drivers and consequences of this phenomenon, as is more clarity in clinical practice and Medicare policy guidelines regarding observation care.
IPPS 2014

“Day is night, and night is day”
The First IPPS
Inpatient Prospective Payment System

1983

• Established the DRG system
Why New Requirements?

• Reduce long observation stays
  – Patients hate OBS
  – Abuse of OBS
    • Gaming the payment system
    • Avoiding readmission penalty

• Reduce one day inpatient stays
  – Deals with abuse especially in surgery
  – Audit focus
Inpatient Is A Three Legged Stool (Until January 2015....)

• Medical Necessity
• Admit Order
• Certification
When is a one day stay OK?

• Inpatient only list
• Patient expires
• Well documented change in plan
• Unexpected recovery
Condition Code 44

• Patient is inpatient but really should have been Observation
• Can be changed back to OBS with a modifier to bill- Condition Code 44
• Must occur prior to discharge and must be ordered by provider
• Patient must be notified
The Good

• Can resubmit inpatient as outpatient (Part A to Part B)
• Definition of inpatient as “2 Midnights” (MN)
• Easier conversion of OBS to inpatient.
• A MN in ED or OBS, or in a transferring facility counts as 1 MN of the 2
The Bad

• MN in ED or OBS counts towards 2 MN inpatient but not to 3 MN for SNF
• Conversion from OBS to INPT will take accurate and specific documentation and ordering
• Day 20 recertification
The UGLY...

• Only a provider with admitting privileges can write the admission status order Residents (and in some locations NPPAs) do not have this privilege

• Custodial admit is still OBS

• Admit order MUST be signed prior to discharge
20 day recert. Policy from CMS

10.4 - Inpatient Hospital Services Certification and Recertification (Rev. 1, 09-11-02)

A certification or recertification statement must contain the following information:

- An adequate written record of the reason for either;
  - Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or
  - Special or unusual services for cost outlier cases for hospitals under the prospective payment system (PPS);
- The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and
- Any plans for posthospital care.
**Admission Status**

<table>
<thead>
<tr>
<th>Status</th>
<th>Code/Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient-Staying</td>
<td>Perfect</td>
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<tr>
<td>Inpatient-Leaving</td>
<td>CC-44</td>
</tr>
<tr>
<td>OBS-Staying</td>
<td>Convert to Inpatient</td>
</tr>
<tr>
<td>OBS-Leaving</td>
<td>Perfect</td>
</tr>
</tbody>
</table>

- This patient requires Inpatient Care because...
- Plan of Care...
- Admit Note if started OBS- refer to component in OBS note if done and Bill the IH code!
Case Examples for discussion

• An 88 year old patient falls and is admitted. No fracture. No family acetaminophen only
• An 88 year old falls and breaks their hip
• An 88 year old with DM, PVD and BKA falls and breaks their humerus non-operative.
• An 88 year old falls and has pelvic pain, no fracture on XRAY. Family and patient want to go home. CT next am shows non operative insufficiency fracture. PT says unsafe for discharge
Case Examples for discussion

• An 88 year old patient falls and is admitted. No fracture. No family acetaminophen only OBS
• An 88 year old falls and breaks their hip Inpatient
• An 88 year old with DM, PVD and BKA falls and breaks their humerus non-operative. Depends
• An 88 year old falls and has pelvic pain, no fracture on XRAY. Family and patient want to go home. CT next am shows non operative insufficiency fracture. PT says unsafe for discharge Custodial
Why should we care...death by Acronym
Why do we have RACs?
Top 8 Federal Programs with Improper Payments 2007

- $2.5 B Old Age Survivors' Insurance Unemployment Insurance
- $1.8 B Food Stamp Program
- $1.4 B National School Lunch Program
- $4.1 B Supplemental Security Income
- $12.9 B Medicaid
- $11.4 B Earned Income Tax Credit
- $10.8 B Medicare
- $6.7 B Other

Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.
Medicare receives over 1.2 billion claims per year.
This equates to:
- 4.5 million claims per work day

*2008 Error Rate for FFS decreased from 3.9% to 3.6% and CMS estimates to have saved over $400 million in the last FY
The wise man builds his house on the rock
Documentation
William Farr (1807-1883)

- General Register Office of England and Wales
- First Medical Statistician 1837

“Each disease has, in many instances, been denoted by three or four terms, and each term has been applied to as many different diseases: vague, inconvenient names have been employed, or complications have been registered instead of primary diseases.”
Jacques Bertillon (1851-1922)

- Chief of Statistical Services of the City of Paris
- The Bertillon Classification of Causes of Death
- August 1900, the first International Conference for the Revision of the Bertillon (International List of Causes of Death)
What does this have to do with anything?
W61.33 Pecked by a Chicken
Bitten by a Cow W55.21

That is an Udder lie!
I DON'T ALWAYS GET SUCKED INTO A JET ENGINE

BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD
True Fact?

- Bitten by a tiger \( \text{T26.78XV} \)
- Armadillo Exposure \( \text{A33.43YZ} \)
- Struck by and Orca- \( \text{W56.22XA} \)
- Contact with a Macaw \( \text{W61.19XS} \)
- Pedestrian on roller skates injured in a collision with three-wheeled motor vehicle \( \text{V02.91XA} \)
- Drowning and submersion due to jumping from burning kayak \( \text{V90.26XS} \)
- Somnolence due to conference attendance \( \text{ZZZ.ZZZ.ZZZ} \)
Red’s not real...

- Bitten by a tiger T26.78XV
- Armadillo Exposure A33.43YZ
- Struck by and Orca- W56.22XA
- Contact with a Macaw W61.19XS
- Pedestrian on roller skates injured in a collision with three-wheeled motor vehicle V02.91XA
- Drowning and submersion due to jumping from burning kayak V90.26XS
- Somnolence due to conference attendance ZZZ.ZZZ.ZZZ
ICD-10 find your code..

Yup, these codes are real

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>ICD-10 CODE DESCRIPTION</th>
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<td>W61.32XA</td>
<td>Struck by chicken, initial encounter</td>
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<td>W61.32XD</td>
<td>Struck by chicken, subsequent encounter</td>
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<tr>
<td>W61.32XS</td>
<td>Struck by chicken, sequela</td>
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<tr>
<td>W61.33XA</td>
<td>Pecked by chicken, initial encounter</td>
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<tr>
<td>W61.33XD</td>
<td>Pecked by chicken, subsequent encounter</td>
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<td>W61.33XS</td>
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<tr>
<td>Y92.72</td>
<td>Chicken coop as the place of occurrence of the external cause</td>
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</table>
What is ICD-10?

• ICD = International Classification of Diseases
• A global health information standard
  – Used to identify health trends and statistics
  – Used to define and report diseases and health conditions
  – Allows worldwide comparison and sharing of health information using common language
What is ICD-10?

- New ICD-10 codes replace ICD-9 sets now used
- Code-omegaly!
- ICD-10 codes provide more detail for diagnoses and procedures
  - ICD-10-CM: Codes used to describe patient diagnoses increasing from 14,000 to 70,000
  - ICD-10-PCS: Codes used for inpatient procedures increasing from 3,800 to 70,000
Provider documentation should indicate mild, moderate, severe, intermittent or persistent

Problem List Term:
Asthma Acute Exacerbation

OR

Problem List Term:
Asthma Mild Intermittent With Acute Exacerbation
ICD-9 code: 493.92
ICD-10 code: J45.21

OR

Problem List Term:
Asthma Mild Persistent With Acute Exacerbation
ICD-9 code: 493.92
ICD-10 code: J45.31

OR

Problem List Term:
Asthma Moderate Persistent With Acute Exacerbation
ICD-9 code: 493.92
ICD-10 code: J45.41

OR

Problem List Term:
Asthma Severe Persistent With Acute Exacerbation
ICD-9 code: 493.92
ICD-10 code: J45.51

Diagnosis code changes – Problem List
It ain’t just Asthma
Bill and Ted
HPI: SOB, fever

PMH: Pancreatic CA s/p recent chemo, hospitalized 2 months ago for cellulitis.

Exam:
T 38.9, RR 30, Pulse Ox 80 on RA,
Pulm: tachypneic, coarse breath sounds R middle lobe

Labs:

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MCV 84.2
Principal Diagnosis
Community Acquired Pneumonia
Secondary Diagnosis
Hypoxia
Anemia
Hyponatremia

Placed on Pipercillin/Tazobactam, Levafluxacin, Vanco
Slowly improves.
D/c to home after 7 days.

Principal Diagnosis
Healthcare Associated Pneumonia due to suspected gram negative organism
Secondary Diagnosis
Acute Hypoxic Respiratory Failure
Pancytopenia due to chemotherapy
Hyponatremia
Placed on Pipercillin/Tazobactam, Levafloxacin, Vanco
Slowly improves.
D/C to home after 7 days

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<th>Principal Diagnosis</th>
<th>ICD-10 Code</th>
<th>MCC/CC</th>
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<td>E87.1</td>
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</tbody>
</table>

DRG 194 Simple Pneumonia
RW: 0.9688
AMLOS 4.5 days
$7,121

<table>
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<tr>
<th>Principal Diagnosis</th>
<th>ICD-10 Code</th>
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<td>Healthcare Associated Pneumonia due to suspected gram negative organism</td>
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<td>Secondary Diagnosis</td>
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<td>Acute Hypoxic Respiratory Failure</td>
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<td>MCC</td>
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<td>Pancytopenia due to chemotherapy</td>
<td>D61.810</td>
<td>MCC</td>
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<tr>
<td>Hyponatremia</td>
<td>E87.1</td>
<td>CC</td>
</tr>
</tbody>
</table>

DRG 177 Respiratory Infection with MCC
RW 1.9492
AMLOS 7.7 days
$15,940
Assigning Severity of Illness and Risk of Mortality

• All ICD-10 codes are run through an encoder.
  – Principal diagnosis
  – Severity of Illness score:
    • The extent of physiologic decompensation or organ system loss of function
    • Scale 1-4
  – Risk of Mortality
    • The likelihood of dying
    • Scale 1-4
Placed on Pipercilliin/Tazobactam, Levafloxacin, Vanco
Slowly improves.
D/C to home after 7 days

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>SOI</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Acquired Pneumonia</td>
<td>P</td>
<td>P</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxia</td>
</tr>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Hyponatremia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>SOI</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Associated Pneumonia due to suspected gram negative organism</td>
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</table>

<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
<th>SOI</th>
<th>ROM</th>
</tr>
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<tbody>
<tr>
<td>Acute Hypoxic Respiratory Failure</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pancytopenia due to chemotherapy</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>DRG</td>
<td>194</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
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</tr>
</tbody>
</table>
| ICD-10 Codes | J15.9  
|        | R09.02   |
|        | D64.9     |
|        | E87.1     |
| Actual LOS | 7 days |
| SOI / ROM | 2 / 1    |
| AMLOS   | 4.5 days  |

<table>
<thead>
<tr>
<th>DRG</th>
<th>177</th>
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</thead>
</table>
| ICD-10 Codes | J15.6  
<p>|        | J96.21    |
|        | D61.810   |
|        | E87.1     |
| Actual LOS | 7 days |
| SOI / ROM | 3 / 3    |
| AMLOS   | 7.7 days  |</p>
<table>
<thead>
<tr>
<th>DRG</th>
<th>194</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Codes</td>
<td>J15.9  &lt;br&gt; R09.02  &lt;br&gt; D64.9  &lt;br&gt; E87.1</td>
</tr>
<tr>
<td>Actual LOS</td>
<td>7 days</td>
</tr>
<tr>
<td>SOI / ROM</td>
<td>2 / 1</td>
</tr>
<tr>
<td>AMLOS</td>
<td>4.5 days</td>
</tr>
</tbody>
</table>

**Quality Measure Reporting**

- **Medicare**
  - Hospital Inpatient Quality Reporting (IQR)
    - Hospital Compare
  - Readmission Measure
  - Mortality Measures
  - VBP
- **Physician and Hospital Profiling**
  - Healthgrades
  - US News and World Report
Bill and Ted Today!!
A word from JAHCO on Copy and Paste

Quick Safety
An advisory on safety & quality issues

Issue 10 February 2015

Preventing copy-and-paste errors in EHRs

Issue:
The use of the copy-and-paste function (CPF) in health care provider’s clinical documentation is increasing as the adoption of Electronic Health Records (EHR) has accelerated in response to national incentive programs. The widespread use of the CPF by providers in the inpatient setting has already been documented in medical literature. While the practice of duplicating information within the same patient record or moving it across multiple records can foster prompt communication, improve efficiencies and, most importantly, increase time spent with patients, these benefits must be weighed against the potential risks to the integrity of the medical record. The risks include:

- Copying and pasting inaccurate or outdated information
- Redundant information in the EHR, which makes it difficult to identify the current information
- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
Assessment and Plan

- Acute Active
- Acute Resolved
- Chronic
- Hospital Care Issues
A word from JAHCO on Copy and Paste

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- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
ICD-10 Impact

• **Affects**
  – Healthcare billing
  – Reimbursement
  – Quality Reporting
  – Research

• **Accommodates**
  – New conditions
  – Technology changes
  – Specificity changes (laterality, etc)
A word from JAHCO on Copy and Paste

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- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
Why Should I Care What is Documented?

• Patient deserves an accurate and complete medical record
• Translates into excellent patient care
• Reflects complex medical and surgical decision making
• Impacts reimbursement
• Impacts our 30 day readmission penalty
• Impacts patient acuity scores
Terms to Know

*Principal Diagnosis*: determines the Medical DRG

“The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

– Fever ≠ Peritonitis ≠ Sepsis
– Always POA
Terms to Know

• **Secondary Diagnoses: refines the DRG**

• “Additional conditions (either present on admission or occurring during admission) that require clinical evaluation or therapeutic treatment or diagnostic procedures or extended length of hospital stay or increased nursing care and/or monitoring.”

  – CKD ≠ CKD 3 ≠ CKD 3 due to type 2 DM
  – Impacts severity of illness and risk of mortality
You need it

*Acuity & Anatomy*

*Laterality*

*Link To Cause*

in ICD-10
Acuity

• Acute
• Chronic
• Acute on Chronic
• Intermittent
• Recurrent

Examples:

– Acute on chronic systolic heart failure
– Acute kidney injury due to ATN secondary to contrast exposure
– Chronic hypoxic respiratory failure due to end-stage COPD on continuous home oxygen

Assume if acuity is not documented, will default to chronic
Anatomy

• Site of disease or manifestation

  – *CVA due to right MCA embolism*

  – *Left lower lobe aspiration pneumonia*

  – *Acute sigmoid diverticulitis*

  – *Chronic left proximal femur osteomyelitis*

  – *Sacral pressure ulcer stage 4 POA*
Laterality

• Include left, right, bilateral, multiple locations

  – *Bilateral inguinal hernias*

  – *Right open oblique radius fracture due to trauma, Gustillo Type IIIA*

  – *Cellulitis left upper arm due to streptococcus*

  – *Acute left lower quadrant pain, suspect diverticulitis without complications*

  – *Chronic idiopathic gout, multiple sites with tophi*
Link To Cause

- Sepsis due to peritonitis
- Ileostomy infection secondary to cellulitis of the abdominal wall due to staph
- Diabetic nephropathy
- Acute kidney injury due to acute tubular necrosis
- Metabolic encephalopathy due to severe hyponatremia
- Acute hypoxic respiratory failure secondary to aspiration pneumonia

Avoid using “with concern for” and “at risk for” to link
• Generalized peritonitis secondary to infected abdominal mesh

• *Staphylococcus* UTI due to indwelling Foley catheter

• *Sepsis due to PICC line staphylococcus infection*
Crohn’s Disease / Ulcerative Colitis / Diverticulitis

• Acuity
  • Acute
  • Chronic
  • Acute on chronic

• Location of bowel involvement

• With
  • Abscess (document site)
  • Bleeding (rectal)
  • Fistula (document type)
  • Obstruction (intestinal)
  • Perforation (document site)
Asthma

• **Acuity**
  – Intermittent
  – Mild Persistent
  – Moderate Persistent
  – Severe Persistent

• **Severity**
  – Status Asthmaticus
  – Exacerbation
  – Uncomplicated
Pneumonia

• HCAP and CAP code to “pneumonia unspecified”.

• More specific:
  – Pseudomonas Pneumonia
  – Gram negative or suspected gram negative pneumonia
  – Aspiration pneumonia secondary to dysphagia
  – Viral Pneumonia secondary to RSV

• Be specific in order to support the use of “broad spectrum” antibiotics and other resources.

• Document all contributing causes of PNA
Sepsis / SIRS

• SIRS = SIRS Criteria + documented non-infectious source
  – SIRS secondary to chemotherapy

• Sepsis = SIRS Criteria + documented infectious source
  – “Sepsis secondary to suspected gram negative pneumonia”

• Do not document “urosepsis”
  – ICD-9 = UTI
  – ICD-10 = No code for urosepsis
Shock

- Document type
  - Hypovolemic
  - Hemorrhagic
  - Septic
  - Cardiogenic

- Documentation of hypotension, tachycardia, hypovolemia, decreased urine output, IV fluid boluses, albumin, CVP monitoring.

- What are you treating?

- “Soft pressures” can not be coded.
Respiratory Failure

• Severity
  – Acute
  – Chronic (ON Home 02 = Chronic!)
  – Acute on chronic

• Type
  – Hypoxic
  – Hypercapnic
  – Both

• Without “acute” defaults to chronic

• Example: Acute on chronic hypoxic respiratory failure
Heart Failure

• Acuity
  – Acute, chronic, or acute on chronic

• Type
  – Systolic, diastolic, combined systolic-diastolic

Example:
Acute on chronic combined systolic and diastolic heart failure

GOOD NEWS!; HFpEF is BACK !!

NOTE: dysfunction / insufficiency cannot be coded to failure (cardiac, renal, respiratory)
Renal Failure

- Renal “insufficiency” classifies to a nonspecific kidney disorder.
- “Acute kidney injury” or “acute renal failure” should be considered when the following are noted:
  - Rise in serum Cr at least 0.3 mg despite rehydration over 6-8 hours, or
  - UO less than 0.5 mL/kg/h for 6 hours (adults)
- Document the specific pathology of acute renal failure when known or suspected:
  - Acute tubular necrosis
  - Acute cortical necrosis
  - Acute interstitial nephritis

Documentation should identify the underlying cause, such as sepsis or dehydration, and should clarify any associated drug or toxic agent.
Renal Failure Continued

- Avoid the use of “acute on chronic kidney disease” because there is no ICD term for “acute kidney disease.”
- Document acute and chronic diagnoses separately or clearly differentiate each condition when combined.
- Examples:
  - “Acute kidney injury on chronic kidney disease, stage 3.”
  - “Acute kidney injury due to ATN on chronic kidney disease stage 3 due to hypertension.”
Encephalopathy

• “Encephalopathy” is the diagnosis that best describes a reversible alteration in mental status due to toxic or metabolic changes.

• Document
  – Cause: infection, sepsis, electrolyte imbalance, dehydration, acidosis, organ failure, drugs, poisons, toxins or hypoxia
  – Type: hepatic, toxic metabolic, hypertensive, etc

• From a coding perspective, the diagnosis of Delirium is best reserved for psychiatric conditions that are unrelated to the underlying systemic conditions.

• Altered Mental Status is classified as a non-specific symptom and the resources utilized go unrecognized.
Malnutrition (ASPEN Criteria)

• When documenting malnutrition, include the following information:
  
  – The **type** of malnutrition (e.g. protein-energy/calorie, kwashiorkor, marasmus)
  – The **severity** (mild, moderate or severe)
  – The **cause** (e.g. due to gastrointestinal surgery, disease, neglect, another cause)
  – Other **associated conditions** such as cachexia, failure to thrive, underweight or morbid obesity including BMI

• Please review the Nutrition Services Evaluation regarding the type and severity of malnutrition. Coders cannot code from the nutrition evaluation or notes because the diagnosis has to be documented by the provider.
Diabetes

• Type
  – Type 1
  – Type 2

• Due to underlying condition
  – Pancreatitis
  – Cushing’s syndrome

• Drug or chemical induced
  – Specify drug or chemical
  – Adverse reaction or poisoning
Diabetes Continued

• Body system **manifestations** related to diabetes
  – Diabetic nephropathy, retinopathy, neuropathy

• **Specific complications**
  – Hypoglycemia/Hyperglycemia
  – Peripheral vascular disease
  – Macular degeneration
  – Chronic kidney disease (document stage)
  – Foot ulcer

• **Default**
  – If type of diabetes is not specified, defaults to Type 2
Atrial Fibrillation

- Paroxysmal: terminates within 7 days
- Persistent: >7 days and subject to a rhythm control strategy to attain or maintain NSR
- Long-standing Persistent: >12 months duration and being treated
- Chronic (Permanent): NSR cannot be sustained, attempts to control ceased
- History of: in the past but now NSR and taking no medication to maintain NSR

2014 AHA/ACC/HRS Guidelines
<table>
<thead>
<tr>
<th><strong>2014 AHA/ACC/HRS Atrial Fibrillation Guideline</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paroxysmal AF</strong>*</td>
</tr>
<tr>
<td><strong>Persistent AF</strong></td>
</tr>
<tr>
<td><strong>Long-standing persistent AF</strong></td>
</tr>
<tr>
<td><strong>Permanent AF</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Paroxysmal AF is defined as recurrent AF (≥2 episodes) that terminates spontaneously within 7 days. Episodes of AF of ≤ 48 hours’ duration that are terminated with electrical or pharmacologic cardioversion should also be classified as paroxysmal AF episodes (2012 HRS/EHRA/ECAS).*
Patient Noncompliance with Medical Treatment

• Diet
• Hemodialysis
• *Underdosing* of Medications
  – Financial hardship
  – Age-related debility
  – Other
• Treatment
• Follow-up care

*This diagnosis is important to document because it can contribute to the reason for readmission*
Give It A Diagnosis

- PVR=800cc  Replace Foley: Urinary retention
- Bump in Cr to 1.5 , 1.0 yesterday: Acute kidney injury
- Chronic ab pain with cont narcotics (Norco, methadone) Pain consult: Narcotic dependence, continuous
- Replete K for 3.0: Hypokalemia
- Multiorgan failure: Acute hypoxic/hypercarbic respiratory failure, Acute kidney injury, Coma
- Low UOP: Oliguria
- Altered Mental Status: Metabolic encephalopathy
- O2 dependent at home: Chronic hypoxic respiratory failure
- Bedbound, requires total assist for ADL’s: Functional Quadriplegia
Linking Examples

- Link diseases to their cause or manifestation
  - Coders cannot do this for you

- Examples:
  - Acute renal failure secondary to acute tubular necrosis related to methotrexate nephrotoxicity
  - Acute blood loss anemia secondary to Duodenal Bleed
  - Hyponatremia secondary to chronic systolic heart failure
  - Ischemic cardiomyopathy secondary to atrial flutter
  - Suspected aspiration pneumonia secondary to dysphagia related to left MCA embolic CVA.
  - Metabolic encephalopathy secondary to severe hyponatremia
  - DM 2 with hyperglycemia with associated retinopathy, peripheral neuropathy, nephropathy, gastropathy.
Comfort Care

Did you know documenting when a patient has been transitioned to “comfort care only” is important?

• Patient’s receiving comfort care only are:
  – Not subject to quality improvement measures, core measures
  – Excluded from certain mortality data
Pancytopenia

• Specify causes:
  • Chemotherapy
  • Other Medications
  • Aplastic Anemia
  • Bone Marrow Infiltration
  • Red Blood Cell Aplasia
  • Myelodysplastic Syndromes
  • Myeloproliferative Disease
  • SLE
  • Leukemia
  • Hemophagocytic Syndrome

May use probable/possible “due to” to capture severity if uncertain of the cause of the Pancytopenia.
Hematology CCs

- Acquired coagulopathy
- Acquired hemolytic anemia
- Amyloidosis
- Aplastic anemia unspecified
- GVHD (acute, chronic, or acute-on-chronic)
- Lymphoma
- Leukemia
- Hodgkin’s
- ITP or hypercoaguable state
- Immune deficiencies
- Pancytopenia
- Precipitous drop in Hgb
- PTLD

Hematology MCCs

- Aplastic Anemia (including pancytopenia) due to: chronic systemic disease, drugs, infection, radiation, toxic
- Factor VIII or IX deficiency
- DIC
- Red cell aplasias
- Sickle cell thalassemia w/crisis
- Tumor lysis syndrome
## What’s the Difference?

<table>
<thead>
<tr>
<th>Principle Diagnosis</th>
<th>Chemotherapy</th>
<th>Chemotherapy</th>
<th>Chemotherapy</th>
</tr>
</thead>
</table>
| Secondary Diagnosis | ● Electrolyte Imbalances  
● Anemia  
● Leukopenia  
● Altered mental status | ● Hyponatremia (CC)  
● Hypomagnesemia  
● Hyperkalemia  
● Pancytopenia (CC)  
● Delirium | ● Hyponatremia (CC)  
● Hypomagnesemia  
● Hyperkalemia  
● Pancytopenia due to Chemotherapy (MCC)  
● Metabolic encephalopathy (MCC) |
| GMLOS               | 2.4          | 2.9          | 5.7          |
| Reimbursement (For Medicare patient) | $5,925.72 | $7,858.09 | $18,333.79 |
| Difference          | +$1,932.37   |              | +$12,408.07 |
CC/MCC

- Chronic systolic (or diastolic) HF-CC
- Acute (or acute on chronic) systolic (or diastolic) HF-MCC
- Chronic CHF-No CC/MCC
- HFP EF-No CC/MCC
## Comparison

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>COPD exacerbation</th>
<th>COPD exacerbation with AKI</th>
<th>COPD exacerbation with AKI due to ATN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MS-DRG Assignment</strong></td>
<td>192-COPD without CC/MCC</td>
<td>191- COPD with CC</td>
<td>190-COPD with MCC</td>
</tr>
<tr>
<td>Geometric Mean Length of Stay (GMLOS)</td>
<td>2.8</td>
<td>3.5</td>
<td>4.2</td>
</tr>
<tr>
<td>2014 Hospital Medicare Reimbursement</td>
<td>$6,054</td>
<td>$7,802</td>
<td>$9,663</td>
</tr>
</tbody>
</table>
Insufficiency vs. Failure

- “Insufficiency” or “dysfunction” does not equal “failure”
- State “failure” when present
- State acuity
  - “acute renal failure”
  - “acute hypoxic respiratory failure”
Comparison

- Acute renal insufficiency - No CC/MCC
- Acute renal failure – CC
- Acute respiratory insufficiency – CC
- Acute respiratory failure – MCC
- Hepatic insufficiency – No CC/MCC
- Acute hepatic failure - MCC
Bacteremia

- Positive blood culture *without* clinical significance
- Indicates lab finding only
- Provides moderate severity through MS-DRG coding
  - Co-morbid condition (CC)
Septicemia

• The term bloodstream infection may be used in place of septicemia
• Positive blood culture with clinical significance
• State cause (“due to”)
• Document organism
• Highest level of severity in MS-DRG coding
  – Major co-morbid condition (MCC)
Major Complications/Comorbid Conditions

Cardiovascular/Cerebrovascular
- Congestive Heart Failure, Acute
  - Acute on Chronic
  - Systolic or Diastolic
- Cor Pulmonale, Acute
- CVA, Stroke, Cerebral Infarct or Hemorrhage
- Cerebral Edema
- Coma
- Endocarditis or Myocarditis, Acute
- MI, Acute
- Pulmonary Embolism, Acute

Respiratory & Infectious Disease
- Aspiration Bronchitis, Aspiration Pneumonia
- HIV Disease
- Peritonitis
- Pneumonia, Including viral
- Pulmonary Edema, Acute, Non-cardiogenic
- Respiratory Failure, Acute
- Respiratory Insufficiency
  - Acute Post-Operative
- Sepsis, Severe Sepsis, Septic Shock

Other MCCs
- Acute Renal Failure with
  - Acute Tubular Necrosis (ATN)
- Aplastic, Anemia due to
  - Drugs, Chemo, Infection, or Radiation
- Diabetic Ketoacidosis or Diabetes with
  - Hyperosmolarity or Other Coma
- Encephalopathy
  - Metabolic or Toxic
  - Other or Unspecified
- End Stage Renal Disease
- GI Disorder With
  - Hemorrhage, Gastritis, Duodenitis Or Diverticular Disease
- GI Ulcer With Perforation, Hemorrhage or Obstruction
- Ischemic Colitis, Acute
- Major Injuries
- Malnutrition, Severe
- Pancreatitis, Acute
- Peritonitis
- Pressure Ulcer Stage III OR IV
- Quadriplegia or Functional Quadriplegia
- SIRS due to Noninfectious Process with
  - Acute Organ Dysfunction
- Volvulus
Billing...
<table>
<thead>
<tr>
<th>Codes</th>
<th>Key Components</th>
<th>Medical Decision Making</th>
<th>or</th>
<th>Total Time with &gt;50% counseling</th>
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</thead>
<tbody>
<tr>
<td>Mayo Code</td>
<td>CPT Code</td>
<td>History and Physical</td>
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<td>or</td>
</tr>
<tr>
<td>IH5</td>
<td>99223</td>
<td>Comprehensive</td>
<td>High</td>
<td>or</td>
</tr>
<tr>
<td>IH4</td>
<td>99222</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>or</td>
</tr>
<tr>
<td>IH3</td>
<td>99221</td>
<td>Comprehensive or Detailed</td>
<td>Low/Straightforward</td>
<td>or</td>
</tr>
</tbody>
</table>

**Initial Hospital Care (IH) Codes (once per service)**

**Subsequent Hospital Care (SH) Codes (code once per day per service)**

| SH3   | 99233 | Detailed | High | or | 35 minutes |
| SH2   | 99232 | Expanded Problem Focused | Moderate | or | 25 minutes |
| SH1   | 99231 | Problem Focused | Low/Straightforward | or | 15 minutes |

**Hospital Discharge Services (DD) Codes (final day of multiple day stay)**

| DD    | 99238 | Discharge Day | Document time | ≤30 minutes |
| DDM   | 99239 | Discharge Day | Document time | >30 minutes |
### Critical Care (KK) Codes
*(Provided to a critical ill/injured patient on a given day)*

<table>
<thead>
<tr>
<th>KK</th>
<th>99291/99292</th>
<th>Document Total Time</th>
<th>≥ 30 minutes</th>
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</table>

### Outpatient Observation Care (OC) Codes

<table>
<thead>
<tr>
<th>OC5</th>
<th>99220</th>
<th>Comprehensive</th>
<th>High</th>
<th>or 70 minutes</th>
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<tbody>
<tr>
<td>OC4</td>
<td>99219</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>or 50 minutes</td>
</tr>
<tr>
<td>OC3</td>
<td>99218</td>
<td>Comprehensive or Detailed</td>
<td>Low/Straightforward</td>
<td>or 30 minutes</td>
</tr>
<tr>
<td>OCD</td>
<td>99217</td>
<td>Discharge Day</td>
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<td></td>
</tr>
</tbody>
</table>

### Subsequent Observation Care (SO)
*(code once per day per primary service/ others use E Codes)*

<table>
<thead>
<tr>
<th>SO3</th>
<th>99226</th>
<th>Detailed</th>
<th>High</th>
<th>or 35 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO2</td>
<td>99225</td>
<td>Expanded Problem Focused</td>
<td>Moderate</td>
<td>or 25 minutes</td>
</tr>
<tr>
<td>SO1</td>
<td>99224</td>
<td>Problem Focused</td>
<td>Low/Straightforward</td>
<td>or 15 minutes</td>
</tr>
</tbody>
</table>

* Initial hospital visits and consults should meet the requirements for all 3 key components (history, exam and medical decision making) or be coded on time (document total time, counseling time and what was discussed and/or coordinated).

** Subsequent visits should meet the requirements for 2 of 3 key components or be coded using time.
| IH3 | CC  
|     | 4HPI  
|     | 2 ROS  
|     | 1 past/family/social history  
|     | 5 system exam  
|     | 2 Diagnosis points  
|     | 2 Data points  
|     | Low risk MDM  
|     | 30 min (w/ >50% counseling)  

| IH4 | CC  
|     | 4HPI  
|     | 10 ROS, reference to CVI that was reviewed w/ patient, statement indicating all reviewed and negative.  
|     | All 3 PMH/PFH/PSH  
|     | 8 system exam  
|     | 3 Diagnosis points  
|     | 3 Data points  
|     | Moderate risk for MDM  
|     | 50 min (w/ >50% counseling)  

| IH5 | CC  
|     | 4HPI  
|     | 10 ROS, reference to CVI that was reviewed w/ patient, statement indicating all reviewed and negative.  
|     | All 3 PMH/PFH/PSH  
|     | 8 system exam  
|     | 4 Diagnosis points  
|     | 4 Data points  
|     | High risk for MDM  
|     | 1 hr 10 min (w/ >50% counseling)  

| IH6 | Prolonged service is used when the direct face to face time with the patient is beyond the typical/average time of the visit code billed. You must document to support why this prolonged visit occurred.  
|     | 1 hr 40 min (w/ >50% counseling)  
|     | Minimum 30 min face to face
<table>
<thead>
<tr>
<th>Code</th>
<th>General</th>
<th>Documentation Needed (2 of 3)</th>
<th>Time</th>
</tr>
</thead>
</table>
| SH1  | Patient is stable, recovering, or improving D/C may be expected next day or waiting for placement | 1 HPI  
1 exam  
MDM supports straightforward to low risk | 15 min |
| SH2  | Patient is responding inadequately to therapy.  
Developed minor complication.  
Requires careful monitoring of co-morbid conditions requiring continuous active management. | 1 HPI and 1 ROS  
2 exams  
MDM supports moderate risk | 25 min |
| SH3  | Patient is unstable  
Significant new problem or complication.  
Immediately following a hospital admission  
Transfer from ICU  
Acute exacerbation of condition | 4 HPI and 2 ROS  
5 exam  
MDM supports high risk  
Or bill on time | 35 min |
| SH4  | Prolonged service is used when: The direct face to face time with the patient is beyond the typical/average time of the visit code billed. | Document reason for prolonged visit.  
30 minutes face to face  
Cannot combine times of 2 providers (NPPA and MD) | Total time of 65 min (w/ 50% counseling) |
History Guidelines

Comprehensive  [P4-5, N4-5, E5, IH4-5, IC4-5, OC4-5, SAD4-5]
- Chief complaint
- HPI: 4 – 8 elements
- ROS: 10 – 14 systems (or review and reference CVI/PPI by date)
- Past Medical/Surgical, Family, and Social History (PFSH): 1 from each area (or review and reference PFH/PPI by date)

Detailed  [P3, N3, E4, IH3, IC3, SH3, OC3, S03, SAD3]
- Chief complaint
- HPI: 4 – 8 elements
- ROS: 2 – 9 systems
- Past Medical/Surgical, Family and Social History (PFSH): 1 from any area

Expanded Problem Focused  [P2, N2, E3, IC2, SH2, S02]
- Chief complaint
- HPI: 1 – 3 elements
- ROS: 1 system

Problem Focused  [P1, N1, E2, IC1, SH1, S01]
- Chief complaint
- HPI: 1 – 3 elements

History of the Present Illness (HPI) Elements
1. Location
2. Quality
3. Severity
4. Duration
5. Timing
6. Context
7. Modifying Factors
8. Associated signs/symptoms
## Examination Guidelines

<table>
<thead>
<tr>
<th></th>
<th><em>Multi-System Exam</em></th>
<th><strong>Body Areas Exam</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive</strong></td>
<td>8-12 organ systems</td>
<td>No comprehensive body area exam</td>
</tr>
<tr>
<td>P4-5, N4-5, E5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IH4-5, IC4-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC4-5, SAD4-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>5-7 organ systems</td>
<td>Extended exam of affected body area(s) and other symptomatic or related organ system(s)</td>
</tr>
<tr>
<td>P3, N3, E4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IH3, IC3, SH3,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC3, S03, SAD3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td>2-4 organ systems</td>
<td>Limited exam of the affected body area and other symptomatic or related organ system(s)</td>
</tr>
<tr>
<td>P2, N2, E3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IC2, SH2, S02</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Problem Focused</strong></td>
<td>1 organ system</td>
<td>Limited exam of the affected body area</td>
</tr>
<tr>
<td>P1, N1, E2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IC1, SH1, S01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
High Risk

- One or more chronic illnesses with severe exacerbation progression or side effects of treatment
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function
  - PE
  - Severe respiratory distress
  - Acute renal failure
  - MI
- Parenteral controlled substance
  - PCA with a narcotic
- Drug therapy requiring intensive monitoring for toxicity
  - Insulin drip
  - Immuno suppression therapy
  - Heparin infusion therapy
  - Blood or blood products
- Abrupt change in neurologic status
  - TIA , weakness, sensory loss
  - Seizures
  - Severe closed head injury (new)
- Decision not to resuscitate or de-escalate care because of poor prognosis
So Now put it all to work

• Reviewed basics of ICD 10
• Billing concepts reviewed

• Now you are ready
A real note Legit?

GI bleed overnight
Hb 6.7
104/70 Pulse 110
Abdo NT
A/P
Transfuse, EGD, PPI

SH3
Finally Going Home!

Hospital Discharge Day Management

Codes 99238-99239 are used to report the total duration of time spent by the provider for final hospital discharge services.

<table>
<thead>
<tr>
<th></th>
<th>History</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99238</td>
<td>Hospital discharge day management, 30 minutes or less</td>
<td>Face-to-face time between the attending and the patient</td>
</tr>
<tr>
<td>99239</td>
<td>Hospital discharge day management, more than 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- Only one hospital discharge service is coded per patient, per hospital stay.
- Only the attending physician of record reports the discharge day code.
- Discharge service is billed on the date of the actual visit by the provider even if the patient is discharged on a different calendar date.
- Includes, as appropriate:
  - Final patient exam
  - Discussion of the hospital stay
  - Instructions for continuing care
  - Preparation of discharge records, prescriptions, and referral forms
- Total time of the visit must be documented to support code assigned.
- All other providers performing a final visit should code subsequent hospital care (99231–99233).
LOONEY TUNES

"That's all Folks!"