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## INTRODUCTION

Regulations, laws, mandates, and guidelines touch almost every facet of healthcare documentation, coding, and reporting. Although healthcare data that is based on documentation is used for payment other, more patient-focused uses of healthcare information may be considerably more important to some users. Already heavily regulated, healthcare is experiencing added pressure from a multitude of reform initiatives created by government to improve outcomes and reduce costs. The transition to ICD-10-CM/PCS helped boost the focus on clinical documentation since greater specificity is vital to accurate data collection. With that transition complete, healthcare organizations should begin to comprehensively analyze data and the organization's regulatory compliance and business success on all fronts. Important to analysis is the understanding of the issues that were identified while using ICD-9-CM and monitoring improvement or decline under ICD-10-CM/PCS.

The robustness of ICD-10-CM/PCS will allow the specificity required to accurately and fully describe a patient's episode of care at a point in time and as well as over time. For instance:

- ICD-10-CM includes the level of detail needed for specific morbidity and mortality reporting in the United States. The system consists of more than 68,000 diagnosis codes.
- The ICD-10-PCS procedure coding system is much more detailed and specific than the previous ICD-9-CM system. ICD-10-PCS codes are "built" through careful selection of defined characters. The system consists of 87,000 procedure codes.

This whitepaper will take a look at significant regulations and initiatives that affect healthcare organizations.

## REFORM, REGULATIONS AND THE ROLE OF CODING AND DOCUMENTATION

One of CMS's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. The top three reasons for inaccurate payment of claims can be attributed to insufficient documentation, medically unnecessary services, and incorrect diagnosis coding<sup>1</sup>.

Let's start with a basic description of coding. Basically coding is the translation of clinical information into classification system terminology. Classification terminology is then "coded" and paints a picture of a patient's condition and evolution of care. Coded

## Summary

This whitepaper provides information on a number of activities that the government is undertaking to drive down healthcare costs and improve patient outcomes. It is imperative that organizations keep a close eye on published regulations, since they often overlap and have cross-over effects on the business of healthcare.

<sup>1</sup> US Department of Health and Human Services. HHS Agency Financial Report, FY 2014. Reviewed May 19, 2015. Available at: <http://www.hhs.gov/afr> accessed 7/13/15.

data has many uses that may include payment; explaining patient outcomes; providing medical necessity for admission and services; describing the patient's evaluation and care to help develop, monitor, or prove that evidence-based best practice protocols were followed; identifying and monitoring patterns for patient populations – the list goes on and on. According to the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS,) on July 31, 2014, the U.S. Department of Health and Human Services (DHHS) issued a final rule finalizing October 1, 2015 as the new compliance date to transition to the ICD-10 code sets. Coding conventions and guidelines for ICD-10-CM are provided by the CDC/NCHS<sup>2</sup> and coding guidelines for ICD-10-PCS are provided by the Centers for Medicare and Medicaid (CMS)<sup>3</sup>.

Health record documentation describes a patient's condition and the medical necessity for evaluation and treatment. This information is vital and achieved through accurate, timely and complete clinical documentation by all providers and accurate, timely reporting of ancillary services.

## INDUSTRY TRENDS

Some of the most impactful initiatives can be identified by looking at industry trends in four categories: - data management, finance, regulatory, and care management.

**Data management** includes such things as data governance and ensuring data integrity; the use of natural language processing to systematically evaluate documentation; dual coding to help compare ICD-9-CM data to ICD-10-CM/PCS data; and database conversion that will “map” ICD-9-CM to ICD-10-CM/PCS and result in the organization's information to be dependent on appropriate mapping.

**Finance trends** involve movement from volume-based to value-based purchasing, which is significantly dependent on outcomes reporting. New programs such as ACOs or changes to other payer programs may require a significant increase in patient co-pays or deductibles and point-of-service collections. Close monitoring of the patient over time is expected to aid in moving to a patient-centric, more cohesive model of patient care, allowing organizations to share in risk and reward for quality patient care.

**Regulatory initiatives** include such things as the implementation of the EHR, more stringent privacy and security requirements, initiation of health information exchanges, the change to ICD-10-CM/PCS, quality reporting, fraud and abuse monitoring, HAC and patient safety scrutiny, and quality reporting to name a few. Each of these initiatives affects the way healthcare organizations do business. Many are discussed in more detail later in this whitepaper.

**Care management** is closely tied to finance trends, since outcomes are closely tied to payment initiatives. Care management includes evaluation and monitoring of an aging population and workforce; population health management; longitudinal coordination of care with successive monitoring in multiple settings – including a

“Some of the most impactful initiatives can be identified by looking at industry trends.”

<sup>2</sup> CDC/National Center for Health Statistics. ICD-10-CM Official Guidelines for Coding and Reporting FY 2016. Updated July 8, 2015. Available at: <http://www.cdc.gov/nchs/icd/icd10cm.htm> accessed July 13, 2015

<sup>3</sup> Centers for Medicare and Medicaid Services (CMS). ICD-10-PCS Official Guidelines for Coding and Reporting 2016. Modified 6.22.15. Available at: <http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html> accessed 7/13/15.

globalization of care; and helping patients understand their health information to make informed decisions – changing the provision of healthcare into a consumer-driven business.

## A CLOSER LOOK

Achieving CMS's goal of paying claims properly the first time depends, of course, on the accuracy of the data supplied. In fact, the top three reasons for inaccurate payments are<sup>4</sup>:

1. Insufficient documentation
2. Medically unnecessary services
3. Incorrect diagnosis coding

By taking a look at results of various audits that span the last few years and understanding that the results are indicative of trends using the ICD-9-CM coding system should make organizations realize that ICD-10-CM/PCS is not a magic “fix.” Continued attention to accurate clinical documentation and appropriate coding is necessary to remediate poor performance.

## LOOKING AT THE NUMBERS: IMPROPER PAYMENT

- The Medicare Fee-for-Service (FFS) gross improper payment estimate for FY 2014 is 12.7 percent or \$45.8 billion for inpatient hospital claims that should have been paid as an outpatient claim under Medicare Part B. The FY 2014 net improper payment estimate is 11.8 percent or \$42.7 billion. This compares to an estimated improper rate of 10.1 percent for FY 2013. This reflects continued poor performance for insufficient documentation, incorrect coding, or provision of unnecessary services<sup>5</sup>.
- The FY 2014 Medicare Part C gross improper payment estimate is 9.0 percent or \$12.2 billion. The FY 2014 net improper payment estimate is 2.9 percent or \$4.0 billion<sup>6</sup>.
- In FY 2014, the Medicare FFS RAC program demanded approximately \$1.9 billion and recovered \$2.4 billion in overpayments by the end of the fiscal year<sup>7</sup>.
- The improper payment rate for home health claims increased from 17.3 percent in FY 2013 to 51.4 percent in FY 2014<sup>8</sup>.

<sup>4</sup> US Department of Health and Human Services. HHS Agency Financial Report, FY 2014. Reviewed May 19, 2015. Available at: <http://www.hhs.gov/afr>.

<sup>5</sup> Additional information on the Medicare FFS improper payment, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf>

<sup>6</sup> i.b.i.d.

<sup>7</sup> i.b.i.d.

<sup>8</sup> i.b.i.d.

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**Fraud and Abuse Prevention** is a complex, time consuming activity. Initiated by the Fraud Prevention System (FPS) on June 30, 2011, as required by the Small Business Jobs Act of 2010 (SBJA), the government was given the directive to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. From October 2012 through September 2013 the government determined that every dollar spent on administrative enforcement yielded five dollars of savings. Fraud/abuse screening and predictive modeling tools yielded \$19.2 billion in related improper payments over the last five years<sup>9</sup>.

An activity that has more recently been the focus of CMS is the **Readmission Reduction Program**<sup>10</sup> in which healthcare claims are evaluated for patients that are admitted within 30 days of discharge. The intent is to ensure that appropriate care was provided to the patient and identify extenuating circumstances that require readmission. Documentation and the associated codes for the following conditions are being reviewed:

- Acute Myocardial Infarction
- Heart Failure
- Pneumonia
- Acute exacerbation of COPD
- Elective total hip arthroplasty
- Total knee arthroplasty

In FY 2017 coronary artery bypass grafts (CABG) will be added to the review list.

**Patient Safety** is not only a clinical concern. Specific documentation is used to code and report some of the top 10 Patient Safety Issues for 2015, including healthcare-associated infections, surgical complications, falls, and other adverse effects of treatment. Organizations and providers strive to improve patient safety by preventing medical errors and other adverse events that are reported via very specific combination codes or groups of codes which are then evaluated by payers and the government to identify trends in unsafe and ineffective patient care. Hospitals and physicians are compared to one another on their outcomes which are available to the general public by accessing [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare). Comparison of physicians and hospitals helps move healthcare to a consumer-centric business model.

<sup>9</sup> Report to Congress. Fraud Prevention System. Second Implementation Year June 2014 <http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf> accessed July 13, 2015

<sup>10</sup> Sect.3025 of the ACA added sect. 1886(q) to the SSA establishing the Hospital Readmissions Reduction Program: requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154). DHHS, CMS Readmission Reduction Program. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>

“Organizations and providers strive to improve patient safety by preventing medical errors”

The healthcare industry is moving from a volume-based to a **value-based purchasing** (VBP) system<sup>11</sup>, essentially using documented and coded patient outcomes to decide whether quality care was provided to a patient. Congress authorized Inpatient Hospital VBP in Section 3001(a) of the Affordable Care Act. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The VBP is a CMS initiative that rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare Beneficiaries. The incentive payments will be based on a hospital's performance on a predetermined set of quality measures and patient survey scores collected during a baseline period compared to a performance period.

Another initiative that affects payment is the **Hospital Acquired Conditions Reduction Program**<sup>12</sup>. Initiated in Section 5001(c) of Deficit Reduction Act of 2005, effective Oct 1, 2014 for all IPPS Hospitals, this program modifies payment for a selective number of conditions if they occur during a hospitalization – when shown not to be present on admission. It is felt that these conditions are preventable if appropriate care is provided and documented. Hospitals ranked in the bottom 25% of all IPPS hospitals will receive only 99% of their Medicare payments in FY 2015.

### **Never Events And Procedure-Related HACs**

Since 2007, CMS has had a non-reimbursement policy for certain HACs deemed “reasonably preventable” through the use of evidence-based guidelines. Subsequently, many states and private insurers have adopted similar policies.

The Medicare HACs to some extent overlap with the National Quality Forum's (NQF's) Serious Reportable Events, or “Never Events,” but not all are included in the NQF's list<sup>13</sup>.

“The VBP is a CMS initiative that rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare Beneficiaries.”

<sup>11</sup> DHHS, CMS Value Based Purchasing. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/>

<sup>12</sup> DHHS, CMS. Hospital-Acquired Conditions (Present on Admission Indicator). Available at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/O5\\_Coding.asp](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/O5_Coding.asp) Information also available at: Agency for Healthcare Research and Quality Hospital Acquired Conditions. Available at <http://www.guideline.gov/resources/hospital-acquired-conditions.aspx>

<sup>13</sup> QualityNet.org: Hospital Inpatient Quality Reporting Program: Electronically Specified Clinical Quality Measures (ECQMs) Programs Overview. <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228773849716> /

**NQF Never Events on the HAC list are:**

- Foreign body retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control

**Procedure-related HACs are:**

- Catheter-associated urinary tract infection (CAUTI)
- Vascular catheter-associated infection
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) - Mediastinitis
  - Cardiac device procedures
  - Bariatric surgery
  - Certain orthopedic procedures (spine, neck, shoulder, elbow)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures (knee or hip replacement)
- Iatrogenic pneumothorax with venous catheterization procedures

**TWO-MIDNIGHT RULE**

On July 1, 2015, CMS released proposed updates to the “Two-Midnight Rule,” regarding when inpatient admissions are appropriate for payment under Medicare Part A<sup>14</sup>. Originally announced in 2013, the rule indicated a reasonable expectation that an inpatient stay would span at least two midnights. Because of extensive industry input CMS is reiterating that the medical judgment of the provider is foremost in the decision making process and although the Two-Midnight rule still stands, cases may be evaluated on an individual basis to determine if Part A payment is appropriate. According to CMS, the Quality Improvement Organizations (QIOs) will oversee the majority of patient status audits, with the Recovery Audit program focusing on only those hospitals with consistently high denial rates. Under the rule, Medicare Recovery Audit Contractors (RACs) can review claims for inpatient stays and determine if the

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<sup>14</sup> DHHS, Centers for Medicare and Medicaid Services. Federal Register. Vol. No 179, 42 42 CFR Parts 411, 412, 416, 419, 422, 423, and 424. [CMS-1613-P] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. July 14, 2014. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-07-14/pdf/2014-15939.pdf>

admission was medically reasonable and necessary. If a RAC determines that the inpatient admission was not necessary and the care should have been provided on an outpatient basis, the inpatient claim would be denied.

The action also may have been a response to the huge number of appeals of RAC denials that reportedly have overwhelmed the Office of Medicare Hearings and Appeals. Such appeals increased 506 percent between 2012 and 2013, compared to growth of 77 percent in appeals of other types of claims. Attempting to reduce the backlog, CMS in September 2014 offered partial payment of 68 percent to any hospital willing to withdraw its pending appeals of claims denied based on patient status.

As rule clarifications continue, it will be important for hospitals to pay close attention to their regulatory progress, in order to avoid misunderstandings and insufficient reporting that could severely reduce or tie up reimbursement. A more detailed summary can be found at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html>.

#### HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

Mandated by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Hospital IQR Program authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates<sup>15</sup>.

In previous years, hospitals that did not participate in the Program had their Medicare base rates reduced by 2 percent. Starting in FY 2015, the reduction is one quarter of a hospital's market basket increase.

For FY 2015, there are 59 quality measures that are being used to determine if a hospital's rate is to be reduced. Hospitals must complete a long checklist of quality measure data submission and validating activities within a specific timeframe to prevent the rate reduction from happening.

In addition to giving hospitals a financial incentive to report the quality of their services, the reporting program provides CMS with data to help consumers make more informed decisions about their health care. Some of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

“Hospitals must complete a long checklist of quality measure data submission and validating activities within a specific timeframe to prevent the rate reduction from happening.”

<sup>15</sup> QualityNet.org Hospital Inpatient Quality Reporting Program: Hospital IQR FY 2015 Changes. Modified December 30, 2013 <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPages%2FQnetTier2&cid=1138115987129>

Coded Data, Hospital Inpatient Quality Reporting (IQR) Program

New or Revised Measures for FY2016 Payment Determination

- Stroke 30-day mortality rate
- COPD 30-day mortality rate
- 30-day risk standardization readmission following total hip/total knee arthroplasty
- Hospital-wide all-cause unplanned readmission (HWR)
- Stroke 30-day risk standardization readmission
- COPD 30-day risk standardization readmission

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