Sunflower Health Plan

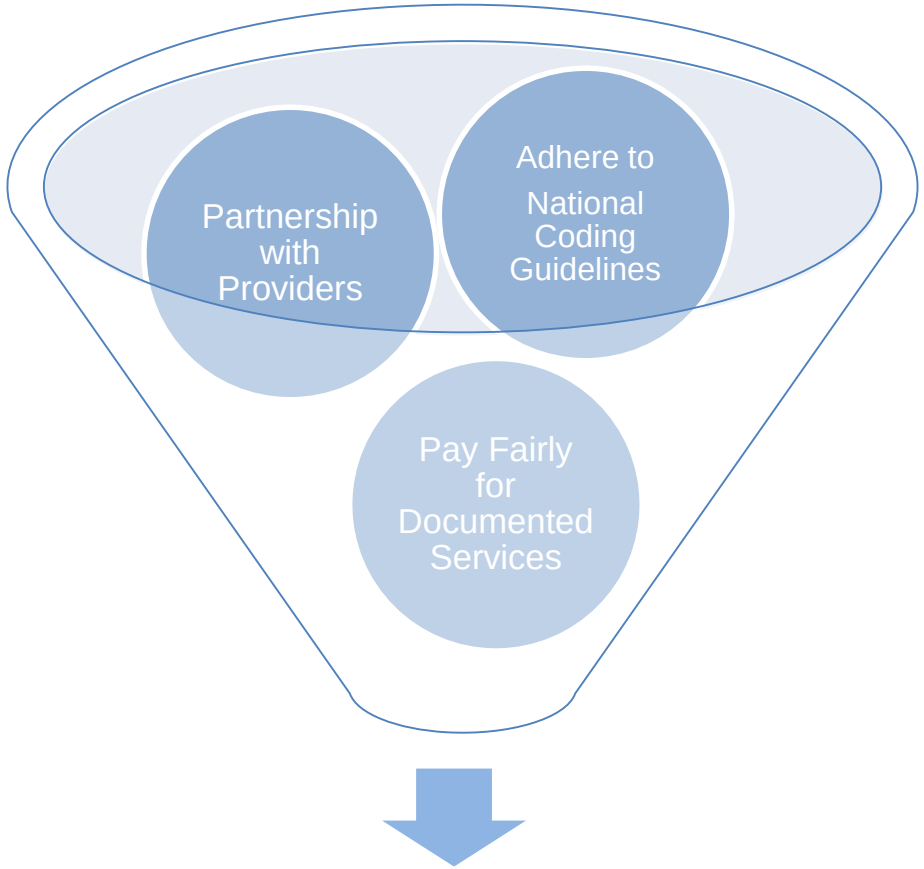
DRG Audit Service

Provider Education

October 2, 2018

KDHE Approved 10-01-2018

Equian DRG Audit Program



Comprehensive DRG Waste Prevention Program

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Audit Process Overview

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Medical Record Requests and Scheduling Audits

- **Provider will receive Letters of Intent requesting either an onsite audit or to send medical records for review in a HIPAA-compliant manner**
  - Letters will include relevant patient details (e.g. name, dates of service)
  - Onsite request includes proposed audit date within 30 days of LOI
  - Medical Record Request includes instructions for sending records to Equian

- **Provider Medical Records/HIM department will be contacted to schedule audits (onsite only)**
  - Equian scheduler will provide necessary auditor information to facility for logins and appropriate access
  - Equian team will look to schedule an exit interview with the facility coding manager at the same time
  - In week prior to audit, Equian will confirm with provider that records/access will be available for audit on agreed date

- **Provider sends Medical Records to Equian (remote audits)**

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Conduct Audit

- **Equian Auditor travels to Provider and signs in with provider (onsite) or begins auditing the medical records from provider (remote)**

- **Auditor reviews medical records**
  - Auditor will only review records; no copying or printing of records
  - If records are not complete, auditor works with facility HIM to obtain complete record
  - If there is a finding, auditor creates worksheet containing before and after codes and rationale

- **At conclusion of audit, Equian auditor participates in exit interview with Provider Coding Manager**
  - Findings worksheets are provided to Coding Manager in advance
  - Opportunity to cement relationship, reduce appeals and associated administrative burden

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Post Audit

- **Provider will receive findings letter including before and after codes and rationale for change**
  - Equian sends to appropriate contact(s) through provider-preferred medium (email, fax, certified mail, etc.)
  - Findings letter includes instructions should the provider want to dispute finding

- **Equian Post-audit team processes incoming provider communication (email, fax, phone, etc.) daily and responds to provider as necessary**
  - Provider disputes received are addressed within the specified timeframe

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DRG Discussion

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DRG Audit Guidelines and Standards

- ICD-10-CM and ICD-10-PCS instructions and coding conventions
- ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting

  (as approved by the Cooperating Parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), CMS and NCHS)
- AHA Coding Clinic for ICD-10-CM/PCS
- Industry standards as outlined by the American Health Information Management Association (AHIMA) such as:

  AHIMA Standards of Ethical Coding and AHIMA Guidelines for Achieving a Compliant Query Process
- Up To Date Clinical References – peer-reviewed medical articles

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Medical Record Documentation

"A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved."

ICD-10-CM Official Guidelines for Coding and Reporting

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Medical Record Documentation

"Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician."

ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2014

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Medical Record Documentation

Facilities need to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions.

CDI and coding staff should query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment when there is conflicting, incomplete, illegible, imprecise, or ambiguous information in the medical record.

If after querying, the attending physician affirms that a patient has a particular condition in spite of certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit.

ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2016
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2017
AHIMA Standards of Ethical Coding

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Focus Conditions

- Sepsis
- Acute Respiratory Failure
- Malnutrition
- Hyponatremia

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Definitions – Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

ICD-10-CM Official Guidelines for Coding and Reporting

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Definitions – Additional Diagnoses

General Rules for Other (Additional) Diagnoses

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

ICD-10-CM Official Guidelines for Coding and Reporting

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Sepsis

- Meets the UHDDS definition of a reportable principal or “other” (additional diagnosis)
- Clear, consistent documentation by the provider of the condition
- Is the diagnosis clinically supported by sepsis III criteria?
- Was the condition due to a complication of procedure/device?
- Does the documentation support the condition being present on admission?
- Validation of co-morbid conditions impacting DRG assignment
- Validation of procedure codes impacting DRG assignment

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Sepsis III Criteria

- Sepsis is defined as a life threatening organ dysfunction due to a dysregulated host response to infection
- Based on SOFA scores
- Criteria included PaO2/FiO2, thrombocytopenia, hyperbilirubinemia, hypotension, Glasgow coma scale, creatinine level, and urine output
- SOFA score of > or = 2 reflects an overall mortality risk of about 10% in a hospital population with infection, and identifies organ dysfunction
- In a patient with existing organ dysfunction, an acute increase in SOFA score > or = 2 reflects the additional organ dysfunction due to infection

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Respiratory Failure

- Meets the UHDDS definition of a reportable principal or “other” (additional diagnosis)
- Clear, consistent documentation by the provider of the condition
- Is the diagnosis clinically supported in the medical record?
- Was the patient intubated for airway protection?
- Was the diagnosis an “expected condition”, i.e., post surgical weaning from vent?

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Respiratory Failure

- pO2 <60 mm Hg (or Sp O2 (pulse oximetry) <91% on room air
- pCO2 >50 and pH <7.35
- pO2 decrease or pCO2 increase by 10mm Hg from baseline (if known)
- Must be associated with clinical signs and symptoms including:
  - For hypoxic respiratory failure: respiratory distress, tachypnea, cyanosis, retractions, increased work of breathing, air hunger, accessory muscle use, nasal flaring, and/or altered mental status.
  - For hypercapnic acute respiratory failure: If not accompanied by hypoxia, often only altered mental status and then coma due to CO2 narcosis.

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Malnutrition

- Clearly and consistently documented
- Meets the UHDDS definition of a reportable principal or “other” (additional diagnosis)
- Diagnosis must be clinically supported by ASPEN criteria (2012 Adult Malnutrition Consensus Statement of the American Society for Parenteral and Enteral Medicine)
- Previously used criteria such as CRP, albumin, prealbumin, transferrin, procalcitonin or BMI may or may not be supportive of the diagnosis but can no longer be used to definitively rule in or out malnutrition
- Physician, NP and/or PA must document the type or severity of malnutrition and reference the nutritionist’s plan of care

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Hyponatremia

- Meets the UHDDS definition of a reportable principal or “other” (additional diagnosis)
- Clear, consistent documentation by the provider of the condition
- Clinical significance of the condition during the hospital stay must be present in the medical record

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Appendix A - Sample Provider Scheduling Letter Template

OMNICLAIM Intelligent partnerships. Real savings. **SUMMARY PAGE**

DRG VALIDATION REVIEW DEPARTMENT

TO:	FROM:
FAX NUMBER:	DATE:
NOTES/COMMENTS:	TOTAL PAGES INCLUDING COVER:

On-Site - DRG Coding Review

OmniClaim, Inc. has been retained by the attached insurance provider(s) to perform a DRG Validation Review with your facility. The purpose of this review is to confirm that inpatient claims paid under the DRG methodology per your contract with the insurance carrier have been coded, billed and paid correctly.

Enclosed is a list of claims to be audited. Please review the attached documents in preparation for the audit. Once reviewed, please contact me via phone or email to arrange a reasonable date.

The contents of this letter of intent are as follows:

1) OmniClaim Introduction/Audit Confirmation letter
2) Letter of Agency and Authorization
3) Claims list for chart retrieval

Thank you in advance for your prompt attention and cooperation. Please feel free to contact me with any questions.

Sincerely,

Name:

Title:

Phone:

Fax:

Email:

OMNICLAIM Intelligent partnerships. Real savings.
300 UNICORN PARK DRIVE ♦ WOBURN, MA 01801
TEL. 877-787-2310 ♦ FAX 646-349-2406

1

OmniClaim, Inc.
300 Unicorn Park Drive
Woburn, MA 01801

June 29, 2017

Facility Contact
Facility Name
Facility Address
City, State, Zip

Re: Request for Medical Records

Dear Health Information Management:

"Insurance Carrier Name" is conducting a review of the claim information below for which our reimbursement obligation has been met. Our vendor OmniClaim, Inc. is administering the review on our behalf.

OmniClaim, Inc. has entered into a Business Associate Agreement with "Insurance Carrier Name" per applicable Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, as defined in 45C>Sec164.03. This agreement allows OmniClaim, Inc. to access medical records, without additional patient authorization, as a business associate for the purposes of payment activities. OmniClaim, Inc. is an agent of "Insurance Carrier Name" and provides identification and recovery of claims overpayments.

Please gather the records requested on the attached page to include the following information and call OmniClaim, Inc. at 877-787-2310 **within 30 days from the date of this letter** to schedule an on-site review.

(X) Face Sheet	(X)Consultations
(X) Discharge Summary and History and Physical	(X)Physician Query
(X) Physician Orders and Progress Notes	(X) Respiratory/Ventilation Sheets
(X) Emergency Room Records	(X)Med Admission Sheets
(X) Laboratory - Final	(X)Treatment Administration Record
(X)Radiology Reports	(X)Itemized Bill and UB 92 or UB04 form
(X)Operative/Pathology/Anesthesia Reports	(X)ICD-10-CM Codes Submitted for Reimbursement

If you have questions, please call 877-787-2310. Thank you.

Sincerely,

2

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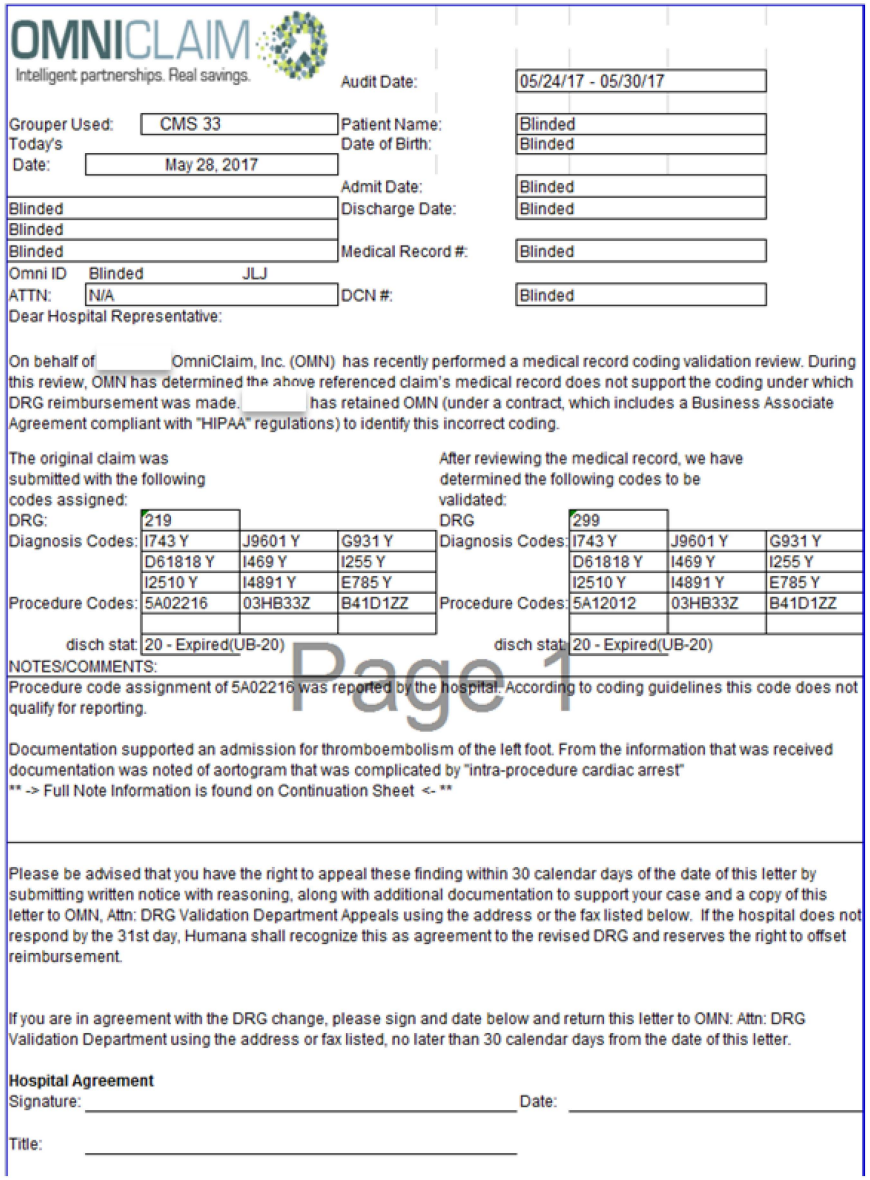
Appendix B - Key Findings Worksheet Example



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Audit Date:	05/24/17 - 05/30/17		
Grouper Used:	CMS 33	Patient Name:	Blinded
Today's Date:	May 28, 2017	Date of Birth:	Blinded
		Admit Date:	Blinded
Blinded		Discharge Date:	Blinded
Blinded			
Blinded		Medical Record #:	Blinded
Omni ID Blinded JLJ			
ATTN:	N/A	DCN #:	Blinded

Dear Hospital Representative:

On behalf of _____ OmniClaim, Inc. (OMN) has recently performed a medical record coding validation review. During this review, OMN has determined the above referenced claim's medical record does not support the coding under which DRG reimbursement was made. _____ has retained OMN (under a contract, which includes a Business Associate Agreement compliant with "HIPAA" regulations) to identify this incorrect coding.

The original claim was submitted with the following codes assigned:				After reviewing the medical record, we have determined the following codes to be validated:			
DRG:	219			DRG	299		
Diagnosis Codes:	I743 Y	J9601 Y	G931 Y	Diagnosis Codes:	I743 Y	J9601 Y	G931 Y
	D61818 Y	I469 Y	I255 Y		D61818 Y	I469 Y	I255 Y
	I2510 Y	I4891 Y	E785 Y		I2510 Y	I4891 Y	E785 Y
Procedure Codes:	5A02216	03HB33Z	B41D1ZZ	Procedure Codes:	5A12012	03HB33Z	B41D1ZZ
disch stat:	20 - Expired(UB-20)			disch stat:	20 - Expired(UB-20)		

NOTES/COMMENTS:

Procedure code assignment of 5A02216 was reported by the hospital. According to coding guidelines this code does not qualify for reporting.

Page 1

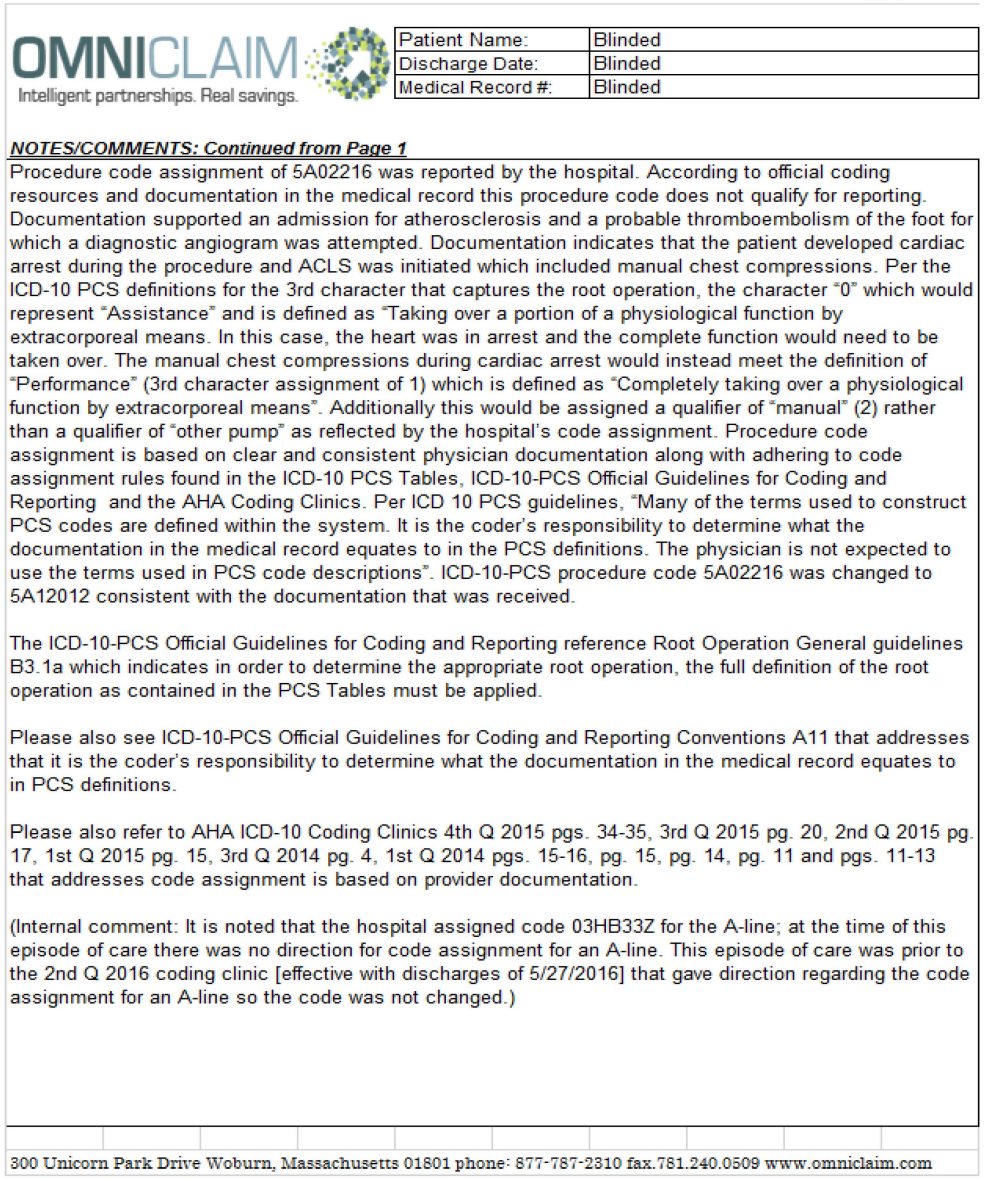
Documentation supported an admission for thromboembolism of the left foot. From the information that was received documentation was noted of aortogram that was complicated by "intra-procedure cardiac arrest"
** -> Full Note Information is found on Continuation Sheet <- **

Please be advised that you have the right to appeal these finding within 30 calendar days of the date of this letter by submitting written notice with reasoning, along with additional documentation to support your case and a copy of this letter to OMN, Attn: DRG Validation Department Appeals using the address or the fax listed below. If the hospital does not respond by the 31st day, Humana shall recognize this as agreement to the revised DRG and reserves the right to offset reimbursement.

If you are in agreement with the DRG change, please sign and date below and return this letter to OMN: Attn: DRG Validation Department using the address or fax listed, no later than 30 calendar days from the date of this letter.

Hospital Agreement
Signature: _____ Date: _____

Title: _____



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Patient Name:	Blinded
Discharge Date:	Blinded
Medical Record #:	Blinded

NOTES/COMMENTS: Continued from Page 1

Procedure code assignment of 5A02216 was reported by the hospital. According to official coding resources and documentation in the medical record this procedure code does not qualify for reporting. Documentation supported an admission for atherosclerosis and a probable thromboembolism of the foot for which a diagnostic angiogram was attempted. Documentation indicates that the patient developed cardiac arrest during the procedure and ACLS was initiated which included manual chest compressions. Per the ICD-10 PCS definitions for the 3rd character that captures the root operation, the character "0" which would represent "Assistance" and is defined as "Taking over a portion of a physiological function by extracorporeal means. In this case, the heart was in arrest and the complete function would need to be taken over. The manual chest compressions during cardiac arrest would instead meet the definition of "Performance" (3rd character assignment of 1) which is defined as "Completely taking over a physiological function by extracorporeal means". Additionally this would be assigned a qualifier of "manual" (2) rather than a qualifier of "other pump" as reflected by the hospital's code assignment. Procedure code assignment is based on clear and consistent physician documentation along with adhering to code assignment rules found in the ICD-10 PCS Tables, ICD-10-PCS Official Guidelines for Coding and Reporting and the AHA Coding Clinics. Per ICD 10 PCS guidelines, "Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions". ICD-10-PCS procedure code 5A02216 was changed to 5A12012 consistent with the documentation that was received.

The ICD-10-PCS Official Guidelines for Coding and Reporting reference Root Operation General guidelines B3.1a which indicates in order to determine the appropriate root operation, the full definition of the root operation as contained in the PCS Tables must be applied.

Please also see ICD-10-PCS Official Guidelines for Coding and Reporting Conventions A11 that addresses that it is the coder's responsibility to determine what the documentation in the medical record equates to in PCS definitions.

Please also refer to AHA ICD-10 Coding Clinics 4th Q 2015 pgs. 34-35, 3rd Q 2015 pg. 20, 2nd Q 2015 pg. 17, 1st Q 2015 pg. 15, 3rd Q 2014 pg. 4, 1st Q 2014 pgs. 15-16, pg. 15, pg. 14, pg. 11 and pgs. 11-13 that addresses code assignment is based on provider documentation.

(Internal comment: It is noted that the hospital assigned code 03HB33Z for the A-line; at the time of this episode of care there was no direction for code assignment for an A-line. This episode of care was prior to the 2nd Q 2016 coding clinic [effective with discharges of 5/27/2016] that gave direction regarding the code assignment for an A-line so the code was not changed.)

300 Unicorn Park Drive Woburn, Massachusetts 01801 phone: 877-787-2310 fax.781.240.0509 www.omniclaim.com

KDHE Approved 10-01-2018

Thank You

KDHE Approved 10-01-2018