Hospital Mortality Coded Data Insights

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Speaker

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• AHIMA-Approved ICD-10-CM/PCS Trainer
• CHIA Past President
• 35+ Year Coding HIM Professional & Leader
  o National Director, Coding Quality, Education, Systems, and Support
  Kaiser Permanente – National Rev Cycle
  Oakland, CA
Disclaimer

• This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.
• The author is not providing or offering legal advice, but rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
• Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.
• Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

Goals/Objectives

• Learn more about capturing SOI and ROM
  o Clinical Indicators and Clinical Signs/Symptoms
• Enhance coding knowledge and skills
• Increase understanding of documentation and the lack of documentation for querying
• Conduct case scenario review and discussion
• Questions/Answers
Quality Matters

- Every American has his or her own definition of high quality health care.
- Severity of Illness and risk of mortality data has become the primary indicator of quality in healthcare.
- Providers need to make complete information about a patient’s health available.

Believe that Quality Matters, Embrace it and Make Every Effort to Ensure it Occurs With Every Patient Encounter!

More emphasis on Quality...

- The Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) Quality Check (www.qualitycheck.org) allows patients to search for accredited hospitals and other health care facilities.
- The National Committee for Quality Assurance (NCQA) has created www.healthchoices.org (www.healthchoices.org) to provide information on health plan report cards and physician groups.
- HealthPages.org (www.healthpages.org) publishes consumer reviews of doctors and hospitals and provides information about different medical conditions.
HEDIS

• The Health Plan Employer Data and Information Set (HEDIS®) is designed to help employers and consumers know how well their care follows accepted standards. Examples of HEDIS measures are the percentage of heart attack patients who are given a drug called a “beta-blocker” that helps prevent another heart attack and the percentage of women ages 52 to 69 who had an annual mammogram.

• Today, HEDIS is used by more than 90 percent of health plans in the United States, including those that participate in Medicare and Medicaid.

CAHPS

• The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a group of surveys asking consumers and patients to report on their health care experiences.

• CMS promotes the surveys and uses the data.
Mortality Data

- Often from death certificates
- Also from medical record data submitted to State and Federal databases
  - Claims data
    - Disposition expired
  - Shared with “Quality” initiatives
- Publically available health care data can be purchased
- Vendors and others can purchase

Mortality... 

- Many fatal illnesses cause similar symptoms, including pain, shortness of breath, digestive problems, incontinence, skin breakdown, and fatigue.
- Depression, anxiety, confusion, unconsciousness, and disability may also occur.
- Symptoms can usually be anticipated and treated.
What is the “Cause of Death”

- In law, medicine, and statistics, the cause of death is the condition or conditions officially determined to have resulted in a human's death. In modern times, such a determination usually is essential data on a governmental death certificate. (Wikipedia)

- **Cause of death (COD)** (http://medical-dictionary.thefreedictionary.com/cause+of+death)
  - Proximate COD: The most important, immediate, direct or actual cause, or last event or act that occurred before the chain of events leading to death
  - Immediate COD: The concluding or final event that actually produces death; other CODs include natural causes, HIV risk factors, injury and poisoning, dementia, periprocedural deaths associated with medical treatment or diagnostic/therapeutic procedures and devices, perinatal death

- **Mechanism of death**

### Causes of Death By Age Group

**10 Leading Causes of Death by Age Group, United States - 2013**

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<tr>
<th>Age Groups</th>
<th>Total</th>
<th>Heart Disease</th>
<th>Cancer</th>
<th>Stroke</th>
<th>Chronic Lung Disease</th>
<th>Diabetes</th>
<th>Influenza &amp; Pneumonia</th>
<th>Alzheimer’s Disease</th>
<th>Diabetes &amp; Nephropathy</th>
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Data Source: NCHS National Vital Statistics System, National Center for Health Statistics, CDC
Produced by National Center for Injury Prevention and Control, CDC.

10 Proprietary Business Document 2016
## State of Washington Statistics

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<tr>
<th>Year</th>
<th>Heart Disease</th>
<th>Cancer</th>
<th>Strokes</th>
<th>COPD</th>
<th>Unintentional Injury</th>
<th>Alzheimer’s</th>
<th>Diabetes</th>
<th>Pneumonia</th>
<th>Suicide</th>
<th>Liver Disease</th>
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<td>9.4</td>
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<td>11.2</td>
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</tbody>
</table>

*Per 100,000 age-adjusted to US 2000 population.

Source: Center for Health Statistics, Washington State Department of Health, 2005-2014

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**Healthgrades.com**

How America finds a doctor.

There's a Right Way to Find the Right Doctor.

There's more to choosing a doctor than insurance plans and office hours. Let us show you how to find the right doctor for you.

Get Started
<table>
<thead>
<tr>
<th>Procedure</th>
<th>In-Hospital</th>
<th>Within 30 Days</th>
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Providence Sacred Heart Medical Center

<table>
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<th>Procedure</th>
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Severity of Illness and Risk of Mortality

- Severity of illness and risk of mortality is dependent on the patient’s underlying problem
- High Severity of Illness and Risk of Mortality are characterized by multiple serious diseases and the interaction of those disorders
- Proprietary software from 3M

ALL-Patient Refined DRGs

- An expansion of the basic DRG concept to better reflect the attributes of the full patient population
  - 3M proprietary technology
- Medicare patients combined with the subdivision of each DRG into four severity and risk of mortality subclasses
- Some States use APR-DRGs for payment and some to assist with quality and mortality metrics
Why Severity & Risk Adjustment?

- Account for differences related to the patient’s severity of illness and risk of mortality so you can focus on the differences in clinical care
- Comparative Performance Reports
  - Internal
  - External
  - Public
- Credibility of Data with Physicians
  - “My patient is sicker!”
- Accreditation Standards
  - Quality Benchmarking standards
- Financial Incentives for High Quality and Low Cost
  - Bonuses for Core Measure results
  - Awards for Quality

Capture SOI and ROM

- Capture severity of illness and Risk of Mortality clearly, appropriately, and accurately documenting the presence of one or more MCCs or CCs (MS-DRGs) will impact hospital reimbursement by accurately reflecting the patient’s true severity of illness and risk of mortality.
- Coding HIM Professionals (& CDI) need to make a conscious effort
- Don’t work in Silos
### Severity of Illness Progression

#### Example of Severity of Illness Progression of Diagnoses

<table>
<thead>
<tr>
<th>Severity Of Illness</th>
<th>Secondary Diagnosis of Diabetes Mellitus</th>
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<tr>
<td>Minor</td>
<td>Uncomplicated Diabetes (250.0X)</td>
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<tr>
<td>Moderate</td>
<td>Diabetes with Renal Manifestation (250.4X)</td>
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<td>Major</td>
<td>Diabetes with Ketoacidosis (250.1X)</td>
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<tr>
<td>Severe</td>
<td>Diabetes with Hyperosmolar Coma (250.2X)</td>
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Using ICD-9CM codes

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### Risk of Mortality Progression

#### Examples of Standard Risk-of-Mortality Progression of Subclass

<table>
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<th>Secondary Diagnosis of Cardiac Dysrhythmias</th>
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<td>Premature beats (427.60)</td>
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<tr>
<td>Moderate</td>
<td>Sinoatrial Node Dysfunction (427.81)</td>
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<td>Major</td>
<td>Paroxysmal Ventricular Tachycardia (427.1)</td>
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<tr>
<td>Severe</td>
<td>Ventricular Fibrillation (427.41)</td>
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</tbody>
</table>

Using ICD-9CM codes

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Courtesy of 3M
SOI & ROM Example

- Example: Imaging showed brain herniation with no other documentation besides radiology report, patient also has stage 4 lung cancer, and family thought comfort care is appropriate for patient – lack of documentation showed SOI/ROM of 2 and 2 when it was in fact 4 and 4.
- Due to coding professional not able to code from radiology, query sent in partnership with radiologist and physicians involved in review process.

Real Example

- 75-yr-old female patient admitted via the ER with documented Sepsis (which is coded). In addition, the patient also has a history of hypertension as well as glaucoma, which is documented and coded.
- On admit to ICU, the patient was put on a Bipap, and ABGs were abnormal x2 over 24 hrs. (No documentation of possible or confirmed respiratory failure in the chart by the provider.) Patient was treated with antibiotics and physician progress note lists “PNA,” but the patient continues downhill after 5 days.
- Patient expires on day 5: What was the risk of mortality? And was this outcome score as expected ... Was this patient sicker than the data shows?
- Action:

  Resource Utilization = Severity / Acuity = Accurate
  Mortality Data = Accurate Reimbursement
Real Example (con’t)

- 86-year-old male patient with CHF admitted with SOB, edema, and weakness. Hx of diabetes type II. Put on O₂, and Respiratory therapist noted the patient was hypoxic but no documentation by the provider of this. (Can’t code for the Respiratory Therapy note.) Per nursing assessment patient has diabetic peripheral neuropathy, and blood sugar was 350 on sliding scale. Blood sugar drawn over 3 days, not documented by the provider.

- Patient expired after 6 days.

- Action??

Let’s Review This Case Together . . .

Chart Summary
- LOS 4 days
- 82-year-old admitted from nursing home after a fall which resulted in a hip fracture, closed reduction with internal fixation performed (surgery).
- Patient began to become more short of breath early the next morning 2nd day post-op and her fluids were stopped.
- She was given IV Lasix without improvement in her symptoms and monitored closely.
- Patient expired two days later.
- NOTE: No associated diagnosis for the reason for the IV Lasix documented by the MD.

Other Documentation
- Patient problem list includes: Hypoxia, pulmonary edema and diastolic heart failure, home O₂ at 2L and baseline wt 136-137 #.
- ED Note: SOB (chronic, unchanged) – cleared for surgery
- H&P: Home meds include Lasix 20 mg twice a day. ROS: Respiratory – right lung with inspiratory crackles to mid lung.
- CXR at 03:34: Findings are similar to radiograph from prior year and likely reflect chronic CHF.
- PN day #4: Found to be hypotensive this AM. Hypoxic on 4L O₂, RR 32 with use of accessory muscles. 20 mg IV Lasix now. Will not treat with BPAP or ventimask per patient and family wishes.
- DxSumm: Multiple comorbidities including diastolic heart failure. Hospital course: she became more short of breath this AM with hypoxia. Fluids stopped. She was given Lasix without improvement in her symptoms. Pt DNR changed to DNI per patient and family wishes. Patient expired.
Health Record Chart Review

The majority of patients enter via the ED. Review ambulance report for hints and clues, physician notes, and nurses’ notes for history, home medications, and current signs and symptoms.

Remember, you can include diagnoses from ED physician documentation as long as the attending physician does not contradict the information.

Review the emergency room records for any secondary diagnoses noted or treated while the patient was in the ER. Look for secondary diagnoses that were present and treated on admission. (Check for Chronic Systemic Conditions)

Assess for orders without clinical correlation such as an IV fluid bolus, medications (e.g., nitro, IV antibiotics, lidocaine, etc.).
ER Chart Review (Con’t)

• Review nursing home transfer notes for decubitus ulcers, indwelling catheters, etc.
• Physician’s Procedure/Operative Report—Read entire operative report for additional procedures performed.
• Read procedure/operative reports for secondary diagnoses such as fluid overload, intraoperative bleeds or lacerations, and suturing.
• Remember, if the diagnosis is already documented by a physician, further clarification is not necessary.

• Read the Medication Administration Record (MAR) — Are there any medications that do not have a documented correlating diagnosis?
• Do not forget IV medications administration:
  o Bolus
  o Injections
  o Infusions
  o Follow coding Guidelines (CPT), etc.
Death Chart Review

• When coding a chart in which the patient expired there are some key and important possible diagnoses to watch for.
• Often there are secondary conditions
• When coding the chart of an expired patient; review the APR-DRG carefully; low severity and/or mortality is a glue/flag that there most likely is some diagnosis missing.
• Major system failure occurring?
  o Query opportunities
• Check patient received palliative care (code)

Support Severity: End of Life Care

• When prognosis is “grave,” the status should be documented:
  Palliative care
  Comfort Care
  Do not resuscitate
  Comfort measure only
Coding HIM Competencies

- Capture, structure, and use of health information
- Clinical vocabularies & nomenclatures
- Severity of illness systems
- Reimbursement
- Data integrity and Coding audits
- Health Sciences:
  - Anatomy & Physiology
  - Medical Terminology
  - Pathophysiology (Disease Process)
  - Pharmacology

Clinical Indicators

- Coding and CDI professionals
- Learning
- Communication
- Disease process
  - Pathophysiology
- Anatomy/Physiology
Know & Understand Symptoms of Dying . . .

- For a person dying of cancer, energy, function, and comfort usually decrease substantially only in the last month or two before death. During this time, the person is visibly failing, and the fact that death is near becomes obvious to all.
- Other diseases, such as Alzheimer disease, liver failure, and kidney failure may follow a more gradual decline from the beginning but sometimes at a rate that is unpredictable.
- Severe heart disease and chronic obstructive pulmonary disease cause a steady decline but with episodes of serious worsening.
- These episodes are often followed by improvement, but usually death comes after an episode or worsening that develops within a few days of being stable.

Organ Failure

- Organ dysfunction or organ failure may be the first clinical sign of sepsis, and no organ system is immune from the consequences of the inflammatory excesses of sepsis.
- Mortality increases as organ failure increases.
- An organ dysfunction condition becomes organ failure when the normal homeostasis can be maintained only with the intervention of external clinical help. There are many symptoms of major organ failures as well as multiple organ dysfunction syndrome.
SOFA

- SOFA = **Sequential Organ Failure Assessment**
  - Often utilized in the ICU
  - Sepsis patients

- SOFA score = The SOFA score is a scoring system to determine the extent of a person's organ function or rate of failure.

- **Six Score Components:**
  - Respiratory, cardiovascular, hepatic, coagulation, renal and neurological systems.

Multiple Organ Dysfunction Score

- There is a process to score the multiple organ dysfunction (MOD).

- The MODS scores six organ systems:
  - Respiratory ($P_{O_2}$: $F_{I_{O_2}}$ ratio in arterial blood);
  - Renal (measurement of serum creatinine);
  - Hepatic (serum bilirubin concentration);
  - Cardiovascular (pressure-adjusted heart rate);
  - Hematological (platelet count)
Neurologic Failure

- Neurologic failure takes place due to a great reduction in the Glasgow Coma Score, which is reflected by an alteration in the level of consciousness.

Decreasing Level of Consciousness

Signs and Symptoms
- The majority of patients traverse the "usual road to death"
- They experience increasing drowsiness, sleep most if not all of the time, and eventually become unrousable
- Absence of eyelash reflexes on physical examination indicates a profound level of coma equivalent to full anesthesia
Brain Compression/Herniation

- By definition: An increase in intracranial pressure can be caused by a number of conditions such as edema, tumors, traumatic head injuries, infections, and hemorrhages.
- Herniation of the brain can also be caused by other factors that lead to increased pressure inside the skull, including:
  - Abscess
  - Hemorrhage
  - Hydrocephalus
  - Strokes that cause brain swelling
- Increases mortality, so capturing this secondary diagnosis is VERY important.

Documentation Clarification via Physician Query

- Utilize a physician query for clarification of the severity, acuity and risk of mortality.
- Follow AHIMA Physician Practice Brief
- Check for templates – consistency and continuity
Discussion

Tips . . .

- Make sure the clinical documentation tells the patient story.
  - What did the patient present with?
  - What did the provider do for the patient?
  - Why did the provider do what he/she did?
    - Example: When NS bolus is ordered and administered, or CT of the head is ordered any symptom or complaint should be documented to support this study.

- Ensure documentation includes the 4 main key elements:
  - Acuity
  - Location
  - Cause
  - Manifestation

- Document and code all comorbidities
- Dialog with your Physician Champion
Next Steps

- Check out Healthgrades, etc.
- Enhance and learn clinical indicators
- Conduct documentation reviews
- Conduct coding reviews
- Discuss and communicate
- Look at Severity or illness and Risk of Mortality
Next Steps and Best Practices

• Continuous review and analysis to support, manage and track documentation and coding improvements cannot be stressed enough.
• Chart reviews monthly of charts (earlier the better)
  o Concurrent
• Data report run monthly to trend deaths by specialty
• Discuss findings

Summary

• Review clinical indicators: they will assist you in understanding possible diagnoses being treated during a patient’s stay

• Physician query opportunities are presented to you within clinical indicators. Use of clinical indicator data to assist you with developing a query.

  o Use the physician query and follow Practice Brief (AHIMA)

• Understanding clinical indicators will assist you when following up with CDI queries.

• Through an understanding of clinical information, coders gain a more complete understanding of the treatment and disease processes.
Summary (con’t)

- Look for and Know the clinical indicators of organ failure
  - Enhance your knowledge
- Know the clinical indicators of Sepsis, SIRS and Septic Shock; and Respiratory Failure
- Death chart – review carefully
- Conduct coding and documentation reviews regularly
- Track and trend your audit results and scores on Healthgrades, etc.

Questions?

- Ask questions and seek more information.
Thank you!

References/Resources

- Guide to Clinical Validation, Documentation and Coding, ICD-10, 2016, Optum
- 3M APR-DRG
- [http://www.healthgrades.com/](http://www.healthgrades.com/)
- [https://en.wikipedia.org/wiki/SOFA_score](https://en.wikipedia.org/wiki/SOFA_score)