Equian DRG Audit Program

- Partnership with Providers
- Adhere to National Coding Guidelines
- Pay Fairly for Documented Services

Comprehensive DRG Waste Prevention Program

KDHE Approved 10-01-2018
Audit Process Overview
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)
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
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
DRG Discussion
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
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
“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
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

KDHE Approved 10-01-2018
Focus Conditions

- Sepsis
- Acute Respiratory Failure
- Malnutrition
- Hyponatremia
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
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
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 $\geq 2$ 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 $\geq 2$ reflects the additional organ dysfunction due to infection
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?
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.
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
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
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 us 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 us with any questions.

Sincerely,

Name:
Title:
Phone:
Fax:
Email:

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

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

Sincerely,
Appendix B - Key Findings Worksheet Example
Thank You