

Professional Coding and the Impact it Has on DRG's, Case Mix Index and Resource Consumption

by

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March 8, 2006

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Cleveland Clinic Foundation Overview

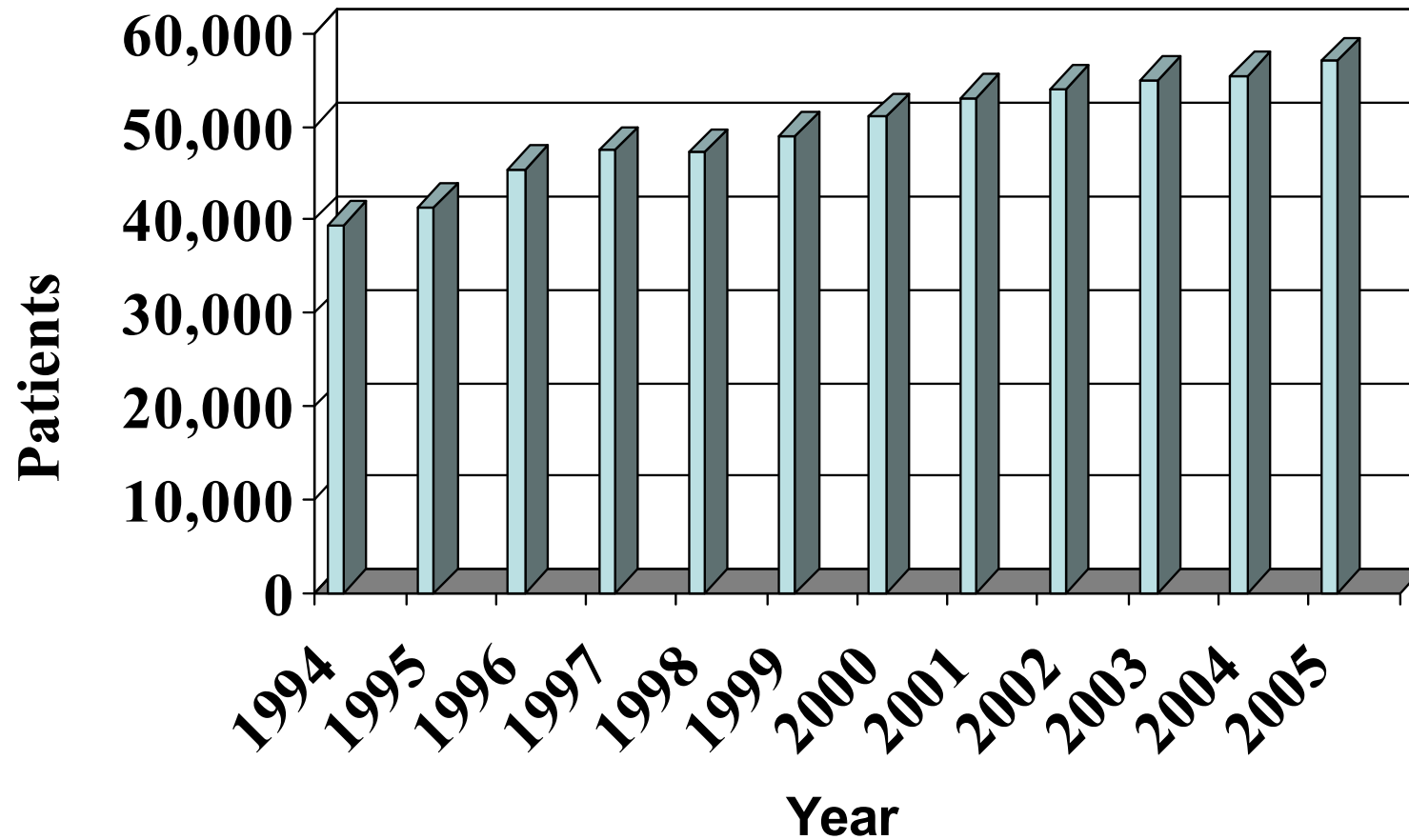
- **CCF Main campus includes**
 - 1000 bed hospital
 - > 60 outpatient clinic services
 - 18,000 employees
- **14 Family Health Centers**
 - 4 ambulatory surgery centers
 - Medical & surgical physician offices
- **Research division**
- **Educational division**

CCF Overview

- **2005 Key statistical information:**
 - **57,000 Admissions**
 - **3,100,000 Clinic visits**
 - **67,000 Surgical cases**
 - **2.31 Medicare Case Mix Index**
 - **Case Mix Index is highest out of all US hospitals with 500 or more beds**

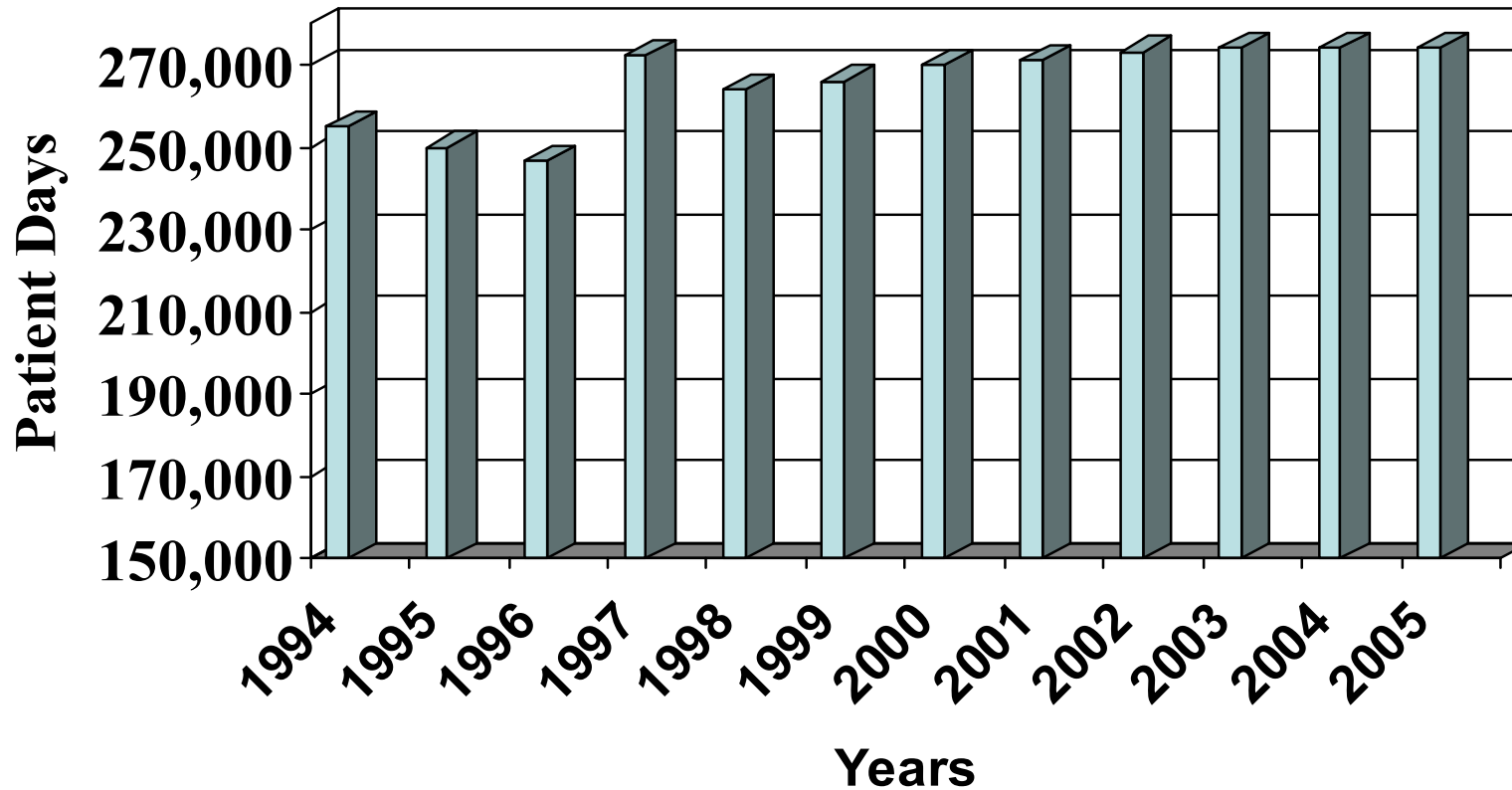
CCF Annual Admissions

ADMISSIONS

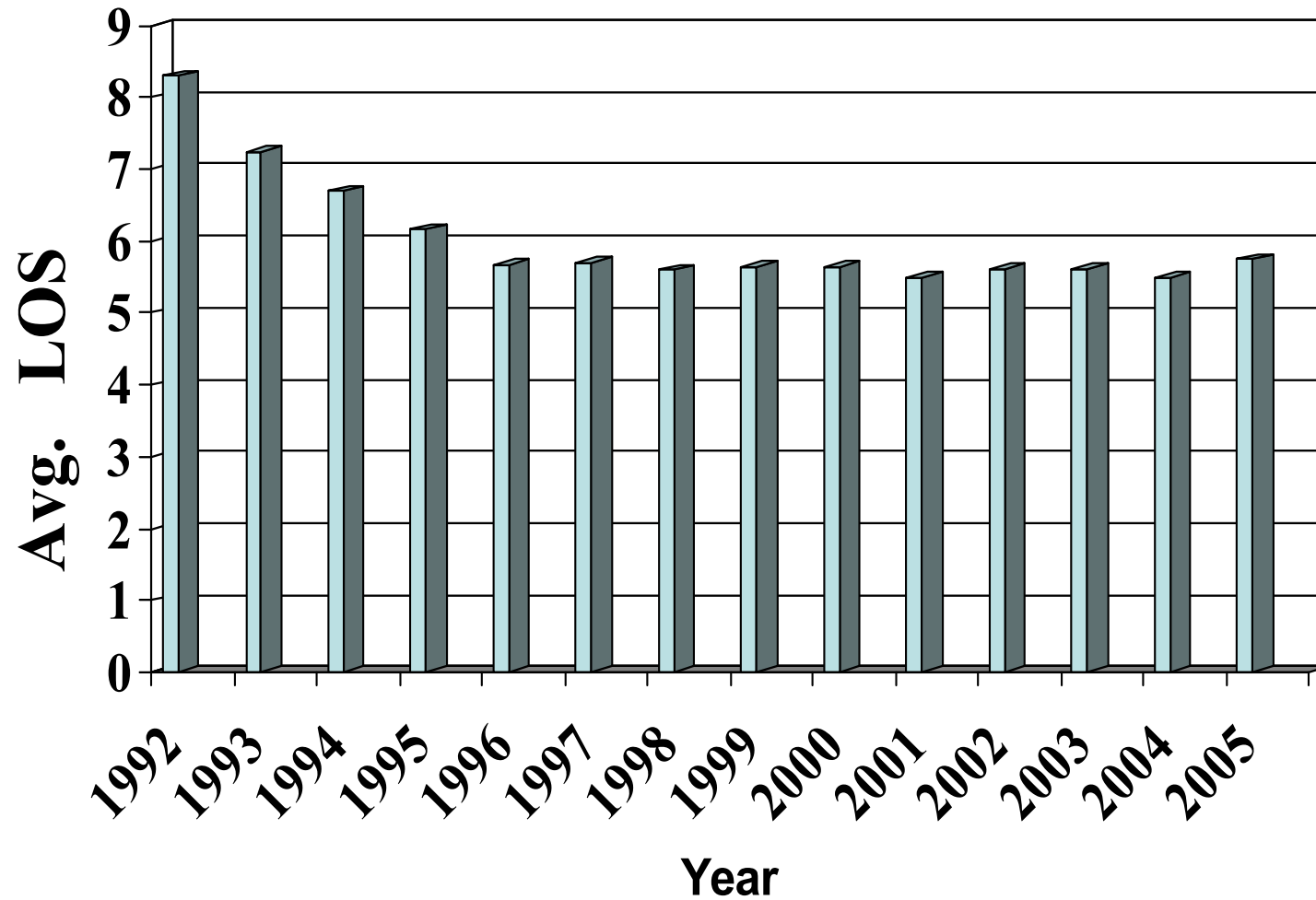


CCF Patient Days

PATIENT DAYS

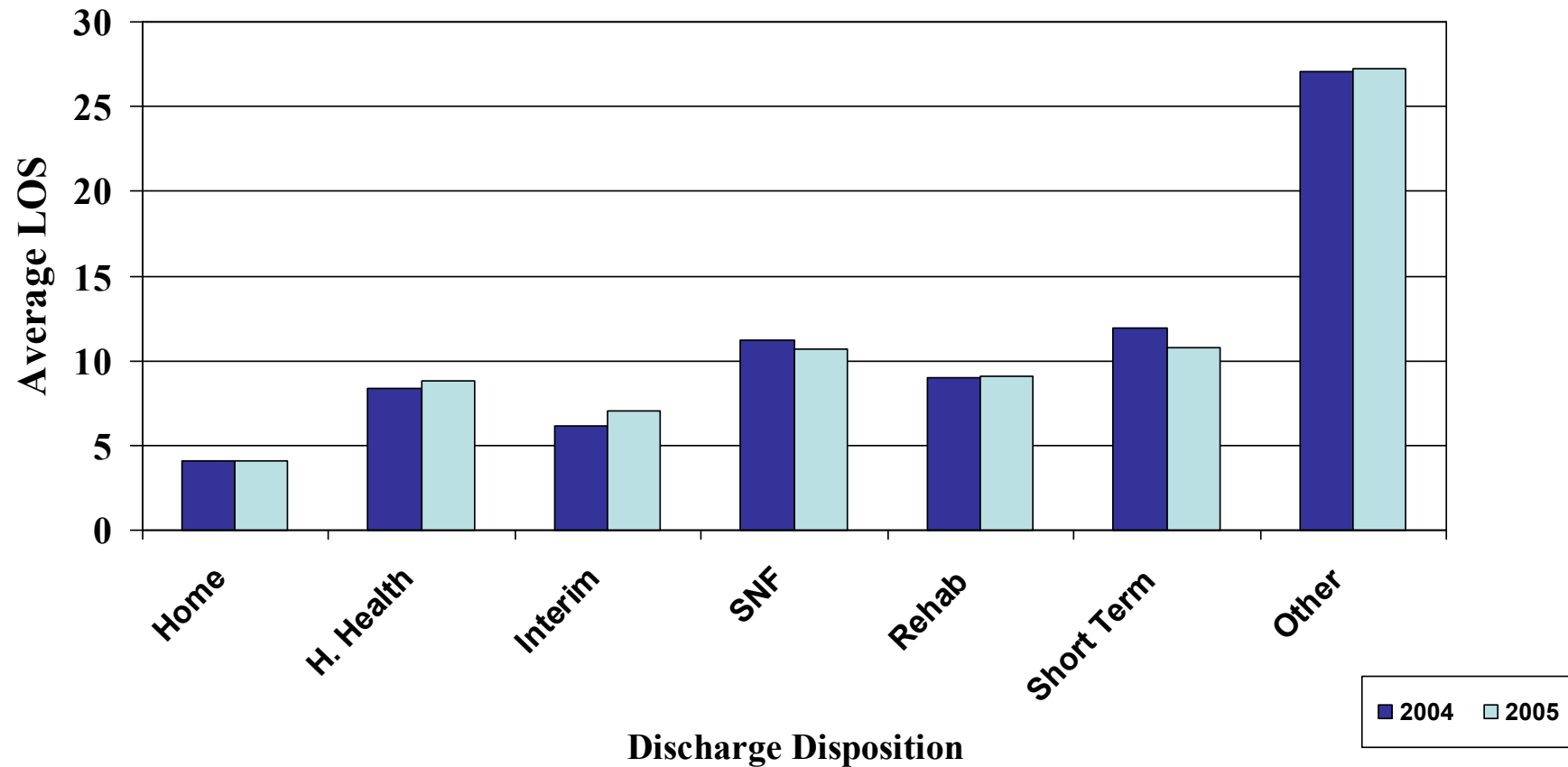


CCF ALOS



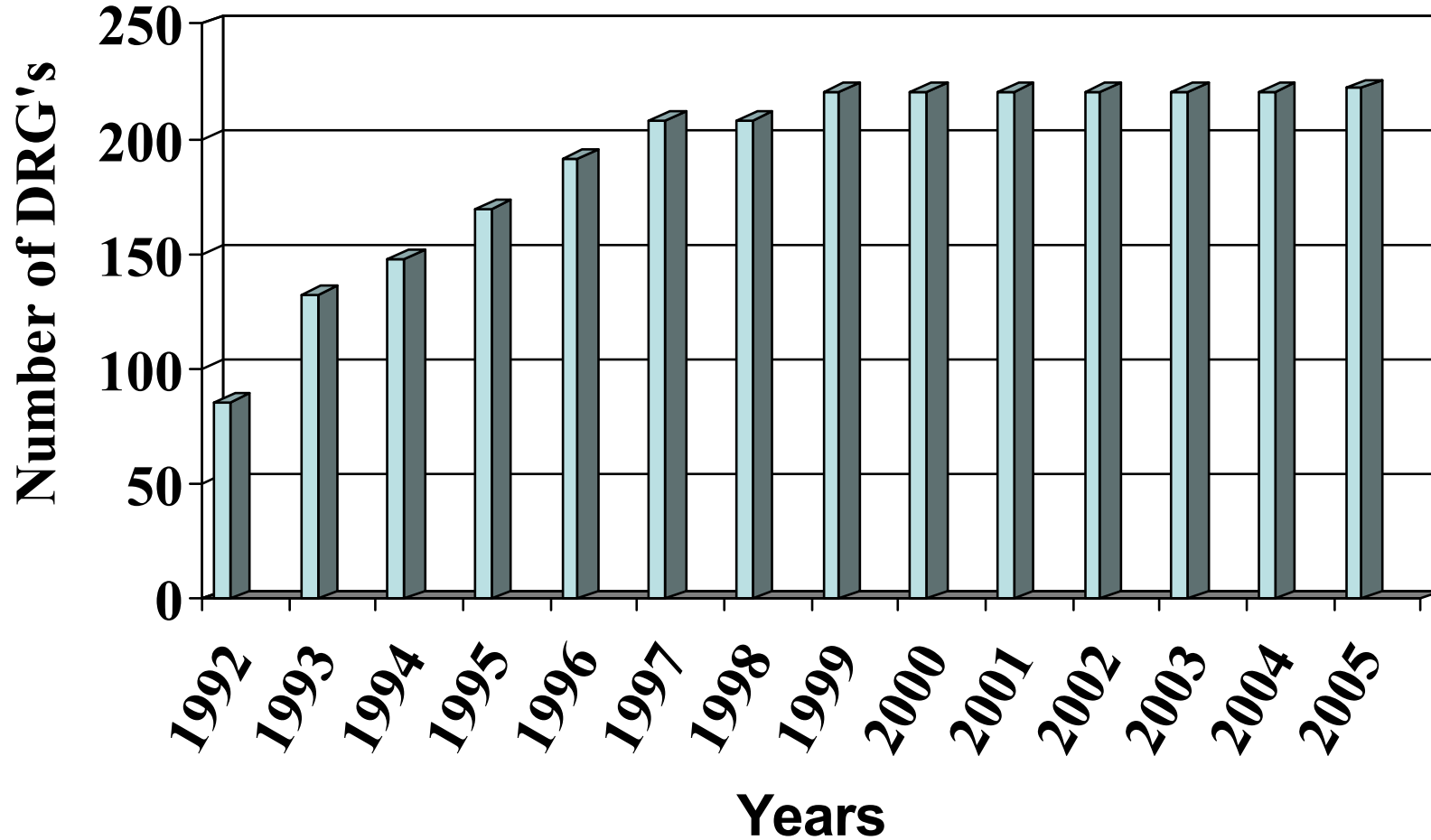
CCF ALOS by Discharge Disposition

AVERAGE LOS BY DISCHARGE DISPOSITION



CCF DRG's

CCF DRG's MEETING TARGET LOS



Definition

- Coder: Health care trained professionals interpreting physician notes into diagnosis and procedural ICD codes.
- Coding: Translating / transforming physician narrative into numbers

Historical Perspective of Coding

- Prior to the 1980's coding was used for clinical statistics
- In the 1980's - DRG perspective payment system was implemented
- morbidity and mortality stats
- In the 1990's - physician and hospital side increased volume of coders
 - Reimbursement, resource consumption, clinical statistics, and more detailed information
- In the 2000's - helping to determine the cost of healthcare and obtaining acute resource consumption

Benefits of using Credentialed Coding Staff

- Know Rules
 - Why people are admitted to the hospital
 - Not necessarily the most complex and/or life threatening conditions
- Consistent application of coding guidelines
- Consistent application of rules for reimbursement

Abstracting Information from Physician Notes

- Physician provides services
- Documents in notes
- Codes received and abstracted
- Coder codes charts

Coding Process

1. Thoroughly review medical record documentation
2. Code from documentation of a licensed physician
3. Determine principal diagnosis
4. Identify secondary diagnoses
5. Identify principal procedure
6. Identify additional procedures
7. Apply codes following coding guidelines

Coding has Helped In U.S.

- Better representation of clinical coding and services provided
- Better documentation of procedures
- Better documentation of supplies used
- Better documentation of services rendered

How to Improve Documentation

- Clinical physician documentation is not always able to be coded
- Documentation by non-physician members of healthcare team
 - dietitian, social worker, therapist
- Physician documentation lacks clarity/specificity
- **GOAL:** Thorough, accurate & complete physician documentation that precisely reflects the severity of illness and risk of mortality of the patients treated and supports the coding process and DRG / APR-DRG calculation
- The reason for a high lag time between coders and doctors is from incomplete information

Coders Work Concurrently in Hospital Reviewing

- Electronic medical record
- Patient charts
- Clinical notes
- Charge tickets
- Nursing notes and ancillary notes
- Other Ancillary staff, social work and case management

CCF Coding Staff

- CCF has a average of 15 FTE's
- Couple of nurses in department to help clarify health information when ever needed

Educational Requirements

- AHIMA
 - American Health Information Management Association
- 1 year of school
 - certified coder
- 2 year associate degree
 - Registered Health Information Technologist
- 4 year bachelor degree
 - Registered Health Information Administrators

Purpose of Medical Coding

- Research
- Planning
- Outcomes measurement
- Benchmarking
- Reimbursement
- Quality review
- Statistics
- Forecast/ trending
- Database

Good Coders Know

- Disease processes
- Anatomy
- Physiology
- Medical terminology
- Standardize Training across USA

Current Code Format

- ICD - 9
- ICD - 10 World Wide
- CPT 4 (physician based)
 - Procedural

Current Code Format

- INPATIENT
 - ICD-9-CM Coding
 - DRGs
 - APR-DRGs
 - Documentation Improvement
- OUTPATIENT
 - CPT-4 Coding
 - APCs
 - Documentation Improvement

DRG Explanation

- Each DRG assigned a relative weight
- Relative weight is based on average resources required to care for patient relative to national average of resources used to treat Medicare patients
- Medicare case assigned a relative weight average of 1.0000
- Relative weights reevaluated and updated each year based on national trends and changes

DRG Explanation (cont)

- Each hospital receives a blended rate based on regional or national adjusted standardized amount that considers hospital type:
 - Urban
 - Rural
 - Teaching
- wage index by geographic area

Comorbidity

- Defined as *“a preexisting condition that, because of its presence with a specific principal diagnosis, will cause an increase in the patient’s length of stay by at least one day in 75 percent of such cases”*
- There are over 1,600 ICD9 cc Codes

Most Recognized Conditions

- Diabetes
- Type 1
- Septicemia
- Anemia
- Angina
- Leukemia
- Certain Malignancy
- Pneumonia
- Post Organ Transplants
- CHF
- Meningitis
- Malnutrition

Importance of Coding

Case Study

- A few Years ago a drop in the case mix index suddenly occurred 2.25 to 2.15
- Investigation began into all of the areas
 - Decrease in complex surgical cases
 - Increase in primary care patients
 - Shift in market area
 - Errors in coding

Case Mix

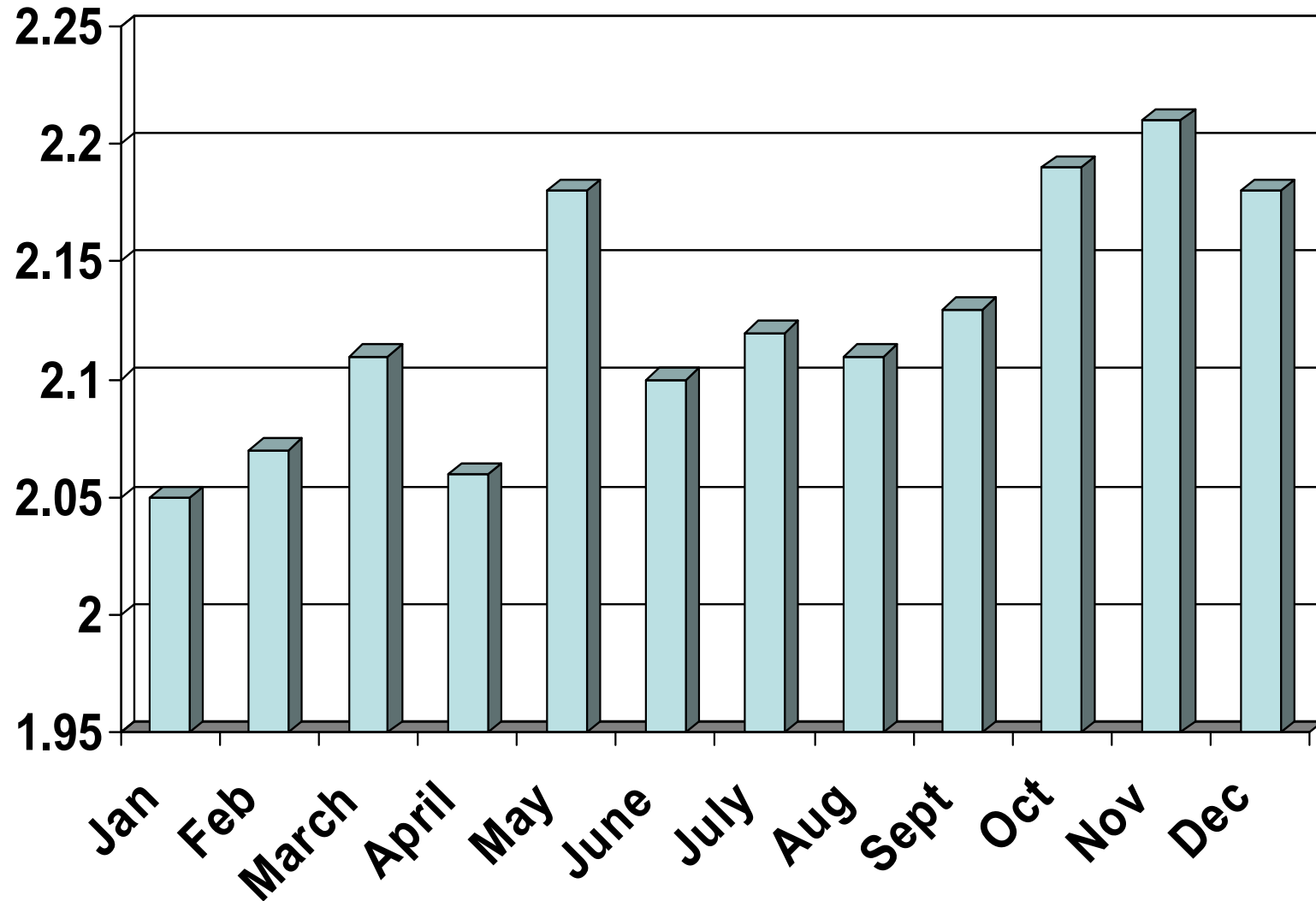
- Turnover of coding
 - Average Target:
 - 4 days outpatient
 - 7 days inpatient
- Each .01 difference in case mix index means
 - Each .01 represented \$55 USD increase or decrease
- Current drop in case mix index would mean about a 30 million dollar reduction in payment

Conclusion

- After reviewing situation for several weeks it was found that the medical record management had many new and inexperienced coders
- Problem was corrected with hiring experienced coders and case mix went back up to normal range

Case Mix Index

January- December 2005



Case Mix

- Case mix index monthly is one of the most important trend in direction a hospital has in the states

Future of Coding in US APR-DRGs

- All-Patient Refined DRGs
- Developed to expand the scope of DRGs to applications beyond resource use, cost and payment – possible new CMS payment methodology

Future of Coding in US APR-DRGs (con't.)

- APR-DRGs expand the basic DRG structure by adding four subclasses to each DRG that address *severity of illness* and *risk of mortality*
- Severity of illness is *‘the extent of physiologic decompensation or organ system loss of function’*
- Risk of mortality is *“the likelihood of dying”*

APR Severity and Risk of Mortality Subclasses

- 4 Extreme
- 3 Major
- 2 Moderate
- 1 Minor

How Fraud is Avoided

- Supervisors monitor coders
- Management monitor supervisors
- External auditors
 - Review organization
 - Third party payers
 - Government
 - Self audit (hiring and outside audit firm)

Conclusion

- Coders are vital to collect detail patient files correctly and with accuracy
- Must use resources to recruit and retain coders
- Thorough, accurate and complete physician documentation is essential
- Coders need easy access to physicians in order to clarify and question physician documentation in necessary
- With the implementation of coders, doctors can spend more time treating their patients