Learning Objectives

- Explain acute coronary syndrome (ACS) and typical physician terminology
- Describe common scenarios and opportunities for ACS queries, as well as potential compliance risks
- Apply lessons learned to clinical scenarios

The Need for Clinical Documentation Improvement

- "Acute coronary syndrome" includes more than one diagnosis
- Those diagnoses can affect:
  - Internal and external reporting of severity of illness and risk of mortality (physician and hospital "report cards")
  - Hospital payments based on Medicare severity diagnosis-related groups (MS-DRG) or All Patient Refined diagnosis-related groups (APR-DRG)
  - Quality reporting and pay for performance
- Documentation of those possible diagnoses can be conflicting or ambiguous
What Is Acute Coronary Syndrome?

- Physicians’ current terminology may not match the diagnosis codes attached to that terminology.
- “ACS” in medical terminology includes:
  - Unstable angina: angina pectoris that is at least CCS Class III or occurs at rest or
  - NSTEMI: acute myocardial infarction (myocardial necrosis) without ST elevations on the electrocardiogram or
  - STEMI: acute myocardial infarction with ST elevations on the electrocardiogram

More Physician Terminology in the ACS Patient

- Atypical chest pain
  - A description of a symptom
  - “Not the usual presentation for cardiac pain”
- Troponin leaks or troponinemia
  - May or may not indicate myocardial necrosis
  - Other possible causes: CHF, AFib, Vfib, heart blocks, SAH, cardiac trauma, burns, infiltrative and inflammatory diseases, PE, pulmonary hypertension, rhabdomyolysis …
- Demand ischemia
  - As the heart works harder, it cannot get enough blood/oxygen to supply the muscle (vessels, valves, blood, oxygen)
  - May or may not indicate myocardial necrosis

Codes in the ACS Patient

- ACS = unstable angina unless further described as AMI, NSTEMI, or STEMI
- NSTEMI or STEMI = acute myocardial infarction
- Troponin leak = abnormal value on blood test
- Demand ischemia = other acute ischemic heart disease

Coding Rules in the ACS Patient

- Source documents
  - Current encounter; documented by an MD/legal provider attending the patient (not pathology or radiology reports, not cosigned medical student notes, not nurses’ notes)
- If only a resident or consultant MD says “AMI”
  - It counts for coding unless later documentation rules it out
- If an MD only documents “AMI” once in the chart
  - It counts for coding unless later documentation rules it out
But It’s OBVIOUSLY …

- If it is “implied” to be ruled out or ruled in
  - Coders may only code what is documented, not what is implied
- “Possible/probable/likely” diagnoses
  - If a diagnosis is possible but not confirmed, it must be documented as such at discharge in order to be coded (inpatient rule)
- If the discharge summary does not include or repeat the earlier diagnosis of an acute MI
  - Not required for coding, but might indicate need for a query

Query Considerations for Coders

- If documentation is unclear, ambiguous, or conflicting, the coder may need to query the provider for clarification (CMS and Official Coding Guidelines)
  - Can the response have significant medical or legal impact on the patient? (seizures, malignancy, HIV)
  - Can the response affect the payment (MS-DRG or APR-DRG)?
  - Can the response affect reporting of severity of illness or risk of mortality?
  - Can the response affect quality metrics?

Quality Reporting

- Acute myocardial infarction is one of the National Hospital Inpatient Quality Measures
- Most acute myocardial infarctions are due to coronary obstruction (ruptured plaque, occlusion due to severe coronary artery disease and/or thrombosis)
- Quality standards for diagnosis and treatment of AMI are based on this likelihood
- If these standards are not met, overall Medicare payment to the hospital can be reduced

Resources: NHIQ Measures for Acute Myocardial Infarction

- Specifications Manual for the National Hospital Inpatient Quality Measures
  - Effective for discharges 1/1/2013 through 12/31/2013
  - Access the site below, click on the download for version 4.2b
  - Look at PDF files 2a through 2j
Consider a Query When …

- Documentation is unclear (ambiguous, conflicting, incomplete, illegible, vague, inconsistent)
- There are clinical indicators without a corresponding diagnosis
- There is a diagnosis without corresponding clinical support
- Documentation of presence on admission is unclear

When an ACS Query Is Probably NOT Needed

- Patient presents with typical symptoms for AMI
- Troponin and ECG are clearly positive
- Admitting physician documents an AMI, NSTEMI, or STEMI
- If a cardiac catheterization is performed, it confirms significant coronary obstruction
- The providers continue to document a diagnosis of myocardial infarction (even if no coronary artery disease [CAD] was found)
- OR: No physician contradicts an earlier diagnosis of AMI on the same encounter

Consider a Query: Acute MI Ruled Out?

- Mildly positive or ambiguous test results (troponin, cardiac enzymes, ECG)
- Cardiac catheterization shows no significant obstruction OR no catheterization is performed
- At least one provider documents some type of MI, but no consistency of diagnosis or no further documentation of the diagnosis
- MD documents "NSTEMI," then "STEMI ruled out"
- AMI is documented, then "D/C ACS protocol, discharge to home for outpatient workup"
  - Short stays are especially suspect

Consider a Query: Acute MI Ruled In?

- Patient symptoms are consistent with possible AMI
- Troponin, cardiac enzymes, and/or ECG are elevated and/or diagnostic for myocardial ischemia
- Cardiac catheterization is performed and confirms significant coronary obstruction
- There is no coronary obstruction, but the patient has other high-risk conditions (especially with other cardiomyopathy or thromboembolism history)
- Physicians document ACS/demand ischemia/troponin leak, but not an AMI/STEMI/NSTEMI
Resources: APR-DRGs and ACS Clinical Indicators

- All Patient Refined DRGs: Methodology Overview

- Mayo Clinic Proceedings, October 2009
  Acute Coronary Syndromes: Diagnosis and Management Part I
  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755812/

- Journal of the American Academy of Family Physicians, July 1, 2005

How to Query (Verbal and Written)

- Include relevant clinical indicators from the chart that support the request for clarification
- Ask that the clarification be documented in the chart
- If a multiple-choice list of diagnoses is presented, include options like “other” and “unable to determine”
- Yes/no queries are allowed in some circumstances (e.g., presence on admission, further specifying a cause or detail on an already documented diagnosis, resolving conflicting documentation by multiple providers)

How NOT to Query

- Do NOT: Tell the doctor what to document
  – “Dear Doctor. I read this chart and the patient did not have an MI. Please change your diagnosis to chest pain or unstable angina.”

- Do NOT: Include the financial impact on the payment for the case
  – “Dear Doctor. You only documented the ‘likely acute MI’ in the history and physical. Please add to the discharge summary so coding can get us the extra money!”

- Do NOT: Ask leading questions
  – “Dear Doctor. Troponin and ECG are positive. Didn’t this patient have a STEM?”

Resources: How & When to Query

- American Health Information Management Association, Journal of AHIMA, February 2013
  http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050018.hcsp?dDocName=bok1_050018

- More examples of query forms at Journal of AHIMA website
  http://journal.ahima.org

- AHIMA Body of Knowledge, “Appendix A: Query Examples” at
  www.ahima.org
Clinical Example #1

• 70-year-old patient diagnosed with chest pain.
• Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted for IV pain control and receives a cardiac catheterization, which shows no coronary artery disease.
• MD’s final diagnosis is “refractory chest pain.”
  – Principal diagnosis is chest pain
  – DRG is 287 @ 1.0709 relative weight
  – Severity of Illness (SOI) & risk of mortality (ROM) = 1

Clinical Example #2

• Same patient.
• Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted for IV pain control and receives a cardiac catheterization, but there is no coronary artery disease. MD adds diagnosis of acute coronary syndrome.
  – Principal diagnosis changes to unstable angina
  – DRG is still 287 @ 1.0709
  – Same: SOI = 1 & ROM = 1

Clinical Example #3

• Same patient, but different cath results.
• Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted for IV pain control and receives a cardiac catheterization, which shows moderate coronary artery disease. MD adds a secondary diagnosis of "CP due to CAD."
  – Principal diagnosis changes to CAD, angina > secondary diagnosis field
  – DRG is still 287 @ 1.0709
  – Same: SOI = 1 & ROM = 1

Clinical Example #4

• A different 70-year-old has no CAD or angina but does have atrial fibrillation.
• Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted for IV pain control and receives a cardiac catheterization, which shows no coronary artery disease. MD documents “CP due to atrial fibrillation with demand ischemia.”
  – Principal diagnosis changes to atrial fibr, secondary diagnosis is demand ischemia
  – DRG is still 287 @ 1.0709
  – Same: SOI = 1 & ROM = 1
  – No change if the two diagnoses are switched
WHAT!!

- MS-DRG 287 includes:
  - Circulatory disorders as principal diagnosis
  - Except for a diagnosis of acute myocardial infarction
  - Without MCC (a significant secondary diagnosis that statistically adds at least a day to the majority of patients and has a severity of illness factor of 3 or 4)
  - That have a cardiac catheterization as the main procedure
- If no cardiac cath was performed, the change in diagnosis does affect the MS-DRG, but not the severity of illness or risk of mortality.

Clinical Example #5

- Same patient as in example 4. Same scenario. Same diagnosis of demand ischemia.
- Late on admission day one he has an episode of ventricular fibrillation, but it resolves without major intervention (not present on admission).
- This adds one of those major CCs.
  - DRG is now 286 @ 2.0617 (nearly double)
  - SOI = 3 & ROM = 2
  - More MCCs: HIV/AIDS, pneumonia, exacerbation of systolic and/or diastolic CHF

Present on Admission?

- Same patient as in #5. Same scenario …
- EXCEPT: Instead of the Vfib being documented late on day one after admission, it is first documented in the emergency room notes prior to admission. MD’s final diagnosis is “chest pain due to ventricular fibrillation with subsequent demand ischemia.”
  - Principal diagnosis changes to ventricular fibrillation
  - DRG is back to 287 @ 1.0709
  - BUT: SOI = 3 & ROM > 3
  - Less $ on the MS-DRG, but increased ROM

Example #1: Before and After Query

- 70-year-old patient.
  - Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted for IV pain control and receives a cardiac catheterization, which shows no coronary artery disease. MD documents “refractory chest pain.”
  - After query for known or suspected cause of the chest pain, MD’s discharge summary says “CP probably due to mild NSTEMI; will discharge to outpatient cardiology follow-up in 3 days.”
    - Principal diagnosis changes from chest pain to NSTEMI
    - DRG drops from 287 @ 1.0709 to 282 @ 0.7736
    - AND: SOI & ROM are still bottomed out at 1’s for both
      DRG 282 = “Acute MI, discharged alive, no MCC”
But WAIT!

- The next CDI reviewer noticed that an echocardiogram showed EF 30% last month. The patient had gained 20 lbs in 2 weeks, was also complaining of shortness of breath, and the attending MD had increased the patient's usual dose of Lasix with improvement in symptoms.
- Due to documentation of treatment and clinical indicators without a corresponding diagnosis, the MD is queried and he/she adds "exacerbation of chronic systolic CHF" as a secondary diagnosis in the chart.
  - DRG is now 280 @ 1.7999 (more than double for NSTEMI alone)
  - Exacerbation of CHF (if documented systolic/diastolic) is an MCC as a secondary diagnosis
  - SOI = 2 & ROM = 2

One Last Example

- 70-year-old patient presents in ED with chest pain.
- Documentation includes: + troponin leak, mildly elevated cardiac enzymes, severe chest pain at rest that is minimally responsive to sublingual nitroglycerine. He is admitted with diagnosis of NSTEMI for IV pain control, and he receives a cardiac catheterization, which shows no coronary artery disease.
- In the electronic medical record, progress notes are cloned sequentially and repeat "NSTEMI" as a diagnosis.
- But: prior to discharge, MD discontinues ACS protocol, documents a final diagnosis of "chest pain," prescribes NO ACE inhibitors or beta blockers or aspirin, and advises the patient to follow up with his family physician in 3 months.

Query the Provider?

- Clinical indicators are mild, cardiac cath is negative.
- No treatment directed at coronary blockage.
- Diagnoses are "cloned" or conflicting.
- Will discharge without follow-up for three months.
- The CDI specialist queries the physician, references the clinical indicators, and asks him to clarify the conflicting diagnoses. MD adds "NSTEMI was ruled out; non-cardiac chest pain" in the discharge progress note.
  - Principal diagnosis is chest pain
  - DRG is 287 @ 1.0709 (but higher than simple AMI)
  - SOI = 1 and ROM = 1 (no worse than simple AMI)
  - Admission is not a "fail" for NHQI reporting

Now and Later

- Don't forget the post-discharge auditors!
  - RAC and other auditors are looking for vague or conflicting documentation
    - Lower the DRG payment
    - Deny the entire admission for lack of medical necessity
  - The effects of excellent (or poor) documentation continue for years.
    - DRG (money for each case, case mix > overall money)
    - APR-DRG (internal and public reporting of complexity)
    - Medical necessity (validate the admission status with severity of illness and intensity of service)
What Have We Learned?

- Documentation for acute coronary syndrome can be all over the map.
- The CFO needs CDI specialists to help ensure that physician documentation will support the most clinically appropriate DRG payment for each patient.
- The quality reporting staff needs CDI specialists to help guarantee that only true AMIs are reported as AMIs.
- The coders need CDI specialists—it's hard enough to code what is there, without trying to figure out how to code what isn't there, if it was there!

And More ...

- The hospital administrators and physicians need CDI specialists to help make certain that public reporting of severity of illness and risk of mortality appropriately reflects how sick their patients really are.
- Payers, especially Medicare and Medicaid, need CDI specialists so that when they pay for an admission, it is appropriate for both the patient and the hospital. (That's taxpayer money, remember?)

Last But Definitely Not Least

- Many queries responses will result in higher SOI/ROM/data/payment. However, a query response might result in lower reimbursement or a lower SOI/ROM. It could add an AMI patient to hospital quality reporting who didn't get the expected treatment protocol.
- You can't please all of the people all of the time!
- Remember that the goal of clinical documentation improvement is reflected in the name—to improve the documentation. No games. No tricks. Just get it right.
- If the diagnoses and procedures are clear, specific, and correct, the codes, reporting, and payments will be correct as well.
- Thanks everyone for all that you do!

Thank you. Questions?

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.