

**Hospital Checklist for Improving Documentation and Coding
to Ensure Appropriate Capture of Claims-Based Measures
August 2018**

The following information was developed based on the perspectives of Alabama hospital quality leaders and is being provided to help hospitals as they look for ways to improve scores on claims-based quality measures through better coding and documentation. **Please know these are suggestions only, not official guidance, and they are only current as of the date published. Measures are continually changing, so it's always best to doublecheck the latest specifications found at [CMS](#) and [AHRQ](#) and to establish any protocols or procedures based on your individual research and hospital needs.**

Key Issues that can Affect Scores on Claims-based measures:

Admission Type – Whether an admission is coded as an emergent or urgent admission, an elective, or one of the other codes, can make a big difference in determining if the incident (HAC or PSI) should be attributed to the hospital.

**[CMS guidance](#) for defining admission type and admission source (always check CMS guidance first)

** [List](#) of admission type codes from northwest QIO (supplementary source)

Admission Source – This is also important, such as appropriately coding patients with pressure ulcers (PSI – 3) who were transferred from another facility. At times, admission source will also dictate the admission type (see below)

- Example – Patient admission source is the physician's office. This could potentially signal a direct admission, which would likely be a non-elective admission under admit type.

**[CMS guidance](#) for defining admission type and admission source (always check CMS guidance first)

** [List](#) of point of origin codes from northwest QIO (supplementary source)

Getting credit for planned readmissions – Proper coding also helps ensure your hospital is not incorrectly labeled for a readmission. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation); otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure. [Click](#) to visit the most recent CMS guidance. Look in the Downloads Section and open “AMI, HF, PN, COPD and Stroke Readmission Updates” and then click on the most current update in the folder. Look at the table of contents to find the section describing planned readmissions and the types of procedures and diagnoses that should be present when a readmission is planned.

Need to be sure any co-morbid conditions are documented – Having the proper co-morbid conditions documented can help with both the risk stratification (observed versus expected) and the inclusions and exclusions that could potentially avoid a HAC/PSI. To be sure these conditions are appropriately captured and documented, some hospitals are creating checklists for physicians. Others have hired nurse practitioners to help with histories and physicals.

*Example of automatic exclusion – If a patient with an iatrogenic pneumothorax (PSI 6) was a patient that had plural effusion, by appropriately documenting the effusion, the condition might not result in a PSI.

CMS is heavily weighting hips and knees in many areas, so it's critical that the coding of co-morbid conditions be as accurate as possible for these and that the appropriate documentation is present to support the coding. Since CMS can actually consider co-morbid documentation on claims for 12 months prior to the index admission, hospitals need to try and get thorough H & Ps, perhaps even checking with primary care physicians prior to the surgery for additional information.

*Example – The following complications can help with risk stratification on the total hip and total knee complication measure: diabetes, certain types of cancer, number of procedures, malnutrition, etc. ([click](#) to download 2018 CMS measure specs; eligible risk factors are found on pp 38 – 39 of specifications; be sure to download the supplemental ICD-10 code lists below it.)

HCCs (list of co-morbid conditions used by CMS) – Since billing software systems were built for capturing payment appropriately, they may not adequately account for the impact of HCCs on quality measures. Therefore, some coding systems may not capture all of the HCCs possible within the CMS limit of 24, and may not sequence the HCCs to ensure they are close enough to the top of the list to count as an exclusionary criterion. Also, CMS has condition-specific crosswalks from the CCs to the ICD-10 codes. ([Click](#) to download the crosswalk for each of the mortality measure CCs; there are also crosswalks for readmissions and other coding guidelines under each of the claims-based measures, typically under “Resources.”)

Review primary versus secondary diagnoses on mortality – Carefully review the admitting diagnoses for COPD and pneumonia mortality patients as the inclusions are not as cut and dry, and the secondary diagnosis may influence the inclusion. With AMI, HF and stroke, the algorithm is more definitive and only uses the primary diagnosis.

The bottom line – With all of the measures, the best way (although not the easiest) is to download the “Measure Updates and Specifications Report and the Supplemental ICD-10 Code List” for each of the measures. Listed below are the links to the pages on which these specifications are found.

[Mortality measures](#) – There are two specification reports to download, along with the accompanying supplemental ICD-10 code sets.

[Readmissions](#) – All specifications reports are available for download, along with the supplemental ICD-10 codes. There are reports for condition-specific readmissions measures; procedure-specific measures and all-cause, hospital-wide measure.

[Medicare spending per beneficiary](#) – There are several documents with information on measure calculation, along with the SAS code to download and run on your own data.

[Payment measure](#) - There is one specifications report for all of the measures, along with the supplemental ICD-10 code list.

[Excess days measure](#) – There is one specifications report for AMI, HF and PN excess days measure, along with the supplemental ICD-10 code list.

[Episode-based payment measures](#)

Tips that apply to all measures:

- National source for all billing and coding questions – [National Uniform Billing Committee](#)
- Be sure coders understand why you're asking them to be careful about coding.

- In clarifying documentation, it's important to understand if your hospital uses the admitting physician, the hospitalist or the consulting physician to clarify documentation issues.
- Be sure your vendor software is appropriately capturing codes, based on the most recent version of CMS and AHRQ criteria. Some vendors even have specific tools for identifying these items (such as the 3M Encoder Smart Tool).
- Check claims before they are submitted. Devise a way to stop inaccurate or incomplete claims from being submitted, such as reviewing all claims with a PSI/HAC indicator.
- It's important to find out how your encoder software identifies HACs/PSIs (where would the coder look to see that a HAC/PSI has been captured).
- Your vendor should provide you with reports you can pull to see claims that will trigger HACs/PSIs. Use these reports to run your own data to validate what you're seeing on Hospital Compare and for benchmarking.
- You can also use the [datasets](#) used to populate Hospital Compare for benchmarking purposes. Downloads can be sorted by state and by measure.

Specific Issues found to be Impacting Hospital Star Ratings (as of July 2018):

- There are some indications that hospitals that report all or most measures due to complexity or volumes may have lower Star Ratings than hospitals that do not have these same volumes of complex patients. This is caused by the redistribution of weights out of the unreported complex measures with the weight being redistributed to other, less complex measures.
- Need to pay close attention to the weighting co-efficients (found on back tab of Hospital Star Report). Co-efficients are subject to change with each release of the Star Ratings. For example, with the December 2017 Hospital Star Ratings revisions, the coefficient for hips and knees changed significantly, which gave it a much higher weight in the scoring.
- Since PSIs are a big part of the patient safety category and are purely claims driven, proper documentation and coding are critical to avoid unnecessary penalties.