Purpose

- To develop standard clinical definitions on select diagnoses & categories to be used consistently across all hospitals in Maryland
  - Definitions will be informed by published criteria, existing hospital-developed definitions and supported by industry consensus and comments from the field
  - Definitions will not conflict with federal inpatient coding guidelines and will be applied to any occurrence of the diagnosis, not only in scenarios that might trigger a PPC
- Our goal is that these definitions will be considered and adopted by hospitals’ Medical Executive Committees
• Under the state’s waiver agreement, hospitals must meet reduction targets for Potentially Preventable Complications (PPCs)
  ▪ Additionally, the Health Services Cost Review Commission (HSCRC) incorporates reduction targets into payment policy
• Having a uniform set of clinically defining criteria may facilitate care improvement
  ▪ Consistency allows for both a performance comparison among hospitals and for a measurement of an individual hospital’s performance improvement over time
  ▪ Consistency helps demonstrate that Maryland hospitals have put in time and effort to achieve clinically significant performance improvement in addition to improvement achieved through revised documentation practices
Participants

HOSPITALS

Johns Hopkins
Lisa Grubb, Director of Quality Management, Johns Hopkins Bayview
David Pearse, MD, Medical Director, Johns Hopkins Bayview
Carol Ware, QI Team Leader for Special Projects, Johns Hopkins Hospital

LifeBridge Health
Carol McNutt, Manager & Clinical Documentation Specialist, Sinai Hospital and Northwest Hospital

MedStar Health
Deborah Cline, Clinical Documentation Specialist, Medstar Franklin Square Medical Center

University Of Maryland
Jason Birnbaum, MD, Chair of Medicine Department & ICU Director, UM Upper Chesapeake Medical Center & Harford Memorial
Tina Simmons, Quality Manager, UM Upper Chesapeake Medical Center

Peninsula Regional Medical Center
Robert Chasse, MD, Critical Care Medical Director, Peninsula
Susan Elerding, Medical Staff Clinical Quality Coordinator, Peninsula
Lisa Gray, Clinical Documentation Specialist, Peninsula
Gwyndle Kravec, Executive Director Health Information Management, Privacy Officer, Peninsula
Charles Silvia, MD, Vice President of Medical Affairs & Chief Medical Officer, Peninsula
Christopher Snyder, Chief Medical Information & Quality Officer, Peninsula
Michelle A. Taylor, Business Intelligence & Clinical Analytics, Peninsula

STAFF

Maryland Hospital Association
Nicole Stallings, Vice President
Justin Ziombra RN, Analyst

Berkeley Research Group
Joni Dion, Associate Director
Kristen Geissler, Managing Director
# Phase 1 Meeting Calendar

<table>
<thead>
<tr>
<th>Department</th>
<th>PPCs</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI</td>
<td>65, 66</td>
<td>January 13, January 28, February 17</td>
</tr>
<tr>
<td>Renal</td>
<td>24, 25</td>
<td>January 20, February 2, February 23</td>
</tr>
<tr>
<td>OB</td>
<td>55, 56, 57, 58</td>
<td>January 29, February 18, March 5</td>
</tr>
<tr>
<td>Respiratory</td>
<td>3, 4, 5, 6</td>
<td>February 5, February 19, March 10</td>
</tr>
</tbody>
</table>

All meetings to be held from 8:30 – 11:30 at MHA
Meeting Workflow Schedule

- **Meeting 1, February 5:**
  - Review coding rules, query rules and how clinical definitions can and cannot be used
  - Review existing definitions to eliminate non-starters, identify similarities and develop an initial consensus
- **Homework prior to Meeting 2:**
  - Participants will review initial consensus with appropriate clinical and administrative stakeholders for input
- **Meeting 2, February 19:**
  - Review feedback from stakeholders and update draft definitions
- **Homework prior to Meeting 3:**
  - Draft definitions will be submitted to hospital field for comment
- **Meeting 3, March 10:**
  - Review comments
  - Finalize definitions
Coding Guidelines
ICD-9-CM Official Guidelines for Coding and Reporting have been approved by the four cooperating parties:

- The American Hospital Association (AHA)
- The American Health Information Management Association (AHIMA)
- The Centers for Medicare and Medicaid Services (CMS)
- The National Center for Health Statistics (NCHS)

The inpatient coding process is based on the documentation provided by licensed providers who are treating the patient:

- Generally, the provider treating the patient will be the “attending physician”
  - The use of attending physician documentation is the “gold standard,” however, sometimes it may not be practical or optimal to only accept documentation from the attending physician

**EXAMPLE**
The consultant documents acute respiratory failure, but the attending physician does not. If there is no conflicting documentation the acute respiratory failure would be coded. If there is conflicting documentation, (i.e., acute respiratory failure vs. acute respiratory insufficiency) the attending physician would be queried for clarification.

References:
1. AHIMA Standards of Ethical Coding
2. Coding Clinic – 3Q/2006, Page 10
3. Centers for Medicare and Medicaid Services
4. Federal Register 42 cfr 412.46
5. ICD-9-CM Official Guidelines for Coding and Reporting
ICD-9-CM Official Guidelines for Coding and Reporting

• **Selection of Principal Diagnosis**
  ▪ The principal diagnosis is “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”

• **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

• Each case has one principal diagnosis, and in Maryland, up to 29 reportable additional conditions
ICD-9-CM Official Guidelines for Coding and Reporting

• Abnormal findings
  ▪ Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance
    ▪ If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, then it is appropriate to ask the provider whether the abnormal findings should be added

• Uncertain Diagnosis
  ▪ If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out” or other similar terms indicating uncertainty, then code the condition as if it existed or was established
  ▪ **Note:** This guideline is applicable only to inpatient billing (not to physician billing)

▪ **Clarify The Documentation If The Outcome Is Determined**
  ▪ Condition “ruled out”
  ▪ Condition “resolved”
Clinical Definitions

- Clinical Definitions:
  - Can provide guidance to coding professionals and/or clinical documentation specialist on when to query the providers
  - Should not replace a query to determine the appropriate code
    - For example, if acute respiratory failure is documented but does not have appropriate clinical indicators per the definitions a query should be generated to confirm the diagnosis
  - Clinical definitions are recommended to be formally approved by hospital medical staff
  - The clinical definitions are intended to serve as a guideline, not replace the provider’s clinical judgment
# Respiratory Failure ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Acute Pulmonary Edema and Respiratory Failure</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute respiratory failure</td>
<td>518.81</td>
</tr>
<tr>
<td>Other pulmonary insufficiency, not elsewhere classified following trauma and surgery</td>
<td>518.52</td>
</tr>
</tbody>
</table>
## Related ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Other Respiratory Diagnoses</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory insufficiency (Dyspnea &amp; respiratory abnormality)</td>
<td>786.09</td>
</tr>
<tr>
<td>Acute respiratory insufficiency (Other pulmonary insufficiency)</td>
<td>518.82</td>
</tr>
<tr>
<td>Hypercapnia (Dyspnea &amp; respiratory abnormality)</td>
<td>786.09</td>
</tr>
<tr>
<td>Hypoxemia</td>
<td>799.02</td>
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</tbody>
</table>
# Respiratory Failure ICD-10-CM Codes

<table>
<thead>
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<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute respiratory failure (includes respiratory failure, not otherwise specified)</td>
<td>518.81</td>
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</table>

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<tr>
<th>ICD-10 Will Require Greater Specificity To Accurately Capture The Condition</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute respiratory failure, unspecified whether with hypoxia or hypercapnia</td>
<td>J9600</td>
</tr>
<tr>
<td>Acute respiratory failure with hypoxia</td>
<td>J9601</td>
</tr>
<tr>
<td>Acute respiratory failure with hypercapnia</td>
<td>J9602</td>
</tr>
<tr>
<td>Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia</td>
<td>J9690</td>
</tr>
<tr>
<td>Respiratory failure, unspecified with hypoxia</td>
<td>J9691</td>
</tr>
<tr>
<td>Respiratory failure, unspecified with hypercapnia</td>
<td>J9692</td>
</tr>
</tbody>
</table>
# Pulmonary Insufficiency

## ICD-10-CM Codes

<table>
<thead>
<tr>
<th>Pulmonary Insufficiency</th>
<th>ICD-9-CM Code</th>
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<tbody>
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</thead>
<tbody>
<tr>
<td>Acute pulmonary insufficiency following thoracic surgery</td>
<td>J951</td>
</tr>
<tr>
<td>Acute pulmonary insufficiency following nonthoracic surgery</td>
<td>J952</td>
</tr>
<tr>
<td>Other chronic pulmonary insufficiency following surgery</td>
<td>J953</td>
</tr>
</tbody>
</table>
Currently Used Definitions
How Hospitals Define Respiratory Failure

- Many hospitals’ criteria include common requirements (bolded numbers encompass ranges of submissions):
  - Hypoxia: \( \text{PaO}_2 < 60 \text{ mmHg} \) on room air or a decrease of 10-15 mmHg, or a \( \text{SpO}_2 < 91\%-89\% \) on Room Air
    - Some facilities also enumerated a P/F ratio <300 as an element to consider
  - Hypercapnia: \( \text{PaCO}_2 > 50 \text{ mmHg} \) on room air with a pH < 7.35
  - Respiratory rate >20-30 breaths/min and/or labored breathing as evidenced by use of accessory muscles
  - Some hospitals include the need for intubation and mechanical ventilation or BiPAP as an element of the defining criteria
- Most hospitals made a point of noting that respiratory insufficiency post surgery was not acute respiratory failure
  - Some hospitals stated that ventilation for up to 48 hours after surgery should be attributed to transient insufficiency related to anesthesia
How Hospitals Define Pneumonia

- Among hospitals that submitted definitions, most cited the Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN) criteria as the basis for the definitions used in their facility
  - One facility states that it does not endorse a definition for pneumonia
- All require the radiologic detection of the presence of infiltrates accompanied by a certain number of signs and symptoms
  - Hospitals differed slightly in the number of signs and symptoms that must be present in addition to a positive chest x-ray or CT scan
    - The list of possible signs and symptoms typically included:
      - Fever greater than 38C
      - Leukopenia or Leukocytosis
      - Purulent secretions
      - Cough, Dyspnea or Tachypnea
      - Worsening $O_2$ Saturation
    - Many facilities submitted criteria that differentiated Community Acquired Pneumonia (CAP), Healthcare-Associated Pneumonia (HCAP), Hospital-Acquired Pneumonia (HAP) and Ventilator-Associated Pneumonia (VAP)
The CDC NHSN has created an algorithm to define pneumonia\(^1\)

- The criteria also incorporate laboratory findings to differentiate among bacterial, viral, and fungal pneumonia

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1: Pneumonia (Ventilator-associated [VAP] and non-ventilator associated pneumonia [Pneu]) Event – CDC, 2015
Workgroup Discussion

- What is our initial consensus?
Homework

• Review the consensus we developed today with the appropriate clinical and administrative staff at your hospitals

• Come to our next meeting prepared to discuss their feedback as well as any additional thoughts or research that you may have

• Our next meeting is here, on February 19th at 830am

Thank You!!