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The Dangers Of HACs

Hospital-acquired conditions not only harm patients, but can hurt a facility's revenue and reputation, too.

By Cheryl McEvoy

On June 6, 2007, Ed Ornelas checked into the emergency department, thinking he had the flu. Doctors diagnosed appendicitis. Ornelas wasn't in pain, which doctors took as a good sign and assured a quick, routine appendectomy.

But things didn't go as expected. His appendix had ruptured, complicating surgery. Internal bleeding sent him back into the operating room and almost claimed his life.

Three days later, Ornelas was still hurting, but he never expected what his doctor would find on an X-ray. "The doctor told me—I'll never forget his words—'There's something inside you. It's a foreign object and we think it's a sponge.'"

Five sponges were removed from Ornelas' abdomen, according to what nurses told his wife. The physical effects were temporary, Ornelas said, but the psychological damage has been permanent.

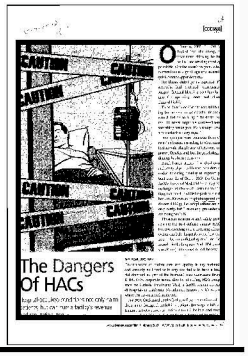
Amid horror stories of medical errors and safety slips, health care providers are under increasing scrutiny to improve patient care. As of Oct. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) no longer reimburses for certain complications that develop while the patient is in the hospital. Known as hospital-acquired conditions (HACs), the complications are not only costly, but "reasonably preventable," according to CMS.

Physician awareness and safety protocols are the best defense against HACs, but documenting and monitoring adverse events can help hospitals avoid lost revenue—plus an unflattering mark on their record—in the long run. And HIM professionals are just the ones to lead the way.

NO POA, NO PAY

"Improvement of patient care and quality is key nationally, and certainly an incentive to improve that is to have a financial deterrent as part of the formula," said Gloryanne Bryant, RHIA, CCS, corporate senior director of coding HIM compliance for Catholic Healthcare West, a health system covering 41 hospitals in California, Nevada and Arizona, which was not where Ornelas received treatment.

For 2009, CMS listed 10 HACs that will not be reimbursed, including any foreign object left in a patient after surgery, falls and trauma, catheter-associated urinary tract infections and severe pressure ulcers. When such a condition is diagnosed, hospitals ▷



must document whether the condition was present on admission (POA) or developed during the patient's stay, which it indicates with "Y" for present, "N" for not present, "W" if the clinician cannot determine POA status or "U" for insufficient documentation. Any secondary diagnoses with a POA indicator of "N" or "U" no longer garner reimbursement.

HAC reporting is intended to rein in reimbursement, but the financial impact on hospitals is debatable. Reports vary, but HAC denials have affected only about 1-4 percent of cases on average, according to what Bryant has heard in the industry. "The financial impact of that 1 percent on overall annual Medicare reimbursement probably isn't as large as some may have thought it would be," Bryant said.

Cheryl Bowling, RHIT, CCS, CHC, C-CDI, HIM compliance director for Kforce Professional Staffing, Tampa, FL, however, said the word on the street is that some hospitals are expecting significant financial drawbacks, particularly specialty hospitals. The real numbers have yet to be crunched.

Besides the risk of lost revenue, hospitals are concerned HACs will hurt their image. Reporting a HAC with a POA indicator of "N," meaning the condition developed while the patient was under the hospital's care, may be considered "a negative on your scorecard of quality," Bryant said.

CODERS ADAPT WELL

With a hospital's reputation hinging on HACs, coders have a critical responsibility to properly report POA indicators. According to Bryant, they are stepping up to the challenge. "I'm not hearing many problems from the HIM coding side," she said.

Hospitals have been required to report POA for Medicare patients since October 2007, so coders already have more than a year of experience. California has been reporting POA for more than 10 years, Bryant said, and other states had similar reporting requirements in place before CMS issued its rule. "It's probably more of a challenge for the states that didn't have this type of reporting [before the CMS rule]," she added.

Bryant advised anyone struggling with POA reporting to read over in detail the American Hospital Association's POA coding guidelines. "It covers multiple scenarios and clinical situations," she said. "They've done a very good job laying out all types of situations and scenarios for hospitals to follow."

When visiting clients and facilities, Bowling was impressed to see coders working together to ensure charts were coded correctly. Many departments conducted peer review before submitting claims, and coders often asked each other for advice on a difficult case.

Despite noting minimal errors, Bryant and Bowling said cases with multiple comorbidities or complications (CCs) require extra vigilance, as they can offset a HAC denial. Only one CC or major CC is needed to bump a case up to a higher DRG payment tier, so when there are multiple CCs or MCCs with only one considered "hospital-acquired," the facility still earns full reimbursement.

"MINE YOUR DATA"

Bryant urged providers to mine their data, which can help distinguish HACs from other CCs or MCCs so the facility can determine which conditions are impacting payment. Mining also can identify common problem areas and quality issues.

When dealing with multiple CCs or MCCs, data mining can use formulas to find which conditions were hospital-acquired and which ones were POA.

Data mining can also help hospitals identify conditions that frequently have POA indicators of "N" or "U"—in other words, the most common conditions that are hospital-acquired or missing documentation. That way, providers can anticipate CMS denials and get to the root of persistent problems.

"If [reviewers are] seeing blanks or 'unknowns,' those are the ones you should question if the volume is significant—more than .5 percent—because they should be rare," Bryant said.

In addition to data mining, Bryant suggests auditing POA indicators, which is a best practice, at least once or twice a year to check coding and POA accuracy.

FILLING IN THE BLANKS

From an HIM standpoint, the best way to avoid the pitfalls of HACs is to bolster documentation practices. The CMS ruling on HACs is a perfect opportunity to get the ball rolling on clinical documentation improvement.

When CMS began requiring POA reporting in October 2007, Bryant's corporate department led a campaign to educate hospital staff and distributed an awareness memo and tip sheets to physicians—each a single-page document. "We tried to make it as concrete and succinct as possible although it's a complicated subject," Bryant explained.

She encouraged coders to query physicians if POA status is questionable, and said it should be a "mainstay" in a hospital practice. Bryant suggests using a spreadsheet to track physician queries. The spreadsheet should note the patient's identification number, the date of the query, the doctor who was questioned and the date the doctor responded. That way, doctors who are consistently delinquent in filling out charts or responding to queries can easily be identified. (See a sample query form and tracking log at *www.advanceweb.com/him*.)

Before launching any POA education or query process with physicians, make sure you have the right approach, Bowling cautioned. Too often, HIM departments will explain how HACs affect financial returns, which can frustrate physicians who aren't concerned about the bottom line. "Make sure you are letting the physician know this

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is for data quality," Bowling said.

Instead of laying out the difference in payment, tell physicians how HAC reports will affect their statistics and case mixes. It also helps to note that information from the reports can end up on hospital and physician grading sites, Bowling said.

LOOKING AHEAD

As hospitals assume the burden of patient safety improvement, HIM professionals should keep an eye on future agendas. CMS is looking to add other complications to the HAC list, including Methicillin-resistant Staphylococcus aureus (MRSA), a highly contagious and potentially fatal infection. MRSA presents a challenge to coders documenting POA; when a patient is admitted without any symptoms, it's difficult to tell when the infection was contracted. "It could have been present and didn't really show up until later or germinate itself and develop to be widespread," Bryant said.

Questionable cases may also prompt calls for an appeals process—something Bryant said providers should consider for comment to CMS. Currently, there is no way to appeal a HAC MS-DRG impact, but Bryant said the matter is worthy of discussion.

Regardless of which changes take hold, providers are generally advised the more information they can collect, the better. Specific details can help prove the medical necessity and severity of a condition, which can mean a higher payout, a clean record and a satisfied patient. ■

Cheryl McEvoy is an editorial assistant with ADVANCE.

To read more about Ed Ornelas' ordeal, go to "More on HACs" at **www.advanceweb.com/him**.