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CDI IN BLOOM | acdis 2023
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Optimizing Hospital Performance Data: Small Group Exercise in Mortality Reviews

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Presented By

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Understand why healthcare organizations should review all in-house mortalities
  - Understand how to successfully implement a mortality review process at your organization
  - Understand the expected and unexpected results of creating a mortality review process
  - Perform small group reviews of actual mortality cases for improved diagnosis capture and documentation revision opportunities
  - Understand when discovered documentation opportunities should or should not be added to a mortality record

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Why UTMC Needed This Process

- **It's a patient care issue, right?**
  - At most hospitals, only catastrophic cases with bad, unexpected outcomes routinely receive appropriate attention
    - Nothing to learn from 'expected outcomes' that could prevent a future catastrophe?
- ☹ **UTMC O:E Mortality Rate > 1.0**
  - Known problem of OSHs dumping cases with minimal to no survival chance because:
    - We are the Level 1 trauma center, the stroke center, and the tertiary referral center leading to numerous auto-accept agreements
    - Other two hospital systems **VERY** data conscious
  - Known problem of inadequate provider documentation for very short LOS cases
    - *A mortality is a mortality is a mortality . . .* they all count against your organization
  - ***Consensus that "bad care" NOT a reason***

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Why O:E Mortality Rate Important

- Publicly reported quality data increasingly impacts patient choice of provider
  - *If you build it, they will come*
- Payers intentionally 'herd' patients to providers with better performance/outcomes
  - *Better outcomes means more payer profits*
- Provides improved negotiating leverage at the contracting table with commercial payers
  - *Can't be excluded from a network if "You Da Man!"*
- Provides improved advertising ammunition in competitive local healthcare markets
  - *Closure of 2 Knoxville hospitals in last 15 years met with shrugs*

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The Actual Process

- UTMC Mortality Task Force created late 2019 through "voluntelling" by CQO
  - Includes COE medical directors, service line heads, dept. chairs, PI dept., CDI, etc.
- Daily list of **ALL** UTMC mortalities (including IP, OBS, ER) sent electronically to coding auditor
- Mortalities manually distributed by coding auditor to all coders' (IP, OP, & ER) daily work queues (*__Remember__*: Only IP cases count against your organization)
  - *We review **ALL** mortalities because never know if/when a claim will convert to IP status*
- ☑ Mortalities prioritized by coders to be the **first-worked** cases every morning
- ☑ IP coders code *with whatever documentation they have* at that time

  __Note__: They **DO NOT** "pend" the initial coding of mortalities for missing documentation as might normally do for "routine" cases

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The Actual Process

- **IF** coder able to "final code" a mortality case at that time, **it is sent to billing *regardless* of SOI/ROM scores, *regardless* if task force review done**
  - ☑ Found that revenue delayed by initial, year-long universal "bill hold" for all mortality claims **until Mortality Task Force review process completed** far outweighed number of cases ultimately sent for rebill
    - i.e., Accounts receivable dollars **>>** RA/payer denial risk
  - – UTMC still has 30 days from date of death to make documentation changes that might lead to coding changes that would necessitate rebilling of a claim
- ***Note*:** Might be different numbers/impact at another facility depending on number of changes/rebills sent

The Actual Process

- ***Every* Monday morning:** Homegrown access-based program pulls **ALL** mortalities that occurred between previous 2 Fridays up to MN of the 2nd Friday
  - – Sent to all UTMC Mortality Task Force members (~26-30 charts per week)
  - – Report includes admit attending, attending of record, admit Dx., prin Dx, prin Px, SOI/ROM scores, and MS-DRG
    - ***Note*: Creates potential 10-day lag before first review**
- COE medical directors/service line heads/dept. chairs/PI review for potential clinical problems/care improvements
  - *Remember: **The main reason to establish this process**!*
- CDI medical director reviews all mortalities **with SOI & ROM scores less than 4 & 4** for documentation improvement opportunities
  - – Ranges from 3 to 12 cases per week

The Actual Process

Potential results of CDI medical director reviews:

1. **Coding** oversight correction or coding interpretation change
   - **If** coder discussion results in coding amendment, claim sent for rebill if impacts SOI/ROM scores &/or MS-DRG
2. Potential **CDI** documentation improvement opportunities:
   - ❏ None found
   - ❏ Found but no SOI/ROM or MS-DRG implications
     - – Used for educational purposes as may impact future cases
   - ❏ Found for SOI/ROM scores *but no MS-DRG implications*
     - – Request for D/C summary addendum *or* post-D/C query sent to attending of record (&/or COE medical director, service line head, dept. chair)
       - • Claim sent for rebill for PI data improvement
         - – No fraud allegation risk if reimbursement **NOT** affected
         - 😠 Payers/RAs **DO NOT** care about SOI/ROM scores

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The Actual Process

Potential results of CDI medical director reviews:

2. Potential CDI documentation improvement opportunities (cont.):
   - ❏ Found for both SOI/ROM scores *and/or* an MS-DRG change go through CDI medical director subjective 'gut check' *before* action taken
   - ***_Note_**: ALL MS-DRG upgrade rebills **will be flagged & reviewed by payer/RA**
     - – **IF defendable**, request for D/C summary addendum *or* post-D/C query sent to attending of record (&/or COE medical director, service line head, dept. chair)
       - • Claim then sent for rebill
     - ☑ **IF fails** "gut check," used for educational purposes only
       - ❌ **DO NOT** unnecessarily feed the RA Beast *or* bait the OIG**‼**
   - ***_Note_**: "*Used for educational purposes*" = CDI findings/recs entered in access program and emailed to attending &/or COE medical director, service line head, dept. chair, etc.
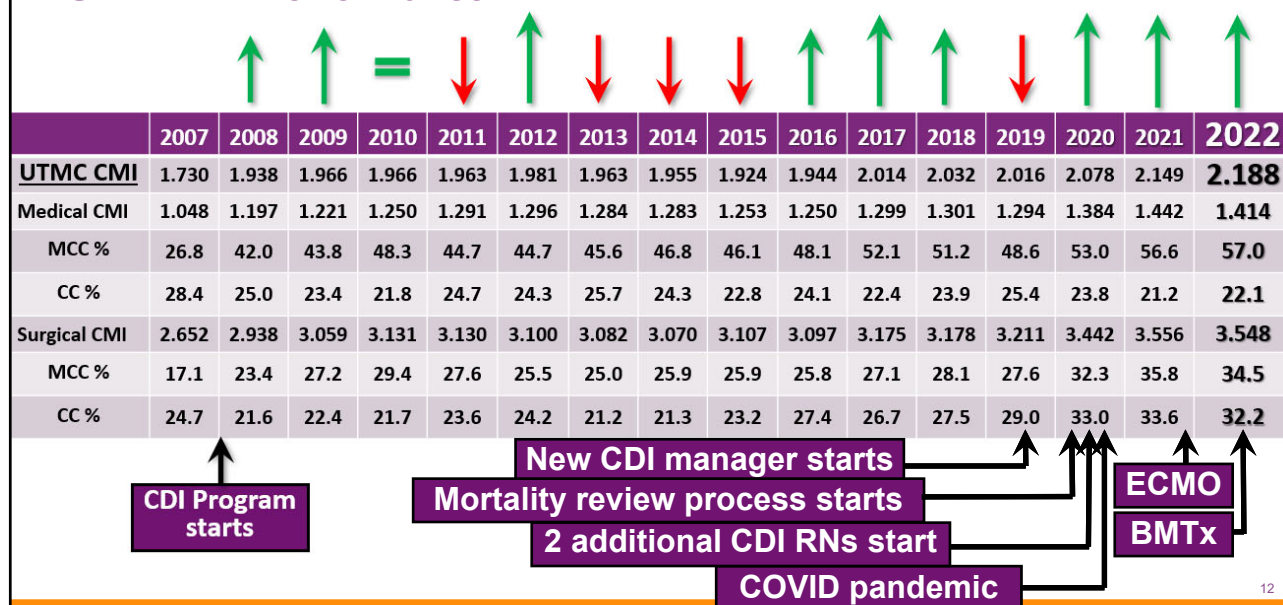
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Expected Benefits Realized

- UTMC O:E Mortality Rate has improved (**1.33 to 0.88**) *but* degree of attribution to mortality review process unreliable due to data being completely skewed by COVID pandemic, numerous other initiatives focused on same issue, *and* Premier calculation recalibration
  - *Why does COVID not sky-rocket SOI/ROM?*
- *Subjectively*, UTMC overall documentation **much** better
  - Particularly on very short LOS cases
    - Number of coded diagnoses definitively increased
- UTMC medical staff/COE medical directors/service line heads/dept. chairs much more aware of documentation importance and coding nuances
  - *If it's important to my boss . . .*
- Number of mortalities with SOI/ROM scores **<** 4 & 4 definitively decreased

UTMC CDI Performance

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	↑	↑	=	↓	↑	↓	↓	↓	↑	↑	↑	↑	↓	↑	↑	↑
UTMC CMI	1.730	1.938	1.966	1.966	1.963	1.981	1.963	1.955	1.924	1.944	2.014	2.032	2.016	2.078	2.149	**2.188**
Medical CMI	1.048	1.197	1.221	1.250	1.291	1.296	1.284	1.283	1.253	1.250	1.299	1.301	1.294	1.384	1.442	**1.414**
MCC %	26.8	42.0	43.8	48.3	44.7	44.7	45.6	46.8	46.1	48.1	52.1	51.2	48.6	53.0	56.6	**57.0**
CC %	28.4	25.0	23.4	21.8	24.7	24.3	25.7	24.3	22.8	24.1	22.4	23.9	25.4	23.8	21.2	**22.1**
Surgical CMI	2.652	2.938	3.059	3.131	3.130	3.100	3.082	3.070	3.107	3.097	3.175	3.178	3.211	3.442	3.556	**3.548**
MCC %	17.1	23.4	27.2	29.4	27.6	25.5	25.0	25.9	25.9	25.8	27.1	28.1	27.6	32.3	35.8	**34.5**
CC %	24.7	21.6	22.4	21.7	23.6	24.2	21.2	21.3	23.2	27.4	26.7	27.5	29.0	33.0	33.6	**32.2**

CDI Program starts

New CDI manager starts

Mortality review process starts

2 additional CDI RNs start

COVID pandemic

ECMO

BMTx

Completely Unanticipated Bonuses

☑ Numerous new invitations and/or avenues of approach to provide service line CDI education/training sessions
  – Neurology, Neuro-Critical Care, Anesthesia Critical Care, Critical Care Medicine, Cardiology, Hospitalists, Urology
  ☺ **Finally got in with Heme-Onc service after 13 years‼**
  ☺ **Finally got in with ED after 15 years‼**

☑ Many individuals previously notorious for being universally recognized as "recalcitrant to CDI" suddenly showed interest and/or documentation improvement
  – Peer pressure?
  – Ego pressure?
  – Public shaming?
  – Better understanding of documentation importance and image impact?

Small Group Exercise Directions

• Divide into **5** groups of approximately **7 to 8** people
  – Groups will have **~20-25 minutes** to review their case and decide what diagnoses (*if any*) were clinically present but not documented and/or coded
• Each group will present their results including any documented diagnoses which were not coded **and/or** any clinically present diagnoses which should have been recognized and documented *as well as the why* (i.e., the supporting evidence)
  ☺ Choose **one person** in your group to be the spokesperson for the summary presentation
• Each case contains the relevant parts of the medical record including:
  – The original coding summary as would be submitted on the claim w/out review
  – All relevant provider documentation (H&P, consults, PNs, D/C summaries, etc.)
  – Labs, radiology studies, diagnostic tests, pertinent vital signs, etc.
*<u>Note:</u> Many notes may say there are 3 or 5 pages but last page is missing
  – No clinical info on many last pages so they were omitted to reduce copy costs

Your Group's Task

1. Identify documented diagnoses that were not coded
   – Be able to provide your reasoning as to why they should be added to the claim
2. Decide if you are going to talk to the coder about something that was documented but not ultimately coded
3. Identify clinically present diagnoses that were not documented in the record
   – Be able to provide your reasoning and evidence
4. Decide if you are going to talk to the involved providers about what you found
   – ***And*** . . . are you are going to ask the involved providers to add or addend the current documentation?

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Review of Our Results

- Plan for approximately **10** minutes total per case summary presentation and subsequent discussion
- In **2–4 minutes**, each spokesperson should present:
  1. A very brief statement about what the hospitalization was for
  2. What diagnoses were clinically present but not documented
  3. What documented diagnoses were not coded
  4. If you would approach the involved providers to get additional documentation
  5. If you would review the case with the coder who may have missed something

  ☺ **There are no wrong answers‼** *Everyone will learn something from this exercise (including me!)*
  – You will likely find stuff that your presenter missed *and* will certainly have differing opinions as to what to do with the review results
- UTMC's subsequent actions based on the original Mortality Task Force review will be presented

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Questions?

GO!

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Case #1—UTI from SNF

CM	POA	Code	Description
1	Y	T83.510A	Infection and inflammatory reaction due to cystostomy catheter, initial encounter
2	Y	N39.0	Urinary tract infection, site not specified
3	Y	C78.5	Secondary malignant neoplasm of large intestine and rectum
4	N	Z51.5	Encounter for palliative care
5	Y	B96.5	Pseudomonas (mallei) causing diseases classd elswhr
6	Y	E03.9	Hypothyroidism, unspecified
7	Y	D50.9	Iron deficiency anemia, unspecified
8	Y	F01.50	Vascular dementia without behavioral disturbance
9	Y	R41.82	Altered mental status, unspecified
10	Y	R19.5	Other fecal abnormalities
11	Y	E78.5	Hyperlipidemia, unspecified
12	N	I95.9	Hypotension, unspecified
13	N	R09.02	Hypoxemia
14	N	R00.0	Tachycardia, unspecified
15	Y	I25.10	Athscl heart disease of native coronary artery w/o ang pctrs
16	Y	E11.65	Type 2 diabetes mellitus with hyperglycemia
17	Y	E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unsp
18		Z86.73	Prsnl hx of TIA (TIA), and cereb infrc w/o resid deficits
19	Y	F32.9	Major depressive disorder, single episode, unspecified
20	Y	N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms
21	Y	E55.9	Vitamin D deficiency, unspecified
22		Z95.810	Presence of automatic (implantable) cardiac defibrillator
23		Z95.4	Presence of other heart-valve replacement
24	Y	Z20.822	Contact with and (suspected) exposure to COVID-19
25		Z79.4	Long term (current) use of insulin
26		Z79.899	Other long term (current) drug therapy
27		Z88.2	Allergy status to sulfonamides
28		Z87.891	Personal history of nicotine dependence
29	N	Z66	Do not resuscitate
30		Z78.1	Physical restraint status

Coding Issues:
- **C18.2** - **Malignant neoplasm of ascending colon** should have been coded as opposed to C78.5

Documentation Issues:
- **CKD stage 3** w/ eGFR = 36 to 49
- **Stage 4 colon cancer w/ mets to liver, porta hepatis LNs, and lungs** as opposed to "metastatic colon CA"
  - *4 codes vs. just 1*
- **Possible GI bleed** w/ dark stools, hemoccult positive and treatment change starting w/ 2/10 PN
- **Acute encephalopathy** w/ MS changes and eventual needs for mittens based on 2/3 PN as opposed to "altered mental status"
- **Acute respiratory failure** with acute decompensation in early AM of 2/10
- **Severe malnutrition** based on NSDW

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Case #1—UTI from SNF

- Would you approach the Coder? **Yes**
- Would you approach the provider for a documentation change &/or addendum?
  - If captured **all** documentation suggestions (particularly severe malnutrition and acute respiratory failure), SOI & ROM would change from 2 & 3 to **4** & **3**
    - *Looks much better, right?*
  - Why would you be hesitant to ask for these things?
    - Does involve an MS-DRG change so **will be reviewed by payer** (w/ CC to w/ MCC)
    - Could acute respiratory failure be just part of dying process and should not be coded?
    - Does severe malnutrition meet criteria for valid secondary diagnosis coding?
    - Could look "coached" if acute respiratory failure and severe malnutrition only appear in the D/C summary
- UTMC used case for teaching purposes only **and did not request additional documentation**

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Case #2—Metastatic Pancreatic CA

CM	POA	Code	Description
1		C25.0	Malignant neoplasm of head of pancreas
2		R18.0	Malignant ascites
3		C78.7	Secondary malig neoplasm of liver and intrahepatic bile duct
4		C34.90	Malignant neoplasm of unsp part of unsp bronchus or lung
5		E46	Unspecified protein-calorie malnutrition
6		Z51.5	Encounter for palliative care
7		Z66	Do not resuscitate
8		R11.0	Nausea
9		D72.829	Elevated white blood cell count, unspecified
10		I10	Essential (primary) hypertension
11		K86.81	Exocrine pancreatic insufficiency
12		Z87.891	Personal history of nicotine dependence

Coding Issues:
- None?

Documentation Issues:
- **Sepsis** (by sepsis-2 criteria) due to intrabdominal source
- **Peritonitis** based on physical exam and probable intrabdominal source
- **Bacteremia** w/ positive blood cultures
- **Acute renal failure** w/ creatinine elevations
- **Hyponatremia**
- **Probable severe malnutrition** based on weight loss and physical exam (needed NSDW for confirmation)
- **Bone metastasis** on CT scan which were new findings

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Case #2—Metastatic Pancreatic CA

- Would you approach the coder? **No Need**
- Would you approach the provider for a documentation change &/or addendum?
  - If captured **all** documentation suggestions (particularly sepsis, peritonitis, and severe malnutrition), SOI & ROM would change from 3 & 2 to **4 & 4**
    - *Looks much better, right?*
  - Why would you be hesitant to ask for these things?
    - Does involve an MS-DRG change so **will be reviewed by payer** (Principal Dx change to Sepsis *and* from w/ CC to w/ MCC)
    - *Definitely "coached" if all these diagnoses suddenly appeared in the D/C Summary*
- UTMC used case for teaching purposes only **and did not request additional documentation**
  - *This is the case that got me into Hem-Onc after 13 years*

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Case #3—Found Down With ICH

CM	POA	Code	Description
1	Y	I61.5	Nontraumatic intracerebral hemorrhage, intraventricular
2	Y	I16.1	Hypertensive emergency
3	Y	S02.19XA	Oth fracture of base of skull, init for clos fx
4	N	N17.9	Acute kidney failure, unspecified
5	Y	I61.1	Nontraumatic intcrbl hemorrhage in hemisphere, cortical
6	Y	I60.9	Nontraumatic subarachnoid hemorrhage, unspecified
7	Y	W18.12XA	Fall from or off toilet w strike against object, init
8	Y	I25.10	Athscl heart disease of native coronary artery w/o ang pctrs
9	Y	I65.21	Occlusion and stenosis of right carotid artery
10	Y	I10	Essential (primary) hypertension
11	Y	E78.5	Hyperlipidemia, unspecified
12	Y	E11.65	Type 2 diabetes mellitus with hyperglycemia
13		I25.2	Old myocardial infarction
14		Z79.84	Long term (current) use of oral hypoglycemic drugs
15		Z79.899	Other long term (current) drug therapy
16		Z88.8	Allergy status to oth drug/meds/biol subst status

Coding Issues:
- **Acute respiratory failure** documented but not coded
- **Neurogenic shock** documented but not coded

Documentation Issues:
- **Acute renal failure** w/ significant rise in serum creatinine (0.98 to 2.63)
- **Acidosis** w/ low serum bicarb and elevated lactic acid level
- **Brain herniation** was described on CT head ("effacement of cisterns") but not documented
- **HTN crisis** as opposed to documented HTN emergency (especially if ICH was nontraumatic)

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Case #3—Found Down With ICH

- Would you approach the Coder? **Yes**
  - If added codes for documented acute respiratory failure and neurogenic shock, SOI & ROM would change from 3 & 3 to **4 & 4**
    - Does involve an MS-DRG change so **will be reviewed by payer** (w/ CC to w/ MCC)
- Would you approach the provider for a documentation change &/or addendum for the remaining missed diagnoses?
  - Why would you be hesitant to ask for these things?
    - Could look "coached" if acute renal failure, acidosis, etc. only appear in the D/C summary
      - *However*, very short stay does not look as bad as case where had been here for a week
- Would you send for rebill?
  - **UTMC absolutely did** but used remaining missed diagnoses as teaching opportunities only

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Case #4—Acute CVA

CM	POA	Code	Description
1	Y	I63.312	Cerebral infrc due to thombos of left middle cerebral artery
2	N	G93.6	Cerebral edema
3	N	G93.5	Compression of brain
4	Y	G81.91	Hemiplegia, unspecified affecting right dominant side
5	Y	E87.1	Hypo-osmolality and hyponatremia
6	Y	J81.1	Chronic pulmonary edema
7	N	F10.139	Alcohol abuse with withdrawal, unspecified
8	Y	R47.01	Aphasia
9	Y	R13.12	Dysphagia, oropharyngeal phase
10	Y	J43.9	Emphysema, unspecified
11	Y	R29.727	NIHSS score 27
12	Y	D72.829	Elevated white blood cell count, unspecified
13	Y	R73.9	Hyperglycemia, unspecified
14	Y	J84.112	Idiopathic pulmonary fibrosis
15	Y	Z51.5	Encounter for palliative care
16	Y	Z66	Do not resuscitate
17		Z87.891	Personal history of nicotine dependence
18		Z99.81	Dependence on supplemental oxygen
19	Y	Z20.822	Contact with and (suspected) exposure to COVID-19

Coding Issues:
- **Chronic respiratory failure** documented in pulmonary consult
- **Acute on chronic hypoxic Respiratory failure** with deteriorating respiratory status in D/C summary

Documentation Issues:
- **Acute pulmonary edema** as opposed to just "pulmonary edema" (which defaults to chronic)
- **Possible sepsis** (based on sepsis-2 criteria) as deteriorated further and was treated w/ ABX
- **Probable septic shock** as was started on vasopressors

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Case #4—Acute CVA

- Would you approach the Coder? **Yes**
  - If added acute on chronic hypoxic respiratory failure, SOI & ROM would change from 3 & 3 to **4 & 4**
    - Anybody want to send a post-D/C query asking for this? **Yes!**
      - **NO** MS-DRG change if query answered positively so *no risk of payer review*
        - *Payers only care about money, <u>not</u> SOI and ROM scores*
- Would you approach the provider for a documentation change &/or addendum for the remaining missed diagnoses?
  - **NO** MS-DRG change if they did add them to the D/C summary so . . .
- **UTMC sent post-D/C query for acute on chronic hypoxic respiratory failure which was answered positively, and the claim was rebilled**
  - UTMC used the remaining missed diagnoses as teaching points only

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Case #5—Valve Replacement

CM	POA	Code	Description
1	Y	T82.857A	Stenosis of other cardiac prosthetic devices, implants and grafts, initial encounter
2	Y	I50.1	Left ventricular failure, unspecified
3	N	I47.2	Ventricular tachycardia
4	Y	I31.8	Other specified diseases of pericardium
5	Y	I35.1	Nonrheumatic aortic (valve) insufficiency
6	Y	E78.2	Mixed hyperlipidemia
7	Y	F17.210	Nicotine dependence, cigarettes, uncomplicated
8	N	R57.0	Cardiogenic shock
9	N	I49.01	Ventricular fibrillation
10	Y	Y71.2	Prosth/oth implnt/mtrls cardiovascular devices assoc w incdt
11	Y	Y83.1	Implnt of artif int dev cause abn react/compl, w/o misadvnt
12	Y	F32.9	Major depressive disorder, single episode, unspecified
13	Y	F41.1	Generalized anxiety disorder
14	Y	R73.09	Other abnormal glucose
15		Z79.891	Long term (current) use of opiate analgesic
16		Z79.82	Long term (current) use of aspirin

Coding Issues:
- None?

Documentation Issues:
- **Acute on chronic HFrEF** based on intraoperative TEE and subsequent documentation
- **Acute blood loss anemia** based on operative note and transfusion needs
- **Probable Peripheral arterial disease** based on inability to cannulate femoral artery
- **Pulmonary HTN** based on PA pressures in pre-op ECHO

Case #5—Valve Replacement

- Would you approach the Coder? **No Need**
- Would you approach the provider for a documentation change &/or addendum for the remaining missed diagnoses? **Yes!**
    - If add code for acute on chronic HFrEF, SOI & ROM would change from 3 & 3 to **3 & 4**
        - *Looks much better, right?*
    - Does involve an MS-DRG change so **will be reviewed by payer** (w/ CC to w/ MCC)
        - *However*, reasonable addition since such a short LOS and was an emergent situation

‼ THIS IS AN ELECTIVE SURGICAL CASE ‼

- **CDI PA contacted medical director of associated COE and suggested a chat with the involved surgeon**
    - Despite numerous contact attempts, the D/C summary was never modified/addended

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Case #6—ETOH/CHF

Principal Diagnosis Codes

Code	Type	Description	POA
I11.0	ICD-10	HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	Y

Secondary Diagnosis Codes

Code	Type	Description	POA
J98.11	ICD-10	ATELECTASIS	Y
I42.9	ICD-10	CARDIOMYOPATHY, UNSPECIFIED	Y
R62.7	ICD-10	ADULT FAILURE TO THRIVE	Y
F19.10	ICD-10	OTHER PSYCHOACTIVE SUBSTANCE ABUSE, UNCOMPLICATED	Y
F10.129	ICD-10	ALCOHOL ABUSE WITH INTOXICATION, UNSPECIFIED	Y
K76.9	ICD-10	LIVER DISEASE, UNSPECIFIED	Y
D69.6	ICD-10	THROMBOCYTOPENIA, UNSPECIFIED	Y
E87.6	ICD-10	HYPOKALEMIA	Y
E83.51	ICD-10	HYPOCALCEMIA	Y
M54.9	ICD-10	DORSALGIA, UNSPECIFIED	Y
K74.60	ICD-10	UNSPECIFIED CIRRHOSIS OF LIVER	Y
G31.9	ICD-10	DEGENERATIVE DISEASE OF NERVOUS SYSTEM, UNSPECIFIED	Y

Coding Issues:
- Is CHF correct Principal Dx.??

Documentation Issues:
- **Chronic hypercapnic respiratory failure** based elevated serum bicarb levels and VBG w/ normal pH & pCO_2 > 50 mmHg
- **Acidosis** w/ low serum bicarb and elevated lactic acid level
- **Alcoholic cirrhosis w/ ascites** based on history and CT scan C/A/P as opposed to just "cirrhosis"
- **Coagulopathy due to liver disease** w/ elevated INR and cirrhosis
- **Alcohol dependence w/ withdrawal** as opposed to "abuse"

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Case #6—ETOH/CHF

- Would you approach the Coder? **Oh Yeah!**
  - The patient was admitted for failure to thrive and/or weakness per the H&P; the CHF did not become an issue until 1 or 2 days *after* admission
    - **Principal Dx change would remove from CHF mortality data bucket**
- Would you approach the provider for a documentation change &/or addendum for the remaining missed diagnoses? **No**
  - If captured **all** documentation suggestions, the SOI/ROM scores would not change from 3 & 2
  - Why would you be hesitant to ask for these things?
    - No MS-DRG change as all are CCs so no payer impetus to review
    - *Definitely "coached" if all these diagnoses suddenly appeared in the D/C summary*
- Would you send for a rebill?
  - **UTMC absolutely did with "weakness" as principal dx. resulting in correct data bucket, less reimbursement, but SOI & ROM scores improved to 3 & 3** (*Go Figure!*)

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Thank you. Questions?

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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 of the program guide.

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