QAPI

Facility: Date:

Prepared by:

Topic:

ADAPT TO SPECIFIC MONITORING FOCUS

The intent of this QAPI is to follow the facility's compliance with
Complete and Accurate ICD-10 coding based on the facility policy, Medicare and/or regulations:
Select Focus Area/ add criteria if indicated

F-Tag/ Reg # or Policy	**Topic/Problem**	**Key Regulatory or Policy Points [ ] Select the focus of the QAPI**
F582 HIM ICD-10 Coding Policy	**Complete and accurate ICD-10 coding for PDPM** **#1/6 Used Acute Diagnosis as principal DX Errors in assignments of CVA codes (acute), Fracture codes, unspecified codes where a more specific diagnosis is present or required** **#6 Face Sheets incomplete for Principal and Secondary diagnoses** **#7 Diagnoses not reviewed timely/**	1) [X] Diagnoses correctly abstracted from Hospital Discharge Summary, Operative reports, Interfacility transfer report Acute MD Progress notes/Consults, Labs, X-rays, etc. and SNF H&P and progress notes = current diagnose. Principal Diagnosis maps, diagnoses coded supported by physician documentation. 2) **System** [ ] Coder process queries attending Physician for clarification of Unspecified diagnosis, conflicting and/or unclear provider documentation regarding a diagnosis 3) [ ] Diagnoses provided by physician is specific without CDI Query 4) **System** [X] Acute code not used for a resolved condition on the health record or claim as per Official Guidelines for Coding and Reporting and HIPAA regulations. 5) [ ] Diagnosis support Medications/treatments ordered – 6) **System** [ ] when there is a clarification needed, the physician is queried to provide diagnosis/clarify a diagnosis/provide supporting documentation 7) **System** [X] ICD-CM coding/diagnoses entered into the computer system to allow for retrieval of diagnostic information/face sheet printed with current Diagnoses 8) [X] Best practice – review primary admission diagnosis, as well as all skilled conditions and comorbidity ICD-CM codes the next business day after admission for complete and consistent assignment of diagnoses by Nursing, Therapy and timely ICD-10 coding and input into the system. 9) [ ] Records reviewed, and codes added and documented in the electronic record: • Each time a resident is admitted/readmitted, returns from a hospital stay • When the physician updates the History & Physical/adds diagnosis(es) to the progress notes and when, i.e.,

	Submitted to Medical Records for coding	change of condition, new services/medications/treatments are ordered when there was no prior diagnosis in the record during the resident's stay or upon discharge 10) **System** [ ] Prior to submission of the UB-04 claim, facility validate that the ICD-CM diagnoses reported on the claim are consistent with the [ ] health record documentation [ ] certification and [ ] MDS information.

Measurable Criteria for Evaluation: (Refer to the attached monitoring criteria for documentation/other performance indicators/measures, or specify below)
1. Principal diagnosis correctly selected/Clinical Category Maps

2. Principal diagnosis correctly coded, as specified by Physician

3. Top 10 secondary diagnoses correctly coded, included all skilled diagnoses.

4. Top 10 diagnoses correctly sequenced, based on coding guidelines.

5. Aftercare codes assigned correctly, based on coding guidelines. Aftercare codes are not used in conjunction with codes with a seventh character extension for the episode of care (Fractures, Injuries)

6. Non-traumatic head injuries (CVD) correctly coded with I69 code

7. If CVD, all residual effects coded

Analysis of the system (identify system impact, cost impact, risk factors):

1. Incorrect or non-specific coding of diagnosis may result in denial of claim
2. Lack of complete, correct coding may result in incomplete or inaccurate reporting of the resident population in facility reports and on the MDS
3. Lack of diagnosis in the chart may put the resident at risk for not receiving needed care and treatment based on diagnosed medical conditions

Root causes:
[ ] 1. Lack of diagnostic documentation from the acute care hospital prior to and upon admission
[ ] 2. Clinical staff not abstracting complete information needed to select and sequence diagnoses day after admission
[ ] 3. Coders – need additional training/monitoring – repeat coding errors, use of non-specific codes – Coders assigning acute care codes for CVA and Fractures
[ ] 4. No MD query process in place to obtain more specific diagnosis when needed
[ ] 5. Lack of feedback to coders for rejected billing due to coding errors

QAPI

AHIS

Goal:

What do we want to accomplish?	Who is involved?	Location, if applicable
Correct Principal Diagnosis Selected/Maps to Clinical Category **– No Acute Care Codes used**	MDS/DON/MRD	
All diagnoses assigned correct ICD-10 codes based on Official coding guidelines – **CVA, Residual effects, Fractures**	MDS/DON/MRD	
Diagnoses entered into computer system/face sheets updated for relevant diagnoses	MRD	
Billing is accurate and $$ received are ____% [ ] based on ICD-Coding [ ] supporting documentation	Bus. Office/DON/MDS/MRD ADMIN	

Improvement Plan – Steps:

1. Medical Record Supervisor, Assistant and MDS will receive coding training by August 15
2. IDT will review Principal admission diagnosis, as well as all skilled conditions and comorbidity ICD-CM codes the next business day after admission for complete and consistent assignment of diagnoses by Nursing, Therapy and timely ICD-10 coding and input into the system
3. Health Information Consultant will do monthly review of ICD-10 performance Measures for ____#, Medicare A residents with trends reported to DON/Admin and QAPI team
4. Billing will report any rejected billing claims due to coding to: Admin/ DON/Medical Records with review by HIM consultant monthly
5. QAA Committee via QAPI process/performance measures determines the system issues
6. Coding training provided as needed based on identified need/trends
7. Other Training or system changes identified – plan developed – monitored

Evaluation:

• Who collects data/how often? Health Information Consultant – monthly • Who analyzes data/how often? Health Information Consultant/DON/MDS – monthly • Who reports data/to whom? Health Information Consultant to Admin/DON/QAPI team	Metrics/Data Collection Results Effectiveness/Recommended Changes Report/Recommendations

Data/Result	**Data/Result**	**Data/Result**	**Data/Result**
Result of data collection/metrics Analysis of results of data collection Actions taken:	Result of data collection/metrics Analysis of results of data collection Actions taken:	Result of data collection/metrics Analysis of results of data collection Actions taken:	Result of data collection/metrics Analysis of results of data collection Actions taken:
Report Monthly QAA	**Report Monthly QAA**	**Report Monthly QAA**	**Report Monthly QAA**
Report Date: Actions/ recommendations:	Report Date: Actions/ recommendations:	Report Date: Actions/ recommendations:	Report Date: Actions/ recommendations:

[ ] PIP to be established

[ ] Reporting period: