

## The role of coders and CDI teams in HACRP success

*by Cheryl Manchenton, RN*

With the advent of the Affordable Care Act in 2010, CMS announced that it would no longer reimburse hospital costs associated with preventable conditions such as mistakes in care or hospital-acquired infections. CMS began incentivizing eligible hospitals to achieve high-quality patient outcomes by linking Medicare payment to quality performance in the inpatient setting.

The CMS Hospital-Acquired Condition Reduction Program (HACRP) evaluates quality outcomes data and adjusts payments to hospitals that rank in the worst-performing 25 percent, penalizing them 1 percent of their total Medicare reimbursement on all inpatient claims. While 1 percent may not sound like a significant penalty, the financial impact can be considerable when it is annualized against the volume of Medicare patient claims.

HIM, CDI, and even inpatient coding professionals can play a significant role in helping their organizations be successful under HACRP by understanding the basis for hospital-acquired condition (HAC) scores, keeping up with the latest HAC regulatory updates, and ensuring that documentation and coding accurately and fully captures patient conditions and complications, including whether they are present on admission. Not only can this protect an organization's revenue, it can also foster a better understanding of the clinical impact of HACs on hospitals and patients.

### **HACRP: What to expect**

Under the HACRP, CMS evaluates quality outcomes data using two performance measurement domains, which are combined to produce an overall HAC score.

Domain 1 accounts for 15 percent of the final HAC score and is derived from a recalibrated CMS Patient Safety Indicator (PSI) 90 measure. Domain 2 is comprised of 85 percent of the final HAC score and is based on the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN) Healthcare-Associated Infections measures.

To ensure hospitals are not inadvertently penalized for extreme performance, CMS began to use "Winsorization," an approach to scoring that prevents extreme performance outliers from distorting scores, in 2018. Under the CMS Winsorized z-score methodology, a hospital's score for each of the many metrics used to calculate Domain scores and the total HAC score is determined based on the difference between the actual measure result and the mean score in standard deviations.

It's a complex scoring system that can't be fully addressed in a short article such as this. To learn more, review the most recent [CMS HACRP fact sheet](#) or this [helpful infographic](#) about the Winsorized z-score methodology at QualityNet.org.

For fiscal year 2019, Domain 1 covers hospital claims data from October 1, 2015, to June 30, 2017. Four key CMS PSI 90 measures contribute the most to the overall PSI 90 score.

Performance scores for these measurements come from observed vs. expected rates for each indicator:

- PSI 03, Pressure Ulcer Rate
- PSI 11, Postoperative Respiratory Failure Rate
- PSI 12, Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13, Postoperative Sepsis Rate

Domain 2 evaluates abstracted hospital data reported to the NSHN between January 1, 2016, and December 31, 2017.

Measures included in 2019 performance include:

- Central line-associated bloodstream infection
- Catheter-associated urinary tract infection
- Surgical site infection
- Methicillin-resistant staphylococcus aureus
- Clostridium difficile infection

The CDC calculates standardized infection ratios for these measures that compare observed-to-predicted numbers of hospital-acquired infections. Performance scores for these measurements come from the reported number of hospital-acquired infections vs. the predicted number of hospital-acquired infections at each facility.

While the 2018 cutoff for the 75th percentile of the total HAC score was set at 0.3712, the 75th percentile cutoff in 2019 is 0.3429. Scoring above this mark results in a one percent payment reduction. For reference, a 1 percent penalty for a large hospital may be more than \$1.1 million annually, while a 1 percent penalty for a mid-sized hospital may be more than \$600,000 annually.

### **Ensuring the accuracy of HAC scores**

With so much at stake when it comes to HAC scores, coding and CDI professionals can play a role in helping their organizations be successful under the HACRP.

To make a positive impact on Domain 1 scores, coding and CDI teams should ensure accurate documentation and coding of complications as well as diagnoses that may provide an exclusion from PSI reporting. Coding and CDI staff should review the actual complications reported as PSIs to verify present on admission status is accurately reported or whether clarification is needed.

Inpatient coders should ask the following questions:

- Is every complication documented and coded clinically significant?
- Are physicians using the word “postoperative” for surgical complications or as a timestamp for conditions arising in the postoperative period?

Hospitals are also encouraged to use clinical validation for high-value conditions, such as postoperative respiratory failure and sepsis. Additionally, a review should occur for appropriate exclusion criteria for each reported PSI.

Coding and CDI staff can impact scoring in Domain 2 by ensuring that specific and thorough documentation is provided for each patient, demonstrating a clear cause and effect for post-admission conditions or complications.

This means careful review, clarification, and assignment of present-on-admission status and all clinical information supportive or non-supportive of hospital-acquired infection code assignment. The [2019 ICD-10-CM Official Guidelines for Coding and Reporting](#) and *Coding Clinic* both state that providers must clearly indicate when a condition is a complication so the clarification of a “possible complication” is crucial during chart review.

Note that NHSN criteria is completely different than criteria utilized by inpatient coding to capture a diagnosis. CDI staff should perform clinical validation for conditions not meeting the CDC's NHSN criteria to ensure the NHSN submission volumes more closely match coded data.

For example, if even a slight doubt exists about whether an infection came from a catheter or a central line, or if an infection may have been present on admission, coders or CDI staff should communicate with the provider to make it clear that probable cause needs to be more definitively documented. If a provider is unable to answer with certainty whether an infection is related to a device, then it cannot be coded as a complication.

Ultimately, there will still be a gap between claims data and NHSN abstracted data and all staff should understand what is reportable via claims data as compared to [NHSN criteria](#).

### **HACRP is here to stay**

Despite changes in the administrations of HHS and CMS, the HACRP will continue as significant changes to the program (or removal of the program entirely) can only be made through legislation.

Accurate reporting of HACs is not just about protecting Medicare reimbursement. More importantly, it's about ensuring that every patient has an accurate medical record, both accessible and actionable by the many providers and healthcare organizations that will care for the patient over a lifetime.

If hospital-acquired infections are underreported, for example, an outside hospital may not know that ongoing monitoring or treatment is needed for proper care of the patient. Accurate HAC data also contributes to the success of population health management programs because the data can be analyzed to understand why certain populations tend to acquire specific conditions and explain incidence rates for risk adjustment. Focusing on the accuracy of the medical record documentation can ensure a claims' integrity and accurate data and should be the primary focus of every organization.

**Editor's note:** *Manchenton is the senior quality consultant, project manager, and quality services lead at 3M Health Information Systems headquartered in St. Paul, Minnesota. She specializes in workflow design, program management, quality metrics, and performance. Contact her at [cmanchenton@mmm.com](mailto:cmanchenton@mmm.com). Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.*

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