Orthopedic Peri-operative Risk Stratification and Comorbidity Coding

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Aahks Risk Adjustment Task Force

As we enter the era of public reporting of surgical outcomes, it is critical that surgeons document the medical and surgical complexity of the care they provide. To date, much of the data reported on the internet is not risk adjusted. Since the performance of surgeons and hospitals will be judged and pay may become tied to quality metrics, the American Association of Hip and Knee Surgeons (AAHKS) has been working on ways to improve risk adjustment for outcomes data for the last several years.

HISTORY

Traditional risk adjustment scales have often been subspecialty specific. For example, the anesthesiologists record the American Society of Anesthesiologists (ASA) class of the patient for each surgery we do. Similarly, the cardiologists either use the American Heart Association (AHA) stages of heart failure or the New York Heart Association (NYHA) Functional Classification functional classification to risk stratify patients. Currently, there are no standard risk stratification scales for orthopedic arthroplasty patients.

Several more complex risk stratification schemes exist: the Charlson comorbidity index and the Elixhauser comorbidity measure are among the most commonly used for research. Others include the Cumulative Illness Rating Scale (CIRS), the Cumulative Illness Rating Scale

1 http://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
2 http://www.learntheheart.com/cardiology-review/accaha-heart-failure-classification/
3 http://en.wikipedia.org/wiki/New_York_Heart_Association_Functional_Classification
for geriatrics (CIRS-G)\textsuperscript{7}, the Kaplan-Feinstein Index\textsuperscript{8}, the Index of Co-existent Disease (ICED)\textsuperscript{9}, the Geriatric Index of Comorbidity (GIC)\textsuperscript{10}, the Functional Comorbidity Index (FCI)\textsuperscript{11}, and the Total Illness Burden Index (TIBI)\textsuperscript{12}.

Currently, the documentation of medical comorbidities and complications dictates hospital reimbursement via the DRG system. Specifically, a total joint arthroplasty that is done with associated comorbidities and major complications (MCC)\textsuperscript{13} is reimbursed at a higher rate than a case without.

WHEN TO CODE MEDICAL COMORBIDITIES

Until about 2 years ago, the HCFA billing form, CMS 1500\textsuperscript{14} only allowed 4 ICD-9 codes as diagnoses. Currently, up to 12 diagnoses can be recorded.

It is mandatory that the impact of these comorbidities on your surgical care be mentioned in your note if you plan to code for them. For example, “the patient’s morbid obesity will increase the risk of deep infection three-fold, slow their rehabilitation, and increase their risk for deep venous thrombosis.”

For diagnoses that occur during the hospital stay, the over- or underuse of complication codes is likely to be problematic. Specifically, “acute blood loss anemia” (ICD9 code 285.1) could be applied to most arthroplasty surgeries. Thus, if hospital A always codes this and hospital B rarely does, it is possible that hospital A may initially receive a higher reimbursement. Conversely, later review of the data may lead insurers to send patients to hospital B and their surgeons. For this reason, definition of these terms will be critical. (In our hospital, we have agreed that a drop in hemoglobin of greater than 4 points would be labelled “acute blood loss anemia.” However, our coders cannot use the code unless we put it in our note.) In current

\begin{thebibliography}{11}
\bibitem{9} http://www.nature.com/ki/journal/v60/n4/fig_tab/4492571t1.html#figure-title
\bibitem{14} http://cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
\end{thebibliography}
usage, this code is often associated with the need to transfuse. If the pre-op hemoglobin is 10, the appropriate code is “chronic anemia” (ICD9 code 285.9).

HOW TO GET STARTED (OFFICE)

The AAHKS Risk Adjustment Task Force has been working with CMS and the Yale Outcomes Group to improve the risk adjustment models used in TJA performance measures. The goal of performance measures is to give surgeons an accurate assessment of their performance, while controlling for patient factors outside the control of providers. The current TJA performance measures being reported on hospitalcompare.gov are based on administrative claims data. Therefore, unless those risk factors that are known to influence outcomes (e.g. smoking, obesity) are captured in the administrative record, your outcomes will not be properly risk adjusted.

To that end we need to begin to document important clinical risk factors for lower extremity arthroplasty and have them tested to see if they improve the current risk model. We have already tested a few of these, that is smoking and obesity, and they improved the model significantly. We hope to continue to optimize the model by adding further clinical variables. Therefore we are seeking your help in systematically capturing the risk variables known to influence outcomes. We have created an easy to use checklist, similar to what you currently use to medical necessity of arthroplasty to avoid RAC audits. We understand that this adds another layer of burden to your preoperative visit, but it is important so that you will be judged fairly and maintain access for our patients.

<table>
<thead>
<tr>
<th>Clinical Risk Factor</th>
<th>ICD9 Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid obesity BMI &gt;40</td>
<td>278.01</td>
<td>Morbid Obesity</td>
</tr>
<tr>
<td>Smoking</td>
<td>305.1</td>
<td>Tobacco use disorder</td>
</tr>
<tr>
<td>Chronic anticoagulant use</td>
<td>V58.61</td>
<td>Long-term (current) use of anticoagulants.</td>
</tr>
<tr>
<td>Chronic narcotic use</td>
<td>305.51</td>
<td>Opioid abuse, continuous</td>
</tr>
<tr>
<td>Workmen’s compensation case</td>
<td>V62.1</td>
<td>Adverse effects of work environment</td>
</tr>
<tr>
<td>Previous intra-articular infection</td>
<td>139.8</td>
<td>Late effect of other and unspecified infectious and parasitic diseases</td>
</tr>
<tr>
<td>Congenital hip deformity</td>
<td>755.63</td>
<td>Other congenital deformity of hip</td>
</tr>
</tbody>
</table>

AMA 2013 ICD-9-CM Book, Professional edition
Angular knee deformity >15 degrees 736.6 Other acquired deformity of knee16
Previous ORIF hip 716.15 Traumatic arthropathy, pelvic region and thigh
Previous ORIF knee 716.16 Traumatic arthropathy, lower leg
Depression/psychiatric disease 300.9 Unspecified nonpsychotic mental disorder

The easiest way to incorporate this into your note is as follows. Those who use Cerner should paste this section into your “pre-completed” new patient note. It should likely appear after Radiographs and before the Impression/Plan. The appropriate diagnoses could be checked or the inapplicable ones deleted. Alternatively, the list could be saved as “autotext.” The comorbidities discussed in the note should ultimately appear on your CMS-1500. This will allow abstraction for data collection.

For Epic users, this form can be pasted into your note or a smartform can be designed that links these diagnoses to the codes that are attached to your note.

HOW TO GET STARTED (HOSPITAL)

To begin with, make sure your office note is included in the hospital chart. Secondly, start to include the comorbidity diagnoses and their impact in your daily notes.

Thus (as examples)

1. Hypertension - Hypertensive meds held due to low blood pressure. Fluid bolus given too.
2. Obstructive sleep apnea – using home CPAP. Also monitoring end tidal CO2 (or pulse oximetry) while patient is using narcotics.
3. Diabetes mellitus – oral agents being held, basal and sliding scale being used daily. Blood sugar control maintained under 200.

Secondly, begin to communicate with the people who do the coding in your hospital.

RESOURCES

1. AAHKS Website – www.AAHKS.org see Practice Management
2. Karen Zupko courses
3. Codex
4. AMA coding books

16 Code is not specific to a 15 degree deformity