Journey Towards a National Coding Standard for Patient Handling Injuries

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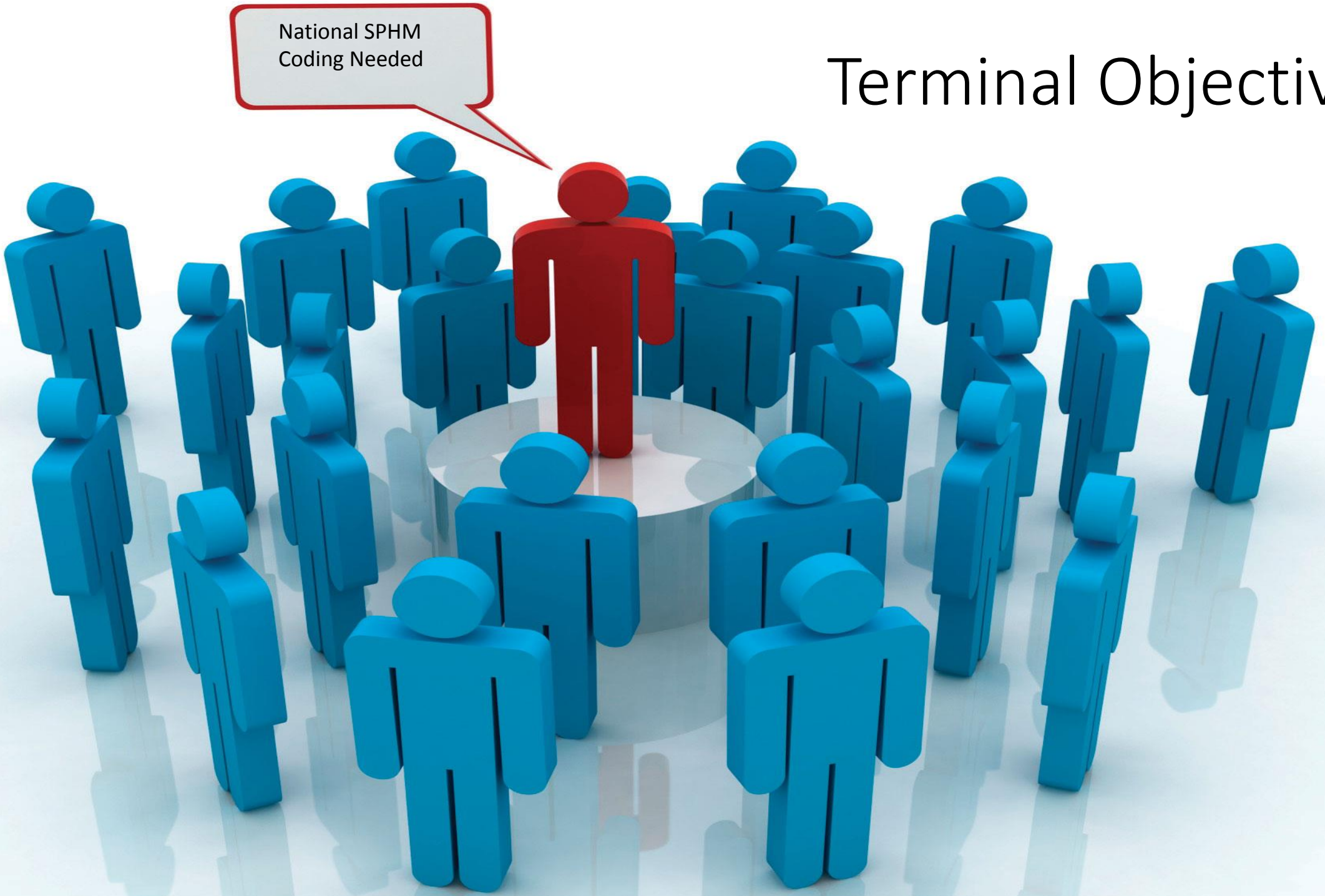
Terminal Objectives



Learning Objectives

1. Understand the current challenges associated with coding patient handling injuries
2. Be able to identify three emerging policies that address safe patient handling practices
3. Correlate the need for a national standard for SPHM claim coding
4. Identify key stakeholders impacted by standardized coding methodology
5. Understand engagement strategies and primary steps that need to be addressed
6. Review case study where new standards were applied

The Origins: Tributary of *Injury Coding*

Plethora of coding

National Coding Standard

80/20 rule

# of HC companies: 784,626

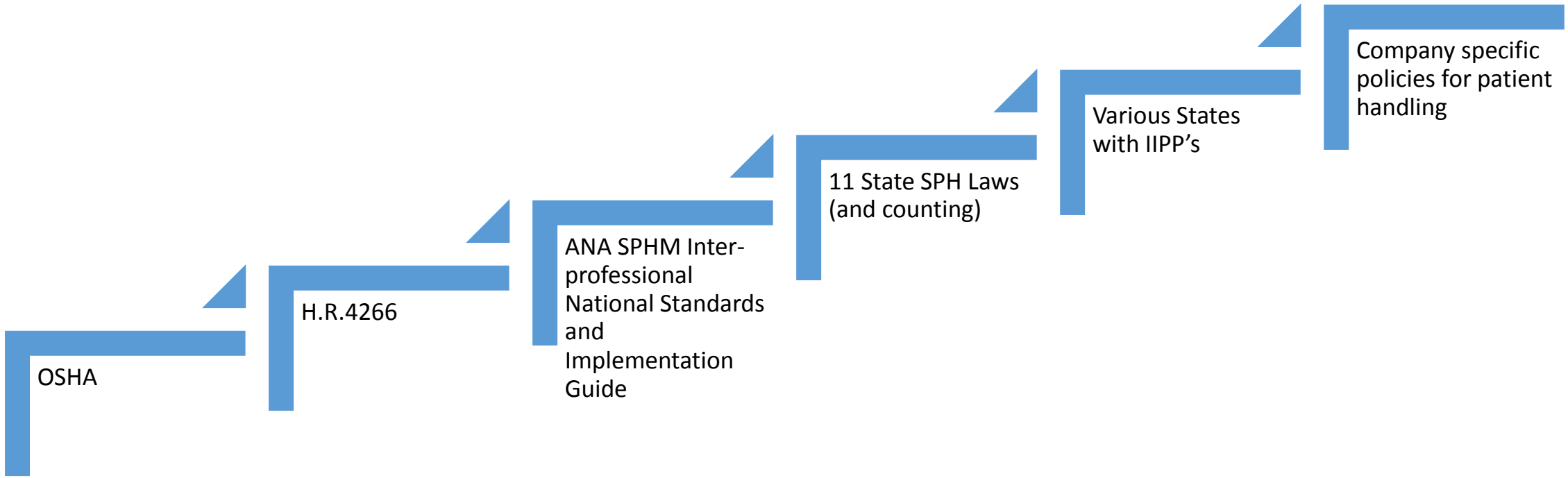
# of HC employees: 16,792,074*

# of WC insurance carriers: 218

# of TPA's: 38

Source: http://www.statisticbrain.com/health-care-industry-statistics/

The Emerging Policies



Measuring Impact on Granular Level

GLOBAL ISSUE IDENTIFIED

BLS Data

Overexertion injury rate for hospital workers was twice the average (68 per 10,000)

PROGRAM FRAMEWORK

SPHM POLICIES PROGRAMS PRACTICES

GLOBAL ISSUE IDENTIFIED

Data Elements Not Distinct

"Overexertion is not industry specific segmentation"

CODING FRAMEWORK

STANDARDIZED METHODOLOGY TO SUPPORT POLICIES, PROGRAMS & PRACTICES

The Idea

EXAMPLE 1: Nursing Home	EXAMPLE 2: Home Health
• Strain or Injury by Transferring Resident • Strain or Injury by Toileting Resident • Strain or Injury while Bathing Resident • Strain or Injury from Combative Resident • Strain or Injury from Dressing/Undressing Resident • Strain or Injury from Falling Resident • Strain or Injury from Repositioning Resident	• MSD from Patient Mobility • MSD from Patient -Repositioning • MSD from Patient -Transfer • MSD from Patient- Ambulating • MSD from Patient -Stair Assist • MSD from Patient- Outside Home • MSD from Patient - Assist with Equipment
EXAMPLE 3: Hospital	Example 4: Assisted Living
• Strain or Injury-Lifting Body Part During Wound Care • Strain or Injury-Lifting Patient • Strain or Injury –Patient Ambulating • Strain or injury – Lateral Transfer of Patient • Strain or Injury- Moving/Lifting Patient During Ambulance/EMT Response • Strain or Injury-Repositioning Patient • Strain or Injury-Pushing or Transporting	• MSD-Transferring Resident to Bed • MSD-Transferring Resident to Chair or Commode • MSD-Bed Repositioning • MSD-Walking with Resident • MSD-Lifting a Resident • MSD-Weighing a Resident • MSD-Bathing a Resident • MSD-Undressing or Dressing Resident • MSD-Transferring a Resident to stand from bed or chair to walker • MSD-Repositioning a Resident • Assisting Resident to or from a Vehicle

Four Tactics to Tune Up a Safe Patient Mobility Program

April 2014

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The Collaboration

- ASPH Board Members
- ASPH Members
- VA Employees
- Insurance
- Managed Care
- Direct End Users
- NIOSH

Our Goal

- **Develop a practical coding methodology to be adopted on a national level that is aligned with emerging policies and consistent with NIOSH, ANA, NCCI and other Legislative entities.**

The National Occupational Research Agenda (NORA)

The National Occupational Research Agenda (NORA) is a partnership program to stimulate innovative research and improved workplace practices. Unveiled in 1996, NORA has become a research framework for NIOSH and the nation. Diverse parties collaborate to identify the most critical issues in workplace safety and health. Partners then work together to develop goals and objectives for addressing these needs. more...

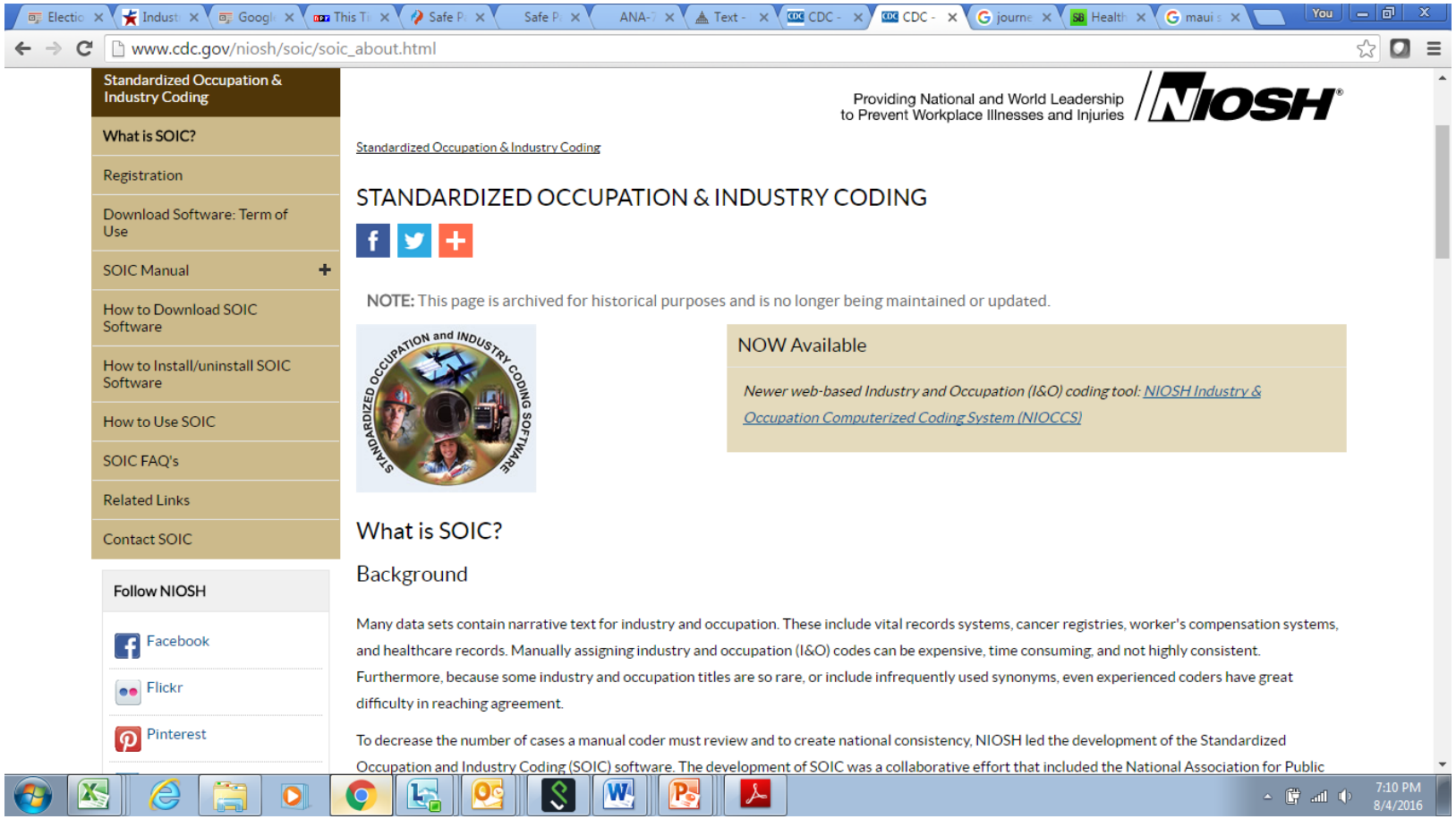
National Sector Agendas

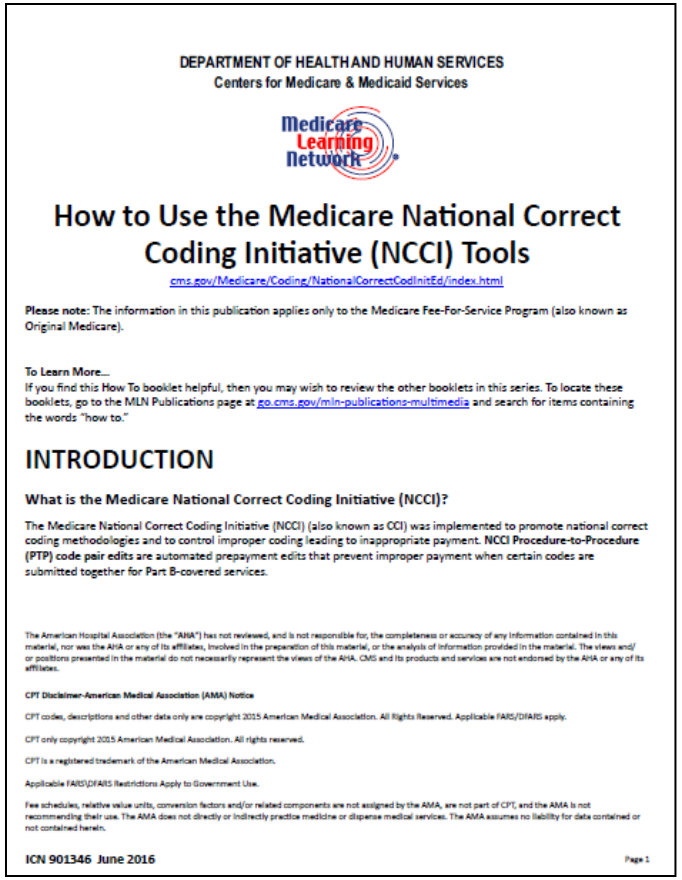
NORA Sector Councils have created sector agendas for the nation to guide research and research-to-practice through the decade ending in 2016. The Councils will update the National Sector Agendas as needed. Please send suggestions for improving the agendas any time. All comments sent to the NORA Coordinator will be forwarded to the relevant Council.

Sector Agendas

- Agriculture, Forestry and Fishing
- Construction
- Healthcare and Social Assistance
- Manufacturing
- Mining
- Oil and Gas Extraction
- Public Safety
- Services
- Transportation, Warehousing, and Utilities
- Wholesale and Retail Trade

Government Leading the Way





DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

To Learn More...
If you find this How To booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the MLN Publications page at go.cms.gov/mln-publications-multimedia and search for items containing the words "how to."

INTRODUCTION

What is the Medicare National Correct Coding Initiative (NCCI)?

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. **NCCI Procedure-to-Procedure (PTP) code pair edits** are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

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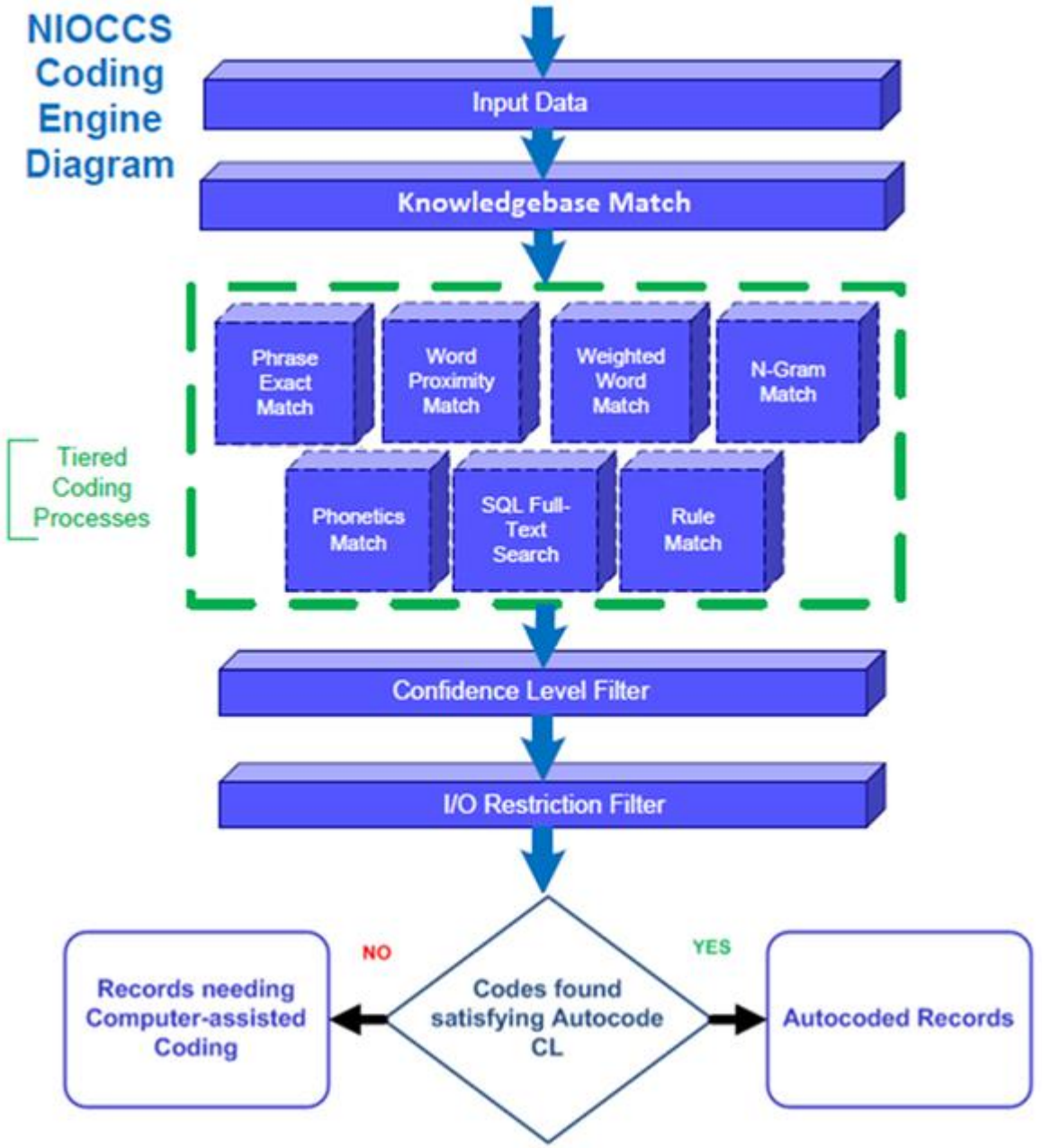
Change Agents

- How can we change big systems?
- How can we get early adopters?
- How do we get buy in from carriers?
- How do we publish the codes?
- How can TPA’s lead the way?
- What is the role of Brokers?
- How can NIOSH help?
- Other associations backing?

Coding Diagram

- Complex
- Time consuming
- Limited application to RMIS



Coding Standard

- Abstract
- Introduction
- Current State
- Patient Handling Claims
- Reaffirming the Core Problem
- Future State
  - Simple
  - Transparent
  - Easy to adopt
- Stakeholder Value
- Engagement Blueprint

Safe Patient Handling and Mobility Claims Coding: A Pragmatic and Functional Approach

Authors: Vicki J. Missar, Michael Fray, Candy Raphan, Mary Matz, Wendy Weaver

Abstract

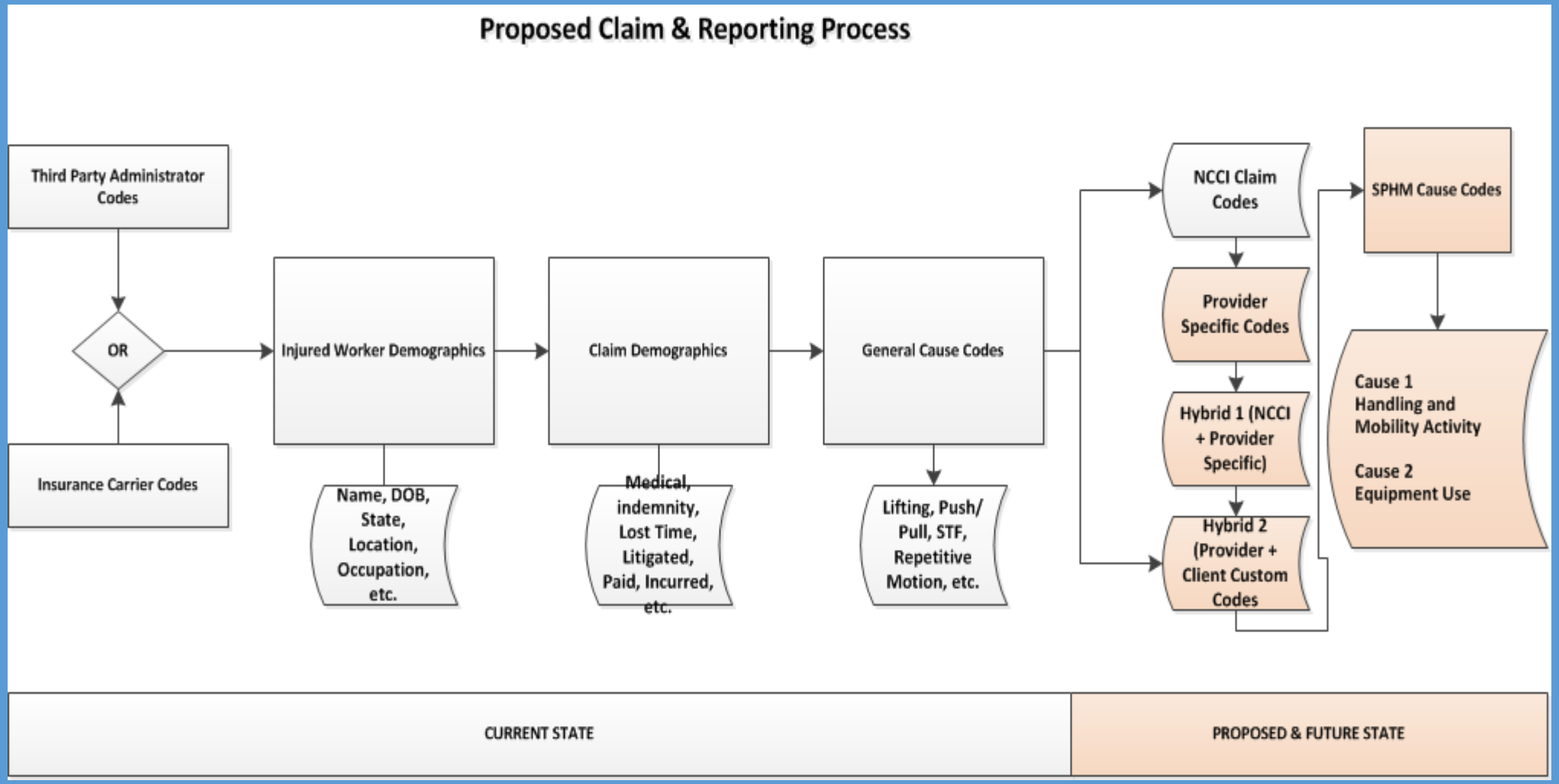
Healthcare organizations are now engaged in Delivery System Transformation (DST), whereby performance-based incentive payment programs are used to support and reward hospitals for investing in projects that advance care and population health while lowering costs. In these efforts, it becomes critical to understand causes of patient handling and mobility workers' compensation injury claims. Until now, programs that are self-administered or utilize a Third Party Administrator (TPA) have differing, if any, codes to determine employee injury trends. Unfortunately, these coding structures, particularly when it comes to causes, lack any real, actionable data to establish investment needs for safe patient handling interventions. Healthcare organizations are left to drill down to the accident-description level and extract key causes of the patient handling injury, a time-consuming and unrealistic option given the human resources demand within healthcare. This paper proposes a condensed, yet powerful, sub-level coding structure for safe patient handling claims that any claims reporting system can easily adopt. As a result, this coding structure will eliminate the need to manually sort through lines and lines of data for relevant trends. Adopting this proposed coding structure nationally will reward the safe patient handling community with a consistent and transparent approach to claims. As a result, it will enable facility-level comparison of key functions and tasks associated with patient handling claims, peer-to-peer benchmarking of these causes and return on investment calculations at the fingertips of the end user.

Introduction

Healthcare companies in today's business environment experience an unprecedented amount of change in terms of change drivers and pace of change: technology, shifting workforce demographics, global opportunity and competition, new sources of competitive advantage and rapidly evolving risk and regulatory requirements. Healthcare is an industry in the midst of fundamental transformation across the entire value chain and to all sectors, including physician groups, individual hospitals, senior care facilities, managed care organizations, insurance companies, wellness organizations, and integrated healthcare systems. As organizations address new business realities driven by healthcare reform and DST, they must reassess their data-mining capabilities around leading loss drivers that impact employee health and safety. With the right data and trending capabilities, safe patient handling claims can be easily dissected and solutions funded.

An apparent need exists to develop a standardized coding method focusing on the sub-category of activity type associated with patient handling injuries. So far, no national standard addresses

The Process


Proposed Claim & Reporting Process
Third Party Administrator Codes
OR
Insurance Carrier Codes
Injured Worker Demographics
Name, DOB, State, Location, Occupation, etc.
Claim Demographics
Medical, indemnity, Lost Time, Litigated, Paid, Incurred, etc.
General Cause Codes
Lifting, Push/ Pull, STF, Repetitive Motion, etc.
NCCI Claim Codes
Provider Specific Codes
Hybrid 1 (NCCI + Provider Specific)
Hybrid 2 (Provider + Client Custom Codes
SPHM Cause Codes
Cause 1
Handling and Mobility Activity
Cause 2
Equipment Use
CURRENT STATE
PROPOSED & FUTURE STATE

Accident and Injury Claim Coding

NCCI Coding

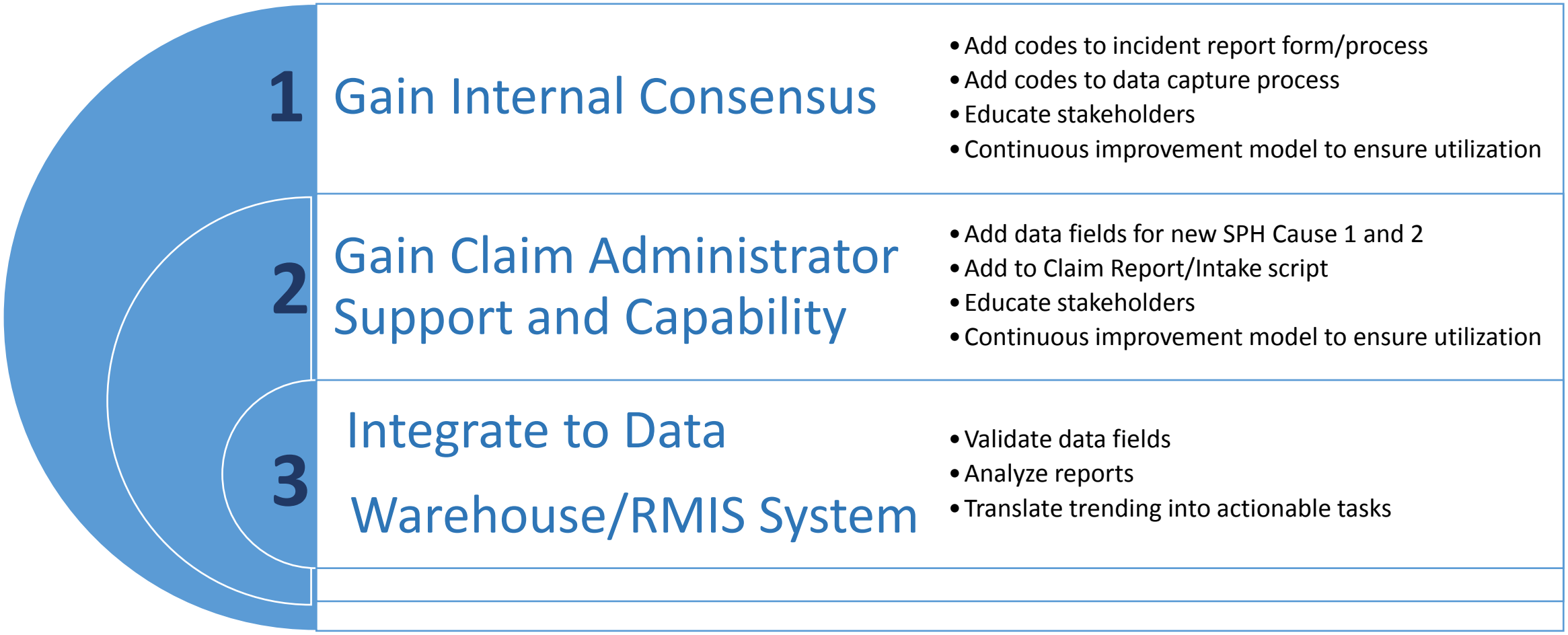
Part Description	Injury Description	Cause Description
LOWER BACK AREA	MULTIPLE PHYSICAL INJURIES ONLY	STRAIN OR INJURY BY – LIFTING
SHOULDER(S)	STRAIN	STRAIN OR INJURY BY - LIFTING
CHEST	STRAIN	STRAIN OR INJURY BY - PUSHING OR PULLING
UPPER ARM	STRAIN	STRAIN OR INJURY BY - PUSHING OR PULLING
MULTIPLE HEAD INJURIES	CONTUSION	STRAIN OR INJURY BY – NOC (Not Otherwise Classified)
LOWER BACK AREA	SPRAIN	STRAIN OR INJURY BY - PUSHING OR PULLING
LOWER BACK AREA	STRAIN	STRAIN OR INJURY BY - HOLDING OR CARRYING
LOWER BACK AREA	STRAIN	STRAIN OR INJURY BY - HOLDING OR CARRYING
SHOULDER(S)	STRAIN	STRAIN OR INJURY BY - PUSHING OR PULLING
LOWER BACK AREA	SPRAIN	STRAIN OR INJURY BY - LIFTING
CHEST	STRAIN	STRAIN OR INJURY BY - LIFTING
LOWER BACK AREA	SPRAIN	STRAIN OR INJURY BY - LIFTING
THUMB	NO PHYSICAL INJURY	STRAIN OR INJURY BY - LIFTING
SHOULDER(S)	STRAIN	STRAIN OR INJURY BY - LIFTING
LOWER BACK AREA	STRAIN	STRAIN OR INJURY BY - LIFTING
SHOULDER(S)	STRAIN	STRAIN OR INJURY BY - LIFTING
SHOULDER(S)	RUPTURE	STRAIN OR INJURY BY - LIFTING
SPINAL CORD (BACK)	STRAIN	STRAIN OR INJURY BY - LIFTING
LOWER BACK AREA	STRAIN	STRAIN OR INJURY BY - LIFTING

Accident and Injury Claim Coding

Patient Handling/Mobility Injury Coding

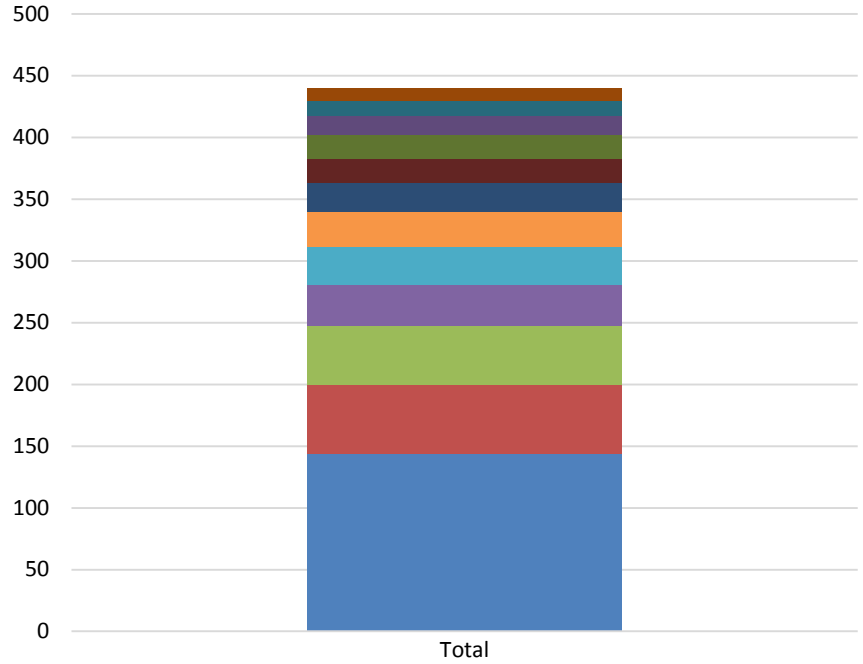
PATIENT/RESIDENT HANDLING and MOBILITY ACTIVITY	PATIENT/RESIDENT HANDLING and MOBILITY EQUIPMENT USE
1. Ambulating/walking patient 2. Bathing/diapering/dressing patient in bed 3. Bathing/showering/diapering/dressing patient other than in bed 4. Fall prevention (preventing patient fall) 5. Fall recovery (off floor/ground, after fall) 6. Lifting/holding limb/head/stomach/other body part 7. Lifting patient up while on ambulance (hydraulic) gurney/board 8. Making occupied bed 9. Managing uncooperative/aggressive behavior 10. Personal care in bed: feeding, brushing teeth/hair, other 11. Personal care other than in bed: feeding, brushing teeth/hair, other 12. Positioning/removing sling/assistive device 13. Repositioning/moving patient side-to-side/up in bed/cot/gurney 14. Repositioning patient in chair/wheelchair 15. Transferring patient to/from toilet 16. Transferring patient in/out of vehicle 17. Transferring patient to/from bed/chair/wheelchair/commode/similar seated items 18. Transferring patient to/from bed/stretcher/trolley/exam table (lateral transfer - from lying position to lying position) 19. Transporting patient in wheelchair 20. Transporting patient by stretcher, gurney, trolley 21. No defined/listed cause	Used patient handling equipment (e.g. lift, assistive/transfer device) 1. Yes 2. No 3. N/A – not appropriate for activity 4. Not known

Engagement Strategy



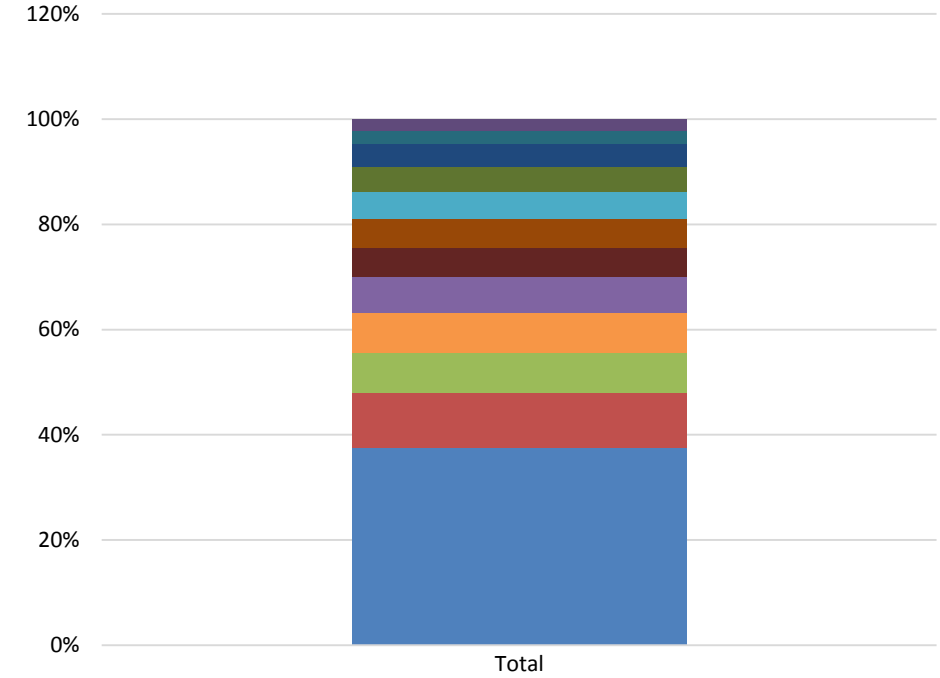
Count and Cost Distribution by Movement

Claim Count by Movement



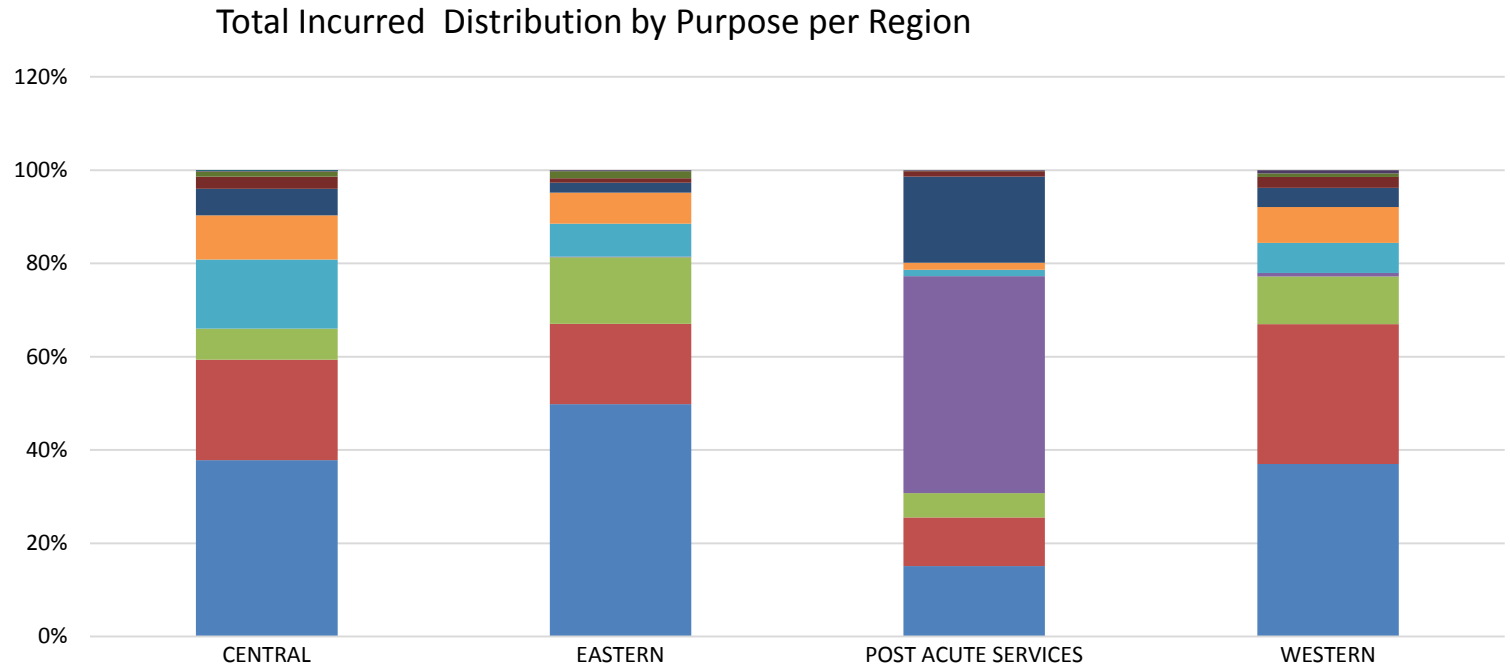
TRANSFER BY WC/STAIRCHAIR/OTHER	10
LIMB HOLDING	12
TRANSFER/VEHICLE	16
STANDING TO SITTING	19
FLOOR RECOVERY	20
UNKNOWN	23
SUPPORTED WALKING	29
SEAT TO SEAT TRANSFER	30
SITTING TO STANDING	34
Fall Prevention	47
LATERAL TRANSFER	56
REPOSITION IN BED	144

Total Incurred (Cost) Distribution by Movement



TRANSFER/VEHICLE	2%
LIMB HOLDING	2%
UNKNOWN	5%
STANDING TO SITTING	5%
SEAT TO SEAT TRANSFER	5%
TRANSFER BY WC/STAIRCHAIR/OTHER	5%
FLOOR RECOVERY	6%
SITTING TO STANDING	7%
SUPPORTED WALKING	8%
Fall Prevention	8%
LATERAL TRANSFER	10%
REPOSITION IN BED	37%

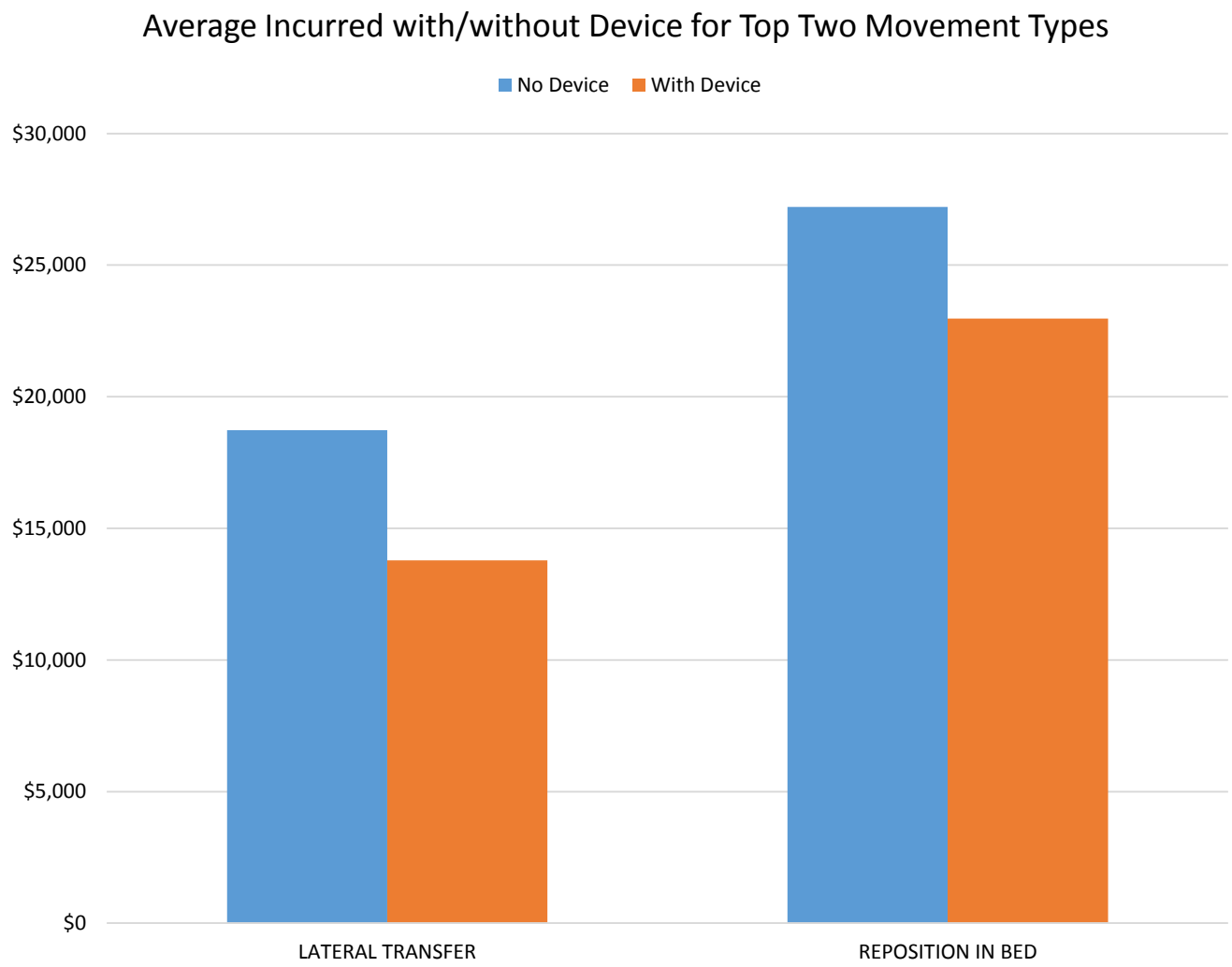
Cost by Purpose



	CENTRAL	EASTERN	POST ACUTE SERVICES	WESTERN
STANDING TO SITTING	0%	0%	0%	0%
ADMISSION/DISCHARGE	0%	0%	0%	1%
REHABILITATION	1%	1%	0%	1%
SPECIFIC TREATMENT - EMERGENCY	3%	1%	1%	2%
TRANSPORT	6%	2%	18%	4%
BATHING OR WASHING	9%	7%	1%	8%
TOILETING	15%	7%	1%	6%
EXTENDED MOBIL OUTSIDE FACILITY	0%	0%	47%	1%
SPECIFIC TREATMENT - ROUTINE	7%	14%	5%	10%
UNKNOWN	22%	17%	10%	30%
CARE/FEED/DRESS	38%	50%	15%	37%

- The above chart shows, for each region, which purpose types made up the total incurred cost.

Cost with/without Devices



- The above chart shows average incurred cost for the top two movement types broken down by claims where a device was involved verses those without a device.
- On average, claims that involved a device were less costly than those without a device.

INDICATOR
METRICS
OPERATIONAL
COST
PLAN
STRATEGIC
EVALUATION
METHODOLOGY
TECHNICAL
COMPARE
PRODUCT
FUNCTIONAL
BEST PRACTICES
TARGET
SPECIFIC
IDENTIFY
BENCHMARKING
UNIT
FINANCIAL
MANAGEMENT
SURVEY
TOOLS
PROCESS
BUSINESS
PERFORMANCE
INFORMATION
TIME
ENERGY
ASPECT
INDUSTRY
IMPROVEMENT
QUALITY
PROCEDURE
RESULT

Streamlined Coding in the USA

The Journey Ahead…