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Background

Medicare is proposing to adopt a Medicare Severity DRG (MS-DRG) classification for IPPS to better recognize severity of illness.

RAND Corporation was awarded a contract in September 2006 to evaluate alternative severity-adjusted DRG classifications.

RAND evaluated these severity adjusted groupers:

- 3M/Health Information Systems (HIS)
 - CMS DRGs modified for AP-DRG Logic (CMS+AP-DRGs)
 - Consolidated Severity-Adjusted DRGs (CS DRGs)
- Health Systems Consultants (HSC)
 - Refined DRGs (HSC-DRGs)
- HSS/Ingenix
 - All-Payer Severity DRGs with Medicare modifications (MM-APS-DRGs)
- Solucient
 - Solucient Refined DRGs (Sol-DRGs)

The RAND contract will be complete by September 1, 2007. **“Once RAND completes its work, we believe we will be in a better position to evaluate whether it would be appropriate to propose to adopt one of the five alternative systems for purposes of the IPPS.”***

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“We have instructed RAND to evaluate the proposed MS-DRGs using the same criteria that it is applying to the other DRG systems.”*

“...we believe the proposed MS-DRGs represent a substantial improvement in the recognition of severity of illness and resource consumption.”*

The initial results demonstrate that all five severity-adjusted DRG systems predict cost better than the CMS DRGs. The analysis suggests that any system adopted to better recognize severity of illness with a budget neutrality constraint will result in payment redistribution that can be expected to benefit urban hospitals at the expense of rural hospitals. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals and the CMS DRGs are not currently recognizing the full extent of these differences.

Comprehensive Review of the CC List

“...the CC list as currently defined has lost much of its power to discriminate hospital resource use.”

Except for new diagnosis codes that were added to the ICD-9-CM after FY 1984 (for example, HIV), the CC list of diagnoses currently used in the CMS DRGs is virtually identical to the CC list created at Yale University.

Patients admitted to the hospital today are on average more likely to have a CC than when the IPPS was implemented. The net effect of better coding of secondary diagnoses, reductions in hospital length of stay, increased availability of post acute care services, and the shift to outpatient care is that most patients (nearly 80 percent) admitted to a hospital now have a CC. **“...the CC list as currently defined has lost much of its power to discriminate hospital resource use.”***

Our intent was to better distinguish cases that are likely to result in increased hospital resource use based on secondary diagnosis. Using a combination of mathematical data and the judgment of our medical officers, we included the condition on the CC list if it could demonstrate that its presence would lead to substantially increased hospital resource use.

Diagnoses may require increased hospital resource use because of a need for such services as:

- Intensive monitoring (for example, an intensive care unit (ICU) stay)
- Expensive and technically complex services (for example, heart transplant)
- Extensive care requiring a greater number of caregivers (for example, nursing care for a quadriplegic)

Based on the current CC list, 77.6 percent of patients have at least one CC present. **“Based on the revised CC list from our 2007 review, the percent of patients having at least one CC present would be reduced to 41.24 percent.”***

The revised CC list is essentially comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases and chronic diseases associated with extensive debility. Compared to the existing CC list, the revised CC list requires a secondary diagnosis to have a consistently greater impact on hospital resource.

MS-DRGs are based on the current CMS DRGs. What this means is that the base DRGs are virtually the same. The major difference from CMS DRGs to MS-DRGs is the change to CCs which have been categorized in major CCs (MCC), CC or non-CC.

“We designated as an MCC any diagnosis that was a CC in the revised CC list *and* was an APR DRG default severity level 3 (major) or 4 (extensive). We designated as a non-CC any diagnosis that was a non-CC in the revised CC list *and* was an AP-DRG non-CC *and* was an APR DRG default severity level of 1 (minor). Any diagnoses that did not meet either of the above two criteria was designated as a CC.”

There are five diagnoses that will be a MCC for patients who live and a non-CC for patients who die:

- 427.42 Ventricular fibrillation
- 427.5 Cardiac arrest
- 785.51 Cardiogenic shock
- 785.59 Other shock without mention of trauma
- 799.1 Respiratory arrest

A base MS-DRG may be subdivided according to the following three alternatives, rather than current “with CC” and “without CC” subdivision.

- DRGs with three subgroups (MCC, CC and non-CC)
- DRGs with two subgroups consisting of an MCC subgroup but with the CC and non-CC subgroups combined. We refer to these groups as “with MCC” and “without MCC”
- DRGs with two subgroups consisting of a non-CC subgroup but with the CC and MCC subgroups combined. We refer to these two groups as “with CC/MCC” and “without CC/MCC.”

“Thus, within each proposed base MS-DRG, some cases will be paid more and some less, but the base MS-DRGs are retained so there is no redistribution between types of cases as would have occurred under the proposed CS DRGs.”

As a result, there are 745 proposed MS-DRGs. **“Thus, within each proposed base MS-DRG, some cases will be paid more and some less, but the base MS-DRGs are retained so there is no redistribution between types of cases as would have occurred under the proposed CS DRGs.”***

Hospital-Acquired Conditions, Including Infections

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present.

The conditions selected met three criteria:

- High cost or high volume or both
- Result in the assignment of the case to a DRG that has a higher payment when present as a secondary diagnosis; and
- Could reasonably have been prevented through the application of evidence-based guidelines

The conditions selected:

- Catheter-Associated Urinary Tract Infections
- Pressure Ulcers
- Serious Preventable Event – Object left in during surgery
- Serious Preventable Event – Blood Incompatibility
- Serious Preventable Event – Air Embolism
- Staphylococcus Aureus Bloodstream Infection/Septicemia

QHR Coding Consultant's Comments

The change to the CC list cannot be over-emphasized. One of the comments from RAND – “increased emphasis on complete coding is likely to lead to implementation costs for training coders and ongoing costs for additional coding staff. Some hospitals have been coding “efficiently,” that is, they have not been coding more than necessary to assign the patient to the highest possible DRG.”

- One of the best examples to illustrate the impact of complete and correct coding and documentation is congestive heart failure. It is a common term used by most physicians. Several years ago, the codes changed to include the terms “systolic” and “diastolic” and added modifiers “acute” and “chronic.” If physicians are still using CHF rather than the more specific terms, hospitals will not get credit for a CC. If they are not using “acute” and “chronic with systolic or diastolic heart failure,” a CC rather than a MCC will be paid. Although these codes are more specific, because CHF was still a CC, there was little incentive for coders to query physicians about a more definitive diagnosis. It's time to make that change now! Ask the HIM Director or Coding Supervisor whether they see these terms in their medical records. If proper education was provided to the medical staff and coding is accurate and complete, hospitals will be paid correctly.
- Another example is chronic kidney disease and its stages. If hospital records still include the terms “renal insufficiency” or “renal failure,” they will not receive correct payment. If physicians use the term chronic kidney disease but do not indicate the stage of the disease, they will not receive correct payment.

Do not overlook the impact of the hospital-acquired conditions. One of the major challenges for hospitals will be to identify whether these conditions were present on admission. If a nursing assessment documents a decubitus ulcer and the physician orders treatment but does not document the ulcer, the coder cannot code the ulcer as present on admission.

QHR provided an educational webinar on the proposed changes on June 11th. This 90-minute web seminar was recorded. If you did not attend this session, learn how to obtain the recording by contacting the QHR Learning Institute at 800-233-1470 ext 4513. You will receive a CD recording of the program and a 12-page action plan for MS-DRGs. The program was for HIM Directors, Coding Supervisors and Coders and focused on complete and accurate coding in preparation for MS-DRGs. Once the final rule is published, QHR will offer additional educational seminars.

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For additional questions regarding this News Alert, please visit QHR's Coding Consultants at The Coding Community Website at www.qhr.com/web/codingcommunity



ACTION PLAN FOR MS-DRGS

Use this action plan in conjunction with the QHR For Coders Only webinar held on June 11, 2007. If you did not attend this session, you can obtain the recording by contacting the QHR Learning Institute at (800) 233-1470, ext. 4513. This action plan includes steps to review data, audit your current coding and documentation practices, plan coding/physician education and develop guidelines for physician queries. Although there are only a few highlighted conditions, if you find you have coding and documentation problems with these issues, it may indicate that you will need additional resources to address coding and documentation on a larger scale. Because the audits require clinical documentation review, it would be helpful for a physician or nurse case manager to assist with the documentation review and education of the coders and medical staff.

These selected conditions from the list of diagnoses that will be CCs under MS-DRGs but are not CCs in the current system have the most potential to improve coding or physician documentation. For all of these conditions, make sure the coders are coding these diagnoses, even though they do not change payment with the current CMS DRGs:

- Unspecified gastroenteritis, viral enteritis and food poisoning
- Dementia, including Alzheimer's dementia
- Hypertensive heart disease
- Systolic and diastolic heart failure
- Chronic kidney disease
- Seizure disorder
- Body mass index
- Late effect of CVA with hemiplegia

Remember, it is all about coding and documentation. You will receive the appropriate payment when coding and documentation is correct. If you find that you have problems with the diagnoses identified in this action plan, you may need assistance from the QHR coding consultants or case managers.

Task	Assigned to	Target Date	Completion Date	Comments
Review present on admission (POA) guidelines				Find the ICD-9-CM coding guidelines on the QHR coding website at coding.qhr.com by clicking on the “coding website links” or go directly to the ICD-9-CM guidelines at http://www.cdc.gov/nchs/datawh/ftpserv/ftp9cm9/ftp9cm9.htm . The POA guidelines begin on page 100.
Review coding and documentation of catheter-associated urinary tract infections				<ul style="list-style-type: none"> • Determine percentage of coding UTI (599.0) vs. catheter-associated UTI (996.64). (According to one source, 66-86% of UTIs follow instrumentation of the urinary tract and should be coded 996.64) • Review a sample of records with code 599.0 for evidence of correct coding. • Ask a physician to review records with UTI in patients with urinary instrumentation to determine if the UTI was associated with the catheter. • Ask nursing for assistance in identifying nosocomial UTIs and catheter-associated UTIs to assist with coding review and coder education. All nosocomial UTIs should have a POA indicator of “N”. • Develop a process for quality review of all UTIs with POA indicator of “N”. • Provide physician, nursing and coder education. • Query physicians when a patient has a UTI with a foley catheter to determine if a catheter associated UTI is present.

Task	Assigned to	Target Date	Completion Date	Comments
Review coding and documentation of decubitus ulcers				<ul style="list-style-type: none"> • Pull a sample of records with decubitus ulcers (707.00 – 707.09). Determine from the physician documentation whether the decubitus ulcer was present on admission and the stage of the ulcer. • If the physician does not document the ulcer present on admission, review the nurse's notes to determine if the nursing assessment included findings of decubitus ulcer. • Report findings to nursing and physicians and provide education on the importance of documenting decubitus ulcers on admission. • Query physicians when present on admission indicator is "N" for decubitus ulcers and there is evidence of nursing documentation of ulcers on admission. • Develop a process for quality review of decubitus ulcers that were not present on admission.
Review list of CCs for MS-DRGs				<ul style="list-style-type: none"> • Provide an education session with the coders to review list of MS-DRG CCs. This will create awareness of these conditions among the coding staff to make sure these diagnoses are coded, even if they do not impact payment for the current CMS DRGs. • Make a list of the top 20 conditions likely to be missed and post in the coding area (some of these are addressed in this action plan) • The CC list is in the federal register (pages 940 through 1049) at http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1198514&intNumPerPage=2000.

Task	Assigned to	Target Date	Completion Date	Comments
Review coding and documentation of unspecified gastroenteritis, viral enteritis, food poisoning and diarrhea				<ul style="list-style-type: none"> • Pull a sample of records with one or more of the following codes as secondary diagnoses: 008.8, 558.9, 005.9 and 787.91 • Review the records for more specific documentation of cause of the enteritis, gastroenteritis or food poisoning. • Ask a physician to review records for clinical evidence of a more specific condition. • Pull a sample of records with volume depletion (276.50 – 276.52) as the principal diagnosis; determine if a secondary diagnosis of gastroenteritis, viral enteritis, food poisoning or diarrhea was documented but not coded. • Educate coders and physicians. • Query physicians if more specific documentation is not present in the record
Review coding and documentation of dementia				<ul style="list-style-type: none"> • Pull a sample of records with uncomplicated senile, presenile or vascular dementia (290.10, 290.40, 290.0) • Review the records to determine if there was documentation of delirium, delusional or depressive features or psychotic conditions. • Review the nurse's assessment and notes to determine if documentation includes complicated dementia. • Ask nursing to assist in improving documentation and developing physician query guidelines. Could the nursing assessment include supportive documentation for complicated dementia so that physicians are queried when necessary? • Provide physician education • Query physicians when coding uncomplicated dementia.

Task	Assigned to	Target Date	Completion Date	Comments
Review coding and documentation of Alzheimer's dementia				<ul style="list-style-type: none"> • Calculate the percentage of cases coded with behavioral disturbance (294.11) for all Alzheimer's dementia (294.10 and 294.11). According to the International Psychogeriatric Association, 83% of patients with dementia demonstrate some type of behavioral disturbance. • Review a sample of records with 294.10 (without behavioral disturbance). Review the records to determine if there was documentation of behavioral disturbance. Ask nursing to review their documentation to determine if nurses are documenting the condition but the physician is not • Provide physician and coder education. • Query physicians when documentation does not include behavioral disturbance.
Review coding and documentation of hypertensive heart disease with CHF				<ul style="list-style-type: none"> • Review a sample of records with hypertension (401.x) and CHF (428.0) • Determine if documentation is present for hypertensive heart disease. • Ask a physician to review the records to determine if hypertensive heart disease was present clinically but not documented. • Provide physician and coder education. • Query physicians about hypertensive heart disease when left ventricular hypertrophy is present with hypertension or when documentation includes hypertension and CHF.

Task	Assigned to	Target Date	Completion Date	Comments
Review coding and documentation of systolic and diastolic heart failure				<ul style="list-style-type: none"> • Determine percentage of patients with diastolic dysfunction and CHF by calculating patients with diastolic heart failure (428.30 – 428.43) and patients with only CHF (428.0). One source indicated 40-60% of CHF patients have diastolic dysfunction. • Review a sample of records with CHF (428.0) without codes for systolic or diastolic heart failure (428.20 – 428.43). • Determine if documentation is present for systolic or diastolic heart failure. Ask a physician to review the records to determine if the condition was present clinically but not documented. • Provide physician and coder education. • Query physicians when echocardiography report indicates systolic or diastolic dysfunction. Query physicians when documentation of CHF does not include mention of systolic or diastolic failure. • Review a sample of records with unspecified systolic or diastolic heart failure (428.20, 428.30, or 428.40). • Review the records to determine if documentation includes acute or chronic heart failure. • Ask a physician to review the records to determine if the condition was present clinically but not documented. • Provide physician and coder education. • Query physicians when code assignment includes 428.20, 428.30 or 428.40.

Task	Assigned to	Target Date	Completion Date	Comments
Review coding and documentation of chronic kidney disease (CKD)				<ul style="list-style-type: none"> • Review a sample of records with diagnosis of renal insufficiency or renal failure (593.9, 585.9). • Determine if documentation includes chronic kidney disease and the stage of kidney disease. • Ask a physician to review the records to determine if the condition was present clinically but not documented. • Provide physician and coder education. • Query physicians when documentation includes renal insufficiency or renal failure to ask for diagnosis of chronic kidney disease and the stage of the disease. • Query physicians when GFR is abnormal. If lab does not provide GFR, can it be added to chemistry panels to assist in identifying CKD patients?
Review coding and documentation of seizure disorder				<ul style="list-style-type: none"> • Review a sample of records with 780.39 Seizures NOS. • Determine if the documentation describes recurrent or repetitive seizures or seizure disorder, which codes to category 345. • Provide physician and coder education. • Query physicians if the patient is on chronic medication for seizure disorder or the diagnosis is described simply as “seizure”

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Review coding and documentation of body mass index				<ul style="list-style-type: none"> • Determine if body mass index is documented in the medical record for patients who have a BMI less than 19 (V85.0) or greater than 40 (V85.4) • Although coders cannot calculate BMI from the height and weight of the patient, a dietician or other ancillary personnel can document BMI in the record to serve as a document for coding. • Query physicians who document morbid obesity and the BMI is not documented in the record
Late effect of CVA with hemiplegia				<ul style="list-style-type: none"> • Review coding practices for adding late effect of CVA with hemiplegia (438.20 – 438.22) even though it does not impact payment in the current CMS DRGs. • Review a sample of records for documentation of an old CVA to determine if there is clinical evidence of a late effect. • Query physicians if nurses document hemiplegia but the physician does not.