MS-DRGs and Clinical Documentation Improvement

Association for Clinical Documentation Improvement Specialists Conference
Las Vegas, NV
May 2008

Speaker

• Gloryanne Bryant, BS, RHIA, RHIT, CCS
  – CHW Corporate Senior Director Coding HIM Compliance
  – San Francisco, CA
Goals and Objectives

• Overview of the MS-DRG system
• Differences and similarities with CMS-DRGs
• New and revised DRGs
• New/revised complications/comorbidities (CCs) and major CCs list
• Reimbursement scenarios
• Documentation challenges

Disclaimer

• Educational materials on MS-DRGs are designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
• Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.
2008 IPPS Final Rule

August 2007 - The Centers for Medicare & Medicaid Services (CMS) issued a final inpatient prospective payment system (IPPS) rule, that is designed to improve the accuracy of Medicare’s reimbursement to acute care hospitals, while providing additional incentives for hospitals to engage in quality improvement efforts.

“The IPPS payment reforms we are making today finalize the changes we proposed in April and build upon three years of consistent, incremental improvements to Medicare inpatient hospital payments,” said CMS Acting Deputy Administrator Herb Kuhn. “With these changes – first proposed by the Medicare Payment Advisory Commission in 2005 – Medicare payments for inpatient services will be more accurate and better reflect the severity of the patient’s condition.”

Per CMS

Expanding DRGs - Suggestions

• Needed patient attributes:
  – Severity of illness, the extent of physiologic decompensation or organ system lost of function
  – Risk of mortality, the likelihood of dying
  – Resource intensity, the relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease
Who’s the Sickest…???

HOW DO WE DETERMINE WHO IS THE SICKEST?

Severity of Illness (SOI)

- Uncomplicated Diabetes
- Diabetes with renal manifestation
- Diabetes with ketoacidosis
- Diabetes with hyperosmolar coma (more severe)

- Bronchitis
- Asthma with status asthmaticus
- Viral Pneumonia
- Respiratory failure (more severe)

You need specificity to capture Severity
Creating MS-DRGs

- Consolidate CMS DRG
- In many cases, subdivide each base DRG into subclasses based on CCs
- However, not in all cases

- Created up to three tiers of payment for each DRG based on the presence of:
  - a major complication or comorbidity (MCC)
  - a complication or comorbidity (CC)
  - no complication or comorbidity

Categorization of CC Codes

<table>
<thead>
<tr>
<th></th>
<th>Number of Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCC</td>
<td>1,096</td>
</tr>
<tr>
<td>CC</td>
<td>4,221</td>
</tr>
<tr>
<td>Non-CC</td>
<td>8,232</td>
</tr>
<tr>
<td>Total</td>
<td>13,549</td>
</tr>
</tbody>
</table>

Per CMS this change reduced “cc” capture rate from 77.66% to 40.34%
Differences in common “CCs” for DRGs vs MS-DRGs, but still need to be documented

- CHF (Congestive Heart Failure) – 428.0
- COPD (Chronic Obstructive Pulmonary Disease – 496
- Parox tachycardia NOS – 427.2
- Atrial fibrillation – 427.31
- CKD Stage 3 - 585.3 – even though that’s where patients get anemias, secondary hyperparathyroidism, other complications
- Anemia of chronic blood loss – 280.0
- Angina (NOS) - 413.9
- Dehydration -276.50
- Volume deletion – 276.51
- Hypovolemia -276.52
- Fluid overload – 276.6
- Hyperpotassemia – 276.7
- Mild or Moderate malnutrition – 263.0, 263.1
- Acute Alcohol intoxication – 303.00, 303.01, 303.02
- Multiple sclerosis – 340
- Mitral stenosis and insufficiency – 394.0, 394.2
- Mitral Valve disorder – 424.0
- Aortic Valve Disorder – 424.1
- NonRheumatic Tricuspid Valve Dis. – 424.2
- Pulmonary Valve Disorder – 424.3
- AV Block 2n Degree NEC – 426.13
- Superficial phlebitis – leg – 451.0
- Thrombophlebitis leg NOS – 451.2

Documentation Specificity is Key . . . To Capture MCC/CC

- “Closed head injury” …
- “Encephalopathy” …
- “Anemia” …
- “Angina” …
- “Low Urine output” …
- “Respiratory insufficiency” …
- Concussion or loss of consciousness
- Type of encephalopathy and the cause
- Specific type of anemia
- Specific type of angina
- Diagnosis or cause
- Is it Respiratory failure
**Breakdown in Severity of Heart Failure**

<table>
<thead>
<tr>
<th>Code</th>
<th>CC Subclass Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>428.21, Acute systolic heart failure</td>
<td>MCC</td>
</tr>
<tr>
<td>428.41, Acute systolic &amp; diastolic heart failure</td>
<td>MCC</td>
</tr>
<tr>
<td>428.43, Acute on chronic systolic heart failure</td>
<td>MCC</td>
</tr>
<tr>
<td>428.31, Acute diastolic heart failure</td>
<td>MCC</td>
</tr>
<tr>
<td>428.33, Acute on chronic diastolic heart failure</td>
<td>MCC</td>
</tr>
<tr>
<td>428.1, Left heart failure</td>
<td>CC</td>
</tr>
<tr>
<td>428.20, Systolic heart failure NOS</td>
<td>CC</td>
</tr>
<tr>
<td>428.22, Chronic systolic heart failure</td>
<td>CC</td>
</tr>
<tr>
<td>428.32, Chronic diastolic heart failure</td>
<td>CC</td>
</tr>
<tr>
<td>428.40, Systolic &amp; diastolic heart failure</td>
<td>CC</td>
</tr>
<tr>
<td>428.0, Congestive heart failure NOS</td>
<td>Non-CC</td>
</tr>
<tr>
<td>428.9, Congestive heart failure NOS</td>
<td>Non-CC</td>
</tr>
</tbody>
</table>

**TABLE 5.-LIST OF MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS-DiGRs), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY**

<table>
<thead>
<tr>
<th>MS-DiGR</th>
<th>FY 2005 Final Risk</th>
<th>FY 2006 Final Risk</th>
<th>Specialty</th>
<th>DRG</th>
<th>TYPE</th>
<th>MS-DiGR Tab</th>
<th>Weight</th>
<th>Geometric Mean</th>
<th>Arithmetic Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>081</td>
<td>No</td>
<td>No</td>
<td>PFP</td>
<td>0483</td>
<td>Heart transplant or implant of heart assist system M/C</td>
<td>1.087</td>
<td>20.0</td>
<td>45.4</td>
<td></td>
</tr>
<tr>
<td>082</td>
<td>No</td>
<td>No</td>
<td>PFP</td>
<td>0483</td>
<td>Heart transplant or implant of heart assist system M/C</td>
<td>1.072</td>
<td>16.0</td>
<td>38.4</td>
<td></td>
</tr>
<tr>
<td>083</td>
<td>Yes</td>
<td>Yes</td>
<td>PFP</td>
<td>0483</td>
<td>Heart transplant or implant of heart assist system M/C</td>
<td>1.065</td>
<td>12.0</td>
<td>31.8</td>
<td></td>
</tr>
<tr>
<td>084</td>
<td>Yes</td>
<td>Yes</td>
<td>PFP</td>
<td>0483</td>
<td>Heart transplant or implant of heart assist system M/C</td>
<td>1.050</td>
<td>10.0</td>
<td>30.4</td>
<td></td>
</tr>
</tbody>
</table>

**DOCUMENTATION SPECIFICITY IS THE KEY!**
Example of Current CMS and MS-DRG (Impact Coding)

Prior DRG

DRG 127 Heart Failure and Shock
RW 1.0490

MS-DRG

MS-DRG 291 Heart Failure and Shock with MCC
RW 1.2585

MS-DRG 292 Heart Failure and Shock with CC
RW 1.0134

MS-DRG 293 Heart Failure and Shock without MCC or CC
RW 0.8765

Example of Current CMS and MS-DRG (Impact Coding)

Prior DRG

DRG 89 Simple Pneumonia, > age 17, with cc
RW 1.0376

DRG 90 Simple Pneumonia, > age 17, without cc
RW 0.6148

DRG 91 Simple Pneumonia, age 0-17
RW 0.5598

MS-DRG

MS-DRG 193 Simple Pneumonia with MCC
RW 1.2505

MS-DRG 194 Simple Pneumonia with CC
RW 1.0235

MS-DRG 195 Simple Pneumonia without MCC or CC
RW 0.8398
### Example of Current CMS and MS-DRG (Impact Coding)

**Prior DRG**

| DRG 544 (Major Joint Replacement or Reattachment of Lower Extremity) | RW 1.9873 |
| DRG 545 (Revision of Hip or Knee Replacement) RW 2.5306 |

**MS-DRG**

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>469</td>
<td>Major joint replacement or reattachment of lower extremity w MCC RW 2.6664</td>
</tr>
<tr>
<td>470</td>
<td>Major joint replacement or reattachment of lower extremity w/o MCC RW 1.9871</td>
</tr>
<tr>
<td>466</td>
<td>Revision of hip or knee replacement w MCC RW 3.5408</td>
</tr>
<tr>
<td>467</td>
<td>Revision of hip or knee replacement w CC RW 2.7523</td>
</tr>
<tr>
<td>468</td>
<td>Revision of hip or knee replacement w/o CC/MCC RW 2.4545</td>
</tr>
</tbody>
</table>

### CMS TOP VOLUME DRGs

<table>
<thead>
<tr>
<th>TOP Ten</th>
<th>2007 RW</th>
<th>2008 MS-DRG(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>127 Heart Failure</td>
<td>1.0490</td>
<td>291 w MCC 1.2585</td>
</tr>
<tr>
<td>89 Simple Pneumonia with CC</td>
<td>1.0376</td>
<td>193 w MCC 1.2505, 194 w CC 1.0235</td>
</tr>
<tr>
<td>544 Major Joint Replacement or Attachment</td>
<td>1.9878</td>
<td>469 w MCC 2.6664, 470 w/o MCC 1.9871</td>
</tr>
<tr>
<td>88 Chronic Obstructive Pulmonary Disease</td>
<td>0.8878</td>
<td>190 w MCC 1.1138, 191 w CC 0.9404</td>
</tr>
<tr>
<td>576 Septicemia w/o Vent &gt;96 Hours</td>
<td>1.5996</td>
<td>871 w MCC 1.7484, 872 w/o MCC 1.3783</td>
</tr>
<tr>
<td>182 Esophagitis, Gastroenteritis, etc with CC</td>
<td>0.7853</td>
<td>391 w MCC 0.9565, 392 w/o MCC 0.7121</td>
</tr>
<tr>
<td>14 Stroke</td>
<td>1.2118</td>
<td>64 w MCC 1.5470, 65 w CC 1.1901</td>
</tr>
<tr>
<td>174 Gastrointestinal Hemorrhage with CC</td>
<td>1.0296</td>
<td>377 w MCC 1.3367, 378 w CC 1.0195</td>
</tr>
<tr>
<td>316 Renal Failure</td>
<td>1.2602</td>
<td>682 w MCC 1.4664, 683 w CC 1.1942</td>
</tr>
<tr>
<td>320 Urinary Tract Infection</td>
<td>0.8769</td>
<td>689 w MCC 1.0587, 690 w/o MCC 0.8000</td>
</tr>
</tbody>
</table>
IPPS Outliers

• Continue BUT… with MS-DRGs we might not see as many cost outliers as before.
• With the MS-DRG capturing Mcc this would have been a DRG that could go to a higher relative weight.
• OIG focus at this time

IPPS DRG Relative Weight

• Charges versus Costs for RW (relative weight) for FY08
• MS-DRG relative weights are based on costs
• Transition into the cost-based methodology
  – 50% based on the DRG RW and 50% on the MS-DRG (2-year transition)
• According to CMS, setting the DRG relative weights based on costs rather than charges is expected “to reduce incentives for hospitals to cherry pick the healthiest and most profitable patients.”
• As a result, the MS-DRGs will lower reimbursement to specialty hospitals, particularly for certain elective cardiac admissions. For example, CMS projects that payments to cardiac specialty hospitals will decline under the new MS-DRG system by more than 5%.
MS-DRG RW is Cost-Based Methodology

- Using the “Cost” data from 13 categories
  - Room and Board… what’s included?
- Specific cost center data will be used:
  - Routine Intensive
  - Drugs Supplies/Equip
  - Therapy Services Inhalation Ther
  - O/R Labor/Delivery
  - Anesthesia Cardiology
  - Laboratory Radiology
  - Other

Inpatient charging matters!

Focus: Hospital & Physician Report Cards

- Who is publishing “Outcomes” and rating our “Performance”? (Newspapers, Television, AARP, magazines…) rating hospitals and physicians publicly?
  - Many organizations use their own rating systems and we don’t always know what criteria they are using…
  - Independent organizations, employers, health-plans, regulators, accrediting agencies, foundations
  - Organizations use their own or purchased metrics and rating systems.
- What we do know is … Complications and Co-morbidities are key factors in measuring severity and the risk of mortality in all known systems
  - DOCUMENTATION IS THE LINK…. A few of the most popular and frequently accessed Websites which provide information about Healthcare are ...
The Components of Report Cards

- Actual Mortality – % of patients who died either in the hospital or within one month of discharge
- Predicted Mortality - % of patients predicted by the risk adjustment model to die while in the hospital – Based on documented clinical condition, comorbidities and complications
- Actual Complications - documented and coded clinical complications
- Predicted Complications - Complications predicted by the risk adjustment model, usually related to procedural DRGs- Based on documented clinical condition, documented comorbidities and complications
Accurate Documentation will Increase Predicted Mortality

- Case Example:
  - 88 year old female (actual example)
  - CAP - documented
  - Sepsis - 1 days later - documented
  - Septic Shock - 3 days later - not documented
    - CAP - 10% Predicted Mortality
    - Sepsis - 50% Predicted Mortality
    - Septic Shock - 80% Predicted Mortality

Have you looked at www.healthgrades.com?
If you don’t get the documentation and the codes for all conditions to capture severity this can distort the hospital and physician scorecard.

Accurate, Complete & Specific Documentation is the Key… inpatient flow

Physician Documentation in the medical record (while the patient is in the hospital)

This Translates to:
Principal & Secondary Diagnosis and Principal & Secondary Procedures
This is performed by HIM Coding

Translated to ICD-9-CM Codes assigned by Coding Professionals
Following specific and detailed coding rules and guidelines

Software (grouper/encoder) assists coding staff in translating diagnoses to codes & DRG assignment
Severity-Level Profiles & Risk-Adjusted Profiles are created with the coded information

Reimbursement/Revenue
Capture Severity data
Quality Measurements
Peer Review
Physician & Hospital Report Cards & Outcomes
Clinical Research
**Documentation & Guidelines for Coding**

Not all information contained in the medical record can be used for inpatient coding (ICD-9-CM)

- Official coding guidelines (national) state:
  - **Only the documentation of a licensed treating physician can be used for hospital coding (with the exception of PA, NP, Residents and wound care providers)**

<table>
<thead>
<tr>
<th>Examples include:</th>
<th>Examples of physicians who are not treating physicians include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physicians</td>
<td>Pathologists</td>
</tr>
<tr>
<td>Consulting physicians</td>
<td>Cardiologists (Interpreting EKG’s, etc.)</td>
</tr>
<tr>
<td>Surgeons</td>
<td>Radiologists (reading x-rays)</td>
</tr>
<tr>
<td>Interventional Radiologists</td>
<td></td>
</tr>
<tr>
<td>Anesthesiologists</td>
<td></td>
</tr>
</tbody>
</table>

**Resident Documentation**

- The resident note or documentation and diagnosis is used for coding, but this is really relating to the Professional Fee Billing under Direct Medical Education and not inpatient ICD-9-CM coding.

- The inpatient setting, you can code from the residents documentation without the co-signature or acknowledgement of the attending.

- However, if there is no contradictory information elsewhere in the record the coder should clarify and confirm the condition/diagnosis.
Documentation from the PA or NP

• In most states the Physician Assistant and the Nurse Practitioners is allowed to diagnosis.
• If the Practitioners is allow (often under State Practice Law) to diagnosis, then you can code from that documentation.

Definition for Reporting/Documenting Secondary or Other Diagnosis

Conditions that affected patient care in terms of requiring:
– clinical evaluation; or
– therapeutic treatment; or
– diagnostic procedures; or
– extended the length of stay; or
– increased nursing care and/or monitoring

• Take Home Message:
“Document all conditions/diagnoses”

Also: Coding guidelines state “… all conditions that coexist at the of admission, that develops subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded”
IPPS Payments - Offset

- CMS: IPPS payments (AHA News 10/07)
- Medicare payment of inpatient claims for discharges in early October could be delayed a few days as updates are made to the agency’s claims processing software, the Centers for Medicare & Medicaid Services announced yesterday.
- The updates incorporate changes made to the fiscal year 2008 inpatient prospective payment system that were enacted by Congress Sept. 27 as part of the TMA, Abstinence Education, and QI Programs Extension Act. The bill reduced a planned “behavioral offset” to the Medicare-Severity Diagnosis-Related Groups to -0.6% from -1.2% in FY 2008 and to -0.9% from -1.8% in FY 2009. “The extra couple of days will ensure accurate claims processing and obviate the need for reprocessing hospital claims,” CMS said.
- CMS does not expect the legislation to delay Medicare payments for Long-Term Care Hospital short-stay outlier cases, which are based on IPPS payment amounts.
- Finance is watching this closely…creates more challenges

CMS’s Solution
Clinical Documentation Integrity

- “We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.”
- Opportunity in this statement if put to action
“If it’s not documented by the physician, it didn’t happen”

In Compliance and in Coding, there is no deviation from this principle. We can’t code it if it isn’t documented, then we can’t bill for it.

TIPS FOR IMPROVING CLINICAL DOCUMENTATION … COMMONLY MISSED DIAGNOSES/CONDITIONS THAT ARE COMPLICATIONS AND CO-MORBIDITIES

To reflect appropriate patient severity, acuity, risk of mortality, resource consumption and to ensure complete and accurate coding, document in the History, MD Orders, or Progress Notes or Discharge Summary ALL diagnostic conditions that affect the current stay. These are reportable secondary conditions … IF IT’S NOT DOCUMENTED, WE CANNOT CODE IT!

- Acidosis
- Alkalosis
- Anemia due to acute blood loss
- Angina – unstable or at rest
- Asthma with status asthmaticus
- Atelectasis
- Arrail Flutter
- BMI Less than 19
- BMI 40 & >
- Cachexia
- Cardiogenic Shock
- Coma
- Crohn’s Disease
- Chronic nephritis
- Decubitus Ulcer
- Diabetic ketoacidosis, uncontrolled
- Diverticulosis with or without hemorrhage
- Diverticulitis with or without hemorrhage
- Drug Use – Dependency, Continuous
- Fracture Rib(s)
- Heart Failure, Acute or Chronic – Systolic or Diastolic
- Hematemesis
- Hepatitis– Acute or Chronic
- Ileus
- Late Effects CVA with hemiplegia
- Malnutrition – Nutritional, Protein or Severe
- Malignant Hypertension
- Melena
- Metastasis (specify site)
- Neutrogenic Bladder
- Pancreatitis – Acute or Chronic
- Paroxysmal Supraventricular Tachycardia
- Paroxysmal Ventricular Tachycardia
- Pleural Effusion
- Pathological Fractures
- Phlebitis, Deep Vein
- Pneumonia – specific type/cause
- Pneumothorax
- Renal Failure - Acute vs Chronic (Stage)
- Respiratory Failure – Acute or Chronic
- Septic Shock
- Urinary Tract Infection
- Ulcerative Colitis
- Ventricular Fibrillation/Flutter

Thank you for your help!

Proprietary business document. Do not copy or distribute outside of CHW System without the expressed written permission of CHW Corporate Coding HIM Compliance Department. Dev. 10/03, Rev. 09/07

17
Documentation Challenge…
Seizure or Epilepsy?

- Assign seizures that the physician does not further clarify to code 780.39. This code is not a CC condition. The physician must specify petit mal or grand mal in order for the coder to assign codes 345.0x or 345.1x. (These would be secondary conditions for the MS-DRG)
- Also, without the presence of intractable epilepsy, it is not a CC.
- Talk to your ED/ER physicians and Neurologists

Documentation Challenge…
Heart Failure

- Lack of physician documentation for specific type… “CHF” is most common
  - These cases should be queried to obtain this specific documentation.
- Ejection Fraction (EF)
- Recommend that case managers, documentation specialists, and/or inpatient coding staff assist in obtaining this information on a concurrent basis.
- Inservice Cardiologist, Cardiac Surgeons, Internists and Hospitalists
- Develop new “HF progress note” to use
Documentation Challenge . . . Debridement

- Excisional debridement (skin) needs to be described in more detail by the physicians and other non-physician providers (exception to rule).
  - Wound care Nurse, Therapist, etc.
- There are very specific coding guidelines relating to this (RAC target)
  - Site/location
  - Depth
  - Removal of devitalized tissue
  - Instrumentation used

Documentation Challenge . . . Decubitus Ulcer

- decubital ulcer, decubitus ulcer, an ulceration caused by an arterial occlusion or by prolonged pressure, as when in a patient allowed to lie too still in bed for a long period of time or is confined to a wheelchair; called also decubitus, bed sore, and pressure u. or sore. (Dorland’s Dictionary)
- Physician’s need to specify decubitus site since it would be a CC or MCC by site specific area
- “Stage” does not correlate to a decubitus
- Physician might co-sign the wound care assessment and concur
- Improve documentation form
Clinical knowledge:
Pressure Sores/Decubitus Ulcers

- Important for POA (more on that later)
- Review the ED documentation closely
- Nursing assessment
- Wound Care documentation
- Excisional debridement of devitalized tissue via instruments that cut away the tissue may result in the assignment of 86.22 excisional debridement procedure code.
- POA impact come 10/1/08 (more on that later)

Clinical Knowledge: Pressure Sores/Decubitus Ulcers (con’t)

- A Stage 1 pressure sore (redness) is still a pressure sore
- Knowledge of the stages is important:
  - **Stage 1:** Nonblanchable erythema of intact skin. The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. A Stage I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following:
    - **Stage 2:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
  - **Stage 3:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
  - **Stage 4:** Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers. Source: National Pressure Ulcer Advisory Panel (NPUAP)
Documentation Challenge...

Body Mass Index (BMI)

The BMI code assignment should be based on medical record documentation, which may be found in a dietitian’s note.

Note that this is an exception to the guideline that requires code assignment be based on the documentation by the physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis. While BMI may be reported on the basis of a dietitian’s documentation, the codes for overweight and obesity should be based on the provider’s documentation.

Coders should not calculate the BMI.

- **40 and over** = V85.4 = “CC”
- **less than 19** = V85.0 = “CC”

ICD-9-CM V Codes to Capture “Body Mass Index or BMI”

Whether the clinical documentation is in the Hospital record or the Physician office, complete and accurate documentation is needed to meet medical necessity, compliance, to gather outcomes data and to obtain payment.

<table>
<thead>
<tr>
<th>Adult Body Mass index (BMI)</th>
<th>ICD-9-CM code</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.0-25.9</td>
<td>V85.21</td>
</tr>
<tr>
<td>26.0-26.9</td>
<td>V85.22</td>
</tr>
<tr>
<td>27.0-27.9</td>
<td>V85.23</td>
</tr>
<tr>
<td>28.0-28.9</td>
<td>V85.24</td>
</tr>
<tr>
<td>29.0-29.9</td>
<td>V85.25</td>
</tr>
<tr>
<td>30.0-30.9</td>
<td>V85.30</td>
</tr>
<tr>
<td>31.0-31.9</td>
<td>V85.31</td>
</tr>
<tr>
<td>32.0-32.9</td>
<td>V85.32</td>
</tr>
<tr>
<td>33.0-33.9</td>
<td>V85.33</td>
</tr>
<tr>
<td>34.0-34.9</td>
<td>V85.34</td>
</tr>
<tr>
<td>35.0-35.9</td>
<td>V85.35</td>
</tr>
<tr>
<td>36.0-36.9</td>
<td>V85.36</td>
</tr>
<tr>
<td>37.0-37.9</td>
<td>V85.37</td>
</tr>
<tr>
<td>38.0-38.9</td>
<td>V85.38</td>
</tr>
<tr>
<td>39.0-39.9</td>
<td>V85.39</td>
</tr>
<tr>
<td>40 and over</td>
<td>V85.4</td>
</tr>
<tr>
<td>between 19-24</td>
<td>V85.1</td>
</tr>
<tr>
<td>less than 19</td>
<td>V85.0</td>
</tr>
</tbody>
</table>

- The BMI code assignment should be based on medical record documentation, which may be found in a physician or dietitian’s note.
- Clinical documentation should always be clear, concise and accurate.
- Always document legibly, sign, date and time all orders.
Data Mining … Target Areas in MS-DRGs

• Look at your overall MCC/CC capture rate
  – Without CC %
  – With CC
  – With MCC

• Capture rate within specific MS-DRGs (tiered & paired)
  – Without CC %
  – With CC
  – With MCC

Track your data: Simple Pneumonia & Respiratory Infection/Inflammation MS-DRGs177/178/179 & 193/194/195

• Know characteristics of different pneumonia's
  – Clinical information and presentation of the patient

• Capture MCC/CC
  – Home oxygen – ? Chronic respiratory failure
  – Heart failure – specify the type
  – Hyponatremia
  – Cachexia
  – Malnutrition (specific degree)
  – BMI

• Look for overlapping “Sepsis” with other conditions (ie. Pneumonia)
  – Know the clinical Signs/Symptoms
  – Shock
Target MS-DRGs: GI Hemorrhage
MS-DRGs 377/378/379

- Patients with upper GI bleed often have blood loss resulting in anemia… physician specific type “Acute Blood Loss Anemia”
  - Review the labs – check Hgb/Hct (monitoring)
  - Review orders for replacement of blood (treatment)
  - 285.1 Acute Blood Loss Anemia is still a CC
- Location of the GI bleed is also important
- Due to an ulcer? … what specific type of ulcer?

Documentation Challenge
Dehydration – Acute Renal Failure

- Review the creatinine
  - Opportunity to “query”
- Look at the circumstances of admission
- AHA Coding Clinic does allow Acute Renal Failure as the Principal diagnosis – review the guidelines
- Hyponatremia is a CC
Documentation Challenge . . .
Acidosis and Alkalosis

• Common electrolyte imbalances
• Acidosis check for HCO3 <18
• Alkalosis check for HCO3 >28
• Can’t code from lab values
  – Need documentation of clinical significant of values – condition or diagnosis

Documentation Challenge . . .
Mental Status Change

• Often we see “Altered Mental Status”
• Acute delirium, dementia, stupor, coma, mania, confusion, psychosis, hallucinations, delusions are all CCs
• Identify via documentation the underlying cause of the mention status change
Documentation Challenge
…Chemical Dependency

• Know the differences between Alcohol or Drug use vs abuse
• A legal use of drug = use
• An illegal drug use = abuse
• Continuous or daily use/abuse documentation needs further documentation (continuous is CC)

Opportunity - Using MD Orders!

• Yes… if the MD order contains a diagnosis this can be used to assign the ICD-9-CM code.
• Assigning codes based on physician orders
  • Coding Clinic, Third Quarter 2005 Page: 18
• Coding from physician phone orders
  • Coding Clinic, Third Quarter 2005 Page: 19
• Inservice your Nursing staff, discuss capturing “diagnostic information” or indication
### Opportunity - Data Mining to Assist

<table>
<thead>
<tr>
<th>Pt Control No</th>
<th>Med Rec No</th>
<th>Drug No</th>
<th>Drug Name</th>
<th>Drug Dose</th>
<th>Drug Route</th>
<th>Drug Type</th>
<th>Drug Class</th>
<th>Drug Code</th>
<th>Drug Quantity</th>
<th>Drug Duration</th>
<th>Drug Frequency</th>
<th>Drug Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>2001</td>
<td>3001</td>
<td>Abc</td>
<td>100mg</td>
<td>IV</td>
<td>Antibiotic</td>
<td>101</td>
<td>1</td>
<td>10000</td>
<td>Daily</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### Data Mining to Assist

#### 743: Ultrasound & adnexa for non-malignancy with CC167

<table>
<thead>
<tr>
<th>Pt Control No</th>
<th>Med Rec No</th>
<th>Drug No</th>
<th>Drug Name</th>
<th>Drug Dose</th>
<th>Drug Route</th>
<th>Drug Type</th>
<th>Drug Class</th>
<th>Drug Code</th>
<th>Drug Quantity</th>
<th>Drug Duration</th>
<th>Drug Frequency</th>
<th>Drug Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>3000</td>
<td>4000</td>
<td>Xyz</td>
<td>50mg</td>
<td>IV</td>
<td>Antibiotic</td>
<td>102</td>
<td>1</td>
<td>50000</td>
<td>Daily</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

#### 747: Virginia, cervix & uterine procedures with CC167

<table>
<thead>
<tr>
<th>Pt Control No</th>
<th>Med Rec No</th>
<th>Drug No</th>
<th>Drug Name</th>
<th>Drug Dose</th>
<th>Drug Route</th>
<th>Drug Type</th>
<th>Drug Class</th>
<th>Drug Code</th>
<th>Drug Quantity</th>
<th>Drug Duration</th>
<th>Drug Frequency</th>
<th>Drug Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>4000</td>
<td>5000</td>
<td>6000</td>
<td>Mno</td>
<td>25mg</td>
<td>IV</td>
<td>Antibiotic</td>
<td>103</td>
<td>1</td>
<td>25000</td>
<td>Daily</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Another IPPS and MS-DRG Initiative…
Present on Admission - POA

• Hospital Acquired Conditions, including Infections (Impact Coding) . . .
Documentation is linked

Hospitals are under increasing financial and legal pressure to eliminate egregious medical errors.
States, consumer organizations, and now the federal government are pushing hard to create accountability.
They believe that withholding payment to hospitals for the extra care that results from provider errors will help to forge that accountability.
POA – Present on Admission

- Hospital acquired conditions
  - Quality and risk
- Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital.
  - Collection/submission is required to start in 10/1/07
- October 2008 impact the MS-DRG grouping and payment
  - If the only MCC/CC

Present on Admission (POA) Definition

- Present on admission is defined as:
  - Any condition being present at the time of the order for inpatient admission occurs
  - Any condition that develops during an outpatient encounter including emergency department, observation or outpatient surgery and are still present at time of inpatient admission.
- Time of inpatient admission = time on the MD order to admit the patient.
  - Only applies to inpatient admission not outpatient encounters.
Hospital Acquired Conditions - POA

• The rule has adopted eight conditions, including three serious preventable events, for which CMS will not provide higher DRG payments if the selected event occurs while a patient is under the care of the hospital.
  – That change will take effect in FY09
  – Better tracking of hospital acquired infections, accidents and adverse events

Guideline for Reporting Secondary Diagnosis – This Hasn’t Changed

• Report conditions that affected patient care in terms of requiring:
  – clinical evaluation; or
  – therapeutic treatment; or
  – diagnostic procedures; or
  – extended the length of stay; or
  – increased nursing care and/or monitoring
Official POA Reporting Guidelines – Appendix I

ICD-9-CM Official Guidelines for Coding and Reporting
Effective October 1, 2007

Appendix I
Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the ICD-9-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the ICD-9-CM Official Guidelines for Coding and Reporting. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

Present On Admission Indicator Definitions

• Y = Yes
  – Condition is present at the time of inpatient admission

• N = No
  – Condition not present at the time of inpatient admission

• U = Unknown
  – Documentation is insufficient to determine if the condition is present on admission

• W = Clinically Undetermined
  – The provider is unable to clinically determine whether condition was present on admission or not
Conditions Selected in IPPS Final Rule FY08

- Object Left in Surgery (998.4)
- Air Embolism (999.1)
- Blood Incompatibility (999.6, 999.7)
- Catheter Associated Urinary Tract Infections (996.64)
- Pressure Ulcers (Decubitus Ulcers) (707.00-707.09)
- Vascular Catheter Associated Infection (999.31)
- Mediastinitis After Coronary Artery Bypass Graft (519.2)
- Hospital Acquired Injuries fractures, burns and injury (800.829, 830-839, 850-854, 925-929, 940-949)
What will happen in October 2008? (Impact Reimbursement) Case Example

- For the conditions that have been chosen, if that condition is the only “cc” on the claim, the claim will be paid at the lower weighted DRG.
- Example:
  - Patient admitted with acute atrial fibrillation (PrDx) and developed a decubitus ulcer* during the hospitalization which is identified by a POA of “N”.
  - The DRG assignment would be MS-DRG 309 RW 0.8233 (medical)
    - With a base rate of $6500 X 0.8233 = $5351.45
  - Payment for this case would be calculated as if the decubitus ulcer was not present – therefore, MS-DRG 310 RW 0.6439
    - With a base rate of $6500 X 0.6439 = $4185.35
  DIFFERENCE MS-DRG 309/310 = $1166

Let’s Look at A Case Example...

This is a code summary sheet for a patient with a Total Hip Replacement ICD-9-CM code 81.51

Decubitus ulcer with POA of No
Note: It’s the only MCC
Again, How Will the Reimbursement be Affected?

- **Today:**
  - Base rate = $5000
  - DRG 469
  - Wt. 2.6664
  - Total Reimb = $13332

- **After October 1, 2008:**
  - Base rate = $5000
  - DRG 470
  - Wt. 1.9871
  - Total Reimb = $9935.50

**Loss Revenue = $3396.50**

Let’s assume the base rate is $5000 for this hospital. Patient’s LOS = 8 days

---

**Physician Awareness & Documentation is Key**

- Capturing accuracy POA indicators will need accuracy and specific physician documentation
- Provide physician awareness
More on Documentation Opportunities

- IPPS MS-DRG create many challenges
- Hospitals need to plan, organize and take action to grasp opportunities
- Not just one inservice to physicians
- Regular and consistent message and information
- Develop a strategy . . .

Continue Home Meds? ... Need Diagnostic Documentation

- **Always document** diagnoses related to all home medications continued during the hospital stay.
- Secondary diagnoses reflect the severity of illness as well as the intensity of service.
- Examples:
  - Theodur – COPD
  - Imdur – Angina Pectoris
  - Lasix – Compensated CHF
  - Lanoxin – Atrial Fibrillation
  - Synthroid – Hypothyroidism
  - Lopressor – Hypertension
PREOP ANESTHESIA... AHA Coding Clinic allows us to code for the Anesthesia Record. Great tool to capture severity!
Blood Transfusion Form – Capture Diagnosis and Severity

Physician/Blood Product Order

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th># of Units</th>
<th>Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician/Provider Documentation Tips

The following is a list of documentation tips for capturing patient severity/acuity and risk of mortality:

1. Physicians must document all diagnoses/conditions that are being treated, monitored, or require more nursing care in order to capture severity.

2. Indicate the condition/diagnosis with the terms “acute” or “chronic” if it is known. In addition, document the underlying “cause” of the disease or condition if it is known (i.e., the causal organism for pneumonia). This helps improve hospital and physician profiling and report cards.

3. The Medicare-Severity DRGs (MS-DRGs) are a new national regulatory initiative affecting acute care hospitals under the Inpatient Prospective Payment System (IPPS) beginning with discharges October 1st, 2007. Capturing patient severity will be achieved via clinical documentation in the medical record and coding (ICD-9-CM Diagnosis and Procedures).

4. Medicare Severity DRGs or MS-DRGs

Medicare Severity DRGs or MS-DRGs

Physician/Provider Documentation Tips

The Medicare-Severity DRGs (MS-DRGs) are a new national regulatory initiative affecting acute care hospitals under the Inpatient Prospective Payment System (IPPS) beginning with discharges October 1st, 2007. Capturing patient severity will be achieved via clinical documentation in the medical record and coding (ICD-9-CM Diagnosis and Procedures).

MS-DRGs:

- Greatly improves CMS’ (Center for Medicare/Medicaid Services) ability to identify groups of patients with varying levels of severity using secondary diagnoses
- Does a better job of identifying technology
- Represents a comprehensive approach to applying severity of illness stratification for Medicare patients throughout the DRGs
- Greater resources are expended for the more severe/acute patient

The following is a list of documentation tips for capturing patient severity/acuity and risk of mortality:

1. Physicians must document all diagnoses/conditions that are being treated, monitored, or require more nursing care in order to capture severity.

2. HIM Coding may need to query the physician if the documentation does not contain enough information to determine if the condition/diagnosis was acute/chronic or both. Please respond/communicate to these queries.

3. Comorbidities/complications (“CCs”) are:
   - Significant acute diseases
   - Acute exacerbations of chronic significant diseases
   - Advanced end stage diseases
   - Chronic diseases with extensive debility
   - Consistently have a greater impact on hospital resources

4. Provide specific documentation using the terms “acute” or “chronic” if it is known. In addition, document the underlying “cause” of a disease or condition if it is known (i.e., the causal organism for pneumonia). This helps improve hospital and physician profiling and report cards.
Develop a MS-DRG Tool Kit

- Encoder software - grouper
- Knowledge of Major CCs
  - List available
- Knowledge of CCs
  - List available
- Coding staff & Others - Disease process - core knowledge
- Coding Staff & Others - Pharmacology knowledge

MS-DRG Tool Kit (con’t)

- DRG Book (Ingenix)
- MS-DRG Memo to the Medical Staff
  - Severity capture
  - Utilization of querying
- Physician Query form's)
  - Follow best practices
- Query usage policy
  - Open communication
MS-DRG Tool Kit (con’t)

- Physician Query Tracking
  - Concurrent
  - Prebill and/or Retro
- Documentation Improvement Program
  - Concurrent
- Documentation Audit/assessment
  - Concurrent reviews
  - Retro reviews
- POA Query form
- POA Memo to the Medical Staff
- Inservice on POA to Quality and Risk Services
- Use the Medical Staff newsletter to enhance awareness

MS-DRG Tool Kit (con’t)

- Create MS-DRG posters/flyers
- Create “Documentation Tip Sheets” (variety)
- Coding Audits
  - Retrospective
  - Verify the UB is correct
- Monitor your MS-DRGs (volumes)
- AHA Coding Clinic on ICD-9-CM (subscription)
- Educate and re-educate … over and over
  - Coding staff
  - Documentation specialists
  - Case Management
  - Dietary, Wound Care, Respiratory, PT/OT, Speech
  - Nursing Leadership and Unit Mgrs.
  - Physicians, ED Physicians as well
  - Hospital Administration/Mgmt (incl CFOs)
Summary

- Remember… Accurate, Complete and Specificity
- Don’t ask to document/write more, ask the documentation that is provided to mean more
- Regulations require healthcare providers to capture all clinical data with new emphasis on complication and “never events” - POA
- Clinical documentation is at the center – Linkage of documentation to the coding and payment systems continues
- There is a linkage to Quality measures and scorecards of performance from documentation and coding
- Develop a Tool-kit – suggestions and ideas to manage MS-DRGs
- Remember…Coding rules and guidelines … be compliant

Listen, Learn and Take Action
Questions?

• Question and Answer Period…

Thank you

Gloryanne Bryant
gbryant@chw.edu
415 438 5721
References/Resources

- FY2008 IPPS Proposed Rule
- FY2008 IPPS Final Rule
- www.cms.hhs.gov/ICD9ProviderDiagnostic-Codes/07_summarytables.asp#TopOfPage
- CMS links to important tables:
  - •CC list
    http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType
    =none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS
    1201734&intNumPerPage=2000
  - •MCC list
    http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType
    =none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS
    1201733&intNumPerPage=2000

ABOUT THE SPEAKER:
Gloryanne Bryant, BS, RHIA, CCS
CHW Corporate Coding HIM Compliance Director

- Ms. Bryant is an RHIA (Registered Health Information Administrator) and a RHIT (Registered Health Information Technician) as well as a Certified Coding Specialist (CCS) with over 28+ years of experience in the health information management (HIM) profession. Gloryanne currently is the Corporate Director of Coding HIM Compliance for Catholic Healthcare West (CHW), located in San Francisco, California. In this role Gloryanne has responsibility for the coding and documentation compliance of 40 acute care facilities and a variety of other non-hospital based healthcare entities (outpatient settings, SNF and Rehab) in three states. She has the charge of developing, implementing/setting and maintaining SystemWide coding policies, and creating an internal coding compliance auditing and monitoring team and process. She is also responsible for maintaining ongoing continuing education to the CHW coding and charging staff, and providing specific documentation related education to physicians, case management, and other ancillary clinicians. In addition, she works closely with Senior Management and those involved with the CDM (Charge Description Master), severity/acuity, and risk of mortality statistics via APR-DRGs, and quality and are a driving force for regulatory updates and communication.

- Ms. Bryant has conducted numerous ICD-9-CM and CPT coding, DRG and APC (OPPS) workshops for hospital based coders. In addition she has made an array of presentations on data quality, medical necessity, compliance and documentation improvement to management executives and healthcare administrators. Over the past three and a half years she has been a guest speaker on compliance issues for several regional, state and national educational programs and associations. Gloryanne has given presentations on planning and implementation of ICD-10 over the past 4 years and provided testimony in support of ICD-10 implementation for the House Ways and Means Committee in April 2006. In addition during 2005 and 2006, Gloryanne spoke to HIM professionals in the states of Oregon, Washington Alaska, and Hawaii on the subject of clinical documentation improvement, APCs, charging and meeting compliance in coding, billing, revenue cycle, reimbursement and other related subjects.

- Gloryanne serves as a volunteer leader on many levels including for the California Health Information Association (CHIA) as a Director to the state board and has served several national positions for AHIMA (American Health Information Management Association). Gloryanne has served as a Director and Past-Chair for the Society for Clinical Coding (SCC), and served two years on the AHIMA Compliance Task Force. As a Health Information Management Practitioner in the HIM Coding arena, she was on the AHA Editorial Advisory Board (EAB) on ICD-9-CM for Coding Clinic for two years and also served a three-year term on the Council on Accreditation for AHIMA. She continues to publish articles and agrees to be interviewed for national publications like “For the Record”, “Medical Record Briefings”, “CHIA Journal”, and “Journal of AHIMA” and “Advance” magazines for HIM.

- In June 2000, Gloryanne received the "CHIA Literary Award", from the California Health Information Association (CHIA) for her many articles and writings related to clinical documentation improvement, compliance, data quality and coding and in 2003 she received the CHIA award for “Distinguished Member”. In August 2005, Gloryanne was appointed to the HHS CMS (Centers for Medicare and Medicaid Services) APC Advisory Panel to work on OPPS policy, coding and reimbursement issues. She was recently appointed to the RAND Expert Panel on Severity DRGs. She was nominated for the AHIMA Triumph Award in the category of “Champion” in 2007. Gloryanne is a sought-after national speaker and author on Healthcare Compliance, reimbursement, clinical documentation, coding regulations (ICD-9-CM and CPT) and serves as a catalyst for change and improvement in healthcare.