The MS-DRG Training Handbook

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Chapter 1: MS-DRGs: Coding/HIM perspective

Under MS-DRGs, coders/HIM staff will continue to report ICD-9-CM codes using the same principal/secondary diagnosis and procedure coding conventions that they used before. The difference is that the conditions that they report will affect reimbursement in a new way.

For example, under CMS-DRGs, when a coder reported septicemia without mechanical ventilation 96+ hours, >age 17 as the principal diagnosis, and the patient had a secondary diagnosis of coma, the DRG would have been 576 (Septicemia with ventilatory support, 96 hrs, age >17). This DRG had a relative weight of 1.5996, which yielded $7,998.00.

Under MS-DRGs, when the coder reports the same clinical scenario, it maps to MS-DRG 871 (Septicemia without mechanical ventilation, 96+hrs with MCC), which has a relative weight of 1.74838. This DRG yields $8,741.90.

How CC changes affect coders

Under MS-DRGs, CMS eliminated many of the conditions that coders used to see on the CC list.

For example, under the CMS-DRG system, CHF unspecified (ICD-9-CM code 428.0) was a CC, and if a physician documented it in the record and a coder assigned it, the CC affected the DRG assignment. But under MS-DRGs, CHF is not a CC. If the physician further specifies CHF as either diastolic (code 428.30) or systolic (code 428.20) in nature, it is a CC. If a physician further specifies CHF as acute diastolic (code 428.31) or acute systolic (code 428.21) in nature, it qualifies as an MCC. But the catch, as always, is that physicians must be very precise with their documentation. See Figure 3 for an example that demonstrates this point.

Figure 3 **Reimbursement comparison for CHF example**

Principal Diagnosis: 410.01 (Acute myocardial infarction of other inferior wall, initial episode of care) Procedures: 37.72 Initial insertion of transvenous (pacemaker) leads [electrodes] into atrium and ventricle; and 37.83 initial insertion of dual-chamber (pacemaker) device	CMS DRG System (FY 2007)	Relative Weight FY 2007 (Payment with wage index of 1)	MS-DRG (FY 2008)	Relative Weight FY 2008 (Payment with wage index of 1)
Case 1: Additional Diagnosis: 428.0 Congestive heart failure, unspecified	551 Permanent cardiac pace-maker implant w/ major cardio-vascular Dx	3.0364 ($16,098)	244 Permanent cardiac pacemaker implant w/o CC/MCC	2.1367 ($11,510)
Case 2: Additional Diagnosis: 428.1 Left heart failure	551 Permanent cardiac pace-maker implant w/ major cardio-vascular Dx	3.0364 ($16,098)	243 Permanent cardiac pacemaker implant w/CC	2.5483 ($13,728)
Case 3: Additioal Diagnosis: 428.31 Acute diastolic heart failure	551 Permanent cardiac pace-maker implant w/ major cardio-vascular Dx	3.0364 ($16,098)	242 permanent cardiac pacemaker implant w/ MCC	3.2586 ($17,554)

Other examples of conditions that are no longer CCs under MS-DRGs include COPD (code 496) and atrial fibrillation (code 427.31), to name a few.

Documentation challenges that coders face

Today, numerous challenges exist for coders when they review the medical record and assign pertinent codes. This

is especially true in the instance of incomplete/nonspecific documentation

For example, patients often present to the emergency room with unstable angina. Coronary disease—the process that causes unstable angina—also causes stable angina and myocardial infarction (MI). Unstable angina occurs when a blood clot forms on a plaque, markedly increasing the degree of blockage in a coronary artery. In unstable angina, the clot does not completely obstruct the artery, but instead increases the degree of blockage.

Unstable angina is often associated with newly diagnosed angina and is characterized by chest pain of increased severity, duration, and frequency. Physicians may use the term unstable angina to describe a syndrome that is intermediate between stable angina and an MI. The condition may also be associated with an accelerated or "crescendo" pattern of chest pain that lasts longer than pain involved with stable angina. The chest pain occurs at rest or with less exertion than in stable angina, or is less responsive to medication.

The challenge coders frequently face with conditions such as unstable angina, toxic encephalopathy, and cardiogenic shock (defined by sustained hypotension with tissue hypoperfusion, despite adequate left ventricular filling

pressure) is that the physician will describe the clinical conditions in great detail, yet will fail to explicitly document the diagnosis in the record.

For example, a patient is admitted to the hospital with a blood pressure of 90/45, a significant amount of infarcted heart tissue, altered mental status, cold extremities, cardiogenic shock, and low urine output. Signs of hypoperfusion include oliguria (< 30 cc urine/hr), cool extremities, and altered mental status. Unfortunately, from a risk of morbidity and mortality standpoint, the physician may not specifically document this diagnosis of cardiogenic shock in the record in conjunction with an MI.

Another challenge confronting coders is when a physician documents a diagnosis that adds severity of illness to the case, and to which a coder can assign an appropriate ICD-9-CM code. However, the medical record documentation may not be explicit enough to assign a more specific diagnosis that best represents the severity of illness, risk of morbidity, and mortality of the patient.

An example is malnutrition. There are at least six ICD-9-CM codes that describe the different variants of malnutrition; however, coders don't often see detailed physician documentation to match this specificity. This is true even with the admission of nursing home patients to the hospital—a

clientele that is more susceptible to malnutrition due to their lack of eating and other contributing factors.

The coder's role under MS-DRGs

Coders play an important role in the correct implementation of MS-DRGs. It is up to coders to recognize all conditions that clinical staff manage during the patient encounter, and to ensure that the diagnoses make it into the record. Ultimately, this means that coders must take the time to study clinical conditions so that they can understand the clinical encounter documented in the record.

Coders should seek clarification from physicians in these instances or when the patient has shock with decreased tissue perfusion and organ failure, regardless of the cause (e.g., septic shock, cardiogenic shock, hemorrhagic shock, hypovolemic shock, etc.). Don't accept lower respiratory tract infection as a substitute for either pneumonia or bronchitis. If a patient has chronic anemia and there's a cause available, don't accept "anemia of chronic disease" when the physician knows the cause of the chronic disease. When there is no chronic disease, use code 285.9.

Coders should also strive to:

1. Be inquisitive and research unfamiliar medical terms and other clinical conditions when they arise in the record.

2. Watch for unlikely clinical scenarios. Patients with end-stage renal disease cannot experience acute renal failure because at that stage of their disease, they no longer have kidney function. Patients who are receiving medications to counteract the effects of anesthesia on the special care unit rather than in the postanesthesia care unit don't have acute respiratory failure. Some physicians purposely keep patients on a ventilator to prevent them from waking up by putting them into an induced coma for cerebral edema or between peeks in laparotomies (e.g., liver transplant or mesenteric vascular occlusion). These patients don't have acute respiratory failure.

In addition, beware of a diagnosis of gram-negative pneumonia when the treatment that the physician prescribes is for all organisms, or when the patient has documented candida pneumonia and the physician treats it only with antifungal swish in the mouth.

Present-on-admission indicator

The present-on-admission (POA) indicator is a new data element that CMS requires hospitals to report as of October 1, 2007, as part of the Deficit Reduction Act of 2005. POA refers to conditions that are present at the time an order for inpatient admission occurs. Conditions that develop during

an outpatient encounter, including emergency department (ED), observation, and outpatient surgery, are considered POA. Coders should report a POA indicator for a principal diagnosis, as well as any secondary diagnoses or E codes.

POA ties in with MS-DRGs because even though a condition may be classified as a CC or MCC, that doesn't mean that it will affect the MS-DRG assignment. This is because as of October 1, 2008, hospitals will not receive additional payments for cases in which one of eight conditions develops but was not POA. CMS will reimburse these cases as though the secondary diagnoses were not clinically present. The eight hospital-acquired conditions CMS targets in the 2008 IPPS final rule (see the August 22 *Federal Register*) include:

- Serious preventable event (object left in surgery)
- Serious preventable event (air embolism)
- Serious preventable event (blood incompatibility)
- Catheter-associated urinary tract infection (CAUTI)
- Pressure ulcers (decubitus ulcers)
- Vascular catheter (associated infection)
- Surgical site infection (e.g., mediastinitis after coronary artery bypass graft)
- Hospital-acquired injuries, fractures, dislocations, intracranial injuries, crushing injuries, burns, and other unspecified effects of external causes

Consider the following example:

A patient was admitted with acute atrial fibrillation and developed a decubitus ulcer during the hospitalization, which is identified by a POA of "N."

The DRG assignment would be MS-DRG 309; however, because the decubitus ulcer was not POA, CMS will calculate this case as though it were not present. This would result in MS-DRG 310.

The UB-04 includes an indicator field specifically designed for POA assignment. Coders have to determine whether a condition was POA when the patient was admitted to the hospital or whether it developed during the hospital stay. Once coders find this information, they can report one of the following indicators in the proper field:

- Y/Yes: Present at the time of inpatient admission
- N/No: Not present at the time of inpatient admission
- U/Unknown: The documentation is insufficient to determine if the condition was present at the time of inpatient admission
- W/Clinically Undetermined: The provider is unable to clinically determine whether the condition was present at the time of inpatient admission

Coders can use several documents to decipher POA information:

- ED notes: ED notes may state the patient's condition in the workup.

- History and physical (H&P): A patient's condition may be diagnosed or found in the workup of the H&P portion of the physician exam notes. Past medical history, as well as current medications, may be found here as well.

- Progress notes: Progress notes are a follow-up on a patient's initial condition diagnosis. These notes may also reveal new findings of existing conditions.

- Consults: Reports from a consulting physician may yield information for management of other conditions that need surgery.

- Admission forms: A nursing admission, an operating room admission, or an anesthesia workup may contain useful POA information.

- Laboratory and x-ray reports: Coders can look for information in the workup of both laboratory and x-ray reports.

Coders should remember that admission forms, lab reports, and x-ray reports don't support a POA indicator. To assign POA, coders must rely on a treating physician's documentation.

Assuming physician documentation is accurate and complete, a coder can consider these tips when assigning the POA indicator:

- Look in the history and physical, as well as the emergency room physician documentation and admitting progress note and orders. The cut-off point in determining whether the condition was POA, is when the admit order was written.

- Look for confirming diagnoses. Perhaps the physician documented a sign or symptom on admission, but didn't render a diagnosis until two or three days later. The physician may have documented a diagnosis as "possible" or "probable," but didn't confirm it until later in the progress notes. Only code a diagnosis listed as "possible" or "probable" if the condition is later confirmed or still qualified as uncertain at the time of discharge. Since the diagnosis is based on signs or symptoms that were POA, the coder would assign a "yes" indicator. Note that an uncertain diagnosis would be POA only when that diagnosis had related signs or

symptoms that were present at the time of admission. Otherwise, if the signs and symptoms developed after the physician order, the diagnosis is not POA.

Physician queries

Even though the switch to MS-DRGs should not change the way that coders assign a code, it will change the way they query. Coders should not fail to query for CCs that are deleted from MS-DRGs. Deleted CCs remain important in that they still contribute to DRG methodologies used in quality ranking.

Look at what physicians actually document versus what needs to be in the chart to capture a CC or MCC. For example, postmyocardial infarction syndrome would be a CC, but physicians often don't name it and instead give symptoms (e.g., nausea, chest pain, and vomiting). When a physician does not properly document a CC, a coder may miss it. For example, postphlebitic syndrome (code 459.1) is a CC, but instead of naming it, physicians typically describe redness, swelling, pain, etc. In this instance, the coder would likely not report the patient's actual syndrome.

Charts often contain many abbreviations and symptoms, but physicians hardly ever indicate relationships between symptoms and diagnoses. Coders need to have the skill set

to recognize these potential relationships, so that they know when to query physicians.

Consider, for example, a patient who presents with chest pain. The hospital conducts a stress test, which comes back negative, and follows this with a ventilation-perfusion scan to rule out a pulmonary embolism. The patient develops pustules, and a physician ultimately diagnoses the patient with herpes zoster.

A coder might look at the chart and simply code the principal diagnosis as chest pain and the secondary diagnosis as herpes zoster. However, the basic chronology of events may not necessarily help determine the principal and secondary diagnoses. Because the physician never made the linkage, the coder listed herpes zoster as the secondary diagnosis instead of the principal diagnosis. If the coder had listed herpes zoster as the principal diagnosis, it would have had three times the severity. If coders can't recognize these potential relationships, they will not understand when to query physicians.

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