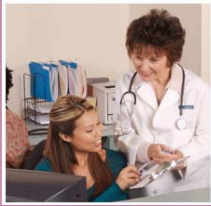


# ***FY08 MS-DRGs ... Overview and More! (Part I & II)***



PRESENTED TO:

**HFMA – Northern California Chapter  
Spring Conference  
Rancho Cordova, CA  
March 2008**



## **Speaker**

- **Gloryanne Bryant, BS, RHIA, RHIT, CCS**
  - CHW Senior Director Corporate Coding HIM Compliance
  - San Francisco, CA



## Goals and Objectives

- Participants will...Understand the rationale for the new MS-DRGs
- Participants will...Enhance knowledge of the specifics for capturing MCC/CC and the challenges
- Participants will...Learn about best practices and what to have in your MS-DRG Tool Kit
- Participants will...Understand ways to communicate with physicians and others regarding the MS-DRG changes and POA
- Q&A Period

## Disclaimer

- IPPS Update materials 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.

## MS-DRGs.....A Significant Change!

- The acute care hospital inpatient prospective payment system (IPPS) final rule for fiscal year 2008 was published in the Federal Register on August 22, 2007.
- This final rule implements a severity adjusted MS-DRG system, which consists of 745 new DRGs that will replace the current 538 CMS DRGs.
- Though MS-DRGs are based on the current CMS DRGs, MS-DRGs are split into a maximum of three payment tiers based on severity as determined by the presence of a major complication/comorbidity (MCC); a CC; or no CC.

## Healthcare Compliance

Type of Error	November 2004 Report	November 2005 Report
No Documentation	3.1%	0.7%
Insufficient Documentation	4.1%	1.1%**
Medically Unnecessary	1.6%	1.6%
Incorrect Coding	1.2%	1.5%
Other	0.2%	0.2%
<b>Total Error Rate</b>	<b>10.1%</b>	<b>5.2%</b>

\*\* This significant decline is due primarily to the CERT program now giving every provider a second chance" to submit sufficient documentation. Increased scrutiny Office of Inspector General (OIG), Quality Improvement Organization (QIO), and RAC (Recovery Audit Contractors).

## Healthcare Compliance - National Error Rates by Year

Year	Total Medicare FFS Payments	Overpayments	Underpayments	Total Improper Payments	Error Rate
Nov 2003	\$199.1 B	\$20.5 B	\$ 0.9 B	\$12.7 B*	6.4%*
Nov 2004	\$213.5 B	\$20.8 B	\$0.9 B	\$21.7 B	10.1%
Nov 2005	\$234.1 B	\$11.2 B	\$0.9 B	\$12.1 B	5.2%

\* These entries have been adjusted to account for the high provider non-response rate in 2003. Had the adjustment not been made, the improper payments would have been \$21.5 B and the national paid claims error rate would have been 10.8%.

**Take Home Message:** CMS and its contractors are making good progress towards the national paid claims error rate goal of less than 4%.

## Golden Rule ...

***“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.

# Public Report Cards

## Hospital Data & Reporting

- Hospital specific administrative data derived from physician clinical documentation and coding (ICD-9-CM) is used by:
  - Hospital based physician credentialing
  - Hospital budgeting
  - State Hospital Associations
  - Federal and State regulatory agencies
    - CMS, QIO, DHHS, JCAHO
  - Transmission to meet reporting requirements
    - CMS Core Indicators
    - State quality and reporting initiatives
    - Payer quality reporting

- The same administrative data is purchased by organizations (without PHI):
  - Healthcare quality and consumer driven internet companies that publish cost and quality information for consumer use
  - Hospital ranking organizations, “Top 100”
  - Consumers through published information to compare hospitals and physician outcomes
  - The future ... “PAY 4 PERFORMANCE”

- 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

### RESEARCH HOSPITALS

**Start your hospital search:**

- FREE Hospital Ratings
- Comprehensive Hospital Report  
Includes additional information on:
  - Costs
  - Patient Safety

State:

Start

**Information on:**

- Quality Ratings
- 28 Common Procedures and Diagnoses
- Award Recipients ... and much more!



### RESEARCH PHYSICIANS

**Start your physician search:**

- Physician by Name
- Physician by City & State / Specialty
- Find New Physicians

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State:

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- Disciplinary Actions
- Board Certification
- Education/Training
- Patient Opinions
- Decision Support Tools ... and much more!



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- [Back and Neck Surgery \(Spinal Fusion\)](#)
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- [Carotid Endarterectomy](#)
- [Cholecystectomy](#)
- [Chronic Obstructive Pulmonary Disease \(COPD\)](#)
- [Community Acquired Pneumonia](#)
- [Coronary Bypass Surgery](#)
- [Coronary Interventional Procedures \(Angioplasty/ Stent\)](#)
- [Diabetic Acidosis and Coma](#)
- [Gastrointestinal Bleed](#)
- [Gastrointestinal Procedures & Surgeries](#)

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- [Distinguished Hospital -- Patient Safety](#)
- [Specialty Excellence](#)

## Brief Background & History of the Inpatient Structure

- Goal was to identify a manageable number of patient groups that shared demographic, diagnostic, and therapeutic attributes
- Medicare changed the structure of reimbursement in late 1983 in an effort to decrease the cost of health care with IPPS (Inpatient Prospective Payment System)
  - Prospective payment based on submitted diagnostic, LOS, etc. elements
    - Predetermine \$
  - 3M had the government contract to develop the methodology into a software



## Brief Background & History

- Development of UHDDS (Uniform Hospital Discharge Data Set)
  - This was established in 1974
  - Specific data elements were required for all hospital inpatient stays
- CMS = Centers for Medicare and Medicaid Services – (formerly known as HCFA or Health Care Financing Administration)
  - Made legislation to address IPPS (Inpatient Prospective Payment System)

## Brief Background & History

- Within IPPS are MDCs (Major Diagnostic Category) which result in being subdivided into DRGs (Diagnosis Related Groups)
- Major diagnostic categories (MDC) is a classification of diagnoses typically grouped by anatomic/organ system and is the basis for the DRG system
- Each DRG falls into a MDC
  - 25 MDCs

## MDCs within IPPS

Major Diagnostic Categories (MDCs)	
1	Diseases and Disorders of the Nervous System
2	Diseases and Disorders of the Eye
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat
4	Diseases and Disorders of the Respiratory System
5	Diseases and Disorders of the Circulatory System
6	Diseases and Disorders of the Digestive System
7	Diseases and Disorders of the Hepatobiliary System and Pancreas
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast
10	Endocrine, Nutritional and Metabolic Diseases and Disorders
11	Diseases and Disorders of the Kidney and Urinary Tract
12	Diseases and Disorders of the Male Reproductive System
13	Diseases and Disorders of the Female Reproductive System
14	Pregnancy, Childbirth, and the Puerperium
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)
19	Mental Diseases and Disorders
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders
21	Injuries, Poisonings, and Toxic Effects of Drugs
22	Burns
23	Factors Influencing Health Status and Other Contacts with Health Services
24	Multiple Significant Trauma
25	Human Immunodeficiency Virus Infections

## Diagnosis Related Groups - DRG

- DRGs are patient categories or groupings by the given diagnoses, grouping like-diagnoses together
  - Like resources or resource consumption
- Also used in the DRG grouping is the presence of procedures, the age, the sex, the presence of a complication or comorbid condition, and the discharge status (disposition/patient status)
  - Principal diagnosis linked & grouped by anatomical body system
  - Patient's surgical status:
    - Principal diagnosis (nonsurgical DRG), or Extent of surgical procedure (surgical DRG)



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## IPPS DRG

- Inpatient Prospective Payment System (IPPS), the hospital is paid an amount for the **expected cost** of treatment and resources for a given DRG or a Diagnostic Related Group
- Each DRG has a Relative Weight or "RW"
  - The relative weight of the DRG is the same at each hospital
  - Relative Weight (RW) = numeric figure (number) to reflect the relative "resource consumption" associated with the specific DRG
  - The higher the RW the greater the expected or predicted resource consumption



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## DRG Terms: Definition of "Complication and Comorbidity"

- **A condition that arises during the hospital stay that prolongs the length of stay at least one day in approximately 75% of the cases**
- **A pre-existing condition that will, because of its presence with a specific diagnosis, cause an increase in length of stay by at least one day in approximately 75% of the cases**

**Having a complication and/or comorbid condition is called a "CC".  
"Complication" does not mean that the physician did anything wrong**



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## Complications and Comorbidities

- The presence or absence of a "CC" can have significant impact on the DRG assignment, the RW and payment
- Within the DRG System, with 500+ DRGs, approximately 110 change to a higher weighted DRG when one or more CCs are present in the physician documentation
  - **A single "cc" will impact the DRG**
    - No impact for multiple "CCs"
  - Annual updating does occur to the "CC List" per CMS
- Complete, accurate, and timely documentation is the primary consideration of the inpatient coding staff **AND** also the ability to recognize and capture CCs (we'll come back to this)



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## Complications and Comorbidities

- The lack of or omission of CC documentation is a key variance identified nationally. What is the financial impact of this to the hospital?
  - Hospital base rate of \$5,000 (based on geographic/labor index), the addition of a single documented CC to a Non-CC DRG can increase payment by \$3000 on average
  - If 100 cases are not documented completed, then can not capture the CC, this results in lost revenue of \$300,000 as well as a loss of severity and acuity data to the hospital and physician

## Documentation & Guidelines for Coding

Not all information contained in the medical record can be used for 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)**

Examples include:

Attending physicians  
Consulting physicians  
Surgeons  
Interventional Radiologists  
Anesthesiologists

Examples of physicians who are **not** treating physicians include:

Pathologists  
Cardiologists (Interpreting EKG's, etc.)  
Radiologists (reading x-rays)



**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

Translates 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**



## FY08 IPPS DRG Changes



Friday, April 13, 2007

### 1. CMS releases proposed inpatient rule

The Centers for Medicare & Medicaid Services late this afternoon put on display its hospital inpatient prospective payment system proposed rule for fiscal year 2008. In the rule, CMS announced the mandated full market basket update of 3.3% for hospitals that report quality data. CMS also proposes creating 745 new Medicare-Severity diagnosis-related groups to replace the current 538 DRGs and lowering the outlier threshold to \$23,015 from \$24,485 in FY 2007. In addition, the proposed rule includes a 2.4% cut in both FY 2008 and 2009 to eliminate what they claim will be the effect of coding or classification changes that the agency claims do not reflect real changes in case-mix. AHA Senior Vice President for Federal Relations Tom Nickels said, "The AHA is opposed to this nearly \$5 billion reduction in payments, which we do not believe is warranted." The rule also proposes eliminating the capital update for urban hospitals and the large urban add-on to capital payments. CMS also is considering discontinuing the teaching and disproportionate share hospital adjustments to capital payments. Comments on the proposed rule will be accepted until June 12, and a final rule, which will take effect on October 1, will be published later this summer. The AHA is reviewing the proposed rule and will send members a Special Bulletin summarizing the specifics of the rule on Monday.



## 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

August 22, 2007 published in the Federal Register



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## IPPS (Inpatient Prospective Payment System)

- **Acute Inpatient PPS**
- [Steps in Determining a PPS Payment](#)
- [Wage Index](#)
- [Outlier Payments](#)
- [Disproportionate Share Hospital \(DSH\)](#)
- [Direct Graduate Medical Education \(DGME\)](#)
- [Indirect Medical Education \(IME\)](#)
- [Effects of Implementing Postacute Transfer Policy](#)
- [Medicare PPS Excluded Cancer Hospitals](#)
- [Wage Index Files](#)
- [Acute Inpatient - Files for Download](#)
- [Historical Impact Files for FY 1994 through FY 2005](#)
- [IPPS Regulations and Notices](#)
- [Acute Inpatient PPS Transmittals](#)

## MS-DRGs

- CMS has created **745 new** Medicare-Severity DRGs (MS-DRGs) to replace current 538 CMS DRGs
  - Based on current CMS DRG
  - Greatly improves CMS' ability to identify groups of patients with varying levels of severity using secondary diagnoses
  - Does a better job of identifying technology
  - Represent comprehensive approach to applying severity of illness stratification for Medicare patients throughout the DRGs

## 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%.



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## RW is Cost-Based Methodology

- Using the “Cost” data from 13 categories
- 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



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Inpatient charging matters!

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## MS-DRGs

- Patient age has been consolidated
- DRGs had 0-17 years old and greater than 17 years
  - Pediatrics
- MS-DRG has no specific age with the DRG groupings
- CMS says that IPPS is primarily representing the elderly not pediatrics
- Newborn DRGs - remain
- Major Diagnostic Categories or MDCs will remain the same and represent major body “systems”
- DRGs will continue to be divided into medical and surgical
- The impact of a surgical procedure can be significant

## Discharge Disposition – (Post-Acute Care Rule)

- Continues under MS-DRGs
- Different DRGs due to the restructuring but same methodology
- Increased from 190 CMS DRGs to 273 MS-DRGs
- Federal Register, table 5 has the list of DRGs and which ones are impacted by PAC rule

## 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



## MS DRGs Increases the Number of DRGs from 538 to 745

1. Consolidate current DRGs into base DRGs
2. Categorize each diagnosis as:
  - Major CC (MCC)
  - CC
  - Non-CC
3. Subdivide each base DRG into subgroups based on CCs
  - No Subgroups
  - 3 groups (MCC, CC, non-CC)
  - 2 groups (MCC/CC, non-CC)
  - 2 groups (MCC, CC/non-CC)

## Major Change from Current CCs

- FY07 CCs number 3,326 diagnosis (codes)
- FY08 MS-DRG number of CCs is 2,583
- **Revised CC list composed of:**
  - Significant acute diseases
  - Acute exacerbations of chronic significant diseases
  - Advanced end stage diseases
  - Chronic diseases with extensive debility
  - Consistently greater impact on hospital resources

CMS reviewed 13,549 secondary diagnosis codes to evaluate their assignment as a CC or non-CC using a combination of mathematical data and the judgment of its medical officers



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## CMS Comparison of the Current CC List

**Table E.--Comparison of Current CC List and Revised CC List**

	Current CC List	Revised CC List
Codes designated as a CC	3,326	2,583
Percent of patients with one or more CCs	77.66	40.34
Percent of patients with no CC	22.34	59.66
Average charge of patients with one or more CCs	\$24,538	\$31,451
Average charge of patients with no CCs	\$14,795	\$16,215

Note: Multiple secondary diagnoses at one level does not cause a patient to be assigned to a higher subgroup. Example: patient two regular "CCs" does not make a MCC

Conditions with higher hospital resource use, requiring extensive monitoring, expensive or technically complex services or extensive care would be included on the CC List.



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## Consolidation of DRGs

- 115 pairs of DRGs that were subdivided based on presence of a CC
- Major cardiovascular conditions
- 3 pairs of burn DRGs
- 43 pediatric DRGs that were defined by age  $\leq 17$
- Several DRGs relating primarily to pediatric or adult population that have very low volume in the Medicare population
- Several elective surgery DRGs that have shifted to outpatient settings
- Some clinically related DRGs that had volume, but no difference in resource use
- MDC 14 & 15 were not consolidated due to low volume

## And remember ... IPPS

- *“The focus of CMS’ efforts is in developing and maintaining a DRG system that is appropriate for its Medicare population.”*
- *“We do not believe that Medicare should undertake the effort and expense to maintain and update a DRG system that will have no application for Medicare beneficiaries.”*

- “CC”, you only need a single cc to group the case to the “with CC” DRG classification.
- Revision made to the “cc List”
- Analysis by CMS and clinical staff
- Clinical Documentation is key
- Only need one Major CC to group the MS-DRG “with MCC”.
- Not chronic conditions (few exceptions)
  - Acute conditions drive the severity per MS-DRGs
- Clinical Documentation is key

### Bring it all together . . .

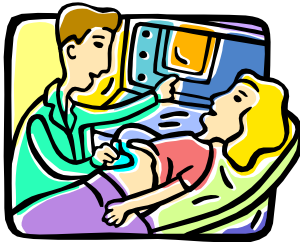
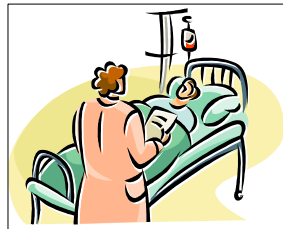
- MS-DRG 195 Simple Pneumonia **without MCC/CC**
  - RW .8398 (FY08)
  - GMLOS = 3.5
- MS-DRG = DRG 194 Simple Pneumonia **with CC**
  - RW = 1.0235 (FY08)
  - GMLOS = 4.5 (this is important for CM/UR)
- MS-DRG = DRG 194 Simple Pneumonia **with MCC**
  - RW = 1.2505 (FY08)
  - GMLOS = 5.5 (this is important for CM/UR)

## 745 MS DRGs

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

MS-DRG	FY 2008		MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
	Final Rule	Special Pay DRG						
001	No	No	PRE	SURG	Heart transplant or implant of heart assist system w MCC	23.117	30.8	45.6
002	No	No	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC	16.2735	16.1	22.8
003	Yes	No	PRE	SURG	ECMO or trach w MV 98+ hrs or PDX ecc	18.7707	33.4	40.6
004	Yes	No	PRE	SURG	face, mouth & neck w maj O.R.	11.4219	23.8	29.3
005	No	No	PRE	SURG	Trach w MV 98+ hrs or PDX; exc face, mouth & neck w/o maj O.R.	10.6120	17.6	23.5
006	No	No	PRE	SURG	Liver transplant w MCC	7.2562	9.1	10.5
007	No	No	PRE	SURG	Liver transplant w/o MCC	8.4002	14.6	17.3
008	No	No	PRE	SURG	Lung transplant	5.1726	10.1	11.8
009	No	No	PRE	SURG	Simultaneous pancreas/kidney transplant	6.4842	18.1	21.7
010	No	No	PRE	SURG	Bone marrow transplant	3.8902	9.2	10.5
011	No	No	PRE	SURG	Pancreas transplant	4.1482	12.8	16.2
012	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC	3.2472	8.9	10.9
013	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	2.6760	6.1	7.2
020	No	No	01	SURG	Intracranial vascular procedures w PDX; hemorrhage w MCC	7.7073	15.2	19.1
021	No	No	01	SURG	Intracranial vascular procedures w PDX; hemorrhage w CC	6.7021	13.4	15.5
022	No	No	01	SURG	Intracranial vascular procedures w PDX; hemorrhage w/o CC/MCC	5.6085	7.8	9.6
023	No	No	01	SURG	Intracranial vascular procedures w PDX; hemorrhage w/o CC/MCC	4.7036	9.0	12.8
024	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX; w MCC	3.8978	6.1	9.9
025	Yes	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX; w/o MCC	4.2362	10.3	13.3
026	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w MCC	3.1582	6.5	8.2
027	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w CC/MCC	2.3259	3.5	4.6
028	Yes	Yes	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC	4.2339	10.8	14.7
029	Yes	Yes	01	SURG	Spinal procedures w MCC	2.8356	5.3	7.3
030	Yes	Yes	01	SURG	Spinal procedures w CC or spinal neurostimulators	1.7617	2.8	3.7
031	Yes	No	01	SURG	Spinal procedures w/o CC/MCC	3.2226	9.2	13.2
032	Yes	No	01	SURG	Ventricular shunt procedures w MCC	1.9342	3.8	5.8
032	Yes	No	01	SURG	Ventricular shunt procedures w CC	1.9342	3.8	5.8

## Who's the Sickest...???



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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)

- Complication/Comorbidity List



## 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
- **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"*

## Categorization of CC Codes

	Number of Codes
MCC	1,096
CC	4,221
Non-CC	8,232
Total	13,549

Per CMS this change reduced "cc" capture rate from 77.66% to 40.34%

## Bye Bye to Some Common “CCs”

- 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 depletion – 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 2nd Degree NEC – 426.13
- Superficial phlebitis – leg – 451.0
- Thrombophlebitis leg NOS – 451.2



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THIS IS SIGNIFICANT!

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## Closer Look at Heart Failure – CC Impact has Changed...

Code	CC Subclass Assignment
428.21, Acute systolic heart failure	MCC
428.41, Acute systolic & diastolic heart failure	MCC
428.43, Acute on chronic systolic heart failure	MCC
428.31, Acute diastolic heart failure	MCC
428.33, Acute on chronic diastolic heart failure	MCC
428.1, Left heart failure	CC
428.20, Systolic heart failure NOS	CC
428.22, Chronic systolic heart failure	CC
428.32, Chronic diastolic heart failure	CC
428.40, Systolic & diastolic heart failure	CC
428.0, Congestive heart failure NOS	Non-CC
428.9, Heart failure NOS	Non-CC



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- “Closed head injury” ...
- “Diabetes poorly controlled” ...
- “Anemia” ...
- “Angina” ...
- “Low Urine output” ...
- “Respiratory insufficiency” ...
- Concussion or loss of consciousness
- Uncontrolled diabetes with a manifestation
- Specific type of anemia
- Specific type of angina
- Diagnosis or cause
- Respiratory failure

CMS TOP VOLUME DRGs

TOP Ten	2007 RW	2008 MS-DRG(s)
127 Heart Failure	1.0490	291 w MCC 1.2585
		292 w CC 1.0134
		293 w/o 0.8765
89 Simple Pneumonia with CC	1.0376	193 w MCC 1.2505
		194 w CC 1.0235
		195 w/o 0.8398
544 Major Joint Replacement or Attachment	1.9878	469 w MCC 2.6664
		470 w/o MCC 1.9871
		190 w MCC 1.1138
88 Chronic Obstructive Pulmonary Disease	0.8878	191 w CC 0.9404
		192 w/o 0.8145
		576 Septicemia w/o Vent >96 Hours
182 Esophagitis, Gastroenteritis, etc with CC	0.7853	872 w/o MCC 1.3783
		391 w MCC 0.9565
		392 w/o MCC 0.7121
14 Stroke	1.2118	64 w MCC 1.5470
		65 w CC 1.1901
		66 w/o 1.0303
174 Gastrointestinal Hemorrhage with CC	1.0296	377 w MCC 1.3367
		378 w CC 1.0195
		379 w/o 0.8476
316 Renal Failure	1.2602	682 w MCC 1.4664
		683 w CC 1.1942
		684 w/o 0.9835
320 Urinary Tract Infection	0.8769	689 w MCC 1.0587
		690 w/o MCC 0.8000

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

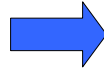
*Current DRG*

*MS-DRG*

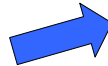
**DRG 127 Heart Failure and Shock  
RW 1.0490**



**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)

*Current DRG*

*MS-DRG*

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



**MS-DRG 193 Simple Pneumonia with MCC  
RW 1.2505**

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



**MS-DRG 194 Simple Pneumonia with CC  
RW 1.0235**

**DRG 91 Simple Pneumonia, age 0-17  
RW 0.5598**

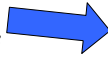


**MS-DRG 195 Simple Pneumonia without MCC or CC  
RW 0.8398**

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

*Current 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*

469 Major joint replacement or reattachment of lower extremity w MCC RW 2.6664

470 Major joint replacement or reattachment of lower extremity w/o MCC RW 1.9871

466 Revision of hip or knee replacement w MCC RW 3.5408

467 Revision of hip or knee replacement w CC RW 2.7523

468 Revision of hip or knee replacement w/o CC/MCC RW 2.4545

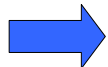
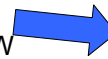


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Example of Current CMS and MS-DRG (Impact Coding)

*Current DRG*

DRG 014 Intracranial Hemorrhage or Cerebral Infarction RW 1.2110



*MS-DRG*

64 Intracranial hemorrhage or cerebral infarction w MCC RW 1.5470




65 Intracranial hemorrhage or cerebral infarction w CC RW 1.1901

66 Intracranial hemorrhage or cerebral infarction w/o CC/MCC RW 1.0303

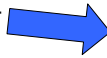




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Example of Current CMS and MS-DRG (Impact Coding)

<i>Current DRG</i>		<i>MS-DRG</i>
DRG 088 Chronic Obstructive Pulmonary Disease (COPD) RW 0.8884		190 Chronic obstructive pulmonary disease w MCC RW 1.1138
		191 Chronic obstructive pulmonary disease w CC RW 0.9405
		192 Chronic obstructive pulmonary disease w/o CC/MCC RW 0.8145

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

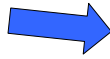
<i>Current DRG</i>		<i>MS-DRG</i>
DRG 575 Septicemia with Ventilator Support 96+ hours Age >17 RW 5.9388		870 Septicemia w MV 96+ hours RW 5.7579
DRG 576 Septicemia without Ventilator Support 96+ hours Age >17 RW 1.5953		871 Septicemia w/o MV 96+ hours w MCC RW 1.7484
		872 Septicemia w/o MV 96+ hours w/o MCC RW 1.3783

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

*Current DRG*

*MS-DRG*

DRG 182 Esophagitis,  
Gastroenteritis and  
Misc. Digestive  
Disorders, Age > 17  
with CC RW .07855



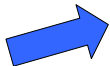
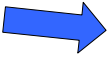
391 Esophagitis, gastroent & Misc  
digest disorders w MCC  
RW 0.9565  
392 Esophagitis, gastroent & Misc  
digest disorders w/o MCC  
RW 0.7121

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

*Current DRG*

*MS-DRG*

DRG 316 Renal Failure  
RW 1.2596

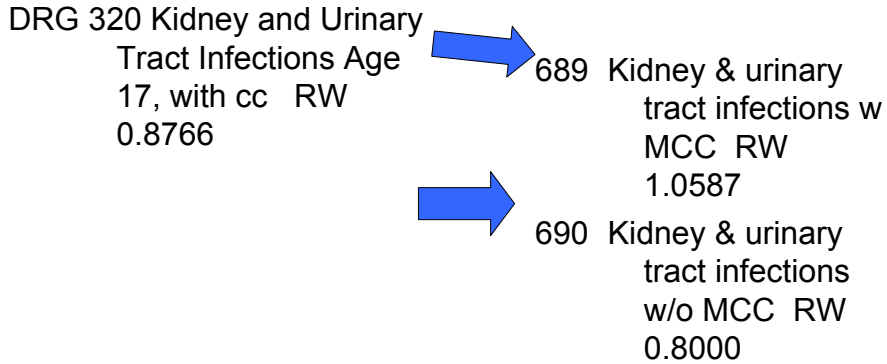


682 Renal failure w  
MCC RW  
1.4664  
683 Renal failure w CC  
RW 1.1942  
684 Renal failure w/o  
CC/MCC RW  
0.9835

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

*Current DRG*

*MS-DRG*



MS-DRG

MS vs. current CMS DRG Groups:  
**Base Group, no splits**

CMS V24	CMS DRG Descriptions	MS v25	MS-DRG Descriptions
524	Transient ischemia	069	Transient ischemia

MS vs. current CMS DRG Groups:  
**3 Groups - MCC, CC, non-CC**

CMS V24	CMS DRG Descriptions	MS v25	MS-DRG Descriptions
027	Traumatic Stupor & Coma, coma > 1 hr	082	Traumatic stupor & coma, coma >1 hr w MCC
		083	Traumatic stupor & coma, coma >1 hr w CC
		084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC

## Major CC or CC?

### 2007 CMS-DRG CC and 2008 MS-DRG CC/MCC TABLE

2008 ICD9CM	CMS-DRG	MS-DRG	Short Title	2008 ICD9CM	CMS-DRG	MS-DRG	Short Title
3843	CMS CC		MITRAL VALVE DIS NEGINOS	4233	CMS CC	MSDRG MCC	TOXIC MYOCARDITIS
3860	CMS CC		RHEUMAT AORTIC STENOSIS	4239	CMS CC	MSDRG MCC	ACUTE MYOCARDITIS NEC
3851	CMS CC		RHEUMATIS AORTIC INSUFF	4230	CMS CC	MSDRG CC	HEMOPERICARDIUM
3862	CMS CC		RHEUM AORTIC STENINSUFF	4231	CMS CC	MSDRG CC	ADHESIVE PERICARDITIS
3869	CMS CC		RHEUM AORTIC DIS NEGINOS	4232	CMS CC	MSDRG CC	CONSTRICTIV PERICARDITIS
3860	CMS CC		MITRALAORTIC STENOSIS	4233	CMS CC	MSDRG CC	CARDIAC TAMPONADE
3861	CMS CC		MITRAL STENOSIAORT INSUF	4239	CMS CC	MSDRG CC	PERICARDIAL DISEASE NEC
3862	CMS CC		MITRAL INSURIAORT STENOS	4239	CMS CC	MSDRG CC	PERICARDIAL DISEASE NOS
3863	CMS CC		MITRALAORTIC VAL INSUFF	4240	CMS CC		MITRAL VALVE D-ISORDER
3869	CMS CC		MITRALAORTIC MULT INVOLV	4241	CMS CC		AORTIC VALVE D-ISORDER
3869	CMS CC		MITRALAORTIC V DIS NOS	4242	CMS CC		NONRHEUM TRICUSP VAL DIS
3870	CMS CC		TRICUSPID VALVE DISEASE	4243	CMS CC		PULMONARY VALVE D-ISORDER
3871	CMS CC		RHEUM PULMON VALVE DIS	4249	CMS CC	MSDRG CC	ENDOCARDITIS NOS
3872	CMS CC		RHEUM ENDOCARDITIS NOS	4249	CMS CC	MSDRG CC	ENDOCARDITIS IN OTH DIS
3880	CMS CC	MSDRG CC	RHEUMATIC MYOCARDITIS	4249	CMS CC	MSDRG CC	ENDOCARDITIS NEC
3889	CMS CC	MSDRG CC	RHEUMATIC HEART FAILURE	4250	CMS CC	MSDRG CC	ENDOMYOCARDIAL FIBROSIS
4010	CMS CC	MSDRG CC	MAL GRANT HYPERTENS/ION	4251	CMS CC	MSDRG CC	HYPERTR GSTR CARDIOMYOOP
4020	CMS CC	MSDRG CC	MAL HYP HT DIS W/O HF	4252	CMS CC	MSDRG CC	OBSC AFRIC CARDIOMYOPATH
4020	CMS CC	MSDRG CC	MAL HYPERT HRT DIS W HF	4253	CMS CC	MSDRG CC	ENDOCARD FIBROELASTOSIS
4021	CMS CC	MSDRG CC	BENIGN HYP HT DIS W HF	4254	CMS CC	MSDRG CC	PRIM CARDIOMYOPATHY NEC
4020	CMS CC	MSDRG CC	HYP HT DIS NOS W HT FAIL	4255	CMS CC	MSDRG CC	ALCOHOLIC CARDIOMYOPATHY
4030	CMS CC	MSDRG CC	MAL HY KID W CR KID LIV	4257	CMS CC	MSDRG CC	METABOLIC CARDIOMYOPATHY
4030	CMS CC	MSDRG CC	MAL HYP KID W CR KID V	4258	CMS CC	MSDRG CC	CARDIOMYOPATHY IN OTH DIS
4031	CMS CC	MSDRG CC	BEN HYP KID W CR KID V	4259	CMS CC	MSDRG CC	SECOND CARDIOMYOPATHY NOS
4039	CMS CC		HYP KID NOS W CR KID V	4260	CMS CC	MSDRG CC	ATRIOVENT BLOCK COMPLETE
4040	CMS CC	MSDRG CC	MAL HY HTKID HV W/O HF	4261	CMS CC	MSDRG CC	ATRIOVENT BLOCK-MOBIZ II
4040	CMS CC	MSDRG CC	MAL HYP HTKID HV W HF	4261	CMS CC	MSDRG CC	AV BLOCK-2ND DEGREE NEC
4042	CMS CC	MSDRG CC	MAL HY HTKID ST V W/O HF	4263	CMS CC	MSDRG CC	BILAT BLOC
4043	CMS CC	MSDRG CC	MAL HYP HTKID STG V W HF	4264	CMS CC	MSDRG CC	TRIFASCICULAR BLOCK
4041	CMS CC	MSDRG CC	BEN HYP HTKID HV W HF	4266	CMS CC	MSDRG CC	OTHER HEART BLOCK
4041	CMS CC	MSDRG CC	BEN HYP HTKID ST V W/O HF	4267	CMS CC	MSDRG CC	ANOMALOUS EXCITATION
4041	CMS CC	MSDRG CC	BEN HYP HTKID STG V W HF	4268	CMS CC	MSDRG CC	LOWN-GANONG-LEVINE SYND
4049	CMS CC	MSDRG CC	HYP HTKID NOS HV W HF	4269	CMS CC	MSDRG CC	CONDUCTION DISORDER NEC
4049	CMS CC	MSDRG CC	HY HTKID NOS ST V W/O HF	4269	CMS CC	MSDRG CC	CONDUCTION DISORDER NOS
4049	CMS CC	MSDRG CC	HYP HTKID NOS ST V W HF	4270	CMS CC	MSDRG CC	PAROX ATRIAL TACHYCARDIA
4050	CMS CC	MSDRG CC	MAL RENOVASC HYPERTENS	4271	CMS CC	MSDRG CC	PAROX VENTRIC TACHYCARD
4050	CMS CC	MSDRG CC	MAL SECOND HYPERTEN NEC	4272	CMS CC	MSDRG CC	PAROX TACHYCARDIA NOS
4100	CMS CC	MSDRG CC	AMI ANTERIOR WALL, INIT	4273	CMS CC	MSDRG CC	ATRIAL FIBRILATION
4101	CMS CC	MSDRG MCC	AMI ANTERIOR WALL, INIT	4273	CMS CC	MSDRG CC	ATRIAL FLUTTER
4102	CMS CC	MSDRG MCC	AMI INFEROLATERAL, INIT	4274	CMS CC	MSDRG MCC	VENTRICULAR FIBRILATION
4103	CMS CC	MSDRG MCC	AMI INFEROPOST, INITIAL	4274	CMS CC	MSDRG MCC	VENTRICULAR FLUTTER
4104	CMS CC	MSDRG MCC	AMI INFERIOR WALL, INIT	4274	CMS CC	MSDRG MCC	CARDIA ARREST
4105	CMS CC	MSDRG MCC	AMI LATERAL NEC, INITIAL	4280	CMS CC		CHF NOS
4106	CMS CC	MSDRG MCC	TRUE POST INFARCT, INIT	4281	CMS CC	MSDRG CC	LEFT HEART FAILURE
4107	CMS CC	MSDRG MCC	SUBENDO INFARCT, INITIAL	4282	CMS CC	MSDRG CC	RIGHT HEART FAILURE NOS
4108	CMS CC	MSDRG MCC	AMI NEC, INITIAL	4282	CMS CC	MSDRG MCC	ACC SYSTOLIC HRT FAILURE
4109	CMS CC	MSDRG MCC	AMI NOS, INITIAL	4282	CMS CC	MSDRG CC	CHR SYSTOLIC HRT FAILURE

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## Major CC or CC?

### 2007 CMS-DRG CC and 2008 MS-DRG CC/MCC TABLE

2008 ICD9CM	CMS-DRG	MS-DRG	Short Title	2008 ICD9CM	CMS-DRG	MS-DRG	Short Title
4352	CMS CC	MSDRG CC	SUBCLAVIAN STEAL SYNDROM	4641	CMS CC	MSDRG MCC	AC TRACHEITIS W OBSTRUCT
4353	CMS CC	MSDRG CC	VERTBROBASLR ARTERY SYND	4642	CMS CC	MSDRG MCC	AC LARYNGOTRACH W OBSTR
4358	CMS CC	MSDRG CC	TRANS CEREB ISCHEMIA NEC	4643	CMS CC	MSDRG CC	AC EPIGLOTTITIS NO OBSTR
4369	CMS CC	MSDRG CC	TRANS CEREB ISCHEMIA NOS	4641	CMS CC	MSDRG MCC	AC EPIGLOTTITIS W OBSTR
438	CMS CC	MSDRG CC	CVA	4645	CMS CC	MSDRG MCC	SUPRAGLOTTITIS W OBSTR NOS
4371	CMS CC	MSDRG CC	AC CEREBROVASC INSUF NOS	4661	CMS CC	MSDRG CC	ACU BRONCHITIS D/T RSV
4372	CMS CC	MSDRG CC	HYPERTENS ENCEPHALOPATHY	4661	CMS CC	MSDRG CC	ACU BRONCHITIS D/T OTH ORG
4374	CMS CC	MSDRG CC	CEREBRAL ARTERITIS	475	CMS CC	MSDRG CC	PERITONSILLAR ABSCESS
4375	CMS CC	MSDRG CC	MOYAMOYA DISEASE	4782	CMS CC	MSDRG CC	CELLULITIS OF PHARYNX
4376	CMS CC	MSDRG CC	NONPYOGEN THROMBOS SINUS	4782	CMS CC	MSDRG CC	PARAPHARYNGEAL ABSCESS
4380	CMS CC	MSDRG CC	LATE EP-HEMPLGA SIDE NOS	4784	CMS CC	MSDRG CC	RETROPHARYNGEAL ABSCESS
4382	CMS CC	MSDRG CC	LATE EP-HEMPLGA DOM SIDE	4783	CMS CC		VOCAL CORD PARALYSIS NOS
4382	CMS CC	MSDRG CC	LATE EP-HEMPLGA NON-DOM	4783	CMS CC		VOCAL PARAL UNLAT PART
4404	CMS CC	MSDRG CC	ATH EXT NTV ART GNSRENE	4783	CMS CC		VOCAL PARAL UNLAT TOTAL
4410	CMS CC	MSDRG MCC	DSCT OF AORTA UNSP SITE	4783	CMS CC		VOCAL PARAL BILAT PART
4410	CMS CC	MSDRG MCC	DSCT OF THORACIC AORTA	4784	CMS CC	MSDRG CC	VOCAL PARAL BILAT TOTAL
4410	CMS CC	MSDRG MCC	DSCT OF ABDOMINAL AORTA	4787	CMS CC	MSDRG CC	LARYNGEAL CELLULITIS
4410	CMS CC	MSDRG MCC	DSCT OF THORACOABD AORTA	4800	CMS CC	MSDRG MCC	ADENOVIRAL PNEUMONIA
4411	CMS CC	MSDRG MCC	RUPTR THORACIC ANEURYSM	4801	CMS CC	MSDRG MCC	RESP SYNCYT VIRAL PNEUM
4413	CMS CC	MSDRG MCC	RUPF ABD AORTIC ANEURYSM	4802	CMS CC	MSDRG MCC	PARINFLUENZA VIRAL PNEUM
4415	CMS CC	MSDRG MCC	RUPF AORTIC ANEURYSM NOS	4803	CMS CC	MSDRG MCC	PNEUMONIA DUE TO SARS
4416	CMS CC	MSDRG MCC	THORACOABD ANEURYSM RUPF	4808	CMS CC	MSDRG MCC	VIRAL PNEUMONIA NEC
4432	CMS CC	MSDRG MCC	DISSECT CAROTID ARTERY	4809	CMS CC	MSDRG MCC	VIRAL PNEUMONIA NOS
4432	CMS CC	MSDRG MCC	DISSECTION ILIAC ARTERY	481	CMS CC	MSDRG MCC	PNEUMOCOCCAL PNEUMONIA
4433	CMS CC	MSDRG MCC	DISSECTION RENAL ARTERY	4820	CMS CC	MSDRG MCC	K. PNEUMONIAE PNEUMONIA
4434	CMS CC	MSDRG MCC	DISSECT VERTEBRAL ARTERY	4821	CMS CC	MSDRG MCC	PSEUDOMONAL PNEUMONIA
4432	CMS CC	MSDRG MCC	DISSECTION ARTERY NEC	4822	CMS CC	MSDRG MCC	H. INFLUENZAE PNEUMONIA
4440	CMS CC	MSDRG CC	ABD AORTIC EMBOLISM	4823	CMS CC	MSDRG MCC	STRPTOCOCCAL PNEUM NOS
4441	CMS CC	MSDRG CC	THORACIC AORTIC EMBOLISM	4823	CMS CC	MSDRG MCC	PNEUMONIA STRPTOCOCCUS A
4442	CMS CC	MSDRG CC	UPPER EXTREMITY EMBOLISM	4823	CMS CC	MSDRG MCC	PNEUMONIA STRPTOCOCCUS B
4442	CMS CC	MSDRG CC	LOWER EXTREMITY EMBOLISM	4823	CMS CC	MSDRG MCC	PNEUMONIA OTH STREP
4449	CMS CC	MSDRG CC	ARTERIAL EMBOLISM NEC	4824	CMS CC	MSDRG MCC	STAPHYLOCOCCAL PNEU NOS
4449	CMS CC	MSDRG CC	ARTERIAL EMBOLISM NEC	4824	CMS CC	MSDRG MCC	STAPH AUREUS PNEUMONIA
4450	CMS CC	MSDRG CC	ATHEROEMBOLISM UPPER EXT	4824	CMS CC	MSDRG MCC	STAPH PNEUMONIA NEC
4450	CMS CC	MSDRG CC	ATHEROEMBOLISM LOWER EXT	4824	CMS CC	MSDRG MCC	PNEUMONIA INTRACRAN
4451	CMS CC	MSDRG CC	ATHEROEMBOLISM KIDNEY	4828	CMS CC	MSDRG MCC	PNEUMONIA E COLI
4459	CMS CC	MSDRG CC	ATHEROEMBOLISM SITE NEC	4828	CMS CC	MSDRG MCC	PNEUMO OTH GRM-NEC BACT
4460	CMS CC	MSDRG CC	PLUC ARTERIS NOS/DIA	4824	CMS CC	MSDRG MCC	LEGIONNAIRE'S DISEASE
4461	CMS CC	MSDRG CC	MUCOCUTAN LYMPH NODE SYN	4829	CMS CC	MSDRG MCC	PNEUMONIA DUE TO BACT
4462	CMS CC	MSDRG CC	HYPERSENSIT ANGITIS NOS	4829	CMS CC	MSDRG MCC	BACTERIAL PNEUMONIA NOS
4463	CMS CC	MSDRG CC	HYPERSENSIT ANGITIS NOS	4830	CMS CC	MSDRG MCC	PNEU MYCP/SM PNEUMONIAE
4463	CMS CC	MSDRG CC	HYPERSENSIT ANGITIS NOS	4830	CMS CC	MSDRG MCC	PNEUMONIA DT CHLAMYDIA
4463	CMS CC	MSDRG CC	HYPERSENSIT ANGITIS NEC	4838	CMS CC	MSDRG MCC	PNEUMON OTH SPEC ORGNISM
4463	CMS CC	MSDRG CC	LETHAL MIDLINE GRANULOMA	4841	CMS CC	MSDRG MCC	PNEUM W CYTOMEG INCL DIS
4464	CMS CC	MSDRG CC	WEGENER'S GRANULOMATOSIS	4843	CMS CC	MSDRG MCC	PNEUMONIA IN WHOOP COUGH
4465	CMS CC	MSDRG CC	GIANT CELL ARTERITIS	4844	CMS CC	MSDRG MCC	PNEUMONIA IN ANTRAL
4466	CMS CC	MSDRG MCC	THROMBOT MICROANGIOPATHY	4846	CMS CC	MSDRG MCC	PNEUM IN ASPERGILLOSIS
4467	CMS CC	MSDRG CC	TAKAYASU'S DISEASE	4847	CMS CC	MSDRG MCC	PNEUM IN OTH SYS MYCOSEES

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- A 1.2% reduction to ensure Medicare spending does not increase due to coding and documentation improvements, CMS estimates 2008 overall hospital payments will increase an average of 3.5% over 2007.
  - the “behavioral offset,” is slated to occur over a three-year period as follows: 1.2% for FY 2008; 1.8% for FY 2009; and 1.8% for FY 2010.
- CMS warns that future reductions for coding and documentation improvements may be required. “Coding Behavioral Adjustment”

## Congress passes bill easing IPPS MS-DRG “behavioral” cuts (9/28/07) and AHA NEWS!! And it’s GOOD...

- **Congress passes bill easing IPPS cuts -**
- The Senate last night approved legislation to prevent the Centers for Medicare & Medicaid Services from fully implementing \$20 billion in prospective payment cuts to hospital inpatient Medicare services over the next five years as part of a so-called “behavioral offset” contained in the inpatient prospective payment system final rule, which takes effect Oct. 1
- CMS included the offset to address what the agency claimed would be changes in hospital documentation and coding practices as a result of the implementation of a refined Medicare-Severity Diagnosis-related Group classification system. The House approved the bill (H.R. 3668) Wednesday. If signed by the president, it would reduce the cuts in 2008 and 2009 by half, from 1.2% to 0.6% and from 1.8% to 0.9% respectively, but leave the 2010 cut of 1.8% intact. The changes to the prospective cuts would result in a restoration of \$2.5 billion over the next two years and \$7 billion over the next five years, assuming no additional retrospective adjustments are made
- **President signs bill easing IPPS cuts 10/1/07**
- President Bush on Saturday signed legislation that prevents the Centers for Medicare & Medicaid Services from fully implementing \$20 billion in prospective payment cuts to hospital inpatient Medicare services over the next five years. The cuts are part of a so-called “behavioral offset” contained in the inpatient prospective payment system final rule, which takes effect today. The legislation (H.R. 3668) reduces the cuts in 2008 and 2009 by half, from 1.2% to 0.6% and from 1.8% to 0.9% respectively, but leaves the 2010 cut of 1.8% intact.
- The changes to the prospective cuts will result in a restoration of \$2.5 billion over the next two years and \$7 billion over the next five years, assuming no additional retrospective adjustments are made. CMS included the behavioral offset to address what the agency claimed would be changes in hospital coding practices resulting from the rule’s refined Medicare-Severity Diagnosis-related Group classification system

## IPPS payments could experience brief delay 10/12/07

- **CMS: IPPS payments could experience brief delay (AHA News)**
- 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

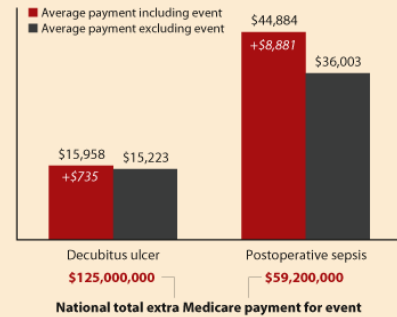
## 10/17/07 News.....

- **CMS poised to resume IPPS payments (AHA News)**
- Medicare payment of inpatient claims for discharges in early October should begin flowing to providers by no later than Monday, according to the Centers for Medicare & Medicaid Services. CMS expects fiscal intermediaries to begin processing the claims by tomorrow, after updating claims processing software to reflect changes to the fiscal year 2008 inpatient prospective payment system. The changes were needed, in part, to increase rates for a provision included in the TMA, Abstinence Education, and QI Programs Extension Act. Enacted Sept. 29, the law 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 AHA worked extensively with Congress to limit the cuts in CMS' inpatient rule. The change is expected to restore \$7 billion in Medicare payments to hospitals over five years. AHA is in constant communication with CMS and is monitoring the situation closely. The association also is identifying options for emergency payment relief if the delay is not addressed promptly.

### HAI's are expensive

Federal studies clearly show that just two of the hospital-acquired conditions that are being considered by CMS for payment exclusion cost Medicare and other insurers millions.

#### Medicare payment for 2 adverse events, 2002



Source: Healthcare Cost and Utilization Project Nationwide Inpatient Sample, 2002.

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 force that accountability.

- Hospital acquired conditions
- 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

## The CMS IPPS conditions (and their ICD-9-CM codes) include:

- Object left in surgery (998.4)
- Air embolism (996.0-999.9)
- Delivery of incompatible blood products (999.6, 999.7)
- Catheter-associated urinary tract infection (996.64 and various urinary tract infection codes)
- Pressure sores (707.00-707.09)
- Vascular catheter-associated infection (996.31) **new code**
- Mediastinitis after CABG (519.2)
- Hospital-acquired Injuries – Fractures (800-829), Dislocations (830-839), Intracranial Injury (850-854)
- Crushing Injury (925-929), Burns (940-949)

- Deficit Reduction Act 2005, POA is required 10/1/07
  - The information will not be used by the claims processing systems until January 1, 2008
- CMS will process on claims 1/1/08
  - Hospitals will be provided with a remark code on their RA advising them that they did not correctly submit the POA code on the claim
- Returned To Provider 4/1/08
  - If hospitals do not report a valid POA code for each diagnosis on the claim, the claim will RTP for correct submission of POA information

## What will happen in October 2008? (Impact Coding)

- 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**



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## Let's Look at A Case...

### Medicare DRG

469 MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC

CMS wt 2.6664 A/LOS 8.4 G/LOS 7.1

Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.

### Principal Diagnosis

\*73342 Aseptic necrosis of head and neck of femur  
 Affects secondary DRG  
 \*SOI=P Principal diagnosis used for SOI calculation  
 \*ROM=P Principal diagnosis used for ROM calculation  
 Present On Admission: Y

### Secondary Diagnoses

\*70705 Decubitus ulcer, buttock  
 \*SOI=3 Major  
 \*ROM=3 Major  
 Present On Admission: N

25000 Diabetes mellitus without complication, type II or unspecified type, not stated as uncontrolled  
 SOI=1 Minor  
 \*ROM=2 Moderate  
 Present On Admission: Y

78039 Convulsions  
 SOI=2 Moderate  
 \*ROM=2 Moderate  
 Present On Admission: Y

#2851 Acute posthemorrhagic anemia  
 SOI=1 Minor  
 ROM=1 Minor  
 Present On Admission: N

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



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Validate the POA Indicator – Check Admission Documentation

H&P and Nursing Assessment on admission revealed no skin breakdown or lesions.

PHYSICAL EXAMINATION

VITAL SIGNS: Height 5'5, weight 129, blood pressure 124/68, pulse 76, respiration 16, temperature 97.9

SKIN: Without lesions.

Admission History & Physical

Comment:

Genitourinary status WDP?  CRF pt?

Continent?  Type of incontinence:

WDP = Voiding spontaneously

Catheter?  Type catheter:

Urine clear, color yellow to amber

Urine color:  Character:

Comment:

Integumentary status WDP?

Skin color:

WDP = Warm, dry, intact skin

Skin moisture:

Normal color for patient

Skin temperature:

Skin integrity:

Comment:



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Validate the POA Indicator – Check Discharge Documentation

Skin pink, warm, dry?  If 'N', describe:

Pressure ulcers?  Location: R BUTTOCK

Type: Stage II

Size: 5 CM X 5.8 CM

Location:

Type:

Size:

Surgical wound?

Location: L HIP

Dressing clean/dry/intact?

Approximated?

Drainage?

Erythema?

Location:

Nursing Assessment on discharge clearly documenting a pressure (decubitus) ulcer was present on discharge thus indicating that this is a hospital acquired condition.



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## Additional Documentation Supporting Decubitus Ulcer

### OBJECTIVE:

Wound #1 (R) buttock Wound #2 left ant. thigh Wound #3 \_\_\_\_\_  
 Wound #4 \_\_\_\_\_ Wound #5 \_\_\_\_\_ Wound #6 \_\_\_\_\_

• Pt. repositioned MAN assist x 2 person(s). Pt. Soiled c/BM, PT cleaned, RN/CNA cleaned.

• Exudate: Dry None Scant Small Mod Large Copious  No dressings over wounds.

• Type: serosanguineous serous sanguineous purulent other Odor: Yes  No

• Periwound attributes: Normal Dry Rash  Erythema Cyanosis Maceration Excoriation Callus  
 Other: \_\_\_\_\_

• Cultures (aerobic & anaerobic): performed per MD orders.

• Measurements:  Dimensions taken  Photograph (s) taken x ( \_\_\_\_\_ Girth measurements taken:  
 R-midfoot: \_\_\_\_\_ R-ankle: \_\_\_\_\_ R-calf: \_\_\_\_\_ L-midfoot: \_\_\_\_\_ L-ankle: \_\_\_\_\_ L-calf: \_\_\_\_\_

• Pain management:  
Applied topical lidocaine x \_\_\_\_\_ min.  RN administered pain meds prior to tx. Soaked dressings x \_\_\_\_\_ min.

• Wound cleansing:  
Allclenz  NaCl Sterile H2O Irrigated with: \_\_\_\_\_ syringe. Pulsed Lavage and \_\_\_\_\_ NaCl.  
W/P @98 deg. F H2O c/ \_\_\_\_\_ Chlorostat \_\_\_\_\_ Betadine x 20min., rinsed c/ \_\_\_\_\_ NaCl or \_\_\_\_\_ sterile water.  
Periwound tissue cleansed with antibacterial soap and rinsed.

• Debridement:  
 Mechanical (brushing, scrubbing, washing), Sharp (minor removal of loose fragments or scraping of tissue), or  
Excisional debridement (cutting away or removal) of nonviable tissue ( skin fascia muscle bone ) with:  
alligator forceps, straight forceps, scissors (cut necrotic tissue), scalpel ( crosshatched, shaved, removed ),  
 moist 4x4's, or cotton swabs.  
Periwound hair \_\_\_\_\_ shaved, \_\_\_\_\_ trimmed.

## How Will the Reimbursement be Affected?

- |                         |                                 |
|-------------------------|---------------------------------|
| • <u>Today:</u>         | • <u>After October 1, 2008:</u> |
| • Base rate = \$5000    | • Base rate = \$5000            |
| • DRG 469               | • DRG 470                       |
| • Wt. 2.6664            | • Wt. 1.9871                    |
| • Total Reimb = \$13332 | • Total Reimb = \$9935.50       |

**Loss Revenue = \$3396.50**

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




## UB-04 Screen Shot


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## Present on Admission (POA) Tips for HIM Coding Staff





*The Present on Admission (POA) indicator is a new national regulatory requirement for acute care hospitals. A joint effort between **the healthcare provider** and **the coder** is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses, procedures, and POA indicators.*

*The POA indicators and definitions for the inpatient record are:*

**Y = Yes, the condition is present on admission at the time of the order to admit to inpatient status.**


**N = No, the condition is not present on admission and it developed during the inpatient stay.**

**U = Unknown (not enough documentation in medical record) Coders must query the physician to seek clarification.**

**W = Clinically Undeterminable by Provider (Physician)**

**Guidelines: Effective May 23, 2007 for all paper claim submission for all states. Date for electronic claims to be determined.**

- The POA indicator is assigned to principal and secondary diagnoses and E codes.
- Some codes are "**exempt**" from national POA reporting. Leave the "present on admission" field **blank** if the condition is on the list of ICD-9-CM codes for which this field is not applicable. **Note:** State reporting requirements may vary, and may not have any "exempt" codes.
- Assign "Y" for conditions that were diagnosed or were obviously present prior to admission. Example: Cancer, COPD, HTN, Diabetes Mellitus.
- When an outpatient is admitted to inpatient status, the conditions documented for the outpatient encounter are considered to be present upon inpatient admission. Assign "Y" for these scenarios.
- HIM Coding may need to **query** the physician if the documentation does not



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## Present on Admission (POA) Physician Documentation Tips



*The Present on Admission (POA) indicator is a new national regulatory requirement. A joint effort between **the healthcare provider** and **the coder** is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses, procedures, and POA.*

The POA indicators and definitions are:

- Y = Yes, the condition is present on admission at the time of the order to admit to inpatient.
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- U = Unknown (not enough documentation in medical record) Coders will have to query the physician to seek clarification.
- W = Clinically Undeterminable by Provider (Physician)

The following is a list of documentation tips for capturing present on admission (POA) indicators:

1. When a patient is admitted to the acute care hospital, there needs to be an MD order clearly indicating the level of care needed. The MD order signifies the change inpatient status. POA is only required for patients that are admitted as **INPATIENTS**.
2. Conditions documented at the time of the MD order for admission to inpatient status **are considered PRESENT ON ADMISSION**.
3. When a patient's account rolls from outpatient to inpatient status, the conditions/diagnoses documented on the outpatient encounter will be reported as present on admission. For example: Patient admitted from ER to inpatient. Diagnoses from ER are considered present on admission.

### PHYSICIAN DOCUMENTATION QUERY PRESENT ON ADMISSION (POA) DIAGNOSIS CLARIFICATION

Dear Dr.: \_\_\_\_\_ Date: \_\_\_\_\_  
MR #: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Documentation clarification is required to meet Federal and State POA compliance.

*It is unclear whether the following condition or diagnosis was present on admission.*

\_\_\_\_\_ (Specific diagnosis/condition)

Physician, please select one of the following:

- Y = Yes, the condition was present on admission at the time of the order to admit to inpatient status.
- N = No, the condition was not present on admission and it developed during the inpatient stay.
- W = Clinically Undeterminable by Provider (Physician)

MD Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*If you have any questions please contact the HIM Department (Medical Records) at # \_\_\_\_\_ Thank You!*

- Additional possibilities for 10/1/08
  - Ventilator associated pneumonia
  - Staphylococcus aureus septicemia
  - Deep vein thrombosis and pulmonary embolism

- What Should HIM and Coding Professionals Do Now and Ongoing to Prepare for and Work with all the IPPS Changes??



- “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.”
  - Direct Quote, CMS 2008 IPPS Final Rule, <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>, page 208

- Coders need to review carefully the final code that the encoder software is providing
  - Use your ICD-9-CM code book
    - Alpha and Tabular
  - Documentation must support the assignment of the code.
  - Coding from memory is dangerous
    - Coding guidelines change –
- Quarterly Coding Clinic



Know the AHA Coding Clinic Pr Dx Guidelines – specific training/education

- Principal Diagnosis Selection Rules
- Symptoms, signs and ill-defined conditions - guideline
- Italicized codes or codes in slanted brackets - guideline
- Acute and chronic conditions - guideline
- Two or more interrelated conditions as principal diagnosis - guideline
- Two or more diagnoses as principal diagnosis - guideline
- Two or more comparative or contrasting conditions - guideline
- Symptom(s) followed by contrasting/comparative diagnoses
- Observation and evaluation for suspected condition - guideline



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Know the AHA Coding Clinic Pr Dx Guidelines

- Original treatment plan not carried out - guideline
- Residual condition or nature of late effect - guideline
- Multiple burns - guideline
- Multiple injuries - guideline
- Neoplasm sequencing - guideline
- Poisoning sequencing - guideline
- Complications of surgery and other medical care - guideline
- Complication of pregnancy – guideline

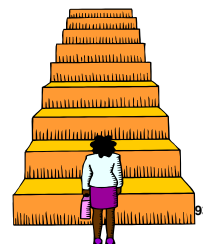


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- The entire medical record **must** be reviewed.
  - Particular attention to: H&P, Consultation, Operative note/procedure note, MD Progress Notes, MD Orders, Vent Flow Sheets, Dx Summary (Physician documentation).
  - Non physician documentation (i.e therapy or nursing notes) can give the coder clues to diagnosis or conditions to query the physician for.

- Additional education
- Have coding staff “shadowing” while on clinical rounds?
- Reaudit documentation and coding
- Audit POA reporting
  - Make physicians aware of POA
- Use your ICD-9-CM books!
- Increase anatomy/physiology knowledge (WebInService lessons)
- Increase pharmacology knowledge



- Recognize that core coding concepts remain the same
  - Accurate and Complete Coding
    - UHDDS Definition to support code assignment
  - Physician Documentation is key
  - Track CMI monthly, look for changes
  - Coding audits
  - Concurrent documentation improvement



- Become the experts
  - MS-DRG methodology and related changes
    - You are here today
    - Keep up with industry information – via email from CHW Corporate
- Create awareness:
  - Senior Management
  - IS personnel
  - Department Directors
  - Financial Team
  - Local contract team



- Understand your IT system impact:
  - 3M Coding and Reimbursement Software
  - QuadraMed Coding via Quantim
  - Meditech, MS4, etc.
  - Patient Accounting
  - Case Mix

**Mission critical will be preparation for claim submission  
No one can do it for you!**

- Inventory
  - Internal facility uses of the DRGs for business purposes
  - Internal facility applications that contain a DRG
- Initiate
  - Discussions with other facility negotiated payers that currently use DRG
    - Will other payers change to MS-DRG
    - May continue with an updated DRG grouper
      - Associated cost

- Order your coding resources in a timely manner

- ICD-9-CM FY08 Coding Books
- DRG Book



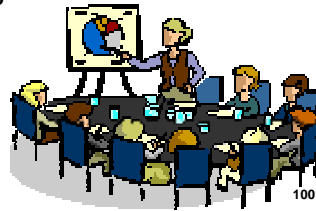
- Assess gaps in medical record documentation

- Clinical Documentation Improvement
- Use Physician Query forms
- Discuss with your Chief of Staff or Chief Medical Officer (CMO)

- Recommended action steps
  - Run facility secondary diagnosis volume data
  - Review high volume diagnoses
  - Understand impact of proposed MS DRGs
  - Identify opportunities for improvement
  - Communicate with Case Mgmt...
    - Weekly or Biweekly rounds together
  - And Medical Staff

## HIM Coding Action Steps

- Prior to MS-DRG/IPPS changes:
  - Expect more training and education
  - Work to ensure coding is up to date prior to transition
  - Evaluate any necessary change in any processes, policies, and procedures
  - Assess gaps in medical record documentation
  - Continue emphasizing medical staff responsibilities
  - Revise some documentation forms



## HIM Coding Action Steps – specifically for POA

- All of your coders should become familiar with the POA indicators and corresponding POA Reporting Guidelines
- Work will need to begin to educate and prepare others throughout the facility for this requirement.
  - Level I – Facility Leadership, Department Directors, Nursing staff, HIM staff
  - Level II – Medical Staff, Case Managers, PAs, Revenue Integrity
  - Level III – Coders, Coding Managers/Supervisors

## HIM Coding Action Steps – Specifically for POA

- Review current policies
- Establish any new processes needed
  - Incorporate POA into QC process
- Think about any potential operational impact
  - Productivity
  - A/R
  - Queries
- Prepare to educate medical staff on the continued emphasis and importance of their documentation and of your clinical documentation improvement plan

## HIM MS-DRG Tool Kit - Develop

- Current ICD-9-CM coding books (2008)
- Updated encoder software
- Knowledge of Major CCs
- Knowledge of CCs
- Coding staff - Disease process - core knowledge
- DRG Book
- Physician Query form and policy
  - Open communication

- Documentation audit/assessment
  - Concurrent reviews
  - Retro reviews
- Coding Audits
  - retrospective
- AHA *Coding Clinic* on ICD-9-CM (subscription)
- Education
  - Coding staff
  - Physicians

FORMS  
IMPROVEMENT  
CAPTURE  
SEVERITY!

CHW

[Hospital Logo](#)

PROGRESS NOTE  
Heart Failure Documentation Note

Dear Dr. \_\_\_\_\_ You have documented Heart Failure. To accurately code this diagnosis we ask that you specify the type(s) of heart failure.

Check all that apply:

- Acute systolic heart failure
- Chronic systolic heart failure
- Acute on Chronic systolic heart failure
- Systolic heart failure, unknown if acute or chronic
- Acute diastolic heart failure
- Chronic diastolic heart failure
- Acute on Chronic diastolic heart failure
- Diastolic heart failure, unknown if acute or chronic
- Acute combined systolic and diastolic heart failure
- Chronic combined systolic/diastolic heart failure
- Acute on Chronic combined systolic and diastolic heart failure
- Combined systolic/diastolic heart failure, unknown if acute or chronic
- Heart Failure
- Congestive Heart Failure
- Other

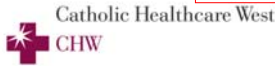
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_  
**THIS IS A PERMANENT PART OF THE MEDICAL RECORD**

## PREOP ANESTHESIA FORM

B.P.	H.R.	R.R.	Temp.	Height	Weight	ASA Physical Status: 1 2 3 4 5 6 E	Code Status:																																																																																				
<b>Review of Systems - (Circle/check if currently present or receiving treatment; comment on these or other problems below):</b>																																																																																											
<table border="0"> <tr> <td><b>General:</b></td> <td><b>Respiratory:</b></td> <td><b>Cardiovascular:</b></td> <td><b>Renal:</b></td> <td><b>Infectious Disease:</b></td> <td><b>Hematological:</b></td> </tr> <tr> <td><input type="checkbox"/> Fluid Overload</td> <td><input type="checkbox"/> Smoking - _____ ppd</td> <td><input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Stable</td> <td><input type="checkbox"/> Acute Renal Failure</td> <td><input type="checkbox"/> Sepsis (SIRS 2<sup>nd</sup> Infect.)</td> <td><input type="checkbox"/> Anemia <input type="checkbox"/> Sickle cell</td> </tr> <tr> <td><input type="checkbox"/> Dehydration</td> <td><input type="checkbox"/> COPD <input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> At rest <input type="checkbox"/> Unstable</td> <td><input type="checkbox"/> CKD Stage 1 2 3 4 5</td> <td><input type="checkbox"/> Septic Shock <input type="checkbox"/> Thrush</td> <td><input type="checkbox"/> Acute Blood Loss</td> </tr> <tr> <td><input type="checkbox"/> Malnutrition <input type="checkbox"/> Severe</td> <td><input type="checkbox"/> Cor Palm <input type="checkbox"/> O<sub>2</sub> Depen</td> <td><input type="checkbox"/> Acute MI <input type="checkbox"/> Cur admit</td> <td><input type="checkbox"/> Incontinence <input type="checkbox"/> UTI</td> <td><input type="checkbox"/> Cellulitis <input type="checkbox"/> + VDRL</td> <td><input type="checkbox"/> Chronic Blood Loss</td> </tr> <tr> <td><b>HEENT:</b></td> <td><input type="checkbox"/> Strab. 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Difficult Airway:</b></td> <td><input type="checkbox"/> Cirrhosis <input type="checkbox"/> Portal HTN</td> <td><input type="checkbox"/> SSS <input type="checkbox"/> RBBB <input type="checkbox"/> LBBB</td> <td><input type="checkbox"/> Uncontrolled (&gt;200)</td> <td><input type="checkbox"/> Hemiplegia 2<sup>nd</sup> old CVA</td> <td><b>Psychiatric:</b></td> </tr> <tr> <td><input type="checkbox"/> Cervical Spandondylosis</td> <td><input type="checkbox"/> OSA <input type="checkbox"/> Asphyxia</td> <td><input type="checkbox"/> Hep. 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PREOP ANESTHESIA... Coding Clinic allows us to code for the Anesthesia Record.. Great tool to capture severity!



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## Blood Transfusion Form – Capture Diagnosis and Severity

PHYSICIAN BLOOD PRODUCT ORDER			
Blood Utilization screening criteria shown in parenthesis			
<b>RED BLOOD CELLS</b>			
Product Ordered	# of Units	Diagnosis: (please choose one)	
<input type="checkbox"/> PRBC		<input type="checkbox"/> Post OP Anemia	<input type="checkbox"/> Iron Deficiency Anemia
<input type="checkbox"/> PRBC Leukopoor		<input type="checkbox"/> Chronic Blood Loss Anemia	<input type="checkbox"/> Nutritional Anemia
<input type="checkbox"/> CMV Neg <input type="checkbox"/> Irradiated CMV		<input type="checkbox"/> Acute Blood Loss Anemia	<input type="checkbox"/> Intraoperative Hemorrhage
<input type="checkbox"/> Washed cells		<input type="checkbox"/> Pernicious Anemia	
<input type="checkbox"/> Directed <input type="checkbox"/> Autologous		<input type="checkbox"/> Aplastic Anemia	<input type="checkbox"/> Other: _____
Other: _____			
Indications: (please mark all that apply)			
<input type="checkbox"/> hgb Results _____ hct Results _____ (hgb < 9 grams / hct < 27%) N/A <input type="checkbox"/>			
<input type="checkbox"/> estimated blood loss _____ ml (> 500 or 20% EBV)			
Vital signs: pulse _____ (pulse > 100), (BP < 100 systolic) _____ / _____ or decrease in BP > 20%			
<b>CO-MORBIDITIES:</b>			
<input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Cerebral Ischemia <input type="checkbox"/> Chronic Renal Failure			
<input type="checkbox"/> Cancer Treatment (site): _____ <input type="checkbox"/> Atrial Fib <input type="checkbox"/> CHF <input type="checkbox"/> Angina			
Other: _____			
<b>PLATELETS</b>			
Product Ordered	# of Units (1 pheresis = 10 plt concentrate)		
<input type="checkbox"/> Pheresis Leukopoor Plts			
Indications: (please check one)			
<input type="checkbox"/> Intraoperative coagulopathy			
<input type="checkbox"/> thrombocytopenia (no active bleeding)	plt ct _____	date/time: _____ / _____	(< 20,000/mm)
<input type="checkbox"/> thrombocytopenia (active bleeding)	plt ct _____	date/time: _____ / _____	(< 20,000/mm)
<input type="checkbox"/> bleeding time (BT) > 15 minutes (active bleeding)	BT = _____ min.		
<input type="checkbox"/> pre-op (BT increased and plts < 100K; BT wnl and plts < 50K)	BT = _____ min.	plts ct: _____	
Other: _____ (hematologist consult, etc.)			
<input type="checkbox"/> Directed <input type="checkbox"/> Autologous	# of Units		



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## Summary



- Coding rules and guidelines
- 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
- Regulations require healthcare providers to capture all clinical data with new emphasis on complication and “never events”

## Summary

- IT Systems need to be ready for POA transmission to the claim
- IT Systems need to be ready to collect POA internally at your hospital/system

## Summary

- Case Management
  - Documentation Improvement
- Risk and Infection Control
  - POA list and future considerations
- Monitor Case Mix Index
- Monitor your “MCC/CC” capture
- Audit and educate
- Encourage Inpatient charging accuracy and consistency



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## Questions?

- Question and Answer Period...



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## Thank you



Gloryanne Bryant

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415 438 5721



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## Speaker Bio

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, 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 (11/06) 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.



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## References/Resources

- FY2008 IPPS Proposed Rule
- FY2008 IPPS Final Rule
- [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage)
- DRG Expert – Ingenix
- Crosswalk from CMS V24 to MS-DRGs V25  
<http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1198678&intNumPerPage=2000>

## References/Resources

- Present On Admission Reporting Guidelines – CMS & NCHS
- CMS Transmittals 1104, 289 & 1240
- AHA Central Office – Present on Admission Indicators Audio Conference, 11/10/06
- 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=CMS1201734&intNumPerPage=2000>
- •MCC list  
<http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1201733&intNumPerPage=2000>