Managing the CMI under MS-DRGs

Audio Seminar/ Webinar

May 15, 2008

Practical Tools for Seminar Learning
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Educational material on CMI and MS-DRGs are designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.
Gloryanne Bryant, BS, RHIA, CCS

Gloryanne Bryant has over 28 years of experience in the health information management (HIM) profession, and currently is the Corporate Senior 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. Ms Bryant 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.

In June 2000, Ms. Bryant 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 appointed in 2006 to the RAND Expert Panel on Severity DRGs. She was nominated and received 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. Ms. Bryant is an RHIA (Registered Health Information Administrator) as well as a Certified Coding Specialist (CCS).
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Goals and Objectives

- Brief overview of the IPPS MS-DRG system
- Factors influencing the Case Mix Index (CMI)
- Understand the Target MS-DRGs
  - MCC/CCs
- Enhance knowledge of MS-DRG and CMI
- Gain an understanding of the documentation challenges and the impact on CMI
- How to use comparative data & data mining
- Action to take...

Diagnostic Related Groups
- Brief Overview

- Within IPPS - Inpatient Prospective Payment System... the DRGs are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital.
  - Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned.
  - This is a “payment” system ($$)
- All inpatient transfer/discharge claims from both PPS and non-PPS facilities, are classified by the Grouper software program into one of 745 diagnosis related groups (DRGs).
Inpatient Prospective Payment System (IPPS) – Brief Overview

- Each Medicare patient (discharge) is classified into a Diagnosis Related Group (DRG or MS-DRG):
  - Principal Diagnosis (why the patient was admitted)
  - Major Complications and Comorbidities or Complication/Comorbidity (MCC/CCs)
  - Surgical Procedures
  - Age (e.g., Newborn)
  - Gender
  - Discharge Disposition (routine, transferred, or expired)

DRGs and Severity (Basics) – Brief Overview

- DRGs can be used to evaluate quality of care that is expected to be received:
  - Clinically similar groups
  - Analysis of treatment protocols
  - Related condition or demographic distribution.
- DRG’s reflect utilization of services (DRG’s include the average # of resources needed to treat each clinical group)
- DRG’s determine the calculation for Relative Weight (RW) or Resources consumed...
**DRG Relative Weight Definition (Basics)**

- **Relative Weight (RW):** An assigned weight (number/figure) to reflect the resource consumption associated with each DRG.
- The higher the RW the higher the resources used to treat that diagnostic grouping thus the higher the PPS payment to the hospital.

**DRG RW (Basics)**

- The greater the # of resources needed to treat a given patient and the greater the intensity of these services within that DRG.
- **Assumption:**
  - The > acuity and resources = > RW
- **Hospital PPS (IP) payment is calculated:**
  - DRG RW X Base Rate (hospital specific) = Hospital Payment ($) for that DRG
Early DRGs and CMI Study - 1989

- Each of the DRGs has an official weight that, in a relative sense, determines payment. A DRG with a weight of two (RW 2.0) is paid twice as much as a DRG with a weight of one (RW 1.0), and so on.
- The array of patients across DRGs in a hospital is the hospital’s case-mix, and the average DRG weight for these patients is the hospital’s case-mix index (CMI).

Early DRGs - Study on CMI in 1989

- RAND Corporation:
  Re-abstracted a nationally representative sample of 7,887 Medicare charts to determine how much of the change in Medicare’s Case Mix Index between 1986 and 1987 was true change in the complexity of cases and how much was upcoding or ‘DRG creep’.
- About two-thirds of the change is true. Most of the remaining third is attributable to a general change in the completeness of coding; some is attributable to changes in the Grouper program.
- Thus, most of the additional $1 billion paid to hospitals because of the Case Mix Index change appears justified by the additional complexity of patients hospitalized.
**Case Mix Index (CMI)**

- CMI = Sum of all DRG RWs divided by the number of cases/ month/ year
- Case Mix Index (CMI) more accurately reflects the type and severity of patients the hospital treats

**Key Factors to CMI**

- Two Major Factors with IPPS DRGs and CMI:
  - Medical record documentation
  - Coding Changes
- Changes in documentation and/or coding practices will affect the DRG assignment and thus the CMI
  - For example, more thorough recording of secondary diagnoses provides greater opportunity for coding complications or comorbidities, which may result in assignment of a case to a higher-weighted DRG. This impacts the CMI
- Changes in the coding process for translating the diagnostic information into standard codes likewise affects DRG assignment
### Other CMI Factors

- Changes in service-line
  - Adding or closing departmental/services
- Volume of high RW MS-DRGs - ie Surgery MS-DRGs
  - Tracheotomies
  - Major Bowel resection
  - Transplants
- Surgeon’s gone, vacation or moved away
  - Volumes will drop for surgical DRGs
- Annual ICD-9-CM coding changes
- Annual IPPS Regulatory Changes & Updates

### CMI Calculation - Monthly stats

<table>
<thead>
<tr>
<th>DRG Description</th>
<th>RW</th>
<th># Cases</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG 195 Simple Pneumonia without MCC/CC</td>
<td>0.8398</td>
<td>9</td>
<td>0.75582</td>
</tr>
<tr>
<td>MS-DRG 193 Simple Pneumonia with MCC</td>
<td>1.2505</td>
<td>12</td>
<td>15.006</td>
</tr>
<tr>
<td>MS-DRG 291 Heart Failure w MCC</td>
<td>1.2585</td>
<td>5</td>
<td>6.2925</td>
</tr>
<tr>
<td>MS-DRG 292 Heart Failure w CC</td>
<td>1.0134</td>
<td>6</td>
<td>6.0804</td>
</tr>
<tr>
<td>MS-DRG 293 Heart Failure w/o MCC/CC</td>
<td>0.8765</td>
<td>10</td>
<td>8.765</td>
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<tr>
<td>MS-DRG 689 UTI w MCC</td>
<td>1.0587</td>
<td>4</td>
<td>4.2348</td>
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<tr>
<td>MS-DRG 682 Renal Failure with MCC</td>
<td>1.4664</td>
<td>5</td>
<td>7.332</td>
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<tr>
<td>MS-DRG 683 Renal Failure w CC</td>
<td>1.1942</td>
<td>3</td>
<td>2.5826</td>
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<tr>
<td>MS-DRG 871 Septicemia w/o Vent w MCC</td>
<td>1.7484</td>
<td>4</td>
<td>6.9936</td>
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<tr>
<td>MS-DRG 872 Septicemia w/o Vent w/o MCC</td>
<td>1.3783</td>
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<tr>
<td>MS-DRG 65 Intracranial Hemorrhage or Cereb Infarction w CC</td>
<td>1.1901</td>
<td>5</td>
<td>5.9505</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>66</strong></td>
<td><strong>74.9305</strong></td>
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</tbody>
</table>

CMI = 1.1353

Base Rate........× 5,500 = per case/discharge $6,244.15 reimbursement
66 cases Expected IPPS reimbursement = $412,113.90
- Very important calculation for financial planning
CMI Calculation - Monthly stats
(difference case volume - same MS-DRGs)

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>RW</th>
<th># cases</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>195</td>
<td>Simple Pneumonia without MCC/CC</td>
<td>.8398</td>
<td>4</td>
<td>.3592</td>
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<tr>
<td>193</td>
<td>Simple Pneumonia with MCC</td>
<td>1.2505</td>
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<td>23.7595</td>
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<tr>
<td>291</td>
<td>Heart Failure w MCC</td>
<td>1.2585</td>
<td>6</td>
<td>7.551</td>
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<tr>
<td>292</td>
<td>Heart Failure w CC</td>
<td>1.0134</td>
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<td>6.0804</td>
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<tr>
<td>293</td>
<td>Heart Failure w/o MCC/C</td>
<td>0.8765</td>
<td>9</td>
<td>7.8885</td>
</tr>
<tr>
<td>689</td>
<td>UTI w MCC</td>
<td>1.0587</td>
<td>5</td>
<td>5.2935</td>
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<tr>
<td>682</td>
<td>Renal Failure with MCC</td>
<td>1.4664</td>
<td>6</td>
<td>8.7984</td>
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<tr>
<td>683</td>
<td>Renal Failure w CC</td>
<td>1.1942</td>
<td>2</td>
<td>2.3884</td>
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<td>871</td>
<td>Septicemia w/o Vent w MCC</td>
<td>1.7484</td>
<td>5</td>
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<tr>
<td>872</td>
<td>Septicemia w/o Vent w/o MCC</td>
<td>1.3783</td>
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<td>8.2698</td>
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<tr>
<td>65</td>
<td>Intracranial Hemorrhage or Cereb Infarction w CC</td>
<td>1.1901</td>
<td>8</td>
<td>9.5208</td>
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Total: 76 cases | CMI = 1.2154

Base Rate...x 5,500 = per case/discharge $6,684.70 reimbursement
76 cases Expected IPPS reimbursement = $508,037.20

• Very important calculation for financial planning

CMI Calculation - Monthly Stats
(surgical case volume impact)

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<th>Description</th>
<th>RW</th>
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<th>CMI</th>
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<td>Maj Joint Replacement w/o MCC</td>
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<td>193</td>
<td>Simple Pneumonia with MCC</td>
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<td>Intracranial Hemorrhage or Cereb Infarction w CC</td>
<td>1.1901</td>
<td>8</td>
<td>9.5208</td>
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Total: 83 cases | CMI = 1.39204

Base Rate...x 5,500 = per case/discharge $7,656.23 reimbursement
83 cases Expected IPPS reimbursement = $635,467.21

• Very important calculation for financial planning & budgeting
Monthly Graph of Hospital CMI - total/avg. (sample)

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CMI Report - Comparing Hospitals (sample)

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Your hospital should have the CMI data and HIM often has this calculated in their HIM Systems as well. Important for HIM to know what the hospital CMI is, track and trend.
**MDC CMI can be a helpful tool**

- **25 MDCs in IPPS**
  - Major diagnostic category is a classification of diagnoses typically grouped by anatomic system and is the basis for the DRG system
- **Take the MS-DRGs within the MDC and determine the volume of cases**
- **Calculate the CMI based of MDC**
- **What is your highest CMI MDC**
- **Is there a pattern with a particular MDC**
- **Compare volumes of medical vs surgical MS-DRGs within MDC**

**MS-DRG Reimbursement Example:**
*Note the RW impact on payment and CMI*

- **MS-DRG 193 Simple Pneumonia with MCC**
  - RW = 1.2505 (FY08) x $5500 base rate = $6877
  - GMLOS = 5.5
- **MS-DRG 194 Simple Pneumonia with CC**
  - RW = 1.0235 (FY08) x $5500 base rate = $5629
  - GMLOS = 4.5
- **MS-DRG 195 Simple Pneumonia without MCC/CC**
  - RW = .8398 (FY08) x $5500 base rate = $4618
  - GMLOS = 3.5
- **Capturing severity with CC/ MCC**
- **Severity of simple pneumonia discharges**
- **This also impacts your Mortality Outcomes analysis**
**Key Concepts when Expanding DRGs to “Severity DRGs”**

- **Needed patient attributes:**
  - Severity of illness, the extent of physiologic decompensation or organ system lost of function
  - Risk of mortality, the likelihood of dying
  - Resource intensity, the relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease

---

**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
MS-DRGs...

- Improvement in cost variation recognizes severity of illness and resource usage will occur.
- Resulting in more appropriately reimbursing hospitals that take care of sicker patients and reducing payments to hospitals providing less complex care.

MS-DRG (Medicare-Severity DRGs)

- MS-DRG System
  - Completely revised the “CC” list
  - Created Major CC subclasses
  - Uses the same ICD-9-CM diagnosis and procedure codes as the current MS-DRG system
  - Reduce incentives for hospitals that attempt to treat only the healthiest and most profitable patients
  - Changes to the MS-DRG RWs are the most significant to IPPS since 1983
**MS-DRGs**

- MS-DRGs also include significant changes that has the potential to result in hospitals receiving a reduction in Medicare case mix and reimbursement.
- IPPS MS-DRG changes relate to the complete reclassification of the 10,690 ICD-9-CM diagnosis codes with regards to a complication/comorbidity (CC) status.
- In original DRGs, 3,326 diagnosis codes were “CCs”.
- In MS-DRGs 2,913 ICD-9-CM diagnosis codes are CCs, and 1,389 codes are major complication/comorbidities (MCCs).

**MS-DRG Assignment**

- MS-DRG assignment requires the following:
  - Selection of the principal diagnosis (with supporting diagnosis)
  - Major Complication/Comorbidity (MCC)
  - Complications or Comorbidity (CC)
  - Procedures coded
  - Discharge Disposition (Patient Status) accuracy
MS-DRG... “CC Capture”

- Under the original DRG structure the assignment of a DRG was determined by the presence or absence of a CC in approximately 50% of a hospital’s Medicare discharges.
- With MS-DRGs, CMS estimated that approximately 90% of MS-DRG assignments will be determined by CCs and MCCs.
  - This is telling providers to look closely at “CC and MCC” capture to obtain accurate CMI.

IPPS MS-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.”
IPPS MS-DRG Relative Weight

- As a result, the MS-DRGs will lower reimbursement to specialty hospitals, particularly for certain elective cardiac admissions.
- For example, CMS projects that payments to cardiac specialty hospitals will decline under the new MS-DRG system by more than 5%.

MS-DRG RW is Cost-based Methodology

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

Inpatient charging matters!
Managing the CMI under MS-DRGs

Impact and Link to CMI

- DRGs Medical vs. Surgical
- Surgical DRGs have higher relative weight
- Traditional surgery patient requires greater resources to treat
Clinical Documentation Link

- Clinical documentation is at the center of healthcare
  - 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

Impact on CMI – Physician Documentation

- Physician terminology is different from ICD-9-CM classification terminology
- Unaware
- Not educated on IPPS and the hospital payment structure
  - Teach your physicians
- Not completing the documentation
  - Written or dictated documentation - delinquency
  - Suspension practices
- Not answering queries
- Not interested... not aware of the link to physician profiles and score cards
- Some problematic areas include:
  - Site of neoplasm/malignancy
  - Site of mets (neoplasm)
  - Comorbidity conditions
  - Complications
  - Other symptoms
  - History/status conditions
Other: Documentation Providers

- **Resident:** The resident note or documentation and diagnosis can be used for coding.

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

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

- **PA & NP:** In most states the Physician Assistant and the Nurse Practitioners are allowed to diagnosis.

- If the Practitioners are allowed (often under State Practice Law) to diagnosis, then you can code from that documentation.

Impact your CMI: Documentation & Guidelines for Coding

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

- Official coding guidelines state:
  - Only the documentation of a licensed treating provider can be used for hospital coding (which includes any qualified health care practitioner i.e., PA, NP, and Residents)

Examples include:
- Attending physicians
- Consulting physicians
- Surgeons
- Interventional radiologists
- Anesthesiologists

Examples of providers who are not treating physicians include:
- Pathologists
- Cardiologists (interpreting EKG's, etc.)
- Radiologists (reading x-rays)
Accurate, Complete & Specific Documentation is the Key...

inpatient flow is complex

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
Severities-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

Definition for Reporting/Documenting Secondary or Other Diagnosis

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

Take Home Message:
“Document all conditions/diagnoses”

Also: Coding guidelines state “... all conditions that coexist at the of admission, that develops subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded”
### Tips for Improving Clinical Documentation... Commonly Missed Diagnoses/Conditions That Are Complications and Co-Morbidities

To reflect appropriate patient severity, acuity, risk of mortality, resource consumption and to ensure complete and accurate coding, document in the History, MD Orders, or Progress Notes or Discharge Summary ALL diagnostic conditions that affect the current stay. These are reportable secondary conditions...

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

Thank you for your help!

### Accurate Documentation will Increase Predicted Mortality (capture of severity)

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

Have you looked at [www.healthgrades.com]? If you don't get the documentation and the codes for all conditions to capture severity this can distort the hospital and physician scorecard.
**Documentation Weaknesses that can Impact MS-DRG assignment and CMI**

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

### Excisional debridement (skin):
- Needs to be described in more detail by the physicians and other non-physician providers (exception to rule).
- ICD-9-CM procedure code 86.22 - surgical
  - Wound care Nurse, Therapist, etc.
- There are very specific coding guidelines relating to this (RAC target)
  - Site/location
  - Depth
  - Removal of devitalized tissue
  - Instrumentation used
- Coding guidelines should not and are not intended to provide clinical criteria for coding
- Recent AHA Coding Clinic – review.
  - 1st Qtr 2008

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

### Coma: often not a clinical term that physicians will use.
- Under MS-DRG this ICD-9-CM code is a MCC
- Glasgow coma score maybe documented... watch for this, it may be a clue
- Audit your Stroke/ CVA and other neuro and trauma records and identify any weaknesses
- Inservice ED/ER, Trauma and Neurologist physicians about difference in terminology and severity capture
Documentation Weaknesses that can Impact MS-DRG assignment and CMI

Decubitus ulcer, an ulceration caused by an arterial occlusion or by prolonged pressure, as when in a patient allowed to lie too still in bed for a long period of time or is confined to a wheelchair; called also decubitus, bed sore, and pressure u. or sore. (Dorland's Dictionary)

- Physician’s need to specify decubitus site since it would be a CC or MCC by site specific area
- “Stage” does not correlate to a decubitus
- Physician might co-sign the wound care assessment and concur
- Improve documentation form
- Quality improvement
- New proposed ICD-9-CM code for FY09 - watch

The BMI code assignment should be based on medical record documentation, which may be found in a dietitian’s note. (See AHA 2005 4 Q Coding Clinic)

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

Coders should not calculate the BMI.
- 40 and over = V85.4 = “CC”
- less than 19 = V85.0 = “CC”

Using MD Orders! … to Capture diagnoses and severity, impact CMI

- Yes… if the MD order contains a diagnosis this can be used to assign the ICD-9-CM code.

- Assigning codes based on physician orders Coding Clinic, Third Quarter 2005 Page: 18

- Coding from physician phone orders Coding Clinic, Third Quarter 2005 Page: 19

- Inservice your Nursing staff, discuss capturing “diagnostic information” or indication
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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.
Principal Diagnosis Definition: The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Application of the PrDx will be key to your DRG grouping accuracy and impact the CMI

Coding Practices Impact CMI: Guideline for Reporting Secondary Diagnosis

- Report conditions that affected patient care in terms of requiring:
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended the length of stay; or
  - increased nursing care and/ or monitoring
Coding Practices Impact CMI: Capture of Secondary Diagnosis

- MCC (Major Complication/Comorbidity)
- CC (Complication/Comorbidity)
- Large challenge to capture these conditions (ICD-9-CM codes)
- Documentation - provider
- Coding variance
  - Not thoroughly reviewing the medical record
  - Lack of knowledge and awareness of MCC/CC list of conditions

Coding Impact on CMI: Chart Review

- The entire medical record should be reviewed.
  - Particular attention to: H&P, Consultation, Operative note/procedure note, MD Progress Notes, MD Orders, Respiratory/Vent Flow Sheets, Dietary Eval/notes, Nursing Notes, X-rays, Lab, Dx Summary
  - Coding must be supported by Physician Documentation!! (with a few exceptions)
  - Pressure to code too quickly can be a weakness
  - Encoder dependence can be a weakness, use as a tool - utilize your ICD-9-CM coding books
Coding Impact CMI: Coding Rules
- AHA Coding Clinic Pr Dx Guidelines

- 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 - guideline
- Two or more diagnoses as principal - guideline
- Two or more comparative or contrasting conditions - guideline
- Symptom(s) followed by contrasting/comparative diagnoses
- Observation and evaluation for suspected condition - guideline
- Original treatment plan not carried out - guideline
- Residual condition or nature of late effect - guideline

Coding Impact CMI: Coding Rule
- AHA Coding Clinic Pr Dx Guidelines

- Multiple burns - guideline
- Multiple injuries - guideline
- Neoplasm sequencing - guideline
- Poisoning sequencing - guideline
- Complications of surgery and other medical care - guideline
- Complication of pregnancy - guideline
Managing the CMI under MS-DRGs

Who’s the Sickest...??  What Impacts CMI?

How do we determine who is the sickest?

Creating Accurate 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
Understanding the MCC/CC severity focus

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

Differences in common “CCs” for prior DRGs vs MS-DRGs, but still need to be documented

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

<table>
<thead>
<tr>
<th>TOP Ten</th>
<th>2007 RW</th>
<th>2008 MS-DRG(s)</th>
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<tbody>
<tr>
<td>127 Heart Failure</td>
<td>1.0490</td>
<td>291 w MCC 1.2585</td>
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<tr>
<td></td>
<td></td>
<td>292 w CC 1.0134</td>
</tr>
<tr>
<td></td>
<td></td>
<td>293 w/o 0.8765</td>
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<tr>
<td>89 Simple Pneumonia with CC</td>
<td>1.0376</td>
<td>193 w MCC 1.2505</td>
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<tr>
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<td>194 w CC 1.0235</td>
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<td></td>
<td></td>
<td>195 w/o 0.8398</td>
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<tr>
<td>544 Major Joint Replacement or Attachment</td>
<td>1.9878</td>
<td>469 w MCC 2.6664</td>
</tr>
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<td></td>
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<td>470 w/o MCC 1.9871</td>
</tr>
<tr>
<td>88 Chronic Obstructive Pulmonary Disease</td>
<td>0.8878</td>
<td>199 w MCC 1.1138</td>
</tr>
<tr>
<td></td>
<td></td>
<td>191 w CC 0.9404</td>
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<tr>
<td></td>
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<td>192 w/o 0.8145</td>
</tr>
<tr>
<td>576 Septicemia w/o Vent &gt;96 Hours</td>
<td>1.5996</td>
<td>871 w MCC 1.7484</td>
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<td></td>
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<td>872 w/o MCC 1.3783</td>
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<td>182 Esophagitis, Gastroenteritis, etc with CC</td>
<td>0.7853</td>
<td>391 w MCC 0.9565</td>
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<td>392 w/o MCC 0.7121</td>
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<td>14 Stroke</td>
<td>1.2118</td>
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<td>65 w CC 1.1901</td>
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<td>66 w/o 1.0303</td>
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<td>174 Gastrointestinal Hemorrhage with CC</td>
<td>1.0296</td>
<td>377 w MCC 1.3367</td>
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<td></td>
<td>378 w CC 1.0195</td>
</tr>
<tr>
<td></td>
<td></td>
<td>379 w/o 0.8476</td>
</tr>
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<td>316 Renal Failure</td>
<td>1.2602</td>
<td>682 w MCC 1.4664</td>
</tr>
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<td></td>
<td>683 w CC 1.1942</td>
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<td></td>
<td></td>
<td>684 w/o 0.9835</td>
</tr>
<tr>
<td>320 Urinary Tract Infection</td>
<td>0.8769</td>
<td>689 w MCC 1.0587</td>
</tr>
<tr>
<td></td>
<td></td>
<td>690 w MCC 0.8000</td>
</tr>
</tbody>
</table>

Run a report on your top volume DRGs and MS-DRGs. Target areas for focused attention and improvement.

MS-DRGs – Capture Severity of Illness (SOI) will Capture your CMI

- 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)

Capture Severity with Specific Documentation
Documentation Specificity is Key...
To Capture MCC/CC and CMI

“Closed head injury”... • Concussion or loss of consciousness
“Encephalopathy”... • Type of encephalopathy and the cause
“Anemia”... • Specific type of anemia
“Angina”... • Specific type of angina
“Low Urine output”... • Diagnosis or cause
“Respiratory insufficiency”... • Is it Respiratory failure?

Clinical Documentation that is: ACCURATE, COMPLETE, SPECIFIC

Focus: CC/MCC Breakdown in Severity of Heart Failure

Closer Look at Heart Failure - CC Impact has Changed...

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

DOCUMENTATION SPECIFICITY IS THE KEY!
Old habits are hard to change... but specificity is key
Closer Look at Heart Failure MS-DRG, Relative Weight Impact

Note the relative weight differences, ...CMI

Monitor Your MS-DRGs Volumes and Your CMI

- Look at your overall MCC/ CC capture rate
  - Without CC %
  - With CC
  - With MCC
- Capture rate within specific MS-DRGs (tiered & paired)
  - Without CC %
  - With CC
  - With MCC
### DRG Pair Report - Data Mining

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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<td>DRG CC Pairs</td>
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<th>COPD</th>
<th>CVN/Stroke</th>
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<td>312</td>
<td>411</td>
</tr>
</tbody>
</table>

**CMI Impact and Compliance Tracking/Trending**

---

### Data Mining to Assist

**DRG - Kidney & urinary tract infections w MCC**

- **Criteria:**
  - 85
  - 80
  - 0.000
  - 0.800
  - 0.000

**Flags:**

- **Change Conditions:**
  - 1 74 F 80 0.800 AHR Medicare

- **Target Cases:**
  - 85
  - 80
  - 0.800
  - 0.000
  - 0.000

**Other Case:**

- **Target Cases:**
  - 85
  - 80
  - 0.800
  - 0.000

**Although retrospective... these cases may warrant further review to assess documentation and coding accuracy. Also target cases with MCC/CC from a compliance perspective.**
Data Mining to Assist

Tip to Enhance Awareness:
Continue Home Meds? ...Need Diagnostic Documentation - Impact severity and CMI

- Always document diagnoses related to all home medications continued during the hospital stay.
- Secondary diagnoses reflect the severity of illness as well as the intensity of service.
- Examples:
  • Theodur
  • Imdur
  • Lasix
  • Lanoxin
  • Synthroid
  • Lopressor
  • COPD
  • Angina Pectoris
  • Compensated CHF
  • Atrial Fibrillation
  • Hypothyroidism
  • Hypertension

Although retrospective... these cases may warrant further review to assess documentation and coding accuracy.
FORMS IMPROVEMENT CAPTURE SEVERITY and IMPROVE CMI!
Note just a check-off, but initial the diagnosis and signature.

Physician/Provider Documentation Tips – Medicare Severity DRGs or MS-DRGs

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

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

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

1. Physicians must document all diagnoses/conditions that are being treated, monitored, increases the length of stay or requires more nursing care in order to capture severity.

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

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

4. Provide specific documentation using the terms "acute" or "chronic" if it is known. In addition document the underlying "cause" of a disease or condition is it is known (ie. the causal organism for pneumonia). This helps improve hospital and physician profiling and report cards.

Remember documentation should be clear, concise and timely. All entries should be signed, dated and timed.

More on MS-DRG and CMI Opportunities

- IPPS MS-DRG creates many challenges
- Hospitals need to plan, organize and take action to grasp opportunities
- Not just one educational inservice to physicians... a series and continuous
- Regular and consistent message and information
- Develop a strategy... A campaign
Strategy to Managing CMI: Develop a MS-DRG Tool Kit

- DRG Book (Ingenix)
- MS-DRG Memo to the Medical Staff
  - Severity capture
  - Utilization of querying
- Physician awareness and education
- Physician Query form's
  - Follow best practices
- Query usage policy
  - Open communication
- Encoder software - grouper
- Knowledge of Major CCs
  - List available
- Knowledge of CCs
  - List available
- Coding staff & Others - Disease process - core knowledge
- Coding Staff & Others - Pharmacology knowledge

Strategy to Managing CMI: MS-DRG Tool Kit (cont’d)

- Physician Query Tracking
  - Concurrent
  - Prebill and/or Retro
- Documentation Improvement Program
  - Concurrent
- Documentation Audit/assessment
  - Concurrent reviews
  - Retro reviews
- Use the Medical Staff newsletter to enhance awareness
- Create MS-DRG posters/flyers
- Create “Documentation Tip Sheets” (variety)
- Coding Audits
  - Retrospective
  - Verify the UB is correct
- Monitor your MS-DRGs (volumes)
- AHA Coding Clinic on ICD-9-CM (subscription)
- Educate and re-educate over and over
  - Coding staff
  - Documentation specialists
  - Case Management
  - Dietary, Wound Care, Respiratory, PT/OT, Speech
  - Nursing Leadership and Unit Mgrs.
  - Physicians, ED Physicians as well
  - Hospital Administration/ Mgmt (incl CFOs)
CMI and Compliance

- Historically: The OIG’s audits of hospital coding and DRG assignments resulted in identification of millions of dollars in overpayments for inpatient Medicare services due to overcoding, at times the result of unsound advice from those providing clinical documentation and coding consulting services to hospital coders.

Summary - Action to take

- Communicate with the Medical staff and MS Offices, including:
  - Electronic newsletters
  - E-mails
  - Web sites
  - Blast faxes
- Remember… Accurate, Complete and Specificity in your clinical documentation will impact your CMI
- Accurate and specific ICD-9-CM coding will also impact your CMI
- Clinical documentation is at the center of healthcare
  - 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
Summary

- Tool-kit - suggestions and ideas to manage MS-DRGs
- Remember... follow coding rules and guidelines ... be compliant
- Hospitals should analyze their data within product lines to identify trends, whether by physician or by specific MS-DRG.
- Develop an action plan and be proactive
- Monitor & manage the changes in CMI to improve the overall capture of severity and financial health of the hospital.

Thank you

Gloryanne Bryant
gbryant@chw.edu
Managing the CMI under MS-DRGs

IPPS MS-DRG Federal Register FY08

- The FY08 final rule revising the Medicare hospital inpatient prospective payment system was published in August 22, 2007, Federal Register, Vol. 72, No. 162. Go to:
- Click on [TEXT] or [PDF]. The following items identify important tables and the pages on which they may be found:
  - Table 5—List of Medicare Severity Diagnosis Related Groups (MS-DRGs), pages 47539-47588
  - Table 6A—New Diagnosis Codes, pages 47588-47563
  - Table 6B—New Procedure Codes, pages 47563-47565
  - Table 6C—Invalid Diagnosis Codes, page 47565
  - Table 6D—Invalid Procedure Codes, pages 47565-47566
  - Table 6E—Revised Diagnosis Code Titles, page 47566
  - Table 6F—Revised Procedure Code Titles, page 47566

References/Resources

- Health Affairs - “Hospital Case Mix Change” - 1989 (article)
- FY2008 IPPS Final Rule
- www.cms.hhs.gov/ICD9ProviderDiagnostic-Codes/07_summarytables.asp
- DRG Expert - Ingenix
- Health Information Management Compliance - Guidelines for Preventing Fraud and Abuse, Fourth edition, Sue Bowman, RHIA, CCS (AHIMA)
- 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
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May 20, 2008

Benchmarking Coding Productivity
June 5, 2008

ICD-9-CM Diagnostic Coding Guidelines for Outpatient Services
June 12, 2008
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http://campus.ahima.org/audio/2008seminars.html

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Certificates will be awarded for AHIMA Continuing Education Credit.
Appendix

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MS-DRG Glossary (5 pages) ...................................................................................... 44-48
CE Certificate Instructions .............................................................................................. 49
Resource List

The FY08 final rule revising the Medicare hospital inpatient prospective payment system was published in the August 22, 2007, Federal Register, Vol. 72, No. 162. Go to:

http://www.fda.gov/OHRMS/DOCKETS/98fr/082207.toc.htm -- Then scroll to “Centers for Medicare & Medicaid Services, RULES, Medicare: Hospital inpatient prospective payment systems and 2008 FY.”

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- Table 6C—Invalid Diagnosis Codes, page 47565
- Table 6D—Invalid Procedure Codes, pages 47565-47566
- Table 6E—Revised Diagnosis Code Titles, page 47566
- Table 6F—Revised Procedure Code Titles, page 47566

Health Affairs - “Hospital Case Mix Change” - 1989 (article)

FY2008 IPPS Final Rule

http://www.cms.hhs.gov/ICD9ProviderDiagnostic-Codes/07_summarytables.asp


DRG Expert – Ingenix

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CMS links to important tables:

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## Glossary/Terms/Abbreviations

- **AHA:** American Hospital Association  
- **AHIMA:** American Health Information Management Association  
- **APR-DRGs:** sophisticated risk adjustment software program that refines Hospital Coding Data to more accurately capture true severity. **All Patient Refined** - Diagnostic Related Groups (3M proprietary software)  
- **AMLOS:** Arithmetic mean length of stay  

## Glossary/Terms/Abbreviations

- **Base Rate:** A # assigned to a hospital used to calculate DRG reimbursement.  
  - Base rates vary from hospital to hospital.  
  - Base rates are adjusted for the individual characteristics of the hospital:  
    - Geographic location,  
    - Urban vs Rural Status  
    - Local labor costs  

- **CMI:** **Case Mix Index** - The sum of all DRG relative weights (RW’s), divided by the number of Medicare cases.
Glossary/Terms/Abbreviations

- **CC**: Complication or comorbid condition
- **CMS**: Centers for Medicare & Medicaid Services
- **Comorbidity**: Preexisting condition that, because of its presence with a specific diagnosis, causes an increase in length of stay by at least one day in 75% of the cases.
- **Complication**: A condition that arises during the hospital stay that prolongs the length of stay by one day in 75% of the cases.
- **CS-DRG**: Consolidated Severity diagnostic related groups

Glossary /Terms/Abbreviations

- **Discharge**: A situation in which the patient leaves an acute care hospital (PPS) after receiving care and treatment.
- **Discharge status**: Disposition of the patient at discharge, for example, AMA, home, transfer to another acute care facility, SNF, Rehab and Home health.
- **DRG**: Diagnosis Related Group
- **FY**: Fiscal year
- **GMLOS**: Geometric mean length of stay
- **Grouper**: The software program that assigns DRGs.
- **HPMP**: Hospital Payment Monitoring Program
Glossary/Terms/Abbreviations

• **InterQual:** InterQual Criteria are set of measurable, clinical indicators, as well as diagnostic and therapeutic services reflecting the need for hospitalization. Rather than being based on diagnosis, they consider the level of illness of the patient and the services required; thus they serve as the criteria for all acute hospital care, regardless of location or size of the hospital. The criteria are grouped into 14 body systems, and there are 3 sets of criteria for each body system:
  - Intensity of Service
  - Severity of Illness
  - Discharge Screens

Glossary/Terms/Abbreviations

• **ICD-9-CM:** International Classification of Diseases, Ninth Revision, Clinical Modification
• **ICD-10-CM & PCS:** International Classification of Diseases, Tenth Edition and Procedure Coding System
• **IS:** Intensity of Service
• **JCAHO:** Joint Commission on Accreditation of Hospital Organizations. JCAHO is the national accrediting body for hospitals and other health care delivery organizations. Hospitals request to have JCAHO evaluate their facility and are charged a fee. Because accreditation is not automatically renewed, a full accreditation survey is required at least every three years.
• **MCC:** Major Complication/Comorbidity
• **MDC:** Major Diagnostic Category, broad classification of Dx, grouped by body system.
Glossary/Terms/Abbreviations

- **MEDPAC**: Medicare Payment Advisory Commission to CMS for changes in IPPS
- **MEDPAR**: Medicare Provider Analysis and Review file which holds all the claims data used to analyze costs, length of stay and utilization (this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.)
- **MCV**: Major cardiovascular condition
- **MMA**: *Medicare Modernization Act*, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 into law on December 8th. The long-awaited and historic changes to the Medicare system have supporters claiming it will "allow the biggest improvements in senior health care in nearly 40 years, and provide seniors with prescription drug benefits and more choices in health care".

Glossary/Terms/Abbreviations

- **OIG**: Office of the Inspector General
- **Other Diagnosis**: All secondary diagnoses that exist at the time of admission or develop subsequently, affect treatment and/or length of stay and meet UHDDS guidelines as a secondary diagnosis.
- **Principal Diagnosis**: The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- **PEPPER**: Payment Error Prevention Program Electronic Report.
Glossary/Terms/Abbreviations

- **QIO**: Quality Improvement Organization, formerly known as PRO (Peer Review Organization)
- **Relative Weight**: An assigned weight to reflect the resource consumption associated with each DRG. The higher the RW the higher the PPS payment to the hospital.
- **SOI**: Severity of Illness
- **Transfer**: When a patient is transferred to another acute care PPS hospital for related care.
- **UHDDS**: Uniform Hospital Discharge Data Set
- **Volume**: The number of patients in each DRG.
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