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Managing the CMI under MS-DRGs

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Practical Tools for Seminar Learning

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Faculty

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 on-going 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…**

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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).**

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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)**

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DRGs and Severity (Basics) – **Brief Overview**

- **DRGs can be used to <u>evaluate quality</u> of care <u>that is expected</u> to be received:**
  - **Clinically similar groups**
  - **Analysis of treatment protocols**
  - **Related condition or demographic distribution.**

- **DRG's <u>reflect utilization</u> of services (DRG's include the average # of resources needed to treat each clinical group)**

- **DRG's <u>determine the calculation for Relative Weight (RW)</u> or Resources consumed…**

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DRG Relative Weight Definition (Basics)

- <u>Relative Weight (RW):</u> = 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.

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DRG RW (Basics)

- The **greater the # of** <u>resources</u> **needed** to treat a given patient **and the greater the intensity** of these <u>services</u> 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

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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 <u>average</u> DRG weight for these patients is the hospital's case-mix index (CMI).**

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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.**

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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

CMI continues to be an important factor with IPPS

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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**

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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**

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CMI Calculation – Monthly stats

MS-DRG 195 Simple Pneumonia without MCC/CC	**RW .8398**	**# cases 9 =** 7.5582
MS-DRG 193 Simple Pneumonia with MCC	**RW 1.2505**	**# cases 12 =** 15.006
MS-DRG 291 Heart Failure w MCC	**RW 1.2585**	**# cases 5 =** 6.2925
MS-DRG 292 Heart Failure w CC	**RW 1.0134**	**# cases 6 =** 6.0804
MS-DRG 293 Heart Failure w/o MCC/CC	**RW 0.8765**	**# cases 10 =** 8.765
MS-DRG 689 UTI w MCC	**RW 1.0587**	**# cases 4 =** 4.2348
MS-DRG 682 Renal Failure with MCC	**RW 1.4664**	**# cases 5 =** 7.332
MS-DRG 683 Renal Failure w CC	**RW 1.1942**	**# cases 3 =** 2.5826
MS-DRG 871 Septicemia w/o Vent w MCC	**RW 1.7484**	**# cases 4 =** 6.9936
MS-DRG 872 Septicemia w/o Vent w/o MCC	**RW 1.3783**	**# cases 3 =** 4.1349
MS-DRG 65 Intracranial Hemorrhage or Cereb Infarction w CC	**RW 1.1901**	**# cases 5 =** 5.9505
Total		**66** **74.9305**

CMI = 1.1353

Base Rate........x 5,500 = per case/discharge $6,244.15 reimbursement
66 cases Expected IPPS reimbursement = $412,113.90
- **Very important calculation for financial planning**

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CMI Calculation – Monthly stats
(difference case volume – same MS-DRGs)

MS-DRG 195 Simple Pneumonia without MCC/CC   **RW .8398**   **# cases 4**   **3.3592**
MS-DRG 193 Simple Pneumonia with MCC   **RW 1.2505**   **# cases 19 23.7595**
MS-DRG 291 Heart Failure w MCC   **RW 1.2585**   **# cases 6**   **7.551**
MS-DRG 292 Heart Failure w CC   **RW 1.0134**   **# cases 6**   **6.0804**
MS-DRG 293 Heart Failure w/o MCC/C   **RW 0.8765**   **# cases 9**   **7.8885**
MS-DRG 689 UTI w MCC   **RW 1.0587**   **# cases 5**   **5.2935**
MS-DRG 682 Renal Failure with MCC   **RW 1.4664**   **# cases 6**   **8.7984**
MS-DRG 683 Renal Failure w CC   **RW 1.1942**   **# cases 2**   **2.3884**
MS-DRG 871 Septicemia w/o Vent w MCC   **RW 1.7484**   **# cases 5**   **8.742**
MS-DRG 872 Septicemia w/o Vent w/o MCC   **RW 1.3783**   **# cases 6**   **8.2698**
MS-DRG 65 Intracranial Hemorrhage or Cereb Infarction w CC   **RW 1.1901**   **# cases 8**   **9.5208**
Total   **76**   **92.3751**

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**

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CMI Calculation – Monthly Stats
(surgical case volume impact)

MS-DRG 469 Maj. Joint Replacement w MCC   **RW 2.6664**   **# cases 3**   **7.992**
MS-DRG 470 Maj Joint Replacement w/o MCC   **RW 1.9871**   **# cases 8**   **15.896**
MS-DRG 195 Simple Pneumonia without MCC/CC   **RW .8398**   **# cases 4**   **3.3592**
MS-DRG 193 Simple Pneumonia with MCC   **RW 1.2505**   **# cases 19 23.7595**
MS-DRG 291 Heart Failure w MCC   **RW 1.2585**   **# cases 6**   **7.551**
MS-DRG 292 Heart Failure w CC   **RW 1.0134**   **# cases 6**   **6.0804**
MS-DRG 293 Heart Failure w/o MCC/CC   **RW 0.8765**   **# cases 9**   **7.8885**
MS-DRG 689 UTI w MCC   **RW 1.0587**   **# cases 5**   **5.2935**
MS-DRG 682 Renal Failure with MCC   **RW 1.4664**   **# cases 6**   **8.7984**
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MS-DRG 872 Septicemia w/o Vent w/o MCC   **RW 1.3783**   **# cases 6**   **8.2698**
MS-DRG 65 Intracranial Hemorrhage or Cereb Infarction w CC   **RW 1.1901**   **# cases 8**   **9.5208**
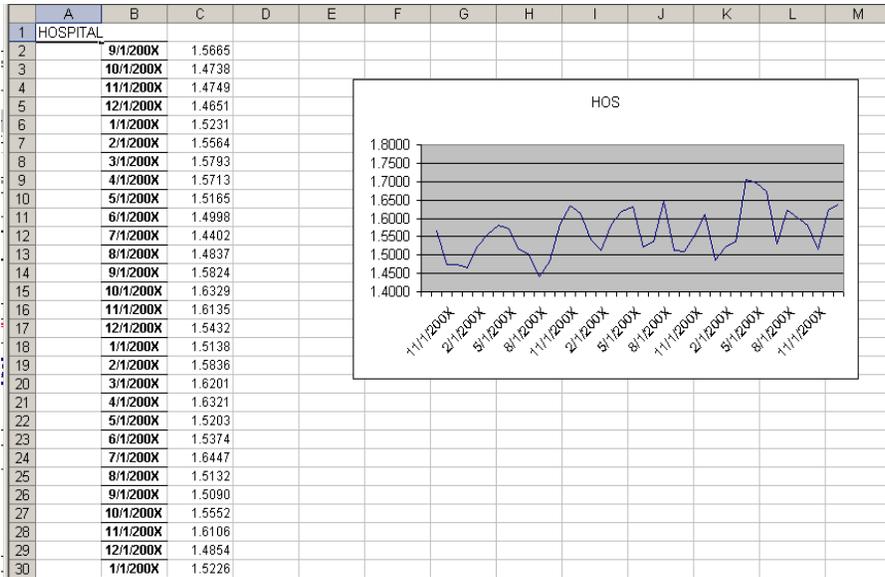**Total**   **83**   **115.5395**

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**

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Monthly Graph of Hospital CMI – total/avg. (sample)

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	HOSPITAL												
2		9/1/200X	1.5665										
3		10/1/200X	1.4738										
4		11/1/200X	1.4749										
5		12/1/200X	1.4651										
6		1/1/200X	1.5231										
7		2/1/200X	1.5564										
8		3/1/200X	1.5793										
9		4/1/200X	1.5713										
10		5/1/200X	1.5165										
11		6/1/200X	1.4998										
12		7/1/200X	1.4402										
13		8/1/200X	1.4837										
14		9/1/200X	1.5824										
15		10/1/200X	1.6329										
16		11/1/200X	1.6135										
17		12/1/200X	1.5432										
18		1/1/200X	1.5138										
19		2/1/200X	1.5836										
20		3/1/200X	1.6201										
21		4/1/200X	1.6321										
22		5/1/200X	1.5203										
23		6/1/200X	1.5374										
24		7/1/200X	1.6447										
25		8/1/200X	1.5132										
26		9/1/200X	1.5090										
27		10/1/200X	1.5552										
28		11/1/200X	1.6106										
29		12/1/200X	1.4854										
30		1/1/200X	1.5226										

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CMI Report – Comparing Hospitals (sample)

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YR AVG
Hosp A	1.7879	1.7415	1.5405	1.6512	1.7368	1.6111	1.7849	1.6492	1.6328	1.5300	1.6452	1.5100	

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Hosp B	2.0401	1.5432	1.6139	1.3326	1.5588	1.8445	1.4945	1.5568	1.5639	1.4500	1.5533	1.6176
Hosp C	1.3269	1.5302	1.2719	1.4084	1.3180	1.3277	1.3836	1.4118	1.3418	1.5026	1.4272	1.3940

> **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.**

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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**

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

- **MS-DRG 193 Simple Pneumonia <u>with MCC</u>**
  - **RW = 1.2505 (FY08) x $5500 base rate = $6877**
  - **GMLOS = 5.5**
- **MS-DRG 194 Simple Pneumonia <u>with</u> 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**

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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

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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

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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.**

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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**

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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).

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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

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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**

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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."**

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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%.**

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MS-DRG 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	

Inpatient charging matters!

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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 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
001	No	No	PRE	SURG	Heart transplant or implant of heart assist system w MCC	23.1117	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
					ECMO or trach w MV 96+ hrs or PDX exc			
003	Yes	No	PRE	SURG	face, mouth & neck w maj O.R.	18.7707	33.4	40.6
					Trach w MV 96+ hrs or PDX exc face, mouth			
004	Yes	No	PRE	SURG	& neck w/o maj O.R.	11.4219	23.8	29.3
005	No	No	PRE	SURG	Liver transplant w MCC or intestinal transplant	10.6120	17.6	23.5
006	No	No	PRE	SURG	Liver transplant w/o MCC	7.2562	9.1	10.5
007	No	No	PRE	SURG	Lung transplant	8.4002	14.6	17.3
008	No	No	PRE	SURG	Simultaneous pancreas/kidney transplant	5.1726	10.1	11.8
009	No	No	PRE	SURG	Bone marrow transplant	6.4842	18.1	21.7
010	No	No	PRE	SURG	Pancreas transplant	3.8902	9.2	10.5
011	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC	4.1482	12.8	16.2
012	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w CC	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	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	4.7036	9.0	12.8
024	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w/o MCC	3.8978	6.1	8.9
025	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w MCC	4.2362	10.3	13.3
026	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w CC	3.1582	6.5	8.2
027	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC	2.3259	3.5	4.6
028	Yes	Yes	01	SURG	Spinal procedures w MCC	4.2339	10.8	14.7
029	Yes	Yes	01	SURG	Spinal procedures w CC or spinal neurostimulators	2.8356	5.3	7.3
030	Yes	Yes	01	SURG	Spinal procedures w/o CC/MCC	1.7617	2.8	3.7
031	Yes	No	01	SURG	Ventricular shunt procedures w MCC	3.2226	9.2	13.2
032	Yes	No	01	SURG	Ventricular shunt procedures w CC	1.9342	3.8	5.8

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Impact and Link to CMI

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

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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**

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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**

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Other: Documentation Providers

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

- The <u>inpatient coding setting</u>, 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.**

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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:
  - <u>Only the documentation of a licensed treating provider can be used for hospital coding</u> (which includes any qualified health care practitioner ie., PA, NP, and Residents)
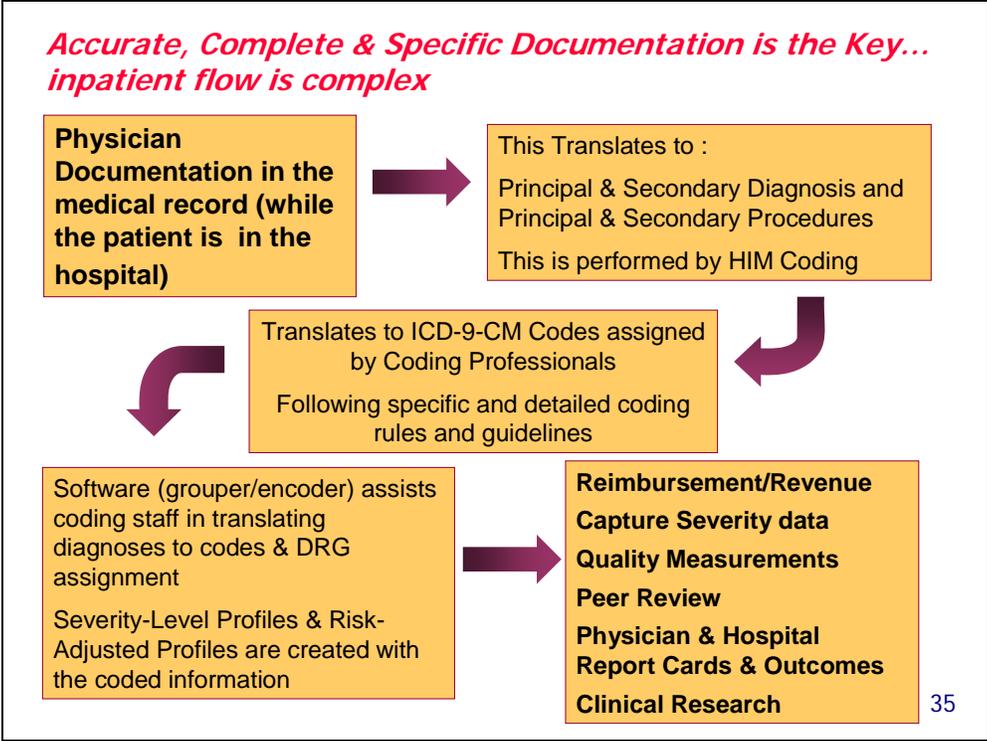
Examples include:

    Attending physicians

    Consulting physicians

    Surgeons

    Interventional radiologists

    Anesthesiologists

Examples of providers who are <u>not</u> treating physicians include:

    Pathologists

    Cardiologists (interpreting EKG's, etc.)

    Radiologists (reading x-rays)

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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

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

35

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"

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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*
- ✓ **Ileus**
- ✓ 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!

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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.

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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 <u>not</u> 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 wound 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

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Documentation Weaknesses that can Impact MS-DRG assignment and CMI

Heart Failure: Lack of physician documentation for specific <u>type...</u> "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

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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 <u>site</u> since it would be a CC or MCC <u>by site</u> 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"

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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.**

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

- <u>Coding from physician phone orders</u>
  Coding Clinic, Third Quarter 2005 Page: 19

- Inservice your Nursing staff, discuss capturing "diagnostic information" or indication

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CMS's Statement on Clinical Documentation Integrity

- **"We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record."**
  - **Direct Quote, CMS 2008 IPPS Final Rule, http://www.cms.hhs.gov/AcuteInpatientPPS/ downloads/CMS-1533-FC.pdf, page 208**

| Opportunity in this statement if put to action |

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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.

44

Coding Practices Impact CMI:
Knowledge and application of the IPPS (MS-DRG) definitions

Principal Diagnosis Definition: The condition established <u>after study</u> to be chiefly responsible for occasioning the <u>admission of the patient</u> to the hospital for care.

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

45

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**

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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**

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Coding Impact on CMI: Chart Review

- **The <u>entire</u> 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**

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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

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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

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

HOW DO WE DETERMINE WHO IS THE SICKEST?

51

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**
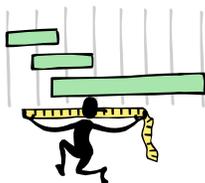
52

Understanding the MCC/CC severity focus

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

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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**

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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
88 Chronic Obstructive Pulmonary Disease	0.8878	190 w MCC 1.1138 191 w CC 0.9404 192 w/o 0.8145
576 Septicemia w/o Vent >96 Hours	1.5996	871 w MCC 1.7484 872 w/o MCC 1.3783
182 Esophagitis, Gastroenteritis, etc with CC	0.7853	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

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

55

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

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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 57

Focus: CC/MCC Breakdown in Severity of Heart Failure

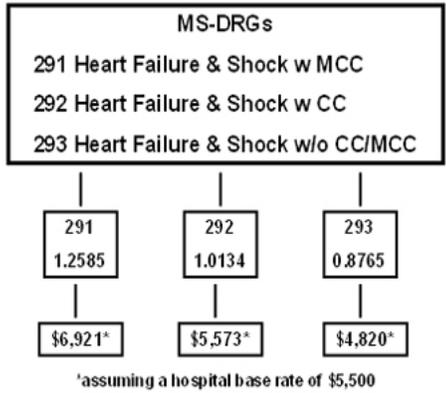**Closer Look at Heart Failure – CC Impact has Changed...**

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

DOCUMENTATION SPECIFICITY IS THE KEY!

Old habits are hard to change... but specificity is key

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Closer Look at Heart Failure MS-DRG, Relative Weight Impact

Note the relative weight differences, ...CMI

```
                  MS-DRGs
        291 Heart Failure & Shock w MCC
        292 Heart Failure & Shock w CC
        293 Heart Failure & Shock w/o CC/MCC

         291          292          293
        1.2585       1.0134       0.8765

       $6,921*      $5,573*      $4,820*
        'assuming a hospital base rate of $5,500
```

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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**

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DRG Pair Report – Data Mining

	A	B	C	D	E	F	G	H	I	J	K	L	M
1													
2	DRG CC Pairs												
3	Medicare Cases												
4													
5		Simple Pneumonia			UTI/Urospesis			COPD			CVA/Stroke		
6		89	79	%	320	416	%	88	87	%	14	524	%
7													
8	Hospital A	57	13	81.4%	24	26	48.0%	39	4	90.7%	81	4	95.3%
9	Hospital B	88	19	82.2%	18	40	31.0%	52	6	89.7%	35	5	87.5%
10	Hospital C	324	79	80.4%	127	147	46.4%	150	88	63.0%	129	27	82.7%
11	Hospital D	54	17	76.1%	22	42	34.4%	60	5	92.3%	28	13	68.3%
12	Hospital E	123	36	77.4%	48	48	50.0%	51	5	91.1%	46	21	68.7%
13	Hospital F	269	95	73.9%	76	178	29.9%	151	42	78.2%	121	36	77.1%
14	Hospital G	57	13	81.4%	24	26	48.0%	39	4	90.7%	21	4	84.0%
15													
16		972	272	78.1%	339	507	40.1%	542	154	77.9%	461	110	80.7%
17	MedPAR	554,440	160,452	77.6%	225,069	288,502	43.8%	427,153	93,725	82.0%	278,864	109,116	71.9%
18	Ctr Case Mgmt	CCM		70%	CCM		65%	CCM		75%	CCM		80%
19			70/30			35/65			75/25			80/20	
20													

CMI Impact and Compliance Tracking/Trending   61

Data Mining to Assist

690 - Kidney & urinary tract infections w/o MCC

Pt Control No	Med Rec No	Disch Dt	Ve	Age	Sex	Tot Chgs	DRG	RW	Pt	Payer	LOS	PLOS	ISS	Coder
			1	85	F	$0	690	0.8000	ARS	Medicare	3	3.6		0.7543

DXs 5990, 42731, 27651, 25000, 53081, 4019, 3559, 2724, 4380, V142, **Flags:**
78009
Procs: **Change Conditions:**

| | | | 1 | 74 | F | $0 | 690 | 0.8000 | AHR | Medicare | 4 | 3.6 | | 0.7942 |

DXs 5990, 2761, 40390, V1302, 5859, 4293, 2720, 79029   **Flags:**
Procs: 0331   **Change Conditions:**

| | | | 1 | 74 | F | $0 | 690 | 0.8000 | AHR | Medicare | 2 | 3.6 | | 0.6891 |

DXs 5990, 591, 4589, 2761, 412, 78909, 56210, 41401, V4582, V4502, **Flags:**
V1301, V145
Procs: **Change Conditions:**

Although retrospective... these cases may warrant further review to assess documentation and coding accuracy. Also target cases with MCC/CC from a compliance perspective.   62

Data Mining to Assist

743 - Uterine & adnexa proc for non-malignancy w/o CC/MCC													
Pt Control No	Med Rec No	Disch Dt	Ve	Age	Sex	Tot Chgs	DRG	RW	Pt	Payer	LOS	PLOS	ISS	Coder
			1	66	F	$0	743	0.8672	AHR	Medicare	2	2.1		0.9868
DXs 6202, 61889, 6170, 2181, 2182, 6259							Flags:						
Procs: 6851, 6563							Change Conditions:						
			1	72	F	$0	743	0.8672	AHR	Medicare	2	2.1		0.9124
DXs 6184, 59651, 496, 78833, 2724, V143, V1508							Flags:						
Procs: 6859, 7050, 7078, 5979, 7095							Change Conditions:						

747 - Vagina, cervix & vulva procedures w/o CC/MCC													
Pt Control No	Med Rec No	Disch Dt	Ve	Age	Sex	Tot Chgs	DRG	RW	Pt	Payer	LOS	PLOS	ISS	Coder
			1	72	F	$0	747	0.8499	AHR	Medicare	1	1.7		0.9445
DXs 6256, 61889, 6185, 4019, 2449, 2724							Flags:						

Although retrospective... these cases may warrant further review to assess documentation and coding accuracy.

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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** • **COPD**
  - **Imdur** • **Angina Pectoris**
  - **Lasix** • **Compensated CHF**
  - **Lanoxin** • **Atrial Fibrillation**
  - **Synthroid** • **Hypothyroidism**
  - **Lopressor** • **Hypertension**

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FORMS IMPROVEMENT CAPTURE SEVERITY and IMPROVE CMI! *Note just a check-off, but initial the diagnosis and signature.*

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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**

Continued...

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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 <u>to query the physician</u> 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 <u>acute</u> 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.

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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**

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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**

- **Current ICD-9-CM coding books (2008)**
- **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**

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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)**

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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.**

- **Contributed to Public Law 104-191, <u>The Health Insurance Portability and Accountability Act, Subtitle A – Fraud and Abuse Control Program implemented August 21, 1996</u>, and the <u>OIG's Publication of the OIG Compliance Program Guidance for Hospitals</u> published in the Federal Register Monday, February 23, 1998.**

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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**

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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.**

Legitimate movement of your DRGs and CMI

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Thank you

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IPPS MS-DRG Federal Register FY08

- 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:
- 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."
- 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 47563–45765
- • 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

IPPS RULE FOR FY09

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References/Resources

- Health Affairs -"Hospital Case Mix Change" – 1989 (article)
- FY2008 IPPS Final Rule
- www.cms.hhs.gov/ICD9ProviderDiagnostic-Codes/07_summarytables.asp
- OIG Compliance Program Guidance for Hospitals published in the Federal Register, 1998.
- 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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Appendix

Appendix

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:

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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 <u>P</u>atient <u>R</u>efined** - 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 a 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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