

# Coding Times

April 2007

Coding, Billing and  
Reimbursement Issues for  
the Coding Professional

## CMS Proposed Rule

**On April 13, 2007, The Centers for Medicare & Medicaid Services issued its proposed rule for FY 2008.** Included are steps claiming to improve the accuracy of Medicare's payment under the acute care hospital inpatient prospective payment system. Payment reforms include restructuring inpatient DRGs to account more fully for the severity of the patient's condition. The proposed rule would create 745 severity-adjusted DRGs - **Medicare Severity DRGs, or MS-DRGs** - to replace the current 538 DRGs. MS-DRGs are considered a refinement in the hospital payment system that began with reforms established last year in expanding a portion of the DRGs to reflect severity of the patient's condition. MS-DRGs are meant to represent a significant improvement to the Medicare program's ability to recognize severity of illness in its inpatient hospital payments.

The CMS has contracted with RAND Corporation to conduct an evaluation of alternative severity DRG systems. The evaluation of five commercially available DRG products began to determine whether they could be used by Medicare to better recognize severity of illness in its inpatient hospital payments. The RAND report is to be available later this year. The CMS has also asked RAND to include the proposed MS-DRG system in the evaluation. **The CMS will not make a decision as to which DRG system to adopt permanently until the RAND evaluation is complete.**

The CMS proposal to adopt a severity DRG system before the completion of the RAND final report is available has taken many by surprise. The final rule in August will give precious little time to prepare before going into effect in October, and then there is no guarantee that another severity DRG system will not be adopted the following year. This time last year, the CMS proposed a radical change to a severity DRG system for FY 2007, however the final rule involved a more gradual change phasing in of severity DRGs in certain areas.

If MS-DRGs are implemented, the increase to 745 DRGs will primarily involve addition of major CC DRGs to virtually all DRG categories, as we saw in this year's limited changes in major small & large bowel procedures, stomach procedures, etc. The MS-DRG list even includes separate DRGs for COPD with CC, COPD with major CC (MCC), COPD without CC/MCC, heart failure & shock with CC, heart failure & shock with MCC, and heart failure & shock without CC/MCC, etc.

Check this link [www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf](http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf) for the entire proposed rule, and find Table 5 (page 838) for the list of proposed MS-DRGs. The proposed rule also contains the table of proposed new diagnosis codes, new procedure codes, and most importantly, the proposed MCC list (page 882).

## Present on Admission - POA

We included information on “*Present on Admission*” in the November 2006 newsletter. The proposed rule for FY 2008 to take effect on October 1, 2007 confirms that a provision will be implemented taking the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient that acquires a condition during a hospital stay. The Deficit Reduction Act requires hospitals to begin reporting secondary diagnoses that are present on admission for discharges on or after October 1, 2007. In the meantime, Health and Human Services will be required to select at least two conditions that are high cost, high volume, or both – that when assigned as a secondary diagnosis result in a higher-paying DRG, and are reasonably preventable through application of “evidence-based guidelines.”

**Beginning in FY 2009, cases with these conditions would not be paid at a higher DRG unless they were present on admission.**

## Respiratory Failure

We have noted that the most recent respiratory failure guidelines outlined in Coding Clinic 1Q05 are not being applied in a consistent manner. This may be attributed to lack of clarity and different interpretations regarding the intent of the new guidelines. The controversy involves sequencing acute respiratory failure and the associated underlying respiratory condition when both meet criteria for PDX.

Coding Clinic 1Q05p3 states “Selection of the PDX will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are responsible for occasioning the admission to the hospital, the guideline regarding two or more diagnoses that equally meet the definition for PDX (Section IIC) may be applied in these situations.” The official guidelines in section IC8c use this same wording, and these two official references do not refer to any difference between respiratory and nonrespiratory conditions as cause of the respiratory failure.

1Q05 goes on to state that the advice **supercedes guideline #1 and #2 in 2Q91p3**. In 2Q91p3, guideline #1 addressed respiratory failure

Proposed conditions that may be selected include: catheter associated UTIs, pressure ulcers, staph aureus septicemia, and serious preventable events such as objects left in surgery, air embolisms, and blood incompatibility.

Check our November newsletter on our website at [www.himexperts.com](http://www.himexperts.com) for additional information on POA. The ICD-9-CM Official Guidelines for Coding and Reporting - [www.cdc.gov/nchs/icd9.htm](http://www.cdc.gov/nchs/icd9.htm) - in Appendix I - covers the comprehensive rules for POA designation. If your hospital has not yet begun reporting this field, it is right around the corner. Reporting this field accurately is important because this data will be used for future DRG calculations.

Severity DRG issues and POA issues above underscore once again the importance of physician documentation. Due to heavy dependence of physician documentation regarding POA and MS-DRGs, the time for physician education and training is now.

associated with a chronic nonrespiratory condition, and guideline #2 addressed respiratory failure associated with an acute exacerbation of a chronic nonrespiratory condition. However, Coding Clinic 1Q05 does not mention guideline #3 in 2Q91. Guideline #3 addresses respiratory failure associated with an acute nonrespiratory condition. Is this guideline also superceded? If so, why does 1Q05 not indicate guideline #3 in addition to #1 and #2 as superceded?

Coding Clinic 1Q05 also states that the advice **is consistent with** ND87p5 and 2Q00p21. These references and examples in 1Q05 do not cite a scenario clearly illustrating an example of sequencing when both respiratory failure and the underlying respiratory condition equally meet the definition for PDX. (All examples use wording that indicate respiratory failure as the reason for admission.) However, there is implication when reviewing the examples in ND87p5, 2Q00p21, and 1Q05p3 that the respiratory condition guidelines were not superceded.

1Q05 does not mention **Coding Clinic 2Q03p21**. This reference states that respiratory failure and pneumonia are not co-equal, and the two or more interrelated conditions guideline does not apply to respiratory failure

associated with a respiratory condition. In this reference, it is stated that when the reason for admission is respiratory failure associated with pneumonia, the respiratory failure should be sequenced as the PDX.

We feel that it is important to determine if Coding Clinic has meant the updated guideline to supercede or be consistent with 2Q03p21. We feel that this clarification would be valuable in verifying the intent of the new guideline.

Coding Clinic 1Q05 also indicates that this issue is **consistent with 4Q04p139**. This is the issue that asked for sequencing direction regarding the new code for myasthenia gravis with acute exacerbation when a patient presents with acute respiratory failure and myasthenia gravis. The answer states, "Acute respiratory failure may be designated as the principal diagnosis if it led to the hospital admission, or it may be listed as an associated condition of it occurs after admission. Code 518.5 is assigned when respiratory failure occurs following surgery or trauma. **This applies to respiratory failure resulting from either a respiratory or nonrespiratory condition** unless the Index or Tabular List instructs otherwise." Publication of this guideline, before the next issue superceded the existing sequencing guidelines, was problematic, as it was in direct conflict with the existing guidelines. (Coding Clinic 2Q91, #2 states that when a patient is admitted in respiratory failure associated with an acute exacerbation of a chronic nonrespiratory condition, that condition is the PDX.) However, now

that our current sequencing guidelines are consistent with 4Q04, what does this mean? Which part of the guideline in 4Q04 applies to both respiratory and nonrespiratory causes of respiratory failure? "**May**" be designated as the PDX? More confusion.

Here is the question: When a patient presents with acute respiratory due to gram-negative pneumonia, and both equally meet criteria for PDX, is it defensible to list the pneumonia as PDX? Or have the required sequencing guidelines **not** been superceded regarding listing respiratory failure due to a respiratory condition?

Are the first three paragraphs of 1Q05p3 used indicating either respiratory failure or gram-negative pneumonia may be sequenced first? Or are the subsequent examples given meant to imply that the first three paragraphs apply only to non-respiratory causes of respiratory failure, and respiratory failure must be sequenced first?

The ICD-9-CM Official Guidelines for Coding and Reporting added acute respiratory failure sequencing guidelines in section IC8c effective November 15, 2006. However, this reference does not address respiratory versus nonrespiratory causes of respiratory failure. Does this mean that this official guideline takes precedence over previous Coding Clinic references? Such an important sequencing issue should be addressed in the official guidelines in IC8c.

We encourage sending a request as we have to Coding Clinic for further clarification and publication regarding this issue.

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