Medical Audit Resource Services, Inc.

Coding Times

September 2007

Coding, Billing and Reimbursement Issues for the Coding Professional

Changes for FY 2008

Changes for Inpatient Reimbursement

We have had precious little time to prepare for the MS-DRG system that goes into effect October 1st. The new MS-DRG system involves complete re-evaluation of the CC list and splitting into two severity levels: MCC, or major complication or comorbidity, and CC, or complication or comorbidity. Most of the 311 base DRGs are split based on MCC, CC, or no MCC/CC, for a total of 745 MS-DRGs.

The current CMS-DRG system results in 78% of cases assigned to the highest severity levels, and the remaining 22% are assigned to the lowest severity levels (non-CC). The CMS expects the new MS-DRG system to more fully reflect severity of illness among patients. The new MS-DRG system is expected to result in approximately 22% of patients being assigned to the severity groups with the highest level of severity, 41% assigned to the lowest severity groups, and 37% assigned to the middle severity groups.

We will all need to learn all over again which conditions are CCs, major CCs, and which conditions are no longer CCs. In many cases, the more specific the documentation, the more likely the condition will fall into one of the CC categories. Hospitals with an advanced query process already in place will be ahead of the game.

The CMS believes most hospitals will educate physicians and coders and/or implement a documentation improvement program to provide better documentation and coding. To account for any potential increase in CMI, the CMS is implementing a "Documentation and Coding Adjustment" to offset any increase and maintain "budget neutrality". ***Essentially, any facility without a documentation improvement program or planned education program will see an immediate reduction in payment of 1.2% in FY08, 1.8% in FY09 and 1.8% in FY10.*** Conversely, any facility with a comprehensive documentation and coding improvement program will receive increased revenue, a windfall for facilities that take advantage of the opportunity.

The CC and MCC lists can be accessed on the CMS website at: www.cms.hhs.gov/AcuteInpatientPPS. Click on "Acute Inpatient - Files for download." (Clicking "All" under "View Items Per Page" will assist in accessing the FY 2008 files.) Tables 6I and 6J, the MCC and CC lists, as well as numerous other helpful tables are available using this link.

The DRGs affected by the post-acute transfer policy will increase from 190 CMS-DRGs to 273 MS-DRGs. The MS-DRGs affected by the post-acute transfer policy are noted in table 5 in the final rule that includes the list of MS-DRGs, weights, and GMLOS, etc. Table 5 is also included in the "files for download" section of the CMS website.

FY 2008 final rule will not include any add-on payments for "new services and technologies."

Updated Official Guidelines, POA News, and New Diagnosis Codes

On October 1st, POA (present on admission) reporting will be required. By now we should all be familiar with the POA guidelines in Appendix I of the ICD-9-CM Official Guidelines for Coding and Reporting, and feel comfortable with applying the guidelines for accurate POA reporting. The Appendix includes general reporting requirements, assignment of POA indicator for combination codes, codes that are exempt from POA requirement, and POA examples, etc. The official guidelines can be accessed at: http://www.cdc.gov/nchs/icd9.htm.

Despite the fact that there will be no financial impact to POA reporting until next year, POA is primarily physician documentation dependent. Reporting can be accomplished based on poor documentation, but accurate POA reporting will require a change in what physicians normally do. This type of change takes months or more to implement, so start soon!

***Note:* The official guidelines have been updated, effective October 1st!** The list of exempt codes has been changed slightly, so if you are currently assigning POA, be sure to access the new guidelines effective October 1st.

Other changes noted in the official guidelines include clarification in the pain section, and coding only confirmed cases of avian influenza.

Most of the diagnosis code changes this fiscal year involve additions for greater specificity. Code 414.2 was created for chronic total occlusion of the coronary artery. The code is to be used with the coronary atherosclerosis code. Code 789.51 was created for malignant ascites, and will be assigned in addition to the code for primary malignant neoplasm of the ovary or secondary malignancy of peritoneum as appropriate. Infection due to central venous catheter has previously been coded 996.62. The new code for infection due to central venous catheter will be 999.31.

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