FY 2011 IPPS proposed rule spurs discussions about regulatory hot topics

The fiscal year (FY) 2011 IPPS proposed rule released April 19 addresses several highly debated topics. They include:

➤ A sizable documentation and coding adjustment (DCA)
➤ A potential code freeze in anticipation of ICD-10
➤ A closer look at payment implications of hospital-acquired conditions (HAC) and the POA indicator

DCA and payment reduction

Acute care hospitals generally can expect a reduction in total payments for operating expenses of 0.1% (i.e., $142 million). This reduction is due to adjustments made to maintain budget neutrality and ensure proper payment of outlier claims, as well as a DCA of -2.9 percentage points.

Experts say this payment reduction will likely hit hospitals hard during these tough economic times.

“Plain and simple, this policy will undermine hospitals’ ability to care for patients and communities across the country.” American Hospital Association (AHA) President and CEO Rich Umbdenstock said in an April 19 AHA press release. “Should this rule take effect, billions of dollars would be taken out of the system just as hospitals are grappling with sweeping changes and payment reductions contained in the new health reform legislation.”

“I am not surprised that there is a DCA adjustment but am a bit surprised about the higher percentage,” says Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CCDS. McCall is director of HIM and coding at HCPro, Inc., in Marblehead, MA. “Hospitals have certainly been working diligently to increase and fine-tune their documentation practices over the past few years.”

Unlike their acute care counterparts, long-term care hospitals (LTCH) will see an update of 2.4% for inflation minus a DCA of 2.5 percentage points. Under the proposed rule, LTCH payments are estimated to increase by 0.8% or $41 million.

HACs and POA

CMS also is taking a closer look at payment implications of HACs and the POA indicator. The agency employed RTI International to conduct an analysis of MedPAR IPPS claims from October 2008 through June 2009.

Regarding the POA indicator, RTI found a total of approximately 50.22 million secondary diagnoses across
approximately 7.17 million discharges. Most of these secondary diagnoses (nearly 84%) were reported with a POA indicator of “Y.” Nearly 7% were reported with “N” (not POA), 0.02% were reported with “W” (status cannot be clinically determined), and 0.22% were reported with “U” (documentation not adequate to determine whether the condition was POA).

RTI’s findings with respect to HACs reveal that only 3,038 of 216,764 discharges with a HAC-associated diagnosis as a secondary diagnosis ultimately resulted in MS-DRG reassignment.

This demonstrates that HACs may not occur as frequently or have as much impact as CMS originally anticipated when it proposed decreasing or withholding payments when conditions are POA and the only CC or MCC on the claim, says Robert S. Gold, MD. Gold is CEO of DCBA, Inc., in Atlanta. “The guidance was that these events were to have occurred frequently and have had high cost impact. Many of them didn’t fit either definition,” Gold says.

Regardless of this finding, CMS proposes to continue implementing its HAC payment policy for all of them, which is frustrating, he says.

However, the net savings of current HACs during the time period previously referenced is $16,442,185, or $5,456 per discharge. Falls and trauma (including fractures, dislocations, intracranial injuries, crushing injuries, burns, and shocks) yielded the highest net savings. That amount ($7,580,774 total or $5,136 per discharge) is for discharges that change MS-DRGs because of the HAC.

“It is our intention to continue to monitor trends associated with the frequency of these HACs and the estimated net payment impact through RTI’s program evaluation and possibly beyond,” CMS said in an April 19 press release.


**Potential code freeze**

Another topic of discussion focuses on a proposed partial or total freeze in the annual updates to ICD-9-CM, ICD-10-CM, and ICD-10-PCS codes. Comments CMS received over the past year range from those supporting a complete freeze for both coding systems to those recommending that both coding systems continue to undergo annual updates before ICD-10 implementation.

After reviewing these comments, CMS proposes the following plan:

- **The last regular annual update to ICD-9-CM and ICD-10 will occur October 1, 2011**
- **Limited code updates to ICD-9-CM and ICD-10 to capture new technologies and diseases will occur October 1, 2012, and October 1, 2013**
➤ Any other issues raised would be considered for implementation in ICD-10 on October 1, 2014—one year after its implementation

“The code freeze is premature. There are too many issues that need fixing before they put in a freeze. We have to fix ICD-9 before we go to ICD-10,” says Gold.

“I do think at some point the code sets should freeze to allow for implementation but in my opinion should not be this far in advance,” says McCall. “The updates to ICD-9-CM for 2011 and 2010 will likely have to be limited anyway because we truly are running out of space, which is one of the reasons we must convert to ICD-10.”

Read the entire discussion regarding the code freeze on pp. 229–236 of the display copy of the proposed rule.

ICD-9-CM code and MS-DRG changes

The proposed rule includes more than 60 new diagnosis codes and more than 50 new V codes. A number of the new codes fall within the 752 code series for congenital anomalies of genital organs. Nearly 20 of the new codes fall within the 999 code series for complications of medical care, not elsewhere classified. Among the new V codes, a significant number pertain to V13 (personal history of other diseases), V85 (body mass index), and new series V90 and V91. The proposed rule also includes 12 new procedure codes.

Proposed MS-DRG changes include:

➤ Deletion of MS-DRG 009 and creation of two new MS-DRGs: MS-DRG 014 (allogeneic bone marrow transplant) and MS-DRG 015 (autologous bone marrow transplant)

➤ Addition of MS-DRG 014, which would include cases reported with 41.02 (allogeneic bone marrow transplant with purging), 41.03 (allogeneic bone marrow transplant without purging), 41.05 (allogeneic hematopoietic stem cell transplant without purging), 41.06 (cord blood stem cell transplant), or 41.08 (allogeneic hematopoietic stem cell transplant)

➤ Addition of MS-DRG 015, which would include cases reported with 41.00 (bone marrow transplant, not otherwise specified), 41.01 (autologous bone marrow transplant without purging), 41.04 (autologous hematopoietic stem cell transplant without purging), 41.07 (autologous hematopoietic stem cell transplant with purging), or 41.09 (autologous bone marrow transplant with purging)

Access the proposed rule in the Federal Register under Special Filings at www.archives.gov/federal-register/public-inspection/index.html. Interested parties may submit comments electronically at www.regulations.gov (with file code CMS-1498-P) or by mail to U.S. Department of Health and Human Services, Attention: CMS-1498-P, P.O. Box 8011, Baltimore, MD 21244-1850. Comments must be received by 5 p.m. June 18. CMS will issue the final IPPS rule for FY 2011 no later than August 1.
CMS Open Door Forum update

FY 2011 IPPS proposed rule, three-day payment window are topics as 500 listeners join April call

CMS discussed several inpatient-related topics during its April 21 Hospital Open Door Forum (ODF). More than 500 listeners joined the call. A summary of topics discussed follows.

FY 2011 IPPS proposed rule

CMS published its fiscal year (FY) 2011 IPPS proposed rule April 19 (see p. 1 for an in-depth look at the proposed changes). During the ODF, several CMS representatives addressed the following new provisions of the rule:

➤ Patient transfers. A CMS representative said the agency proposes applying the Post Acute Care Transfer (PACT) policy to transfers from an acute care hospital to another acute care hospital even when the receiving hospital doesn’t participate with Medicare. The PACT policy also will apply to transfers from acute care hospitals to critical access hospitals. Read the complete discussion on pp. 480–484 of the display copy of the rule at www.federalregister.gov/OFRUpload/OFRData/2010-09163_PI.pdf.

➤ Disproportionate share hospital (DSH) adjustments. When hospitals treat a high percentage of low-income patients, they receive a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the DSH adjustment, yields a percentage increase in Medicare payments for qualifying hospitals.

A CMS representative said the agency proposes altering the way in which it determines the Supplemental Security Income (SSI) ratio. Changes include matching eligibility records for Medicare beneficiaries and SSI recipients and using more recent SSI eligibility information from Social Security Administration and a more updated version of MedPAR likely to include more claims data. Read the complete discussion on pp. 496–518 in the display copy of the rule.

➤ Healthcare reform. A CMS representative said the agency will issue a supplemental proposed rule and notice regarding how it will implement healthcare reform provisions in the recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively referred to as the Affordable Care Act). Read the complete discussion on pp. 47–48 in the display copy of the rule.

➤ Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). A CMS representative said the agency proposes changing its measures list and program requirements throughout FY 2012, FY 2013, and FY 2014.

For the FY 2012 payment determination, CMS proposes adding 10 claims-based measures to the RHQDAPU program measure set, including:

- Two Agency for Healthcare Research and Quality Patient Safety Indicators (PSI): PSI-11 (postoperative respiratory failure) and PSI-12 (postoperative pulmonary embolism or deep vein thrombosis)
- Eight hospital-acquired condition measures: foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcer stages III and IV, falls and trauma (including fracture, dislocation, intracranial injury, crushing injury, burn, and electronic shock), vascular catheter-associated infection, catheter-associated urinary tract infection, and manifestations of poor glycemic control.

Questions? Comments? Ideas?

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For the FY 2013 update, CMS proposes 35 new measures that hospitals must report in 2011. The agency proposes four new measures for FY 2014 that hospitals must report in 2012. A representative reiterated that inpatient Medicare payments for subsection D hospitals are reduced by two percentage points of the annual market basket update for failure to report the required quality data and meet program requirements. Read the complete discussion regarding the RHQDAPU on pp. 371–480 in the display copy of the rule.

**Three-day payment rule**

Yet again, CMS fielded several questions about the three-day payment rule during the Q&A portion of the ODF call.

One caller asked how hospitals should apply the rule to continuous care episodes (i.e., those in which the patient is admitted as an inpatient through the ED). A CMS representative said hospitals may not include unrelated non-diagnostic charges on the inpatient claim. They do, however, have the option of billing those charges separately.

Another caller asked CMS to explain the time frame for the rule. A representative said a patient becomes an inpatient when a physician writes an order for admission. The three-day payment rule applies to services provided on the day of admission and three calendar days before admission. The inpatient claim should include all diagnostic services. Include only non-diagnostic services with an exact ICD-9 code match.

A third caller expressed concern about the need to separate unrelated non-diagnostic services from other services on inpatient claims, particularly in continuous care scenarios. A CMS representative acknowledged the operational challenges and invited further dialogue and provider comments.

A fourth caller asked whether billing systems will generate a patient copayment when hospitals opt to separately bill unrelated non-diagnostic services. A CMS representative said a copayment would be generated and that the agency is consulting with its office of general counsel and the Office of Inspector General regarding whether hospitals may waive part or all of the copayment in these situations.

A fifth caller said he is unaware of any hospitals that actually bill separately for unrelated non-diagnostic services. He asked whether hospitals should revamp their billing systems and hire additional coders in response to the three-day rule clarification or whether they should wait until CMS alters its definition of “related.”

A CMS representative said changing the three-day payment rule would require rulemaking that includes a notice and comment period similar to the process in which the U.S. Department of Health and Human Services secretary developed the current definition of “related” and its application to the three-day payment rule. The representative said CMS would consider callers’ comments. In the interim, the only real requirement for hospitals is exclusion of unrelated non-diagnostic services from inpatient claims.

A sixth caller said certain contractors continue to hold providers accountable to an older reference in the Medicare Benefit Policy Manual, Chapter 3, Section 40.3, Subsection A. It states that when a beneficiary receives hospital outpatient services on the date immediately preceding hospital admission, outpatient hospital services are treated as inpatient services when the beneficiary has Part A coverage. A CMS representative said the three-day payment rule replaced this provision and that contractors should not reference it.

For more information about complying with the three-day payment rule, see the article on p. 6.

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**Clarification**

The article about auditing POA indicators on pp. 1–3 of the March Briefings on Coding Compliance Strategies states that acute renal failure and acute kidney injury are present when there is an abrupt rise of serum creatinine (more than 0.3 mg/dl). Note that this criterion applies after a patient has been adequately resuscitated with fluids. Learn more at http://ccforum.com/content/11/2/R31.
Five tips to ensure compliance with three-day payment rule

If you’ve listened to recent CMS Hospital Open Door Forum calls, you know that the three-day payment rule has caused quite a stir among hospitals. Consider the following five tips to ensure compliance:

1. **Know the rule.** The three-day payment rule states that all diagnostic services provided the day of an inpatient admission or three calendar days immediately preceding the admission are bundled and paid as part of the inpatient stay. However, non-diagnostic preadmission services are bundled only if they are related to the inpatient stay. CMS defines the term “related” as an exact match of all digits between the ICD-9 principal diagnosis code on the inpatient claim and the first-listed diagnosis code on the outpatient claim—regardless of whether the outpatient services led to the inpatient admission.

When non-diagnostic services aren’t related, hospitals have the option of separately billing them to Part B if the patient has Part B coverage. However, they must create a separate account to do so.

Splitting of charges could be an operational nightmare, says Debbie Mackaman, RHIA, CHCO, instructor for HCPro’s Medicare Boot Camp—Hospital Version and Critical Access Hospital Version. However, CMS is clear that regardless of whether hospitals decide to separately bill for unrelated non-diagnostic services, they absolutely cannot include those charges on the inpatient claim, Mackaman says.

2. **Strive for better documentation.** Because CMS defines related services as those that have an exact ICD-9 match, ensuring detailed documentation that would yield and support diagnosis codes with the highest specificity possible is of utmost importance, says Dinh Nguyen, CHC. Nguyen is the principal consultant at Healthcare Compliance Solutions, LLC, in Pasadena, CA. The same is true with respect to documentation in outpatient clinics or ambulatory care centers where patients receive services and treatment before admission.

3. **Open the lines of communication.** Some billing and scheduling systems include an edit that flags accounts for patients seen in the outpatient setting and then admitted to the hospital within three days, says Nguyen. If a hospital’s system doesn’t have this functionality, inpatient and outpatient coders must devise a way to communicate and ensure compliance that follows the facility’s protocol, he says.

4. **Enlist the aid of clinical documentation improvement (CDI) specialists.** CDI specialists can conduct concurrent reviews and determine whether admissions truly are related to ED visits. “When it’s clear that the outpatient visit is going to be very different from the inpatient admission, coders can code and drop the outpatient claims immediately,” says Mackaman.

CDI specialists can help improve ED documentation to ensure that physicians document a final diagnosis (when known) rather than a sign or symptom, says Nguyen.

5. **Think like a RAC auditor.** HealthDataInsights, Inc., already has added the three-day payment rule to its list of approved issues, and other RACs are likely to follow suit, says Mackaman. RACs generally will be looking for an exact ICD-9 match and will want to know whether services were rendered within three days of admission, she says. Prepare for RAC audits by data-mining Medicare paid claims from October 1, 2007, going forward. Identify scenarios in which patients were admitted to the hospital from the ED, observation, or operating room. Then ask the following questions:

- Did the outpatient service occur within three calendar days before the inpatient admission?
- If yes, were the services diagnostic or non-diagnostic? Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.3B, for more information. Visit www3.cms.gov/manuals/downloads/clm104c03.pdf and refer to p. 122.
- If services were non-diagnostic, were they related to the admission (i.e., was there an exact ICD-9 match)? If not, remove those charges from the inpatient claim and consider billing separately on an outpatient claim.
RAC corner

Don’t let improper discharge disposition codes fly under the radar at your facility

Monitor application of PACT policy to ensure compliance

Editor’s note: “RAC corner” is an ongoing series that explores coding and documentation compliance tips pertaining to several MS-DRGs and issues slated for RAC validation audits.

You may think the discharge disposition codes you assign are correct, but discharge plans often change after patients leave the hospital. Discharge codes should reflect those changes, particularly when compliance ramifications—and dollars—are at stake.

Hospitals could inadvertently leave money on the table when cases fall into MS-DRGs subject to the Post Acute Care Transfer (PACT) policy, says William E. Haik, MD, director of DRG Review, Inc., in Fort Walton Beach, FL. The PACT policy reduces hospital payments to a per diem rather than a full DRG amount when patients are discharged to certain postacute care settings. (See p. 9 for more information about the PACT policy.)

Many hospitals don’t follow up with patients post-discharge and simply assume the per diem payment is correct, says Haik. The countless retrospective audits he performs often reveal significant underpayments due to incorrect assignments of discharge disposition codes that trigger the PACT policy. “There’s a myriad of pitfalls where the hospital can be adversely affected financially with this payment methodology,” he says.

RACs already are taking a closer look at patient discharge status. For example, CGI Federal (the RAC for Region B) is auditing hospital-to-hospital transfers to identify MS-DRG inpatient claims improperly reported as a discharge to home instead of a transfer to another hospital. When patients are discharged home, transferring hospitals receive a full DRG payment they might not actually deserve.

HealthDataInsights (the RAC for Region D) is auditing incorrect patient status in the inpatient rehabilitation facility setting. Its intent is determining the validity of discharge status codes when patients are transferred to another facility.

RACs aren’t alone in looking for overpayments. CMS has implemented billing edits through its Common Working File—a major repository for Medicare admissions, discharges, and transfers—to identify overpayments as well. Ironically, no edits identify underpayments, underscoring the need for hospitals to monitor and retrospectively audit discharge disposition codes, says Haik.

Many hospitals are unaware of condition codes they can report, when appropriate, to circumvent the PACT policy and receive a full MS-DRG payment, says Debbie Mackaman, RHIA, CHCO. Mackaman is an instructor for HCPro’s Medicare Boot Camp®—Hospital Version.

Consider the following scenario:

➤ A patient with pneumonia and acute respiratory failure (MS-DRG 193) is discharged home after four days with instructions to follow up with a home healthcare agency regarding care for pneumonia within the next three days

➤ A coder or biller assigns discharge disposition code 06 to denote a patient was discharged or transferred to home under care of organized home health services in anticipation of covered skilled care to begin within three days of discharge

➤ A hospital receives a per diem DRG payment based on the PACT policy because the transfer occurred before the geometric length of stay for this DRG (i.e., 5.3 days)

However, what happens when a patient postpones home healthcare so that services are rendered after three days have passed?

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When this occurs, coders and billers should report discharge disposition code 06 and condition code 43, which denotes discharge with home care services that don’t begin until after the third day post-discharge. This allows transferring hospitals to receive a full DRG payment.

Another question concerns what coders and billers should do when home healthcare is unrelated to the reason for the inpatient stay. For example, if a patient with a urinary tract infection (UTI) is discharged to home healthcare for resumption of care for a decubitus ulcer (and not the UTI), coders and billers can report condition code 42, says Haik.

This condition code indicates the home health treatment plan is unrelated to any conditions or services addressed during the inpatient stay. Conditions treated during the hospital stay include those for which a patient was admitted, as well as any new conditions that developed during the stay, says Haik.

Many hospitals don’t report condition codes 42 and 43, says Mackaman. Instead, they simply assign discharge disposition code 01 (discharge to home) when patients don’t meet the criteria for 06. This practice is noncompliant and could subject hospitals to Office of Inspector General reviews and RAC audits, she says.

Coders and billers should audit claims retrospectively to ensure correct discharge disposition status codes based on the setting to which a patient ultimately went—not necessarily the setting the physician may have ordered, says Mackaman. “Just because the physician ordered something doesn’t mean that it actually occurred,” she says. “Sometimes you have to dig into nursing notes, social work notes, or case management notes.”

The audit process can be laborious, but it’s well worth it in the end, Haik says. A recent audit revealed $400,000 in missed reimbursement over the course of 16 months. The culprit? Incorrect discharge disposition codes that inadvertently triggered the PACT policy.

During retrospective reviews, coders and billers should:

➤ Generate a report of all cases with discharge status codes that trigger the PACT policy. (See “Post Acute Care Transfer policy” on p. 9 for more information.) Compare the hospital length of stay (LOS) for each transfer with the geometric mean length of stay (GMLOS) for the specific DRG. When the hospital LOS is less than the GMLOS, follow up with the facility to which the patient supposedly was transferred. This task typically is assigned to a case management staff member who calls the postacute care facilities directly, says Haik.

Coders also sometimes perform this task, Mackaman says. Calling postacute care facilities is often an onerous process, particularly when the name of the specific facility isn’t documented. In urban areas with numerous home health agencies, for example, determining which one actually provided services is much more difficult, she says.

Focusing on high-volume or high-dollar MS-DRGs is another approach. Determine whether any of these DRGs are subject to the PACT policy and whether any related claims include discharge status codes 06. Then audit for compliance and to determine whether condition codes 42 or 43 would have been applicable, says Mackaman.

Reviewing discharge dispositions generally should be part of larger audits that look at documentation, coding, and other aspects of the chart, she adds.

➤ Open the lines of communication with education. If coders understand the PACT policy, they can educate discharge planners regarding the importance of documentation of patient discharge status, says Mackaman.

➤ Be inquisitive. Ask questions during retrospective audits. Determine whether documentation supports assignment of the specific discharge disposition code. If it doesn’t, additional coder or discharge planner education may be necessary.
When a discharge disposition code triggers the PACT policy, call the postacute care facility and ask:
- Did the patient go to that postacute care setting, or did the patient refuse care entirely?
- If the patient received home healthcare, on which day did the services begin? Was it within three days of discharge? Was the home health service related to the reason for hospitalization?
- If the patient received skilled nursing care, was it actually skilled care, or was it custodial care, intermediate care, or hospice care? Only skilled care is subject to the PACT policy, says Haik.

### Post Acute Care Transfer policy 101

Coders may know about the Post Acute Care Transfer (PACT) policy, but many don’t understand its implications for hospital reimbursement, says Debbie Mackaman, RHIA, CHCO, Mackaman is an instructor for HCPro’s Medicare Boot Camp—Hospital Version. “Coders tend to know only that they must assign a discharge code and that it has to be as accurate as possible,” Mackaman says. The following are four FAQs about the PACT policy:

➤ **What is the PACT policy?** It’s a policy that reduces payment to a per diem rate when patients are transferred to one of the following postacute care settings:
- A non-IPPS hospital or a distinct non-IPPS unit (i.e., a hospital other than a short-term acute care hospital, including inpatient rehabilitation facilities and units): discharge disposition code 62
- Long-term care hospitals: discharge disposition code 63
- Psychiatric hospitals and units: discharge disposition code 65
- Children’s and cancer hospitals: discharge disposition code 05
- Medicare skilled nursing facility or skilled nursing facility unit within a hospital (excluding swing beds): discharge disposition code 03
- Home healthcare beginning within three days of discharge: discharge disposition 06

The PACT policy is triggered only for certain qualifying DRGs. Access a complete list in Table 5 of the fiscal year (FY) 2010 IPPS final rule at [http://tinyurl.com/2crlydk](http://tinyurl.com/2crlydk).

➤ **What happens when the PACT policy is triggered?** Generally, discharges considered transfers are paid as follows:
- The first day of the admission is paid at twice the per diem rate because of the extra expenses incurred that day
- All subsequent days are paid at the per diem, up to the full DRG amount

➤ **What are “special pay” transfer DRGs?** Special payment rules apply to some qualifying DRGs. The special payment rules apply only to postacute transfers and not other discharges treated as transfers. For special pay transfer DRGs, transferring hospitals receive 50% of the full DRG payment plus a single per diem for the first day. Hospitals receive 50% of the calculated per diem for each subsequent day up to the full DRG payment.

➤ **How does it work?** Consider the following example that illustrates DRG payment for a discharge paid as a transfer for a DRG that pays $10,000 with a GMLOS of five days *(Note: The per diem is $10,000 divided by five, or $2,000)*:
- Regular transfer DRG payment would be $4,000 for day one (per diem rate times two) and $2,000 per day for days two through four. After day four, the transferring hospital would receive $0 because the DRG was already paid in full ($4,000 + $2,000 x three = $10,000).
- Special pay transfer DRG payment would be $7,000 for day one (50% of the DRG plus one per diem) and $1,000 per day (50% of the per diem) for days through four. After day four, the transferring hospital would receive $0 because the DRG was already paid in full ($7,000 + $1,000 x three = $10,000).

Include clinical details when posing queries about congestive heart failure

Querying when physician documentation seems sparse may be tempting. However, coders and clinical documentation improvement (CDI) specialists should only initiate a query when clinical evidence in the medical record supports doing so.

Queries should always include clinical details as well because they help provide a context for physicians to understand the purpose of the queries, counsels Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS, a consultant in Orlando, FL.

The AHIMA query practice brief, Managing an Effective Query Process, also encourages coders to query using clinical information gleaned from the record. The practice brief states:

*It is recommended that queries be written with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case.*

Congestive heart failure (CHF) is one example of a condition for which coders and CDI specialists should understand clinical indicators before querying physicians, says Lynne Spryszak, RN, CCDS, CPC-A, a CDI educator at HCPro, Inc., in Marblehead, MA.

Be on the lookout for these specific clinical clues to provide clinical support for a CHF query, says Spryszak:

▸ An echocardiogram that shows an ejection fraction (EF) of less than 50%, which is indicative of systolic heart failure, or an EF of greater than 50%, which generally indicates diastolic heart failure.

▸ An echocardiogram that shows ventricular hypertrophy, an indicator of chronic heart failure. Look for evidence of decreasing EF and usage of home heart failure medications.

▸ Increasing doses of diuretics (e.g., physician order of “Lasix 40 IVP now” or “Increase Lasix to BID”). These orders may indicate treatment of an acute or acute-on-chronic episode of heart failure.

▸ Physician orders that reference cardiology consults, an echocardiogram, or a heart failure standing order set.

▸ Other indicators, such as a CHF teaching form, CORE measures documentation form, or a nursing assessment that includes jugular venous distension, moist breath sounds, shortness of breath, or labored breathing.

In general, consider the following tips when using clinical criteria to support a query:

▸ Include the date and time of the test along with the normal (or abnormal) findings.

▸ Ensure that the clinical information is logical and that it supports the question. Don’t query when the data do not support the definition of a certain condition, says Brown.

▸ Identify the location, date, and provider that pertain to documentation that needs clarification or validation.

▸ Reference appropriate clinical definitions or resources (e.g., RIFLE criteria for renal failure).

▸ Reference pertinent clinical findings, such as lab values, medications, or treatment descriptions of the patient’s condition, pertinent medications, pertinent abnormal test results, or normal test results that contradict documentation of an abnormality.

Editor’s note: Content in this article was originally presented during HCPro’s audio conference “Physician Queries Workshop: Tools and Techniques for Compliant, Effective Clarification.” During the presentation, Spryszak and Brown discussed querying tips for several other problematic conditions, including renal failure, sepsis, and encephalopathy. For more information, visit http://tiny.cc/x6dy9.
Understand causes of anemia in cancer patients before reporting 285.22

by Robert S. Gold, MD

Name as many reasons why a cancer patient may develop anemia as you can. Is anemia in neoplastic disease (285.22) the first cause that comes to mind? If so, think again because it’s probably the least likely reason.

Strictly speaking, 285.22 is supposed to represent anemia that occurs when cancer affecting the bone marrow through some sort of immune type of mechanism causes a reaction that leads to a reduction in the release of erythropoietin. It’s comparable to the effect of systemic inflammatory response syndrome (SIRS) in which the body produces cytokines or mediator chemicals as a reaction to the cancer. These chemicals stop the production of red cells. When this occurs, coders should report a code from the 285.2x series (anemia of chronic disease). In this case, the chronic disease is the cancer, and it justifies the assignment of 285.22.

Certain types of cancer

Anemia also can occur in patients with leukemia, lymphoma, or myeloma because there is a cancer of the bone marrow. When patients have anemia with one of these three conditions, coders should report the specific underlying condition that causes the anemia (i.e., the leukemia, lymphoma, or myeloma).

When the blood cells require more specific treatment (e.g., when there is bleeding from the bladder, gastrointestinal tract, or gums due to a lack of platelets), coders should assign individual codes for the condition(s) that require the more specific treatment. For example, coders may need to assign a code for thrombocytopenia (low platelets) and one for the anemia of chronic blood loss (280.0). A patient may receive platelet packs and packed red cells to treat both conditions.

Several other types of cancer can cause anemia when the cancer invades the bone marrow. Examples include cancer of the breast, prostate, kidney, lung, adrenal, or thyroid. When the cancer destroys bone marrow cells, this is truly myelophthisis (284.2). In addition to these cancers taking over the bone marrow, fungal elements can replace the cells in the bone marrow that are supposed to make new red cells. As a result, anemia is normochromic (i.e., the normal color of each red cell) and normocytic (i.e., the normal size of each red cell). When fibrous tissue—rather than cancers or fungi—replace the bone marrow, the resulting condition is termed “myelofibrosis.” This is also a normochromic, normocytic anemia.

It is important to recognize that conditions in which bone marrow is replaced by another tissue actually lead to a reduction of the formation of the red cell line, white cells, and platelets. When all three cell lines decrease in number, the condition is termed “pancytopenia.” Myelophthisis and myelofibrosis lead to pancytopenia rather than anemia alone. Myelophthisis falls within the 284 code category labeled “aplastic anemia and other bone marrow failure syndromes,” which refers to a lack of the production of all three cell lines. Also, ICD-9-CM categorizes anemias caused by broadly delivered radiotherapy—a standard treatment for Hodgkin’s disease—as pancytopenia due to radiation therapy (284.89).

Antineoplastic (chemotherapeutic) drugs

Administration of specific antineoplastic (chemotherapeutic) drugs also can cause anemia. More commonly, though, all three cell lines (i.e., red cells, white cells, and platelets) are affected by most chemotherapeutic agents. When a chemotherapeutic agent affects all three cell lines, this is referred to as pancytopenia due to drugs (284.89). However, when only the red cells are affected, coders should assign 285.3 (antineoplastic chemotherapy-induced anemia).

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Clinically speaking  
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More anemias in cancer

Occasionally, anemia and its symptoms lead to the finding of a cancer. This commonly occurs with patients who have colon cancer. Gastroenterologists know that newfound iron deficiency anemia in older patients is right colon cancer until proven otherwise. Why? Loss of red cells from the body to the outside through chronic, low-grade blood loss results in loss of a person’s iron stores. The result is microcytic (i.e., smaller than normal red cells), hypochromic (i.e., paler than normal) anemia.

Why the right colon? Because left colon cancers in which the diameter of the left colon is approximately 1–1.5 inches across usually obstruct as they grow larger. With right colon cancers, the diameter of the colon is approximately 2.5–3 inches in diameter. This type of cancer can grow to very large sizes before there are any obstructive symptoms.

When these patients have iron deficiency anemia from the long-term loss of blood, coders should report 280.0 (iron deficiency anemias due to chronic blood loss). This also can occur in patients who have bladder, uterine, and liver cancers.

Patients who have one of the following conditions also can develop anemia of acute blood loss that is totally unrelated to the cancer (285.1):

➤ Ulcer disease
➤ Mallory Weiss syndrome
➤ Hemorrhage from an angiodysplasia, auto accident, or ruptured abdominal aortic aneurysm

Some cancers lead to bleeding diathesis from platelet deficiency that can be caused by the cancer. Some cancers can cause spontaneous rupture of the liver. Sequestration of blood in the spleen can also occur (289.52). All of these may lead to anemias of acute blood loss (285.1).

A patient with cancer can have progressive renal disease regardless of whether it’s related to or caused by the cancer or totally unrelated to it. Patients may develop anemia of chronic kidney disease or have had it prior to identification of the cancer. Either way, coders should report 285.21.

An individual who has cancer may have a congenital or deficiency anemia, such as:

➤ Sickle-cell anemia, 282.6x
➤ Mediterranean anemia, 282.4x
➤ Glucose-6-phosphatase dehydrogenase deficiency (G-6-PD), 282.2
➤ Iron deficiency anemia, unspecified, 280.9
➤ Vitamin B-12 deficiency, 281.1

Furthermore, a cancer patient may develop anemia due to acquired nutritional deficiencies caused by problems with or without absorption from the gastrointestinal tract. The protein deficiency that might occur can lead to anemia of protein deficiency (281.4). Specific other dietary and nutritional deficiencies can also lead to anemia (281.8). When the deficiency causing a patient’s anemia is unknown, report 281.9.

Nothing says a cancer patient can’t have anemia totally unrelated to the cancer. Actually, the anemia is probably unrelated to the cancer more frequently.

Pregnancy

Another classification of anemia that can occur in a patient who has cancer is anemia of pregnancy (648.2x). I disagree with advice regarding assignment of this code when it doesn’t occur until after delivery. However, in cancer patients, the anemia may be related to the patient’s cancer or its treatment. In this case, report 648.2x as well as the specific code for the anemia. Also report any additional codes for the adverse outcome of the pregnancy, the delivery, or the status of the infant.

Editor’s note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician clinical documentation improvement programs. Contact him at 770/216-9691 or DCBAInc@cs.com.
We want your coding and compliance questions!
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Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Be sure to review all documentation specific to your individual scenario before determining appropriate code assignment.

When patients experience chronic leg or back pain, should we simply code this as leg or back pain, or should we also code chronic pain as secondary?


Codes from category 338 may be used in conjunction with codes that identify the site of pain (including codes from chapter 16) if the category 338 provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

The ICD-9-CM guidelines also state that the sequencing of these codes depends on the circumstances of the encounter or admission.

For example, when the encounter is for pain control, sequence 338.29 (other chronic pain) followed by the ICD-9-CM code to identify the site of pain. In the previous scenario, it would be 729.5 (pain in limb).

When the encounter is for a reason other than pain control—and the provider has not documented a related, definitive diagnosis—assign the code for the specific site of pain first, followed by the appropriate code from category 338, as per the ICD-9-CM guidelines.

Paula Archer, RHIA, managing consultant at BKD, LLP, in Little Rock, AR, answered the previous question.

My question pertains to inpatient admissions during which the conditions are resolved at the time of discharge. On the discharge summary, the physician may document a diagnosis such as gastroenteritis, resolved. However, the admission treatment is directed toward alleviating the signs and symptoms. Should I code the signs and symptoms, or should I code gastroenteritis?

Don’t code the signs and symptoms, as they are due to the gastroenteritis, resolved.

The ICD-9-CM Official Guidelines for Coding and Reporting, Section II, Selection of Principal Diagnosis, (A) Codes for symptoms, signs, and ill-defined conditions, state:

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

In this particular case, the definitive diagnosis is gastroenteritis, resolved. Another example is a patient who presents with chest pain. Upon discharge, a physician documents that the definitive diagnosis is an acute anterolateral myocardial infarction, resolved. The principal diagnosis is the acute myocardial infarction.

When there is no definitive diagnosis, sequence the signs and symptoms as principal.

A patient is admitted due to intractable pain from a compression fracture sustained the day before...
admission. ICD-9 guidelines state that when pain is not documented as acute or chronic, coders may not assign codes from the 338 category.

Should coders query physicians to determine whether the pain is acute or chronic rather than report the fracture as the principal diagnosis, particularly when documentation indicates that pain control is the primary reason for admission?

Because the physician didn’t document acute or chronic, a query regarding the severity of the intractable pain is appropriate.

The ICD-9-CM Official Guidelines for Coding and Reporting, Chapter 6, Diseases of Nervous System and Sense Organs (320-389), (A) Category 338 Codes as Principal or First-Listed Diagnosis, state:

Category 338 codes are acceptable as principal diagnosis or the first-listed code: When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

Therefore, report a code from category 338 (pain, not elsewhere classified) as principal, followed by a code for the additional diagnosis of compression fracture.

Sandra Sillman, RHIT, PAHM, DRG coordinator at Henry Ford Health System in Detroit, answered the previous two questions.

A patient presents to the ED complaining of abdominal pain, and a physician diagnoses the problem as a kidney stone. The patient returns to the ED two days later with persistent symptoms of abdominal pain. Before discharge, the patient tells the physician that he had been snowboarding before the symptoms began. The physician then diagnoses an abdominal sprain. Should I code the abdominal sprain or only abdominal pain?

The physician diagnosed an abdominal sprain. Therefore, the law requires that you code the abdominal sprain. Based on this limited information, I recommend reporting code 848.8 (Other specified sites of sprains and strains) plus an E code to report the cause (snowboarding) if the physician has documented this.

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA, of Safian Communications Services in Orlando, FL, answered the previous question.

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