Inpatient-only procedures: Ensure compliance, avoid RAC recoupments

Inpatient coders may lack familiarity with the inpatient-only procedure list because CMS publishes it annually in the OPPS final rule. Nonetheless, they should review this list of CPT® codes and know its implications.

Inpatient-only procedures are those for which CMS has determined patients require at least 24 hours of postoperative care due to the invasive nature of the procedure or the underlying condition. The list clearly distinguishes these procedures from those that may be performed in the outpatient setting, says Deborah K. Hale, CCS, CCDS, president and CEO of Administrative Consultant Service, LLC, in Oklahoma City.

A controversial and confusing topic

CMS’ maintenance of the inpatient-only list has been somewhat contentious since its implementation commensurate with the OPPS in 2000. Surgical societies, in particular, have lashed out against CMS because they feel that retaining certain procedures on the list—thereby requiring physicians to perform them on an inpatient basis—“slows down the progress of medicine,” says Hale.

Hospitals lament the list because they must ensure that physicians write orders to admit patients prior to performance of inpatient-only surgical procedures. Some procedures on the list are also somewhat counterintuitive; some physicians and others view them as procedures that can be performed on an outpatient basis.

RACs have only complicated matters.

Karen Bowden, RHIA, senior vice president of consulting at Craneware Insight, a subsidiary of Craneware in Atlanta, describes what happened during the RAC demonstration project in Massachusetts. DCS Healthcare Services, Region A RAC, denied many Massachusetts cases. It said that procedures performed were not on the Medicare inpatient-only list and that these cases could not be billed as inpatient.

Many cases were appealed to an administrative law judge; in some instances it took as long as two years to overturn them in the hospitals’ favor, says Bowden. The judges were consistently clear that if procedures were not on the inpatient-only list, hospitals were not precluded from billing them as inpatient procedures. In the interim, Medicare retained as much as $4 million from one hospital.

“The inpatient-only procedure list is a list of procedures that can only be safely done in an inpatient setting,” says Bowden. “It doesn’t mean that other procedures can’t be inpatient, but that’s how the RAC interpreted it.”
Inpatient-only procedures < continued from p. 1

Despite this controversy, however, CMS has said that its creation and continued maintenance of the inpatient-only list is ultimately intended to protect beneficiaries, says Hale. “When you [perform] a complex procedure that requires more than 24 hours of hospital care in the outpatient setting, the patient usually owes more in terms of coinsurance and self-administered drugs than they would have had they been admitted as an inpatient,” she explains.

The role and coding requirements

Regardless of the continuing debate, coders should understand the rule and its operational requirements. Generally, if a physician performs a procedure on the inpatient-only list on an outpatient basis—and the procedure appears on a hospital outpatient claim—the Outpatient Code Editor denies the APC payment for the surgical procedure. When a hospital anticipates a denial, it should file the surgical procedure code as non-covered, says Hale. CMS provides guidance for doing so in the Medicare Claims Processing Manual, Chapter 1, Section 60.1.3.1 (www.cms.gov/manuals/downloads/clm104c01.pdf).

Emergent procedures add yet another layer of compliance complexity. Patients sometimes expire during an emergent inpatient-only procedure before the provider has an opportunity to admit them. Coders, typically those reporting outpatient services, should append modifier -CA (patient expired without inpatient order) to the inpatient-only procedure code on an outpatient bill type, says Hale. When reporting modifier -CA, the UB-04 form also should include patient discharge status code 20 to indicate that the patient expired. This scenario entitles the hospital to APC 375, which has a national unadjusted payment rate of $6,372.10.

When patients survive emergency procedures on the inpatient-only list, hospitals should admit them after the procedure and before transferring them to a higher level of care. In this case, the facility that provided the inpatient-only procedure and stabilized the patient will receive a transfer/per diem DRG payment.

Most hospitals use claim scrubbers to help outpatient coders catch outpatient claims that include inpatient-only procedure codes before they are submitted for payment, says Hale. These procedures have status indicator C, which means they are not payable in the outpatient setting. Conversely, surgeons may bill CPT codes on the inpatient-only list for their professional services and receive payment even though the procedures were performed in the outpatient setting.

The role of inpatient coders

So how does all of this affect inpatient coders, you might wonder?
When inpatient coders review records—particularly those that include procedures on the inpatient-only list—they must ensure that inpatient orders are dated, timed, and signed before the inpatient-only procedure occurs, says Hale. A written physician order for inpatient admission preceding the inpatient-only procedure satisfies requirements in the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2K (www.cms.gov/manuals/downloads/clm104c03.pdf). It also drives inpatient coders’ determination of the principal diagnosis.

“The very concept and definition of a principal diagnosis is based on the circumstance of the date and time of the admission order,” says Hale. “Reviewing the admit order and its timing is critical to compliance with official coding guidelines.”

However, despite this clear-cut guidance, hospitals frequently lack an admission order prior to performance of inpatient-only procedures, says Hale. “I think people would be shocked if they knew just how many times an inpatient claim for an inpatient-only procedure had the order written after the procedure. I see it coast to coast,” she adds.

Although some inpatient-only procedures are emergent, many patients are electively scheduled for these procedures, says Bowden. This underscores that hospitals have sufficient time to obtain an order for admission, she says. For non-Medicare payers, hospitals must also obtain pre-authorization before performing inpatient-only procedures.

“How hospitals need to look at this operationally all the way back to when these procedures are booked in the [operating room],” says Bowden. The list of inpatient-only procedure codes should be embedded in the operating room scheduling system so that the system prevents schedulers from booking any of these procedures on an outpatient basis, she says. If hospitals can’t embed these codes, schedulers must manually check the inpatient-only list before booking procedures, says Bowden.

If an inpatient order for admission is lacking or is not dated and timed before the inpatient-only procedure, inpatient coders may not bill a surgical procedure code. Absent an order, CMS considers these procedures outpatient. Coders may only bill a medical DRG for the recovery using the reason for outpatient surgery as the principal diagnosis for admission. The ICD-9-CM Official Guidelines for Coding and Reporting, Section II (selection of principal diagnosis), Subsection J (admission from outpatient surgery) states:

When a patient receives surgery in the hospital’s outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication or other condition is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

One caveat: When an outpatient procedure is converted midway to an inpatient or inpatient-only procedure, the physician can write the order immediately after the procedure. Inpatient coders can use the order to justify reporting the surgical procedure on the inpatient claim, says Bowden.

How inpatient coders can help

The simplest thing inpatient coders can do to help ensure compliance is to make sure everyone—including operating room schedulers, physicians, other coders, and case managers—has the most up-to-date inpatient-only procedure list. This ensures that everyone is on the same page and working with the same information, says Bowden.

Next, inpatient coders can work with case managers to help review the operating room schedule two or three days beforehand to identify any inpatient procedures—including those on the inpatient-only list.

> continued on p. 4
Inpatient-only procedures < continued from p. 3

Coders and case managers together can verify whether the hospital has obtained admission orders or pre-authorization, says Bowden.

When inpatient coders notice trends in orders that aren’t timed, dated, or signed before the inpatient-only procedure is performed, they should relay this information to case management and administration, says Hale. “The inpatient coder is the alarm. He or she can bring this to the attention of the compliance department and get people on board to fix the problem,” she says.

Addressing the problem now can only help in preparing for the future, including future RAC audits. In particular, RACs are auditing for the presence of an admission order to justify inpatient services, says Hale. “If the case management department is not aware that this precludes the coder from coding and billing the surgical procedure, they need to be made aware,” she says.

Editor’s note: CMS publishes the inpatient-only list in Addendum E of the OPPS final rule. Access the list in Addendum B of the rule by identifying procedures with status indicator C. Addendum B is available online only at www.cms.gov/HospitalOutpatientPPS. Select “Addendum A and Addendum B updates.”

Consider remote coding to attract top-notch professionals

Jean Stone, RHIT, CCS, has never met some of the coders who report directly to her. That’s right—she has never met them in person.

Stone has, however, spoken with them by telephone, and in some cases, she has seen their wedding or other personal photographs. This is because nearly all members of her department work remotely.

“There are parts of [a remote program] that are hard for me as a boss. I miss having people there, quite frankly,” says Stone, coding manager-HIMS at Lucile Packard Children’s Hospital at Stanford, a 311-bed facility in Palo Alto, CA. Yet the benefits of such a program seem to far outweigh any feelings of loss or strangeness about working in a virtual environment, she adds.

Remote coding departments are a far cry from the old days when coders worked on-site, often in adjacent cubicles, interacting with one another—and physicians—face-to-face.

Does the configuration (or lack thereof) in Stone’s department sound a bit futuristic? Perhaps, but hospitals are increasingly considering remote coding options to reduce costs and attract the best and brightest coders. in today’s tough economy, remote coding may be a solution that addresses increasing demands, staffing shortages, and other concerns.

A creative solution to a vexing problem

Lucile Packard decided to implement a remote coding program shortly before Stone began working there in July 2008. At the time, the hospital was experiencing coder shortages and advertised several open coding positions. It sought applicants with the CCS certification and at least two years of hospital coding experience.

In particular, the hospital wanted professionals with experience coding pediatric cases, especially cases involving long lengths of stay (e.g., preterm infants, congenital heart disease, and transplants). Candidates had certification or experience, but not both, Stone recalls, based on her understanding of events preceding the decision to establish a remote coding program and broaden the search.

The good news? Contract coders retained by the hospital to fill staffing gaps had both the relevant certification and experience. The bad news? “None of them lived close enough to our facility to make it worthwhile for them to work here,” says Stone. The remote
coding program evolved primarily because of the hospital’s desire to hire these coders considered the “cream of the crop,” she explains.

A full-time, work-at-home position was appealing, says Jason Lawrence, CCS, one of the contract coders hired for a remote position. He liked the stability and the lack of a commute. Before receiving an offer for a full-time position, Lawrence was working six-day shifts and commuting by air to Lucile Packard from his Southern California residence nearly 400 miles away. Working as a remote coder has been a refreshing change, he says.

Today, four full-time inpatient coders—three of whom were originally contract coders—work from home. One assistant auditor who performs inpatient coding and two outpatient coders also work from home.

Coders have been elated about working remotely, says Stone. “Our facility is very committed to employee retention. I think that people really appreciate being able to work from home and that they are well compensated,” she adds.

Work out the details

As with any new initiative, crossing every “t” and dotting every “i” before implementation is essential. Remote coding requires hospitals to address many details.

Consider the following questions when establishing a remote coding program:

➤ Can your facility provide secure remote access?

The privacy and security of information is a primary area of concern for remote coding programs. Lucile Packard’s remote coders use a VPN (virtual private network) for secure access. They also sign a telecommuting policy, a portion of which addresses privacy and security. They all must prepare individual narrative statements describing how they will personally ensure the privacy and security of printed and electronic information. This includes articulating details about their private work space, confirming that they own a paper shredder, and any other relevant information. “There’s a certain element of trust. They know they could lose their jobs if there’s any breach of information,” adds Stone.

➤ Will your facility provide computer equipment and other hardware? Lucile Packard provides its remote coders equipment and hardware (e.g., monitor, computer, keyboard, and surge protector). The hospital also provides coding manuals and coding software, but it doesn’t pay for Internet access.

➤ How will coders handle queries? With an EMR, coders can easily submit queries electronically and even e-mail physicians directly to remind them of outstanding queries. However, simply submitting a query doesn’t always ensure a good response rate. Lucile Packard’s query completion process is part of the chart completion process; physicians face suspension for failure to respond to queries.

➤ Will coders have a set schedule? Lucile Packard’s coders work according to a previously agreed-upon set schedule that varies according to each coder’s preference. However, coders must be accessible during a specific time period for meetings and if needed for various tasks.

➤ Will there be geographic limitations? Lucile Packard requires its remote coders to live in California because of insurance and tax requirements. However, it doesn’t have a specific geographic radius requirement within the state. Remote coding programs can extend beyond state borders, but HR staff must address any implications related to taxes, insurance, or other benefits.

Establish and monitor productivity standards

Keeping tabs on remote coders’ productivity is essential and helps ensure that the department runs efficiently. Lucile Packard’s coding productivity standards and compensation are based on length of stay (LOS) as follows:

➤ LOS seven days or less (including same-day surgeries and observation cases): 5 charts per hour
➤ LOS greater than eight days: 1.3 charts per hour

> continued on p. 6
Remote coding
< continued from p. 5

One coder is assigned daily to cases in which LOS exceeds eight days. This assignment flows through the department on a rotating basis so that each coder works on these cases once every three to four weeks. Remote coders receive hourly compensation based on these productivity standards.

Coders' responsibilities include minimal abstracting, says Stone. Two full-time abstractors perform the majority of the task. The coders abstract the main procedure episode details (e.g., episode number, principal surgeon or anesthetist, and type of anesthesia), and they also designate the attending physician for prolonged LOS.

Separating this process allows coders to focus more on higher coding volume, says Stone. Also, although coding requires specialized knowledge, abstracting requires a different type of knowledge, such as knowing which specific data elements are required for external reporting to various agencies. Separating the abstracting process also made it easier to hire and train someone specifically for this purpose, she adds.

Stone monitors productivity in several ways. First, coders report their productivity standards daily, and Stone tracks this by generating productivity reports in the EMR. She also randomly audits one coder’s work during one day each month to ensure that productivity standards being reported are actually being met.

Coders also send themselves e-mail when they check in and out of their workstation (e.g., to start the day, when taking a break for lunch, and when leaving for the day). At the end of each two-week shift, coders download the e-mail into a Word document that they submit with their time cards.

When remote coders who reside locally fail to meet expected productivity standards for more than a week or two, they must work on-site until they consistently meet the standards again, says Stone.

Select remote coders wisely

Requiring employees to work on-site to ensure that they can meet productivity and accuracy standards before you send them home is always a good idea, says Stone. “Use the same cautionary approach that you would when hiring someone to work in the office but with the added issue of making sure that they’re motivated, focused, and disciplined people who can work in a remote environment,” she says. They need to be able to work in a closed environment with few interactions with other people, she explains.

Address isolation

Coder isolation can become problematic in a remote setting when not addressed properly. Stone tries to keep all employees connected and encourages them to call each other when questions arise. The department also meets regularly by telephone to complete engagement projects; team members code the same record, share their results with the group, and explain their code selection rationale.

On a lighter note, Stone sends weekly e-mail messages she calls “Friday funnies.” She poses an interesting non-work-related question, such as, “If you had a million dollars, what would you do?” or, “What is your personal motto?” She compiles the responses and distributes them to staff members so they can enjoy a light-hearted read and get to know each other. The hospital is also in the process of using its annual education allowance to schedule an on-site meeting for an ICD-10 training session during which all employees will meet each other face-to-face.

Lawrence says he definitely feels as though he is a member of the team and that having a manager who engages the group has been helpful. Isolation typically is an inherent part of coding, he adds.

“As a coder, you’re more isolated anyway because it requires so much attention to go through the records to make sure you don’t miss anything,” he says. When questions arise, Lawrence knows he can e-mail colleagues or pick up the telephone. He says his colleagues’ responses are generally timely and effective.
Know how ICD-10 could affect your bottom line

Exactly how will ICD-10 affect MS-DRG assignment? As coders began learning the intricacies of ICD-10, this question remained largely unanswered. That is, until CMS released its ICD-10-CM/PCS MS-DRG Version 28 Definitions Manual in February so hospitals could start learning how ICD-10 codes will translate to MS-DRGs.

Minimal impact—for now

The good news is that the draft ICD-10 MS-DRGs published by CMS are meant to replicate the ICD-9 MS-DRGs, says Richard Averill, MS. Averill is senior vice president of clinical and economic research at 3M Health Information Systems in Wallingford, CT. 3M, the company with which CMS contracted to convert MS-DRGs from ICD-9 to ICD-10, did not use ICD-10’s additional specificity to alter MS-DRG assignment. This means that when coders correctly report the same record in both ICD-9 and ICD-10, MS-DRG assignment should be the same, explains Averill.

“If the ICD-10 MS-DRGs had been optimized to use the additional specificity in ICD-10, there could have been a substantial shift of patients across MS-DRGs, making them inconsistent with the existing MS-DRG payment weights,” he says.

Replication of ICD-9 MS-DRGs was the only feasible option for the initial version of the ICD-10 MS-DRGs, says Averill. 3M worked to create a simulated ICD-10 database by using the General Equivalence Mappings (GEM), as no large-scale database including diagnosis and procedure data coded in ICD-10 is currently available. The simulated ICD-10 data is based on FY 2009 Medicare Provider Analysis and Review (MEDPAR) data. This includes all Medicare inpatient claims from acute care hospitals with a discharge date from October 1, 2008, through September 30, 2009—a total of 10,984,798 inpatient claims. The ICD-10 MS-DRG grouper then was used to assign MS-DRGs to the ICD-10 version of the MEDPAR data.

The results of the payment impact analysis illustrate that the MS-DRG conversion will have a minimal impact on aggregate payments to hospitals and the distribution of payments across hospitals, says Averill.

‘Garbage in, garbage out’

However, the previous statement can be misleading, says James S. Kennedy, MD, CCS, managing director of FTI Healthcare in Atlanta. Even though the impact may be minimal, this is based only on the assumption that hospitals have a strong CDI program and that coders are currently assigning accurate ICD-9 codes, Kennedy explains.

“Garbage in is garbage out. This axiom doesn’t change in ICD-10. There’s going to be more incomplete documentation identified in ICD-10 because ICD-10 is expanded and it does require added specificity,” he says.

Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources at AHIMA in Chicago, agrees. “If you’re struggling with documentation and reimbursement in ICD-9, you will continue to struggle with this in ICD-10,” she says.

When ICD-10–coded data becomes available after October 1, 2013, CMS will likely begin to optimize MS-DRGs to take advantage of the additional specificity in ICD-10, says Averill. This will allow CMS to simultaneously recalibrate MS-DRG payment weights, he adds.

APR-DRGs are undergoing a similar conversion to ICD-10, and a major update is expected in October 2011, says Averill. As with MS-DRGs, the initial ICD-10 APR-DRGs will replicate the October 2011 updated ICD-9 APR-DRGs. When ICD-10–coded data becomes available after 2013, APR-DRGs will be optimized to make use of the added specificity in ICD-10, he adds.

Recalibrating APR-DRGs and MS-DRGs may mean more accurate payments, which is always a good thing for hospitals, says DeVault.

“What’s the point of having this highly specific system if we can’t show this in our reimbursement?” she says. “ICD-10 is more clearly going to reflect the severity

> continued on p. 8
of illness of our patients and the risk of mortality, and we want … providers to receive appropriate reimbursement based on this.”

Some questions remain unanswered

However, hospitals must remember that whenever a supposedly revenue-neutral change occurs across the board, there will still be winners and losers at the individual hospital level, depending on each facility’s unique case-mix index, says Kennedy.

One fear is that coders may not be able to rely on previous issues of Coding Clinic, which could pose compliance risks, says Kennedy.

In some instances, advice might not be relevant, especially when new ICD-10 guidelines override old requirements, says Nelly Leon-Chisen, RHIA, director of coding and classification at the AHA in Chicago. The AHA will announce when it will begin accepting ICD-10–related questions. This is unlikely to occur before 2013 because the Cooperating Parties decided that questions should be based on real medical records, says Leon-Chisen.

“The plan for the first year or two of ICD-10 is similar to what we do today in terms of publication,” she says. “We currently publish commonly asked questions or questions for which the answers are not abundantly clear based on the alphabetic and tabular indices, or where there may be gray areas that need clarification or standardization,” she says.

Aside from the relevance of current Coding Clinic guidance, it also remains unclear as to how ICD-10 official coding guidelines will ultimately affect MS-DRG assignment. “There are some things we know will change because the rules are changing,” says DeVault.

For example, the DRG for cases in which patients have anemia associated with certain types of malignancies will have a lower relative weight when applying relevant ICD-10 guidelines. That’s because of a new ICD-10 coding guideline that requires reporting the malignancy as the principal diagnosis followed by a code for the anemia due to that malignancy. For example, using the ICD-10 guidelines to code severe anemia due to left breast carcinoma yields ICD-9 DRG 599 (relative weight 0.6265). However, using ICD-9 guidelines, coders would have reported anemia as the principal diagnosis, yielding ICD-9 DRG 812 (relative weight 0.7957).

Another example relates to gangrenous pressure ulcers. Using ICD-9 guidelines, coders would report the pressure ulcer as the principal diagnosis followed by the presence of gangrene as the secondary diagnosis. This yields ICD-9 DRG 593 (relative weight 1.0709). However, using ICD-10 guidelines, coders must report the presence of gangrene as the principal diagnosis followed by a code for the pressure ulcer, yielding ICD-9 DRG 300 (relative weight 0.9776).

Other new ICD-10 guidelines will yield higher-weighted DRGs. Consider a patient with steroid-induced diabetes due to prolonged use of corticosteroids. According to ICD-9 guidelines, coders should report secondary diabetes as the principal diagnosis followed by V58.7 (long-term use, insulin) and an E code to identify the adverse effect of the steroids. This yields ICD-9 DRG 639 (relative weight 0.5544). Using ICD-10 guidelines, coders must report the adverse effect of the steroids as the principal diagnosis followed by a code for the drug-induced diabetes and a code for the long-term insulin use. This yields ICD-9 DRG 923 (relative weight 0.6808).

“To the extent possible, differences in ICD-10 structure and coding rules were incorporated into the replicated ICD-10 MS-DRGs,” says Averill. “The impact of any residual difference has been estimated to be minimal—a small fraction of 1%.”

Prepare now: Do the math

So how can hospitals prepare for the potential financial impact of ICD-10 both now and in the future? Consider the following:

- Select a group of inpatient records for your review.

For example, randomly select a statistically significant
group (75–100 records) or simply select your top 10 medical DRGs and your top 10 surgical DRGs.

➤ Code these records using ICD-9, and assign an ICD-9 MS-DRG for each using the ICD-9 MS-DRG grouper and a pricer program to compute expected payment.

➤ Code the same records using ICD-10, and assign an ICD-10 MS-DRG for each using the ICD-10 MS-DRG grouper and a pricer program to compute expected payment. Compare the two payment results to determine your anticipated financial impact.

Aside from calculating actual differences in payment, simply reviewing the definitions manual is helpful, says DeVault. For example, each DRG includes a list of the ICD-10 diagnosis and procedure codes (with code titles) that drive the DRG. If reviewing code titles suggests that current documentation won’t support ICD-10 code assignment—and the subsequent DRG—concentrating CDI efforts in this area might be helpful, she says.

Specialty coders may want to review specific ICD-10 codes related to procedures they code often and determine how those procedures might map to particular DRGs under ICD-10, says DeVault. “This is a quick way to isolate the procedures associated with that particular DRG or range of DRGs. It might offer [coders] a different perspective of looking at the coding system,” she adds.

**Encourage greater specificity now**

It’s certainly not too soon to start asking physicians to document ICD-10–related information, says DeVault.

Now that hospitals can see how ICD-10 codes will map to DRGs and affect reimbursement, they may have an even more compelling reason to urge physicians to start documenting with more specificity now, she adds.

Every hospital should examine its query forms to ensure that they incorporate ICD-10 requirements, says Kennedy.

In particular, consider adding specificity to queries for the following conditions:

➤ Anemia due to malignancy: Differentiate whether anemia is due to the cancer, the treatment for the cancer, or both. This information will affect new sequencing requirements under ICD-10.

➤ Myocardial infarctions (MI): Specify subsequent MIs.

➤ Diabetes: Differentiate whether diabetes is poorly controlled, uncontrolled, or due to an adverse reaction to medication.

*Editor’s note: Access additional information about the MS-DRG conversion from ICD-9 to ICD-10 at www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp#TopOfPage.

Access the ICD-10 official coding guidelines at www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf.*
HAC data goes public: Is your hospital ready?

If you haven’t already heard, HAC data is now publicly available on CMS’ website, and as of April 21, it also became available on the Hospital Compare website.

And here’s something else that you should know if you don’t already know it—hospitals can’t suppress their results.

The publicly reported HAC data pertains to all IPPS hospitals participating in the Hospital Inpatient Quality Reporting Program that were open as of February 3, said Marian V. Wrobel. A senior researcher at Mathematica Policy Research, Inc., in Cambridge, MA, Wrobel explained how HAC data will be available to hospitals and the public during a recent CMS Special Open Door Forum.

Providing safe healthcare is a top priority for CMS and it will remain a focus for the agency. “The establishment of public reporting of the hospital-acquired conditions on Hospital Compare will undoubtedly promote continued improvements in the delivery of quality healthcare,” John Cooper, MD, CMS chief medical officer, said during the call.

Consumers currently won’t be able to use Hospital Compare features to specifically assess hospitals according to HAC measures, but they will be able to download hospital-specific reports.

The reports will include the following information for each HAC measure:

➤ A hospital’s numerator (i.e., the number of HACs)
➤ A hospital’s denominator (i.e., the number of eligible discharges, such as the number of surgical discharges [for foreign object retained after surgery] or the total number of medical and surgical discharges [for all other HAC measures])
➤ The rate per 1,000 discharges (i.e., the numerator divided by the denominator)

Reports also will include the national numerator, denominator, and rate for each measure. Hospital reports available via My QualityNet, the secure part of the QualityNet website, will include patient data such as the HAC category, CMS’ patient identification number, birth date, admit date, discharge date, and the first nine diagnoses (with corresponding POA indicators) on the claim.

CMS’ data source for calculating HAC rates is the Standard Analytic File. The agency used a special September 2010 release of the file, which included several corrections to errors related to E codes and the POA indicator, said Wrobel. Discharges occurring between October 1, 2008, and June 30, 2010, were included in the data. The following cutoff dates were used for processing claims: June 26, 2009 (for 2008 discharges), June 25, 2010 (for 2009 discharges), and September 24, 2010 (for 2010 discharges).

The data included Medicare fee-for-service claims only. It excluded claims that were exempt from POA reporting or that included a missing or invalid POA indicator for one of the first eight secondary diagnoses.

National results and looking ahead

“The very good news is that each one of these hospital-acquired conditions are rare,” said Wrobel.

The national HAC rate for each of the eight measures adopted for the Hospital Inpatient Quality Reporting Program is generally less than one per 1,000 discharges. Blood incompatibility and air embolism are extremely rare, she added. Conversely, falls and trauma are more common with 10,564 cases nationally.

“Removing preventable harm is necessary to achieve a high-quality 21st-century health system. We really can’t profess to have the highest-quality health system if patients continue to be injured by that system,” said Michael Rapp, MD. “Although many HACs are rare
events, we can continue to push to remove preventable patient harm from our national health care system,” Rapp, director of CMS’ quality measurement and health assessment group, said during the call.

Wrobel shared other statistics, notably that 19% of hospitals reported no HACs and 81% reported at least one HAC.

During the live Q&A portion of the call, a caller questioned whether hospitals accurately report HACs. He expressed fear that forced public reporting of this information may deter hospitals from continuing to report it. A CMS representative said the agency would monitor HAC trends over time and thanked the caller for his comment.

Learn more about how hospitals can access their specific HAC reports via My QualityNet at http://qualitynet.org. Click on Hospitals-Inpatient, and select HACs from the drop-down menu. Direct inquiries about the program to HACmeasures@mathematica-mpr.com.

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Note the intent of ICD-9-CM codes you report

**by Robert S. Gold, MD**

Coders often get into the habit of assigning codes simply because they see diagnoses written in the chart. Sometimes this process is correct, and sometimes it’s not.

**Primary cardiomyopathy**

Coders are surely familiar with ICD-9-CM code 425.4. This code appears in the ICD-9-CM Manual as follows:

**425.4 Other primary cardiomyopathies**

Cardiomyopathy:

- NOS
- congestive
- constrictive
- familial
- hypertrophic
- idiopathic
- nonobstructive
- obstructive
- restrictive

Other primary cardiomyopathy is listed as a CC. Many coders have been taught to assign 425.4 when a physician documents any of the sub-terms on this list. Consider these examples. When a physician documents dilated cardiomyopathy, assign 425.4, and when a physician documents restrictive cardiomyopathy, assign 425.4. Consequently, consultants teach physicians to exclude certain descriptors so coders can assign 425.4. Physicians are told that even when they know the cause of a diseased heart to omit it so that coders can report a CC.

Assigning 425.4 when another code is more appropriate is wrong. It undermines the intent of the code. For example, coders who see documentation of ischemic cardiomyopathy should assign 414.8 (other specified forms of chronic ischemic heart disease), which is not a CC. If a physician writes hypertensive cardiomyopathy, assign 402.90 (hypertensive heart disease, unspecified, without heart failure), which is not a CC.

Code 425.4 is designated as “other primary cardiomyopathy,” meaning it’s a condition inherent in the heart and its muscle with no external causation. If a patient has a hypertrophic primary cardiomyopathy, assign 425.4. If a patient has a dilated primary cardiomyopathy, assign 425.4. If the only designation is primary cardiomyopathy, assign 425.4. If it’s not primary cardiomyopathy, don’t assign 425.4.

A physician who knows the cause of the cardiomyopathy should document it, and coders should code it regardless of whether it’s a CC. When a cause of cardiomyopathy is documented, and the cause is listed...
in the ICD-9 index, assign the specific code for the cardiomyopathy due to that cause. If a physician identifies a cause that’s not listed in the index, assign 425.9 (secondary cardiomyopathy, unspecified), a CC—unless the physician distinctly specifies that it’s a primary cardiomyopathy. Coders are misled into assigning the wrong code because they incorrectly assume nonessential terms listed under 425.4 apply to all cardiomyopathies; they apply only to primary cardiomyopathies.

**Acute postoperative pain**

Consider another example: other acute postoperative pain, ICD-9-CM code 338.18. I’ve heard that coders assign it when physicians document that Demerol® controls postoperative pain and when physicians document advising patients how to use a Dilaudid® pump to control postoperative pain.

During the first few days after a surgical procedure, all patients have postoperative pain and receive pain medication. However, the presence of postoperative pain immediately after a procedure doesn’t mean that coders can report it. Some cases involve no additional observation, no additional treatment, and no additional length of stay, which means it doesn’t meet UHDDS (Uniform Hospital Discharge Data Set) criteria as a valid secondary diagnosis.

Code 338.18 denotes a patient who, after the normal postoperative period, develops or continues to experience pain above and beyond that which is expected. Postoperative pain may be one reason why a patient presents to a pain clinic, particularly if it is proven not to be due to a wound infection or abscess. Sometimes, postoperative pain is the admitting diagnosis a week after surgery when a patient has a wound infection or peritoneal abscess.

Code 338.18 isn’t intended for use for usual postoperative pain that doesn’t lead to anything.

**Conditions complicating a pregnancy**

Now I’d like to focus my attention on two other codes that I also believe are often subject to misuse:

- 648: Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium
- 649: Other conditions or status of the mother complicating pregnancy, childbirth, or the puerperium

Coders are told to assign an additional code for a complication if and when it occurs. These codes include “the listed conditions when complicating the pregnant state, aggravated by the pregnancy, or when a main reason for obstetric care,” as stated in the *ICD-9-CM Manual*. Conditions listed in 648 and 649 include, but are not limited to, diabetes, thyroid disease, anemia, drug dependence, mental disorders, congenital cardiovascular disorders, bone and joint diseases of the pelvis, gestational diabetes, smoking, obesity, bariatric surgery status, and coagulation defects.

Coders should report 648 and 649 for these conditions when identified during pregnancy, not when a condition first occurs after delivery. How many of them occur after delivery and continue to adversely affect the pregnancy? How many mothers develop congenital heart disease or become gestational diabetics after delivery? Not many. Anemia is the only listed condition that can appear after delivery when it didn’t exist beforehand.

Do other conditions listed under 648 and 649 occur right after delivery or adversely affect the pregnancy if they didn’t exist during pregnancy? No. Code 648.2x denotes sickle-cell anemia during pregnancy, nutritional anemia during pregnancy, other hemolytic anemias during pregnancy, or any anemia during pregnancy. These conditions pose potential risk for mother, baby, or both during pregnancy, delivery, or the immediate postpartum period. When a mother first becomes anemic after delivery, don’t assign 648.22.

Editor’s note: Dr. Gold is CEO of DCBA, Inc., an Atlanta consulting firm that provides physician-to-physician clinical documentation improvement programs. Contact him at 770/216-9691 or rgold@DCBAInc.com.
We want your coding and compliance questions!
The mission of Coding Q&A is to help you find answers to your urgent coding/compliance questions.
To submit your questions, contact Briefings on Coding Compliance Strategies Contributing Editor Lisa Eramo at leramo@hotmail.com.

Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Review all documentation specific to your scenario before determining appropriate code assignment.

A 59-year-old man with metastatic lung cancer presents for an electroencephalogram (EEG) in the office with a diagnosis of status epilepticus. For the diagnosis, I reported the following ICD-9-CM codes:
➤ 345.3 (status epilepticus not otherwise specified)
➤ 197.0 (secondary malignant neoplasm of the lung)
➤ 199.1 (malignant neoplasm without specification of site, other)

I was advised to report codes 345.3, 162.9 (malignant neoplasm of bronchus and lung, unspecified), and 199.1. Shouldn’t I code the metastatic lung cancer as a secondary neoplasm?

Reporting ICD-9-CM codes 345.3, 162.9, and 199.1 is correct.

Code the metastatic lung cancer as the primary site—not as a secondary neoplasm. Refer to Coding Clinic, May/June 1985, pp. 10–12, which addresses metastatic site as principal diagnosis. Coding Clinic states:
If only one site is stated in the diagnosis and that site is qualified as “metastatic,” and the body of the medical record provides no further information to assist in coding the diagnosis, the following step must be taken:
Code to the category for “primary of unspecified site” for the morphology type stated in the diagnosis, such as:
➤ 174.9 (metastatic infiltrating duct carcinoma)
➤ 157.4 (metastatic islet cell adenocarcinoma)

182.0 (metastatic endometrial sarcoma)
171.9 (metastatic malignant histiocytoma)

Members of our coding department disagree regarding how to code a coccyx pressure ulcer. Some staff members say we should report one of the following ICD-9-CM codes:
➤ 707.03 (pressure ulcer of the lower back [coccyx, sacrum])
➤ 707.05 (pressure ulcer of the buttock)
➤ 707.09 (pressure ulcer of other site)

I think code 707.09 is correct because the coccyx is the bone between the buttocks. Your help is greatly appreciated.

Begin in the ICD-9-CM alphabetic index, reference ulcer, decubitus (unspecified site) (see also Ulcer, pressure) – coccyx. This leads you to code 707.03. Therefore, the correct ICD-9-CM code for pressure ulcer of the coccyx is 707.03. Reporting codes 707.05 (pressure ulcer of the buttock) and 707.09 (pressure ulcer of other site) is inappropriate.

Sandra L. Sillman, RHIT, PAHM, DRG coordinator at Henry Ford Hospital & Health Network in Detroit, answered the previous two questions.

I have a question regarding how to code a compromised left below-knee amputation flap. Should I report ICD-9-CM code 996.52 (mechanical complication of prosthetic graft of other tissue not elsewhere
> continued on p. 2
classified)? I worry that 996.52 is not the correct code because it references a graft—not a flap.

I’m also considering ICD-9-CM code 997.69 (other amputation stump complication). However, the physician states that the amputation flap is not a complication of the amputation stump.

The patient’s other diagnoses are osteomyelitis of the left foot, wet gangrene of the left foot, and diabetic neuropathy. The patient also had a left below-the-knee amputation.

The meaning of “compromised” in the physician’s diagnostic statement is unclear. Remember that a flap is considered an advancement or pedicle type of graft per the ICD-9-CM procedure index, so it is indeed a graft.

_Coding Clinic_, Fourth Quarter 1995, p. 82, states:

*Category 997.6, Amputation stump complication, is for use to describe all complications of amputation stumps … Examples of amputation stump complications are infections, such as cellulitis or abscess, and neuroma formations.*

Note that this list is not inclusive. The ICD-9-CM alphabetic index also includes the following reference for other types of amputation stump complications:

➤ Nonhealing
  – Stump (surgical)—997.69

Also, the tabular portion of ICD-9-CM has the following reference for other types of amputation stump complications:

➤ Disruption of wound, category 998.3x
  – Excludes:
    Disruption of amputation stump (997.69)

The additional diagnoses of osteomyelitis of the left foot, wet gangrene of the left foot, and diabetic neuropathy are of the same extremity as the below-knee amputation. Therefore, don’t code the osteomyelitis and gangrene if there is no evidence that these conditions exist elsewhere.

Physicians make the final determination about code assignments. However, including the aforementioned _Coding Clinic_ guidance in a query and asking whether the physician agrees with the assignment of this code might be helpful.

Jean Stone, RHIT, CCS, coding manager-HIMS at Lucile Packard Children’s Hospital at Stanford in Palo Alto, CA, answered the previous question.