Dear reader:

BCCS is pleased to present this 16-page special report on pneumonia upcoding. The government’s investigation into this coding problem has yielded more than $40 million so far with no sign of stopping.

This report is designed to serve as a reference guide and resource as you work to make sure your pneumonia coding and billing is as accurate as possible. With that in mind, we have included information about physician querying, benchmarking, how to self-disclose overpayments, self-auditing, and more.

We look forward to continuing to provide you with timely, pertinent information and tools to help you in your coding compliance efforts.

Sincerely,

Beth Easley, MA
Managing Editor
Coding pneumonia—what coders must know

by Gloryanne Bryant, RHIT, CCS

Have you noticed we are still seeing settlement agreements associated with diagnosis-related group (DRG) pneumonia coding? Yes, it's still a risk area.

Using DRGs, you can classify pneumonia as either “simple” or “complex,” and in general terms as either “viral/unspecified” or “bacterial” (including aspiration). The two medical DRGs classified to pneumonia are

- DRG 089 (simple pneumonia & pleurisy, age greater than 17 with CC)
- DRG 079 (respiratory infections and inflammations, age greater than 17 with CC)

National MedPAR (Medicare Provider Analysis Review) statistics from 1999 indicate that DRG 79 represented approximately 25% of all DRG 89/79 cases. Benchmarking data show that bacterial pneumonia accounts for about 3% of the total cases of pneumonia. When a facility exceeds this percent benchmark by more than 5%, it can send out a red flag. Keep in mind that the Office of Inspector General does not just review last year's charts; it may go back five to nine years. Having clinical documentation in the medical record that describes what type of pneumonia or the causal organism/agent is crucial.

Determining specificity

Coders should assign the ICD-9-CM code for pneumonia that reflects the greatest specificity documented in the body of the medical record by the physician, such as Staphylococcal pneumonia, aspiration pneumonia, gram-negative pneumonia, or Pseudomonas pneumonia. Not only does using the most specific code provide accurate statistics for your facility, it also helps to reflect the severity, acuity, and risk of mortality. It also protects your facility from government investigations. We know that coding for greatest specificity depends on accurate and thorough physician documentation. This is the center of the issue. The American Hospital Association’s Coding Clinic, 2nd Quarter 1998, provides the following guidelines for coding pneumonia:

- Never assume
- Do not assign codes based on lab or x-ray values alone

- For documentation purposes, review linkage of sputum culture results to the pneumonia
- Code as specifically as possible, based on physician documentation
- Review the entire medical record for clarity

Querying the physician

When documentation is unclear, ambiguous, or inconclusive, the coder should query the physician for clarification. When assigning codes for diagnoses addressed in the consultant's report, review all documentation to make sure there is no contraindication from the attending physician. You should be careful when querying not to lead the physician into documenting a particular diagnosis that is not supported by the clinical picture. The Centers for Medicare & Medicaid Services have decided to allow physician query forms to remain as a permanent part of the medical record when the physician responds to them.

See p. 5 for a physician query form specific to pneumonia, used at San Francisco’s Catholic Healthcare West. The physician query form can be used on a concurrent basis (by both coding/health information management (HIM) and case management staff) and also retrospectively. Your facility or organization should have a physician query form and usage policy to help guide the coding and case management staff on proper use.

Coders should use caution when coding pneumonia, unspecified, code 486, (although this is a very common pneumonia code), when there is clinical evidence of a more specific type of pneumonia being treated. In this case, a query to the physician would be appropriate. Working with the case manager or nursing clinicians can also help in this area.

Coding Clinic reminds us to use code 486 only when neither the diagnostic statement nor a thorough review of the record provides documented information to allow for a more specific code. When the physician documents atypical pneumonia, community-acquired pneumonia, assign code 486 (pneumonia, organism unspecified). Assign code 482.89 (pneumonia due to other specified bacteria) when there is documentation of a specific type of bacterial pneumonia and no specific code for that particular bacterial organism. continued on p. 4
is indexed in ICD-9-CM. When a physician documents bacterial pneumonia without further specificity, you should assign 482.9 (pneumonia, bacterial, unspecified).

Self-auditing and education
It is strongly recommended that hospitals perform self-audits as well as external audits on the pneumonia DRGs to reduce the risk of noncompliance with laws and regulations. More specifically, performing self-audits at least once a year in areas that could pose a threat to your facility is a good practice. These audits give you reasonable assurance that you are complying with government regulations.

Be familiar with your facility’s coded data and audit when your statistics are out of the norm. A sample size of 50 records (depending on your facility volumes) for a self-audit is a good place to start. In brief, you should perform self-audits until you are reasonably satisfied that you are in compliance with the laws and regulations.

Physician education should be multi-faceted. The sample below is from a PowerPoint presentation for physician education on providing greater specificity in their documentation.

In summary, coding professionals are to assign ICD-9-CM codes based only on physician documentation and should query when in doubt.

Editor’s note: Bryant is director of coding/HIM compliance at Catholic Healthcare West in San Francisco. If you have questions or desire additional information, contact her at gbryant@chw.edu.

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Physicians Improve your Profile!
Document Clinical **Specificity**!

PNEUMONIA

DRG “79” COMPLEX
or
DRG “89” SIMPLE

Not Sure of the Cause?

“Probable” “Suspected” “Possible” can be documented on inpatient records to show the organism (i.e., “Suspect Klebsiella” or “Probable gm neg. Pneumonia”). A positive sputum culture is not required, for you to document the specific type of pneumonia for are treating, for example: “Gram neg. Pneumonia”. This will help reflect the severity and acuity of the illness and reflect the risk of mortality.

Suspect Aspiration Pneumonia?

It can be documented as “Probable” “Suspected” “Possible” Aspiration Pneumonia. Contact the HIM/Coding Department for further details.
Dear Dr: ___________. Date: _____________
Med. Rec. #: _____________

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflection. Please respond to the query below on the progress notes or as an addendum for your patient ________________, admitted _____________.

Because there is documentation of “Pneumonia” in the medical record, clarification is needed. Additional documentation is necessary to identify the organism or causative agent of the pneumonia, if known (i.e., pseudomonas, viral, aspiration, streptococcus, etc.).

Please document, if known, the appropriate specific pneumonia diagnosis on the progress notes or on this form as an addendum. If the suspected cause is possible, probable, or suspected, please document as such. (Sign and date all documentation)

_______________________________________________________(specific diagnosis/condition)

____________________MD Signature
____________________Date

If you have any Questions, please contact the HIM Department (Medical Records) at #_______________. Thank You

Note: Negative or inconclusive sputum cultures do not preclude a diagnosis of a specific bacterial pneumonia in patients with the clinical evidence of this condition. (per: AHA Coding Clinic). If you are/were treating a suspected, possible or probable gram negative/positive pneumonia or Sepsis, please document as such. Thank you.

***************This form is a permanent part of the medical record***************
Thought the confusion over coding and billing for pneumonia was over? With Hackensack (NJ) University Medical Center’s (HUMC) July 18 $4.2 million fraud settlement, the issue has returned to the forefront of compliance concerns for many hospitals.

Early in 2000, HUMC self-disclosed its overbilling for Medicare inpatient pneumonia cases from 1993 to 1999. **Peter DeMauro, MD**, co-director of performance improvement, says the settlement is the result of “a misunderstanding of highly complex government regulations.”

The hospital had begun conducting audits, and routine claims reviews of complementary diagnosis-related group (DRG) pairs identified a higher rate for more complex pneumonia cases.

In a press release from the U.S. Attorney’s Office, District of New Jersey, acting U.S. Attorney **Ralph J. Marra Jr.**, says, “A voluntary settlement is in the best interests of the Medical Center and the United States. The Medicare program receives the reimbursement it is owed, and a well-regarded medical center avoids potentially harsher sanctions. This is the kind of corporate behavior we want to encourage.”

“We feel very fortunate that our own in-house monitoring picked up on the problem and that corrective measures were put in place to ensure that it will never happen again,” says DeMauro. “The medical center is, and always has been, committed to complying with all government regulations on both a state and federal level, and especially in the area of Medicare benefits.”

As part of its compliance program, HUMC requires continuing education for both coders and physicians. “We have also hired a physician DRG coordinator and conduct both routine and independent reviews of all error-prone DRGs,” says DeMauro.

“The medical staff has been extremely cooperative—we have gotten excellent feedback regarding our ongoing training programs.”

Internal auditing and monitoring could save your facility in the event of overbilling. The government could have sought triple damages and other penalties in the HUMC case. “We feel the government has been supportive and cooperative with the medical center,” says DeMauro.

“It is extremely important to ensure that all internal and external monitors are in place. Physician cooperation has played a major role in allowing the medical center to address the issue and work hand-in-hand with our employees,” adds **Thomas Flynn**, HUMC’s chief compliance officer. “This has enabled the medical center to remain committed to strong adherence to the regulations and guidelines.”

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R0001  Pneumonia coding
A look at the government’s upcoding project

The government’s “Pneumonia Coding Project” began with a 1996 whistleblower suit filed in Pennsylvania against more than 100 hospitals for pneumonia upcoding. The allegations said the hospitals overused ICD-9-CM code 482.89 (pneumonia, other specified bacteria).

Providers who select that code can assign diagnosis-related group (DRG) 79, for which Medicare pays more than it does for DRG 89.

The project first appeared in the Office of Inspector General’s 1998 Work Plan and has been an initiative in every plan since.

Just in case you think the initiative is winding down, take a look at these pneumonia upcoding settlements, all from 2002:

- Southcoast Hospital Group, New Bedford, MA, has agreed to pay $3,034,993 for false and fraudulent claims to Medicare in bacterial pneumonia billings.

  The agreement settles allegations made by the United States against Southcoast that from October 1, 1992, through September 30, 1995, the provider submitted claims to Medicare with the principal diagnosis code of 482.89 for complex pneumonia, due to “other specified bacteria.” However, the corresponding medical records did not support claims under that diagnosis code.

- St. Mary’s Hospital and Medical Center, Grand Junction, CO, designated a principal diagnosis by using the code corresponding to “pneumonia due to other specified bacteria,” allowing it to obtain reimbursement under DRG 79. Coding for DRG 79 v. DRG 89, for “simple pneumonia” pays about $2,700 more per patient, says the U.S. Attorney. The hospital paid $1,250,261 to settle allegations with no admission of liability.

- Wilcox Memorial Hospital of Kauai, HI, paid $1,521,428.82 and agreed to abide by a three-year corporate integrity agreement for allegations of overbilling. The investigation began as part of the nationwide pneumonia upcoding initiative but expanded to include nine other categories of claims.

- University Medical Center of Southern Nevada (UMC) has agreed to pay the government $1,163,488 to settle allegations of Medicare fraud, according to the Department of Justice. Under a corporate integrity agreement, UMC must retain an independent review organization to perform regular billing and coding reviews, including random claims reviews.

  It must also provide coding and compliance training to employees, as well as retain a compliance officer and compliance committee to develop and implement policies to ensure compliance with federal health care program requirements and meet the requirements of the integrity provisions.

- Gateway Regional Health System, Mount Sterling, KY, and 80-bed Lee County Community Hospital, Pennington Gap, VA, in January became the 37th and 38th hospitals to settle allegations of pneumonia upcoding.

  Gateway will pay $445,161 to resolve allegations that it billed Medicare for a more serious form of pneumonia than it actually treated from 1993 to 1998. Lee County will pay $187,500 to settle similar allegations. Both hospitals denied wrongdoing and neither was required to sign a corporate integrity agreement. -牛奶-
Disclosing overpayments: Be first to tell the feds

Discovering that your facility has been overpaid can be frightening for even the most diligent coding manager. You may worry that the government will begin an extensive investigation or will decide to prosecute. However, most overpayment situations are settled amicably.

Members of the health care industry often say innocent billing errors are blown out of proportion by misguided investigators.

“If an individual makes an error, that’s not the problem—it’s how he or she responds to it,” says Stephen Walker, vice president and special counsel for program safeguards at Highmark, Inc, a Medicare contractor, who expressed his personal opinions on this issue.

If you exercise appropriate diligence, you’ll have the comfort of knowing that you have nothing to hide and nothing to fear, says Walker.

“If someone, whether it is the government, contractor, competitors, or patients, is always scrutinizing your business. You might as well do it yourself.”

With whistleblowers starting nearly all of the major health care fraud settlements, you should always assume that someone in your organization would expose the issue, says Mark Olson, Esq., a principal with Olson & Associates in Chicago.

Don’t hide an overpayment

Before disclosing a potential overpayment, providers must determine what happened and why it happened, says Olson.

Don’t try to hide your refund by sending a little at a time and hoping that the carrier won’t realize it is part of a larger problem.

Organizations need to acknowledge that there was a problem, define the problem, and tell how they’ve corrected it, advises Julie Leu, billing compliance officer at Creighton University in Omaha, NE.

Creighton University is working on a policy for handling overpayments. It’s understood that if there’s an overpayment, the money will be refunded, so the policy is focused on who is responsible for the paperwork, initiating the refund, and communicating with the contractor, says Leu.

Generally, providers should disclose an overpayment to their intermediary, rather than the OIG. However, go to the OIG if the overpayment is your organization’s fault because of an inherent problem or an error in your billing and reporting system, says Olson.

Intent is key

If you know about an overpayment, but do not disclose it, the government may assume that you deliberately created or consented to the circumstances that resulted in the overpayment, says Olson.

It’s hard to say you have a credible and ethical compliance program if you have identified overpayments, but haven’t returned the money, says Walker.

Most overpayment situations lead to civil resolutions. If the government wants to prosecute it criminally, it has to establish intent.

These prosecutions usually occur when a provider has done something egregiously wrong, such as billing for services not provided or deliberately upcoding, not because of a glitch in a computer system, says Olson.

Contractors gather information to determine whether there is a problematic pattern and any evidence of intent to warrant an investigation, says Walker.

It will consider the following factors:

- Is there evidence that the provider had actual knowledge of events leading to the overpayment?
- Did the provider act in deliberate ignorance or reckless disregard of events which led to the overpayment?
- What prior education did the provider receive regarding circumstances which led to the overpayment? This includes provider bulletins, newsletters, education letters, and local medical review policies.
Although some verification will take place regarding the facts associated with the return of funds a provider determines to be an overpayment, the amount of overpayment may dictate how the issue is handled in terms of verification of the underlying facts, but quality of care is also considered, says Walker.

Over time, if a contractor is seeing a pattern of mistakes, that information may be of greater interest to government entities, which may decide to take additional action.

Walker noted that only the Department of Justice itself can furnish an entity assurance regarding the lack of civil or criminal exposure concerning the facts that caused the inappropriate acquisition of government funds.

**Protect your organization**

If you suspect that the government is looking at the overpayment as fraud, you have options. You can ask the investigator whether your organization is the target of a criminal investigation. If you ask a direct question, they must give you a direct answer. The government doesn’t have to tell you if you don’t ask, says Olson.

Also, keep counsel informed. Some communications can be protected as attorney-client privilege, says Olson. Attorneys should gather information and direct audits to protect the information. 

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**What will happen with ICD-10?**

The debate over when ICD-10-CM will go into effect in the United States rages on, but won’t impact coding conventions or guidelines, says **Susan Hull, RHIA, CCS**, coding practice manager for the American Health Information Management Association.

The codes will look different simply because they are alphanumerical, but the way you arrive at a given code will not change. Because the codes consist of up to six digits, “a whole lot more specificity can be obtained,” says Hull.

However, “if your coders are shaky with ICD-9, the change to ICD-10 will just exacerbate that,” she says. “There are always issues of adequate training, and that will be more of an issue with ICD-10 because everyone will have to be trained.” If your concerns over pneumonia mostly relate to physician documentation, “ICD-10 is not going to fix that.”

As an example, aspiration pneumonia, currently assigned code 507.0 in the category pneumonitis due to solids and liquids, will be coded J69.0 in ICD-10-CM, also from the category pneumonitis due to solids and liquids. Pneumonia due to Pseudomonas currently is assigned code 482.1, other bacterial pneumonia, would be coded as J17.5, from the category Bacterial Pneumonia Not Otherwise Classified. Pneumonic processes in diseases coded elsewhere that are currently reported with one code based on the underlying disease will be coded in the same way in ICD-10-CM. For example, Candidal pneumonia, currently assigned code 112.4 from the Candidiasis category will be coded as B37.1 in ICD-10-CM, from the same category.

However, “if training in coding guidelines or the disease process is inadequate with ICD-9-CM, the change to ICD-10-CM will only exacerbate data quality and reimbursement issues. If the concerns relate to physician documentation rather than code selection accuracy, conversion to ICD-10-CM for reporting will not help.”

A downloadable draft copy of ICD-10-CM can be found at [www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm](http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm).
Benchmarking your pneumonia caseload

Compare your data so you can track coding compliance

If you want to see how your coding levels stack up against other providers, and whether anything requires further scrutiny, the best way is to benchmark your coding data and compare it against national norms.

“Benchmarking gives hospitals a sense of where they stand relative to everybody else,” says David Hochheiser, PhD, an analyst with HSS, Inc., Hamden, CT. “When the OIG [Office of Inspector General] targets something in its Work Plan, it typically targets the top offenders, whether that’s the top 200 facilities or the top 10% of facilities. So, it’s important to know where you stand, and if you are in that high rate, that gives you incentive to look at your coding more closely, so you can defend it if the government knocks on your door.”

Despite this, he says most people take the ostrich mentality when it comes to benchmarking. “They stick their head in the sand and say, ‘What I don’t know can’t hurt me.’ ”

Although the OIG began its pneumonia upcoding initiative in 1996, the agency isn’t going to stop looking at pneumonia, Hochheiser says. That’s why he explained how to benchmark your coding data during a recent audioconference presented by the American Health Information Management Association.

The first step is to look at your hospital’s coding data. In Fig. 1, we’re measuring Hospital A’s percentage of diagnosis-related groups (DRG) 79/80.

“Hospital A is coding 53% of their pneumonia cases” as DRGs 79 and 80, says Hochheiser.

The very small change between 1997 and 1998 indicates that Hospital A was slow to see the effect of a new coding process after the government announced that it would be looking for pneumonia upcoding. Then, there are sharp decreases between 1998 and 1999 and between 1999 and 2000. This indicates that the hospital realized it was upcoding and took steps to fix that.

“This hospital seems to be adapting well to what the government has said about upcoding,” he says.

In Fig. 2, we are now seeing where Hospital A’s pneumonia coding falls compared to national norms. “We want to look externally so we can see if the first figure is truly reflective of our pneumonia cases,” says Hochheiser.

For this comparison, Hochheiser used the Medicare Provider Analysis Review (MedPAR). The MedPAR data set contains all inpatient claims of all hospitals with 10 or more discharges of the four DRGs (79, 80, 89, 90).

The line in Fig. 2 is the same line from Fig. 1. The line separating the top two regions represents the 90th percentile for that coding rate. For example, in 1997, the 90th percentile was right around 56%. “That means 10% of the hospitals had a ratio higher than 56% and 90% had a ratio lower than 56%,” he says. You can see that, over time, the rates of these DRGs go down significantly, especially the 90th percentile.

The line between the next two regions is the 75th percentile and the line between the bottom two regions is the median.

This means that hospitals coding at a very high rate realized something was wrong and they had to make a quick change, says Hochheiser. “That’s why the top regions have much more drastic decreases. The hospitals that already had fairly low coding percentage rates didn’t have to change their practices much. They were already doing a pretty good job.”

We can also see that even though Hospital A’s rate of coding these DRGs has gone down, it still uses DRGs 79 and 80 frequently. “We can’t necessarily say it’s a problem, but the fact that it’s so different [from its peers] is reason for the OIG to notice,” he says.

You can use this same process for any other ICD-9-CM diagnoses that the OIG targets. For example, the OIG recently took great interest in the use of code 482.89 (pneumonia, other specified bacteria), Hochheiser says. You can use your data the same way we showed you in the examples above, replacing the percentage of DRGs 79 and 80 with ICD-9 482.89 to see where it falls within your pneumonia caseload. You can then compare that rate to national norms (see figs. 3 and 4).
Fig. 1
Hospital A’s DRG coding over time

Fig. 2
Hospital A’s DRG coding rate compared to national coding rates over time

Fig. 3
Hospital A’s coding of 482.89 over time

Fig. 4
Hospital A’s coding of 482.89 compared to national coding rates over time
Survey shows lots of effort, few worries

A simple survey conducted by HCPro found that most hospitals are comfortable with the accuracy of their pneumonia coding and billing, and they do not fear a government investigation.

Forty-eight percent of respondents said they are very comfortable with their accuracy, and 47% are comfortable. Five percent said they are not comfortable. Of that 5%, 83% attributed their discomfort to problems with physician documentation.

Forty-two percent attributed their lack of comfort to confusion over coding guidelines, 8% to untrained coders, and 25% to incomplete records.

“Based on my professional experience,” says Susan Hull, RHIA, CCS, coding practice manager for the American Health Information Management Association, “most records are appropriately reported with the correct codes when an adequately trained staff is available. Confusing documentation or misinterpretation of coding guidelines causes most of the problems found in pneumonia coding that result in an incorrect DRG payment.”

On the other hand, “the documentation may be excellent, but if the coder is careless, or under pressure, or doesn’t take the time to review the whole documentation, then the coding still isn’t going to be accurate. That all comes under coder training.”

Coder training leads the list of things hospitals have done to work toward accurate coding and reimbursement for pneumonia (see Fig. 1). Among the answer in the “other” category, respondents named auditing as another effort they’ve made. Did auditing come in second? After the other choices?

Most survey respondents (89%) said they accurately code pneumonia, while 11% said they downcode. Through her own personal experience as a former consultant, Hull said, “there is a wide range of expertise out there and a wide range of adequacy of documentation.

I would say that most of the records that I’ve looked at are fine. The number that are potentially upcoded and potentially downcoded are about equal.”

Only 5% of respondents said they are concerned about the possibility of a government audit.

These answers probably mean the nation’s hospitals have spent the last couple of years addressing pneumonia coding and billing. “These answers are “really reflective of the OIG’s [Office of Inspector General] [diagnosis-related group] 79 efforts,” said Hull.

Coders shouldn’t rest too easy, however. “As long as the OIG is finding things they’re going to keep investigating. It’s interesting that nobody’s worried about it.”

Fig. 1
What have you done to work toward accurate coding and reimbursement for pneumonia? (Check all that apply.)

Implemented a clinical documentation improvement program. 39%
Created forms for pneumonia coding. 25%
Increased coder training. 70%
Increased group physician training. 30%
Increased individual physician training. 40%
Conduct interventions with noncompliant physicians. 16%
Other 19%

Editor’s note: Results are based on the results of 63 respondents to a survey posted in HCPro e-zines.
When the federal Payment Error Prevention Program (PEPP) began, the nation’s peer review organizations (now known as quality improvement organizations, QIOs) were charged with evaluating their states’ hospitals for areas of inaccurate coding and billing and developing educational programs to help prevent these problems.

The Texas Medical Foundation (TMF) started by looking at the code for “gram negative pneumonia and pneumonia, other specified bacteria” (482.89). After that study, analysts noticed a sudden increase in aspiration pneumonia, says the foundation’s Marianne Lundgren, RHIA, CCS, diagnosis-related group (DRG) specialist. Some of the problems stemmed from the fact that “the coding guidelines for the gram negative pneumonia for comorbid conditions did not require a lab indicating gram negative pneumonia,” Lundgren says. Coders were also making broad interpretations, assuming that older patients from nursing homes must have gram negative pneumonia.

In addition, coders were making assumptions about candida pneumonia as well, TMF found. “People were looking at lab tests that showed yeast and automatically making connections,” says Lundgren. “Just because there’s a growth on a lab test doesn’t mean the patient has candida pneumonia. The physician needs to identify that as the cause.”

The organization developed a coding worksheet and coding guidelines. But Lundgren points out that “you can’t pinpoint one area. With all of the DRG problems, documentation—everything feeds into it. The coders can’t make assumptions. By the same token, doctors need to document what happened so coders can code more accurately.”

Through its effort, the TMF has “seen progress made,” she says. “We have seen an improvement over time; the numbers are much better. What is the correct number? You can’t say this is where everybody should be. We just know that in reviewing cases, we’re finding fewer errors.” (See pp. 14–15 for a copy of the review worksheet.)

Not surprisingly, CMRI, the QIO for California, identified physician documentation as the biggest obstacle to accurate pneumonia coding.

In its studies, CMRI reviewed DRG 79 and 89 for all California hospitals submitting claims for these DRGs between October 1, 1998, and June 30, 1999. Hospitals with a proportion equal to or greater than 40% were asked to perform a review of their DRG 79 cases. Hospitals with a proportion equal to or less than 10% were asked to review their DRG 89 cases. Some went ahead and reviewed all their cases; those asked to perform reviews had at least 30 cases for the time period.

CMRI found that 48 hospitals had a proportion equal to or greater than 40%, indicating a high probability of overcoding DRG 79. Thirteen hospitals had proportions equal to or less than 10%, indicating an increased probability of undercoding DRG 79. The overall miscoding rate for both DRGs was 7.04%. Financial losses from miscoding totaled $1,882,101, with $855,576 due to overpayments and $1,026,525 due to underpayments.

The organization developed a tip sheet to help coders determine when to code which

Illustration by David W. Harbaugh

“Based on your documentation, a patient is assigned a DRG unrelated to his problem; do you write a referral, up your malpractice insurance, or read a book on the curse of cursive?”

continued on p. 16
Pneumonia coding

**DRGs 079/080 Pneumonia Review Worksheet**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>HIC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Admission date:</td>
<td>Discharge date:</td>
</tr>
<tr>
<td>Billed principal diagnosis:</td>
<td>ICD-9-CM code:</td>
</tr>
</tbody>
</table>

(narrative)

Was the patient receiving antibiotics prior to this admission?  [ ]YES  [ ]NO

Presenting symptoms upon admission: 

Does the patient have (check all that apply):
- Difficulty swallowing/dysphagia
- History of cerebrovascular accident/disease/dementia
- Problems with aspiration
- Vomiting
- Tracheostomy
- Other: ____________________

Chest x-ray results/date(s) (list all):

Initial WBC/date: ____________________

Sputum culture results/date: ____________________

A. Pneumonia diagnosis

1. Is the pneumonia diagnosis clearly substantiated (through physician documentation, clinical indications, etc.)?  [ ]YES  [ ]NO

2. Was a physician inquiry required to substantiate a principal diagnosis of pneumonia?  [ ]YES  [ ]NO
   If YES, please attach a separate document containing coder questions and physician response.

B. If pneumonia is substantiated:

1. What did the physician document in the medical record as the cause of the pneumonia (i.e., specific bacteria, aspiration, organism)? ____________________

2. If the cause was not documented by the physician, is there any documentation present in the medical record that could substantiate a more specific pneumonia diagnosis?  [ ]YES  [ ]NO

C. If pneumonia is not substantiated in the medical record, please specify the reason for admission and treatment: ____________________

D. Are the secondary diagnoses clearly substantiated?  [ ]YES  [ ]NO

List any diagnosis codes requiring clarification from the physician: ____________________

**Refer to the coding guidelines for correct coding of pneumonia**
### Originally Billed Codes/DRG | Revised Codes/DRG
---|---
Principal diagnosis code: |  
Secondary diagnosis codes: |  
Procedures: |  
Discharge status: |  
DRG: |  

### Result of Review:
- [ ] Correct
- [ ] Incorrect

If incorrect, revised DRG: _______________________

Reviewer name: ______________________  Title: ______________  Date: __/__/____

Rationale for revised DRG: __________________________________________


### Follow-up Action Required by Hospital for Revised DRG:

If the revised DRG is different than the originally billed DRG, the hospital must submit a revised Medicare UB-92 claim form to the Medicare Part A fiscal intermediary. A copy of the revised UB-92 claim form should be attached to this worksheet and submitted to TMF. TMF will initiate follow-up with the fiscal intermediary regarding the hospital’s submission of the adjusted claim.

### Certification Statement

I certify that a revised UB-92 claim form was submitted to the Medicare Part A fiscal intermediary on __/__/____

Hospital designated contact name  Signature  Date
Coding pneumonia

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DRG. The sheet explains what documentation must be in the record to support each DRG.

“The tip sheet] was very well received,” says Carol Osterburg, RN, MS, manager of PEPP for CMRI. She and her team also did presentations with data obtained from California hospitals. “We wanted to look at why they were making the errors. The main problem with pneumonia coding was that the documentation wasn’t clear.” So, her efforts went toward improving physician documentation and making sure the labwork was in the record to help coders make coding decisions.

Meanwhile, the state’s QIO offered its hospitals the following efforts:

- Education of hospital executives and health information management professionals regarding the issues associated with these DRGs by placing information on its Web site and in newsletters, direct mailing to hospitals, on-site visits, and telephone conferences
- Distribution of hospital-specific data to hospitals
- Requiring hospitals to review medical records determined to be coded in error and submitting their results to the QIO
- Technical assistance in performing continuous quality improvement techniques when requested by hospitals

MissouriPRO reviewed pneumonia miscoding as part of its pulmonary conditions project “because patients often present with similar symptoms caused by different etiologies,” says Glenna A. Schindler, MPH, RN, CHES, CPHQ, compliance specialist.

The organization also developed three coding audit tools for specific types of pneumonia as well as coding guidelines. “Coders have been enthusiastic about the tools and we have had many requests for them,” she says. “Coders have been even more enthusiastic about our coding guidelines and have asked for regular updates.”

Schindler attributes miscoding to coders’ and hospital executives’ fear of overcoding. “Fear of appearing to be doing something wrong has impacted coders over time. We identified a great deal of undercoding of the pulmonary DRGs at baseline. Most likely because of our educational efforts on undercoding, overcoding errors increased in Missouri at re-measurement.”

Some small hospitals in Missouri have begun exchanging small samples of blinded medical records (all identifying information removed) with larger facilities and having the record re-coded to test for reliability. “This has led to a support system for the coders and an educational opportunity to increase accuracy,” says Schindler.

In addition, some health systems have hired coding specialists who work at the corporate level with member facilities. These specialists act as an in-house specialist and a resource for coders. “These corporate level specialists [and] experts have implemented educational programs involving physicians, as well as coders. They address issues of documentation and the query process as well as coding accuracy. The success rate is variable among hospitals.”

Editor’s note: To access the TMF’s PEPP Web site, go to www.tmf.org/pepp/index.html. Go to www.cmri-ca.org/healthcare_pepp.html to see more information about CMRI’s pneumonia coding efforts. To access MissouriPRO’s coding audit tools and other PEPP information, go to www.mpcrf.org/MU/PEPP/main.html.