

Getting It Right Up Front: Inpatient Documentation and Coding

REVIEW, RESPONSE AND REVERSAL: RAC Success During the Discussion Period

This newsletter simplifies complex regulations mandated by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health & Human Services Office of Inspector General (OIG) to facilitate your hospital's understanding of and adherence to the regulations.

Below are real-life case studies in which providers successfully disputed claim denials by providing additional information or documentation in response to a recovery audit contractor (RAC)

demand letter (for an automated review) or a review-results letter (for a complex review). The goal of this issue is twofold:

- To help reduce or eliminate the number of claim denials that extend beyond the discussion period; and
- To use claim denials to educate providers on how they can improve documentation and coding, and prevent claim denials in the first place.

The "discussion period" for denied claims allows providers to submit additional information or documentation to dispute the RAC's finding.

CASE 1: UNCODED CCs

RAC Letter

A review of this case shows that the MS-DRG assignment can appropriately be changed from 164 to 165. This change results in an overpayment.

This determination was based on the following.

The secondary diagnosis code 197.2 (metastatic malignancy pleura) was deleted from this claim. There is no physician documentation in the medical record submitted by the facility for review to support the coding and reporting of the diagnosis noted above. As the American Hospital Association's (AHA) *Coding Clinic*, 2nd Quarter 2000, pages 17–18 states, "All diagnoses should be supported by physician documentation."

INITIAL CODE ASSIGNMENTS

On its original claim, the facility assigned the following codes. (Note that the "Y" in the second column indicates that the condition was present on admission [POA].)

Diagnoses		
CODES	POA	DESCRIPTIONS
162.3	Y	Mal neo upper lobe lung
197.2	Y	Second malig neo pleura
401.9	Y	Hypertension NOS
272.4	Y	Hyperlipidemia NEC/NOS
496	Y	Chr airway obstruct NEC

327.23	Y	Obstructive sleep apnea
305.1	Y	Tobacco use disorder
300.00	Y	Anxiety state NOS
414.00	Y	Cor ath unsp vsl ntv/gft
Procedures		
CODES	DESCRIPTIONS	
32.49	Lobectomy	
32.29	Destroy loc lung les NEC	
34.22	Mediastinoscopy	
40.11	Lymphatic struct biopsy	
DRG		
164	Major chest procedures w CC	
Relative Weight		
2.595273		

CORRECTED CODE ASSIGNMENTS

The revised code assignments are below.

Diagnoses		
CODES	POA	DESCRIPTIONS
162.3	Y	Mal neo upper lobe lung
401.9	Y	Hypertension NOS
272.4	Y	Hyperlipidemia NEC/NOS
496	Y	Chr airway obstruct NEC
327.23	Y	Obstructive sleep apnea
305.1	Y	Tobacco use disorder
300.00	Y	Anxiety state NOS
414.00	Y	Cor ath unsp vsl ntv/gft

Procedures	
CODES	DESCRIPTIONS
32.49	Lobectomy
32.29	Destroy loc lung les NEC
34.22	Mediastinoscopy
40.11	Lymphatic struct biopsy
DRG	
165	Major chest procedures w CC
Relative Weight	
1.803632	

Provider Response

To Whom It May Concern:

We agree with the deletion of code 197.2 from the claim. However, we disagree with the proposed change in MS-DRG from 164 to 165 for the following reasons.

Upon further review, we believe that DRG 164 is accurate, and we further believe that the following ICD-9-CM codes should be added to the claim:

- 512.1 Iatrogenic pneumothorax
- 171.8 Neoplasm of other specified sites of connective tissue and other soft tissue

|| CASE 1 ... continued from page 1 ||

428.32 Chronic diastolic heart failure

In the progress notes of 3/28 and 3/29, Dr. B documents “air leak, maintain chest tube.” This is supported by the chest X-ray on 3/29 (development of apical pneumothorax) and by Dr. W., the attending physician, who documents the following in the discharge summary: “His post-operative course was relatively uneventful. He did require aggressive pulmonary toilet and support with oxygen.”

The attending physician’s (Dr. W.) operative report indicates “non-small cell carcinoma with probable squamous cell carcinoma with invasion of a blood vessel.” The ICD-9-CM code book index indicates the following: “neoplasm of blood vessel – see neoplasm, connective tissue.”

The patient has a history of quadruple coronary artery bypass graft (CABG), previous myocardial infarction (MI) with aneurysm and atrial flutter. Pre-operative assessment indicates that an echocardiogram shows grade II diastolic dysfunction.

A letter from Dr. W. with additional information about this case is attached [provided below] for your review.

Respectfully submitted,
Coding Manager

To Whom It May Concern:

As the attending physician for the above-named patient, I wish to clarify that the reason for the aggressive pulmonary toilet and oxygen support following surgery was indicated by Dr. B. for the treatment of the development of a small apical pneumothorax, otherwise referred to as air leak. This pneumothorax developed following the lobectomy on 3/26, resolved on 3/28 only to recur on 3/29 as noted in the chest X-rays for the respective dates.

I should further like to clarify that this patient with grade II diastolic dysfunction does have chronic diastolic heart failure.

Respectfully submitted,
Dr. W.

Lessons Learned

Upon receipt of the RAC’s letter, the coding manager immediately reviewed the medical record intending to re-code the entire record without being persuaded by the original code assignments or the revised code assignments from the RAC.

While re-coding the record, she found that there was no documentation to support code 197.2 (secondary malignant neoplasm, pleura).

However, the coding manager did find that there was documentation to support the following secondary codes:

- 512.1 Iatrogenic pneumothorax
- 171.8 Neoplasm of other specified sites of connective tissue and other soft tissue
- 428.32 Chronic diastolic heart failure

The coding manager had an informal meeting with the attending physician. (She did not schedule a meeting in advance because she wanted the physician to be relaxed and not feel stressed or pressured). She asked the physician about the clinical significance of the apical pneumothorax and the diastolic cardiac dysfunction. Based on his response, she then asked him to write a letter explaining the clinical significance of the apical pneumothorax and the diastolic heart failure in this patient.

The coding manager’s letter and the attending physician’s letter helped to overturn the RAC’s proposed change of the DRG from 165 to 164.

The coding manager realized that the case was poorly coded initially, and she used this case as an opportunity to provide one-on-one training with the coding specialist who originally worked on this case.

CASE 2: TREATING A “PRESUMED” CONDITION

RAC Letter

A review of this case shows that the DRG assignment can appropriately be changed from 224 to 225. This DRG change results in an overpayment.

This determination was based on the following:

The secondary diagnosis code 486 (pneumonia, organism unspecified) was changed to 466.0 for acute bronchitis.

The admission history and physical review of systems documents the patient’s statement that a cold started a few days prior to admission with suspected low-grade fever. The admission chest X-ray was noted as negative for infiltrate. The 2/20 medical consultation report was requested with an assessment of fever spikes; the most likely culprit was respiratory infection. Antibiotics were started. The hospitalist’s handwritten consultation note for the same day gives a diagnosis of

“presumed pneumonia.”

Following the progress notes, the 2/23 hospitalist’s note documents increased temperature secondary to respiratory infection, with two more days of Levaquin ordered. The progress note of 2/24 documents the diagnosis of “acute bronchitis” with the patient improved. The discharge summary only documents upper or lower respiratory tract infection; pneumonia is not mentioned again. The physician’s documentation of presumed pneumonia should not be reported as it is an uncertain or interim diagnosis not documented at the time of discharge. The physician diagnosed the patient with acute bronchitis.

The AHA’s *Coding Clinic* 2005, Third Quarter, page 22, states the following: “According to the Official Guidelines for Coding and Reporting (sections II and III), in short-term, acute, long-term care and psychiatric hospitals, if the

diagnosis documented at the time of discharge is qualified as ‘probable,’ ‘suspected,’ ‘likely,’ ‘questionable,’ ‘possible,’ or ‘still to be ruled out,’ code the condition as if it existed or was established. This advice should not be applied to admitting or interim diagnoses.”

INITIAL CODE ASSIGNMENTS

On its original claim, the facility billed the following codes:

Diagnoses		
CODES	POA	DESCRIPTIONS
427.2	Y	Parox tachycardia NOS
486	Y	Pneumonia, organism NOS
996.04	Y	Mch cmp autm mplnt dfbrl
428.22	Y	Chr systolic hrt failure

|| CASE 2 ... continued on page 3 ||

CASE 2 ... continued from page 2

427.31	Y	Atrial fibrillation
427.32	Y	Atrial flutter
414.01	Y	Crnry athrscd natve vssl
244.9	Y	Hypothyroidism NOS
Procedures		
CODES	DESCRIPTIONS	
37.94	Implt/Repl carddefib tot	
37.22	Left heart cardiac cath	
37.75	Revision of lead	
88.50	Angiocardigraphy NOS	
DRG		
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	
Relative Weight		
7.952109		

CORRECTED CODE ASSIGNMENTS

The revised code assignments are below.

Diagnoses		
CODES	POA	DESCRIPTIONS
427.2	Y	Parox tachycardia NOS
996.04	Y	Mch cmp autm mplnt dfbrl
428.22	Y	Chr systolic hrt failure
466.0	Y	Acute bronchitis
427.31	Y	Atrial fibrillation
427.32	Y	Atrial flutter
414.01	Y	Crnry athrscd natve vssl
244.9	Y	Hypothyroidism NOS
Procedures		
CODES	DESCRIPTIONS	
37.94	Implt/Repl carddefib tot	
37.22	Left heart cardiac cath	
37.75	Revision of lead	
88.50	Angiocardigraphy NOS	
DRG		
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	
Relative Weight		
5.900599		

Provider Response

To Whom It May Concern:

This is to advise you that we do not agree with your proposed DRG change from 224 (cardiac defib implant with cardiac without AMI/HF with MCC) to 225 (cardiac defib implant with cardiac without AHI/HF without MCC).

The consultation documentation states the following: “Lungs: patient does have an area of rhonchi that failed to clear with deep inspiration or cough at the left base posterior” and “fever spikes with most likely culprit being respiratory

infection. Probably lower respiratory on the basis of examination.” The link for lower respiratory infection and pneumonia is made when the same physician documents (in the progress note for the same date) the following: “lungs mostly CTA but has persisting rales (L) base. Will start antibiotics for presumptive pneumonia.” Finally, this diagnosis is carried through the discharge summary, which states “thought he had either an upper or lower respiratory infection and was started on Levaquin.”

Further, a negative chest X-ray does not preclude the diagnosis of pneumonia based on the physician’s judgment.

Respectfully submitted,
RAC Coordinator

To Whom It May Concern:

As the attending physician for the care of this patient, I concur with the above statement and reiterate that the lower respiratory infection is further specified as a presumed pneumonia as well as bronchitis. These were treated with Levaquin.

Respectfully submitted,
Dr. J.

Lessons Learned

After receiving this letter, the RAC coordinator

reviewed the medical record and realized the facility coder had “dropped the ball” when she didn’t ask the attending physician to include the “presumed pneumonia” diagnosis in the final progress note and/or the discharge summary.

This “presumed pneumonia” condition, although treated with Levaquin, was only documented by a hospitalist in a 2/20 progress note.

During her consultation about this case with the attending physician, the RAC coordinator also found that the physician treated both pneumonia and bronchitis. So, not only did the attending physician agree that the pneumonia was present, but he also confirmed that bronchitis was present (as determined by the RAC).

The letter from the RAC coordinator and the attending physician helped to overturn the RAC’s proposed change of the DRG from 224 to 225.

The RAC coordinator used this case to remind the facility’s coding specialists that, while it is appropriate to code “presumed” pneumonia for an inpatient case (see official guideline below), this condition should have appeared as a final diagnosis in the medical record. Since it didn’t, the physician should have been queried.

Source: ICD-9-CM Cooperating Parties, ICD-9-CM Official Guidelines for Coding and Reporting, p. 90, retrieved on September 16, 2011, from http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf



From the Desk of the Doc-U-Mentor

Robert S. Gold, MD

There is no doubt that pneumonia is a clinical diagnosis and the presence of a chest X-ray demonstrating an infiltrate is not mandatory to be able to diagnose the condition and select appropriate treatment. Should a physician be able to use clinical skills of historical and physical examination of the patient to make the diagnosis, no oversight organization has a right to supersede the physician who actually treated the patient, but be aware of two things.

- If an initial thought was of the presence of pneumonia but the clinical course and findings did not truly support it, the physician must be SURE to document that it was RULED OUT.
- The physician may rule out pneumonia without stating it was ruled out, but maintain documentation of acute bronchitis, acute exacerbation of chronic bronchitis, acute heart failure or another diagnosis he concluded was appropriate in the case. It is not uncommon for a staff person to ask the physician to re-dictate the discharge summary to reflect the thought that it was “possibly,” “probably” or “likely” there at the time of admission. Advice to the physician: Don’t do it.

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