DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – The publication titled "Hospital Outpatient Prospective Payment System" (March 2011) is now available in print format from the Medicare Learning Network®. This fact sheet is designed to provide education on the Hospital Outpatient Prospective Payment System (OPPS) including background, ambulatory payment classifications, how payment rates are set, and payment rates under the OPPS. To place your order, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page.

MLN Matters® Number: SE1121 Revised

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Recovery Audit Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals

Note: This article was updated on July 31, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

This article is for all Inpatient Hospital providers that submit Fee-For-Service (FFS) claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

Provider Action Needed

Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

Background

Section 302 of the Tax Relief and Health Care Act of 2006 made the Recovery Audit Program permanent and required the Secretary to expand the program to all 50 states by no later than 2010. Each Recovery Auditor is responsible for identifying overpayment and underpayments in approximately ¼ of the country. The Recovery Audit Program jurisdictions match the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) jurisdictions. (See the Recovery Audit Program information at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html on the Centers for Medicare & Medicaid Services (CMS) website.) In 2009, CMS developed a phased in approach to reviewing claims submitted in the FFS program. Recovery Auditors began with automated and DRG Validation review.

Issues/Vulnerabilities

One of CMS' strategies to reduce the Comprehensive Error Rate Testing (CERT) error rate is to correct identified vulnerabilities discovered by the Recovery Auditors and other Medicare contractors. Recovery Auditors have identified coding errors while performing DRG Validation review. DRG Validation review focuses on the hospital's selection of principal and secondary diagnoses and procedures on a claim. A significant amount of claims have an incorrect principal diagnosis.

Recovery Auditors review the entire medical record when performing DRG validation. Some hospitals may choose to code the record prior to receiving the complete medical record (e.g., not waiting for discharge summary or operative reports). Hospitals do this at their own risk since they are responsible for reporting codes that accurately reflect the patient's conditions and procedures. Therefore hospitals may increase their chance of errors by choosing to code the case prior to receiving the complete medical record. Recovery Auditors will not take this into consideration.

The Emergency Room report, History and Physical (H&P), and early progress notes may indicate the patient has one condition, but continuing workup and evaluation may determine something entirely different. By having access to the complete medical record, more accurate codes can be assigned. Recovery Auditors will review data from the entire medical record.

When coding claims, if there is conflicting or contradictory information in the medical record, a coder should query the attending physician to clarify the correct principal and secondary diagnoses.

Remember that the "Coding Clinic, First Quarter 2004" states, if there is conflicting physician documentation, and the coder fails to query the attending physician to resolve the conflict, hospitals are encouraged to code the attending physician's version. However, the failure of the attending physician to mention a consultant's diagnosis is not a conflict. So, if the consultant documents a diagnosis and the attending physician doesn't mention it at all, it is acceptable to code

it. A conflict occurs when 2 physicians call the same condition 2 different things – for example, the attending physician documents a sprained ankle and the orthopedist refers to the same injury as a fracture.

As with all codes, clinical evidence should be present in the medical record to support code assignment. The Uniform Hospital Discharge Data Set (UHDDS) Guidelines for coding and reporting secondary diagnosis allow the reporting of any condition that is clinically evaluated, diagnostically tested for, therapeutically treated, or increases nursing care or the length of stay of the patient.

Principal diagnosis is defined in the UHDDS as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. When determining the principal diagnosis, all documentation by licensed, treating physicians in the medical record must be considered.

All ICD-9-CM coding guidelines can be found at: http://www.cdc.gov/nchs/data/icd9/icdguide09.pdf on the Internet.

Additional Information

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.