**Q&A: Identifying the principal diagnosis beyond DRG capture**

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**Q:** I am a relatively new CDI specialist in a relatively new CDI program. We learned that we should be examining the health record with an eye toward “what bought the bed.” When we raise this concept to our coders, however, they disagreed with the premise telling us that such a concept was in line with coding regulations. Can you explain how we may have misunderstood this concept or help us to understand where the difference in perception may lay?

**A:** In 2010 the Recovery Auditors (then called Recover Audit Contractors or RACs) began to challenge both DRG assignment (coding practices) *and* medical necessity. Recovery Auditors soon found great returns financially with the medical necessity denials; in fact many organizations see this type of denial as their Recovery Auditor’s main focus.

Traditionally coding teams needed to only focus on assuring proper codes were assigned, following the *Official Guidelines for Coding and Reporting* for sequencing. As long as the “rules” were followed they had no concerns. They were also in the habit of making sequencing choices allowed within the guideline that would lead to the greatest reimbursement.

This practice is not necessarily wrong but with new initiatives related to indirect reimbursement it may lead to take-backs, denials, or other problems. For example, quality measures, readmission monitors, value based purchasing etc., all provide hospitals with potential for indirect reimbursement or financial loss if the hospital does not meet assigned goals based on data derived from DRG and code assignments. Severity of illness and risk of mortality measures are based on the same data.

Those who work in the CDI role and come to the profession from a nursing background may be more familiar with the concept of medical necessity related to inpatient status requirements. Particularly, those CDI professionals who may have come from a case management or utilization review experience understand and have struggled with medical necessity for years. This focus area now is even more front and center for those who work within the revenue cycle.

I have often discussed sequencing for a lesser paying DRG based on what the patient was actually treated for, or what would have “bought the bed,” rather than assigning a code for a diagnosis that was documented and may have reimbursed at a higher level.

Let me give an example of what I mean:

A patient comes to the hospital with a urinary tract infection (UTI) and renal failure/acute tubular necrosis (ATN). Both conditions were present on admission. The UTI if listed as the principal diagnosis with renal failure/ATN as the MCC, provides a relative weight of 1.1 with payment of approximately $4,200. If the renal failure with ATN is the principal diagnosis we have a relative weight of .9655 with approximately $3,500 in reimbursement. As a CDI specialist, with medical necessity in mind, our first question is to determine whether the patient required an admission for the treatment of the UTI. Could the UTI have been treated on an outpatient basis with antibiotics? Looking at the creatinine level and renal function and the presence of ATN the next question is could the renal failure have been treated/monitored at home? Or did it require an inpatient stay? The choice of principal diagnosis should be a thoughtful decision reflecting the condition that brought the patient to the facility’s door and what treatment was provided, and what needed to be done to lead to stability and discharge.

Coders know well the definition of a principal diagnosis as identified by the Uniform Hospital Discharge Data Set as:

*“The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”*

Your program may want to consider conducting monthly coder-CDI team meetings to review difficult cases where the principal and secondary diagnosis assignment may be unclear. Also reach out to those in denial management to request examples of medical necessity denials to re-examine as a team. Review the diagnoses that are frequently denied and discuss how that denial impacts revenue loss. Look at the possibility of other choices for principal diagnosis that might not have triggered a denial for medical necessity. This may be information that the coding staff has not been exposed to, and by working together to regularly review items such as these you can strengthen both your CDI and coding efforts.

The more discussion and exposure everyone involved in the revenue cycle has in regard to choice of principal diagnosis, the better the outcome on quality measures, potential denials, and payment incentives.

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