Who's Driving the DRG Bus: Selecting the Appropriate Principal Diagnosis

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Explain the coding guidelines to ensure accurate selection of the principal diagnosis
  – Identify the effects of proper assignment of a principal diagnosis and incorporated secondary diagnoses on CC/MCC capture rates, maximization of SOI/ROM and decreasing the mortality index
  – Discuss the specific challenges of principal diagnosis selection using Chapter Specific Coding Guidelines

Principal Diagnosis Definition

• Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as:

  “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
The definition of principal diagnosis is UNCHANGED in ICD-10-CM

After Study

• “The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated”

• The term encounter is used for all settings, including hospital admissions
Why Is an Appropriate Principal Diagnosis Important?

- Morbidity/mortality indicators
- Severity of illness/risk of mortality
- Core measure reporting
- Public reporting
- Reimbursement
- RAC auditing
- Drives research
- Quality
- It’s the right thing to do

Timing Is Everything

- The time of the inpatient order can be a determinant in driving the principal diagnosis
- Observation and outpatient to inpatient status
Observation to Inpatient

- What occasioned the order to inpatient status?
- What are the clinical indicators supporting the change in status?

Outpatient to Inpatient

- The following coding 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 admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis
Symptoms

• Signs, symptoms, and ill-defined conditions are not to be used as principal diagnosis when a related definitive diagnosis has been established.

• When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. **However, if the symptom code is integral to the conditions listed, no code for the symptom is reported.**

Equally Meet

• In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup, and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first.
Equally Meet

- Equally meet ≠ equally treat

- If you take one diagnosis away, can the other stand alone?

Examples of Equally Meet

- Dehydration with pneumonia

- Seizure with acute respiratory failure

- AKI with CHF
Interrelated Conditions

- When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

The Driver

- Principal diagnosis is called the driver

- Who’s driving the DRG bus?
The Qualifications

- Chiefly responsible
- Medical necessity
- Definitive diagnosis

The Journey

- The journey begins with the importance of getting everyone on the bus initially
**POA**

- Don’t leave anyone behind
- If the patient didn’t come into the facility with it, then we gave it to them
- The driver is already on board, either directly or indirectly
- Linking signs and symptoms

**Documentation**

- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not.
- Think in INK!
Case Study

- 65 year old with a history of diabetes mellitus Type 2 admitted with nephropathy
- Chief complaint was increased lower extremity edema and ascites; proteinuria was found on workup
- Dx: 1. Diabetes  
  2. Nephropathy

Query

- Linking signs and symptoms to the underlying etiology can drive us to a more appropriate principal diagnosis
- A query to clarify the link between the diabetes mellitus and manifestation is warranted
The Bus Stop

• At each stop, new information is brought aboard
• Lab and radiology results, consultant notes, etc.
• Check your Coding Clinics

The Passengers

• For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  – Clinical evaluation; or
  – Therapeutic treatment; or
  – Diagnostic procedures; or
  – Extended length of hospital stay; or
  – Increased nursing care and/or monitoring
• Secondary diagnosis
  – Reflect the acuity of the patient
  – Support medical necessity
Traffic Signals

Red - STOP!!

Do you need more information?

Traffic Signals

Yellow – CAUTION!!

Are you following the map?
Traffic Signals

Green – **GO!!**

You have the appropriate driver!

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The Map

- *Coding Clinic*
- Official coding guidelines
- Chapter-specific coding guidelines
Sequencing

**Caution** – Don’t go down the wrong road!!

For example: respiratory failure and poisoning

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Respiratory Failure Sequencing

- Diseases of respiratory system chapter-specific coding guidelines:
  - Acute and chronic respiratory failure may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.
Poisoning Sequencing

• Injury and poisoning chapter-specific coding guidelines:
  – When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration) **first assign the appropriate codes from categories T36–T50 (ICD-9 960–979)** … Use additional code(s) for all manifestations of poisonings.

RAC

• Recovery audit prepayment review demonstration project
  – Involves 11 states
    • 7 states with high population of fraud- and error-prone providers: CA, FL, IL, LA, MI, NY, TX
    • 4 states with high claim volumes of short inpatient hospital stays: MO, NC, OH, PA
Case Study

- Patient with:
  - BP 220/130
  - HA, blurred vision, n/v, confusion
  - Abatement of s/s after treatment of blood pressure
  - Documentation included “hypertensive emergency, possible TIA”

Principal Diagnosis

Transient ischemia 435.9/G45.9

MS-DRG 69 RW 0.7449 GLOS 2.2

Hypertension 401.9/I10

MS-DRG 305 w/o MCC RW 0.6176 GLOS 2.1
Consider Hypertensive Encephalopathy

- Refers to a relatively rapidly evolving syndrome of severe hypertension in association with severe headache, nausea, and vomiting; visual disturbances; convulsions; altered mental status; and, in advanced cases, stupor and coma

Who Is Driving This Bus?

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>MS-DRG</th>
<th>RW</th>
<th>GLOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient ischemia</td>
<td>435.9/G45.9</td>
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</tr>
<tr>
<td>Hypertension w/o MCC</td>
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<td>Hypertensive encephalopathy</td>
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</tbody>
</table>
**CC Opportunity**

- There is also an opportunity to query for accelerated hypertension; this will capture an additional CC

**The Road**

- Chiefly responsible for occasioning the admission
- Clinical indicators
Case Study

- Admission findings:
  - SOB, DOE several nights ago
  - Recent admission for pseudomonas UTI with discharge to SNF for continued IV antibiotics, still on po Bactrim
  - 3+ leukocyte esterase with 11 white blood cells in urine, culture with pseudomonas
  - Troponin 1.39 on admission
  - History of kidney transplant
  - Leukocytosis
  - Cefepime IV ordered
  - Diagnosis: leukocytosis, anemia, NSTEMI, UTI

Case Study

- Day 2: The patient was stable, doing well. Cardiology medically managing NSTEMI. Transplant graft fully functioning per renal.
- Day 3: The patient was found pulseless with agonal breathing.
- CPR initiated, the patient pronounced after 42 minutes of life-saving efforts.
- Expiration note states cause of death: Myocardial infarction.
Case Study

UTI with MCC: DRG 689
 RW 1.1300   GLOS 4.3   SOI/ROM 3/2

AMI with expiration with CC: DRG 284
 RW 0.7614    GLOS 1.8     SOI/ROM 2/1

• Don’t fall into the trap of choosing principal diagnosis solely on higher-weighted or increased severity of illness (SOI)/risk of mortality (ROM)
• Remember “after study” of the complete record
• Do you really die of a UTI?

STOP!

• Before assigning a principal diagnosis, remember:
  – Not to assign a symptom instead of a definitive diagnosis
  – The condition that brought the patient to the hospital isn’t necessarily what occasions the admission
Ask Yourself

• Which diagnosis required INPATIENT care?
• Was the principal diagnosis directly or indirectly present on admission?
• Are you following the map (coding guidelines, Coding Clinics, etc.)?

References


Thank you. Questions?

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