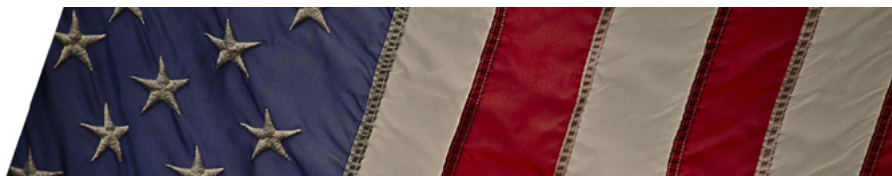


THE LIVANTA CLAIMS REVIEW ADVISOR



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and provide guidance about Livanta's
Claim Review Services*

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Higher-Weighted DRG Validation

Sometimes hospitals are paid for adjusted claims under the Inpatient Prospective Payment System (IPPS) for services rendered to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has statutory and regulatory claims review authority under 42 CFR 412.60(d)(2) and 476.71(c)(2), such as when an adjusted claim requests a payment higher than the claim it is adjusting. For Claim Review Services, CMS has contracted with Livanta as its Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to validate the appropriateness of higher payments by completing Diagnosis Related Group (DRG) validation reviews. These reviews ensure that the diagnoses, the procedures, and the discharge status of the patient reported on the hospital's claim are supported by the patient's medical record and the attending physician's notes. For this purpose, Livanta employs highly-trained credentialed coding auditors who adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When required, active, practicing physicians review for clinical validity based on the presence of supporting documentation and clinical indicators.

Principal Diagnosis Definition

A first step toward understanding and selecting the principal diagnosis is the initial guideline at the beginning of Section II of the Official Coding Guidelines, which states that "the circumstances of inpatient admission always govern the selection of principal diagnosis." Thus, closely examining the documentation around the circumstances of admission is required and necessary, i.e., the reason for coming to the hospital, chief complaint, emergency room documentation (including history and physical and consultations), initial signs and symptoms, initial assessment and treatment plan, initial tests ordered and their results, and physician orders.

The Uniform Hospital Discharge Data Set (UHDDS) was implemented in 1974 and is the core data set for inpatient admissions. The data is collected on inpatient hospital discharges for Medicare and Medicaid programs. The goal of UHDDS is to obtain uniform comparable discharge data on all inpatients.



The UHDDS defines the principal diagnosis as, “The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” Here are some important things to keep in mind when applying this definition:

- This guideline refers to the reason for inpatient admission, not the reason the patient was seen in the emergency department or admitted to observation status.
- Complications that are unrelated to the reason for admission cannot be assigned as the principal diagnosis even if they were the focus of the admission.
- There are multiple chapter-specific guidelines that cover principal diagnosis assignment for certain diagnostic classes including sepsis, COVID-19, obstetrical coding, and HIV disease, among others.
- With a few exceptions, codes for signs and symptoms may not be assigned as principal diagnoses if the reason for the signs/symptoms is documented, as the reason for the signs and symptoms would then be principal diagnosis.
- While it should not be a common occurrence, when two or more conditions meet the definition of principal diagnosis in terms of causing the admission and being equal in terms of being the focus of the admission, as well as requiring the same level of resources, either condition may be assigned as the principal diagnosis.
- Coders should follow the “code first” and “use additional code” instructional notes in the tabular section of the ICD-10-CM coding book.
- Section II of the Official Coding Guidelines includes many, but not all, of the sequencing rules for principal diagnosis assignment. Sequencing direction can also come from Coding Clinic, chapter-specific guidelines, and as instructional notes in the tabular section of the coding book. The “coding book” is the common name for ICD-10-CM and ICD-10-PCS (see reference below).

Don’t confuse the admitting diagnosis, the primary diagnosis, and the principal diagnosis.

- The **admitting diagnosis** describes **the** patient’s condition at the time of hospital admission before all test results are available.
- The **primary diagnosis** is the diagnosis to which the majority of the resources were applied. Occasionally, complications and comorbidities may overtake the principal diagnosis in terms of treatment length and aggressive treatment.
- The **principal diagnosis** describes the underlying cause behind a patient’s initial hospital admission and is assigned only after a physician has completed necessary tests and examinations.

An incorrect principal diagnosis is the most common cause of DRG changes found during compliance audits because it is a major data element for DRG calculation. For this reason, the importance of principal diagnosis accuracy cannot be overstated. It is a fundamental aspect of coding and pivotal to compliance.

Note: The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40.

What Does Not Qualify

A diagnosis does not qualify as the principal diagnosis, and/or does not meet qualifications for an inpatient acute care hospital admission if:

- It required treatment only with oral medications that can be taken at home and was not causing severe symptoms that required monitoring and/or separate treatment; or
- It did not contribute to the decision to admit the patient, even if present on admission; or
- It was not present on admission. Note: Contrary to the guidelines for assignment of present on admission (POA) indicators, every aspect of a principal diagnosis code need not be present before the code may be assigned as principal diagnosis. For this reason, in rare instances, a principal diagnosis may have a POA indicator of No (N).

Why the Principal Diagnosis is Important

The principal diagnosis is one of the main factors that determines hospital reimbursement because it helps to determine the DRG, as does the presence/absence of complications or comorbidities/major complications or comorbidities (CCs/MCCs) and any assigned procedure codes.

Keep in mind that principal diagnosis is a coding concept and its assignment is the responsibility of the coder. It is not appropriate to query the physician for the principal diagnosis, as physicians are not privy to the myriad rules governing its assignment. Coders should, however, query physicians for guidance in cases where it is difficult to determine the correct principal diagnosis. In such cases, it is not appropriate to ask a physician for the principal diagnosis. Nor is it appropriate to ask for a list of conditions that occasioned the admission and then select whichever one results in the highest-paying DRG. Instead, queries involving principal diagnosis selection should be as specific as possible and should be open-ended in a way that allows the coder to use the additional physician input to determine the correct code.

How to Choose the Correct Principal Diagnosis

Here are some examples that might help the coder determine the correct principal diagnosis:

- The patient reported to the emergency department complaining of a headache. Routine laboratory results indicated that he had acute renal failure. He was admitted for treatment of the renal failure, as the headache was not serious enough to require inpatient care. Therefore, the acute renal failure would be the correct principal diagnosis, not the headache.
- The patient was admitted for hyperglycemic coma due to insulin noncompliance. Soon after she was brought to the nursing unit from the emergency department, she fell out of her bed and broke her hip. Her diabetes was brought under control within 48 hours of the admission, but she had to stay in the hospital for another week due to the hip fracture and subsequent surgery to repair it. Since the hip fracture occurred after the admission, it does not qualify as the principal diagnosis.
- The patient was admitted for anemia. It was later documented that the anemia was due to known

end-stage renal disease (ESRD). Even though the anemia caused the admission, the principal diagnosis would be the ESRD because of the “code first” instructional note under D63.1 (anemia due to ESRD).

- The patient’s admission diagnoses were fever, low pulse-ox (SpO₂) of 86, chronic obstructive pulmonary disease (COPD) exacerbation, and rule-out pneumonia. Treatment consisting of intravenous azithromycin and aerosol inhalation of albuterol was started in the emergency department and continued after admission. One day later, pneumonia was ruled out, a urinary tract infection (UTI) was diagnosed, and the antibiotics were immediately changed to oral nitrofurantoin. Once the patient’s SpO₂ returned to her baseline, she was discharged. The discharge diagnosis was documented as UTI and COPD exacerbation. The correct principal diagnosis is COPD exacerbation. Even though the patient was admitted with a fever and pneumonia was ruled out, the UTI does not qualify as the principal diagnosis because it was treated with oral antibiotics only (azithromycin was given for possible pneumonia) and did not cause complications needing inpatient care. Exacerbation of COPD was the cause of the admission.

Examples of Noncompliant Principal Diagnoses

Situations concerning the above advice that Livanta has seen in recent reviews include the following scenarios.

- Sepsis was sequenced as the principal diagnosis but did not qualify for these reasons:
 - It was never documented except on a query; or
 - The patient did not receive any IV antibiotics; or
 - There were insufficient clinical indicators; or
 - It was not present on admission, i.e., no clinical indicators or documentation on admission; or
 - The sepsis was due to a complication so the complication that caused the sepsis should be sequenced as the principal diagnosis.



- The billed principal diagnosis was not present on admission, meaning it was not a known problem and/or did not show symptoms until after admission:
 - CHF was listed as the final diagnosis and sequenced as the principal diagnosis but when the patient was admitted, he had no edema, no respiratory symptoms, and the BNP was either normal or had not been checked.

- Pneumonia was a discharge diagnosis and was assigned as the principal diagnosis. However, on admission, the chest x-ray was normal, and the patient was afebrile with a normal WBC count, and normal respiratory status.
- NSTEMI was a discharge diagnosis and sequenced as the principal diagnosis. The patient had been admitted for treatment of acute kidney injury and had no complaints of chest pain, a normal EKG, and normal troponin on admission.
- The billed principal diagnosis was present on admission, but it did not occasion the admission and was not the focus of care:
 - The billed principal diagnosis was acute kidney injury (AKI). The patient was admitted with diagnoses of AKI, dehydration, syncope, rule-out transient ischemic attack (TIA) or cerebrovascular accident (CVA). The AKI and dehydration resolved in the emergency department with intravenous hydration. The focus of care was to rule out a CVA. The patient was eventually diagnosed with a TIA, which would be the correct principal diagnosis as it was the condition after study that caused admission.
 - The billed principal diagnosis was acute respiratory failure. The patient arrived at the emergency department in cardiorespiratory arrest. He was intubated for airway protection. He was diagnosed with a massive cerebral embolism. After a 5-day stay, he was terminally extubated. The discharge diagnoses included cerebral embolism and acute respiratory failure. The focus of care was to diagnose and attempt to treat the embolism. The lungs were not diseased. The intubation and ventilation were done to protect the airway because the patient was in a coma following massive cerebral embolism, therefore acute respiratory failure does not qualify as the principal diagnosis.
- A symptom was billed as the principal diagnosis when the etiology of the symptom is known or suspected at the time of discharge:
 - The principal diagnosis was billed as chest pain. The patient was admitted for chest pain. A stress test was negative. A chest x-ray showed probable malignant lung tumors. Chest pain and probable lung cancer were the discharge diagnoses but since chest pain is an inherent symptom of lung cancer, the lung cancer would be the correct principal diagnosis.
 - The patient was admitted for syncope. The patient was worked up and it was determined that she had orthostatic hypotension. The final diagnosis was syncope and orthostatic hypotension. Since syncope is inherent to that condition, the correct principal diagnosis would be the hypotension, not the syncope since orthostatic hypotension is a definitive diagnosis and syncope is a symptom.

Conclusion

Although the DRG can be affected by the presence of CCs, MCCs, procedures, and even the discharge disposition, the primary determinant of the DRG, and therefore hospital reimbursement, is the assignment of the principal diagnosis. Therefore, it is imperative that this code be correct applying the Official Coding Guidelines to the documentation in the medical record. If the principal diagnosis is not correct, the DRG will likely not be correct, and as a result, the hospital could be paid improperly.

References

CMS, ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 -- UPDATED April 1, 2022 (October 1, 2021 - September 30, 2022)

<https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf>

(Contains the Chapter-Specific Coding Guidelines starting on page 19/115)

CMS, ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 – UPDATED January 1, 2021 (October 1, 2020 - September 30, 2021)

<https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf>

(Contains the Chapter-Specific Coding Guidelines starting on page 20/126)

CMS, ICD-10-PCS Official Guidelines for Coding and Reporting FY 2021 -- UPDATED December 1, 2020

<https://www.cms.gov/files/document/2021-official-icd-10-pcs-coding-guidelines-updated-december-1-2020.pdf>

CMS, ICD-10-PCS Official Guidelines for Coding and Reporting FY 2022 -- UPDATED December 1, 2021

<https://www.cms.gov/files/document/2022-official-icd-10-pcs-coding-guidelines-updated-december-1-2021.pdf>

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