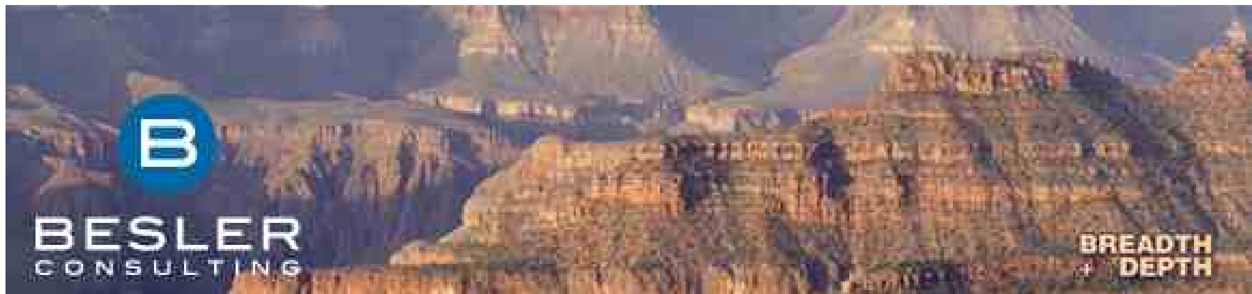

Clinical Documentation and Accurate Coding Impacts Your Facility

FY 2009 Inpatient Prospective Payment System (IPPS):
Focus on Hospital Acquired Conditions and Clinical Documentation Issues

By:

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The Centers for Medicare and Medicaid Services (CMS) has released its fiscal year 2009 Medicare Inpatient Prospective Payment System (FY2009 IPPS) final rule that will become effective October 1, 2008. This rule will bring the final transition to:

- Medicare Severity DRG's
- Introductions of Medicare Severity Long Term Care DRG's
- Expansion of Hospital Acquired Conditions (HAC) list
- Stronger attention to Presentation On Admission (POA) selections
- Updated coding guidelines with new ICD-9-CM diagnosis codes to provide greater specificity for conditions such as pressure ulcers, septicemia, headaches and leukemia, just to name a few.

The true financial impact of the FY2009 IPPS Rule will be dependent upon the level of clinical documentation and coding accuracy at each facility. According to the FY2008 IPPS Final Rule CMS states, "The documentation and coding adjustment was developed based on the recognition that the MS-DRGs, by better accounting for severity of illness in Medicare payment

rates, would encourage hospitals to ensure they had fully and accurately documented and coded all patient diagnoses and procedures consistent with the medical record in order to garner the maximum IPPS payment available under the MS-DRG system." The decrease in total IPPS reimbursement expected for FY2009 can be offset with a strong clinical documentation improvement program.

In FY2008, CMS launched a nationwide effort to prevent hospital-acquired conditions (HAC) by requiring hospitals to report whether predetermined conditions were present at the time of a patient's admission. CMS required POA indicators be collected for all Medicare patients beginning October 1, 2007. On January 1, 2008, hospitals started receiving notices of non-compliance for claims without POA indicators and on April 1, 2008, Fiscal Intermediaries started denying Medicare claims without POA indicators.

Although facilities have had one year to correct any coding, documentation and POA selection inaccuracies**, the pressure to report accurately on these diagnoses increases October 1, 2008 when Medicare will no longer reimburse a higher-paying MS-DRG if a selected HAC is not documented as present on admission.** The FY2009 IPPS Final Rule HAC list is as follows:

Foreign Object Retained After Surgery – ADDITIONAL ICD-9-CM CODE ADDED

Air Embolism

Blood Incompatibility

Stage III and IV Pressure Ulcers – REVISED ICD-9-CM CODES

Falls and Trauma

- Fractures
- Dislocations
- Intracranial Injuries
- Crushing Injuries
- Burns
- Electric Shock

Manifestations of Poor Glycemic Control – NEW CATEGORY ADDED FOR FY2009

- Diabetic Ketoacidosis
- Non-ketotic Hyperosmolar Coma
- Hypoglycemic Coma
- Secondary Diabetes with Ketoacidosis
- Secondary Diabetes with Hyperosmolarity

Catheter-Associated Urinary Tract Infection (UTI) - INCLUDES UTI CAUSED BY MRSA

Vascular Catheter-Associated Infection

Surgical Site Infection Following:

- Coronary Artery Bypass Graft (CABG) - Mediastinitis
- oBariatric Surgery - NEW CATEGORY FOR FY2009

Laparoscopic Gastric Bypass
Gastroenterostomy
Laparoscopic Gastric Restrictive Surgery

- Orthopedic Procedures - NEW CATEGORY FOR FY2009

Spine
Neck
Shoulder
Elbow
Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) – REVISED CATEGORY AND TARGETED ICD-9-CM CODES

Based on the increased number of HACs and the changes to the ICD-9 diagnosis and procedure codes associated with the final HACs, **facilities must have a strong clinical documentation team to support initiatives for an organization's financial success.** An organization's first line of defense for appropriate documentation of the severity of illness is with the case/utilization management department(s). These department(s) typically conduct the first level review to verify severity of illness and intensity of the services that the patient is receiving. If the documentation needs to be improved, these department(s) will be the first to know upon admission. Considering CMS has already determined providers will see an increase in their Case Mix Index (CMI) and has adjusted MS-DRG reimbursement down as a result of this anticipated improved documentation and coding, it

is crucial that facilities invest educational resources to minimize reimbursement deficits. Facilities making this important investment in clinical documentation education for physicians, case managers, and coders will realize a high return on their investment through better coding and improved CMI.

All of these changes – Medicare Severity DRGs, Hospital Acquired Conditions, and the Present on Admission Indicator – are indicative of CMS's move to a "pay for performance" environment. HAC is an example of a type of "pay for performance" category which will impact the bottom line for acute care hospitals. These HAC type payment reductions will be implemented by non-Medicare payers as well. Therefore, it is imperative that hospitals be prepared by taking the necessary steps to identify the current discharges that would be subject to HAC and determine if the proper documentation is in order for those discharges.

Other key components include quantifying potential financial impact and educating all clinicians, as well as physicians, in order to avoid discharges falling into the HAC or lower MS-DRGs, where applicable.

Organizations need to start today to improve documentation and coding for tomorrow.

Remember: *you must have a strong clinical documentation team to support initiatives for an organization's financial success.*

For more information and how BESLER Consulting can help you please contact:

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RESOURCES:

CMS FY2009 IPPS Final Rule –
http://www.cms.hhs.gov/AcuteInpatientPPS/
CMS Hospital Acquired Conditions –
http://www.cms.hhs.gov/HospitalAcqCond/
Center for Disease Control (CDC) – http://www.cdc.gov/
Agency for Healthcare Quality and Research (AHQR) –
http://www.ahrq.gov/