



TOPIC: Omission of Procedure Codes has Significant Impact on Medicare Payment

TOPIC OVERVIEW

According to the most recent five years of Medicare Provider Analysis and review data, between 45 percent of all Inpatient hospital admissions are being processed without a primary ICD-9 procedure code. This code is a critical part of what determines the diagnosis-related group under which a Medicare admission is processed. Admissions that do not include the code in the assigned field may be subject to lower payment than those in which the appropriate code is provided. It is of course important to include all the procedures done:

1. For compliance
2. To capture DRG significant procedures, and
3. In case CMS determines a procedure not currently included in the DRG methodology to be significant in the future. This change could only come about if data is available to assess the impact of the procedure.

TOPIC HIGHLIGHTS

For the most recent year (CMS FY04), four high volume DRGs showed an unusually high percentage of submissions in which the primary procedure code field was blank. These DRGs listed below may have significant procedures that impact DRG reimbursement but are viewed as Medical diagnoses, so it is easy to understand why overlooking procedures is possible.

- 088 (chronic obstructive pulmonary disease)
- 089 (simple pneumonia and pleurisy, age greater than 17 with complications)
- 127 (heart failure and shock)
- 143 (chest pain)

Additionally, attention should be given to lung biopsies. A closed lung biopsy done via needle aspiration (33.26) has no impact on DRG 89 (simple pneumonia). DRG 89 has a relative weight of 1.0420. A transbronchial lung biopsy (33.27) does have a DRG impact. The use of 33.27 with a diagnosis code such as 485 or 486 = DRG 76, Other Respiratory System OR Procedure with CC. (DRG relative weight 2.8647.

These DRG's may have significant procedures that impact DRG reimbursement but are viewed as Medical diagnoses, so it is easy to understand why overlooking procedures is possible. Within each of these DRG's, at least 69 percent of the admissions were processed with the primary procedure field blank. Although the differences in CMS payments for these four DRGs were not as high as the overall figures, each of the DRGs showed at least a 14 percent higher CMS payment when the primary procedure code field was populated compared with when it was blank. Because the combined volumes for



these four DRGs exceeded 2.45 million, the potential difference in payment to hospitals is significant.

ACTIONS TO BE TAKEN

To receive proper payment for the services they perform, hospitals need to make sure that all Medicare admissions are properly documented, with the level of detail that will ensure the accurate assignment of the DRG under which the subsequent claims will be processed.

- Determine your Hospital's top Medicare DRGs and include the DRGs listed above for report writing purposes.
- Create a report for the HIM department to capture the IP Medicare claims that display blank primary procedure fields for claims with those DRGs
- Review the report to identify trends to eliminate the errors and provide necessary education to eliminate the root cause of the lack of procedural coding.
- Continue to review the report to ensure the root cause has been remedied; track the increased reimbursement and follow up with the appropriate staff with feedback on improvement.
- Share the success with all Department Directors and HIM staff involved in the project.

RESOURCE

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