The DRG Family for Heart Failure and Shock and The DRG Family for Renal Failure (Part A)

Hello, I am Lynn Kelly, senior provider education consultant at Palmetto GBA.

The DRG families we will be focusing on in part one of this two-part DRG series:

- DRG Family for Hearth Failure and Shock
- DRG Family for Renal Failure

As a Medicare Administrative contractor for CMS, Palmetto GBA is tasked with preventing claims payment errors. Our Provider Outreach and Education department helps providers like you understand the fundamentals of Medicare, as well as any significant changes and new initiatives. This includes national and local policies, procedures, and issues identified through data analysis.

Our goal is to create a strong Health Information Supply Chain. This helps reduce incorrect billing and payments, and at the same time ensures that your patients are receiving the correct level of care they need.

CMS has identified the top DRG families by Medicare reimbursement as areas for improvement in the supply chain.

In this two-part video series we'll take a look at each of those families.

CMS selected each of the DRG families we cover in this series after an analysis of billing data showed abnormal billing practices for these DRGs.

These abnormal billing practices potentially occur when the principle and secondary diagnoses are improperly assigned, which results in overpayments to hospitals.

The most common areas were related to sequencing of the principal diagnosis and improper coding of secondary diagnosis.

Secondary diagnoses errors were related to selecting the improper code based on physician documentation or the addition of a secondary diagnosis that was not documented within the medical record.

The goals of these videos are:

- To identify where and how DRG errors take place
- To determine if there is a process in your office or institution to double check for proper DRG assignments
- To ensure all components are included on the claims before submitting them for payment
- To reduce improper payments

Improper payments can result in overpayments and underpayments. To make sure your facility is being properly reimbursed for the services you bill, please follow the guidelines I offer in this video.

Before we get started, let's clarify the definition of the principal diagnosis:

The principle diagnosis is that condition established after study to be chiefly responsible for the patient's admission to the hospital for care. Two or more diagnoses may equally meet the definition for principal diagnosis. This is in terms of the circumstances of admission, diagnostic workup, and/or therapy provided.

Be aware that there is a difference between admitting a patient to treat two conditions, and two conditions being present at the time of admission. The principal diagnosis is always the reason for the admission.

Now let's talk about our first DRG family, the DRG family for heart failure or shock: DRG 291, 292 and 293.

Heart failure and shock are conditions related to weakening heart muscles as a result of:

- High blood pressure
- Rheumatic heart disease
- Congestive heart failure

Based on service-specific probe edits, the most common errors for the Heart Failure and Shock DRG family were:

- Not meeting medical necessity
- No response in 30 days to an additional documentation request
- Incorrect billing
- No orders for inpatient admission

Documentation in the medical record should substantiate the cardiovascular disorder. This includes these symptoms:

- Ankle swelling and/or pitting edema of the lower extremities
- Jugular vein distention
- Fatigue with exertion
- Paroxysmal nocturnal dyspnea
- Orthopnea
- Presence of dyspnea with mild exercise
- Results of the chest x-ray
- Cyanosis of lips, nail beds and skin
- Decreased urine output
- Altered mental status

Now in our second DRG family in part one of the DRG series, we will focus on the DRG family for renal failure: DRGs 682, 683 and 684

The documentation in the medical record should support the principal and secondary diagnoses. This includes the following:

- Clinical signs and symptoms
    - Skin darkening
    - Itching
    - Muscle cramps
    - Progressive rise in BUN
    - Elevated urine protein
- Documented work up
    - Kidney CT scan
    - Kidney venogram or arteriogram
- Documented treatment
    - IV erythropoietin
    - Dialysis
- Potential underlying cause
    - Diabetes
    - Hypertension
    - Trauma
    - Ibuprofen use
- Specificity of whether acute or chronic failure

If the record documentation raises questions about the diagnosis, a process should be in place for the coder to clarify the diagnosis with the physician prior to coding the claim.

The coder should refer to the applicable Coding Clinic guidelines:

- CMS considers Coding Clinic, published by The American Hospital Association, to be the official source for coding guidelines
- Hospitals should follow the Coding Clinic guidelines to ensure accuracy in ICD-9 or ICD-10 coding and DRG assignment

Remember: errors can occur if there is not a system of checks and balances in place. Insufficient documentation leads to inadequately conveyed medical assessments.

Incorrect coding and billing errors can delay claim payments when additional information is required. Ultimately, improper payment can be made or claims are denied.

We believe if your internal process includes the Medicare billing and documentations recommendations we made in these videos, you will help create and maintain a strong Health Information Supply Chain.

This will help you deliver the best care possible and avoid costly errors that could result in the loss of Medicare coverage and payment.

I’m Lynn Kelly with Palmetto GBA. Thanks for watching.