Five RAC Coding Targets: Demonstration Program Identified Key Areas of Improper Payment

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The Centers for Medicare and Medicaid Services (CMS) expects to have four Recovery Audit Contractors (RACs) operating by 2010. Each RAC will be responsible for identifying overpayments and underpayments in a region of the country. Based on the results of the demonstration program, the permanent program will enable CMS to detect improper payments from the past and prevent future improper payments.

During the demonstration program, "most of the overpayment amounts collected by the RACs (about 85 percent) were from inpatient hospital providers," and "almost half of the improper payments were the result of incorrect coding," according to CMS.[1] Most improper payments occurred when providers submitted claims that did not comply with Medicare's coding or medical necessity policies and rules. With statistics such as these, coding professionals should begin preparing for the expansion of the RAC program by internally monitoring their coding processes.

This article examines five areas of improper payments due to incorrect inpatient coding found during the RAC demonstration project and references the AHA *Coding Clinics* applicable for each.

Excisional Debridement

During the demonstration projects in New York, California, and Florida, RACs found that excisional debridement coding was the leading ICD-9-CM procedure coding error. They found coding of excisional debridement (86.22) that did not meet the definition of excisional debridement. According to CMS, "In the medical record, the physician writes 'debridement was performed,'" and the "hospital coder assigned a procedure code of 86.22."[2]

In order to code excisional debridement, documentation must meet the requirements outlined in the 1991 Third Quarter AHA *Coding Clinic* . If the documentation does not meet these requirements, the procedure should be coded to the nonoperative ICD-9-CM code 86.28, Nonexcisional debridement.

When coding professionals hear the words excisional debridement, they should first ask if the record contains the proper documentation to support the code. Obtaining accurate and complete documentation to support code assignment involves educating providers on the components needed in the documentation to support the code. These components include:

- Size
- Depth
- Removal of devitalized tissue
- Instruments used
- Definite cutting away of tissue (not the minor removal of loose fragments)

When in doubt concerning the documentation of a debridement case, coders should query the physician. Multiple AHA *Coding Clinic* references are available regarding excisional and nonexcisional debridements, including:

- 2008 First Quarter, volume 25, page 3
- 2004 Fourth Quarter, volume 21, page 137
- 2004 Second Quarter, volume 21
- 2000 Second Quarter, volume 17, page 9
- 1991 Third Quarter, volume 8
- 1988 Fourth Quarter, volume 5

Coding professionals should reread these *Coding Clinics* , educate their coding staff, and perform quality reviews.

Note: since the RAC permanent program will include claims paid on or after discharges of October 1, 2007, appealing a RAC determination will require researching the appropriate AHA *Coding Clinic* reference. For example, if the discharge date on the claim is October 30, 2007, then any AHA *Coding Clinic* advice from the first quarter 2008 will not apply and should not be referenced in the appeal letter. This will apply to any RAC findings.

Lysis of Adhesions

RACs in South Carolina found coding lysis of adhesions problematic during the demonstration program. They found that the ICD-9-CM procedure code for lysis of adhesions was being assigned as an additional procedure, when in fact the lysis of adhesions was used as an approach.

According to the 1990 Fourth Quarter AHA *Coding Clinic*, "Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon."[3]

Minor adhesions may exist without being organized, causing any symptoms or additional difficulty performing the procedure. Coding lysis of adhesions in these cases is inappropriate, as it is the approach for a larger procedure.

Coders should not code the procedure for lysis of adhesions if the lysis is used as an approach. The exception is when the surgeon documents the procedure as "extensive" lysis of adhesions in the operative note. *Extensive* might include an obese patient or a patient with multiple adhesions due to previous surgeries, but this must be documented as extensive by the physician.

Coders should code the procedure for lysis of adhesions when the procedure is documented as such. In this case, they should code both the lysis of adhesions and the definitive surgery.

The following AHA *Coding Clinic* references apply to procedural coding of lysis of adhesions:

- Fourth Quarter 1996, volume 13, pages 65–67
- Third Quarter 1994, volume 11, page 8
- Fourth Quarter 1990, volume 7, pages 18–19

Wrong Principal Diagnosis

RACs also cited principal diagnosis as a leading area of concern in the demonstration project. RACs found that the principal diagnoses on claims did not match the principal diagnoses in the medical record. For example, respiratory failure (code 518.81) was listed as the principal diagnosis, but the medical record indicated that sepsis (code 038.0–038.9) was the principal diagnosis.

The most common DRGs with this problem were DRG 475, Respiratory System Diagnoses, and DRG 468, Extensive OR Procedure Unrelated to Principal Diagnosis. The RACs issued overpayment request letters for the difference between the amount for the incorrectly coded services and the amount for the correctly coded services.

The Uniform Hospital Discharge Data Set defines principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[4]

Given these findings hospitals may want to consider implementing a clinical documentation improvement program. Clinical documentation specialists can concurrently query physicians to determine the correct principal diagnosis prior to discharge. When the record is received in the coding department, there is no question as to the correct principal diagnosis.

Coagulopathy

Other states in the demonstration program experienced coding errors in the code category of coagulation disorders (286.x). Coders may be incorrectly assigning 286.5, Hemorrhagic disorder due to intrinsic circulating anticoagulants, to describe all

patients on anticoagulants, whether or not there is a resulting hemorrhagic disorder.

Points to remember when coding coagulopathy include:

- Code 286.5 is used only when such an adverse condition has occurred in cases like lupus, secondary hemophilia.
- Coumadin is not a circulating anticoagulant.
- If an abnormal lab finding is documented, diagnosis code 790.92 should be assigned.
- If a question remains, query the physician.

Coding professionals should reference the following AHA *Coding Clinics* as a refresher on this code assignment:

- Third Quarter 1990, volume 7
- Third Quarter 1992, volume 9
- Fourth Quarter 1993, volume 10
- Third Quarter 2004, volume 21

DRGs Designated as CC or MCC with Only One Secondary Diagnosis

RACs identified improper payments due to the coding of DRGs with complications or comorbidities (CC) or major complications or comorbidities (MCC) with *only one* secondary diagnosis.

Examples of these MS-DRG groupings include:

- MS-DRG 329, Major Small and Large Bowel with MCC 4.5059
- MS-DRG 330, Major Small and Large Bowel with CC 2.8935
- MS-DRG 331, Major Small and Large Bowel w/o cc/MCC 1.8415

Coders should not code findings from pathology reports on inpatient records without confirmation of the diagnosis from the attending physician. Physicians should be queried regarding the clinical significance of radiological findings through an effective clinical documentation program.

The following AHA *Coding Clinics* regarding code assignments from pathology and radiology reports should be referenced:

- First Quarter 2004, volume 21, pages 20–21
- Second Quarter 2002, volume 19, pages 17–18
- Third Quarter 2008, volume 25

Notes

1. Centers for Medicare and Medicaid Services. "CMS RAC Status Document, FY 2007: Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program." February 2008. Available online at www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf.
2. Ibid.
3. AHA. *Coding Clinic*. Fourth Quarter 1990.
4. National Center for Health Statistics. "Draft ICD-10-CM Official Guidelines for Coding and Reporting for Acute Short-Term and Long-Term Hospital Inpatient and Physician Office and Other Outpatient Encounters." June 2003. Available online at www.cdc.gov/nchs/data/icd9/draft_i10guideIn.pdf.

References

AHIMA. "Standards of Ethical Coding." September 2008. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Centers for Medicare and Medicaid Services. "E-mail Updates." Available online at https://subscriptions.cms.hhs.gov/service/multi_subscribe.html?code=USCMS.

Hirschl, Nancy, and Leslie LaStofka. "Update on RAC Audits." May 8, 2008. Audio seminar/Webinar. Available online at www.ahima.org.

HPMP Recourses. "About PEPPER." Available online at www.hpmpresources.org/PEPPER/AboutPEPPER/tabid/1209/Default.aspx.

More RAC Resources

To learn more about how organizations in the demonstration project prepared for RAC audits, read the February Journal article "RAC Ready: How to Prepare for the Recovery Audit Contractor Program" online in the FORE Library: HIM Body of Knowledge.

Members can also log on to the Recovery Audity Contractor Community of Practice for the latest news and discussions on the RAC program.

Log on to both resources at www.ahima.org for the latest updates on the RAC program.

CMS offers RAC program information and updates at www.cms.hhs.gov/RAC.

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