The DRG Shift: A New Twist for ICD-10 Preparation

By Peri L. Long, RHIA

Every generation has a few defining moments they can look back upon-big news events, clothing and fashion trends, hair styles, and maybe even a dance craze or two.

Today's healthcare industry is currently experiencing a defining moment of its own: preparations for the transition to the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) and Procedure Coding System (ICD–10–PCS). These two code sets-ICD-10-CM replacing ICD-9-CM diagnosis codes and ICD-10-PCS replacing the ICD-9-CM procedure codes-will change the way we assign diagnosis and hospital inpatient procedure codes. Together they are known as the I-10 initiative.

Background

The origins of this long-awaited transition begin with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA encourages the development of standards and requirements to facilitate the electronic transmission of certain health information. A final rule published in the *Federal Register* on January 16, 2009, modified the standard medical code set to adopt ICD-10-CM and ICD-10-PCS and established the original compliance date of October 1, 2013. Identification and submission of diagnosis and procedure codes is a key function of healthcare revenue cycles in the United States. While most nations have already made the transition to ICD-10 diagnosis coding, the reimbursement foundational impact in the US is a more significant implementation difference than in other countries. As a result, there is much to digest, understand, analyze, reassess, and prepare when a new standard is established.

Significant questions that arise during preparation include:

- What are these new codes?
- How will the new codes be applied in the Medicare Severity Diagnosis Related Group (MS-DRG) system?
- What is the cost of implementing this new code set?
- Where are the pitfalls? In other words, how does the organization identify and minimize financial risk?
- How will this standard be effectively implemented when there are already a number of important initiatives underway (meaningful use, 5010, privacy and security)?
- Where does the initiative truly fit in the priority matrix if it is "just codes"?
- How will these new codes work in the future?

Sample DRG Shift Results In ICD-10*

The implementation of ICD-10 will cause new shifts within the MS-DRG framework. This table takes a closer look at some examples of the shifts taking place.

ICD-9 MS-DRG and DESCRIPTION	ICD-10 MS-DRG and DESCRIPTION	EXPLANATION	SUMMARY	RESULT
DRG 039 – EXTRACRANIAL PROCEDURES W/O CC/MCC	DRG 027 – CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	ICD-10 procedure coding has multiple alternatives that are more specific than ICD-9, which could cause shifts to new MS-DRGs. Specifically, in reviewing the multiple ICD-10-PCS translations of ICD-9 procedure code 38.12.	The specificity of ICD-10-PCS causes multiple translations for extracranial procedures for head & neck endarterectomy and angioplasty of precerebral vessels, including specific root	Shift to higher weighted DRG

		Extirpations of upper arteries with an open approach are grouped to DRG 039. The same procedure in ICD-10 with both percutaneous and percutaneous endoscopic approaches group to DRG 027.	operations and approaches, causing the DRG shifts. Coding will be based on the documentation provided in the record, so this shift is likely to be experienced.	
DRG 781 – OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	DRG 998 – PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	Antepartum complications ICD-9 codes such as 642.43, "Mild or unspecified pre-eclampsia, antepartum" map to unspecified trimester codes in ICD-10. This is a "new" concept in ICD-10 diagnosis coding. The ICD-9 designations for antepartum, postpartum, or delivered are no longer part of the pregnancy classification in ICD-10. Shift is caused only when the translation to the unspecified trimester of these conditions is used (e.g. O14.00 Mild to moderate pre-eclampsia, unspecified trimester).	ICD-10 cases will most likely be coded to the specific trimester based upon record documentation (e.g. O14.03, Mild to moderate pre-eclampsia, third trimester). This is a shift unlikely to be experienced. This is, however, a good example of the pitfalls of sole reliance on General Equivalence Mappings (GEMs) for code translation for future processing.	Shift to a non-specific DRG
329 – MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	347 – ANAL & STOMAL PROCEDURES W MCC	ICD-9 code 45.62 "Partial small bowel resection NEC" was classified as a bowel procedure under ICD-9; however, in ICD-10, some of the PCS codes to which this ICD-9 procedure code is mapped (i.e. 0DBA0ZZ, Excision of Jejunum, open approach) are now reclassified as anal and stomal procedures which are moving them further down the list of hierarchy for DRG assignment.	The specificity of ICD-10-PCS results in multiple translations for this ICD-9 procedure. Depending on root operation, location and approach, some small intestinal procedures with the "excisional" approach move to another DRG while others with "resection" as the root remain in the original DRG assignment.	Lower weighted DRG
945 – REHABILITATION W CC/MCC	949 – AFTERCARE W CC/MCC	ICD-9 code V57.89 "Rehabilitation procedure NEC" maps to Z51.89 "Encounter for other specified aftercare." The ICD-10 code moves the rehab claim to DRG 949. NOTE: There is not a specific Z code for encounter for rehabilitation as in ICD-9-CM.	Translation from ICD-9 to ICD-10 diagnosis results in a DRG shift. A review of the definitions manual reveals that there are only two diagnosis codes that will direct to DRG 945: Z44.8, Encounter for fitting and adjustment of other external prosthetic devices, and Z44.9, Encounter for fitting and adjustment of unspecified external prosthetic device.	Lower weighted DRG NOTE: The majority of Rehab DRGs (945-949) are paid on a per diem basis under most contracts and are typically identified by revenue code.
*Analysis performed with 2012 ICD-10 CM/PCS draft 2012 codes and MS-DRG v29.0				

Important Considerations

Many concepts in current healthcare regulations will require careful consideration during preparations for the impact of ICD-10. With the increased number of codes available-diagnosis codes spanning from three to seven alphanumeric characters, and procedures being seven alphanumeric characters-the successful implementation of a change as far-reaching and detailed as ICD-10 may seem like an overwhelming task. But boldly moving forward is the logical option when faced with the current constraints of ICD-9-CM as the alternative.

The first concept concerning the revenue cycle is "budget neutrality," a method of calculation where in any given year the estimated aggregate payments for services under the old method remain the same trended forward. The expectation is that the MS-DRG system (grouping and payments) will work the same despite the ICD-10 changeover. However, because the grouper is new and has only recently been available for testing and analysis with ICD-10 codes, optimism remains reserved. Will a whole new code set produce the same results? Will neutrality be the reality?

A second factor is the impact of expanded diagnoses and procedures acceptance. The current implementation of the HIPAA Version 5010 format has the increased capacity to process 25 diagnoses and 25 procedure codes on hospital inpatient claims. Prior to this expanded format, only 9 diagnoses and 6 procedures could be processed. Version 5010 is scheduled for implementation July 1, 2012, with ICD-9-CM as the current code set. The intelligence around this expansion will be useful, but will change with the volume of code options and granularity offered by ICD-10. While there has been an expansion for acceptance of additional codes, the decision to utilize all accepted codes in grouping has not been finalized. This decision would have further implications on MS-DRG assignments and case mix. Consider the implications of surgical hierarchy impact, along with the volume of codes for conditions classified as complications.

As previously mentioned, there are a number of concurrent healthcare initiatives underway: 5010, ICD-10, EHR meaningful use, and quality measures. Not only are they following similar timelines, they are also impacting many of the same resources that have roots in electronic health information. With all of these competing priorities, it is not difficult to understand why ICD-10 is often mistakenly thought of as only a coding initiative rather than an entire healthcare movement.

Impending Shifts

Much like an unpacked gift box is impossible to return to its original condition, something fundamental has shifted in today's healthcare system as a result of the ICD-10 transition. ICD-10 coding is a new set that needs to be opened, explored, and analyzed in order to determine not only how the codes will be assigned, but how the specificity in translations will have an impact and interact with the MS-DRG framework. For the most part, the large pieces fit nicely back in the package known as the MS-DRG system. There are some shifts, however, that don't seem to quite fit back in the grouper box as expected. These are examined more closely in the table on page 77.

Summary

Analysis of your specific business is a key component of ICD-10 implementation. An understanding of your organization's current reimbursement trends will go a long way to assessing and preparing for the impact of ICD-10 in your environment. If you cannot be prepared for each detailed scenario, remember that much of the analysis and resolution requires familiar coding, DRG analysis, and claims processing best practices. Now, they simply have the new twist of researching new codes and some new concepts. The news of a delay in the implementation compliance date, along with the release of grouper Version 29, should encourage your educational and business analysis efforts. This is a great opportunity to maintain open communication with the Centers for Medicare & Medicaid Services, Department of Health and Human Services, and Centers for Disease Control. This is also a key time to report any unusual or discrepant findings in order to provide input to the final rule.

References

CMS. "Converting MS-DRGs 26.0 to ICD-10-CM and ICD-10-PCS." Centers for Medicare and Medicaid Services ICD-10 Website. www.cms.gov/ICD10.

CMS. "Draft ICD-10-CM/PCS MS-DRG v29.0 Definitions Manual." Centers for Medicare and Medicaid Services Table of Contents Website. www.cms.gov/ICD10Manual/version29-fullcode-cms/P0001.html.

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