Trouble with DRGs

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by Robert J. Mahoney, MD, CCS-P

A major frustration among coding professionals, particularly in the inpatient setting, is the difficulty in translating physician documentation into diagnostic related group (DRG) data. Some hospitals have attempted to improve their coding effectiveness by establishing time-consuming physician query processes to clarify the differences between what is written and what is coded.[1] In many cases, however, query and coding process problems arise not from improper documentation by physicians but from idiosyncrasies in the DRG criteria and the ICD-9-CM system on which they are based.

Upon reviewing the list of overcoded DRGs highlighted by the Office of Inspector General (see "10 Overcoded DRGs," below), you will find that these DRGs are not necessarily coded incorrectly due to intentional abuse or fraud. In many cases, problems are caused by ambiguities in how DRGs are defined. These "hot zones" of payment errors are particularly frustrating to physicians, who are often asked to rethink their definitions of a disease to fit within these often esoteric criteria.

10 Overcoded DRGs

DRG	Description
79	Respiratory infections and inflammations age > 17 w/cc
87	Pulmonary edema and respiratory failure
121	Circulatory disorders w/AMI and cardiovascular complication, discharged alive
144	Other circulatory system diagnoses w/cc
188	Other digestive system diagnoses age > 17 w/cc
239	Pathological fractures and musculoskeletal and connective tissue malignancy
316	Renal failure
416	Septicemia age > 17
429	Organic disturbances and mental retardation
475	Respiratory system diagnosis with ventilator support

Source: Office of Inspector General. "Using Software to Detect Upcoding of Hospital Bills." Department of Health and Human Services, 1998.

This two-part article will review ways in which DRGs differ from standard clinical knowledge. This article will focus on differences in DRG definitions and clinical practice definitions. Part 2 will discuss difficulties in merging DRG criteria with clinical practice and will present some ways you can improve your coding process. After reading this article, you may agree that your coding issues arise more often from the DRGs themselves than from problems with your query process.

DRGs Redefine Clinical Definitions

During the physician query process, the criteria that coders use to initiate a query regarding the presence of a particular disease may differ markedly from the criteria a physician would use to diagnose that disease. In some cases, a query based solely upon DRG criteria may encourage a physician to document a diagnosis that is not appropriate based on a physician's training.

For example, a query regarding **respiratory failure** may focus on parameters of arterial blood gases or accessory muscle use. A physician's understanding of respiratory failure, however, may not incorporate these specific criteria. Rather, the physician may use the term "respiratory failure" to reflect a more global inability of the respiratory system to provide adequate oxygen and carbon dioxide exchange. A query regarding the presence of respiratory failure in this circumstance may appear as a request to document a diagnosis that the physician is not comfortable making.

The term "insufficiency" is commonly used in clinical practice to describe a dysfunction of an organ system that remains adequate to support life, and the term "failure" is used to describe a life-threatening dysfunction that requires artificial intervention.[2] For example, physicians typically use "respiratory failure" to describe a situation in which the mechanism of breathing is so disrupted by disease as to require artificial intervention (such as mechanical ventilation). This is in contrast to "respiratory insufficiency," in which ventilatory supply does not equal demand but still does not require invasive intervention.

The adherence of physicians to the term "failure" in this circumstance is somewhat controversial, as there are other types of failure (such as heart failure) that do not necessarily require artificial intervention. But it explains why queries regarding respiratory failure often involve a discussion of whether the patient in question is intubated and ventilated. In the absence of mechanical ventilation, physicians may not feel the term "respiratory failure" is appropriate. This similarly explains why queries regarding renal failure versus renal insufficiency focus on the need for hemodialysis.

Terms such as **malignant hypertension** can lead to diagnostic confusion as well. "Malignant" hypertension is medically defined as a specific pathologic entity involving rapidly progressive organ dysfunction and arteriolar fibrinoid necrosis.[3] It does not properly refer to hypertension that is merely poorly controlled. It is also not appropriate to use this term simply because of manifestations of end-organ damage. However, many queries regarding hypertension begin with documentation of poor control and may prompt physicians to provide misleading documentation.

Queries regarding **lobar pneumonia** may suffer similar confusion. In ICD-9-CM, the term lobar pneumonia refers to pneumonia caused by the pneumococcus (*Streptococcus pneumoniae*). The term more properly refers to pneumonia that is radiographically and pathologically confined to a single lobe of the lung. While the pneumococcus is responsible for the majority of lobar pneumonia, there are other pathogens that can cause this type of pneumonia.[4] Treating the terms synonymously is not necessarily appropriate.

Queries regarding **sepsis** frequently create confusion. Bacteremia is well understood to refer to the presence of bacteria in the bloodstream. Septicemia is a broader term that refers to the presence of bacteria or their toxins in the bloodstream.[5] Bacteremia is typically diagnosed by blood cultures in which a sample of blood is taken and mixed with a culture medium that promotes the growth of any bacteria present. There are assays under development for the detection of bacteria in the bloodstream without cultures, but the blood culture remains the standard means of diagnosis.[6] Physicians may have a clinical suspicion of bacteremia, but the diagnosis cannot be made in the absence of laboratory confirmation.

However, not all bacteremia or septicemia causes illness. It is typically the body's response to bacteria or toxins—not the action of bacteria themselves—that is most responsible for illness. Sepsis and sepsis syndrome refer to this systemic response to infection. Bacteremia does not need to be present for a patient to develop sepsis, but it is a common inciting factor. "Sepsis" and "septicemia" are not interchangeable terms, despite their frequent synonymous use in clinical practice.

Queries regarding sepsis are often initiated when bacteremia is found together with systemic manifestations such as tachycardia or an elevated white blood cell count. While this constellation of findings may satisfy the DRG criteria for sepsis, there may be reasons other than sepsis to explain why a bacteremic patient may have such findings (e.g., dehydration). Such queries may lead to inappropriate documentation when this syndrome has another explanation.

In some cases, DRG criteria have brought attention to areas in which clinical language is imprecise. One such controversial diagnosis is "urosepsis." In most cases, urosepsis refers to sepsis arising from an infection of the urinary tract.[7, 8] However, many physicians use the term "urosepsis" to refer simply to a urinary tract infection, which frequently causes confusion for coders.[9] Until consensus can be reached about the meaning of terms such as "urosepsis," they will continue to be the subject of queries.

Notes

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