Trouble with DRGs: Part 2

by Robert J. Mahoney, MD, CCS-P

Last issue's article presented some ways that DRG criteria redefine well-established clinical entities such as respiratory failure and sepsis. This article will discuss two other incompatibilities between DRG criteria and clinical practice: the clinical distinctions required by the DRG system and the potentially hazardous documentation that may result from satisfying DRG criteria.

Drawing Difficult Distinctions

DRG-based queries often ask physicians to make distinctions between diagnoses that are clinically similar. Although making a specific diagnosis is a cornerstone of good medical practice, many diagnoses lie on a spectrum of manifestations or severity that makes rigid separation difficult. Often, the treatment is the same for disorders along a spectrum, and such distinction is of limited clinical significance.

Frustration with queries regarding **pneumonia** likely stems from this difficulty. Deciding which DRG to assign to a particular patient with pneumonia depends on the causative organism.[1] However, sputum studies have a low sensitivity for identifying a causative organism, and the yield from blood cultures is little better.[2,3] In many cases, the etiologic agent for pneumonia is never identified.

This poses a minor problem for clinicians, who must use broader-spectrum antibiotics to treat pneumonia effectively. It poses a much larger problem for coding professionals, who are required to use clues (such as the presence of aspiration or immunocompromise) to decide whether DRG 079, Respiratory Infections and Inflammations, is appropriate.

Many pneumonia queries focus on the potential presence of Gram-negative organisms, as many of these are listed among the agents included in DRG 079. However, Gram-negativity does not automatically confer increased virulence. In fact, Hemophilus influenzae, a Gram-negative organism, is properly classified under the less complex DRG 089, Simple Pneumonia. Querying physicians as to whether a patient's pneumonia could possibly involve a Gram-negative organism may lead to misleading documentation.

Queries regarding **obstructive lung disease** are similarly frustrating. Clinicians often divide obstructive lung disease into asthma (in which airway obstruction is acute and generally reversible) and COPD (in which airway obstruction is more chronic and less reversible). Although pathophysiologically distinct, the diseases clinically exist along a spectrum of reversibility, severity, and acuity and are generally treated with the same group of medications. Clinically, distinctions among the various diagnostic entities, particularly during a single episode of care, can be difficult. For this reason, queries regarding the chronicity of asthma symptoms or the reversibility of COPD symptoms may not always be answered to a coding professional's satisfaction.

Distinction is even more challenging (and more confusing) in **diabetes**. The history of diabetes is characterized by multiple attempts at simplifying its diagnostic classification. ICD-9-CM has attempted to keep up with these changes, resulting in more confusion than clarity.

Initially, diabetes was divided into juvenile-onset and adult-onset forms, based on age at presentation. As the pathophysiology of diabetes became better understood, the classification evolved, and the categories of insulin-dependent (type 1) and noninsulin-dependent (type 2) diabetes were introduced. Other categories, such as gestational diabetes and impaired glucose tolerance, were subsequently added.[4]

Type 1 diabetes is believed to result from an absolute deficiency of insulin production. For this reason, type 1 diabetics must receive exogenous insulin via regular injections (i.e., insulin-dependent). Type 2 diabetes, on the other hand, is believed to result

from resistance to the action of insulin, rather than from an absolute deficit in the production of insulin itself. These patients can frequently be treated with oral agents that increase insulin production or decrease insulin resistance. However, many type 2 diabetics will eventually require insulin injections for optimal glucose control.

The significant clinical overlap between type 1 and type 2 diabetes and confusion about the terms "insulin-dependent" and "noninsulin dependent" have led to multiple attempts at reclassification. The introduction of new terms such as "insulin-requiring" has done little to help clarify the distinction. For this reason, the most recent classification system proposed by the American Diabetes Association (ADA) removes all reference to insulin, retaining only the terms "type 1" and "type 2."[5] However, many clinicians continue (incorrectly) to use type 1 diabetes to refer to any diabetic who is currently using insulin.

The moving target of diabetes classification has posed a significant problem for coders in the attempt to reconcile the multiple ways in which the diagnosis may be documented with relatively specific ICD-9-CM terminology. In keeping with the recent ADA classification changes, references to insulin have been removed from the ICD-9-CM descriptors for diabetes, effective October 1, 2004. The term "juvenile type" is retained, although clinical use of this term is de-emphasized in the ADA classification.

It is unclear what impact ICD-10-CM will have on diabetes coding. While the distinction between type 1 (E10) and type 2 (E11) is preserved, there is a much greater emphasis in ICD-10-CM on the etiology of diabetes, including expanded distinctions among secondary diabetes (E08) and drug-induced diabetes (E09).[6] This will no doubt lead to an increased frequency of queries asking for greater precision in diagnosis.

DRGs Require Hazardous Documentation

It is understandable that the severity of disease would play a major role in the assignment of DRGs and comorbidities. However, in some cases a query will request a physician to provide documentation that at best impugns management and may be medicolegally irresponsible. For example, documenting "uncontrolled diabetes" for a patient admitted with diabetic ketoacidosis is perfectly reasonable. However, the same is not necessarily appropriate for a patient who requires occasional sliding scale insulin for mildly elevated blood glucose readings. Coders are sometimes encouraged to query physicians regarding the presence of uncontrolled diabetes in precisely this situation, as this constitutes an important comorbidity.

One can imagine a scenario in which an unforeseen complication in a hospitalized patient is blamed on that patient's uncontrolled diabetes—when the patient simply received a few extra units of insulin occasionally. Such documentation may also prompt chart reviewers to wonder how a patient can be in the hospital for three days and still have diabetes that is uncontrolled.

Making Your Queries More Effective

While it is not likely we will soon see dramatic changes to address these issues in the DRG system, there are some simple steps that coding professionals can take to improve the results of their queries and to improve clinician documentation overall.

Acknowledge the differences between DRG language and clinical understanding. Many coding professionals become frustrated when their efforts to educate physicians about the meanings of various diagnostic terms are unfruitful. Many queries stop short because of disagreements regarding the meaning of sepsis or respiratory failure. The majority of physicians have a concrete understanding of these terms that may vary markedly from what is described in coding manuals.

Focus on specificity, not accuracy. Because of these differences in terminology, physicians may be uncomfortable documenting diagnoses that you feel are indicated according to DRG criteria. Rather than emphasizing the use of specific words or phrases, encourage physicians to document their diagnoses and plans with as much specificity as possible. Instead of suggesting that physicians document a "possible Gram-negative pneumonia," encourage them to describe the antibiotic coverage of "Gram-negative pathogens" in their notes. When physicians document nebulous diagnoses such as "urosepsis" (a term whose meaning differs even among physicians), suggest "UTI with delirium" or "UTI with sepsis."

Don't force the issue. When a physician does not have the information needed to make a fine diagnostic distinction (such as asthma versus COPD) and such information does not bear on treatment, asking that all diagnostic possibilities be listed will only lead to muddled documentation. It may still be possible to find common ground. Instead of compromising on "asthma/COPD,"

perhaps the physician could document "dyspnea" or "asthma with probable COPD." If a physician does not feel comfortable documenting that a disease is "uncontrolled," there may be a good reason behind it.

Establish a relationship. Most coding professionals will agree that the key to effective queries is developing an understanding with their physicians. Anonymous requests for better documentation will uniformly remain unanswered. Physicians are not resistant to improving their documentation; they are, however, reluctant to provide documentation that they find misleading. The first step is to develop rapport with the physicians and explain the role of the query. Bear in mind that you may disagree from time to time. But keeping the above principles in mind will keep discord to a minimum.

Notes

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3. Campbell, Samuel G., Thomas J. Marrie, Rosemary Anstey, Garth Dickinson, and Stacy Ackroyd-Stolarz. "The Contribution of Blood Cultures to the Clinical Management of Adult Patients Admitted to the Hospital with Community-Acquired Pneumonia: A Prospective Observational Study." *Chest* 123, no. 4 (2003): 1142–50.
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6. Centers for Disease Control and Prevention, National Center for Health Statistics. "Pre-release Draft, June 2003: International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)." June 2003. Available online at www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm.

Robert J. Mahoney *(rmahoney@wustl.edu) is an assistant professor of medicine at the Division of Hospital Medicine at Washington University School of Medicine and an attending physician at Barnes-Jewish Hospital, St. Louis, MO.*

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