# Documentation & DRGs: A Physician's Guide

An Introduction

## Physician Documentation: It's not just for patient care

In medical school, physicians are trained to record clinical information in medical records for patient care, including communication with other healthcare professionals, as well as for quality improvement purposes. The curriculum does not, however, address how physician documentation translates into ICD-10-AM diagnoses and procedure codes.

Appropriate assignment of diagnosis and procedure codes is imperative. These codes are used in:

- the collection of information regarding disease and injury
- inpatient hospital reimbursement
- analysis of hospital costs, utilization patterns and clinical outcomes, providing the data used in benchmarking performance for process improvement and contracting with health plans

## Goal & Format

- This Physician Documentation Guide is intended to improve the quality of physician documentation and to demonstrate how such documentation is translated into ICD-9-CM diagnosis and procedure codes by health information management professionals, leading to correct DRG assignment and appropriate reimbursement to the hospital for services rendered.
- The guide for each topic includes:
- Documentation Dos and Don'ts -- common pitfalls relating to appropriate DRG assignment
- Helpful hints and reminders
- Sample physician diagnostic statements with explanations of their impact on DRG assignment

## DRGs in a Nutshell

Since the Medicare Prospective Payment System was implemented in 1983, Health Information Management professionals have been faced with the challenge of accurate coding for appropriate hospital reimbursement. Coding for reimbursement requires facilities to minimize coding errors AND improve physician documentation.

***Definitions***

Diagnosis related group (DRGs) are classifications of diagnoses within which patients are medically related with respect to diagnoses and treatment and are statistically similar in their lengths of stay. A patient admission is mapped to a DRG based on the following elements:

- **Principal diagnosis** -- the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital
- **Secondary diagnoses** -- all conditions that coexist at the time of admission, that developed subsequently, or that affect the treatment received and/or the length of stay
- **Age**
- **Gender**
- **Surgical procedure**

- **Complication/comorbidity (CC)** -- A complication is a condition arising during hospitalization that affects the course of the patient's illness or the medical care required. A comorbidity is a condition existing at the time of hospitalization which has potential for affecting the course of illness or medical care provided.
- **Discharge status** -- the disposition of the patient at discharge (e.g., left against medical advice, discharged home, home care services, skilled nursing facility, acute care facility, rehabilitation facility, expired) must be assigned correctly for appropriate DRG assignment and reimbursement.

There are currently 511 Medicare DRGs. Each is assigned a relative weight by HCFA intended to reflect the relative resource consumption associated with that particular DRG. The DRG payment includes the full range of inpatient hospital services (including certain preadmission tests) to date of discharge for each patient.

***Major diagnostic categories***

DRGs are generally considered clinically uniform and are grouped into 25 major diagnostic categories (MDCs). The MDCs were formed by physician panels as the first step in insuring that the DRGs would be clinically coherent. The diagnoses in each MDC typically represent a body system. Since not all diseases can be grouped to an organ system based MDC, a few residual MDCs were created (e.g., Myeloproliferative Disorders, Multiple Significant Trauma, Systemic Infectious Diseases).

***What can we learn from DRG data?***

DRGs provide the means for hospitals to gain an understanding of the type of patients being treated and the costs incurred, and to predict the types of services that may be required in the future. As medical practice and technology change and extensive data is collected, the definition of DRGs and the classification of patients into DRGs will continue to be reviewed and revised.

## Principal Diagnosis vs Primary Diagnosis

### An Important Distinction

Physicians often find it difficult to distinguish between the principal diagnosis and the primary diagnosis, although they have very different meanings. For correct DRG assignment, the difference between principal and primary diagnoses must be clearly understood by the physician.

**Definition**: **Principal Diagnosis** is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. The principal diagnosis is listed first on the attestation.

**Definition**: **Primary Diagnosis** is the condition having the most impact on patient's health, length of stay, resource consumption and the like, regardless of when it occurred during the hospital admission. The primary diagnosis may or may not be the same as the principal diagnosis.

## Assignment of the principal diagnosis:

### Why is it so important?

Appropriate DRG assignment is largely predicated on the assignment of the correct principal diagnosis. If a diagnosis code is inappropriately used as the principal diagnosis, either an overpayment or an underpayment in hospital reimbursement will result.

The sample discharge summary and discussion on the following pages are designed to illustrate the importance of making the distinction between the primary and principal diagnoses.

## Bridging the Gap: the Physician/Coder Partnership

- **Medical record coders rely on physician documentation** to assign the appropriate ICD-9-CM diagnosis and procedure codes, leading to the appropriate DRG and reimbursement.

- **The physician is responsible for providing complete and comprehensive progress notes** outlining all diagnoses, procedures, complications and comorbidities, and abnormal test results that relate to the current episode of care.

- Coders **CANNOT** assign an ICD-10-AM diagnosis code based on laboratory values or diagnostic test results alone. **Only a physician can assign a diagnosis**.

- **Remember, it's not how much you write, but <u>what</u> you write.**

**BE CLEAR!**

**BE PRECISE!**

**BE EXPLICIT!**

**BE CONCISE!**

## General Principles of Medical Record Documentation

- The medical record should be complete and legible.
- For each inpatient admission, document the following:

  - Reason for the admission, relevant history, findings of physical examination, diagnostic test results

  - Assessment, clinical impression and diagnosis

  - Plan for care

  - Date and legible signature of the physician

- The rationale for ordering diagnostic and other ancillary services should be clearly documented.
- Past and present diagnoses should be stated clearly.
- Relevant health risk factors should be identified.
- Document the patient's progress, response to treatment, changes in treatment and any revision of diagnosis.
- Remember, all diagnoses and procedures must be explicitly documented by the physician in the medical record; laboratory, radiological and other test results that may indicate a diagnosis cannot be coded without express confirmation by the physician.
- The Discharge Summary must contain all of the following:

  - The patient's chief complaint

  - Clinical findings (i.e., laboratory and test results)

  - Course in hospital

  - Clear documentation of the diagnosis established after study to have caused admission to the hospital

**Remember, the Discharge Summary and the progress notes should accurately reflect the same events.**