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Savvy Sequencing Using the Two or More Guideline

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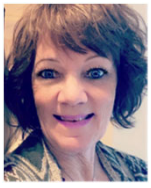

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Discuss how sequencing opportunities can be missed by traditional CDI/Coding/QA programs
  - Identify two commonly missed high volume sequencing opportunities and how to defend them
  - Describe high value sequencing opportunities and how to find them

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Principal Diagnosis Coding

Definitions, Guidelines, and Coding Clinics

The UHDDS Definition of Principal Diagnosis

- "That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- UHDDS adherence is a requirement based on the code of federal regulations, (CFR).
  - The Code of Federal Regulations (CFR) is the codification of the general and permanent regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
- In terms of regulatory hierarchy, Laws and regulations such as the UHDDS definition of the principal diagnosis trump "guidance" which includes coding guidelines and manuals (e.g., ICD-10-CM Official Guidelines for Coding and Reporting, AHA's *Coding Clinic*, and Medicare Claims Processing Manual)
- If these examples such as Medicare Claims Processing Manual are simply guidance, "then UHDDS wins."
- The definition of principal diagnosis and circumstances of admission must be met first before the application of any sequencing guidance from the OCGs or *Coding Clinic*.

Selection of Principal Diagnosis Hierarchy

1. The **principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS)** as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
2. "The **circumstances of inpatient admission** always govern the selection of principal diagnosis."
3. In determining principal diagnosis, coding conventions in the ICD-10-CM, the **Tabular List and Alphabetic Index** take precedence over the official coding guidelines (OCGs). (See Section I.A., Conventions for the ICD-10-CM)
4. The **OCGs Chapter-Specific guidelines** pertaining to sequencing (e.g., HIV, obstetrics, sepsis, poisoning, acute respiratory failure, etc.) are applied next.
5. The **OCGs general sequencing guidelines** (e.g., A. Codes for symptoms, signs, and ill-defined conditions, **B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis, C. Two or more diagnoses that equally meet the definition for principal diagnosis**, D. Two or more comparative or contrasting conditions, F. Original treatment plan not carried out, G. Complications of surgery and other medical care, H. Uncertain Diagnosis) are applied if no guidance from steps 3 & 4 apply.

Reference: ICD-10-CM Official Guidelines for Coding and Reporting, Section II. Selection of Principal Diagnosis. Effective October 1, 2021 - September 30, 2022

Be Careful Using Coding Clinic for Sequencing Advice

Conflicting Coding Clinic Advice

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2018: Page 90

Question:

When advice published in Coding Clinic conflicts with the Official Guidelines for Coding and Reporting or the ICD-10-CM/PCS classification, should coding professionals still follow the published advice or adhere to the instructions in the guidelines and/or the classification?

Answer:

"…When there is a discrepancy between the conventions in the classification, the guidelines and/or advice published in Coding Clinic, coding professionals should adhere to the following hierarchy: Conventions in the ICD-10-CM and ICD-10-PCS classification take precedence over the Official Guidelines for Coding and Reporting, and both the classification and guidelines take precedence over Coding Clinic advice."

"The advice published in Coding Clinic is not intended to replace the instructions in the classification nor the Official Guidelines for Coding and Reporting. The advice is meant to be used when the ICD-10-CM/PCS classification and the guidelines do not provide direction."

Caution: The sequencing advice provided in *Coding Clinic* is specific to the case presented & cannot be assumed to be applicable to all cases involving the same diagnosis(es). *Coding Clinic* often does not provide sufficient detail about the case under review to allow us to safely apply their response to similar cases.

"Two or More" Guidelines

Section II. Selection of Principal Diagnosis

The Guidelines further state:

> "in determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence" over the Guidelines. Section II.C., contains rules governing code assignment for two or more conditions that equally meet the definition for principal diagnosis.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

Reference: ICD-10-CM Official Guidelines for Coding and Reporting, Section II. Selection of Principal Diagnosis.

Present on Admission

- Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. -OCGs
- There is no required time frame as to when a provider must identify or document a condition to be present on admission.
- In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission.
- In some cases, it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission.
- Determination of whether the condition was present on admission is based on the applicable POA guideline or the provider's best clinical judgment.

Reference: Appendix B, AHA Coding Handbook

Circumstances of Inpatient Admission

- It is the circumstances of admission (i.e., reason for the encounter) that explain and identify the potential principal diagnosis options. It is critical to determine which POA conditions are driving the circumstances of admission.
- What documents do you review to find this evidence?
- What questions do you ask yourself to make this determination?

Circumstances of Inpatient Admission

Remember—the circumstances of admission (i.e., intent or reason for admission) is your first determinate of the principal diagnosis. This does not mean that the diagnosis listed by the provider as ***reason for admission*** will be your principal diagnosis every time. Why? 2 key reasons:

1. The patient may in fact be admitted for several reasons and only one may be specifically listed as the "admitting diagnosis" or "reason for admission" by the provider.
2. We must apply the "after study" to arrive at the principal diagnosis based on the UHDDS definition.

"Two or More" Guidelines

Section II. Selection of Principal Diagnosis

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

The first phrase **"In the unusual instance"** has not aged well since the guidelines were first published for use in 1990. The inpatient population today is older, with more chronic illness and a higher acuity level than in the past. It is not uncommon, especially for Medicare patients, to be admitted as an inpatient for more than one diagnosis that after study and application of the hierarchy of coding sequencing guidelines would equally qualify for reporting as the principal diagnosis.

"Two or More" Guidelines

Section II. Selection of Principal Diagnosis

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more **diagnoses** **equally meet the criteria** for principal diagnosis **as determined by the circumstances of admission, diagnostic workup and/or therapy provided,** and the **Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction,** any one of the diagnoses may be sequenced first.

*In terms of **equally meet the criteria…as determined by…"diagnostic workup and/or therapy provided"** this statement has been interpreted and applied many ways and is undoubtably responsible for many principal diagnosis sequencing errors we have uncovered.*

We often see this interpreted to mean that treatment of the contenders for principal diagnosis must be "equal", but this is not true—it simply doesn't make sense. Why?

1. Sometimes the provider may determine no treatment (such as medication or surgery) is the best course of action for a patient, maybe monitoring the patient at a different level of care, for instance in the ICU versus placement on a medical/surgical floor is best. It really would depend on the circumstances of the admission.
2. No definition of "equal" treatment has ever been provided by the Cooperating Parties. Would this be equal cost of resources to provide the treatment, equal impact on LOS, equal skill in provision of the treatment, equal risk of providing the treatment? Without a clear definition and criteria, we would have no way to apply this consistently across all inpatient encounters coded each year.

Utilization of the Tabular List or Alphabetic Index to make sequencing decisions makes sense as these rank just below circumstances of admission and the UHDDS definition of principal diagnosis in the hierarchy of coding guidelines.

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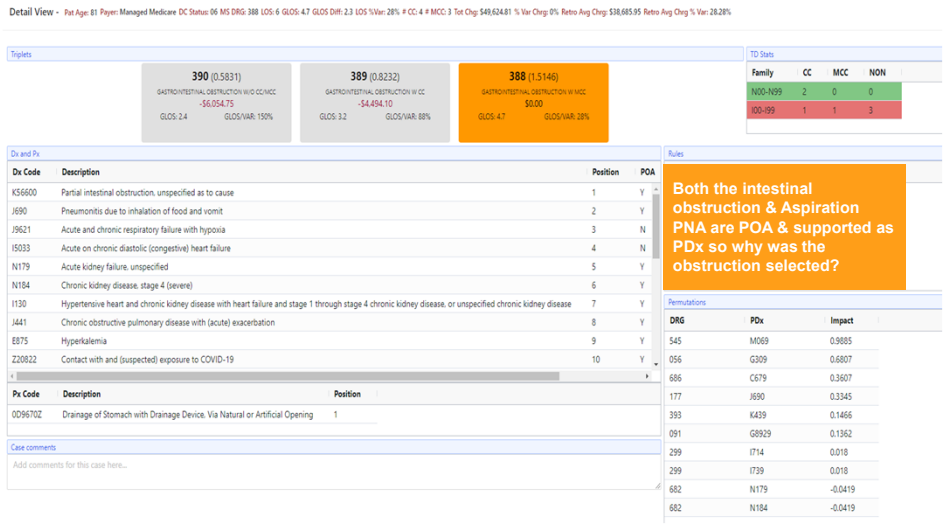
"Focus of Treatment" Conundrums

Common Sequencing Decision Making



Both the intestinal obstruction & Aspiration PNA are POA & supported as PDx so why was the obstruction selected?

O.R. Procedures Unrelated to the Principal Diagnosis

Procedures unrelated to the principal diagnosis warrant a consideration for sequencing evaluation. If two diagnoses that are both POA and based on circumstances of admission, either could be the principal diagnosis, but one required an OR procedure and one did not, sequencing the one requiring the OR procedure as principal to avoid DRGs 981-989 may be advisable although this is not a hard and fast rule. Doing so may insulate the case from payer review and potential denial, but the ultimate goal is to assign the most appropriate principal diagnosis not what will avoid payer scrutiny.

MS-DRG	Post-Acute DRG	Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	4.6145	8.4	11.7
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	2.5366	4.6	6.2
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.6523	2.3	3.0
987	Yes	Yes		SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	3.2759	7.7	10.4
988	Yes	Yes		SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	1.7064	4.3	5.6
989	Yes	Yes		SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.1236	2.3	3

Coding Clinics – Thrust of Treatment-Hematuria

Hemorrhagic disorder due to circulating anticoagulants
Coding Clinic, Fifth Issue 1993 Page: 16

Question:
When is it appropriate to use …Hemorrhagic disorder due to circulating anticoagulants? Does the sequencing of codes depend on the thrust of treatment? Or is this code not used as a principal or secondary diagnosis even if a hemorrhagic disorder such as a hematuria was due to an anticoagulant such a Coumadin?

Answer:
Code …Hemorrhagic disorder due to circulating anticoagulants, **is very rarely used**. This is because the thrust of treatment is directed towards the control or treatment of bleeding, such as hematuria or hematemesis. Therefore the bleed, such as …Hematuria, would be the principal diagnosis…

We disagree with the statement that the hemorrhage secondary to extrinsic circulating anticoagulants, D68.32, is "very rarely used" as a principal diagnosis. This is a sequencing strategy that is missed by many coders, but it does require certain treatment to support the sequencing.
#1 The anticoagulant has been discontinued, AND
#2 The patient is ordered a reversal agent such as Vit K, Kcentra or FFP, AND
#3 There should be continuous monitoring of INR/PT unless with Eliquis

Focus of Treatment CC – Acute Bronchitis with Acute Exacerbation of Asthma

Acute Bronchitis with Acute Exacerbation of Asthma
Coding Clinic, Fourth Quarter 2004 Page: 137

Question:
If a patient has both acute bronchitis and an acute exacerbation of asthma, which condition should be sequenced first?

Answer:
When a patient is admitted with two acute conditions, the condition requiring the most treatment, or which is the major focus of care, should be sequenced first…Acute bronchitis is not equivalent to an acute exacerbation of asthma.

How does *Coding Clinic* define "the most treatment?" Is that in terms of days of treatment, intensity of treatment (e.g., 4 days of IV vs 6 days), overall cost of treating one condition over another (e.g., IV drug # 1 cost $800 and IV drug #2 cost $400)? If so, how is a coder to determine this?

We are not Cost Accounts!

Is "major focus of care" even the same as "most treatment?"

If we require a consultant for one diagnosis and not the other—is that a "major focus?"

Focus of Treatment CC – Multiple Myeloma

Hypercalcemia due to Multiple Myeloma
Coding Clinic, Third Quarter 2012 Page: 16

Question:
An 84-year-old female with multiple myeloma and numerous severe complications has been hospitalized several times with gradual expected deterioration in her general condition. …She was noted to be markedly hypercalcemic from the multiple myeloma. The patient was given intravenous hydration and supportive care. Aggressive treatment for the multiple myeloma was not pursued and the patient was transferred to hospice. How should this case be coded?

Answer:
The thrust of treatment was directed at the hypercalcemia. Hypercalcemia is a complication of the multiple myeloma. Assign … Hypercalcemia, as principal diagnosis. … Multiple myeloma, without mention of having achieved remission, and …Encounter for palliative care, as additional diagnoses.

As stated in *Coding Clinic* Second Quarter 2010, The basic rule for designating principal diagnosis is the same for neoplasm as for any other condition; that is, the principal diagnosis is the condition found after study to have occasioned the current admission or encounter. There is no guideline that indicates that a code for the malignancy takes precedence. Because the principal diagnosis may be difficult to determine, the focus of treatment can often be used as a guide.

Note the language over time has changed and softened. "Focus of treatment" is now stated as "can be often used as a guide" when the principal diagnosis is difficult to determine.

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High Volume Sequencing Opportunities

Top 25 DRG Shifts Using "Two or More" Guidelines

1. 291, HEART FAILURE AND SHOCK W MCC
2. 190, CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC
3. 189, PULMONARY EDEMA AND RESPIRATORY FAILURE
4. 308, CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS W MCC
5. 378, GASTROINTESTINAL HEMORRHAGE W CC
6. 640, MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES W MCC
7. 689, KIDNEY AND URINARY TRACT INFECTIONS W MCC
8. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC
9. 682, RENAL FAILURE W MCC
10. 312, SYNCOPE AND COLLAPSE
11. 392, ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS W/O MCC
12. 690, KIDNEY AND URINARY TRACT INFECTIONS W/O MCC
13. 617, AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS W CC

Top 25 DRG Shifts Using "Two or More" Guidelines

14. 641, MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES W/O MCC
15. 194, SIMPLE PNEUMONIA AND PLEURISY W CC
16. 683, RENAL FAILURE W CC
17. 176, PULMONARY EMBOLISM W/O MCC
18. 637, DIABETES W MCC
19. 811, RED BLOOD CELL DISORDERS W MCC
20. 304, HYPERTENSION W MCC
21. 069, TRANSIENT ISCHEMIA WITHOUT THROMBOLYTIC
22. 603, CELLULITIS W/O MCC
23. 280, ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC
24. 064, INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC
25. 100, SEIZURES W MCC

Top 10 DRG Shifts Audit Results Using "Two or More" Guidelines

#1. 291, HEART FAILURE AND SHOCK W MCC (RW 1.2683) GLOS 3.8

1. 682, RENAL FAILURE W MCC (RW 1.4727) GLOS 4.3
2. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC (RW 1.312) GLOS 4.1
3. 207/208, RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT >96 HOURS, or <=96 HOURS (RW 5.7361, 2.5448) GLOS 4.9/11.9
4. 177, RESPIRATORY INFECTIONS AND INFLAMMATIONS W MCC (RW 1.8491) GLOS 5.4

#2. 190, CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC (RW 1.1251) GLOS 3.6

1. 189, PULMONARY EDEMA AND RESPIRATORY FAILURE (RW 1.2261) GLOS 3.6
2. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC (RW 1.312) GLOS 4.1
3. 291, HEART FAILURE AND SHOCK W MCC (RW 1.2683) GLOS 3.8

Top 10 DRG Shifts Audit Results Using "Two or More" Guidelines

#3. 189, PULMONARY EDEMA AND RESPIRATORY FAILURE (RW 1.2261) GLOS 3.6

1. 291, HEART FAILURE AND SHOCK W MCC (RW 1.2683) GLOS 3.8
2. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC (RW 1.312) GLOS 4.1
3. 177, RESPIRATORY INFECTIONS AND INFLAMMATIONS W MCC (RW 1.8491) GLOS 5.4

#4. 308, CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS W MCC (RW 1.2009) GLOS 3.5

1. 291, HEART FAILURE AND SHOCK W MCC (RW 1.2683) GLOS 3.8
2. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC (RW 1.312) GLOS 4.1
3. 177, RESPIRATORY INFECTIONS AND INFLAMMATIONS W MCC (RW 1.8491) GLOS 5.4

Top 10 DRG Shifts Audit Results Using "Two or More" Guidelines

#5. 378, GASTROINTESTINAL HEMORRHAGE W CC (RW .9935) GLOS 3.0

1. 811, RED BLOOD CELL DISORDERS W MCC (RW 1.3793) GLOS 3.6
2. 813, COAGULATION DISORDERS (RW 1.5451) GLOS 3.6

#6. 640, MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES W MCC (RW 1.2308) GLOS 3.3

1. 682, RENAL FAILURE W MCC (RW 1.4727) GLOS 4.3
2. 70, NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC (RW 1.6796) GLOS 4.5

#7. 689, KIDNEY AND URINARY TRACT INFECTIONS W MCC (RW 1.1142) GLOS 3.8

1. 682, RENAL FAILURE W MCC (RW 1.4727) GLOS 4.3
2. 70, NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC (RW 1.6796) GLOS 4.5

Top 10 DRG Shifts Audit Results Using "Two or More" Guidelines

#8. 193, SIMPLE PNEUMONIA AND PLEURISY W MCC (RW 1.312) (18 different DRG shifts) GLOS 4.1

1. 177, RESPIRATORY INFECTIONS AND INFLAMMATIONS W MCC (RW 1.8491) GLOS 5.4
2. 280, ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC (RW 1.6069) GLOS 4.1

#9. 682, RENAL FAILURE W MCC (RW 1.4727) GLOS 4.3

1. 70, NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC (RW 1.6796) GLOS 4.5
2. 207/208, RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT >96 HOURS, or <=96 HOURS (RW 5.7361, 2.5448) GLOS 4.9/11/9

#10. 312, SYNCOPE AND COLLAPSE (RW .8387) GLOS 2.3

1. 683, RENAL FAILURE W CC (RW .8793) GLOS 3.1
2. 57, DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC (RW 1.2675) GLOS 3.9

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High Value "Diamonds in the Rough" Sequencing Opportunities and How to Find Them

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MS DRG 460 Shifts to 457

460, SPINAL FUSION EXCEPT CERVICAL W/O MCC (RW 3.9307) GLOS 2.7

- 457, SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH CC (RW 6.4959) GLOS 5.2 ($23K impact)

Sequence original principal diagnosis M48.061, for Spinal stenosis, lumbar region without neurogenic claudication as a secondary diagnosis.
Sequence original secondary diagnosis M41.86, for Other forms of scoliosis, lumbar region as the new principal diagnosis.

The patient presented with lumbar stenosis and scoliosis and underwent spinal fusion. The MRI states left convex curvature which corresponds to the patient's symptoms and interrelated stenosis from the curvature. Either diagnosis may be sequenced as principal diagnosis based on the definition of principal diagnosis, circumstances of admission, and sequencing guidelines, the medical record supports another optimal principal diagnosis according to either the ICD-10-CM general sequencing guideline of "two or more interrelated" conditions.

MS DRG 460 Shifts to 457

- 460, SPINAL FUSION EXCEPT CERVICAL W/O MCC (RW 3.9307) GLOS 2.7
- 457, SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH CC (RW 6.4959) GLOS 5.2 ($32K impact)
- Sequence original principal diagnosis T84226A for Displacement of internal fixation device of vertebrae, initial encounter as a secondary diagnosis.

Sequence original secondary diagnosis M4854XA for Collapsed vertebra, not elsewhere classified, thoracic region, initial encounter for fracture as the new principal diagnosis.

Based on the definition of principal diagnosis, circumstances of admission, and sequencing guidelines, the medical record supports another optimal principal diagnosis according to either the ICD-10-CM general sequencing guideline of “two or more” conditions.

54y female presents after conservative treatment for back pain due to T12 compression fracture scheduled for extensor fusion with pulling of the screws at T12 and putting new screws in T10-T11 L1 and L2 and prophylactic vertebroplasties. 3/29 Op report Dr. X: “…severe osteoporosis, proximal junctional kyphosis, and T12 compression fracture…”

MS DRG 64 Shifts to 207/208

64, INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH MCC (RW 1.913) GLOS 4.4

- 208, RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT <=96 HOURS (RW 2.5423) GLOS 4.9 ($5,448)
- 207, RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT >96 HOURS (RW 5.7361) GLOS 11.9 ($25,511)

Sequence current principal diagnosis I6389 for Other cerebral infarction as a secondary diagnosis.

Sequence secondary diagnosis J9601 for Acute respiratory failure with hypoxia as the new principal diagnosis.

OCG Acute Respiratory Failure. When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or non-respiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II, C.) may be applied in these situations.

Most Common Denials Using "Two or More" Guideline

- Chronic condition managed on an outpatient basis, without an acute exacerbation or a change in treatment was sequenced as PDX but was not supported in the documentation as the acute reason for the patient's hospitalization.
- The reason the patient first presented for OP observation may be different from the reason for admission to inpatient status. The reason the patient's status changed from outpatient to inpatient, after study, will the be PDX.
- Minor injury that would not qualify a patient for inpatient admission that was coded as the principal diagnosis in a multiple trauma setting involving more severe injuries, where the guidelines support PDX code assignment for the most severe injury first (or querying the attending if unclear which injury is most severe).
- Acute care transfer situation where the patient is treated at facility "A" for several days in acute care but develops a new condition that prompted transfer to hospital "B" for specialty management. The acute reason prompting the transfer to hospital "B" meets the definition of principal diagnosis based on the documented circumstances of admission, yet the reason the patient presented to hospital "A" remains POA for hospital "B" admission and under continued care (yet is not supported as the PDX).

In Summary, Our Sequencing Advice…

- If there are no guidelines saying you can't then assume you can!
- Don't create restrictions that are not there.
- Long held assumptions about sequencing requirements may be unfounded.
- "Circumstances of admission" is the crux of all sequencing decisions—after POA!
- Know the hierarchy of coding guidelines.
- General sequencing guidelines like the "two or more" or "two or more interrelated" are trumped by all other sequencing advice—so use them as a last resort. However, when the "two or more" guideline applies—don't be afraid to leverage it for optimal payment and a more accurate reflection of GLOS.
- Treatment can help you select the principal diagnosis, but this is not a requirement.
- There is no requirement that treatment be "equal" and there is no definition of "equal" provided by the Cooperating Parties.
- Denials based on the "two or more" guidelines are not as common as you might think and can be appealed if you focus on the clinical evidence to support POA and circumstances of admission.

Is It Ok to Optimize Payment Using the "Two or More" Guidelines?

Per CMS "As we stated in the FY 2008 IPPS final rule with comment period, we do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment as long as the coding is fully and properly supported by documentation in the medical record."

Federal Register/Vol.73, No. 161/Tues. Aug. 19, 2008/Rules & Regulations, pgs.48448

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Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.