

Instructions for Using the DRGs 079/080 Pneumonia Review Worksheet

Purpose

The review worksheet can be used to evaluate simple coding errors as well as complex errors that impact the DRG assignment. It can be used to identify problems in coding or DRG assignment or to monitor improvement in coding or DRG assignment. The worksheet can be used in either post-payment review or prepayment review.

Preparation

Review the related coding conventions and guidelines and be aware of any coding problems that can occur. The Centers for Medicare & Medicaid Services (CMS) considers the *Coding Clinic*, published by the American Hospital Association, to be the official coding guidelines hospitals should follow in order to assure accuracy in ICD-9-CM coding and DRG assignment.

Record Review

Review the medical record to ensure that the diagnosis billed as principal meets the necessary requirements (present on admission, the principal reason for admission, and was treated or evaluated during the admission).

Review the medical record to determine if all secondary diagnoses, complications/comorbidities, and procedures billed are supported and coded correctly.

Refer cases with physician documentation questions to the physician for clarification.

Discussion about Coding Pneumonia

The following are common problems noted in the incorrect coding of pneumonia:

- **Lack of documentation to substantiate a diagnosis of pneumonia.**

A diagnosis of pneumonia must be determined by a physician. A coder should not determine the type of pneumonia based on laboratory findings and other information in the medical record without seeking clarification from the physician.

When reviewing a diagnosis of pneumonia, note the documentation substantiating pneumonia including the results of the chest x-ray, sputum culture, white blood cell count, and temperature of the patient. If the record documentation raises questions concerning the diagnosis of pneumonia, clarify the diagnosis with the physician.

- **Pneumonia coded to a more specific diagnosis based on laboratory results without clarification from a physician.**

A physician must determine the type of pneumonia. A coder should not determine the type of pneumonia based on laboratory findings or other information in the medical record without seeking clarification from the physician.

- **Incorrect coding of aspiration pneumonia (507.x) coded when the physician only states aspiration or pneumonia.**

Physician documentation of aspiration pneumonia must be present in the medical record before it is coded. A mention of possible aspiration pneumonia in the chest x-ray does not substantiate the diagnosis. The clinical significance of abnormal findings on a chest x-ray, laboratory reports, etc., must be determined by the physician. See *Coding Clinic*, second quarter 1990, pages 15-16. With a diagnosis of aspiration pneumonia, expected documentation would include substantiation of pneumonia (documented on chest x-ray) as well as evidence of aspiration (e.g., barium swallow report), difficult swallowing, vomiting, a history of cerebrovascular accident (CVA), cerebrovascular disease, dementia, or tracheostomy, etc.

The presence of aspiration alone does not substantiate a diagnosis of aspiration pneumonia. A diagnosis of pneumonia must be supported in the medical record documentation. When only aspiration is substantiated, only the aspiration should be coded. If only aspiration is present, then ICD-9-CM code of 507.x (aspiration pneumonia) should not be used.

If both aspiration and bacterial pneumonia are present, both may be coded. The order depends on the circumstances of the admission.

- **Pneumonia coded to gram-negative bacteria (482.83) based on gram stain finding or without positive culture or physician documentation.**

A gram stain showing gram-negative bacteria is not conclusive evidence of a gram-negative pneumonia. Pneumonia can be coded to gram-negative pneumonia without a positive culture when the physician has determined the diagnosis and documents the rationale. *Coding Clinic*, third quarter 1988, page 11, give information regarding the clinical indications that are to be used as a basis for determining when a physician should be queried about the possible presence of gram-negative pneumonia in the absence of positive blood cultures.

- **Candidal pneumonia (112.4) coded based on a positive sputum culture.**

The physician must make this diagnosis. It is not uncommon to find yeast on the sputum culture after a patient has been treated with antibiotics.

- **Pneumonia coded to other specified bacteria (482.89) when specific bacteria are identified or only gram stain findings are present.**

Coders are coding pneumonia due to multiple bacteria or findings on gram stains to other specified bacteria. When multiple bacteria cause pneumonia, each different bacterial pneumonia should be coded separately. Only when a bacterial pneumonia does not code to one of the other specified bacterial pneumonias (482.0-482.84) should code 482.89, pneumonia due to other specific bacteria, be coded.

DRGs 079/080 Pneumonia Review Worksheet

Patient Name: _____ HIC: _____

Age: _____ Sex: _____ Admission date: _____ Discharge date: _____

Billed principal diagnosis: _____ ICD-9-CM code: _____
(narrative)

Presenting symptoms upon admission: _____

Does the patient have (check all that apply):

- Difficulty swallowing/dysphagia
- History of cerebrovascular accident/disease/dementia
- Problems with aspiration
- Vomiting
- Tracheostomy
- Other: _____

Chest x-ray results/date(s) (list all): _____

Initial WBC/date: _____

Sputum culture results/date: _____

A. Pneumonia diagnosis

1. Is the pneumonia diagnosis clearly substantiated (through physician documentation, clinical indications, etc.)? Yes No
2. Was a physician inquiry required to substantiate a principal diagnosis of pneumonia? Yes No
If YES, please attach a separate document containing coder questions and physician response.

B. If pneumonia is substantiated:

1. What did the physician document in the medical record as the cause of the pneumonia (i.e., specific bacteria, aspiration, organism)? _____
2. If the cause was not documented by the physician, is there any documentation present in the medical record that could substantiate a more specific pneumonia diagnosis? Yes No

C. If pneumonia is not substantiated in the medical record, please specify the reason for admission and treatment: _____

D. Are the secondary diagnoses clearly substantiated? Yes No
List any diagnosis codes requiring clarification from the physician: _____

****Refer to the coding guidelines for correct coding of pneumonia****

Originally Billed Codes/DRG

Revised Codes/DRG

Principal diagnosis code:

Secondary diagnosis codes:

Procedures:

Discharge status:

DRG:

Result of Review

DRG originally billed:

Correct

Incorrect

If incorrect, revised DRG: _____

Reviewer name: _____ Title: _____ Date: _____

Rationale for revised DRG: _____

Follow-up Action Required by Hospital for Revised DRG:

If the revised DRG is different than the originally billed DRG, the hospital must submit a revised Medicare UB-92 claim form to the Medicare Part A fiscal intermediary. A copy of the revised UB-92 claim form should be attached to this worksheet and submitted to NDHCRI. NDHCRI will initiate follow-up with the fiscal intermediary regarding the hospital's submission of the adjusted claim.

Certification Statement

I certify that a revised UB-92 claim form was submitted to the Medicare Part A fiscal intermediary on ___/___/___.

Hospital designated contact name

Signature

Date