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Payers Push Back on Respiratory and Other Principal Diagnoses; 'It's Insane This Is a Thing'

By Nina Youngstrom

When a Missouri hospital submitted a claim with a principal diagnosis of pneumonia, the commercial payer swapped it out for respiratory failure, which changed the MS-DRG, something that's repeated in some form or another by many payers, probably at most hospitals, with respiratory diagnoses a popular target. The hospital appealed because the admission order included both conditions, and coding guidelines allow hospitals to sequence the principal diagnosis of their choice if either occasioned the admission, coders and lawyers say.

The outcome was a little different here because the payer never answered or took the money back. More than a year went by, and the hospital won the appeal by default because a Missouri state law prohibits recoupment after a year, said Richelle Marting, an attorney and certified coder in Overland Park, Kansas, who prepared the appeal. "I will still be monitoring this account for another year to make sure the payer doesn't take this recoupment," she said.

The experience is a reminder that hospitals have to monitor "the merits of coding, contractual rights and obligations, and state law," she said.

At its heart, the song remains the same: The sequencing of diagnoses drives a lot of downcoding by commercial payers and Medicare Advantage plans in DRG validations, Marting said. "Just because of the order of the diagnosis, they will pay you $5,000 less? It's insane to me this is even a thing." With the financial blow they have suffered from COVID-19, "facilities should be fighting denials where payers can't show a violation of coding rules—but that the payers merely would have exploited the gray area to a different outcome than the hospital did."