Clinical Documentation Improvement

AN INTRODUCTION TO THE FIELD OF CDI

COURSE CONTENT

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SECTION I

INTRODUCTION TO CLINICAL DOCUMENTATION IMPROVEMENT

Section I:
Introduction to CDI

- Definition – CDI and CDI Department
- Goals/Benefits
- Structure and Departmental Organization
- Stakeholders
- Current and Potential Auditors
- Evolution

DEFINITION - What is CDI?

- CDI (Clinical Documentation Improvement) refers to a niche within the HIM field focused on improving the quality of documentation in the medical record from a clinical point of view.
- Clinical documentation is a term referring to the information written by providers in a medical record pertaining to clinical findings, presentation, signs, symptoms, diagnoses, history, diagnostic tests, procedures performed, etc.
- The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of health records for conflicting, incomplete, or nonspecific provider documentation.
- These reviews usually occur on patient care units or in outpatient clinics, or they can be conducted remotely via the *electronic health record (EHR)*.

Definition (contd)

- The diagnoses and procedures documented in the record need to be clearly supported by clinical indicators so that the ICD-10-CM/PCS codes assigned are accurate and correctly assigned.
- The method of clarification used by the CDI professional is often written queries in the health record.
- Verbal and electronic communications are also methods used to make contact with providers.

Definition (contd)

- In 2015, the AHA (American Hospital Association) conducted a survey of more than 1,000 CDI, coding, HIM, and other hospital professionals:

- The "Clinical Documentation Improvement Trends Survey" showed that most hospitals now have some form of a CDI program.

- These programs generally feature:
  - Dedicated CDI resources
  - Reviews on mostly Medicare cases
  - Some focus of quality measures and metrics

Definition (contd)

- CDI could be thought of as an interface between physicians & coders designed to promote greater accuracy and specificity of clinical documentation, especially for complex cases.

- This may result in more appropriate reimbursement to the hospital for services provided.

- Even when reimbursement is unaffected, it reinforces the acuity of these patients, which is reflected in future quality scores impacting both hospital and physicians.

Definition (contd)

- A CDI program that provides all of this must be clinically-driven, not financially-driven.
- It must be pervasive, not competitive, involving everyone in a mutual success.
- This will also require administrative commitment and dedication so that resources are allotted to ensure success.
- A CDI program cannot succeed without support from outside of the CDI program itself.
  - It is necessary to communicate and work well with others who have different goals in mind.

Definition (contd)

For purposes of CDI, CMS defines the following:

- Hospital

  Referred to as provider by 42 CFR 400.202

- Physician

  Referred to as supplier by 42 CFR 400.202, refers to physician, practitioner, or any entity other than provider that furnishes healthcare services under Medicare program

CDI GOALS/BENEFITS

- Keep in mind that all of the benefits of an excellent and efficient CDI program we have discussed are results of achieving the CDI program's goal, but are not themselves the goal of CDI.

- The goal of CDI, summarized, is documentation that accurately and precisely paints the patient's clinical picture so that coders in the HIM department can paint the exact same clinical picture in codes.

- Within this scope, there are numerous goals that a particular CDI program may strive for, a list of examples of such goals is provided on the next slides.

CDI Goals/Benefits (contd)

- Obtain clinical documentation that captures the patient's SOI and ROM
- Identify and clarify missing, conflicting, or nonspecific provider documentation related to diagnoses and procedures
- Support accurate diagnostic and procedural coding & MS-DRG assignment leading to appropriate reimbursement
- Promote health record completion during the patient's course of care, which promotes patient safety
- Improve communication between physicians and other members of the healthcare team
- Provide awareness and education
- Improve documentation to reflect quality and outcome scores
- Improve coding professionals' clinical knowledge

CDI Goals and Benefits (contd)

- These efforts result in improved accuracy and completeness in:
  - Documentation
  - Coding
  - DRG assignment
  - Reimbursement
  - Severity of illness (SOI) score
  - Risk of mortality (ROM) score
  - Proper severity-adjusted Case Mix Index (CMI)
- Proper painting of the picture that describes the patient in words and subsequent proper reflection of the same picture in codes has amazing results—that is clinical documentation improvement.

CDI Goals and Benefits (contd)

- There are numerous additional benefits of an excellent and efficient CDI program, some of which are caused by a domino effect in areas well beyond the scope of the CDI program itself.
- These include:
  - Proper reflection of the risk-adjusted mortality index (RAMI)
  - Proper charge capture for inpatient and outpatient procedures that are diagnosis-driven.
  - Decreased interventions by the insurance companies that are looking for justification of that additional day on the intensive care unit.
  - Appropriate evaluation and management services professional billing by the medical staff

CDI Goals and Benefits (contd)

- Consultants who are happy to receive requests for help from other physicians
  - because, when they see the record already established, they know the consulting physician knows what else is wrong with the patient, so they can concentrate on their specific area rather than having to waste valuable time and start from scratch.
- Happy compliance officers
  - who realize the notes in the medical record will provide whatever words and clinical justification they need to withstand an Office of Inspector General review.

CDI Goals and Benefits (contd)

- A content legal department
  - that realizes a medical record can really stand on its own in defense of a frivolous lawsuit.
- Coders who can ask a valuable, clinical retrospective question rather than something in HIM jargon that a physician cannot fathom.
- Overall success, regardless of what the payers do in the future, regardless of how the rules change.
  - Other initiatives can not say that.

STRUCTURE AND CDI DEPARTMENTAL ORGANIZATION

Develop Mission of CDI

- Scope of work
- Monthly, quarterly and annual goals
- Stated mission in writing that conveys purpose of implementing CDI such as:
  - potential impact on revenue
  - increased capture of patient complexity
  - Increased accuracy/quality of data
- What class of payers will review
- What type of patients review
- Content of review and how often
- Written procedure for queries

Structure And CDI Departmental Organization (contd)

Determine Focus of Specific CDI Department

- CMS quality initiatives
- Overall documentation quality
- Revenue enhancement
- Risk reduction
- Public reporting (organization and provider)

Structure And CDI Departmental Organization (contd)

Conducting the Chart Review

- Initial CDI review

  Usually "admission review"

  Purpose: To identify working MS-DRG

  Should capture:

  - clinical evaluation
  - therapeutic treatment
  - further dx studies, procedures, consultation
  - extension of length of stay
  - documentation by members of the healthcare team other than treating provider with understanding that documentation by these team members cannot be used to establish diagnosis, but, can be used as clinical indicators for queries

Structure And CDI Departmental Organization (contd)

WHEN DOES CDI REVIEW OCCUR?

- Traditionally concurrent, however, can be retrospective
- Can be combination of both
- Following discharge if there are open documentation issues
- Can be beneficial at discharge as discharge summary may find additional information or conflict with other documentation while in hospital
- Subsequent or follow-up reviews

Can be based on:

- Type of patient (surgical intervention, increase level of care)
- Working DRG (LOS exceeds GLOS)
- High risk working DRG

Structure And CDI Departmental Organization (contd)

FOCUS OF CDI REVIEWS

WHAT CLASS OF PAYERS?

- Payer mix
- Medicare

  Requires least amount of staff
- DRG payers

  Typically a financial focus
- All payers

  Support quality focus but requires most staff

WHAT TYPE OF PAYERS?

- Adult population (except OB) – tradition for CDI department
- Subset of adult population

Structure And CDI Departmental Organization (contd)

STAFF/PRODUCTIVITY METRICS

- Number of Reviews per case
- Number of Cases Reviewed

Considerations:

- Volume of pts and LOS usually varies by service line (Oncology vs Cardiology)
- Is there time for provider education for cases reviewed

- Volume of reviews per number of discharges

Considerations:

- Not all payers or types of cases yield the same return on investment

- Volume of queries per % of reviews

- Query quota could appear to promote "fishing"

- Query response rate

- Measured over specific amount of time
- Make certain workflow allowed CDI follow-up on open queries

- Working DRG vs final/billed agreement rate (DRG reconciliation)

- Make certain CDI specialist "graded" on concurrent record
- Do not penalize for procedure assignment errors as not focus item

Structure And CDI Departmental Organization (contd)

DEPARTMENT METRICS

- CC/MCC capture rate
  - Includes PEPPER data
  - Separate medical from surgical DRGs
- SOI/ROM capture rates
- Benchmark for query responses
  - Goal of 85% response within 3 business days
  - Disagreement part of query process

ORGANIZATIONAL METRICS

- Case Mix Index (CMI)
- Mortality Index
- Bill hold times
- Volume of cases identified for overpayments by external sources

Structure And CDI Departmental Organization (contd)

CASE MIX INDEX (CMI)

DEFINITION:

Average of the relative weights for a given population and/or specified period of time

- Impacted by:
  - Types of services
  - Volume of medical/surgical inpatient cases
  - DRG assignments
  - Quality of documentation (or lack thereof)
- Higher CMI may indicate treatment of more severe illnesses
- Lower CMI may indicate DRG assignments that do not reflect resources utilized

CALCULATION OF CASE MIX INDEX

Diagnosis	DRG	Relative Wt		# Discharges		Total Relative Wt
Simple Pneumonia w/o CC or MCC	195	.665	X	3	=	1.995
Aspiration Pneumonia w/MCC	177	1.8453	X	5	=	9.2265
COPD w/o CC or MCC	192	.6949	X	4	=	2.7796
Acute Respiratory Failure	189	1.2248	X	3	=	3.6744
TOTALS				**15**		**17.68**
CMI = Total Relative Wt	(17.68)/	# Discharges	15)	=		**1.18**

CASE MIX INDEX
Practice Exercise #1

Diagnosis	DRG	Relative Wt		# Discharges		Total Relative Wt
Hypoxemia	206	.8842	X	8	=	
Urinary Tract Infection	690	.7922	X	7	=	
Simple Pneumonia	195	.665	X	4	=	
Heart Failure	293	.6526	X	2	=	
TOTALS						
CMI = Total Relative Wt	()/	# Discharges)		=		

CASE MIX INDEX
Practice Exercise #1

Diagnosis	DRG	Relative Wt		# Discharges		Total Relative Wt
Hypoxemia	206	.8842	X	8	=	7.074
Urinary Tract Infection	690	.7922	X	7	=	5.5454
Simple Pneumonia	195	.665	X	4	=	2.66
Heart Failure	293	.6526	X	2	=	1.3052
TOTALS				**21**		**16.58**
CMI = Total Relative Wt	16.58/ 21	# Discharges)		= .790		

CASE MIX INDEX

Practice Exercise #2

Diagnosis	DRG	Relative Wt		# Discharges		Total Relative Wt
Heart Failure	293	.6526	X	10	=	
Diabetes Mellitus	639	.6093	X	7	=	
Inguinal Hernia w/Gangrene	395	.6497	X	2	=	
Osteomyelitis Foot	541	.8406	X	2	=	
TOTALS						
CMI = Total Relative Wt		# Discharges)		=		

CASE MIX INDEX

Practice Exercise #2

Diagnosis	DRG	Relative Wt		# Discharges		Total Relative Wt
Heart Failure	293	.6526	X	10	=	6.526
Diabetes Mellitus	639	.6093	X	7	=	4.2651
Inguinal Hernia w/Gangrene	395	.6497	X	2	=	1.2994
Osteomyelitis Foot	541	.8406	X	2	=	1.6812
TOTALS				**21**		**13.77**
CMI = Total Relative Wt	13.77/21	# Discharges)		= .656		

CDI STAKEHOLDERS

- The benefits of a CDI program that effectively and efficiently meets these goals extends well beyond the CDI program itself.
- Beneficiaries of improvement in clinical documentation are referred to as CDI stakeholders.
- These are the professions and departments whose functions are made easier, more efficient, or more effective as a result of the success of the CDI program.
- Such professions and departments have a vested interest in improving clinical documentation.
- CDI professionals should work together with these stakeholders to achieve mutual success.

Stakeholders (contd)

- CDI Stakeholders include:
  - HIM and coding departments
  - Case management and utilization review
  - Medical staff and provider leadership
  - Executive leadership
  - Patient financial services or billing
  - Finance and revenue cycle
  - Quality and risk management
  - Nursing
  - Compliance and ethics

CURRENT AND POTENTIAL AUDITORS

- In addition to these internal stakeholders, there are external influences that contribute to the need for CDI as well.
- These external influences are those entities with the ability to audit records for clinical validation.
- When auditors deem a reported diagnosis that affects reimbursement as clinically unsupported, facilities may be required to return funds to the payor.
- Other external influences also include those entities who could audit records as part of an investigation to determine if fraud & abuse are being committed.

CDI-Current and Potential Auditors (contd)

Auditors include:

- CMS – Center for Medicare and Medicaid Services
- OIG – Office of Inspector General
- FBI
- RAC – recovery audit contractors
- ZPIC – zone program integrity contractors
- Commercial Carriers
- HHS auditors – state insurance exchanges
- Medicare Advantage RACs

The Evolution of CDI

- Often CDI programs begin with focused concurrent review of a specific payor type (such as Medicare) or payment type (such as DRG).
  - However, this is not a requirement and the focus will depend on the individual organization.

- Although CDI programs are traditionally found in the acute inpatient setting, they also exist in other healthcare settings such as:
  - Provider offices
  - Ambulatory care
  - Acute rehabilitation hospitals
  - Skilled nursing facilities

The Evolution of CDI (contd)

How do CDI Specialists effectively and efficiently work to improve clinical documentation?

- Various methods have been utilized over the last 20 years, such as:
  - Concurrent Coding
    - Coders at acute care facilities would go to the nursing units and begin reviewing records while the patients were still in the hospital.
    - When documentation issues were identified by the coder, queries could be generated and placed on the record so the provider would see it on their rounds the following day.
    - However, coders are not usually trained clinically, unless they were previously a nurse or some other clinician.

The Evolution of CDI (contd)

- Nurses
  - Utilizing nursing staff for documentation improvement has historically taken on two different forms.
  - The first was utilizing nurses who were actively involved in the care of the patient.
    - This required training the nurses to identify documentation issues, to recognize potential CCs, and to identify a working principal diagnosis – as if these nurses did not already have enough to do.
  - The second form was utilizing nurses who were working as case managers.
    - These nurses had to be trained the same way, and although they were not as involved in the clinical care of the patient, they did at least have clinical training and, ideally, clinical experience – something coders do not usually have.

The Evolution of CDI (contd)

- CDI Specialists
  - The latest incarnation of this role is the CDI Specialist.
  - These are most often nurses as well, though a coder could also fill the role, as could a physician, quality professional, or other clinician.
  - Sometimes CDI programs are staffed entirely by nurses, entirely by HIM coders, by quality professionals, hospitalists, or any combination of these.
  - CDI Specialists have a clinical and/or HIM coding background.

- In short, a CDI Specialist must be clinically astute, able to understand the nuances of clinical patterns, and be able to apply coding concepts and guidelines.

The Evolution of CDI (contd)

Regardless of which background the CDI Specialist comes from, they must also possess knowledge and skills in the following areas:

- Clinical knowledge
- Payment systems and methodologies
- ICD-10-CM/PCS coding concepts and guidelines
- Healthcare regulatory compliance
- Experience in hospital acute care or other settings
- Strong verbal and written communication skills

The Evolution of CDI (contd)

The role of a CDI Specialist has been likened to that of a detective.

- For example:
  - If you review a record and see that a patient has received a fluid bolus, the CDI specialist needs to know that this is typically administered for the following:
    - Low blood pressure
    - Low urine output
    - High heart rate

The Evolution of CDI (contd)

The specialist also needs to know some possible diagnoses associated with these symptoms, which can include:

- Shock
- Dehydration
- Acute kidney injury
- Hypovolemia
- Anemia
- Low plasma protein levels
- Medication side effect (e.g., vasovagal response)

The Evolution of CDI (contd)

Certifications have been developed to give recognition to CDI professionals who have demonstrated a mastery of the various skillsets involved in CDI.

- These include:
  - Certified Clinical Documentation Specialist (CCDS)
    - Certification from the Association of Clinical Documentation Specialists (ACDIS).
  - Certified Documentation Improvement Practitioner (CDIP)
    - Certification from the American Health Information Management Association (AHIMA).

The Evolution of CDI (contd)

- Certified Clinical Documentation Specialist (CCDS) prerequisites (must meet one of the following):
  - An RN, RHIA, RHIT, MD or DO and two (2) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.
  - An Associate's degree (or equivalent) in an allied health field (other than what is listed above) and three (3) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.
    - The education component must include completed college-level course work in medical terminology and human anatomy and physiology.
  - Formal education (accredited college-level course work) in human anatomy and physiology, medical terminology, and disease process, or the AHIMA CCS or CCS-P credential, and a minimum of three (3) years of experience in the role as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.

The Evolution of CDI (contd)

- Certified Documentation Improvement Practitioner (CDIP) prerequisites (must meet one of the following):
  - An RHIA, RHIT, CCS, CCS-P, RN, MD or DO and two (2) years experience in clinical documentation improvement
  - An Associate's degree or higher and three (3) years of experience in clinical documentation improvement (candidates must also have completed coursework in Medical Terminology and Anatomy and Physiology)

Section II
THE CDI PROCESS

Section II:
The CDI Process

- General Process
- Reimbursement Methodology
- MS-DRG's
- HIM Coders

CDI PROCESS

- The CDI Specialist uses software designed for CDI programs to identify charts that should be reviewed by CDI.
- The CDI Specialist will then "pull" those records.
  - This could mean going to the unit where the patient is located in the hospital and physically reviewing the record (old way), or
  - This could mean accessing the record using the facility's EHR system, from wherever the CDI Specialist's office is located, and reviewing the record electronically (new way).
- Any appropriate queries are then attached to the record, either physically or electronically.
- CDI then follows up for query response.

CDI PROCESS (contd)

DOCUMENTATION REVIEW:

- ATTENDING PROVIDER

  Supercedes documentation of all other treatment providers (including consultants) when there is a conflict.

  Documentation To Review:

  - Admitting Diagnosis
  - History and Physical
  - Past Medical/Social/Family History
  - Medications
  - Physical Assessment
  - Plan of Care
  - Progress Note
  - Operative/Procedure Reports
  - Discharge Summary

CDI PROCESS (contd)

- **OTHER DOCUMENTATION FOR REVIEW**
  - EMT Report
  - ED Report
  - Specialty Consultations
  - Anesthesia Assessments
  - Physician orders
  - Medication administration records (MARs)
  - Imaging Reports

  Coders cannot assign diagnosis codes from these reports, may be used information as clinical indicators for queries

  Coding Clinic does, however, allow utilizing radiology reports for specific anatomical site as long as treatment MD documents dx

CDI PROCESS (contd)

- **OTHER DOCUMENTATION FOR REVIEW (continued)**
  - Lab results

    Cannot assume from abnormal lab values. If meets definition of reportable diagnosis, can utilize clinical indicators to query
  - Nursing Documentation

    Clues to incomplete, vague or missing diagnoses

    Can be used to capture BMI and pressure ulcer staging
  - Therapies

    Source of clinical indicators

CDI PROCESS (contd)

- The CDI specialist will assign ICD-10 codes and a working DRG
  - These codes & DRG are based on the information available at the time of CDI review.
  - There may be additional information added subsequently that affects the DRG.
    - Procedure performed
    - MCC or CC documented
  - In cases where more than one condition is a potential PDx, subsequent documentation could also affect PDx selection (which also affects the DRG).
- HIM Coders must verify every code assigned, whether added by CDI or afterward in HIM.

REIMBURSEMENT AND CDI

- Before we can explore the importance of constantly improving clinical documentation for reimbursement purposes (among the many other purposes), we must first understand how reimbursement works in the healthcare field.

- CDI is most commonly utilized in the inpatient, acute care setting – hospitals. Many organizations extending their CDI efforts to outpatient as this reimbursement methodology moves towards "bundled" prospective payment system similar to Medicare Part A utilized for inpatient currently.

- However, CDI is being utilized more and more in other settings, each of which have their own distinct reimbursement-related issues.

- CDI professionals must learn the payment methodologies that pertain to the setting(s) in which they work.

Reimbursement & CDI

Multiple Methodologies

- **DRG** Diagnosis Related Groups (the first risk adjusted reimbursement system), now ICD-10-based
  - Used for inpatient visits by Medicare, Medicaid, and most commercial insurance
- ***MS-DRG*** Medicare Severity-Adjusted Diagnosis Related Groups
  - Used by Medicare (and sometimes by Medicaid)
  - CCs & MCCs may affect DRG assignment
- ***APR-DRG*** All Patient Refined-Diagnosis Related Groups
  - Most complicated
  - Used by Medicaid (some states, not all)
  - Multiple codes affect DRG assignment
- ***Risk Adjustment or HCCs*** ICD-10 based

Reimbursement & CDI Multiple Methodologies (contd)

Two sets of Coding Guidelines:

- **CPT** – Current Procedural Terminology
  - This is used in the outpatient setting
  - Maintained by the American Medical Association (AMA)

- **ICD-10** – International Classification of Diseases, tenth edition
  - Used for procedures in the inpatient setting & for diagnoses in all settings
  - Maintained by CMS and the NCHS (National Center for Healthcare Statistics)
  - Within ICD-10 there are guidelines for diagnosis coding & guidelines for procedure coding.
  - ICD-10 began October 1, 2015, in the US

Multiple Methodologies
APR-DRGs

- Divide patients into four groups

  Minor = 1 Major = 3

  Moderate = 2 Extreme = 4

- First, each stay assigned to one of 314 base APR-DRGs
- Then, each stay is assigned to 1 of 4 levels of severity:

  Minor, moderate, major or extreme

- Severity depends on number, nature, and interaction of complications and comorbidity
  - APR-DRG 139 – 1 is pneumonia, severity 1 (minor)
  - APR-DRG 139 – 2 is pneumonia, severity 2 (moderate)

Multiple Methodologies APR-DRGs (contd)

- Each diagnosis has its own Severity of Illness/Risk of Mortality value
- The total of diagnoses/procedures on encounter determines the final APR-DRG
- Complete documentation important for most accurate severity of illness/risk of mortality
  - Documentation to support more specific codes
  - Capturing all 2nd dx
  - Accurate severity of illness means accurate reimbursement

Severity of Illness	2nd Dx-Diabetes
1-Minor	Uncomplicated DM
2-Moderate	DM/Renal Manifestation
3-Major	DM w/Ketoacidosis
4-Extreme	DM w/Hyperosmolar Coma

Risk of Mortality	2nd Dx-Cardiac Dysrhythmias
1-Minor	Premature Beats
2-Moderate	Sinoatrial Node Dysfunction
3-Major	Paroxysmal Ventricular Tachycardia
4-Extreme	Ventricular Fibrillation

MS-DRGs

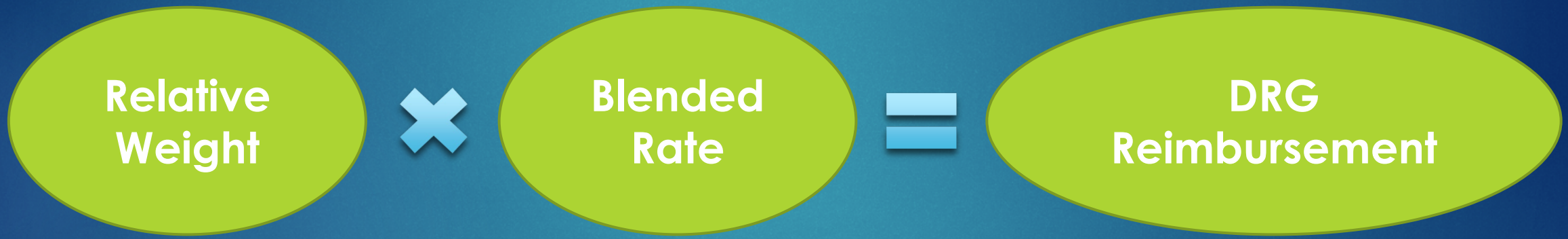
- Acute care inpatient accounts are reimbursed by CMS under the **Inpatient Prospective Payment System (IPPS).**
- Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
- This payment system is referred to as the inpatient prospective payment system (IPPS).
- Under the IPPS, each case is categorized into a diagnosis-related group (DRG).
- Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

MS-DRGs (contd)

- The base payment rate is divided into a labor-related and non-labor share.
- The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost of living adjustment factor.
- This base payment rate is multiplied by the DRG relative weight.
- There are also add-on payments for hospitals that treat a high percentage of low-income patients, and for approved teaching hospitals.

MS-DRGs (contd)

Basic IPPS DRG Reimbursement Calculation:



(DRG specific)

(Facility specific)

MS-DRGs (contd)

Factors that Determine the DRG:

MS-DRGs (contd)

- DRGs are partitioned as Medical/Surgical based on whether qualifying procedure(s) performed
- The DRG severity division is as follows:
  - DRG without CC or MCC (lowest weighted)
  - DRG with CC without MCC (higher weighted)
  - DRG with MCC with or without CC (highest weighted)
- Not all DRGs are affected by CC/MCC.
- Some DRGs are divided only two ways – the DRG will be the same if there is either a CC or MCC.
- These statements are also true whether the DRG is medical or surgical.

EXAMPLES OF CCs

- Bacteremia
- Hemiparesis
- Hematemesis
- Acute renal failure
- Urinary tract infection
- Chronic systolic heart failure
- Acute exacerbation of COPD
- Anemia due to acute blood loss
- Dementia with behavioral disturbances
- Chronic kidney disease (CKD) stages 4/5
- Alcohol Abuse with complications
- Cholelithiasis with chronic cholecystitis
- Many displaced fractures, initial/subsequent encounter
- Diverticulitis

EXAMPLES OF MCCs

- Stage 3 or 4 decubitus ulcer
- Acute respiratory failure
- End stage renal disease
- Pneumonia (most)
- Metabolic encephalopathy
- Coma
- Cerebral edema
- Cerebral infarctions due to thrombosis
- Meningitis
- Sepsis

EXAMPLE OF MS-DRGS

MDC 4 (partial list only)

DRG	Description
163	Major Chest Procedures with MCC
164	Major Chest Procedures with CC
165	Major Chest Procedures without CC/MCC
166	Other Respiratory System OR Procedures with MCC
167	Other Respiratory System OR Procedures with CC
168	Other Respiratory System OR Procedures without CC/MCC
175	Pulmonary Embolism with MCC
176	Pulmonary Embolism without MCC
177	Respiratory Infections and Inflammations with MCC
178	Respiratory Infectious and Inflammations with CC
179	Respiratory Infections and Inflammations without CC/MCC

EXAMPLE OF MS-DRGS

MDC 4 (partial list only)

DRG	Description	GMLOS	AMLOS	Relative Wt
163	Major Chest Procedures w/MCC	9.1	11.7	4.9611
164	Major Chest Procedures w/CC	4.4	5.4	2.6392
165	Major Chest Procedures without CC/MCC	2.6	3.1	1.9136
166	Other Respir System OR Proc w/MCC	8	10.6	3.7913
167	Other Respir System OR Proc w/CC	3.7	5	1.8619
168	Other Respir System OR Proc without CC/MCC	2.1	2.6	1.3691
175	Pulmonary Embolism w/MCC	4.1	5.1	1.5442
176	Pulmonary Embolism without MCC	2.6	3.2	0.8867
177	Respir Infections/Inflamm with MCC	5.4	6.8	1.8453
178	Respir Infections/Inflamm with CC	4	5	1.2059
179	Respir Infections/Inflamm without CC/MCC	3	3.7	0.8711

MS-DRGs (contd)

- For inpatient accounts with no surgical procedure, the DRG is determined by the PDx and whether there is a CC or MCC.
- If there is a surgical procedure, then this is also factored in.
  - **Example:** A patient is admitted for treatment of pneumonia. There are no CCs or MCCs and no procedures were performed. The patient's sputum cultures were negative and the etiology of the pneumonia is unknown.
  - **PDx:** J18.9, Pneumonia, unspecified organism.
  - Since there are no CCs, MCCs, or surgical procedures the resulting DRG is **195, Simple pneumonia & pleurisy w/o CC/MCC**.
  - Relative weight is 0.665.

PNEUMONIA DRGS

DRG	MED/SURG	Description	Relative Wt
193	MED	Simple Pneumonia/Pleurisy with MCC	1.3107
194	MED	Simple Pneumonia/Pleurisy with CC	.863
195	MED	Simple Pneumonia/Pleurisy without MCC/CC	.665
163	SURG	Major Chest Proc with MCC	4.9611
164	SURG	Major Chest Proc with CC	2.6392
165	SURG	Major Chest Proc without MCC/CC	1.9136
166	SURG	Other Respir Sys OR Proc with MCC	3.7913
167	SURG	Other Respir Sys OR Proc with CC	1.8619
168	SURG	Other Respir Sys OR Proc without MCC/CC	1.3691

REIMBURSEMENT CALCULATION

Reimbursement Formula:

RELATIVE WEIGHT X BLENDED RATE = DRG REIMBURSEMENT

DRG 195 Simple Pneumonia/Pleurisy without MCC/CC

0.665 (Relative Weight DRG 195)

X X.XXX (Blended Rate – Facility Specific)

= $xxxxx.xx FACILITY REIMBURSEMENT – DRG 195

Average Facility Reimbursement DRG 195 - **$4,915.54**

MS-DRGs (contd)

- A patient with the same PDx, and also without any surgical procedures, but CDI query results in documentation of a diagnosis of COPD exacerbation, will end up in a different DRG:
  - Now that we have 2 diagnoses, we have to determine which should be PDx.
  - PDx is defined by UHDDS as "that condition found after study to have chiefly occasioned the admission of the patient to the hospital for care".
  - When two or more conditions equally meet this definition, either may be listed as PDx as long as they were both equally treated – otherwise, the condition that was treated more aggressively should be listed as PDx.

REIMBURSEMENT CALCULATION

Reimbursement Formula:

RELATIVE WEIGHT X BLENDED RATE = DRG REIMBURSEMENT

DRG 194 Simple Pneumonia/Pleurisy with cc

.863 (Relative Weight DRG 194)

X X.XXX (Blended Rate – Facility Specific)

= $xxxxx.xx FACILITY REIMBURSEMENT – DRG 194

Average Facility Reimbursement DRG 194 - **$6,163.27**

Increase of $1,247.73

PNEUMONIA DRGS

DRG	MED/SURG	Description	Relative Wt
193	MED	Simple Pneumonia/Pleurisy with MCC	1.3107
194	MED	Simple Pneumonia/Pleurisy with CC	.863
195	MED	Simple Pneumonia/Pleurisy without MCC/CC	.665
163	SURG	Major Chest Proc with MCC	4.9611
164	SURG	Major Chest Proc with CC	2.6392
165	SURG	Major Chest Proc without MCC/CC	1.9136
166	SURG	Other Respir Sys OR Proc with MCC	3.7913
167	SURG	Other Respir Sys OR Proc with CC	1.8619
168	SURG	Other Respir Sys OR Proc without MCC/CC	1.3691

MS-DRGs (contd)

On the next few slides, we will examine how this is applied in a patient with pneumonia & CHF exacerbation.

SCENARIO 1

- A patient with a history of systolic CHF is admitted with respiratory symptoms such as SOB & cough, has a fever, pedal edema, and is diagnosed with pneumonia and CHF exacerbation.
- Treatment includes IV steroids & IV diuretics.

- Since both the pneumonia & CHF exacerbation appear to be equally contributing to the presenting symptoms (reason for admission) and are equal parts of the focus of care (both treated with IV medication), these conditions equally meet the UHDDS definition of PDx and either may be listed as PDx.

MS-DRGs (contd)

SCENARIO 2

- A patient with a history of systolic CHF is admitted with respiratory symptoms such as SOB & cough, has a fever, pedal edema, and is diagnosed with pneumonia and CHF exacerbation.
- Treatment includes IV diuretics & p.o. antibiotics.
- Both the pneumonia & CHF exacerbation appear to be equally contributing to the presenting symptoms (reason for admission) however the CHF seems to be the primary focus of care (treated with IV medication, while pneumonia was treated with p.o. medication).
- The CHF exacerbation should be listed as PDx & the pneumonia should be listed as an additional diagnosis – pneumonia will act as MCC.

MS-DRGs (contd)

SCENARIO 3

- A patient with a history of systolic CHF is admitted with respiratory symptoms such as SOB & cough, has a fever, pedal edema, and is diagnosed with pneumonia and CHF exacerbation.
- Treatment includes IV antibiotics & p.o. diuretics.
- Both the pneumonia & CHF exacerbation appear to be equally contributing to the presenting symptoms (reason for admission) however the pneumonia seems to be the primary focus of care (treated with IV medication, while the CHF exacerbation was treated with p.o. medication).
- The pneumonia should be listed as PDx & the CHF exacerbation should be listed as an additional diagnosis – CHF exacerbation will act as an MCC.

MS-DRGs (contd)

- The 2 different DRGs we are dealing with in these 3 scenarios are as follows:

- Pneumonia, J18.9, as PDx & systolic CHF exacerbation, I50.23, as an MCC:
  - **DRG 193;** relative weight 1.3107
  - National Avg Payment Rate for this DRG would be: **$8,984.57**
- Systolic CHF exacerbation, I50.23, as PDx & pneumonia, J18.9, as an MCC:
  - **DRG 291**; relative weight 1.3409
  - Natl Average Reimbursement would be: **$9,174.88**

MS-DRGs (contd)

Points for CDI to consider:

- If (at the time of CDI review) the CHF is not documented as exacerbated, could a query be generated?
  - Effect: Could add an MCC to the PDx of pneumonia, and could also give the HIM coder a potential 2nd choice for PDx, depending on what becomes the focus of care.
- If sputum cultures are drawn, the results could indicate a more specific code for the pneumonia (codes cannot be based on results alone).
  - Certain organisms such as Staph, Pseudomonas, or Klebsiella, result in a different DRG when they cause pneumonia.
  - Listing one of these pneumonias as PDx, with an cc, results in DRG 178, Respiratory infections and inflammations w/cc; relative weight 1.2059; average reimbursement $8,324.16.

MS-DRGs (contd)

Points for CDI to consider (continued):

- Does the patient's clinical picture, as described by the documented clinical indicators in the record, actually look like a picture of pneumonia and/or CHF exacerbation?
  - Sometimes the physician's diagnoses on admission are their suspected diagnoses, and these may be ruled out by discharge.
  - If a diagnosis of pneumonia is documented but the patient is afebrile, shows no infiltrates on cxr, and has a normal WBC, could it be that the patient does not have pneumonia after all?
  - CHF exacerbation as PDx without an MCC or CC results in DRG 293; relative weight 0.6526; avg reimbursement $4,837.40.
  - Reporting pneumonia as an MCC when this condition was ruled out would represent an overbilling of $4337.48 (per case).

MS-DRGs (contd)

Points for CDI to consider (continued):

- Does the patient have other diagnoses that affect code assignment or sequencing?
  - For CHF, such conditions would be hypertension or chronic renal failure.
  - If the patient has CHF and hypertension then the CHF should be coded as related to the hypertension.
  - This means that the hypertensive heart disease code, I11.0, should be PDx rather than the CHF code, as per sequencing instructions in the ICD-10-CM book.

MS-DRGs (contd)

Points for CDI to consider (continued):

- If the patient also has chronic renal failure/disease/insufficiency, then the PDx would be hypertensive heart and renal disease, I13.0, or I13.2 if the CKD is specified as stage 5 or as ESRD.
- Listing either I11.0 or an I13.- code as PDx would result in the same DRG as listing the CHF itself as PDx, since we have another MCC – pneumonia.
- If the CHF exacerbation code were the only MCC, then this would not count as an MCC with I11.0 as PDx (but would with I13.- as PDx).
- This is due to something called CC/MCC exclusions – more on this in a couple slides.

MS-DRGs (contd)

Points for CDI to consider (continued):

- Was evaluation of CHF performed to determine current systolic/diastolic dysfunction, such as an echo?
  - It is possible, for instance, for patients with diastolic dysfunction to develop systolic dysfunction.
- If the type of CHF (systolic or diastolic) had not been specified, clarification of this would be necessary as this would affect the CHF code – acute exacerbation of unspecified/unknown type of CHF is not a CC or MCC.
- If the initial suspicion of CHF exacerbation turned out to be merely chronic CHF without any current exacerbation, then this would be a CC rather than an MCC.
- Clarifying could prevent another overbilling situation.

MS-DRGs (contd)

- CC/MCC Exclusions:
  - These are conditions which are normally a CC or MCC but do not act as a CC/MCC when a certain condition is listed as PDx.
  - Examples of this include:
    - Acute/exacerbated/decompensated CHF of specified type, I50.-1 or I50.-3 (systolic, diastolic, or mixed) with Hypertensive Heart Disease, I11.0, listed as PDx.
    - UTI, N39.0, with Foley catheter infection, T83.511A listed as PDx.
    - Specified pneumonias, such as aspiration pneumonia, Pseudomonas pneumonia, etc., with another specified pneumonia listed as PDx.
      - Such as J69.0 as PDx with J15.1 as an additional diagnosis.

HIM CODERS AND CDI

- The specific role of coders will vary from program to program, facility to facility.
- However, one thing that is essential for an effective and efficient CDI program is for the CDI professionals and the HIM coders to work seamlessly together.
- Communication between HIM and CDI is imperative.
  - Typically, coders have a strong documentation background and less of a clinical background while CDI specialists have a strong clinical background and less of a documentation background.
  - Because of this, they will not always see eye-to-eye.
  - If CDI and HIM work together, unnecessary queries can be reduced or eliminated, and queries that are necessary can be more effective.

HIM Coders & CDI (contd)

- As you can see from these simple scenarios, it is beneficial to the HIM coders to have an efficient and effective CDI program in place.
- When coders work on a case that has already been initially coded by CDI, with a working DRG already assigned, it is quite common for queries to have already been presented to the physician, answered, and put back in the record.
- This saves the coder valuable time, and keeps the revenue cycle flowing – a plus for everyone!
- On the other hand, an inefficient or ineffective CDI program wastes everyone's time and causes unnecessary delays in the revenue cycle.

HIM Coders & CDI (contd)

- While HIM coders can generally identify areas where clinical documentation is not clear, is incomplete, or is otherwise in need of clarification for proper code assignment, coders often struggle to word queries effectively.
    - Physician's do not understand "coder-talk" – quoting coding guidelines or Coding Clinic to a physician does not help them understand the question or the reason for the question.
    - Queries which are not worded well in the physician's mind often lead to frustration and tension between the physicians and coders.
- CDI Specialists are often used as "gatekeepers" of the query process – determining when and how a physician query will be presented.

HIM Coders & CDI (contd)

- CDI Specialists therefore often act as a translator between the documentation-oriented HIM coders and the clinically-oriented healthcare providers.

- When a coder identifies the need for a retrospective query, the CDI Specialist is often involved in the query process and may even get to decide whether or not the query is actually presented to the physician.

- There are times when the CDI Specialist may not understand the need for clarification, and the coder will have to convince them.
  - Remember that CDI Specialists are often trained primarily on the clinical side and therefore do not usually understand the nuances of coding guidelines, Coding Clinic, or the so-called "gray areas" in coding.

HIM Coders & CDI (contd)

- Some facilities have CDI Specialists assign a working DRG to cases and will often require the HIM coder to notify and explain any DRG changes made at the time of coding.
  - Such changes could be the result of:
    - Documentation supporting more than one potential principal diagnosis.
    - Documentation of a CC or MCC noted after the CDI Specialist reviewed the record, or other changes as a result of such subsequent documentation.
    - Query response received at the time of coding with which the CDI Specialist has not yet followed up.
    - The CDI Specialist may have simply misapplied the coding guidelines, or been unaware of pertinent Coding Clinic advice, resulting in a working DRG that "didn't work".

HIM Coders & CDI (contd)

- Just as CDI Specialists can help coders understand the clinical aspects of the documentation in a medical record, the coders can also help the CDI Specialists better understand the documentation aspects in light of coding guidelines and Coding Clinic advice.
  - This is IF the CDI team and the HIM team are committed to working together for mutual success – a key to meeting the goals of both CDI and HIM.

- If either the HIM coders or the CDI specialists allow the process to become a battle of who's right and who's wrong, or let ego get in the way, then the entire process can become cumbersome and ineffective.
  - This will reduce both teams' ability to meet their goals.

SECTION III
CDI AND PHYSICIANS

Section III:
CDI and Physicians

- General
- The Statistics: Physician Errors
- Effects of CDI
- Physician Documentation
- The Physician Champion

General

- An effective CDI program depends on physician interaction and engagement.
- This requires convincing physicians of the high value of clinical documentation.
- Physicians are not trained on clinical documentation, so this is often a difficult task.
- Many physicians seem to see CDI as a revenue-related initiative rather than a patient care or quality-related initiative.
  - Key to effectively engaging physicians in CDI is dispelling this myth.

General (contd)

- CDI is not about increasing revenue, though revenue is affected by documentation standards.
- Inappropriately increased revenue creates a whole series of problems and headaches all its own, with which no facility wants to be plagued.
- Effective CDI programs promote appropriate revenue collection, thereby reducing the problems caused by inappropriate revenue collection.
- Effective CDI programs also have the potential to improve quality of care.
  - (Quality of care is something physicians care about much more than hospital revenue.)
  - CDI programs are moving into the outpatient setting in Risk Adjusted Reimbursement models (and physicians do care about their own revenue)

General (contd)

- Research conducted by AHIMA shows a positive link between clinical documentation accuracy and higher quality of care.

- A 2008 Archives of Internal Medicine article indicated that:
  - "Medical records for patients with NSTEMI (a type of myocardial infarction) often lack key elements of the history and physical examination."

  - "Patients treated at hospitals with better medical records quality have significantly lower mortality . . . (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care."

The Statistics: Physician Errors

Closed claims
59% serious 30% deaths

In-office

181 closed claims
(Average 3 or more errors)

Failure of judgment	79%
Failure of vigilance or memory	59%
Too little knowledge	48%
Failed to properly hand-off case to another doctor	20%

**Annals of Internal Medicine
Oct 3, 2006

Effects of CDI

- AHIMA's research also showed that clinical documentation accuracy has a positive effect on:
  - Case Mix Index
  - Severity of Illness (SOI) score
  - Risk of Mortality (ROM) score
  - Length of Stay (LOS) – meaning *shorter* lengths of stay with better outcomes!

- SOI & ROM measurements are used to reflect the quality of physicians when compared to their peers and are featured on public websites like healthgrades.com and Medicare's Physician Compare.

Effects of CDI (contd)

- The goal of CDI is not to increase revenue, it is to improve quality of care.
  - However, as CMS continues to move to value-based reimbursement models, improved quality of care will result in an increase in revenue.
  - Ties revenue to providing quality care
  - This should be seen as a by-product of CDI though, not the reason for CDI.
- The proven link between clinical documentation and quality of care is the basis for CMS's transitioning from fee-for-service reimbursement to value-based reimbursement in the first place.
- "Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they can provide – and do it by 2016" - Sylvia Mathews Burwell, Health & Human Services Secretary (Jan 16, 2015)

Effects of CDI (contd)

- CMS now incentivizes/penalizes hospitals by using quality-based programs and measures such as:
  - Value-based purchasing..rewards hospitals for quality care
  - Readmissions reduction program
  - Hospital-acquired conditions (HACs)
- CMS bases many of these factors on quality scores from DRG data recorded two years ago.
- Therefore, data generated by today's documentation will reflect in these measures two years from now.
- These same quality scores are also used to assist with risk adjustment for acuity…some are more ill than others

Physician Documentation

- As CMS moves toward value-based reimbursement, the way physicians document needs to change.
- In the 2015 Clinical Documentation Improvement Trends Survey, two-thirds of participants stated that physician lack of understanding of the importance of accurate clinical documentation prevents physicians from being effectively engaged in CDI.
- CDI can work to keep physicians engaged by ensuring they understand the link between quality of care and the quality of their own clinical documentation.

Physician Documentation (contd)

- Why CDI not in medical school?
  - At first glance it may seem like the solution to all of this is to begin teaching clinical documentation in medical school.
  - However, the 2015 Clinical Documentation Improvement Trends Survey found that real-time, one-on-one, patient-specific conversations are the most effective education strategy to make physicians aware of how to improve documentation.

Physician Documentation (contd)

- Sufficient Documentation is focusing on two areas:
  - Quality measures
  - ICD-10
  - Both are new concepts for physicians

- Therefore requires:
  - Auditing
  - Education
  - Queries
  - CDI specialists

The Physician Champion

The Physician Champion:

- An effective means of addressing these issues that is gaining popularity in the CDI world is employing a physician-to-physician model.
- In this model, a physician advisor known as the "Physician Champion" (or "advisor", "liaison") is involved in all formal training provided to physicians, as well as serving in a support role to the CDI Specialists.
- The physician champion confers with certain treating physicians about key clinical indicators and risk factors in the case while the patient is still in the hospital.
- Physician champions help promote an effective peer-to-peer communication environment.

Physician Champion (contd)

The Physician Champion (continued):

- The physician champion's role includes:
  - Conducting reviews
  - Communicating with other physicians or providers about documentation issues
  - Promoting open lines of communication – particularly when there is a lack of response to queries.

- The CDI Specialists should work collaboratively with the physician champion to develop resources that can be provided to the medical staff.

- And to identify physicians they need help with!

In Summary

- It is imperative that providers learn to embrace CDI – and for the right reasons.
- Undercodes AND Overcodes
- According to AHIMA's Guidance for Clinical Documentation Improvement Programs:
  - "The focus of most CDI programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures . . . Improving the accuracy of clinical documentation can **reduce compliance risks, minimize a healthcare facility's vulnerability during external audits, and provide insight into legal quality of care issues**." (emphasis added)

SECTION IV
THE QUERY PROCESS AND CDI

Section IV:
The Query Process and CDI

- What Are Queries
- Responsibility in Query Process
- The Query Process
- Risk with Queries
- Sample Queries
- Additional Query Guidance
- Acceptable Query Guidance
- Query Scenarios
- Query Compliance

What Are Queries?

- Routine communication and education tool that encourages complete and compliant documentation
- One method of requesting additional documentation or clarification to ensure all clinical conditions are documented that were managed during the encounter
- A properly constructed query is a valuable tool for facilities and providers which is used to help ensure both the accuracy and defensibility of the codes and DRG assigned
- Presented to the provider, usually in written format

Responsibility in the Query Process

- CDI Department and/or coding
- Coding queries usually occur following discharge
- CDI queries usually occur concurrently which usually improves responses and response times as the provider is still documenting in the record

Responsibility in the Query Process(contd)

- Expectation to consult providers for clarification and possible additional documentation prior to code assignment when conflicting, ambiguous or missing information in the health record
- Utilize to assist and educate provider in areas such as:
  - Additional specificity
  - Resequencing, or additional diagnoses or procedures when needed to reflect the severity of the encounter
- Coder should not change codes or include diagnosis(es), procedures based on payment of insurance coverage
- Should not misrepresent clinical scenario through incorrect coding unsubstantiated by included documentation

The Query Process

PRE-QUERY

- Make certain to make available provider education before starting the querying process to include areas such as:
  - Inpatient reimbursement methodology
  - Purpose of the query process
  - Examples of query forms

Make certain providers understand that the query process is not intended to question their clinical judgement, but to make certain that the documentation supports services billed.

The Query Process (contd)

WHEN QUERIES ARE APPROPRIATE:

- Clarification of Present of Admission (POA) Status
- Documentation is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Documentation Includes clinical indicators, diagnostic evaluation, and/or treatment not

  related to a specific condition or procedure
- Clinical evidence of diagnosis but no documentation of condition
- Evidence that a higher level of severity is present
- Cause and effect relationship between conditions needs clarification
- Notice the majority of reasons for query have to do with clinical validation.
  - CDI is often primarily responsible for identifying when such queries are necessary, generating the queries, and any necessary follow up.

The Query Process (contd)

REGULATION OF QUERIES:

- Correct use of queries is heavily regulated
- AHIMA has authority to provide guidance to CMS/federal guidelines on the query process
- OIG (Office of Inspector General) initiates investigations on inadequate/insufficient querying
- CMS efforts focus on diagnosis(es)/procedures that affect reimbursement
- All queries should be accompanied by relevant documentation that led to the reason for the query
- Query may be rendered invalid if question is worded in a leading manner

The Query Process (contd)

BASIC ELEMENTS:

- Specific Issue
  - List diagnosis that requires clarification
  - State where documented within record
  - Provide list of clinical indicators
  - Specific to patient and specific episode of care
  - Query should be unique to patient

- Specific Problem
  - Can diagnosis be further clarified/specified
  - What is the relationship to other diagnosis/procedures

- Resolution
  - How to respond
  - When/where to respond

The Query Process (contd)

ACCEPTABLE QUERY VERBIAGE:

General Requirements:

- Is NOT Leading
- Does not introduce new information not contained in the record
- Provides clarification
- Consistent with other documentation in the medical record
- Clear and concise
- Presents only the facts and why clarification is necessary
- Should always allow a way for the provider to respond without agreeing by adding additional documentation

The Query Process (contd)

PROPER QUERY SHOULD NOT:

- Indicate impact on reimbursement (or DRG, relative weight, etc.)
- Exclude reasonable responses (when multiple choice), including "unknown", "other", and "unable to be determined".
- Include clinical findings unrelated to the query.
- Lead the provider to a desired answer.

  Leading query is not supported by clinical elements in the record or directs provider to specific diagnosis
- Ask a question not supported by clinical findings already documented in the record.
- It is also advisable that queries *not* include choices that are contradictory to documentation already in the record.

Risks With Queries

- Construction of query
  - Is it leading?
  - Does it introduce new information?
- The justification query is appropriate
  - Is it appropriate or a "fishing expedition"?
- Failure to obtain clarification and reporting a higher weight MS-DRG
  - Reporting diagnosis w/out supportive clinical indicators
  - Failure to adhere to official guidelines regarding query issues

Sample Queries

EXAMPLE 1: QUERY NOT APPROPRIATE

Queries should not be used when the documentation is already clear.

A patient is admitted from the ED with signs & symptoms of infection, including fever & elevated WBC. The admitting diagnosis is UTI with suspected sepsis. Possible sepsis is noted on the H&P and the infectious disease consult. Progress notes initially include "sepsis". The blood culture comes back negative however and following this the diagnosis of sepsis continues to be documented on the progress notes as these are copied-and-pasted from day to day. The Discharge Summary documents "UTI – sepsis was ruled out".

EXAMPLE 1: Sepsis Ruled Out

- Even though sepsis is documented on just about every page of physician documentation in the record, it is clear that this was ruled out at the time of discharge.
- It would be inappropriate to query the physician for clarification as to whether or not he/she actually meant the diagnosis documented on the Discharge Summary.
- The purpose of a query is not to question a physician's documentation or final diagnosis.

EXAMPLE 2: QUERY NOT APPROPRIATE

A patient develops anemia following a major surgery. The OR states that there was some bleeding, however there were no additional procedures performed to control the bleeding that would not otherwise have been done. The patient was transfused though, and serial H&Hs were followed throughout the remainder of the admission. Fluid overload also developed during the admission, around the same time as the patient was transfused. The final diagnosis on the Discharge Summary is simply "anemia". The body of the Discharge Summary attributes this to hemodilution from IV fluids.

- Until the Discharge Summary, the coder may be thinking about querying for clarification of the etiology of the anemia – if due to postop blood loss, then this would be a CC.

EXAMPLE 3: QUERY NOT APPROPRIATE

Patient comes in with a fractured hip with plans to undergo a total hip replacement. At the time of CDI review, the physician has not documented any further specificity regarding the hip fracture. An x-ray was ordered for the right hip, and the radiology report describes the location of the fracture as intertrochanteric.

Should the CDI Specialist query the physician for clarification regarding the laterality and specific location of the hip fracture, referring to the x-ray report as supporting clinical information?

- Radiology reports cannot be used as the sole documentation to support a diagnosis however they can be used to support coding a documented diagnosis to a greater level of specificity, such as the site of a fracture – no query is necessary (unless subsequent documentation contradicts the radiologist's description).

Additional Query Guidance

Clinical Validation

- Introduced in 2011 Recovery Audit Scope of Work
- Clinical review of the documentation to determine whether the diagnoses documented in the record are appropriate
- Performed only by clinician, or clinical with approved coding credentials

Acceptable Query Formats

GENERAL REQUIREMENTS:

- Patient Name
- Admission Date/Time
- Account Number/Medical Record Number
- Date Query Initiated
- Contact Information of CDI or Coder Initiating Query
- Content of query providing clinical evidence of condition queried
- May be written or verbal
- Query "templates" may be utilized but must be editable

Acceptable Query Formats (contd)

VERBAL QUERY REQUIREMENTS:

- Must have an audit trail
- Sometimes preferable when addressing a complex issue where interaction of conversation may be required
- Contains same clinical indicators and format as written queries
- Audit trail should contain the actual questions posed to the provider

Acceptable Query Formats (contd)

Open-Ended

- Preferred query format by AHIMA
- More difficult to construct for desired response

Multiple Choice

- Easier to construct
- Should include "Other" and "Unable to Determine" or "Unknown"
- Should include clinically significant options
- There may be only one reasonable option

Yes/No

- Cannot be utilized to add new diagnosis
- Limited to POA status prior to Query Practice Brief February, 2013
- Resolving conflicting documentation from multiple providers
- Determining cause and effect relationship between documented conditions
- Include "other" and "clinically undetermined" allows provider to add free text

Acceptable Query Formats (contd)

OPEN ENDED QUERY EXAMPLES:

EXAMPLE:

ED record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7. Blood cultures positive for E coli. UTI identified as admitting diagnosis. Treatment includes antibiotics, and fluids

Open-Ended Query:

Please clarify condition being monitored and treated.

Acceptable Query Formats (contd)

MULTILE CHOICE QUERY EXAMPLE

EXAMPLE:

ED record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7. Blood cultures positive for E coli. UTI identified as admitting diagnosis. Treatment includes antibiotics, and fluids

Open-Ended Query:

Please clarify condition being monitored and treated

A. Sepsis due to UTI
B. UTI only
C. Other: (Please specify) _____
D. Unknown

Query includes all possible diagnostic statements as well the option of "other" and "unknown" in the event neither of the diagnostic statements are appropriate.

Acceptable Query Formats (contd)

YES/NO QUERY EXAMPLE:

EXAMPLE:

ED record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7. Blood cultures positive for E coli. UTI identified as admitting diagnosis. Treatment includes antibiotics, and fluids. ED physician states "E Coli UTI".

Yes/No Query:

Do you agree with E coli UTI:

A. Yes
B. No
C. Other: _____
D. Unable to determine

The ED physician identified E Coli UTI, however attending did not mention in any of his documentation.

Query Scenario 1
Appropriate Query?

CLINICAL DOCUMENTATION:

Patient admitted with 5 days history of nausea and vomiting. Chest X-Ray indicates left upper lobe pneumonia. Antibiotics ordered.

Proposed Query:

Is the patient's pneumonia due to aspiration?

Is this query appropriate, and, if not, WHY?

Query Scenario 1
Appropriate Query? (contd)

Query is NOT appropriate as written due to:

- Leading question
- Diagnosis is included within the scope of question
- Provider did not document findings

How can the verbiage be changed to construct an appropriate query?

Yes/No would not be appropriate as diagnosis was not mentioned in record

Query Scenario 1
Alternative Queries

PROPOSED QUERY: OPEN-ENDED

Query 1:

Can the etiology of the patient's pneumonia be further specified?

Query 2:

Based on the information provided, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia.

Query Scenario 2
Appropriate Query?

CLINICAL DOCUMENTATION:

Diagnosis of hypokalemia is documented in the progress note; labs indicate a potassium of 3.8

Proposed Query:

Please clarify the status of this diagnosis by documenting your response below

___ Hypokalemia was ruled out

___ Hypokalemia is valid diagnosis for this encounter

___ Hypokalemia was clinically insignificant finding

___ Unable to determine

___ Other (Please specify): _____

Is this query appropriate, and, if not, WHY?

Query Scenario 2
Appropriate Query?

Query IS appropriate

RATIONALE:

Potassium level of 3.8 does not demonstrate a clinical significance for hypokalemia, therefore, allowing the choices of ruled out, clinically insignificant, valid, unable to determine and other would be appropriate.

No clinical indicators have been included that were not in the record, and appropriate choices have been provided.

PRACTICE QUERY WRITING

Clinical Scenario 1:

Prostate mass is documented in the final discharge summary by the provider; however, the pathology report specifies prostate cancer.

Write a Yes/No Query for this scenario:

QUERY CONTENT:

Clinical Scenario 1 – Query Writing (contd)

QUERY:

Do you agree with the pathology report specifying the prostate "mass" indicated in your discharge summary as prostate "cancer". Please document your response in the health record or below:

_ Yes

_ No

_ Other (Please specify)_____

_ Clinically Undetermined

Comments: As the diagnosis is already present in the health record, however, the pathologist does not render patient care, it could not be assigned without the interpretation of the treating/attending provider.

Clinical Scenario 2 – Query Writing

Clinical Scenario 2:

Wound care nurse states "new stage 3 pressure ulcer, right knee, not noted at time of admission to hospital"

Write a Multiple-Choice Query for this scenario:

QUERY CONTENT:

Clinical Scenario 2 – Query Writing (contd)

QUERY CONTENT:

Please provide a diagnosis associated with the finding of "new stage 3 pressure ulcer, right knee" which was not noted at the time of admission to hospital as documented in the MM/DD wound care nurse record:

__ Pressure ulcer, right knee, stage 3, not present on admission

__ Pressure ulcer, right knee, stage 3, present on admission

__ Non-pressure ulcer, right knee, not present on admission

__ Non-pressure ulcer, right knee, present on admission

__ Other (Please specify) _____

__ Unable to determine

Additional Query Writing

Please see ancillary documents for examples of common Queries

Refer to CDI Workbook for Additional Practice

We will practice Query writing during our Practice Exercises

Query Compliance

FACILITY QUERY POLICIES

- Protocol that identifies where queries are saved in the medical record
- Process for notifying medical staff of presence of query in record
- Process to address open queries
- Query on a consistent basis for incomplete diagnosis across all reviewed payers
- Written policies governing query process
  - Who queries
  - When to query
  - How long to hold a query (85% queries should be closed within 3 business days)
  - Ongoing education
  - Monitoring
  - Query retention
  - Escalation process for unanswered queries
  - Whether queries should be made a part of the health record
  - Query measurement rates
- Standardized list of clinical indicators to support need to query or question validity of diagnosis

Query Compliance (contd)

QUERY QUALITY CONTROL

- Who monitors written queries
- Number of queries reviewed
- Frequency of query reviews
- What feedback needed
- Who will take correction action
- Reporting of QA results and retention

Query Compliance (contd)

QUERY RATE MEASUREMENT

- Query response rate within specified timeframe
- What is to be measured
  - New diagnosis added
  - New diagnosis only when impacts reimbursement
- Number of queries reviewed
- Frequency of query reviews
- What feedback needed
- Who will take correction action
- Reporting of QA results and retention

Note: Query rate statistics could identify overuse or inappropriate use of queries

Query Compliance (contd)

QUERY RETENTION

- AHIMA recommends retaining query as part of health record
- Queries are discoverable and should be released with all record requests from federal auditors, however it is usually at the discretion of the auditing entity whether they will accept queries to support claim.

  (Per CMS FAQ 2759 "CMS requires that providers include appropriate documents that justify services billed. This may require that a provider include entire medical record including physician queries"

- What feedback needed
- Who will take correction action
- Reporting of QA results and retention

Section V

CDI Earnings

CDI Earnings

- ACDIS conducted a CDI Salary Survey in 2013, which included 700 respondents nationwide & showed the following:
  - Most earned a salary in the $60,000-$69,999 range.
  - 70% reported receiving a raise in the last year.
  - CDI Managers reported earning salaries in the $80,000-$89,999 range.
    - The report also noted that 10.6% of CDI Specialists and 11.3% of HIM directors earned that amount.
    - There were about as many HIM directors earning less than this amount as there were earning more than this amount.

CDI Earnings (contd)

- The ACDIS 2013 CDI Salary Survey also noted that:
  - 158 respondents had a CCDS (Certified Clinical Documentation Specialist, credentials issued by ACDIS)
  - 35 held a CCS (Certified Coding Specialist, credentials issued by AHIMA)
  - 31 had an RHIT (Registered Health Information Technician, issued by AHIMA)
  - 11 held an RHIA (Registered Health Information Administrator, issued by AHIMA)
  - The CCDS credential proved to be the highest paying, overall, with 41.2% earning greater than $80,000 – compared to just 6.4% of those with an RHIT and 28.6% of those with a CCS.

CDI Earnings (contd)

- According to Payscale.com, salaries for CDI Specialists ranged from $68,029-76,680 nationally – as of 2020.
- The median salary is $73,786.
- For comparison:
  - The range for an RN is $43,403 - $83,171; median is $68,371.
  - The range for an RHIA is $32,089 - $73,833; median is $68,730.
  - The range for an HIM Director is $38,119 - $106,681; median is $71,596.

Section VI

General Documentation Concerns/Requirements

Section VI:

General Documentation Concerns/Requirements

- General Documentation Concerns
- Chapter 1: Infectious and Parasitic Diseases
- Chapter 2: Neoplasms
- Chapter 3: Blood and Blood-Forming Organs/Immunology
- Chapter 4: Endocrine, Nutritional and Metabolic
- Chapter 5: Mental, Behavioral and Neurodevelopmental
- Chapter 6: Nervous System
- Chapter 7: Chapter 9: Circulatory System
- Chapter 10: Respiratory System

Section V:
General Documentation Concerns/Requirements

- Chapter 11: Digestive System
- Chapter 12: Skin and Subcutaneous Tissue
- Chapter 13: Musculoskeletal System/Connective Tissue
- Chapter 14: Genitourinary System
- Chapter 15: Chapter 18: Symptoms, signs, abnormal clinical/lab findings
- Chapter 19: Injury, poisoning, consequences of external causes
- Chapter 20: External causes of morbidity
- Chapter 21: Factors Influencing health status

General Documentation Concerns/Requirements

- Why do providers not just simply document things right the first time?
  - They often do, however there are many reasons why documentation may need improvement.
- Research on clinical documentation by Brett M. Cascio from the Department of Orthopaedic Surgery at Johns Hopkins University in Baltimore, Maryland, and Yuri W. Novitsky from the University Hospital in Cleveland, Ohio, reveals the lack of adequate documentation throughout the healthcare industry (Cascio et al. 2005, 346; Novitsky et al. 2005, 627).
- The peer-reviewed academic literature also shows a relationship between documentation and quality of care, as well as support for concurrent clinical documentation improvement (CDI) programs.

General Documentation Concerns/Requirements (contd)

- Researchers identified the following reasons and causes of poor-quality clinical documentation:
  - Medical school and residency programs do not teach clinical documentation practices.
  - The importance of physician clinical documentation is not a top priority for healthcare organizations.
  - The information, especially in the inpatient setting, is complex.
  - Multiple providers are needed when there are longer patient stays, resulting in additional clinical documentation with increased inconsistency between provider documentation.
  - Unstructured or inconsistent processes for recording and collection of information are prevalent (Cascio et al. 2005; Novitsky et al. 2005).

General Documentation Concerns/Requirements (contd)

- Providers, being human, all have personalities and sometimes those personalities affect how they document in the record.
- Certain providers may believe, for instance, that documenting certain key words helps the HIM staff (it doesn't, unless of course they're documented legitimately).
- Others may have a unique set of clinical criteria they use for a condition, which causes them to document a more severe condition than their patients actually have much of the time.
- There are also providers who, for one reason or another, seem afraid or too timid to document a severe condition even when their patients obviously have the condition.

General Documentation Concerns/Requirements (contd)

- In addition to cases such as these, there will be others where the provider is simply a poor communicator when it comes to the written word.
- There will also be documentation issues that have nothing to do with personality or the provider themselves really, such as when two providers with different specialties each think the patient's main problem is a condition from within their area of expertise.
  - "Pick your specialist, pick your diagnosis."
- The reality is, most physicians tend to document for other physicians, not for HIM staff and not for reimbursement.
  - On one hand, this is good because physicians aren't trying to get 'extra' money by using keywords, and on the other hand it makes life difficult for HIM at times, as it leads to numerous documentation issues.

General Documentation Concerns/Requirements (contd)

- The bottom line where documentation is concerned is that if it isn't documented then it didn't happen – even when it really happened.
  - If it's illegible, then it isn't really documented.
- New concept:
  - Just because it is documented doesn't mean it actually happened
  - Clinical indicators or clear documentation must be present in the record for coders to assign codes – reasoning matters
- Inpatient and Outpatient – IT DOESN'T MATTER WHICH IT IS!
- Good documentation should work for any reason…for all purposes
- It must be:
  - Necessarily thorough and Specific

General Documentation Concerns/Requirements (contd)

- This is where CDI can help providers document more accurately, by looking for clinical patterns and nuances that could indicate something not yet mentioned in the record.
  - Sometimes the providers believe these things are obvious and shouldn't need to be "spelled out" – they do.
- Additionally, CDI can seek clarification of conflicting or deficient documentation while the patient is still in the hospital, resulting in quicker resolution of the documentation issue rather than delaying final coding and billing.

- How does CDI do this?
  - In a word: Queries

Chapter 1: Infectious and Parasitic Diseases

POSSIBLE CLINICAL INDICATORS: (that may generate a query)

- Antibiotics (broad spectrum, multiple, IV)
- Vasopressors
- CBC with diff
- Chest x-rays, CT/MRIs
- Urinalysis
- ID consult
- Isolation precautions
- Antipyretics
- Mechanical ventilation
- ICU monitoring

Chapter 1: Infectious and Parasitic Diseases (contd)

QUERYING FOR ORGANISMS

- Querying for causative organism should occur when DRG assignment is affected
- Most infectious disease has a "code also" note for underlying organism
- Identification of organism can add CC or MCC
- Identification of organism can impact severity of illness (SOI) or risk of mortality (ROM) under APR-DRG system

Chapter 1: Infectious and Parasitic Diseases (contd)

- ICD-10 guidelines (Section IIH)

  If diagnosis documented at time of discharge stated as "probable", "suspected", "likely", "questionable", "possible" or similar terms condition should be coded as if condition existed (inpatient only)

- Condition stated as "possible" or similar terms in progress note cannot be assigned unless also stated in final progress note/discharge summary as condition status may change

- Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical indicators of condition

- Encourage providers to document "organism not isolated" or "no growth in xxx days" as this is more accurate statement as the organism may in fact be present but not isolated

- Provider may also state "treating" condition and may be coded

SAMPLE QUERY
Infectious and Parasitic Disease

Patient has diagnosis in the record of (infectious disease). Please state the associated organism, if known, or the likely organism. This may be based on presentation, epidemiology and/or response to treatment. Positive blood cultures are not mandatory to identify an organism

__ Organism (Please specify) _____

__ Probable/Possible:_____

__ Evidence of: _____

__ Unable to determine

__ Other (Please specify) _____

Hepatitis

DOCUMENTATION SPECIFICITY

- Type of Hepatitis
- Acuity of Hepatitis
- Manifestation

DOCUMENTATION IMPROVEMENT

- Chronic viral hepatitis adds CC
- Hepatic coma adds MCC

Human Immunodeficiency Virus (HIV)

- HIV primary over other chapter specific codes except pregnancy
- Only code confirmed cases (remember confirmation does not require positive culture)
- Z21 utilized when:
  - no documentation of HIV symptoms
  - documentation indicates "HIV positive", similar terms
- B20 assigned when:
  - presence of HIV-related condition during admission
  - History of ever having HIV-related condition
  - Diagnosis of AIDS
- If patient with HIV disease admitted for condition unrelated such as trauma, HIV would NOT be principal

HIV (continued)

DOCUMENTATION IMPROVEMENT

- HIV code B20 adds CC when secondary diagnosis
- HIV still drives the DRG even when assigned as secondary diagnosis when identified as "major HIV related diagnosis"
- Sepsis to be discussed extensively in Section VII

Urinary Tract Infections

- Most common nosocomial infection
- Large percentage due to indwelling bladder catheter

CLINICAL INDICATORS:

- Positive quantitative culture >= 105 microorganisms/ml), maximum 2 isolated microbial species
- Mention of UTI and presence of indwelling catheter

DOCUMENTATION IMPROVEMENT:

- Relationship between UTI/catheter infection must be documented
- Word "with" does not convey relationship, only linkage

COVID-19

- Exception to certain guidelines:
  - Code only confirmed cases, using code U07.1 (Guideline IC.1.g.1.a):
    - Confirmation does not require a positive test result; the provider's documentation that the patient has the condition is sufficient.
    - If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID- 19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.
  - Asymptomatic individuals who test positive for COVID-19 (Guideline IC.1.g.1.h):
    - For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.
      - (This means we assign the COVID-19 code based on a test result.)

COVID-19

- Other pertinent guidelines:
  - If the reason for admission is COVID-19 or a manifestation of COVID-19, such as acute respiratory failure, pneumonia, viral enteritis, etc., that is linked to COVID-19 in the documentation, then the Principal Diagnosis should be U07.1, COVID-19. (OCG IC.1.g.1.b thru IC.1.g.1.d)
  - Individuals with or without symptoms who are suspected to have COVID-19 (without a positive test result) should be assigned code Z20.822, Contact with and (suspected) exposure to COVID-19. (OCG IC.1.g.1.e & IC.1.g.1.g)

COVID-19

CLINICAL INDICATORS:

- Positive test
- Fever or chills
- Cough
- Shortness of breath/dyspnea
- Fatigue
- Muscle/body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

COVID-19

DOCUMENTATION IMPROVEMENT:

- Test results – could be difference between Z20.822 or U07.1
- Manifestations could add CC/MCC
  - Remember that concurrent infections such as pneumonia or sepsis could be due to a different organism if there is more than one infectious process, and such details could affect sequencing.

OTHER CONSIDERATIONS:

- Listing U07.1 as a secondary diagnosis may not affect DRG but still increase reimbursement.

Chapter 2: Neoplasms

POSSIBLE CLINICAL INDICATORS:

- Chemotherapy/Radiation Therapy during admission could change the principal dx/DRG Assignment
- Chemo/Rad only principal when reason for admission
- Pay particular attention to sequencing

Neoplasms (contd)

ICD10 GUIDELINES:

- Malignancies in 2 or more sites should be clarified as to the correct status of each malignancy site
- Do not assign neoplasm codes to "mass" or "lump"
- Sequencing depends on reason for admission
- Primary malignant neoplasm that overlaps 2 or more contiguous sites should be classified to .8 subcategory
- Term "overlapping" replaces terminology "contiguous" from ICD-9
- If malignancy has previously been excised/removed and no evidence of malignancy and no longer being treated, code as history of
- If treatment continues following excision, code as current condition
- Term "neoplasm" and "tumor" can be used interchangeably

Neoplasms (contd)

DOCUMENTATION IMPROVEMENT:

- Analyze radiology/imaging reports for detail for neoplasm coding. Query when necessary
- Review pathology reports. If findings, query physician to include in documentation
- Sequencing is determined by reason for admission, i.e., malignant, chemo/rad, complications. Query when unclear.
- Malignancy adds CC when secondary diagnosis
- If attending documents "mass", pathologist documents "carcinoma", will require query to attending to clarify
- No ICD-10 codes in Neoplasms that are MCCs

SAMPLE QUERY: Neoplasm

Please clarify below the status of "prostate cancer" as documented in the History and Physical in this patient. Appears patient may still be taking antineoplastic medication (list)

___ Prostate Cancer as current condition/diagnosis

___ Patient has "history of" (has been eradicated and received medication prophylactically only)

___ Unable to determine

___ Other (Please specify): _____

Example of Neoplasm Sequencing

CLINICAL SCENARIO

Female with history of uterine cancer was admitted through the ED with right shoulder pain progressively worse over the past 3-4 months.

INITIAL IMPRESSION: Met ca to right shoulder

COPD on oxygen

Patient was started on antibiotics for possible pneumonia, which was ruled out prior to discharge.

FINAL DIAGNOSES;

Malignant neoplasm of the uterus

Met uterine ca to bone in rt shoulder

Joint pain

DX/DRG ASSIGNMENT
Neoplasms

Primary Diagnosis: Pneumonia

Secondary Diagnosis: Primary Malignant Neoplasm Middle Lobe Lung C34.2

DRG ASSIGNMENT: **194** (Simple pneumonia & pleurisy with CC)

$5,588.58

If coded with Neoplasm as principle, would have coded to:

DRG 180 Respiratory neoplasms with MCC - $11,457.16

Overpayment: $5,868.58 (per case)

Chapter 3: Blood and Blood-Forming Organs/Immunology

DOCUMENTATION IMPROVEMENT

- Many diagnoses within this chapter can add CC or MCC
- Coagulation Disorders should be reviewed for cause of the coagulopathy
- Anemia (covered extensively in Chapter VII) identify:
  - Acuity of anemia (acute vs chronic)
  - Type/Etiology (post hemorrhagic, drug induced)
  - Secondary to hemorrhage from procedure (complication code)
- Sickle Cell Disease
  - MCCs usually captured on admission
  - Capture the following:

    Type of sickle cell disease (Hb-SS, Hb-C, Other)

    If patient in crisis

    Sickle cell w/crisis is MCC as secondary diagnosis

Chapter 4: Endocrine, Nutritional and Metabolic

CLINICAL DOCUMENTATION

- Diabetes (covered extensively in Section VII)
  - Classified into five subcategories
    - Type 1
    - Type 2
    - Secondary
      - Due to underlying condition
      - Drug or chemical induced
    - Other specified type
  - Also combination codes that include:
    - Type of diabetes
    - Body system affected
    - Chronic complication(s)
  - If cause of 2nd diabetes not documented, look for clinical indicators and query

Chapter 4: Endocrine, Nutritional and Metabolic (contd)

- Diabetic Manifestations Codes

  Type of Diabetes

  - Manifestation/chronic complication:

    Kidney/Renal

    Ophthalmic

    Neurological

    Circulatory

    Without complication

    Unspecified complication

- Kidney/Renal complications
  - Diabetic nephropathy (glomerulonephrosis, Kimmelstiel-Wilson disease)
  - CKD
  - Other diabetic kidney complication

Chapter 4: Endocrine, Nutritional and Metabolic (contd)

- **Ophthalmic complications**
  - Mild nonproliferative
  - Moderate nonproliferative
  - Severe nonproliferative
  - Proliferative
  - Unspecified
  - With macular edema or without macular edema

- **Neurological complications**
  - Mononeuropathy
  - Polyneuropathy
  - Autonomic neuropathy (diabetic gastroparesis)
  - Diabetic amyotrophy
  - Neuropathy, unspecified
  - Other neurological complication

Chapter 4: Endocrine, Nutritional and Metabolic (contd)

DOCUMENTATION IMPROVEMENT

- No longer need to query "controlled" or "uncontrolled"
- ICD-10 assumes a relationship between diabetes and each of the conditions included under the subentry "with" under the main entries for Diabetes by type – linkage does not need to be documented to code as related, in fact they must be coded as related unless documented otherwise. If there is indication of one or more of these conditions being due to another condition, CDI may need to query
- For example: If no other relationship has been established for gangrene, assume consequence of diabetic peripheral vascular circulatory disorder. Assign diabetes w/peripheral circulatory disorder AND gangrene (which adds CC)
  - Index: "Diabetes, type 2, with, gangrene . . . E11.52"; Tabular: E11.52, Type 2 DM with diabetic peripheral angiopathy with gangrene.

DIABETES DOCUMENTATION SAMPLE

72-year-old female is discharged after a 4 day stay due to the following diagnoses listed in discharge:

1. Ulcer with muscle necrosis – rt foot
2. Diabetes Type 2

Coded as follows (without query):

E11.621 Type 2 diabetes mellitus with foot ulcer

L97.923 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle

DRG: 638 Diabetes with CC $6,266.63

DIABETES DOCUMENTATION SAMPLE

Queried for Linkage

- Query confirmed as:
  - Pressure ulcer of right heel with muscle necrosis

While "foot ulcer" is included in the subentries listed under "with" for the main term "Diabetes", so a link is assumed, this is not true for pressure ulcers (even if on the foot). So, a pressure ulcer is not automatically coded as a diabetic manifestation.

Codes now assigned:

L89.614 Pressure ulcer of right heel, stage 4

E11.9 Type 2 diabetes mellitus without complications

DRG Assignment changed to: **DRG 594 - $5,884.11**

Decrease: $382.52 – per case

Chapter 4: Endocrine, Nutritional and Metabolic (contd)

MALNUTRITION CLINICAL DOCUMENTATION

- Clarify type of malnutrition
- Make sure provider specifically references protein calorie
- Clarify degree of malnutrition (mild, moderate, severe)
- Should be diagnosed when at least 2/6 characteristics documented:
  1- Insufficient energy intake
  2- Weight loss
  3- Loss of muscle mass
  4- Loss of subcutaneous fat
  5- Localized/generalized fluid accumulation that may mask wt loss
  6- Diminished functional status measured by hand grip strength
- It is NOT appropriate to assign E41 nutritional marasmus if doc only reflects emaciated/emaciation w/out doc of malnutrition
- Malnutrition extensively covered in Section VI

Chapter 4: Endocrine, Nutritional and Metabolic (contd)

OBESITY CLINICAL DOCUMENTATION

- Obesity defined as >20% of ideal body weight
- Morbid obesity defined as:
  - 100 lbs > ideal body weight
  - BMI 40 or higher
- It is not the diagnosis of obesity that is a CC, but the BMI code could be
- Provider must document diagnosis of obesity for the BMI to be captured from documentation of other clinicians
- BMI >40 can be utilized a clinical indicator for query for morbid obesity

Chapter 5: Mental, Behavioral and Neurodevelopmental

ICD 10 CODING GUIDELINES

Substance Use

- In remission only when documented as such

- When provider documentation indicates use, abuse and dependence, only one code is assigned as follows:
  - If use/abuse both documented, assign only abuse
  - If use, abuse and dependence all documented, assign only dependence
  - If use and dependence documented, assign dependence

Chapter 5: Mental, Behavioral and Neurodevelopmental (contd)

ICD 10 CODING GUIDELINES

Substance Use (contd)

- Dependence defined as at least 3 of following:
  - Tolerance
  - Withdrawal syndromes
  - Impaired control
  - Preoccupations with acquisition/use
  - Continuous use despite adverse consequences
- Only level of use that can be described as remission
- Only level described as "with withdrawal" (CC)
- Also described as "with persisting dementia" (CC)

Chapter 5: Mental, Behavioral and Neurodevelopmental (contd)

ICD 10 CODING GUIDELINES

Substance Use (contd)

- Identify type of substance
- Identify level of consumption (use, abuse, dependence)
- Current intoxication with substance (must be documented)
- Associated complications such as:
  - Delirium (CC)
  - Mood disorder
  - Hallucinations (CC)
  - Others including sleep disorder, anxiety disorder

Chapter 5: Mental, Behavioral and Neurodevelopmental (contd)

ICD 10 CODING GUIDELINES

Nicotine Use

- Only dependence level (no abuse)
- Specificity of cigarettes, chewing tobacco
- Tobacco exposure codes:
  - Exposure to environmental tobacco smoke (Z77.22)
  - History of tobacco use (Z87.891)
  - Occupations exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

CHART CLARIFICATION – POSSIBLE QUERY

Patient diagnosed with vascular dementia is admitted and being medicated with Lorazepam. Progress notes from nursing indicate the patient is abusing staff verbalizing as well as attempting to "attack" the staff. The patient has a known history of cerebral arteriosclerosis and cerebral infarction without any stated residual deficits, but also not stated to be without deficits.

Determine whether query necessary:

Vascular dementia with behavioral disturbance due to cerebral arteriosclerosis: DRG 071

Vascular Dementia with behavioral disturbance due to previous cerebral infarction: DRG 057

DRG 071: $7,094.70

DRG 057: $8,691.55 **Difference: $1,596.85**

Therefore, query would be beneficial to clarify condition.

QUERY FOR CLARIFICATION

Patient is a 65-year-old admitted with a diagnosis of vascular dementia medicated by Lorazepam. There is a documented history of both cerebral arteriosclerosis and previous cerebral infarction.

Please clarify the etiology of the vascular dementia:

___ Vascular dementia due to cerebral arteriosclerosis

___ Vascular dementia due to previous cerebral infarction

___ Unable to determine

___ Other (Please specify): _____

Chapter 6: Nervous System

ICD 10 CODING GUIDELINES

Epilepsy/Seizures

- Coded utilizing G40-G47 series

- "Intractable" interchangeable for:
  - Pharmacoresistant
  - Treatment resistant
  - Refractory
  - Poorly controlled for G40 Epilepsy and G43 Migraine

Chapter 6: Nervous System (contd)

DOCUMENTATION IMPROVEMENT

Epilepsy/Seizures

- Convulsions that are CCs:
  - R56.00 Simple febrile convulsions
  - R56.01 Complex febrile convulsions
  - R56.1 Post-traumatic seizures
- Verify provider is making diagnosis of epilepsy not recurrent convulsions
- Several seizure codes are CCs or MCCs depending on specificity
- Status epilepticus MCC as secondary diagnosis
- *Coding Clinic 4th Qtr, 2013* states when encephalopathy due to postictal state of sz, should not be coded separately

Chapter 6: Nervous System (contd)

ICD 10 CODING GUIDELINES

Cerebrovascular Diseases

- Documentation needs to differentiate between neuro dz (TIA) and traumatic brain injuries for accurate code assignment
- 3rd Qtr 2014 *Coding Clinics* allows "imaging reports may be utilized to provide greater specificity of anatomic site"
- 1st Qtr 2010 *Coding Clinic* indicates "Hemiplegia….should be coded even if the hemiplegia resolves, with or without treatment and affects the care the patient receives even when they have resolved at the time of discharge"
- Weakness due to previous CVA is coded as hemiplegia if both limbs on one side are affected, or as monoplegia if only one limb is affected (per Coding Clinic 1st Qtr 2015, p25 & 1st Qtr 2017, p47)

Chapter 6: Nervous System (contd)

ICD 10 CODING GUIDELINES

Cerebrovascular Diseases

- Dominant/nondominant side defaults:
  - ambidextrous, default should be dominant
  - left side affected, default is nondominant
  - right side affected, default is dominant

- There is no time limit on utilizing a late effect code

- Late effects sequenced as follows:
  - nature of late effect first
  - late effect code

  Exception when late effect followed by manifestation code

Chapter 6: Nervous System (contd)

ICD 10 CODING GUIDELINES

Cerebrovascular Diseases

- Codes from I69 (sequelae) may be assigned with codes from I60-I67 (cerebrovascular dz) if patient has current Cerebrovascular Dz and deficits from old cerebrovascular dz

- No timeframe defining chronic pain – provider documentation drives assignment of code

- Chronic pain syndrome is NOT the same as chronic pain

Chapter 6: Nervous System (contd)

DOCUMENTATION IMPROVEMENT

Cerebrovascular Diseases

- Physicians may document TIA/CVA in record if clinical evidence suggests
- Physician should be queried to determine if CVA suspected, possible, probable
- Providers should document "evidence of"
- DRG 069 (transient ischemia) target of audits – educate providers to be more specific than "TIA"
- Cerebral artery syndromes are often based on symptomology only, therefore educate physicians to document "evidence of"
- Review imaging reports for clinical indicators that may prompt query for occlusion

Chapter 6: Nervous System (contd)

DOCUMENTATION IMPROVEMENT

Cerebrovascular Diseases

- Documentation should clearly indicate whether new onset of manifestations due to current/acute episode or from sequelae of previous condition
- When record documents symptoms assoc with stroke, educate providers clinical indicators are sufficient to support CVA dx
- Diagnosis of pain alone often fails medical necessity – educate providers to document cause/etiology of pain when known
- Watch neurological conditions present in nursing notes as significant neuro conditions are often identified by increased nursing care
- Hemorrhagic strokes are classified as intracerebral or subarachnoid, additional dx of cerebral edema (MCC), coma (MCC) and/or brain compression (MCC) common with these strokes
- Encephalopathy covered in detailed in Section VI

Chapter 6: Nervous System (contd)

DOCUMENTATION IMPROVEMENT

Cerebrovascular Diseases

- Documentation Requirements:
  - Type of hemorrhage or infarction (traumatic/non-traumatic)
  - Artery affected
  - Laterality

- Positive CT findings are not required if sufficient clinical indicators to support findings of CVA

- Review imaging to determine if signs of stenosis/occlusion

Chapter 9: Circulatory System

ICD 10 CODING GUIDELINES

Circulatory System

- Causal relationship no longer required to be stated to assign HTN w/heart disease
- Use an additional code from I50 category to identify type of heart failure
- Not all patients have volume overload; therefore, term "heart failure" is preferred over "congestive heart failure"
- There is no direct correlation between left- or right-sided heart failure and type of heart failure (systolic, diastolic)
- The term "decompensated" is interpreted to be synonymous with "acute-on-chronic" for heart failure

Chapter 9: Circulatory System (contd)

ICD 10 CODING GUIDELINES

Circulatory System

- ICD-10 presumes cause-and-effect relationship between HTN and CKD
- Hyperlipidemia may be assigned when confirmed OR referring to elevated lipid profile results
- Clinical significance of Unspecified Hyperlipidemia (E78.5) and/or Elevated Triglycerides (E78.1) should be documented
- CAD combination codes assume relationship between CAD and angina
- Many CAD/Angina codes are CCs
- "Small vessel" CAD should be reported as I25.10 Coronary atherosclerosis native coronary arteries

Chapter 9: Circulatory System (contd)

ICD 10 CODING GUIDELINES

Myocardial Infarctions

- Classified as:
  - STEMI (ST-elevated MI)
  - NSTEMI (Non-ST-elevated MI)
  - AMI (acute myocardial infarction)

- Default is I21.9 for unspecified acute MI

- *Coding Clinic, 3rd Qtr 2014* allows for more specific code assignment based on findings in imaging studies, therefore, can be utilized for more exact site of MI when doc

- When admitted with CAD and MI, AMI should be sequenced first

Chapter 9: Circulatory System (contd)

ICD 10 CODING GUIDELINES

Myocardial Infarctions

- Patient cannot have subsequent MI w/o first MI in preceding 4 wks

- Patient admitted for MI has second MI during same hospitalization, principal dx is Initial MI

- *Coding Clinic 4th Qtr, 2012:*

  Admitted with acute transmural MI anterior wall. On Day 7 of admission, suffers another transmural MI inferior wall.

  Principal Dx: I21.09 STEMI coronary artery, anterior wall

  2nd Dx: I22.1 Subsequent STEMI, inferior wall

- Complications require provider to link complications to MI

Chapter 9: Circulatory System (contd)

ICD 10 CODING GUIDELINES

- Cardiac arrhythmias/Conduction Disorders cannot be assigned based on EKG strip only
- Arrhythmia often associated with syncope as the symptom

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

- I50.1 Left Ventricular Failure – CC
- I50.9 now excludes (Excludes 2 note) fluid overload unrelated to CHF
- Fluid overload is coded E87.70 Fluid overload, unspecified
- Use of heart failure code as principal dx makes claims suspect
  - Medical necessity – observation/inpatient
  - CMS quality measures not met
- Educate providers to avoid "chest pain", query to determine if unstable/stable angina with CAD instead
- Assign Z92.82 S/P admin of TPA if administered in different facility within 24 hours or still receiving at time admitted to current facility

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

- When CAD documented:
  - Review record/med list for hyperlipidemia
  - Query for relationship between CAD/hyperlipidemia
  - Review of clinical indicators of angina
  - Possible query for angina or ischemic chest pain
  - Review for possible history of CABG
  - Query if CABG is bypass graft or native vessel

- Educate physicians to document age of MI as new guidelines of 4 weeks for old vs new MI (was 8 weeks ICD-9)

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

- When MI diagnosis:
  - Anatomical location of MI
  - Type of MI (STEMI or NSTEMI)
  - TPA Administered
  - Discharged alive

- When cardiac arrhythmia/conduction disorder "history of" dx documentation must support monitored, diagnostics, treatment, increased nursing care to support coding

- Only MCCs for Cardiac Arrest -- I46.2, I46.8, I46.9 - Cardiac Arrest Codes

I49.01	Ventricular fibrillation
R09.2	Respiratory arrest
R57.0	Cardiogenic arrest
R57.1	Hypovolemic shock
R57.8	Other shocks

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

- Atherosclerosis requires:
  - Laterality
  - Site
  - Manifestations

    Include: Intermittent Claudication, rest pain, ulceration, gangrene (CC)
  - Type of artery

- Extremity atherosclerosis requires:
  - Type of vessel (native, bypass graft – autologous, non-autologous)
  - Complication

- Certain conditions listed under the subentry "with" under the main term "Arteriosclerosis" should be coded as complications of the atherosclerosis unless documented otherwise.

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

- Heart failure documentation needed:
  - Type of heart failure (Systolic/Diastolic/Combined)
  - Acuity (Chronic, Acute, Acute-on-chronic, Decompensated)
  - Associated symptoms
  - Heart failure may not be the condition that occasioned the admission, so watch documentation or clarify

Chapter 9: Circulatory System (contd)

DOCUMENTATION IMPROVEMENT

Circulatory System

SAMPLE QUERY (Type of CHF)

Patient has history of CHF, now admitted for decompensated CHF. Please clarify if the type of CHF is known.

__ Systolic CHF

__ Diastolic CHF

__ Mixed Systolic and Diastolic CHF

__ Unable to determine

__ Other (Please specify): _____

Chapter 10: Respiratory System

ICD 10 CODING GUIDELINES

Respiratory System

- When respiratory condition documented as more than one site, it should be classified to lower anatomic site
- Avian or other Novel Influenza A should only be coded when the diagnosis is confirmed by the physician (this is an exception and does not require documentation of positive lab testing).
- If documented as "suspected", "possible", "probable", code as "unidentified influenza", J11 series.

Chapter 10: Respiratory System (contd)

ICD 10 CODING GUIDELINES

Respiratory System – ASTHMA CLASSIFICATIONS

- Mild Intermittent
  - Symptoms => 2 times/week
  - Asymptomatic between exacerbations
  - Brief exacerbations varying intensity
  - FEV_1 or PEF >= 80%, PEF variability < 20%
- Mild Persistent
  - Symptoms > 2 times/week, <1 time/day
  - Exacerbations affecting activity
  - FEV_1 or PEF >= 80% predicted, PEF variability 20%-30%

Chapter 10: Respiratory System (contd)

ICD 10 CODING GUIDELINES

Respiratory System – ASTHMA CLASSIFICATIONS

- Moderate Persistent
  - Daily symptoms
  - Daily use of inhalant
  - Exacerbations affects activity
  - Exacerbations =>2/week, =>1 day
  - FEV_1 or PEF – 60- 80% predicted, PEF variability >30%
- Severe Persistent
  - Continual symptoms
  - Limited physical activity
  - Frequent exacerbations
  - FEV_1 or PEF <= 60% predicted, PEF variability >30%

Chapter 10: Respiratory System (contd)

DOCUMENTATION IMPROVEMENT

Respiratory System

- Many respiratory conditions now require reporting tobacco exposure as an additional code

- Acute URI infections include MCCs in the following:

  J04.11 Acute tracheitis with obstruction

  J04.31 Supraglottitis, unspec, with obstruction

  J05.11 Acute epiglottitis with obstruction

- DRG assignment for pneumonia can be affected by notation "code first underlying disease"

- Encourage "evidence of" for pneumonia based on clinical indicators when appropriate

Chapter 10: Respiratory System (contd)

DOCUMENTATION IMPROVEMENT

Respiratory System

- Pneumonia should be assigned based on:
  - General Cause (Aspiration, Bacterial, Viral)
  - Location
  - Organism is identified must be linked to pneumonia
  - "Evidence of" gram negative organism – clinical indicator for "complex pneumonia"

Chapter 10: Respiratory System (contd)

DOCUMENTATION IMPROVEMENT

Respiratory System

- Asthma – many opportunities for CCs
  - acute exacerbation
  - asthma with status asthmaticus
  - respiratory therapy

- J80 Acute respiratory distress syndrome – MCC
- J90 Pleural effusion, not elsewhere classified – CC
- J91.0 Malignant pleural effusion – CC
- J91.8 Pleural effusion in conditions classified elsewhere – CC

- Respiratory complications must be documented by provider as such

Chapter 10: Respiratory System (contd)

DOCUMENTATION IMPROVEMENT

Respiratory System

- Ventilator Assisted Pneumonia (J95.851)
  - Code assignment based on documented relationship between condition and procedures
  - J95.851 only assigned when documented as such
  - Query when clinical indicators present
  - When ventilator assisted pneumonia develops after admission, principal diagnosis would be reason for admission, with J95.851 as additional code – provides a CC.
- Educate providers to document acute, chronic, acute/chronic
- Respiratory failure covered in detail in Section VII

Clinical Scenario: DRG Assignment

87-year-old female admitted with the following diagnoses on H & P:

- Hypoxia
- Hypercarbia
- Sleep disordered breathing
- Renal insufficiency
- Anemia

Discharge summary indicates the following:

History of Chronic Anemia and Renal Insufficiency

- Hypoxia
- Dyspnea
- Anemia

Principal Diagnosis Assigned: Acute Respiratory Failure

DRG 189 **$8,443.25**

POSSIBLE REASSIGNMENT OF PDX

- Is Principal Dx of Respiratory Failure appropriate?
- If not, what would you assign as Principal Diagnosis?

Hypoxemia	ICD-10 R09.02	**DRG 206**	**$6,296.88**
	Overpayment	**$2,146.37**	

Chapter 11: Digestive System

ICD 10 CODING GUIDELINES

Digestive System

General Guidelines:

- Identify type/etiology of GI condition
  - Ulcer
  - Varices
  - Bacterial Infection
- Site/Location of condition
- Associated complications

Chapter 11: Digestive System (contd)

ICD 10 CODING GUIDELINES

Digestive System

- Ulcers
  - Capture any complications related to ulcer:
    Perforation
    Abscess
    Hemorrhage
  - Axis for classification is body site, not disorder
  - Gastric, duodenal or peptic ulcers classified to:
    Acute(CC)
    Chronic
    Unspecified

Chapter 11: Digestive System (contd)

ICD 10 CODING GUIDELINES

Digestive System

- Control of bleeding ulcer is now coded in ICD-10-PCS as "control", though this was initially coded as "repair" since "control" was only applicable to correct postoperative bleeding.
  - This was changed in 2017.

- Hernia specificity coding:
  - Bilateral/unilateral
  - Recurrence
  - With gangrene/without gangrene
  - Obstructed (incarcerated, strangulated)

- Crohn's disease of small intestine w/rectal abscess is coded as:

  K50.014 Crohn's dx small intestine w/abscess

  K61.1 Rectal abscess

Chapter 11: Digestive System (contd)

ICD 10 CODING GUIDELINES

Digestive System

- Ulcerative Colitis

  Make sure to link complication w/underlying disorder such as:

  - Rectal bleeding due to
  - Abscess with

- Liver Disorders should specify:
  - acute/chronic
  - w/ or w/out coma
  - all related conditions/complication
  - is ETOH/alcohol linked when appropriate

Chapter 11: Digestive System (contd)

ICD 10 CODING GUIDELINES

Digestive System

- Intestinal Malabsorption – recently added codes, all of which are CCs

  (K90.4-, K90.8-, K90.9)

Chapter 11: Digestive System (contd)

DOCUMENTATION IMPROVEMENT

Digestive System

- Gastroparesis with underlying disease will change DRG assignment to outside the digestive system
- Code specificity for hernia of "with gangrene" is MCC
- Code specificity for hernia of "obstruction" is CC
- Alcoholic Hepatitis/Cirrhosis are generally chronic conditions and therefore usually not principal dx
- Liver Disorders

Chapter 12: Skin and Subcutaneous Tissue

ICD 10 CODING GUIDELINES

Infections of Skin/Subcutaneous Tissue

- Pressure ulcer stage codes may be based on medical record documentation from clinician's who are not the patient's provider with associated diagnosis of pressure ulcer doc by patient's provider
- Pressure ulcer stage coded once at the highest stage during encounter
- POA indicator is based on pressure ulcer presence, not stage. Therefore, if pressure ulcer is stage 2 at admission, advances to stage 3 during stay, POA=Yes

Chapter 12: Skin and Subcutaneous Tissue (contd)

DOCUMENTATION IMPROVEMENT

Infections of Skin/Subcutaneous Tissue

- Infections that are CCs:
  - Cutaneous abscess
  - Cellulitis
  - Acute lymphangitis
  - Pilonidal cyst w/abscess
  - Pilonidal abscess w/abscess
  - Erythrasma

- L76 Category – Intraoperative/Postprocedural Complication of Skin and SQ Tissue – most of these CCs

Chapter 12: Skin and Subcutaneous Tissue (contd)

DOCUMENTATION IMPROVEMENT

Infections of Skin/Subcutaneous Tissue

- Stage 3/Stage 4 pressure ulcers MCC when present on admission

CORRECT/INCORRECT CODING??

CLINICAL SCENARIO:

74-year-old with right degenerative joint disease admitted with infected knee hematoma. During hospitalization, performed arthrotomy with drainage of hematoma. Recent history of total knee arthroplasty. Medical history: asthma, CAD, AFib, CHF, MI, ischemic cardiomyopathy.

Principal Diagnosis:	Other Operative Infection
Secondary:	Hematoma due to Complication Prosthetic Dev
Correct or Incorrect?	INCORRECT
	Infection and inflammatory reaction due to internal prosthetic device, implant, graft

CORRECT DRG ASSIGNMENT/PAYMENT

PDx: Infection and inflammatory reaction due to internal prosthetic device, implant, graft

Addtl: Other complication due to internal joint prosthesis

DRG changed from:

DRG 857	Postop or Post Traumatic Infection w/OR Procedure w/CC	$13,547.03
To		
DRG 487	Knee Procedure w/PDx Infection w/o CC/MCC	$11,061.63
	OVERPAYMENT	**$2,485.40**

Chapter 13: Musculoskeletal System/Connective Tissue

ICD 10 CODING GUIDELINES

Musculoskeletal System/Connective Tissue

- Classification of Injuries:
  - Traumatic
  - Pathological
  - Stress/Fatigue
  - Doc regarding placement of device, graft, implant

- Osteoporosis
  - M80 pts with current pathological fx at time of encounter
  - M81 pts with osteo w/out current path fx due to osteo

Chapter 13: Musculoskeletal System/Connective Tissue (contd)

ICD 10 CODING GUIDELINES

Musculoskeletal System/Connective Tissue

- Fractures
  - Anatomic location
  - Traumatic, pathological, stress/fatigue
  - Open/Closed
  - Episode of care (initial, subsequent, sequela)
  - Associated underlying pathology

- 7th digit character Fractures:
  - A (initial encounter) still under active treatment
  - D (subsequent encounter) completed active treatment

Chapter 13: Musculoskeletal System/Connective Tissue (contd)

ICD 10 CODING GUIDELINES

Musculoskeletal System/Connective Tissue

- Recently added Category – Fatigue Fractures (Stress Fractures)

Chapter 13: Musculoskeletal System/Connective Tissue (contd)

DOCUMENTATION IMPROVEMENT

Musculoskeletal System/Connective Tissue

- Osteoporosis with current pathological fracture M80

  Utilized for ANY patient with known osteoporosis who suffers fracture

- Fractures require 7th digit as follows:

  A – active treatment

  D – subsequent encounter

- Location of injury & episode of care influence the final DRG for fractures

Chapter 14: Genitourinary System

ICD 10 CODING GUIDELINES

Genitourinary System

- Urosepsis now requires specific condition as urosepsis in ICD-10 directs coder to code condition (unlike ICD-9)

- Kidney/Urinary complications must clearly link mechanical complication or infection/reaction to device to utilize the complication code(s)

  RAC Determination:

  Patient with generalized weakness with chronic Foley catheter diagnosed with Urinary Tract Infection

  Coded infection due to indwelling urinary cath

  DRG 700 (Other Kidney/Urinary Tract Dx)

  RESULTS:

  RAC determined no link between UTI/catheter

  Resequenced to UTI/DRG 690

Chapter 14: Genitourinary System (contd)

DOCUMENTATION IMPROVEMENT

Genitourinary System

- Codes that are MCCs

  Acute Nephritic Syndrome (N00.-)

  Rapidly Progressing Nephritic Syndrome (N01.-)

- Recently Added Codes that are CCs

  N02.- Recurrent and persistent hematuria

  N06.2-N06.5 Isolated proteinuria w/glomerulonephritis

  N07.2-N07.5 Hereditary nephropathy w/glomerulonephritis

- Need to differentiate between:
  - Nephritic/Nephrotic
  - Recurrent/persistent hematuria
  - Isolated proteinuria
  - Acute/Chronic
  - Rapidly progressive

- Acute Renal Failure covered extensively in Section VI

CORRECT DIAGNOSIS ASSIGNED??

84-year-old male presented for generalized weakness. History includes: chronic Foley catheter, Hx of UTIs, HTN, neurogenic bladder w/chronic indwelling Foley catheter. Diagnosed with UTI.

PDx: T83.518A, Infection and inflammatory reaction due to other urinary catheter, initial encounter

Add'l Dx: N39.0, Urinary tract infection, site not specified

DRG: 699, Other kidney & urinary tract diagnoses with CC

DO YOU AGREE??

NO, Physician must link infection to the device – was not documented

Therefore, PDx changed to Urinary Tract Infection

DRG 699 (Other Kidney/Urin Tract Dx w/CC	$7,185.44
To	
DRG 690 (Kidney/UTI w/out MCC	$5,717.12
Overpayment	**$1,468.32**

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings

ICD 10 CODING GUIDELINES

Signs/Symptoms

- NOT to be used as principal dx when related definitive diagnosis has been established
- May be assigned when NOT routinely associated with reported diagnosis(es)
- As of October 1, 2020, coma scale codes, many of which are MCCs, can only be used in conjunction with traumatic brain injury codes.
  - When only total coma score listed, utilize R40.24
- Chest pain should be investigated for definitive diagnosis

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings

DOCUMENTATION IMPROVEMENT

Signs/Symptoms

- Review charts with signs/symptoms as Pdx until definitive diagnosis can be assigned

- **Hypoxia vs Hypoxemia**

  -Hypoxia R09.02 low level of 02 within body tissue

  -Hypoxemia (also R09.02) pathological decrease in levels Ca02 or Pa02 and/or Sa02 in arterial blood

  -Usually will not meet inpatient criteria

  -Look for clinical indicators of acute respiratory failure

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings

DOCUMENTATION IMPROVEMENT

Altered Mental Status

- Documentation of "confusion" defaults to disorientation not AMS
- Principal Dx should be dx associated with the AMS
- Coma score documented by non-physicians does not need clarification (as long as traumatic brain injury is documented by physician)
- EMT documentation of coma score would be appropriate to utilize (*Coding Clinic 1st Qtr 2014) when patient has traumatic brain injury.*
- If coma score is reported, should also look for all associated diagnoses such as:
  - cerebral edema
  - respiratory failure or status

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings (contd)

DOCUMENTATION IMPROVEMENT

Functional Quadriplegia

- Not a true paresis
- Immobility due to severe physical disability or frailty

Syncope

- Watch for documentation of underlying cause

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings (contd)

DOCUMENTATION IMPROVEMENT

Symptom Codes that are CCs

- R04.2 Hemoptysis
- R04.81 Acute idiopathic pulmonary hemorrhage-infants
- R04.89 Hemorrhage other sites respiratory passages
- R04.9 Hemorrhage respiratory passages, unspecified
- R06.3 Periodic breathing
- R09.01 Asphyxia
- R09.2 Respiratory arrest
- R17 Unspecified jaundice
- R18.0 Malignant ascites
- R18.8 Other ascites
- R29.0 Tetany
- R29.1 Meningismus
- R29.5 Transient paralysis
- R39.0 Extravasation of urine
- R40.20 Unspecified coma
- R40.3 Persistent vegetative state

Chapter 18: Symptoms, Signs, Abnormal Clinical/Lab Findings (contd)

DOCUMENTATION IMPROVEMENT

Symptom Codes that are CCs

- R41.4 Neurological neglect syndrome
- R44.0 Auditory hallucinations
- R44.2 Other hallucinations
- R44.3 Hallucinations, unspecified
- R45.851 Suicidal Ideations
- R47.01 Aphasia
- R56.00 Simple febrile convulsions
- R56.01 Complex febrile convulsion
- R56.1 Post traumatic seizures
- R57.9 Shock, unspecified
- R64 Cachexia
- R65.10 Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction
- R71.0 Precipitous drop in hematocrit
- R78.81 Bacteremia
- R82.0 Chyluria
- R82.1 Myoglobinuria

Chapter 19: Injury, Poisoning, Consequences of External Causes

ICD 10 CODING GUIDELINES

- Applicable extensions (except fractures)

  A = Initial Encounter (still under active treatment

  D = Subsequent Encounter (no longer active treatment)

  S = Sequelae

  (Applicable placeholder "X")

- If provider does not document external cause information, may utilize non-physician documentation. Physician documentation takes precedence over non-physician documentation when there is a conflict

- Code for most significant injury coded first

- Code T07 unspecified multiple injuries should not be assigned for inpatient stays (list specific codes for specific injuries)

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

ICD 10 CODING GUIDELINES

- Superficial injuries such as abrasions, contusions not listed if more significant injury to same anatomical site

FRACTURES

- Categorized by:
  - Traumatic/Non-traumatic
  - Pathologic
  - Stress/Fatigue

- Coding Guidelines
  - Fractures coded individually by site
  - Fractures not indicated as displaced/non-displaced coded as displaced
  - Sequenced in order of severity

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

ICD 10 CODING GUIDELINES

FRACTURES (continued)

Applicable Extensions for Fractures:

A - Initial encounter (still under active treatment) closed fracture

B - Initial encounter (still under active treatment) open fracture

D - Subsequent encounter fracture routine healing

G - Subsequent encounter fracture delayed healing

K - Subsequent encounter fracture with nonunion

P - Subsequent encounter fracture with malunion

S - Sequelae

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

ICD 10 CODING GUIDELINES

BURNS AND CORROSIONS

- Corrosions - burns due to chemicals (new)
- Guidelines the same for burns/corrosions
- Classified by:
  - Depth (First-, Second-, Third-degree)
  - Extent
  - Agent
- When admission for multiple burns, burn of highest degree listed first
- Assign separate codes for each site
- Necrosis coded as non-healed burn
- Infected burn sites require addtl code for infection

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

ICD 10 CODING GUIDELINES

BURNS AND CORROSIONS (continued)

- Categories T31/T32 assigned by "rule of nines")

ADVERSE EFFECTS

- Poisoning
  - Error in prescription
  - Interaction of drugs/alcohol
  - Intentional overdose
  - Interaction between non-Rx drug and Rx drug properly taken
  - Principal diagnosis from categories T36-T50

- Adverse Effect
  - Principal diagnosis manifestation, symptom, adverse condition
  - Secondary diagnosis from T36-T50 category

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

COMPLICATIONS

- Complications sequenced first
- Documentation must reflect linkage
- Transplant complication code ONLY assigned if complication affects function of transplanted organ

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

DOCUMENTATION IMPROVEMENT

- **INJURIES**
  - Specific anatomical location
  - Laterality
  - Severity of injury (w/wout LOC, w/wout spinal cord damage, traumatic/non-traumatic
  - Associated injuries (nerves, muscles, tendons)
  - Foreign Body
  - Open/closed, Displaced/Non-displaced, Union/Malunion Fractures
  - Lacerations/Contusions (length)

Chapter 19: Injury, Poisoning, Consequences of External Causes (contd)

DOCUMENTATION IMPROVEMENT

- **INJURIES** (continued)
  - Initial encounter (extension A) assigned when patient delays seeking treatment (even if fx has progressed to malunion/nonunion)

CLINICAL SCENARIOS FOR BASIC DOCUMENTATION ISSUES

We will be applying these basic documentation principles in Practical Applications later.

Section VII
Specific Documentation Concerns

Section VII:
Specific Documentation Concerns

- Diagnosis: General
- Respiratory Failure
- Acute Renal Failure
- Sepsis
- Malnutrition
- Anemia
- Encephalopathy
- Present on Admission (POA)

Section VII:
Specific Documentation Concerns

- Procedures: General
- Debridement: Resection vs Excision
- Broncho Biopsy
- New Issues with Documentation:
  - "With"
  - Diabetes Mellitus
  - Control

General Documentation Issues

- Over the next several slides we're going to look at some common issues related to specific conditions, the relevant clinical indicators, and how to construct a proper query, if a query is needed.
- The conditions we'll look at are ones that have been specifically identified as "vulnerable to challenge" by AHIMA:
  - Respiratory failure
  - Sepsis
  - Malnutrition
  - Encephalopathy
- We've also included acute renal failure, based on our own experiences as auditors.
- Examples of procedure-related queries will also be provided.

Respiratory Failure

- In ICD-10-CM there are different codes for respiratory failure based on whether it is acute (J96.0-), chronic (J96.1-), acute-on-chronic (J96.2-), or unspecified (J96.9-).
- There are also different codes for hypoxic (J96.-1)& hypercapneic (J96.-2) respiratory failure, as well as for postprocedural respiratory failure (J95.82-).
- When it comes to coding and DRG assignment, all of the respiratory failure codes are at least a CC, and therefore have the potential to affect DRG assignment.
- If the respiratory failure is acute, acute-on-chronic, or postprocedural, then it is an MCC.

Respiratory Failure (contd)

- Documentation issues easily arise when a patient has an acute respiratory dysfunction of some sort and rapidly improves.
- Perhaps acute respiratory failure was suspected on admission, and it was later thought to be merely respiratory insufficiency, which is neither a CC nor an MCC, but is a symptom code – R06.89, Other abnormalities of breathing.
  - However, "pulmonary insufficiency" NOS is J98.4, Other disorders of lung, which is also not a CC but is at least not a symptom code.
  - Unless it is acute and following surgery, in which case it is coded J95.1 or J95.2, depending on whether the surgery was thoracic or non-thoracic – and both of these codes are MCCs.

Respiratory Failure (contd)

- Perhaps the respiratory symptoms indicating respiratory failure on admission were deemed to simply be related to another respiratory diagnosis such as COPD, pneumonia, or a URI – each of which come with their own sets of documentation issues that could affect code & DRG assignment.

- Ideally, this should all be clarified in the Discharge Summary if it is not clarified earlier in the record, or if the physicians involved do not seem to quite agree on the final diagnosis.
  - Perhaps in the progress notes the pulmonologist calls the condition respiratory failure while the attending refers to it as respiratory insufficiency, for instance.

Respiratory Failure (contd)

- Patients sometimes present with what are thought to be acute respiratory symptoms in the ED, only to find out after inpatient admission that the patient has a history of COPD and associated chronic respiratory failure.
- Sometimes these patients are initially documented as having acute respiratory failure, though there may not actually be any acute worsening of the chronic respiratory status of the patient after further study.
- Other times, the physician treating the patient in the hospital may not be aware of the patient's chronic respiratory status and does not initially know whether the respiratory failure is acute or chronic.
  - This is common when a patient is from out of town, for instance.

Respiratory Failure (contd)

- Often, it can become difficult for HIM coders to determine whether the respiratory failure was acute, chronic, or acute-on-chronic after study, due to documentation of all of the above in the record at one point or another.
- Even if it is documented as acute or acute-on-chronic initially, then documented as chronic after further study, if there is marked improvement in the patient's condition then the respiratory failure could have been acute on admission.
  - The subsequent documentation of chronic respiratory failure could be due to the acute component resolving with treatment rather than being ruled out.

Respiratory Failure (contd)

- If it is not clearly documented that the patient had a specific condition (insufficiency vs failure) . . .
- If the diagnosis is clearly documented as respiratory failure but the acuity/chronicity is not specified . . .
- If the physicians involved do not seem to agree on the diagnosis (insufficiency vs failure, acute vs chronic, etc.) . . .
- If the diagnosis documented doesn't seem to be supported by the clinical findings documented in the record . . .
- If the clinical picture painted by the clinical indicators appears more or less severe than the diagnosis documented by the provider(s) . . .

. . . A query should be generated to clarify the issue.

Respiratory Failure (contd)

Clinical Scenario:

73-year-old man presents with difficulty breathing and confusion.

Physical exam reveals tachypnea, wheezing, and cyanosis.

Admission diagnosis: Acute respiratory distress secondary to COPD.

- *Day 1 Progress note: Tachypnea and cyanosis still noted. Patient confused and cannot speak in full sentences. Pulse oximetry at 92 percent on 2 liters of oxygen.*
- *Day 2 Progress note: Patient doing better.*
- *Day 3 Progress note: Patient continues to improve.*
- *Day 4 Progress note: ABG normal. Discharge patient.*

Discharge diagnosis: Acute respiratory distress.

Respiratory Failure (contd)

Rules for Coding:

- According to Coding Clinic, respiratory failure can only be listed as PDx when it is present at the time of admission.
- If respiratory failure is not actually documented at the time of admission, but is later documented in the hospitalization, there must be clinical indicators recorded at the time of admission to support the diagnosis later.
- If respiratory failure occurred after admission, it can only be listed as a secondary diagnosis.
- Respiratory insufficiency or respiratory distress with clinical indicators of respiratory failure does not allow coders to code respiratory failure, however, it does allow CDI to clarify the condition being treated.
- Septicemia/sepsis sequencing also affects the assignment of the PDx.
  - If a patient is admitted in respiratory failure due to sepsis, sepsis must be listed first.
- This becomes troublesome when there are multiple conditions present that may have caused the respiratory failure. (Ex: A patient is admitted in acute respiratory failure with CHF, sepsis and pneumonia. If the respiratory failure was due to CHF, respiratory failure may be listed as PDx. If the respiratory failure was due to sepsis, sepsis must be listed as PDx.).

Respiratory Failure (contd)

Common Issues:

- Physician has not documented respiratory failure at all when there is supporting documentation for it.
- Physician documents respiratory failure on day 2 or 3 of admission, when indicators support it was present at the time of admission.
- Physician documents respiratory failure with limited or no clinical support.

Respiratory Failure (contd)

What to Look For:

- We need to make sure "acute respiratory failure" is documented as present at the time of admission and that there is clinical evidence to support (see below).
- Review the ABGs at the time of admission:
  - Approx. ABGs of pH <7.30 or >7.5; pCO2> 50; pO2<60.
- For COPD patients:
  - pCO2 findings of 10-15 mmHg above the patient's normal level and pO2 findings of 10-15 mmHg below the patient's normal level.

Respiratory Failure (contd)

What to Look For:

- Other clinical indicators of respiratory failure:
  - Using accessory muscles to breath;
  - Low O2 sats such as ≤83; RR≥24.

- Additional clinical signs include:
  - Cyanosis, ashen color and rapid airway management, unable to speak in complete sentences, extreme anxiety and feeling of "impending doom", tripod position, and confusion/altered mental status/obtunded.

Respiratory Failure (contd)

What to Look For:

- If sepsis is also present, we need to know which diagnosis caused the respiratory failure; there may be more than one.
- If respiratory insufficiency or respiratory distress is documented, review the chart for above indicators of respiratory failure.

Respiratory Failure (contd)

What to Look For:

- Treatments that may indicate the physician is treating acute respiratory failure:
  - O_2 therapy, may be 2-4 L per NC for some patients "CO2 retainers", BiPAP (Bi-level positive airway pressure)
  - CPAP (Continuous positive airway pressure)
  - Mechanical ventilation
  - Non-rebreather (50-100%)
  - Treatment of underlying cause of the failure
  - IV and/or inhaled steroids
  - Bronchodilators

Respiratory Failure (contd)

What to Ask For:

- **ER Physicians** – Document all clinical indicators such as ABGs and pertinent exam findings; specific diagnosis of acute respiratory failure.

- **Attending Physicians** – Same plus specific documentation of most probable underlying cause, if sepsis is also present.
  - ***Ex:*** Acute Respiratory Fail due to Sepsis; ARF due to CHF, etc.

What to Do:

- Educate the physicians on the differences between coding and clinical languages.

Respiratory Failure (contd)

The Query:

- Include clinical findings documented in the record that support the reason for asking the question.
  - This helps the physician by not having to flip back into the chart and clarifies the "facts in evidence".

- ***Example*:** "ER report shows ABGs of pH<7.30, CO2 of 80, O2 of 50 with diagnosis of COPD Exacerbation".

- ***Example:*** ER report states patient in respiratory distress, O2 sats low (82), patient intubated, and other diagnoses of pneumonia and CHF are documented on ER report.

Respiratory Failure (contd)

Sample Query:

Based on the patient's signs, symptoms, and treatments above are you able to further clarify the patient's diagnosis? Possible diagnoses include, but are not limited to:

Chronic Respiratory Failure

Acute COPD Exacerbation

Acute Respiratory Failure

Acute-on-Chronic Respiratory Failure

Respiratory Acidosis Alkalosis

Respiratory Acidosis or Alkalosis

Metabolic Acidosis or Alkalosis

Acute Respiratory Insufficiency

Acute Respiratory Distress

Other _____

Unable to determine

If one of the above conditions is the source of the respiratory symptoms, please also document the acuity, severity, and type or cause if known.

Acute Renal Failure

- Acute vs Chronic is also a documentation issue for the diagnosis of renal failure.
- Sometimes patients present to the ED without a full history being known.
- When these patients are found to be in renal failure, it may not be known whether it is acute or chronic.
- It could be assumed to be acute on admission and found to be chronic after study.
- Sometimes a patient with known chronic renal failure is thought to be in acute renal failure on admission but is found to have experienced progression to the next stage of chronic renal failure instead.

Acute Renal Failure (contd)

- Failure vs Insufficiency is also an issue for patients with kidney dysfunction.
- Sometimes the nephrologist and the attending simply don't document the same level of dysfunction.
- Other times abbreviations with more than one potential meaning might be used, such as "AKI".
  - This could be "acute kidney injury", which is coded as acute renal failure, N17.9, a CC, or it could be "acute kidney insufficiency", which is coded N28.9, which is not a CC.
  - When the acute kidney dysfunction is PDx, N17.9 & N28.9 result in different DRGs as well – and the insufficiency results in higher reimbursement than the failure, unless there is an MCC.

Acute Renal Failure (contd)

- When renal insufficiency is documented, ICD-10 uses the same code for chronic insufficiency as for chronic renal failure, N18.9.
- This is also true for chronic kidney disease (CKD), but not for acute kidney disease or kidney disease NOS, which codes the same as acute renal insufficiency or dysfunction, N28.9
- A common diagnosis seen in medical records is "acute-on-chronic kidney disease" (or "Acute-on-CKD").
  - This is often meant to mean "acute-on-chronic renal failure" by the physician but does not code the same by the book.
  - This has the potential to affect the DRG as well, since acute renal failure is a CC, but acute kidney disease/dysfunction/insufficiency is not.

Acute Renal Failure (contd)

- If it is unclear whether the acute renal dysfunction was insufficiency or failure/injury . . .
- If it is unclear whether the renal failure was acute or chronic . . .
- If it is unclear whether the renal insufficiency was acute or chronic . . .
- If there is conflicting documentation . . .
- If the diagnosis documented doesn't appear to be supported by the documented clinical findings . . .

. . . A query should be generated.

Acute Renal Failure (contd)

Clinical Scenario:

68-year-old man presents with weakness, tiredness, SOB, and decreased urine output.

Physical exam reveals swelling in the ankles and feet.

Admission diagnosis: Acute-on-CKD, hypertension, and DM II.

- *Day 1 Progress note: SOB, weakness, and swelling improving. BUN/Cr 53/3.2. Continue IVF.*
- *Day 2 Progress notes: AKI much improved. BUN/Cr 46/2.4.*
- *Day 3 Progress note: Renal insufficiency, at baseline. BUN/Cr 32/1.9.*
- *Day 4 Progress note: Patient's renal function at baseline. Discharge home.*

Discharge diagnosis: Acute-on-CKD

Acute Renal Failure (contd)

Rules for Coding:

- Code assignment is based entirely on physician documentation.
- Acute renal insufficiency is coded as N28.9, acute renal failure & acute kidney injury is coded N17.9.
- If indicators of renal failure or acute kidney injury are present without corresponding documentation, clarification from the physician is necessary.

Acute Renal Failure (contd)

Common Issues:

- Many times, physicians will use the term "insufficiency" interchangeably with "failure" or "injury".
- Often "acute-on-chronic kidney disease" is used when the acute renal disease can be further specified.
- Severe renal insufficiency may very well be acute renal failure or acute kidney injury.
- Renal insufficiency, while having a specific ICD-10 code, does not provide any increase in the severity of illness.
- "Insufficiency" will not always warrant clarification, however, if clinical indicators support it, clarification should be obtained.
- Even CRF (chronic renal failure)/CKD (chronic kidney disease/CRI (chronic renal insufficiency) with high values should be clarified.
- Especially if previous values are documented and are lower than current levels.

Acute Renal Failure (contd)

What to Look For:

- Past Medical History of renal function problems or diagnoses.
- Lab results such as elevated BUN/Cr and/or GFR (Glomerular Filtration Rate).
  - Creatinine rise of 0.5mg higher than the patient's norm may be an indicator of failure.
  - A GFR reduction of 50% equates to failure.
- The treatment provided, such as high volume IV fluids.
- Follow up plans after discharge to see a nephrologist.
- Orders for renal consult while in the hospital.
- Review consultants' notes for specific documentation.

Acute Renal Failure (contd)

What to Ask For:

- Simply if the documentation of acute kidney disease in this patient can be further specified and documented as acute renal insufficiency, acute renal failure, or acute kidney injury.

What to Do:

- Educate physician on the importance of documenting specific diagnoses.

Acute Renal Failure (contd)

The Query:

- Include lab values and treatment provided to clarify if acute kidney disease could be documented as acute renal failure or acute kidney injury.
- **Example:** This patient's BUN/Cr were 53/3.2 on admission and IV fluids have been ordered at 150cc/hr. Patient's BUN/Cr at discharge, described as baseline, were 32/1.9.

Acute Renal Failure (contd)

Sample Query:

Based on the patient's above signs & symptoms, could you please clarify the level of acute renal dysfunction this patient experienced?

_____ Acute renal dysfunction of unknown severity

_____ Acute renal insufficiency

_____ Acute renal failure

_____ Acute kidney injury

_____ Other _____

_____ Unable to be determined

Please also specify the stage of CKD, if known: _____

Sepsis

- Sepsis is a diagnosis that has a lot of associated potential documentation issues.
- Part of the problem with sepsis is that the definition and the associated terms used in ICD-9 & ICD-10 have been changed multiple times in the last 20 years.
- It used to be that "sepsis" and "septicemia" both coded to the same ICD-9 code (038.9).
- Then sepsis was classified to codes in a different subcategory (995.9X), which were to be used as additional codes sequenced after codes for the systemic infection (such as 038.9, which was septicemia).
- SIRS was considered essentially synonymous with sepsis, unless documented as due to a non-infectious condition such as trauma.

Sepsis (contd)

- Now, in ICD-10, there is no equivalent to ICD-9's category 995.9X, and "sepsis" & "septicemia" both code to the same code again, A41.9.
- ICD-10 has no index entry for SIRS related to infection, only for SIRS of noninfectious origin (R65.1-).
- When SIRS is documented without sepsis or septicemia, and it is related to an infection, only the infection is coded.
  - Example:
    - SIRS due to pneumonia is coded as pneumonia, J18.9.
    - SIRS due to UTI is coded as UTI, N39.0.
- However, many physicians still document SIRS with the intention of documenting systemic infection/sepsis.

Sepsis (contd)

- Sepsis is also commonly over-documented.
  - Meaning, sepsis may be documented even though the patient is not exhibiting signs & symptoms of systemic infection.
- Sepsis is also commonly under-documented.
  - Some physicians use the term "bacteremia" when the patient has septicemia or sepsis.
  - Bacteremia is classified by ICD-10 as an abnormal finding, and as such the guidelines for signs & symptoms apply.
  - This means that bacteremia is rarely defensible as PDx in the inpatient setting.
  - Even though bacteremia, R78.81, results in the same DRG as sepsis, A41.9, when listed as PDx, it is rarely defensible to list R78.81 as PDx.

Sepsis (contd)

- Because of the use of terms like SIRS & bacteremia when sepsis is meant, it is common to have two or more physicians using different terms for the same condition.
  - Although the physicians may agree about what is wrong with the patient, the use of different terms results is a problem for HIM coders.

- Another term that presents a similar problem is "urosepsis".
  - In ICD-9, the index entry for "urosepsis" directed coders to the same code as UTI (599.0).
  - There were subentries for "meaning sepsis", which directed coders to the code for sepsis (995.91), and for "meaning urinary tract infection", which directed coders to the code for UTI (599.0).
  - In ICD-10, however, the Index directs us to "code to condition" – urosepsis itself is not a codable diagnosis.

Sepsis (contd)

Clinical Scenario:

An 82-year-old patient presents with AMS, fever of 102, chills, weakness, SOB, productive cough, and a history of COPD.

Findings include low BP, respirations 22, in acute distress, WBC over 14,000, CXR shows an infiltrate

Admitting Diagnosis: Suspected sepsis, pneumonia, and COPD exacerbation

- Day 1 Progress note: Suspected sepsis from pneumonia, cultures pending, continue IV antibiotics, IV steroids & Duonebs
- Day 2 Progress note: Sepsis & pneumonia with COPD exacerbation, improved, continue tx
- Day 3 Progress note: Possible sepsis, pneumonia, COPD exacerbation, improved, continue tx
- Day 4 Progress note: Infectious process resolved. Discharge home on p.o. antibiotics and steroids.

Discharge Diagnosis: Pneumonia & COPD exacerbation.

Sepsis (contd)

Rules for Coding:

- If a condition, such as sepsis, is suspected early in a hospital stay and is treated, but is later ruled out, coders cannot assign the code for it.

Common Issues:

- Sepsis may be documented by an ED physician or attending/consulting physician early in the stay, but later, this documentation no longer appears.
- It is not known by the coder if sepsis was ultimately ruled out or resolved.
- If sepsis was present, but resolved after treatment initiated, it can be coded.
- If sepsis was ruled out, it is not coded.

Sepsis (contd)

What to Look For:

- Continuing treatment of sepsis.
- Blood culture results.
- Discharge plans/medications. Are they being discharged on antibiotics or even IV antibiotics?
- Physical exam indicators of sepsis, like tachycardia or low BP, elevated or lowered temp, elevated WBC (this could be at a normal level), altered mental status, etc.

Sepsis (contd)

What to Ask For:

- Simply if the sepsis was ruled out or still suspected at the time of discharge.

What to Do:

- Educate physicians on the importance of continuing to document all the conditions a patient is being treated for, and include all conditions treated on the Discharge Summary or final progress note – not just the conditions the patient still has at the time of discharge.

Sepsis (contd)

The Query:

- Include blood culture results or treatment plan.
- Show lab results or physical exam indicators.
- Ask for clarification if sepsis was ruled out, ruled in, or still suspected at the time of discharge.
- **Example:** Suspected sepsis was documented initially but was not mentioned on the last progress note or the Discharge Summary. On admission, the patient had AMS, fever of 102, chills, low BP, SOB, and a WBC of 14,000. The patient was treated with IV antibiotics & IV steroids.

Sepsis (contd)

Sample Query:

Based on the above findings, please clarify whether:

_____ Sepsis was ruled out

_____ Sepsis was ruled in

_____ Sepsis improved (partial or resolved)

_____ Sepsis still suspected

_____ Other _____

_____ Unable to determine

Malnutrition

- When a patient has documented malnutrition, the severity determines the precise code – which may be either a CC or an MCC.
- Unspecified, mild, moderate, first-degree, or second-degree malnutrition are all CCs and are coded E44.0, E44.1, or E46.
- Severe or third-degree malnutrition are MCCs and are coded E43 or, if specified as with marasmus, E41.
- There is also Kwashiorkor, which is an MCC but generally should not be used in the U.S. since this diagnosis is extremely rare here – using a Kwashiorkor code is a red flag and better be backed up with the necessary documentation, especially if it is the only MCC.

Malnutrition (contd)

- Essentially, if a diagnosis of malnutrition can be established then the severity should also be known.
- Many physicians will simply document "malnutrition" and not specify the severity.
- Sometimes different physicians document conflicting degrees of severity.
- If there is unclear, inconsistent, or conflicting documentation . . .
- . . . A query should be generated.

Malnutrition(contd)

Clinical Scenario:

A 69-year-old patient with a history of Crohn's disease who is status post partial colectomy presents with diarrhea, nausea, vomiting, and weakness.

Physical findings include a BMI of 18, cachexia, and muscle wasting.

Labs show a serum albumin level of 3.4.

Admitting diagnosis is AGE.

- Day 1 Progress note: AGE, dehydration, hypoalbuminemia, cachectic. IV rehydration, IV Protonix, and IV antibiotics. Refer to dietician.
- Day 2 Progress note: AGE, dehydration, malnutrition. Ensure added. Continue tx.
- Day 3 Progress note: Improved. Continue tx.
- Day 4 Progress note: Much improved. Ready for discharge.

Discharge Diagnoses: AGE, dehydration, malnutrition – resolved.

Malnutrition(contd)

Rules for Coding:

- Conditions for which ICD-10 codes exist to specify severity, such as malnutrition, should be coded to the greatest specificity known.

Common Issues:

- The physician should know the severity of the malnutrition being treated however the severity may not be specified in the record.

- Malnutrition listed as a secondary diagnosis may be a CC or an MCC, depending on severity.

Malnutrition(contd)

What to Look For:

- Documentation of malnutrition
- Signs of muscle wasting
- Referral to a dietician
- Treatment with nutritional supplements
- Cachexia or cachectic-appearing
- Hypoalbuminemia
- Poor eating habits
- Changes in weight

Malnutrition(contd)

What to Ask For:

- Simply ask whether the severity of the malnutrition can be further specified.

What to Do:

- Educate physicians on the importance of specifying the severity of conditions such as malnutrition.

The Query:

- Include lab results such as albumin levels, physical exam indicators, treatment, and pertinent dietician comments.

- **Example:** Patient with BMI 18 and albumin 2.5 diagnosed with malnutrition.

Malnutrition(contd)

Sample Query:

Based on the above findings, please clarify the severity (or degree) of the malnutrition as:

_____ Mild/First degree malnutrition

_____ Moderate/Second degree malnutrition

_____ Severe/Third degree malnutrition

_____ Malnutrition of unknown severity/degree

_____ Other _____

_____ Clinically unable to determine

Anemia

- Anemia can affect the DRG in certain scenarios (other than when listed as PDx).
- These include:
  - Anemia due to acute blood loss – this is a CC.
  - Postop anemia due to blood loss (not specified as chronic) – this is a CC.
  - Aplastic anemia – this can be a CC or an MCC, depending on the specific form of aplastic anemia.
  - Acquired red cell aplasias – these can be a CC or MCC, depending on the specific form of red cell aplasia.
- Anemia due to chronic blood loss does not affect the DRG assignment as this is not a CC.

Anemia(contd)

- The most common documentation issue is related to anemia due to blood loss.
- Many physicians will document the anemia as due to blood loss without specifying the anemia as acute or chronic.
- ICD-9-CM allowed for "anemia due to acute blood loss" to be coded as "acute blood loss anemia" & had includes notes in the Tabular List to show this.
- These includes notes do not exist in ICD-10-CM, and so far there hasn't been any official advice published stating whether this remains true for ICD-10-CM or not.

Anemia(contd)

Rules for Coding:

- Anemia – Unspecified code for anemia is used when specific site, type or cause is not documented.
- Clinical indicators – Documentation of a diagnosis of "low hemoglobin" or "low hematocrit" is sufficient for use of code D64.9.
- However, no other clinical indicators are sufficient for assigning an anemia code, and this exact wording, "low hemoglobin" or "low hematocrit," is necessary to assign D64.9 without documentation of "anemia".

Anemia(contd)

The Issue:

- Anemia – Physicians typically do not provide the site, type, or cause of anemia, leaving coders with no option but to assign an unspecified code. (Big loss in revenue.)
- Clinical Indicators without diagnosis of "anemia" – Very often, physicians will document clinical indicators of anemia, but not the actual diagnosis.
- **Example:** Patient's Hgb drops 4 points after surgery, is transfused 2 units PRBC everyday for 3 days and H&H are monitored twice daily throughout the hospitalization.

Anemia(contd)

The Issue (continued):

- While "low hemoglobin" codes to D64.9 according to the ICD-10-CM Index, the use of down arrows such as "↓H&H" or even "↓Hgb" are not sufficient according to Coding Clinic.
- Likewise, documentation of a low hemoglobin level such as, "H&H 7/26" is also not sufficient.
- No other clinical indicators of anemia are sufficient for assigning an anemia code without documentation of "anemia".
- "Low hemoglobin" is only acceptable because there is a specific ICD-10-CM Index entry for this which directs us to code D64.9.
- However, it is still best practice to obtain clarification, especially if a more specific anemia code could otherwise be used.

Anemia(contd)

The Issue (continued):

- If there is documentation of H&H levels which are low but there is no documentation of either "anemia" or "low hemoglobin" then the provider should be queried regarding the clinical significance of these abnormal laboratory findings rather than for clarification of whether the patient has anemia.
- Most surgeons will not document the diagnosis of "acute blood loss anemia due to surgery" because they don't want supposed "complications" to appear.
- Many times, it is expected that the patient will lose a lot of blood in surgery.
- However, this could still be an acute blood loss anemia and clarification should be obtained accordingly.
- The physician may use their own clinical judgment regarding whether this actually represents anemia or a complication of surgery, according to Coding Clinic.

Anemia(contd)

What to look for:

- The type of patient (surgical, internal medicine, GI, etc).
- Commonly associated conditions such as bleeding, iron deficiency, etc.
- Physical exam (generalized fatigue, shortness of breath, rapid heart rate).
- Lab work (initial, pre-op, and post-op labs for H&H levels – a drop of 3 on Hgb is significant; or 2 if H&H started low).
- Treatment (transfusion, vitamins, iron supplements, etc.).
- Evaluation/monitoring (how often H&H are being monitored).

Anemia(contd)

What to Ask for:

- Anemia – Specification of type, site or cause of anemia.
- **Example:** Suspected GI bleed [acute or chronic]; anemia of chronic disease, iron deficiency anemia, etc.
- Clinical indicators without diagnosis of "anemia" – An answer to the question, "Is this anemia?"
  - If so, also specify type, site or cause.

Anemia (contd)

What to Do:

- Educate surgeons and internal medicine physicians on the importance of documenting diagnoses – primarily orthopedic surgeons and gastrointestinal physicians.
- Not documenting this diagnosis when present can result in a significant loss of revenue.

The Query:

- Include clinical findings & treatment.
- Medical patients – "labs on day of admit show H/H of 7/26; pt. was transfused 2 units PRBC".
- Surgical patients – "pre-op labs show H/H of 11/41; post-op labs show H/H of 7/26; pt. transfused 2 units PRBC".

Anemia (contd)

Sample Query 1 – for Documentation of "Anemia":

This patient's diagnosis has been documented as anemia. Please specify this diagnosis below due to following indicators found in the medical record:

_____

_____

Acute Blood Loss Anemia

Chronic Blood Loss Anemia

Anemia from GI Blood Loss – Acute

Anemia from GI Blood Loss - Chronic

Postoperative Anemia due to Acute Blood Loss

Expected Acute Blood Loss Anemia

due to Surgery

Anemia due to Chronic Renal Failure

Anemia due to Cancer

Other:

_____

Unable to Determine

Anemia (contd)

Sample Query 2 – for Documentation of Clinical Indicators of Anemia without Documentation of "Anemia":

The following clinical indicators have been documented in this patient's medical record without a specific diagnosis:

_____

_____

Please clarify:

_____ Acute Blood Loss Anemia

_____ Chronic Blood Loss Anemia

_____ No Clinical Significance

_____ Unable to Determine

_____ Other: _____

Encephalopathy

- The diagnosis of encephalopathy is defined by Dorland's Medical Dictionary – available in 3M's encoder as well as the TruCode encoder – as:
  - *"any degenerative disease of the brain"*
- This definition is also consistent with the Greek etymology of the word:
  - *Encephalo = brain; pathy = disease*
- Even though this diagnosis has such a vague definition, it is an MCC when unspecified, G93.40, or due to metabolic, G93.41, and/or toxic, G92, etiologies.
  - It is also a CC when due to certain other etiologies such as anoxia, G93.1, or hypertension, I67.4.
  - Yet, it is neither CC nor MCC when due to "diseases classified elsewhere", G94.

Encephalopathy (contd)

- Keep in mind that encephalopathy did not become a CC/MCC until the MS-DRG system was introduced in 2007.
- When challenged as to why conditions such as unspecified encephalopathy, metabolic encephalopathy, and toxic metabolic encephalopathy should be MCCs, CMS stated in its fiscal year (FY) 2012 IPPS rule that:
  - "its clinical advisers recommended that these encephalopathy codes remain at an MCC level because these patients with encephalopathy typically utilize significant resources and are at a higher severity level."
  - (Federal Register Vol. 76, pp. 51544 & 51545)
- CMS does not appear to use Dorland's definition of encephalopathy as it appears inconsistent with this statement in the Federal Register.

Encephalopathy (contd)

- It may prove beneficial to keep the following alternative definitions in mind when dealing with encephalopathy:

- The National Institute of Neurological Disorders and Stroke
  - "Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure"
    - http://tinyurl.com/NINDSencephalopathy.

Encephalopathy (contd)

- Adams and Victor's Principles of Neurology, 10th Edition:
  - "A global brain dysfunction that has an underlying cause distinct from any other named brain disease (e.g., Alzheimer's)"
  - It could be a general medical condition (e.g., metabolic encephalopathy), a poisoning (e.g., toxic encephalopathy), chronic liver failure (e.g., hepatic encephalopathy), diffuse anoxia, or the like that results in the diffuse brain dysfunction.
  - These, of course, would have to be defined, differentiated, and documented by the provider, emphasizing that they are separate, distinct, or overlying another underlying diffuse brain disease (e.g., Alzheimer's)

Encephalopathy (contd)

- Encephalopathy not specified further can result in a higher paying DRG than encephalopathy that is specified further – such as when the etiology is specified as anoxia, hypertension, or "diseases classified elsewhere".
- Therefore, the use of code G93.40, Encephalopathy, unspecified, will be most able to withstand the scrutiny of third-party reviewers, such as RAC auditors, when the physician was queried for clarification of the cause (and the answer supports unknown, or no answer was provided).
- Reporting this code without a query could leave the facility open to "corrections" in reimbursement down the road.

Encephalopathy (contd)

Rules for Coding:

- Encephalopathy is a non-specific diagnosis. For accurate code assignment, the underlying cause should be specified. If no cause is documented, then the physician should be queried for clarification.

- Depending on the etiology, encephalopathy may be a CC or an MCC, and therefore has the potential to impact the DRG.

The Issue:

- Encephalopathy is often documented without explicit linkage to the underlying cause.

- Encephalopathy can be a transient condition that resolves quickly and is most often addressed by treating the underlying cause – especially if the underlying cause is acute.

Encephalopathy (contd)

What to Look For:

- Signs of encephalopathy, especially AMS.

- Documentation of acute or chronic conditions that are commonly associated with encephalopathy, such as:
  - Acute infection
  - Hepatic failure
  - Alcoholic cirrhosis
  - Poisoning
  - Anoxia
  - Wernicke's syndrome
  - Etc.

Encephalopathy (contd)

What to Ask For:

- If documentation of encephalopathy already exists, simply ask for clarification of the type & underlying cause, such as: metabolic, toxic, septic , anoxic, hepatic, other, undetermined, etc.

- If documentation of encephalopathy does not exist but encephalopathy is strongly indicated clinically, ask whether the AMS & other clinical indicators are related to a specific diagnosis or process, such as encephalopathy (ask for specification of type/cause as above), dementia, and/or any other conditions that may be indicated in the record.

Encephalopathy (contd)

What to Do:

- Educate physicians about the importance of identifying encephalopathy in the documentation and specifying its cause.
- Query the physician when encephalopathy is documented, and the cause is not specified.
- Query the physician when clinical indicators of encephalopathy are present, without linkage to another condition, or when the linked condition implies the indicators are due to the underlying condition by way of encephalopathy (AMS due to anoxia, UTI, alcoholic cirrhosis, etc.).

Encephalopathy (contd)

The Query:

- Include all pertinent clinical indicators documented in the medical record, including all documented conditions commonly associated with encephalopathy.

- **Example:** This patient presented with AMS, UTI, and has a history of alcoholic cirrhosis. Encephalopathy is documented however it is not linked to any specific condition.

Encephalopathy

Sample Query:

Based on the above findings, please specify the type/cause of encephalopathy as follows:

Metabolic encephalopathy

Toxic encephalopathy

Septic encephalopathy

Anoxic encephalopathy

Hepatic encephalopathy

Encephalopathy due to other condition: _____

Type/Cause of encephalopathy is unable to be determined

CLINICAL SCENARIOS FOR SPECIFIC DOCUMENTATION ISSUES

- SEE WORKBOOK

Present on Admission

- One of the reasons for which querying is allowed – and necessary – is when it is unclear whether a documented condition was present on admission or developed subsequently.
- This is important because each ICD-10-CM code assigned must be reported with a POA Indicator, unless the code is specifically exempt from POA reporting.
  - Exempt codes are typically either 'history of' codes, or sequelae codes, which are, by definition, present prior to admission.
- This is especially important for conditions classified as HACs (Hospital-Acquired Conditions).
  - When a HAC develops during an admission, it does not affect the DRG.
  - These conditions would be a CC or MCC if POA.

Present on Admission

- Whether a condition was POA or not can also impact the selection of PDx.
  - Conditions that develop after inpatient admission do not qualify as PDx.
  - This is true even if that condition becomes the focus of care and consumes the majority of resources – including major surgery.
  - Even if a condition develops within hours or even minutes after admission, it cannot be reported as PDx.
  - Example: A patient trips going to the bathroom and breaks her hip, requiring a total hip replacement, only minutes after being admitted for treatment of a UTI.
  - The UTI is still the reason for admission and should be listed as PDx.
  - The hip fx is a HAC and will not affect the DRG, even though it would be an MCC if POA – the hip replacement will still change the DRG.

Present on Admission (contd)

- DRG 983, Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC has a RW of 1.6371.
  - This is the resulting DRG when a surgery is performed for a condition that was not the reason for admission without a CC/MCC – including when a HAC is reported with an N for the POA indicator.
- DRG 981, Extensive O.R. procedure unrelated to principal diagnosis w/MCC has a RW of 4.4907.
  - This is the resulting DRG when a surgery is performed for a condition that was not the reason for admission with an MCC – as in, the DRG that would result if the HAC counted as an MCC.
- The difference in reimbursement can *easily* be upwards of $15,000!
  - (Depending on the specific facility's blended rate.)

Present on Admission (contd)

- Some of the more common conditions classified as HACs, which do not affect the DRG when not present on admission, include:
  - Several postoperative complications
  - Decubitus Ulcers (stage III & IV)
  - Blood incompatibility
  - Falls & Trauma
  - Catheter-Associated UTI
  - Vascular catheter-associated infection
  - Iatrogenic pneumothorax w/ vascular catheterization

- For a complete list visit:

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

Present on Admission (contd)

- Conditions which are not documented on admission but are discovered subsequently to have been present at the time of admission are reported as being POA.
  - The condition does not have to be known at the time of admission to be reported as POA.
- An understanding of disease process and symptomatology is important in determining whether a condition was POA, and when to clarify POA status with the provider.
  - If a patient is admitted with a symptom that is later linked to another condition, which was not a known condition on admission, that condition must have been POA, or it could not be causing the symptom that was POA.

Present on Admission (contd)

- POA status must be reported using one of the following indicators:
  - Y = Yes: the condition was present at the time of inpatient admission.
  - N = No: the condition was not present at the time of inpatient admission.
    - This means the condition developed after admission, not that it resolved prior to admission, such as a condition that resolved in the ED.
  - U = Unknown: documentation is insufficient to determine if condition was present on admission
  - W = Clinically undetermined: provider is unable to clinically determine whether condition was present on admission or not
- There is no required timeframe as to when a provider must identify or document a condition to be present on admission.

Present on Admission (contd)

- Chronic conditions are always reported as POA, even if they are diagnosed during the current admission.
  - If a single code identifies both the chronic condition and the acute exacerbation, the POA indicator is determined by whether the acute exacerbation was POA.
  - If a single code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of chronic leukemia), assign "Y", even if the acute exacerbation developed during the admission.

- For conditions documented as impending or threatened at the time of discharge:
  - If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".
  - If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign "N".

Present on Admission (contd)

- Combination Codes
  - Assign "N" if any part of the combination code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)
  - Assign "Y" if all parts of the combination code were present on admission (e.g., patient with acute prostatitis admitted with hematuria)
  - If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y".
  - For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Present on Admission (contd)

- Same Diagnosis Code for Two or More Conditions
  - When the same ICD-10-CM diagnosis code applies to two or more conditions during the same encounter (e.g., two separate conditions classified to the same ICD-10-CM diagnosis code):
  - Assign "Y" if all conditions represented by the single ICD-10-CM code were present on admission (e.g., bilateral unspecified age-related cataracts).
  - Assign "N" if any of the conditions represented by the single ICD-10-CM code was not present on admission (e.g., traumatic secondary and recurrent hemorrhage and seroma is assigned to a single code T79.2, but only one of the conditions was present on admission).

- There are additional POA reporting guidelines found in Appendix I of the official guidelines, however these are mostly for OB, perinatal, and congenital conditions, as well as for external cause codes.

Present on Admission (contd)

Rules for Coding:

- Most ICD-10-CM codes are required by CMS to be reported with a POA indicator.
- The POA indicator can affect the selection of PDx and can affect whether a CC/MCC actually counts as a CC/MCC for conditions classified as HACs.

The Issue:

- CMS has initiated the process by which it will not pay for conditions the patient acquired while in the hospital. Their reasoning is quite simple:
  - Why should they have to pay for poor quality of care or for a hospital's or doctor's mistake?
- Physicians often do not document all conditions being worked up or that are present at the time of admission.

Present on Admission (contd)

What to Look For:

- Documentation of symptoms or signs present at admission and later documentation establishing a diagnosis that account for them.

What to Ask For:

- If presenting symptoms were due to a diagnosis later established.
- Specifically, whether a condition was present at the time of admission or not.

Present on Admission (contd)

What to Do:

- Learn or have quick access (cheat sheet) to the conditions that will affect reimbursement if not present at the time of admission.

- If documentation is present of symptoms at admission and later documentation establishes a diagnosis for those symptoms, make sure the physician(s) clearly documents the relationship.

The Query:

- Include the documentation that appears to support a particular condition as being present at admission and ask if it was.

Present on Admission (contd)

Sample Query:

This patient has been diagnosed with _____. Please specify whether this condition was **Present on Admission (POA)** or **Occurred After Admission (While In the Hospital)**.

_____ Condition was Present on Admission (POA)

_____ Condition Occurred After Admission

Procedures

- Just as there are many documentation issues that arise regarding diagnoses, there are many more that arise regarding procedures.
- Many procedures will result in different DRGs based on whether the intent was diagnostic or therapeutic.
- Example: A patient with liver cirrhosis and associated ascites has a paracentesis performed.
  - A diagnostic paracentesis is coded 0W9G3ZZ, which does not affect the DRG assignment.
  - A therapeutic paracentesis is coded 0W9G3ZX, which does affect the DRG assignment.
  - The difference in reimbursement can easily be more than $3,000.

Procedures: Debridement

- When it comes to debridement, ICD-10-PCS differentiates between extraction (non-excisional debridement) and excision.

- The depth (deepest layer of tissue debrided) also affects code assignment.
  - Note: Skin & subcutaneous tissue were considered the same layer in ICD-9, however ICD-10 includes subcutaneous tissue with fascia rather than skin.
  - Many providers are still unaware of this significant change.

Procedures: Debridement (contd)

- In the case of a patient with a decubitus ulcer of the sacrum who is admitted for wound care, including debridement (the ulcer is the PDx), both extraction and excision will result in a surgical DRG.
  - In ICD-9, non-excisional debridement never grouped to a surgical DRG.
  - However, extraction and excision do group to different surgical DRGs in ICD-10.
  - Extraction does not group to a surgical DRG if is coded to skin – the layer must be subcutaneous tissue or deeper.

Procedures: Debridement (contd)

- For the sake of this example, we will use L89.153, Pressure ulcer of sacral region, stage 3, as our PDx.
- Coding extraction of subcutaneous tissue of the back, open approach, 0JD70ZZ, will result in DRG 581, which has a relative weight of 1.2599.
- Coding excision of subcutaneous tissue of the back, open approach, 0JB70ZZ, will result in DRG 572, which has a relative weight of 1.1026.
- If our facility would be reimbursed $7,673.18 for DRG 572 (excision), then the reimbursement for DRG 581 (extraction – non-excisional) would be $8,664.46.
  - The non-excisional debridement actually ends up in a higher paying DRG than the excisional debridement!

Procedures: Debridement (contd)

Rules for Coding:

- For proper reporting, the procedure of "debridement" needs to be specifically documented as to:
  - The type of debridement performed (excisional or non-excisional) and
  - The deepest layer involved (skin, subcutaneous tissue, fascia, muscle, bone, etc.).

Procedures: Debridement (contd)

The Issue:

- For coding and reimbursement purposes, a debridement must be documented as excisional or non-excisional (root operation "extraction").
  - Coders may make this determination based on documentation in the Operative Report, if neither of these terms are used.
- It is common for physicians to document the instruments used to perform the debridement rather than the type of debridement.
  - Code assignment may not be based solely on the type of instrument used without documentation of the type of debridement or how the instrument was used (i.e., scraping, cutting, etc.).
- Coders need to know if tissue was excised or if the wound was simply irrigated, scrubbed, or even incised and drained.

Procedures: Debridement (contd)

The Issue *(continued)*:

- The term "I&D" is commonly used by physicians to mean:
  - "incision and drainage"
  - "incision and debridement"
  - "irrigation and debridement"
- If meant as debridement, clarification will be needed.
- Coders cannot assume the meaning of I&D.
- Debridement may be performed by a non-physician clinician, such as the wound management team, or physical therapist.

Procedures: Debridement (contd)

What to Look For:

- Documentation of "debridement", "wound debridement", "I&D" or other similar terms not specified as excisional or non-excisional.
- Review any available operative report or procedure note to determine if more specific information can be found.
  - Sometimes physicians performing a consult will perform a bedside debridement while they are doing their consult and include documentation of the debridement in the dictated consult report rather than a separate procedure report.
- The use of sharp instruments does not automatically mean the debridement was excisional; however, this is indication that it may have been and should be included in the query.

Procedures: Debridement (contd)

What to Ask For:

- Specific documentation of excisional or non-excisional and the deepest layer involved (skin, subcutaneous tissue, fascia, muscle, bone, etc.).
  - Excisional: Such as that by surgical removal or cutting away, etc.
  - Non-excisional (mechanical): Such as that by brushing, washing, scrubbing, scraping, etc.

Procedures: Debridement (contd)

- Elements Documented Support Excisional Debridement:
  - Technique used
  - Instrument used
  - Nature of Tissue removed (slough, necrosis, devitalized tissue)
  - Appearance/Size of Wound (fresh bleeding tissue, viable tissue)
  - Depth of debridement
  - Documentor should use phrase “down to and including”

Procedures: Debridement (contd)

What to Do:

- Query the physician or clinician who performed the procedure.
- Educate physicians (and other clinicians who perform debridement at your facility) about the importance of specifying the type of debridement and the deepest layer involved.

Procedures: Debridement (contd)

The Query:

- Include any information found in the documentation to help support the question such as:
  - Instrument(s) used ("a #10 blade was used to remove tissue to obtain viable bleeding tissue")
  - Depth described
  - Other such descriptors of the debridement type or site

Procedures: Debridement (contd)

Sample Query:

This patient had a wound debridement performed on _____.

Please specify the type of debridement performed as:

- Excisional (such as that by surgical removal or cutting away, etc.)
- Non-Excisional (such as that by brushing, washing, scrubbing, etc.)

Also specify the deepest layer involved in the debridement as:

- Skin
- Subcutaneous tissue
- Fascia
- Muscle
- Bone
- Other: _____

Procedures: Resection vs Excision

- Another issue that is new with ICD-10 is that of resection vs excision.
  - In ICD-9, these terms were synonymous and did not affect code assignment.
- In ICD-10, resection refers to removal of an entire body part.
  - "Body part" refers to the specific body parts shown in the applicable ICD-10-PCS table.
  - Removal of the entire ascending colon is a resection, even though this is not a total colectomy.
- The term "excision" is used to refer to removal of a portion of a body part.
- However, many physicians use the term "resection" to mean removal of either a portion of a body part or the entire body part – and are not familiar with the ICD-10 body part divisions.

Section	**0**	Medical and Surgical
Body System	**D**	Gastrointestinal System
Operation	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	*Approach*	*Device*	*Qualifier*
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **4** Esophagogastric Junction **5** Esophagus **6** Stomach **7** Stomach, Pylorus **8** Small Intestine **9** Duodenum **A** Jejunum **B** Ileum **C** Ileocecal Valve **E** Large Intestine **F** Large Intestine, Right **G** Large Intestine, Left **H** Cecum **J** Appendix **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier
Q Anus	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **X** External	**Z** No Device	**X** Diagnostic **Z** No Qualifier
R Anal Sphincter **S** Greater Omentum **T** Lesser Omentum **V** Mesentery **W** Peritoneum	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

Procedures: Resection vs Excision (contd)

- According to the ICD-10-PCS guidelines, coders are responsible for determining when all of a body part is removed or a portion of a body part is removed, based on the entirety of the surgeon's documentation, not just their use of the term "resection".
- However, it is not always clear and sometimes clarification is necessary.
- Surgeons are mostly unaware of what constitutes an entire body part according to ICD-10-PCS.
  - A physician may document "partial colectomy of ascending colon" to refer to a removal of the entire ascending colon or to refer to removal of part of the ascending colon.
  - Since ascending colon has its own body part character in ICD-10-PCS, removal of the entire ascending is a resection and not an excision, even though the physician called it "partial".

Procedures: Resection vs Excision (contd)

Rules for Coding:

- ICD-10-PCS contains specific body parts for anatomical subdivisions of a body part, such as lobes of the lungs or liver and regions of the intestine.
- Resection of the specific body part is coded whenever all of the body part is cut out or off, rather than coding excision of a less specific body part.
- **Example:** Left upper lung lobectomy is coded to Resection of Upper Lung Lobe, Left rather than Excision of Lung, Left.

Procedures: Resection vs Excision (contd)

The Issue:

- Detailed descriptions of the body parts removed, where transections/incisions were performed, etc., are necessary to determine whether the procedure should be coded to the root operation “resection” or “excision”.

- Knowledge of the body part character divisions for the procedure performed is necessary for both the coder and CDI specialist.

Procedures: Resection vs Excision (contd)

What to Look For:

- Documentation stating precisely where the body part removed during surgery was cut.
  - Terms such as "partial" and "total" or "resection" and "excision" may not have the same intended meaning in the documentation as in ICD-10-PCS.

- The body part character options available in the ICD-10-PCS table that pertains to the procedure performed should be noted.

Procedures: Resection vs Excision (contd)

What to Ask For:

- Whether the body part in question, according to the body part character options in ICD-10-PCS, was completely excised or partially excised.
  - Example: Was the ascending colon excised completely or partially?
  - There are usually only 2 possibilities here, so options like "other", "unknown", and "unable to be determined" do not typically apply.
  - Do **not** ask whether a body part was resected or excised rather than whether it was removed totally or partially.

Procedures: Resection vs Excision (contd)

What to Do:

- Educate physicians, especially surgeons, regarding the importance of describing transection points and the specimens removed as detailed and accurately as possible.

The Query:

- Include documentation from the procedure note or Operative Report describing the specimen removed and/or the transection points, if available.

- Documentation from the pathology report describing the specimen submitted may also be useful.

Procedures: Resection vs Excision (contd)

Sample Query:

This patient underwent surgical removal of __(Insert body part as per the ICD-10-PCS table here)__.

Please further specify whether this was removed partially or entirely.

Procedures: Resection vs Excision (contd)

- It should be noted that the sample query on the previous slide could easily be an oversimplification.
- Care should be taken to make sure that the query is as detailed as possible.
- In some instances, it may be clear that a transection was performed past the end of particular body part, and the question is instead whether a significant portion of the next body part was removed.
  - Example: Transection of the colon was performed past the proximal end of the sigmoid in the descending colon.
  - In this case, if we know the entire sigmoid was removed, the question is then whether a significant amount of the descending was also removed – if so, then excision of the descending colon should be coded in addition to the resection of the sigmoid.

Procedures: Broncho Biopsy

- ICD-10-PCS classifies biopsy procedures according to the method by which they were obtained, the site at which they were performed, and the approach used to get there.
- All biopsy procedures should be reported with qualifier Z for diagnostic.
- There are two methods (root operations) for biopsy collection:
  - Excision
  - Drainage
- Excision is used for tissue matter while drainage is used for liquid matter.

Procedures: Broncho Biopsy (contd)

- Difficulty can arise when documentation regarding the site is unclear.
- This is probably most common during bronchoscopy biopsies.
- Common documentation issues related to biopsies performed during bronchoscopy include:
  - Physicians using the term "transbronchial" when the biopsy was actually performed as an "endobronchial" biopsy.
    - Transbronchial is when the biopsy forceps are passed through the wall of the bronchus; endobronchial means inside the bronchus.
  - Physicians referring to lung biopsies when a bronchial biopsy is what was actually performed.
  - Brush biopsies, for instance, are sometimes referred to as lung biopsies, even though they are always bronchial.

Procedures: Broncho Biopsy (contd)

- If a patient has a suspected lung cancer and undergoes biopsy to confirm, the site of the biopsy can have a significant impact on reimbursement:
  - Using C34.31, Malignant neoplasm of lower lobe, right bronchus or lung, as our PDx . . .
  - Assigning ICD-10-PCS code 0BB38ZX, Excision of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic, does not affect the DRG, resulting in a medical DRG rather than a surgical DRG.
- The resulting DRG, without any CC/MCC, is 182, Respiratory neoplasms w/o CC/MCC; relative weight = 0.7875.
- Reimbursement to a facility with a blended rate of $4,000 would be: $3,150.00.

Procedures: Broncho Biopsy (contd)

- However, using the same PDx without any CC/MCC & assigning ICD-10-PCS code 0BBD8ZX, Excision of Right Middle Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic, results in a surgical DRG.
  - DRG 168, Other respiratory system O.R. procedures w/o CC/MCC.
  - Relative weight: 1.3691.
  - Reimbursement: $5,476.40.

- The difference between body part character 3 & body part character D for this facility is $2,326.40!

Procedures: Broncho Biopsy (contd)

Rules for Coding:

- Documentation to support the collection of tissue from a specific site – lung vs bronchus – must be present.

The Issue:

- The exact site of a biopsy and/or the tissue involved is not always clearly documented.
- Descriptions used by the physician may not be used with the same intended meaning that is used in the ICD-10-PCS coding system.
  - "Brush biopsy of the lung" is a misnomer – it is not actually of the lung, but of the bronchus.

Procedures: Broncho Biopsy (contd)

The Issue (continued):

- Pathology reports many times list the specimen with a basic or limited description of the tissue.
  - Example: Describing a specimen as "lung tissue" but not specifying the appearance in the description as "alveolar", "lung", or "lung parenchyma".

What to Look For:

- Documentation in the Op report of commonly misused terms such as "transbronchial biopsy", "brush biopsy of lung", or "endobronchial lung biopsy".
- Pathology report to verify the type of tissue submitted in the description – the more detailed, the better.

Procedures: Broncho Biopsy (contd)

What to Ask For:

- Exactly what was biopsied or attempted to biopsy.

What to Do:

- Educate physicians, primarily pulmonologists, of the effect of documentation for this procedure.

The Query:

- Include documentation from the operative report or procedure note.

- Ask for clarification of what was biopsied.

Procedures: Broncho Biopsy (contd)

Sample Query:

This patient had a transbronchial biopsy performed on _____.

Please further specify this as the following:

Biopsy of the lung (specimen shows: lung, alveolar, and/or parenchymal tissue)

Biopsy of the bronchus (specimen shows: bronchial tissue; no lung tissue)

Biopsy of other site (specify): _____

Procedures

- The bottom line is that with procedures, as with diagnoses, whenever the documentation is unclear, inconsistent, incomplete, or contradictory, a query should be generated to obtain clarification.

- Valuable time can be saved by CDI generating these queries whenever possible, so the clarification is ready prior to coding in HIM.

New Issues

"With":

- A significant change to the official guidelines regarding how the word "with" is interpreted in the ICD-10 coding system was made on October 1st, 2016, and a slight update was made October 1st, 2019 as well.

- The new guideline, found in section I.A.15, states:
  - The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis"). For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.
  - The word "with" in the Alphabetic Index is sequenced immediately following the main term **or subterm**, not in alphabetical order.

New Issues (contd)

"With" (continued):

- Historically, conditions listed under the sub-term "with" in the Index had to be linked by the physician in the documentation or they were supposed to be coded separately.
  - There were exceptions to this however they were few in number and specifically addressed in Coding Clinic.
  - Example: Hypertension with CKD was always coded as related unless specifically documented otherwise.
  - Hypertension with any other conditions, such as CHF, were coded separately unless specifically linked in the provider's clinical documentation.

New Issues (contd)

"With" (continued):

- As of October 1st, 2016, this new guideline change means that when a patient has CHF and hypertension, the link will be assumed by ICD-10 unless the provider's clinical documentation specifically states that the conditions are unrelated.

- When coding hypertensive heart disease with CHF, two codes are used:
  - I11.0, Hypertensive heart disease with heart failure
  - I50.-- for the CHF, depending on type (4th digit) & acuity (5th digit); if type is unknown then I50.9 is used.

New Issues (contd)

"With" (continued):

- Code I11.0 must be sequenced first, followed by the code from category I50, so if the reason for admission is the CHF, code I11.0 would be the PDx.
- This results in the same DRG as listing the heart failure code from category I50 as PDx.
- However, if the patient also has CKD, then a code from category I13 is used rather than a code from I11.
- This also does not change the DRG in itself, though CHF of specified type and with an acute component (I50.-1 or I50.-3) will act as an MCC when the PDx is from category I13, but not when the PDx is from category I11 – which does change the DRG.

New Issues (contd)

Diabetes Mellitus:

- Perhaps one of the longest list of entries under the sub-term "with" in the ICD-10 Index is found under the main term "diabetes".
- Historically, any condition associated with diabetes had to be specifically linked to the diabetes by the provider's clinical documentation or the conditions were coded separately.
- Even prior to the October 1st, 2016 guideline change regarding "with", Coding Clinic published advice stating that ICD-10 assumed a link between diabetes and the conditions listed under the sub-term "with" in the Index.
- As with hypertension, the diabetic complication codes take sequencing precedence over the codes for the specific conditions, which will result in numerous DRG changes going forward.

New Issues (contd)

Diabetes Mellitus (continued):

- Example: A patient admitted with an ulcer of the right midfoot (not a pressure ulcer), with muscle necrosis, who has a history of DMII and no documentation specifically linking the ulcer to the DM.
  - Previously: The physician should be queried for clarification regarding whether the ulcer was related to DM. If not, or if no answer to the query was provided, the case would be coded with the ulcer code as PDx and uncomplicated DMII listed as an additional diagnosis.
  - This would result in DRG 594, which has a RW of 0.8187.

New Issues (contd)

Diabetes Mellitus (continued):

- Now: The ulcer is automatically assumed to be due to the DM since the documentation does not specifically state otherwise, so the diabetic complication code is listed as PDx and the ulcer code, which is a CC, is listed as an additional diagnosis:
  - E11.621, Type 2 diabetes mellitus with foot ulcer
  - L97.413, Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
  - This will result in DRG 638, which has an RW of 0.8794.

New Issues (contd)

List of conditions found under sub-term "with" under the main term "diabetes", subterm "type 2" (first indentation level only):

- amyotrophy
- arthropathy NEC
- autonomic (poly) neuropathy
- cataract
- Charcot's joints
- chronic kidney disease
- circulatory complication NEC
- complication
- dermatitis
- foot ulcer
- gangrene
- gastroparesis
- glomerulonephrosis intracapillary
- glomerulosclerosis, intercapillary
- hyperglycemia
- hyperosmolarity
- hypoglycemia
- ketoacidosis
- kidney complications NEC
- Kimmelsteil-Wilson disease
- mononeuropathy
- myasthenia
- necrobiosis lipoidica
- nephropathy
- neuralgia
- neurologic complication NEC
- neuropathic arthropathy
- neuropathy
- ophthalmic complication NEC
- oral complication NEC
- osteomyelitis
- periodontal disease
- peripheral angiopathy
- polyneuropathy
- renal complication NEC
- renal tubular degeneration
- retinopathy
- skin complication NEC
- skin ulcer NEC

New Issues (contd)

Control:

- The October 1st, 2016 update to the official guidelines also changed the definition of the root operation "control".
- Prior to this date, "control" was only used for control of postprocedural bleeding.
- Any procedure done to control bleeding that was not postprocedural bleeding was coded to whichever root operation was performed, but not "control".

New Issues (contd)

Control:

- As of October 1st, 2016, this definition has been expanded to include "other acute bleeding" as well as postprocedural bleeding.
- However, if initial attempts to control bleeding are unsuccessful and one of the other, more definitive, root operations is performed to control bleeding, then that root operation should be coded rather than control.
- Example: Resection of spleen to stop bleeding is coded to Resection instead of control.

Section VIII

Future of CDI

Section VIII:
The Future of CDI

- General
- LTACs
- Outpatient
- Outpatient - ED
- Outpatient – Ambulatory Clinics

Future of CDI -General

- The HIM field, including CDI, is projected to have a 22% growth rate between 2012 & 2022, according to the U.S. Bureau of Labor Statistics.

- As U.S. healthcare continues its transition from fee-for-service based reimbursement to value based reimbursement, the role of CDI is an essential component of maximizing reimbursement potentials for healthcare providers and facilities.
  - Fee-for-service model is based on volume.
  - Value model is based on quality of care, on which clinical documentation has a direct impact.

- CDI programs are an essential component of a successful transition from the outgoing fee-for-service model to the incoming value-based model.

General (contd)

- The more that reimbursement is tied to quality of care, the more essential CDI programs become.
- Because of this, the future of CDI is bright as it is a vital component of the future of healthcare itself.
- This also means that CDI programs are continually evolving, and that there is a growing demand for both implementing new CDI programs as well as expanding existing CDI programs.
  - Both of which mean increased need for CDI staffing.
- All indicators point to CDI's role in healthcare as becoming more solidified and increasingly more important as time goes on.

General (contd)

- There is currently an increased interest in CDI expansion into other areas of healthcare, including:
  - Emergency department
  - Ambulatory care
  - Physician offices
  - LTACs (Long-Term Acute Care)
  - HCCs (Hierarchical Condition Categories)
  - And more
- The ACDIS's 2013 CDI Salary Survey showed that 89.9% of respondents worked in the short-term acute care setting.
- 1.2% worked in critical access facilities.
- Only 7.5% worked in "other" settings.

LTACs

- For each 1.0 point of a DRG's relative weight, a short-term acute care hospital is paid an average of $5,000-$12,000.
- For a long-term acute care facility (LTAC), that amount is increased to $38,000-$58,000 per 1.0 point.
- The reason for these ranges is that a large portion of the equation is based on the facility-specific "blended rate".
- Let's look at DRG 207, which is one of the higher weighted DRGs as well as one of the more common DRGs reported in the LTAC setting:
  - Short-term acute care relative weight: 5.3498; reimbursement range: $26,749-$64,197.60
  - Long-term acute care relative weight: 1.867; reimbursement range: $70,946-$108,286
- This significant difference is one reason that CDI is expected to expand in the LTAC setting.

LTACs (contd)

- Legislation changes affecting long-term care hospitals (LTCHs), which includes LTACs, also seem to be setting the stage for increased CDI involvement in the long-term care setting.

- New regulations are currently being phased in which will result in two different systems used to reimburse LTCHs:
  - Full IPPS DRG reimbursement for patients who spent at least 3 days in an ICU or at least 96 hours on mechanical ventilation.
  - All others will be reimbursed at a per-diem "site-neutral" rate.

- By late 2020, 50% of Medicare patients must meet this new long-term care facility criterion in order to qualify as a long-term care facility.

LTACs (contd)

- CMS provides oversight of reporting of indicators in the LTCH setting.
- Section 3004(a) of the Affordable Care Act amended section 1886(m)(5) of the Act, requiring the Secretary to establish the Long-Term Care Hospital Quality Reporting Program.
- This program applies to all hospitals certified by Medicare as LTCHs.
- These quality measures include:
  - Catheter-Associated UTI Outcomes
  - Central Line-associated Bloodstream Infection Outcomes
  - Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (short-stay)

LTACs (contd)

- Additionally, because patients in the long-term setting tend to have spent time in an ICU during the preceding acute care admission, these patients tend to have higher SOI & ROM scores.
  - We have already looked at how important it is for these scores to be assigned accurately, as they are used to compare physicians & facilities.
- The scope of DRGs for LTACs is, however, much smaller than in the acute care setting.

LTACs (contd)

- The most reported scenarios are:
  - Septicemia
  - Ventilator weaning
  - Osteomyelitis
  - Complex wound management & debridement
  - Amputations
  - Other multiple and complex comorbid conditions
- Although the scope of DRGs is much smaller than in the acute care setting, the LOS is much longer, resulting in much larger records to review.
- CDI Specialists must be diligent and persistent in assessing all on-going physician documentation & clarifying specificity as needed.

Outpatient

- The same code set, ICD-10-CM, is used to report diagnoses regardless of the care setting, be it inpatient or outpatient.
- However, procedures are reported using CPT codes rather than ICD-10-PCS codes in the outpatient setting.
- Outpatient CDI is still being defined and as such, CDI's role and expectations vary greatly, making programs difficult to compare.
- Typically, however, Outpatient CDI focuses on claims that will be covered by the Outpatient Prospective Payment System (OPPS).
- This system uses Ambulatory Payment Classifications (APCs) rather than the Diagnosis-Related Groups (DRGs) used in the inpatient setting.
- Unlike inpatient DRGs, more than one APC can be assigned to the same outpatient claim.

Outpatient (contd)

- Outpatient CDI is a very broad concept and the areas where CDI can be most effective have not yet been identified.
- Inpatient CDI effectiveness is usually measured by improved compliance with quality-of-care measures as well as improved financial measures.
- Likewise, outpatient CDI tends to focus on areas where it is felt they can impact quality of care measures and/or financial measures.
- The specific scope of outpatient CDI programs therefore varies from facility to facility based on variables such as denials for medical necessity.

Outpatient - ED

- Emergency Departments (EDs) see a significantly higher volume of patients than the inpatient setting.
- Chart review must be timely due to the quick turn-around time.
- ED staff must be aware of the CDI specialist's role so as to avoid the temptation of using them as an extra pair of hands (especially when the CDI specialist is a nurse).
- CDI should work together with case management and utilization review rather than replacing them.
- Each of these services is beneficial to the ED and each has their own area of focus.

Outpatient – ED (contd)

- CDI specialists working in the ED can help physicians ensure their clinical documentation:
  - Supports the physician's clinical judgment
  - Demonstrates medical decision-making
  - Captures the acuity of the patient

Outpatient – ED (contd)

- Such clinical documentation will lead to fewer medical necessity denials.
- Since the ED is also the point of entry for many inpatient admissions, strong clinical documentation regarding the reason for inpatient care assists in determining the most appropriate principal diagnosis.
- This also strengthens the medical necessity of the inpatient admission.
- Because patients have a tendency to improve with treatment rather than worsen, they are often at their worst health-wise while in the ED.
- Therefore, if the severity of the patient's condition is not captured in the clinical documentation in the ED, it can be lost during the admission process.

Outpatient – ED (contd)

- Other benefits of CDI specialists working in the ED include:
  - Accurate capture of facility ED level charges (i.e., facility E/M)
  - Improved documentation of infusions and injections
  - Creation of an accurate problem list starting in the ED
  - Improved accuracy of present on admission (POA) indicators
  - Improved patient safety due to a complete and comprehensive health record
  - Addressing and correcting fragmentation or gaps in patient care during the ED encounter
  - Improved documentation supporting observation services as well as observation start times
  - Proactive capture of data elements associated with quality-of-care measures that may be specific to the ED setting (i.e., ED transfer communication) or that also impact the inpatient setting

Outpatient – Ambulatory Clinics

- Ambulatory clinic encounters include:
  - Primary care services
  - Infusion services
  - Diagnostics
  - Ambulatory surgery
  - Wound care clinics
- Each of these can benefit from outpatient CDI efforts for various reasons unique to each type of service.
- The focus again is on accurate clinical documentation to ensure accurate billing and maximum quality of care.

Hierarchical Condition Categories (HCCs)

- CDI essential in obtaining the highest "risk score" for HCC
- This involves review of the medical chart(s) and the determination of conditions that:
  - may be documented and not coded
  - not coded correctly
- Providing education to documentors on improved documentation

EXAMPLE:

Depression does not risk adjust

Major Depression DOES risk adjust and result in additional reimbursement

IN SUMMARY - CDI

- Many opportunities await those who enter the world of CDI.
- Are you the type of person who would be a good fit for such opportunities?
- CDI Specialists should have excellent communication skills, should be outgoing (able to engage and confront physicians), and able to work well with others from a wide scope of practices – case management, nursing, physicians, HIM, utilization review, etc.
- If you think you have what it takes and would like to learn more, please visit: www.ACDIS.org, where you can learn about the steps to take next to become a CDI specialist, obtain certification, and gain employment in this important, exciting, and developing field within the healthcare industry.

THE END

QUESTIONS/COMMENTS?

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