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**Documentation for the Hospital-Based Provider:
Criteria for Common Diagnoses**

acdis
9TH ANNUAL CONFERENCE

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Learning Objectives HCPPro

- At the completion of this educational activity, the learner will be able to:
 - Describe two new Medicare physician payment methodologies linked to documentation
 - Explain how documentation reflects patient severity of illness
 - Discuss the significance of listing all diagnoses in the discharge summary
 - Recognize the importance of accurately describing the degree, stage, and/or complexity of a disease/condition/diagnosis

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How to Help? HCPPro

- Realize physicians have not been educated in clinical documentation integrity
- Educated by their professors in residency
- Have limited education in
 - SOI
 - ROM
 - DRG
 - CMI

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Understand Circumstances

- Physicians are not familiar with “query rules”
- Physicians
 - “Just tell me what to write”
- Cardiologist example
 - “Where are those ladies who tell me what to write in the chart?”
 - Can you say “leading?”

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Educational Opportunities

- Principal diagnosis
 - The condition after study to be chiefly responsible for occasioning the admission to the hospital
- Secondary diagnosis
 - Conditions that consume one of the following
 - Clinical evaluation
 - Therapeutic treatment
 - Diagnostic procedures/testing
 - Extended length of stay (LOS)
 - Increased nursing care and/or monitoring

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POA

- Principal diagnosis
 - Must be present on admission—POA
- All diagnoses are designated with POA indicators

Indicator	POA	
Y	Yes	
N	No	
U	Unspecified	Designated NO
W	Clinically cannot determine	Designated YES

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POA and HAC

- Principal diagnosis
 - Must be present on admission—POA
 - Atrial fib example
 - “Atrial fib with RVR caused by worsening respiratory failure and anemia”
 - Caution: Hospital-acquired condition (HAC)
 - Line sepsis example
 - SIRS criteria were present on admission
 - Nighttime hospitalist documented “febrile illness”
 - ID doctor came behind (after admission) and documented “line sepsis”
 - DKA example
 - ER doctor used D5NS in a diabetic who was NPO for N/V
 - Patient went into DKA

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Educational Opportunities

- Diagnose using coding-based language
 - Make sure your doctors put the diagnoses in the chart at least once
- Understand physicians are not educated in coding
- Secondary diagnoses into one of 3 buckets

No SOI	CC	MCC
Not sick	Sick	Very sick

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Educational Opportunities

- Educate doctors
 - “Insufficiencies” do not impart severity of illness
- Educate physicians to document the acuity
 - Acute
 - Improving, worsening, resolving, resolved
 - Use CDI pocket cards
- Educate them to avoid documenting “*postop*”
 - Exception: LTAC documentation

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Educational Opportunities

- List **all** diagnoses on the discharge summary
- Educate your doctors to stop using **“History of”**
- **“Possible,” “probable,” “likely,” “suspected” ...**

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Uncertain Diagnoses

- If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, code the condition as if it existed or was established
 - Auditor denial example
 - “Probable sepsis” documented multiple times, then hospitalist changed and UTI was documented on the DC summary

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Conflicting Documentation

- “Audit candy”
- Work with hospitalists to clarify and specify subspecialist documentation without conflicting it
 - e.g., troponin elevation, Type 2 event, NSTEMI

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Copy and Paste

- Can be abused


or

- Can be used correctly if proofread and updated
- Can be used to bring radiography and pathology reports into the clinical record

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Clinical Criteria




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Clinical Intuition

Symptom	Diagnosis
Altered mental status	Coma
Altered mental status	Encephalopathy
Altered mental status	Sepsis
Altered mental status	Shock



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Sepsis-2: If "Some" Are Due to Infection +HCPPro

- SIRS criteria
- Altered Mental Status
- Significant edema or positive fluid balance

**UPDATED
FEB 22, 2016**

- Hyperlactatemia (> 1 mmol/L)
- Decreased capillary refill or mottling

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Sepsis-2 +HCPPro

- **Severe sepsis**
 - Sepsis w/ evidence of end-organ damage

**UPDATED
FEB 22, 2016**

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Sepsis-3 +HCPPro

- **New terms and definitions**
 - Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection
 - Organ dysfunction can be identified as an acute change in total SOFA score ≥ 2 points consequent to the infection
 - A SOFA score ≥ 2 reflects an overall mortality risk of approximately 10% in a general hospital population with suspected infection

<http://jama.jamanetwork.com/article.aspx?articleid=2492875>

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Sepsis-3 Bedside qSOFA

- qSOFA
 - Alteration in mental status
 - Systolic blood pressure ≤ 100 mmHg
 - Respiratory rate ≥ 22 /min

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The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

A) SOFA Variables

- Respiratory rate
- Mental status
- Systolic blood pressure

B) SOFA Variables

- PaO₂/FIO₂ ratio
- Glasgow Coma Scale score
- Mean arterial pressure
- Administration of vasopressors with type and dose rate of infusion
- Serum creatinine or urine output
- Bilirubin
- Platelet count

The baseline Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score should be assumed to be zero unless the patient is known to have preexisting (acute or chronic) organ dysfunction before the onset of infection. qSOFA indicates quick SOFA; MAP, mean arterial pressure.

<http://jama.jamanetwork.com/article.aspx?articleid=2492881#introduction>

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The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Table 1: Sequential [Sepsis-Related] Organ Failure Assessment Score³

System	Score					
	0	1	2	3	4	
Respiration	PaO ₂ /FIO ₂ , mm Hg (kPa)	≥400 (53.3)	+400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation	Platelets, ×10 ³ /μL	≥150	+150	<100	<50	<20
Liver	Bilirubin, mg/dL (μmol/L)	+1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular	MAP ≥70 mm Hg	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose) ⁴	Dopamine 5.1-15 or epinephrine ≥0.1 or norepinephrine ≥0.1 ⁴	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1 ⁴
Central nervous system	Glasgow Coma Scale score	15	13-14	10-12	6-9	<6
Renal	Creatinine, mg/dL (μmol/L)	+1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
	Urine output, mL/h			<500		<200

Abbreviations: FIO₂, fraction of inspired oxygen; MAP, mean arterial pressure; PaO₂, partial pressure of oxygen.
³ Adapted from Vincent et al.¹⁷
⁴ Catecholamine doses are given as μg/kg/min for at least 1 hour.
⁵ Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

<http://jama.jamanetwork.com/article.aspx?articleid=2492881#introduction>

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Sepsis for ICD-10 +HPro

ICD-10 code	Description	CC or MCC
A41.9	Sepsis, unspecified organism (Includes septicemia, NOS)	MCC
A40.3	Sepsis due to Streptococcus pneumoniae	MCC
A41.01	Sepsis due to MSSA	MCC
A41.02	Sepsis due to MRSA	MCC
A41.50	Gram-negative sepsis, unspecified	MCC
R65.20	Severe sepsis without septic shock	MCC
R65.21	Severe sepsis with septic shock	MCC

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Shock +HPro

- Shock is associated with evidence of inadequate tissue perfusion

**UPDATED
FEB 22, 2016**

Consensus on circulatory shock 2014
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4239778/>

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Septic Shock-3 +HPro

- Adult patients with septic shock can be identified using the clinical criteria of
 - Hypotension requiring vasopressor therapy to maintain mean BP 65 mmHg or greater

and

 - Having a serum lactate level greater than 2 mmol/L after adequate fluid resuscitation

<http://jama.jamanetwork.com/article.aspx?articleid=2492876>

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Shock for ICD-10 +HCPPro

ICD-10 code	Description	CC or MCC
R57.0	Cardiogenic shock	MCC
R57.1	Hypovolemic shock	MCC
R57.8	Other specified shock	MCC
R57.9	Unspecified shock	CC

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Acute Renal Failure/Acute Kidney Injury +HCPPro

- KDIGO: Increase in the patient’s serum creatinine of 0.3 mg/dl or more over their normal baseline level
- Link
 - Dehydration
 - Azotemia
- Do not document
 - Acute renal insufficiency
- Acute renal failure is a comorbidity/complication (CC)
- ATN is a major comorbidity/complication (MCC)

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Acute Kidney Failure for ICD-10 +HCPPro

ICD-10 code	Description	CC or MCC
N17.0	ATN	MCC
N17.9	Acute kidney injury	CC
N28.9	Acute renal insufficiency— disorder of kidney, unspecified	--
E86.0	Dehydration	--
E86.1	Hypovolemia	--
E86.9	Volume depletion	--
N19	Unspecified kidney failure (uremia NOS)	--

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Chronic Kidney Disease (not "CRI" or "CRF")

Stage 1	GFR > 90 ml/min	
Stage 2	GFR = 60 to 89	
Stage 3 A&B	GFR = 30 to 59	
Stage 4	GFR = 15 to 29	HCC & CC
Stage 5	GFR < 15	HCC & CC
"ESRD"	On dialysis	HCC & MCC

Chronic Kidney Disease for ICD-10

ICD-10 code	Description	CC or MCC
N18.1	CKD stage 1	--
N18.2	CKD stage 2	--
N18.3	CKD stage 3 A&B	--
N18.4	CKD stage 4	CC
N18.5	CKD stage 5	CC
N18.6	ESRD	MCC
N18.9	CKD unspecified; includes chronic renal insufficiency	--

Heart Failure: Q1 2016 Coding Clinic

Question:

- Please reconsider the advice previously published in *Coding Clinic*, First Quarter 2014, page 25, stating that the coder cannot assume either diastolic or systolic failure or a combination of both, based on documentation of heart failure with preserved ejection fraction (HFpEF) or heart failure with reduced ejection fraction (HFrEF). Would it be appropriate to code diastolic or systolic heart failure when the provider documents HFpEF or HFrEF?

Answer:

- Based on additional information received from the American College of Cardiology (ACC), the Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF). HFpEF may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as diastolic heart failure. HFrEF may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning systolic heart failure. These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic.
- Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as "diastolic heart failure" or "systolic heart failure," respectively, or a combination of both if indicated, and assign the appropriate ICD-10-CM codes.

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Heart Failure

- **Acute or chronic**
 - Acute on chronic
 - Exacerbation
 - Decompensated
- **Systolic** (EF < 40%)
 - HFrEF
- **Diastolic** (normal EF)
 - HFpEF
- **Both**
 - Simply writing “EF = ____%” is not sufficient
- **Heart failure**
 - Not dysfunction

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Heart Failure for ICD-10

ICD-10 code	Description	CC or MCC
I50.20	Systolic HF	CC
I50.21	Acute systolic HF	MCC
I50.22	Chronic systolic HF	CC
I50.23	Acute on chronic systolic HF	MCC
I50.30	Diastolic HF	CC
I50.31	Acute diastolic HF	MCC
I50.32	Chronic diastolic HF	CC
I50.40	Combined systolic & diastolic HF	CC
I50.41	Acute combined systolic & diastolic HF	MCC
I50.9	CHF	--

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Diabetes Mellitus

- **Type 1 or Type 2** or due to underlying condition
 - Steroids, gestational
 - Postpancreatectomy (Whipple)
- **Hyper- or hypoglycemia**
 - With or without coma
 - With DKA
- **Diabetes-related complications:**
 - Peripheral neuropathy
 - Nephropathy
 - Vasculopathy

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Diabetic Coma

- According to the Mayo Clinic
 - A diabetic coma is a life-threatening diabetic complication that causes unconsciousness
 - Unconscious codes to coma in ICD-10
 - Definition of “unconscious”
 - Not knowing or perceiving : not aware
 - Free from self-awareness
- Diabetic coma
 - Altered mental status should make the physician consider the diagnosis of diabetic coma in the uncontrolled diabetic with hyper- or hypoglycemia

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Diabetes Mellitus for ICD-10 Over 250 Codes

ICD-10 code	Description	CC or MCC
E10.10/E10.11	DM type 1 with DKA w/ or w/o coma	MCC
E10.21/E10.22	DM type 1 with diabetic nephropathy/diabetic CKD	--
E10.40	DM type 1 with diabetic neuropathy	--
E10.52	DM type 1 with diabetic gangrene	CC
E10.641	DM type 1 with hypoglycemia with coma	MCC
E10.649	DM type 1 with hypoglycemia w/o coma	--
E10.65	DM type 1 with hyperglycemia	--

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Diabetes Mellitus for ICD-10

ICD-10 code	Description	CC or MCC
E11.01	DM type 2 with hyperosmolarity with coma	MCC
E11.21/E11.22	DM type 2 with diabetic nephropathy/diabetic CKD	--
E11.40	DM type 2 with diabetic neuropathy	--
E11.52	DM type 2 with diabetic gangrene	CC
E11.621	DM type 2 with foot ulcer	--
E11.641	DM type 2 with hypoglycemia w coma	MCC
E11.649	DM type 2 with hypoglycemia w/o coma	--

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Pressure Ulcer

- Decubitus ulcers
 - Document the “present on admission” status for decubitus ulcers
 - Provider should document the wound etiology and location
 - Wound care nurse can document the stage
- Must also UN-link diabetes to wounds when clinically appropriate
 - Trauma causing a wound unrelated to DM
- Document if the wound is a complication
 - Injury
 - Surgery
 - Device
 - The provider must document the causal link if possible

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Pressure Ulcer for ICD-10 Laterality, Site, Etiology, Type

ICD-10 code	Description	CC or MCC
L89.150	Pressure ulcer sacral region, unstageable	--
L89.151	Pressure ulcer sacral region, stage 1	--
L89.152	Pressure ulcer sacral region, stage 2	--
L89.153	Pressure ulcer sacral region, stage 3	MCC
L89.154	Pressure ulcer sacral region, stage 4	MCC
L89.159	Pressure ulcer sacral region, unspecified	--
L89.310	Pressure ulcer of right buttock, unstageable	--
L89.320	Pressure ulcer of left buttock, unstageable	--

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Respiratory Failure

- **Acuity**
 - Acute, chronic, or acute on chronic
- **Type**
 - Hypoxic or hypercapnic
- Criteria for **acute** respiratory failure includes 2 out of 3:
 - pO₂ < 60 mmHg
 - pCO₂ > 50 mmHg with pH < 7.35
 - Respiratory distress—document this in the physical exam
- Chronic respiratory failure
 - Continuous home oxygen or normal pH w/ high CO₂

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Respiratory Failure for ICD-10

ICD-10 code	Description	CC or MCC
J96.00	Acute respiratory failure, unspecified	MCC
J96.01	Acute respiratory failure with hypoxia	MCC
J96.02	Acute respiratory failure with hypercapnia	MCC
J96.10	Chronic respiratory failure, unspecified	CC
J96.11	Chronic respiratory failure with hypoxia	CC
J96.12	Chronic respiratory failure with hypercapnia	CC
J96.90	Respiratory failure, unspecified	MCC
J96.91	Respiratory failure with hypoxia	MCC
J96.92	Respiratory failure with hypercapnia	MCC

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Malnutrition

- ASPEN ≥ 2 criteria
 - Insufficient energy intake
 - Weight loss
 - Loss of muscle mass
 - Loss of subcutaneous fat
 - Localized or generalized fluid accumulation that may sometimes mask weight loss
 - Diminished functional status as measured by hand grip strength

Notice that **ALBUMIN** and **PREALBUMIN** are **NOT** criteria for diagnosis

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Malnutrition for ICD-10

ICD-10 code	Description	CC or MCC
E44.0	Moderate protein calorie malnutrition	CC
E44.1	Mild protein calorie malnutrition	CC
E43	Unspecified severe protein calorie malnutrition	MCC

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Anemia

- **Acute blood loss anemia**
 - Anemia linked to a hemorrhagic process
 - GI bleed
 - Fracture
 - Any procedure or surgery
 - This should be documented *separately* from its cause
- Post-procedure anemia:
 - Drop in hemoglobin/hematocrit due to CABG/C-section
 - Acute blood loss anemia due to hip fracture

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Anemia for ICD-10

ICD-10 code	Description	CC or MCC
D64.9	Anemia, unspecified	--
D62	Acute post hemorrhagic anemia (acute blood loss anemia)	CC
D50.9	Iron deficiency anemia	--
D53.9	Nutritional anemia, unspecified	--
R71.0	Precipitous drop in hematocrit (drop in hemoglobin)	CC

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Encephalopathy

- Do NOT document
 - Altered mental status
 - Mental status changes
 - Confusion
- **Encephalopathy**
 - *Definition:* Global cerebral dysfunction in the absence of structural brain disease
 - Underlying etiology:
 - Toxic/metabolic
 - Sepsis
 - Anoxic
 - Hypertensive

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Encephalopathy for ICD-10

ICD-10 code	Description	CC or MCC
R41.82	Altered mental status, unspecified (includes change in mental status)	--
R41.0	Disorientation, unspecified (includes delirium & confusion)	--
G93.40	Encephalopathy, unspecified	MCC
G93.41	Metabolic encephalopathy (includes septic encephalopathy)	MCC
G92	Toxic metabolic encephalopathy	MCC
I67.4	Hypertensive encephalopathy	CC
G93.1	Anoxic brain damage (includes anoxic encephalopathy)	CC
P91.63	Severe hypoxic ischemic encephalopathy	MCC

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Pneumonia

- **Simple pneumonia** when a principal Dx
 - Community-acquired pneumonia
 - Healthcare-associated pneumonia (HCAP)
 - Nosocomial pneumonia
- **Probable Gram-negative pneumonia, Rx Zosyn**
- **Probable MRSA pneumonia, Rx Vancomycin**
- **Suspected aspiration pneumonia**
 - Clindamycin or Flagyl Rx

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Pneumonia for ICD-10

ICD-10 code	Description	CC or MCC
J15.9	Unspecified bacterial pneumonia	MCC
J18.9	Pneumonia, unspecified organism (includes CAP & HCAP & nosocomial)	MCC
J69.0	Aspiration pneumonia	MCC
J15.6	Pneumonia due to Gram-negative bacteria	MCC
J15.212	Pneumonia due to MRSA	MCC

- Simple pneumonia maps to DRG 195 Pneumonia
- Specified codes map to DRG 177 Resp Diseases

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Cardiac HCPPro

- 3 P's of A. fib
- Atrial fibrillation
 - Paroxysmal: Resolves in < 7 days
 - Persistent: > 7 days w/ attempted rhythm control, electrically or medically (look for amiodarone)
 - Permanent (chronic): No further attempts to control rhythm

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Cardiac Documentation for ICD-10 HCPPro

ICD-10 code	Description	CC or MCC
I48.0	Paroxysmal atrial fibrillation	--
I48.1	Persistent atrial fibrillation	CC
I48.2	Chronic (permanent) atrial fibrillation	--
I48.91	Unspecified atrial fibrillation	--
I48.3	Typical atrial flutter	CC
I48.4	Atypical atrial flutter	CC
I48.92	Unspecified atrial flutter	CC

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Troponin Elevation Is NOT a Diagnosis HCPPro

- Not clinically relevant
 - CKD stage __
- Demand ischemia
 - Does not code to an AMI
 - I24.8, other forms of acute ischemic heart disease → CC
- AMI

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NSTEMI Type 2 vs. Demand Ischemia

- Very similar pathophysiologically
- Demand ischemia
 - I24.8, other forms of acute ischemic heart disease (CC)
 - Due to supply/demand mismatch
- NSTEMI Type 2 codes to NSTEMI (MCC)
 - Due to supply/demand mismatch
 - Associated with a higher severity of illness
 - Quality metrics tracked for AMI

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Acute Myocardial Infarction

- ICD-10
 - Must specify NSTEMI vs. STEMI
 - Unspecified **AMI** will default to STEMI
 - Significant problem with ICD-10

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Acute Myocardial Infarction for ICD-10

ICD-10 code	Description	CC or MCC
R79.89	Other specified abnormal findings of blood chemistry (troponin elevation)	--
I21.4	NSTEMI	MCC
I21.3	STEMI of unspecified site (includes AMI, NOS)	MCC
I21.01	STEMI of the L main	MCC
I21.02	STEMI of the LAD	MCC
I21.09	STEMI of the anterior wall	MCC
I21.11	STEMI of the RCA	MCC
I24.8	Other forms of acute ischemic heart disease (includes demand ischemia)	CC

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Morbid Obesity

- **Morbid obesity** BMI > 40
 - Physician must ascribe clinical relevance to the BMI
 - Cannot be taken from a calculated BMI
 - BMI > 40: **Morbid obesity**
 - BMI < 19: Underweight malnourished

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Morbid Obesity for ICD-10

ICD-10 code	Description	CC or MCC
E66.9	Obesity, unspecified	--
E66.01	Morbid obesity due to excess calories	--
E66.1	Morbid obesity with alveolar hypoventilation	CC

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COPD

- **COPD *with*** acute exacerbation
 - COPD is a chronic condition
 - Consider acute exacerbation
 - Steroids & nebs
- List any tobacco exposure
- Evaluate for:
 - Acute respiratory failure
 - Increased oxygen requirement and respiratory distress
 - Chronic respiratory failure
 - Continuous home oxygen

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COPD for ICD-10

ICD-10 code	Description	CC or MCC
J44.0	COPD with acute lower respiratory infection	CC
J44.1	COPD with acute exacerbation	CC
J44.9	COPD unspecified	--
F17.200	Nicotine dependence unspecified, uncomplicated	--
F17.203	Nicotine dependence unspecified with withdrawal	CC
Z87.891	Personal history of nicotine dependence	--
Z72.0	Tobacco use	--

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COPD Audit Protection

- Documentation to support medical necessity of admission
 - 3 nebulizer treatments in the ER
 - Pulse ox < 89%
 - ABG with PaO2 50
 - Respiratory distress as noted by accessory muscle usage
 - Increased work of breathing as noted by fragmented sentences or hunched-over posture

Feedback from an insurance company medical director

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Physician Quality Ratings

- Predicted mortality rates for some disease processes:
 - Community-acquired pneumonia = < 5%
 - Sepsis = 10%
 - Septic shock = 40%
- If the patient survives, your ratings will be much higher in the public quality reporting data because you took care of a "sicker" patient
 - Goal: Expected mortality **higher** than actual mortality

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Thank you. Questions?

DrBrundage@Gmail.com

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