Coder Meets CDI: Partners in Denial Prevention

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Presented By

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - List ICD-10-CM *Official Coding Guidelines* that are a focus of payer denials
  - Describe examples of inconclusive and/or conflicting documentation that can create opportunities for denials
  - Identify documentation that does not meet coding criteria for reporting as a principal and/or secondary diagnosis
  - Examine strategies for CDI and coding to collaborate on missed opportunities

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DRG Downgrades and Denial Examples

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Downgrading the DRG by Removing a Single CC

Dx removed: K63.3 (Ulcer of intestine)

DRG Downgrade by Removing Secondary DX

Reviewer Rationale:
Secondary diagnosis code assignment of K63.3, Ulcer of intestine was reported by the hospital. According to coding guidelines and documentation in the medical record, this diagnosis did not qualify for reporting. Documentation supported an admission for Malignant neoplasm of sigmoid colon. From the information that was received, **provider documentation indicating the condition of a small intestinal ulcer was not found.** Although the "Colonoscopy: A frond-like/villous, fungating, infiltrative, polypoid and ulcerated partially obstructing large mass was found in the sigmoid colon 35-40cm from the anal verge" was noted, "pathology confirmed Adenocarcinoma of sigmoid colon." Code assignment is based on code assignment guidelines for using both the Index and Tabular.

On physical exam, the patient was noted with "No irritable bowel, Crohn's or Ulcerative Colitis." Provider documentation throughout the medical record and on the discharge, summary was consistent for a patient presenting with hematuria and a suprapubic mass with central necrosis and ruled in for adenocarcinoma of the sigmoid colon for which an exploratory laparotomy, low anterior resection, en bloc resection of sigmoid mass (Cystoscopy, bilateral ureteral stent placement, complex Foley catheter placement, partial cystectomy, and bilateral ureterolysis were performed.

Referencing the code in the ICD-10 Tabular, indicates ICD 10-CM diagnosis code K63.3 is for a primary ulcer of the small intestine. In addition, medical record documentation did not indicate that an intestinal ulceration met the UHDDS definition of a secondary diagnosis during this episode of care as it was not clinically evaluated, did not receive therapeutic treatment, had diagnostic procedures, extended the length of hospital stay or increased nursing care/monitoring. Instead, provider documentation on the surgery consult made no mention of a small intestine condition with work-up focused in the sigmoid colon. Based on the above, ICD-10-CM diagnosis code K63.3 was removed from the claim consistent with the documentation that was received.

What they are denying and why they are denying it

Clinical findings leveraged to support the denial

The references used to support their denial

Official Guidelines Applicable to This Denial

18. Default codes

A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

1. Locating a code in the ICD-10-CM

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

ICD-10-CM Alphabetic Index

Ulcer, ulcerated, ulcerating, ulceration, ulcerative

- amebic (intestine)A06.1
- amebic (intestine)A06.1 skinA06.7
- intestine, intestinal K63.3
- intestine, intestinal K63.3 amebicA06.1
- intestine, intestinalK63.3 duodenal see Ulcer, duodenum

ICD-10-CM Tabular Index

K63.3 Ulcer of intestine

Primary ulcer of small intestine

Excludes1:

duodenal ulcer (K26.-)
gastrointestinal ulcer (K28.-)
gastrojejunal ulcer (K28.-)
jejunal ulcer (K28.-)
peptic ulcer, site unspecified (K27.-)
ulcer of intestine with perforation (K63.1)
ulcer of anus or rectum (K62.6)

Evaluating the Denial Rationale

The Gist of the Denial Rationale	Was the Rationale Accurate?
• The code assigned as a SDX codes to ulcer of small intestine not sigmoid intestine.	• **True**
• Documentation of an ulcer of small intestine was not found.	• **True**
• The code did not meet SDX guidelines for reporting.	• **True**

What the Record Revealed:

- A “Colonoscopy demonstrated a frond-like/villous, fungating, infiltrative, polypoid and **ulcerated, partially obstructing** large mass was found in the sigmoid colon 35-40cm from the anal verge”
  - Pathology confirmed adenocarcinoma of sigmoid colon.
  - Underwent an exploratory laparotomy, low anterior resection, en bloc resection of sigmoid mass.
- Partial cystectomy, bilateral ureterolysis and bilateral ureteral stent placement performed by urology.
  - His foley remained in place given his urologic surgery.
- Pt progressed well after surgery only requiring medical surgical floor status.
- Pt had a slow return of bowel function, however, did not require any bowel rest.

Taking a Closer Look With a Clinical Eye + Coding Acumen

- Slow return of bowel function. Was there documentation of **ileus** that would retain DRG?
  - No diagnosis of ileus and no backsliding of diet thus would not pass a clinical validation audit even if it was coded.
- Any mention **metastatic sites** that could retain DRG?
  - No: The patient did not have metastasis per oncology staging.
- Mention of "**partially obstructing mass"** of colon. Is this amenable to coding?
  - **Alphabetic Index**:
  - Obstruction→ colon→
    - see obstruction, intestine →
    - Intestine → partial K56.600
  - **Tabular Index:**
  - K56.600 Partial intestinal obstruction***, unspecified as to cause***
    - ***This is a CC, but I cannot use it to retain DRG because the mass was malignant, so we know cause. See also AHA 2nd Quarter Coding Clinic 2017 Intestinal obstruction due to peritoneal carcinomatosis***
- Why were bilateral ureteral stents placed? Is there documentation of **hydronephrosis**?
  - Yes. Documentation by the urology surgeon did document **hydronephrosis**.

DRG Comparison

PDX	SDX (CC)	DRG	Weight	Initial Evaluation
C18.7 (Malignant neoplasm of sigmoid colon)	K63.3 (Ulcer of small intestine)	**330**	2.4554	Off table (patient did not have ulcer of small intestine)
C18.7 (Malignant neoplasm of sigmoid colon)	NA	**331**	1.7088	On table (if no other CC can be identified to retain DRG)
C18.7 (Malignant neoplasm of sigmoid colon)	N13.30 (unspecified hydronephrosis)	**330**	2.4554	On table (confirmed CC in the record)

Appeal Letter

Restate rationale

State your intent

Provide evidence

Conclusion/request

We are in receipt of your denial of the above diagnosis code as secondary diagnosis. Your rationale states that code K63.3 (Ulcer of intestine) is an ulcer of the small intestine, which this patient did not have, therefore did not qualify for reporting based on UHDDS definition of secondary diagnosis.

We do agree this was coded in error. However, pursuant to the Payor reopening the claim, we have performed a retrospective audit of the coding and identified a code omitted in error. Please note the following documentation:

- Urology operative report Indication for surgery: "Patient has an obstructing colon mass with **hydronephrosis** of the right ureter. We discussed partial cystectomy with bilateral ureteral stents"

In view of the above documentation, as well as the coding guidelines noted below, code N13.30 (hydronephrosis, unspecified) has been added as a secondary diagnosis since it meets coding guidelines of "Additional Diagnoses" based on treatment and evaluation. Therefore, please consider the DRG as originally submitted.

Appeal Letter Continued

References

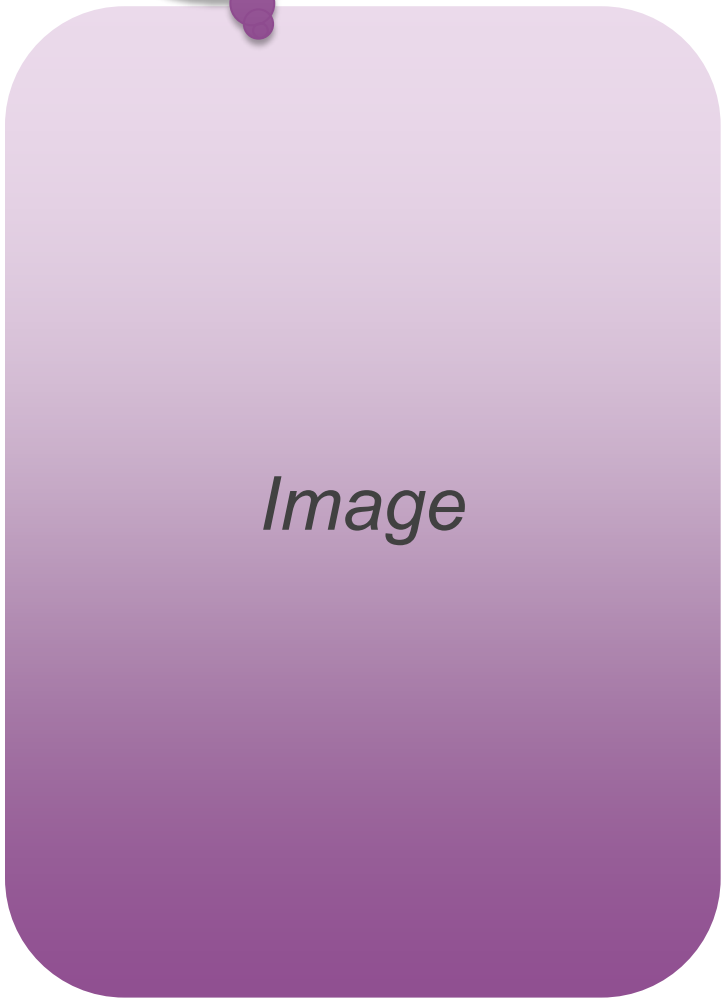
Reference: ICD-10-CM Official Coding Guidelines Section III. Reporting Additional Diagnoses

For reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Now who's your daddy?



Downgrading the DRG by Resequencing Diagnoses

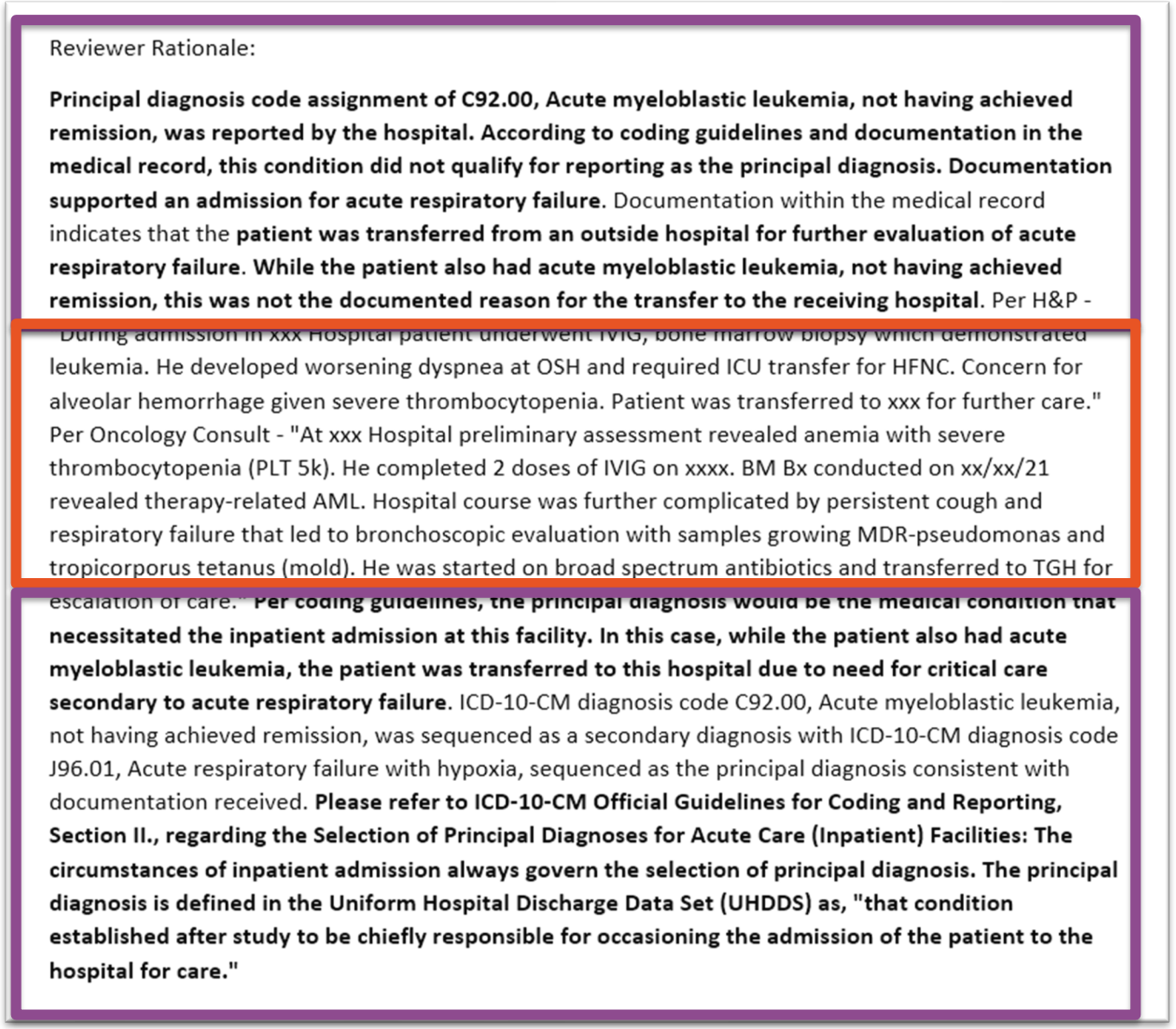
Dx codes resequenced: C92.00 (Acute myeloblastic leukemia (AML)) resequenced as a secondary DX; J96.01 (Acute respiratory failure with hypoxia) resequenced as PDX

DRG Downgrade by Resequencing PDX

What and why they are denying

The evidence they found in the Medical record

The references used to support their denial



Reviewer Rationale:

Principal diagnosis code assignment of C92.00, Acute myeloblastic leukemia, not having achieved remission, was reported by the hospital. According to coding guidelines and documentation in the medical record, this condition did not qualify for reporting as the principal diagnosis. Documentation supported an admission for acute respiratory failure. Documentation within the medical record indicates that the **patient was transferred from an outside hospital for further evaluation of acute respiratory failure. While the patient also had acute myeloblastic leukemia, not having achieved remission, this was not the documented reason for the transfer to the receiving hospital.** Per H&P - "During admission in xxx Hospital patient underwent IVIG, bone marrow biopsy which demonstrated leukemia. He developed worsening dyspnea at OSH and required ICU transfer for HFNC. Concern for alveolar hemorrhage given severe thrombocytopenia. Patient was transferred to xxx for further care." Per Oncology Consult - "At xxx Hospital preliminary assessment revealed anemia with severe thrombocytopenia (PLT 5k). He completed 2 doses of IVIG on xxxx. BM Bx conducted on xx/xx/21 revealed therapy-related AML. Hospital course was further complicated by persistent cough and respiratory failure that led to bronchoscopic evaluation with samples growing MDR-pseudomonas and tropicorporus tetanus (mold). He was started on broad spectrum antibiotics and transferred to TGH for escalation of care." **Per coding guidelines, the principal diagnosis would be the medical condition that necessitated the inpatient admission at this facility. In this case, while the patient also had acute myeloblastic leukemia, the patient was transferred to this hospital due to need for critical care secondary to acute respiratory failure.** ICD-10-CM diagnosis code C92.00, Acute myeloblastic leukemia, not having achieved remission, was sequenced as a secondary diagnosis with ICD-10-CM diagnosis code J96.01, Acute respiratory failure with hypoxia, sequenced as the principal diagnosis consistent with documentation received. **Please refer to ICD-10-CM Official Guidelines for Coding and Reporting, Section II., regarding the Selection of Principal Diagnoses for Acute Care (Inpatient) Facilities: The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."**

Official Guidelines Applicable to This Denial

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

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

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

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

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

Evaluating the Denial Rationale

The Gist of the Denial Rationale	Was the Rationale Accurate?
• Acute respiratory failure and Acute Leukemia were not co-equal	• **True**
• Acute respiratory failure was reason for transfer to the hospital	• **False**
• Patient was already evaluated and treated at OSH for Leukemia	• **True**
• PDX should be respiratory failure	• **False**

What the Record Revealed:

- Patient had bone marrow biopsy and intravenous gammaglobulin at the OSH where a diagnosis of Acute myeloblastic leukemia was confirmed.
- Patient was refractory to platelet transfusion with severe thrombocytopenia due to alloimmunization. Platelets 5K. Anemic with HGB 4.0. Neutropenic 3.2.
- Developed worsening dyspnea and cough at OSH so bronchoscopy was performed revealing MDR-pseudomonas and tropicorporus texanus.
- Transferred to this facility due to concern for alveolar hemorrhage in view of thrombocytopenia.
- Treatment is equally provided for multi-drug resistant pneumonia and severe thrombocytopenia: PRBC and platelet transfusions and IV abx.
- Respiratory failure is managed with HFNC, septic shock is documented, and patient expired the next day.

DRG Comparison

PDX	SDX (MCC)	DRG	Weight	Initial Evaluation
C92.00 (Acute myeloblastic leukemia not having achieved remission)	J96.01 (Acute hypoxic resp failure) And J15.1 (PNA due to pseudomonas)	834	5.53	Off the table
J15.1 (PNA due to pseudomonas	J96.01 (Acute hypoxic resp failure)	177	1.7799	On the table
J96.01 (Acute hypoxic resp failure)	J15.1 (PNA due to pseudomonas)	189	1.207	Off the table
D69.6 (Thrombocytopenia, unspecified)	J96.01 (Acute hypoxic resp failure)	813	1.5651	On the table

Taking a Closer Look With a Clinical Eye + Coding Acumen

- Septic shock…. Was **sepsis** POA? (This could shift the DRG to 871)
  - There was no query and septic shock was only documented on discharge summary so changing the PDX to sepsis would likely not be upheld and likely would then be targeted for clinical validation audit.

- Was the patient on a **vent** that didn't get coded? (This could shift DRG to 208)
  - No vent, patient was DNR and expired.

- Thrombocytopenia, anemia and neutropenia *equates* to **pancytopenia**.
  - AHA Coding Clinic 3rd Quarter 2020 states separate codes should be assigned unless the provider explicitly documents pancytopenia.

- Was "pancytopenia" documented in the medical record?
  - Yes. The oncologist documented in the consultation report **"Pancytopenia due to acute myelogenous leukemia."**

PDX	SDX (MCC)	DRG	Weight	
C92.00 (Acute myeloblastic leukemia not having achieved remission)	J96.01 (Acute hypoxic resp failure) And J15.1 (PNA due to pseudomonas)	834- ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH MCC	5.5300	Off the table (Not the reason for admission)
J15.1 (PNA due to pseudomonas	**J96.01 (Acute hypoxic resp failure)**	177- RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	**1.7799**	**On the table (equally responsible for admission)**
J96.01 (Acute hypoxic resp failure)	J15.1 (PNA due to pseudomonas)	189- PULMONARY EDEMA AND RESPIRATORY FAILURE	1.2070	Off the table (Not the reason for admission)
D69.6 (Thrombocytopenia, unspecified)	J96.01 (Acute hypoxic resp failure)	813- COAGULATION DISORDERS	1.5651	Off the table (A more specific condition is coded)
A41.9 (Sepsis, organism unspecified)	J96.01 (Acute hypoxic resp failure) J15.1 (PNA due to pseudomonas) R65.21 (Severe sepsis with septic shock)	871- SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	1.9572	Off the table (Unknown if POA)
D618.18 (Other pancytopenia)	**J96.01 (Acute hypoxic resp failure)** **J15.1 (PNA due to pseudomonas)**	808- MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS WITH MCC	**2.141**	**On the table (equally responsible for admission)**

Appeal Letter

Restate rationale

State your intent

Provide evidence

Conclusion/request

We are in receipt of your denial of the above diagnosis code as principal diagnosis. Your rationale states that AML was not the reason for transfer and as such could not be principal diagnosis. Your rationale indicates that the reason for transfer was documented to be for management of respiratory failure and rests on documentation: "He developed worsening dyspnea at OSH and required ICU transfer for HFNC".

While we agree the reason for transfer and subsequent admission to our facility was not AML, we disagree the reason for transfer was acute respiratory failure. Please note the pertinent evidence in the medical record:

- **The patient was on HFNC at the transferring facility which was maintained** until the second day of this admission.
- The documentation and admitting orders specifically state reason for transfer "Concern for alveolar hemorrhage given severe thrombocytopenia"
  - This was initiated after bronchoscope evaluated and confirmed pneumonia due to pseudomonas
  - ***This statement is also in the Payor's own rationale***
- The oncologist documented "**Pancytopenia** due to acute myelogenous leukemia"
  - Platelets 5K, HGB 4.0., WBC 3.2
  - **Transfused multiple units PRBC and platelets**
- Infectious disease was consulted due to multi drug resistant **pneumonia due to pseudomonas** and tropicorporus texanus
  - **IV imipenem, IV Fluconazole**

In view of the above documentation, as well as coding guidelines noted below, both pneumonia due to pseudomonas and pancytopenia equally meet the definition of principal diagnosis. Therefore, we have re-sequenced the principal diagnosis to D618.18 (Other pancytopenia) resulting in DRG 808 and not DRG 189 as the payor has suggested. Please process the corrected DRG.

Appeal Letter Continued

Take that! Bam Bam!!!

References

Image

Reference: ICD-10-CM Official Coding Guidelines

Section II. Selection of Principal Diagnosis
The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

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

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

DRG Mismatch and Resolution

- The provider has documented “respiratory syncytial virus (RSV), chest x-ray unremarkable, no PNA or bronchitis, hypoxic respiratory failure on 3 liters supplemental O2”.
  - The coder and CDIS have a DRG mismatch

What Is the Best DRG?

A. 865 VIRAL ILLNESS WITH MCC
   - PDX B97.4 (Respiratory syncytial virus as the cause of diseases classified elsewhere)
   - SDX J96.01 (Acute hypoxic respiratory failure)

B. 152 OTITIS MEDIA AND URI WITH MCC
   - PDX J06.9 (Acute upper respiratory infection, unspecified)
   - SDX J96.01 (Acute hypoxic respiratory failure)

C. 189 PULMONARY EDEMA AND RESPIRATORY FAILURE
   - PDX J96.01 (Acute hypoxic respiratory failure)

D. UNGROUPABLE due to underlying infection not documented (Query needed)

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SDX Denials Based on *Official Coding Guidelines*

Coding and CDI Takeaways for Denial Management and Prevention

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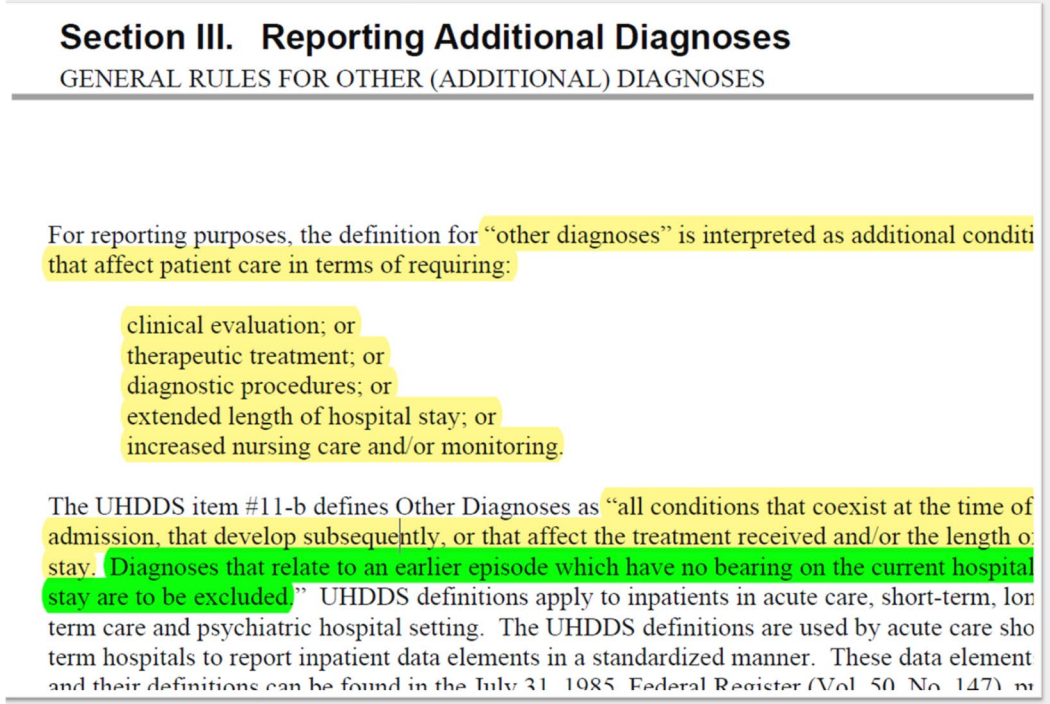
1. Denial “Other/Additional Diagnoses”



Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditi that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length o stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” UHDDS definitions apply to inpatients in acute care, short-term, lon term care and psychiatric hospital setting. The UHDDS definitions are used by acute care sho term hospitals to report inpatient data elements in a standardized manner. These data element and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pa

This is an ___admitted on ___with vomiting and increased blood glucose. The provider assigned code D68.0 (Von Willebrand's disease) as a secondary diagnosis. The documentation in the medical record does not support the assignment of coda D68.0 as a secondary diagnosis.. Per the guidelines referenced below, for reporting purposes the definition for "other diagnoses~ Is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. The UHDDS Item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay."

It was noted that this condition did not require any evaluation, management, nor monitoring this hospital stay, and the significance of this condition to the current admission was also not documented by the provider. Therefore, code D68.0 is removed. This recommendation results in a change ***in DRG from 420 {DIABETES) with an SOI of 3 to 420 {DIABETES) with an SOI of 2.***

2. Denial "Previous (Resolved) Conditions"

The provider assigned code K56.600 (Partial Intestinal obstruction, unspecified as to cause) as a secondary diagnosis. The documentation in the medical record does not support the assignment of K56.600 as a secondary diagnosis. It is noted that the physician documents surgical **past history** involving multiple small bowel obstructions in the ED notes. Per the guidelines referenced below, some providers include in the diagnostic statement resolved conditions or diagnoses and status post procedures from previous admissions that have no bearing on the current stay. Such conditions are not to be reported, The medical record supports the diagnosis or condition has resolved and has no bearing on the current stay. Therefore, as a result of this review, it is recommended that code K56.600 be removed. **This recommendation results in a change in DRG from 241 (PEPTIC ULCER AND GASTRITIS) with SOI of 3 to 241 (PEPTIC ULCER AND GASTRITIS) with SOI of 2.**

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admissions that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

3. Denial “Signs and Symptoms” or “Conditions Integral”

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all, codes for symptoms.

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Audit Determination: Disagree with SOI

Explanation: This patient is a __-year-old female admitted on ___ With full body swelling. The provider assigned code E88.09 (Other disorders of plasma-protein metabolism, not elsewhere classified) as a secondary diagnosis. The documentation in the medical record does not support the assignment of E88.09. It is noted that the attending physician documents, "hypoalbuminemia" in the emergency department note. Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification. The medical record documentation supports that a (low serum albumin is a sign of nephrotic syndrome and an integral part of the disease process. Therefore, as a result of this review, il is recommended that code E88.09 be removed. This recommendation results in a change in DRG from 462 (NEPHRITIS & NEPHROSIS) with an SOI of 3 to 462 (NEPHRITIS & NEPHROSIS)with an SOI of 2.

Reference: ICD-10-CM Official Coding Guidelines for Coding and Reporting, Section 1.8.5, Conditions that are integral part of a disease process.

4. Denial "Conflicting Documentation"

The patient was a ___ yr. old ___ admitted for SBO.

Following medical record review the secondary diagnosis unspecified malnutrition (E46) will be disallowed resulting in an APR-DRG reassignment to 263-3 from 263-4.

Documentation noted HAL for malnutrition due to prolonged NPO however the nutritional consult indicated no evidence of malnutrition.

According to the Official Coding Guidelines, conflicting documentation should be reconciled by the provider.

14. Documentation *by Clinicians Other than the Patient's Provider*

Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

5. Denial “Abnormal Findings”

The provider assigned code I47.1 (Supraventricular tachycardia) as a secondary diagnosis. Upon review of the documentation provided, code I47. I was not supported. Although it was documented that “telemetry showed a short one of what appears to be atrial tachycardia”, there was no treatment directed to the condition and was not monitored. Per the guidelines referenced below, for reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation: or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay, or increased nursing care and or monitoring. In accordance with this reference and physician documentation provided, code I47.1 has been removed as a secondary diagnosis.

This results in a change in DRG from 261 to DRG 262.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

6. Denial “Uncertain Diagnoses/Ruled Out”

The provider assigned 126.99 (Other pulmonary embolism without acute cor pulmonale) as a secondary diagnosis. The evidence in the medical record did not support the assignment of I26.99. It was noted that the physician documented presumed pulmonary embolism in the H&P and Progress Notes. However, the computed tomography scan of the chest indicated right middle lobe and right lower lobe consolidations and ground glass opacity within the upper lobes. A ventilation perfusion scan was then performed and indicated a low probability for acute pulmonary embolism. The nonsegmental and subsegmental matched defects were likely attributed to poor inspiratory effort and underlying parenchymal lung disease. Per Official Coding Guidelines, uncertain conditions may not be coded unless they are still suspected at the time of discharge. Therefore, as a result of this review, the diagnosis code(s) 126.99 has been removed.

This results in a change in DRG from 7204 to DRG 7203

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” “compatible with,” “consistent with,” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

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Identifying Missed Opportunities

Coding and CDI Takeaways for Bullet-Proof Reimbursement

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CDI and Coding Takeaways for Denial Management and Prevention: Look for Missed Opportunities

- More than 1 MCC or CC on a claim is a deterrent to the payer.
  - **Appeal Example**: *We have retrospectively performed a review and noted omitted coding: Code J98.11 (atelectasis) and J81.1 (pulmonary edema) will be placed as secondary diagnoses:*
    - "This morning's chest x-ray was just done and shown to me at bedside. It has not been read officially. It does look a bit wet and there is some atelectasis/opacity at the left base". **(Evaluated)**
    - "I have encouraged the patient to use her incentive spirometer and Acapella and I will add mechanical percussion to her pulmonary toilet regimen **(Treat/increased care).** I will be checking lab work again today at noon and 6 PM **(Evaluate**) and I will change her IV to half-normal saline and 20 potassium at 50 ml's per hour **(Treat)** because she appears to have some pulmonary edema on her chest x-ray, and she also has a history of ischemic cardiomyopathy."

CDI and Coding Takeaways for Denial Management and Prevention: Imagine the Possibilities

- Think about disease pathology and ***what could/might happen*** and look for documentation or clinical indicators of the same:
  - Malignancy with spread to lymph nodes or other secondary sites.
  - Malignancies with weight loss equating to malnutrition.
  - Adverse effects of medications causing AMS; think toxic encephalopathy.
  - Obesity with BMI that affects patient care; think body habitus inhibiting diagnostics or causing surgical difficulties.
  - Chest tubes related to pneumothorax or air leak.
  - Intraabdominal surgery with hemoperitoneum or abscess of any organs.
  - Progression of CKD to next stage (Think APR-DRG: Stage 3a to 3b).
  - AKI that does not resolve within 72 hours; progression to ATN.

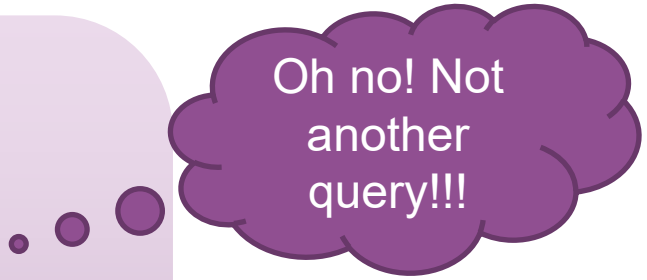
Raise-Your-Hand Question: DRG Mismatches

The reconciliation process for a DRG mismatch at our facility:

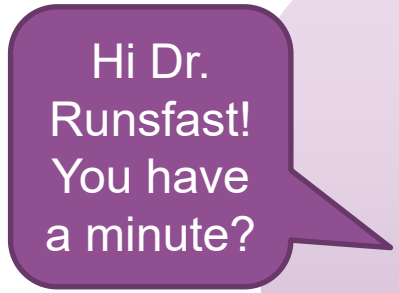
1. The coder has the final say
2. The CDS has the final say
3. The coding supervisor has the final say
4. The MD/PA has the final say
5. A 3rd party vendor has the final say

Benefits of CDI and Coding Collaboration

Image



- ✓ Enhances CDI/Coding skill sets
- ✓ Facilitates good relationships
- ✓ Leverages accurate payment
- ✓ Results in fewer denials
- ✓ Disempowers the payor
- ✓ Results in fewer denials
- ✓ Reduces query fatigue



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Thank you. Questions?

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

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