CODING CORNER

Seven things coders wish physicians knew about acute blood loss anemia

by Sarah Nehring, CCS, CCDS

Acute blood loss anemia, when coded as a secondary diagnosis, can increase expected reimbursement, the length of stay, and the severity of illness for an encounter. It’s also a common target for payer denials, however. For these reasons, there are seven things coders wish providers knew about acute blood loss anemia.

7. “HGB 14.5 → 11.6” isn’t as good as “hemoglobin dropped from 14.5 to 11.6”

Sometimes hemoglobin drops after a procedure or a delivery, and it is not anemia. It isn’t due to the minimal intraoperative blood loss either, but you’re monitoring with repeat lab work and/or watching for accompanying symptoms or evidence that there might be ongoing bleeding. In cases like this, we are unable to code “HGB 14.5→11.6” (we can’t code arrows), but we can code a drop in hemoglobin. “Hemoglobin dropped from 14.5 to 11.6” is a few more keystrokes for you, but it can add value when coded. If a drop in hemoglobin was something you were monitoring during the hospitalization, please document it in a way we can code.

6. If there isn’t significant blood loss, it’s hard to defend acute blood loss anemia

Documenting acute blood loss anemia after every surgery or every delivery to avoid a query doesn’t work. We can’t ignore your documentation. If there is no other documented bleeding condition, and we don’t see at least 200 or 250 mL of estimated blood loss during a procedure (or much more than that for a delivery), however, we may query and ask you to document the clinical criteria that support the acute blood loss anemia diagnosis. If we don’t, a payer/auditor certainly will ask us to remove it—or we’ll have to try to defend it, a process that can be time-consuming and is often futile.

5. Expected/inherent does not mean insignificant

Significance from a clinical standpoint and a coding standpoint are a little different. From the coding perspective, the fact that a condition is expected doesn’t mean it didn’t happen or that it didn’t matter. If the patient has a 2- to 3-gram drop in hemoglobin after at least 200 to 250 mL of blood loss, has a hemoglobin less than 9, and/or has symptoms of anemia, and we can show that you were monitoring for further drop in hemoglobin or symptoms of anemia—then acute blood loss anemia meets the definition of a significant, codable diagnosis. But we need you to document it.

If you keep the patient in the hospital an extra night to monitor his or her hemoglobin, that’s significant from a coding standpoint. We want to be able to code a diagnosis that justifies the length of stay, such as acute blood loss anemia or a drop in hemoglobin. If you have ordered transfusions, you are treating something, and if that something is acute blood loss anemia, we want to code it as such. The documentation and the code that goes with it support the use of the additional resources.

4. Acute blood loss anemia following a procedure is not coded as a complication unless you call it one, but it may be a perceived complication

Coders don’t make assumptions. We never code acute blood loss anemia that follows a procedure as a complication of the procedure unless you tell us it is one. For example, if you document “postop period was complicated by mild acute blood loss anemia,” you’ve documented a complication, and it’ll be coded as one.

If you document “patient experienced mild acute blood loss anemia during the postop period which was monitored and did not require transfusion,” we will code the acute blood loss anemia, but not as a complication of the procedure.

One caveat: For every code we assign, we must indicate if the condition was present on admission or not.
When we code conditions as present on admission, they are considered comorbid conditions. Conditions that are not present on admission are perceived complications regardless of whether we have assigned a complication code.

In cases when patients present after trauma or with acute bleeding conditions and acute blood loss anemia is present on admission, please indicate that in your notes—especially if the anemia is not documented until a day or two into the admission.

3. "Anemia due to acute blood loss, asymptomatic" is problematic documentation

To meet the definition of a reportable (codable) diagnosis, a condition must be evaluated, monitored, or treated (including continuation of outpatient medications during admission), or it must increase nursing care or lengthen the inpatient admission.

When you document “anemia due to acute blood loss, asymptomatic,” it creates a conundrum for coders. The use of the word “asymptomatic” implies to us that you were monitoring the patient for signs and symptoms. If the patient also meets the criteria mentioned in numbers six and five, we have a clinically valid, reportable diagnosis. However, we know from experience that payers will often deny acute blood loss anemia that is documented this way, arguing that it was asymptomatic and therefore insignificant.

We don’t want you to document that the anemia was symptomatic when it wasn’t. We don’t necessarily want you to stop documenting that the anemia was asymptomatic, but when you do use that word, it will help if you also indicate that you are monitoring the condition. “Acute blood loss, monitoring, remains asymptomatic”—it can be as simple as that. We still may not win in a battle with a payer, but we will have a better chance.

2. Unless a suspected condition has been ruled out, include it in the discharge summary

Uncertain diagnosis is the term coders have for a diagnosis documented with a qualifier such as:

- Probable
- Suspected
- Likely

- Questionable
- Possible
- Still to be ruled out
- Compatible with
- Consistent with

In the inpatient setting, we can code these uncertain diagnoses, if they are still suspected—and documented—at the time of discharge. This coding rule means that if you’ve documented “anemia, likely due to acute blood loss” in all of your progress notes, but just “anemia” in the discharge summary, you are probably going to get a query. He or she will likely ask if, at the time of discharge, you still suspected that anemia was due to acute blood loss or another cause.

1. CDI and coding staff do not query for no reason/when it does not matter

When we query you, it’s not because we like to annoy you and waste your time. Far from it! We work hard to write queries that are intelligent, succinct, and necessary. We do have some rules about how and what we can ask you, though. We can’t just tell you directly what to document. We can’t tell you how a query will impact the reimbursement or quality reporting either.

We hope that if a query is confusing, unclear, or just way off base, you will communicate with us about it. I would always prefer a reply explaining why my query is “stupid” than no response at all. When you don’t respond, we don’t know what went wrong—and that means we’ll likely do it again. It also means you don’t know why the query is necessary—and that means you’ll get it again.

We hope you’ll come to trust that when we query you, it’s because we don’t have enough information to complete the chart without clarification, we are trying to improve the observed to expected ratio for things like length of stay, severity of illness, and risk of mortality, or we’ve identified what appears to be a clinically valid and appropriate way to improve reimbursement. Sometimes, it is all of the above.

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